Gloucestershire Safeguarding Adults Board

Annual Report 2011/2012


Forward: Introduction from Chair

The issue of safeguarding vulnerable adults is currently high on the agenda of government legislative planning. It has also been implanted in the nation's conscience by high profile television documentaries showing horrific abuse perpetrated in care establishments.

Whilst the professionals from the many agencies in Gloucestershire who strive to safeguard vulnerable people need no reminder of the significance of their work, it can only be a positive development that the wider community is now gaining an increased appreciation of the importance of caring for those less able and indeed the value of the work of this Board. It is particularly sad however that the public have to gain such an insight by witnessing the abuse and suffering of others on their television screens.

Our response to the Panorama documentary on Winterbourne View was swift, comprehensive and conclusive. The methodology and findings of our investigations are included in the main body of this report and on our website. Areas for improvement were found and these form the backbone of our strategic plan for the coming year.

The Board also provided valuable input in to the research that has preceded the forthcoming statute which will place adult safeguarding on a mandatory footing and we feel confident that we are well placed to meet the demands of the legislation when it arrives.

During 2010/2011 I commissioned a Serious Case Review in to the events that led to the tragic death of an elderly gentleman in a house fire in the Forest of Dean. This process uncovered valuable learning opportunities and as a partnership we owe it to the gentleman and his family to ensure that those lessons are learned and practices are improved.

It is worthwhile to reflect that without the rapid and gratifying developments of this board since its inception in 2009, we would not have been in a position as a county to respond to all the above challenges in the manner we have done.

Those developments are evident across a whole range of work streams and another year on we are better placed to measure and audit performance, follow improved policies, train frontline practitioners and communicate amongst ourselves and with the public.

Whilst this report evidences a year of hard work and achievement, it would be wrong to assert that our potential to keep the vulnerable safe from harm has been fully met. We must guard against complacency and continue to move forward despite the effects of the economic climate. Austerity must be overcome if we are to meet the demanding schedule of work we have set ourselves in next year's business plan.

A paucity of money and consequently resources necessitates improved working practice and I firmly believe that the best way to achieve this is by strengthening partnership working even more. In Gloucestershire we intend to do that in several ways.

On 1st April 2012 I took up the post of joint chair of both the Safeguarding Adults Board and the Safeguarding Children Board. This move is intended to develop best practice across both boards, to maximise efficiency and effectiveness and to promote a family centred approach to safeguarding. Whilst this is an exciting opportunity to improve service delivery to both young and old, care must be taken that areas specific to just one agenda are preserved.

The Safeguarding Adults Board will also contribute to a root and branch review of how we share and use information to best effect in order to protect the vulnerable across the county.

In conclusion the Gloucestershire Safeguarding Adults Board has come a long way over the last twelve months. The journey continues however and it is my belief that we will only get to where we want to be by improving our capacity to listen to the voice of those who know the most – service users and carers. Amongst all of the challenges we have set ourselves for 2012/2013, this must be considered a priority.

Roger Clayton
Independent Chair
Gloucestershire Safeguarding Adults Board
April 2012.

Section 1: Background

1.1 National Context

Law Commission review of Adult Social Care Law

The guidance for safeguarding adults "No Secrets" (DH 2000) was published over 10 years ago. Both public awareness and the development and delivery of safeguarding services have considerably grown over the last decade. A review of the No Secrets guidance has been undertaken nationally.

The DOH STATEMENT OF GOVERNMENT POLICY ON ADULT SAFEGUARDING Published 16 May 2011 Gateway reference: 16072, builds on "No Secrets", which will remain as statutory guidance until at least 2013.

The Government now intends to seek to legislate for Safeguarding Adults Boards which will help to hold agencies accountable in ways which guidance, differentially binding on the partners, has not so far been able to do.

This move is fully supported by the Gloucestershire Safeguarding Adults Board (GSAB) which has already strengthened its partnership working and engendered the growth of agency contribution.

GSAB has had direct contact with the lead DOH Policy Manager about areas of particular interest to us.

- It seems that whilst there is an agreement to put safeguarding adults boards on a statutory footing, there will not be a prescriptive approach but should consist of a framework that is flexible and underpinned by guidance.
- The core membership of the Boards will need to consist of Local Authority, NHS and Police members.
- It will be an expectation that Boards produce an Annual Report and Strategic Plan.
- There will be more focus on learning from Serious Case Reviews.
- Self Neglect is likely to be included in the No Secrets Criteria.

Department of Health Review – Winterbourne View

Following the BBC Panorama programme on 31st May 2011 uncovering systematic abuse of patients by staff at Winterbourne View, the Department of Health set out a number of recommendations and actions that needed to be taken forward by NHS bodies and local authorities.

A further BBC Panorama programme on 23rd April 2012 has revealed the appalling treatment of an elderly care home resident with dementia in the London Borough of Camden.

The Gloucestershire Safeguarding Adults Board have been shocked and disturbed at the scenes of abuse shown in these BBC Panorama programmes and are determined to act in any way possible to prevent anything of this nature occurring in Gloucestershire.

In the aftermath of the broadcast last year, the South West Region Safeguarding Adults Programme recommended that all Safeguarding Adults Boards ensure that they:

- Provide clarity regarding review processes, stipulating the required standard and what constitutes a good review.
- Conduct a mapping process to ensure they have an overview of all joint funded placements both within and outside of their geographical area.
- Are mindful of the South West Cross Boundary Information Sharing Protocol.
- Have systems in place to monitor all alerts raised in provider services to ensure repeated concerns are detected and responded to appropriately.
- Ensure that all partners have Whistle Blowing policies and procedures which are suitable and fit for purpose, and that consideration is given to how reports from whistle blowers will be received and how the whistle blower will be supported.

1.2 Safeguarding Adults in Gloucestershire

Much has been done in recent years to improve the quality of services delivered to vulnerable adults in Gloucestershire in particular those who live in care establishments.
However following the Winterbourne View BBC Panorama programme, a report was commissioned by the Gloucestershire Safeguarding Adults Board (GSAB) to clearly identify any further areas for improvement. The report outlined how Gloucestershire County Council (GCC), NHS partners and the Care Quality Commission (CQC), individually and collectively regulate, inspect and monitor the quality and standard of service provision in care establishment facilities in Gloucestershire. The report did not include services that are provided in peoples own homes, however many of the protocols and information sharing will be the same.
The findings evidenced that more change is needed, indeed such an in depth investigation would be of very limited value if it had not identified areas for improvement.

Position Statement Executive Summary – Appendix 1

The GSAB carried out the first Serious Case Review in 2011 in relation to the death of a vulnerable adult that could have been both predictable and preventable. The Panel considered in some depth the circumstances and critically reflected on the practices of all the agencies involved. Important lessons have been identified and a number of recommendations have been made which would significantly impact on the care and protection offered to older people in Gloucestershire.

Serious Case Review Executive Summary – Appendix 2

This GSAB Annual Report 2011-12 gives an account of the boards work and the Strategic Plan identifies priorities for next year. The report demonstrates how the board and all its constituent partners are focusing on redefining and establishing more effective processes and systems in order to ensure service, professional and personal accountability for good practice. This practice should be of a high standard and promote service improvement.

Section 2: Case Studies

It is evident in many of the safeguarding investigations that the close interagency relationships that are established in Gloucestershire have improved the speed of response and ensured a better outcome for the individuals involved. Here are three case examples that demonstrate this.

Case Study 1

All names and locations have been changed to protect confidentiality

Background:

Robert (87 yr old) has advanced Alzheimer's disease and lives in a Nursing Home. It was reported that Robert had pushed another resident when he was trying to get to the lounge but fortunately the other resident was not hurt. At this point the home made sure there was increased monitoring of Roberts behaviour but no further action taken. The following week, Robert became very agitated and pushed another resident, knocking them to the ground. This resident sustained bruising and was very distressed by the incident. The home raised a safeguarding alert with social care.

Actions Taken:

The incident was reported to the police, who then attended the home.

Professional assessments found that Robert lacked the capacity to understand his actions, and therefore the police decided not to pursue a criminal investigation.

The Home Manager reported the incident to the Care Quality Commission.

A Safeguarding strategy meeting was held involving representatives from Adult Care, the Community Mental Health Team, Continuing Healthcare Nurses, the Home Manager and the Quality Assurance Team.

Robert's mental health was re-assessed and his medication was adjusted.

As the incidents happened during the late afternoon when it was growing dark, the mental health nurse identified that Robert's agitation may also be due to change in Roberts environment caused by the change in the light (known as the "sundowning phenomenon") Information and advice was provided regarding supporting Robert around this time of day to prevent his agitation levels rising.

The social worker discussed the issues with his family and the family of the resident that he pushed over. All were happy with the care provided in the care home generally and did not want their parents to move.

The Continuing Health Care Nurse reviewed Robert's needs and also provided advice to the home in relation to managing his behaviours.

The County Council Quality Assurance Team carried out a full review of the quality and standards of care provided at the home and found no serious concerns.

Outcome: Robert has been able to stay living at the care home with appropriate support and care. No further incidents have been reported.

Strengths: Effective communication and cooperation between all agencies. Appropriate coordinated multi agency treatment and support for Robert, the other residents and the care home.

Learning: The home took appropriate action to raise a safeguarding alert because harm had occurred, and while Robert's behaviour may not be called abuse (because it was not intentional on his part), a failure by a care home to act on incidents of this nature could be regarded as neglect on their part.

Case Study 2

All names and locations have been changed to protect confidentiality

Background:

Edward (76 years old) lives at home with his son, who heavily drinks alcohol.
Edward's friend phoned the adult social care helpdesk stating that:
Edwards's son bullies him and makes Edward go to the shop every day to buy alcohol and cigarettes for the son with Edwards own money.
When his son is intoxicated on alcohol, he can be aggressive and has threatened to kill Edward on more than one occasion. Earlier that week Edwards's son had got drunk and Edward had barricaded himself in his bedroom very frightened.
Edward had been staying with the friend for the past few days, and his son has been round to her house demanding money and making threats.
Edward is assessed as having the capacity to make his own decisions and refused to get help or call the police because he did not want to alienate his son from his life.

Actions Taken:

A safeguarding strategy meeting was convened with police, social worker, Community Psychiatric Nurse and GP input.
Police reported son had previous convictions for violence and drug dealing.
GP was aware that the son had mental health services support in the past. The GP agreed to make a new referral to the mental health services.
To safeguard Edward in the short term, he was offered a period of respite in a care home, which he accepted.
Edward was given a "Lifeline" alarm pendant, so he could call for help.
The police put a marker on Edward's address to ensure a swift response should there be any calls from the address
A referral was made to the Domestic Abuse and Vulnerable Adult Unit, and a Multi Agency Risk Assessment Conference was held and an Independent Domestic Violence Advocate was allocated to Edward.
The police informally visited Edward in the care home to discuss his situation and raise the concerns people had about his safety.
As an adult with mental capacity Edward could not be forced to make decisions against his own wishes. A plan was put in place to offer him support and to share intelligence with appropriate agencies.

Outcome:

Edward returned home and his son became violent and threatening towards him only a week later. Edward did use his lifeline and the police attended and the son was arrested. Edwards's respite period gave him the opportunity to think about his situation and he realised that he "couldn't go on like that anymore". He has since decided to sell his house and move in with his friend.

Strengths: This case demonstrates the benefits of professionals working together to achieve the best possible outcome for a vulnerable adult being subject to abuse.

Learning: Even where a vulnerable adult has the capacity to make their own decisions, a multi agency approach to ensure support is available is essential.

Case Study 3

All names and locations have been changed to protect confidentiality

Background:

Jane (54 yrs old) was a resident in Gloucestershire but was moved to a specialist hospital after having to have a serious operation on a brain tumour. Jane also has severe learning disabilities. Whilst recovering from the operation, Jane started to display behaviour in the form of hitting her head and punching herself. As the medical staff were concerned that Jane would damage the site of the operation, they started to use restraint in order to prevent her from causing serious harm to herself. Due to the methods needing to be used, they identified that they were depriving Jane of her liberty and granted themselves an Urgent Authorisation under DoLS and made an application to the Gloucestershire DoLS service.

Actions Taken:

A Best Interests Assessor and Mental Health Assessor were commissioned to visit and begin the assessment with Jane.
The following restrictions were identified as depriving Jane of her liberty:
Staff regularly held Jane's arms to prevent her from striking her head.
Jane was receiving medication to calm her behaviour.
A member of staff was with Jane at all times to monitor her and used distraction to try to prevent her from striking herself.
During sustained periods where Jane persistently tried to hit herself, her arms were strapped to the bed so she could not lift them.
The best Interests assessment concluded that the measures being used within the hospital to protect Jane from harm were in her best interests. The assessor also found, following discussion with staff and her social worker that the measures were proportionate, given the extent of the harm that could occur if Jane were to hit the site of the wound.

Outcome:

Jane who was moved back to Gloucestershire where her care and treatment needs were met in a local hospital and then in her eventual placement in a residential home.

Learning:

It is essential that all hospital and care home staff have an understanding of the Deprivation of Liberty Safeguards legislation and practice guidance. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to an incapacitated person, and if the restraint used is proportionate to the likelihood and seriousness of the harm.

Section 3: Progress and Looking Forward

3.1 Key Developments and Achievements 2011-12

There have been a number of key developments in the last year which have individually and collectively led to a reduction in the risk of harm to all vulnerable people in Gloucestershire.

Gloucestershire Safeguarding Adults Board (GSAB)

The GSAB has overall governance of policy, practice and implementation of safeguarding and this includes quality assurance of standards and risk management of safeguarding across the partnership.

GSAB has a clear business planning framework linked both to risk and regional best practice. The boards sub groups have produced effective policy & procedures to cover multi agency safeguarding, mental capacity and serious case reviews and developed comprehensive strategies for training and media including a new GSAB website. A regime of performance management and audit is in place with further development planned.

The contribution to looking after the wellbeing and safety of the vulnerable is not the sole remit of the safeguarding board. Of equal importance are the recent attempts to ensure closer working of other partnerships together to achieve coordination of effort which include:

Gloucestershire Safeguarding Children's Board
Learning Disabilities Partnership Board
Health & Wellbeing Board
Domestic Abuse & Sexual Violence Board
Multi Agency Public Protection Arrangements
HMS Prison Partnership Board

Furthermore the close and efficient working relationship with the Care Quality Commission provides considerable reassurance as does the support provided by statutory and non- statutory advocacy services.

Multi Agency Policy & Procedures

Having completed the Gloucestershire Safeguarding Vulnerable Adults Multi-Agency Policy which was ratified by the GSAB Board in March 2011, the Policy and Procedure sub group has undertaken a review of the supporting Procedures and produced an Easy Read version of the Policy. As part of the work programme, the group has reviewed a range of documents that have an impact on safeguarding these include:

ADASS information for the South West region
Legal guidance
Large scale investigation guidance
Raising Concerns
Information sharing protocol (which was developed in a multi agency context)

The group has produced an Equalities Impact Assessment, and this will be further developed for the GSAB. Further work is being undertaken on the Whistleblowing policy. As a result of the work undertaken within the county following publication of the Winterbourne review, and the publication and ratification of the Position Statement for Gloucestershire, the Policy and Procedures Group has amended the work programme to support the required actions during 2012/13. Ongoing work includes reviewing agencies safeguarding policies and procedures, during the past year the group has reviewed policies from 2gether Trust, and Gloucestershire Constabulary.

Anonymous Alerts in Gloucestershire

We have recently developed a protocol for Gloucestershire outlining how anonymous safeguarding alerts will be responded to.

Anonymous alerts are those where the person making the alert does not provide their identity to the party to whom they are making the allegation. These are different from alerts and allegations where the person provides their identity but then seeks confidentiality. (Responding to Suggestions, Complaints and Allegations by the South Wales Department of Education and Training).

Anonymous Alerter's will be advised that if they remain anonymous they will not be able to receive any feedback regarding any action taken in response to their alert nor will investigators be able to gather further useful information, should they need it.

All anonymous alerts received by the Gloucestershire County Council Safeguarding Adults Team will be responded to proportionately, taking into account the feasibility of investigating the alert based on the information received, the credibility of the concern and on the potential risk of serious harm to a vulnerable adult/s.

Workforce Development

It was a great achievement that the face to face training target of 5000 set by the GSAB at the beginning of the year was reached. The updated enhanced training was introduced in September and has been taken up well. New Safeguarding leadership e-learning was launched towards the end of 2011, with 151 people accessing it between January and March 2012.

There are now 53 active trainers throughout Gloucestershire organisations delivering foundation level training under the locally accredited train the trainer's scheme.

In addition throughout 2011 a rolling programme of Mental Capacity Act training for professional leads was introduced with very good take up by County Council staff and excellent evaluations.
A significant ongoing piece of work is that the Workforce Development leads for the Gloucestershire Safeguarding Adults and the Children's Board are meeting regularly to review respective training & development with the aim of sharing best practice and aligning those training pathways which are appropriate and will achieve better outcomes.

Gloucestershire's Abuse Awareness Campaign and GSAB Website

Keeping vulnerable people safe is everyone's business – that was the message behind an abuse awareness campaign launched in Gloucestershire in November 2011. The campaign was organised by the Gloucestershire Safeguarding Adults and Children's Boards.

Posters went up on bus shelters and leaflets were available in libraries and in GPs surgeries. These used images portraying different kinds of abuse along with simple explanations of what to do if you or someone you know is experiencing it and where to report it.

The campaign also tied in with the launch of the new Gloucestershire Safeguarding Adults Board (GSAB) website
http://www.gloucestershire.gov.uk/safeguardingadults

The website provides people with information about the types of abuse and harm people can experience, how to recognise it, what to do about it and where to go to get help. The leaflets are also available to download from the website.

2011/12 also saw the development of a shared communications group for both the adults and children boards. This has enabled greater sharing of best practice and an increase in joint campaigns and raising awareness.

Abuse of Vulnerable Adults Data

Every year, the Department of Health requires us to complete a Safeguarding Adults data collection called the Abuse of Vulnerable Adults (AVA) return. In order to help us ensure that our services to safeguard adults are amongst the best in the country we will scrutinise the published the results of the 2011/12 return in order to identify key areas where our performance appears to be significantly different from other authorities. We can then, ensure we further investigate and where appropriate get our processes independently checked.

Safer Recruitment

A multi-agency 'Safe Recruitment Good Practice Guidance' has now been developed to ensure that policies and procedures are in place to prevent unsuitable people from working with vulnerable adults across the statutory, voluntary and independent sectors. The guidance cross references with the Care Quality Commission outcome 12, regulation 21, schedule 3.

In addition a specification for a Safe Recruitment E-learning package has been drafted and will then go through a process to procure.

Clinical Governance and Adult Safeguarding- An Integrated Process

Healthcare professionals play a key role in safeguarding adults: first, in the identification of abuse, harm and neglect, and second, in developing appropriate responses to it. There is guidance to clarify the relationship between adverse incident reporting, complaints, and safeguarding in order to encourage reporting in a way that supports the investigation and empowers staff in the process.

GSAB has established a Clinical Governance and Safeguarding group which has started to identify procedures and systems currently in place across the 3 NHS organisations in Gloucestershire. We need to ensure an integrated reporting and management of adult safeguarding process is in place, whether information is received through an incident report, complaint or other patient safety or governance process. The aim is to then further develop and clarify any necessary changes and amendments to NHS organisational procedures to ensure that safeguarding becomes fully integrated into NHS systems.

3.2 Future Priorities and Challenges

Ageing population

The two primary challenges driving current changes in adult social care are demographic change and financial pressures. By 2033 we are expecting the number of over 65 yr olds to double and over the next ten years the number of people living alone to increase by 24%, the number of over 75 yr olds will increase 30% and over 85 yr olds will go up by 44%, meaning more people are likely to need support services.

Our priority is keeping people safe from harm and abuse and in the face of this growing demand we need to continue to work individually and collectively to safeguard vulnerable adults in the county.

Personalisation & Safeguarding

In Gloucestershire we recognise that independence and safety are both important. We want to support people to be active members of society and take risks that they understand. The GSAB work to make sure that staff ensure the balance of empowerment and protection is appropriate.
A 'Promoting Choice: Positive Risk Management ' policy is in place to ensure the requirements of health & safety legislation, care standards and safeguarding adults policies are not compromised.

Promoting User & Carer participation

It is important when safeguarding vulnerable adults to focus on the individual concerned, empowering them to define the outcomes they want themselves and to work with them in their own context to negotiate the level of risk enablement and safeguarding that are appropriate.

Supporting carers is also a high priority. Carers hold a range of roles regarding safeguarding, as partners, informers or can be causing harm and/or vulnerable themselves.

Participation by people who use services and carers in their own safeguarding is seen by the GSAB as a key area for development for 2012/13.

Whistle Blowing Policy & Procedures

Whistleblowers can perform an invaluable service by bringing to light abuse and neglect of adults at risk, but they are also at risk of being singled out and punished by their employers and colleagues.

A number of organisations in Gloucestershire have Whistle Blowing Policies in place which ensure staff are able to obtain support from staff side representatives, colleagues, professional advisors and line managers. The GSAB Policy & Procedure Sub Group is planning to review these policies to ensure they afford adequate protection to those raising concerns.

Gloucestershire Safeguarding Adults Board developments

It must be recognised that both the determination and capacity of constituent agencies to safeguard adults is limited somewhat by budgetary constraints consequent to public sector financial cuts. This is particularly evident in respect of (but not confined to) training and serious case review. Resource contributions to the work of the Board, financial or otherwise need to be considered further in 2012-13.

Effective engagement with and by NHS General Practitioners (GP's) in the future must be achieved in order to ensure that their valuable contribution is harnessed.

The Safeguarding Adults Board continues to work with the Gloucestershire Safeguarding Children's Board (GSCB) to ensure consistency, efficiency and effectiveness of approach. In the interests of efficiency, be it in respect of safeguarding the vulnerable or from a cost perspective, all opportunities to work closely need to be considered.

3.3 Strategic Plan 2012-13

The main priorities for the GSAB during the next year are identified in the strategic plan and capture the developments required following national and local work over the last 12 months. All objectives which best address local needs and priorities are in line with the 5 domains and associated outcome measures within the South West Assessment Quality & Performance Framework for Safeguarding Adults.

Strategic Plan 2012/13 – Appendix 3

Section 4: Governance & Accountability

4.1 Who is responsible for safeguarding adults?

Local Authority

Safeguarding adults is a key responsibility of the local authority and one that has particularly developed over the last ten years as people have become more aware of 'vulnerable' adults experiencing harm in establishments, in their own homes and in the community. Work has been framed by government guidance (No Secrets, Department of Health, 2000) which requires council social services departments to take the role of lead agency when developing and implementing multi-agency safeguarding adult's policies, procedures and codes of practice.

The Director of Adults Social Services (DASS) is responsible for ensuring that:

- There is a clear organisational focus on safeguarding adults in vulnerable situations.
- That clear protocols are in place for dealing with adults identified as being at risk and that all staff are aware of these protocols.
- That the local Safeguarding Board is working effectively.

All Organisations

No Secrets clearly states that responsibility for identifying, investigating and responding to allegations of abuse lies with operational staff across all organisations, and that arrangements are required to ensure that all agencies share a common understanding of what constitutes abuse and what an initial response should be. Adult social care is likely to take the lead agency role. However many agencies will need to be involved in investigative or preventative work and police or health practitioners may take the lead for investigation and assessment.

One of the challenges in multi-agency safeguarding work is to ensure that everyone involved is clear of who is doing what, when and their associated responsibilities. This is no easy task given the range of agencies that might work together in adult safeguarding, which are continually increasing as the number and range of care providers grows in response to the personalisation agenda.

4.2 Gloucestershire Safeguarding Adults Board

Gloucestershire Safeguarding Adults Board (GSAB) is well established and has wide representation from across the partnership and active members, who are sufficiently senior in their organisations to influence, lead and support the boards business and further development.

The independent chair of the GSAB provides independent leadership and strategic vision to the board and ensures that there is appropriate challenge and agencies are held to account for their work in safeguarding vulnerable adults.
In addition the Chair ensures that partner organisations/agencies collaborate effectively to safeguard vulnerable adults and promote their wellbeing.

During 2011 as the GSAB and its business developed, a 'Constitution and Memorandum of Understanding' was created providing a more comprehensive clearly defined statement of the Boards terms of reference, purpose and functions.

This has a particular importance because it clearly defines the permissions that members of a partnership give each other. All partner agencies have signed up to being held to account by their partners for their own contribution to the collective safeguarding effort. Thus there is a consensual accountability between members.

During 2012-13 the GSAB 'Constitution and Memorandum of Understanding' will be reviewed and a Register of Interest will be included.

GSAB attendance report 2011/12 – Appendix 4

Reporting & Accountability Frameworks

The GSAB has a Management Committee in place. Its role is to act as a conduit between the Board and its five sub groups, ensuring at all times that the work is carried out synergistically, and that developments are streamlined where appropriate.

Multi-Agency Sub Group Structure – Appendix 5
Reporting & Accountability Framework – Appendix 6

Safeguarding Adults Team

The Safeguarding Adults Team is part of Gloucestershire County Council and the team has responsibility for ensuring continuous improvement in safeguarding adults work. This includes collaboratively working with designated safeguarding leads in key partner organisations. The team also works with professionals, service users, carers and other groups and interested parties.
A shared, holistic approach has been adopted by close working between the Safeguarding Adults Team and those involved in the Multi Agency Risk Assessment Conference (MARAC) process.

4.3 Scrutiny

The GSAB Annual Report is presented to the Health & Community Care Overview and Scrutiny Committee, which plays a central role in strengthening the way in which the views and concerns of local communities are represented. This is one of the critical checks and balances to hold the GSAB to account for the effective leadership and management of safeguarding services across the partnership.

Safeguarding Adults is a priority for improving outcomes for Health & Wellbeing and has been aligned with the 'Promoting & Maintaining Independence & Inclusion' plans. Clear reporting links will need to be established with the new Health & Wellbeing Board as described in the NHS White Paper: Liberating the NHS (July 2010) and the Gloucestershire Stronger Safer Justice Commission as it further develops.

In the future the new Clinical Commissioning Groups in Gloucestershire will have to demonstrate that they meet their statutory responsibilities in relation to Safeguarding and the MCA and ensure that there are appropriate systems and policies in place.

Section 5: Serious Case Reviews

The Gloucestershire Safeguarding Adults Board (GSAB), Serious Case Review (SCR) subgroup was established in 2010 and meets on a quarterly basis reporting to the GSAB Management Committee. It is currently chaired by the Head of the Gloucestershire Constabulary Public Protection Bureau.

The purpose of the subgroup is:

- To ensure that local practice is in line with national guidance
- To support the view that the public interest is best served by the presence of an effective serious case review process.
- To facilitate a consistent approach to the process and practice of undertaking a serious case review in Gloucestershire.
- To acknowledge that voluntary involvement does lead to good practice development although there is no statutory requirement for agencies to cooperate with such reviews.

Learning from the experience of Serious Case Reviews (SCR), undertaken in any part of the country, is a key role of the subgroup. The Sheffield SCR of 'Ann' and its nine recommendations were considered. 'Ann' was a vulnerable adult who had declined services over a period of time and the subgroup considered the impact of the recommendations for Gloucestershire.

During 2011-12 the subgroup undertook its first Serious Case Review (SCR) on behalf of the GSAB following the death of a vulnerable male. The man died as a result of a house fire in March 2011, and the case was referred to the group by Gloucestershire Fire and Rescue Service.
The review was completed by agencies examining their involvement and submitting Individual Management Reviews (IMR), to enable an independent overview author to consult with the victim's family and produce an overview report. Learning opportunities were identified for a number of single agencies, the SCR subgroup, and the GSAB members. These are associated with both the process of completing a SCR, along with recommendations arising from the specific circumstances which led to this tragic death. A comprehensive action plan was produced in order to take the recommendations forward.
Serious Case Review Executive Summary – Appendix 2

The sub group works very closely with agencies within Gloucestershire in order to ensure that it is able to discharge its duties on behalf of the GSAB. 2gether NHSFT referred two cases to the group during the year.
One of these followed the appointment of a specialist management consultant, by the Strategic Health Authority, to conduct an independent review into a historic case. It was decided that the SCR subgroup would not duplicate the review and therefore no further action was proposed. The subgroup will consider the outcome of this review in order to ensure that any learning opportunities are taken.
The second case involved the death of an adult who died as a result of an assault outside the county, but was receiving services from Gloucestershire 2getherNHSFT. Although the case did not meet the requirements for a SCR the 2getherNHSFT conducted a thorough internal investigation in order to identify learning from this case, which was shared with the GSAB.

Section 6: Performance & Activity 2011-12

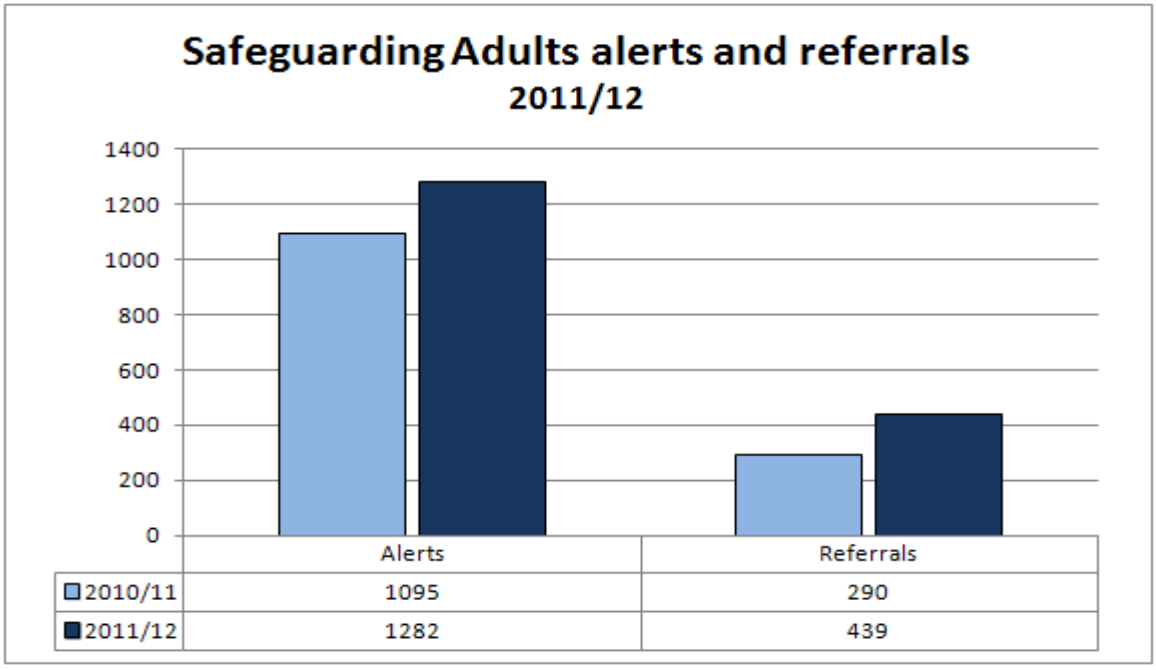
Safeguarding concerns reported to Gloucestershire County Council's Adult Help desk (01452 426868) are called **Alerts.** Within 24 hours a decision is made as to whether the thresholds for safeguarding adult procedures are met and if so the alert then becomes a **Referral**. The number of alerts reflects how effectively the safeguarding message has been communicated.

During **2011/12** the number of alerts rose **17%** from the previous year (from **1095** to **1282**) while the number of alerts that became referrals rose **48%** (from **290** to **439**). We examine the nationally reported safeguarding adult statistics to identify key areas where our performance seems to differ significantly from other local authorities. This year we identified differences in:

- **A higher than average number of alerts relating to allegations of a sexual nature.** Each allegation has been looked at to try to establish common factors (e.g. age groups, living arrangements etc.) and each one discussed with the police, but at present no clear explanation has been identified.

- **A higher than average number of alerts relating to people with dementia**. Although the number of alerts relating to people with dementia is much higher than other local authorities, at 20% of the total of alerts this does not appear to be inappropriate. Our numbers may be high because we cross reference alerts with all other information we have about people's social care needs, so are actively identifying where dementia is a condition.

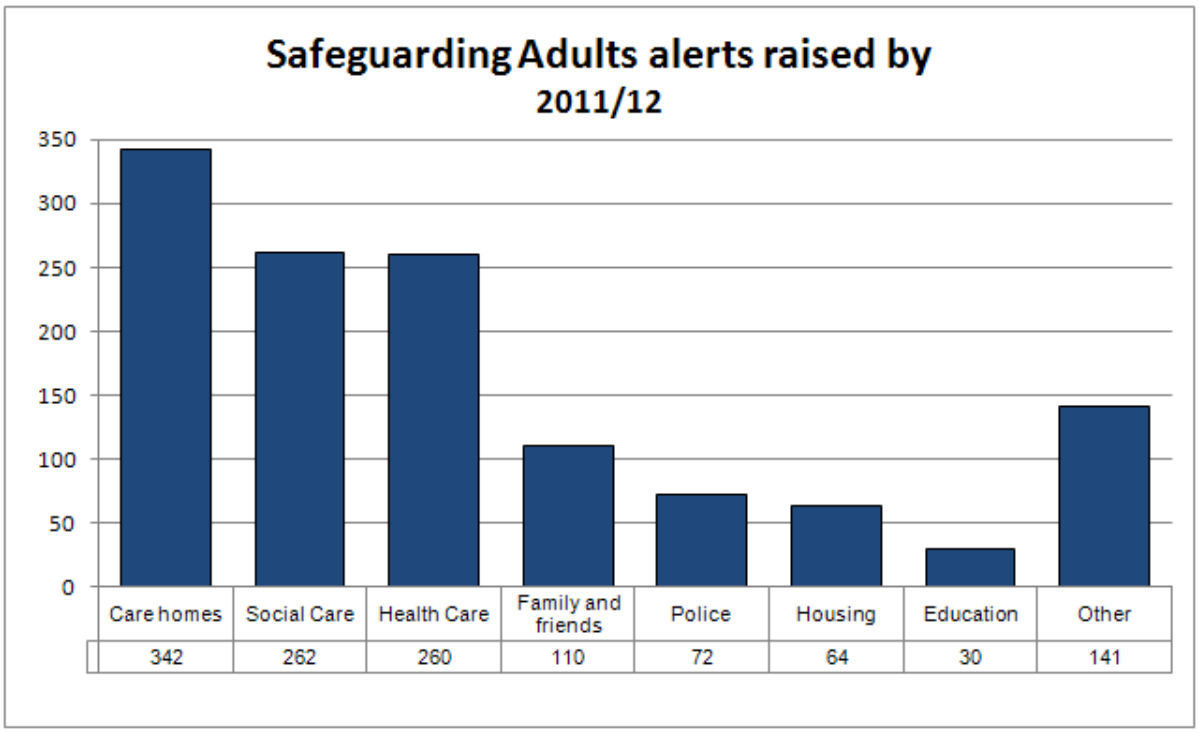
- **A lower than expected number of alerts relating to people from the Black and Minority Ethnic community.** The Councils Community Involvement team has carried out a lot of work this year to ensure the safeguarding message is reaching all of Gloucestershire's communities. The numbers are small and we continue to monitor the situation on a monthly basis.



Alerts are raised by a wide variety of agencies and members of the general public:

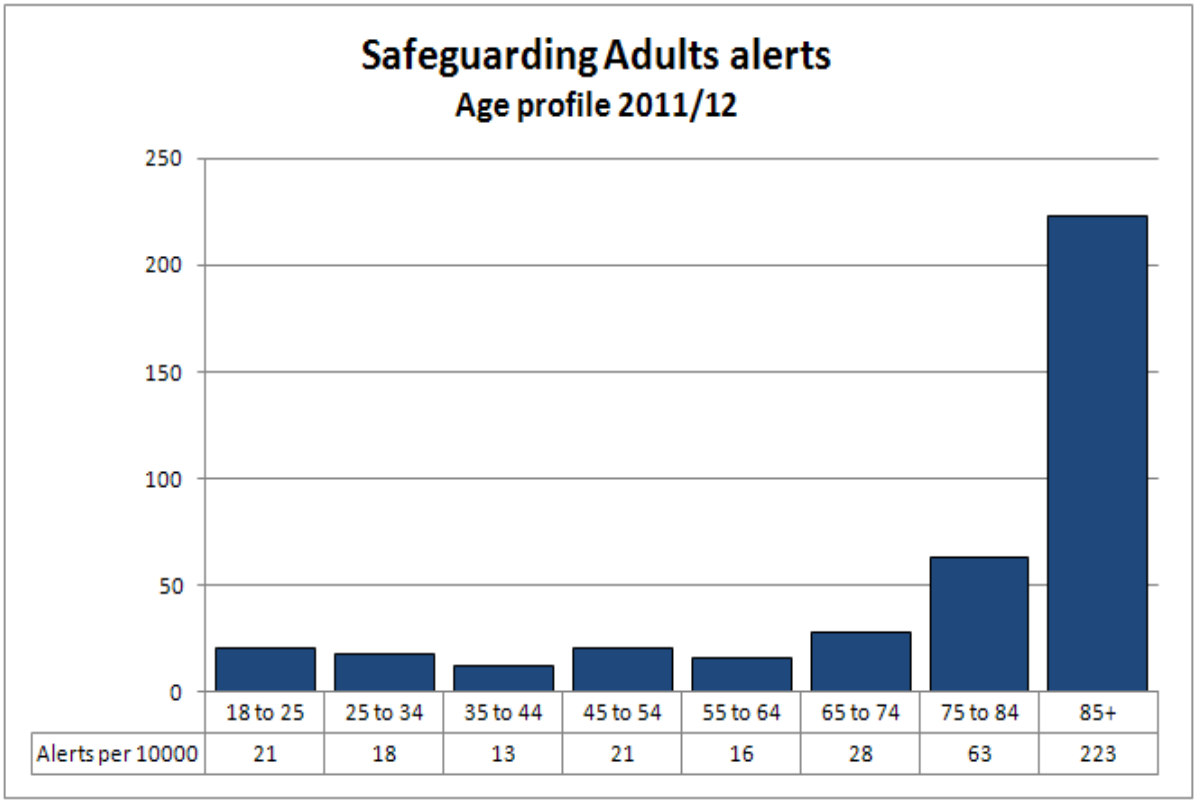
Most alerts were raised by residential care home staff where their contracts require them to report any relevant incidents.

The **260** alerts raised by Health Care staff were made by acute health services (**98**), mental health services (**88**) and community health services (**74**).

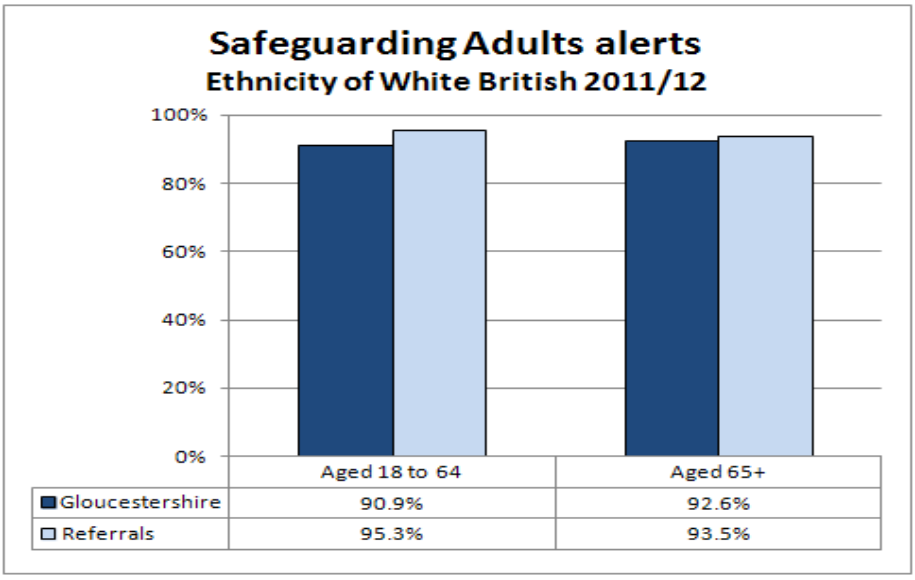


What do we know about vulnerable adults?

Vulnerable adults fall into all age groups, but those aged **85 and over** have a higher vulnerability than other ages
Age profile figures are a rate of alerts per 10,000 population and emphasise the vulnerability of older people



The percentage of vulnerable adults who were recorded as “White British” was slightly higher than the corresponding ethnicity of Gloucestershire as a whole:



(Office of National Statistics midyear estimates 2007)

Due to very small numbers we are unable to draw any significant conclusions about any other particular ethnic minority but a further **3%** of all vulnerable adults were also recorded as White but from other backgrounds (Irish, European etc).

Section 7: Workforce Development

The target of 5000 set by the GSAB at the beginning of the year for face to face training was met, with notable increased uptake from key partner organisations. Enhanced level training has been updated and was introduced in September and has been taken up well, particularly by County Council staff. In addition new Safeguarding leadership e-learning was launched towards the end of 2011, with 151 people accessing it between January and March 2012.

There are now 53 active trainers delivering foundation level training under the locally accredited train the trainer's scheme. A Continuous Professional Development event put on for trainers last year attracted 60% attendance and was well evaluated. It included sessions on case studies led by the Safeguarding team. Three community minority ethnic groups have now received targeted training, attracting 55 attendees.

A rolling programme of Mental Capacity Act training for professional leads was introduced during the year with very good take up by County Council staff and excellent evaluations.

Workforce Development leads for the Gloucestershire Safeguarding Adults and the Children's Board have met regularly to review respective training & development pathways with the aim of sharing best practice, aligning pathways and integrating approaches where appropriate. The Safeguarding Children's Board is keen to make better use of e-learning, e-assessment and the train the trainer approach so safeguarding adults have been pleased to share work in these areas.

Proposals for joint developments included manager training, evaluation to evidence the impact of training on practice, and fully aligning the Workforce Development sub groups together across adults and children's safeguarding by April 2013

The training tables on the following page evidence the take up of training and e-learning during 2011/12 compared to 2010/11.

The Voluntary and Independent Provider (VIP) reflect external providers for residential and domiciliary care. These have been difficult to break down into the older people, learning disability and domiciliary care categories for the MCA & Safeguarding E-Learning figures.

Figures recorded under 'Other' include Dental Practices, Shared Lives, Carers, and Schools etc.

The whole data base for recording training is under review for 2012/13.

Safeguarding Figures From 1st April 2011 to 31 March 2012						
	MCA E-Learning	DoLS E-Learning	MCA Training	Safeguarding E-Learning	Safeguarding Training (Foundation)	Safeguarding Training (Enhanced)
Annual Total	**3083**	**2922**	**202**	**4310**	**4888**	**343**
Voluntary & Independent Provider (VIP) Older People	**0**	**462**	**28**	**0**	**949**	**78**
(VIP) Learning Disability	**0**	**86**	**3**	**0**	**519**	**44**
(VIP) Dom Care	**0**	**259**	**1**	**0**	**458**	**20**
Total VIP	**930**	**0**	**24**	**1900**	**162**	**0**
GCC	**196**	**217**	**128**	**274**	**199**	**138**
Acute Trust	**1250**	**1323**	**0**	**1231**	**230**	**0**
NHS Care Services	**65**	**41**	**18**	**152**	**815**	**7**
2gether Trust	**27**	**19**	**0**	**1**	**315**	**4**
GP Practices	**0**	**0**	**0**	**0**	**0**	**0**
Tri - Service	**0**	**0**	**0**	**0**	**12**	**0**
Glos Constabulary	**1**	**0**	**0**	**26**	**837**	**13**
Adult Education	**0**	**6**	**0**	**30**	**22**	**0**
Carers	**0**	**0**	**0**	**0**	**31**	**0**
Support Groups	**0**	**0**	**0**	**0**	**39**	**23**
Housing Providers	**0**	**0**	**0**	**0**	**174**	**12**
Private Hospitals	**0**	**0**	**0**	**0**	**0**	**4**
Other	**614**	**509**	**0**	**696**	**126**	**0**
Probation Service	**0**	**0**	**0**	**0**	**0**	**0**
Total	**3083**	**2922**	**202**	**4310**	**4888**	**343**

In comparison to last year:

Safeguarding & MCA/DOLS - E-learning & training uptake 1st April 2010 to 31st March 2011						
Name of work area	MCA E-Learning (Kwango)	DoLS E-Learning (Kwango)	MCA Training (Multi Agency)	Safeguarding E-Learning (Kwango)	Safeguarding Training (Foundation)	Safeguarding Training (Enhanced)
Older People (VIP)		287	90		1267	112
Learning Disability (VIP)		240	46		671	58
Dom Care (VIP)		127	22		625	41
VIP - Total	**634**	**654**	**158**	**1732**	**2563**	**211**
GCC	415	284	57	496	284	32
Acute Trust	1227	1308		1365	3	7
NHS Care Services	133	50	22	185	136	6
2gether Trust	50	16	1	26	120	33
GP Practices	3	7		2		
Tri - Service	2			1	10	2
Glos Constabulary	4			1		1
Adult Education	9	4		162	53	
Carers					16	
Support Groups					140	9
Housing Providers			1		28	8
Private Hospitals					10	
other	240	193	3	768	10	3
Probation Trust					85	1
Prison Service			1			
Total Apr to Mar	**2717**	**2516**	**243**	**4738**	**3458**	**313**

Section 8: Deprivation of Liberty Safeguards (Mental Capacity Act)

The Deprivation of Liberty Safeguards (**DoLS**) were introduced by an amendment to the Mental Capacity Act **(MCA)** 2005 via the MHA 2007 and became law in April 2009. They provide a legal framework to protect those who may lack the capacity to consent to arrangements for their treatment or care in a hospital or care home and where levels of restriction or restraint used in delivering that care are so extensive as to be depriving the person of their liberty.

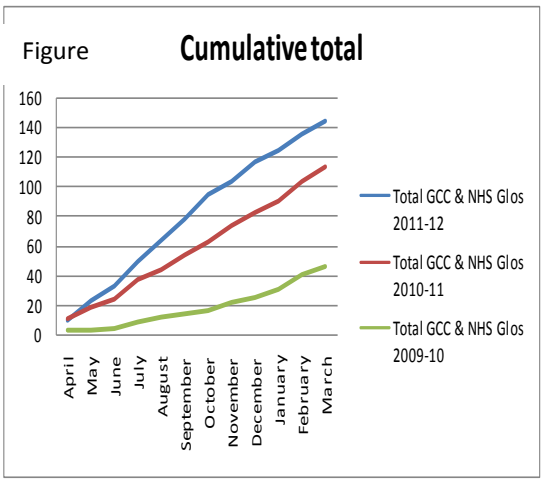
The DoLS Service, which is integrated with the Safeguarding team, works on behalf of the 2 Gloucestershire Supervisory Bodies, NHS Gloucestershire (NHSG) and Gloucestershire County Council (GCC). NHSG are responsible for hospital applications and GCC for Care Home applications. The service provides an information and advice service to Managing Authorities (Care Homes & Hospitals) in Gloucestershire and also to those where Gloucestershire residents are accommodated outside of the county.

The **MCA** came into force during 2007 and provides:

- A statutory & quality framework that empowers & protects some of the most vulnerable people in society.
- A legal & statutory framework for decisions around capacity & best interests providing legal protection for staff & others.
- Protection for people who lack capacity by setting out a mandatory procedure for making decisions on their behalf.
- Powers for people who have capacity to plan for a time when they may lack capacity, and to record their wishes for future treatment.
- Power for staff & others to make a 'best interests' decision on behalf of another person.

http://www.gloucestershire.gov.uk/safeguardingadults/utilities/action/act_download.cfm?mediaid=15935

DoLS - Activity for 2011/12



DoLS applications have risen 27%. From 113 in 2010/11 to 144 in 2011/12. Since 2009, a steepening curve over the past year indicates an on-going developing awareness of the DoLS. This increase has been mirrored across the region & nationally. At the start of the year a prediction of 150 applications was made based on a balance between DoH predictions and activity to-date.

Gloucestershire has received the 3rd highest number of Local Authority referrals in the South West region & 5th highest for NHS applications, higher than last year.

Table A - DoLS Performance Indicators	2011-2012	2010-2011
Number of GCC DoLS referrals	100	95
Number of NHSG DoLS referrals, of which:	44	18
• 2gether Trust	18	4
• Care Services (NHS Gloucestershire)	10	2
• GRH	4	5
• CGH	4	3
• North Bristol	6	4
• Private Hospital	2	0
Number of above where Managing Authority is Out of County & Supervisory Body is Gloucestershire	26	20
Third party referrals	1	6
Reviews	13	10
% of DoLS applications authorised (national position10/11 50%)	53%	50%
% of DoLS applications which are urgent	69%	76%
% of Urgent applications needing extending	24%	19%

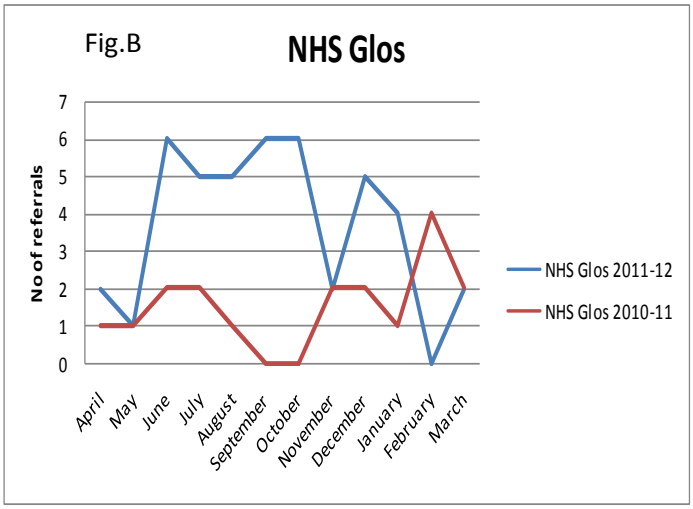


Figure B illustrates NHSG applications over the last two years which have increased from 18 in 2010/11 (Year 2) to 44 in 2011/12 (Year 3), **an increase of 144%.** This is very encouraging & demonstrates that the DoLS programme of awareness activity has had a positive effect. Table A demonstrates a good spread of hospital applications between 2gether NHSFT, GRHNHSFT & Care Services (Community Hospitals).

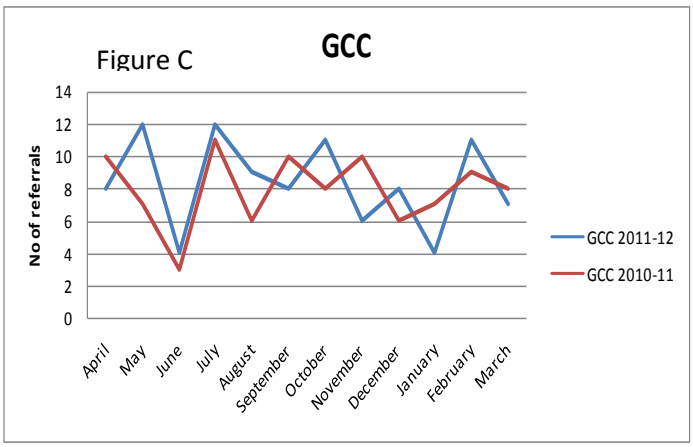


Figure C illustrates LA applications over the last two years. Applications have increased from 95 in 2010/11 to 100 in 2011/12, an increase of 5%.

Key Priorities for 2011/12:

- To work towards the target figure of 150 applications to ensure there are no illegal DoLS in Gloucestershire & to ensure the service is sufficiently staffed to meet statutory requirements.

Main Achievements:

- Steady increase in applications, including a significant rise from the NHS.
- Recruitment of 7 new Best Interest Assessors (BIA's).
- Delivery of bi-monthly DoLS forums & recruitment of 26 multi-agency trainers.
- A new BIA contract with increased expectations & spread of allocations.
- Creation of a Supervisory Board 'Scrutiny Panel' as part of the DoLS Quality Assurance framework.
- A high performing DoLS IMCA service, achieving the 2nd highest level of referrals nationally for DoLS IMCA instructions.

- **Improved Outcomes:**
- The increase in applications is evidence that there is a reduction in the number of people illegally deprived of their liberty in Gloucestershire & who are now receiving these safeguards.
- Leverage over the delivery of less restrictive practice as a result of the use of 'conditions'.
- Initial advice & support provided by the IMCA service to all Relevant Persons Representatives (RRPs).
- Scrutiny of care plans by experienced independent professionals directed towards best interests.
- A voice for the patient & those involved in their care around whether there are less restrictive options or alternatives.
- Un-befriended people gaining access to representation & advocacy.

- **Future Challenges:**
- Mechanisms for the dissemination of the implications of a rapidly changing legal context.
- Establish potential DoLS in supported living environments.
- Transfer of NHS responsibilities to the LA in April 2013 & the best use of the one off grant of £14,064 that has been made available for this purpose.
- Timely allocation of applications to BIAs who have the competing demands. .Progress to be made by a combination of use of independent BIAs & a revised BIA contract.

Section 9: Monitoring & Evaluation

9.1 Quality Assurance

Gloucestershire County Council Quality Assurance Team

Gloucestershire County Council has a Quality Assurance (QA) team working alongside the Safeguarding Team.

A quality assurance framework and service review programme is in place and all care homes for older persons, domiciliary care agencies and Supporting People funded contracts are subject to an in depth review looking at areas of the service to ensure they provide the best possible care to vulnerable older people. The framework is continually refreshed in line with national and local legislation, guidance and learning.

Services are reviewed against set standards which include; management, recruitment, safeguarding, training, health & wellbeing, medication care planning, policies & procedures.

The QA team will be on site for a minimum of two days to observe and evidence what goes on, talking to residents, families and care staff.

Any areas that require improvements are identified and a report is produced of actions the home needs to take, some of which may be immediate and others within set timeframes – all actions must be completed within an overall time frame of 3 months.

Homes with improvement actions work with the QA team to make sustainable changes in the interests of older people. The QA team will continue to monitor and validate the improvements required returning a number of times and often unannounced. Homes are required to reach an acceptable standard before the review process is completed and the QA team withdraws.

The QA team work in conjunction with the GCC/NHS Care Homes Support Team (CHST) which offers advice support, guidance and training on clinical skills, any action plans of the CHST with care homes dovetail with the QA improvement plans.

Gloucestershire Care Providers Association (GCPA) also support individual homes both through facilitating Persons in Care forums and where appropriate providing individual mentorship for both home managers and home owners. The GCPA have also developed a number of audit tools from safe recruitment to outcomes compliance self assessment, available to all association members.

Learning Disabilities

A ‘360 Degree’ monitoring system has been piloted with five residential providers and feedback received from family, paid carers, health professionals, operational staff and Doctors.

Gloucestershire Voices were used as Quality Checkers. This is a group of Service Users who will visit the establishments and chat informally to the Service Users at that service to get feedback on their view of the service.

Key learning and next steps from this pilot included:

- Priority to ensure each resident is visited by a family member, advocate, or befriender. A number of people with Learning disabilities receiving services had no significant person visiting from outside the home.
- After only 5 residences visited the Quality Checkers have learned a great deal about how they will do it differently and have generally improved their confidence and skills to a very effective level. The User Led Organisation (Gloucestershire Voices) has now been approached to run similar exercises in health facilities.
- The process itself is efficient however commissioners have to allow enough time to really analyse the volume of information received and actually tackle the issues presented.

The pilot has being closely watched by the Care Quality Commission who see it as both innovative and having strong future potential.

Other Quality Initiatives:

- Out of County Initiative: We are currently reviewing **all** our out of county placements to ensure, in the first instance, the quality of service is appropriate, and secondly if appropriate, to provide the placement back in County where appropriate quality monitoring will be regular and robust.
- Unannounced Visits: Commissioners undertake unannounced visits to resources on a regularly scheduled basis.
- Safeguarding Event Chronology: Commissioners work with the safeguarding team to ensure patterns of safeguarding events are picked up on and responded to. This moves away from looking solely at single incidents and toward 'pattern recognition interventions'.
- Embargo and Suspension: Commissioners regularly suspend or embargo resources from further placements where there are safeguarding issues or even where commissioners believe that an investigation warrants their full attention.

Mental Health (MH)

NHS Gloucestershire is the lead commissioner for a wide variety of health and social care services for adults with mental health problems.

Where it is deemed that individuals assessed health and social care needs cannot be met by existing services, then either the Health or Local Authority will need to consider funding additional services via agreed pathways (Complex Care Needs Panel and Adult MH Social Care Panel).

Specialist services are commissioned from independent, voluntary sectors and private organisations through contracting arrangements. These services include residential and nursing provision, housing with care, domiciliary care, day care, adult placements, personal assistants, and direct payments.

In addition Supporting People (SP) services are commissioned to meet low-moderate levels of need specifically intended to maintain or enable independent living.

NHS Gloucestershire employs Clinical Case Managers who undertake assessments in response to requests for funding from GPs/2gether NHSFT. They are responsible for reviewing of existing care packages, (joint/sole funded) which are in or out of county.

2gether NHSFT have a Social Care Review Lead (Adult Mental Health) who works with care managers to ensure that all funded care packages are reviewed in line with GCC Policies and Procedures. They regularly liaise with Clinical Case Managers with regards to 100% PCT funded packages and joint funded care packages and work closely with all local providers of adult mental health social care.

NHS Continuing Health Care (CHC) and Funded Nursing Care (FNC)

All NHS Continuing Healthcare Nurse Assessors are allocated a number of nursing registered care homes and are responsible for the CHC and FNC considerations, decisions and reviews for all the residents receiving nursing care. In order to fulfill this role they need to visit the home on a regular basis and this would usually be, as a minimum, 2 to 3 times a month. The nurses follow countywide safeguarding procedures if they find areas of concern when assessing or reviewing individuals in the care home.

GSAB Quality Assurance Group

Representatives from statutory partner agencies are represented on this group which either meets when required or communicates virtually.

In 2011, the *Raising Concerns* protocol was developed to ensure timely and effective reporting of poor practice at care homes and other care providers.

Concerns of poor practice in services are shared and discussed amongst the group members and any potential safeguarding concerns reported to the Safeguarding Team and managed through correct process.

Raising concerns has become part of everyone's core business with appropriate tools and mechanisms in place for partners to raise any concerns to the attention of relevant members of the QA group where actions can be delegated immediately and managed appropriately.

During 2012-13 this group will now focus on the GSAB strategic plan where the outcomes achieved will produce an accurate picture of all commissioned business activities and produce a work programme that will ensure a robust QA framework is in place for commissioned services.

9.2 Audit

A multi-agency GSAB Audit work stream was established in May 2011 with a key objective to ensure that audits and self assessment processes are in place and there is effective monitoring and implementation of necessary changes.

Requests for the audit work stream to carry out particular activity come from both the board and its management committee.

Since its inception, the group has undertaken a variety of activity.

- Development of Terms of Reference.
- Development of an initial audit activity programme for 2011/2012.
- Ongoing benchmarking within all partner agencies against the South West Safeguarding Adults Reporting Framework 2011.
- Development of an audit tool to review the process of Safeguarding Alerts and Referrals
- 2 audit sessions reviewing the management and recording of a number of Safeguarding Alerts, with feedback to teams where appropriate.

Planned Activity for 2012/2013

- Continue the benchmarking activity started in 2011/2012.
- Quarterly review sessions to look at safeguarding processes. This will include referrals where no alleged perpetrator has been recorded.
- In-depth review of multiagency records for a group of vulnerable patients / service users who access a range of services to ensure that processes are followed and that information sharing and actions are timely and effective.

9.3 Risk Management

GSAB Risk Register

The GSAB Risk Register allows for defensible prioritisation and management decision making. Each area of business as undertaken by the boards sub groups is risk assessed and recorded. Risk management is fully embedded into the strategic business planning process and the register is subject to regular scrutiny by board members.

Each member of the GSAB is held responsible for ensuring that there are clear links between their own agencies risk management process and that of the GSAB.

Gloucestershire County Council has the protection of vulnerable adults as a strategic risk which is monitored corporately.

‘Failure to protect vulnerable adults in Gloucestershire from abuse or neglect in situations that potentially could have been predicted and prevented’.

GSAB Risk Register – Appendix 7

9.4 Performance Indicators

GSAB Performance Dashboard

The GSAB Performance Dashboard allows the board to effectively monitor progress in the extent to which it is achieving its aim of improving adult safeguarding services in Gloucestershire. It is informed by input from across the Board partners and from

the ADASS SW joint Safeguarding and Performance Network task group on developing a shared performance framework.

GSAB Performance Dashboard – Appendix 8

Priorities for 2012-13

- Ensure indicators capture performance of all partners on the basis of commonly agreed and understood definitions.
- Expand the scope of indicators that were initially limited because of data collection issues.
- Develop qualitative measures of peoples' experience of safeguarding processes.
- Develop useful measures of adult care provider quality in relation to safeguarding.
- Continue to work with ADASS SW performance and safeguarding group to identify priority performance indicators for benchmarking and joint-monitoring.

Section 10: Partnership Working

10.1 [2]gether NHS Foundation Trust ([2]getherNHSFT)

[2]gether NHSFT continues to be fully committed to the contribution to and development of the Safeguarding Agenda and are represented on the Gloucestershire Safeguarding Adults Board by the Director of Quality and Performance.

[2]gether NHSFT have robust representation on all of the sub groups and actively contributed to the Serious Case Review conducted this year, which resulted in an internal action plan which is being managed through the 2gether NHSFT governance processes.

Organisational arrangements

- An internal Safeguarding Committee is in place which meets every month to oversee safeguarding compliance for both children and adults who access services in both Gloucestershire and Herefordshire ([2]getherNHSFT expanded their services in April 2011 and now provides Mental Health and Substance Misuse services in Herefordshire).
- [2]gether NHSFT is committed to developing robust arrangements to ensure that safeguarding becomes fully integrated into their systems, resulting in greater openness and transparency about clinical incidents and learning from safeguarding concerns with partner agencies.
- Dedicated links to MAPPA, MARAC and PREVENT are established and joint working arrangements continue to be developed in order to achieve effective multi-agency working.

Developments during 2011/12

- Appointment of an additional Safeguarding Practitioner to work full time alongside the [2]gether NHSFT safeguarding lead. Together they promote the safeguarding of children and adults throughout the Trust.
- Human Resources, Serious Incident and Complaints policies and processes have been reviewed to strengthen them to assist staff in identifying when safeguarding processes should be followed. Have begun the process of reporting safeguarding incidents on their electronic system which is used for Risk reporting.
- Safeguarding is specified as a key responsibility in Job Descriptions and Annual Appraisals.

Training and Development

- As part of [2]gether NHSFT Corporate Induction all new members of staff receive face to face Level 1 Safeguarding Training (in both Children's and Adults).
- An integrated "Think Family" training model combining both Children's and Adults safeguarding is mandatory for all (clinical) staff, every 3 years. This has been regularly delivered since September 2011. We have identified 3 additional trainers to assist in the delivery.
- Staff can access multi agency safeguarding training and e-learning modules.

- Consideration for adults safeguarding has also now been included in Risk, Supervision and Investigation training sessions.
- [2]gether NHSFT produce a monthly Safeguarding Bulletin which is sent to all staff in the Trust. The most recent one included guidance on making alerts to the Local Authority. This provides clarity on reporting and improved positive partnership working.

Trish Jay
Director of Quality & Performance, [2]gether NHS Foundation Trust

10.2 Gloucestershire Care Services

Gloucestershire Care Services (GCS) remains committed to playing a full and active role in the multi agency Safeguarding Adults agenda.

GCS is represented on the Gloucestershire Safeguarding Adults Board by both the Joint Director of Operations (Adults) and the Head of Nursing. The Clinical Quality Manager has lead responsibility for the audit work stream which is part of the Quality and Performance sub-group.

GCS have increased their representation on a variety of sub-groups and work streams, and at time of reporting actively participate in the following

- Policy and Procedure group.
- Management Committee
- Practitioner Forum.
- Serious Case Review group.
- MCA and DoLs.
- Workforce Development group.

Key Achievements in 2011/12

- Development of a dedicated section on the organisations intranet site for Safeguard Adults and Children policies, guidelines, referral pathways etc.
- Identification of a professional lead for adult safeguarding.
- Activity to ensure compliance with the Care Quality Commission Outcome 'Safeguarding people who use services from Abuse' (Outcome 7).
- Inclusion of a section on patients suffering with dementia or with cognitive impairment in the monthly clinical practice audits within community nursing and community hospital inpatients.
- 815 members of staff have accessed foundation level training - Safeguarding Awareness – A case study approach. Training numbers have been restricted during the later part of 2011/12 as the number of trainers temporarily reduced as a result of organisational restructuring.

Key plans and objectives for 2012/12

- Launch of the joint Safeguard Adult and Children Training policy.
- Establish a steering group which will have responsibility for the implementation and monitoring of the organisations Safeguarding Adults strategy and related action plans.
- Development of monthly communications relating to Safeguarding Adults.
- An increase in the number of trainers able to deliver foundation training within each locality.
- Further development of the GCS organisations safeguarding intranet site.
- Development of the Safeguarding champion role within localities.
- Review of Care Services existing policies and guidelines related to Safeguarding Adults, MCA and DoLS.

Gill Vickers
Joint Director of Operations

10.3 Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)

GHNHSFT remains committed to partnership working to safeguard vulnerable adults within Gloucestershire as part of Gloucestershire Safeguarding Adults Board (GSAB) Annual Business Plan and Gloucestershire's Multi-Agency Safeguarding Adults policy and procedures. The Trust Executive Lead for Safeguarding attends GSAB and there is senior Trust representation on each of the GSAB sub-groups and each is actively engaged with the work plan.

GHNHSFT has an established Safeguarding Adult Strategic Board, chaired by the Trust Lead Executive for Safeguarding, which has representation from all key Trust stakeholders involved in Safeguarding. The Board meets on alternate months and has responsibility for implementation and monitoring of GHNHSFT Safeguarding Adults strategy and action plan. The Safeguarding Adults Strategic Board also has responsibility to monitor the implementation of Trust Dementia Strategy, Learning Disability Strategy also the Mental Capacity Act Action plan. This group reports to Trust Quality Committee and Trust Main Board.

Key achievements over 2011/2012

- An increased number of Safeguarding Alerts have been raised by GHNHSFT during 2011/2012, with work-in progress to capture reporting.
- GHNHSFT continue to deliver 3 levels of in-house Mandatory Safeguarding Adult training. Increased compliance is demonstrated for Training at level 1(93% compliance) and at level 2 (77% compliance). Training at level 3 is targeted to Senior Clinical Staff with 230 staff having completed this training. Training compliance targets are being reviewed for 2012/2013.
- Supporting vulnerable patients remains a strategic objective. Further developments have been implemented to continue to improve patient and carer experience for the Patient with a Learning Disability and Patients with known Dementia. These include patient and carer surveys, staff training and resources to support care planning. There is Dementia Champion and a Learning Disability Champion in each care team with a programme of Champion events held during each year. A Dementia Peer Review was undertaken in July 2011, the Trust received positive feedback from the Peer Review Team.
- GHNHSFT continue to promote integrated arrangements between safeguarding children and safeguarding adults with quarterly joint meetings held between Trust Safeguarding Adult and Safeguarding Children Strategy Boards.
- The Trust Safeguarding Adult Steering Group held Trust wide Events to raise awareness across Trust teams - Carers Week in June 2011, Dementia Awareness Week in July 2011.
- A series of information articles are published within the Trust Newsletter 'Outline' articles have included, 'Dignity and Respect', 'Nutrition awareness', 'Supporting the Patient with Dementia' Supporting the Patient with Learning Disability.

- Participation in the 2011 Gloucestershire Mental Capacity Act Audit and have undertaken a Trust MCA audit -Further developments have been implemented as part of supporting best practice in the application of the Mental Capacity Act and as part of Multi -Agency MCA Policy and Procedures. Development of an Acute Hospital bespoke e-learning package on Mental Capacity Act and Deprivation of Liberty Safeguards.
- Refreshed Staff Safeguarding Intranet Site.
- Updated Trust policy and guidance regarding use of restraint, implementation of Safer Holding Training.
- Trust Senior Nurse /Safeguarding chairs the Trust Essence of Care Steering Group, this group reports to Trust Safeguarding Adult Strategic Board. There is an Essences of Care Champion in all clinical teams. This purpose of this group is to promote best practice in the application of clinical care Standards.

<u>Safeguarding Vulnerable Adult Key Objectives for 2012/2013</u>

- To achieve all objectives of the Trust 2012/2013 work plan.
- To review and update Trust Safeguarding Adult Policies and to include guidance on supporting vulnerable adults whose need lie outside of Adult Safeguarding.
- A Safeguarding Adults case notes review is planned for 2012 as part of GSAB Audit Sub-Committee work plan.
- Work is in progress to develop a reporting system to track the outcomes of all safeguarding Alerts raised by the Trust.
- Work is in progress to extend application the Trust Safeguarding Log(IT system).
- A Trust wide joint Safeguarding Vulnerable Adult, Children and Domestic Abuse Event is planned for the 15th May 2012 also an event as part of Dementia Awareness Week 21st to 25th May.
- Review and update evidence against Care Quality Commission Outcome 7 Regulation 11(Safeguarding people who use services from abuse).
- Partnership working with GSAB Clinical Governance Sub-Committee to develop joint processes in line with the Department of Health Clinical Governance and Safeguarding Adults Guidance
- Continue partnership working as part of GSAB 2012/2014 business plan to safeguard vulnerable adults.

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

10.4 NHS Gloucestershire

- NHS Gloucestershire (NHSG) recognises and endorses the requirement to prioritise Safeguarding Vulnerable Adults and to raise knowledge and understanding of safeguarding across the organisation.

- NHSG is represented on the Gloucestershire Safeguarding Adults Board (GSAB) by the Director of Clinical Development. The Joint Commissioning Manager, Older People and Physical Disabilities, has lead responsibility for the Safeguarding Adults Policy and Procedures working group, linked to one of GSAB sub groups. The organisation has further representation on the Policy and Procedure Group, the Audit Group, the Communications Group, the Safeguarding Adults Training Group, the DOLS Joint Management Board, the Serious Case Review Group and the Quality Assurance Group.

- Through the Governments White paper “Equity and Excellence: Liberating the NHS” the intention is to put clinicians in the driving seat for commissioning services for local people. The new Clinical Commissioning Group for Gloucestershire has been developing during 2010/11 and when they take over from PCTs in 2013 they will have statutory responsibilities in relation to Safeguarding.

- NHSG has accepted its responsibility to ensure that all contracted providers and commissioned services are aware of their responsibilities to safeguard vulnerable adults, with the appropriate requirements included in contracts, with monitoring and reporting arrangements being put in place.

- Papers relating to the development of the updated Multi Agency Safeguarding Vulnerable Adults Policy and Procedures have been taken to the NHSG Integrated Governance Committee on two occasions during the last year, which has endorsed the policy and recognised the priority that the organisations need to give to the promotion of safeguarding vulnerable adults in all work undertaken.

- NHSG contributed to the Serious Case Review, and will ensure that the learning from this and any recommendations that arise are considered to ensure a consistent approach is taken, and relevant staff are supported and clear about their responsibilities.

- NHSG staff continue to have access to the multi-agency training.

Jill Crook
Director of Nursing
NHS Gloucestershire

10.5 Gloucestershire Constabulary

Gloucestershire Constabulary takes the lead role for investigating the abuse of vulnerable adults. The constabulary also contributes to the safeguarding process by officers raising alerts and attending strategy meetings

During the course of 2011/12 the Domestic Abuse and Vulnerable Adult Unit was established so that a team of detectives with particular expertise in dealing with vulnerable adults are responsible for the investigation of serious crimes towards that group of people. The unit now holds the operational lead for such investigations and also for determining the police's safeguarding response in individual cases. The protection of vulnerable adult has now become a fundamental part of the remit of the Public Protection Bureau under the leadership of a Detective Superintendent.

Strategically the Constabulary was represented and fully engaged in all the relevant workgroups of the GSAB. A police inspector was seconded for 50% of his time in order to drive the work forward and this was both productive and warmly welcomed by partner agencies.

An interim vulnerable adult database was created to track cases (pending the adoption of an integrated application later in 2012).

Foundation training was tailored for the police and delivered to 837 frontline officers and senior investigating officers. As a result, the number of safeguarding adult alerts originating from the police rose from 32 to 72. Internal policy and guidance for dealing with vulnerable adult cases has been ratified across the force.

Richard Cooper
Detective Superintendent
Gloucestershire Constabulary

10.6 District Councils

District Councils are represented at GSAB by Peter Williams, Group Manager-Planning and Housing at Forest of Dean District Council. Information from the Board is distributed to other districts through an established network of contacts. Issues for the Board are raised through this arrangement. Individual authorities have responsibility for managing arrangements within their organisations.

The Forest of Dean District Council has carried out a significant piece of work through 2011 in its contribution to the SCR in relation to the death of an individual in a fire. Learning from the exercise is to be developed into an action and training plan. For the forthcoming year the primary focus will be on rolling out staff training to raise awareness of safeguarding more widely with staff. No additional resources have been made available for this so it will draw on the existing e-learning packages available from the County Council.

Peter Williams
Group Manager- Planning and Housing at Forest of Dean District Council

10.7 Great Western Ambulance Service NHS Trust (GWAS)

Great Western Ambulance Service NHS Trust (GWAS) provides emergency and urgent care and patient transport services across Wiltshire, Gloucestershire and the former Avon. The trust employs more than 1,700 staff across 33 operational sites – 30 ambulance stations and three emergency operations centre's – and in its headquarters.

Last year (2010-11), GWAS responded to more than 264,000 emergency calls. Our Patient transport Service also carried out more than 238,000 patient journeys. The trust covers an area of 3,000 square miles with a population of almost 2.4 million people and is party to seven local safeguarding adults' boards and the equivalent number of children's boards.

The Director of Nursing champions safeguarding for all vulnerable adults and children and ensures that it is highly visible on the trust board agenda. Day to day safeguarding matters are managed by the Clinical Standards Manager who monitors the referral process, liaises with the board leads.

During 2011-12, GWAS made 418 vulnerable adult / welfare referrals and have participated in two vulnerable adult serious case reviews.

GWAS safeguarding policy offers a process and practice guidance to allow staff to raise such concerns, which are then reported to the appropriate agency – most usually the relevant local authority care services to consider what action might need to be taken.

Taking clinicians 'off the road' to attend training as well as meeting GWAS operational duties is a challenge, however all staff with patient contact receive safeguarding training on induction to the trust and GWAS are currently working on update training by means of distance learning packages along with multi-agency training for employees with key responsibilities to provide support and advice to colleagues.

GWAS participates actively with the national ambulance safeguarding group to work collaboratively to produce national training and good practice guidelines and locally with the boards, taking the lead from Gloucestershire Safeguarding Adult's Board.

GWAS is currently undergoing an acquisition process with South Western Ambulance Service NHS Foundation Trust (SWAST) and 2012-13 will be a period of change and opportunity. The two organisations are in early conversations on how best to provide a safeguarding service that will provide equality of assurance that GWAS are fulfilling their safeguarding duties for all vulnerable adults and the provision of education and support to staff with patient contact working across the new trust area.

Liam Williams
Director of Nursing, Great Western Ambulance Service

10.8 Gloucestershire Probation Trust

Gloucestershire Probation Trust (GPT) works with adult offenders in the cessation of further offences. In their work they encounter vulnerable adults as offenders, victims or as associates or household members. Therefore, it is essential for all GPT staff to be aware of how best to safeguard against harm for this group of individuals. The Director of Operations is on the Safeguarding Adults Board and leads the practice in the organisation to keep it up to date and relevant. The MAPPA (Multi Agency Public Protection Arrangement) Coordinator sits on the panel for Serious Case Reviews and assimilates learning via GPT Safeguarding 'Champions' that are identified for each operational team.

Over the last year GPT have re-vamped their quality management systems and now conduct quarterly audits of casework where safeguarding issues are specifically monitored. This information assures the GPT Board and the Senior Managers that Safeguarding is kept as an integral part of their work. Staff can obtain scores and feedback in relation to this audit so improvements can be made if needed.

GPT aims to continue to improve their understanding and practice in relation to Safeguarding issues. Although processes are in place for staff to follow, GPT will never relax on seeking out areas for improvements. As with all of GPT work, safeguarding processes will always be sought out to be amended to incorporate the ever changing variables that can influence the work. A continuing consideration for GPT is the budgetary constraints endured as a public sector body. GPT holds in high priority safeguarding and public protection. For this reason GPT minimise the impact budgetary cuts will have on front line staff finding alternative ways of making the necessary savings. In doing so GPT are hopeful that improving the available resources and working more efficiently not least of all in relation to partner agencies, they will be able to continue to improve and keep vulnerable adults safeguarded appropriately.

Charlie Baker
Director of Operations
Gloucestershire Probation Trust

10.9 The Voluntary and Community Sector in Gloucestershire

The Voluntary and Community Sector in Gloucestershire comprises over 2,500 organisations of various sizes, delivering services and support within the community across the county. Staff and volunteers of these organisations therefore have an important contribution to make to the safeguarding of vulnerable adults. The sector is represented by Christina Snell, CEO of Age UK Gloucestershire on the Gloucestershire Safeguarding Adults Board.

Two specific pieces of work undertaken by the GSAB during the year, to which the VCS were able to contribute, related to training development and safer recruitment. The introduction of e-learning packages around safeguarding that are free to access has been of great benefit, particularly for smaller organisations who struggle with the costs of more formal training, as well as the challenges of providing training for volunteers in a way they are able and prepared to access. The development of safer recruitment guidance was welcomed, and will provide a useful and important framework to support continuous improvement in this critical area.

More generally, it is important that the 'voice' of the VCS is heard in safeguarding matters, as third sector organisations often have a different perspective and relationship with service users. It is also critical that the sector increases its awareness of safeguarding issues – both in terms of recognising abuse or potential abuse, and action to take in response to concerns.

In the coming year, the focus will be upon highlighting the training and recruitment resources available, with a view to encouraging VCS organisations to make best use of these to improve awareness and practice in respect of the safeguarding of vulnerable adults.

Christina Snell,
CEO of Age UK Gloucestershire

Section 11: Appendices

Appendix 1 – Position Statement Executive Summary

Executive Summary - Care Esatablishment:

Appendix 2 – SCR Executive Summary

Gloucestershire Safeguarding Adults I

Appendix 3 – Strategic Plan

Gloucestershire Safegaurding Adults I

Appendix 4 – GSAB Attendance figures

Attendance period April 2011 to March 2

Appendix 5 – GSAB Multi agency sub group structure

GSAB Multi -Agency Sub - Group Structure

Appendix 6 – GSAB Reporting & Accountability Structure

Reporting and Accountability Framev

Appendix 7 – Risk Register

iSafeguarding Board Risk Register 2012-1

Appendix 8– Dashboard

GSAB performance dashboard 2011-12 (: