Gloucestershire
Safeguarding Adults
Board

Gloucestershire Safeguarding Adults Board

Annual Report 2015/16

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Foreword: Introduction from Chair

Welcome to this year's Gloucestershire Safeguarding Adults Board (GSAB) Annual Report which is my second annual report, having taken up the role of Independent Chair in June 2014.

The GSAB brings together a number of agencies from across the County to ensure that there is a joined up approach to adult safeguarding. Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It's also about working together to support people to make decisions about the risks that they face in their own lives, and protecting those who lack mental capacity to make these decisions.

It is my responsibility to support and encourage agencies to work collaboratively for the benefit of adults with care and support needs and bring about continual improvement. It is also part of my role 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 past 12 months has been a very significant period of development for the Board as we have evolved and adapted to meet the requirements set out in the Care Act 2014, which placed us on a statutory footing in April 2015.

I am pleased to report that the Board and its partners have strengthened their ability to safeguard adults with care and support needs, which reflects the continued commitment and quality across the partnership.

The GSAB Annual Report 2015-16 outlines the work of the Board over the last twelve months. It shows how partner agencies have worked together to improve the safety of adults at risk of abuse and neglect, and deliver against our three year strategic plan. The report contains details of how safeguarding has been promoted and developed through the work of the Board, its sub groups and its statutory partners.

In the past 12 months we have undertaken and completed two Safeguarding Adult Reviews, and a third will be completed this year, whilst a number of others are in various stages of completion. In the light of the Care Act we have reviewed all our policies and developed a quality assurance framework in order to help challenge ourselves and each partner agency in assessing our real effectiveness in safeguarding people and ensuring we deliver their desired outcomes.

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:

- Implementing the revised Gloucestershire Multi Agency Safeguarding Adults Policy and Procedures.
- Development of the Board's Information Sharing Guidance, its Adult Self Neglect Best Practice Guidance and the Quality Assurance Framework.
- A joint protocol with the Gloucestershire Safeguarding Children Board and Gloucestershire Health and Well-Being Board.
- Production of our new quarterly Mental Capacity Act and Safeguarding Newsletters.
- Expansion of our Fire Safety Development Sub Group.

As outlined in this report, the Board and its partners have seen improvements which have made a significant contribution to adult safeguarding but as always, there are some challenges and opportunities ahead.

We still need to get better at understanding the wishes and needs of the wider community to inform our strategic plan and the voice of our service users, in line with the central theme of Making Safeguarding Personal. We need to evidence what difference we are making to the lives of individuals who are safeguarded, by maximising the use of our quality assurance framework. Also, we must ensure we are able to respond, as a partnership, to the increasing number of Safeguarding Adult Reviews and that lessons are learnt.

As an Independent chair I am confident that the GSAB is in a good place going forward. Finally I would like to acknowledge the commitment of all our partners who have helped us achieve a great deal in the past 12 months and who continue to contribute to improving the way we all work together, to protect some of our most vulnerable people in society, adults with care and support needs.

Paul Yeatman
Independent Chair
Gloucestershire Safeguarding Adults Board

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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".

During the past year the Board has carried out significant developments across all of its areas of responsibility to encompass the provisions laid out in the Care Act that came into force in April 2015. Last year's GSAB Annual Report 2014/15 gave a clear detailed description of the statutory requirements in relation to adult safeguarding.

On 10th March 2016 the Department of Health published the long awaited refreshed edition of the Care and Support statutory guidance. The statutory guidance supports implementation of part 1 of the Care Act 2014 by local authorities, the NHS, the police and other partners. The new edition supersedes the version issued in October 2014. It takes account of regulatory changes, feedback from stakeholders and the care sector and developments following the postponement of social care funding reforms to 2020. Not all chapters were revised and some only received minor clarifications to improve understanding following feedback from the sector. Chapter 14 of this guidance covers the adult safeguarding sections 42-46.

The Care and Support statutory guidance update.

Chapter 14 of this guidance covers the adult safeguarding sections 42-46 of the Care Act 2014 and includes:

- Adult safeguarding – what it is and why it matters.
- Abuse and neglect – understanding what they are and spotting the signs, reporting and responding to abuse and neglect.
- Carers and adult safeguarding.
- Adult safeguarding procedures.
- Local authority's role and multi agency working.
- Criminal offences and adult safeguarding.
- Safeguarding enquiries.
- Safeguarding Adults Boards.
- Safeguarding Adults Reviews.
- Information sharing, confidentiality and record keeping.
- Roles, responsibilities and training in local authorities, the NHS and other agencies.

Most revisions were made for reasons of accuracy or clarity. Some were more substantial, reflecting learning through the first period of implementation and feedback from stakeholders and partners.

Adult safeguarding key amendments within the revised guidance include:

- Reinforcement that a formal safeguarding enquiry (Section 42) is primarily aimed at those suffering abuse or neglect from a third party and is not necessarily appropriate where people are failing to care for themselves. Assessment should be on a case by case basis.

- Additional information in relation to financial abuse to reflect significant increases in internet, postal and doorstop scams and crime.

- Guidance for practitioners to consider the need for criminal investigations and take advice if necessary. Forensic evidence can be lost if a crime is not reported or investigated quickly enough.

- Reminder to Local Authorities that they have powers even where they do not have duties – undertaking adult safeguarding enquiries is one area where this may be significant.

- Reinforcing the prevention agenda (better to prevent abuse than act after the event) and reminding practitioners of the importance of identifying and managing risk of abuse and neglect, even where those concerns are not the initial presenting issue.

- New guidance around allegations about people in positions of trust - emphasis that this is a responsibility of Local Authorities and other partners, as well as the large and diverse independent provider sector. Important link made to children's safeguarding and considering risk in the round. The requirement to have a Designated Adult Safeguarding Manager (DASM) has been removed as the introduction of this job title was proving to be confusing strategic and operational roles and distracting from improving practice.

- Encouragement for Local Authorities to use existing tried and tested surveys to understand the experience of carers and service users who have been involved in a safeguarding process.

- Strengthening the role of professional and practice leadership in adult safeguarding to recognise the need to have expertise within an organisation where practitioners and their managers can go for advice and guidance.

- Revised section on strategic leadership, clearly articulating the need for a strategic and accountable lead for safeguarding at a senior level in an organisation to ensure action to implement the Safeguarding Adults Board Strategic Plan.

2. Key Achievements 2015-16 and Strategic Plan 2015-18

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

- Implementing the revised *Gloucestershire Multi Agency Safeguarding Adults Policy and Procedures from* April 2015.
- Developing the *Gloucestershire Safeguarding Adults Board Information Sharing Guidance* following extensive discussions and research nationally and locally.
- Developing the *Adult Self-Neglect Best Practice Guidance* which outlines the procedure and guidance for dealing with issues and concerns of self-neglect in relation to adults with care and support needs.
- Finalising the *Safeguarding Adults Board - Quality Assurance Framework*.
- Developing a *Gloucestershire Safeguarding Adults and Children Board Working Protocol with Gloucestershire Health and Well-Being Board.* This protocol supports four key partnerships to operate effectively in terms of safeguarding adults and children and by being clear about their respective roles, responsibilities and relationships to each other.
- Evaluating the impact of the Level 3 and 4 Safeguarding Adults (SA) training which highlighted that the benefits included: deeper job role understanding, improved confidence and greater knowledge of the appropriate and effective actions required across the workforce.
- Expanding the membership of the Fire Safety Development Sub Group from 6 to 24 agencies and focusing on raising fire safety awareness within organisations and training of staff.
- Raising awareness of and improving fire safety through the Safe and Well campaign. This campaign has engaged numerous adults across the county and fitted additional fire alarms in their homes.
- Welcoming Trading Standards to the Board. Trading Standards are responsible for enforcing 100 Acts of Parliament and many of these link directly into supporting the most at risk people in Gloucestershire. Work includes tackling scams and rogue traders and there are approximately 170,000 incidents of door step crime a year from rogue traders.
- Producing a quarterly Mental Capacity Act (MCA) and Safeguarding Newsletter providing news updates and information about current topics relating to Safeguarding, the MCA and the Deprivation of Liberty Safeguards (DoLS).

Strategic Plan 2015-18 – The high-level priorities set out in the Board's Strategic Plan are reflected across these 5 areas:

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:

- Raising awareness of adult safeguarding, particularly via awareness days and a poster campaign with media releases to support this.
- Ensuring that the GSAB Website is kept up to date with documents and links. Hero and Flash panels are now being used to increase awareness.
- Delivering revised workforce development sessions, in line with the required competencies in the National Competency Framework for Safeguarding Adults.

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:

- Establishing a group to ensure full implementation of the Making Safeguarding Personal programme so the individual experiencing abuse or neglect is always at the centre and where possible leads the safeguarding process with choice and control.
- Identifying and 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:

- Refreshing the Multi Agency Safeguarding Policy and Procedures to incorporate the new edition of the Care and Support statutory guidance.
- Finalising an Easy Read version of the Gloucestershire Multi Agency Safeguarding Adults Policy and Procedures.
- Assuring the Board that effective structures are in place to improve the outcomes and experience of safeguarding for adults with care and support needs.
- Providing the Board with information from multi agency audits and give assurance that actions are being taken to mitigate any identified risks and improve services.

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:

- Identifying fire safety risk and referral pathways.
- Developing a Hoarding Guidance for practitioners that will form part of the Self-Neglect Policy.
- Finalising the script for a generic public services staff induction E-learning module and source design/production for the module.

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:

- Completing work on a GSAB Framework for Responding to Organisational Failure or Abuse to ensure there are coordinated proportionate multi agency efforts to address service failures and to hold providers to account where there have been systemic failures.
- Being clear and explicit about the definitions and levels of intervention with respect to providers' and commissioners' responsibilities to ensure safe and high quality care is being provided and that of the core duties of the police to prevent and detect crime and protect life and property.

Priority - Partnership

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

- Strengthening the relationship with the Health & Wellbeing Board.
- Engaging in the Anti Slavery Partnership Board and its agenda as it evolves in Gloucestershire.
- Continuing to work and have two way information sharing with Healthwatch Gloucestershire.
- Identifying the lessons to be learnt from Safeguarding Adults 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:

- Supporting the GSAB members to be able to carry out their role effectively, for example finalising an Induction Pack and coordinating annual GSAB member development sessions.
- Identifying methods to fully embed the GSAB Quality Assurance Framework.
- Ensuring the Board's performance management information includes feedback.
- Ensuring the Board has the capacity to plan and carry out its strategic objectives in line with the Care Act.

The Board's Strategic Plan is set for the next 3 year period as recommended by the Care Act Statutory Guidance. The full plan can be found on the GSAB Website.
Strategic Plan
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3. Key issues & Challenges for the coming year

Key issues and Challenges

Making Safeguarding Personal

- Focusing practice on improving the safety and wellbeing of people and the realisation of the outcomes they want.
- Evidence of increasing engagement and involvement of individuals who experience safeguarding services.
- Effective application of the Mental Capacity Act and appropriate use of advocacy.

Communication and engagement

- Engaging and consulting with the wider community.
- Promoting the work of the Safeguarding Adults Board.
- Increasing awareness of Domestic Abuse, Modern Slavery and Self-Neglect.

Quality Assurance Framework

The GSAB has developed a Quality Assurance Framework in order to give assurance that the Board and its constituent partner organisations have effective systems, structures, processes and practice in place to improve outcomes and experience in the context of safeguarding adults at risk. The Board needs to feel confident that it has the information that it needs to identify potential risks and to assure itself that actions are being taken to address these and to improve services.
In addition the following are particularly challenging, with finite resources across all partner agencies:

- Implementing the key amendments within The Care and Support Statutory Guidance.
- Conducting Safeguarding Adults Reviews with commitment of time and cost in commissioning or identifying the author, and then supporting the method and process.

The Board has produced 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 3 year Strategic Plan. These risks are scored (based on Likelihood and Impact) and categorised as either: financial, strategic leadership, reputational, information governance, operational delivery or statutory/regulatory/legal.
The Risk Register identifies the potential consequence of the risk and what actions have been taken in order to mitigate, manage or reduce the residual risk. Each risk is RAG Rated (Red/Amber/Green based on its score) and the Board currently has no risks which are rated Red, which would be of considerable concern to the Board. The Board's Risk Register can be found on the GSAB website. 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. The following 2 case examples demonstrate this and are followed by a case study reflecting Safeguarding and MCA; 'Best interests in the real world'.

Case Study 1

All names and locations have been changed to protect confidentiality

Lisa is 26 years old and has a learning disability. She lives with her mother, who is widowed. Lisa emailed the Social Care Help Desk to say that she wanted to leave home. She had recently started going out with someone she met at the Drop-in Centre and her mother was angry about it. As a result her mother had stopped Lisa from going to the Drop-in Centre and had also confiscated Lisa's mobile phone so that she couldn't contact her boyfriend. A safeguarding enquiry began into the potential psychological abuse of Lisa.

Actions taken

The social worker visited Lisa and her mother at home. Lisa's mother was adamant that Lisa should not be getting into relationships with boys and said she was worried she would get pregnant. She also said that she would stop Lisa from going to college if this continued. The social worker broached the issue of Lisa wanting to think about leaving home and becoming more independent. Her mother was very distressed by this suggestion and said that Lisa would never manage on her own.

Lisa was assessed as having capacity in the area of relationships, and also to choose where she should live.

The social worker arranged an advocate for Lisa to help represent her views and wishes to her mother and put Lisa in touch with Gloucestershire Voices which is a self-advocacy group for people with learning disabilities.

Over a period of time and through building a relationship with Lisa's mother, the social worker came to understand that Lisa's mother was frightened of being left alone. She also still viewed Lisa as a child and did not want to accept that she was now an adult. Through a sensitive approach to Lisa's mother, the social worker was able to help her to accept that Lisa had the right to leave home and make an independent life for herself, and that support could be provided to Lisa to help her achieve this. She encouraged Lisa's mother to get involved with a carers' group, where she made some new friends and began to view Lisa's wishes to be independent in a different light.

Outcomes

Lisa is receiving support with independent living skills and a supported living property has been found a couple of miles away from her mother. Lisa is preparing to move there in the next few months. She has also received support around sexual relationships. Her boyfriend has visited her at home and her mother is now accepting of the relationship.

Issues highlighted/learning

Sometimes families find it difficult to accept that their disabled child is now an adult and may wish to live independently. While Lisa's mother's intentions were not to cause harm to her daughter, her refusal to allow her to become an adult posed a risk to Lisa's development and independence. She was also on the verge of isolating her daughter socially by preventing her from taking part in activities she enjoyed. Sensitivity on the part of the social worker was needed to help her mother to accept Lisa's wishes and also to recognise that her mother may be behaving in this way due to her own fear of loneliness. Putting her in touch with sources of support helped to alleviate this, as well as preserving the relationship between Lisa and her mother.

Case Study 2

All names and locations have been changed to protect confidentiality

Mr Brown is 72 years old and has dementia. He was living in his own home but his living conditions had become increasingly chaotic. A neighbour expressed concerns that he was being targeted by drug users in the area, who had been seen going in and out of his house throughout the day and night. Mr Brown is fiercely independent and had previously refused all offers of support. When the social worker visited him, he found evidence of drug use in the house, and of hoarding. There was out of date food in the fridge and the bathroom was unusable. Mr Brown himself appeared neglected and underweight. He was however very angry at the suggestion that he needed help and told the social worker to leave him alone.

Actions taken

The social worker assessed Mr Brown as being unable to make decisions about where he should live to receive care and treatment. They also assessed him at being at risk of harm, from the people using his property, and of self-neglect. The social worker contacted the GP, who informed him that Mr Brown had always been a hoarder. The Police were contacted about the drug users frequenting the property and the social worker arranged for an Independent Mental Capacity Advocate (IMCA) to work with Mr Brown.

The social worker visited again with a member of the Fire Service, who deemed the conditions at the property to pose a significant risk of fire. Because of the severity of the concerns, it was agreed that Mr Brown needed to move out temporarily and a care home placement was found, however Mr Brown was resistant to leaving his home.

After taking legal advice, the Local Authority lawyers applied to the Court of Protection to seek an order authorising them to temporarily remove Mr Brown from his home. This was granted and Mr Brown went into respite care. Although Mr Brown's physical condition quickly improved, he was very unhappy at being kept "in prison" as he referred to it and made frequent attempts to leave the home.

In the meantime the social worker arranged for a clean up of the property with a view to Mr Brown returning there once this was complete. The police arranged to have CCTV cameras installed outside the property to monitor the people visiting the house. The social worker made contact with Mr Brown's nieces, who lived locally and had not seen Mr Brown for a few years. They were however supportive of his wish to return home and visited him while he was in the care home.

Outcome

After a three month period in the care home, Mr Brown returned to live in his property with a package of care. Police Community Support Officers made a point of patrolling the area to check for people using his property, and the neighbour who raised the concerns initially agreed to alert them if she saw people going in and out. No reports have been received and the CCTV may have acted as a deterrent. The situation is not entirely free from risk – carers found that Mr Brown had eaten raw meat out of the fridge one day when they visited, so it was agreed that raw meat would no longer be stored at the house, however the risks are now managed to the extent that Mr Brown has been supported in his wish to live at home.

Issues highlighted/learning

The concerns about Mr Brown's living conditions were so serious that a move to a care home was clearly in his best interests at the time. However, his desire to return home was very strong and agencies must respect people's human rights, in particular Articles 5 and 8, which relate to a person's right not to be deprived of their liberty, and to respect for private and family life.

This case demonstrates how effective multi agency working which places the person's wishes at the centre of the process can uphold these rights and mitigate the risks to an acceptable level. This can be achieved even when the severity of the concerns may make this seem unlikely at the outset.

Case Study 3

All names and locations have been changed to protect confidentiality

Safeguarding and MCA- Best interests in the real world
Bedford Borough Council v (1) Mrs LC (2) Mr C [2015] EWCOP 20 (Bodey J)
Best interests – residence

Background and Referral
This case concerned LC's (Mrs C's) best interests in relation to residence, contact with her husband and a deprivation of her liberty.
Mrs C was a 74 year old woman with a diagnosis of dementia, diabetes and stroke-related illness. Mrs C had been married to Mr C for over fifty years. Until June 2010, they had lived together in their matrimonial home. In June 2010, there was an incident in which a carer reported that Mr C had pushed Mrs C in the face. Mr C pleaded guilty to assault and was given a community sentence. Following this incident, she was taken to a care home as a place of safety and has remained there ever since.
Mrs C did not wish to see her husband for some time after the assault. After 8 ½ months, Mrs C wished to see her husband. Gradually, Mr and Mrs C rebuilt their relationship back up. The current arrangements are that Mrs C goes to the matrimonial home twice a week for up to four hours and her husband is able to visit the care home whenever he likes. The couple have "supported rather than supervised" telephone contact at Mr C's instigation. Mrs C did not have the capacity to initiate a telephone call.

Actions following referral
Mr C contended that it was in his wife's best interests to return to the family home. However, the local authority disagreed and contended that it was in Mrs C's best interests to remain in the care home and for all contact with her husband to be supervised.
One factor for the judge's consideration was that the local authority could not afford or would not agree to fund a package of care at home which would cost more than £700 per week. In particular, the local authority would not fund 24 hour care for Mrs C in the matrimonial home. Having regard to the level of funding, the judge had to decide which one of three options was in Mrs C's best interests:

1. To return to the matrimonial home with a personal budget of £700 per week, sufficient to buy approximately 50 hours of care per week, or 25 hours of 2 carers working together;
2. To continue residing at the care home; or
3. To reside in a different care home.

After making detailed findings of facts and weighing up the various competing opinions, District Judge Eldergill decided that it was in Mrs C's best interests to remain in the care home. Of particular concern was the evidence that Mrs C's needs had increased since 2010 but the local authority would not or could not fund more than £700 of care per week which was the same level of care that Mrs C received in 2010. The judge concluded that Mrs C would not receive the care at home that she required.

Outcomes
In reaching a best interests decision, District Judge Eldergill carefully considered the various factors set out in section 4 MCA 2005. In particular, he was satisfied that Mrs C's present wishes and feelings were to live at home with her husband. However, he was constrained by the local authority's position regarding funding. He stated at paragraphs 26-27:
"*26. This court does not have the power to review the lawfulness of this financial needs assessment and it has not been challenged by any of the parties by way of judicial review.*
27. I must proceed on the basis that the local authority's financial needs assessment in this

respect is lawful and binding on me unless and until it is set aside by the appropriate court or modified by the local authority, if ever."

Therefore, despite finding that it was Mrs C's wish to return home to her husband, the judge held that it was not in her best interests because she would not receive the care she required on the level of funding that the local authority could provide. No viable alternative care package, whether from friends, family or volunteers, had been put forward by Mr C.

Learning

This case is a reminder of the burden on local authorities thoroughly to investigate the issues and to bring the matter to court in a timely manner. District Judge Eldergill criticised the local authority's "unacceptable delay" in bringing the matter to court. Mrs C was admitted to the care home in June 2010 but it was not until December 2012 that the local authority applied for declarations in relation to residence, deprivation of liberty and other issues. After further delay, the matter reached the judge on 7 March 2014, by which time Mr and Mrs C had been separated for almost four years without a hearing of the issues. The judge said:
"Bearing in mind the length of her marriage, any objective view of her best interests should have led a local authority to facilitate an early determination of the issues. That was the overriding procedural consideration."

The judge was also critical of the poor documentation that he received, as it was confusing. He also expressed several concerns about the way in which the local authority had prepared its case and about the quality of some of its evidence, for example:
• Allegations were made which could not be substantiated and which ought not to have been part of the case;
• There was a tendency to look to hold Mr C responsible for all care difficulties;
• Mr C was described as 'lacking insight' when sometimes he simply took a different view to that of the professionals; and
• The local authority's witnesses were unable to provide basic care planning information.

Mental Capacity and Best Interest and Public Law Obligations

The Mental Capacity Act 2005 is about empowering people in two different ways. First, it is about not jumping to premature conclusions that a person lacks capacity, but recognising that they may require support to make decisions. Second, when a person lacks capacity, the Act states that people must be encouraged to participate in the decision and their past and present wishes taken into account. Although these wishes do not have to be followed (as in this case) they still carry significant legal weight (Mental Capacity Act 2005, Section 1).

The principle of proportionality in safeguarding is explicit in the Human Rights Act 1998 and the Mental Capacity Act 2005. For instance, under Article 8 of the European Convention on Human Rights, there is a right to respect for family, home and private life. If a local authority (or other public body) is considering action in response to safeguarding concerns – such as where a person lacking capacity should live, whom they should see or what they should do – it must first consider less restrictive options before a decision is taken in the person's best interests. However not all decisions taken by a public body about care provision are best interest decisions, i.e. how and where to meet the assessed needs of the individual. This does not mean that such decisions are not to be taken without reference to the individual's welfare or their views, but they are decisions which are, ultimately, decisions that are taken by the public bodies in the discharge of their public law obligations, not decisions taken on behalf of the individual in question. They are therefore not best interests decisions, and (1) any meetings which are convened to discuss them should not be labelled best interests meetings; and (2) any challenge to them lies not in the Court of Protection but in the Administrative Court.

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5. Partnership Achievements 2015/16 and Priorities 2016/17

Again over the past year there have been a number of achievements both individually by partners and collectively which have led to a reduction in the risk of harm to adults with needs for care and support who are experiencing or at risk of abuse and neglect in Gloucestershire.

5.1 Gloucestershire Constabulary

The last year has seen significant emphasis at a national and local level on protecting vulnerable people generally particularly around cases of child abuse, both historical and those linked to Child Sexual Exploitation. This has seen the police prioritise training, resourcing and IT to address demand but not at the expense of protecting vulnerable adults, including those with care and support needs.

The CID and Public Protection Bureau have a combined strategic lead thereby allowing more operational flexibility on a daily basis. Training and awareness continues in relation to safeguarding adults at risk through all levels of the police family with an expectation that it is everyone's business. The Police Central Referral Unit, which coordinates information with partner agencies, has been increased by three members of staff to address demand; in the world of vulnerable adult referrals that equates to an increase of in excess of 150% for the police.

In order to seek to address demand generally, make the referral smarter and service user based, the police in the county are pioneering an electronic risk assessment called the Vulnerability Identification Screening Tool (VIST). This will allow police officers to understand the risks presented and in conjunction with the individual look at how they are best mitigated. That information is then able to be assessed and if appropriate shared with partners. It has been trialed at the start of the year and is to be rolled out in June 2016 across the Constabulary.

Investigative wise, we have no paper files now and all decisions are recorded electronically. Cases of a sexual nature within an adult at risk setting are peer reviewed by Supervisors to ensure opportunity is not missed and decisions are appropriate.

The Constabulary has increased its contribution to the Gloucestershire Safeguarding Adults Board and remains fully committed to the Board and its sub groups to improve and drive improvements.

Simon Atkinson
Detective Superintendent 463
Head of Public Protection and Investigations

5.2 2gether NHS Foundation Trust (2getherNHSFT)

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

Achievements 2015/2016

- 2getherNHSFT has continued to focus on improving the take up of training for safeguarding adults with a 'Think Family' approach. This involves Making Safeguarding Personal (MSP) and incorporates safeguarding children within the adult's social network.
- An external Review of the Safeguarding Structures within 2getherNHSFT has confirmed the Trust's commitment to ensure good practice and future planning to make safeguarding personal – and meaningful.

Specific work in line with the Board's objectives have included:

- Shared learning from Safeguarding Adults Reviews (SARs), Serious Case Reviews (SCRs) and other learning models.
- Improvement in partnership working: focusing on Domestic Abuse (DA); Perinatal Mental Health; Substance Misuse (SM); Female Genital Mutilation (FGM) and Prevent.
- Active participation in Board and sub group activity.

Key Objectives 2016/2017

Over the next year, 2getherNHSFT plans to continue working in partnership to improve overall safeguarding activity, including participation in all sub groups, while specifically focusing on:

- Learning from: multi agency and internal single agency audits; Domestic Homicide Reviews (DHRs); SARs, SCRs and other learning models (e.g. Significant Incident Learning Process - SILP)
- Increasing safeguarding supervision to teams working with adults- concentrating on MSP while ensuring the safety of children within the service user's social network.
- Continuing to update the Think Family training approach, improving take up of Level 3 Multi Agency for Adults, Children and Health WRAP (Workshop to Raise Awareness of Prevent)
- Working in partnership to meet the Safeguarding Boards' objectives- to include focus on (FGM); Sexual Exploitation (for adults and children); Prevent and Self-Neglect.

2getherNHSFT looks forward to continually improving practice with partner agencies to ensure an adult's right to live in safety, free from abuse and neglect, is protected. This will be done in conjunction with Safeguarding Children.

Marie Crofts
Director of Quality,
2gether NHSFT

5.3 Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)

Gloucestershire Hospitals NHS Foundation Trust remains a committed partner to safeguarding adults at risk of abuse of neglect as part of Gloucestershire's Multi-Agency Safeguarding Adults Policy and Procedures and Gloucestershire Safeguarding Adults Board (GSAB). Our Trust Nursing and Midwifery Director, as our Executive Lead for Safeguarding is a proactive member of GSAB. We continue to be proactively engaged in each GSAB sub group with senior level representation.

Structure and Approach to Safeguarding Adults within GHNHSFT

Our Trust Safeguarding Adult Strategic Board, chaired by the Trust Lead Executive for safeguarding, has representation from key Trust stakeholders involved in safeguarding and reports to the Trust Quality Committee and main Board. Our Trust Safeguarding Board has responsibility for implementation of our Safeguarding Adults Policy and action plan, including our Trust Dementia Strategy, Learning Disability Strategy and Mental Capacity Act Action Plan.

Key achievements 2015/2016

- Safe, harm free care, delivering the best care for everyone and promoting positive patient and carer experience is our Trust vision. Safeguarding remains core as part of our strategic objectives and our Trust Health and Well-being Strategy. Safeguarding is also within our recruitment process, employment contracts and role specifications of all staff. It is a fundamental principle of all professional codes of practice.

- We have implemented Trust specific actions to support the GSAB Fire Safety Development Sub Group action plan. This has included Fire Safety and Safeguarding Communication events, Trust wide public displays, development of a fact pack for staff, joint working with Mental Health Liaison Team and Alcohol Liaison Team colleagues who now give out Fire Safety Home Safe and Well Check information to patients who are assessed by their teams. The Trust continues joint working with the hospital based Adult Social Care Team in support of referrals as part of discharge planning.

- We have an agreed annual programme of safeguarding communications and activities aimed at raising awareness for our patients, our public and our staff.

- Our Trust Safeguarding Adults Team continues to provide real time support and guidance to all our staff. This includes guidance and resources to support best practice application of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) in practice. Our team delivers training and has a responsibility to develop, implement and review policy, process and resources. In addition to monitoring by Trust Senior Clinical Staff and Matrons, a key function of our team is the real time monitoring of practice, trend reporting and promotion of prevention actions, which are promoted as part of our Trust Champion development programme. Our team's objectives are the promotion of prevention actions, best practice and trend monitoring in real time. This includes trend data reporting and rapid implementation of learning based on

trend monitoring and case reviews or prompt and timely escalation of concerns to Trust safeguarding Executive Lead.

- We have completed an update of our Trust Clinical Staff Safeguarding Level 2 training package. Safeguarding training is core to all Trust training programmes for all Trust staff. Our revised Safeguarding Adults at Risk Policy is to be released in May 2016.

- We have developed and implemented a Trust Safeguarding site for our patients and public. Fire Safety Information is also linked from this webpage. www.gloshospitals.nhs.uk/en/Patients-and-Visitors/Safeguarding-our-Patients/

- We remain a committed partner as part of Gloucestershire's Multi-Agency DoLS Policy and Procedures. Our Trust DoLS operational policy and e-learning update have been completed, including the development of an assessment checklist document, to be released to staff May 2016.

- We have integrated Safeguarding Children, Safeguarding Adults at Risk and Domestic Abuse procedures. We have developed further training in detection and a response process where Female Genital Mutilation (FGM) is detected within a Trust adult setting, both to support the adult and to take action on any possible safeguarding children concerns.

- We are committed to partnership working with people, with all partners and organisations in support of safeguarding and in support of patient safety and well-being.

Key objectives 2016/17

- Progress our Trust wide Safeguarding Adult Action plan 2016/17.
- Continue to promote delivery of the National Clinical Care Benchmarks, "Essence of Care Clinical Care Standards'' Department of Health (2010) and safe, harm free care.
- Continue to further strengthen working in partnership with GSAB to safeguard adults within Gloucestershire and within our Hospitals.
- To further increase staff awareness, to develop staff resources and training in relation to recognition and response action for people experiencing FGM, Modern Slavery, Human Trafficking or sexual exploitation. To work in partnership as part of county wide multi agency joint working to detect, to respond, to report and to support.
- We are committed to listening and learning, to working in partnership and to further improving safeguarding and care experience for all our patients.

Mrs Maggie Arnold
Nursing and Midwifery Director and Executive Lead for Safeguarding – GHNHSFT

5.4 Gloucestershire Care Services NHS Trust (GCSNHST)

Achievements within the last financial year

Development of the adult safeguarding team within GCS: Following the departure of the Head of Safeguarding we have successfully recruited to the post of Named Nurse Safeguarding Adults. The Director of Nursing now takes the overall lead for safeguarding; this ensures that safeguarding remains a key priority for the Trust and that leadership is robust. The process to recruit a specialist nurse for adult safeguarding (to include emphasis on service improvements for people with a learning disability) is now well underway.

Training: Our Safeguarding Foundation Day Training (level 2) has been updated to incorporate changes contained within The Care Act 2014. The day which combines children and adults safeguarding elements in line with our 'Think family' approach continues to be highly regarded as evidenced by participant evaluation.

In response to the Care Quality Commission recommendations, our training strategy has been updated to ensure all staff groups are clear about which training they are required to undertake. Training requirements are aligned to the countywide workforce development plan and national standards. We have set specific training targets and aim to achieve 80% of colleagues trained by July 2016. This will include Trust Board members.

Priorities for the next 12 months

- To raise the profile of safeguarding across the Trust
- To ensure that our systems can capture training data across staff groups and to monitor compliance
- For the adults' and children's elements of the safeguarding team to work more closely together in line with the 'think family' approach
- Engagement with front line staff
- To ensure we have capacity within the adult safeguarding team to achieve our objectives
- To progress our work in relation to learning disabilities
- Ongoing analysis of the number of safeguarding concerns being raised following the Trust's initial report of declining numbers in the reporting of concerns
- Focus on staff understanding and application of the Mental Capacity Act

Resource constraints

GCS has strengthened the adult safeguarding team despite resource constraints, enabling us to continue to commit to the work of GSAB. We have also appointed an Ambassador for Cultural Change which incorporates the Freedom to Speak up Guardian role (recommended in the Francis Report 2015). This will further promote a culture where staff feel empowered to speak out and raise concerns about care.

Quality Assurance

The GCS Safeguarding Governance and Operational Group has been revitalised and leads on the safeguarding component of the GCS Clinical and Professional Care Strategy. It now also:

- Maintains a quality and performance dashboard that is presented to the quality and performance committee, ensuring robust quality assurance
- Monitors and acts upon performance based activity data supplied by GCC on a monthly basis
- Reviews safeguarding incidents and Serious Incidents Requiring Investigation (SIRI) where there has been GCS involvement, ensuring that learning is shared and disseminated.
- Ensures that safeguarding policy and guidance documents to support practice are current and available on the GCS intranet.

Susan Field
Director of Nursing
Gloucestershire Care Services NHS Trust

5.5 Gloucestershire Clinical Commissioning Group (GCCG)

Gloucestershire Clinical Commissioning Group (GCCG) recognises and endorses the requirement to prioritise safeguarding adults at risk of abuse and neglect when commissioning health services across Gloucestershire. There is a clear line of accountability set out in the management structure of the GCCG, with an identified General Practitioner (GP) lead for adult safeguarding at Board level. The Executive Nurse is accountable for safeguarding, with the responsibility sitting with the Deputy Director of Safeguarding. The GCCG has recently appointed a safeguarding nurse specialist who supports this role.

Achievements in 2015/16
GCCG has developed a set of Safeguarding Commissioning standards which are now routinely included in all provider contracts, identifying their roles and responsibility to safeguard adults at risk. Performance against these standards is robustly monitored for compliance by the Clinical Quality Review Groups (CQRG). A safeguarding update is provided bi-monthly to the Information and Governance Group to ensure the Board is kept up to date with safeguarding issues both locally and nationally.

The GCCG contribute financially to the Gloucestershire Safeguarding Adults Board (GSAB) budget, in order to support its function. This is reassessed annually.

GCCG has developed a Mental Capacity Act guidance document for GP and primary care and an adult safeguarding advice pack, which is now available on the intranet and disseminated to all GP's on G Care. This is a newly set up data base available to all partner agencies supporting communication and effective joint working.

The GCCG also produces a bi-monthly newsletter for care homes in Gloucestershire, 'Care Homes Matter', which provides relevant safeguarding information.

The GCCG is represented on the GSAB, contributing to the work plan where appropriate. The organisation is further represented at a variety of the Boards Sub Groups, for example, the Safeguarding Adults Review, Policies and Procedures and joint adult and children's safeguarding Communications Group.

Safeguarding adults training continues to be a mandatory requirement for all CCG staff. Compliance is monitored by the Safeguarding Nurse Specialist and levels of training are reported to the Board on a regular basis.

Priorities for 2016/17
Looking forward, GCCG is in the process of recruiting a Named Safeguarding GP. This is an exciting new role which will ensure GPs in Gloucestershire have the support they require to fulfil their safeguarding responsibilities.

Marion Andrews-Evans
Executive Nurse & Quality Lead
Gloucestershire Clinical Commissioning Group
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6. Safeguarding Adults Reviews

As expected we have seen a rise in the number of referrals being raised for consideration by the Safeguarding Adults Review Sub Group, as the requirement to undertake reviews became statutory in April 2015.

The purpose of Safeguarding Adults Reviews is not to re-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 sets out recommendations for change and actions to address these.

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. Reviews need to be proportionate and promote effective learning and improvement action, with a view to preventing future deaths or serious harm from occurring.

Two reviews have been completed in the past 12 months, and a number are in various stages of completion.

Safeguarding Adults Review "Sexual and financial abuse in supporting living home X" – A Traditional Serious Case Review & Root Cause Analysis - To be completed by May 2016:

This was a major adult case review which was commenced in 2014 by an Independent Author and was published on 26th February 2015, having been presented to the Gloucestershire Safeguarding Adults Board (GSAB) earlier that same day.

A copy of the full report can be found at: Safeguarding Adults Review

The Adult Case 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.

There were 12 key recommendations which fell out of the review and were accepted by the GSAB, 8 of which were completed in 2015. It is anticipated that the remaining 4 actions will be completed by May 2016 and presentations are being delivered to the GSAB at the May meeting.

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

Again this review was commenced in 2014 and the final report was presented to the GSAB on 26th February 2015.

A copy of the full report can be found at: Safeguarding Adults 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 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.

There were 6 key recommendations which fell out of the review. These were accepted by the GSAB and were completed before Christmas 2015.

Safeguarding Adults Review – "R" – Systems Type Methodology - Completed:

The review was commissioned in 2015 and the final report was presented to the GSAB in August 2015. It was undertaken by an Independent Author and the learning process involved front line practitioners, their managers and subject matter experts.

A copy of the full report can be found at: Safeguarding Adults Review

R is an adult at risk who funds his own care and who sustained a serious injury as a result of self-neglect.

There were 6 recommendations arising out of the review which were all actioned and completed by March 2016.

Safeguarding Adults Review – "AT" – Multi Agency Learning Event to be held and review completed by May 2016:

AT was an adult who had bi-polar affective disorder, with mobility issues, who died in 2015. It was decided that a Multi Agency Practice and Learning Event would be held in respect of the circumstances; this will take place on the 29th April 2016 and the review report completed by May 2016.

Safeguarding Adults Review – "SJ" – A Root Cause Analysis - To be completed by May 2016:

This review was commissioned in 2015 and a draft report was presented to the GSAB in November 2015 in the form of a Root Cause Analysis.

SJ was a 68 year old woman with mobility issues who died as result of a fire in June 2015. There were 4 recommendations arising out of the review which are currently in the process of being actioned.

Safeguarding Adults Review – "KH" Systems Type Methodology – Review Commenced March 2016:

KH is an adult with mobility issues following a road traffic collision many years ago and who was admitted to hospital in December 2015 in an extremely neglected state. An Independent Author has been appointed and the review is underway.

Safeguarding Adults Review – "DA" – Review by LD Commissioner and Learning Disability Performance Improvement Plan: Ongoing

DA is an adult with Autistic Spectrum Disorder who sustained serious injuries in 2015. This case was considered by the Safeguarding Adults Review Sub Group in February 2016 regarding possible neglect/self- neglect. It was agreed that the Learning Disability Commissioner should undertake a review of the circumstances.

Safeguarding Adults Review – "PS" – Decision Taken Safeguarding Adult Review Not Required.

PS was an adult male with epilepsy who was alcohol dependent and died in a fire. The circumstances were discussed at an extraordinary meeting of the Safeguarding Adults Review Sub Group in October 2015. It was clear that there was evidence of sustained attempts by agencies to engage with PS and some evidence of good practice, in what were very difficult circumstances. A decision was agreed that the case did not meet the requirements for a Safeguarding Adults Review as no further concerns or potential learning was identified.

Safeguarding Adults Review – "WP" – Decision Taken Safeguarding Adult Review Not Required.

WP was admitted to hospital in December 2015 having allegedly been assaulted by his son who has a learning disability. WP subsequently died of natural causes whilst in hospital.

A decision was made in December 2015 that the case did not meet the requirements for a Safeguarding Adults Review as no concerns or potential learning was identified and WP was receiving good care from agencies.

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7. Sub Group Achievements 2015/16 and Priorities 2016/17

7.1 Workforce Development

Achievements 2015/16:

- The table overleaf highlights take up of GSAB training and E-learning by partners in 2015/16. It demonstrates consistent uptake of E-learning for Safeguarding, MCA and DoLS, and the Safeguarding Adults Level 2 Foundation. All training was updated to meet Care Act requirements, and supported by local GSAB Policies and Procedures.

- An impact evaluation undertaken of Level 3 and 4 Safeguarding Adults (SA) training indicated that **all** attendees felt that they were able to use the skills/knowledge gained on the training within their work roles, and that **no** respondents felt there had been no value to them in attending. Benefits highlighted included deeper job role understanding, improved confidence and greater knowledge of action required.

- The annual Continuous Professional Development (CPD) trainers' event was attended by 50 approved trainers; the day included updates from Child Sexual Exploitation, Fire Service, Trading Standards, Domestic Abuse, the role of Gloucestershire Domestic Abuse Support Service, and a showing of the GCC sexual abuse awareness video for adults with learning disabilities. Currently 92% of trainers have been observed/re-observed for quality assurance; 70 are approved to deliver the Level 2 Safeguarding Adults Foundation Programme.

- A Train the Trainer workshop was held in November 2015, from which 12 new trainers intend joining the GSAB Foundation trainer network. Groups currently covered by the network include Social Care, Health (GCSNHST, 2GetherNHSFT, GHNHSFT, Adult Education, Housing, Faith Groups and the Gloucestershire Fire and Rescue Service.

- We are in collaboration to design a Train the Trainer package for the Mental Capacity Act and DoLS, with the same quality assurance processes as the Safeguarding Adults Foundation Training. Work on the course design is well underway, with a view to approving the first group of trainers in late 2016.

- Training levels and the GSAB Training Pathway have been reviewed to ensure they align with the new National Competency Framework for Safeguarding Adults.

- Safeguarding reporting – monthly meetings take place to share data on training, CQC reports and quality assurance for providers who have not raised a concern or contacted the safeguarding advice line for 12 months or more.

- A Safeguarding Adults information sharing session was held for GCC elected members, which was attended by both County and District Councillors.

- Sarah Jasper facilitated two Masterclass events for Senior Practitioners and Social Workers, looking at 'The Somerset Case' and the multi agency approach to the case; over 60 staff attended.

Priorities for 2016/17 are:

- Annual GSAB member development session organised for April 2016.
- A generic public services staff induction E-learning module is to have the script finalised and design/production for the module sourced in 2016/17.

Safeguarding & MCA/DOLS - E-learning & training uptake April 2015 to March 2016 (TOTAL FOR YEAR)

Name of work area	MCA E-Learning (Kwango or equivalent)	DoLS E-Learning (Kwango or equivalent)	MCA Training	MCA , DOLS Awareness	Safeguarding E-Learning (Kwango or equivalent)	Safeguarding Foundation training (L2) *= e-learning	Safeguarding Multi-agency training (L3)	Safeguarding Specialist training (L4)	Total
Older People (Independent)	127	104	20	96	272	630	40		1289
Learning Disability (Independent)	68	86	28	35	111	241	70		639
Dom Care (Independent)	74	113	6	0	120	210	31		554
GCC	74	57	133	0	112	127	41	39	583
Acute Trust	2209	0	345	0	4556	1505 *	7		7117
NHS Glos (CCG)	0	0	0	0	0	0	0	1	1
Glos Care Services	38	60	50	0	109	262	4	2	525
2gether Trust	1	0	1	0	455	295	2		754
GP Practices	17	15	0	0	50	24	0		106
Ambulance service	0	0	0	0	0	0	0		0
Voluntary and community sector	37	24	0	0	162	26	11		260
Glos Constabulary	0	0	0	0	34	0	0		34
Adult Education GCC	0	0	0	0	0	0	0		0
District council	0	0	0	0	12	0	0		12
Dental	6	1	0	0	19	0	0		26
Supporting People	3	3	7	7	39	75	3		137
Support Groups	0	0	0	0	0	0	0		0
Housing Providers	0	1	0	0	22	99	3	1	126
Approved Training Providers	7	1	0	0	23	0	1		32
Glos Fire and Rescue	5	1	0	0	65	0	0		71
Private Hospitals	0	0	0	0	0	0	0		0
other	119	117	8	0	185	39	6	1	475
Probation Service	0	0	0	0	0	0	0		0
BME	0	0	0	0	0	0	0		0
Carers	32	20	0	0	48	9			109
Trading Standards	0	0	0	0	0				0
Total	**2817**	**603**	**598**	**138**	**6394**	**2037**	**219**	**44**	12850

7.2 Fire Safety Development.

The Fire Safety Development sub group was established in October 2014 and its membership number has grown from 6 to 24 agencies. During the last year the group has worked hard to meet the objectives it set out for itself and has had many successes. In summary, each agency developed its own action plan that fed into the multi agency action plan. The multi agency action plan focused on raising fire safety awareness within organisations, training of staff and promotion of safe and well checks within organisations for the service users.
The group has also met following a number of fire deaths within the county and has escalated up to the Safeguarding Adults Review sub group. As a result one review has taken place following a fire fatality this year.

There have been many achievements in 2015/16 which include:

- Alzheimer's Society:

The Alzheimer's Society Dementia Advisers are able to refer people affected by dementia for fire safety checks, which has been beneficial and can help people to live more safely in their own homes. The Alzheimer's Society has included the issues around fire safety and hoarding into their internal safeguarding policy.

- Adult Helpdesk, Gloucestershire County Council:

Customer Service Officers now automatically prioritise referrals from the Gloucestershire Fire & Rescue Service automatically as urgent due to the risk of harm to anyone who may have an impairment that could hinder their escape in the case of any emergency.

- Clinical Commissioning Group Gloucestershire:

The Clinical Commissioning Group in Gloucestershire is now represented on the Fire Safety Development sub group. This will be a benefit to the group in view of the strengthened links with Primary Care, aiming to support information gathering when necessary. Equally, this should facilitate improved links for dissemination of fire safety and prevention messages outwards across the Hospital Trusts and Primary Care.

- Safeguarding Adults Team, Gloucestershire County Council:

We have increased awareness within the specialist safeguarding team of fire safety and hoarding, which then forms part of discussions with and recommendations to front line workers.

Priorities for 2016/17 are:
The group is currently writing its action plan for 2016/17 which will focus around five key areas:

- Training
- Risk identification and referral pathways
- Action plans following fatalities and near misses
- Quality Assurance
- Information Sharing

The group has also agreed to form task and finish groups that will focus on specific areas of work. The first task and finish group will look at developing Hoarding Guidance for practitioners that will form part of the Self-Neglect Policy.

7.3 Communications

During 2015/16 the joint adults' and children's Communication sub group for the Gloucestershire Safeguarding Adults and Children Boards was established. The Communication sub group meets bi-monthly and brings partner communication colleagues together, with sub group champions to determine the safeguarding communication and campaign priorities for each year. This ensures that safeguarding communication activities are coordinated across Gloucestershire in line with national campaigns and awareness days. The priority audiences of all safeguarding activity are staff of partner organisations (particularly front line staff), the public and the media.

Achievements during 2015/16 are:

- Communicating the updated Adult Safeguarding Multi Agency Policy and Procedures to all staff of the GSAB organisations via available internal channels.
- Raising awareness of and improving fire safety through the Safe and Well campaign. This campaign has engaged numerous adults across the county and fitted additional fire alarms in their homes.
- Managing the communication and media of safeguarding adults reviews (SARs).
- Raising awareness of adult safeguarding, particularly via awareness days.
- A poster campaign has been created and will be disseminated to partner communications colleagues. Media releases will support this poster campaign.

Other communications activity that has taken place includes:

- Trading Standards raising awareness of scams amongst elderly and other people in vulnerable circumstances, by issuing regular media releases and highlighting national awareness days.
- Development of a sexual abuse awareness video and training course for adults with learning disabilities and their families, in response to a Safeguarding Adults Review
- GSAB communication alerts on a range of topics throughout the year.
- The production of a quarterly Gloucestershire Mental Capacity Act and Safeguarding Newsletter providing news updates and information about current topics relating to Safeguarding Adults, the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). The Newsletter aims to actively engage with professionals and the public to raise awareness
- Continuous development and update to GSAB website. From 1/4/15 – 31/3/16 there have been **over 25,000 hits/page reviews**. Policy & Procedure, training and information for professionals being the most popular pages visited

Priorities for 2016/17:

- Promoting GSAB to the wider community
- Adult Abuse week
- Self-Neglect
- Domestic Violence, Modern Slavery, CSE & Adults
- Board member conference - Engaging with practitioners
- Development of a Safeguarding App
- Adult safeguarding tweets to engage the public via social media

7.4 Policy & Procedures

Achievements for 2015/16:

The Policy & Procedure sub group has developed and implemented a number of key documents throughout the previous year:

- Gloucestershire Multi Agency Safeguarding Adults Policy and Procedures have been implemented in a final draft version for the last year. The Department of Health recently published the long awaited revised edition of the Care and Support statutory guidance. The GSAB will now give priority to incorporating the changes, finalising these key policy and procedures to support agencies and individuals to work together effectively, in line with a personalised approach.

- The publication of Gloucestershire Safeguarding Adults Board Information Sharing Guidance following extensive discussions and research into information sharing nationally and locally. While the Chair of the Safeguarding Adults Board acknowledged that each individual agency will have their own information sharing protocols, this Guidance is specifically relevant to all adult safeguarding areas of business. It was developed following the implementation of the Care Act 2014 and adheres to the wider overarching Gloucestershire Information Sharing Partnership Agreement (GISPA) principles.

- Adult Self-Neglect Best Practice Guidance, which outlines the procedure and guidance for dealing with issues and concerns of self-neglect in relation to adults with care and support needs. This procedure and guidance follows a broad concern to enquiry operational model as outlined in the Gloucestershire Safeguarding Adults Policy and Procedures, and should be read alongside that document.

- Gloucestershire Safeguarding Adults Board Quality Assurance Framework. This supports the Board to give assurance that the constituent partner organisations have effective systems, structures, processes and practice in place to improve outcomes and experience in the context of safeguarding adults at risk. In order to fulfil their role in quality assurance the Board needs to feel confident that they have the information it needs to identify potential risks and to assure itself that actions are being taken to address these and to improve services.

Priorities for 2016/17:

- An Easy Read version of the Gloucestershire Multi Agency Safeguarding Adults Policy and Procedures has been drafted and is currently out for feedback and comments
- Making Safeguarding Personal (MSP) guidance is being developed. A Task & Finish Group will be established to implement the MSP programme throughout safeguarding work across GSAB partners
- A GSAB Framework for Responding to Organisational Failure or Abuse and a GSAB Positions of Trust Guidance is in development, working alongside our colleagues in the West Midlands. Guidance will then be included in the overarching Gloucestershire Multi Agency Safeguarding Adults Policy and Procedures. The Care and Support Guidance is clear that "safeguarding is not a substitute for:
  - providers' responsibilities to provide safe and high quality care and support;
  - commissioners regularly assuring themselves of the safety and effectiveness of commissioned services;
  - the Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action; and
  - the core duties of the police to prevent and detect crime and protect life and property.
- A Policy Library has recently been developed to ensure that existing policies and guidance documents are reviewed appropriately and are in line with the Care Act 2014. During 2016/17 the sub group is planning to review the following GSAB guidance documents; Safer Recruitment, Whistle Blowing & Escalation Policy.

7.5 Activity & Data 2015-16

1. The total numbers of calls made to the Gloucestershire County Council Safeguarding Adults Team Advice Line were **4412** for this financial year.

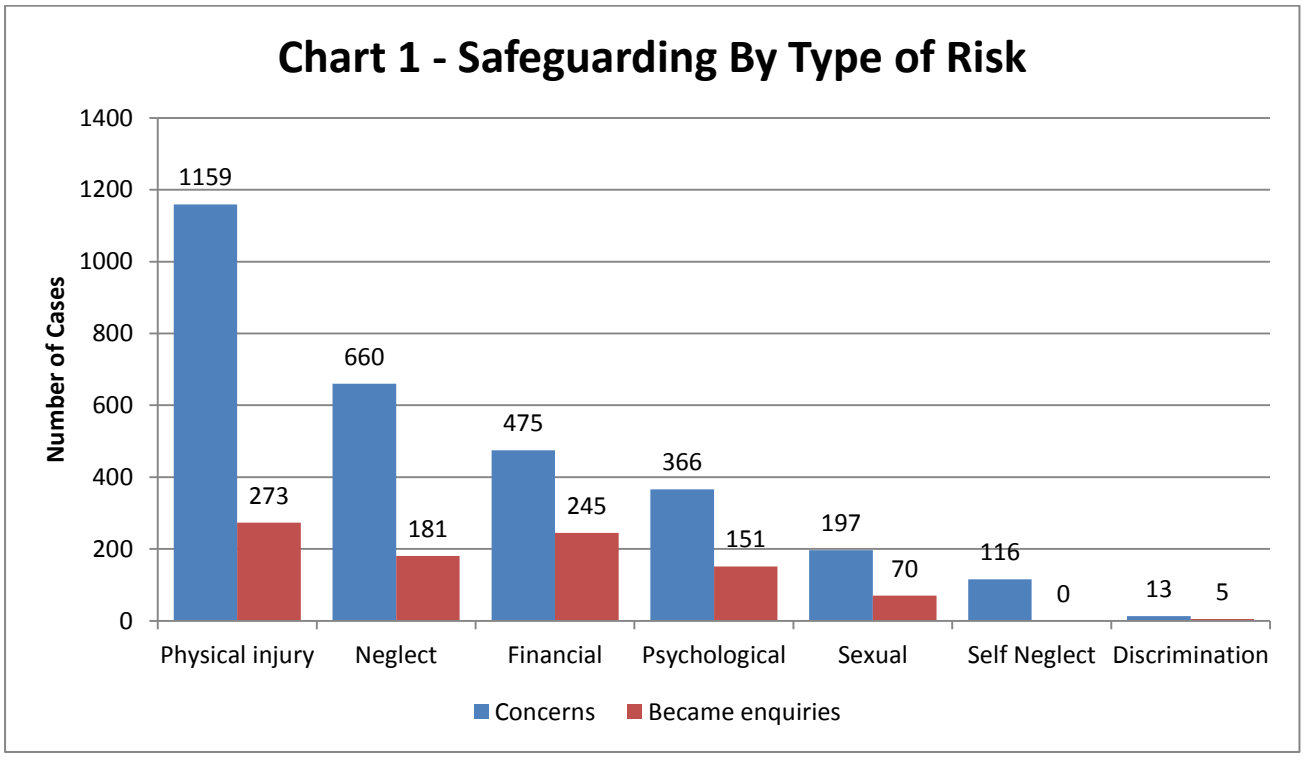
2. The number of Safeguarding concerns raised on behalf of adults at risk is **3291**, which is down on last year by **14.6%** (**3854**). Of these 3291 concerns, **918** (**27.9%**) went on to become enquiries; this is down again from the previous year (**1353 – 35.1%**).

3. The Police provided information for 531 of the concerns raised and 107 of these concerns had a police incident number attached. 57 were recorded as a criminal matter and 15 went on to formal criminal prosecution or cautions.

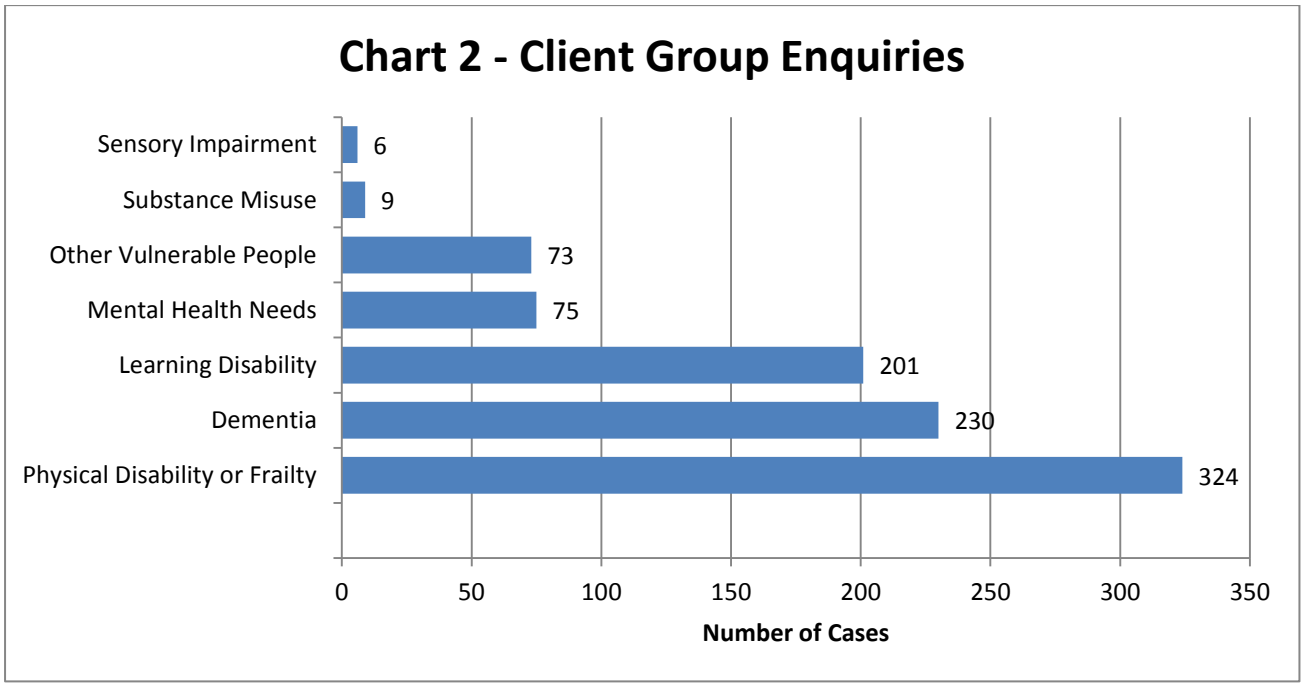
Table 1 - Source on Concerns Raised 2015/16

Source	Total Concerns	% Concerns	Total Enquiries	% Enquiries
Residential Care Home	*1045*	*31.75%*	*153*	*16.67%*
Home Care	*373*	*11.33%*	*115*	*12.53%*
Gloucestershire County Council	*363*	*11.03%*	*134*	*14.60%*
Gloucestershire Hospitals NHS Trust	*278*	*8.45%*	*101*	*11.00%*
Gloucestershire Police	*198*	*6.02%*	*74*	*8.06%*
Gloucestershire Care Services	*160*	*4.86%*	*49*	*5.34%*
Friends and family	*160*	*4.86%*	*73*	*7.95%*
2gether NHS Foundation Trust	*109*	*3.31%*	*33*	*3.59%*
Other source	*229*	*6.95%*	*64*	*7.00%*
Housing	*73*	*2.22%*	*22*	*2.40%*
General Practitioner	*54*	*1.64%*	*21*	*2.29%*
South Western Ambulance Service	*47*	*1.43%*	*11*	*1.20%*
Care Quality Commission	*35*	*1.06%*	*10*	*1.09%*
Education/Training/Workplace Establishment	*29*	*0.88%*	*9*	*0.98%*
Day care	*25*	*0.76%*	*6*	*0.65%*
Other - charity	*24*	*0.73%*	*9*	*0.98%*
Anonymous	*24*	*0.73%*	*9*	*0.98%*
Self	*17*	*0.52%*	*7*	*0.76%*
Other - Mental Health	*16*	*0.49%*	*9*	*0.98%*
Other - medical	*15*	*0.46%*	*3*	*0.33%*
Public	*13*	*0.40%*	*5*	*0.54%*
Gloucestershire Fire Service	*2*	*0.06%*	*1*	*0.11%*
Police	*1*	*0.03%*	*0*	*0.00%*
Other	*1*	*0.03%*	*0*	*0.00%*
Total	***3291***	***100.00%***	***918***	***100.00%***

4. As in previous years the main 'Risks' are Physical Injury and Neglect, but some cases can involve more than one type of risk, this year **263** cases had multiple risks.

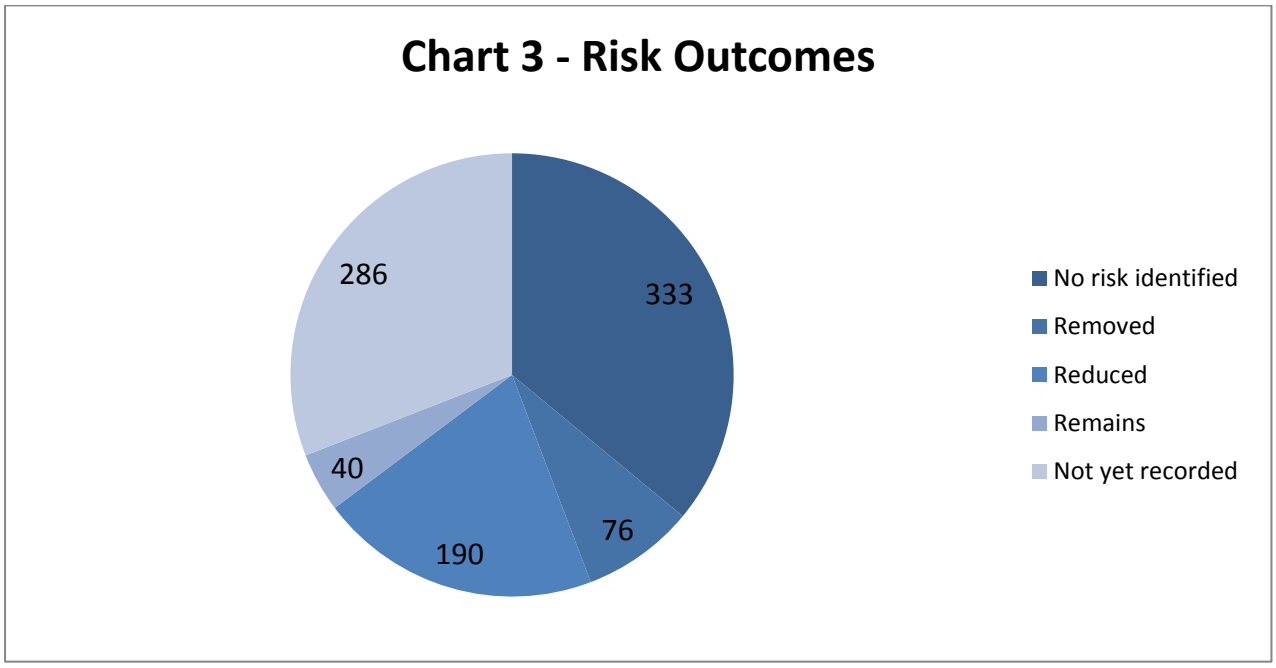


5. The breakdowns of the vulnerabilities of the Enquires were as follows:



6. The Risk outcomes for the Enquiries by Type of Risk for 2015/16 were:

Risk	No risk identified	Removed	Reduced	Remains	Not yet recorded
Physical injury	*94*	*29*	*64*	*18*	*68*
Neglect	*75*	*17*	*31*	*2*	*56*
Financial	*78*	*15*	*45*	*5*	*102*
Psychological	*54*	*13*	*37*	*12*	*35*
Sexual	*30*	*1*	*13*	*3*	*23*
Self Neglect	*0*	*0*	*0*	*0*	*0*
Discrimination	*2*	*1*	*0*	*0*	*2*
Total	***333***	***76***	***190***	***40***	***286***



7. The enquiries can be broken down into Age groups as follows:

	18 - 64		65 - 74		75 - 84		85 +		Total
Gender	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	
Female	*245*	*55.4%*	*60*	*52.2%*	*113*	*68.1%*	*137*	*70.3%*	***555***
Male	*197*	*44.6%*	*55*	*47.8%*	*53*	*31.9%*	*58*	*29.7%*	***363***
Total	***442***		***115***		***166***		***195***		***918***

8. The percentage split of individuals/organisations that caused the concern can be classed as:

Known to Individual	69.0%
Employed to Provide support	9.8%
Unknown to Individual	4.6%
Unclassed	16.7%

7.6 Quality Assurance

Audit Group

The work of the Audit sub group is one of the key elements in the GSAB Quality Assurance Framework, which is designed to:

- Provide a means of assuring the GSAB that effective structures are in place to improve the outcomes and experience of safeguarding for adults with care and support needs at risk of abuse or neglect.
- Provide the GSAB with the information it needs to identify potential risks and assurance that actions are being taken to mitigate those risks and improve services.

The group has a new Chair, John Lynch-Warden from the Public Protection Bureau.

Priorities for 2016/17 are:

- Establish some clear terms of reference for the group.
- Agree a revised work plan for next year.
- Focus on carrying out multi agency audits.
- Consider various ways to carry out audits effectively, drawing on local experience and that of other safeguarding adult's boards.

Making Safeguarding Personal (MSP)

What it is and why it is happening?

The Health and Social Care Information Centre (HSCIC) intend to collate data to evidence that organisations have taken a Making Safeguarding Personal approach when completing Safeguarding Enquiries. This information will be mandatory from April 1st 2016. The Care Act 2014 has made it clear that all safeguarding responses need to be informed by the views and preferred outcomes of the person experiencing, or at risk of experiencing abuse or neglect.

Following on from the 'Outcomes Pilot' Gloucestershire conducted in 2014, Gloucestershire Safeguarding Adults Board (GSAB) is committed to evidencing the MSP approach is embedded in practice.

Making Safeguarding Personal enhances practitioners' approaches to enable adults at risk to feel in control.

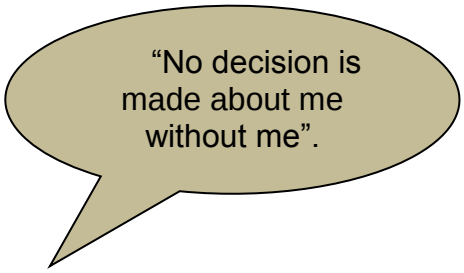
In addition, MSP enables practitioners to focus on a person centred approach and use their skills, knowledge and professional judgment. Ultimately, this approach is designed to improve outcomes for the adult at risk of abuse.

The Board continues to receive a dashboard report, which provides good information about safeguarding activity in Gloucestershire. As part of implementing 'Making Safeguarding Personal' the Board will want to see evidence of increasing

engagement and involvement of those individuals who experience safeguarding services, and improved knowledge of the following:

- Evaluation of not only the outcome of investigations but also the experience of those people experiencing having support from the safeguarding services;
- An understanding of how effective support is provided for carers;
- Effective application of the Mental Capacity Act and appropriate use of advocacy
- An increased understanding of emerging trends and how this information can inform practice development across GSAB agencies.

What we plan to do



Practitioners and service users

- To complete a feedback questionnaire – how confident were they in using an outcome based approach to safeguarding.
- Use an aide memoire (designed to act as a prompt) when discussing outcomes with people.
- To record 3 outcomes wherever appropriate at the beginning, middle and end of an investigation.
- To record if outcomes were met, partly met or not met.

Some Challenges

- Demands of time.
- The need for recording/IT systems to be responsive to person centred practice.
- Difficulty in maintaining outcomes at the centre of the whole process.
- Difficulties in using the approach with those who lack mental capacity.
- A need to promote the use of advocacy wherever appropriate.

What we plan to do next

- Keep the approach alive and active – promote ownership.
- Greater use of advocacy services.
- Increase the participation of service users at safeguarding meetings.
- Ensure outcomes are at the heart of adult multi agency care learning and development – not simply an add on.
- Share our tools, guidance and experience with other Local Authorities.

8. Carers

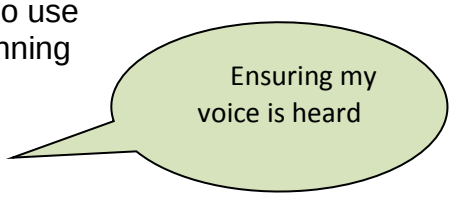
The Care Act 2014 puts much greater emphasis on the importance of the informal caring role and the need for carers to be properly supported. It is therefore important to identify the times when carers are at risk from harm and to make sure that support plans are put in place to keep them safe.

Carers look after friends and family who are disabled, frail, or ill and who may be vulnerable to abuse or neglect in their home or whilst in a care setting, such as a residential care home, day centre etc. Carers themselves may be vulnerable to abuse from the person they care for.
The Safeguarding Adults Board Policy & Procedures have taken into account that a carer may also be an adult at risk with care and support needs and includes consideration to:

- involving carers in safeguarding enquiries relating to the adult they care for, as appropriate;
- whether or not joint assessment is appropriate in each individual circumstance;
- the risk factors that may increase the likelihood of abuse or neglect occurring; and
- whether a change in circumstance changes the risk of abuse or neglect occurring. A change in circumstance should also trigger the review of the care and support plan and/or, support plan.

9. Independent advocacy & Safeguarding under the Care Act

The Care Act 2014 aims to strengthen the voice of people who use services, and their carers, over the process of assessing, planning and safeguarding. Local Authorities need to commission independent advocacy services to support people who may require it. Under the Care Act 2014, Local Authorities must arrange an independent advocate to facilitate the involvement of a person in their assessment, in the preparation of their care and support plan and in the review of their care plan, if two conditions are met:



- the person has **substantial difficulty** in being fully involved in these processes
- There is **no one appropriate available** to support and represent the person's wishes.

Within Gloucestershire there is now an increased awareness and focus on using advocates and asking people who use services if they would like the support of an advocate. Often these people prefer the support of family members to advocate for them.

It is recognised that there are some people who do not have family members/friends to advocate on their behalf. In these circumstances the Local Authority is obliged to make these resources available for them to access someone independent as required by the Care Act 2014.

10. The Board's Resources

Membership
The Care and Support Act Statutory guidance states that members of the Board are expected to consider what assistance they can provide in supporting the Board in its work. This might be through payment to the local authority or to a joint fund established by the local authority to provide, for example, secretariat functions for the Board. Members might also support the work of the Board by providing administration support, premises for meetings or holding training sessions.

The following organisations must be represented on the GSAB and are:
- Gloucestershire County Council
- Gloucestershire Clinical Commissioning Group GCCG)
- Chief Constable of Gloucestershire

In addition the Board should assure itself that it has the involvement of all partners necessary to effectively carry out its duties. Boards may include other organisations and individuals that the Local Authority considers appropriate having consulted with the GCCG and police. The Board can also invite additional partners to some meetings depending on the specific focus or to participate in its work more generally. This year the Board has again welcomed new members. A full list of the Board's current membership can be found at Board Membership

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) have agreed to continue their financial contribution to the Gloucestershire Safeguarding Adults Board, with the Constabulary increasing its contribution by 1%.

In addition, the Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company have agreed to make a financial contribution to the Gloucestershire Safeguarding Adults Board this year of £1000.

These contributions help with costs associated with the running of the Board with 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.

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

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

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