Gloucestershire
Safeguarding Adults
Board

Gloucestershire Safeguarding Adults Board

Annual Report 2016/17

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Foreword: Introduction from Chair

I am pleased to present the Gloucestershire Safeguarding Adults Board (GSAB) 2016/17 Annual Report.

The Care Act 2014 states each Safeguarding Adults Board (SAB) must publish an annual report detailing:

- what it has done during the year to achieve its main objective
- what it has done during the year to implement its strategy
- what each member has done during the year to implement the strategy
- its Safeguarding Adults Reviews (detailed further below)

The report contains details of how safeguarding has been promoted and developed throughout Gloucestershire, through the work of the Board and its sub groups, which are populated by senior representatives from our statutory partners, along with other agencies including representatives from the voluntary and community sector.

It outlines the comprehensive programme of work of the Board, undertaken over the past twelve months, and shows how partners have worked together to achieve its objectives and implement its 3-year Strategic Plan 2015-18. Details of the work and outcomes that have been achieved are provided in this report and it is essential that the work undertaken over the past year is recognised and celebrated.

I am pleased to say that Gloucestershire has a strong and committed Board, and that Board and sub group members have continued to demonstrate their continued support for the work of the Board and for the principles and values which underpin safeguarding adults with care and support needs.

As I have stated previously, it is my responsibility to support and encourage partners and agencies in Gloucestershire to work collaboratively for the benefit of adults with care and support needs and bring about continual improvement. It's 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.

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:

- Enhancing and updating our GSAB Website
- Delivering our first Roadshows – themed on Self-Neglect, Learning from SARs and Modern Slavery (these will now become an annual event)
- Establishing closer links with the Voluntary and Community Sector, Gloucester Diocese and Age UK Gloucestershire
- Continued production of our Quarterly Mental Capacity Act and Safeguarding Newsletters for practitioners
- Publication of Hoarding Guidance and a Framework for Responding to Organisational failure, and

- Delivery of training for General Practitioners and Dentists.

Like other Boards, over the past 12 months we have seen a rise in the number of cases being referred for consideration of a Safeguarding Adults Review under section 44 of the Care Act 2014. These are detailed later in the report. In terms of reviews under this section, the Care Act 2014 defines what must also be included within an annual report:

- the findings of the reviews arranged by it under section 44 (Safeguarding Adults Reviews) which have concluded in that year (whether or not they began in that year),
- the reviews arranged by it under section 44 which are ongoing at the end of that year (whether or not they began in that year),
- what it has done during that year to implement the findings of reviews arranged by it under that section, and
- where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.

As Independent Chair I am constantly seeking to make improvements in the way we deliver safeguarding adults work in Gloucestershire and ensure that we are always learning how we can be more effective. As a result of this we are about to take part in a thematic review of Safeguarding Adults Reviews across the South West region, in order to benchmark ourselves and establish best practice.

During the final year of our 3-year strategy the Board and its partners will seek to establish a new Communication and Engagement Sub Group along with a Service User Engagement Forum. This is in order to ensure that we can effectively engage with the public of Gloucestershire and front line practitioners in all our agencies. It also ensure that the voice of individuals with care and support needs is heard, thereby directly contributing to continuous improvements in adult safeguarding in Gloucestershire. We will also embrace the principles of Making Safeguarding Personal in order to ensure that the wishes and views of service users are respected and are central to their experience of safeguarding.

Finally I would like to acknowledge the commitment of all our partners, who once again have delivered a great deal in the past 12 months, and who continue to contribute to improving the way we all work together to protect adults with care and support needs from the risk or experience of abuse. I would also like to acknowledge the commitment and dedication of all front line practitioners who work in the field of safeguarding adults with care and support needs, including the public and voluntary and community sectors.

As we commence the final year of our 3-year strategic plan, the Board is enthusiastic and committed to taking this agenda forward with the continued support of all its partners, remembering importantly that “safeguarding is everyone’s business”.

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".

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

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

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

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

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

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

2. Key Achievements 2016-17 and Strategic Plan 2015-18

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

- Establishing links with the Voluntary and Community Sector (VCS), Gloucester Diocese, Age UK Gloucestershire
- Self-Neglect poster campaign
- Road shows – key themes around Self-Neglect, Learning from SARs and Modern Slavery
- Social Care Institute for Excellence (SCIE) SAR training for Board Members
- Partner agency self-assessment audit
- Easy Read versions of Multi Agency Policy & Procedures and public facing documents
- Launch of new data collection tool to incorporate MSP outcomes
- Publication of Hoarding Guidance and Framework for Responding to Organisational Failure
- Development of SAR briefing paper for agencies to evidence shared learning
- Induction pack for Board Members
- Updated website – http://www.gloucestershire.gov.uk/gsab/

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

Priority - Empowerment

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

Although all of the principles are important, in many ways, this underpins everything. Working in a way that always considers how to achieve the outcomes that people have identified and how to ensure that people make their own decisions about their own lives is the key to empowering people to keep themselves safer in the future.

Priority - Protection and Prevention

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

Safeguarding responses to abuse or neglect have to be effective and timely. All the partners contribute to a county-wide response to work with people who have experienced harm. The Multi-agency Safeguarding Procedures provide the blueprint and guidance for all partners when responding to a safeguarding concern. All partners have a key contribution to make to protecting people, whether the agency role is to report or to respond.

Priority - Proportionality

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

All safeguarding activity requires a balance to be reached between providing support and intruding and taking over people's lives. Whatever approach is used, it has to enable people to make important decisions about their own safety, while at the same time ensuring that the minimum level of involvement does not leave people at risk of harm. Partners take a range of approaches to ensuring that they offer a proportionate response to safeguarding concerns.

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

Working with partners, sharing information and co-operating with responses to safeguarding concerns are key activities for all organisations. Partnership is not just about partner agencies working together, it is also about working alongside local communities to recognise the capacity of local communities to make their own areas safer places to live or to support and empower citizens to keep themselves safe. All of the partners work together, through the Board and as organisations, to recognise, report, respond and reflect on safeguarding concerns.

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.

The main function of the Safeguarding Adults Board is to hold organisations across the county to account for their safeguarding activity. The Board and its sub groups ensure that the work of partners is coordinated and oriented towards the achievement of the three year plan. The Board presents its Annual Report to the Health and Well Being Board and to the Health Scrutiny Committee. The Annual Report also needs to be considered by the Police and the CCGs as statutory partners alongside the Local Authority. Most importantly, the Board should be held accountable by hearing the voice of the people who use the services.

The Board's Strategic Plan is set for the next 3 year period as recommended by the Care Act Statutory Guidance. The plan can be found in supporting documents.

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 in supporting documents.

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3. Key Issues & Challenges for the coming year

Making Safeguarding Personal

- The ADASS Temperature Check, carried out in November 2016 to review progress on MSP found that, while Local Authorities feel they are well on track in terms of delivering person-centred approaches to safeguarding enquiries, this has yet to be translated into action by other partners. This is therefore a key priority for the coming year.
- Statutory partners locally have already started to make the changes needed. The next Board CPD event will continue the conversation with our partners about how they can implement cultural change within their organisations to move towards a more person-centred approach to the safeguarding enquiry process.

Social Isolation

- Two of the SARs carried out this year ('KH' and 'Ted') featured social isolation as a major contributory factor to what happened to the individuals. Of particular note was that, for both of these adults, their social isolation was self-imposed, in that they both withdrew from their communities and were unwilling to engage with services. Both of them had the capacity to make this decision.
- Self-imposed social isolation appears to be on the rise, and it is often a factor in cases where adults are self-neglecting - this is a complex issue and one which is not likely to be easily addressed. However it will be a priority for the Board in the coming year to build stronger links with the Voluntary and Community Sector to look at the part they can play in the preventive agenda, as it is within communities that these situations develop. Our partners in this sector are in a unique position given the relationships they are able to develop at a community level, and the Board will work with them to explore the potential to engage with individuals where this is a factor.

Service User engagement

- In the next 12 months it will be a priority for the Board to find ways to increase the engagement of people with care and support needs in the work of the Board. Our aim is to set up a forum for people who use services to seek their views and input into the safeguarding process.
- Making Safeguarding Personal is a national priority and it is essential that adults are placed at the centre of any safeguarding enquiry aimed at supporting them, and that their wishes and views are respected as far as it is possible to do so.
- We will embark on this important development by working with service user groups to find a way of achieving this which is meaningful to those who participate, and capable of providing a person-centred focus to the work of the Board.

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4. Case Studies

Many safeguarding enquiries in Gloucestershire with effective interagency working evidence speedy responses and achieve a better outcome for the individuals involved. The following 2 case examples demonstrate this and are followed by case study 3 reflecting Safeguarding and MCA; 'Best interests in the real world'.

Case Study 1

All names and locations have been changed to protect confidentiality

Isobel is 78 years old, and lives with her husband of nearly 60 years, Derek. She recently suffered a stroke which has affected her speech and left her with weakness down one side of her body, which impacts on her mobility.

During a recent physiotherapy session, Isobel was tearful. She disclosed that Derek has hit her, and appeared afraid, anxious and in pain. The physiotherapist was worried for Isobel, having identified this as a domestic abuse situation, and felt that this should be reported as a Safeguarding concern. Before doing so, she asked Isobel if she was willing for a referral to be made. Isobel was worried about the potential implications of this, but had built up a good relationship with the physiotherapist and agreed to a referral.

Actions taken:
The referral proceeded for a Safeguarding enquiry, and a social worker visited Isobel at her next physiotherapy session. She reassured Isobel that her views and wishes in relation to the concern were of paramount importance. Once reassured, Isobel opened up and explained that her husband shouts at her constantly, and makes her engage in sexual acts despite this causing her pain and asking him to stop. Isobel feels that her stroke has worsened Derek's behaviour – he was previously verbally aggressive but had never hit her in the past. However Isobel described that over the whole course of the marriage he would have sex with her when he wanted, with no regard to her feelings or wishes.

Isobel was asked what she wanted to happen, and she explained she felt the time had come for her to leave the marriage. She did not want any Police involvement in relation to the sexual abuse, but agreed to a referral to GDASS who gave Isobel practical advice around her options, helped with confidence building and generally supported her until she had explored her options and felt strong enough to take steps to end the marriage and move out. In the meantime, the social worker assessed Isobel's needs and arranged a daily package of care which Isobel felt would ease the pressure on Derek, who had been caring for her mainly by himself. This was also a way in which the situation at home could be monitored. The social worker kept in regular touch with Isobel, to continue to ensure that action being taken remained in accordance with what she wanted, and at her pace. At Isobel's request, the social worker met with Isobel and her daughter, and Isobel explained the situation to her daughter, who was distraught both at what her mum had been experiencing, and also at the thought of her dad as a perpetrator of domestic abuse.

Outcome:
Isobel's daughter was able to make arrangements for Isobel to go and live with her. Isobel wanted to ensure that her daughter maintained links with Derek. She felt strong enough to explain to Derek why she had left, and that her daughter was not to be blamed for splitting them up. Despite her difficulties, Isobel expressed that she feels free and more independent than she has in years.

Issues highlighted / learning
It is important that professionals identify domestic abuse when it is happening to an older person rather than assume that a perpetrator's behaviour is a result of 'carer stress', as this may narrow down the approach taken to the disclosure. It would also mean that the person would not be able to access the support available from the domestic abuse support service, which was very important to Isobel's recovery in this case. There is emerging evidence that sexual abuse of older people is more widespread than previously realised; it is therefore crucial that professionals do not make assumptions based on a person's age. Being alert to the fact that older people do experience domestic abuse and sexual violence is the first step towards ensuring that older people gain access to the right type of support when it is needed.

Case Study 2

All names and locations have been changed to protect confidentiality

Carly is 24 years old and has a mild learning disability. Carly disclosed to a worker at the Drop-in centre that money was missing from her bank and that it must be down to Jade, her sister. With Carly's agreement a Safeguarding referral was made due to potential financial abuse.

Actions taken
A social worker, Fran, visited Carly as part of the safeguarding enquiry, to find out what the circumstances of the situation were, and what Carly wished to happen. Carly asked if her mum and Fran could sit with her to go through her bank statements because she wanted to understand how her balance could be lower than it should be. She said she thought Jade might have had some money off her but didn't want to say too much in case she was mistaken. Carly was previously assessed as having capacity in the area of her finances. Fran revisited this and remained satisfied that Carly has capacity.

Almost immediately Carly herself noted that there were two debit card transactions that looked unusual, larger than expected amounts to Tesco on consecutive days. Fran asked Carly if she gave her debit card to anyone, and Carly said she'd given her card to Jade to get some cigarettes. Carly asked how much cigarettes cost, and when her mum told her, Carly identified that Jade had probably had cash back from Tesco. Carly was very upset, and she said she knew she had made a mistake in giving Jade her bank card & PIN, but Jade is her sister and she didn't want her to get into trouble.

Fran explored this with Carly in a sensitive way, reassuring her that lots of people trust family members and she shouldn't feel down on herself. Carly understood that

she could report Jade to the Police, but she was adamant that wasn't something she wanted. Fran said she respected Carly's wishes but wanted to ensure she was protected from further financial abuse. Carly said she would speak with Jade, and didn't need Fran to do anything more for now. Fran advised Carly that she could change her PIN if she wanted, so that Jade would no longer know it. She had reservations about leaving the matter there, but agreed with Carly that she would visit her in a week's time to check that she was alright.

Outcomes
Carly spoke with Jade without her mum's or Fran's involvement. It is not clear what was said but they still have a good relationship. Carly's mum helped her to change the PIN for her card, and Carly agreed with Fran that she will tell her mum if anything happens again with her money.

Issues highlighted/ learning
Following the principles of Making Safeguarding Personal meant that Carly's wishes and feelings needed to be central to the safeguarding enquiry. Frequently, particularly where family members are concerned, the person may not want the police involved as their relationship with that person is more important to them than seeking redress. Skill and sensitivity is needed in the approach to these types of cases, particularly where the risk of harm may be so high that a decision has to be taken to go against the adult's wishes. In Carly's case however, she remained in control of what happened and felt able to deal with the situation herself, with the support of her mum and the social worker. This case also demonstrates how a safeguarding enquiry may be resolved without the need for a full multi agency response if a proportionate approach is taken.

Case Study 3

All names and locations have been changed to protect confidentiality

AB is a 48 year old woman living in a rented flat. She has a diagnosis of mild learning disability and a history of depression and anxiety. Gloucestershire Police contacted Gloucestershire County Council Adult Helpdesk in March 2016 with concerns about her contact with foreign males over the internet. A local travel agent had contacted the Police after AB had approached them to make arrangements to travel to North Africa. AB had been overheard speaking to a "foreign sounding male" to get instructions about where to travel. AB's finances were controlled by Gloucestershire County Council acting as her Deputy for property and affairs.

AB had approached the Council's Client Affairs Team to request money for a holiday in North Africa. A safeguarding concern was raised with the Council. A social worker visited AB and as a result of their conversation, ascertained that she was planning to travel to North Africa to meet a man she met over the internet ("Y"), with the intent of marrying him. The social worker had significant concerns for the safety and well being of AB, were she to travel to North Africa.

AB had been advised by her social worker of the risks of travelling to a part of North Africa which is not associated with tourism. Initially AB stated that she was not intending to meet anyone there but to visit for a holiday and had found the destination in travel brochures. The social worker had been able to view photographs of Y via Facebook. The photographs did not include the heads of the people photographed. There was therefore a significant concern about the reliability of the people AB was communicating with. AB had been in communication with "Y" since April 2016. AB believed she had been in communication with him for over a year, but demonstrated a lack of a concept of time. The social worker carried out a mental capacity assessment with AB. She found this difficult as AB was clearly able to express her wishes, so the assessment was carried out over two visits.

Outcomes

An application was made to the Court of Protection for a determination as to whether it was in AB's best interests to travel to North Africa to meet Y. GCC was able to obtain a temporary court order for the removal of AB's passport at the outset of the case, to ensure she was not able to travel until the court had made a final determination.

As part of the application, a further capacity assessment was undertaken. Both assessments were comprehensive, both noted the clear wishes of AB to visit North Africa but concluded that she lacked an understanding of the risks to her. Although AB was able to verbalise the risks when asked, she was only able to repeat information told to her, rather than demonstrate that she could weigh up the information to come to a decision. The Court of Protection made a declaration that it was not in AB's best interests to travel to North Africa either on her own or with another person as a chaperone. AB's passport was removed from her due to the risks of her saving funds to make the trip and travelling alone.
Interestingly the Court ordered a further capacity assessment from a medical professional despite there being two clear assessments from social workers.

Learning

This case highlights the need for clear capacity assessments in complex cases and the need for swift action in applying to court. It also highlights the fact that, while Making Safeguarding Personal principles require workers to put the adult's wishes and feelings at the centre of any work with them, the risks to the person also have to be taken into account; in this case they were clearly significant and required the social worker to go against AB's wishes.
This case also demonstrates the need to seek proper legal sanction by a court when a local authority is intending to act in a way that infringes a person's article 8 rights under the European Convention on Human Rights (the right to respect for private and family life), even when the action is taken to protect the person.

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5. Partnership Achievements 2016/17 and Priorities 2017/18

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

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

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

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

As this report is being published the inaugural meeting of our newly formed community and engagement sub group, which is to be chaired by a representative organisation from the voluntary and community sector has been arranged. We intend to consult with this new sub group in order to co-produce our future strategy and review the content of future annual reports.

5.1 Gloucestershire Constabulary

The police have seen a number of strategic changes in the last twelve months that have positively impacted on the response to protecting adults at risk. The electronic risk assessment, called the Vulnerability Identification Screening Tool (VIST), is now operational and has made the recording and sharing of relevant information more efficient with partners. In short police officers can obtain information within a consistent framework that helps make a judgement on any risk and share that remotely with those in the Multi-Agency Safeguarding Hub.

All police information in relation to adults at risk is now held centrally and accessible to all the organisation allowing informed contextual based decisions that are both supportive and recognise the voice of the service user. This is a significant and

important change that required extensive local and national information technology adjustment to ensure that police officers had the right information at the right time. The reporting of public protection offences of all types continues to increase and the police have again increased the resources in the Police Central Referral Unit, which coordinates information with partner agencies. This will be subject to further examination and review but awareness raising within the police locally has seen a significant increase in referrals being made to local authority partners.

The police continue to support all aspects of the Board and the sub groups and have spent much time raising the awareness of modern day slavery with members as this is an area of business that particularly affects adults at risk.

Simon Atkinson
Detective Superintendent 46, 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 2016/17
2gether NHSFT has continued to improve the take up of training for safeguarding adults with a 'Think Family' approach. This involved Making Safeguarding Personal (MSP) and incorporated safeguarding children within the adult's social network. Staff working within Adult Teams have also received improved access to internal safeguarding supervision via the Trust's Safeguarding Team. This is modelled on Reflective Practice as advocated within children's Safeguarding, and includes formal group and one to one sessions.

In line with the Board's objectives, 2gether has specifically shared learning from Safeguarding Adults Reviews, Serious Case Reviews and other learning models; shared learning from Multi Agency and Single Agency (internal) Audits; focused on Domestic Abuse and Sexual Violence, Perinatal Mental Health, Substance Misuse, Female Genital Mutilation and Prevent. 2gether has actively participated in Board and sub group activity. This has ranged from chairing sub groups, facilitating learning events (Practice Learning Reviews) and front line staff keenly partaking in learning events/audits.

Priorities for 2017/18
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; learning from Domestic Homicide Reviews, Safeguarding Adults Reviews, Serious Case Reviews and other learning models (e.g. Significant Incident Learning Process). 2gether will continue to increase the provision of safeguarding supervision to teams working with adults - concentrating on MSP while ensuring the safety of children within the service user's social network. It will also continuing to update the Think Family training approach (level 2), improving take up of Level 3 and 4 Multi Agency

for Adults, all levels for Children and Health WRAP (Workshop to Raise Awareness of Prevent)

2getherNHSFT looks forward to continually improving practice with partner agencies to ensure that an adult's right to live in safety, free from abuse and neglect, is protected. This will be done in conjunction with Safeguarding Children. Safeguarding Adults and Children remain a priority in the delivery of Mental Health services, irrespective of financial demands and constraints in the current economic climate.

Quality Assurance
2getherNHSFT will continue to provide assurance to the Board that Safeguarding priorities are in line with best practice and evidence positive outcomes for families.

Marie Crofts
Director of Quality, 2gether NHSFT

5.3 Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)

Gloucestershire Hospitals NHS Foundation Trust is committed to safeguarding adults, we are a core, statutory member of Gloucestershire's Safeguarding Adults Board (GSAB), and are proactively engaged in the work plans of all GSAB sub-committees, with senior staff representatives involved on each.

Structure and Approach to Safeguarding Adults within GHNHSFT
Within our Trust, Safeguarding is led by our Nursing and Midwifery Director, as our Executive Lead for Safeguarding. The Trust Safeguarding Adult Strategic Board, chaired by our Executive Safeguarding Lead, has representation from all key Trust stakeholders involved in Safeguarding Adults. Our Trust Safeguarding Adults Board has responsibility for implementation of the Trust Safeguarding Adults policy and action plan, including Trust Dementia Care Strategy, Learning Disability Care Strategy and Mental Capacity Act/Deprivation of Liberty Safeguards Action plan. Safeguarding activity and outcomes are reported to our Trust Quality Committee, to Trust Main Board and to GSAB. Our Trust Safeguarding Adults Board and Trust Safeguarding Children Board are combined, with a dedicated joint agenda section at each meeting.

Key achievements 2016/2017

- Safe, harm-free care, delivering the best care for everyone and promoting positive patient and carer experience are the vision of our Trust. Safeguarding is reflected in our Trust Health and Wellbeing Strategy.
- We follow GSAB "Safer Recruitment" guidance and recruit to ensure that our staff deliver compassionate care. Safeguarding is a core objective for all our staff; it is a fundamental part of employment contracts and staff role specifications. It is an essential principle of all professional codes of practice.
- Within our Trust we have integrated Safeguarding Children, Safeguarding Adults at Risk and Domestic Abuse procedures.
- We have developed and implemented resources to best support staff to fulfil their safeguarding roles in practice. We have a bespoke Trust Safeguarding Intranet webpage for our staff and have developed staff pocket prompt reference guides.

- We have an agreed annual programme of safeguarding communications and activities aimed at raising awareness for our patients, carers, our public and our staff. This has included Domestic Abuse awareness, Home Fire Safety, and awareness of self-neglect.
- We have further developed our Trust public Safeguarding Internet webpage, Home Fire Safety Information is also linked from this webpage. www.gloshospitals.nhs.uk/en/Patients-and-Visitors/Safeguarding-our-Patients/
- Our Trust Safeguarding Adults Team provides real time support and guidance for all Trust staff. This includes guidance and resources to support best practice application of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). At this time we are testing in practice a DoLS checklist, this is used by staff to assess patient care needs to determine if DoLS is triggered. Our team deliver training, have a responsibility to develop, implement and review Trust policy, process and resources. In addition to monitoring by our Trust Senior Clinical Staff and Matrons, Trust Safeguarding Team enables real time monitoring of practice, monthly trend reporting and promotion of prevention actions. A core objective is the rapid implementation of learning based on trend monitoring and case reviews.
- Our Trust bespoke Safeguarding Level 2 training package, completed by all care team staff, has been updated and enhanced. Alongside this our Trust Safeguarding Adults at Risk Policy has been updated.
- We are working in partnership with local NHS Trusts to benchmark safeguarding practices and to further improve our services.
- We continue to learn from feedback and to taking action to further improve care experience for our patients who have a learning Disability and for our patients living with Dementia. Our new Trust Dementia Strategy was implemented in January 2017.
- We have implemented Trust specific actions to support Gloucestershire's Safeguarding Adults Board Fire Safety and Prevention Sub Group's action plan. This has included home fire safety and safeguarding now being a core part of our level 2 Safeguarding Adult training. We have delivered targeted staff training for specific teams, held displays to raise public awareness and have further developed our Safeguarding Internet webpage. We have supported the development of a multi-agency home fire safety and safeguarding risk assessment document; this is set to be tested in practice during spring of 2017.
- We are involved as part of the development of Gloucestershire's Multi-agency Safeguarding Adults at Risk and Pressure Ulcer Policy.

Key objectives 2017/2018

- To continue to work in partnership with GSAB to safeguard adults with care and support needs, both within Gloucestershire and within our Hospitals.
- To work with all our partners in support of Gloucestershire's Multi-agency Safeguarding Adults at Risk Policy and Procedures.
- To further raise awareness of detection and response in connection with Human Trafficking, concerns of adult self-neglect and Home Fire Safety and Safeguarding.
- To continue to proactively support the work of GSAB and the work plans of all sub groups.

- To continue integrated working between the Safeguarding Adults team, Safeguarding Children team and our team supporting those at risk of or experiencing Domestic Abuse.
- We are committed to promoting best care for all our patients, to listening and learning, to working in partnership with our patients, their families/carers, and to further improving care experience.
- We are committed to listening and learning, to partnership working in support of patient safety and wellbeing and in support of safeguarding.

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

5.4 Gloucestershire Care Services NHS Trust (GCSNHST)

The focus of Adult safeguarding work within Gloucestershire Care Services continues to be guided by the Gloucestershire Care Services NHS Trust Clinical and Professional Care Strategy (2014 – 19). Robust safeguarding that enables the delivery of compassionate and considerate care and ensures that service users remain safe from avoidable harm is central to the strategy.

Achievements in the last year

The children and adults elements of the safeguarding team within Gloucestershire Care Services NHS Trust (GCS) continue to work more collaboratively in line with our 'think family' approach. This strengthens the team and provides resilience across services. This has been evidenced so far in the production of joint policies and the development and delivery of training. GCS delivers adult and children's safeguarding training in the same session at level 2. This training is mandatory for all our clinical staff and following a focused effort we have managed to increase the number of staff that have received face to face training from 38.33 % in June 2016 to 85.61% at the end of February 2017. Level 1 eLearning has increased from 11.58% to 82.01% in the same period.

GCS has also played a key role in developing the GSAB Multi-agency Mental Capacity Act "Train-the-Trainer" programme and has been instrumental in the production of resources to highlight issues around self-neglect and hoarding. Internally further work has been undertaken to raise staff awareness of issues in relation to domestic abuse.

We have made resources available to all our staff in order to meet the requirements of the Accessible Information Standard. This includes an easy read family and friends test that will enable us to better understand the experience our service users with learning disabilities and will enable us to improve care to this client group. The

Accessible Information Standard information is linked to the learning disabilities information on the Trust intranet, which has additional information regarding legislation, safeguarding and advocacy relevant to learning disability services.

We now have a designated clinical pathway lead for dementia to ensure that the care of service users living with dementia is designed to best meet their needs and improve their experience of care.

The mortality review process has commenced in Gloucestershire, and this will ensure that improvements can continue to be made in all areas of learning disabilities provision. Clients with learning disabilities may be subject to health inequalities, and the reviews will help the Trust to ensure that all clients get the same access to the health care they require.

To enable staff to reflect and learn from the outcomes of Safeguarding Adult Reviews, both within the county and nationally, the Named Nurse for Safeguarding Adults and the Specialist Nurse for Safeguarding Adults have developed a toolkit. This is designed to be used as part of routine team meetings, and incorporates links to Nursing and Midwifery Council Revalidation requirements as well as Department for Education guidance.

The GCS Safeguarding team have a programme of key safeguarding messages which are being promoted through our CORE Colleague network communication.

We have further developed the safeguarding elements of our electronic record to include a question to alert practitioners to fire safety issues within service users own homes, a chronology template for adult safeguarding activity and system 'flags' to indicate domestic abuse concerns.

The safeguarding team continues to provide all GCS staff with advice and support in safeguarding practice and ensures that our Trust policies, protocols and procedures are reviewed regularly and in line with changes in guidelines and legislation.

Priorities for next year

Whilst it appears, from the available data, that our staff are utilising the safeguarding professional helpline, the number of concerns raised via the adult social care helpdesk is lower than might be expected. We are developing a communication strategy to ensure that staff report their concerns via the approved route and will support this with measures to ensure staff feel confident and competent to implement safeguarding principles, utilising a person centred approach. We are developing a process within our internal recording system to identify where a safeguarding concern has been raised to ensure that we can monitor our levels of referral activity accurately.

Our mission to ensure that staff understand the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards and are able to apply this legislation will continue

with the development of our trainers, utilising ongoing training opportunities and increasing resources to support practice.

We are undertaking further work to ensure that learning from Safeguarding Adult Reviews is cascaded to all appropriate services within the organisation and that this learning is reflected in changes in practice where necessary. This work will also link to our internal incident reporting system to improve patient safety.

Supporting safeguarding and contributing to the GSAB agenda in a landscape of increased demand and financial constraints

The adults safeguarding team within GCS is at planned capacity and as such is able to continue in its support of the GSAB subgroups. The Director of Nursing will continue to take overall lead for adult safeguarding.

Despite staffing pressures we have prioritised safeguarding training, highlighting issues which staff may come across in practice and ensuring they know how to raise a concern and access help and support.

Quality assurance

The GCS Safeguarding Governance and Operational Group maintains a quality and performance dashboard that is presented to the quality and performance committee. This group meets bi-monthly to identify safeguarding priorities and review the safeguarding action plan. In addition it:

Monitors performance based activity data supplied by GCC. This will be supplemented by internally generated data as described above.

Ensures that learning is shared and disseminated. Safeguarding incidents and Serious Incidents Requiring Investigation (SIRI) are reviewed where there has been GCS involvement.

Safeguarding policy and guidance documents are reviewed to ensure they are current and easily available to staff.

Susan Field
Director of Nursing, Gloucestershire Care Services NHS Trust

5.5 Gloucestershire Clinical Commissioning Group (GCCG)

Gloucestershire Clinical Commissioning Group (GCCG) continues to recognise and endorse 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. The Executive Nurse is accountable for Safeguarding, with the responsibility sitting with the GCCG Named Nurse / Lead for Safeguarding. GCCG has an identified General Practitioner (GP) lead for Adult Safeguarding at Board level. Also appointed as CCG Deputy Clinical Chair, this serves to further strengthen the discussion and our ability for regular liaison on Safeguarding matters.

The GCCG Safeguarding Commissioning Standards are routinely included in all provider contracts. Performance continues to be measured against these standards and monitored for compliance by the provider Trust Clinical Quality Review Groups (CQRG). Bi-monthly updates of local and national Safeguarding issues are raised to the Integrated Governance and Quality Committee, which ensures the Board is kept up to date with safeguarding matters.

The GCCG has welcomed the appointment of the Named GP (commenced June 2016). This Specialist GP role ensures Gloucestershire GPs are supported to fulfil their safeguarding responsibilities for both Adults and Children. With increased staff capacity the organisation is well represented across the GSAB sub groups. Furthermore, the Named Nurse / Lead for Safeguarding has taken on the additional role as Chair of the Safeguarding Adult Review Subgroup.

GCCG began a GP Adult Safeguarding forum in December 2016, welcoming 35 GP Leads from across the County. The agenda covered the Mental Capacity Act awareness (referencing the G-Care Toolkit), PREVENT (Counter Terrorism Awareness Raising), Anti-Slavery / Human Trafficking brief and Q&A with the Gloucestershire Adult Safeguarding team. The forum is initially planned as a bi-annual event.

The Gloucestershire Dental Forum has been supported by CCG in their request for both Adults and Children Safeguarding themes at their forums. GCCG facilitated a Dementia / MCA Awareness forum in March 2017. This learning event was well received and extremely well evaluated by the 83 staff and practitioners that attended. Praise for the content and quality of the key professional speakers evoked discussions about how Dementia and Mental Capacity impact on the wider and often challenging aspects dental practice.

The Designated Doctor (Safeguarding Children / Children in Care) leads the Safeguarding Strategic Health Group for Gloucestershire Named Health Professionals. From October 2016 the group has encompassed the Adult and Child Safeguarding agenda, fully supported, endorsed and welcomed by all Lead Professionals.

Plans for 2017/18

The GCCG Safeguarding Team is committed to raising the profile of Adult safeguarding in General Practice by embedding an awareness of Safeguarding responsibilities within Primary Care. Commencing April 2017 GCCG is facilitating Adult Safeguarding Training (Level 2) delivered by GSAB approved trainers directly to GPs across 6 localities, including 'Out of Hours' doctors. This ambitious project aims to train Gloucestershire's GPs and Primary Care Health staff, achieving high uptake by delivering through each locality's planned dates and venues. Future plans are to identify training needs specifically for Lead GPs for Level 3 (Adult) training.

GCCG Safeguarding Team has specifically identified four priority areas of work as follows:
Domestic Abuse – linking with all Board and County level processes such as Safeguarding Adults Review and Domestic Homicide Review.
Learning Disability – focus on raising awareness and recognising safeguarding issues for those adults with additional learning needs. Also strengthening the current mortality review (LeDeR) processes so there is county wide learning for the improvement of the health of people with a learning disability.
Training – providing a clear directive for Safeguarding training requirements and organisational expectations (Health).
MCA/DoLS – maintaining this as a high profile topic and support any needs for training and development across Gloucestershire Health Organisations including Primary Care.

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

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6. Safeguarding Adults Reviews

For these SARs, reports were commissioned with an accompanying action plan. The oversight of the delivery of these actions is undertaken by the SAR sub group. As part of our evolving developments, different methodologies were used matched to each specific case.

The review into the death of SJ was signed off by partners at the GSAB meeting in November 2016. The death of SJ and proposed review of the care she received is described in the following summary and the subsequent learning from it:

SJ, a 68 year woman, lived alone in a semi-detached bungalow with communal entrance owned by a housing agency. She had a daily care package for personal hygiene needs arranged by health and social care agencies and a network of friends and family members who visited at varying frequencies. SJ was able to mobilise in her bungalow with the use of aids and was independent for preparation and cooking of her meals as well as transfers between bed, chair and between rooms.

On 8 June 2015 passers-by noticed smoke coming from the bungalow and unfortunately SJ was found inside having been overcome by the smoke. The source of the fire has been confirmed as the television in the lounge. An inquest undertaken on 15 November 2015 confirmed cause of death as smoke inhalation.

Key findings from the review: Health and Social Care providers did not appreciate the fire risk to SJ in her environment - she had been housebound since 2012 with implications for her ability to exit the accommodation in an emergency. The Fire Safety Development Sub Group is taking forward the actions.

'AT' was an adult who had bi-polar affective disorder, with mobility issues who died in 2015. A multi agency Practice and Learning Event was held in April 2016 and the report was completed in May 2016

The circumstances of AT's case reflect a number of issues which have been identified as causing difficulties for professionals working with people who self-neglect. It is acknowledged that since his death in May 2015, more resources are available which offer best practice guidance to professionals. However, it is also possible that the agencies involved with AT did not recognise his failure to engage with health care as self-neglect, as it is often equated with hoarding behaviours. It is possible that a more proactive approach to his refusal to engage, in line with best practice guidance on self-neglect, may have changed the outcome for AT.

While there was clearly concern from 2gether Trust about the state of AT's physical health during February and March 2015, it seems that the level of concern was not understood by other agencies. At this point a multi-agency meeting may have helped to identify the risks that AT was facing and arrived at a plan which attempted to re-engage AT with the support that was available to him. The fragmented nature of the communication between the agencies involved led to missed opportunities to understand the whole picture as the concerns accumulated in early 2015.

Some good practice was identified during this review, in particular:

- the creative approach taken by his Care Co-ordinator in trying to maintain contact with AT when he was sometimes unwilling to engage
- the proactive approach of his GP in trying to get him to attend appointments, and
- the good rapport developed with AT by the carers who visited to support him.

'KH' is an adult with mobility issues following a road traffic collision years previously and who was admitted to hospital in December 2015 in an extremely neglected state. The review concluded in December 2016.

The Independent Reviewer has asserted that nothing in the report negated KH's or his family's responsibility for him, or the responsibility of staff who were involved directly or indirectly in decisions or actions to promote KH's wellbeing and care during 2015. Likewise, so much in the current agenda of asset-based approaches to the person as a citizen or patient relies on the active, positive support / participation of the individual and those around the individual which, if it is absent, may result in more negative experience. At the Learning Event, one of the team reflected the conundrum for many of the role of family, friends and neighbours, when it was asked, "If not them, who?" Learning from these difficult instances helps organisations and staff to practise in new ways which are more closely aligned to the positive, asset-based agenda.

'Ted' was aged 72 at the time of his death. The review commenced in July 2016 and concentrated on the period from Ted's admission to hospital in late August 2015 to the date on which he was found deceased, at home, in late February 2016. The report was published in January 2017.

Ted returned home from hospital at the beginning of October 2015 with support from the Reablement Service. At the end of October the service ended as Ted no longer required their services. He was managing self-care and medication independently.

Over the coming weeks, Ted was seen "out and about" on a number of occasions. The last recorded sighting of Ted was in early/mid-January 2016. At about the same time, the alarm was activated in Ted's flat but when contact was made with him by the Alarm Call Centre, Ted responded that the alarm had been activated by mistake. Some seven weeks later, concerns were raised by a neighbour about Ted's safety. The police made a forced entry and both Ted and his dog were found dead. No known cause has been adduced because of the state of decomposition of Ted's body – in June 2016 the Coroner recorded an open verdict: "No ascertainable cause of death".

During the review it became clear that Ted was a very private, fiercely independent man with no known/declared next of kin. The reviewer concluded that, in all the circumstances and at the time, his death was neither predictable nor preventable. However, there were lessons to be learned from the sad events and these lessons are reflected in the action plan.

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

6.1 Safeguarding Adults Referrals

'HE': HE had complex needs which resulted in many organisations being involved in her care. HE had a long history of behaviours that were high risk and increased her vulnerability. HE was a young woman from Gloucestershire who died aged 26, on 27th May 2016. A SAR commenced in July 2016 and it is expected that the report will be submitted to the Safeguarding Adults Board in May 2017.

'AD': 47 year-old male with a learning disability, who died unexpectedly. The referral did not meet the SAR criteria but was referred for a Mortality Review

'SH': 50 year-old female who sustained life threatening injuries in a house fire. This did not meet the criteria for a SAR, however a Serious Incident Requiring Investigation was undertaken by 2gether NHSFT.

'CH': 27 year-old female with learning disabilities who died as a result of choking. The referral did not meet the criteria for a SAR but was referred for a Mortality Review.

'DK': 65 year-old male with complex care needs who died in hospital. He had four hospital admissions over a 3 month period. More information has been requested before a decision can be made regarding holding a review.

'LM': 27 year-old female who lived in a residential care home. LM was seriously assaulted by another resident. More information has been requested before a decision can be made regarding holding a review.

'LC': a 24 year-old male who drowned in the bath following a seizure as a result of an overdose of anti-depressant medication. At the time of his death LC was on the waiting list for counselling having disclosed childhood sexual abuse. This case did not meet the criteria for a SAR, however a review of the circumstances has been undertaken and the learning will be shared with the agencies involved.

'YB': A 45 year old lady with alcohol issues, who was known to services, had 256 admissions to A&E and was a frequent caller to the ambulance service. This case did not meet the criteria for a SAR, however a review of the circumstances has been undertaken and the learning will be shared with the agencies involved.

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7. GSAB Management Committee

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

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

During 2016/17 the Management Committee met quarterly and worked to a standard agenda which included oversight and updates to the Risk Register. A function of the Management Committee is also to review any reports that will be presented at Board meetings.

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

8.1 Workforce Development

- The training figures highlight take up of all GSAB training and E-learning by partners in 2016/17. It evidences a significant increase in take up of taught, face-to-face Level 2 Safeguarding training compared with the previous year. A notable area of increase is in the voluntary and community sector. Fewer Mental Capacity Act training places were taken up this year, and this is under review with the Head of Adult Social Care. All training supported local GSAB Policies and Procedures, and some content, particularly at Levels 2 and 3, is contextualised for relevance to the local Safeguarding Adults picture, following Safeguarding Adults Reviews.
- The annual CPD Trainers event was attended by 55 approved trainers; the full day included an overview of the work of the Safeguarding Team, a Fire Service update, a presentation on Female Genital Mutilation (FGM) and forced marriage, and a bespoke workshop on Modern Day Slavery by a specialist trainer (aligning with the Anti Slavery Partnership Board's strategy for the County).

- Currently 93% of trainers have been observed/re-observed for quality assurance; 64 trainers are approved to deliver the GSAB Level 2 SA programme, with the annual Train the Trainer workshop planned for September 2017. Groups currently covered by the network include Social Care, Health (GCS, 2gether Trust, Acute Trust, CCG, Mental Health Services and Hospices), Adult Education, Housing, Faith Groups, Fire Service and the Voluntary Sector.
- The first ever Safeguarding Adults Roadshows took place in February and March 2017. The events were extremely well attended and well received, with 197 people from a wide variety of partner organisations attending over four half-day workshops. The Roadshow title was: "Am I **YOUR** Job?", and focused on two of the new Care Act areas of abuse – Self Neglect/Hoarding and Modern Slavery. Partner groups worked on delivery of sessions (with the National Crime Agency also attending), and the events were received extremely positively. A trainer resource (training session plan and videos) on Self-Neglect has been produced for the Roadshow which can be offered out for organisations to use, both locally and potentially nationally.
- Joint work with the CCG has been done to embed a Safeguarding Adults Workforce Development strategy within Primary Care – 2017/18 will see the planned roll out of face-to-face Level 2 training to GPs and other practice staff, and a number of CPD events for both GPs and dentists have focused upon Safeguarding Adults.

MCA Training pathway. –

- Simon Thomason, MCA Governance Manager from 7 Jan 2017, is delivering one-day Level 3 MCA Training once a month.
- A Train the Trainer package was produced through joint working between GCC and GCS; a workshop for trainers to be approved to deliver MCA and DoLS Awareness Level 2 courses was held in November 2016, new trainers are currently being observed/quality assured to become approved to deliver, and two more Train the Trainer workshops are planned for April (GCS only) and June (multi-agency) 2017.

Identified Priorities for 2017/18:

- Annual Board development session is being organised for May 2017.
- A second set of Safeguarding Adults Roadshows – themes to be selected.
- Targeting contact with the Criminal Justice System as a staffing group to engage in Safeguarding Adults training.

Financial/Resource Implications:

Plan implemented on budget.

2016/17 Training Figures can be found in supporting documents.

8.2 Fire Safety Development.

Below is a summary of the progress we have achieved this year through joint working with our partners:

- **Gloucestershire Clinical Commissioning Group**
  GCCG Patient Engagement and Experience has had sight of the Fire and Rescue Events calendar to consider wider current events across the County and better join up working with all agencies. GFRS has facilitated information stands at GCCG Provider and GP training events.

  GCCG (both Named Nurse and Specialist Safeguarding Nurse) are actively raising the profile of Adult Safeguarding across Primary Care in Gloucestershire. As a direct result of learning events (GSAB Roadshows and Adult Safeguarding GP Forums), matters and concerns relating to managing and coordinating care in self-neglect and hoarding cases have been raised widely. Significantly, GCCG is aware of proactive co-working with GFRS, enabling joint home visits with General Practitioners.

- **Safeguarding Adults Team and Adult Social Care, Gloucestershire County Council:**
  With regard to training, we were involved in the production of the Hoarding Guidance; we were also a key participant in the Roadshows, and have attended training sessions/meetings of both Adult Social Care and partner agencies which have included reference to self-neglect & hoarding. We also include reference to self-neglect & hoarding and recent SARs. All of this feeds into the risk identification element of ASC's work with adults. GFRS practitioners regularly liaise with ASC around fire risks, and chair or attend meetings where there are fire risks.

- **Gloucestershire Care Services:**
  How to make a referral to the Fire Service is covered in all level 2 safeguarding face-to-face training sessions as well as 'Safe & Well Check' cards being available. Learning from incidents and national information is disseminated at the GCS Safeguarding Operational and Governance group meeting.

  The following prompt to assist practitioners in recognising fire risk is now included in the Integrated Community Team's (District Nurses, Physiotherapists and Occupational Therapists) core assessment: 'Has this patient had a Safe & Well check?' If the answer is 'no' the free text area has to be completed.

This year has been a success for the Fire Safety Development Group. There is still much work to do but I believe the work this group does is vital when we consider the importance of working together to safeguard people.

A total of 7,142 Safe and Well visits were completed during last year, which exceeded our target. Of these visits, 73% were targeted at identified fire risk groups

and this is testament to the close working relationships partners have established through this group.

Over the last year the group has become proactive in supporting each other's media campaigns and has been particularly successful in Twitter campaigns. The group has established a reactive element to it as well whereby critical safety information is shared quickly and widely e.g. tumble dryer safety advice.

A task and finish group was established to develop a multi agency hoarding framework which has now been completed and forms part of the Self-Neglect Policy. To complement this, the group has also designed and developed credit card sized prompt cards for staff, which remind people what to look out for when going into someone's home and where they can seek help. These resources will be tested by Dietetic teams, Occupational Therapy teams, Phlebotomy teams, vulnerable women Midwifery teams and Village Agents. Test results will be fed back to the group in July, any alterations made and then the resource pack for practitioners will be cascaded out.

Priorities for 2017/18:
The group is currently writing its action plan for 2017/18 which will focus on five key areas. Most of these areas have remained constant, however the actions that will be set against them and the measures put in place are now much more specific and include:

- SJ recommendations
- Risk identification and referral pathways
- Communications and Engagement
- Quality Assurance

This group is testament to what can be achieved when agencies work together across boundaries to benefit the communities of Gloucestershire. We will set ourselves tough targets for this year to ensure we push ourselves and our agencies to work together effectively to keep people safe.

8.3 Communication & Engagement

The communications sub-group brings partner communications colleagues together with sub-group champions to determine the safeguarding communication and campaign priorities for each year. During 2016/17 the joint communications sub-group agreed that the frequency of meetings would be reduced with the sub group becoming a network using electronic communication, with an annual summit stocktake meeting after 6 months.

Achievements in 2016/17:

- A self-neglect campaign plan was produced and sent out for consultation to the Safeguarding Adults Review sub group. Two Adult Road Shows took place in January and February 2017 focussing on Modern Slavery and Self Neglect.

- In the New Year there were plans to undertake a public facing survey which will act as a baseline to measure any future campaigns and to help target and develop people's understanding of safeguarding but due to the Communication lead for GCC leaving the authority this will be a priority for 2017/18.

- A session took place with the Ageing Well Group (AgeUK) who took the time to review the safeguarding information leaflets and posters and feed back was positive. The group will consider undertaking other projects to raise awareness of abuse and neglect of adults at risk.

- Representatives from Adults and Children attended a 'Market Stall' aimed at elected members during December where a full council meeting took place. As a result of this there are plans in place to develop a council member's induction pack to include a section on safeguarding and training information.

- GCC launched its new website and intranet in the New Year to enable the customer journeys to be simpler. The new GSAB web page for 'I am a service user' includes a 'hide page' button as a hidden icon which will allow the user to be taken to another site i.e. BBC if they do not want anyone seeing them accessing this information.

- The VCS have offered their support in getting them effectively engaged with safeguarding issues in the county. They held a VCS Health and Wellbeing forum during February and the Head of Safeguarding attended. A bespoke event/workshop session is arranged to take place in April for the Head of Safeguarding to provide an overview of Safeguarding and discuss the specific role the VCS can play in supporting this.

- Safeguarding Adults and Childrens business managers attended a Staying Safe Conference on 21st March which was hosted by Inclusion Gloucestershire who are an all age, all disability, and user-led organisation.

- Communication alerts continued to be distributed on a range of topics throughout the year.

The communications priorities for the GSAB during for 2017/18 are:

- Ensuring that the messages from both adult and children's SARs/SCRs are disseminated and properly communicated to everyone.
- Targeted social marketing campaign and Road Shows aimed at raising awareness of safeguarding, hoarding, self-neglect and neglect based on the principle that "Safeguarding is everybody's Business" and that MSP is being integrated in agencies practice.
- The Board considers that all partner agencies are aware of each other's responsibilities and practices and what the limitations of these may be
- To review the Communication and Engagement Sub Group in order to provide evidence of community awareness of adult abuse and neglect and how to

respond; to raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect; provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult.

8.4 Policy & Procedures

Achievements for 2016/17:

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

- An Easy Read version of the Gloucestershire Multi Agency Safeguarding Adults Policy and Procedures has been implemented to sit alongside the main Policy.
- Making Safeguarding Personal (MSP) guidance which supports the new data collection tool with the move towards a more person centred, less process driven approach to the safeguarding enquiry process. A Task & Finish Group has been established to implement the MSP programme throughout safeguarding work across GSAB partners and this remains a key priority for the coming year.
- A Framework for Responding to Organisational Failure or Abuse.
- The Guidance was 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".

- The Positions of Trust Guidance is still in development, working alongside our colleagues in the West Midlands.
- Policy Library. This is to ensure that existing policies and guidance documents are reviewed appropriately.
- During 2016/17 the sub group have reviewed the following guidance documents; Safer Recruitment, Whistle Blowing, SAR Protocol, Out of Contact Service User, & Escalation Policy.

Priorities for 2017/18

- Update the information sharing agreement between the active members of the Board to reflect the implementation of the new EU General Data Protection

Regulation in 2018; the statutory requirements for data sharing agreements and the impact of the EU GDPR on information sharing.

- Agree a prevention strategy.
- To produce Safeguarding Transition Guidance aligned to both the Adult and Children Board.
- With relevant partners produce guidance in relation to financial abuse.

8.5 Activity & Data 2016/17

The Safeguarding Adults Collection 2016/17

NHS Digital (formerly the Health and Social Care Information Centre) is responsible for compiling an annual Safeguarding Adults Collection (SAC), which records details about national safeguarding activity for adults aged 18 and over in England. Each local authority has a statutory obligation to contribute towards this collection, and the data outlined and described below represents the significant areas of Gloucestershire's contribution. The collection includes demographic information about the adults at risk and details of the incidents that have been alleged.

The SAC is an updated version of the Safeguarding Adults Return (SAR) which collected safeguarding data for the 2014/15 and 2015/16 reporting periods. Some of the categories collected have remained the same but there are also some significant differences. As a result of some of these differences, it is difficult to compare data across the collections in all areas.

However, we continue to make improvements to our recording and statistical monitoring systems, which have allowed us to monitor more systematically the progress of all cases open in Gloucestershire at any given time.

In terms of the data collected during this financial year, the number of Safeguarding concerns raised on behalf of adults at risk is **2049**, which is down on last year **(2747)**. This decrease has been investigated and is judged to be due to the success of the Safeguarding Adults Team Advice Line, which professionals can call to discuss a case and receive advice on whether or not a safeguarding concern needs to be raised.

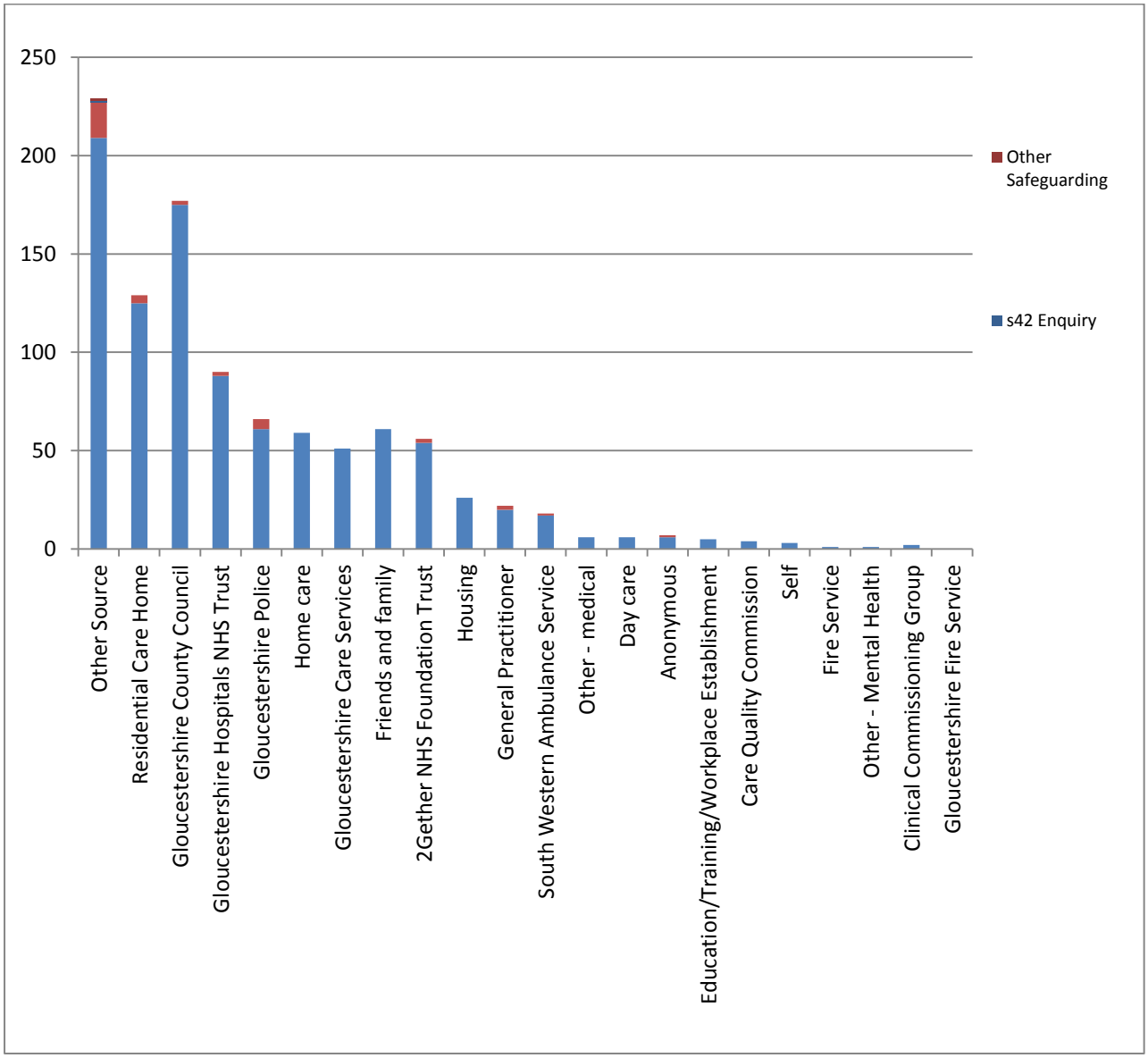
Of these **2049** concerns, **980** went on to become enquiries; this is up from the previous year **(883)**. The total number of calls made to the Gloucestershire County Council Safeguarding Adults Team Advice Line was **3422**.

124 of the safeguarding concerns reported to the Adult Social Care help desk were made by Gloucestershire Police; **54** of the **124** led to enquiries; **52** of this year's concerns have police incident numbers. The Police provided information for **284** of the enquires, **29** were recorded as a criminal matter.

Source of Concern raised 2016/17

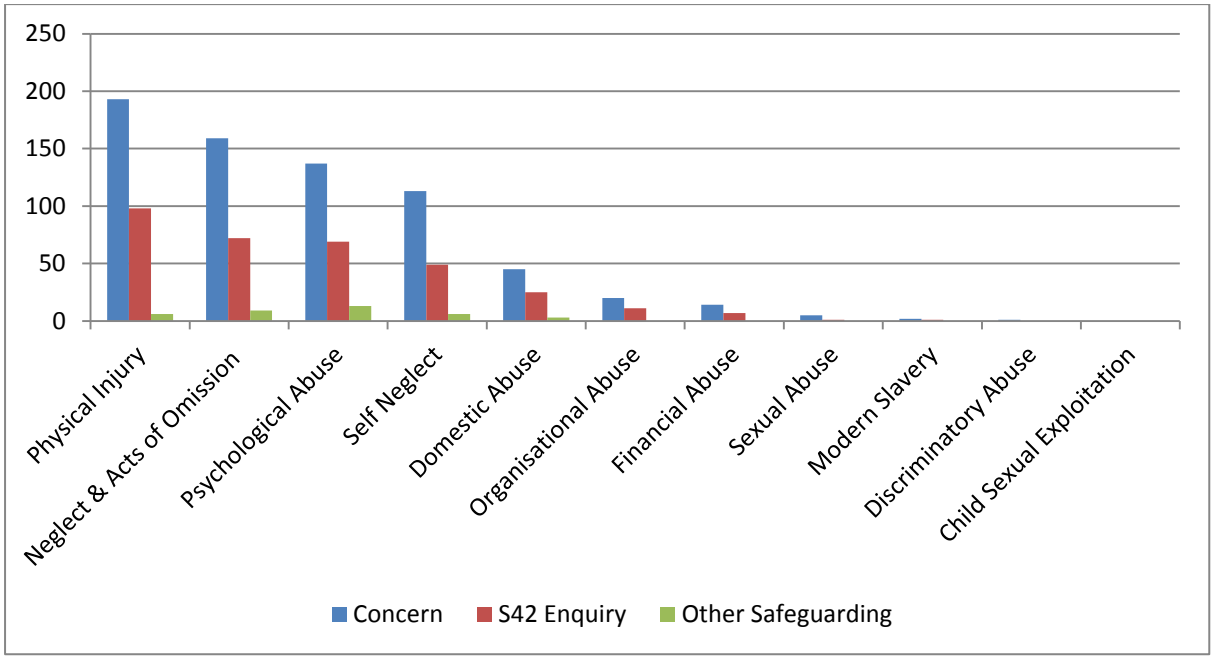
NHS Digital has requested statistics on the number of "other safeguarding enquiries" carried out during the year. This relates to enquiries which have not met the section 42 criteria, however some form of safeguarding enquiry is needed, for example, the

person is no longer at risk but an enquiry is still needed. We have begun to gather this data since January 2017.



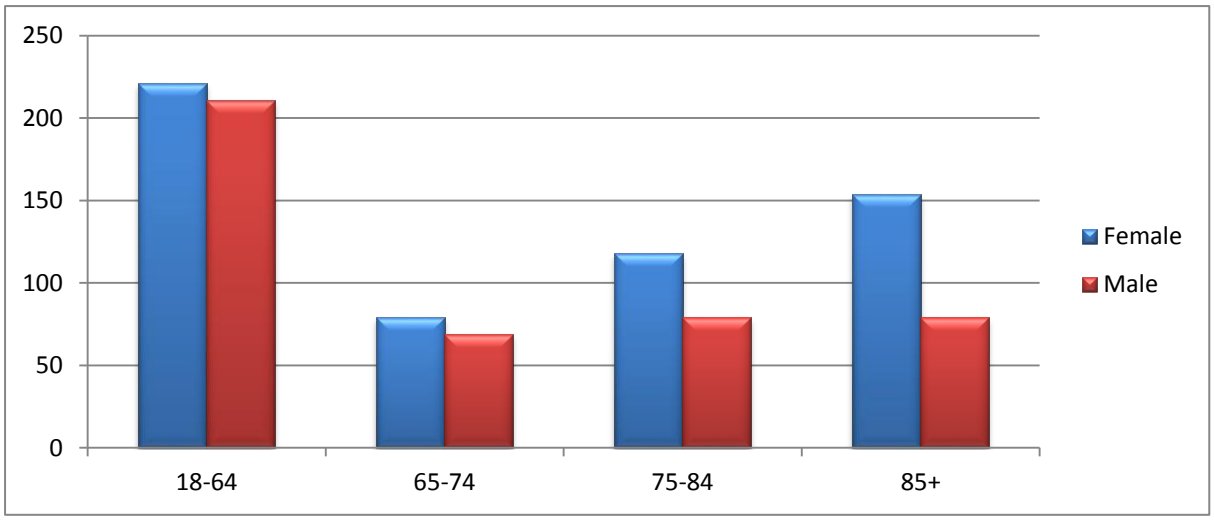
Safeguarding by Type of Risk

The main 'risks' continue to be physical injury and neglect, but some cases involve more that one type of risk.



Age Groups

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



8.6 Quality Assurance

Audit Group

The work of the Audit sub group is one of the key elements in the GSAB Quality Assurance Framework. It 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 Audit group revised its terms of reference this year and devised a work plan of audits, some of which were designed to examine the progress on recommendations from Safeguarding Adults Reviews. There have been 3 multi agency audits conducted, which yielded useful learning for dissemination more widely. A further audit, on Making Safeguarding Personal, has recently been carried out with Adult Social Care.

There is a tension inherent in the undertaking of audits: carrying out large scale audits provides quantitative data across a high number of cases but provides little qualitative information which can provoke reflection, highlight good practice and offer areas for improvement. As statistical information is already available from the Data and Performance sub group, the Audit group has favoured carrying out smaller scale audits, looking in depth at a few cases at a time.

To illustrate this, an audit of five section 42 enquiries into sexual abuse provided evidence of robust multi agency working and good information sharing between professionals, particularly with the Police. There was evidence of good adherence to the principles of Making Safeguarding Personal, with open communication with the adult affected and their wishes and feelings being central to the enquiry. It also raised the issue about how complex such enquiries can be, particularly in cases where the adult lacks capacity to take part in the enquiry and the allegation cannot be corroborated. In the case audited it was clear that professionals had been thorough in their approach to the enquiry and had gone as far as they could in trying to establish what had happened to the adult, a woman with advanced dementia living in a care home.

Priorities for 2017/18:

- Continue to work to the agreed work plan, taking into account any learning which emerges from Safeguarding Adults Reviews.
- Carry out multi agency audits regularly as well as conducting single agency case file audits when appropriate.

- Continue to consider ways of carrying out audits more effectively drawing on the experiences of other Safeguarding Adults Boards.

9. Safeguarding Outcome and Performance Self-Assessment Audit 2016

A key part of this year's work was looking at the further development of the self-assessment framework for partners, to understand the progress their organisations are making in safeguarding adults. All partners completed this assessment and they were collated for the board. Assurance on the ability of members to safeguard adults was good overall and areas for future work were highlighted. These areas include:

- Community engagement
- Embedding the Mental Capacity Act
- Learning from audits and SARs
- Improving delivery to minority groups

What is also clear from the self-assessment audit, in comparison to the 2014 audit, is the continued commitment of all agencies to the safeguarding adult's agenda. Agencies reported significant developments and improvements across many areas, along with areas of priority. There was evidence of a great deal of work having been undertaken within agencies over the past 2 years, in what have been very difficult times. A further round of self-assessment will be implemented in 2018/19.

10. The Board's Resources

Independent Chair's comments on Board attendance
We have worked hard once again to ensure that all partner organisations on the Safeguarding Adults Board are represented by a post holder of sufficient seniority and expertise and that ideally the same person should attend each meeting. However, there are inevitably operational pressures on individuals. I am very grateful to the senior representatives of each organisation who have given so much time, interest and commitment to the work of the Board during 2016/17.
A full list of the Board's current membership can be found in supporting documents.

Funding Contributions
The Board is pleased to confirm that the Gloucestershire Constabulary & the Clinical Commissioning Group (on behalf of 2getherNHSFT, Gloucestershire Hospitals NHSFT and Gloucestershire Care Services NHS Trust) have agreed to continue their financial contribution to the Gloucestershire Safeguarding Adults Board.

GSAB Business and Activity costs 2016/17

Independent Chair	20,000
Other staffing includes:	
30% Head of Safeguarding Adults	
1 x GSAB Business Manager	
1 x Administrator	
15% Admin Manager	
Total	101,400
Workforce Development	65,000
Safeguarding Adult Reviews	20,000
Comms. & Publicity	4,000
Total	210,400

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

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

For 2016/17 the Police increased their contribution to the GSAB by 1% and Probation contributed 0.5%. The increase has allowed additional resources to the Business unit in terms of the Safeguarding Administration Manager dedicating some time to assist with supporting the independent reviewers as a result of the increase in SARs. Other partners have contributed with their time and commitment to the Board's work and by providing access to resources such as meeting venues, conferences, etc.

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

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

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