Annual Report 2013-2014
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**Introduction/Foreword (2013-14)**

This Annual Report is published as we now know the outline configuration for the new architecture for adult safeguarding in England. The Care Act 2014 places Local Safeguarding Adults Boards (LSABs) on a primary legislative statutory footing. There will be new duties on agencies to co-operate and to share information when requested by the LSAB, closely mirroring duties that already apply to the local authority and its statutory partners (NHS and the Police) in respect of safeguarding children. In particular circumstances LSABs will be required to commission and to publish safeguarding adult reviews, previously known as serious case reviews. The LSAB will have a duty to publish annual business plans and annual reports. Although in some respects this might appear to be business as usual, the clear expectation is that locating these duties within primary legislation will raise the profile of adult safeguarding and strengthen multi-agency commitment to working together to protect adults at risk of significant harm. We will see. Meanwhile, the outcome of consultation on the new regulations and statutory guidance that will flesh out the new duties is awaited. Implementation of the new arrangements is expected in April 2015 and this LSAB has already begun its preparations.

Unlike in Wales there will be no power of entry given to social workers to enable them to enter premises where an adult is suspected of being at risk of significant harm. Nor will there be a duty on practitioners and managers to report safeguarding concerns. Unlike in Scotland there will be no new powers to protect people at risk of significant harm from abuse and neglect. Research evidence exists (Preston-Shoot and Cornish, 2014) that such provisions can help local authorities and their statutory partners to protect people from abuse and harm whilst respecting their human rights. In my view these omissions illustrate that public policy is not also informed by available evidence.

In some respects also the new legislation mirrors the flaws in the legal rules relating to safeguarding children. Agencies are encouraged to contribute alongside adult social care to the resourcing of LSAB but, as Independent Chair, I cannot command them to do so and thus must rely on powers of persuasion. Similarly, agencies are required to co-operate but there are no effective sanctions should they fail to do so. Much therefore depends on relationships that are established and maintained locally. In Luton, practitioners, managers and agencies take seriously their commitments to adult safeguarding and to working together but there are inevitable strains in a time of financial austerity and in a context where there are multiple indicators of deprivation competing for resources. Moreover, whilst the LSAB already has amongst its membership the agencies that are likely to be named in regulations and statutory guidance that will accompany the new duties in the Care Act 2014, there are also sub-groups to resource to ensure appropriate commissioning of safeguarding adult reviews, training and inter-agency audits, and refinement of policies and procedures generally. The adult safeguarding remit also extends to ensuring that Luton’s different communities are fully engaged and that the voices are service users and family carers are heard.

Moreover, adult safeguarding is challenging. Concerns remain about standards of nursing and residential care; Orchid View (West Sussex Safeguarding Adults Board, 2014) is one recent example that illustrates that the events at Winterbourne View (Flynn, 2011b) were not unique. Such occurrences demonstrate the limitations of current workforce regulation and inspection regimes,
and also the challenges facing would-be whistle blowers, especially when there is no duty to report, as mentioned earlier. LSABs must do more to make their presence known to practitioners in settings where people might be vulnerable and to local communities who also have a role in alerting statutory agencies to possible situations of abuse and neglect. This LSAB has stepped up its requirements to ensure that residents are safe and respectfully cared for in Luton’s nursing and care homes.

Nationally and locally there are concerns about single and multi-agency responses to domestic violence and to people with mental distress. These are two areas where LSABs must align their work with Local Safeguarding Children Boards (LSCBs) and with Community Safety Partnerships, in order that the complex mosaic of governance, policy-making and quality assurance of service provision makes effective use of expertise and resources locally. In Luton the LSAB does now have closer linkages with the LSCB and, in anticipation of the Care Act 2014 and in respect to the Luton Serious Case Review on Adult A (Flynn, 2011a), has secured procedures for ensuring that the needs of vulnerable young people are fully considered at the point of transition between children’s services and adult services. There is, though, more to do to ensure that all the quality assurance and governance arrangements in Luton are fully aligned, for example with respect additionally to hate crime, gangs, and all forms of extremism.

Decisions of the Supreme Court have also resulted in a considerable increase in the use of Deprivation of Liberty Safeguards. There are also cases, some involving adults who self-neglect and some people who are taking risky decisions and where their mental capacity to do so is uncertain, where multi-agency working is really tested and requires continual senior management oversight. This LSAB has, in response, extended the remit of its serious case review sub-group so that any practitioner or manager can refer cases where there are concerns about an adult at risk and where multi-agency working has not succeeded in mitigating the risks.

The number of safeguarding alerts being received is increasing and this is to be welcomed if it demonstrates that staff and local communities are now more aware of the importance of ensuring that people live in dignified and respectful surroundings. The services then offered must be personalised and empowering whilst also demonstrating a duty of care that includes protection where necessary. This is at times challenging but there are practitioners and managers who meet these responsibilities on a daily basis and they deserve our appreciation and support.

References
West Sussex Safeguarding Adults Board (2014) Orchid View: Serious Case Review.

Professor Michael Preston-Shoot
Independent Chair, Luton Safeguarding Adults Board
August 2014
Executive Summary


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

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

Acknowledgements

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

The Care Act 2014
The Care Act 2014 received Royal Assent in May 2014 and is a single, modern law for adult care and support that replaces existing outdated and complex legislation. The Act introduces a number of changes to safeguarding adults at risk which will in turn lead to changes in practice over the coming two years. These are:

- A duty to make enquiries where the local authority has reasonable cause to suspect abuse or neglect of an adult at risk (Section 42);
- A duty to share information about a person for safeguarding purposes (Section 45);
- Safeguarding Boards will be placed on a statutory footing with a minimum core membership of the local authority (which retains the lead for adult safeguarding); the police, and the clinical commissioning group (Section 43);
- Safeguarding Adults Reviews will be statutory and will replace serious case reviews (Section 44);
- Section 47 of the National Assistance Act 1948 (which gives a local authority power to remove a person in need of care from home) ceases to apply to persons in England.

The Care Act removes the idea of thresholds for safeguarding adults and instead focuses on the level of risk of harm posed to the individual and seeks to ensure that principles of human rights and self determination at the heart of all safeguarding adult responses. It reinforces the government’s previously stated six principles for safeguarding previously outlined in the statement of policy issued in May 2011 and the White Paper Caring for our future: reforming care and support published in July 2012 the Government issued a further statement on adult safeguarding in 2013 which stated the following key principles of safeguarding adults:

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

An easy read version of this report was published in August 2013

The Care Act Draft Regulations and Guidance are being consulted upon until 15 August 2015.
LGA, ADASS and SCIE (Social Care Institute for Excellence) Making Safeguarding Personal

“Making Safeguarding Personal is a sector led initiative in adult safeguarding. It has arisen in response to findings from peer challenges, the response to the ‘No Secrets’ consultation and other engagement with councils and their partners. It aims to develop an outcomes focus to adult safeguarding work and a range of responses to support people to improve or resolve their circumstances. This should result in safeguarding being done with, and not to, people.”

Making Safeguarding personal Summary of key findings 2013-14.

Councils were invited to engage in work on Making Safeguarding Personal at one or more of three levels:

- Bronze: working with people (and their advocates or representatives if they lacked capacity) as soon as concerns are raised about them to identify the outcomes they wanted and then looking at the end of safeguarding at the extent to which they were realised;
- Silver: the above, plus developing one or more types of responses and or recording and aggregating information about outcomes;
- Gold: the above, plus independent evaluation by a research organisation.

The project found itself with more than twice the number of participating Councils, 53, than it had hoped for – a very positive indication that making safeguarding personal is a key area for development and improvement recognised nationally. All the Councils who completed impact statements stated that they had seen real benefits to people who needed the support of safeguarding services, as well as better social work practice. They intended to continue the work that they started as part of the project.

The next step in the Making Safeguarding Personal 2014 -15 project is for those Councils who have begun the work to continue and new participants to sign up. Around 120 councils so far have signed up to begin the next stage of the programme. A series of workshops will be delivered and all councils will be offered brief individual discussions about the support that can be offered to progress making safeguarding personal.

National reports inquiries and guidance 2013-14

The impact on Winterbourne View continued to have implications nationally.

The serious case review

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

- Strengthening accountability and corporate responsibility for the quality of care;
- Monitoring and reporting on progress;
- Tightening the regulation and inspection of providers;
- Improving quality and safety.
Confidential Inquiry into the Premature Deaths of People with Learning Disabilities, University of Bristol

Mencap’s report *Death by Indifference* described the circumstances surrounding the deaths of six people with learning disabilities who died while they were in the care of the NHS, exposing ‘institutional discrimination’. An Independent Inquiry chaired by Sir Jonathan Michael followed, which recommended the establishment of the learning disabilities Public Health Observatory, and a time-limited Confidential Inquiry into premature deaths of people with learning disabilities. The Confidential Inquiry into the deaths of people with learning disabilities (CIPOLD) was tasked with investigating the avoidable or premature deaths of people with learning disabilities through a series of retrospective reviews of deaths. The three-year study into the extent of premature death in people with learning disabilities found that those with learning disabilities are more likely to have a premature death compared with individuals in the general population.

The findings, published in a Department of Health report, have made a series of recommendations aimed at improving the quality of healthcare that people with learning disabilities receive.

Researchers from the University’s Norah Fry Research Centre and School of Social and Community Medicine, together with colleagues from NHS Bristol and the Royal College of General Practitioners, reviewed the sequence of events leading to all known deaths of 233 adults with learning disabilities, 14 children with learning disabilities and 58 comparator cases (adults without learning disabilities who died in the study area during the same period of time). All deaths occurred over a two-year period in any of five Primary Care Trust (PCT) areas of South West England. The findings showed that people with learning disabilities are more likely to have a premature death than those in the general population. Researchers found that men with learning disabilities died, on average, 13 years sooner than men in the general population. Women with learning disabilities died, on average, 20 years sooner than women in the general population. Overall, 22 per cent of the people with learning disabilities were under the age of 50 when they died compared with just nine per cent of people in the general population.

Dr Pauline Heslop, the study’s lead author at the University of Bristol Norah Fry Research Centre, said:

“This report highlights the unacceptable situation in which people with learning disabilities are dying, on average, more than 16 years sooner than anyone else. The cause of their premature death is not, like many in the general population, due to lifestyle-related illnesses. The cause of their premature deaths appears to be because the NHS is not being provided equitably to everyone based on need. People with learning disabilities are struggling to have their illnesses investigated, diagnosed and treated to the same extent as other people.

These are shocking findings and must serve as a wake-up call to all of us that action is urgently required. We have, over the past few years, been rightly horrified by the abuse of people with learning disabilities at Winterbourne View hospital and of vulnerable patients at Mid-Staffordshire. The findings of the confidential inquiry into the deaths of people with learning disabilities should be of no less a concern.”
Orchid View (West Sussex Safeguarding Adults Board, 2014)
Orchid View was a privately run nursing home which accommodated up to 87 older people including those with dementia. While it was open there were a number of safeguarding alerts and investigations, including the deployment within the home from August 2011 of a team of health and social care staff to mitigate the poor quality of care, leadership and management within the home, provided by Southern Cross Healthcare at regional and national levels. There was sustained police involvement in the safeguarding investigations from 2011. Five members of staff were arrested but the CPS decided there was insufficient evidence to prosecute. At the inquest in October 2013 the Coroner found that five people had “died from natural causes attributed to by neglect” and that several other people “died as a result of natural causes” with “insufficient evidence...to show that this suboptimal care was directly causative” of their deaths.

The SCR over view report used the questions raised by relatives and synthesised these into four questions with 34 recommendations. The questions which have wider relevance are:

1. How can the public be confident that: the organisations they entrust their care to, or that of their loved ones, are properly managed, with good governance and financial security? They provide the good quality of care that they advertise and receive payment for from private individuals and from the public purse?
2. How can people be confident that they or their relative will be safe and well cared for?
3. What support is available to residents and their relatives, how do they know about it and how to use it if there are concerns about the service?
4. How can organisations and individual professionals be held accountable for the safety, quality and practice in their services?

Other Relevant Guidance published in 2013-14

LGA and ADASS Adult safeguarding and domestic abuse: A guide to support practitioners and managers, April 2013
This is a guide for practitioners and managers in councils and partner agencies engaged in working directly or indirectly with people who have care and support needs, whose circumstances make them vulnerable, and who may also be victims of domestic abuse. The guide aims to:

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

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards
The Mental Capacity Act 2005 (MCA) set out the principles and provides a framework to empower and protect people who may lack capacity to make decisions for themselves. “The underlying philosophy of the MCA is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made, or action taken, on their behalf is made in their best interests”. Ministry of Justice website
The five key principles in the Act are:

1. Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise.
2. A person must be given all practicable help before anyone treats them as not being able to make their own decisions.
3. Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
4. Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests.
5. Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

The Deprivation of Liberty Safeguards are an amendment to the MCA and apply in England only. The Act allows restrictions and deprivation of liberty to apply but only if they are in the person’s best interests. Since it’s inception, case law has grown around the interpretation of the Act and on 19 March 2014, the Supreme Court handed down its judgment in the case of “P v Cheshire West and Chester Council and another” and “P and Q v Surrey County Council”. The full judgment can be found on the Supreme Court’s website at the following link:
The judgment is significant in the determination of whether arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty.

A deprivation of liberty for such a person must be authorised in accordance with one of the following legal regimes: a deprivation of liberty authorisation or Court of Protection order under the Deprivation of Liberty Safeguards (DoLS) in the Mental Capacity Act 2005, or (if applicable) under the Mental Health Act 1983.

Key points from the Supreme Court judgment
Revised test for deprivation of liberty
The Supreme Court has clarified that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights in the following circumstances: The person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements.

The Supreme Court held that factors which are NOT relevant to determining whether there is a deprivation of liberty include the person’s compliance or lack of objection and the reason or purpose behind a particular placement. It was also held that the relative normality of the placement, given the person’s needs, was not relevant. This means that the person should not be compared with anyone else in determining whether there is a deprivation of liberty. However, young persons aged 16 or 17 should be compared to persons of a similar age and maturity without disabilities Deprivation of liberty in “domestic” settings. The Supreme Court has held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This will include a placement in a supported living arrangement in the community. Hence, where there is, or is likely to be, a deprivation of liberty in such placements that must be authorised by the Court of Protection.

The accompanying press release with a short description of the cases under consideration can be found at the following link:
Safeguarding Developments and Changes in Luton

The main developments and changes are summarised below.

**Hospital Discharges:**
Although there continue to be alerts raised about the quality of hospital discharges these are decreasing in number, as is the severity of the issues raised. To put the numbers into context, there are an average of four alerts raised per month relating to discharge against an average of 8000 discharges that take place. However work will continue to assure improvements in the discharge process are made.

**Pressure Damage:**
There is a county wide pressure ulcer group and an area team pressure ulcer group to improve pressure ulcers within the county. Providers of services are ensuring that appropriate training is in place, especially the grading of pressure ulcers and documentation regarding essence of care and body maps. This is an ongoing issue that is being monitored regularly by the Clinical Commissioning Group Quality team.

**Multi Agency Safeguarding Hub:**
Bedfordshire Police is currently working towards the formation of a county wide Multi-Agency Safeguarding Hub (MASH). Whilst primarily aimed at child protection it is envisaged that as it matures there will be a place for Safeguarding Adults referrals which will enhance our partnership working.

**Involving people in development of safeguarding services**
SEPT has developed a Safeguarding Questionnaire for those subject to investigation. Feedback is reported regularly and influences the process of engaging service users, their families and advocates. Two ‘Lets Talk’ Service User and public events have been held in Bedfordshire this year.

**Making Safeguarding Personal:**
Luton Borough Council took part in the Making Safeguarding Personal Project at Bronze Level. The Council is now taking part in the second phase of the project and will consolidate its Bronze level position and is aiming to meet Silver level by 2015/16. Making Safeguarding Personal is about ensuring that the person is central to the safeguarding adults’ process and their wishes and outcomes are met. Luton Borough Council is working with partner agencies to ensure that this principle is embedded into all responses.

**Community Safety Partnership:**
The past year has been a period of significant change and challenge for the CSP as a result of both national and local developments. Locally, restructuring within the responsible authorities has had an impact on the CSP, resulting in reductions and changes to staffing across the Police, Local Authority and Fire Service. Transforming Rehabilitation; the government’s programme to overhaul probation services, will also prompt changes within the Partnership. The proposals, which see Probation Trusts’ responsibilities split between a small national public sector service (providing risk assessment and managing high risk offenders), and regional services operated by the private, voluntary and community sector.
(managing low to medium risk offenders) are to be implemented by autumn 2014. While there will clearly be an on-going role for the new providers of probation services within the Partnership, it is anticipated that this is likely to occur within the context of reduced resources and wider geographical responsibilities.

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

Since September 2013 the team’s remit has grown and incorporates placement activity for residential, nursing and domiciliary care. The addition of Brokerage has widened and strengthened our ability to gather local intelligence from a host of professionals which we use to inform our pre risk assessment of providers on a quarterly basis.

The team has now embedded the ADASS contract monitoring toolkit for statutory and non-statutory services into its practice and this data is shared with our ADASS partners to enable effective management strategies across different authorities with the common providers. ADASS reports including comparative scoring by authority and provider are disseminated through the appropriate Director.

The Strategic Partnership (Homecare) is now in the adolescence phase and the substantive issues post tender; delays in placement and timings of calls have mostly been resolved. The latest report to Scrutiny Committee in July 2014 identified improvements made in the overall quality of service provided and this is reflected in individual feedback received as part of our monitoring activity. There are still areas for improvement in relation to call reliability and communication to ensure individuals receive safe, timely care and support. The team is working purposely with the Strategic Partners through its monitoring regime and other forums to influence change in this respect and where a more formal approach is required evoke the Council Escalation policy.

The team successfully introduced call bandings in June 14 after it emerged that demand for home care at certain times of the day outstripped supply causing late and sometimes missed calls for those most vulnerable and affected greatest by delays. Call Banding is a process that categorises individuals by risk using a set of criteria and forms part of the assessment process completed by care management.

The criteria (set out below) is applied when assessing individuals to determine the priority of calls and the banding itself is up to 1 hour before or after the preferred time. For individuals who meet the criteria call should be received within 15 minutes of the agreed planned time and for those people who do not meet the test the time is negotiated between the individual/family and the Strategic Partner but no later than 1 hour earlier or later than the preferred time.
<table>
<thead>
<tr>
<th>Priority</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>Is there <strong>time critical</strong> medication administered?</td>
</tr>
<tr>
<td>Skin Management</td>
<td>Is the individual vulnerable from pressure ulcers or incontinence that requires a <strong>time critical</strong> call?</td>
</tr>
<tr>
<td>Nutrition &amp; Fluid</td>
<td>Is there a <strong>time critical</strong> need for food or fluids?</td>
</tr>
<tr>
<td>Impact on other services</td>
<td>Is the call <strong>time critical</strong> because of transport or any other fixed and reoccurring commitments?</td>
</tr>
</tbody>
</table>

The current data received indicates that only 12% of calls are time critical. This is monitored by Brokerage on a monthly basis and a full review of the criteria and benefit realisation is scheduled for Jan 2015.

Continuing with home care the Purchasing and Quality Assurance’s post tender review identified failure demand in relation to the Strategic Partners capability to accept same day packages which particularly affected the hospital. In collaboration with the Hospital and Care Management a dedicated in take service was commissioned to accept all discharges the aim of which is to reduce the number of delayed discharges and associated risks of cross infection, delayed recovery, increased morbidity, loss of skills and financial penalties. There has been no service failure for 7 months and the hospital report good outcomes.

In the period April 2013 to April 2014 the team conducted 62 service reviews in total which represented 100% of all statutory services at the time. 18 organisations (4 Domiciliary, 4 Nursing, 2 Supported Living & 8 Residential) failed to perform to the expected standards and moved to Provider Performance status under the Councils Escalation Procedure. Of the 18 organisations 6 (2 Domiciliary, 2 nursing, 2 Residential) failed to make the necessary improvements and were escalated to stage two Serious Concerns status. 6 organisations (1 Domiciliary, 1 Nursing, 3 Supported Living and 1 Residential) were under Provider Performance on more than one occasion in a 52 week period from the date of the original review but none reached stage two.

Since April 2014 a total of 7 organisations (2 Domiciliary, 1 Nursing & 4 Residential) have fallen short of the standards expected and moved to Provider Performance but none have escalated any further. The Quarterly Summary Workbook attached provides the up to date position on reviews completed including domain and overall scores.

The Provider Forum convenes on a quarterly basis providing a platform for colleagues and Providers to disseminate information and share best practice. The forum includes a representative of the Safeguarding Board providing a valuable link and resource.

The team’s forward plan includes further integration with the CCG in relation to monitoring and pricing particularly in respect to nursing where bed capacity is limited and demand from health is high potentially leading to a two tiered economy.

The team is at the forefront of discussions with our ADASS colleagues in relation to implementing a regional kite mark that providers will aspire to achieve based on a number of
quality criteria. The aim is to enable purchasers to be able to make an informed choice when making decisions about their care and for commissioners to influence and shape the market. This is at the very early stages of development and as soon as more information is available we will circulate this to colleagues.

The new residential contract for Older Persons and Learning Disabilities is completed pending management sign off. The updated versions now references DBS checks, Human Rights Act 1998, National Minimum Wage, End of Life and discharge arrangements back to the home which are not explicitly covered at present.

The team is represented on the Commissioning & Safeguarding work streams as part of the Councils response to the new Care Act 2014.

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

The safeguarding training programme devised for 2013/2014 was commissioned following a Workforce Needs Analysis, where staff across the Council and private, voluntary and Independent (PVI) identified the needs of the current workforce. The programme developed encompassed a cross section of training for staff within Adult Social Care (ASC) ranging from basic awareness, reporting and responding to safeguarding alerts, investigation knowledge and skills, chairing strategy and recording strategy meetings.

The number of staff booked on training was 709, however the actual number of staff attending reduced to 513, again this was reflective of both statutory and PVI employees. In addition LBC’s Corporate Learning & Development Team introduced a combined safeguarding training for children and adults, which has been delivered as mandatory training for all LBC staff, this training is now part of a rolling programme to ensure all LBC staff are aware and understand their safeguarding responsibilities. Over the year engagement has also been made with some faith groups, and training events have been held within the churches for individuals who either support children, young people and/or adults with additional needs who need to understand the elements of safeguarding and safer working practices.

The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training programme for 2013/14 linked the learning outcomes required to support the competency based frameworks providing the underpinning knowledge staff require to achieve the competency within their role and responsibilities. The embedding of the knowledge into practice of this training has remains the responsibility of the operational managers.
Challenges for the year ahead

Multi-agency Safeguarding Hub (MASH)
Development of a MASH for Safeguarding Adults in Luton. The LSAB will be asked to consider the case for development of a MASH in Luton. A MASH offers the opportunity to improve the sharing of information between agencies, helping to protect the most vulnerable children and adults from harm, neglect and abuse. They are usually staffed by the Police, Health, Probation Trust, Schools, Children's Social Care and Adult Safeguarding, working together in a MASH office.

The MASH receives safeguarding concerns from professionals such as teachers and doctors as well as members of the public and family members. For those concerns that meet the threshold for safeguarding involvement, representatives from the different agencies in the MASH and outside, would collate information from their respective sources to build up a picture of the circumstances of the case and the associated risks to the adult. This collaborative working enables better decision making about what action to take to safeguard the individual. Better co-ordination between agencies will lead to an improved service for adults at risk of abuse.

Deprivation of Liberty Safeguards (DOLS)
DOLS will have major implications for care providers in determining whether there is a deprivation of liberty occurring and whether or not a Deprivation of Liberty Safeguard Authorisation is required. It also has the potential to have major resource implication on the Local Authority which is the Supervisory Body for all applications made for its residents as described above.

DOLS applications have a legal timeframe that must be adhered to - Urgent Authorisations must be completed within 7 days and Standard Authorisations must be completed within 28 days otherwise the Managing Authority will be acting illegally. If the Supervisory Body does not complete it's duties within the legal timeframe it could be legally challenged by the Managing Authority and by the person's representative.

Best Interest Assessments are commissioned by the Local Authority and can cost in the region of between £250 and £600 per assessment plus expenses. Currently there is a shortage of Best Interest Assessors (BIAs) that local authorities can employ directly as a lot have set up as independents and can micro commission with local authorities. Nationally reports are that there are not enough qualified BIAs to meet demand. Some authorities are planning to tackle the problem by training every adults' social worker as a BIA or creating a dedicated BIA team. In the meantime freelance BIAs are getting a large amount of work.

In Luton the Senior Management Team agreed to recruit two locum Best Interest Assessor posts for 6 months. 1.5 posts have been successfully recruited to and it is hoped that we can recruit to the other 0.5 of the post. This has meant that we have been able to cut some of the costs associate with commissioning Best Interest Assessments.
Section 12 doctors are commissioned by the Local Authority and are independent. They carry out other duties such as Mental Health Assessments. In Luton we currently have a number of doctors who we can commission to carry out the necessary assessments for DOLS. For people who live out of area we have successfully commissioned Sec 12 doctors in those areas to carry out the assessments.

IMCAs should be used when a standard authorisation is in place and the person has an unpaid relevant person’s representative. (Paid representatives are expected to understand their role and to provide the person with appropriate support.) There is a need for the Luton Commissioning Team to work with the current provider of advocacy services to develop the service so it can meet the expected demand for IMCAs’.

With regard to safeguarding adults work, there has been an increase from 268 to 584 Alerts in the first quarter of 2014/15 compared to the same period last year. This has coincided with a significant increase in DOLS requests - from 43 in the whole of 2012/13, to 109 in the first quarter of 2014/15.

**Working towards implementation of the Care Act 2014**

The Care Act introduces major reforms to the legal framework for adult care and support in England. The Act introduces reforms to the duties of local authorities; to the rights of those in need of care and support; and to the funding system for care and support. These changes will impact on the way councils do business and the roles of their workforce. They will also have an impact on care providers and user organisations and their roles in the delivery of care, and the expectations and duties placed on them by the new legislation. Implementation will also have implications for the adult social care workforce in England. In Luton work has begun in preparing for the changes required by the Act. There is a Safeguarding Adults work stream which has involvement of all strategic partners. The group is working on the development of a Memorandum of Understanding for the Luton Safeguarding Adults Board; an information sharing protocol and ensuring that Making Safeguarding Personal is embedded in practice and protocol.

**Quality of local care services**

As the above update on the activity of the Purchasing & Quality Assurance team illustrates there is still more to do to improve the quality of care services and ensure that the lessons learnt from the Orchid House serious case review are addressed in Luton.
Partner Reports

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

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

Luton Clinical Commissioning Group /NHS Luton

Introduction
This annual report for Adult Safeguarding is produced to reflect on the progress in Adult Safeguarding in Luton Health Economy between April 2013 to March 2014 but mainly focuses on work since October 2013 when the Head of Adult Safeguarding and Designated Nurse was recruited into post. This report is the first for Luton Clinical Commissioning Group (LCCG) since undertaking its statutory functions.

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

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

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

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

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

**Governance**

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

The Designated Nurse and Doctor for Adult Safeguarding are line managed by the Director of Quality and Clinical Governance.

The Head of Adult Safeguarding is a member of the Luton Safeguarding Operational Adult Board, Serious Case Review (SCR) Group and participates in multi-agency ‘task & finish’ groups as required.

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

Both the Designated Doctor & Nurse attend Adult Safeguarding Peer Reviews chaired by the NHS England Area Team to facilitate discussion and learning across the region.

The Key Health Professionals across NHS Luton meet with the Head of Adult Safeguarding and Designated Nurse monthly to ensure good partnership working and communication providing a forum to share learning.

The Designated Nurse receives supervision and peer support from the Professor for Leadership and Adult Safeguarding at the University of Bedfordshire.

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

- Sexual exploitation;
- Prevent Trainer the Trainer WRAP;
- Making Serious Case Reviews (SCR) Work;
- Roles and Responsibility for CCG’S adult safeguarding leads with the NHS England.

**Progress on work**

**Quality Schedules for Providers**

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

**Gelifish**

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

There is now an Adult Safeguarding site which was introduced. The information is reviewed regularly to ensure it is accurate and up to date and is also emailed out to all providers and the Safeguarding Champions.

**Safeguarding Data**

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

In August 2013 there was an increase in alerts because SEPT started to send all alerts to the local authority (prior to this SEPT managed the mental health alerts in house). The health alerts from SEPT were received by LCCG in August, some of the alerts dated back to May and July 2013. In December 2013 there was an increase in alerts, but no patterns or themes were found. We believe this was due to an escalation in alerts.
Neglect has been the main category for safeguarding alerts received into LCCG since July 2013. Within the category of neglect there are three main themes these are:

- Pressure Damage;
- Discharge;
- Medication.

**Pressure Ulcers**
A member of the Quality team attends the County wide Pressure Ulcer group and the Area Team Pressure Ulcer group to improve pressure ulcers within the county. During the past year we have worked with Providers to ensure appropriate training has been put in place, especially the grading of pressure ulcers and documentation regarding essence of care and body maps. This is an ongoing issue that is being monitored regularly by the CCG Quality team.

**Discharges**
The Head of Adult Safeguarding meets with the Lead for Adult Safeguarding and the Integrated Discharge Manager at the Hospital bi-monthly to discuss any issues regarding discharges. This monitors themes and patterns and taking appropriate learning and actions is evident that this is a real positive approach. Communication within all disciplines has steadily improved with joined up working within multidisciplinary teams which ensures that everyone is sharing assessment and are aware of any issues for a safe discharge. This is evident within the reduced number of safeguarding alerts around discharging.

**Medication**
The Head of Adult Safeguarding is working with the Bedford Clinical Commissioning Group (BCCG) looking at the policy in regards to covert medication including the MCA act this is collaboration with the BCCG Head of Adult Safeguarding and the Designated Doctor for Bedfordshire and the lead Pharmacist for the community in BCCG.

**Ill treatment or wilful neglect**
The government has responded to the consultation of making it an offence to wilfully neglect a patient with capacity (it is already in place for those who lack capacity). It will apply to all formal health and social care provision (excluding children’s services, as this is already covered by legislation).

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

During this past year a process has been put into place to request information from GPs to contribute to the MARAC where possible. However, at times information isn’t shared quickly enough for MARAC, one of the problems is the issue of one secure email address for some GP Practices. There is ongoing work to solve this issue. The designated nurse is part of the MARAC group and specifically asked to attend if there is Health related issues.
These risks remain on the LSCB Risk Register.

**PREVENT**

Prevent strategy aims to stop people becoming terrorists or supporting terrorism and to prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support. Working with sectors and institutions where there are risks of radicalisation that we need to address, PREVENT is part of existing safeguarding responsibilities for the health sector, not an additional job. Healthcare workers have the opportunity to refer vulnerable individuals for support in a pre-criminal space by recognising vulnerable adults, children and young people who may be at risk of radicalisation.

Working in partnership to reduce risk and protect the individual, the designated nurse attends the prevent forums and sits on the CHANNEL panel Bi-Monthly to give Health representation this is shared with the designated doctor and the safeguarding lead at the local hospital this is to give adequate and necessary support as part of a proportionate multi-agency partnership. PREVENT coordinators are being aligned to the Home Office (HO) priority areas, which includes Luton.

**MCA/DOLS**

In March 2014, the Supreme Court delivered a judgement in relation to conjoined appeals of “Cheshire West” and “P & Q”. This judgement should be in force in 2014-15. The precedent created has significantly widened the definition of deprivation of liberty. In short, it is now clear that if a person lacking capacity to consent to the arrangements, is subject both to continuous supervision and control and is not free to leave, they are deprived of their liberty. This has significantly widened the definition of deprivation of liberty and it is clear that people living in domestic and supported living arrangements are now also potentially subject to DOLS.

NHS England has secured 6.1 million pounds for the system to deliver the House of Lords Inquiry into MCA. The Head of Adult Safeguarding will work with the local authority and update all the providers as necessary.

**Personal Health Budget (PHB)**

The implementation was approved by the LCCG Board to allow the process of developing personal health budgets (PHB) in Luton. The Department of Health / NHS England have agreed to pay £20,000 in February 2014 to LCCG for the implementation of PHB. NHSE have been given evidence of the use of this money and progress in the Markers of Progress report submitted on 04/04/2014 and have allowed for LCCG transition. NHSE have been assured that Luton CCG is working towards the implementation of Personal Health budgets for those who are eligible for Continuing Healthcare who have the right to ask for a personal health budget in October 2014. The action plan needs to be agreed by LCCG Board as soon as possible to move forward. The Head of Adult Safeguarding and Designated Nurse is part of the PHB panel for any health related quality issues.

**Training**

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

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

Cambridgeshire Community Services (CCS)

Safeguarding adults
Cambridgeshire Community Services has a commitment and a duty to safeguard vulnerable adults as stipulated in Outcome 7 of the Care Quality Commission Regulations. To achieve this ambition the organisation has to ensure robust systems and policies are in place and are followed consistently, to provide training to enable staff to recognise and report incidents of adult abuse, to provide expert advice and to reduce the risks to vulnerable adults.

Mid-Staffordshire
Concerns about mortality and the standard of care provided at the Mid Staffordshire NHS Foundation Trust resulted in an investigation by the Healthcare Commission (HCC) which published by a highly critical report, chaired by Robert Francis QC, in March 2009 and reviewed in 2013. The Inquiry received many complaints about the patient experience and the report highlighted how basic nursing care, as opposed to clinical errors, led to injury or death. Other areas of concern included lack of and disengaged staff; inadequate cleanliness and infection control; lack of correct diagnosis and treatment; poor standards of communication and discharge management. The culture of staff and management (up to and including Board level) and lack of adequate governance arrangements were also criticised. All of these issues could be characterised as abuse of vulnerable people.

There are clear recommendations from the Inquiry that CCS have identified, from clinical to Board level, throughout 2013 the Chief Nurse has undertaken an organisation wide round of back to the floor visits, attendance at team meetings and staff workshops to ensure that the findings from the Frances report and key learning is embedded in all services. Back to the floor visits by the senior team have taken the opportunities of service focused meetings to initiate conversations with staff and service users to identify how patients and staffs concerns are responded to,
CCS has a responsibility to learn from and act upon the findings and experiences of this case, by ensuring that staff have the highest level of awareness and vigilance regarding and providing for the needs of all adults at risk and under their care.

Albeit that CCS are not the commissioned provider of Learning Disability or Mental Health (as per caseload at Winterbourne View) to the local community, the requirement to support service users with these diagnosis is acknowledged and the work plan for adult safeguarding for 2014-15 will reflect an increased response to the vulnerabilities through networking and the development of safeguarding and learning disabilities champions.

PREVENT
Prevent is part of the government’s anti-terrorism strategy CONTEST, and its aim is to stop people becoming terrorists or supporting terrorism. The strategy promotes collaboration and co-operation among public service organisations. The health service is a key partner in Prevent and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients. CCS has a cohort of Home Office and Department of Health approved Health Wrap Trainers who are rolling out a clinically prioritised programme of awareness training to staff. The CCS resilience team hold the portfolio for PREVENT and report to the Head of Professional Practice. There is active engagement with local CHANEL panels and regional network meetings.

CCS meet the monthly requirement to identify number of staff having received Health WRAP training, number of DOH / HO accredited trainers and the number of referrals made to local CHANEL panels. Prioritisation of training is for a roll out to Safeguarding Team, Senior Management and Execs, Drug and Alcohol Services, Walk in Centre Staff and School Nurses, reflecting the vulnerabilities and risk categorisation of the clients. Health Wrap training, is now included into the corporate Induction programme, and remaining staff will be trained over the coming months.

Workforce Development
Training
CCS must be able to demonstrate to the CQC that ‘Outcome 7 – Safeguarding’ is met: “People are safeguarded from abuse, or the risk of abuse, and their human rights are respected and upheld”.

As a community health services provider, CCS must, therefore, ensure that all employees, volunteers and agency staff are knowledgeable about safeguarding and are confident and competent in carrying out their responsibilities. To fulfil this responsibility, basic awareness training in safeguarding is mandatory for all staff and the trust is able to offer a variety of
formats of training including e-learning via the NHS core learning system, face to face workshops (compulsory to newly appointed staff via corporate induction) and via local authority training programmes, Mental Capacity Act training and Deprivation of Liberty training are available also as e-learning and via local authority training teams. The target for compliance for adult safeguarding training is 95%.

Maintaining training compliance has been an area of focus this year, systems have been reviewed and integrated to ensure consistency, and the training programmes reviewed.

The current compliance rates are on track to be complete by year end. This is monitored by the Trust Board via the Quality report and dashboard on a monthly basis. The risk of noncompliance has been monitored using the Board assurance Framework given the priority given to this issue.

**Training Statistics**
Compliance with adult safeguarding mandatory training is at 98% for the Luton unit. Twice monthly face to face sessions continue for patient facing staff and an NHS Core-Learning unit available to raise awareness for non-clinical non-patient facing staff. Training provided face to face at corporate induction and to pre-registration students embarking on community placement.

**Partnership working**

*Governance and assurance*
As part of the Trust's adult safeguarding responsibilities it is required to provide senior Trust representatives as Board members on the local multi agency safeguarding adult boards. The Trust is currently represented on Luton Safeguarding Adults Board and is an integral decision maker in the development and progression of the local safeguarding agendas. The Trust is also well represented on a number of Partnership Safeguarding Adult Board sub-groups; including Mental Capacity Act/Deprivation of Liberty Safeguard, Training and Development, Policy and Audit.

The Luton Adult Safeguarding Board has established a Care Bill implementation group and is attended by local partner safeguarding leads and is key to the information share development of a strategic approach to the implementation of the new Bill, CCS named nurse for safeguarding will be a member of this working group.

The Trusts’ incident reporting database Datix has been re-modelled to provide data on Adult Safeguarding concerns ranging from potential and suspected abuse, to confirmed and reported episodes of abuse that are escalated to full investigation by the local adult safeguarding teams. The data provides an over view of clusters and trends with both internal and external providers of care that is able to be shared with local council leads.

The CCS safeguarding adult policy supports local Safeguarding Adult Board Multi-Agency policies, is reviewed and updated and is available to all staff on the Trust intranet.
Involving people in development of safeguarding services

Work has started on implementing Safeguarding champions within CCS services in conjunction with Luton CCG and Luton and Dunstable Hospital. Six members of staff from different services within CCS Luton will be attending the training programme, commencing in May 14. The champion will act as an advocate for safeguarding issues, a point of contact for all and a resource to staff within their department. Regular updates will be attended by the safeguarding champion to discuss issues and concerns, Discuss trends and patterns within their areas and gather information to feedback to their teams.

The programme will aim to:

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

Luton and Dunstable Hospital

Prevention and Raising Awareness
Adult Safeguarding continues to have a high profile across the Trust with a continuing commitment to develop awareness across all staff groups the organisation. This awareness is raised through the Adult Safeguarding Board that has Executive leadership and also by ensuring that Adult Safeguarding remains on the Agenda at all quality board meetings.

Safeguarding process flow charts have been further developed to assist all nursing staff across the organisation to understand their roles when a Safeguarding alert has been raised particularly out of hours. These have been disseminated to the appropriate staff via different forums such as the Senior Nurse meetings as well as all training sessions. This has been especially helpful for Senior Staff out of hours in understanding when certain alerts or situations require immediate escalation to our external partners.

The Trust intranet site continues to provide comprehensive information for staff including step by step guides and access to reporting forms that are found under one folder. The Safeguarding lead continues to review and update this as necessary.

Individual care reviews are presented at Senior Nurse forums and provide rich intelligence and key learning that can be disseminated down to all clinical teams.
Awareness of the Prevent programme continues to be disseminated across the Trust by the Safeguarding lead through Safeguarding awareness training sessions. In addition to this the Trust’s safeguarding lead also represents the Trust at the Luton Channel panel meeting alongside the Safeguarding lead for the Clinical Commissioning group to ensure that any health related issues raised either within the community or within the Trust are discussed. There is also Trust representation at Regional Prevent meetings.

**Workforce Development**

A new Adult Safeguarding lead-Chris Harvey was appointed for the Trust in October 2013 to replace the previous post holder who now works for the Clinical Commissioning group as the Adult Safeguarding lead and Designated nurse. Having the previous post holder working alongside the new Trust lead has been very beneficial in maintaining excellent working relationships with our external partners.

There continues to be excellent support provided to the Safeguarding Lead by the Executive lead (Chief Nurse) and also the Lead Consultant for Adult safeguarding lead. There is a weekly meeting between the safeguarding lead and named Consultant to discuss any safeguarding issues that arise and ensure that Safeguarding remains a high priority for the Medical workforce.

The Dementia Nurse specialist works closely with the Adult Safeguarding lead to ensure this particularly vulnerable group are safeguarded. The post holder also provides cross cover for annual leave and sickness to ensure there is continuity and resilience for Adult Safeguarding. There is joint training delivered by the two post holders in Mental Capacity and Deprivation of Liberty to highlight the needs of this patient group. The Dementia nurse also works closely with the psychiatric teams in the identification and assessment of patients with cognitive impairment to ensure they receive the most appropriate care.

The Learning Disability Liaison Nurses are employed by SEPT but contracted to the Trust to provide a liaison service for learning disability patients and hospital staff responsible for providing on-going care. They work closely with the Matrons Senior Nurses and Safeguarding lead to ensure that these patients are reviewed on a daily basis. They provide weekly assurance to the corporate nursing team that these daily reviews are undertaken.

There is a third Safeguarding Champions course that has been commissioned. This will be run in conjunction with the Clinical Commissioning group and the University of Bedfordshire. For the first time the course will comprise of staff from the Community as well as the acute setting. This will have tremendous benefits in establishing cross organisational relationships and promoting cross organisational working. There are 15 attendees from both sectors. These champions will provide a level of support and expertise to their colleagues within their own clinical areas.

Dementia champions are now in place across the trust. These staff have attended workshops and received extended training for the management of behavioural and psychological symptoms of dementia.
Partnership Working

Working with our external health and social care partners is essential if we are to continue to provide a robust service that develops and delivers effective practice.

The Trust continues to actively engage with key local authorities, Luton and Central Bedfordshire and Bedford Borough. In addition to this we also work closely though less frequently with Hertfordshire and Aylesbury Vale. As the Executive lead the Trusts Chief Nurse attends the quarterly Board meetings for Luton and Bedfordshire and the Trusts Safeguarding Lead nurse attends the quarterly operational board meetings. The safeguarding lead also meets regularly with the CCG and Safeguarding social workers from LBC and CBC to discuss and review open cases and alerts.

Partnership working has been central to the improvement work regarding discharge. The safeguarding leads from the Trust and Clinical Commissioning group review all discharges that have been raised as alerts to identify issues and develop improvement plans.

In November 2013 LBC launched their bid to become a Dementia friendly community. The Luton and Dunstable Hospital were present to support and promote this bid. The Alzheimer’s society is also working with the hospital to facilitate dementia friendly sessions that is aimed at non clinical as well as clinical staff.

The Trust has also worked closely with our external partners to support initiatives such as Dementia awareness week. The Trust Dementia lead has supported these initiatives by facilitating stands and raising awareness both within the Trust and also in the community.

The Trusts Safeguarding lead represented the Trust at the Eastern Region Safeguarding conference and the Buckingham University Safeguarding Conference: Risk and Vulnerability. Both these conferences provided the opportunity to develop relationships with our external partners from both a practice and academic background and led to valuable discussions regarding changes in legislation and working practices.

Quality Assurance

Last year 328 safeguarding alerts were raised by the Trust and 66 against the Trust. The emerging themes from the alerts raised against the organisation were around discharges, issues relating to pressure damage, alleged neglect of care and poor communication and documentation. We have worked and continue to work with our external partners to address the issues highlighted by these alerts to improve the outcomes and experience for all our patients. Similarly we are working with our commissioner and local authority partners to support any developments that have arisen out of the safeguarding alerts raised by the Trust and subsequent investigations that have taken place.

In April 2013 as part of our agreed CQUIN scheme the Trust commenced a survey of carers of patients with dementia. In May the key question ‘Do you feel adequately supported while your relative is in hospital’ was introduced to monitor progress in this area and to seek recommendations from carers for action if they do not feel supported. The information gleaned from these surveys will continue to allow us to develop the care that this specific patient group and their carers require. In addition we continue to screen our patients for cognitive impairments that may possibly indicate the early onset of Dementia.
The Trust has maintained its robust response to the Francis report. Several work streams were identified from the report and these responses are being led by the Divisional Matrons and overseen by the Chief Nurse. Progress on this work streams is provided at Trust board meetings including the Nursing Midwifery Board. These developments are then further cascaded through the Ward Sister meetings to the clinical teams. The Trust has continued working towards the development of a positive patient safety culture.

Training and Development
A review of the training programme delivered by the Adult Safeguarding lead was undertaken by the new post holder after commencing in post. Changes to presentations occurred to incorporate new legislation and changes in practice. The review also included mental capacity and Deprivation of Liberty training. Previous training had been delivered by an external expert but after review these training sessions are jointly led by the Safeguarding lead and Dementia Nurse Specialist. In addition to this it was recognised that there was a need for greater awareness of these issues so the training programme was re-evaluated and the number of sessions across the year subsequently increased.

There continues to be an on-going review to ensure that the training programme provides access to all staff and also provides training specific to each individual’s role. Therefore the Safeguarding lead is currently developing a future training programme that will deliver this.

Recent changes in Mental Capacity and Deprivation of Liberty legislation will also mean that the training programme for this will be reviewed and updated accordingly once further guidance has been issued by the Department of Health.

The safeguarding lead recognises the importance of Safeguarding training for Medical staff. All Medical staff are required to complete online training for Adult Safeguarding. However, further training is provided upon request especially on mental capacity and Deprivation of Liberty to divisions. Sessions have thus far been provided to DME and also to the Emergency department.

Improvements to Discharge
As previously mentioned in this report the Safeguarding lead meets regularly with the CCG Lead nurse as well as the Integrated Discharge manager to review safeguarding alerts related to discharge. Much work has been done to improve the process and safety of the discharge of patients from hospital. Some of the improvements that have been made include:

- Attend residential and care forums;
- Attend care provider forums;
- Have arranged for pharmacist to attend Care Provider forums;
- Twice weekly teleconferences with providers / social services and health to facilitate safe discharges;
- Working closely with the Navigation Team;
- Joined up working with Bed Flow Managers to provide a seamless service;
- Recruitment of more discharge officers;
- Management of ward clerks and enabling the Clerks to train as discharge officers;
• Direct access for care providers to discharge planning.

Although we continue to have alerts raised against discharges these are decreasing as is the severity of the issues raised. In context we have an average of four alerts raised per month relating to discharge against an average of 8000 discharges that take place. However we will continue to work towards no alerts being raised against discharges by working with our partners to ensure all issues raised are resolved.

**Improvements made in Adult Safeguarding during 2013-14**

**Prevention and raising awareness** – Awareness of safeguarding continues to be maintained through the Safeguarding board and its Executive leadership and the awareness training provided by the Adult Safeguarding lead nurse. There is greater awareness of key roles within the safeguarding process following the development of process flow charts.

**Workforce Development** – The new Adult Safeguarding lead has developed closer working relationships with the Dementia Nurse specialist and learning disability nurses to ensure that there is greater resilience for Adult Safeguarding across the organisation. The strengthening of the relationships with the Clinical Commissioning group has led to more collaborative working in safeguarding.

**Partnership Working** – The Trust continues to work and further develop its relationships with all its external partners to ensure there is a collaborative approach to Adult Safeguarding. It will work all its external agencies to further enhance the care for Dementia patients.

**Quality Assurance** – The Trust continues to respond positively to safeguarding alerts raised against us and identify themes that arise from them. The increased awareness from the development of process flow charts and through training has enhanced the response to alerts. The case note review of discharge related alerts has continued to improve practice and the patient’s experience.

**Training and Development** – The review of the training delivered to all groups of staff has increased awareness of Adult Safeguarding across the organisation. The provision of a second and now third safeguarding champion’s course has increased the knowledge and expertise available in the clinical areas.

**Improvements Planned in Adult Safeguarding 2014-15**

**Prevention and raising awareness** – A further review of the training programme will ensure that all training is specific to the individual concerned.

**Workforce Development** – The addition of administrative support to the Adult safeguarding team will allow the safeguarding lead to deliver further training and provide greater support to the clinical areas. The continuation of closer working relationships with the Dementia Nurse specialist and the Learning disability nurses will ensure greater resilience within Adult Safeguarding.
Partnership Working – The Safeguarding Lead Nurse and Executive Director for Safeguarding will continue to work in Partnership with LBC to improve outcomes for patients, communication and processes across the system, responsiveness to alerts and agreeing what is an appropriate level of response to an alert.

Quality Assurance – The continuing case note review of alerts relating to discharge will improve practice and the patient experience for patients and carers.

Training and Development – The further an on-going review of the training programme and content will ensure that all training is delivered to the right staff. It will also ensure that it is relevant and reflect new legislation and national and local changes.

Virtual Dementia Tour – An external training company provided Virtual Dementia Tour training that was held within the Trust. This training allows staff who have contact with patients suffering with Dementia to experience the world from the patients perspective using techniques to de-sensitise the individual. This is an excellent innovative training programme and further training will be accessed and made available for all staff across the organisation to increase awareness of the difficulties these patients experience.

Medication Administration Record (MAR Sheets) – As a patient safety initiative the Trust is working towards the development of MAR chart that can be used across all organisations both in the Acute Hospital and also the community. This will seek to avoid duplication of medication charts when a patient’s care is transferred between organisations and this will assist in the prevention of medication errors in the future.

**East of England Ambulance Service NHS Trust**

**Introduction**
All NHS organisations must ensure that they have effective systems in place to safeguard children, young people and adult’s identified to be at risk. Effective safeguarding is an essential part of the East of England Ambulance Service clinical governance arrangements and overall risk management strategy in relation to high quality care. The Trust puts effective safeguarding practise at the heart of good management, patient safety and clinical practice.

**Trust Profile**
The East of England Ambulance Service NHS Trust serves a population of more than 5.8 million in the east of England covering an area of 19,000 km². This region is made up of the counties of Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk. It is predicted that by 2031, this population will grow to around 7 million, with the greatest increase being among the elderly population. An estimated 13% of the population has an ethnic background other than white-British according to the Office for National Statistics. The Trust was established on July 1, 2006 in accordance with Schedule 2 of the NHS and Community Care Act 1990 and by its Establishment Order number 1619.

While the Trust is best known for its emergency ambulances, it provides a range of services including:
• Emergency services – the 999 emergency response which includes handling 999 calls and either deploying the right ambulance staff and vehicles to the patient (ambulance and rapid response provision) or providing the appropriate telephone assessment and referral for the patient. The Trust also transport patients to hospitals from GP referrals known as GP urgent transfers.
• Primary care operations – such as General Practice (GP) and a range of out of hours services (OOH).
• Scheduled transport services – providing pre-planned transport including patient transport services (PTS), courier transport and acute neonatal transport services.
• Special and partnership operations – including resilience and emergency planning, working with charities and air ambulance services, community volunteers and the Hazardous Area Response Team (HART), which is specially trained to provide the ambulance response to major incidents and hazardous environments to enable provision of aid to casualties in situ.

The Trust operates from more than 130 sites across the region with a fleet of more than 1,000 vehicles. Its operations are largely co-ordinated through three Health Emergency Operations Centres (HEOCs) which are located in Bedford, Chelmsford and Norwich. The Trust’s headquarters are based at Cambourne in Cambridgeshire.

The Trust employs nearly 4,000 staff and more than 2,500 volunteers who all work towards ensuring patients get the right treatment in the right place at the right time. Volunteers support the Community First Responder programme or work as volunteer ambulance car drivers.

The Trust support eleven Local Authorities, nineteen CCGs, three NHS England Area Health Teams, six Police forces and many acute and primary health care settings in providing effective safeguarding seamless services.

Safeguarding Team
The Safeguarding Team provide expert knowledge, advise, direction and education in safeguarding issues across the Trust. The team liaise with clinicians, heads of service and directorate managers together with managers who have responsibility for clinical governance and risk management. The remit of the Safeguarding Team includes:

• To have in place policies, procedures and guidelines for safeguarding across the organisation;
• To communicate information relating to safeguarding to all relevant parties within the Trust;
• To ensure that training in safeguarding is accurate and appropriate to the relevant staff groups;
• To work with other clinicians to improve referrals and to strengthen safeguarding in the Trust;
• To provide appropriate safeguarding advice, taking into account national guidance, to key Trust committees;
• To carry out and quality assure safeguarding audits within the Trust;
To ensure all statutory requirements are met and partnership working remains effective both regionally and nationally.

Safeguarding Committee Structure and Accountability
The Safeguarding Group is the main forum for reviewing changes to policy or practice relating to safeguarding. The membership of the group is multi-disciplinary and includes representation from clinical general management and senior management. The group is chaired by the Interim Medical Director and Named Doctor and meets bi-monthly.

The Interim Medical Director and Named Doctor also provide a monthly update in the Board dashboard in relation to referrals and a quarterly report to the Quality Risk and Assurance Committee in the Quality Report.

Additionally, Safeguarding Assistant General Managers (SAGMs) have been identified in each division (this has been difficult in the last year with changes and moving of senior managers within the Senior Operations Managers structure). The SAGMs also come together in a Safeguarding Group chaired by the Head of Safeguarding (this has not been possible in the last year), to help to facilitate best practice and act as a forum for education and discussion.

All SAGMs and the Business Support Manager for NES have Safeguarding supervision from the Head of Safeguarding; all identified leads have undertaken supervision in the last 12 months.

Assurance
The assurance process includes internal and external measures. Internally, the accountability exercised via the committee structure described above ensures that there is scrutiny of compliance against national standards and local policies and guidelines, as well as scrutiny of the safeguarding programme. External assessments are also used as the Trust has a statutory responsibility in relation to Section 11 reviews, undertaken by local safeguarding boards, adult safeguarding audit undertaken by the local safeguarding adult boards of the Eastern Region and Care Quality Commission standards. External assessments are also carried out by the CCGs of the Eastern region, National Peer Review of Ambulance Safeguarding and Deloitte Safeguarding audit.

Peer Review
The National Ambulance Safeguarding Forum (NASF) (the Head of Safeguarding is currently Chair of the forum) managed and monitored by the National Quality Governance and Risk Directors Group (QGARD). Part of the work defined by QGARD is to undertake Peer Reviews in our specialist areas. The trust has been involved in others to include (IPC). The attached report is the outcome of the Peer Review undertaken by London Ambulance and South East Coast Safeguarding Leads.

Deloitte Audit
The Safeguarding Team ensure that all audit results are relayed back to the staff member via the Trust email system, copied into the email is the Safeguarding Assistant General Manager (SAGM) for the area. This is to ensure that if the member of staff needs support or
advice regarding the results they can have a discussion with their SAGM to discuss any issues.

Common themes from reviews and audits

- Review of how training records are stored within the Trust to ensure safeguarding is reflected on staff records;
- Resilience within the safeguarding team;
- Capacity to manage the demand of training within the safeguarding team;
- Identified senior manager leads in all areas of operations;
- Review and update policies;
- Review Corporate Induction to ensure safeguarding is included;
- Management training on safer recruitment;
- Review volunteers training in safeguarding;
- Identify senior management leads in operations and ensure commitment to safeguarding and attendance a multiagency working;
- Manage the risk register and review content;
- Review Trust Safeguarding group and extend invitations out to wider audience;
- Identify a NED from Safeguarding.

Feedback to staff

The Safeguarding Team strive to give feedback to staff after they have made a referral. The Safeguarding Team make contact with the LAs and GPs two weeks after the referral was made and request an update on action taken.

The Safeguarding Team has recently undertaken a review of the Trust system to include the covering letter on referrals to both LAs and GPs. This has seen an increase in external agencies feeding back to the Trust on safeguarding.

The Trust had a Quality Account to provide a minimum of 30-35% feedback to all staff. The Safeguarding administrator designated to the task has consistently produced feedback of an average of 34% over the year. This is an increase of 113% due to the escalation of referrals made during this time period.

Safeguarding Referrals

The Trust Safeguarding Team monitors the safeguarding referrals daily to ensure the quality of information being sent to the General Practitioners and Local Authorities around the Eastern region. The Trust has seen an escalation in referrals by 85% over the last year from 625 – 1229 per month. The upward trend is viewed as positive as it demonstrates increased engagement and ownership by operational staff. This upward projection is not adverse to the National Ambulance Safeguarding referral picture, it is not clear why this has occurred, but has been seen as a positive move towards greater engagement of front line staff and a heightened awareness of patient’s holistic needs.

The Trust was asked by QGARD (The National Ambulance Service Quality Governance and Risk Directors committee) to supply figures regarding Trust referrals per 10k 999 calls to
enable comparisons to with other Ambulance Trusts nationally. As seen below there has been significant increase over the last year 2012-13. The national comparative data is still awaited.

_Safeguarding Reports to the Board_
The monthly safeguarding update and quarterly report forms part of the Quality Report to the Trust Board. The report also highlights any topical safeguarding issues and incidents occurring in clinical practice. The safeguarding annual report for the whole Trust is submitted to the Trust Board. Progress reports are provided to the Quality and Risk Assurance committee. All safeguarding reports are published on the intranet and public web page.

_Partnering Working_
The Trust continues to work in partnership with local Safeguarding Children Boards and the local Safeguarding Adult Boards around the Eastern Region. The assistant general managers with safeguarding responsibilities have started to attend these meetings supported by the Head of Safeguarding, in order to strengthen local area networks. In some area this has been more embedded than others, but there are still gaps within some localities, including Luton, which presents a risk to effective local partnership working.

_Serious Case Reviews (SCR)_
The Trust continues to engage in Serious Case Reviews (SCRs) and Domestic Homicide Reviews (DHRs) in support of all LSABs and Community Safety Partnership Agencies from around the Eastern Region. The Trust continues to receive good feedback regarding the quality of the reports submitted and the level of analysis undertaken.

_Training Programmes_
Trust records have demonstrated clear progress in ensuring frontline staff receive robust training in safeguarding children and adults and that they are informed about the Trust policies and procedures. Consistent approaches to ensuring safeguarding is completed by the Head of Safeguarding was good this year, training staff engaged in booking well in advance to ensure the training was integral in their courses.

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

- Trust training – review of training standards to ensure trust compliance to Intercollegiate Guidance;
- Trust training – ensure that there is a consistent approach to safeguarding training throughout the trust during this year of heavy recruitment;
- Adult safeguarding – evaluate compliance to statutory obligations when issued in October 2014;
- Trust Locality leads – ensure that lead managers are identified in each area and have clear responsibility regarding safeguarding expectations;
- Mental capacity – review capacity documentation;
South Essex Partnership Trust (SEPT)

Highlight report of key issues arising during 2013-14

Prevention / raising awareness
A series of preventative and awareness raising initiatives have been implemented this year within the Trust and audits have evidenced that staff awareness and response to Safeguarding issues has improved in the timeframe process and quality of investigations. Analysis of all SEPT safeguarding cases are analysed for any trends and reported to the Trust Safeguarding Group.

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

Quality Assurance
A weekly report to the Trust Executive Team to give assurance of Safeguarding activity and compliance to timescales. The Trust Safeguarding Group monitors the Safeguarding action plan for assurance.

Involving people in development of safeguarding services
The Trust has developed a Safeguarding Questionnaire for those subject to investigation. Feedback is reported regularly and influences the process of engaging service users, their families and advocates. Two ‘Lets Talk’ Service User and public events have been held in Bedfordshire this year.

Outcomes and improving people’s experience
The outcomes of audits and Service User feedback demonstrates an improved service has been delivered and experienced by Service users.

Improvements made in adult safeguarding during 2013-14

Prevention / raising awareness
The numbers of referrals this year continues to rise and reflects the training programmes delivered which aim to raise awareness of safeguarding issues.

Workforce development
All relevant staff in the mental health service have received a series of specific training programmes this year including Investigations and PREVENT.
**Partnership working**
The Trust continues to be active members of the Luton Safeguarding Board, Operational Group and other sub groups. The Safeguarding Practitioner has raised awareness of mental health services to Luton Social Care staff and has made strong links with LBC Safeguarding Team.

**Quality Assurance**
The Trust has reported consistent improvements in the safeguarding process and outcomes of investigations.

**Outcomes and improving people’s experience**
The process for investigating cases has continued to improve. 95% of Strategy discussions and Closures comply with the Local Authority procedures.

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**Bedfordshire Police**

**Introduction**
Bedfordshire Police uses a risk-based approach, focusing resources in areas and crimes that cause the most harm to individuals and communities. The Force and the Commissioner share a long-term ambition to be a top twenty performing police force for key areas of crime so that members of the public are less likely to be a victim of crime in Bedfordshire than they are across the country as a whole.

Bedfordshire Police continue to place the service to the most vulnerable in society as a key priority. This commitment is reflected in the fact that we have retained safeguarding hubs within the North and South of the county, focussing on vulnerable adult and child abuse investigations.

In addition the Bedfordshire Police and Crime Commissioner places emphasis on victims of Hate Crime, Anti-Social Behaviour and Domestic Abuse within Bedfordshire’s Police and Crime plan.

**Workforce development**
Bedfordshire Police continue to develop the services we provide to the most vulnerable in our communities. Our Safeguarding Investigation Units North and South of the county are now well embedded with well-defined referral processes working well.

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

In response to the HMIC findings around Bedfordshire Police’s response to domestic abuse numerous pieces of work have been undertaken; the most notable being the redesign of our domestic abuse structure and processes. The redesign has been based on a set of clearly defined principles which aim to deliver the best possible solution for the victim. The new structure and processes focus on:
• Ensuring a victim focused approach;
• Improving levels of victim satisfaction;
• Improving the quality and consistency of risk assessment (clear and consistent ownership when transferring between business areas);
• Improving quality (safety planning, reassurance, investigations and outcomes for victims).

Management and membership change
Over the last quarter of this review period the management personnel within the Public Protection Unit has changed slightly. Detective Superintendent Karena Thomas (the Head of Department) remains in post, supported by Detective Chief Inspector Liz Mead who replaces DCI Will Hawkes. D/Supt Thomas and DCI Mead are supported by four Detective Inspectors.

Workforce development/ Partnership working
Work is currently underway around the formation of a county wide Multi- Agency Safeguarding Hub (MASH). Whilst primarily aimed at child protection it is envisaged that that as it matures there will be a place for safeguarding adult referrals which will enhance our partnership working.

The utilisation of the Domestic Violence Disclosure Scheme (DVD’s) and Domestic Violence Protection Notices / Orders (DVPN’s + DVPO’s) have been embedded within Bedfordshire since March and June respectively. DVD’s introduce a recognised and consistent process for disclosing information that enables a new partner of a previously violent individual make informed choices about whether and how to take forward that relationship.

A DVPN / DVPO are aimed at perpetrators who present an on-going risk of violence to the victims with the objective of securing a co-ordinated approach across agencies for the protection of victims and the management of perpetrators. Since implementation, Bedfordshire Police have applied to the magistrates courts on three occasions for the issuing of a DVPO, each have been successful applications.

Raising awareness
Bedfordshire Police are currently in the process of training 59 new recruits who will receive an input from the Public Protection Unit on the safeguarding of vulnerable adults. This particular session is delivered as part of a wider package of training relating to safeguarding and the Public Protection Unit in general. The new recruits will also complete an e-learning package around safeguarding in addition to mental health training which has become mandatory for frontline staff.

All front line staff has received an input from specialist officers within the Domestic Abuse Team around the changes that have taken place since our HMIC visit alongside details of the DVD scheme and rollout of DVPO’s. All front line staff are in the process of completing an e-learning package around DVPN/O’s which has become mandatory for all front line staff.

Bedfordshire Police have also introduced a number of crime investigation seminars, which will be held throughout 2014-15 at Bedfordshire Police HQ. The seminars are designed to
improve the professional competence of all police officers and staff engaged in criminal investigations. Key elements will be:

- New legislation;
- Victim Care;
- A range of guest speakers – Including Op Trident;
- Updated force policies and procedures;
- Serious case reviews and organizational learning;
- Case studies;
- Investigative opportunities and innovative techniques.

The seminars form part of the force’s Transformation Programme, which aims to improve the thoroughness of investigations and the delivery of care to victims of crime and will provide evidence towards investigators continual professional development and maintenance of the PIP accreditation. Over 350 crime investigators have been selected from across all areas of the force to attend the mandatory two-part event.

Quality Assurance
Currently the Standard Operating Procedures (SOPS) for Vulnerable Adult and Child Safeguarding are being reviewed as part of the Public Protection improvement Plan. The aim is to bring all policies and SOPS in line with the Authorised Professional Practice (APP) provided by the College of Policing. APP is the body of consolidated guidance for policing and significantly reduces the amount of national guidance in circulation and encourages the use of professional discretion. APP is authorised by the professional body for policing (the College of Policing) as the national source of professional practice on policing.

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

In the last year 2256 safeguarding adults referrals were processed in the PPU Support Team. Of these, 129 were formally investigated by the Safeguarding Investigation Units with 62 investigations for the North of the county and 67 for the South (which includes Luton). Although this may appear to be a small proportion, the supervisors within the PPUST deal with many of the referrals at source ensuring the police participate in strategy meetings where required and provide advice and guidance on police involvement. Should there be any disagreement on the level of police involvement escalation will take place.

Like many statutory and voluntary agencies, Bedfordshire Police are facing serious financial challenges over the next few years. In order to help address these challenges, we have embarked upon a Continuous Improvement process throughout the organisation to improve service to our communities, reduce wasteful activities, improve our financial stability and enhance Bedfordshire as a place to live and work. The Crime and Public Protection business areas have been identified as priorities for the force due to the seriousness of the crimes
with which they are involved and the level of risk that they are managing on a daily basis. Imperative to the success of the project is engaging with key stakeholders and partners to better understand the effectiveness of our engagement and what improvements may be necessary to enhance that working relationship.

The continuous professional development (CPD) of the workforce will remain a priority with CPD days scheduled in at regular intervals in addition to the Crime seminars details within this document.

**Community Safety Partnership**

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

**Key issues arising during 2013-14**

The past year has been a period of significant change and challenge for the CSP as a result of both national and local developments. Locally, restructuring within the responsible authorities has had an impact on the CSP, resulting in reductions and changes to staffing across the Police, Local Authority and Fire Service.

By working more collaboratively the Community Safety Partnership has minimised duplication of activity and resources by delegating responsibility to progress specific areas of work across these Boards and organisations. Specifically the Community Safety Partnership has agreed that the countywide Demand Reduction Board (a sub-group of the Local Criminal Justice Board, Chaired by the Police and Crime Commissioner), will oversee countywide activity relating to reducing offending and re-offending. Similarly, the Partnership has also agreed to progress key elements of the Luton Domestic Abuse Strategy via another countywide sub-group of the Criminal Justice Board, which focuses on improving the response and performance of criminal justice agencies to domestic abuse. This enables partners to address common issues without replication and ensures more resources are targeted at delivering services. A key example of this over the past 12 months has been the development of the Partnership’s ‘Tackling the Street Sex Trade Strategy’. Working with the support of the Health and Wellbeing Board the Partnership secured additional funding through Public Health to develop new initiatives which support women to exit the on-street sex trade, while simultaneously targeting Partnership resources to tackle demand and support residents. This joint approach is not only the key to the successful delivery of this particular strategy, but also the success of the broader Community Safety agenda.

Our closer links with the local Safeguarding Boards reflect our commitment to safeguarding our residents from harm caused by crime and anti-social behaviour. From developing services to support children affected by domestic abuse, to identifying and supporting vulnerable victims of crime, the Community Safety Partnership recognises the importance of working alongside safeguarding professionals to protect our most vulnerable citizens and make the town a safer place for everyone.
Transforming Rehabilitation; the government’s programme to overhaul probation services, will also prompt changes within the Partnership. The proposals, which see Probation Trusts’ responsibilities split between a small national public sector service (providing risk assessment and managing high risk offenders), and regional services operated by the private, voluntary and community sector (managing low to medium risk offenders) are to be implemented by autumn 2014. While there will clearly be an on-going role for the new providers of probation services within the Partnership, it is anticipated that this is likely to occur within the context of reduced resources and wider geographical responsibilities.

One area where this has already prompted a major change is in relation to Integrated Offender Management (IOM). Locally Bedfordshire Probation Trust have invested heavily in this countywide Partnership initiative, which has achieved considerable success in reducing re-offending rates of prolific offenders. In anticipation of the fact that the new Probation providers would be unlikely to be able to match the current level of resource provided by Bedfordshire Probation Trust, and with the support of countywide colleagues including the Police and Crime Commissioner, partners have established an independent charity; ‘YouTurn Futures’ to oversee the co-ordination of Integrated Offender Management and to develop new Community Safety initiatives. This is a highly innovative step, making Bedfordshire Integrated Offender Management the first voluntary sector led IOM scheme in the country.

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

Over the past year, levels of all crime in Luton fell by 2% (this was a decrease of 304 offences). Offence specific data for priority areas are provided below.

- Domestic burglary fell by 22% from 1564 offences in 12/13 to 1220 offences in 13/14;
- Personal Robbery fell by 16% from 500 offences in 12/13 to 420 offences in 2013/14.

Reporting of domestic violence incidents to the police increased in 13/14 however, because of changes to the Home Office definition of domestic abuse (to include 16 and 17 year olds) which came into effect in 2013, the Partnership is unable to make direct comparisons between the volume of reported incidents of domestic abuse over the period.

During 13/14, the priority ASB team continued work in the area of highest risk anti-social behaviour cases and were able to expand their caseload to include medium-level cases. This meant that there was an additional focus on preventing anti-social behaviour and escalation into more serious issues. As a result, there was a drop in reported ASB incidents in the town as a whole as repeat reports have reduced. The team dealt with 835 cases in 2012, and 676 in 2013; a fall of 19%.

Other key areas of work for the CSP over the past 12 months included the launch of the new force-wide hate crime strategy, the continuation of the CSP’s first on-street sex trade strategy, and continuing work to address gang and related violence in the town.
The policies and strategies referred to above have all been discussed at the Safeguarding Operational Board meetings to ensure coordinated working.

**Bedfordshire Fire and Rescue Service**

**Prevention and raising awareness**
The Service continues to deliver a programme of Home Fire Safety Checks. The board should note that whilst vulnerable adults form part of the target audience not all HFSC’s are delivered to vulnerable adults. During 2013-14 completed 3608 Home Fire Safety Checks countywide (including Luton).

As the enforcing authority of the Regulatory Reform (Fire Safety) Order 2005 on the majority of premises covered by the order in Bedfordshire the Service conducts a risk based audit programme. This includes auditing Residential Care Homes and day care centres. The frequency of audits completed at premises is determined by the level of fire risk.

**Workforce Development**
The Service has its own safeguarding policy which all staff are familiar with. The process of reviewing and updating this policy was commenced during 2013/14.

During the year the Service has developed new Safeguarding training packages. We have developed a basic level bespoke e-learning package and a more advanced classroom based training package for Officers and staff who frequently work with vulnerable adults and children.

**Partnership working**
Managers continue to attend partnership board meetings and when necessary operational meetings relating to Safeguarding Adults.

**Quality assurance**
The Service continue to monitor the number of referrals the service receives to make sure the information provided is correct and all the correct processes have been followed. In 13/14 19 Safeguarding Adult referrals were made.

**Improvements planned in adult safeguarding during 2014-15:**
During 2014/15 all staff within the organisation will complete one of the two Safeguarding courses developed during 2013/14.

A reviewed Safeguarding Policy and procedures documents will be published. This will separate out the Policy and the procedure and incorporate procedures for providing information requested by Multi Agency Safe Guarding Hubs.

**POhWER**

**Key issues arising during 2013-14**
The IMCA service responded to 39 cases referred to POhWER during 2013-14. Of the 39 referrals, 10 were referrals in respect of safeguarding, with one Deprivation of Liberty
Safeguards (DoLS) referral. The IMCA resource is 0.4 f.t.e. 29% of the IMCA’s time has been spent on Safeguarding and DoLS issues.

There have been some instances (3) where inappropriate IMCA referrals have been made – these have been referrals which, on investigation have not met the criteria for the service. The three that did not meet the criteria for IMCA were individuals who actually had capacity. (This is a marked improvement on 2012/13 where 9 people did not meet the criteria.) In all 3 cases the IMCA has reviewed the case with the decision maker and, where appropriate, a Community advocate has been provided.

The Community Advocacy service also receives referrals to support individuals who have been subject to a safeguarding alert. Advocates additionally raise alerts where disclosures have been made to them. During 2013-14 community advocates supported people with 12 safeguarding issues.

**Improvements made in adult safeguarding during 2013-14**

The Luton Community Development Worker continues to work with the Voice groups for people with learning disabilities, to raise awareness and understanding of safeguarding issues.

A modular training programme has been developed by Community advocates. The voluntary training under the generic title “Keep Safe” has been delivered to individuals who have been subject to safeguarding alerts and whom it was thought would benefit. This programme was designed at the request of the Bedford Borough Council safeguarding team. There has been a delay in rolling this out on Luton as there has been a change of Community Development Worker during the period.

POhWER held a very successful conference for service users with learning disabilities in March 2014, with the theme of keep safe, keep well, keep healthy. The conference was also attended by services users from Luton and all together over 700 people attended. All Voice group delegates produced posters on the themes, which were displayed at the conference. Conference delegates enjoyed entertainment and a disco, and were also able to talk to representatives from Bedfordshire Police, the Fire service and the Ambulance Service, as well as a range of other local service providers. The Conference was opened by POhWER’s Chief Executive, Damian Brady, with entertainment being provided by the Bramingham Signers.

Regular staff training updates have taken place during the year, both POhWER-wide and within the local teams, to refresh knowledge on safeguarding issues and on the role of the IMCA/DoLS service.

**Improvements planned in adult safeguarding during 2014-15**

- Continued monitoring of inappropriate IMCA referrals and regular reporting to Safeguarding Leads;
- Further development of “Keep Safe” training modules;

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• Fast-track training of community advocates to enable them to undertake IMCA work in light of Cheshire West ruling;
• POhWER advocates to obtain feedback, where possible, from clients on their experiences of the safeguarding process.
Data on Safeguarding and Mental Capacity Act & DOLS

The Safeguarding Adults Abuse of Vulnerable Adults’ AVA return was discontinued and replaced by a new Safeguarding Adults Return (SAR) in 2013-14. The SAR is a much shorter return, many data fields have been discontinued making comparisons with previous years more difficult. At the time of writing this report only limited data with no analysis is available from NASCIS, making it difficult to compare many areas of Luton’s SAR return with other authorities.

Alerts and Referrals
In 2013-14 Luton received 1,623 alerts and 574 referrals, this compares with 1,113 alerts and 545 referrals in 2012-13. The numbers of alerts shows a significant, 46% increase on last year with a 5% increase in referrals. Based on previous published information for 2012-13 and measured per 100,000 population, Luton’s alerts and referrals are high compared to other councils.

Information collected for the SAR shows over half 299 (52%) of the referrals concerned individuals already known to Adult Social Care (ASC) with 275 or 48% being previously unknown to Adult Social Care (ASC). The ratio of known to previously not known seems to vary significantly between authorities. Initial restricted data published by NASCIS suggest that in five of the 15 other authorities in Luton’s comparator group ASC knew over 90% of the referrals. (See chart included on page 50 under the heading ‘reaching the whole community’).

The SAR does not collect information on the source of the referral. However in previous years the majority of alerts and referrals have been made by professionals (mainly health or care staff) rather than family, friends or the public. Locally collected data supports this, with professionals being the majority of alerters.
Types of alleged abuse or risk
Two new categories of reported abuse were introduced in the SAR: domestic abuse and hate crime. The category ‘multiple’ was removed.

The table below shows the types of abuse and how this has changed. As in previous years neglect was the most common type of reported abuse.

<table>
<thead>
<tr>
<th>Types of abuse</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual</td>
<td>11</td>
<td>16</td>
<td>28</td>
<td>46</td>
</tr>
<tr>
<td>Discriminatory</td>
<td>10</td>
<td>24</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Institutional</td>
<td>19</td>
<td>46</td>
<td>32</td>
<td>28</td>
</tr>
<tr>
<td>Emotional</td>
<td>24</td>
<td>129</td>
<td>127</td>
<td>92</td>
</tr>
<tr>
<td>Psychological</td>
<td>51</td>
<td>137</td>
<td>81</td>
<td>112</td>
</tr>
<tr>
<td>Financial</td>
<td>125</td>
<td>324</td>
<td>194</td>
<td>183</td>
</tr>
<tr>
<td>Physical</td>
<td>216</td>
<td>671</td>
<td>275</td>
<td>251</td>
</tr>
<tr>
<td>Neglect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple</td>
<td></td>
<td></td>
<td></td>
<td>104</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Hate Crime</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

Notes: Clients may experience more than one form of abuse. Most alerts relating to pressure ulcers / skin tissue damage are recorded under the neglect or physical categories.

Locations of safeguarding cases that were investigated in 2013-14
For 2013-14 the SAR requires information about the location of alleged cases to be collected in a slightly different way, enabling correlation to the source of the risk as the charts overleaf show. In 2013-14 as in 2012-13 the most common location was the home.
Individual or organisation believed to be the source of the risk

Note: Social Care Service (SCS) includes self funded, contracted and commissioned services. By correlating SCS with the different types of alleged risk or abuse it is evident that most (109) allegations in 2013-14 fell under the category of neglect or acts of omission, a further 38 cases were recorded as ‘physical’, 12 financial, 10 emotional, 9 institutional and 6 sexual.

Conclusion of safeguarding investigations 2013-14
Given the sensitive nature of allegations and the high percentage of cases that fall under ‘neglect / acts of omission’, it is not surprising that only 99 (17.9%) of the 554 cases that were investigated were fully substantiated, a further 59 (10.6%) partly with 54 (9.7%) being stopped at the request of the individual (victim).

<table>
<thead>
<tr>
<th>Source of Risk</th>
<th>Not substantiated</th>
<th>Inconclusive</th>
<th>Substantiated – partially</th>
<th>Substantiated – fully</th>
<th>Investigation ceased at individual’s request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown / Stranger</td>
<td>13</td>
<td>18</td>
<td>18</td>
<td>98</td>
<td>8</td>
</tr>
<tr>
<td>Known to Individual</td>
<td>41</td>
<td>27</td>
<td>33</td>
<td>98</td>
<td>42</td>
</tr>
<tr>
<td>Social Care Service</td>
<td>45</td>
<td>14</td>
<td>17</td>
<td>78</td>
<td>4</td>
</tr>
</tbody>
</table>
Outcomes of safeguarding investigations
While a very high percentage of cases result in no further action under safeguarding, safeguarding events are recorded on the service user’s record and impact on the frequency of reviews and how risk is managed through community care packages.

<table>
<thead>
<tr>
<th>Action and Risk</th>
<th>No Further Action</th>
<th>Action and Risk Removed</th>
<th>Action and Risk Reduced</th>
<th>Action and Risk Remains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remains</td>
<td>111</td>
<td>5</td>
<td>36</td>
<td>3</td>
</tr>
<tr>
<td>Reduced</td>
<td>167</td>
<td>10</td>
<td>54</td>
<td>10</td>
</tr>
<tr>
<td>Removed</td>
<td>104</td>
<td>8</td>
<td>45</td>
<td>1</td>
</tr>
</tbody>
</table>

Deprivation of Liberty Safeguards (DoLS)
The Mental Capacity Act 2005, which provides a statutory framework for acting and making decisions on behalf of individuals who lack capacity, came into force in October 2007. The Deprivation of Liberty Safeguards (DOLS) were added to the Mental Capacity Act to provide safeguards for those who for their own safety and in their best interests, need to be accommodated under care and treatment regimes which may be depriving them of their liberty, but who lack the capacity to consent. LBC has always acted as the responsible authority for health, organising Best Interest Assessments and signing off authorisations for anyone in hospital or residential and nursing care homes. Along with all other authorities the Council formally took on Supervisory Body responsibility for Health from 1 April 2013.

In 2013/14, Luton had 29 applications for Deprivation of Liberty Safeguards. Of these applications 17 were granted and 12 were not granted. As explained earlier in this report the High Court ruling on 19 March 2014 has led to a significant increase in applications with 109 received between 01/04/2014 and 31/07/2014.

Safeguarding investigations and Mental Capacity Act Assessments
The SAR requires authorities to collect information on the capacity of individuals who were involved in safeguarding investigations to make an informed decision about their capacity to share information. Of the 89 clients who had a mental capacity assessment in 2013-14, just over 30% were found to lack the capacity to make an informed decision about sharing information.
Equality Issues

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

As of 2013-14 the SAR ties together information about safeguarding and equalities – gender, ethnicity, age and client groups – with information about whether referrals were known to the local authority. This is a useful correlation to consider and it is reflected in the charts in this section.

Gender

370 (64%) of the safeguarding referrals made during 2013-14 were about possible abuse of women and 204 (36%) concerned men. Women are also more common in the care management caseload¹, making up 65% of over 65 year olds. Although more referrals concerned women, there is gender balance in respect of referrals being previously known / unknown to ASC.

<table>
<thead>
<tr>
<th></th>
<th>Unknown to LA</th>
<th>Known to LA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>275</td>
<td>299</td>
<td>574</td>
</tr>
<tr>
<td>Female</td>
<td>180</td>
<td>190</td>
<td>370</td>
</tr>
</tbody>
</table>
| Male      | 95            | 109         | 204   | ¹ Data taken from the 2013-14 Referrals Assessments and Packages of Care (RAP) return

Age

In 2013-14 of all 574 referrals 199 (35%) concerned adults 18-64 and 65% concerned people over 65. This is a similar pattern to the previous year in which 33% of referrals concerned adults 18-64 and 67% concerned people over 65.

Comparison with the care management caseload shows that the number of referrals from adults 18-64 is more or less proportionate to the care management caseload, which is 39%.
In 2013-14 58 referrals (10%) concerned people 65-74, 155 referrals (27%) concerned people 75-84 and 162 referrals (28%) concerned people aged 85 and over.

![Safeguarding referrals by age](chart)

In the 65+ age groups, safeguarding referrals were more likely to be for people already known to the authority. In the 18-64 age group, 58% of people referred were not known to the authority.

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

![Older people in Luton: 2011 census](chart)

In 2013-14 126 referrals (22%) came from B&ME groups, compared to 123 (23%) in 12/13. This is slightly less than the percentage of ASC B&ME service users which is 27%. 64 of the referrals concerned people of Asian or Asian British origin (compared to 65 in 12/13) and 42
people of Black African/Black Caribbean/Black British origin (compared to 35 in 12/13). As the above chart on the profile of the older population shows, a far higher proportion of older people in Luton are 'white' and they make up 79% of the care management caseload. This age group constitutes 65% of all referrals so we would expect more referrals to concern white people.

<table>
<thead>
<tr>
<th>Client groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Because of the nature of the adult safeguarding system (which is concerned with adults with care and support needs), almost all safeguarding work is focused on protecting people with some form of disability. Data for 2013-14 shows that the number of referrals for adults with learning disabilities increased to 69, (12%) compared to 45, (8%) in 2012-13. The numbers with substance misuse problems also increased to seven compared to one case and other vulnerabilities to 29 compared to five cases in 2012-13. The number of referrals 129 (22%) for adults and older people with mental health problems shows a small decrease compared to last year 142, (26%). As the chart below illustrates referrals for people with MH problems include far higher proportions that were not known to the authority before the safeguarding referral than for other client groups.</td>
</tr>
</tbody>
</table>
Reaching the whole community

2013-14 data shows that 299 or 52% of referrals were previously known to Adult Social Care compared to 59% last year, indicating that safeguarding is reaching a broader group of at risk residents than those already in receipt of ASC services, especially those with mental health problems.

The NASCIS initial data consolidation shows that Luton performs well on the balance of safeguarding referrals not known to the authority.

<table>
<thead>
<tr>
<th>Client Group</th>
<th>Unknown to LA</th>
<th>Known to LA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Disability, Frailty and Sensory Impairment</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>of which: Sensory Impairment</td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>37</td>
<td>92</td>
<td>129</td>
</tr>
<tr>
<td>of which: Dementia</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>14</td>
<td>55</td>
<td>69</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Other Vulnerable People</td>
<td>4</td>
<td>25</td>
<td>29</td>
</tr>
</tbody>
</table>

Reaching the whole community

<table>
<thead>
<tr>
<th></th>
<th>Luton</th>
<th>Comparator group</th>
<th>All England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>48%</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td>Already known</td>
<td>52%</td>
<td>74%</td>
<td>77%</td>
</tr>
</tbody>
</table>
Serious Case Reviews and other Reviews

One Serious Case Review was commissioned in 2013/14. The case concerns the murder of a man by his neighbour whose behaviour was initially thought by the Police to raise some risks to himself, but not to others. Neither adult was in receipt of adult social care services. Individual Management Reviews (IMR’s) have been completed but the SCR and IPCC report have not yet been published.

The Safeguarding Adults Board also commissioned an independent review of two cases in which women known to health and social care died, with the purpose of identifying whether there were common themes or issues and whether there were opportunities for more effective learning and working within, across and between agencies. The Independent Reviewer’s report was shared across agencies at the beginning of April and a learning event is being held in 2014.
Are we making a difference?
It is always hard to know whether we are making a difference. We have always tried to show what impact our works has on the lives of individuals through case studies.

Case studies

Case Study 1.
A Safeguarding Adults Team member read an article in the local newspaper about a hate crime in Luton. A Screening Manager contacted the police and discussed the matter and a Safeguarding Alert was subsequently made by police colleagues. The Safeguarding Team worked with the adult at risk and his family, as well as police and housing colleagues to agree a safeguarding plan going forward. This included identifying a house move. However the family and the adult at risk rejected the housing offer instead preferring to stay in their current accommodation. The police took action against the offenders.

Case Study 2.
A Safeguarding Alert was made about a young woman who was alleging that she was the victim of sexual slavery. She alleged that she had been brought to the United Kingdom by an “uncle” and that he had made her work without wages in his business as a cleaner and as a sex worker. The young woman was frightened; she was in a place of safety locally but was still fearful. The police were informed and made investigations into the matter. The police found evidence to support the young woman’s claim. A place of safety was identified out of area and the young woman moved there where she is receiving counselling support. The police investigation is on going.

Case Study 3:
A Safeguarding Alert was raised about two adults who were living with their parent in a house that was a hoarding risk. The family were at risk of eviction due to non payment of rent; the fabric of the building and environmental risks. The Alert stated that the adults had not been allowed out of the house for a number of years. Following initial investigation, the case was deemed to be one that required complex case management and was allocated to social workers to work with the family to address the issues.

Case Study 4.
Two Safeguarding Alerts were received from the same professional stating that they were the victim of abuse on two separate occasions. A person the Alerter was working with had tried to hit them with their walking stick on one occasion and on another had made an inappropriate comment. The Alerter was contacted by a member of the Safeguarding Adults Team and informed that as she was not an adult at risk, the Alerts were inappropriate. The staff member’s manager was also informed with a recommendation that the staff member attend further Safeguarding Training.
## Appendix: Luton Safeguarding Adults Board – Structure and Accountabilities

<table>
<thead>
<tr>
<th><strong>Solutions (Community Safety Partnership Board)</strong></th>
<th><strong>Health &amp; Wellbeing Board</strong></th>
<th><strong>Council and Scrutiny</strong></th>
</tr>
</thead>
</table>
| Safeguarding Adults also makes an important contribution to community safety. Accountability managed through Member and officer representation and joint working on specific issues, including domestic abuse, forced marriage, hate crime. | • Safeguarding Adults Board is Accountable to the Health and wellbeing board.  
• Annual Report and additional reports on request to Board or subgroups | • Annual Report in Autumn each year (Covering 01 April – 31 March)  
• Additional reports on request |

### Luton Safeguarding Adults Board (LSAB) – Sets the strategy, budgets, ensures safeguarding strategy is effective

**Membership:** Nominated Chief Officers who link with Chief Executives & Corporate Directors, LBC Lead Councillor for ASC, Lead GP

**Organisations:** LBC Adults Social Care & Community Safety, Luton CCG, NHS England, Luton and Dunstable Hospital, SEPT, Cambridge Community Services (Luton), Ambulance Service, Bedfordshire Police, Probation Service.

### Operational Safeguarding Board – ensures safeguarding is working effectively operationally, remits issues and concerns to LSAB

**Membership:** Service Directors and Heads of Service, Professional Officers with responsibility for safeguarding, stakeholder representatives

**Organisations:** LBC: Adults Social Care, Housing, Children & Learning, Community Safety, Luton Drug and Alcohol Partnership, Luton CCG, Cambridge Community Services (Luton), SEPT, Luton & Dunstable Hospital, Ambulance Service, Bedfordshire Police, Bedfordshire Probation, Advocacy Representative, Healthwatch, stakeholder care provider representatives (to be decided and reviewed regularly)

### Serious Case Review Subgroup – meetings arranged 4 times a year, additional meetings if necessary

### Pan Bedfordshire Subgroups – agreed jointly with Joint CBC and BBC Safeguarding Board. 4 main groups: Policy and Procedures, Quality audit and management review, Training and Development, Mental Capacity and Deprivation of Liberty Safeguards. Meets 4 times a year