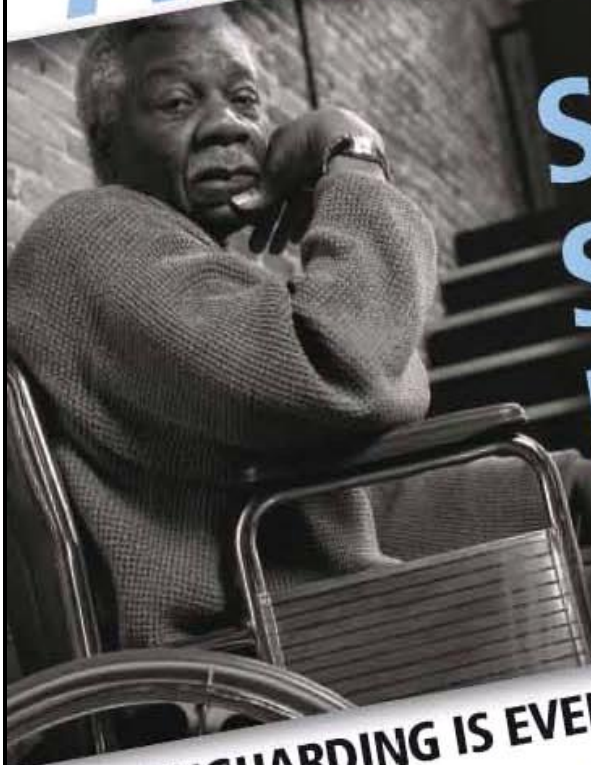




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Adults Board
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Annual Report 2012- 2013

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Introduction/Foreword (2012-13)

I am delighted to introduce this year's Annual Report on behalf of the Luton Safeguarding Adults Board. Publication coincides with the Care Bill navigating its way through Parliament. When enacted, it will profoundly influence – and arguably significantly enhance – the role of Local Safeguarding Adults Boards (LSABs). The Board contributed to national consultations, which preceded the drafting of the Care Bill, and continues to strive to implement best practice derived from standards for effective governance of adult safeguarding policy and practice (Braye, Orr and Preston-Shoot, 2012).

Part of good governance is publication of the Annual Report. The inquiry into events at Mid Staffordshire NHS Trust has reported (Francis, 2013) and there are salient lessons to be learned for commissioners, providers, regulatory bodies and safeguarding boards, not least around information sharing and taking seriously people's escalation of concerns. Perhaps the most important is that patients/service users should be put at the centre of what organisations do rather than performance targets. The lessons from Winterbourne View (DH, 2012) have also been at the forefront of the Board's attention, with provision for learning disabled and mentally distressed service users reviewed in line with government guidance for good practice. Once again, there are salient lessons to be learned, including the need for sound complaints procedures and whistle blowing procedures, and effective monitoring and inspection of service provision. These benchmarks of quality will continue to govern how the Board holds its statutory partners, and the wider partnership network of domiciliary and residential care service providers, accountable.

Serious Case Reviews continue to attract greater media interest in safeguarding adults at risk. In this Annual Report, the Board reports on the conclusion and publication of the Inquiry into events on Ward 17 at Luton and Dunstable NHS Trust hospital. The Board, alongside the local authority's Overview and Scrutiny Committee, continues to monitor provision for vulnerable people at the hospital, including on discharge, the outcome of which is described in this annual report. The Board is also participating in a national initiative, Making Safeguarding Personal, in order to learn from best practice elsewhere in England. Next year's annual report will report on this initiative in more detail.

Mindful of the above, and as the Annual Report details, partner agencies have participated fully in the implementation and ongoing review of the service redesign of the structures for the governance and delivery of adult safeguarding in Luton. The Board is now appropriately resourced both financially and in terms of senior executive leadership. I am pleased to report that the new arrangements have begun to work well and are being continually refined on the basis of experience.

There is now effective engagement with senior leaders in partner agencies and with those responsible for strategic policy development and operational delivery.

Quarterly reports are scrutinised on the safeguarding standards and outcomes of the Board's statutory partners. Equally, much closer attention has been paid to ensuring that appropriate standards in residential and nursing care homes are being met, with beneficial outcomes in terms of standards of provision. The adult safeguarding implications of hate crime, gun crime and sexual exploitation are being given greater prominence by the Board.

Action plans from the SCRs or investigations, covered in the last annual report, have been completed. The action plan derived from the Inquiry into Ward 17 is monitored regularly and good progress has been made in implementing the recommendations of that investigation. Jointly with the LSAB covering Central Bedfordshire and Bedford Borough, work continues to align as closely as possible sub-groups, policies, procedures and practices across the three local authority areas in Bedfordshire in order to maximise efficiency and effectiveness at this time of financial austerity.

I am grateful to all those managers and practitioners who seek to ensure that adults at risk are safeguarded and who uphold the highest standards of care and support. I hope that you find the Annual Report informative and reassuring, even though the practice surrounding the safeguarding of adults at risk is always complex and frequently challenging.

References

Braye, S., Orr, D. and Preston-Shoot, M. (2012) 'The governance of adult safeguarding: findings from research'. *Journal of Adult Protection*, 14 (2), 55-72.

DH (2012) *Transforming Care: A National Response to Winterbourne View Hospital. Department of Health Review. Final Report*. London: Department of Health.

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive Summary*. London: The Stationery Office.

Professor Michael Preston-Shoot

Independent Chair

(Professor Michael Preston-Shoot, is also Independent Chair of the Safeguarding Children Board,)

Executive Summary

This Annual Report covers the period July 2012 – August 2013. The performance data in the report covers the period 1 April 2012 – 31 March 2013.

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?* Progress against priorities for 2012-13, 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. The final section covers Priorities for 2013/14.

Acknowledgements

The Board would also 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

In line with recommendations made by the Law Commission and the Government in 2011 Safeguarding Adults will be put on a statutory footing.

Draft Care and Support Bill

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

- A duty to make enquiries where the local authority has reasonable cause to suspect abuse or neglect of an adult at risk (Clause 41).
- A duty to share information about a person for safeguarding purposes (Clause 44)
- Safeguarding Boards will be placed on a statutory footing with a minimum core membership of the local authority (which retains the lead for adult safeguarding); the police, and the clinical commissioning group (Clause 42).
- Safeguarding Adults Reviews will be statutory and will replace serious case reviews (Clause 43)
- Section 47 of the National Assistance Act 1948 (which gives a local authority power to remove a person in need of care from home) will cease to apply to persons in England
- Within the overall unifying principles of the Bill:
 - The well-being of the individual is paramount
 - Local authorities must promote the individual's well-being in all decisions made with and about them
 - 'Well-being' is the outcomes that individuals seek for themselves

Association of Directors of Adult Social Services (ADASS): Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services March 2013

The ADASS advice note is intended to fill the vacuum until the introduction of the Care and Support Bill by bringing together the impacts of recent changes, anticipating forthcoming changes and utilising learning from high profile cases, in order to provide Directors with a common approach. It complements but does not replace the robust guidance already set out in ADASS/LGA (Local Government Association) National Framework of Standards, Department of Health Guidance, No Secrets and its later update. The key messages from this guidance are:

- A focus on people and the outcomes they want, valuing the difference that is made; process is an important means of achieving good outcomes but is not an end in itself.
- Collaborative leadership - supporting, integrating and holding partners to account – is key to cross agency engagement and effectiveness.

- Effective interfaces are essential - with developing Health and Wellbeing Boards, Community Safety Partnerships, Safeguarding Children Boards.
- Responsive specialist services need to be in place and have a portfolio of responses to support people with difficult decision making.
- Ensure that concerns are addressed proportionately so that systems are not swamped and serious concerns are not missed.
- Commissioning, contracts management, care management review and safeguarding intelligence must be fully integrated.

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

March also saw the publication of the final report of a project run by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) to undertake some small scale development work in relation to Making Safeguarding Personal. This work which was overseen by a project group, and included our Chair Michael Preston-Shoot, draws together the findings from four test bed sites and other councils that are using or developing person centred, outcome focused responses to safeguarding adults. The report focuses on process, outcomes, impact on practice and cost effectiveness. (Note: we are now involved work to pilot this approach in Luton, see priorities for 2013-14.)

Statement of Government Policy on Adult Safeguarding- May 2013

Building on the statement of policy issued in May 2011 and the White Paper *Caring for our future: reforming care and support* published in July 2012 the Government issued a further [statement on adult safeguarding](#).

This reiterates the earlier statement of principles for Local Authority Social Services and housing, health, the police and other agencies to use, for both developing and assessing the effectiveness of their local safeguarding arrangements. It describes, in broad terms, the outcomes of adult safeguarding, for both individuals and organisations. It reinforces the government's six principles for safeguarding:

- **Empowerment** - Presumption of person led decisions and informed consent.
- **Prevention** - It is better to take action before harm occurs.
- **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented.
- **Protection** - Support and representation for those in greatest need.

- **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** - Accountability and transparency in delivering safeguarding

An [easy read version of this report](#) was published in August 2013

National reports inquiries and guidance 2012-13

In last year's annual report we referred to the Panorama programme on **Winterbourne View** and [the serious case review](#).

In December 2012 the Department of Health published its response *Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report*. This report focuses on:

- Strengthening accountability and corporate responsibility for the quality of care;
- Monitoring and reporting on progress;
- Tightening the regulation and inspection of providers;
- Improving quality and safety.

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

Linked to this in March 2013 the NHS Commissioning Board published *Safeguarding Vulnerable People in the Reformed NHS -Accountability and Assurance Framework*. This aims to:

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

In response to these reports the Safeguarding Board has received reports on Winterbourne View and Commissioning Learning Disabilities services at two of its meetings during the year.

The Francis Report into the Mid Staffordshire NHS Foundation Trust Public Inquiry published February 2013 has major implications for the NHS and social care system in terms of improving dignity and quality of care. Sir Robert Francis QC ends his report with the message to focus on what is truly important which requires:

- Emphasis on and commitment to common values throughout the system by all within it;
- Readily accessible fundamental standards and means of compliance;
- No tolerance of non compliance and the rigorous policing of fundamental standards;
- Openness, transparency and candour in all the system's business;
- Strong leadership in nursing and other professional values;
- Strong support for leadership roles;
- A level playing field for accountability;
- Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation

In recognition of the importance for all organisations of Robert Francis's Inquiry the Board received a report in June 2013 covering key messages from the Inquiry and the Governments response '*Patients and Service Users First and Foremost*' which was remitted with recommendations to health partners and Luton's Corporate Management Team.

Other Relevant Guidance published in 2012-13

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

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

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

ADASS, Prisoners and Safeguarding Briefing Note, April 2012

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

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

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

ADASS and LGA Guidance: Making effective use of data and information to improve safety and quality in adult safeguarding August 2012

The guidance points out that the questions SABs are most likely to want to answer are unlikely to be addressed by the performance reports that they currently receive. It asks SABs to consider what information they need to help them be more confident of spotting when things are starting to go wrong somewhere so that they can better safeguard people. The guidance recommends that to hold each other to account and effectively plan together SABs need confidence in a fuller picture that requires three fundamental questions to be answered:

- What data is necessary to run and understand the business?
- What intelligence is needed to plan for the future?
- And what evidence is required to show the impact of the service?

The guidance recommends that SAB leads draw up a matrix to describe what is available and identify gaps. While contents need to be determined locally, they are likely to include complaints, information from care management and police intelligence, as well as CQC intelligence, and locally gathered information about the quality of services.

Governance and Accountability

The Luton Safeguarding Adult Board (LSAB) undertook a full review of its governance, functioning and structure and implemented changes in November 2010. The Terms of Reference for the Boards was reviewed and amended slightly in June 2012 and have been updated for 2013 to take account of the demise of Primary Care Trusts and formation of Clinical Commissioning Groups and NHS England.

The membership of the LSAB reflects the Law Commission's recommendations and is in keeping with the Governments proposals for Safeguarding Adults Boards. The structure is outlined diagrammatically in appendix 1.

The LSAB has been chaired by Michael Preston –Shoot Dean of Social Work at the University of Bedford an independent chair since 2008. The independent chair also chairs the Operational Board and Serious Case Review Panel (SCRCP) and the Luton Safeguarding Children Board (LSCB).

The Luton Safeguarding Adults Board (LSAB) meets quarterly and is attended by Chief Officers and or their representatives.

The Luton Safeguarding Adults Operational Board (LSAOB) meets quarterly in the month before the LSAB. This board considers operational issues, performance data, an update on provider performance, and since January 2012 has also received partner reports. It remits reports and issues to the LSAB.

Serious Case Review Sub Group – has not met this year.

Pan Bedfordshire Sub Group – meets four times a year

The training and development, quality and audit and policy and procedure sub groups were amalgamated with those of the Joint Bedfordshire Safeguarding Board in the summer 2011. The joint sub group has enabled the three authorities and partners to report on their own activity across Luton and the county of Bedfordshire and has streamlined the work for the benefit of partners who work across the three authorities. This sub group continues to look at training and development, quality and activity, policies and procedures and the implementation of the Mental Capacity Act 2005. The sub group has been successful in developing one safeguarding alert form across the three local authorities to the benefit of all partners.

Safeguarding Developments and Changes in Luton

As LBC has the lead responsibility for safeguarding LBC changes and developments have been summarised below, followed by reports from statutory partners in the next section. Developments in community safety which reflect the work of the whole partnership are included at the end of the section on partner reports, following reports from Police and Probation, rather than here although the work is led by LBC.

LBC Adult Social Care Assessment and Care Planning Teams lead on safeguarding adults' investigations. These teams underwent significant restructuring in 2011-12, creating a larger central Safeguarding Adults Team and merging a number of other teams to form two Community Teams and a Discharge Assessment and Rehabilitation Team (DART) (based on two sites, one of which is in the Luton and Dunstable hospital). Safeguarding work is led and coordinated by the Safeguarding Adults Team who manage all of the work involved in alerts and enquiries and over 70% check of the work involved in referrals/investigations, with the remainder being managed by the other Assessment and Care Planning teams including SEPT.

In preparation for Luton becoming a commissioning led authority and because of concerns expressed by the Safeguarding Board and others about the quality of care services in the independent sector, a re-evaluation of commissioning needs within Adult Social Care led to a development of two new commissioning teams. LBC made the decision to separate out the planning and development activities of commissioning from procurement and quality assurance. As a result an integrated Commissioning Team with the PCT now CCG was formed and a new team for Purchasing (contracting) and Quality Assurance Team came into effect in July 2011. The work of this team is included overleaf.

Safeguarding Adults Team

The new Central Safeguarding Adults Team which also has responsibility for Mental Capacity Act and Deprivation of Liberty Safeguards began operating as a team managing alerts in summer 2012 although it was not fully staffed. The Strategic Safeguarding Manager took up her post in October 2012. The team consists of:

- A Strategic Safeguarding Manager
- 3 Safeguarding Managers to oversee the operational work
- 4 Safeguarding social workers (1 post has been covered by an agency social worker, because of difficulties in recruiting experienced social workers. An additional locum has been brought in to increase capacity for a temporary period)
- 4 (3.6 fte) Safeguarding Administrative workers

The three Safeguarding Managers each have lead responsibilities for specific areas of work, for example MCA DoLs, Domestic Violence, Children's Social Care and act as link managers for key partnership organisations, the L&D Hospital Trust; SEPT, CCS. The Safeguarding Adults Team also has a role in training future social workers and had one student on placement during 2012/13 and plans to continue this work.

The council and Safeguarding Board recognised the need to raise public awareness about Safeguarding Adults and a series of posters and leaflets were developed which show that abuse can happen to anyone not just older people. Awareness raising has also been promoted through an information section about safeguarding and abuse being included in a publication that was sent to all households in Luton as well as a newspaper article which included details about the safeguarding team and the ways to report concerns or suspicions of abuse.

The Safeguarding Adults Team has developed stronger links with Community Safety Partners and a link Safeguarding Manager has been identified to work closely with the MARAC and attends the Domestic Violence Operations Group. The Safeguarding Manager was involved in the multi agency response to recent gang crime activities.

The team works closely with safeguarding colleagues in neighbouring authorities to achieve a consistent approach to safeguarding adults. This is important for partner organisations such as the Police and the Luton and Dunstable Hospital as well care providers who provide services across the wider Bedfordshire area. (For update see Progress against Priorities 2012-13 Section)

The Strategic Safeguarding Manager regularly attends the Luton and Dunstable Hospital Safeguarding Committee and the Bedfordshire Police Safeguarding Committee.

A regular multi agency Safeguarding and Prevention meeting is held, attended by operational staff from health and social care at which intelligence and information is shared about provider services and improvement actions agreed.

The Safeguarding Team works closely with the Purchasing and Quality Assurance Team who monitor the majority of care services purchased from independent sector care providers in Luton. The Purchasing and Quality Assurance Team report quarterly to the Safeguarding Board on the quality of care services and the number of providers being monitored for improvements under the Escalating Concerns Procedure. The Safeguarding Team is also involved in Serious Concerns meetings concerning care providers held under this procedure.

Purchasing and Quality Assurance Team

The Purchasing and Quality Assurance Team previously worked through two sub teams. The Quality sub team who undertook contract monitoring of services regulated by the Care Quality Commission (CQC) and the Contracts sub team who were responsible for the contract monitoring of services that are not regulated by CQC. Due to changes in staffing an opportunity arose to develop the team in a way whereby officers now work across both regulated and non-regulated providers. The rationale behind this is that the fundamental standards of service provision in regards safeguarding, dignity & respect, choice and control etc are required across both regulated and non-regulated services. There are clear benefits in all staff working across both service types and using their skills and knowledge in different ways depending on the monitoring framework being used for the particular service type. An additional benefit is the ability of the team to be more flexible in both planned work and responding to crisis situations.

The Purchasing and Quality Assurance Team has been fully operational since November 2011 (although there have been a number of staff changes and the team is currently operating with vacancies). It has set up a programme of inspection/monitoring of all CQC regulated providers that Luton Borough Council purchase care services from who deliver services within the Borough. See page 56 for more information about care services that have been monitored in 2012/13. The team also monitor non-regulated services that were previously commissioned through the Supporting People initiative which includes services which provide for example housing related support.

Regulated care services within Luton are monitored and assessed against the East of England Contract which reflects the Care Quality Commissions standards. Officers have over the last nine months been working with ADASS members from other authorities to develop and pilot a new East of England regional monitoring workbook which incorporates all aspects of the CQC standards and additional contractual requirements as agreed with the regional LA partners. Following the success of the input provided by Luton officers in developing the monitoring workbook for regulated services it has been agreed that Luton will play a leading role in compiling and developing an ADASS workbook for non-regulated services.

At the regional ADASS meeting on the 4th September 2013 it was agreed that the workbook for regulated services which has now been fully tested by authorities will move from a pilot to formal status. As such, ADASS will collate reports submitted by each regional member and will produce reports covering the regional on a quarterly basis. These will demonstrate how service providers have been assessed as performing in each local authority area in comparison to other East of England areas.

Development of the workbook included devising a risk management tool which is completed on a quarterly basis and risk rates those services with the highest risk factors. The risk rating is based on factors such as: the number of safeguarding alerts, complaints, length of time since last CQC or LA inspection and change of manager. The Purchasing & Quality Assurance Team has been using this tool since May and it has proved very effective in helping to plan monitoring work.

Staff in the team work in partnership with the Designated Lead Safeguarding Nurse for NHS Luton to monitor and quality assure nursing home providers. Other key partnerships in relation to contract monitoring and management include internal partners' such as the safeguarding team, complaints manager, care management, brokerage and commissioning. External partners include the Care Quality Commission (CQC), Health professionals, Luton and Dunstable Hospital, environmental health and service providers.

Contract monitoring carried out in 2011/12 showed that the quality of Home Care (domiciliary) services was a particular concern and that local concerns reflected many of the wider national issues. It was agreed that LBC would undertake a tender exercise with the chosen model being that of a Strategic Partnership with the intention of developing closer partnership working and greater quality improvement in this service area. The tender exercise was completed in December of 2012 with notification of contract awards undertaken in January 2013. Due to challenges made by providers who were not

successful in achieving strategic partnership status the start date for the new contract was delayed until 13th May 2013.

During the period between notification of contract award and contract start date the Quality Assurance Team worked in conjunction with care management colleagues to assess all customers whose home care providers were not part of the new strategic partnership, to either arrange for them to change provider or revert to a direct payment arrangement. It was anticipated that there could be a spike in safeguarding referrals as a consequence of the contractual changes as this has been the experience of other local authorities who have undertaken similar exercises. To date this has not been the case locally; however safeguarding alerts continue to be monitored. This was a challenging period for all involved.

Financial pressures continue to be of concern from feedback given by local residential service providers. The ongoing fall in demand locally for residential beds continues, causing some of the smaller independent providers to suffer high void/ under occupancy levels. Providers are also highlighting inflationary increases in their running costs as a further pressure. This means there are risks around the suitability of some service providers in the medium term and the impact on the quality of service provided where the provider is struggling financially.

The Purchasing and Quality Assurance Team led on the inflationary increase in fee levels for in Borough providers for the year 2013/14 and negotiated an increase of 1.5% across all residential service providers. Moving forward the Team has requested that providers engage in an 'open book' approach to allow the team to fully understand cost pressures and inform the discussions for any potential inflationary increase for the coming financial year. The financial pressures which providers are describing has had a negative/ challenging effect on some of the relationships the Purchasing & Quality Assurance Team had built and requires a sensitive approach whilst reinforcing the requirement for providers to ensure service provision is still maintained at the appropriate level.

It is standard practice for care services to be audited by the 'Host Authority' and this process should become more consistent within the East of England as all authorities will be monitoring services against the newly agreed workbook. However, social workers and health colleagues will still need to play a vital role in evaluating how the service performs at the point of customer assessment /review and feedback any concerns accordingly. The Purchasing and Quality Assurance Team will continue to offer guidance and support to care management colleagues in relation to how they can best achieve this. The Team has developed its own systems for collating ongoing information on services. A tracker tool allows the team to collate all audits and their outcomes, as well as other information including complaints, safeguarding alerts and investigations. This helps the team maintain an overview of risks and historical data in ongoing involvement with a care provider.

During the year the team worked with safeguarding and other colleagues in reviewing and updating the Escalating Concerns Framework which is used in the event that a service is assessed as underperforming. One of the key changes is the implementation of a 'Liquidated Damages' clause whereby the council can seek to recover reasonable costs from a provider in the event that the input in regards to contract monitoring activity is

assessed as over and beyond an acceptable level. The process is not used as a punitive measure but as a way for the council to recover reasonable costs and ensure monitoring activity is appropriately resourced in the event that a provider is draining the teams' limited staffing resource.

Challenges for the year ahead

The council is currently developing a new workforce development strategy which involves reviewing how we gather and interpret information about care provider staff qualifications and training through our contract monitoring. The aim is to procure quality care services which treat individuals with respect, dignity and compassion from providers who employ staff who have the required skills and competencies. This will include ensuring all health and care staff meets the standards set out in the new Code of Conduct and National Minimum Training Standards which will be launched later this year following the Government's response to the Cavendish Review in the autumn. We anticipate that this role out will be discussed further from a contractual basis within the ADASS Eastern Region working group as this may require some amendments to the monitoring tool kit and could lead to additional costs for some providers.

Further integration with the CCG over contract management, commissioning and monitoring of activities will also be a priority piece of work.

The development of the newly formed domiciliary care strategic partnership is imperative to drive up the standards of home (domiciliary) care within the Borough. The intention for the partnership is that it becomes self critical and reflective for both individual partners and more importantly the whole partnership and is able to move from a parent / child type relationship into a more progressive arrangement.

The Care Quality Commission is looking at changing the way they inspect services. The challenge will be to ensure that providers understand the differences in monitoring activity of the Regulator and contractual expectations of the authority and the challenges this may bring in implementing local escalation procedures under contract compliance. This requires the continuing shaping of our provider expectations about what is good quality, how they self assess this and act on this information to improve their services.

Dignity and Respect

The Purchasing and Quality Assurance Team continue to participate within a range of stakeholder meetings outlining the activities we are undertaking and ensuring that stakeholders understand our role and have clear expectations regarding the team remit. We have recently discussed with stakeholders how we have as part of the ADASS partnership agreed how we will measure Dignity and Respect within care services. Measuring Dignity and Respect is challenging because it means different things to different people and it is clear that is not simply a case of asking questions but in fact a combination of discussions and observations. As a team we are confident that the new ADASS toolkit, (which is still draft and under development), will provide a more evidence based approach to determining how dignity and respect can be achieved and maintained. The new toolkit has a 'Golden Thread' running through it which should assist in measuring dignity and

respect in each of the relevant standards. It will enable the team to consider elements such as:

- the way in which documentation is written, to determine if it reflects a person centred approach and demonstrates user involvement,
- staffing levels, so as to ensure users have appropriate time and support at for example meal times,
- evidence of users making their own choices and taking control, to enable us to check and assess the ability of the service to accommodate individual preferences, as opposed to service users being fitted into the service providers pre determined practice.

Training

The delivery of an effective Safeguarding Adults service depends on a competent and well trained multi-agency workforce. The LBC safeguarding training programme devised for 2012/13 was commissioned having identified the needs of the current workforce following a Training Needs Analysis, which included both statutory services and private, voluntary and independent (PVI) providers. The programme which was developed and run by the Corporate Learning and Development Team encompassed a cross section of training for staff within Adult Social Care (ASC) ranging from basic awareness, reporting and responding to safeguarding alerts, investigation knowledge and skills, chairing strategy meetings and taking minutes. The number of staff booked on training was 285, however the actual number of staff attending reduced to 247, again this was reflective of both statutory and PVI employees (see appendix 2 for details). Staff within ASC have been actively encouraged to undertake multi agency safeguarding children to ensure that staff are also equipped to recognise and effectively respond to concerns around the protection of children young people and their families. The delegates who have attended these events, to date have been identified as working with adults with learning disabilities, who support young people within the transition phase from children services into the adult sector. The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training programme for 2013/14 linked the learning outcomes required to support the competency based frameworks providing the underpinning knowledge staff will require to achieve the competency within their role and responsibilities. The embedding of the knowledge into practice of this training has remained the responsibility of the operational managers. In 2013/14 the impact of both safeguarding and MCA/DOLS training will be monitored by the introduction of a new quality assurance process which will be able to analyse the effect of putting into practice the learning gained.

Other public bodies especially NHS Providers including the hospital, community health and mental health providers arrange safeguarding training for their many employees. Training activity is summarised in their partner reports.

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:

• NHS Luton / Luton CCG from 01/04/2013	18
• Cambridge Community Services (Luton)	21
• The Luton and Dunstable Hospital	25
• East of England Ambulance Service NHS Trust	33
• South Essex Partnership Trust (SEPT)	38
• Bedfordshire Police	40
• Bedfordshire Probation Service	43
• Community Safety Partnership	47

Luton Clinical Commissioning Group /NHS Luton

Introduction

The NHS has had a widespread organisational restructure which has changed the way care is both commissioned and delivered nationally and locally. As part of the new arrangements NHS Luton ceased to exist in March 2013 and was replaced by Luton Clinical Commissioning Group (LCCG). LCCG is led by a highly committed group of GP's and allied health care professionals who has taken over responsibility for commissioning and monitoring the quality and safety of health services in Luton. LCCG will continue to be an NHS organisation.

One of LCCG'S priorities is to ensure vulnerable adults remain safe whilst they are in NHS care in Luton. This priority remains at the heart of all our commissioning planning and decision-making. We have continued to work in partnership with all agencies in the town to achieve this and make sure that all providers in Luton understand their role in the health and wellbeing of vulnerable adults.

The Commissioning Strategy for Safeguarding Adults 2012 – 2013 sets out Luton CCG's plans to improve its systems and processes to deliver high standards of safeguarding adults practice via our commissioning responsibilities during a time of significant NHS organisational change.

This annual report is produced to reflect on the progress in delivering the aspirations within the strategy during 2012/13, with reference to provider declarations, regular quality

reporting, one to one meetings between the provider leads for safeguarding adults and LCCG's Head of Adult safeguarding.

Workforce Development

Luton CCG completed an audit with GP practices in Luton and requested that each GP practice identified a safeguarding lead for their organisation; all 31 GP practices in Luton now have an adult safeguarding lead with direct access to support and advice through the Named GP for Safeguarding Adults.

As part of the training strategy the GP leads will be required to attend a face to face training session which it is anticipated will be delivered by the end of year (31st March 2014). This will be developed by the Named GP for Safeguarding Adults for LCCG and the Safeguarding Nurse for Adults for LCCG.

The LCCG safeguarding team have been promoting Skills for Health e-learning module for Safeguarding adults to all staff, CCG members and practice staff. This has been led by the Named GP for Safeguarding Adults. The module provides a basic level of training and education for Safeguarding Adults which will be built upon in the face to face sessions for clinicians.

LCCG also has an official GP extranet site which has a specific Safeguarding Adults section that is regularly updated by the LCCG Safeguarding Team and provides further information to all practices.

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

Strengthening Leadership in Health

LCCG'S Chief Officer is responsible for ensuring that the organisation has appropriate strategies, structures, policies and Procedures in place to ensure that adults are safeguarded from harm and abuse. The Director of Quality and Clinical Governance has an executive lead and attends the Safeguarding Adults Board together with the Named GP for Safeguarding Adults.

LCCG Head of Adult Safeguarding has responsibility for monitoring and assessing the level of safeguarding risk within commissioned services and ensures that the Chief Officer, the Director of Quality and Clinical Governance, board members and Commissioning leads are kept informed.

LCCG work in partnership with Luton Borough Council's Safeguarding Adults Team and social care staff, to ensure that patients and carers who require safeguarding are treated with respect and dignity and are central to any decisions made. We work with patients/ service users, families /carers and providers to achieve recommended improvements and meet the service user's desired outcome.

The provider services that LCCG commission include the acute hospital, community health services, mental health and learning disability services for Luton residents both locally and out of area. Safeguarding Adults is seen as a key priority when commissioning services; our providers are required through our contractual agreements to be compliant with all relevant legislation and regulations, which relate to the services they provide (e.g. The Care Quality Commission Essential Standards of Quality and Safety 2010).

We work closely with our providers to ensure safe, good quality services. A closely monitored quality-reporting schedule is in place with our main providers, this seeks to identify emerging issues in order that they are promptly addressed. Providers are also required to seek the views of service users and carers regarding the quality of their service. This evidence is used as part of a wide range of quality monitoring information and assists in determining achievements against set outcome measures.

Provider site visits are also undertaken where the views of service users and families are also sought. LCCG also works proactively and in partnership with the local authority in carrying out quality audits within our local nursing care homes. This enables first hand monitoring of services and includes face-to-face contact with service users and their families.

Outcomes and Improving Experience

Neglect is the main category for safeguarding referrals received into LCCG, it is therefore seen as a priority to work with our providers in achieving the NHS ambition, which supports 'Harm free'.

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

The top five themes for 2012/13 were as follows;

- 1) Neglect
- 2) Physical
- 3) Pressure Care
- 4) Poor Discharge
- 5) Medication

Pressure Ulcers are the highest reported serious incidents (SIs), with falls resulting in fracture being the second highest reported incident. The majority of patients developing a pressure ulcer are patients who have multiple co-morbidities, are elderly and may decline pressure relieving equipment until the pressure ulcer has developed. In some cases assessment of pressure areas has been incomplete; however, the "SSKIN bundle" is now being introduced by providers, which includes skin inspection risk assessment and treatment. The Clinical Commission Groups host a 'Harm Free' Care Group and County Wide Pressure Ulcer Group in which data is reviewed, both from SIs and the Safety

Thermometer and recommendations and actions are shared. Representatives from all providers attend both these groups. Initiatives this year includes pressure care training to care home staff, and a review of the publicity material on pressure ulcers in order to take forward an awareness campaign. The providers also participate in the 'Pressure Alert' System in which pressure ulcers that have occurred outside the providers care are passed to the relevant provider and if necessary raised as an SI or shared with the Safeguarding Team.

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

Improvements made in Adult Safeguarding during 2012/2013, addressing the priorities

The adult safeguarding database has been enhanced to capture themes and trends with providers. This has proved useful in identifying problematic discharges from the acute trust. An action plan was compiled by the trust and work is being undertaken to address the themes identified.

Data sharing from the acute trust in relation to hospital admissions from care homes helps to identify independent providers who may require extra support or reasons for admission that can be avoided.

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

Improvements planned in Adult Safeguarding during 2013/14 addressing the priorities

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

A New Director of Quality and Clinical Governance has been appointed who starts work in September and a new Head of Adult Safeguarding for LCCG has recently been appointed, to start work in October. Priorities for the post holder include:

- To commence face to face safeguarding training with Luton GP's, (working with the Named GP for LCCG) and for the continuation of promoting safeguarding awareness training at Health professionals meetings.

- To monitor and act on incidence of pressure ulcer reporting, via the 'serious incident' (SI) reporting process.
- Developing a strategy to capture patient experience; to listen and learn from the patients and public to gain a greater understanding. This will be used as an early warning indicator and support the commissioning of pathways based on patient views.

Cambridgeshire Community Services (CCS)

Introduction and Background

This report outlines the work, which has been undertaken by Cambridgeshire Community Services Luton Unit (CCS) over the past year in respect of its commitments and responsibilities in maintaining the safety and protection of vulnerable adults. The report explains the principles of adult safeguarding and also identifies national developments, as this important issue continues to advance across all aspects of social and health-related care. It contains a review of LCS' progress against national and local commitments during 2012, and identifies key objectives for further developments in safeguarding for 2013/14.

As part of CCS Luton's adult safeguarding responsibilities it is required to provide representatives as board members on the local multi-agency safeguarding adult boards. CCS is currently represented on Luton Safeguarding Vulnerable Adults Boards and is an integral decision maker in the development and progression of the local safeguarding agendas. The CCS representatives play a key role in informing both multiagency boards on the development of safeguarding pathways and initiatives specifically related to healthcare in the primary care sector. CCS is also represented on the safeguarding board sub-groups.

The Named Nurse for Safeguarding Vulnerable Adults (NNSVA) represents CCS Luton on multi-agency boards and is responsible for:

- Providing leadership across CCS in relation to adult safeguarding;
- Advising internally on all matters relating to safeguarding and CCS' obligations in terms of compliance with local and national policies and outcome measures;
- Continuous development of internal strategies to maintain compliance with the evolving national safeguarding agenda;
- Delivering training;
- Developing a training strategy that meets evolving national guidance;
- Frontline liaison and support for clinical managers;
- Actively participating in safeguarding strategy meetings and case conferences;
- Supervision of CCS staff in relation to adult safeguarding cases.

Training

CCS ensures that all staff working with patients have undergone basic awareness training in safeguarding vulnerable adults.

An updated training needs analysis was undertaken in 2012 and in order to have continuity across all areas of Cambridgeshire Community Services and it was decided that all staff, clinical and non clinical, will receive basic awareness training on a two yearly basis. Basic awareness training has been provided in house for CCS staff, face to face training is provided by the named nurse for patient facing staff, non patient facing staff have the option of a two stage e-learning package quality assured through the NHS Core Learning Institute. The NNSVA will continue to work with the Safeguarding sub-group for Learning and Development to develop a new approach to Multi-Agency Training and to explore the ratification of partner provided training.

85.5% of staff as of 31st July 2013 (target of 95%) have completed level 1 training. The NNSVA has undertaken additional training in Mental Capacity, Deprivation of Liberty Safeguards, Safeguarding and The Law, Domestic Homicide Report Writers Training and Safeguarding and the Human Rights Act. The NNSVA was funded by the Joint Improvement Partnership to undertake an MSc module in Safeguarding Adults which was successfully completed in 2012.

Clinical supervision has been established throughout CCS clinical services with all clinical staff having regular access to facilitated supervision. The NNSA continues to provide a focused safeguarding session six-monthly to all existing clinical supervision groups.

Post-strategy meetings are held with staff as a supportive de-briefing exercise or to address concerns raised through the safeguarding investigation. This exercise supports CCS' disciplinary procedures.

Safeguarding Adult Competencies have been undertaken for all clinical staff within the Luton Adult Unit and will continue for non clinical and management levels.

Alerts and referrals/safeguarding investigations

During the financial year 2012-13 63 alerts were raised against CCS and CCS staff raised 102 alerts about concerns by others. All but one of the alerts raised against CCS concerned neglect or physical abuse by staff and all but six of the alerts raised against others concerned neglect or physical abuse. Eight of the 63 alerts raised against CCS did not meet the threshold and 39 were not substantiated, one was substantiated and another partially, the outcome on 14 cases is not yet known. Of the 102 cases raised against others, 22 did not meet the threshold for investigation, 12 were substantiated and 17 partially substantiated, the outcome of 51 cases is not yet known.

Safer recruitment and staffing related issues

The Care Quality Commission requires Primary Care Trusts and NHS Trusts to provide assurance that they comply with the standards laid down in the Essential Standards of Quality and Safety (March 2010). CCS is able to evidence compliance with CQC Self-

Assessment and to provide assurance that it complies with all the outcomes. Several of these have specific references to safeguarding. In particular, this includes, Outcome 7: Safeguarding people who use services from abuse; Outcome 12: Requirements relating to workers; Outcome 13: Staffing; Outcome 14: Supporting workers.

The Disclosure and Barring Service (previously Criminal Records Bureau) checking process is now managed electronically, which has significantly reduced the time taken for staff to get clearance. This means that there is no need for any staff member to start in a post without clearance.

A policy for the management and support of staff subject to domestic abuse has been ratified and is designed to increase line management awareness of the issue of domestic abuse and to provide support within the working environment in addition to identifying the availability of external support services and promotes intervention via MARAC.

The named nurse for safeguarding and named nurse for children's safeguarding have initiated a work stream with the local Public Protection Team to review the pathways for information sharing of known risk to staff and patients.

PREVENT

PREVENT is one element of the government's anti-terrorism agenda. PREVENT specifically focuses on the pre criminal space relating to individuals who are or have been groomed by violent extremists and aims to support and de-radicalize these individuals. CCS Luton has two DOH/ Home office approved training facilitators for the delivery of the Workshops to Raise Awareness of PREVENT (WRAP) and is a member of the SHA Advisory Group. A roll out of PREVENT training is currently underway in CCS. PREVENT pathways and protocols have been developed. The NNSA is a member of the Eastern Region PREVENT in addition to membership of the Luton CHANEL.

Joint Improvement Partnership

The NNSVA continues to work with the Eastern Region Joint improvement Partnership Safeguarding Adults Programme to review the role of and engagement of Health Partners with local Safeguarding Boards.

Datix

All adult health care incidents are reported via Datix and are reviewed weekly by the NNSVA, to identify trends in safeguarding concerns and to overview un-reported safeguarding incidents. Agreement has been made to share identified trends in Datix reported concerns concerning Domiciliary Care Providers and Residential and Nursing Homes with LBC Adult Safeguarding Team and LBC Quality Team formally at the monthly Prevention and Safeguarding Meeting.

Pressure Damage

CCS has a Safeguarding page on its intranet site which is accessible to all staff which includes all policies, publications, documents and training. Adult Safeguarding and Child

Protection notice boards are also maintained at CCS Adult Services bases and publicity posters and information sheets are available in areas of public attendance. .

Clinical staff are provided with a laminated safeguarding referral flowchart to support recognition and reporting of incidents of abuse. This has been updated to reflect the changes in structure at the Clinical Commissioning Group and Luton Borough Council Safeguarding Team.

The named nurse for safeguarding holds monthly surgery sessions for clinical staff to attend as a forum discuss their concern for patients who are either non compliant with care or perceived to be 'self-neglecting'. The forum identifies management strategies, supportive services, documentation and communication with partner agencies and frequently hosts multi-disciplinary case review meetings.

Following the release of the Francis report the CCS Chief Nurse has undertaken a series of workshops focusing on the domains of dignity and respect within our services, this work will continue to be embedded in the next 12 months.

Work plan for 2013-14

This includes:

- Ongoing revision and delivery of level 1 training to achieve 95% attendance;
- Continue to develop our multi-agency role in the active development of safeguarding adults;
- Development and roll out of competency framework
- Pursue pathways for information sharing with Children's safeguarding and Public Protection.

The Luton and Dunstable Hospital

Prevention and raising awareness

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

The Trust intranet-safeguarding site, that was launched in August 2011 and has been continually updated since, was designed to support staff by providing access to information, procedures, policies and referral forms. The information has also been available in a Safeguarding Folder in all clinical areas since October 2012. This has been a highly successful project with excellent feedback from staff, especially when trying to find forms and other documentation for referral and clarification of procedures.

In order to identify patients who have had previous safeguarding issues on admission or attendance to A&E, a 'Safeguarding Alert' has been installed on both the A&E and main patient information systems. This is crucial for the ongoing management of patients and will be particularly beneficial for discharge planning.

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

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

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

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

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

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

Workforce Development

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

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

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

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

Partnership working

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

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

The Deputy Chief Nurse and Operations Director attended an Overview & Scrutiny Committee Task & Finish Group: Hospital Discharge Review meeting with Luton Borough Council following concerns regarding discharges from the hospital. In response to this the group visited the hospital to understand the patient pathway and process from admission to discharge. The work is ongoing and now includes the Integrated Operations Manager for the Trust. The safeguarding Lead Nurse and the integrated discharge Manager continue to audit patient notes relating to management on discharge. This information is shared with the CCGs and the overview and scrutiny task and finish group.

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

Quality Assurance

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

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

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

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

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

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

Following the publication of the Francis report, the Trust set out its plan to brief and engage staff on the findings of the report. The approach taken was to hold a number of Trust wide listening events, the purpose of which was to engage and listen to as many staff as possible, identify key risks and early warning signs that the organisation face and agree and prioritise actions. The key message and aim was to create a common patient safety culture across the Trust where 'patients not numbers come first'. A review of the Department of Health publication 'Patients First and Foremost - the initial government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry' has also been undertaken

In addition to the internal Trust projects, we have been working with our UCL Partners to accelerate improvement in light of the Francis report. Led by the Chief Nurses and Medical Directors across UCLP, a small number of carefully chosen initiatives have been prioritised;

- Understanding and measuring what matters to patients (developing a ward health check)
- Understanding what matters to patients (developing the UCLP Promise)
- Understanding and acting on what matters to staff

- Developing ward sister training and accreditation

Involving People

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

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

Outcomes and Improving Experiences

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

- Robust performance management and monitoring of safeguarding adults arrangements to drive service improvements. All safeguarding adult alerts/referrals are reported to the Trust Board and Executive Team through COSQ (Clinical Outcomes, Standards and Quality) reporting structure and reported externally to Adult Safeguarding Boards.
- Monitoring and ensuring that staff safety briefs identify and consider the needs of vulnerable individuals. All vulnerable adults with safeguarding concerns are identified daily and recorded as part of the matron 'walkabout' Regular monitoring and audit of safeguarding knowledge and practice is undertaken through the Nursing Assurance Framework which is linked explicitly to the CQC outcomes. This includes self, peer and external peer assessment. The assessment consists of questions and observations to both patients and staff
- Multi-agency pan Bedfordshire sub-group working focussing on learning from safeguarding investigations and identifying themes, trends whilst holding partner organisations to account for outstanding actions. NHS Luton and L&D Hospital Safeguarding Leads meeting with Luton Borough Council Adult Safeguarding Social Worker monthly to review all open cases involving L&D Hospital, ensuring all parties are aware of the progress of the case and agreed plan of action. The outcomes of the meetings are shared with the CQC by LBC in accordance with reporting requirements

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

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

Improvements to Discharge

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

The Trust has also been working in collaboration with Health Scrutiny and Social Care partners to examine and identify ways to improve services and patients' experiences of discharge from hospital. Some of the key actions include:

- Introduction of discharge facilitators on all wards
- Reducing the time patients have to wait for their medication to take home. The Trust is currently undertaking a review of Pharmacy services to identify the blocks in the system and improve the service to patients.
- Ensuring Doctors complete the discharge summary letter which includes the prescription so that medication can be dispensed in a timely manner thus expediting a safe, early discharge.
- Generally patients will not be discharged after 9pm to their own home and 6pm for Residential and Nursing homes and rehabilitation beds
- Use of a 'Stamp' that is used in the medical notes to denote that the patient has had a 'safe' discharge. This is clearly signed by the responsible nurse.

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

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

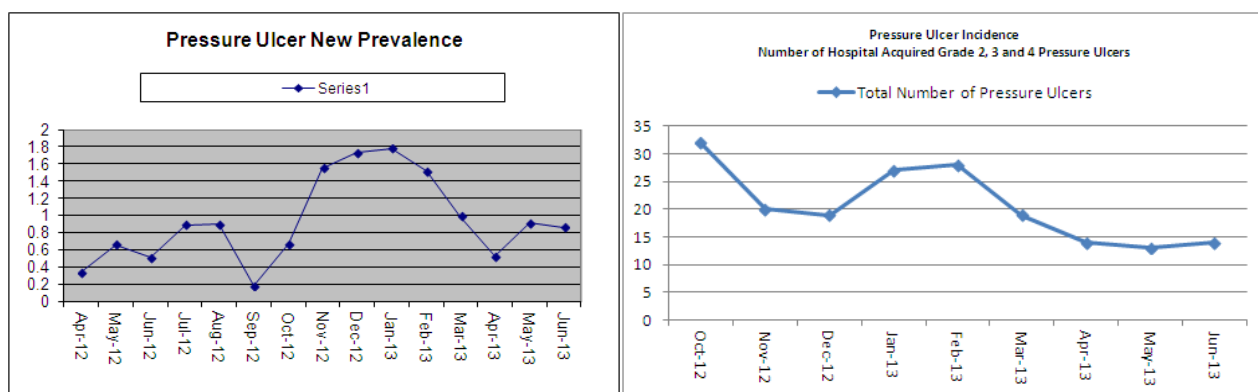
The Voluntary Services Manager has secured a volunteer from the Alzheimer's Society to set up a Dementia Support Service, based in Elderly Care Unit on a bi weekly basis commencing May 2013 as part of Dementia Awareness Week. We have continued to improve care for this client group in line with the National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

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

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

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

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



Key issues arising during 2012/13

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

The geographical position of the Trust has created some challenges when raising alerts with the local authorities; as highlighted in the Ward 17 Inquiry Review published in January 2013. The publication of the revised ADASS protocols in January 2013 clarified that the

location where the abuse occurred determines which local authority the alert should be sent to but there is still a need for partner agencies to agree the process and embed the changes in practice in line with the recommendations of the Ward 17 Inquiry Report.

Improvements made in adult safeguarding during 2012/13

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

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

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

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

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

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

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

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

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

Improvements planned in adult safeguarding during 2013/14

Prevention and raising awareness - The PREVENT agenda is particularly important for the L&D given the demographic and cultural mix of the local population; the area has been identified as one of the top 3 high risk areas nationally. Trust staff need to be aware of the

early warning signs that someone may be at risk of being coerced or in the process of planning terrorist activities and how to escalate this concern to the appropriate authorities.

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

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

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

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

Partnership working - The Safeguarding Lead Nurse and Executive Director for Safeguarding will continue to work in Partnership with LBC to improve outcomes for patients, communication and processes across the system, responsiveness to alerts and agreeing what is an appropriate level of response to an alert.

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

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

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

East of England Ambulance Service NHS Trust

Prevention and raising awareness

The Trust has processes in place to inform all new members of the Trust workforce of their responsibilities regarding safeguarding members of the public who use our services.

Training is mandatory of all operational and non-operational staff and is integral in professional updates annually as well as all basic training programmes.

The Trust has a low threshold for referral and operational staff are informed to relay any concern through to the local authority and GP as the issues arise.

It is often difficult for Trust staff to gain a full insight into the patient/person's lived experience and therefore the Trust believes a low threshold for referral is the safest measure the Trust can have in place.

Often the Trust does not have much knowledge of the patient/person prior to the 999 contact and as such it is often difficult for the Trust to take action prior to harm occurring. However where possible, when Trust staff do have concerns for the safety of a patient they share the information known with the relevant professionals.

The Trust has process in place to identify frequent callers; this process identifies monthly, people using the 999 service. The Trust has a process of evaluating the frequency via a stipulated process set out in the Trust policy (this is also part of a National evaluation process within Ambulance Trusts). Once a person is identified then their information is checked with the Trust safeguarding team, where the safeguarding team are aware of the person, the safeguarding team will check with the person's GP and the local authority to see what actions have been taken from the information previous shared via a referral.

Workforce development

Safeguarding is integral to appropriate work streams, the Trust safeguarding team works closely with areas of the Trust such as PALs and Complaints, HR and operations to ensure that effective communication is initiated at the time any incidents become apparent or where concerns may be notified by an external agency.

The Trust has robust policy and procedure inclusive of Safeguarding adults, children and consent and capacity.

The Trust reports quarterly to the board to inform of any issues or concerns in service delivery.

Clear lines of accountability are identified within the Trust structure. All staff have access to line managers and clinical managers who have received training in safeguarding, as well as access to named professionals.

The Trust was visited by the CQC in January 2013. The CQC was focused on safeguarding specifically as part of their evaluation of the Trust.

The CQC found:

- Safeguarding team within the trust who offer expert advice and guidance on all safeguarding matters
- Complete safeguarding quality audits across the trust and ensure the trust's policies and procedures were robust

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

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

Partnership working

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

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

Quality Assurance

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

- An audit of the referrals numbers made by staff and what areas of the Trust they have been made by
- The quality of the referrals made by the Out of Hour (OOH) call handlers regarding data entry and accuracy of information
- The quality of the information supplied by the Trust member of staff making the referral
- Tracking the referral from 999 call through to the patient care record completed and referral data entered, the audit looks to see if the information ties up together and if environmental issues are recorded
- Feedback from the Local Authority (LA) and the General Practitioner (GP) is obtained. This process is to check what actions have been undertaken once the referral is made. Included in this is an assurance process of the Local Authority or GP having received and processed the information
- Auditing of the pathway selected by the Trust practitioners and to ensure that any referral made to the GPs for a vulnerable person has been made appropriately and does not need to be a safeguarding concern requiring the LAs focus
- The Trust has very closely monitored the referral pathway for vulnerable patients; this information is sent through to the patients GP the following working day
- The safeguarding team will check these referrals within three working days to ensure that the GP was the correct option and that there are no concerns that may require action from the LA
- A sample of Patient Care Record's relating to referrals are also audited

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

Involving people in development of safeguarding services

The Trust has a regular PPI engagement and the Head of Safeguarding has accessed this forum to gauge some support around having feedback from service users.

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

Outcomes and improving people's experience

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

Improvements made in Adult Safeguarding during 2012/13

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

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

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

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

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

Improvements planned in adult safeguarding during 2013/14

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

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

South Essex Partnership Trust (SEPT)

Prevention / raising awareness

A series of preventative and awareness raising initiatives have been implemented this year within the Trust and audits have evidenced that staff awareness and response to Safeguarding issues has improved in the timeframe process and quality of investigations. Analysis of all SEPT safeguarding cases is undertaken to explore any trends.

Workforce development

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

Quality Assurance

A weekly report is sent to the Trust Executive Team to give assurance of Safeguarding activity and compliance to timescales. The Trust Safeguarding Group monitors the Safeguarding action plan for assurance. The Trust has presented monthly reports to the Partnership Management Group and quarterly reports to Luton Local Safeguarding Adult Board.

Involving people in development of safeguarding services

The Trust has developed a Safeguarding Questionnaire for those subject to investigation. Feedback is reported regularly and influences the process of engaging service users, their families and advocates. Two 'Lets Talk' Service User and public events have been held across Bedfordshire this year. These are joint sessions where the safeguarding service is explained and discussed and participants have given feedback on the development of posters and leaflets etc. As a result new Safeguarding Leaflets have been developed and distributed to all Trust areas.

Outcomes and improving people's experience

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

Improvements made in adult safeguarding during 2012/13

Prevention / raising awareness - The numbers of referrals this year continues to rise and reflects the training programmes delivered which aim to raise awareness of safeguarding issues. Routine assessments now contain an assessment of risk and safeguarding issues which aim to identify potential concerns at an early stage thus preventing Safeguarding investigations being required.

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

- Reflective practice
- Investigations training
- Mental Capacity and DoLs
- Safeguarding introduction and Level 3

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

A focussed piece of work has been developed for staff working in inpatient areas. This work aims to raise awareness of service user to service user incidents and explore preventative measures. This work is on-going but has produced some excellent feedback from staff who now feel more confident in raising alerts and seeking advice.

Partnership working - The Trust continues to be active members of the Luton Safeguarding Board, Operational Group and Partnership Management Group. The Trust Associate Director and Safeguarding Practitioner have regularly met with the Luton Strategic Safeguarding Manager to improve systems and communication pathways in readiness for Luton to take over the decision making process following a safeguarding alert. Good progress and working relationships have been made.

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

Outcomes and improving people's experience - The process for investigating cases has continued to improve. 95% of Strategy discussions and Closures comply with the Local Authority procedures. The result has meant that service user concerns are responded to and processed effectively and that all service users are involved in the process where appropriate.

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

As a result of the Francis Inquiry the Trust has formed a number of groups to explore how services can be further enhanced for service users. The Trust has developed an electronic anonymous system for staff to raise a concern.

Improvements planned in adult safeguarding during 2013/14 include:

- Compliance for training is to be raised to 95%
- Continue developing joint working strategies with Luton Safeguarding Team
- The Trust Francis Inquiry programme will continue to be implemented

Bedfordshire Police

Introduction

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

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

Below are some of the headlines from the past year.

Workforce development

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

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

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

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

Management and membership change

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

Improvements made in adult safeguarding during 2012/13

Workforce development/ Partnership working

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

The police response to Hate Crime is managed by Chief Inspector Gavin Hughes – Rowlands and he has coordinated improvements in the way this crime is recorded and managed. The connections with this and Anti-Social Behaviour are well understood and

following a recent inspection Bedfordshire Police have been given positive feedback on the improvements made.

Raising awareness

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

Quality Assurance

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

Currently the Standard Operating Procedures (SOPS) for Vulnerable Adult and Child Safe guarding are being reviewed as part of the PPU improvement Plan, with new practices being included.

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

Outcomes / investigations

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

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

In the last year 1834 SOVA referrals were received / processed in the PPU Support Team. Of these, 121 were formally investigated by the Safeguarding Investigation Units with 55 investigations for the North of the county and 66 in the South (which covers Luton). Although this may appear to be a small proportion, the supervisors within the PPUST deal with many of referrals at source ensuring the police participate in strategy meetings where required and provide advice and guidance on police involvement. Should there be any disagreement on the level of police involvement escalation takes place.

The data below covers of the categories of abuse for incidents received by the PPUST and investigated by the north and south Safeguarding Investigation Units.

Category of abuse		North	South* (*includes Luton)
Physical abuse	269	14	24
Sexual Abuse	79	10	5
Neglect	223	6	4
Emotional	241	3	1
Financial	223	11	16
Other Concerns	860	12	15
<u>Total investigated</u>		<u>56</u>	<u>65</u>

Improvements planned in adult safeguarding during 2013/14

As previously mentioned there is currently a Post Implementation Review taking place within Bedfordshire Police where structures are once again being reviewed. The review will report back in the autumn and clearly the financial pressures will have some impact on decisions made.

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

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

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

Bedfordshire Probation Trust

Key issues arising during 2012/13

Over the last few years the Ministry of Justice published 'Breaking the Cycle', and 'Punishment and reform; effective Probation services'. Both consultation documents looking at the future delivery of community Probation services or community criminal justice.

These consultation documents used in conjunction with the 'Transforming Rehabilitation' programme agenda laid out plans on how the Government aims to rehabilitate offenders in the future.

The new ways of working included a 12 month statutory community supervision or licence for all offenders serving a period of 12 months or less in custody (not currently delivered by the Probation Trusts). The new ways of working also included a through the gate resettlement programme, opening up the majority of community Probation services to competition in the private sector and introducing payment by results incentives to new providers for reducing reoffending rates.

Since March, timeframe dates for completion of the competitive process and the implementation of new programmes of work have been set to start in the summer 2013 and completing with new contracts up and running by January 2015. The Probation Trust will be delivering 'business as usual' services to both offenders and partnerships until further notice. Changes to service delivery that may impact on partnership working will be communicated as the new processes are rolled out.

Prevention

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

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

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

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

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

Quality Assurance

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

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

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

Improvements made in adult safeguarding during 2012/13

Involving people.

2012 saw the commencement of BPT's offender engagement and service user feedback project. Over the last 8 months staff across the organisation have been involving victims and offenders in the planning, development and improvement of services delivered, it is now widely accepted that service users are experts through their own life experiences at knowing where problems exist in the criminal justice process and how in their opinion, measures can be put in place to improve service delivery.

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

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

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

Improvements planned in adult safeguarding during 2013/14

Workforce Development

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

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

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

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

Community Safety Partnership

Community safety partnerships (CSPs) are a statutory partnership of organisations who work together to create strategies and practical interventions to reduce crime and disorder in their local area. Members of these partnerships are known as the 'responsible authorities' and include the police, local authority, probation trust, Fire service and, from April 2013, Clinical Commissioning Groups (CCGs).

Key issues arising during 2012/13

The past year has been a period of significant change and challenge for the CSP as a result of both national and local developments.

Following the election of Police and Crime Commissioners in November 2012, CSPs no longer receive any central government funding despite retaining their statutory responsibilities. Consequently although both the partnership and the Office of the Police and Crime Commissioner are committed to developing strong working relationships and will share many common objectives there is likely to be an impact on the ability of the partnership to target resources at a local level.

Transforming Rehabilitation; the government's programme to overhaul probation services, also presents significant challenges for the CSP. The proposals; which see Probation Trusts' responsibilities split between a small national public sector service providing risk assessment and managing high risk offenders, and regional services operated by the private, voluntary and community sector (managing low to medium risk offenders) are to be implemented by 2014. It is currently unclear how the new providers will engage with the CSP in future, but, there is concern that the new providers will have fewer resources and broader geographical responsibilities and may be unable to match the pivotal partnership role played by Bedfordshire Probation Trust.

Locally, restructuring within the 'responsible authorities' has also had an impact on the CSP resulting in reductions and changes to staffing across the Police, Local Authority and Fire Service.

Outcomes

In spite of these changes the Partnership has remained focused and has continued to deliver reductions in crime and ASB across the town.

Over the past year, levels of all crime in Luton fell by 12% (this was a decrease of 2,085 offences, from 17,787 offences in 2011 to 15,702 offences in 2012). Offence specific data is provided below.

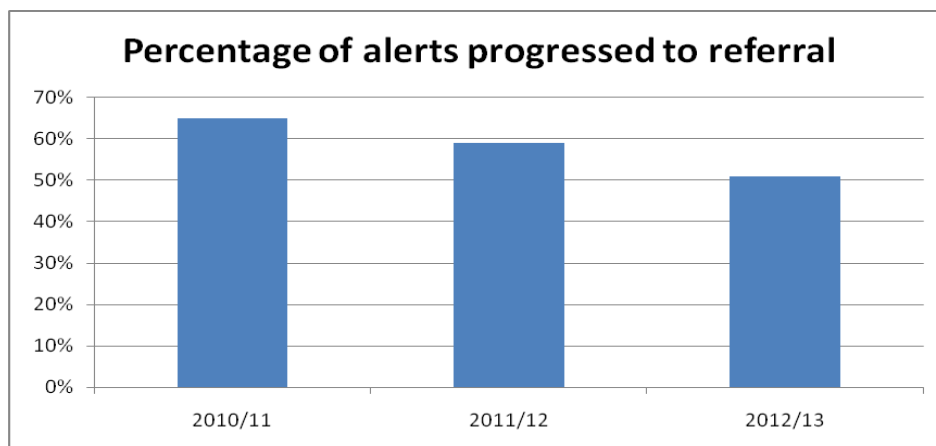
- Domestic burglary -1% (a reduction of 17 offences, from 1,652 offences to 1,635 offences)
- Criminal damage -15% (a reduction of 419 offences, from 2,797 offences to 2,378 offences)
- Violence against the person -17% (a reduction of 632 offences, from 3,706 offences to 3,074 offences)
- Anti-social behaviour -10% (a reduction of 1,322 incidents, from 13,347 incidents to 12,025 incidents)
- Environmental anti-social behaviour -20% (a reduction of 1,670 reports, from 8,313 reports to 6,643 reports)
- Domestic Violence Offences - Down 9% (A reduction of 117 offences from 1282 in 2011 to 1165 in 2012)

Other key areas of work for the CSP over the past 12 months have included the launch of the new domestic abuse strategy 2012-15, the development of the CSP's first on-street sex trade strategy, embedding the Priority Anti-social behaviour case management service, developing a Hate Crime policy and procedure and work to address serious knife and gun related violence in the town.

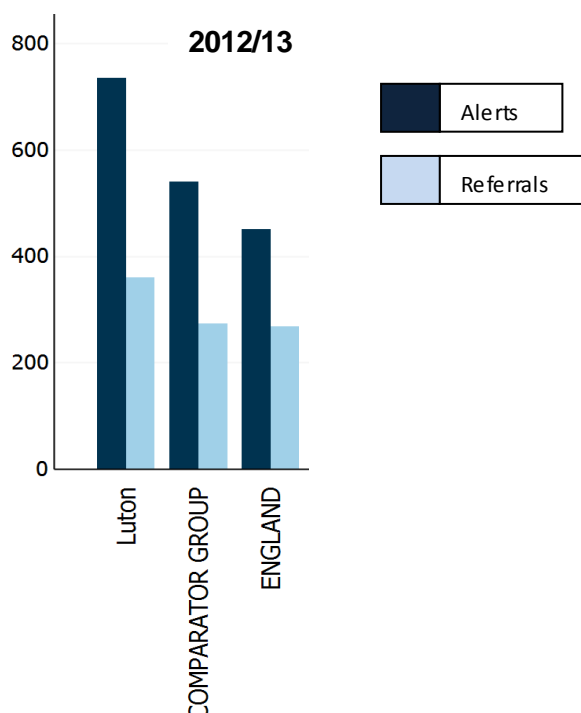
The policies and strategies referred to above have all been discussed at the Safeguarding Operational Board meetings to ensure coordinated working.

Data on Safeguarding and Mental Capacity Act & DOLS

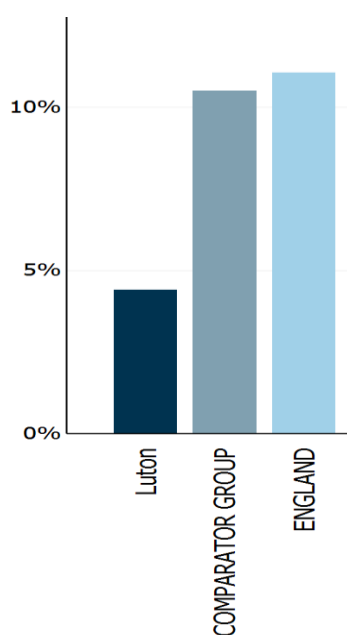
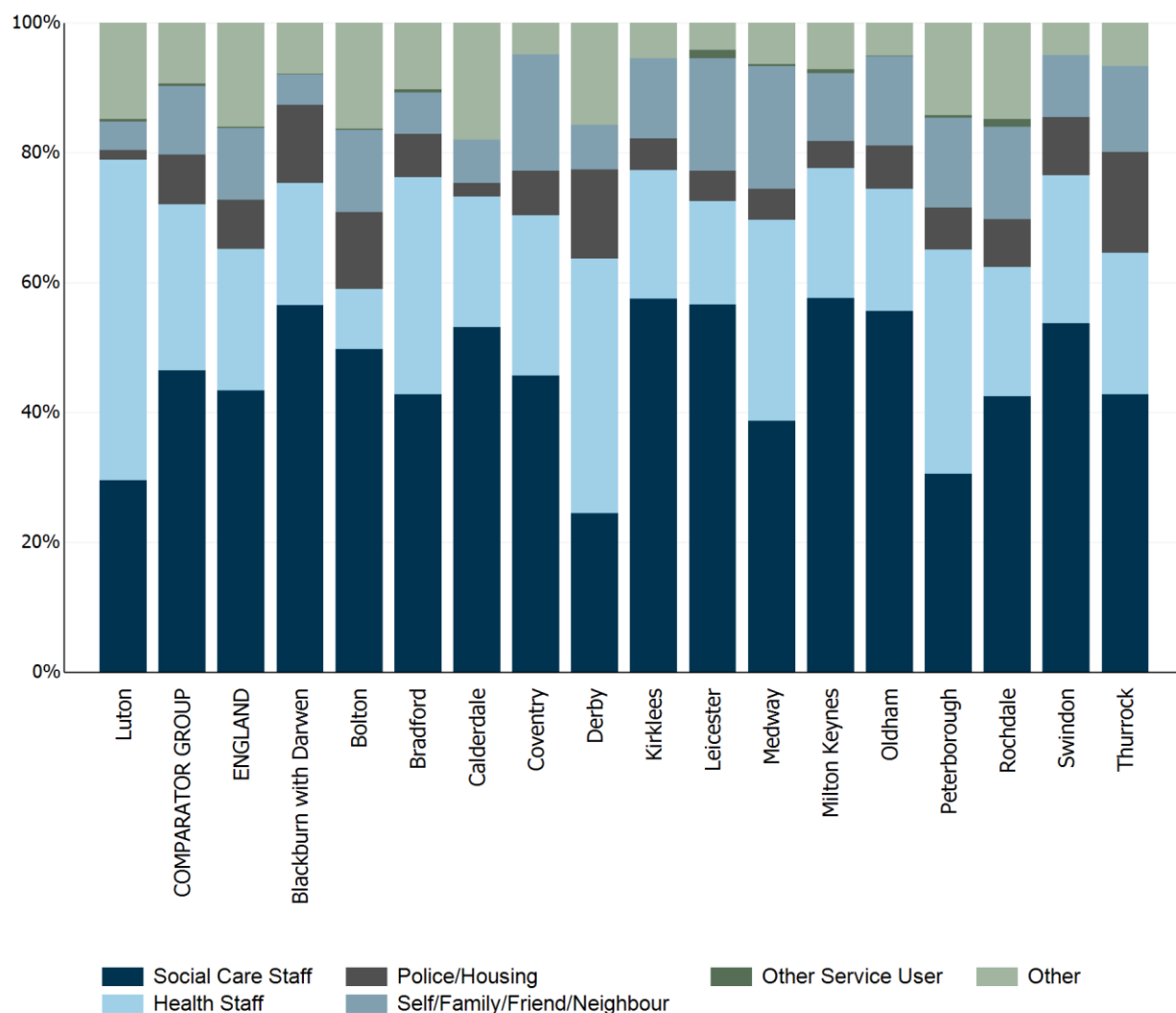
In 2012/13 Luton recorded 1113 alerts and 545 referrals (alerts that went on to be investigated) with 49% being dealt with at alert stage and 51% progressing to investigation. These numbers are both very high when compared to other councils, but show an increasing proportion being managed at the alert stage over a three year period. In our neighbouring authorities the percentage of alerts progressing to referral/investigation are lower, with only 26% progressing in Bedford Borough and 37% in Central Bedfordshire.



The chart below shows Alerts and Referrals for 2012/13 per 100,000 population, using NASCIS first cut data (which may be amended/updated). (The comparator groups are CIPFA Statistical Nearest Neighbours and all England). The data shows that Luton has a higher proportion of alerts and referrals than other authorities although this is beginning to change as clearer thresholds are being introduced.

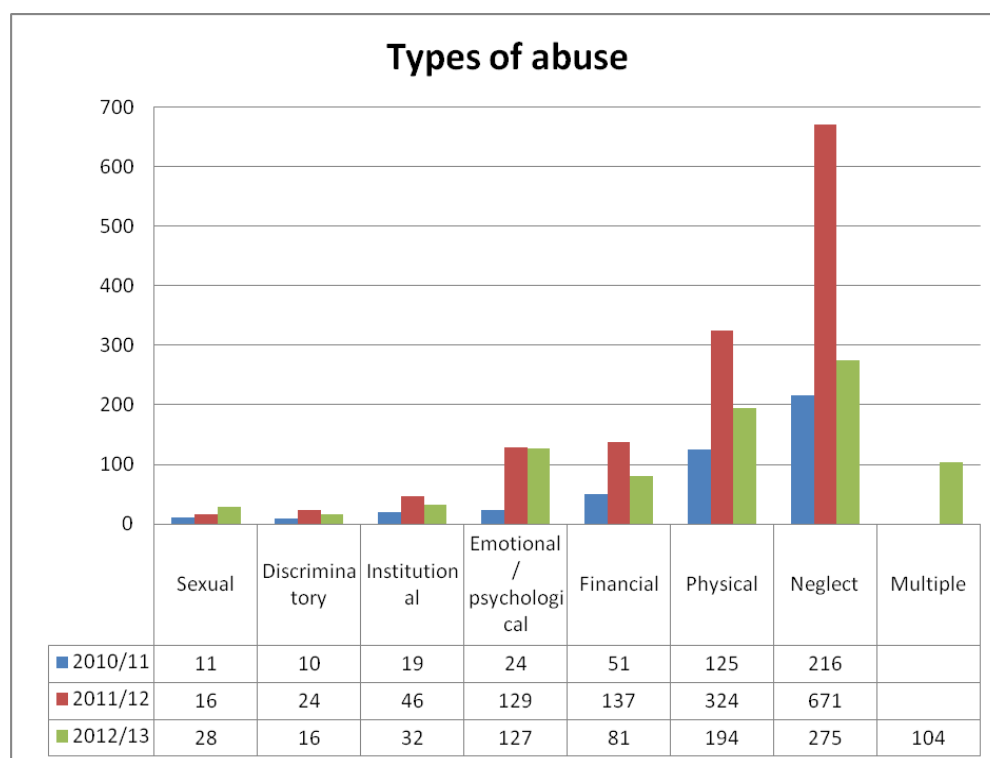


The high number of alerts and referrals indicates a high level of awareness about safeguarding amongst professional staff who reported 80% of referrals, with the highest proportion being made by health staff. However, as the graph below shows, levels of reporting by Police and Housing are low in comparison with others.



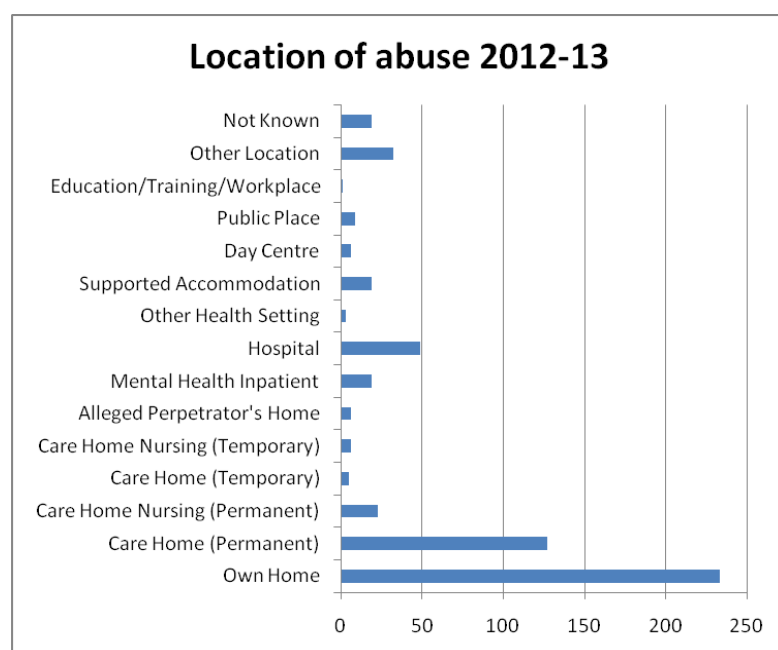
Luton also continues to have a lower level of reporting by self, family and friends than either other authorities in Luton's comparator group or England as the charts above and below show, indicating a need to continue to promote greater awareness.

In 2012/13 as the table below shows the **types of abuse** changed in several categories from previous years.



Notes: Clients may experience more than one form of abuse. Most alerts relating to pressure ulcers /skin tissue damage are recorded under the neglect or physical categories. In Luton the policy used to be to automatically refer all grade 3 and 4 pressure ulcers to safeguarding. For NHS organisations this policy changed at the beginning of 2012 with pressure ulcers being recorded as SIs and only referred to safeguarding where the pressure ulcer is considered to be avoidable. As can be seen this has reduced the number of referrals/ investigations captured under the neglect and physical categories in 2012/13.

Location of alleged abuse – 2012/13 data shows that the location of abuse in Luton is highest in the person's Own Home, followed by a Care Home, and then a Health setting.



Deprivation of Liberty Safeguards (DoLS)

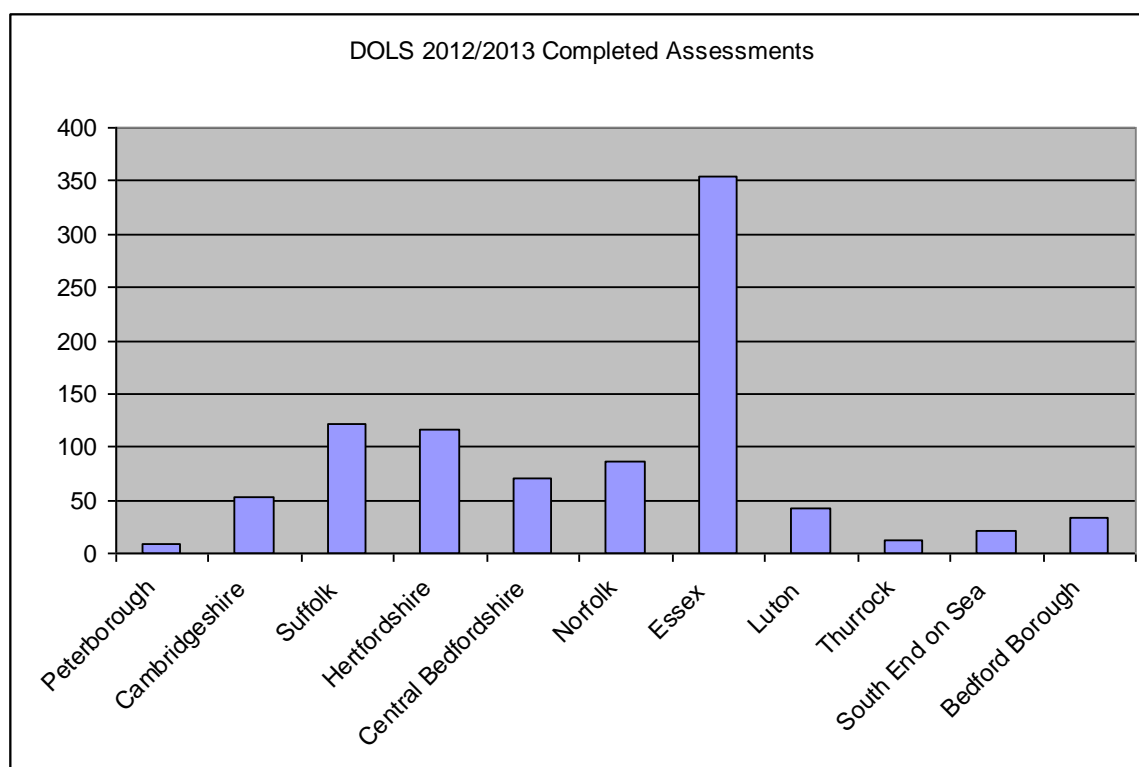
The Mental Capacity Act 2005, which provides a statutory framework for acting and making decisions on behalf of individuals who lack capacity, came fully into force in October 2007.

The Deprivation of Liberty Safeguards (DOLS) were added to the Mental Capacity Act to provide safeguards for some of the most vulnerable people in our society, those who for their own safety and in their best interests, need to be accommodated under care and treatment regimes that may be depriving them of their liberty, but who lack the capacity to consent.

The Deprivation of Liberty Safeguards were implemented on 1st April 2009 to ensure that any decision to deprive someone of their liberty is made following defined processes and in consultation with specific authorities. LBC has always also acted as the responsible authority for the PCT and for organising Best Interest Assessments and signing off any requests for authorisations for anyone in hospital or residential and nursing care homes. Along with all other authorities the Council formally took on Supervisory Body responsibility for Health from 1 April 2013.

In 2012/2013, Luton had 43 applications for Deprivation of Liberty Safeguards. Of these applications, 26 were granted and 17 were not granted.

The graph below shows assessments undertaken by supervisory bodies in the East of England in 2012/2013, indicating that the number of assessments undertaken by Luton is reasonable given the difference in population.

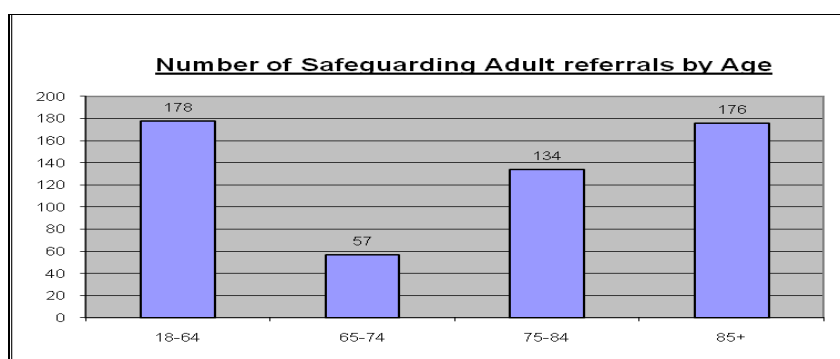


Equality Issues

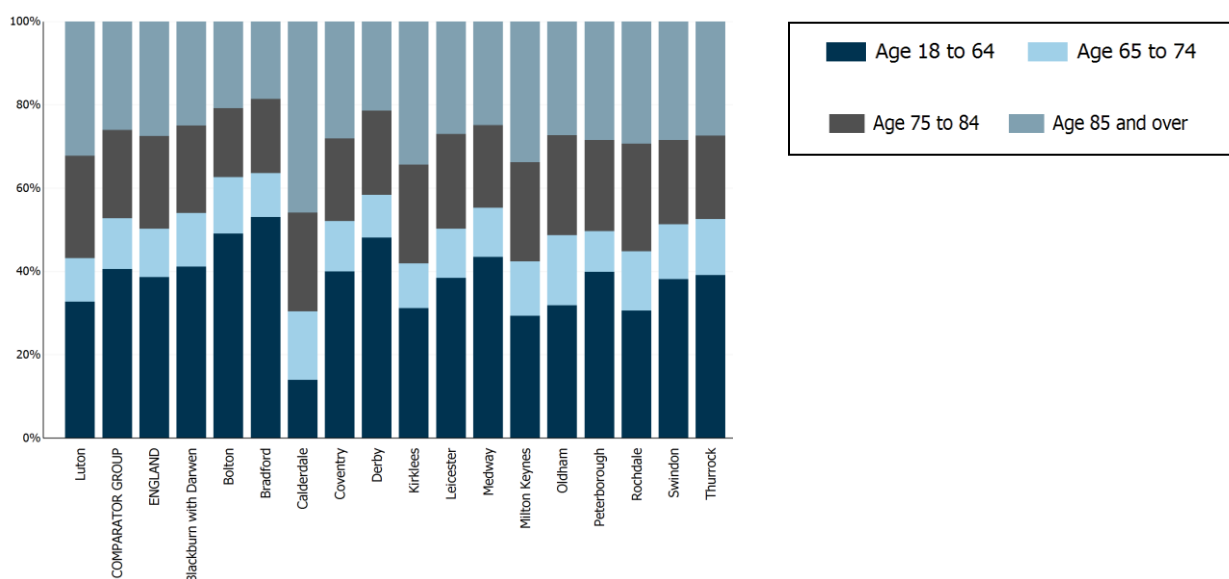
Under equalities legislation, public bodies have a particular responsibility to ensure that people do not suffer harassment or disadvantage because of “protected characteristics” including disability, gender, race, sexual orientation and religion. Safeguarding data makes it possible to monitor broadly the protected characteristics of people about whom alerts and referrals are made.

647 (58%) of the safeguarding alerts made during the 2012/13 year were about possible abuse of women and 466 (42%) concerned men. Women are also more common in the care management caseload, making up 66% of the over 65 year old total.

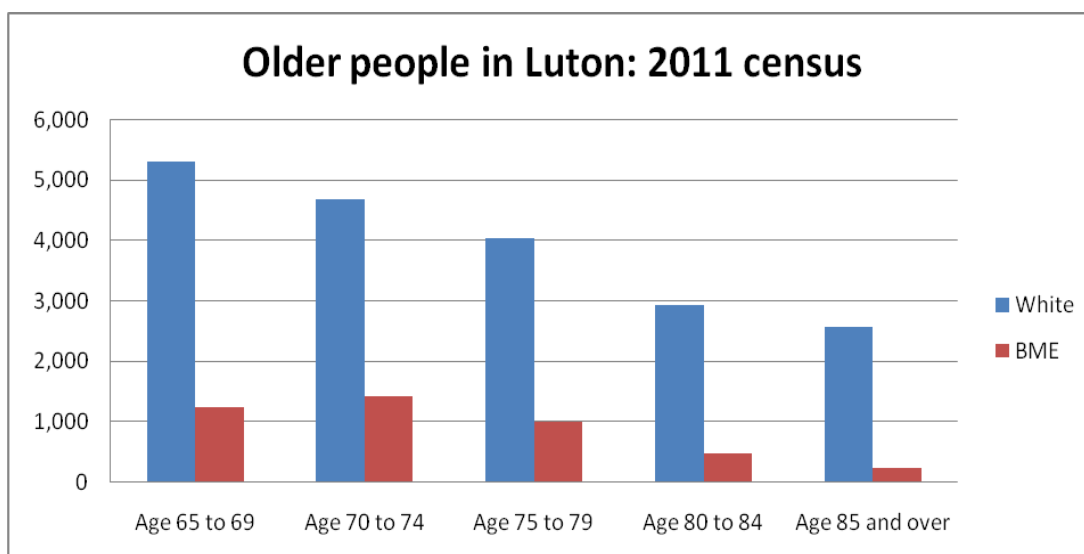
Of all 1,113 alerts 394 (35%) and (33%) of referrals concerned adults 18-64, 65% of alerts and 67% of referrals concerned people over 65. 119 alerts (11%, 10% referrals) concerned people 65-74, 274 alerts (25%, 25% referrals) concerned people 75-84 and 326 alerts (29%, 32% referrals) concerned people aged 85 and over. Comparison with the care management caseload shows that the proportion of alerts from adults 18-64 is now, compared with last year, more or less proportionate given that overall care management caseload is 39%.



As the data for Luton’s comparator group on referrals by age shows there is variation between councils, however the majority are for older people 75+.

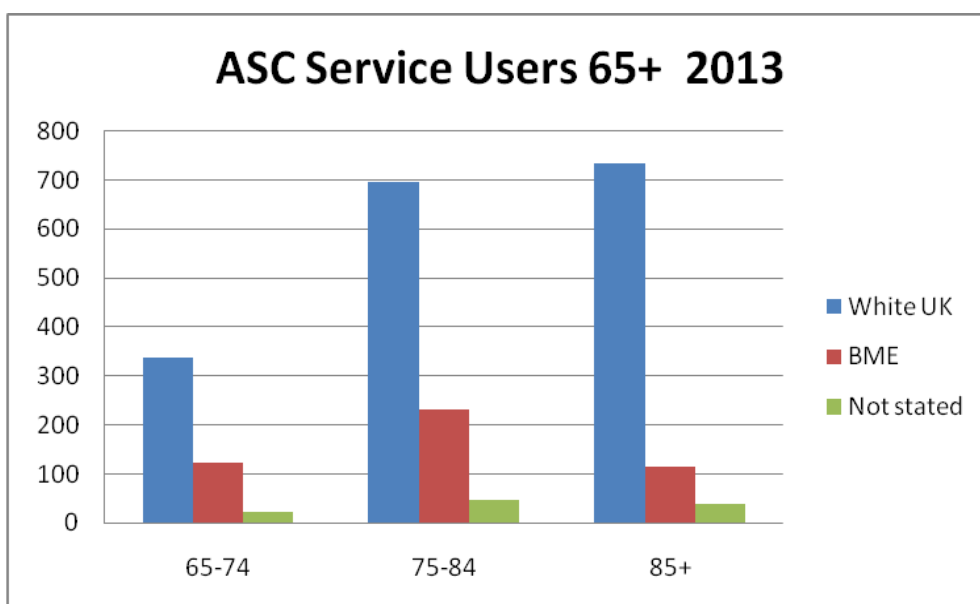


While the B&ME population of Luton is now estimated to be 45%, the percentages vary significantly between ages. 61% of under 18s are estimated to come from a B&ME community, 44% of working aged adults, and only 18% of people over retirement age (65 and over.) This reduces to 11% of people 80 and over.

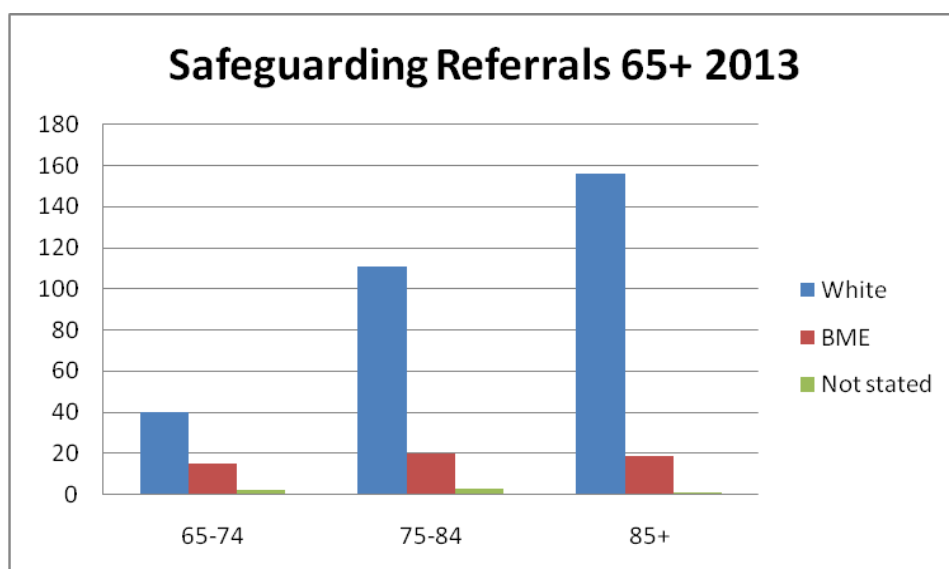


Safeguarding data for 2012/13 show 228 (20%) alerts and 123 (23%) referrals came from B&ME groups. This is slightly less than the percentage of ASC B&ME service users¹ which is 26%. 65 of the referrals/investigations concerned people of Asian or Asian British origin and 35 people of Black African/Black Caribbean/Black British origin. A further break down by age shows 31% of alerts and 35% of referrals in the 18-64 age group came from B&ME groups compared to 35% of B&ME ASC service users in this age group.

The next two charts compare the numbers of 65+ ASC service users by ethnicity and age with the numbers of safeguarding referrals using the same parameters.

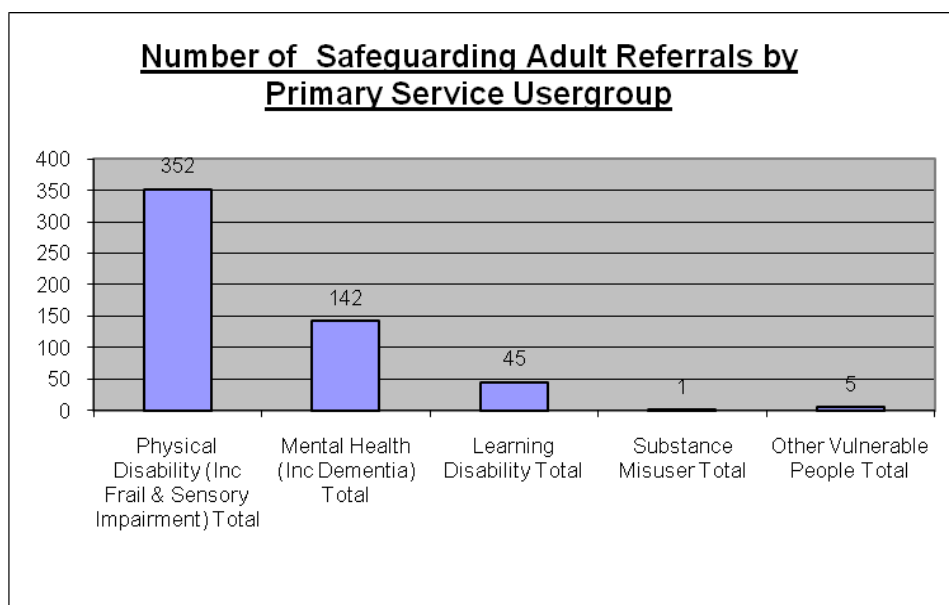


¹ Adults and older people helped through safeguarding need to have care and support needs, many are likely to be known to ASC Assessment Teams. It is therefore useful to compare safeguarding cases with ASC data.

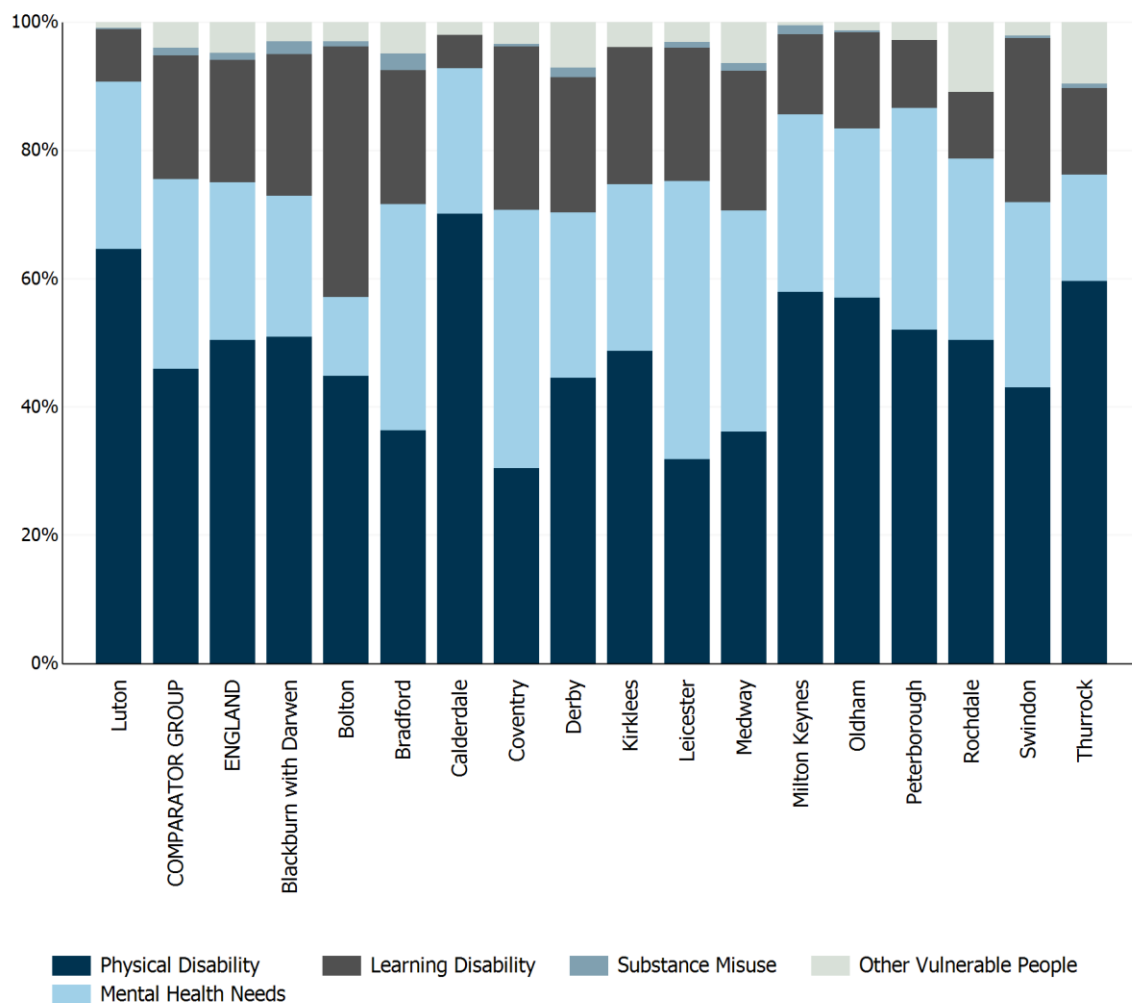


For the 65+ group 15% of alerts and 16% of referrals came from B&ME groups compared to 20% of B&ME ASC service users. As the chart above shows, the proportion of BME service users 85+ drops markedly to 13% and it is this age group which accounts for 48% of referrals for people 65+. This means that the percentage differences are not significant.

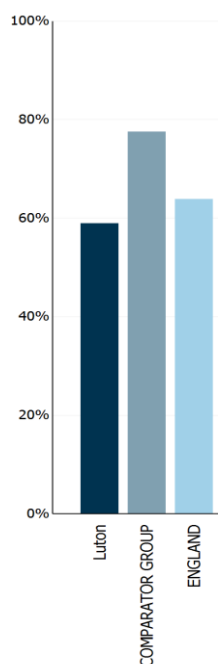
Because of the nature of the adult safeguarding system (which is concerned with adults with care and support needs), almost all safeguarding work is focused on protecting people with disabilities. However, analysis of first cut data for 2012/13, from other councils (see chart overleaf) suggests that Luton has fewer referrals from adults with learning disabilities 45, (8%), substance misuse problems (only 1 case recorded) and other vulnerabilities (only 5 cases recorded) and far higher proportions of alerts from adults with physical disabilities 352 (64%) than other councils. The proportion of referrals 142, (26%) for adults and older people with mental health problems appears to be in line with other councils. The high proportion of alerts for adults with physical disabilities may be due to the way we record information on the data base, including the practice of recording all grade 3&4 pressure ulcers as alerts under 'physical disability' even if the service user has for example dementia.



As the chart below shows Luton has a high proportion of referrals for adults and older people with physical disabilities, rather than other disabilities.



Reaching the whole community



Luton's data shows that we are reaching the whole community.

Safeguarding data submitted to the Government in the AVA return requires councils to provide information on the number of referrals where the subjects are already known to the Council. Where all or nearly all referrals are already known to a council, the comment from the National Information Centre is that it may not be reaching the whole community. The graph shows that Luton is broadly in line with the national position (with just under 60 of referrals already known to the council) which shows that safeguarding is reaching a broader group of people than just those in receipt of ASC services.

The Quality of Local Care Services

As explained earlier (p13) LBC's Purchasing and Quality Assurance Team inspect /monitor all CQC regulated providers that Luton Borough Council purchase care services from who deliver services within the Borough. The impact of this monitoring is reported to the Safeguarding Board quarterly and captured in the table below for 2012/13.

	# providers	#monitored	% monitored	# providers subject to improvement plans	# providers subject to embargoes	# providers subject to serious concern
OP - Residential Homes	17	15	90%	15	2	1
OP - Dual Reg/Nursing Homes	7	7	100%	7	0	0
LD - Residential Homes	12	8	66%	8	0	0
MH - Residential Homes	8	3	35%	3	0	0
MH/LD Homes (dual)	1	0	0%	0	0	0
Supported Living LD*	8	5	65%	3	0	0
Domiciliary Care**	21	10	47%	8	2	1

* Registered with CQC as Domiciliary Care ** Generic/older persons

Serious Case Reviews and other Reviews and Inquiries

No Serious Case Reviews have been carried out during the period. However together with the Joint Bedfordshire Safeguarding Board an independent Inquiry (based on SCR principles) into the sexual abuse case at the hospital, following the suicide of the alleged perpetrator was carried out by Derek Law (former Director in North Yorkshire) and published in December 2012. [Joint Safeguarding Review full report](#).

A Review of the Council's Transport Services was also carried out following three serious incidents that occurred in 2012. This Review has recently been finalised and the [report and action plans](#) were considered by the September 2013 meeting of the Health and Social Care Review Group (Scrutiny).

The Health and Social Care Review Group also undertook a Review of multi-agency discharge arrangements in summer 2013. [Discharge from hospital](#). This Review has requested that the Safeguarding Board maintain ongoing oversight and monitoring of safeguarding issues relating to discharge.

The Safeguarding Board also responded to inquiries made by the Equality and Human Rights Commission who were following up on issues raised in their report 'Hidden in Plain Sight' (published September 2011) which included Adult A. The council on behalf of the Board subsequently responded to their progress survey 2013 to evidence that the Council and its partners take disability related harassment very seriously.

Are we making a difference? Progress against Priorities 2012-13

In last years annual report we set several strategic priorities for this year. We report on progress against these below. The priorities were grouped under four areas:

- Implementing the changes as agreed in the Safeguarding Review
- Improving the quality of care services
- Improving recording including outcomes
- Other, three further priorities identified by Board Members

Implementing the changes as agreed in the Safeguarding Review

This covered two areas: establishing the new Safeguarding Team and working more closely with the Joint Bedfordshire Safeguarding Board.

Progress- Safeguarding Team

Most of the team were appointed to in 2011-12. However the Strategic Safeguarding Manager did not take up her post until October 2012. Staff have now come together as a team however there have also been difficulties in recruiting and retaining experienced social workers and having sufficient capacity to manage the case load.

Closer working with the Joint Bedfordshire Safeguarding Board

Three Priorities were identified:

1. *Improving the management of safeguarding alerts in the hospital, across Luton and Central Bedfordshire to ensure that a consistent approach is taken across both authorities and all patients are safeguarded.*

Progress

There are still some differences in the way alerts are managed and workflow that aids the process is being developed. The Inquiry Report written by Derek Law recommended that the ADASS Protocol is followed which means Luton taking a lead role in all alerts where allegations are made against the hospital including in those cases where the patient lives outside of Luton.

2. *Examining processes and forms in use for safeguarding across the three authorities (LBC, CBC, BBC) to ensure greater consistency and enable partners to use one set of forms.*

Progress

A Pan Bedfordshire Alert form has been developed and implemented which means that partner agencies now use just one alert form across three local authority areas.

A Safeguarding Adult Alert Screening Tool and a Referral Risk Assessment Tool have been developed by us (LBC) and shared with Central and Bedford Borough Safeguarding leads for their consideration.

3. *The Luton Safeguarding Board under guidance from the Strategic Safeguarding Manager and the Independent Chair needs to make a clear decision about adopting the Bedfordshire Policy and Procedures.*

Progress

The Strategic Manager has considered the Policy and Procedures in use across Luton and the two Bedfordshire Councils and worked through the Pan Bedfordshire sub group to produce the forms mentioned above. However the Joint Bedfordshire Board recently changed/amended their procedures and do not wish to make further changes at this time. The principles underpinning the Safeguarding Adults Policy across all three local authorities' areas are the same but the practice and therefore procedures are different in Luton primarily due to the implementation of a dedicated Safeguarding Adults Team.

At the Safeguarding board Away Day (16/09/13) the Board agreed to revise and amend the 2008 Safeguarding Vulnerable Adults Policy and Procedure to bring them up to date with local and national changes.

Improving the quality of care in services

Two priorities were identified

1. *Continuing to drive up standards of care in regulated services.*

Progress

This is covered in the Quality and Purchasing Team report (page 13) and data about care services subject to improvement action see page 56.

The Safeguarding Adults Team has worked with providers to assist them in bringing their safeguarding adults policies, practice and procedures in line with local and national expectations. Also with the Quality and Contracts Team to draw concerns about poor practice to their attention, (also see case study 4 and progress under '*what good looks like*' page 60).

The Safeguarding Adults Team has agreed a programme of visits and talks to providers of services to raise awareness of safeguarding adult issues and Mental Capacity and Deprivation of Liberty Safeguards.

The Team also attended provider forums during the year and will continue to do this.

- 2. Ensuring that standards of care in non regulated services used by ASC service users (for example day care and transport) are also good.*

Progress

For transport services, improvements were identified in the Review of Transport and have been incorporated into the SLA. These include the service adopting all appropriate CQC standards that apply to NHS transport services on a voluntary basis.

Improving recording including outcomes

Four priorities were identified

- 1. Checking that all reported concerns/alerts that involve adults with drug and alcohol problems and learning disabilities are recorded as alerts, even if the issues are subsequently addressed through care management.*

Progress

Limited progress has been made, although the first quarters performance report for 2013/14 shows 20 referrals for adults with learning disabilities and 3 for drug and alcohol, which is a significant increase.

- 2. Starting to routinely interview service users involved in safeguarding to capture the outcomes they want and gain their feedback and or capture whether individuals (or their carers where the person lacks capacity) say that they feel safer as a result of the safeguarding intervention.*

Progress

Some progress has been made in 2012/13 as victims are consulted and their views are captured in case recording. However it has not been possible to capture personal service user outcomes in a way that can be aggregated. Luton is about to participate in a pilot 'making safeguarding personal' running October 2013- January 2014 which should assist in both capture and the ability to extract and aggregate information on outcomes.

For evidence of how safeguarding is making a difference to the lives of individuals see case studies at the end of this section page

- 3. Capturing evidence that changes in practice and procedures have occurred where the need for this has been identified in a safeguarding adult's investigation.*

Progress

Changes in practice are routinely monitored through Safeguarding Conferences that take place at the end of an investigation where this is part of the action plan. However it is currently difficult to aggregate this information.

- 4. Improve performance reporting to the Board*

Progress

A new quarterly report format was introduced in summer 2012 drawing on the reporting format used in Central Bedfordshire. This captures ASC safeguarding data and concerns about care providers. Partners now also include trend information in their quarterly reports. Following publication by ADASS and LGA in July 2013 of '*Making effective use of data and information to improve safety and quality in adult safeguarding*' ([link](#)) work will begin in autumn 2013 to consider what other data and information can be brought together from across partner agencies. A priority for 13-14 will be to provide the Board not only with high level data as reflected in the AVA but also to provide more data that allows for more in depth trend analysis and addresses where possible the key questions set out in the ADASS report.

Other priorities from the Survey Completed by Board Members (which was derived from the ADASS standards launched in October 2011)

Three further priorities were identified:

1. *Becoming more public facing (evidence of success should be seen by an increase in alerts from service users, family and friends)*

Progress

New Safeguarding posters have been produced and widely distributed. Information about safeguarding adults from abuse and details on how to report were included in a publication that went to all households in Luton and in a newspaper article. The council organised a number of information sharing events and Safeguarding Adults has been part of these. The impact of this work is yet to be evidenced by an increase in reporting of concerns by service users, family and friends. Further work is identified in the business plan for 2013-14.

2. *Build senior management sign up*

Progress

The Hospital Trust has set up a Safeguarding Committee, as has Bedfordshire Police. Both committees have senior management representation across key partner agencies as well as senior strategic and operational managers from their own organisations.

The LSAB Away Day (16 September 2013) reviewed senior management sign up across all partners, recognising the difficulties that some regional partners have in attending many local safeguarding boards in these times of austerity and downsizing. The Board discussed how participation might be enabled in different ways, for example participation in meetings through video conferencing.

3. *Be clearer about what good looks like in all services*

(It is understood that 'good' means different things in different services and to different groups and is also the responsibility of Commissioners and often the Regulator)

(CQC). Good in terms of safeguarding adults also need to be based on the six principles for safeguarding adults set out by Government [statement on adult safeguarding](#)

Progress

Commissioned Care and Health Services - The new East of England Contracts for Care Services which are increasingly used by LBC link clearly to the Care Quality Commissions Essential Standards of Quality and Safety. While it is difficult to decommission services unless CQC is also taking enforcement action, two contracts which involved providers who were subject to performance improvement action under our Escalating Concerns Procedure have not been renewed/extended. One of these contracts was for rehabilitation services, the other for domiciliary care. Case Study four below also shows how safeguarding alerts can lead to improvement action in care services and thus prevent further abuse/poor care.

There are some services in Luton that the Local Authority does not do business with for example services which provide detox programmes commissioned privately or by out of area commissioners. The safeguarding adults team has worked with such services to ensure that they are providing services that are not putting their customers at risk of harm or abuse.

The Francis Report into Mid Staffordshire, which was discussed at the June 2013 Board has provided a stern warning to all, to ensure that patients and users needs come first and foremost. All NHS Providers have produced action plans to take forward his recommendations.

The strategic aims for 2013-14 focus on the Government's six principles.

Case Studies 2012-13

The four case studies below, taken from work carried out in 2012-13 show how safeguarding has made a difference to the lives of adults who were being harmed/abused as well demonstrating the value of multi-agency working to achieve outcomes for users.

Case Study One

The Safeguarding Team received a telephone call from an energy company to state Mr. X did not appear to be very well and his bills had not been paid for months.

A Safeguarding Social worker telephoned Mr. X to ensure he was okay; he explained his health was variable and he was having support from his GP. However, he informed her he had seen his bank statements and money was going out to gambling companies and he did not gamble himself. Mr. X explained his close relatives looked after his finances and pay his bills and obtain his shopping for him.

Mr. X showed the social worker the statements; he was overdrawn at the bank. A lot of money had been withdrawn. Mr. X agreed to make a statement to the police regarding his concerns.

The social worker took Mr. X to the bank to cancel his bank card so no-one could use the card to purchase anything else and when Mr. X's pension money went into the bank the social worker took Mr. X shopping and then supported him to arrange support from a care agency to help with shopping and a voluntary agency to support with the finances.

Mr. X has not seen his relatives as they have declined to contact him any further. However, Mr. X is now getting his bills paid and he feels happier, healthier and back in control of his life. The police are investigating and are hoping to arrest and charge the perpetrators with fraud and theft. They will be presenting the case to the Crown Prosecution Service.

In conclusion, the safeguarding intervention has assisted Mr. X to stop further abuse, has improved his safety and has supported him in achieving his desired outcomes.

Case Study Two

A safeguarding alert was received from the Police which concerned a female, Ms A, who had previously received support for problematic drug and alcohol use. She alleged that a male had taken her possessions and was being physically and emotionally threatening towards her. Ms A reported this to the police but subsequently withdrew her allegation. The alert was progressed to a safeguarding referral and following a safeguarding intervention it was discovered that Ms A had been threatening towards the male who it transpired was the vulnerable person in the situation. Ms A was using his accommodation to store her possessions and to take drugs and alcohol. When the male had taken back her key to his flat, Ms A had gone to the police to "mess him up".

The safeguarding intervention uncovered this situation and was able to ensure that the male was supported to attend a safeguarding meeting at which he was able to put his side of the events. He was not eligible nor in need of social care services but is now being supported by a third sector organisation to be more assertive. He understood that he had

been taken advantage of by this woman whom he had feelings for, and required support to build up his self esteem.

Case Study Three

A safeguarding alert was received that described a young man who may have had a learning disability being kept in a locked room above a shop in the town. The Fire Service had been called to the premises and discovered the man in the locked room, who had accidentally started the fire when he was having a cigarette. The safeguarding team and colleagues from Bedfordshire Police attended the address on the day the alert was received. The Police ascertained that no crime had been committed; the young man's family had kept him in the room as they could not manage his behaviours. As a result of this intervention, the locks were removed from the door and a referral was made to the Learning Disability Team for a Community Care assessment to be carried out as a matter of urgency to ascertain the man's needs and put support services in place.

This case demonstrates good multi agency working. The prompt response of all agencies involved ensured that this man and his family now receive the support they require.

Case Study Four

A number of alerts were received by the safeguarding team over a period of time that described concerns that did not individually meet the threshold of significant harm and did not progress to referral stage. However following receipt of further alerts and a review of the previous alerts it was decided to instigate a safeguarding investigation. This included colleagues from the Quality and Contracts Team and the regulator as well as community health services and commissioners. As a result of the investigation, the Escalating Concerns Procedure was used which resulted in an embargo on the services by the LBC Quality and Contracts Team. All relevant parties were notified of the concerns and advised to review their clients. An improvement plan was put in place by the provider which included staff training in a number of areas such as medication, manual handling and safeguarding adults. The provider's action plan was regularly monitored by the Quality and Contracts Team to ensure improvements in the service occurred and these were sustained.

Strategic Objectives for 2013-14

The Board discussed this at the away day on 16 September which was facilitated by RIPFA. It was agreed our strategic objectives need to be based on the six principles for safeguarding adults set out by the Government see [statement on adult safeguarding](#) . These are:

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

Also that our business plan for 2013/14 needs to accommodate the strategic aims already agreed by the Joint Bedfordshire Safeguarding Board which many of our partner agencies are also members of. These are:

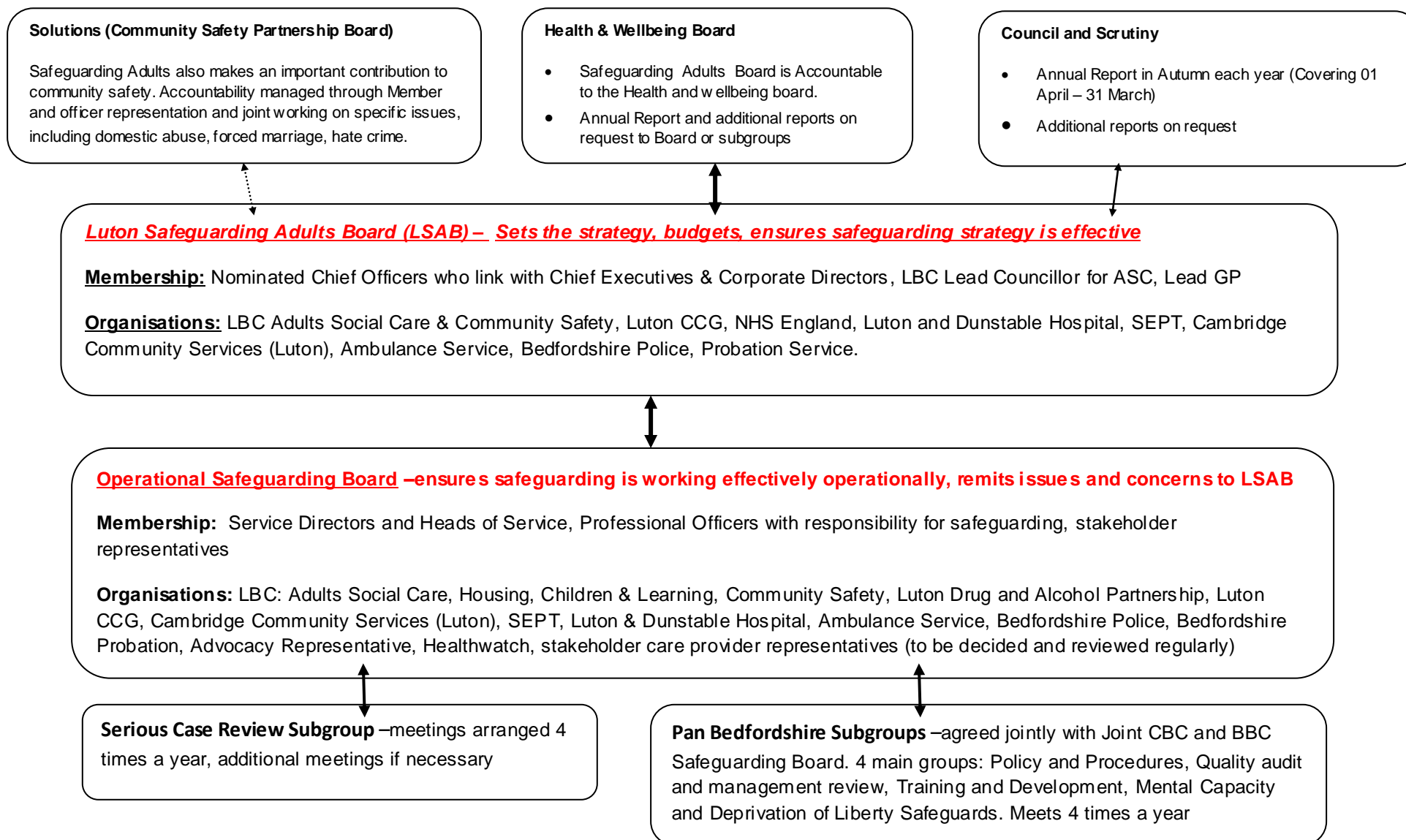
1. Prevention and Raising Awareness
2. Workforce Development and Accountability
3. Partnership Working
4. Quality Assurance and Protection
5. Involving People and Empowerment
6. Outcomes and Proportionality

Participants at the day agreed to adopt these six aims and discussed things we are doing well and things that need improving in each of these areas. These are summarised in the action plan from the day and have informed the 2013/14 Business Plan.

The outstanding issue of whether Luton should adopt the Joint Bedfordshire Safeguarding Adults Procedures was also discussed and it was agreed that there are some differences that cannot be resolved. Therefore Luton needs to agree new policy and procedures for safeguarding adults building on Bedfordshire's wherever possible, national best practice and what works in Luton.

The Business Plan for 2013/14 is published as a separate document

Luton Safeguarding Adults Board – Structure and Accountabilities



Safeguarding Adults Training 2012 – 13 organised by LBC

		Booked	Attended	DNA
Safeguarding Adults Basic Awareness Training	Internal	100	91	9
	External	31	23	8
	Total	131	114	17

Safeguarding Adults Refresher	Internal	55	46	9
	External	25	18	7
	Total	80	64	16

Safeguarding Adults Responding to Reports and Concerns of Abuse	Internal	11	10	1
	External	19	18	1
	Total	30	28	2

Safeguarding Adults Financial & Material (stage 1)	Internal	2	2	0
	External	7	7	0
	Total	9	9	0

Safeguarding Adults Minute Taking	Internal	9	8	1
	External	3	3	0
	Total	12	11	1

Safeguarding Adults Chairing Meetings	Internal	8	8	0
	External	0	0	0
	Total	8	8	0

Safeguarding Adults Investigations	Internal	10	10	0
	External	5	3	2
	Total	15	13	2

MCA1 - Basic Awareness	Internal	53	45	8
	External	91	74	17
	Total	144	119	25

MCA2 - Putting it into Practice	Internal	27	24	3
	External	26	19	7
	Total	53	43	10

MCA3 - Safeguards	Internal	28	25	3
	External	16	11	5
	Total	44	36	8



Luton and Dunstable Hospital
NHS Foundation Trust



Luton 

Primary Care Trust
A teaching Primary Care Trust



Providing Partnership Services in Bedfordshire,
Essex and Luton




Bedfordshire