Bury Safeguarding Adults Board

Annual Report

2022 – 2023

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Document Owner: Bury Safeguarding Adults Board

Contents

Foreword from the Bury Safeguarding Adults Board Independent Chair

I was delighted to have been appointed as the Independent Chair and Scrutineer for the Bury Safeguarding Partnership in September 2022.

As the Independent Chair, I chair the Bury Safeguarding Adults Board (BSAB) and I have been closely involved in the establishment of the new governance arrangements during 2022/2023 including the subgroups within the BSAB.

I also provide scrutiny and advice in respect of safeguarding adults reviews, together with supporting strategy and policy development.

Safeguarding adults does not begin and end at the start and finish of financial years and whilst the report covers the reporting period of 1 March 2022 up to 31 March 2203, the report recognises some of the work beyond this period which had already started, and which continued into the next reporting year.

I would like to give my personal thanks to practitioners and managers across all agencies who are working so hard to make a difference to safeguarding adults in Bury.

Maxine Lomax
Independent Chair

Introduction

What is adult safeguarding?

The Care Act 2014 statutory guidance describes adult safeguarding as:

“Protecting an adult’s right to live in safety, free from abuse and neglect. It is about 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 the adult’s wellbeing is promoted including where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.”

Who does safeguarding apply to?

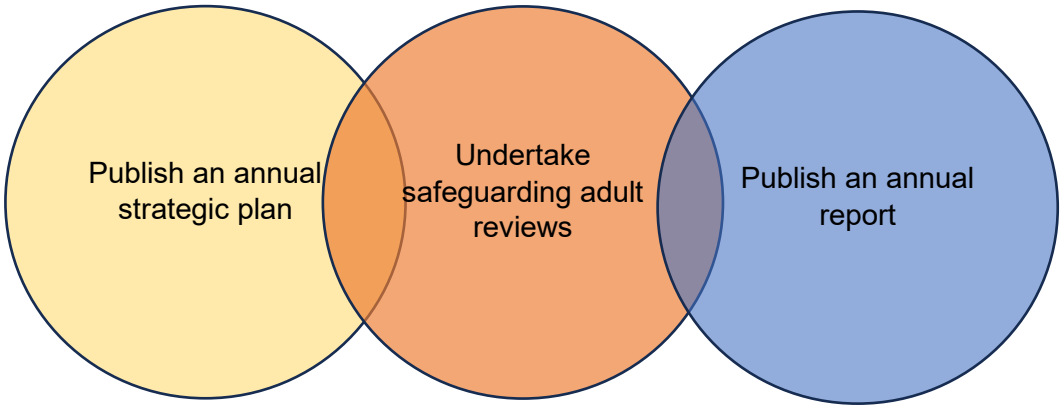
Safeguarding is everyone's responsibility, and the Board has a role to play in assuring our community that ‘adults at risk’ are safeguarded from abuse or neglect. An adult at risk can be anyone aged 18 or over who:

- Has care and support needs (even if no agency is involved in meeting those needs) and;
- Is experiencing, or at risk of, abuse or neglect; and/ or
- As a result of those care and support needs, is unable to protect themselves from either the risk of, or the experiences of abuse or neglect.

Background

The Care Act 2014 requires Safeguarding Adults Boards to ensure that vulnerable adults are safe, and that agencies work together to promote their welfare. The Act sets out a legal framework for how local authorities and other organisations should protect adults at risk of abuse or neglect.

The board has three core duties:



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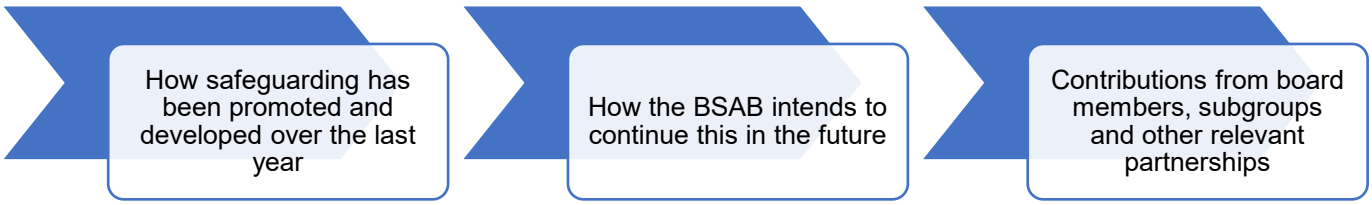


Safeguarding adults' performance data 2022-2023

This section presents data and information for 2022-23 in relation to safeguarding adults. It gives an overview of the number of safeguarding concerns that have been received, and the number and type of enquiries (investigations) that have been concluded. The council in its lead role for safeguarding has an overview of all safeguarding concerns received within the borough. As such, data from the council's case management system has been used to inform this section.

2021/2022	2022/2023	
1712	1862	Individuals involved in safeguarding concerns
721	735	Individuals involved in Section 42 Enquiry[1]
88	28*	Individuals involved in other safeguarding enquiry
168	161	Number of individuals involved with more than one Section 42 enquiry
8	9	Number of safeguarding adult reviews

[1] Definition of Section 42 Enquiry in the Care Act 2014

*Reduced this year due to data cleansing in the adult social care system

Vision of the Bury Safeguarding Adults Board

We will all work together to enable people in Bury to live a life free from fear, harm and abuse.

Outcomes

- Confidence in multi-agency safeguarding responses, with people being safeguarded from abuse and neglect.
- Our partners work within a framework of policies and procedures that keep people safe.
- Confidence that services are learning and improving in their safeguarding practice and adult safeguarding risk is better understood by the SAB and appropriately assessed by partners.
- Adults at risk are identified early and have their needs met promptly and effectively.
- Individuals feel empowered and for their voices to be heard in safeguarding practice and policy development.
- Individuals are supported by a skilled and competent workforce.

Priorities

The priorities and the strategic plan for 2022-24 are the key delivery mechanisms for the Bury Safeguarding Adult Board in achieving its aims. This is the first Business Plan for our newly reformed multi-agency safeguarding board, and specifically focusses on a few key areas of work where the BSAB feel they can make the most difference. The priorities identified are based on concerns and issues facing at risk adults in Bury, their families and our practitioners, and are backed up by evidence from data, auditing and inspection, and themes identified in our local Safeguarding Adult Reviews.

The priorities for 2022-2024, were agreed by the BASB, and were as follows:

Strategic Aim 1: **SAB Priority**:	**Accountability, Assurance & Leadership** Ensure the BSAB provides strategic leadership to embed the principles of safeguarding across agencies and contribute to the prevention of abuse and neglect.
Strategic Aim 2: **SAB Priority**:	**Policies, Strategies & Procedures** To be assured that multi-agency safeguarding strategies, policies and procedures are regularly reviewed to ensure currency, reflecting emerging legislation, policy and/or learning, and that these are easily accessible to frontline staff and used effectively.
Strategic Aim 3: **SAB Priority**:	**Learning from SAR's – Performance, Quality and Audit** Assure learning from SAR's is effectively distributed and embedded into practice across agencies, implement quality assurance mechanisms, and refocus safeguarding data to define SAB priority areas.
Strategic Aim 4: **SAB Priority**:	**Prevention & Early Intervention** Ensure the SAB has a focus on prevention that clearly identifies how it will aim to reduce incidence of abuse and neglect (including self-neglect) in Bury.
Strategic Aim 5: **SAB Priority**:	**Making Safeguarding Personal** To ensure the work of the SAB and safeguarding responses are person centered.
Strategic Aim 6: **SAB Priority**:	**Learning and Development** Ensure the workforce is equipped to support adults appropriately where abuse including neglect is suspected.

Update on achievements

An important part of this report is to update you on what we said we would do and what we have achieved during the last 12 months.

Strategic objective one – accountability, assurance and leadership

We said we would:

- Ensure clear and transparent annual budget plans are in place for all BSAB activities.
- Develop the SAB and broader governance arrangements.
- Escalate and influence commissioning arrangements for the borough, considering the ICB development, key transformation programs and commissioning plans.
- Provide regular briefings for partnership boards (Health and Wellbeing Board, Community Safety Partnership Board) on the progress of the SAB.
- Continually strive to develop arrangements to be responsive and adapt to emerging safeguarding themes, based on available performance data.

What we have done

Budget and Resources

Each of the statutory partners, and some relevant agencies contribute to the Bury Safeguarding Adults Board budget, and all partners offer their time and expertise to the activities of the Partnership. These activities include participating in meetings, safeguarding adults reviews, delivering training and ensuring the roll out of key learning and messages. The commitment, contribution and engagement of partners in supporting adult safeguarding in Bury is acknowledged and valued.

A summary of financial contributions is included in Table 1.

Partner	Contribution
Bury Council Adult Social Care	£70,000 Plus £56,700 from corporate Council funding for SAB and Bury Safeguarding Children Partnership
NHS Greater Manchester Integrated Care (Bury locality)	£44,080 – single contribution for SAB and Bury Safeguarding Children Partnership
Greater Manchester Police	£23,700 - single contribution for SAB and Bury Safeguarding Children Partnership
Housing	£5000 - single contribution for SAB and Bury Safeguarding Children Partnership

Table 1: Financial contributions 2022/2023

Effective Arrangements

At the beginning of the reporting year, the Bury Integrated Safeguarding Partnership was a joint safeguarding partnership, with adults and children's. In September 2022, it was recognised that there needed to be greater focus on both children and adults safeguarding individually, and the Executive agreed to separate the governance. The impact of this has meant there has been an increased focus for the SAB on discussions centred on safeguarding issues relating to adults and greater emphasis on priorities for adults. However, we maintained a partnership focus in respect of young adults transitioning from childrens social care, by having a joint Complex Safeguarding Subgroup.

The successful functioning of Bury Safeguarding Adults Board (BSAB) would not be possible without the commitment and involvement of our partner agencies.

The BSAB aims to strengthen relationships to ensure we are working together as efficiently as possible. The transparency and the sharing of information by our partners is integral to this approach. Figure 1 shows the governance of the SAB.

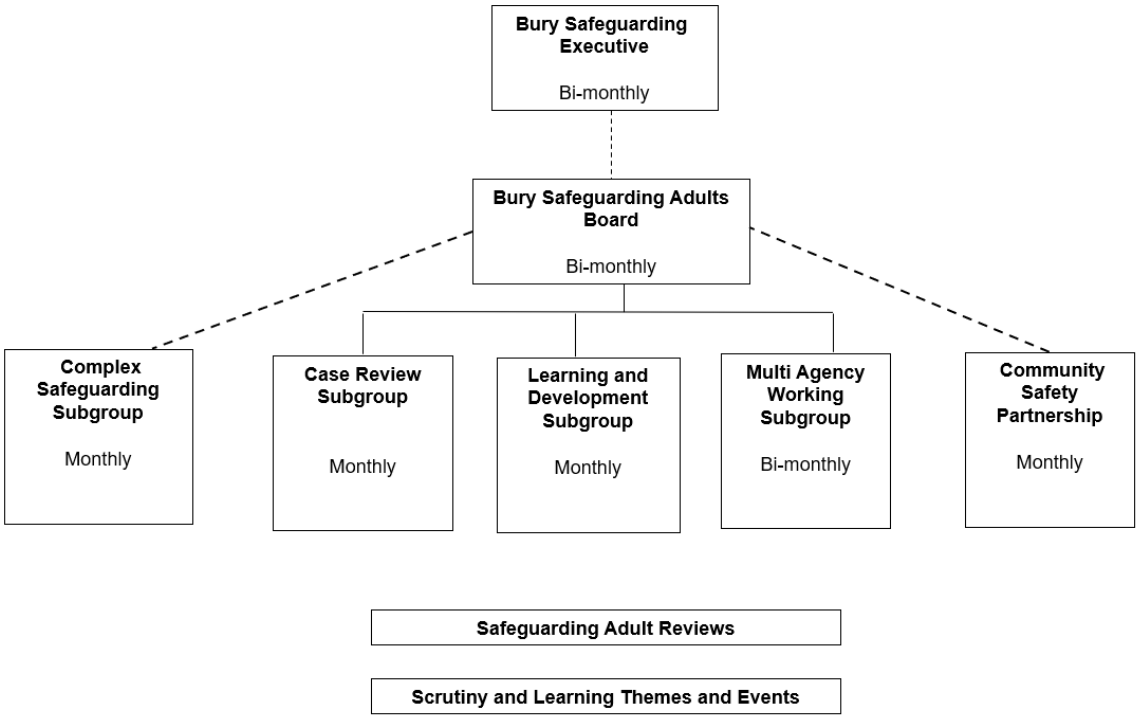


Figure 1: How the BSAB is organised

During the reporting period, the SAB has built stronger links with partnerships. Reciprocal reporting arrangements and attendance at Community Safety Partnership meetings are in place, so that there is an opportunity for joint responses to safeguarding matters. An example of this approach is the pre-emptive checks and procedures in place for large scale police-led multi agency community safety operations, such as Operation Avro in May 2022 to ensure known safeguarding issues built into planning and sufficient capacity to respond to safeguarding concerns resulting for enforcement activity. The SAB also has a rhythm of reporting on its progress to the Health and Wellbeing Board, submitting its annual report for consideration.

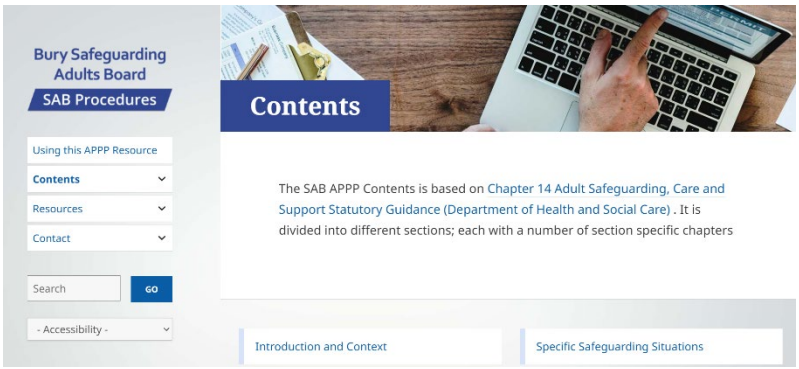
Strategic objective two – policies, strategies and procedures

We said we would:

- Ensure the publication of the SAB strategy and review every 12 months.
- Launch a suite of Safeguarding Policies and Procedures to support frontline practitioners.
- Develop arrangements to manage allegations against People in a Position of Trust (PIPOT)
- Review the Safeguarding Adults Review (SAR) protocol.
- Ensure the publication of the SAB annual report.

What we have done

An operational delivery plan underpins the SAB's strategic priorities and is driven by the Multi Agency Working Group. A range of inter-agency policies and procedures have been developed, with a dedicated website launched to support frontline practitioners.



An updated referral form and screening process are in place to strengthen Safeguarding Adult Reviews. This is to ensure that the referrer is prompted to provide as much information as possible to support the screening panel in making a decision on whether they consider that the criteria for a SAR are met. These will be kept under review and adapted in line with any national, regional or local guidance.

A thematics tracker has also been developed in the reporting period to support learning and development activity.

A dedicated case review officer was appointed to support the SAB in the undertaking of safeguarding adults reviews (SARs), as there continued to be a consistent level of the number of SARs in comparison to the 2021-2022 reporting period.

The BSAB has also reviewed how it undertakes SARs, and training has been delivered by SCIE on undertaking SARs in rapid time. This model will be piloted in the next reporting year. The challenge of capacity across the SAB continues in terms of authoring of SARs, and external commissioners are utilised.

The BSAB continues to be guided by the North West Policy for managing concerns around people in positions of trust with adults who have care and support needs. Local guidance will be developed during 2023/2024 to provide clarity on the management of risk so that actions are transparent and consistent.

A large-scale organisational safeguarding was raised after an investigative programme into the care and treatment of patients within a hospital setting in our area. Agencies have worked collaboratively together to identify and respond to allegations of abuse and protect patients, whilst also reviewing and improving systems to ensure services are safe. All statutory duties were carried out and continue with thanks to mutual aid from regional partners.

Strategic objective three – learning from safeguarding adult reviews – performance, quality and audit

We said we would:

- Complete SAR processes, including publication of review and development of SAR action plan.
- Ensure the SAB has robust multi-agency safeguarding performance data.
- Assure a culture of openness and transparency is adopted for learning and recognising success.
- Develop a quality assurance framework which will robustly evaluate quality assurance process.
- Conduct multi-agency quality assurance audits, with the aim to providing an analytical overview of safeguarding across individual agencies and as a partnership.

What we have done

A review of the SAR processes commenced in quarter 4 and continued into the next reporting period. In light of the changes to the referral form, where more information was now available to inform the decision on whether to proceed with a SAR, screening panel arrangements were also updated with changes to membership to include the Local Authority Director of Adults Social Services and the NHS Greater Manchester Integrated Care Board's Associate Director for Nursing, Quality and Safeguarding.

To strengthen action planning, a new action plan framework was introduced, including the involvement of the learning and development subgroup, so that the learning from the SARs forms part of the programme of learning for the SAB.

In 2023/2024 we will develop our arrangements for robust multi-agency safeguarding performance data, and we will introduce a scrutiny process, as part of our assurance framework, so that there is an ongoing culture of openness and transparency for learning.

Strategic objective four – prevention and early intervention

We said we would

- Improve the website for the Partnership and review annually.
- Seek assurance regarding the quality-of-care provision within Bury and develop a mechanism where system assurance can be gained.

What we have done

Prevention and early intervention is a core strand of all work of the BSAB including a focus on multi-agency training and workforce development to enable people to recognise various forms of abuse and know what action to take.

A new website has been launched, making information more accessible and user friendly. As with any new website, we are continuing to add content so that it is kept up to date.

The Multi Agency Risk Management (MARM) framework has been reviewed, to support anyone working with an adult where there is a high level of risk and the circumstances sit outside the statutory adult safeguarding framework, but where a multi-agency approach would be beneficial. In the next reporting period, the MARM framework will be agreed, to enable a proactive approach which helps to identify and respond to risks before crisis point is reached

Strategic objective five – making safeguarding personal

We said we would:

- Quality assure activity to gauge whether safeguarding practice is person-centred and outcome-focused.

What we have done

The Care Act says that adult safeguarding is about protecting individuals, but people are all different. So, when we are worried about the safety of a person, we should talk to them to find out their views and wishes. Then we should respond to their situation in a way that involves the individual as much as possible, enabling them to have choice and control over what happens in their life, so they can achieve an improved quality of life, wellbeing, and safety. This is referred to as Making Safeguarding Personal (MSP).

The BSAB continues to be committed in ensuring the adult is central to everything we do, and the voice of the adult is always considered. Work started on strengthening the public facing page of the BSAB website to ensure adults with lived experience have accessible information to be able to provide feedback. It has been recognised that getting feedback from people with lived experience has been a challenge. The BSAB, when working with

individuals or families through the SAR process, ensures that the voice of those with lived experience is taken into account by working with them to understand how safeguarding practices have affected the person at the subject of the SAR, and that their experiences shape the report and any recommendations to improve practice. It is really positive that families have chosen to engage in the SAR and share their experiences and voice of the family. During the reporting year, there was only one family that chose not to engage. During 2023/2024 BSAB will explore the range of ways that people and carers can give feedback so we can understand their experiences of safeguarding processes and use this to improve our practice.

Strategic objective six – learning and development

We said we would:

- Develop a training strategy which includes mechanisms to review the impact and effectiveness of training.
- Explore opportunities for multi-agency training delivery, across statutory and voluntary sector services.
- Gain assurance from individual agencies regarding internal training opportunities.

What we have done

Implementing the Learning

The Learning and Development Subgroup reviewed the themes from the learning from SARs to inform the training strategy. It was agreed that a learning day was required to disseminate the learning in an effective and efficient manner from previous SARs. The agreed themes were:

Theme	**Found in SAR**
Eating Disorders	K21, O22, H23
Confident Decision Making / Professional Curiosity	I21, M21, N21,O21,C22, N22
Mental Health	I21, M21, N21, N22, M22
Mental Capacity Act	I21, M21, N21, O21, C22, O22, C23, E23, H23

Assurance was provided by SAB partners in relation to single agency training and partners have offered a range of training to the workforce including:

- Primary Care including Safeguarding Leads – Prevent, Mental Capacity Act (including GP trainees), Level 3 Think Family.
- Local Authority specialist Section 42 enquiry training.
- Safeguarding training for Elected Members.
- Local Authority preparedness for the introduction of Liberty Protection Safeguarding.

- Managing Allegations Against People in Positions of Trust.
- Community Safety Partnership training on domestic abuse.

Work will commence in the next reporting period to develop the training strategy, with increased focus on impact and effectiveness of training.

Safeguarding Adult Reviews

The purpose of a SAR is not to hold any individual or organisation to account but to learn lessons when an adult in its area dies as a result of abuse or neglect, whether known or suspected; and

• There is concern that partner agencies could have worked more effectively to protect the adult.

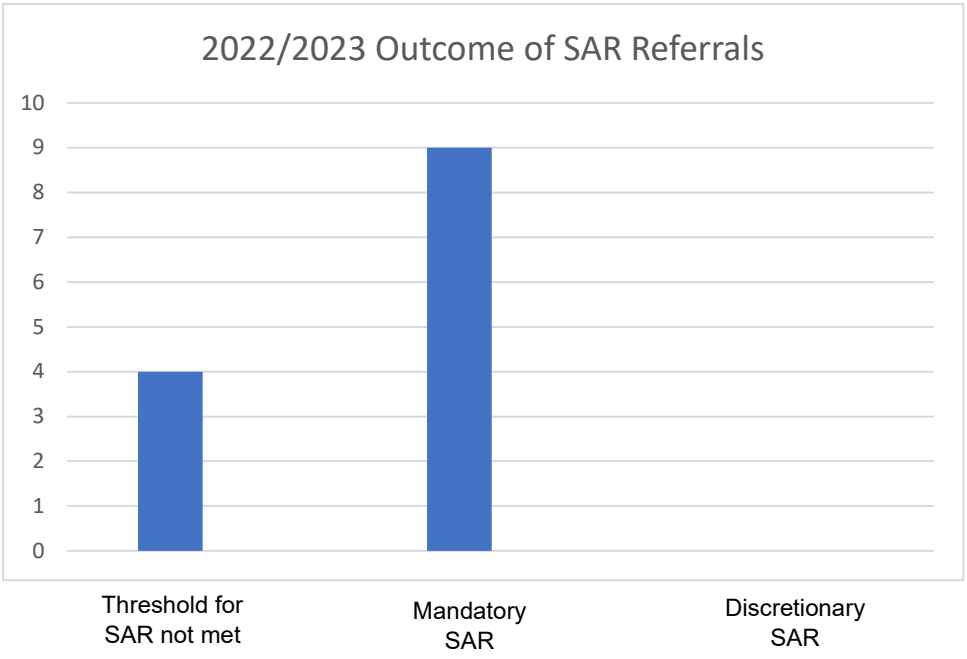
OR

• An adult in its area has not died, but the SAB know or suspects that the adult has experienced serious abuse or neglect.

Referrals for Safeguarding Adult Reviews (SARs)

During the reporting year 2022/2023, the Safeguarding Adult Review Panel continued to see regular referrals being made and had a similar number of referrals in comparison to the previous reporting year, which saw a total of 16 referrals (of which there were 7 mandatory SARs, 1 discretionary SAR, and 7 did not meet threshold for SAR).

In 2022-23, there was a total of 13 SAR referrals and the below graph shows 9 of those were mandatory SARs, and 4 did not meet threshold for SAR).



Mandatory SAR - A SAR must be commissioned if there is a statutory requirement to do so when all the criteria and conditions have been met.

Discretionary SAR - A discretionary SAR may be needed where part of the criteria/conditions have been met and the panel feel there is multi agency learning.

Current mandatory SARs

SAR Robert (M22)

Robert was 60 years old when he died. He had a learning disability and a diagnosis of schizophrenia. He resided in a care home and was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation as he was assessed to lack mental capacity to make decisions about where he resided.

SAR Penelope (N22)

Penelope was a young person in her late teens when she died. She spent much of her teenage years in mental health settings and was in a care home leading up to the time of her death. Concerns were raised about Penelope's self-harm behaviours which had escalated both in frequency and seriousness.

SAR Lisa (O22) and **SAR Emily** (H23)

A desktop review commenced in relation to Lisa and Emily, both of whom were high risk due to their low BMI's, and neither had a diagnosed eating disorder.

SAR Linda (B23)

Linda was 68 years old when she died. Linda had a number of health conditions and was in receipt of a package of care in her own home and lived relatively independently until eight months prior to her death due to her deteriorating health.

Sar Ann (C23)

Ann was 66 years old when she died of hypothermia and pneumonia. She had a long history of contact with various public services, but most specifically Substance Misuse and Mental Health Services. Ann struggled during the covid lockdown and there were concerns for her welfare.

SAR Stuart (E23)

Stuart was 54 years old at the time of his death from respiratory failure in 2022. He had long term mental illness and had been hospitalised for long periods of time throughout his life. He also had several long-term physical health conditions.

SAR Ruby F23

A joint review with Wigan Safeguarding Adults Board commenced in relation to Ruby, following her death in 2022. Ruby had an extensive history of trauma throughout her childhood and early adult life. She was care experienced and had a history of poor mental health and substance misuse.

SAR Rebecca (I23)

Rebecca died in 2022. She had been looked after by the local authority as a young person. Her life experience as a young person and young adult included substance misuse, domestic abuse, mental and behavioural disorder, and suicidal ideation, diabetes, exploitation and cuckooing and self-neglect.

SARs completed during this reporting year

SAR Michael (I21 which includes linked SARs M21 and N21 thematics of neglect, mental capacity, challenge to engage, housing issues, substance misuse)

Michael died in 2021, his cause of death recorded by the coroner as 'misadventure to which a contributory factor was self-neglect'. Michael had made prior suicide attempts, including one where he sustained a brain injury, which left him suffering short term memory loss. Michael had complex needs related to the co-existence of substance misuse and poor mental health,

Review themes include:

- Neglect
- Substance misuse
- Mental health needs
- Challenge to engage the person with services
- Consideration of mental capacity
- Instability of accommodation
- Professional curiosity

SAR Walter (O21)

Walter was admitted to hospital following a suspected fall at home, and subsequently passed away. Walter sustained a brain injury at an early age and whilst he was able to communicate verbally, he would sometimes find it hard to communicate his wishes and feelings or respond to a situation quickly. Walter resided in a residential care home specialising in care services for people with learning disabilities and subsequently and had to be rehomed during the pandemic to a different care home due to increasing support needs.

Review themes include:

- Consideration of mental capacity.
- Neglect.
- Professional curiosity.
- Multi agency co-ordination of care.
- Communication with individuals who have speech and language difficulties.
- Person centred care

SAR Alice (C22)

Alice was 93 at the time of her death and had lived independently until approximately 2018 when she required help and support due to deteriorating physical health and a diagnosis of dementia in 2019. During the last two years of Alice's life, her 70-year-old son resided with her, and he was known to have care and support needs, and Alice was his carer over a long period of time.

Review themes include:

- Challenge to engage the person with services
- Neglect
- Consideration of mental capacity
- Timeliness and co-ordination of care and carers assessment
- Professional curiosity

Partner updates

All BSAB partner agencies were asked to provide assurance by way of a self-assessment of on key areas of safeguarding and this included provided a summary of the highlights/challenges for reporting year. A summary of the responses has been provided below.

Adult Social Care

- Significant development activity underway, including preparing for CQC assurance.
- Multi Agency Risk Management process for Adult Social Care has been reviewed.
- Safeguarding and the DoLS Teams have both been expanded.
- Multi agency response to the independent review in a hospital setting in our area – working together to identify and respond to allegations of abuse, and reviewing and improving systems to ensures patients are safe.
- Section 42 conversion rates are around 35%-40% evidencing effective screening arrangements.
- Safeguarding and DoLS audit processes in place and completed monthly.
- Elected Members' safeguarding training delivered.

NHS Greater Manchester Integrated Care Board (NHS GM ICB) (Bury Locality)

- Organisational transition from Bury Clinical Commissing Group to NHS GM ICB – ensured statutory responsibilites were met
- Multi agency response to the independent review in a hospital setting in our area – working together to identify and respond to allegations of abuse, and reviewing and improving systems to ensures patients are safe.
- Sought assurance from commissioned services with regards to their safeguarding activity.
- Delivered development sessions to safeguarding leads from each GP Practice.
- Case support and supervision to NHS provider safeguarding, practitioners in complex care team and primary care services.
- Delivered training to primary care regarding self-neglect and Mental Capacity Act identified through SARs.

Greater Manchester Police

- Implemented the Adult Safeguarding Unit to support domestic abuse performance and support to victims.
- Realigned the MASH to support Adult Safeguarding under the ASU. The work within the MASH ensures GMP has a dedicated response to safeguarding adults at risk at the earliest opportunity with appropriate referrals made to partners for effective intervention and support.
- MASH live audits at learning events following case reviews.
- Delivery of training in relation to domestica abuse to all staff within ASU/MASH.
- Supported the partnership in relation to the independent review of a hospital setting.

NHS Northern Care Alliance

- Successfully embedded a programme of Mental Capacity Act (2005) audit with quarterly reportable returns.
- All NCA Staff members inclusive of Fairfield General Hospital and Bury Community Services are fully compliant with Adult Safeguarding Level 3 training.
- The NCA have engaged and prepared for the introduction of the Liberty Protection Safeguards.
- The NCA encompass a Nursing Assessment Accreditation System (NAAS) inclusive of community services and theatres. The NAAS/CAAS/TAAS provides a programme of audit aligned with the CQC key lines of enquiry (KLOES), inclusive within the programme of audit are the safeguarding standards; providing further assurance that safeguarding measures are routinely audited across the NCA.
- The learning from SAR is a core agenda item held within the governance structure of the Safeguarding Steering Committee.
- NCA Adult Safeguarding Service in conjunction with Bury Care Org has a regular bimonthly safety summit meeting that encourages oversight and learning.

Pennine Care

- There has been an increase of 122% in consultations to its central safeguarding team
- Increased compliance with level 3 safeguarding adults training by 15% in Quarter 3 and 4.
- The safeguarding team have reviewed all level 3 training packages to include localised learning.
- Quarterly newsletter with varying themes for learning and monthly quality report including localised learning.
- Continue to audit learning and have completed Quality Walks into carers and dip samples on peer-on-peer abuse and victim blaming language.
- Celebrated adults safeguarding week with a series of lunch and learns.
- Reviewed safeguarding supervision arrangements and deliver a drop-in offer.

Six Town Housing

- Delivered training to students at Bury College covering domestic violence safeguarding and hoarding within homes.
- Eyes wide open training provided to all colleagues and partners on the learning of dangers around damp and mould. This included how to report concerns for safeguarding.
- Introduced Tenancy Support Strategy to ensure timely, targeted tenancy support is provided to supporting customers who need help or where risks have been identified. Supported 350 customers within their homes.
- Embedded learning from case review including supported with safe sleeping and trained the Tenancy Support team on Essential Parenting and implemented a risk assessment for those properties where the gas may be capped to review the risk of young families.
- Implemented and reviewed Hoarders policy and procedure to clearly identify the level of risk within the home and with customers ensuring a partnership approach to mitigate any risk.
- Delivered cost of living workshops within our communities and provided 121 support to families to assist with financial pressures and reduce cost of utilities and food.
- Provided training from Achieve this year to front line staff to understand the risk and impact substance misuse have on families and those adults who also suffer with mental health conditions.

Community Safety Partnership (CSP)

- Reciprocal highlight reporting arrangements with CSP and SAB progressing.
- Preparation for Serious Violence Duty including sourcing input into local Strategic Needs Assessment.
- Pre-emptive checks and procedures in place for large scale police-led multi agency community safety operations, such as Operation Avro in May 2022 to ensure known safeguarding issues built into planning and sufficient capacity to respond to safeguarding concerns resulting for enforcement activity.
- Review of Bury Prevent Steering Group and Channel Panel Terms of Reference and work through respective chairs to ensure full attendance of colleagues to mitigate the risk of exploitation in relation to radicalisation.
- Joint promotion of training opportunities across partnership colleagues, including as part of GM week of action on Safeguarding Against Hateful Extremism in September 2022; honour-based violence awareness; and neglect training.

GM Fire and Rescue Service

- All staff are trained to Level 1 which includes, how to identify safeguarding concerns, how to report and record.
- Promoted and developed the Home Fire Safety Assessment focusing on the most vulnerable individuals within the community.
- Prevention Team have supported support all safeguarding professionals' processes throughout Bury.
- Alerting appropriate support at earliest opportunity to the identified need of vulnerable persons.
- Training plans are in place for staff whose role involves more in-depth contact with children and/or adults at risk and training records are maintained and can be monitored/audited.