Gloucestershire
Safeguarding Adults
Board

Gloucestershire Safeguarding Adults Board

Annual Report 2014/15

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Foreword : Introduction from Chair

Welcome to our annual report. This is my first annual report having taken up the role of Independent Chair in June 2014 and it is my responsibility to support continual improvement in the work of all agencies responsible for safeguarding 'adults at risk' in Gloucestershire.

It is important to remember that the Safeguarding Adults Board does not deliver operational services and is not solely responsible for all safeguarding arrangements in Gloucestershire. The Board's role is to exercise oversight and assurance in respect of safeguarding arrangements, some of which may be developed and led by others.

The Safeguarding Board itself is made up of senior managers from a wide range of partners and agencies, including the voluntary and community sector. As in previous years, attendance at the Board has been high.

The past year has been a real challenge for the Board members and in particular the statutory partners, who have had to make significant budget savings. Despite this, commitment to safeguarding adults remains high and I am grateful to colleagues for the work they put into the Board.

This next year is a very significant year for safeguarding adults. For the first time safeguarding adults is based on a legal framework from 1st April 2015 and all councils are required to have a Safeguarding Adults Board. Gloucestershire has had a Safeguarding Adults Board since 2009 and is therefore well placed to implement the new Care Act in relation to safeguarding adults. The Board will be working hard to make sure that the Care Act principles are central to how we work.

The Safeguarding Adults Board Annual Report 2014-15 outlines the work of the Board over the last twelve months and how partner agencies have worked together to improve the safety of adults at risk of abuse. The report contains details of how safeguarding has been promoted and developed over the last year through the Board and its sub-groups. The report also describes how the Board intends to continue this in the future.

It is well recognised that safeguarding is complex and challenging work, and is never more so than when an individual dies or is seriously harmed through abuse or neglect.

In the past 12 months we have undertaken and completed two Safeguarding Adult Reviews, with a third to be completed this year. The circumstances leading to these reviews have a devastating impact on the lives of the victims and their families, as well as the carers and professionals involved. They are never taken lightly by any organisation or professional involved in the case. The learning from the reviews is now being progressed and implemented.

Over the last 12 months we have seen a number of developments and improvements being put in place in order to enhance safeguarding or to minimise the risk of harm to adults at risk. These include:

- Significant work towards the revised Multi Agency Safeguarding Adults Policy & Procedures document.
- Establishment of a Fire Safety Development Group.
- A framework for the resolution of professional disagreements in working relationships for the safety of adults at risk.
- A joint safeguarding communication campaign calendar covering adults and children.
- A joint working protocol between Healthwatch Gloucestershire and the Board.
- Safeguarding Adults Team membership of the Multi Agency Safeguarding Hub (MASH).

As outlined in this report we have seen improvements which have made a significant contribution to safeguarding, but all Boards face a number of challenges as we move forward. Many of these are being actively addressed or are in the process of being implemented, whereas the impact of others is simply unknown.

These include: continuing austerity, potential increases in demand, maintaining quality at the same time as putting the person at the centre of the process, the inclusion of self-neglect within the Care Act and engaging and consulting with the wider community.

Gloucestershire Safeguarding Adults Board is not complacent about the work ahead and is committed to seeking continuous improvement and learning. We will work in a supportive and collaborative way, challenging ourselves in order to assess our effectiveness in safeguarding adults at risk in Gloucestershire.

Paul Yeatman
Independent Chair
Gloucestershire Safeguarding Adults Board

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1. Vision

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

During the past year the Board has carried out significant developments to ensure it enshrines the national principles of safeguarding and encompasses the provisions laid out in the Care Act across all of its areas of responsibility. The Board is confident they are fully prepared for April 2015 when the Care Act requirements come into force.

The Care Act 2014

The Act refers to an adult at risk as someone who:

a) has needs for care and support (whether of not the Local Authority is meeting any of those needs),

b) is experiencing, or is at risk of abuse or neglect, and

c) as result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The Act sets out the first ever statutory framework for adult safeguarding which stipulates local authorities' responsibilities and those with whom they work, to protect adults at risk of abuse or neglect.

These provisions require the local authority to:

- Carry out enquiries into suspected cases of abuse or neglect.
- Establish Safeguarding Adults Boards in their area.
- Arrange where appropriate for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or review.

The provisions require a Safeguarding Adults Board to:

- Publish an annual report detailing what the Board has done to achieve its objectives and what it and its members have done to implement its strategy.
- Arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if certain laid out conditions are met.
- Request where necessary a person to supply information to it or to some other person specified in the request; the person to whom the request is made must comply if certain laid out conditions are met.

Local Authorities have always been expected to **lead** adult safeguarding and this legislation will **formalise that as a duty**. However **safeguarding has to be everybody's business,** therefore the Local Authority plays a pivotal role in building strong relationships with other organisations such as the NHS, the police, third sector and providers. They form the trust and bedrock on which a multi agency approach thrives and they lead the formation of sound local policies, procedures and lines of accountability.

2. The Board's Key Achievements 2014-15 and Strategic Plan

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

- Working with colleagues locally and nationally to revise the Multi Agency Safeguarding Adults Policy and Procedures to ensure agencies and individuals continue to work together effectively in line with all the wellbeing and personalisation principles set out in the Care Act.
- Refreshing the Workforce Development Strategy to deliver both a generic and bespoke training programme to support all people working with and caring for adults who may be at risk of abuse or neglect.
- Establishing a Fire Safety Development Sub- Group which is developing ways to respond to and support people whose fire safety is significantly compromised and reduce avoidable fires and the injuries and deaths that can occur as a result.
- Working with colleagues providing services to children to deliver a successful joint Communication Summit. This was followed by a safeguarding campaign which delivered key messages out across the communities about keeping adults and children at risk safer.

Multi Agency Safeguarding Hub (MASH)

A further achievement for the Board over the last 12 months is that Gloucestershire County Council's Specialist Adult Safeguarding Practitioners joined Gloucestershire's MASH in January 2015.
The Mash came into operation in 2014 for agencies providing services to children and it is now proving of real benefit for safeguarding adults services to be represented there. Partners are located together in a secure environment where information can be shared in a dynamic and confidential way in order to identify and assess risk early on.

Through the following year Gloucestershire County Council's Safeguarding Adults Team will be actively looking to create further improvements to ensure improved outcomes for those adults experiencing or at risk of abuse or neglect.

It is important to realise that the MASH is not a new way of reporting safeguarding concerns. Anyone who has a concern about an adult with care and support needs should continue to report this in the same way to **Gloucestershire County Council's Adult Helpdesk on 01452 426868.**

Priority - Empowerment

We will aim to give individuals relevant and clear information about recognising abuse, how to report it and the choices available. This will be achieved by:

- delivering the Safeguarding Communication Strategy;
- keeping the Board's Website updated;
- reviewing the Workforce Development strategy in line with the Care Act 2014.

We will consult with and listen to the voice of people who have experienced the safeguarding process as a way of learning how to improve our safeguarding services. We will achieve this by:

- learning from the national Safeguarding Outcome Pilot Survey;
- engaging with the national Making Safeguarding Personal Programme;
- establishing relationships with service user/carer groups/forums.

Priorities - 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. We will achieve this by:

- implementing the new Multi Agency Safeguarding Policy and Procedures in line with the Care Act and Making Safeguarding Personal;
- ensuring that the individual suffering abuse or neglect is at the centre of the safeguarding process and has choice and control;
- continuing the commitment for Safeguarding Adults to be an active partner in the Multi Agency Safeguarding Hub.

We will ensure our workforce and wider community have the appropriate knowledge, skills and confidence to protect adults at risk. We will achieve this by:

- ensuring learning from Safeguarding Adults Reviews is put into practice;
- refreshing the 3 year Workforce Development Strategy in line with the Care Act;
- supporting all commissioning processes to include safeguarding principles;
- ensuring compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards;
- ensuring effective and timely progress against national and local commitments to the Winterbourne View Improvement programme;
- ensuring that all Council Members understand their responsibilities in relation to Safeguarding Adults.

Priority - Proportionality

We will make sure professionals work in the best interests of adults at risk and only get involved as much as needed. We will achieve this by:

- being clear and explicit about the definitions and levels of intervention;
- continuing to provide an effective initial screening and triage service to all concerns that are reported and consider potential alternatives if criteria for a safeguarding enquiry are not met;
- developing our workforce to have competent specialists across all partner agencies that can both assess risk and fully understand the range of legal and welfare interventions;
- promoting the role of advocacy as outlined in the Care Act to provide people with support throughout the safeguarding process.

Priority - Partnership

We will have effective multi agency partnership arrangements and information sharing agreements. We will achieve this by:

- the Board and the independent chair holding themselves and other partners to account;
- having information sharing and escalation protocols that are understood by all staff;
- strengthening relationships and links with other strategic partnerships;
- identifying the lessons to be learnt from safeguarding adult reviews and applying those lessons to future practice and cases.

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. We will achieve this by:

- embedding quality assurance processes within all the work of the Board;
- ensuring the Board's performance management information includes feedback;
- producing a Board's annual report and presenting it to both the Health and Care Overview Scrutiny Committee and the Health and Well Being Board;
- ensuring the Board has the capacity to plan and carry out its strategic objectives in line with the Care Act;
- undertaking an annual self assessment process with key partner agencies.

The Board's Strategic Plan is set for a 3 year period in the light of the Care Act Statutory Guidance, which recommends that Safeguarding Adults Boards set a strategic plan for the next 3 – 5 years.
The full plan can be found on the GSAB Website GSAB Strategic Plan

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3. Key issues & Challenges for the coming year

Key issues and Challenges

The Board's main challenges for the next couple of years will to meet the increasing demand and to continue to ensure high quality of practice. Practice needs to focus on improving the safety and wellbeing of people and the realisation of the outcomes they want. This is particularly challenging, with finite resources across all partner agencies.
The board aims to achieve this by:

- supporting those at risk of abuse or neglect to reach the resolution that is right for them and which also protects others;
- putting the adult at risk at the centre of the process;
- maintaining a collective focus from all partners of the Board on protecting adults at risk at a time when all agencies are faced with meeting increasing demand within tight financial constraints;
- expecting Board members to be transparent with each other about successes and the areas where they struggle and want to improve;
- supporting staff to share information intelligently in order to safeguard people's rights;
- making sure quality of service is maximised and the right people and systems do the right thing;
- ensuring the Board has effective links between itself and the local Children's Board, Health & Wellbeing Board, Community Safety Partnerships and NHS England Quality Surveillance Groups.

The Board is committed to working together to improve outcomes for people who are experiencing or are at risk of harm or abuse and the Board will continue to strive to prevent and mitigate these risks.

The Board will have a unique set of risks to monitor and manage which will include, and go well beyond, gaining assurance that partner agencies are managing their own risk in relation to safeguarding adults.

There are a number of aspects of the Board's work that if compromised may result in a possible high risk of the Board not fully achieving its objectives. The Board's Risk Register reflects these collective potential risks which we face.

The format reflects a national safeguarding risk register that has been developed, and we are involved in testing this out alongside other safeguarding boards across the country.
The Board's Risk Register can be found on the GSAB website – GSAB Risk Register

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4. Case Studies

Many safeguarding investigations in Gloucestershire with effective interagency working evidence speedy responses and achieve a better outcome for the individuals involved. Here are 3 case examples that demonstrate this.

Case Study 1

All names and locations have been changed to protect confidentiality

Background

Elizabeth is 85 years old and had lived alone in her own home since her son, who used to live with, her died 2 years previously. The local butcher phoned the Social Care Helpdesk to raise a concern that Elizabeth was ordering a lot of meat to be delivered on a weekly basis. Elizabeth told the butcher that she gives it to her friends, but the butcher was unsure of this. When he had called to deliver the meat that week, he said the smell coming from the property was overpowering and he could see lots of flies in the house. He also said that the house looked extremely cluttered and Elizabeth herself looked unkempt.

Actions Taken

A social worker visited Elizabeth but she refused to let him in. The social worker spoke to Elizabeth's neighbour who said Elizabeth has always been a private person but since her son died had become "reclusive" and hardly left the house. The neighbour shared the contact details for Elizabeth's daughter, who lives in Scotland. The daughter told the social worker that her mum has a gardener who visits, so the social worker contacted the gardener and arranged to visit when he was there. This time Elizabeth let the social worker in and it was clear that the property was in a very poor state, with rotting meat left on the kitchen floor, very cluttered and a potential fire risk because Elizabeth was using an old electric heater. Elizabeth was wearing dirty clothes and did not appear to be taking care of her personal hygiene. The social worker assessed Elizabeth to have the mental capacity to understand her situation and she refused offers of help, saying she just wanted people to leave her alone. The social worker arranged a meeting with the Doctor, the Fire Service and Environmental Health, where actions were agreed to try to mitigate the risks to Elizabeth. The Environmental Health Officer visited and issued a clean-up notice because the property was found to be verminous and there was a public health risk. In the meantime the social worker continued to try and build a relationship with Elizabeth by visiting regularly. Elizabeth was clearly still grieving for her son which was perhaps causing her to shut off from everyone else.

Outcomes

The daughter helped to arrange a clean-up of the property. Over time Elizabeth was encouraged to accept some support with keeping the property in a reasonable state of hygiene. Elizabeth also allowed the Fire Service in to install smoke detectors. She was using the electric heater because her central heating boiler had broken and the social worker obtained funding through a charity for the boiler to be replaced. While Elizabeth remained resistant to what she felt as too much "interference", she did accept a level of support that enabled her to continue living at home as she wished. She also accepted visits from a befriender which were arranged by the local village agent, with whom she then had the opportunity to talk about her son.

Issues highlighted/ learning
This case highlights some of the difficulties of working with someone who neglects their care and is at high risk of serious harm as a result. Where someone is deemed to have mental capacity, they have the right to make unwise decisions; however that does not mean that professionals should just withdraw. The risks in this situation were such that Elizabeth's wishes were overridden in terms of involving other agencies such as Environmental Health, who have powers to enforce actions where there is a public health risk.

The social worker had to think creatively in order to gain access and begin to build a relationship with Elizabeth. It can take time and the good use of interpersonal skills to build trust with an individual who is wary of accepting help. Sometimes the offer of something the person sees as useful (in this case arranging for a replacement boiler) can mark a breakthrough in helping the person to accept support. The issues around self-neglect are often very complex, but bereavement and loss have been identified as contributory factors.

The fact that the safeguarding concern was raised by the local butcher is encouraging as it suggests that the message may be getting out to other people in the community about what to do if you are concerned about an individual. The social worker went back to the butcher to thank him for making the local authority aware, as it is important to feed back appropriate information to the person raising the concern.

Case Study 2

All names and locations have been changed to protect confidentiality

Background
Michael is 25 years old, has a mild learning disability and lives in supported accommodation. Michael is deemed to have capacity to make decisions about his lifestyle and receives 5 hours week of support at flexible times to assist him with various things. Michael is very sociable and likes going to the local pub regularly, where he often drinks to excess. He met a group of people there and started to invite them home late at night. The friends were noisy and disruptive and on one visit actually caused some damage to the property. Michael did not want any action to be taken because he said they were his friends; however the support worker was concerned that he was being exploited by these people and therefore raised a safeguarding concern.

Actions Taken
A social worker visited Michael with the support worker the next day. Michael refused to open the door on the first visit and the social worker went back another time again with the support worker. This time Michael did let them in and they saw he had a black eye. Michael wouldn't explain how this had happened and didn't want to discuss his "friends", however the social worker thought Michael seemed frightened. The support worker had talked to Michael's neighbours, who had complained about the noise and could identify one of the members of the group they had seen regularly entering Michael's flat. His name was checked with the police and he was found to have a number of convictions for drug dealing, theft and assault.

The social worker was now concerned that Michael was being exploited by this group and that he was at risk of potentially serious harm. Because of this assessment the social worker decided it was necessary to override Michael's wishes and arranged a safeguarding meeting. He invited the Police and a local Police Community Support Officer, Housing, a Community Learning Disabilities Nurse and Michael's advocate, whom the social worker had arranged to support Michael. Michael refused to attend the meeting but the advocate was able to report that Michael had admitted that one of the members of the group had hit him, that they had got him to buy drinks for them and would take any money he had left at the end of the night. However Michael still maintained that they were his friends and didn't want any action taken. The advocate felt that the group was preying on Michael because they had recognised he was vulnerable and she felt that Michael was lonely and liked the company.

Outcomes

There had been previous concerns about Anti Social Behaviour by this group in the area and the Housing department decided to seek an injunction preventing certain individuals from entering Michael's property.

The advocate and social worker engaged Michael with a local social group where he quickly made some new friends. The police were not able to prosecute any of the group for the damage to Michael's property because Michael refused to make a complaint. However the Police Community Support Officers made regular drop-in visits to Michael and gave him advice on keeping safe.

Issues highlighted/ learning

The principles of Making Safeguarding Personal and the Care Act make it clear that the person's wishes should always be central to any safeguarding enquiry. However there are circumstances where this principle needs to be overridden. There was evidence that Michael was being exploited and the information from the Police heightened that concern. "Mate crime" is recognised as a form of abuse but is often very difficult for the police to investigate due to its ambiguous nature and the reluctance of the victim to make a complaint.

Michael's social isolation made him vulnerable to this exploitation and working with him to overcome that made him less likely to fall victim to this in the future. Supporting Michael to build a network of positive relationships and advising him on keeping safe improved Michael's quality of life as well as helping him to develop the personal resources needed to protect himself.

Housing departments have powers that can have a big impact on protecting the person from harm. In this case, excluding the perpetrators from Michael's property was a significant factor in improving his personal safety.

Case Study 3

All names and locations have been changed to protect confidentiality

Background

Ann is a 75 year-old woman who had suffered a severe stroke and was cared for at home by her husband Edward, who is 79. Ann was immobile and was cared for in bed. She had been assessed as lacking the capacity to make decisions about where she should live to receive care and treatment. Edward was determined to care for her without help. Domiciliary care support had been arranged in the past but Edward had cancelled this after a short time. Edward was very particular about certain things to do with Ann and had been described at times as “difficult” and “confrontational”.

A District Nurse who visited raised concerns, saying that Edward was leaving Ann to go out shopping, locking her in, and he was not using the correct equipment to move her in bed to deliver personal care (Edward had placed a bin liner under her bed sheets to enable him to move Ann more easily). An Occupational Therapist assessed that this was inappropriate and could lead to pressure sores. It was also a risk to Edward’s health as he should have been using a hoist to move Ann. Both the District Nurse and Occupational Therapist felt that Ann was not safe at home and that a move to a care home should be considered.

Actions Taken

A social worker visited Ann and Edward at home. It was clear to the social worker that they were devoted to each other. Ann didn’t take her eyes off Edward and although she could not communicate easily she smiled and laughed a lot when he was with her and seemed to be following any conversations. Edward was happy to chat with the social worker. Ann had been disabled by childhood polio and he had always been her carer. They had travelled the world together through his job and had a son, who was sadly killed in a road accident so they had no immediate family. Ann looked very well cared for and Edward told the social worker how he made her a home cooked meal every day, and washed and changed her frequently throughout the day and night. The social worker raised the issue of Edward leaving Ann at home alone, but he said that his next door neighbour kept an eye on Ann when he was out.

Outcomes

Over time the social worker built a good relationship with Edward and was honest with him about the concerns raised. Edward accepted a fire safety check and some telecare equipment to improve Ann’s safety for the periods when he was out of the house. He also allowed a carer to come in twice a week and sit with Ann while he was out. Edward continued to refuse the offer of a hoist but Ann did not appear to show any ill health effects from being moved in the way Edward preferred to do it.

Sadly Edward’s health began to deteriorate and his ability to care for Ann began to decline as well. Care was put in place but Edward found this difficult to accept and it became apparent that Ann needed more care than could be provided at home. The situation got worse and the social worker had to suggest to Edward that the time may have come for Ann to go into a care home. He was adamantly opposed to this and so the social worker sought legal advice.

All professionals were then concerned for Ann's safety and the case had to be presented to the Court of Protection for a decision. The Court agreed with the Local Authority that Ann's needs could no longer be met at home and a move would be in her best interests. The Judge praised Edward for his devotion to his wife. Ann was moved to a care home and to ensure that this was the least restrictive option available, a Deprivation of Liberty Safeguards authorisation was granted. Edward visited her as often as he could but he was by now very unwell himself. He sadly died a couple of months after Ann's move.

Issues highlighted/ learning

Despite their difference of opinion, the social worker managed to maintain a good relationship with Edward. The social worker was always honest and Edward said he respected her for that. A person-centred approach is essential to all safeguarding concerns and the views and wishes of the person must always be sought and seen to be paramount.

When professionals identify that a person is at risk of harm, this often creates understandable anxiety, firstly about the wellbeing of the person but also because there is a tendency to blame professionals if things go wrong. This can lead to a focus on protecting the person above all else. However, risk is not only about physical safety. The Mental Capacity Act requires a "balance sheet approach" to the best interests of a person lacking capacity and the social worker in this case weighed up the risks to Ann of remaining at home against the risks to her and Edward's happiness if they were separated. She arranged some measures to minimise the risks to Ann and advocated for the protection of Ann and Edward's article 8 rights (the right to private and family life) as public authorities are required to do under the European Convention on Human Rights. The social worker's intervention ensured that the couple stayed together for as long as possible.

Sir James Munby, President of the Court of Protection, in a speech about personal dignity said:

"The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness. What good is it making someone safer if it merely makes them miserable?"

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5. Partnership Achievements 2014/15 and Priorities 2015/16

There have been a number of achievements both individually by partners and collectively over the last year which have led to a reduction in the risk of harm to adults at risk in Gloucestershire.

Gloucestershire Constabulary

Achievements

- We have restructured our intelligence capability and increased our analytical capacity. In practical terms this has meant we are able to maintain an overview of emerging trends/threats in relation to vulnerable adults, including repeat occurrences.
- The Constabulary mapping system, Javelin, has been used to record the locations of care homes to assist in the response to vulnerable adults.
- We have made our staff aware of the Care Act 2014 and the implications for them in terms of the statutory responsibility to identify vulnerable adults, share information and investigate offences.

Priorities

- To make the identification and sharing of information relating to vulnerable adults more efficient and effective by placing the process on a mobile device for our officers.
- To transfer the stand-alone vulnerable adults database onto the police intelligence system, allowing better access to information and auditability.
- To conduct a root and branch review of the police Central Referral Unit (CRU) to improve process efficiency and create capacity. The CRU is the link between the police and all other agencies in the county either directly or through the Multi Agency Safeguarding Hub.

Demand Control

- We have uplifted the investigative resources available to investigate offences against vulnerable adults by two sergeants and four detectives.
- We are going through the CRU review, considering the necessity of what we do and if there are more efficient or effective ways of doing things.
- We have created the post of missing person coordinator in order to provide tactical advice to our staff and initiate a problem solving approach to safeguarding the most vulnerable who go missing.

Quality assurance

- Supervision resource has been increased and now ensures proactive and timely, well considered investigations take place in relation to the most vulnerable.
- The CRU are able to filter and quality control referrals to the Gloucestershire County Council Safeguarding Adults Team.

2gether NHS Foundation Trust (2getherNHSFT)

[2]gether NHS Foundation Trust is fully committed to true partnership working with Gloucestershire Safeguarding Adults Board and is immensely proud of the advances that have been achieved in the previous 12 months. Our Trust has enjoyed the challenge of endeavouring to make real sustainable improvements for vulnerable adults in Gloucestershire. We believe that we have been a diligent and active partner in the boards work in the last year. Our own achievements in the previous 12 months include:

- a review and refresh of Trust safeguarding dashboards;
- an improved focus on increasing access and quality of safeguarding training within the organization;
- maintaining a high level of organisational focus on safeguarding within the organisation via the Trust's safeguarding committee, quarterly board reports, newsletters, intranet pages and visiting teams to raise the profile of safeguarding best practice.

Looking forward to 2015/16 our priorities will remain aligned to the Gloucestershire Safeguarding Adults Board Strategic Plan, with a particular organisational focus on improving the quality of recording safeguarding information, improving access to training for professionals and work around delivering our shared responsibilities under the new Care Act. We are developing our 2015/16 organisational level safeguarding plan with a range of objectives. These include areas such as audit, improving information systems and sharing learning from case reviews, all aiming to provide robust quality assurance.

We acknowledge, like our partners, the challenges faced by services in times of financial pressure and increasing demand. However as a Trust we continue to maintain our safeguarding specialist team and continually seek to improve efficiency in providing sound and safe care with regard to safeguarding adults in our county.

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)

GHNHSFT is a committed partner to safeguarding adults at risk of abuse and neglect. The Trust's Nursing and Midwifery Director, is the Executive Lead for safeguarding and is a proactive member of GSAB. There is senior level Trust representation on GSAB sub-groups with proactive engagement in all work plans.

Key achievements 2014/2015

- Safeguarding those in our care forms part of our strategic objectives including nursing and midwifery. Harm prevention, promotion of quality, compassionate care and positive patient and carer experience are at the centre.
- Initiatives to support continued improvements to patient and carer experience for patients with dementia or a learning disability and with vision and hearing impairment, remain of high priority to GHNHSFT.
- Safeguarding is an integral part of patient assessment; staff follow multi-agency safeguarding policy and procedures and Trust safeguarding adult reporting protocol. A Trust Safeguarding Adult Clinical Checklist document is used and a Trust Domestic Abuse Checklist promoting best practice.
- We continue to promote integrated arrangements between safeguarding children, safeguarding adults and the domestic abuse process.
- Safeguarding adults, Mental Capacity Act and Deprivation of Liberty Safeguards training is mandatory, with compliance at 95%. Our safeguarding training now also includes Domestic Abuse awareness training.
- We held a series of staff events to promote, Patient Nutrition and Hydration, Dementia Awareness, Carers Involvement, Focus on Prevention, Domestic Abuse awareness campaigns and best practice Tissue Viability Care.
- A series of information articles are published in our Trust Newsletter 'Outline' including, 'Best Practice Clinical Care Standards', 'Supporting Dementia Care',' Domestic Abuse Awareness', 'Patient and Carer Experience', 'Duty of Candour' and information to support our new Raising Concerns Policy.
- Safeguarding trends are monitored and reported. Our Safeguarding Adults Team has strengthened monitoring in support of best practice.
- An updated Trust Mental Capacity Act and Deprivation of Liberty Safeguards action plan has been developed, supported by staff case discussion sessions. A revised Mental Capacity Act Protocol implemented, with tools to support practice, underpinned by the Multi Agency Mental Capacity Act Policy.
- Trust Safeguarding Adult Policy has been updated and is undergoing further review in light of the new requirements for safeguarding adults within the Care Act and the update of the multi-agency policy.
- Our Trust safeguarding adults website has been enhanced to ensure fast access to resources to promote safeguarding those in our care.
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Key objectives 2015/16

- Strengthen best practice delivery of the Mental Capacity Act and progress our action plan.
- Update Trust Deprivation of Liberty Safeguards Protocol and tools.
- Review and update of Trust Safeguarding Training programme and packages
- Continue to promote Essence of Care Clinical Care Standards.
- We are committed to listening and learning, to working in partnership and to further improve safeguarding and care experience.

Gloucestershire Care Services NHS Trust (GCSNHST)

During 2014/15 GCSNHST has continued to play an active part in the work of the Board and its sub-groups.

Achievements within the last financial year

- Within the organisation we have been able to bring the adult and children's safeguarding teams together under a GCSNHST Head of Safeguarding post, with a new post of Specialist Nurse for safeguarding adults being created.
- The existing Safeguarding Adults Committee has been reviewed, has increased membership from operational services and is now called the Strategic Safeguarding Operational Group.
- 444 employees have completed formal safeguarding training and bespoke training has also been delivered to non-service user facing employees and our volunteers. A further 450 have attended the safeguarding session provided to all staff as part of their induction. This demonstrates the organisation's continued commitment to training and education despite continued pressure on our services.
- Our safeguarding dashboard has been further developed and the Head of Safeguarding attends the Quality and Governance Committee on a regular basis to brief members and discuss issues such as ongoing serious case reviews. Governance processes have been refined to ensure quality assurance is in place.
- Both the corporate induction and foundation day training have been refreshed to ensure Care Act compliance.
- We have participated in national campaigns such as "stop the pressure".
- Our first safeguarding adults newsletter has been produced and circulated.
- We achieved the target set by commissioners to reduce the number of pressure ulcers that individuals developed while in our care.

Priorities for the next 12 months

- Development of a communications programme so each month sees some activity in the organisation relating to safeguarding and associated topics.
- Implementation of the National Safeguarding Adults supervision tool to demonstrate the knowledge transfer for staff once they have completed training.
- Monitor the training and education provision and uptake by % of employees trained.
- Further development of the safeguarding work plan and dashboard

Gloucestershire Clinical Commissioning Group (GCCG)

GCCG is committed to ensure that safe and effective health services are commissioned for all service users in Gloucestershire.

There is a clear line of accountability set out in the management structure, with a Lead GP for Adult Safeguarding identified at Board level. The Executive Nurse is responsible for adult safeguarding supported by the Safeguarding Lead Nurse. There is an identified GP Lead for the Mental Capacity Act (MCA). Deprivation of Liberty Safeguards and MCA update training is a Care Quality Commission (CQC) requirement for all GP practices.

All GCCG staff are required to complete Level 1 Adult Safeguarding Training as part of the mandatory training programme and this is monitored by the Lead Nurse. The GCCG has an identified a PREVENT Lead who has established links with the Regional PREVENT Lead.

The GCCG has committed to contribute financially to the GSAB budget on an annual basis to support the GSAB. The GCCG is an active member of the GSAB and sub-groups, contributing to the GSAB work plan where appropriate.

There is now a funded representative from health to work as a researcher in the Multi Agency Safeguarding Hub, providing a health component in the information gathering process.

The GCCG is a member of the NHS England Adult Safeguarding Group which has started work to implement the Care Act 2014 and develop an Adult Safeguarding Information Pack for Primary Care.

GCCG works closely with the local authority and CQC to ensure that any safeguarding concerns in relation to care homes in Gloucestershire are robustly investigated in a timely way, and the welfare of the residents remains paramount.

The GCCG has contributed to 2 Adult Case Reviews and 2 Domestic Homicide reviews during 2014-15. The learning from these has been reported to the Information and Governance Group (I & G Group) and actions pertaining to the GCCG noted and completed. The I and G Group receive a bi-monthly safeguarding report and are alerted to areas of concern through the reporting process.

Any safeguarding updates or information are disseminated across the organisation using the GCCG intranet, CCG Live. There is also a monthly newsletter that is communicated directly with Primary Care. The safeguarding pages are updated on a regular basis to ensure information is current and contact details are up to date.

Looking to the future, the GCCG is in the process of developing the Designated Adult Safeguarding Manager role. This person will work closely with their counterparts in partner organisations to improve multi agency working across the county to protect vulnerable adults from abuse and neglect in Gloucestershire.

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6. Safeguarding Adults Reviews

During 2013/14 the Board revised its approach to conducting Serious Case Reviews in line with the requirements of the Care Act 2014, renaming them Safeguarding Adult Reviews. The Care Act 2014 has not only introduced statutory Safeguarding Adults Reviews but has also introduced flexibility when determining the most appropriate learning methodology to be used, in order to maximise learning.

When determining the methodology to be used in conducting the review, the sub-group has to be mindful of which agencies and individuals were involved in the case. The sub-group will weigh up what type of review would be proportionate to the case and will promote effective learning and improvement action, with a view to preventing future deaths or serious harm from occurring.

The purpose of Safeguarding Adults Reviews is not to investigate abuse, or to apportion blame but rather to provide an opportunity to improve multi-agency working, to share best practice, and learning. All Safeguarding Adults Reviews have an action plan which set out recommendations for change and actions to address these.
Two reviews have been completed in the past 12 months, and a further one was commenced in early 2015.

Safeguarding Adults Review "Sexual and financial abuse in supporting living home X" - Completed:

This was a major adult case review which was completed by an independent author and was published on 26th February 2015, having been presented to the Gloucestershire Safeguarding Adults Board (GSAB) that same day.

A copy of the full report can be found at Safeguarding Adult Case Review .

The Safeguarding Adults Review was commissioned by the Board following the imprisonment of both Adult A on 20th March 2014 for the rapes of three women with learning disabilities and Adult B on 25th April 2014, for offences of fraud by abuse of position of trust.

The methodology used in conducting this review was of a hybrid nature. A root cause analysis was applied to what was considered a key event in 2007 in order to understand the underlying causes of failings, whereas a traditional serious case review was taken for the learning event as a whole.

There were 12 key recommendations which fell out of the review. These were accepted by the GSAB and are now being actioned.

Apologies for the failings in this case were delivered in person to those families and victims who asked to meet with the Independent Chair of the Board.

Safeguarding Adults Review - Significant Incident Learning Process (SILP) – "Peggy" – Completed:

This review was published on 30th March 2015 and was conducted using a SILP method which has been used before by both the Adults and Children's Boards in Gloucestershire. The final report was presented to the GSAB on 26th February 2015.
A copy of the full report can be found at Safeguarding Adult Case Review.

Peggy was an 88 year old woman who suffered from dementia and lived in a local care home. Peggy left the care home in the middle of the night on 12th March and was found within 10 minutes, but had suffered a stroke. She died some 3 days later.

The SILP model engages frontline staff and their managers in reviewing cases, focusing on why those involved in the case acted in a certain way at the time.

Peggy's family were fully involved throughout the period of the review to inform them of the process and ensure their views were taken into account and included.

There were 6 key recommendations which fell out of the review, which were accepted by the GSAB and are now being actioned.

Safeguarding Adults Review – "RH" – Ongoing:

This review was commissioned by the GSAB on 12th December 2014 and involves an adult at risk who funds his own care and who sustained a serious injury as a result of self-neglect.

This is the first review that the Board has undertaken in respect of an individual who funds their own care. It is hoped that the learning which arises from this case will help deliver continuous improvement in individual and inter–agency working, with individuals who fund their own care in Gloucestershire.

An independent author has been appointed and the learning process will involve front line practitioners, their managers and subject matter experts.

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Sub-Group Achievements 2014/15 and Priorities 2015/16

Workforce Development

Achievements:

- 12,705 GSAB approved training & development courses were undertaken during the year. Within this total, 4,770 were face to face training programmes and 7,935 e-learning completions. See table GSAB Training Summary 2014/15.
- The new specialist programme for social workers and their managers has been rolled out, with excellent evaluations. 100 staff attended during the year.
- Impact evaluations from a sample of courses evidence increased confidence and practice improvements.
- Two highly regarded Continuous Professional Development days for safeguarding trainers were held, the second one focused on requirements of the Care Act 2014.
- A further cohort of train the trainers was supported to deliver GSAB Foundation level training
- Provision of Mental Capacity Act and Deprivation of Liberty Safeguards Awareness courses for trainers.
- Enhanced support, trainer mentoring and guidance provided by the Safeguarding Adults Workforce Development Coordinator.
- Generic safeguarding induction module developed and joint training for commissioners with Gloucestershire Safeguarding Children Board.
- Bespoke safeguarding meeting minute taking courses delivered.
- Supervision tool for managers introduced (to evidence knowledge transfer).
- All training and development materials reviewed and updated to meet Care Act requirements.
- Bespoke training for Primary Care developed and pilot site agreed.
- PREVENT alignment reviewed and remains under discussion.
- Joint ethnic minority community safeguarding training under development with Gloucestershire Safeguarding Children Board.

Key plans for 2015/16 include building on the above, plus specifically:

- Incorporating the new Multi Agency Safeguarding Adults Policies and Procedures.
- Annual Board development session to be organised for late 2015.
- Widen partner engagement.
- Report statutory sector % training compliance.
- Ensure workforce development needs of the Board's Strategic Plan, further Care Act requirements and emerging case reviews are addressed.
- Continue to support knowledge transfer and practice development needs.
- Resource observation and mentoring support for Deprivation of Liberty Safeguards awareness trainers.
- Address council member development needs.
- Consider manager / leader development needs.

Fire Safety Development.

The Board has established a Fire Safety Development Group in the later part of 2014 following six fire deaths and a subsequent Thematic Review .The Board is grateful for all the enthusiasm and support for this group, particularly the Gloucestershire Fire & Rescue Service that has and continues to lead this work. The aim is to reduce the risk of harm to adults who have care and support needs living in their own homes or in residential care. As a result there is more protective equipment being installed in people's homes so they can stay safe from fire. Residential care homes have also improved their staff training and availability of a range of fire safety equipment to keep people safer.

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The aims are:

1) To develop a risk management process to respond to people where their fire safety is significantly compromised.
2) To develop a Fire Safety Framework outlining how partner agencies will work together effectively to safeguard adults who are at significant fire risk.
3) To implement the Fire Safety Framework as a means of reducing avoidable fire deaths and 'near miss' fire incidents which have resulted in serious injury.

Objectives:

1) To advise the Board on a range of approaches to enable the identification of people at significant fire risk to enable outreach work to be undertaken.
2) To produce a Gloucestershire Fire Safety Action Plan.
3) To develop a shared Fire Safety Framework to be approved by the Board. This to cover the following:
   - Respective roles and responsibilities of partner agencies.
   - Agreement of thresholds re level of response.
   - Clarification regarding information sharing duties and powers.
   - Legal powers and remedies potentially available.
   - Prevention and early intervention measures.
   - Practice guidance and toolkits and links to self neglect, hoarding, etc.
   - Avoidable fire deaths and near misses linked into learning and review frameworks.
4) To meet within 72 hours of a fire fatality to ascertain whether or not the case should go to the Safeguarding Adults Review sub-group for consideration.

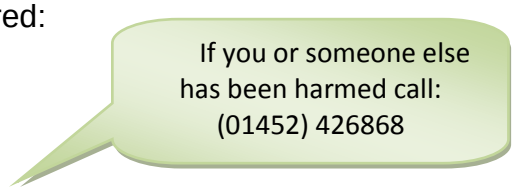
Achievements.

Since the 19th December, the group has met three times – 2 were scheduled meetings and one was called following a fire fatality. The group is currently working on the multi agency action plan which it hopes to take to the Board soon for sign off. The group is well attended with a wide range of agencies represented. There is a clear commitment to this area of safeguarding work and a real desire to make a difference on a multi agency level.

Communications

The Safeguarding Communication Summit was attended by GCC, Police, Health Partners, District/Borough Councils and voluntary sector representatives, who agreed a structured communication campaign which ensured:

- People were made aware of what to do to keep themselves and others in Gloucestershire safe.
- People were informed where they can go if they, or others, are at risk of harm.



Each safeguarding campaign had bespoke messages and specific audiences appropriate to the safeguarding issue. Campaigns carried out included:

- Introducing the Multi Agency Safeguarding Hub (MASH).
- Domestic Abuse.
- Hospital safeguarding awareness events.
- Fire Safety.
- Dementia Summit.
- Forced Marriage.
- Internet Safety.

Communication campaign priorities for 2015/16 will include:

- Self Neglect.
- Care Act and Making Safeguarding Personal.
- Fire Safety.
- Domestic Abuse.
- Missing Adults.
- Isolated carers 'Who will fill your shoes?'
- Learning from Safeguarding Adults Reviews.
- Black and Ethnic Minorities Safeguarding Inclusion Day.

Policy & Procedures

Gloucestershire were invited to join the West Midlands region in developing their Safeguarding Adults Multi Agency Policy and Procedures. The West Midlands kindly agreed Gloucestershire could adopt these locally. The policy reflects the principles of the Care Act 2014 and sets out the approach taken to safeguarding adults in Gloucestershire. The procedures will explain how agencies and individuals should work together to put the Gloucestershire Safeguarding Adults Policy into practice.

With wellbeing, and *Making Safeguarding Personal* as the underlying principles, the Care Act gives new duties to professionals involved in adult safeguarding in England. It also gives new rights to adults who need care and support and their carers. The Care Act leaves no doubt that it is the person, not the process that determines how safeguarding work is taken forward by professionals.
Because of the new legislation and guidance from government on adult safeguarding, the policy and procedures will be seen as draft documents that will be tested out and developed extensively during 2015/16.

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7. Activity & Data 2014-15

During 2014-15, **2,901** calls were made to the Gloucestershire County Council Safeguarding Adults Team Advice Line. There has been a **3.8%** reduction in the number of safeguarding concerns reported to Gloucestershire County Council's Adult Help desk (01452 426868), **3,854** during 2014-15 compared to **4,008** in 2013-14.

These concerns can be separated out into three distinct categories:

1) Concerns that an adult with care and support needs is at risk of serious harm.
2) Concerns that an individual is causing serious harm to an adult with care and support needs.
3) Concerns that an individual is at risk of serious self neglect.

	2013/2014	2014/2015	Change
Adults at risk	2,991	2,844	-4.9%
Possible cause of risk	730	763	+4.5%
Self neglect	287	247	-13.9%
Total	4,008	3,854	-3.8%

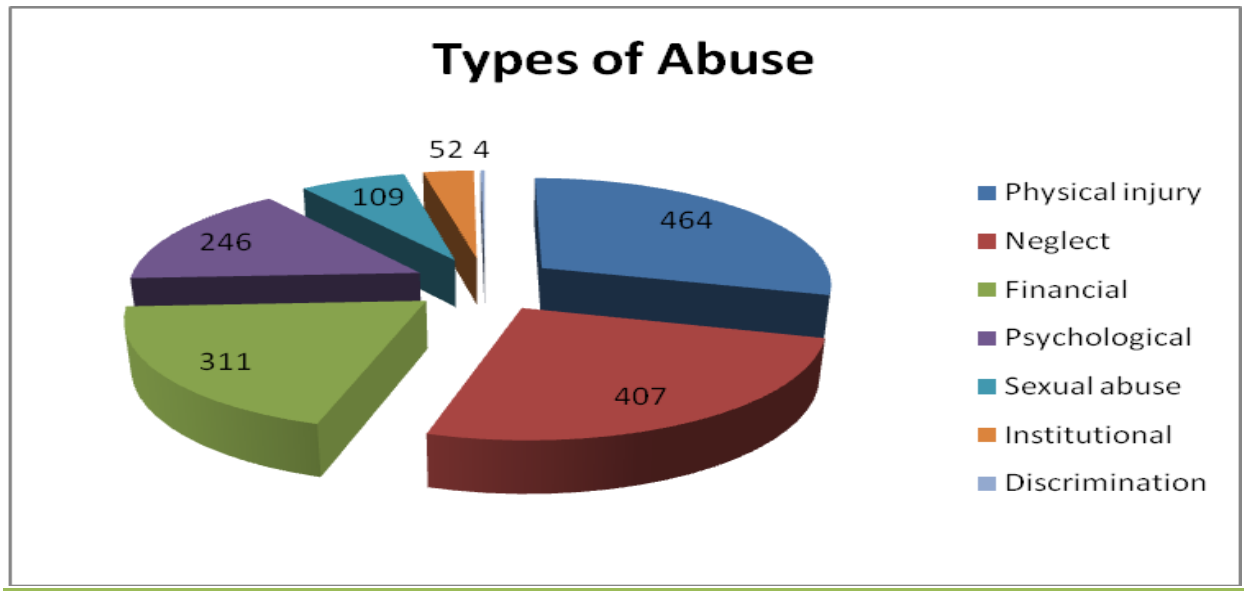
The number of those concerns investigated under safeguarding procedures was **35.1%**. This was a **4.0%** reduction to the year before (**1,353** compared to **1,419**).

Concerns were reported by:

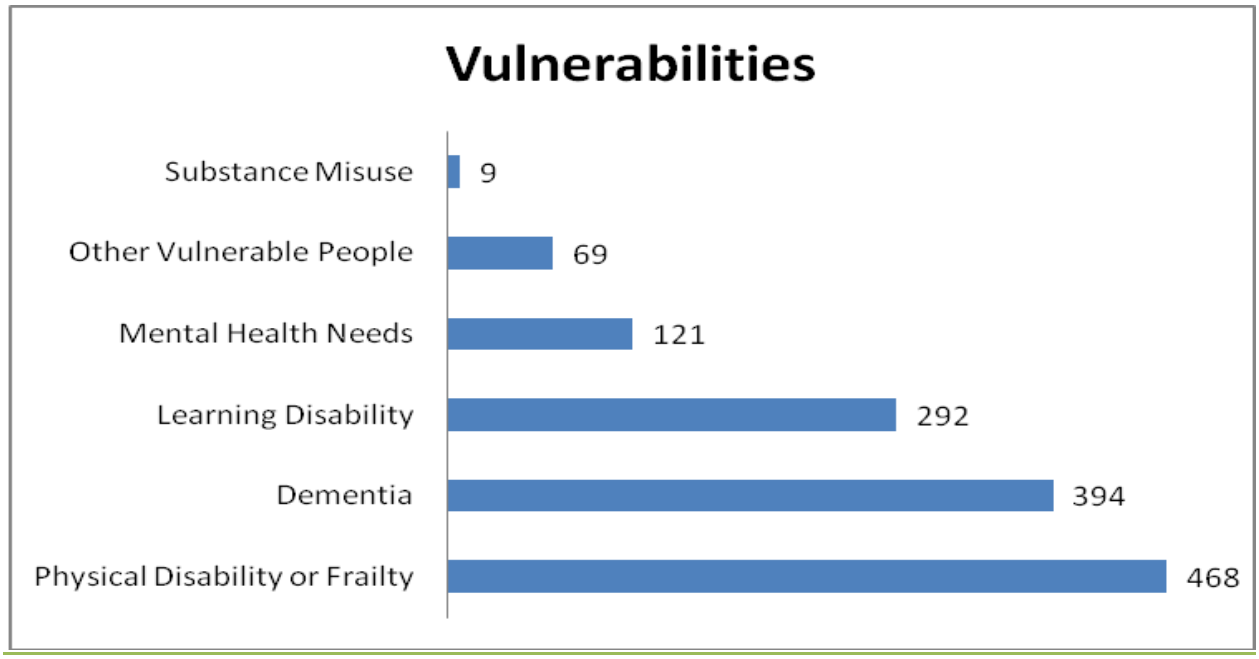
Source	Concerns
Residential Care Homes	1,459
Home Care	471
Gloucestershire Hospitals NHS Trust	296
Gloucestershire County Council	234
Gloucestershire Care Services	219
Friends and family	208
Gloucestershire Police	202
2Gether NHS Foundation Trust	159
Housing	131
General Practitioner	73
South Western Ambulance Service	69
Other - charity	60
Education/Training/Workplace Establishment	58
Other source	53
Anonymous	45
Other - medical	28
Day care	20
Care Quality Commission	19
Public	16
Self	16
Gloucestershire Fire Service	10
Other - Mental Health	8
Total	**3,854**

Most concerns were raised by residential care home staff as their contracts require them to report any relevant incidents.

Physical injury and neglect continue to be the most common reasons for an investigation, however there are cases which involve more than one abuse type:



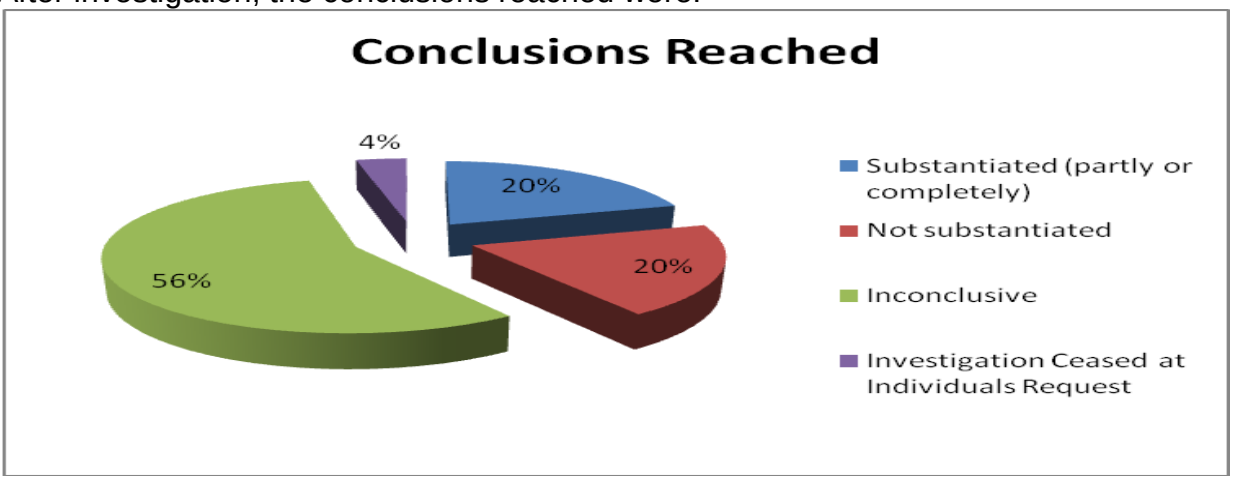
The **1,353** investigations carried out related to people with various vulnerabilities:



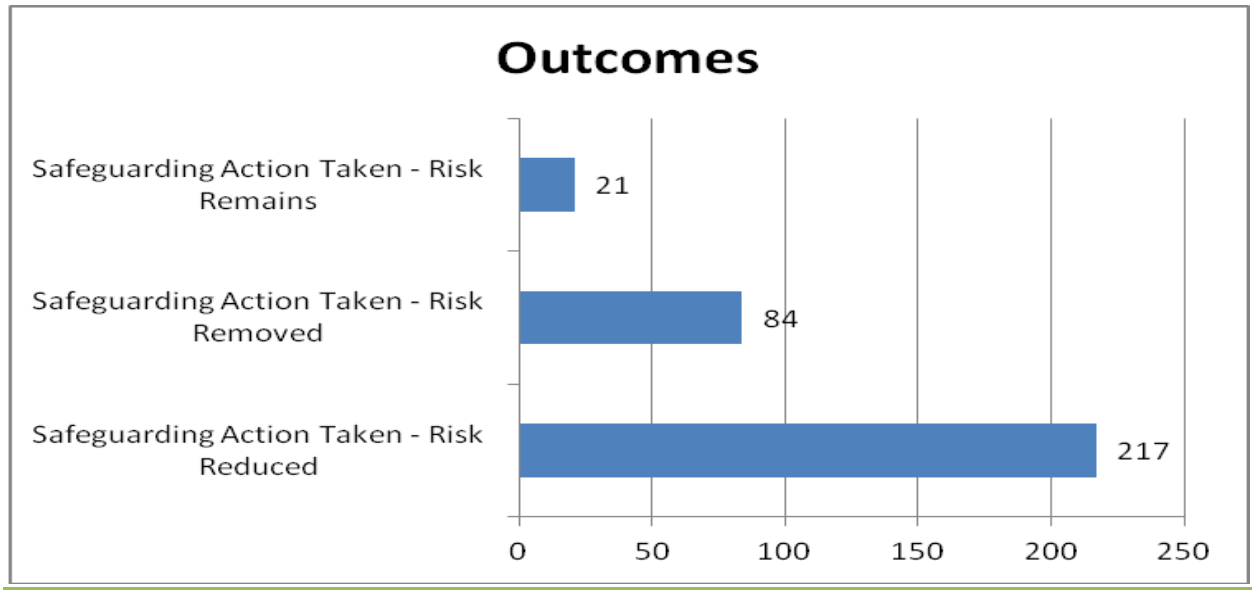
And the incidents took place in:

Location	Enquiries
Own Home	610
Care Home	449
Any Other Setting	135
Hospital	52
Public Place	49
Service within the Community	31
Another Person's Home	27

After investigation, the conclusions reached were:



However, next year, the Department of Health requires us to focus on how the risk of further harm has been managed rather than just a determination of whether allegations can be substantiated. During 2014/15 the relevant figures were:



Of those people that concerns were raised about, we also know that:

- **1,117** (82.5%) were already known to the county council.
- **784** (57.9%) were female.
- **521** (38.5%) were aged 80 and over.
- **409** (30.2%) were suffering from dementia.
- **335** (24.8%) of these investigations carried out were thought to be a criminal matter.
- **305** (22.5%) were regarded as lacking mental capacity.
- **229** (16.9%) had somebody to represent them.
- **183** (13.5%) have suffered a stroke.
- **178** (13.2%) have subsequently died.
- **82** (6.1%) are recorded as autistic.

Of the individuals or organisations causing the concern:

- **70.4%** were already known to the adult.
- **25.3%** were being employed to provide support.
- **4.3%** were strangers.

Of the 3852 safeguarding concerns reported, 202 had the involvement of Gloucestershire Police. 89 of these 202 led to further enquiries and 63 of them were investigated as a criminal matter and included the following actions:

- Taken into custody.
- Disclosure and Barring Service Referral.
- Charges dropped at the victims request.
- Domestic Violence Protection Order.
- Formal and Informal Cautions.
- Arrested and bailed – pending court appearances.
- Pending Crown Prosecution Service decision.
- Restorative Justice.
- Police Information Notice - to raise awareness of risk with relevant people.

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8. Quality Assurance

Audit Group

The Board's Audit Group was established in April 2014 and has given priority over the last year to checking quality of practice through multi agency case file audits:

The Group's Purpose is to:

- Consider how to measure the impact of safeguarding procedures on the lives of adults at risk of abuse and neglect.
- develop information on outcomes of the safeguarding process, including protection plans and the impact the process has on people's quality of life.
- To raise standards of practice and compliance with procedures through audit and review activity.

The Group's Overall Responsibilities are for:

- Identifying areas where audits may prove useful and informative.
- Carrying out audits identified by the Board itself, it's Management Committee or the Audit Group in agreement with the Board.
- Producing regular reports.
- Feeding back any issues, concerns or learning.
- Promoting an environment of multi agency shared learning.
- Updating the audit strategy on a yearly basis.
- Developing a multi agency audit tool.
- Ensuring that any audit recommendations from Safeguarding Adults Reviews are carried out in line with Board's requirements.
- Reviewing the audit procedure in line with any changes recommended by the Board and/or the Management Committee.

The group has conducted two full day multi agency audits this year. Both audits looked at a small number of cases in depth. This was felt to be preferable to auditing a higher number of cases as it enabled the group to focus on the approach to safeguarding rather than the process, and provided qualitative information.

The first audit in November 2014, examined 6 cases where an adult had been the focus of a safeguarding concern, and the second focused on 7 complex cases where self-neglect had been identified as an issue. Agencies who took part were provided with details of the cases beforehand so that they could research the cases and bring information about their involvement.

Agencies who participated found the experience very helpful in identifying strengths and areas for improvement.

Priorities for 2015-16 will focus on the new requirements of the Care Act and include:

- Examination of how central the adult at risk's wishes and views are to the safeguarding enquiry.
- Domestic violence and safeguarding adults.
- Decision-making under section 42 of the Care Act.

Safeguarding Outcomes Measure Pilot Study

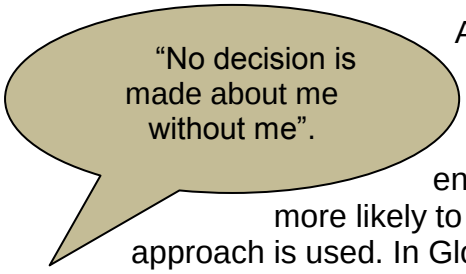
Currently there are not any national safeguarding outcome measures that focus on people who have been supported by adult safeguarding services and therefore the Board welcomed taking part in national pilot survey in 2014. This involved collecting information about adult safeguarding outcomes as a way of improving services to find out the views of people who had experienced safeguarding.

A number of staff from the Board's partner agencies were involved in meeting with people individually who had experienced safeguarding services to find out if they felt listened to and safer as a result of the support they had received.

Although numbers were small, the findings evidenced that people did feel listened to but did not always feel in control. Most people who were willing to participate did feel safe from continuing harm, but this sometimes depended on other factors such as their general health and wellbeing. Some people told us that agencies needed to work better together to ensure people get the help they want. For example, when there is not enough evidence for a Police prosecution, people would like this to be explained to them. Any concerns raised with us during the meetings have been acted on.

Making Safeguarding Personal

The "Making Safeguarding Personal" initiative is a national project set out to develop person-centered responses to safeguarding circumstances. It encourages councils and their partners to develop a range of responses they can offer to people who have experienced harm and abuse, so that they are empowered and their outcomes are improved. This includes ways of ensuring outcomes can clearly be identified through safeguarding processes.



A successful approach is to ask the person at the beginning of the process what outcomes they want to achieve, to check these midway and then review whether or not the outcomes had been met at the end. It is clear that people want to feel in control and are more likely to do so when an outcome focused, person-centered approach is used. In Gloucestershire we are taking this forward by:

- Reviewing the multi agency policy and procedures.
- Reviewing training arrangements and approaches.
- Ensuring safeguarding information is more accessible to the public and staff.
- Ensuring that we are asking these questions at all stages of the safeguarding process.

Carers

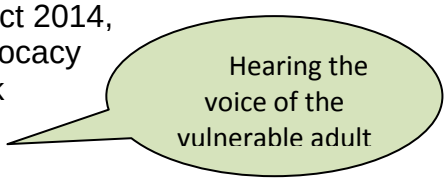
The Care Act 2014 recognises the key role of informal carers in relation to safeguarding. An example would be when a carer may witness and report a situation where abuse or neglect is potentially occurring. Carers may be experiencing intentional or unintentional harm from the person they are trying to support or care for but also can be put in a position that they may intentionally or unintentionally harm or neglect the adult they support.

The Gloucestershire Safeguarding Adults Board will ensure that each situation is seen individually and holistically and that the safety and wellbeing of both the cared for and the carer will be taken into account. The Board will always try to prevent the situation from deteriorating or breaking down totally.

Independent advocacy & Safeguarding under the Care Act 2014

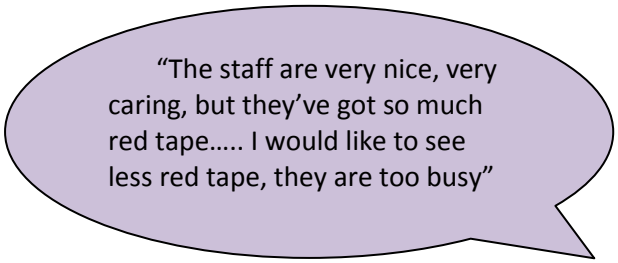
The Care Act 2014 puts adult safeguarding on a legal footing and from April 2015 each local authority must arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adults Review where the adult will have 'substantial difficulty' in being involved in and understanding the process and where there is no other appropriate adult to help them.

Gloucestershire County Council, in response to the Care Act 2014, began undertaking a review of information, advice and advocacy relating to care and support. Providers were asked to work with the council to develop a strategic approach to the way information, advice and advocacy services are commissioned and delivered in the future. A number of stakeholder events were held throughout the year to listen to views, share ideas and develop solutions.



Care Home Whispers Project Report

The Care Home Whispers report covers the findings of a project led by Age UK Gloucestershire, working in partnership with Gloucestershire Safeguarding Adults Board ,Gloucestershire Care Providers Association, and Gloucestershire County Council and funded by the Gloucestershire Police and Crime Commissioner.



The Care Home Whispers Project sought to find out about the real experience of the older people living in care homes in Gloucestershire and hearing from residents about their lives, what matters to them, what makes them feel safe and what they think makes a good life in care.

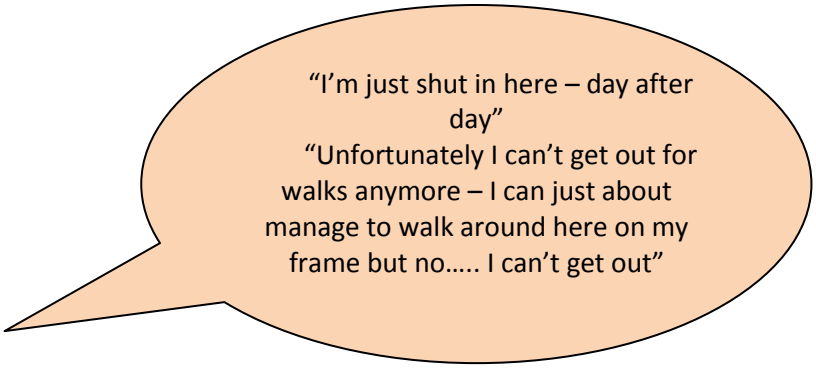
Nearly 90 older people contributed via in-depth interviews, with specialist communication techniques used to engage with people living with dementia or other cognitive impairment, living in a range of residential and nursing care homes in the

county, including large and small, rural and city-based homes and homes reflecting a mix of socio-economic groups

The target was to make sure that at least a third of participants were people most at risk of being overlooked due to barriers to communication, such as sensory loss and dementia, or who have no external contacts and therefore no-one to advocate on their behalf.

Six key themes have emerged:

- Being comfortable.
- The importance of good relationships.
- Opportunities to make choices.
- Meaningful activities.
- Having the opportunity to get out of the home.
- Maintaining identity.



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10. The Board's Resources

Membership

The Board continually reviews its membership, and particularly in light of it being put on a statutory footing from April 2015, our aim is to ensure it is has appropriate relationships and systems in place for discharging its safeguarding roles and responsibilities.

This year the Board has welcomed additional new members.
Link to Board attendance.

GSAB Funding Contribution Arrangements

The funding for the Board and its activities includes proportionate costs associated with:

- The Boards' independent chair.
- Gloucestershire County Council Head of Safeguarding Adults post.
- The Board's Business and Project Officer.
- The Board's Administrator.
- Multi Agency Safeguarding Adults Workforce Development Strategy and training pathway.
- Safeguarding Adults Reviews.
- The Board's communication and publicity.

The Board was pleased to confirm last year that *Gloucestershire Constabulary & The Clinical Commissioning Group (on behalf of 2getherNHSFT, Gloucestershire Hospitals NHSFT and Gloucestershire Care Services NHS) have agreed a contribution to the Gloucestershire Safeguarding Adults Board, with continued commitment for the period 2014-2016.*

These contributions are valuable in order for the Board to continue meeting its responsibilities. It will be important that such commitment continues beyond this time despite the continued threat from competing demands and reduced resources.

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All documents and supporting reports referred to in this annual report can be found on the GSAB website Documents & Supporting Reports.

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