Gloucestershire Safeguarding Adults Board

Annual Report 2017/18

Contents

Foreword: Introduction from Chair

I am pleased to introduce the Gloucestershire Safeguarding Adults Board (GSAB) 2017/18 Annual Report, which contains details of how adult safeguarding has been promoted and developed in the past 12 months.

It has been a particularly busy year for the Board and its sub groups and I would like to extend my thanks for all the hard work and commitment shown by all Board and sub group members and our partners.

We are very fortunate in that we have had a Safeguarding Adults Board in Gloucestershire since 2009 (some 6 years before boards became statutory), which reflects the continued support, commitment and importance that Board partners and agencies in Gloucestershire place on adult safeguarding.

My role as the Independent Chair is to support, encourage and challenge partners and agencies in Gloucestershire to work collaboratively for the benefit of adults with care and support needs and bring about continuous improvement. It is also my responsibility to hold agencies to account, ensuring that individually, they do what they say they are going to do, and that collectively agencies are working together to address issues surrounding abuse and neglect.

The report provides an open and transparent comprehensive insight into the work of the Board over the past year which is the last year of our 3-year Strategic Plan 2015-18.

The past 12 months have been particularly challenging as we have seen an increase in referrals in respect of individuals who are engaging in risky behaviour who are deemed not to have care and support needs. Many of these individuals are known to have suffered adverse childhood experiences and pose a real challenge for agencies to engage with. It is imperative that we prioritise this group of individuals and develop a multi-agency response that is able to help and manage these individuals who are high risk to themselves.

Last year we took part in a thematic review of Safeguarding Adult Reviews across the South West region, in order to benchmark ourselves and establish best practice. We are using the findings from this review to ensure that we learn from Safeguarding Adult Reviews and other learning events. Furthermore, as a result of the Safeguarding Adult Reviews and learning events undertaken by the Board, we have been invited to participate in an academic study with the University of Sussex, in respect of how we embed the learning from reviews into front line practice, in order to minimise the risk of the circumstances occurring again.

This year has seen a number of key developments and improvements being put in place in order to enhance safeguarding or minimise the risk of harm to adults with care and support needs.

These include:

- Launch of our new Communications and Engagement Sub Group
- Launch of our Service User and Co-Production Sub Group
- Delivery our six Safeguarding Adults Roadshows – themed on "Finding the Balance" between meeting an individual's preferred safeguarding outcomes and balancing with any risks posed in meeting those needs
- Production of a new quarterly report, including tables, graphics and narrative, to improve performance data reporting
- 18,500 Gloucestershire staff and volunteers completed GSAB approved safeguarding training
- 'Four Questions' produced by the Fire Safety Development sub group. These questions have been adopted by the National Fire Chief's Council. Prompt cards have also been designed for staff going into people's homes

The role of the newly formed Service User Co-Production Sub Group is a key development. It will play a vital role for the board and its sub groups and is essential to ensure that the voice of individuals with care and support needs is heard, thereby directly contributing to continuous improvements in adult safeguarding in Gloucestershire.

It is our shared responsibility to safeguard adults at risk in Gloucestershire, which can only be achieved by collaboration, working together and understanding the challenging and dynamic environment that our partners face on a daily basis. Safeguarding adults is everyone's business.

We are about to finalise our new draft 3-year Strategic Plan 2018-21 on which we have been consulting widely for a number of months. Prevention is a major theme that the Board wishes to prioritise during the tenure of our new strategy in order to minimise the risk of individuals with care and support needs becoming a victim of abuse or neglect. Making Safeguarding Personal, in order to ensure that the wishes and views of service users is respected and are central to their experience of safeguarding, remains a further priority.

Finally, I am cognisant of the ever increasing demand on the members of the Board and I would like to acknowledge the hard work, commitment and dedication of all front line practitioners who work in the field of safeguarding adults with care and support needs, along with families, carers, the public, and the voluntary and community sector.

Paul Yeatman

Independent Chair
Gloucestershire Safeguarding Adults Board

Back to Contents

1. Vision

"Gloucestershire Safeguarding Adults Board seeks to empower and protect adults with care and support needs who are at risk of abuse and neglect, as defined in legislation and statutory guidance".

There continues to be an increasing focus on the profile of safeguarding adults work. It is clear from national developments that partnerships are a critical aspect in sustaining the impetus for improvement and hence the importance of pressing ahead with a local vision for Gloucestershire. Gloucestershire's Safeguarding Adults Board's (GSAB) Strategic Plan sits alongside a number of other key documents, enabling the Board to strategically review and plan work. Each provides direction and continuity to the strategic annual plan, ensuring that the achievements of the Board are built upon each year and actions are focused on the Board's overall priorities and objectives.

The priorities reflect the direction set out in current national drivers for change. For this reason the priorities are designed around the six key principles that underpin all adult safeguarding work (Care Act, 2014), as reflected in the Strategic Plan 2015/18.

To achieve this vision the Board will need to work throughout the partnership and with local communities to:-

- Prevent abuse and neglect from happening;
- Identify and report abuse and neglect;
- Respond to any abuse and neglect that is occurring;
- Support people who have suffered abuse or neglect to recover and to regain trust in those around them; and
- Raise awareness of safeguarding adults and the role everyone can play in responding to, and preventing, abuse and neglect.

GSAB Vision – sets out the overall vision of the Board and the outcomes it wants to achieve for adults at risk in Gloucestershire.
GSAB Priorities – establishes the strategic themes that need to be delivered to achieve the Board's vision; providing the overarching direction to inform subsequent years' strategic plans.
GSAB Strategic Plan – provides a detailed plan of specific key actions, supporting actions and timescales required to deliver the Board's vision and priorities.
GSAB Annual Report – reviews progress in relation to the actions laid out in the strategic plan.

The Gloucestershire Safeguarding Adults Board has worked to promote an understanding and taken action to demonstrate that "safeguarding is everybody's business". The development of this vision marks the commitment from partners to a shared aim of keeping adults safe and protected from abuse and neglect.

2. Key Achievements 2017-18 and Strategic Plan 2015-18

The Board's key achievements during the past year include:

- Holding six 'Finding the Balance' Roadshows, in four locations across Gloucestershire, with presentations on the Mental Capacity Act, the different types of Advocacy available in Gloucestershire and an interactive play by Dramatic Change, Inclusion Gloucestershire
- A Board Development Event for Board members covering the learning from Safeguarding Adults Reviews and the new draft Strategic Plan 2018-21
- Completion of a partner agency Safeguarding Adults at Risk Self Assessment Audit
- Production of a new quarterly report, including tables, graphics and narrative, to improve performance data reporting
- Publication of a Positions of Trust Framework and Elected Members' Induction Pack
- Launch of new Communication and Engagement sub group
- Launch of new Co-Production and Service User Engagement Group
- 'Four Questions' produced by the Fire Safety Development sub group. These questions have been adopted by the National Fire Chief's Council. Prompt cards have also been designed for staff going into people's homes.
- Completion and publication of the 'Danny' Safeguarding Adults Review (SAR)
- 18,500 Gloucestershire staff and volunteers completed GSAB approved safeguarding training
- Establishing stronger links with community groups in Gloucestershire
- Updated website – http://www.gloucestershire.gov.uk/gsab/

Strategic Plan 2015-18 – The high-level priorities set out in the Board's Strategic Plan are reflected across these 5 areas: (a copy of the Strategic Plan can be accessed via this link Strategic Plan which details the Board's objectives and how these have been met).

Priority - Empowerment
We will give individuals relevant and clear information about recognising abuse, how to report it and the choices available.

Priority - Protection and Prevention
We will support people to report signs of abuse and we will respond and take actions to reduce risk and prevent further abuse occurring.

Priority - Proportionality
We will make sure professionals work in the best interests of adults at risk and only get involved as much as needed.

Priority - Partnership
We will have effective multi agency partnership arrangements and information sharing agreements.

Priorities - Leadership, Accountability & Governance
We will ensure that the Board and all partners know what is expected of them and that lines of accountability are clear.

Strategic Plan 2018-21

Under the Care Act, one of the core duties of the Board is to develop and publish a Strategic Plan, setting out how the Board will meet its objectives and how its member and partner agencies will contribute. The Strategic Plan is a living document which will evolve and be updated over the three year period.

A new draft three year Strategic Plan has been produced and the Board is consulting widely on this, both with professionals and members of the public. Three different types of feedback form have been produced for the consultation and include Easy Read and Easier Read versions. All three forms and a copy of the new draft Strategic Plan can be found on the GSAB website, accessed by the following link:

https://www.gloucestershire.gov.uk/gsab/draft-strategic-plan/

The Board also produces a Risk Register which details, manages and monitors risks which can potentially impact upon its ability to deliver the priorities as set out within its three year Strategic Plan.

The Risk Register identifies the potential consequence of the risk and what actions have been taken in order to mitigate, manage or reduce the risk. Each risk is RAG Rated (Red/Amber/Green) based on its score. The Board currently has no risks which are rated Red, which would be of considerable concern to the Board.

A new Risk Register will be produced once the 2018/21 Strategic Plan has been finalised.

The Board's current Risk Register can be found in supporting documents.

Back to contents

3. Key Issues & Challenges for the coming year

Service User Engagement

- We have made some progress on this priority over the past 12 months with the establishment of a Co-production and Service User Engagement Group. Over the coming year we are holding a number of meetings at various venues in order to reach and engage with our diverse communities. Through these meetings we hope to recruit individuals who are interested in joining our Co-production and Service User Engagement Group. We are striving to establish a core sustainable group of 12-15 individuals who are prepared to meet regularly as well as a virtual county wide group.

Learning from Safeguarding Adults Reviews (SARs) and other Learning Events

- We have undertaken 14 SARs/Learning Events over the past few years and it is vitally important that we learn from these events and that positive change takes place in front line practice. In partnership with the University of Sussex and 7 other local authorities we are seeking to identify best practice in embedding learning in order to minimise the risk of such events happening again in the future. Over the next 12 months, along with our partners, we are trialling various methods by which to disseminate to, and engage with, front line practitioners and to ascertain its impact and effectiveness.

High Risk Individuals

- Over the past 12 months we have come across an increasing number of individuals who are deemed to have capacity and yet choose to engage in risky behaviour, for example, drug and alcohol misuse. These individuals often lead very chaotic lives and are notoriously challenging and difficult to engage with. Many of these individuals have suffered adverse childhood experiences, which has a tremendous impact on their adult life.

- We will prioritise these individuals and establish a multi agency process in order to help safeguard them and also to assist agencies in managing them efficiently and effectively.

Back to Contents

4. Case Studies

Many safeguarding enquiries in Gloucestershire with effective interagency working evidence speedy responses and achieve a better outcome for the individuals involved. The following examples of self-neglect, Adverse Childhood Experiences (ACEs) and out of county cases demonstrate this. All the names and locations have been changed to protect confidentiality.

Case Study 1

Celeste is a 70 year old woman living in a housing association property. Her care needs aren't entirely clear as she refuses to engage with Adult Social Care, but she is known to have had a bowel re-section, suffers from diverticulitis and by her own admission drinks alcohol daily – alcohol has always been a big part of her life. She frequently rings 999 when she has fallen, and is often found naked with faeces on her body when first responders attend. She is not observed to be intoxicated although there is often a number of empty vodka bottles around the property. There are also concerns that her property is cluttered, and on occasion it has been reported that there are faeces and used continence pads scattered around. Celeste is described as frail, and it is reported that there is never much food in the fridge or kitchen.

Actions taken:

An earlier safeguarding concern had been raised by the Housing provider, however this did not proceed for a Section 42 enquiry as Celeste gave the impression that she would accept help. This is usually considered to be the most appropriate route to tackle the concerns. The most recent concern did, however, prompt a Section 42 enquiry as Celeste was admitted to hospital following a fall, when previously she was always uninjured and simply wanted help to get up. This latest fall indicated a possible increased risk, and efforts to support her to resolve the situation had not worked.

The Housing provider has tried to engage with Celeste regularly over the five years she has lived in the property. The provider has tried to encourage her to keep a habitable environment to prevent enforcement action being taken. Previous deep cleans of the property have been undertaken but it is not considered appropriate again, as the situation deteriorates quickly, and there are also cost implications.

The Fire Service has visited on numerous occasions, and fitted smoke detectors as well as attending as First Responder. They have indicated that the level of clutter is 5-6 on the Clutter Image Rating Scale.

Celeste's GP has visited her at home, and recognises that there are concerns around her living conditions, but has reported that there are no concerns in relation to Celeste's capacity to understand the risks.

Adult Social Care has been involved, and Celeste's allocated worker has painstakingly tried to build a relationship with her. Celeste has refused a section 9 care needs assessment but one has been undertaken in accordance with the Care Act duty to assess (where it appears the adult may have needs for care & support

and is experiencing or at risk of self-neglect).

A series of multi agency meetings have taken place to share information and updates, and to try to tackle the issues. Celeste has always been invited but has chosen not to attend. Consideration has been given to discussing call-out fees with Celeste for the occasions when she has used the First Responder service. Additionally, it has become clear that Celeste is now at real risk of losing her tenancy.

Outcome:

Through compassionate persistence, the Social Worker has been able to build a relationship with Celeste, and she is taking steps to try to address the concerns about her living conditions. Celeste explained that things changed for her when her husband died, shortly before she moved into the housing association property. She suffered from depression after his death and explained that she had just "given up" and stopped caring about her surroundings. The worker put her in touch with a bereavement counselling service and other groups locally who could offer support and companionship.

Celeste is now actively seeking quotes from companies who would be able to clean her flat, and she has accepted the need for a cleaner to help her remain on top of things. Another possible prompt to encourage Celeste has been a more formal approach from the housing provider. Celeste recognises that she could lose her property, and this has coincided with more concerted efforts to engage with professionals. Legal action against Celeste has ceased. In relation to the falls, these are not considered to be alcohol related and tests are being undertaken to determine the cause.

Issues highlighted / learning:

This case shows that a person's situation is not fixed, and it was identified that there was a point when a Section 42 enquiry was appropriate. It can sometimes be a challenge to identify when this point might be reached but identifying it is easier when a multi agency approach is taken due to regular updates and the value of differing perspectives.

Research into people who self-neglect has identified that short term efforts to improve the situation (i.e. arranging for the property to be cleaned) rarely have a lasting effect. It has also identified that bereavement can be a significant factor in self-neglect. Time taken to build a relationship with the person may help to uncover the underlying reasons for the self-neglect, and offering support with the underlying causes is more likely to assist the person in making more sustainable changes. This requires a non-judgemental approach and for workers to use compassionate persistence when trying to engage with the person.

People who self-neglect and are deemed to have capacity present a dilemma to professionals when trying to take a Making Safeguarding Personal approach, as they frequently express a desire to be left alone. This then requires professional judgement to decide when abiding by the person's wishes is the appropriate thing to

do, and when the risks are such that intervention is necessary.

Case Study 2

Jade is a 22 year old woman who has been dependent on heroin and crack since the age of 13. She injects drugs into her groin which has caused large ulcers and she possibly has a blood clot on her lung due to her heavy drug use and lifestyle. She has presented to the Emergency Department on three occasions in 2018, and eighteen occasions in 2017, five of which resulted in admissions. In addition to this, there were 2 outpatient appointments.

Jade is anxious to engage with drug & alcohol services. She is currently involved with an older man who is described as being “best friends” with her since she was a child.

Another man gives Jade significant sums of money and drugs. He demands she sleeps at his house and when she is intoxicated rapes her. This has been ongoing since Jade was very young; there is reason to believe she has been a victim of a paedophile ring since the age of 6 and a belief that her mother, who she currently lives with, is involved.

It is understood that Jade is ‘not allowed’ to claim benefits by one of the men who abuse her.

Jade is desperate to move to a different part of the county to escape these influences but this is being hampered by her belief that if she moves, her mother will inform those she is currently involved with. Additionally, Jade’s previous behaviour causes housing providers to decline any applications to rehouse her.

Actions taken:

Jade has an outreach worker who has raised a Safeguarding concern in relation to the sexual abuse and control that others are perpetrating towards Jade. Jade has made a specific allegation of sexual assault which is being investigated. However, despite Jade saying at times she would take part in a video interview, this has not yet happened due to Jade not attending. The Police consider that Jade has the capacity to decide whether to engage in the criminal justice process, but is choosing not to co-operate with the Police. The case is therefore still open but on hold. However, in the intervening period Jade was herself arrested for supplying class A drugs and released pending further investigations.

A referral was made to Gloucestershire Domestic Abuse Support Service (GDASS) who are willing to work with Jade, as well as Housing and drug and alcohol services.

Jade’s outreach worker has managed to open a bank account for her, and is trying to arrange for her to claim benefits and arrange a script in relation to her drug use.

There are frequent attender and safeguarding plans in place for Jade at the hospital. The safeguarding plan states that the Independent Domestic Violence Advocate (IDVA) should be contacted when she presents at hospital.

The case proceeded for a non-Statutory safeguarding enquiry because Jade has support needs only, rather than care and support needs, so does not meet the criteria for a statutory enquiry. A multi agency meeting took place with all agencies mentioned to discuss the concerns and try to establish a protection plan. Jade decided not attend, however the IDVA represented her views and wishes at the meeting.

Outcome:

Efforts are continuing to work with Jade although successes are sporadic. She has tentatively started working with the agencies who can support her, although there are periods of non-engagement. With ongoing liaison between agencies, regular multi agency meetings and a sensitive approach taking her difficulties in engaging into consideration, it is hoped that more sustained success to help Jade will follow. Jade's circumstances are now being considered in terms of a Modern Slavery situation.

Issues highlighted / learning:

The concerns around Jade illustrate the often lifelong impact of severe abuse and neglect in childhood (now referred to as Adverse Childhood Experiences). Jade is indicating she would like to work with agencies, and while she may have the capacity to decide not to, she appears to be subjected to coercion and duress by people in her life, which is hampering efforts to support her. Her arrest also demonstrates that, although she may be committing criminal acts, this is very likely to be a symptom of the fact that she is under pressure from others to commit these offences.

A great deal of resources are taken up trying to support young adults like Jade; more work is needed nationally to identify the best ways to support adults to overcome the damage caused by their childhood experiences, to empower them to live a life free from abuse.

In this case it seems that the key to being able to assist Jade most effectively is with the Police being able to disrupt the gangs that are exploiting her. This is proving difficult without Jade's testimony although thinking creatively of this as a possible Modern Slavery issue may open up a way forward.

Case Study 3

Byron is a 28 year old man with a moderate learning disability, living in a residential home with four other adults. His placement is funded by a county in the north of England. He has started attending an art group every Wednesday and while there he has disclosed to a worker that one of the other male residents at his home, who is also funded by a local authority elsewhere in the country, is very unpleasant to him – calling him names, entering his room without permission and throwing items at him. Byron also says on two occasions the man has hit him, including the day before, and he's frightened it will happen again

Byron says he's explained all this to his key worker and the home manager as it's happened regularly, and while they seem to listen to him, nothing changes and he is becoming increasingly sad about the situation. He says that he likes living in the home but not with this man. Byron appears to be the only person subject to such treatment by this man. Byron is described as a 'gentle giant' who would never retaliate.

Actions taken:

The art group worker spoke directly to the home manager but didn't feel reassured that they were taking the matter as seriously as required. A Safeguarding concern was raised by the art group worker, and it was identified that the former manager of the home had contacted the Safeguarding advice line two years previously to indicate what was described as a minor issue between Byron and the other resident. At the time the matter did not proceed under Safeguarding as the manager gave assurances that they were able to manage the relationship between both men, and prevent any reoccurrences – it was described as a one-off random event. The home manager confirmed they had reported the incident to both residents' social workers.

The Safeguarding Adults team proceeded the case for a formal Section 42 enquiry as Byron has care & support needs, is experiencing abuse and is unable to protect himself as a result of his care & support needs. It was identified that neither Byron nor the other man had been visited by their social workers for several years to review their placements. Neither funding authority had been made aware of any incidents since the one reported by the previous home manager two years before. Byron's social worker was advised to visit him to support him, discuss how he is feeling and assure herself of the safety and appropriateness of the placement.

The social worker for the perpetrator was also advised to visit their service user to explore what the issues are from his perspective, and support the home in managing his behaviour and assuring themselves of the safety and appropriateness of the placement.

The home manager was required to investigate the concerns and report their findings to the Safeguarding Adults team. It was recommended that they speak directly to Byron to assure him they are committed to keeping him safe, and explain to him how they would do this. It was also recommended that they interview all staff and review incident forms and daily records to gain an understanding of what was going on.

CQC and GCC's Commissioning team were informed of the situation to inform their responsibilities in ensuring fundamental standards of care are being met, and that the residents are living in a safe environment.

Outcome:

In the short term, the perpetrator moved to another home operated by the care provider, which was considered to be more suitable to his needs.

Byron was visited by his social worker after three weeks, and she considered that the placement was the right one for Byron. He expressed that he was happy now that the other man had been moved. A referral for an advocate was made on Byron's behalf.

The home manager's investigation was considered to be lacking in detail and despite being asked supplementary questions by the Safeguarding Adults team, there are still some points waiting to be answered. This has been shared with CQC and GCC's Commissioning team.

Issues highlighted / learning:

This case illustrates problems which can arise when a person is placed out of area. It is essential that placing authorities maintain contact with the person, including regular reviews of the placement to ensure its continued suitability. People placed out of area are often more vulnerable to abuse because they are more likely to be at a distance from their family and friends, which makes it even more important that the placing authority assures itself that the person is safe and their placement remains appropriate. This was the situation at Winterbourne View Hospital and a recent Safeguarding Adults Review (written by Margaret Flynn, author of the Winterbourne report) criticised the placing authorities involved for doing little more than "place finding" for the people they placed at the service in question. She has called for regulation to be introduced by the Government in this area.

Another issue is the importance of ensuring residents are suitable to live together. While Byron is now safe and returning to a sense of happiness about where he's living, the provider has a responsibility when accepting new residents to consider the compatibility of the people who will be living together.

5. Partnership Achievements 2017/18 and Priorities 2018/19

This year's annual report, like previous versions, focuses upon the achievements and priorities of our statutory partners.

However, it is recognised that the delivery of safeguarding in Gloucestershire extends well beyond the statutory county partners, across each of our district councils and into the communities and voluntary sector.

Over the past 12 months we have continued to work with a number of Gloucestershire strategic partnerships, some of which are listed below; however this list is not exhaustive, as it has not been possible to list all of them in this document.

Health and Wellbeing Board
Mental Health Partnership Board

Back to Contents

Learning Disability Partnership Board
Safer Gloucestershire
Transforming Care Board
Learning Disability Review Steering Group
Gloucester Diocesan Board
Anti-Slavery Partnership Board
NHS England Quality Surveillance Group
Child Sexual Exploitation Board
Domestic Abuse and Sexual Violence Implementation Group
Multi Agency Public Protection Arrangements
Dangerous Drugs Network (County Lines)
Sexual Assault Referral Centre Strategic Board
Community Safety Partnership Board

5.1 Gloucestershire Constabulary

Over the last twelve months, Gloucestershire Constabulary has continued to evolve their Adult Safeguarding service delivery. We continue to support all aspects of the Board and its sub groups, and have ensured our staff have been given Continuous Professional Development across a number of areas including vulnerability, domestic abuse, and modern slavery/human trafficking.

The Vulnerability Identification Screening Tool (VIST) which was introduced within last year's report is now embedded as best practice, and there has been an increase in the quantity and quality of VIST submissions into the Multi Agency Safeguarding Hub (MASH). This increase is in line with national trends for vulnerability referrals, with the upwards trajectory predicted to continue over the coming years. Currently 37% of all vulnerability referrals relate to adult vulnerability.

A priority for the organisation this year is to ensure that the relocation of the MASH from police premises to Shire Hall takes place on/before our target date of September 2018. This will align multi-agency triage and decision makers: Police, GDASS, Health and Education with the Children's Services 'front door', ensuring that we expeditiously and holistically safeguard those most vulnerable within our communities. It will be important for us to explore how we can work with partners to seek the future inclusion of Adult Safeguarding into an enhanced MASH.

The Public Protection Service Delivery Board (chaired by Assistant Chief Constable Julian Moss) has commissioned a Strategic Problem Profile for 'Adults at Risk' which will include an attempt to assess the number of service users in the County, the demographics of the population, and the likely future demand. Assisted by colleagues from across the Constabulary, not least Neighbourhood PCSOs, we can then map vulnerability within our communities, begin to close some of our intelligence gaps, and subsequently use all this information as evidence to help shape our resourcing model to appropriately meet demand.

The use of the THRIVE+ (Threat, Harm, Risk, Investigation, Vulnerability, Engagement, Prevention & Intervention) model in the Force Control Room and by operational staff provides a consistent and clear model for vulnerability to be

considered and assessed. The 2017 HMICFRS PEEL Efficiency inspection assessed the Constabulary as “Good” in this specific area.

We look forward to working with our colleagues on the Board to continually improve our service throughout 2018/19 and beyond.

Kath Davis
Detective Superintendent, Head of Public Protection

5.2 2gether NHS Foundation Trust (2getherNHSFT)

2gether NHS Foundation Trust (*2g*) continues to play an active part and is fully committed to multi agency working, with all partners of the Gloucestershire Safeguarding Adults Board, in order to safeguard adults at risk of neglect and abuse.

Key Achievements 2017/2018
2g has continued to improve the take up of training for safeguarding adults using a ‘Think Family’ approach (internal single agency - level 2) and multi-agency (level 3) training. This involved increasing the availability of level 3 multi agency training, jointly run with the County Council.

In line with the GSAB objectives, 2g has shared learning from Safeguarding Adult Reviews and other learning models; from Multi Agency Audits and ensured all communication from GSAB is disseminated to all staff in the organisation.

2g particularly focused on Modern Slavery, improving documentation of safeguarding activity, Self-neglect, MAPPA and the Prevent agenda (including level 3 training).

2g has continued to actively participate in GSAB and GSCB sub group activity, helping to ensure a ‘Think family’ approach to Safeguarding within the service users’ network.

Priorities for 2018/2019
2g plan to continue working in partnership to improve overall safeguarding activity. This will involve participation in all sub groups, focusing on learning from multi agency and internal single agency audits; learning from Domestic Homicide Reviews, Safeguarding Adult Reviews, Serious Case Reviews and other learning models (e.g. Practice Learning Reviews). 2g will also concentrate on increasing the provision of safeguarding supervision to teams working with children and adults; improving the quality of safeguarding referrals by evidencing ‘Making Safeguarding Personal’ (*MSP*) and increase awareness (multi agency policy and procedures) around Domestic Abuse and Sexual Violence (*DASV*); Prevent, MAPPA - and to include MSP and early help for children and families.

In order for us to ensure we have the capacity to deliver all requirements, we have committed to recruiting substantively for a Safeguarding nurse within our team.

2g looks forward to continually improving practice with partner agencies to ensure outcomes for adults improve. Safeguarding Children and Adults remain a priority in

the delivery of Mental Health services, irrespective of financial demands and constraints in the current economic climate.

Quality Assurance - 2g will continue to provide assurance to the Board that Safeguarding Priorities are in line with best practice and evidences positive outcomes for families. Through our own internal Safeguarding Sub committee we will monitor our objectives to ensure they are delivered in line with the Safeguarding Adults Board strategic agenda.

Marie Crofts
Director of Quality, 2gether NHSFT

5.3 Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) provides specialist NHS acute hospital care and treatment, where the health care needs of the person requires the care of an acute hospital consultant. This can be planned care, or care in an emergency.

Our Trust continues to be a committed, proactive partner as part of safeguarding adults at risk and we are a core, statutory member of Gloucestershire's Safeguarding Adults Board (GSAB). We are actively engaged as part of the annual action plans of all GSAB sub-committees, with dedicated, senior representation as part of each.

Structure and Approach to Safeguarding Adults within GHNHSFT
Within our Trust Safeguarding is led by our Chief Nurse, as our Executive Lead for Safeguarding. Our Trust Associate Chief Nurse has an active Safeguarding leadership role. Our Trust Safeguarding Strategic Board, chaired by our Executive Safeguarding Lead, has been reviewed and is now an integrated board, combining safeguarding of Adults at Risk, Domestic Abuse pathway and Safeguarding Children. There is representation from all key Trust stakeholders involved in Safeguarding. Our Trust Safeguarding Board has responsibility for implementation of Trust Safeguarding Adults at Risk policy and our Trust's annual Safeguarding improvement plan, including Trust Dementia Care Strategy, Learning Disability Care Strategy and Mental Capacity Act/Deprivation of Liberty Safeguards annual improvement plan. Safeguarding activity and outcomes are reported to our Trust Quality Performance and Quality Committee, to Trust Main Board and to GSAB. Safeguarding is also reflected in our Trust Health and Wellbeing Strategy.

Key Achievements 2017/2018

- We work together with all our partners to support safeguarding. We are making further improvements to our safeguarding pathway to strengthen our participation as part of Making Safeguarding Personal and to working with our patients, their carers and families. We work particularly closely with Gloucestershire County Council's Safeguarding Adults Unit and Hospital Adult Social Care Teams.
- Our Trust Safeguarding Adults at Risk Advisory Team provides real time support and guidance for all Trust staff. This includes guidance and resources

to support best practice application of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). A new Safeguarding Adults at Risk Advisory Sister joined our team in April 2018, extending our team to three members of staff. A key part of this new role is direct support for teams in practice and a key outcome is to further improve safeguarding response actions and application of the Mental Capacity Act in practice.

- The Trust Safeguarding Adults at Risk Advisory Team deliver training Trust wide and have a responsibility to develop, implement and review Trust policy and process. We have developed and implemented resources to support staff to fulfil their safeguarding roles in practice. We have a bespoke Trust Safeguarding Intranet webpage for our staff. We are continuously working to make improvements and to learning from feedback.
- We have implemented a Trust DoLS checklist, this is used by our teams to assess patient care needs to determine if a DoLS need is triggered. Also a guide to help staff to complete the DoLS application form has been implemented.
- A Trust bespoke capacity assessment sticker, flow chart and pocket prompt guidance is being pilot tested in practice. This will be evaluated and the pilot testing extended. It is anticipated that this will be implemented Trust wide.
- Safeguarding training is mandatory for all Trust staff. We actively promote training and target training to specific groups of our staff, so as to best promote safeguarding in action.
- We have implemented Trust specific actions to support GSAB Fire Safety and Prevention sub group's annual plan. Home fire safety and safeguarding is a core part of our level 2 Safeguarding Adults at Risk training. We have supported the pilot testing and the evaluation in practice of the multi agency home fire safety and safeguarding risk assessment document.
- We are a core partner in the development of Gloucestershire's Multi agency Safeguarding Adults at Risk and Pressure Ulcer Policy. We have implemented a Trust specific clinical practice guide to support our teams.
- Our Trust is working in partnership with our core partners in best supporting patients presenting with risk and safety factors. We are strengthening our pathway in collaboration with 2getherNHSFT and Gloucestershire Constabulary.
- Our Trust public Safeguarding Internet webpage has been further improved. www.gloshospitals.nhs.uk/your-visit/staying-us/keeping-you-safe/

Key Objectives 2018/2019

- To continue to work in partnership with GSAB to safeguard adults at risk, with care and support needs, within our Hospitals, our community and as part of Gloucestershire's Safeguarding Adults strategic plan.
- To continue to proactively support the work of GSAB sub groups and to work with all our partners in support of Gloucestershire's Multi agency Safeguarding Adults at Risk Policy and Procedures.
- To continue integrated working across all safeguarding pathways. Working together in support of safeguarding of Adults at Risk (under the Care Act), Domestic Abuse pathway and Safeguarding Children and Young People pathway.

- To be proactive partners in support of safeguarding and transition planning.
- To implement the recommendations from GSAB Safeguarding Adult Reviews.
- A review is planned of the multi agency discharge policy to further support improved communications.
- For Trust Safeguarding Adults at Risk Advisory Team, to continue to proactively support all our teams in practice in achieving their safeguarding role and responsibilities and to monitoring, reporting and to improving outcomes.
- Delivering the best care for everyone, promoting positive patient and carer experience and outstanding care for all our patients.

Lynne McEwan-Berry
Senior Sister Safeguarding Adults at Risk Advisory Team
Gloucestershire Hospitals NHS Foundation Trust

Jon Burford
Associate Chief Nurse
Gloucestershire Hospitals NHS Foundation Trust

Steve Hams
Chief Nurse
Gloucestershire Hospitals NHS Foundation Trust

5.4 Gloucestershire Care Services NHS Trust (GCSNHST)

Gloucestershire Care Services (GCS) remains committed to ensuring safeguarding is part of its core business and recognises that safeguarding adults with care and support needs is a shared responsibility with the need for effective joint working between partner agencies and professionals. In order to do this Trust colleagues work closely with others to ensure that all of the services provided have regard to the duty to protect individual human rights, treat individuals with dignity and respect and safeguard them against abuse, neglect, discrimination, harassment or poor treatment.

The Trust recognises that all its colleagues have a legal responsibility to prevent the abuse of adults at risk of abuse, harm, or neglect (including self-neglect) and to act positively to report abuse.

Team

Adult Safeguarding leads within the Trust are the Director of Nursing, who has executive responsibility, the Named Nurse Safeguarding Adults and the Specialist Nurse for Safeguarding Adults (including learning disabilities).

Supporting Gloucestershire Safeguarding Adults Board activity

The Trust is an active partner of the Gloucestershire Safeguarding Adults Board (GSAB) and is represented on the Board by the Director of Nursing. During 2017/18 the Trust has participated in GSAB activities which have included attendance at

Board meetings, involvement in sub group work, updating the Gloucestershire multi-agency policies and procedures and participating in Safeguarding Adult Reviews (SARs).

Safeguarding Adult Reviews

Recommendations resulting from SARs undertaken in the 2017/18 period produced two specific actions for the Trust; both of these actions have been completed to the satisfaction of the GSAB:

A thematic review of SARs across the South West region has identified a number of issues including poor risk assessment processes and failure to assess mental capacity.

Those regional themes reflect those of local reviews and of issues in practice experienced by Trust colleagues. This is also evidenced through the Trust's internal incident reporting system and associated investigations.

The themes identified have been highlighted throughout all the Trust's safeguarding adults and Mental Capacity Act training delivered within this reporting period and will continue to influence the focus of the Trust's adult safeguarding agenda and development of training for the following year.

Training

Adult Safeguarding training is provided for all Trust colleagues through the statutory/mandatory training programme and new staff induction programme. All colleagues receive mandatory updates, either face to face or by eLearning, every three years. Compliance with training attendance is recorded via the Electronic Staff Record and monitored through monthly reports to line managers.

Adult safeguarding training compliance at the beginning of April 2018 was **89.1%** for level 2 Adult Safeguarding training, an increase of 3.5% on the previous year and **95.3%** for level 1, and increase of 13.29%.

Mental Capacity Act and Deprivation of Liberty Safeguards training has been delivered to **406** colleagues. Of these, **7** undertook the train the trainer session.

Concerns

The number of safeguarding concerns reported by the Trust decreased significantly from **315** in the period 2016/17 to **146** in the year 2017-18. This is consistent with a decrease in the number of concerns reported by all agencies and is likely to be due to the increased number of calls to the safeguarding advice line. Many of these calls concern queries about whether or not to raise a safeguarding concern, consequently limiting the number of concerns raised.

Whilst the figures are lower, our referral rate has been consistently higher than other Gloucestershire providers. The GSAB acknowledges, however, that these figures

are likely to be inaccurate as the Trust is often incorrectly categorised. Gloucestershire County Council (GCC) is undertaking work to rectify this.

Challenges for 2018/2019

Whilst we have improved our compliance with statutory and mandatory safeguarding training we need to ensure we achieve our target of 95% compliance. Working with operational colleagues will progress in order to achieve this.

We will also progress in delivering MCA & DoLS training as we are aware that colleagues find it difficult to implement this legislation. We will, therefore, continue our schedule of visits to support staff in applying MCA in practice.

To monitor progress we will be progressing our audit schedule and will be implementing more robust data collection processes in regards to DoLS applications/authorisations.

The Trust adult and children's safeguarding teams are now co-located and planning further integration. We are also exploring joint working with safeguarding colleagues in 2gether Trust in anticipation of the proposed merger of the two Trusts.

The Trust Adult Safeguarding team has received training in supervision methods and hopes to be able to offer some supervision to adult practitioners across the Trust; this has previously not been available.

It is our intention to improve and increase Domestic abuse and DASH training.

Susan Field
Director of Nursing, Gloucestershire Care Services NHS Trust

5.5 Gloucestershire Clinical Commissioning Group (GCCG)

GCCG continues to recognise, endorse and promote our requirement to safeguard adults at risk of abuse and neglect when commissioning health services across Gloucestershire. We understand our shared responsibility and are committed to seeking assurances from across the health partnership that our most vulnerable adults are effectively safeguarded. The GCCG key leadership roles ensure a clear line of accountability as well as provision of clinical expertise and strategic advice. GCCG is well represented at Board level by GCCG's Executive Nurse, as well as at Management and Subgroup levels by both the Safeguarding Lead (Named Nurse) and the Specialist Nurse Safeguarding. GCCG Safeguarding Lead has taken additional responsibility as Chair of the Safeguarding Adult Review Subgroup. We also benefit from the clinical expertise of our Named GP for Safeguarding, supporting excellent working links across Primary Care.

Key Achievements 2017/2018

- Named GP as an expert advisor, giving practical and strategic support to Primary Care in relation to chronologies and IMR provision, assuring active

contribution and high quality standards. GCCG now directly supports Primary Care to meet any required improvements related to Safeguarding.

- Adult Safeguarding Forum is now established as 3 times per year. Led by GCCG Named GP and Specialist Nurse, this forum is increasingly well attended with numbers up to 50 county GPs per session. The CCG informs on pertinent 'hot topics' and focused learning, including Domestic Abuse and Sexual Violence (DASV), Mental Capacity Act (MCA) and Do Not Attempt Resuscitation (DNAR) guidelines. There is learning from SARs and a standing item to discuss cases and concerns.
- GCCG Safeguarding Team ensured 46 community Clinical Pharmacists (GP Practice based) received a multi-agency safeguarding adults (and children) training day in collaboration with GSAB and GSCB approved trainers.
- Dental Forums are held 3 times per year and evidence excellent attendance from across the county. Again, these sessions cover both adult and child safeguarding topics, and welcome all dental staff groups.
- CCG Safeguarding Team has successfully facilitated locality based and Primary Care focused, Adult Safeguarding Training - Level 2. Delivered by GSAB approved trainers, the aim was to provide a standardised training session for Gloucestershire GPs and Practice Staff. The project achieved an incredibly high uptake with over 300 staff trained.
- Created and produced the short animation 'Abuse can be hard to spot', devised to promote Safeguarding awareness particularly for Care Home and Domiciliary Care staff.
- GCCG Safeguarding Lead initiated a CCG funded one year programme of externally facilitated group supervision currently in place for Named Nurses (Safeguarding Leads within their organisation) from all 3 Provider Trusts (adult and child).
- Representation on Gloucestershire Anti-Slavery Partnership Board and leading in the health contribution for a multi-agency Modern Slavery Reception Centre and Response Planning.

Priorities for 2018/2019

- To update GCCG's Strategy for Safeguarding Adults and Children to reflect CCG strategic Safeguarding priorities.
- To seek both Provider and Patient assurances for Out of County and In County care placements, establishing a high regard for visibility and oversight of safeguarding considerations.
- To provide evidence of the impact of CCG learning events, forums, bespoke and external training events (GSAB) through timely and informative evaluations. GCCG is trialing a recently devised 'Smart Survey' as a way of effectively capturing this.
- To continue with innovative work, being collaborative and maintaining awareness for adults with care and support needs. The team is currently

working with Inclusion Gloucestershire; plans to create a short film will re-badge 'did not attend' as 'was not brought' for those adults needing active support to attend medical appointments.

- To actively support the delivery of the GSAB strategic objectives.

Marion Andrews-Evans
Executive Nurse & Quality Lead, Gloucestershire Clinical Commissioning Group

5.6 Gloucestershire District Councils

Key Achievements
District Councils are uniquely placed to work with our communities to support the safeguarding agenda. With this in mind the six district councils have formed a safeguarding network that shares good practice and challenges and allows us to work together to reduce the risk to our communities. Through this group we have worked with the GSAB to look at the training we offer our staff and how best to ensure they are equipped to deal with the safeguarding of adults who directly and indirectly come into contact with our Councils. We have also worked with the police to raise awareness of County Lines so that our staff are able to respond should they become of aware of the problem. We have also looked at how we can work together better on the issue of Modern Slavery especially getting the message out to the public.

Priorities for 2018/2019
In the coming year as we embed a new quality assurance framework for safeguarding children we will consider how we can extend this to ensure the quality of our safeguarding adults practice. We also hope to work more closely with partners across the system around the complex issues of self-neglect and hoarding, ensuring that districts take appropriate actions when necessary. We will continue to work through the network and other partnerships with the Police to reduce the impact of organised crime on the most vulnerable in our communities. As a network we have just begun to explore the topics of Adverse Childhood Experiences (ACEs) and hope to develop ways of using this to support our work with vulnerable children and adults to support them and the communities they live in to thrive.

Tracy Brown
Safeguarding and Partnerships Manager

5.7 Gloucestershire PREVENT Partnership Board

Gloucestershire PREVENT Partnership Board (GPPB) is a multi-agency steering group committed in safeguarding communities within Gloucestershire against radicalisation and extremism through the PREVENT Duty. Members represent LAs, GCC Safeguarding Boards, educational establishments, Police, Fire & Rescue, Probation services, GARAS, Independent Advisory Group and Health Organisations.

Key Achievements 2017/18

The Home Office conducted a 1-day Peer Review that found GPPB has a strong appetite to succeed with commitment from senior officers across all partners. Relationships between police and key partners are strong. The use of an anonymised Channel case, with strong positive outcomes, was being used to bring Channel to life in training but greater inclusion of adult services within Prevent and Channel arrangements was required.

Members from the Muslim Community attended a GPPB meeting to give members an insight into how the Prevent Strategy affects both their working and personal lives on a daily basis. A frank and honest discussion was had and one of the outcomes highlighted was the need for greater community engagement.

A Prevent Workshop was attended by members which not only concentrated on Prevent with regards to Islamic extremism, but also the rise of the extreme right wing, gang membership and dissident Irish republicanism. This workshop also looked in detail at the journey that individuals go on and how they become radicalised.

40 referrals had been received from April 2017 to March 2018. Approximately 20% are adults and the majority of referrals originate from health organisations or Probation Service.

Looking forward for 2018/19

GPPB continues to engage with partner agencies to strengthen governance arrangements for Prevent across statutory safeguarding boards via the Safer Gloucestershire Board. Looking to develop an appropriate and effective referral system/process for multi-agency information gathering, ensuring that Adult Social Care is involved. GPPB now have representation from Adult Social Care and are looking to arrange a stand at forthcoming Adult Safeguarding roadshows. The Board is committed to proactively working with community groups in raising awareness as well as informing communities on how to spot signs as well as where/who to contact with their concerns.

Jayne Putland
Civil Protection Office & PREVENT Co-ordinator

6. Safeguarding Adults Reviews

The Safeguarding Adults Review sub group receives all requests made to the GSAB Chair, assisting the process of information gathering, identification of relevant agencies and proceeding to assessment and analysis of each case. The sub group has a responsibility to recommend whether a request meets the requirements for a statutory or non-statutory review (Care Act 2014).

Safeguarding Adults Reviews

For the preceding year (2016/17) SAR themes were solely linked to that of self-neglect; the learning from each of those cases (‘KH’, ‘Ted’ and ‘AT’) advised that agencies consider unwise decision making within the complexity of deemed mental capacity, and how mental health, physical illness and learning disability may impact

on delivery of health or social care services. The GSAB Roadshows support wide disseminated of learning to all agencies.

The GSAB has published two SARs this year, 2017/18:

'Hannah' *was a young woman from Gloucestershire who died aged 26, on 27th May 2016. Hannah died in hospital of natural causes. Health concerns prior to her death included the effects of obesity and an on-going wound infection which she had had during the last six months of her life.*

Hannah used a lot of services and on many occasions, both mental health and physical health services. The Review showed how much is expected of people as patients today where they are expected to cooperate with and be "in control" of their own care. This isn't always straightforward for anyone who may be more vulnerable. In general, however, there were many things which worked sufficiently well for Hannah. On occasion, it was harder to see who the lead professional in the situation was due to the arrangements for acquiring and monitoring care. Therefore, an aspect noted for further consideration was the overall working arrangements between commissioners and providers of domiciliary care services.

The review recommended that steps to encourage greater "parity of esteem" or equality between the response to mental health needs and physical health needs, be strengthened. Also, it has been recommended that efforts be made to promote a wider availability of different accommodation for people with mental health needs.

'Danny' *was a white British man, aged 64 when he died. Throughout his life he had significant mental health and learning disabilities, with diabetes diagnosed in 2001. His physical health was exacerbated by lifestyle choices he made regarding his diet. He lived in Supported Accommodation with an extensive care package aimed at supporting his independence whilst ensuring personal and home care needs were met. His support worker team was consistent over many years and the service was effective, despite several hospital admissions, until his final few months when his needs became complex and challenging in this setting.*

Concerns had arisen regarding the way in which organisations worked together to ensure Danny's safety and wellbeing, especially around hospital admissions and discharges, with areas for learning and improvement identified. Danny's discharges from hospital were planned in advance but delays and failure to communicate effectively and in a timely way led to rapid readmissions. Funding the different components of Danny's care was also not straightforward and needed improvement.

The sub group has worked effectively as a multi-agency group. Meetings are consistently well represented by key partners, and well supported by the GSAB Business Manager and an Administrator.

A significant challenge from January 2017 was having a number of action plans each addressing many specific recommendations. The professional commitment of the sub group has been instrumental in all elements of the Review process; providing excellent multi-agency representation for the Reviews undertaken and ensuring that there is robust professional challenge and quality assurance throughout each report.

The sub group has considered SAR action plans in a pragmatic and pro-active way, identifying the relevant organisational lead for each agreed recommendation. As a result, the group is confident that progressive actions are well evidenced within each 'closed' plan report.

Significant action outcomes for 2017/18 include:

- Holding Public Health and Commissioning Leads to account; specifically in relation to the commissioner-care provider continuum, and linking the GSAB with the national work of the Health Select Committee regarding suicide prevention.
- Direct influences to adapt and enhance Adult Safeguarding (Level 3) training and Mental Capacity Act training to include supporting a person-centred approach regarding 'unwise' decision making.
- Advising the work of multi agency and single agency auditing – e.g. Lead Professional in Sec 42 Enquiry.
- Self-neglect guidance; a full review and update, linked with a GSAB communication plan for training and dissemination.

Overview of SAR referrals received 2017/18
The table below demonstrates an overview of the SAR referrals made to GSAB, capturing the breadth of referral sources as well as time period when referrals were made.

	Q1	**Q2**	**Q3**	**Q4**
Referrals Received	1	0	4	4
Referral Source	Health - 2gether	-	• Suicide Crisis • GSAB Chair • Family • Adult Social Care	• Adult Social Care • Health - GCS • GCC – SG Adult (SAFE1) • Police
SAR Undertaken	0	0	1	0
Name	MQ	-	LD (Out of County SAR)	-
Learning Event	1	0	0	0
Comments	Learning Event held June 2018	-	GSAB linked (OOC)	X2 cases pending decision (DL/HK)

Planning for 2018
GSAB has commissioned one SAR and one Local Learning Review. A further SAR is taking place out of county whereby GSAB will be involved and disseminate the key learning. Nationally, there is an emerging theme relating to out of county placements, commissioner oversight, confidence in appropriate case management and management of risk. Gloucestershire SARs this year appear to reflect aspects of this theme.

A new SAR Tracker will be instrumental in improving future oversight and analysis of all the SARs undertaken. Advantages will include being able to reflect on previous SAR learning, actions taken and learning methodology; this should better govern decision making in all aspects of SARs.

The SAR sub group welcomes the GSAB Strategic Plan that will connect the work of all GSAB sub groups.

The full reports can be found on the GSAB website at:
http://www.gloucestershire.gov.uk/gsab/

7. GSAB Management Committee

The role of the Management Committee is to effectively manage the Board's business, co-ordinating the work programme and overseeing key business functions on behalf of the Board. This includes:

- Co-ordinating the development and implementation of objectives and priorities outlined in the strategy;
- Driving the development of good practice in safeguarding adults work;
- Establishing sub groups and task and finish groups;
- Providing direction and support to sub groups and task and finish groups;
- Monitoring and reviewing safeguarding adults performance in Gloucestershire and providing an analysis of performance through quarterly reports to the GSAB;
- Promoting effective community engagement with safeguarding adults work and ensuring that the voice of the citizen is heard;
- Implementing lessons learned from Safeguarding Adults Reviews;
- Receiving minutes from the Board and undertaking actions arising from the minutes as required;
- Production of the GSAB Annual Report.

During 2017/18 the Management Committee met quarterly and worked to a standard agenda which included oversight and updates to the Risk Register. A function of the Management Committee is also to review any reports that will be presented at Board meetings.

The Management Committee will be changing its name to the Business Planning Group and increasing its remit in 2018/19. The group will take on additional responsibility for the work of the GSAB sub groups and only exception reporting will go to the board. New Terms of Reference have been produced to reflect the changes. The format of future Board meetings will also change to make them more engaging and to increase the board's assurance role.

8. Sub Group Achievements 2016/17 and Priorities 2017/18

8.1 Workforce Development

- Training figures (found in supporting documents) highlight the take up of GSAB training and e-learning by partners during the year. In summary,18,500 Gloucestershire staff (and volunteers) undertook GSAB approved Safeguarding courses; nearly half of these completed level 1 e-learning and the other half participated in training at levels 2, 3 and 4. There was an increase in e-learning completions within the Acute Trust due to programme enhancements which required staff to update.
- Within 2gether NHSFT, level 3 training was made mandatory for all staff at band 6 and above. We worked jointly to develop capacity to ensure an estimated additional 200 staff per year have access to this programme. Additional courses are now being delivered by the Trust's GSAB approved trainer, with input from our Safeguarding team and quality assurance by GSAB's multi agency level 3 trainer. In order to ensure the multi agency model is maintained, 10 places on each course are offered to partners.
- The annual train the trainers workshop for new level 2 trainers was held in September with 21 participants. Organisations represented included GFRS, Glos. Constabulary, Age UK, Adult Education, a faith group and health & Social Care providers. Follow up supported observations have been delayed although we have recently commissioned an external trainer to prioritise the eight outstanding trainer observations and also the quality assurance requirement for two yearly follow up observations for all trainers.
- The annual CPD day for trainers took place in October with 60 trainers attending. The theme this year was Making Safeguarding Personal with presentations on dementia, coercion & control, fuel poverty and Advocacy in Gloucestershire. All participants rated the event highly.
- Work was undertaken to review and refresh our database of GSAB approved trainers in Gloucestershire. We currently have 63 active approved safeguarding trainers, with 8 awaiting observations.
- The second set of annual GSAB roadshows were held during March and April, with excellent feedback. This year's theme was 'finding the balance' looking at the issue of capacity within safeguarding and the impact on Making Safeguarding Personal.
- The annual CPD session for Board members was held at the Guildhall in April. A presentation by the Head of Safeguarding Adults on the outcomes from South West SARs was followed by group activity to review and feed back on the new draft strategic plan.

2018/19 priorities include ensuring we deliver on the generic safeguarding awareness induction programme, re-focusing on obtaining impact evaluation, learning from the engagement sub-group on how people with lived experience can contribute to workforce development and reporting the percentage training compliance rates within statutory health & social care partners.

2017/18 Training Figures can be found in supporting documents.

8.2 Fire Safety Development

This past year the group has made progress in many areas. Last year's priorities were as follows:

SJ SAR Recommendations:
The group has ensured that the recommendations to come out of the SJ SAR have been actioned. It has designed a prompt card for staff going into people's homes around the four questions that formed part of the SAR.

These questions have been adopted by the National Fire Chief's Council and were used as part of the work undertaken nationally following the Grenfell Tragedy. Locally, all media campaigns, interviews and newspaper articles include the four questions and staff across Gloucestershire can access the prompt cards.

Risk Identification and referral pathways:
Whilst we have made good progress in the area of risk identification, there is some further work to embed fire risk as a standard part of assessments in people's homes carried out by partners. Referral pathways are established. Both risk identification and referral pathways are included in safeguarding training which partners access. The e-learning package that was developed by the Royal College of General Practitioners has been shared with the Safeguarding Workforce Development Sub Group and will be included in their suite of e-learning packages.

Comms and Engagement:
The FSDG will be represented on the Safeguarding Board's Comms and Engagement sub group. Comms is a standard agenda item which looks at up and coming campaigns to see how partners can support. This summer will see a #safesummer campaign which will run through all GFRS open days. Partners will be invited to attend in order to spread their messages at the popular events. The group continues to look at how they can better engage with hard to reach groups. One example is the advertising of Safe and Well visits on pharmacy bags in an attempt to reach people in one of the risk groups (prescription drugs).

The Group will be signing a consensus statement which describes our intent to work together to encourage joint strategies for intelligence-led early fire safety intervention and prevention; ensuring people with complex needs get the personalised, integrated care and

support they need to live full lives, sustain their independence for longer and in doing so reduce preventable hospital admissions and avoidable fire injuries and fatalities.

In order to achieve this partners who sign up to this consensus statement commit to:

- Work together to use our collective capabilities and resources more effectively to enhance the lives of the people we work with and we will support and encourage our local networks to do the same in their communities.
- Work together to develop ways of sharing information to help front line staff provide better safety solutions based on fire risk.
- Work together to use our collective capabilities and resources to ensure the people we work with get the appropriate safety equipment at the right time.
- Work together to ensure our staff understand fire risk and its wider implications.
- Work together to ensure there is a referral pathway into Gloucestershire Fire and Rescue Service.
- Work together to, as far as possible, mitigate risk for people in their homes.

The group has developed a Fire Fatality report that looks at all information gathered following a fire fatality in order to decide if it needs to be referred for SAR consideration. If the group decides that it doesn't meet the threshold of a SAR then the Fire Fatality report sets out recommendations which the group actions.

One of the main areas of work this year will be to complete the Coroner's Gap Analysis. This will look at all coroner recommendations nationally that have come out of fire fatalities over the past ten years to do a Gloucestershire comparison and gap analysis. This will inform next year's Action plan.

There has been some fantastic work done this year and we will continue to deliver against the high targets we set ourselves.

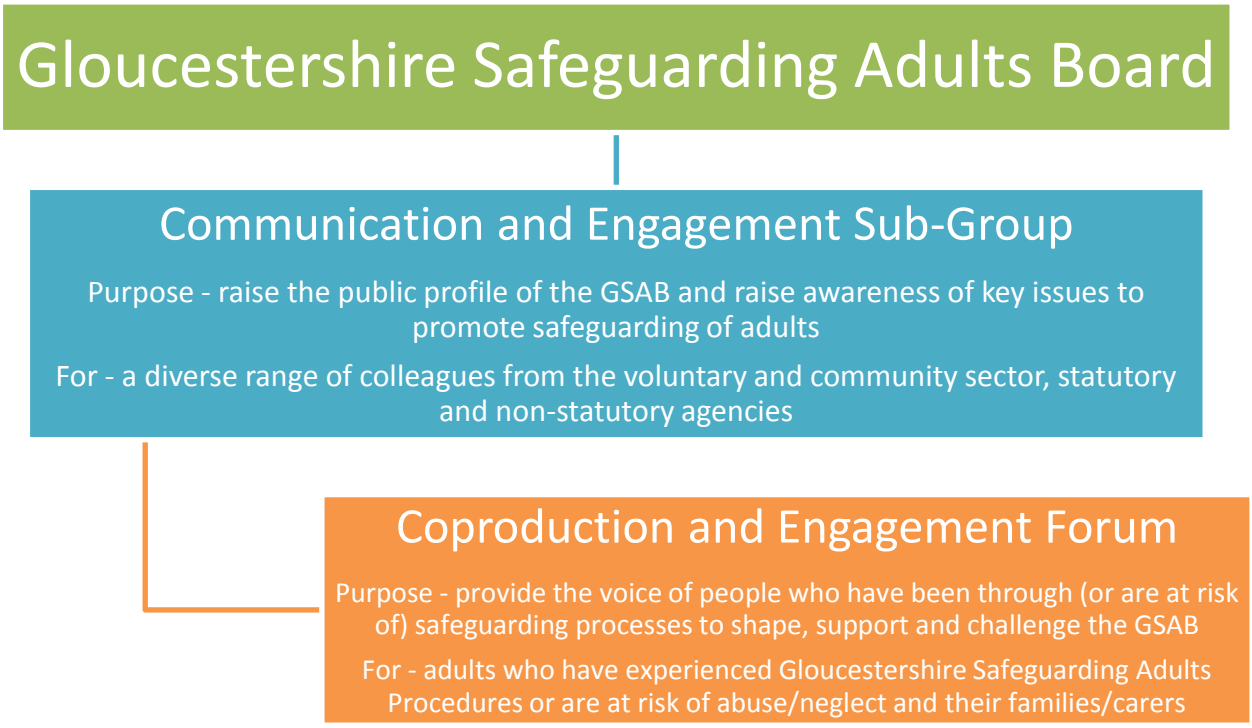
8.3 Communication & Engagement

The Communication and Engagement sub group was reinvigorated in 2017/18 and physical meetings resumed in September 2017. The sub group brings together statutory agencies, partners and providers.

Achievements in 2017/18

- Relaunched and publicised physical quarterly meetings of the sub group with new partners involved, particularly from the voluntary and community sector
- Created Terms of Reference for the Communication and Engagement sub group
- Created and ratified Communication and Engagement Strategy for the GSAB
- Set up Co-production and Engagement Forum to provide user's perspective on safeguarding processes and co-produce policies, procedures and publicity
- Created Terms of Reference for the Co-production and Engagement Forum and co-produced aims and values for the group

- Chair of the sub group attended the South West ADASS annual safeguarding conference and Making Safeguarding Personal conference. Both informed the priorities of the sub group and forum and the latter informed the design and planning of the Co-production Forum.



Priorities for 2018/19

- Raise awareness of safeguarding and promote the welfare of adults at risk, utilising the networks that members of the Communication and Engagement sub group have in the community.
- Increase engagement with the voluntary and community sector so that they can support the preventative agenda.
- Ensure GSAB policies and procedures are communicated to partner agencies and communities in formats that are accessible and engaging.
- Disseminate advice and guidance on identifying, recognising and reporting abuse.
- Grow membership of the Co-production and Engagement Forum and ensure that the group is supporting the GSAB to deliver person-centred approaches to safeguarding and hear the voice of people with care and support needs.
- Monitor implementation of the Communication Strategy by the wider board.

8.4 Policy & Procedures

Achievements for 2017/18

The continued engagement from partner agencies has ensured the Policy and Procedures sub group has been able to produce and update a significant number of documents in the last year. This includes:

- The Out of Contact Protocol was updated in May 2017
- The Safeguarding Adults Review (SAR) Protocol was updated in May 2017
- Safer Recruitment Guidance was amended in May 2017
- Whistleblowing Guidance was updated in May 2017
- The Escalation Policy was refreshed in May 2017
- The Positions of Trust Framework was produced in September 2017
- Policy and Procedures Easy Read version was updated in November 2017
- The GSAB Member Induction Pack was updated in November 2017
- The Elected Member Induction Pack was created in November 2017
- GSAB Constitution & Memorandum of Understanding was ratified in November 2017

Priorities for 2018/19

- The Gloucestershire Multi Agency Safeguarding Adults Policy and Procedures will be updated later in the year following a refresh by the West Midlands Editorial Group.

- Safeguarding Transition Guidance will be produced, aligning both the Adults and Children's Boards; a Task and Finish group will be created to take this forward.

- The formation of the South West Editorial Group, chaired by Sarah Jasper, Acting Head of Safeguarding Adults, with direct links back to the Policy and Procedures sub group.

- The creation of a Management of Risk Policy and Organisational Abuse Procedures.

- The Safeguarding Adults Review (SAR) Protocol will be updated.

- Production of the Safeguarding Adults Pressure Ulcer Protocol.

- Stronger links are being forged through a new GSAB Co-production and Service User group. Feedback on future policies and procedures, at the production stage, will be sought through this group. Easy read versions of relevant documents will also be produced.

- Common language will be used to ensure future documents are accessible to everyone, encompassing the principles of making safeguarding personal.

8.5 Activity & Data 2016/17

Calls to the Safeguarding Adults Team Advice Line, where professionals can call to discuss a case and receive advice on whether or not to raise a safeguarding concern remain high, with **3398** calls. The number of Safeguarding concerns raised on behalf of adults at risk was **1673**, when this is added to the number of advice line calls it makes a total of **5071** contacts with the team.

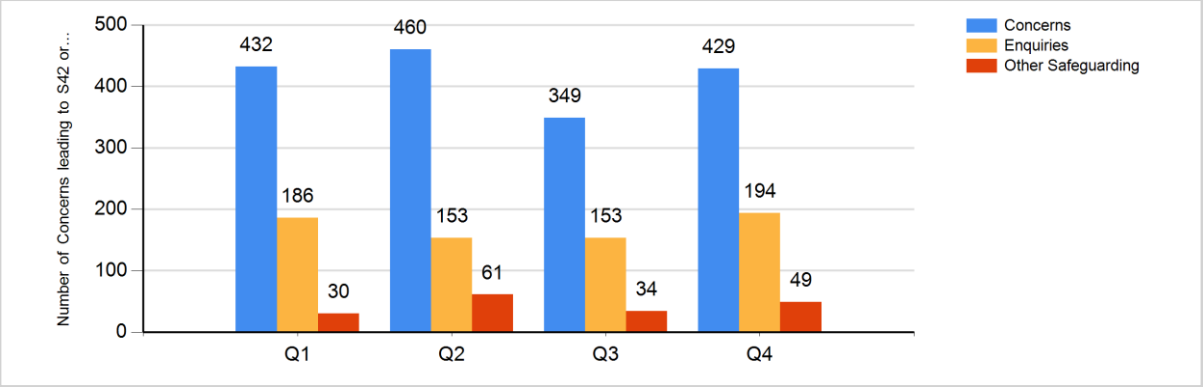
Of the **1673** concerns, **684** went on to become section 42 enquiries and **175** became 'Other' enquiries, making a total of **859**. 'Other' relates to enquiries which have not met the criteria for a statutory enquiry, however some form of safeguarding enquiry is deemed to be required, for example, the person is at risk of abuse and has support needs, but not care needs.

162 of the safeguarding concerns reported to the Adult Social Care help desk were made by Gloucestershire Police, an increase from **124** last year. Of these **60** led to enquiries. The Police provided information for **475** enquires and **32** were recorded as a criminal matter.

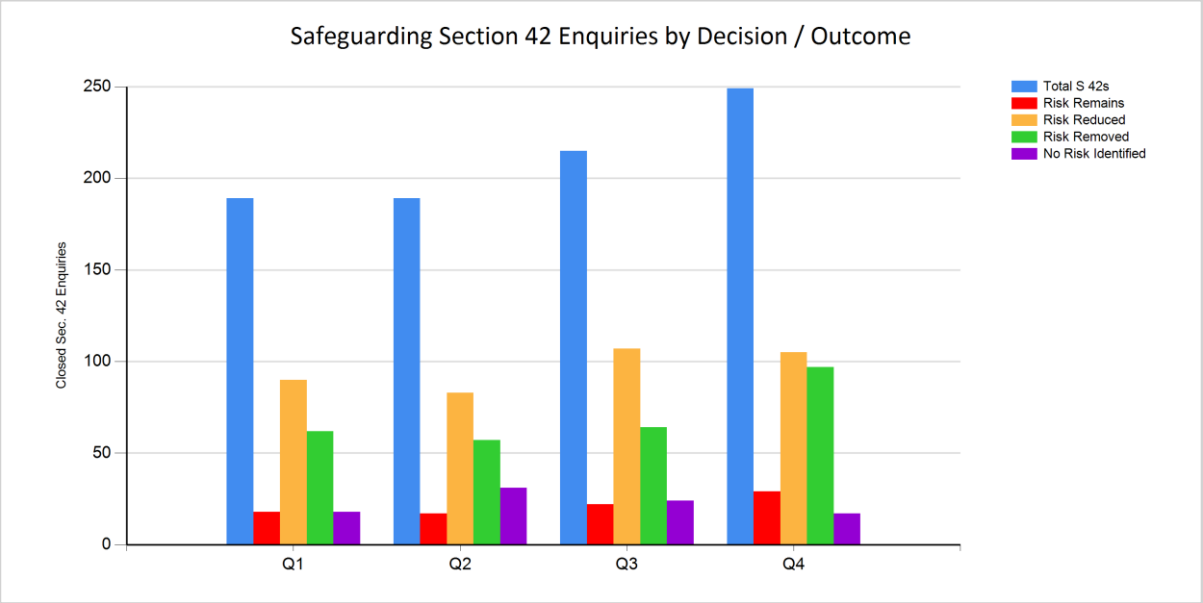
Advice Line Calls 2017/18

Quarter	Month	Advice Line Calls
Q1	Apr 2017	258
	May 2017	220
	Jun 2017	269
	Total	**747**
Q2	Jul 2017	375
	Aug 2017	227
	Sep 2017	253
	Total	**855**
Q3	Oct 2017	305
	Nov 2017	302
	Dec 2017	235
	Total	**842**
Q4	Jan 2018	309
	Feb 2018	318
	Mar 2018	327
	Total	**954**

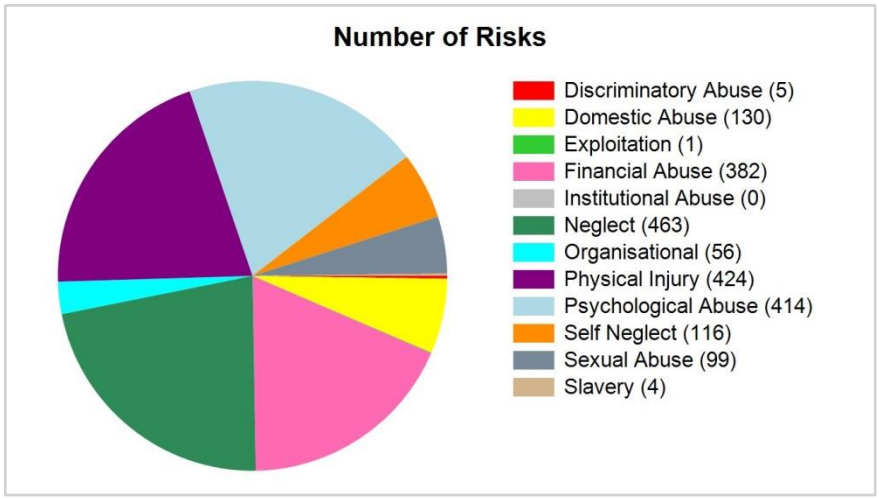
Concerns Leading to Section 42 or Other Safeguarding Enquiries 2017/18



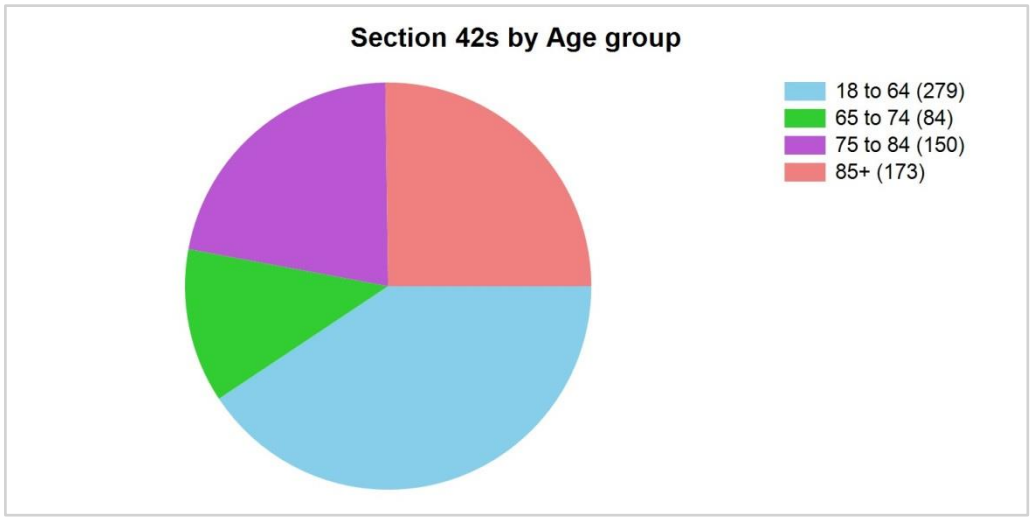
Closed Section 42 Enquiries and Risk



Quarter	Total Closed S 42s	Risk Remains	Risk Reduced	Risk Removed	No Risk Identified
Q1	189	18	90	62	18
Q2	189	17	83	57	31
Q3	215	22	107	64	24
Q4	249	29	105	97	17
Total	**842**	**86**	**385**	**280**	**90**



Section 42 Enquiries by Age Group



8.6 Quality Assurance

Audit Group

One of the Audit sub group's main responsibilities is to complete an agreed multi agency annual programme of planned audits in response to emerging themes or areas of concern - identified by GSAB, its Management Committee or the Audit Group (in agreement with GSAB).

The group has undertaken 8 multi agency case file audits this year, which consisted of 3 general audits with the other five covering the following themes:

- financial abuse
- repeat concerns
- section 42 decision making
- Mental Capacity Act

- Making Safeguarding Personal.

The results of the audits are fed back to the teams concerned, including where there is evidence of good practice. Any broader learning identified is directed to the relevant group for sharing more widely. For example the findings from the recent Mental Capacity Act audit have been shared with the Mental Capacity Act Governance Lead to inform the strategy of that group.

GCC's Internal Audit team will be carrying out an audit of the work of the group. This consultancy review will seek to determine whether there is a robust framework in place for ensuring the effective identification, assessment and delivery of the multi agency annual programme of planned audits.

Priorities for 18/19 include:

- A further audit on repeat concerns in order to understand the reasons why adults frequently have more than one safeguarding concern raised.
- Sexual abuse concerns – continuing to track responses to such concerns in the light of the Home X Serious Case Review.
- Domestic abuse – recognition of domestic abuse as it relates to adults with care and support needs.
- Self-neglect – auditing whether the learning from the Safeguarding Adults Reviews in this area is being embedded into practice.
- Developing the work of the group further by seeking new methods of auditing safeguarding adults work that goes beyond case file audits and encompasses the work of partner agencies other than Adult Social Care.
- Incorporating emerging issues from SARs into the work of the group as required by GSAB.

9. Safeguarding Adults at Risk Self Assessment Audit Tool 2017/18

In January 2018 an updated Safeguarding Adults at Risk Self Assessment Audit tool was sent out to partners for completion. The aim of the audit tool is to provide organisations in Gloucestershire with a consistent framework to assess and monitor Safeguarding Adults arrangements. This in turn supports the Board in ensuring effective safeguarding practice across the county.

The tool provides an overview of the Safeguarding Adults arrangements in place across the county, identifying:

- Strengths, in order that good practice can be shared
- Common areas for improvement where organisations can possibly work together with the support of the Board
- Single agency issues that may need to be addressed by the Board

The audit tool is a two-part process, with initial completion of the self assessment audit, followed by scrutiny and challenge. Over the next two months meetings will be

held with partners to quality assure the self assessments and highlight any areas where further work is needed. A further update will be provided in the GSAB 2018/19 Annual Report.

10. The Board's Resources

Independent Chair's comments on Board attendance
We have worked hard once again to ensure that all partner organisations on the Safeguarding Adults Board are represented by a post holder of sufficient seniority and expertise and that ideally the same person should attend each meeting. However, there are inevitably operational pressures on individuals. I am very grateful to the senior representatives of each organisation who have given so much time, interest and commitment to the work of the Board during 2017/18.
A full list of the Board's current membership can be found in supporting documents.

Funding Contributions
The Board is pleased to confirm that the Gloucestershire Constabulary & the Clinical Commissioning Group (on behalf of 2getherNHSFT, Gloucestershire Hospitals NHSFT and Gloucestershire Care Services NHS Trust) have agreed to continue their financial contribution to the Gloucestershire Safeguarding Adults Board. The Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Companies (Probation Service) have also provided a contribution.

GSAB Partner Contributions 2017/18

Health	38,877
Police	20,440
Probation	1,000

GSAB Business and Activity Costs 2017/18

Independent Chair	20,000
Other staffing (Includes 30% Head of Safeguarding Adults, 100% GSAB Business Manager, 15% Admin Manager & 100% Administrator)	101,400
Workforce Development	65,000
Safeguarding Adult Reviews	20,000
Comms. & Publicity	4,000
Total	**210,400**

These contributions help with costs associated with the running of the Board, including its Independent Chair, the Gloucestershire County Council Head of Safeguarding Adults post, costs in conducting Safeguarding Adults Reviews, Communication & Publicity and delivering on the Board's Workforce Development and Training Pathway.

Other partners have contributed with their time and commitment to the Board's work and by providing access to resources such as meeting venues, conferences, etc.

All documents and supporting reports referred to in this annual report can also be found on the GSAB website, supporting documentation.

Special thanks are reserved for all agencies who have contributed to this report and the achievements of the Gloucestershire Safeguarding Adults Board over the last year.

Back to Contents