Gloucestershire Safeguarding Adults Board

Annual Report 2020/21

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Foreword: Introduction from Chair

This report covers an unprecedented year during which we were in the midst of the Covid 19 Pandemic, which has raised the profile of adult social care and the importance of Adult Safeguarding to a new level. Whilst the virus has affected all communities, it has had a significant impact on our more vulnerable, including individuals with a learning disability and our older generations, many of whom receive care and support, often in residential and nursing homes, or within their own homes

I would like to offer my condolences on behalf of the Board to all those individuals who have been affected by the pandemic, especially those individuals who have lost loved ones.

Despite the impact of the pandemic, during the past year the Board and its sub groups have continued to operate on a virtual basis; Board members have also participated in many meetings and forums designed to monitor and respond to the impact of the virus, to ensure that the health and well-being of adults with care and support needs is prioritised and that lessons are learnt.

During 2020 we continued to focus and deliver on the final year of the priorities that were set out in our 3-year strategic plan 2018/21, namely: Making Safeguarding Personal, Prevention and Improving Safeguarding Practice and Board Effectiveness.

Once again, our annual report includes:

- 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 2020 and March 2021 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.

Our Safeguarding Adults Review sub group has been heavily engaged in a number of reviews that have been focusing upon individuals with complex health and social care needs and the Care Act requires us to provide updates on these in the Annual Report. The Board is looking to develop the findings from these reviews to help influence how the County and its Health and Social Care partners can work together to produce better person centred outcomes.

The Board is also responding to the findings and recommendations of the first National analysis of Safeguarding Adults Reviews in England that looked at all

published reviews during the period April 2017 – March 2019 and included those submitted by Gloucestershire Safeguarding Adults Board. The analysis provides a real opportunity for Gloucestershire Safeguarding Adults Board to benchmark itself and to deliver real improvements in safeguarding practice for the benefit of adults with care and support needs.

Our Workforce Development Group has been particularly agile and creative owing to the fact that all face to face training was postponed and subsequently cancelled for the year. As an alternative to face to face training, the Safeguarding and Mental Capacity Act level 2 programmes were translated into e-learning content and launched as e-learning packages in May 2020. Later in the summer, the multi-agency Safeguarding Level 3 day was successfully launched as a remote learning programme and was then delivered throughout the year.

At the beginning of 2021 we commenced our consultation and engagement with other Boards and partners including the voluntary and community sector, on what our new priorities should be, with a view to establishing a new 3 year strategy. Consultation will be widened during 2021 to include Healthwatch and the wider communities across Gloucestershire.

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

- 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;

- Reviews of a number of key Board partnership guides, policies and procedures were conducted;

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

- A total of 22,747 individual GSAB approved Safeguarding and MCA course places were taken up by Gloucestershire staff (and volunteers). This includes 6417 and 6256 courses of Safeguarding Adults Level 1 and 2 courses respectively;

- Agreeing to conduct three Safeguarding Adults Reviews during this period.

Finally, I would like to pay tribute to all those who have been working tirelessly during the pandemic to keep adults with care and support needs safe. The safeguarding of some our most vulnerable members of the community remains a key priority for the Board and all its partners.

I have witnessed some great examples of partnership working in Gloucestershire, in which the voluntary and community sectors have played a key role. This puts us in a good place to respond to the ongoing impact of the pandemic that will have a strong influence on the work of the partners well into 2021 and beyond.

As always 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.

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 2020-21 and Strategic Plan 2018-21

The Board's key achievements during the past year:

- GSAB Roadshows were held in April 2021, a week of morning events, held virtually, shining a light on safeguarding during the COVID-19 pandemic. The particular focus was on the Voluntary and Community Sectors contribution to keeping people safe during this challenging time. Each day had a specific theme; these were Financial Abuse, Domestic Abuse, Substance Misuse, Mental Heath and Disability. These were attended by approximately 400 people across the whole week.

- Identification of two new tools for the 2021/22 Safeguarding Adults at Risk Self Assessment Audit by partner agencies, including the Voluntary and Community Sector for the first time.

- Further development of the GSAB Quarterly Report, using Power BI, as the reporting tool.

- Receiving Multi-Agency High Risk Behaviour referrals, as a result of the 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.

- Undertaking three Safeguarding Adults Reviews (SARs) during the last year, primarily on the theme of complex needs including homelessness, substance misuse, trauma and Adverse Childhood Experiences (ACEs).

- As an alternative to face to face training, the Safeguarding and MCA level 2 programmes were translated into e-learning and launched in May 2020. Later in the summer, the multi-agency Safeguarding Level 3 training was successfully launched as a remote learning programme and delivered throughout the year.

- 22,747 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 the four areas shown below.

As this plan is in its last year, a new Strategic Plan is currently being produced, covering 2021-2024. It is hoped that this will go live in September 2021.

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 Strategic Plan and Risk Register can be found in supporting documents.

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3. Key Issues & Challenges for the coming year

Strategic Plan 2021 - 2024

- To continue to engage with all our Partners including Healthwatch, the Voluntary and Community sector and our communities in order to help shape and influence our future priorities for the Board.

Complex Needs

- To use the learning and recommendations from our Safeguarding Adults Reviews to help shape and influence how all the agencies in Gloucestershire support and respond to individuals with complex health and social care issues, which are strongly related to Adverse Childhood Experiences and the need for trauma informed working practice.

National SAR Analysis

- To use the learning and recommendations from the National Safeguarding Adults Review analysis in order to ensure that we commission and conduct quality reviews and that we maximise our opportunity to learn from and develop good practices that provide better outcomes for individuals with care and support needs.

COVID-19

- To continue to respond to the threat of COVID-19 and to listen to our communities who have been directly impacted upon by the pandemic. To take every opportunity to analyse and review its impact. To use this analysis 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

- The essential role that the Voluntary and Community sector provides in Safeguarding has never been more evident than during the pandemic. To continue with meaningful interaction with our highly valued diverse voluntary and community sector organisations within the county in order to raise awareness of adult safeguarding themes, reduce isolation and to reduce the risk of harm and keep people safe.

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4. Case Studies

The names and some of the details have been changed to protect confidentiality.

Case Study 1

Jim is a 78 year old white man with mild dementia. He had been living alone in his own home since his wife died two years earlier. During this time he started drinking heavily and had to be returned home by the police on one occasion because he was intoxicated and couldn't remember where he lived. In an effort to keep him safe, his son David started to lock the outer gates to his property so that he was not able to leave his garden and a neighbour reported this to the local authority, as she had seen him standing at the gates shouting for someone to let him out. A social worker visited and advised David that he could not lock his father in in this way. The social worker assessed Jim as lacking capacity to understand the risks posed by his drinking and that he was at risk of harm if he continued to live alone.

David, who has Lasting Powers of Attorney for finances and health and welfare for his father, arranged for Jim to go into a care home on a self-funded basis. Jim objected strongly to being in the care home and frequently tried to leave. A DoLS application was made by the home and a Best Interests Assessor (BIA) visited Jim to assess his capacity and whether the placement was in his best interests to prevent harm to him. Because he was objecting, the Assessor authorised the deprivation for a short period of time only and arranged for Jim to have an Independent Mental Capacity Advocate (IMCA) to support him to challenge his detention in the Court of Protection. The BIA liaised with the social worker and advised her that a less restrictive alternative to the care home should be considered given Jim's objection to being there.

Before the case reached the Court, the social worker visited Jim again. Jim's drinking had decreased significantly during his time in the care home and his cognitive functioning had therefore improved; this time the social worker assessed him as having capacity to make decisions about where he should live. Jim explained to the social worker that he had been drinking so much because he was lonely after his wife died and that he would like to live somewhere there were other people around for company. With David's support, a sheltered housing flat was found for him, with care provided. This minimised the restrictions on Jim and meant that he was no longer deprived of his liberty.

Learning points
The DoLS process is based on Article 5 of the European Convention on Human Rights (the right to liberty). It provides a safeguard against people being arbitrarily detained and gives people the right to challenge any detention in the Court of Protection. The assessment by the BIA helped to ensure that Jim's rights were upheld and that a solution was found which provided him with the company he needed as well as helping to ensure his safety.

Case Study 2

Emma is a 27 year old white woman. She was in care as a child from the age of 13

due to familial sexual abuse. She is described as having a mild learning disability, foetal alcohol syndrome and a diagnosis of Emotionally Unstable Personality Disorder. She misuses alcohol and when intoxicated she is vulnerable to sexual and financial exploitation, and also experiences seizures when under the influence of alcohol. She has gone to railway bridges in the area on more than one occasion and has threatened to jump, requiring police intervention. She has had numerous self-harm episodes and is a frequent attender at A&E; in addition she has been involved in criminal activity, including theft and assault. Professionals have struggled to find ways to engage Emma as she refuses all offers of help.

Numerous safeguarding enquiries had been undertaken but had little impact on reducing the level of risk Emma was experiencing. She was then referred to the High Risk Behaviours Panel and a meeting was convened under this policy, chaired by a practitioner in the safeguarding team. Emma was offered an advocate to support her through this process but she refused and also would not attend the meetings. Senior professionals from relevant statutory and voluntary agencies across the county were invited, as well as frontline workers, to consider any other actions that could be taken.

It was established through information gathering that Emma was due in court having been charged with assault and the safeguarding practitioner liaised with the criminal justice liaison team regarding Emma's progress.

At the first meeting, professionals were at a loss as to what else could be offered to Emma to help reduce the risks to her. However there was a helpful discussion about the impact of childhood sexual abuse on Emma being a likely significant factor in her presentation currently. Agencies all agreed that frontline workers needed to take a trauma-informed approach to working with her, and the Nelson Trust agreed to try to make contact with Emma to see if they could offer her support.

Emma was given an alcohol treatment requirement order by the court and her probation officer attended subsequent High Risk Behaviour meetings. The ATR had some positive impact on Emma's drinking but once this ended her drinking resumed. She was assigned a key worker from Nelson Trust who persisted in trying to work with Emma despite her initial reluctance, and over time she was able to build a warm and trusting relationship with her. There have been some small improvements in the quality of Emma's life thanks to this and consideration is being given to offering her a rehab placement when she feels ready to accept it. During a recent hospital admission, the ward staff had been advised of Emma's childhood abuse and also took a trauma-informed approach to her – she commented that ward staff had been "really kind" and she was more accepting of treatment during this admission than she had been in the past, when she had self-discharged.

Learning points

The impact of trauma in childhood, or at any age, should not be underestimated. Alcohol/drug addiction is often linked to the experience of trauma and used as a way of coping with the painful feelings associated with the aftermath of abuse. Thanks to initiatives locally such as promoting awareness of the impact of Adverse Childhood Experiences (ACEs), there is growing recognition that professionals need to actively consider whether trauma is at the root of the individual's difficulties when working

with people with complex lives. It is positive that as a result of the ACEs initiative, the need for trauma-informed approaches is increasingly recognised by statutory agencies in Gloucestershire, such as the NHS and the Police, who are beginning to adopt this approach. This is in line with some voluntary sector services, who have been working from a trauma-informed perspective for some time.

High Risk Behaviour meetings can be helpful in escalating safeguarding cases where the section 42 enquiry process has not been successful in mitigating the risks due to non-engagement. There are rarely easy solutions to be found but an agreed plan can be devised for use at a point when the person is ready to accept support, and people are encouraged to look creatively at how they can work together to support individuals at high risk like Emma.

5. Partnership Achievements 2020/21 and Priorities 2021/22

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

In March 2021, the Constabulary launched "Our Approach to Vulnerability". The approach, launched jointly by both the Chief Constable and the Police and Crime

Commissioner, sets out the approach to better serve those who are vulnerable through age, disability, mental health, addiction and circumstance. Addressing issues of vulnerability is an absolute priority for Gloucestershire Constabulary. It is reflected in the Police and Crime Commissioner's Plan as well as being a cross-cutting theme that touches every one of our operational objectives. The approach seeks to focus our work and will guide our work in relation to safeguarding adults.

Our priorities for 2021-2022 will be to establish and develop the new Safeguarding Adults, Missing & Mental Health (SAMM) team to provide an effective and appropriate response to vulnerable adults whether it is through exploitation, neglect, mental health and missing episodes. We will continue to manage the increased demand in relation to Vulnerability Identification Screening Tools (VISTs) and embed the approach to vulnerability across the Constabulary.

COVID-19:
The Constabulary recognised the risk that Covid posed and took an early decision to split teams up into pods, reducing the risk of transmission. A Covid command structure was set up, which took the daily decisions around our organisational response to the pandemic. A significant financial commitment was made to purchase laptops enabling our staff to continue working; this led to an increase in agile working across the force. Many benefits associated with a more agile workforce have been realised, some of which will no doubt continue. During the peak of the pandemic a Covid response team was set up, who were supplied with full PPE and able to respond to incidents where infections were suspected.

Restructuring:
During the past year a decision was taken to undertake a force restructure, which took the force from a command based arrangement to a locally based structure. Now, each local policing area, Cheltenham and Tewkesbury, Forest and Gloucester and Cotswold and Stroud has its own geographically based resources, each under the leadership of a Superintendent.

The Public Protection function within our Crime Command remains centrally located.

More recently, Superintendents Arman Mathieson and Emma Davies conducted a review of police Community Harm reduction teams including, Missing and Mental Health, Youth Offending Team, Children First and Harm Reduction teams. All of these teams provide key prevent and early intervention services for the Vulnerable. The review identified a need to develop a more holistic response to vulnerability and align particular services both in the police and with partners. The new Local Policing Model adopted within Gloucestershire and the renewed Police and Crime plan 2020 -2022 has also required reflection on Community Harm reduction and the plans for the future. As a result of the review a proposal to move these teams under the management and oversight of the Public Protection Unit was agreed by our Executive Board. The perceived benefits are improved alignment, enhanced delivery and an opportunity for continuous improvement and innovation, all in line with the National Vulnerability Action Plan (NVAP).

As detailed in previous board reports, the Constabulary has been working on plans for the last 18 months to improve our response to adults at risk within the county.

The move of the Harm Reduction teams into Public Protection provides an opportunity to develop this plan further, allowing for an enhanced service delivery for vulnerable adults.

The restructure will allow closer alignment with our existing Public Protection teams, such as Child Abuse Investigations (CAIT), Child Sexual Exploitation (CSE), Management of Sexual and Violent Offenders (MOSOVO) and Multi-Agency Safeguarding Hub (MASH).

Following further consultation it has been agreed that the adult missing and mental health team will align with safeguarding adult investigators. The new Safeguarding Adults, Missing & Mental Health (SAMM) team will be led by Inspector Sarah Simmons. This team will ensure the alignment of these services and will strengthen our partnership relationships, providing a more consistent and effective approach to vulnerable adults.

Demand:
Over the past year we have seen a significant increase in the numbers of risk assessment tools submitted for Adults at Risk (AAR). In April 2020, 385 Vulnerability Identification Screening Tools (VISTs) were submitted to the MASH. In April 2021, 767 AAR VISTs were submitted. This represents almost a 100% increase in referrals compared to last year. The increase from 2019-2020 represented almost a 140% increase. So whilst the rate of the increase has reduced when compared to the previous year, the referrals continue to increase each month. This trend results in substantial demand within the MASH. AAR VISTs now represent almost 45% of the total number of VISTs submitted. In addition to this demand, the MASH are also responsible for attending multi-agency meetings, creating crimes and any necessary research following a referral. This new demand may well be due to officers being better able to recognise and articulate the risk. The increase in VISTs is not thought to be attributed to the pandemic, although it may have played a part in the rise. We are continuing to analyse the increase in demand in order to more effectively respond in the future. We have appointed an additional MASH Decision Maker taking our total now to three. We have also increased our administrative and research pools who carry out these functions, supporting all areas of vulnerability. Although this is not specifically for AAR, the additional staff support the management and processing of VISTs. The Decision Makers work closely with partners and have strengthened working relationships in addition to developing and refining working processes. They review the referrals at the earliest opportunity ensuring they are appropriately risk rated and shared with the relevant partners. This has made a huge difference to the quality of service we offer to adults at risk and is allowing identification of trends as well as repeat victims. The Decision Makers work closely with our vulnerability officers within the neighbourhood teams to ensure that any safeguarding actions are carried out.
A great deal of work has gone into electronically converting our VIST into a completed Core Record Management System (RMS) entry. This is aimed at not only improving efficiency and speed, but also releasing staff from wholly administrative functions to being able to add value. This has been a challenging project and we are optimistic that we will start realising the benefits over the next few months. A further enhancement planned is the use of automated robotic technology (BOTS) to convert

data from other documents into our core RMS and to complete validation tasks, again further releasing staff into more productive roles.

A new marker was created in December 2020 in order to improve recognition and response of Adults at Risk at first point of contact. This marker highlights Adults at Risk on our core RMS, ensuring officers and staff that come into contact with these vulnerable individuals take appropriate safeguarding action and submit a VIST. The marker has also realised a key aim of being able improve analytical capability to monitor patterns of exploitation and enable early interventions. The data produced by the marker is still in its early stages, however, it is anticipated that it will eventually produce good quality information to enable the new SAMM team to formulate their four P plan (Prepare, Protect, Prevent and Pursue).

5.2 Gloucestershire Health and Care NHS Foundation Trust (GHC)

Key achievements 2020/21

In light of the pandemic, the last year has been unprecedented and the consequent impact on service provision has been significant. Throughout the pandemic, the Trust safeguarding team has continued to function as a priority service, albeit with adaptations in place to work around restrictions and lockdowns. The team have kept a presence at the base with team members also working from home. Most core functions have continued throughout the year.

Safeguarding training was cancelled early in the pandemic due to the huge changes in service provision and uncertainty about the virus. Since November 2020, training has resumed using a virtual platform. The feedback for level 3 adult safeguarding has been favourable although some staff find receiving training through virtual platforms challenging.

The advice line, which is open to all Trust staff, has continued to function throughout the year with calls for adult safeguarding queries increasing from the previous year.

One noticeable impact of the pandemic was the increase in reports of domestic abuse. The team have continued to support the MARAC information sharing process putting additional resource in when needed. Processes within the team have been streamlined.

Priorities for 2021/22

- We will be seeking to improve our accordance with the Making Safeguarding Personal principles and to improve the quality of referrals made by the Trust to the local authority safeguarding team.
- We will be looking at ways to improve how learning from SARS, DHRs, Serious Incidents, audits and complaints is disseminated to our staff, for example, by using brief video recordings.
- People with learning disabilities and older people have been disproportionality affected this year and we would like to have a focus on evolving safeguarding practice in these areas.

- The onset of the anticipated Liberty Protection Safeguards is looming and this will inevitably form a big piece of work for the Trust once national guidance (Code of Practice) has been published.
- Developing domestic abuse specific training for all staff - and options for developing domestic abuse champions within the Trust is currently being explored and will continue as a priority area in the coming year.
- We will be continuing to develop our offer of adult specific safeguarding supervision for teams across the Trust.

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 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)

Gloucestershire Hospitals NHS Foundation Trust was fully focused during 2020/2021 on managing patients with COVID-19 and saw greater levels of critical illness and death than we have ever seen before. In the lulls between surges of COVID-19, we have seen higher levels of acute illness than is normal in a 'normal year'.

Despite this focus, our staff have raised concerns on 2,178 occasions related to abuse, neglect or self-neglect in patients aged 18 years and older. Of these, less than 10% met the threshold for referral to Adult Safeguarding for consideration of a Section 42 enquiry and fewer still had those safeguarding concerns substantiated.

We have far greater concerns about the numbers of victims of domestic abuse identified by ourselves and our multi-agency partners and that the percentage of pregnancies where potential safeguarding concerns are identified has increased steadily over the year from 6-10% to 10-13.7%.

Activity and Performance
Our staff have identified 2,178 occasions during 2020/2021 when they had safeguarding concerns for adults.

Of these concerns, 181 concerns met the threshold for referral to Adult Safeguarding for a safeguarding investigation, albeit not all of these went on to be substantiated.

Of the remaining majority of concerns raised the themes were domestic abuse, homeless people, older adults developing increased care needs, deteriorating mental health and alcohol-related issues.

We have taken an active part in all the LeDeR reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews and are progressing all of the

recommendations applicable to our organisation

Progress against priorities
Safeguarding risk assessments are now embedded as part of the routine ward admission processes. This has been achieved courtesy of the phased introduction of an Electronic Patient Record. As this rolls out further into the Emergency Departments, Maternity, Children's Services and Outpatients we will be able to provide routine safeguarding screening opportunities, tailored to age, across all entry points.

Following an intensive virtual teaching schedule during summer 2020 staff are more attuned to Mental Capacity being time and decision-specific. Questions from staff are now about trying to word decisions well to test capacity against that decision i.e. I don't think they understand that they will not manage at home without help – how do I test their capacity for that?

Our work on Mental Capacity is an essential preparation for the introduction of Liberty Protection Safeguards on 1st April 2022.

Our internal quality monitoring system is consistently showing achievement of all of the safeguarding standards we have set.

We have reviewed and clarified the staff Allegations Management protocol and guidance. In testing this revision has been well-received.

Achievements
Despite staff focus being understandably on the COVID-19 pandemic we have been impressed with the sensitivity of staff to recognise subtle signs of potential safeguarding needs. They have asked for help and guidance early and followed policy.

We have been able to award several 'Safeguarding Star of the Month' for some superb safeguarding practice by staff who have gone more than the extra mile to advocate for our most vulnerable patients.

5.4 Gloucestershire Clinical Commissioning Group (GCCG)

The COVID-19 pandemic has had a significant impact on all areas of health-related safeguarding work. At the onset and subsequently throughout the year we have advocated a heightened and sustained awareness of safeguarding at the forefront for all healthcare providers. Under such huge pressure of staff redeployment to frontline posts, GCCG has worked closely and supportively with both Trusts and Primary Care to assure their adherence to safeguarding roles as a Priority 1 service (defined by NHSE/I).

The key work areas of 2020 included:

- Gloucestershire COVID-19 ICS Independent Sector Scrutiny and Review meeting. Chaired by Director of Integrated Services, this frequent meeting facilitated dynamic and reactive communication to support related to IPC, care quality, Public Health and safeguarding.
- CCG staff led the initiative for support telephone calls to shielded and clinically vulnerable patient groups. With colleagues achieving circa 10,000 calls, the CCG Safeguarding Team ensured sufficient support through safeguarding training provision and domestic abuse awareness.
- CCG End of Life Group brought together relevant partners to discuss and address the needs of the staff and areas dealing with the increased deaths of people due to COVID-19.
- GP Safeguarding Forum using MS Teams as a virtual meeting place and interactive learning venue for Gloucestershire's Safeguarding Liaison GPs. The adult focused sessions have had excellent participation for sessions held 2020-21. Presentations and briefings included MAPPA awareness, Gloucestershire Rape and Sexual Abuse Centre (GRASAC) on sexual violence against older women, Gloucestershire Action for Refugees and Asylum Seekers (GARAS) update on refugees and Asylum Seekers in county, Safeguarding Adult Review update and an update regarding GSAB High Risk Behaviour policy.
- GCCG has provided Adult Safeguarding Level 3 single agency training to Primary Care Networks. Funding an accredited GSAB trainer and Zoom platform, feedback is very positive and uptake is good, continuing in 2021/22 but ensuring we do provide a 'blended' approach.
- CCG COVID-19 Primary Care Bulletin and GCCG Safeguarding Newsletter; Named GP, Dr Katy McIntosh has sustained a timely and succinct communication with GPs and Practice Managers.

Looking towards 2021/22:

For our local population to receive the best care, NHS England/Improvement's 10-year Long Term Plan aims to better join up health and care services into new Integrated Care Systems (ICSs). As part of this development there is a requirement that each local area sets out how it will integrate a range of existing services, which includes health-related safeguarding for the benefit of residents and health and care professionals. For Safeguarding, there are two specific ICS work plans:

- Gloucestershire benefits from a high standard of local expertise from the CCG and both Provider Trusts, but there are opportunities to address gaps and duplication in service provision, as well as in enhancing ease of access and simplicity for our partners. GCCG has commissioned a project to create a single, integrated, health-related safeguarding service, covering both adults and children.
- GCCG will continue to work closely with Provider Trusts and GCC in preparation for enactment of the Mental Capacity (amendment) Act and the reform to Liberty Protection Safeguards. This is an opportunity for health and social care to collaborate effectively, for example working together on training and shared information systems. Under the leadership of GCCG/GCC's MCA

Governance Manager, GCC Head of Safeguarding and CCG Safeguarding Lead are progressing a joint project plan within Gloucestershire ICS.

The Domestic Abuse Bill became law in April 2021 therefore widening the legal definition beyond physical violence to include emotional, coercive and controlling behaviour and economic abuse. GCCG recognises domestic abuse as high risk and a safeguarding priority, alongside the detrimental impact on health and wellbeing for all ages. We have senior representation on the newly formed Domestic Abuse Partnership Board, supporting work at both strategic and operation levels.

The pandemic has caused an interruption for all health staff in undertaking safeguarding training. In addition, the impact of repeated lockdown on everyone, but especially for our vulnerable groups means we remain vigilant to recognising and responding to risk, abuse and neglect. GCCG Safeguarding Team will sustain our focus on training provision and compliance as a high priority.

6. Safeguarding Adults Reviews

The Safeguarding Adults Review (SAR) sub group continues to take responsibility to recommend whether a request meets the requirements for a statutory or non-statutory review (Care Act 2014). Decision making on each referral follows the 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. As such, the sub group acknowledges unwavering administrative support of both the GSAB Business Manager and the Safeguarding Adults Administration Staff.

The COVID-19 pandemic impacted how all agencies and organisations were able to work from March 2020, meaning a significant change to 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. However, SAR sub group meetings have continued to take place as planned, SARs have progressed to publication and action plans are in place.

Foreword overview on findings

Themes emerging from the SARs of 2020/21, including the emerging outcomes from the thematic audit (alcohol related deaths) are consistent; they are strongly related to Adverse Childhood Experiences and the need for trauma informed working practice. Those with early experience of abuse frequently cope by using alcohol and/or drugs, experience loss of children (child protection removal) and further suffer through that as bereavement, but often do not get timely support. As such, people with this type of history can respond better to 1:1 support and a less rigid health and social care service and there are problems with sustaining accommodation. Professionals struggle to work with such complexity, and despite many good services in

Gloucestershire, there is disconnection and disparity leading to a fragmented approach.

Safeguarding Adults Reviews

For the year 2020/21, GSAB commissioned one new SAR (JK); a joint review with the Gloucestershire Safeguarding Children's Partnership (GSCP). GSAB has also undertaken a comprehensive 'Alcohol Related Deaths' audit following concerns raised and subsequent referral to SAR sub group.

JK Learning Review
As an adult, a care-leaver sustained life changing injuries from drug use/overdose. The joint SAR, with the GSCP) is in progress, due to report in September.

Alcohol Related Deaths – Deep Dive Audit
In June 2020 there were eight deaths of alcohol dependant hospital patients in a two week period. At the start of the COVID-19 lockdown there were also three deaths at home. As a cohort, they have died in greater numbers than any other group during lockdown. Gloucestershire Hospitals NHS Foundation Trust completed a SAR referral for seven of the deaths; these individuals were known to agencies.

Following discussion, it was agreed to undertake an audit to look at the themes, gaps in services and how partners worked together. Information relating to the seven individuals was collated and the main themes identified. A report of the findings is now being finalised (June 2021) with analysis and learning disseminated.

Overview of SAR referrals received 2020/21

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	MV	AJ MD Alcohol Related Deaths	JK	SD
Referral Source	Adult Social Care Locality Team	LeDeR Review Suicide Crisis Gloucestershire Hospitals NHS Foundation Trust	GCC Children's Social Care	DASV Strategic Coordinator, Gloucestershire Constabulary
SAR Undertaken	0	0	1	0
Name	-	Alcohol Related Deaths Audit	JK	-
Learning Event	0	0	0	0
Comments	-	An audit of seven alcohol related deaths was undertaken	This is a joint review with Children's	-

Case referrals not progressing to SAR

MV – A case for concern was raised (Q1) from GCC Adult Social Care following concerns about the care provided by a family member. Following investigation and discussion, this case did not meet criteria for SAR, as the issues were around care quality and end of life planning.

AJ – A case for concern was raised (Q2) following a LeDeR Review. The concerns related to the suitability of the care home placement. Due to the single issue aspect of this case (commissioning), it did not meet the criteria for a SAR, as there were no concerns about how agencies worked together.

MD – A referral was made (Q2) by Suicide Crisis regarding concerns about the care received and medication issues. Following investigation, it was agreed using the GCC Complaints process was the correct route.

SD – A referral was made (Q4) by the DASV Strategic Coordinator at Gloucestershire Constabulary. This was already being progressed as a Domestic Homicide Review (DHR) and it was agreed that relevant agencies would sit on the DHR Panel.

2020/21 Priorities update

NC 'Nick' – 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 related to gut insufficiency, after a relatively short period of declining health. The report was published on 9th April 2021; the recommendations were disseminated and are being progressed.

SWOP (Sex Workers Outreach Project) 'Five Women' – Referred from the Nelson Trust, this SAR highlights the deaths of five 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 of abuse and trauma suffered at an early age. This thematic review aims to better understand how the county can work to support similar vulnerable groups. The initial draft report is expected in July 2021; it will be published in early autumn.

PH 'Peter' – 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. The draft report has been received and is currently being considered by the SAR sub group prior to planning publication.

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 has been published, with two recommendations relevant to Gloucestershire. These are being tracked and their progress monitored.

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 2021/22:

- The learning from the three completed SARs will be disseminated and taken forward during the coming year (NC 'Nick', SWOP 'Five Women' and PH 'Peter').
- The findings of the Alcohol Related Deaths Audit will be shared with relevant agencies.
- The JK Joint SAR will be completed, with the emerging themes disseminated.
- The Gloucestershire recommendations from the Warrington SAB commissioned 'LD' SAR will be progressed.

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

7. GSAB Business Planning Group

During 2020/21 the Business Planning Group met quarterly; due to COVID-19 the meetings were held virtually. The group worked to a standard agenda, which included oversight and updates to the Strategic Plan and Risk Register. Attendance at meetings continues to be good, with engagement from statutory partners and the voluntary and community sector.

8. Sub Group Achievements 2020/21 and Priorities 2021/22

8.1 Workforce Development

Due to COVID-19 all face to face training was initially postponed and subsequently cancelled for the year. This posed a huge challenge, yet also provided an opportunity to learn and experience a new way of delivering training. Moving to remote learning was not an easy task for trainers, learners and different IT systems. Fortunately our trainers and course participants embraced both the learning and the delivery of virtual training. As an alternative to face to face training, the Safeguarding and MCA level 2 programmes were translated into e-learning content and launched as e-learning packages in May 2020. Later in the summer, the multi-agency Safeguarding Level 3 day was successfully launched as a remote learning programme and was then delivered throughout the year.

Despite the pandemic, the take up of GSAB e-learning and remote interactive training has been high. Training figures (found in supporting documents) highlight a total of 22,747 individual GSAB approved Safeguarding and MCA course places were taken up by Gloucestershire staff (and volunteers). Given the challenges faced

throughout the pandemic, this is a very positive outcome. Of particular note is the high volume of take up by GHNHSFT staff.

Although an over-reliance on e-learning currently remains a (reduced) risk, GSAB WD sub group are hopeful that as COVID-19 restrictions ease, we can soon return to face to face learning. As a result of learners having welcomed remote platforms, it is likely that a future model of training will continue to include interactive remote learning, along-side traditional class based learning.

Participant feedback has been excellent in terms of course delivery and learning, despite initial IT glitches. Post course evaluation, via surveys, has also been gathered to identify the impact Safeguarding level 3 training has had in practice. Despite a low return rate, delegates who responded evidenced an increase in confidence around safeguarding and the reporting process and a greater understanding of safeguarding investigations which supported practice improvements.

This year the GSAB roadshow events have been scheduled in April 2020 over a week of morning events. They will be delivered virtually using MS Teams. The theme will be shining a light on safeguarding during the COVID-19 pandemic. Each day will be focusing on a specific theme including Financial Abuse, Domestic Abuse, Substance Misuse, Mental Health and Disability. The event is aimed predominantly at the voluntary sector.

2020/21 Training Figures can be found in supporting documents.

8.2 Fire Safety Development

The Fire Safety Development sub group works as a multi-agency partnership to reduce the risk from fire for people in Gloucestershire. The group ensures that analysis and learning from national, regional and local data contributes to helping 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 sub group can identify emerging trends and assist in creating initiatives to mitigate the risk.

The work of the group was significantly impacted by the COVID-19 pandemic for several months during 2020/2021. The operational demands on Gloucestershire Fire & Rescue Service affected the capacity to embed the learning from a gap analysis of Coroners' Reports which had been a key theme from 2019/2020. However, the appointment of a new Chair in February 2020 has enabled the group to begin longer term planning and the virtual meetings in the latter half of the year have been productive and well-attended.

In 2019, the group identified that a better understanding of local risks was needed to inform partners about emerging concerns. Gloucestershire Fire & Rescue Service has now completed an analysis of local risks and national fire data to produce a new Prevention Risk Profile. This has formed the basis for setting community safety objectives for the next three years. The national and regional information was shared with agencies and is now being used to update the Group's Action Plan for 2021/2022. Becoming better informed about the people who are most at risk from

fire in Gloucestershire and how individual agencies can recognise that risk and support intervention has become a renewed focus of the group.

The key concern arising from fire safety work during the pandemic has been to identify any new risks. Partners reported increasing cases of self-neglect, which often presents as hoarding, poor housekeeping, isolation or substance misuse. These are factors that increase the potential for serious injury from a fire. The multi-agency partners in the Fire Safety Development sub group have continued to send requests for home fire safety checks and Safe and Well visits throughout the pandemic and work has continued to identify and support people who need help. There were fewer agencies able to cross the threshold of people's homes during the pandemic but fire safety has remained a priority and all agencies remain committed to meeting the Board's objectives.

8.3 Communication & Engagement

Achievements 2020/2021

- Held quarterly meetings of the sub group to support delivery of the GSAB Strategic Plan, specifically the communications and engagement work within the plan.
- Onboarded a new chair from the VCS Alliance. This provides the group with specific knowledge of the VCSE and supports us to engage more effectively with the sector. The Alliance is well-placed to spread the safeguarding message throughout the VCS in the county.
- Arranged, managed and chaired the Safeguarding Roadshow 2021 focussing on the VCSE and safeguarding during COVID-19. This was provided as an online series of events over the course of a week, each day focussing on a particular safeguarding theme.
- Roadshow themes included: Financial Abuse, Domestic Abuse, Substance Misuse, Mental Health and Disability. The roadshows focussed on the VCSE and its delivery with 16 presentations throughout the week.
- 480 people attended the events with breakout rooms used as an engagement tool to collect information on what should be in the new GSAB Strategic Plan. This was written up into a series of reports and distributed to relevant partners.
- The Communications and Engagement sub group is also taking collective responsibility for producing the content of the quarterly newsletter.

Priorities for 2020/2021

- To further increase representation in the group, including better cross sector representation, to be more inclusive and diverse.
- 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.
- Support the creation of the new GSAB Strategic Plan.
- Carry out another roadshow and ad hoc events to support communications and engagement

8.4 Policy & Procedures

Achievements for 2020/21

Due to COVID-19, meetings were postponed for a few months and started again, virtually, in September 2020. 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 during the last year:

- Organisational Abuse Policy was reviewed and updated in October 2020.
- Easy Read Policy and Procedures were reviewed and updated in October 2020.
- Elected Member Guidance was updated and ratified in February 2021.

Priorities for 2021/22

Policies to be reviewed and updated over the next year include:

- High Risk Behaviours Policy
- Positions of Trust Framework
- Safeguarding Adults Review (SAR) Protocol

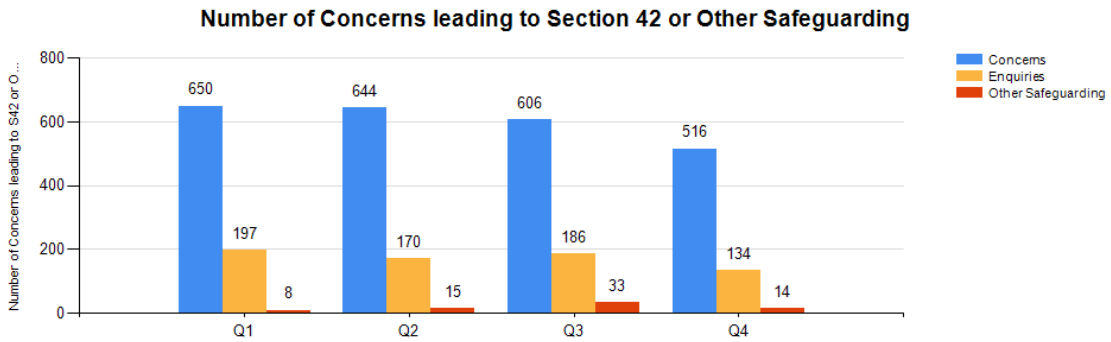
8.5 Activity & Data 2020/21

The data below covers the period 1st April 2020 to 18th March 2021. Due to a change in our Adult Social Care IT system on 19th March 2021, we are unable to provide data for the full year.

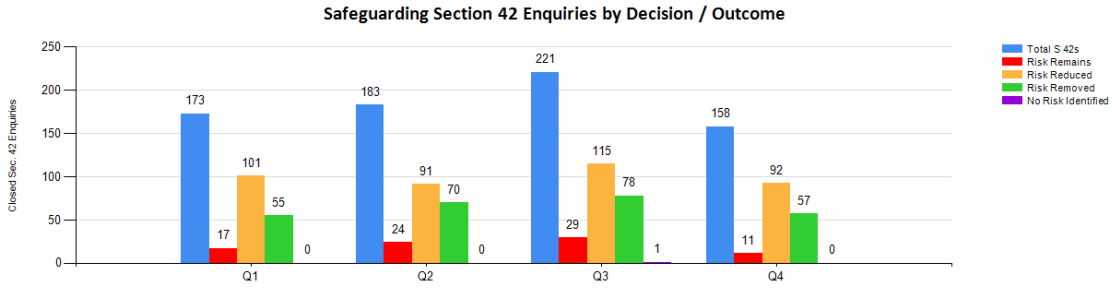
The number of Safeguarding concerns raised on behalf of adults at risk was **2416.**

Of the **2416** concerns, **687** went on to become Section 42 enquiries and **70** became 'Other' enquiries, making a total of **757**. '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.

Concerns Leading to Section 42 or Other Safeguarding Enquiries 2020/21

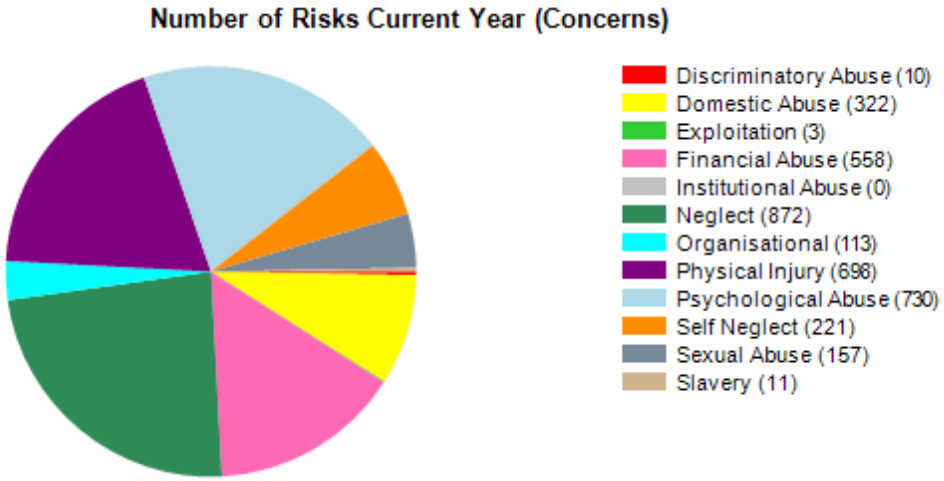


Closed Section 42 Enquiries and Risk

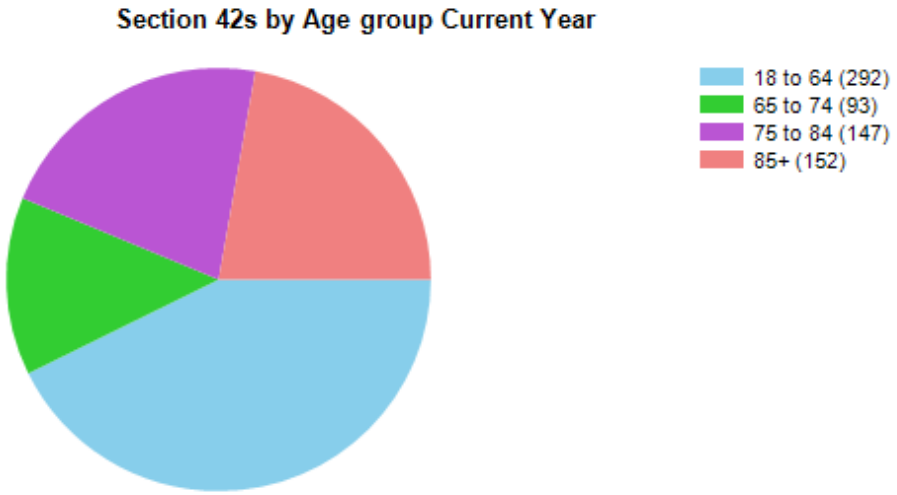


Financial Quarter	Financial Year	Total Closed S42s	Risk Remains	Risk Reduced	Risk Removed	No Risk Identified
Q1	2020/21	173	17	101	55	0
Q2	2020/21	183	24	91	70	0
Q3	2020/21	221	29	115	78	1
Q4	2020/21	158	11	92	57	0
Total		**735**	**81**	**399**	**260**	**1**

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.

The multi-agency group conducts audits every other month on a selected sample of cases and is well supported by its core members. In addition to its regular membership, the group will be inviting professionals on an ad hoc basis to provide specialist input on particular themes relevant to the audits. This is as a result of previous audits highlighting the potential benefits of specialist input, for example, from the domestic abuse or learning disability specialist services. Themes are decided by the audit steering group (held twice yearly). In this period, they have inevitably been influenced by the impact of COVID-19 and the resulting complexity of cases.

Due to the pandemic, the first scheduled audit was cancelled and the subsequent schedule was reshuffled. Audits took place using virtual platforms and were focused on the following themes:

- Other vulnerable people
- Physical health
- Domestic Abuse
- Working age adult mental health

The audits provide valuable insight in to aspects of adult safeguarding practice across the multi-agency with learning, feedback and good practice identified for respective agencies to take away and progress, for example the use of the GSAB High Risk Behaviour Policy and the benefit of holding multi-agency meetings. Each audit has an associated action log, so that there is an accountable structure in place to ensure actions are monitored and concluded.

Feedback from the audit activity is disseminated through the GSAB Business Planning Group and to the Board.

For the year 2021-22 the agreed schedule of audits is:

- Deep dive on repeat concerns for an individual
- Complex cases during COVID-19 - self neglect
- Financial abuse
- Deep dive in to an individual case
- Dementia
- Mental Health

9. 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 2020/21.

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.

GSAB Partner Contributions 2020/21

Health	38,877
Police	20,440

GSAB Business and Activity Costs 2020/21

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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