BRISTOL SAFEGUARDING ADULTS BOARD

ANNUAL REPORT 2017-18

Bristol Safeguarding Adults Board

ANNUAL REPORT 2017-18

MESSAGE FROM THE CHAIR

I am pleased to introduce Bristol Safeguarding Adults Board Annual Report for 2017/18. The Board oversees and leads the multi agency adult safeguarding arrangements across Bristol. It has been another exceedingly busy year for the Board. We have made significant progress in many areas of our work as we conclude our first Strategic Plan 2015 - 2018. I would like to thank the staff in the Joint Business Unit, the Chairs and members of our sub groups and Board members whose hard work, time and commitment have ensured we have met our statutory responsibilities and completed our annual business plan.

The report details all the work that has been undertaken from April 2017 to March 2018. In particular I was pleased to see, in conjunction with Bristol Safeguarding Children Board, the publication of guidance on Engagement with Faith Based Establishments which involved a wide ranging consultation with faith groups across the City. There is more work for the Board to do to engage with our diverse communities and we are committed to taking this forward over the next three years. Over the last 12 months the Board

have broadened its understanding of the wider safeguarding agenda including adult sexual exploitation, modern slavery and mate crime. We will continue to enhance our understanding of these subjects and their implications for our safeguarding work.

In 2017/18 considerable work has been undertaken to complete a number of statutory and non-statutory reviews. The Board published a Serious Case Review that had far reaching implications for a number of organisations across England. One of the findings of this review was the need to improve the assessment and management of risk for people with complex mental health problems. In response Bristol held a multi-agency learning event. I found it very encouraging to see significant numbers of practitioners from a wide range of agencies working together to improve practice in this area. We also published our first Safeguarding Adults Review which identified a number of learning points for health and social care practice in Bristol. The Board is committed to ensuring that the changes to practice identified in the review are implemented over the next year to improve outcomes for service users.

Organisational change in many of our partner organisations has continued throughout this year. At times this has challenged the continuity of representation of some Board members which risks undermining the effectiveness of our multi agency partnership. However all partners have demonstrated consistent commitment to the work of the Board. As always finances have remained under pressure and we remain intent on working as efficiently as possible.

After extensive and wide ranging consultation we have developed a new Strategic Plan for 2018-2021. I am confident that the priorities identified in the plan will make a difference to the people of Bristol. I am also assured that given people's continued

passion and commitment to our work we will meet our priorities for the next year and beyond. Safeguarding is everyone's business and I hope you find this report interesting and helpful and if you wish to make any comments or find out more about the work of the Board please contact the Business Unit at bsab@bristol.gov.uk

Louise Lawton

Independent Chair of Bristol Safeguarding Adults Board

CONTENTS

1. ABOUT THE BOARD

Governed in accordance with the provisions of the Care Act 2014 sections 42 – 46, the BSAB is the key statutory body overseeing multi-agency adult safeguarding arrangements across the City of Bristol. It was established in line with the statutory requirement to have a Local Safeguarding Adults Board in each Local Authority area set out in the Care Act 2014.

The BSAB comprises senior leaders from a range of different organisations. It has two basic objectives **to help and protect adults who meet the criteria for safeguarding** by **co-ordinating the safeguarding work of agencies** and **to ensure that this work and the work of individual organisations effective.** It oversees and leads on adult safeguarding across the locality and considers a range of matters that contribute to the prevention of abuse and neglect. These include the safety of patients in its local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders, and responsiveness of further education services.

WHAT IS SAFEGUARDING ADULTS?

Safeguarding adults is about protecting those at risk of harm from suffering abuse or neglect. Abuse can happen anywhere. It can happen at home, in a residential or nursing home, in a hospital, at work or in the street.

Safeguarding adults is about working with adults with care and support needs to keep themselves safe from abuse or neglect. It is about people and organisations working together to prevent abuse.

Section 42 (1) of the Care Act 2014 states: Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

BRISTOL SAFEGUARDING ADULTS BOARD STATEMENT OF PRINCIPLES

Safeguarding is a responsibility for everyone. The following 6 key safeguarding principles must be followed and underpin the ways in which the BSAB agencies, professionals and other staff work with adults:

1. **Empowerment** – Presumption of person led decisions and informed consent. People feeling safe and in control, being more able to share concerns and manage risk of harm either to themselves or others.
2. **Prevention** – It is better to take action before harm occurs. Working on the basis that it is better to take action before harm happens.
3. **Protection** – Support and representation for those in greatest need. Support and help for those adults who are vulnerable and most at risk of harm.
4. **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented. Responding in line with the risks and the minimum necessary to protect from harm or manage risks.
5. **Partnership** – Local solutions through services working with their communities. Working together in response to local needs and expectations.
6. **Accountability** – Accountability and transparency in delivering safeguarding. Focusing on outcomes for people and communities and being open about their delivery.

INDEPENDENT CHAIR

The Independent Chair of the BSAB is Louise Lawton. Louise has held this post since October 2014. She is supported by the Bristol City Council Service Manager for Safeguarding Adults; a Safeguarding Business Unit Manager; and the BSAB's Joint Business Unit which was set up in partnership with the Bristol Safeguarding Children Board. The Independent Chair is tasked with ensuring the Board fulfils its statutory objectives and functions. Key to this is the facilitation of a working culture of transparency, challenge and improvement across all partners with regards to their safeguarding arrangements.

The ultimate responsibility for the effectiveness of the BSAB rests with the political leaders of Bristol City Council and the Chair is accountable to Head of Paid Services.

JOINT BUSINESS UNIT

The BSAB is supported by a partnership Business Unit. The team works across the BSAB and the Bristol Safeguarding Children Board, to support improved consistency and a family focus.

1 Business Manager
1 Policy and Projects Officer
1 Project Officer
0.5 Data Analyst
1.5 Administrators

BOARD MEMBERSHIP

The following organisations are the core statutory members of the Board and operate as an Executive Group with responsibility for overseeing the governance of the BSAB:

- Bristol City Council
- Bristol Clinical Commissioning Group (NHS)
- Avon and Somerset Constabulary

Alongside the above the following partners are also members of the Board.

- NHS England
- University Hospitals Bristol NHS Foundation Trust
- North Bristol NHS Trust
- BCC Councillor (Lead Member) for People Directorate
- Avon and Wiltshire Partnership Mental Health NHS Trust
- National Probation Service
- BGSG Community Rehabilitation Company
- Bristol Community Health
- Care Provider Representatives
- Voluntary Sector Representatives

A number of organisations are Associate Members of the Board. Associate members support the work of the Board and its Sub Groups but only attend meetings with agenda items relevant to their organisational remit. They are comprised of the following organisations:

- The Prison Service
- The Crown Prosecution Service
- Care Quality Commission (CQC)
- South West Ambulance Service NHS Trust
- Healthwatch – The Care Forum
- Avon Fire and Rescue
- Bristol Dementia Partnership
- One25
- Voluntary, Faith and Community Sector organisations
- Representatives of service users and carers' forums

BOARD ATTENDANCE

Board members' attendance is monitored by the Joint Business Unit to ensure agencies' commitment to this work. If there is repeat non-attendance this is challenged by the Board Chair.

P	Present
D	Deputy attended
A	Apologies sent
NA	No attendance or apologies
0	Not Board member at the time

Membership	Role	Agency	May - 17	Aug -17	Nov-17	Mar-18	% attendance
EXECUTIVE	Board Chair	Independent	P	P	P	P	100%
	Director of Adult Social Services	Bristol City Council - Adult Social Care	A	P	A	P	50%
	Bristol Police Commander	Avon & Somerset Police	P	A	P	P	75%
	Director of Nursing and Quality	Clinical Commissioning Group	D	P	D	D	25%
FULL BOARD MEMBER	Clinical Director	Bristol Community Health	P	D	D	D	25%
	Head of Bristol & South Glos LDU	National Probation Service	D	NA	D	NA	0%
	Assistant Chief Officer	BGSW CRC	NA	NA	NA	NA	0%
	Lead Cabinet Member	Bristol City Council	NA	P	P	A	50%
	Head of Patient Experience	NBT	P	A	P	P	75%
	Deputy Chief Nurse	UHB	P	P	P	D	75%
	Provider Representative	Care Homes Director Brunel Care	P	A	P	P	75%
	Provider Representative	Chief Executive Freeways	P	P	P	P	100%
	Associate Director	AWP	D	P	P	P	75%

	VOSCUR Rep 1	Bristol Drugs Project	0	P	P	P	100%
	VOSCUR Rep 2	St Mungo's	0	0	0	P	100%
ASSOCIATE MEMBERS (ATTENDANCE AS REQUIRED)	Inspection Manager	CQC	A	A	A	P	25%
	Head of Safety	HMP Bristol	P	A	A	P	50%
	Area Manager, Risk Reduction	Avon Fire and Rescue	NA	NA	NA	NA	0%
	Named Professional Safeguarding	South West Ambulance Service NHS Trust	A	A	A	NA	0%
	Bristol Manager	Healthwatch	NA	NA	NA	NA	0%
	Service Manager - Crime and Substance Misuse Service	Bristol City Council - Safer Bristol	A	A	A	0	0%
	Service Manager - Children Social Care	Bristol City Council - Children Social Care	P	A	P	A	50%
	Principal Social Worker	Bristol City Council	0	P	P	A	66%
	Team Manager	Bristol Dementia Partnership	P	P	P	P	100%
	CEO	One25	NA	P	P	P	75%
	Service Manager - Children Social Care	Bristol City Council - Children Social Care	P	A	P	A	50%
	Consultant	Public Health	0	0	0	P	100%

	Head of Housing Options	Bristol City Council Neighbourhood Services and Housing	0	0	P	NA	50%
SUB GROUP CHAIRS	Sub Group Chair	Performance and Information Sub Group	P	A	P	P	75%
	Sub Group Chair	Safeguarding Adult Review Sub Group	P	P	P	P	100%
	Sub Group Chair	Communication & Engagement Sub Group	P	P	P	P	100%
	Sub Group Chair	Learning & Development Sub Group	P	A	P	P	75%

BOARD STRUCTURE AND SUB GROUPS

The BSAB meets as a full Board four times a year at a minimum. At the full Board decisions are made on the Business Plan for the year, agreement is sought for new policies or procedures, reports and audits are scrutinized in respect of the effectiveness of safeguarding arrangements in the city, Safeguarding Adults Reviews are received and new operating models are reviewed and evaluated. Board members are senior decision-making managers from their agency who can be held accountable for practice within their organisation or agree to align resources to respond to identified issues.

The full Board is supported through the Executive Group. This group is chaired by the BSAB Independent Chair and is attended by the senior managers from the three core funding agencies and the BSAB Business Manager. This group drives forward strategic improvement, maintains oversight of the resourcing of the Board, and ensures compliance with governance arrangements.

The operational work of the BSAB is undertaken by the Board's Sub-Groups and Working Groups. A Sub-Group is a permanent standing group of the Board and a Working Group is a time-limited group supporting the delivery in a specific area of practice. They are attended by representatives from across the city who ensure that the Strategic Business Plan for the year is delivered. This includes activities such as developing new resources, running conferences and undertaking multi-agency audits.

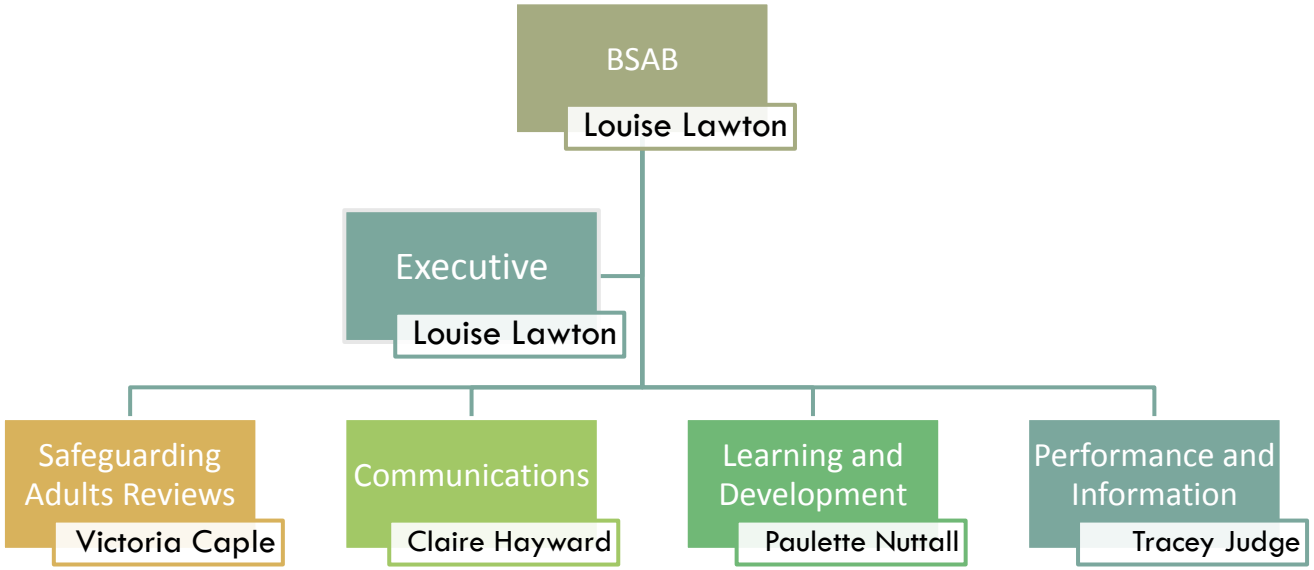
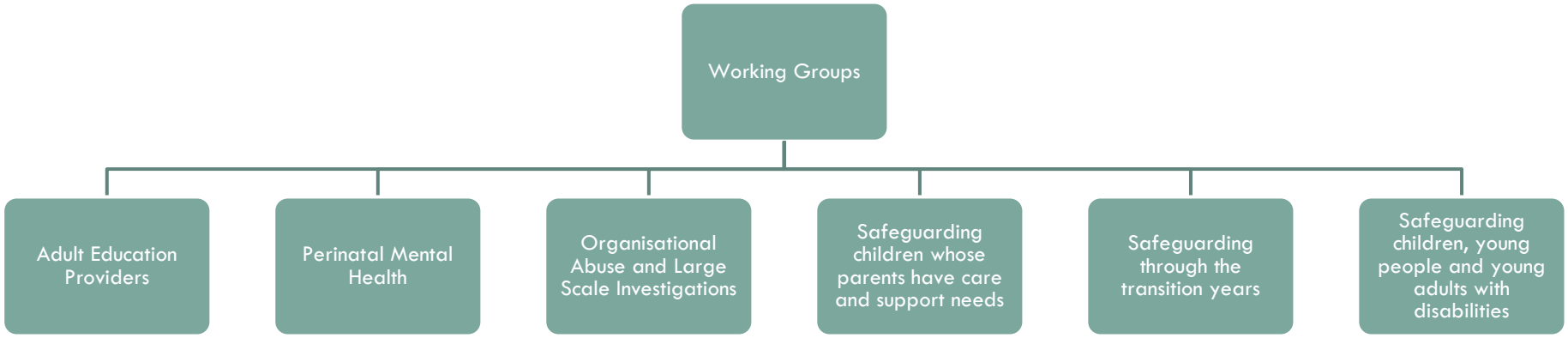


Diagram of Bristol Safeguarding Adults Board Structure and Chairs


Working Groups
Adult Education Providers
Perinatal Mental Health
Organisational Abuse and Large Scale Investigations
Safeguarding children whose parents have care and support needs
Safeguarding through the transition years
Safeguarding children, young people and young adults with disabilities

FINANCIAL ARRANGEMENTS 2017-2018

Income 2017-2018	Actual Expenditure 2017-2018	
BCC Core Contribution 54,020	BSAB Chair Salary	16,340
A&S Core Contribution 15,597	BSAB Chair Travel	1,996
CCG Core Contribution 27,010	JSBU Staff Salaries	92,599
BGSW CRC Contribution 1,500	Website Development	1,826
NBT Contribution 3,000	Legal fees	1,250
Surplus 2016/2017 14,650	BSAB Development day	313
A&S 2015/2016 Additional Set Up Contribution 3,000	ADASS SAR Thematic	300
Use of BSAB Comms materials	Facilities for Board meetings	84

150		
Annual Safeguarding Conference 1,950	Staff development	111
	Conference expenses	70
Total Income £120,877	**Total Actual Expenditure £114,989**	**£5,988 Surplus Carried Forward**

In addition core funding partners equitably share the costs of SARs commissioned by the BSAB. In 2017-18 these costs came to **£11,770**.

2. TRANSPARENT ANALYSIS OF SAFEGUARDING IN BRISTOL

BRISTOL CONTEXT[1]

Bristol is the 8th largest city in England and the 10th largest local authority in England. Bristol Local Authority accounts for around 70% of the total population of the built-up area of the city, which is often referred to as 'Greater Bristol', or the 'Bristol Urban Area'. The population in 2016 was estimated to be 456,000 people.

Population by age

Bristol has a relatively young age profile with more children aged 0-15 than people aged 65 and over. The median age of people living in Bristol in 2016 was 32.9 years old, this compares to the England and Wales median of 39.9 years. The profile of Bristol's population by age band and sex is illustrated below.

Age Band	Males		Females		Persons	
	Number	Percentage	Number	Percentage	Number	Percentage
0-15	43,100	18.9	41,700	18.3	84,800	18.6
16-24	35,100	15.4	35,800	15.7	70,900	15.6
25-49	90,300	39.6	84,100	36.9	174,400	38.3
50-64	32,800	14.4	33,400	14.7	66,200	14.5
65 and over	26,900	11.8	32,700	14.4	59,600	13.1
All ages	**228,300**	100	**227,700**	100	**456,000**	100

[1] Population information taken from 'The Population of Bristol: June 2018. https://www.bristol.gov.uk/documents/20182/33904/Population+of+Bristol+June+2018/53020277-05de-a153-2052-aa080338bb57

WORKING AGE

Bristol has a much higher proportion of working age (16-64 year old) people than nationally - 68% of the total population in Bristol is of working age compared to 63% in England and Wales. The highest proportions are amongst the 20-34 year olds which make up 30% of Bristol's total population compared to 20% nationally.

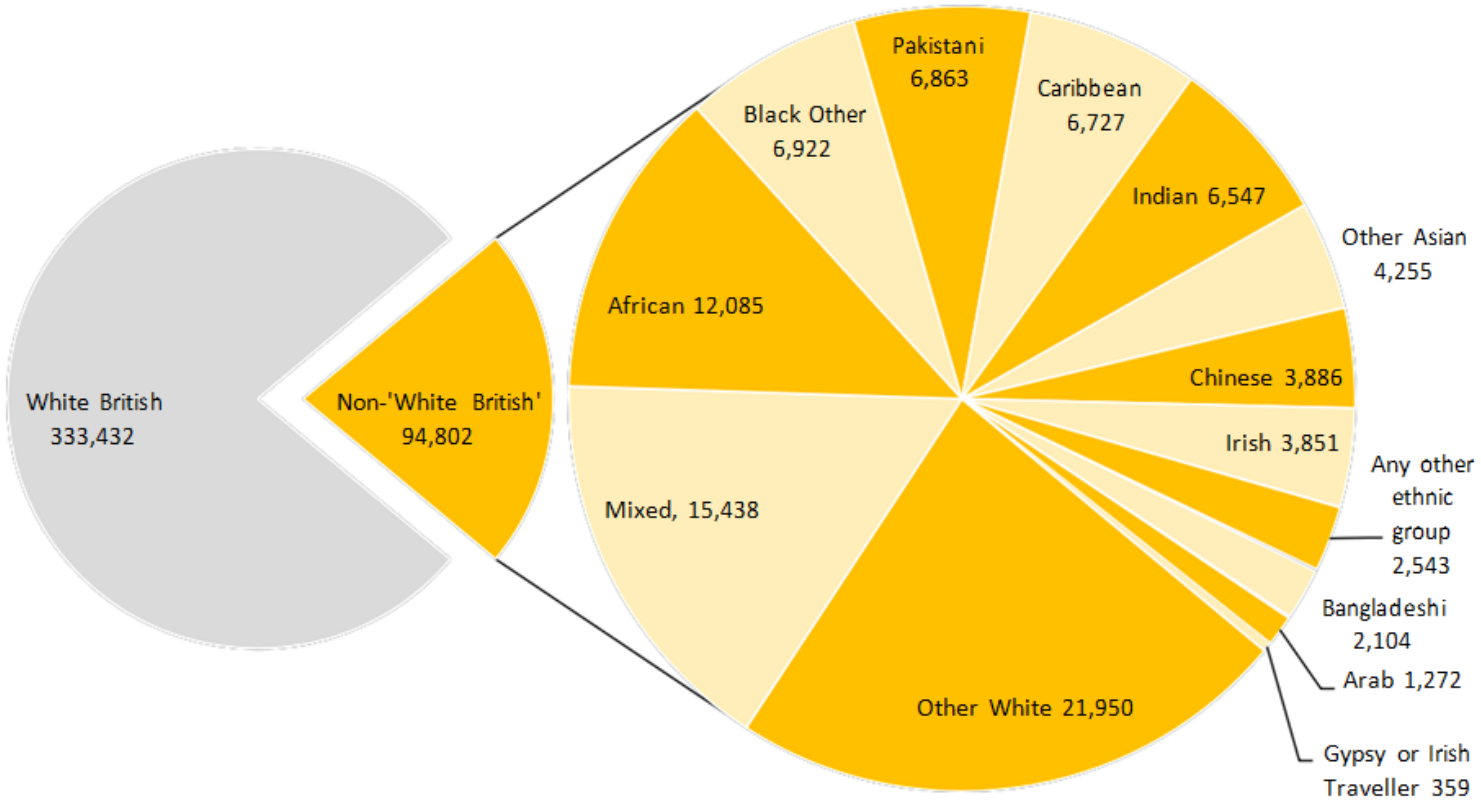
OLDER PEOPLE

Bristol's 59,600 older people make up 13% of the total population, i.e. 1 in every seven people living in Bristol is aged 65 or over. The proportion of older people is lower than in England and Wales as a whole where 18% of the population are aged 65 and over. There are 9,000 people living in Bristol aged 85 and over.

ETHNIC GROUP

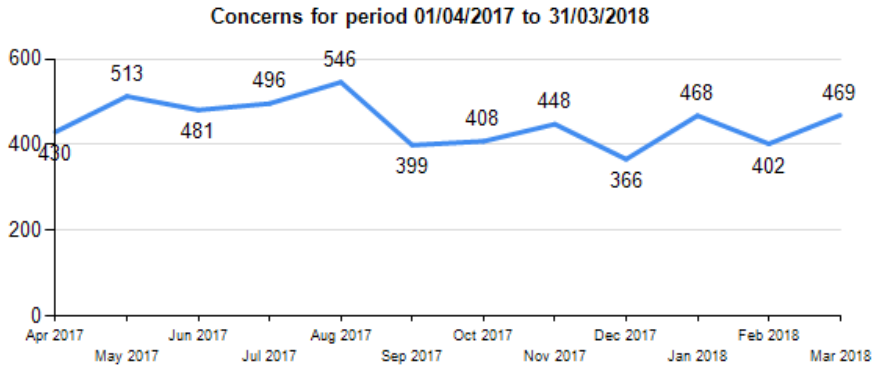
The Black or Minority Ethnic group (BME) population (all groups with the exception of people who define as 'White') make up 16% of the total population in Bristol. This is an increase from 8.2% of all people in 2001. All groups with the exception of people who define as 'White British' make up 22% of the total population in Bristol – this group includes people who define as White European for example. This is an increase from 12% of all people in 2001.

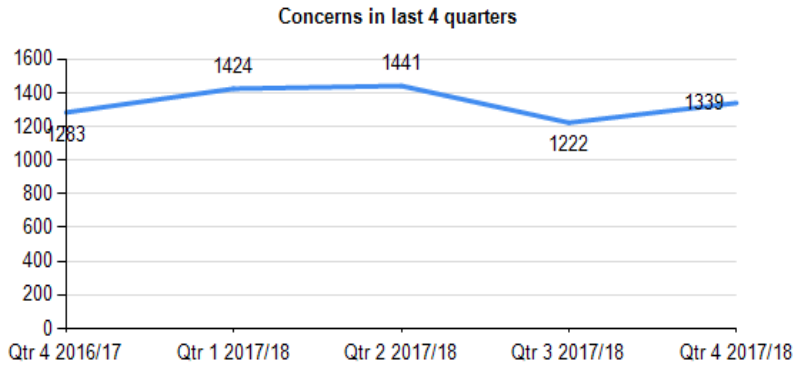
The age profile of the BME population is much younger than the age profile of the Bristol population as a whole. The proportion of children (aged 0-15) who belong to a BME group is 28%, the proportion of people of working age (aged 16-64) who belong to a BME group is 15% and the proportion of older people (aged 65 and over) who belong to a BME group is just 5%. This means that Safeguarding Adults services may have less experience of meeting the needs of these groups and require ongoing support and coordination of services.



Source: 2011 Census Office for National Statistics © Crown Copyright 2013 [from Nomis]

SAFEGUARDING ADULTS REFERRALS





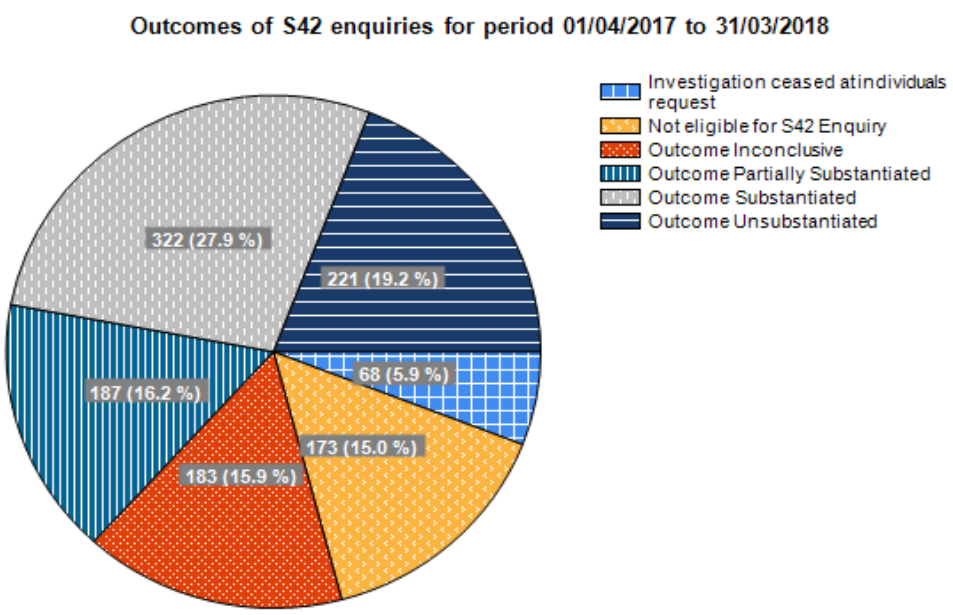
In 2017-2018 the number of safeguarding concerns reported to the Bristol City Council Safeguarding Adults Team was 5,426. This is significantly higher than in the previous two years (an increase of 29% from 2016/2017 when 4205 concerns were raised). The lowest number of concerns was raised in Q3, following a high of 1441 contacts in Q2 with the highest number of contacts in August.

17% of safeguarding concerns in 2017/18 were reported by External Agency, 16% by Primary Health Staff, 13% by Police and 11% by Secondary Health Staff. However the highest number of concerns that progressed to Section 42 (Care Act 2014) Enquiry was reported by Primary Health Staff with a fifth of all Enquiries in 2017/18 from the source

156 concerns were reported by individuals including friends, neighbours and family members and 21 contacts were self-referrals. The number of contacts made by individuals has remained steady over the past 3 years. Contacts made by individuals have one of the highest conversion rates to enquiries with almost a half of those contacts progressing to Section 42 Enquiry in 2017/18.

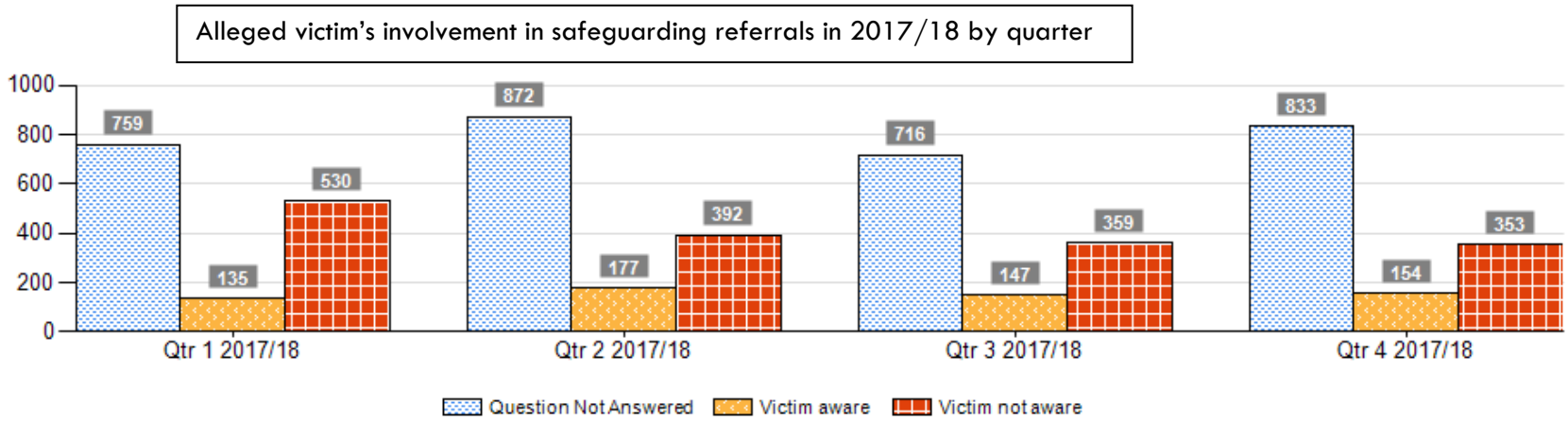
13% of referrals were made by police. This is similar to the previous year but a significant increase on 2015/16 when there was a drop to 5% (from pre-Care Act level of 24% referrals from police in 2014/2015) after a change in the constabulary's operating model. In 2017/18 only a tenth of all contacts from the Police progressed to Section 42 Enquiries in 2017/18, this continues to be monitored by BSAB and the police have implemented a new risk assessment tool this year.

SECTION 42 SAFEGUARDING ADULTS ENQUIRIES



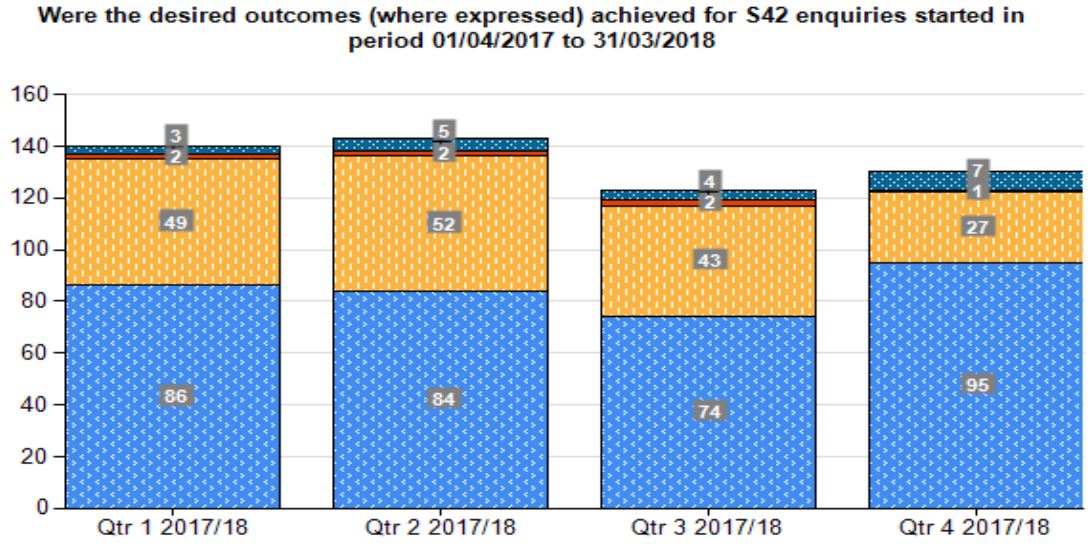
1,254 referrals progressed into Section 42 Enquiries (this is almost 10% less than in 2016/17 despite a significant increase in the number of concerns raised). 1154 enquiries (92%) were completed at the time of reporting. 68 enquiries ceased at the individuals request. 173 were deemed ineligible for a section 42 during the process and the enquiry was halted (60% increase from the previous year), 183 had an outcome that was inconclusive, 187 had an outcome that was 'partially substantiated', 322 had an outcome fully substantiated; and 221 had an outcome that was 'unsubstantiated'. Of the 978 enquiries completed in 2017/18 that required safeguarding action, risk was reduced or removed in 86% of cases. Inconclusive outcomes most often occur where there are mental capacity issues and the adult at risk is unable to give their own account and there are no witnesses. In these cases a protection plan is still put into place as the person may still be at risk of further harm or neglect.

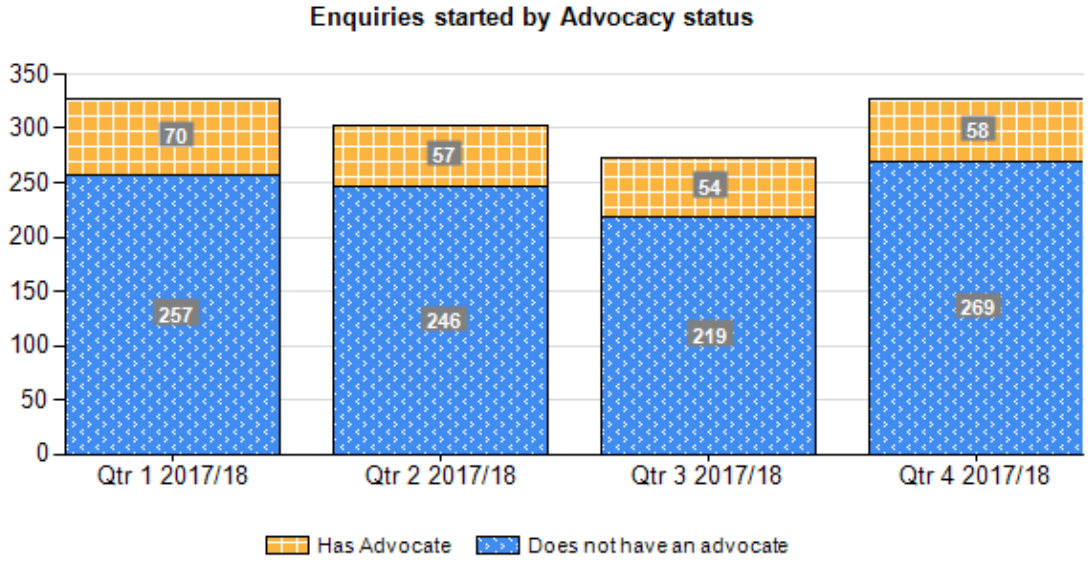
CONSENT



One of the BSAB priorities is to improve the involvement of adults in their safeguarding. Despite work in this area we have seen little increase in the number of adults who were made aware of the Safeguarding Adults Team referral by the referrer with the average over the year being only marginally higher than the last. In 2017-2018 we supported Bristol City Council in the redesign of their referral form to make the expectation for this more explicit and will be monitoring the impact of this change in 2018-19.

Only 11% of alleged victims are informed of the referral to Safeguarding being made. In a large proportion of cases the questions on victim's involvement in the enquiry are not answered by professionals. It is unclear from the data whether this is a recording issue or whether alleged victims are not consulted at the time of referral by referrers. Excluding the cases where the referrer didn't answer the question, the proportion of alleged victims who are aware of the referral increases to 27%, which is still very low when you take into account that some adults will not have capacity to consent to safeguarding referral. This is a key indicator of improvement in 2018-19 for the partnership in respect of Making Safeguarding Personal.



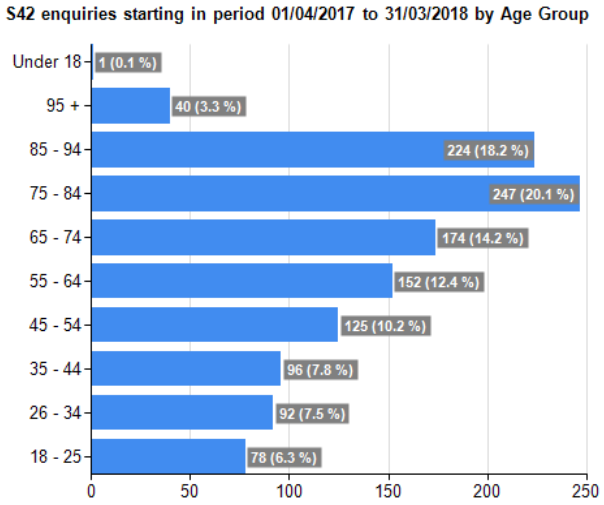


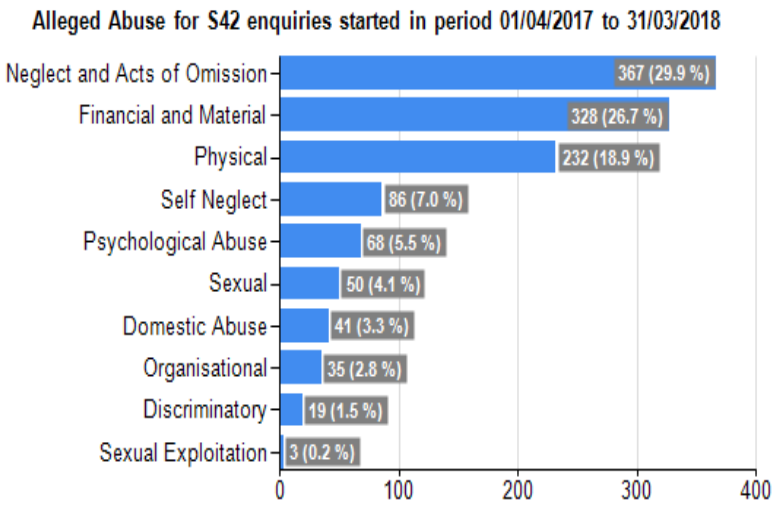
Half of adults with care and support needs referred to Section 42 enquiry in 2017/18 were consulted about their desired outcomes y Bristol City Council Safeguarding Adults Team. This is similar to last year but we will continue to support this to increase for adults who have capacity in this area of their lives. The outcomes were partially or fully met in most cases (95%) as shown in the chart on the left. The proportion of cases where the expressed desired outcomes were met fully has increased significantly in the last year when comparing to the previous year.

The downward trend in adults recorded as having an advocate in Section 42 Enquiries continued in 2017/18. However the proportion of alleged victims in S42 enquiries who lacked mental capacity who had advocate remained steady at just under a quarter (same proportion as in 2016/17).

PREVALENCE OF ABUSE

As might be expected, the groups with the highest rate of referrals to the Safeguarding Adults Team were older adults, with more than a half of alleged victims under Section 42 enquiries aged over 65. This is likely to be because of a larger population of adults in these age groups who are in receipt of care and support. Neglect and acts of omission closely followed by financial and material abuse were the two primary concerns for alleged victims of enquiries in 2017/18 (57% of cases).



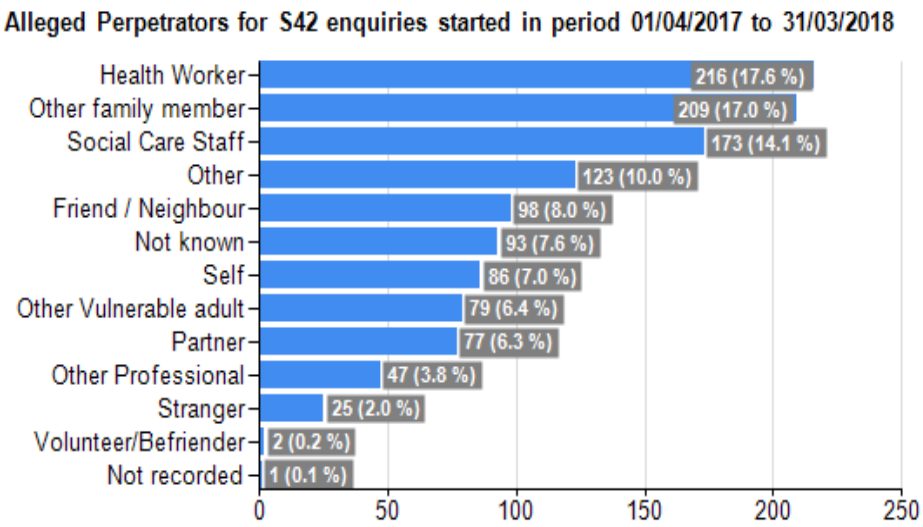


Almost half (47%) of alleged abuse investigated through Section 42 enquiries in Q4 17/18 happened in victim's own home, 19% of victims of alleged abuse were in a care home and 13% were in a hospital. 9% of alleged abuse was recorded as within the community. This is similar to the previous year.

Over a third of cases (36%) where alleged abuse took place at victim's own home were related to Financial and material abuse (36%), this is a significant increase by almost 10% from the previous year. The frequency of Financial and Material abuse in Section 42 enquiries in general has increased significantly over the past year with an average of 27% of all alleged abuse being labelled as such in Section 42 enquiries in 2017/18 (compared to just 19% the previous year). Just under a half of all alleged abuse in care homes and hospitals in 2017/18 was due to neglect and acts of omission, which is similar to last year.

Abuse type	Care Home	Community Service	Hospital	Other	Own Home	Total
Discriminatory	3	1	3	5	7	**19**
Domestic Abuse	0	1	2	8	30	**41**
Financial and Material	23	47	19	32	207	**328**
Neglect and Acts of Omission	121	15	81	12	138	**367**
Organisational	24	0	2	3	6	**35**
Physical	71	21	44	21	75	**232**
Psychological Abuse	7	7	10	10	34	**68**
Self-Neglect	2	12	0	9	63	**86**
Sexual	11	9	7	10	13	**50**
Sexual Exploitation	0	0	0	2	1	**3**
Total	**262**	**113**	**168**	**112**	**574**	**1229**

As part of our continuous efforts to raise awareness of self-neglect, our Safeguarding Adults Conference last year was themed around self- neglect. A policy on self-neglect was developed by BSAB last year and published in March 2017. Self-neglect accounted for 7% of cases referred to Section 42 enquiries in 2017/18 (a 2% increase from 2016/17).



Safeguarding enquires were most likely to be made due to suspected abuse or neglect by a health worker or family member other than a partner. These made up over a third of all referrals. Social care staff were the third highest source of suspected abuse (14% of Section 42 enquiries in 2017/18). This is a significant drop from the previous year when social care staff were the most common alleged perpetrator (in almost a fifth of Section 42 enquiries in 2016/17).

DEPRIVATION OF LIBERTY SAFEGUARDS

The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005. The DoLS under the MCA allows restraint and restrictions that amount to a deprivation of a person's liberty to be used in hospitals and care homes – but only if they are in a person's best interests. To deprive a person of their liberty, care homes and hospitals must request standard authorisation from a local authority. A 2014 Supreme Court judgement found that more adults were found to meet the criteria of requiring DoLS assessment and authorisation than had been previously applied.

Bristol City Council have faced the same challenges of capacity and resource reported by local authorities nationally with the high number of people requiring DoLS assessments. BSAB receives regular reports on the number of outstanding DoLS assessments to maintain oversight of this.

As reported in last year's annual report, in March 2017 The Law Commission published a report setting out recommendations, together with a draft Bill following extensive consultation. The final report and draft Bill recommends that the DoLS be repealed with pressing urgency and sets out a replacement scheme for the DoLS. In March 2018 the Government published their final response and agreed that DoLS should be replaced and that they were broadly in agreement with the Law Commission's Liberty Protection Safeguards Model.

Due to a change of recording systems, creating a backlog in uploading data the BSAB has not received consistent data from Bristol City Council on DoLS referrals and assessments. We have received assurance that this will be up to date in April 2018 and we continue to request assurance data for oversight of this important safeguarding function.

CARE QUALITY COMMISSION

The Care Quality Commission has inspected 109 services in Bristol in 2017/18. The majority (68%) were rated as Good. 6 were rated Outstanding (5.5%). 25% were rated as Requires Improvement. This is lower than the national average of 30.6% of services. 4 services were rated as Inadequate. From this we know there is some very high quality practice in Bristol, but also significant work to do to ensure that adults receive the highest quality, most effective services. To ensure better scrutiny and oversight, the BSAB now receives quarterly reports on Service of Concern in Bristol so they are able to monitor any trends or respond quickly to issues. As part of the strategic plan for 2018-19, the BSAB will be working with the local Quality Surveillance Group to build stronger links and oversight of safety issues across providers of health.

3. STRATEGIC PLAN UPDATE

EARLY INTERVENTION AND PREVENTION

The Prevention and Early Intervention Strategy was approved by the Bristol Adult's Safeguarding Board (BSAB) in 2016 setting out our multi agency requirements in this area through our commissioning, contract and procurement activity as set out in the Care Act (2014).

In August 2017 a request to provide details of the primary, secondary and tertiary prevention services was sent out to our core agencies including the Police and Crime Commissioners Office so that we could conduct a needs analysis. This would allow the BSAB to have oversight of what early support is provided through our care and support systems at a primary, secondary and tertiary level. The data set showed a snapshot of what services are commissioned and provided. This led to the development of 12 recommendations (some of which have already been implemented/completed) to ensure that Early Intervention continues to be at the core of our work moving forward into the next financial year.

PROTECTION

ORGANISATIONAL ABUSE AND LARGE SCALE INVESTIGATIONS

This business year the BSAB has developed how the partnership work together to respond in cases of organizational or large scale abuse. This responded to learning that was highlighted in a number of Serious Adult Reviews both nationally and in adjoining local authorities. The work was summarized in a new guidance document, and included engagement with commissioning, Procurement and Contracts so that any

changes required could be embedded into contractual arrangements. The guidance outlines the importance of Early Intervention and Prevention and the multi-agency response required when there are concerns about an Organisation. It guides agencies through how to coordinated large scale investigations which would involve a wide range of agencies concerned with both the protection of individual adults and quality of care issues. Further explanation is given to enable professionals to understanding of the role of the Police and criminal investigations together with CQC as the regulator with inspection, enforcement and emergency powers.

Safeguarding arrangements at commissioned organisations will be monitored through a regional Self-Assessment Audit this year together with measurement of awareness at Test and Check Audits that will take place amongst front line professionals.

CHILDREN, YOUNG PEOPLE AND YOUNG ADULTS WITH DISABILITIES

Whilst children and young adults with a disability experience the same types of abuse as others they can be more vulnerable to being targeted and harmed. This has been reflected in many Serious Case and Safeguarding Adult Reviews. The low number of young adults referred to safeguarding in the city informed an intensive consultation process including learning event where over 80 professionals, adults and parents provided input. We consulted children, young people and young adults with disabilities including those that use communication aids. This work highlighted the barriers many young adults with disabilities face and was at the center of the work to develop practice.

A multi-agency task group was responsible for developing the new guidance which sets out the need for professionals to identify low level risks and ensure there is early intervention and prevention to minimise the risk and harm that could occur. It makes clear that young adults with disabilities are more vulnerable to all forms of abuse, exploitation and neglect including the risk of radicalisation, however due to barriers that they face it can be more difficult to identify. The guidance sets out how the barriers that exist can be overcome which includes best practice guidance for Achieving Best Evidence and the importance of advocacy.

A further task group is to be set up to oversee compliance with the guidance and drive forward further improvements in practice in particular better more accessible communication aids for young adults with safeguarding content. A series of test and check audits are planned to monitor how senior managers have disseminated this guidance and embedded it into practice.

PERINATAL MENTAL HEALTH

In response to learning from the **ZBM Serious Case Review,** a new partnership approach to safeguarding women and children experience Perinatal Mental Ill Health Protocol has been developed. The new processes, including the implementation of a new specialist team, is set out in the Bristol Perinatal protocol which:

- Provides a clear understanding of the systems/pathways in place in Bristol;
- Sets out the importance of professionals taking collective responsibility for women, baby and the family and responding effectively and quickly;
- Encourages identification of high risk women and signposting at the earliest opportunity;
- Establishes greater role and professional awareness;
- Mandates clear, concise and regular communication between professionals;
- Defines best practice and the role of the Lead Professional;
- Focuses on early intervention, to prevent the onset of Mental Health illness in women and help those known to be at risk and act quickly when illness occurs.

A consultation took place with mothers and their partners which was facilitated by one of our third sector agencies in Bristol who ensured that their voices were recorded throughout the document so that we can ensure that our professional practice is more person and outcome focused.

The Joint Business Unit facilitated 5 Multi Agency Briefings, attended by over 130 professionals that included learning from the ZBM and Baby L Serious Case Reviews in respect of maternal mental health needs, details of the new guidance and good practice around referrals to First Response.

A Perinatal Mental Health Audit of randomly selected cases has recently been completed to provide further assurance that front line practice complies with the protocol.

SAFEGUARDING OLDER ADOLESCENTS AND YOUNG ADULTS

The BSAB in partnership with the Bristol Safeguarding Children Board identified the need to tighten up practice between children and adult's services when children, young people and young adults fall between services at a time of increased independence and greater vulnerability.

A task group of key professionals across the City that work directly with those in their transition years was convened. We worked with children, young people and young adults so that we reflected their voice throughout the document. The document was aligned with NICE Guidance, what young people tell us what good practice is, how they can be helped to stay engaged and what professionals are experiencing when working with this age group and what works for them.

A short practice guide that gives top tips for professionals was created and disseminated amongst professionals and awareness will be measured through a regional Test and Check Audits planned for this year.

PARTNERSHIP AND ENGAGEMENT

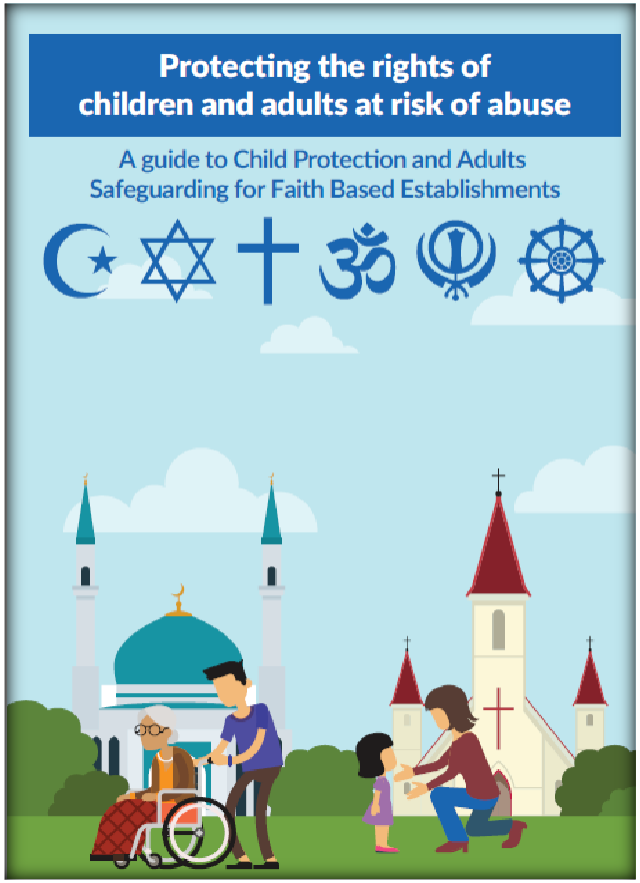
ENGAGEMENT WITH FAITH BASED ESTABLISHMENTS

In recognition of the important role faith based establishment have in identifying abuse and neglect, and safeguarding adults from harm, this year the BSAB in partnership with the BSCB sought to develop resources for the community. Widespread consultation with all faiths took place within our local community which included over 50 religious representatives and attendance at a meeting of the Multi Faith Forum.

A guide to Child Protection and Adult Safeguarding for Faith Based Establishments was produced to support establishments in their responsibilities of ensuring the safety of children and adults at risk. It focuses on Abuse and Neglect, its impact, and defines the safeguarding processes which includes the Prevent and Channel process.

A safeguarding pack that included this guide with a free training offer to Safeguarding Leads was sent out to over 150 faith based establishments across the City.

The Independent Inquiry into Child Sexual Abuse (ICSA) has already highlighted failings within organisations to have the necessary protection in place for children therefore it is vital that organisations have robust and effective safeguarding arrangements in place. The BSCB and BSAB have adapted this document to support organisations in ensuring that they have the correct arrangements in place to ensure they fulfil their duty of safeguarding children and vulnerable adults.



ENGAGEMENT WITH ADULT EDUCATION SETTINGS

This year the BSCB was alerted to a group of young adults who died by suicide whilst attending the University of Bristol. The BSAB called the University to attend the full Board with Public Health and present their response plan. As a result the BSAB supported the development of better links between police and the University. In addition we set up an Adults Education Working Group in partnership with adjoining LSABs. We consulted the group on key issues for adult education and identified concerns that the sector's role and involvement in responding to adult safeguarding issues was unclear. We therefore developed the regional safeguarding adults guidance to clarify expectations of all partners in respect of education's role. The group also highlighted internal confusion about the difference between their Care Act 2014 responsibilities and other pathways such as those to support victims of domestic abuse, and those to access mental health support. In response we developed Safeguarding Training Standards to ensure key staff are receiving appropriate levels of training. We also produced a aide memoire resource which explained the relationships and pathways of the different sources of support. We will be requesting reassurance on the progress the University of Bristol have made in respect of their response plan in 2018-19.

ANNUAL CONFERENCE – SELF NEGLECT

In June 2017 the BSAB held a joint conference with South Gloucestershire SAB on the theme of Self-Neglect. The keynote speaker was Professor Michael Preston-Shoot, Professor Emeritus (Social Work) pictured here with Louise Lawton, Independent Chair of BSAB.

Participants attended workshops on: a community safety response to hoarding; early intervention and prevention practice response to hoarding; consent and covert medication; self-neglect and substance

misuse; consent and self-neglect in care homes; consent and self-neglect in the community; and managing ethical dilemmas when information sharing about consent.

The conference was attended by over 120 professionals from across organisations in the city.

ACCOUNTABILITY

This year the BSAB implemented a schedule of multi-agency thematic audits. This work has enabled us to have greater scrutiny on the effectiveness of the partnership. In this business year we audited Safeguarding referrals and application of threshold; S42 enquiries and the Peri-natal mental health pathway. The audits highlighted that the quality of safeguarding referrals across the city was inconsistent. In response the Board has developed a good practice training session which has been

4. SAFEGUARDING ADULTS REVIEWS (SARS)

A Safeguarding Adults Review (SAR) is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is to promote effective learning and improvement, not to apportion blame.

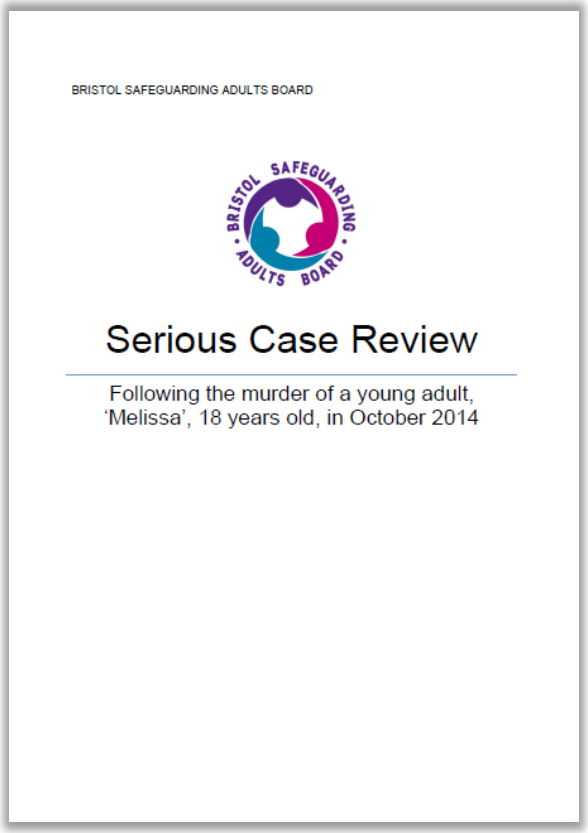
A Safeguarding Adult Review (SAR) is a multi-agency review conducted by a Local Safeguarding Adults Board. The Care Act 2014 states that a SAB must commission a SAR when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult
- if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.
- SABs are free to arrange for a SAR in other situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include exploring examples of good practice.
-

In 2017-2018 the BSAB published one Safeguarding Adult Review, one Adult Serious Case Review, and a non-statutory thematic review. An additional Safeguarding Adult Review commissioned in 2016-17 is due to be published in the 2018-19 period and will therefore appear in the next annual report. The full reports with Board responses and professional briefing documents can be found here.

'MELISSA' ADULT SERIOUS CASE REVIEW

The 'Melissa' review was published in Autumn 2017 and concerned the murder of a young woman by a young man in the care home they were both residents in. As this review was commissioned before the implementation of The Care Act 2014 it is an Adult Serious Case Review rather than Safeguarding Adults Review.



This review raised a number of concerns around the actions taken by individual agencies. The Care Quality Commission was informed of the findings of the review and re-inspected the care home, rating it 'Good' after an inspection in May 2016. The care home has also introduced compatibility assessments to use with residents. The placing authority of the perpetrator commissioned a local independent inspection of their transitions services and have reviewed and updated their governance processes.

Systemic findings of the review included:

- the lack of robust contingency plans for Out of Area placement breakdown
- the reluctance of some residential schools in reporting safeguarding concerns and other incidents to the Police
- a national shortage of accommodation for service users with Autistic Spectrum Condition and Asperger's Syndrome
- the necessity for support levels to be expressed unambiguously within placement agreements
- difficulties in managing the transition of service users from Children's to Adults services.

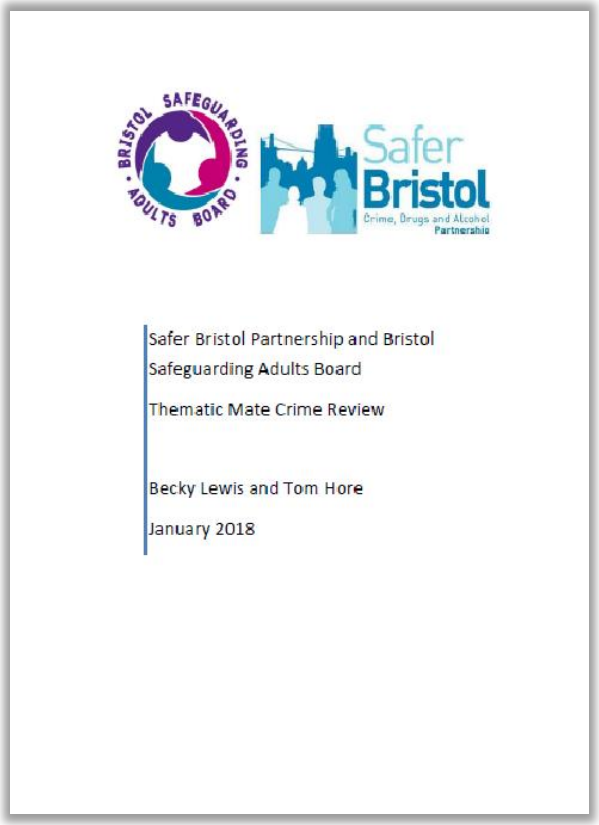
Since the circumstances of this case the BSAB published Information Sharing Guidance in 2016 which included the importance of accurate recording of safeguarding concerns The review has been shared with the BSCB and Bristol City Council Education department to inform safeguarding training around the issue of reporting incidents within residential schools, and the Bristol City Council Adult Social Care database has been reviewed to include provision for potential placement breakdown (this is due to be implemented in 2018/19).

The BSAB have also notified a number of national bodies of the findings of this review in order to effect national improvements. The Department of Health (DoH) and the Association of Directors of Adult Social Services (ADASS) have been notified in regard to practice around the potential for placement breakdown when placing out of area; NHS England and ADASS in regard to the need for unambiguous statements in the provision of staff support levels; the Department for Education regarding reporting incidents in residential schools; the DoH regarding the requirement for a national Safeguarding Adults Review database (Social Care Institute of Excellence has been commissioned to produce this); and NHS England regarding the lack of suitable provision for adults with Autism Spectrum Conditions/ Asperger's. We have been informed that this issue will be addressed by the national Transforming Care Delivery Board.

The BSAB is commissioning the development and evaluation of an inter-personal assessment tool for use by Bristol group accommodation providers. This will be launched in 2018. This piece of work was initiated by feedback from professionals who attended a BSAB Learning Event on improving safety in group accommodation settings which shared the findings of the Melissa review and other relevant reviews.

'DERRICK' MATE CRIME THEMATIC REVIEW

In March 2017 the BSAB received a referral to consider the case of 'Derrick', for a Safeguarding Adult Review. When Derrick died concerns were raised that he had been the victim of Mate Crime (in which a vulnerable adult is exploited by individuals who claim to be their friend) while living in supported accommodation. As Derrick's death did not result from abuse or neglect the criteria for a SAR were not met.



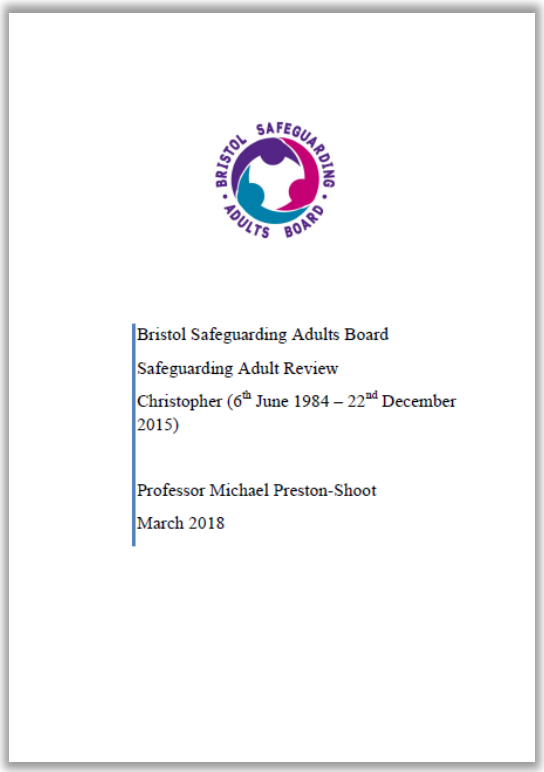
However, the case raised concerns about agencies' knowledge and ability to respond effectively to Mate Crime. It was agreed that the BSAB and Safer Bristol Community Safety Partnership would undertake a joint Thematic Review to consider whether there were practice issues in this instance and/or opportunities for development in the protection of adults in the city in this area. The final report was completed in January 2018.

The Thematic Review found that:

- there is not a consistent understanding or awareness of Mate Crime in the city
- it is crucial to establish expectations of both the adult and their family to prepare for increased independence, ie. a move from a home environment in to supported accommodation
- care should be reviewed regularly and in collaboration with the adult and their family
- there is a need to reinforce the professional commitment to responding robustly to Mate Crime.

13 recommendations were made to BSAB and Safer Bristol, and these are being implemented in collaboration. The regional Joint Safeguarding Adults Policy has now been updated to include Mate Crime, and an annual conference on Mate Crime has been planned for Stop Adult Abuse Week 2018. Work has been undertaken to improve the process of making safeguarding referrals, including automatic receipting of online referrals. Work planned for 2018/19 includes the development of a training offer around improving the professional response to Mate Crime and the production of resources to help adults identify where they may be a victim. Resources will also be produced to prepare families for when a relative moves in to supported accommodation, and for the providers to balance an adult's right to independence with effective family engagement.

'CHRISTOPHER' SAFEGUARDING ADULT REVIEW


Bristol Safeguarding Adults Board

Safeguarding Adult Review

Christopher (6th June 1984 – 22nd December 2015)

Professor Michael Preston-Shoot

March 2018

The Christopher SAR was completed and approved at the end of the 2017-18 year and published in April 2018. Christopher died in 2015 as a result of a respiratory tract infection and pre-existing health conditions, compounded by recent weight loss.

Christopher moved into supported living for fifteen months before his death having lived with his father for the majority of his adult life. He was admitted to hospital after becoming ill and losing significant weight as a result of refusing food and medication in his supported living. The SAR found that Christopher experienced systemic organisational neglect as a result of the lack of coordination of his care to manage his complex needs.

Findings included:

- the degree and nature of family involvement in this case was never clarified, nor kept under constant review
- the centrality of person-centred care
- the importance of practitioners understanding and correctly applying the law regarding mental capacity.

14 recommendations were made, and BSAB continue to monitor their implementation. In response to this review the BSAB has reviewed and relaunched the escalation policy, and work to develop a culture of challenge will continue into 2018/19. The BSAB has undertaken multi-agency audits of Section 42 Threshold applications and responses to self-neglect, produced a Joint Supervision Guidance alongside the BSCB, produced a quick reference guide to

the adults at risk pathways available in Bristol, and launched a Self-Neglect policy. A training package on making a good referral has been developed, and the BSAB will continue to develop a framework to support agencies in their safeguarding training.

Further work that will be undertaken in 2018 includes undertaking an audit of the application of Mental Capacity Assessments and facilitating multi-agency learning forums to develop practice in this area. Guidance will be produced on working with family members and advocates, and resources for family members to explain the safeguarding process. The BSAB will strengthen its data collection on the use of advocates for adults with complex physical health needs and learning disability, and support statutory partners to undertake a review of the lead professional role within complex cases. An audit of transitions to supported living facilities will be undertaken by BSAB members, and guidance produced to support best practice.

5. PRIORITIES FOR 2018-2019

Following consultation with adults at risk, carers and professionals the following four areas will be priorities for improvement in 2018-2021.The full Strategic Plan can be found here.

REPORT SUSPECTED ABUSE: SAFEGUARDING ADULTS AT RISK

If you're being abused or think someone else is being abused, you must tell someone.

If you're a professional use the online **safeguarding adults referral form** https://www.bristol.gov.uk/en_US/social-care-health/report-suspected-abuse

CALL CARE DIRECT

Telephone 0117 922 2700 8.30am to 5pm Monday to Friday (answerphone outside office hours).

CALL THE POLICE

Telephone 101

In an emergency telephone 999

Textphone 18001 followed by 101

Textphone in an emergency 18000