Gloucestershire Safeguarding Adults Board

Annual Report 2019/20

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Foreword: Introduction from Chair

I am pleased to present this year's Gloucestershire Safeguarding Adults Board (GSAB) Annual Report 2019/20, as we continue to manage and respond to the unprecedented level of demand placed upon us all by the impact of COVID-19.

We are currently in the midst of some of the most challenging times ever experienced by our communities and our statutory and non-statutory partners, as well as the wider Community and Voluntary Sector, across Gloucestershire. In order to meet this demand we have seen a number of agencies restructure and refocus their resources where they are most needed in order to be more agile and responsive to the evolving picture.

The GSAB has a key assurance role and statutory responsibility to monitor and evaluate what is done by partner agencies individually and collectively, to safeguard and promote the health and well-being of adults with care and support needs, and that continues throughout the pandemic.

The Board operates at a senior level, with membership across a wide range of both statutory and non-statutory partners, including representatives from the Community and Voluntary Sector. The report demonstrates that in Gloucestershire we have continued to build on the strong partnership that we have developed since the foundation of the Board in 2009, to meet the many challenges facing agencies in ensuring that we keeping adults at risk safe.

The purpose of the annual report is to give confidence and reassurance to the Gloucestershire public, and those that represent their interests, and of course the leadership of organisations involved in protecting adults with care and support needs across Gloucestershire, that the Safeguarding Adults Board is properly committed to, and capable of, discharging its responsibilities in a person-centred way.

Our annual report has to include:

• how the Board has achieved its objectives, set out at the start of the year and how we implemented our strategy;

• how each of our partners has implemented the strategy and worked to deliver effective safeguarding services;

• the findings of 'Safeguarding Adults Reviews' – these are reviews which have been concluded between April 2019 and March 2020 and where an adult has died or where there have been serious issues and concerns; and where it was identified that there could be learning and improvements made by organisations to ensure that similar issues do not recur.

During 2019 we continued to focus on the priorities that we all signed up to in our 3-year strategic plan 2018/21: Making Safeguarding Personal, Prevention and Improving Safeguarding Practice and Board Effectiveness are our 4 key themes.

During 2019/20 we received the findings from the work that we had completed with the University of Sussex, along with 8 local authorities, on identifying best practice to embed learning from Safeguarding Adult Reviews. We are now working on the findings from the study which is being led by our Safeguarding Adults Review sub group.

Some of the work delivered by the Board and its sub groups during this period is outlined below:

- two of our planned six Roadshows that were aimed at raising awareness of Safeguarding Adults with the Voluntary and Community Sector. Presentations were delivered by the County Councils Safeguarding Adults Team, our Advocacy service, 'POhWER' and the County's Mental Capacity Act Governance Manager. Unfortunately the last four Roadshows were cancelled owing to COVID-19 and therefore all individuals who were due to attend were sent a GSAB Quarterly Newsletter highlighting the content of the Roadshows;

- we held an annual development day for Board members, entitled "Finding Creative Solutions for Complex Needs". Further work is planned in this area in 2020/21 with a number of learning events in the planning;

- statutory partners completed the biennial Safeguarding at Risk Self-Assessment audit tool;

- further ongoing work to develop our Quarterly Performance and Data Report, to include new partnership data which enables us to better reflect and evidence the impact we are having on safeguarding adults;

- our Audit sub group undertook a comprehensive programme of audits including a number of multi-agency and single agency audits, which have highlighted good practice and also areas for improvement;

- our Policy and Procedure sub group have continued their annual programme of reviews and updates to our comprehensive library of individual policies and procedures, including the Gloucestershire Multi-Agency Safeguarding Adults Policy and Procedures document. We have also received a number of Multi-Agency Risk Behaviour referrals as a result of our new High Risk Behaviours policy;

- agreeing to conduct three Safeguarding Adults Reviews during this period;

- we have produced and disseminated our Quarterly GSAB Newsletter covering a variety of themes;

- 12,306 Gloucestershire staff and volunteers completed GSAB approved safeguarding training.

I would like to extend my thanks and appreciation to my Board Business Manager, the Board and members of our various sub groups, for their continued support and commitment to developing and promoting the work of protecting adults with care and support needs, especially during these unprecedented times. I would also like to acknowledge the work and commitment of our front-line practitioners, as safeguarding adults at risk would not happen without the dedication and professionalism of our front-line staff.

There is a lot more that we need to do in order to reduce the risks of abuse and neglect in our communities and support people who are most vulnerable to these risks, and I look forward to leading and chairing the partnership as we move forward and strive to support the health and well-being of 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".

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. The Gloucestershire Safeguarding Adults Board (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 2018/21

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 2019-20 and Strategic Plan 2018-21*

The Board's key achievements during the past year:

- Holding two of the six planned roadshows (due to COVID-19), these were aimed at the voluntary and community sector (VCS). They included presentations from the GCC Safeguarding Adults Team, Advocacy provider POhWER and the Mental Capacity Act Governance Manager.
- A Board Development Event for Board members was held on the topic of 'Finding Creative Solutions for Complex Needs'.
- Completion of the 2019/20 Safeguarding Adults at Risk Self Assessment Audit Tool by partner agencies.
- Ongoing work to develop the quarterly report, to improve performance data reporting and include multi-agency data.
- Working with the University of Sussex and seven other local authorities to identify best practice in embedding learning from Safeguarding Adults Reviews (SARs). The University of Sussex Report has now been received and the findings are being taken forward.
- Updating the Gloucestershire Multi-Agency Safeguarding Adults Policy and Procedures.
- Receiving Multi-Agency High Risk Behaviour referrals, as a result of the new High Risk Behaviours Policy.
- Producing and disseminating four issues of the GSAB Quarterly Newsletter, covering a variety of themes, including one which focused on the content of the GSAB Roadshows, for those unable to attend the events.
- Agreeing to conduct three new Safeguarding Adults Reviews (SARs) this year.
- 12,306 Gloucestershire staff and volunteers completed GSAB approved safeguarding training.
- Establishing stronger links with community groups in Gloucestershire.
- Updated website – http://www.gloucestershire.gov.uk/gsab/

Strategic Plan 2018-21

The Board's Strategic Plan covers a three year period as recommended by the Care Act Statutory Guidance. The high-level priorities are reflected across these four areas: (a copy of the Strategic Plan can be accessed via this link Strategic Plan which details the Board's objectives and how these have been met).

Priority – Improve GSAB Effectiveness
To ensure that the GSAB is fit for purpose, in that it has the right membership, has the right support and is resourced and run in an efficient and effective manner, so that it can fulfil all of its statutory functions to a high standard. The outcome of its work must meet the requirements of the Care Act 2014, and the Board must lead on and make a positive contribution to adult safeguarding in Gloucestershire.

Priority – Improve Safeguarding Practice
To ensure that the Board and its partners deliver efficient and effective outcomes that are person centred, and that evolve to meet new challenges and take into account best practice and learning from across the safeguarding landscape.

Priority – Focus on Preventative Practice
The Board recognises the importance of preventative practices in order to protect individuals from being abused and/or neglected and also early intervention which minimises and mitigates harm. In doing so we should embrace a person centred approach, which takes into account the needs and wishes of people who are the subjects of safeguarding enquiries.

Priority – Embed the Ethos of Making Safeguarding Personal
To ensure that the ethos of Making Safeguarding Personal is embedded within the practice of all Board member organisations.

Risk Register 2018-21

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

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

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

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3. Key Issues & Challenges for the coming year

COVID-19

- To continue to respond to the threat of the COVID-19 virus and to take every opportunity to analyse and review its impact. To enable us to maximise our response to, and minimise the risk posed to, some of the most vulnerable members of our community, especially those who are isolated or live in the many residential and nursing homes in our county.

Voluntary and Community Sector Links

- To have greater and more meaningful interaction with our highly valued voluntary and community sector Organisations within the county. To raise awareness of adult safeguarding themes, reduce isolation and to reduce the risk of harm and keep people safe.

Training

- Owing to the impact of COVID-19 and the absence of face to face training, to develop our safeguarding adults board workforce development plan, to ensure that we have accessible e-learning and webinar training to meet partnership needs.

Board Quarterly Performance Report

- To continue to develop our Multi Agency Board Quality Assurance Report.

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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 examples of complex needs and the use of advocacy demonstrate this. The names and locations have been changed to protect confidentiality.

Case Study 1

Natalie is a 23 year old woman with an acquired brain injury, weakness down one side of her body and substance misuse issues. She has been living in a house converted into separate dwellings all occupied by young adults who are supported by the same care provider. She receives 4 hours 1:1 a day support to administer her medication, prompt her around personal care and support her at mealtimes. There is a shared sleep-in on site.

Over a period of two months Natalie has become involved with a known drug user and is believed to have accrued a drug debt. There are concerns that Natalie has been physically harmed by drug dealers, as well as being coerced into having sex to pay off some of the money she owes. Natalie is not accepting her care, and there have been concerns that the provider has not been robust in its approach in trying to engage with Natalie. Her actions are now impacting on several of the other young people in the house. Natalie often stays out late and when she returns she can be disruptive and verbally abusive, and she brings guests home who are considered to pose a threat to other tenants.

A Safeguarding concern was raised following receipt of a Vulnerability Identification Screening Tool (VIST) by the Police who attended a lockdown party and found Natalie in attendance. The concerns widened from the risks arising from Natalie's involvement in the drug scene to include looking at potential neglect by the provider.

The provider's view is that Natalie has capacity to make decisions around taking drugs, to consent to sex and to manage her finances, although this has not been formally assessed. The Police view was that she may lack capacity, although she was believed to be under the influence of drugs at the time she was spoken with.

Action taken:

Natalie was initially visited by a social worker to ensure her views were understood as soon as possible. Natalie was not comfortable discussing the issues with them other than expressing she was "ok" and that she considered the male to be her boyfriend. A referral for advocacy was considered but not made as the worker felt Natalie could take part in the Section 42 enquiry.

The social worker was able to establish that Natalie did not agree that her actions towards other tenants in the house were inappropriate, or that she may be at risk. The worker felt that Natalie had capacity although said formal assessments had not been completed due to Natalie's "difficult engagement".

A Safeguarding meeting was called, attended by the Social Worker, care provider,

CQC and Police, as well as a representative from Headway to provide specialist knowledge of brain injury and Gloucestershire Domestic Abuse Support Service (GDASS) for expertise around domestic abuse.

The key actions identified were to assess Natalie's capacity in relation to various decisions she was making that impacted on the risks to her and others, discussing with Natalie practical ways in which she could protect herself, completing a DASH form to understand the risks Natalie faced, reviewing her care package to ensure it was safe & effective, and establishing how to manage Natalie's conduct to minimise the impact on the other tenants. Natalie was invited to take part in the meeting but declined.

Issues highlighted/learning

Natalie's brain injury was considered to have an impact on her decision making, although not to the extent that her capacity was compromised. This meant that actions to ensure Natalie's safety under the Mental Capacity Act were not available. Natalie does not see herself as a victim despite our own views. While agencies can only go so far to protect Natalie from her unwise decisions, focus is needed on ensuring that other tenants are not impacted.

When an individual exhibits risky behaviour and is disruptive to other people in a service, there can be a tendency to view that person as a source of the risk rather than as someone who may be experiencing neglect by the care provider. The learning from a recent Gloucestershire Safeguarding Adults Review (LM, July 2019) was that in these cases, the provider's actions in keeping the person safe need to be examined to ensure that they are not neglectful in their duty of care towards that individual.

Case Study 2

Geraint has a learning disability. He can understand most of what is said, but he cannot verbalise fully. He can use signs and make himself understood with his current support team as they know him so well.

Geraint's had a Care Act Advocate appointed during assessment and support planning processes. Geraint informed his advocate that another person in the same house was pressurising him, taking his things and selling them. The Provider team leader was aware that this had in fact been happening for some time, and Geraint was upset about it and felt that he couldn't stop it happening. As a result Geraint wanted to move accommodation.

The team leader was newly in post but she said all the incidents from previous years had been documented. The advocate asked if a safeguarding referral had been raised about this, but she was unsure.

Geraint was supported by his advocate to decide if he wanted to speak with the police about this and he decided that he did. The advocate checked with Geraint several times and he continued to say yes. Although Geraint could not verbalise, his

understanding was very good and he was able to engage in meetings fully, making himself understood, and was able to correct professionals if he felt he had been misunderstood.

It appeared that Geraint had been a victim of theft for some time, with no clear actions being taken. A safeguarding referral was raised by the support planner along with a referral for advocacy, to allow the same advocate to support Geraint throughout the safeguarding process.

The matter was raised with the safeguarding team as a concern and they advised that it had not been raised before and that it would be investigated.

The ongoing nature of these incidents was a concern and despite the care provider documenting and being aware of these incidents, Geraint had not previously been given the opportunity to speak to the police and no safeguarding referral had been raised previously. The Quality Team at GCC have been advised of this matter.

The combination of GCC Adult Social Care professionals, a new team leader and the ability to have the same advocate throughout the different processes enabled Geraint to have the opportunity to voice his wishes about these experiences and this will form part of a plan for his ongoing support in the future, including where he lives.

5. Partnership Achievements 2019/20 and Priorities 2020/21

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

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

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

Health and Wellbeing Board
Mental Health Partnership Board
Learning Disability Partnership Board
Safer Gloucestershire
Transforming Care Board
Learning Disability Review Steering Group
Gloucester Diocesan Board
Anti-Slavery Partnership Board
NHS England Quality Surveillance Group
Child Sexual Exploitation Board
Domestic Abuse and Sexual Violence Implementation Group
Multi-Agency Public Protection Arrangements

Dangerous Drugs Network (County Lines)
Sexual Assault Referral Centre Strategic Board
Community Safety Partnership Board
PREVENT

5.1 Gloucestershire Constabulary

Through educating all our staff, not just front line officers, and creating the Adults at Risk function, Gloucestershire Constabulary has continued to increase its understanding of, and response to, vulnerable adults. Additionally, perhaps as a result, we have experienced a significant increase in Adult at Risk (AAR) referrals, from a monthly average of 157 in last year's report, to 299 per month between January 2019 and January 2020. This represents an increase of 90%.

We have appointed two Multi Agency Safeguarding Hub (MASH) Decision Makers with responsibility for Adults at Risk, who review high risk referrals at the earliest opportunity. The Decision Makers have established clear pathways to support AARs and developed strong working relationships with partners to protect people at the earliest opportunity.

We have developed an AAR action plan to ensure that we continuously improve our processes, service delivery and risk identification; this is supported by a Quality Assurance process where AAR features as part of broader vulnerability audits. This plan is embedded in our Public Protection Unit (PPU) business plan, which is subject to quarterly executive scrutiny and implementation, and supports and records the identification of vulnerability and risk mitigation.

Gloucestershire Constabulary also participate in the Vulnerability Knowledge and Practice Programme (VKPP) which is a national transformation process, seeking to share evidence-based responses to vulnerability across Forces. We also contribute to the National Vulnerability Action Plan (NVAP) which drives practice improvements through a regional AAR Board where we are represented by the Head of PPU. This connectivity ensures we are able to learn from innovation and best practice elsewhere, and gives us a network of police colleagues with whom we can problem-solve, in addition to our local work partnership work.

We have recently developed our 'Adult's Journey' process, which maps out the experience of a vulnerable adult as they come into contact with the police, and helps us identify the potential gaps and inhibitors to safeguarding them effectively and expeditiously. This is just one example of how we constantly reflect on the experience of the communities we serve, and seek to both proactively protect them from harm, and improve the quality of our response if they become victims of crime.

5.2 Gloucestershire Health and Care NHS Foundation Trust (GHC)

Gloucestershire Health and Care NHS Foundation Trust (GHC) was formed in October 2019. This followed the merger of 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust, to provide joined up mental health and learning disability services with physical health services.

As previously separate organisations and now as a single organisation, commitment to working with all partners of the Gloucestershire Safeguarding Adults Board (GSAB) to safeguard adults from the risk of abuse and neglect has been and remains a priority.

Key achievements 2019/20
As a merged team, GHC has a Head of Safeguarding – overseeing both adult and children's safeguarding, a Named Lead for Safeguarding Adults, two full time Adult Safeguarding Practitioners and a part time Domestic Abuse Specialist Practitioner. The Trust now has a single merged advice line that all staff in the Trust can access for advice on safeguarding adults or children.

GHC has shared with the wider Trust all learning from the GSAB including learning from Safeguarding Adults Reviews and audits. The GHC safeguarding team are involved in co-delivering level 1, 2 and 3 training for safeguarding adults and the level 2 training package has recently been updated. The merger of the Trust will provide an opportunity in training for the formally separate organisations to share learning and develop a consistent approach to safeguarding adults, with Making Safeguarding Personal (MSP) principles at the heart of their safeguarding practice.

A representative from the GHC adult safeguarding team attends MAPPA level 2 meetings and the adult team has started to offer safeguarding supervision to some staff who work with potentially high risk cases. GHC continues to actively participate in GSAB and GSCE sub group activity.

Priorities for 2020/21
The GHC safeguarding team has a clear set of objectives for the year across adult and children's safeguarding. The GHC adult safeguarding team will be focusing on improving the quality of safeguarding referrals to the Local Authority with particular reference to the MSP principles and Mental Capacity Act in safeguarding; in addition to involvement with audits and improving practice around recording who is in the client's network. Preventative practice will have a focus on modern slavery; dangerous drugs networks (County Lines) and transitional arrangements for young people moving into adult services. Work on improving understanding and responses to domestic abuse will continue across adults and children's safeguarding practice.

As a result of the merger, a safeguarding training needs analysis will be conducted, particularly to look at which staff in the organisation will need level 3 and 4 adults safeguarding training in the future.

Quality Assurance
GHC will continue to provide assurance to the Board that safeguarding priorities are in line with best practice and evidence positive outcomes for families. We will seek to improve our data collection and reporting and we will monitor our objectives to ensure they are delivered in line with the Safeguarding Board strategic agenda through the Trust's monthly Safeguarding Group and the Trust's Quality Committee.

5.3 Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)

Key issues to note

Workplans for 2019/20 were achieved. Notably:

- Safeguarding Hub has been established and Think Family approach.
- Safeguarding risk assessments are now available for completion at all points of entry, albeit an Electronic Patients Record (EPR) for inpatient adult areas and paper documents in all other areas. The change to EPR has not yet occurred in Children's Services.
- Training programmes at all levels for both adults and children have been revised and improved performance is starting to filter through as a result. COVID halted face-to-face training, but sessions have been revised to enable delivery over Microsoft Teams. Lower training compliance has been highlighted in training reports due to the changeover in training provision.
- The Hospital-based Independent Domestic Violence Advisor (HIDVA) contract has been reviewed and commissioners have agreed to ongoing funding.

Risks and issues of note are:

- There is a gap in service provision to patients with complex and multiple conditions as they transition from Paediatrics to Adult Services, which is the root cause of many poor patient experiences, complaints and expression of safeguarding concerns.
- There is a gap in care facility provision for alcohol-dependent people who do not wish to stop drinking but have developed care and support needs chronologically early.

Safeguarding workloads have been broadly stable, with the exception of Domestic Abuse, which has seen month on month increases, except latterly during the strictest pandemic restrictions. This affects all areas of the Trust, but is most often detected by the Emergency Departments and maternity staff.

During the year there have been several Domestic Homicide Reviews and Safeguarding Adult Reviews with recommendations for all partners coming out of each review. GHFT is obliged to deliver on these recommendations, all of which entail quality improvements to our services. Most notably during 2019/20 a large project to revise our letters to GPs after outpatient appointments has delivered distinct improvements, without clinicians having to remember to do something different for a patient who was not brought to their appointment. This is a Trustwide improvement which applies to all patients of all ages.

LeDeR reviews have consistently raised 4 concerns about care at GHFT – these are:

1. Dysphagia management
2. Use of the Hospital Passport (to be known in future as the Health Passport)
3. Communication with non-verbal patients
4. Listening to the experience and concerns of family and paid carers

All of these are being taken forward as workstreams by the Learning Disability Steering Group.

The Emergency Departments are now using a tailored mental health triage tool for all those identified as having mental health needs and the Mental Health Liaison Team are making follow-up calls to all patients who do not wait to be seen in the Emergency Departments, where mental health or alcohol-dependency have been identified. These two improvements have considerably reduced the risks related to these patient groups waiting for extended periods for mental health assessment.

Frequent Attender management has been taken into the Safeguarding workplan so that it is tracked, monitored and reviewed, rather than being *ad hoc.* GHFT will be participating in a regional High Impact Users project and this has enabled additional consultant and safeguarding time to be given to patients who have complex needs and require summarised background knowledge and a consistent approach to management. This approach has already demonstrably worked with patients who have primarily mental health or alcohol-dependence concerns and this project offers the opportunity to extend this improvement to physical health complexities.

An increase in the number of allegations made against our staff in the early months of 2020 has prompted a review and revision of the process managers are to follow when investigating such allegations. This work is being led by the Operational Director of People and Organisational Development.

Conclusions

At the end of 2019/20 Safeguarding is better able to assure the Board that concerns have been identified, raised to the correct specialities and authorities and responded to in a manner that takes account of the wishes of the patient concerned. That work and recommendations coming out of the many formal case reviews during the year dictates the work required in the forthcoming year.

Implications and Future Action Required

Review recommendations across age groups require that we:

1. Risk assess all patients more robustly on presentation to our services.
2. Demonstrate more professional curiosity about patient histories and answers to questions and are not afraid to compassionately challenge stories that are inconsistent with our observations and examination, with particular emphasis on meeting the needs of those who present in crisis with self-harm and other mental health disorders, particularly when there are children in the household.
3. Demonstrate that mental capacity assessment has been factored into our patient management decisions.
4. Demonstrate that we have actively asked patients what their preferred outcomes are for both care and treatment and safeguarding interventions.
5. Signpost patients with evidence of alcohol intoxication or alcohol dependence to alcohol services.
6. Work towards incorporating the Pathfinder Toolkit into our services to enhance the response to domestic abuse.
7. Address concerns raised about the quality of our care by LeDeR reviews.
8. Pursue a county care facility for alcohol-dependent men using a whole system approach.

5.4 Gloucestershire Clinical Commissioning Group (GCCG)

Gloucestershire Clinical Commissioning Group (GCCG) has an established Safeguarding Team providing key leadership roles to ensure a clear line of accountability alongside the provision of countywide clinical expertise and strategic advice. GCCG is well represented at Board level by GCCG's Executive Nurse and at the Business Planning Group and across sub-groups by the Safeguarding Lead and Specialist Nurse for Safeguarding. The good operational links with Primary Care continue through the work of the CCG's Named GP for Safeguarding. GCCG's Adult Safeguarding Lead continues as Chair of the Safeguarding Adult Review sub group.

GCCG recognises, endorses and promotes the health services responsibility to safeguard adults at risk of abuse and neglect when commissioning health services across Gloucestershire. Working together with our health partners we jointly take action to prevent abuse and neglect, as well as seeking assurances that our staff always act in a way to protect vulnerable people in our society and those using our services.

With consideration of the priorities set out in the previous year, the CCG Safeguarding Team has sought to continue our collaborative work with partners and sustain and raise the profile of Safeguarding Adults through innovative practice to improve services. The following evidences the key parts of that work:

Key Achievements 2019/20

- The GCCG's Strategy for Safeguarding Adults and Children has been ratified by the CCG Governing Body and is available on the CCG website. The policy also outlines the key Safeguarding priorities for the CCG and local health services over a three year period.
- Facilitation of the first CCG Safeguarding Conference: 'Health at the Core of Safeguarding'. Aiming to further raise the Safeguarding profile across the health professional community, the focus of the conference was on stalking/harassment, domestic abuse, ACEs, exploitation and vulnerability. The daylong event welcomed 140 attendees including GPs, Practice Nurses, District Nurses, Health Visitors, Midwives and Dental Practitioners.
- Gloucestershire GP Practices are signed up to a revised Primary Care Offer (contract) which supports the CCG in obtaining specific assurances for Safeguarding practices and GP engagement.
- Primary Care has significantly improved their contribution and engagement in the work of statutory reviews, supported by the Named GP, specifically for SARs and DHR reports and disseminating learning. The GP Safeguarding Forums remain a priority work area as they provide a fundamental link with practices across the county; as a result of Covid-19 these are now taking place using 'virtual' platforms. This has been a successful innovation and will continue for the foreseeable future. Whether face to face or via a virtual method the attendance by GP practice staff at these forums is always very good.
- Focused work has been undertaken to support the CCG's Continuing Healthcare Nursing Team. This has enabled the nurses to undertake advanced Safeguarding training (GSAB approved Level 3) and further embed a process of regular Safeguarding supervision and support provided by the CCG Safeguarding Specialist Nurse.

Priorities for 2020/2021

The GCCG will continue to lead the local health service contribution to support the delivery of the GSAB strategic objectives.

The GCCG are committed to:

- The Safeguarding Adults Strategic Health Group, led by GCCG aims to progress the development of the health dataset, drawn from the adult safeguarding activity delivered by the local health providers. This provides the health service and partner agencies with better insight as to the level and type of adult neglect and abuses, so that actions may be planned to reduce the incidence of abuse and neglect and support victims.
- There will continue to be a sustained focus on training; this will include an assurance that healthcare providers commissioned by the CCG undertake the necessary staff and volunteer training. In addition the CCG is committed to a higher level and more inclusive system of adult safeguarding training for its own staff.
- Develop closer, more integrated working between the CCG and the two local NHS provider Foundation Trusts. This will ensure a more joined up approach to adult safeguarding across the local NHS and shared learning.
- General Practice – The CCG's Named GP and CCG Primary Care Audit Team will undertake an annual audit in GP practices in relation to adult safeguarding activity. By doing this the CCG aims to improve the quality of clinical coding of adult safeguarding concerns. The aim is to support improved recording consistency so providing a better understanding of the safeguarding concerns managed in primary care, the actions taken to respond to concerns and the lessons that can be learnt for the future that can influence policy and training in primary care. This audit will also provide assurance to the CCG and CQC that the GP practices have the correct policies, procedures and training in place to manage adult safeguarding effectively.
- The CCG acknowledges the importance of recognising and understanding mental capacity and that undertaking assessment are fundamental to all health practitioners. As such the CCG Safeguarding Team will continue to support the preparation and progress towards implementation of the forthcoming Mental Capacity (Amendment) Act, including Liberty Protection Safeguards through collaboration between the CCG, Healthcare Providers and the Local Authority.
- The CCG is committed to reduce the number of out of county placements, continue to improve the monitoring and to ensure that when patients do go out of county for treatment that the patients receive high quality, safe care and that there is learning from the patient's experience of such placements.

6. Safeguarding Adults Reviews

The Safeguarding Adults Review (SAR) sub group has excellent representation from all key partners. We appreciate the full administrative support of the GSAB Business Unit. The SAR sub group takes the responsibility to recommend whether a request meets the requirements for a statutory or non-statutory review (Care Act 2014). SAR 'case for consideration' requests are reviewed by both the GSAB and SAR Chairs and, where appropriate, cases are progressed to the sub group. Decision making on each case follows identification of relevant agencies, information gathering and

subsequent analysis. As SARs are progressed, the sub group works together on all proposed recommendations, supporting SMART action planning and ensuring that key learning is cascaded. The GSAB Business Unit maintains the SAR Tracker, utilising this information as a mechanism to support the bi-annual self-assessment on learning from SARs.

The Covid19 pandemic impacted on the way that all agencies and organisations were able to work from 23rd March 2020, not least our Health and Social Care Providers having to significantly alter working practices. For Safeguarding Adult Reviews, this has affected how GSAB has been able to progress and complete the current SARs, subsequently causing some delay. SAR sub group meetings have continued to take place as planned.

Safeguarding Adults Reviews

For the year 2019/20, GSAB has commissioned three SARs. In addition, there is one out of county SAR; GSAB's continued involvement in the 'LD' SAR is for information and sharing relevant local learning.

Further details:

NC – Referred for a SAR following the Learning Disabilities Mortality Review (LeDeR). NC was a gentleman with complex health conditions, including a learning disability, and receiving care, treatment and support from health and care organisations. NC died in early 2018 aged 58 from malnutrition, after a period of declining health. A draft report is complete, pending SAR panel feedback. The publication date is to be confirmed, but likely to be autumn 2020.

SWOP (Sex Workers Outreach Project) – Referred from the Nelson Trust, this SAR is highlighting the deaths of five sex working women over a period of two years. At the time of their deaths, all women were engaging with services, with a common theme for each as abuse and trauma suffered at an early age. This thematic review aims to highlight the causes here, but also to better understand how the county can work to support similar vulnerable groups. The SAR remains in the early stages; terms of reference agreed, and external panel members in place.

PH – Referred from Cheltenham Borough Council, this SAR is about a homeless man who died (in 2019) in Cheltenham town centre. PH had been rough sleeping prior to his death; he had mental health issues and was known to both statutory and voluntary agencies. GSAB are currently seeking an appropriately experienced reviewer to progress this SAR.

Warrington SAB commissioned a statutory review (LD) in 2017. Referred by family members, this young person died whilst receiving inpatient psychiatric care outside of Gloucestershire. The report is in the final draft stages, delayed due to local workload capacity issues.

Overview of SAR referrals received 2019/20

The table below shows an overview of the SAR referrals made to GSAB, capturing the breadth of referral sources as well as time period when referrals were made.

	Q1	Q2	Q3	Q4
Referrals Received	NC TA	BH PH SWOP WP	0	0
Referral Source	CCG Police	Safeguarding Adults Team District Council Nelson Trust GP	-	-
SAR Undertaken	1	2	0	0
Name	NC	PH SWOP	-	-
Learning Event	0	0	0	0
Comments	-	-	-	-

Case referrals not progressing to SAR

WP – A case for concern was raised (Q2) from a GP regarding self-neglect. Following investigation and discussion this case did not meet criteria for SAR; an area of learning was taken forward by one agency.

TH/TA – A case was raised (Q1) though the Health Provider Serious Incident progress following a homicide of a service user living in supported mental health accommodation and perpetrated by a service user. An extraordinary SAR sub group (May 2020) meeting explored the complexity of this case, drawing on findings of Gloucestershire Health and Care (GHC) Serious Incident Report to consider the organisation's response and assess the threshold for a SAR. This case has not progressed to SAR; GHC are continuing to work with the family of the deceased to ascertain their specific requests and needs.

2019/20 Priorities update

University of Sussex Disseminating Learning from SARs Project
Partner agencies from GSAB, along with five other SABs, were involved in work with Dr David Orr from the University of Sussex, seeking to understand the effectiveness of disseminating learning about adult self-neglect SARs. The project lasted 10 months, with each SAB being allocated an area of work to undertake and feed back. The GSAB partnership held several focus groups, including health and Adult Social Care. The report from the University of Sussex has now been produced and the recommendations will be reviewed by the SAR sub group and taken as a further short piece of work for 2020/21.

Transitions Thematic Review; work with Glos Safeguarding Children Executive

GSAB SAR sub group have taken forward the thematic SWOP Review aiming to explore the complexities and challenges of five specific and worrying cases. GSCE will continue this as a separate work stream.

SAR Action Tracker

The SAR Tracker is fully utilised and reviewed each quarter by the GSAB Business Manager. This tool is enabling continued oversight of SAR work, influencing action plans and picking up themes as they develop.

Planning for 2020/21:

- Three SARs will be progressed / undertaken during the coming year (NC, SWOP and PH) disseminating learning from the emerging findings.
- Disseminating learning from the self-neglect SARs Project; the sub group will progress a single action to share the recommendations from the University of Sussex Project, producing a one page 'bulletin'; alongside the sub group using a benchmarking approach to GSAB SAR learning.
- Explore and review the SAR referral pathway, specifically to consider a potential dynamic approach to use a 'Rapid Review' process for SARs.

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

7. GSAB Business Planning Group

The Business Planning Group (previously known as the Management Committee) increased its remit in 2018/19, taking on additional responsibility for the work of the GSAB sub groups and only exception reporting now goes to the Board.

During 2019/20 the Business Planning Group met quarterly and worked to a standard agenda, which included oversight and updates to the Strategic Plan and Risk Register. Meetings now also include a presentation, which provides information on the safeguarding adults work of other partner agencies and the voluntary and community sector.

8. Sub Group Achievements 2019/20 and Priorities 2020/21

8.1 Workforce Development

- Training figures (found in supporting documents) highlight the take up of GSAB training and e-learning by partners during the year. In summary, 12,306 Gloucestershire staff (and volunteers) undertook GSAB approved Safeguarding courses; MCA, DoLS and Safeguarding e-learning are still being actively used. A Modern Slavery e-learning module was launched in July to support and empower staff to recognise victims of modern slavery.

- Feedback has been gathered to identify the impact Safeguarding level 3 training has had in practice. Delegates gained an increase in confidence around safeguarding and the reporting process, and a greater understanding of safeguarding investigations, which supported practice improvements.
- The annual CPD session for Board members was held in July 2019. The theme was "finding creative solutions for complex needs". Discussions were held around adults with complex needs, who don't always meet the criteria of an adult with care and support needs and how they can be supported. Presentations were given from the Blue Light Project, Cheltenham Borough Homes, and a talk on creative solutions based on an initiative to bring together partner agencies to "think outside the box" when supporting those with complex needs.
- The annual train the trainer's workshop for new trainers for Safeguarding Level 2 was held in September 2019 with 20 participants. Organisations represented included the Order of St John's Trust, GRASAC and trainers from other independent providers. GCC's Safeguarding training coordinator subsequently scheduled follow up trainer observations to ensure quality assurance requirements are met. Most have now been signed off as approved.
- We now have 69 active trainers in the county. The annual CPD day for trainers took place in October. This provided the GSAB approved trainers with an overall update from the board, the safeguarding team and the upcoming changes with DoLS to LPS. The event also included relevant case examples which allowed the trainers to discuss the possible outcomes, as well as a workshop on managing difficult delegates.
- The annual train the trainer's workshop for new trainers for Mental Capacity Act and Deprivation of Liberty Safeguards Level 2 was held in February 2020. Twenty delegates attended, and due to a high interest a second course was scheduled for April 2020. Unfortunately the April course has been postponed due to the outbreak of Covid-19.
- Six half-day GSAB roadshow events were scheduled for Spring 2020, unfortunately due to the Covid pandemic, only two of these sessions were able to go ahead. The event was aimed predominantly at the voluntary sector, with the theme based on "Back to Basics".
- 2Gether NHS Trust (now GHC) has been leading on a project to enhance mandatory safeguarding training using simulation based education. We are working collaboratively with them on this project, which aims to use simulation activities to provide training that will ensure person-centred conversations, focussing on issues of risk, choice and capacity, with adults in need of safeguarding. This project is a joint approach to embed multi-agency safeguarding training across local health and social care partners, with shared topics related to patient safety.

2019/20 Training Figures can be found in supporting documents.

8.2 Fire Safety Development

The Fire Safety Development Group works as a multi-agency partnership to reduce the potential threat of fire and fire injuries to people in Gloucestershire. The group ensures that learning from across all Fire and Rescue Services is shared to help front line staff understand fire risk and its wider implications for the local community. Bringing together resources and knowledge enables teams to deliver the appropriate advice and equipment at the right time. By working together and understanding different roles, the Fire Safety Development Group can identify emerging trends and assist in creating initiatives to mitigate the risk.

During 2019-20, Gloucestershire Fire & Rescue Service was faced with significant workloads following formal inspection, which resulted in some drift in ongoing Fire Safety Development Group work strands. However, some key work has been undertaken. There has been a focus on developing a risk profile for fire in Gloucestershire, following the foundation laid in the South West Fire Review in 2018.

Some key themes have emerged from this analysis, once again highlighting the danger posed by hoarding, which will continue to be a priority for work in 2020-21. Work has taken place to help front line staff understand and identify standardised levels of hoarding, which has improved the quality of information in referrals from different partners. The use of an app to categorise the level of hoarding has improved the information given to Gloucestershire Fire & Rescue Service and enabled better prioritisation of Safe and Well Visits.

Work continued on a gap analysis from coroners' reports, and learning from other areas has revealed potential fire risks from continence materials and the use of paraffin-based creams. This has led to information being published to support carers and staff and demonstrates the value of a multi-agency group.

The focus for 2020-21 will be to develop a reporting dashboard for fire incidents and referrals and use the analysis of that data to inform partners of emerging concerns, reveal any gaps and improve training where needed. Raising awareness of the potential dangers of hoarding and finding ways of reducing it will remain a key priority.

Communication will continue to be an essential part of the work of this group, supporting national fire safety campaigns and offering risk management advice.

8.3 Communication & Engagement

This is the third year of the Communications and Engagement sub group. The group brings together statutory and non-statutory agencies, and VCS organisations. The purpose of the sub group is to raise the public profile of the GSAB and raise awareness of key issues to promote safeguarding of adults.

Achievements 2019/2020

- Held quarterly meetings of the sub group with new partners involved, particularly from the voluntary and community sector.

- Supported the Coproduction and Engagement Forum to provide users' perspectives on safeguarding processes and feedback on what safeguarding really means for the individuals most affected by it.

- Provided feedback on the GSAB Strategic Plan.

- The group saw a change of chair with that role being taken by the Gloucestershire VCS Alliance. As an independent voice for the voluntary and community sector in the county the Alliance is well-placed to spread the safeguarding message throughout the VCS in the county.

- A bi-annual slot has been secured at the Learning Disabilities Partnership Board in order to raise the issue of safeguarding.

- Following a discussion on the increase of scams within residential settings, material was circulated on how to identify financial scams.

- At each meeting there was a focus on two specific strategic objectives from the GSAB Strategic Plan. This enabled those especially involved in the relevant area of work to present to the group and to discuss and consider how they might promote safeguarding within those communities e.g. those who are socially isolated and/or those with frailty, carers and those being cared for.

- Spreading the message regarding the GSAB Roadshows with its focus on the VCS in the county. Arranging speakers from the VCS to present at the Roadshows and publicising the roadshows amongst the VCS.

- At each meeting all partners were invited to discuss what was working and if there were any gaps regarding safeguarding knowledge, skills and confidence in their respective workforces.

Priorities for 2020/2021

- To further increase representation from the VCS within this group.

- Raise awareness of safeguarding and promote the welfare of vulnerable adults, utilising the networks that members of the Communication and Engagement sub group have in the community.

- Utilise the agenda item at the Learning Disabilities Partnership Board

- Ensure that safeguarding is included as a standing agenda item at meetings attended by members e.g. Mental Health & Wellbeing Partnership Board and the Carers Partnership Board

8.4 Policy & Procedures

Achievements for 2019/20

The continued engagement from partner agencies has ensured the Policy and Procedures sub group has been able to produce and update a significant number of documents in the last year. The GSAB Policy Library is the group's work plan, detailing the progress of policies and their review date. Listed below are some of the policies that have been updated over the last year:

- The updated Out of Contact Protocol was ratified in May 2019.
- The Escalation Protocol was updated in line with the Children's version and signed off in July 2019.
- The Safer Recruitment Guidance was reviewed and updated in August 2019.

- The Self Neglect Best Practice Guidance was updated and ratified in September 2019.
- The Multi-Agency Safeguarding Adults Policy & Procedures were ratified at the February 2020 Board meeting.

Priorities for 2020/21

Policies to be reviewed over the next year include:

- Information Sharing Guidance
- Elected Member Induction Pack
- Safeguarding Adults Review (SAR) Protocol
- Whistle Blowing Guidance
- GSAB Member Induction Pack

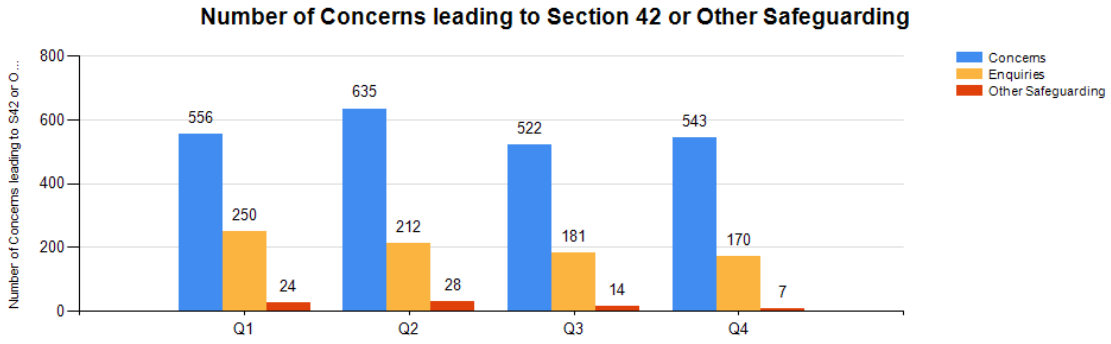
8.5 Activity & Data 2019/20

The number of Safeguarding concerns raised on behalf of adults at risk was **2256.**

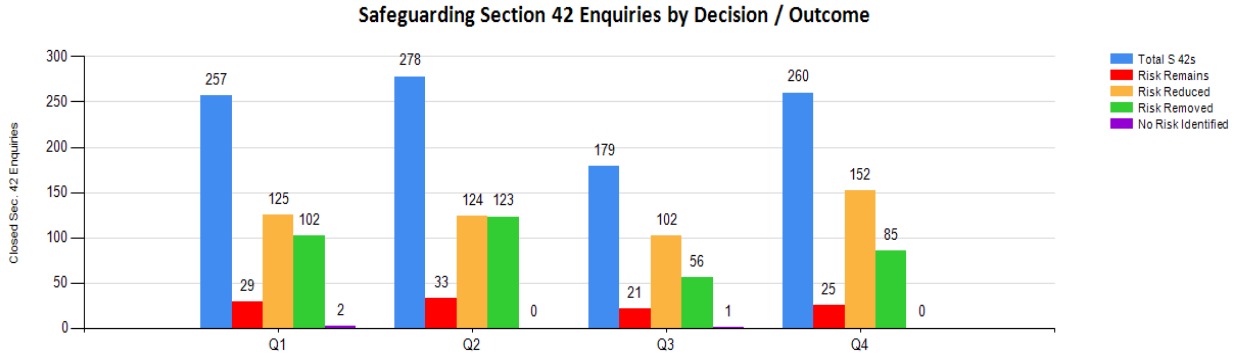
Of the **2256** concerns, **813** went on to become Section 42 enquiries and **73** became 'Other' enquiries, making a total of **886**. 'Other' relates to enquiries that have not met the criteria for a statutory enquiry, however some form of safeguarding enquiry is deemed to be required, for example, the person is at risk of abuse and has support needs, but not care needs.

178 of the safeguarding concerns reported to the Adult Helpdesk were made by Gloucestershire Police, a small increase from **175** last year; of these **55** led to enquiries.

Concerns Leading to Section 42 or Other Safeguarding Enquiries 2019/20

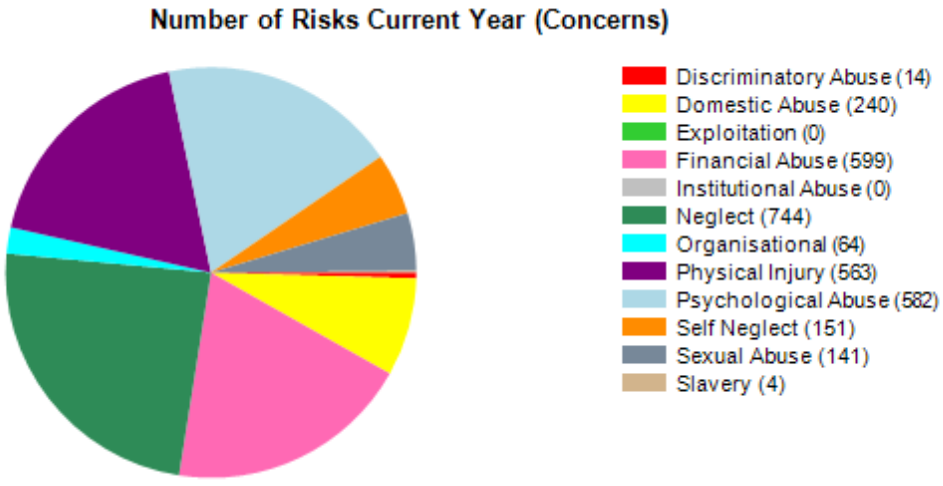


Closed Section 42 Enquiries and Risk

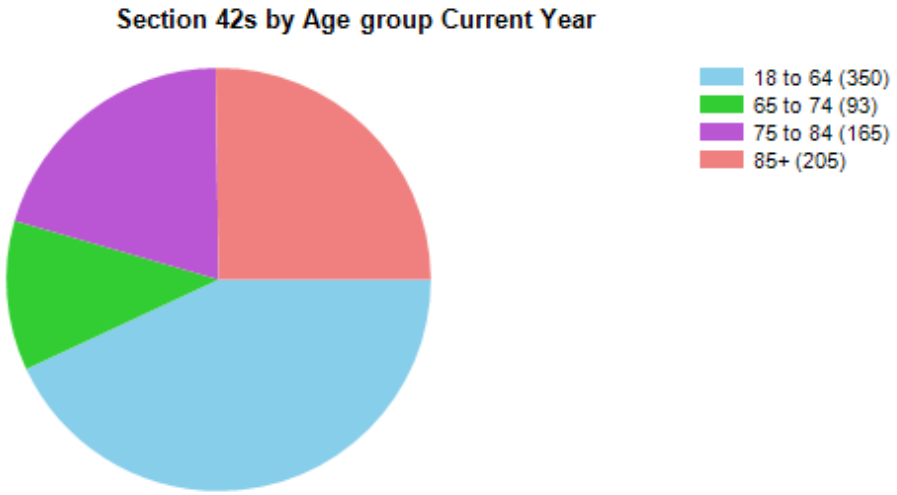


Financial Quarter	Financial Year	Total Closed S42s	Risk Remains	Risk Reduced	Risk Removed	No Risk Identified
Q1	2019/20	257	29	125	102	2
Q2	2019/20	278	33	124	123	0
Q3	2019/20	179	21	102	56	1
Q4	2019/20	260	25	152	85	0
Total		**974**	**108**	**503**	**366**	**3**

Number of Risks



Section 42 Enquiries by Age Group



8.6 Quality Assurance

Audit Group

The purpose of the Audit Sub Group is 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.

This is achieved by running regular case file audits attended by multi agency partners, each based on different themes. Themes for audit are selected by the Steering Group to reflect priorities that have emerged locally and nationally.
The group has undertaken seven case file audits this year, including four focused on concerns raised by specific partners:

- Gloucestershire Care Services (now Gloucestershire Health and Care Foundation Trust - GHC)
- Primary Care
- Police
- Mental health

These audits yielded some useful learning and in one case led to a new way of working together, where the GCC safeguarding team now meets regularly with the Safeguarding Lead for mental health to review and follow up on enquiries the Local Authority has caused to be made by mental health workers. This has been helpful in quality assuring these enquiries and ensuring they are completed in a timely way.

A further three audits were also carried out:

- Self-neglect
- Domestic abuse – a review of previously audited cases to check progress
- Complex cases

Learning from the audits is shared with the appropriate sub groups, mainly Workforce development and there is a plan in 20/21 to include the learning in the GSAB newsletter as another way of disseminating the learning.

A schedule of audits has been agreed for 20/21and includes:

- Cases involving advocates
- Concerns raised by the Acute Trust
- Financial abuse
- GHC – physical health
- Police.

Unfortunately the first quarter's planned meeting had to be cancelled due to the Covid emergency. Ways of conducting audits virtually are currently under consideration.

9. Safeguarding Adults at Risk Self Assessment Audit Tool

In December 2019 an updated Safeguarding Adults at Risk Self Assessment Audit tool was sent out to partners for completion. The aim of the audit tool is to provide organisations in Gloucestershire with a consistent framework to assess and monitor Safeguarding Adults arrangements. This in turn supports the Board in ensuring effective safeguarding practice across the county.

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

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

The audit tool is a two-part process, with initial completion of the self assessment audit, followed by scrutiny and challenge. Meetings were held in November 2018 allowing partners to quality assure their self assessments and highlight any areas where further work is needed. Several partners changed their ratings, to show that further work was needed. Progress in these areas will be reviewed later in the year.

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 2019/20.
A list of the Board's current membership can be found in supporting documents.

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

GSAB Partner Contributions 2019/20

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

GSAB Business and Activity Costs 2019/20

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

These contributions help with the costs associated with the running of the Board, including its Independent Chair, the Gloucestershire County Council Head of Safeguarding Adults post, costs in conducting Safeguarding Adults Reviews,

Communication & Publicity and delivering on the Board's Workforce Development and Training Pathway.

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

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

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

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