Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Bath and North East Somerset Health & Wellbeing Board

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	Date:	11 November 2014

To: All Members of the Health & Wellbeing Board

Members: Councillor Paul Crossley (Bath & North East Somerset Council), Dr. Ian Orpen (Member of the Clinical Commissioning Group), Ashley Ayre (Bath & North East Somerset Council), Councillor Simon Allen (Bath & North East Somerset Council), Bruce Laurence (Bath & North East Somerset Council), Councillor Dine Romero (Bath & North East Somerset Council), Jo Farrar (Bath & North East Somerset Council), Pat Foster (Healthwatch representative), Diana Hall Hall (Healthwatch representative), John Holden (Clinical Commissioning Group lay member) and Tracey Cox (Clinical Commissioning Group)

Non-voting member Julia Davison (NHS England - Bath, Gloucestershire, Swindon and Wiltshire Area Team)

Observers: Councillors John Bull and Vic Pritchard

Other appropriate officers
Press and Public

Dear Member

Health & Wellbeing Board

You are invited to attend a meeting of the Board, to be held on **Wednesday, 19th November, 2014** at **10.00 am** 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 Guildhall Bath (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. **Recording at Meetings**:-

   The Openness of Local Government Bodies Regulations 2014 now allows filming and recording by anyone attending a meeting. This is not within the Council's control.

   Some of our meetings are webcast. At the start of the meeting, the Chair will confirm if all or part of the meeting is to be filmed. If you would prefer not to be filmed for the webcast, please make yourself known to the camera operators.

   To comply with the Data Protection Act 1998, we require the consent of parents or guardians before filming children or young people. For more information, please speak to the camera operator

   The Council will broadcast the images and sound live via the internet www.bathnes.gov.uk/webcast An archived recording of the proceedings will also be available for viewing after the meeting. The Council may also use the images/sound recordings on its social media site or share with other organisations, such as broadcasters.

4. **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;
   - Civic Centre, Keynsham;
   - The Hollies, Midsomer Norton;
   - Public Libraries at: Bath Central, Keynsham and Midsomer Norton.

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

6. **Declarations of Interest**

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting.

   (a) The agenda item number in which they have an interest to declare.
   (b) The nature of their interest.
   (c) Whether their interest is a **disclosable pecuniary interest** or an **other interest**, (as defined in Part 2, A and B of the Code of Conduct and Rules for Registration of Interests)

Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer or a member of his staff before the meeting to expedite dealing with the item during the meeting.

7. Attendance Register:

Members should sign the Register which will be circulated at the meeting.

8. 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

Wednesday, 19th November, 2014
Council Chamber - Guildhall, Bath
10.00 am - 12.00 pm

Agenda

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting.

   (a) The agenda item number in which they have an interest to declare.

   (b) The nature of their interest.

   (c) Whether their interest is a **disclosable pecuniary interest** or an **other interest**, (as defined in Part 2, A and B of the Code of Conduct and Rules for Registration of Interests)

   Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer or a member of his staff before the meeting to expedite dealing with the item during 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. HEALTH AND WELLBEING BOARD TERMS OF REFERENCE (5 MINUTES)

   The Board is asked to agree three amendments to the Health and Wellbeing Boards terms of reference:

   - The Health and Wellbeing Board is **co-chaired** by the Council's Cabinet Member for Wellbeing and the Chair of Clinical Commissioning Group.
   - That the new statutory responsibility for completing and publishing a **Pharmaceutical Needs Assessment** is added to the terms of reference.
   - That the Health and Wellbeing Board's new responsibility for the B&NES **Better Care Fund**, including the 'sign off' of the plans, is added to the terms of reference

9. CLINICAL COMMISSIONING GROUP OPERATIONAL RESILIENCE & CAPACITY PLAN FOR 2014/15 (15 MINUTES)

The Board is asked to review the ORCP and confirm that this provides adequate assurance for the CCG's and wider health community's preparations for this winter.

10. ALCOHOL HARM REDUCTION STRATEGY FOR BATH AND NORTH EAST SOMERSET (2014 - 2019) (20 MINUTES)

The Board is asked to agree that:

- The Health and Wellbeing Board endorse the Alcohol Harm Reduction Strategy for Bath and North East Somerset (2014 – 2019) and support its delivery by maintaining its strategic commitment to the reduction of alcohol misuse and encouraging stakeholder engagement to contribute towards delivery of its outcomes.
- The Health and Wellbeing Board uses its influence as a collective, and as individual organisations and community representatives, to actively engage in the call for evidence based national initiatives to support local delivery such as minimum unit pricing, a reduction in blood alcohol levels for driving, a public health objective in the Licensing Act and restrictions on advertising and sponsorship by the alcohol industry.

11. LOCAL SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2013-14 (20 MINUTES)

The Board is asked to:

1. Note the Annual Report and Business Plan
2. Raise any queries or concerns on safeguarding activity
3. Recommend areas they would like the LSAB to focus on.

12. JOINT HEALTH AND WELLBEING STRATEGY PERFORMANCE REPORT NOVEMBER 2014 (15 MINUTES)

The Board is asked to consider and comment on the performance report.

13. TIME TO CHANGE - TACKLING MENTAL HEALTH STIGMA IN B&NES (5 MINUTES)

The Board is asked to agree that:

- The enclosed plan is implemented in B&NES
- The plan is submitted on behalf of the Board as its pledge to the Time to Change programme
- An update on progress is provided to the board as part of the 6-monthly Health and Wellbeing Strategy delivery report on mental health.

14. SECTION 256 AGREEMENT AND FUNDING ALLOCATION 2014/15 (15 MINUTES)

The Board is asked to support the agreed use of Section 256 funding in 2014/15.

15. B&NES LOCAL FOOD STRATEGY (15 MINUTES)

The Board is asked to agree that it will:

- Provide high-level support for the B&NES Local Food Strategy and implementation plan.
- Nominate at least one representative to attend stakeholder events and engagement sessions as appropriate.

16. TWITTER QUESTIONS (5 MINUTES)

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

Bath and North East Somerset Council

NHS Bath and North East Somerset

HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 17th September, 2014, 10.00 am

Dr. Ian Orpen	Member of the Clinical Commissioning Group
Ashley Ayre	Bath & North East Somerset Council
Councillor Simon Allen	Bath & North East Somerset Council
Bruce Laurence	Bath & North East Somerset Council
Councillor Dine Romero	Bath & North East Somerset Council
Diana Hall Hall	Healthwatch representative
Tracey Cox	Clinical Commissioning Group
Councillor Paul Crossley	Bath & North East Somerset Council
Ronnie Wright	The Care Forum

Co-opted Non-Voting Member:

Julia Davison	NHS England - Bath, Gloucestershire, Swindon and Wiltshire Area Team

35 **WELCOME AND INTRODUCTIONS**

The Chairman welcomed everyone to the meeting.

36 **EMERGENCY EVACUATION PROCEDURE**

The Democratic Services Officer drew attention to the evacuation procedure as listed on the call to the meeting.

37 **APOLOGIES FOR ABSENCE**

Jo Farrar, Pat Foster and John Holden had sent their apologies for this meeting. David Trethewey was a substitute for Jo Farrar and Ronnie Wright was a substitute

for Pat Foster.

38 DECLARATIONS OF INTEREST

Councillor Simon Allen declared an other interest in 'Mental Health Update' agenda item as he was employed by the Avon and Wiltshire Mental Health Partnership (AWP) NHS Trust.

39 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There was no urgent business.

40 PUBLIC QUESTIONS/COMMENTS

There were none.

41 MINUTES OF PREVIOUS MEETING

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

42 BETTER CARE FUND (40 MINUTES)

The Chairman invited Jane Shayler (Deputy Director for Adult Care, Health and Housing Strategy and Commissioning) to introduce the item.

The Chairman thanked officers for the work they put into this document.

The Chairman also said that the Better Care Plan 2014/15-2018/19 built upon the previous joint working between the Council and the Clinical Commissioning Group

The Chairman also welcomed Janet Rowse (Sirona Chief Executive), James Scott (The RUH Bath Chief Executive) and Philip Rhodes (AWP Community Services Manager from BaNES Locality) to this meeting and asked for their views.

Janet Rowse commented that the Plan had been a phenomenal piece of work though it would be easy to get lost in some of the detail and technical terms. The Plan had been excellent in terms of the delivery and in explaining on how everyone should work together. Janet Rowse concluded that, in her view, focus should be on delivery of services to an individual.

James Scott commented that, given that the RUH has been providing acute services to much wider population, B&NES would be in much better starting position considering the history of integration between health and social care partners in this area. The Board of the RUH had supported this document in principle, though the biggest risk would be in the rise in demand and the hospital had relatively fixed capacity. James Scott took the Board through some of the issues that the RUH had been facing in terms of the increases in A&E attendances and emergency admissions above its contracted values for 2014/15, all of which could create a potential risk to the CCG and the RUH and the BCF Plan.

Ian Orpen commented that the CCG recognised the points made by James Scott in

terms of the pressure and risks that the RUH could have. However, whilst there were notable increases above the CCG's plan when activity levels were compared against last year's out-turn the growth was much lower.

Tracey Cox commented that the CCG had been in discussion with the RUH on these issues, especially on pressures and risks. Tracey Cox agreed with James Scott that this year's contractual arrangements were proving quite challenging. There would be a number of additional initiatives set as a part of the Operational Capacity and Resilience Plan (ORCP) for this winter that should improve the position. The CCG would need to provide further assurance to the RUH that there were other initiatives to support admission avoidance and to reduce the demand. `

The Chairman asked if the framework of the BCF Plan had gone far enough in terms of what the requirements were.

Janet Rowse responded that she has not been aware of any framework for risk sharing. The performance around the BCF had been associated with the small number of metrics. All providers haven't had the opportunity to discuss what the metrics were and what implications these might have for different providers.

James Scott said that it would be in everyone's interest to maximise the resources from the NHS England. All providers would want to support the general direction of travel. This was a system wide issue, not just for one provider.

The Chairman said this was a start of the long journey together and asked providers if they had any request from the Health and Wellbeing Board.

Janet Rowse said that providers would appreciate clarity of what the Board's role is.

Jane Shayler highlighted that page 18 of Appendix 1 clearly sets that the contingency funding for the management of financial risk, including the specific risk associated with non-achievement of the target reduction in emergency admissions, had been included in both CCG and Council financial plans, based on assumptions consistent with those in the Better Care Plan.

Julia Davison said that, from the NHS England perspective, this has been seen as joint approach which would reduce burden on health services. The funding would be going to the CCG who would, together with the Health and Wellbeing Board, decide what to do with that funding.

Bruce Laurence welcomed the Plan and commented that the Board should promote joint evaluation of the scheme. The Board should also understand what the drivers were. Bruce Laurence concluded that the main key would be liaison between the Better Care Fund and the CCG's 5 year strategy and also with the Health and Wellbeing Strategy.

Bruce Laurence asked about governance arrangements.

James Scott informed the Board on the establishment of System Resilience Group (SRG) as an obvious forum to monitor the effectiveness of the BCF. This was a forum where all the partners across the health and social care system came together to undertake the regular planning of urgent care service delivery. The role

of SRGs had recently been extended to include elective care as well. This still recognised the independence of Clinical Commissioning Group and local authority decision making bodies.

Jane Shayler commented that the Board would receive a detailed submission with proposed management on governance arrangements. This document would be amended to include the SRG.

The Board and service providers from Sirona, the RUH and AWP also debated how patients' experience would be embedded in the plan, what would be next steps (use of resources as one of issues), the role of the Board in terms of the engagement of patients and public, focus on 'end of life' care and also challenges that the RUH would be facing considering that their catchment area was with three Clinical Commissioning Groups.

The Chairman concluded the debate by saying that everyone involved should be realistic what resources were available and how the Health and Wellbeing Board should hear from the public on provision of services.

It was **RESOLVED** to:

1) Agree the summary of schemes to be funded from the Better Care Fund as revised from that approved by March 2014 HWB;
2) Delegate to the Chair of the Health and Wellbeing Board and the CCG's Acting Accountable Officer of sign-off of BaNES BCF submission in the required revised format on 19th September 2014.

43 MENTAL HEALTH UPDATE (40 MINUTES)

The Chairman invited Andrea Morland (Clinical Commissioning Group) and Paul Scott (Public Health team) to introduce the item.

Members of the Board welcomed the report, in particular information within bullet point 1 of the report ('what do we know about mental health?').

Councillor Romero asked about bed provision for young people with mental health issues.

Ashley Ayre commented that traditionally, in South West, it was difficult for people to access the right facilities for young people due to specific geography of the region. Ashley Ayre added that there is a need for a lot of work to be done on this matter.

The Board supported the concept of the Parity of Esteem Programme, which was about valuing mental health equally with physical health.

The Parity of Esteem Programme has been currently developed through discussions with stakeholders and the NHS England had identified three areas as initial priorities for urgent focus during 2013/14:

- Improving Access to Psychological Therapies (IAPT)
- Improving diagnosis and support for people with Dementia

- Improving awareness and focus on the duties within the Mental Capacity Act

Members of the Board asked what the Board could do in terms of raising awareness and reducing stigma about mental health.

Andrea Morland and Paul Scott mentioned ‘Time To Change’ campaign, England's biggest programme to challenge mental health stigma and discrimination, and suggested that the Board could sign up to that campaign.

The Chairman welcomed that suggestion and invited the Board to sign up to the ‘Time To Change’ campaign.

The Board unanimously agreed with the Chairman.

Councillor Crossley welcomed the initiative to improve the employment options for people with serious mental health problems in B&NES. Councillor Crossley also endorsed an increase in the self-management of long-term health and mental health conditions through piloting a Wellbeing College.

The Chairman asked if officers worked together with the Economic Development team on Economic Strategy.

Paul Scott responded that there had been close working relationship with the Economic Development team.

Andrea Morland commented that employment of people with mental health problems links to stigma and that the next step would be addressing these issues with the private sector.

The Chairman commented that the Board could trigger discussion with the biggest local employers, and then engage smaller companies.

Ronnie Wright commented that reducing stigma should be on everyone’s agenda. Ronnie Wright suggested that ‘Stigma about mental health’ should be discussed at one of the future Health & Wellbeing Network meetings and results of that discussion could be presented to the Board.

The Chairman welcomed suggestion from Ronnie Wright.

The Chairman asked about inpatient facilities.

Andrea Morland replied that people would like to feel safe in these facilities, though often they don’t. Andrea Morland also said that services would need to think about needs of people who are frail, whether they are elderly or young. Andrea Morland commented that Hillview Lodge was not seen as good environment and the AWP would be exploring an option of decanting, demolishing and rebuilding Hillview to accommodate extended in-patient (wider than B&NES basis) services and community teams.

The Chairman concluded the debate by saying that this was the first of series of conversations on mental health.

It was **RESOLVED**:

1) That the Health and Wellbeing Board would sign up to 'Time To Change' campaign;
2) That the Health and Wellbeing Board would speak with partners and other organisations about reducing stigma about mental health;
3) To note the progress to date across all commissioning, strategy and provision areas;
4) To support the concept of the Parity of Esteem; and
5) To receive a review of specialised services from the NHS England.

44 TWITTER QUESTIONS (10 MINUTES)

The Chairman read out the relevant tweets and comments from the public that were posted during the meeting.

The meeting ended at 12.05 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**19/11/14**
TYPE	**An open public item**

Report summary table	
Report title	Health and Wellbeing Board terms of reference
Report author	Helen Edelstyn (01225 477951)
List of attachments	Appendix One: Proposed amendments to the Health and Wellbeing Board terms of reference
Background papers	NA
Summary	This report seeks agreement for 3 amendments to the Health and Wellbeing Boards terms of reference.
Recommendations	The Board is asked to: • Agree 3 amendments to the Health and Wellbeing Boards terms of reference (attached as Appendix One): ○ The Health and Wellbeing Board is **co-chaired** by the Council's Cabinet Member for Wellbeing and the Chair of Clinical Commissioning Group. ○ That the new statutory responsibility for completing and publishing a **Pharmaceutical Needs Assessment** is added to the terms of reference. ○ That the Health and Wellbeing Board's new responsibility for the B&NES **Better Care Fund**, including the 'sign off' of the plans, is added to the terms of reference
Rationale for recommendations	The amendments to the terms of reference reflect the increased joint working between the Council and the CCG and new statutory responsibilities for development of a Pharmaceutical Needs Assessment and approval of the B&NES Better Care Fund.
Resource implications	There are no direct resource implications arising from this report.
Statutory considerations and basis for proposal	There are a number of core duties set out in the Health and Social Care Act 2012 which underpin the work of the Health and Wellbeing Board and which are set out in its terms of reference: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
Consultation	Consultation has been undertaken with the Chair and Vice Chair of the Health and Wellbeing Board, Strategic Director - People and Communities, as well as nominated representatives of the Chief

	Financial Officer and the Monitoring Officer Vernon Hitchman.
Risk management	An assessment of risk has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

1.1 The Health and Wellbeing Board terms of reference were agreed by Bath and North East Somerset Council on 16 May 2013, in accordance with policy and procedure. This report proposes some small revisions to the terms of reference, ensuring that the Board's governance continues to reflect its ways of working and new statutory responsibilities.

1.2 The Council's Democratic Services team have advised that the changes can be agreed by the Health and Wellbeing Board at an open public meeting and do not require agreement by full Council.

1.3 The revisions are highlighted in Appendix One and are described below:

- **Co-chairing**
  It is proposed that the Clinical Commissioning Group Chair co-chairs the Health and Wellbeing Board with the Council's Cabinet Member for Wellbeing. This recognises the value and importance of the shared ambition between the two organisations in promoting good health and wellbeing across Bath and North East Somerset.

  It is suggested that the chairing of each meeting will alternate between the two co-chairs and that matters of agenda planning will be considered jointly. The co-chairs will also be able to provide cover and support to each other in the absence of one of them.

- **Pharmaceutical Needs Assessment**
  As well as developing and publishing a Joint Strategic Needs Assessment for the area, Health and Wellbeing Boards have a new statutory responsibility to publish and keep up to date a statement of the local needs for pharmaceutical services - referred to as the Pharmaceutical Needs Assessment (PNA). The suggested revision to the Health and Wellbeing Board's terms of reference would ensure that this key responsibility is included.

  A project group is currently working on the development of the PNA which will be presented to the Health and Wellbeing Board at a future meeting (deadline for publication is April 2015). The PNA will inform the commissioning of pharmaceutical services in the context of local priorities, and will be used by NHS England when making decisions on pharmacy applications.

- **Better Care Fund**
  The Better Care Fund is a new government funded budget to support more integrated care at a local level. It will act as a key enabler in the delivery of integrated and timely interventions which support and safeguard older or vulnerable people to remain independent. It will also help to reduce unnecessary and unplanned admissions.

  The suggested revision to the Health and Wellbeing Board's terms of reference would ensure that the Board's new responsibility for the Better Care Fund, including the 'sign off' and ongoing oversight of the plans is included.

Please contact the report author if you need to access this report in an alternative format

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Bath & North East Somerset Council

NHS
Bath & North East Somerset Clinical Commissioning Group

HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

1. Statement of purpose

1.1 By working together the Board will aspire to reduce health inequalities and improve health and wellbeing in Bath and North East Somerset.

1.2 To achieve these aims the Board will work collaboratively with partners to join up commissioning and provision across the NHS, social care, public health and other areas related to health and wellbeing (where appropriate).

2 Roles and responsibilities

2.1 The Board will be responsible for:

- developing a joint strategic needs assessment (JSNA) and pharmacy needs assessment (PNA)
- preparing the joint health and wellbeing strategy (JHWS)

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- considering whether the commissioning arrangements for social care, public health and the NHS are in line with the JHWS
- considering whether the Clinical Commissioning Groups' (CCG) commissioning plan has given due regard to the JHWS
- reporting formally to the NHS Commissioning Board, Clinical Commissioning Group, and council leadership if local commissioning plans have not had adequate regard to the JHWS
- The Better Care Fund for B&NES including sign off and ongoing oversight.

2.2 The Board will seek to:

- influence the strategic planning and service delivery of the NHS and Council in B&NES through the promotion of the JSNA, PNA and JHWS
- promote joint working and the use of the NHS Act 2006 flexibilities to increase joint commissioning, pooled and aligned budgets (where appropriate), to support the effective delivery of the JHWS
- influence planning, transport, housing, environment, economic development and community safety in order to address the wider determinants of health and wellbeing
- work collaboratively with the B&NES Public Services Board
- strategically performance manage key activity against the key priorities of the JHWS

2.3 Responsibility for the scrutiny of health and wellbeing will continue to lie with the Council's Policy Development and Scrutiny Panels.

3. Scope

3.1 The Boards' scope shall be set out within the Joint Health and Wellbeing Strategy.

3.2 The Health and Wellbeing Board may consider services beyond health and social care enabling the Board to look more broadly at factors affecting the health and wellbeing of the B&NES population.

4. Accountability

4.1 Accountability for the discharge of statutory responsibilities remains with the Council, CCG and Local Healthwatch.

4.2 The Board is responsible for working with the Children's Trust Board to deliver strategic commitments and outcomes, in line with the JHWS.

4.3 Accountability for safeguarding lies with the Local Safeguarding Adults Board, Children's Trust Board and Local Safeguarding Children's Board.

4.4 The Safeguarding Children Board, the Safeguarding Adult Board and the Children's Trust Board will report to the board on relevant performance outcomes against the JHWS priorities, through a regular performance reporting process.

5. Membership

5.1 Membership of the Board is:

- B&NES Council x 6 (Chief Executive, Director of Public Health, Director of People and Communities Services, Leader of the Council, Cabinet Member for Wellbeing, Cabinet Member for Early Years, Children and Youth)
- Clinical Commissioning Group x 3~~, including the role of Vice Chair~~ (CCG Chair x 1, CCG Board member x 1, CCG lay member x 1)
- Healthwatch B&NES x 2
- Bath, Gloucestershire, Swindon and Wiltshire Area Team x 1 (non-voting status)

5.2 In the event of members considering it necessary to have a formal vote, all Board members will have a voting right, except the Bath, Gloucestershire, Swindon and Wiltshire Area Team who will not have a voting right.

5.3 The Board will be co-chaired by the Council's Cabinet Member for Wellbeing and the Chair of the Clinical Commissioning Group. Chairing of each meeting will alternate between the two co-chairs and matters of agenda planning will be considered jointly. Co-chairs will also be able to provide cover and support to each other in the absence of one of them.

~~5.4 The Council, at its annual meeting, allocates nomination rights to political groups for the role of Chair.~~

5.5 The quorum for the meeting will be six members of the Board with two members of the Clinical Commissioning Group, one member of Healthwatch B&NES and three members of the Council.

5.6 Board members may nominate a named substitute from an appropriate member of their organisation or service.

6. Wider engagement

6.1 By working together the Health and Wellbeing Board will proactively embed good public and patient engagement within the day-to-day business of the Board through adhering to the following principles:

- Taking responsibility for good public engagement
- Clarity about purpose
- Harnessing a range of engagement methods
- Engaging with everyone
- Committed to cultural change
- Providing access to information
- In partnership
- Feeding back engagement results
- With Healthwatch B&NES
- Evaluating engagement

6.2 The Board will seek to engage all stakeholders (including key health and social care providers) on the JHWS and commissioning plans.

6.2 The Council's overview and scrutiny function offers an opportunity for broader engagement on key issues.

6.3 It is intended that one representative of each Political Group on the council, not currently represented on the board, be invited to Board meetings in an observer capacity.

7. Business management

7.1 The Board is a statutory committee of the Council and will be treated as if it were a committee appointed by the Council under section 102 of the Local Government Act 1972.

7.2 The Board will act in accordance with the Council's committee procedures.

7.3 Formal Board meetings shall be held in public. The Board may resolve to hold closed sessions in accordance with the Access to Information rules.

7.4 The Board will develop an operating model and work programme framed by the JHWS which will guide its work.

7.5 The Board will meet 6 times per year (bi-monthly).

7.6 The Board may establish sub-committees to lead on issues such as the JSNA, joint commissioning and health inequalities.

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**19/11/2014**
TYPE	**An open public item**

Report summary table	
Report title	Operational Resilience & Capacity Plan for 2014/15
Report author	Dominic Morgan, Urgent Care Network Programme Lead
List of attachments	Appendix 1: BaNES Health & Wellbeing Board (19th November 2014) Briefing Paper - Operational Resilience & Capacity Plan Appendix 2: ORCP presentation (19th November 2014)
Background papers	The production of the ORCP was in response to national guidance produced in June 2014. The guidance is available at the link below:- http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf
Summary	The purpose of this paper is to present to Board members the Operational Resilience & Capacity Plan (ORCP) for 2014/15.
Recommendations	The Board is asked to review the ORCP and confirm that this provides adequate assurance for the CCG's and wider health community's preparations for this winter.
Rationale for recommendations	Operational Resilience and Capacity Planning (ORCP) guidance was issued on 13 June 2014 by NHS England, the NHS Trust Development Agency, Monitor and Association of Directors of Adult Social Services. It requires local systems to build on the previous work of Urgent Care Working Groups and to extend their remit to include both urgent and elective care. The ORCP for BaNES is in response to this guidance and is designed to ensure that all providers within the health and social care system across Bath and North East Somerset and other CCG areas that directly relate to the Royal United Hospital (RUH) in Bath, are prepared and able to respond to the increased needs and/or service demands throughout the year. The ORCP describes how the whole care community will: • Plan for periods of high demand caused by seasonal pressures, infection control, flu or major incident, by ensuring that there is a coordinated and planned response in order to meet additional need

	• Ensure the high quality planned and unplanned services are maintained and that financial and performance pressures are managed • Use escalation triggers to ensure an integrated and shared process between primary, community and secondary care providers and with local authorities • Accurately monitor the daily individual and UCS Escalation status to ensure appropriate action is taken in a coordinated manner to support the UCS The ORCP links to the following CCG strategic objectives:-. • Improving quality, safety and individuals experience of care • Improving consistency of care and reducing variation of outcomes • Creating a sustainable health system within a wider health and social care partnership • Empowering and encouraging people to take personal responsibility for their health and wellbeing
Resource implications	ORCP non-recurrent funding (BaNES £1.135M)
Statutory considerations and basis for proposal	The production of the ORCP was in response to national guidance produced in June 2014.
Consultation	The System Resilience Group (formerly Urgent Care Working Group) is made up of Executive level provider and commissioning representatives from within the B&NES and from neighbouring areas that refer into the RUH. This group and the System Resilience Provider Forum have contributed to the production and oversight of the ORCP.
Risk management	The System Resilience Group operates a risk register in relation to the delivery of the ORCP. A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

Briefing Paper - Operational Resilience & Capacity Plan & accompanying presentation attached.

Please contact the report author if you need to access this report in an alternative format

BaNES Health & Wellbeing Board (19th November 2014)

Briefing Paper - Operational Resilience & Capacity Plan (ORCP) 2014/15

Author: Dominic Morgan, BaNES CCG Urgent Care Programme Lead (UCPL)

Responsible Director: Tracey Cox, BaNES CCG Acting Accountable Officer

1.0 ORCP – The New National Approach for 2104/15

Newly created Operational Resilience and Capacity Planning (ORCP) national guidance was issued to all CCGs on 13th June 2014 by NHS England, the NHS Trust Development Agency, Monitor and Association of Directors of Adult Social Services.

It requires all local systems to build on the previous work in 2013/14 of the Urgent Care Working Groups (UCWG) and to extend their remit to now include both urgent and elective care.

2.0 System Resilience Group (SRG)

Change in name of UCWGs to System Resilience Groups (SRGs) and empowered to co-develop strategies and collaboratively plan safe, efficient services for patients across local health and social care systems. In addition to oversee the coordination and integration of services to support the delivery of effective, high quality accessible services which are good value for taxpayers.

The SRGs are seen as crucial to delivering an integrated approach across health providers and commissioners, as well as local authorities and social care partners. The SRG are also held accountable for the delivery of financial sustainability of all providers.

3.0 ORCP Planning Requirements and Best Practice

ORCP planning requires the principles of good practice to be included within each SRG ORCP. The core aspects of good practice that local systems must include in their planning for 2014/15 include:-

- Best practice in planned care (set out within the ORCP guidance).
- Best practice in non-elective care (set out within the ORCP guidance).
- Wider considerations, plans need to comprehensively cover all wider planning elements (set out within the ORCP guidance).
- Governance, whilst SRGs are not statutory bodies and hence have no formal binding decision making role, governance is especially important.
- Building on existing work, operational resilience and capacity plans must align with and build upon capacity planning already being done throughout the system.
- Mechanisms for monitoring delivery and allocating non-recurrent funding (BaNES £1.135M) and any additional local funding allocated to ORCP for 2014/15.
- Setting the ground work for the longer term changes to strategic and operational delivery to deliver the Urgent and Emergency Care Review (UECR) and now the newly issued NHS Five Year Forward View (5YFV).

4.0 BaNES ORCP

The ORCP for BaNES is in response to this new national guidance and is designed to ensure that all providers within the health and social care system across Bath and North East Somerset and other CCG areas that directly relate to the Royal United Hospital Bath NHS Foundation Trust are prepared and able to respond to the increased needs and/or service demands throughout the year.

It is crucial that SRGs develop operational resilience and capacity plans by involving all key local organisations, in order to fulfil both planning requirements and ensure good system working in the future. These plans collaboratively developed and signed-off by all SRG member organisations have a number of mandatory elements that need to be included.

The System Resilience Group (formerly Urgent Care Working Group) is made up of Executive level provider and commissioning representatives from within B&NES and from neighbouring areas that refer into the RUH. This group and the System Resilience Provider Forum have contributed to the production and oversight of the ORCP.

BaNES ORCP sets out how the whole care community will:

- Plan for periods of high demand caused by seasonal pressures, infection control, flu or major incident, by ensuring that there is a coordinated and planned response in order to meet additional need
- Ensure the high quality planned and unplanned services are maintained and that financial and performance pressures are managed
- Use escalation triggers to ensure an integrated and shared process between primary, community and secondary care providers and with local authorities
- Accurately monitor the Demand, Capacity, Flow and Performance within the Urgent Care System (UCS)
- Accurately monitor the daily individual and UCS Escalation status to ensure appropriate action is taken in a coordinated manner to support the UCS

All local provider organisations have been requested to share the ORCP with their respective Boards.

5.0 SRG & Earned Autonomy

There are three cohorts of systems with differing levels of scrutiny which have resulted in different levels of earned autonomy for each SRG.

1. **High**: The systems most at risk of delivery of A&E and/or RTT will be subject to a diagnostic from a specialist support team.
2. **Low:** In very high-performing areas (defined as systems where RTT and A&E standards have been met consistently) there will be a policy of 'earned autonomy'.
3. **All other systems:** not defined as 'high' or 'low' as described above, will be expected to produce plans that contain all actions from the best practice guidance, which will then be assured.

BaNES is classed as Medium – with assurance

6.0 BaNES Approach

The ORCP links to the following CCG strategic objectives:-.

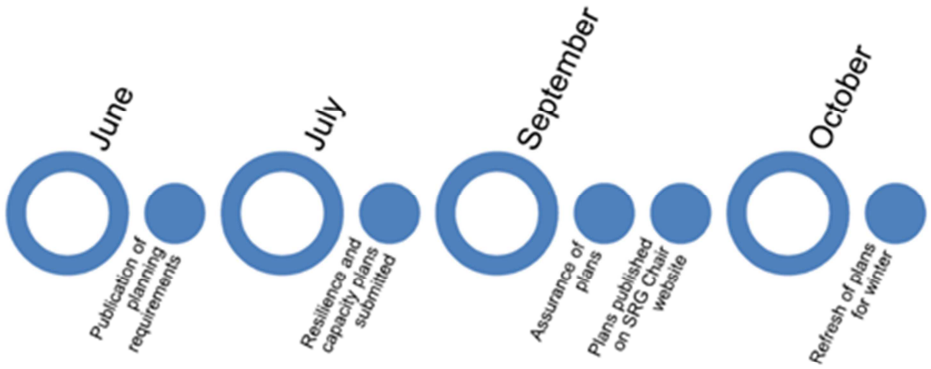
- Improving quality, safety and individuals experience of care
- Improving consistency of care and reducing variation of outcomes
- Creating a sustainable health system within a wider health and social care partnership
- Empowering and encouraging people to take personal responsibility for their health and wellbeing

BaNES ORCP approach is designed to:

- Respond to the NHS England ORCP guidance and evidence that the ORCP is robust through a changed focus towards strong Demand, Capacity & Escalation (DC&E) planning.
- Demonstrate a high level of system oversight, assurance and continuous performance with a complete a whole system independent analytical review (IAR).
- Re-instate the Urgent Care Dashboard (UCD) (introduced in 2013/14) and develop monthly monitoring across both urgent and planned care.
- Show clear leadership and accountability through the continued use of the BaNES Operational Performance Management Framework (OPMF).
- Demonstrate the preventative measures and planned flexibility and summarise the contributions from all provider organisations.
- Evidence the ORCP is delivering best practice and is being continuingly reviewed, developed and tested.
- Demonstrate the effective use of non-recurring ORCP funding and how the SRG will intervene where ORCP is ineffective.

7.0 ORCP – Key Dates

All SRGs have been working to the national timeline and have been required to meet key dates as part of the ORCP assurance process.



ORCP planned projects to provide overall system resilience have been set to start on November the 1st 2014 and therefore many have or are being mobilised at this time.

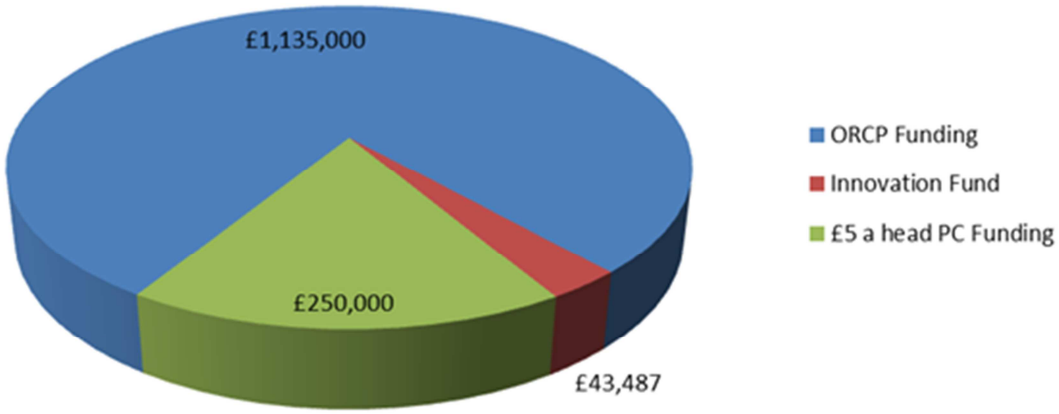
New Requirement – all SRGs were required to confirm by the 17th September their level of confidence in delivery of the 4 hour target at their acute Trust for the remainder of this year.

BaNES gave a 75% level of assurance.

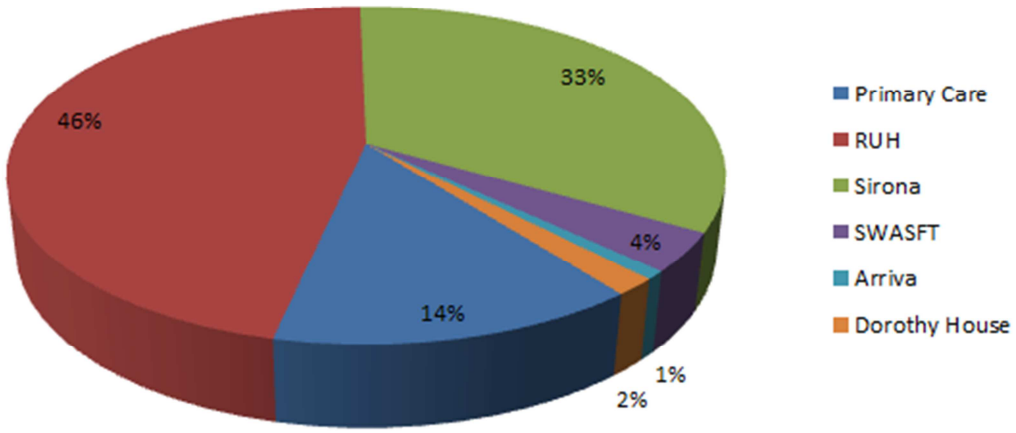
8.0 BaNES SRG Breakdown of Funding

The CCG has received non-recurrent national resilience monies of £1.3m for 2014/15 The SRG has agreed a further range of others sources of funding that have also been targeted at system resilience for 2014/15.

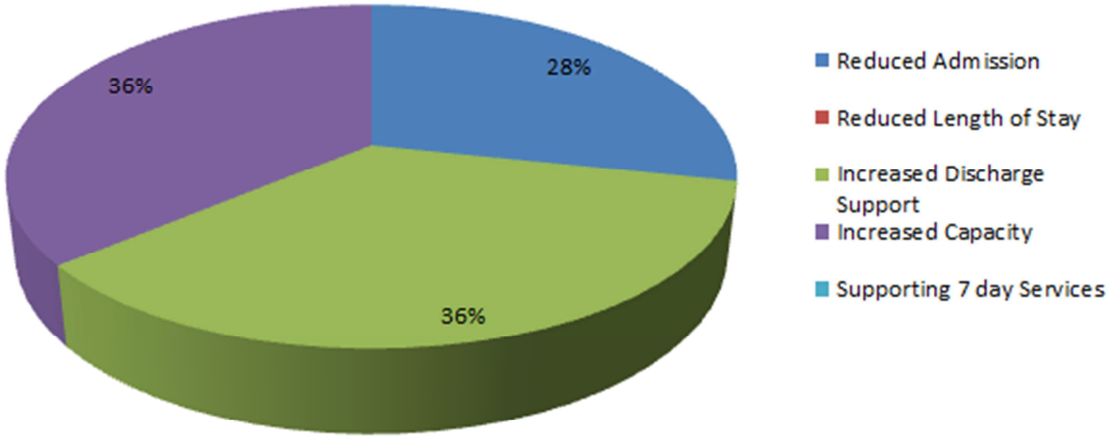
BaNES SRG ORCP funding sources



BaNES SRG ORCP funding allocations by providers



BaNES SRG ORCP targeted project areas



- Reduced LOS is being achieved within Increased Discharge Support projects
- Increased 7 day services are being achieved within Increased Capacity projects

9.0 Examples of BaNES ORCP Funded Schemes for 2014/15

9.1 BaNES Primary Care

Extra GP and Nurse sessions in primary care.

9.2 Royal United Hospital Bath NHS Foundation Trust (RUH)

Increase in flexible non-elective medical bed capacity. 12 beds have been identified to be used during periods of escalation and 10 beds overnight.

Increased radiology capacity CT/MRI/US to support ED, MAU, SAU, ESAC and Medical Ambulatory Care.

9.3 Sirona Care and Health

In reach therapy to reablement beds. The provision of 20 step down beds within the Community Resource Centres (6) Residential care (10) and Nursing Home (4).

9.4 South West Ambulance Service Foundation Trust (SWASFT)

Mobile Rapid Support Vehicle (MRSV) for fallers.

Mental health nurse in Clinical hubs.

9.5 Arriva (ATSL)

Integrated Community Discharge model.

9.6 Dorothy House

Additional potential capacity of 2,500 Hospice at Home hours, providing 24/7 care in people's homes, to prevent admission and facilitate discharge, and provide a rapid response/supported discharge service for RUH patients in the last year of life.

10 ORCP Reporting Arrangements

The use of funds to strengthen resilience and transform urgent and elective care should be transparent within each system and to support this National Health Service England (NHSE) has created a national reporting system through the UNFIY reporting arrangements.

NHSE and BaNES SRG are required to review the whole care system's ongoing performance and on a monthly basis an update on the use and impact of non-recurrent resilience funding. This would include a discussion involving the full group on the use of any other non-recurrent funds to support system resilience.

The System Resilience Group will monitor the delivery and impact of the ORCP through its monthly meetings. The CCG will be advised of progress through the monthly performance reports.

The System Resilience Group operates a risk register in relation to the delivery of the ORCP and a summary of the identified risks and agreed actions are set out in the register.

11 Next Steps

Published plans will be used to hold SRGs to account for delivering safe, sustainable, high quality services for patients and to assess the impact that non-recurrent monies are having on local health systems. In line with the principles of transparency and openness, published plans will also allow patients to see how organisations in their local health system are preparing for episodes of increased pressure. BaNES ORCP will be available via the CCG's website.

The national vision is that SRGs offer a powerful opportunity to improve care for patients by, for example, fully integrating emergency healthcare development with primary care (where most unscheduled care takes place). In some areas SRGs have already helped to establish more patient-centred care and are encouraging shared learning across health and social care communities by working in partnership.

Successful SRGs should work across boundaries to improve patient experience and clinical outcomes, by establishing partnerships and better working relationships between all health and social care organisations in a geographical area and health community. SRGs can work towards these goals by agreeing and developing local standards and protocols to underpin audit and training; developing and sharing infrastructure, for example data metrics and policy documentation; and by developing a mechanism in order to improve and spread knowledge and skills throughout the whole system.

Bath and North East Somerset Clinical Commissioning Group

Operational Resilience & Capacity Plan (ORCP) 2014/15

Date: 06/11/2014

Author: Dominic Morgan, BaNES CCG Urgent Care Programme Lead (UCPL)

Healthier, Stronger, Together

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Bath and North East Somerset Clinical Commissioning Group

System Resilience Group (SRG)

- Change in name of UCWGs to System Resilience Groups (SRGs)
- Empowered to co-develop strategies and collaboratively plan safe, efficient services for patients across local health and social care systems
- Delivery of effective, high quality accessible services which are good value for taxpayers
- Seen as crucial to delivering an integrated approach across health providers and commissioners, as well as local authorities and social care partners
- Accountable for the delivery of financial sustainability of all providers.

Bath and North East Somerset Clinical Commissioning Group

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Bath and North East Somerset Clinical Commissioning Group

BaNES ORCP

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Bath and North East Somerset Clinical Commissioning Group

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NHS Bath and North East Somerset Clinical Commissioning Group

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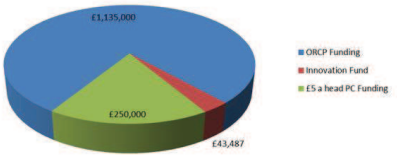

NHS Bath and North East Somerset Clinical Commissioning Group

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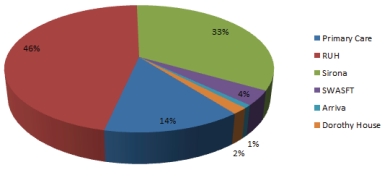
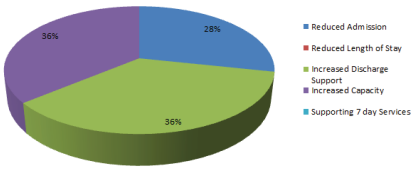


NHS Bath and North East Somerset Clinical Commissioning Group

BaNES SRG ORCP targeted project areas



NHS Bath and North East Somerset Clinical Commissioning Group

Examples of BaNES ORCP Funded Schemes for 2014/15

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- **Royal United Hospital Bath NHS Foundation Trust (RUH)** - Increase in flexible non-elective medical bed capacity. 12 beds have been identified to be used during periods of escalation and 10 beds overnight and increased radiology capacity CT/MRI/US to support ED, MAU, SAU, ESAC and Medical Ambulatory Care
- **Sirona Care and Health** - In reach therapy to reablement beds. The provision of 20 step down beds within the Community Resource Centres (6) Residential care (10) and Nursing Home (4)
- **South West Ambulance Service Foundation Trust (SWASFT)** - Mobile Rapid Support Vehicle (MRSV) for fallers and mental health nurse in Clinical hubs
- **Arriva (ATSL)** - Integrated Community Discharge model
- **Dorothy House** - Additional potential capacity of 2,500 Hospice at Home hours, providing 24/7 care in people's homes

NHS Bath and North East Somerset Clinical Commissioning Group

ORCP Reporting Arrangements

- National Health Service England (NHSE) has created a national reporting system through the UNFIY reporting arrangements
- NHSE and BaNES SRG are required to review the whole care system's ongoing performance and on a monthly basis
- The System Resilience Group will monitor the delivery and impact of the ORCP through its monthly meetings, reporting to the CCG
- The System Resilience Group operates a risk register in relation to the delivery of the ORCP

NHS Bath and North East Somerset Clinical Commissioning Group

Next Steps

Published plans - BaNES ORCP will be available via the CCG's website

The national vision is that successful SRGs should work across boundaries to improve patient experience and clinical outcomes, by establishing partnerships and better working relationships between all health and social care organisations in a geographical area and health community.

NHS
Bath and North East Somerset
Clinical Commissioning Group

NHS
Bath and North East Somerset
Clinical Commissioning Group

Thank you!
Any questions?

Healthier, Stronger, Together

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MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**19/11/2014**
TYPE	**An open public item**

Report summary table	
Report title	Alcohol Harm Reduction Strategy for Bath and North East Somerset (2014 – 2019)
Report author	Cathy McMahon (01225 394064)
List of attachments	Appendix 1: Alcohol Harm Reduction Strategy for Bath and North East Somerset (2014 – 2019)
Background papers	
Summary	The current B&NES Alcohol Harm Reduction Strategy (2012) was adopted by B&NES Council in April 2012. A commitment to refresh the Strategy in light of national and local developments was agreed with Wellbeing Scrutiny Policy, Development and Scrutiny in May 2012. A Joint Scrutiny Inquiry Day in October 2013 and its subsequent recommendations have informed the Strategy refresh, alongside national and local developments since 2012.
Recommendations	The Board is asked to agree that: • The Health and Wellbeing Board endorse the Alcohol Harm Reduction Strategy for Bath and North East Somerset (2014 – 2019) and support its delivery by maintaining its strategic commitment to the reduction of alcohol misuse and encouraging stakeholder engagement to contribute towards delivery of its outcomes. • The Health and Wellbeing Board uses its influence as a collective, and as individual organisations and community representatives, to actively engage in the call for evidence based national initiatives to support local delivery such as minimum unit pricing, a reduction in blood alcohol levels for driving, a public health objective in the Licensing Act and restrictions on advertising and sponsorship by the alcohol industry.
Rationale for recommendations	The recommendations contribute to the delivery of the outcomes of the Joint Health and Wellbeing Strategy, in particular under the theme of 'Helping people to stay healthy' and the specific objective to reduce rates of alcohol misuse.

Resource implications	The Council currently contributes financially towards the delivery of the Alcohol Harm Reduction Strategy predominantly from the Public Health Grant, Adult Health and Social Care and from across other Council departments such as licensing. B&NES Clinical Commissioning Group also contribute towards prescribing costs and hospital based services. Probation and Wiltshire Drug and Alcohol team contribute to the treatment budget. Strategy delivery is reliant on cross agency working and we aim to influence the work and use of resources of partners and key stakeholders to make best use of existing resources and lever in additional funding where possible. The Strategy contributes towards the delivery of B&NES Clinical Commissioning Group Strategic plan and joint working on shared outcomes will contribute towards reduced costs across the health and social care system. Strategy delivery is subject to ongoing financial support from partners and the Council.
Statutory considerations and basis for proposal	Public Health and Inequalities, Crime and Disorder, Children There are significant inequalities in the impact of alcohol misuse across Bath and North East Somerset. The Strategy aims to address these inequalities through targeting of specific groups including children and young people, men, those with mental health problems and those living in more deprived areas.
Consultation	The Strategy has been developed in consultation with B&NES Alcohol Harm Reduction Steering Group and the B&NES Night Time Economy Group. Membership of these groups includes Police, Fire and Rescue Service, Royal United Hospital, University representation, resident association representation, Bath Transport Police, Bath Business Improvement District, Licensing, Community Safety, Public Health, Drug and Alcohol Service commissioners and providers, Avon and Wiltshire Mental Health Trust, children's services, housing and probation services. The Strategy priorities are directly informed by the Scrutiny Inquiry Day on Alcohol held in October 2013 hosted jointly by 3 B&NES Council Policy Development and Scrutiny panels representing Wellbeing, Economic and Community Development and Early years, children and youth policy in October 2013. 68 people including councillors, officers, stakeholders and residents attended. In November the Strategy will also be presented for consultation to the Responsible Authorities Group and Wellbeing Policy Development and Scrutiny Panel. The Strategy will then be presented to B&NES Council Cabinet for sign off.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

1. Alcohol is the third greatest overall risk to health after smoking and raised blood pressure (WHO 2009). Reducing alcohol-related harm, by encouraging a more sensible drinking culture, will help to achieve a range of indicators outlined in the Public Health Outcomes Framework for England 2013 – 2016. These include reducing the number of:

    - people killed or seriously injured on our roads
    - alcohol related hospital admissions
    - falls and injuries among the over-65s
    - deaths from cardiovascular disease (including heart disease and stroke), cancer and liver disease
    - low birth weight babies
    - violent crimes (including sexual violence) and domestic abuse
    - pupil absences
    - chlamydia diagnoses among young people aged 15–24 years

2. Overall our alcohol consumption is reducing but we are still drinking twice as much compared to 1960's levels. 91% more alcohol was consumed in 2010 compared to1960. Alcohol contributes to over 60 different types of diseases and injuries. Impact on health and health services is evident through the rising number of alcohol related hospital admissions nationally and locally.

    - Admissions for alcohol related conditions have risen by an average of 12% each year since 2002/03 in line with national trends, but remain lower than regional and national rates.
    - People living in the most deprived areas of Bath and North East Somerset are significantly more likely to be admitted for an alcohol related condition than those living in the least deprived areas.
    - Bath and North East Somerset has significantly higher rates of under 18's admitted to hospital for alcohol specific conditions than nationally.

3. The harm from alcohol impacts not only on the individual but society as a whole. The total estimated cost in B&NES of the harm arising from alcohol-use disorders is some £45.0 million a year, of which £21.3 million is a result of crime and £5 million healthcare costs. (Cabinet Office 2003)

4. The refreshed Alcohol Harm Reduction Strategy outlines the key structural and service developments locally which will contribute to and influence delivery. Its structure reflects the B&NES Council and B&NES Clinical Commissioning Group intention to

apply an Outcomes Based Accountability model to commissioning and performance management.

5. The Strategy builds on the good progress that has been made since 2012 across a number of areas including building awareness, skills and confidence amongst frontline professionals to address alcohol misuse, increasing the focus and capacity of the treatment system to respond to alcohol clients and proactive management of the night time economy to address crime and anti-social behaviour. Key actions since 2012 include:

   - The training of over 700 local professionals to use evidence based tools for alcohol misuse identification and brief advice
   - The introduction of systematic screening for alcohol misuse in the NHS Health Check and as part of the inpatient and community mental health services contract from 14/15
   - Re-commissioning of the Drug and Alcohol Treatment Services to include a Single Point of Access for clients and professionals, a dedicated alcohol team and additional capacity for community detoxification.
   - A new Alcohol Liaison Service at the Royal United Hospital, funded by B&NES CCG and Wiltshire Drug and Alcohol team
   - Young Carers group set up for children affected by parental substance misuse
   - Families also matter (FAM) service developed by DHI to support those affected by someone else's substance misuse
   - Retaining Bath City Centre's Purple Flag status year on year
   - Midsomer Norton Community Alcohol Partnership introduced a range of town management initiatives to reduce antisocial behaviour and underage drinking in the high street.

6. The high level priorities within the refreshed Strategy aim to ensure adequate emphasis is given to prevention and early detection of alcohol misuse and that there is greater ownership of the agenda and vision amongst the residents, businesses and visitors to Bath and North East Somerset. The main priorities are:

   - Greater emphasis on prevention of alcohol harm through national and local policy
   - Developing a clear narrative about what a healthy drinking environment in B&NES looks and feels like
   - A local licensing policy that considers a broader range of issues and impacts including health
   - Embedding screening and brief advice across the system
   - Ensuring high quality accessible treatment services, which have recovery at their heart.

7. What works in preventing alcohol related harm?

   The National Institute for Health and Care Excellence (NICE PH 24) recommends the following evidenced based approaches to reducing alcohol related harm in the population:

   - Price increases
   - Restricting physical availability
   - A reduction in drink drive alcohol limits
   - Control on advertising

- Identifying problems sooner
- Good quality treatment services
- Good quality communication/education programmes

8. The top four of these recommendations are predominantly reliant on action at a national level and reiterate the importance of lobbying national government on the key issues of price, availability, advertising and regulation.

9. Effective local approaches to tackling alcohol related harm are identified in the 4 Outcome Frameworks which are at the heart of the Strategy. The 4 outcomes the Strategy is aiming to achieve are:

- Children grow up free from alcohol related harm
- Communities are safe from alcohol related harm
- People can enjoy alcohol in a way that minimises harm to themselves
- People can access support that promotes and enables sustained recovery

10. Priority actions identified for 14/15 are:

- Refresh of Children and Young People Substance Misuse needs assessment
- Improved understanding of Under 18's Alcohol Specific Hospital Admissions
- Developing and communicating a vision of the Night Time Economy for B&NES
- Introduction of screening for alcohol misuse across mental health services and RUH Emergency Department
- Increasing alcohol treatment capacity and the percentage of people who successfully complete treatment
- Developing a local response to treatment resistant drinkers

11. The indicators we will monitor to measure progress related to each outcome are:

- Alcohol Specific Hospital Admissions of under 18 year olds
- Night time economy related crime and disorder (8pm – 4am)
- Alcohol related hospital admissions (18yrs+)
- Percentage of people leaving treatment successfully

12. How will this Strategy be delivered?

The B&NES Alcohol Harm Reduction Steering Group will co-ordinate delivery of this Strategy through a Outcomes Action Plan. Each outcome has a lead officer who will take responsibility for driving forward the relevant actions. The Group will co-ordinate directly with key partnerships on delivery of action plans including the Young People's Substance Misuse Group, Night Time Economy Group, the Responsible Authorities Group and the Joint Commissioning Group for Substance Misuse.

13. Governance and reporting

The Group will report to the Responsible Authorities Group twice yearly
The Group will also report to the Children's Trust Board twice yearly within the context of the Children and Young People's Plan.
The Group will report to the Health & Wellbeing Board twice yearly and via the Board's Joint Annual Account.

14. Review timetable

This Strategy will be reviewed after 3 years to ensure it continues to reflect local and national priorities.

Please contact the report author if you need to access this report in an alternative format

Bath & North East Somerset
Alcohol Harm Reduction Strategy

October 2014 - 2019

Background

This document is a refresh of the Alcohol Harm Reduction Strategy 2012 (Milner et al 2012). The 2012 Strategy identified the key needs, gaps and priorities for Alcohol Harm Reduction in B&NES through extensive consultation and stakeholder engagement. Eight service and organisational development activities were prioritised in the Strategy and Appendix 1 outlines the significant progress that has been made across all eight areas over the past 2 years.

This Strategy refresh takes into account the recommendations of the following key documents:

- The Governments national Alcohol Strategy 2012 (March 2012)
- The recommendations from the Joint Scrutiny Inquiry Day on Alcohol Harm Reduction in B&NES (Oct 2013)
- The recommendations from the LGA Peer Challenge Report on B&NES Health & Wellbeing Board (Feb 2014)

High level recommendations include:

- Greater emphasis on prevention of alcohol harm through national and local policy
- Developing a clear narrative about what a healthy drinking environment in B&NES looks and feels like
- A local licensing policy that considers a broader range of issues and impacts including health
- Embedding screening and brief advice across the system
- Ensuring high quality accessible treatment services, which have recovery at their heart.

This document outlines the key structural and service developments locally which will contribute to and influence delivery of this Strategy. Its structure reflects the B&NES Council and B&NES Clinical Commissioning Group intention to apply an Outcomes Based Accountability model to commissioning and performance management.

National Context and Trends

Alcohol is the third greatest overall risk to health after smoking and raised blood pressure (WHO 2009)

Reducing alcohol-related harm, by encouraging a more sensible drinking culture, will help B&NES Council meet its statutory duty to achieve the indicators outlined in the Public Health Outcomes Framework for England 2013 – 2016. These include reducing the number of:

- people killed or seriously injured on our roads
- alcohol related hospital admissions
- falls and injuries among the over-65s
- deaths from cardiovascular disease (including heart disease and stroke), cancer and liver disease
- low birth weight babies
- violent crimes (including sexual violence) and domestic abuse
- pupil absences
- chlamydia diagnoses among young people aged 15–24 years

Overall alcohol consumption is reducing but we are still drinking twice as much compared to 1960's levels. 91% more alcohol was consumed in 2010 compared to 1960

Alcohol was 45% more affordable in 2011 compared to 1980 – as real household income has risen significantly

Mortality from liver disease is regarded as one of the best barometers of alcohol related ill health. Between 1970 and 2000 UK deaths from liver disease in people aged under 65 years increased fivefold, while death rates from other diseases have declined.

The majority of drinking takes place in the home.

Nationally violent crime has been reducing since 2001

The Governments Alcohol Strategy (March 2012) strengthened and extended powers for local areas to restrict alcohol sales late at night and the option to introduce a late night levy on premises.

There is a growing number of older people with increasingly complex issues.

The clustering of unhealthy behaviours such as smoking, unhealthy eating, alcohol misuse and lack of physical activity are widening health inequalities.

There is significant cross over between mental health issues and alcohol and substance misuse.

Local Developments supporting delivery of this Strategy

Joint Health and Wellbeing Strategy 2013 – 2016 – This Strategy prioritises alcohol harm reduction within its theme of Keeping People Healthy. In April 2013 a Joint Working Framework was agreed between the Council and the CCG, setting out the mechanisms that will deliver integrated commissioning of services across health, public health, adults and children's services. This aims to improve outcomes and service user experience across the system, make the most efficient and effective use of our combined commissioning resource and to help delivery the Joint Health and Wellbeing Strategy.

Connecting families programme has been introduced to engage with 215 of the most complex families living in the local area to support them to make positive change and live full and active lives. Substance misuse, domestic violence and mental health problems are among the issues families are dealing with. This programme will support reduction in substance misuse amongst adults and children in these families and facilitate access into treatment where appropriate.

Domestic violence
Working with the Interpersonal Violence and Abuse Strategic Partnership (IVASP) B&NES Council is taking a whole system approach towards developing a new model of helping victims of domestic abuse. This work is aligned with new Police neighbourhood-based operating models, the PCC's Integrated Victims strategy and approach ('Lighthouse') and B&NES work to developing a Multi-Agency Safeguarding Hub.

The Family Nurse Partnership (FNP) was introduced in 2013. FNP is an intensive preventative programme for teenage mothers. Starting in early pregnancy and based on a therapeutic relationship, it supports the clients' intrinsic desire to be the best mother that she can be by offering holistic support and guidance until the child is two years old. The team screen for alcohol use and drug use on entry to the service and work with clients to reduce consumption to safe levels.

Integrated Commissioning of Substance Misuse Services

Substance misuse services were re-commissioned during 12/13. The process was a joint one between children's services and adult services. This has enabled a more integrated service to be designed with a single point of access and improved transition between children and adult services for example.

The Local Picture

Admissions for alcohol related conditions have risen by an average of 12% each year since 2002/03 in line with national trends, but remain lower than regional and national rates. 60% of all alcohol related hospital admissions are people over 60

People living in the most deprived areas of Bath and North East Somerset are significantly more likely to be admitted for an alcohol related condition than those living in the least deprived areas.

Bath and North East Somerset has significantly higher rates of under 18's admitted to hospital for alcohol specific conditions than nationally. Approximately 45% of young people's admissions are children under 16 and the majority of admissions are girls.

60% of adults seen by the RUH alcohol liaison service (from Dec – June 2013) were also experiencing mental health issues.

The total estimated cost in B&NES of the harm arising from alcohol-use disorders is some £45.0 million a year, of which £21.3 million is a result of crime and £5 million healthcare costs. (Cabinet Office 2003)

There has been a 26% reduction in the number of crimes linked to the Night Time Economy in B&NES between 2008 and 2013

24% of the B&NES adult population is estimated to be drinking at increasing or high risk levels, which is similar to national estimates.

The estimated number of people in B&NES dependent on alcohol is 6,854 of all people aged 18 - 64 years. During 12/13 there were 388 people in treatment for alcohol misuse in B&NES. This represents 5.7% of the estimated population of dependent drinkers locally. Numbers in treatment have risen significantly since 2009 and this trend has continued in 13/14.

In 2013, 22% of B&NES secondary school pupils (Yr8 and Yr10) reported 'drinking alcohol in the last week' compared to 30% in 2011.

Community Voice

There is a significant difference in self-reported exposure to alcohol (drinking in the last week) for primary school pupils who qualify for free school meals compared to those who do not qualify for free school meals.

Girls self-report higher levels of drinking and are over represented in treatment services for alcohol misuse and also in alcohol related hospital admissions.

Qualitative feedback from young people using treatment services (Project 28) is consistently positive and satisfaction is high

High self-esteem amongst B&NES secondary school girls dropped from 42% in 2011 to 33% in 2013.

When asked in 2012 about drunk and rowdy behaviour in public places in their local area, 21% of voice box survey respondents believed it was either a very big problem, or a fairly big problem.

For further detail on local needs go to www.bathnes.gov.uk/jsna

Gaps in services and commissioning

68 people including councillors, officers, stakeholders and residents attended a Scrutiny Inquiry Day in Oct 2013 where a range of recommendations were made under the following themes:

- More education programmes that encourage a voluntary shift in attitude toward alcohol
- Improved and more frequent alcohol screening mechanisms
- Greater emphasis on prevention of alcohol harm through national and local policy
- More accessible training that emphasises issues and the effects of alcohol related harm
- Improved engagement at local level through more positive and proactive information sharing and publicity
- Community safety approaches that encourage collective and integrated working across partners and stakeholders

What works in preventing alcohol related harm

The National Institute for Health and Care Excellence (NICE PH 24) recommends the following evidenced based approaches to reducing alcohol related harm in the population:

- Price increases
- Restricting physical availability
- A reduction in drink drive alcohol limits
- Control on advertising
- Identifying problems sooner
- Good quality treatment services
- Good quality communication/education programmes

The top four of these recommendations are predominantly reliant on action at a national level and reiterate the importance of lobbying national government on the key issues of price, availability, advertising and regulation. Effective local approaches to tackling alcohol related harm are identified in the Outcomes Frameworks below.

Strategic Vision:

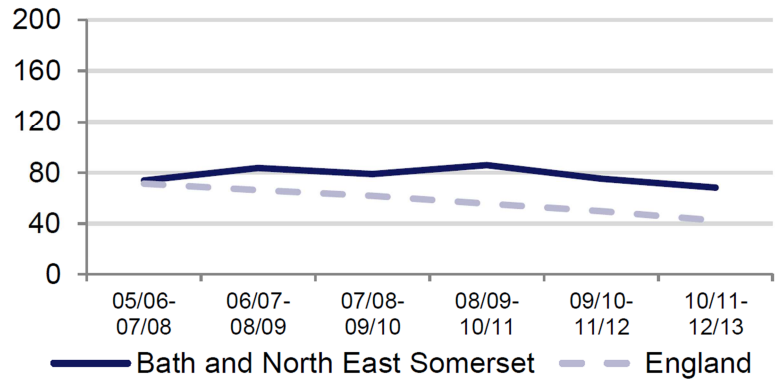
A cultural environment where everyone can have fun and enjoy themselves safely, with or without alcohol.

Outcomes we want to achieve:

- Children grow up free from alcohol related harm
- Communities are safe from alcohol related harm
- People can enjoy alcohol in a way that minimises harm to themselves
- People can access support that promotes and sustains recovery

Each of the above outcomes and their associated indicators for monitoring progress are outlined in the Outcome Framework below:

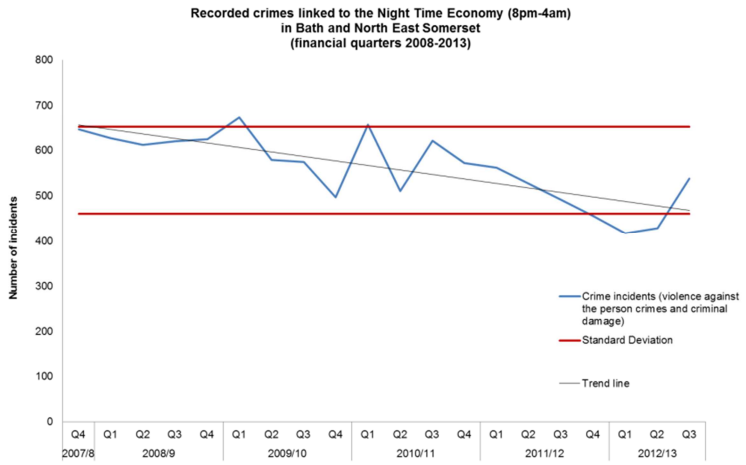
Outcome Framework: Children grow up free from alcohol related harm

Outcome & Indicator	Baseline and story behind it	Partners	What works to do better locally?
Outcome: Children grow up free from alcohol related harm **Indicator:** Alcohol specific hospital admissions to U18's **Population:** B&NES residents population under 18 yrs	**Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)**  	Children & Families services Schools Colleges Parent support organisations Connecting families team Social care teams RUH License holders Retailers Parents Youth services Sexual health services Drug and Alcohol service providers Voluntary orgs CAMHS School nursing & health visiting Children's centres Maternity services Community Alcohol Partnership MSN	Screening for alcohol misuse in young people's settings Targeting of high risk /vulnerable groups Support to children whose parents misuse substances. Multi agency working strategically, with families and in communities Holistic approach to health education in schools via PSHE/DPH award Social marketing campaigns aimed at parents/carers and young people Enforcement of underage sales, proxy sales and responsible retailing law
Data issues/gaps: Are high admissions a result of lower thresholds or protocol at RUH? School survey data shows reduced levels of reported drinking and drunkeness amongst young people during period 2011 to 2013 Missing ED attendances therefore underestimating scale of alcohol misuse What % of those being admitted are: known to services Repeat attenders access or need treatment Looked after children	**Story behind the baseline: (examples of contributory factors)** Alcohol seen as a supermarket commodity - normalised Fall in price of alcohol Alcohol drug of choice - rise in binge drinking culture amongst girls in particular Pre-loading culture Trend towards stronger drinks and larger glasses Marketing of alcohol to children (alco-pops etc) Deprivation link – young people in most deprived quintile of B&NES are significantly more likely to be admitted to hospital for alcohol specific condition than those in the least deprived quintile. Levels of self-reported drinking have reduced amongst B&NES secondary school pupils. Girls are over represented in drinking and smoking behaviours, hospital admissions for alcohol and in treatment services for alcohol misuse. Girls also over represented in self-harm admissions MSN and Radstock higher rates of admissions		**Commitment to lobby on:** Minimum unit pricing Restrictions on advertising and sponsorship of alcohol

Outcome Framework: Children grow up free from alcohol related harm

Current good practice in B&NES on protecting children from alcohol related harm	Gaps/Needs Identified
• Holistic approach to promoting health and wellbeing across educational settings in B&NES through the Director of Public Health Award and PSHE& Drugs Consultant • Specific resources developed for primary schools on alcohol and campaigns/initiatives such as alcohol drama project for Secondary Schools • High Quality Treatment services delivered through DHI/Project 28, including family support and supported transition from children to adult treatment services. • Drink Think Alcohol Screening Tool and Training Programme – embedding screening on alcohol misuse amongst the children and young people workforce – working especially well amongst school nursing and sexual health services. • Young carers support group. • B&NES Connecting Families programme working intensively to support 200 most vulnerable families • The Family Nurse Partnership working closely with up to 100 young pregnant women (under 25's) to support health in pregnancy • Self-harm register introduced at RUH with the aim of reducing repeat attendances for self-harm	• Strengthen preventative work which targets both young people and parents/carers. • Develop targeted education programmes for specific vulnerable groups, including: younger children by encouraging schools to start introducing topics sensitively from primary school age and encourage schools to facilitate further work through Personal Social Health Education. • Better knowledge of the causes of self-harm through alcohol use. • Mainstream screening and brief advice across key children's services providers. • Develop a clear referral pathway for children's workforce when working with young people misusing alcohol. • Prioritise support to children whose parents are misusing alcohol. • On-going commitment to enforcement of underage sales, responsible retailing and action on irresponsible promotions.
Key Priorities • Improved understanding of U18's hospital admissions – why is B&NES an outlier on this indicator? • Better knowledge of self-harm through alcohol use • Refresh drug and alcohol needs assessment for children and young people	

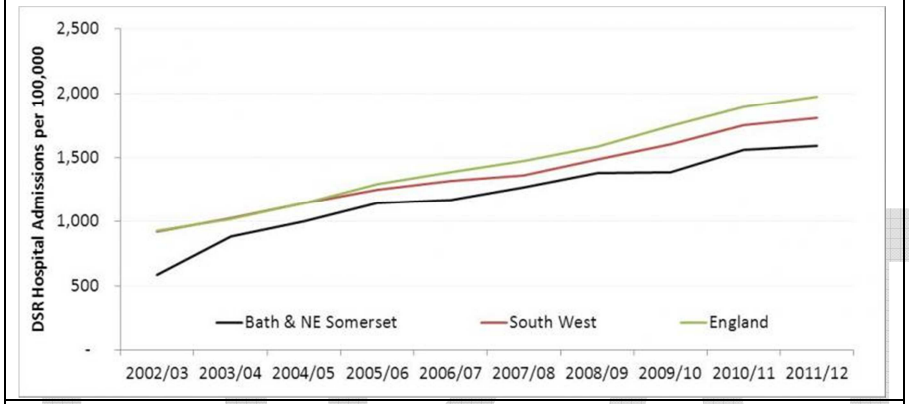
Outcome Framework: Communities are safe from alcohol related harm

Outcome & Indicator	Baseline and story behind it	Partners	What works to do better locally?
Outcome: **Communities safe from alcohol related harm** Indicator: **Night Time Economy related Crime and Disorder** Population: B&NES residents population 18+yrs Offences of violent crime and criminal damage occurring between the hours of 20:00 and 04:00 taking place outside of the home not otherwise defined as domestic violence or hate crime	 **Story behind the baseline: (examples of contributory factors)** Relaxation of regulation on availability/sales over time Increase in licensed outlets Fall in price of alcohol Increase in drinking in the home/pre-loading Population drinking twice as much per head than in 1960 Trend towards stronger drinks and larger glasses Higher proportion of young people (aged 18 – 21) in B&NES due to student population Attracts large numbers of people from surrounding areas due to range of offer 80% of crimes committed by Men, majority aged 16 – 27yrs 60% of offenders have problem with alcohol misuse. There has been a 26% reduction in the number of crimes linked to the Night Time Economy in Bath and North East Somerset over the 5 year period between 2007/08 - 2012/13. Downward trend in drink driving offences from 177 in 10/11 to 142 in 12/13	Police Transport Police Licensing Environmental Health Trading Standards Community Safety License holders Bath Improvement District Avon Fire & Rescue Probation Road Safety DV support organisations Social services D&A Treatment providers Assc. Of Town Centre Management Tourism & Leisure Universities & Colleges Student Community Partnerships Youth Offending teams Connecting families team	Multi agency working strategically and in communities Best practice schemes with licence holders e.g.Night watch/Pub watch Proactive management of the Night Time Economy Enforcement of underage sales and responsible retailing regulations Licensing policy to reflect health and community impact. Working with offenders Drink Driving campaigns & enforcement Working with Domestic violence perpetrators
Data issues/gaps: This definition is designed purely to assess levels of offending within the public realm where alcohol can be deemed likely to have been a contributing factor with a moderate degree of statistical certainty Data needed on assaults presenting at RUH & location			**Commitment to lobby on:** Health objective in Licensing Act Reduction of blood alcohol levels for driving

Outcome Framework: Communities safe from alcohol related harm

Current Good Practice on Alcohol Related Community Safety in B&NES	**Gaps/needs identified:**
• Active multi-agency partnership focussing on the Night Time Economy with governance links to Responsible Authorities Group • A range of good practice initiatives to manage the night time economy including Taxi Marshalls, Safe and sound paramedic response team, Street Pastors, Pubwatch and Nightwatch. • Bath City Centre has retained its Purple Flag Status since 2010. The Purple Flag status is similar to Blue Flag for beaches, it indicates that Bath City Centre is a safe, inclusive and diverse entertainment centres for all visitors. • Midsomer Norton Community Alcohol Partnership has made significant improvements to the night time economy in MSN through community focussed activity, awareness raising, working with traders and license holders and introduction of Street Marshalls and Designated Public Place Order. • Training programme delivered by the Drug and Alcohol Action Team including 'Toxic Trio' training • Alcohol Treatment Orders implemented via the probation service alongside a range of behaviour change programmes with offenders • A River Safety working group which co-ordinates action to improve safety along the Avon. • Avon Fire & Rescue Service campaign and schools work with young people and students on alcohol and water safety	• Develop a vision of what B&NES' night time economy will look like (including an overview of cultural expectations). This high-level vision to be supplemented by district level aspirations (such as Bath, Keynsham, Midsomer Norton, Radstock) • Appraisal of the impact of Night Time Economy initiatives in reducing alcohol related crime and anti-social behaviour • Refresh the B&NES licensing policy to acknowledge prevention of alcohol harm • Explore the option of including a condition in a license around minimum unit pricing, high strength alcohol restrictions and/or irresponsible promotions where the evidence suggests this would be appropriate. • Improve the information available to residents about making complaints and contributing to licensing reviews. • Refresh existing information about licensing contacts and processes in the B&NES Connect magazine and on the B&NES website. • Extend existing initiatives, or foster new approaches in encouraging collective working between all alcohol traders (both on and off-trade). • Ongoing commitment to enforcement of underage sales, responsible retailing and action on irresponsible promotions.
Key Priorities - Developing a vision of the B&NES Night Time Economy Joint Strategic Needs Assessment update for Night Time Economy B&NES Licensing Statement Review	

Outcome Framework: People can enjoy alcohol in a way that minimises harm to themselves

Outcome & Indicator	Baseline and story behind it	Partners	What works to do better locally?
Outcome: Safe, healthy and responsible alcohol consumption amongst B&NES population **Indicator:** Alcohol Related Hospital admissions **Population:** B&NES residents population 18+	B&NES Alcohol Related Hospital Admissions 02/03 – 11/12  **Story behind the baseline: (examples of contributory factors)** Relaxation of regulation on availability/sales over time Increase in licensed outlets Fall in price of alcohol Increase in drinking in the home Population drinking twice as much per head than in 1960 Trend towards stronger drinks and larger glasses Marketing of alcohol to women and children (alco-pops etc) Older population - living longer with increasing complexity of conditions Clustering of risk behaviours (smoking/drinking/obesity) Deprivation link - People in most deprived quintile of B&NES are more than 4 times more likely to be admitted to hospital for alcohol specific conditions than those in the least deprived quintile.	CCG/primary care Sirona AWP RUH Drug & Alcohol Treatment providers Mental health service providers Public Health Older people's services Employers	Making every contact count - Routine screening and brief advice for alcohol misuse across frontline services Alcohol liaison services in hospital Improving access to treatment services Targeting of high risk /vulnerable groups Multi agency working strategically and in communities Workplace initiatives Social marketing campaigns Licensing policy to reflect health and community impact
Data issues/gaps: Missing ED attendances therefore underestimating impact on health services and opportunities for earlier intervention (est 15-20% of ED attendances alcohol related) Local prevalence data for adult drinking patterns not collected.			**Commitment to lobby on:** Minimum unit pricing Health objective in Licensing Act Restrictions on advertising and sponsorship of alcohol

Outcome Framework: People can enjoy alcohol in a way that minimises harm to themselves

Current Good Practice in B&NES	Gaps/needs identified:
• Annual Training programme for frontline staff focussing on Identification and Brief Advice – over 400 people trained in 2013/14 • Alcohol Liaison Service introduced at Royal United Hospital in 2013 which aims to reduce bed days, attendances, admissions and increase engagement with community based treatment services. The service contributed towards a 65% reduction in patient hospital spells following intervention. • Screening for alcohol misuse introduced into the NHS Health Check programme from April 2014 – approximately 6000 people aged 40 – 74 will be screened annually. • Screening for alcohol misuse has been introduced into community and inpatient services in Avon and Wiltshire Partnership Trust. • Healthy lifestyle services and physical activity teams using evidenced based screening tool (AUDIT) as part of their client assessment.	• The Every Contact Counts approach to mainstreaming screening and brief advice on alcohol misuse needs supporting across the key service providers in acute care, social care, community service and mental health. This approach needs to be implemented across both adult and children and young people's services. • Develop targeted education programmes for specific vulnerable groups, including older working age and over 65's • Encourage improved workplace health by developing a simple toolkit that local employers can use in the workplace. This initiative seeks to raise awareness about alcohol use in employees and colleagues • Training need for professionals around preventing and minimising the harm of alcohol misuse in older age. • Increase social marketing campaigns using innovative approaches eg scratch cards/apps to encourage self-assessment of drinking levels. • Improve the quality of data on alcohol related attendances from RUH
Key priorities Introduction of screening and brief advice across mental health services Introduction of screening within RUH Emergency Department Improved data on alcohol related hospital attendances at RUH	

Outcome; People can access support that promotes and enables sustained recovery

<table>
<tr><th>Outcome & Indicator</th><th>Baseline and story behind it</th><th>Partners</th><th>What works to do better locally?</th></tr>
<tr>
<td rowspan="2">Outcome:

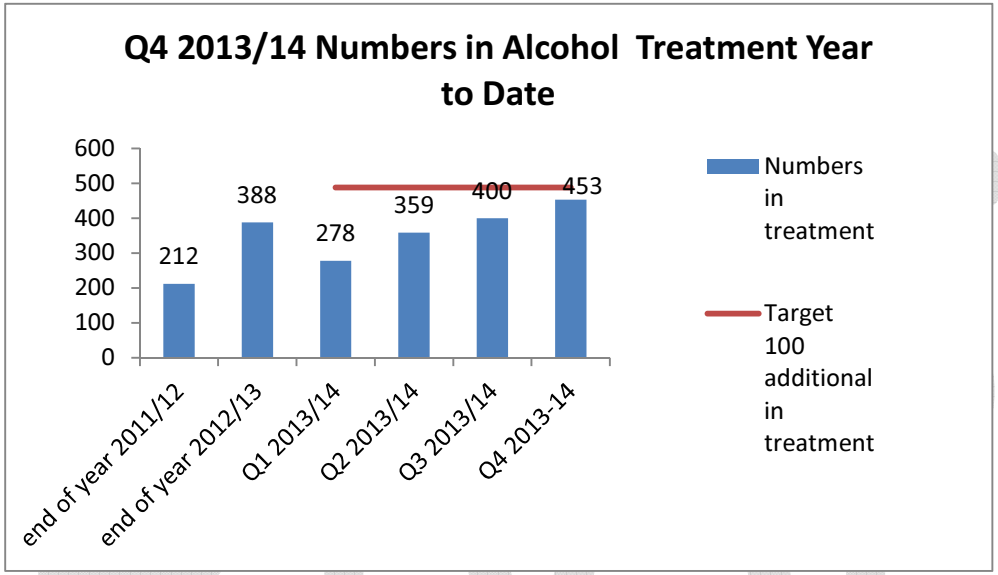
People can access support that promotes and enables sustained recovery

Indicator:
Numbers in treatment: increase by 100 by Q4 2014-15 (baseline 2012-13 = 388)

40% of alcohol clients will successfully complete treatment (baseline 2012-13 = 30.1%)

Population:
All B&NES resident population</td>
<td>

Numbers in treatment over time – adults/children
Trend over time and comparison to national



<u>Story behind the baseline: (examples of contributory factors)</u>
Numbers of opiate users in treatment declining
Numbers of alcohol users increasing
Increasingly complex clients – mental health problems/poly drug use
Recovery based model introduced nationally and locally
Capacity to work with treatment resistant drinkers limited
Welfare benefit changes have increased stress on families & individuals
Stigma attached to ‘needing help’ from services for alcohol misuse
Older people - loneliness and isolation could lead to increased alcohol misuse
% of those who have both drug & alcohol problem in treatment higher in B&NES
% of male deaths due to alcohol are higher in B&NES than regional average (LAPE 2014)
</td>
<td rowspan="2">Primary Care/CCG
Sirona
AWP & other mental health providers
Connecting families team
Social care teams
RUH
Probation
Universities
Workplaces
Housing services
Youth services
Sexual health services
Drug and Alcohol service providers
Voluntary orgs
CAMHS
School nursing & health visiting
Children’s centres
Maternity services
Children & Families services</td>
<td>

Routine screening for alcohol misuse in frontline services
Clear pathways into treatment – inc hospital liaison services
Recovery at the heart of the treatment model
Mutual Aid – SMART, AA etc.
Working with families/carers
Targeting of high risk /vulnerable groups – mental health, homeless, offenders, domestic violence perpetrators
Develop approaches to working with treatment resistant drinkers
Commitment to aftercare, housing, employment etc

Commitment to lobby on:

Minimum unit pricing
Restrictions on advertising and sponsorship of alcohol

</td>
</tr>
<tr>
<td>Data issues/gaps:

% dependent population accessing treatment – no agreed way to calculate this figure</td>
</tr>
</table>

Outcome Framework: People can access support that promotes and sustains recovery

Current good practice in B&NES	Gaps/needs identified
• Integrated commissioning model for both Adult and Children's treatment services. • Single point of entry and effective partnership working between main providers • Increased capacity for alcohol treatment since 2013 • Alcohol Liaison Service introduced at Royal United Hospital in 2013 which aims to reduce bed days, attendances, admissions and increase engagement with community based treatment services. • Good cross-council working e.g between drug and alcohol team and housing to support community detoxification • Investment in community based detoxification facilities has recently strengthened as a cost effective approach to treatment that supports earlier discharge from hospital and more seamless care. • Annual training programme for GP's, pharmacists and other frontline health and social care workers	• Increased referrals to alcohol team via RUH and GP's - capacity issues likely to be an issue longer term • Explore options to working with treatment resistant drinkers, including training, pathways and commissioning of services. • Accessibility of services for specific groups - e.g. older people, working adults; men • Increase referrals from those working with DV perpetrators • Dual diagnosis - training need for professionals • Embed the use of World Health Organisations alcohol 'AUDIT' screening tool at assessment and at review for all drug and alcohol clients.

Key Priorities
Capacity and Engagement: Increase alcohol treatment capacity and engagement by priority group alcohol clients
Client outcomes: Increase the % of alcohol clients who successfully complete treatment
Support the workforce: Drug and alcohol training programme focus – alcohol & mental health, older people
Treatment resistant drinkers project – complete workshops and respond to findings/recommendations

Key Indicators we will monitor to measure progress on this Strategy:

Alcohol Specific Hospital Admissions of under 18 year olds
Night time economy related crime and disorder (8pm – 4am)
Alcohol related hospital admissions
Percentage of people leaving treatment successfully

How will this be delivered:

The B&NES Alcohol Harm Reduction Steering Group will co-ordinate delivery of this Strategy through a Outcomes Action Plan. Each outcome will have a lead officer who will take responsibility for driving forward the relevant actions to achieve the outcome. The Group will co-ordinate directly with key partnerships on delivery of outcome action plans including the Young People's Substance Misuse Group, Night Time Economy Group and the Responsible Authorities Group, Joint Commissioning Group for Substance Misuse.

Governance and reporting

The Group will report to the Responsible Authorities Group twice yearly
The Group will also report to the Children's Trust Board twice yearly within the context of the Children and Young People's Plan.
The Group will report to the Health & Wellbeing Board twice yearly and via the Board's Joint Annual Account.

Review timetable

This Strategy will be reviewed after 3 years to ensure it continues to reflect local and national priorities.

References

For more information on local statistics quoted in this report please visit the Bath and North East Somerset Joint Strategic Needs Assessment Wiki page at www.bathnes.gov.uk/jsna

Milner er al. (2012) Alcohol Harm Reduction Strategy for Bath & North East Somerset

Cabinet Office Strategy Unit, London, 2003. Alcohol misuse: how much does it cost?

World Health Organisation (2009) Global Health Risks: Mortality and Burden of Disease attributable to selected major risks

The Governments Alcohol Strategy (March 2012)

A Review into Alcohol Harm Reduction in B&NES (2013) B&NES Scrutiny Team

National Institute for Health and Care Excellence (PH24) Alcohol Use Disorders – preventing harmful drinking

Appendix 1 Service & Organisational Development Recommendations (2012) and Actions completed

Service and Organisational Development Recommendations (2012)	**Actions completed**
Increase alcohol treatment capacity for people in B&NES who misuse alcohol	Drug and Alcohol Treatment services were re-commissioned from April 2013 and included the development of a dedicated Alcohol Team and additional capacity for community based alcohol detoxification. An Alcohol Liaison Team based at the RUH has been funded by the CCG from April 2013. This team also provides additional capacity within recovery services to facilitate access to community treatment. There has been a significant rise in numbers of people accessing treatment services for alcohol misuse in 13/14 and also an increase in client outcomes with more clients successfully leaving treatment having addressed their alcohol misuse.
Roll-out of identification of people in B&NES who misuse alcohol and are offered brief interventions	Identification and brief advice training for alcohol misuse has been delivered to over 700 local professionals since 2011/12 including GP's, pharmacists, health, housing and social care workers. Alcohol screening has been introduced into the NHS Health Check from April 2014 which means over 6000 40 -74 year olds will be screened each year. Screening has been introduced into inpatient and community mental health services from April 2014.
Identification, risk reduction and support of children of problem drinkers	Hidden Harm work with CYPS and the DAAT to safeguard children Young Carers Support Group set up by DHI/Project 28 to support young people affected by parental alcohol and drug misuse FAM (Families Also Matter) support services set up by DHI to support the families who are affected by alcohol and drug misuse
Set up Alcohol Harm reduction Group	The Alcohol Harm Reduction Steering Group has been in place since April 2011. The group has driven Strategy implementation and has co-ordinated the multiagency response to local challenges and opportunities. The Group reports directly to the Health and Wellbeing Board and from April 2014 will also report directly to the Children's Trust.

Clear and consistent messages around alcohol and the behaviour expected of B&NES citizens and visitors that the local statutory agencies expect	The B&NES Night Time Economy Group has championed the Purple Flag as the vehicle for promoting Bath City Centre as a diverse and well managed town centre at night. Bath has achieved Purple Flag Status for 3 years in a row and in 2013 celebrated Purple Flag Week through a range of high profile events and publicity to celebrate those achievements as well as conveying important safety messages. This included the development of a 'Great Night Out' leaflet highlighting harm reduction messages and local facilities such as taxi ranks.
Local Indicators and information sources for alcohol misuse priorities identified through the Joint Strategic Needs Assessment	Local data on hospital admissions, crimes in the night time economy, treatment outcomes and community feedback have been collated and presented within the Joint Strategic Needs Assessment Wiki page on Alcohol. The Councils Joint Strategic Needs Assessment is highly accessible to local partners and regularly updated.
A comprehensive care pathway for people with alcohol misuse in B&NES that is clear to users, citizens, commissioners and providers.	The re-commissioning of drug and alcohol treatment services emphasised joint working across the treatment system and the development of a single point of entry for both the public and professionals. Training for professionals on pathways and referral processes has been extensive since April 2013 including a Treatment system launch conference and Focus on Recovery Conference.
Big Society initiatives and engage local communities and citizens on reducing alcohol related harm	The Midsomer Norton Community Alcohol Partnership is a key example of how a local community has taken ownership of a problem and drawn in resources from a range of agencies and sources with the aim of tackling underage drinking and anti-social behaviour in the MSN night time economy. A range of effective interventions have been delivered including training for local license holders, a Designated Public Place Order and Street Marshall initiative. Multi agency working has also increased the reach and impact of a range of harm reduction campaigns that have been run annually, including Dry January, Love Your Liver, Make it a night to remember and 'Don't make river water your last drink'

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MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**19/11/2014**
TYPE	**An open public item**

Report summary table	
Report title	Local Safeguarding Adults Board Annual Report 2013-14
Report author	Lesley Hutchinson (01225 396339)
List of attachments	Appendix 1: Local Safeguarding Adults Board Annual Report 2013-14 and Business Plan
Background papers	None
Summary	The Local Safeguarding Adult Boards Annual Report 2013-14 highlights the work of the Board during the period and the safeguarding case activity and outcomes information. The Business Plan sets out the outcome domains and the objectives the Board has focused on during 2012 to 2014. The Business Plan is routinely monitored and reviewed with new actions included as required. A new plan will be developed in February 2015 for sign off in June 2015 agreeing the areas of focus for 2015 – 2018.
Recommendations	The Board is asked to: 1. Note the Annual Report and Business Plan 2. Raise any queries or concerns on safeguarding activity 3. Recommend areas they would like the LSAB to focus on
Rationale for recommendations	The Local Safeguarding Adult Board contributes to the Health and Wellbeing Strategy and in particular to the delivery of the outcome of theme two - Improving the quality of people's lives. It does this through the commitment of its Partners to ensuring all aspects of the safeguarding system work as effectively as they can within the resource available. The Report seeks to assure the Health and Wellbeing Board of the quality and focussed work it delivers in order to manage the safeguarding system across B&NES.
Resource implications	None, however there remain capacity issues caused by the continued increase in safeguarding adult's alerts and referrals, the implications for these are being considered.
Statutory considerations	The Association of Directors of Adults Social Services recommends that LSABs present their Annual Reports to the

and basis for proposal	Health and Wellbeing Board for consideration. The report has been presented to the Board (and previously Partnership) for a number of years and the LSAB welcomes its views. From April 2015 the LSAB will be placed on a statutory footing in the same way as the Local Safeguarding Children's Board. The Council will have statutory responsibility to ensure the development of the LSAB.
Consultation	The draft report has been considered by the LSAB on the 3rd September 2014 and by Healthwatch Bath and North East Somerset Advisory Group on the 2nd September 2014. The final report was presented to Wellbeing Policy Development & Scrutiny Panel on the 9th September 2014.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

1.1 The Health and Wellbeing Board are asked to consider the information provided in the LSAB Annual Report 2013-14.

1.2 The LSAB Annual Report 2013-2014 provides:

- an overview of changes to national and local policy
- confirms the Boards governance arrangements and changes made within year
- sets out the Boards activity during the year and safeguarding case activity
- compares safeguarding case activity with national data
- demonstrates the commitment of member agencies through their individual agency reports

1.3 Appendix 4 to the Report is the Business Plan 2012-2015; a working document that is monitored at each LSAB meeting and new actions are added when required through-out the year. In February the LSAB will hold a development day and the focus of this will be the new business plan.

1.4 The Report also contains an Executive Summary (pages 5 to 7) which was requested by the Health and Wellbeing Board last year.

Please contact the report author if you need to access this report in an alternative format

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Appendix 1

Annual Report

2013 – 2014

Bath & North East Somerset Council

NHS
Bath and North East Somerset
Clinical Commissioning Group

working together for health & well-being

Avon and Somerset Probation Trust

AVON FIRE & RESCUE

AVON & SOMERSET CONSTABULARY

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Royal United Hospital Bath NHS
NHS Trust

curo

Carers' Centre
Bath and North East Somerset

Freeways

Bath & North East Somerset ageUK

Royal National Hospital for Rheumatic Diseases NHS
NHS Foundation Trust

NHS England

Sirona care & health

Chair's Foreword

This has been a tough year for services, with significant national events, new legislation, implementing the recommendations of a serious case review, ever increasing demand for safeguarding, the changed approach to DOLS and many other demands, at a time when resources are under great strain.

The LSAB has to balance a degree of sensitivity to the pressures on services and on staff, while remaining firmly focused on the quality and effectiveness of safeguarding. This inevitably leads to consideration of which areas can be prioritised over others. My surprise has been that there remains a real drive to try to continue as before. While this is admirable in one sense, I remain concerned as to how practical this is and the extent to which this drive and enthusiasm needs to become more targeted.

Part of the evidence for this level of commitment is in the work that has been produced this year by the sub-groups, as shown in this report. There is a remarkable range and amount of work much of which has been turned into practical and tangible products aimed at supporting the delivery of safeguarding. I am enormously appreciative of the commitment and expertise that this work represents.

We know that there is much good practice in B&NES and the Board sees regular evidence of this. We have, though, had two serious case reviews in the last four years. We know that there are particular areas where risk is hard to quantify and we are aware that more work is needed to fully connect some agencies to safeguarding. Making practice more person-centred also remains a challenge. We should never be complacent but, at the same time, should recognise and celebrate good practice.

A challenge for the Board is the need to improve our understanding of how the many policies, protocols and guidelines are used and the difference that they make to lives of people at risk. This remains a focus of our work with commissioners and other partners.

B&NES Council is carrying out more structural changes, some of which will lead to closer alignment between adult and children's protection. This is to be welcomed and should produce the opportunity for shared business support for both Boards.

A major area of work is examining the need for improved multi-agency decision making through a hub arrangement. This work is gathering pace and the initial phase will be concluded shortly.

We have dealt with tragic situations, delivered a high volume of work and tried to make sense of complex issues. This has been possible through the skill, dedication, energy and character strengths of colleagues on all fronts. Board members have given unstinting support and the sub-group chairs have been brilliant colleagues. The B&NES commissioning team has given outstanding support – at the same time as being scrutinised for what they deliver.

With huge thanks,

Robin

Robin Cowen. Independent Chair

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Executive Summary

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

This report summarises the LSAB's activities that has taken place between April 2013 and March 2014. It highlights the commitment to multi-agency working; the robust performance management and quality assurance mechanisms in place and the achievements of the LSAB.

Safeguarding adults maintained a high profile during 2013-14 locally, regionally and nationally both in terms of Government initiatives and in the media. Multi-agency working to prevent abuse and safeguard adults at risk of abuse has continued to be scrutinised. 2013-14 saw a raft of new guidance notes and reports produced to help agencies work more effectively to prevent abuse. Section 3 of the report outlines the detail of these; of particular significance is the Care Bill receiving royal assent in May 2014 now the Care Act 2014. This places safeguarding adults on a statutory footing; it puts in place the legal requirement for a LSAB (clause 43) and what the responsibilities of the LSAB are (Schedule 2).

Another significant focus during the year has been given to '*Making Safeguarding Personal'.* In March 2014 the LGA and ADASS published, ***Making Safeguarding Personal 2013/14 Report of the Findings***, authored by Jane Lawson, Sue Lewis and Cathie Williams. This report outlines the findings of the second wave pilot study into agencies working in a personalised way when safeguarding. The safeguarding procedure has been seen by some as a bureaucratic procedure which doesn't take into account the needs and wishes of the individual and does not enable the individual to formulate their wishes in their own time as the procedures largely are timescale specific – this pilot challenges this approach. B&NES agencies were involved in the second wave pilot and the findings of this will be reported in next year's Annual Report. The Department of Health now expect all Councils and LSABs will be making safeguarding personal and this will be embedded no later than March 2017. The three year timescale is to enable Councils and Safeguarding Adults Boards to review their existing multi-agency and single agency procedures in light of this.

The LSAB membership is the same as the previous year however there remains a gap for a service user representative on the Board. Through-out the year the Awareness, Engagement and Communications sub-group have worked hard to get service user representation and the Board has approved a proposal for Healthwatch to recruit two lay members to carry out this role and represent the voice of service users. This is noted in the sub-group section of this report.

The Board has worked through the actions set out in the business plan and the recommendations of the Serious Case Review (SCR), set out on page 26. The LSAB acknowledge the significant learning that has taken place as a result of this SCR and the enormous undertaking that each agency involved committed to. The report has been shared with the LSCB and the Responsible Authorities Group to ensure they are aware of the learning identified.

Work has progressed with partners on whether a multi-agency safeguarding hub would be of benefit locally. A piece of work has been commissioned to scope this and to look at what is being delivered in other areas. A final report is expected in October 2014.
Sirona Care and Health has provided an increased number of staff from within their own agency and from the voluntary and independent sector with safeguarding adults training as set out on page 21. In addition to this, other agencies on the LSAB provide their own staff with safeguarding training in-house. The member agencies report the percentage of staff they have trained in section 7.

Single agencies have provided a significant amount of training in domestic abuse; organisations have offered their training out to other LSAB member agencies which has been increased the number of trained staff across the community.
The Council undertook its annual Social Care Survey which it reports to the Department of Health. The survey looks at many areas however domain 4 asks people to consider how safe they feel. The figures below set out the responses:

ASCOF indicator	2011-12	2012-13	Provisional data 2013-14
Proportion of people who use services who feel safe	68.3	65.1	70
Proportion of people who use services who say that those services have made them feel safe and secure	75.2	78.5	80

Those respondents who have stated they do not feel safe are contacted to see if they need any additional help or review of their situation. An improving picture is being reported for 2013-14. The questions do not relate directly to someone being supported through the safeguarding procedure; however the Department of Health are looking at a measure to put in place to collect this.

Links with community safety and the work of the Responsible Authorities Group (RAG) and sub groups has strengthened further through-out the year. Members of the LSAB sub groups are now also members of all the RAG sub groups. The Council in partnership with NHS Banes CCG and Avon and Somerset Police, has jointly funded a mapping exercise / gap analysis into the local understanding of domestic abuse services and Multi-Agency Risk Assessment Conference (MARAC). The results of this are intended to be shared with the RAG and LSAB in September 2014. The PCC and NHS Banes CCG have jointly funded the delivery of the “IRIS” programme; this programme will create a clear referral pathway for domestic violence for GP surgeries. It is initially funded for a period of three years and the IRIS approach is endorsed by the Royal College of Practitioners and by the Nice Guidelines on domestic abuse 2014.

B&NES received 684 new alerts during 2013-14 and continued to support 86 service users through the safeguarding procedure who had been referred during the previous year. At the end if the March 2014, 106 cases remained open and 664 had been closed. The increase in the number of alerts received from 2012-13 to 2013-14 was 31%, the same as the previous year.

664 cases were terminated/closed during the period; a 20% increase, demonstrating the increase in work taking place. Page 32 of this report sets out the information on the number of safeguarding alerts received showing the year on year increase since 2005.

Of the alerts received 57% met the threshold for progressing through the safeguarding procedure; the Health and Social Care Institute for Excellence report on average 50% of alerts meet that threshold. Although there is a higher number in B&NES, Sirona Care and Health and B&NES Council have worked closely together to look into this and during the year ran two workshops on threshold decision making; these workshops were attended by the majority of Team Managers and Assistant Team Manager. Staffs were largely consistent in the threshold applied demonstrating a consistent approach is taken. The B&NES Council Safeguarding and Quality Assurance team also audit all alerts that do not reach the threshold to give assurance it is being applied robustly.

The gender and age of the service users which alerts are received for, and those which meet the criteria for progressing through the safeguarding procedure are similar to previous years and to the national picture. However there are a low percentage of alerts for non-white service users – this is a concern and although focussed work took place during 2012-13 this will need revisiting to ensure we are meeting the needs of the community.

The number of referrals for physical abuse remains the highest; however referrals for neglect and acts of omission have increased for 2013-14 in comparison to 2012-13. This is thought to be as a result of continued awareness raising and staff and the community having a wider understanding of what they can refer.

Avon and Somerset Constabulary were involved in at least 34% of cases, (see page 36), this is an increase on previous years and triangulates with the Police data which shows a significant increase in demand for their involvement.

There has been an increase in the number of ‘other family members’ (not partners) and strangers that are suspected of causing significant harm to vulnerable adults at risk. This is of concern and the Quality Assurance, Audit and Performance Management sub group of the LSAB will see if this continues during April – October 2014.
The outcome of cases remains broadly similar to previous years with 33% of cases substantiated and 17% partly substantiated. A new outcome category of ‘investigation ceased at individuals request’ was included as part of the Safeguarding Adult Return the Department of Health require; 4% of closed cases had this outcome recorded. For cases where the alleged perpetrator was a professional worker, 25% were substantiated; where ‘other family members’ were identified as the alleged perpetrator, 21% were substantiated; where a neighbour / friend was the alleged abuser, 38% were substantiated. In cases where another vulnerable adult was the alleged abuser 5% were substantiated. The National comparator data available does not provide this information so it is unclear how this compares to other areas. B&NES Council is going to ask the sub-regional neighbours if they can share this data for next year’s report.

The LSAB will continue to review the Business Plan during 2014-15 adding into it areas from this report that require further scrutiny and work. During 2014-15 it will draft a new 3 year plan which will be consulted upon.

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 It is committed to ensuring that all agencies working in B&NES and the wider community work together to minimise and reduce the risk of abuse and neglect to adults and families.

1.3 This report summarises the LSAB's activities that has taken place between April 2013 and March 2014. It highlights the commitment to multi-agency working; the robust performance management and quality assurance mechanisms in place and the achievements of the LSAB.

Section 2: Background

2.1 Safeguarding adults maintained a high profile during 2013-14 locally, regionally and nationally both in terms of Government initiatives and in the media. Multi-agency working to prevent abuse and safeguard adults at risk of abuse has continued to be scrutinised. 2013-14 saw a raft of new guidance notes and reports produced to help agencies work more effectively to prevent abuse.

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. The parliamentary process for making safeguarding a statutory duty started in July 2012. The Care Bill continued to progress through Parliament during 2013-14 and at the same time the Government published a second ***Statement of Government Policy on Adult Safeguarding****;* this was provided to act as a bridge between No Secrets and the duties and powers contained in the draft Care Bill (May 2013). It builds on *No Secrets* which will remain as statutory guidance until the Bill is implemented in April 2015.

2.3 **Who is a vulnerable adult?**

An adult at risk (defined in 'No Secrets' as a vulnerable adult) is:

- 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. The Government, the Local Government Association (LGA), the NHS and Association of Directors of Adult Social Services (ADASS) to name but a few organisations have continued to give focus to safeguarding adults at risk through-out 2013-14.

3.2 The Care Bill received Royal Assent in May 2014, becoming the Care Act 2014. During 2013-14 a significant campaign was led by Action on Elder Abuse requesting the Government include three new areas into the Care Bill, including a Power of Entry. However, other organisations argued against such a power and the Government decided not to include this power in the legislation.

3.3 In June 2013 the Care Quality Commission (CQC) launched its consultation on the future of inspection and regulation and set out its plans to change the way health and social care is regulated. The changes were proposed in response to the findings of the ***Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*** (Francis 2013) alongside comments from service users, the public and other reviews. The initial consultation focused on hospital care with a further consultation on adult social care later in the year. One of the key changes involved the move to specialist rather than generalist inspectors.

3.4 The CQC strategy ***'Raising standards, putting people first - Our strategy for 2013 to 2016'*** sets out its plan to raise standards in registered services. The strategy was implemented for NHS hospitals and mental health trusts in 2013 in the first instance. One of the reasons for this is the findings published in the State of Care report noted below. The plan is to extend the approach to other sectors in 2014-16.

3.5 In November 2013 CQC published ***The State of Health Care and Adult Social Care in England 2012/13*** which reported on the findings of 35,000 inspections it had undertaken during the year. The report stated 'In around 90% of cases, people were treated with dignity and respect and were receiving care, treatment and support that met their needs and was safe. But, despite improvements in each type of care setting, we are disappointed that in around 10% of cases people received poor quality care.' (p4)

Regarding Safeguarding and Safety the report states:

‘Our inspectors reported that all types of adult social care service improved the safety of their services in 2012/13. In particular, services showed a better awareness of their safeguarding responsibilities and the procedures for raising concerns and contacting the local authority safeguarding team. However, the results still leave a long way to go – particularly for nursing homes where almost one in five inspections found a problem to do with the safety of residents, and for residential homes, where the figure was one in eight. Common problems were: Failing to give out medicines safely, and not maintaining adequate records of who needs which medicine.’ (p 27).

The report also stated however that in NHS hospital settings there was no improvement in safeguarding and safety or in treating people with dignity and respect (p36). In independent health care settings and independent ambulance services, safeguarding and safety was a problem in one in eight inspections (p50 and 51). 93% of dental care settings were reported to be safe and understanding of what to do when someone at risk of abuse is identified.

3.6 The LGA continued to run its safeguarding adults programme which it has done for the past four years and has published a number of documents during the year including:

Safeguarding Adult: Learning from Peer Challenges (April 2013) – this report looks at the findings from the Local Authorities and SABs who have been through a peer challenge (formerly known as reviews). One of the areas highlighted through the report is that service users are not routinely asked what outcome they would like from the safeguarding work. The report recommends ‘that people are asked at the beginning, during the information gathering stage, what outcome they want.’ (p12) It sets out a range of practice guidance that SABs, commissioners and agencies need to consider to improve practice. B&NES peer challenge is scheduled for December 2014.

3.7 The LGA continues to support the safeguarding community on the Knowledge Hub – the Hub has hosted a number of hotseat discussions and webinars to share good practice and discuss issues. For example in June 2013 a hotseat discussion was held on the Wirral System Based Review – looking at serious case reviews and the impact the Care Act will have on this.

https://knowledgehub.local.gov.uk/group/adultsafeguardingcommunityofpractice

3.8 The LGA jointly with ADASS published the following documents during the year including:

Adult safeguarding and domestic abuse: A guide to support practitioners and managers (April 2013). The guide aims to:

‘• Improve recognition and understanding of the circumstances in which adult safeguarding and domestic abuse overlap and should be considered in tandem
• Contribute to the knowledge and confidence of professionals so that the complexities of working with people who need care and support, and who are also experiencing/reporting domestic abuse are better understood, and better outcomes for people can be achieved as a result

• Offer good, practical advice to staff and managers to ensure that older, disabled and mentally ill people in vulnerable circumstances have the best support, advice and potential remedies if they are harmed or abused by a partner or family member
• Identify some of the organisational developments which can support best practice in this area.' (p5)

The guide sets out what defensible decisions are and what legal frameworks are available to support action.

Making effective use of data and information to improve safety and quality in adult safeguarding (July 2013). This document sets out tips for SABs to use to help them improve their effectiveness through managing the data and intelligence it receives; directs the SAB towards other bodies, Boards and agencies that have data which will be of use and confirms the need to ensure that information sharing protocols and data protection principles are in place, understood and adhered to.

Making Safeguarding Personal (March 2013) written by Cathie Williams and Deborah Klee in partnership with the Social Care Institute for Excellence (SCIE). The report described what a number of 'test' Councils were doing in terms of focusing on outcomes for and the experiences of, people who use safeguarding services. The report set out some of the challenges the test Councils' found.. Significantly it started to link safeguarding practice with the transformation of adult social care that has been taking place since *Putting People First* (DH 2007). One of the outcome statements from the project was 'There is a need to move adult safeguarding from a process driven approach to one that is focused on improving outcomes for, and the experience of, people who are referred to the service.' (p21)

During the year a further pilot was undertaken and 43 Councils fully participated. B&NES Council in partnership with Sirona Care and Health and AWP completed the impact assessment for the pilot and verbally contributed to the final report. The outcomes of the pilot were published in March 2014 by the LGA and ADASS, ***Making Safeguarding Personal 2013/14 Report of the Findings***, authored by Jane Lawson, Sue Lewis and Cathie Williams.

The aims of the second wave of pilots stage are described in the Executive Summary as follows:

> 'The intention is to facilitate person-centred, outcomes-focused responses to adult safeguarding. The key focus is on developing and/or re-establishing the skills to facilitate effective conversations in order to gain a real understanding of what people wish to achieve. Then it is about recording those desired outcomes and seeing how far they have been realised. Making Safeguarding Personal 2013/14 also continues to explore how best to support people at risk of harm to resolve the circumstances that put them at risk.' (p2 of Executive Summary)

16 core benefits were identified:

1. People felt more empowered and in control of their safeguarding experience when they and / or their representative were involved from the start.
2. Benefits to social work practice
3. The majority of councils have begun to include outcomes discussion and

recording prior to and/or during key safeguarding meetings. Many have also put dedicated time, processes and supports in place to enable people to participate in safeguarding meetings about them, in a meaningful way.
4. A significant number of councils referred to the need to simplify the language used in conversations with people about safeguarding. Many of these councils have produced guides for people about what safeguarding is and what they can expect from the support offered.
5. The majority of councils have been able to gather and report on both quantitative and qualitative evidence to some extent, to demonstrate that good outcomes have been achieved for people.
6. A significant number of councils recognised the importance of reviewing outcomes and developed their understanding of the extent to which outcomes can change throughout safeguarding support.
7. A significant number of councils report that the project has helped key partners, such as the Police, NHS and providers, to understand and see the benefits of an outcomes-focused approach to safeguarding.
8. A number of councils reported that their MSP project led to activities to support prevention and awareness raising in their local areas, perhaps with specific groups of people who were under-represented or difficult to contact.
9. Involving the person and / or their representative from the start of safeguarding also increases consideration of involvement of an advocate, IMCA and/or significant others.
10. Sound practice in applying the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) in safeguarding adults is important.
11. Assessment and management of risk alongside the person is integral to MSP and practising a person-centred approach to working with risk can support risk enablement.
12. Existing recording systems need to be improved, or new ones created , in order to help record and measure outcomes, and support the change to person-centred practice in safeguarding.
13. Safeguarding policies and procedures need to be revised and changed to reflect MSP and remove potential barriers to person-centred safeguarding practice.
14. The development of core practice skills, and having the tools to support good practice, are essential to introducing MSP.
15. Supporting practitioners and front-line managers to achieve a shift in practice is a key component of introducing person-centred practice in safeguarding.
16. Introducing person-centred, outcomes-focused practice to safeguarding is a cultural change that needs wide ownership and feeds into a much broader context.

The Department of Health (DH) have recently announced that *Making Safeguarding Personal* is no longer optional and all Councils and partners will roll this out over the next three years.

3.9 The LGA, ADASS, Social Care Institute for Excellence (SCIE) and Solace published ***Towards excellence in adult social care - Progress with adult social care priorities England 2012/13*** (Aug 2013). The report looked at all aspects of councils social care performance through focusing on the Adult Social Care Outcomes Framework (ASCOF) measures. Included with in these measures are two which relate to how safe service users feel. The report stated:

'The recorded increase in the number of people who said they felt safe is welcome, and improvement in the extent to which services make people feel safe is an even more positive change.

In respect of services making people feel safe, the picture is one of modest improvement, but it is a small rise and means that despite receiving services, over one in five service users still do not feel safe and secure. It points to the need for further improvement work with both providers and commissioners on how to identify, manage and prevent abuse to vulnerable adults.' (p64)

B&NES performance in relation to these two indicators is noted later in the report.

3.10 The DH in ***The Adult Social Care Outcomes Framework 2013/14*** (November 2012) set out a new placeholder indicator for domain 4 which relates directly to safeguarding and safety. The indicators are surveyed annually and are reported on later in the report. However Domain 4 titled: Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm and the new placeholder (meaning the DH are working out how to collect the data), will gather information on the proportion of completed safeguarding referrals where people report they feel safe. The measure requires piloting before it is rolled out but if effective will provide more data.

3.11 Health and Social Care Information Centre produced the ***Abuse of Vulnerable Adults in England 2012-13 Final Report, Experimental Statistics*** (February 2014). This is the final report in this format as the AVA return changes in 2014-15 and is replaced by the Safeguarding Adult Return (SAR). This change has been brought about by a large-scale data collection change the DH has implemented called the Zero Based Review. Safeguarding data was one of the first to be formally changed. The local data provided in this report for 2013-14 meets the SAR criteria which is different in some part to that provided to AVA so not all areas can be compared like for like. This report has sought to make comparisons where possible.

3.12 The Department of Health (DH) continued to monitor the actions set out in ***Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report*** in December 2012. All actions are required to be completed by 2016 and are being robustly monitored. The LGA and NHS Commissioning Board, through the Winterbourne View Joint Improvement Programme, continue to ensure the lessons learned and recommendations are implemented.

3.13 The report ***Respect and Protect. The experience of older people and staff in care homes and hospitals*** (Nov 2013), written by Carol Lupton and Clare Croft-Wright, was published by Preventing Abuse and Neglect in Institutional Care of Older Adults (PANICOA). PANICOA is a research initiative funded by Comic Relief and the Department of Health – the report draws on 11 studies the initiative has undertaken during 2009 and 2013. It makes conclusions and recommendations to improve:

- the experience of residents and patients by getting their feedback, reducing systematic neglect and improving 'performance on privacy and dignity in personal care (especially when using the toilet)' (p8)

- the experience of care staff by improved communication and information; skills development; mindfulness of the real risk of burn out; improving support to staff from minority backgrounds

- the experience of care provider organisations suggests they would benefit from more support on safeguarding issues and a more consistent approach from the regulator and commissioner (p8)

The report sets out a series of next steps for all organisations and bodies to improve the experience of the patient / resident, staff and organisation.

3.14 In November 2013 the Home Office published ***Evaluation of the pilot of Domestic Violence Protection Orders*****.** The Home Office piloted Domestic Violence Protection Orders (DVPOs) in three police force areas (Wiltshire was one of these) in 2011/12. 'DVPOs are a new civil provision designed to provide immediate protection for victim-survivors of domestic violence where no other enforceable restrictions can be placed upon the perpetrator.' (Gov.uk website) The report findings were in the main positively received by both practitioners and victim-survivors and saw a reduction in re-victimisation. The report recommended wide scale roll out. In March 2014 DVPOs were implemented across England and Wales. The new power enables the police and magistrates to put in place protection immediately after a domestic violence incident such as the perpetrator being banned with immediate effect from returning the residence and having contact with the victim for up to 28 days. This new power is part of the Crime and Security Act 2010.

3.15 The new ***Enterprise and Regulatory Reform Act 2013*** received royal assent in March 2013. In the context of Whistleblowing this now

> 'makes an explicit requirement that all disclosures must be in the public interest, in order to be protected by the Public Interest Disclosure Act 1998. Given this new public interest test, the previous legal requirement that a disclosure needed to be made in 'good faith' has been removed - although Tribunals can reduce compensation to employees where they find that they have not acted in good faith. These two provisions will be effective from 25 June.' (Whistleblowing Helpline Newsletter June 2013)

3.16 In September 2013 the Law Commission opened a consultation into what the obstacles are to sharing data between public bodies, and whether those obstacles are desirable. The consultation looked at whether there is a problem with the law - does the law itself erect barriers that unduly restrict data sharing between public bodies?; is it too complex and hard to understand and is data sharing too difficult and is there a gap in education, guidance and advice. The report was expected in the Spring 2014.

3.17 **Silver Line Helpline** - a free, 24 hours a day, confidential advice and help line for older people - was launched in November 2013. The number is 0800 4 70 80 90. One of the four aims of the helpline is to protect and support those who are suffering abuse and neglect.

Section 4: Governance and Accountability

4.1 Principles of the Board

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

- 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 and carers in the development of safeguarding arrangements
- 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 Procedures
- Quality Assurance, Audit and Performance Management
- Awareness, Engagement and Communication
- Training and Development
- Mental Capacity Act and Deprivation of Liberty Safeguards Quality and Practice
- Joint Interface Group of Local Safeguarding Children and Adults Boards

4.7 Terms of Reference for the LSAB and the sub-groups are available on the B&NES website. The LSAB Terms of Reference are due for review in September 2014.

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. Although there is a carers representative, there remains a gap for the service user representative place on the Board. Throughout the year the Awareness, Engagement and Communications sub-group have worked hard to get service user representation and the Board have approved a proposal for Healthwatch to recruit two lay members to carry out this

role and represent the voice of service users. This is noted in the sub-groups section of this report.

4.10 The sub-group members are from a variety of specialisms to ensure the group has relevant expertise in order to carry out its role. For example, the Quality Assurance, Audit and Performance Management group representative is the lead in quality and data for Avon Fire and Rescue; the Awareness, Engagement and Communications group has the Council's Information Officer; the Training and Development sub-group has a representative from the Police; the Mental Capacity Act and Quality Assurance Group has the voluntary sector agency SWAN Advocacy in attendance and the Policy and Procedure group has a newly recruited representative from the City of Bath College.

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; NHS B&NES Clinical Commission Group; NHS England; 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
- **User led and Carers organisations:** Vacancy for the voice of service users representative; the Carers Centre represents the voice of carers and carer organisations
- **Private, Independent and Voluntary sector organisations** including: Freeways on behalf of Health and Wellbeing Partnership Network; Age UK on behalf of voluntary sector and housing related support providers; Curo on behalf of registered social landlords; Sirona Care and Health (a Community Interest Company); vacancy for residential and nursing homes and domiciliary care representative
- **Education organisations**: Vacant
- **Council Cabinet member**: portfolio holder for B&NES Council Social Care, Health and Housing

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

- Local Safeguarding Children's Board
- Department of Work and Pensions
- Divisional Director for Tourism, Leisure and Culture, B&NES Council
- South West Ambulance Service

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, Avon and Somerset Police for the funding of the Independent Chair. The Chair continues to be funded to provide 20 days per year. Avon Fire and Rescue also make a financial contribution for the functioning of the Board and this commenced in 2013-14.

4.21 The LSAB published the Serious Case Review (SCR) Concerning PQ in July 2013. The report and its recommendations are discussed in detail later in the report. Financial contributions to the report were as follows: NHS B&NES and the Council shared the cost of the SCR report writer (though NHS Banes paid a significant proportion of this) and the Council funded the Independent Chair. Agencies involved in the SCR all dedicated resource and capacity through attendance at SCR panel meetings and the completion of very extensive Individual Management Review reports. One of the actions taken as part of the SCR action plan was the commissioning of a gap analysis report into agencies awareness of domestic abuse and the Multi-Agency Risk Assessment Conference (MARAC) process. Avon and Somerset Police, NHS Banes CCG and the Council funded and commissioned this report from Julian House. This report is expected in September 2014. Contributions have also been made from Sirona Care and Health, NHS Banes CCG and B&NES

Council who have commissioned research into the local need for a safeguarding multi-agency type hub and the outcomes and effectiveness of hubs in other areas. The final report is expected in October 2014.

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

4.23 Onward reporting structures

4.24 The Board has continued to report via B&NES Council commissioning to the Partnership Board for Health and Wellbeing (PBH&WB). The amount of reporting has been significantly reduced during 2013-14 at the request of the PBH&WB.

4.25 The Board has started to link with Healthwatch and this report will be discussed at a Healthwatch in September 2014.

4.26 Safeguarding activity during 2013-14 continued to be 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.

4.27 The Cabinet are no longer required to sign off the report, this is done by the Cabinet Member for Wellbeing.

Section 5: Achievements of the LSAB during 2013-14

5.1 Achievements and Outcomes of LSAB and Sub-groups Work during 2013-14

5.2 The Board and its sub-groups have been working to achieve the actions set out in the Business Plan; progress on each action is included in Appendix 5.

5.3 Policy and Procedure sub-group

5.4 The Director of Regulated Services at Freeways representing the Health and Wellbeing Partnership Network on the LSAB continued to chair the sub-group during 2013-14. The group are multi-agency, include service user representation and continued to be very active and productive.

5.5 The group has undertaken the following work:

- Developed the following multi-agency documents for the LSAB's consideration and approval:
  - (i) Approved the revised **LSAB Multi Agency Safeguarding Adults Policy** in line with the new procedures revised in the previous year. This was approved by the Board in June 2013.
  - (ii) Mid-way through revising the **LSAB Multi Agency Information Sharing Principles** as a result of learning from Serious Case Reviews to ensure key partners have the relevant information. The Board considered the revised document in December 2013; minor changes were requested which have been actioned and shared with all partners. Partners are now

sharing it with their own organisations to ensure they can comply; the document was approved by the Board in June 2014.

(iii) Devised at the request of the Board an **LSAB Induction Pack** which has since been used in the induction of all new LSAB and sub group members to ensure they understand the role of the Board or sub group and their own responsibilities within that role. The Induction Pack has been shared with the LSCB who intend to develop their own pack based on this.

- The group has prompted appropriate sub groups to review existing policies where review is due. To this end the Mental Capacity Act and Quality Assurance sub-group reviewed the **LSAB Multi Agency Safeguarding Adults Consent Guidance.**
- The group has also had approval from the LSAB to move the review of policies to a three yearly cycle, unless exceptional circumstances require this to be sooner. This move from two to three years ensures that there is sufficient time to review not just the content but also the use and dissemination of the policy before it is reviewed again.
- The group has also continued to try and progress the Multi-Agency Trigger Protocol and Guidance on Thresholds and are awaiting the outcome of work being done locally as a result of the SCR action plan and regionally before these pieces of work can be completed in 2014-15.
- Another large piece of work being undertaken by the group is the LSAB Protocol for Managing Large Scale Investigations which will be completed in 2014. (This was also approved at the LSAB in June 2014).
- Finally the group has supported events to promote the new LSAB Multi Agency Safeguarding Adults Policy and Procedures.

5.6 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) Quality and Practice sub-group

5.7 The Head of Safeguarding and Quality Assurance at B&NES Council continued to chair the sub-group during 2013-14.

5.8 The group has undertaken the following work:

- Presented an annual report specifically to the LSAB on the ***Deprivation of Liberty Safeguards (DOLS) 2012-13*** in December 2013 which identified that applications had significantly increased on previous years from 59 to 80. The report demonstrated a much improved picture for B&NES though recognised that further work needed to be done.
- Routinely monitored the number of DOLS applications, the referral source and the compliance with application processing timescales.
- Discussed with the Independent Mental Capacity Advocacy Service provided by SWAN Advocacy how their service is progressing and number of referrals received.
- Monitored and reviewed the training programme provided to stakeholders by the Council by offering new courses during 2013-14; planning the 2014-15 programme based on training requests from sub-group members; amending the basic MCA awareness course to include more information on safeguarding as recommended in the SCR.
- Provided bespoke training session on MCA as requested.

- Continued the process of gathering information from agencies on the mechanisms they have in place for assuring themselves that the MCA is being delivered in practice within their agency. The RUH and Sirona Care and Health shared the audit reports they had undertaken regarding this.
- Convened a multi-agency task and finish group to develop a draft set of performance indicators for MCA and DOLS; the group met several times and worked through potential indicators however none were able to deliver a meaningful outcome for assurance. The group discussed this with the Board and will continue to try and develop this but will wait for regional support with it.
- Continued to share information on case law activity and the Court of Protection (CoP) newsletter, shared briefing papers on cases from a variety of Solicitors firms; discussed issues such as when to use the MCA or Mental Health Act?, when to use Guardianship or the MCA?, when to apply to the CoP if serious medical treatment is required and how quickly can this be done? and considered the issue of the incapacitated but compliant patient.
- Discussed the National DOLS report 2012-13 published by the Health and Social Care Intelligence Centre and the data collection requirements for 2013-14.
- Reviewed the **LSAB Multi-Agency Consent Guidance**.

5.9 Awareness, Engagement and Communication sub-group

5.10 The group was chaired by the Chief Executive of the Carers' Centre.

5.11 This group has continued to undertake a significant amount of work this year as set out below and has undertaken the following work:

- Reviewed a Human Rights DVD and Hate Crime training pack and made it available for people to borrow.
- Published an article in Council Connect magazine; continued to advertise on Council Connect TV – on the one hour loop series in B&NES Council offices, leisure centres and libraries to raise awareness.
- The group also collated local examples of anonymised safeguarding case studies to draw upon for future safeguarding articles.
- Sirona Care and Health Service User Panel reviewed the service user feedback report which was positive but the panel were keen to see numbers grow and that all service users and carers involved in safeguarding would be given a feedback questionnaire. The group implemented this recommendation by adding a box on the form and on CareFirst (client data record system) to ensure a prompt was made to all staff working through the safeguarding procedure. The report was also shared with social care teams.
- Sirona Care and Health Service User panel also reviewed a DVD on safer recruitment of Personal Assistants and were asked to consider whether this was a useful tool for the Council to purchase on behalf of the LSAB to share with stakeholder agencies; the service user panel feedback was negative and the DVD was not purchased taking into account the service users views.
- The Service User questionnaire 'Keeping You Safe' was reviewed by the panel and made simpler and an easy read version was developed.
- The group proposed to the Board that two lay members should be recruited to represent the voice of service users; it drafted a role descriptor and worked with Healthwatch to pull together this proposal. The Board approved the proposal and the sub-group are waiting for Healthwatch to recruit the two lay members.

- Existing safeguarding literature was reviewed and renewed.
- A new ***Awareness, Engagement and Communications Strategy*** was written and adopted by the Board in March 2014.
- Joint working with the Children's Safeguarding Board began with a regular agenda item added and members of the Children's Safeguarding Board attending the sub-group.
- The document ***Advocacy: a voice for our future,*** Voluntary Organisations Disability Group (2012) was reviewed; in light of this sub-group members looked as their role as advocates and SWALLOW wrote a case study reflecting their position.

5.12 Analysis of 'Keeping You Safe' questionnaire was underway and reported to the Board outside this reporting period; findings to be included in next year's report.

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

Safeguarding - leaflets, posters and articles | Bathnes

5.14 The Council, Sirona Care and Health and AWP took part in the national pilot for *Making Safeguarding Personal*. The report from the pilot is discussed in Section 3 of the report; however the local analysis was discussed at the June 2014 Board and will be included in next year's Annual Report. The Board has requested that the agencies participate in the second wave of the pilot – this has been agreed however as stated in section 3, DH have now indicated this is no longer optional and all areas will engage in this programme.

5.15 Other awareness raising activities that have taken place includes:

- The Council was one of the sponsors for the Safeguarding conference ran by Care Learning in June 2013 and ran an information stall at the event.
- Representatives attended a safeguarding workshop held by Care and Support West in January 2014. Along with sub-regional safeguarding lead officers was a panel member answering queries from local and regional providers on safeguarding procedures and expectations of providers.
- Promoted safeguarding at the Learning Disability Partnership Conference in January 2014 through a brief presentation of last year's Home Office visit and which touched on 'Keeping You Safe' questionnaire.
- Ran a safeguarding stall at the Councils Market Play Day in February 2014 to promote the LSAB and how the Council and partners support agencies to safeguard adults at risk.
- Disseminated the work of the LSAB via the Chairs Key Messages through a range of mechanisms such as in the Interagency newsletter the Policy and Partnerships networks; Healthwatch e bulletin
- Routinely attend the forums to disseminate new information, answer questions and raise awareness such as the bi-monthly strategic domiciliary care agencies meeting.
- Presented at the MARAC awareness raising stakeholder event (this is referred to later in the report).

5.16 The Chairs of the Local Children Safeguarding Board and the Safeguarding Adults Board meet regularly to update each other on the progress and developing issues for both Boards.

5.17 The Chair is also linked with the National Chairs' network and routinely shares information with the Board and other agencies about safeguarding developments across the country.

5.18 Training and Development sub-group

5.19 The Operations Director of Sirona Care and Health continued to chair this sub-group during 201-14.

5.20 During 2013-14 the group has:

- Continued to develop a range of training opportunities in line with the LSAB business plan.
- Rolled out an extensive multi-agency training audit. A multi-agency audit of Safeguarding Adults training across the B&NES area was carried out in April / May 2013. All agencies affiliated to the LSAB and its sub-groups plus key domiciliary strategic partners and carers agencies of the Council were invited to respond and the responses were to be returned to the B&NES Council Safeguarding Adults and Quality Assurance Team. Considering that this was the first exercise of this kind in B&NES, the response was extremely good – a total of 23 agencies responded. The responses represented a wide range of organisations, from large services such as Sirona, AWP and the Police (over 1,000 staff each) to very small providers such as Crossroads (10 staff) and Shaw Trust (5).

  Agencies were asked to state how many alerts they had raised over the past year, answers varied from 78 (Sirona) and 88 (RUH) to zero. Because of the variations between organisations, it was difficult to draw any direct conclusions about a direct link with the quality / quantity of training. A wide variety of training providers was reported, some agencies having in-house trainers while others relied on external providers. However, at least one third of the responders received some or all of their training from Sirona Care and Health.

  Many of the answers were very reassuring and some of the responses were excellent, providing very full answers. There was a considerable range of responses to questions which related to the number of new staff who were trained within 3 months of starting work and the number of staff who were up-to-date with their training. These ranged between 100% (several organisations) for both questions to only 25%. Following the collation of responses a best practice guide was developed and shared with all participating agencies. The LSAB plan to repeat the exercise for the year 2014-15 to provide information on progress made in this area and to audit the extent and quality of training provided.

- Organised and delivered the LSAB's first stakeholder engagement day led by Michael Mandelstam; the event took place in October 2013. The event covered national topics (Francis Report and Winterbourne view), the impact of the Care Bill on Safeguarding systems and a workshop on thresholds for safeguarding. The event evaluated well as an

opportunity for over 80 practitioners from a wide range of agencies to meet to debate key safeguarding practice issues and will be repeated in 2014.

5.21 Sirona Care & Health continues to be commissioned to deliver core training programmes to a wide range of organisations from the Independent and Voluntary sectors. The table below outlines the numbers of staff trained over the last two years at various levels.

5.22 Table 1: Number of Staff Trained by Sirona Care and Health and Organisation Type at Each Level

Organisation/Sector	Level 1	Level 2	Level 3	2013-14 Level 2
AWP	0	7	6	5
Primary Care (GP's)	0	7	0	4
Independent and Voluntary sector	1	326	26	149
North Bristol Trust	3	0	0	0
NHS other	3	7	5	1
Other B&NES	0	13	1	3
NHS Banes Commissioning	0	4	1	2
Council Commissioning	0	6	5	0
Sirona Care and Health	614	1068	72	517
Total	**621**	**1438**	**116**	**681**
Figures for 2012-13	**31**	**845**	**61**	

5.23 Table 2: Number of Staff Trained at Level 2 by Sirona Care and Health 2010-14

Organisation /Sector	Staff Trained at Level 2			
	2010-11	2011-12	2012-13	2013-14
AWP	2	3	3	7
Primary Care (GP's)	12	12	1	7
Independent and Voluntary sector	331	160	150	326
NHS Other	22	4	4	7
North Bristol Trust	0	2	1	0
Other B&NES	0	3	0	13
NHS Banes Commissioning	6	10	2	4
Council Commissioning	8	10	7	6
Sirona Care and Health	380 (Health staff) 359 (Social care staff)	585	652	1068
Total	**1120**	**791**	**845**	**1438**

5.24 The tables above demonstrate a significant increase in the attendance of voluntary and independent sector staff at the training.

5.25 Organisations across B&NES also provide their own staff training and these figures are not captured in this report. For those agencies the Council have a contract with, training figures are reviewed as part of the review process. In addition to this Board member agencies report their training figures as part of the Annual Report in their agency updates.

5.26 A range of other bespoke training sessions / launches were provided during the period:

- Sirona Care and Health also delivered specialist training to GP's in this period via the GPert training forum.
- One of the outcomes of the Serious Case Review Concerning PQ (noted later in the report) is that Sirona Care and Health facilitated a workshop with Police and Council representatives invited, on the impact of domestic violence on vulnerable adults; Curo also delivered training on this to their staff.
- Sirona Care and Health commissioned four 1 day workshops on investigation and interviews training in partnership with Avon and Somerset Police and South Gloucestershire Council. The Police facilitated the day and the invitation extended to B&NES Council Safeguarding Adults and Quality Assurance team as well as Sirona staff working in B&NES.
- Sirona Care and Health also provided two sessions on Safeguarding adults templates and note taking training. The sessions attracted 35 participants and were extended to AWP note takers.
- Council staff provided training to staff at AWP working in their hospitals, and secondary mental health teams
- NHS Banes CCG provided training to GP's and their staff in February 2014;
- In April 2013 the Joint Commissioning Team of NHS Banes and the Council launched the Drug and Alcohol Treatment System. This launch was open to all stakeholders and a presentation on safeguarding and risk management was delivered during the afternoon by the Drug and Alcohol Commissioner.

5.27 Quality Assurance, Audit and Performance Management sub-group

5.28 The group has continued to be chaired by the Assistant Director of Nursing and Quality from NHS Banes.

5.29 The group has undertaken the following work this year in order to develop the work of the LSAB and provide assurance:

- Reviewed the process for the multi-agency safeguarding adults audits and looked at methodology used elsewhere. The group adopted a new audit tool for these audits. The issue of identifying cases and data protection remains problematic. Throughout the year the group has undertaken six multi-agency case file audits. This process has highlighted both gaps and good practice; both have been fed back to relevant organisations.
- At each meeting the group reviewed a published Serious Case Review with a view to ensuring that lessons learned are applied locally, the group has reviewed the following SCR's:
    - The Death of Mrs Gloria Foster by Surrey Safeguarding Adults Board.

- Serious case review in respect of female adult JT (died May 2012), Overview Report by Dorset Safeguarding Adults Board.

- Reviewed safeguarding referral data sources to ensure there were no obvious gaps in providers making alerts and that information triangulated between agencies, further work is required to check the robustness of reporting and representatives from the RUH and Sirona Care and Health have agreed to do this.
- Commenced work on developing a risk register for the LSAB; this work has been ongoing and an amended version will be presented to the LSAB in September 2014.
- Did further work on the survey report that looked at the effectiveness of the LSAB. All LSAB and sub-group members were asked to complete an on-line survey. The Survey Monkey questionnaire went to 66 people with 40 responses (60% response rate). There were a lot of positive comments and some areas for improvement identified for example: Further analysis and actions were presented to the LSAB in March 2013 and June 2013.
- Continued to review the plans agencies had in place in response to the Francis and Winterbourne View reports, all health and social care providers provided reports/ presentations on their internal actions in relation to these.
- Led the Self-assessment process; this involved collating self-assessment responses from 13 partners of the LSAB. This was presented to the LSAB in December 2013 and there are on-going actions for the group.

5.30 Joint Interface Group of Local Safeguarding Children and Adults Boards

5.31 The group continues to be chaired by the Head of Safeguarding Adults and Quality Assurance at B&NES Council.

5.32 The group has been progressing the seven areas that the LSCB and LSAB approved joint working on:

- **Training and development** – the aim to merge the LSCB and LSAB training and development sub-groups is being put on hold during this period to enable the LSCB group to develop its training framework; this will be revisited during 2014-15.
- **Learning opportunities** – the group has shared its SCR reports and consider the relevance of the learning for adult and child care services; the LSAB has considered the recent Children Services inspection report to ensure it contributes to improving delivery and strategic planning where possible. The group has also considered the documentation on Child Sexual Exploitation to assess the relevance for adults; this is an important concern that is important for adult care to recognise. Finally the LSAB shared its newly developed Induction Programme which the LSCB are considering adopting.
- **Trigger Protocol / Intelligence Gathering / Information Sharing** – the Council and Police are working closely to consider the development of an intelligence sharing / multi-agency safeguarding hub type model. An update on this is included later in the report.
- **Communications and Awareness Raising** – the LSCB have nominated a representative to join the adults group.
- **Chairing arrangements** – the intention of a single chair for the LSCB and LSAB remains on the agenda. The LSCB appointed a new Independent Chair in

October 2013; the recruitment included scoping the Chairs interest of chairing the LSAB in the future and understanding of adult safeguarding.

- **Transition of Children to Adult Services** – work has been slow to take off in this area. A commitment has been made to move this forward during 2014-15.
- **Safer Recruitment of Personal Assistants for Adults and Children** – the Council took up the offer from the Disclosure and Barring Service to run two workshops for on the 'Duty to Refer' for providers, looking at the legal changes to safer recruitment and referral requirements when disciplinary matter occurs. 139 people attended the morning session and 67 attended the afternoon session from children and adult care services including schools and nurseries which took place in October 2013.

5.33 Additional Work Carried Out by the LSAB during 2013-14

5.34 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 from the work being undertaken by the LSCB and received copies of the LSCB Annual Report and Work Programme
- Received routine updates and information from the LSAB Chairs network via the Chair
- Monitored the actions within the LSAB Business Plan for 2013-15 (**Appendix 4** of the report)
- Received up to date briefing on adult safeguarding information and documentation posted by the Government (DH), LGA and ADASS, for example:
    - **ADASS / LGA** ***Safeguarding Adults Advice and Guidance to DASS*** (March 2013)
    - **Government Statement on Adult Safeguarding** (March 2013)
- Invited a number of guest speakers to present current issues affecting adult safeguarding, for example on:
    - ***Welfare Reform Act 2012*****,** both the Council and Curo presented the potential impact of this on vulnerable adults in B&NES
    - ***Healthwatch*** and discussed their roles and responsibilities and the contribution it can offer to the LSAB
    - The NHS Banes response to the Urgent Care system and the mechanisms put in place to assure that last year's winter pressures do not impact in the same way for the winter of 2013-14
    - ***Prevent and Channel;*** a presentation on the work that is taking place regarding this and the reminder to agencies to undertake WRAP training
    - The new inspection regime that CQC are piloting. CQC presented the inspection programme and the RUH shared their experience of this as one of the hospitals in the South West to be inspected under the new framework.
    - The new social care pathway being developed by Sirona Care and Health and the Council. In July 2014 Sirona Care and Health will launch a new ASIS Team which will handle all safeguarding referrals for service users not in receipt of social care or not known to services.
- Discussed the Care Bill and the implications for adult safeguarding.

- Received updates on the South West ADASS Safeguarding Programme at which a B&NES Council Team Manager has the roll as the representative for the

  South West Safeguarding Adults Leads Group and considered the proposed South West safeguarding indicators; these are yet to be approved by South West ADASS.
- Approved the Board performance indicators for 2013-14.
- Received assurance from NHS Banes on the mechanisms they have in place for monitoring progress with health providers about the recommendations of the Francis Report.
- Routinely agreed the key messages that the LSAB wanted to share with all local stakeholders and disseminate these after each meeting by way of a chairs report.
- Approved 2012-13 LSAB Annual Report and received constructive feedback from the Health and Wellbeing Board who requested an Executive Summary be included and the Wellbeing Policy Development and Scrutiny Panel who reminded B&NES Council Commissioner, AWP and Sirona Care and Health they must continue to ensure compliance with procedural timescales is adhered to.
- Held an away day in November 2013, the theme for which was 'Improving Collective Board Activity'. The away day focused on how the LSAB can most effectively fit with commissioning, what is its role, how can it influence, what are the barriers and tensions; how is the Council and NHS Banes CCG as commissioning organisations held to account? The afternoon session focused on managing risk at a time of resource constraint and pressure. The away day built on the work that had taken place in the previous year on the role of commissioning and later in the year NHS Banes CCG and the Council set out a joint report for the Board to discuss further.
- Held its first Board Induction session using the new Induction Pack for Board members who had joined within the last year.
- As well as approving a revised Multi-Agency Safeguarding Policy earlier in the year, also approved the development of a sub-regional policy. Work commenced on this during the year and is to be shared with all four sub-regional Boards in June / July 2014. Somerset SAB may also share this policy. It will offer consistency across the area.
- Board members have also been asked to participate into research carried out by Practitioner Alliance for Safeguarding Adults into their report on adult safeguarding and housing and into a forthcoming report into self – neglect.

5.35 Of particular note is the publication of the Board's second Serious Case Review. The Board held an extraordinary meeting in April 2013 to consider the findings of the SCR panel and Chair. The Chair, Margaret Sheather presented the report to the Board. The report was approved and the Executive Summary was published in June 2013. The LSAB also approved the action plan to address the concerns raised regarding PQ and the multi-agency actions taken.

The summary report can be found following the link below:

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

In brief PQ is a woman in her 70's who became involved in a relationship with a man (RS) who became abusive to her and she was then the victim of rape in 2012 by another man (TU) who is now serving a prison sentence, having been found guilty of one offence of rape. RS introduced TU to PQ.

The report made 13 recommendations for which the LSAB has developed and action plan to ensure the recommendations are delivered. The recommendations are as follows:

- **Recommendation 1:** That the LSAB agrees the actions necessary to address the specific issues raised by this review about the application of the safeguarding procedures.
- **Recommendation 2:** That the LSAB continues its review of arrangements for training on Mental Capacity Act awareness and assessment for all agencies, including the links made to Safeguarding policy and procedures in that training, and makes recommendations for any improvements necessary.
- **Recommendation 3:** That the LSAB seeks assurances about arrangements for multi-agency identification of adults at risk as being at risk (and how they are at risk), the sharing of responsibility and knowledge, and proposes the changes necessary to strengthen those arrangements, including across service or authority boundaries.
- **Recommendation 4:** That the LSAB assures itself about arrangements for multi-agency identification of perpetrators, the sharing of responsibility and knowledge; and proposes the changes necessary to strengthen those arrangements.
- **Recommendation 5:** That the LSAB, in conjunction with the Community Safety Partnership, promotes strengthened awareness of domestic abuse and responses to it, including the functioning of the MARAC process. This would include:

  All agencies to:-

  - ensure that domestic abuse awareness forms part of mandatory training for all staff
  - raise awareness amongst relevant staff of MARAC process
  - identify the internal process for making MARAC referrals
  - identify a senior member of staff to champion domestic abuse and lead on implementation of DASH/CAADA

  LSAB to influence a review of MARAC membership to ensure that active membership is in place and that all member organisations are clear about their role and responsibilities. This may need to include the development of a role description

  LSAB to consider asking B&NES Council to review its position regarding the administration of MARAC.

  In the light of the significant resource implications for agencies to research and report information to MARAC, LSAB to promote appropriate action by Social Care and Health Commissioners to:-

- Identify resourcing of MARAC involvement by providers and their responsibilities.
- Consider how involvement from all health providers can best be co-ordinated and information collated on victims and perpetrators and how health services can be represented on MARAC

- **Recommendation 6:** That the LSAB requests that the MAPPA Strategic Management Board works with the LSAB to ensure MAPPA awareness-training takes place with relevant staff.

  That all relevant agencies:-

  - identify the internal process for making MAPPA referrals
  - identify a senior member of staff with responsibility for MAPPA referrals

- **Recommendation 7:** That the LSAB considers what additional engagement may be possible and effective with the CPS and HM Prison Service in order to raise awareness and implementation of Safeguarding Adults processes, whether this should be local or regional work and takes appropriate action.

- **Recommendation 8:** That the LSAB establishes a task and finish group to consider whether multi-agency agreement can be reached on a system for identifying the triggers within all agencies for repeat contacts from either adults at risk or perpetrators. This might include:-

  B&NES Council, Avon & Somerset Constabulary and B&NES CCG considering the development of a multi-agency soft intelligence system to bring together information on victims and perpetrators, if legally possible, within public protection safeguards.

  Considering the potential of the healthcare IT system ("System One") to improve information sharing between a number of agencies.

- **Recommendation 9:** That the LSAB establishes and monitors an implementation programme for B&NES Self Neglect Policy.

- **Recommendation 10:** That the LSAB receives a report back on the implementation of all agencies' own action plans in response to their IMR recommendations.

- **Recommendation 11:** That the LSAB invites B&NES Council, Sirona and AWP to review their current approach to the commissioning and provision of care packages with reference to current best practice – based around achieving service users' chosen outcomes combined with effective resource management.

- **Recommendation 12:** Consideration to be given by Health Commissioners to a specialist nursing service for older people within primary care who would support those outside of the receipt of statutory social services provision.

- **Recommendation 13:** That the LSAB identifies any specific points from this review that it thinks should be raised with national agencies.

5.36 The LSAB acknowledge the significant learning that has taken place as a result of this SCR and the enormous undertaking that each agency involved committed to. The report has been shared with the LSCB and the Responsible Authorities Group to ensure they are aware of the learning identified.

5.37 The LSAB had already started conversations about developing a trigger protocol and trying to improve intelligence. The SCR gave sharp focus to this need with several recommendations requiring progress in this area. In October the LSAB Chair invited Sirona Care and Health, Avon and Somerset Police, AWP, Children and Adult Care services for both South Gloucestershire and B&NES Council and the CCG to scope the commitment to the development of a multi-agency safeguarding hub (MASH). (South Gloucestershire Council was invited as the SCU team of the Police work across both areas). Following this meeting the Police convened a conference in January 2014 to move things forward. Further work continues to take place across the Force area and in B&NES to try and establish the benefits of developing an intelligence sharing hub. The Community Safety Partnership are working closely in partnership with the development as consideration is given to sharing intelligence on incidents of domestic abuse.

5.38 Other Work in Relation to Safeguarding Adults

- As reported in last year's Annual Report, B&NES Council Risk and Assurance Service audited the mechanisms of control the Council Safeguarding Adults and Quality Assurance team have in place for safeguarding adults; the auditor found the team to have excellent mechanisms in five areas and good mechanisms in one area. Three areas of weakness were identified and these have been addressed during 2013-14.

- The Council undertake the required Annual Social Care Survey as part of the requirement for the Department of Health in accordance with the ***NHS Outcomes Framework 12/13*** (DH Dec 2011). In 2013-14, 1126 people were surveyed 490 (43.5%) responded to the survey and the results are as follows:

ASCOF indicator	2011-12	2012-13	Provisional data 2013-14
Proportion of people who use services who feel safe	68.3	65.1	70
Proportion of people who use services who say that those services have made them feel safe and secure	75.2	78.5	80

Those respondents who have stated they do not feel safe are contacted to see if they need any additional help or review of their situation. An improving picture is being reported for 2013-14.

- B&NES Council, NHS Banes and CQC have continued to work closely meeting on a bi monthly basis to discuss inspection and review findings of regulated services and triangulate this with any information received from reviews, safeguarding alerts and complaints to the Council and Serious Untoward Incident reporting and complaints to NHS Banes and whistleblowing to each agency. The meetings prove useful and helped the early identification of concerns to help prevent abuse from occurring or potentially escalating.

- The links between safeguarding, community safety and the Council's wider preventative agenda has been strengthened still further this year. As well as

ensuring routine attendance by the LSAB at MARAC and MAPPA meetings, the Council's Head of Safeguarding Adults and Quality Assurance has played a key role in the Community Safety Partnership through attendance at the Responsible Authorities Group. There has also been significant impact on Community Safety Partnership working groups such as the Interpersonal Violence and Abuse Strategic Partnership (IVASP) and its sub-groups; the Partnership Against Hate Crime (PAHC); the MARAC Steering Group; the Door Step Crime Forum and the Prevent Steering Group.

- These effective relationships have allowed for a number of new projects to be progressed aimed at providing more integrated and effective services. These include:
    - Through Bath & North East Somerset's membership of the Public Service Transformation Network, partners have been brought together in a series of service redesign workshops to map the process of tackling domestic abuse, with a view to ensuring more focused services for victims. This work has built on the highly-regarded Domestic Abuse Problem profile which contained high-quality data relating to Safeguarding and Domestic Abuse (highlighted in last year's report). The outcomes of this material have been refined into a Draft Business Case which focuses on earlier intervention and better data sharing. This has formed the basis for an Expression of Interest to the Government's Transformation Challenge Award which has now been progressed to "full bid" stage. A workshop facilitated by the Health and Wellbeing Network in January 2014 helped raise the profile of domestic abuse further in B&NES. Safeguarding data from the Domestic Abuse Problem profile was included in this.
    - The Council in partnership with NHS Banes CCG and Avon and Somerset Police, have jointly funded a mapping exercise / gap analysis into the local understanding of domestic abuse services and MARAC. The results of this are intended to be shared with the RAG and LSAB in September 2014.
    - The delivery of the "IRIS" programme to create a clear referral pathway for domestic violence for GP surgeries. Initially IRIS has been jointly funded by the PCC and CCG for a period of 3 years. The IRIS approach is endorsed by the Royal College of Practitioners and by the Nice Guidelines on domestic abuse 2014.
    - Membership of the short life advisory group for the newly commissioned Sulis Project provided by Bristol Rape Crisis.
- MARAC sub-group of Interpersonal Violence and Abuse Strategic Partnership (IVASP) which in turn is a sub-group of the Responsible Authorities Group, runs quarterly multi-agency domestic abuse awareness training. Issues covered during 2013/14 include honour based violence and forced marriage. The next session will run in October 2014. As a result of the SCR the Council funded a stakeholder event in November 2013 to raise awareness of domestic abuse and MARAC, a presentation on safeguarding was included as part of this.
- Following concerns raised at Hate Crime Case Review panel about the number of hate crime incidents involving taxi drivers either as victims or perpetrators working with the B&NES Equalities and the Taxi Forum training was developed and delivered to the Forum members supported by a specifically produced leaflet. This work has also led to improved communication with the Trading Standards Team at the Council and a raised awareness of other powers that can support and enhance safeguarding work.

- Show Racism (and homophobia) the Red Card, the Partnership Against Hate Crime is now working with Bath City Football Club, Somerset FA and local schools to deliver this programme during the 2014/15 football season its remit will be extended to include homophobia.
- A strategic-level meeting has been established of Safeguarding Leads/Chairs, the Police and Crime Commissioner and the Strategic Director to ensure alignment of these approaches.
- In addition, a range of projects had been developed or expanded which link safeguarding to community safety and to our wider "Connecting Communities" agenda to strengthen communities. These include:
  - The maintenance of our IDVA service linking with the range of services provided by Southside Family project, including a family support service, and support for volunteers.
  - The launch of the Avon and Somerset wide Safe Places scheme took place in February this scheme is an endorsement of the approach taken in B&NES and builds on the local Safe Zones previously set up in Midsomer Norton, Radstock, Keynsham and Central Bath. These local Safe Zones have now been reviewed and rebranded as Safe Places. Safe Places marks an increased focus and greater partnership involvement by the police who since the launch been involved in recruiting Safe Places across Twerton, Odd Down and Snow Hill as well as across the wider Avon and Somerset area.
  - The expansion of the Village Agents project, now operating in 20 parishes. As well as home visits, Village Agent "Roadshows" are held at local village halls and have covered subjects such as falls prevention. The Village Agents scheme contributes significantly to our overall strategy of tackling loneliness and isolation, as does the establishment by AgeUK of a pilot hub based at the Stoke Inn, Chew Stoke. This will be used as the base for a "Finding the lost voice of older people' pilot project, funded by the Council's Community Empowerment Fund.
  - The Campaign to End Loneliness has awarded Bath & North East Somerset its "Gold" standard for our Joint Health and Wellbeing Strategy. The Health and Wellbeing Board has established a task-and-finish group to further progress the strategy and this will fully involve Safeguarding services.
  - Avon and Somerset Police launched the This is not an excuse website; this site offers advice and information to people experiencing domestic abuse. The Police invited the Force area to localise a poster campaign to raise awareness and promote the site, B&NES have done this and the Policy and Partnership team have widely circulated the posters. Below is an example of one of the posters.

    http://www.thisisnotanexcuse.org/

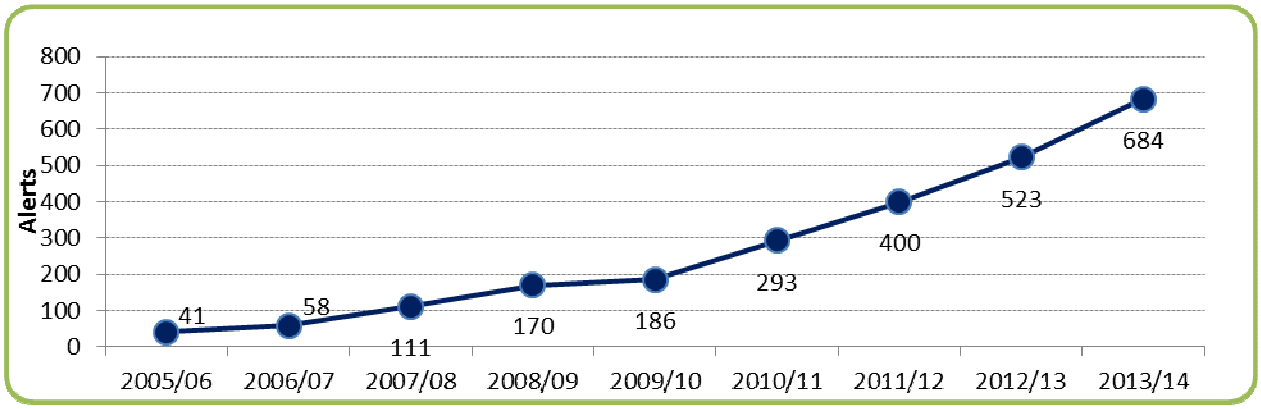
Section 6: Analysis of Safeguarding Case Activity 2013-14

6.1 In February 2014 the Health and Social Care Information Centre (HSCIC) published ***Abuse of Vulnerable Adults in England 2012-13: Final Report, Experimental Statistics*** (the report is available to the public as Experimental Statistics, which means the statistics are undergoing evaluation based on returns from all 152 Councils). This is the only benchmarking data available at present to help the LSAB compare its data and activity and is a year old. The HSCIC data for 2013-14 has not yet been released and is expected later in the year. It is important to note the following two points:

> '2012-13 is the last year for collection of the AVA return. Information about adult safeguarding activity will still be collected through a new Safeguarding Adults Return (SAR). The SAR is one of the outcomes of a review of adult social care data collections… An *alert* is the first contact between a person concerned about alleged abuse and the council safeguarding team. Following receipt of a concern, an evaluation is made to determine the risk of harm. Where significant risk is present, the concern is said to meet the *safeguarding threshold* and this triggers a full safeguarding investigation. For the purpose of the AVA return, this trigger and subsequent investigation are known as a *referral*.' (p5)

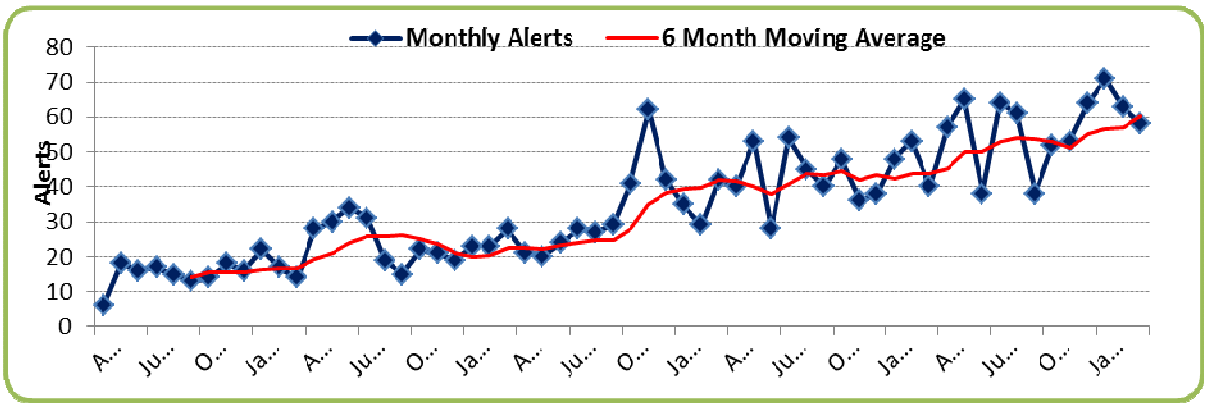
6.2 B&NES received 684 new alerts during 2013-14 and also supported 86 service users through the safeguarding procedure who had been referred during the previous year. At the end if the March 2014, 106 cases remained open and 664 had been closed. The increase in the number of alerts received from 2012-13 to 2013-14 was 31%, again the same as last year. Of the Councils that submitted data on the number of alerts to the Information Centre 78% recorded an increase in alerts during the period. (HSCIC 2014, p10) The Chart below shows the rise in alerts from 2005-14 for B&NES.

6.3 **Chart 1: Number of Safeguarding Alerts 2005-14**



6.4 The chart below shows the number of alerts from April 2009-14 by month. There was a significant drop in the number of alerts received in June and September 2013 compared to other months in the period. There was also a similar drop in June 2012, it remains unclear as to why this is the case.

6.5 **Chart 2: Monthly Safeguarding Alerts from April 2009 – 14**

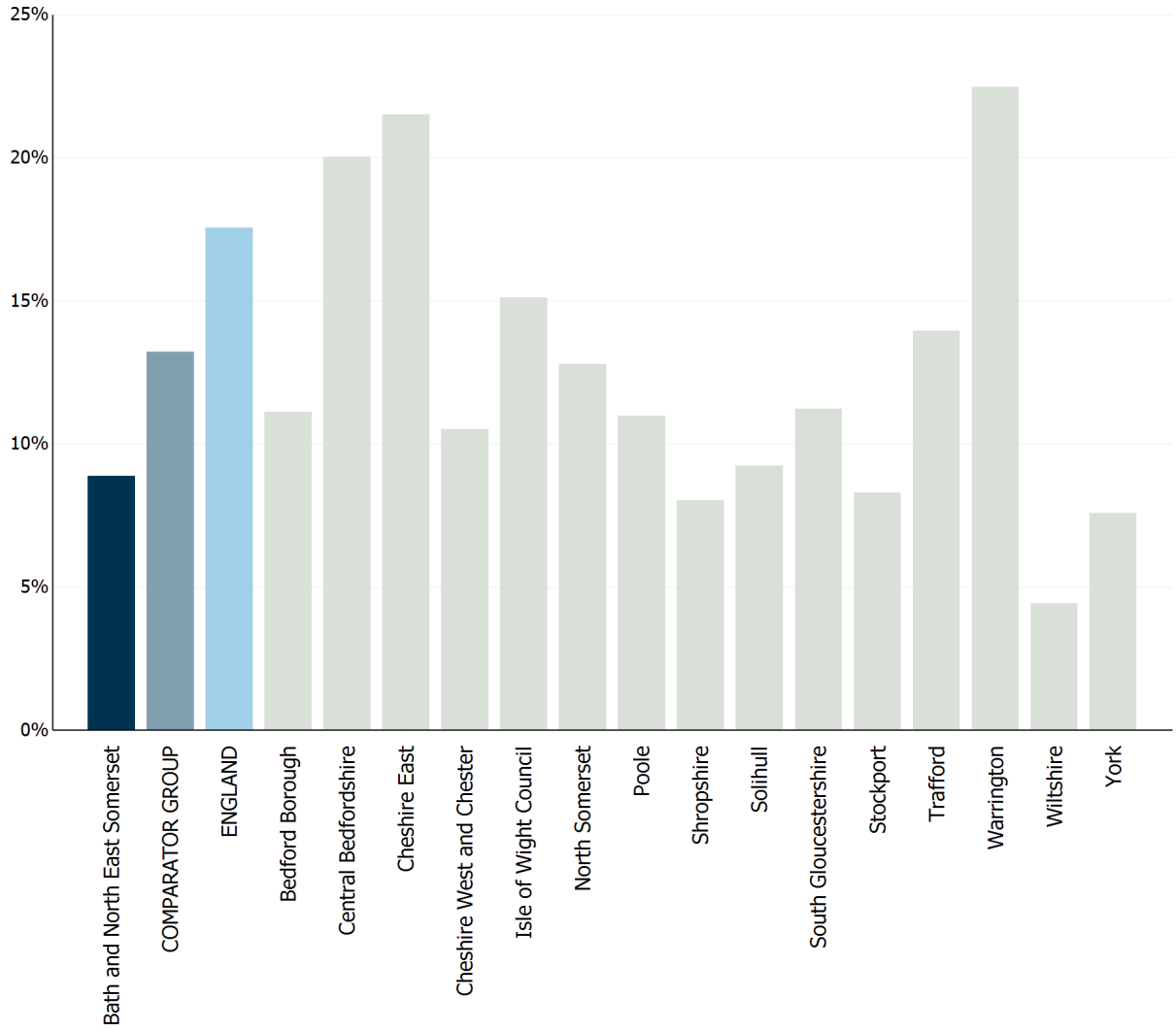


6.6 'For the 132 councils who provided information on both alerts and referrals, 50 per cent of the alerts reported met the safeguarding threshold and instigated a referral.' (HSCIC 2014, p13) In B&NES 57% met the threshold; Sirona Care and Health and B&NES Council have worked closely during the year to look at threshold decision making and ran two workshops which were attended by the majority of Team Managers and Assistant Team Manager; the staff were largely consistent in the threshold applied demonstrating a consistent approach is taken. Also the Council team audit all cases that do not reach the threshold and there has been a reduction in 2013-14 on the number of decisions challenged.

6.7 The NHSIC report a 2% increase in national referrals from last year (a reduction in the percentage increase) with 109, 000 new referrals accepted in England. When comparing B&NES data from 2012-13 there was a 20% increase in the number of referrals that progressed through the safeguarding procedure (2012-13 324 and 2013-14 389). Significantly higher than the national increase albeit a year earlier. The Council cannot explain this variation. The South West region however alongside Yorkshire and the Humber have the lowest number of referrals per 100,000 population in comparison to the rest of the country (HSCIC 2014, p2).

6.8 27 service users had more than one referral for safeguarding (alerts that met the threshold), these are known as repeats. Of these repeats; the majority of service users had two referrals, one service user had four referrals and three service users had three referrals. Sirona Care and Health and AWP analyse these cases annually to see if there are any trends. The reports are currently with the Commissioner to be discussed at the next performance meetings in September 2014.

6.9 Chart 3: Repeat Referrals as a Percentage of all Referrals – B&NES and Comparator Group



The above table is from the HSCIC ***Abuse of Vulnerable Adults Comparator Report 2012-13: Bath and North East Somerset,*** (February 2014, p9)

6.10 The chart demonstrates we bench mark in the middle of all our comparator group Councils for repeat referrals and below the England average during 2012-13 and this figure is not dissimilar to the 2013-14 figure.

6.11 There has been two large scale investigations completed during the period; both are closed and the providers complied with comprehensive action plans that were monitored through the Council's commissioning and contract leads and CQC when required. Large scale investigations involve a significant amount of work for all parties and increase the pressure on the safeguarding system. The Policy and Procedures sub-group have developed Large Scale Protocol. It was intended to be considered by the Board in 2013-14, however it required a considerable amount of consultation and was instead approved in June 2014. A lessons learned meeting took place for one of the large scale investigations and the findings were used to develop the protocol.

6.11 Table 3: below sets out the **Safeguarding Alert by Gender and Age**

No. of Alerts by Gender				**No. of Alerts by Age**					
				18-64			**65+**		
	11-12	12/13	**13/14**	11-12	12/13	**13/14**	11-12	12/13	**13/14**
Male	148 (37.2%)	192 (36.2%)	**263 (38.4)**	91 (22.9%)	107 (20.5%)	**126 (18.4%)**	57 (14.3%)	83 (15.9%)	**137 (20%)**
Female	250 (62.8%)	331 (63.1%)	**421 (61.5%)**	81 (20.4%)	123 (23.6%)	**137 (20%)**	169 (41.5%)	208 (39.9%)	**284 (41.5)**
Total	398	523	**684**	172 (43.2%)	230 (44.1%)	**263 (38.4%)**	226 (56.8%)	291 (55.9%)	**421 (61.5%)**

6.12 The age breakdown by gender is similar to previous years though there is a decrease this year on the number of younger (18-64 years) adults' referrals and an increase in 65+ age; this is more consistent with the national picture with 62% of referrals being for those 65+ years. The percentage of females to males has slightly reduced but replicates the national picture which shows the number of female referrals is 61% and the number of males is 39%. Although the above reports on alerts rather than referrals the figures as expected are broadly similar. (HSCIC 2014, p16)

6.13 For 2013-14 of the people that disclosed their ethnicity (8% either refused or didn't declare it) 3% were non White. This is a reduction from last year and further focussed work is needed to ensure all groups are reached. The HSCIC reported that 6% of all referrals were for vulnerable adults were from non White groups (p21).

6.14 Table 4 below shows the break down by service user group for 2011-12, 2012-13 and 2013-14. It shows that the proportion of alerts for each service user group has remained relatively consistent with last year, with adults with a physical disability receiving the most alerts and adults with a learning disability receiving more alerts than for adults with a mental illness. The national report also indicates that adults with a physical disability receive the most referrals at 51%; however nationally

adults with a mental illness receive the second highest number of referrals. (HSCIC 2014, p16)

6.15 Table 4: Number of Alerts by Service User Group 2011-14

Service User group	2011-12	2012-13	2013-14*
Physical disability	221 (55%)	289 (55%)	397 (60%)
Mental health	65 (16%)	96 (18%)	111 (17%)
Learning disability	90 (23%)	117 (23%)	124 (19%)
Substance misuse	4 (1%)	8 (0.2%)	5 (1%)
Vulnerable people	17 (4%)	11 (0.2%)	22 (3%)
Adult carer	3 (1%)	2 (0%)	5 (1%)
Total	**400**	**523**	**684**

* % are rounded to the nearest whole

6.16 Last year saw a 48% increase in the number of mental health alerts from the previous year; this year that increase has reduced to 16%. However percentage increase for people with a physical disability has increased by 6% on the last reporting period.

6.17 664 cases were terminated/closed during the period; a **20%** increase in cases.

6.18 56% of the referrals for safeguarding adults were for service users known to the Council. This is below the national the average of 66%. B&NES has a higher than average number of self funders who are not known to services.

6.19 Table 5: Percentage of Referrals by Abuse Types

Abuse Type	HSCIC National 2012-13	B&NES 2012-13	B&NES 2013-14
Physical	28%	33%	30%
Emotional	16%	18%	14%
Financial	18%	15%	19%
Neglect	27%	20%	28%
Sexual	5%	10%	7%
Institutional	4%	3%	1%
Discriminatory	1%	1%	0.5%

6.20 In comparison to national figures the percentage split of abuse type is broadly similar though locally neglect and acts of omission have increased for 2013-14 in comparison to 2012-13 and institutional abuse has reduced and is lower than the national percentage. This is thought to be as a result of increased awareness, large scale investigations that have been carried out and contract monitoring and governance.

6.21 The continued increase in neglect referrals is thought to be down to the impact of Winterbourne View, Ash House and the Mid Staffs with people being much more aware.

6.22 **Table 6:** below sets out the **Source of Alert** for B&NES for **2013-14** and compares this with the HSCIC data for 2012-13

Alert Source	HSCIC 2012-13	B&NES 2012-13	B&NES 2013-14
Social care staff (all)	44%	49%	51%
Health staff	22%	23%	21%
Family Member/ Friend/ Neighbour/ Self Referral	11%	9%	3%
Police	9%	4%	4%
Other (including housing, CQC, education)	14%	15%	21%
Total	**100%**	**100%**	**100%**

6.23 The table demonstrates a continued increase in social care staff referrals than the previous year and a slight decrease in health staff referrals; however they are broadly in line with the national picture for health.

6.24 **Table 7**: below sets out the **level of police involvement** in safeguarding adults cases:

Year	% of total cases Police involved in
2013-14	**38%**
2012-13	27%
2011-12	22%
2010-11	32%
2009-10	38%
2008-09	36%
2007-08	31%

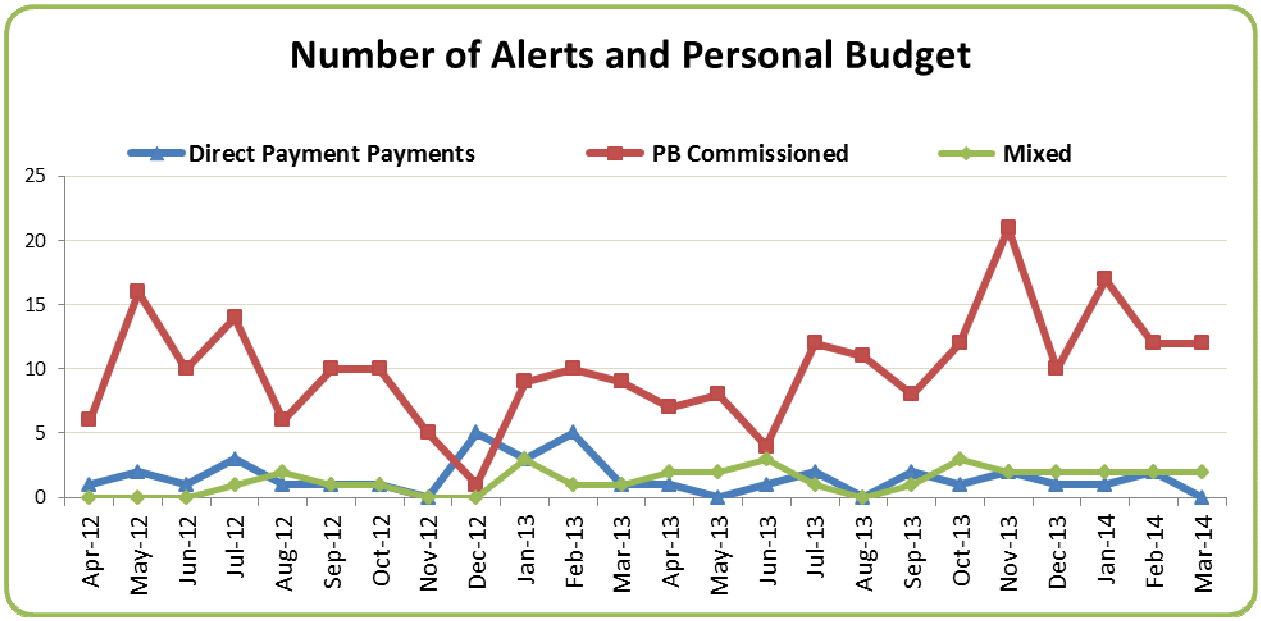
6.25 Avon and Somerset Police are reported to have been involved in 38% of cases that had completed the data field. However there were 345 cases where the field has not been completed. It is unlikely that the Police would be involved in cases that did not progress to Strategy – taking this into account it is possible that even with the blank fields they were involved in at least 34% of cases. The Police are certainly reporting an increase in activity in adult safeguarding. Sirona Care and Health and AWP ensure that all mandatory data fields are completed before a case is signed off. It is recommended that the LSAB, Council Commissioner and Avon and Somerset Police request that the recording of Police involvement become a mandatory reporting field to enable a clearer position to be established. Five cases are recorded as resulting in criminal prosecutions this is an increase from three last year and 15 have required other police action and one referral to MAPPA was made. During the year Sirona Care and Health, AWP, Avon and Somerset Police and B&NES Council have held a workshop afternoon looking at interface issues and learning about changes within their organisations. The workshops looked at lines of accountability and the evidence needed for the Crown Prosecution Service. The session was a success and is to be repeated on a six monthly basis.

6.26 B&NES saw an increase on last year on the number of alerts that are alleged to have taken place in the service user's own home 42%, this figure is more in line with previous years with the national statistic being 39% for 2012-13. The percentages of cases that are alleged to have taken place in care homes (residential and nursing both permanent and temporary placements included) is very similar 39% rather than 38% for last year. The national picture reports 36%. (HSCIC 2014, p38).

6.27 The majority of service users who live in the community and receive funding from the Council to access these services do this through a budget process (PB). There are three types of PBs: a PB Direct Payment, where the service user manages their own budget and 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.

6.28 The chart below sets out how many safeguarding alerts were received each month in relation to the type of community package the service user is in receipt of. Of these 22% (the same as 2011-12) are either a Direct Payment (14%) or a Mixed Package (8%).

6.29 Chart 4: Number of Alerts and Personal Budget



6.30 The number of people in receipt of a DP increases year on year. The chart above demonstrates that people who manage their own budget are not at increased risk of abuse, neither are those who have a mixed package. This is reassuring as during the implementation of PBs there was a concern that vulnerable adults would be more at risk particularly as there is no legal requirement for personal assistants to have CRB checks in place. That said a number of the cases involving personal assistants have been complicated to manage as the service user – a vulnerable adult has to engage the same employer investigation as other providers which they can sometimes find a challenge. Social care staffs from the Council, Sirona Care and Health and AWP support the service user in this role as much as possible. However, a safeguarding

investigation is easier to manage when the service user has sufficient insurance to cover a company's fees to support them in employee investigations and disciplinary procedures but some service users may choose not to take out this cover due to the cost implication. The Council, Sirona Care and Health and AWP would support service users who did not have the resource to do this themselves as an employer.

6.31 The relationship between the alleged perpetrator and the vulnerable adult is set out in the table below. The percentage split is different in many cases to those reported last year and to the HSCIC figures, with the exception of the other professional section, which is similar. Of note is the significant increase in other family members being the alleged perpetrator and strangers. The Quality Assurance, Audit and Performance Management group will review the relationship information for the first six months of 2014-15 to see if there is a change in the data for the forthcoming periods.

6.32 Table 8: Relationship between Alleged Perpetrator and Vulnerable Adult

Alleged Perpetrator	HSCIC 2012-13 (p40)	B&NES 2012-13	B&NES 2013-14
Other professional (incs: health and social care and other profs)	43%	34%	45%
Other family member	16%	14%	27%
Other	7%	10%	10%
Not known	12%	7%	
Partner	7%	11%	4%
Other vulnerable adult	12%	12%	10%
Neighbour/friend	6%	10%	3%
Stranger	2%	2%	10%

6.33 664 safeguarding alerts were terminated/closed during the reporting period. As reported earlier 41% of these were terminated at alert stage and did not meet the threshold for referral to safeguarding investigation. Of the cases that did progress the following outcomes were decided:

6.34 Table 9: HSCIC Average Outcomes 2012-13 Compared to B&NES 2012-13 and 2013-14

Outcome	HSCIC 2012-13	B&NES 2012-13	B&NES 2013-14
Substantiated	32%	33%	33%
Partly substantiated	11%	16%	17%
Not determined and inconclusive	27%	14%	14%
Not substantiated	30%	38%	32%
Investigation ceased at individuals request	N/A	N/A	4%

6.35 Sirona Care and Health, AWP and the Council staff took on board the request from the Health and Wellbeing Board several years ago to look carefully at the outcome of cases that met the criteria for not determined and inconclusive. The definitions from the HSCIC are below:

‘Not determined/inconclusive
If an investigation could not reach a conclusion as to whether the allegations are true or false on the balance of probabilities then the case should be recorded as Not Determined / Inconclusive. Referrals should also be recorded as Not Determined / Inconclusive where the investigation is stopped before it is fully completed. Example: If there is not enough reliable evidence to show whether the allegations are true or false then the referral should be recorded as Not Determined / Inconclusive. (2014, p93)

There is routine challenge from the commissioner about cases that fall into this category to ensure one of the others is not a better fit.

6.36 Staff are asked to compare the risk of harm to the person at the outset of safeguarding procedures and at the point it has been concluded. Although not all cases were rated, the following statistics represent the cases where it has been recorded:

- 74% cases were rated as the risk being reduced
- 13% of cases confirmed the risk was removed
- 13% of cases stated the risk remained.

The LSAB acknowledges that there will always be a number of vulnerable adults who have mental capacity about their care and treatment and who will make/take risky decisions. Agencies work closely with these service users to support them to minimise risks in the most effective way possible.

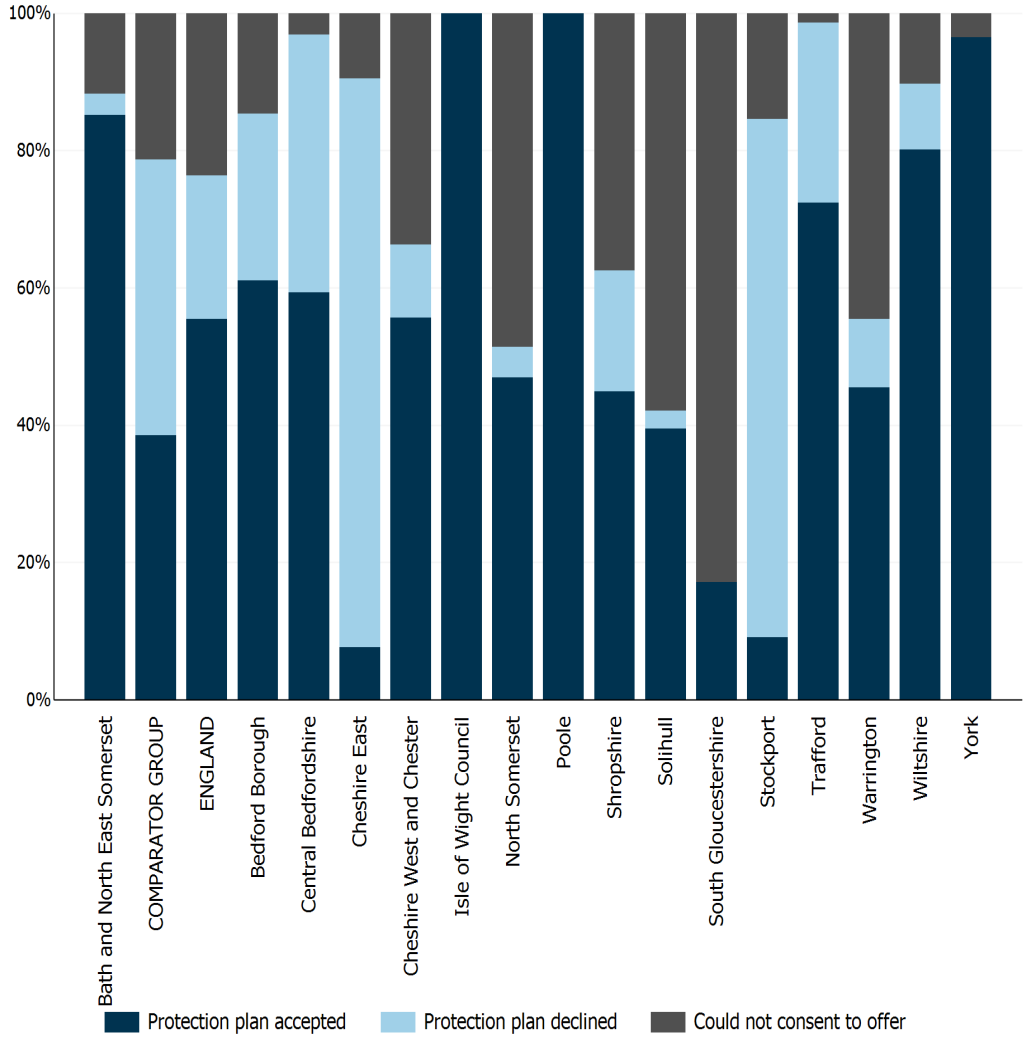
6.37 For cases where the alleged perpetrator was a professional worker, 25% were substantiated; where ‘other family members’ were identified as the alleged perpetrator, 21% were substantiated; where a neighbour / friend was the alleged abuser, 38% were substantiated. In cases where another vulnerable adult was the alleged abuser 5% were substantiated. National data available did not provide a comparator for this specific information.

6.38 The following outcomes have been recorded for victims: increased monitoring; no further action; referral for community care assessment and/or other social care and health services; referral to MARAC; civil action; removed from property; referral to court and so on. More than one action is sometimes undertaken for service users.

6.39 **Advocacy** support through specialist advocacy services was provided in 6% of cases during the procedure, an increase on last year’s figures. The **Independent Mental Capacity Act Service** supported 3% of the service users.

6.40 All service users that require a **Protection Plan** are offered one; the table below sets out the percentage of protection plans accepted and declined in B&NES in comparison to its statistical neighbours for 2012-13; the percentage of protection plans accepted in 2013-14 remains consistently high.

6.41 Chart 5: Protection Plans in Comparison to Comparator Group



6.42 The above data is from HSCIC (2014, p 18) ***Abuse of Vulnerable Adults Comparator Report 2012-13 Bath and North East Somerset***

6.43 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.

6.44 There can be more than one action recorded for the perpetrator. 'No action' was 39% of all actions taken for the perpetrators, the national figure is 35%; 20% of the actions were taken 'to continue to monitor the perpetrator and the situation,' this is the same as the national figure. 1% of cases resulted in criminal prosecution/formal cautions and a further 5% in police action; this is consistent with national data. Disciplinary action accounted for 4% of actions in B&NES; the national picture at 5%. B&NES figures are almost identical to national ones with the exception of the no further actions reported. HSCIC figures are reported on page p58.

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

6.46 Table 10: Outcome at Procedural Stage by Terminated Cases from Referral 2013-14

Termination Stage	Investig-ation Ceased at Persons Request	Not Determined / Inconclusive	Not Substan - tiated	Partly Substan -tiated	Substan -tiated	Total of all stages
Strategy	5	13	50	10	18	25% (96)
Assessment	2	4	13	1	13	9% (33)
Planning	5	18	36	31	54	38% (144)
Review	2	17	22	23	44	28% (108)
Total of all outcomes	4% (14)	14% (52)	32% (121)	17% (65)	34% (129)	

6.47 The teams are committed to trying to undertake more strategy discussions rather than strategy meetings. This is to reduce the pressure on all providers attending meetings – it does not mean the work is less robust; strategy discussion notes are taken and distributed in the same way as strategy meeting notes. More cases are progressing through to review stage before closure and anecdotal evidence from Sirona Care and Health, AWP and the Council would suggest cases are becoming more complex and so consequently longer term involvement is required to address presenting risks.

6.48 Compliance with safeguarding procedural timescales continues to be monitored on a monthly basis by the Commissioner. The LSAB, CCG 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 Health, AWP and the Council performance has improved from the previous year, this is despite no additional resource in the Sirona Care and Health and AWP social work teams. However of particular concern is 2b and % of strategy meetings held within eight days from the referral where 13 cases breached this timescale. Sirona Care and Health have looked into each of the 12 cases it is responsible for and have plans in place to try and prevent this occurring again; AWP are also aware of the reason for the breach on the one case they coordinated and the relevant team has considered why this occurred and is taking steps to try and ensure this does not happen in the future.

6.49 Table 11: Performance in Relation to Multi-Agency Procedural Timescales

Indicator	Target	% Completed on time from April 13 – Mar 14		RAG	Direction of travel from last year
1. % of decisions made in 48 working hours from the time of referral	95%	Sirona C&H	97% 544/559		↔
		AWP	95% 109/115		↑
		Combined	**97% 653/674**		↑
2a. % of strategy meetings/discussions held within 5 working days from date of referral	90%	Sirona C&H	87% 266/307		↓
		AWP	91% 75/82		↓
		Combined	**88% 341/389**		↓
2b. % of strategy meetings/discussions held with 8 working days from date of referral	100%	Sirona C&H	96% 295/307		↔
		AWP	99% 81/82		↔
		Combined	**97% 376/389**		↑
3. % of overall activities/ events to timescale	90%	Sirona C&H	87% 1212/1396		↑
		AWP	89% 302/339		↓
		Combined	**87% 1514/1735**		↓

6.50 Sirona Care and Health and AWP have been vigilant in working with the Commissioner to examine each breach. There is a lot of evidence from the breach reports to indicate 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. In over 90% of cases where Sirona Care and Health were identified as breaching a 'valid' reason was presented.

6.51 The new arrangement for Council staff chairing all AWP safeguarding cases in the same way it does for Sirona Care and Health came into effect from April 2013 – delivering a consistent approach across the sector. The Council lead implementing this change has worked very closely with AWP staff to ensure a smooth transition by meeting regularly to iron out initial teething problems and through setting up a new arrangement for inputting AWP safeguarding cases onto CareFirst (the client record system) to ensure all safeguarding alerts regardless as to whether they progress to referral stage are monitored.

Section 7: Partner Reports

7.1 LSAB partner organisations have provided information outlining the specific safeguarding adults activity they have undertaken in 2013-14 and their achievements on the LSAB indicators.

Agency Name: AGE UK (B&NES)

Brief outline of agency function:

Achievements during 2013-2014: (in bullet points)

- 4 safeguarding training sessions. 2 Held in February, 2 planned for November. Mandatory training for all staff and volunteers
- 6 cases identified during 2013 to present. All reported to Safeguarding BANES. 3 gone to safeguarding strategy meeting.

Performance to LSAB indicators 2013-2014:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	95%	Induction process/ Supervisions & probation process, regular reviews
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and CCG Commissioned members only)***	90%	100%	Now mandatory. All Staff, volunteers, bank staff to attend training. 4 Training sessions held twice a year for refresher training or new employees.
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(Non - LA and CCG Commissioned members only)***	80%	N/A	See above
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)***	80%		Not happening at present. To introduce in the coming year. Possibly elearning
Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP***	95%	N/A	

only)			
Relevant staff to have an up to date DBS checks ***(All)***	100%	100%	Yes
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**	Safeguarding lead for Organisation identified. Arranges training, record keeping, notifying Safeguarding Team.		

Describe how you raise awareness of safeguarding in your agency:

- Through regular Supervisions
- Set item on Team Meeting Agenda,
- Regular reviews, feedback and contact with Staff and Service Users.
- Regular monitoring of services with staff, Managers. Training sessions

Describe how you have supported service users and carers through the safeguarding adults procedure:

- Service users have been visited or phoned and regular updates given.
- Reassurance also given, and information passed to them on ongoing regular basis.
- Notifying SW team of any concerns.
- Staff are given reassurance and support at meetings.
- Procedures explained to them and every effort to support them through training, supervisions, meetings given.

Objectives for 2014-2015:

- Continue to raise awareness of Safeguarding and procedures.
- Continue with training.
- Keep raising the Profile with regards to Safeguarding
- To arrange for relevant staff to undertake the Mental Capacity Act training

Agency Name: Avon Fire and Rescue Service

Brief outline of agency function:
Our mission statement is to “improve public safety through preventing, protecting and responding”. Preventing and protecting is done through proactive education and interventions programmes. Our role has widen to include shaping communities rather than just managing the effects which is our response aspect.

Achievements during 2013-2014: (in bullet points)

- Introduced and consolidated safeguarding within the Service through e-learning and other training,
- Providing regular updates to the Combined Fire Authority.
- Now provided a number of alerts from crews.

Performance to LSAB indicators 2013-2014:

Indicator	**Target**	**Outturn**	**Comment**
New staff to undertake safeguarding learning as part of Induction within 3 months	95%	100%	All new staff as part of their

of starting employment ***(All)***			induction complete level 1.
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter	90%	95%	Although not LA/CCG we will re-visit training for relevant staff.
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)***	80%	N/A	
Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP only)***	95%	N/A	
Relevant staff to have an up to date DBS check ***(All)***	100%	100%	Currently under review.
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**			

Describe how you raise awareness of safeguarding in your agency:

- Training,
- Feedback to staff from alerts (but this requires strengthening),
- CFA papers
- Posters

Objectives for 2014-2015:

- Refresh the Service Policy E05 taking account of changes to legislation or local procedures.
- Introduce a risk assessment process as identified via audit.

Agency Name: Avon and Somerset Constabulary

Brief outline of agency function:

Public Protection, Safeguarding people and investigating and detecting crime through policing

Achievements during 2013-2014: (in bullet points)

During 2013/14 Avon and Somerset Constabulary made significant inroads into improving the operational and strategic response to dealing with incidents involving vulnerable adults, and the safeguarding of adults who are potentially vulnerable.

- 'Integrated Victim Care' is a joint project between the Constabulary and the Office of the Police and Crime Commissioner. The aim is to bring together all the key roles and organisations involved in providing services to victims, including crucial third sector partners, to create a more cohesive end-to-end approach. The new model will reduce complexity and duplication within our systems, and provide victims with a single-point of contact to ensure they are engaged and supported during their journey

The programme involves a number of detailed work packages, with complex interdependencies, and challenging timescales. The ultimate goal is t**o** place the voice of the victim at the heart of our service, through effective collaboration, cohesion and innovation amongst service providers that ensures victims feel engaged and supported.

Within our organisation, we want everyone to know and understand their role and responsibility for victim care and be able to identify vulnerability and recognise the part they play can impact on the victim's journey through the criminal justice system.

- In Feb 2014 we launched the Safe Places scheme across Avon and Somerset to help people feel safe and supported when they are out and about in the community. Locations such as local shops, cafes or libraries that are signed up to the scheme, provide a recognisable safe place for people to seek advice, reassurance and help.

  The scheme will help people get out and about in their community but with the reassurance that there is help available should they need to deal with difficult situations. This could be anything from getting lost, losing a mobile phone or feeling harassed or bullied.

Indicator	**Target**	**Outturn**	**Comment**
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%		Safeguarding Vulnerable Adults training is being developed for the force area. An input is given to student police officers during initial training and an e-learning awareness package has been produced which is aimed at all staff who may come into contact with SA issues
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and CCG Commissioned members only)***	90%		N/A
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)***	80%		N/A
Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care***	95%		N/A

Homes and Hospitals, Sirona and AWP only)			
Relevant staff to have an up to date DBS check ***(All)***	100%	100%	All staff are CRB checked prior to employment with the Constabulary
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**			Safeguarding Champions established across the force area - Front-line PCs and PCSOs who help and support the PPU to identify and protect vulnerable people

Describe how you raise awareness of safeguarding in your agency:

- An initial e-learning awareness package has been produced which is aimed at all staff who may come into contact with SA issues and further in-depth specialist training for PPU and other appropriate staff is in progress.
- A PPU monthly newsletter is published which includes national perspectives and 'lessons learned'.
- A Safeguarding Champions network of front-line staff has been established and these Champions are a specialist point of contact for all district staff and have regular inputs and contact with their local SCUs.
- The flagging of all 'vulnerable persons' premises highlights incidents and crimes within our recording systems and will enable us to develop processes around pattern identification and analysis and also inform response protocols
- A separate project has also been completed enabling any reported incident or crime with a vulnerable adult as a victim or suspect to be flagged. This ensures that SCUs undertake the correct referrals and interventions, as well as maintain an overview of the investigations

In addition to the above:

- In Conjunction with SARI we have developed 2 conferences entitled 'Policing for Disabled People' which will take place in September and November 2014. The purpose of the conference is to improve the awareness and confidence of police officers to recognise disability hate crime and advise on how they can be more effective when investigating it, as well as proving them with a general understanding and appreciation of issues impacting the lives of disabled people.

  The topics to be covered include:

- Autism & the Criminal Justice System
- Alzheimer's & Dementia
- Being A Wheelchair User – Impacts & Barriers & how Police can be accessible
- Mental Health
- Sensory Impairments
- Input from Disability Advisory Group (DIAG)
- Panel discussions with Service Users.

Objectives for 2014-2015:

- Moves to establish co-location of multi-agencies to provide a more holistic approach to all safeguarding issues are still underway and are at different stages across the force areas.
- A recent co-creation day was hosted by police where all agencies indicated that they are keen to progress this.
- Plans are being progressed to achieve better information and intelligence exchanges and access by partner agencies to police intelligence systems is being developed
- Improve and increase training opportunities for front-line staff in respect of dealing with vulnerable adults and safeguarding adult's issues. Initial training in the form of two autumn conferences (as detailed above) will aim to target as many officers as possible.

Agency Name: Avon & Wiltshire Mental Health Trust – B&NES Locality

Brief outline of agency function:
Providing primary and secondary mental health services within Bath and North East Somerset

Achievements during 2013-2014: (in bullet points)

- Good levels of training.
- Good inter-agency working and collaboration.
- Improved communications.

Performance to LSAB indicators 2013-2014:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%		We do not report specifically on new starters and their attendance at safeguarding training. However, new starters are either booked in for relevant training or advised to complete the eLearning as part of their induction programme. The safeguarding figures are at an all-time high thanks to a lot of work from the localities, in encouraging staff to attend training. Safeguarding 1 & 2 including prevent = 86% Level 3 = 92%
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and CCG Commissioned members only)***	90%	86%	
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)***	80%	89%	This figure includes DoLs training.
Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP only)***	95%		

Relevant staff to have an up to date DBS check ***(All)***	100%		There is a continuous DBS checking system in place. We check monthly those roles that need a DBS. DBS needs to be renewed every 3 years.
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**			A MARAC and a MAPPA representative have been identified for the locality we have also a Safeguarding lead for the locality.

Describe how you raise awareness of safeguarding in your agency:

- Through Governance meetings especially Risk and Safety locality meeting.
- Through Monthly team meetings
- Individual supervision

Objectives for 2014-2015:

- To ensure high levels of training and awareness.
- To participate fully in LSAB and priority sub-groups.
- To collaborate in potential development of MASH.

Agency Name: Carers Centre

Brief outline of agency function: Provide support to unpaid carers in Bath and North East Somerset to keep carers and their families safe and to improve their health and well-being.

Achievements during 2013-2014: (in bullet points)

- Sent safeguarding information to over 3000 carers in hard copy and e:versions
- Sent safeguarding to over 1000 new referrals in their welcome packs
- Safeguarding was considered in every support intervention with over 1500 carers
- New referral pathway set up with Chairs of safeguarding meetings to ensure carers are recognised as being in a safeguarding process and highlighted as being in crisis leading to intensive support.

Performance to LSAB indicators 2013-2014:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	100%	As part of induction documents
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and CCG Commissioned members only)***	90%	100%	Training is compulsory for all staff
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up	80%	NA	

post and/or completed refresher training every 2 years thereafter ***(Non - LA and CCG Commissioned members only)***			
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)***	80%	Not currently in place	Plans are in place to provide this training
Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP only)***	95%	NA	
Relevant staff to have an up to date DBS checks ***(All)***	100%	100%	Mapping process has been undertaken to ensure the Carers' Centre is using DBS checks in compliance with the law.
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**	The Chief Executive is the Safeguarding Champion and ensures safeguarding is a standing item in every supervision. All safeguarding issues get discussed with the Chief Executive and in her absence the Deputy Chief Executive.		

Describe how you raise awareness of safeguarding in your agency:
Safeguarding is regularly mentioned in E-bulletins and newsletters, leaflets are available at each office for carers and their families to collect. Every new carer has a leaflet included in their welcome pack.

Describe how you have supported service users and carers through the safeguarding adults procedure:
Alerts are made when there are safeguarding concerns, these are discussed with the Chief Executive and the safeguarding policy and procedure is followed. Alerts are discussed with carers and if relevant alerts are discussed with referring agencies. Occasionally the Carers' Centre provides low level advocacy at safeguarding meetings when required. A referral process has been set up with the Chairs of safeguarding meetings and these referrals are treated as Carers in Crisis enabling a more intensive service to be provided to carers who are referred.

Objectives for 2014-2015:
Monitor referrals from Chairs of safeguarding meetings and identify if improvements can be made to the referral processes.
Continue to raise awareness through publications
Raise awareness of safeguarding through a safeguarding week run in partnership with the old Avon area LSABs.

Agency Name: Curo

Brief outline of agency function: Provider of social housing for people in housing need; provider of support to older and younger people.

Achievements during 2013-2014: (in bullet points)

- 39 potential safeguarding cases referred to Local Authority in 2013/14
- Supporting People assessment within B&NES scored the Retirement Living Service an 'A' grade with the evidence provided in the 'Safeguarding and protection from abuse' section of the Quality Assessment Framework.

Performance to LSAB indicators 2013-2014:			
Indicator	**Target**	**Outturn**	**Comment**
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	100%	Within first month of joining all staff as part of induction are given safeguarding learning
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and CCG Commissioned members only)***	90%	98%	All staff are given review training every two years. The 98% figure represents the fact that 1 member of staff is on long term absence so has not been available to complete this refresher training when due.
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)***	80%	N/A	N/A for Curo
Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP only)***	95%	N/A	Not applicable as no care home management
Relevant staff to have an up to date DBS check ***(All)***	100%	100%	All staff are DBS checked prior to engagement and take up of role and then every 2 years via HR
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**			Safeguarding champion identified for Retirement Living; one Team leader takes the lead and is the named contact for the local authority to contact.
Describe how you raise awareness of safeguarding in your agency: Safeguarding is covered at induction by managers with all new staff. Each person is given an overview of the safeguarding procedure, insight and access to the safeguarding policy and familiarised with the reporting procedure and forms to			

complete to refer cases to the Local Authority adult duty team.
Safeguarding training is also delivered to all staff members within their first three months of joining.
A central log is maintained of all cases which is updated and monitored by dedicated staff.
Safeguarding is a standard agenda item at all team meetings for staff and managers alike to discuss cases or potential issues if the team are unsure of what action to take.

Objectives for 2014-2015:

- All front line staff to be trained in Domestic Abuse training – a bespoke one day training course developed by Curo's Head of Tenancy Solutions in partnership with Southside.
  Colleagues participate in real time scenarios acted out by professional actors in a Curo property.

Agency Name: FREEWAYS

Brief outline of agency function:
We are a voluntary organisation working across the old Avon area. We provide residential care and floating support for housing related and/or social care needs to adults with learning disabilities, physical and sensory impairments to lead independent and active lives.. We also support volunteering and employment opportunities as well as providing domiciliary care and hydrotherapy

Achievements during 2013-2014: (in bullet points)

- All floating support team have attended B&NES Council Safeguarding Alerters training.
- Continued to keep MCA/ DOLS/ Safeguarding as a relevant topic in team meetings / Supervisions etc.
- All staff have had annual updates in safeguarding, MCA and DOLS (where applicable) training, both in house and by external agencies.
- All new staff have received MCA and DOL's training within 6 months of taking up their post as part of their induction process.
- Floating support service has 2 x Safeguarding Champions. Encouraged to bring new news to team meetings
- All services have a good reputation within B&NES for raising safeguarding issues. Which has in turn prevented financial abuse occurring
- Ran 2 courses for service users around abuse awareness

Performance to LSAB indicators 2013-2014:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	100%	
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and CCG Commissioned members only)***	90%	90%	We provide annual refresher internally
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)***	80%	100%	Provided internally as well as accessing Council training

Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP only)***	95%	100%	Provided internally as well as accessing Council training
Relevant staff to have an up to date DBS check ***(All)***	100%	100%	
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**		2 in place in floating support	2 to be prioritised in residential service

Describe how you raise awareness of safeguarding in your agency:
Ongoing continuous professional development: Annual training (various methods-team training sessions, supervision discussions, staff meetings, coaching, reflection sheet on safeguarding concern form. Attendance on forums and updates disseminated through the organisation.
Accredited qualification pathway: Diplomas levels 3-5.
Occasion/incident reports and the follow up actions.
Annual complaints audit.
Annual safeguarding audit; recording the number of safeguarding referrals made by each service.
Bi-monthly visit/report by senior managers; discuss safeguarding issues.
Discussed with service users using our accessible policy, training and resident meetings

Objectives for 2014-2015:

- Get relevant training completed for staff member who has returned from Maternity leave.
- Maintain yearly refresher training for all staff in safeguarding, MCA and DOLS
- Keep abreast of relevant external training to supplement internal training
- Continue to raise Safeguarding / DOLS/ Mental Capacity within team meetings and supervisions.
- Continue to encourage staff to participate in Safeguarding
- Support service users to report concerns themselves to safeguarding
- Run a specific training course for service users in B&NES on abuse awareness
- Safeguarding champions to be selected and recognised in residential service and link to existing selected dignity champions.

Agency Name: NHS B&NES Clinical Commissioning Group

Brief outline of agency function:
NHS B&NES CCG commissions and performance manages NHS funded care.

The Director of Nursing and Quality in NHS B&NES is executive lead for Safeguarding and attends the Local Safeguarding Adults Board meetings. The Quality & Adult Safeguarding Lead now chairs the Quality and Assurance sub-group; sits on the Policy & procedures and MCA & DOLS groups and will attend future board meetings.

Achievements during 2013-2014: (in bullet points)

- Care Home forum which supports the delivery of clinically effective, safe and evidence based care. A one day meeting was held in October and a second day is planned for September.

- The CCG supported the Local Authority with their care home review programme and undertook a series of joint visits.
- A pressure ulcer thematic review was completed in October 2013 in collaboration with RUH and Sirona. The results demonstrated key themes associated with the development of pressure ulcers and will be used to inform further cross-boundary prevention work.
- Work with Care Homes to encourage investigations of pressure ulcers
- Joint working with B&NES Council Safeguarding Team to ensure concerns relating to NHS providers are managed in a responsive and efficient manner.
- Development of a provider dashboard which is a monitoring tool that allows an over-view of concerns relating to quality and safety. It includes areas such as CQC, Safeguarding, and Serious Incidents etc.
- The CCG has been working with Providers to ensure they all recruit named Prevent leads.
- Prevent has been added to all Provider contracts and a pack containing literature and guidance has been distributed to all larger providers.
- Member of working group to develop training indicators for Prevent – theses have now been adopted nationally
- Development and delivery of a programme of supervisory visits for provider safeguarding leads
- NHS England guidance on Adult Safeguarding and Profound and Multiple Learning Disabilities was been distributed to primary care and providers.
- The Standard Adult Safeguarding schedule was comprehensively reviewed and now includes 6 standards, an annual audit return and 7 Key Performance Indicators (KPI's). Following negotiation with providers, these were included within 2014/5 contracts.
- Collaboration between CCG Children's and Adults Designated and Named Leads Development of CCG intranet & internet safeguarding resources
- All 27 GP practices in B&NES were sent a letter of introduction when the Adult Safeguarding Lead took up post in April 2013 and by the GP Adult Safeguarding lead who took up post in November 2013.
- Whilst the Primary Care training programme was in development, GP's were encouraged to access e-learning training to ensure they were able to identify and safeguard adults at risk.
- A questionnaire was created and distributed to all GP practices to explore the engagement of practices with adult and child safeguarding investigations and identify barriers to participation. Learning from this survey is being used to inform CCG training and strategy.
- An update including learning from the Tinker's Lane and B&NES 2013 SCR's was sent to Practices; these were also presented at the GP forum in February.
- An Adult Safeguarding training session was delivered to the CCG Board in 2013
- A training session to GP's and Nurse Practitioners at the Walk in Centre was given in February 2014.
- Active contribution to the LSAB and its sub-groups
- The review of Serious Incident reports and working with providers to improve practice based on 'lessons learnt'
- Attendance at bi-monthly CQC Cause for concern meetings. This is an opportunity to share intelligence and raise flags on services which cause concern.
- Review of Serious Case Reviews, both local and national.

- Attendance at bi-monthly meetings with BANES Council Safeguarding Team
- Attendance at the NHS England quarterly regional Adult Safeguarding forum
- Membership and attendance at the South West regional Adult Safeguarding network
- Following a recommendation from the 2013 SCR, the CCG has supported the recruitment of a Health Visitor for the Elderly who is now in post
- Winterbourne View: The CCG worked to ensure an effective commissioning process was in place for services for people with LD. There was also engagement with Public Health to ensure the JSNA appropriately identified the needs of the whole population and that these needs were incorporated into the commission strategy. Separate, more detailed reports are made to the CCG Board and Quality Committee.

Performance to LSAB indicators 2013-2014:

Indicator	**Target**	**Outturn**	**Comment**
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%		A process is now in place for 2014/15
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and CCG Commissioned members only)***	90%	54%	This figure is not accurate due to an IT problem with Skills for Health – they are currently addressing this
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)***	80%		
Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP only)***	95%		
Relevant staff to have an up to date DBS check ***(All)***	100%	92%	Improved process in place since Apr. 2014
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**		The CCG has an Adult Safeguarding Lead	

Describe how you raise awareness of safeguarding in your agency:

- Ensure appropriate safeguarding performance indicators are included within commissioning for health contracts
- Working jointly with the Local Authority to support safeguarding activity relating to healthcare

Objectives for 2014-2015:

- The challenges for safeguarding over the coming year is to continue to develop, expand and embed safeguarding practice within the core work of the CCG; and to further develop partnership working with the local authority, local health providers, the CQC and NHS England.

- *Alignment of Safeguarding and Serious Incident investigations:* The CCG and Local Authority safeguarding team are working to align the two processes so that duplication of effort is avoided and to enable timescales to be met and learning recorded/shared a.
- *Health-related adult safeguarding risks:* The LA & the CCG plan to develop a matrix that identifies the high risk areas which will allow for action to be taken to address the risks with providers.
- *Health-related adult safeguarding actions*: Develop a process for monitoring safeguarding actions when these relate to health commissioned services.
- *Support clinical teams to improve practice:* The LA & the CCG will develop a matrix to map out safeguarding referrals in order to allow identification of teams/areas with high numbers of safeguarding concerns. These teams will then be supported/encouraged to improve the quality of their practice.
- *CCG Adult Safeguarding action plan:* This was developed following completion of an LSAB self-assessment in 2013. The action plan is comprehensive and addresses areas where improvement is required by the CCG to enable it to fully meet its Adult Safeguarding obligations.
- *Clinical Supervision policy:* This will be developed in collaboration with the Designated Nurse for Children, alongside a programme of supervisory visits for provider safeguarding leads.
- *Adult Safeguarding Forum:* Scope the possibility of establishing a group to support primary care and providers to improve their skills, knowledge and practice in relation to adult safeguarding.
- *Pressure Ulcers:* Continue the community-wide pressure ulcer prevention work that was commenced in 2013.

NHS England

NHS England is an executive non-departmental public body. It works under its Mandate from the Government to improve the quality of NHS care and health outcomes, reduce health inequalities, empower patients and the public and promote innovation. Its key responsibilities include:

- Authorisation and oversight of CCGs and support for their on-going development
- The direct commissioning of primary care, specialised health services, prison healthcare and some public health services (including, for a transitional period, health visiting and family nurse partnerships)
- Developing and sustaining effective partnerships across the health and care system.

NHS England has a single operating model and is largely organised into three functional areas, i.e. nationally, regionally and locally. Its Safeguarding Policy is due for publication July 2014 and will provide guidance of the expectation of its entire staff in relation to Safeguarding. There is senior clinical leadership at all levels, including those with responsibility and expertise in safeguarding. The NHS England Local Area Team will each have a Director of Nursing who is responsible for supporting and providing assurance on the safeguarding of children and adults at risk of abuse or neglect. The Area Team have the responsibility to ensure the assurance of the safeguarding system is working across Primary Care and CCGs.

For 2014/15, NHS England Bath, Gloucestershire Swindon & Wiltshire Area Team will be focusing on gaining assurance on safeguarding competences across all staff groups with in Primary Care, ensuring information and resources are available for staff to achieve the

appropriate level of competence for their role. A system for providing salient Safeguarding updates across Primary Care and embedding lessons learnt in practice across the whole range of vulnerable adult groups will be implemented.
In November 2013, NHS England was required to give evidence at the House of Lords inquiry into the implementation of the Mental Capacity Act 2005(MCA). Whilst gathering evidence for the inquiry, NHS England found a number of emerging themes relating to inconsistent application of the Act including training, patient/family and carer experience and access to advocacy. The findings of this inquiry have been published http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm
In anticipation of this report NHS England BGSW Area Team submitted a bid for a MCA/DoLS (Deprivation of Liberty) project was approved and implemented.

The outcomes we are aiming for are:
- To arrange patient/carer experience events to ascertain real time feedback;
- To identify with CCG colleagues, provider organisations and local authority partners specific local requirements and consider short term secondments/pump prime initiatives; and
- To establish a development programme for MCA leaders across the system to understand their local issues and explore best practice.

The project started in April 2014 and will be reporting findings in September 2014. Following the report the Area Team will develop and implement an action plan based on the findings.

Agency Name: Royal National Hospital for Rheumatic Diseases (RNHRD)

Brief outline of agency function:
Founded in 1738 the Royal National Hospital for Rheumatic Diseases (RNHRD), also known as 'The Min' a reference to its original name 'The Mineral Water Hospital', is a specialist hospital in central Bath with an international reputation for research, and expertise in specialist rehabilitation for complex long-term conditions. The core services the hospital provides are in rheumatology, pain management, Chronic Fatigue Syndrome/ME (CFS/ME). The Trust has a small but internationally known Clinical Measurement department with access to advanced equipment and technology, and a diagnostic endoscopy service.

Achievements during 2013-2014: (in bullet points)
Objectives set for 2013-2014:
1. Achieve compliance in the training targets for safe guarding: see below-training compliance improved during 2013-14.
2. Review training guidelines for all safeguarding across all professional groups-completed with Learning and development team.
3. Increase reporting of all safeguarding discussions/concerns-completed with setting standards for putting all safeguarding concerns on to the hospital data base. Monthly reports set up.
4. Develop Q&A sessions for staff with CCG safeguarding representatives
5. Organise an awareness week in Oct 2013-completed, information in the main reception area for 'Elderly abuse'.
6. Review and update the policy on Safeguarding adults-completed-both safeguarding adults, and safeguarding children policies reviewed in 2013-14. A new policy for MCA created in 2014 (supporting safeguarding adults' policy section on MCA).

Performance to LSAB indicators 2013-2014:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding	95%	99.5%	Trust policy states

learning as part of Induction within 3 months of starting employment ***(All)***			that all staff should attend induction prior to commencing work
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and CCG Commissioned members only)***	90%	95.5%	Specific focus on increasing training compliance in 2013-14, with extra sessions, monthly reports, managers' support, working with learning and development team and generally awareness among staff.
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)***	80%	95.5%	As above
Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP only)***	95%	95.5%	As above
Relevant staff to have an up to date DBS check ***(All)***	100%	94%	Due to service needs 6% staffs commenced while the DBs in progress. A risk assessment was completed on 6%, worked with supervision and completed DBs received.
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**		100% in all clinical areas	Improved structure for safeguarding link person in clinical areas with link person for both children and adult safeguarding groups.

Describe how you raise awareness of safeguarding in your agency:

- Improved structure for safeguarding link person in clinical areas with link person for both children and adult safeguarding groups.
- Committee meeting held every 2 months and managers from all areas attend
- Information sent out to the link staff from the leads
- Link person discusses new information within their team at meetings, notice boards or to individual staff members.
- Improved training structure
- Poster presentation on awareness weeks.

- Gap analysis on new NICE guidelines and national guidelines, and action plans implemented.
- Appropriate external training /study days attended by specific staff across the Trust. Information shared to committee members, link persons.
- Information communicated from individuals, specialist teams and learning from clinical cases to leads and committee members for safeguarding.
- Supervision sessions for all clinical staff.

Objectives for 2014-2015:

Recommendations for 2014-15

- Review training requirements by specific roles within each team
- Review quarter and annual report structure in line with new requirements
- Ensure the Supervision structure is embed for the ward nursing
- Annual audit plan-priority for completion of the supervision audit, and need for case note reviews
- Devise Datix guidelines for Safeguarding incidents
- Identify National Safeguarding Awareness days/weeks appropriate to the Trust
- Review committee meeting structure to include more time for lessons learnt
- Review alert systems for clinical notes, such as new log sheets for safeguarding concerns: look at Notes from RUH, AWP, Sirona
- Involvement in external training to demonstrate our expertise
- Achieve the Trust targets for Dementia, Prevent and MCA / DoLS
- Completion of Dementia action plan for the Trust

Agency Name: Royal United Hospital

Brief outline of agency function:
The Royal United Hospital Bath NHS Trust provides acute treatment and care for a catchment population of around 500,000 people in Bath, and the surrounding towns and villages in North East Somerset and Western Wiltshire.

The Trust provides 565 beds and a comprehensive range of acute services including medicine and surgery, services for women and children, accident and emergency services, and diagnostic and clinical support services

Achievements during 2013-2014: (in bullet points)
The RUH is constantly working to improve the adult safeguarding service that it delivers.

- The RUH continues to play a key role within the multi-agency framework, with representatives at the LSAB and all of its sub-groups, covering Training and Development, Quality Assurance, Policy and Procedures and Awareness, Engagement and Communications.
- Development of links with the RUH's newly appointed Named Nurse for Child Protection.
- Recruitment of a Senior Nurse for Adult Safeguarding who took up post in September 2013, and a team administrator who commenced employment in December 2013.
- The Trust has continued to seek to improve its delivery of safeguarding in practice, with revision of the policy and guidance to staff and a change of

referral process.

- Awareness of adult abuse and protection continues to increase across the organisation.
- Figures for staff with safeguarding training were significantly improved over last year's figures
- Successfully run "Deprivation of Liberty Safeguards" (DoLS) workshops for senior staff.
- Following CQC inspection in December 2013, the RUH is compliant with outcome 7.
- Successfully aligned the Serious Incident and Datix incident reporting systems with the safeguarding process.

Performance to LSAB indicators 2013-2014:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	Level 1 83.5% Level 2 72.6%	
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and CCG Commissioned members only)***	90%	72.6%	
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(Non - LA and CCG Commissioned members only)***	80%	N/A	
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)***	80%	72.6%	
Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP only)***	95%	72.6%	
Relevant staff to have an up to date CRB/DBS check ***(All)***	100%	100%	100% of new staff that have started employment within the organisation have been CRB/DBS checked & 100% of relevant employment rechecks have been completed.
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for**	We do not have safeguarding champions across the organisation. There are		

champions in your agency if not in each team in comments	Operational Safeguarding Leads who are senior nurses who work across the Trust, promoting, training and supporting staff within the safeguarding arena, and representing the Trust where required.

Describe how you raise awareness of safeguarding in your agency:

- Adult Safeguarding Policy
- Trust intranet web pages for DoLS, MCA and Safeguarding Adults.
- Adult safeguarding on Trust internet for public to access
- Safeguarding Adults, DoLS, MCA leaflets.
- BANES Abuse posters are displayed in outpatient and inpatient areas, PALS and in the corridors
- Awareness raising through training, induction, refresher and ad hoc training.
- Governor Induction
- Working with partnership agencies

Objectives for 2014-2015:

- Continue to raise awareness
- Continue to improve on training targets
- To continue to contribute to the work of the LSAB and its sub-groups
- Develop Adult Safeguarding quality dashboard
- Development of the Matrons role within the safeguarding arena
- To launch and monitor implementation of Deprivation of Liberty Safeguards in line with the new guidance following the Cheshire West judgment.

Agency Name: Sirona Care and Health

Brief outline of agency function:

Sirona Care and Health provides a wide range of services covering community health, adult social care and some children's services. It also employs social workers who undertake the majority of Safeguarding Adults investigations.

Achievements during 2013-2014: (in bullet points)

- A total of 567 alerts (Sirona cases) were received and investigated - an increase of 28% over last year. An additional 102 alerts were received on behalf of AWP (grand total of 669 cases)
- A very complex 'whole service' investigation was carried out, which included a large series of individual investigations
- An Action Plan was completed and implemented as a result of the Serious Case Review undertaken in 2012
- Workshops were held with commissioner colleagues to ensure greater consistency over thresholds
- Training was organised for all social workers and CSCs around domestic violence and safeguarding
- Sirona continued to play a key role within the multi-agency framework, with representatives playing an important part in the work of the LSAB and all of its sub groups, covering Training and Development, Quality Assurance, Policy and Procedures and Awareness, Engagement and Communications
- Feedback received from service users (through the Making Safeguarding Personal pilot and previous system) was largely positive and outcomes from Safeguarding cases were mainly good
- Initial planning was undertaken to reorganise the social care teams with the aim (in part) of making the service more responsive and consistent in its response to Safeguarding alerts.

Performance to LSAB indicators 2013-2014:			
Indicator	**Target**	**Outturn**	**Comment**
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	71%	
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and CCG Commissioned members only)***	90%	66%	Further work is needed to ensure that these figures are accurate.
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)***	80%	41%	Further work is needed to ensure that these figures are accurate.
Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP only)***	95%	88.4%	
Relevant staff to have an up to date DBS check ***(All)***	100%	100%	
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**		Champions meet quarterly with Maggie Hall, Safeguarding Adults Co-ordinator	We have a large number of Champions across the organisation. While this does not equate to a Champion in every team, it is a widely representative group.

Describe how you raise awareness of safeguarding in your agency:

- It is expected that Safeguarding issues are raised at all team meetings and in the course of all supervision sessions involving front-line staff
- Safeguarding Adults issues are routinely reported on at Quality Committee and at Board level
- Safeguarding training (Level 2) is mandatory for all front-line staff and Safeguarding Adults input has been more closely aligned with Safeguarding Children training in the induction programme
- A new one-day course on undertaking investigations with the police was rolled out, plus courses on Safeguarding Adults and Domestic Violence
- Good links are in place between the Complaints process, the Adverse Event reporting system and Safeguarding
- Our Safeguarding Adults Co-ordinator provides advice and support to staff and attends MARAC meetings etc
- Our Professional Lead for Social Work monitors outcomes and co-ordinates issues relating to performance and training; also attends MAPPA meetings

Objectives for 2014-2015:

The key workstreams planned for 2014/15 are:

- To reorganise the social care teams with the aim of making the service more

responsive and consistent in its response to Safeguarding alerts (new dedicated ASIST team to go live on 1st July)

- To complete work on our updated Safeguarding Adults policies and procedures in line with the new, revised multi-agency policies and procedures, and to re-launch them early in the financial year
- To review the approach to delivery of Safeguarding training, redoubling our efforts to ensure that all front-line staff are up-to-date with the appropriate level of mandatory Safeguarding Adults training
- To continue to contribute fully to the work of the LSAB and its sub groups
- To continue to contribute fully to the work of MAPPA and MARAC within B&NES
- To continue a dialogue with B&NES Council colleagues around reaching consensus on 'risk' and 'thresholds'
- Continually improve our practice based on 'lessons learnt' from the recent SCR and other cases
- 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
- To continue to support and develop the Safeguarding Champions Group
- To organise a number of evening Safeguarding training sessions for B&NES GPs
- To raise staff awareness through a Stop Adult Abuse Week (June 2014)

Section 8: Priorities for the Coming Year 2014-15

8.1 The LSAB is in the final year of the three year business plan 2012-15. Progresses on the actions within the plan have been monitored through –out the year and new actions included when identified by the sub-groups or Board itself.

8.2 The business plan follows the template recommended by ADASS South West region. It 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 4.

Author:

Lesley Hutchinson
Head of Safeguarding Adults, Assurance and Personalisation
B&NES Council
Health and Wellbeing Partnership
June 2014

The content of the report are approved by the LSAB. The report is accessible formats on request to B&NES Council. Telephone (01225) 477000 and ask for the Safeguarding Adults and Quality Assurance team who will be able to help with this.

Appendix 1

LOCAL SAFEGUARDING ADULTS BOARD
Membership as at March 2014

NAME	ORGANISATION
Cllr ALLEN Simon	Cabinet Member for Wellbeing B&NES Council
BLANCHARD Helen *Mary Lewis = sub*	Director of Nursing Royal United Hospital, NHS Trust
BRUCE-JONES Bill *Liz Richards (= sub)*	Clinical Director Avon & Wilts Mental Health NHS Trust *Manager (B&NES), AWP MH Trust*
CLARKE Dawn	Director of Nursing & Quality (Designate) NHS B&NES CCG
COWEN Robin	Independent Chair B&NES LSAB
DABBS Janet	Rep for Provider Forum Age UK, Bath & North East Somerset
DAY Kevin	Senior Probation Officer Avon & Somerset Wiltshire Probation Service
DIXON Mick	Head of Risk Reduction and Operational Training Avon Fire & Rescue
ELLIOT, Kevin	Patient Experience Manager Area Team: Bath, Gloucestershire, Swindon & Wiltshire NHS England
EVANS Julie	Director of Customer Services (Housing & Support), CURO Housing Group
HOWARD Damaris	Director, Regulated Services Freeways
HUTCHINSON Lesley	Head of Safeguarding Adults, Assurance & Personalisation B&NES Council
HUTCHISON Sonia	Chief Executive Officer Carers Centre (B&NES)
JANSON Val	Assistant Director of Performance and Quality (Commissioning) NHS B&NES CCG
LEACH Louise (Dr)	GP responsible for Safeguarding NHS B&NES CCG
LEWIS Mary	Associate Director of Nursing, Quality and Patient Safety Royal United Hospital NHS Trust
McDONALD Rayna	Director of Operations & Clinical Practice Royal National Hospital for Rheumatic Diseases
MANN Kirstie	Manager Your Say Advocacy
ROWSE Janet	Chief Executive Sirona Care and Health
SHAYLER Jane	Deputy Director - Adult Care, Health & Housing Strategy and Commissioning, B&NES Council
THEED Jenny	Director of Operations Sirona Care & Health

TOZER Clare	Personal Assistant to Lesley Hutchinson Administrator/Notetaker for B&NES LSAB
TRETHEWEY David	Divisional Director Policy & Partnerships B&NES Council
WILLIAMS Rachel *DCI Simon Crisp = sub*	Acting Det Superintendent PPU Avon & Somerset Constabulary
Vacant	Representatives for Education
Vacant	Representative for Care Home and Domiciliary Care
ASSOCIATE MEMBERS	
DEAN Mark	Head of Public Protection & Safeguard, Avon & Wiltshire Partnership Mental Health NHS Trust
BUTTON Justine	CQC Compliance Manager
SWASFT (new person tbc)	Clinical Standards Manager South Western Ambulance Service NHS Foundation Trust (SWASFT)
Job Centre Plus Manager	Representing the Dept Work & Pensions
B&NES LSCB	Members of the Local Safeguarding Adults Board sit on the Local Safeguarding Children's Board and have responsibility for reporting activity and sharing information between the two.
B&NES Council	Divisional Director for Tourism, Leisure & Culture B&NES Council

Appendix 2

Membership List of Local Safeguarding Adults Board sub-groups (at March 2014)

Safeguarding Adults Training and Development sub-group
Meet: Bi-monthly
Chair: Jenny Theed (Sirona Care and Health)
Sue Tabberer (B&NES Council)
Dennis Little (B&NES Council)
Geoff Watson (Sirona Care & Health)
D Heaton (Agincare Domiciliary Care)
Jackie Cooke (RNHRD)
Amanda Pacey (RNHRD)
Jane Davies (RUH)
Belinda Lock (Way Ahead)
David Trumper (B&NES Carers Centre)
Helen Ponting (Avon & Somerset Constabulary)
Nick Quine (Avon & Somerset Constabulary)
Sonya Stocker (Avon& Somerset Constabulary)
Sophie Cousins (AWP)

Policy & Procedures sub-group
Meet: Bi-monthly
Chair: Damaris Howard (Freeways)
Alan Mogg (B&NES Council)
Sue Tabberer (B&NES Council)
Rebecca Jones (B&NES Council)
Rebecca Potter (B&NES Council)
Maggie Hall (Sirona Care & Health)
Lindsay Smith (Sirona Care & Health) *for info only*
Amanda Lloyd (Avon & Somerset Constabulary)
Sally Eaton (City of Bath College)
Roanne Wootten (Julian House)
Jenny Shrubsall (Service User)
Kate Purser (NHS BaNES CCG)
Deborah Janes (AWP) *for info only*
Huge Jupp (AWP)
Jo Green (AWP)
Gemma Box (RUH)

Awareness, Engagement and Communications sub-group
Meet approx: Bi-monthly
Chair: Sonia Hutchison (Carers' Centre, Bath & NE Somerset)
Lesley Hutchinson (B&NES Council)
Karyn Yee-King (B&NES Council)
Melanie Hodgson (B&NES Council)
Sarah McCluskey (B&NES Council – Children)
Maggie Hall (Sirona Care & Health)
Martha Cox (Sirona Care & Health)
Kirstie Mann (Your Say Advocacy)

Dr Hannah Connell (RNHRD) *for info*
Debra Harrison (RUH)
Lilianna Rawlings (AWP)
Bev Craney (SWALLOWS)

Quality Assurance, Audit & Performance Management sub-group
Meet approx: Bi-monthly
Chair: Val Janson (NHS BaNES CCG)
Lesley Hutchinson (B&NES Council)
Alan Mogg (B&NES Council)
Geoff Watson (Sirona Care & Health)
Russ Bennett (Avon Fire & Rescue)
Mike Williams (Avon & Somerset Constabulary)
Janet Dabbs (Age UK)
Amanda Pacey (RNHRD)
Jackie Cooke (RNHRD)
Dr Claire Williamson (AWP)
Fran McGarrigle (AWP) *for info*
Andrew Snee (Curo Group)
Rob Elliot or Sue Leathers (RUH)

Mental Capacity Act and Quality & Practice Group
Meet: Quarterly
Chair: Lesley Hutchinson (B&NES Council)
Dennis Little (B&NES Council)
Karyn Yee-King (B&NES Council)
Tom Lochhead (B&NES Council)
Christine Somerset (B&NES Council)
Pete Campbell (B&NES Council)
Kate Purser (NHS BaNES CCG)
Maggie Hall (Sirona Care & Health)
Polly Compton-Dart (SWAN Advocacy)
Karen Webb (Four Seasons)
Jackie Cooke (RNHRD)
Pam Dunn (Carewatch)
Philip Rhodes (AWP)
Gemma Box (RUH)

Joint Interface Group LSCB/LSAB
Chair: Lesley Hutchinson (B&NES Council)
Richard Baldwin (B&NES Council)
Sarah McCluskey (B&NES Council)
Jenny Theed (Sirona Care and Health)
Sonia Hutchison (Carers Centre)
Sophia Swatton (NHS BaNES CCG)
Kate Purser (NHS BaNES CCG)

Appendix 3: LSAB SAFEGUARDING INDICATORS 2013-14

Indicator	Target
1. % of decisions made in 2 working days from the time of referral	95%
2a. % of strategy meetings/discussions held within 5 working days from date of referral	90%
2b. % of strategy meetings/discussions held with 8 working days from date of referral	100%
3. % of overall activities / events to timescale	90%

Other Mechanisms for Assurance:

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 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

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

- 90% of relevant health and 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 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 / CCG 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/DBS check in place

- 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 CCG 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 4

Business Plan

April 2012- March 2015

Contents Page

Chair's foreword

I welcome this business plan as an opportunity to be clear and explicit about the LSAB's work plan 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 2012

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

Note: the Business Plan is a working document and updated at each LSAB meeting via sub-group chairs and lead officers.

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**	**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	12/13	P&P group / LSAB agencies	Complete (Dec 13: on agenda for LSAB approval; awaiting final version for authorisation in June 14)	G
	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	Complete (Mar 14: new audit tool piloted in Nov 13 and audits carried out)	G
	C. Develop and implement an effective Triggers Protocol (including both Commissioners and Providers triggers)	To be confirmed	P&P group	Dec13: currently awaiting outcome of SCR action plan re MASH before continuing this work **Mar 14: as above**	A
1.2 Ensure Carers needs are supported	A. Implementation and review of Carers Action Plan	12/12	AEC group	Complete (June 13: Action plan reviewed in June. Carers Centre updating plan)	G
	B. LSAB partners to support and promote joint working with carers centre	12/12	AEC group	Complete (Carers Centre has met with Sirona, Curo and AWP and has begun discussions on how to work more effectively together)	G
1.3 Support service users to identify risks and	A. Monitor service user feedback from safeguarding process	06/13	AEC group	Complete (Oct 13: Reviewed feedback questionnaires with Sirona and Yoursay and service users edited)	G

to reduce and prevent abuse occurring	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	**March 14:** 'Joint Thresholds Workshops x2 for Sirona and B&NES Managers facilitated by GW and LH in Jan 14 Positive feedback from senior managers re both events –felt would aid supervision standards	G
	C. Develop further service user feedback opportunities	09/14	AEC group	Complete (Dec 13: Agreed and now awaiting Healthwatch to recruit lay members)	G
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	Complete	G
	B. LSCB/LSAB chairs and B&NES Council Strategic Director for People and Communities to make proposals to both Boards	03/13	LSAB / LSCB	Complete (Dec 13: work on going)	G
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	Complete (July 13: agreed with LSAB Chair in Subgroup : No further action required)	G
	B. Draft multi-agency lessons learned guidance	12/14	P&P group	Oct/Dec 13: Oct LSAB approved request timescale extended to 12/14 request that it is lined to SCR protocol review due June 2014 and do both by Dec 2014 **Mar 14: Not due**	A
	C. Ensure recommendations from	12/12	QAAPM	Complete (Oct 13: All providers (RUH,	G

	Winterbourne View and Francis Report are actioned and risks fully understood; ensure included in contract monitoring		group	RNHRD, AWP & CCG/ LA presented an update at the Sept QAAPM)	
NEW **Assurance that IMCAs are appropriately used in adult safeguarding**	A. Monitor use of IMCAs for Safeguarding cases and report back to the LSAB (currently use of IMCAs is low for B&NES and we are an outlier regionally)	09/14	MCA group	**Mar 14:** The group is aware of this and is working with Sirona Care and Health, AWP and Council staff to promote the use. SWAN Advocacy – the IMCA provider is also monitoring the applications and referral routes	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**	**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 CCG	**Mar 14:** CCG rep developing primary care training strategy for 2014/15 to include joint training opportunities	A
	B. Monitor CCG actions from SCR recommendations and lessons learned	On going	QAAPM group	Complete (Dec 13: Actions for CCG are being implemented)	G
	C. Provide training for independent contractors	03/13	Council and CCG	Complete (June 13: Four workshop were provided to independent contractors during quarter 4 2012-13)	G
2.2 Formalise accountability arrangements between the LSAB, commissioner and	A. Draft guidance note as required setting out the Commissioner and LSAB responsibilities	12/12	Council to draft for LSAB discussion	Dec 12: 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	A

commissioned services				progress March 13: Discussion paper presented to the LSAB and workshop planned June 13: LH and RC finalising details of session on this – considering LSAB Away day Oct 13: Awayday planned for Nov at which this will be discussed Dec 13: Considered at LSAB awayday and Commissioners to bring paper to LSAB in March 14 in terms of commissioner accountability **Mar 14: paper to LSAB**	
2.3 LSAB agencies to complete self - assessment annually to demonstrate continuous development **NEW ACTION**	A. Identify areas for improvement from partner agencies and LSAB through annual self-assessment and include progress in annual report	06/12	QAAPM group	**Mar 14: Updated paper to Feb QAAPM then to LSAB based on feedback from last LSAB – expected June 14**	A
	B. Incorporate areas for improvement into LSAB Business Plan annually	12/12	QAAPM group	**Mar 14: areas for business plan to be included once LSAB has approved final report**	A
	C. As a follow on from the Feedback questionnaire on the effectiveness of the LSAB it has been agreed that a survey will be undertaken to obtain feedback from LSAB partners and wider groups involved in safeguarding eg. Care Forum, Strategic Dom Care Partners on the performance of the LSAB Chair	06/14	QAAPM group	***June 14:*** *provide outline proposal for undertaking this survey*	

2.4 Assure sub-groups are meeting strategic objectives of the LSAB	A. Review sub group Terms of Reference	06/12	All sub groups	Complete	G
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	Complete	G
	B. Incorporate and monitor learning from annual reports into Business plan	annual	Council Commissioning Lead	Complete	G
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	Complete (June 13 statement in SA Policy)	G
	B. Review LSAB and sub group agencies whistle blowing policies and procedures and report back to LSAB	12/12	QAAPM	Complete (Dec 12)	G
	C. Disseminate Whistle blowing best practice guidance widely	09/12	AEC group	Complete (Request for good practice example to balance the bad practice example – to be included when document reviewed)	G
2.7 Assurance that the work of the LSAB is incorporated into contracts and embedded in the work of partner agencies	A. Confirmation of how safeguarding and MCA/DOLS indicators are monitored in commissioned services contracts	12/12	Council and CCG Commissioning	Complete	G
	B. Propose mechanisms to improve reporting and monitoring arrangements	03/14	Council and CCG Commissioning	Dec 12: Initial conversation taken place about the development of an overarching health and social care assurance framework (including children services for	A

				safeguarding) building on adults assurance framework that currently exists. June 13: Work is in progress on this. Oct 13: Work is slow and request move timescale to 03/14 Dec 13: Meeting scheduled for 9th Dec for commissioners to agree assurance and monitoring arrangements **Mar 14: paper presented to LSAB**	
	C. Monitor implementation of above mechanism	09/13	QAAPM group	**Mar 14: Meeting held in Dec. Proposal to LSAB in Mar 14**	A
	D. Develop / review assurance arrangements regarding MCA practice (5.1 ToR)	03/14	MCA group	**Mar 14: multi-agency task and finish group have met three times but have been unable to develop indicators and assurance. Next step is to look at North Somersets assurance model for MCA**	A
	E. Propose MCA / DOLS indicators for LSAB	03/14	MCA group	**Mar 14: As above**	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**	**RAG Score**
3.1 Ensure service users and alerters have a positive	A. Monitor and review service user experience questionnaire responses (linked to outcome 1)	12/12	AEC group	Complete (June 13)	G

response from professionals through-out the Safeguarding procedure	B. Review audit of 'front door' response to safeguarding alerts	12/12	Sirona report to QAAPM	Complete (June 13; to be repeated Oct 14)	G
3.2 Assure a systematic approach to providing SA and MCA information/ updates to all people /agencies is in place ***(disseminating)***	A. Develop a calendar of opportunities to routinely and strategically disseminate information for i) citizens ii) providers iii) publications	12/13	AEC and MCA group	**Mar 14: Draft Strategy is being presented to LSAB in Mar 14; calendar of opportunities is underway**	A
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	Complete (paper to LSAB in June 13)	G
	B. Evidence of continual improvement in response to feedback and involvement of service users *(requested from AEC group)*	03/13 **New** **09/14**	QAAPM group	June 13: report being discussed with LSAB in June 13; QAAPM group to consider report and agree how they will achieve this. Oct 13 : Discussion at Sept QAAPM Dec 13: QAAPM member reminded of the recommendation and will take account of these in the next survey **Mar 14: Request change of date for completion to Sept 14 as next service user survey is due June 14 LSAB**	G

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 support available Consider Advocacy and Adult Safeguarding document from ADASS	**06/15**	AEC group	June 13: Advocacy and Adult Safeguarding document from ADASS was considered at June 13 meeting Will look at the review of current feedback and consider future needs and opportunities. A new IMCA provider is starting and the group will introduce themselves to identify professional support available. **Mar 14: Not due until 06/15**	A
3.5 Raise awareness of discriminatory abuse	A. Agree awareness raising activities specifically for this type of abuse	12/13	AEC group	**Mar 14: Additional work is taking place to co-ordinate activity with Avon wide Comms Adult Safeguarding Sub Groups including an Adult Safeguarding Week**	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**	**RAG Score**
4.1 Assure that service users and carers where appropriate, are fully involved and	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	Complete (Dec 12)	G

participate at every stage of the safeguarding process and robust evidence that best interests decisions are made where necessary and clearly recorded *(personalised; sharing)*	B. Implement and monitor guidance	03/14	QAAPM group	Complete (Mar 14: Group has asked that the policy is updated in line with revised multi-agency procedures. It was also agreed that as we are already looking at service user involvement as part of each case audit and other audits are carried out, that no additional surveys will be undertaken)	G
	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	Complete (Mar 14: In process of revising the audit tool to include standards that both AWP and Sirona can adhere to)	G
	D. Include this in the Carers Action plan in Domain 1.	09/12	AEC group	Complete	G
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**	**RAG Score**

4.2 Assure that multi-agency policies and procedures are reviewed and best practice guidance is developed (including responses to	A. Ensure multi-agency policy and procedure review dates are set and list is reviewed on an annual basis	03/13	P&P group	Complete (June 12)	G

vulnerable perpetrators) *(personalised; sharing)*	B. Ensure each multi-agency documents are reviewed on a bi-annual basis	06/12 – 03/15	P&P group	June 13: In progress. We have 3 due for review by the end of the year – consent, thresholds and media/comms – need to identify lead reviewers for these. Oct 13: Raised at June 13 LSAB in progress Dec13: Comms and consent being reviewed by relevant subgroups and threshold by 12/14 **Mar 14: policies being reviewed are on the agenda for approval. We would like to ask that policies are reviewed on a tri annual basis unless major changes are needed. Time delay between approval and use means that reviewing quickly with less than 2 year's use. We would like to ask that P&P monitor policy review list but policies are reviwed by appropriate sub group eg MCA policy or staff framework.** **TORs are due for review by each subgroup and LSAB this year – please inform via LSAB that these have been updated**	A
	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	Complete (June 13: QAAPM group routinely do and is now regular agenda item) **Mar 14: P&P group - Lessons learned guidance to be developed**	G

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	03/14	P &P group	**Mar 14: draft written in Dec 13; consultation has been extended request extension to June 14 LSAB**	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**	**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	Complete (Audit tool has been circulated with new framework document to all partnership agencies)	G
	B. Review Audit Tool (Multi-agency Staff Development Framework) to include MCA	09/13	T&D group	**Mar 2014:** Original audit tool to be circulated to 2013-14 non responders to get further baseline across wider range of partner agencies Audit tool to be amended to include questions to review standard of content of each level of training in each partner organisation to be used with agencies that submit response to audit in 2013-14	A
	C. Report audit findings to LSAB	12/13	T&D group	Complete	G
	D. Propose further roll out to other commissioned services	12/13	T&D group	**Mar 14:** As per update in section B	A

	E. Develop requirements for Chief Executives, Elected Members and Board members	12/13	T&D group	**Mar 14:** Option to consider use of MACIE approach by providing event in 2014-15 for safeguarding adults leads from partner agencies	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	Complete	G
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	Completed	G
	B. Ensure service user training is provided through appropriate agency	09/12	Council Commissioner	Complete (Mar 13: 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
5.4 Assure that training meets LSAB standards and competencies set out in the Staff Development	A. Review training provided by Sirona Care and Health and all LSAB agencies	12/12	T&D group	**Mar 14:** Standards of training to be reviewed as part of framework audit in 2014	A
	B. Work with the carers centre and support carers to deliver safeguarding training	03/14	T&D group	**Mar 2014 :** No progress to date	R

Framework are delivered and that service users and carers are involved in delivery where possible	C. Work with service user representative to support service users to participate in SA training delivery	To be agreed	T&D group	**Mar 2014 :** No progress to date	R
	D. Propose level 4 training in Staff Development framework to LSAB	03/13	T&D group	**Mar 14:** See 5.2 E update	R

The following items are **Core Business** and specific B&NES Council or 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 safeguarding procedures that have	B&NES Council Safeguarding Adults and Practice Development Team	Monitored by People and Communities Department

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

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MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**19 November 2014**
TYPE	**An open public item**

Report summary table	
Report title	Joint Health and Wellbeing Strategy Performance Report November 2014
Report author	Helen Edelstyn (01225 477951)
List of attachments	Appendix One: Performance report
Background papers	Bath and North East Somerset Joint Health and Wellbeing Strategy: http://www.bathnes.gov.uk/health-wellbeing-board
Summary	This performance report charts progress towards delivering the outcomes and ambitions set out in the Joint Health and Wellbeing Strategy.
Recommendations	The Board is asked to: • Consider and comment on the performance report
Rationale for recommendations	The Health and Wellbeing Board has made a formal commitment to the performance management of the Joint Health and Wellbeing Strategy, as noted in its Terms of Reference. The Board agreed, at a meeting in February 2013, to receive twice yearly performance reports on the delivery of the Joint Health and Wellbeing Strategy.
Resource implications	There are no direct resource implications arising from this report.
Statutory considerations and basis for proposal	Relevant considerations are included within the full Joint Annual Account 2014.
Consultation	HWB members should have been consulted on their priority area as part of the member lead system. Consultation on this report has taken place with the Health and Wellbeing Board Chair and Strategic Director, People and

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

THE REPORT

1.1 The Bath and North East Somerset Health and Wellbeing Board agreed (at a meeting in February 2013) to receive twice yearly performance reports on the Joint Health and Wellbeing Strategy 11 priority areas. The 6 monthly performance report is set out in appendix One.

1.2 There are some examples of good practice in many of the priority areas including:

a) Dementia training courses run by Dorothy House to improve end of life care

b) Dementia Friends sessions that have been attended by staff from Sainsbury's

c) Positive feedback from the Government Troubled Families Unit and family members on our Connecting Families programme.

"We would not be in the positive place we are now. My eldest son has a job and the other is working towards getting a job. My youngest has had excellent help with problems at school good support with dealing with my marriage breakdown." (family member, connecting families programme)

d) The Wellbeing College which will provide courses that help people manage their long term conditions and mental health, develop a healthy lifestyle, manage key social issues such as housing, employment and debt and achieve wellbeing.

e) Following discussion on domestic violence and abuse at the Health and Wellbeing Board in January 2014 the IRIS (Identification and Referral to Improve Safety) project has been commissioned. This project works with GPs to develop a clear pathway from GP to domestic abuse services. The project launches this month (November 2014).

f) The Bath and North East Somerset Economic Strategy launches this month (November 2014). The Strategy includes a cross cutting theme on health and wellbeing and recognises the importance of addressing issues such as unemployment and worklessness to improving health outcomes.

1.3 There are some areas of challenging performance including:

a) The dementia diagnostic rate which is in the bottom quartile for the south of England (currently the diagnosis rate is 47% against a target of 66%)

b) Hospital admissions for alcohol-related conditions (the rate per 100,000of the population has increased by 25% between 2009/10 and 2013/14 This is a greater increase than that of south west England (15%) but lower than the national and regional rate).

c) Under 18's hospital admissions for alcohol-related conditions (68 per 100,000 population is the highest in the south west and significantly higher than the national rate (45 per 100,000 pop)).

2

2.1 In May the Health and Wellbeing Board agreed a system of priority leads (whereby Health and Wellbeing Board members take responsibility for 'championing' one of the 11 Joint Health and Wellbeing Strategy priority areas).The below table sets out the 11 JHWS priority areas, member and officer leads. (*Please note that there have been some changes to both the lead members and officers since May 2014).*

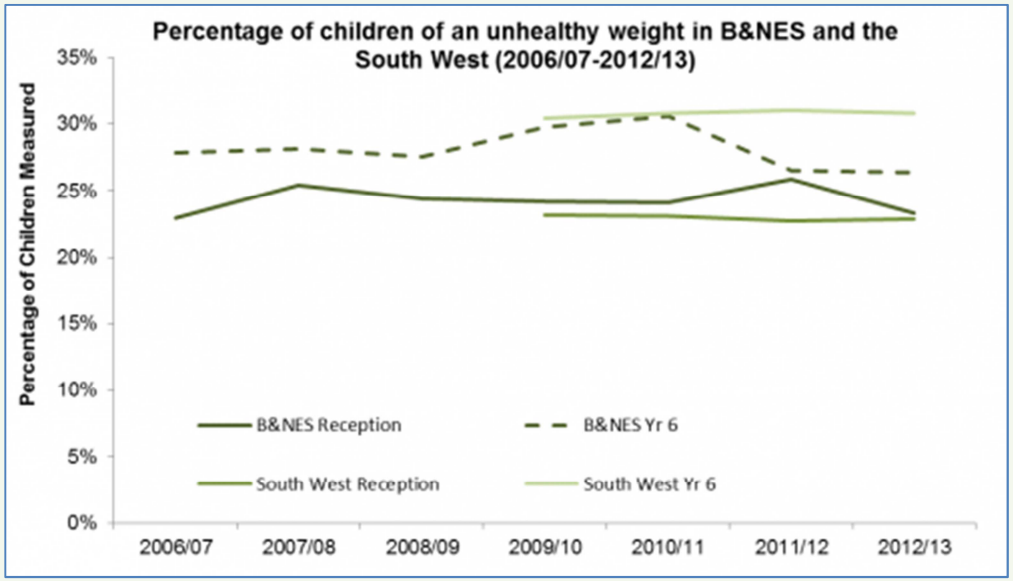
2.2 Officer leads have been encouraged to make contact and share information with member leads on their priority areas over the last 6 months.

Joint Health and Wellbeing Strategy priority	member lead	Officer lead
Helping children to be a healthy weight	Cllr Dine Romero	Jameelah Ingram
Improved support for families with complex needs	John Holden	Paula Bromley
Reduce the rates of alcohol misuse	Ashley Ayre	Cathy McMahon
Create healthy and sustainable places	Jo Farrar	Paul Scott
Improved support for people with long term health conditions	Julia Davidson	Laura Marsh
Promote mental wellbeing and support recovery	Tracey Cox	Andrea Morland
Enhanced quality of life for people with dementia	Dr Ian Orpen	Laura Marsh
Improved services for older people which support and encourage independent living and dying well	Diana Hall Hall	Margaret Allen / End of life care – Catherine Phillips
Improve skills, education and employment	Bruce Laurence	Benjamin Woods / Duncan Kerr
Reduce the health and wellbeing consequences of domestic abuse	Cllr Paul Crossley	Andy Thomas / Richard Baldwin
Increase the resilience of people and communities including action on loneliness	Pat Foster	Andy Thomas / Margaret Allen

Please contact the report author if you need to access this report in an alternative format

Appendix One – Joint Health and Wellbeing Strategy performance report (November 2014)

JHWS Priority	**Helping children to be a healthy weight**
Outcome	**All children are a healthy weight**
Officer lead	**Jameelah Ingram, Public Health Development and Commissioning Manager**
HWB member lead	**Cllr Dine Romero, Cabinet Member for Early Years, Children and Youth, B&NES Council**

Outcome & Indicator	Baseline and story behind it	Partners	What works to do better locally?
Outcome: All children are a healthy weight **Indicator:** National Child Measurement Programme (Overweight and Obesity prevalence of reception/yr. 6) Infant feeding: Breastfeeding prevalence initiation and continuation at 6-8 weeks **Local:** Overweight and obesity prevalence of pregnant women at 1st antenatal booking School Health Survey **Population:** Pregnant women, Children and young people aged under 18		Local residents Sirona – Health Visiting, School Nursing, SHINE Weight management, Cook it!, HENRY Bath University Play Services Children's Centres, private nursery and play group settings Maternity Services Schools Director of Public Health Award Parks and open spaces Sports Clubs Sports and Active Lifestyles Dieticians GPs Paediatricians Oral Health – Dentists Curo	Controlling exposure to and demand for consumption of excessive quantities of high calorific foods and drinks. Increasing opportunities for and uptake of walking, cycling, play and other PA in our daily lives, reducing sedentary behaviour. Establishing lifelong habits and skills for positive behaviour change through maternal health and early life interventions. Staffs are competent, confident and effective in delivering brief interventions and are able to signpost and refer to commissioned service with

Data issues/gaps:

- Have mechanism to monitor BMI of pregnant women at 10 week booking at RUH but need to obtain data from Bristol trusts also to get B&NES resident population
- Only record obesity prevalence in reception and Yr. 6
- Only measure children in B&NES schools – do not include children who study out of area
- Updated NCMP maps – detailing ward areas with highest rates and with schools mapped for targeting inequalities work.
- Poor physical activity data for children and young people – no national indicator
- Missing – Play and active travel indicators, measuring utilisation outdoor space and facilities.
- Mapping of all service provision in the area needs to be undertaken to identify gaps and areas of duplication
- Linking NCMP with pupil attainment and free school meals data.
- Neighbourhood profiles

Story behind the baseline: (examples of contributory factors)

As shown in figure 1 the percentage of unhealthy children in reception year in B&NES between 2006/07 and 2012/13 has been higher than in the South West as a whole. In contrast the percentage of unhealthy children in year 6 in B&NES between 2006/07 and 2012/13 has been lower than in the South West as a whole.

Further profiling data is taken from analysis conducted on the 11/12 data **14**

- Children from Black ethnicities in year 6 were significantly more likely to have an unhealthy weight and children from Other White ethnicities were significantly less likely to have an unhealthy weight than the B&NES average.
- There is significant variation in rates of unhealthy weight between schools, with rates ranging from 4%-50% in reception and 12%-49% in year 6.
- Rates of obesity in different schools vary from 0%-31% in reception and 5%-32% in year 6.
- There is considerable geographical variation by ward of residence of children in levels of obesity and unhealthy weight for reception and year 6 children.
- Keynsham (particularly Keynsham South) and Midsomer Norton/Radstock areas consistently have higher levels of unhealthy weight and obesity than other areas in B&NES.
- More deprived areas in B&NES have higher rates of obesity and unhealthy weight than less deprived areas, for year 6 this difference is significant for both obesity and unhealthy weight.
- Children and young people with disabilities are more likely to be obese than children without disabilities and this risk increases with age (analysis of HSE 2006-2010 for children aged 2-15 with a LLTI)
- Maternal obesity is a major risk factor for childhood obesity, which persists into adulthood independent of other factors.
- Research shows that 3 year olds are now experiencing tooth decay – with sugary drinks being a key factor.

Infant Feeding

- 84% of babies in B&NES are breastfed at birth, higher than regionally (78%) and nationally (74%). At the 6-8 week check this rate has dropped to 65% as of Q2 2013/14, although this is still higher than regional (49%) and national (47%) rates. These rates have been relatively flat over the past few years, but seem to be rising locally.

Youth Connect
Foodbanks

confidence.

A holistic integrated weight management pathway which

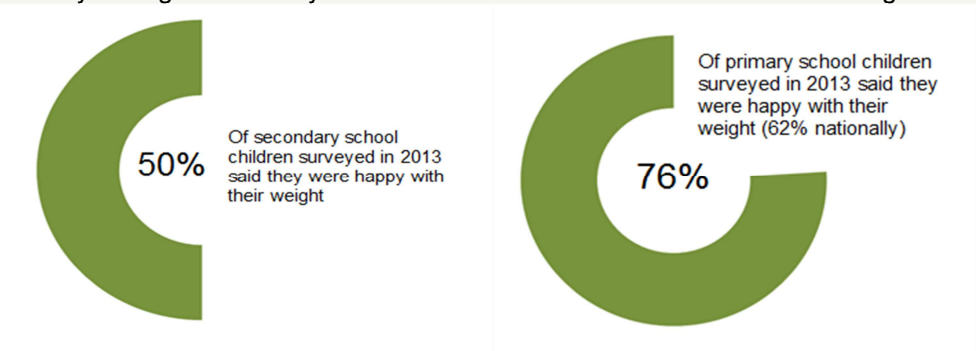
Include clear outcomes for lifestyle interventions in all relevant commissioning and procurement processes.

Harnessing the contribution of existing community resources within local healthy weight pathway.

Maximising on the contribution of local partnership organisations. (e.g. sports clubs, play groups etc.)

Building local intelligence: of resources Auditing and evaluating existing provision to identify gaps, avoid duplication and determine contribution to outcomes.

Developing the necessary mechanisms to ensure effective local signposting is in place for commissioned services.

showing trends dietary behaviour, activity levels and unhealthy weight prevalence in maternal and child health • Measuring longer term outcomes (6/12 months for commissioned services). • Service user feedback on commissioned services.	• Within B&NES there is considerable variation in rates of breastfeeding between different areas, with 9 wards having 6-8 week rates of less than 50%, the lowest being 29%. It is difficult to distinguish the influence of geographical deprivation from age of mother from the data in B&NES as some of the most deprived areas, with the lowest rates of breastfeeding, also have the highest numbers of teenage mothers. • In 2012/13, 41.2% of people in B&NES use outdoor space to exercise for health/reasons, the highest regionally and significantly higher than the national average (1.3%) **Physical Activity** • Bath and North East Somerset is significantly lower than the national average regarding the percentage of children participating in at least 3 hours per week of high quality PE and sport at school (age 5-18 years) **4** **LISTENING TO THE PUBLIC AND SERVICE USERS** In 2013 the Child Health-Related Behaviour Survey in B&NES in 2013 results on healthy eating and activity were similar or better than the national average.  • Primary school - 83% of primary school children reported enjoying physical activity at school and in leisure time. They also reported that they are adopting healthy eating behaviours; 98% have breakfast and 32% reported eating 5 or more portions of fruit or vegetables. Approx. 1 in 5 said they would like to lose weight. Almost half of primary school children (47%) travel to school by car. • Secondary school - 1 in 10 children are skipping meals, with 11% reporting that they did not have lunch on the day before the survey. Fewer secondary school children (21%) are eating their recommended portions of 5 a day. However more secondary children are walking to school (54%) and 75% of		

	respondents are enjoying physical activity 'quite a lot or a lot. 68% (59%) of Year 10 pupils said they worried about at least one of the issues listed 'quite a lot' or 'a lot' • A focus group of young mums with preschool aged children highlighted issues around availability of good facilities and activities (including for under 3's and for parents) and crèche facilities whilst exercising • A youth focus group highlighted the need for indoor and outdoor spaces to socialise within their age group • A group of disabled people commented that transport is one of the main barriers to participating in activities as well as access issues • A survey by the University of Bath (2012) highlighted that parents have a significant effect on young people's physical activity levels with barriers including: fears of parenting skills being judged, not knowing other parents or workers, cost of services, lack of awareness of services and reacting badly to being told that their child is overweight		

Outcome Framework: All pregnant women, children and young people are a healthy weight

Current good practice in B&NES	Gaps/Needs Identified
A holistic integrated weight management pathway for the whole population which includes prevention, an ethos of taking personal responsibility for the both the health and wellbeing of the family and individuals with the offer of specialist support when needed	
Maternal Health • Health in pregnancy support service **Early Years 0-5** • Healthy Start • HENRY • Cook IT – to include food growing • Director of Public Health Award • Health Visiting: Healthy Child Programme • HENRY and HENRY Parenting • Breastfeeding & infant feeding • Peer Support for Under 26s • Nutritional Guidance in early years settings • Play inclusion Worker **5-19 Years** • SHINE weight management for 10-17 year olds	**Maternal Health** • To introduce integrated commissioning of maternal and child health to ensure a holistic approach to positive parenting, early messaging of importance of healthy lifestyles for the whole family both antenataly and postnataly. • Ensure universal early year's services such as Health Visiting/Children Centres staff are competent in raising and addressing the issue of weight and promoting breastfeeding. **Early Years 0-5** • Greater promotion of Start4IIfe social marketing campaign for • Increase the number of HENRY programmes • Incorporate healthy lifestyle messaging into all commissioned parenting programmes. **5-19 Years** • Family based weight management service for 7-10 year olds which is parental lead • More parental support and advice needed in SHINE programmes

• Healthy Child Programme • Cook it! – to include food growing and cooking skills programme (up to 17 years) • Director of Public Health Award • School nursing • National Child Measurement Programme (Proactive telephone follow up for reception • Dietetics/Paediatric support	• More work with schools in referring into weight management and having the confidence to raise the issue of weight. • Closer links with schools in supporting or referring to weight management services. • The majority of secondary schools do not provide meals that are compliant with nutritional guidelines. There is a need to improve the nutritional quality and offer of food in secondary schools. • Increase public awareness Raising the issue with parents of reception aged children • Assess the whole Early Years/school/College environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight and be physically active. • Improving the nutritional quality of food supplied in schools. • Improve link with oral health services **Across birth and childhood years** • Develop community development approach to delivering interventions which include an intergenerational approach to healthy weight – where the influence on a child's weight is from its wider community not just their main carer • A greater focus on reducing diet-related inequality is needed by focusing services on low-income residents/families with priority given to children from Black and Minority Ethnic Backgrounds, Children with a physical or learning difficulty • Continue to provide effective services for those at risk of unhealthy weights, ensuring that commissioned interventions include psychosocial aspects of being overweight. • Create opportunities for integrated commissioning of family based services. • Enable staff to have increased confidence in raising the issue of weight and the competencies to deliver/refer to weight management interventions where appropriate.
Controlling exposure to and demand for consumption of excessive quantities of high calorific foods and drinks	

• Eat out Eat Well
• 5 A Day
• Change 4 Life
• School Food Plan
	• Help families and children make healthier lifestyle choices for diet, prioritising:
	  ○ Families in low socioeconomic groups
	  ○ Children with disabilities and/or who have parents with a disability
	  ○ BME children
	  ○ NEETS
	• Link in with national Change4Life programme to deliver key messaging on the dangers of sugary and caffeinated drinks and portion sizes/over snacking locally.
	• Work with street trading team to reduce the number of outlets which offer unhealthy snack and drink in areas close to educational settings and family

	leisure facilities. • Reduce the number of new fast food outlets near educational settings. • Increase the availability of affordable fruit and vegetables in neighbourhoods of high need.
Increasing opportunities for and uptake of walking, cycling, play and other PA in our daily lives, reducing sedentary behaviour	

• **Maternal Health**
***Currently no specific commissioned services available antenataly**
• Moving on Up – Postnatal exercise group (Sirona)
• Healthy Lifestyle Service
 	
Early Years 0-5 years
• HENRY 2 day core training for Health visitors and children's centre staff
• Play inclusion workers and community play teams
• Triactivate - cycling for pre-schoolers
• Director of Public Health Award (nurseries, child-minders and children's centres)
• Cycle training for pre-schoolers
 	
5-19 years
• Bike it!
• Dance research
• Wheels for All
• Everyday Activity in schools
• Triactivate
• Director of Public Health Award (schools and colleges)
	• Investment into leisure facilities to modernise them and make them more attractive to young people and families.
	• Work across sectors to increase everyday activity and opportunities for play in children, young people and families. Prioritise:
	  ○ Develop a physical activity offer for pregnant women
	  ○ Families in low socioeconomic groups
	  ○ Children with disabilities and/or who have parents with a disability and
	  ○ BME children
	  ○ Girls aged 12 upwards
	  ○ NEETS
	• Assess the whole Early Years/school/College environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight and be physically active.
	• Work with Leisure and Tourism, parks and allotments and open spaces to create opportunities for spontaneous play and maximising opportunities for physical activity.
	• Ensure development of the transport plan includes opportunities for families to travel sustainably and contributing to climate change and traffic calming agenda
	• Strengthen partnership with Planning Department to influence the need for families to be physically active as a routine part of their daily life on new planning applications.
	• Invest in training for planners (urban, rural and transport), architects and designers on the health implications of local plans.
	• Increase the opportunities for active travel for families – considering key transition points – such as starting preschool/school/college/university.
	• Introduce walking buses to and from educational settings
	• Playing out schemes which residential roads are closed to cars from 3pm to 5:30pm to enable children to play safely close to their home
	• Introduce new scheme which increase the number of opportunities for families to walk to school. For example, introducing car free zones within ½ mile radius of local preschool and primary schools.
	• Mapping of free/ discounted exercise opportunities for young people.
	• Explore opportunities for co-locating health, leisure and NHS services to offer a holistic approach to supporting families.

	• Remove the cost of venue hire for commissioned services operating in public sector venues to enable more families to access services.
Increasing responsibilities of organisations for the health and wellbeing of their employees working in children's services.	
• Workplace Wellbeing Charter • Incentives • Eat Out Eat Well • NHS Health Checks • Healthy Lifestyles Service offer as part of Healthy Workplaces Award (includes slimming on referral) • Passport2health • Exercise on referral • Lifestyles advisors • Active travel incentives: workshops, cycle training	• Upskill local public sector workforce so that they are healthier in themselves, reducing sickness absence and improving productivity.
Key Priorities 14/15 • Refresh of Healthy Weight Strategy • Development of Partnerships and implementation plans for interrelated strategies, Play, Food, Fit for Life • Maximise on opportunities to promote Change4Life campaigns with partnership organisations focussing on highlighting the dangers of sugar and raising awareness of portion size. • Integrated commissioning for children's services (health visiting and school nursing), incorporating maternal health • School food plan - Improving the nutritional quality of food provided in secondary schools. • Improve access to a healthy and affordable diet prioritising families in low income groups. (Food Strategy) • Seek opportunities for the development of food skills (i.e.) cooking and growing to be incorporated into numerous service delivery programmes. • Enhance the uptake, use and awareness of food-welfare schemes by eligible families • Leisure facilities procurement – ensuring a targeted and family based offer for increasing physical activity and weight management. • Delivery of Healthy Child Programme – 0-19s, through health visiting and school nursing • Development and implementation of the Fit for Life Strategy and Food Strategy • Roll out making every contact counts for professionals working in children's services • Improve the data quality of local indicators to measure outcomes • Prioritise physical activity opportunities for pregnant women, girls aged 11-19 and activities for families which preschool aged children. • Develop an agreement with NHS and Local Authority to offer free venues for public sector commissioned lifestyle activities. • Ensure all organisations represented at Health and Wellbeing Board delivers Making Every Contact to frontline staff.	
Progress Report - October 2014 **NCMP Performance against outcome measures:** **Please note that the following figures are provisional and produced by our local analytical team. We are awaiting the national report which is due out in December 2014.** • Participation levels remain higher than the national average. Both reception and Year 6 participation rates are slightly lower than the previous year. For Year 6	

coverage rates, the School Nursing Team are reporting that the increase in Pupil Opt-Outs is because the young people want to be measured but do not give their consent to the data being published as part of the surveillance programme.

Reception

	Number of children measured	Number of children eligible for NCMP	Children measured as % of those eligible for NCMP	Parent Opt-Out	Pupil Opt-Out
2012-13	1739	1757	98.88%	10	1
2013-14	1776	1800	98.67%	13	1

Year 6

	Number of children measured	Number of children eligible for NCMP	Children measured as % of those eligible for NCMP	Parent Opt-Out	Pupil Opt-Out
2012-13	1608	1654	97.22%	24	8
2013-14	1557	1616	96.35%	32	24

Reception Year

- Very overweight (obese) **increased** from 8.5% in 2012/13 to 8.9% in 2013/14.
- Overweight from **fell** from 14.7% in 2012/13 to 14.2% in 2013/14.
- Results in a **very small difference** in unhealthy weight (overweight and obesity) – from 23.2% in 2012/13 to 23.1% in 2013/14.
- Underweight remains unchanged at 0.3%.

Year 6

- Very overweight (obese) **increased** from 14.7% in 2012/13 to 15.8% in 2013/14.
- Overweight from **increased** from 11.7% in 2012/13 to 13.4% in 2013/14.
- Results in an **increase** in unhealthy weight (overweight and obesity) – from 26.4% in 2012/13 to 29.2% in 2013/14.
- Underweight has increased very slightly from 1.1% to 1.2%.

Conclusion: Year 6 pupils are 'heavier' than last year and the year before, thus reversing the recent falling trend.

Performance against action plans

- The current Shaping Up! Strategy is due to expire in December 2014. Priority has been given to strategic leadership and development of this theme. There is now a Healthy Weight Strategy Group, which is leading on the refresh of the existing Shaping Up strategy. This group is partner between Health, Local Authority and the voluntary sector, it has an adopted set of Terms of Reference and has now met twice and will continue to meet quarterly.

- The first draft of the refreshed Shaping Up strategy is currently being consulted on with Healthy Weight Strategy Group members. It is anticipated that the final draft will be presented at Health and Wellbeing Board in March 2014. It has been designed using the outcomes based accountability model.
- The school food plan is currently delivered across B&NES with all key stage 1 children now being offered a free school meal. From January 2015, it will be a statutory requirement for maintained schools and new academies to comply with new food based standards. The Food in Educational Settings programme is currently working with new academies to ensure they meet the new standards. However, there is concern around the lack of engagement from Academies who are *not* new who are not required to comply with the standards
- The Local Food Strategy will be completed by November 19th and an implementation plan developed accordingly. A stakeholder/action planning event will be held in late January 2015.
- The council now has adopted a cross cutting physical activity strategy 'Fit for Life', an executive board has been established to oversee the implementation of the strategy with the support of a Fit For Life Partnership who will lead on the development of the implementation plan.
- The local authority is currently undertaking a leisure facilities procurement, which is now mid-point in progress. The procurement panel are shortlisting in October 2014 with a view to award a contract in December 2014.

Request / recommendation to the HWB

- For each Board member to champion the 'making every contact count' brief advice training in their organisation and develop a plan for cascading out to employees so that it becomes a mandated part of staff induction
- For Health and Wellbeing Board members to sign an agreement that all public sector commissioned lifestyle services will not be charged venue hire if they deliver in a public sector venues (e.g. hospitals, doctors, children centres)
- Support the implementation of local food planning policy: to ensure the protection of growing spaces and allotments, protect markets and restrict number of fast food outlets in close proximity of schools as well as ensuring new developments have adequate cooking and dining space for residents.
- Support the development of a refreshed play strategy for B&NES
- Support for the board to develop a stronger partnership with leisure, transport and education to promote and deliver outside learning programmes for both preschool and school aged children. (Targeting children who are disabled/learning difficulty and young girls)
- Increase level of investment in promoting active travel to families (improving links with the Local Sustainable Transport Fund, Highways and Education)

JHWS Priority	**Improve outcomes for families with complex needs**
Outcomes required as at March 2015	**All 215 families to have been allocated a key worker, and worked with. 100% of the attachment fee's claimed 100% of the payment by results claimed; improved outcomes for families linked to and reduced under 18 crime and ASB, Families into work training, children and young people attending well at school. As linked to the troubled families financial framework.**
Officer lead	**Paula Bromley, Connecting Families Manager**
HWB member lead	**John Holden, BaNES CCG lay member**

THE BIG PICTURE

Key facts

- The government has estimated that there are 210-220 families experiencing multiple problems
- In 2013/14 the local Council's 'Connecting Families' team was in contact with 43 of these families
- Out of work benefit claims and education absence represented the most common needs of the Connecting Families caseload

Multiple disadvantage ('Troubled families')

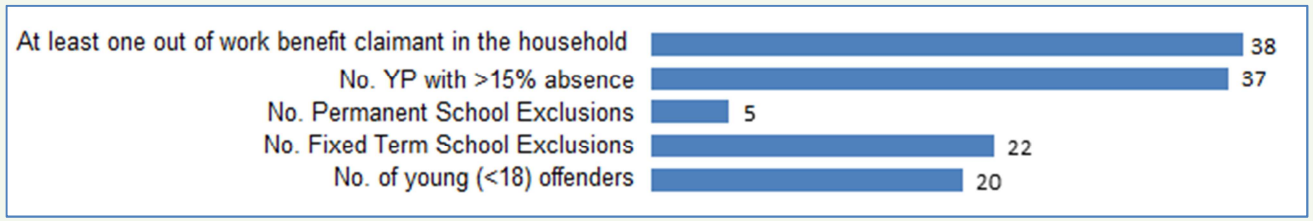
- In 2012, the government estimated that there are 120,000 families living with multiple disadvantages in England. Of these, it was estimated that 210-220 lived in Bath and North East Somerset

Are we meeting the needs

In April 2013, the council's Connecting Families team was working with 43 families, composed of 112 children and young people and 74 adults.

- Adults in the caseload were 53%/43% female/male, whereas children and young people were 48%/42% female/male. 33 families were single parents, of which the majority were single mothers
- 58 (52%) children and young people on the caseload had identified Special Educational Needs or were on a school action plan
- The Ethnicity profile of the cohort largely matches that of the population as a whole
- There is quite a broad geographical variation of the location of families, with only Twerton and Southdown local government wards having >5 families resident
- Fig 1 identifies the breakdown of specific nationally defined criteria by the caseload and demonstrates that out of work benefit claims and education absence are the most common criteria experienced in Bath and North East Somerset

Figure 1 - Connecting Families Caseload (Feb 14) by national criteria



Health inequality

See item above that details special educational needs details within the team. As part of phase 2, the Government have requested that we add a new area of criteria; parents and children with a range of health problems – and there will be a range of outcomes linked to these.

DELIVERING THE PRIORITY

Aims of the services

- To support these families to make positive change and live full active lives. The staff team (called family key workers) work alongside these families, helping them to achieve their aspirations and with parents to give their children an enjoyable, successful childhood and preparing them for adult life
- By working in a co-ordinated way, staff will support the whole family including children and young people with school / college to get the best from educational opportunities and through positive activities to engage with the wider community
- Co-ordinating the right services at the right time to meet the family's needs, improve outcomes and reduce the impact of crime, lack of education, worklessness, and physical and mental ill health amongst the most disadvantaged families

Successes and challenges

- Key successes to date have included:
    - Results linked to Payment by results to meet the Governments requirements
    - Outstanding work with families delivered by the core teams family workers
    - Progress made by families to date
    - Positive feedback from the Government Troubled Families Unit
    - Positive feedback from the family members via family feedback
- Challenges to date:
    - Sustaining positive parenting
    - Obtaining flexible curriculum opportunities

THE PATIENT AND PUBLIC VOICE

"Well from my point of view I am 100% happy with the help I was provided and if I ran into any problem with my family or with finances I was always helped. I just can't thank you all enough for what you have done for me and my family. I will never forget your help, kindness and understanding. I would not be where I am now if it was not for your project"

"I would still be unemployed and my confidence wouldn't be as good as it is as they helped me build my confidence and other skills."

"My keyworker's down to earth approach, she makes me feel relaxed and comfortable, does not judge. My son has taken to our worker, he doesn't take to many"

"We would not be in the positive place we are now. My eldest son has a job and the other is working towards getting a job. My youngest has had excellent help with problems at school. Good support with dealing with my marriage breakdown."

ASSESSING PERFORMANCE

Connecting Families criteria
The family would need to meet 3 of the national criteria or 2 national and 1 local criteria

- National criteria
  - School Attendance - exclusion, in a Pupil Referral Unit or 15% unauthorised absences across the last 3 consecutive terms.
  - Crime / Anti-Social Behaviour – under 18 year old with a proven offence in the last 12 months; anti-social behaviour order, anti-social behaviour injunction, anti-social behaviour contract, or subject to a housing-related anti-social behaviour intervention in the last 12 months
  - Out of Work and Claiming Benefits - households which has an adult on DWP out of work benefits (Employment and Support Allowance, Incapacity Benefit, Carer's Allowance, Income Support, Jobseekers Allowance or Severe Disablement Allowance
- Local criteria
  - Domestic Violence
  - Mental ill health
  - Children on the edge of care
  - Substance abuse

The next page sets out the B&NES Council Connecting Families Team Dashboard for 2014.

Bath & North East Somerset Council

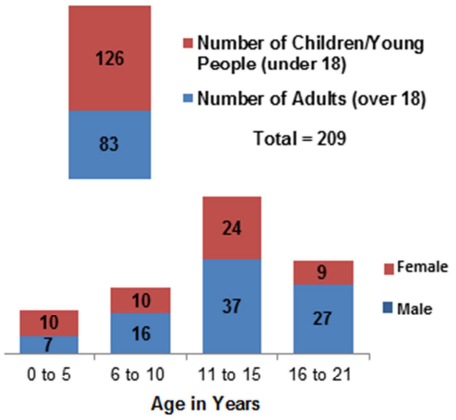
Bath and North East Somerset Council: Connecting Families Team Dashboard

Profiles of Families allocated to the Core Team

Total Number of Families: 50

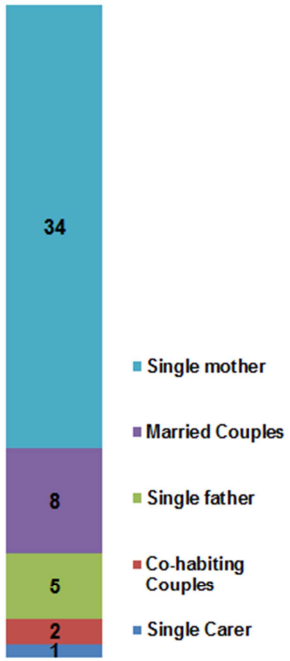
Connecting Families

Age / Gender Profile

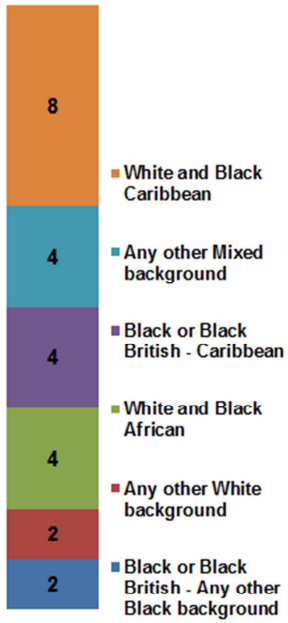


Gender

Relationship Profile

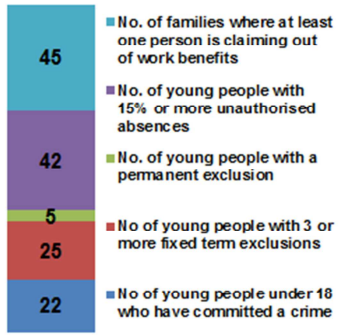


Ethnicity Profile

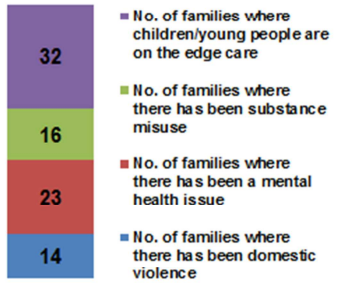


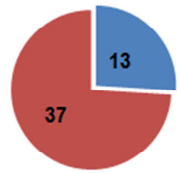
Criteria Profile

National Criteria



Local Criteria

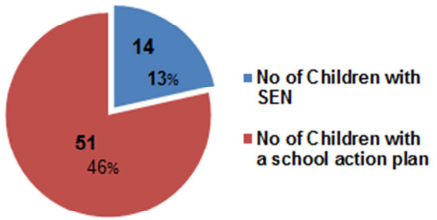




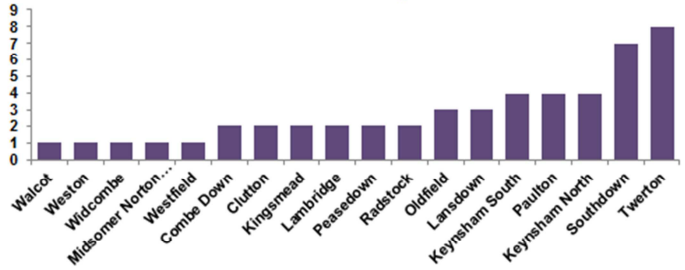
No of families matching 3 national criteria

No of families matching 2 national criteria

Education Details



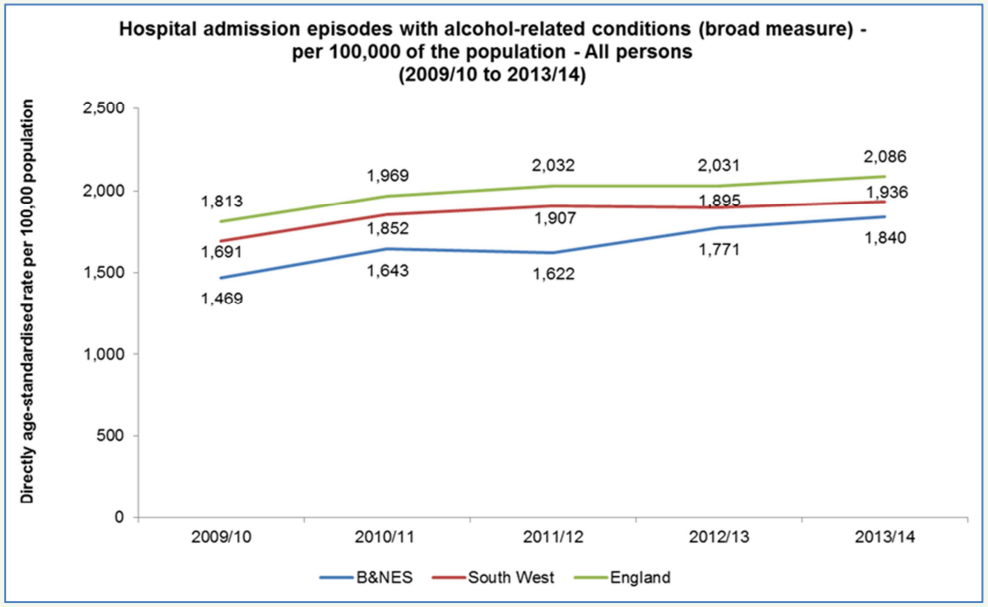
No. of Families by Wards



JHWS Priority	Recued rates of alcohol misuse
Outcomes	Safe, healthy and responsible drinking amongst the B&NES population
Officer lead	Cathy McMahon, Public Health Development and Commissioning Manager
HWB member lead	Ashley Ayre, Strategic Director – People and Communities, B&NES Council

THE BIG PICTURE

- The hospital admission episodes with alcohol-related conditions (broad measure) – rate per 100,000 of the Bath and North East Somerset population has increased by 25% between 2009/10 and 2013/14. This is a greater increase than that of the South West and England (15%) but has constantly been lower than regional and national rate. During this period there has been a 23% increase in the rate of these admissions for men and a 30% increase for women.
- People living in the most deprived areas of Bath and North East Somerset are significantly more likely to be admitted for an alcohol related condition than those living in the least deprived areas.
- Bath and North East Somerset has significantly higher rates of under 18's admitted to hospital for alcohol specific conditions than nationally.



Health inequality

- There are more alcohol related hospital admissions amongst men than women and more men in treatment and estimated to be dependent on alcohol in B&NES than women.
- Those living in more deprived areas of Bath and North East Somerset are four times more likely to be admitted to hospital for an alcohol related cause than those living in less deprived areas.
- 16% of people in alcohol treatment services in B&NES also have a severe mental illness.
- Problematic drug and alcohol use and mental health problems are key factors in the lives of people who have recently slept rough (St Mungo's June 2013 report)
- Alcohol specific hospital admissions amongst under 18's in B&NES are more frequent amongst girls than boys and girls are more likely to be receiving treatment for alcohol misuse than boys.
- There is a significant difference in self-reported exposure to alcohol (drinking in the last week) for primary school pupils who qualify for free school meals compared to those who do not qualify for free school meals.

DELIVERING THE PRIORITY

- The B&NES Alcohol Harm Reduction Strategy 2012 has been refreshed to reflect national policy and local priorities.

- A full children and young people's substance misuse needs assessment in underway and due to report by March 2015. This process will update and broaden the 2010 needs assessment and will cover prevention, early intervention, treatment and harm reduction in relation to smoking, alcohol, illegal drugs and novel psychoactive substances and the relationship with risk taking behaviour.
- B&NES Council Statement of Licensing Policy has been reviewed over the last 6 months. The Review has enabled recognition of new powers such as Early Morning Restriction Orders and recommends the retention of the Cumulative Impact Policy for Bath City Centre. It also acknowledges the wider public health agenda and health as a Responsible Authority and has led to the development of a voluntary code for licensed premises to promote responsible retailing of alcohol.
- Project 28, the young people's drug and alcohol treatment service provider for B&NES, has recently been successful in securing funding from Children in Need for an additional 2 years' delivery of the Drink Think Alcohol project. The service has also been successful in attracting National Institute for Health Research (NIHR) funding to evaluate the impact of its Drink Think Alcohol Screening Tool in reducing alcohol misuse amongst young people.
- Systematic screening for alcohol misuse is now included in the NHS Health Check and as part of the inpatient and community mental health services contract for 14/15. The RUH Alcohol Liaison Service will begin systematic screening for alcohol misuse in the Emergency Department this autumn.
- The Substance Misuse commissioner is working with treatment providers to support increased capacity for alcohol clients. There is also increased focus on mutual aid as a key step in the recovery journey for example working with AA, SMART and peer mentoring approaches to increase successful outcomes.
- Additional community detoxification capacity has been created in Burlington Street Dry House for RUH patients. This facility is contributing to the substantial bed day savings that have been made as a result of intervention by the Alcohol Liaison Service in the RUH.
- The Blue Light Treatment Resistant Drinkers project with Alcohol Concern has produced a range of resources to support local strategy for this client group, including a local needs assessment. It is estimated there are approximately 200 people that meet the definition in B&NES, costing local services around £10 million pounds. A working group has been set up to develop a local action plan.

THE PUBLIC AND PATIENT VOICE

- Girls self-report higher levels of drinking and are over represented in treatment services for alcohol misuse and also in alcohol related hospital admissions. Qualitative feedback from young people using treatment services (Project 28) is consistently positive and satisfaction is high
- When asked in 2012 about drunk and rowdy behaviour in public places in their local area, 21% of voice box survey respondents believed it was either a very big problem, or a fairly big problem.

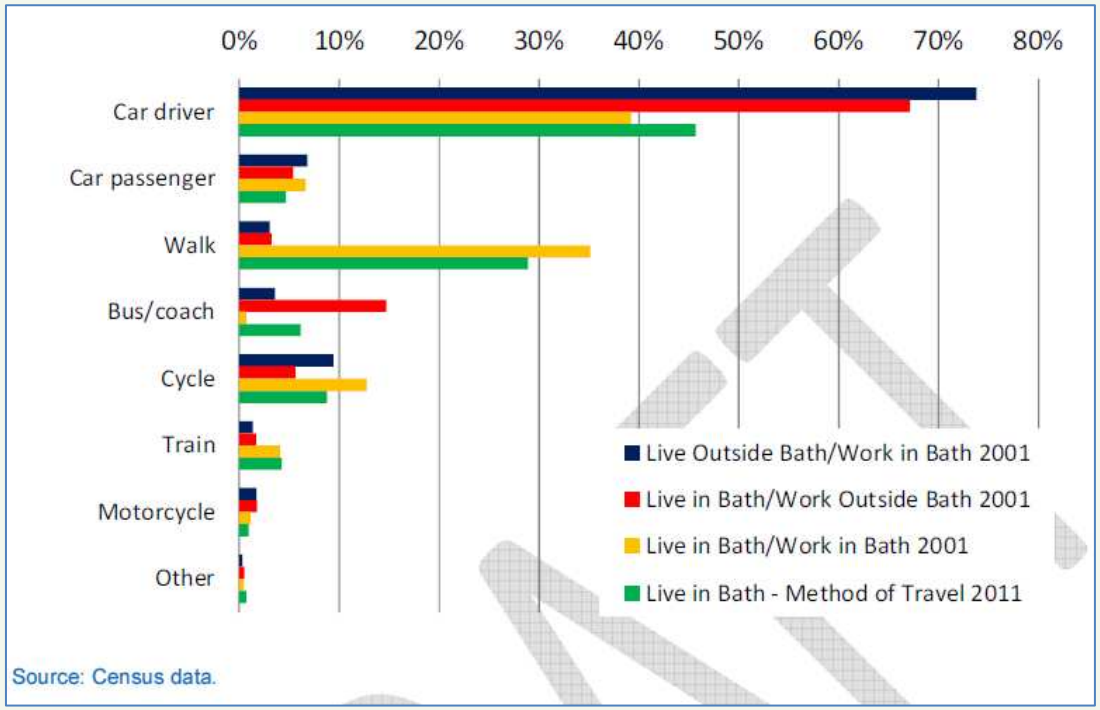
ASSESSING PERFORMANCE

Indicator	Performance	Trend	Comment
U18's Alcohol Specific Hospital admissions	B&NES rate (69 per 100,000 pop.) is the highest in the South West and significantly higher than national rate (45 per 100,000 pop.)	The rate of admissions is on a downward trajectory, in line with national trends.	A working group has been set up to better understand this issue.
Alcohol related hospital admissions (18+)	B&NES rate lower than national and regional rate	25% increase between 09/10 and 13/14, higher than regional and national increase of 15%	There was a 4.4% drop in alcohol specific hospital admissions in 13/14 compared to 12/13. The introduction of the Alcohol Liaison Service at the Royal United Hospital is thought to have contributed significantly to this reduction.

Crimes linked to the Night Time Economy	There has been a 26% reduction in the number of crimes linked to the Night Time Economy in B&NES between 2008 and 2013. From 2,504 recorded crimes (Q4 07/08 – Q3 08/09) to 1,841 crimes (Q4 11/12-Q3 12/13)	Downward trend in violent crime at both national and local level	Nationally violent crime has been reducing since 2001
Numbers in alcohol treatment % successfully leaving treatment and not returning within 6 months	In 13/14 there were 467 people in alcohol treatment with 302 of these starting their treatment in 13/14 40% of people leaving alcohol treatment in B&NES during 13/14 left successfully with no return within 6 months. 63% of young people left Project 28 drug free in 2013/14, 32% left as 'occasional' users (In total 55 young people left treatment last year)	This reflects a year on year increase in the numbers of people accessing alcohol treatment. This is better than national average performance of 36% and improving 11% more young people leaving drug free than 12/13.	With rising numbers of people accessing alcohol treatment year on year there are potential capacity issues in meeting future demand Increase could be related to the introduction of '28 day challenge' where young people are challenged to spend 28 days without using drugs or alcohol but sample size is small

JHWS Priority	**Create healthy and sustainable places**
Outcome	**The built and natural environment in B&NES enables all people in our communities to lead healthy and sustainable lives**
Officer lead	**Paul Scott, Assistant Director of Public Health, B&NES Council**
HWB member lead	**Jo Farrar, Chief Executive, B&NES Council**

THE BIG PICTURE



- 27% of Bath and North East Somerset population undertake 30 minutes of moderate intensity exercise on 3 or more days a week (22.3% national, South West 22.9%). This rate is higher among men than women both locally and nationally and there is no difference by ethnicity. (Source: The Active people survey 2011-12)
- Only 30% of 65-74 year-olds and less than 15% of adults aged 75 and over reported any exercise lasting at least ten minutes during four weeks (Health Survey for England, 2008).
- There is evidence of health inequalities as several of our most deprived wards in B&NES also have the lowest levels of physical activity and higher than average levels of obesity.
- 41.2% of people in B&NES are using outdoor space for exercise/health reasons compared to the England average of 15.3%. B&NES has the highest figure in England. (Adults aged 16+ years, Feb 2012 to March 2013, Source: PHOF). Nonetheless, it would be helpful to understand who the 59% of the population are that are not using outdoor space for exercise/health reasons and whether they have worse physical and mental health outcomes which could benefit from greater access and use.
- In B&NES there are 197 leisure facilities per 100,000 population. This is one of the highest rates in the country - as a comparison, South Gloucestershire has 120 per 100,000 and 86 per 100,000 for Oxfordshire (Source: B&NES JSNA).
- 9.5% of households are considered as being in fuel poverty, compared to 10.4% across England (2012, Source: PHOF)
- During the winter of 2013 B&NES experienced rainfall and flooding in a pattern consistent with the findings projected by local climate change impacts research. Over the same period, the area has experienced subsidence problems for buildings and roads, again in line with the projected research.
- The figure overleaf from 'Getting around Bath' shows that the majority of all journeys to work are made by car, particularly for people living outside of Bath where few journeys are made by bike, bus or train. The recent transport plan for Bath aims to shift this proportion towards active travel modes.

DELIVERING THE PRIORITY

A working group has been set up to progress this priority, with representation from all three council directorates (Place, People and Communities and Resources). The group's aim is that:

- The built and natural environment in B&NES enables all people in our communities to lead healthy and sustainable lives.

By working with key colleagues our ambitions are to:

- Increase active travel
- Improve access to high quality open and green spaces
- Improve local food environments (shops, markets, growing, culture)
- Improve the number of energy-efficient, safe and affordable homes
- Mitigate the impacts of climate change and environmental hazards
- Integrate these issues in to the local planning system

A key principle will be to ensure these things are possible for areas or communities currently experiencing higher levels of deprivation or worse health outcomes than the general population. Otherwise, there is the risk of widening inequalities across the district rather than narrowing them.

The approach of the group is to work with partners across the council and elsewhere:

- to make the most of the health and sustainability opportunities arising in key plans which may otherwise be missed
- to provide colleagues with the technical or strategic support to enable this to happen.

Key areas that working group members have been contributing to, influencing or developing over the recent period include:

- Fit4Life - an active living strategy for B&NES has been published. The working themes for this include leisure, travel and active environments and we are working with colleagues involved to support the development of this in a coordinated way.
- Working with regeneration colleagues so that wellbeing and sustainability are now included as cross-cutting themes of the refreshed Economic Strategy for B&NES.
- Working with planning colleagues to ensure that Objective 6 of the Core Strategy (which is to plan for development that promotes health and wellbeing) is sufficiently reflected in the current Placemaking Plan Options which are to be agreed and consulted on shortly.
- At a more detailed level, we have carried out a health impact assessment and contributed to wider sustainability appraisal of the Bath enterprise area master plan.
- A local food strategy has been published and consulted on with very positive engagement from a wide variety of external organisations.
- Adaptation to climate change has been agreed in the Council's Strategic Review as a project area needing further development which will be led by members of this group. To support this work, it has been agreed to update the Local Climate Impact Profile (LCLIP) study.
- A report was produced for the council leadership to help understand what we know about the health impacts of air pollution in B&NES and potential recommendations arising from that. These are being taken forward with public protection and transport colleagues.

THE PUBLIC AND PATIENT VOICE

Public voice is being captured through consultations on a number of key plans at present, including Fit for Life, Getting around Bath and so on. The working group

needs to more proactively capture views of the public arising in these consultations that relate to healthy and sustainable places views.

ASSESSING PERFORMANCE

Although a number of population indicators have been set out in the 'big picture' section at the start of this report, our aim is to use local indicators arising from the various plans indicated above. Although the economic, leisure, placemaking and travel plans will have a wide variety of actions, we propose to agree a small number of indicators from each which relate specifically to our ambition and can be used to track progress as part of their delivery, rather than being outside and unrelated. The indictors have not yet been agreed yet as the various plans are all still new.

JHWS Priority	**Improved support for people with long term health conditions**
Outcome	**Improving the quality of people's lives**
Officer lead	**Laura Marsh, Commissioning Manager for Long Term Conditions (NHS BaNES CCG)**
HWB member lead	**Julia Davison, Bath, Gloucestershire, Swindon and Wiltshire Area Team representative**

THE BIG PICTURE

- Nationally, people with long term conditions account for:
  - 50% of all GP appointments
  - 64% of outpatient appointments
  - 70% of all inpatient bed days
  - In total around 70% of the total health and care spend in England (£7 out of every £10) is attributed to caring for people with LTCs
  - This means that 30% of the population account for 70% of the spend
- The number of people with long term health conditions is projected to be relatively stable over the next 10 years but the number of people with multiple long term conditions is set to increase by approximately 50%.
- Age is a major factor for the prevalence of long term conditions and 14% of those aged under 40 report having a long term condition compared to 58% of those aged over 60. Age is also an indicator for prevalence of multiple long term conditions with 35% of over 60s having two or more.
- In 2011, 7% of the B&NES population (12,267 residents) reported that their daily activities were limited through a long term illness or disability.
- Diabetes has the fastest rising prevalence of any long term condition and local prevalence is increasing by 5% a year. There are increasing numbers of people aged 45 and under being diagnosed with type 2 diabetes and up to 20% of all inpatients in the RUH now have diabetes. Therefore diabetes is currently the main LTC area of focus for BaNES CCG.

Health inequality

- There is a 60% higher prevalence of long term conditions in people from the lowest socio-economic group to those in the highest.
- People with at least one LTC are also more likely to have risky health behaviours and are more likely to have high blood pressure and be obese, though it is unclear the direction of causation.
- Older people are much more likely to have a long term condition (58% of those aged 60+ compared to 14% of those aged under 40)
- People with a limiting long term condition are half as likely to have a job than those with a non-limiting LTC or with no LTC

DELIVERING THE PRIORITY

<u>Current Service Provision</u>
People with long term conditions typically come into contact with the whole health care system – GPs, acute hospitals, community clinics, specialist care centres, community pharmacy and more. Care pathways for long term conditions therefore need to transcend the organisational boundaries of social, primary, community and secondary care.

As an example we created a new clinically led and patient centred approach to delivering heart failure care. Heart failure is one of the most common causes of

readmission to the RUH and patients can be admitted many times over the course of their illness and particularly towards the end of their life. In the previous pathway, providers addressed specific aspects of care but often in isolation from each other and in a way that left patients feeling unsupported so we formed a heart failure stakeholder group to map the pathway and develop a patient owned 'Heart Failure Passport'. The passport includes all the key information about a patient's condition including their treatment plans, all medications and end of life planning where appropriate. So, if a patient sees a healthcare professional who isn't part of the heart failure team all their vital information is easily available. In addition to this, our multidisciplinary team invested in telehealth technology so that patients can monitor their weight so as to better monitor their heart condition, supported by their heart failure nurse as necessary. Since redesigning the pathway, community heart failure nurses have been supported by direct access to a consultant cardiologist with regular multidisciplinary team meetings. Meeting in this way enabled the team to share valuable lessons and experiences which enhanced the continuity of care with clear improved patient outcomes and a particular emphasis was placed on end of life planning supported by the palliative care team.

To better understand the whole patient experience, a new friends and family test (FFT) specifically designed around the heart failure pathway was introduced. It surveyed patients along a pathway of care at different touch points, rather in a single care setting and over three months, more than 2000 patients responded giving their feedback on services from their GP, their heart failure nurse, cardiology inpatient and outpatient services at RUH, as well as patients from A&E at RUH. Overall 94% of respondents were either likely or extremely likely to recommend their provider, and services received in the community rated highest for treating patients kindly, as well as listening and explaining.

<u>Successes with Current Service Provision</u>

The Long Term Conditions Work programme covers numerous projects and this year the CCG has:

- Expanded the IMPACT service (community COPD service) to six days per week
- Commissioned a Dementia Support Worker service
- Implemented the new Community Cluster Team Model including the Active Ageing Service
- Commissioned a redesigned community bladder and bowel service
- Expanded specialist neurology nursing provision
- Expanded the Parkinson's Disease Multi-Disciplinary Team at the Clara Cross Rehab Unit
- Expanded the Early Supported Discharge service for Stroke patients

<u>Challenges with Current Service Provision</u>

There have been several difficulties in maintaining and improving current services, including:

- Difficulty maintaining good stroke performance. However, a revised action plan is now being developed.
- Difficulty developing the clinical model for supporting patients with non-cystic fibrosis bronchiectasis in the community
- Difficulty improving dementia diagnosis rates despite significantly increased activity at the RICE memory clinics and introduction of the Dementia Support Worker service

<u>Next Steps for Service Provision</u>

- Diabetes is a strategic priority for the CCG so the Long Term Conditions Work Programme is now going to focus on the redesign of diabetes services. This is essential in order to manage the increasing numbers of people with type 2 diabetes.

THE PUBLIC AND PATIENT VOICE

65 people with long term conditions were surveyed in 2011. Nearly half (47%) of respondents indicated that they were not very or not at all confident about managing their condition. More detailed patient feedback is sought as part of the commissioning cycle and recently, surveys have focussed on diabetes as this is a priority area for the CCG and also continence as the community bladder and bowel service has recently been redesigned.

Diabetes

In September 2012, NHS B&NES in partnership with Diabetes UK requested feedback on diabetes services from all Diabetes UK members who live within Bath and North East Somerset. 310 questionnaires were sent out in September 2012 and 163 were returned – a response rate of 53%. The key findings can be summarised as follows:

- 78% of all respondents said that the healthcare professional they see most often always explains things clearly to them.
- Only 13% of all respondents had been offered a written copy of their care plan.
- Only 60% of all respondents said that the information they received about diabetes was always easy to understand.
- 80% of all respondents rated communication between the healthcare professionals involved in their diabetes care as good or excellent.
- 86% of all respondents have not needed to repeat important information they had already told the healthcare professional.
- Almost three quarters of all respondents said they were always able to contact their healthcare professional and a further 18% said they could sometimes make contact.
- 64% of all respondents always understood their test results. However, 28% said they only sometimes understand them and 6% said they never understand them.
- 40% of all respondents were not given the opportunity to discuss their physical activity levels and/or diet. Of the respondents who did talk about these issues, 72% said the discussions supported them to make lifestyle changes.

More recently, the 'Your Health Your Voice' patient group has been consulted on the proposed new diabetes pathway and to help us better understand what people need to help them better manage their diabetes, a further survey for patients with type 2 diabetes is planned for the coming months.

Continence

Patient feedback was sought from patients attending a first appointment for incontinence at the RUH uro-gynaecology clinics. This cohort of patients should have tried conservative treatments for urinary incontinence via the community continence service prior to their appointment. Feedback was received from 51 patients (24 from B&NES, 25 from Wiltshire and 2 with postcodes that could be B&NES or Somerset). In summary, the feedback showed that:

- Two thirds (17/24) of respondents reported that they saw the community continence service soon enough to be able to help them.
- 71% (36) respondents had seen their GP about their continence problem
- 55% (28) of respondents waited for more than 2 years before seeking help for their continence problem. A further 10 respondents waited between 1 and 2 years. Only 12% (6) patients waited less than 6 months.
- All of the youngest respondents (aged 25-34) and all of the oldest respondents (aged 75-84) waited for at least a year before seeking help.
- Ten of the respondents described how urinary incontinence was negatively impacting on their lives.
- Five women indicated they would like to be able to manage their incontinence better if it couldn't be cured.

An online survey was also conducted as it is recognised that continence can be an embarrassing subject with many people not seeking help and managing their incontinence using pad products that can be readily bought from supermarkets and pharmacies. Only 21 responses were received but the results showed that: the majority of respondents (87%) had had a continence problems for longer than one year with 22% respondents having an issue for over 5 years; 24% of respondents

hadn't sought help or advice from any source about their continence problem; and the ability to self-refer to the community continence service was important to most people

ASSESSING PERFORMANCE

- There are a number of national indicators in the CCG outcome indicator set (CCGOIS) that aim to improve the care for people with long term conditions:

Indicator type	Indicator Description	BaNES 2011 / 12	BaNES 2012 / 13	BaNES 2013 / 14	England Average 2014 / 15	To improve	Compared to England average and data trend		Supporting Narrative
National	Health-related quality of life for people with long-term conditions (CCGOIS 2.1)	0.79	0.79	0.77	0.74	⇧	G	⇧	BANES results for 2013/14 in the top 25% of CCGs. Health-related quality of life refers to the extent to which people have problems: walking about, with self-care (e.g. Washing and dressing), usual activities (e.g. work, study). Also if they are in pain or discomfort and feel anxious or depressed.
National	Health-related quality of life for carers, aged 18 and above (CCGOIS 2.15)	0.86	0.84	n/a	0.80	⇧	G	⇔	Please Note: 2013/14 data for BaNES was supressed due to small numbers to responses. Health related quality of life is as in CCGOIS 2.1 above.
National	People feeling supported to manage their condition (CCGOIS 2.2)	70.5	70.3	71.0	65.1	⇧	G	⇧	BANES results for 2013/14 just outside the top 5% of CCGs. These are health conditions, that are expected to last for a significant period of time, and if people feel they have had sufficient support from relevant services and organisations to manage their condition.
National	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (CCGOIS 2.6)	627	672	589	781	⇩	G	⇩	BANES results for 2013/14 in the top 25% of CCGs This measures how many people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. These conditions include, for example, diabetes, epilepsy and high blood pressure.

National	People with diabetes diagnosed less than a year who are referred to structured education (CCGOIS 2.5)	20.3%	26.6%	n/a	18.4%	⇧	G	⇧	BANES results for 2012/13 in the top 25% of CCGs (England results are for 2012/13). These are the latest available results.
National	Emergency admissions for acute conditions that should not usually require hospital admission (CCGOIS 3.1)	854	911	872	1165	⇩	G	⇩	BANES results for 2013/14 in the top 15% of CCGs. These conditions include, for example, ear/nose/throat infections, kidney/urinary tract infections and heart failure.

Sources of Information used in this section include:
Bath and North East Somerset JSNA - **http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics**
Health and Social Care Information Centre – **https://indicators.ic.nhs.uk/webview/** (please note: some of this website is limited to relevant access)

JHWS Priority	**Reduced rates of mental ill health**
Outcome	**Reduced rates of mental ill health**
Officer lead	**Andrea Morland, Senior Commissioning Manager – Mental Health and Substance Misuse**
HWB member lead	**Tracey Cox, BaNES CCG Acting Accountable Officer**

THE BIG PICTURE

- Mental health problems are common (around 1 in 6 people affected at any one time), often start in childhood and are a leading cause of disability.
- Intervening early for children with mental health problems has been shown not only to reduce health costs but also realise larger savings such as improved educational outcomes, reduced unemployment and less crime.
- Prevalence of depression in B&NES is similar to the national average, with almost 9000 adults in B&NES recorded as having depression by their GP.
- Emergency hospital admissions due to self-harm in B&NES are significantly higher than national average. This may be due to different thresholds for admission compared to other areas. The highest admission rates are amongst teenage girls and young women. Admission rates show a close relationship with deprivation levels around the district.
- The number of suicides fell slightly during the mid-2000s but has returned to previous levels. It is similar to the national rate, but lower than the South West rate.
- 66% of adults on the Care Programme Approach (CPA) are in settled accommodation which is higher than the national average but has fallen over the last 18 months. 14% of adults on the Care Programme Approach (CPA) are in employment, which is double the national average.
- The proportion of mental health related social care clients receiving home care is higher than the national average. The proportion receiving day care services is lower than the national average.
- The number of carers of adult mental health clients whose needs were assessed during the year is lower than the national rate.
- B&NES has good performance compared to national averages across a range of service activities. Attendances at the emergency department and days spent in hospital beds for mental health issues are both lower than national average.
- Emergency admissions for people with schizophrenia are much lower than the national rate.
- Detentions under the mental health act are double the national rate.
- Admissions to a mental health bed per 100,000 population is at national average levels.
- Hospital admissions for deliberate and unintentional injuries amongst people aged 0-24 years are higher than the national average.
- 47% of people completing primary care psychological therapies treatment are rated as moving towards recovery, which is similar to the national rate.
- In 2012/13 B&NES spent less per head of population on mental health specialist services than the national average.

DELIVERING THE PRIORITY

Wellbeing

- Public Health England is publishing a national approach to improving wellbeing in October 2014 and we will use this national work to review local work in B&NES.
- June 2014 Pupil Parliaments highlighted the need to focus on gender support for females and males, building on equalities work across schools
- A wide variety of actions to support the wellbeing of young people are being coordinated via the Children and Young People's Emotional Health and Wellbeing Strategy including work on the early identification of, and intervention with, children and young people displaying emotional distress. This includes counselling services, peer support and training to support attachment and nurture of the child.

- A new pilot service is starting in November 2014 allowing young people (aged 16-18) to directly access CAMHS practitioners. This may help address “reluctant” young people being referred from other services who subsequently do not engage with treatment and encourage other vulnerable young people to seek help without needing to approach an interim ‘referring’ service.
- The Director of Public Health Awards are given to those schools and colleges that increase the levels of support to targeted vulnerable groups of pupils and which actively promote emotional health and wellbeing in their settings. Settings are encouraged to reflect on local ‘intelligence’ from the School Health Educational Unit surveys and Pupil Parliaments.
- A Wellbeing College has been commissioned as a pilot project by B&NES CCG, Adult Care and Public Health. Work is underway to provide courses which help people manage their long term conditions and mental health, develop a healthy lifestyle, manage key social issues such as housing, employment and debt and achieve wellbeing through learning new skills and pursuing interests. Through a "college" approach a range of educational courses and access to resources can be made available for people to understand their conditions, share their experiences, learn ways to manage their conditions, build their skills, support one another and take control.
- A joint approach to improving the physical health of people with severe mental illness is also being implemented. This will require more systematic checks of key lifestyle risk factors amongst people using the services of Avon and Wiltshire Mental Health Partnership NHS Trust (AWP).
- Somer Valley FM have been piloting an information campaign to promote the Five Ways to Wellbeing amongst local people demonstrating success in widening the organisation’s seen to be delivering a wellbeing message.

Self-harm

- A new programme of support for people who attend the RUH emergency department following self-harm starts in September 2014. We expect to see a reduction in the number of people who are readmitted in the future.

Suicide prevention

- In addition to promoting wellbeing and reducing self-harm, we are working closely with specialist mental health services for young people and adults to ensure that key national recommendations for reducing suicide risk are being implemented locally.
- The feasibility of setting up a bereavement support group for people affected by the sudden death of a family member or friend is being explored.
- Targeted specialist support is provided to schools – staff and pupils - who have experienced a suicide of a school member.
- Training sessions on suicide were provided during the Spring of 2014 to around 150 front line staff across B&NES from all sectors.
- We are working closely with colleagues across the West of England, Bristol University and AWP to develop a joint system for monitoring suicide data from the Avon Coroner. This would provide more timely and insightful data than has been available.

Mental Health services update

Within primary and community mental health services we have seen:

- A continued increase in the development of peer support and service user/carer led activities through the Building Brides to
- Wellbeing and Creative Arts projects as well as maintaining funding into Quartet grants.
- An increase in the self-management of long-term health and mental health conditions through piloting a Wellbeing College.
- Fully develop a Single Point of Entry Primary Care Mental Health service combining the Primary Care Talking Therapies and
- Liaison teams in order to expand the range and types of intervention available and meet the national target of 15% of the prevalent population accessing services by the end of 2014-15.
- The provision of an episode of mental health reablement normally for up to 6-8 weeks (or up to 12 weeks in a smaller number of cases) at the beginning of a pathway of care providing intensive support to resolve acute social care related issues that may be undermining mental wellbeing.

- The development of a short stay Respite facility attached to the reablement team for those who would benefit from short periods in a different environment.
- A remodelling of Sirona Care and Health floating support services, to staff an expanded reablement service and a Community Links service (previously Community Options).
- Supporting service users who have received long term support from Sirona Care and Health to access an alternative provider of floating support by October 2014 (or by January 2015 in exceptional circumstances).
- The establishment of a social prescribing service across B&NES to link with new domestic violence initiatives.
- The re-design of the vocational and job retention employment service in the context of low levels of employment compared to the rest of the population. Further advice and support from the health and wellbeing Board ion this issue is welcome.

Within Specialist Acute Mental Health services we have seen:

- Improvement in the local integration of specialist mental health services into all the pathways of care as described above.
- Improvement in organisations working together to address people's physical and mental health needs such as the mental health liaisons services
- An improvement in a how we support people needing treatment at home or an assessment in a crisis e.g. the Place of Safety assessment suite being used rather than a police cell to assess someone in distress picked up by the police. A new, all age Place of Safety has been opened at Southmead Hospital.
- Work taking place with commissioners to improve the quality of local adult in-patient facilities following serious concerns from staff and CQC about the ward environments.

THE PUBLIC AND PATIENT VOICE

All mental health community service developments are taking place in conjunction with the Mental Health Wellbeing Forum, service users and carers. The mental health commissioning strategy is being rewritten focused around the service users and carer research document "Bridging the Gap".

AWP, Oxford Health and commissioners have already and will continue to engage with Healthwatch, Your Health, Your Voice (CCG participation group) stakeholders, clinicians, staff, service users and carers regarding in patient provision in line with their public duty requirements to involve the community under Section S244 of the NHS Act 2006 (as amended).

ASSESSING PERFORMANCE

All service will continue to be monitored against the KPIs embedded in their contracts that inform the content of this paper.
In order to monitor ongoing performance against priorities we need to develop metrics for success in relation to:

- Embedding the notion of Parity of Esteem for physical and mental health
- Embedding support for people in a mental health crisis across all sectors
- Improving accommodation options for adults with serious mental health problems in B&NES
- Improving the employment options for adults with serious mental health problems in B&NES
- Reducing stigma about mental health and promoting wellbeing

However, work is already taking place with providers of services in relation to Parity of Esteem and the mental health crisis concordat and will inform local measures of success. In addition, the Health and Wellbeing Board have agreed to sing up to the Time to Change campaign in order to support reducing mental health stigma and promoting wellbeing.

We will continue to measure the accommodation and employment status for those with the most serious mental health problems and work with the private and statutory housing and employment sectors to encourage greater understanding and support for adults with mental health problems.

JHWS Priority	**Enhanced quality of life for people with dementia**
Outcome	**Improving the quality of people's lives**
Officer lead	**Laura Marsh, Commissioning Manager for Long Term Conditions (NHS BaNES CCG)**
Member lead	**Dr Ian Orpen, Health and Wellbeing Board Vice Chair and NHS BaNES CCG Chair**

THE BIG PICTURE

- The percentage of population diagnosed with dementia has increased both locally and nationally, to 0.61 in BaNES and 0.65 in England (September 2014).
- 1,225 people in BaNES are registered as having dementia (September 2014).
- Nationally the Department of Health and Alzheimer's Society have set an estimated prevalence of people with dementia for each CCG area and the expectation is that CCGs will achieve 66% of people with dementia being diagnosed and appearing on GP QOF databases by 2015. The BaNES dementia diagnosis rate was 47.2% in September 2014 and the overall South of England diagnosis rate was 50.9% with no CCG meeting the 66% target.

Health inequality

- People living in rural areas may have difficulty accessing services
- Black, minority and ethnic communities experience lower levels of awareness of long term conditions such as dementia
- 50% of nursing homes residents are estimated to have dementia

DELIVERING THE PRIORITY

Current Service Provision

If a patient is having memory problems and dementia is suspected, patients in BaNES would be referred to the memory clinic which is operated by RICE at the RUH. At the memory clinic, patients are assessed and, if appropriate, diagnosed with dementia. A Dementia Support Worker and Carer's Support Officer are usually present at the clinic in order to provide immediate support to the person diagnosed with dementia and their carer if necessary. There is a history of strong partnership working with the voluntary sector in BaNES and the CCG continues to facilitate the dementia care pathway group in order to bring all partners together on a regular basis.

In order to ensure patients with dementia receive good quality support, the CCG has commissioned:

- A Dementia Support Worker service to support people recently diagnosed or in the process of obtaining a diagnosis of dementia (provided by the Alzheimer's Society)
- Memory Technology to support people with dementia remain as independent as possible (provided by Sirona Care and Health CIC)*
- Integrated hospital and community pathways using dementia co-ordinators and additional mental health liaison nurses in order to ensure patients with dementia are on correct care pathway and to facilitate timely discharge (provided by RUH)*
- A Rural Independent Living Support Service to help people living in rural areas access services (provided by Curo)*
- A Home from Hospital service to support a successful discharge from hospital (provided by The Carers Centre and Age UK BaNES)*
- A Community Hospital and Care Home Support and Assessment service to help community hospitals and care homes better people in their care with dementia (provided by Avon and Wiltshire Mental Health Partnership Trust)*

**These projects were the Dementia Challenge Fund projects that the CCG agreed to fund for 2014-15. Funding for 2015-16 will be decided pending evaluation.*

In addition to the CCG commissioned services, other services include:

- Dementia cafes and singing for the brain is offered in various locations in B&NES with other community developments underway
- Guideposts Trust provides information from dementia diagnosis to end of life care – including a B&NES specific information prescription the website.
- A dementia friendly ward at the RUH (Combe Ward). The garden attached to Combe Ward is currently being completed.
- Home Safety Checks
- Carers Support

Successes with Current Service Provision

- Dorothy House provide dementia training courses for registered practitioners and care homes and are working with AWP's community hospital and care home liaison service to improve end of life care training and support for staff.
- Dementia Friends sessions have been made available for CCG and Council staff and the sessions are now being offered to other organisations including the Sainsbury's store in Odd Down, Bath.

Challenges with Current Service Provision

- There has been difficulty improving the dementia diagnosis rate and BaNES is in the bottom quartile for South of England. The memory assessment pathway for primary care have been reviewed and revised to ensure patients receive a more timely diagnosis but a data quality exercise will now also be conducted to ensure that diagnosed patients have been recorded appropriately. Currently the diagnosis rate is 47.2% against a target of 66%.
- Work regarding the re-provision of assessment beds for service users with dementia is ongoing.

Next Steps for Service Provision

- Continue focus on improving dementia diagnosis rates.
- Continue to support the development of dementia friendly communities.
- Evaluation of the five Dementia Challenge Fund projects.

THE PUBLIC AND PATIENT VOICE

The 'Your Health Your Voice' group (a group of members of the general public who the CCG consult with) were consulted on the provision of mental health inpatient facilities including the assessments beds for service users with dementia in September 2014.

ASSESSING PERFORMANCE

NHS England is committed to pushing up dementia diagnosis rates and has a national target to achieve 66% of people with dementia being diagnosed and appearing on GP QOF databases by 2015. In BaNES we are tracking our progress and working to meet this target.

Indicator type	Indicator Description	BaNES 2012 / 13	BaNES 2013 / 14	BaNES 2014 / 15	South England 2014 / 15	England Average 2014 / 15	To improve	Compared to England average & data trend		Supporting Narrative
Local	Referrals to the RICE memory clinic for assessment / diagnosis	517	641	662	n/a	n/a	⇧	G	⇧	Increased referrals to the RICE Memory Clinic support increased diagnosis. The referrals meet the planned levels in BaNES. (2014/15 is forecast out turn based on data up to August 2014.)
Local	People receiving memory assessments	404	511	550	n/a	n/a	⇧	G	⇧	People referred to the RICE Memory Clinic meet with the service and where appropriate a full assessment is carried out. Around 80% of people referred have an assessment. (2014/15 is forecast out turn based on data up to August 2014.)
National	% of population diagnosed with dementia	0.58%	0.61%	0.61%	0.72%	0.65%	⇧	G	⇧	The % of population diagnosed with dementia is lower than the national average and this is probably due to lifestyle factors (e.g. lower smoking rates, lower obesity rates etc.). The number of diagnoses compared to the GP population (2014/15 results are as at September 2014.)
National	Estimated diagnosis rate for people with dementia.	42.1%	47.3%	47.2%	50.9%	54.1%	⇧	R	⇔	This is the national indicator often quoted in the news. The measure compares an estimated prevalence of dementia within BaNES against the number of people diagnosed with dementia and recorded on GP systems. (2014/15 results are as at September 2014.)

Once people are diagnosed with dementia the aim is to improve the care and experience of these people and their carers. There are a number of services (detailed above) that have been set up and continue to develop to improve care and experience. The five Dementia Challenge Fund projects are currently being evaluated and as the CCG commissioned services develop; performance assessment will be set up and shared.

Sources of Information used in this section include:
Bath and North East Somerset JSNA - **http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics**
Health and Social Care Information Centre – **https://indicators.ic.nhs.uk/webview/** (please note: some of this website is limited to relevant user access)
Primary Care Web Tool – Dementia Prevalence Tool - Authorised access only

JHWS Priority	**Improved services for older people which support and encourage independent living and dying well**
Outcome	**For older people to feel safe and well supported to the end of their life**
Officer lead	**Sarah Shatwell, Senior Commissioning Manager for Non-Acute & Social Care** **Catherine Phillips, Commissioning Manager for Maternity, Urgent Care and Non-Acute Services**
HWB member lead	**Diana Hall Hall, Healthwatch B&NES representative**

THE BIG PICTURE

- The projected population increase in Bath & North East Somerset between now and 2021 is 30% and this is expected to mainly be in older age groups; in particular the 85+ age group is expected to increase by 1.2% in the same time period. The main demand pressure for all forms of health and social care services is arising from the growing elderly population and rising life expectancy.
- The health of people in Bath & North East Somerset is generally better than the England average. Over the last 10 years, mortality rates for all causes have fallen by 32% - reduced from 731 per 100,000 in 1993 to 495 per 100,000 in 2010- a downward trend which is reflected in England and in similar authorities. Life expectancy is rising (currently 80 years for males and 84 years for females in B&NES).
- The four leading causes of mortality in Bath & North East Somerset are conditions of the heart; cancer; conditions of the lungs; and diseases of the bowels, liver, kidney, stomach although levels of all these conditions are lower than all England and South West average rates.

Trend in Demand - LTC

Condition	2012	2021	Number Change	Percent Change
Hypertension	42,221	45,270	3,049	7%
Chronic Kidney Disease	13,428	14,823	1,395	10%
Angina	6,406	7,121	715	11%
Diabetes	7,422	8,004	582	8%
Dementia	2,449	2,871	421	17%
Atrial Fibrillation	3,045	3,458	412	14%
Asthma*	13,162	13,513	352	3%
Congestive heart failure	2655	2973	318	12%
COPD	3,656	3,924	268	7%
Stroke	1,057	1,169	112	11%
Rheumatoid arthritis	1,274	1,377	103	8%
Depression*	4,658	4,748	90	2%
Fibromyalgia	4,338	4,394	55	1%
Epilepsy*	1,736	1,787	51	3%
Parkinsons Disease	345	388	43	13%

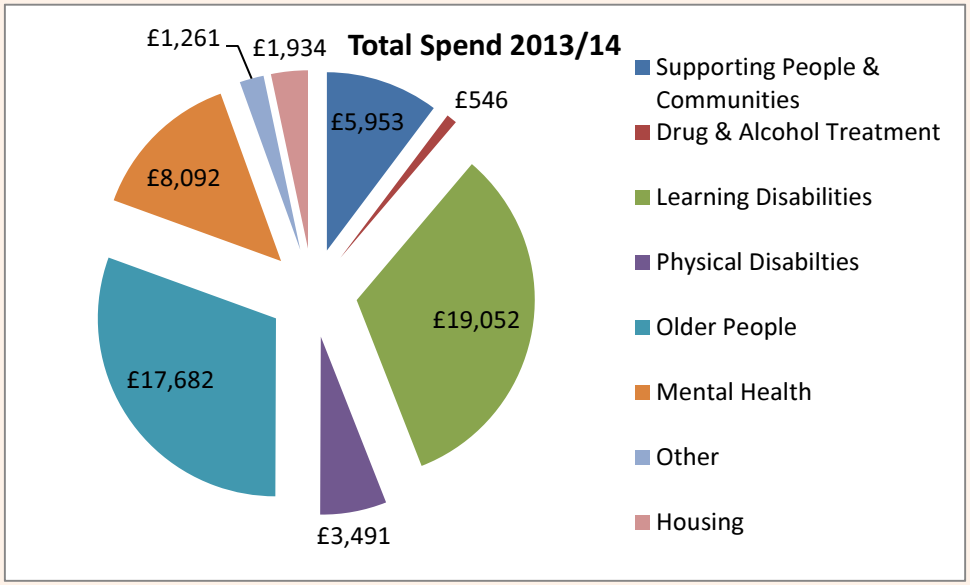
- With these demographic changes comes a corresponding increase in the prevalence of long term conditions such as diabetes, circulatory, respiratory and neurological conditions which means that often people are living longer with increased complexity of health and social care needs. The health of people in Bath & North East Somerset is generally better or in line with the England average, however, as shown in the table below, the prevalence of all conditions is rising, in line with national and regional rates.
- The National Dementia Strategy indicates that there are approximately 700,000 people in the UK with dementia and this number is expected to double within the next 30 years. However, only 45% of people in England receive a formal diagnosis of dementia or have contact with specialist services and without this diagnosis and support, they are unable to make informed plans for their future or access support and treatments that could help.
- The prevalence of reported dementia in Bath & North East Somerset is slightly lower at 0.4% than the national average of 0.5% although we believe there is significant under-reporting; the Clinical Commissioning Group (CCG) is aiming to increase the diagnosis rate. The number of people with dementia is expected to increase by 23% for females and 43% for males between now and 2025 however there are more women than men with this condition both now and predicted for the future. Local surveys tell us that Dementia and Alzheimer's are specific conditions which cause most concern for local people and demand data from partner providers suggests an increasing need for specialist dementia nursing beds.
- Despite relatively low levels of social inequality in Bath & North East Somerset a small number of areas experience significant inequality (Twerton West, Whiteway,

Twerton, Fox Hill North, and Whiteway West. For example the difference in life expectancy is 6.5 years between these areas and the least deprived areas (48 wards are in the least deprived 20%). In the most deprived areas social inequality has a significant relationship with a wide range of health and social care needs and this is reflected in demand for Adult Social Care services.

- There is a 60% higher prevalence of long term conditions and 60% greater severity of conditions for local people living in the most deprived areas of Bath & North East Somerset with a higher prevalence of problematic alcohol use and mental ill health adding further complexity.
- In Twerton West, Twerton and Fox Hill North more than 20% of residents of working age are in receipt of out of work benefits which is significantly greater than the wider Bath & North East Somerset community.
- Recent welfare reform changes suggest that the greatest economic impacts will be experienced by local people living in the most deprived areas with corresponding increase in demand for Council funded support.

DELIVERING THE PRIORITY

The number of people seeking assistance from social services has changed over the past five years. Local analysis of social services contact activity between April 2012 and February 2013 highlighted that more than 4,200 individuals made more than 6,000 separate contacts to request assistance of some kind. In 27% of cases contact resulted in no action being taken by social services as the request related to another Council department or local service provider. These findings prompted the development of a Council wide Information & Advice strategy and also significant review and re-design of the Adult Social Care pathway. Early data from the redesigned pathway shows us that a similar number of contacts are being made with social services however a greater number of people are being diverted into other services such e.g. re-ablement to help them maintain their independence.



In 2013-14 we spent just over £58m on adult social care services in B&NES including residential and nursing home placements, Personal Budgets & Direct Payments and domiciliary care services for all service user groups. More than £17m of the total budget was spent on service for older people.

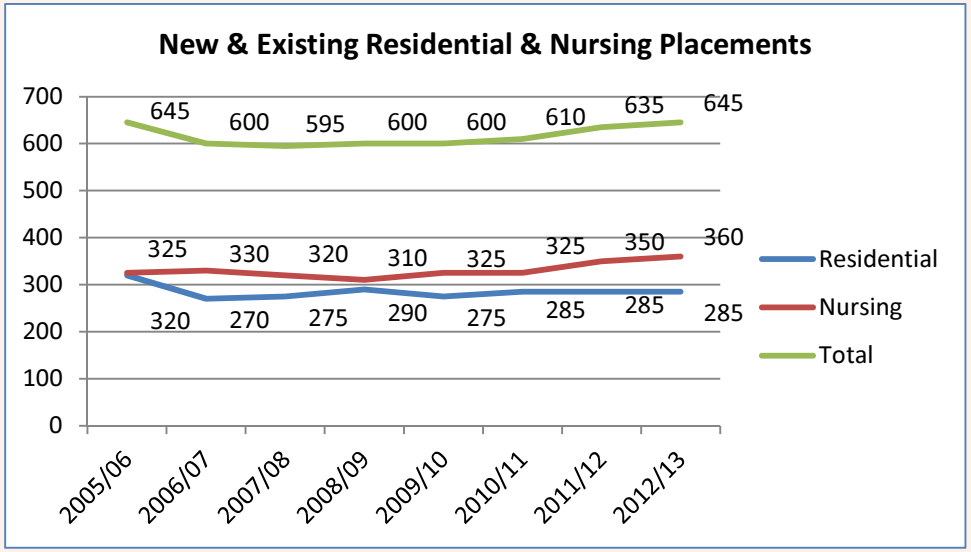
There are currently 57 residential and nursing homes under contract in B&NES, mainly providing placements for older people, but also including a small number for people with learning disabilities and mental health problems. All local providers who meet CQC essential standards and are able to demonstrate compliance with the B&NES services specification for residential and/or nursing care may be issued with an umbrella contract subject to these quality checks.

Once a contract is established Sirona are responsible for making placements in care homes as part of their delegated social work function. We estimate that around 55% of all care home beds are occupied by people who fund their own care which means that Sirona commission 45% on behalf of the Council.

The self-funder market in B&NES is strong and the Council must work closely with providers to ensure that we can secure the number of placements we require to meet statutory demand. We are aware that the balance of income between self-funding clients and those placed by the local authority is a key factor in making provider finances stack up.

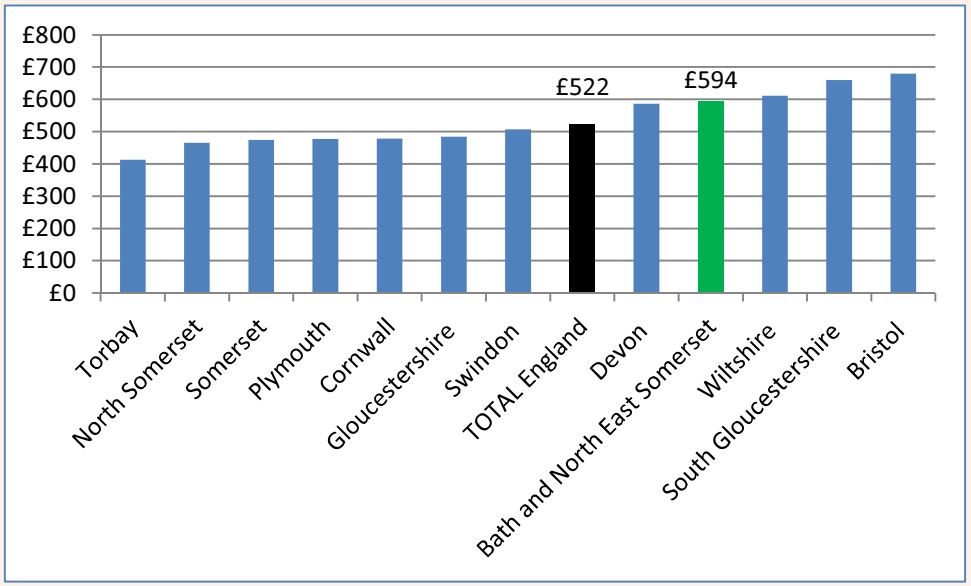
There are four large providers in B&NES (including Sirona) who supply 51% of all placements commissioned by the local authority with the remainder being supplied by the other 53 providers. Price is the greatest limiting factor in relation to the largest providers with smaller operators being able to offer more competitive rates locally, likely to be a reflection of the types of business models smaller providers operate e.g. not for profit, sole traders, family concerns.

B&NES benchmarks high in terms of residential and nursing home placements when compared to other local authorities, the chart below show the number of *new and existing* placements that were made in each calendar year by B&NES over the last eight years. Although the overall number of placements has not changed significantly, there has been a marked shift from residential to nursing placements with a substantial proportion of the latter being dementia nursing placements.



Snapshot analysis of care home residents in B&NES shows that 26% are male and 74% female with average ages of 81 and 86 years respectively, which compares with average life expectancies across the whole of B&NES 80 and 84 years respectively. This suggests that the quality of care home provision in the area contributes to a rise in life expectancies and/or that we are effectively targeting the most needy, and this in turn has an impact on the duration of placements as illustrated by the table below.

A significant proportion of individuals placed by B&NES (31%) maintain their placements for two years or more which contributes to a cumulative effect, when considered alongside new placements, of increasing demand pressure. However, the average length of stay for B&NES care home residents (Council placements) is an estimated 621 days which compares to 801 days found by a large scale investigation commissioned by BUPA[1]. This may reflect the fact that local authority placements tend to be made at later life stages when compared to self-funders who tend to enter the care market earlier, although the local data does support the view that the rate of placements in B&NES is higher in part due to shorter length of stay and a higher 'turnover' rate.



The average weekly cost of supporting people in residential or nursing care in B&NES is approximately £594 compared to the all England average of £522.

At the time of writing there were four domiciliary care 'strategic partners' under

[1] Length of stay in care homes (Julien Forder and Jose-Luis Fernandez, January 2011)

contract in B&NES and four spot providers, plus a small number of 'one off agreements'. The contract with strategic partners is a framework agreement under which providers are paid in advance for the projected number of hours they will deliver, then this amount is adjusted to reconcile with the actual hours delivered. Between October 2013 and December 2013 the total hours delivered by all contracted providers ranged between 4672 and 5040 which is within projected demand limits.

The strategic partners are commissioned to accept the majority of all referrals for domiciliary care made by Sirona part of the statutory social care assessment and care management process. As at 31st December 2013 just over 81% of all commissioned domiciliary care was being delivered by the strategic partners with the remaining 19% being delivered by either contracted spot providers (16%) or under 'one off agreements' (3%).

The table below shows the number of domiciliary care hours commissioned in B&NES at equivalent points during 2012-13 and 2013-14. The fall in hours during the first two quarters of 2013 relates to the exit of one contracted domiciliary care provider from the market and the corresponding transfer of service users to other support services.

The transfer process highlighted the fact that a significant proportion of service users who had been receiving a traditional care service no longer required it, and could be appropriately transferred to alternative forms of support such as the local independent living service or pilot 'enabling service'. These findings provided further support for the re-modelling of our adult social care pathway to focus greater attention on short term, rehabilitative interventions, and also indicate the need for providers to enhance their levels of specialism to support more complex packages of care in order to avoid residential admissions.

	April	June	August	October	December
2012	5016	4922	5006	4627	4796
2013	4489	4451	4661	4658	4874
Net change	-527	-471	-345	+31	+78

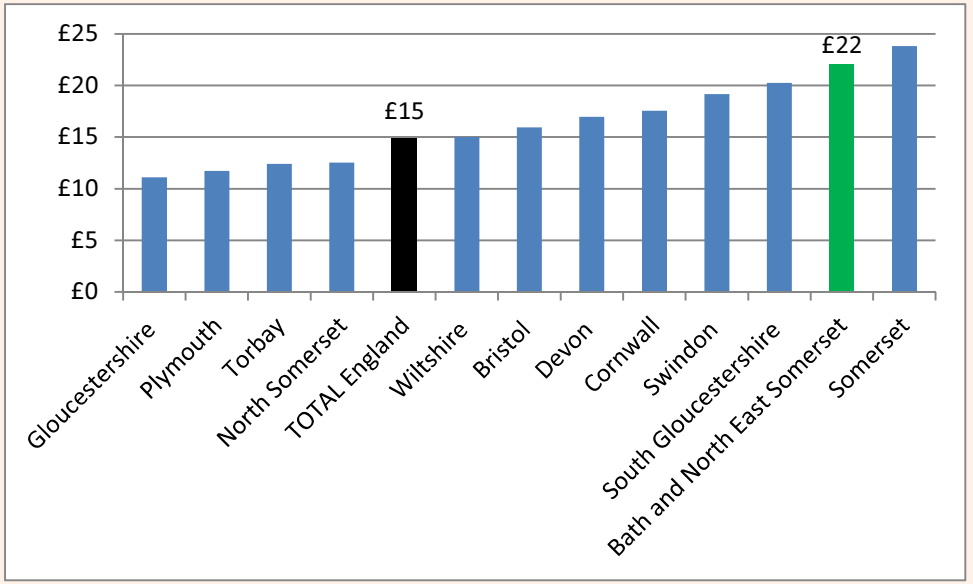
The average gross hourly cost of home care in B&NES is around £22 compared to the all England average of around £15.

The fall in domiciliary care commissioning is however of some concern when seen in the context of national trends which show a 3% increase in expenditure on domiciliary care services and day services in recent years. Based on the comparator rates above, the relative cost of supporting someone to live at home could be considered to be more expensive than placing them in residential care, especially if their care needs are high, which may to some extent explain the bias towards residential provision in the area.

Another factor influencing the range and type of care packages that are supported in the community, with domiciliary care being the main element, is the availability, specialty and quality of current provision, particularly in supporting service users at the end of their life, as well as the availability of related end of life care support for community care packages.

The National Audit of Intermediate Care captures key data about our integrated health & social care re-ablement service. The service, delivered by Sirona received 3115 referrals in 2011-12, rising to 3462 in 2013-13. The acute hospital was the main source of referrals to the service followed by GPs then other community sources. Of all referrals received in 2011-12 95% were accepted and this rose to 96% in 2012-13. The number of individual contacts with service users also rose during this period from 24,198 to 29,31l although the average duration of the service fell by one day from 38 to 37 suggesting a higher intensity service is now being delivered i.e. more contacts over fewer days.

The number of whole time equivalent staff engaged in delivering the service has been boosted from 48.65 in 2011-12 to 55.51 in 2012-13 with further investment in 2013-14 to facilitate seven day working. Performance data for the service shows that on average 85% of service users are able to continue to live independently after receiving re-ablement.



A range of other re-ablement services have been trialled during 2012-14 with the aim of supporting an increasingly diverse range of service users in less traditional ways, for example through the delivery of home safety checks prior to hospital discharge, extended practical support in the home post discharge and bespoke step down units in community settings (refurbished and adapted social housing stock). Re-ablement support has been delivered to younger people, people with problematic drug/alcohol use and non-weight bearing service users via these innovative pilots.

The Care Act which received Royal Assent on 14th May 2014 places evermore attention on providing help for people who fund their own care. We are aware that, as a Council, we will need to review our activities in the near future to ensure that people who self-fund make the right choices at the right time to make best use of their resources. Our early analysis shows that due to proposed changes to financial eligibility thresholds for care and a more generous care cost cap, more people are likely to fall into eligibility for social care. This, alongside a broader offer to carers will impact both on the volume of assessments the Council will need to offer and the share of market provision we will need to secure.

The Association of Directors of Adult Social Services (ADASS) has developed a financial model to assess the likely impact of the Act on local authority finances. The model uses current demand information to project the potential financial picture at the point at which the full impact is felt, thought to be 2019.

Overall estimates have been made to inform the strategic planning process however, such early estimates should be treated with caution as they are constrained by a number of factors:

- Availability and accuracy of information, particularly in relation to people who currently fund their own care
- Lack of final guidance from central Government, due in November 2014
- Unknown market response to Care Act as it comes into force
- The potential behaviour of service users and carers
- Flaws in modelling tools

The model is premised on two elements:
The care cap - the amount an individual will have to pay towards their own care before social services has a duty to fund them
Threshold changes - the income and capital an individual may keep, below which amount social services must pay for their care

In B&NES it is estimated that these key changes will have limited impact on services for older adults until 2019. However, it is estimated that the council will see a potential loss of income in relation to younger disabled adults i.e. the financial changes will mean that social services becomes responsible for funding the care needs

of younger disabled adults to a greater extent than is currently the case and as a result income from charging for services is likely to be forfeited.

A third significant element of the Act will be the **Deferred Payment Scheme** under which recipients of social services will be able to set the value of any property they own against the cost of their care. The immediate cost of care will be met by the local authority, potentially resulting in financial flow issues as well as changes in the administrative arrangements to manage the scheme.

It also recognised that the volume of requests for both service user and carer assessments will increase significantly and that the provision of social care services to carers is also likely to increase given the broader definition of eligible carers signalled by the Act. Carers assessments could potentially increase by as many as 2998 based on current rates with the provision of services increasing by as many as 330 additional care packages or direct payments.

Providers should anticipate a potential increase in demand for services such as replacement care however it is challenging at this stage to estimate the likely scale of this. Contractual arrangements with carers' services and with a range of other providers will be reviewed as required as the new legislation is enacted.

In summary, it is anticipated that the changes brought about by the Care Act are likely to result in additional cost pressures on the Council in the region of £2.4m, some but not all of which will be met by new burdens funding from central Government.

We have identified the need to develop the market in a number of service areas, building on existing good practice and mainstreaming models of care & support that we have already tested. The redesign of our adult social care pathway means we will be placing much greater emphasis on short term services which promote people's recovery and less emphasis on longer term packages of care which may create dependency.

A large proportion of community health and social care services in B&NES, including professional services such as community nursing, re-ablement and social work are delivered under contract by Sirona. A major priority for commissioners at the time of writing is to clarify more accurate timescales for the re-procurement process and to establish which service elements within the current contract will be re-let. The outcome of early discussions will have significant bearing on commissioning intentions for the wider care market in B&NES across all areas including residential, domiciliary, community and voluntary sector provision.

In the meantime, our current commissioning priorities are outlined below:

Complex Nursing & Dementia Care Beds

Whilst demand for standard residential beds is declining, we are experiencing increasing difficulty in securing a sufficient volume of complex nursing and dementia nursing beds within our care home sector in B&NES. If we continue to see demand pressure at the same rate as presently, accounting for demographic growth and duration of placements, we estimate that we will require between 75 to 120 additional placements over the next five years.

Providers will need to consider the physical suitability of care home premises as well as any registration and staffing requirements to be in a position to respond to market demands. Models of provision will need to be flexible enough to support service users with the following conditions and presentations:

- Progressive and degenerative conditions such as Motor Neurone Disease, Parkinson's Disease, stroke, heart conditions and dementias
- Complex and/or challenging behaviour associated with a range of dementias or acquired brain injury
- Intensive nursing needs to maintain skin and tissue viability
- Bariatric care

Domiciliary Care Services
As the care and support needs of people supported to remain in the community become more complex, the domiciliary care market will need to respond accordingly. As well as a shift in culture and practice towards the delivery of active re-ablement support, providers will need to further develop and increase their specialisms in the following areas:

- Dementia care
- End of life care
- Support with complex health packages e.g. managing long tern neurological conditions

Providers are also likely to need to adapt to different ways of delivering their services for example offering localised, patch based interventions in specific geographical areas (rural support model), offering low level enabling services (independent living model) and managing Personal Budgets on behalf of service users (Individual Service Fund model).

Despite the recent downward trend, with a focus on increased specialism of provision we anticipate that demand for domiciliary care services will rise steadily over the next five years. This will be partly in response to changing models of service delivery which aim to avoid the need for traditional residential care and support people to live as independently as possible with interventions from re-ablement services wherever possible. Based on these trends we estimate that we will require additional hours of domiciliary care over the next five years and we would also like to see the market for Personal Assistants grow in order to offer greater flexibility and more personalised services to service users and carers

Re-ablement & Rehabilitation
Our existing integrated re-ablement model is set to expand with additional investment from the Better Care Fund in 2015/16, with investment in 2014/15 by the Council to enable early implementation. Our intention is to provide a short term, intensive period of re-ablement to anyone who has clearly defined rehabilitation potential or appears to be in need of social care services. The model of service delivery we are building on comprises three main components:

- Integrated health & social care assessment leading to an integrated re-ablement plan, contributing to onward assessment (where appropriate) for longer term care
- Partnership with domiciliary care strategic partners
- A range of settings for re-ablement including bespoke step down units, non-weight bearing beds in care homes and ‘at home’ as well as in-reach re-ablement into care homes and extra care schemes

In order to deliver our expanded vision for integrated health & social care re-ablement we will rely strongly on our domiciliary care strategic partners to work collaboratively with Sirona to provide a seamless service to users. We anticipate that the service will receive in the region of 6000 referrals per year and will require domiciliary care capacity up to the equivalent of 48 full time re-ablement workers.

Domiciliary care staff will be required to work in a different way to deliver re-ablement care and support plans and this is likely to have an impact on the volume of longer term packages of care that we commission. Staff will need to be trained and supervised to shift their thinking and practice from ‘caring for’ towards re-abling.

THE PUBLIC AND PATIENT VOICE

Service users have indicated, particularly in relation to end of life support, that we could improve how things work in the following ways:

- Make it easier for people to access a hospital bed at home to help with the delivery of end of life care
- Make it easier to access night care at home for people who are near the end of their life
- Improve the clinical skills and investment in training and support for care staff

- Make it easier to access continence pads
- Make it easier for families and carers to have a say about their loved ones' end of life
- Build the confidence of care staff so unnecessary admissions to hospital can be avoided towards the end of a person's life

ASSESSING PERFORMANCE

The Adult Social Care Survey and Carers survey provides feedback on both service performance and service user satisfaction on a range of social re related issues.

	2011/12	2012/13	2013/14	Trend / RAG rating	Notes
1A - Social care-related quality of life	18.7	18.8	19.3		Not a percentage, maximum score 24
1B - Proportion of people who use services who have control over their daily life	76	78.2	80		
1C(1) - Proportion of people using social care who receive self-directed support	47.4	51.3	56.3		
1C(2) - Proportion of people using social care who receive direct payments	12.6	14.9	17.4		
1D - Carer-reported quality of life		8.5			From carer survey 2012/13, no surveys in 11/12 or 13/14
1I - Proportion of people who use services and their carers, who reported that they had as much social contact as they would like	49.3	45.7	46		
2A(2) - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	973.2	970.8	896.4		Figures for 2013/14 provisional as using projected population estimates for mid-2013
2B(1) - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service)	93.9	86.2	86.3		

2B(2) - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (offered the service)	2.1	3.2	3.8		Indicator for 2013/14 provisional as it has been calculated using available HES data 2012/13
2C(1) - Delayed transfers of care from hospital per 100,000 population	12.7	12.3	10.8		Indicator for 2013/14 provisional, calculated by NP from data available on NHS website
2C(2) - Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	4.7	6.8	5.8		Indicator for 2013/14 provisional, calculated by NP from data available on NHS website
3A - Overall satisfaction of people who use services with their care and support	63.1	63.2	66		
3B - Overall satisfaction of carers with social services		47.6			From carer survey 2012/13, no surveys in 11/12 or 13/14
3C - Proportion of carers who report that they have been included or consulted in discussion about the person they care for		70.4			From carer survey 2012/13, no surveys in 11/12 or 13/14
3D - Proportion of people who use services and carers who find it easy to find information about services	73	74.8	78		This is the social care client component only for 2011/12 & 2013/14. Only 2012/13 value has the combined client and carer survey values
4A - Proportion of people who use services who feel safe	68.3	65.1	70		
4B - Proportion of people who use services who say that those services have made them feel safe and secure	75.2	78.5	82		

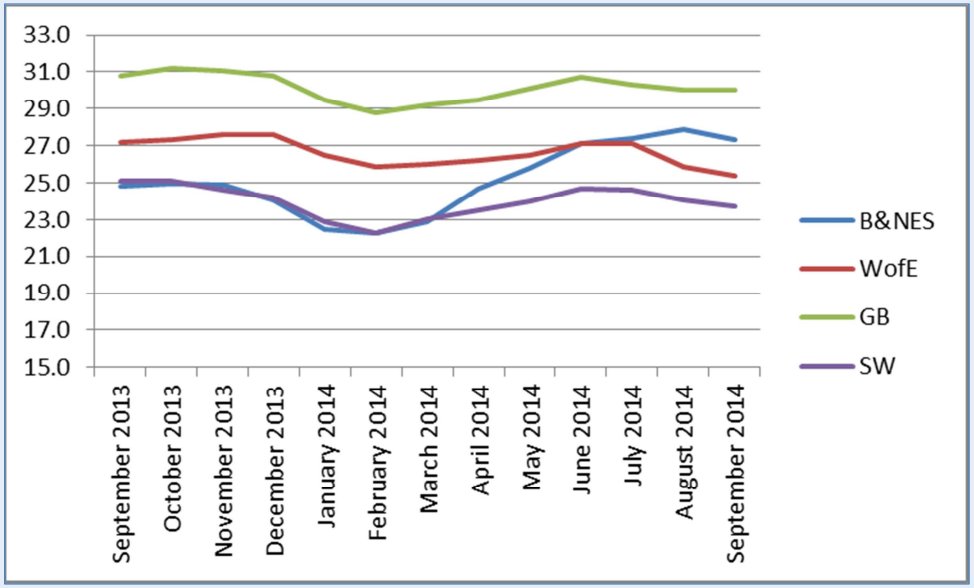
JHWS Priority	Improve skills, education and employment
Outcome	Improve skills, education and employment
Officer lead	Benjamin Woods, Group Manager - Economy & Culture, Skills & Regeneration
HWB member lead	Bruce Laurence, Director of Public Health, B&NES Council

THE BIG PICTURE

Bath and North East Somerset has managed to weather the storm of the economic crisis of 2008 and the following recession. Unemployment is now below 1%, which is its lowest point since May 2008. This is encouraging but there are still levels of long term benefit claimants that represent a resident group experiencing ongoing barriers to entering the labour market. There are issues with lower levels of growth compared to the rest of the region and resident wages remain below national comparators (2% lower). This is especially concerning when compared to average house prices being over 40% higher than the national average.

Health inequality

The graph shows those claiming JSA over 12 months as a % of all claimants in B&NES. Over the last 12 months the proportion of those claiming over 12 months has fluctuated but has remained on a steady increase to a level above the West of England and the South West. **(NOMIS Claimant count age and duration Oct 2014.)**



DELIVERING THE PRIORITY

The B&NES Economic Strategy was approved by Cabinet in September 2014, this is split into three themes; Place, Business & People. The People theme concentrates on the provision of employment and training for local residents and has a sector focus on the Core sectors of Health Care, Hospitality, Retail & Tourism. There is also a focus on improving the provision of Targeted, Recruitment & Training through the planning and procurement process.

THE PATIENT AND PUBLIC VOICE

There is ongoing feedback from employers that young people are not equipped with the right vocational skills in the work place to meet their business needs. Increasingly qualifications are becoming viewed as secondary to the ability to operate competently in the work place. This is also reinforced by the reported lack of available labour force in construction and production engineering/ manufacturing.

This is also further supported by a recent Business West Business Survey suggested that 66% of employers found difficulties recruiting suitably skilled staff and a low percentage believe that school leavers (7%), college leavers (17%) and the long term unemployed (6%) are well prepared for work. The survey also found that this

difficulty in recruiting was one of the top three barriers to growth.

The local care sector has also reported through a work force development event in July that there are increasing issues in both recruiting and retaining staff with the necessary personal skills to deliver a quality care provision.

ASSESSING PERFORMANCE

- Economy and Culture quarterly performance report Total Number of Apprenticeship Starts in the Council and through planning and procurement. 2014 – 2015 target 20 – Q1&Q2 on target with 7 starts.
- S106: Purnell residential development – 12 x work experience placements (with CSCS card provision) and 1 x Apprenticeship start. BWR 3 year training and employment programme complete with 10 x apprenticeships engaged
- Procurement: Keynsham Town Hall development – 2 x apprenticeship starts and 1 x placement for child leaving care. Undercrofts – 10 x work experience placements included in developer agreements
- Core Sectors: Care workforce development event July 2014 attended by over 30 local care providers, has led to the development of a Care Sector Based Work Academy

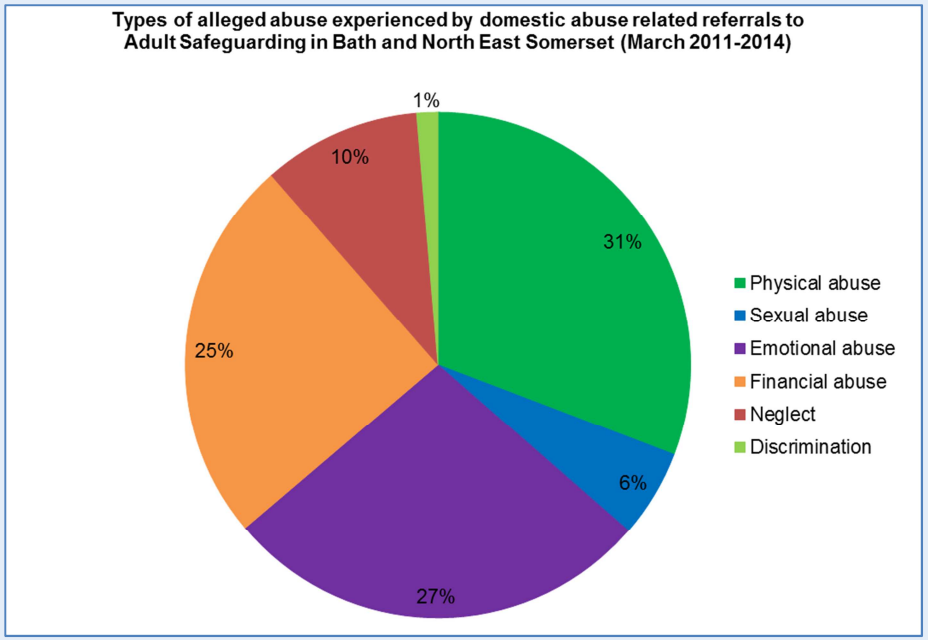
JHWS Priority	Reduce the health and wellbeing consequences of domestic abuse
Outcome	Reduce the health and wellbeing consequences of domestic abuse
Officer lead	Andy Thomas, Group Partnership Manager - Strategy and Performance (B&NES Council)
HWB member lead	Cllr Paul Crossley, Leader of B&NES Council

THE BIG PICTURE

- **£17m** – the estimated cost of domestic and sexual abuse to public services in B&NES
- An estimated 5,936 women aged 16-59 in B&NES will have been a victim of domestic abuse in the past year

Health inequality

There is a "rich picture" of information about this issue locally available in the **Domestic Abuse** section of the JSNA. Estimates suggest women who suffer from ill-health and disability in Bath and North East Somerset are almost twice as likely to experience domestic abuse as those who do not. The main health and vulnerability issues affecting the referrals to Adult Safeguarding linked with domestic abuse in Bath and North East Somerset between March 2011 and March 2014 is set out in the diagram.



THE PATIENT AND PUBLIC VOICE

We involved SEEDS, our domestic abuse survivors' group in recent workshops to co-design new services. From listening to survivors, we have learnt that:

- It is hard to take the first step and tell someone about what they are going through
- Victims would most prefer to receive support from Doctors amongst any professional but nationally only 15% of victims have any reference on an NHS care record
- IDVAs are highly valued in creating a "seamless journey"
- Victims value a range of different ways of reporting domestic abuse

The Health and Wellbeing network also held a workshop on this issue in January 2014 and the meeting notes can be found **here**.

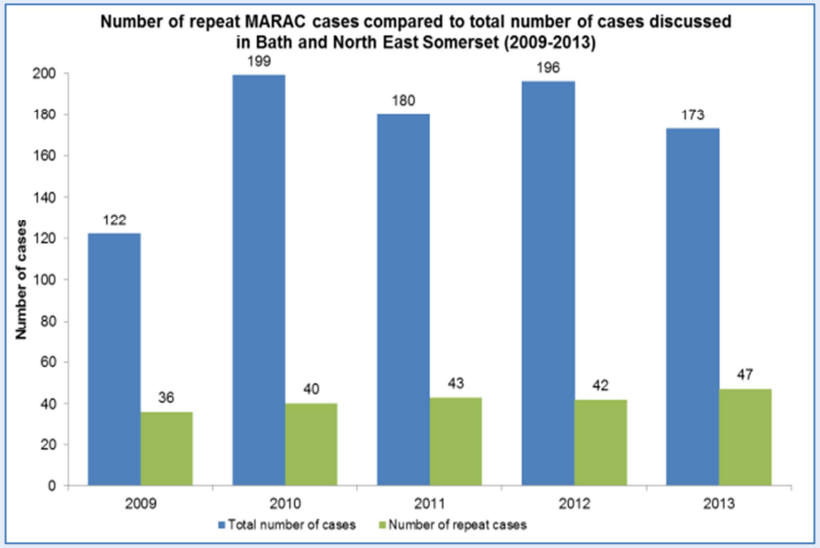
DELIVERING THE PRIORITY

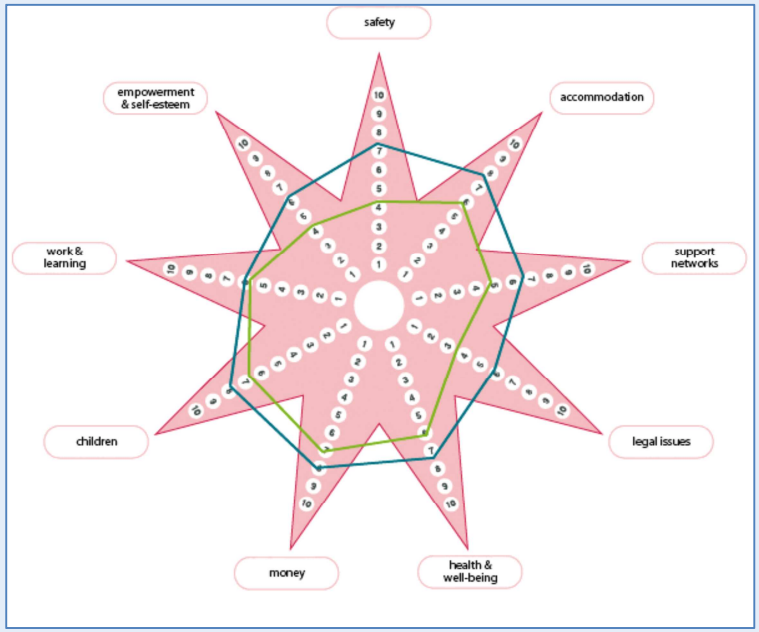
- A summary of existing provision can be found in the **report** on this issue to the January 2014 Board. Our work through the Public Service Transformation Network has highlighted that there are effective services for "high-risk" victims through the MARAC and IDVA services.

- A key challenge however is helping “low to medium” risk victims as well as those who are likely to underreport. Victims of domestic abuse would prefer to be able to disclose to their GP and want them to have the confidence to offer support to those patients who they believe are or have suffered domestic abuse. Conversely GPs and other health professionals report their lack of experience and skills in identifying and responding to domestic abuse.
- The IRIS (Identification and Referral to Improve Safety) project addresses this through a clear pathway from GPs to domestic abuse services. CCG and PCC funding has been brought together to commission IRIS. IRIS will begin operating in November 2014. In addition:
- The new Avon and Somerset-wide “Lighthouse” project aims to improve services for victims of crime, and includes all victims of domestic abuse in its “enhanced” service. Bath & North East Somerset has taken the lead on a cross-Avon and Somerset bid to central government for more early intervention services for victims of domestic abuse, linked to the Lighthouse.
- Bath-based **Voices UK** has been founded by women who have experienced Domestic Abuse. It provides peer support and recovery programmes for women who are experiencing or have experienced Domestic Abuse and is a platform for enabling voices of victims and survivors to inform and improve service provision in response to their needs. The MATES project is designed and led by women survivors of Domestic Abuse to give other women with similar experiences the chance to meet & support each other
- Work is taking place to align commissioning for domestic abuse related services across the Council
- It has been agreed that the Bath & North East Somerset MASH will include domestic abuse

ASSESSING PERFORMANCE

- The key national indicator has historically been MARAC (multi agency risk assessment conference) repeats. We also monitor the number of domestic violence incidents and work with the Police to identify trends. Reporting across Avon and Somerset area has increased and there is some evidence that this is linked to efforts being made to address under-reporting.
- We are increasingly also able to measure the outcomes for people we help using the “outcomes star”.





JHWS Priority	Increase the resilience of people and communities including action on loneliness
Outcome	To be agreed jointly with Public Services Board "everyone has a good network" theme
Officer lead	Andy Thomas, Manager Partnership Delivery- Strategy and Performance (B&NES Council)
HWB member lead	Pat Foster, Healthwatch B&NES representative

THE BIG PICTURE

- **3,000** estimated additional residents aged over 75 in our area by 2021
- **38%** projected increase in over 95s over the same period
- **37%** percentage defining themselves as "single"- higher than regionally and nationally

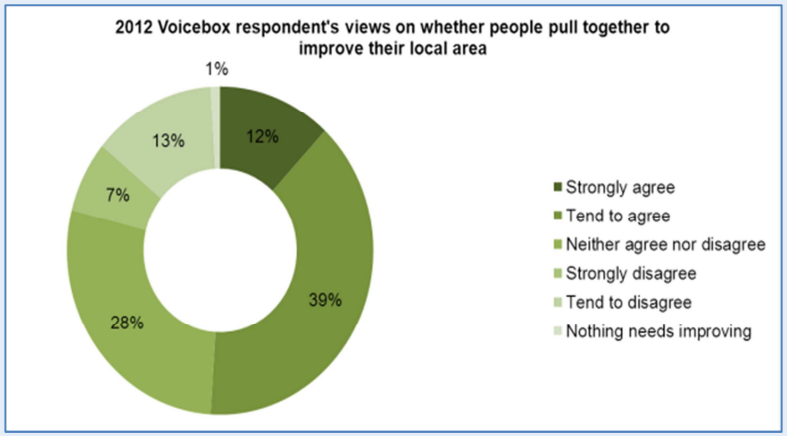
Health inequality

The Health and Wellbeing Board at a recent meeting noted a number of risk factors identified with loneliness, including age and living in rural communities. A recent study by the International Longevity Centre (ILC-UK) and the charity Independent Age noted that there was a particular risk for older men who - the research suggests - are often reluctant to take part in activities designed for older people.

THE PUBLIC AND PATIENT VOICE

"Now I've been to the Village Agents Roadshow and seen the support on offer, it's given me confidence about staying put"

- It is important to distinguish between isolation and perceptions of loneliness and involvement in social networks. We have therefore commissioned research in Bath & North East Somerset (using the international "Duke Scale") so that we can better identify the issues across our area.
- The Health and wellbeing Network at a session in July highlighted a number of key issues including the need to focus on the "quality" of face-to-face relationships between public services and isolated individuals. The notes of the meeting can be found **here.**
- We are also starting to measure the resilience of our communities e.g. our Voicebox highlights that that information about local services was the main mechanism that respondents stated might help them improve things in their local area (35%)



DELIVERING THE PRIORITY

- A summary of existing provision – ranging from befriending schemes to the "Hub in the Pub"- is set out in the **report** to the Board in July. This priority also draws on a range of projects and workstreams which have focused on building stronger communities. In

particular, the Connecting Communities programme aims to build resilience in localities and help communities to help themselves by using all of the capacity available in local communities. The Supporting People and Communities team have identified 81 contracts that help deliver this outcome

- The key challenge in delivering this priority is identifying gaps in provision and bringing together a disparate range of services. In addition, funding for key schemes such as Village Agents is not secure (funding for the Village Agents scheme ends in April 2015)
- A working group is being established to link together a variety of commissioning frameworks. However, "on the ground" projects that deliver what people want are essential. For example, on 1st October Age UK B&NES's Men's Event marked Older People's Day. Hosted at the Bath Cricket Club, the day featured a speech from former England and Bath rugby player Nigel Redman. The event was organised to give Age UK B&NES the opportunity to hear first-hand from men in our area about what sorts of events they would want to be involved with. The results of this are set out below:

ASSESSING PERFORMANCE

The Campaign to End Loneliness has awarded a "Gold" standard for our Joint Health and Wellbeing Strategy - one of only 11 to be awarded it.

150 - number of local volunteers for Age UK B&NES

20 Parishes with Village Agents

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**19/11/2014**
TYPE	**An open public item**

Report summary table	
Report title	Time to Change – tackling mental health stigma in B&NES
Report author	Paul Scott, Assistant Director of Public Health
List of attachments	'Time to Change' Action Plan for B&NES Health & Wellbeing Board
Background papers	Closing the Gap: Priorities for essential change in mental health (Department of Health, 2014) www.gov.uk/government/publications/mental-health-priorities-for-change Time to Change programme www.time-to-change.org.uk/
Summary	Since 2008, national research shows that discrimination has slightly reduced and social attitudes have improved towards people with mental health problems. However, many people are still afraid to seek help and can face discrimination and negative attitudes when they do. Time to Change is England's biggest programme to challenge mental health stigma and discrimination. The Department of Health's ambition is that all Government departments and NHS organisations sign the Time to Change pledge. The enclosed report sets out an action plan to tackle the stigma associated with mental health problems in B&NES. This is part of the work taken forward within the Health and Wellbeing Strategy's objective of improving wellbeing and supporting recovery for people living with mental health problems. If agreed by the Board, the pledge and plan will be signed and submitted to the national Time to Change programme.
Recommendations	The Board is asked to agree that: • The enclosed plan is implemented in B&NES • The plan is submitted on behalf of the Board as its pledge to the Time to Change programme • An update on progress is provided to the board as part of the 6-monthly Health and Wellbeing Strategy delivery report

	on mental health.
Rationale for recommendations	The production of the plan was agreed at the September 2014 Health and Wellbeing Board. It contributes directly to the Health and Wellbeing Strategy which has a specific priority to improve wellbeing and support recovery of people living with mental health problems.
Resource implications	There is no requirement for additional financial resource arising from this plan. Campaign resources are available from the national Time to Change programme. The action plan will be led from existing resources and personnel within the public health division of B&NES Council, in partnership with colleagues from across the Council, the CCG and other local organisations.
Statutory considerations and basis for proposal	People experiencing severe mental illness have a significantly shorter life expectancy than the general population, are less likely to find employment and to live in settled accommodation. Tackling the stigma and discrimination associated with mental illness will contribute to reducing these inequalities. The plan is not mandatory, but the Department of Health have set out their aspiration for all Government departments and NHS organisations to sign the Time to Change organisational pledge.
Consultation	In preparing this headline action plan there have been discussions with colleagues from B&NES CCG, B&NES Council, Sirona Care and Health and the Time to Change national programme. In designing and implementing actions within the plan we would seek to work with local organisations advocating for and representing people living with mental health problems in B&NES.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

Please contact the report author if you need to access this report in an alternative format

‘Time to Change’ Action Plan, B&NES Health and Wellbeing Board

November 2014

“We pledge that we will work to reduce the stigma associated with mental health problems in Bath and North East Somerset (B&NES) by taking a range of actions in our own organisations and providing information to local residents that challenges myths and provides information about sources of support.

We will be running a campaign through our community pharmacies, creating a social norms project with our local college students, working to complete the Workplace Wellbeing Charter and using local media to normalise seeking help from our services.

The work will be led by the council’s Public Health division and overseen by the B&NES Health and Wellbeing Board”.

Activity	Internal lead	Timescale	Time to change resources required	Performance indicator (optional)
Use this plan to progress the anti-stigma component of the B&NES Joint Health and Wellbeing Strategy priority of 'Promoting Wellbeing and Supporting Recovery'. This ensures joint-work between the CCG, Children's Services, Adult Social Care and Public Health and provides overall governance of the work, with sponsorship from senior leaders in the council and NHS.	Paul Scott Public Health, B&NES Council	November 2014 for sign-off and 6-monthly for reporting progress	N/A	Performance reports on mental health for the Health and Wellbeing Board will include updates on the progress of the Time to Change action plan.
Ensure the detail of the work becomes embedded in the forthcoming B&NES Mental Wellbeing strategy.	Paul Scott Public Health, B&NES Council	March 2015	N/A	Anti-stigma work is explicitly set out in the objectives and outcomes of the strategy.
Work with schools to use the range of local resources and programmes available to promote staff and pupil mental health and to tackle stigma and negative attitudes. These include resources for both primary and secondary school and are supported by the DPH Award programme which offers specialist advice and support to all schools in B&NES.	Kate Murphy, Drug & PSHE Consultant, School Development, B&NES Council	On-going programme.	Locally created resources will be used.	School health survey results indicating levels of pupil wellbeing and self-esteem Number of schools using the Positive Mental Health Resources and feedback on impact Numbers of schools with E-Teams (Equality teams) to help promote inclusion and challenge stigma

Work in partnership with the B&NES Workplace Wellbeing programme to support their work on improving mental health and reducing stigma in workplaces, including B&NES Council itself.	Paul Scott and Cathy McMahon, Public Health, B&NES Council	December 2014 to have established links. On-going work thereafter	Variety of resources including postcards, leaflets, event boxes, etc.	B&NES Council will have successfully signed up and completed the Workplace Wellbeing Charter, including the Mental Health component. The number of businesses across B&NES who are engaged with our Workplace Wellbeing programme (eg. through regular attendance at good practice events).
Complete the Time to Change Workplace Health Check self-assessment for the council and the CCG in B&NES, if sufficient funding is available for the national programme to continue in 2015/16. If the Time to Change Workplace Health Check programme is unable to operate in 2015/16 then we will look to undertake something similar, to complement the staff surveys we are already undertaking locally. Use these results and learning from other areas **strengthen our organisational approach to improving and supporting staff mental health.**	Paul Scott and Cathy McMahon, Public Health, B&NES Council and a representative from B&NES CCG	March 2015 July 2015	Advice and support from the Time to Change Health Check team, including self-assessment materials.	The findings from the Health Check self-assessment are included in the next annual refresh of the Time to Change Action Plan and can support the Workplace Wellbeing programme and organisational development work.
Run a case study in Council Connect magazine (delivered to every home in B&NES) with a case study about the journey of someone	Paul Scott, Public Health and B&NES Council Communications	Spring 2015	Time to Change media and reporting guides	Work with a local service in the month after the article has been published to record the number of people who site the article as a

who sought help for a problem and their positive experience as a result. Could be a council or NHS employee and could focus on work retention and good management as well. Key services focused on could be local Psychological Therapies Service or a local employment support, housing or social care service, etc.	Team			source for how or why they contacted these services.
Run a marketing programme across local pharmacies in B&NES normalising the high prevalence of mental health problems and the range of local services available, using case studies where possible to mirror the work done on smoking cessation in recent years (along the lines of '…it's an illness not a weakness' and that services are effective and free).	Paul Scott and Paul Sheehan, Public Health, B&NES Council	Planning: October – December 2014 Delivery: March 2015	Variety of resources including postcards, leaflets, etc.	To develop outcome indicators during the planning phase in autumn 2014.
Meet with Bath City College to explore potential of creating a social norms social marketing programme aimed at improving knowledge about mental health problems and reducing the stigma associated with them.	Paul Scott Public Health, B&NES Council	Exploratory discussions by March 2015 If feasible, work to occur by March 2016	May need a variety of postcard and leaflet resources to start discussions but ultimately the project should build on this to create local materials as well.	A project has been undertaken funding 2015/16. Change in knowledge and attitudes of a sample of college students, before and after the project.

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**19/11/2014**
TYPE	**An open public item**

Report summary table	
Report title	Section 256 Agreement and Funding Allocation 2014/15
Report author	Jane Shayler (01225 396120)
List of attachments	Appendix 1: "Section 256" Funding Allocation & Investment Summary Appendix 2: NHS England Area Team Funding Allocation and Agreed Use Appendix 3: BaNES CCG Funding Allocation and Agreed Use
Background papers	None
Summary	Over the past four years, funding from the Department of Health has been passed, via local NHS commissioners (previously the Primary Care Trust, now, following NHS Reform, a combination of the Clinical Commissioning Group and NHS England Area Team). For the 2014/15 financial year, NHS England will transfer £1.1bn from the Mandate to local authorities; this paper sets out the use of the B&NES allocation of £3.345m & £1.4m of local funding.
Recommendations	The Board is asked to: • Support the agreed use of Section 256 funding in 2014/15
Rationale for recommendations	The Health and Wellbeing Board agreed the B&NES Better Care Plan on the 17th Sept 2014 this set out a summary of the schemes to be funded from the 2014/15 S256 allocation. To formalise the transfer of funding in 2014/15 the NHS England guidance and governance process require the HWB to agree the use of the funding in 2014/15 and the appended S75 agreements. The joint local leadership of Clinical Commissioning Groups and local authorities, through the Health and Wellbeing Board, is at the heart of the health and social care system. NHS England will ensure that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. This local vision is aligned with and makes a significant contribution to delivery of the outcomes in the Joint Health and

	Wellbeing Strategy as follows: Theme One - Helping people to stay healthy: • Reduced rates of alcohol misuse; • Creating healthy and sustainable places. Theme Two – Improving the quality of people's lives: • Improved support for people with long term health conditions; • Reduced rates of mental ill-health; • Enhanced quality of life for people with dementia; • Improved services for older people which support and encourage independent living and dying well. Theme Three – Creating fairer life chances: • Improve skills, education and employment; • Reduce the health and wellbeing consequences of domestic abuse; • Increase the resilience of people and communities including action on loneliness.
Resource implications	In 2014/15, £3.345m will transfer from the Area Team to the Council under the Section 256 agreement (Appendix 2) The local S256 agreement will transfer £1.4m between the CCG and Council (Appendix 3) The funding allocation going into 2015/16 will form part of the B&NES Better Care Fund with the local element £11.091m of the national £3.8bn. The 2015/16 funding allocations have been incorporated into both the Council and CCG financial plans.
Statutory considerations and basis for proposal	This report and the S256 agreements meet the NHS England guidance for the funding transfer from NHS England to social care – 2014/15 issued on the 9th May 2014.
Consultation	The use of the 2014/15 section 256 funding and BCF plan have been developed in consultation with: • Council Section 151 Officer • CCG Chief Finance Officer • Strategic Finance Business Partner – Joint Commissioning • Head of Finance – NHS England Area Team • Senior Commissioning Managers (Council & CCG)
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

1.1 Broadly, Section 256 funding is intended for use in addressing pressures in the health and social care system, including those arising from demographic change; reducing admission to and length of stay in hospital; and to fund community based interventions that prevent an escalation of people's need and support them to live as independently as possible, in the community for as long as possible. The Appendices to this report set out further background detail and agreed use of Section 256 funding for the current year.

1.2 Better Care Fund – Of the £1.1bn national 2014/15 funding £200m has been identified as the 2014/15 BCF allocation, the B&NES element of this funding is £608k. As part of the BCF submission this amount has been earmarked to fund the implementation of the Care Act. As the HWB has agreed the BCF plan submission this conditions relating to this element of the funding should already be satisfied.

1.3 For the remaining funding of £2.737m the NHS England guidance states The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used.

1.4 Bath and North East Somerset has a good track-record of investment of Section 256 funding in early intervention and preventative services and to achieve system change with the aim of achieving longer-term sustainability in the health and social care system. However, as pressure on public resources increases, it is likely to become increasingly difficult to achieve an appropriate balance between responding to immediate pressures in the system including, for example, increases in avoidable hospital admissions; whilst also investing in a longer-term strategic approach to achieve best value, sustainability and, most importantly, better outcomes for service users and carers.

1.5 In this context, plans for use of S256 funding in 2014/15 and the Better Care Fund from 2015/16 onwards have been designed to support delivery of joint objectives set out in key strategies, including B&NES' Joint Health and Wellbeing Strategy and "Seizing Opportunities", the CCG's Five Year Strategy. Accordingly, the overarching aim is to further develop integrated, sustainable models of care that will deliver a greater proportion of care and support to people in their own homes and communities with services that:

- Co-ordinate around individuals, providing person centred care and support that is experienced as seamless by those individuals;
- Maximise independence and community inclusion through an increased focus on early intervention, prevention, self-care and peer support; and
- Empower people to remain in control of their own lives by extending self-directed support and ensuring access to information, advice and advocacy.

1.6 The joint objectives are:

- Proactively identify people who are at most risk of loss of independence or hospital admission and put in place an integrated, personalised care plan, including intensive community support.
- Deliver integrated services that support and safeguard older and vulnerable people to remain independent though timely interventions that contain, stabilise, decrease and/or de-escalate emerging risks, care and support needs.
- Maximise use of health and social care resources through an integrated approach that responds in a sustainable way to the increasing volume, complexity and acuity of older people and those with long-term conditions.
- Further develop and embed integrated commissioning and provision to encompass not only mental health, physical health, social care, public health and housing but also further alignment of the resources, services and partners that influence the wider determinants of health and wellbeing.
- Create a transformation programme that responds to the wider strategic landscape of the Better Care Plan, Joint Health & Wellbeing Strategy, the Care Act, the Council and CCG's wider strategic priorities (especially reducing avoidable admissions and facilitating discharges and reliance on acute care), and the NHS *"A Call to Action".*

1.7 During 2014/15 S256 is being utilised to:

- Consolidate funding and allow for expansion of some existing initiatives
- Support projects that have been funded on a temporary basis or are being piloted to test their impact
- Contribute to the protection of adult social care provision
- Allow for the expansion of 7 day service provision in key priority areas
- Support integrated re-ablement, hospital discharge and admission avoidance schemes
- Support our approach to early intervention & prevention

1.8 Services funded in 2014/15 include:

- Integrated Health & Social Care Reablement & Rehabilitation Service to support prevention of unplanned admissions and hospital discharge;
- Expansion of the Independent Living Service;
- Extended hours working (evenings and weekends);
- Responding to the increases in activity in adult social care including those related to increases in safeguarding referrals;
- Mental Health pre-crisis/respite beds for adults of working age;

- Social Prescribing Service to enable clinicians and health workers to redirect suitable patients away from health services and towards opportunities in their local community;
- Implementation of new duties under the Care Act 2014;
- Handyperson service, step-down accommodation with care, intensive home from hospital (all designed to support hospital discharge);
- Social care pathway redesign to place greater emphasis on prevention, early intervention and rehabilitation, thus reducing and/or delaying the need for more complex health and social care interventions.

Please contact the report author if you need to access this report in an alternative format

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Appendix 1 Summary of schemes to be funded from S256 / Better Care Fund

Better Care Fund	2014/15	2015/16	Description
	£000	£000	
Funding Streams:			
Council Reserve	1,659		
Sub Total	**1,659**	**0**	
National Framework Funding	2,612	2,612	Existing mandated s256
Local Reablement	900	900	CCG Reablement funding
14/15 BCF Allocation	608	608	
Balance transfer*	125	125	*Balance of DCLG NHS allocations to BANES, subject to confirmation
Disabled Facilities Grant		552	
Social care capital		406	
Carer's Breaks		234	
Better Care Funding		6,612	
Sub Total	**4,245**	**12,049**	
Total	**5,904**	**12,049**	
BCF Schemes			
7 day working	350	350	Service developments including adjustments to the Sirona contract
Admission avoidance	208	208	Targeted rural domiciliary care service aimed at admission avoidance
Care Bill Implementation	654	481	Includes contribution to client finance
Hospital discharge	327	342	Handyperson, Step Down & Intensive home from hospital
Integrated reablement	500	500	Sirona - Re-ablement & Rehab
Integrated reablement and hospital discharge	209	209	7 day working - Hospital SW & Core re-ablement
Prevention and early intervention	100	100	OP Independent Living Service
Protection for adult social care services	1,613	1,575	Sirona demographics, safeguarding & employment inclusion
Implementation of new adult social care pathway - Expansion of the Integrated Reablement and Rehabilitation Service	1,425	2,000	Pathway re-design reducing and / or delaying the need for more complex health and social care interventions
Increased capacity in the Approved Mental Health Practitioner Service & DOLS	150	150	Strengthening Councils duty to fulfil its requirements for Deprivation of Liberty Safeguards
Increased capacity in the Learning Disabilities Social Work Service	168	168	Building capacity to carry out reviews and safeguarding
Mental Health Reablement Beds	100	100	Providing a 3-bedded Adult of working age pre-crisis/respite facility
Social Prescribing	100	100	Social Prescribing to enable clinicians and health workers redirect suitable patients away from the NHS and towards opportunities in their local community
Disabled Facilities Grant		552	Essential adaptations to give disabled people better access to essential facilities within the home
Social care capital		406	Capital funding to contribute towards social care community projects
Integrated Care & Support		2,008	
		234	
Adult Social Care demographic change & Preventative Services		2,566	
Total	**5,904**	**12,049**	
Balance	**0**	**0**	

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THIS AGREEMENT is made on [……..]

BETWEEN:

(1) NHS ENGLAND Bath, Gloucester, Swindon and Wiltshire AREA TEAM of Bewley House, Marshfield Road, Chippenham, SN15 1JW ("**NHS ENGLAND BGSW AREA TEAM** "); and

(2) BATH AND NORTH EAST SOMERSET COUNCIL of Guildhall, Bath, BA1 5AW ("**Council**"),

(together the "**Parties**").

WHEREAS:

(A) The NHS ENGLAND BGSW AREA TEAM is empowered by section 256 of the 2006 Act to make payments to the Council in certain circumstances towards expenditure incurred by the Council

(B) The NHS ENGLAND BGSW AREA TEAM has agreed to make payment to the Council to contribute towards the costs of 1) Carers, 2) Grants to Voluntary Bodies and 3) Local Reablement ("Schemes") for the benefit of improving health and wellbeing

(C) By resolution of the NHS ENGLAND BGSW AREA TEAM Board - the transfer of funding for the scheme was recommended pursuant to section 256 of the 2006 Act.

(D) The NHS ENGLAND BGSW AREA TEAM is satisfied that this Grant is in accordance with the 2006 Act and complies with the Directions.

NOW IT IS HEREBY AGREED as follows:

1. **Definitions and Interpretations**

1.1. In this Agreement the following expressions shall unless the context otherwise requires have the meanings herein:

"2006 Act" means the National Health Service Act 2006;

"Annual Voucher" means the statement of compliance with conditions of Grant and expenditure certification as set out in the Schedule 2;

"Balance" means the Total Capital Costs less the Grant;

"Directions" means the Directions by the Secretary of State for Health as to the conditions governing payments by health authorities and other bodies under Section 28A of the National Health Service Act 1977 dated 28 March 2000;

"Financial Year" means 1st April of one year to 31st March of the following year;

"Monies" means the amount of money set out in Schedule 1 payable by the NHS ENGLAND BGSW AREA TEAM to the Council in respect of the Scheme on the understanding that the Council will meet the costs of the Scheme to the extent that it is not funded by the money;

"Nominated Officers" means the Area Team Finance Director (for the NHS ENGLAND BGSW AREA TEAM) and Chief Finance Officer (for the Council) or such replacements as may be notified by Party in writing from time to time;

"Scheme" means the schemes as more specifically described in Schedule 4; and

1.2. The headings in the Agreement are for ease of reference only and shall not affect the construction hereof.

1.3. The Schedules form part of this Agreement and shall have effect as if set out in full in the body of this Agreement and any reference to this Agreement includes the Schedules.

1.4. Words in the singular shall include the plural and vice versa.

1.5. A reference to any Act of Parliament, Order, Regulation, Statutory Instrument, Directions or the like shall be deemed to include a reference to any amendment or re-enactment of the same.

1.6. Where the words include(s), including or in particular are used in these terms and conditions, they are deemed to have the words without limitation following them and where the context permits, the words other and otherwise are illustrative and shall not limit the sense of the words preceding them.

2. Conditions relating to the Funds Transfer

2.1. In consideration of the Council entering into the Agreement and subject to the terms of this Agreement, the NHS ENGLAND BGSW AREA TEAM shall pay the Monies to the Council as described in Schedule 1 and if the Monies are to be paid in instalments, in such instalments as described in Schedule 3.

2.2. The Council shall submit an Annual Voucher which has been duly authenticated and certified in accordance with the Directions to the Chief Financial Officer by no later than the 28 days following the end of each Financial Year.

2.3. The NHS ENGLAND BGSW AREA TEAM and the Council shall at any meeting convened under Clause 2.10 consider the payments made in respect of the Scheme and the NHS ENGLAND BGSW AREA TEAM reserves the right to reduce the amount of any future payments in accordance with section 2(5) of the Directions.

2.4. The Council shall use the Monies in respect of the Scheme and shall not use the Monies for any other purpose other than the Scheme and shall repay to the NHS ENGLAND BGSW AREA TEAM a sum equal to the amount of any part of the Monies which is not so applied.

2.5. The Council shall at all times observe the NHS ENGLAND BGSW AREA TEAM obligation to obtain best value for money.

2.6. The Council shall provide any services that are part of the Scheme:

2.6.1. In such way as to secure the most efficient and effective use of the amount paid

2.6.2. In accordance with all relevant legislation and the Directions; and

2.6.3. In accordance with any policies, performance objectives, eligibility criteria and standards set out at Schedule 4.

2.7. Any part of the Monies that remains in the Council's possession following completion of the Scheme and is not expended by the Council on the Scheme in accordance with Clause 2.4 shall be declared to the NHS ENGLAND BGSW AREA TEAM and both Parties shall use their reasonable endeavours to agree the future use of such remaining funds including, where appropriate

i. The immediate return of the remaining funds to the NHS ENGLAND BGSW AREA TEAM .
ii. The Re-allocation of the funds to finance identified projects/plans in future years.

2.8. The Council shall be responsible for the operational management of the scheme.

2.9. The Council shall provide the NHS ENGLAND BGSW AREA TEAM with the information detailed in Schedule 5 and access to such other information as the NHS ENGLAND BGSW AREA TEAM may reasonably request.

2.10. The NHS ENGLAND BGSW AREA TEAM and the Council shall meet at such intervals as the Parties agree, having regard to the nature of the scheme, to review the scheme.

2.11. Any variation to this Agreement or the scheme must be agreed in writing by an authorised officer of each Party.

2.12. Any complaints in relation to the Scheme shall be notified immediately to the Nominated Officers who shall agree an appropriate course of action to ensure that all such complaints are dealt with appropriately.

3. Authority

3.1. Both Parties warrant that all required approvals and any necessary delegated authority which a Party may be responsible for ensuring, shall be put in place and complied with regarding the execution and performance of this Agreement.

4. **Dispute Resolution**

4.1. Both Parties agree that it would be in their best interests for any disagreement to be resolved locally as soon as possible and shall use their reasonable endeavours to negotiate in good faith and settle any disagreement arising out of or relating to this agreement.

4.2. If any disagreement is not resolved through ordinary negotiations it shall be referred to the Area Director of the NHS ENGLAND BGSW AREA TEAM and the Chief Executive of the Council for discussion and resolution. If the disagreement is not resolved, the Parties shall use reasonable endeavours to settle it by mediation in accordance with the Centre for Effective Dispute Resolution Model Mediation Procedure. To initiate a mediation a Party must give notice to the other Party requesting a mediation in accordance with Clause 4.2. The cost of the mediation shall be met in equal shares by the Parties and the outcome of such mediation shall be binding on both Parties.

5. Cancellation and reimbursement

5.1. The Council shall inform the NHS ENGLAND BGSW AREA TEAM in writing should the Scheme come to an end or the Council ceases to carry out those functions in connection with which the Monies are paid.

5.2. Should the Scheme come to an end or the Council ceases to carry out those functions in connection with which the Monies are paid prior to completion of transfer of the Monies, then the NHS ENGLAND BGSW AREA TEAM shall be under no obligation to pay the Monies or make further instalments of the Monies.

5.3. If the Council does not use the total amount of the Monies in connection with the Scheme, then the Council shall reimburse to the NHS ENGLAND BGSW AREA TEAM any part of the Monies which the Council has received and which has not been used in connection with the Scheme and shall provide details in writing as to why such part of the Monies was not used. The Parties, acting reasonably, shall meet to review how the unused part of the Monies shall be treated.

5.4. In the event the NHS ENGLAND BGSW AREA TEAM ceases to pay the Monies or the Council is obliged to reimburse the Monies in accordance with this Clause , the NHS ENGLAND BGSW AREA TEAM and the

Council shall work together to ensure there is minimal disruption to individuals benefiting from the Scheme.

6. Contracts (Rights of Third Parties) Act 1999

6.1. The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and nothing in this Agreement shall confer to purport to confer or operate to give any third party any benefit or any right to enforce any term of this Agreement except as expressly provided in this Agreement.

7. Communication

7.1. Except as otherwise provided in this Agreement all notices which are required to be given under this Agreement shall be in writing and shall be sent to the address of the Nominated Officer or such other address in England as the recipient may designate by notice given in accordance with the provisions of this Clause. Any such notice may be delivered personally or by first class pre-paid letter and shall be deemed to have been served on the day of delivery if delivered by hand when delivered and if by first class post 48 hours after posting.

8. No Agency

8.1. The Parties are independent and nothing in this Agreement is intended to, or shall operate to, create a partnership or any employment relationship between the Parties, or to authorise either Party to act as agent for the other, and neither Party shall have authority to act in the name or on behalf of or otherwise to bind the other in any way (including the making of any representation or warranty, the assumption of any obligation or liability and the exercise of any right or power).

9. Freedom of Information

9.1. The Parties acknowledge that they are and each other is subject to the requirements under the Freedom of Information Act 2000 ('the FOIA') and shall assist and cooperate with each other free of charge to enable them to comply with these information disclosure requirements.

9.2. The Parties acknowledge that they may, acting in accordance with the Secretary of State for Constitutional Affairs' Code of Practice on the

discharge of public authorities' functions under Part 1 of the FOIA, be obliged to disclose information:

9.2.1. Without consulting with the other Party, or

9.2.2. Following consultation with the other Party and having taken its views into account.

10. Assignment

10.1. This Agreement is personal to the Council and the Council shall not assign or transfer (or purport to assign or transfer) the benefit or burden of this Agreement to the other Party.

11. Governing Law

11.1. This Agreement shall be governed by and construed in accordance with English Law.

Schedule 1

Memorandum of Agreement
Section 256 transfer

Reference number: [Bath, Gloucester, Swindon and Wiltshire Area Team NHS England S256 / B&NES Council – 2014/15]

Title of Scheme: 1) Purchase of Social Care

1. **How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?**

   1.1. This is funding from the National Health Service and is to invest in social care services to benefit health and to improve health gain.

   1.2. Towards this aim, the agreement for the transfer is made between the NHS England BGSW Area Team and the Council. The Council will use the monies to ensure the sustainability and development of services for both health and social care and jointly support the agreed priorities within the Scheme.

2. **Description of Scheme**

   2.1. Funding via the NHS to mutually benefit social and healthcare services.

   2.2. The funding will aid the commissioning of a range of services as detailed in question 4 below.

3. **Financial details (and timescales):**

   Total amount of revenue funding to be transferred and amount in each year:

Funding Stream	Year	£	Invoicing Dates
S256 Monies	2014/15	£3,344,700	1 April 2014

4. Please state the evidence you will use to indicate that the purposes described at questions 1 and 2 have been secured.

4.1. NHS ENGLAND BGSW AREA TEAM will ensure that appropriate governance frameworks are put into place to demonstrate that the pre-determined health and social care outcomes are achieved. This is to be carried out in a transparent and efficient manner with the Council to keep NHS ENGLAND BGSW AREA TEAM informed of the progress in delivery.

4.2. The Council will keep complete and accurate records in relation to the scheme and will allow the NHS ENGLAND BGSW AREA TEAM /s representatives to inspect all such records and will supply copies on request.

4.3. The Parties will have regular meetings for the purpose of discussing the spend and outcome measures and how it is delivering Health and Social Care benefits in the economy.

4.4. The Parties shall agree key performance indicators or measures to evidence success for the Scheme.

4.5. The key outcomes that the Scheme is seeking to achieve include:

4.5.1. Support for avoidance of unnecessary emergency hospital admissions.

4.5.2. Increased support and assistance for older people living independently for longer.

4.5.3. <u>Prevent admissions to residential care & escalations in community care packages</u>

4.5.4. Support achievement of locally agreed Delayed Transfer of Care (DToC) target of 1% for acute beds and 5% within community hospitals.

Signed : …… for the Board/clinical commissioning group

…… Position

…… Date

Signed : …… For local authority / other recipient body

…… Position

…… Date

Schedule 2

S256 Annual Voucher

PART 1 STATEMENT OF GRANT EXPENDITURE FOR THE YEAR 2014/15

Proposed used for the NHS Funding for Social Care

Service Areas	Scheme Details	£000	Health Outcomes	Measures and metrics
Community equipment and adaptations	Handyperson Services & Minor Adaptations (Care & Repair) - Home Safety Checker and subsequent arrangement of essential adaptations to repairs to enable an older or disabled person to be discharged from hospital and return home safely	50	Support avoidance of unnecessary emergency hospital admissions and readmissions	Permanent admissions to residential/nursing homes (rate per 10,000) 65+ *(14/15 planned reduction 3.9%)* % of cases maintained in current setting (outcome of short term services)
Community equipment and adaptations	Housing renewal - financial assistance to older and disabled people to make essential improvements to their homes, including addressing trip hazards, fire-safety, home security, home energy	120	Prevent admissions to residential care & escalations in community care packages	% of cases maintained in current setting (outcome of short term services) The scheme will influence the public health outcomes framework metric: Injuries due to falls in people aged 65 and over
Integrated crisis and rapid response services	Targeted rural domiciliary care service aimed at admission avoidance	208		Permanent admissions to residential/nursing homes (rate per 10,000) 65+ *(14/15 planned reduction 3.9%)*

Maintaining eligibility criteria	Social Care Placement and Personal Budgets - the increasing complexity and acuity of people being supported to live in the community is giving rise to cost pressures associated with higher staffing levels and/or skill-mix and, therefore placement and care package unit costs	460	Increased support and assistance for older people living independently for longer	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *(14/15 planned change 0.9%)* Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).
Reablement services	Sirona Care & Health - Re-ablement & Rehab	500	Support avoidance of unnecessary emergency hospital admissions and readmissions	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *(14/15 planned change 0.9%)* Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population
Reablement services	7 day working - Hospital SW & Core re-ablement	278	Support avoidance of unnecessary emergency hospital admissions and readmissions	Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+). Total non-elective admissions in to hospital (general & acute), all-age,

				per 100,000 population
Early supported hospital discharge schemes	Step Down Accommodation, Care & Support (Curo Housing & Sirona) - provision of mobility standard flats with care and support to enable step-down from hospital and support return home	203	Support achievement of locally agreed Delayed Transfer of Care (DToC) target of 1% for acute beds and 5% within community hospitals	Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).
Early supported hospital discharge schemes	Community Stroke Co-ordinator	24		
Early supported hospital discharge schemes	Intensive Home from Hospital	50	Support avoidance of hospital readmissions	
Mental Health Service	AMHP Service capacity	50	Support avoidance of unnecessary emergency hospital admissions and readmissions	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population
	MCA DOLS capacity	50	Increased support and assistance for people living independently in the community in the least restrictive way; prevent admission to residential care as least restrictive action and package in place in accordance with peoples wishes	Number of adults been assessed in accordance with legal framework Better outcomes for people who lack mental capacity Assurance that services are not unlawfully deprived
	Out of Hours	50	Building resilience in the Mental Health service	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population

Employment support	Employment Inclusion for Learning Disabilities & Mental Health	15	Adults with LD and MH needs will have improved mental and physical health through greater independence and economic wellbeing. Positive mental health supported through greater social inclusion	
Employment support	Mental Health Primary Care Employment worker	38	Support people with common mental health problems supported in primary care to return to work and/or come of sickness and benefits payments.	
Integrated records or IT	Implementing the Care Act	608	Agreed through the Better Care Fund to enable the system change to be compliant with the requirements of the Care Act	
Joint health and care teams/working	Strategic planning capacity	100	Prevent admissions to residential care & escalations in community care packages	Permanent admissions to residential/nursing homes (rate per 10,000) 65+ *(14/15 planned reduction 3.9%)*
Joint health and care teams/working	Increased support in Safeguarding	44		
Other social care (please specify)	Sirona Care & Health - Service Developments (contractual commitment	350	Support achievement of locally agreed Delayed Transfer of Care (DToC) target of 1% for acute beds and 5% within community hospitals	Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).
Other social care (please specify)	Income maximisation service - to assist older and disabled people to maximise their income from welfare benefits and enable them to fund or partially fund care and support	47	Increased support and assistance for older people living independently for longer	

Other intermediate care (please specify)	OP Independent Living Service	100	Prevent admissions to residential care & escalations in community care packages	Permanent admissions to residential/nursing homes (rate per 10,000) 65+ *(14/15 planned reduction 3.9%)*
Total		**3345**		

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each Scheme agreed by the NHS ENGLAND BGSW AREA TEAM in accordance with the Directions made by the Secretary of State under section 256 of NHS Act 2006.

Signed …… Date ……

Chief Financial Officer
Bath & North East Somerset Council

Certificate of Auditor

The Statement of Responsibilities of grant-paying bodies, authorities and appointed auditors in relation to grant claims and returns, issued by the Audit Commission, sets out the respective responsibilities of these Parties, and the limitations of our responsibilities as appointed auditors.

I/We have:

- Examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the authority in accordance with Certification Instruction A1 prepared by the Audit Commission for its appointed auditors; and

- Carried out the tests specified in Certification Instruction [……] prepared by the Audit Commission for its appointed auditors, and I/we have obtained such evidence and explanations as I/we consider necessary.

(Except for the matters raised in the attached qualification letter dated)*

I/we have concluded that the entries are

- Fairly stated; and

- In accordance with the relevant terms and conditions

Signature ……
Name (black capitals) …….....
Company/Firm……..
Date ……

*Delete as necessary

Schedule 3

Financial details (and timescales):

Total amount of revenue funding to be transferred each year and instalments due (if this is subsequently changed, the memorandum must be amended and re-signed):

Funding Stream	**Year**	**£**	**Invoicing Dates**
S256 Monies	2014/15	£3,344,700	1 April 2014
TOTAL		**£3,344,700**	

Schedule 4

Description of Schemes (see Schedule 2 PART 1)

i. These Schemes provide for the transfer of the social care funds given to the NHS ENGLAND BGSW AREA TEAM in to the Council to support the sustainability and development of its services and related health and social care activities.

ii. The funding will aid the commissioning of a range of services to support the outcomes as detailed in Section 4 of Schedule 1.

Schedule 5

Management Information

The Council shall keep complete and accurate records in relation to the Scheme and shall allow the NHS ENGLAND BGSW AREA TEAM 's representatives to inspect all such records and shall supply copies on request and other such information as NHS ENGLAND BGSW AREA TEAM may reasonably request.

The Parties will use the Joint Committee for the Oversight of Joint Working, for the purpose of discussing the spend and how it is delivering health and social care benefits in the economy.

IN WITNESS whereof the Parties have signed this Agreement

Signed by …….

On behalf of **NHS ENGLAND Bath, Gloucester, Swindon and Wiltshire AREA TEAM**

Title: Area Team Finance Director

Name: Jennifer Howells

Signed by …….

On behalf of **BATH AND NORTH EAST SOMERSET COUNCIL**

Title: Chief Finance Officer

Name: Tim Richens

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Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

BATH & NORTH EAST SOMERSET COUNCIL

and

BATH and NORTH EAST SOMERSET CLINICAL COMMISSIONING GROUP

AGREEMENT

2014/15

Transfer of Funding in Bath & North East Somerset.

(MADE UNDER SECTION 256 OF NATIONAL HEALTH SERVICES ACT 2006)

THIS AGREEMENT is made on 1st April 2014

BETWEEN:

(1) BATH and NORTH EAST SOMERSET CLINICAL COMMISSIONING GROUP of St Martins Hospital, Bath, BA2 5RP ("**CCG**"); and

(2) BATH AND NORTH EAST SOMERSET COUNCIL of Guildhall, Bath, BA1 5AW ("**Council**"),

(together the "**Parties**").

WHEREAS:

(A) The CCG is empowered by section 256 of the 2006 Act to make payments to the Council in certain circumstances towards expenditure incurred by the Council

(B) The CCG has agreed to make payment to the Council to contribute towards the costs of 1) Carers, 2) Grants to Voluntary Bodies and 3) Local Reablement] ("Schemes") for the benefit of [improving health and wellbeing]

(C) By resolution of the CCG Board - the transfer of funding for the scheme was recommended pursuant to section 256 of the 2006 Act.

(D) The CCG is satisfied that this Grant is in accordance with the 2006 Act and complies with the Directions.

NOW IT IS HEREBY AGREED as follows:

1. **Definitions and Interpretations**

1.1. In this Agreement the following expressions shall unless the context otherwise requires have the meanings herein:

"2006 Act" means the National Health Service Act 2006;

"Annual Voucher" means the statement of compliance with

conditions of Grant and expenditure certification as set out in the Schedule 2;

"Balance" means the Total Capital Costs less the Grant;

"Directions" means the Directions by the Secretary of State for Health as to the conditions governing payments by health authorities and other bodies under Section 28A of the National Health Service Act 1977 dated 28 March 2000;

"Financial Year" means 1st April of one year to 31st March of the following year;

"Monies" means the amount of money set out in Schedule 1 payable by the CCG to the Council in respect of the Scheme on the understanding that the Council will meet the costs of the Scheme to the extent that it is not funded by the money;

"Nominated Officers" means the Chief Financial Officer for the CCG) Divisional Director – Finance for the Council) or such replacements as may be notified by Party in writing from time to time;

"Scheme" means the schemes as more specifically described in Schedule 4; and

.

1.2. The headings in the Agreement are for ease of reference only and shall not affect the construction hereof.

1.3. The Schedules form part of this Agreement and shall have effect as if set out in full in the body of this Agreement and any reference to this Agreement includes the Schedules.

1.4. Words in the singular shall include the plural and vice versa.

1.5. A reference to any Act of Parliament, Order, Regulation, Statutory Instrument, Directions or the like shall be deemed to include a

reference to any amendment or re-enactment of the same.

1.6. Where the words include(s), including or in particular are used in these terms and conditions, they are deemed to have the words without limitation following them and where the context permits, the words other and otherwise are illustrative and shall not limit the sense of the words preceding them.

2. Conditions relating to the Funds Transfer

2.1. In consideration of the Council entering into the Agreement and subject to the terms of this Agreement, the CCG shall pay the Monies to the Council as described in Schedule 1 and if the Monies are to be paid in instalments, in such instalments as described in Schedule 3.

2.2. The Council shall submit an Annual Voucher which has been duly authenticated and certified in accordance with the Directions to the Chief Financial Officer by no later than the 28 days following the end of each Financial Year.

2.3. The CCG and the Council shall at any meeting convened under Clause 2.10 consider the payments made in respect of the Scheme and the CCG reserves the right to reduce the amount of any future payments in accordance with section 2(5) of the Directions.

2.4. The Council shall use the Monies in respect of the Scheme(s) and shall not use the Monies for any other purpose other than the Scheme and shall repay to the CCG a sum equal to the amount of any part of the Monies which is not so applied.

2.5. The Council shall at all times observe the CCG obligation to obtain best value for money.

2.6. The Council shall provide any services that are part of the Scheme:

2.6.1. In such way as to secure the most efficient and effective use of the amount paid

2.6.2. In accordance with all relevant legislation and the Directions; and

2.6.3. In accordance with any policies, performance objectives, eligibility criteria and standards set out at Schedule 4.

2.7. Any part of the Monies that remains in the Council's possession following completion of the Scheme and is not expended by the Council on the Scheme in accordance with Clause 2.4 shall be declared to the CCG and both Parties shall use their reasonable endeavours to agree the future use of such remaining funds including, where appropriate

i. The immediate return of the remaining funds to the CCG.
ii. The Re-allocation of the funds to finance identified projects/plans in future years.

2.8. The Council shall be responsible for the operational management of the scheme.

2.9. The Council shall provide the CCG with the information detailed in Schedule 5 and access to such other information as the CCG may reasonably request.

2.10. The CCG and the Council shall meet at such intervals as the Parties agree, having regard to the nature of the scheme, to review the scheme.

2.11. Any variation to this Agreement or the scheme must be agreed in writing by an authorised officer of each Party.

2.12. Any complaints in relation to the Scheme shall be notified immediately to the Nominated Officers who shall agree an appropriate course of action to ensure that all such complaints are dealt with appropriately.

3. Authority

3.1. Both Parties warrant that all required approvals and any necessary delegated authority which a Party may be responsible for ensuring,

shall be put in place and complied with regarding the execution and performance of this Agreement.

4. **Dispute Resolution**

4.1. Both Parties agree that it would be in their best interests for any disagreement to be resolved locally as soon as possible and shall use their reasonable endeavours to negotiate in good faith and settle any disagreement arising out of or relating to this agreement.

4.2. If any disagreement is not resolved through ordinary negotiations it shall be referred to the Chief Executive of the CCG and the Chief Executive of the Council for discussion and resolution. If the disagreement is not resolved, the Parties shall use reasonable endeavours to settle it by mediation in accordance with the Centre for Effective Dispute Resolution Model Mediation Procedure. To initiate a mediation a Party must give notice to the other Party requesting a mediation in accordance with Clause 4.2The cost of the mediation shall be met in equal shares by the Parties and the outcome of such mediation shall be binding on both Parties.

5. Cancellation and reimbursement

5.1. The Council shall inform the CCG in writing should the Scheme come to an end or the Council ceases to carry out those functions in connection with which the Monies are paid.

5.2. Should the Scheme come to an end or the Council ceases to carry out those functions in connection with which the Monies are paid prior to completion of transfer of the Monies, then the CCG shall be under no obligation to pay the Monies or make further instalments of the Monies.

5.3. If the Council does not use the total amount of the Monies in connection with the Scheme, then the Council shall reimburse to the CCG any part of the Monies which the Council has received and which has not been used in connection with the Scheme and shall provide details in writing as to why such part of the Monies was not used. The Parties, acting reasonably, shall meet to review how the unused part of the Monies shall be treated.

5.4. In the event the CCG ceases to pay the Monies or the Council is obliged to reimburse the Monies in accordance with this Clause , the CCG and the Council shall work together to ensure there is minimal disruption to individuals benefiting from the Scheme.

6. Contracts (Rights of Third Parties) Act 1999

6.1. The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and nothing in this Agreement shall confer to purport to confer or operate to give any third party any benefit or any right to enforce any term of this Agreement except as expressly provided in this Agreement.

7. Communication

7.1. Except as otherwise provided in this Agreement all notices which are required to be given under this Agreement shall be in writing and shall be sent to the address of the Nominated Officer or such other address in England as the recipient may designate by notice given in accordance with the provisions of this Clause. Any such notice may be delivered personally or by first class pre-paid letter and shall be deemed to have been served on the day of delivery if delivered by hand when delivered and if by first class post 48 hours after posting.

8. No Agency

8.1. The Parties are independent and nothing in this Agreement is intended to, or shall operate to, create a partnership or any employment relationship between the Parties, or to authorise either Party to act as agent for the other, and neither Party shall have authority to act in the name or on behalf of or otherwise to bind the other in any way (including the making of any representation or warranty, the assumption of any obligation or liability and the exercise of any right or power).

9. Freedom of Information

9.1. The Parties acknowledge that they are and each other is subject to the requirements under the Freedom of Information Act 2000 (‘the

FOIA') and shall assist and cooperate with each other free of charge to enable them to comply with these information disclosure requirements.

9.2. The Parties acknowledge that they may, acting in accordance with the Secretary of State for Constitutional Affairs' Code of Practice on the discharge of public authorities' functions under Part 1 of the FOIA, be obliged to disclose information:

9.2.1. Without consulting with the other Party, or

9.2.2. Following consultation with the other Party and having taken its views into account.

10. Assignment

10.1. This Agreement is personal to the Council and the Council shall not assign or transfer (or purport to assign or transfer) the benefit or burden of this Agreement to the other Party.

11. Governing Law

11.1. This Agreement shall be governed by and construed in accordance with English Law.

Schedule 1

Memorandum of Agreement

Section 256 transfer

Reference number: B&NES CCG S256 – 2014/15]

Title of Scheme: 1) Carers
2) Grants to Voluntary Organisations
3) Local Reablement

1. **How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?**

   1.1. This is funding from the National Health Service and is to invest in social care services to benefit health and to improve health gain.

   1.2. Towards this aim, the agreement for the transfer is made between the CCG and the Council. The Council will use the monies to ensure the sustainability and development of services for both health and social care and jointly support the agreed priorities within the Scheme.

2. **Description of Scheme**

   2.1. Funding via the NHS to mutually benefit social and healthcare services.

   2.2. The funding will aid the commissioning of a range of services as detailed in question 4 below.

3. **Financial details and timescales:**

   Total amount of revenue funding to be transferred and amount in each year:

Funding Stream	**Year**	**£**	**Invoicing Dates**
S256 Carers	2014/15	£266,000	1 April 2014

S256 Grants to Voluntary Organisations	2014/15	£234,000	1 April 2014
S256 Local Reablement	2014/15	£900,000	1 April 2014

4. Please state the evidence you will use to indicate that the purposes described at questions 1 and 2 have been secured.

4.1. CCG will ensure that appropriate governance frameworks are put into place to demonstrate that the pre-determined health and social care outcomes are achieved. This is to be carried out in a transparent and efficient manner with the Council to keep CCG informed of the progress in delivery.

4.2. The Council will keep complete and accurate records in relation to the scheme and will allow the CCG/s representatives to inspect all such records and will supply copies on request.

4.3. The Parties will have regular meetings for the purpose of discussing the spend and outcome measures and how it is delivering Health and Social Care benefits in the economy.

4.4. The Parties shall agree key performance indicators or measures to evidence success for the Scheme.

4.5. The key outcomes that the Scheme is seeking to achieve include:

4.5.1. Funds are transferred to support carers as agreed

4.5.2. Grant Payments are made to the agreed Voluntary Organisations

4.5.3. Investment in local Reablement and improvement projects for reablement are undertaken and business cases sighted

Schedule 2

Annual Voucher

PART 1 STATEMENT OF GRANT EXPENDITURE FOR THE YEAR 2013/14

Proposed used for the NHS Funding for Social Care

Proposal	**£**	**Health benefit**
Carers 2014/15	£266,000	To provide sustainable support to those carers providing care to service users with Health needs, so reducing the need for admission or social cares services
Voluntary Organisations 2014/15	£234,000	To contribute on behalf of the CCG to those voluntary organisations that provide direct or indirect support for the delivery of the Health & Social Care Agenda
Local Reablement 2014/15	£900,000	To provide funds locally to support and enhance local reablement, in addition to the national funding. So as to provide investment funds and support those services which will reduce the demand on Secondary Care Services, or reduce the length of stay in such services.
TOTAL – 2014/15	**£1,400,000**	

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each Scheme agreed by the CCG in accordance with the Directions made by the Secretary of State under section 256 of NHS Act 2006.

Signed …… Date ……..

Divisional Director of Finance

Certificate of Auditor

The Statement of Responsibilities of grant-paying bodies, authorities and appointed auditors in relation to grant claims and returns, issued by the Audit Commission, sets out the respective responsibilities of these Parties, and the limitations of our responsibilities as appointed auditors.

I/We have:

- Examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the authority in accordance with Certification Instruction A1 prepared by the Audit Commission for its appointed auditors; and

- Carried out the tests specified in Certification Instruction [……] prepared by the Audit Commission for its appointed auditors, and I/we have obtained such evidence and explanations as I/we consider necessary.

(Except for the matters raised in the attached qualification letter dated)*

I/we have concluded that the entries are

- Fairly stated; and

- In accordance with the relevant terms and conditions

Signature …… Name (black capitals) ……..

Date …….
*Delete as necessary

Schedule 3

Financial details and timescales:

Total amount of revenue funding to be transferred each year and instalments due (if this is subsequently changed, the memorandum must be amended and re-signed):

Funding Stream	Year	£	Invoicing Dates
S256 Carers	2014/15	£266,000	1 April 2014
S256 Grants to Voluntary Organisations	2014/15	£234,000	1 April 2014
S256 Local Reablement	2014/15	£900,000	1 April 2014
TOTAL		**£1,400,000**	

Schedule 4

Description of Schemes (see Schedule 2 PART 1)

i. These Schemes provide for the transfer of the social care funds given to the CCG in to the Council to support the sustainability and development of its services and related health and social care activities.

ii. The funding will aid the commissioning of a range of services to support the outcomes as detailed in Section 4 of Schedule 1.

Schedule 5

Management Information

The Council shall keep complete and accurate records in relation to the Scheme and shall allow the CCG's representatives to inspect all such records and shall supply copies on request and other such information as CCG may reasonably request.

The Parties will use the Joint Commissioning Leadership Team, for the purpose of discussing the spend and how it is delivering health and social care benefits in the economy.

IN WITNESS whereof the Parties have signed this Agreement

Signed by ……

On behalf of **Bath and North East Somerset Clinical Commissioning Group**

Title: Chief Finance Officer

Name: Sarah James

Signed by ……

On behalf of **BATH AND NORTH EAST SOMERSET COUNCIL**

Title: Chief Finance Officer

Name: Tim Richens

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**19/11/2014**
TYPE	**An open public item**

Report summary table	
Report title	B&NES Local Food Strategy
Report author	Sophie Kirk, Corporate Sustainability Officer, (01225 477932)
List of attachments	Appendix 1: B&NES Local Food Strategy 2014-2017
Background papers	Strategy appendices are available for inspection upon request. Please contact report author.
Summary	Update and engage the Health and Wellbeing Board on the development of the B&NES Local Food Strategy.
Recommendations	The Board is asked to agree that it will: • Provide high-level support for the B&NES Local Food Strategy and implementation plan. • Nominate at least one representative to attend stakeholder events and engagement sessions as appropriate.
Rationale for recommendations	The B&NES Local Food Strategy will help to meet outcomes set out in the Joint Health and Wellbeing Strategy by providing a framework for action to reduce diet related ill-health and inequality. Specifically the B&NES Local Food Strategy will contribute to the delivery of the following Health and Wellbeing Strategy outcomes: • Create healthy and Sustainable Places • Help children to be a healthy weight • Improve jobs, skills and training Strategic support for the Local Food Strategy by the Health and Wellbeing Board will enable high-level engagement and help to facilitate delivery.
Resource implications	None
Statutory considerations and basis for proposal	• The B&NES Local Food Strategy sits beneath the high-level B&NES Environmental Sustainability and Climate Change Strategy 2012-2015 and is overseen by the B&NES

	Environmental Sustainability (ESP) Board. • The need for a B&NES Local Food Strategy arose from the synergy between the Environmental Sustainability Partnership objectives to reduce carbon emissions and environmental impacts from the food sector and the Health & Well-Being Board objectives to reduce diet related ill-health and inequality. In addition, the importance of a thriving local food economy to local economic well-being is included in the new Economic Strategy.
Consultation	The strategy has been consulted on via the following activities: • Sustainable food stakeholder event attracting over 60 attendees • Public online consultation • Internal consultation The Draft Local Food Strategy has been consulted on by representatives from a wide range of organisations and interests including elected members, food and farming businesses, public sector organisations, non-governmental organisations, local advisory groups, community groups, local food banks and emergency food providers, health care providers and members of the public. The results of the consultation have informed the strategic approach accordingly.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

- The B&NES Local Food Strategy (2014-2017) provides a framework for partnership action to increase the production, accessibility and consumption of healthy, local and sustainable food in Bath and North East Somerset to reduce diet-related ill health and inequality, to reduce the environmental impact of the food sector including its contribution to climate change and to improve the local food economy.

- The B&NES Local Food Strategy provides a framework for partnership action against three delivery themes. The delivery themes are:

  - **Theme 1: Support local and sustainable food production**. This theme is about increasing opportunities for local and sustainable food production and supply, including community food growing, to increase food security, reduce carbon emissions and environmental degradation, and to promote economic opportunities for local food and farming businesses.

  - **Theme 2: Improve food provision and access.** This theme is about increasing access to, and provision of, good food in B&NES including in public sector and private sector organisations, and by improving the food retail offer in B&NES and by supporting low income residents to access good food. It aims to make the good food choice the easiest choice for the population to make.

  - **Theme 3: Encourage a healthy and sustainable food culture.** This theme is about promoting and developing a healthy and sustainable food culture to increase the demand for healthy and sustainable food. It aims to raise the profile of good food, increase engagement in sustainable food behaviours and increase opportunities for people to cook from scratch, grow their own food, celebrate food, and develop food related knowledge and skills that enable them to make informed food decisions and to improve their diet.

- The next steps are to establish a Local Food Partnership, on behalf of the B&NES ESP, to provide the strategic leadership role in taking forwards and delivering the B&NES Local Food Strategy working with partners and the wider population. This proposed partnership would act as a sub-group of the ESP, reporting to the ESP Board.

Please contact the report author if you need to access this report in an alternative format

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B&NES Local Food Strategy 2014 - 2017

Councillor Foreword

"Food is not only essential to survival and health but it shapes our environment and landscapes, underpins our economy, helps build resilient communities and is at the heart of our culture and society.

In Bath and North East Somerset food and farming has always been an integral and important part of our area. We have a diverse food and farming sector, and vibrant community, voluntary and business sectors that have long been active on food issues.

However, nationally and locally, we face some important food-related challenges, such as rising obesity levels, health inequalities, food poverty, food security and the impact of food production and supply on the natural environment, including its contribution to climate change. There are also economic challenges facing some local food and farming businesses.

Bath and North East Somerset Council (B&NES) is committed to providing leadership through the B&NES Environmental Sustainability Partnership (ESP) to support local action on these issues and to contribute to improving the health and wellbeing of our residents, to supporting a thriving local food economy, and to reducing our impact on the environment and climate. For these reasons, the B&NES ESP has overseen the development of the B&NES Local Food Strategy to help us to rise to these challenges.

The importance of healthy and sustainable food and the need for a food strategy is now greater than ever. We are confident that, by working in partnership, the delivery of the B&NES Local Food Strategy will help to drive significant change to improve the health of our communities, the environment, both here and more widely, and the local food economy."

Councillor Paul Crossley: Leader of Bath and North East Somerset Council

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Section 1: Executive Summary

i) Vision

Bath and North East Somerset is a place where everyone can access good quality, safe, affordable food and enjoy a healthy diet, with more locally produced food that sustains the environment and supports the local economy.

In particular we want to reduce diet-related ill health and inequality, reduce the local environmental impacts of food production and supply including its contribution to climate change, increase food security and support a strong and prosperous food economy.

We want Bath and North East Somerset to be a place where good quality food is widely provided, celebrated and promoted and where everyone has the opportunities to develop food related skills and to reconnect with food and where it comes from.

ii) Purpose of the B&NES Local Food Strategy

The B&NES Local Food Strategy provides a framework for action that encompasses social, economic and environmental sustainability in a coherent and coordinated manner.

The strategy has been designed to bring together the full range of current food activities and to identify future opportunities within a single strategic framework, enabling greater co-ordination, cross-fertilisation and closer working between partners and stakeholders across the local authority.

It is the intention that this more integrated approach will increase the opportunities for our strategic ambitions to be realised, working in partnership with public sector organisations, food and farming businesses, the voluntary sector and local communities.

iii) Why do we need a local food strategy: The Evidence

The negative impacts of food and diet on health, the environment and the local economy are well evidenced in local and national data:

Health and wellbeing impacts:

The B&NES JSNA tells us that:

- 56% of adults are obese or overweight.
- 23% of reception aged children are obese or overweight - higher than the UK national average.
- In 2010 overweight and obesity in B&NES cost the NHS £45.8 million - a figure set to rise to £49 million by 2015.

- Poor diet and unhealthy weight disproportionately affects children living in more deprived areas or from a black or ethnic minority background.

Environmental sustainability and food security impacts

Local and national data tells us that:

- The global food sector accounts for between 14-30% of global greenhouse gas emissions (Vermeulen *et al*., 2013).
- The UK imports approximately 47% of total food products potentially leaving us vulnerable to disruptions in global food supply and contributing to carbon emissions associated with food transportation, refrigeration and packaging (DEFRA, 2013a).
- 70% of B&NES land is in agricultural use providing significant opportunities to upscale local food supply and reduce reliance on imports.
- Food supply in B&NES depends heavily on transport fuels and petroleum-derived agrochemicals and is therefore vulnerable to peak oil, and contributes significantly to climate change (Local Climate Impact Assessment 2011).
- A third of all food produced in the UK is wasted (FAO, 2013).

Economic impacts

Local and national data tells us that:

- Full-time agricultural employment in B&NES has decreased by more than half between 2000 and 2010 (DEFRA, 2010).
- Domestic food expenditure in Bath and North East Somerset is around £382m/yr (DEFRA, 2013d). More of this could be retained in the local economy.
- Expenditure on local food generates an economic return of £3 for every £1 spent contributing to the local multiplier effect (Orme *et al*., 2011).
- Public interest in healthy and local food is high with 81% of residents stating that they are willing to buy more locally-produced food to reduce carbon emissions (B&NES Council, 2009).

iv) Local Food Strategy Delivery Themes

The food strategy is structured around three delivery themes which have emerged from discussions across the key partnerships and with stakeholders across the community (See appendix 2).

The delivery themes are:

- Theme 1: Local food production
- Theme 2: Food provision and access
- Theme 3: Healthy and sustainable food culture

Theme 1 is about increasing opportunities for local and sustainable food production and supply to increase food

security, reduce carbon emissions and environmental degradation and to promote economic opportunities for local food and farming businesses.

Theme 2 is about increasing access to, and provision of, good food in B&NES including in public sector and private sector organisations, by improving the local food retail offer and by supporting low income residents to access good food. It aims to make the good food choice the easiest choice for citizens to make.

Theme 3 is about promoting and developing a healthy and sustainable food culture to increase the demand for healthy and sustainable food. It aims to raise the profile of good food, increase engagement in sustainable food behaviours and increase opportunities for people to cook from scratch, grow their own, celebrate food, and develop food related skills that enable them to make informed food decisions and to improve their diet.

v) Meeting local targets

The need for a B&NES Local Food Strategy arose from the synergy between the Environmental Sustainability Partnership objectives to reduce carbon emissions and environmental impacts from the food sector and the Health & Well-Being Board (HWB) objectives to reduce diet-related ill health and inequality. In addition, the importance of a thriving local food economy to local economic well-being is included in the new Economic Strategy.

The B&NES Local Food Strategy will help to meet district wide targets set out in the Environmental Sustainability and Climate Change Strategy and the Joint Health and Wellbeing Strategy (See table 1):

- The Environmental Sustainability and Climate Change Strategy sets out a framework to reduce greenhouse gas emissions across the district by 45% by 2026. It includes nine work-streams to help achieve this – one of which focuses on up-scaling local and sustainable food production and supply.

- The Joint Health and Wellbeing Strategy sets out a framework to improve health and reduce inequalities including diet-related health and obesity. It includes eleven priorities including the “healthy and sustainable places” priority which includes objectives to increase the production and consumption of local food.

vi) Table 1: Examples of how the local food strategy will contribute to priorities outlined in the Health and Wellbeing Strategy and the Environmental Sustainability and Climate Change Strategy

Health and Wellbeing Strategy Priorities	Environmental Sustainability and Climate Change Strategy Priorities
Improve health and wellbeing and reduce inequality • Supporting more people to access, afford and choose good quality, healthy food can enhance the consumption of good food and improve dietary health. • Supporting more people to develop skills in food growing and cooking will equip them with the knowledge, skills and confidence to prepare healthy meals.	**Reduce B&NES Contribution to GHG emissions** • An increase in local and sustainable food production can reduce GHG emissions associated with long-distance food transportation and energy-intensive food production. • Reducing and recycling food waste reduces GHG emissions caused by the break-down of waste food in land-fill.
Improve jobs, skills and employment • Up-scaling local food production and supply can provide a fairer economic return for local producers and stimulate new jobs in food processing, distribution and retail sectors, contributing to income growth and containment and job creation. • Supporting the establishment of direct-selling initiatives such as farmers markets, and seeking market opportunities for local food in a wider range of outlets provides economic opportunities to local food and farming businesses and contributes to the local multiplier effect.	**Reduce the impacts of emergencies likely to arise from climate change and peak oil** • Climate change and peak oil are predicted to impact negatively on global food systems. Local and sustainable food production and supply improves long-term food security and can enhance our resilience to shocks and shortages in global food supply chains.
Create healthy and sustainable places • Local and sustainable food production, including community food growing can reduce B&NES's contribution	**Maintain and enhance our natural environment and wildlife and realise the wide benefits of green infrastructure.** • The use of sustainable farming methods can reduce the

to GHG emissions, decrease negative environmental impacts, increases food security and generates an increase in community food growing and associated health benefits. •	negative environmental impacts of farming, helping to increase biodiversity and improve the quality of natural resources. • Improving opportunities for community food growing can contribute to biodiversity, green infrastructure networks and enhance the natural environment.
Increase the resilience of people and communities Engaging people in communal activities associated with food such as cooking and growing can contribute to community cohesion and social engagement. There is a portfolio of academic evidence that associates communal food-related activity with mental and physical health benefits, including social activity.	

vii) Implementing the strategy

The B&NES Local Food Strategy sits beneath the high-level B&NES Environmental Sustainability and Climate Change Strategy 2012-2015 and is overseen by the B&NES Environmental Sustainability Partnership (ESP) Board. The strategy has been produced at a time of financial uncertainty for many of the agencies involved. Effective implementation will only be achieved if we are clear about our priorities and about the best ways to support and facilitate action within resource constraints. The following delivery approaches are designed to enable coordinated and effective action within this context and will be applied to each of the three delivery themes.

- **Partnership working: Bringing together the right people to make things happen.** The successful delivery of the strategy will be dependent on co-ordinated action and strong working relationships across sectors. We will work with and facilitate partnership working between: public sector organisations, parish and town councils, food, farming and retail businesses, landowners and advisory groups, the voluntary and community sector and individuals and organisations working in the food sector.

- **Community enablement: Enabling residents and community groups to achieve their health and sustainability aims.** There are existing examples of community action to build upon, including community food groups, cookery clubs and community food-growing projects. We will continue to support local community groups and individuals working on food issues that contribute to delivery of the strategy. We will facilitate coordination and the sharing of experience and resources to increase community capacity.

- **Leading by example: Bold action from the Council and our B&NES ESP & HWB partners.** The Council and other public sector organisations will provide the leadership to effectively deliver the B&NES Local Food Strategy. These organisations will champion the B&NES Local Food Strategy at a strategic level and will drive positive change within their organisations providing exemplars of good practice.

viii) Action Planning

Action will be planned against the three delivery themes of the strategy. For each delivery theme, the action plan will include existing and potential future action points and will encompass the above delivery approaches. A proposed B&NES Local Food Partnership will further develop the action plan and provide the day to day monitoring of its implementation, overseen by the B&NES ESP Board.

ix) Glossary of Terms

"Good food" is the over-arching term used to describe the type of food that we are aiming to promote in Bath and North East Somerset. Our definition of good food is used widely across the UK and was coined by the Bristol Food Policy Council:

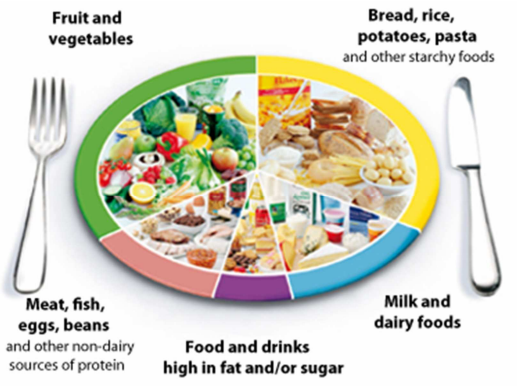
Good Food: "As well as being tasty, safe, healthy and affordable the food we eat should be good for nature, good for workers, good for local businesses and good for animal welfare."

Community: The population of Bath and North East Somerset, including, but not limited to, distinct community groups and members of the population with a specific interest in food, farming and/or health.

Direct Selling Initiative: A form of direct food retail between food producers and consumers. Examples include farmers' markets, box-schemes and farm-shops.

Farmers Market: A retail market at which farmers and food producers sell products directly to consumers.

Healthy Food: There is no legal definition of healthy food. When it comes to a healthy eating, balance is the key to getting it right. This means eating a wide variety of foods in the right proportions, and consuming the right amount of food and drink to achieve and maintain a healthy body weight. The NHS guidance for a healthy diet is based on the "eat-well plate" which demonstrates the ratios for different food groups and suggests that the majority of the diet should be made up of fruit and vegetables, bread, rice, pasta and other starchy foods. The health benefits of fruit, vegetables and fish are particularly well-evidenced and therefore ample quantities should be incorporated as part of a healthy diet. It is important to note that the evidence around healthy diet is constantly evolving and the official NHS dietary guidance could be subject to change.



Intensive farming: Energy intensive farming systems based on a high-input- high output model. Intensive farming is

characterized by a low fallow ratio and the heavy use of fertilizers and pesticides relative to land area.

Local Food: Food that is produced, processed, distributed, traded and sold within a 30 mile radius of Bath and North East Somerset.

Local Multiplier effect: The local multiplier effect refers to the greater local economic return generated by money spent at locally-owned businesses due to the retention and recirculation of money within local economies.

Organic Food: Food that is produced without the use of chemical fertilizers or pesticides.

Sustainable production: Agricultural and food production systems that enhance and sustain the agricultural resource base over the long term including air, water and soil quality , biodiversity, landscape character and climate. Examples of sustainable food production methods include low agro-chemical use, the provision of wildlife habitat space, improvements to energy efficiency, effective soil and water management and the practice of high animal welfare standards.

Section 2: The need for a local food strategy: The evidence base

This section outlines the evidence that underpins and informs the strategic approach (as outlined by the strategy delivery themes; Section 3).

An outline of the key food related issues and causes, potential solutions and the recommended B&NES response are provided in relation to

- Health, wellbeing and equality
- Environmental sustainability and food security
- Strong and prosperous local food economy

i) Health, well-being and equality

What are the issues?

After tobacco, diet and physical activity have the greatest impact on UK health (WHO, 2002). Unhealthy diets are characterised by high intakes of fat, sugar and salt, and low intakes of fruit, vegetables, fibre and oily fish. The consumption of unhealthy diets has contributed to a significant rise in obesity in B&NES and is a major risk factor for chronic diseases including diabetes, stroke and some cancers (WHO 2002).

Diet related ill-health and inequalities in B&NES

In B&NES over half (55.7%) of adults are estimated to be obese or overweight, which is lower than the UK national average (B&NES Council, 2014). However B&NES has a higher than national average of reception-aged children who are obese or overweight (23%) and therefore addressing childhood obesity is a particular priority for our district (B&NES Council 2014). Elderly people are also vulnerable to diet-related ill-health and suffer disproportionately from malnutrition (B&NES Council 2012).

Diet-related health inequalities are apparent in B&NES with poor diet and unhealthy weight disproportionately affecting residents who live in areas of multiple deprivation and children who are from a black or ethnic minority background (See appendix 6). People living on low incomes in B&NES are also more likely to formula feed their babies and wean earlier than 6 months - a behaviour which is associated with elevated weight gain in infants.

What are the key causes of unhealthy diets? Analysis of the evidence

The reasons why people eat unhealthy diets are complex and are associated with issues relating to food *accessibility, affordability* and *culture.*

Affordability

In B&NES people living on a low income tend to have diets that are less healthy than people living on higher incomes (JSNA, 2014). This trend is related to "food poverty" which is the inability to access or afford foods that make up a healthy diet (See appendix 6). Rising food prices, inadequate provision of healthy and affordable food options, and a lack of access to finance, transport, cooking skills and facilities are all factors that contribute to food poverty and unhealthy diets (Maslen *et al.,* 2013).

Accessibility

The accessibility and provision of healthy and unhealthy food can also influence peoples' dietary choices and their ability to easily access good food. Some rural and urban communities in B&NES have little or no food retail provision which could potentially affect residents' ability to access good food, particularly if they have no means of private transport and infrequent bus links (See map: appendix 5).

Although research into the link between food availability and diet is relatively undeveloped some academic studies suggests that low healthy food retail provision and high unhealthy food provision (such as fast food takeaways) are associated with poor dietary behaviours (Caldwell *et al.,* 2009; Zenk *et al.,* 2009). In B&NES there are approximately 116 fast food takeaway outlets with an average of 52-63 outlets per 100,000 population (See map appendix 6). This is lower than the UK national average of 77 fast food takeaways per 100,000 population (See appendix 6).

Food Culture: Cooking, knowledge, skills

The causes of unhealthy diets and obesity are also linked to shifts in food culture. Over the last decade there has been an increasing trend towards the consumption of fast food, pre-prepared, convenience food products and a decline in cooking from scratch (Grinnel-Wright *et al*., 2013; Ute, 2013). Evidence from Change For Life suggests that 96% of households use pre-prepared foods (e.g. pizza, chicken nuggets) and only 16% cook from scratch every day (Ute, 2013).

This shift in consumer behaviour is not only associated with a rise in obesity, but it has contributed to a national decline in cooking ability, with 1 in 6 people lacking the skills, confidence and ability to cook and prepare meals from scratch affecting their ability to feed themselves healthily and affordably (Good Food 2011; Short, 2003). Evidence suggests that the reasons for these trends are associated with increased time constraints, shifting family priorities, the effect of food advertising, an increased availability of pre-prepared foods and decreased opportunities for cooking skill acquisition both within the home and public-sector educational organisations (Chenhall, 2010).

What are the potential solutions to improve diet-related health and equality? Analysis of the evidence

Adopting approaches that address the key causes of poor diets, i.e. food accessibility, affordability and culture will act to improve diet-related health and equality.

Improve the accessibility and affordability of good food:
Food accessibility and affordability can significantly influence food choice and dietary quality. For example, studies suggest that people living in areas with shops and markets selling a wide range of affordable, fresh produce eat more fruit and vegetables than those living in areas with a limited range or supply (Cadwell *et al*., 2009). Ensuring that communities have access to healthy, fresh food within easy walking distance of where they live, and improving the retail offer of fresh, healthy and affordable food is important to improving food accessibility and to encourage people to eat healthier diets.

Enhancing the provision and availability of good food in a wider range of public organisations and businesses, such as schools, workplaces, catering and retail establishments can also help to improve the nutritional intake of their users and increase access to healthier food.

Encourage a healthy and sustainable food culture: Education, knowledge and skills
Evidence suggests that raising awareness of good food and a healthy diet and improving opportunities for people to develop skills in cooking and growing helps drive positive behavioural change and enables people to make informed and responsible food choices, equipping them with the skills needed to prepare healthy and affordable meals (Hartmann *et al.,* 2012).

Cooking from scratch and food growing is linked to higher fruit and vegetable consumption, skill development and cost savings and therefore further opportunities should be provided for food-related skill development to drive behavioural change and to address issues associated with food affordability (Grinnel-Wright *et al.,* 2013; Hartmann *et al*., 2012; Reese, 2012). There is a clear need for education on healthy eating, food systems and cooking and growing skills to equip people with the skills and knowledge to make healthy and sustainable food choices.

The B&NES response to improving health and equality

The B&NES Local Food Strategy will create the framework for action to reduce diet-related ill-health and inequality in Bath and North East Somerset by addressing the key causes of poor diet i.e. accessibility, affordability and culture. In particular, the framework will include action to enhance the

provision of good food in a wider range of organisations and businesses to improve food accessibility and will inform action to address food poverty to enable low income groups to afford good food. The strategy framework will include action to improve food culture by increasing opportunities for local people to develop food related knowledge and skills, building on existing work with families and schools and by co-ordinating communal events that promote good food to the public and by providing more community food growing space and opportunities for people to reconnect with local producers.

ii) Environmental sustainability and food security

What are the issues?

People are aware that the food they eat affects their health, but what is less well known is the impact producing, processing and distribution has on the world's resources and environmental quality. The global food system has a huge environmental impact. It accounts for between 14-30% of global greenhouse gas emissions, generates an enormous amount of waste and pollution, and contributes to the degradation of natural resources such as air, water and soil quality, wildlife and biodiversity (Vermeulen *et al*., 2012).

What are the key causes of environmental degradation and food insecurity?

The key causes of food-related environmental impacts and food insecurity are associated with intensive food production methods, food transportation and food waste:

Food Production

Although green-house gas emissions are generated from all stages of the food supply chain, the majority of emissions (80-86%) are associated with food production (Vermeulen *et al*., 2012). Energy-intensive production methods including the use and manufacture of agro-chemicals, inefficient soil management that releases rather than absorbs greenhouse gas emissions, slurry storage and factory farming of animals are major causes of GHG emissions and contribute significantly to climate change, water pollution, soil erosion, biodiversity loss and poor animal welfare (Bellarby *et al.,* 2013; DEFRA, 2013b). Livestock's contribution to climate change is particularly significant accounting for up to 18% of food system GHG emissions (FAO, 2006).

As well as contributing to climate change, food production systems are, in turn, vulnerable to climate change impacts; The Intergovernmental Panel for Climate Change (2014) predicts negative impacts on food production as a result of the increase in extreme weather events such as flooding and heat waves, threatening global food security (IPCC, 2014).

Food Transportation

The impact of food transportation on the environment and climate change is also significant: The UK is heavily dependent on imported food, currently importing 47% of total food products, and 95% of fruit (DEFRA 2013a). The majority of this food is distributed via centralised supply networks and is processed, manufactured and retailed by large multi-national companies. Current food transportation contributes to air pollution, traffic congestion and GHG emissions with food transport in the UK, for example, accounting for 19 million tonnes of carbon equivalent emissions in 2002 (Vermeulen *et al.,* 2012). The UK's reliance on imported food threatens future food security as our ability to import sufficient quantities of food in the future is vulnerable to climate change, peak oil, rising world population, shifting dietary preference for meat and dairy and increased price volatility.

Food Waste

Other major environmental impacts of the food supply chain are associated with food waste and food packaging: In the UK approximately 30% of all food produced is wasted along various stages of the food supply chain (FAO, 2013). Not only is food waste a huge waste of money and resources, but food that is diverted into landfill produces methane - a powerful greenhouse gas that contributes to climate change (Bingemer and Crutzen, 1987; FAO, 2013).

What are the potential solutions to improve environmental sustainability and food security?

Adopting approaches that address unsustainable food production, supply, consumption and disposal will act to improve environmental sustainability and food security. The following recommendations will inform the B&NES strategic approach as outlined in the strategy delivery themes (See section 3).

Encourage sustainable food production

The use of sustainable production methods can significantly reduce environmental impacts associated with the local food sector (DEFRA 2013c). Approximately 70% of land in Bath and North East Somerset is in agricultural use and therefore environmental stewardship of land by farmers is incredibly important to provide environmental outcomes for the landscape such as climate regulation, flood mitigation, soil fertility and biodiversity provision. Sustainable food production methods, including low agro-chemical use, the provision of wildlife habitat space, improvements to energy efficiency, effective soil and water management and high animal welfare standards, will help to create farm systems that are healthy, robust and resilient to future changes in climate.

Encourage local food production and supply

Up-scaling local food production and supply can contribute to local food security and resilience whilst decreasing GHG emissions, pollution and congestion associated with long-distance transportation. Increasing provision of community

food growing space, protecting local food infrastructure and seeking market opportunities for local food are all examples of action to increase local food production and supply.

Reduce food waste and packaging

Supporting residents, businesses and organisations to reduce food waste and food packaging will reduce GHG emissions and environmental impacts associated with food waste.

Encourage a sustainable food culture

Evidence suggests that many people in the UK are disconnected from food production systems and supply chains and as a result know very little about where food comes from, how it is produced and its impact on human health and the environment (Clonan *et al.,* 2010; Duffy *et al.,* 2005). There is a clear need for education on food systems to increase demand for local and sustainable food.

The B&NES response to improving environmental sustainability and food security

The B&NES Local Food Strategy will create the framework for action to reduce the global and local environmental impacts of food production, supply and disposal and to increase food security within the context of climate change, through increasing local food production and supply, supporting sustainable food production in Bath and North East Somerset and by continuing to support residents and organisations to reduce food-related waste including food packaging. Facilitating a joint approach to local food supply chain development, implementing environmental standards in public sector food contracts and increasing the provision of community food growing space are examples of action to improve environmental sustainability and local food security.

iii) Strong and Prosperous economy

What are the issues and key causes of economic decline?

The agri-food sector, including food production, processing, manufacture and retail, is an important component of the UK economy, employing approximately 12.5% of UK workers (Food Ethics Council, 2009). However, current food system trends including food importation, rising agricultural input prices and a consolidation in food retail has had detrimental impacts on many small and medium sized food businesses across the UK as they face increasing pressure and competition from large and/or international businesses (Lang, 2009). As a result, the UK has seen wide-scale agricultural decline and the disappearance of local abattoirs, processors and independent food retailers.

In B&NES there are approximately 399 farm businesses and an estimated agricultural labour force of 909 people (Note: this data does not include businesses that fall below the VAT

threshold) (DEFRA, 2010). The health of the agricultural sector in B&NES has worsened over the past 2 decades with full time agricultural employment declining by more than half between 2000 and 2010 (See appendix 4). Agriculture has had a fundamental influence on the rural economy and the character of rural landscapes and its current problems raise long term implications for the food and farming economy as well as rural poverty.

What are the potential solutions to improve economic and job opportunities in the food and farming sector?

Adopting approaches that support local businesses and enhance trade of local food will help to support a strong local food economy. The following recommendations will inform the strategic approach as outlined in the strategy delivery themes (See section 3.)

Increase trade of local food

Increased trade of local food could provide multiple economic benefits; It generates income growth for food and farming businesses, helps to create new jobs in local food processing and distribution and retail trades, and contributes to the local multiplier effect where money is retained and circulated in the local economy (Kneafsey *et al.,* 2013; Orme *et al*., 2011). In B&NES an estimated

An example of the economic benefits of local food is provided in the Food For Life 2011 report which found that increasing school meal spend on local, seasonal ingredients generated an economic return of £3 for every £1 spent, contributing to local income growth and containment and the creation and retention of jobs (Orme *et al*., 2010). Furthermore there is strong community interest and engagement in local food with 81% of residents stating that they would be willing to buy more local food to help reduce carbon emissions (B&NES Council 2009).

Examples of successful initiatives to increase local food trade include: facilitating the development of the local food supply chain, networking and trading links and seeking market opportunities for local food in public sector organisations and private businesses.

Support local food and farming businesses

Championing and supporting local farming, distribution, processing, retail and catering businesses can contribute to income growth and enable them to prosper. Although supermarkets and multiple chain retailers have a Examples of successful initiatives to support local businesses include: championing local independent businesses, encouraging people and businesses to “buy local”, raising awareness of local food and influencing policy making to better support local business.

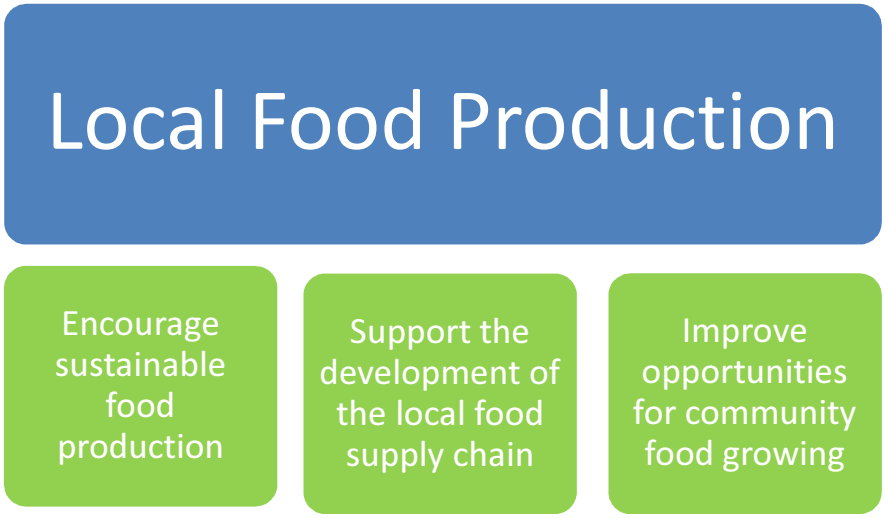
The B&NES response to providing a strong and prosperous economy:

The B&NES Local Food Strategy will create the framework for action to stimulate economic opportunities in the food and farming sector and to contribute to a prosperous food and farming economy in Bath & North East Somerset. In particular the framework will include action to seek market opportunities for local food in a wider range of businesses and public sector organisations, facilitate local food supply chain development, raise the profile of local food and contribute to skills, jobs and development opportunities in food, catering and farming sectors.

Section 3: Strategy Delivery Themes

The B&NES Local Food Strategy is structured around three delivery themes. Each delivery theme identifies action needed to achieve our strategy vision. An action plan will be developed accordingly.

Delivery Theme 1: Local Food Production



Introduction:

This theme sets out a framework for action to support and encourage more local and sustainable food production and supply in Bath and North East Somerset to increase food security, reduce the negative environmental impacts of the local food sector and to support local food and farming businesses.[1] An overview of the agricultural sector in B&NES is provided in appendix 4.

Objectives:

- To increase the amount of food that is produced, within B&NES.
- To increase the environmental and ethical standards of locally grown food, particularly to reduce green-house-gas emissions.
- To increase the amount of locally produced food that is distributed and sold locally.
- To increase the amount of community food growing space across the district such as allotments, community gardens and communal orchards.

Action:

(i) Encourage sustainable food production

Effective environmental stewardship of agricultural land is essential for good environmental outcomes for our landscape. In B&NES there are many examples of good farming practice, however there are some pockets of land, including in the Bath World Heritage Site, that are in poor condition and therefore co-ordinated action is needed to further support sustainable food production.

[1] Note: The distance travelled by food, whilst significant, is not the only measure of foods' environmental impact and other factors' such as production methods and storage are important. This delivery theme addresses ways in which we can localise food production and supply, but only where it provides environmental, social and economic benefits and contributes to a sustainable food sector that provides wide diversity and choice.

Current examples of good practice:

- Approximately 62% of farmers in B&NES are enrolled in agri-environment schemes. These are funding schemes to support farmers to manage land to high environmental standards.

- There are a number of locally active advisory bodies, farming organisations, charities and government agencies that provide training, advice and support to farmers to adopt high environmental and animal welfare standards.

Potential future action:

- Develop a B&NES Local Food Partnership to strengthen relationships with the agricultural community and to facilitate support from expert advisory groups that encourage local farmers and food growers to adopt high environmental and animal welfare standards and to enhance the agricultural stewardship of B&NES landscape (including the Bath World Heritage Site).

- Encourage more farmers to enrol in training and support programmes for environmentally-responsible farming and effective land management such as land management schemes, Linking Environment and Farming schemes and RSPCA freedom food animal welfare schemes.

- Support farmers to reduce carbon emissions (and minimise waste) by investing in cost-effective renewable energies such as anaerobic digestion and wind energy.

(ii) Support the development of the local food supply chain

In 2007 B&NES council commissioned a report exploring the barriers to local food supply in Bath and North East Somerset. The key barriers reported include restrictive planning policies, inadequate food processing infrastructure, and a lack of time for food producers to identify retail markets (Belshaw, 2007).

Local food supply is reliant on local food infrastructure such as processing, storage, distribution and retail facilities as well as high-grade agricultural land. The protection of these facilities is needed, along with a co-ordinated approach to seek market opportunities for local food, to facilitate and enable local production and supply both now and in the future.

Current examples of good practice:

- There are a number of local food marketing initiatives in place including three farmers markets, a number of home delivery veg-box schemes and an online local food distribution service.

Case Study: Bath Farmers' Market

Bath's Farmers' market was the first in the country to be set up in 1997. It is held weekly every Saturday and provides an important outlet for local farmers and producers to sell their food.

Potential future action:

- Develop a B&NES Local Food Partnership to facilitate joint action on local food supply chain development. Develop initiatives and projects to facilitate local food supply such as a local food directory and meet the buyer events.

  Develop planning policies further to support the development and diversification of agricultural businesses and to protect high-grade agricultural land and supply chain infrastructure

- Facilitate an increase in the number, frequency and geographic spread of farmer's markets and direct food- selling initiatives throughout the district.

- Enhance market opportunities for local food in public and private businesses and organisations (see delivery theme 2).

- Continue to engage with West of England Partners to address gaps in local infrastructure and to co-ordinate opportunities for local food supply.

(iii) Improve opportunities for community food growing

Community food growing provides people with a source of local and healthy food, contributes to physical activity, provides dietary and mental health benefits and can improve opportunities for community cohesion and social engagement (Davies et al., 2014; Litt et al., 2011; Van de Berg 2010).

There are 42 allotment garden sites across Bath and North East Somerset. The Council is responsible for just the 23 sites in Bath. Elsewhere allotments are managed by other local bodies, such as Parish Councils and social housing organisations. There are a number of other community food growing projects in Bath and North East Somerset including community gardens, nutteries, orchards and agricultural projects.

In B&NES there is a high demand for allotments with nearly every site across the District now full with a waiting list (the Green Space Strategy research is due to be updated in Spring 2015). Further provision of allotments and community food growing space is needed to meet the demand for community food growing and to enable a wider number of people to benefit from the health and sustainability benefits of food growing.

Current examples of good practice:

- Bath Area Growers and Transition Keynsham are amongst a number of networks and organisations to have set up community food growing projects in B&NES.

- Bath City Farm works with vulnerable people to develop skills in sustainable agriculture and food growing.

Potential Future action:

- Support allotment provision and management via the delivery of the Allotments' Management Plan and by working in partnership with Parish Councils.

- Provide further guidance on local policies that support the provision and retention of allotments and community food growing space, including site criteria, through the forthcoming Place Making Plan (2016) and develop the work of regeneration to incorporate food growing space into new and existing developments.

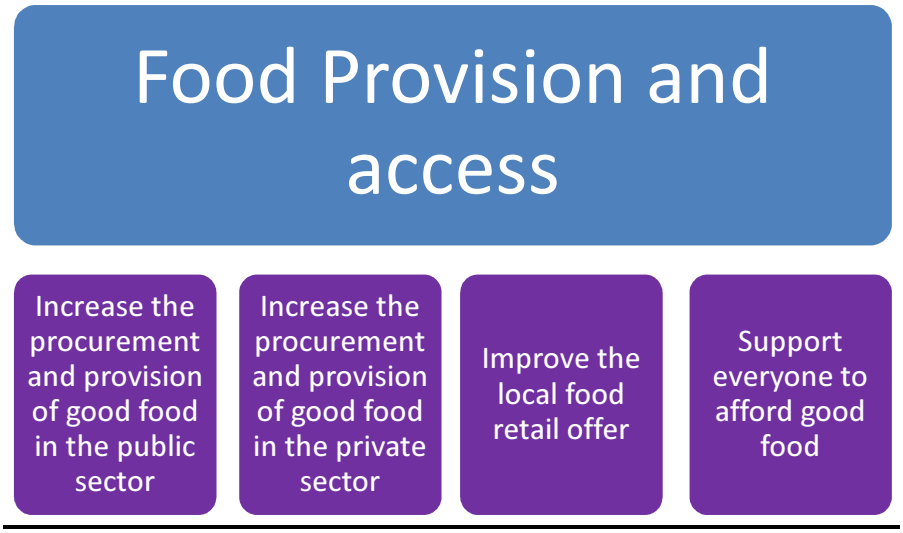
Case Study

The Community Farm is a member-owned community supported agriculture project growing organic vegetables and fruit on 32 acres of land in the Chew Valley area. The social enterprise supplies local, organic vegetable and fruit boxes and wholesale to the Bristol and Bath area and works with a co-operative of Somerset growers to shorten food supply chains and provide an outlet for locally grown produce. The farm fulfils its social remit by providing opportunities for volunteering and learning agricultural skills, as well as school visits and traineeships for disadvantaged adults.

- Develop initiatives and guidance to support an increase in community and commercial food growing on public land.

- Continue to incorporate edible and fruiting plants into public spaces to provide residents with a source of fresh, local food.

Delivery theme two: Food provision and access



Introduction

For people to make healthy and sustainable food choices good food options must be easily available and accessible. This theme sets out a framework for action to increase access to, and provision of, good food in B&NES by enhancing the procurement and provision of good food, by improving the local food retail offer and by supporting all residents to afford good food. It aims to make the good food choice the easiest choice for residents to make.

Objectives:

- Improve the provision of good food in a wider range of organisations and businesses
- Improve the retail opportunities for good food, particularly in areas of low food accessibility.
- Increase the ability of all groups to access healthy, good quality food.

Action:

(i) Increase the procurement and provision of good food in the public sector

A third of all meals eaten outside of the home are in publically funded institutions such as schools, universities, hospitals, care-homes and staff canteens. The major public sector bodies in Bath and North East Somerset include B&NES Council, the NHS, Bath University, Bath Spa University and the Police Service. The provision and procurement of good food by these organisations can significantly influence and improve the nutritional intake of their users, including vulnerable groups such as ill,

elderly and low income groups, whilst creating significant economic opportunities for local food and farming businesses.

Current examples of good practice:

- The Council's Food Forum has an important role supporting schools, colleges and early year settings to increase the quality and uptake of lunchtime meals and to reduce the amount of unhealthy food that children consume within educational settings. The Food Forum has also supported the implementation of the School Food Plan, including support to implement universal free school meals for all key stage 1 primary school children from September 2014. This will help to reduce cost for all families and help children to be healthy and ready to learn.

Case Study: Council Catering Service Food For Life Partnership Award

The Council catering service which procures and provides meals for 61 primary schools in the district has received the Soil Associations' Bronze Food For Life Catering Mark for providing healthy meals sourced from fresh, local and organic ingredients, produced to high animal welfare standards.

- B&NES Council have recently developed a "Think Local" procurement policy to help overcome the barriers that prevent local, small and medium sized businesses from tendering and winning contracts. The policy aims to create a more level playing field for small and local businesses.

- With Council support, Fairtrade status has been awarded to Bath and North East Somerset district, Bath City, Keynsham, Norton Radstock and Chew Magna.

Potential Future Action:

- Continue to support schools, colleges and Early years' settings to improve the quality of food provided and eaten in educational settings by supporting the implementation of the school food plan, by developing the Director of Public Health Award and by developing initiatives to support secondary schools, academies and colleges to adhere to Food For Life Catering Mark Standards as a minimum.

- Include sustainability criteria in the use and award of all public sector food contracts including the use of local, fair trade and higher-animal welfare products.

- Support all public sector organisations to serve freshly prepared, nutritious meals that comply with an accredited quality and sustainable food standard such as the Food For Life catering mark.

(ii) Increase the procurement and provision of good food in the private sector

The provision of good food in retail and catering outlets and workplaces enables people to make healthy and sustainable food choices when food shopping, dining out and at work. By sourcing more good food, individual food businesses can positively influence the nutritional intake of B&NES citizens and provide significant market opportunities for the sale and provision of local food, contributing to the local economy

Current examples of good practice:

- Delivery of the "Eat-out, Eat-Well" award by the Council and Sirona supports food outlets and catering businesses to provide a wider range of healthy food options and to reduce the level of trans-fats, salt and sugar provided in their foods.

- Sirona delivers the "Work-Place, Wellbeing Charter" to support workplaces to promote healthy-eating practices.

- A "Baby Welcome" scheme has been established in B&NES to encourage and welcome breastfeeding in cafes and venues across the local authority area.

Case Study: The Great Bath Breakfast

There are 25 businesses enrolled in the "Great Bath Breakfast"- an initiative that recognises Bath businesses that supply locally-sourced breakfast items.

Potential Future Action:

- Identify market opportunities for good food in a wider range of retail and catering businesses including independent shops, supermarkets and convenience stores and facilitate trading links between relevant members of the food supply chain.

- Develop and promote suitable campaigns and communications to encourage the supply of good food by local businesses.

- Continue to monitor and advise on food safety and hygiene issues along with the food standards agency to support food businesses to provide safe and hygienic food.

- Continue to support workplaces to provide healthy food options, improve the dining environment and to provide staff with information about healthy eating and good food.

- Continue to support food-outlets and public environments to welcome breast-feeding.

(iii) Improve the local food retail offer

The nature and type of food retail has a significant influence on peoples' food choices and their ability to easily access good food. It is important that communities have easy access to affordable, fresh produce provided by a diverse range of retail outlets and markets.

Nevertheless there is a need to monitor the prevalence of fast-food takeaways to prevent potential over-clustering in the future.

Current examples of good practice

- Freshford community shop is built, owned and managed by the local community. It was set up following the closure of other local shops and serves the community with every-day household needs.

Potential future action:

- Support the establishment of more food markets, fruit and vegetable stalls, independent retail, buying groups and food CO-OPs to increase community access to good, affordable food.

- Provide further detail and guidance regarding essential retail provision in the Place-making Plan (2016) to complement existing policies in the Core Strategy.

Case Study: South Side Food CO-OP

Southside Food CO-OP offers people in the south & west of Bath an opportunity to buy fresh locally grown produce at affordable prices from their office in Twerton.

- Continue to encourage the provision of healthy street food such as fruit and vegetable stalls and healthy food takeaways.

- Continue to monitor the prevalence and distribution of fast-food takeaways in B&NES and inform policy making accordingly.

(iv) Support everyone to afford good quality food

In Bath and North East Somerset residents living in areas of multiple deprivation are more likely to suffer from poor diet and unhealthy weight than those that do not (See appendix 6). Rising food prices, high costs of healthy food and a lack of access to cooking and transport facilities are all factors that can make it harder for low-income groups to eat healthily and sustainably. Although there are a number of organisations working to tackle food poverty in Bath and North East Somerset including food banks, community kitchens and food re-distribution services further action is needed to reduce diet-related inequalities across the local authority area.

Current examples of good practice:

- The National Healthy Start Voucher and vitamin schemes providing free milk, fruit, vegetables and vitamin supplements, are available for eligible low income families during pregnancy and with children under the age of five.

- There are a number of food banks and community kitchens that provide emergency food hand outs and meals to people in need such as the Bath Food Bank, Food Cycle and Julian House.

Potential future action:

- Prioritise low-income groups in the delivery of projects.

- Increase the use of healthy start vouchers by eligible families.

- Increase the acceptance of healthy start vouchers in retail establishments across B&NES including at fruit and veg market stalls, farmers' markets, convenience stores and independent shops.

- Continue to support the implementation of the school

Case study: Bath Food Cycle

Bath Food Cycle provides a weekly free three course meal to people in need using surplus food provided from numerous businesses including Bath Sainsbury's.

food plan to provide free school meals to all key stage 1 pupils.

- Continue to support the redistribution of fit-for-purpose waste food working with supermarkets, charities, food banks and community kitchens.

- Provide training opportunities for low-income groups to develop skills and knowledge in cookery, growing and healthy eating (See delivery theme 3).

Delivery theme three : Promote a healthy and sustainable food culture

Introduction

This work stream sets out a framework for action to promote and develop a healthy and sustainable food culture, to increase the demand for and use of healthy and sustainable food.

Objectives

- Increase the demand for local, healthy and sustainable food.
- Increase the number of people with the skills, knowledge, confidence and desire to create a healthy diet.
- Raise the profile of good food and the range of benefits that it provides.
- Increase the number of residents, businesses and organisations participating in sustainable food behaviours such as food waste redistribution, reduction and recycling.

Action

(i) Provide enjoyable opportunities for residents to learn about food and nutrition and to develop skills in cooking and growing

Improving opportunities for people to learn about good food and to develop skills in cooking and growing is essential to promoting positive dietary behavioural change and to make cost-savings on food (Hartmann *et al*., 2013; Reese 2012).

Current examples of good practice:

- The B&NES Council Food Forum delivers a range of programmes in schools and early year- settings to engage children in food-related activities such as cooking, growing, composting, farm visits and healthy eating. Targeted programmes include the Director of Public Health Award, SHINE and HENRY.

- The Council commissions the Cook-it Service; a five week programme teaching families in identified children's centre areas to cook affordable, healthy meals.

- A pilot model between Age UK and Chew Valley Secondary School has been launched to engage older people in schools to share knowledge and skills around cooking and food skills.

- There are a number of farms and community gardens that hold demonstration and engagement days for members of the public to learn about local agriculture and food growing,

Case study: Food For Life Partnership in B&NES

The majority of schools in B&NES are enrolled in the food for life partnership programme which raises food awareness amongst children and engages them in food growing, cooking and composting activities. A national evaluation of the FFLP programme showed that following their participation in FFLP programme, the proportion of primary school children eating 5 or more pieces of fruit and veg a day increased by 28%.

Potential Future Action:

- Continue to support schools and other places of education to embed food food-related skills and education into the curriculum using a whole-school approach.

- Seek further training opportunities for residents to develop cooking, hygiene and food growing skills.

- Seek further opportunities to engage the community with food and farming education opportunities including farm demonstration days and communal food growing activities.

(ii) Increase public awareness of good food and the benefits that it provides

Increasing communications and marketing, and supporting food events and festivals will help to raise resident awareness of good food.

Current examples of good practice:

- B&NES Council has set up a B&NES Environmental Sustainability Network website that includes a local food topic group for interested members to share information, projects and events related to good food.

- A number of communal food events and festivals are held in B&NES including the Great Bath Feast , the Keynsham Food Festival, and communal harvest celebrations.

Case Study: FareShare South West

Fare Share South West redistributes surplus fit-for-purpose food to 10 organisations in Bath, helping to address food poverty and reduce food waste

Potential Future Action:

- Encourage more events, festivals and markets that appeal to a wider range of audiences and are accessible to all particularly those which celebrate the link between local food and the local countryside in which they are produced.

- Continue to develop the B&NES Environmental Sustainability Network website's food section to build membership across the community and to promote particular food related campaigns, events and projects

- Continue to co-ordinate and provide health and nutrition advice and communications specific to people at all life stages.

iii) Support residents, businesses and public sector organisations to reduce, redistribute and recycle food waste

Encouraging people to reduce their food waste will help them to save money, whilst reducing carbon emissions and diverting waste from land-fill (Wrap, 2012). Although great progress has been made in B&NES to reduce food waste, there are many households, businesses and organisations that continue to waste fit-for-purpose food and do not participate in food waste recycling.

Current examples of good practice:

- The Council has partnered with the national Love Food Hate Waste campaign to support residents to reduce food waste via educational road shows, events, competitions and door knocking.

- The Bath BID provide a collaborative trade waste and recycling service to support Bath-based businesses to recycle their food waste.

Potential Future Action:

- Continue to deliver public awareness and engagement campaigns to support residents to reduce food waste.

- Continue to develop the waste collection service to support more schools, residents and businesses to reduce their food waste.

- Seek opportunities and initiatives to support retailers, businesses and residents to reduce food packaging waste.

- Continue to support the redistribution of fit-for-purpose waste food by farmers, supermarkets and retailers, charities, food banks and social enterprises

Section 4: Next Steps for the strategy

This strategy serves to communicate the ESP's strategic approach to local food in Bath and North East Somerset. A proposed B&NES Local Food Partnership will be established to oversee the development and implementation of the local food action plan. The strategy will be updated as needed to reflect any changes in our strategic approach, every three years.

For more information please contact the sustainability team at Bath and North East Somerset Council: sustainability@bathnes.gov.uk.

The strategy will be made available upon request in a range of languages, large print, Braille, on tape, electronic and accessible formats. Please contact Sophie Kirk: Tel: 01225477932 or Sophie_Kirk@BATHNES.GOV.UK

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