Gloucestershire
Safeguarding Adults
Board

Gloucestershire Safeguarding Adults Board (GSAB)

Annual Report 2021/22

Contents

Welcome from the GSAB Chair

Welcome to the Gloucestershire Safeguarding Adults Board Annual Report for 2021-22

Welcome to the Gloucestershire Safeguarding Adults Board (SAB) annual report, the production of which is one of the statutory requirements of the Care Act 2014 and covers the period April 2021 to March 2022.

The past 12 months have continued to challenge our extended safeguarding partnership, which has worked tirelessly to ensure the safety and well-being of adults with care and support needs, as we moved away from the height of the COVID-19 pandemic. Things are far from normal and we continue to operate in a pressured environment that is still in a state of recovery, and is trying to establish its “new” normal.

Like many areas across the Country, we have seen first hand how both the Health and Social care systems have had to cope with unprecedented demand and at the same time, cope with the challenge of staff isolating due to COVID, and the retention and recruitment of staff.

Owing to a number of factors, we have seen an ever-increasing volume and complexity of safeguarding issues and concerns with individuals experiencing severe and multiple disadvantages, including homelessness, contact with the criminal justice system, substance misuse, sex working and mental health. This has also been evidenced in a number of Safeguarding Adults Reviews (SARs).

The SAB itself maintained focus on a virtual basis and strived to deliver the objectives of its extended 3-year Strategic plan 2018-2021: Improving Effectiveness of the Board, Improving Safeguarding Practice, Preventative Strategies and Making Safeguarding Personal.

I am pleased to report that we have now launched a new 3-year Strategic plan 2022-2025, and I would like to thank everyone involved for their contribution in setting our clear priorities for the next few years.

Another of the statutory requirements of the SAB is to commission SARs, where certain criteria are met. During 2020/2021 the Board received 6 referrals for consideration of undertaking a SAR, of which one is proceeding to a SAR and another a learning event. Three completed SARs were also published during this period.

Our SAR Sub Group also continues to oversee the implementation work on the recommendations of three SARs in order to ensure that service improvements are embedded and maintained.

The SAR Sub Group also continues to respond 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.

Our Workforce Development Group continues to respond to any challenge that it faces, and 12,478

Gloucestershire staff (and volunteers) undertook GSAB approved Safeguarding and Mental Capacity Act (MCA) courses in the past year. Some training was able to be delivered on a face-to-face basis during the final few months. Moving forward training will be delivered by way of a blended approach as there have been some benefits identified in delivering training with a remote option.

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

- The Policy and Procedure Group have continued with its annual review plan of all relevant Board policy and procedure documents review.
- Commissioning of a new Multi-Agency Risk Management (MARM) Framework, to go live potentially in 2022/3.
- The annual CPD day for trainers took place virtually in November using MS Teams.
- Our Multi-agency Audit Group has undertaken focused multi-agency audits on self-neglect, dementia, a deep dive on repeat concerns, mental health enquiries and a Deep dive into complex alcohol misuse/self-neglect and financial abuse.
- Increasing awareness of using a trauma informed approach when working with individuals with complex needs.
- Our Fire Safety Development has produced an action plan that aligns with the Fire Standards Board Prevention Standards. It sets priorities for improving inter-agency working, training frontline practitioners from all agencies to recognise fire risks in homes and to ensure that safeguarding is embedded in all fire risk reduction activity.

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.

I would also like to acknowledge the work and commitment of our front-line practitioners, for their dedication and professionalism in these challenging times.

Paul Yeatman

Independent Chair
Gloucestershire Safeguarding Adults Board

This is Gloucestershire

The 2021 Census showed that Gloucestershire's population was 645,076 in 2021. This is an increase of 8.1%% between 2011-21, which is higher than the growth rate of 6.3% for England and Wales.

Gloucester continues to have the largest population with 132,416 people and the Forest of Dean has the smallest at 87,004. Between 2021-22, Tewkesbury had the most population growth at 15.8% followed by Cotswold with a 9.6% increase. Cheltenham saw the lowest rate of growth with an increase of 2.7% or around 3,000 people.

The overall gender distribution for Gloucestershire is 48.9% males and 51.1% females, in line with the gender split seen at a national and regional level

In 2021, an estimated 517,644 adults aged 18 and over lived in Gloucestershire, of these around 139,810 people were over-65s

The proportion of the population who are of working-age (16-64) is 60.84%% in Gloucestershire. This is lower than the overall working-age proportion in England and Wales (% 62.93%) but slightly higher than in the South West (60.73%).

The proportion of people over the age of 65 is higher in Gloucestershire (21.6%) than in England and Wales (18.66%) but slightly lower than in the South West (22.34%)

In the 12-month period to May 2020, around 12,100 adults and older people were receiving social care services funded by Gloucestershire County Council, including about 6,200 who received long-term care such as domiciliary care, residential care and nursing care. There were also around 1,400 adults in Gloucestershire receiving council-funded services as a carer in the same period.

Gloucestershire has a larger proportion of older population (age 65+) than nationally. Its older population is forecast to rise at a faster pace than nationally in the next 25 years, from 135,000 to 205,900 people between 2018 and 2043.

There were around 20,200 informal carers aged 65+ in Gloucestershire in 2020, this is expected to increase to 25,100 in 2030.

Studies suggest that the level of unmet social care need is higher among older people on low incomes than those on higher incomes. In Gloucestershire, 8 neighbourhood areas were ranked among the national top 10% income deprivations affecting older people.

From Older People in Gloucestershire Prevalence of Needs Report (link below)
https://www.gloucestershire.gov.uk/media/2099482/op_prevalance_of_need_2020_final.pdf

Key Achievements 2021/22 and the 2018-21 Strategic Plan

Key Achievements

- 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.
- Completion of two new national tools for the 2021/22 GSAB 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.
- Commissioning of a new Multi-Agency Risk Management (MARM) Framework, to go live in 2022.
- Producing and disseminating four issues of the GSAB Quarterly Newsletter, covering a variety of themes.
- Completing and publishing the 'Five Women' Safeguarding Adults Review (SAR) during the last year and undertaking a new joint review with the Gloucestershire Safeguarding Children's Partnership.
- Commissioning a scoping exercise to transitions (child to adult) in Gloucestershire, to highlight gaps in services and where further work is needed.
- 12,478 Gloucestershire staff and volunteers completed GSAB approved safeguarding training.
- Using a blended approach to Safeguarding and MCA training, to include e-learning, virtual and face to face training will be delivered throughout the coming year.
- Increasing awareness of using a trauma informed approach when working with individuals with complex needs.

GSAB Strategic Plan

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. This plan is in its last year and a new Strategic Plan has been produced, covering 2022-2025. Consultation on the content of the new plan was conducted by Healthwatch.

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 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.

A new Risk Register, covering the period 2022-25 is currently in production. This will link with the new 2022-25 Strategic Plan. The Board's current Strategic Plan and Risk Register can be found in supporting documents.

Key Issues and Challenges

Severe and Multiple Disadvantage

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.

SAR Quality Markers

To use the learning and recommendations from the SAR Quality Markers 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.

Voluntary and Community Sector Links

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, health inequalities and to reduce the risk of harm and keep people safe.

Service User Engagement

Look to expand the ways in which we engage with individuals who have raised concerns and been the subject of a safeguarding enquiry in order to develop best practice and achieve better person centred outcomes.

Safeguarding Adults Board (SAB)

The Care Act 2014 Statutory Guidance confirms that "the main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area" who meet the safeguarding criteria (chapter 14.133).

Role and Purpose

The overarching purpose of an Safeguarding Adults Board (SAB) is to help and safeguard adults with care and support needs. It does this by:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- assuring itself that safeguarding practice is person-centred and outcome-focused
- working collaboratively to prevent abuse and neglect where possible
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

The SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies.

SABs have three core roles. They must:

- develop and publish a strategic plan, setting out how they will meet their objectives and how their member and partner agencies will contribute
- publish an annual report detailing how effective their work has been
- commission Safeguarding Adults Reviews (SARs) for any cases which meet the criteria

What is Safeguarding?

The Care Act 2014 Statutory Guidance confirms that "Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect" (14.7)

A local authority must act when it has 'reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.' (Care Act 2014, section 42)

Safeguarding is for people who, because of issues such as dementia, learning disability or mental ill-health, have care and support needs that may make them more vulnerable to abuse or neglect.

Who is at a higher risk?

- People with care and support needs, such as older people or people with disabilities, are more likely to be abused or neglected. They may be seen as an easy target and may be less likely to identify abuse themselves or to report it.
- People with communication difficulties can be particularly at risk because they may not be able to alert others.

Sometimes people may not even be aware that they are being abused, and this is especially likely if they have a cognitive impairment. Abusers may try to prevent access to the person they abuse.

What are the six principles of Safeguarding?

Empowerment

People being supported and encouraged to make their own decisions and informed consent

Prevention

It is better to take action before harm occurs

Proportionality

The least intrusive response appropriate to the risk presented

Protection

Support and representation for those in greatest need

Partnership

Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability

Accountability and transparency in safeguarding practice

How to report a safeguarding concern

A safeguarding concern is raised where there is reasonable cause to suspect that an adult who has, or may have, needs for care and support is at risk of, or experiencing, abuse or neglect. Care Act 2014 Section 42 (1) (a) and (b).

If you are concerned that you or another adult is being abused or neglected, please report it.

Some adults are particularly vulnerable to be hurt or abused because they have a disability, illness, or impairment and need help and support. Depending on others can sometimes make them vulnerable and at risk of abuse, very often from people they know. This isn't always intentional... but it is still abuse.

Helpful Information

- Why you are concerned
- The name, age and address of the adult at risk
- If anyone lives with them
- If they are getting help from any organisation
- Who may be carrying out the abuse

Don't delay in reporting the abuse if you're not sure about some of these details.

Contact the Adult Help Desk

- Telephone 01452 426868
- 8.00am to 5pm Monday to Friday
- Or when out of hours call the Emergency Duty Team on 01452 614194
- You can also email: socialcare.enq@gloucestershire.gov.uk

Professionals Only

Professionals reporting safeguarding concerns about an adult with care and support needs should complete a **Safeguarding Adults Referral Form** (link below) https://forms.gloucestershire.gov.uk/AdultSocialCareReferral

Safeguarding activity in Gloucestershire

The data below covers the period 1st April 2021 to 31st March 2022.

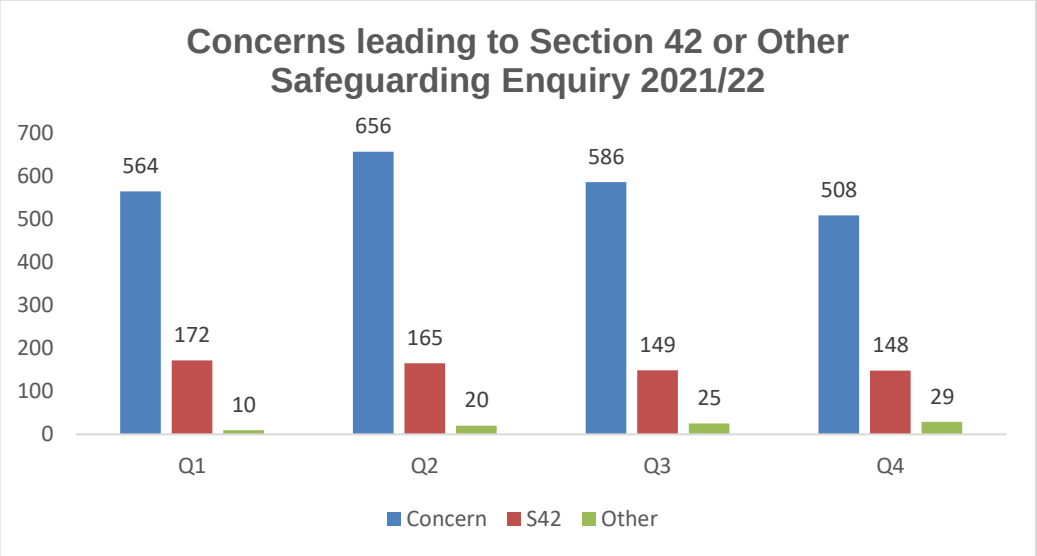
The number of Safeguarding concerns raised on behalf of adults at risk was **2,314.**

Of the **2,314** concerns, **634** went on to become Section 42 enquiries and **84** became 'Other' enquiries, making a total of **718**.

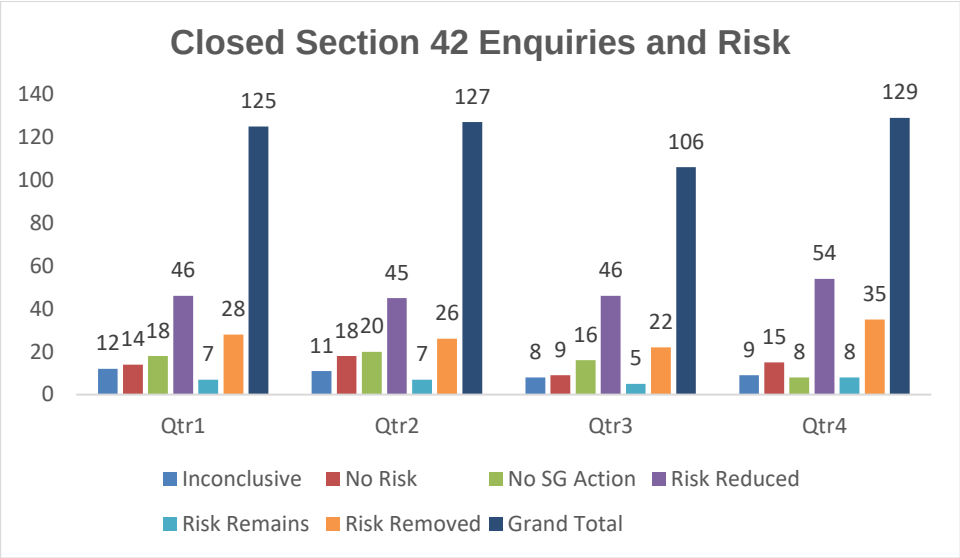
'Other' relates to enquiries that have not met the criteria for a statutory enquiry, however some form of safeguarding enquiry is deemed to be required, for example, the person is at risk of abuse and has support needs, but not care needs.

Safeguarding Activity 2021/22

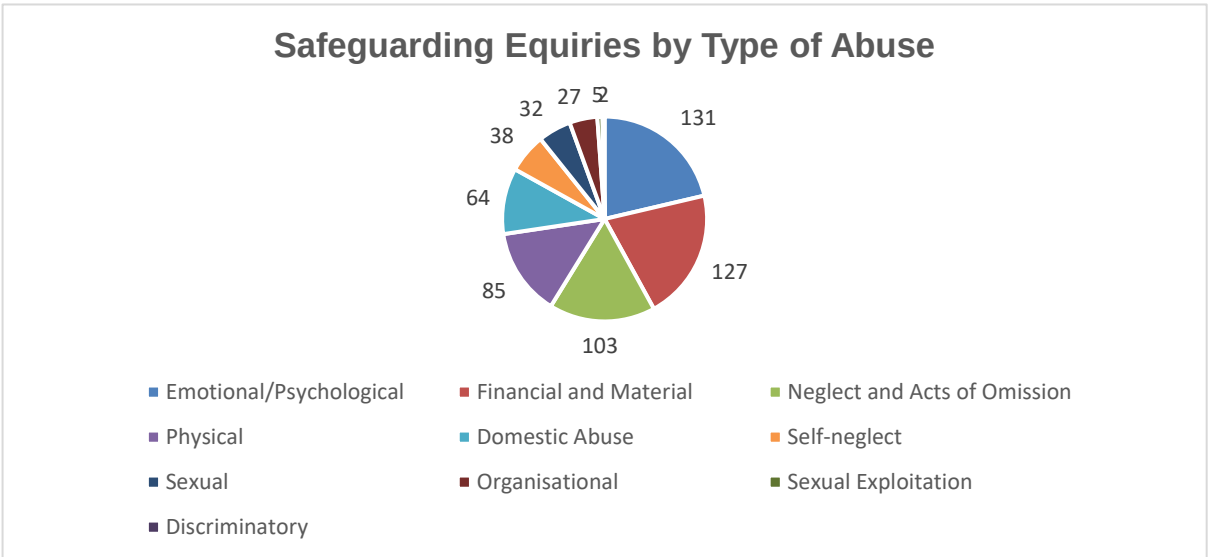
LA	Safeguarding Concerns	Section 42 Safeguarding Enquiries	Other Safeguarding Enquiries	Total Enquiries
Gloucestershire	2,314	634	84	718



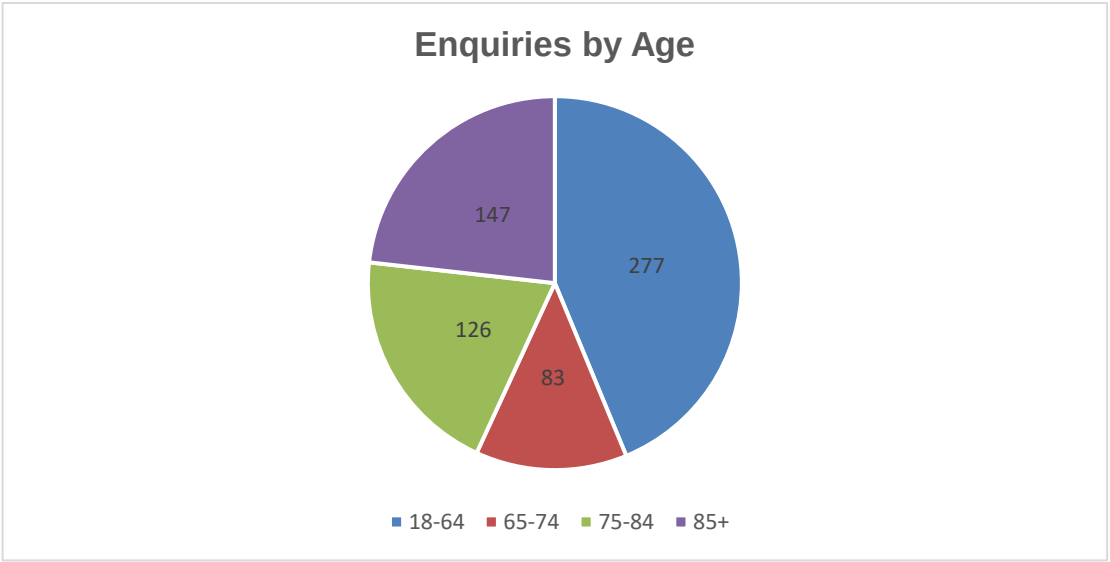
	Q1	Q2	Q3	Q4
Concern	564	656	586	508
S42	172	165	149	148
Other	10	20	25	29



	Inconclusive	No Risk	No SG Action	Risk Reduced	Risk Remains	Risk Removed	Total
Q1	12	14	18	46	7	28	125
Q2	11	18	20	45	7	26	127
Q3	8	9	16	46	5	22	106
Q4	9	15	8	54	8	35	129
Total	40	56	62	191	27	111	487



Abuse Type	Safeguarding Enquiries	Safeguarding Episodes
Emotional/Psychological	131	36%
Financial and Material	127	35%
Neglect and Acts of Omission	103	29%
Physical	85	24%
Domestic Abuse	64	18%
Self-neglect	38	11%
Sexual	32	9%
Organisational	27	8%
Sexual Exploitation	5	1%
Discriminatory	2	1%



Case Study (Names and some of the details have been changed to protect confidentiality)

Dwayne is a 27 year old male with an acquired brain injury which impacts on his impulsivity and understanding of social cues. He lives in supported living accommodation with several other young adults (males & females). He has two hours 1:1 support on three days a week, and shared support at other times (including a sleep-in).

Dwayne is an avid user of social media and has started using dating apps. During a conversation with his keyworker (with whom he has a good relationship) Dwayne indicated that one of the males he is in contact with is asking him to send him some money. The keyworker sensitively explored the issue with Dwayne, and it became apparent that the male said he is 14 years old, and if Dwayne didn't send him money 'people' would come to his home and beat him up.

Dwayne allowed his keyworker to look at his apps and it was clear that although Dwayne didn't appear to be specifically contacting underage males, there were four or five who looked to be underage out of the fifty people Dwayne was in contact with online.

Dwayne's keyworker submitted a Safeguarding concern due to the threats made to Dwayne but that same night a group of males congregated outside the home Dwayne shares with the other adults and shouted obscenities and threw eggs at the property, their anger apparently directed at Dwayne. The Police attended and dispersed the males.

The Safeguarding Practitioner who picked up this case immediately recognised it triggered the S42 duty – Dwayne has care and support needs, he is at risk of physical abuse and because of his needs is unable to protect himself (by recognising the age issue which then causes him to be at risk).

The Practitioner contacted the Police to understand their view of the risks to Dwayne, including whether any of the males who attended the property were known to them. The Police view was that their interaction with the group of males gave them some comfort that Dwayne was not at imminent danger – it was made clear to the group that Dwayne was 'vulnerable' himself and may not comprehend that what he had done was wrong. Although two of the group were known to the Police, there was nothing within that intelligence to suggest they would take matters further, and the attending officers described their discussion with the group as "productive". Nonetheless, they are aware that others within the local community may be inclined to get involved. It was confirmed that a 'marker' had been put on the property address and the local vulnerabilities officer would display a presence in the area for the immediate future.

The Practitioner also spoke to Dwayne's care provider to discuss how they were able to protect Dwayne and the other tenants, should a repeat visit by would-be vigilantes occur. Whilst staff were unnerved, the provider said they were intending to hold an urgent team meeting to discuss the issues and support the staff. All were aware and it was emphasised to them that they should not hesitate to contact 999 and their on-call manager should they be concerned about any activity in the vicinity of the home.

The Practitioner called an urgent Safeguarding meeting to include the Police, Care Provider, Dwayne's allocated social worker and a representative from the local head injury team who are working with Dwayne. Prior to the meeting, the Practitioner requested that the social worker urgently assess Dwayne's capacity to decide to use social media and dating apps, and to assist the Police in determining Dwayne's understanding of the age of consent with a view to considering any Police action towards Dwayne. A referral for an advocate to support Dwayne through the enquiry was also immediately submitted.

The meeting explored the perceived level of risk, the protective measures in place, and how Dwayne could be supported to use social media safely. It had been determined prior to the meeting that, although he is aware of the age of consent and the inappropriateness of engaging with underage boys, he had been "tricked" (in the Police's words) into the communications and they did not intend to investigate further. Unfortunately it was not possible to identify the source(s) of the profiles of the underage boys. Dwayne has agreed to be open with his keyworker about anyone he intends contacting via social media and has asked that the sleep-in staff member locks his phone in the safe after 10pm so that he is not tempted to use it without supervision.

Dwayne's social worker and care provider were both clear that Dwayne is settled where he is, and unless there is anything to suggest an increased risk, he will remain living where he is. Dwayne agreed that he will go out into the community with staff support (either his 1:1 or as a group).

A review meeting took place three weeks later, and thankfully no further incidents had occurred. Dwayne was continuing to access social media / dating apps with the support of his keyworker, no further threats had been received and no concerning activity outside the home.

This case highlights the risks that social media can pose to adults with care and support needs, particularly younger adults with cognitive impairments. This is a growing area of concern because a balance must be struck between respecting the person's right to privacy and keeping them safe from harm. In such cases the person's capacity to understand the potential risks of social media use is important.

The role of local police vulnerabilities officers is also highlighted by this case. They play a valuable part in ensuring adults at risk are protected, and their knowledge of the local community can help to support this. Working in partnership with the right agencies and sharing information appropriately are all protective factors when undertaking safeguarding enquiries, and the inclusion of an advocate helped to ensure that Dwayne's views and wishes were central to any safeguarding plan.

Update from the GSAB Sub Groups

Workforce Development

Training figures (found in supporting documents) highlight the take up of GSAB training and e-learning by partners during the year. In summary,12,478 Gloucestershire staff (and volunteers) undertook GSAB approved Safeguarding and Mental Capacity Act (MCA) courses.

Trainers and course participants have continued to embrace remote training and as things have steadily returned to normal following COVID-19 this has allowed for some trainers to return to traditional class-based learning. This blended approach has reduced the risk of an overreliance on e-learning. Also reflected in the training figures is the successful launch of a remote Safeguarding Level 4 programme. This training is bespoke, for GCC and GHC Adult Social Care staff who are responsible for undertaking section 42's.

The annual train the trainer workshop for new level 2 trainers was held in September 2021 with 18 participants. Organisations represented included Gloucestershire Constabulary, GRASAC and Health & Social Care providers. Follow up supported observations have taken place.

The annual CPD day for trainers took place virtually in November using MS Teams. The event provided an opportunity for GSAB trainers to learn and strengthen good practice as well as update their knowledge and skills to help influence local practice. Presentations were given on a range of topics from complex needs, the Liberty Protection Safeguards and the new Domestic Abuse Bill. All participates rated the event highly.

Following a SAR recommendation, work has begun to produce a bespoke Acquired Brain Injury awareness e-learning/interactive training package. The content is being developed with input from Gloucestershire Royal Hospital's Brain Injury Team, Headway and the Mental Capacity Act Governance Manager. Once finalised, the module will be available or learners to access via Learn Pro.

This year the GSAB Roadshow events have been scheduled in April 2022 over a week of morning events. They will be delivered virtually using MS Teams. The theme will be Safeguarding in a Changing World. Each day will be focusing on a specific theme including the Changing Nature of Crime, the Role of the Community, Changing Systems in Gloucestershire, and Safeguarding Is Everyone's Responsibility.

The key areas of focus for Workforce Development in 2022/23 will be awareness, prevention, and continuous improvement in learning and development.

2021/22 Training Figures can be found in supporting documents.

Fire Safety Development

The purpose of the Fire Safety Development Sub Group is to bring agencies together to safeguard adults who are at risk of fire related serious injury. There are eight risk factors which increase the likelihood of both having a fire and being unable to escape from it, which cut across health, social care and housing. This means that effective management of these risks can only be achieved by working together in a person-centred approach.

Representation at the Fire Safety Development group has been improving throughout 2021, with representation from most key agencies. The engagement of health, adult social care and housing has been consistent throughout the year and this has enabled the development of some key pieces of work. The next steps will be to bring together more regular representation from Police and Primary Healthcare who are such a crucial part of the referral and risk mitigation pathway.

Priorities and Achievements in 2021/22

An **action plan** has been produced and has been aligned with the Fire Standards Board Prevention Standards. This plan has set priorities for improving inter-agency working, training frontline practitioners from all agencies to recognise fire risks in homes and to ensure that safeguarding is embedded in all fire risk reduction activity.

National data was shared across the agencies represented by this the group and the Gloucestershire **community risk profiles** were created and published. This detailed information has helped deepen the understanding of how connections between age, health and environmental factors increase the risk of fire related injury and helped guide our work to support people who are most at risk of serious fires and fire injury in Gloucestershire. These profiles will be used to target safeguarding activity during the next year.

Hoarding behaviour is recognised as a challenge for all agencies. Hoarding is often associated with self-neglect which results in calls to the police, housing and fire. Some people who tend to hoard do not present with care and support needs but may have unmet mental health needs, making this an area that demands a multi-agency and trauma-aware approach. Work is underway on a multi-agency approach, initiated by work in Gloucester City Council and funded by GFRS, to train staff across the County and to offer a support network and advice forum to people who hoard in the first steps to managing this behaviour and reducing risk.

There are two main strands of fire prevention work underway; firstly to identify and engage with people who have the highest likelihood of a serious fire and who are more likely to have both lifestyle and environmental risk factors, which make it difficult to self-rescue from such a fire, and secondly to provide education and advice to the larger but lower risk group who have domestic dwelling fires but with less serious outcomes. This work is being informed by the analysis of Gloucestershire data to focus on the highest risk whilst improving education and information to reduce it for all residents.

Priorities for 2022/2023

Homelessness and Fire. It is recognised that having set fires can make it more difficult for people to access housing and convictions for arson can result in eviction and homelessness. This year, the group will focus on how we can support people who may be denied accommodation, by working with agencies to reduce the risk and advise providers on risk mitigation measures.

Cost of Living Crisis and Energy Costs. The group will be monitoring trends in dwelling fire and injuries associated with the use of unsafe forms of heating. We will find ways to communicate with people who are most at risk of being injured by using unsafe equipment and seek to reduce the impact of the rise in the cost of living and energy price rises.

Adopting the Multi-agency Risk Management Framework. The group will support the introduction of the new framework which is seen as a way to support agencies working with complex cases. This will enable the group to focus on Safeguarding those people with care and support needs and at risk of fire, and safeguarding people who do not meet the threshold for social care to remain safe and as independent as possible, with their wishes and voice at the centre of those decisions.

Communication & Engagement

Achievements 2021/2022

- Held quarterly meetings of the sub group to support delivery of the GSAB Strategic Plan, specifically the communications and engagement work within the plan.
- Sub group board members taking responsibilities for supporting content creation for the newsletter.
- Coordinated, organised and chaired the Safeguarding Adults Roadshow 2022, focussing on Safeguarding in a Changing World. This was provided as an online series of events over the course of a week, each day focussing on a particular safeguarding theme.

  This included:
  - **Changing Systems** – Trauma Informed Approach, Integrated Care System and Community Mental Health Transformation Framework.
  - **Changing Nature of Crime** – INCEL, Modern Slavery, Cyber Crime
  - **Changing Nature of Community and its response to safeguarding** – Hate Crime

- 16 presentations were delivered throughout the week to over 200 people.
- Highly positive feedback was received for the events, which provided us with an opportunity to inform people about the amazing work happening in Gloucestershire to support some of the most vulnerable people in our communities.

Priorities for 2022/2023

- To further increase the diversity of voice on the sub group, to ensure it is representative of our communities and able to communicate effectively with those communities.
- Develop a plan to engage more effectively and impactfully with the Public on safeguarding issues. We have developed a strong network of professionals from across a variety of sectors, however, a gap in our communications is with the general public. We need to put more effort and be more creative in how we engage with the public and communicate directly with them.
- Continue to develop the Safeguarding Roadshow to new audiences and build on the success of the last two years.

Quotes from the Roadshows:

"We need professional curiosity!"

"The trauma informed presentation was inspirational"

"Communication is key, let's get everyone talking!"

Policy & Procedures

Achievements for 2021/22

Meetings have continued to be virtual, due to COVID-19. 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:

- Out of Contact Protocol was reviewed and updated in April 2021
- Information Sharing Guidance was reviewed and updated in April 2021
- Whistle Blowing Guidance was reviewed and updated in April 2021
- Making Safeguarding Personal (MSP) Guidance was reviewed and updated in October 2021
- Safer Recruitment Guidance was reviewed and updated in November 2021
- Escalation Protocol was reviewed and updated in January 2022
- Production of the new Medication Errors and Safeguarding Guidance in January 2022
- Production of the new Safeguarding vs safeguarding Guidance in January 2022

Priorities for 2022/23

- The creation of a Multi-Agency Risk Management (MARM) Framework
- Review of the High Risk Behaviours Policy, after the completion of the MARM
- Updating of the Safeguarding Adults Review (SAR) Protocol, in line with the new SAR Quality Markers
- Review of the Positions of Trust Framework
- Finding a new chair for the sub group

Audit

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 audits have continued on a bi-monthly basis and continue to be well supported by multi agency partners. All audits have been conducted virtually via Teams and have focused on the following areas:

Self-neglect
Dementia
Deep dive repeat concerns
Mental health enquiries
Deep dive complex alcohol misuse/self-neglect
Financial abuse

The deep dive audits provide a valuable opportunity to examine a single case and yield rich qualitative learning. Established routes for disseminating the learning are employed, including Workforce Development and other Board sub groups, and the actions log continues to provide a means of monitoring the actions arising from each audit.

Domestic abuse and section 42 enquiries has emerged as an area for further audit activity during 2022-23, and issues that arise from statutory reviews (e.g. Domestic Homicide Reviews, Safeguarding Adult Reviews) will be incorporated into the audit schedule for the coming year.

Learning from our Safeguarding Adults Reviews

A key statutory duty of the SAB is to carry out Safeguarding Adult Reviews (SARs) as appropriate under Section 44 of the Care Act.

The Safeguarding Adults Review (SAR) sub group are responsible for deciding whether a SAR referral meets the criteria for a S44 Review under the Care Act (2014). Decision making on each referral follows the identification of relevant agencies, information gathering and subsequent analysis. As SARs are progressed, the group works together on all proposed recommendations, ensuring that key learning is cascaded.

Headline Themes from Recent SARs

Adverse Childhood Experiences (ACEs) and the need for a trauma informed approach and working practices

Safeguarding Adults Reviews

For the year 2021/22, no new SARs have been commissioned, one is ongoing and two have been published. A new SAR and Learning Event have recently been commissioned and these will commence in autumn 2022.

JK Learning Review (Ongoing)
As an adult, JK, a care-leaver sustained life changing injuries from a drug overdose. The joint review, with the Gloucestershire Safeguarding Children's Partnership (GSCP) is nearly complete and due to report in August 2022.

Overview of SAR referrals received 2021/22

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	Nil	JS	CA AG	PP MM MON
Referral Source	-	Gloucestershire Constabulary	Gloucestershire Constabulary (for both)	LeDeR Review GHC DASV Strategic Coordinator
SAR Undertaken	-	0	0	1
Name	-	-	-	MM
Learning Event	-	0	1	0
Comments	-	-	-	-

SAR Case Referrals 2020/2021:

JS – A case for concern was raised (Q2) by Gloucestershire Constabulary following concerns about a care home resident. A GCC Investigation was undertaken, and the learning is being taken forward.

CA – A case for concern was raised (Q3) by Gloucestershire Constabulary following a homicide. This did not meet the criteria for a SAR, but an independent review is being undertaken.

AG – A referral was made (Q3) by Gloucestershire Constabulary following the death of care leaver. Individual agencies undertook their own investigations and learning was identified. It was agreed that a SAR would not illicit any further learning, but that a one-off learning event looking at individuals with complex needs would be beneficial. This will be held in the autumn of 2022.

PP – A referral was made (Q4) following a LeDeR Review, after information gathering was completed, it was agreed that the case did not meet the criteria for SAR as there were no concerns about how agencies worked together.

MM – A referral was made (Q4) by GHC following the death of a man, with care and support needs, there was suspected financial abuse and possible neglect. It has been agreed that a SAR will be undertaken, which will begin in the autumn of 2022.

MON – A referral was made (Q4) by the DASV Strategic Coordinator at Gloucestershire Constabulary. Information gathering did not highlight care and support needs. This was already being progressed as a Domestic Homicide Review (DHR).

Recently published SARs
The full SAR reports can be found at: http://www.gloucestershire.gov.uk/gsab/

Peter SAR

Peter was found deceased by a member of the public in Cheltenham in November 2019. Peter had been street homeless for approximately six weeks. The Coroner's Report records the cause of Peter's death as 'drug toxicity/drug related death'.

Peter was a man of white British heritage, aged fifty-nine when he died. He was well known to a range of services within Gloucestershire due to experiencing enduring mental health issues, intermittent homelessness and dependency on alcohol and drugs. Usually related to his dependencies, Peter was a suspect (and victim) in many criminal offences.

Key Learning Points:

When working with individuals with complex needs, agencies need to share information, including the positives and strengths of the person, to ensure a holistic picture is formed.

Trauma-informed practice needs to be embedded across all agencies in Gloucestershire. Sharing tools and examples of good practice between and across agencies around this topic would help partnership working and transfer of theory to practice particularly with complex cases.

Compassionate persistence is needed when working with complex individuals. And multi-agency perseverance is needed if a situation is high risk and an individual is not engaging.

Where there is a possibility or a suspicion that an individual may have an Acquired Brain Injury which is masked by the person's alcohol or drug use, professional curiosity needs to be demonstrated and further exploration advocated.

Any multi-agency meetings need to record and monitor actions and outcomes within a multi-agency Care Plan. A Lead Professional should be identified to coordinate such meetings. Partners to be made aware they can challenge outcomes, engagement from agencies and utilise the GSAB Escalation Policy if appropriate.

Supervision policies should ensure that supervision for all staff within all systems includes reference to Safeguarding Adults, space to critically reflect on cases and learning, support for and checks regarding learning transfer, and monitoring need for, and uptake of, Continuing Professional Development.

Protected time around Continuing Professional Development and reflective supervision needs to be created and maintained within and across all systems and agencies.

The Five Women SAR

A request for a Safeguarding Adults Review (SAR) was made by the Nelson Trust, to learn from the circumstances of the deaths of five women in Gloucestershire between November 2017 and September 2019. The Nelson Trust is a charity that works with women who have multiple and complex needs and at the time of their deaths, all of the women were all engaging with their service.

The five women were known to a range of statutory and non-statutory services. They all experienced childhood trauma. Three had been in the care of the local authority during childhood. All experienced trauma in their adult lives. Their deaths, between the ages of 19 and 43, were related to their drug use.

The review aimed to better understand how the county can work to support similar vulnerable groups.

Key Learning Points:

One service cannot address the needs of marginalised groups alone. The role of all organisations involved should be identified and understood in order to create an effective system around the person.

For some individuals, mental health issues arising from childhood and adult trauma must be addressed as part of any plan to address substance misuse, self-harm or similar behaviours.

Coordinated and timely responses are often needed to meet the needs of marginalised groups. Organisations must be aware of how 'windows of opportunity' may present and use this understanding in building and contributing to contingency plans.
When engagement with services is vital, organisations in the system around the person must work with the person to identify and support an engagement plan, including engagement strategies, contingency planning and avoidance of re-traumatisation.

Statutory organisations (local authority, police, health) can benefit from awareness raising activities about the lives of the women and other marginalised groups with the intention of improving the identification of exploitation, duress and coercion, understanding the basis for self-neglect and self-harming behaviours, and how care and support needs may be indicated in this group.

It is essential that all organisations are aware of the impact of trauma on the lives of people and on how they present to and engage with services, as well as the trauma aware or trauma informed approaches that can be attempted.
The development of an improved pathway for care leavers, which should also consider care leavers who are being supported by another local authority whilst living in Gloucestershire. The pathway will also include young people who have not been in care but who are being exploited or are in circumstances presenting a risk to life.

Case Study (Names and some of the details have been changed to protect confidentiality)

Brenda is a 78 year old woman who has COPD, a minor sight impairment and reduced mobility following a stroke in 2018. She is a wheelchair user and lives in a quiet village where she keeps herself to herself. Brenda has no family nearby.

A Safeguarding concern was raised by a neighbour in relation to a female who befriended Brenda during 2020 and offered her assistance with shopping and other tasks. The neighbour explained that the female had posted leaflets through residents' letterboxes during the early days of the first lockdown. As it's a small community the female is known to a degree by the neighbour. The neighbour considers her to be quite rude generally but she observed a few concerning interactions between Brenda and the female over the previous few weeks, including a row that reduced Brenda to tears and a comment from the female to the effect of "it's not like you pay me much, despite having all that money". The neighbour said she appreciated it was just a suspicion but she felt something wasn't right.

A Practitioner picked up the concern and called the neighbour who confirmed that she had spoken to Brenda about her concerns, and that didn't put her mind at rest. Brenda had seemed edgy and said "you can't expect people to do something for nothing". The neighbour asked Brenda if she would like some help from "Social Services" and although initially reluctant, she conceded it might help.

The Practitioner was able to identify Brenda's GP through her Adult Social Care records and a call to him gave a bit more background into Brenda's health conditions. The GP said Brenda hadn't been to the surgery for the last 4 months but she was accompanied by the female at her last appointment and the GP recalled her being "a bit overbearing". The GP suggested the Practitioner speak to the local vulnerabilities officer.

The Practitioner did call the officer and she was very helpful – she was aware of the female and had concerns as she was previously suspected of a fraud offence, although there was scant evidence and therefore no conviction. "Words of advice" had been given in relation to her offering her services but this was very general as the Police could not prevent her offering to help the vulnerable in the village. However, the officer felt that Brenda was likely to be the only person using the female's services given the social connections between most of the other members of the community. The officer further disclosed that Brenda was from a particularly wealthy family and would be a "prime target" for someone wishing to exploit her financially.

The Practitioner determined that the case triggered the Section 42 duty. Consideration was given as to whether Brenda agreeing to "help from Social Services" constituted consent to a Safeguarding concern being raised on her behalf. Given the observations of the neighbour, the information from the Police Vulnerabilities Officer about both Brenda and the female, and given that Brenda would be expecting to be contacted by the local authority, it was deemed appropriate to proceed.

The case was passed to the local Adult Social Care team to meet with Brenda at a time when the female was not around, to talk about the concerns and find out what Brenda's views and wishes were around both the concerns and her care in general. A social worker spoke to the neighbour and identified that there was a clear pattern to the female's visits, so a call was made to Brenda when it was known she would be alone, and then a visit arranged. The worker struck an instant rapport with Brenda who opened up about the cruel things the female would say, which had severely dented her confidence, particularly as she was still coming to terms with her stroke. Brenda allowed the worker to look at some post that was in the kitchen, including a bank statement. Brenda asked the worker to look and see if anything seemed remiss, and instantly she spotted several debit card payments to a bookmakers. The worker reflected afterwards that she felt Brenda knew that the female was not trustworthy, hence her willingness to have her bank statement looked at.

With support, Brenda felt able to report the matter to the Police. It was identified that the female had stolen £6000 from Brenda, although the thefts had only occurred relatively recently, so it was a large amount and in a short period. It seemed that the female had considered she'd ingratiated herself sufficiently with Brenda to start stealing from her. It was also identified that Brenda was paying the female £500 per week for very basic assistance, although the Police could not take this further in spite of it being considered excessive as it was an agreed amount (and a capacitated decision on Brenda's behalf).

With the social worker's assistance Brenda moved into nearby sheltered accommodation and has carers visiting her five days a week. One of Brenda's nephews was contacted on Brenda's behalf and he agreed to assist Brenda to manage her money – although he was a "favourite nephew" Brenda had not wanted to trouble him in the past.

Brenda's circumstances made her 'situationally vulnerable' to the abuse she experienced – her isolation was compounded by the pandemic restrictions which made it easier for the abuser to exploit her. The vigilance of her neighbour and her reporting her concerns to the local authority show the value of working to ensure that members of the public, and not just professionals, understand what to do if they are concerned that someone with care and support needs may be at risk of abuse.

Consent is usually required prior to taking any action, however there are circumstances when that can be overridden. In this case the local authority could have proceeded with the enquiry without Brenda's implied consent as other people were potentially at risk of abuse and exploitation by the individual.

Statutory Partners

Gloucestershire Health and Care NHS Foundation Trust (GHC)

Throughout the last year, the pandemic has continued to have a significant impact on GHC service provision and the pressures faced by our operational teams has been considerable. The Trusts Safeguarding Team has remained a priority 'ring-fenced' service and has continued to deliver on core areas of work, which include; training, staff advice line, safeguarding supervision, MARAC Information Sharing, MAPPA and Prevent work, safeguarding related audit, GSAB membership and contribution to sub groups, and participation in safeguarding related reviews.

2021/22 notable achievements include:

- The establishment of a regular adult specific Safeguarding Group Supervision to priority operational teams. Teams include the Homeless Health Care, Mental Health Recovery and Assertive Outreach, and Integrated Care Teams. One-to-One safeguarding supervision is now available on request, which is a new offer
- Since October 2021 GHC have two Mental Health Independent Domestic Violence Advisors (MHIDVAs) employed by GDASS, but working with our Mental Health Hospitals and Community Mental Health Teams. The MHIDVs are providing staff with domestic abuse and Domestic Abuse Stalking and Harassment (DASH) Tool training, raising awareness of domestic abuse, developing a network of domestic abuse champions and taking direct referrals from mental health teams
- Successful recruitment of an additional Specialist Practitioner for Safeguarding Adults and a MARAC Administrator, who co-ordinates MARAC information sharing requests and action plans
- Due to the pandemic safeguarding training was put on hold throughout much of 2022/21, whilst new virtual training packages and platforms were developed. 2021/22 has seen the recovery of our delivery of Level 2 Safeguarding Adult/Children Training and Level 3 Safeguarding Adult Training. This is reflected in training compliance rates.

Priorities for 2022/23:

- Further work is required around the effective application of the MCA and DoLS in GHC. In June 2022 we re-commenced our MCA training programme and in July 2022 we will be welcoming a new role in the Trust, MCA/LPS Lead. The postholder will work with the safeguarding team and operational teams to audit, improve, and oversee the use of the MCA. The postholder will also lead on our Liberty Protection Safeguards preparatory work, including the establishment of a GHC LPS Implementation Group
- Develop domestic abuse and DASH training for all staff. This is in line with the action plans of recent Domestic Homicide Reviews
- To establish a robust system of safeguarding support/oversight with Section 42 enquiries. This system is currently being developed in communication with the GCC Adult Safeguarding Team. This work includes the expansion of Level 4 Safeguarding Adult Training for GHC Team Leads and Care Co-ordinators and improved case management supervision
- Develop innovative ways to improve the dissemination and application of learning from SARS, DHRs, Serious Incidents, audits and complaints, and to consider ways of how to measure the impact of that learning

Quality Assurance

GHC will continue to provide assurance to the GSAB that safeguarding priorities are in line with best practice and evidence positive outcomes for families. We will monitor our safeguarding annual plan to ensure they are delivered in line with the Safeguarding Board strategic agenda through the Trust's Safeguarding Group and Quality Committee.

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)

Gloucestershire Hospitals NHS Foundation Trust was focused on both managing patients with COVID-19 and with trying to meet the backlog of demand for healthcare built up during the pandemic. This has been made more difficult by considerable levels of increased care need and reduced availability of residential and nursing care homes in the county, which are the major root causes of the congestion inside and outside our Emergency Departments.

Nevertheless, our staff have identified and raised concerns on 996 occasions related to abuse, neglect or self-neglect in patients aged 18 years and older. Of these, 273 (27%) met the threshold for referral to Adult Social Care for consideration of a Section 42 enquiry although fewer still had those safeguarding concerns substantiated.

We remain concerned about levels of domestic abuse. Our staff found a total of 421 cases in non-maternity areas, this is an increase of 9% on the previous year and echoes findings in other agencies.

Our midwives identified 839 pregnancies of concern, in 20% of which domestic abuse was the concern. This is an additional 168 female victims of domestic abuse.

Activity and Performance

Our staff have identified 996 occasions during 2021/2022 when they had safeguarding concerns for adults. This is less than half the number of concerns raised in the previous year, but with a far higher proportion of referrals warranting consideration of a section 42 enquiry.

Once again, the concerns which do not reach the threshold of referral for consideration of a section 42 enquiry divide into two major themes of older people with increasing care needs and deteriorating mental health. These issues can be addressed by other teams in the hospital, leaving the Safeguarding Team to work with the smaller areas of concern which require more intensive support such as homeless patients, modern day slavery, sexual assault, ensuring associated children are safeguarded and working with Patient Safety and security colleagues to address criminal behaviour by patients.

We have taken an active part in all the LeDeR reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews and have incorporated all the applicable recommendations into our processes. In the year ahead, this will enable us to move to providing assurance for Community Safety Partnerships that our processes meet current best practice.

There are always a few safeguarding allegations against our hospital services and staff. When investigated, most of these are due to inadequate numbers of staff for the numbers and needs of patients or some misunderstanding about care needs or the legal basis on which we are allowed to make decisions.

Progress against priorities

Last year we were able to report that safeguarding risk assessments are now embedded as part of routine ward admission processes. This year we can report that with the roll-out of our Electronic Patient Record into our Emergency Departments safeguarding risk assessments for all ages are now routine on arrival to and departures from Emergency Care. The next phase will see these rolled out to Outpatients.

In September 2021 we radically altered our Safeguarding Adults training to pre-recorded on-line videos supplemented with live virtual training over MS Teams. We are seeing levels of compliance of over 95% at level 1 and over 70% for both 2 and 3.

Within this reshape we chose to make Mental Capacity training mandatory at levels 2 and 3 as this is so fundamental to safeguarding practice. We are therefore assured that levels of Mental Capacity knowledge have increased and practitioner intelligence indicates that safeguarding referrals and incident reports now routinely make comment on whether or not a patient has capacity. This is reassuring ahead of preparations for the introduction of Liberty Protection Safeguards, but we are well-aware that this needs constant attention.

We also chose to make 2 hours of training on domestic abuse mandatory within level 3 Safeguarding Adults training, reflecting our concerns about the number of patients this affects at all times, not just in a year when we are the recipients of disclosures.

We continue to attend to policy revisions and have revised both our Safeguarding Adults and Deprivations of Liberty Safeguarding policies during the year, to reflect updated legislation, GSAB policies, training and processes.

After successful results from the SHarED project, in which we participated with the West of England Academic Health Sciences Network (WEASHN) we are now working alongside the CCG to review high impact users of all health services in the county and putting individual tailored plans in place, including allocation to Social Prescribers to prevent safeguarding concerns reaching legal threshold levels. This is proving very popular with the patients concerned, who overwhelmingly say that no one has ever listened to them before.

Achievements

We are really proud of the increasing skill of our staff in recognising subtle signs of potential safeguarding needs, despite the incredible demands on our services. They have noticed, taken time to be professionally curious, asked for help and guidance early and followed policy and process.

Whilst we continue to award ‘Safeguarding Stars’ to staff whose practice has been exemplary, it is the daily vigilance of all staff which makes the very small percentage of abused or neglected people visible.

Gloucestershire Clinical Commissioning Group (GCCG)

Recovery from the Covid-19 pandemic has been a priority through the past year. The impact of the Covid pandemic continues to impact in terms of how we work and demand on health and care services. Though we are gradually encouraging staff back into the office, the use of virtual platforms to meet, for training and for forums continues to be very popular and we have no plans to change at the moment.

The key areas of work in 2021/22 included:

The GP Safeguarding Forums continue to be well received, using MS Teams as a virtual meeting place and interactive learning venue, with a significant number of practices attending. Presentations and briefings included a Prevent update, the Domestic Abuse Act 2021 update, Liberty Protection Safeguards update, a presentation on the new policy from GSAB ‘Safeguarding vs safeguarding’, an update by the safeguarding lead from ‘Change, Grow, Live’, a presentation on ‘Child on Parent abuse’ and an update from the GP Development Support Worker from GDASS.

The Safeguarding Team and Named GP have been keen for Safeguarding to be specifically included within GP enhanced service contracts, in-line with best practice seen in other counties and allowing the CCG to be more effective in holding Primary Care to account in this extremely important area. From April 2020, Safeguarding has formed part of the Primary Care enhanced service offer. Due to the pandemic this was extended into the 2021/22 contract and it is hoped this will continue in future years.

We continue to see good impact and continued engagement across GP Practices in these areas:

- Sharing national guidance regarding Covid-19 related Safeguarding advice

- Safeguarding Lead GPs and Practice Managers are continuing to sign up to GSAB/GSCE newsletters and alert systems, supporting the dissemination of wider Safeguarding information and training.
- Recognising the rise in Domestic Abuse; there are an increased number of Domestic Abuse Champions in Primary Care.
- We have held two Practice Manager Safeguarding forums with many practices attending. The presentations were delivered on Information Sharing when there is a safeguarding concern, the Domestic Abuse Act and information on how to sign up for GSAB newsletters.
- In December 2021, some local hotels were commissioned by the Home Office to receive refugees and asylum seekers into Gloucestershire. The safeguarding team have attended the Asylum Seeker Contingency Hotel Health Sub-Group Meetings to ensure a robust safeguarding presence and to give safeguarding support and advice. This attendance is now included at the Health Ukrainian Sub-Group, to advise in this area.
- Safeguarding staff attend the Integrated Care System's Oversight Panel for Learning Disabilities which reviews the care and placements for our residents who are placed in inpatient units or secure accommodation. The aim is for the safeguarding team to provide safeguarding advice and support when reviewing and discussing these complex individual cases, which is undertaken by a group of Gloucestershire senior clinical and care professionals. These reviews were initiated following the Cawston Park Safeguarding Adult Review and are designed to ensure that there is greater oversight of service users placed in specialist accommodation.
- A joint project was agreed between Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Health and Care NHS Foundation Trust and NHS Gloucestershire CCG to explore the opportunity the Integrated Care System could bring to the integration of the three organisation's safeguarding teams. The project has been overseen by a project board and nine task and finish groups have been established to explore a variety of areas that can be integrated. The teams are keen to work closer together, with an eventual aim of full integration sometime in the future.

Looking towards 2022/23:

Liberty Protection Safeguards; Mental Capacity (Amendment) Act
After a long delay, the consultation on the draft Code of Practice that is required to support the enactment of the new processes for Liberty Protection Safeguards has been announced. Liberty Protection Safeguards (LPS) will replace the current Deprivation of Liberty Safeguards (DoLS) and this new process for authorising deprivations of liberty for patients who are unable to make the decision for themselves will impact on health organisations, as they are required to become responsible bodies. The actual implementation date of the Act is unconfirmed but is understood to be not before October 2023.

CCG Safeguarding Team
There are changes within the safeguarding team at the CCG. The Adult Safeguarding Lead has left after 6 years in post and a successful replacement has been appointed to a new role of Assistant Director for Integrated Safeguarding and Designated Nurse. A new post of Adult Safeguarding Manager has been created which will be appointed to in the early summer of 2022. The team are looking forward to welcoming the new team members and consolidating the good progress made over recent years.

Gloucestershire Constabulary

Since its launch in March 2021, the Constabulary has been developing "Our Approach to Vulnerability".

Strategic Intention
Keeping those who become vulnerable safe from harm is an incredibly important part of the service we deliver. The way in which we police Gloucestershire now will affect attitudes and culture long into the

future. It is not an easy challenge and is not made any easier by the competing pressures across the public sector. However, we know that getting it right now will make a positive difference to vulnerable people as well as reducing future demand.

We will:
• Promote the safety, welfare and well-being of all vulnerable children, young people and vulnerable adults
• Listen to vulnerable people and respect their opinions. This may not affect the way we utilise the criminal justice system but we will consider alternative avenues for addressing behaviour. We will not unnecessarily criminalise vulnerable people
• Identify, respond to and protect all vulnerable children, young people and vulnerable adults from harm. We will be pro-active in our approach, including to those who may be vulnerable to exploitation
• Gather and analyse information and intelligence about those who seek to exploit vulnerable children, young people and adults
• Respond to calls for service, together with multi-agency partners, from the perspective of 'vulnerability first', considering the needs of any victim and identification of any offender
• Assess all the circumstances of vulnerable people. Every interaction is both an intervention and an opportunity. Our engagement will be positive and opportunities will be sought to enhance our relationship with vulnerable people. At all times, we will carefully consider the necessity for the detention of the vulnerable in Police custody
• Record vulnerabilities accurately, supporting our assessment of risk, understanding, analysis and future engagement
• Share our information and intelligence with partners, working together to keep vulnerable children, young people and vulnerable adults safe from harm, via safeguarding and proactive investigation

Our priorities for 2022-2023 will be to further develop the new Safeguarding Adults, Missing & Mental Health (SAMM) team alongside the Vulnerabilities officers working within local policing 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.

Restructuring and development
The SAMM team has been established within the Public Protection Bureau and despite resourcing challenges has begun to bring cohesion across the Constabulary. Serious crimes are investigated by trained staff within the Investigations command and each local policing area has designated Vulnerability officers who regularly identify the vulnerable and work collaboratively to improve the situation and reduce the risk of harm.

Demand
The growth previously reported has stabilised however continues to represent a significant increase on previous referrals. We are now seeing around 800 VISTs each month and with the overall increases this is challenging to service. We are working to improve the thresholds for submission to better manage those referrals that require additional safeguarding and looking at better signposting to those that do not require services but could benefit from support networks. The MASH decision makers continue to triage every referral and make decisions and onward referrals to the most appropriate agencies. The acceptance rate with ASC remains high indicating that this is much more consistent with thresholds.

The BOTS technology previously mentioned has not resulted in successful deployment due to poor data quality however the Constabulary is shortly to commence a project on replacing our Core Records Management system which allows the opportunity to address these issues. This is an exciting development however due to the scale will take up to 4 years to become embedded. This will also be consistent with 29 other UK police forces, allowing a more consistent approach and process and enable more seamless cross border referrals.

Police Case Studies

A 70 year old male who is visually impaired, disabled and was living in squalor as he was not able to look after himself. He can be volatile and hence many agencies would not deal with him. He was at risk of losing his tenancy from his council bungalow due to anti-social behaviour towards his neighbours.

This male caused a great impact on local services. He was calling multiple times daily both the Police and Ambulance Service on their 999 systems. Between Christmas and Easter this male had called the Police up to 300 times on 999. He was also the suspect or victim of multiple crimes in the same period.

Police safeguarding got involved and set up a collaboration of professionals to try to help this male improve his life circumstances. The desired outcome of this would be reduced demand on both Police and Ambulance resources.

An email chain was set up between Police Safeguarding, Adult Social Care, P3 and Housing. Police Safeguarding also liaised with the man's GP.

This led to the following actions:
The male was treated for an infection. He had a mental health assessment and was prescribed the correct medication. Funding was applied for by the Police, P3 and the District Council to provide a deep clean to the male's property to protect his tenancy, a new fridge/freezer as he had no way of storing food, a new washing machine as he could not keep clean, waste removed from his property and the garden tidied.

This male has effectively had a reset of his life. It is a work in progress and the collaboration continues. He is much improved and hardly ever calls the Police or Ambulance service which greatly reduces demand on both services.

A young female adult living in supported accommodation with an eating disorder and emotionally unstable personality disorder. This female also has frequent thoughts of suicide and is at risk of self-harm.

Around Christmas 2021 this female was presenting to either train tracks or high buildings in an emotionally volatile state threatening to take her own life four times a week. This had a significant impact on Local Police resources, delays to train journeys, the town centre being cordoned off in case she jumped from the roof of a high building, and multiple detentions under section 136 of the Mental Health Act 1983.

Police Safeguarding now meet regularly with this female and take her for a coffee. This gives an opportunity for her to vent frustrations. She has also been given the option that when she is triggered and wants to flee her accommodation she can come directly to the Police Station rather than heading for the train tracks or high buildings.

This intervention has resulted in a significant reduction in incidents in relation to this female, which reduces demand on Police resources, prevents disruption to the community, and reduces demand on the 136 Maxwell Suite.

This is ongoing work which takes one officer 1-2 hours every 3 weeks.

Financial Summary

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.

CORE BUDGET INCOME AND EXPENDITURE 2021-22

Partner Contributions	Amount
Clinical Commissioning Group	38,877
Gloucestershire Constabulary	20,440

GSAB Business and Activity Costs	Expenditure 2021/22
Independent Chair	20,000
Other Staffing (Includes 30% Head of Safeguarding Adults, 100% GSAB Business Manager, 15% Admin Manager and 100% Administrator)	101,400
Workforce Development	65,000
Safeguarding Adult Reviews (SARs)	20,000
Comms and 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.

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.