Bracknell Forest Council

Safeguarding Adults Annual Report 2010/11

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July 2011

Contents

1. Introduction

1.1 In 2000 the Department of Health published guidance to all Councils with Adult Social Services Responsibilities (CASSR's). The report entitled 'No Secrets' set out guidance to local authorities and their partner agencies relating to the safeguarding of vulnerable adults within their communities.

A key recommendation in 'No Secrets' is that: "Lead officers from each agency should submit annual progress reports to their agency's executive management body or group to ensure that adult protection policy requirements are part of the organisation's overall approach to service provision and service development".

1.2 In line with 'No Secrets' guidance, Bracknell Forest Council has lead responsibility for co-ordinating multi agency procedures that address allegations, disclosures or suspicions of the abuse of adults whose circumstances make them vulnerable. Work with partner agencies ensures that effective prevention strategies are developed and implemented. It is also essential that the Council and its partners have in place policies and procedures to enable an effective and timely response to all safeguarding alerts. At the heart of these processes the Council and its partners should also ensure that people at risk are fully involved in achieving desired outcomes.

2. Progress against the 2010/2011 objectives set out in the 2010 annual report

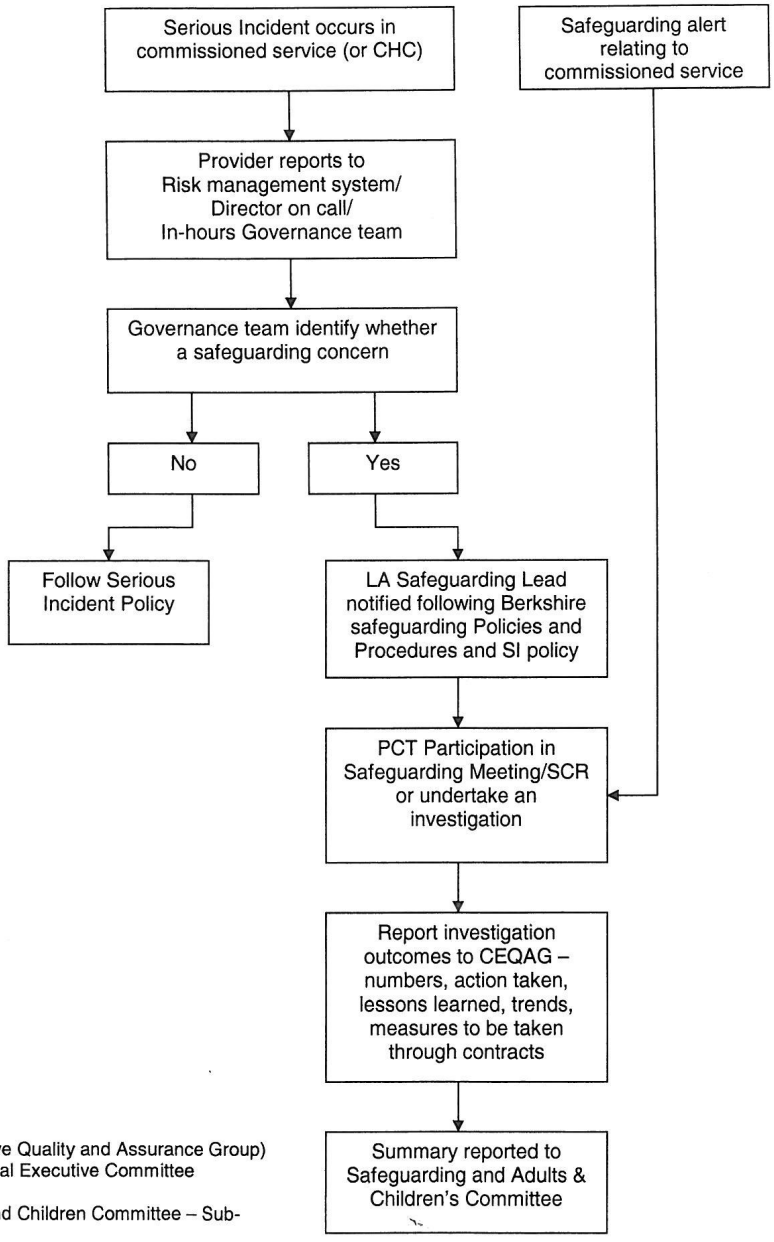
All of the nine objectives set out in last year's report have been achieved and are detailed as follows:-

2.1 **To review the Berkshire Safeguarding Adults Policy and Procedures (2008).** This objective has been achieved. A Project Group was established comprised of representatives from Bracknell Safeguarding Adults Partnership Board, Royal Borough of Windsor & Maidenhead Safeguarding Adults Partnership Board, Slough Safeguarding Adults Partnership Board, West of Berkshire Safeguarding Adults Partnership Board and Berkshire East Primary Care Trust. A developer specialising in public sector web based policies and procedures was identified to review and amend the safeguarding policy. This is currently in draft version and is due to be launched in June 2011.

2.2 **A Serious Untoward Incident/Serious Case Review Protocol to be developed in conjunction with South Central Strategic Health Authority, Berkshire East PCT and Berkshire East Local Authorities.**

NHS Berkshire East

Safeguarding Process Map



CEQAG (Clinical Executive Quality and Assurance Group) – Sub-committee of Clinical Executive Committee

Safeguarding of Adults and Children Committee – Sub-committee of the Board

The PCT provides a health lead in inter-agency planning for safeguarding vulnerable adults, and ensuring health agencies are contributing to inter-agency planning. Serious allegations of abuse are to be reported as serious incidents requiring investigation (SIRI). The PCT must inform the SHA when a Local

Safeguarding Adult Board (LSAB) Serious Case review is to be undertaken. Once an incident has been raised a completed safeguarding alert is to be sent to the local safeguarding team. The safeguarding process will then be initiated with a local investigation, and this investigation will feed the serious incident process. Regular communication is maintained to ensure that a report is produced with identifiable action plan and lessons learnt. Serious safeguarding issues will be reported by the provider Trusts as a serious incident requiring investigation.

2.3 **To work in partnership with health agencies and other local authorities in East Berkshire to use Contracts and Commissioning processes to ensure that adults are appropriately safeguarded when using services commissioned by Berkshire East Primary Care Trust, Berkshire Healthcare Foundation NHS Trust (BHFT) and local authorities in East Berkshire.** A Commissioning for Adult Safeguarding Group was established in April 2010 comprised of:

- Berkshire East Primary Care Trust:
  - Assistant Director – Commissioning
  - Continuing Care Lead,
  - Contracts and Commissioning Manager
- Adult Safeguarding Leads for Slough Borough Council, Bracknell Forest Council and Royal Borough of Windsor and Maidenhead.

Terms and Conditions for contracts have now been updated to take into account recent legislative requirements such as the Deprivation of Liberty safeguards (DoLS). There is now a consistency within health and unitary authority contracts in terms of safeguarding requirements of the provider, compliance with Mental Capacity Act and the DoLS.

2.4 **To ensure that there is a consistent quality of safeguarding training being delivered across Berkshire East, to establish shared standards of safeguarding.** This objective has been achieved and details of safeguarding training activity can be found in section 10 of this report.

2.5 **To ensure that all providers of care homes in Bracknell receive the appropriate training and support in relation to the Deprivation of Liberty Safeguards.** Sixty one departmental and external agency staff attended this training in this reporting year. In addition a DoLS event for providers was held in February 2011 at Bracknell Sports and Leisure Centre. The event was attended by 42 people and nine Managing Authorities (Care Homes) were represented. Attendees benefited from working through case studies with peers from other organisations, Best Interests Assessors (BIAs) and representatives from the Independent Mental Capacity Advocate (IMCA) service. Feedback received from attendees indicated that they had learned a lot more about DoLS and would like to attend further events to maintain their knowledge. Another event is being planned for November 2011. A DoLS quarterly newsletter was developed in September 2010. This is sent to all care homes within Bracknell forest, all staff within Adult Social Care & Health and SAPB membership.

2.6 **Revision of the Council's safeguarding adults staff guidance incorporating the new IT system safeguarding module.** This objective was achieved in June 2010. Guidance was provided for operational staff in how to follow the IAS safeguarding process and also a guide as to how this can be achieved by putting

the person at the centre of the process. Some performance management reports are available and further reports will be available next year.

2.7 **Consideration to be given that all relevant Council employees undertake mandatory Safeguarding Awareness training**. The Corporate Management Team considered this approach and agreed that they would pilot an e-learning tool for adult safeguarding awareness, with a view to it being mandatory for all staff within the Council. This was piloted in March 2011 and agreed for wider roll out.

2.8 **A review to ascertain which Council employees are required to undertake a Criminal Records Bureau (CRB) check**. This issue was considered by Corporate Management Team in August 2010. It was agreed that the identification of roles that require CRB checks was at the discretion of Directors of Departments, and that appropriate review should be undertaken.

2.9 **Raise safeguarding awareness with BME communities in Bracknell Forest.** The Head of Adult Safeguarding gave a safeguarding presentation to the Nepalese Community in February 2011. This was attended by 38 people. Safeguarding referrals are monitored by ethnicity and the analysis will indicate whether this has made a difference in the numbers of referrals received.

3. Bracknell Forest Safeguarding Adults Partnership Board (SAPB)

3.1 The Bracknell Forest Safeguarding Adults Partnership Board was established in March 2009. as a successor to the East Berkshire SAPB. A rolling action plan is developed, agreed and monitored throughout the year. The action plan includes specific actions relating to all of the headings contained in this report.

3.2 The Board is chaired by the Director of Adult Social Care and Health.

3.3 The Board meets bi monthly and during 2010/11was regularly attended by core member organisations including:-

- Bracknell Forest Council
- Thames Valley Police
- Berkshire East PCT
- Berkshire East Community Health Services
- Berkshire Healthcare NHS Foundation Trust
- Ealing Social Services (representing Broadmoor High Security Hospital)
- South Central Ambulance Service
- Care Quality Commission
- Bracknell Forest Voluntary Action
- Berkshire Care Association

This membership represents a wide range of organisations working with adults who may be at risk and therefore has the ability to ensure that safeguarding strategies and key messages are disseminated to relevant people and organisations throughout the Borough. The membership has undertaken a range of safeguarding activity which can be summarised by the following reports from relevant organisations:

3.4 Berkshire Care Association – held a Safeguarding for Managers Study Day in March 2011. This was attended by 26 Registered Managers of care homes in

Berkshire. The day comprised of exploring the risk factors that can contribute to the likelihood of abuse and how these risks can be minimised, and relevant legislation including the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2008. Feedback from the day was very positive and a range of examples of how registered managers would improve safeguarding arrangements in their care homes were recorded in the evaluation forms. These included:-

- More likely to report abuse if in doubt and be more aware of the impact on the resident.
- Make sure that all trained nurses are aware of the safeguarding reporting framework, timescales and how to activate the safeguarding process.
- Ensure that the four point capacity test is undertaken as part of assessments of mental capacity and that the ten point checklist, as defined in the Mental Capacity Act Code of Practice 2005, is undertaken when making best interest decisions.

3.5 Thames Valley Police - A new Adult Protection Policy was produced and published.
Training options were approved by the Training Prioritisation Board including

- level 1 training to be delivered to all front line staff,
- level 2 training to be delivered on a multi agency basis to all specialist staff and
- level 3 training to be delivered on a multi agency basis to specialist supervisors.

These levels are based on the Berkshire East Safeguarding Adults Training Strategy 2010-12. Thames Valley Police have also produced three Options Papers looking at a revision of the internal reporting process (now work in progress as part of implementation of new crime recording system), internal to external referral process (work is ongoing to define crystal reporting process) and an external to internal referral process (result – decision to remain with local area procedures). A classification of S44 (Mental Capacity Act 2005) is now available as part of the crime recording system, which enable the recording and reporting of incidents of "wilful neglect", which is an offence under S44 of the Mental Capacity Act 2005. Information and guidance on the Mental Capacity Act is available for all Thames Valley Police staff on the local policing intranet site and has been circulated to all Inspectors and above. A risk matrix has also been introduced for Anti Social Behaviour which is completed during initial response to incidents and contains questions which are relevant to adults at risk.

3.6 Bracknell Forest Voluntary Action (BFVA) – have reviewed their safeguarding policy and procedures and these were signed off by their Trustees in April 2011. Since November 2010 BFVA have arranged monthly safeguarding training sessions for the voluntary community sector, enabling these volunteers to identify and report suspected, disclosed or alleged abuse. 31 volunteers have attended so far. Safeguarding awareness is also highlighted in the BFVA quarterly newsletter and via email when information regarding safeguarding needs to be disseminated more quickly. Safeguarding awareness is also part of training for all staff and trustees of BFVA.

3.7 Berkshire East Community Health Service (BE CHS) – have produced their own safeguarding adults policy and this has been placed on the staff intranet alongside the Berkshire Safeguarding Adults Policy and Procedures. 14 staff have undertaken the level 2 safeguarding adults training and work independently of, or alongside local authority staff in investigating and assessing safeguarding concerns. All safeguarding concerns within BE CHS are reported to the local

authority and the Safeguarding Lead for BE CHS. All new staff received safeguarding awareness training as part of their induction. BE CHS has now become part of Berkshire Healthcare NHS Foundation Trust and the safeguarding activity will now be the responsibility of the safeguarding lead with that organisation.

3.8 Berkshire East Primary Care Trust (BEPCT) – have established a PCT Children and Adult Safeguarding Committee chaired by the Director of Public Health with non executive representation. This committee has helped develop the PCT`s corporate approach to safeguarding adults. The PCT has also developed a policy regarding the reporting of serious incidents requiring investigation and how this links to safeguarding. In January, February and March of 2011 adult safeguarding awareness training was provided at Bracknell United in Learning and Development (BUILD) sessions, and the equivalent sessions in Slough and RBWM. This was a significant step forward and addressed one of the major risks highlighted to date. These sessions were attended by a total of 182 GPs, 58 Practice Nurses and 4 Practice Managers. All but one practice across East Berkshire was represented at these sessions, providing a good coverage of primary care. It is hoped that the numbers of referrals will increase as a result of this.

3.9 Berkshire Healthcare NHS Foundation Trust (BHFT) – have reviewed their internal safeguarding adults policy and procedures with the intention of clarifying and making explicit the requirement to raise a safeguarding alert with the local authority for all patient-on-patient incidents. They have also reviewed their Incident Reporting Policy with the intention of including a flow chart to explain the process and timeframes for raising safeguarding alerts. Regular meetings have commenced with local authority safeguarding managers to review this activity. The safeguarding lead within BHFT reviews all incidents reported via the electronic recording system and will liaise with the team where the incident happened if safeguarding concerns have not been identified, requesting that they discuss with the local authority safeguarding team.

3.10 Broadmoor High Security Hospital (West London Mental Health Trust & Ealing Social Services) – Work has gone into revising Broadmoor's safeguarding policy and procedures. A Broadmoor Safeguarding Panel has been established comprising of the social work, clinical and security leads. The role of the panel is to

- identify staff training needs and either deliver or commission the training,
- provide regular analysis of safeguarding activity within the hospital,
- identify clear thresholds applicable to the seriousness of the safeguarding alert and involve external agencies as appropriate,
- clearly identify safeguarding roles within the workforce and
- maintain the positive relationship with the Bracknell Forest safeguarding team.

The Chair of the Panel provides a biannual report to the Bracknell Safeguarding Adults Partnership Board detailing safeguarding activity.

4. Bracknell Forest Safeguarding Adults Forum

4.1 The Forum continues to meet on a quarterly basis and is an information sharing and consultation Forum, which ensures that local stakeholders are engaged in the safeguarding agenda. The Forum has been in operation for four years, and

continues to be regarded by local stakeholders as a positive group, which is useful to the local community. The Forum reports to the Bracknell Forest Safeguarding Adults Partnership Board.

4.2 59 people have attended the group over the past year this includes representatives from:-

- People who use services
- Bracknell Forest Council
- Care Home providers
- Domiciliary Care agencies
- Advocacy organisations
- Berkshire East Primary Care Trust
- Independent Hospitals
- Berkshire East Community Health Services
- Ealing Social Services (Broadmoor High Secure Hospital)
- Berkshire Healthcare NHS Foundation Trust

4.3 A range of external speakers have addressed the Forum including:-

- Ian Grimwood from the Independent Mental Capacity Advocacy (IMCA) service (Matrix) for all the unitary authorities in Berkshire. Ian explained what an IMCA does and what type of best interests decisions they can support people who lack capacity to contribute to, including
    - a move/or change of accommodation,
    - consent to serious medical treatment,
    - support with a care review,
    - support through any safeguarding process, or Deprivation of Liberty safeguards.
- The Safeguarding Adults Development Worker provided the Forum with an overview of the role including the intention to work with service providers in developing their safeguarding processes and ensuring compliance with the Mental Capacity Act
- The Bracknell Forest Head of Adult Safeguarding has provided the Forum with an update on local activity in relation to the Deprivation of Liberty Safeguards.
- At the February 2011 Forum the Terms of Reference were reviewed by all attendees. It was decided that the Forum should move to a less formal setting than the Council Chamber and that case studies should be introduced to enable reflection on good practice, and identify where practice could be improved. This will be achieved within the current budget.

5 Care Governance Board (CGB)

The Care Governance Board meets monthly to share, discuss and agree actions in relation to information received regarding both internal and external providers of services. Sources of information include:

- CQC Reports and Regulatory letters/information
- Cautions, alerts or references from other Local Authorities
- Safeguarding Adults Alerts/Referrals

- Requests and authorisations for Deprivation of Liberty Safeguards
- Complaints, MP enquiries and member enquiries
- Financial and insurance checks
- Feedback from individuals, providers or care management reviews.
- Quality Assurance Tool

When a concern or concerns are triggered from one or more of the sources detailed above the Care Governance Board will decide what degree of caution needs to be "assigned to" the provider, based on the seriousness of the concerns. This may mean that a decision is made to temporarily suspend the commissioning of new services from those providers, whilst the concerns are being resolved. The following method is used to determine the level of caution that should be taken once concerns have been received.

A **red flag** indicates a possible high risk to people using that service and no new packages will be commissioned whilst the concerns are being resolved. All individuals receiving support via BFC will be reviewed, and other relevant local commissioning organisations (Local Authorities and NHS) informed. A robust action plan may be developed with the provider and monitored. Outcomes from the plan will be reviewed and any action plan updates will be shared with the Care Governance Board to inform decisions about future levels of caution. Each provider will have been sent a guide to the cautions approach, and are always informed when a red flag has been decided upon. Providers are also provided with a named contact within the local authority with whom they can discuss the concerns raised. It is important to note that a red or amber flag does not necessarily mean that a provider has done 'something wrong'. It does mean that the local authority has received information which makes it necessary to proceed with caution until concerns are resolved.

An **amber flag** indicates a medium risk and will indicate that there is a robust action plan and monitoring regime in place. The commissioning of packages may be agreed after a risk management plan has been completed. As with services where the degree of caution necessitates a red flag, action plan updates and review outcomes will be shared at Care Governance Board and decisions made as to caution status.

A **green flag** indicates a low or no risk and will be given when the Chief Officer and Care Governance Board are satisfied that all quality issues and concerns have been addressed. All service providers where there have been no concerns will automatically have a green flag status.

5.2 Significant improvement has been evidenced as a result of Care Governance Board involvement and feedback from the Quality Assurance Tool. These improvements include:-

- A care home has now implemented new activities plans to suit each individual resident enabling them to maximise their abilities and pursue their interests e.g. One resident goes to the library once a week, one resident is supported to visit a pub on a regular basis and the home will hire a minibus so that residents can enjoy planned group outings.
- In another care home the manager has now arranged for the care plans and staff files to be administered properly i.e. No pages falling out and ordered logically.

- A care home has revised its quality assurance system so that it receives relevant feedback from residents and families rather than just yes or no answers.
- Another care home is now implementing a suggestion box as part of their quality assurance monitoring so that residents and visitors can feed back anonymously, and at any time.
- Two providers of support for people with learning disabilities who live in their own homes have worked closely with learning disability services at Bracknell Forest to more effectively integrate people with autism and sensory needs with their peers.
- Learning disability services have also worked with providers of support for people who live in their own homes to improve person centred support planning for people with complex needs, and improve risk assessment and risk management. This has resulted in an increase in quality of life for people who use these services.

CQC star ratings are being phased out and the proposals for a replacement system are now out for public consultation. The CQC website still shows some providers as having a one star status even though this assessment may have been based on historic inspection reports. Bracknell Forest Council is using a Quality Assurance Tool with providers and attaching a flag status according to the outcome. This provides a fairer way in assessing the quality of services that the local authority commissions. Pending the new Excellence Scheme, the Quality Assurance Tool has been amended in line with CQC provider compliance assessment tool.

Concerns raised at the Care Governance Board are shared with all other commissioning agencies. This is achieved through ensuring that minutes are circulated to health agencies and that information is shared with Contracts/Commissioning leads and safeguarding leads from other local authorities who commission services from the provider in question.

6 Associated Safeguarding Groups and Forums[1]

6.1 **Multi Agency Risk Assessment Conference (MARAC)** - A MARAC is a monthly multi agency meeting which has the safety of people who are at high risk of domestic abuse as its core focus. The identification of people at high risk has been made possible by the use of a risk identification tool agreed between Coordinated Action Against Domestic Abuse (CAADA) and the Association of Chief Police Officers (ACPO) for use across a wide range of agencies. This has enable practitioners, both within the criminal justice system and outside, to identify high risk victims of domestic abuse. The MARAC involves the participation of all the key statutory and voluntary agencies who might be involved in supporting a victim of domestic abuse. This includes those from the criminal justice system, those supporting children, the health service, the local authority (in particular roles in safeguarding children and adults and operational staff), housing agencies, substance misuse and specialist domestic violence agencies. A focussed information sharing process is undertaken with each referral to MARAC followed by a the creation of a simple multi agency action plan which is put into place to support the victim and make links with other public protection procedures including those that safeguard adults.

[1] All information shared is in accordance with the SAPB and/or other appropriate information sharing protocols

6.2 **Multi Agency Public Protection Arrangements (MAPPA)** – is the name given to arrangements in England and Wales for the `responsible authorities` tasked with the management of registered sex offenders, violent and other types of sexual offenders and offenders who pose a serious risk of harm to the public. The `responsible authorities` who jointly chair the Bracknell MAPPA include Probation and Thames Valley Police. The monthly meeting is also attended by representatives of Children's Social Care, Adult Social Care, health, housing, victim support and the voluntary sector. Detailed multi agency risk management plans are developed to minimise the risk of further offending and protect vulnerable people from further offending. Adult safeguarding has an important role to play in terms of identifying vulnerable adults who have previously or may be at risk from the offender.

6.3 **Anti Social Behaviour Working Group** – This multi disciplinary group meets monthly and is led by the Anti Social Behaviour Coordinator. The group is essentially a problem solving group who explore available options around, and make decisions about, people who have been identified as exhibiting anti social behaviour. In particular the group will; look at making full use of the tools and powers available to tackle anti social behaviour including Acceptable Behaviour Contracts (ABCs and Anti Social Behaviour Orders (ASBOs). In addition to this day to day information sharing and collaboration will take place in urgent and persistent cases. A member of the Adult Safeguarding team is present at the meetings where an adult victim or perpetrator is, or is suspected to be, a vulnerable adult in order to take full account of their needs when deciding on a course of action.

6.4 **Anti Exploitation Group -** This group meets monthly and consists of

- Head of Adult Safeguarding
- Representatives from Adult Social Care and Health operational teams
- Representative from advocacy groups
- Representative from support providers
- Representative from Thames Valley Police.

The aim of the group is to open channels of communication, exchange information, raise concerns and develop risk management strategies for those vulnerable people who may lead chaotic lifestyles, or do not always work with agencies, or who are vulnerable to exploitation. Since March 2010 the group has developed multi agency risk management plans for 18 people. These plans have helped minimise risk for people in terms of increasing opportunities and venues to report abuse, initiate safeguarding procedures where relevant, link in with agencies such as housing where necessary and ensure that new risks are identified and managed in a timely manner.

6.5 **Domestic Abuse Forum** – The Association of Chief Police Officers (ACPO) define domestic abuse is `any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between any people who are over the age of 16, and who are, or have been intimate partners or family members regardless of gender (family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in laws or step family). Family members are defined as `mother, father, son, daughter, brother, sister and grandparents, whether directly related, in laws or step family.

The Forum aims to increase public awareness and improve services to those experiencing domestic abuse. This will include vulnerable adults. The Forum, comprised of local partner agencies (statutory and voluntary), aims to identify and

promote good practice, thus ensuring that agencies know about each other, are well equipped to deal with domestic abuse and provide them with the opportunity to develop a multi agency strategy aimed at reducing the level of domestic abuse in Bracknell Forest.

6.6 **E-safety group** – e-safety can be described as relating to all fixed and mobile devices that allow access to content and communications that could pose risks to personal safety and wellbeing. Examples are PCs, laptops, mobile phones and gaming consoles such as X Box, Playstation and Wii.

E safety is a safeguarding issue rather than an IT issue and needs to be considered as part of the overall arrangements in place to safeguard and promote the welfare of all vulnerable people within the community. It is important that carers who work with vulnerable adults are clear about safe practices, so that so that they can advise any people they are supporting who use such technologies to be aware of how to stay safe online. Care workers should also be aware of how they need to safeguard themselves from any misunderstandings or allegations of inappropriate behaviour whilst on line.

This group meets on a quarterly basis and is a sub group of the Community Safety Partnership. The purpose of the group is to ensure that

- all vulnerable members of the community are equipped with the knowledge and skills to ensure safety online,
- all people who work with vulnerable people have access to good quality procedures and effective training,
- systems and services are in place to prevent incidents as well as enable reporting,
- all victims are protected and given an appropriate level of support and
- offenders are identified and prosecuted.

Group membership consists of representatives from:

- BFC IT Support
- SEGfL (South East Grid for Learning)
- BFC Crime and Disorder
- BFC Safeguarding Adults
- BFC Learning and Development
- BFC Libraries
- BFC Youth Service
- BFC Education
- BFC Anti Bullying
- Thames Valley Police

6.5 **SE Regional Safeguarding Network** - membership of this network includes safeguarding representatives from all 19 local authorities in the South East region, Department of Health and South Central Strategic Health Authority. The meetings are held quarterly and co chaired by an Association of Directors of Adult Social Services (ADASS) rep. The network undertakes the following roles:-

- Promotes and shares good practice in relation to adult safeguarding through benchmarking standards of good practice and sharing of policy frameworks and initiatives.
- Acts as a consultative body for development of national and regional policy.
- Provides expert advice to other groups and/or professional bodies.

- Works collaboratively with national bodies such as Care Quality Commission, Office of the Public Guardian and Department of Health.
- Provides information and guidance to the ADASS national policy group on adult safeguarding.
- Acts as a support network for local authority safeguarding Adults Coordinators/ Managers/Leads.

7 Safeguarding Adults Policy and Procedures

7.1 The Berkshire Multi-Agency Safeguarding Adults Policy and Procedures (2008) been updated. The revised procedures include information on:-

- Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards
- Processes for learning from Serious Case Reviews
- The links between Serious Untoward Incidents and Serious Case Reviews
- Safeguarding and the Personalisation agenda
- Community Safety agenda and how this links to safeguarding
- Multi Agency Risk assessment Conferences (MARAC)
- Multi Agency Public Protection Arrangements (MAPPA)
- The role of the Independent Safeguarding Authority
- 'No Secrets 2' (if published)

7.2 The revised procedures are web based enabling ease of navigation and reporting of safeguarding concerns. They are currently being trialled by each of the four Berkshire Safeguarding Adults Partnership Boards and are due to be launched in June 2011.

8 Strategic Developments

8.1 The post of Safeguarding Adults Development Worker was recruited to in January 2011. This post holder is responsible for supporting the Head of Adult Safeguarding in the implementation of the safeguarding agenda across the Borough, to provide advice and assistance to team managers and operational teams in terms of safeguarding training, process and practice and to work collaboratively with the third sector (private, independent and voluntary organisations) to ensure that safeguarding is an intrinsic part of their business.

8.2 Vetting & Barring Scheme and Criminal Records Regime Review -

The Government has announced a new scaled-back scheme, with the following recommendations:-

a) A state body should continue to provide a barring function to help employers protect those at risk from people who seek to do them harm via work or volunteering roles.

b) The Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) should be merged and a single Non-Departmental Public Body or Agency created to provide a barring and criminal records disclosure service.

c) The new barring regime should cover only those who may have regular or close contact with vulnerable groups.

d) Barring should continue to apply to both paid and unpaid roles.

e) Automatic barring should apply for those serious offences which provide a clear and direct indication of risk.

f) Registration should be scrapped - there should be no requirement for people to register with the scheme and there will be no ongoing monitoring.

g) The information used by the state barring body (currently the ISA) to make a barring decision should be serious in nature.

h) Criminal records disclosures should continue to be available to employers and voluntary bodies but should be revised to become portable through the introduction of a system which allows for continuous updating.

i) The new regime should retain current arrangements for referrals to the state barring body (currently the ISA) by employers and certain regulatory bodies, in circumstances where individuals have demonstrated a risk of harm to children or vulnerable adults.

j) The current appeals arrangements should be retained.

k) The state barring body should be given a power to vary review periods in appropriate circumstances.

l) Services relating to criminal records disclosure and barring provisions should be self-financing. We recommend the Government consults on raising the cost of the criminal records disclosure fee to cover the costs incurred.

m) The new system will retain two offences; it will continue to be an offence for a barred person to work with vulnerable groups in regulated activity roles. It will also be an offence for an employer or voluntary organisation knowingly to employ a barred person in a regulated activity role.

n) Finally, the Government should raise awareness of safeguarding issues and should widely promote the part everyone has to play in ensuring proper safeguarding amongst employers, volunteer organisations, families and the wider community.

The Terms of Reference along with the full VBS review report, can be found at: http://www.homeoffice.gov.uk/crime/vetting-barring-scheme/

8.3 Throughout the year detailed planning has been undertaken for the Thames Valley Sexual Assault Referral Centre (SARC) This will open on the 1st April 2011 and will be run by Harmoni for Health and has been named `SOLACE`. The main site is based at Upton Hospital in Slough, with a smaller hub in Bletchley, Buckinghamshire. SOLACE will provide crisis intervention for all victims of sexual assault and rape, female or male, whether or not they report to the Police. People will be offered a medical examination, emergency contraceptives and support. If they wish to report, or have reported the incident to the Police, evidence will be gathered and they will be able to give their statement in comfortable surroundings. SOLACE will also provide telephone support and signposting for those who have experienced sexual assault but do not wish, or are unable to attend the Centre.

9 Performance Monitoring

9.1 Further audits have been undertaken into compliance with the Mental Capacity Act 2005, with all Adult Social Care & Health Teams. It was found that there were inconsistencies in the recording of assessments of capacity and Best Interests decision making. As a result of this two training workshops were arranged and delivered by Bracknell Forest Council Legal Services. These events were attended by 72 health and social care staff from the Adult Social Care & Health Department. A further audit is planned for September 2011.

9.2 A rolling programme of audit into the application of the safeguarding procedures is in place:

- All safeguarding assessments and application of the process is audited by either a Team Manager or Assistant Team Manager prior to the closure of the safeguarding process.
- Random samples of safeguarding assessments are audited by the relevant Head of Service.
- An audit of all safeguarding cases for this reporting year is currently underway and is due to be completed by November 2011.

10 Training

10.1 Level 1 safeguarding training is aimed at all staff, carers, people who use services and volunteers to enable them to recognise evidence and indicators of abuse, and report concerns about abuse using appropriate systems. There is an ongoing rolling monthly programme of Safeguarding Level 1 Awareness training.

10.2 Level 2 training is aimed at staff in the Adult Social Care and Health department, Thames Valley Police and NHS staff and enables the development of skills and knowledge required to conduct safeguarding investigations and assessments.

10.3 Level 3 training is aimed at operational team managers and assistant team managers enabling them to make sound and consistent safeguarding decisions, and chair safeguarding meetings effectively.

10.4 Progress on Safeguarding Adults training has been significant during the period of this report. A wide range of training has been delivered by Bracknell Forest Council and strategic partners. The table below indicates the numbers of people who have received appropriate safeguarding training for the year.

Level of training	**Number of attendees (BFC and external staff)**
Level One	232
Level Two	11
Level Three	4
3 x Safeguarding Adults Workshops	72
Mental Capacity Act Awareness	47
2 x Mental Capacity Act Workshops	72
Deprivation Of Liberty Safeguards	61

10.5 A new contract has been agreed with Matrix Training Associates who have been commissioned to provide level 2 and level 3 Safeguarding training for practitioners and managers/supervisors.

10.6 The Safeguarding Workforce Strategy 2010-12 which was produced in conjunction with Safeguarding Adults Partnership Boards of Slough Borough Council and Royal Borough of Windsor & Maidenhead continues to provide clear strategic direction regarding training for all agencies and people working with adults at risk.

11 Mental Capacity Act 2005 (please refer to Annex 1 for Glossary of Terminology)

11.1 To ensure compliance with the Mental Capacity Act 2005 and the associated Codes of Practice, there is a rolling programme of audit. The outcomes of the audit are shared with the Departmental Management Team and recommendations from the audit reports are implemented.

11.2 There are specific circumstances under which Local Authorities must engage an Independent Mental Capacity Advocate (IMCA):

- When considering that a residential care home may be appropriate for an individual who has been assessed as not having the capacity to make this decision, and there are no family or friends available to support them in this decision.
- When decisions are needed regarding the provision, withholding or stopping of serious medical treatment and there are no family or friends available to support them with this decision.
- When someone may need to be deprived of their liberty.
- Local Authorities have a discretionary power to engage an IMCA in Safeguarding Adults investigations even if there are family members or friends involved.

11.3 Bracknell Forest is a member of the Berkshire Implementation Network (BIN) for the Mental Capacity Act. This group meets on a quarterly basis to share information and agree training for Best Interest Assessors (see 12.2). A pooled budget is in place to commission both training and the IMCA service across Berkshire.

11.4 The training programme relating to Mental Capacity Act will continue in 2011/12 to ensure that all new staff are appropriately trained.

11.5 During 2010/2011, 30 referrals were made for an IMCA. This is a 25% increase from the previous year. This increase can be attributed to increased staff awareness and understanding of the IMCA role and when to make a referral, as well as to particular projects such as the reprovision of a number of registered care homes. There is also a far greater cross section of referral sources, which again indicates a greater awareness of the IMCA role and when to refer. Referrals (numbers in brackets) were in relation to people in receipt of services from the following teams:

- Mental Health - Older People (5)
- Learning Disabilities (17)
- Older Persons Teams (2)

- Safeguarding (1)
- Supervisory Body (4)
- Personalisation Team (1)

The IMCA service provides detailed information regarding these referrals and this is available from the Head of Adult Safeguarding.

12 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards introduce a range of new terminology, and a guide to this new terminology is attached as annex 1. For a full glossary please refer to the DoLS Code of Practice.

12.1 The Deprivation of Liberty Safeguards were implemented in April 2009. The safeguards apply to adults in a care home or hospital setting who lack capacity to consent to their stay in the care home or hospital in order to receive support or treatment, and whose care regime is such that it amounts to a deprivation of their liberty. There is no simple definition of deprivation of liberty. The question of whether the actions taken by staff or institutions to manage a person safely amount to a deprivation of that person's liberty is ultimately a legal question, and only the courts can determine the law. The Deprivation of Liberty Safeguards Code of Practice assists staff and institutions in considering whether or not the steps they are taking, or proposing to take, amount to a deprivation of a person's liberty. The Deprivation of Liberty Safeguards give best interests assessors the authority to make recommendations about proposed deprivations of liberty, and supervisory bodies the power to give authorisations that deprive people of their liberty.

12.2 It is the role of Best Interest Assessor (BIA) to undertake six assessments, with an appropriately trained Doctor, for the purpose of determining whether the person is being, or needs to be, deprived of their liberty. In relation to Care Homes, it is the responsibility of the Council as Supervisory Body to ensure this happens and that the code of practice is complied with. Where the potential deprivation of liberty is in relation to receiving treatment in hospital, the relevant PCT is the Supervisory body, and have responsibility for ensuring compliance. The six assessments are:-

- **Age assessment (BIA)** – The purpose of the age assessment is to confirm whether the relevant person is aged 18 or over
- **No Refusals assessment (BIA)** – The purpose of the no refusals assessment is to establish whether an authorisation to deprive the relevant person of their liberty would conflict with other existing authority for decision making for that person e.g. an advance decision to refuse treatment.
- **Mental Capacity assessment (BIA or Doctor)** – The purpose of the mental capacity assessment is to establish whether the relevant person lacks capacity to decide whether or not they should be accommodated in the relevant hospital or care home to be given care or treatment.
- **Mental Health assessment (Doctor) –** The purpose of the mental health assessment is to establish whether the relevant person has a disorder within the meaning of the Mental Health Act 1983
- **Eligibility assessment (BIA)** - This assessment relates specifically to the relevant person's status under the Mental Health Act 1983. If they are already detained under the Mental Health Act, DoLS would not be used
- **Best Interests assessment (BIA)** – The purpose of this assessment is to establish the following:-

- whether deprivation of liberty is occurring;
- and, if so, whether it is the best interests of the relevant person to be deprived of liberty;
- whether it is necessary for them to be deprived of liberty in order to prevent harm to themselves and;
- whether deprivation of liberty is a proportionate response to the likelihood of the relevant person suffering harm and the seriousness of that harm.

12.3 There have been 5 DoLS applications to Bracknell Forest as the Supervisory Body in this reporting year, of which 4 have been granted. Across east Berkshire where hospitals have been the Supervisory Body there have been 18 applications in which 2 have been authorised.

12.4 A DoLS Newsletter is published quarterly, providing care home providers, the Bracknell Safeguarding Adults Partnership Board and staff from Adult Social Care & Health with articles relevant to DoLS. These have included real life (anonymised) case studies, an audit questionnaire for providers, a DoLS quiz and information on upcoming training opportunities. Feedback has been very positive saying that the newsletter is informative and useful.

12.5 A DoLS Managing Authority Conference was held in February 2011 at Bracknell Sports Centre. The event was attended by 42 people with representation from 9 managing authorities. Speakers included a member of the Berkshire wide IMCA service explaining the roles of IMCA and Best Interest Assessors from Bracknell Forest. A number of case studies were worked though exploring the appropriate use of DoLS and how the implications for managing authorities. Feedback from the day was very positive with attendees expressing views that they had learned a lot and that this will influence their practice.

13 Statistical Analysis

13.1 Excluding the information from Broadmoor Hospital, the overall picture of safeguarding activity in Bracknell in 2010/11 is that there was a 12.2% reduction (from 147 to 129) in referrals compared to the last reporting year. This decrease can be attributed to a continuation of pertinent factors which are listed below.

- Care Governance Board has made decisions not to make placements in poor performing homes, or to purchase packages from poorly performing agencies, whilst working with these services to improve standards.

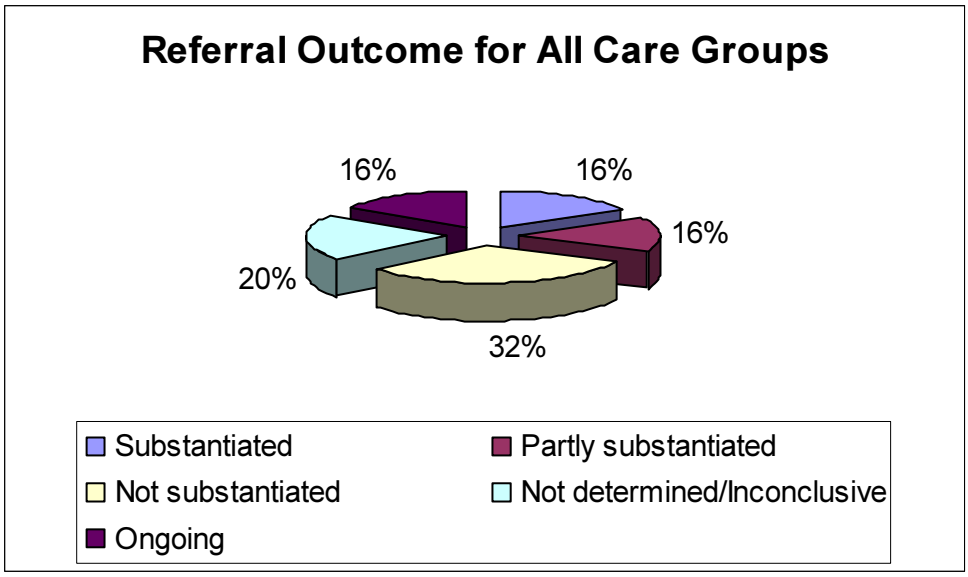
- The experience of Designated Safeguarding Managers within each of the operational Adult Social Care & Health teams has meant that decisions are now being taken about whether a safeguarding alert needs to be progressed to a safeguarding referral, or whether it can be managed safely through effective care management and robust risk assessment/risk management. In previous reporting years the vast majority of safeguarding alerts were progressed through the safeguarding process, sometimes unnecessarily. The Department of Health has said that the safeguarding process should be one of many options in ensuring that people at risk are effectively safeguarded.

- Continued safeguarding activity on the prevention of abuse, appropriate training, raising awareness and consistency of response.

13.2 For some of the following figures it is difficult to compare this year's data to last year's data due to the use of different data categories in recording and reporting. Broadmoor High Security Hospital referrals have been included separately in this reporting year.

13.3 Referral outcomes for all care groups

Referral outcomes for all care groups	
Substantiated	21
Partly substantiated	20
Not substantiated	42
Not determined/Inconclusive	26
Ongoing	20
Total	129

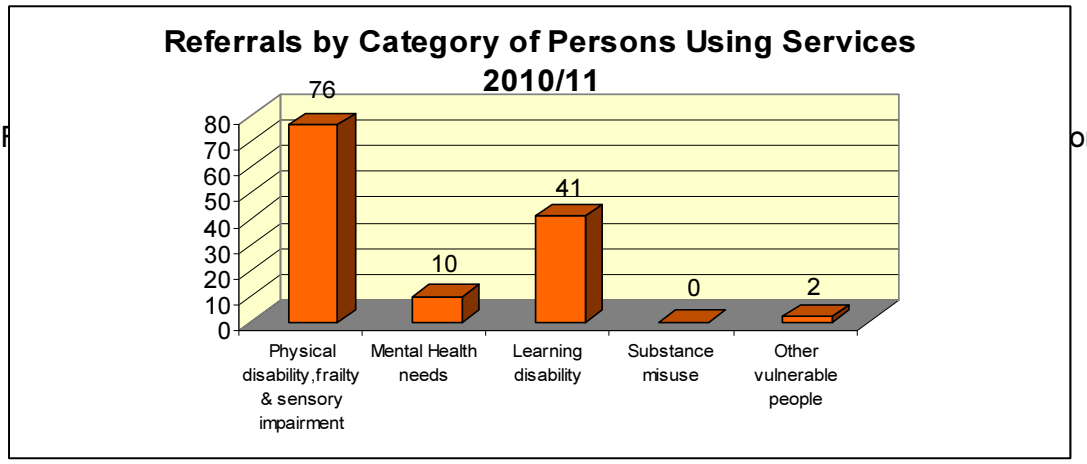


This indicates that for this reporting year 32% of all referrals were substantiated or partly substantiated. This is a 10% decrease from last year when 42% of referrals were substantiated or partly substantiated. The data also indicates a far more even spread of outcomes for this year.

The decrease in substantiated or partly substantiated can be attributed to the issue of pressure sores: any grade 3 or 4 pressure sore is now automatically referred as a safeguarding alert, under the category of neglect, and progressed through the safeguarding process. However, in a high number of these situations, the pressure sores are not the result of any action or inaction in relation to the care of the individual. Of 50 alerts categorised as neglect only 13 were substantiated or partly substantiated.

13.4 Referrals by care group of persons using services

	2009/10	2010/11
Physical disability, frailty & sensory impairment	80	76
Mental Health needs	17	10
Learning disability	49	41
Substance misuse	0	0
Other vulnerable people	1	2
Total	147	129



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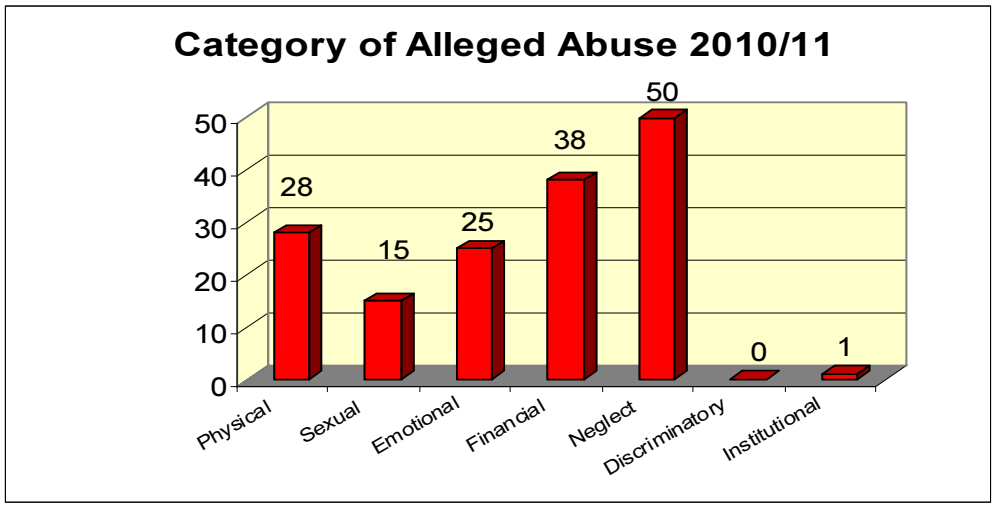
This does not indicate any significant difference from last year's data and proportionately represents the range of adults in Bracknell receiving services.

13.5 Category of alleged abuse for all referrals

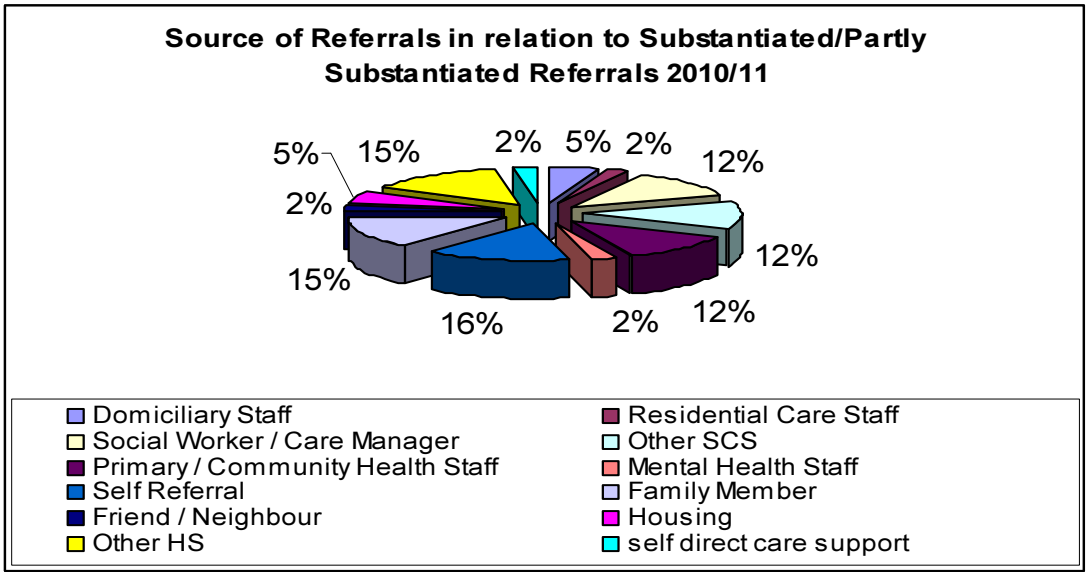
	2009/10	2010/11
Physical	Comparable data not recorded	28
Sexual		15
Emotional		25
Financial		38
Neglect		50
Discriminatory		0
Institutional		1
Total		**157**



This illustrates that there has been a significant increase (23 to 50) from last year in referrals where the allegation is one of neglect. This can be attributed to the increased reporting of Grade 3 or 4 pressure sores which must now all be referred to safeguarding teams.

13.6 Source of Referrals in relation to Substantiated/Partly Substantiated referrals

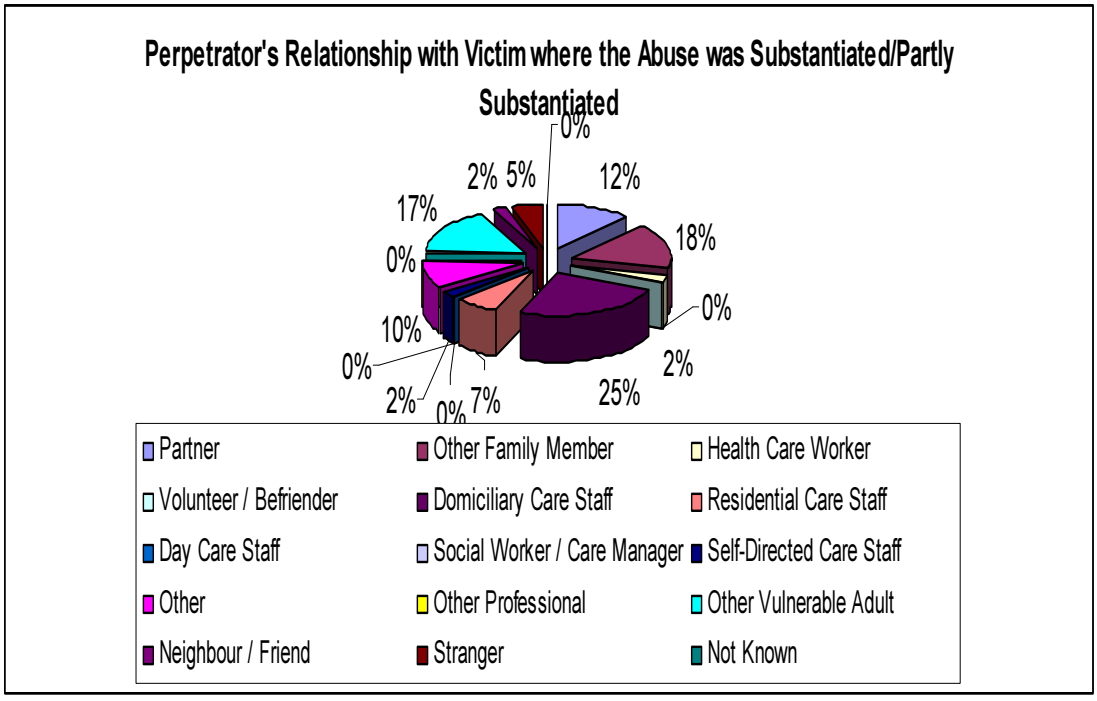
	2009/10	2010/11
Domiciliary Staff	Comparative data not recorded	2
Residential Care Staff		1
Social Worker / Care Manager		5
Other SCS		5
Primary / Community Health Staff		5
Mental Health Staff		1
Self Referral		6
Family Member		6
Friend / Neighbour		1
Housing		2
Other HS		6
Self directed support		1
Total		**41**



This illustrates that there is a wide cross section of referral sources which is positive. There is no data to compare with last year.

13.7 Perpetrators relationship with victim, where abuse is substantiated or partially substantiated

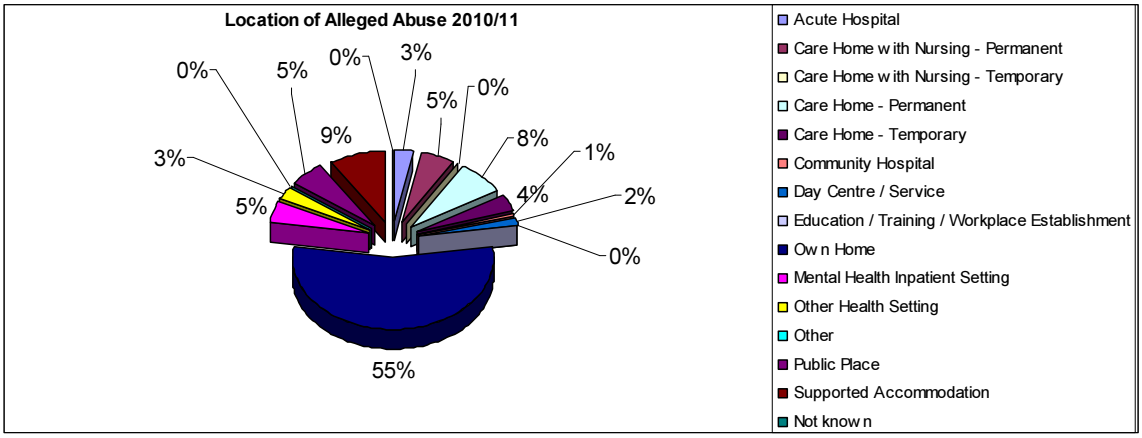
	2009/10	2010/11
Partner	Comparative data not recorded	5
Other Family Member		7
Health Care Worker		1
Volunteer / Befriender		
Domiciliary Care Staff		10
Residential Care Staff		3
Day Care Staff		0
Social Worker / Care Manager		0
Self-Directed Care Staff		1
Other		4
Other Professional		0
Other Vulnerable Adult		7
Neighbour / Friend		1
Stranger		2
Not Known		0
Total		**41**



This data shows the perpetrator's relationship with the victim where the abuse was substantiated/partly substantiated. Again this data was not collected last year but this year's data does show a wide cross section of perpetrators. The comparative number of staff from domiciliary care agencies vs residential care homes reflects the balance of support arrangements.

13.8 Location of alleged abuse for all referrals

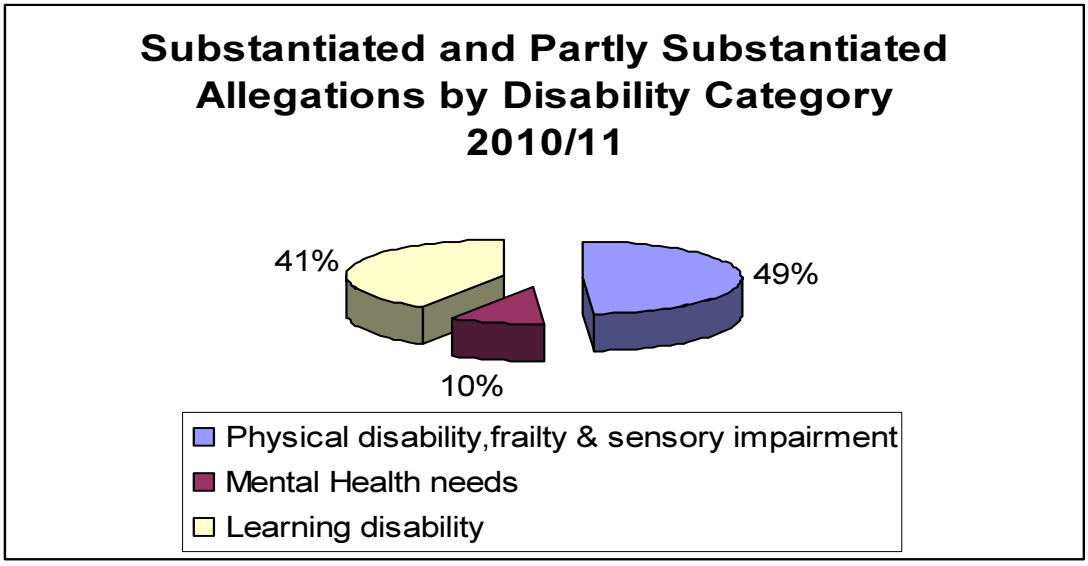
	2009/10	2010/11
Acute Hospital	n/k	4
Care Home with Nursing - Permanent	6	7
Care Home with Nursing - Temporary	n/k	0
Care Home - Permanent	10	10
Care Home - Temporary	n/k	5
Community Hospital	n/k	1
Day Centre / Service	n/k	2
Education / Training / Workplace Establishment	n/k	0
Own Home	72	71
Mental Health Inpatient Setting	n/k	6
Other Health Setting	n/k	4
Public Place	n/k	7
Supported Accommodation	12	12
Not known	47	0
Total	**147**	**129**



This data indicates that the highest proportion of alleged abuse continues to happen in a person's own home. This is unsurprising as most people in receipt or in need of community care services do live in their own home. In other locations, data is broadly similar to last reporting year.

13.9 Substantiated/partly substantiated allegations by disability category

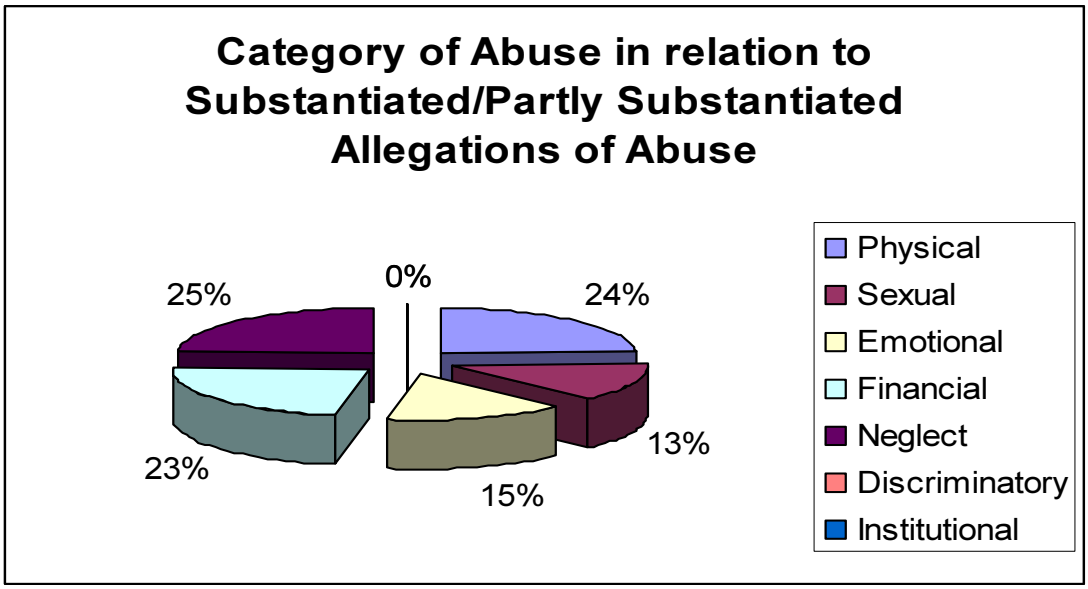
	2009/10	2010/11
Physical disability, frailty & sensory impairment	Comparative data not recorded	20
Mental Health needs		4
Learning disability		17
Substance misuse		0
Other vulnerable people		0
Total		**41**



Given that people with a learning disability make up 9% of people in receipt of social care, this information (41% of substantiated/partially substantiated allegation) indicates that people with a learning disability are either more susceptible to abuse, or that the evidence leading to substantiation is better. The former is themore likely interpretation.

13.10 Category of abuse in substantiated/partly substantiated allegations

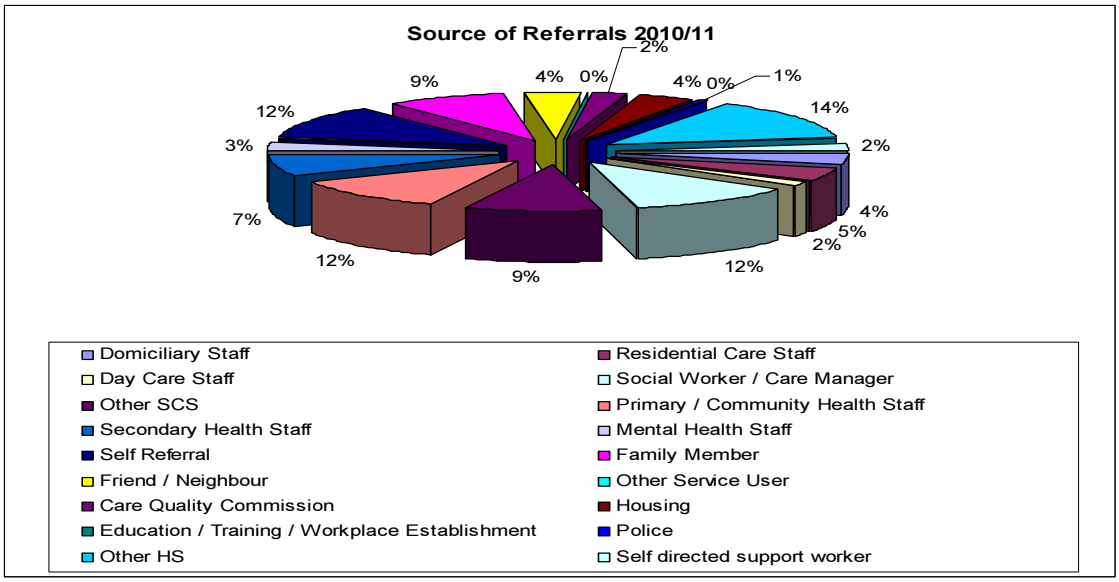
	2009/10	2010/11
Physical	19	13
Sexual	4	7
Emotional	9	8
Financial	16	12
Neglect	10	13
Discriminatory	0	0
Institutional	0	0
Total	**58**	**53**



The data illustrated above shows the similarity between this year and last year with physical abuse, financial abuse and neglect continuing to be the most prevalent.

13.11 Source of referrals of all allegations

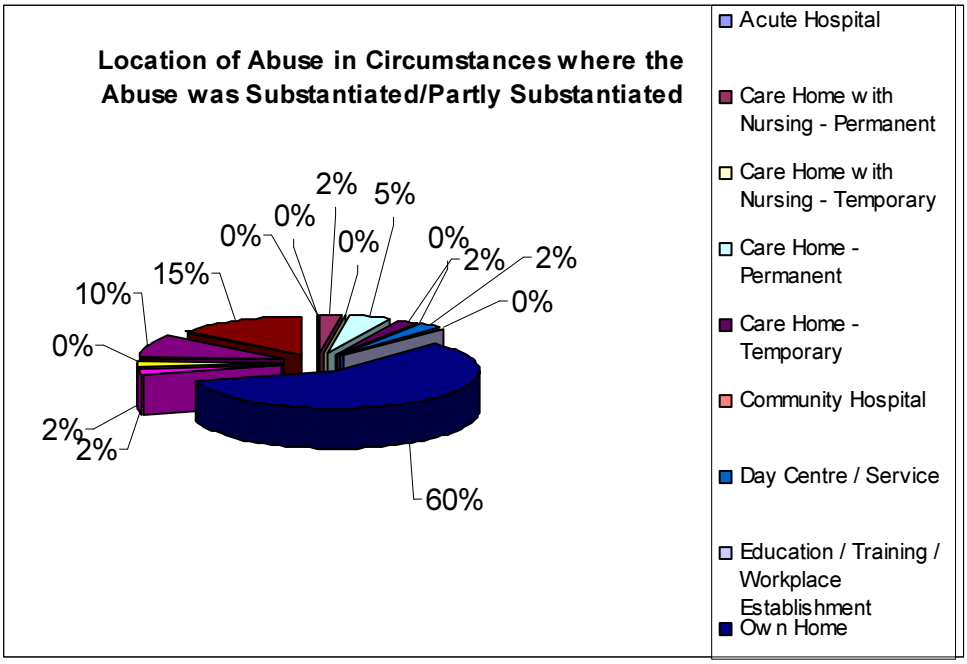
	2009/10	2010/11
Domiciliary Staff	Comparative data not recorded	5
Residential Care Staff		6
Day Care Staff		2
Social Worker / Care Manager		15
Other SCS		12
Primary / Community Health Staff		15
Secondary Health Staff		9
Mental Health Staff		4
Self Referral		15
Family Member		11
Friend / Neighbour		5
Other Service User		0
Care Quality Commission		3
Housing		5
Education / Training / Workplace Establishment		0
Police		1
Other HS		18
Self directed support worker		3
Total		**129**



This information demonstrates the wide range of referral sources. In previous years data was recorded against 9 categories.

13.12 Location of abuse in circumstances where the abuse was substantiated/partly substantiated

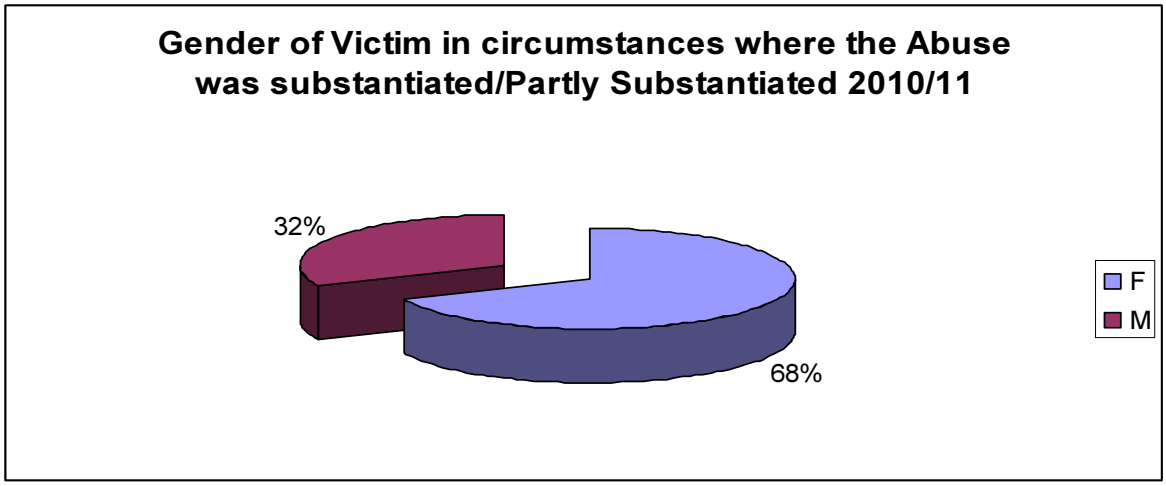
	2009/10	2010/11
Acute Hospital	Comparative data not collected	0
Care Home with Nursing - Permanent		1
Care Home with Nursing - Temporary		0
Care Home - Permanent		2
Care Home - Temporary		1
Community Hospital		0
Day Centre / Service		1
Education / Training / Workplace Establishment		0
Own Home		24
Mental Health Inpatient Setting		1
Other Health Setting		1
Other		0
Public Place		4
Supported Accommodation		6
Not known		0
Total		43



The categories for the location of abuse is recorded has increased from five to fifteen, so comparisons with last year are difficult. What is clear from last year's data and this year's is that a person's own home continues to be the most likely place where abuse happens. As stated under 13.6 this reflects the fact that most people in receipt of, or in need of social care services live in their own home.

13.13 Gender

	2009/10	2010/11
F	33	28
M	27	13
Total	60	41

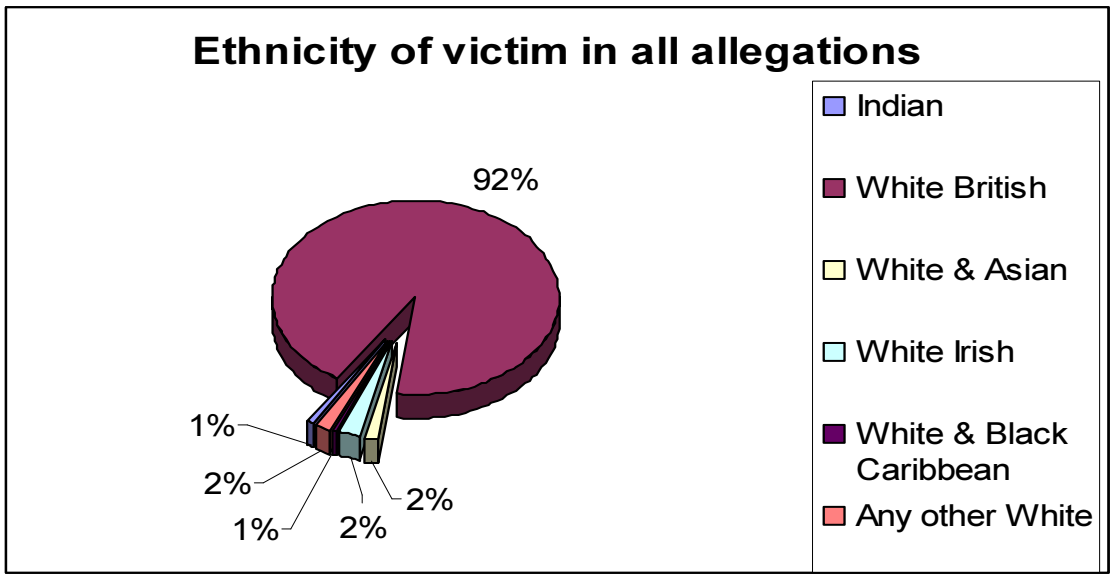


This table shows the gender of victim in circumstances where the abuse was substantiated/partly substantiated. This broadly reflects the gender differential for people who receive social care services which is male 38% and female 62%.

The figures from last year demonstrate a pattern markedly different to the demographic differential, and further analysis would need to be undertaken to understand any reasons behind this.

13.14 Ethnicity of alleged victims for all referrals (exc. Broadmoor)

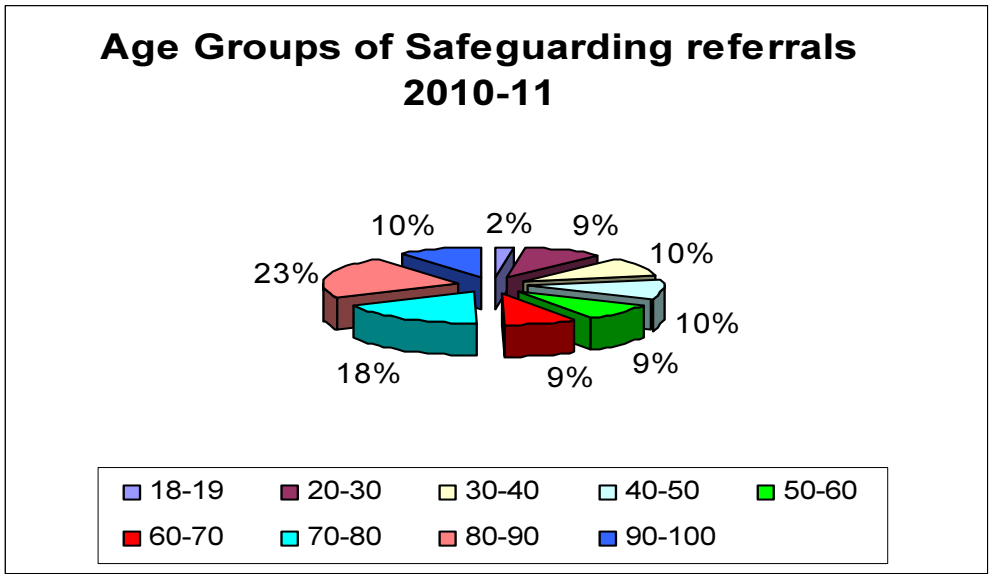
	2009/10	2010/11
Indian	Data not reported	1
White British		120
White & Asian		2
White Irish		3
White & Black Caribbean		1
Any other White		2
Nepali		0
Total		**129**



This data indicates the ethnicity of victims/alleged victims in all referrals and broadly reflects the ethnic demography of people in receipt of community care services which is 89.5% White British.

13.15 Age Group for all referrals

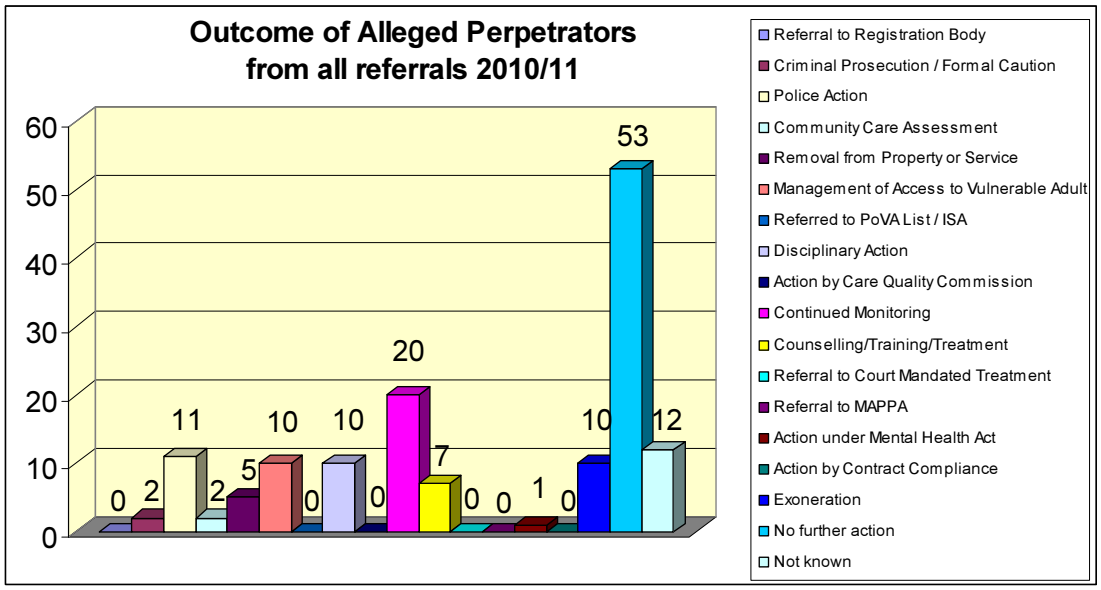
	2009/20	2010/11
18-19	Data not reported	3
20-30		12
30-40		13
40-50		13
50-60		12
60-70		11
70-80		23
80-90		29
90-100		13
Total		129



The data above indicates a broad range of age ranges for victims in all safeguarding referrals.

13.16 Outcome for alleged perpetrators from all referrals

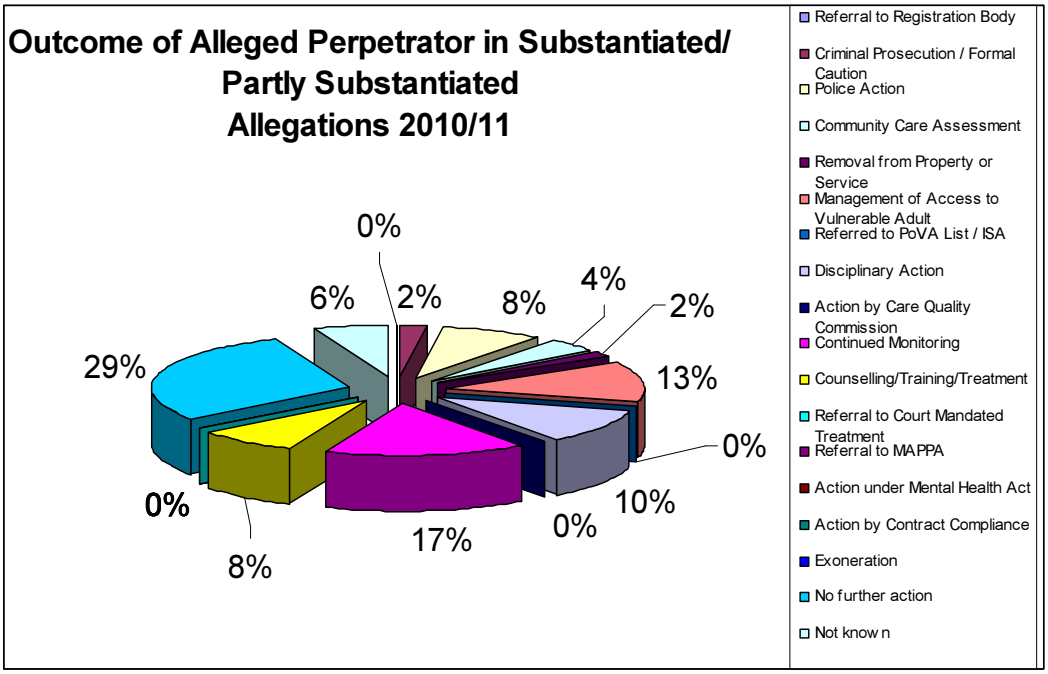
	2009/10	2010/11
Referral to Registration Body	Comparative data not recorded	0
Criminal Prosecution / Formal Caution		2
Police Action		11
Community Care Assessment		2
Removal from Property or Service		5
Management of Access to Vulnerable Adult		10
Referred to PoVA List / ISA		0
Disciplinary Action		10
Action by Care Quality Commission		0
Continued Monitoring		20
Counselling/Training/Treatment		7
Referral to Court Mandated Treatment		0
Referral to MAPPA		0
Action under Mental Health Act		1
Action by Contract Compliance		0
Exoneration		10
No further action		53
Not recorded		12
Total		**143**



This data was not collated last year but does indicate variety of outcomes for perpetrators/alleged perpetrators. 69% of all safeguarding referrals were not substantiated or inconclusive which would account of the high number under `no further action`.

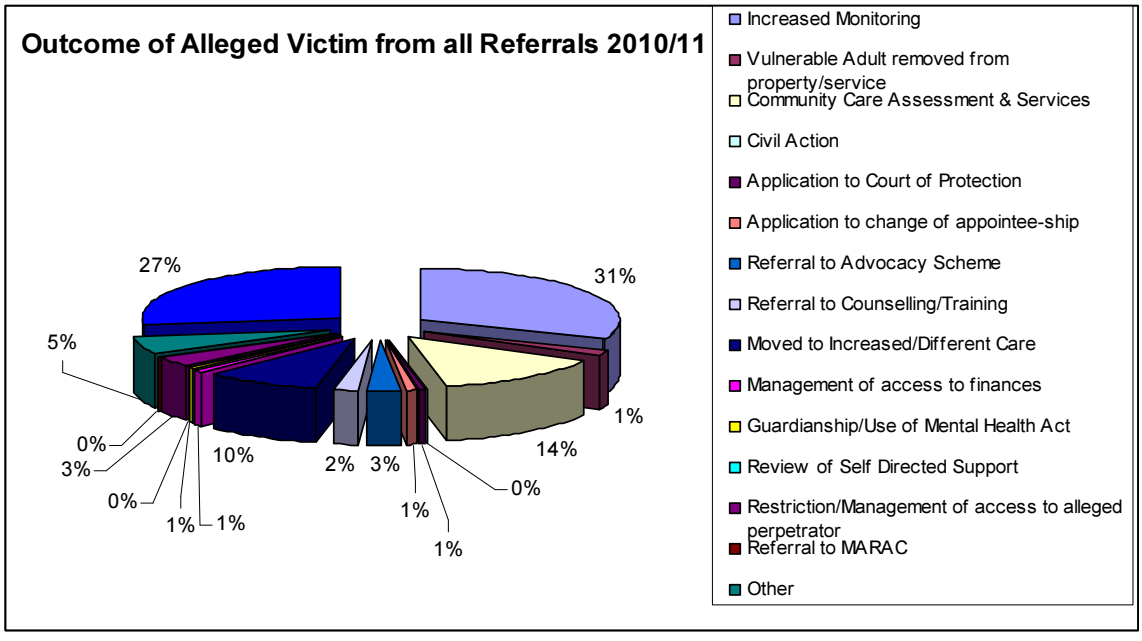
13.17 Outcome for alleged perpetrator in Substantiated/Partly Substantiated Allegations

	2009/10	2010/11
Referral to Registration Body	Comparative data not recorded	0
Criminal Prosecution / Formal Caution		1
Police Action		4
Community Care Assessment		2
Removal from Property or Service		1
Management of Access to Vulnerable Adult		6
Referred to PoVA List / ISA		0
Disciplinary Action		5
Action by Care Quality Commission		0
Continued Monitoring		8
Counselling/Training/Treatment		4
Referral to Court Mandated Treatment		0
Referral to MAPPA		0
Action under Mental Health Act		0
Action by Contract Compliance		0
Exoneration		0
No further action		14
Not recorded		3
Total		48



13.18 Outcome for alleged victim from all referrals

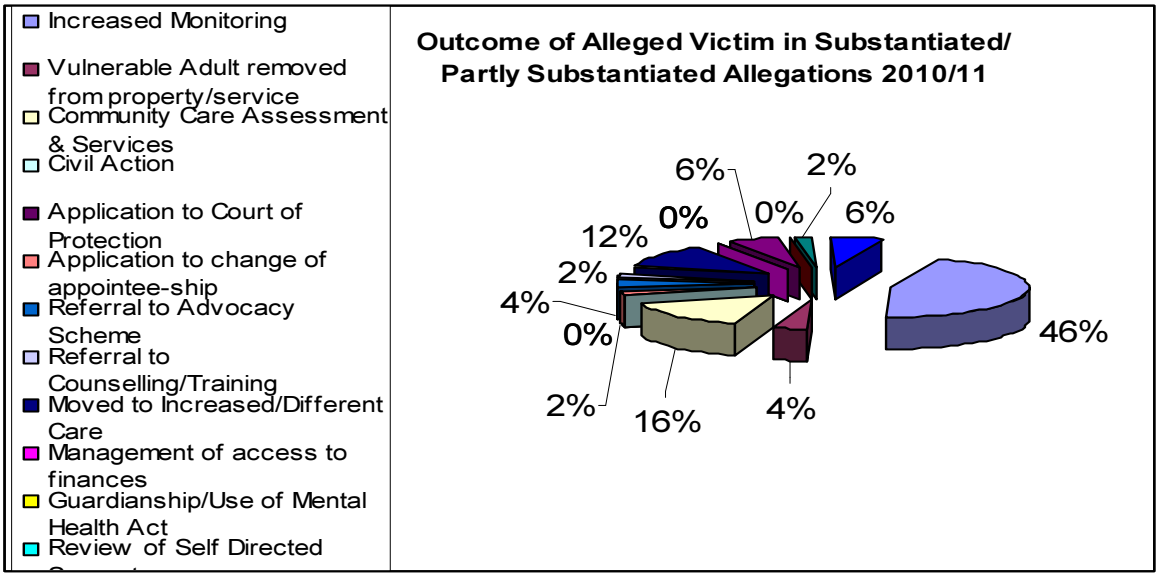
	2009/10	2010/11
Increased Monitoring	Comparative data not recorded	46
Vulnerable Adult removed from property/service		2
Community Care Assessment & Services		21
Civil Action		0
Application to Court of Protection		1
Application to change of appointee-ship		1
Referral to Advocacy Service		4
Referral to Counselling/Training		3
Moved to Increased/Different Care		14
Management of access to finances		1
Guardianship/Use of Mental Health Act		1
Review of Self Directed Support		0
Restriction/Management of access to alleged perpetrator		5
Referral to MARAC		0
Other		8
No further action required		40
Total		147



In all safeguarding referrals, whether or not they were substantiated or partly substantiated, there will have been one or more outcome for the victim or alleged victim. This data shows the range of outcomes.

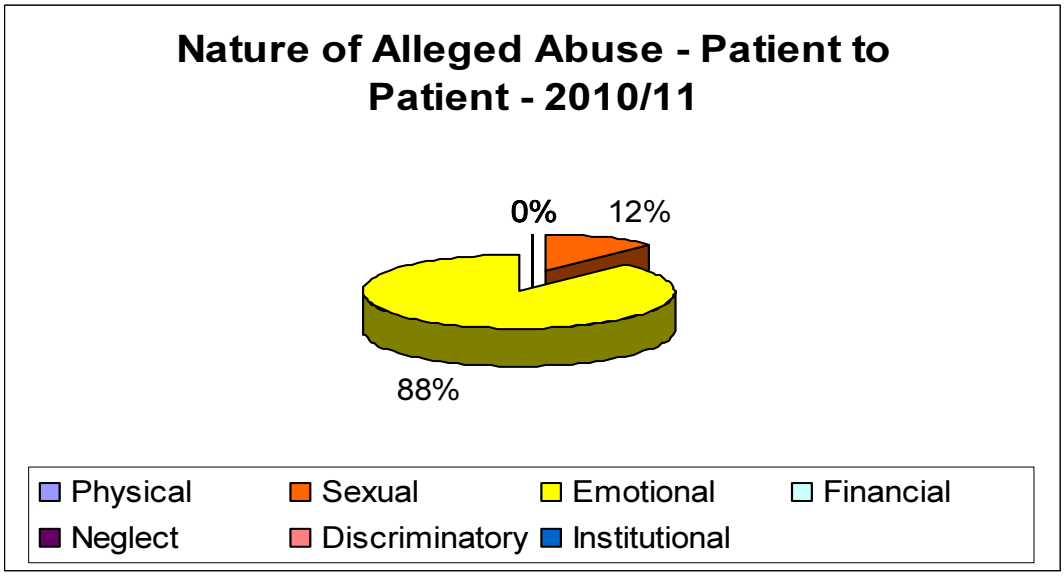
13.19 Outcome of alleged Victim in regard to Substantiated/Partly Substantiated Allegations

	2009/10	2010/11
Increased Monitoring	Comparative data not recorded	22
Vulnerable Adult removed from property/service		2
Community Care Assessment & Services		8
Civil Action		0
Application to Court of Protection		0
Application to change of appointee-ship		1
Referral to Advocacy Scheme		2
Referral to Counselling/Training		1
Moved to Increased/Different Care		6
Management of access to finances		0
Guardianship/Use of Mental Health Act		0
Review of Self Directed Support		0
Restriction/Management of access to alleged perpetrator		3
Referral to MARAC		0
Other		1
No further action required		3
Total		**49**



13.20 Broadmoor Hospital - Nature of Alleged Abuse, Patient to Patient – information supplied by Broadmoor Hospital

	2009/10	2010/11
Physical	Comparative data not reported	0
Sexual		3
Emotional		23
Financial		0
Neglect		0
Discriminatory		0
Institutional		0
Total		**26**



The above data indicates the types of abuse involving patient on patient abuse at Broadmoor High Security Hospital. The 23 cases of emotional abuse mainly related to patients feeling bullied or threatened by other patients usually on the same ward.

1. Objectives for 2011/12

The following objectives have been agreed throughout the year by the Safeguarding Adults Partnership Board, and have been informed by Government guidance and examples of good practice. There is a particular focus on empowerment and enabling people who are in need or receipt of services to have a far greater input into safeguarding arrangements in Bracknell Forest.

14.1 Build on existing practice and expertise to ensure that wherever possible, individuals who are alleged to have been abused are involved in the safeguarding process, and that the plans and outcomes are in accordance with their stated wishes.
This will be achieved by November 2011.

14.2 The Safeguarding Adults Partnership Board will establish structures and/or processes through which vulnerable people can influence the work and the decisions of the Board.
This will be achieved by March 2012.

14.3 Safeguarding Adults Partnership Board to request that the safeguarding adults agenda is recognised as a priority within TOR of GP Consortia.
This objective is difficult to predict when it will be achieved as there remains uncertainty as to the time line for GP Consortia.

14.4 Establish a Forum for level three trained Designated Safeguarding Managers to support practice development.
This will be achieved by August 2011.

14.5 Hold a Safeguarding Adults Partnership Board workshop to focus on how vulnerable adults will be empowered to safeguard themselves, and to participate in the development of the strategic approach to safeguarding adults in Bracknell Forest..
This will be achieved by August 2011, with a draft action plan developed for discussion at the following SAPB meeting

14.6 Complete audits of safeguarding practice and compliance with Mental Capacity Act 2005.
This will be achieved by August 2011.

14.7 Review the development programme for service providers.
This will be achieved by March 2012.

14.8 Review the work and role of the Care Governance Board to ensure that its work is effective and transparent, and reflects local and national developments.
This will be achieved by March 2012.

14.9 Development of an approach to evaluate people's experience of the safeguarding process, to inform practice.
This will be achieved by March 2012.

14.10 Review the reporting suite to ensure that the analysis is as informative as possible. This will include reporting in relation to

- alleged victims of abuse who have dementia, and
- outcomes/actions where abuse had been substantiated or partially substantiated and perpetrators are paid staff.

This will be in place for the 2011/12 annual report.

Annex 1 – Glossary – Deprivation of Liberty Safeguards (DoLS)

Terminology	Explanation
Managing Authority	Has responsibility for applying for authorisation of deprivation of liberty for any person who may come within the scope of the deprivation of liberty safeguards: In the case of a care home or a private hospital, the Managing Authority will be the person registered, or required to be registered, under part 2 of the Care Standards Act 2000 in respect of the hospital or care home.
Supervisory Body	Is responsible for considering requests for authorisations, commissioning the required assessments and, where all the assessments agree, authorising the deprivation of liberty. The supervisory body for care homes is normally the local authority where the relevant person is ordinarily resident.
Best Interest Assessor (BIA)	A person who carries out a deprivation of liberty safeguards assessment. This can be an approved mental health professional, a Social Worker, a state registered occupational therapist or a registered nurse who has undertaken the prescribed Mental Capacity Act training. The BIA must be independent of the admissions/care planning process.
Mental Health Assessor	A registered medical practitioner with at least three years' post-registration experience in the diagnosis or treatment of mental disorders, such as a GP with a special interest or a registered medical practitioner who is approved under section 12 of the Mental Health Act 1983. This includes doctors who are automatically treated as being section 12 approved because they are approved clinicians under the Mental Health Act 1983. Again even if Section 12 approved, the doctor must have undertaken the prescribed Mental Capacity Act training. The preference will always be for a medical practitioner who is familiar with the relevant person.
Approved Mental Health Practitioner (AMHP)	A social worker or other professional approved by the local social services authority to act on their behalf in carrying out a variety of functions under the Mental Health Act.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service was established by the Mental Capacity Act 2005 and is not the same as an ordinary advocacy service.
Relevant Person	A person who is, or may become, deprived of their liberty in a hospital or care home.

Terminology	Explanation
No refusal assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether there is any other existing authority for decision-making for the relevant person that would prevent the giving of a standard deprivation of liberty authorisation. This might include any valid advance decision, or valid decision by a deputy or donee appointed under a Lasting Power of Attorney.
Mental capacity assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether a person lacks capacity in relation to the question of whether or not they should be accommodated in the relevant hospital or care home for the purpose of being given care or treatment.
Best Interest Assessment	An assessment prepared by the appointed BIA for the purpose of the deprivation of liberty safeguards, of whether deprivation of liberty is in the detained person's best interests, is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm.
Eligibility Assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether or not a person is rendered ineligible for a standard deprivation of liberty authorisation because the authorisation would conflict with requirements that are, or could be, placed on the person under the Mental Health Act 1983.
Age Assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether the relevant person has reached age 18.
Mental Health Assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether a person has a mental disorder.
Relevant person's representative	A person, independent of the relevant hospital or care home and the relevant supervisory body, appointed to maintain contact with the relevant person, and to represent and support the relevant person in all matters relating to the operation of the deprivation of liberty safeguards. An IMCA could be instructed to support a family member in this role.