Commission for Social Care Inspection

Making Social Care Better for People

Service Inspection Report

INDEPENDENCE, WELLBEING AND CHOICE

Bedfordshire County Council

May 2008

Safeguarding Adults



COMMISSION FOR SOCIAL CARE INSPECTION

The Commission for Social Care Inspection (CSCI) was set up in April 2004. Its main purpose is to provide a clear, independent assessment of the state of adult social care services in England. CSCI combines inspection, review, performance and regulatory functions across the range of adult social care services in the public and independent sectors.

Our Vision and Values

The Commission for Social Care Inspection aims to:

- put the people who use social care first;
- improve services and stamp out bad practice;
- be an expert voice on social care;
- practise what we preach in our own organisation.

INSPECTION OF INDEPENDENCE, WELLBEING AND CHOICE

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INTRODUCTION AND BACKGROUND

An inspection team from the CSCI visited Bedfordshire in May 2008 to find out how well the council was safeguarding adults whose circumstances made them vulnerable. To do this the team focused on services for all adults.

Before visiting Bedfordshire the inspection team reviewed a range of key documents supplied by the council and assessed other information about how the council was delivering and managing outcomes for people. This included crucially the council's own assessment of their overall performance. The team then refined the focus of the inspection to cover those areas where further evidence was required to ensure that there was a clear and accurate picture of how the council was performing. During their visit, the team met with people who use services and their carers, staff and managers from the council and representatives of other organisations.

This report is intended to be of interest to the general public, and in particular for people who use services in Bedfordshire. It will support the council and partner organisations in Bedfordshire in working together to improve the lives of people and meet their needs.

SUMMARY

Safeguarding Adults

The Commission rates council performance using four grades. These are; poor, adequate, good and excellent. **We concluded that in Bedfordshire safeguarding of adults was adequate.**

The established safeguarding arrangements were effective in safeguarding some people. Recently there had been some increase in awareness of safeguarding across the community. The council had recognised that there was considerable work to do at both high level and operationally to secure improved outcomes for people whose circumstances make them vulnerable. There was an established Adult Safeguarding Board in Bedfordshire. A joint Bedfordshire and Luton Safeguarding Board had recently been created to support the close working relationship the council had with Luton council on safeguarding.

New safeguarding procedures had just been introduced which were beginning to provide better support to staff within the council and staff from other agencies. The previous procedures had not provided enough clarity on when a safeguarding referral should be made. This was made clearer in the new procedure. Over the last year the number of referrals had varied considerably between different service user groups with some having high numbers and others having relatively low numbers of referrals. There was a low referral rate from people black and minority ethnic communities in comparison to the percentage population. More detailed analysis and further work was needed to address some of these variances.

The council had recently introduced a single point of access except for referrals from people with mental health problems but awareness of these arrangements was low amongst the people we met. Priority was given to safeguarding referrals and responses were beginning to improve. The quality of safeguarding practice and management was variable but staff were becoming increasingly confident in managing safeguarding referrals and investigations. There was an established programme of training, aligned to the old procedures and a programme for the new procedures was being developed. In the meantime there had been briefings for staff in adult social care on the new procedures. Staff stated training was accessible, relevant, and met their needs. Awareness of and access to training for independent and third sector agencies was limited.

The management of safeguarding for people with mental health problems had been delegated to Bedfordshire and Luton Health and Social Care Partnership Trust (BLPT). There was more work to do to ensure that these arrangements consistently provided safe services for people who use them and their carers. Good partnership working was evident within community safety; in particular the response of the police to safeguarding was very good. Staff had access to a range of low-level preventative services that supported safeguarding arrangements and home security. The council needed to continue to promote public awareness of adult safeguarding.

Capacity to Improve

The Commission rates council capacity to improve its performance using four grades. These are; poor, uncertain, promising, and excellent. **We concluded that capacity to improve in Bedfordshire was uncertain.**

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. Overall adult social services had a recent track record of improvement but this was not fully reflected across safeguarding. The council had recognised that it needed to take significant steps to improve safeguarding arrangements and had begun to implement some of this improvement work. Whilst there were some early signs that this improvement work was beginning to make a difference to some people who use services, this was limited. The council had also recognised the need to develop new ways to manage the performance of all safeguarding work more effectively and plans were in place in response to this. However overall there was a lack of co-ordinated, multi agency strategies in place for the improvement work.

Senior managers within adult social care were committed to keeping people safe and recognised the role they had to play in continuous improvement. Staff reported senior managers to be visible and supportive. The council and its partners had work to do to develop a joint workforce strategy to ensure that staff had the right skills and knowledge for the future.

The emerging vision for safeguarding was just beginning to inform and shape the commissioning of safe services. Service user and carer consultation groups were in place to ensure that people who use services were involved in the planning and delivery of services. However it was less obvious how people who used services were involved specifically in the provision of safe services as the people and carers we met had little understanding of safeguarding. Commissioning strategies did refer to adult protection and community safety but this was limited and the inclusion of safeguarding needed to be strengthened. Arrangements to support the commissioning of high quality services had resulted in considerable improvement in the performance of independent providers of care homes and domiciliary care agencies. This approach should also be applied to the council's own services, in particular those not externally regulated.

There was good partnership working in relation to the community safety that was providing better protection for people in vulnerable situations in the community. Whilst high-level relationships with BLPT had become stronger, operationally there was still more work to do. There was a need for the council to better ensure the quality of safeguarding in mental health service provision. Relationships with the PCT were positive however more could be done to look at how the council and the PCT could work more closely together and jointly commission safe services more effectively.

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.

CONTEXT

Bedfordshire is on the northern fringe of London and is one of the smallest councils in England with a population of 392,200. It comprises of three districts Bedfordshire District Council, mid Bedfordshire District Council and south Bedfordshire District Council. In April 2009, two new unitary authorities will be created which will replace the existing councils. Bedfordshire is relatively diverse. Although it is mainly rural, 60 percent of the population live in large towns. Over 11 per cent of people are from black and minority ethnic (BME) communities. This ranges from 19 per cent in Bedford to five percent in mid Bedfordshire. There are 49 different spoken languages with the largest BME groups being Asian and Italian. Overall the area is affluent but does have some pockets of deprivation.

Bedfordshire Primary Care Trust (PCT) serves the health community. In 2007 the Healthcare Commission judged Bedfordshire PCT as delivering 'fair' on the quality of services and 'fair' on the use of resources. Scores were awarded on a four-point scale: weak, fair, good and excellent. Bedfordshire and Luton Mental Health and Social Care NHS Trust provide mental health services and was judged to be delivering 'fair' on the quality of services and 'fair' on the use of resources. At the time of the inspection, the council was assessed by the Audit Commission to be improving strongly and demonstrating a three star performance. A recent inspection of the supporting people arrangements judged the council to be providing a 'fair' service with 'promising' prospects.

Last year CSCI had judged Bedfordshire to be improving in the provision of adult social care with the judgement of 'good' in the delivery of outcomes and 'promising' in capacity for improvement resulting in the award of two stars.

The Director of Community Services has responsibility and authority for ensuring that the local authority maintains a clear organisational and operational focus on safeguarding vulnerable adults and that relevant statutory requirements and other national standards are met including POVA requirements.

KEY FINDINGS

1. Safeguarding Adults

1.1 Safeguarding against poor treatment

Some people were effectively safeguarded against abuse, neglect and poor treatment. Over recent months there had been some increase in the awareness of safeguarding across the community. Some stakeholders agreed that front-line knowledge and action on safeguarding had improved over the previous six-month period however this was not the experience of all. As the council was aware, there was considerable work to do, at both strategic and operational levels to secure improved outcomes for people who use services and adults whose circumstances make them vulnerable.

There had been an established safeguarding board in Bedfordshire for a number of years and this was still in operation. However it was now supplemented by the recent creation of the Joint Strategic Bedfordshire and Luton Safeguarding Board. It was hoped that these arrangements would provide for more joint work with Luton on areas of commonality whilst allowing certain areas of work to maintain a local focus. The council needed to ensure that there was a mechanism in place to assess the effectiveness of these new arrangements as there were risks of duplication and that members may not be able to fully participate in the work of both boards. The Bedfordshire safeguarding board reported to the multi agency Adult Strategic Partnership, whose role it was to oversee the safeguarding vulnerable adults agenda, ensuring the board fulfils its terms of reference. The reporting arrangements for the new Bedfordshire and Luton safeguarding board were unclear.

The Safeguarding Annual Report 2007-08 had provided a general oversight on national and local developments and local achievements over the last twelve months. It did not provide a clear strategic and operational framework for safeguarding. It lacked any in-depth analysis of safeguarding activity such as trends in numbers of referrals and the impact of geography and demography on referral patterns. Therefore the impact and effectiveness of current arrangements on outcomes for people who use services had not been comprehensively assessed. Further analysis would have informed the targeting of support resources and identified priorities for the coming years work plan. The Annual Report had been submitted to the Health and Adult Social Care Overview and Scrutiny Committee. This had begun to raise some political awareness of adult safeguarding.

The council had a strong partnership with the police and the contribution of the Bedfordshire Police Adult Protection Team to the management of safeguarding was highly valued by practitioners. Case files demonstrated that the involvement of police in safeguarding work was commendable. Good partnership working was also evident within community safety at both strategic and operational level. The Community Safety Strategy and associated framework reflected some alignment to adult protection and

safeguarding vulnerable groups. Both documents were due to be reviewed using information from the Joint Strategic Needs Analysis (JSNA), which should inform strengthened approaches to ensure targeted safety of vulnerable people.

The council had recently enhanced resources within the Safeguarding Adults Team that had led to the creation of an additional post at senior practitioner level and dedicated administrative support. It was hoped that this would provide additional operational oversight and support, and enhance strategic and policy development. As these arrangements only came into place very recently it was too early to establish their effectiveness. The Adult Safeguarding Manager had good links with colleagues from other councils across the region.

In 2007-08 there had been a considerable variation in the reported number of referrals across care management teams, for example, there were high levels of referrals reported in learning disability and older people teams and low levels in physical disability and sensory impairment teams and from mental health. Whilst an assertion had been made that, in the main, this was due to threshold and data collection issues it was not clear if any detailed analysis and benchmarking activity had been carried out to confirm this. There was a low referral rate from people black and minority ethnic communities in comparison to the percentage population. The needs of people from black and minority ethnic communities had not received sufficient profile within safeguarding arrangements and potential links with hate crime and racist abuse could be developed further.

The council had delegated the management of safeguarding for people with mental health problems to Bedfordshire and Luton Health and Social Care Partnership Trust (BLPT). There was a review of the Section 75 Agreement planned in June 2008. There had been a low level of referrals from mental health. Whilst quarterly reporting requirements were in place in regards to safeguarding, these were mainly reliant upon the integrity of the IT system. There had been some challenges with data collation and that current reporting arrangements did not sufficiently capture the quality of frontline practice. These issues combined with confusion over contact and referral arrangements for people with mental health problems presented some key risks for the council that need to be addressed.

People who were funding their personal care and support arrangements received the same protection and support as other people in vulnerable circumstances. The council had taken some robust, proactive measures to safeguard people in a local, privately run healthcare service. The council reported that this had resulted in significant improvements to the quality of the service. At the last reported inspection of the service, the Healthcare Commission, who regulates the service, had confirmed this.

1.2 Making sure that staff and managers know what to do

There were some mechanisms in place that ensured managers and staff knew how to respond to safeguarding referrals appropriately. The council

had recognised that up until very recently there had been uncertainty across stakeholders about what constituted a safeguarding referral. The council had recently introduced a new protocol. The previous safeguarding protocol had failed to provide clear guidance on referral thresholds. This had resulted in some referrals being made that could have been managed appropriately outside of safeguarding processes. Adult social care had provided additional capacity to care management teams in order to manage the extra workload that had occurred as a result of this. Staff reported that the new protocol did provide greater clarity for when a safeguarding referral was required and this would be supported further in the future when the new toolkit for staff was introduced. Some independent and voluntary sector providers were unaware of the new protocol. The council had a rolling programme of briefings arranged to address this.

Priority was given to safeguarding referrals and response was beginning to become increasingly prompt. When concerns were raised most staff were aware of the need to secure people's safety and some did so appropriately. Staff were becoming increasingly confident in the management of safeguarding cases. The council had recently introduced a single point of access except for referrals from people with mental health problems. Whilst BLPT had agreed to this arrangement, it had not yet been put into operation. Any contacts relating to people with mental health problems were redirected to the local Trust. This was a point of confusion for people who use services and practitioners alike. The level of awareness of the new contact arrangements was low amongst the people we met.

The quality of safeguarding practice and management was variable. In case files seen during the inspection completion of notification forms (AP1) and management decision forms (AP2) was good. There was commitment to attend strategy meetings by the majority of stakeholders and records of meetings were found to be comprehensive. Compliance with timescales, as set out in the safeguarding procedures, was problematic. At times it was not clear from case files why they were not being met and risk was not re-evaluated as a result of this. It was not always clear when safeguarding cases had been closed and that all appropriate agencies had been notified. No stand-alone protection plans were seen and where care plans had been amended or developed from the outcome of the strategy meeting, these lacked detail and had not been holistic or outcome focussed.

The completion of 'risk evaluation' was of variable quality and appropriate contingency plans were not always recorded. Some staff acknowledged that their confidence and competence in risk assessment was not fully secure. The council did provide dedicated risk assessment training for its staff and over the last 12 months, 40 council employees had completed this training. Further training was planned for the coming year. The council recognised that the outcomes of comprehensive risk assessment must underpin all care management arrangements and its importance for people using self-directed care when balancing people's rights to choice against the recognition and management of risk. However as this was not always achieved people's safety could be compromised. The direct

payment policy did not give sufficient emphasis to securing safe arrangements for people and should be reviewed in light of this.

Often the on-going involvement of the alleged victim in the safeguarding process was not evident in the case files seen. On going communications with people who use services, carers, advocates and providers of services was not always recorded. In particular providers and advocates were often not updated on the progress of investigations or when a case had been closed. Staff and providers reported that access to advocacy services was good. Evidence of the use of advocacy in some cases was not always obvious. Advocacy was not being commissioned to provide post-investigation support. There was more work to do to ensure that information about advocacy was readily available and that it was accessible for all people using services. There were effective Independent Mental Capacity Act (IMCA) arrangements in place.

Social care staff reported that in supervision managers monitored safeguarding practice; additionally managers were regularly available for support outside of this process. Staff valued the support and advice provided by the Adults Safeguarding Manager. There were plans in place for a network of safeguarding champions across teams that would provide additional support to practice. This role was not yet aligned to a set of specific competencies that would ensure that champions had the necessary knowledge and skills base.

There was an established programme of training, aligned to the old protocol and a programme for the new protocol was being developed. Staff stated that training was accessible, relevant, and met their needs. In 2007-08, 335 training days had been completed involving 191 staff from the council. Not all aspects of the training were run on a multi agency basis as only 'Achieving Best Evidence' was run jointly with the police. There was a low level of take up of council led training by independent and third sector agencies who reported that their awareness of and access to training was limited. Elected members had not undertaken safeguarding training.

1.3 Making sure that there are services to help prevent abuse and neglect

There was a growing focus on strengthening prevention in community services that safeguarded people in potentially vulnerable situations. Staff had access to a range of preventative services that supported safeguarding arrangements and home security. Staff also had access to support for people who did not meet Fair Access to Care Services (FACS) criteria, which were contributing to the management of low-level risk. Awareness of staff of these services was good. There was a programme of support for people with learning disabilities with a strong focus on anti-bullying. Plans were in place to enhance this further with the development of a tool-kit for people with learning disabilities that focused on personal safety. There was a need to ensure people with learning disabilities had better access to support in the area of personal and sexual relationships, the current guidance for staff was under review. There were some commendable initiatives in place in support of people's

security in the community. These included the 'Bobby Van Scheme', which undertakes crime reduction home improvements for people in vulnerable situations. The council also employed its own special constables whose work focused on preventing and responding to distraction burglaries.

Preventative practice needed further development in the area of support to carers both as alleged victims and perpetrators. Most carers we met had very limited awareness of safeguarding and the services that maybe available to support them. Carers also reported shortages in the availability and range of respite care provision.

There was more work to do to promote public awareness of adult safeguarding and guidance on how to report concerns. The council's website now provided a good range of information on safeguarding but not in accessible format. New safeguarding leaflets had recently been introduced. Despite the council consulting with people who use services in the development of the leaflet, people spoken to during the inspection found them to be confusing and unclear in their messages. Availability of the leaflets across the county was variable. Easy read leaflets were in the process of being developed. There was an early sign that these new initiatives were raising awareness, as the council reported an increase in the number of self-referrals in April 2008. The development of a communication strategy to support a more co-ordinated approach to the launch of the new protocol, the distribution of the leaflets and the introduction of the single point of access may help to sustain and further build on this. Further consideration needs to be given to accessibility of the wider public information around safeguarding such as advocacy, IMCA, Guide to Care Programme Approach, and bogus calling as this was found to be limited.

1.4 Making sure that quality assurance processes are in place and working effectively

The council acknowledged that the current data collection and quality assurance processes were in need of development. It recognised the need to further expand the IT system so that it supplied more specific data on safeguarding activity. This would provide for a higher degree of scrutiny by managers and inform service development and improvement. A new bespoke safeguarding system had been created and was due to be implemented shortly, which it was hoped would address these issues. The new system is aligned to the new toolkit for staff.

The council had strengthened its arrangements for the quality assurance of independent and voluntary providers but recognised that there was still scope to develop a more equitable and systematic approach. The same strengthened approaches were not always applied to the council's own provision, in particular unregulated services such as the day service visited. Here, the awareness of safeguarding issues, including respect and dignity, was low. The revised Quality Assurance Strategy provided a strong framework for work with independent providers. The council was in the process of introducing new contracts that sharpened the focus on outcomes and strengthened approaches to safeguarding arrangements.

Safeguarding was integrated into the contract monitoring processes. The council had taken a robust approach to managing the poor performance of independent providers that had resulted in an impressive reduction in the number of these services. Some providers did not always experience these arrangements as consistent, fair or transparent and a more developmental rather than problem centred approach would be valued. There were well-established provider forums in place that were appreciated by the providers who attended.

Quality assurance of care management processes did not have a framework in place and was based on measures such as supervision, random case file audits and the reporting of some performance data. It was recognised that these measures did not provide sufficient evidence on outcomes for people who use services. The current measures were soon to be enhanced by the introduction of the new safeguarding component of the IT system, an audit sub group of the safeguarding board and a Quality Assurance and Safeguarding Steering Group.

1.5.1 Making sure that POVA arrangements are robust and work well

The Bedfordshire Adult Safeguarding Board, now chaired by the Assistant Director of Adult Services, had not provided clear strategic leadership to safeguarding activity across the council and the wider community. Historically chairmanship of the board had been inconsistent and the lack of continuity of leadership may have hampered its development as an effective strategic body. The safeguarding board had secured membership from the majority of key partners and stakeholders. The seniority of some representatives did not necessarily reflect the decision-making responsibilities that would be required to take forward the work of the board on behalf of other agencies. This could create delays to the progress of improvement and developmental work.

There was still work to do to secure representation from people who use services and their carers to ensure that their views were captured within the work of the board. The board also needed to ensure that membership was representative of Bedfordshire's diverse communities. There were links between board representatives and other relevant groups such as Multi Agency Public Protection Panel, Domestic Violence and the Children's Safeguarding Board. It had recognised that it needed to strengthen links with the Crown Prosecution Service.

The board had a significant development agenda. A work plan for 2008-09 had been devised. It had been recognised that this plan was in need of further development as it was not outcome focused, lacked detail, did not identify allocation of resources, and partner agency contributions had yet to be agreed. Despite the board being established for some time there were no subgroups in place. The creation of sub groups was critical to delivery of the work plan however this had not yet been discussed by the board, which could cause further delays to improvement activities.

1.6 Making sure that people's privacy and confidentiality are respected

The council had a range of measures in place that ensured people's privacy and confidentiality was assured. The new multi agency adult safeguarding protocol includes guidance on confidentiality. Case files did not always identify that consent had been obtained from the victim to initiate a safeguarding referral. However a new consent form had been developed as part of new protocol that was specific to safeguarding activity. There were a number of multi agency information sharing protocols in place to support safeguarding procedures. The sharing of information was also included in the new safeguarding leaflets.

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2. Capacity to Improve

2.1 Leadership

Leadership of safeguarding across the county had recently been strengthened. This had begun to enhance the priority given to people's safety and increase awareness of safeguarding across the community. However there was a need for a stronger, more structured strategic framework, which would ensure a consistent drive for improved outcomes. The council reported that strategically safeguarding was being driven by the multi agency Adult Strategic Partnership. However the safeguarding board had a critical role in providing sustained strategic leadership to ensure there was a whole system approach to safeguarding but this was not being achieved.

There was an evolving vision for safeguarding that would promote a more preventative and personalised approach to keeping people safe. Understanding of this vision was variable amongst staff, and was not obvious to some stakeholders. The vision was not underpinned by comprehensive, co-ordinated and deliverable multi agency plans. There was increasing political awareness and support for safeguarding. Elected members were beginning to recognise their responsibilities in regards to safeguarding and had begun to challenge officers to provide more detailed performance information. Members would further benefit from more systematic reporting of relevant national information on safeguarding and the provision of safeguarding training.

There had been a recent record of improvement in adult social care, however this was not fully reflected across safeguarding. Over the last year the council had recognised that it needed to take significant steps to improve safeguarding arrangements. Whilst it had begun to implement some of this improvement work, the impact of this on the experiences of people who use services was limited. There was a lack of strategic and targeted operational plans for this improvement work. There remained some areas for development that had not been fully addressed from the previous CSCI inspection of learning disabilities services in 2005, which related to safeguarding, in particular performance management and

quality assurance, accessibility of information and the needs of people from BME communities. However progress had been made on the recommendation from the inspection in regards to anti-bullying. It was imperative that the approaching creation of two unitary authorities in April 2009 did not create a hiatus to improvement work. The council needed to actively manage this risk to ensure people are kept safe during the transition. Community Services had taken some early steps in response to 'Putting People First'. Resources from the Transformational Grant had been allocated to safeguarding through enhancement of the current contract monitoring processes.

The work of the safeguarding board did not interface with the development of local service strategies, improvement priorities and service plans, including the Community Services Directorate Plan 2007-2009. This was creating a fragmented approach to safeguarding activity across service user groups. For example, some development work had been undertaken across learning disability services on personal safety yet this work had not been considered in other service areas or taken through the safeguarding board for wider multi agency consideration and dissemination. A number of service user and carer consultation groups were in place to ensure that the strategic development, planning and commissioning of safe services was informed by the experiences of people who use services and their carers. People who use services had been used to reshape the new contract that is currently being introduced. However it was less obvious how people who used services were involved specifically in the provision of safe services as the people and carers we met had little understanding of the concept of safeguarding.

Senior managers within Community Services were committed to keeping people safe and recognised the role they had to play in continuous improvement. Staff reported senior managers to be visible and supportive. Stability within the senior management team would be key during the transition to the new unitary authorities. The council and its partners had work to do to develop a joint workforce strategy that would underpin the creation of the new unitary authorities. It would also need to capture the emerging priorities; models of self directed care and the potential for future integration. Whilst the timing of this work maybe complex, opportunities should be recognised and acted upon.

A number of operational policies were found to be in need of review, improvement and updating to ensure they reflect safe practice. The council had a rolling programme of review in place. There was an inconsistent approach to the completion of equality impact assessments of new and reviewed policies.

The council had recognised the need to develop new ways to performance manage safeguarding activity more effectively. Safeguarding practice would benefit from a more systematic approach to target setting, with scrutiny of data being supported by clearer reporting expectations and arrangements. Some plans were in place to address this. The safeguarding board had not been using its performance management role to drive up improvements in safeguarding practice or to act as a vehicle to disseminate lessons learnt across all partner agencies.

2.2 Commissioning

The evolving vision for safeguarding was only just beginning to inform and shape more focused commissioning of safe services. Detailed analysis of need supporting the delivery of safe services was not sufficiently developed but it was planned that the Joint Strategic Needs Analysis would address this in the near future. Commissioning strategies made some reference to adult protection and community safety but this was limited and inconsistent across the different service user groups. Arrangements to support the commissioning of high quality services had resulted in considerable improvement in the performance of independent providers and the department was developing these processes further. There was evidence of commissioning and decommissioning of services to drive up the quality of services. In particular the work the council had undertaken some effective work in formal care settings where the number of poor services had reduced significantly from forty-six to seven in the last twelve months. Relationships with independent and voluntary sector providers were variable.

There were examples where preventative services were supporting the management of low-level risk for people. This work would benefit from a joint strategic framework so that more consistent outcomes could be efficiently achieved. Effective partnership working was evident in relation to the community safety partnership. As the Community Safety Unit was sited within the same directorate as adult social care, there were effective links that facilitated opportunities to promote a safe environment for people in vulnerable situations.

Relationships with Bedfordshire PCT were constructive. There was beginning to be a shared understanding of the priority given to safeguarding which was starting to inform opportunities for its integration into on going and future joint work. This was particularly relevant to joint commissioning opportunities, which were recognised as being underdeveloped. Whilst strategic relationships with BLPT had become more secure, operationally there was still more work to do to ensure people were effectively safeguarded. In response to the concerns within regulated services a range of both strategic and operational actions had been taken to strengthen safeguarding within BLPT and a more structured professional infrastructure was now in place. There was a need for the council to ensure that governance and reporting arrangements are sufficiently robust and that they capture the quality of safeguarding across mental health services.

APPENDIX 1 INSPECTION THEMES AND DESCRIPTORS

INSPECTION THEME 1 (Core Theme) People Are Safeguarded	
1.1	Adults who are vulnerable are safeguarded against abuse.
1.2	Workers are competent in identifying situations where adults who are at risk may be abused and know how to respond to any concerns. The council makes sure that all managers are aware of how to manage safeguarding issues.
1.3	Workers are aware of and routinely use a range of preventative support services and this has led to an increase in the reporting of incidents of abuse. There is satisfactory closure in all cases.
1.4	Robust quality assurance processes are in place and working effectively.
1.5	Adult Protection Committees, or similar arrangements, are in place; they work effectively and accord to POVA requirements.
1.6	People who use social care services are assured of privacy and confidentiality through the consistent application of appropriate policies and procedures.

Leadership	
8.1	Highly competent, ambitious and determined **leadership skills** of senior officers in the council champion the needs of all people who use adult social care and their carers, to ensure that [the selected themes[1]]. Senior officers make sure there is **effective staff contribution**, both within the organisation and across partnerships, to planning and delivery of key priorities and to meeting suitably ambitious outcomes in the selected themes.
8.2	**Plans** to ensure the delivery of the selected themes **are comprehensive** and linked strategically and address key developmental areas. They identify **national and local priorities** for the selected themes[2]. Realistic **targets** are being set and are being met. Coordinated working arrangements across the council and with external partnerships are reflected in **strategic planning** to ensure delivery of the selected themes. There is evidence that this working has resulted in improvements in the selected themes.
8.3	There are the **people, skills and capability** in place at all levels to deliver **service priorities** and to maintain high **quality services** to ensure the good outcomes in the selected themes.
8.4	**Performance Management, quality assurance**, and scrutiny arrangements are in place and effective to ensure that good outcomes in the selected themes: performance improvement can be demonstrably linked to management action.

Commissioning and Use of Resources	
9.1	The council, working jointly with relevant partners, has a detailed **analysis of need** for the selected themes with comprehensive gap analysis and **strategic commissioning plan** that links investment to activity over time. Expenditure on relevant services reflects national and local priorities and is fairly allocated to meet the needs.
9.2	The council secures services relating to the selected themes at a **justifiable cost**, having identified the range of options available and made comparisons in terms of quality and cost with other areas and nationally. There are robust **financial management planning and reporting systems** in the services delivering the selected themes.

[1] People are safeguarded / people receive personalised services / people have access to preventative services.
[2] Safeguarding Adults / Delivering personalised services / Prevention

9.3	The council makes sure that all people who use services, carers groups and staff groups relevant to the selected themes are integral to the commissioning process through **consultation, design and evaluation of service provision**. There is evidence that the council has information about costs in relation to quality and these are used in strategic and service planning and in commissioning to improve the economy, efficiency and effectiveness of the selected themes.
9.4	The council has a clear **understanding of the local social care market** relating to the selected themes and there are innovative measures taken jointly with providers to meet the needs of both publicly funded and self-funded individuals. Optimum use is made of **joint commissioning and partnership working** to improve the economy, efficiency and effectiveness of the selected themes. Informed choices are made about the balance of cost and quality in commissioning and de-commissioning services.

APPENDIX 2 METHODOLOGY

This inspection was one of a number inspections carried out by the Commission for Social Care Inspection (CSCI) in 2007- 08 under the Independence, Wellbeing and Choice agenda[3]. The aim of this inspection was to evaluate how well Bedfordshire safeguarded adults.

The inspection had a particular emphasis on improving outcomes for people. The views and experiences of adults in need of community social care services were at the core of this inspection.

An inspection design team created the inspection methodology. The Themes and Descriptors (see Appendix 1) were developed from the CSCI's Outcomes and Descriptors[4].

The inspection team consisted of two inspectors from CSCI and two 'experts by experience'. At the beginning of the inspection process, we invited the council to provide evidence, supplementary to that provided in their annual self-assessment survey, related to the focus of the inspection. Before the fieldwork, we reviewed all available evidence on the performance of the council. We also wrote to other agencies for their views about the council in relation to the focus of the inspection.

The fieldwork consisted of four days 'on site' in the council community. During the fieldwork, we met a wide range of people with knowledge and experience of the services provided and commissioned by the council, including:

- people who had experience of receiving services
- organisations which advocate or represent people who use services and carers' interests
- council staff
- key staff in other parts of the council and partner organisations

[3] Department of Health 'Independence, well-being and choice' (2005) and subsequent White Paper 'Our health, our care, our say' (2006).
[4] CSCI 'Outcomes Framework for Performance Assessment of Adult Social Care' 2006-07