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SECTION ONE
Foreword
Foreword

Our Adult Social Care Services Local Account really matters to us and we hope it matters to you too. It is a great way for us to share with you, our local residents, how we have performed over the last year in 2018-2019 against the priorities we highlighted, and for you to hold us to account. We aim to share our priorities and plans for 2019-2020 and share with you some of our achievements and challenges over the past 12 months.

We think it is important to publish a Local Account every year and we continue to do all we can to empower our local communities, to enable you to shape and contribute to the design and delivery of future services through collaborative approaches, with people who use our services, carers and with our partners who come from a range of multi-agency professionals and organisations.

Bedford Borough Council’s Adults’ Services Directorate has an excellent record of delivering services through innovative practice with value for money and we continue to transform our services with an increasing focus on delivering individual resilience, promoting independence, maintaining wellbeing, choice and inclusion. We want to take this further so we can continue to respond to the rising demands as well as the increasing austerity measures placed upon us to ensure sustainability.

We cannot do our work in isolation and we fully recognise the vital role of the Community and Voluntary Sectors in helping us to work together to support our most vulnerable people in the local community. We intend to continue to engage and to build on our strengths based approach to support early help and intervention wherever possible, and above all, to support our local residents to maintain their independence and where possible to reduce the likely need for intrusive and dependent models of care.

Your views are important to us. If you would like to comment on anything in this Local Account please contact Mark Harris, mark.harris@bedford.gov.uk

Councillor Wendy Rider
Portfolio Holder, Adults’ Services

Kate Walker
Director of Adults’ Services
SECTION TWO
Reflections from Healthwatch
Reflections from Healthwatch Bedford Borough

Adult Social Care Services - The Local Account 2018/19
Healthwatch Bedford Borough (HBB) is pleased to be requested to comment on this important document. The following comments refer to the relevant page number in the document as presented.

Carers - HBB is pleased to note the year on year increase in Carers Reviews being undertaken. However there is some concern, placed against a background of increasing numbers of Carers, the level of Carers Assessments has fallen since 2016/17. We do however recognise the increase in the routes carers are receiving early help and support through Carers in Bedfordshire as well as through Local Community Coordination.

Shared Lived Lives Bedford Borough – HBB was pleased to see that the Care Quality Commission’s (CQC) latest report on this organisation, published in May 2019, is still rated as “Good” overall.

Deprivation of Liberty Safeguards – It is pleasing to note that, whilst the overall number of applications has reduced in the last year, Bedford Borough Council does not have a backlog of DoLS cases and is to be commended.

British Red Cross Home Support and Reablement Service – HBB has had the opportunity of observing the results of this service. We are pleased to report on both the rapid response and the quality of service actually provided.

Discharge to Assess Model – HBB acknowledges that Adult Social Care is a part of a joint working approach together with Bedford Hospital NHS Trust on this important matter. HBB continues to receive reports of both delayed and unsafe discharges and where any concerns may exist across the health or social care system, the Borough Council is committed to working collaboratively to support any required improvements. HBB welcomes the Priorities as noted for 2019/20.

General Comments
In the Local Account 2016/17 reference was made to an “improved Healthwatch Signposting Service” – with a comment that it acts “as a clearing house for unmet needs, picked up across the system”.

There is no doubt since that time of reporting, the Signposting Service continues to deal with cases particularly involving co-morbidity: viz the presence of one or more additional conditions co-occurring with a primary condition and where a silo based service has difficulty in providing adequate support. This is also where HBB is dealing with cases where the provision of translation/interpretation such as BSL, etc. are not being made readily available by service providers.

HBB is able to discuss any reports or concerns raised in respect of care delivery to residents with the Borough Council, in any setting. Whilst again HBB is pleased to see the use of “I” style stories in demonstrating the outcomes to the work of the respective Adult Services in the Borough, whilst it may only be an impression, it would be really positive to hear such stories from people from the vast range of local communities across Bedford Borough.
SECTION THREE

Introduction
Introduction

This Local Account explains how Bedford Borough Council’s Adult Social Care Services performed from April 2018 to March 2019. Our Improved outcomes are shown in the form of key performance information with examples and feedback from Service users, Carers, and Partner Organisations.

Overall, our Local Account shows that Bedford Borough Council continues to deliver good services to local residents within the resources available.

The Adult Social Care Outcomes Framework

The Adult Social Care Outcomes Framework is published by the Department of Health and specifies outcomes in four domains.

1. Enhancing quality of life for people with care and support needs.
2. Delaying and reducing the need for care and support.
3. Ensuring that people have a positive experience of care and support
4. Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm.

We have used the domains as our headings in our local account so that you can see how we are doing. We hope that you find our account an interesting and honest critique of our progress.
What does Adult Social Care Services in Bedford do?

Bedford Borough Council is committed to maintaining safe and effective services for individuals, their carers, older people, those with frailty and those with disability and special needs.

‘A Borough where people, particularly the most vulnerable are able to lead happy, independent lives and fulfil their potential’.

Our purpose

• To provide person centred, practical care to adults and carers
• To work with individuals with care and support needs arranging person centred outcomes based on care and support to help them to lead independent and fulfilling lives, wherever possible in their own homes and communities.

Our aim

• To promote an individual’s wellbeing; supporting them to live independent and fulfilling lives in their own homes and communities and achieving the outcomes that are important to them.
• To ensure that the right level of support is provided at the right time, in the right place and at the right cost, to vulnerable adults and carers in Bedford.

Our responsibilities

• To provide information, advice and advocacy
• Carry out needs assessments
• Commissioning
• Provide and/or arrange services for adults with eligible care and support needs
• To keep people safe (safeguarding adults at risk or abuse or neglect)

Who we support

• People with physical disabilities
• People with learning disabilities
• Young people transitioning - preparing for adulthood requiring support by Adult Social Care Services
• Older People - People with mental health needs - these services are commissioned by Bedford Borough Council and provided by East London NHS Foundation Trust
• People with sensory disabilities including dual sensory impairment
• Carers - We strongly believe in and continue to grow our model of strengths based approaches; supporting people to live independent and fulfilling lives by focusing on what people can do, not what they can’t do.
Challenges Facing Adult Social Care Services

Adult Social Care Services across Bedford continue to face challenges:

- **People want better quality and choice in the services they use**
- **The population is living longer with complex needs putting further demand on social care**
- **The financial climate is imposing massive constraints on local authorities**
- **We need to develop further integrated services and pathways with our Health and other partners**

An estimated 62,000 people in Bedford Borough are over the age of 50, of whom 29,300 are over 65 and 4,300 are over 85.

From 2016 to 2031 the number of people aged 65 and over is projected to increase from 29,300 to 42,000, a 43% increase.

New duties within the Care Act 2014 continue to place a greater emphasis on prevention, which is at the forefront of promoting independence and choice for people. We continue to work together with communities and organisations to enable people to take greater control of their own health and wellbeing.

The increase in the numbers aged 85 and over is likely to result in additional demand for Nursing and Residential Care and, also, Extra Care provision.

As vulnerable people continue to face increasing challenges we must ensure we continue to have robust and effective safeguarding procedures in place for adults. We continue to see rising numbers of adult safeguarding contacts year on year, as well as increasing applications regarding Deprivation of Liberty Safeguards (DoLS).

There is higher demand for housing and there has been a rise in the numbers of individuals presenting as homeless.

Our Care Standards Team and Commissioners must therefore continue to work closely with our care providers to prevent provider failure, support the market to continue to be sustainable and to maintain safe quality services, delivered with high standards of care.

Workforce pressures across the social care sector including recruitment and retention of front line care staff remains a pressure.
SECTION FOUR
Our priorities in 18/19 were:
Our priorities for 2018/19

**PRIORITY ONE**
Continue to collaborate and join up health and social care services for the best outcomes of our shared local population.

**PRIORITY TWO**
Continue to build and strengthen communities through early help and personalisation; increase the uptake of direct payments and build on our Local Community Coordination and strength based approaches to protect an individual’s independence, resilience and ability to make choices and maintain wellbeing. Supporting a person’s strengths can help address needs for support in a way that allows the person to lead, and be in control of, an ordinary and independent day-to-day life as much as possible.

**PRIORITY THREE**
Increase the numbers of carers receiving an assessment or a review and assure that information and advice is readily available.

**PRIORITY FOUR**
Monitor and where possible reduce the number of admissions to residential care for younger adults (18-64) and continue to monitor the reduction of residential care for people aged 65 and over.

**PRIORITY FIVE**
Continue to build on our good work with younger adults to assist them in ‘Preparing for Adulthood’ by working closely with our partners in children’s services, our independent living team, education partners and our local supported employment scheme.

**PRIORITY SIX**
Work with all partners to assure that we continue to keep vulnerable people safe. We will also review referral pathways so we can continue to direct our safeguarding resources to those who are at risk of abuse, and to assure that we make safeguarding personal at all times. Our practice is to put individuals in full control of the safeguarding process, involving them every step of the way in terms of how the issue is investigated, and what action is taken as a result. Going through a safeguarding process can be very traumatic for some people and our aim is to put the power back into individuals’ hands through a fully personalised service. Not only does this ensure that we achieve the outcome/s that the individual wants, but also allows people to have a positive experience of a process that respects their views and wishes, supports their wellbeing, promotes their independence, and ultimately makes a positive impact on their life.
Collaborate and join up health and social care services for the best outcomes of our shared local population

During the past year we have undertaken a range of initiatives with other key partners to enhance the lives of our local residents who have care and support needs. Here are some highlights below:

Introducing a Home Safety Advisor – Supporting Bedford Dementia Sufferers

We are proud to announce a multi-agency initiative which we have jointly developed with our partners.

The service supports a Bedford wide Home Safety Advisor service which undertakes safe and well checks in the homes of those living with dementia and their carers.

Evidence show that the greatest risk of injury or death from fire incidents lies with the following groups:

- People with Mental impairment
- People with mobility issues
- People with alcohol usage
- People who live alone

People with a combination of these factors are at higher risk. It is known that a significant percentage of fatalities nationally involve people with dementia. Additionally, injury from slips, trips and falls is a risk for the same groups of people as above.

The service is led by the Bedfordshire Fire and Rescue Service working in partnership with multi agencies to increase the safety of those living with dementia and their carers.

The main purpose is to reduce the risk of harm from fire related incidents, complete home safety checks which reduce risk of harm from slips, trips and falls, advise on home safety and security fittings and arranging for the work to be undertaken and note external threats or concerns such as hate crime or local anti-social behaviour directed at property or the person with dementia.

Bedford Support Service

The main aim is supporting individuals affected by long term physical health conditions, physical inactivity and social isolation to help them gain confidence, self-manage and reconnect to their community, therefore maintaining independence. The service is provided by the British Red Cross working in partnership with multi agencies to increase the support to those who access the service.
The purpose and Objectives are:

- Provides low level support for vulnerable adults aged 18 years and over and older people, for a period of time determined by their needs but no longer than 12 weeks
- Promotes security and safety of clients
- Promotes social inclusion
- Provides positive outcomes for clients through assisting them to sustain independent living and encouraging positive engagement with professionals and the wider community
- Supports clients to access services that can help them to maintain and sustain independence such as local interest groups, health and leisure services
- Supports clients to access other support provision, including third sector providers with the aim of maintaining physical and emotional wellbeing
- Can work closely with other providers to benefit the service user
- Is designed and delivered with a focus on the service user, is outcome focused and promotes choice and inclusion
- Reduces individuals experience of loneliness and isolation
- Promotes good safeguarding practices
- Promotes reduced reliance on health and social care services and an increase on independent living.

Addressing Loneliness through a Telephone Befriending Service

This service delivers a Bedford wide telephone friendship network service with the main aim of supporting older people who feel socially isolated and lonely to help them gain confidence, self-manage and reconnect to their community, therefore maintaining independence.

The service consists of a regular weekly/fortnightly phone call. The relationship is structured so that each befriender makes the call at a regular pre-agreed time. All befrienders are trained and supported volunteers. The service is provided to Bedford Borough residents aged 50 years and over.

The service is provided by Age UK working in partnership with multi agencies to increase the support to those who access the service.

Purpose and Objectives

- Provides ongoing low level support for vulnerable older people aged 50 years and over.
- Promotes security and safety of clients
- Promotes social inclusion
- Provides positive outcomes for clients through assisting them to sustain independent living and encouraging positive engagement with professionals and the wider community
- Supports clients to access services that can help them to maintain and
sustain independence such as local interest groups, health and leisure services
• Supports clients to access other support provision, including third sector providers with the aim of maintaining physical and emotional wellbeing
• Can work closely with other providers to benefit the service user
• Is designed and delivered with a focus on the service user, is outcome focused and promotes choice and inclusion
• Reduces individuals experience of loneliness and isolation
• Promotes good safeguarding practices
• Promotes reduced reliance on health and social care services and an increase on independent living.

Increased Trusted Assessor Post
Last year we implemented new Trusted Assessor posts. Qualified Nurses carry out assessments for people being discharged from hospital into care homes. These have made a significant impact to the system and this has resulted in a reduction of delayed transfers of care. As such the team is being expanded to cover homecare and other services.

Increased Dementia Provision
The Borough has been working with Tibbs Dementia Foundation, a Community Interest Company to implement some new developments supporting those suffering with Dementia and their families. These initiatives include;

Step into 2019 with a spring and a bounce
A series of workshops to experience and develop fitness, resilience and wellbeing for family carers, with an accompanying activity group for their cared for person with dementia.

Weekly sessions of 6 weeks each focusing on:
• Cooking skills and nutrition – Jan to mid Feb
• Exercise - small changes can make a big difference Mid Feb to end of March
• Resilience and wellbeing April- early May
Health and wellbeing workshops at the Gurdwara Queen’s Park

Building on existing success focusing on delivering a healthy lifestyle message as a way of engaging with a new (to TIBBS) community. An initial big workshop day followed by a number of focused wellbeing sessions over a period of three – four months, building ongoing rapport and partnerships.

Increased Media

Exploring opportunities to set up a local community dementia radio station. This would ideally broadcast daily – for maximum impact as a means of providing company, routine, news, information, topical issues including health and wellbeing messages, orientation, daily quiz, daily armchair exercise for people with dementia and family carers unable to access community groups- taking the community to the individual.

Village Agents

The Village Agents Service provides low level support to residents of Bedford Boroughs rural areas. This includes help with applying for welfare benefits support or other applications such as Blue Badges or assistance to relay people in the rural areas to health appointments. Village agents also address issues relating to social isolation and liaise with the good neighbour group.

Increase Provision to Village Agents 2018-2019

• Bedford Borough Council funds Village Agents to act as a bridge between vulnerable and isolated people and local support
• Networks and services in rural communities. Further funding has provided an expansion of the support including:
  • Increased identification of vulnerable people living in rural areas (both new and existing clients) who need support over the winter.
  • Signposting clients as appropriate to BRCC’s Local Community Coordinators and other support agencies.
  • Piloting winter warmer activities – such as ‘soup and a roll’ sessions, with free transport provided by BRCC’s Community Transport team, including passenger assistants where needed. Activities will ensure social contact to prevent loneliness and improve health and wellbeing.
  • Piloting chair-based exercise classes, keeping frailer residents fitter and more confident that they won’t fall, boosting their resilience. Also providing increased social contact preventing loneliness.
• Increasing links between Community Agent clients and Good Neighbour Schemes – where they exist – to provide clients with a larger support base.
• Increasing links between Community Agent clients and Health Walk groups – where they exist – to promote active lifestyle and social interaction (while acknowledging that depending on the severity of the winter, active participation may be deferred until the spring).
• Information and advice on how to keep warm in winter, provided through home visits, attending community groups and producing bespoke information sheets.
• Advice on benefits and entitlements (such as free boilers, loft and cavity wall insulation etc), and other ways to cut energy bills
• Direct practical assistance to meet identified need for improving winter wellbeing and independent living, including providing new equipment such as carbon monoxide monitors, energy saving products and temp/humidity monitors
Strengthening Communities

In our previous Local Account we identified one of our key priorities for 2018/19 would be to continue to strengthen communities through early help and personalisation.

We are proud to update you on The Local Community Coordinator Service, (LCC) which is delivered by Bedfordshire Rural Communities Charity on behalf of Bedford Borough Council. The service commenced in April 2017 and provides a robust, early help offer, which promotes independence, resilience and choice and is available to adults 18+ who reside in Kempston, Queens Park, Cauldwell and Kingsbrook, Goldington and Putnoe, Harpur and De Parys wards.

Since the service began our Local Community Coordinators have worked with 487 local residents and this includes 84 new people during the period 1st January to 31st March 2019.

How has the service benefitted individuals in their community?
Please see our case studies which demonstrate the benefits of this valuable service in the local community.

Case Studies
How Local Community Coordination (LCC) is making a real difference

(Mr A)

Situation
• Mr A an 80 year old gentleman lives alone and has suffered from decreased mobility over the previous few years. Mobility issues have made it harder for Mr A to move around the home or go out safely
• A family member provides support but is finding it more difficult to manage. Mr A’s income was very low

Actions taken
• The Local Community Coordinator supported Mr A to check his welfare entitlements and supported him to claim Attendance Allowance, which he was entitled to
• Mr A was supported by LCC to make a Blue Badge application
• The LCC also arranged for Mr A to get a telecare system installed as he is at a high risk of falls

Outcomes to date
• Mr A feels more confident and able to remain independent
• Mr A has additional financial support, through access to Attendance Allowance, which has enabled him to pay for hot meals, now delivered to his home
(Mr B)

Situation

• Mr B is a 49 year old man who is a full-time Carer for his Mother (71 years) who has Parkinson’s Disease, which is getting worse and has affected her ability to live independently.
• Mr B’s Mother was undergoing memory assessment

Actions Taken

• The LCC supported Mr B to claim Carers Allowance which he did not know he was eligible for.
• Further information has been provided regarding council tax reduction for ‘Severe Mental Impairment’
• Mr B has now also been registered with Carers in Bedfordshire and is receiving support as a Carer

Outcomes to date

• This financial support has enabled Mr B to carry on caring for his Mother, as he had to stop work.
• Mr B is now attending a Carers in Bedfordshire, monthly ‘Carers Café’ to meet other carers to help support him emotionally

(Ms C)

Situation

• Ms C is a 75 year old lady who lives alone and has suffered from decreased mobility over the previous few years.
• It has been harder for Ms C to move around the home and to go out safely.

Actions Taken

• The LCC supported Ms C to claim Attendance Allowance. Ms C now has more money to do the things she enjoys which has increased her mood, and she can now afford a chiropodist.
• In addition to the above, the LCC supported Ms C with a blue badge application
• Ms C is now also awaiting a visit from Occupational Therapy to look at home adaptations such as hand rails and assistance to get in and out of the bath, which has become more difficult of late

Outcomes to date

• Additional financial support has enabled Ms C to remain independent, as her income was very low
• Ms C now has more money to do the things she enjoys which has increased her mood, and she can now afford a chiropodist
• It is now easier for Ms C’s family to take her out
Over the last year, the following areas have been reviewed with local residents to continue to strengthen communities through early help and personalisation:

- Your Lifestyle
- Looking after Yourself
- Managing your Symptoms
- Work
- Volunteering
- Other Activities
- Money Management
- Where you Live
- Family and Friends
- Feeling positive

Between October 2018 and January 2019, 58% of clients made a big improvement in these areas of their lives, with 21% making a smaller positive increase and the remainder of residents are working towards a change.

The Local Area Co-ordinators are catalysts for the development of community capacity and "self-help" groups, helping people develop networks to enhance social engagement. The LCC's have been working in partnership with a group leading a small community garden and the Queens Park Community Orchard (QPCO). A feasibility study will be undertaken to gauge the level of support to develop a community orchard and open community area in Kempston.

People using the service are supported to access a variety of organisations to meet their individual needs. These may include voluntary sector organisations, such as Carers in Bedfordshire, who support carers or the Tibbs Dementia Foundation, who offer services for people living with dementia. People can be signposted to access welfare benefits advice and a range of other services such as Age UK, telecare services, Mind Peers Support or the Recovery College.

The Local Community Coordination works with a broad range of service providers in the local community.
Increase the numbers of carers receiving an assessment or a review and ensure that information & advice is readily available

Last year we said that we would focus on some key priority areas. One of those areas was in respect of Carers. Carers are so important to us and we knew we needed to make some improvements. We therefore said that we would increase the number of carers receiving an assessment or a review and that we would ensure that the information and advice needed is readily available to help Carers to be supported to carry out the invaluable care that they provide.

Over the last twelve months we have seen an increase in those accessing information and advice through our carer’s digital portal. This has enabled the council to offer support at an early point to sign post carers to resources to support them to continue in their role. There are currently 111 carers registered as using the Digital Resource in Bedford Borough with promotional plans being developed to increase this number over the coming year.

We have also worked closely with Carers in Bedfordshire to build on our relationship and the services we commission through them. In partnership we have strengthened existing support and assessment mechanisms whilst also developing exciting new schemes such as unpaid carers attending Luton Town football matches free of charge.

During the period April 2018 – December 2018, 267 new adult carers contacted Carers in Bedfordshire for the first time with a further 2377 contacts having taken place with carers already known to the service. During this period, 9053 support interventions were carried out using a variety of means including helplines, emails, texts, face-to-face meetings or by other means such as sending out information and advice.

We have also reached a number of carers through community based schemes such as the local community co-ordinators. In total 42 carers were supported through this service, achieving a number of outcomes including access to the correct welfare entitlements and support to continue to live independently through access to mobility aids.

Bedfordshire Rural Communities Charity have continued to work closely with us to support carers and the people they support in their local community. The majority of referrals have been made at a very early stage and have enabled us to offer support to maintain and enhance caring situations, achieving the best outcomes for the carers and the people they offer such valuable support to on a daily basis.

As a Council we continue to work with Carers through our own internal care management teams, including specialist carers support workers, to ensure that carers’ needs are at the centre of all relevant assessments. Our Adult Services review team has also been central to
this work, and has seen the number of carers reviews increase. Carers in Bedfordshire are also commissioned by the council to provide early support to carers which is reflected in the drop in carers assessments during this hand over phase. Over the next twelve months we plan to continue to focus on this partnership to increase the total in 19/20.

In Bedford Borough we have expanded our Partnership Board offer which has increased the level of engagement we have with carers. Through these meetings we are pleased to see more Carers views being represented. As such carer’s voices and opinions are key to processes and decision making within the organisation and with the organisations we work with collectively.

Over the next twelve months we look forward to pushing forward on other schemes together with Carers in Bedfordshire and other agencies supporting carers.

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Monitor and where possible reduce the number of admissions to residential care for younger adults

In our last local account we said we would monitor and where possible reduce the number of admissions to residential care for younger adults (18-64) and that we would continue to monitor the reduction of residential care for people aged 65 and over.

One of our main priorities for 2018/19 was to provide appropriate support, at the right time in order to reduce the need for younger adults accessing residential care. In 2018/19 we have seen a small reduction in the number of younger adults accessing permanent residential care (178 in 2018/19 compared to 180 in 2017/18).

We have continued to support both younger and older adults with a focus on improving independence and building on their strengths rather than focusing on what they are unable to achieve. Services integral to maintaining our performance in this area included our Reablement and Telecare Services along with other traditional services such as domiciliary care and day services. In 2018/19 we helped 3,560 adults with services like these.
Preparing for Adulthood.

We have promoted and further developed collaborative working across our partners in children services, independent living team, education and local supported employment services. We proactively support “Preparing for adulthood” to ensure that a clear and fully co-ordinated move in to adult services is planned at the most appropriate point in time for the young person.

The Children and Families Act 2014 provides the framework for Local Authorities to implement the changes required under the Special Educational Needs and Disability (SEND) reforms; to support and proactively focus on children, young people and their families to achieve life outcomes such as paid employment, independent living, housing, choice and control, through personal budgets and access to health care that promotes and sustains health and wellbeing.

In parallel to the Children and Families Act a key change in legislation has been The Care Act 2014, which has brought significant changes and an outcome focus for Adult Social Care. This Act also contains provisions to help prepare for adulthood for children, young carers and child carers. In Bedford we believe that every young person deserves a positive experience of transition so that they are well prepared for adulthood. Across the Children’s and Adults’ Directorates we work together to support those in transition from being a child to becoming a young adult.

“Preparing for adulthood” means preparing for:

- Further education and/or employment – this includes exploring different employment options, such as support for becoming self-employed and supported internships.
- Independent living – this means young people having choice, control and freedom over their lives and the support they receive, their accommodation and living arrangements.
- Participation in society - this means having friends and supportive relationships, participating in and contributing to the local community.
- Being as healthy as possible in adult life.

Preparation for adulthood (PFA) involves assessing how the needs of young people change as they approach adulthood and also how carers’, young carers’ and other family members’ needs might change over time. It is a continuous process reflecting the principles set out in the SEND Code of Practice 2015. This support includes earlier planning, access to consistent information, access to supported employment services and wider local options for appropriate education and training. It is also essential that a clear and fully coordinated move into adult services is planned and at the most appropriate transition point suitable to the young person.
Drawing on the key messages from the code, Bedford Borough Council and partner agencies are committed to ensure that a multi-agency and person centred approach is in place; to ensure the individual outcomes we aim to achieve with children and young people to enable them to take their place as valued adult citizens of Bedford Borough; where their voices are heard, where they will continue to learn and develop as they gain greater Independence, control and choice of their lives.

In Bedford we do this through quarterly tracking between multi-disciplinary teams, including Adult Services, Health, Education and Children's' Social Care; identifying and monitoring the progress of support for those affected by PFA. This in turn supports the forecasting of future needs undertaken by adults’ services, to give a realistic projection of the presenting needs year on year up to 2030, allowing us to plan resources and support available.

When young people who have not been in contact with children’s services present to the local authority as a young adult, they often do so with a high level of need for care and support. That is why tracking and forecasting has been proactive in identifying these groups as early as possible so they can plan and prevent the development of care and support needs.

Our approach is cross referenced with our Transforming Care Agenda to consider the needs of young people with a range of complex needs who may require support from other sources other than, or combined with the Local Authority approaches; such as Continuing Health Care and Mental Health Aftercare Services with Bedfordshire Clinical Commissioning Group. We think our collective approach is a key priority as it promotes the early identification of those with complex needs and allows us to plan and develop local services to meet those needs. Therefore the continuation of collaborative work with Bedfordshire CCG is essential, to develop more local provision to support diverse need that will be proactive and sustainable.

The appointment of a PFA advanced practitioner in our Adult Learning Disability Team (ALDT) has provided a central point to have a strategic view, as well as proactively supporting and developing the workforce’s knowledge of key elements of law that impact directly on practice, for example the mental capacity legislation and deprivation of liberty safeguards.
The PFA role provides support to other professionals involved with individual cases that have complex needs. Providing the steer and prompt for timely applications to Continuing Health Care (CHC), referrals for specific support services for health and social care needs, to ensure we move away from disjointed or delayed transfers of care from children to adults.

It is also a role that has established good working relationships with our service users, families’ carers and all our partners, to support and improve the experience of transition for all concerned. Our key lead attends multidisciplinary forums, Educational Health and Care Planning (EHCP) reviews in schools and is influential in the PFA steering groups which were set up to ensure we collectively meet the outcomes and targets of the SEND reforms.

A PFA protocol between children and adult services is now operational since 2017. This ensures co-production happens in a meaningful way to provide a clear pathway for the transition from child to adult. We are proud to have developed annual ‘open’ events, twice a year which were established in 2016. Providing the opportunity to look at and interact with services that are available through our ‘Local Offer’ in a more meaningful and interactive way, for young people, their carer’s and families. The events have included employment, further education, housing/independent living options, and social and leisure activities.

We recognise that increased knowledge and access to personal budgets and direct payments, needs to continue momentum, through the care management assessment and EHCP review. This is an integral part of the assessment and planning process for preparing for adulthood.

Even if a young person is not eligible for services, a transition assessment with good information and advice about support in the community can be particularly helpful for these groups as they are less likely to be aware of available options, and this approach enables effective signposting to more appropriate services that will best meet the needs of the young person.
Priority Six

Working with all partners to keep vulnerable people safe

Last year we agreed that we would work with all partners to assure that we could keep vulnerable people safe. We also agreed we would review referral pathways so as to assure we make safeguarding priority decisions with our most vulnerable residents in mind.

In 2018/19 we expanded our work in the safeguarding arena which is explained in more detail in section 8 of this report.
SECTION FIVE
Expenditure
How much did we spend?

Expenditure

<table>
<thead>
<tr>
<th>Service</th>
<th>£</th>
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</thead>
<tbody>
<tr>
<td>Memory &amp; Cognition</td>
<td>2,850,865</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>18,285,517</td>
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<tr>
<td>Mental Health</td>
<td>6,414,108</td>
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<tr>
<td>Physical Support</td>
<td>30,815,122</td>
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<tr>
<td>Sensory Support</td>
<td>276,606</td>
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<tr>
<td>Social Support - Socialisation</td>
<td>297,518</td>
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<tr>
<td>Social Support - Support for Carer</td>
<td>308,122</td>
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<tr>
<td>Social Support - Substance Misuse</td>
<td>159,264</td>
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<tr>
<td>Assistive Equipment &amp; Technology</td>
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<tr>
<td>Social Care Activities</td>
<td>4,868,495</td>
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<tr>
<td>Information &amp; Early Intervention</td>
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<tr>
<td>Commissioning &amp; Service Delivery</td>
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<td>Adult Community Learning</td>
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<td><strong>Total Expenditure</strong></td>
<td><strong>69,651,188</strong></td>
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## Income

<table>
<thead>
<tr>
<th>Service</th>
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<tbody>
<tr>
<td>Memory &amp; Cognition</td>
<td>1,347,684</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>2,552,285</td>
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<tr>
<td>Mental Health</td>
<td>3,304,668</td>
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<tr>
<td>Physical Support</td>
<td>9,482,503</td>
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<tr>
<td>Sensory Support</td>
<td>133,641</td>
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<td>Social Support - Socialisation</td>
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<td>Social Support - Support for Carer</td>
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<tr>
<td>Social Support - Substance Misuse</td>
<td>46,820</td>
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<td>Assistive Equipment &amp; Technology</td>
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<td>Social Care Activities</td>
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<tr>
<td>Information &amp; Early Intervention</td>
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<tr>
<td>Commissioning &amp; Service Delivery</td>
<td>1,529,291</td>
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<tr>
<td><strong>Total Income</strong></td>
<td><strong>21,017,705</strong></td>
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SECTION SIX

Enhancing lives
Enhancing quality of life for people with care and support needs

Personalisation

Over the last twelve months every team in the Adults’ Directorate has played a role in enhancing the quality of life for the people we support. Chief amongst these have been the reablement team who have supported hundreds of people to be discharged from hospital, and other settings, and then going on to support them to realise personal goals around levels of independence and function. This was recently highlighted by a particular case study.

The Reablement team work with people for a period of up to 6 weeks to promote recovery following an episode of illness or other change in circumstances. Staff have been specially trained to help people regain independent living skills and promote their independence through the use of goal setting and review.

Case Study 1

Mr A was a 64 year old man; following an operation on his heart he was discharged home from hospital. He was assessed by a team coordinator from the Reablement service in his home. His goals were to be able to walk to the shop to purchase his daily paper.

During the first week his goal was to walk up and down his lounge. This was achieved.

Week 2 his goal was to walk to the end of his drive which he achieved.

Week 3 he achieved his goal of walking to the corner of the street.

Finally in week 4 he achieved his goal to walk to the shop.

He walked daily with a Reablement Support Worker and eventually his breathing and mobility improved to a level where he was able to reach his goal of walking independently to the local shop to purchase his paper.

The teams have also been working towards a strength based approach, which will be more formally rolled out in the next 12 months, were people’s strengths are identified and supported. Outcomes remain central to our work and each support plan is focused on the individual and their wishes. Teams have also taken personalisation beyond direct payments and have developed practice
to effectively enable people to maintain and affect change in their lives. Dignity and respect are also key to practice and the right to self-determination is central. This was recently particularly highlighted in another longer piece of support offered by the reablement service:

Case Study 2
Mrs B was a 57 year old woman; she had a stroke and a weakness on her left side. On discharge from Luton and Dunstable Hospital she was assessed by a Reablement Coordinator in her own home. As part of the assessment Mrs B identified her goals as follows;

Care package 7xam 7xlunch and 7xpm calls
1. To wash and dress independently
2. To be able to shower independently
3. To prepare food and a drink of choice independently
4. To access the community independently

Reablement Support workers worked alongside the Neuro Rehab Support Workers

Week 1
Reablement Support Workers assisted Mrs B to complete personal care tasks assisting where required with washing and dressing. Meal preparation - Reablement Support Workers assisted and initiated Mrs B to complete meal preparation and encouraged her to make her hot drink; Staff only intervened when required. The night time call over the first week resulted in her gaining confidence and was able to complete tasks by the end of the week. The Neuro Rehab team completed an Occupational Therapy (O/T) assessment and installed the equipment required and they visited daily to complete Physio tasks.

Week 2
The evening call was cancelled as Mrs B was confident in her bedtime routine. Reablement Support Workers continued to encourage with personal care and dressing on the morning call. Lunch calls - Meal preparation - staff continued to encourage and only intervened when required. Neuro rehab continued with their daily visits building up confidence with Physio tasks.
Week 3
Recorded vast improvements in all abilities. Personal care – independent with most tasks; Bath board in situ so Mrs B is able to shower independently. Meal preparation – this has also improved and gadgets were put in place to assist with areas less able. Neuro rehab were still involved with physio tasks.

Week 4
Lunch calls cancelled and also Sunday calls cancelled as Mrs B wished to see if she could manage and knew her family were around if she needed any assistance. Neuro Rehab team were now reducing their Physio input.

Week 5 and 6
Morning calls were reduced and Reablement Support Workers visited later in the morning just to ensure she had managed to achieve her goals. Neuro Rehab team continued for an additional 2 weeks to enable Mrs B to access the community via the bus.

Week 7 and 8
Mrs B was discharged from the Reablement service as she was now confident in all tasks and achieved self-caring.
Parkside

Parkside residents are enjoying participating in a Grow Your Own project. The project enables people living at Parkside to plant, grow and then harvest their own Fruit, Vegetables and Herbs. The produce is then used by the home’s kitchen within their daily menu’s, to conjure up a range of hearty meals that are appreciated by everyone in the home.

Residents are enjoying spending time outdoors and watching their produce growing. The scheme also enable’s people to play an active role in the running of the home and to become more involved in the planning of meals, and healthy eating. New recipes are discussed and put forward to make best use of the produce.

The scheme has become such a success that we are considering launching it in some of our other homes, and extra care schemes.

Residents at Parkside have fed back regarding the Grow Your Own project:

All have said that growing veg reminds them of their youth and several residents have said they are growing salad and veg, so that when we leave the EU we will be self-sufficient if there is a supply shortage

One resident is growing peas as it "reminds me when I was younger and I would sit on the garden wall shelling them, and eating them when my mum wasn't looking"

Another resident is growing tomatoes as he grew them every year in his own garden for his family. Another resident has said "it will be lovely to help to grow them and then see them on the menu, being eaten and enjoyed"
Delay Transfers of Care (DToC)

Reducing the time a patient remains in hospital once they no longer require medical treatment is a key priority and delayed transfers of care are a significant concern for both health and social care. Patients who experience long stays in hospital are known to experience low mood and reduced motivation and there can be a significant negative impact on muscle strength resulting in a decline in mobility particularly in older people. Longer stays in hospital also increase the risk of infection and also can negatively impact the patient flow through hospitals increasing the waiting time in A & E.

We have worked hard to decrease the number of delayed transfers of care ensuring that patients are discharged at the right time with the right level of support. The reduction has not only had a positive impact on the patients but has also enabled the hospital to focus their resources on patients most in need of their support.
Reablement

Our Reablement Service saw 482 referrals progressed to a reablement assessment in 2018/19. Of these 320 were to provide support enabling a safe hospital discharge. Reablement continues to support those who would have been at risk of admission to residential care if it were not for the support they provide. Our Reablement Team helps people regain independence following an illness or injury and this continues to be a large part of our prevention agenda.

Along with supporting the avoidance of residential admissions the service also works to reduce reliance on formal home care services. In 2018/19 the rate of self-caring achieved at the end of March was 46% with 15% of service users requiring less support at the end of the team’s intervention.

Number of people living in residential care who have been placed by the Council

The increase in the number of people admitted to residential care, in spite of all the services in place to prevent that, is evidence that the long term forecast ‘demographic time bomb’ is starting to make itself felt. However it is felt that without services such as Reablement the growth in the number of admissions would have been larger.

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</thead>
<tbody>
<tr>
<td>Older People</td>
<td>407</td>
<td>454</td>
<td>465</td>
<td>562</td>
<td>573</td>
</tr>
<tr>
<td>Adults 18-64 years</td>
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<td>152</td>
<td>161</td>
<td>180</td>
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<td>Grand Total</td>
<td>551</td>
<td>606</td>
<td>626</td>
<td>742</td>
<td>751</td>
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</table>
Transforming existing Supported Living service provision to improve outcomes for people we support

Phase 1
At the start of the project care was provided by a large number of providers, this often meant that levels of practice could vary and providers hadn’t been challenged to consider their approach around how the company provided care or offered best value to the local authority. Whilst the local authority doesn’t take potential changes to care provision lightly, we do have a duty under relevant legislation to review contract provision. More importantly this offered us the chance to work with people who were being supported to see how we could affect that change to improve outcomes for individuals.

Phase one of the learning disabilities supported living accommodation tender was carried out throughout 2016/17, with an implementation date of April 1st 2017. A lot of the work undertaken informed phase two of the project. Phase one offered us the chance to reflect on our engagement with stakeholders and how we communicate what can be concerning scenarios. As such from an early point we were able to offer assurances concerning phase two, about what changes would be brought about by the re-provision, as an example the vast majority of staff transferred over to the new provider, and as such those receiving care wouldn’t face issues around continuity in this regard.

Since the award of the contract we have worked closely with the provider, family members, and those being supported by the service to monitor and work through any issue’s that have arisen. Whilst the majority of the transfer has gone smoothly we are committed to continue this process and meet on a regular ongoing basis.

Phase 2
As we acknowledge that any type of potential change can cause concern and anxiety, we decided to manage the retender in two phases, so support could be offered to both groups affected by this process. This also meant that the likely outcome of the tender process was that there would be two providers, which reduces concerns around one provider delivering the entire supported living / residential contract.

As a result of Phase one we had identified that some previous providers hadn’t embraced the supported living model fully, and personalised care, with the person at the centre of the care provision, could have been better. As a result of these findings we worked closely with providers in both Phase 1 and 2 to ensure these areas were focused on to improve outcomes for those we support. We also linked in with forums such as the learning disabilities partnership board, to talk about the process and what people wanted to get from it.
During 2018 several care service provider contracts became due for renewal as a legal requirement under Contract and Procurement Law as part of the procurement process.

Those affected were provided the detail of the service specification to better understand how Bedford Borough Council wish to develop accommodation based services so they are sustainable in the long term.

Previously there were 3 different organisations delivering care that had contracts that were coming to an end. The tender process was carried out during 2018 with an aim to begin a new contract by the 1st of April 2019.

Service users were consulted with through a series of meetings and offered several ways of feeding back their comments and concerns around the process and what the change would mean for them.

The aims and objectives of Bedford Borough Council working collaboratively with all Partners and Stakeholders are to:

- Reduce the current fragmentation between services and securing a more integrated approach to service delivery.
- Focus on improving the outcomes that services achieve, rather than on the detail of how they are structured.
- Provide clear care pathways through services, so that, irrespective of how people come into services, there is a shared understanding as to how people will be supported without being blocked or delayed by organisational boundaries.
- Improve access to services, with care and treatment based on assessed needs and good practice guidelines.
- Improve the service user’s experience of care and services.
- Ensure that all public services are supporting people to access and remain in employment.
- Move more health provision into the community.
- Educate, inform and involve the community in improving their own health and wellbeing.
- Ensure the system is safe, effective, efficient, affordable and sustainable.

The new provider will be taking over during 2019 and is working closely with the current providers and Bedford Borough’s commissioning and operational team to ensure a smooth transition takes place.
**Wootton and Wixams**

Extra Care is a vitally important central pillar to our accommodation strategy in Bedford Borough and offers the increasing population a number of key advantages over more traditional housing solutions. These include but are not limited to, having your own living space, help being available in an emergency, flexible care and support and opportunities to socialise with other residents. The last point is also key as we try to support people facing challenges around loneliness locally. Extra care housing can also prevent or delay the need for a care home thus enabling people to maintain levels of independence for longer. During the year we have been working closely with the developers of two new exciting developments at the Wixams and Wootton.

**Equalities in Bedford**

_In Bedford Borough we are committed to promoting equal opportunities, in providing equal access to all our services. At a time when we have to make savings it is vital that we carefully look at the impact on our service users. We make sure that the needs of our service users are taken into account, looking particularly at issues of age, gender, disability and racial equality. Equality assessments are a useful tool to assess the implications of our decisions on our communities. Good equality analysis helps us to tackle inequality and target resources efficiently._
**Wootten Vale Retirement Community**

This 55 unit complex offers support to those over the age of 45. We have worked closely with BPHA to ensure they can meet the complex and diverse needs of the local community. As such they will be able to support people who require assistance with physical tasks of daily living alongside needs based around both mental health and learning disabilities. The council have nomination rights over the majority of units and are working closely with the onsite care provider, and care support, to ensure the complex becomes a valuable and active part of the local community.

The building has both single and double rooms so can support couple’s, with varying needs, and can ensure partners can be supported in the same environment for as long as possible.

**Wixams Retirement Village**

The Wixams retirement village is a private development where the council has nomination rights on over 40 units. The village supports people aged over the age of 55, who have care and support needs. The complex has a number of facilities attached to the scheme and the council has worked closely with developers to ensure these reflect the needs of those living in the retirement village. We are also working to develop other bespoke units on the Wixams village site, which will open over the next two years.

**Bedford Borough Social Prescribing Service**

Social prescribing supports adults to access help and information to meet social, practical, emotional and economic needs, thereby allowing them to manage their own health and wellbeing. Factors contributing to poor health and health inequalities can include financial, educational, poor housing, low self-esteem, isolation, relationship difficulties, and physical and mental health problems. Social prescribing reduces pressures on general practice and frontline social care services by enabling GPs and social care practitioners to spend more of their time managing individual’s core needs.

The Bedford Borough social prescribing service accepts referrals from GPs and other healthcare professionals for adults aged 18 and over with mild to moderate anxiety and depression or feeling socially isolated. Referrals are to a trained health coach who arranges a meeting with the individual to discuss their needs and aspirations and to agree a personal action plan. The community coordinator will then arrange, and support if required, visits to a range of community-based groups and activities as well as relevant statutory services. The individual continues to receive support from the coordinator throughout the programme.
Bedford Day Opportunity Service at the Kempston Centre - Digital Approaches

Bedford Day Opportunity Services at the Kempston Centre is an In-House Service and provides a range of day opportunities to people who have learning disabilities and multiple complexities of need. The Kempston Centre supports the needs of people with multiple disabilities and has specialist personal care facilities on site.

At the service all staff work in a person-centred way. This enables individuals to have an informed choice on the activities that they participate in during the day. Kempston Centre works closely with a range of Multi Disciplinary Teams and agencies for example, Physiotherapy Team, Sensory Department and Health Teams.

Over the past year The Kempston Centre has been working with service users on bringing the digital model of Inclusive Technology into the communications, learning and activities that they offer as part of daily routines. They recognised that Adults with Profound Learning Disabilities and Complex Physical Disabilities whom they support were often socially excluded from accessing modern technology and the internet due to barriers around learning and physical abilities.

They introduced 9 IPads to their Complex Care and Autism unit to support the individuals who receive service there. They were able to download specially created Apps for Assistive Technology and offer an Inclusive Communication approach whilst engaging interactive sensory activities using the touchscreen technology. This enables service users to communicate and make choices in ways other than through verbal or use of sign language.

They have noticed that in using this new technology people are also improving in their visual learning skills whilst maintaining hand/eye coordination and enjoying the sensory delights of cause and effect on the screen.

The IPads can be used as person centred communication tools that allows service users not only to enjoy the fun learning apps but to be engaged in conversations and social care assessments through the use of symbols or real photographs that are meaningful to that individual.

This ensures that the service is offering an enhanced level of person centred total communication and to ensure inclusion and understanding of the discussions going on around them, promoting choice and independence and increasing social interactions.

In time the Centre hope to begin working with the fantastic innovative Eye Gaze software which is designed to monitor an individual’s eye movements to highlight their choices and the symbols they are communicating to others with.
This project has been a very special learning experience for service users and staff around overcoming the barriers of modern technology and using it to improve daily lives.

Some service users in the Complex Care unit received IPads for Christmas from their families so this new approach to technology can continue to be a regular part of daily life as it is for so many of us.
Bedford Day Services Centre for Independent Living - Empowering Approaches with Living Skills by training to stay safe in the digital world.

The Centre for Independent Living is a day opportunity service which supports adults with learning disabilities to maintain and improve their daily living and independence skills. It is mainly accessed by people who are not reliant on a building base to meet their needs.

The service offers opportunities for individuals to progress to more independent lifestyles through activities and by accessing services in and around the town of Bedford.

The Centre for Independent Living is a base close to the town centre.

The approach

During the past year service users and staff have been working together to increase awareness and skills for dealing with Hate Crime and Internet Safety. The aim of the training is to empower adults and safeguard those with Autism and Learning Disabilities who are working to improve their independent living skills to access community resources and live in the local community as safely and independently as possible.

Modern technology, especially the internet and social media platforms are an important part of accessing information and creating inclusive communities for those who may be restricted in leaving their homes, creating friendships and breaking down the barriers of communication.

To understand this social issue The Centre for Independent Living have been covering subjects such as Cyberbullying, Safer Gaming and Social Networking, Financial exploitation through Scams, Mate Crime and Hate Crime. We are also looking at understanding Radicalisation, County Lines and Cuckooing which are also significant issues that are increasingly affecting Adults with Learning Disabilities who live independently in their own homes.

We are keen to create open communication and understanding of these issues so our services users have the skills and confidence in recognising possible risks and know how to report situations either online or to another adult who can ensure they are safeguarded from harm.

Sadly we know that sometimes with independent lives, travelling in local communities and the increased use of social media and internet gaming there is a risk of our vulnerable adults of being targeted due to their disabilities and lack of social awareness by those who will befriend and sometimes offer romance which is referred to as Mate Crime.
We have been focussed on Different Relationships, Consent and learning to recognise the signs of Hate Crime and Mate Crime through a qualification in E-Safety and Personal Safety. This offers the service users knowledge and crucial skills in how to recognise, respond and report situations where they feel they are being abused, befriended with intention to exploit or generally made to feel uncomfortable either online or out in the community. Like everyone else, adults with learning disabilities seek belonging, friendship, romance and excitement, unfortunately this also makes them vulnerable to ‘new’ friends whom they are very eager to please. We feel that the training sessions we are offering will enable our service users with Autism and Learning Disabilities to recognise the concept of true positive relationships and empower them to live as independently and safely as possible whilst accessing the technology of a modern society.
The current Bedford Borough social prescribing service is delivered by Bedfordshire Rural Communities Charity (BRCC) and was launched on 21st August 2018 from the London Road Surgery and Elstow Medical Centre. At the end of October 2018, the Kings Street Surgery in Kempston went live and at the beginning of January 2019, The De Parys Group appointed their own coordinator from BRCC as part of their multidisciplinary primary care home pilot which has a focus on mental health and wellbeing. The NHS will provide additional funding in 2019 for networks of GP practices to employ social prescribing coordinators. The local ambition is for all GP networks to have access to a social prescribing coordinator and to extend the referrals to other frontline services. The Community Voluntary Services (CVS) is actively supporting a wide range of voluntary sector organisations to become part of the referral pathway, including having a minimum level of quality assurance.
The Higgins Bedford

The Higgins Bedford has become established as a wellbeing hub for residents of Bedford Borough with grant support from The Harpur Trust, offering over 780 hours of wellbeing activity leading to over 2,600 engagements. Alongside gentle physical activities with tai chi, yoga and wellbeing walks (in collaboration with the Borough Sports Development Team), the Higgins has supported art therapy activities for vulnerable adults who are living with dementia, are recovering from strokes and are experiencing mental health issues.

In partnership with East London Foundation NHS Trust (ELFT) staff, the ‘Break the Stigma’ initiative held 12 art workshops led by and offered to those living with mental health issues for 6 participants and culminated in a successful exhibition of artwork from May – Sept 2018.

In partnership with Tibbs Dementia Foundation, up to 20 people per session have enjoyed stimulating art sessions, support and each other’s company. The Brushstrokes art group has enabled stroke survivors to engage with creative activities, socialise with others in the same situation and receive expert advice from the Stroke Association and Bedfordshire NHS Community Services professionals. 13 workshops have taken place since September 2018 attracting an average of 16 participants.

One participant commented: “I find it very difficult to motivate myself to do things. The group gives me a safe stimulating place to help me believe in my abilities. It also helps me to know that I have not completely lost the person I was”. The two groups have co-produced an exhibition at the Higgins running between April – September 2019.

Monthly ‘Stressbusting Saturdays’ have offered art sessions, tabletop games, yoga and poetry writing for all residents who feel they might benefit from free wellbeing activities and has attracted over 200 engagements. ‘Sketch Fridays’ provides art materials for anyone to use on a drop-in basis. People with learning disabilities who use services at the Centre for Independent Living and students with Special Educational Needs and Disability (SEND) who also attend Bedford College have benefited from these sessions.

Wellbeing activities will continue to be supported and expanded through 2019-2020.
**Appointee Service**

Bedford Borough Council operates a Money Management Scheme for service users who are in receipt of care services funded by the council, and who lack the capacity to manage their own finances and have no other suitable person to manage them on their behalf.

Where the Council is the Corporate Appointee for the service user and the service user accrues savings consistently of more than £15,000, the Council will review whether it needs to apply to be appointed Deputy but will ensure that this is in the service user’s best interests to do so before applying. This process is supported by legislation, including the mental capacity act and enables us to safeguard peoples financial affairs in a structured way. The council is appointee to 184 people and deputy for 39.
Public Health

Public Health provide services, evidence and information on a broad range of health and wellbeing issues, to improve local health and wellbeing and reduce health inequalities. In 2018/19 this included:

- Continuing to commission General Practitioners (GPs) to deliver free NHS Health Checks to eligible adults aged 40 to 74.
- Continuing to commission Cambridgeshire Community Services (iCaSH) to deliver an integrated contraception and sexual health service for adults and young people across Bedfordshire. The Kings Brook bespoke hub in Bedford brings all aspects of sexual health services under one roof, and a second hub in Dunstable Priory opened in August 2018. Brook and Terrence Higgins Trust also provide community outreach services.
- Promoting the online Express Test Home STI (sexually transmitted infection) Kit, particularly to people who do not display any symptoms. Over 1,800 kits were dispatched to Bedford Borough residents between April and November 2018.
- Supporting over 400 residents to stop smoking and delivering specialist treatment programmes to vulnerable groups.
- Continuing to commission BeeZee Bodies to successfully deliver a wide range of weight management programmes for pregnant women, children, young people, families and adults.
- Re-procuring the weight management contract following the expiry of the existing contract. The new provider, MoreLife UK, will deliver the contract from 1 April 2019.
• Supporting 8 local businesses to achieve the Healthier Options Food Award.
• Leading the development of the Bedford Borough Social Prescribing Model which is delivered by Bedfordshire Rural Communities Charity (BRCC). The service was launched at the end of August 2018 and over 70 people from two pilot GP Practices were supported in the first 6 months.
• Continuing to commission East London NHS Foundation Trust (ELFT) ‘Path to Recovery’ (P2R) to provide drug and alcohol treatment. There has been an increase in the number of people moving through the service and successfully completing their treatment.
• Providing support, advice and guidance to families, children and young people through the 0-19 Health Visiting and School Nursing teams.
• Supporting local organisations to ensure they fully appreciate the impact of childhood adversity and trauma and understand how to mitigate against the possible negative outcomes by strengthening resilience and supporting recovery.
• Updating the Joint Strategic Needs Assessment (JSNA), which is a local assessment of current and future health and social care needs; available on the Council website.
• Issuing 411 flu vaccination vouchers to Bedford Borough frontline social care staff.
• Delivering flu, shingles and pneumococcal awareness sessions to the Bedfordshire Carers Forum and in sheltered and residential settings.

• Attending a wide range of public engagement events including the Queen’s Park Gudwara Health event and the Queen’s Park Community Health event.
• Providing a range of Infection, Prevention and Control Training to nurses and other relevant frontline staff.
**Shared Lives Bedford Borough**

**What is Shared Lives?**

Our Shared Lives Scheme is a great example of how we are transforming the lives of local residents.

Shared Lives Bedford is run by Bedford Borough Council and is rated as good. It is regulated and monitored through the Care Quality Commission. The scheme links people who need help and support to live in the community, with people who can provide that help and support in their own home. It is very much about opening the door to choice, satisfying experiences, achieving a sense of belonging whilst at the same time enabling people to maintain and develop their own independence.

Similar to fostering, our scheme currently supports people with a learning disability from age 16 years into adulthood. Support can vary from short breaks, community access during the day time or on a full time basis.

The ethos is that a shared lives carer opens up their home and family life to include the young person or adult who needs extra support to live well. It’s a way for people to share family and community life. It can often result in people with support needs doing things for the first time in their lives such as joining a club or community group, making friends or going on holiday. People can also be involved in activities such as going to the theatre, cinema, visiting the pub or going for a walk and a chat.

The scheme aims to support and oversee the provision of placements within a safe and homely environment, based on ordinary living principles and to support each individual to live a fulfilling life.

Our scheme is small but perfectly formed and is currently providing support to 9 long term placements, 1 community access placement and is preparing to support a range of service users with either a respite placement or further community access opportunities.

As well as offering an excellent form of person centred quality care and support, Shared Lives saves, on average around £26,000 per year, per individual, against the cost of residential care.

2018-19 was a busy year and the Shared Lives Bedford Team has been out and about to a range of locations to promote the service with an aim to recruit a wider range of carers. Additionally, the service has been promoted through various social media platforms, leading to an increased number of enquiries, which in turn has led to 6 new carers working with Shared Lives in the past year, which is extremely positive.
How does it work and what are the supports?

Shared Lives follows nationally recognised rigorous training, approval and matching processes, recruiting and training carers to make sure becoming a shared lives carer is the best match for the individual.

During the approval process carers are screened, undertake training in the roles and responsibilities of caring and they develop an important oversight of key legislation to help them to be the best carers possible with the right skills.

Matching is a key part of the journey to ensure compatibility through sharing some interests and ambitions. After successfully matching, transition visits and overnight stays are progressed and if everyone is in agreement, the placement agreement is signed and the placement will formally begin.

Shared Lives Bedford oversees the placement providing support and information to both the individual and the carer through regular visits. All the individuals supported through the scheme and carers have a close bond, the support is very individual and person centred.
Shared Lives Case Study - Annie*

The Bedford Borough Council Adult Learning Disabilities Team thought of the benefits the scheme may bring to Annie who required some support with accessing the community. Annie had not accessed any other services prior to being referred to Shared Lives Bedford.

Whist Annie could speak some English she and her family did not have this as a first language. The referring professional in the Adult Learning Disabilities Team therefore requested to see if a carer could be sourced that spoke the same language as Annie and her family.

Through the service promotion on social media Shared Lives has sourced new carers and were able to match a carer to Annie. Now that the carer has completed the shared lives placement assessment and training they have been introduced to Annie and are looking to start her placement.

This introduction has also led to a placement being set up for another eligible individual who required support to access the community.

The service user also required a carer to speak the same language, but also had care and support needs around his epilepsy. A carer was identified that could support with his language and communication needs. They are now completing the required epilepsy training so they can begin providing support.

We acknowledge the diverse needs and are pleased we can match people to the scheme in a person centred way.
A referral was received from the Council’s Children’s service for a 17 year old young lady to see if Shared Lives could be explored and for a match to be sought with a carer for respite care (short breaks) with the view that when Brenda turned 18 years old, she would be looking for a longer term placement.

It was great that a match for respite was made with a carer who has a young lady already living as part of their family in a long term placement.

The family were very active, met frequently with friends, went on holidays and all enjoyed going on days out. Brenda’s match was successful and she settled in very well and enjoyed family parties, attending craft workshops as well as trips to places like Harry Potter studios and formed a great friendship with the other young lady and the extended family.

During the craft workshops held at weekends the shared lives carer providing short breaks noticed a great bond and friendship forming between Brenda and another member of the craft group. The crafter was a good friend of the carer and they would socialise regularly as families.

Shared Lives discussed becoming a carer with the crafter and with Brenda with the thought of a long term placement with the lady and her husband. They both loved the idea and after completing the approval process Brenda moved in a few days after her 18th birthday.

Brenda has enjoyed fantastic holidays with her Shared Lives Carers, attending craft events as well as Youth Clubs. Brenda has also been supported to take up horse riding as the family have horses and she is now completing her dressage exams. Brenda’s confidence and daily living skills continue to increase through making drinks and keeping her room clean and tidy. Her Shared Lives Carers have also supported her to carry on her education focusing on her love of animals.

Brenda still has a really good friendship with the young lady where she attended respite. It is wonderful how Shared Lives enabled the placement to grown and it is so good to see a younger adult develop and grow through positive experiences, both for her and wider benefits created for family and Brenda alike.

*all names are changed
What next for Shared Lives Bedford?

Over the coming year we are considering how we can expand the service so it is available to as many residents as possible. One of the areas being explored is supporting people who are being discharged from hospital.

Our aim would be to offer the service to people who are well enough to be discharged home but may need some support in that initial period. It is hoped that by having access to the service people can avoid remaining in hospital longer than necessary or having to access respite care while they recuperate.

People accessing the service could choose between being supported in their own home or being supported in a shared lives carer’s home, whichever is more appropriate at the time.

In addition the team also exploring broadening the service to support a wider user group and include older people and people with physical disabilities.

Are you interested in Shared Lives? - We’d love to hear from you.


For more information e-mail shared.lives@bedford.gov.uk
SECTION SEVEN

Delaying and reducing need
### Delaying and reducing the need for care and support

**About no limits**

Whilst some of our disability sessions have been running for many years, the Disability Resource Centre (DRC) in conjunction with the County Sports Partnership, Team Beds and Luton and Bedford Borough Council secured almost £360K from Sport England in 2015 to create more sustainable opportunities for disabled people to take part in sport in Bedfordshire. This award is one of 44 projects across England, which will collectively inject £8million into disability sport.

**What activities are currently on offer?**

There are already a wide range of No Limits activities taking place across Bedford Borough.

- Weekly Multi Activity/Social Clubs Mondays and Tuesdays, 16 years plus (Tuesdays 15+)
- Weekly Disability Football, 16 years plus, No Limits Teams playing in the Bedfordshire FA Ability Counts League
- Weekly Pilates Sessions, 16 years plus
- Monthly Football League, open to all players 15 years plus
- Opportunity to attend bespoke training courses, such as an FA Level 1 Football Coaching Course, 13 participants qualified as Level 1 coaches.
- Partnership working with local clubs, groups, agencies
- We now employ 2 support assistants who started with us as participants.

No Limits is the much needed catalyst for change that will create more genuine opportunities for people with a disability to access quality sports in this Borough.

NO LIMITS ... to an individual’s capacity to be involved!

NO LIMITS ... to an individual’s aspiration to succeed!

NO LIMITS ... to regular sports participation!

For further information please contact Hayley Elphee on 01234 718835, email; hayley.elphee@bedford.gov.uk
Gentle Exercise Classes

The decision to run community Gentle Exercise classes was reached after visiting schools and talking to parents about what exercise they would like to take part in.

It became apparent that having not done exercise for many years many were scared to try, so the Sports Development Team started the Gentle Exercise classes as a stepping stone back into a wider range of local physical activity programmes. The sessions aim to offer people who only felt comfortable with doing this level of exercise did not feel judged or threatened and could relax in an enjoyable environment.

The first class started in Queens Park with one 83 year old lady! The wide range of classes run predominately in areas of deprivation and are subsidised by external funding grants in order to make them affordable and therefore more accessible to everyone.

The classes have attracted large numbers and groups from the community and have participants ranging in age from 33 - 85 years all working at their own level.
The Exercise Referral Scheme (GPER) is administered by Bedford Borough Council’s Sports Development team in partnership with the Lifestyle Hub. If you are looking to lead a healthier lifestyle by making some positive changes and wish to increase your physical activity levels, then speak to your GP and request a referral to the Lifestyle Hub. Providing you meet the criteria you will be invited to join the scheme which offers a range of different options at locations around Bedford, delivered by Fusion-Lifestyle and others.

There is a gym based exercise programme, currently available at Robinson Pools & Fitness; Kempston Pool; John Bunyan Sports & Fitness Centre; The University of Bedfordshire; and The Paula Radcliffe Sharnbrook Community Centre.

Alternatively we offer some non-gym based physical activity sessions including a Sunday morning gentle exercise class at John Bunyan Sports & Fitness; daytime gentle swim sessions at Kempston Pool; and an evening relaxation swimming session at Robinson Pools & Fitness. We also hope to add an Aquatone class at Kempston Pool. The scheme lasts for 10 weeks and upon completion you will receive details of ongoing physical activity opportunities at a discounted price.

For more information email sport@bedford.gov.uk
Over 70s

Bedford Borough Council Sports Development Team provide a wide range of easily accessible opportunities for older people to be active on a regular basis. Their ‘Over 70’s’ programme involves a variation of gentle exercise and physical activity classes which focus on building strength and confidence whilst focusing the mind on the body as well as encouraging regular social engagement. Some examples of the activities on offer are short tennis, chair-based yoga, line dancing and badminton.

Physical activity and exercise are recognised as contributing towards a better quality of life, not only for the elderly but for individuals of all ages; with academic research proposing that physical activity and gentle to moderate exercise is one of the most important things older people can do to enhance their health and wellbeing.

Regular participation in physical activity is one of the most common and supported remedies to not only prevent early aging but as an encouraged form of rehabilitation and recovery. The bodies’ reactions to physical activity incur a number of favourable responses that contribute to a healthier lifestyle as well as general overall positive wellbeing.

The programme has gone from strength to strength and now attracts over 100 attendances each week! The success and popularity of the programme has led to a further new session launching earlier this year at John Bunyan Sports & Fitness.

Not only does exercise benefit physically and mentally, there are many social advantages too; this does not necessarily mean whether the participants make friends or not, it involves their interaction with others to prevent loneliness, being in an environment which involves communicating with others and increasing levels of happiness and social wellbeing.
Participants have reported numerous positive benefits as a result of attending the Over 70s exercise classes “helps to keep the brain active (as well as my feet!)”. The social aspect to the classes has also seemed to play an important part in the enjoyment as another participant said ‘I like meeting other people of my age, having a chat over coffee and biscuits and getting some focused exercise all in one!’.

Bedfordshire Care Directory
To enable our local residents to have information at their fingertips we have continued to work jointly with Care Choices (publisher) and Central Bedfordshire Council to produce a yearly edition of the Care Directory which provides listings of care providers for care at home or residential care along with information on health and wellbeing, community involvement, staying independent and charging and funding. The latest edition will be available for distribution in June 2019.

Ageing Well Exhibition
The Aging Well Exhibition is an event older people can attend to gain unique access to a range of providers of services geared specifically for the over 50’s. The stall holders provide a wide range of information and advice on a host of issues pertinent to the age group.

The event is hosted by Age UK Bedfordshire, on behalf of Bedford Borough Council. This is the fourth year the event has taken place. Last year the exhibition attracted over 750 older people, with 32 exhibitors, providing information and advice on subjects as diverse as Benefit Entitlements, Dance and Exercise Classes, Hand Massage and the benefits of becoming friends of Milton Keynes Theatre.
Seven activity Taster Sessions were held, including Zumba, Line Dancing and Dance4all. Feedback received from Exhibitors achieved a 100% rating for the organisation of the event as excellent.

Comments from Visitors include:

“Friendly and busy lots of useful information”

“Really good event with lots of organisations together”

“Range of stalls, covers awareness, podiatry and Alzheimer’s”

“Everyone friendly and helpful”

“Caring staff - good communication skills - well organized”

“Good variety of information - friendly atmosphere”

This exhibition is held in the summer whilst the weather is warmer as requested by our local residents rather than in October, the traditional date to celebrate International Older Peoples Day.
Lifestyle Hub

The Lifestyle Hub is a central point of contact for weight management and physical activity programmes.

A trained team of Lifestyle Advisors use motivational techniques to deliver a healthy lifestyle approach that is unique and new to the residents of Bedford Borough. This includes the use of Health Apps, available on Smart phones, to support clients.

Individuals are referred by Primary Care Health professionals and other relevant health care professionals and are assessed on a one to one basis in an informal, relaxed atmosphere. Lifestyle Hub operates from 4 different venues including evenings and Saturday mornings to suit all schedules. Telephone and Skype appointments are also available. All individuals have the opportunity to discuss their experiences, likes and dislikes in relation to diet, exercise, smoking and other lifestyle factors.

During the period January – December 2018, 904 initial appointments were made with 1520 follow up appointments.

The Lifestyle Advisor will then suggest referral programmes and signposting options based on the information presented by the individual. The advisor can also explain the eligibility criteria and prices of these programmes. If the person doesn’t choose one of these options or doesn’t want to try one, then together with the Lifestyle Hub Advisor they can agree on achievable and realistic targets to increase physical activity and make simple diet changes/swaps under the Let’s Get Moving Programme.

Everyone is offered the opportunity to review their goals and progress to ensure they are supported through the process with a further 3 follow up appointments over the next 24 weeks. So far the Lifestyle Hub has accepted just over 5000 referrals. 71% of patients report their overall experience with the Lifestyle Hub to be “excellent” and a further 26% report their overall experience as “very good”.

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Telecare

Telecare Services offer individuals, their families and carers, security and peace of mind, through services that enable people to stay independent in their own home for as long as possible. Our Telecare services provide a range of personal and environmental alarms that can send alerts to relatives / carers / neighbours when an individual needs support. Telecare covers a wide range of needs, and is intended to support people and enable them to continue living in their own home, independently or with the assistance of carers, for as long as possible.

It also supports carers and families by providing additional help and support with caring responsibilities and all-important peace of mind. The equipment includes pendant alarms, fall detectors, door sensors, heat and smoke sensors and silent panic alarms. It is very positive to report that in 2018/19 the Telecare Services supported 2106 individuals within Bedford Borough, an increase of 577 additional people who are supported to be as independent and to remaining in their own homes.

Community Equipment Service

Our Community Equipment Services plays a crucial role in helping us to support people to remain in their own homes. This jointly commissioned service between Health and Social Care across the whole of Bedfordshire and Luton provides a range of equipment as well as minor works which enable people (children and adults) to carry out day to day activities as independently and safety as possible. The services provided facilitate timely hospital discharges and also prevent admission to care home settings and other forms of care.

Falls Prevention and Awareness

Falls continue to be a major cause of disability and the leading cause of mortality resulting from injury for older people. In 2017/18, emergency hospital admissions due to falls in Bedford Borough residents aged 65 years and over were higher than the England average. The number of hip fractures continues to decrease and is currently lower than the England average (www.fingertips.phe.org.uk) however it is important to remember that there is an ageing population and in excess of 95% of hip fractures are fall related.
Locally developed Falls Prevention and Awareness Manuals continue to be used by our Bedford Borough Care Home Falls Champions in residential & nursing homes and extra care housing. Falls awareness training for the Champions continues to be offered to all care homes across the Borough.

The role of the Falls Champion
- Attend the Falls Awareness training
- Lead the falls prevention work within their care home
- Act as the main point of contact for falls related matters and ensure that advice is sought from the relevant professionals
- Attend falls prevention meetings led by Bedfordshire Clinical Commissioning Group and Bedford Borough Council, which provide education on a wide range of falls related topics, training and peer support
- Provide guidance updates to their wider care home team

The most effective method of falls prevention is community based strength and balance exercise programmes, particularly if they are tailored to the needs of the individual. Even those who take up exercise in later years reap significant benefits from participating in strength and balance exercises. Bedford Borough Council’s Sports Development Team continues to support care homes to deliver strength and balance exercises to their residents.

They also provide a wide range of community based activities for older people, including those for the over 70s and gentle exercise classes: [www.bedford.gov.uk/leisure_and_culture/sports_development.aspx](http://www.bedford.gov.uk/leisure_and_culture/sports_development.aspx)

The Council’s First Response Team continues to provide an assessment to people who have fallen within their own home, but do not require any medical assistance or admission to hospital. The team provide equipment, advice and information and will liaise with relevant support services if required.

Falls: First Response Service
- The First Response service has been expanded to take referrals from other healthcare professionals and continue to deliver a seven day service.
- An outpatient fracture liaison service continues to operate at Bedford Hospital to reduce the risk of subsequent fractures by identifying, treating and referring appropriate patients over 50 years old to relevant services and information.
- Continuation of delivery of strength and balance sessions to the Bedford Borough community which are very well attended.
- Continue to support the delivery of chair based exercises in care homes to support reduction in falls. This has been very well received.
- Reporting shows a continued decrease in the number of hospital admissions which is likely to be as a result of a combination of interventions.
Mindful Sport

The Mindful Sport initiative led by the Borough Council Sports Development Team aims to improve the mental wellbeing of community members through physical activity sessions which are tailored specifically to individuals who may be suffering with a mental health illness.

Since its launch as a one off pilot in June 2015, the Mindful Sport programme has expanded from a one hour session to now offering a range of activities including; Yoga, Table Tennis, Swimming and Badminton. The programme initially targeted adults over 18; however, in October 2017 the programme launched a ‘Mindful Sport for Young People,’ offering Mindful physical activity sessions to 12-18 year old’s as well as continuing to support those over 18.

In October 2018 this expanded again for offer different activity options. The Mindful Sport programme is led and managed by the Sports Development Team who have continued to collaborate with numerous organisations and charities in order to support the programme and its participants. Some of our partners include; the NHS East London Foundation Trust Wellbeing Service, Childrens Adolescent Mental Health Services (CAMHS) mental health service for young people, Mind BLMK Bedford, Luton and Milton Keynes and the University of Bedfordshire who promote the sessions to local community members who may be experiencing a mental health illness.
The Mindful Sport programme does not require a clinical diagnostic and participants can attend the sessions via self-referral.

The Adult programme has engaged with 263 participants in the last 12 months with over 2000 attendances across the 4 different sports that are available on a weekly basis. More than 9 different mental health conditions have been reported with anxiety and depression as the most common conditions reported.

The sessions include Mindful yoga £3, Mindful table tennis £2, Mindful Swimming £3 and Mindful walks Free. All take place on a weekly basis. The data collected shows that the perceived feelings of wellbeing are improved across 95% of participants after the exercise session. (via the ONS questions on wellbeing).

The Young People’s programme has engaged over 30 young people with 197 attendances across a 6 month period. The Younger Minds session is held every Tuesday 4-5.30pm at John Bunyan Sports and Fitness Centre, with three activities on offer, each session is £3 and participants can take part in as many activities as they feel comfortable in. The World Mental Health Day 2018 was an even bigger event than in 2017 and 2016 with 20 different mental health organisations, charities and public services taking part in the town centre event. The event includes free yoga, free table tennis, free tai chi and lots of information on all the local services available.

The Sports Development Team are keen to continue to develop the programme and support the local community with a variety of activity sessions to suit those experiencing mental health illnesses and improve mental wellbeing.
Disabled Facilities Grants (DFG)

Disabled Facilities Grants are used to fund essential adaptations to promote independence, safety and control within an individual’s own home. Bedford Borough Council spent £1,374,875 on Disabled Facilities Grants in 2018/19, resulting in 149 major adaptations being completed. These include the provision of ground floor facilities, Stairlifts, ceiling track hoists and showering facilities to allow individuals to continue to live in their own homes for as long as possible.

A case study to reflect these essential works is as follows: “A double amputee who is incredibly independent, required essential adaptions to their home to manage and facilitate the daily detailed treatment they require without the need for additional care calls. The Disabled Facility Grant, overhauled the bathroom to make a level access shower, adapted a small area in the bedroom for a specialist sink, provided additional heating and installed a Clos-o-mot toilet”.

Minor adaptations were also completed by Bedford Borough Council and BPHA to meet the needs of 371 individuals. Such works include the installation of grab rails, stair rails, lever taps and other small changes to promote independence and safety in their homes.
SECTION EIGHT
Care and support
Ensuring that people have a positive experience of care and support

Care homes 2018/19

We have continued with our extensive refurbishment programme upgrading 5 of our residential homes throughout the year; works completed and currently in progress have included:

- Installation of tracking hoist equipment for individuals who require specialist support
- Redecoration of interiors and the upgrade of satellite kitchenette areas for our residents and visitors to use in unit style homes
- Installation of new wet rooms and bathroom upgrades for our residents
- Replacement of exterior cladding and the creation of new entrance and reception areas that are disability friendly
- Replacement of all lighting within the homes with energy efficient LED sensor and touch enabled light fittings
- Installation of additional elevators to improve access facilities between floors
- Replacement fire door programme

During the year our residents have been fully consulted regarding all stages of the works and they have chosen the colour schemes for their individual rooms and communal areas of the homes. Each home has worked closely with the Council’s Property Team and contractors, to ensure that works undertaken have had minimal disruption to residents and visitors. The works will be fully completed across all of the homes this year.
Refurbishment programme Outcomes

Rivermead entrance before upgrade

Rivermead new entrance

New reception area

Wet Room

New cladding

Old cladding
Care Standards Monitoring and Review Service

In Bedford we believe in the importance of quality services delivered to our local residents. We are passionate about standards of care. This is why we have continued to focus on monitoring and supporting our local care providers to achieve the best they can. We have supported providers to sustain their continuity and quality of care. We have been able to do this through our continued focus on two key work streams - Monitoring and Review.

Our Monitoring Service

Bedford Borough Council’s Care Standards Team continues to use two work streams for monitoring all registered care provision within Bedford Borough. The first is through our quality assurance database where our social care management teams or safeguarding team professionals can submit referrals about an individual receiving a service or about a service provision. We feel this is not only important for making referrals regarding quality concerns that require further input, but equally about positive feedback and experiences.

The other tool we are embedding to assess and monitor standards of care is the Provider Assessment Marketing Management Solution (PAMMS). This tool is used across the Eastern Region and is endorsed by the Association of Directors of Adults’ Services (ADASS). The web based monitoring tool analyses a range of information gathered during our assessments and works out an overall rating. The assessment uses the same fundamental standards as the regulator, The Care Quality Commission (CQC), assessing key areas to assure services are Safe, Effective, Caring, Responsive and Well-led.

On completion of our assessment the provider gains a rating, which can be Excellent, Good, Requires Improvement or Poor. Where actions are identified our Care Standards Team will support the provider to complete an action plan with clear outcomes and timeframes.

Our Team is in its first year of using the PAMMS system and will be starting a second round of PAMMS assessments for providers later this year. The team will also be starting to use PAMMS for non-regulated providers in the near future. In Bedford Borough we have also benefited from the involvement of pharmacists from the Complex Care Team who have supported and complemented our own areas of expertise, to ensure quality assurance in the medication standards covered in the assessments.

We are really pleased with the developments so far but strive to do more. Over the next twelve months we are therefore looking to develop ways of making it easier for local residents receiving the services we are assessing to contribute to the assessment. For example currently we are looking at how we could involve experts by experience to support us with our assessments of individuals who have a learning disability.
What Difference do we make?

In November/December 2018 our Care Standards Monitoring Team worked with a National Provider who was experiencing financial viability and difficulties and was no longer able to provide a service to a number of local residents. This involved our Team working closely with the Council’s Commissioning Team to plan a way forward and assess the risk. We are very pleased that such positive collaborative work enabled both the staff from the provider service and all care packages to be successfully transferred to another of Bedford Borough Council’s approved providers, just before Christmas. This positive work meant that continuity of care was delivered with a seamless transfer, no missed care calls and no matters of concern raised.

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<th>Key Figures</th>
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Our Care Standards ethos is to have a proactive approach to risk with support to providers at an early stage of difficulties being identified by coordinating input from partner agencies and services to minimise risk of harm to individuals and provider failure. We actively liaise with (CQC) inspectors sharing information and intelligence where we may have a provider concern that has led to the instigation of a provider action plan, both ourselves and the inspector see it as more productive that they may delay a visit or inspection until the action plan has been completed so that they can see that the changes made are being maintained by the provider.
Specialist Sensory Impairment Team

Bedford Borough Council has its own Specialist Sensory Impairment Team that works with adults & children who have a permanent hearing or visual loss which cannot be overcome through use of glasses or hearing aids. Our Team can provide equipment that may assist with independence and safety, such as large button telephones, flashing doorbells, TV listeners and vibrating child monitors.

For clients with a Visual Impairment, a period of Mobility Training can be completed with a Rehabilitation Officer to familiarise them with their local area, school or work place. Additionally the team can support with a period of rehabilitation with activities of daily living to increase independence with meal preparation or personal care.

Support with communication with the wider community can also be considered through specialist equipment or personal assistants via a Direct Payment.

Our overall the Sensory team worked with the following numbers of people in 2018-19:
• Visual Impairment – 193 adults
• Hearing Impairment – 105 adults + 4 children
The Care Standards Review Team

Our Adult Services Review Team carry out an annual care review for people in receipt of a support package, whether they have a Learning, Physical, or Sensory Disability or are over 65 years of age. The annual care review is provided for all service users who have a funded package of care support from the council; those who have been assessed as self-funding their own care are also offered this service.

Section 27 of the Care Act 2014, outlines the importance of the Annual Review of support services, as both a revision and reassessment of the support and care plans that are in place.

How does this work?

The review process ensures that we liaise with the service user, keeping them at the centre of the review and obtain their feedback along with family, next of kin, carers, and the Care Provider to obtain their view of the support in place. Reviews can take place in the person’s own home, day centre, residential or nursing home.

Our Reviewing Officer will explore whether the support provided continues to meet the assessed needs and has achieved the previously identified outcomes. There is a clear focus on service user strengths, family, community networks and encouraging service users to be proactive in achieving greater independence.

A review meeting is also an opportunity to evaluate the service provision and consider if changes are required to enhance the efficiency of the service and the person’s experience.

The review meeting ensures that services in place are supportive and effective in meeting assessed need and reduce the risk of requiring further support wherever possible. For example referrals are made to other services; Reablement, Occupational Therapy, Continence Service, Falls Prevention, Telecare and Carers in Bedfordshire.

Changes to care packages may include an increase, reduction or a new service provision including community based resources. Any recommended changes to a care package are presented to a panel for consideration and validation.

On completion of the review a revised review report and care plan is provided to the Service User, their Next of Kin and any involved professionals in line with GDPR guidelines. The review documents reflect current need and preferred outcomes with an outline of how the needs and outcomes will be met to ensure the service user is safeguarded living in their local community.
Quality Assurance and Valuable Feedback

Along with the review documentation a feedback form is included to gain quality assurance information and feedback on the review process. In 2018, 663 feedback forms were received and utilised for staff and team development.

The review team not only reviews the care and how needs are being met but they also report any safeguarding concerns and provide regular Quality Assurance feedback; liaising with both the Council’s Safeguarding and Monitoring Teams to strive for best practice in the on-going support of vulnerable people in our local community.

Over 2,000 reviews took place in 2018/19.

Case 1:

Jenny is an 87 year old lady who lives with her husband, he is bedbound due to extensive health problems; he has a package of care in place, Jenny is principle carer. Jenny undertakes all of the household chores. Unfortunately Jenny had a heart attack and was hospitalised for three weeks with associated health complications.

Jenny had told the carers and health professionals at the time she had been coping in her caring role but reflected to the Reviewing Officer confidentially she is actually overwhelmed and exhausted by her own health issues. Jenny felt she was letting her husband down by not being able to cope anymore and at times she struggled to attend to his needs, when the carers were not there, due to feeling fatigued.

Jenny had lost weight as she no longer cooked for herself due to fatigue and was forgetting to take her medications. Jenny and her husband have a son but he does not live locally and is in full time employment.

The Reviewing Officer arranged for carers to support with meals on a short term basis to ensure Jenny was eating. Jenny was referred for a Telecare assessment and consequently a medication carousel was provided. A sitting service was sourced to enable Jenny 2 hours 2 afternoons a week to enable her to sleep undisturbed if she wished to or attend appointments. Jenny was signposted to Carers in Bedfordshire who have been a great support and have suggested a potential Carers Grant.

After 6 weeks support Jenny reported that her general health and wellbeing had now improved and she felt better able to continue in her caring role. The support was reduced to once a week sitting service, to enable her to have a regular break from her caring role.
Case 2:

Sam is a 19 year old gentleman who has a significant Learning Disability, Autism and Epilepsy. Sam lives at home with his brother and mother who has her own serious health problems. Sam has support in place which enables him to attend college, day opportunities and one-to-one weekend community access.

At the Annual review Sam’s mother reflected that she is no longer able to support Sam with some of his daily personal care needs. This impacts on Sam’s support as his hygiene is not being maintained. Sam finds it hard to communicate his needs, resulting in behaviour others find challenging.

Sam is experiencing more health related problems which his mother is finding increasingly hard to manage. Sam’s seizures have increased which impacts on his daily routines resulting in him being very tired throughout the day. Sam’s mother was worried that as her health deteriorates Sam’s needs would not be met as he is not always able to communicate them.

Sam’s day services were no longer meeting his needs and he was not enjoying going; impacting on his behaviour. Other day opportunities were considered with Sam and his mother, and after taster days Sam’s day services were transferred to another provider.

The Social worker liaised with the carer providing one-to-one support to assist with personal hygiene and Sam has since engaged with having his hair washed and other hygiene needs.

Sam was referred to The Health Facilitation Team at Twinwoods for support with appointments, and to have eye tests with the Sensory Team. A Psychology referral was made due to Sam’s increasing challenging behaviours.

In addition a referral to Telecare was arranged for a sensor mat to ascertain if Sam was having seizures during the night which could account for his tiredness and increased challenging behaviours.

Sam’s mother was signposted to Carers in Bedfordshire for support and information was provided to apply for a Carer’s Cinema Pass. Sam’s mother is really happy that she has support for her son and her role as mother and carer has been recognised.
Comments, Compliments and Complaints

In Bedford we welcome feedback on the services that we provide and on the services we arrange for people but might be provided by another care provider. Hearing people’s views on the services helps us to identify where improvements are required as well as where things are going well.

We aim to provide a complaints service that is accessible and fair and we try to ensure the response to the complaint is proportionate to the issues being raised. A key part of the complaint process is to find a resolution to the issue giving rise to the complaint and provide an explanation if the service has not been to the standard we would expect.

Our ‘Comments, Compliments and Complaints’ leaflet is given to all service users and carers following their assessment or review.

A total of 26 complaints were received in 2018/19 that were addressed in accordance with the Adult Social Care Complaints Procedure. This compares to 23 recorded in 2017/18

• Of the 26 complaints all were looked at under the local resolution stage.
• 29 compliments, 11 enquiries, 7 requests for service and 1 comment were also recorded.
• 1 decision has been made by the Local Government & Social Care Ombudsman in this period.

Learning from complaints

We continue to learn from complaints and feedback. There were 9 pieces of learning or recommendations recorded for complaints received in 2018/19. Here are a couple of examples:

• The team will be reminded of the importance of ensuring sensitive conversations take place away from other service users wherever possible.
• Signing in system to be revised to ensure where multiple carers are present they are all required to sign in.
Compliments

Compliments are important feedback that tell us what we are doing well and helps to spread good practice. 29 Compliments were recorded in 2018/19. Here are some examples:

- Thanks and compliment to Parkside staff for providing mum with 5 happy years.
- Compliment about the kind and reliable support provided after being discharged from hospital.
- Compliment about duties carried out with “compassion, professionalism, care, diligence, to the utmost highest standards.
- Compliment about fantastic respite care and support provided by staff and social workers.
Mental Health Partnership Board

Towards the end of 2018, we reinstated our Mental Health Partnership Board, which had been taking place in a different way since 2016. This decision was largely based on the rising demand for mental health support and also a new more modern approach of engaging with people through boards. We also considered the learning from the success of the two other Partnership Boards, which are supported by the Adult Services Directorate with our co-chairs. Both the Older People’s and Learning Disabilities Partnership Boards have become increasingly focused on being driven by those who make up the board, which is proving to be invaluable.

Our Partnership Boards have taken on a new themed approach around agreed topics, selected by service users and a range of stakeholders. As people have put these suggestions forward, it’s clear that there is a desire for the issues to be discussed and addressed by the board. Since the approach has changed we have seen an increase in engagement and attendance. As an example the Older Person’s Partnership Board have tackled subjects such as travel and mental health services, achieving positive outcomes in both regards and assuring progress that can be linked to the board.

Two meetings have been undertaken in regards to the Mental Health Partnership Board and the third is due to take place in May 2019. The meetings so far have largely focused on the makeup of the board and its governance, but we are hoping to move forward from May onwards to mirror the success of the other boards, with Co-Chair and co-production with a themed approach. Our Board will consider the recovery aspects of Mental Health with service users and core partners and agencies in the community such as the Recovery College.

The Recovery College, run by East London Foundation Trust (ELFT) in partnership with the University of Bedfordshire is open to everyone living and working in Bedfordshire and Luton. They offer a series of educational based workshops and courses which aim to help and support individuals with their journey of recovery. The Recovery College has extended its prospectus of courses this year, to very positive feedback. On a recent survey 96% accessing the service agreed that they were satisfied with the range and content of courses available. The college has worked closely with the University of Bedfordshire, which has developed a mutually beneficial relationship where students from the university can also gain knowledge and experience.
Complex Needs Unit

Clarence House – One Year on

In Bedford we recognise the diverse needs of our community. It’s hard to believe that it’s been a year already since we announced the opening of the Complex Needs Unit. It has now been open for just over 12 months and has continued to go from strength to strength. We are pleased to report that a number of people have already been supported by the scheme to find suitable housing as a result of their stay.

The service provides support to individuals who have been assessed as needing support with a number of areas such as long term homelessness, a history of substance misuse and a long standing Mental Health Diagnosis.

Before the unit was opened people could often find themselves in a cycle of homelessness and substance misuse without suitable resources to meet their needs. A number of the people supported by the project have also re-engaged with their families, which has offered them a new network of support to establish ways forward. The opening of the unit has placed Bedford Borough Council at the forefront of such provision, and is arguably leading the region in this regard.

Close work between the Bedford Borough Council, East London Foundation Trust and One Housing Group, has ensured the unit has been used to its full potential and we will continue to work with the service area to build on its strengths and supports to assist people even further in the next couple of years.
Transfers of Care

Reducing the number of delayed transfers of care (DToC) continues to be a priority both at a national, regional and local level. A delayed transfer of care occurs when a patient is ready for discharge from hospital (acute or non-acute care) and is still occupying a bed.

In Bedford we take any delays very seriously and again this year we have worked closely with the local hospital, community health services and the local care market to reduce delayed transfers of care wherever possible. We have continued to perform very well in this area for a number of years and we continue to be top in the region for the lowest delayed transfers of care in 2018/19. We have been exceptionally proud of the hospital social work team’s achievement and this reflects the strong working relationships that have been developed between the team and other partner organisations. Over the next 12 months we want to build on this success strengthening the relationships further with a focus on more integrated working with our health partners.
SECTION NINE
Safeguarding
Domestic Abuse – A Strategy to Tackle the Causes and Effects of Domestic Abuse (2017 – 2021)

In our last Local Account we announced the launch of the Bedford Borough Council Strategy to Tackle the Causes and Effects of Domestic Abuse (2017 – 2021) which was approved by the Council in June 2017. The Strategy is available and has been published on the Council’s webpages.

Preventing and tackling the effects of domestic abuse remains a key priority of the Borough’s Community Safety Plan. Since the implementation of the Strategy a considerable amount of work has been undertaken to make good progress on the Strategic Aims:

• Governance
• Information and Communication
• Partnership
• Provision
• Prevention

We consider Domestic Abuse as everyone’s business. Our vision is to create a society in Bedford Borough where domestic abuse is not tolerated, and to reduce the level and impact of incidents in the Council area.

What is Domestic abuse?

Domestic abuse is defined by the UK government as ‘any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.’ This can encompass, but is not limited to, psychological, physical, sexual, financial and emotional abuse’.

Controlling behaviour is defined as ‘a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.’

Coercive behaviour is ‘an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim’.

A report commissioned by the Council found that there were 3,137 domestic abuse incidents reported to the police in 2014/15 in Bedford Borough, which is relatively high considering its population. It is estimated that there are approximately 4,900 victims aged 16 and older in Bedford Borough, based on the prevalence of domestic abuse in England and Wales. Despite there being an average of 100 calls a
The Local Account - 2018/19

In terms of safeguarding, this structure ensures that the responsibility is shared throughout the Council and a whole family approach to domestic abuse is considered, including the direct victim of the abuse and the perpetrator as well as any children impacted by the abuse. It also means that there are direct links into other Strategic Boards such as Adult Safeguarding Board, Children’s Safeguarding Board, Community Safety Board and the Health and Wellbeing Board to incorporate actions into relevant strategies and ensure a joined up approach to Domestic Abuse.

**Strategic Aim 1: Governance:**

The Borough has a structured and co-ordinated approach to domestic abuse

We know that a joined up approach is needed to tackle domestic abuse and in 2017 we worked with our Children’s Services Directorate to identify a key lead to take our combined strategy work forward. With a key lead in place, Bedford Borough Council has established a robust Domestic Abuse structure with a shared responsibility between Children’s Services, Adult Services, Environmental Services and Public Health Services. The Intervention & Strategy Coordinator is now the link between the Bedford Borough Council’s Domestic Abuse Strategic Group and BBC Domestic Abuse Operational Delivery Group and externally, the Pan Bedfordshire Domestic Abuse Strategic Board, Police Group, the Pan Beds Domestic Abuse Partnership, and a range of wider and valued associated partners.

**Strategic Aim 2:**

Information and Communication

We focus specifically towards Domestic Abuse awareness raising such as the International 16 Days of Domestic Abuse Campaign which runs every year, or events where incidents of Domestic Abuse may increase such as major sporting events and holiday periods. Literature, poster campaigns, local events and joint press releases are shared to ensure that consistent messages are put out through all relevant media platforms to the public and across the Borough.

minute to the police being made nationally, domestic abuse remains a hidden crime, with many victims still not coming forward. On average, only 37% of victims tell someone in an official position about the abuse they experience, with only 4% telling a specialist support service. Many more adults and children will be hidden victims because of under-reporting due to perceived stigma and shame.
Strategic Aim 3: Partnership

To bring together all those involved in the domestic abuse agenda to achieve shared goals and outcomes

One of the key priorities for the Intervention & Strategy Coordinator since being in post has been to develop an Action Plan to deliver the Strategy to Tackle the Causes and Effects of Domestic Abuse. Taking the view that Domestic Abuse is a shared responsibility, all statutory partners including the Police, Probation, Health, Clinical Commissioning Group and our voluntary partners as well as relevant corporate directorates were consulted to create the Action Plan. The plan incorporates the recommendations from the SafeLives audit conducted in early 2018 which scrutinised our response to Domestic Abuse.
Strategic Aim 4:

Provision: A range of high quality services are available to meet the needs of victims, their Families and perpetrators.

In 2018, Bedford Borough Council and Central Bedfordshire Council jointly worked on commissioning perpetrator services for the 2 Authorities; the successful bidder was The Change Project. The Outreach Perpetrator Worker started at the beginning of August 2018.

In 2018 Families First Bedfordshire continued to run a programme in Bedford Borough to work with the victims of abuse and are bringing together a programme to support male victims.

Strategic Aim 5:

Prevention: We want to ensure support is available to prevent domestic abuse and intervene at the earliest stage to prevent escalation

This will mean that victims, children and perpetrators are identified early and referred appropriately by a wide range of frontline practitioners and partner agencies; that victims are supported to recover, build resilience and not to tolerate domestic abuse in the future, and that young people are able to recognise if they are in an unhealthy relationship and know how to access support.

In the two years since the implementation of the Strategy to Tackle the Causes and Effects of Domestic Abuse a considerable amount of work has been achieved, particularly under the Strategic Aims of Partnership, Provision and Prevention. In the coming year work will now focus on sustaining and developing the Partnership work already achieved, improving communication and raising awareness within the Community, particularly in hard to reach sectors such as Male Victims and Elder Abuse and considering future provision for victims and those impacted by Domestic Abuse. At the beginning of 2020, work will commence on developing a new Draft Strategy for the following 3 years.
Abuse is Everybody’s Business – Safeguarding is our Responsibility

Adult safeguarding means protecting a person’s right to live in safety, free from abuse and neglect. Adult safeguarding applies to any person aged 18 or over who has care and support needs, is experiencing or is at risk of abuse or neglect and as a result of those care and support needs is unable to protect themselves from either the risk or the experience of abuse or neglect.

Abuse is a deliberate or unknowing mistreatment by any other person or persons that causes harm to a person or violates a person’s human and civil rights. The abuse can vary from treating someone with disrespect in a way which significantly affects their quality of life, to causing actual physical suffering. Adult safeguarding is about preventing and responding to concerns of abuse, harm or neglect of adults. The aims of adult safeguarding are to stop abuse or neglect wherever possible, prevent harm and reduce the risk of abuse or neglect to adults with care and support needs, safeguarding adults in a way that supports them in making choices and having control about how they want to live, and promote an approach that concentrates on improving life for the adults concerned.

In Bedford we work within the Care Act 2014 statutory guidance that states that safeguarding should be personal; it should be person led and outcome focused; it should enhance involvement, choice and control as well as improving quality of life, wellbeing and safety. Safeguarding is managing risk about the safety and wellbeing of an adult in line with the 6 key principals that underpin all adult safeguarding work

• Empowerment
• Protection
• Prevention
• Proportionality
• Partnership
• Accountability

The Care Act 2014 states that local authorities must make enquiries, or cause others to do so, if they reasonably suspect an adult with care and support needs is, or is at risk of, being abused or neglected. The purpose of an enquiry is to decide whether or not the local authority or another organisation or person should do something to help and protect the adult.

The safeguarding duties (three stage test) apply to an adult who:
• has needs for care and support (whether or not the local authority is meeting any of those needs) and;
• is experiencing, or at risk of, abuse or neglect; and
• as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.
The objectives of an enquiry into abuse or neglect are to:
- establish facts;
- ascertain the adult's views and wishes;
- assess the needs of the adult for protection, support and redress and how they might be met;
- protect from the abuse and neglect, in accordance with the wishes of the adult;
- make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect; and
- enable the adult to achieve resolution and recovery.

Where an individual does not have the mental capacity to decide how to protect them self from abuse, organisations will actively use legislative frameworks to protect that person and an Independent Mental Capacity Advocate must be sought to represent their interests during adult protection procedures.

The local Multi Agency Policy and Procedures are built on multi-agency partnerships working together, with adults to prevent abuse and neglect where possible, and provide a consistent approach when responding to safeguarding concerns.

When a safeguarding concern is received by the Bedford Adult Safeguarding Team, safeguarding initial enquires are made to decide what action is required and whether a Section 42 Safeguarding Enquiry should be implemented under the Multi Agency Safeguarding Adults policy. For 2018/19, the Safeguarding Team received 1527 safeguarding concerns of which 219 resulted in safeguarding initial enquires being made and as a result of the initial enquires 65 were raised to a formal Section 42 Safeguarding Enquiry. Of the 1462 initial enquiries that did not progress to a formal Section 42 Safeguarding Enquiry, actions such as care management involvement, reviews of care packages, risk assessments and actions for providers were put in place.

Detection and awareness of safeguarding continues to improve across Bedford and safeguarding enquiries result in a range of outcomes resulting in the person being safeguarded. Contacts to the team continue to rise, many of the contacts/concerns the team receive are not treated under safeguarding and indicate a risk but not of a safeguarding concern, and are forwarded to the most appropriate agency to support/deal with the concern. Ongoing work continues with partner agencies and providers to ensure contact with the safeguarding team is relevant and appropriate meaning the team can focus support to those at risk of abuse.
There is strong multi-agency partnership work in place around addressing issues of exploitation of vulnerable adults by information sharing, developing disruption toolkits, raising awareness of issues such as modern slavery and exploitation, and a shared approach to managing concerns.

There continues to be a greater awareness of domestic abuse due to awareness campaigns among both professional and the public, and an increase in concerns reported to the team including cases of abuse against males.
### Section 42 enquiries by type of abuse

<table>
<thead>
<tr>
<th>Type</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>60</td>
<td>34</td>
<td>23</td>
<td>26</td>
<td>39</td>
</tr>
<tr>
<td>Discriminatory</td>
<td>1</td>
<td>-</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neglect</td>
<td>124</td>
<td>56</td>
<td>68</td>
<td>65</td>
<td>61</td>
</tr>
<tr>
<td>Sexual</td>
<td>24</td>
<td>17</td>
<td>13</td>
<td>32</td>
<td>24</td>
</tr>
<tr>
<td>Emotional/ Psychological</td>
<td>27</td>
<td>20</td>
<td>9</td>
<td>14</td>
<td>24</td>
</tr>
<tr>
<td>Financial</td>
<td>45</td>
<td>21</td>
<td>19</td>
<td>49</td>
<td>32</td>
</tr>
<tr>
<td>Institutional</td>
<td>6</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>26</td>
<td>39</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>287</td>
<td>152</td>
<td>137</td>
<td>212</td>
<td>219</td>
</tr>
</tbody>
</table>

The above figures show that the least intrusive and most proportionate response has been considered since the implementation of the Care Act 2014, against the risks presented.

The Central Bedfordshire and Bedford Borough Adults Safeguarding Board is a joint statutory board following the implementation of the Care Act and exists to ensure that all member agencies are working together to help keep Central Bedfordshire and Bedford Borough Adults safe from harm and to protect their rights.

The Board has an Independent Chair supported by additional multi-agency forums and key operational groups.

The implementation of the Care Act places safeguarding adults on a statutory footing. Making Safeguarding Personal is an essential part of all our work. We engage the adult in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.
Case Study

Mr M had contacted the police as he said his daughter had stolen money from him. She had access to his bank account and debit card as she supported him with his food shopping.

The lead investigator from Older People’s Team worked with the officer from Bedfordshire Police. The Police Officer interviewed the daughter and she admitted to taking money from his bank account and using his debit card to order items from the internet.

Mr M who has mental capacity said he did not want his daughter charged with theft as long as he got his money back. She is now paying the money back to her father monthly, under the supervision of the police officer.

Mr M’s care package has been increased so he is now supported by the paid carers to complete his own food shopping and also has social inclusion time.

Mr M is also being supported by his brother & sister to move to Luton to be closer to them.

Our key priorities for 2018/19 will be to:

Work with all partners to assure that we continue to keep vulnerable people safe. We will also continue to review the referral pathways to ensure the most effective use of the safeguarding team so we can continue to direct our safeguarding resources to those who are at risk of abuse, and to ensure that we make safeguarding personal at all times. Our practice is to put individuals in full control of the safeguarding process, involving them every step of the way in terms of how the issue is investigated, and what action is taken as a result. Going through a safeguarding process can be very traumatic for some people and our aim is to put the power back into individuals’ hands through a fully personalised service. Not only does this ensure that we achieve the outcome/s that the individual wants, but also allows people to have a positive experience of a process that respects their views and wishes, supports their wellbeing, promotes their independence, and ultimately makes a positive impact on their life.

We will continue to work with partner agencies to address issues of exploitation that may affect and impact on the lives of vulnerable adults in the community.
Mental Capacity Act 2005- Deprivation of Liberty Safeguards

Since the Supreme Court Ruling in 2014, Bedford Borough Council continues to receive and process large numbers of requests to assess people under the Deprivation of Liberty Safeguards (DoLS). DoLS ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and in the person’s best interests.

Representation and the right to challenge a deprivation are other safeguards that are part of DoLS
For 2018/19, a 6% decrease was observed with a total of 1240 requests being processed. The breakdown of requests per quarter are as follows:

<table>
<thead>
<tr>
<th>Period</th>
<th>Number of Applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>April to June 2018</td>
<td>319</td>
</tr>
<tr>
<td>July to September 2018</td>
<td>320</td>
</tr>
<tr>
<td>October to December 2018</td>
<td>289</td>
</tr>
<tr>
<td>January to March 2019</td>
<td>312</td>
</tr>
<tr>
<td><strong>Total applications received for 2018/19</strong></td>
<td><strong>1240</strong></td>
</tr>
</tbody>
</table>

% of all DoLS authorisation applications completed at end of 31/03/2019 95%

Nationally, the number of requests continues to rise with a large number of supervisory bodies experiencing a backlog of cases. For 2017/18, 227,400 DoLS applications were received in England with a reported backlog of 125,630 cases. It is highly likely that national backlogs will be reported for 2018/19. We are proud of the fact that Bedford Borough Council does not have a backlog and this has been the case since the ruling in 2014.

According to national statistics for 2017/18, the average number of days from applications being received to being completed across England was 138 days. This means that many people assessed under the safeguards are potentially subject to periods of unlawful deprivation, if a decision is made to issue a standard authorisation to lawfully deprive a person of liberty. Bedford Borough Council remains committed to ensuring assessments are undertaken within statutory timescales as is practically possible. For 2018/19, 9% of cases resulted in persons being subject to a period of unlawful deprivation.

There are a number of reasons as to why Bedford Borough has been able to continue to manage demands associated with DoLS and these include:

- Continued support from Leaders with regards to securing the Human Rights of people who lack capacity to consent to their care and support in care home and hospital settings. DoLS remains a priority agenda item and updates are disseminated via a number of forums, including the Safeguarding Board with focus on local, regional and national practice.

- A supportive and committed pool of Approved s12 Doctors and Best Interests Assessors. Six-weekly supervision is available to all Best Interests Assessors and this forum provides an opportunity to share knowledge and reflect on best practice. Assessments are quality assured by advanced practitioners on the DoLS team.
An efficient and robust DoLS process. There is a dedicated team that focuses on all DoLS related activity. A signatory DoLS rota is in place which ensures that assessments are scrutinised and authorisations are granted/not granted in a timely manner.

The team operates a renewal process to prevent gaps in standard authorisations. This process has proven effective in supporting the team to manage DoLS requests and ensure timely allocation to assessors.

Partnership working with Managing Authorities. The team has developed positive networks with local providers required to submit authorisation requests. Support is available to manage and respond to queries and to ensure safeguards are in place.

The team has a positive working relationship with the Care Standards monitoring team. They offer support and monitor DoLS compliance of individual providers and also respond to concerns highlighted through the assessment process.

The team notify care management teams of any issues or concerns that may arise from assessments, which ensures timely action is taken to address identified challenges.
Collaborative working with neighbouring Supervisory Bodies, the Eastern Region and Pohwer (advocacy service). Attendance at the national DoLS meetings and the annual MCA Action Day.

Access to six weekly basic awareness training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. The training is available to staff working in the field of health and social care, including the private, voluntary and independent sector.

It is widely accepted that the Deprivation of Liberty Safeguards are fundamentally flawed and urgent reform is needed. In July 2018, the Government published a Mental Capacity (Amendment) Bill, which if passed into law will reform the DoLS, and replace them with a scheme known as the Liberty Protection Safeguards (LPS). A statutory LPS Code of Practice will be produced and Bedford Borough Mental Capacity Act Coordinator has volunteered to contribute to some of the working streams.
SECTION TEN
Partnerships
Updates on Partnerships

Over the last year we have strengthened our existing partnerships whilst also developing new ones. An example of a new partnership can be seen in the work we have engaged in through the Directorate with developers and housing associations, concerning new housing schemes in the Borough. These have ranged from large extra care facilities to smaller bespoke specialist developments. Partnerships have been founded on new ways of working, realising best value, personalised care and seeking innovative practice to place the Council at the forefront of initiatives and developments.

Our existing partnerships have been strengthened by robust performance monitoring and reporting mechanisms to ensure the relationships meet the requirements of the Council and the vulnerable people we support. There have been challenges in this regard, but these situations have been turned into opportunities to review and improve practice in the long term. An example of this can be seen in the partnership work we have strengthened with East London Foundation Partnership Trust to quality check the provision of Mental Health Services whilst assuring the best quality of response from the Approved Mental health Professional Service, provided on the Council’s behalf by our partners East London NHS Foundation Trust.

We work with many partners who are all invaluable, in fact too many to mention! The voluntary sector also plays a vital role in our partnership working, and has been supported by an increased attendance at the various partnership boards and other forums. As an example of this positive work, the relationship with Cares in Bedfordshire continues to grow and develop and reflect our commitment to engagement and partnership working.”

We have strengthened our relationship with the Fire Service to work together to keep our local people safe, promoting a collaborative approach and ensuring essential checks are in place in peoples own homes.
Workforce, Commissioning and Partnerships

Bedfordshire and Luton Approved Mental Health Practitioner Service

The AMHP Service (Approved Mental Health Professional) is provided by East London Foundation NHS Trust (ELFT) on behalf of Bedford Borough Council, Central Bedfordshire Council and Luton Borough Council.

People are assessed under the Mental Health Act 1983, Monday to Friday, 9am-5pm. Out of hours this service is provided by the Emergency Duty Team (EDT), which is provided by Central Bedfordshire Council.

AMHPs are qualified Nurses, Social workers, Occupational Therapists or Psychologists, who have completed additional training that means they can make an application under the Mental Health Act 1983 to detain a person to hospital for a period of assessment or treatment.

This will happen if there is a concern that the person has a mental disorder and is a risk to their own or others health and safety, but are unwilling or unable to agree to come into hospital or stay in hospital.

Alongside the AMHP, two doctors will also be part of the assessing team, one must have special training in the assessment and diagnosis of mental disorder and one who is a registered medical practitioner.

The AMHP will make all reasonable attempts to liaise with the person’s nearest relative if application for assessment (section 2 is being considered) and must consult with the nearest relative if application for treatment (section 3) is being considered.

Referrals for a mental health act assessment can be made by professionals or a nearest relative if they have concerns.

Over the last year Bedford Borough, Central Bedfordshire and Luton have worked with ELFT to further develop partnership working and service improvements. All of our joint policies and procedures have been reviewed so we can ensure our statutory responsibilities are carried out to the highest standard possible and within the frameworks of the Care Act and the Mental Health Act. This collaborative way of working will continue in the forthcoming year.
**Stroke Early Supported Discharge**

- In Bedford an established joint health and social care pathway provides support to people who need both health and social care intervention to be discharged from hospital sooner and to receive the care and support they need in their own home environment.
- Since implementation the service has been operating at capacity. As a result, the community provision has been expanded. This has been positive and has meant that more people have been discharged sooner from hospital.
- The results of the revised pathway continue to demonstrate that patients (our local residents) are achieving their goals quicker and more people are receiving the care they need in a timely way. 71% of people using the service said their confidence had increased.

On 13th March 2019, A Life After Stroke open day was held, where the public and other professionals attended to see how the service helps to improve the daily lives of stroke survivors, by providing a programme of activity after stroke.

The Social Care aspect of this pathway is delivered by fully qualified ARNI (Action for Rehabilitation from Neurological Injury) trained staff.

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**British Red Cross Home Support and Reablement Service**

**In the last year**

- Funding was increased due to demand on service and impact of delivery
- This is an excellent service providing support to people who are discharged and leaving hospital. The service settles people back into their own home and increases confidence and independence. The service includes home from hospital supports, home support and reablement services.
- The service in place prevents readmission and supports timely discharge from hospital
- In first 3 quarters of 2017/18, the service supported 242 people. 94% reported improved ability to manage day to day activities
Stroke Recovery Service

This scheme supports reducing hospital admissions, through delivering Information, Advice and Support & Prevention to people who have suffered a stroke. Six month reviews are also carried out to identify areas of unmet need, in order that these can be addressed, further reducing the incidence of stroke.

During Q1, 2 and 3, 83 unmet needs were identified and acted upon to reduce the risk of stroke.

During Q1, 2, and 3, 374 outcomes were met by people using the service reducing the risk of further stroke whilst enabling people to better cope with and understand the effects of their stroke.

The team maintain a close working relationship with the Bedford Hospital Stroke ward.

The Recovery Service run activities to support social engagement and peer support. An art group is held at the Higgins in Bedford called ‘Brushstrokes’. These sessions provide Stroke survivors with a chance to use a range of materials and create individual and group pieces of art. Sessions are run in partnership with the NHS Speech and language therapy team. Tai Chi and Short Mat Bowling are also available with a range of other activities to aid recovery.
**Better Care Fund (BCF)**

We are very proud to report that each year sees improvements towards integration with health and social care services. 2018/19 has continued to build upon the strong foundations developed in previous years.

The driving force to improvements has been a result of the appetite for collaborative working supported at all levels of Bedford Borough Council and Bedfordshire Clinical Commissioning Group. This includes more formal stakeholder Boards including the BCF Partnership Board, the Bedford Borough Health and Care Transformation Group and the A & E Delivery Board.

**Our plan for 2017/18 has been delivered and some of its successes include the following:**

**Implementation of our Local Vision for Health and Social Care**

The heart of our local ambition for greater collaboration in Bedford Borough is our jointly agreed Integrated, Out of Hospital Strategy.

The strategy puts patients and people who use services at the centre of the health and social care system and in control of their care. Central to the strategy is our Primary Care Home Model - the key delivery mechanism for place based health and social care in Bedford Borough.

Key deliverables towards this have included:

- GP alignment to cluster working across Bedford
- Alignment of Community Health Staff provided by East London Foundation NHS Trust (ELFT) to clusters
- Since July 2018, Multi-Disciplinary Teams (MDTs) have been set up and are operating consistently throughout Bedford Borough providing a focus on frailty, dementia, multi health needs and people who are high users of health and social care services.
- MDT’s consist of Community Matrons, Specialist Nursing, General Practitioners, and Social Care Professionals.

2019/20 will continue to see progress towards Primary Care Networks as this vision continues to unfold supporting people to remain at home and managing their conditions to remain as independent as possible.
Improving Falls

A successful project to train ‘Falls champions’ in Care Homes has been in operation throughout 2018/19. Falls Champions are established in all Care Homes across Bedford Borough. Throughout 2018/19 Falls champions were invited to quarterly meetings for education, peer learning and support on falls prevention specific topics including Dementia, Medication, getting up safely following a fall. These were very well attended. There has been a positive impact on the number of falls and individual residential and nursing homes have reported reductions in falls.

In addition to this, the Better Care Fund funds the Fracture Liaison Service at Bedford Hospital Trust. The Fracture Liaison Service identifies patients over 50 years of age that have had a fragility fracture and aims to prevent further fractures by the assessment and treatment of osteoporosis.

Many patients who have a fragility fracture will go on to have subsequent fractures and will not have had their falls and osteoporosis risk factors assessed or managed. The role of the FLS is to intervene after the first fracture and prevent further fractures which can be life changing for the individual and costly to the health and social care system. This service delivers positive outcomes.

Discharge To Assess Model

Discharge to assess is another key component of the out of hospital strategy. Together we have developed the integrated discharge to assess pathway in line with our joint Out of Hospital Strategy. The model below shows the pathway that has gone live in Bedford. The principle behind our discharge to assess pathway is that once a patient is medically fit, they should not remain in hospital simply because they are waiting for assessments to take place or additional care and support to be arranged. The pathway identifies four specific pathways for discharge.

Enhanced Care Homes

Enhanced Care to Care Homes is another key component to the out of hospital strategy. It is also a big focus of the A & E Delivery Board who has mandated an operational group to deliver the high impact change model of which enhanced care to care homes is one.

Elements of enhanced care to care homes that have progressed during 2018/19 include:
- Increased health care resource capacity to support care homes seven days a week
- Development and implementation of assistive telecare and telemedicine in care homes. All care homes across Bedford have been financially supported to ensure they have digital support. This includes
up to date Wi-Fi and secure emails. In addition, the Whzan project provides remote clinical monitoring in care homes. This enables care home staff to record the vital monitoring of residents on a regular basis to establish what is a ‘normal’ reading for them and to recognise when they are unwell and in need to clinical support.

- Supporting care homes through the development and implementation of a robust training programme. Throughout 2018/19, targeted training programmes have been established to deliver consistent training to care homes across Bedford. These include hydration and hydration champions in homes, My Home Life Training to care home managers, Advanced dementia and validation therapy, train the trainer, coaching and mentoring for managers, advanced continence management, practising compassion training and diabetic training. This training will continue throughout 2019/20 and will be added to, for example, an end of life programme including champions training is being developed.

- Development and implementation of the red bag scheme across Bedford. The innovative red bag scheme is helping to provide a better care experience for care home residents by improving communication between care homes and hospitals. The red bag is the most visible part of successful collaboration between care homes, hospitals and ambulance staff, known as the hospital transfer pathway.

- During 2018/19, Bedford piloted an initiative which provided care homes with direct access to the GP Out of Hours service. This has now been rolled out and is in place as business as usual.
**Community Health Services**

After an extensive procurement programme last year, a new five-year Community Health Service outcomes based contract went live from 1st April 2018. It is delivered by East London Foundation NHS Trust (ELFT) in partnership with Cambridgeshire Community Services NHS Trust (CCS). The contract is joint between Bedford Borough Council’s Adult Social Care Services, Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group.

A range of adult and children’s community health and care services and also other specialist services are covered by the provision including nutrition and dietetics, podiatry services, wheelchair services, community dental services, as well as drug and alcohol services for children and young people.

The first year of the contract has seen significant progress. This includes the implementation of a new Single Point of Access (SPoA) providing both the public and professionals a SPoA for adult community services referrals. The SPOA has a vision to facilitate adults in need of care and support and carers to receiving faster access to the services they needed at home or closer to home and to reducing the need to go into hospital or stay in hospital longer than needed. It operates 24/7/365 days a year and through clinical triage assesses all referrals and directs these to the appropriate service for response/deployment of services.

Significant progress has been made during the first year of this contract towards the Primary Care Home model. The Primary Care Home model is a model that Bedford Borough Council and Bedfordshire CCG committed to delivering over the next couple of years. It relies on health and social care services working together in a coordinated way to enable individuals to achieve the outcomes that are important to them.

During 2018/19, a transformation group was set up consisting of ELFT, BBC, CBC and CCG representation. This group oversees a robust transformation programme to bring about improvements to community health services. During 2018/19, some of these improvements include:

- Implementing a community cancer service
- Continue to develop the Primary Care Home model
- Further development of the Rapid Response Service
- Additional Specialist Nursing in the community for neurological conditions
End of Life Care

Through our Better Care Fund Programme, jointly commissioned by Bedford Borough Council and the Bedfordshire Clinical Commissioning Group, palliative care is provided by Sue Ryder Care. This is a 24 hour, 365 days per year service with a single point of access for people with end of life illnesses, their families, carers and professionals. This includes 24 hour phone access to a specialist nurse.

2018/19 has seen the roll out of a new initiative, developed in partnership with stakeholders across health and social care to improve services to patients and their families at end of life. The new fast track service increases the quality of care to patients and their families in their homes. This initiative is delivered by Sue Ryder in partnership with East London Foundation NHS Trust (ELFT) and is integrated within our Bedford Borough system, delivering specialist end of life services.

The Better Care Fund has also benefitted a lot of work to support the continued take up of Advanced Planning. An Advanced Care Plan is for people before or on the end of their life journey setting out their wishes, how they want to be cared for, where they want to be cared for etc. This is a patient held document and experience shows that if a person’s plan is written down it is more likely to happen in the way the person has wanted. Plans are being developed to consider the advanced care plans being put on a person’s social care record so that key information is consistently accessible in a health and social care setting as part of a person’s care record.

To support consistent improvements to end of life across the system, a joint End of Life Strategy is also being developed during 2019/20. The local strategy aligns to the National Strategy for End Life and focuses on improvements as identified through a multi-agency wide audit undertaken by our Adults Safeguarding Board. These include the two areas: improved communications and improved workforce skills.
Joint rehab and enablement including step down beds

The last year has seen a strengthening of the joint working between teams within the Local Authority and our local Community Health services particularly in relation to the provision of rehabilitation and reablement services following hospital discharge. The teams continue to use joint paperwork ensuring that support is provided by the most appropriate service in a timely manner. This has eliminated the duplication of services and has increased the capacity within the services. The joint work has also contributed to the reduction in delayed transfers of care, supporting timely discharge from hospital. There are plans to extend the joint working arrangements to cover the new ‘At Home First’ service currently being implemented by East London Foundation NHS Trust within the Community Health Services.

Collaborative Working - New schemes and ongoing developments in 2018/19 through the Better Care Fund

Implementation of new schemes, including feature on Carers UK Digital Resource.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Description</th>
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<tbody>
<tr>
<td>Hospital based Independent Domestic Violence Advisor (IDVA)</td>
<td>Service supports a reduction in hospital admissions through:</td>
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<tr>
<td></td>
<td>• High number of first time referrals/victims being identified and supported</td>
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<td></td>
<td>• The increased awareness of domestic abuse across the hospital due to proactive and continued communication and engagement, training and visibility</td>
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<td></td>
<td>• Research suggests a high proportion of victims attend A&amp;E 15 times each</td>
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<tr>
<td>Additional Therapy input into Winter Beds</td>
<td>Better Care Fund (BCF) has funded therapeutic interventions in additional beds purchased in the community to alleviate winter pressures.</td>
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</table>
The carers digital platform supports and empowers carers with the information, signposting and skills they need to continue to care for their loved ones at home, which reduces reliance on health and social care services. Since in place, it’s seen a number of carers registering with the site and accessing the carers platforms.

The service started in November 2017. It is extremely valued by carers.

This additional resource to the dementia programme has impacted by increasing resources to do more around helping people with dementia live well in the community, reduce carer breakdown as well as to reduce Hospital A&E attendances. The role is pivotal in maintaining contact with carers and people living with dementia.

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<td>Additional resources to support dementia peer support groups, activity groups and memory programme.</td>
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SECTION ELEVEN
Achievements
We are proud of Safeguarding Adults

Background
The safeguarding team was established many years ago, however, following the introduction of the Care Act 2014 and the revised legal guidance on Deprivation of Liberty Safeguards (DoLS), the team has expanded and adapted to meet the new challenges.

The focus
The safeguarding team is the first point of contact for any safeguarding concerns involving any individual with care and support needs. The team have engaged in working with individuals and partners on initiatives relating to protecting vulnerable people who are at risk of adult exploitation such as domestic abuse, County Lines (Drug related violence and exploitation) and modern slavery.

The teams work and expertise with Deprivation of Liberty Safeguards, include continuous auditing regarding the quality of assessments and supervisions in place to Best Interest Assessor’s as well as reflective practice to assure focus on both the Mental Capacity Act 2005 and DoLS to safeguard individuals in the least restrictive way.
The difference
When a safeguarding concern is received by the Safeguarding Team, initial enquires are made to decide what action is required and whether a Section 42 Safeguarding Enquiry should be implemented under the Multi Agency Safeguarding of Vulnerable Adults policy. Under the direction of Advanced Practitioners, the team complete initial safeguarding enquires by gathering further information from the referrer and other relevant sources to assess levels of risk and identify what safeguarding measures have been put in place. Once information has been assessed, a decision will be made at this point as to whether a S42 Enquiry is proportionate or required. Often by gathering additional information and making safeguarding initial enquiries at the point of the team receiving a safeguarding concern, the team are able to establish what the concerns are and to manage the concerns through other more appropriate routes than a S42 Enquiry. Enquiries lead to a wide range of outcomes resulting in the person being safeguarded such as care management involvement, reviews of care packages, risk assessments and actions for providers being put in place.

In 2018/19 we saw an increase in the number of domestic abuse cases reported to the team. This is likely to be a result of a much greater awareness of domestic abuse due to awareness raising campaigns among both the public and professionals.
Unlike many other areas, Bedford Borough have managed to meet its obligations under DoLS, without creating a backlog of cases. There are a number of reasons as to why we have been able to continue to manage these demands including:

- **Continued support from Council Leaders and Senior Officers with regards to securing the Human Rights of people who lack capacity to consent to their care and support in care home and hospital settings.** DoLS remains a priority agenda item and updates are provided via a number of forums, for example, the Safeguarding Adults Board with focus on local, regional and national practice.

- **A supportive and committed pool of Approved Doctors (specially trained, referred to as Section 12 Doctors) and Best Interests Assessors (Specially Trained Professionals).**

- **Regular professional practice supervision providing an opportunity to share knowledge and reflect on best practice.**

- **An efficient and robust DoLS process.** There is a dedicated team that focuses on all DoLS related activity. A signatory DoLS rota is in place which ensures that assessments are scrutinised and authorisations are granted/not granted in a timely manner.

- **Partnership working with Care Homes and Hospitals (known as Managing Authorities).** The team has developed good networks with all local providers required to submit authorisation requests and support is available to manage and respond to queries.

- **Collaborative working with neighbouring Supervisory Bodies, the Eastern Region and our advocacy service (POhWER)**

The DoLS Team have taken on a significant role in training and provide a rolling programme of basic Mental Capacity Training, DoLS training and are able to provide bespoke training to teams, providers and partner agencies.
Our Social work Academy Launched and Health Check Carried out

In Bedford, like many other Local Authorities recruiting social workers had been challenging. We decided to try something new and in 2018 we developed and launched our Social Work Academy. Over the last year Adults’ Service has supported degree graduates in their first year of work. This has been a great success in its first year and has enabled five newly qualified social workers to join the council and to seek statutory learning experiences across a range of Adult Services.

On 19th March 2019 we joined several other health and social care organisations to celebrate World Social Work Day with the University of Bedfordshire. The theme of the day was “Human Relationships” and afforded us an excellent opportunity to highlight the positive work being undertaken in the Borough. The day gained coverage in both local and national press and enabled us to proudly demonstrate several areas of expertise.

We take pride in our workforce and are required to undertake a Health Check. The Annual Social Work Health check is an internal questionnaire which was sent to all social workers within adult’s services. The results reflect positive movement in a number of areas from the previous year, and the exercise was overall a very positive reflection of the workforce. With 100% of staff feeling positive about their work, and no one reporting that they had to take time off due to work based stress in the last 12 months. The report also gave us areas to focus on, and prepared us to support staff through the next period of transition, namely to a strength based model of practice.
SECTION TWELVE
Priorities for 2019/20
We have considered carefully the areas we would like to work on in the coming year and our priorities will be as follows:

**PRIORITY ONE**
To support even more residents to remain as independent as possible and to remain in their own homes, reducing where possible the need for 24 hour care in a residential care setting

**PRIORITY TWO**
Continue to develop our early help and strengths based approach- supporting more people through a personalised process to build individual strengths and capability

**PRIORITY THREE**
We will aim to increase the number of carers receiving an assessment or a review.

**PRIORITY FOUR**
We will work with our partners and provider services to promote and enhance the local adult social care sector workforce

**PRIORITY FIVE**
We want to continue to find better ways to engage residents, with our health partners, to have a focus on preventing ill health and supporting people to live healthy lives
Finding out more

If you would like further copies, a large-print copy or information about us and our services, please contact us at our address below.

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