Central Bedfordshire and Bedford Borough
SAFEGUARDING ADULTS BOARD

Safeguarding Adults Board
Bedford Borough and Central Bedfordshire
Annual Report 2023-24

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Foreword By Safeguarding Board Independent Chair – Maud O'Leary

As Independent Chair Safeguarding for Bedford Borough and Central Bedfordshire Safeguarding Adult's Board (SAB) it is my pleasure to present the Board's Annual Report for 2023/24. This is the first report I have introduced since I took up my role in May 2023.

I would like to take this opportunity to thank all partner agencies and Board members who extended me a warm welcome and supported me in my first year.

The format of this year's report has changed slightly from last year making it, we hope, more succinct for ease of reading.

During my first year I have met with Board members on an individual basis, and I have been struck by the strength of commitment and dedication consistently expressed across the system for safeguarding vulnerable adults. However, financial challenges were a constant theme in my partner meetings and the concern about growing demand, increasing complexity of need and ongoing saving targets was ever evident in our discussions. As agencies continue to address these pressures, it is my view that the role of the Board and safeguarding functions will be increasingly more crucial.

I would like to make mention here of some of the achievements of the last year. In October, following the actions and learning from the Max Safeguarding Adults Review (SAR), a development day took place. The high level of attendance and engagement from all system partners combined with honest reflections demonstrated I believe a true commitment to change and continuous learning.

Central Bedfordshire and Bedford Borough both had independent audits undertaken and have been able to use the audit outcomes to give assurance to the SAB.

An online platform has been developed for all safeguarding policies, procedures and locally developed resources for practitioners with access to all applicable statute, guidance and case law, offering access to all agencies and people experiencing safeguarding.

Among other training offers, the Bedfordshire Hospitals NHS Foundation Trust, Central Bedfordshire Council and others have delivered the Oliver Mc Gowan training for Learning Disability and Autism and the NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) has hosted two summits on Preparing for Adulthood. East London Foundation Trust (ELFT) has delivered a range of training including 'Think Family'.

Bedfordshire Police completed a successful operation which resulted in six people being arrested on human trafficking and sexual exploitation charges. Further details are available in the report.

The SAB has set an ambitious programme for the year agreeing five priorities instead of the previous three. An "in person" SAB priorities meeting established that there was much the Board aspired to achieve and so we brace ourselves for another busy year ahead!

To conclude I wish to thank all agencies for their hard work and commitment to our safeguarding agenda over the past year and the Business Unit who support our activities, delivery programme and events.

Maud O'Leary

Maud O'Leary
Independent Chair

About The CBC & BBC Safeguarding Adults Board (SAB)

The Care Act 2014 makes Safeguarding Adults Board a statutory requirement. This SAB has joint arrangements covering the two local authority areas of Central Bedfordshire Council and Bedford Borough Council. These shared arrangements were established prior to safeguarding boards being a statutory requirement and ensure consistency of safeguarding arrangements across the areas, benefitting partner agencies, practitioners and local communities. Learning and best practices as well as policies and procedures and Board resources are all shared thereby minimising burdens both in terms of cost as well as professionals time.

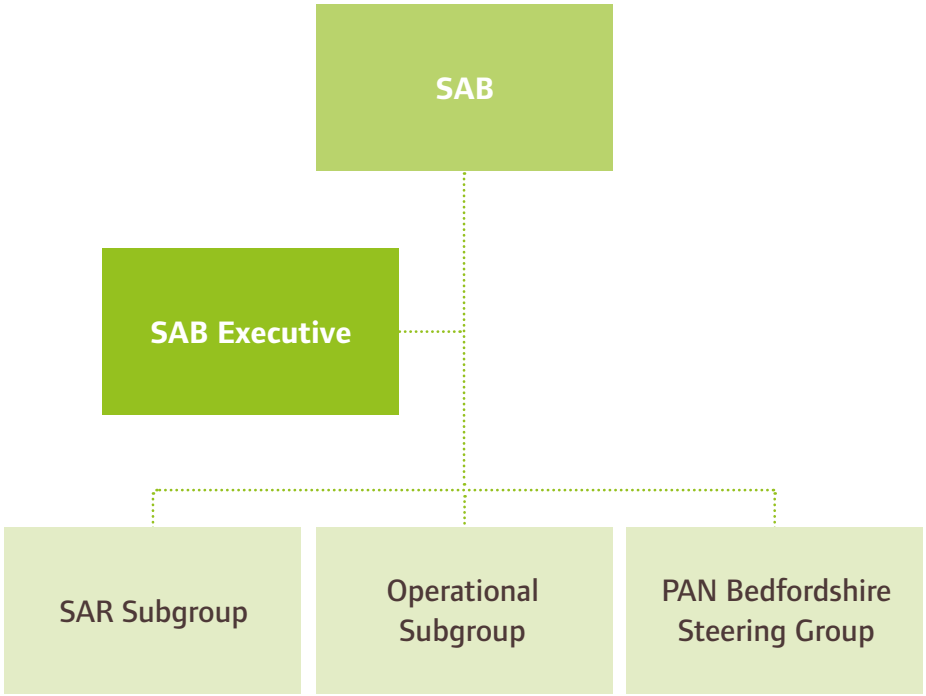
The Safeguarding Adults Board's statutory core duties under the Care Act 2014 are to:

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

The SAB meets these statutory objectives by:

SAB Structure and Governance

This Safeguarding Adults Board covers two local authorities' areas with Central Bedfordshire Council and Bedford Borough Council agreeing shared arrangements. This has allowed for robust and effective sharing of safeguarding information and learning across boundaries also aiming at ensuring consistency and quality. The SAB is chaired by an Independent Chair to ensure effective leadership and independent scrutiny.



SAB Executive. This is chaired by the Independent Chair. Membership consists of statutory partners from both local authorities, health and police. The SAB Executive provides for top level leadership, ensures adequate resourcing and statutory oversight of safeguarding activities and priorities. The SAB Executive meets at minimum four times annually.

Safeguarding Adults Board. The SAB is chaired by the Independent Chair and is inclusive of statutory partners and local organisations with key safeguarding responsibilities as follows:

- Bedford Borough Council (Adults and Children Services, Housing, Public Health and Domestic Abuse)
- Central Bedfordshire Council (Adults and Children Services, Housing, Public Health and Domestic Abuse)
- Council Members – Adult Social Care portfolio holders in both councils
- Bedfordshire Police
- Bedfordshire, Luton and Milton Keynes Integrated Care Board
- Bedfordshire Fire and Rescue
- Care Quality Commission
- East of England Ambulance Service
- East London Foundation Trust (Mental Health, Community Nursing, Path to Recovery)
- Bedfordshire Hospitals Foundation NHS Trust
- Private & Voluntary Care Providers Association, Bedfordshire Care Group
- Healthwatch Bedford Borough
- Healthwatch Central Bedfordshire
- Voiceability (Advocacy)
- Bedfordshire Domestic Abuse Partnership (BDAP)
- Safeguarding Children's Boards
- HMP Bedford Prison
- Probation Services
- Department of Work and Pensions

The SAB meets at minimum four times annually with additional meetings when needed. For 2024-25 the SAB will be identifying rough sleeping and homelessness leads in response to the Ministerial direction to seek assurance that safeguarding arrangements are robust and effective.

Safeguarding Adults Review (SAR) Subgroup. This Subgroup's focus is on receiving alerts and referrals under Section 44 of The Care Act. The Subgroup is chaired by the statutory partners (taking it in turn) and the Subgroup meets every six weeks. The SAR Subgroup further oversees the progression and completion of SAR's as well as overseeing the implementation of actions resulting from SAR's.

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

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

Local and National Collaboration

The SAB Independent Chair and local delegates take a full part in national safeguarding meetings hosted by ADASS. The Independent Chair also attends the SAB Chairs Network now hosted by the Independent Safeguarding Board Chair's Network. This ensures that any national issues are considered locally and learnings from local safeguarding cases can be shared whilst avoiding duplication.

Alongside this the SAB Chair attends CBC's Safeguarding Chairs Network that includes the Chairs of the Safeguarding Adults Board (SAB), Safeguarding Children's Board (SCB), Bedfordshire Domestic Abuse Partnership (BDAP), Community Safety and Health and Well-Being Board Chairs and the Network coordinates shared priorities to avoid duplication and with a focus on improving practice taking a 'think family' view.

Locally there are at minimum bi-annual meetings between the various partnership Board Chairs/Scrutineers to coordinate and agree shared priorities.

The Six Principles of Safeguarding

1. Empowerment

People being supported and encouraged to make their own decisions and informed consent.

I am asked what I want as the outcomes from the safeguarding process, and these directly inform what happens.

2. Prevention

It is better to act before harm occurs.

I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.

3. Proportionality

The least intrusive response appropriate to the risk presented.

I am sure that the professionals will work in my interest, in consultation with me and they will only get involved as much as needed.

4. Protection

Support and representation for those in greatest need.

I get help and support to report abuse and neglect. I get help to ensure take I can part in the safeguarding process to the extent to which I want.

5. Partnership

Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.

6. Accountability

Accountability and transparency in delivering safeguarding.

I understand the role of everyone involved in my life and so do they.

Safeguarding Principles – The Safeguarding Board Partner Pledge

- ✓ The SAB will continue to monitor that safeguarding practice is reflecting of the six principles.
- ✓ The SAB and its partners will develop ways to involve people with lived experience of safeguarding in developing strategy and practice.

Demographics

Snapshot of Central Bedfordshire

Central Bedfordshire's attractive market towns and villages complement the beautiful local countryside which boasts 30 sites of special interest and 14 nature reserves. On our doorstep are the Chiltern Hills, Dunstable Downs, Greensand Ridge and the Forest of Marston Vale, areas of outstanding natural beauty.

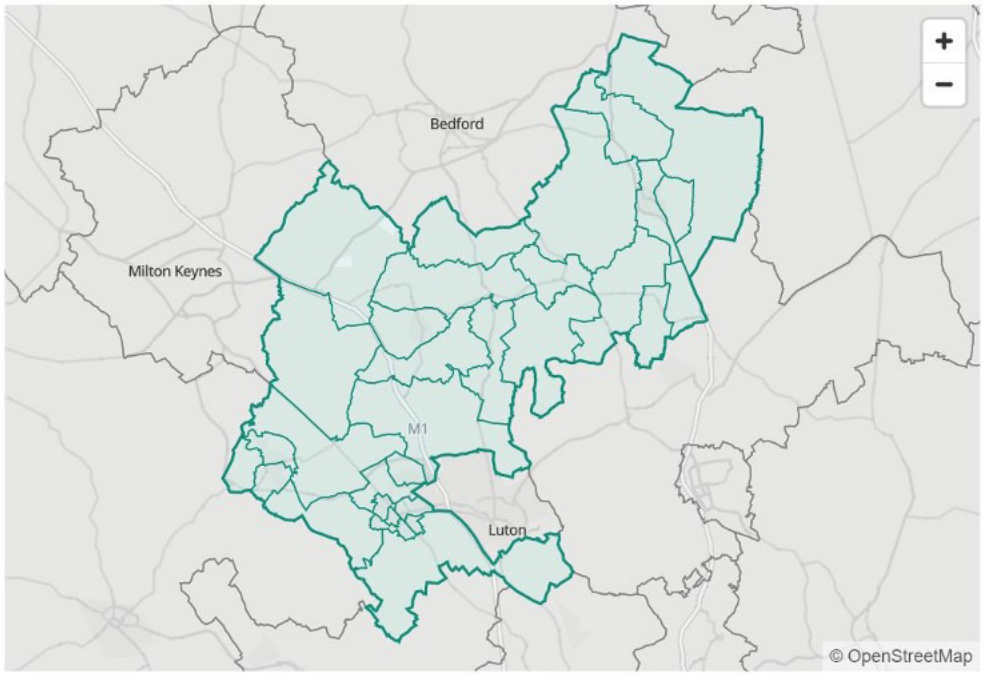
Our area has excellent road and rail transport links. The A1, M1 and A428 connect north, south, east and west. Three major rail lines run through Central Bedfordshire, connecting us directly with two international airports; we can be in the centre of London in 35 minutes.

Amongst our amenities are Woburn Safari Park, Whipsnade Zoo, Center Parcs and Woburn Abbey, which bring people from all over the country to Central Bedfordshire every year. We also boast Cranfield University a post-graduate public research university specialising in science and engineering.

Central Bedfordshire is a popular place to live with a growing population. We are one of the top ten fastest areas of growth in the country. We attract new families, and we want Central Bedfordshire to remain a place that is sustainable, affordable, and family friendly.†

The area is generally prosperous. People living here earn more than the national average, with above-average levels of employment and low rates of claiming Universal Credit. But we also know that some residents across all parts of Central Bedfordshire are struggling; demand for food banks and debt advice is increasing. We want all our communities to thrive, support each other, and be the best they can be.

More and more employers are looking to come to our area. With our fantastic transport connections, we're an attractive location for businesses and have a strong and growing†economy, with growth in medium and large businesses outpacing the national average. Collins†Aerospace, Nissan, Lockheed Martin, MBMA Systems and Amazon have chosen to†make Central Bedfordshire their home.



Snapshot of Bedford Borough

The Borough of Bedford was awarded Charter status by Henry II in 1166, and includes the county town of Bedford, the urban area of Kempston and forty-three rural villages - an area of around 120,000 acres. Its population is approximately 185,000 and is one of the most cosmopolitan in the UK, with some sixty ethnic groups being represented.

Situated on the arc between Oxford and Cambridge and with easy access to London and Milton Keynes, Bedford has the advantage of proximity to both the M1 and the A1, and has excellent transport links. Bedford is a significant growth area and approximately 27,000 new homes are planned by 2040 with expectations that the Borough's population will carry on growing well into the future.

Bedford and Kempston make up the urban centre of the district - a centre noted for its excellent shops, wide range of high-quality housing, first class educational facilities and unrivalled recreational amenities. The River Great Ouse is a central and attractive feature of the town.

Today, Bedford is a lively market town with plenty of opportunities and a cultural diversity.

Progress against priorities 2023-24

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

The SAB and its partners continued to work on the implementation of the Max SAR (November 2022) recommendations during the year 2023-24 aimed at improving the experience of young people transitioning from children to adult's services. Also see Section 6.0 Max SAR Action Update. Work continued across all agencies and was focused on embedding newly developed processes into practice and prompting a cultural change amongst agencies to:

- Start the process of transition from children to adult's services early.
- Avoid sudden cliff edges and work in a way that provides consistency and fluidity across what maybe age specific services.
- Take a multi-agency approach.
- Support young people and their families to shape strategy and practice and for agencies to measure and ascertain the views of people with lived experience.

Priority 2: Having reviewed available safeguarding training during 2022-23 the SAB will aim to ensure the following back to basic training during 2023-24:

- **Safeguarding criteria (when to raise a safeguarding alert) into adult social care**
- **SAR criteria (Section 44 Safeguarding Adults Review)**
- **Hoarding Guidance and Best Practice**
- **Application of Mental Capacity Act in safeguarding**

The SAB does not itself commission annual safeguarding training, but each safeguarding partner agency provides an array of training that is tailored to meeting the needs of the workforce (See partner reports for details in Section 7). However, the SAB does manage and provide for the Bedfordshire wide policies and procedures including any practice resources and tools. In meeting the above criteria, the SAB partner agencies:

- Reviewed the safeguarding policies and procedures (previously a word/PDF document) and developed an online platform that not only provides easy access to the policies and procedures but also local practice resources, SAR learning and access to MCA, DoLS and other up to date case law applicable. Internal practices including content of partner agency training will be influenced by and based on statute and best practice as described and accessible on the new safeguarding policy platform. Webinars were held with around 600 attendees from across agencies to introduce and provide training and a walk though of this new resource.
- Access Safeguarding Policies and Procedures: https://panbedfordshiresabs.trixonline.co.uk

- Operational Subgroup delegates shared and reiterated the LGA/ADASS criteria for raising safeguarding alerts and these are applied locally:
- LGA/ADASS Guidance on What Constitutes a Safeguarding Concern - Sept 2020
- The application of the MCA in safeguarding is embedded in the safeguarding policies and practice guidance and tools accessible to any front-line practitioner.
- The policies and procedures platform and all its information and resources can be accessed by anyone including people going through the safeguarding process.
- See Partner agency reports in Section 7. Training provided across agencies includes:
  - Mandatory Safeguarding and Mental Capacity Act Training
  - PREVENT
  - Non-Statutory Section 42
  - Domestic Abuse
  - Self-Neglect and Hoarding
  - Transitional Safeguarding

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

The SAB reviewed the information available from data and from assurance reports and asked partners about any outcomes from audits and quality assurance in safeguarding. Both local authorities, as the statutory lead agencies for safeguarding, have reviewed the way they record the safeguarding processes including evidencing that the relevant person's wishes and views have been ascertained and expectations met. Furthermore, the local authorities provided evidence as to how they seek the views of people with lived experience.

To highlight:

In CBC, independent audit of safeguarding found that "from the small sample of cases audited that practice was sound, demonstrating legal literacy, good case recording, safeguarding principles and defensible decision making. It was possible to 'see' the adult in the case recording and a sense of how they felt and what they wanted. Even where the S42 duty was not met, there was evidence of a person-centred approach to the needs of the adult and evidence of addressing wellbeing and provision of advice and information (S1and S4 Care Act 2014)."

In BBC independent audits likewise led to positive feedback and the Team are developing recording pathways that better capture the views and support as well as making the processes more effective.

The SAB took part in an LGA/ADASS safeguarding network independent self-assessment at the start of 2024 and the SAB will take forward the following areas informing the SAB's Business Plan and Priorities for 2024-25:

- The development of a prevention strategy/framework in safeguarding (Draft available for consideration/agreement).
- Assurance regarding 'well trained workforce' and monitoring impacts of training.
- Involving people with lived experience in the SAB's work.
- Monitor and, when needed, put in place strategies to ensure equality in safeguarding.

Making Safeguarding Personal and the six safeguarding principles should underpin the SAB's Strategic Plan and be covered in the SAB's Annual Report.

Regarding Right Care Right Person

Right Care, Right Person (RCRP) is a partnership agreement and approach that was implemented this year, and which aims to ensure that individuals in mental health crisis are seen by the right professional, to improve outcomes and the experience for people who need mental health support. It also applies to calls to Police regarding concerns about welfare. This being a new strategy, the SAB invited ELFT and Bedfordshire Police to provide reports regarding implementation and the effects and outcomes for people. This did not raise any concerns so far, to the contrary, the changes ensured that the right support was made available from either mental health or police as appropriate.

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

The SAB and its partners reviewed the template for SAR action plans and set out a new way of recording these. There is now a focus on setting out expected outcomes as well as how success will be measured. In each case this must now also include how the views of people with lived experience will be sought in measuring change and ultimately success. Inputs, outputs and the views and experiences of people have all been linked.

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

As already detailed, the SAB reviewed all policies and tools and put these online for easy access. Bedford Borough continues to have external Self Neglect on their Safeguarding Training schedule that is accessible to workers and partners.

The Adult Social Care Risk Enablement/High Risk Panels in both local authorities continue to be an effective collaboration group for multi-agency case discussions which provide insight to interagency information sharing and expertise, to provide holistic options and solutions.

Bedford Borough Council reports a greater use of Non-Statutory Section 42 enquiries, considering cases of self-neglect where individuals are part of the underserved population. Noteworthy is that in most of these cases there were also significant concerns relating to domestic abuse, exploitation including sexual exploitation.

Central Bedfordshire Council has used the Research in Practice (Ripfa) subscription which has specialist tools and resources such as a "Working with people who self-neglect" Practice guidance that is supplemented by a webinar, as well as training on "Working with people who hoard and who self-neglect" and "Neglect and Poverty aware practice".[1]

Bedfordshire Police have undertaken continuous professional development (CPD) sessions on neglect and self-neglect to upskill and ensure these concerns are identified and reported. Bedfordshire Police also maintain the vulnerability and exploitation hub where information and guidance and tools are available.

1. Self-neglect tools | Research in Practice

Safeguarding Adults Reviews (SAR)

Max SAR Actions update.

The Max SAR report was published in November 2022 and the SAB, and its partners kept the progress of action under scrutiny and review. The SAB had bi-annual updates from partner agencies, implementation of actions becoming a standing item as well as being a regular discussion point at the local meeting of partnership board Chairs providing oversight and scrutiny at the highest level of inputs and actions. During the summer of 2023 the SAB commissioned Sarah Williams (Max SAR Independent Reviewer) to undertake a review of the actions taken and to provide a progress report. In October 2023 the SAB facilitated a Bedfordshire wide multi-agency 'Transitions to the Max' development day for CEO's, SAB delegates, senior and junior managers and front-line practitioners and professionals and user advocacy groups representing both children's and adult's services including
all partner agencies.

Speakers included a video from a young person giving feedback about her recent transition experience giving a powerful testimony. The development day gave an opportunity to review, evaluate and challenge. It provided assurance that new pathways, processes and cultural changes needed to smooth the 'cliff edge' at 18 have been agreed, resourced and were being implemented. However, that the effectiveness and impact on the experience is yet to be fully evidenced over time. What was most apparent was the passion by all to improve and get transitions right for people like Max and the commitment at all levels to do so. In 2024-25 agencies will be asked to provide evidence of audits including feedback from people with lived experience.

The 'Transitions to the Max' development day slides are available here: transitions-to-the-max-full-slide-pack-for-publication.pptx (live.com)

Audit of all SAR referrals 2021-24 & identifying themes from SAR referrals

Numbers of SAR referrals over the years increased year on year with this year showing the first ever reduction in numbers. However, numbers where SAR criteria are met have not changed over the past two years remaining around 35%. Also notable are the numbers of SARs that are on hold. This is because of ongoing criminal investigations and prosecutions in the courts demonstrating the length of time it can take in pursuing and achieving criminal justice in what are very complex cases of abuse of adults with care and support needs and general delays within the criminal justice system as widely reported in the media.

Whilst quick wins and any apparent risks are identified and addressed the full learning cannot be identified until a SAR is carried out. However, with cases taking years to conclude the value of such learning also decreased putting this SAB and others nationally in a conundrum. 4 cases remain on hold. Two dating back to 2021 and both are currently being heard in the courts. The SAB recognises that criminal justice remains to be the highest level of justice for victims and their families.

The SAB undertook a review of SAR referrals and cases over the last three years

(See info below)

Total SAR Referrals to SAB

8 (2021-2022) 14 (2022-2023) 11 (2023-2024)

Central Bedfordshire

4 (2021-2022) 8 (2022-2023) 7 (2023-2024)

Bedford Borough

2 (2021-2022) 6 (2022-2023) 4 (2023-2024)

Total SAR criteria met

2 (2021-2022) 5 (2022-2023) 4 (2023-2024)

Total SAR criteria NOT met

6 (2021-2022) 9 (2022-2023) 7 (2023-2024)

Conversion rate

25% (2021-2022) 35% (2022-2023) 36% (2023-2024)

SARs completed

2 (2021-2022) 2 (2022-2023) 1 (2023-2024)

SARs currently ongoing

0 (2021-2022) 1 (2022-2023) 1 (2023-2024)

SARs in planning

0 (2021-2022) 0 (2022-2023) 2 (2023-2024)

SARs on hold

2 (2021-2022) 2 (2022-2023) 0 (2023-2024)

The following themes were identified:

Themes from SAR referrals - The voice of older people/alleged familial neglect (hidden harms)

- 3 referrals relating to alleged neglect by family members.
- All three cases had similarities:
- All three were female and older people
- All had multiple health needs
- Family members take over care
- Existing services and care are refused and said to be no longer needed or offers of assessments and care and support refused by the fmily member (again with absence of direct consultation)
- Contact between professionals are with family members NOT the relevant person
- The relevant person is NOT seen or spoken to on their own

The SAB considers the protection of older adults to not only be paramount but a matter of achieving equality in safeguarding. The first serious evidence of failing safeguarding systems came on 17 July 2019 when her Majesty's Inspectorate of Constabulary and Fire & Rescue Services and Her Majesty's Crown Prosecution Service Inspectorate (HMCPSI) conducted a joint inspection of how the Police and the Crown Prosecution Service (CPS) respond to crimes against older people 'The poor relation'. The report identifies that whilst "older people account for 18 percent of the population, eight out of ten victims of doorstop scams are elderly, and they also comprise a quarter of domestic homicide victims." It "praised the work of police officers in their initial dealings with older victims of crime, including attending promptly to reports of crime from older victims. But afterwards, officers struggled to deal with some of the complex needs of older people" and identified that support to older victims to have their voices heard were not effectively used. At the time of publication of the report this SAB discussed these findings and followed up via assurance reports from partners that safeguarding alerts were being raises relating to crimes against older people as the report found that: "Older people were not always properly safeguarded. For example, in 77 of 153 cases where a safeguarding referral should have been made by police to the local authority this was not done."

Currently numbers of alerts and Section 42 enquiries relating to older people have markedly risen. As well as this, the audit of SAR referrals identified that not only do we receive a high percentage of SAR referrals relating to older people but that three of these include clear evidence of the relevant person, the older person not being heard. Within families, domestic abuse within their older generation often remains a taboo both between married couples as well as intergenerational. The SAB will be working with the Older People's Partnership Boards to drive awareness and prevent harm and ensure the older peoples voices are being heard each time.

Themes from SAR referrals - transitions and child to parent abuse

Cases Max, SN, and RB are all concerned with transitional safeguarding. They have in common:

- All are white males (one is transgender)
- Max and SN died within months of their 18th birthdays. RB is alive but remains at significant risk of harm and significant incidents occurred soon after his 18th birthday.
- None had physical care needs
- All three were using drugs and/or alcohol but refused theraputic services
- MH and/or neurodiversity needs/diagnosis not always identified or responded to at the point of transitioning
- Police involvement in all three cases due to domestic abuse, missing persons, drug use/selling, self-harm and exploitation
- Child or parent violence a feature in all three cases
- All three had substantial involvement from children's services pre18

Both themes identified will be carried forward as part of this year's SAB priorities for 2024-25. The SAB and its partner agencies are already linking in with the PAN Bedfordshire wide case audit of 'child to parent/carer' abuse and the SAB Independent Chair has committed to facilitating a meeting with parents with lived experience to feed into this review and will be carrying forward any recommendation resulting from this thematic audit and review being carried out.

Interface SARs & LeDeR

3 cases were subject/referred under LeDeR-SAR criteria NOT met

1/3 LeDeR reviews has been completed and report shared with SAR Subgroup and a second report awaited. The final case did not meet the criteria

Cases taken forward both revolved around white, working age females with diagnosis of LD

Case one considered the reponses to a care home resident who later died from the effects of Covid (March 2023)

The second case revolved around emergency responses to seizures, training (lack thereof following Covid pandemic) and administration of emergency medications and how this is and was being managed. Awaiting the report.

Recommendations are monitired via LeDer, but SAR Subgroup can agree additional actions to disseminate learning

There is a very clear interface with LeDeR (Learning from lives and deaths – People with a learning disability and autistic people). Three SAR referrals over this period met LeDeR criteria and whilst they did not meet SAR criteria, were also referred and considered. The SAR Subgroup and SAB have regular six-monthly updates sharing crucial findings from LeDeR reviews generally and specific to cases.

Partner Agency Reports
Central Bedfordshire Council

Total number of residents in Central Bedfordshire:

301,501

Over 65:

54,618

5612

Number of safeguarding concerns received by the local authority during the year

606 (10.8%)

Of safeguarding concerns became section 42 enquiries

60.2%

Of concluded Section 42 enquiries, the risk was located in their own home

84.7%

Of concluded Section 42 enquiries, the risk was reduced or removed

25%

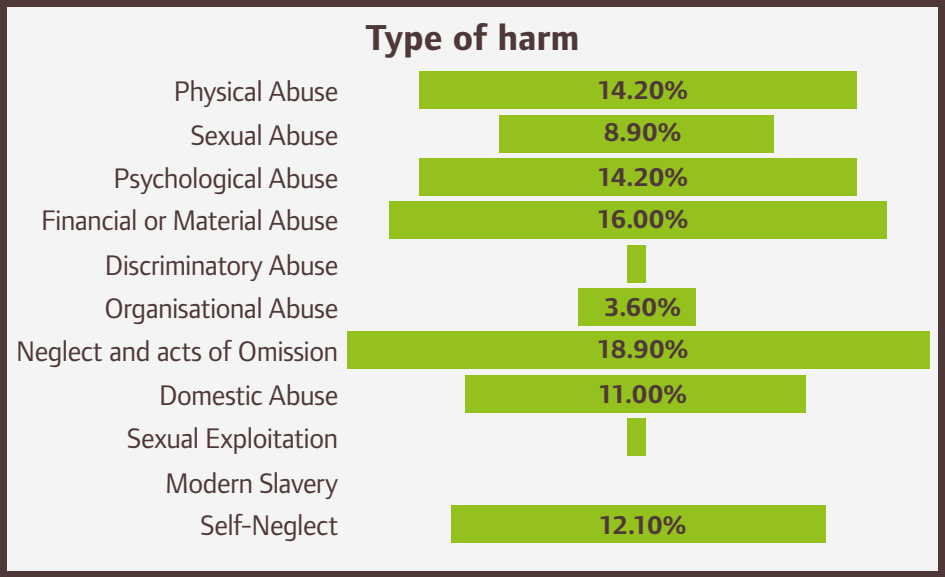
Of concluded Section 42 enquiries, the adult lacked capacity

46.1%

Of those lacking mental capacity % provided with an independent advocate

52.1%

Where the person expressed and outcome this was partially or fully met



The annual total referrals to the CBC safeguarding team this past year amounts to 5612. This is a considerable increase in referrals which has been managed by funding additional posts, a new process to triage daily, and supplemented by a rotation of the safeguarding leads to help with oversight of demand, risk and allocation of work. As a result, the safeguarding leads continue not to be able to undertake audits given the persistent demand pressure on the safeguarding team. The safeguarding audits have, however, continued to be primarily undertaken by the social work teams as well as by the quality improvement team to provide the necessary assurance and oversight.

Several actions to ensure that colleagues, partners, and the public know where to refer non-safeguarding referrals have been explored. As an example, information about referral pathways has been added to the signatures of all members in the adult safeguarding team and the guidance on what constitutes a safeguarding concern by the LGA/ADASS has been broadly shared across the partnership.

To support other emerging safeguarding concerns such as Modern slavery in Care Homes, a briefing from the Modern slavery lead in Bedfordshire Police was delivered across all adult social care teams. A session was also held by a safeguarding trainer for managers on Non statutory safeguarding enquiries and there are more planned sessions via the practice surgeries to support practitioner knowledge in this area.

In this period, the safeguarding team noticed a pattern emerging of safeguarding concerns raised by parents experiencing abuse from young children aged 13 and upwards. Between April 2023 to March 2024, a total of 68 alerts relating to "Child to Parent Abuse" were received.

The safeguarding team utilised the domestic abuse specialist officer role to develop specialist knowledge and skills in this area, to best support parents and their children. This entailed undertaking specialist training and working in collaboration with children's services and the strategic commissioning team, to highlight the presenting issues and risks. This emerging trend in safeguarding concerns was also discussed at the Local Partnership Board and as a result, the age range for support for children providing specialist support by the Chrysalis Centre, was further widened to incorporate younger aged children.

In addition, the safeguarding team have developed a practice guide for "Child to Parent Abuse" and have run practice surgeries for adult and children's services on the available local specialist services that can support the adult and the child in such circumstances.

There has also been very wide-ranging collaboration across adult and children's services in this area of work, including in strategic planning. To continue learning, there are planned audits to further consider how we can progress and develop our offer of support with a "Think Family" approach to emerging abuse of this nature.

Quality Audits:

Overall, the standard of practice was found to be good and in accordance with the Care Act 2014. Local procedures were followed, the principles of Making Safeguarding Personal (MSP) were evident, the six safeguarding principles were applied and there was a good standard of partnership working. The local authority decision making against S42(1) was clearly said to be evidenced in all six records audited and was considered fair, justified and judged by the audit to be reasonable in all six cases. The auditors noted that there was no deviation noted from Care Act S42(1) responsibilities of the local authority.

Record keeping was considered thorough, detailed and with good evidence of staff seeking out further opportunities to signpost and liaise with partnership organisations. The auditor reported that there was a good knowledge demonstrated regarding available community and neighbourhood support services to keep adults safe and improve their quality of life and reported that there is a culture of having direct conversations with partner agencies either via MS Teams or phone calls which was noted to be positive practice. It was further noted that there was reference to the Professionals Guide to Child to Parent Abuse, showing a good standard of knowledge of applicable guidance.

As a result of audits there were lots of good practices identified including robust risk assessment, person centred and strength-based practice etc. and few recommended improvements including improving the clarity of contingency plans and lack of evidence of document sharing.

Safeguarding Case Example “Stacey”

This case relates to Stacey a 41-year-old, white British female, married to a white British male and living with significant mental health needs. Stacey engaged with the local community mental health service to access support with managing these. Stacey was also known to adult social care though she was reluctant to engage. Her husband was notably also her carer and he attended many of Stacey’s therapy session and meetings. Stacey attended a day activity, and her husband provided the transport to and from.

Whilst attending the day activity Stacey made significant disclosures of domestic abuse by her husband. This included disclosures of incidents of serious and extreme physical violence, and sexual violence , financial (no money and not in control of property and affairs, being locked out of her home), emotional violence and coercive control (not being allowed a social life or involvement with family or friends), humiliation and degrading treatment and that her husband was controlling of all aspects of Stacey’s life (including her mobile phone and e-mail etc). She reported to be subjected to the most horrific and severe ‘punishments’ for not following her husband’s word.

The Adult Protection Team worked with the Community Mental Health Team in responding to the safeguarding disclosure. Consideration was given to the risk to Stacey should her husband find out that she has made disclosure and therefore the situation needed to be managed so as not to put Stacey’s safety in jeopardy. Stacey was supported via the mental health team to complete a Domestic Abuse, Stalking and Honour Based Violence Risk Assessment and referral was made to MARAC (Multi-Agency Risk Assessment Conference). Police, GP, mental health, adult services and the people at the day activity worked together to safeguard Stacey. Communication and consultation with Stacey continued via the day activity where she was supported by professionals throughout the safeguarding processes to make decisions regarding her life and future. Stacey ultimately wished to get away from her husband and stop the abuse.

The police commenced a criminal investigation, and the alleged perpetrator was arrested and remanded. Stacey was supported to move out of the area to a safe location. The last update from Stacey was that she was selling her home and that she will permanently move out of the area and start life afresh, free from harm and abuse.

Partner Agency Reports
Bedford Borough Council

BEDFORD BOROUGH COUNCIL

Total number of residents in Central Bedfordshire:

187,466

Over 65:

31,395

2731

Number of safeguarding concerns received by the local authority during the year

216 (7.9%)

Of safeguarding concerns became section 42 enquiries

45.3%

Of concluded Section 42 enquiries, the risk was located in their own home

91.8%

Of concluded Section 42 enquiries, the risk was reduced or removed

30.7%

Of concluded Section 42 enquiries, the adult lacked capacity

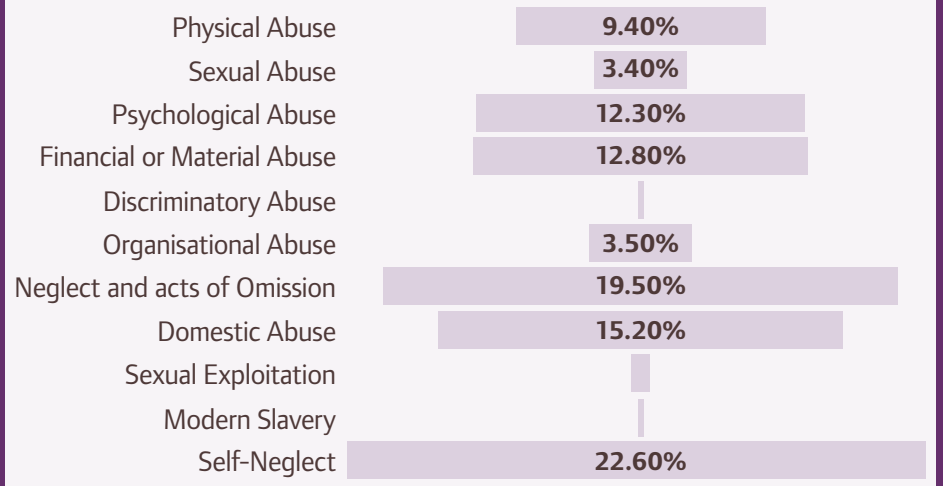
23.5%

Of those lacking mental capacity % provided with an independent advocate

95.6%

Where the person expressed and outcome this was partially or fully met

Type of harm



The complexity and volume of safeguarding referrals has again increased during this period with 2731 safeguarding referrals recorded on the system, the team continue to receive referrals that are not of a safeguarding nature. BBC has reviewed the initial triaging process at the point of entry to minimise risk, based on the information supplied. Through some analysis of those referrals that do not have a safeguarding nature or meet the safeguarding threshold we have begun conversations with our Adult Social Contact team with regards to referral routes, and in turn ensuring that our partners are aware of the options available when wanting to make enquires.

BBC has seen an increase in Domestic Abuse referrals, we continue to have representation from the safeguarding team at monthly MARAC. There has also been an increase in referrals where there is violence amongst non-related individuals often where there is involvement in substance misuse and often in some way linked to drug debt/illegal activity.

The Safeguarding Team Bedford have had to instigate the councils Serious Concerns Protocol for two services, one regulated and one unregulated provider, we needed to ensure continuity of care, whilst managing the risk and maintaining the provider care market. This work has been successful, we have worked in conjunction with the providers, care standards, commissioning, ICB, regulators CQC and care management colleagues. Both the providers have made significant improvements, and they are now currently being monitored under the Provider of Concern Pathway.

There has been an increase in care provider's obtaining Oversees Sponsorship licenses. On receipt of notifications from the Home Office with regards to suspensions, we liaise with the CQC regulators and the providers to ensure the requirements are acted upon.

From data it was identified that the following four areas showed increased activities and referral rates:

- Transitions
- Abuse against Older people
- Self-Neglect
- Financial and Material Abuse

All four areas will therefore be reflected in both the SAB's business plan for higher level monitoring as well as the priorities developed for 2024-25.

Quality Audits

In the last year BBC has had the opportunity to have external and internal audits to provide that objective view of the safeguarding processes, this included the way that the safeguarding team responded to referrals, and also the journey of the S42 enquiry process. The audits reflected that Making Safeguarding Personal and empowerment is embedded in practice. The team have produced a development plan based on the findings of the audits. The auditor reflected that the SV1 referrals from partners were at times inconsistent with information missing and not completed in line with the Pan Bedfordshire Safeguarding Policy and Procedures, which can hinder the safeguarding teams initial triaging. To address this, we have been engaging with our partners and providing feedback on their referrals in line with the LGA Understanding What Constitutes as Safeguarding Concern. Following feedback, we are also reviewing the decision monitoring tool template that will provide greater succinct narrative.

Following an Internal audit, a recommendation is for practitioners to reflect on a person's care management record the status of a S42 enquiry. Meaning the S42 Enquiry will remain open until criminal investigations have concluded whilst ensuring that the relevant person safety and wellbeing remains at the central to decision making.

- To maintain our statutory reporting the safeguarding team have been working with our performance and care management colleagues in relation to performance reports.
- Following the introduction of our care management system Liquid logic 4 years ago which provides a very clear safeguarding recording pathway, we have been reviewing the Safeguarding module and looking at ways that we can evidence our initial triaging process on the system at point of entry.

Safeguarding Case Example – Paul

Concerns raised by care agency that Paul did not have access to money or available food and was reliant on foodbank. Paul was found to be in arears with rent which was putting his tenancy at risk and a Notice to seek Possession had been issued and additionally, he also had non-payment of care fees. It was identified that Paul had nominated a family member to be Lasting Power of Attorney (LPA) to look after his finances. There had been no history of Paul not being in any debts previously. A safeguarding enquiry commenced because of the allegation of financial and material abuse.

Although the case was referred to the Police, Paul did not wish Police involvement and felt that he had expected to much of the LPA and did not wish for them to get into trouble, therefore a Police investigation was not pursued. Paul was deemed to have capacity to make this decision.

With agreement from Paul, the allocated enquiry officer made serval attempts to engage with the LPA, but these went unanswered. Paul wished for the Office of Public Guardian (OPG) to make the decisions regarding the LPA position to act on his behalf. The OPG were unable to gain engagement with the LPA also. Paul was deemed to lack capacity and insight to manage his own finances. A care advocate was also instructed to support Paul through the enquiry.

The lead enquiry officer needed to build up a rapport and trust with Paul at a difficult time that was implicating a family member. Paul was deemed to have mental capacity regarding the safeguarding process and wanted to understand the reason for these debts. With support, Paul was able to obtain bank statements that evidenced sufficient funds to pay for their outgoings, they also provided the evidence that LPA was not acting in Paul's best interest and using Paul's monies to maintain their own lifestyle.

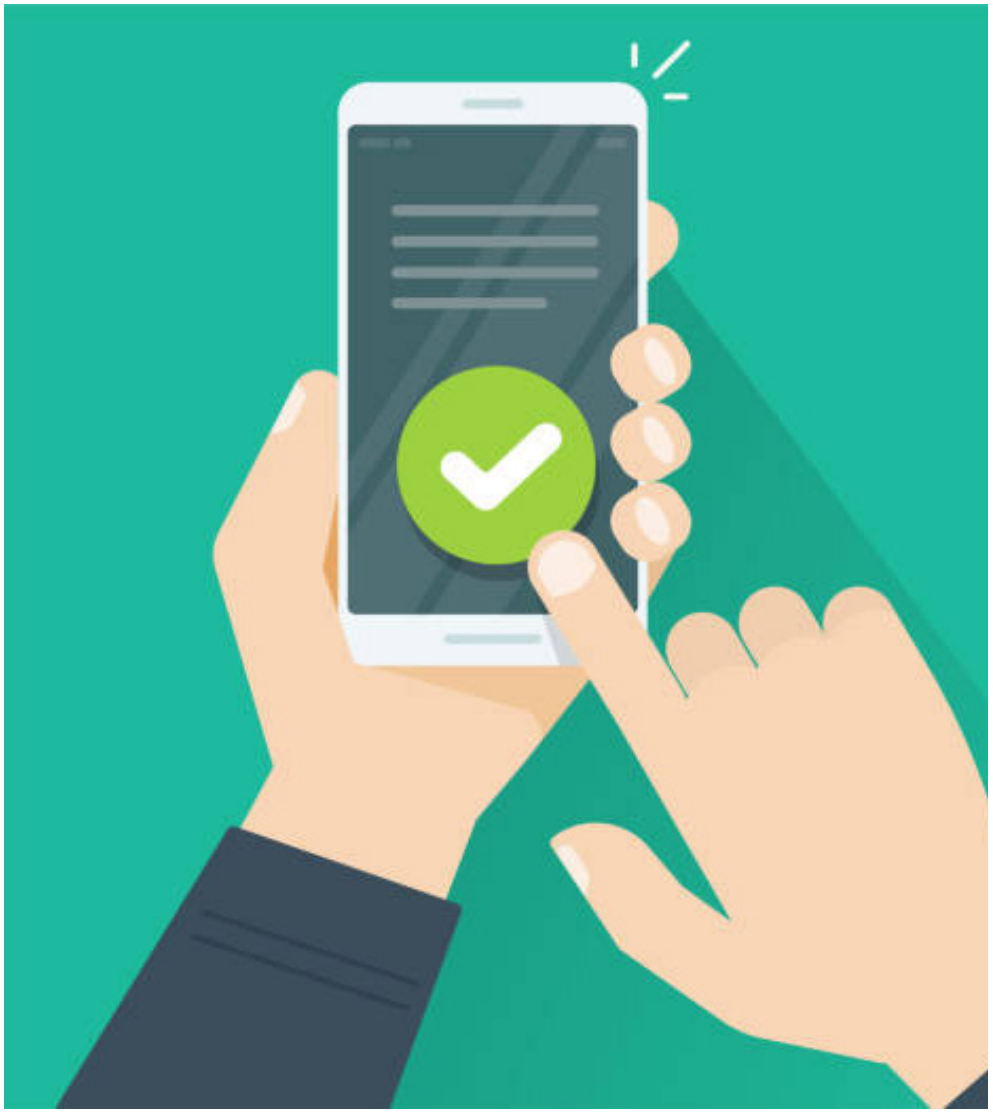
A referral was made to the local authorities Money Management team, appropriate benefits have been obtained, the OPG investigated, and LPA role has been relinquished. A plan was put in place to pay debts which satisfied the court process.

Paul has been able to remain in tenancy and has support from money management services for ongoing support to manage finances and deputyship is in place between Paul and local authority. Throughout the enquiry, partner agencies; DWP, Housing, Police and Care provider worked in collaboration whilst maintaining the Paul's wishes.

Deprivation of Liberty Safeguards (DoLS)

Nationally there were an estimated 300,765 applications for DoLS received during 2022-23[3]; an 11% increase. This trajectory is reflected in our own data and continuing in 2023-24 in both local authority areas. With the proposed Liberty Protection Safeguards now permanently on hold and alternatives being considered, DoLS is here to stay for the time being, and timely completion of applications ensures the rights of vulnerable people when their rights and liberty are restricted.

Nationally the proportion of standard applications completed within the statutory timeframe of 21 days was 19% in 2022-23; this has fallen from 20% in the previous year. The average length of time for all completed applications was 156 days, compared to 153 days in the previous year.[4] Both local authorities exceed this national average in meeting the statutory requirements under DoLS. It means that locally, whenever individuals rights are restricted and meeting the 'acid test', the safeguards under DoLS protect people from harm.



3. Mental Capacity Act 2005, Deprivation of Liberty Safeguards, 2022-23 - NHS England Digital
4. Mental Capacity Act 2005, Deprivation of Liberty Safeguards, 2022-23 - NHS England Digital

Central Bedfordshire

Deprivation of Liberty Safeguards	Annual 2023-2024	Annual 2022-2023
Total number of DoLS applications received 1st April 2023 to March 2024	2029	1967
% of All DoLS authorisation applications completed at end of March 2024	90%	85%

CBC has seen a small increase in referrals and managed these well, slightly increasing the percentage completed. Both internal and independent Best Interest Assessors are used and commissioned alongside Independent Section 12 doctors. A well-established DoLS Team are in place to manage this aspect of safeguarding.

BEDFORD BOROUGH COUNCIL

Deprivation of Liberty Safeguards	Annual 2023-2024	Annual 2022-2023
Total number of DoLS applications received 1st Apriln2023 to March 2024	1,304	1,196
% of All DoLS authorisation applications completed at end of March 2024	77.8%	97%

The Deprivation of Liberty Team has seen a 10% increase in referrals from last year, the variation on the % as some will have been signed off beyond year end. BBC have maintained compliance through use of a pool of excellent independent Best Interest Assessors and Section 12 doctors. There has been a challenge at times with obtaining Relevant Person Paid Representatives for out of county placements and Court of Protection 1.2 representatives: we have used our network with the current Advocacy Provider and spot purchased for 1.2 Advocacy representatives which has been successful in ensuring our service users have appropriate advocacy representation.

Bedfordshire Police

Bedfordshire Police have an annual delivery plan that focuses all officer/staff on our own priorities and how to work together to achieve these. In the last year this has included vulnerability as an overarching theme which will incorporate vulnerable adults.

We have ongoing work in respect of improving our vulnerability strategy in line with national themes and guidance.

We regularly undertake reviews as fast time learning becomes available internally with all types of cases across the pan beds arena. We also undertake scrutiny panels for a variety of crime types and work strands where numerous cases are reviewed and learning shared and identified.

There is governance in place for all audits and reviews, so they are tracked and for corporate memory and this is undertaken across several departments and strategic owners.

Within Bedfordshire Police we have a Central Intelligence Bureau (CIB) that is divided up into thematic crime desks. One such desk is the Vulnerability & Exploitation Desk that holds responsibility for developing and responding to information and intelligence relating to Modern Day Slavery, Human Trafficking and Organised Immigration Crime.

The desk receives intelligence from numerous different sources (the public, partner agencies, crime stoppers, informants etc) which is assessed by the intelligence team staff. It will be graded and where appropriate a variety of tactics to proactively develop the information will be undertaken to advance the intelligence and assist understanding of the 'bigger picture'.

The intention of this development process is that it will ultimately result in some form of action, this will in many cases be with the requirement of multi-agency response. Quite often the action will include enforcement to arrest suspected offenders and safeguard victims.

Case example modern slavery: Operation Cairo

Intelligence and information received by police regarding Romanian females being trafficked into the UK and forced into sex work at various locations. After a period of development, an enforcement day was held whereby numerous search warrants were executed. This resulted in 6 persons being arrested on suspicion of human trafficking and sexual exploitation.

A 'Reception Centre' was set up to ensure that any victims identified during the enforcement activity had a suitably prepared place to be taken to and ensure support was effectively offered. Numerous victims were identified during the activity with them being taken to the reception centre and offered support.

The Police (and other partner agencies) utilise the National Referral Mechanism (NRM),[5] which is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support. One of the victims identified during the operation has since entered the NRM to receive on-going support, assistance and protection. A criminal investigation is still in progress to prosecute the offenders.

5. National referral mechanism guidance: adult (England and Wales) - GOV.UK (www.gov.uk)

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Bedfordshire, Luton, and Milton Keynes (BLMK) Integrated Care Board (ICB)

The ICB continue to strengthen arrangements following the merge to BLMK and have improved the governance for safeguarding within the organisation, for example, joined up policies for safeguarding practice, improved monitoring of supervision, and introduced strategic leads for priority areas.

Strategic leads include:

- Prevent
- Domestic Abuse
- Violence Against Women and Girls
- And Self-Neglect

Prevent:

The Prevent duty was revised last year and embedded across the ICB. The Prevent lead introduced a seven-minute briefing for everyone in the ICB with aim to raise awareness of 'notice, check, share' and aligned the levels of Prevent training with staff roles and responsibilities. The Prevent Focus Group was also introduced and is an information sharing group within the ICB.

Domestic Abuse (DA):

One of the team's Designated Nurse for Adult Safeguarding scoped the availability of Domestic Abuse Champions within primary care services. Involvement at local Domestic Abuse Partnerships Boards and deciding priorities moving forwards. Part of serious violence duty expected to set up internal support for DA – work ongoing with HR department.

Violence Against Women and Girls (VAWG):

Pan-Beds Police colleagues have spoken with General Practitioner (GP) safeguarding leads about VAWG in terms of presentation and implications for those women and children who are affected by it. This has led to more referrals into the system via primary care and GPs have also expressed an interest in displaying signposting information in their surgeries for support and help for those who need it.

The ICB hosted two Preparing for Adulthood Summits bringing together partners to consider several priorities including SEND, looked after children, mental health and Learning Disability and autism to develop shared principles for transition. ICB safeguarding processes have been strengthened to ensure learning from SARs and other investigations are shared and embedded in practice. Health partners across the ICB have worked together as part of the neurodevelopment pathway review to ensure pathways and systems are in place to support children and young people (CYP) and families as they move into adult services. During 2023/24 the keyworker service hosted by Autism Bedfordshire has increased its age range to 25, in recognition of the need to be able to support young people at risk of admission and those inpatients awaiting discharge from inpatient services.

Bedfordshire Fire and Rescue

Through investing in our staff, enhancing our systems, and improving our governance, Bedfordshire Fire and Rescue has made significant strides in our safeguarding protocols.

- We remain dedicated to providing timely feedback to all individuals who submit referrals, maintaining a 100% feedback commitment.
- Building upon our updated policy framework, the service has revised all training modules, including tailored sessions for our cadre duty Group Commanders.
- As a result of our advancements, there has been a substantial increase in referrals compared to the previous year, with an overall surge of 48%.

Our Safeguarding Priorities for 2024/25 centre on ongoing investment in the training and professional growth of our personnel, along with guaranteeing the effectiveness and efficiency of our referral systems and processes for both us and partners who receive our referrals.

Finally, it is important to highlight that our year-on-year progress would not have been possible without the invaluable support from our safeguarding partners. Due to the support, we have obtained from our partners Bedfordshire Fire and Rescue Service is now more prepared than ever to safeguard and assist the most vulnerable individuals.

Bedfordshire Hospitals NHS Trust

During the period of 2023-2024, Bedfordshire Hospitals Foundation NHS Trust has continued to be an active member of the SAB and subgroups aligned to the SAB. The Trust continued to be represented at VARAC (Vulnerable Adult Risk Assessment Committee), MARAC (Multi-agency Risk Assessment Conference), Modern Day Slavery Strategic Group, LeDeR (Learning Disability Mortality Reviews) Strategic groups and Quality Assurance panels, Domestic Homicide Reviews and other multi-agency forums where safeguarding vulnerable adults and children is paramount.

As a Safeguarding team, we have continued to deliver training to staff, as appropriate to their roles in a variety of forms including E-Learning packages, Face to Face training, through virtual platforms alongside role modelling in clinics/ departments and hospital inpatient wards. This has remained a priority for the Trust. It is evident in the last year that our continued collaboration between the Adult Safeguarding team, Safeguarding Children and Safeguarding Midwifery teams is supportive of our 'Think Family' ethos. This includes the co-location of teams on both sites, allowing a greater opportunity to share good practice and develop our safeguarding skills. We continue to have a Joint Trust Safeguarding Board which not only incorporates both the safeguarding adults and children's agenda but also both hospital sites.

The Trust continues to have a very good partner relationship with the safeguarding board alongside the wider MDT including ICB, community nursing, mental health teams, schools, health visitors, police and social care. This relationship has proved to be invaluable over the past 12 months given the pressures faced by all organisations. Open communication is key to safeguarding our adults, children and young people. This will continue in 2024-25.

Recognitions received in 2023/24:

- Two East of England Celebration excellence in experience awards – Hope Boxes
- Two Bedfordshire Domestic Abuse Partnership & High Sheriff of Bedfordshire Recognition Awards – outstanding practice in DA
- A nomination to the MJ Achievements Awards – Falls Protocol

Our previous priorities for 2023/24 included the following:

- Continued with the delivery of Safeguarding Adult Training to increase training compliance, skills and knowledge base across both hospital sites.
- Reviewed the model (including capacity) of both hospital sites Safeguarding teams to ensure appropriate resource levels to meet the increasing complexity of safeguarding activity within the hospitals.

Implementation of the following:

- Oliver McGowan Training for Learning Disability and Autism
- 16 Days of Action programme
- Commenced training for nursing/ midwifery students at the University of Bedfordshire
- Implemented a frequent attenders Safeguarding Review panel. #
- Supporting the development and implementation of the multiagency falls protocol for safeguarding.
- Aligning of pathways/ systems/ data collection and training for both adult safeguarding, Dementia and Delirium across both sites.

Successful funding and Implementation of the following services also took place during 2023-24.

- Emergency Department Navigators
- Delirium co-ordinator
- Alzheimer's support worker

Development of the following cross site guidance/ policies etc. were completed:

- New Guidance on staff allegations
- New Restraint Policy including the development of new risk assessments, care plans, reporting tools etc.
- Domestic Abuse Policy
- Child Death overview panel Policy
- Learning Disability Policy and Learning Disability Strategy
- Service Level Agreement for the MH Law Office
- Completion of robust job descriptions for named doctors for safeguarding

The team have also presented at regional and national forums regarding hospital safeguarding procedures deemed as good practice.

These included the following:

- Bedfordshire DA and MVAWG conference
- East of England Crossing pathways: integrating best practice within health and DA
- East of England Foundation in Paediatric Surgical Nursing

Training:

The Team have also developed 2 specialist safeguarding conferences on DA and exploitation within the Trust whereby over 200 staff attended in total. The team were also involved in the University of Bedfordshire's research programme for on street sexual exploitation.

NHS
East London
NHS Foundation Trust

East London Foundation Trust (ELFT)

Through our mental health, addiction, primary care and community health services ELFT staff encounter and support many adults experiencing abuse and neglect across Bedfordshire. To help ensure our staff provide the highest quality support, over the last year we have focused on improving the quality, compliance and offer of our safeguarding training. Adult Safeguarding level 3 training compliance has increased by 20% since 2022-23 and now sits at over 82%. The Trust compliance with WRAP (Workshop to Raise Awareness of Prevent) training is at 94.93% compared to 82.43% in the previous year and compliance for Basic Prevent Awareness is at 94.43%.

The Trust safeguarding team delivered 68 level 3 adult and children's Safeguarding training sessions across the Trust in 2023-24 and trained 3485 staff in 2023-24 compared to 2650 staff members in 2022-23. This is a 32% increase in training attendance.

In addition to statutory training, the safeguarding team have offered a range of other training sessions to our clinicians including:

- Think Family Training
- Working with families with that have multiple Needs
- Adultification and Intersectionality
- Forced Marriage Awareness
- Contextual Safeguarding
- Perplexing presentations
- Learning from Child Q Children's Safeguarding Practice Review
- Learning from safeguarding children practice reviews
- Learning From Safeguarding Adult Reviews and Domestic Homicide

Reviews

- Safeguarding legal update training
- Self-Neglect
- Neglect of children
- Domestic Abuse and its impact

ELFT continues to engage with our service user and patients to ensure we embed their lives experience and insights into our safeguarding practice. We are doing this through close engagement with our People Participation Leads, review of our training materials by service users, and service user representation at our safeguarding committee and domestic abuse steering group.

SAB Priorities 2024-25

Considering the data from 2023-34 the following areas showed an increasing projectile:

- Domestic Abuse of older people
- Transitions
- Self-Neglect
- Financial and Material Abuse

Priority 1 – Review and refresh the governance and functioning of the SAB and its Subgroups taking account of feedback from partners and the SAB audit.

Actions:

- Review the SAB Structure and Terms of Reference.
- Develop a Business Plan.
- Refresh the Information Sharing Agreement (ISA)
- Refresh the SAR Framework
- Develop a Prevention Framework
- Refresh the Hoarding Pathway
- As a golden thread consider and improve the involvement of people with lived experience of safeguarding throughout this review.

Priority 2 – Improving assurance, reporting and challenge

Actions:

- Improve the data collections analysis and interpretation to provide more effective assurance and outcomes.
- Evidence from partners to show sustained effective and safe transitions including feedback from people with lived experience and their families.
- To report on increasing numbers of alerts relating to older people, domestic abuse, self-neglect and financial and material abuse with a view of reducing numbers.
- For partner agencies to carry out an audit of what underpins increasing reports of abuse of older people including domestic abuse of older people and increasing numbers of self-neglect and financial and material abuse (all adults) with a view to developing preventative measures and risk reduction strategies.
- Set out and agree a forward plan for agencies to present specific assurance reports.
- Consider equality.
- Seek assurance that safeguarding training (provided by partner agencies) is effective and reflecting of best current practice.

Priority 3 - Develop better systems of engagement and co-production

Actions:

- Utilise partner agencies existing user groups and ensure that partners agencies include the feedback from people with lived experience as part of assurance reports.
- For the SAB to host, develop or commission service user forums, engagement and co-production groups.
- Work with the older people partnership and older people with lived experience to prevent hidden harms and domestic abuse.
- For partner agencies to evidence improvements in the voices of older people being heard and support made available including advocacy, intermediaries etc.

Priority 4 – Child to parent abuse

Actions:

- For all partner agencies to take part in the Bedfordshire wide multi-agency audit.
- To facilitate an expert by experience discussion group of affected parents/carers and ascertain their views.
- Consider the findings of the audit and support strategies for development.

Priority 5 – Rough sleeping and homelessness (Ministerial Directive)

Actions

- Identify lead officers representing both local authority areas.
- For the SAB to be informed of the current safeguarding risks relating to rough sleepers and homelessness affecting people with care and support needs.
- Take forward any actions resulting of the review and information provided in relation to this priority.
- Seek assurance that safeguarding arrangements are robust in preventing and responding to allegations of harm and abuse relating to this group.

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

and intimidation or other abuse that is used to harm, punish, or frighten their victim. Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or stepfamily (Home Office 2012).

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

EEAST East of England Ambulance Service

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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