

South Gloucestershire

Safeguarding Adults Board

Annual report

2018-2019



Foreword from the Independent Chair

It is my pleasure to welcome you to the annual report of the South Gloucestershire Safeguarding Adults Board [SGSAB]. This report covers the period between April 2018 and March 2019.

I believe the report reflects the commitment of all Board partners as we strive to achieve our published priorities. Certainly, the engine house of the boards business – its subgroups, have each had a very busy and productive year. Details of all subgroup activities can be found within the body of this report.



One achievement during this reporting period has been the establishment of a "Prisons subgroup" and I thank the strategic leads from each of the 3 prisons within South Gloucestershire for their support and drive to make this happen. Very early benefits of this new subgroup are highlighted within the report.

During the year I have had the opportunity to attend several training courses both for my own development and to dip sample the quality of training provided by the Board to our partners. Suffice to say, I learnt a great deal and I was able to report back to the Board the value of the courses provided.

I have also had the opportunity to attend and partake in two conferences, one focussed on domestic abuse the other on mental capacity and again I refer readers to the more detailed reviews and positive feedback reports later in this document. Planning and preparing successful events such as these take a huge amount of time and effort but equally as important as the organising of such events is the development into daily practice of the learning taken from such occasions. I look forward to checking and testing that learning over the coming months.

Summary details of a Safeguarding Adults Review carried out within this reporting period plus a hyperlink to the full report are contained within this document. The action plan agreed by the Board following the publication of the review plus the embedding of the learning from that review is an ongoing piece of board business. Progress of that work can be monitored through the Boards minutes.

I would like to thank all subgroup members for their commitment which, without exception, is provided in addition to their individual roles within their own organisation. I would also like to thank colleagues who sit on the board for their ongoing commitment to the purpose and objectives of the board.

Tony Oliver

Independent Chair

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The South Gloucestershire Safeguarding Adults Board's (SGSAB) Annual Report is designed to give an overview of the multi-agency work across South Gloucestershire in pursuit of the Government's aims to:

- Stop abuse or neglect wherever possible
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- Safeguarding adults in a way that supports them in making choices and having control about how they want to live;
- Promote an approach that concentrates on improving life for the adults concerned;
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect;
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and
- Address what has caused the abuse or neglect.

The report provides information about South Gloucestershire generally, about the Board and what it does and then goes on to provide information about safeguarding activity. This information covers both the safeguarding activity to individuals and also the work of the Board and its sub-groups to monitor, support and improve the services available. At the end of the report is a statement of the plans for the year 2019-2020

In line with statutory requirements and best practice the SGSAB annual report and 2018-2020 business plan will be shared with:

- The Director of Children, Adults and Health
- The Chief Executive
- The Police and Crime Commissioner
- The Children, Adults and Health Cabinet
- The Health and Wellbeing Board
- The Safer and Stronger Communities Strategic Partnership
- The Safeguarding Children Board

This report has been authored by Sarah Taylor, Safeguarding Board Business Manager with the assistance of several contributors including sub group chairs, performance analysts and the independent chair.

The report was approved by SGSAB on 5th September 2019 and published on the SGSAB website on 6th September 2019

Should you require the report in any other format to support accessibility please contact Sarah Taylor with your request: sarah.taylor2@southglos.gov.uk

Glossary of Terms

Glossary of Terms

BNSSG Bristol, North Somerset, South Gloucestershire Clinical Commissioning

Group

CPD Continuing Professional Development

CQC Care Quality Commission

DA Domestic Abuse

DBS Disclosure and Barring Service

DV Domestic Violence

FGM Female Genital Mutilation

GP General Practitioner

LA Local Authority

LSAB Local Safeguarding Adults Board

LSCB Local Safeguarding Children Board

MAPPA Multi Agency Public Protection Arrangements

MARAC Multi Agency Risk Assessment Conference

MISPER Missing person

PREVENT A government programme aimed at preventing radicalisation

SAR Safeguarding Adult Review

SGSAB South Gloucestershire Safeguarding Adults Board

SGSCB South Gloucestershire Safeguarding Children Board

The Board

From April 2015 with the implementation of the Care Act 2014 the Safeguarding Adults Board (SAB) has been placed on a statutory basis. Prior to that it functioned as a multi-agency partnership following No Secrets Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (Dept. of Health 2000).

The overarching purpose of a 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

SABs have three core duties. 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 for these.

The main objective of the Board is to improve local safeguarding arrangements and ensure partners act to help and protect adults experiencing, or at risk of neglect and/or abuse. The SGSAB is a multi-agency strategic Board that will coordinate the strategic development of adult safeguarding across South Gloucestershire, ensure the effectiveness of the work undertaken by partner agencies and organisations in the area and promote the safeguarding of adults within South Gloucestershire through working together. This involves raising awareness of adult safeguarding to reduce abuse and protect adults at risk. Where abuse is found to have occurred, agencies work together to support future protection and recovery.

The SGSAB has an independent chair – Tony Oliver. Tony is accountable to the Director of Children, Adults and Health at South Gloucestershire Council. The SAB structure can be seen in Appendix One. The Memorandum of Understanding for Board members is shown in Appendix Two. Board membership and attendance for the year 2018/19 can be seen in Appendix Three and a Financial Report is at Appendix Four.

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. It gave local authorities new safeguarding duties and as a result of this Act, Safeguarding Adult Boards became statutory.

"Until now it's been almost impossible for people who need care, carers, and even those who manage the care system, to understand how the previous law affecting them worked. Over nearly 70 years it has been added to again and again and is out of date and confusing. The Care Act has created a single, modern law that makes it clear what kind of care people should expect."

Former Care Minister Norman Lamb

The Six Safeguarding Principles

Empowerment: people being supported and encouraged to make their own decisions and give 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 and transparency in safeguarding practice

Living in South Gloucestershire

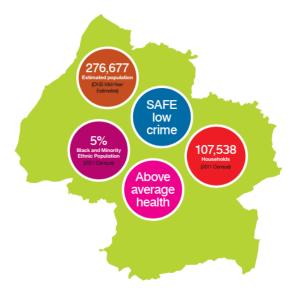
South Gloucestershire is a mix of long established urban communities, market towns, small villages and substantial new development. Characterised by very differing communities with individual needs and aspirations, the diversity of its landscapes and neighbourhoods contribute to a high quality of life.

South Gloucestershire's location and its proximity to the city of Bristol present a number of cross boundary opportunities and challenges which are dealt with by working in partnership with the neighbouring authorities of Bristol City, Bath and North East Somerset and North Somerset.

The most recent <u>Joint Strategic Needs Assessment</u> shows that South Gloucestershire is on the whole a relatively affluent area. Only 16% of local authority areas in England are estimated to be more affluent than South Gloucestershire. However there are pockets of deprivation where health outcomes are less good.

South Gloucestershire is predominately rural although most of the population live in the urban areas. The South Gloucestershire population has grown over the past decade by 10% and is projected to rise by a further 17% by 2037. The biggest increases will be in the older age groups. At least 30,000 new homes are planned to be built by 2036 in South Gloucestershire.

According to the 2011 census 18% of the population aged sixteen and over has day to day activities limited by a long term health problem or disability, which is lower than the England average of 21%. Based on the 2011 census figures it is estimated that there are currently approximately 22,500 people aged 65 or over with a limiting long term illness that limits their day to day activities, this figure is predicted to rise to 33,400 by 2030. Of those aged 18-64, it is estimated that there are approximately 16,800 with a moderate or severe physical disability, a figure set to rise to 18,000 by 2030. From a



safeguarding perspective a proportion of people with disabilities or severe ill health will be perceived as at risk as a result of ill health or disability.

The area is served by Avon and Somerset Police Constabulary and a Police and Crime Commissioner.

Social Services are provided by South Gloucestershire Council Unitary Authority.

Health services are delivered by Bristol, North Somerset & South Gloucestershire Clinical Commissioning Group (BNSSG), Avon and Wiltshire Mental Health Trust, North Bristol Trust and other commissioned providers.

There are three custodial establishments in the area. HM Prison Ashfield and HM Prison Leyhill are both prisons for men and HM Prison Eastwood Park is for women.

Probation and Rehabilitation Services are provided by The National Probation Service and The Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company (BGSW CRC)

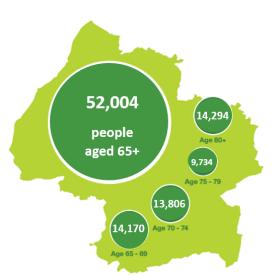
Care in South Gloucestershire

Increasingly, people are being supported at home for longer periods. In general homes for people with learning difficulties or disabilities tend to be smaller than homes for older people. Homes for people with learning difficulties house 3 – 35 people and care homes, including nursing homes for older people house 23 – 80 people.

According to figures obtained from the last Census (2011) the growth in older people in South Gloucestershire is above the national average.

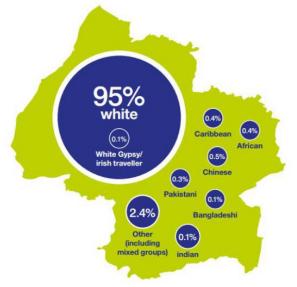


From a safeguarding perspective a higher proportion of older people will be perceived as at risk as a result of ill health or disability.



This ethnicity data for people in South Gloucestershire is taken from the 2011 census information.

The statistics in this map diagram show the age group data for adults over 65 living in South Gloucestershire according to the midyear estimates published by the Office for National Statistics.



*Linda's Safeguarding Story



Be in the **know**...

Doorstep crime and rogue trading is a high priority area for Trading Standards. The effects on a victim of these crimes are not only financial detriment, but can be psychologically harmful as well.

During an investigation into prolific rogue traders, Trading Standards officers identified Linda as a possible victim of their criminal acts. Linda is in

her 60s and lives alone. She suffers from long term ill health which requires short stays in hospital. She has no apparent support network after losing her mother in recent years.

Linda was introduced to the rogue traders a number of years ago following an unsolicited visit to her home, where they offered to undertake home maintenance works. During conversations with Trading Standards Linda disclosed that, over time, she had agreed to other work the rogue traders deemed necessary, often with no price agreed upfront and no contractual paperwork, something required by law. Linda considered the roque traders her friends, coming to her aid by offering to maintain and repair her home. The rogue traders visited frequently, taking her shopping and walking her dog when she was in hospital. She also allowed them to use her car, which they used to commit other criminal offences. Linda was reluctant to co-operate with Trading Standards initially, not wanting to jeopardise this 'friendship' and gave a misleading account of her dealings with them. Trading Standards officers remained concerned and followed up the initial visit with further contacts. It is a known tactic by rogue traders to befriend victims where they believe they can manipulate them for monetary gain, revisiting them to undertake unnecessary home improvements at inflated costs, to persuade them to hand over valuables and, in the most extreme cases, to take over their homes.

During follow up visits, Linda began to trust the Trading Standards officer and open up, admitting to recently lending the rogue traders more money which she has been unable to get back. The loans and the work the rogues undertook amounted to a loss in excess of £32,000. Trading Standards raised a safeguarding concern and a social worker became involved. Linda finally confided in a social worker that she was becoming concerned about the actions of the rogue traders and that she had actually changed her will so those individuals would inherit her home, rather than a family member. Linda realised this was an error and asked for assistance to change her will back. She also confided that she hears noises during the night and believes the rogue traders come and go as they please using a set of house keys she gave them. She began to realise these men were not her friends.

The investigation continues with a view to prosecuting these offenders, whilst both adult social care and Trading Standards continue to offer Linda the support, advice and practical assistance to remove these individuals from her life.

*Not her real name

Summary of Safeguarding Activity in South Gloucestershire

The Safeguarding Adults Board oversees analysed performance data for safeguarding in South Gloucestershire via the Quality Assurance sub-group, and at the full Board.

When someone contacts the Council's Customer Service Desk about a situation which concerns them, a record is made of that contact. This is called a *Safeguarding Concern*. Trained staff make a decision based on the information they have been given as to whether the situation is one which requires further inquiries within the safeguarding process.

Example of a Safeguarding Concern One:

Mary's mother was not given her medication this morning. When Mary speaks to the nursing home staff they check with a health colleague who said the medication can be given later. This would be recorded but not progressed as a safeguarding concern.

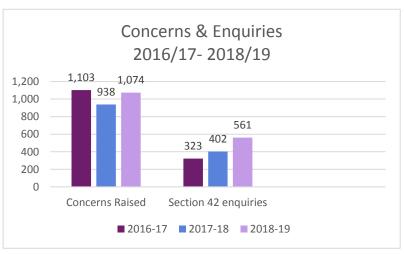
When a concern is raised, a *referral* is generated. The referral will be closed at the end of the safeguarding involvement whether this is after a few days of information gathering and analysis, or after several months of enquiry, including a risk assessment and the development and implementation of a safeguarding plan.

Example of a Safeguarding Concern Two:

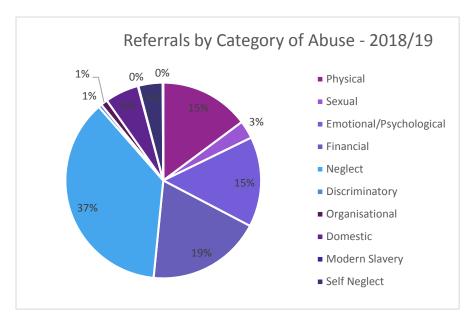
Mary's mother was not given her medication this morning. This is medication for Parkinson's disease and is time specific. When Mary speaks to the nursing home staff they don't seem worried and say she will just get her next dose on time. This is likely to progress to a further enquiry.

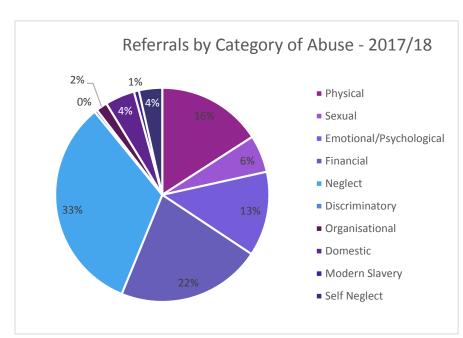
This section of the report looks at data we have for safeguarding activity between April 2018 and March 2019.

52% of all Safeguarding concerns raised within this time period resulted in a Section 42 safeguarding enquiry. In 2017-18 Last year this was 43%. Those safeguarding concerns that do not lead to an enquiry are logged, and other forms of support offered and advice and guidance is given.



Referrals by Category of Abuse





The two charts on this page show referrals by the category of abuse over the last two years.

The biggest change in 2018-19 has been a rise in Neglect (increase of 4%) This does not include self-neglect, as this is categorised separately and has remained stable.

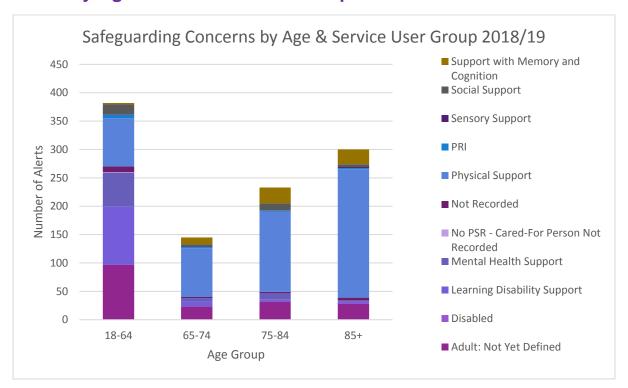
Emotional and Financial abuse have decreased slightly.

Domestic abuse has risen to 6%, although is still a very small proportion of referrals. Auditing during 2018-19 has shown that domestic abuse has sometimes been identified by a presenting feature ie. Physical abuse when there is an injury, rather than as domestic abuse. In reality it is probable that domestic abuse referrals are higher than the 6% recorded.

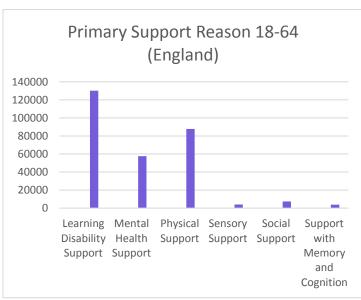
Safeguarding Activity

Safeguarding Activity

Alerts by Age and Service User Group



For younger people, the majority of concerns relate to Mental Health and Learning Disability. These have a tendency to be lower level concerns. The number of all concerns reported for those over 65 is much greater, the majority of work happens with older members of the population.

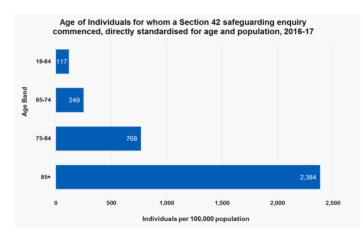


The most recent national comparators (NHS Digital: England) show that South Gloucestershire statistics differ when compared with the rest of England in terms of the Primary Support Reason.

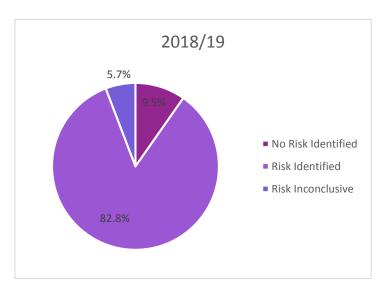
Physical Support is 30% for England and 22% for South Gloucestershire. Learning Disability Support is 45% for England and 27% for South Gloucestershire and Mental Health Support is 19.5% for England, and 15.5% for South Gloucestershire.

There are less categories listed for England statistics so the actual figures are likely to be closer than these charts show.

The age statistics for England also show that South Gloucestershire's statistics are as expected. For England 36% of alerts are for the 18-64 age group and in South Gloucestershire 36%. The England statistic for those aged 65 and above is 63% and the South Gloucestershire statistic is 64%.



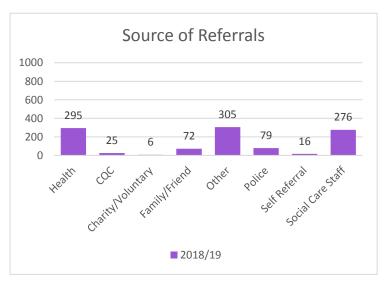
Safeguarding Outcome



There has been no change over this period in cases where risk has been identified. There has been a slight increase in the number of inconclusive findings and a corresponding fall where no risk has been identified.

Source of Referrals

The distribution of safeguarding concerns has remained stable this year with little change. Referrals from health, social care and 'other' being the largest proportions. Self-Referral remains very low, although referrals from Family and friends has risen.



Organisational Enquiries for 2018-2019

In March 2019 South Gloucestershire Safeguarding Adults Board adopted new Multi-Agency Organisational Abuse Procedures developed in response to the recommendations and learning from the Nightingale Care Safeguarding Adults Review.

Not all abuse that occurs within care services will be organisational; some incidents between adults or actions by individual members of staff may occur without any failings on the part of the organisation. Organisational abuse refers to those incidents that derive to a significant extent from an organisation's practice and culture (particularly reflected in the behaviour and attitudes of managers and staff) policies and procedures.

A combination of research and safeguarding practitioner experience has identified a number of elements that could be early indicators of concern.

The indicators can be grouped into six key themes. These themes provide important information about key aspects of service design and delivery which increase the risks of abuse and harm for people.

The 6 main areas to think about are:

- 1. Concerns about management and leadership
- 2. Concerns about staff skills, knowledge and practice
- 3. Concerns about adults' behaviours and wellbeing
- 4. Concerns about the service resisting the involvement of external people and isolating individuals
- 5. Concerns about the way services are planned and delivered
- 6. Concerns about the quality of basic care and the environment



Based on the numbers currently rated by the Care Quality Commission there are 22 care homes with nursing and 60 care homes without nursing in South Gloucestershire. There are 48 domiciliary care providers, 7 supported living services and 5 extra care housing services. There is 1 shared lives service. There are 958 beds within the care homes with nursing and 1013 within the care homes without nursing.

The majority of nursing homes are for older people and have between 40 and 80 beds. The care homes without nursing will range from 4 to 50 beds with many being small homes in the 4-10 bed range providing services for people with learning difficulties.

Figures released by CQC in April 2019 show that services in South Gloucestershire are rated significantly better than the national average.

Local Authority	Outstanding	Good	Requires improvement	Inadequate	Grand Total
South Gloucestershire	14.4%	80.5%	5.1%	0%	100.00%
National figures	3.5%	80.0%	15.3%	1.2%	100.00%

There continue to be a number of full organisational enquiries. The level of enquiry is proportionate to the risk involved and varies from a desk top review to a full enquiry and follow up which can last for many months. These enquiries are triggered either when someone raises a concern about the whole service or the organisation, or where there are a pattern of concerns. Sometimes enquiries begin because *no* safeguarding concerns have been reported. The aim is to achieve the earliest intervention with providers in order that concerns are tackled effectively and promptly.

In 2018-19 seven enquiries were carried out during the year. These were all occasions where situations progressed beyond the initial screening and went to a full review with other services within the multi-agency forum. In a small number of situations it was necessary to stop placing people with the service while action was taken to ensure a safe provision. A number of other services were also screened and although no formal enquiry was carried out work was undertaken to manage and reduce risks to people using those services.

The Organisational Safeguarding Team works proactively with services to enable early identification of organisational concerns. This means that situations can be resolved more quickly and without the need for a formal organisational abuse enquiry.

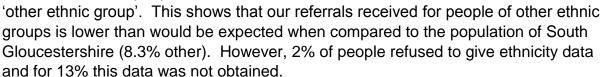
We work closely with neighbouring local authorities, especially where residents are from outside South Gloucestershire or residents of South Gloucestershire are placed elsewhere.

Equalities Impact Assessment

Each quarter the SGSAB receives a performance report which includes information related to equalities data.

Analysis

Referrals into Social Care show that 80% of referrals are for people who describe themselves as White British. 5% of referrals are for people who describe themselves as



For adults aged 18-64, 53.5% of referrals are for women, and 46.5% for men. This shows that males are underrepresented when compared to expectations based on population data for South Gloucestershire. For adults aged 65+, there are twice as many referrals for women than men, again this shows that males are underrepresented when compared to expectations based on population data for this age group in South Gloucestershire.



In September 2018, representatives from HMP Eastwood Park, HMP Leyhill and HMP Ashfield attended the first Joint Board and Prison Sub Group meeting.

Tony Oliver – Independent Chair SGSAB, Amy Weir – Independent Chair SGSCB and Sarah Taylor - Board Manager, had been keen to develop links with the 3 prisons that reside within South Gloucestershire. The creation of this sub group has enabled opportunity for information sharing and advice, development of policy and training, and contribution at the wider Safeguarding Adults Board.

From HMP Eastwood Park's perspective this has enabled positive changes and a recent Her Majesty's Inspection of Prisons (H.M.I.P) inspection noted our good safeguarding arrangements.

We also benefit from strong links to the Local Authority with regards to Social Care. A Local Authority Social Care assessor works across the 3 prisons, assessing and arranging care and equipment for prisoners in need of social care. Effective working relationships are key to ensuring that care is delivered in what can be a challenging environment.

Suzanne Smith, Eastwood Park

Equalities
South Gloucestershire
eople of other ethnic eopulation of South or give ethnicity data

Communication

A multi-agency communication and engagement sub group, that includes representatives from both the Safeguarding Children and Safeguarding Adults Boards, meets quarterly. The group is accountable to



the boards and works to an agreed annual communications plan, supporting the board's objectives and planning and delivering effective communications to:

- Ensure that safeguarding is everybody's business
- Deliver the common message of "if in doubt speak out" across all safeguarding services
- Proactively raise awareness of safeguarding issues and the role members of the public can play to create a safer community and enable them to be more likely to recognise and report abuse
- Promote creative and engaging safeguarding campaigns that address the issues identified within our community
- Promote the welfare of vulnerable people whether they are children, young people or adults, and their rights to be free from abuse.
- Reassure vulnerable children, young people, adults and their families and the
 general public that they will be listened to and to give details of what happens
 if a safeguarding concern is reported



The Safeguarding Board continues to engage with practitioners and members of the public by using the website, which feedback tells us is easy to navigate and is accessible, mobile device friendly and well used. Increasingly the LSAB also

communicates using its dedicated twitter account launched in May 2018, and within the first week, tweets were reaching over 1000 people.



Stop Adult Abuse Week

The SGSAB participated in the 'Stop Adult Abuse Week' campaign to raise public awareness of safeguarding and supporting the public to report any concerns, alongside our neighbouring safeguarding adults boards. This initiative began in 2014, and runs each year across the Avon & Somerset Police Force area in June.

This was promoted through the website and social media across our partners.



'If In Any Doubt, Speak Out'

Making Safeguarding Personal

Making safeguarding personal Questionnaires are given to service users after their involvement in the safeguarding process.

This helps us to hear the views of people we work with and change practice where themes emerge. We are engaging with the teams who issue these questionnaires to increase the number we receive. Outcomes are fed back to individual practitioners where possible and themes shared with teams.

In 2018-2019 we learned the following:





33% were able to choose who to support them



64% got the decision they wanted



75% were kept up to date



30% thought something could have been better Whilst the information gathered in these surveys is useful and they are considered on a quarterly basis, we have recognised that the number of returns is very small. The Communications and Engagement sub group are working on amending the questionnaire and a new way to distribute the questionnaires to ensure more are provided to people following the safeguarding process.



Empowerment: What has been achieved?

What Does this Mean?

People should be supported and encouraged to make their own decisions. This should be done by:

- + Making services more personal
- + Giving people choice and control over decisions
- + Asking people what they want the outcome to be

What does this mean for the adult?

You are asked what you want to happen and services plan safeguarding round this

Each board meeting begins with a safeguarding story from one of the agency members, this aims to maintain focus on adults in need of safeguarding at the centre of the work of the board.

The Quality Assurance Sub Group conducts regular thematic multi-agency case file reviews. In this reporting period, the Quality Assurance Sub Group have undertaken four case file audits in the following areas; (Q1)Physical Abuse; (Q2)Younger Adults under 25, (Q3)Neglect and Acts of Omission and (Q4) Scam.

The audits have identified areas of good practice in the following areas:

- The voice of the individual had been heard and supporting people to make decisions about their own safety was noted.
- The 6 key principles that underpin the work of adults safeguarding were used by practitioners.
- Good multiagency working was identified in a number of complex cases which includes working with individuals and their families.
- The use of advocacy.

Adults are now contacted to ask for their views for inclusion in each multi agency audit

The Communications and Engagement sub group review all of the making safeguarding personal forms completed by adults following involvement with Adult Social Care in South Gloucestershire. These forms have been made available electronically on the SGSAB website in addition to being delivered as hard copies this year however the sub group have identified that the process for sending these needs to be changed in order to elicit a higher response rate.



Prevention: What Has Been Achieved?

What Does this Mean?

Organisations should work together to stop abuse before it happens by:

- + Raising awareness about abuse and neglect
- + Training staff
- + Making sure clear, simple and accessible information about what abuse is and who to ask for help

What does this mean for the adult?

You will get clear and simple information about what abuse is and who to ask for help

New Practice Guidance for Domestic Abuse was published in August 2018, and Guidance for Managing allegations against people in positions of trust was published in December 2018

Revised Organisational Abuse Procedures were published in March 2019 based on the recommendations and learning from the Nightingale Care Safeguarding Adults Review.

The summary and findings of the multi-agency audits have been presented to the Board for discussion. A learning brief and links for further training for practitioners have been provided for board members who are responsible for disseminating the learning within their own organisations.

Two new leaflets were published to help adults understand the safeguarding process and help recognise and report abuse What is Abuse, and How Do I report it? Information for Adults at Risk

These are currently being adapted in Easy Read format.





Trained

The SAB's multi-agency

programme of training courses has continued to be in place, offering all employers in South Gloucestershire access to a "core" pathway of safeguarding adults training for their workforces.

All courses have been attended by significant numbers of staff from agencies across the statutory and independent sectors. We also offer agencies the opportunity to buy in single-

agency safeguarding training, via the council.

The Safeguarding Adults Trained Trainer Network that launched in spring 2017, now has a total of 25 trainers from 17 different agencies, so there is a good momentum behind the initiative. A total of 348 employees received safeguarding adults training delivered by members of the local Network.



We have also continued to coordinate a programme of Mental Capacity Act training for all local organisations to access; this consists of four different half-day training modules. 308 staff attended these in 2018-19, a slight increase from last year.

Safeguarding Adults Board Multi Agency Training Offer

COURSE TITLE	Attendance, 2018-19	BREAKDOWN BY SECTOR / AGENCY
Raising Safeguarding Concerns (prev. "SGA Alerter") (2017-18: 459)	363	South Glos Council 20.5%, Health Agencies inc CCG 19%, Residential Care 19%, Day Services 16%, Housing-related Support 9%, Voluntary sector 8.5%, Domiciliary Care 5%, Probation 1.5%, Direct payments PA 1%, FE Sector 0.5%
Managing Good Practice in Safeguarding Adults Issues (2017-18: 106)	104	Health Agencies 29%, Residential Care 23%, South Glos Council 16.5%, Housing-related Support 10.5%, Day Services 9.5%, Domiciliary Care 6.5%, Voluntary sector 5%
Managing and Preventing Organisational Abuse (2017-18: 37)	35	South Glos Council 28.5%, Residential Care 23%, Housing-related Support 25.5%, Day Services 11.5%, Domiciliary Care 5.75%, Health Agencies 5.75%
Hoarding & Self-Neglect (2017-18: 36)	47	South Glos Council 57.5%, Sirona 10.5%, Day Services 8.5%, Domiciliary Care 8.5%, Residential Care 6.5%, AWP 4.5%, Housing-related Support 2%, Police 2%
Domestic Abuse and Coercive Control (2017-18: n/a)	38	South Glos Council 61.5%, AWP 13%, Housing-related Support 8%, Sirona 5%, Residential Care 5%, Day Services 5%, Domiciliary Care 2.5%
Human Trafficking & Modern Slavery Awareness (2017-18: 63) - Joint course with SCB	71	South Glos Council 91.5%*, Health Agencies 4%, Voluntary sector 3%, Housing-related Support 1.5% * children services (62%), adult services inc Home Choice and 0-25 (28%), customer services (5%) public health (3%), safe and strong (2%)

Across the 'core' multi-agency Safeguarding Adults courses run in 2018-19, the overall attendance rate was 80%. This means that 20% of all bookings on these courses resulted in either a 'no show' or a late cancellation, this percentage has fallen from the previous year from an attendance rate 83%.

Quality Assurance is primarily by the use of bespoke questionnaires completed by delegates at the end of training and then by follow up questionnaire six weeks later.



he Work

the Board

"I have since attended a safeguarding meeting, so I felt this training prepared me for that. I was able to fully understand and feel confident."

Feedback from employees who attend all the main safeguarding training is very positive. Typically, around 98% of course delegates report that they feel confident about applying what they have learnt in the workplace.

SGSAB Conference

In June 2018 we hosted a Safeguarding Adults Board Conference jointly with Bristol Safeguarding Adults Board.





The conference took place midway through Stop Adult Abuse Week and focussed on the theme of Adult Exploitation, Mate Crime and Coercive Control. The keynote speaker was Rod Landman from ARC (pictured)



Delegates attended from across the Bristol & South
Gloucestershire

region from a variety of organisations.

There were also a



number of workshops running throughout the day that were all well received by delegates attending the day:

Lots of case law to relate to and research

Excellent thought provoking session, great speaker

Very informative and interesting, food for thought



Proportionality: What Has Been Achieved?

What Does this Mean?

When dealing with abuse situations services must ensure that they always think about the risk. Any response should be appropriate to the risk presented. Services must respect the person, think about what is best for them and only get involved as much as needed.

What does this mean for the adult?

Services think about what is best for you and only get involved when they need to.

Work is ongoing with the Access Team to review and update the safeguarding paperwork (Strategy Discussion and Meeting minutes) to ensure it fits with Making Safeguarding Personal and the Mental Capacity Act. Drafts of these documents are being trialled prior to being adopted.

During the year the Local Government Association (LGA) conducted a peer review of adult social care, the findings and action plan resulting from this will be reported to the Safeguarding Adults Board in accordance with the Business plan.

An <u>Escalation policy</u> has been created and adopted by the board, titled 'Resolution of Professional Differences'

The independent advocacy service SWAN Advocacy have been invited to become a member of the Safeguarding Adults Board.



Protection: What Has Been Achieved?

What Does this Mean?

Organisations must ensure they know what to do when abuse has happened by:

- + What to do if there are concerns
- + How to stop abuse
- + How to offer help and support for people at risk

What does this mean for the adult?

You get help and support to tell people about abuse and can get involved in safeguarding as much or as little as you want

This year the Safeguarding Adults Board conducted a self-audit of agencies working with adults with care and support needs in South Gloucestershire. Thirty three agencies completed the audit. 100% of responses indicated that organisations have a senior member of staff responsible for safeguarding, 91% report receiving training for this role.

71% of responses indicated that organisations have a senior member of staff responsible for MCA/DOLS, and of these all had received training for this role. 88% of organisations rated good for accurate and clear systems to record all actual, alleged and potential harm, abuse and neglect. Those that rated requires improvement described anticipated changes in their systems to improve both data capture and analysis capabilities.

All organisations responded confidently about their safer recruitment practices, and about their levels of safeguarding training. There were nine recommendations made to the Safeguarding Adults Board:

- 1. The role of the LSAB is not fully understood by organisations working with adults in South Gloucestershire and the board should take action to raise the profile of the board and its role, in particular in relation to the publication of Safeguarding Adults Reviews and how the learning is understood and embedded across the region. This also needs to include information about the shared multi-agency safeguarding adults policy and procedures.
- 2. Staff identified as being a lead for safeguarding must attend training to support them in this role
- 3. Future LSAB self-audits must make it clearer that evidence must be provided alongside a rating, learning from the submissions to this audit are that a number of organisations rated themselves 'good' but provided no information to evidence this.
- Access to advocacy should not depend on the adult's ability to pay. SGSAB
 must take action to provide a fact sheet to support organisations in their
 understanding of advocacy
- 5. Raise the profile of Stop Adult Abuse Week so that more organisations engage
- 6. Agencies to review the need for safeguarding information to be provided in alternative formats
- 7. Take action to improve understanding about, and quality of, Mental Capacity Assessments and DoLs.
- 8. Clear messages of 'Safeguarding is Everybody's Business' to be promoted in South Gloucestershire to help address the lack of understanding about think family.
- 9. All organisations should include audits as standard practice to be able to assure themselves and the LSAB of the quality of safeguarding work.



Partnership: What has been achieved?

What Does this Mean?

Organisations should work in partnership with each other and local communities. Local people also have a part to play in preventing, detecting and reporting abuse.

What does this mean for the adult?

Staff look after your personal information and only share it when this helps to keep you safe

This year each Safeguarding Board meeting has begun with a Safeguarding Story. This story will be a short summary of someone's experience of safeguarding in South Gloucestershire, identified and presented by a board member. In the next twelve months we intend to strengthen this aspect of the LSAB by visiting service user groups currently meeting in South Gloucestershire to talk about the work of the board and establish effective ways to engage with adults in the community. This year SWAN Advocacy have been invited to become board members as it was recognised in our Business planning that Independent Mental Capacity Advocates (IMCA) were not represented.

During this year a Safeguarding Adults Review was published by the board, details of this can be found in the Learning from Practice section of this report. Following publication, board members were required to report to the board how they had disseminated learning within their organisations, and share how they planned to monitor the impact on practice and subsequently impact on people they work with. The board has strengthened the quality assurance framework with the multi-agency audits now requiring a response from all agencies about how learning is being embedded.



Accountability: What Has Been Achieved?

What Does this Mean?

Safeguarding is everybody's business. Everyone must accept that we are all accountable as individuals, services and as organisations. Roles and responsibilities must be clear so that people can check how safeguarding is done.

What does this mean for the adult?

You know what all the different people should do to keep you safe.

In 2018-19 the LSAB established a risk register which is now being used to monitor and measure risks. This has increased accountability for partners where there are concerns.

Providers who do not raise safeguarding concerns are now being monitored by the Organisational Safeguarding Team and this is covered in the Organisational Abuse Guidance that was published in March 2019. All providers are reviewed every 3

months, and a list is generated from this review and providers are visited. One of the criteria that may prompt a visit is low or no referrals.

A <u>fact sheet</u> for families has been created to help them know about and understand the safeguarding process if they or a family member are involved following a safeguarding concern being raised, so that they have knowledge about what to expect. An Easy Read version of this booklet is being designed.

Joint Half Day Conference: Think Family

In November 2018, the LSAB and LSCB in South Gloucestershire worked together to host a half day conference on the theme of

Think Family. The focus of the event was on identifying and celebrating







collaborative working approaches in supporting the whole family, for example in working with domestic abuse, substance misuse and mental health. This included performance of 'Lady in Red' by Certain Curtain Theatre Company which focused on a theme of coercive control. The event was attended by over 100 practitioners from across the children's and adult workforce in South Gloucestershire.

Workshop for Care Providers: Welcoming Feedback

In March 2019, the LSAB invited care providers to attend a free workshop to consider how to manage complaints effectively following publication of a Safeguarding Adults Review in South Gloucestershire. This was attended by over 60 delegates and the event considered:

Handling complaints well

Gaining Feedback as Routine Practice

Case example of good practice from a provider



Learning from Practice

The Quality Assurance Sub
Group of the South
Gloucestershire Safeguarding
Adult Board (SGSAB) conducts
regular thematic multi-agency
case file reviews. A key
objective of Local Safeguarding
Adults Boards is to improve
local safeguarding
arrangements and ensure
partners act to help and protect



adults experiencing abuse, or at risk of neglect and/or abuse and to ensure the effectiveness of the work undertaken by partner agencies and organisations. The Quality Assurance subgroup provides a process for a wide range of organisations, who are members of the Safeguarding Adults Board, to review the support they have provided to individuals, and monitor the effectiveness of local arrangements, and provides a forum for challenge between organisations to identify where improvements can be made across the adult safeguarding system.

In 2018-19 Multi Agency thematic case file reviews were undertaken on the following themes:

- Physical Abuse
- Young Adults Under 25
- Neglect
- SCAMs

For this year a learning brief is being created for each audit to enable agencies to share the findings in an accessible format. These learning briefs are included over the next few pages.

Since December 2018 a quality assurance feedback form has been issued to all board members immediately after the LSAB meeting. This enables the QA sub group to ensure that learning is being disseminated and that the audit findings are being followed up and appropriate action are being taken when required.

Physical Abuse Multi Agency Audit - May 2018

practice guidance, SGSAB

with statutory and good consistent response in line implemented a robust and organisations have

cases and whether

physical abuse

regularly. Safeguarding

moved into residential broken nose. Husband

care, Jane visits

ended as no longer at

risk while living apart

four adults experiencing of the audit was to to safeguarding. The aim reviewed the records of ascertain whether there physical abuse and open The audit of 1st May 2018



finding of the audit were considered. They reflect

the findings from the previous audit, and show

that Domestic Abuse is not always being

Safeguarding Adults Board on 7th June 2018, the

At the meeting of the South Gloucestershire

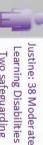
Overleaf you will find details of some supporting would be produced to help disseminate learning

resources available in South Gloucestershire

recognised by practitioners. It was agreed that a learning brief from each quality assurance audit

sateguarding work underpinning all adult and the six key principles policies and procedures standards for managing were good multi-agency John: 60 Not previously safeguarding concerns known to Social Care. 3 Controlling behaviour, witholding money & Abuse from his wife. related to Domestic food, verbal and

GPs, Sirona and AWP involvement with the Organisations that Adult Social Care, four adults were: audited their



Learning from Practice

physical abuse from Learning Disabilities boyfriend who also Two safeguarding referrals about

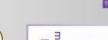


has LD.



James: 86 Advanced

and epilepsy. Supporting had a stroke. Verbal and Jane: 82 History of falls her husband after he



by both James and his wife meetings. James currently have resulted in referrals dementia. Physical abuse living in a nursing home towards professionals Regular multi agency Aggressive behaviour

Physical Abuse Multi Agency May 2018 Assurance Quality Audit:



physical aggression from

husband resulting in

- All four cases were categorised as physical Findings domestic abuse. abuse, but should have been reported as
- DASH (Domestic Abuse, Stalking & Practitioners are not thinking 'domestic abuse' routinely completed by practitioners in all Harassment) Risk Assessment not being agencies
- Rationale for decision making is not always of the cases

Evidence of good multi agency working in two

There is a risk of 'starting again' with a new referral and not reflecting back on case history and risk assessments



Learning from Practice

and the six key principles practice guidance, SGSAB sateguarding. The aim of neglect and were open to under 25 years who had underpinning all adult policies and procedures statutory and good robust and consistent have implemented a whether organisations multi-agency standards whether there were good response in line with for managing cases and the audit was to ascertain experienced abuse or records of four adults 2018 reviewed the

> Remains at high risk of engage with services.

exploitation &

domestic abuse

allegations by mother of

physical assault.

assault and counter

Link, Police and AWP Adult Social Care, GPs, Sirona Next four adults were:

The audit of 10th August



involvement with the



mental health. Care package Surrey where he had Camhs of autism, mild LD and poor identifies as male. Diagnosis following domestic abuse by input as a child. Referral boyfriend. Boyfriend no provided. Moved from Kim: 19 Transgender, longer in the area.



Organisations that

audited their

Kayleigh: 23 Living in supported

emotional and physical following allegation of Arrested Jan 18 for possible LD/ Menta abuse by mother. accommodation, Health. Referral

Alleged perpetrator is

58. Kate refusing to

exploitation, thought

to be continuing.

known to children's Kate: 18 Previously

services due to



Findings

- Transitions There is a gap in the sharing of children to adults information when a young person transitions from
- Good use of the DASH and safeguarding risk assessment
- Missed opportunity for obtaining safeguarding feedback questionnaire
- A capacity assessment should be undertaken capacity in relation to safeguarding and the IMCA if the person has difficulty in understanding Consideration should be given to the use of an outcome documented when there are concerns raised about a person's
- Making Safeguarding Personal There was good evidence that the Service user had completed their Coercive control was considered risk assessment supported by the support worker the safeguarding process



accommodation. Concerns

abuse and mate crime raised about financial Kris: 25 Learning Disability

and autistic, living in supported

safeguarding work



Under 25s experiencing abuse Quality Assurance Audit: August 2018 Multi Agency & neglect

Learning from Practice

sateguarding work and the six key principles policies and procedures practice guidance, SGSAB with statutory and good consistent response in line implemented a robust and organisations have standards for managing open to safeguarding. The experiencing neglect and underpinning all adult cases and whether were good multi-agency ascertain whether there aim of the audit was to records of four adults 2018 reviewed the



involvement with the GPs, Sirona Next Adult Social Care, four adults were: Link, Police



confident with removal and reapplication of HALO brace Physiotherapist identified a result of nursing staff not sore. This developed as a over a weekend in March wound, grade 3 pressure following C7 fracture.



Organisations that

audited their

Libby: 32, admitted to rehab unit with a halo brace





of dementia, diabetes,

Lucinda: 86 Diagnosis

Concerns raised about

Lucinda being

hydrocephalus.

neglected, left alone all

day. Concerns about

financial abuse by son

and father. Currently

living in a care home

neurological degeneration. Very restricted movement and limited vocal ability. Moved to nursing home from previous home in Len: 74 Undiagnosed

smell in home, disrespectfu Identification of unpleasant Len's wife noticed a scab on staff, lack of staff on duty. his head and red marks on France, self funding. cheekbone.



Adults experiencing Neglect Quality Assurance Audit:

Multi Agency

November 2018

Findings

- Consider use of Escalation where appropriate
- Successful early intervention by Active Ageing Health Visitors and Age UK
- Good multi agency working, still ongoing
- Voice of the person has not been heard for two
- voice when needed Ensure the family are contacted to help hear the
- Whilst there were concerns about the recording of Expected referrals have been made to agencies action in place risk the agency investigated and put mitigating



poor quality care, missed

medication reported.

Number of missed visits,

home alone with package

of care 4 times a day.

Larry: 90 and diagnosis of

Paget's Disease. Lives at



included in the audit

Learning from Practice

adults involved were sateguarding work. The underpinning all adult and the six key principles policies and procedures practice guidance, SGSAB statutory and good tor managing cases and whether there were good audit was to ascertain scamming. The aim of the where possible and robust and consistent have implemented a whether organisations multi-agency standards have experienced 2019 reviewed the contacted for their views response in line with records of four adults who

involvement with the GPs, Sirona, Trading Adult Social Care, Standards, Police four adults were:

Organisations that

lived independently with support Marilyn, age 99 (died March 18)

from daughter. Unknown caller

audited their

Michael: age 22 has a learning disability.

The audit of 7th February

subscription. Caller returned and multiple victims identified and statement could be taken but cleaning. Marilyn died before asked for £40 for guttering requested £20 for TV Guide prosecution proceeding.

scams, current sateguarding she met online and is giving lives with her daughter who Standards identify this as a she is an army wife having mental health support and 'married' a man in Nigeria surrounds Meg believing is a care leaver. History of Meg: age 57 receives him money. Trading romance scam

woman he met online

He gave £465 to a

who Michael said was

his girlfriend. The

online when he told woman blocked him

her he had no more

Lives with his mother.



Findings

Good Multi Agency working between Trading Standards

Adults experiencing SCAMS Quality Assurance Audit: February 2019 Multi Agency



Documenting of the first look at referrals by the access Good communication between agencies and the family and the police identified with prosecution pending team needs to be improved, this work has already

- Educate and disrupt process for 'romance scams' as identifying perpetrators very difficult
- AWP & GP need to provide information for the audit Signposting by professionals to trading standards to

help educate individuals who have been victims of a

Letters from clairvoyants are only sent to people who

Morgan: age 53 receives mental health support

for schizophrenia. Morgan told his social worker he had received letters from a

clairvoyant asking for money and he had sent

some. He has also been contacted by a fibre optic phone company asking him for itunes

vouchers. This was identified by care agency

supporting him.

- are on scammer's distribution lists (also known as a
- Early intervention to address scams are effective Professionals are not always making a referral to Trading Standards when a scam is identified

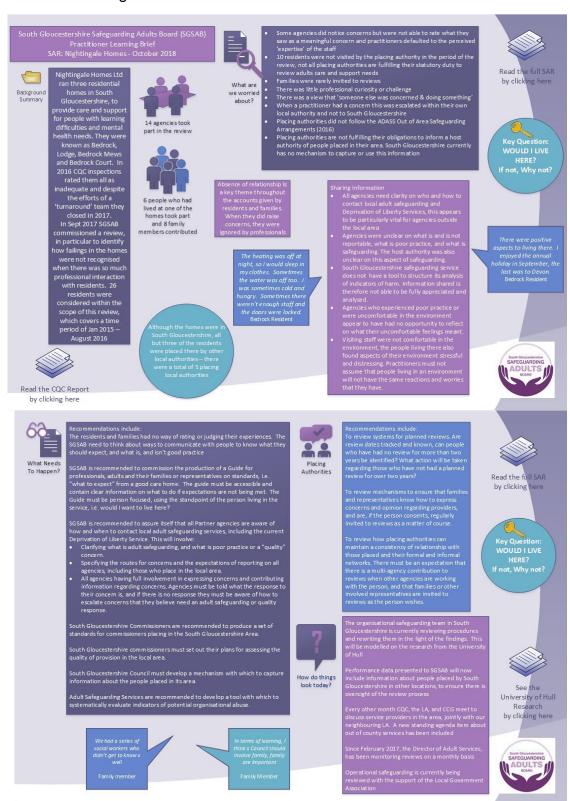
Evidence of making sateguarding personal



Safeguarding Adult Review: Nightingale Care

In October 2018 the Safeguarding Board published a SAR about the Nightingale Care group of homes in South Gloucestershire.

The full report including the learning identified is available <u>here</u>. The board also published a learning brief which is included below:



Priorities for the Coming Year

Our vision for safeguarding in South Gloucestershire is that children and adults thrive, reach their full potential and live their lives safe from harm (violence, abuse, neglect, exploitation). To achieve this vision we will work together and with local communities to improve outcomes and to ensure South Gloucestershire is a place where safeguarding is everybody's business (SGSCB & SGSAB Vision 2016)





Safeguarding Adults is Everyone's Responsibility If in Any Doubt Speak Out

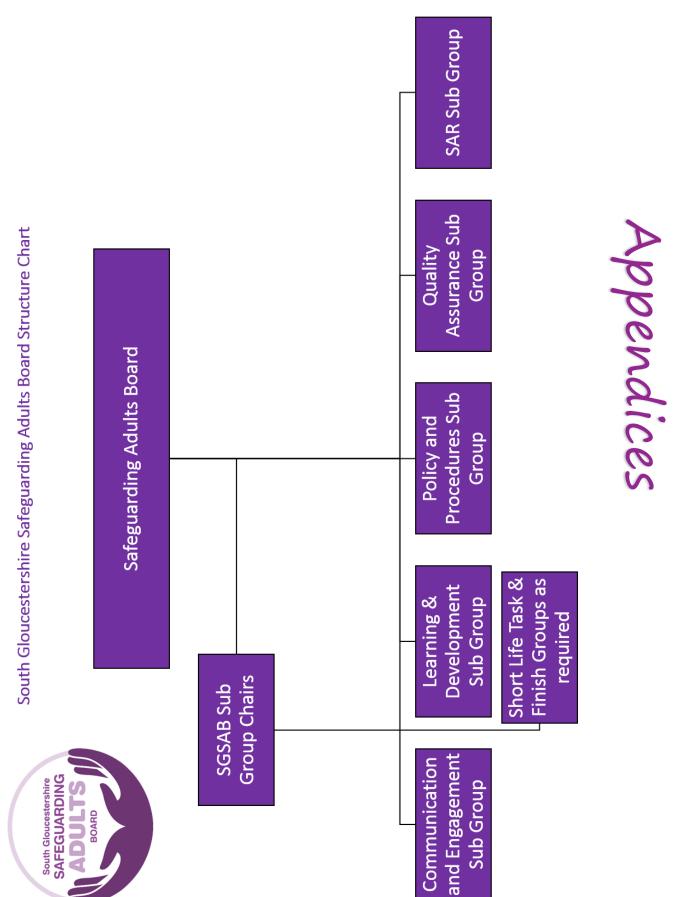


Call South Gloucestershire Council on 01454 868007

Or 01454 615165 out of hours and at weekends

If an adult is in immediate danger – please call 999 and ask for police assistance





Appendix Two: Memorandum of Understanding

The Care Act 2014 sets out the statutory requirements of a Local Safeguarding Adults Board (LSAB)

This includes the following statements in respect of members of an LSAB:

- 1) Members of an LSAB should be people with a strategic role in relation to safeguarding within their organisation. They should be able to:
 - speak for their organisation with authority;
 - commit their organisation on policy and practice matters; and
 - hold their own organisation to account and hold others to account.
- 2) All LSAB member organisations have an obligation to provide LSABs with reliable resources (which may include financial resources) that enable the LSAB to be strong and effective. Members should share the financial responsibility for the LSAB in such a way that a disproportionate burden does not fall on a small number of partner agencies.

This Memorandum of Understanding sets out the South Gloucestershire Safeguarding Adults Board expectations for members. The members shall, for the purpose of this Memorandum of Understanding, include the organisation and the individual representing the organisation who are defined as Statutory Board Members and Member Organisations ('Board Member').

Each Board Member will agree to accept the following responsibilities which shall commence immediately and will thereafter work diligently in accordance with the terms of reference of the Board and the duties placed on each member of the Board and their employing organisation in accordance with statutory requirements and guidance

This Memorandum of Understanding is not legally binding on any of the Members or Member Organisations and creates no legal rights or obligations.

Commitment to the Purpose and Objectives of the Board

In order for the Board to operate effectively, Members must be committed to the collective purpose, ethos and aims of the Board. This means to:

- 1) Develop and deliver a Local Safeguarding Board in accordance with the range of roles and statutory functions as set out in the South Gloucestershire Safeguarding Adults Board Constitution.
- 2) Work effectively and efficiently so as to ensure the Board meets its statutory objectives which are to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding adults at risk in the area and to ensure the effectiveness of what is done by each such person or body for those purposes.
- 3) Support achievement of the priorities that have been agreed by the Board in its Strategic Business Plan.
- 4) Ensure that confidential information is not shared beyond the Board without the permission of the chair.

Promote and Support the Objectives of the Local Safeguarding Adults Board

Appendice

In order to ensure the work of the Board is effective, each Board Member shall be a champion for safeguarding adults at risk¹. This means that:

- 1) Each Member shall scrutinise vigorously the arrangements in place within their own organisation in respect of working with adults and carers to ensure that the arrangements are fit for purpose.
- 2) Each Member shall take such steps as are necessary within their individual organisation to promote improved arrangements where they deem appropriate.
- 3) Each Member shall promote effective communication, both within their organisation and with other partner organisations/agencies.
- 4) Each Member shall promote the work of the Board within their individual organisation and disseminate relevant documentation and information as appropriate so as to raise greater awareness of the issues relating to the safeguarding of adults amongst a wider community.

It is accepted that the role of the Representatives on the Board is slightly different in that they cannot have responsibility for other providers/members of the group they represent, however it is expected that they will undertake items 3 and 4.

This Memorandum of Understanding is signed by:
Name:
Organisation:
Signature
Date:
And received by the Strategic Safeguarding Service Manager
Name: Catherine Boyce
Date:

Appendix Three: Membership and Attendance

Agency	Name	Role	Attendance
Independent Chair	Tony Oliver		100%
·	Councillor Ben	Adults, Housing & Public Health	75%
	Stokes	Committee Chair	
	Catherine Boyce	Strategic Safeguarding Services	750/
		Manager	75%
	Anne Clarke	Head of Adult Social Care & Housing	50%
	Sara Blackmore	Director of Public Health	0%
Carrella	Judith Eke	Team Manager, Safeguarding Adults	75%
South	Mark Pullin	Stronger, Safer Communities	4000/
Gloucestershire		Manager	100%
Council	Nick Thorne	Workforce Development Manager	100%
	Chris Sivers	Director, Children, Adults and Health	0%
	Rebecca Harrold	Commissioning Manager	100%
	Rosemary Johnson	Service Manager, Children, Adults &	F.00/
		Health	50%
	Sarah Weld	Consultant in Public Health	50%
	Sarah Taylor	Board Business Manager	100%
NPS	Katy Trundley	Senior Probation Officer (Acting)	75%
Oli di sal	Paulette Nuttall	Head of Adult Safeguarding	75%
Clinical	Pippa Stables	Lead GP for Safeguarding	0%
Commissioning	Jan Baptiste Grant	Nurse Director, Head of Quality &	F.00/
Group (CCG)		Safeguarding	50%
Sirona Care & Health	Simon Allen	Safeguarding Lead	75%
North Bristol Trust	Gill Brook	Head of Patient Experience	75%
Avon Fire & Rescue	Neil Liddington	Unitary Group Manager	00/*
Service			0%*
Milestones Trust	Jeff Parry	Director of Operations	50%
AWP	Lynn Franklin	Clinical Director	50%
The Care Forum	Morgan Daly	Director of Community Services	25%
Care Quality	Paul Chapman	Manager	00/
Commission			0%
Merlin Housing	Paul Coates	Director of Housing and	0%
Society		Communities	0/8
Avon and Somerset	Ben Moseley	Chief Inspector, Avon & Somerset	100%
Police		Police	
AbleCare Homes	Sam Hawker	Director	75%
South West	Simon Hester	Safeguarding Manager	0%*
Ambulance Service			070
Freeways	Sharon Prowse	Senior Manager	100%
Liverty Housing	Mark Coates	Assistant Director, Supported	0%
		Housing	
HMP Eastwood Park	Sue Smith	Head of Safety	25%
NextLink	Carol Metters	CEO	75%
SWAN Advocacy	Andy Roger		25%
CRC	Marilyn Harrison		50%

^{*}Agreement for these agencies not to attend meetings

Appendix Four: Financial Report

SOURCE OF FUNDS		ADULTS	
2018-2019 SAFEGUARDING CONTRIBUTION		KV367 BUDGETED CONTRIBUTION £	
POLICE & CRIME COMMISSIONER		£6,635.00	
BGSW CRC Ltd		£500.00	
SOUTH GLOUCESTERSHIRE DEPARTMENT		£63,910.00	
NATIONAL PROBATION SERVICE		£523.00	
TOTALS		£71,568.00	
APPLICATION OF FUNDS			
2018-2019 BUDGET OUTTURN		BUDGETED EXPENDITURE	
		£	
PAY			
Adult Safeguarding Board Manager (£1500 per month)		£22,800.00	
Staffing		£6,420.00	
Independent Chair		£15,000.00	
	TOTAL	£44,220.00	
NON PAY			
Provision for Serious Case Review			
Safeguarding Adult Reviews			
Conference			
Conference attendance			
Board Meeting Costs		£100.00	
Catering		£175.00	
Publications/Procedures		£50.00	
- The Granary subscription			
- SAR Thematic Review			
- Easy read annual report			
	TOTAL	£325.00	
TRAINING			
Adult Safeguarding Training			
Income from Training			
	TOTAL	£0.00	
OTHER	2 _	2000	
Computer Equipment		£560.00	
Car Parking		£130.00	
Mileage		£15.00	
	TOTAL	£705.00	
TOTALS		£45,250.00	
DEFICIENT		£26,318.00	

Appendix Five: Safeguarding Process

SAFEGUARDING CONCERN

Phone calls, emails and other contact with the local authority raising concerns about an adult. These are all logged by our Customer Service Desk and passed to a Senior Social Worker to make a decision. Not all concerns are dealt with via safeguarding. Some are dealt with by other means such as a care management review. Those dealt with under safeguarding will be categorised in one of two ways.



SAFEGUARDING REFERRAL

Concerns that appear to meet the threshold for an individual safeguarding enquiry are logged as a safeguarding referral. The referral will remain open until the enquiry is concluded. Each referral is screened by a Senior Social Worker who may gather further information to help their decision making.



SAFEGUARDING INCIDENT NOTIFICATION

Relate to low level incidents which on their own do not meet the threshold for a full safeguarding enquiry, but when looked at together can help to form a picture of a service. They include falls/accidents, medication errors, missed home care visits and person on person incidents. These are logged on the service provider's record and used as part of the screening process for Organisational Abuse enquiries.



Allocated to a social worker for further safeguarding enquiries. The social worker will start to gather information about the concern.

SCREENED OUT

Does not meet the
threshold for a
safeguarding enquiry.
Referral closed.



STRATEGY DISCUSSION

Should take place within five working days of the referral being received by the local authority. It will range from a discussion between two people to a full multi-agency meeting. The discussion will document the person's desired safeguarding outcomes, the current level of risk, and if required will agree actions and timescales for the enquiry.



ENQUIRIES STARTED

Safeguarding referrals that are not closed at the Strategy
Discussion stage are recorded on the local authority database as
Enquiries Started. The social worker will continue with their
enquiries or may ask others to carry out enquiries on their behalf.



SAFEGUARDING ENDED

Risk has been removed or reduced to an acceptable level. Referral closed.



CASE CONFERENCE

Often called a Planning Meeting. These normally take place within four weeks of the safeguarding referral being received. They will normally be multi-agency meetings and the adult at risk may also be present for all or part of the meeting. They take place when risks still remain that need to be addressed.



SAFEGUARDING PLAN

These are logged on the local authority database after the Case Conference where risks still remain. They record what action is being taken to keep the person safe.



SAFEGUARDING ENDED

Risk has been removed or reduced to an acceptable level. Referral closed.



REVIEW

A further multi-agency Case Conference to review the Safeguarding Plan. They will be held on a regular basis for as long as the meeting agrees there is still a risk to the person.



SAFEGUARDING ENDED

Risk has been removed or reduced to an acceptable level. Referral closed.