Safeguarding Vulnerable Adults from Abuse in Bedfordshire

Annual Report of the Bedfordshire Safeguarding Vulnerable Adults Board

April 2008- March 2009

Introduction

This is the second annual report of the Adult Safeguarding Board for Bedfordshire covering the last twelve months of the County Council's operation and the period leading up to creation of two new unitary local authorities for Bedford Borough and Central Bedfordshire from 1st April 2009. These organisational changes and many personnel changes during the year have seen an unprecedented amount of change in the County and the Safeguarding Board has also been busy in preparing for and then responding to a full scale inspection of safeguarding in the county by the Commission for Social Care Inspection. The year concluded with the first meeting of the new joint Adult Safeguarding Board for Bedford Borough and Central Bedfordshire on 30th March 2009.

You, like us, know that safeguarding matters and that safeguarding is a vital part of a council's Adult Social Care responsibilities. We have a duty to protect people from harm and it is critical that we, you and our partner agencies get it right, and that means working together. Safeguarding is about more than just adult protection, it is about protecting the safety, independence and wellbeing of vulnerable people, and our approach to safeguarding has been and still is changing. At the heart of government policy, personalisation is transforming the way that we will deliver services to adults and these radical changes will bring safeguarding challenges to us all in the years to come - challenges which we simply must be prepared for.

In May of 2008 the Commission for Social Care Inspection judged safeguarding services in Bedfordshire to be adequate with uncertain prospects. This was in our view a generous judgement and as we take on responsibility for safeguarding in the new unitary councils we are in no doubt about the scale of the task in transforming services and especially the safeguarding arrangements in our areas from the current position to one of excellence or the importance of this task. We will pursue this goal relentlessly until it is achieved.

This report considers

- the key issues in safeguarding in Bedfordshire during 2008/09
- the findings of the safeguarding inspection
- the level and nature of safeguarding activity during the year and
- priorities for the partnership in the next twelve months and beyond

We are at the start of a new journey which we confidently expect to lead to greater independence, more choice and better support for the most vulnerable people in our communities. Above all our role is to ensure that this happens in an environment which protects people from abuse and maintains personal dignity and respect.

Frank Toner
Executive Director of Adult Services
Bedford Borough Council and
Chair of the Bedford and Central
Bedfordshire Safeguarding Board

Julie Ogley
Director of Social Care, Health & Housing
Central Bedfordshire Council

SAFEGUARDING IS OUR RESPONSIBILITY

Safeguarding is "all work which enables an adult who is or may be eligible for community care services to retain independence, well being and choice **and** to access their human right to live a life that is free from abuse and neglect"

Safeguarding Adults, A national framework of standards for good practice and outcomes in adult protection work ADSS 2005.

Abuse is mistreatment by any other person or persons that violates a person's human and civil rights. The abuse can vary from treating someone with disrespect in a way which significantly affects the person's quality of life, to causing actual physical suffering.

Abuse can happen anywhere – in a residential or nursing home, a hospital, in the workplace, at a day centre or educational establishment, in supported housing or in the street.

Abuse is a violation of an individual's human or civil rights by any other person or persons.

"No Secrets" Department of Health, March 2000

Abuse may happen to people with a learning, sensory or physical disability, older people, people with mental health problems, people with dementia or people who cannot always look after or protect themselves.

Abuse comes in many forms – physical, sexual, psychological, financial, neglect or discriminatory abuse. Institutional Abuse can happen when people are mistreated because of poor or inadequate care, neglect and poor practice that affects a whole service. Any of these forms of abuse can be either deliberate or be the result of ignorance, or lack of training, knowledge or understanding.

The person who is responsible for the abuse is very often well known to the person abused and could be a paid carer or volunteer, a health worker, social care or other worker, a relative, friend or neighbour, another resident or service user or an occasional visitor or someone who is providing a service. It could be anyone.

ABUSE IS EVERYONE'S BUSINESS

1. The Safeguarding Board's work in Bedfordshire in 2008/09

1.1 The Bedfordshire Safeguarding Adults Board was established in September 2005 to review and determine inter agency policy in the county, monitor the level and effectiveness of reported incidents and service provision and facilitate the joint agency programme. Membership of the Board was initially those agencies most concerned with the investigation of alleged incidents of abuse but membership has been widened as the importance of safeguarding has been recognised by an increasing number of partner organisations.

1.2 In its inspection report, the Commission for Social Care Inspection observed:

> *"Leadership of safeguarding across the county had recently been strengthened however the safeguarding board had not provided the strategic leadership that was needed to ensure a whole system approach to the development and improvement of safeguarding activity."*

Prior to the inspection there had been several changes of chairmanship and the Board was operating at an operational level rather than taking the required strategic approach to safeguarding. During 2008/09 the Safeguarding Board was strengthened but further work is required to embed safeguarding at a strategic level, to increase the knowledge base and awareness of safeguarding in the Boards and Executives of all partners and to ensure that this expertise cascades through their organisations.

1.3 New Multi agency policy and procedures were introduced in April 2008 following an audit in February 2008, consultation and review. The inspectors found that

> *"New safeguarding procedures had just been introduced which were beginning to provide better support to staff within the council and staff from other agencies"*

As a result of these new procedures and the associated training and awareness campaign, safeguarding alerts continued to rise in 2008/09.

1.4 The County Council developed the Local Involvement Network (LINk) to strengthen working arrangements between service users, carers, quality assurance and commissioning processes. The Bedfordshire LINk undertook a service user and carer consultation regarding the experiences of people who were involved in the SOVA process during 2007/08 and this informed the safeguarding action plan.

- Userviews (an advocacy organisation) conducted face to face interviews and discussion groups involving 52 people representing all of the client groups.
- The interviews revealed that on the whole, most people had felt 'believed' and not 'judged' by investigating staff when they had reported a case of abuse.
- The single biggest issue raised by interviewees was a desire for more feedback during the process and at the outcome of the investigation into their abuse.
- As a result the Council implemented a new consultation and consent process at the beginning of all investigations and the final case conference at the end of all investigations to ensure that everyone was made aware of the outcomes and lessons learnt from investigations.

1.5 The Council undertook a widespread pre-inspection and post inspection publicity campaign to raise public awareness of abuse through the use of newspaper articles, bill board posters, revised leaflets and posters, a refreshed website and public forums. The safeguarding leaflet was given, as part of an information pack, to each service user at their review.

1.6 The County Council provided a number of briefings, level 1 (safeguarding awareness) sessions and level 2 (specific alerting) guidance to a variety of groups, independent and voluntary organisations, teams, public and individuals and have engaged with large numbers of people during the last year. However they represent a very small percentage of the population in the County and much more work is required to make all people in the county aware of abuse.

1.7 Two conferences were organised during the year:

The first, in July 2008, looked at action against elder abuse, improving physical health, management of falls, the Mental Capacity Act and Deprivation of Liberty Safeguards and multi agency training. Safeguarding alerts increased by 76% in the month following the conference and requests for safeguarding training for staff increased by 46% over the following quarter. This increased awareness of abuse and where to report it raised the numbers of alerts in the last two quarters of the year by 80% on the first two quarters of the year.

As a result of this work, a number of partner agencies from health, housing, private and voluntary agencies have appointed/nominated safeguarding leads, which has improved communications, understanding of roles and responsibilities and enabled developments in interagency work.

The second conference was hosted by Aragon Housing and Supporting People services with a safeguarding theme and prevention of falls, which was presented by NHS Bedfordshire's falls co-ordinators.

1.8 The safeguarding team worked with eleven separate provider organisations where significant issues had been indentified and the Serious Concerns Protocol implemented. In each case a multi agency approach was deployed involving the Contract Compliance Team, Quality Assurance Team, Commission for Social Care Inspection or Health Care Commission, Police and NHS Bedfordshire. As a result of this work over 600 vulnerable people were safeguarded in addition to those where abuse alerts had been raised. This work will have improved the quality of care in each of these services as well as preventing abuse and in most cases this has resulted in an improved quality rating.

One of these establishments has been the subject of support from the Safeguarding Team and the Healthcare Commission (now part of the Care Quality Commission – CQC) over a sustained period. In this establishment we have supported the provider to address significant numbers of incidents between service users, build their infrastructure and policies and procedures to focus on prevention and post-incident management, improve quality assurance arrangements, develop person centred planning and shift the balance from medicalised interventions to a social model of support. The impact of this intervention has been to reduce the number of incidents from over 50 a month before the intervention began to an occasional level.

2. Independence Wellbeing and Choice Inspection - May 2008

2.1 In May 2008, The County Council was subject to a regulatory inspection by the Commission for Social Care and Inspection (CSCI) looking at how well the council was safeguarding adults whose circumstances made them vulnerable. Preparation for the inspection and responding to its findings was the major focus of safeguarding activity during the period.

2.2 The Inspector concluded that in Bedfordshire safeguarding of adults was adequate and capacity to improve was uncertain. The report of the inspection made 11 recommendations and the Safeguarding Board has started to implement an improvement plan. However, considerable further work remains for the new Safeguarding Board to address.

RECOMMENDATIONS

Outcome theme	Recommendation
Safeguarding adults	The council should: • Work with Bedfordshire and Luton Health and Social Care Partnership Trust to ensure that governance arrangements deliver safe, high quality services. • Ensure that safeguarding procedures are consistently applied in a timely way to safeguard people who use services and carers. • Ensure that plans to identify safeguarding champions in all teams are implemented and that their role is aligned to a set of competencies in support of their role. • Ensure that independent and voluntary sector providers are fully aware of the new safeguarding protocol and that all stakeholders have access to a range of safeguarding learning and development opportunities. • Continue to work with all groups of people who use services, their carers and the wider public to continue to raise awareness of how to report incidents of abuse and to increase awareness about the range of support available. This should include people from black and minority ethnic communities.

Leadership and Commissioning	The council should: • Work with partners to ensure that the Bedfordshire Adult Safeguarding Board promotes the safeguarding of people in vulnerable situations by providing strong strategic leadership across all health and social care agencies. • Ensure that a sufficiently detailed work programme is in place for the safeguarding board that clearly informs the improvement work for the coming year. • Work with partners to promptly establish subgroups of the safeguarding board to ensure that the range of improvement activity is taken forward in a timely way. • Ensure that plans to enhance performance management and quality assurance systems are implemented and are effective in delivering improved outcomes for people who use services and their carers. • Work with partners to develop a joint strategic framework for the provision of preventative support. • Work with partners to develop a joint workforce strategy that would underpin the creation of the new unitary authorities, capture emerging priorities, models of self directed care and the potential for future integration.

2.3 In response to the inspection findings Bedfordshire Adult Safeguarding Board produced an action plan. The Director of Adult Services wrote to all chief officers and executives seeking their engagement with the safeguarding agenda and the safeguarding board. A new Business Plan was developed combining the Safeguarding Board's work plan with the inspection action plan.

2.4 The new joint safeguarding board has reviewed progress since the inspection and incorporated all outstanding actions to deliver the recommendations in its revised action plan. During 2009/10, it will ensure that all corrective actions are completed.

2.5 A separate safeguarding board for Luton Borough Council was established following the October 2008 meeting. Prior to this date Luton had a separate Board as well as the joint one.

3. User Views 2008/09

3.1 In June 2008, Bedfordshire County Council commissioned a survey of people who had been through the process of reporting abuse. The research included face to face interviews and discussion groups involving 60 people.

3.2 The interviews revealed that on the whole, most people had felt 'believed' and not judged by investigating staff when they reported abuse.

3.3 The biggest issue raised by interviewees was a lack of feedback during the whole process, many felt that they had not been fully involved or that they had very little control over the process.

> "*So we went along. There was us, a senior social worker and the manager, then there were the managers from the care agencies that he has input from, it was quite overkill actually, we thought*"

3.4 This was especially felt by parents of (adult) children with a learning disability. Some people commented that there appeared to be no choice about how their abuse could be dealt with and that a full investigation took place whether they wanted it to or not.

Suggestions about how things could be made better resulted in three main themes:	**The Council has responded to this feedback by**
The adoption of one single telephone number that could be used for confidential advice as well as reporting abuse	Setting up a single telephone number and email address with a dedicated team to listen and respond to people's concerns and to make sure that a social worker visits within 2 days.
Provide better feedback and involve parents and family members	Social workers will seek victims consent before progressing with an investigation or the family / carers consent if they are not able to consent. Victims and their families will be encouraged to take part in all safeguarding meetings and where this is not possible, they will be offered advocacy representation who will inform them when the meetings will be taking place and the outcomes of those meetings.
A leaflet that tells people what abuse is and has the telephone number clearly identified	New leaflets were distributed and explained to all services users at review.

4. The Developing Regulatory Context for Safeguarding

4.1 The law regulating the protection of vulnerable adults from abuse derives from a complex mismash of legislation, guidance and ad hoc court interventions and the government is still considering the case for specific adult protection legislation. Some key drivers influenced safeguarding developments nationally in 2008/09.

4.2 **The Safeguarding Vulnerable Groups Act 2006** which will be implemented in October 2009 introduces a vetting and barring scheme to replace the current Protection of Vulnerable Adults (POVA) list. An Independent Safeguarding Authority has been created to administer the scheme. Every person who wants to work or volunteer with vulnerable people will need to register with and be approved by the new authority before they can commence their duties. The scheme will work in conjunction with the criminal records bureau.

4.3 The **Commission for Social Care and Inspection (CSCI) national inspection** report, “Safeguarding Adults, A Study of The Effectiveness of Arrangements to Safeguard Adults from Abuse” was published in November 2008. The report said:

- Progress in developing effective safeguarding arrangements was uneven.
- The quality of support provided to people who experience abuse is variable.
- More needs to be done to safeguard people who use self directed support.
- More action is needed to prevent abuse and support people in the long term.
- The best Council’s are demonstrating active leadership on safeguarding but there is some distance between the best and the worst.
- There is a link between the care services overall quality rating and its ability to safeguard adults.

All of these observations have been used to inform the local safeguarding plan described in the last two pages of this report

4.4 **“No Secrets” Review**

A review of the 2000 National guidance began in February 2008. All bodies with health and social care responsibilities and those who accessed these services were asked for their views and opinions about what a revised framework should look like to improve the prevention of abuse. The Bedfordshire Safeguarding Board submitted a response as did our service users and the Bedfordshire and Luton Partnership Trust. The Department of Health announced that they would publish a response to their findings in April 2009.

4.5 **Deprivation Of Liberty Safeguards**

The Deprivation of Liberty Safeguards were introduced as an addition to the Mental Capacity Act 2005 as a response to the decision of the European court of human rights in the case known as the ‘Bournewood’ Judgement. The safeguards are intended to support vulnerable people who lack capacity to consent to care and treatment, which are essentially for their safety and best interests, but which may deprive them of their liberty. The County Council made preparations to implement this Act from 1st April 2009 including the recruitment and training of Best Interests Assessors. The procedures put safeguards in place to ensure that any deprivation is fully assessed as being in a person’s best interests and measures that are taken are the least restrictive and subject to timely review.

5. Safeguarding Activity in Bedfordshire in 2008/09

The new unitary authorities have identified the need to improve the timeliness and accuracy of recording safeguarding activity as a priority and the statistics which appear in this report have been produced after considerable end of year data cleansing. As a result of the safeguarding modules introduced in SWIFT this year, we are now able to produce more statistical data to monitor and assess the presenting trends and dynamics of those who abuse vulnerable people.

5.1 **Safeguarding Alerts**

In the twelve months from April 2008, a total of 1596 SOVA Alerts were received. This has more than doubled from the previous reporting year in which 610 alerts were made. 553 of the alerts in 2008/09 related to the Bedford Borough area and 1043 to Central Bedfordshire.

The increased number of Safeguarding Alerts is attributed to the:

- Publicity and awareness raising campaign
- Creation of the centralised point of access
- Strengthened advocacy support
- Strengthened partnership working arrangements
- Re-training for all paid and voluntary staff
- Revised business processes and standardised frameworks
- Strengthened quality assurance systems

Bedfordshire has reached a stage where greater awareness of safeguarding has been achieved but further work is required to distinguish between safeguarding issues and other matters for action such as regulatory and contract management issues. This will be a particular focus of training and publicity work in 2009/10 as it is our ambition to identify all incidents of abuse but without applying safeguarding measures where an alternative approach is more appropriate.

As of 1st April, the SWIFT outcomes report only gave outcomes for 53% of those alerts including 586 (35%) filtered out by the safeguarding team as being non-SOVA incidents. The new unitary councils regarded clearing up the remaining cases as a priority in order to provide meaningful strategic and management information for the Board and by 14th May outcomes were recorded for 1,499 of the alerts and the rest were all under active investigation and monitoring.

5.2 Analysis by **gender** - in 42% (463) of alerts referred for investigation, the vulnerable person was a male. 57% (635) were female (gender was not recorded in one case).

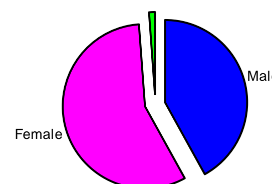


Figure 1Gender

5.3 The **incidence** of safeguarding referrals in Bedfordshire is higher than in comparable areas or in neighbouring authorities. Of 1596 alerts, 400 were substantiated, 397 were unsubstantiated, 752 proved to be non-safeguarding issues and the rest are continuing investigations. In view of the high incidence of safeguarding referrals in Bedfordshire relative to other authorities, consideration should be given to exploring the proposition that the number of cases referred to teams for investigation is too high and that this is obstructing the priority investigations. This is recommended as a key action for 2009/10.

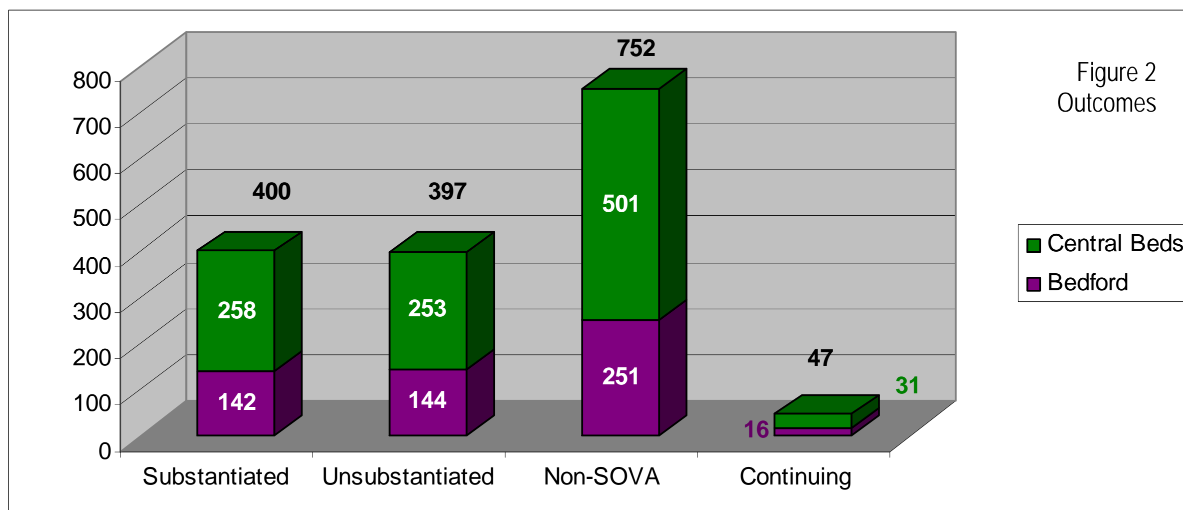


Figure 2 Outcomes

5.4 Analysis by **care group** - There was a significant increase in the number of alerts made for the 65+age group on the previous year's figures from 280 incidents (35%) to 543 (51%) in the Central Bedfordshire area. This is attributed to the awareness raising campaign, staff training and providers' conference. However, this was not replicated in Bedford Borough and further work is required in 2009/10 to ensure a consistent approach to safeguarding in all areas.

The number of referrals relating to physical disability services has increased, addressing last year's concerns about a lack of referrals of younger adults with a disability.

Figures for learning disability are much higher in comparison to other categories and this is attributed to over reporting of lower level concerns and include a large number of alerts in the Bedford Borough area relating to a single service.

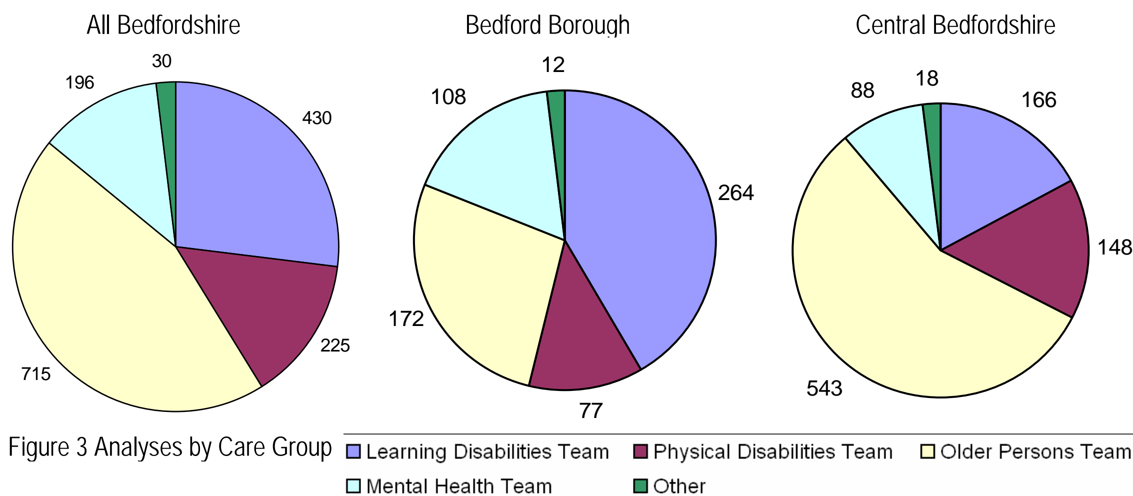
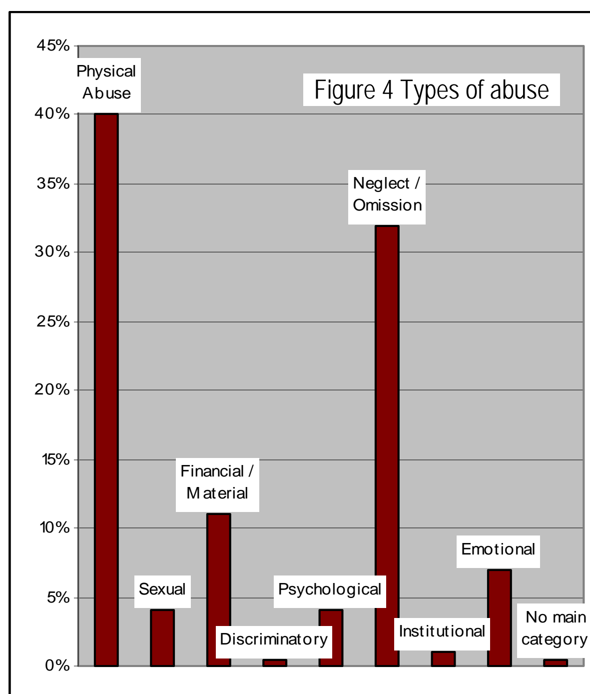


Figure 3 Analyses by Care Group

5.5 **Types of abuse** - As in most authorities, acts of physical abuse, neglect and financial or material abuse make up the majority of incidents.

The number of alerts referring physical abuse remains consistent and this category includes a wide range of incidents including missed medication, falls and physical assaults.



The increased numbers for neglect and acts of omission is attributed to the work with provider services in being able to understand and fulfil the wider implications of risk management.

A new Quality Assurance Feedback Process went live in September 08. Early indications are that this mechanism is identifying poor practices sooner and safeguarding people at risk of harm before it occurs.

An increasing number of people are being financially abused and this is consistent with CSCI's observations nationally. Increased awareness of financial abuse and support for service users is a priority for 2009/10 especially in the context of the drive to increase direct payments and individual budgets.

5.6 Analysis by **ethnicity**

The inspection observed that "*there was a low referral rate of people from black and minority ethnic communities in comparison to the percentage population.*"

Significant work has been undertaken to improve awareness, trust and accessibility with the various minority ethnic groups within the county. This included work with the Asian women's group, Asian elders group, and Afro-Caribbean group. The impact of this positive engagement has shown in the increase in the number of people from minority communities reporting and seeking support. However, the vast majority of referrals (923 reports, comprising 86% of all referrals) continue to be about the White British community and further work is required to reach each of the communities in Bedfordshire.

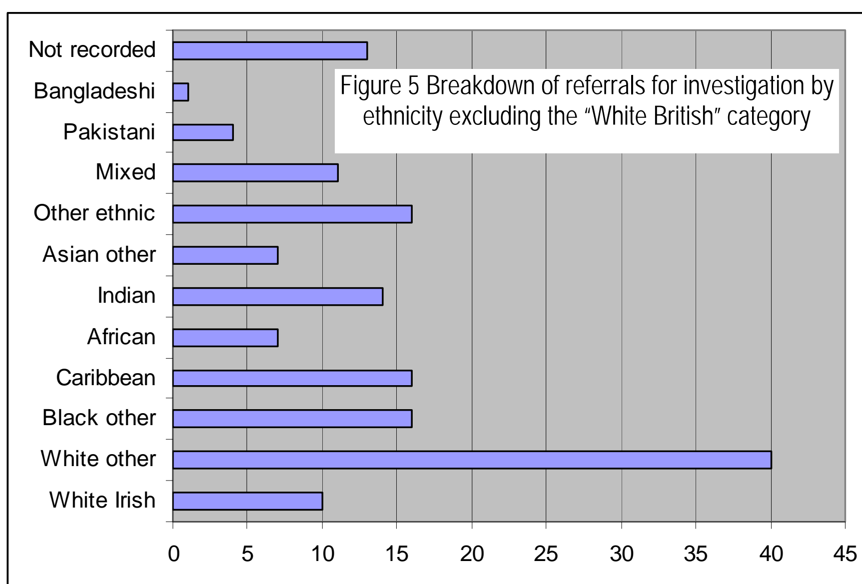


Figure 5 analyses contacts by recorded ethnic origin for all contacts excluding those recorded as White British. Whilst there has been an increase in the number of reports about incidents affecting people from minority communities significantly more work is required and this remains a priority for 2009/10.

5.7 **Location -** the awareness campaign helped raise the proportion of alerts about people living in their own homes to 37.5%. This is a significant increase on the previous year, but statistical comparison is not possible as this data was not recorded then.

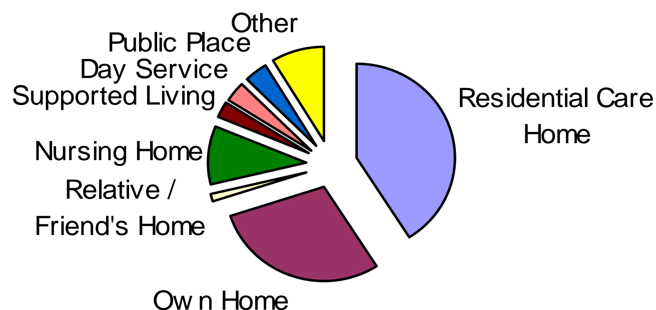


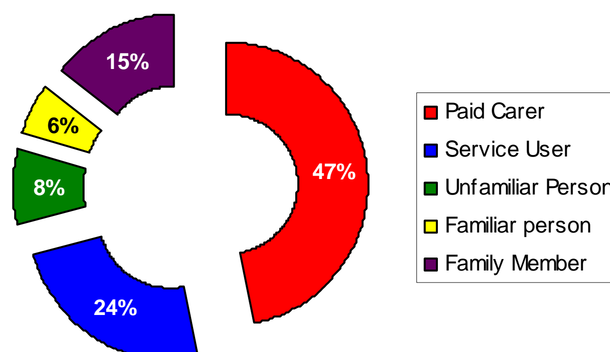
Figure 6 - Location of Abuse

The majority of abuses still occur in residential care services. It is a widely held view that people are safer in care homes than in their own homes, however national research and these figures would challenge this view. Many of the incidents involve allegations involving abuse of service users by other service users. People in group living situations often have little control over who they live with and are generally dependent on others for their essential daily needs so are at a much higher risk of experiencing poor practices and abuse.

Alerts from hospitals are recorded under "other", but changes to the IT system during 2008/09 make it possible to identify these cases separately in the future.

Reports from day services remain fewer than expected so further work is required to raise general awareness of abuse and reporting requirements there.

5.8 **Relationship** - The highest proportion of those reported as perpetrators are individuals who are paid to provide services to vulnerable people. Many of these relate to physical abuse or neglect, where staff have failed to follow plans and procedures correctly.



There is also a need to increase awareness and support mechanisms to people who live in their own homes and their carers, to understand the basic standards of care that they should expect and where they can seek support to address issues of their support that falls below the accepted standards.

5.9 **Police Investigations**

The Vulnerable Adult Investigation Unit have worked closely with social care teams and the Crown Prosecution Service to support vulnerable people through the judicial system and there has been an increase in criminal cases pending court hearings. The Public Protection Unit in Bedfordshire has 7 dedicated officers to support vulnerable people to gain equitable access to the criminal justice system. However, there are many barriers to overcome before any case may proceed to a court hearing. The existing concerns which are prevalent in proving vulnerable adult abuse cases are evident both nationally and locally. All of the police criminal investigations seek to identify key witnesses together with any supporting corroborative evidence. All of the aforementioned, taken as a whole needs to pass an evidential threshold test prior to any further progression into the judicial system. Once the threshold test has been applied and passed then the evidence needs to be presented to the courts in the best possible form. Every stage of the investigation presents its own challenges and in order to

secure a successful prosecution several organisations and agencies are required to work together with perfect synergy.

The number of successful prosecutions and pending cases within Bedfordshire although relatively low has demonstrated a steady increase.

Prosecutions pending	Bedford Borough	Central Bedfordshire
Physical Assault	3	7
Financial abuse	3	2
Sexual assaults	4	1
Neglect	0	1

Bedfordshire Police robustly pursue every opportunity to tackle abuse and will continue to prosecute where appropriate and to work with partner agencies to protect the most vulnerable in our community. 21 cases are currently pending.

6. Priorities for the Safeguarding Partnership in 2009/10

Our experiences and review of the last year have identified our new priorities.

6.1 The new Safeguarding Board for Bedford Borough and Central Bedfordshire has been established and is being chaired by the Executive Director of Adult Services for Bedford Borough Council with the Director of Social Care, Health and Housing for Central Bedfordshire Council as deputy chair. The intention is to maintain the arrangement of a joint Board throughout 2009/10 and during this period to establish senior level participation by all key stakeholders. At the end of the first year the Board will review whether the joint Board should continue or be replaced by separate Boards for both authorities. It is anticipated that chairmanship will eventually pass to an independent person, but not before it establishes itself at a sufficiently senior and strategic level. The board will manage the safeguarding plan and procedures to protect vulnerable people at a strategic level.

6.2 Membership of the new joint Safeguarding Board comprises:

Elected representatives of Bedford Borough and Central Bedfordshire Councils

Senior representatives of:

- Bedford Borough Council
- Central Bedfordshire Council
- NHS Bedfordshire
- Bedfordshire and Luton Partnership Mental Health NHS Trust
- Bedford Hospital Acute Trust
- Luton & Dunstable Acute Trust
- Bedfordshire Police
- Bedfordshire Probation Service
- Bedfordshire Community Health Services
- Service users (with support)
- Care Quality Commission
- Bedfordshire Victim Support
- Bedfordshire Advocacy Alliance
- Bedfordshire Advocacy Service for Older People
- Voluntary Sector
- The Home Owners Federation
- Bedfordshire Domiciliary Care Association
- LINks
- Domestic Abuse Team
- Supporting People
- Community Safety and
- Children's Safeguarding Board

6.3 Both new unitary authorities formed safeguarding teams the same size as previously available to Bedfordshire County Council, effectively doubling dedicated capacity for safeguarding.

6.4 The safeguarding action plan for 2009/10 details six priority areas

The safeguarding improvement plan April 2009 – March 2010

1) Strategic leadership

i) Develop a formal link with the Local Strategic Partnership (LSP) in both new authorities
ii) Ensure the Seniority of participation in the safeguarding board is sustained
iii) For each agency to identify their specific contributions to safeguarding
iv) For Safeguarding Board members to all approve and sign a Concordat
v) To achieve a consistent approach by all care groups
vi) To develop new safeguarding governance arrangements for mental health in accordance with new section 75 agreements and the outcome of the BLPT tender and to review the new Operational Protocol
vii) To review multi agency safeguarding procedures and ensure that they comply with best practice and CQC standards for excellence
viii) To achieve disaggregation of the safeguarding teams without disruption
ix) To ensure safeguarding is prominent in the review of commissioning plans
x) To implement the Deprivation of Liberty Safeguards
xi) To provide training and support for safeguarding champions and monitor their effectiveness
xii) To implement the vetting and barring arrangements
xiii) To achieve meaningful inclusion of service users and carers in the Safeguarding Board with appropriate support
xiv) To provide an annual safeguarding report to the councils' executives and scrutiny committees and the Boards of major partners
xv) To review protocols between the Adult Safeguarding Board and the Children's Safeguarding Board, and the Community Safety and Domestic Violence partnerships

2) Training and competence

i) To operate an effective training sub group which delivers the development commitments for safeguarding:
ii) To review all safeguarding training provision to ensure the quality, content, availability and uptake for all appropriate staff, users and carers.
iii) To ensure that compliance against standards is monitored through routine audits of adult protection records
iv) To increase the proportion of staff in provider services with safeguarding training and achieve targets promised in the two councils' Self Assessment
v) To review the competence framework to ensure training is being effective
vi) To increase the safeguarding knowledge base of elected members in both new councils
vii) To develop safeguarding awareness and expertise in unregulated services, especially day services
viii) To continue awareness raising in the voluntary sector
ix) To develop awareness of safeguarding matters among informal carers
x) To hold a training programme for the new joint safeguarding board
xi) To commission new Mental Capacity Act training for all stakeholders

3) Learning Lessons from abuse

i) To carry out an audit of the management of incidents of alleged abuse
ii) To disseminate learning strategically through the Safeguarding Board and operationally
iii) To revise and formally adopt the Serious Concerns Procedure
iv) To revise and formally adopt the Serious Case Review Policy

4) Prevention

- i) To carry out a review of thresholds and the scope of safeguarding activity
- ii) To review quality assurance arrangements
- iii) To analyse trends and use this analysis to inform the work of the Board
- iv) To review the effectiveness of the People In Partnership (PIP) anti-bullying programme in LD services and the potential for extending it to other groups
- v) To ensure that a strong safeguarding theme runs through the development programme for self directed support
- vi) To develop improved support frameworks for people who have suffered abuse and their carers
- vii) To agree a joint protocol with the police regarding incidents of discrimination and harassment in neighbourhoods affecting Adult Social Care users and carers

5) Communication

- i) To update and re-brand safeguarding literature and public information to reflect best practice
- ii) To carry out an audit of the impact of safeguarding awareness
- iii) To carry out a further public awareness campaign with targeted input to Black and Minority Ethnic communities
- iv) To raise awareness of safeguarding among GPs and in Community Health Services
- v) To run an awareness programme for the Deprivation of Liberty Safeguards

6) Performance management

- i) To implement the new National Minimum data set for safeguarding
- ii) To implement the new SWIFT adult protection modules
- iii) Monitoring of compliance – to improve the timeliness and accuracy of recording safeguarding activity
- iv) To develop new management reports at operational and strategic levels to monitor responses to safeguarding alerts and lessons from investigations
- v) To audit "Best Interest" decisions under the Mental Capacity Act
- vi) To develop arrangements for the reporting of safeguarding compliance in contracted services

We can all stop abuse.

We can make a difference by taking notice of what is going on in our workplace, in our home or neighbourhood.
If you are being abused or you suspect that someone you know, may be the victim of abuse you should call Adult Services as soon as possible between 9am and 5pm. Out of these hours and at weekends or bank holidays please call the Emergency Duty Team on 0300 300 8123.
Your concern will be taken seriously and you will receive prompt attention.
If the abuse is also a crime such as assault, racial harassment, rape or theft, you should involve the police to prevent someone else from being abused. If the police are involved, Adult Social Services will work with them and you to support you.

Contact details:

Telephone 01582 818085
Fax 01582 818031
Email adult.protection@bedford.gov.uk
adult.protection@centralbedfordshire.gov.uk