Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Bath and North East Somerset Health & Wellbeing Board (Shadow)

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	Date:	30 October 2012

To: All Members of the Health & Wellbeing Board (Shadow)

Members: Tony Barron (Chair of the PCT Board), Councillor Paul Crossley (Bath & North East Somerset Council), Patricia Webb (CCG B&NES), Councillor Simon Allen (Bath & North East Somerset Council), Ashley Ayre (Bath & North East Somerset Council), Diana Hall Hall, Ed Macalister-Smith (NHS B&NES), Dr. Ian Orpen (St James Surgery, Bath), David Smith (NHS), Simon Douglass (Member of the Clinical Commissioning Group), Councillor Dine Romero (Bath & North East Somerset Council), Paul Scott (Director of Public Health) and Jo Farrar (Bath & North East Somerset Council)

Observers: Councillor John Bull (Bath & North East Somerset Council) and Councillor Vic Pritchard (Bath & North East Somerset Council)

Other appropriate officers
Press and Public

Dear Member

Health & Wellbeing Board (Shadow)

You are invited to attend a meeting of the Board, to be held on **Wednesday, 7th November, 2012** at **2.00 pm** in the **Council Chamber - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
Committee Administrator

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

1. **Inspection of Papers:**
   Any person wishing to inspect minutes, reports, or a list of the background papers relating to any item on this Agenda should contact Jack Latkovic who is available by telephoning Bath 01225 394452 or by calling at the Riverside Offices Keynsham (during normal office hours).

2. **Public Speaking at Meetings:**
   The Partnership Board encourages the public to make their views known at meetings. They may make a statement relevant to what the meeting has power to do. Advance notice is requested, if possible, not less than *two full working days* before the meeting (this means that for meetings held on Wednesdays notice is requested in Democratic Services by 4.30pm the previous Friday).

3. **Details of Decisions taken at this meeting** can be found in the draft minutes which will be published as soon as possible after the meeting, and also circulated with the agenda for the next meeting. In the meantime details can be obtained by contacting Jack Latkovic as above. Appendices to reports (if not included with these papers) are available for inspection at the Council's **Public Access Points:**

   - Guildhall, Bath;
   - Riverside, Keynsham;
   - The Hollies, Midsomer Norton;
   - Public Libraries at: Bath Central, Keynsham and Midsomer Norton.

4. **Substitutions**
   Members of the Board are reminded that any substitution should be notified to the Committee Administrator prior to the commencement of the meeting.

5. **Declarations of Interest**
   Board Members do not need to declare an interest in their ex officio status on the Board. If they have a closer involvement with any specific issue (via membership of a Sub-Committee for example), consideration would need to be given to whether a declaration was needed, and advice sought from the Monitoring Officer if necessary.

   The following member of the Board has roles in the Council and PCT:

   Ashley Ayre: Strategic Director for People and Communities, operating across the Partnership

   The following member of the Partnership Board has role in BANES and Wiltshire PCT Cluster:

   Ed Macalister-Smith: NHS BANES and NHS Wiltshire Chief Executive

   However, when attending a meeting of the Partnership Board, each member is attending in the role shown on the invitation to attend the meeting, which is on the first page of the papers for the meeting.

6. **Attendance Register:**
   Members should sign the Register which will be circulated at the meeting.

7. **Emergency Evacuation Procedure**

If the continuous alarm sounds, you must evacuate the building by one of the designated exits and proceed to the named assembly point. The designated exits are sign-posted.

Arrangements are in place for the safe evacuation of disabled people.

Health & Wellbeing Board (Shadow)

Wednesday, 7th November, 2012
Council Chamber - Guildhall, Bath
2.00 pm

Agenda

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

   Board Members do not need to declare an interest in their *ex officio* status on the Board. If they have a closer involvement with any specific issue (via membership of a Sub-Committee for example), consideration would need to be given to whether a declaration was needed, and advice sought from the Monitoring Officer if necessary.

   The following member of the Board has roles in the Council and PCT:

   Ashley Ayre: Strategic Director for People and Communities, operating across the Partnership

   The following member of the Partnership Board has role in BANES and Wiltshire PCT Cluster:

   Ed Macalister-Smith: NHS BANES and NHS Wiltshire Chief Executive

   However, when attending a meeting of the Partnership Board, each member is attending in the role shown on the invitation to attend the meeting, which is on the first page of the papers for the meeting.

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

6. PUBLIC QUESTIONS/COMMENTS

7. MINUTES OF PREVIOUS MEETING

   To confirm the minutes of the above meeting as a correct record.

8. ORGANISATIONAL UPDATES (20 MINUTES)

   The Board are asked to consider the following verbal updates:

   - Local Healthwatch (Derek Thorne)

- Public Health (Paul Scott)
- NHS (Ed Macalister-Smith)
- CCG (Ian Orpen)
- Council (Ashley Ayre)

9. HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES (25 MINUTES)

   This is an information report to supplement the presentation on Healthy and sustainable places and communities.

10. HEALTHWATCH - COMMUNITY ENGAGEMENT PILOT (15 MINUTES)

11. DEMENTIA CHALLENGE FUND (15 MINUTES)

12. UPDATE REPORTS (30 MINUTES)

    The Board are asked to consider the following update reports:

    - Children's Safeguarding Report (Maurice Lindsay)
    - Children's Health Commissioning Report (Liz Price)
    - Adult Safeguarding Annual Report (Lesley Hutchinson)
    - Adult Health and Wellbeing Commissioning Report (Tracey Cox)

13. FORWARD HEALTH AND WELLBEING BOARD (SHADOW) DATES

    The Board are asked to note the schedule of future meetings:

    - Wednesday 6th February 2013 at 2pm in Kaposvar Room, Guildhall.
    - Wednesday 17th April 2013 at 2pm in Kaposvar Room, Guildhall.

The Committee Administrator for this meeting is Jack Latkovic who can be contacted by telephoning Bath 01225 394452

HEALTH & WELLBEING BOARD (SHADOW)

Minutes of the Meeting held

Wednesday, 19th September, 2012, 2.00 pm

Councillor Simon Allen	-	Bath & North East Somerset Council
Ashley Ayre	-	Bath & North East Somerset Council
Dr. Ian Orpen	-	St James Surgery, Bath
David Smith	-	NHS
Paul Scott	-	Director of Public Health
Jo Farrar	-	Bath & North East Somerset Council
Councillor Dine Romero	-	Bath & North East Somerset Council

13 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

The Chair also welcomed new Board Members – Councillor Dine Romero (new Cabinet Member for Early Years, Children and Youth) and Jo Farrar (new Chief Executive for Bath and North East Somerset Council).

14 EMERGENCY EVACUATION PROCEDURE

The Democratic Services Officer drew attention to the evacuation procedure.

15 APOLOGIES FOR ABSENCE

The following Board Members gave their apologies:

- Diana Hall Hall – Jill Tompkins was her substitute.
- Ed Macalister-Smith – Jenny Howell was his substitute.
- Councillor Paul Crossley
- Dr Simon Douglass
- Patricia Webb.

16 DECLARATIONS OF INTEREST

The following member of the Board has roles in the Council and PCT:

Ashley Ayre: Strategic Director for People and Communities, operating across the Partnership

There were no other declarations of interest.

17 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There was no urgent business.

18 **PUBLIC QUESTIONS/COMMENTS**

There were none.

19 **MINUTES OF PREVIOUS MEETING**

The minutes of the previous meeting were approved as a correct record and signed by the Chair.

20 **ORGANISATIONAL UPDATES (35 MINUTES)**

Local Healthwatch (procurement) – Derek Thorne said that HealthWatch is progressing positively, as planned. The procurement phase will start in October with expectation to have provider in December so the service could start running in February 2013. The timeline is good and everything is according to the plan.

Public Health – Paul Scott

- *Transition Plan* – By April next year Public Health will join the Local Authority. Work was underway for the last 18 months. Very good relationship with the Local Authority and the main contact is through Ashley Ayre's directorate but also with the other services across the Council. There are good planning procedures in place and good engagement from the Clinical Commissioning Group (CCG). New project manager was appointed recently as a part of the strategy, to help moving on in practical arrangements (i.e. IT, desks, etc.).
- *Memorandum of Understanding* – the purpose of it is to establish a framework for working relationships between B&NES CCG and Public Health in B&NES Council. Memorandum of Understanding (MoU) Signatories are: Paul Scott (Public Health), Dr Ian Orpen (CCG), Ed MaCalister-Smith (NHS B&NES Chief Executive) and Jo Farrar (B&NES Council Chief Executive).

Members of the Board unanimously welcomed the MoU document as it sets out what will be expected in the future.

Jane Pye (LINk) commented that the LINk was not involved in the Equality Impact Assessment (EIA) on this document. Paul Scott explained that the EIA had been cleared by the Equality Officer from the Council but he welcomed a suggestion from Jane Pye to also engage LINk on this matter.

NHS – Jenny Powell said that the pace of the NHS reform picking up in speed and only six and a half months left before the PCTs are abolished. The biggest impact locally is that some of the PCT's functions will be transferred to the National Commissioning Board (NCB) who will have the responsibility for direct commissioning of primary care. Other local area teams will take the responsibility for the specialised commissioning. The property services company will be managing much of the assets. They will become landlord not only for commissioning bodies but also for community services. Our PCT is ahead of the game with the transition as we recognised what was required few months back.

Clinical Commissioning Group (CCG) –

Dr Ian Orpen said that there is a lot on going work at the moment. There are 8 days before the CCG send all the documents for authorisation. The Joint Working Framework between the CCG and Council was presented last week to all Councillors. Jan Stubbings will be interim director for the Local Area Team. Dr Orpen highlighted the commissioning support in back office arrangements are progressing. Appointments: 2 lay members – one for Public and Patient Engagement and the Vice Chair for the CCG; Dr Ian Orpen has been confirmed as Chair of the CCG; Dr Simon Douglass has been appointed as Clinical Accountable Officer; Sarah James has been appointed as Chief Finance Officer; and Tracey Cox has been appointed as Chief Operating Officer. The CCG started advertising for the Executive/Chief Nurse recently. As mentioned earlier the date for sending documents for authorisation is 1st October and the formal site visit will be on 9th November. The results of the process will be known in January 2013. Dr Orpen said that he and his colleagues feel that they are in the right place with this process.

Council –
Ashley Ayre said that the 1st phase of the consultation on change of the structure of department has been completed with one Divisional Director yet to be appointed. The 2nd phase of the restructure is just about to be launched. The final phase will start in January and the new structure will be functional as from 1st April 2013 (in line with the changes within the NHS). Mike Bowden will deputise for Ashley Ayre on Children's Services whilst the deputy for Adult and Community Health Commissioning is still to be appointed. Partnership agreement between the Council, Public Health and NHS, which exists since 2008, is to be refreshed to be ready with formal establishment of the local CCG as from April 2013. The Council is quite keen to develop a strong working relationship with the Local Area Team.

21 **JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE (10 MINUTES)**

The Chair invited Jon Poole (Research and Intelligence Manager) to give a presentation.

Jon Poole gave a presentation in which highlighted the following points:

- Aim of the JSNA
- Our approach
- Website - www.bathnes.gov.uk/jsna
- Next steps
- Requests
    - Note the findings
    - Is this format suitable?
    - What researches is missing?

A full copy of the presentation is available on the Minute Book in Democratic Services.

The Chair thanked Jon Poole and his team for the work they did on the JSNA. The Chair felt that the update format is great and has potential to reach 'hard to reach groups'.

Ashley Ayre said that the document is easy for pulling out data that are key to certain groups – i.e. child measurement data could be sent out to head teachers, like child health etc.

Paul Scott also said that the website is really good but that information on what we achieved in the last 5-10 years are missing. Paul Scott also suggested that the JSNA should present show what the priorities are for the area. Paul Scott also welcome that the website has economic needs assessment as well as community safety assessment.

Jo Farrar also welcomed the document and the website and suggested that the document should also focus on mental health as part of the emotional wellbeing.

Councillor John Bull pointed out the different information in the CCG report and the JSNA document about the children obesity rate in the area.

Paul Scott explains why the figures could be seen different as some of the figures are about the obesity comparison with national average and some are about the overweight figures comparison.

The Chair said that issues like these show how the JSNA is important.

Dr Ian Orpen said that it is really important getting the feedback from the public on the JSNA.

The Chair thanked everyone for the debate and suggested that Board Members could have info about the JSNA in their email signatures as a way to promote it.

It was **RESOLVED** that the Board:

1) Noted the findings of the report and presentation given to them.
2) Asked the officers to take on board comments and suggestions from the debate above.

22 **STRATEGIC PRIORITIES (25 MINUTES)**

The Chair invited Helen Edelstyn (Strategy and Plan Manager) to take the Board through the report.

Members of Board the welcomed the report.

Jo Farrar commented that this is really good piece of work and that she particularly liked the principles of operation and high quality service delivery within available resources.

Jane Pye (LINk) said that the LINk would like to be involved in the next stages. Jane Pye also said that there is a need to identify which are statutory authorities and which are not.

Councillor Vic Pritchard said that the list of the 7 strategic priorities is quite aspirational and asked that the outcomes be presented to the public.

Derek Thorne commented that the HealthWatch will be the key agent to present the

outcomes to the public.

It was **RESOLVED** that:

1. The Board agreed with the following 7 strategic priorities:
    a. Improve outcomes for people who experience mental health problems
    b. Improve the outcomes of families experiencing complex needs
    c. Improve the outcomes of vulnerable groups
    d. Improve the outcomes of people with long term conditions (including end of life)
    e. Improve the outcomes of our aging population
    f. Reduce economic inequality (linked with poor health outcomes)
    g. Develop healthy and sustainable places and communities
2. The Board agreed to review the strategic priorities in line with the 3 year duration of the CCG Plan.

23 NHS BANES CLINICAL COMMISSIONING GROUP STRATEGIC PLAN (20 MINUTES)

The Chair invited Dr Ian Orpen to introduce the report.

Dr Orpen took the Board through the CCG Plan by saying that each Clinical Commissioning Group is required as part of the CCG Authorisation process to develop an integrated plan. The integrated plan includes: a high level strategic plan for the 3 year period to 2014-15; the CCG's Operational Plan for 2012/13; Draft commissioning intentions for 2013/14.

The Board welcomed the plan and said that it is easy to understand document with clear strategic objectives.

Some Board Members and also some members of the public asked questions about the Urgent Care Re-Design Project. The Chair commented that this would be not the right venue to go into detail on this subject considering that no specific report on the Urgent Care Re-Design Project was on the agenda for this meeting. The Chair informed the meeting that this issue will be on the agenda of Wellbeing Policy Development and Scrutiny Panel on Friday 21st September.

Jane Pye (LINk) commented that LINk was invited to participate in creation of this document and that they contributed in the process by doing the Equality Impact Assessment.

Janet Rowse (Sirona Chief Executive) said that she like the portability and the accessibility of the document which makes this document easy to understand.

It was unanimously **RESOLVED** that the Board fully supported the NHS BANES Clinical Commissioning Group Strategic Plan.

24 COMMUNITY ENGAGEMENT (25 MINUTES)

The Chair invited Helen Edelstyn to introduce the report and give a presentation on

the approach to community engagement.

Helen Edelstyn highlighted the following points in her presentation:

- Health and Wellbeing Board duty to engage the public
- Health and Wellbeing Board commitment
- Health and Wellbeing Board principles
- Local Engagement Framework and Healthwatch
- Next steps

A full copy of the presentation is available on the Minute Book in Democratic Services.

The Chair said that there are two elements to consider with regards to public engagement – role of the Healthwatch and role of the Board Members.

Helen Edelstyn added that Local Involvement Network was fully involved in this exercise.

Members of the Board welcomed the report and supported the commitment to engage the public in their work.

Members of the Board debated with the public and the officers on the approach to engage community groups into their work. Helen Edelstyn and David Trethewey said that the Healthwatch would have significant role in engaging the public and community groups in consultation.

It was **RESOLVED** that the Board **AGREED** with the set of principles for community engagement as printed in the report.

25 **FORWARD HEALTH AND WELLBEING BOARD (SHADOW) DATES**

It was **RESOLVED** to note the future dates.

The meeting ended at 3.55 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board (Shadow)
MEETING DATE:	7 November 2012
TITLE:	Healthy and sustainable places and communities
AN OPEN PUBLIC ITEM	
List of attachments to this report: None	

1 THE ISSUE

1.1 A brief information report to supplement the presentation on Healthy and sustainable places and communities.

2 RECOMMENDATION

2.1 This is an information report to supplement the presentation on Healthy and sustainable places and communities.

3 FINANCIAL IMPLICATIONS

3.1 There are no financial implications associated with this report.

4 THE REPORT

4.1 Why healthy and sustainable places and communities?

A sustainable approach to health and social care will consider environmental issues alongside social and economic because it can help:

- Reduce health inequalities
- Protect those in vulnerable circumstances
- Improve the resilience of individuals, communities and services
- Save money and increase efficiency
- Meet CCG / Council environmental requirements (Public Services Act 2012).

The NHS has been aware of the need to reduce energy consumption in NHS estates, through the supply chain and in transport. The NHS accounts for 25% of the carbon emissions of the UK public sector, so this focus is important. But there is now a growing body of literature demonstrating the co-benefits to health, wellbeing and the environment across a range of activities, for example:

- Action to improve household energy efficiency can help to reduce fuel poverty and reduce the health impact of that, which currently costs the NHS in B&NES £3.8 million a year;
- Meeting targets to reduce greenhouse gases from transport will require more active travel - walking and cycling - and less motor vehicle use, bringing health benefits from reduced cardiovascular disease, depression and diabetes;
- Increasing local food growing and access to local, fresh and seasonal food across the social gradient reduces carbon emissions from intensive farming, processing and distribution, whilst increasing access to healthier food;
- Improving access to good quality green space across the social gradient increases opportunities for outdoor play and exercise, brings positive mental health impact and improves local air quality and sustainable urban drainage/flood alleviation, which is becoming increasingly important as climate change brings increase in extreme rainfall.

The Marmot Review recognises that climate change is one of the biggest public health threats of the century with the potential to increase health inequalities. It recommends prioritising policies and interventions and making spending decisions that BOTH reduce health inequalities and mitigate climate change.

4.2 What does the B&NES JSNA say?

- **Air quality**
    - *Areas in Bath and Keynsham have higher nitrogen dioxide levels than government objectives. Exposure can irritate lungs, inflame airways and increase the risk of acute respiratory illness. The effects on life expectancy are bigger than smoking and car accidents.*
    - *The prevalence of asthma in B&NES (6.2%) for 2010/11 is higher than the England average (5.9%)*

- **Climate change & energy**
    - *60,000 households have insufficient insulation in B&NES. There is emerging evidence that significant cost savings can be realised in the health service by making homes more energy efficient. In B&NES, it is estimated that the health impacts of cold homes are costing the local NHS £3.8 million a year.*
    - *17% of households experience fuel poverty in B&NES. As fuel prices rise there is an increased risk of fuel poverty and associated poor health outcomes. Energy prices are predicted to rise between 30-40% by 2020.*

- *Climate change is already happening and will continue to do so, increasing the risk to health from more extreme weather events (heat stress, drought, cold snaps, storm and flood) and changes to disease vectors (eg malaria moving north) and impact on food, water and energy supply.*
- *The Council's work on climate change impacts highlights the increased vulnerability of the poorest and most vulnerable residents, those in energy inefficient homes or in rural areas relying the most expensive oil-fuelled heating and those living in flood zones and steep slopes.*

- **Natural and built environment**
  - *Access to the natural environment can have positive effects on mental health and physical activity. Bath has been awarded a 'purple flag' for good city centre environmental management.*
  - *There is evidence (Marmot) that access to green space within one kilometre of home reduces disease prevalence. It states: 'Health inequalities related to income deprivation in all-cause mortality and mortality from circulatory diseases were lower in populations living in the greenest areas.'*
  - *The natural environment holds the key to a number of solutions to environmental and health issues for example through the development of local renewable energy schemes and local food production.*

4.3 How can the Health and Wellbeing Board and the Environmental Sustainability Partnership (ESP) work together to add value to this shared agenda?

The HWB can help promote a sustainable approach to health and social care by encouraging commissioners and providers to take an integrated approach to sustainability, as well as influencing other public services and service areas to take action, for example:

- Wiltshire Mental Health Partnership NHS Trust with support from Bristol Council set up Go Low, a programme to reduce the amount of petrol used by community health teams. They have purchased low-emission cars and electric bikes and encouraged team members to use them.

  The programme helps improve air quality and therefore health by reducing the number of 'petro-miles' that staff do.

- *The Councils housing team has worked with the PCT and included information on how to access grants for home insulation with the flu jab letter. This almost doubled the uptake of insulation measures by elderly and vulnerable households.*

On behalf of the ESP, the Council is leading an emerging Community Delivery Partnership to deliver the Green Deal (new financing mechanism for energy efficiency) in B&NES in order to support the fuel poor and more vulnerable households, as well as maximise carbon reduction. We will be looking for more ways, like the flu jab example,

to work with partners across the public and community sectors to increase uptake. GP surgeries could have a big role to play in promoting the Green Deal.

The ESP has work-streams across a range of issues that link with the Health and Wellbeing agenda, from energy efficiency and carbon reduction in operational buildings, through to community engagement projects on domestic energy efficiency, sustainable energy and transport, community renewable energy development and an emerging strand of work led by the Public Health team on food.

5 RISK MANAGEMENT

5.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

6 EQUALITIES

6.1) An EqIA has not been completed for the following reasons: this is an information report that aims to supplement a presentation and Board discussion.

7 CONSULTATION

7.1 Select from: *Ward Councillor; Cabinet Member; Other B&NES Services; Service Users; Local Residents; Community Interest Groups; Other Public Sector Bodies; Section 151 Finance Officer; Chief Executive; Monitoring Officer*

7.2 Say HOW consultation was or will be carried out (mandatory).

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Select from: *Social Inclusion; Customer Focus; Sustainability; Human Resources; Property; Young People; Human Rights; Corporate; Health & Safety; Impact on Staff; Other Legal Considerations*

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	*Jane Wildblood and Helen Edelstyn x 01225 477951*
Background papers	*List here any background papers not included with this report because they are already in the public domain*
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board (Shadow)
MEETING DATE:	7th November 2012
TITLE:	Children's Safeguarding Report
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1: Safeguarding Children Performance Indicators	

1 THE ISSUE

1.1 To provide the Board with a progress report in respect of the key indicators of safeguarding children activity, as reported in the Annual Report and Business Plan of the Local Safeguarding Children Board (LSCB) and monitored by the business meetings of the LSCB. This includes a combination of national performance indicators and locally determined indicators. The latter, which are being collated for the first time, will provide more evidence of the quality and impact of child protection services for the child and their family, to supplement the national performance indicators which are fundamentally output measures.

1.2 Progress is shown in relation to previous years and in comparison with other Local Authorities and is reported at the end of each quarter. This report details the position at the end second quarter of 2012/13.

2 RECOMMENDATION

2.1 The Partnership Board for Health and Wellbeing is asked to note the report and actions being taken and receive updated performance reports at each meeting of the Board.

3 FINANCIAL IMPLICATIONS

3.1 There are no direct financial considerations arising from this report.

4 THE REPORT

4.1 Appendix 1 details Bath and North East Somerset's performance in respect of the national performance indicators for safeguarding children activity, as reported to the Local Safeguarding Children Board, and our first reports in respect of locally determined indicators. The following paragraphs provide a commentary and performance summary in respect of each indicator, together with corrective actions where appropriate. Proposals for further local performance indicators and how these will be collected and recorded are outlined in paragraph 4.12.

4.2 Number of children subject to child protection plans

4.2.1 This is not a national performance indicator, but a significant indicator of child protection activity, though it should be interpreted with caution. A child protection plan is made following a multi-agency case conference and assessment that a child is at continuing risk of significant harm or impairment of health and development. Early intervention and the provision of services can result in a child's needs to being met any earlier stage, thereby preventing the escalation to risk of significant harm and the need for a child protection plan – resulting in a smaller number/percentage of children with plans. On the other hand, small numbers could be the result of inappropriately high thresholds for intervention.

4.2.2 Our thresholds for intervention are monitored by the LSCB's Safeguarding Children Sub Committee and reported to the LSCB. The Children's Service regularly audits thresholds for interventions. These are considered to be appropriately and consistently set and understood by other agencies.

4.2.3 As reported previously to the Board, there was a spike in numbers in 2010/11 (106) which was investigated by the Children's Service and reported to the LSCB. Subsequent to this, actions were taken to address the factors which have resulted in an appropriate reduction in the number of children with protection plans throughout 2011/12 and more children in need plans – whilst ensuring that protection plans are in place for all who require them. The numbers returned to the average for the previous 5 years and currently stands at 80.

4.2.4 Whilst it is likely that the figure for 2010/11 represented a spike within overall figures, it is probable that the current figure will steadily increase over the next few years in line with the recent trends and projected increases in the demands for Children's Social Care Service, and the number of initial and core assessments undertaken, and will probably reach 100 – 105 by 2014/15. These trends and projections are in line with comparator authority and national positions.

4.3 Child Protection Plans lasting two years or more (NI 64)

4.3.1 This national performance indicator is used to indicate the effectiveness of the child protection plan in eliminating and significantly reducing the risk of significant harm – and is based upon research evidence that this is most likely to be achieved within a two year period. If not, the Local Authority should consider whether action is required to remove children from care in which they are assessed as being a continuing risk of significant harm. There are circumstances in which plans may exceed 2 years – for example when there have been changes in household composition that required further assessments: when addressing issues of neglect and improvements in parenting are being effected but further improvements are required and the assessment is that these can be achieved; when working with parents whose mental health and/or learning difficulties impact upon their parenting.

4.3.2 The Children's Service Integrated Safeguarding Officer has completed an extensive audit of all cases where plans have exceeded 2 years and presented a report to the LSCB and the Children's Leadership Team. The audit has highlighted areas for improvement including greater clarity about risk factors, more robust reviewing arrangements (via core group meetings

and case conference), more focussed work by all agencies working with families. A progress report will be presented to the LSCB in December 2012.

4.3.3 In order to effect improvements, the Children's Service has introduced new arrangements whereby parents will be seen at home by the Independent Chair prior and subsequent to the initial conference, to ensure clear understanding of the purpose of the conference and the risk factors, protective factors and protection plan detailed at the conference. This will provide a clear starting point for the work with the child/young person and parents and will assist better reviews of progress and decisions about the need for continuing child protection plans. This action has been supplemented by actions to improve the written reports submitted by all agencies and the work of the core group. In combination these should reduce the number of plans lasting 2 years or more, and the need for repeat plans (see below).

4.3.4 For this performance indicator, a low score is indicative of good performance.

4.3.5 The improvement noted throughout 2010/11 (which resulted in the end of year figure being only slightly off target), was maintained in 2011/12 and the end of year target achieved. It must be noted that these percentages represent a small number of children and families. Target was met for first quarter but not for second. The end of year target should be achieved. We have processes in place to review the circumstances of each child. Each child protection plan is reviewed by a multi-agency case conference, and the decision to continue with child protection plans quality assured by the LSCB's Safeguarding Children Sub Committee.

4.4 <u>Children becoming subject to a child protection plan for a second or subsequent time (NI 65)</u>

4.4.1 This national indicator is used to measure the effectiveness of child protection plans in eliminating risks of significant harm – i.e. the risks have been eliminated, do not reappear and necessitate a further child protection plan. In practice, this is determined by the quality of services provided and work undertaken with parents and child(ren) through the plan: the quality of assessment of risks of significant harm and actions taken: the provision and accessibility of any support services subsequent to the child protection plan.

4.4.2 For this performance indicator, a low score is indicative of good performance.

4.4.3 As has previously been reported, our performance in this area had been strong for a number of years – exceeding both the national and family of Local Authorities' performance – but was off target in 2011/12 (and above national and comparator positions) and whilst gradual improvements were achieved throughout 2011/12 the end of year target was not achieved.

4.4.4 Performance during the first two quarters of 2012/13 has slipped below target as this period saw an increase in the need for repeat plans (including for some large sibling groups) which impacted upon performance. All repeat plans were made as the result of multi-agency child protection conference decisions and have been audited by the LSCB sub committee.

4.4.5 It should be noted that absolute numbers are small but it is important to continue to evaluate the overall effectiveness of the services provided by agencies at the conclusion of child protection plans to prevent risks from re-emerging. Ensuring that these are in place and consistently accessed by families is central to the re-design of Children's Social Care Service currently underway and has been reported to the LSCB. The actions outlined in paragraphs 4.3.3 should effect improvements in future.

4.5 Child protection cases which were reviewed within timescales (NI 67)

4.5.1 It is important that all child protection plans are reviewed (by multi agency case conferences) to ensure that they are being implemented and remain appropriate to a child's needs and assessed risk of significant harm. Also to determine whether any further actions are required. Child protection plans must be reviewed within 3 months of the initial case conference and within (at least) six monthly intervals thereafter.

4.5.2 For this performance indicator, a high score is indicative of good performance.

4.5.3 Our performance is 100% and has been for the previous eight years. The reported performance for 2011/12 (98.5%) represented one case not being received within timescales. There was a child protection plan in place and this has been reviewed.

4.5.4 Although this indicator is no longer part of the National Indicator set for safeguarding, we will continue to monitor this area of performance given its importance in underpinning good and timely planning.

4.6 Initial assessments by Children's Social Care carried out within ten working days of referral (NI 59) – (previously seven working days)

4.6.1 Initial assessments are an important indicator of how quickly services can respond when a child is thought to be at risk of serious harm or thought to be a child in need. As the assessment involves a range of local agencies, this indicator also shows how well multi-agency arrangements are established. The child or young person must be seen, and their wishes and feelings taken into account, within the completion of the initial assessment.

4.6.2 For the performance indicator, a high score is indicative of good performance.

4.6.3 As reported previously, the Service struggled to meet the target for this indicator throughout 2011/12 (despite a strong start) due to capacity issues in the front of house team as a consequence of staff turnover and vacancies (now resolved) at a time when the Service was dealing with a very significant increase in the number of referrals for services and consequently in the number of initial assessments required (as reported in the report to the Board on 13th June 2012). These factors have continued to impact upon performance in 2012/13. The capacity issues have been addressed within the re-design of Children's Social Care Service, with an additional Deputy Team Manager and 2 Qualified Social Worker posts added to the staffing establishment. Improved arrangements for tracking progress with the completion of assessments and management sign off have been introduced, and a Performance Management Group (chaired by the Director of People

and Communities Department) meets fortnightly to monitor progress and provide additional direction and support. A week by week performance of 82.5% completion is required in order to meet the end of year target, and this has been achieved in recent weeks so that overall performance on 12th October 2012 has been raised to 70.5% (against end of year target of 75%).

4.6.4 The Service has always asserted the importance of seeing the child/young person as part of the initial assessment, and has therefore introduced a local performance indicator showing how many were seen within 5 days of referral. All children/young people will be seen within 10 working days, so this indicator illustrates how quickly children are seen.

4.6.5 Whilst striving to complete initial assessments within 10 working days, the Service recognises the importance of assessments being completed within a timescale appropriate to the child's needs (and always incorporating their views) and this may exceed 10 working days. As a result, we have introduced a local indicator to report the completion of assessments within 15 working days. This is reported for the first time. The capacity issues outlined above have impacted upon this, but a significant step towards achieving the end of year target was made in the second quarter.

4.7 Core assessments by Children's Social Care Services that were carried out within 35 working days of their commencement (NI 60)

4.7.1 Core assessments are an in depth assessment of a child and their family, as defined in the Framework for Assessment of Children in Need and their Families. There are also the means by which section 47 (child protection) enquiries are undertaken following a strategy discussion. It is important that the Council investigates and addresses concerns in a timely and efficient way, and that those in receipt of an assessment have a clear idea of how quickly this should be completed. Successful meeting of the timescales can also indicate effective joint working where multi-agency assessment is required.

4.7.2 For this performance indicator, a high score is indicative of good performance.

4.7.3 As reported previously, the Service struggled to meet the target for this indicator throughout 2011/12 due to capacity issues in the front of house team as a consequence of staff turnover and vacancies (now resolved) at a time when the very significant increase in referrals and initial assessments was necessitating a similarly significant increase in core assessments (a 50% increase in this workload during a 3 year period). These factors have continued to impact upon performance into 2012/13. The actions detailed in paragraph 4.6.3 have been applied to effect improvements in the completion of core assessments. A week by week performance of 94% is required to achieve the end of year target.

4.7.4 Whilst striving to complete core assessments within 35 working days, the Service recognises the importance of assessments being completed within a timescale appropriate to the child's needs (and always incorporating their views) and this may exceed 35 working days. As a result, we have introduced a local indicator to report the completion of assessments within 45 working days. This is reported for the first time. The capacity issues outlined

above have impacted upon this, but a significant step towards achieving the end of year target was made in the second quarter.

4.8 Percentage of closed cases resulting in repeat referrals within 6 months (Local)

4.8.1 The Children's Social Care Service has introduced a local indicator designed to demonstrate the effectiveness of its specialist services in meeting the needs of the child/young person **and** ensuring that at the conclusion of these services appropriate support is being provided by other services/agencies (if required) to continue to meet these needs, thereby avoiding repeat referrals to Children's Social Care. This absence of a repeat referral should be indicative of improvements having been sustained. This is being reported for the first time and the target set will need to be kept under review as it may require some refinement. It must be noted that despite the success of services at one time, a child's circumstances may require a repeat referral.

4.8.2 For this performance indicator, a low score is indicative of good performance.

4.8.3 The first reported performance appears strong, but this must be considered over a much longer timeframe.

4.9 Percentage of looked after children cases reviewed within required timescales (rolling 12 month programme – NI66: and in financial year to date – local indicator)

4.9.1 When a child/young person is admitted to the Council's care, the Council is assuming responsibility for keeping him/her safe. The timely reviewing of the child's care plan and placement plan are essential elements of this. A planning meeting is held prior to or immediately following admission to care: reviews are held after 1 month, after 4 months, and at least 6 monthly thereafter throughout the time the child/young person is in care. Such reviews, linking with care proceedings as required, will make decisions about whether children should return to their family's care.

4.9.2 The calculation requires that all reviews (1 month, 4 month, subsequent 6 month) have been held on time for the child within the 12 month period.

4.9.3 For the performance indicator, a high score is indicative of good performance.

4.9.4 Strong performance has been established for the rolling figure for the first two quarters 2012/13, and the performance reported for the financial year 2012-13 to date, is underpinning this strong performance.

4.10 Stability of placements for looked after children: percentage who had 3 or more placements during the year (rolling 12 months) (NI62)

4.10.1 One of the five measures within the Every Child Matters Staying Safe Outcome, is that 'Children and young people have stability, security and are cared for' – and a key indicator of performance is the stability of placements for these children and young people who are looked after by the Local Authority. Research evidence shows that looked after children who experience stable and secure care arrangements make better

progress in all areas and achieve better outcomes throughout their childhood, and into adult life.

4.10.2 For this performance indicator, a low score is indicative of good performance.

4.10.3 The Service has maintained very strong performance for a number of years, above the national and family authority performance, reflecting the sound arrangements for matching children with carers and the level of support (including tailored support) provided to carers and children. We have already set an ambitious target for this indicator. Although slightly off target for the second quarter, performance remains very strong.

4.11 Stability of placements of looked after children: length of placement (NI63)

4.11.1 For the reasons outlined in paragraph 4.10.1, this is an important indicator of performance in providing and sustaining stable and secure care arrangements. There is a relatively small number within this cohort of children at any time, so that small changes in absolute numbers can result in what appear to be significant changes in percentages.

4.11.2 For this performance indicator, a high score is indicative of good performance.

4.11.3 The Service has maintained strong performance for a number of years, above national and family authority averages, reflecting the sound arrangements for matching children with carers and the level of support provided (including a tailored support) to children and carers. Although slightly off target for the second quarter, performance remains strong.

4.12 As well as introducing the local performance indicators outlined above, the Service is also progressing plans to collate information which will provide qualitative measures of performance.

Any qualitative measures, to include:-

- Percentage of children reporting that the provision of social care services had made a positive difference to their lives / made them feel safer
- Percentage of parents reporting had made a positive difference to their parenting and their child safer
- Percentage of plans incorporating the child's expressed views and opinions

5 RISK MANAGEMENT

5.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

5.2 The risks associated with ensuring effective safeguarding arrangements are assessed and managed by the LSCB (which receives quarterly performance reports) and its constituent members. Within the Council, these issues are identified within the Service Risk Register.

6 EQUALITIES

6.1 Promoting diversity and supporting individual identity and recognising and valuing the racial and cultural diversity of Bath and North East Somerset's communities and a commitment for anti-discriminatory practice are values underpinning the work of the LSCB.

6.2 An Equalities Impact Assessment has been completed in respect of the LSCB's Annual Report and Work Programme which incorporates these performance indicators.

7 CONSULTATION

7.1 Cabinet Member; Staff; Other B&NES Services; Service Users; Other Public Sector Bodies; Section 151 Finance Officer; Monitoring Officer.

7.2 Consultation with other BANES Services and other Public Sector Bodies via reports to and discussions at the Local Safeguarding Children Board quarterly meetings.

7.3 Discussed with staff at Team and Management Group meetings and via LSCB Stakeholders' event.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Young People.

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	**Maurice Lindsay**, Divisional Director - Safeguarding, Social Care and Family Service Maurice_lindsay@bathnes.gov.uk, 01225 396289
Background papers	Previous reports to Health and Wellbeing Partnership Board: most recent 13th June 2012.
Please contact the report author if you need to access this report in an alternative format	

Appendix 1: Safeguarding Children Performance Indicators (National and Local)

Safeguarding Children performance indicator/activity	2010/11 England	2010/11 Family	2010/11 BANES	2011/12 BANES	2012/13 Target	2012/13 Quarterly			
						Q1	Q2	Q3	Q4
1. Number of children subject to child protection plan			106	70	N/A	82	80		
2. Child protection plans lasting 2 years or more (NI 64)	6.0%	7.0%	10.4%	5.4%	8%	6.6%	10.6%		
3. Children becoming subject to a child protection plan for a second or subsequent time (NI 65)	13.3%	15.0%	23.5%	14.9%	12%	19.0%	20.0%		
4. Child protection cases which were reviewed within required timescales (Local)	97.1%	96.9%	100%	98.5%	100%	100%	100%		
5. Initial assessments by Children's Social Care carried out within 10 working days (NI 61)	75.7%	68.2%	67.5%	71.2%	75%	47.2%	69.1%		
6. Percentage of children seen within 5 working days of referral (Local)	-	-	-	-	50%		57.1%		
7. Initial assessments completed within 15 working days (Local/New)	-	-	-	81.2%	95%	62.5%	79.5%		
8. Core assessments carried out by Children's Social Care carried out within 35 working days of their commencement (NI 60)	75.1%	68.9%	59.3%	67.5%	75%	40.7%	64.3%		
9. Core assessments completed within 45 working days	-	-	-	80.6%	95%	52.7%	75.0%		
10. Percentage of closed cases	-	-	-	34.2%	20%	34.8%	19.7%		

resulting in repeat referrals within 6 months									
11. Percentage of looked after children cases, in care for a year or more, which were reviewed within required timescales (rolling 12 months) (NI 66)	96.8%	88.8%	86%	79.7%	87%		84.4%	88.9%		
12. Percentage of all LAC reviews on time (financial year to date)	-	-	-	-	87%		97.9%	97.6%		
13. Stability of placements of looked after children: percentage who had 3 or more placements during the year (rolling 12 months) (NI 62)	10.9%	12.9%	5.6%	9.1%	9.0%		7.1%	9.3%		
14. Stability of placements of looked after children: length of placement (NI 63)	68.6%	69.4%	79.5%	72.7%	75%		76.2%	77.3%		

Note: This table details performance for 2010/11 and comparisons with England and our family of Local Authorities (most recent national data available): Bath and North East Somerset performance for 2011/12: targets for 2012/13 and our actual performance at the end of each quarter (colour coded to indicate current status of performance to target – Red/Amber/Green).

Note: There are no England or Family Comparators for locally set performance indicators.

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board (Shadow)
MEETING DATE:	7th November 2012
TITLE:	Children's Health Services Commissioning Performance
AN OPEN PUBLIC ITEM	
List of attachments to this report: 1. The Children's Performance Scorecard as reported to the Children's Trust Board relating to healthy outcomes. 2. Sirona' s Key Performance Indicator scorecard for children's services	

1 THE ISSUE

1.1 The purpose of this report is to provide information on the performance of People & Community Departments commissioning of children's health services. This report provides information about the top 5 areas that are going well and 2 areas in which there are currently challenges. Also provided for information in Appendix 1 is the the Children's Performance Scorecard as reported to the Children's Trust Board relating to healthy outcomes. The scorecard on key performance indicators for Sirona who provide our community health services for children is provided in Appendix 2.

2 RECOMMENDATION

The Board is asked to agree that:

2.1 This report and the issues raised are noted.

3 FINANCIAL IMPLICATIONS

3.1 All services funded within current budgets.

4 THE REPORT

4.1 key areas that are going well

Ref	Issue	Comments	What support is requested from HWB?
1	Young People's Substance Misuse	The temporary contract for our substance misuse service, Project 28, was won by the DHI in February 2012 following liquidation of the previous provider company. The impact of these difficult changes for the young people using the service appears to have been minimal. The number of young people accessing treatment has increased from 67 in quarter 1 (2012/13) to 104 in Quarter 2 (2012/13). During Quarter 2, 54 young people have reduced their substance misuse and 12 left treatment drug and alcohol free. Both adults and young people's substance misuse services are being re-commissioned for April 2013.	To note
2	Emotional health of children in care	This is measured by the average score in Strength & Difficulties Questionnaires for children aged 4 to 16 who have been in care a year or more. Lower scores are better. The provisional 2011/12 result of 15.4 did not meet the target of 14.5 and was also higher than the average score for statistically similar authorities for 2010/11 which was 14.8. (The 2011/12 results for other authorities are not yet available.) Placement stability is a key factor and performance on this tends to be very good. To explore performance in more depth the service has begun looking at changes in individual's scores over time, rather than just comparing the average scores of different cohorts at different points in time. There are 73 individuals where the two most recent annual SDQ scores can be compared and these show an average improvement of -1.7 in scores. Similar results looking at average changes over 2, 3 and 4 years also all show an average improvement in scores. There are always a number of questionnaires not completed for various reasons. In 2011/12, eight were not completed and were recorded as "carer refused". In one case the child themselves refused. Four others were also not completed for "other" reasons. The service has looked at its processes for these	To note

Ref	Issue	Comments	What support is requested from HWB?
		questionnaires and aims to ensure as good coverage as possible for this recording in 2012/13.	
3	Early Implementation of new Health Visiting Programme	This service contributes to the DoH plan to significantly increase the number of health visitors by 2015 and to deliver an improved Healthy Child Programme. Sirona has received a substantial increase in funding from the PCT to employ more qualified health visitors. Since April 2011 the service has recruited 11 additional full time health visitors and by March 2015 should have another 8 qualified members of staff. Families will receive the full Healthy Child 'core offer' from January 2013. The new service includes invitations to first time mothers to meet their health visitor in the antenatal period and offers of a comprehensive developmental review for all infants around their second birthday. Smaller caseloads should ensure health visitors have more time to advise and support each family e.g. with breast feeding, post natal depression, weaning, parenting and immunisations. In addition to universal services, health visitors support families requiring specific short term support and those who with longer term multi-agency requirements, e.g. safeguarding. Our local service has been an 'Early Implementer Site' for the new service vision and has received additional support and scrutiny from DoH. Although performance monitoring is still undertaken locally, the NHS Commissioning Board is due to oversee this expansion programme, at least for the next couple of years.	To note
4	Introduction of diabetes best practice tariff for children	From 1st October 2012 outpatient and community nursing services for children and young people with diabetes will be provided by the RUH as an integrated service, offering a "year of care" to families. This means that families can have expectations of the number of contacts they will have with a multidisciplinary team of doctors, specialist nurses and dieticians, with the ultimate aim of greater control over their diabetes and thus better outcomes for the child, including avoidance of admission to hospital. The year of care is paid for by a nationally set "Best Practice Tariff" which excludes admissions to hospital. The children's commissioning team has worked closely with the existing and new providers to develop an agreed service specification and roll out plan.	To note

Ref	Issue	Comments	What support is requested from HWB?
5	Child & Adolescent Mental Health Services	Oxford Health NHS Foundation Trust (OHFT) are contracted to provide primary and specialist Children and Adolescent Mental Health Services until March 2015. Although the services were commissioned separately, having the same provider for both services does facilitate a smooth progression along the pathway to and from more specialist support. The new model of services introduced by OHFT have reduced waiting times (and complaints!) about Camhs services. At the end of the second quarter 95% of referrals to specialist Camhs and 99 % of referrals to primary Camhs were assessed within 4 weeks.	To note

4.2 Top 5 challenges

Ref	Issue	Comments	What support is requested from HWB?
1	Safeguarding children & young people through contract monitoring	Following the Ofsted/ Care Quality Commission (CQC) inspection of safeguarding last January in which the health aspects were judged to be inadequate a lot of work has been put in to address the short falls identified in the report and complete the CQC action plan. Commissioners have been working with Karen Littlewood, the Designated Nurse for Safeguarding in the Wiltshire Banes PCT cluster, to add more detailed requirements about safeguarding to the contracts. Karen and her new deputy Sophia Swatton have been working with the Named Nurses and Doctors in each of the providers to improve quality assurance processes. The PCT cluster has also introduced a quality assurance committee to re-enforce standards. The Strategic Health Authority has reviewed the CQC action plan with us and is satisfied with progress.	To note
2	Children's therapy services provided by RUH	Following concerns about children's community occupational therapy services provided by the RUH last year an independent review was undertaken of the occupational therapy and physiotherapy services.	To note

Ref	Issue	Comments	What support is requested from HWB?
		Recommendations from the review are being addressed and both services now have a joint clinical manager who is implementing staffing and service changes. The new joint service has been launched and quarterly performance meetings will be starting soon to ensure that the expected service improvements are realised. There may be future benefits from basing this service in the community rather than in the acute hospital.	

5 RISK MANAGEMENT

5.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

6 EQUALITIES

a) An EqIA is not appropriate in relation to this performance reporting..

7 CONSULTATION

7.1 This is a report on performance in children's health services so the overall report has not been consulted upon with anyone except the staff managing the contracts. Any issues raised within the report will be part of contract monitoring discussions with providers.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 This performance report reflects the quality of services we deliver to children and young people.

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	*Liz Price, Acting Divisional Director Children's Health, Commissioning & Strategic Planning*
Background papers	*None*
Please contact the report author if you need to access this report in an alternative format	

Appendix 1 The Children's Performance Scorecard

Table 1: Be Healthy former National Indicators – by financial years

Indicator	England	Region	Previous target	Previous annual result		Target	Latest figure	
NI 53 Prevalence of breastfeeding at 6-8 weeks from birth a – 6-8 weeks			49% (10/11)	61% (10/11)	G	62% (11/12)	60.3% (Q2 12/13)	
b – Recording			95% (10/11)	100% (10/11)	G	95% (11/12)	99.4% (Q2 12/13)	
NI 55 Obesity among primary school age children in Reception Year	9.4% (10/11)	8.8% (10/11)	7.0% (10/11)	8.4% (10/11)	R	Not yet available	Future of indicator unclear	
Our reception obesity rate seems to be static, yet both the regional and national rates have gone down. It is also worth noting our incredibly high coverage rate – which is thought to give a higher (more accurate) obesity rate. Areas which have lower obesity rates may also have lower coverage rates e.g. Cornwall has an obesity rate of 15.7% but we know they have a much lower coverage rate, so their rate may be less reliable. We currently do not know what indicator /outcome we are working towards in relation to childhood obesity. We are awaiting clarification from DH. *The national report with figures for local areas can be found here:* www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/ncmp%202010-11/NCMP_2010_11_Report.pdf								
NI 56 Obesity among primary school age children in Year 6	19.0% (10/11)	16.1% (10/11)	12.0% (10/11)	16.9% (10/11)	R	Not yet available	Future of indicator unclear	
Our year 6 rate has increased which is in line with national and regional rates. In B&NES our rate is still slightly higher than Wiltshire and South Gloucester, but is now lower than Swindon and Gloucester (last year their rates were equal to B&NES). We currently do not know what indicator /outcome we are working towards in relation to childhood obesity. We are awaiting clarification from DH.								
NI 58 Emotional and behavioural health of children in care (mean Strengths & Difficulties Questionnaire score – lower scores are better)	13.9 (10/11)	14.8 (10/11, (statistical neighbours)	14.5 (10/11)	15.4 (11/12 estimate)	R	15.0 (12/13)	13.2 (Q2 estimate)	G

Table 2: Individual child in care scores

Coverage of SDQ recording at end quarter 2

Green	31.7% up to date for 2012/13 return
Amber	33.3% where SDQ entry is less than 1 year old
Red	34.9% where SDQ entry is not present or is more than one year old

Changes in SDQ scores over time as at 30/9/2012

Changes over period of	Changes counted	Average latest score	Average previous score	Difference in average scores
1 year	73	14.4	16.1	-1.7
2 years	40	14.1	14.4	-0.3
3 years	25	15.8	16.6	-0.8
4 years	10	15.4	19.0	-3.6

Appendix 2 Sirona Care & Health (Community Health & Social Care) Key Performance Indicators 2011/12

Service	Measure	2011/12				2012/13
		Q1	Q2	Q3	Q4	Q1
Health visitors	% of parents accepted reviews for 2 - 2.5 years old	91%	90%	90%	80%	86%
School nurses	Total Contacts	1399	1203	1921	2163	2014
Children's Learning Disability Nurses	Total Contacts	188	129	150	176	166
Community Paediatrician	RTT 18 week % seen	99.7%	99.6%	99.6%	100%	98.8%
Community Paediatric Audiology	RTT 18 week % seen	100%	100%	99.4%	100%	99.7%
Lifetime - core service	Number of hospital admissions saved	61	36	74	51	58
Speech and Language Therapy	Children are able to eat and swallow safely and gain adequate nutrition and hydration from food and drink or reach their full potential in speech, language and communication skills. Episodes recorded as recorded as “fully”, “mostly” or “partially”	98.7%	98.9%	99.3%	99.0%	98.8%

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board (Shadow)
MEETING DATE:	7th November 2012
TITLE:	Update Report Adult Safeguarding Annual Report 2011-12
AN OPEN PUBLIC ITEM	
List of attachments to this report: Attachment 1 Local Safeguarding Adult Board Annual Report 2011-12 (including Business Plan 2012-15)	

1 THE ISSUE

1.1 The Local Safeguarding Adults Board (LSAB) has produced an Annual Report which outlines the work its multi-agency partners carried out during 2011-2012 and includes the proposed Business Plan for 2012-15. The report (including the business plan) requires the approval from the Partnership Board for Health and Wellbeing.

2 RECOMMENDATION

2.1 The Board is asked to agree the Annual Report and Business Plan

3 FINANCIAL IMPLICATIONS

3.1 None, however there are capacity issues caused by increased safeguarding adults referrals the implications for these are being considered.

4 THE REPORT

4.1 The LSAB Annual Report 2011-12 provides an overview of changes to national policy relating to safeguarding adults at risk; outlines the Boards activity during this period; analyses the case activity that has taken place and outcomes for service users; reports progress on learning points identified in the 2010-11 annual report and sets out the business plan for 2012-15.

4.1 key areas that are going well

Ref	Issue	Comments	What support is requested from HWB?
1	Multi-agency engagement	Multi-agency partners of the LSAB and its sub groups are well engaged and committed to raising awareness of adult abuse and improving outcomes for service users	Continued support for the work of the LSAB
2	Ensuring the safeguarding procedure is followed according to the multi-agency procedure	Agencies work together to ensure the safeguarding adults procedure is followed according to timescale; on some occasions breaches occur and there are acceptable reasons for this; where breaches occur and the reason is not justifiable agencies change practice to address this	Continued monitoring
3	The profile of safeguarding adults referrals and outcomes for service users	For the first time there is national and regional comparator data available on the profile of safeguarding adults referrals (such as the age, gender, service user group, type of abuse and details on the alleged perpetrator) and the outcomes of the referral as it progresses through the safeguarding procedures (for example is it substantiated or not). This comparator data provides the LSAB with confidence, as the number and profile of referrals received in B&NES during 2011-12 and the outcomes for service users are not dissimilar to other areas.	Continued monitoring
4	LSAB self – assessment framework and local indicators	LSAB partners completed a Self - Assessment Framework and each partner agency is committed to improving and developing safeguarding arrangements; the LSAB partners (including non-commissioned partners) agreed a set of indicators to measure progress against	Continue monitoring

Ref	Issue	Comments	What support is requested from HWB?

4.2 Top 5 causes for concern

Ref	Issue	Comments	What support is requested from HWB?
1	Assurance that action is being taken to address the recommendations and findings from reports into Winterbourne View and Mid-Staffordshire NHS Foundation Trust	The LSAB and commissioners are aware of the recommendations that have come from the various reports into Winterbourne View and Mid Staffordshire NHS Foundation Trust and seek assurance that appropriate action is taken to try and prevent this occurring in B&NES.	Awareness of the findings and implications of the recommendations
2	Strengthen arrangements to help identify and prevent abuse occurring	The LSAB recognises the need to strengthen joint working arrangements with the Responsible Authorities Group and increase the focus on the prevention of adult abuse (for example, through raising awareness with the Village Agents Project)	Approval to develop the joint working arrangements
		The LSAB recognises that multi-agency partners hold a significant amount of intelligence between them which is not systematically shared. If shared more effectively this may help prevent and identify abuse.	Support the LSAB in its aim to improve and formalise intelligence sharing arrangements
3	User involvement	The LSAB is committed to user involvement in both strategic and operational arrangements for its work and is committed to developing this during 2012-15.	To monitor the LSAB progress with this issue

5 RISK MANAGEMENT

5.1 The report author, Lead Cabinet member and Local Safeguarding Adults Board have fully reviewed the risk assessment related to the issue and recommendations, in compliance with the Council's decision making risk management guidance.

6 EQUALITIES

6.1 An Equalities Impact Assessment has not been carried out on the Annual Report itself and is not believed to be required. However an assessment will be carried

out on the Business Plan element of this and discussed with the LSAB in December 2012. Equalities issues and impact assessments are carried out on policies and protocols that the LSAB approve.

7 CONSULTATION

7.1 Cabinet Member; Staff; Other B&NES Services; Community Interest Groups; Stakeholders/Partners (including Service Users Organisation; Carers Centre; Care Home representative and Health and Wellbeing Network representative); Other Public Sector Bodies (including Police; Probation; Fire and Rescue; AWP; RUH and RNHRD); Section 151 Finance Officer; Chief Executive; Monitoring Officer; Strategic Director for People and Communities Department.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Human Rights;

9 ADVICE SOUGHT

9.1 Advice has been sought from the Council's Strategic Director People and Communities Department and the Cabinet Member. The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	Lesley Hutchinson Assistant Director for Safeguarding and Personalisation (01225) 396339
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

Annual Report

2011 – 2012


AVON
FIRE & RESCUE


AVON & SOMERSET
CONSTABULARY


Avon and
Somerset
Probation Trust


Avon and Wiltshire
NHS
Mental Health Partnership NHS Trust


SOMER
Community
Housing Trust
curo


Royal United Hospital Bath
NHS
NHS Trust


Royal National Hospital
NHS
for Rheumatic Diseases
NHS Foundation Trust


Carers'
Centre
Bath and North East Somerset


Sirona care & health


Freeways


People
First
Bath and North East Somerset

Chair's Foreword

This comprehensive annual report describes the work for which the LSAB has been responsible. It also provides a significant amount of information and intelligence on the performance of our partners on safeguarding over the last year. While we know that there is always more to do and Serious Case Reviews remind us of areas that need critical attention, this has been another productive year.

There has been a huge amount of information, briefing and learning coming from Winterbourne View and other serious cases. New guidance and regulation has emerged and the future statutory role of LSABs remains unresolved.

The LSAB has lost some members and welcomed new Board and sub-group members. Despite the significant pressures that all agencies are experiencing attendance and commitment has been very good and this is greatly appreciated. The sub-groups have delivered enormous contributions and are the engines that drive the Board to deliver against its tasks. We agreed to lose one sub-group as it was felt that personalisation could be absorbed across the other groups and this has freed up some much needed capacity.

The figures show, as ever, increasing demand on services and some good areas of performance despite this. While this is a good sign it also represents a pressure at a time when organisation roles and boundaries have been shifting. The Board needs to consider how to respond to this is a way that retains an overview without adding to the pressure any more than can be helped.

I would like to express my personal appreciation for the work that has taken place over this last year. Despite the fact that the Board's role is one of oversight and support rather than delivery, I am delighted to see that the effect of this work on people who are at risk is evident in a number of areas.

Robin Cowen
Independent Chair

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Section 1: Introduction

1.1 The B&NES Local Safeguarding Adults Board (LSAB) is the strategic body that oversees multi-agency working to assure that adults at risk from abuse are safeguarded effectively.

1.2 The LSAB is committed to ensuring that all agencies in B&NES and the wider community work together to minimise the risk of abuse and neglect to adults.

1.3 This annual report summarises the LSAB's activities that has taken place from April 2011 to March 2012 and highlights the commitment to multi agency working including robust performance management and quality assurance.

Section 2: Background

2.1 The profile and scrutiny of multi-agency working to prevent and safeguard adults at risk of abuse has continued to rise during 2011-12.

2.2 ***No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*** (DH 2000) continues to provide the framework for multi-agency working to safeguard adults at risk, however in May 2011the Coalition Government set out a ***Statement Of Government Policy On Adult Safeguarding*** this document builds on *No Secrets*, which will remain as statutory guidance until at least 2013.

2.3 Who is a vulnerable adult?

- a person aged 18 or over
- who is or may be in need of community care services by reason of mental or other disability, age or illness

and

- who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation. *No Secrets (DH 2000)*

2.4 What is abuse?

"Abuse is a violation of an individual's human or civil rights by any other person or persons." No Secrets (DH 2000)

Abuse may be behaviour that is intended or caused by lack of training and ignorance.

2.5 Where does abuse happen?

Abuse can happen anywhere, in someone's own home, in a public place, in a care home, in community care or in a hospital. Abusers or 'perpetrators' are often already known by the adult at risk. Perpetrators can be people such as a professional worker, another service user, a relative, a friend, a group or an organisation.

Section 3: Overview of the National and Regional Context and Guidance

3.1 The profile of safeguarding adults at risk continues to be raised. Not only has the Government increased the focus but so too did the BBC. The BBC focused the wider community's attention on adult abuse through the airing of the Panorama documentary in May 2011 **Undercover Care: The Abuse Exposed**, which exposed physical, psychological and institutional abuse and neglect at **Winterbourne View Hospital** ran by Castlebeck, a large national health and social care provider. The programme resulted in:

- A criminal investigation being undertaken by Avon and Somerset Police Constabulary
- Gloucestershire Council undertaking a Serious Case Review
- Care Quality Commission (CQC) initiating an investigation
- The Strategic Health Authority (SHA) requesting reviews and assurance of commissioning arrangements
- Paul Burstow (the then) Minister of State, Department of Health (DH) reporting to the House of Parliament that the DH were launching a review into the events and stating they would review: CQC's investigative report; the South Gloucestershire LSAB Serious Case Review; the National Health Service (NHS) Serious Untoward Incident investigations and previous serious case reviews and investigations and any other relevant documents
- The Association of Directors of Adult Social Services (ADASS) producing a guidance note for Local Authorities and Safeguarding Adults Boards recommending the assurance and not wait for findings and reports being published.

B&NES LSAB has received commentary and updates relating to Winterbourne View at each of its meetings during this period.

3.2 In April 2011 ADASS produced ***Safeguarding Adults 2011 Advice Note***. This note provides ADASS' views on outcomes; supports the Law Commission's proposal to amend the No Secrets definition of 'vulnerable adults' to 'adults at risk'; promotes the use of the terms 'harm'; emphasizes the role Local Government should play in providing strategic leadership for the *'safety for all agenda'*; supports the recommendation for Boards to be on a statutory footing and the duty of partners to co-operate (highlighting GP consortia now Clinical Commissioning Groups (CCG)) and requests a clear link be made with Health and Wellbeing Boards described in the NHS White Paper *Equity and Excellence: Liberating the NHS* (July 2010). The note also addresses the safeguarding and personalisation agenda; states the need for a focus on achieving outcomes for individuals and evidencing these rather than processes; highlights the importance of preventive work; the promotion of harm across the wider community and the development of the workforce. B&NES LSAB recognises the importance of the personalisation agenda and has this as a regular agenda item. It also has representation from the CCG and reports to the Health and Wellbeing Partnership Board.

3.3 The Law Commission published its final report on proposed changes to adult social care in May 2011in ***Law Commission No. 326 Adult Social Care***. Seven safeguarding recommendations have been made in part 9 of the report, all are

significant but the following three are highlighted for their specific impact on current arrangements:

Recommendation 39: The statute should:
(1) provide clearly that local social services authorities have the lead co-ordinating responsibility for safeguarding;
(2) place a duty on local social services authorities to investigate adult protection cases, or cause an investigation to be made by other agencies, in individual cases; and
(3) place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the process for adult protection investigations.(p113)

Recommendation 40: Adults at risk should be those who appear to:
(1) have health or social care needs, including carers (irrespective of whether or not those needs are being met by services);
(2) be at risk of harm; and
(3) be unable to safeguard themselves as a result of their health or social care needs.

In addition, the statute should provide that the duty to investigate should apply only in cases where the local authority believes it is necessary.

Harm should be defined as including but not limited to:
(1) ill treatment (including sexual abuse, exploitation and forms of ill treatment which are not physical);
(2) the impairment of health (physical or mental) or development (physical, intellectual, emotional, social or behavioural);
(3) self-harm and neglect; or
(4) unlawful conduct which adversely affects property, rights or interests (for example, financial abuse). (p120)

Note: the definition of adult at risk proposes a change to the current definition and includes self harm (no identified perpetrator). Several recent Serious Case Reviews have requested self harm is included in safeguarding adults policies.

Recommendation 44: Adult safeguarding boards should be placed on a statutory footing. In order to achieve this, the statute should:
(1) give the local social services authority the lead role in establishing and maintaining adult safeguarding boards;

(2) specify the following functions for adult safeguarding boards:
(a) to keep under review the procedures and practices of public bodies which relate to safeguarding adults;
(b) to give information or advice, or make proposals, to any public body on the exercise of functions which relate to safeguarding adults;
(c) to improve the skills and knowledge of professionals who have responsibilities relating to safeguarding adults; and
(d) to produce a report every two years on the exercise of the board's functions;

(3) give the Secretary of State and the Welsh Ministers a regulation-making power to add to this list;

(4) To require each of the following to nominate a board member who has the appropriate skills and knowledge:

(a) local social service authority;
(b) the NHS; and
(c) the police;

(5) give the Secretary of State and the Welsh Ministers a regulation-making power to add to this list;

(6) give the Care Quality Commission, the Care and Social Services Inspectorate Wales and the Healthcare Inspectorate Wales a power to nominate an appropriate representative to attend meetings;

(7) give the local social services authority a power to appoint any other person with the necessary skills and knowledge relevant to the board, and responsibility for appointing the chair; and

(8) provide that adult safeguarding boards should commission serious case reviews and establish a duty to contribute to these reviews.

The code of practice should provide guidance on when information can and should be shared with adult safeguarding boards.(p137)

Recommendation 45: The enhanced duty to co-operate should include specific provision to promote co-operation between relevant organisations in adult protection cases. *(p138)*

3.4 The Coalition Government produced a ***Statement Of Government Policy On Adult Safeguarding*** (May 2011) as mentioned in 2.2 above; this sets out the Government intention to seek to legislate for Safeguarding Adults Boards (SABs), making existing Boards statutory.[1] It also sets down six principles to govern the actions of adult safeguarding boards:

- Empowerment – taking a person-centred approach, whereby users feel involved and informed
- Protection – delivering support to victims to allow them to take action
- Prevention – responding quickly to suspected cases
- Proportionality – ensuring outcomes are appropriate for the individual
- Partnership – information is shared appropriately and the individual is involved
- Accountability – all agencies have a clear role

3.5 The Department of Health launched ***Transparency in Outcomes: a Framework for Quality in Adult Social Care*** The 2011-12 Adult Social Care Outcomes Framework in March 2011. The framework has four domains of which domain four is *'Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm'*. The domain has two outcomes, the overarching one being *'the proportion of people who use services who feel safe'* (and this can relate to any service) and the second being *'the proportion of people who use services who say that those services have made them feel safe and secure.'* This is expected to relate to adult safeguarding more specifically. The responses are collected through

[1] The Government have responded to this and in July 2012 published both the White Paper ***Caring for our future: reforming care and support*** (DH) and the ***Care and Support Bill*** clauses 34-38 relating to safeguarding adults specifically. Consultation on the Bill ends in October 2012

an annual survey (the Adult Social Care Survey) and the outturn for 2011-12 is reported in 6.52 below.

3.6 In addition to the aforementioned Advice Notes ADASS produced a number of other papers including:

- ***Carers and Safeguarding Adults – Working Together to Improve Outcomes*** (July 2011), this paper sets out the issues for carers and suggests ways to improve practice. The paper groups carers into three categories: '*...carers speaking up about abuse or neglect within the community or within different care settings; carers who may experience intentional or unintentional harm from the person they are trying to support or from professionals and organisations they are in contact with...' and '...carers who may unintentionally or intentionally harm or neglect the person they support.'* (p5). B&NES LSAB has approved a local action plan in light of this. The plan is being led by the Carers Centre on behalf of the LSAB see 5.14 below for more information.

- The South West Region ADASS group have produced ***Advocacy and Adult Safeguarding: Information on using and commissioning Independent Advocacy services for Safeguarding Adults*** (October 2011). The paper provides background on the legislation supporting the use of advocacy; outlines how the involvement of an independent advocate should be used in the safeguarding process and '*...explores how the involvement of an advocate helps to ensure that best interests are kept at the forefront*.' (p2). The LSAB have not had the opportunity to explore the issue of advocacy support and safeguarding however section 6.43 notes the limited number of referrals to advocacy services as part of the safeguarding procedure.

- ***The Case for Tomorrow Facing the Beyond*** *A joint discussion document on the future of services for older people* was also published by ADASS (March 2012) and assesses the progress made with older people services; it makes a set of recommendations that it requests the Government work with them and partner agencies on. The two recommendations relating to safeguarding older people are: *'....Review the approaches which have developed to support quality assurance and safeguarding of self-directed support services, and recommend a minimum set of expectations for these arrangements'* (p16) and '*...Encourage all agencies concerned with the safeguarding of older people to have multiagency arrangements in place which are effective and rigorous.'* (p17)

3.7 ADASS, in partnership with The Local Government Group, The NHS Confederation and Social Care Institute for Excellence (SCIE) published ***Standards for Adult Safeguarding*** in October 2011. The standards are identified through the following themes:

- Outcomes for and the experiences of people who use services
- Leadership, Strategy and Commissioning
- Service Delivery, Effective Practice and Performance and Resource Management
- Service Delivery, Effective Practice and Performance and Resource Management
- Working together

The themes are broken down into eight elements. Safeguarding Boards are the focus of the 'working together' theme though cut across others.

3.8 The Department for Education published ***The Munro Review of Child Protection: Final Report - A child-centred system*** Munro, E (May 2011). The document focuses on the care and wellbeing of the child but makes reference throughout to the importance of partnership working and states *'Adult services are therefore vital in recognising the possible impact that such problems may be having on children.*' (p186). This reminds services of the importance of 'seeing' the whole family.

3.9 Like ADASS, SCIE has also produced a number of documents during the period that relate to safeguarding:

- ***The Governance of Adult Safeguarding: Findings from Research into Safeguarding Adults Boards,*** Braye, S.; Orr, D.; Preston-Shoot, M. (September 2011). The paper states that *'...Robust governance arrangements will be assured by the following Board features: strong statements of strategic purpose and scope, with explicit multiagency commitment; clear structures with explicit divisions of responsibility and robust coordinating mechanisms; explicit commitments on membership, in roles that are understood and agreed, including clarity on the authority of the Board in relation to member agencies; broad stakeholder involvement; clarity on the role and status of the chair, and Board rules of engagement, including resources; strategic leadership on a range of functions, including strategic planning, policy and procedural guidance for member agencies, performance monitoring and quality improvement; explicit involvement of people who use services and carers in the work of the Board, and standards for their empowerment in all safeguarding activity and clear internal standards for Board performance, and clear external accountability routes.'* (pviii)

- ***User Involvement in Adult Safeguarding*** Wallcraft, J.; Sweeney, A.; (September 2011). This document recommends how service users should be involved in strategic planning, the safeguarding process, research and audit and community outreach and directs SABs how to do this. It also identifies the type of training staff need to do this. The LSAB have not reviewed this document to influence the working practice, however are committed to improving user involvement in 2012-13.

- ***Self-neglect and Adult Safeguarding: Findings from Research*** Braye, S.; Orr, D.; Preston-Shoot, M. (September 2011)

- ***Assessment: Financial crime against vulnerable adults*** City of London Police (November 2011) *for the Association of Chief Police Officers/ Home Office/Department of Health*. This document considers the problem of financial crime against vulnerable adults and highlights a range of strategic recommendations to reduce the threat of this. Five recommendations are made in all, three of which are: to publish the findings making them widely available and to *'raise awareness of the threat that financial crime poses to vulnerable adults and to help organisations to consider ways of improving their safeguarding arrangements at a local level'* (p46); to develop a toolkit for practitioners and to ensure the information in this document informs the *'Safeguarding and investigating the abuse of vulnerable adults' guidance that is currently being developed by the National Policing Improvement Agency (NPIA) and the ACPO vulnerable adults portfolio, as well as future training packages for police and safeguarding partners.'* (p46).

- ***Safeguarding Adults at Risk of Harm: A Legal Guide for Practitioners*** Mandelstam, M. (December 2011). The guide was commissioned by the DH in 2009 and outlines the legal basis for the safeguarding of vulnerable adults at risk of harm in England. It is up to date to December 2010.

- ***Commissioning care homes: common safeguarding challenges*** Cass, E. (February 2012); this document provides a guide for commissioners and providers to identify the issues that *'commonly'* lead to safeguarding procedures in care homes and the underlying issues. A series of preventative checklists are provided and other resources.

3.10 The South West SHA in partnership with the South West Joint Improvement Partnership and ADASS Safeguarding Adults Programme commissioning an audit of the regional Self Assessment Quality and Performance Framework and review of Board annual reports. ***Audit of Safeguarding Adult Boards in the South West Region*** Ogilvie, K. (January 2012) makes a set of recommendations for forthcoming annual reports including: *'...for more consistency and completeness, SABs should be encouraged to follow the headings in the annual report template'* (p20) The structure of this report is modelled on the recommendations made with the exception of a case study being included. A case study will be included in next year's report however there was not sufficient preparation time to include one in this report.

3.11 The NHS Information Centre for Health and Social Care (NHSIC) published ***Abuse of Vulnerable Adults in England 2010-11: Experimental Statistics Final Report*** (March 2012). The report summarises the key findings from the **Abuse of Vulnerable Adults (AVA)** data collection for period 1 April 2010 to 31 March 2011. 152 Local Authorities submitted the data required for the AVA return and the findings of this are used in this report to compare B&NES safeguarding data.

3.12 The House of Commons Committee of Public Accounts published the committee discussion on ***The Care Quality Commission: Regulating the quality and safety of health and adult social care*** Seventy-eighth Report of Session 2010–12, (March 2012). The Committee made eight recommendations of which the following are most specific to protecting adults at risk: *the Commission has been poorly governed and led and not been able to strike the balance between registration and inspection; the Commission's role is unclear and it does not measure the quality or impact of its own work; the information provided to the public on the quality of care is inadequate and does not engender confidence in the care system* (by this it means that there is insufficient data on enforcement action and it doesn't give the public a clear picture of the state of care available), *Residential care homes are no longer awarded star ratings, which previously helped the public to differentiate between providers. The Commission should collect and publish data on enforcement, together with information on the extent to which providers in particular areas are meeting the essential basic standards to allow the public to get a national, regional or local picture of the state of care. In addition, the Department should address the gap left by the removal of star ratings* and *the Commission must strengthen its whistleblowing arrangements* (p5 and 6). The CQC are represented on the LSAB and the Councils adult services meet on a bi-monthly basis with them to discuss registered services.

Section 4: Governance and Accountability

4.1 Principles of the Board

4.2 The Board is committed to ensuring the following principles are practiced:

- Safeguarding is everybody's business and the Board will work together to prevent and minimise abuse as doing nothing is not an option
- Everyone has the right to live their life free from violence, fear and abuse
- All adults have the right to be protected from harm and exploitation
- All adults have the right to independence that involves a degree of risk

4.3 Functions of the Board

4.4 The Board has responsibility for:

- Developing and monitoring the effectiveness and quality of safeguarding practice
- Involving service users in the development of safeguarding arrangements
- Ensuring service user and carers are involved in all aspects of safeguarding planning
- Communicating to all stakeholders that safeguarding is 'everybody's business'
- Providing strategic leadership

4.5 Structures of the Board

4.6 The Board meet on a quarterly basis to carry out its functions; in addition to this six sub groups work to deliver the Boards agenda. The sub groups are:

- Policy and Procedure
- Safeguarding and Personalisation
- Quality Assurance, Audit and Performance Management
- Awareness, Engagement and Communication
- Training and Development
- Mental Capacity Act Local Implementation Network

4.7 Terms of Reference for the LSAB and the sub groups are available on the B&NES website

http://www.bathnes.gov.uk/services/adult-social-care-and-health/safeguarding-adults-risk-abuse/local-safeguarding-adults-board

4.8 Membership of the Board and sub groups

4.9 Members of the Board are at a senior level within their organisation and are from the Statutory, Voluntary and Independent sectors. There are both service user and carers specific representatives as well.

4.10 The sub group members are from a variety of specialisms to ensure the group has the relevant expertise it needs to carry out its role. For example, the Quality Assurance, Audit and Performance Management group representative from the

RUH is their Lead for Quality Assurance; the Awareness, Engagement and Communications group has the Information Officer from B&NES Council People and Communities Department, who is responsible for adult care communication and the Training and Development sub group is chaired by Sirona Care and Health, the lead agency commissioned to deliver safeguarding adults training across B&NES, and also has the training lead from RNHRD.

4.11 Members of the Board and sub groups are listed in Appendix 1 and 2.

4.12 **Core members of the Board** represent the following:

- **Statutory organisations** including the: Local Authority; Primary Care Trust; Clinical Commission Group; Royal United Hospital; Royal National Hospital for Rheumatic Diseases; Avon and Somerset Constabulary; Avon and Wiltshire Mental Health Partnership NHS Trust; B&NES Avon Fire & Rescue Service; Avon & Somerset Probation Trust; Community Health and Social Care Services (until 30th September 2011 and became Sirona Care and Health)
- **User led and Carers organisations** representing the voice of service users and carers including: Bath People First on behalf of service users and the Carers Centre on behalf of carers and carer organisations
- **Private, Independent and Voluntary sector organisations** including: Four Seasons Health Care, representing local care homes; Freeways Trust on behalf of Care and Support West (private and voluntary sector service providers); Stonham Housing Association on behalf of housing related support providers; Somer Community Housing Trust on behalf of registered social landlords (became Curo in July 2011); Sirona Care and Health (a Community Interest Company formed in October 2011)
- **Education organisations**: including Norton/Radstock College on behalf of further Education establishments
- **Council Cabinet member**: portfolio holder for B&NES Council Social Care, Health and Housing

4.13 **Associate members of the Board** represent the following:

- Department of Work and Pensions
- Great Western Ambulance Service NHS Trust

4.14 The Safeguarding Children's Board is represented through five statutory organisation members who sit on both the Children's and Adults Boards and the Responsible Authorities Group (RAG) (more commonly known as Community Safety Partnerships in other areas) is similarly represented through five statutory organisation members who sit on both groups.

4.15 Role of the Chair and Board members

4.16 The LSAB is chaired by Robin Cowen, an Independent Chair appointed early in 2011. The Chair's role includes:

- Providing strong leadership and an independent, objective voice for the Board
- Promoting the strategic development of the LSAB

- Ensuring the LSAB works effectively to achieve its vision, objectives, priorities and plans
- Representing the LSAB locally and nationally
- Ensuring the LSAB delivers its functions and responsibilities
- Ensuring that all local agencies are supported to work together to deliver high quality services that safeguard adults at risk
- Offering mediation, where required, in any dispute resolution in relation to safeguarding adults
- Ensuring that any Serious Case Reviews are undertaken rigorously; are consistent with guidance; that lessons are effectively communicated; and that associated action plans are delivered
- Leading the LSAB in ensuring that the views of service users and carers are incorporated in the Board's activities

4.17 The role of the Board Members is set out in the LSAB Terms of Reference which can be found following the link highlighted in 4.7 above. Each sub group chair is a core member of the Board.

4.18 Financial arrangements

4.19 Each agency contributes to the resourcing of the Board and sub groups through their time and capacity to deliver the work of the Board. This involves a significant amount of staff time and commitment from both Board members and other agency colleagues who are released from 'regular duties' to support the work of the Board.

4.20 Direct financial contributions are currently made by B&NES Council; NHS Banes and Avon and Somerset Police for the funding of the Independent Chair. The Chair is now funded to provide 20 days rather than 16 in line with the arrangements for the Independent Chair of the Local Safeguarding Children's Board.

4.21 B&NES Council coordinate the Board; finance media campaigns and awareness raising materials and commission Sirona Care and Health to deliver a range of safeguarding training to the voluntary, independent and private sectors.

4.22 Onward reporting structures

4.23 The Board report via B&NES Council commissioning bi monthly to the Partnership Board for Health and Wellbeing (PBH&WB). Membership of the PBH&WB included the Chair of the PCT, Leader of the Council, Cabinet Members, PCT Non Executives, Chief Executive of Health and Wellbeing Partnership, Council Chief Executive, Chair of the Professional Executive Committee, PCT, Joint Director of Public Health and Strategic Director for Children's Services. Membership changed during the year to take account of changing Health and Social Care structures and included representation from the Clinical Commissioning Group.

4.24 Safeguarding activity is reported quarterly to B&NES Council and monthly to the NHS Banes Board. Each Board member retains their own existing lines of accountability for safeguarding and promoting the safety of adults at risk within their organisation.

Section 5: Summary of Activity during the Past Year

5.1 Learning Points Identified in LSAB Annual Report 2011-12

5.2 The following nine learning points were identified as areas to address from the analysis of 20102011 safeguarding referral and outcome data and from the activity of the LSAB. The actions taken to address the learning points are described below.

- **Learning point 1: Review Training and Development sub group membership and engagement**
  Membership has been reviewed however engagement has remained a struggle through-out the year though did improve following a request from the LSAB.

- **Learning point 2: Work with Drug and Alcohol services to raise awareness and ensure appropriate referrals are being made. Understand the interface with community safety arrangements.**
  The Statutory Drug and Alcohol Service are now involved in monthly performance meetings and case work is audited.

  Attendance at Multi-Agency Public Protection Authority (MAPPA) and Multi-Agency Risk Assessment Conference (MARAC) meetings has been formalised and more work has taken place with the Community Safety team as outlined in section 5.27 below.

- **Learning point 3: Raise awareness of safeguarding amongst carers through Carer organisations and the carers forum.**
  This has been achieved, a carers action plan has been developed and is being monitored following the publication of *Carers and Safeguarding Adults – Working Together to Improve Outcomes* (ADASS 2011). Safeguarding is routinely on the carers forum agenda.

- **Learning point 4: 10% of referrals were for service users that were in receipt of a direct payment. A rise in the take up of direct payments from the Council is anticipated and it would be useful for the LSAB to analyse safeguarding direct payment cases that occur during 2011-12 to ascertain whether there are any trends in safeguarding activity; particularly whether there is an increase in financial abuse cases.**
  Completed and analysis included in section 6.25 and 6.26, however B&NES did not see a rise in safeguarding activity for people in receipt of a direct payment.

- **Learning point 5: LSAB to discuss the relationship between self neglect and safeguarding and develop local policy.**
  Discussion has taken place regarding and taken into account research from SCIE published in September **2011*Self-neglect and Adult Safeguarding: Findings from Research*** and the recommendations from Sheffield Adult Safeguarding Partnership Board ***Serious Case Review – Ann*** (Margaret Flynn, 2011). The LSAB awaited a position from the Government following the possibility that self neglect might be included in new safeguarding guidance and in the meantime produced the local ***Guidance to Staff on Managing Self Neglect*** which was adopted in March 2012 and is available on the Council website.

- **Learning point 6: Undertake detailed analysis of referrals and outcome by service user group.** Analysis discussed in section 6.39 below, this remains limited and the AVA return does not break this down for adults over the age of 65.

- **Learning point 7: Analyse pressure ulcer cases both in patient and community cases that have resulted in safeguarding procedures being invoked.** The Adult Safeguarding Lead (interim) for NHS Banes undertook a review of serious incidents for the first 3 quarters of 2011-12 (April 2011 to January 2012). The purpose of this review was to analyse pressure ulcer cases both in inpatient and community setting, to determine whether or not there is appropriate consideration of adult safeguarding issues and whether safeguarding procedures have been invoked. Under the Serious Incident Reporting Framework there is an expectation nationally that all grade 3 and 4 pressure ulcers are considered in relation to safeguarding processes. When a serious incident is reported, providers are required to carry out a thorough investigation of the incident. Most NHS organisations use the National Patient Safety Framework (NPSA) Root Cause Analysis Tool (RCA) for carrying out investigations. During the course of an RCA, the investigating team seek to identify a root cause for the incident; what were the contributory factors and what are the lessons learnt. From this, the investigation team agrees a set of recommendations and an action plan. The commissioners of NHS services monitor the action plans until actions are complete. During a general audit of RCA's reports undertaken by NHS Banes eight reports were reviewed and the reviewer concluded that four should have been referred to safeguarding as there was no doubt about meeting the criteria for referral and two possibly should have been. None of the pressure ulcer serious incidents were referred to the safeguarding team. The audit report made recommendations to improve work on ensuring appropriate links are made between safeguarding and pressure ulcers and to revise the existing protocol. In addition, the commissioners plan to hold a pressure ulcer master class in 2012 to which all providers will be invited where the links between adult safeguarding and pressure ulcers will be clarified. NHS South West are developing The South West Quality Improvement Framework for the Prevention and Management of Pressure Ulcers which will be launched in December 2012. This links to planned work locally on the Protocol for Determining Neglect in the Development of a Pressure Ulcer which is under review.

- **Learning point 8: Awareness, Engagement and Communications group to propose a strategy for gathering service user feedback and improve the current position.**
  The group developed a proposal and Sirona Care and Health piloted this for three months (September to December 2011) in one of the locality teams. The pilot resulted in a small number of returns. Although the sample was too small to provide a meaningful analysis, some lessons were learnt about the best way to apply the questionnaire before it was rolled out across all the teams. The process for gathering feedback was reviewed and improvements were made before the system was rolled out across all Sirona Care and Health teams from April 2012.

- **Learning point 9: Raise awareness of discriminatory abuse.**
  There has been no specific work carried out during 2011-12 in this area,

5.3 Achievements and Outcomes of LSAB and Sub Groups Work during 2011-12

5.4 Policy and Procedure sub group

5.5 The LSAB has successfully appointed a new chair for the group - the Acting Director for Residential Services at Freeways representing the Health and Wellbeing Partnership Network on the LSAB.

5.6 The group has undertaken the following work:

- Developed the following multi-agency documents for the LSABs consideration:

  I. ***Guidance on Criteria and Thresholds***: this was adopted by the LSAB and is a shortened version of the South West Region Safeguarding Adults Thresholds Guidance (ADASS, March 2011)
  II. ***Guidance to staff on managing self neglect***: adopted by the LSAB
  III. ***Safeguarding Adults: Service User Consent Guidance***: adopted by the LSAB

- Continued to develop a Trigger Protocol however progress has been slow and the group and LSAB need to reflect on the barriers to completing this
- Compiled a list of all the multi-agency safeguarding documents and have a two year review cycle planned; they have requested all LSAB sub groups review their Terms of Reference

5.7 Safeguarding and Personalisation sub group

5.8 The group has continued to implement the recommendations set out in the South West Regional ***Safeguarding and Personalisation Framework*** (revised January 2011). As part of this it has informed the LSAB that there is no legal requirement for service users who employ Personal Assistants (PAs) through a Personal Budget (Direct Payment) to undertake CRB checks as a protective measure. Although the Safeguarding and Personalisation Framework states PA's should be CRB checked; this can only be recommend and encouraged; service users to do this and ensure other safer recruitment practices are in place, such as requesting references.

5.9 The Council Corporate Audit Team reviewed the Personal Budget programme during this period and drew the groups' attention to a practice issue regarding a service user who had been allegedly financially abused by their PA. The Audit Team questioned the availability and appropriateness of support for the service user to undertake the investigation into her own PAs activities; this is complex as the service user is the employer though a 'vulnerable adult', is the victim of the abuse and is spending public money. Legal advice was sought and guidance notes are being drafted as a result of this. The group also invited a specialist PA insurance company to describe the type and level of cover they offer in order to help inform the position.

5.10 Mental Capacity Act Local Implementation (MCA LIN) sub group

5.11 During 2011-12 the sub group has:

- Continued to share information on case law activity, discuss areas of good practice and raised awareness
- Continued to monitor the number of Deprivation of Liberty Safeguards applications the Local Authority and PCT has received
- Developed the ***Multi-Agency Mental Capacity Act Policy***. This was approved by the LSAB and agencies use as the overarching document which individual agency policies relate to. The Policy was launched at an event at Fry's Club and Conference Centre in February 2012; it was well attended by care home and domiciliary care providers and also attended by AWP and Sirona Care and Heath representatives. Separate sessions are planned for hospital staff

5.12 An annual report on the Deprivation of Liberty Safeguards (DoLS) work undertaken during 2010-11 was presented to the LSAB. B&NES continued to have a comparatively low number of DoLS referrals when compared to other Supervisory Bodies in the South West and continues to be below the national average. However the position has significantly improved on last year and B&NES is no longer the lowest; moreover the number of applications increased by 73% from 2010-11 to 2011-12. The report is available on B&NES Council web site and includes the latest case law; information on training and awareness raising activities and the recommended areas of focus.

5.13 Awareness, Engagement and Communication sub group

5.14 This group has undertaken a significant amount of work this year to help raise awareness and try and facilitate service user and carer involvement in the safeguarding procedure. The group has:

- Developed an induction to safeguarding presentation; this is available on the B&NES Council website and can be used by any agency
- Developed an information book for service users about the procedure in easy English, this is be based on Derby County Councils booklet
- Worked with Sirona Care and Health to develop and improve service user feedback on the safeguarding procedure; a new system for doing this was proposed and a 10 question feedback questionnaire was developed. This was piloted, and a brief summary of the pilot is noted in 5.2 above
- Considered a range of awareness raising DVDs and recommended the purchase of three that are available for any agency in B&NES to use
- Designed and funded through the Council and RUH a safeguarding credit card.

- Published a variety of safeguarding adverts throughout the year for example the 'stop abuse' poster was included in the Spring and Autumn editions of Connect magazine which goes to every household in B&NES and in the Friends of the RUH Guide

- Continued to have safeguarding adults information on the one hour loop series on Council TV in B&NES Council offices, leisure centres and libraries to raise awareness
- Continued to discuss safeguarding adults at a variety of forums and groups for example the Domiciliary Care Services group.
- Finalised the Multi-Agency Communication and Media Protocol which was adopted by the LSAB
- Proposed a carers and safeguarding action plan in response to *Carers and Safeguarding Adults – working together to improve outcomes (*ADASS, 2011) and contributed to webinar discussions about this. The action plan (for which the Carers Centre took the lead in developing) was approved by the LSAB and is monitored by the sub group

5.15 All promotional material is available to print on the Council website via the hyperlink below:

Safeguarding - leaflets, posters and articles | Bathnes

5.16 The RUH published a safeguarding children and adults article in its Insight spring edition.

5.17 During the year Bath People First and the Shaw Trust delivered training to over 140 disabled people including those from Bath Ethnic Minority Senior Citizen Association, AgeUK, Carers Centre and schools. The training covered the following areas:

- What is safeguarding and the safeguarding procedure?
- Different types of abuse and how it differs from being upset or unhappy?
- Different types of places abuse can happen
- What is a risk assessment?
- The Mental Capacity Act and making decisions
- Worries people sometimes have if they make an alert
- How the Human Rights Act can empower you
- Support planning - risk enablement
- Reporting and awareness of hate crime

Different methods of training and aids were used including PowerPoint Presentations, role play, a quiz and picture association to involve people.

Anecdotal feedback from the sessions is that *'people said they felt safer because they were clearer about different types of abuse. They had often had a very narrow perspective on what abuse was. Some people felt they would tackle early signs of abuse by trying to be clear about what was not acceptable eg several people told us that if they had been on the course before their own situation happened, they would have dealt with it very differently and recognised early signs of abuse. There has been a feeling of increased confidence about being able to report any concerns. People are talking more openly about keeping safe. People have been sharing their experiences and how they have dealt with safeguarding issues which achieves greater awareness and preventative measures'.* Meri Rizk (Bath People First, 2012)

5.18 Training and Development sub group activity

5.19 The group struggled during the early part of the year with membership, however following a one-off meeting to consider whether the group should continue in its current form; the outcome was that it should and since this time attendance and membership has improved.

5.20 The group recommended the LSAB move away from the Training Strategy and replace this with a new Multi-Agency Staff Development Framework which includes audit and evaluation tools. The purpose of the Framework is threefold:

- To establish a common understanding across all LSAB partners about the competencies expected of staff in relation to safeguarding adults
- To agree general standards of learning and development appropriate to different groups of staff
- To establish an auditing, monitoring and evaluation process for staff development

The Framework is based on the ***National Competence Framework for Safeguarding Adults*****,** (Galphin, D and Morrison, L. 2010 Bournemouth University and Learn to Care) and is consistent with all of the following:

- Essential Standards of Quality and Safety (CQC,2010)
- NHS Knowledge and Skills Framework (NHS, 2004)
- Common Induction Standards (Skills for Care, 2010)
- Qualifications and Credit Framework (Ofqual, 2010)
- National Occupational Standards for Social Work (Topss UK Partnership, 2002)

The Framework sets out the competences that are required for each level of training. Level 1, 2, 3 and 4 are the same as those described in the previous Multi-Agency Training Strategy; however level 4 is still to be described and service user training is no longer included as it does not fit with staff development; this is highlighted as a gap, however Bath People First and the Shaw Trust have developed a service user training pack. The LSAB adopted the Framework in March 2012 and requested the sub group propose what is needed for level 4 competencies for strategic and senior managers.

5.21 Bath People First developed training packs for the following agencies: Bath Ethnic Minorities Senior Citizens Association; Age UK; Carers Centre; Schools and Colleges as described in 5.17 above and these are available for other agencies to share.

5.22 Sirona Care and Health (formerly Community Health and Social Care Services) are commissioned to provide level 2 and 3 courses to the voluntary and independent sector, however they also offer each General Practice in B&NES a place on level 2 training and offer Council employees access to training. The figures in the table below set out the number of staff trained in level 2 and from which organisation they are from.

5.23 Table 1: Number of Staff Trained by Sirona Care and Health and Organisation Type at Level 2 in safeguarding adults

Organisation Type	No. Staff Trained 2010-11	No. Staff Trained 2011-12
AWP	2	3
Independent and Voluntary Sector Providers	331	160
General Practices	12	12
NHS Other	22	4
PCT Commissioning	6	10
PCT Provider other	0	2
Sirona Care and Health (including when CH&SCS)	380 (Heath staff) 359 (Social care staff)	585
Council	8	10
North Bristol Trust	0	2
Other	0	3
Total	**1120**	**791**

Note: Organisations also provide their own staff training and these figures are not captured in this report.

In addition to this Sirona Care and Health trained 50 of its own staff at level 2 and a further 18 staff in level 3 safeguarding training.

5.24 Quality Assurance, Audit and Performance Management sub group

5.25 The group has:

- Continued to undertake multi-agency case file audits. This process has highlighted both gaps and good practice both have been fed back to relevant organisations
- Reviewed actions identified in 2010-11 Annual Report and feedback to the LSAB
- Monitored the progress of the local Serious Case Review action plan and the action plan which was developed from a review of the recommendations in Somerset LSAB ***Serious Case Review into Parkfields Care Home*** by Margaret Sheather (May 2011)
- Reviewed new LSAB agency members Safeguarding Adults policies and noted that in two of these 'institutional' abuse was missing from the abuse type list. This has been raised with the agencies
- Highlighted the need for assurance of work undertaken on safeguarding investigations for service users in out of area placements that are coordinated by the host authority. This remains outstanding and the recommendations from Winterbourne View will possibly give an additional steer for LSABs and Local Authorities about this
- Replaced the local self assessment tool with the ***South West Self-Assessment Quality and Performance Framework for Safeguarding Adults*** (ADASS SW 2010) one. Each LSAB agency submitted their return and this was analysed and will be presented back to the LSAB. It was agreed that where agencies have a 'red' highlight against an activity/target, the QAAPM have requested those agencies provide an action plan setting out how they will address this

- Began a discussion on Whistle blowing and how they would seek assurance from providers about their agency responses to this in light of Winterbourne View

5.26 Additional Work Carried Out by the LSAB during 2010-11

5.27 In addition to the work the sub groups have undertaken the following has also been carried out by the LSAB during its meetings through-out the period. The Board has:

- Received routine updates and information from the LSAB Chairs network via the Chair

- Received continual updates on Winterbourne View and sought assurance on any B&NES service users that may have been directly affected by the treatment exposed. At the time of the Panorama programme B&NES did not have any service users placed in the hospital however had placed a small number of people there previously, their placements were immediately reviewed. The LSAB considered the ***ADASS Regional Advice Note on Winterbourne View*** and received an update on the interim findings. The LSAB also requested CQC rejoin the Board; this has happened and they are now a core member

- Considered the impact of Southern Cross and its financial position and sought assurance on care homes affected by this in B&NES

- Considered the ***Statement of Government Policy on Safeguarding Adults*** (May 11) and is pleased that safeguarding arrangements will be strengthened

- Considered the Law Commission report ***Adult Social Care*** ordered by the House of Commons (May 11), particularly part 9 Adult Protection recommendations 39-46 and the impact of these on the current arrangements; including the recommendation of the removal of the word 'significant' to the definition of the threshold for the type of harm and the inclusion of self neglect

- Briefly looked at the ***Transparency in outcomes: a framework for quality in adult social care*** (DH March 2011) and were informed of the possible information that would be gleaned from *Domain 4: Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm.*

- Discussed the ADASS's advice note on what to include on safeguarding in the Joint Strategic Needs Assessment (JSNA). The JSNA is a document produced by the Local Authority which identifies and predicts what the health and social care needs of your community will be. ADASS provided Local Authorities and LSABs with a set of recommendations for issues to consider and include in ***JSNA and Safeguarding.*** Previously safeguarding had not been included in the JSNA, but the inclusion has been requested by the DH. A 'high level' summary statement is being complied and will draw on information from last year's annual report however more detailed work is required. A small number of LSAB members met with the Community Safety Team to pull together some ideas for inclusion. The Councils Research and Development Team are working in close partnership with Public Health colleagues on behalf of the Partnership Board for Health and Wellbeing have agreed to offer support with the development of this

- Reviewed the safeguarding section for the Local Authority *Local Account* setting out the Boards activity and safeguarding profile in B&NES. The Local Account is what Local Authorities have to produce to describe what they have done during the year to support adults who are eligible for social care services

- Listened to a presentation on *The Mental Capacity Act 2005 – a brief look at the interface with Safeguarding Adults* delivered by the Local Authority lead for the Mental Capacity Act and considered recent case law and the implications for practice

- Considered the six recommendations of ***The Summary Report on the Serious Case Review Concerning Ms A (deceased)*** (Peter Norris November 11) and approved an action plan to address the recommendations. The Quality Assurance, Audit and Performance Management sub group are responsible for monitoring the implementation of the recommendations

- Held a half day workshop in September 11 discussing a new strategic plan and the priority areas; the following were identified:
  I. Prevention
  II. Personalisation
  III. Accessibility
  IV. Dissemination of lessons learned and practice
  V. Service User outcomes and involvement (i.e. what difference does the safeguarding process make to their lives)

  The members discussed the ADASS ***South West Safeguarding Adults Dashboard*** and the five domain areas and six outcome areas it recommends LSAB measure and the direction to have a business plan (rather than a strategic plan. The LSAB agreed to follow the recommended business plan format and try and incorporate the priority areas into the five domains. Development of the business plan commenced

- Received regular updates from the Local Safeguarding Children's Board (LSCB) including information on the inquiry into Little Ted's Nursery in Plymouth and the Munro Report

- Held a joint away day in January 2012 with the LSCB to look at the potential for a Joint Strategic Safeguarding Board and joint sub groups. The Boards decided not to join at the strategic level but agreed that a joint LSCB and LSAB working group would meet and discuss the areas of interface and work together on these. The group is in the process of being convened

- Discussed operational redesigns that affect the safeguarding system including:
  I. A new arrangement put in place with the organisational change brought about by Community Health and Social Care Services (the provider arm of NHS Banes and Local Authority Adult Social Care Department) becoming Sirona Care and Health a new community interest company on 1st October 2011 independent from NHS Banes and the Local Authority. The new arrangement involves Sirona Care and Health retaining the responsibility to receive and process safeguarding referrals and co-ordinate the cases throughout the procedure, however the chairing of the strategy, planning and review meetings is retained by the

Local Authority. This is set out in Appendix 3.The Multi-Agency Safeguarding Adults Procedure needs reviewing in light of this

II. Changes to the Access Team services which Sirona Care and Health manage; the functions of the service including receiving safeguarding alerts have been transferred to the Locality Team

III. Avon and Somerset Constabulary's structural change involving restructuring of the Police Protection Unit that responds to safeguarding cases

- Responded to anecdotal concerns from a small number of providers that safeguarding alerts were not always treated with sufficient seriousness. The Board requested Sirona Care and Health undertook an audit which was completed in October 2011. 33 questionnaires were sent out to referrers 12 were returned providing a 36% response rate. Overall the respondents did feel they were getting the right response, however Sirona Care and Health stated that they needed to be more aware of letting referrers know the outcome of safeguarding alerts

- Agreed the performance indicators for 2012-13 these are set out in Appendix 4

- Worked with agencies to ensure the Community Safety agenda was being fulfilled for example:

  I. Ensured routine attendance at MARAC and MAPPA meetings took place

  II. Presented the lessons learned from the Serious Case Review process to the Responsible Authorities Group (RAG) in January 2012 and discussed the similarities between this and the ***Domestic Homicide Review Protocol*** participated in the work of the RAG sub groups and are members of the Interpersonal Violence and Abuse Strategic Partnership (IVASP) and Partnership Against Hate Crime (PAHC) groups. The IVASP group was formerly known as the Partnership Against Domestic Violence and Abuse however has revised its terms of reference and membership as it acknowledged that sexual violence is also prevalent and although the gendered nature of domestic, sexual violence and abuse in that the majority of victims are women and girls, men and boys may also become victims of domestic and sexual violence

  III. Noted the ***Domestic Violence Problem Profile*** for B&NES which was published in June 2011 and found that approximately 11% of victims at MARAC are disabled and that Twerton, Abbey, Southdown, Keynsham North, Kingsmead wards continue to have significantly high rates of domestic violence crimes per 1000 population with Twerton having the highest rate. The profile does not mention the link to safeguarding. A new profile will be commissioned in 2012 and the Board will take the opportunity to feed into this

  IV. The Police Community Safety Team have continued to lead the work on doorstep crime, which is specifically targeted at the vulnerable and through the Doorstep Crime Forum and have maintained the No Cold Calling Zones around sheltered housing areas within Bath

  V. Representatives from the LSAB are members of each RAG and the Councils Divisional Director responsible for community safety is a core member of the Board.

The Community Safety Plan 2009-2012 is cross cutting with most services and links to the Local Strategic Partnership, the Local Area Agreement,

Safeguarding Adults and Children, Policing Plan, Fire safety, etc. The Council Community Safety Team have continued to monitor the progress and delivery of the Independent Domestic Violence Adviser (IDVA) service, which from April 2009 was extended to support domestic violence victims of same sex couples; and a range of support services (SARI, EACH and Victim Support) for victims of hate crimes who are instrumental in the work of the PAHC. A RAG action plan is in place to focus on 'increased protection of the most vulnerable victims of crime (domestic violence, sexual abuse and hate crime)' - this covers all victims (adults and children) of domestic violence, sexual abuse and hate crime.

The Community Safety Zone in Radstock and Midsomer Norton and Keynsham continue to offer safe places for people with learning disabilities experiencing Hate Crime incidents when out and about in their community.

In 2012-13 there will be an expansion of the Village Agents project from 11 to 20 rural parishes; this will help support the work of the LSAB by raising awareness of safeguarding in rural areas; a preventative approach.

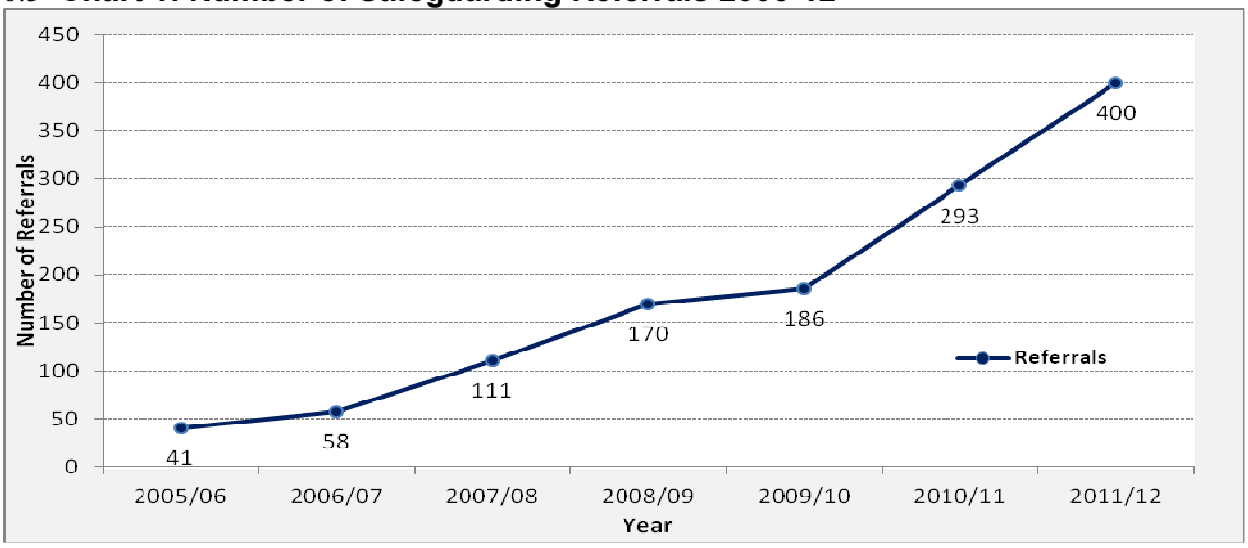
5.28 The Board recognised the outstanding issues identified in the work it is progressing, some of these are captured in section 8 below and others are included in business plan.

Section 6: Analysis of Safeguarding Case Activity (2011-12)

6.1 In March 2012 the NHS Information Centre (NHSIC) published ***Abuse of Vulnerable Adults in England 2010-11: Final Report, Experimental Statistics*** (the report is available to the public as Experimental Statistics, which means the statistics are undergoing evaluation and is based on returns from 152 Councils). In September 2011 SW Region ADASS **published *An Overview of the returns on the Abuse of Vulnerable Adults (AVA) Regional Benchmarking*** written by K Spreadbury and S Adams which also examines 2010-11 data. Information provided in from these reports will be used to inform analysis of the B&NES position as this is the most up to date data for comparison available at the time of the report.

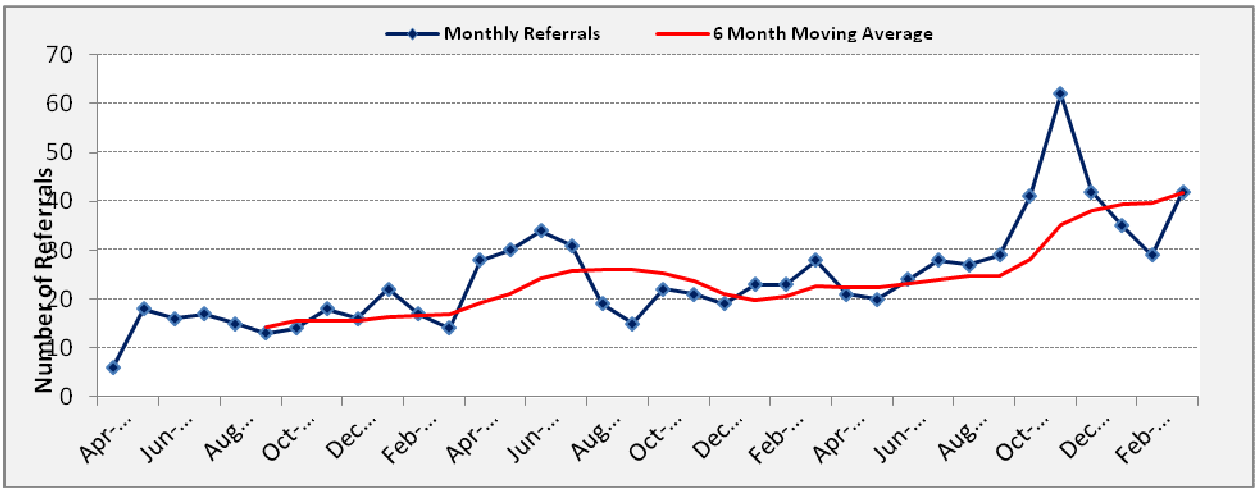
6.2 The NHSIC report states 96,770 safeguarding adults referrals were made nationally during 2010-11. However of these 95,065 had all the key information required for full analysis. This is the first time data has been collected nationally in this way and this sets the benchmark figure for future comparisons. Locally 400 safeguarding referrals were made, this is an increase of 37% on the previous year though a reduced increase when compared to the rise from 2009-10 to 2010-11 of 58%. Overall from 2006 - 12 there has been an increase of over 850% referrals this is demonstrated in the chart below. The increase from 2005 - 09 was 300% and from 2009 - 12 is 135%.

6.3 **Chart 1: Number of Safeguarding Referrals 2005-12**



6.4 The NHSIC report the number of referrals per 100,000 population (standardised for age and gender) was significantly lower than all other areas in the Southern regions with the South West being particularly low at 128 referrals per 100,000 population; the Eastern region being the second lowest with 190 referrals per 100, 000 population). The North West and East Midlands had the highest with 297 and 298 per 100, 000 respectively during 2010-11. Information from the census data indicates there are approximately 145 500 adults in B&NES (note this is not a standardised figure) and not directly comparable, however this would indicate that B&NES referrals are approximately 177 per 100,000 suggesting we are not an outlier in the South West but remain low in comparison to the rest of the UK. This is an improvement on the position from previous years.

6.5 **Chart 2: Monthly Safeguarding Referrals from April 2009 – 12**



6.6 The chart above shows a month by month breakdown of the number of safeguarding referrals received and reflects an increasing monthly average since August 2009 to March 2012. The chart demonstrates the spike in referrals was received in November 2011. During the first half of the year an average of 25 referrals were received per month, however in the second half (excluding the spike in November) 37 referrals were received on average. Changes were made during November to the way notifications from Avon and Somerset Constabulary, GWAS and Avon Fire and Rescue Services were recorded; however when the spike was

noticed an audit of these cases was carried out and where a case had been incorrectly coded it was removed. It therefore appears that the increase is an anomaly. Although the safeguarding arrangement changed with the formation of Sirona Care and Health in October 2011 this would not have generated the increase in the number of referrals as alerts are made by any agency and citizen and Sirona Care and Healths' responsibility continued as it had when they were Community Health and Social Care services.

6.7 Repeat referrals for B&NES during 2011-12 were 14% of the actual number of referrals which is in line with the NHSIC report which identified 15% of all those with key information was a repeat.[2] This is double the figure recorded in 2010-11. 41% of repeats where for vulnerable adults with a physical disability; this mirrors the NHSIC report of 41%; 30% of repeats in B&NES was for adults with a learning disability where as the NSHIC report just under 30% and 26% were for mental health service users whereas the NHSIC report records slightly less as the national average at 23%. The remaining repeats were for people with hearing and vision needs and for people with drug and alcohol needs.

6.8 The percentage of male and female referrals for 2011-12 is very similar to previous years; this gender profile is consistent with the national one for 2010-11 which shows 62% of women and 38% of men are referred; the average for the South West was 64% and 36% respectively.

6.9 Table 2 below sets out the **Referral by Gender and Age**

No. of Referrals by Gender				**No. of Referrals by Age**					
				18-64			**65+**		
	09-10	*10-11*	**11-12**	*09-10*	*10-11*	**11-12**	*09-10*	*10-11*	**11-12**
Male	*76 (40.9%)*	*113 (38.6%)*	**148 (37.2%)**	*36 (19.4%)*	*57 (19.5%)*	**91 (22.9%)**	*40 (21.5%)*	*56 (19.1%)*	**57 (14.3%)**
Female	*110 (59.1%)*	*180 (61.4%)*	**250 (62.8%)**	*29 (15.6%)*	*54 (18.4%)*	**81 (20.4%)**	*81 (43.5%)*	*126 (43%)*	**169 (41.5%)**
Total	*186*	*293*	**398**	*65 (34.9%)*	*111 (37.9%)*	**172 (43.2%)**	*121 (65%)*	*182 (62.1%)*	**226 (56.8%)**

Note: the age data was missing from one service user record and the gender from another hence the record of 398.

6.10 The age breakdown by gender has changed from previous years with an increase in the younger age group (18-64 years) referred for both men and women. The age

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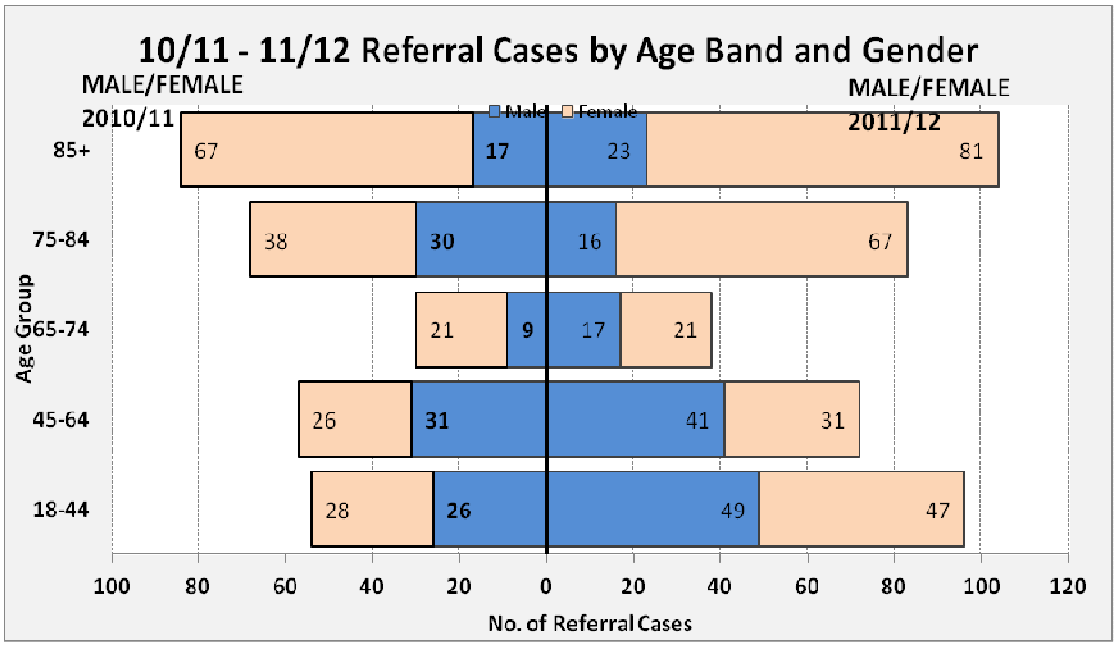
2 *A repeat referral is a safeguarding referral where the vulnerable adult about whom the referral has been made, has previously been the subject of a separate safeguarding referral during the same reporting period. The requirement that both referrals need to be in the same reporting period limits the usefulness of this data as it does not give a complete picture of the magnitude of repeat referrals.* ***Abuse of Vulnerable Adults in England 2010-11: Final Report, Experimental Statistics,*** NHS Information Centre, 2012, pg 21

breakdown is different from that recorded nationally which shows a smaller number of referrals related to adults in the 18 to 64 age group, 39% in 2010-11 and the average for the same period reported in the South West of 38%; this is similar to what B&NES report for 2010-11, 37.9% but is different to the 43.2% reported for 2011-12. The data shows that B&NES has significantly more women over 65+ referred than men and that there has been a reduction in the percentage of men as a proportion of the total number of referrals in this age group over the last three years. The LSAB will keep a watch on this when the 2011-12 NHSIC data is available to see if there is a change nationally.

6.11 **Chart 3: 2010-11 – 2011-12 Referral Cases by Age Band and Gender**



6.12 The above chart shows an increase in the number of referrals for both men and women between the age of 18-44 years and an increase in the number of referrals for women aged 75-84 years. There is not a comparison available of age group and gender however the NHSIC states *'the number of referrals for females was higher than males in each of the age groups. This proportion increased with age, ranging from 53 per cent of referrals in the 18-64 age group to 75 per cent of referrals in the 85 and over age group and may reflect the fact women tend to live longer than men. Therefore, the proportion of females in England is higher in the older age group than that of men.'* (p15)

6.13 During 2011-12 there has been a reduction to 89.4% in the number of white British recorded as the ethnicity of the service users in comparison to the last three years. However of note is that 5.5% of cases had missing data for this field, this is potentially an area of risk for equalities monitoring. The number of non white British referrals recorded is 5.1%. A full breakdown of referrals by gender, age and ethnicity for 2009-10 can be found in Appendix 5. The NHSIC reported that 89% of all referrals were for vulnerable adults belonging to the white ethnic group. (p18)

6.14 **Table 3: Safeguarding Adult Referrals 2005 - 10 by Service User Group**

	2005/6	2006/7	2007/8	2008/9	2009/10
Older people	23	33	53	119	121
People with learning disabilities	11	12	33	21	34
People with physical and/or sensory disabilities	2	9	14	15	19
People who use mental health services	5	4	11	7	9
People who use HIV /AIDS services	0	0	0	0	0
People who use drug services	0	0	0	3	3
Carers	0	0	0	5	0
Total of above	41	58	111	170	186
Year on year % change		41%	91%	53%	9%

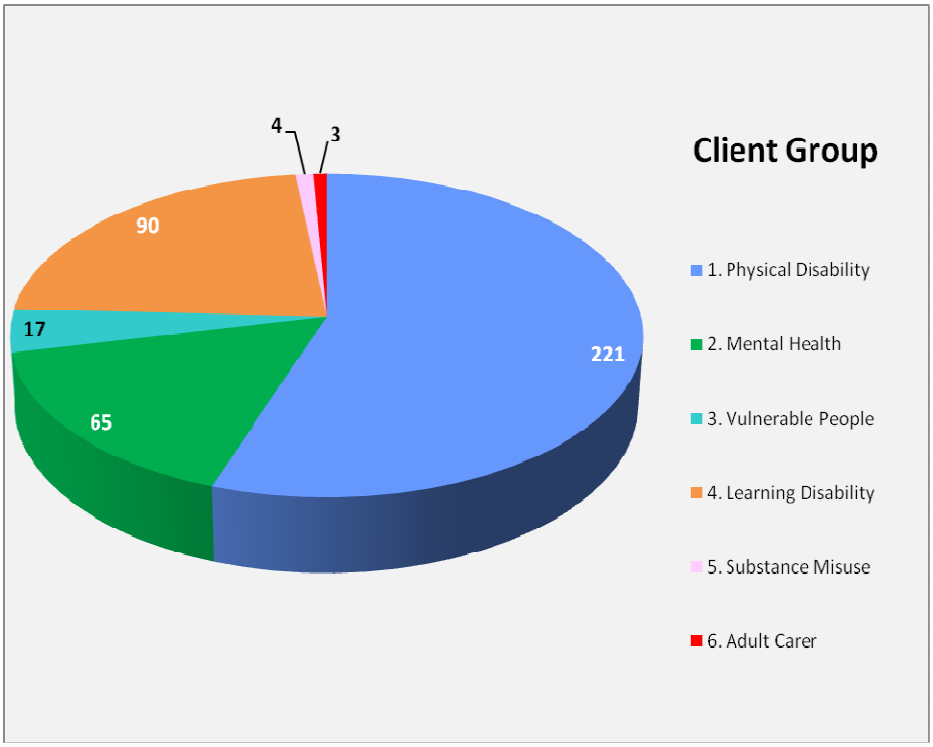
Note: older people figures includes all service user groups for people over the age of 65+

6.15 Reporting in relation to service user groups changed to fit the AVA categories in 2010-11 and table 4 below shows the break down for 2010-11 and 2011-12.
Service User Group and Referral Breakdown 2010-11, 2011-12 and South West

Service User group	**2010-11**	**2011-12**	**South West 2010-11**
Physical disability	151 (51%)	221 (55%)	52%
Mental health	83 (28%)	65 (16%)	21%
Learning disability	55 (19%)	90 (23%)	23%
Substance misuse	2 (1%)	4 (1%)	1%
Vulnerable people	1 (0%)	17 (4%)	3%
Adult carer	1 (0%)	3 (1%)	
Total	**293**	**400**	

Note: % rounded to nearest whole number

6.16 **Chart 4: 2011-12 Referral Breakdown by Service User Group**

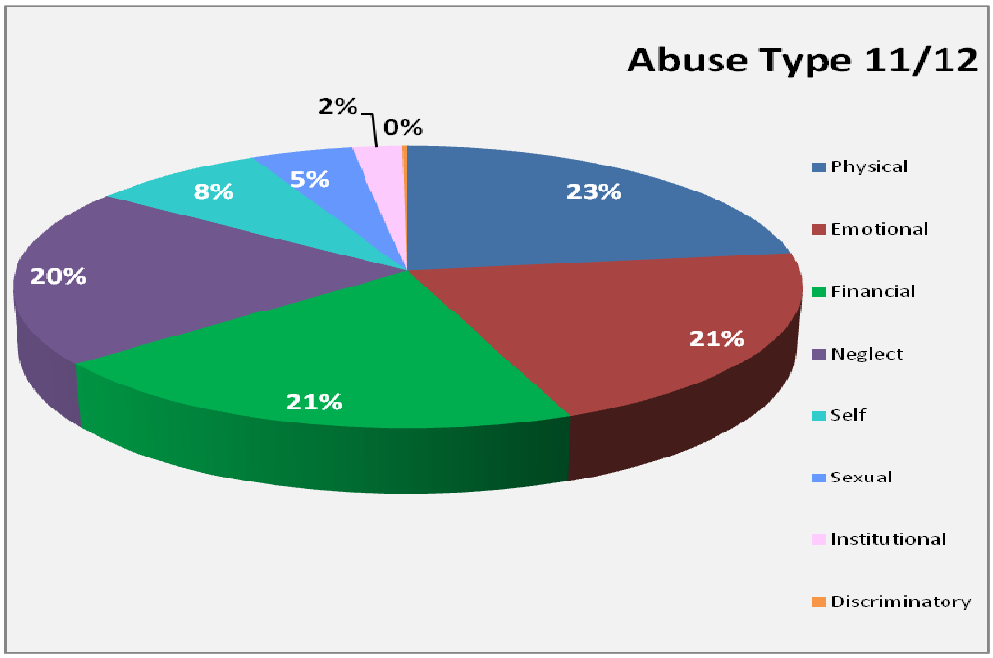


6.17 The data indicates a decrease in the number of mental health referrals, this was following a large increase in the previous year. An increase in the referrals for adults with learning disabilities was predicted following the impact of the BBC Panorama programme on Winterbourne View. This is consistent with the NHSIC data which shows that in 48% of referrals for adults between the age of 18-64 years was for learning disabled service users; whereas 66% of referrals for over 65+ was for physically disabled service users. When compared to other South West authorities the proportion of referrals for service user groups are similar.

6.18 31 safeguarding cases were open on 1st April 2011 and a further 400 referrals were received during the financial year. 354 cases were terminated/closed during the period.

6.19 47% of the referrals for safeguarding adults were for service users not previously known to the Council. This is significantly below the national and regional averages, however B&NES report above average number of service users are in placements from out of area and self funders which might be part of the reason. It may also be an indicator that there is high awareness amongst the 'community' and confidence in reporting.

6.20 **Chart 5**: **Nature of Abuse at Referral Stage**



6.21 Physical abuse has remained the highest alleged abuse type, closely followed by emotional and financial abuse; neglect has also remained high 20% as indicated in the chart above. This is largely in line with the national picture for 2010-11. The NHSIC reported *'The most common type of abuse cited in the 95,065 referrals where the three pieces of key information is known is physical abuse, which accounts for 30 per cent of the total abuse allegations reported.'* (p27).

The NHSIC go on to say: *'…This is followed by neglect, accounting for 23 per cent of the abuse reported. A fifth (20%) of the type of abuse cited was financial abuse, 16 per cent of referrals were related to emotional or psychological abuse, followed by sexual abuse accounting for six per cent. Institutional abuse and discriminatory abuse accounted for three per cent and one per cent respectively of all allegations contained within the referrals'* Abuse of Vulnerable Adults in England 2010-11: Final Report, Experimental Statistics NHSIC 2012, p27. Institutional abuse allegations have remained low (2%) this figure would have been thought to have been higher given the impact of Winterbourne View.

6.22 The table below (Table 5) sets out the **Source of Referrals** for B&NES for 2011-12 and compares this with the NHSIC data and South West Region data for 2010-11

Referral Source	**B&NES 2011-12**	**NHSIC 2010-11 Average (p23)**	**SW Region ADASS AVA 2010-11 Average (p25)**
Social care staff (all)	41%	44%	47%
Health staff	31%	21%	20%
Family Member/ Friend/ Neighbour/ Self Referral	8%	12%	13%
Police	3%	5%	6%
Other (including housing, CQC, education)	17%	17%	14%
Total	**100%**	**99%**	**100%**

The table demonstrates a high number of health referrals, reflecting close working and engagement of local health organisations; the joint commissioning partnership with adult social care and health and the focus provided to safeguarding by the Partnership Board for Health and Wellbeing. The number of police referrals is again low in comparison to the regional and national averages however the police are engaged in the work of the LSAB. The numbers of cases the police were involved in during the period decreased from last year to 22%.

6.23 Table 6 below sets out the **level of police involvement** in safeguarding adults cases:

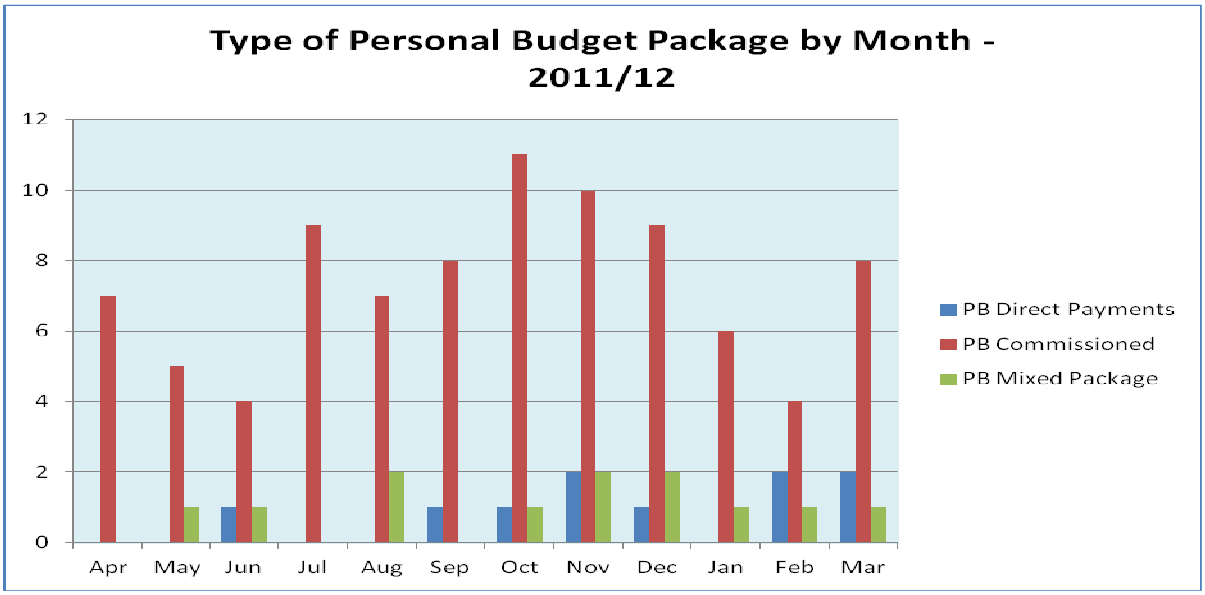
Year	% of total cases Police involved in
2011-12	22%
2010-11	32%
2009-10	38%
2008-09	36%
2007-08	31%

The police are looking into the reason(s) for the decrease in 2011-12. It is possible that as awareness about the different types of abuse increases that a decrease would be expected, as not all abuse types meet the threshold for police intervention.

6.24 In B&NES 52% of referrals were for the alleged abuse taking place in the service user's own home and 29% in a care home (residential and nursing both permanent and temporary placements included). This is the same as was reported last year. The NHSIC data reports 41% and 34% in these settings and South West ADASS report 42% and 33%. For all other locations such as the perpetrators own home, hospital settings, supported living settings and so on B&NES figures are similar to those provided on average by the South West ADASS report.

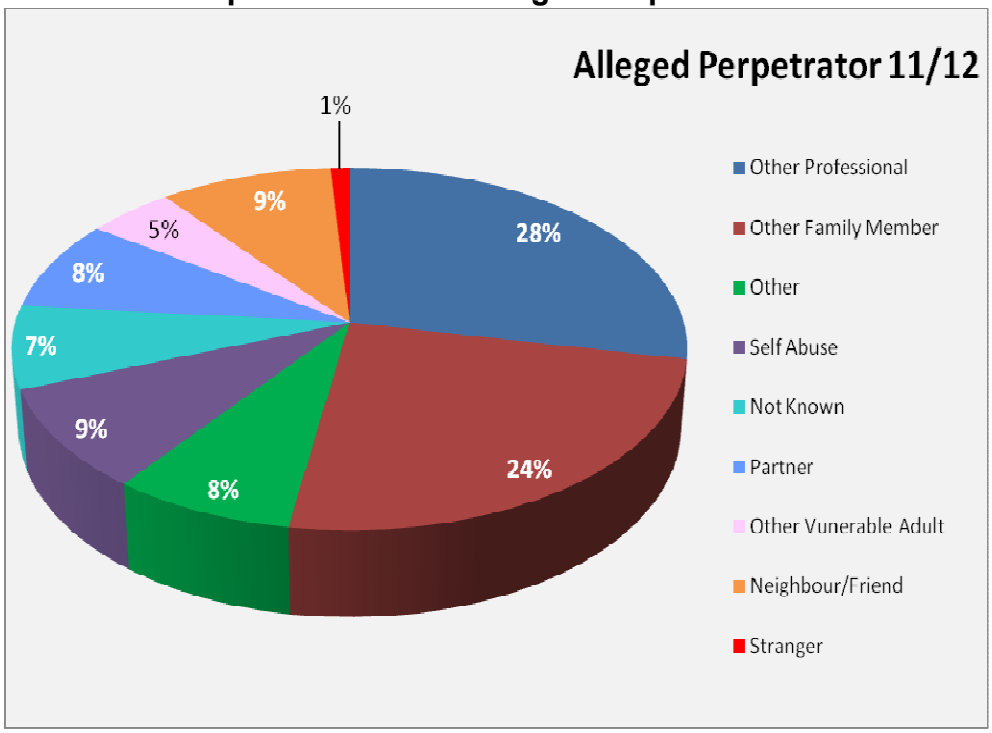
6.25 The majority of service users living in the community with a package of care funded through the Council receive this in the form of a Personal Budget (PB). There are three types of PBs: a PB Direct Payment, where the service user purchases their own social care to help them remain at home; a PB Commissioned package, where Sirona Care and Health or AWP organise the social care package and purchase this from agencies the Council has a contract with and the third is a PB mixed package, which is a combination of each of the two above. The majority of service users in receipt of Council funded social care services choose the PB Commissioned arrangement. The table below sets out how many safeguarding referrals were received each month and the type of package the service user is in receipt of. Of these 22% were either the Direct Payment type or Mixed Package type, however this was 5% of the total number of referrals made. These figures do not include self funders or those from out of area as their packages will not be funded from B&NES Council.

6.26 Chart 7: Type of Personal Budget Package by Month



6.27 The relationship between the alleged perpetrator and the vulnerable adult is set out in chart 6 below. The findings are similar to those reported last year with other professional being the highest number of alleged perpetrators and family member being the second highest.

6.28 Chart 7: Relationship of Victim with Alleged Perpetrator at Referral



6.29 The high number of referrals being made for people living all home and a significantly high number of abuse alleged caused by 'other family member; neighbour/;friend; partner is consistent. B&NES report this figure as 32% which is higher than the NHSIC findings states *'...'behind closed doors' abuse, a family member (including the vulnerable adult's partner) was recorded in 25 per cent of the allegations*,' (p33), the average for the South West is 31%.

6.30 Breaking down more closely the percentage of alleged abusers that are social care staff the table below shows B&NES when compared to the national and regional averages (albeit the reporting period has one year's difference)

6.31 **Table 7: Breakdown of Alleged Perpetrator – Social Care Staff**

Alleged Perpetrator – social care staff	B&NES 2011-12*	NHSIC 2010-11 Average (p34)*	SW Region ADASS AVA 2010-11 Average (p29)
Domiciliary care	4%	6%	3.9%
Residential care	23%	15%	16.3%
Day care	0%	1%	0.6%
Social worker/care manager	0%	1%	0.2%
Self directed support	0%	0%	0.4%
Other	1%	2%	0.9%
Social Care Staff total as % of overall alleged abusers	**28%**	**25%**	**22.5%**

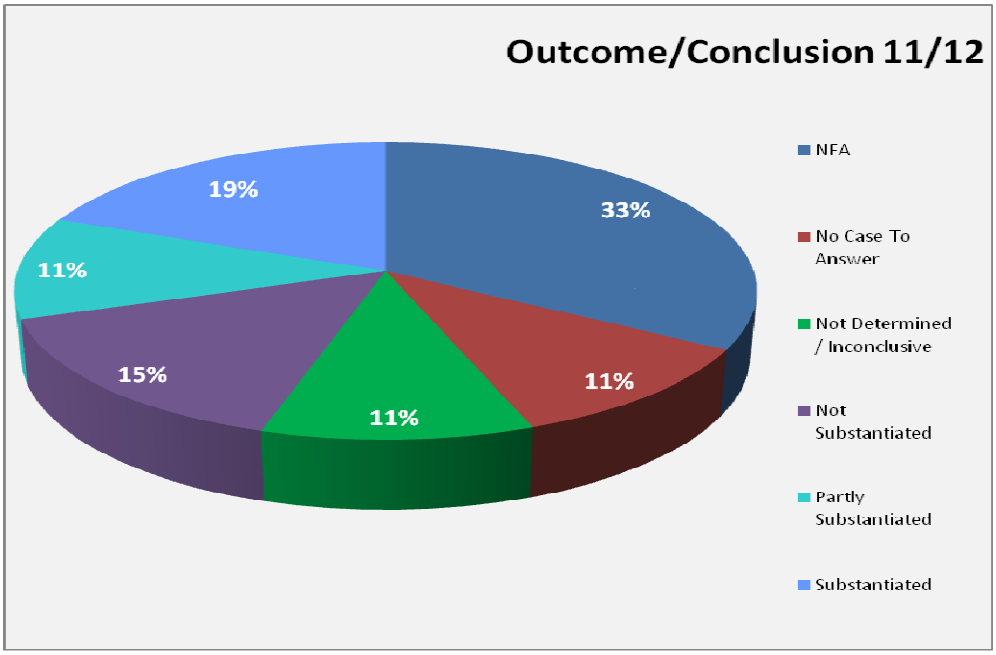
*Note figures are rounded to nearest percentage

6.32 The B&NES AVA return submitted to the NHS C (figures included in above table) indicates 0% of self directed support care staff was the alleged abuser; however this is inconsistent with the break down that is noted in 6.24 and 6.25 above which shows 5%. The figure of 5% came from a regular return from Sirona Care and Health to the Council commissioner to enable an increased watch in this area as speculators predicted there would be an increase in the number of financial abuse cases caused by self direct support arrangements being introduced in 2009 (Action for Elder Abuse), however this does not appear to be the case from the data, but greater clarity is needed from the NHS Information Centre and B&NES performance team to understand the reporting differences. It would appear the AVA return may not be collecting or receiving the data in the way it might to glean a clear picture of self directed support and abuse.

6.33 B&NES have a higher number of residential care staff identified as the alleged abuser than regional and national averages; analysis of the reason for this is needed – for example does B&NES have a higher percentage of people living in residential settings when compared to other areas?

6.34 354 safeguarding referrals were terminated/closed during the reporting period. Of these 19% of referrals were substantiated and 11% were partly substantiated. In 11% of cases there was not enough evidence to confirm whether or not the abuse had taken place. This is reflected in chart 7 below.

6.35 Chart 8: Outcome of Terminated Cases 2011-12



6.36 The AVA return takes a different cut of information for terminated/closed cases from that above and looks at the cases with one of the following four outcomes: substantiated, not substantiated, partly substantiated and not determined. Further clarification is needed regarding the reporting of this information from a local and AVA perspective to ensure analysis is accurate and comparable. The category No Further Action in the chart above refers to those cases that do not meet the threshold of significant harm and do not progress through the safeguarding procedure beyond stage 3; however the outcome of No Case To Answer needs more unpicking as to what is measured and how far through the procedure this case progresses.

6.37 Table 8: Outcome by Service User Group and Age Band

% by Age Group and Outcome:		Substantiated		Partly Substantiated		Not Substantiated		Not Determined / Inconclusive	
		% of age band	% of total cases	% of age band	% of total cases	% of age band	% of total cases	% of age band	% of total cases
Age groups	TOTAL 18 - 64	62%	17%	32%	5%	19%	7%	32%	5%
	TOTAL 65 - 74	4%	1%	5%	1%	12%	5%	22%	3%
	TOTAL 75 - 84	16%	4%	24%	4%	26%	10%	16%	3%
	TOTAL 85+	17%	5%	39%	7%	43%	17%	28%	5%
Total	TOTAL 18 +	99%*	27%	100%	17%	100%	40%	98%*	16%

*Note % are rounded to the nearest whole number

6.38 NHSIC statistics for 2010-11 report that for 148 Councils (four Councils refused to include data on outcomes in the return) 32% of cases were substantiated; 9% were partly substantiated; 31% were not substantiated and 28% were not determined and inconclusive. B&NES figures when compared to these and South West Regional data are not outliers in any of the outcome groupings. When comparing the outcomes for each age range B&NES has a higher number of cases substantiated for people aged 18-64 years than the national average and a higher number of cases not substantiated for the 85+ age group.

6.39 The outcome of cases by service user group is broken down for those aged 18-64 years only for NHS IC AVA returns only and not for those over 65+. Learning disabled service users have the highest number of substantiated cases (58%); this is also the highest % of outcomes for all groups and outcome type (28%).

6.40 Physical abuse was the abuse type that was most substantiated; followed by emotional, then substantial and then neglect. When compared to last year the cases of physical abuse that were both substantiated and partly substantiated has increased from 11% to 14%. Financial abuse was the highest abuse type in both the not substantiated and not determined outcome categories. In some cases financial abuse is alleged, however the alleged perpetrator denies this is the case saying the vulnerable person gave their permission and the investigator cannot determine whether this was the case or not.

6.41 Table 9: Outcome of Investigation Relating to (Alleged) Perpetrator

Alleged Perpetrator	Not Determined / Inconclusive	Not Substantiated	Partly Substantiated	Substantiated
Other Professional	5%	12%	8%	9%
Other Family Member	6%	6%	5%	6%
Other	2%	2%	1%	2%
Self Abuse	0%	0%	1%	2%
Not Known	2%	4%	1%	2%
Partner	2%	1%	2%	3%
Other Vulnerable Adult	1%	1%	2%	5%
Neighbour/Friend	2%	4%	1%	6%
Stranger	1%	0%	0%	1%

Note this excludes cases recorded as no further action of no case to answer; percentages are rounded to the nearest whole number.

6.42 In comparison to previous years data the findings are largely similar, however the number of other family member that were partly or full substantiated as the perpetrator has increased from 8% to 11% and the number of other professionals has decreased by 3%. The regional and national data available did not provide a comparator for this specific information.

6.43 There are 16 types of actions listed in the AVA return that can be taken to support the victim, these include things such as referral to MARAC; increased monitoring; no further action; civil action; removed from property; referral to court and so on. In just under 25% of cases the action was to increase monitoring of the victim this is

within the average range when compared to other South West Authorities and comparable to the NHSIC report of 26% (p41) for their 2010-11 figures. The NHSIC also report that in 31% of cases no further action was taken and this is similar to B&NES 34%; B&NES moved a slightly higher number of people from their service / setting at 10% than the NHSIC figure of 7% (p41). The area identified for concern is the number of referrals to advocacy services. There was only one case referred in B&NES and the NHSIC reported only 1% of referrals for 2010-11.

6.44 There are 18 types of actions listed in the AVA return for the perpetrator; these include things such as criminal prosecution/formal caution; community care assessment; removal from the property or service; referral to Protection of Vulnerable Adults list/Independent Safeguarding Authority; disciplinary action; continued monitoring; exoneration and no further action. In 6% of cases in B&NES police action was taken and in a further 2% cases criminal prosecution/formal caution was undertaken. This is consistent with the NHSIC report which shows 5% and 1% respectively (p47); in 15% of cases continued monitoring was put in place in B&NES this is also consistent with NHSIC figure of 17% (p47); disciplinary action was taken in 6% of cases in B&NES and 5% nationally; 2% of alleged perpetrators were exonerated in B&NES and nationally (p47). B&NES are almost identical in each area of action with the exception of the no further actions reported; NHSIC report 34% of cases where as B&NES reported this in 52% of cases. Multiple actions can be recorded however further analysis of this is needed.

6.45 Sirona Care and Health routinely ask service users whether they feel safer as a result of the intervention taken. 47% reported that they did feel safer and 12% responded that they did not. Sirona Care and Health analysed those cases that reported 'No' and found a range of explanations but 'broadly' found that service user believed *'...I didn't feel myself to be unsafe in the first place' or 'I have chosen to continue with my previous lifestyle/take certain risks which I choose to accept...' Report on Safeguarding Adults Cases 2011-12: Did People Feel Safer,* Geoff Watson June 12 (p2).

6.46 The table below describes the stage within the safeguarding procedure at which the case was terminated and the conclusion of the termination/closure.

6.47 **Table 10: Outcome at Procedural Stage for Terminated Cases 2011-12**

Termination stage			**Outcome**				**Total**
	NFA	No Case to Ans-wer	Not Determined / Inconclusive	Not Substantiated	Partly Substantiated	Substantiated	
Decision	134	6	2	1	1	1	145 (41%)
Strategy	0	22	15	20	10	13	80 (23%)
Investigation	0	8	6	10	8	12	44 (13%)
Planning meeting	0	1	8	19	4	8	40 (11%)
Review	0	5	5	2	7	24	43 (12%)
Total	134	42	36	52	30	58	352

6.48 There has been an increase in the percentage of cases closed at the decision stage when compared to last year and a decrease in the percentage of cases closed at the strategy meeting stage; however the numbers progressing through investigation and beyond have remained similar. This indicates an increase in the number of referrals which do not meet the threshold for significant harm.

6.49 Compliance with safeguarding procedural timescales continues to be monitored on a monthly basis by the Commissioner. The LSAB, Health and Wellbeing Partnership Board, PCT Board and Council Corporate Performance Team receive regular reports on this. The table below describes progress against the procedural timescales during the period. Sirona Care and Heath and AWP have performed very well against the targets set, with the exception of one case that had a strategy meeting outside of the eight day requirement. Sirona Care and Health undertook a review into this case and put an action plan in place to try to ensure this did not occur again.

6.50 Table 11: Performance to Multi-Agency Procedural Timescales

Indicator	Target	% Completed on time from April 2011 – March 2012		RAG	Direction of travel from 2010-2011
1. % of decisions made in 48 working hours from the time of referral	95%	Sirona C & H	99% 328/331		↑
		AWP	97% 58/60		↑
		Combined	**99%** 386/391		↑
2a. % of strategy meetings/discussions held within 5 working days from date of referral	90%	Sirona C & H	94% 175/186		↑
		AWP	100% 43/43		↑
		Combined	**95%** 218/229		↑
2b. % of strategy meetings/discussions held with 8 working days from date of referral	100%	Sirona C & H	99% 185/186		New
		AWP	100% 43/43		New
		Combined	**100% (99.5%)** 228/229		New
3. % of overall activities/ events to timescale	90%	Sirona C & H	93% 688/741		↔
		AWP	95% 151/159		↑
		Combined	**93%** **839/900**		↑

6.51 Detailed exception reports have been provided on each procedural breach during 2011-12. Evidence from these cases indicated that there can be practical and best practice reasons for timescales to be breached, for example when all parties are not able to attend a strategy meeting within five days or when an investigation report cannot be completed within 28 days as information is outstanding. However there

was not a valid reason for the case outside the eight day strategy indicator. The new arrangement with Sirona Care and Health and the Council can into place on the 1st October 2011 and has not affected or delayed performance to the timescales. In addition to the exception reports provided cases are audited to ensure the quality of delivery is to a high standard.

6.52 The Adult Social Care Outcomes Survey for 2011-12 identified that 68.3% of people who use services feel safe and 75.2% of people who use services say the services have made them safe and secure.

Section 7 Partner Reports

7.1 Each LSAB partner organisation has provided information outlining the specific safeguarding adults activity they have undertaken in 2011-12.

7.2 Royal United Hospital

The Royal United Hospital Safeguarding Adults group has been established for 6 years and consists of the following group members:

- Executive Lead, Director of Nursing
- Operational lead, Matron for Critical Care Services
- Operational Lead, Matron for Older Persons
- Operational lead, Operation Support Manager
- Medical Lead, Consultant Geriatrician
- Sister for Quality Improvement for Mental Health & Learning Disability
- Senior Nurse for Quality Improvement & Adults at Risk

The Executive Lead attends the Local Safeguarding Adults Board meetings. As per agreement at LSAB level, there is RUH representation at each of the Sub groups. The Tissue Viability Service has a robust interface with the Safeguarding operational leads in order to consider referral. Over the past 3 years there has been a steady rise in the number of alerts made to the Operational safeguarding leads from 39 to 50. It should be noted that not all alerts following investigation, generate a safeguarding referral.

Achievements 2011-12

- Appointment of Senior Nurse for Quality Improvement & Adults at Risk
- Successfully run “Deprivation of Liberty Safeguards” (DoLS) workshops for senior staff.
- Half day induction training for all registered staff aligned to BANES /Sirona training matrix level 2
- Internal and external web pages for Safeguarding Adults have been constructed.
- Compliance with Outcome 7 following the CQC inspection in November 2011.
- Highly satisfactory outcome to the South West Partnership Dementia Peer Review
- Continued pilot participation in the Department of Health Confidential Inquiry into deaths of patients with learning disabilities.
- 100% attendance at LSAB
- 100% CRB checks compliance for all new staff
- 100% Root cause analysis investigation undertaken on pressure ulcers at grade 3 and 4.

- 66.6% of all staff trained in safeguarding adults level 1

Objectives for 2012-13

- Core skills training review underway which will include a training needs analysis for adult safeguarding.
- 95% of all new staff to have undertaken safeguarding learning as part of induction within 3 months of starting employment.
- 80% of relevant (as defined by CQC) staff to have undertaken Safeguarding Adults training at level 2a (level taken from BANES/Sirona training matrix) within 6 months of taking up post and or completed refresher training every 2 years thereafter.
- Strategic link to the Department of Health's "PREVENT" strategy
- Implementation of relevant recommendations arising from the Winterbourne View Serious Case Review

7.3 Avon & Somerset Probation Trust (ASPT)

ASPT works with both Offenders and Victims. Vulnerable adults could be part of the case load or could be the dependents or associates of those on the caseload. In addition, our work with victims will have specific aspects of identifying or supporting vulnerable adults. ASPT staff will generally undertake the role of "Alerter" such that staff could become aware of a potential threat to a Vulnerable Adult. These concerns are reported and resolved in multi-agency partnership with Local Authority policy and procedures and Police action if appropriate. The Trust is geographically structured with a Local Delivery Unit Leader covering each Local Authority. This structure helps strengthen local links with Safeguarding Boards. ASPT covers 5 Local Authorities – Bristol, South Gloucestershire, Bath and North East Somerset, North Somerset and Somerset.

ASPT are aware that the identification and protection of Vulnerable Adults is core to our work. This is due to the nature of Probation business both as a statutory agency and in partnership in the community. No single Policy can cover all aspects of this work and ASPT have taken a Portfolio approach to discharging these responsibilities. Our Safeguarding role is also expressed in the following documents:

- ASPT Recruitment Policy
- ASPT Victims Policy
- ASPT Approved Premises Guidance
- ASPT core training as per our Learning and Development Plan
- ASPT Single Equalities Scheme
- MARAC and MAPPA protocols

Achievements for 2011-12

- 100% enhanced CRB for all staff employed by ASPT
- Safeguarding adults awareness is embedded in core Probation Practice and reflected within PPDAs, OASys, MAPPA, MARAC,IMMS, PSRs and other related Probation reports
- Safeguarding adults level 2 training is a mandatory requirement as per Learning and development plan

Objectives for 2012-13

- For 2012-13 safeguarding training will be a mandatory requirement to staff induction.

7.4 Avon and Somerset Constabulary

From January 2012 Avon and Somerset Constabulary have undertaken a significant programme of change to restructure and modernise the way our Public Protection (PPU) Services are delivered.

Our objective has been to improve the way we protect vulnerable people through better co-ordinated assessment of risk, building capacity to address resilience issues, whilst at the same time delivering financial savings in this difficult economic climate where our public services are facing drastic budget cuts. For the Police there will be a 20% reduction in budget over 4 years which commenced in 2011.

The main change is the creation of three **Safeguarding and Co-ordination Units (SCUs)** - at Bristol, Keynsham (for Bath and North East Somerset and South Gloucestershire Local Authority areas) and Taunton (for Somerset and North Somerset Local Authority areas) which act as the central point for management of all information coming in and out relating to the abuse of vulnerable people and children and the offenders that commit these offences.

The SCUs have adopted consistent and streamlined risk assessment processes and information sharing and started to break down 'silo' working across different areas of abuse in recognition that child abuse, domestic abuse, and adult abuse are often interlinked with each other, which is reflected within the referrals and investigations that the Police deal with. Initially these SCUs will be police single agency units but plans are afoot to pave the way for them to become multi agency safeguarding units in the future

Vulnerable Adult abuse is no longer investigated in isolation but is managed within the newly formed PPU investigations teams, which are multi skilled to deal with a spectrum of offences. This means better identification of risk and management of cases.

Investigation Teams continue to be locally based with the exception of South Gloucestershire and Bath & North East Somerset which are co-located at Keynsham. The investigation teams covering the South are located at Yeovil, Taunton and Weston-Super-Mare. This will increase our resilience and capability to respond appropriately to all forms of Public Protection, including abuse of vulnerable adults, ultimately providing a better service to our victims.

Within the last year the Police have experienced an increase in referrals linked to care home settings and institutional issues, since the investigation into abuse of patients within Winterbourne View Hospital. This is viewed as a positive and demonstrates the improved awareness of vulnerable adult abuse amongst the public and partner agencies. This matter is currently still under investigation, to date 11 individuals are being prosecuted for offences relating to neglect and ill treatment under the Mental Capacity Act. All 11 defendants have now pleaded guilty to offences and we await sentencing for them which is to begin on 22.10.12.

Headquarters Public Protection Unit have drawn up a 24 point development plan under the heading "Safeguarding Adults against significant harm or exploitation". The plan is sub divided into processes, training, intelligence, performance, partnerships, learning and publicity and represents the most comprehensive commitment to address all aspects of abuse of vulnerable adults the force has ever mounted.

Application of key learning from Serious Case Reviews and other review processes

The development plan referred to above has been designed following the learning from local and national Serious Case Reviews that relate particularly to policing.

Planned safeguarding activities for 2012-13

The constabulary's focus over the next twelve months is to embed the new processes brought about by the restructure of Public Protection services across the force area whilst progressing the 24 action points contained in the Safeguarding Adults Development Plan.

One such process is the trial on Bath and North East Somerset police district of a new flagging system within police databases to better record and understand levels of reporting in relation to safeguarding vulnerable adults. Headquarters PPU are also working to develop processes to flags concerns in premises where vulnerable adults reside.

7.5 Freeways

As a provider it is very important that following on from Winterbourne View and the Serious Case Review that all organisations are held to account and follow the numerous recommendations made in light of that particular case. It is important that we continue with the message that safeguarding is everyone's business and take every opportunity to make anyone aware of the need to promote positive risk taking, education and training for adults at risk to prevent safeguarding issues arising but also to challenge and report when things do go wrong. Partnership working is vital to the success of this message and not looking for someone to blame.

We prefer not to wait for a national scandal but ensure that all staff and the individuals that we support are aware of safeguarding and are encouraged and enabled to raise any concerns through our Complaints, Grievance or Whistleblowing policies and procedures. We support a group of our service users to develop accessible policies to replace our wordy staff-focused policies and this year they have completed our 'Treating People Fairly' Policy to replace 'Equality and Diversity' and have just finished consultation with our service user focus groups on our new 'Keeping Safe in Freeways' which replaces our 'No Secrets' policy. The new policy is based largely on the 'Keeping Safe in B&NES' policy which B&NES People First wrote for everyone living in Bath and North East Somerset, the group are very grateful for being allowed to use this.

Achievements in 2011-12

In terms of our performance against the QA indicators set by the LSAB for 2011-12:

- 100% of relevant staff receive training within first 6 months and annual update (not 2 yearly as per indicator)

- 95% of relevant staff receive training in MCA and receive an annual update
- 95% of relevant staff receive DOLS awareness training or an annual update
- 95% of relevant staff receive internal induction training on safeguarding within first 3 months and 100% within 6 months
- 100% of staff CRB checks are up to date
- Safeguarding is discussed in team meetings, supervisions, as part of service user complaints process and staff are involved in making alerts and attending strategy meetings where relevant and appropriate
- Both our support teams have 2 named Safeguarding champions to promote the importance of prevention , awareness, training and reporting concerns

7.6 Avon Fire & Rescue Service

Avon Fire & Rescue Service continues to actively engage in the Safeguarding Adults agenda, both from an operational perspective where we generate alerts, and also the management perspective where we are represented on the Local Safeguarding Adults Board and during 2011-12 has chaired the Quality Assurance, Audit and Performance Management sub group.

Achievements for 2011-12

- Avon Fire & Rescue Service has produced a service wide policy dealing with Safeguarding and is an active participant on both Adult and Children Safeguarding boards in all four Unitary Areas
- 100% Intervention staff that remain within the community safety department of Service Delivery have up to date CRB checks. Remaining FRS staff are not deemed relevant and not CRB checked
- The service has produced a standard operating procedure E5, Safeguarding Children and Vulnerable Adults Policy and Guidance. This is disseminated throughout the workplace and viewed by all staff. Managers. Senior Mangers (including Duty Group Response Managers are referenced within the reporting process)

Objectives for 2012-13

- Deliver against the action plan formulated from the self assessment
- Deliver a safeguarding training policy and briefing to the Strategic Management Board
- E learning alerter training (L1) will be delivered to all front line staff in November/December 2012. Senior Managers and selected staff to partake in L2/L3 training in December 2012 and January 2013

7.7 Carers' Centre Bath & North East Somerset

The Carers' Centre Bath and North East Somerset represents carers and voluntary carers' organisations on the Safeguarding Adults Partnership Board. Safeguarding updates continue to be shared at the Voluntary Sector Carers Provider Forum through regular updates and gaining feedback from carers' provider services.

The Carers' Centre Bath and North East Somerset has represented carers views on the Safeguarding Adults Awareness, Engagement & Communications Sub-Group. This has led to a Plan for Carers and Safeguarding Adults based on Working

Together to Improve Outcomes Paper (ADASS July 2011). This comprehensive plan is being monitored to ensure improvements are made to Safeguarding to benefit carers. The Carers' Centre also wrote a Service User and Carer Involvement Safeguarding Strategy in partnership with Bath People First and the Carers' Centre has supported the group to implement the strategy with Sirona Care and Health to gain regular feedback from carers about their experience of Safeguarding to improve meeting the No secrets (2000) guidance.

7.8 Bath & North East Somerset People First

Bath & North Somerset People First - a voice for disabled people is involved in Safeguarding Adults from a service user perspective.
The focus of this is to ensure that disabled people have an awareness of what abuse is and what to do if they think they, or someone they know is being abused. Also to have an awareness of some of the terminology used in matters relating to safeguarding and to understand the procedure that would happen once an alert is made.
Safeguarding can have the effect of limiting the choices in disabled peoples' lives to an extent that the quality of their life can feel diminished. An approach to risk enablement can be a more positive path to support people to lead full, active and included lives.

We have now run courses for over 180 disabled people by small training groups so they can have the confidence to speak out about their personal lives. The groups have included a wide range of disabilities and ages including black and minority ethnic communities.

Through our work with the Local Safeguarding Adults Board, we wanted to ensure that disabled people understood that they have the **right** to feel empowered within the safeguarding procedure and be offered support if needed.

Also to

- ensure service users are involved in all aspects of safeguarding planning, training, quality and monitoring
- ensure barriers to inclusion are overcome
- ensure adults at risk are given the opportunity to look at options even if they differ from a professional's choice
- involvement in levels of risk taking and decisions
- ensure there is enough time for service users to make informed decisions and not be rushed.

There has been a feeling of increased confidence about being able to report any concerns. People are talking more openly about keeping safe.
People have been sharing their experiences and how they have dealt with safeguarding issues which achieves greater awareness and preventative measures.

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We have an accessible safeguarding policy and continue to be involved in meeting both individuals and organisations of disabled people to hear their views and needs on keeping safe. We are involved in two sub-groups: Safeguarding and Personalisation, and the Awareness, Engagement & Communications group.

Our main focus will continue to be about empowering disabled people to be included and understand how to recognise early signs of possible abuse as prevention is our top priority.

7.9 Avon and Wiltshire Mental Health Partnership Trust (AWP)

AWP continues to seek to meet its duties to safeguard adults by undertaking further development work throughout 2011-12.

AWP has taken an active role in the Safeguarding Adults Board and its work. AWP's Head of Safeguarding and Deputy Caldicott Guardian attends the Board on a regular basis.

Additionally AWP has a variety of staff involved in all the Board's sub groups. Therefore AWP looks forward to playing a continuing role in working with the Banes Safeguarding Adult Board to ensure the effective safeguarding of vulnerable people with mental illness from abuse, and to respond to the challenges and opportunities presented by the proposed new national guidance and legislation to safeguard adults.

Achievements in 2011-12
As an organisation working with adults and older people with mental illness, many of which are very vulnerable, AWP has implemented major changes this year, including:

- Reviewing its training strategy in relation to safeguarding training in order to strengthen and re-enforce key messages at Awareness level training
- Delivery of discrete safeguarding adults training to inpatient staff
- The launch of service user, carer and easy read safeguarding leaflets
- The development of outward facing website with discrete safeguarding pages
- Continued development of Trust wide documents, templates and intranet based information to ensure effective management of safeguarding adult alerts
- Maintaining trust wide data collection and performance reporting of safeguarding adult activity, both internally and to the Safeguarding Adult Board
- Developing monitoring to ensure that our workforce is checked and monitored on an ongoing basis to ensure that they are safe to work with vulnerable adults
- Updating the Trust Policies to Safeguard Adults to reflect local and national policy and guidance changes, and regulatory requirements
- Policy and procedures re-launched in relation to Mental Capacity Act to ensure staff are aware of the application of the MCA, including when it may be appropriate to approach the court of protection
- Implementing learning arising from serious cases reviews both locally and nationally

These changes have raised the profile of adult safeguarding in the Trust, and this has been supported by the continued work of a dedicated safeguarding team, working to support and advise practitioners in their safeguarding practice in Banes .

Objectives for 2012-13
AWP's key plans for next year in relation to Safeguarding are :

- Continue to work through action plans developed in response to AWP Self Assessment in relation to the South West's Adult Safeguarding Performance and Quality Framework .
- To deliver strengthened Safeguarding training via AWP Learning and Development to staff
- To implement any learning from local, regional or national Serious Case Reviews in order to keep vulnerable people safe from abuse

7.10 Sirona Care and Health

The creation of Sirona Care and Health in October 2011 brought about a significant change in working practices relating to Safeguarding as, from this point the social workers, managers and other staff involved with Safeguarding Adults work were employed by a social enterprise rather than by the Local Authority.

Because of the legislative requirements that the local authority is ultimately responsible for all community care assessments (which is taken to include those relating to safeguarding issues), new 'delegated responsibility' arrangements had to be made to ensure that B&NES council maintained assurance and accountability. In practice, this meant that a small team of Team Managers was set up on the council side to maintain an overview of all cases through audit and to chair all strategy and planning meetings. The practicalities of this have been challenging, given the need for continuous dialogue between Sirona managers and the new team of 'Chairs' but - apart from some minor teething problems - the new arrangements have been effective. Regular meetings are held between the two sets of managers to resolve any misunderstandings or difficulties.

The issue of note taking for meetings has been one of the harder issues to resolve due to the steady increase in referrals, the tendency to hold more meetings than before, the length of meetings and competing demands on admin staff time. This is in the process of being resolved through the recruitment of dedicated note-takers who are to be directly managed by the Safeguarding Adults Co-ordinator.

Performance to Quality Indicators for 2011-12
The quality indicators required of Sirona Care and Health by commissioners in relation to Safeguarding are shown below with outcomes in italics:

- 100% CRB checks in place for staff requiring them. *99.5% in place and the remaining 0.5% are being actively followed up*
- All new staff to undertake Safeguarding Adults awareness training included as part of new staff induction programme. *Achieved*
- Report to be completed outlining audits undertaken (15% of all cases). *Completed*
- Report to be completed giving reasons for all case where there was more than one referral. *Completed*
- Report to be completed detailing the number of service users who felt safe as a result of Safeguarding interventions. *Completed*

Work plan for 2012-13
The key workstreams planned for 2012-13 are as follows:

- To update all our Safeguarding Adults policies and procedures in line with the new Sirona / B&NES 'delegated responsibilities' arrangements and the revised multi-agency policies and procedures
- To complete and launch updated Mental Capacity Act guidelines
- To continue to support the Safeguarding Champions Group
- To amend the Safeguarding Adults input into the Sirona induction programme to ensure that it is more closely aligned with Safeguarding Children training
- To update the Level 2 Safeguarding Adults training programme in line with national and local developments
- To ensure that all staff are up-to-date with their Safeguarding training and that bespoke training is provided to teams with specific needs
- To continue to contribute fully to the work of the LSAB and its sub groups
- To continue to audit cases and continually improve our practice based on 'lessons learnt' from these cases
- To ensure that the roll-out of the service user feedback questionnaire is successful
- To ensure that awareness of Safeguarding issues permeates the organisation from senior managers and Board level through to front line staff in every area and setting

7.11 Royal National Hospital for Rheumatic Disease

2011-12 has been a busy and turbulent year of change for the RNHRD with financial pressures, reduction in referrals and changes in Commissioner behaviour affecting activity and income. An unannounced visit by the CQC on 25th October 2011 identified moderate concerns with outcome 7, Safeguarding Adults from abuse due to lack of staff training and understanding. The trust was deemed non-compliant and was required to develop an action plan to achieve compliance by the end of December 2011. The Trust achieved the action plan within the allotted timescale and has worked hard to maintain high levels of mandatory training compliance.

The Trust has continued to engage well and continues to have good relationships with the Local Adult Safeguarding Board and its sub committees. Representation at the Local Safeguarding Board for Children has been achieved this year but due to the small, mainly adult focused and specialist nature of the Trust the level of time and commitment to attend both adult and children's safeguarding Board will be reviewed in 2012-13.

Review against Quality Requirements for 2011-12

- The table below provides detail on the Trust performance against quality requirements within our contract with Commissioners regarding for safeguarding training

Safeguarding Training Performance in 2011-12

2011/12	Q1	Q2	Q3	Q4	Target
Safeguarding Children Level 1	52%		100%	99.3%	
Safeguarding Children Level 2	15%	74%	82%	83%	
Safeguarding Adults Level 1			100%	98%	
Safeguarding Adults Level 2	66%	67%	86%	85%	
Mental Capacity Act & DoLs Level 1		34%		100%	
Mental Capacity Act & DoLs Level 2			76%	86%	

Safeguarding training has had a wide ranging review during 2011-12 and the figures in Table 1 demonstrate significant improvement in each quarter of the year. Induction training has been redeveloped and face to face presentations for level 1 children, adults safeguarding and Mental Capacity Act and DoLs at level1 ensure that all new starters receive this training. Safeguarding training is on-going for staff and is usually via an e-learning system.

- All areas have leads for safeguarding who attend the Safeguarding committee
- Disseminate lessons learnt and change practice accordingly
- All supervisors have been informed of the necessity to ensure that discussion regarding safeguarding and DoLs takes place during supervision sessions. In addition there is broader discussion within the regular patient MDT meetings in all specialties.
- The Director of Operations and Clinical Practice is the executive on the board with responsibility for safeguarding and attends the local Inter-Agency Partnership Board. The trust has representation on all the sub-committees of the partnership board.
- Patient Safety co-ordinator – Training sub –committee
- Head of Nursing – Quality and Audit committee
- Clinical Pathway Manager – Public Awareness and Communications
- Partnership and sub committees all attended regularly by the Trust representatives and actions/feedback are disseminated to clinical areas and the Trust Safeguarding Committee.
- The BANES poster and awareness material has been distributed to staff and all clinical areas, certain notice boards are being targeted in clinical areas for poster display.
- Access to Safeguarding information on the Mintranet has been updated and a separate link being set up on the front page to ensure easy access for all staff.
- There have been no complaints received in 2010-11

7.12 Curo (formerly Somer Community Housing Trust)

Somer Community Housing Trust (Curo from July 2011) has some 9200 homes in Bath and North East Somerset. 1761 of these are sheltered housing properties for older or disabled people and 90 of these are extra-care units. We recognise that many of those using our services may be vulnerable to abuse. Their age or disability may affect their ability to take care of themselves and protect themselves from significant harm or exploitation. Over the course of the year we have sought to extend our safeguarding activities and expertise. The role of our staff is primarily that of alerters.

Developments in 2011-12 include:

- The Director of Neighbourhoods now sits on the safeguarding Adults Board.
- The Head of Tenancy Solutions now sits on the Quality Assurance, Audit and Performance Management Sub Group.
- Our safeguarding policy and procedure has been updated and all housing services staff and managers have received training in relation to this.
- All new customer-facing staff now receive safeguarding training as part of their induction, with additional sessions for care and support staff.
- Safeguarding is a routine part of all housing services supervisions and team meetings.
- Our Independent living service was launched in January 2011. The service now supports almost 500 people with very diverse backgrounds and support needs. 42% of current clients are not Curo residents.

Objectives for 2012-13:

- Enhancements to safeguarding induction training planned.
- Roll out of safeguarding adults and children training and a “concern card” process for all 70 trade staff who work in our homes.
- Delivery of a plan formulated from the outcome of the self-assessment.
- Extended pre-tenancy assessment of customers and enhanced tenancy management planning.
- Development of a safeguarding page for customers on the new Curo website.

Section 8: Priorities for the Coming Year 2012-13

8.1 The LSAB have developed a three year business plan 2012-15 outlined in appendix six of this report. The business plan follows the template recommended by ADASS South West region. The plan includes objectives and actions previously agreed by the LSAB and also new actions identified from this report also agreed by the LSAB.

8.2 The business plan is separated out into five domain areas and six outcome areas:

- **Domain 1: Prevention & Early Intervention**

  Outcome 1: a pro-active approach reduces risks and promotes safe services whilst ensuring independence, choice and control.

- **Domain 2: Responsibility & Accountability**

Outcome 2: There is a multi-agency approach for people who need safeguarding support

- **Domain 3: Access & Involvement**

  Outcome 3: People are aware of what to do if they suspect or experience abuse

  Outcome 4: Local practice and the commissioning of services and support are informed by feedback and satisfaction levels of those who have had experience of the safeguarding process

- **Domain 4: Responding to Abuse & Neglect**

  Outcome 5: People in need of safeguarding support feel safer and further harm is prevented

- **Domain 5: Training and Professional Development**

  Outcome 6: Staff are aware of policies & procedures, their practice safeguards adults and promotes understanding of harm

8.3 The local objectives and actions proposed by the LSAB to fulfil the domains and outcomes are set out in appendix 6 and will be monitored by the LSAB and sub groups routinely to ensure they are achieved. The details of the plan will be reviewed annually.

Author:

Lesley Hutchinson
Assistant Director Safeguarding and Personalisation
B&NES Council
Health and Wellbeing Partnership
October 2012

Appendix 1

LOCAL SAFEGUARDING ADULTS BOARD
Membership as at March 2012

NAME	ORGANISATION
Cllr ALLEN Simon	Cabinet Member for Wellbeing (B&NES)
COWEN Robin	Independent Chair
CARR-SMITH Gary	Unitary Manager, Avon Fire & Rescue Service
DAY Kevin	Senior Probation Officer, Avon & Somerset Wiltshire Probation Service
DEAN Mark	Head of Public Protection & Safeguard, Avon & Wiltshire Partnership Mental Health NHS Trust
DOBLE Stella	Strategic Director, Adult Services, Sirona Care & Health (formerly Community Health and Social Care Services)
EVANS Julie	Director of Customer Services (Housing & Support), Curo (formerly Somer Community Housing Trust)
GOODFELLOW Janet	Regional Manager, Four Seasons Health Care
GRAY Jo	Divisional Director for Adult Safeguarding, Care & Practice Development, B&NES Council
HUTCHISON Sonia	Chief Executive Officer, Carers Centre (B&NES)
HUTCHINSON Lesley	Assistant Director Safeguarding and Personalisation, B&NES Council
HOWARD Damaris	Operational Director, Freeways Trust
KELLY Annie	Director of Operations & Clinical Practice, RNHRD
KENT-LEGER Sophie	Assistant Head, Teacher Threeways Special School B&NES Council
KNIVETON Myriam	Area Business Manager, Stonham West Regional Office
Dr LEACH Louise	B&NES Clinical Commissioning Group Representative
LEWIS Mary	Assistant Director of Nursing (Medicine), RUH
MONNINGTON Mary	Director of Nursing, B&NES PCT & Wiltshire Cluster
RIZK Meri	Manager, B&NES People First
ROWSE Janet	Chief Executive, Sirona Care and Health (formerly Community Health and Social Care Services)
SMITH Sue	Clinical Standards Manager, GWAS (Associate Member of LSAB)
TAYLOR Karen	Compliance Manager, CQC South West Region
THOMPSON Francesca	Director of Nursing Royal United Hospital, NHS Trust, Bath
TOZER Clare	Personal Assistant to Lesley Hutchinson & note-taker for LSAB B&NES Council
TRETHEWEY David	Divisional Director Policy & Partnerships, B&NES Council
WESSELL Geoff	Det Superintendent PPU Avon & Somerset Constabulary

Appendix 2

Membership List of Local Safeguarding Adults Board sub groups (as at March 2012)

Safeguarding Adults Training and Development sub group
Meet: bi monthly
Chair: Jenny Theed / Stella Doble (Sirona Care and Health)
Simon Ibbunson (RNHRD)
Patricia Mills (RUH)
Myriam Kniveton (Stonham West Regional Offices)
Sophie Cousins (AWP)
Jane Davies (RUH)
Dennis Little (B&NES Council)
Sue Tabberer (Sirona Care and Health)
Geoff Watson (Sirona Care and Health)

Policy & Procedures sub group
Meet: bi monthly
Chair: Damaris Howard (Freeways)
Alan Mogg (B&NES Council)
Lesley Hutchinson (B&NES Council)
Fran McGarrigle (AWP)
Simon Brickwood (Avon & Somerset Police PPU)
Chiquita Cusens (CH&SCS)
Rebecca Jones (B&NES Council)
Sue Leathers (RUH)
Sue Tabberer (Sirona Care and Health)
Hugh Jupp (AWP)
Lindsay Smith (Sirona Care and Health)
Rebecca Potter (B&NES Council)
Lynne Scragg (Bath College)
Neil Boyland (RUH)
Dennis Little (B&NES Council)
Deborah Janes (AWP)

Awareness, Engagement and Communications sub group
Meet approx: bi-monthly
Chair: Mary Lewis (RUH)
Lesley Hutchinson (B&NES Council)
Martha Cox (Sirona Care and Health)
Camilla Freeth (B&NES Council)
Damaris Howard (Freeways)
Helen Robinson-Gordon (RUH)
Meri Rizk (B&NES People First)
Sonia Hutchison (Carers Centre)
Mel Hodgson (B&NES Council)
Geoff Watson (Sirona Care and Health)

Quality Assurance, Audit & Performance Management sub group
Meet approx: bi-monthly
Chair: Denis McCann / Gary Carr-Smith (Avon Fire & Rescue)
Denis McCann (Avon Fire & Rescue) replaced by Gary Carr-Smith

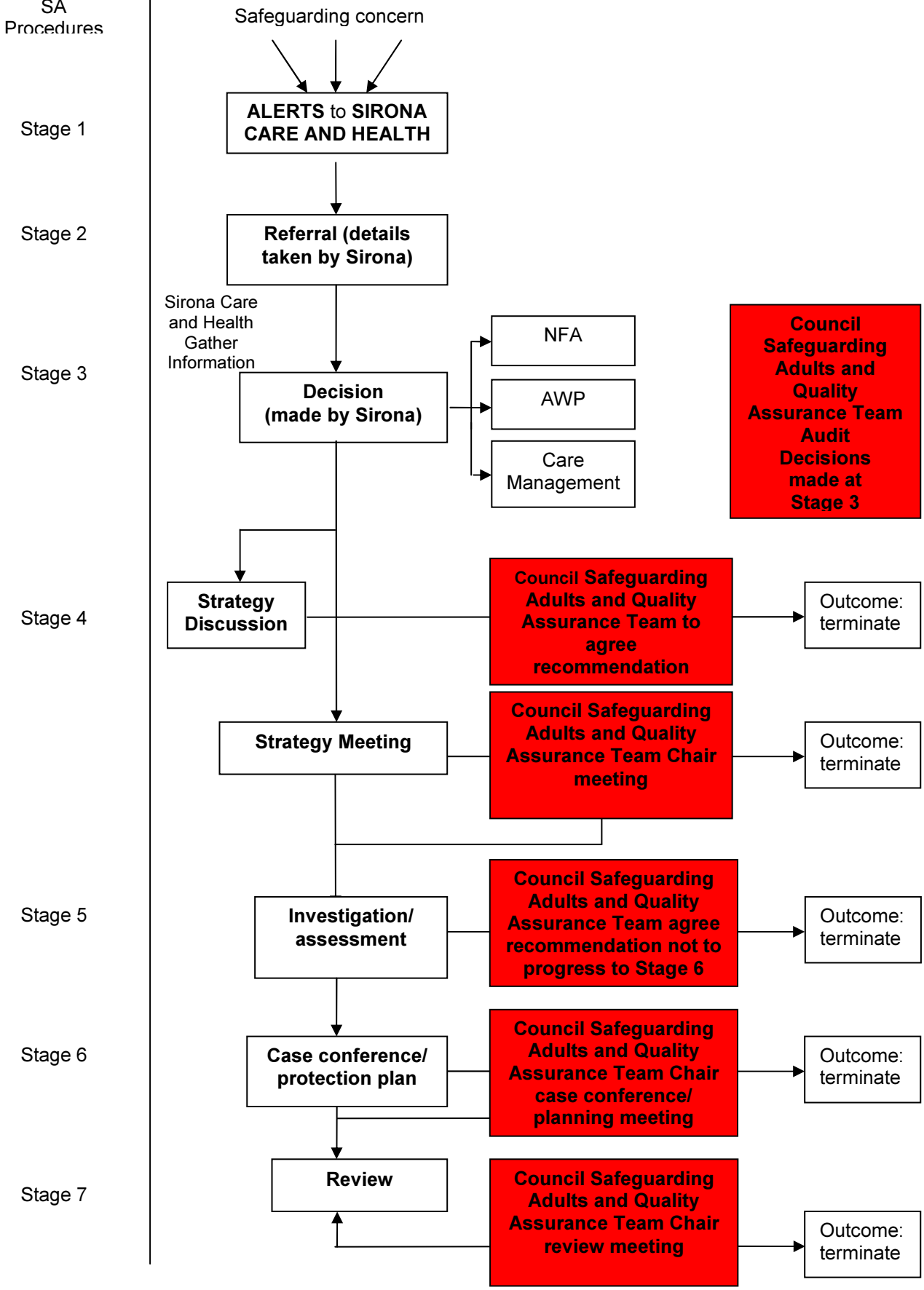
Amanda Pacey (RNHRD)
Caroline Latham (Sirona Care and Health)
Fran McGarrigle (AWP)
Geoff Watson (Sirona Care and Health)
Mike Williams (Avon & Somerset PPU)
Lesley Hutchinson (B&NES Council)
Stella Doble (Sirona Care and Health)
Mark Dean (AWP)
Rob Eliot (RUH)
Julie Evans (Curo)
Rob Elliot (RUH)
Sue Leathers (RUH)
Alan Mogg (B&NES Council)

Mental Capacity Act Local Implementation Group
Meet: Quarterly
Chair: Lesley Hutchinson (B&NES Council)
Dennis Little (B&NES Council)
Tom Lochhead (B&NES Council)
Louise Russell (RNHRD)
Pam Dunn (Carewatch)
Sue Tabberer (Sirona Care and Health)
Debbie Incledon (B&NES Council Legal)
Steve Knight (Sirona Care and Health)
Gemma Box (RUH)
Karen Webb (Four Seasons)
Maria Wallen (NHS BaNES)
Dr Rajpal (CH&SCS)
Dr Harrison (AWP)
Rosemary Carroll (Sirona Care and Health)
Sally Cook (Bath Mind)
Andy Rogers (Bath Mind)

Safeguarding & Personalisation sub group
Meet: Quarterly
Chair: Lesley Hutchinson (B&NES Council)
Jenny Shrubsall
Clare Gray (Shaw Trust)
Meri Rizk (B&NES People First)
Roanne Wootten (Julian House)
Geoff Watson (Sirona Care and Health)
Karyn Yee King (AWP / B&NES Council)
Dennis Little (B&NES Council)

Appendix 3

Safeguarding Adults Assurance / Non Delegation Flow Chart



Appendix 4: LSAB SAFEGUARDING INDICATORS 2011-12

Indicator	Target	Logic for Change and Actions
1. % of decisions made in 2 working days from the time of referral	95%	1. Maintain a high target (reduce by 3%) as this is a crucial time for identifying when someone is at risk of abuse and stopping abuse from escalating 2. Allows for 5% of decisions not to be made in 48 working hours because further information is needed 3. Breach reports provided for cases outside of timescale which set out the evidence of work taking place to ensure service user is safe whilst decision being made
2a. % of strategy meetings/discussions held within 5 working days from date of referral	90%	1. Maintain a high target (reduce by 8%) as this is also a crucial time for ensuring swift action is taken to ensure potential abuse is prevented from continuing 2. Allows 10% leeway as there are occasions when: - relevant partners are not able to meet within timescale but their presence is essential - additional time is needed to gather all the information to facilitate a meaningful discussion 3. Breach reports provided for cases outside of timescale
2b. % of strategy meetings/discussions held with 8 working days from date of referral	100 %	1. Provides assurance that all cases have a strategy meeting/discussion within an agreed timeframe
3. % of overall activities / events to timescale	90%	1. 10% leeway allowed because: - there can be justifiable reasons that prevent CH&SCS and AWP from completing assessment/ investigation in timescale and for holding planning and review in accordance with timescale 2. Breach reports provided for cases outside of timescale

<u>Other Mechanisms for Assurance:</u>

In addition to the above the following mix of targets and quality measures will remain/be put in place to provide assurance about safeguarding practice:

Monthly: AWP and SIRONA CARE AND HEALTH (CH&SCS) ONLY

- Exception reports required and reported for each breach of procedural timescale
- Exception reports on repeat referrals
- Exception reports on cases with the outcome of Not Determined and Inconclusive
- Evidence that 15% of safeguarding case file audits are undertaken per annum (proportionate across all service areas) and reported bi annually

Annually: AWP and SIRONA CARE AND HEALTH (CH&SCS) ONLY

- Report on the experience and outcome for the service user (to include service user experience as well as involvement in safeguarding arrangements)

Quarterly: LSAB and Local Authority / PCT Commissioned Agencies who Deliver Health and Social Care Services

- 97% of relevant social care staff will have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter (the term 'relevant' is defined by CQC)

- 80% of relevant health staff will have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter (the term relevant here excludes staff without direct contact with patients / service users and certain other categories – eg support staff, Children's Health staff)

- 80% of relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post (relevant staff includes people that directly provide health and social care or are in a position to make decisions about the service users care - training to include DOLS awareness)

- 95% of relevant staff to have undertaken DOLS training within 6 months of taking up post (the term relevant here includes those staff responsible in law for making a DOLS application - training must be comparable to B&NES DOLS training)

.

Annually: ALL LSAB Members and LA / PCT Commissioned Services

- 95% new staff to undertake safeguarding learning as part of Induction within 3 months of starting employment

- 100% relevant staff to have an up to date CRB check in place and / or be registered with the Independent Safeguarding Authority (the term relevant here applies to those staff that are required in law to have a CRB and or be registered with the ISA)

- Evidence of safeguarding discussions / raising awareness (eg, supervision arrangements to include this)

- Safeguarding champions identified for each team

Annually: LSAB Agencies / Non Local Authority and PCT Commissioned Services Whose Primary Role is not Health and Social Care Delivery

- 80% of relevant staff to have undertaken Safeguarding Adults 2a training within 6 months of taking up post (the term relevant here includes staff that have direct contact with vulnerable people).

Appendix 5 Breakdown of Referrals by Gender, Age Band and Ethnicity 2011/12 (All Cases)

Ethnicity	No. of referrals by Gender			No. of referrals by Age Band										No. by ethnicity	
				18-44		45-64		65-74		75-84		85+			
White British	Male	128	*32.2%*	38	*39.6%*	38	*50.0%*	17	*44.7%*	15	*18.1%*	20	*19.0%*	356	89.4%
	Female	228	*57.3%*	39	*40.6%*	27	*35.5%*	20	*52.6%*	66	*79.5%*	76	*72.4%*		
White Other	Male	2	*0.5%*	1	*1.0%*	1	*1.3%*							8	2.0%
	Female	6	*1.5%*	1	*1.0%*					1	*1.2%*	4	*3.8%*		
Black/Brit-African	Male	1	*0.3%*	1	*1.0%*									1	0.3%
	Female	0													
Black/Brit-Carib	Male	3	*0.8%*	3	*3.1%*									4	1.0%
	Female	1	*0.3%*									1	*1.0%*		
Asian/Brit-Indian	Male	0												0	
	Female	0													
Mix White/Black-Carib	Male	1	*0.3%*	1	*1.0%*									2	0.5%
	Female	1	*0.3%*			1	*1.3%*								
Info not yet obtained	Male	11	*2.8%*	5	*5.2%*	2	*2.6%*			1	*1.2%*	3	*2.9%*	22	5.5%
	Female	11	*2.8%*	7	*7.3%*	3	*3.9%*	1	*2.6%*						
Other	Male	2				1						1		5	1.3%
	Female	3				3									
Total	Male	**148**	***37.2%***	**49**	***51.0%***	**42**	***55.3%***	**17**	***44.7%***	**16**	***19.3%***	**24**	***22.9%***		
	Female	**250**	***62.8%***	**47**	***49.0%***	**34**	***44.7%***	**21**	***55.3%***	**67**	***80.7%***	**81**	***77.1%***		
	Total	**398**		**96**	***24.1%***	**76**	***19.1%***	**38**	***9.5%***	**83**	***20.9%***	**105**	***26.4%***		

Appendix 6: Business Plan 2012-2015

Business Plan

April 2012- March 2015

Contents

Chair's foreword

I welcome this business plan as an opportunity to be clear and explicit about the LSAB's workplan and to measure the impact of that work. In these pressured times, responding to plans can feel like an additional burden. My view is that this will actually help us to be more effective through targeting scarce resources on the most urgent and important areas over the next three years.

In addition to the work that has been taking place this plan provides opportunities to develop the preventive agenda, to respond to the lessons from Winterbourne View and other serious cases, to seek ways to improve our intelligence gathering, to work more closely with the Responsible Authorities Group and to ensure that our work focuses on and engages with the people who are most at risk and their carers.

The people who use safeguarding services, their carers and the population of Bath and North East Somerset should be in a position to hold the LSAB and partners to account for a lack of progress and to recognise improvements. This plan provides that opportunity.

I would like to take this opportunity to thank LSAB and sub-group members for helping to develop this plan and for their continuing commitment to the safeguarding agenda.

Robin Cowen

Independent Chair

LSAB

1. Introduction

This Business Plan is prepared by B&NES Local Safeguarding Adults Board (LSAB) to outline and explain its strategic goals and business during the next three years. The Business Plan will be made widely available to all those with an interest in Safeguarding Adults and be uploaded on to B&NES Council website. The plan represents an agreement between each of the agencies represented on the LSAB about the activities to be undertaken and the priority afforded to each of them over the next three years. The Business Plan sets out the work of the LSAB sub groups. Each sub group will provide regular updates on progress to the LSAB.

2. Aims & Objectives of the LSAB

The aims and objectives of B&NES Local Safeguarding Adults Board are set out in both the Multi-Agency Safeguarding Policy and the LSAB Terms of Reference below.

The LSAB is responsible for overseeing strategic planning that promotes inter-agency cooperation at all levels of safeguarding adults art risk work. In order to protect vulnerable people at risk from harm and abuse; it is essential that all partners and stakeholders work closely together to develop policies and effective processes that result in timely and robust inter-agency responses. The LSAB oversees this partnership approach by working strategically to consider, direct, assure quality and monitor actions and initiatives which enhance and improve practice across all partner agencies.

The method by which the LSAB aim to achieve their objectives are set out within their agreed terms of reference which are:

3. Terms of Reference

The Terms of Reference for the LSAB are available on the B&NES Council website on the safeguarding adults pages or can be found via the hyperlink below:

http://www.bathnes.gov.uk/sites/default/files/siteimages/Social-Care-and-Health/Safeguarding Adults at Risk of abuse/lsab_terms_of_reference_sept_2012.pdf

4. Monitoring Arrangements

The LSAB will monitor progress of the plan and will report progress in the Annual Report. The Report will be shared with the Health and Wellbeing Partnership Board and will require approval from the B&NES Council Cabinet.

5. Business Planning and Strategic Goals for 2012 - 2015

Building on the Safeguarding Strategic Plan 2009-2011 and moving to a business planning model; the LSAB have set out below the strategic goals they will focus on during 2012 – 2015. The goals are:

- Strengthen arrangements to ensure the ***prevention*** of abuse is given greater focus and includes a particular emphasis on service users and citizen awareness.

- Ensure the voice of the service user is heard; that service users are treated with dignity and respect; that they have choice and control and are empowered during the safeguarding procedure and supported appropriately to take informed risks. Ensuring responses are ***personalised***

- Improve the ***accessibility*** of services and information provided regarding adult protection

- Improve the safeguarding system through ***learning, sharing*** and ***disseminating*** best practices

The above goals were agreed by the LSAB at a workshop in September 2011 and have been woven into the five domains and associated outcome measures prescribed within the South West Self-Assessment Quality & Performance Framework for Adult Safeguarding.

This framework has been developed in partnership with the Strategic Health Authority and approved by the South West Association of Directors of Adult Social Services Safeguarding Adults (SW ADASS) Advisory Group which has health, social care, CQC and police representation. The request and recommendation from SW ADASS is that LSABs use the framework to self assess progress against the five domains which are presented as areas that LSABs should focus adult safeguarding work on. The five domains and outcome measure are:

Domain 1: Prevention & Early Intervention

Outcome 1: a pro-active approach reduces risks and promotes safe services whilst ensuring independence, choice and control.

Domain 2: Responsibility & Accountability

Outcome 2: There is a multi-agency approach for people who need safeguarding support

Domain 3: Access & Involvement

Outcome 3: People are aware of what to do if they suspect or experience abuse

Outcome 4: Local practice and the commissioning of services and support are informed by feedback and satisfaction levels of those who have had experience of the safeguarding process

Domain 4: Responding to Abuse & Neglect

Outcome 5: People in need of safeguarding support feel safer and further harm is prevented

Domain 5: Training and Professional Development

Outcome 6: Staff are aware of policies & procedures, their practice safeguards adults and promotes understanding of harm

The LSAB believe the goals it has are a good fit and compliment the above domains and will serve to strengthen the safeguarding system in B&NES by keeping a local focus whilst addressing the key domains the SHA and South West ADASS have set out.

The business plan will assist the LSAB to support, monitor and review what partner agencies do individually and collectively to fulfil their safeguarding duties.

The LSAB have agreed the appropriate actions within these domains which best address local goals, needs and priorities and have set out the priority areas for the coming three years below:

6. **Actions, Timescales, Lead Agency Responsible, Progress**

Key
Red: Not to timescale
Amber: In progress
Green: To target
Blank: No action to date

QAAPM: Quality Assurance, Audit and Performance Management sub group
P&P: Policy and Procedures sub group
T&D: Training and Development sub group
AEC: Awareness, Engagement and Communications sub group
MCA: Mental Capacity Act Practice Development sub group

Domain 1. Prevention & Early Intervention Outcome 1: a pro-active approach reduces risks and promotes safe services whilst ensuring independence, choice and control.					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
1.1 Assure that information is shared appropriately and in a timely manner within and across partner agencies	A. Review LSAB and single agency information sharing protocols (relate to Trigger Protocol). Identify key areas for information sharing	03/13	P&P group / LSAB agencies		
	B. Carry out multi-agency audits routinely and report gaps and good practice to LSAB to help improve and shape future practice	Quarterly on going	QAAPM group	Progressing; RHNRD presented x3 cases	A
	C. Develop and implement an effective Triggers Protocol (including both Commissioners and Providers triggers)	03/13	P&P group	Slow progress to date; needs LSAB focus Risk is capacity to develop and implement across key agencies	
1.2 Ensure Carers needs are supported	A. Implementation and review of Carers Action Plan	12/12	AEC group	Action plan reviewed in June. Carers Centre updating plan.	A
	B. LSAB partners to support and promote joint working with carers centre	12/12	AEC group	Carers Centre agreed to visit all LSAB agencies to discuss new contract and formalise joint working. RUH and F&R pathways are identified also supporting AWP via Hillview Lodge but need to go to other teams	A

Domain 1. Prevention & Early Intervention Outcome 1: a pro-active approach reduces risks and promotes safe services whilst ensuring independence, choice and control.					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
1.3 Support service users to identify risks and to reduce and prevent abuse occurring	A. Monitor service user feedback from safeguarding process	Report by12/13	AEC group	6 month review requested. Review report to be prepared 12/12	A
	B. Promote through training, development and effective supervision, an ethos of choice and control by achieving the right balance between safeguarding action and proactive risk enablement	12/12	T&D group		
	C. Develop further service user feedback opportunities	09/14	AEC group	Plan to discuss with Your Say once joined the LSAB	
1.4 Work more closely with the LSCB to ensure areas of cross over are addressed; eg Transitions and Mental Health	A. Establishment joint LSAB / LSCB working group	9/12	LSCB and LSAB working group	Working group met at the beginning of Sept and have agreed a set of recommendations which will be proposed to the LSAB and LSCB at December meetings for consideration	A
	B. LSCB/LSAB chairs and B&NES Council Strategic Director for People and Communities to make proposals to both Boards	03/13	LSAB / LSCB		

Domain 1. Prevention & Early Intervention Outcome 1: a pro-active approach reduces risks and promotes safe services whilst ensuring independence, choice and control.					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
1.5 Assurance that robust lessons learned arrangements are in place (including learning from SCRs, case law and other review documents)	A. Review lessons learned guidance that LSAB agencies and sub groups have in place	06/13	QAAPM group	Agenda item for Dec 2012 meeting looking add routine item to agenda of 'learning from national reports' Risk that agencies have insufficient capacity to implement.	A
	B. Draft multi-agency lessons learned guidance	12/13	P&P group		
	C. Ensure recommendations from Winterbourne View and Francis Report are being considered and actioned and risks fully understood; ensure included in contract monitoring	12/12	QAAPM group	Winterbourne View discussed routinely at LSAB; Workshop dedicated to the learning arranged for 16th Oct. Francis report presented to LSAB last year; assurance needs to be sought that agencies have taken on board recommendations Risk for contract and commissioning capacity	A

Domain 2. Responsibility & Accountability Outcome 2: There is a multi-agency approach for people who need safeguarding support					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
2.1 Develop and improve links with Clinical Commissioning Groups (CCGS)	A. Provide joint training events for Practice and District Nurses	12/12	Sirona Care and Health and PCT		
	B. Monitor CCG actions from SCR recommendations and lessons learned	On going	QAAPM group	Early engagement with CCG and Medical Director involved; Commissioner attended CCC with report on SCR and involvement required; report to LSAB on allocation of resources in June 2012	G
	C. Provide training for independent contractors	03/13	Council and PCT	Training / workshop sessions have been agreed; administration is in place. Details of dates to follow	A
2.2 Formalise accountability arrangements between the LSAB, commissioner and commissioned services	A. Draft guidance note as required setting out the Commissioner and LSAB responsibilities	12/12	Council to draft for LSAB discussion	Initial discussion with LSAB Chair and Dept People and Communities taken place; P&C leadership team agreed to develop draft for 01/13; timescale of 12/12 will slip until Jan 13 though work is in progress	A

Domain 2. Responsibility & Accountability Outcome 2: There is a multi-agency approach for people who need safeguarding support					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
2.3 LSAB agencies to complete self - assessment annually to demonstrate continuous development	A. Identify areas for improvement from partner agencies and LSAB through annual self-assessment and include progress in annual report	06/12	QAAPM group	Self-assessments completed and analysed	G
	B. Incorporate areas for improvement into LSAB Business Plan annually	12/12	QAAPM group	Agenda item for Dec meeting Commissioner to report back	A
2.4 Assure LSAB sub groups are meeting the strategic objectives of the LSAB	A. Review sub group Terms of Reference	06/12	All sub groups	AEC group in draft form all others complete	A
2.5 Assure that learning identified in SA annual reports are addressed	A. Monitoring of progress on addressing action points in annual report 10/11	09/12	QAAPM group		G
	B. Incorporate and monitor learning from 11/12 annual report into Business plan	10/12	Council Commissioning Lead	This is in progress and incorporated however final annual report awaiting sign off	A

Domain 2. Responsibility & Accountability Outcome 2: There is a multi-agency approach for people who need safeguarding support					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
2.6 Assure that Whistle blowing arrangements are robust	A. Whistle blowing statement to be included in revised multi-agency policy	12/12	P&P group	Statement ready for inclusion in policy when reviewed	A
	B. Review LSAB and sub group agencies whistle blowing policies and procedures and report back to LSAB	12/12	QAAPM	Initial questionnaire submitted request for Policy and Procedures is being considered	A
	C. Disseminate Whistle blowing best practice guidance widely	09/12	AEC group	Bristol guidance reviewed and made specific to B&NES; finalise content 09/12; 10/12 put on B&NES website and email to all stakeholders	A
2.7 Assurance that the work of the LSAB is incorporated into commissioned	A. Confirmation of how safeguarding and MCA/DOLS indicators are monitored in commissioned services contracts	12/12	Council and PCT Commissioning		

Domain 2. Responsibility & Accountability Outcome 2: There is a multi-agency approach for people who need safeguarding support					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
2.7 Assurance that the work of the LSAB is incorporated into commissioned continued	B. Propose mechanisms to improve reporting and monitoring arrangements	03/13	Council and PCT Commissioning	Initial conversation taken place about the development of an overarching health and social care assurance framework (including children services for safeguarding) building on adults assurance framework that currently exists. This should be ready by Jan 13	A
	C. Monitor implementation of above mechanism	09/13	QAAPM group		
	D. Develop / review assurance arrangements regarding MCA practice (5.1 ToR)	12/12	MCA group	Gather MCA figures on annual basis; new tender for IMCA	A
	E. Propose MCA / DOLS indicators for LSAB	03/13	MCA group	Early discussion has taken place, initial thoughts include: no. of IMCA referrals, DOLS application and process to timescale; safeguarding cases where formal capacity assessments have been undertaken	A

Domain 3. Access & Involvement Outcome 3: People are aware of what to do if they suspect or experience abuse Outcome 4: Local practice and the commissioning of services and support are informed by feedback and satisfaction levels of those who have had experience of the safeguarding process					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
3.1 Ensure service users and alerters have a positive response from professionals through-out the Safeguarding procedure	A. Monitor and review service user experience questionnaire responses (linked to outcome 1)	12/12	AEC group	Agenda item for next meeting	A
	B. Review audit of 'front door' response to safeguarding alerts	12/12	Sirona report to QAAPM	Agenda item for next meeting	A
3.2 Assure a systematic approach to providing safeguarding and MCA information and updates to all people / communities is in place ***(disseminating)***	A. Develop a calendar of opportunities to routinely and strategically disseminate information for i) citizens ii) providers iii) publications	06/13	AEC and MCA group	Agenda item for 03/13. Advert and wording completed for national publication Health and Community Guide	A

Domain 3. Access & Involvement Outcome 3: People are aware of what to do if they suspect or experience abuse Outcome 4: Local practice and the commissioning of services and support are informed by feedback and satisfaction levels of those who have had experience of the safeguarding process					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status RAG Score**
3.3 Assure that mechanisms are in place for service user and carers feedback to inform improvements to policy, practice, commissioning and service development ***(personalised; sharing)***	A. Monitor effectiveness of service user feedback questionnaire process and responses	12/12	AEC group	On forward plan for next agenda	A
	B. Evidence of continual improvement in response to feedback and involvement of service users *(requested from AEC group)*	03/13	QAAPM group	Recorded in Adult at risk involvement guidance	A
3.4 Service users and carers who have been through the safeguarding process to provide peer and mentoring support to other service users and carers	A. Develop a work programme to progress this objective including reviewing the advocacy support available Consider Advocacy and Adult Safeguarding document from ADASS	06/15	AEC group		

Domain 3. Access & Involvement Outcome 3: People are aware of what to do if they suspect or experience abuse Outcome 4: Local practice and the commissioning of services and support are informed by feedback and satisfaction levels of those who have had experience of the safeguarding process					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status RAG Score**
3.5 Raise awareness of discriminatory abuse	A. Agree awareness raising activities specifically for this type of abuse	03/13	AEC group		

Domain 4: Responding to Abuse & Neglect Outcome 5: People in need of safeguarding support feel safer and further harm is prevented					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
4.1 Assure that service users and carers where appropriate, are fully involved and participate at every stage of the safeguarding process and robust evidence that best interests decisions are made where necessary and clearly recorded *(personalised; sharing)*	A. Develop person centred procedures on service user involvement to be available and used by all LSAB partners ensuring service users and carers are treated with dignity	09/12	P&P group	Draft for LSAB to consider	G
	B. Implement and monitor guidance	12/12	QAAPM group		
	C. Request 15% sample audit of cases undertaken by AWP and Sirona Care and Health include a section on compliance with this and demonstrate it is achieved	05/13 for report	QAAPM group to consider audit report	11/12 reports received from both agencies; request 12/13 nearer the time	G
	D. Include this in the Carers Action plan in Domain 1.	09/12	AEC group		A

Domain 4: Responding to Abuse & Neglect Outcome 5: People in need of safeguarding support feel safer and further harm is prevented					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
4.2 Assure that multi-agency policies and procedures are reviewed and best practice guidance is developed (including responses to vulnerable perpetrators) *(personalised; sharing)*	A. Ensure multi-agency policy and procedure review dates are set and list is reviewed on an annual basis	03/13	P&P group	Completed 06/12	G
	B. Ensure each multi-agency document is reviewed on a bi-annual basis	06/12 – 03/15	P&P group	In progress	
	C. Recommend good practice guidance, policies and procedures be written resulting from new information provided nationally, locally from SCRs, quality assurance information from audits and lessons learned information	06/12 – 03/15	QAAPM and P&P group	QAAPM group routinely do and is now regular agenda item	G
				P&P group	
4.3 Ensuring a robust process for the management of large scale investigations	A. Develop large scale investigation guidance and procedures with a clear definition	12/12	P &P group		A

Domain 5: Training and Professional Development Outcome 6: Staff are aware of policies and procedures, their practice safeguards adults and promotes understanding of harm					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
5.1 Ensure organisational commitment to support the development of safeguarding adults and MCA competence in the workforce	A. Roll out audit to LSAB and sub group agencies, carers organisations and Dom Care partners	09/12	T&D group	Audit tool has been circulated with new framework document to all partnership agencies	G
	B. Audit the Multi-agency Staff Development Framework (includes MCA)	09/13	T&D group		
	C. Report audit findings to LSAB	09/13	T&D group		
	D. Propose further roll out to other commissioned services	12/13	T&D group		
	E. Develop requirements for Chief Executives, Elected Members and Board members	12/12	T&D group	For discussion next meeting in October 2012	A
5.2 Assure that LSAB training targets are achieved	A. Set up a system for LSAB training target reporting (including MCA, DOLS and SA training)	06/12	LSAB	LSAB discussed how this can be collected	G

Domain 5: Training and Professional Development Outcome 6: Staff are aware of policies and procedures, their practice safeguards adults and promotes understanding of harm					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
5.3 Ensure safeguarding and risk assessment training is delivered and available to service users and carers	A. Ensure training request is included in Carers Centre service specification	09/12	Council Carers Lead Commissioner		**G**
	B. Ensure service user training is provided through appropriate agency	09/12	Council Commissioner	Delivery of training is included in LD specification for Your Say and for direct payment users through Shaw Trust; Bath People First have funding to deliver this for all service user groups as well *however this is not commissioned against a service spec and the agency is currently reviewing its viability and there may be a future gap*	**G**

Domain 5: Training and Professional Development Outcome 6: Staff are aware of policies and procedures, their practice safeguards adults and promotes understanding of harm					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
5.5 Assure that training meets LSAB standards and competencies set out in the Staff Development Framework are delivered and that service users and carers are involved in delivery where possible	A. Review training provided by Sirona Care and Health and all LSAB agencies	12/12	T&D group	Review progressing well to align training with safeguarding children training	A
	B. Work with the carers centre and support carers to deliver safeguarding training	To be agreed	T&D group	Not progressed to date	
	C. Work with service user representative to support service users to participate in SA training delivery	To be agreed	T&D group	As above	

Domain 5: Training and Professional Development Outcome 6: Staff are aware of policies and procedures, their practice safeguards adults and promotes understanding of harm					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
5.5 Assure that training meets LSAB standards and competencies set out in the Staff Development Framework are delivered and that service users and carers are involved in delivery where possible	D. Propose level 4 training in Staff Development framework to LSAB	03/13	T&D group		

The following items are **Core Business** and specific B&NES Council or PCT/CCG Responsibilities and not included in the Business Plan; exception reports will be provided to the LSAB when there is a concern:

Core Business Item	Responsible Team	Monitoring Route
1. Compliance with safeguarding adults procedures timescales	B&NES Council Safeguarding Adults and Practice Development Team	Monthly performance reports; exception reports for breaches; reports to PCT Board; CCG and Partnership Board for Health and Wellbeing.
2. Identify and develop the areas of cross over for safeguarding adults and community safety eg, prevention, village agents, domestic violence problem profile review	Joint working between B&NES Council Safeguarding Adults and Practice Development Team and Policy and Partnerships Team	(Work has already commenced in this area however it needs to be formalised. Attendance at MAPPA, MARAC, IVASP; PAHC and RAG (when required); discussed DHR and SCR links). Meeting in place to enable plan to be ready for Dec meeting Monitored by People and Communities Department
3. Ensure JSNA informs and influences work of LSAB and other commissioners and agencies	B&NES Council Safeguarding Adults and Practice Development Team and Research and Development Team	High level safeguarding information in JSNA; agreement to commence further work; Monitored by People and Communities Department
4. Ensure that information about adult safeguarding and MCA be available in a variety of formats	B&NES Council Safeguarding Adults and Practice Development Team	Recently reviewed translation is available if requested; Monitored by People and Communities Department
5. Monitor service specification and contract indicators	B&NES Council Commissioning	Performance to each contract is monitored in scheduled compliance meetings by NHS Banes; CCG and People and Communities Department
6. Monitor LSAB safeguarding indicators	B&NES Council Commissioning	New process being implemented during 2012/13; Monitored by People and Communities Department
7. Review and monitor arrangements with Emergency Duty Team	B&NES Council Non Acute Contract and Commissioning Team	In discussion; Monitored by People and Communities Department
8. Review the monitoring and recording arrangements for	B&NES Council Safeguarding Adults and Practice Development Team	Monitored by People and Communities Department

safeguarding procedures that have been carried out for B&NES service users living outside B&NES geographical boundary		
9. Secure support from B&NES Council Research and Development Team to ascertain whether B&NES referral rates are within an expected range	B&NES Commissioning	Monitored by People and Communities Department

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board (Shadow)
MEETING DATE:	7th November 2012
TITLE:	Adult Health and Wellbeing Commissioning Report.
AN OPEN PUBLIC ITEM	
List of attachments to this report: Annex 1 NHS B&NES Performance Exception Scorecard Annex 2 Adult Social Care Outcomes Framework Scorecard	

1 THE ISSUE

1.1 To provide the Board with a summary of current commissioning performance within Adult Health and Social Care and Housing. The summary report provides an overview at Month 5 for the period 2012/13.

2 RECOMMENDATION

2.1 The Health and Wellbeing Board (Shadow) is asked to note the performance as described in the report.

3 FINANCIAL IMPLICATIONS

None directly relating to this report.

4 THE REPORT

4.1 Performance Summary

At the end of August (month 5) we are able to see which areas are performing well against targets and which areas require actions for improvement. Performance against all targets in the Operational and Outcome Frameworks are being monitored by the Partnership Commissioning Directorate.

Performance for the ambulance 8 and 19 minute targets, the 18 week Referral to Treatment targets for both the admitted and non- admitted and the A&E for the 4 hour wait targets continue to be met in August. All of the cancer targets also continue to be met and there have been no further MRSA incidents in B&NES. The RUH were above the trajectory for Clostridium Difficile infections in August (3 actual against a target of 2) but are still meeting the year-end trajectory. The VTE risk assessment target continues to be met at the RUH. Delayed Transfers of Care (DTOC) at the RUH has improved slightly at 4.44% in August of which 2.11% were

for B&NES patients. A weekly strategic call to review the DTOC (Delayed Transfers of Care) position is held with Accountable Officers from both B&NES and Wiltshire CCGs.

The proportion of people using social care who receive self-directed support and those receiving direct payments is meeting the target. The proportion of adults with learning difficulties in paid employment is exceeding the August target of 7% with performance at 8%. Most recently two people have gained employment as a resulting of completing the Project Search programme (supported by the Council) and subsequently receiving job coaching support.

The proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services continues to meet its target of 91%. The increased emphasis on the development and growth of re-ablement services over the last year, including a number of new service pilots, has allowed performance to be maintained despite increased demand pressure. Performance of all five pilots was reviewed in September with positive outcomes consistently identified.

The local targets the Partnership are monitoring show that the percentage of carers receiving a service or advice and information as an outcome of their assessment or review is meeting its monthly target of 13.9% and performance continues to improve following the contract award to the new Carers Centre with an increased focus on assessment and service planning for carers. The housing local monthly indicators are also being met for the number of households living in temporary accommodation (26 against a target of less than 37) and the average time for major adaptations to be completed (32 weeks against a 40 week target).

4.2 key areas that are going well

Ref	Issue	Comments	What support is requested from HWB?
1	Urgent Care Review	The patient and public engagement process began at the end of September. An engagement document and questionnaires have been produced and widely circulated. It has also been produced in easy read format for people with learning disabilities. All the information has been made available on the CCG's new website. By the end of October six engagement events will have taken place, four in the evening and two during the day. A range of stakeholders have been invited to participate in helping to complete the impact assessment and equalities impact assessment. These assessments along with a full report of the outcome of the public engagement will be presented to the Wellbeing Policy Development & Scrutiny Panel on 16th November.	To note

Ref	Issue	Comments	What support is requested from HWB?
2	Dementia	The CCG supported four applications to the South of England Dementia Challenge Fund on 21st September as well as supported a RUH application with Wiltshire CCG. A regional panel will review all applications and let CCGs know the outcome by 26th October.	To note
3	Personal Budgets	The proportion of people who receive self-directed support (Personal Budgets). Service user engagement is about to begin in relation to the Personal Budgets Resource Allocation System with a view to implementation during 2013.	To note
4	Hip and Knee pathway	Early data from the hip and knee pathway suggests that the new pathway is leading to significant improvements in quality of life and mobility for patients as well as delivering savings. This pathway was drawn up by the CCG in collaboration with clinicians in secondary care and community services. The pilot is still underway and data continues to be collected and will be reviewed by the clinically led Musculoskeletal Stakeholder Group but early results and patient feedback are very positive.	To note
5	Mental Health	• Monitoring of specialist mental health service performance and quality continues, especially in relation to the implementation of new services in Primary Care. GP feedback is that services are improving. Further work continues to ensure the care pathways work smoothly across all aspects of care i.e. Crisis to long term care. • Development and implementation of psychiatric liaison services in the RUH, community hospitals and care homes in order to prevent admission and facilitate discharge is underway. • Recommendations are going to the NHS Cluster Board meeting in October regarding the future commissioning arrangements for AWP. The B&NES report is in the context of continuing improvement in the locality approach to services and the steady achievement of quality assurance measures.	To note

4.3 Top 5 causes for concern

Ref	Issue	Comments	What support is requested from HWB?
1	Permanent admissions to residential care of people over 65 years.	Although the rate of permanent admissions has decreased significantly from last year's outturn, the performance target is not being met. The impact of alternative step down accommodation for people leaving hospital is positive and plans are in place to increase the number of step down units.	To note
2	Complex nursing and dementia care beds	The key issue continues to be the availability and quality of complex nursing and dementia care beds. Negotiations with providers continue with the aim of increasing capacity within the cost envelope available.	To note
3	Mixed sex accommodation breaches	Performance has continued to deteriorate at the RUH with 4 mixed sex accommodation breaches in July and 17 breaches in August which places the RUH as an outlier regionally and nationally. Again performance notices are being issued and the RUH have been asked to revise the EMSA action plan to focus on practical actions to change Medical and Surgical Assessment Units (MAU/SAU) that will prevent future breaches.	To note
4	Adult Safeguarding	203 safeguarding referrals have been received at the time of writing this report. This is an increase on the equivalent period last year of 60% (121 received from April – August 2011/12). AWP have seen a similar number of referrals for the same period and the increase is being managed by Sirona Care and Health. Sirona are commissioned to provide the duty response to the referrals; however such a significant increase will impact on their capacity as timescales are short and they have two days to decide whether the referral reaches the threshold to progress to a strategy meeting. However the increase in referrals has not led to the same percentage increase in cases going to strategy meeting or onto investigation. During April to August 2011, 90 strategy meetings were held in comparison to 103 in the same period for 2012; this is a percentage increase of 9% and for the number of cases progressing to investigation there was an 8% increase. Although more referrals are being received they are not meeting the threshold of "significant harm".	To note

Ref	Issue	Comments	What support is requested from HWB?
5	Children's Safeguarding	The Partnership are all working towards strengthening the existing governance in relation to the safeguarding children activity in RUH, the RNHRD, Oxford health, AWP,GWH (maternity) and Sirona. The Designated Nurse Safeguarding Children anticipates that there will be a further inspection by Ofsted/CQC between March – June 2013 if not before. A key line of enquiry is likely to be how the PCT interrogate the evidence from the providers about their safeguarding arrangements and how confident the PCT are that the CQC improvement plan has had an impact on safeguarding activity.	To note

5 RISK MANAGEMENT

5.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

6 EQUALITIES

6.1 Any equality issues are highlighted in the full performance report.

7 CONSULTATION

7.1 Not applicable to this issue.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Service performance impacts on a wide range of issues including Social Inclusion; Customer Focus; Sustainability; Human Resources; Young People; Human Rights; and Impact on Staff.

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	Tracey Cox , Chief Operating Officer, B&NES CCG 01225 831736 Jane Shayler, Programme Director, Non-Acute Health, Social Care & Housing, 01225 396120
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

1a Operating Framework for 2012/13: August 2012

Strategic Direction	Code	Measure	Dir	Definition	A/Q/M	Criteria	Org.	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Year to Date	Forecast Outturn	11/12 Outturn
1. Quality	PHQ04	Cancer Measures	MR	Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service	M	Plan		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
						Actual	NHSB	0/0	0.00%	0/0	100.00%									75.00%	75.00%	100.00%
	PHQ11	Mental health measures - CR/HT	JH	Commissioner measure is number of episodes, provider measure is % of inpatient admissions that have been gatekept by CR/HT	M	Plan	NHSB	22	22	22	22	22								110	264	265
						Actual		19	28	22	19	14								102	245	284
	PHQ13	Mental Health Measures - IAPT	JH	The proportion of people who complete treatment who are moving to recovery	Q	Plan	NHSB			50.0%			50.2%			50.4%			50.6%	50.0%	50.6%	Not comparable to last year's
						Actual				41.5%										41.5%	42.0%	
	PHQ21	RTT waits	JH	RTT - incomplete % within 18 weeks	M	Plan		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	Not comparable to last year's
						Actual	NHSB	92.1%	90.8%	90.1%	89.7%	89.2%								89.2%	89.2%	
	PHQ26	Mixed Sex Accommodation Breaches	JH	Numbers of unjustified breaches	M	Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
						Actual	RUH	19	0	0	6	17								42	101	29
	PHQ27	HCAI measure (MRSA & CDI)	MR	MRSA bacteraemia	M	Plan	RUH	1	0	0	0	0	0	0	0	0	0	0	0	1	1	3
						Actual		0	1	0	1	0								2	5	1
	PHQ28	HCAI measure (MRSA & CDI)	MR	CDI	M	Plan	NHSB	7	4	6	5	4	10	6	4	5	4	6	5	26	66	80
						Actual		7	8	6	3	4								28	67	68
						Plan	RUH	3	3	2	2	2	2	3	4	2	3	3	2	12	31	59
						Actual		1	0	5	2	3								11	26	46
	PHQ30	Smoking Quitters	MR	Number of smoking quitters	Q	Plan	NHSB			265			265			265			453	265	1248	
						Actual				134										134	536	
	PHQ31	Coverage of NHS Health Checks	MR	% people ages 40-74 who have received a health check	Q	Plan	NHSB			2.50%			2.50%			2.50%			2.50%	2.50%	10.00%	9.00%
						Actual				1.56%										1.56%	6.24%	8.92%
				G&A available beds - Day	Q	Actual	RUH			48										48	48	54
2. Resources (Finance, Capacity & Activity)	PHS05	Acute Bed Capacity	JH	G&A available beds - Overnight	Q	Plan	RUH			602			585							602	602	
						Actual				603										603	603	607
	PHS06	Non elective FFCEs	JH	Non-elective FFCEs	M	Plan	NHSB	1210	1223	1223	1267	1214	1248	1380	1317	1332	1357	1202	1339	6137	15312	14630
						Actual		1333	1399	1217	1381	1277								6607	15857	16037
	PHS07	GP written referrals to hospital	JH	No of GP written referrals	M	Plan	NHSB	3158	3264	3785	3562	3104	3184	3260	3613	2795	3149	3389	3073	16873	39336	37107
						Actual		3192	3726	2986	3496	3339								16739	40174	40304
	PHS08	Other referrals for a first outpatient appointment	JH	No of other referrals	M	Plan	NHSB	2410	2615	2693	2517	2232	2357	2311	2339	2122	2115	2182	1957	12467	27850	19756
						Actual		2453	2876	2274	2906	2434								12943	31063	25605
	PHS09	First outpatient attendances following GP referral	JH	No 1st outpatient attendances after GP referral	M	Plan	NHSB	2614	2703	3051	3080	2639	3042	2944	3529	2890	2937	2781	3256	14087	35466	34089
						Actual		3147	3665	2939	3439	3303								16493	39583	34059
	PHS10	All first outpatient attendances	JH	No of first outpatient attendances	M	Plan	NHSB	4582	4831	5460	5437	4669	5297	5113	6032	4860	5196	4928	5642	24979	62047	52632
						Actual		4444	5445	4113	5001	4720								23723	56935	58518
	PHS11	Elective FFCEs	JH	No of elective FFCEs (ordinary adms & separately daycases)	M	Plan	NHSB (total)	1758	1643	1852	1864	1773	1915	1886	1950	1668	1736	1744	1957	8890	21746	20238
						Actual		1765	2058	1482	1902	1921								9128	21907	22015
						Plan	NHSB Daycase	1392	1270	1447	1438	1375	1528	1477	1528	1302	1372	1379	1536	6922	17044	15866
						Actual		1394	1629	1188	1502	1562								7275	17460	17232
	PHS12	A&E attendances	JH	Number of attendances at A&E departments in a month (Type 1 and Total)		Plan	RUH Type 1	5814	5814	5814	5586	5586	5586	5649	5649	5649	5496	5496	5496	28614	67633	65878
						Actual		5208	6944	5561	5628	6584								29925	71820	68199
						Plan	RUH Total	5814	5814	5814	5586	5586	5586	5649	5649	5649	5496	5496	5496	28614	67633	65878
						Actual		5208	6944	5561	5628	6584								29925	71820	68199
						Plan	SFT Type 1	3580	3580	3580	3620	3620	3620	3620	3620	3620	3542	3542	3542	17980	43086	40749
						Actual		3185	4273	3507	3374	4327								18666	44798	41506
						Plan	SFT Total	3580	3580	3580	3620	3620	3620	3620	3620	3620	3542	3542	3542	17980	43086	40749
						Actual		3185	4273	3507	3374	4327								18666	44798	41506
	PHS16	Numbers waiting on an incomplete Referral to Treatment pathway	JH	Total numbers waiting at the end of the month on an incomplete RTT pathway	M	Plan	NHSB	10254	10308	10210	10204	10247	10180	10194	10164	10296	10264	10261	10229	10247	10247	7941
						Actual		10364	10931	10964	10432	10902								10902	10902	10118
3. Re for	PHF07	Choice	-	Bookings to services where named consultant led team was available (even if not selected)	M	Actual	NHSB	73.3%	76.7%	77.8%	77.1%	78.0%								76.6%	76.6%	75.8%
	PHF08			Proportion of GP referrals to first outpatient appointments booked using Choose and Book	M	Actual	NHSB	50%	48%	45%	47%									47%	47%	

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1b Social Care Outcomes Framework. Bath & North East Somerset: September 2012

	Measure	Dir	A/Q/M	Criteria	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Year to Date	Forecast Outturn	1112 Outturn
1C (NI130)	Proportion of people using social care who receive self-directed support, and those receiving direct payments.	SS	M	Plan	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	60%
				Actual	63.7%	61.2%	60.3%	58.3%	57.2%								57.2%	57.2%	31.6%
1E (NI146)	Proportion of adults with learning disabilities in paid employment	MM	M	Plan	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	8%
				Actual	7%	7%	7%	7%	8%								8%	8%	7%
1F (NI150)	Proportion of adults in contact with secondary mental health services in paid employment	AM	M	Plan	18%	18%	18%	18%	18%	18%	18%	18%	18%	18%	18%	18%	18%	18%	18%
				Actual	16%	16%	16%	16%	15%								15%	15%	17%
1G (NI145)	Proportion of adults with learning disabilities who live in their own home or with their family	MM	M	Plan	63%	63%	63%	64%	64%	65%	65%	66%	66%	67%	67%	68%	64%	68%	63%
				Actual	63%	62%	62%	63%	63%								63%	63%	62%
1H (NI149)	Proportion of adults in contact with secondary mental health services living independently, with or without support	AM	A	Plan	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
				Actual	75%	77%	77%	77%	74%								74%	74%	76%
2A	Admissions of people to permanent residential and nursing care - people aged 65+ per 10,000 population	SS	M	Plan	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80
				Actual	83	93	91	95	NYA								95	95	99
2A	Adults aged 18-64 admitted on a permanent basis in the year to residential or nursing care per 10,000 population	SS	M	Plan	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.2
				Actual	0.0	0.0	0.4	1.1	NYA								1.1	1.1	1.3
2C (NI125)	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	CE	M	Plan	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	95%
				Actual	95%	84%	95%	92%	91%								91%	91%	94%

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