Central Bedfordshire and Bedford Borough
SAFEGUARDING ADULTS BOARD

Safeguarding Adults Board
Bedford Borough and Central Bedfordshire
Annual Report 2022-23

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Foreword By Safeguarding Board Independent Chair – Mr Terry Rich

Welcome to our annual report covering the period from April 2022 to March 2023. This is the first full year post COVID and has continued to see increased pressures on social care and health teams. The numbers of concerns being raised continues at high levels. Staff across the sector are stretched, and the Board is grateful for their continued dedication in working to keep people safeguarded.

The report reviews the progress made by the Board and its constituent partners over the course of the year.

This year we saw the publication of the "Max" Safeguarding Adults Review. This is covered in some detail within the report. Max was a young autistic man who died in tragic circumstances in unsupported and inappropriate housing in Bedford at the age of 18 – having been previously in the care of Central Bedfordshire's children's services. The report highlighted a number of ways in which agencies had failed Max through his transition to adulthood: There were gaps in collaborative assessment and planning for his transition; there were limited specialist housing options, there was siloed working between mental health and social care agencies with practitioners taking entrenched positions, and there was a limited multi-agency safeguarding response.

The Board has sought assurances from all agencies that these failings are being addressed, and work needs to continue to ensure that progress is made. The Board needs to be assured that suitable supported accommodation options are commissioned by local authority partners locally so that the mistakes in this case are not repeated. Siloed working attitudes need to continue to be challenged, and overall there must be an increased understanding of the needs of autistic people, particularly as they move into adulthood. I would expect the Board to pay particular attention to this in the year ahead and welcome the decision to commission a multiagency conference in the autumn to check on the solutions being planned and implemented.

Thanks to all Board members for their continued commitment and contribution to the work of the Board, and of course to our business manager Barbara Grell.

After 7 years as Independent Chair I am now handing over to Maud O'Leary. I am sure that under Maud's leadership the essential work of independent scrutiny and challenge will continue and through this, the Board will play its part in ensuring vulnerable people are safeguarded from harm either through abuse or neglect.

Terry Rich
Independent Chair

Introduction

The Safeguarding Adults Board's statutory core duties under the Care Act 2014 are to:

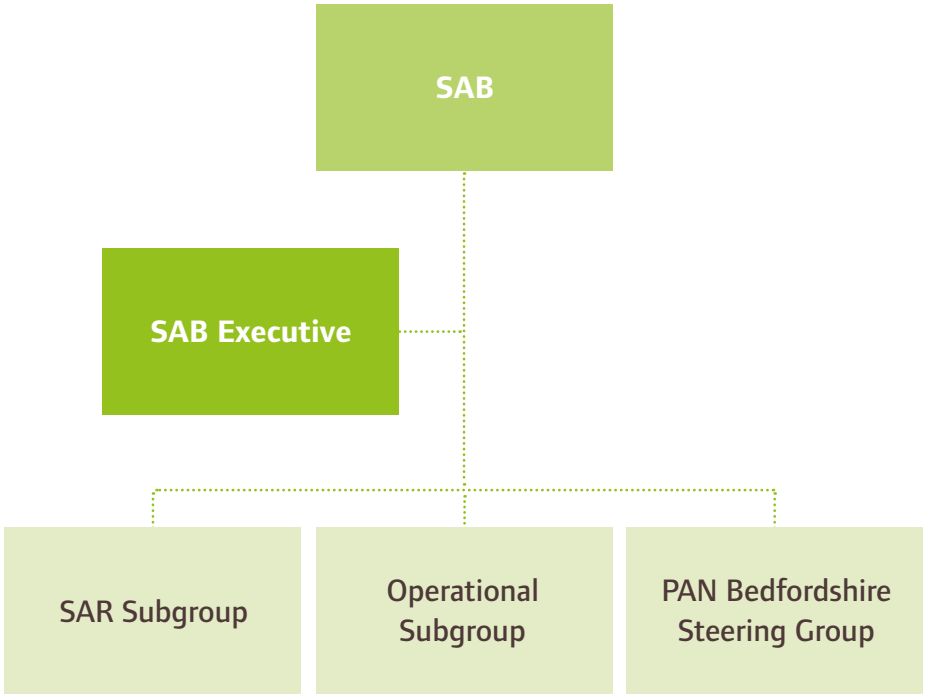
- Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- Publish an annual report detailing how effective their work has been.
- Commission Safeguarding Adult Reviews for any cases which meet the criteria for these.

The SAB meets these statutory objectives by:

1. Setting out annual priorities for assurance and improvement
2. Measuring the effectiveness of local safeguarding arrangements.
3. Ensuring that safeguarding practice is person-centred, proportionate and focused on improving outcomes.
4. Supporting partners and enable to them to work collaboratively in preventing harm and abuse.
5. Seeking assurances of continuous improvement with regard to safeguarding arrangements both as single agencies and as a partnership.
6. Undertaking, learning and driving improvements from Safeguarding Adults Reviews.

SAB Structure and Governance

This Safeguarding Adults Board covers two local authorities' area with Central Bedfordshire Council and Bedford Borough Council agreeing shared arrangements. This has allowed for robust and effective sharing of safeguarding information and learning across boundaries also aiming at ensuring consistency and quality. The SAB is Chaired by the Independent Chair to ensure the SAB is chaired by an Independent Chair to ensure accountability and effective governance and diligent working of the board with all partners to champion and promote the prevention of abuse and neglect to adults across all agencies.



SAB Executive. This is Chaired by Independent Chair. Membership consists of statutory partners from both local authorities, Integrated Care Board and police. The SAB Executive is a new arrangement that was to up to strengthen leadership, ensure adequate resourcing and statutory oversight of safeguarding activities and priorities. The SAB Executive meets at minimum twice annually.

Full Safeguarding Board. This is Chaired by the Independent Chair and inclusive of statutory partners and local organisations with key responsibilities as follows:

- Bedford Borough Council (Adults and Children Services)
- Central Bedfordshire Council (Adults and Children Services)
- Council Members – Adult Social Care portfolio holders in both councils
- Bedfordshire Police
- BLMK Integrated Care Board
- Bedfordshire Fire and Rescue
- Care Quality Commission
- East of England Ambulance Service
- East London Foundation Trust
- Bedfordshire Hospitals Foundation NHS Trust
- Private & Voluntary Care Providers Association, Bedfordshire Care Group
- Healthwatch Bedford
- Healthwatch Central Bedfordshire
- Voiceability (Advocacy)
- Domestic Violence Partnership
- Community Safety Partnership
- Safeguarding Children's Boards
- Bedford Prison
- Probation Services
- Department of Work and Pensions
- Care home/domiciliary care provider representative

The SAB meets at minimum four times annually with additional meetings when needed.

SAR Subgroup. This Subgroup's focus is on receiving alerts and referrals under Section 44 of The Care Act. The Subgroup is Chaired by the independent Chair and meets at minimum four times annually. The SAR Subgroup further oversees the progression and completion of SAR's as well as overseeing the implementation of actions resulting from SAR's.

Operational Subgroup. This subgroup progresses SAB priorities and activities via its eight or more annual meetings. The focus is on linking safeguarding strategy with operation and practice, gather assurance and progress the work of the board actively. Membership of the operational Subgroup is reflecting of that of the board. Senior Managers within local authorities currently chair this meeting.

PAN Bedfordshire Steering Group. This group links the work of the local SAB with that of the Luton SAB, covering the whole of Bedfordshire. This group is responsible for keeping the policies and procedures up to date with a further focus on sharing learning and progressing shared priorities. The group seeks to ensure consistency across Bedfordshire ensuring consistency across Bedfordshire for all partner agencies and the public.

Local and National Collaboration

The SAB Independent Chair and local delegates participate in national safeguarding meetings hosted by ADASS and the Independent Chair attend the Chairs network now hosted by the Independent Safeguarding Board Chair's Network. This ensures that any national issues are considered locally and learnings from local safeguarding cases can be shared.

Alongside this the SAB Chair attends CBC's Safeguarding Chairs Network which includes the Chairs of the Safeguarding Adults Board (SAB), Safeguarding Children's Board (SCB), Domestic Violence (DV) Partnership Board, Community Safety and Health and Well-Being Board Chairs. This network functions to coordinate shared priorities with a focus on improving practice taking a 'think family' view.

SAB Priorities and Summary of Achievements 2022-23

A new SAR referral raised concern that not all young people transitioning into adulthood are adequately safeguarded. The SAB will be seeking further assurances and will be commissioning a SAR to identify learning in one case. (Ongoing)	✓ The Max SAR was completed and published in November 2022. ✓ Proposed agency actions and action plans have been monitored during 2022-23. ✓ For 2023-24 this item will be ongoing: ✓ The SAB have commissioned the Independent Reviewer to undertake a system analysis of actions and outcomes following the review commencing May 2023. ✓ A Max SAR – Transitions Development is planned 03 October 2023 to share findings of the former and to measure and evidence real change that is making a difference to people like Max.
Consider the impacts of legislative, financial and structural changes that will or are likely to impact on safeguarding adults.	✓ The SAB and its Operational Subgroup gave due consideration to all these aspects throughout the reporting period. ✓ BLMK/ICB reported on its own structural changes and increased its resources providing a safeguarding lead to both Bedford Borough and Central Bedfordshire 'at place', previously a shared post. ✓ The SAB monitored partner agencies readiness for the implementation of the LPS. The government decided to place legislative change on hold. Agencies, and the SAB provided feedback throughout the LPS consultation period. ✓ Regular discussions and reassurances from partner agencies regarding the local state of the care market and any challenges, and possible pressures within health and social care formed part of regular discussions. ✓ The upstart of any unregulated social housing providers and risks associated with these have been closely monitored by local authorities, if needed in conjunction with CQC to ensure adequate safeguarding arrangements.

Develop a training and communications strategy including seeking lived experiences.	✓ The SAB undertook a review the availability of training within partner agencies that is accessible to others. This evidenced that multi-agency training needs to be improved. ✓ The SAB hosted several learning events in relation to SARs. ✓ The SAB ensured that family and friends were supported and enable to engage fully in SARs ensuring that 'the lived experience' is captured and at the heart of learning. ✓ SAB web content was reviewed, currently hosted by local authorities. ✓ A new Pan-Bedfordshire Safeguarding Policy and Procedures platform is underway and will launch in the autumn 2023. ✓ In addition, the SAB will during 2023 be providing. ✓ 'Safeguarding or Care Management' – The criteria and pathways for safeguarding, health, and social care. ✓ Hoarding update ✓ Section 44 SARs, the criteria and making a referral
Consider the continued impacts of the Covid pandemic on safeguarding and increase in reporting of incidents of self neglect.	✓ The SAB continued to consider the impacts of Covid and increasing complexity and numbers of safeguarding alerts into adult social care. The SAB have no doubt that due to Covid some individuals did not present immediately leading to further complexity and higher risks at the time that safeguarding risks are identified. In many cases the relevant person was not known to social care services previously. ✓ Both local authorities, and BLMK/ICB increased its staff resources because of increasing adult safeguarding alerts and activities. ✓ The SAB are considering the various risk management Terms of Reference e.g., hoarding panel, VARAC, risk panels etc. to map and consider partner agencies call for more guidance and an escalation and risk management system for self-neglect like that developed by the SAB in relation to hoarding.

Section 44 Safeguarding Adults Reviews

Section 44 of The Care Act 2014 requires Safeguarding Adults Boards to undertake a Safeguarding Adult Review when specific criteria are met. This is when abuse results in the death or significant and possibly life-changing harm of an adult with care and support needs. (Read Government Information about the Care Act 2014 and SARs). Safeguarding Adult Reviews (SAR) are not enquiries into how someone died or suffered injury, or to find out who is responsible.

They:

- Look at any lessons we can learn from the case about the way professionals and agencies worked together
- Review the effectiveness of our safeguarding adults' procedures
- Inform and improve practice
- Identify what can be done better to avoid a similar circumstance from reoccurring

The SAB aims to share learning from Safeguarding Adult Reviews widely with local organisations and through National Safeguarding Network.

SAR Referrals 2022-23

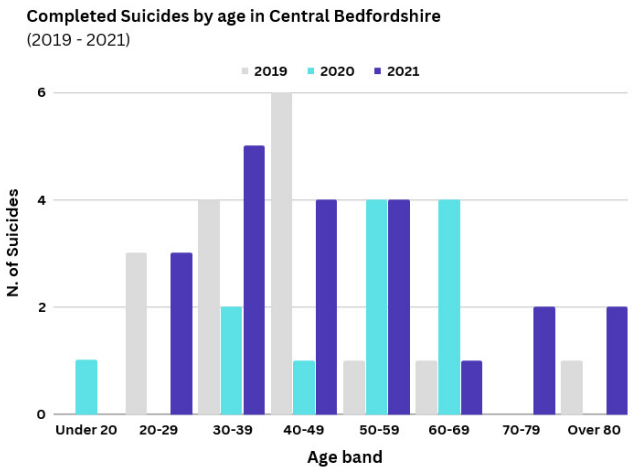
A total of fourteen SAR referrals were received this year, compared to seven last year. Of these SAR referrals:

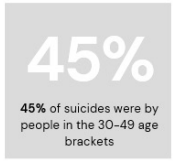
- Eight related to BBC and in two cases SAR criteria were met. Six related to CBC and in three cases SAR criteria were met.
- One SAR was completed (Max) during 2022/23.
- One SAR remains paused due to an active police investigation currently. This SAR is looking at the circumstances surrounding a young adult taking her own life. It will examine her journey through the care system and impacts of sexual abuse, disclosure, and effectiveness of safeguards to prevent harm.
- One SAR is being completed jointly with a DHR. This is also paused due to an ongoing police investigation.
- One SAR was commenced in 2022 and is due for completion in the summer 2023. This is examining the circumstances of a middle-aged man looking at how we support working age adults who misuse alcohol and live with alcohol addiction, impacts on relationships and the level and effectiveness of professional support and accessibility to appropriate services.
- One further SAR relates to an incident between two residents in a care home leading to significant harm to one. This SAR is now at the procurement stage, having been delayed due to an ongoing police investigation.

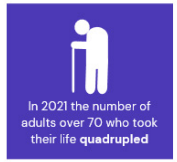
The SAB and SAR Subgroup monitor for any changes in safeguarding data and content of SAR referrals to identify any themes and risks. SAR referrals were very varied in content this year. However, the SAB was concerned about the level of risk that can occur between residents and service users in care homes. Both local authorities' quality teams, ELFT and BLMK/ICB provided support to providers to review risk management arrangements and completed placement reviews. A SAR has been commissioned that will look at the circumstances of one such incident and what more can be done to protect residents in care homes and communal living.

Central Bedfordshire - Suicide Audit 2019-2021

Age







Bedford Borough - Suicide Audit 2019-2021

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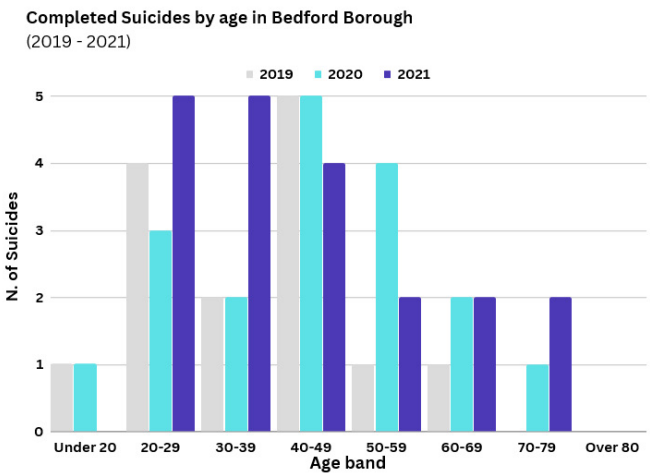
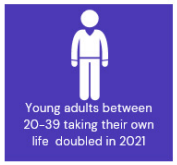




The SAB will have a significant focus in the coming year on older people, incidents of reports of domestic abuse, and an apparent increase of suicides in people over the age of 70 (see tables above). It is yet unclear what has led to this increase and the SAB have asked Public Health and BLMK to undertake analysis to identify any possibly 'triggers' to reduce the risk of older people taking their own life. Each suicide represents a personal tragedy with potentially devastating effects on families, friends, colleagues, first responders, staff, the wider community and beyond. Whilst statistically speaking, this affects only very small numbers of people there is a danger in drawing too many, or too definitive, conclusions based on this data alone and therefore the SAB are undertaking more analysis and its partner agencies will be reporting back any findings. The SAB is monitoring this and other risks via its now established SAB Risk Log.

SARs and Learning Reviews completed in 2022-23

One Safeguarding Adults Review (Max) was completed during 2022-23. A second SAR was commenced and this is due for completion in the summer of 2023.

Max was an 18-year-old White British man who had been adopted in infancy, who was described as a mischievous, 'smashing young man', a free spirit who could be very kind. He was passionate about music and extremely talented, able to play any song by memory and generously helped other young people on his music course with their work. He was very proud of his sister's achievements, and was very pleased to attend an awards ceremony where she won a prize. The description of Max as having 'high functioning' autism may have been misleading to practitioners working with him. Although Max was not learning disabled, his full-scale IQ had been assessed 73, which placed him on the borderline of learning needs. Certainly, his autism and anxiety made it more difficult for Max to understand his place in the world and he had poor impulse control due to attention deficit hyperactivity disorder which contributed to poor decisions. Max lacked insight into the intentions and motivations of others, which made it difficult for him to make or sustain friendships, but his desperate longing to belong meant that he was very vulnerable to those who could exploit him.

Systems finding

Finding: Gaps in collaborative assessment and planning for Max's transition and rigid application of 'eligibility' criteria for individual services meant that no adult services were in place at the point Max turned 18 despite his unquestionably complex needs. Pathways to secure a timely assessment of Max's care and supports needs were opaque and overreliance on services designed to provide 'life skills' support impeded preventative work to stop risks from escalating. A clear pathway is needed for young people with autism transitioning to adulthood across Bedfordshire, irrespective of their level of functioning, across Children and Adults' mental health and social care, with specialist services that can meet the assessed needs.

Recommendation 1: ELFT, Central Bedfordshire Council and Bedford Borough Council should review existing mechanisms for dispute resolution and escalation in cases where either there is delay, a disagreement in respect of whether Health or Social Care should take the lead on carrying out a care assessment or review (including interdepartmental disputes), or where any agency (or the individual or their family) holds concern that the assessment or care plan are inadequate to meet a person's needs, to ensure disputes are promptly and decisively resolved and that all agencies are held to account for meeting the individual's needs during this process. The SAB should promote awareness of these pathways and dispute resolution mechanisms across the partnership.

Recommendation 2: The SAB to seek an assurance report from ELFT in respect of the effectiveness of its strengthened transitions policy and audit process, and from Central Bedfordshire in respect of the introduction of a Transitions Panel. Subject to an evidence-based assessment of the benefits of this panel, Bedford Borough should consider adopting a mirror process, to ensure a seamless service provision across Bedfordshire for all young people transitioning to adulthood, irrespective of where they live in the county. The SAB Quality Assurance Sub-group should include audits on the timeliness and quality of transition referrals from CAMHS and Children's Social Care, and the quality of the response from adult services in its annual audit cycle.

Recommendation 3: Improvements to ELFT's practice, such as the move to residence-based allocations for the adult mental health teams and introduction of

transition specialists within the Neurodiversity teams, should be captured within policies so that these are transparent to patients and other practitioners. The SAB should promote awareness of these policies across the wider partnership and seek assurance from partners in respect of current workstreams to improve access to specialist Neurodiversity pathways, in accordance with duties under the Autism Act 2009 and Equalities Act 2010.

Finding: Limited options for specialist accommodation resulted in Max moving to private accommodation that could not meet his needs in the absence of an effective care plan. There is a clear need for specialist placements or, in the interim, greater flexibility from commissioners locally to use powers under National Health Service Act 200623, Mental Health Act 1983 and Care Act 2014 to provide accommodation-based support that is needs-led rather than diagnosis-led.

Recommendation 4: A housing/accommodation pathway and protocol for vulnerable adolescents and young adults, including care experienced young people, should be coproduced by Central Bedfordshire and Bedford Borough councils, ELFT and BLMK to ensure that young people and young adults already at risk are not placed at an even greater risk as a result of being placed in unsuitable housing. The protocol and pathway should allow for more bespoke commissioned placements or support packages to target the needs of individuals, involving joint commissioning with Health to ensure that there is a seamless spectrum of provision from individuals with pure social care needs to those with neurodiversity, continuing healthcare needs or who are being discharged from mental health wards.

Recommendation 5: In any cases where individuals are placed, including temporarily, in accommodation which is unsuitable for their vulnerabilities or mental health needs, a multiagency strategy meeting should be promptly convened by the lead agency and the resulting safeguarding plan kept under review to ensure that risk is continuously re-assessed and managed. Any care and support, pathway or aftercare plan in place must be reviewed to ensure that the holistic individual's health, care and/or support needs are met in this accommodation.

Finding: Siloed working between mental health and social care resulted in practitioners taking entrenched positions in respect of each agencies' analysis of Max's needs, functioning and mental capacity. This was exacerbated by the sheer number of agencies involved, without any taking a leadership or coordinating role and incompatible ICT systems hindering information sharing. Although agencies eventually resolved this and started to work in a collaborative and strategic way to care plan and manage risk, this delay had allowed Max's needs to spiral dangerously. The bureaucracy of arranging complex care plans further hindered efforts to provide an agile response to the escalating crisis. This fragmented approach also meant that clinicians from the mental health ward were not integrated in safeguarding planning.

Recommendation 6: The SAB should consider whether any existing risk forums can be utilised, expanded, merged or a new panel established to provide clear strategic oversight, a cohesive multi-agency response across Bedfordshire and contemporaneous problem-solving by budgetholders in complex, urgent and high-risk cases. Recommendation 7: In situations where a person has frequent mental health admissions, clinical staff on keys wards should be invited, and commit to attending multi-agency professional and strategy meetings, to strengthen an integrated approach between hospital mental health teams and the wider professional network, with an aim to reducing reliance on mental health admissions and identify effective crisis plans.

Recommendation 8: ELFT should consider how the role of the care coordinator can be strengthened in complex cases, in particular when multiple agencies are involved in supporting the individual. The SAB should agree a protocol to enable

a clear lead professional to be identified to coordinate agencies in complex cases where a care coordinator is not allocated.

Recommendation 9: CBC's Children's Social Care should strengthen training programmes for children's social workers and personal advisors in respect of mental capacity, including the concepts of executive and fluctuating capacity, to improve transition planning and bolster the confidence of their staff in challenging decisions on capacity by adult services, seeking legal advice if necessary. This is of particular importance in light of the upcoming legislative changes in respect of Liberty Protection Safeguards. Consideration of mental capacity in respect of key aspects of independent living needs to be embedded in referrals from Children's to Adult Social Care and considered fully in transition and pathway planning meetings and SEN reviews. Page 23 of 27

Recommendation 10: Partners should consider how to strengthen ICT systems to parse key safeguarding information between agencies and departments.

Finding: The overwhelming urgency of resolving Max's needs for specialist care and support drew focus from the issue of exploitation, resulting in a limited multi-agency safeguarding response. An all-ages approach to exploitation should be developed ensure that pathways, tools and training are available to all practitioners working with people experiencing exploitation, with a particular focus on embedding knowledge for practitioners working with younger adults who have transitioned from children to adults' services. This requires legal literacy in respect of frameworks for intervention and an effective multi-disciplinary strategic approach.

Recommendation 11: The Safeguarding Children Partnership and members of the Safeguarding Adult Board should more widely publicise the multi-agency exploitation strategy, training and tools to facilitate an all-ages approach to tackling exploitation.

Recommendation 12: The SAB should consider providing more extensive information and guidance about the Transitional Safeguarding needs of care experienced young people, drawing on the recently published briefing document 'Bridging the Gap' from the Chief Social Worker for Adults.

The full report for the Max SAR can be accessed online:

Communications - Max Safeguarding Adults Review.pdf - All Documents (sharepoint.com)

The SAR Subgroup, SAB and SCB have been monitoring partner agencies actions in preventing similar tragic circumstances occurring and will be focused on measuring real change for people with autism and neurodiversity continuing as a priority during 2022-23. In addition, the SAB have commissioned an analysis of actions by the Independent Reviewer in the Max case, commencing in spring 2023 and this will inform a SAB hosted 'Transitions to the Max' development day in October 2023 that will bring together managers and front-line professionals.

It will identify any ongoing barriers and enablers and showcase what best practice looks like as well as provide a platform for multi-agency collaboration. The actions/action plan review and evaluation are aimed at not only measuring single agency actions but to measure corroboration between agencies and effective multi-disciplinary practice. The SAB are reassured that as a result of the review an interagency protocol has been put in place whenever there is disagreement regarding duties and responsibilities between agencies and that a review of the local commissioning and housing strategy was prompted by the findings that considers the needs of people like Max. The SAB and its Independent Chair are committed toward making improvements to ensure that people with autism and neurodiversity are safeguarding during transition to adulthood.

Summary of Partner Agency Achievement

Central Bedfordshire Council (CBC)

This year, most of the safeguarding activity has been focused on managing demand, risk, and complexity. The safeguarding team have continued to see a significant rise in safeguarding concerns and although the conversion rate to safeguarding enquiry has remained static (7%), there has been a rise in cases of self-neglect. The increase in activity has also been seen in Assessment and case management teams particularly in relation to those cases deemed not appropriate for a section 42 enquiry.

A peer review of adult social care was undertaken in November 2022 and the conversion rate highlighted for further consideration. The review team were reassured by the approach but advised this was kept under review focusing on the outcomes to people.

In this period, we have updated and re issued the risk enablement policy and the panel has been getting new cases forward for multi-agency discussion. This has been a supportive arrangement and will continue to be developed.

There has been good participation in a number of safeguarding adult reviews and domestic Homicide reviews, with all relevant practitioners and their managers taking in learning and contributing to system wide learning.

The safeguarding team has had good representation at the new Hoarding panel, making good contributions which has been very beneficial to finding solutions in complex cases at a multidisciplinary level. This panel is now well embedded receiving referrals from practitioners on a regular basis.

The biggest challenge this year has been the continuing increase in demand of the number of safeguarding concerns presented to the safeguarding team. This trend has been ongoing since Covid and to manage demand, risk and complexity, there have been several additional posts created and funded by the council. Namely, an additional Lead safeguarding post, a support worker post and the domestic abuse specialist officer post has now been made permanent.

The additional posts have helped manage the increase, but there is still limited capacity to undertake audits and practice surgeries given the pressures due to focusing on demand.

Returning to safeguarding audits and presenting themed practice surgeries will be a key priority in the team moving forward, as this supports quality assurance and continuous improvement.

Changes CBC made as a result of the finding in the Max SAR:

A review of the dispute resolution protocol has been undertaken involving CBC Adults, BBC, Children's services and ELFT. The dispute resolution protocol includes a commitment from all parties that the initial point of entry will hold the case until safe transfer to the appropriate agency/team is arranged. It has gone through sign off at the appropriate governance structures and launched with staff.

The terms of reference (ToR) for the Transitions Panel, has been reviewed alongside the co-operation between team's protocol. There is now a planned schedule of internal audits of transition cases scheduled jointly with children's services.

CBC are working across the partnership as a member of the Pan Beds Transitions Group under Safeguarding Adults Board, working across councils, various health agencies and adult and children services on.

1. review current practice and any immediate gaps.
2. review emerging best practice, including as outlined in Bridging the Gap
3. considering future service developments to offer assurance of effective safeguarding through transitions.

CBC Adults - An Accommodation Strategy for adults with care and support needs has been created spanning 2022-2027.

ELFT, Housing, commissioners within Adults and Children are working to further develop above protocol to ensure safe, and suitable placements and /or housing for young adults. There are several workstreams underway to improve services and collaborative approaches between LAC/ELFT/Housing. Housing now sits on the Corporate Parenting Panel. A Housing and Children's Services protocol has been developed which will include a housing pathway for care experienced young people immediately leaving care.

The protocol opens up pathways for Colleagues in Children's to have improved access to supported housing provision. Housing is looking into how they can support Children's with 'light-touch' suitability assessments when properties within the private rented sector are being considered. ELFT are reviewing the supported housing provided for those with assessed need. CBC housing are involved in this work and there will be a specific focus on out of area placements for people with clinical care needs.

The Risk Enablement Practice Guidance and Panel procedure CBC (adult & Children) has been updated and distributed internally and to all partners agencies and shared discussed with practitioners. An Exploitation Practice surgery held by Lisa Robinson (Police exploitation Lead) to Adult and Children Practitioners, and this was very well attended.

A good practice guidance on transitional safeguarding (RIPFA) has been circulated to all practitioners in CBC. Transitional safeguarding training course and Eligibility and Human rights training. Workers from Adults and Children's Services attended a Transitional Safeguarding webinar by LGA) in February. The Learning and development team is refining the transitional training options and will roll it out in the coming months.

Safeguarding Case Example – Making Safeguarding Personal and giving a voice to people.

An adult with a learning disability was being financially abused by another resident. It was also established that the allocated support hours were not being used accordingly in the supported living placement putting the adult at risk of danger in the community.

A safeguarding investigation was started to protect the adult financially and also for his wellbeing to be met through agreed support, as per the care plan. The enquiry was also focused on finding a way for the adult to be paid back his money, as this was one of his desired outcomes.

His family wanted him to move to another provision due to the significant financial abuse he has experienced but he initially did not want to move unless it was to live in the family home which was arranged as an interim arrangement.

One of the key elements of person-centred practice in this case was the use of advocacy to give him a voice. This promoted the use of person-centred approaches in listening to his views. It also promoted the use of strength-based practice in capitalising on his current independent living skills.

Other areas were explored such as the use of assistive technology to keep him safe, by putting in a door sensor which alerted the staff, a further agreement was the involvement of the contracts team to monitor the placement provider. A full review of his care needs was also undertaken and as a result, an updated care and support plan was agreed.

The adult couldn't get his money back initially, but this was resolved via the provider eventually.

Through advocacy, he was able to express his views that he didn't want to move and wanted staff to protect him and live more independently e.g., support during meal preparation, maximising life skills. The door sensor being in place alerted staff when he was going out, so they could accompany him and protect him from danger.

After a short period with his family, he was able to move back to his placement with reassurance that his care support was going to be implemented as agreed. He also expressed that he would like his biological mother to be more involved in his life and to attend his meetings and this was facilitated.

The lead investigator and the allocated worker worked on reviewing his needs and monitoring the support he was receiving to ensure support was being provided as commissioned and contracts remained involved in monitoring the placement.

During the initial safeguarding meetings whilst he had been living with his family, he would often leave the meetings or would give short answers, engagement was often poor. This transformed throughout the safeguarding enquiry and at the final safeguarding case conference, he initiated discussion, smiled and he would talk for long periods of time about things of interest to him or others. He felt able to clarify his wishes and he kept saying "because this is what I wanted (moving back into his supported living placement) and you listened". This shows how in the safeguarding enquiry kept the person central to all decision making and achieved great outcomes. A good practice example of Making safeguarding personal.

Bedford Borough Council (BBC)

To enhance and develop our oversight and response to quality and safeguarding, from October 2022 the Council reviewed its structure, combining our Care Standards Monitoring service and Safeguarding Adults Team under one senior manager. We have seen the benefits for our residents, with sharing of information around the care provider market and actions taken around quality assurance and our safeguarding intelligence, particularly where safeguarding alerts received do not meet the Section 42 enquiry (S42) threshold. This has enabled us to make better use of the market-based intelligence the care standards team gather, and for this then to inform decision making within our safeguarding processes.

The Safeguarding Team has continued to receive high volumes of alerts / and or contacts, all of which are screened at point of entry. Additional resources to cope with the demand were put in place to support this additional demand in activity. Our conversion rates to S42 enquiry remain low; however, our Decision Monitoring Tools (DMTs) demonstrate the extensive information gathering enquires to ensure a safe and proportionate response. As part of an external safeguarding audit recently commissioned by the Council, all but 1 of the cases reviewed demonstrated agreement with the decision made by our practitioners. Of the one case, we evidenced how follow up by the care standards team had supported safeguarding from a quality assurance perspective. This high-level initial investigation enables us to make effective use of our limited resources as well as being able to focus them on those most in need or at risk of abuse.

The Safeguarding Team continue to represent the Council at a range of multi-agency meetings to support the best outcomes to local residents; these continue to demonstrate the effective use of information sharing and prevention to support safeguarding of residents.

In the past year we have initiated joint care provider, care standards and safeguarding provider engagement calls. These have facilitated improvements in communication and collaboration with our partners and colleagues promoting safeguarding and also sharing news. This has enabled seamless working both within the Council and externally. A special area of focus has been the area of transitions from Children's services. This work continues.

It is positive to report that our Deprivation of Liberty service continues to manage all authorisation requests in line with statutory requirements and time frames.

The volume of contacts to the Safeguarding Team has remained challenging, particularly those cases where it is not evident that a person has care and support needs under the Care Act. Engagement with some partners around what Safeguarding is, the perception of consent, and widening the scope of holistic working has been used to promote positive sign posting.

The increase in self-neglect and hoarding cases has remained over the past year as has the potential link between this and the impact of the cost-of-living crisis with strains on families and communities. Additionally, we have seen an increase in residents between 18 – 24 years who may have been victims of cuckooing who are at risk of further exploitation. Our Safeguarding leads have made links through the Contextual-safeguarding group to begin to better understand and address these matters.

Bedford Borough Council has a significant amount of registered care providers within its footprint which then lends its self to other local authorities funding placements in unregulated but lawful housing settings, particularly Supported housing providers. This can be problematic at times when residents locally are not known, and risks are heightened.

Changes BBC made as a result of the Max SAR:

As a result of the Max SAR a revised multi-agency transition preparing for adulthood policy is being co - produced, which will include extensive involvement and feedback from our Bedford Parent Carer Forum, whereby a set of standards will be created to measure our progress against. Having clearly defined steps and processes will enable people to navigate through the system with reduced stress and anxiety.

Bedford Borough Council's Adults' services has also reviewed its term of reference for its Risk Enablement Panel by extending the invite to Primary Care Partners and to the Domestic Abuse lead. The multi-disciplinary team attendance has also increased which has expanded the groups influence to consider complex cases and reduction of risk to residents.

Transitional Safeguarding and Learning from Safeguarding Adult Reviews (SAR) now forms part of the Bedford Borough safeguarding training schedule.

Safeguarding Case Example – Alleged Financial Abuse

A person with learning disabilities and mental health illness, had lived independently all their life but due to increased vulnerability and changing needs had transitioned into a supported tenancy, with care provided by a domiciliary care provider for key parts of the day and overnight.

A whistleblowing concern regarding one of the paid carers was raised in relation to physical, financial, and material abuse.

It was important for those carrying out the enquiry to ensure the individual was empowered and enabled to be part of the S42 investigation. The person had mental capacity. An advocate was offered to ensure the individual's desired outcomes were fully known, to ensure we focused on making safeguarding personal. The individual's preferences were respected through the safeguarding enquiry supported by the carers in place and social worker whom the person trusted.

Significant exploration surrounding the details of the whistle blower account were made, with extensive reconciliation of the facts from presenting care records and audits. This resulted in specific recommendations to safeguard the individual's autonomy, assuring dignity as well as the standard of care continuity, which enabled them to be further safeguarded in their own home.

Throughout the S42 enquiry, the service user was kept informed all-be it at the time the individual had become increasingly disinterested and not clear as to the outcome they wanted to achieve. The individual was happy that those involved where working through issues to make things better and safer for them for the future.

As part of the S42 enquiry, it became apparent the alleged person to have caused harm, had an historical criminal record. From further enquires made, the provider demonstrated they had a robust recruitment process in place and person had a positive safeguarding risk assessment that was reviewed on a regular basis by the domiciliary care provider.

Alongside this S42 enquiry, the Care Standards team also completed a Provider Assessment and Market Management Solution (PAMMS) monitoring assessment with the providers to ensure quality and governance procedures were in place for all.

The conclusion of the S42 could not be upheld but it provided an opportunity to make recommendations to the care provider regarding its monitoring of care provided. Further risks were also mitigated with systems to reduce financial exploitation through the Council's money management services and improved record keeping of finances with the individual and care provider.

ICB/BLMK

The Integrated Care Board and Integrated Care Partnership was established in July 2022. The BLMK ICB continues to work in close partnership with all partners in achieving and supporting priorities agreed by the Safeguarding Adult Board. The ICB as one of the three strategic partners is represented by the Chief Nurse, Associate Director Quality and Safeguarding and Designated Professionals for Safeguarding Adults. Previous functions held by Clinical Commissioning Groups were dissolved as the new integrated care boards were established. BLMK ICB continues to provide financial support to the safeguarding partnership as one of the statutory partners.

Priority One - Learning and Assurances from SAR:

The ICB has engaged with action planning following recommendations outlined within Max SAR.

Internally opportunities have been maximised to share learning from the review and promote collaborative discussion. The CYP Transformation Board has identified Preparing for Adulthood / Transition as a key priority, and the ICB lead for this programme also chairs the CBC Transitional Safeguarding group.

Priority Two - Consideration of legislative, financial, structural changes:

With the introduction of Integrated Care Boards, the function of Clinical Commissioning Groups for each place-based area has changed. The ICB continues to provide financial support to the Safeguarding Partnership Boards as one of the statutory partners.

BLMK ICB Safeguarding team structures have been strengthened to enable the ICB to support operational functioning at each place. The recruitment of a Head of Safeguarding and Specialist Safeguarding nurses, working alongside Designated Nurses, along with a new Named GP for Safeguarding mean that safeguarding partners continue to receive support and guidance at both strategic and operational level.

Professional support has been provided to local acute hospitals and community services during industrial action of nurses and medical professions.

The ICB has an MCA Lead who has delivered training across the system covering mental capacity principles and driving work to support the implementation of Liberty Protection Safeguards (LPS).

Priority Three - Training and Communications strategy:

Mapping of training provision against Intercollegiate documents has been concluded by the ICB and a new Training Matrix offering a blended model of safeguarding for primary care colleagues was launched early 2023.

Priority Four- Continued consideration of impact of pandemic on safeguarding:

Self-neglect continues to be a concerning area of safeguarding. Complexity of safeguarding cases also continues to rise with concerns interlinking across all aspects of mental and physical health and social care needs.

Supporting better understanding of local population needs the ICB has continued to be represented on both the hoarding triage meeting and hoarding professional panels. Launched last year a review of the hoarding pathway is now being jointly led with BFRS.

Challenges:
The number of and awareness of referral pathways into safeguarding has been raised for discussion within Safeguarding Operational Group. Process mapping exercise is being undertaken. Recognising delays can occur whilst professionals are navigating pathway use.

There has been an increase in the number of SAR referrals during Q3/4 which has provided challenges to the frequency of meeting for the SAR subgroup and commissioning of reviewers (recognised regionally and nationally as a limited pool). Rapid learning has the potential to be lost.

Complexity in cases has increased contributing to additional safeguarding time, signposting and support needing to be provided to partners.

Changes we are making as a result of the Max SAR:
Preparing for Adulthood and Transition remains a focus within ICB with progression of transition focused workshops to review current practice and drive improvements. Linking all services, education, social care, health and wider partners.

Safeguarding Case Example – Self-neglect/neglect post Covid Pandemic

A Safeguarding referral was submitted for consideration in relation to older person in relation to possible self-neglect/neglect. During community visit(s) concerns were raised in relation to extensive pressure damage, evidence of bruising, dietary intake, and lack of available resources in the home to support care provision.

Concerns were raised for consideration included the hidden carer, family support.

During and post pandemic the impact of caring for family members has been recognised as a theme, with the increased risk for potential safeguarding concerns given impact this can have on both parties.

Communication with GP in relation to escalation has been supported through the ICB and request for internal primary care significant health concern initiated.

Information gathering will continue to further support progression of discussion.

Bedfordshire Police

As police the early arrest of offenders is often used to safeguard victims of domestic abuse, rape or other offence type. The police will use bail conditions or charge and remand the offender to safeguard the victim. It is during the investigation process Police will use Victim Engagement Officers to support and safeguard the victim throughout the criminal justice process.

Victim Engagement Officers (VEO)

The VEO will conduct an Initial safeguarding review and provide advice for high-risk victims, prior to IDVA allocation. Where the victim is risk assessed as medium or low risk, if in the professional judgement a VEO during a face-to-face meeting they will provide support and safeguard the victim. The VEO is responsible for:

- Review safety planning when perpetrators are being released from Prison.
- On receipt of court results or appearances. Update victim and safeguard depending on the result.
- Represent police at professionals' meetings regarding the victims when the OIC is not available.
- Identify repeat victims and develop multi-agency plans to support the victims and prevent/track all work to support the victim to prevent further harm. (MDAV)
- Identify refuges or alternative housing for victims.

Additionally, the VEO will:

- ✓ Attend appointments where the victim needs additional support.
- ✓ Complete Clare's Law process and disclosures. (Clare's Law, often known officially as a Domestic Violence Disclosure Scheme or similar, designates several ways for police officers to disclose a person's history of abusive behaviour to those who may be at risk from such behaviour. It is intended to reduce intimate partner violence. Clare's Law is named after Clare Wood, a woman murdered in England by a former domestic partner who police knew to be dangerous.) Clare's Law has two main elements: a 'right to ask', which allows members of the public, including a domestic partner, to request information from the police about a potential abuser; and a 'right to know', which, in certain circumstances, permits police to disclose such information to the public on their own initiative. Reference: https://en.wikipedia.org/wiki/Clare's_Law
- ✓ Provide victim support advice to officers.
- ✓ Provide internal and external training on VEO and DARA (Domestic Abuse Risk Assessment) process
- ✓ Support MARAC with high-risk domestic abuse reviews and meetings where needed.
- ✓ Support with medium risk domestic abuse reviews, and International Child Protection Certificates and other strategies where needed.

MARAC

The MARAC team are made up of 4 MARAC Officers and a MARAC Manager covering meetings in all three Local authorities, Luton, Central Beds and Bedford Borough. The Luton MARAC is currently attended fortnightly and a pre-MARAC meeting is held fortnightly each Monday. In Bedford and Central Bedfordshire MARAC meetings are held monthly and pre-MARAC meetings are held each Thursday. The MARAC team receive, record, and research referrals from police and other agencies in cases of domestic abuse. MARAC markers are added for each case which shows upon Athena highlighting further incidents in the following 12 months. The MARAC team carry out risk assessments of each case to ensure high risk cases are identified, using the THRIVE principles (Threat, Harm, Risk, Investigation, Vulnerability and Engagement) in all key decision making when assessing and re-assessing risk, with rationale for amendment of risk recorded on Athena. If risks remain high a Modus report is completed to refer to MARAC. The MARAC Team develop and maintain effective liaison with key personnel in the police and other agencies.

The MARAC team Participate in other multi-agency meetings including, safeguarding strategy meetings, professionals' meetings, and ICPC's, as required to support multi-agency safeguarding. This often includes Adult Protection incidents in which Domestic abuse is identified. Additionally, the team carries out Clare's law investigations, Domestic Homicide Review, research, and Police National Database searches.

The VARAC

The VARAC is the only one of its kind in the country and identifies vulnerable adults who need longer term support and safeguarding, working jointly with partners to address lifestyle issues.

Challenges and Barriers:

Police have on occasions struggled to obtain 3rd party material for ongoing investigations to secure a charge and remand such as medical evidence.

The JTAI report will impact on current police processes and ways of working.

As new officers are being recruited it has at times be difficult to provide the specialist safeguarding and other related training immediately.

We have been working with both local authorities to address any backlogs of referrals for medium or low risk and these are reducing.

Specialist investigation teams do not always attend safeguarding strategy meetings and as a force we want to get better at having the best representation.

Safeguarding Case Example – Physical abuse in a care home

Bedfordshire Police responded to an assault by one resident (B) on another (V) at a residential care home on causing Section 18 Grievous Bodily Harm resulting in injuries. B was arrested, charged, and remanded for the assault. There had been a previous incident reported to police earlier in the year between the two residents where V attacked B and took his beer. This incident was reported to police however, no arrests were made due to the vulnerabilities of both parties. B had also assaulted a member of staff the night before he assaulted V which was not reported to police.

The investigation revealed that B was in his early 40's compared to V who was in his early 70's. During the incident that took place in the dining room V pushed B into the back which in turn caused him to react by punching V who also tried to defend himself. V ends up on the floor with B continuing to punch B and proceeded to kick and stamp on his head. Staff intervene and tell the B to go to his room. As the member of staff walks away, B returns and commences a further assault by stamping on the victim's head between four or five more times whilst no one is looking. B goes to his room and returns stepping over V who remained on the floor.

No member of staff is seen to conduct First Aid at the scene despite V being unconscious on the floor. Police did not attend the location until 2 hours after the original call from the care home.

Following this incident, a SAR referral was made to the board and SAR criteria met. The police undertook a review of the policing response. We provided training for staff at the care home and how to respond to such incidents and the need to refer all cases to the police.

Fire and Rescue

In May 2022 we restructured our Prevention department and created a dedicated Safeguarding Advisor position to support and coordinate the Service's Safeguarding approach. To support the new role, a Safeguarding team was formed, comprising of subject matter advisors in youth, vulnerability and healthcare. The BFRS Safeguarding Team's quarterly meeting schedule is supplemented by our Safeguarding reports, which are shared internally and externally to demonstrate progression and inform future practice.

The Service has made significant progress to enhance our ability to identify and refer those at-risk, refresh our safeguarding governance and refine our data capture. Examples include:

- Providing feedback to all referrers
- Enhancements to our training and referral pathway following a recent staff safeguarding survey
- Review and refresh our staff training package and internal Safeguarding Policy
- Refinements to our data capture to enable better reporting

In 2022/23 BFRS has seen an increase of 22% more safeguarding referrals compared to the previous year. Our percentage increase is significantly above the national 4-year average annual growth rate of 8%. Staff survey data demonstrates that following enhancements to our training packages and usability of our referral process, our staff feel more equipped and confident to raise a safeguarding referral than ever before.

Although capacity for safeguarding focused work was created following our restructure, due to the impact and success of the Safeguarding team the demand often overruns the supply in terms of capacity. A significant increase in casework combined with competing organisational priorities result in our availability being spread sparingly in addition to progression being compromised.

BFRS is a pan Bedfordshire Service coordinating with 3 separate local authorities remains a significant challenge, examples include:

- Duplication of work
- Competing meeting commitments
- Local authority referral nuances
- Barriers to sharing of information

Changes we made because of the Max SAR:

Although BFRS did not engage with Max whilst he was alive, the SAR findings and recommendations were scrutinised by our Safeguarding team with a view to understand and implement relevant learning.

Recommendation 10: Partners should consider how to strengthen ICT systems to parse key safeguarding information between agencies and departments.

- Since the introduction of our Safeguarding Advisor, (with support from out Prevention administrator) we have worked closely with local authorities to improve our referral information gathering and secure data capture. All cases generated by our referrals are tracked though established lines of communication with each local authority. The SAB updated on the improvements we had introduced via a presentation in February 2023.

Safeguarding Case Example –

In September 2022, a BFRS fire crew raised a safeguarding referral following a cooking fire at an address, where cooking was burnt activating smoke alarms at the property, indicating concerns for the safety of the resident and support from carers. It was identified by attending BFRS crews that this was a reoccurring event and that we had been called in total 15 times to the address due to false alarms as a result of unsafe cooking behaviours and false alarms.

5 Home Fire Safety Visits had been made to the address in total, but despite this, the unsafe practices were continuing. Concerns were shared directly as a safeguarding referral and passed to other professionals supporting the individual. Although this did not result in a section 42 enquiry, the initial safeguarding referral led to ongoing work with the care agency, occupational therapists and those working closely with the individual. Following staff training provided by ourselves, monitoring of further call outs and advice given, a decision was taken by those supporting the individual to make a best interest decision to disable the cooker/hob at the address unless the person is appropriately supervised by the carers.

As a result, since January this year, there have been no repeat calls to this address. This is a strong example of partnership working, information sharing, support from the expertise of our staff including the awareness of our fire crews and a positive outcome for an individual following a safeguarding referral and actions by all agencies involved.

ELFT

The ELFT Safeguarding Adults team provide Level 3 Safeguarding adults training to ELFT staff twice a month. This training is fully subscribed, and good feedback has been received from staff attending. Section 42 Enquiry training is available for staff who are required to undertake Section 42 Enquiries. The team also provide training to staff on several other areas that are identified as a training need through audits, Serious Incident investigations, Section 42 Enquiries, Safeguarding supervisions and SAR learnings. These sessions include Self-Neglect and Hoarding, Information Sharing, Domestic Abuse, No recourse to public funds and Gambling and its impact.

The Trust Safeguarding Adults Team facilitate a quarterly safeguarding event jointly with Safeguarding Children colleagues for staff covering a variety of relevant topics.

The team undertake quarterly audits of cases in the form of Section 42 audits or thematic audits.

Safeguarding Supervision is offered to all teams on a quarterly basis or more frequently where extra support is required.

Named Professionals for Safeguarding adults attend meetings with partners and work collaboratively as part of the Safeguarding Adults operational subgroup and SAR subgroup.

Named professionals take part and contribute to Safeguarding Adults Reviews, Domestic Homicide reviews and act as subject matter experts in Serious Incident Investigations.

Challenges:

- Domestic Abuse is an endemic that needs tackling and staff needs the knowledge to identify and act proportionately to tackle this abuse using the Trauma Informed Approach, which is addressed in our yearly planning.
- Knowledge and application of the Mental Capacity Act (MCA) poses a challenge and staff will be offered training to understand MCA and its application in Safeguarding, this is being addressed through supervision and MCA teaching packages.
- Duplicate recordings of multiple systems pose a risk and staff are likely to miss recording of important information potentially putting service users at risk and this is being addressed with the Local Authorities across the trust.
- The increase in complexity of self-neglect cases.
- Knowledge and Implementation of SAR learning is a challenge, and this is being addressed via trainings, supervision and newsletters.
- The cost-of-living crisis will impact on the vulnerable population leading to further health and economic inequalities and surfacing as safeguarding concerns.

Changes we made because of the Max SAR:

- Introduced safeguarding supervision for all trust staff.
- Added Transition safeguarding to the Adult safeguarding Policy.
- Develop Safeguarding escalation pathway for section 42 enquiry.
- The trust has a complex case panel chaired by the Director of Social Work.
- The Trust appointed an Adult Transitions Lead.
- Advanced MCA training is being offered to staff.

Our priorities:

- To ensure that transition is robust between each team at the point of transition from child to adult services is a time of particular risk for vulnerable young people.
- Domestic abuse and violence will continue to have high priority within the work of the safeguarding team's key priorities. Safeguarding team to support other teams to embed and support Domestic Abuse screening in all the assessments completed by the trust staff.
- To ensure co-production in Level 3 safeguarding training offered by the trust.
- To ensure Trauma Informed care is embedded in the safeguarding supervision and training offered to all trust staff.
- To continue to raise awareness about hidden harms with a focus on Older People and Learning Disabilities.
- To meet the training trajectory for safeguarding training
- To ensure that the Trust 'Think Family' ethos and professional curiosity is embedded into everyday practice.
- Continue to embed organisational learning from serious incidents and adult/child reviews.
- Corporate Safeguarding Adults and Children team to deliver 'Intergenerational' and 'Intersectional' Safeguarding training for staff.

Safeguarding Case Example – Mr B and Mrs A

Mrs A and her husband Mr B have been married for 47 years and they came to the attention of services when Mrs A, Mrs B and several members of the public called the police out to their family home and various public places. The concerns from the public were around domestic abuse. Mr B was witnessed and heard shouting at his wife and physically grabbing and pulling her back into the house or to the car. Mr B often called the police due to his wife being aggressive with him and even threatening him with a knife. Mrs A called the police and reported that there was an intruder in her house. Mrs A has a diagnosis of Alzheimer's disease.

Mr B was resisting any intervention to provide support and would not allow his wife to be assessed, he was openly hostile to staff visiting the house. Assessing Mrs A's capacity and gaining her views and wishes was increasingly difficult as any attempts to engage was met with hostility and threats.

Mr B was offered a carer's assessment, care support for his wife and respite care but he declined all support. The concerns raised to the police continued to increase and the team sought legal advice. A letter was written to Mr B informing him of the safeguarding concerns and requesting his cooperation to avoid further legal intervention.

Mr B arranged permanent care for his wife independently following a period of attempts to support him and his wife and several professionals' meetings with the aim to protect Mr B and Mrs A's right to private life whilst also ensuring that Mrs A is protected from the alleged abuse and neglect. The safeguarding enquiry supported Mr B to understand the seriousness of the concerns and enabled him to take decisive action to safeguard his wife.

Following Mrs A's placement in residential care, Mr B agreed to attend a meeting with professionals to discuss the concerns. Mr B explained to the attendees how difficult it was to care for his wife especially on days that she did not recognise him as her husband and saw him as an intruder. He explained how sleep deprivation made it difficult to cope during the day. Mr B apologised to staff for his hostile behaviour and agreed to work with the care home to ensure that his wife settles in. Mr B still visits daily to see his wife but reported feeling much better as he is able to sleep at night.

The Safeguarding meeting achieved a good resolution for Mrs A and Mr B and managed to restore relationships to ensure that Mr B could reach out for support if needed in the future.

Bedfordshire Hospitals Foundation NHS Trust

During the period of 2022-2023, Bedfordshire Hospitals Foundation NHS Trust has continued to be an active member of the Safeguarding Board and subgroups aligned to the Board.

The Trust continues to be represented at VARAC (Vulnerable Adult Risk Assessment Committee), MARAC (Multi-agency Risk Assessment Conference), Modern Day Slavery Strategic Group, LeDeR (Learning Disability Mortality Reviews) Strategic groups and Quality Assurance panels, Domestic Homicide Reviews and other multi-agency forums where safeguarding vulnerable adults and children is paramount.

As a Safeguarding team, we have continued to deliver training to staff, as appropriate to their roles in a variety of forms including E-Learning packages, Face to Face training, through virtual platforms alongside role modelling in clinics/ departments and hospital inpatient wards. This has remained a priority for the Trust.

It is evident in the last year that our continued collaboration between the Adult Safeguarding team, Safeguarding Children and Safeguarding Midwifery teams is supportive of our 'Think Family' ethos. This includes the co-location of teams on both sites, allowing a greater opportunity to share good practice and develop our safeguarding skills. We continue to have a Joint Trust Safeguarding Board which not only incorporates both the safeguarding adults and children's agenda but also both hospital sites.

Covid 19 has continued to be challenging to manage within the acute trust during 2022-23. Staffing shortages and pressures continued whereby the safeguarding team had to increase their support to clinical areas to support the safeguarding agenda. As we move into the new financial year, services are returning to pre-pandemic levels.

Safeguarding Case Example – Self-neglect

Patient presented in a state of self-neglect, with dry faeces on their skin and fingernails. It was noted there was also a recent decline in mobility, due to pain and concerns of possible short term memory loss. It was identified that this patient was mainly supported by their mother but lived alone with their children. Staff were informed that they had recently been declining support and/or treatment and was having difficulty in adjusting to their life changing condition.

As a result, an adult safeguarding concern was raised by A & E staff alongside an information sharing Document for children's safeguarding.

The relevant person was admitted to an inpatient ward whereby a Mental Capacity Assessment was completed (relevant person lacked mental capacity to consent to accommodation and treatment) and Best Interest decision for provision of care and treatment was completed. They remained fully dependent on nursing staff. A Deprivation of Liberty Safeguard request was also completed and authorised by the local authority.

Through assessments it was identified that the patient was unable to understand the potential risk of harm associated with her declining medical health and refusal of support services. The patient regularly stated that she wanted to return home and care for herself and her children.

Following initial enquiries, a section 42 enquiry was commenced and overseen by the local authority.

The hospital Adult Safeguarding Team and ward manager attended a planning meeting whereby the following risks were identified, and a safeguarding plan was agreed to address the risks:

1. Risk of self-neglect if she was to return home.
2. Risk of skin integrity
3. Risk of falls
4. Risk of rapid deterioration in her health and wellbeing
5. Risk of disengagement in health services
6. Risk of making unwise decisions in relation to health and social care needs
7. Risk of deterioration in patient's mental

Patient was discharged on the discharge to assess pathway, ensuring the placement was as close to home as possible to enable patient's mother and children to visit. This also allowed the community neuro team to continue to work with the patient.

Evidence Good Practice and Making Safeguarding Personal

- *A & E staff raising adults safeguarding concern and Information sharing document with Children's' social services.*
- *Ward – Clinical practice in line with the Mental Capacity Act 2005*
  - Mental capacity Assessment and Best Interest Decisions.
  - Application for Authorisation of Deprivation of Liberty Safeguards
- *Multiagency working*
  - Section 42 Enquiry initiated
  - Risks and protective factors identified jointly with LA at an early stage
  - Joint planning to manage risks and safe discharge completed.
  - Independent Mental Capacity Advocate appointed to ensure consideration of Patient's thoughts and wishes in relation to the section 42 enquiry and her care and treatment going forward.
  - Support for patient's mother, in relation to her caring role and for the children.
  - Joint working with children's services to provide adequate and appropriate support and services.

East of England Ambulance

2022/23 has been a busy year for the Safeguarding Team as we continue to develop safeguarding at EEAST. Activity has included:

- Second Patient Survey Report seeking views of patients. Patients were generally satisfied with the service received from the Trust, with 91.7% of patients rating the service as either 'good' or 'very good (3% up on previous year)
- Introduced the Child Protection Information System (CPIS) with a requirement to check the CPIS record prior to discharging on scene for any male 18 years or younger and any female 60 years or younger
- Continued development of the Single Point of Contact (SPOC) referral pathways (approximately 2,500 referrals a month are made to safeguarding, social care and GP's)
- Continued participation in safeguarding reviews across 11 local authorities (in excess of 100 reviews in 2022-23).
- Continuation of core trust safeguarding business including training, allegations, safer recruitment, private ambulance service providers compliance visits, regional forums engagement, policy reviews etc
- Reviewed and updated Level 1, 2 and introduced Level 3 safeguarding training packages
- Delivered over 45 virtual level 3 training sessions to more than 1000 staff – ensuring that the Trust is on target to be fully compliant with its 90% target by April 2024. (The cohort requiring level 3 training has increased significantly to include all registrants from circa 70 to almost 2000).
- Scoped in excess of 4,500 Multi Agency Risk Assessment Conferences (MARAC) cases in partnership working with Local Authorities.

For 2023/24 the safeguarding team has a busy year planned including: continue to work to increase the level of training compliance across the service, development of a level 3 safeguarding e-learning package, implementation of allegations tracker software, repeating the safeguarding patient survey report and increasing our visibility both inside and outside the Trust

Performance and Assurance Information
Central Bedfordshire Council

Demographics

Central Bedfordshire is a unitary authority serving a growing population of around 294,100 in 2020. It is a largely rural area with over half the population living in the countryside and the rest in a number of market towns. The largest of these are Leighton Linslade, Dunstable, Biggleswade, Houghton Regis, Flitwick, Sandy and Ampthill.

Central Bedfordshire total Population:

294,096

(used in SALT return)

Population:

By 2032 the population is estimated to increase by

314,343

Safeguarding Adults Data

A total of 4191 concerns were received by Central Bedfordshire Council, 7.6% were taken forward for formal Enquiry under the Care Act 2014.

	2020-21	2021-22	2022-23
Number of Concerns	3,382	4,101	5,616
Numbers progressing to Section 42	262	313	390
% Progressing to Section 42	7.7%	7.6%	6.9%

Ethnicity:

83.5% are white

16.5% Other

Older people:

Of the total population

52,945	over 65
13,246	over 80
2,160	over 90

Commentary

The number of safeguarding concerns has continued to increase year on year. The percentage increase from the year 2021-22 to the year 2022-2023 was a rise of 38% in the number of concerns received. The conversion rate from concerns to safeguarding enquiry has remained relatively similar at 6.9%. To manage demand, risk, and complexity the council increased the staffing resource in the safeguarding team.

The number of outcomes expressed in this year period was higher than in previous ones. However, the number of outcomes not achieved was also higher than in previous years. This can be down do a variety of reasons mainly related to the adult not getting the outcome they desired for the person causing harm. Positively in 123 out of 147 safeguarding enquiries outcomes were fully or partially met.

It is notable that there has been an increase in safeguarding cases within the older population category in the 74-84 and the 85 to 94 age bracket categories. For the category of 75 to 84 there has been a 52% increase and for the category of 85 to 94 there has been a 45% increase. This is an area that will be monitored in the months ahead to see if this trend prevails and to consider the appropriate implications.

In terms of location of abuse, the main location being a person's own home followed by care homes (nursing and residential), this is in line with the pattern in previous years.

The type of abuse that has been most prevalent has been Neglect and Acts of omission which was followed by Physical abuse.

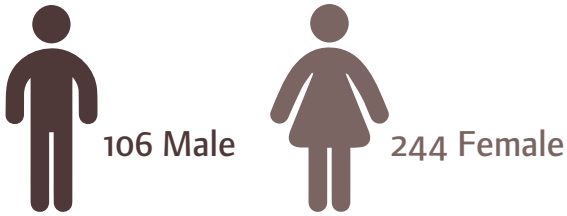
Despite the rise last year in cases of Self-neglect, cases in this period have reduced very slightly, these cases are frequently of high complexity and require excellent multidisciplinary working to minimize risks.

It is notable that Domestic abuse cases in this year has halved in numbers. This is likely to be because of several initiatives to rehabilitate perpetrators of abuse as well as the impact of the extra specialist domestic abuse roles embedded across various teams in adult care services.

In 189 safeguarding enquiries risk was removed or reduced, and in 26 cases risk remained. Cases where 'Risk remains' were slightly lower this year than in previous ones.

Central Bedfordshire Profile of Section 42 Enquiries:

Gender:



Counts of Individuals by Age Band	Age
18-64	149
65-74	49
75-84	99
85-94	90
95+	12

Location	
Own Home	134
In the community (excluding community services)	1
In a community service	4
Care Home – Nursing & Residential	88
Hospital - Acute	1
Hospital - Mental Health	0
Hospital - Community	6
Other / not known	19

Ethnicity:

White - 337

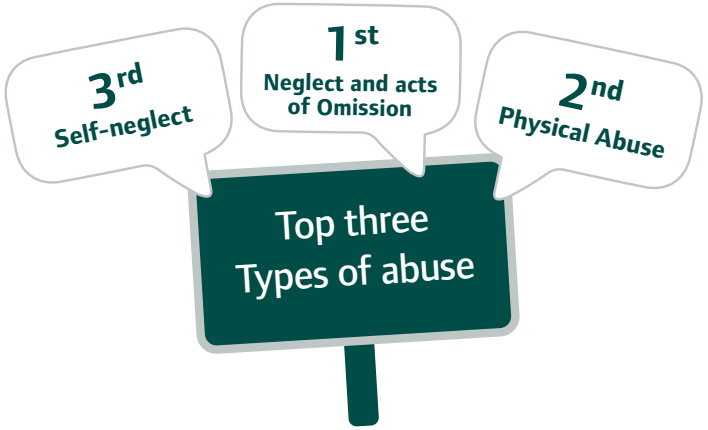
Undeclared - 34

Mixed / Multiple - 2

Black / African / Caribbean / Black British - 5

Asian / Asian British - 4

Another Ethnic Group - 8



Performance and Assurance Information
Bedford Borough Council

BEDFORD BOROUGH COUNCIL

Demographics

Bedford Borough Population:

185,761[1]

(ONS mid-year estimates 2021)

Population:

By 2032 the population is estimated to increase to

198,283

Ethnicity:

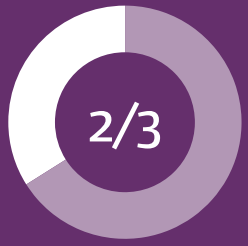
64.1% are white

35.9% are non-white

Older people:

Of the total population

31,274	over 65
8,520	over 80
1,651	over 90



2/3 of the population live in the urban areas.

Over 100

different ethnic groups live in Bedford Borough.

Safeguarding Adults Data

A total of 2835 Concerns were received by Bedford Borough Council, 7% were taken forward for formal Enquiry under the Care Act 2014.

	2020-21	2021-22	2022-23
Number of Concerns	2,835	2,337	2,602
Numbers progressing to Section 42	199	191	97
% Progressing to Section 42	7%	8.2%	3.7%

Commentary

In comparison to previous years Bedford Safeguarding Adults Team have seen an increase in alerts for location of abuse in peoples' own home and in community services eg public space, day service. We have seen a slight increase in type of abuse such as in sexual assault, physical abuse and cuckooing categories.

The number of contacts to the team remained consistent in comparison to last year in quarter 1 and 2 but we saw an increase in reporting quarters, 3 and 4. A contact refers to any information received by the team, including information where a risk is identified but is not a safeguarding risk, information sharing, requests for assessments and changes in packages of care and all safeguarding referrals. Where a contact to the team is not managed under the safeguarding process, it will be forwarded to the most appropriate Care Management or relevant team to manage, or sign posted to the most suitable route.

The 180 completed S42 enquires also represents where there was some enquires concluded from the previous year. There is ongoing work being undertaken to do a deep dive of our reported performance figures.

In quarter 4 Bedford Borough had one care home provider under its Serious Concerns protocol due to quality concerns identified by the local authority, our partners and Care Quality Commission (CQC). The care standards team and partners provided intensive support to stabilise the home, the care provider took the decision to close the service and residents were successfully supported in conjunction with families to identify new placements.

For the year ahead, the safeguarding team will continue with its Independent safeguarding training. Also to work with colleagues across the Adult services directorate to review and develop the safeguarding, care management and quality assurance pathways.

Bedford Borough Profile of Section 42 enquiries:

Gender:

37 Male

60 Female

Counts of Individuals by Age Band	Age
18-64	58
65-74	11
75-84	12
85-94	15
95+	1

Location	
Own Home	90
In the community (excluding community services)	7
In a community service	17
Care Home – Nursing & Residential	3934
Hospital - Acute	6
Hospital - Mental Health	4
Hospital - Community	2
Other / Not recorded	20

Ethnicity:

White - 71

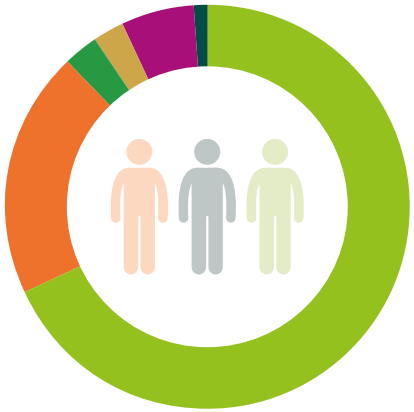
Undeclared - 14

Mixed / Multiple - 0

Black / African / Caribbean / Black British - 7

Asian / Asian British - 4

Another Ethnic Group - 1



Deprivation of Liberty Safeguards (DoLS) Case Study – Deprivation of Liberty – The Safeguards

P is an older person who has a long-standing history of mental disorder. P lived at home with support from her family. She had a fall at home and was admitted to an acute hospital for care and treatment. Following a relapse in mental health P was transferred to a psychiatric hospital for the purposes of assessment and treatment of a mental disorder. P was detained under the Mental Health Act 1983 (amended 2007).

On discharge from hospital, P was admitted to a residential placement (at the height of COVID-19). P objected to the arrangements and wished to return home. This view has consistently been shared by P. P was assessed under the Deprivation of Liberty Safeguards; a short authorisation was issued noting P should be supported to the challenge the authorisation under s21a of the Mental Capacity Act 2005. A person is legally entitled to challenge any authorisation and should be supported to do so as this ensures independent scrutiny by the Court of Protection. A Paid for Relevant Person's Representative (PRPR) was appointed by the local advocacy service and P was supported to challenge the deprivation of liberty. The case has been considered by the Court of Protection with a number of short authorisations being issued to protect P's article 5 rights (right to liberty and security) and the court later extending the authorisations. Throughout the process P's PRPR was commissioned to act as litigation friend. This meant P had continuity of support and ensured her voice was represented in decisions made relating to her care and support.

P has since been supported to return home with 24-hour care. The package continues to amount to a deprivation of liberty and has been authorised by the Court of Protection. P has settled and is happy to be home.

DoLS Data – BBC

Total DoLS Request 2022-23	1201
Number Authorisation Granted	926
Number NOT granted	210
In Progress (as of 31/03/2023)	65

Bedford Borough Council Dols team have seen a decrease of 9.4% from the previous year. Of the requests received 466 (38.8%) were urgent, 721(60.1%) were standard request with 14(1.1%) were reviews of standard authorisations. Of the assessment outcomes that did not progress to a Dols authorisation 210 were not granted. This included 24 assessments where a person was evidenced to have mental capacity, 89 sadly passed away, 8 people were admitted to hospital, 6 were detained under the Mental Health Act. Eighty three people were discharged or moved, placed to receive end of life care and supported by the Mental Capacity Act to prevent the person being put through unnecessary assessment, had authorisations extended by Court of Protection or were found to be the responsibility of another local authority.

There were 338 assessments that had a period of unlawful deprivation due to delays in completion of assessments to then having them signed off and authorised this equates to 28% (an increase of 3% on previous year). Breaking this down 246 of these were less than 10 days, the longest period of unlawful deprivation was 102 days which was accounted for due to another local authority processing the request in error before passing to Bedford Borough as the funding authority. As in previous years, a number of delays were due to Covid-19 related home closures as needed, in line with national infection control guidance and to allow time for the person who was to be assessed to recover.

Challenges for the team remain with Best Interest Assessors (BIA) accepting referrals for urgent authorisations due to the tight timescales for completion or not wishing to travel for out of area assessments due to increases in fuel costs. To mitigate risks of unlawful deprivations from occurring a new contract with a Best Interest recruitment agency was introduced. Other challenges that can cause delay at times when lack of information received from providers and partners required before the assessment can be allocated. Bedford uses a consistent pool of independent BIA's which enables us to be compliant with the current requests. As part of our own employed social worker's personal development, some workers have expressed an interest undertaking the Best Interest qualification, which is currently being explored further.

DoLS Data CBC

Total DoLS Request 2022-23	1968
Number Authorisation Granted	945
Number NOT granted	734
In Progress (as of 31/03/2023)	289

The 2022/2023 annual Deprivation of Liberty Safeguards (DoLS) data for CBC shows a minor decrease in the number of total DoLS requests received when compared with the numbers received in 2022/2023 (just over a 1% decrease). Furthermore, the number of those 'in progress' at the end of the reporting period also being comparable with the number "in progress" last year.

The Central Bedfordshire Council DoLS team is focussed on implementing the current system and this is even more important given the Government announced on the 5th of April 2023, that it would delay the implementation of the Mental Capacity (Amendment) Act 2019 and Liberty Protection Safeguards until "beyond the life of this Parliament."

The performance of Central Bedfordshire Council in the Deprivation of Liberty Safeguards (DoLS) is significantly better than the national average with 85% of all requests received in 2022/2023 having been completed at the end of the reporting period, and the remaining being in progress. This is in contrast to the latest nationally figures that show the number of DoLS cases not completed in 2021-22 was an estimated 124,145 (4% more than the previous year). The effect of the national backlog means that individuals are often left without safeguards for an extended period of time and local authorities are not meeting their statutory duties.

DoLS Case Example

Bedford Borough Council received a DoLS request for a person following the 'discharge to asses' pathway, for recuperation. The Best Interest Assessor (BIA) carried out an assessment. As part of this assessment, the assessor consulted with the person's family, who had reported that they had not been consulted regarding the location of the discharge placement, which happened to be out of the Bedford area and was proving difficult for them to visit.

The BIA recorded this within the assessment and discussed the matter with the DoLS team. A referral was made to the adult services care management team to request a review of the placement and to consider a move closer to home to enable the person to have contact with their family.

This resulted in a Care Act Assessment and whilst this identified that the person still required long-term 24-hour care in a care home it led to the person being moved to a care home in Bedford where family and friends could visit regularly and stay in touch. DoLS in conjunction with good care management ensured that the person's right to family life is protected. The person and their family were involved in identifying the right placement with the persons best interests at the heart of decision making.

SAB Priorities 2023-24

1. The SAB to seek assurance that the Max SAR recommendations have led to measurable change in the way people with autism experience transition from child to adulthood.

2. Having reviewed available safeguarding training during 2022-23 the SAB will aim to make available the following back to basics training during 2023/24:
   a. Safeguarding criteria (when to raise a safeguarding alert) and referrals for social care.
   b. SAR criteria (when to raise a Safeguarding Adults Review, Section 44).
   c. Hoarding Guidance and Best Practice
   d. MCA – considering consent and mental capacity when making a safeguarding alert.

3. For the SAB and its partners to focus on outcomes and for the SAB to seek assurance that safeguarding actions make a difference.

4. To improve SAR action plans to become SMART and outcomes measurable.

5. To improve guidance and tools for safeguarding and front-line practitioners and professions in responding to self-neglect.

To contact the SAB or it's Independent Chair Maud O'Leary

SAB@centralbedfordshire.gov.uk

Abuse: includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory, domestic and organisational abuse and modern-day slavery.

ADASS (Association of Directors of Adult Social Services): the national leadership association for directors of local authority adult social care services.

Advocacy: support to help people say what they want, secure their rights, represent their interests and obtain services they need. Under the Care Act, the local authority must arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or a safeguarding adult review if they need help to understand and take part in the enquiry or review and to express their views, wishes, or feelings.

Alert: a concern that a person at risk is or may be a victim of abuse, neglect or exploitation. An alert may be a result of a disclosure, an incident, or other signs or indicators.

Alerter: the person who raises a concern that an adult is being, has been, or is at risk of harm, abuse or neglect. This could be the person themselves, a member of their family, a carer, a friend or neighbour or could be a member of staff or a volunteer.

BBC Bedford Borough Council: The Lead agency for making adult safeguarding enquiries (under The Care Act) within its Council area.

Care Act 2014: came into force in April 2015 and significantly reforms the law relating to care and support for adults and carers. This legislation also introduces a number of provisions about safeguarding adults at risk from abuse or neglect. Clauses 42-45 of the Care Act provide the statutory framework for protecting adults from abuse and neglect.

CBC Central Bedfordshire Council: The Lead agency for making adult safeguarding enquiries (under The Care Act) within its Council area.

CCG (Clinical Commissioning Group): these were formally established on 1 April 2013 to replace Primary Care Trusts and are responsible for the planning and commissioning of local health services for the local population.

Community safety: a range of services and initiatives aimed at improving safety in the community. These include Safer Neighbourhoods, anti-social behaviour, hate crime, domestic abuse, PREVENT, human trafficking, modern slavery, forced marriage and honour violence.

CQC (Care Quality Commission): the body responsible for the registration and regulation of health and social care in England.

DOLS (Deprivation of Liberty Safeguards): measures to protect people who lack the mental capacity to make certain decisions for themselves which came into effect in April 2009 as part of the Mental Capacity Act 2005 and apply to people in care homes or hospitals where they may be deprived of their liberty.

DA/Domestic Abuse/DV/Domestic Violence: any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to psychological, physical, sexual, financial and emotional abuse. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed

for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or stepfamily (Home Office 2012).

DHR Domestic Homicide Reviews: statutory reviews commissioned in response to deaths caused through domestic violence. They are subject to the guidance issued by the Home Office in 2006 under the Domestic Violence Crime and Victims Act 2004. The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic abuse offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

EEAST East of England Ambulance Service

ELFT East London Foundation Trust: Locally provides for alcohol and drug services, community nursing and mental health services across CBC and BBC.

Harm: involves Ill treatment (including sexual abuse and forms of ill treatment which are not physical), the impairment of, or an avoidable deterioration in, physical or mental health and/or the impairment of physical, intellectual, emotional, social or behavioural development.

Hate crime: any crime that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability.

Human trafficking: the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.

LeDeR Learning Disability Mortality (death) Review Programme: Process by which a suitably qualified person examines the circumstances around the person's life and death to identify any learning and recommendations to improve quality
and practice.

LSCB Local Safeguarding Children's Board: The role of the LSCB is to coordinate what is done by everyone on the LSCB to safeguard and promote the welfare of children in the area to make sure that each organisation acts effectively when they are doing this.

MARAC (Multi-Agency Risk Assessment Conference): a multi-agency forum of organisations that manage high risk cases of domestic abuse, stalking and 'honour'- based violence.

MSP/Making Safeguarding Personal: Making Safeguarding Personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

IOM Integrated Offender Management: Bedfordshire Police Intense support via high risk offender management programme aimed at preventing re-offending.

NHS (National Health Service): the publicly funded health care system in the UK.

Out of Area Placement: A person being accommodated, treated or cared for outside of their area of residency.

PPE – Personal Protective Equipment: equipment such as masks, gloves, gowns, visors etc. worn to prevent spread of infection, including Covid 19.

PREVENT: The Government strategy launched in 2007 which seeks to stop people becoming terrorists or supporting terrorism. It is the preventative strand of the government's counter-terrorism strategy and aims to respond to the ideological challenge of terrorism and the threat from those who promote it; prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support and work with sectors and institutions where there are risks of radicalisation that need to address. It is the preventative strand of the government's counter-terrorism strategy, CONTEST.

Public Health: Public health refers to all organised measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole.

SAB Safeguarding Adults Board, The Board: a statutory, multi-organisation partnership committee, coordinated by the local authority, which gives strategic leadership for adult safeguarding, across the local authority. A SAB has the remit of agreeing objectives, setting priorities and coordinating the strategic development of adult safeguarding across its area under Section 43 of The Care Act.

Safeguarding: activity to protect a person's right to live in safety, free from abuse and neglect. It involves people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that their wellbeing and safety are promoted.

SAR Safeguarding Adult Review: a statutory review commissioned by the Safeguarding Adults Board in response to the death or serious injury of an adult with needs of care and support (regardless of whether or not the person was in receipt of services) and it is believed abuse or neglect was a factor. The process aims to identify learning in order to improve future practice and partnership working.

Safeguarding enquiry/Section 42/S42: the action taken or instigated by the local authority in response to a concern that abuse, or neglect may be taking place. An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry under section 42, right through to a much more formal multi-agency plan or course of action. This is sometimes referred to as a section 42 enquiry'.