Bath & North East Somerset Council

NHS
Bath and North East Somerset
Clinical Commissioning Group

# Bath and North East Somerset
# Health & Wellbeing Board



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| | | |
| | Date: | 20 October 2015 |



To: All Members of the Health & Wellbeing Board

**Members:** Dr Ian Orpen (Member of the Clinical Commissioning Group), Councillor Vic Pritchard (Bath & North East Somerset Council), Ashley Ayre (Bath & North East Somerset Council), Bruce Laurence (Bath & North East Somerset Council), Jo Farrar (Bath & North East Somerset Council), Councillor Tim Warren (Bath & North East Somerset Council), Councillor Michael Evans (Bath & North East Somerset Council), Morgan Daly (Healthwatch Representative), Diana Hall Hall (Healthwatch representative), John Holden (Clinical Commissioning Group lay member), Tracey Cox (Clinical Commissioning Group)

**Non-voting member:** Debra Elliott (NHS England)

**Observers:** Councillors Tim Ball and Eleanor Jackson (Bath & North East Somerset Council)

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, 28th October, 2015** at **2.00 pm** in the **Community Space, Keynsham - Market Walk, Keynsham.**

The agenda is set out overleaf.

Yours sincerely

David Taylor
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 David Taylor who is available by telephoning Bath 01225 394414 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 David Taylor 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 **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.

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

## 7. Emergency Evacuation Procedure

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

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

**Health & Wellbeing Board**

**Wednesday, 28th October, 2015**
**Community Space, Keynsham - Market Walk, Keynsham**
**2.00 - 4.00 pm**

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## 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 on 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; and

   (c) Whether their interest is a **disclosable pecuniary interest** or **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 22ND JULY 2015

   To confirm as a correct record the Minutes of the previous meeting held on Wednesday 22nd July 2015

8. UPDATE ON YOUR CARE, YOUR WAY

   To receive this Update Report for information

9. TRANSFORMATION GROUP UPDATE

   The Board is asked to note the Briefing

10. PRIMARY CARE CO-COMMISSIONING UPDATE

    The Board is invited to (1) note both the national and local context for Primary Care GP

Services in B&nes; and (2) consider any other issues that should inform the Emerging Primary Care Strategy in B&nes

11. B&NES CHILDREN AND YOUNG PEOPLE CAMHS TRANSFORMATION PLAN

The Board is asked to (1) note the range of multi-agency parties, including schools and colleges, supporting health and wellbeing in B&nes; (2) note the Final CYP's CAMHS Transformation Plan; (3) consider and endorse the Final CYP CAMHS Transformation Plan; (4) support the continued commitment to, and funding of, current "spend" on emotional health and wellbeing for children and young people in B&nes; and (5) receive a progress report on the implementation of the Plan in 6 months (April 2016)

12. LSAB ANNUAL REPORT

The Board is asked to (1) note the report and Business Plan; (2) raise any queries or concerns on safeguarding activity; and (3) recommend to the LSAB any areas for additional focus and assurance

13. B&NES WIDE ANTI-MICROBIAL RESISTANCE STRATEGIC COLLABORATIVE

The Board is asked to (1) agree to the establishment of a B&nes Anti-Microbial Resistance Strategic Collaborative, chaired by the CCG Clinical Chair, reporting to this Board at 6 monthly intervals; and (2) support the European Antibiotic Awareness Day on 18th November and pledge to become an Antibiotic Guardian

The Committee Administrator for this meeting is David Taylor who can be contacted by telephoning Bath 01225 394414

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**Bath and North East Somerset Council**

**NHS Bath and North East Somerset**

**HEALTH & WELLBEING BOARD**

# Minutes of the Meeting held

Wednesday, 22nd July, 2015, 2.00 pm

| | |
|---|---|
| Dr Ian Orpen (Chair) | B&NES Clinical Commissioning Group (CCG) |
| Councillor Vic Pritchard | Bath & North East Somerset Council |
| Ashley Ayre | Bath & North East Somerset Council |
| Bruce Laurence | Bath & North East Somerset Council |
| Councillor Michael Evans | Bath & North East Somerset Council |
| David Trethewey (In place of Jo Farrar) | Bath & North East Somerset Council |
| Morgan Daly | Healthwatch representative |
| Diana Hall Hall | Healthwatch representative |
| Dawn Clarke (In place of Tracey Cox) | Bath & North East Somerset CCG |
| Observers: | |
| Councillor Tim Ball | Bath & North East Somerset Council |
| Council Brian Simmons | Bath & North East Somerset Council |

1 **WELCOME AND INTRODUCTIONS**

The Chair welcomed everyone to the meeting and requested that attendees switch their mobile phones etc to silent. He stated that the meeting was being webcasted live and the recording stored on the Council website.

2 **EMERGENCY EVACUATION PROCEDURE**

The Administrator drew attention to the emergency evacuation procedure

3 **APOLOGIES FOR ABSENCE**

There were apologies from Jo Farrar (Chief Executive, B&NES Council) and Tracey Cox (Chief Officer, B&NES CCG) and their respective substitutes were David

Trethewey, Divisional Director of Strategy and Performance, B&NES Council) and Dawn Clarke (Director, Nursing and Quality, B&NES CCG). There were also apologies from John Holden (Lay Member B&NES CCG) and Councillor Tim Warren (Leader of B&NES Council).

4 **DECLARATIONS OF INTEREST**

There was none

5 **TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR**

There was none

6 **PUBLIC QUESTIONS/COMMENTS**

There was none

7 **MINUTES OF PREVIOUS MEETING**

The Minutes of the previous meeting were approved by the Board and signed by the Chair as a correct record

8 **UPDATE ON YOUR CARE, YOUR WAY**

The YCYW Programme Manager, Sue Blackman, gave a presentation on “Your Care, Your Way: Designing Community Services”. It covered issues of key functions; the current situation; the impact of population and financial data; and responses from the community from the extensive engagement so far undertaken. It concluded by saying that people needed to work together and implement the core principles of shaping services that were joined up, focussed on the whole person, increased community capacity and ensured their information was available to those who needed it. It was an opportunity to be bold, ambitious and imaginative.

Members asked questions to which the Officer responded as appropriate. Morgan Daly stated that the Healthwatch group valued the work being done and would support the project. Councillor Vic Pritchard stated that the Authority was starting this in a good position as a result of the joint work undertaken with the CCG and the formation of Sirona 4 years ago.

**RESOLVED** to note the Update

9 **HEALTH PROTECTION BOARD ANNUAL REPORT**

The Director Public Health gave a presentation on the Health Protection Board Annual Report 2014/15. It covered various issues including the definition of health protection; the duties to be performed; health protection assurance; screening and immunisation; a focus on flu vaccination and health screening campaigns; health care associated infections; communicable diseases and environmental hazards; health emergency planning; sexual health; and substance misuse.

Councillor Michael Evans raised the issue of whether there was a prostate cancer screening programme. The Director of Public Health replied that there was currently

no systematic programme; it was unclear regarding survival rates of implementing a screening programme but men of an age of 40+ could request to be screened. The Chair provided some information on the limitations of such testing as things stood.

Councillor Vic Pritchard considered that, when there was a national threat to health, it needed to be widely publicised, such as in the case of Bird Flu. The Authorities were well prepared but the publicity had not always been as effective as it might be. The public needed to be informed of an outbreak and informed what was being done about it. He moved that this be included in the recommendations. The Director agreed that this was an important point and that clarity and consistency were required. The Board approved the motion.

The Chair referred to the issue of flu vaccinations and the difficulty in persuading people to be immunised. He considered how much services for drug and substance misuse had improved in the last 10 years.

**RESOLVED** to note the Annual Report and the following priorities for the Health Protection Board for 2015/16:

(1) To ensure that Local Health Resilience Partnership/Local Resilience Forum Plans are effectively operationalised for B&nes by (a) signing off the B&nes Health Protection Incident Control Plan to agree roles and responsibilities, identify gaps and practical solutions to ensure preparedness and response; and (b) identify lessons learnt from outbreaks and incidents and implement action plans;
(2) To help to ensure resilience of Health Emergency Planning in B&nes;
(3) To support the development of Air Quality Action Plans (AQAPs) for Saltford and Keynsham;
(4) To improve the uptake in all childhood immunisation programmes;
(5) To improve the uptake of flu vaccinations in target groups; and
(6) To continue to monitor performance in specialist areas, identify risks and ensure mitigation is in place and escalate as necessary.

The Board confirmed approval of the motion by Councillor Vic Pritchard during consideration of this item.

## 10 SEXUAL HEALTH BOARD ANNUAL REPORT

Paul Sheehan reported on the Sexual Health Board's Annual Report.

Members considered the Report and asked questions to which the Officer responded as appropriate. The Director Public Health commended the work done by the Sexual Health Board and the Needs Assessment. There would be psychological aspects which would be challenging for young people but the service would be improved by more public engagement with the young. Other Members also commended the work being undertaken by the Sexual Health Board. The Chair queried the linkage with "Your Care, Your Way". The Officer responded that there would be links with care services, sexual health promotion and delivery of education sessions.

**RESOLVED** to approve the Annual Report

11 **LSCB ANNUAL REPORT 2014-15 AND BUSINESS PLAN 2015-18**

The Head of Safeguarding and Quality Assurance, Lesley Hutchinson, delivered the LSCB Annual Report 2014-15 and Business Plan 2015-18. She took Members through the Report and responded to various questions as appropriate. She gave the apologies of the Board's Independent Chair, Reg Pengelly, who could not attend the meeting.

Members raised various concerns as requested. It was queried whether the public would be reassured by action taken against child sexual exploitation. The Head of Safeguarding and Quality Assurance responded that there was a comprehensive training programme and various facilities available for assistance – information was received from the Police and vulnerable children could be identified. Other matters raised were:

- checks on public transport in and out of the district
- school attendance
- child sexual exploitation, training and heightened awareness being required
- the permanence of children placed out of the area and their specific needs
- the mechanisms in place by Authorities, agencies and in the community
- sharing information and learning from experiences in other local authorities
- close partnership working was essential

The Chair summed up the debate and referred to the inter-relationship with this Board and the LSCB and the need to hold each other to account, which perhaps was a better distinction than to "scrutinise".

**RESOLVED** to note the Annual Report and Business Plan

12 **B&NES ECONOMIC STRATEGY REVIEW**

The Group Manager, Economy and Culture, submitted a report on the Economic Strategy Review. He provided a presentation which covered the context for the Review; themes and priorities; cross-cutting themes; delivering economic growth and the Health and Wellbeing Board; physical regeneration and the Board; skills and employment and the Board; and digital B&NES and the Board.

Members considered the report. Reference was made to the opportunity to be more proactive when looking at the workforce for health and wellbeing. It was stated that it was difficult to make a direct link between the two areas and what means of support would be available when there were inequalities such as for the disabled. There would need to be more private sector involvement due to a shrinking public sector. The Group Manager responded to some of these queries as appropriate.

**RESOLVED** to support the delivery of the wider Economic Strategy Review Action Plan

13 **JOINT HEALTHWATCH AND HEALTH AND WELLBEING NETWORK UPDATE**

The Healthwatch B&NES General Manager provided an update report and power point presentation on the Joint Healthwatch and Health and Wellbeing Network.

There were 3 themes on Helping People to Stay Healthy, Improving the Quality of People's Lives, and Creating Fairer Life Chances. The report appended the Annual Report for 2014/15 which contained 3 Case Studies relating to these themes.

Members discussed the report. Reference was made to loneliness and isolation and the statistics available from the Healthwatch Advisory Group – there was a duty to provide a service to the increasingly diverse community which would not be to the detriment of the service as a whole. A Member stated that Healthwatch had held successful events which had resulted in recommendations being accepted by the RUH and considerable improvements in services.

**RESOLVED** to agree that the approach taken (1) fulfils the expectations of how local Healthwatch will integrate with the Health and Wellbeing Network; and (2) complements the aims of the Joint Health and Wellbeing Strategy

## 14 TWITTER QUESTIONS/STATEMENTS

The Chair stated that there were no Twitter questions or statements. The Board noted that there had been 238 people following the meeting on live webcast.

The meeting ended at 4.05pm

Chair ..........................................................................................

Date Confirmed and Signed ..................................................................

**Prepared by Democratic Services**

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Bath & North East Somerset Council

healthwatch Bath and North East Somerset

NHS Bath and North East Somerset Clinical Commissioning Group

| MEETING | B&NES HEALTH AND WELLBEING BOARD |
|---|---|
| DATE | 28/10/2015 |
| TYPE | An open public item |

| Report summary table | |
|---|---|
| **Report title** | Your Care Your Way Update |
| **Report author** | Sue Blackman |
| **List of attachments** | Not applicable |
| **Background papers** | Your Care Your Way – Making Plans<br>Your Care Your Way – Consultation Survey |
| **Summary** | Your care, your way is a bold and ambitious review of community health and care services for children, young people and adults being carried out jointly by NHS Bath and North East Somerset Clinical Commissioning Group and Bath & North East Somerset Council.<br><br>We've been talking to people since January 2015 to understand what services are like at the moment and how they could be improved. We've listened to what people told us and used their ideas to develop some different options for how we can support people in the future. Our findings were published on the 10th September in the Consultation Document and accompanying plain English survey.<br><br>At the meeting, we will present to the Board an update on the Your Care Your Way programme that will include;<br><br>• Emerging themes from formal consultation<br>• Emerging themes from market engagement<br>• Next steps and key milestones |
| **Recommendations** | Approval not required content for information. |
| **Rationale for recommendations** | Not applicable |
| **Resource implications** | Not applicable |
| **Statutory considerations** | Not applicable |
| **Consultation** | Barry Grimes, Communications Manager |
| **Risk management** | Not applicable |

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Bath & North East Somerset Council

healthwatch Bath and North East Somerset

NHS Bath and North East Somerset Clinical Commissioning Group

| MEETING | B&NES HEALTH AND WELLBEING BOARD |
|---|---|
| DATE | 28/10/2015 |
| TYPE | An open public item |

| Report summary table | |
|---|---|
| **Report title** | Transformation Group Update |
| **Report author** | Tracey Cox, Chief Officer BaNES CCG |
| **List of attachments** | Summary Report - Transformation Group Update – 18th September 2015 |
| **Background papers** | n/a |
| **Summary** | The Transformation Group meets on a bi-monthly basis and currently has the following membership:-<br><br>Tracey Cox) – Chief Officer, BaNES CCG (Chair)<br>Dr Ian Orpen – Clinical Chair, BaNES CCG<br>Dr Ruth Grabham (RG) – Medical Director, BaNES CCG<br>Vic Pritchard (VP) – B&NES Health & Wellbeing Chair<br>James Scott (JS) – Chief Executive, RUH NHS FT<br>Dr Tim Craft – Medical Director, RUH<br>Janet Rowse (JR) – Chief Executive, Sirona Care & Health<br>Liz Richards (LR) – Inpatient services Manager , AWP<br>Dr Andrew Smith (AS) – Chief Executive, BEMS+<br>Bruce Laurence (BL) – Director Public Health<br>Ashley Ayre (AA) – Strategic Director People & Communities<br>John Davies (JD) – Chief Executive, Dorothy House<br>Morgan Daly (MD) – Healthwatch Representative<br><br>In addition a representative of the 3rd sector is being sought. The attached briefing note provides a summary of the issues discussed at the meeting held on the 18th September 2015. |
| **Recommendations** | The Health and Well-being Board is asked to note the briefing. |
| **Rationale for recommendations** | n/a |
| **Resource implications** | n/a |
| **Statutory considerations & basis for proposal** | n/a |
| **Consultation** | n/a |
| **Risk management** | n/a |

**SUMMARY REPORT - TRANSFORMATION GROUP UPDATE (18TH SEPTEMBER MEETING)**

## 1. EXECUTIVE SUMMARY

This report updates the Health & Wellbeing Board on the activity conducted by the Transformation Group at its last meeting on 18th September 2015.

## 2. BACKGROUND

The Transformation Group is a sub group of the Health and Wellbeing Board to provide a forum supporting the delivery and implementation of ***'****Seizing Opportunities',* BaNES CCG's 5 Year and shared system oversight of the Better Care Fund, and to support the development of future service models and enable active input into the Health and Wellbeing Board's strategic planning.

## 3. BUSINESS UNDERTAKEN AT MEETING HELD ON 18TH SEPTEMBER 2015

The Transformation Group met on 18th September 2015 and the group discussed the following agenda items:-

- Interoperability of Clinical Systems in BaNES Update
- Prevention & Self Care Update
- *Your care, your way :* CCG and Council's Consultation Document and Next Phase
- Provider Work on Frequent Admissions – Principle and Benefits of Approach

## 4. KEY DISCUSSIONS AND DECISIONS

### 4.1 Interoperability of Clinical Systems in BaNES Update

An update on progress of the Interoperability project was noted. It is anticipated that a draft business will be shared with the Interoperability Programme Board on the 17th November 2015. It was agreed that all partner organisations' Boards would approve the final business case for Interoperability of Clinical Systems by end of December 2015.

The Group also discussed the recently published NHSE guidance "Digital Roadmaps" which describes the key expectations from the Five Year Forward View of harnessing the information revolution as a key enabler to securing a sustainable NHS.

## 4.2 Prevention & Self Care Update

Dawn Clarke, Director of Nursing & Quality provided an update on the CCG's Prevention and Self Care work stream including work with 8 identified practices where inequalities are higher. A detailed mapping exercise will be carried out of preventative initiatives currently in place to identify the potential areas for focus across the whole local health and care system.

The potential to use CQUINS to support self-care into 2016/17 contracts was discussed and for all providers to work on a system wide approach to staff health and wellbeing.

## 4.3 Y*our care, Your way:* CCG and Council's Consultation Document and Next phase

The CCG's and Council's Consultation document and market engagement process were reviewed. Detailed discussion focussed around the market engagement in particular the key dates and methods of how this process will be undertaken. It also covered reflections and key messages from national meetings that have recently taken place in particular the focus around collaboration, how to get clinical input, and the new models of care emerging nationally in particular the Vanguard site in South Somerset.

## 4.4 Provider Work on Frequent Admissions – Principle and Benefits of Approach

James Scott provided an update on a piece of work initiated by the RUH to look at B&NES patients who had 5 or more admissions in one year. Providers were reviewing and triangulating their understanding of this patient cohort to understand what could be done differently. This project is on-going and key themes were still emerging.

## 5. FUTURE BUSINESS

The next meeting will take place on 6th November 2015 and include the following agenda items:

- Progress Report on MSK Programme
- Future Savings : Opportunities / Planning assumptions
- *your care, your way* Update
- Interoperability : 'Digital Map' Guidance / Business Case / Financial Implications

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Bath & North East Somerset Council

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NHS Bath and North East Somerset Clinical Commissioning Group

| MEETING | B&NES HEALTH AND WELLBEING BOARD |
|---|---|
| DATE | 28/10/2015 |
| TYPE | An open public item |

| Report summary table | |
|---|---|
| **Report title** | Primary Care and Co-Commissioning Update |
| **Report author** | James Childs-Evans, Senior Commissioning Manager, Primary Care, BaNES CCG |
| **List of attachments** | |
| **Background papers** | A list of any background papers relevant to this topic are as follows:-<br><br>GP Patient Survey July 2015 - https://gp-patient.co.uk/surveys-and-reports<br><br>CCG 5 Year Strategy - http://www.bathandnortheastsomersetccg.nhs.uk/documents/strategies/five-year-plan<br><br>Five year forward view - https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf<br><br>BMA GP Survey - http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/surveys/future-of-general-practice<br><br>Your Care Your Way Community Services Redesign - http://www.yourcareyourway.org/<br><br>PMS Review Framework - http://www.england.nhs.uk/wp-content/uploads/2014/09/pms-review-guidance-sept14.pdf |
| **Summary** | The report provides a contextual update to the issues facing Primary Care, and the strategic approach undertaken in BaNES to address them. |
| **Recommendations** | Health and Wellbeing Board members are asked to note both the national and local context for Primary care GP services in B&NES and are invited to consider any other issues that should inform the emerging primary care strategy in B&NES. |
| **Rationale for** | A sustainable model of primary care in B&NES is integral to the |

| | |
|---|---|
| **recommendations** | development of the CCG's 5 Year Strategy, the development of the emerging services models arising from Your Care, Your Way and key to the delivery of the broader Health and Well-being Strategy. |
| **Resource implications** | None. |
| **Statutory considerations and basis for proposal** | National guidance and policy direction as outlined above. |
| **Consultation** | Dr Ian Orpen, Chair, BaNES CCG<br>Tracey Cox, Chief Officer, BaNES CCG |
| **Risk management** | A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's and CCG's decision making risk management guidance. |

**PRIMARY CARE & CO-COMMISSIONING UPDATE**

**Background**

1.1 BaNES GPs serve a generally healthy and relatively wealthy population with patient experience often reported as above the national average.

Despite overall good clinical outcomes we continue to face the challenges of an ageing population, and have small geographical areas which are equivalent to some of the worst performing in England. By 2021 we will see a 27% increase in the number of patients aged 75-79 and a 38% increase in those aged over 90.

In addition, local authority housing development projections outline how the population will increase due to new housing developments. The data shows an approximate increase of 28,000 people based on around 13,000 dwellings to be built over the next 20 years. This equates to approximately 16 WTE GPs required based on NHS England calculations, assuming a GP led model for future delivery. Nearly half of the expected increase is likely to be built in the Bath city area. Local authority planning policy representatives and the CCG have presented to the BaNES GP forum, outlining the high level themes.

Further work is underway to maximise the linkages across public sector services and planning for infrastructure changes. The CCG is coordinating arrangements for a meeting between NHS England, NHS Property Services, Public Health and Local Authority Planning Policy representatives to discuss future infrastructure requirements in more detail.

Alongside this broadly positive position, primary care as with other areas of the health & social care system is responding to a variety of national challenges:

- Increasing pressure on NHS financial resources
- Persistent inequalities in access and quality of primary care
- Growing reports of workforce pressures including recruitment and retention problems
- Growing dissatisfaction with access to services

In response to these challenges, NHS England published the ‘Five Year Forward View’ during 2014. This sets out a clear commitment to strengthen primary care and general practice as the bedrock of a secure and sustainable NHS. The ‘Five Year Forward View’ noted that the foundation of NHS care would remain list-based primary care, and that a ‘new deal’ was needed for GPs to be part of new care models for the future.

**2. Developing Primary Care at Scale - Primary Care Preparing for the Future (PCPF)**

In October 2014 NHS England and the CCG invested into the development of a local project - ‘PCPF’, which seeks to respond to the challenges and themes outlined above. Bath and North East Somerset Emergency Medical Services (BEMS+) is a local not-for-profit organisation led by BaNES GPs, and commissioned to run PCPF on behalf of the CCG.

There are four workstreams of PCPF, which seek to support general practice by:

- Providing insight and support, to find new ways of working together
- Develop staff
- Develop infrastructure
- Provide benefits for patients 7 days a week (Focussed Weekend Working)

PCPF will run until October 2016.

## 3. Co-commissioning of primary care

Co-commissioning was an opportunity for CCGs to have increased responsibility and influence over local decisions affecting primary care (medical). Three commissioning options were originally offered to CCGs by NHS England in May 2014:

- Greater involvement for CCGs in primary care decision-making; NHS England retained responsibility for all commissioning decisions
- Joint arrangements where CCGs and NHS England assumed joint responsibility for an agreed set of functions potentially under a joint committee. Pooled funding arrangements could be considered, although not mandatory
- Delegated arrangements where CCGs assumed full responsibility for commissioning all the functions of general practice services, (excluding performers' lists, appraisal and revalidation)

In March 2015 the CCG membership voted in favour of constitutional changes to proceed with joint arrangements with NHS England, with the first joint public committee taking place in July 2015. Whilst this approach is developing and still relatively new, the main focus of co-commissioning during 2015/16 has been:

- The development of a primary care strategy, alongside the 'Your Care, Your Way' community services redesign
- Primary care funding, and in particular the 'PMS review' process

NHS England has invited CCGs to move delegated commissioning with a requirement to submit applications by 6 November 2015. This was considered by the CCG Board, with the decision not to progress to full delegation at this stage. This would be reviewed on completion of the PMS review process and further development on the primary care strategy.

## 4. Developing a Primary Care strategy in B&NES

Whilst BaNES CCG does not have a stand-alone primary care strategy, in common with many CCGs the strategic statements are incorporated within the main CCG strategy. These note:

- Vision: Delivery at scale
- Enablers: Sustainable model of Primary Care, Enhanced services delivered 7 days a week
- Approach: Cluster working / MDT model, out of hospital care

More detail on the development of these statements and implications for future primary care delivery are outlined in the attached presentation. At this stage the CCG recognise the ‘Your Care, Your Way’ consultation and planning for the future model of community services should inform the next stage of strategy development.

## 5. Quality

As noted above, practices perform well in terms of patient experience, as reported in the GP Patient Survey (GPPS). The latest data are based on the July 2015 survey results combining two waves of fieldwork, from July to September 2014 and January to March 2015. Generally the CCG performs above the national and Bath, Gloucestershire, Swindon and Wiltshire averages. More detail is provided in the accompanying presentation.

Much of the data around quality in primary care is held by NHS England, Care Quality Commission (CQC) or the General Medical Council. NHS England is developing standard quality reports to be shared with the CCG as part of the co-commissioning process.

NHS England use two main collections of indicators, the General Practice Outcome Standards (GPOS) and General Practice High Level Indicators (GPHLI) to provide a summary view on GP data. The CQC use its Intelligent Monitoring system to analyse data and support its inspection process. All use similar sources (QOF, GP Patient Survey, Prescribing data). BaNES CCG is not an outlier across the south region and specific areas of variation in the data have been shared with individual practices.

We are yet to have any practices inspected following registration with the CQC. The CQC inspect to consider whether services are safe, effective, caring, responsive or well-led.

## 6. National PMS Review of Contracts

The vast majority of GP practices in England hold either GMS or PMS contracts. The GMS contract is nationally negotiated. All BaNES practices hold PMS contracts, locally negotiated to better tackle particular needs of patients based on local priorities. The PMS review aims to ensure any extra funding above and beyond what an equivalent GMS practice would get is clearly linked to providing extra services.

The NHS England review has identified a total PMS premium of approximately £1m paid to practices in B&NES. During the course of 2015 practices have had the opportunity to:

- Meet with NHS England, the Local Medical Committee and CCG to review their element of the premium

- Describe where it is serving special populations that merit continued additional funding over and above core, additional, enhanced and any current locally commissioned services.

From April 2016 implementation of phased reinvestment will begin, ending in 2020/21.

Further detail on progress in the areas highlighted will be provided in the accompanying presentation for Health & Wellbeing Board.

## 7. Recommendations

Health and Wellbeing Board members are asked to note both the national and local context for Primary Care GP services in B&NES and are invited to consider any other issues that should inform the emerging primary care strategy in B&NES.

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Bath & North East Somerset Council

healthwatch Bath and North East Somerset

NHS Bath and North East Somerset Clinical Commissioning Group

| MEETING | B&NES HEALTH AND WELLBEING BOARD |
|---|---|
| DATE | 28/10/2015 |
| TYPE | An open public item |

| Report summary table | |
|---|---|
| **Report title** | B&NES Children and Young People CAMHS Transformation Plan |
| **Report author** | Mary Kearney-Knowles, Senior Commissioning Manager, Specialist Services; 01225 394412<br><br>Margaret Fairbairn, Project Manager, Children's Health Commissioning, 01225 394170 |
| **List of attachments** | • Appendix 1 Children and Young People's CAMHS Transformation Plan<br>• Annex 1 Local Transformation Plan for Children and Young People (summary) |
| **Background papers** | Future in Mind https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413393/Childrens_Mental_Health.pdf |
| **Summary** | In 2015, NHS England announced that an additional 1.5 billion would be made available through 2020 to improve support for the emotional health and wellbeing of children and young people; and to specifically respond to the recommendations contained in the Futures in Mind Report, published March 2015.<br><br>Guidance on how the spending could be drawn down was published in August 2015. The guidance indicated that local areas were required to submit an initial draft Children and Young People CAMHS Transformation Plan by September 16th 2015 (completed) and a final Children and Young people CAMHS Transformation Plan by October 16th 2015 (completed). The final transformation Plan was signed-off by Dr Ian Orpen, Co-chair, B&NES Health & Wellbeing Board and Vic Pritchard Co-chair, B&NES Health & Wellbeing Board; on behalf of the Health & Wellbeing Board.<br><br>The B&NES Transformation Plan has been led by the Children and Young People's Emotional Health & Wellbeing Strategy Group, a multi-agency group supported by CCG / LA commissioners and a sub-group of the B&NES Be Health Outcomes Group that leads on the Children and Young People's Plan (CYPP) 2014-2017. This group reports to the Children's Trust Board. |

| | |
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| | NHS England has advised that the CCG will be notified on November 1st 2015 if the plan has been approved, and authorise drawn down of the money to be spent in the current financial year, as indicated in the plan.<br><br>NHS England has advised that local areas will have greater flexibility about the use of the funds in the following years. |
| **Recommendations** | The Board is asked to:<br><br>1. Note the range of multi-agency partners, including schools and colleges, supporting emotional health and wellbeing in B&NES.<br>2. Note the final Children and Young People's CAMHS Transformation Plan.<br>3. Consider and endorse the Final Children and Young People CAMHS Transformation Plan.<br>4. Support the continued commitment to and funding of current "spend" on emotional health and wellbeing for Children and Young People in B&NES.<br>5. Receive a progress report on the implementation of the Plan in 6 months, April 2016. |
| **Rationale for recommendations** | The Children and Young People's Plan 2014-17 (CYPP) sets out the strategic priorities for Children and Young People: http://www.bathnes.gov.uk/services/children-young-people-and-families/strategies-policies-planning/childrens-trust.<br><br>Emotional Health and Wellbeing is a key priority in the CYPP 2014-17 as indicated above. The CYPP has been closely aligned with the Health and Wellbeing Strategy, and this was further enhanced in the updated Health and Wellbeing Strategy 2015, specifically with reference to; Theme 2: Improving the quality of people's lives; Priority 6: Promoting mental wellbeing and supporting recovery, "Promoting children's emotional health". Page 18. |
| **Resource implications** | The proposed Children and Young People's CAMHS Transformation Plan will be delivered within the current budget spend on children and young people's emotional health and wellbeing – Local Authority, CCG, Schools, Voluntary Service - and the "new / additional" NHS monies to be drawn down once the plan is approved on November 1st 2015.<br><br>The Plan cannot be delivered without the continued commitment, partnership working, current spend and new funding. |
| **Statutory considerations and basis for proposal** | This plan is a requirement as set out by NHS England. |
| **Consultation** | All partners included in the Emotional Health and Wellbeing Strategy Group, have been included in the development of the plan. Findings from all engagements / consultations with Children and Young people have been incorporated into the plan [SHUE, Primary and Youth Parliaments, Equalities Conference, Youth |

| | |
|---|---|
| | Forum, Member of Youth Parliament, CAMHS]. It has not been possible to establish a separate consultation with service users due to short period of time available to complete the plan. Service users will be engaged in implementing the plan. |
| **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. |

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Bath & North East Somerset Council

NHS
Bath and North East Somerset
Clinical Commissioning Group

# Children & Young People's
# CAMHS Transformation Plan
**Version 2 16/10/15**

The purpose of the Transformation Plan is to help improve the emotional wellbeing and mental health of children and young people (aged < 18) living in Bath & North East Somerset (B&NES). This plan evidences the strong partnership approach and commitment to emotional health and wellbeing; that is well established in B&NES. It aims to further transform local provision with greater co-production with schools, colleges and service users; with the intended outcome of B&NES "families" having improved resilience and positive emotional wellbeing. The Plan co-ordinates the planning and commissioning of services to ensure that resources in all partner agencies are used in the most effective way to improve children and young people's emotional health.

## 1. National Context

DoH evidence[1] confirmed that

- The cost of mental health problems to the economy in England has recently been estimated at £105bn, with treatment costs expecting to double in the next 20 years.
- 50% of lifetime diagnosed cases of mental illness start by the age of 14
- Poor mental health in childhood is associated with poor childhood <u>and</u> poor adult outcomes.
- 10% of children at any one time have mental health problems

The 2010 national public health strategy[2] gave equal weight to both mental and physical health and focused on tackling the underlying causes of mental ill-health. The strategy noted;

- 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.
- 25-50% of mental health problems are preventable through interventions in the early years.

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[1] *Healthy Lives, Healthy People (Nov 2010) and No Health Without Mental Health (Feb 2011)*
[2] *Healthy Lives, Healthy People (Nov 2010),*

National strategy expects early intervention and preventative services to be provided by partnership working between the NHS, local government and the third sector.

A number of documents have been published since 2011 which illustrate the government's commitment to improve mental health for all age groups.

The most recent and important one for children and young people, published in 2015 is: *Future in Mind*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Others relevant documents are listed in Appendix 1:

## 2. Links with Children and Young People's Plan (CYPP)

a) The CYPP 2014-2017 - the commissioning and delivery plan to improve the general health and wellbeing of children and young people across B&NES - outlines the Children's Trust Board's vision and priorities for the period 2014-17.

The vision is:

*'We want all children and young people to enjoy childhood and to be well prepared for adult life.'*

The CYPP's 3 key outcomes are:

Children and Young People are Safe
Children and Young People are Healthy
Children and Young People have Equal Life Chances

The vision for good mental health for children and young people is**:**

*'All children and young people, from birth to their eighteenth birthday, are supported to develop and maintain good mental health, a sense of well-being and emotional resilience. Any children and young people with emotional difficulties and mental health disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.'*

Bath & North East Somerset commissioners aim to commission and develop services which:

- Help children & young people learn the skills they need to stay emotionally healthy
- Ensure the delivery of a comprehensive range of services to tackle mental health problems before they become entrenched

- Work with adult mental health services to minimise the impact of parental mental ill-health on children and young people
- Identify children & young people who need extra support and provide it as early as possible for as long as it is needed
- Meet children & young people in the most accessible place possible
- Periodically review services to ensure resources are being used in the best possible way

b) The following commissioning principles are promoted:

**Multi-agency working**: a key principle of the strategy is that mental health is the 'business' of all agencies, and a joint approach is required to improve children & young people's mental health. There is a commitment to an integrated care pathway for children & young people with emotional and behavioural difficulties which addresses how universal, targeted and specialist services work together to best meet the needs of children, young people and their families. Children & young people may have a 'lead professional' to help coordinate services.

**Early Intervention:** There is a focus on early intervention; in terms of early in the life cycle, early identification of difficulties and early intervention. Hence multi-agency services that promote the mental health of all children & young people (including building resilience) and provide early identification and preventative interventions are commissioned alongside services to meet the needs of children & young people with established or complex problems. Interventions are best provided 'nearest' the child or young person i.e. provided by practitioners with the 'lowest level of specialism' (but nevertheless with the necessary skills and competencies).

**Evidence-based practice**: Services should provide mental health care which is based upon the best available evidence, including relevant NICE guidelines.

**Addressing inequalities**: Services must be provided to children & young people regardless of their ethnicity, gender, sexual orientation and/or religion. All services should pro-actively consider the specific needs of children and young people

- from black and minority ethnic groups (including migrant families),
- with physical and learning disabilities
- who are - or are at risk of becoming - young offenders
- who are - or are at risk of entering - the care system
- who are lesbian, gay, bisexual, transgender or questioning their sexuality
- who are being bullied or discriminated against for other reasons e.g the way they look or their economic circumstances

**Service User involvement:** All services should have a commitment to increasing the participation of service users, parents and carers in the planning and evaluation of services to ensure that services are designed around the needs of children, young people and their carers as opposed to the needs of individual agencies.

**Clear service expectations and outcomes**: Services will be commissioned against clear expectations, outputs & outcomes, detailed in service specifications and monitored to ensure compliance and quality.

c) Links with other strategic work;

- There are links to the Suicide Prevention Strategy Group and the Self-Harm Steering Group via the Mental Health representative from Public Health. Some actions from the Suicide Prevention Strategy Action Plan form part of the Action Plan for the EHWB Strategy.
  The current Suicide Prevention Strategic Plan and Action Plan can be viewed here: http://www.bathnes.gov.uk/services/public-health/guide-programmes-strategies-and-policies/suicide-prevention-strategy-2012

- Perinatal Mental Health.
  B&NES is working towards creating a perinatal mental health strategy. The working group consists of commissioners and providers from maternity, adult mental health, children and adolescent mental health and health visiting and primary care services.

## 3. Promoting and protecting good Mental Health

The Mental Health Foundation[3] believes that good mental health is characterised by a child's ability to fulfil a number of key functions and activities, including:

- The ability to learn
- The ability to feel, express and manage a range of positive and negative emotions
- The ability to form and maintain good relationships with others
- The ability to cope with and manage change and uncertainty

There are a number of 'protective' and 'risk' factors known to be associated with good emotional health. These are reproduced in Appendix 2.

## 4. Prevalence of emotional and mental ill-health in Bath and North East Somerset

[3] **http://www.mentalhealth.org.uk/**

Symptoms of poor emotional health may differ according to a child's personality, personal history, community and environmental factors. Symptoms include behavioural problems, substance misuse, self-harm, suicide attempts, eating disorders, depression, anxiety, obsessions and episodes of psychosis.

## Local Profile of CYP

- 2013 population estimates for the 0-17 population living in households in B&NES was 34,214. This is 19% of the total population. ONS mid-year population estimates)
- Planned housing: The Core Strategy 2014 cites an increase in housing of 13,000 with the main areas for development being: Bath (7,020); Keynsham (2,150) and Somer Valley (2,470).
- 6,273 (25%) are lone parent households. Lone parents with dependent children rose by 17% between the 2001 and 2011 census.
- 2013 school census data suggests that B&NES school population (4-18 years) is 21,408 in total (January 2013), of which 10.72% classify themselves as BME (i.e. non-white British). In 2015 the population of BME under 5's was 14.6% (1,307) with the highest density in Central Bath (Parkside Children's Centre area – at 24.5%, or 255 children; Moorlands CC area 21%; Weston 19% and St. Martin's 18.7%).
- The growing under 5 y/o BME population is further evidenced by looking at the % of new-born BME children born in the last year. This was 20.2% compared with 13.6% of current 4 year olds.
- The 2011 Census showed the population of Bath & North East Somerset to be 90% White British and 10% other ethnicities.
- In 2014, 1.70% of primary school children and 1.30% of secondary school children and young people had statements of special educational needs compare with the national English average of 2.8%. (DfE National Statistics: Special Educational Needs in England: January 2015).
- • 2013-14, only 19.6% of SEND children attained 5+A*-C grades at GCSE compared to 69.2% of 'non SEND' children in B&NES. This gap is wider than the national England gap of 43.9%.
- According to the 2011 Census:
    - 1.09% of children aged 15 and under in B&NES were providing some (1+ hours) unpaid care per week, similar to the South West (1.21%) and England (1.11%).
    - 3.0% of young people aged 16-24 in B&NES were providing some (1+ hours) unpaid care per week, significantly lower than the South West (4.2%) and England (4.8%).
    - 0.21% of children aged 15 and under in B&NES were providing considerable (20+ hours) unpaid care per week, the same as the South West and England.
    - 0.6% of young people aged 16-24 in B&NES were providing considerable (20+ hours) unpaid care per week, significantly lower than the South West (4.2%) and England (1.0%).

- In addition, in the 2015 SHEU survey of school pupils (see later), 186 pupils (6% of respondents) said they cared for family members after school on the day before the survey, suggesting caring roles may be unreported in the Census.
- The JSNA in Bath and North East Somerset is a "live" document that is updated on ongoing bases, as new data/feedback becomes available.

**Local intelligence regarding emotional health and wellbeing**

Intelligence on the emotional health and wellbeing of children and young people B&NES, alongside mental health problems, comes from a number of sources. The following data is predominately drawn from Bath and North East Somerset's Joint Strategic Needs Assessment, Public Health England ( 2014) CYP MH profile, National Child and Maternal Health Intelligence Network, CAMHS Needs Assessment Tool and the Authority's Schools Health Related Behaviour Survey.

**a. Self reported difficulties**

B&NES Public Health, commission The Schools Health Education Unit (SHEU) to complete a Health Related Behaviour Survey in both primary and secondary schools on a biennial basis. The surveys have been developed by health and education professionals, and cover a wide range of topics. The SHEU Surveys in B&NES in 2015, 2013 and 2011 asked school children in B&NES a number of questions linked to their wellbeing in terms of satisfaction with life, the extent to which they worry about things and their self-esteem.

Data from this survey can inform planning and discussion on the basis that a large number of B&NES' pupils complete it. At time of writing only secondary school data for 2015 is available with year 8 (1,648) and 10 students (1,487) having participated. It should be noted, however, that those completing the survey do not represent a random sample of young people in the authority and excludes those attending non-participating schools (2 out of 14 secondary schools), young people absent on the day due to illness or exclusion, those with limited access to computers, those attending schools elsewhere and those who opted out. Primary school data will be analysed, summarised and reported by December 2015. Each school has additional access to its 'own' data and, in conjunction with public health colleagues, can think about addressing specific issues pertinent to their individual school e.g. revising PHSE programmes.

The survey asks a number of questions relating to emotional health and wellbeing. When it is stated that something is significantly higher/lower it means that the difference is statistically significant

Satisfaction with life
When rating how satisfied they felt with their life using a scale of 1 to 10, of the pupils surveyed, a significantly higher proportion of girls (19%) rated their satisfaction as low (0-4) compared to boys (8%). A significant proportion of those who were eligible for a free school meal in the last six years also scored their satisfaction lower compared to those non-free school meal pupils (13%)

Bullying
A quarter of young people surveyed said they felt afraid to go to school sometimes because of bullying. This was significantly higher for girls (33%) than boys (16%) and significantly higher for pupils who had been eligible for free school meals in the last six years (32%), compared to those who hadn't (24%). Appearance, size and weight were the main reasons pupils cited for having been picked on or bullied.

Self-esteem
The survey generated self-esteem scores based on the pupils' responses to a set of ten statements taken from a standard self-esteem enquiry method. The scale is based on social confidence and relationships with friends. The scores range from 0-18. A significantly higher proportion of girls (28%) had a med-low self-esteem score (9 or less) compared to boys (15%). The proportion of pupils that stated that they had been eligible for free school meal in last six years that had a med-low self-esteem score was significantly higher (29%) than non-free school meals pupils (20%).

Worries
The survey asked pupils how much they worried about a range of issues. A significantly higher proportion of girls (64%) said they worried a lot about at least one of the issues than boys (48%). The issues girls most worried about were: exams and tests (70%), the way they look (57%), family (49%) and career (48%). Boys also worried about these issues, though to a lesser extent, with over half worrying about exams and over 40% family and career.

Coping with low self-esteem and worries
When surveyed pupils were asked what they were likely to do when they had a problem that worried them. Over two third of boys (66%) and nearly two thirds of girls (58%) said that they would talk to an adult. Over two thirds (65%) of girls and nearly a half (48%) of boys said they would talk to a friend. A significant of proportion of girls (37%) and boys (26%) however said that they would keep worries to themselves. 20% of girls and 12% of boys said they eat when they are worried and 15% of girls and 12% of boys turn to the internet or social media. 10% of girls and 3% of boys said they self-harm.

94% of boys and 88% of girls said that they have at least one adult they can trust.

### b. Seeking support at school

In 2014/15, School Nurses (including 2 FE College nurses) in B&NES had 1869 contacts with young people which related to emotional or mental health.

In quarter one of 2015/16, the majority of School Nurse face-to-face contact time was spent supporting children and young people with their mental health, predominantly with anxiety but also a significant proportion with issues around self-harm. The data recording is currently limited to just the number of contacts, so it is not possible to indicate how many children and young people this equates to.

The school nursing service allocates its capacity by reference to a matrix which reflects local inequalities e.g. free school meals, indices of income deprivation etc. Access to the service is also monitored by pupils home postcode place in Index of Multiple deprivation. A pilot school nurse health review of vulnerable Year 9 pupils is being undertaken in two secondary schools.

Reports from the recent 2015 School Parliaments also highlighted pupils' attitudes to the importance of mental health

Final Young Parliament Me Myself

Final Primary Parliament Me Myself

### c. Estimating prevalence of mental ill health

The prevalence of mental health problems in children and adolescents (aged 5 – 16 years) was last surveyed over 10 years ago in 2004. This study (Green et al [1].) estimated that at any one time, almost 1 in 10 children aged 5-16 years old had a clinically diagnosable mental disorder, causing distress to the child or having a considerable impact on their daily life. More recently Public Health England (2014) estimated that 8.4% of children and young people aged between 5 – 16 years in B&NES have a mental health disorder. This is similar to estimates for England (9.6%) as a whole and the South West (8.9%). Boys are more likely (11.4%) to experience mental health problems than girls (7.8%). Based on the same rates, the table below shows the **estimated** prevalence (note the true figure could vary from this) of mental health disorders by age group, gender and condition for B&NES' population aged 5 – 16 years (2014).

***Table 1****: Estimated prevalence of mental health disorders by age group, gender and condition (2014). Total population 5-16 years of age (inclusive) = 22,853*

| NUMBERS | 5 to 10 | | | 11 to 16 | | |
|---|---|---|---|---|---|---|
| | Male | Female | All | Male | Female | All |
| All disorders | 510 | 250 | 760 | 665 | 500 | 1160 |
| Conduct disorder | 355 | 135 | 490 | 404 | 235 | 640 |
| Emotional disorder | 105 | 125 | 230 | 225 | 305 | 525 |
| Hyperkinetic disorder | 140 | 150 | | 125 | 30 | 150 |

| Less common e.g. ASD, eating disorders | 110 | 40 | 145 | 95 | 45 | 135 |
|---|---|---|---|---|---|---|

*Source: Local authority mid-year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014).*

Public Health England also estimated the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 based on rates provided by Kurtz (1996 [3]). The following table shows these estimates for the population aged 17 and under in B&NES, 2014. It is important to note that these estimates do not make any adjustment for local characteristics which may impact on need for services.

***Table 2:*** *Estimated number of children / young people who may experience mental health problems appropriate to a response from CAMHS per year in B&NES.*

| CAMHS Tier | Tier 1 (2014) | Tier 2 (2014) | Tier 3 (2014 | Tier 4 (2014) |
|---|---|---|---|---|
| BANES | 5,165 | 2,410 | 640 | 30 |

*Source: Office for National Statistics mid-year population estimates for 2014. CCG population estimates aggregated from GP registered populations (Oct 2014).*
*Kurtz, Z. (1996).*

### d. Local specialist child and adolescent service (CAMHS)

Specialist CAMHS services in B&NES have been provided by Oxford Health NHS Foundation Trust (OHFT) since 2010. Additional services (PCAMHS), delivering lower level interventions, were commissioned from the same Trust in 2011. The funding, and hence the caseloads, for both services have remained fairly static since then. Approximately 550 children and young people are receiving P/CAMHS services at any one time. During 2014/15 there were 1239 discharges from P/CAMHS.

An approximate breakdown by referral agency is given below:

| | |
|---|---|
| GPs | 50% |
| Community Paediatricians | 20% |
| School Nurses/Schools | 15% |
| Social Care | 7% |
| Other | 8% |

There is a single point of access to primary and specialist CAMHS. In 2014/15 the percentage of referrals not accepted by the CAMHS averaged 17%, although this ranged from 6% - 30% in different months.

During 14/15 the percentage of referrals assessed within 4 weeks was 95% for referrals to the Outreach service (which include urgent cases), 72% for more routine CAMHS referrals and 73% for PCAMHS. There is an ambition for 90% of accepted routine referrals to be assessed within 4 weeks.

The primary CAMHS service is currently commissioned by NHS B&NES CCG and costs £245,712 per year.  The specialist CAMHS service, commissioned by NHS B&NES CCG for £1,924,680, includes a £392,000 contribution from the local authority.  OHFT employs 24 (16.7 WTE) practitioners in specialist CAMHS, and a further 18 (16.1 WTE) in PCAMHS and the Outreach team.

The OHFT CAMHS service forms part of the Oxford and Reading CYP IAPT collaboration which formed in 2012. The Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) is a service transformation programme delivered by NHS England that aims to improve existing CAMHS working in the community.
More detail is available here:

CYP IAPT Key Facts Document Sept 14 (1

Part of the CYP IAPT programme is training for CAMHS practitioners.  To date, in B&NES the following numbers of staff have been trained:

| | |
|---|---|
| Year 1, 2012/13 | 5 therapists trained in CBT, 1 in parenting. |
| Year 2, 2013/14 | 4 therapists trained in CBT, 1 in parenting. |
| Year 3, 2014/15 | 4 therapists trained in SFP, 1 in IPT-A. |

A key part of IAPT has been the introduction of goal based measures to all patients in CAMHS and to introduce session by session Reported Outcomes Measures by all clinicians.

**Eating Disorders**

At least 1.1 million people in the UK are affected by an Eating Disorder (ED), with young people in the age-group 14-25 being most at risk of developing this type of illness. Based on the 2007 Adult Psychiatric Morbidity Survey and the BANES 16-24 resident population, it is estimated that in 2013 there were 3,879 young people aged 16-24 in the authority area with an eating disorder. Highest prevalence is in 16-24 year old girls.

The number of admissions for eating disorders in B&NES has increased although this may be due to changes in diagnosis rather than an actual increase in prevalence.

The local specialist ED service, provided by OHFT, meets latest NICE Guidance

ed nice audit.docx

But there are new access and waiting times which must be implemented:

cyp-eating-disorders
-access-waiting-time-

And the CAMHS provider, OHFT has developed a new specialist eating disorder service to meet these standards which will be part funded by new Transformation Plan funding:

SWB CAMHS ED
proposal final 02.09.

### e. Inpatient (Tier 4) care

During 2014-15 there were 8 admissions to CAMHS beds for B&NES CYP, 5 of these to the 'local' beds at Marlborough House, 3 to more specialist provision out of area. The average length of stay as an inpatient was 164 days, although the median stay was x days, reflecting the complex needs of a very small number of CYP.

Between 2009 and 2012 OHFT were jointly commissioned by Wiltshire CCG and B&NES CCG to provide generic CAMHS beds and specialist community CAMHS (Tier 3). Since 2012 NHS England specialists have commissioned all CAMHS inpatient beds on behalf of CCGs.

The community Outreach Service for Children and Adolescents (OSCA) works particularly closely with inpatient facilities at Marlborough House, Swindon and Highfield Unit, Oxford to ensure that admissions are appropriate and timely, and that CYP are discharged as soon as they can be supported in their own homes.

The new Transformation Plan investment in specialist Eating Disorder Services may reduce both the need for some inpatient admissions associated with EDs and the length of stay required for those who are admitted. In addition, by 'in reaching' into acute hospitals the ED Service should also be able to reduce the length of stay in acute hospitals to those CYP with EDs who present with advanced physical deterioration.

In the near future there may be a national re-procurement of CAMHS beds, and local CCG commissioners are committed to working closely with NHS England to ensure that appropriate provision is secured for CYP from B&NES. The SW Strategic Clinical Network (SWSCN) facilitates discussions between NHS England, CCG commissioners and local CAMHS providers, and local children's health commissioners attend regularly and contribute to SWSCN's work.

In addition, there is a joint NHS England and CCG Co-Commissioning group which meets monthly. CAMHS is one of the top 5 key priorities on the co-commissioning agenda

**f. Liaison and Diversion Services, also known as Court Assessment and Referral Service (CARS)**

CYP from B&NES have been in receipt of the nationally specified and commissioned all-age Liaison and Diversion (L&D) services. L&D practitioners are based at the local custody suite (Keynsham) and aim to improve early identification of a range of vulnerabilities, (including but not limited to mental health, substance misuse, personality disorder and learning disabilities), in people coming into contact with the youth or criminal justice systems. Further to identification and assessment, individuals can be referred to appropriate treatment services so contributing to an improvement in health and social care outcomes, which may in turn positively impact on offending and re-offending rates. At the same time, the information gained from the intervention can improve fairness of the justice process to the individual, improve the efficiency of the criminal justice system, and ensure that charging, prosecuting and disposal decisions are fully informed. If offenders receive non custodial sentences then this may be on condition that they agree to engage with relevant support services. The L&D service may offer support to their first appointment and the capturing of outcomes.

Due to the possibility of some young offenders already 'being known' to CAMHS, the local CAMHS provider, OHFT has created a Memorandum of Understanding with AWP, to local L&D service. This clarifies working arrangements when the L&D service has concerns about a young person in custody or at the court or when CAMHS are contacted about someone who they think would benefit from an L&D assessment.

MOU Oxford Health CAMHS -final.docx

In September 2015 a review of the Memorandum of Understanding concluded that arrangements were working well.

**g. Crisis Concordat**

The Crisis Concordat review and action plan is a joint plan between statutory public, community and third sector organisations in B&NES. The B&NES Mental Health Crisis Care Concordat sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

The Concordat focuses on four main areas: Access to support before crisis point, urgent and emergency access to crisis care , quality of treatment and care when in crisis, recovery and staying well.

Oversight of the B&NES plan is via a Crisis Concordat Task Group with all agencies represented by senior local staff (this includes children's and adults mental health commissioners, substance misuse commissioner, police, acute trust, CAMHS, AWP, community services, ambulance service). The plan includes consideration for children and young people in mental health crisis and was commended for its strong partnership approach.

The latest copy of the review and action plan is here

BNES MH Crisis Concordat Review an

The CAMHS service forms part of the Crisis Concordat within B&NES. Regarding urgent and emergency access to crisis care, all young people up to the age of 18 who present at the local acute hospital (Royal United Hospital Bath) following an act of deliberate self-harm and who are admitted to either the Paediatric ward or the Observation Ward are assessed the following day by a clinician from the CAMHS Team. A full assessment of their mental health needs and mental state is undertaken and follow up assessment / intervention offered as appropriate to their needs.

There is a national determination to ensure that no young person is inappropriately detained in police cells by ensuring that there is sufficient provision of Place of Safety facilities for young people to be assessed under Section 136 of the Mental Health Act. Children and young people who are detained by the police under the Mental Health Act, are currently taken to a Place of Safety at Southmead Hospital in Bristol.  To reduce the risk of children and young people being taken the Southmead unnecessarily, the Police Service and the CAMHS service have recently implemented a protocol in which the police consult the local CAMHS service before deciding to transport the CYP to Southmead.

S136 MoU tween OHFT and police.pdf

## 5. Commissioning

B&NES CCG and LA have had integrated commissioning for a number of years, across a number of children and young people services. This has been further enhanced with Public Health becoming part to the Local Authority commissioning arrangements in 2014.  More recently, the LA/CCG are working with other partners , including schools to maximize the use of resources, and a number the more recent pilots identified in Table 4 are being co-produced with schools.

Responsibility for commissioning local EHWB services lies with a number of agencies; CCG, Early Years (LA), Youth Service (LA), Schools and Colleges (LA and academies), Specialist Commissioning (National Commissioning Board), Public Health (LA) and Voluntary Sector funding. A model of comprehensive service provision is reproduced in Appendix 3.

**Table 4: Services currently (October 15) commissioned to support the Emotional Health of Children and Young People**

EHWB support commissions Sept15.›

Previously there have been 7 EHWB strategic action plans for Bath and North East Somerset, the latest one dated 2014-2017. Significant progress has been made in the priorities identified within the previous strategies.

a. **During the current year 2015/16, the following developments have been prioritised:**

1. The consideration and development of a single point of access or ‘single front door’ to enable practitioners, parents/carers and CYP to contact and thereafter receive, at the earliest opportunity, the most appropriate help.
2. To improve school/college/CAMHS liaison by introducing ‘Resilience Hubs’ at each school and college. These Hubs will provide opportunities for monthly face-to-face meetings where CAMHS link workers, selected school/college staff, school/college nurses and independent counsellors can meet for consultation, training and mutual support.
3. To increase the level of therapeutic support offered to statutory social workers and parents/carers who are struggling to prevent the breakdown of fostering and adoptive placements. This will take the form of a CAMHS psychologist being seconded to the LA placements team. This additional service is being introduced as an attempt to readdress the inequality of Looked after Children who frequently suffer a higher incidence of mental ill-health.
4. To further increase the skills of a number of practitioners who work directly with families and schools whose younger children/pupils display behaviours which present barriers to learning
5. To improve the digital guidance for national and local EHWB services. This will include the published Transformation Plan, suggestions for CYP self-care, guidance for referrers etc. all presented in an informative and accessible manner.
6. To pilot a children and young people’s on-line counselling service.
7. Ensure that transitions to adults services for all CYP, including those with EHCP plans, are well managed.

b. **Since April 2015 a number of developments to support the transformation plan have begun:**

1. *Pilot - Extended CAMHS support: for > 18 y/o's* who were receiving CAMHS interventions when they turned 18 and, although they are particularly vulnerable, do not meet the referral criteria for adult mental health services. This cohort will include, but is not restricted to, Care Leavers and will provide intensive emotional support.
2. *Pilot - Early Intervention in Psychosis:* Pilot to improve fidelity to the early intervention in psychosis model by building links with CYP substance misuse, developmental disorder, CAMHS, schools and other services.
3. *Pilot - School Based Counselling:* Independent counsellors have been commissioned to provide individual 'drop in' advice sessions and formal counselling sessions at seven secondary schools from September.
4. *Pilot - Resilience Hubs: (*See above) These complement school based counselling and have also started in the new academic year.
5. *Pilot - Mindfulness Pilot:* 32 members of staff from *2* secondary schools have undertaken an 8 week Mindfulness course. 2 staff from each school will now be trained to deliver Mindfulness in Schools sessions/resources directly to young people.
6. *KS4 resource packs:* Mental Health PSHE Resource packs for Key stages 3&4 are being developed in partnership between School Improvement and the CAMHS participation group.
7. *Specialist Family Support and Play re-procurement:* A review has resulted in a new combined service model being procured to provide early intervention with 5-13 years olds with a range of emotional and social issues.
8. *Protocol between CAMHS and police:* has been implemented to reduce inappropriate attendances at the S136 suite.
9. *Pilot - CAMHS self-referral for 16 and 17 y/o's:* is being trialled by provider
10. *ASD support service:* Additional SLT sessions have been commissioned to 'speed' up ASD diagnosis and a new parent support worker will visit families whose children with ASD refuse to attend school.
11. *Eating Disorder Specialist service:* Agreeing new service model with provider and neighbouring CCGs

Some of these developments are included in the tracker spreadsheet.
*NOTE The strategic group are still currently working at conceptualising and describing services and pathways using the outcomes suggested by the Liverpool model (as opposed to Tiers), i.e.*

- *Improved environments so that C&YP can thrive*
- *Increased identification of C&YP with early indicators of distress and risks*

- *Reduction in mild to moderate distress*
- *Reduction in the development of moderate to severe distress*
- *Reduction in life long distress*

## 6. Children and Young People participation

In B&NES, children and young people's views are used effectively and consistently to influence change, shape services, improve practice and service delivery and have so for a number of years. Children and young people contribute through models of co-production as set out in the Service User Engagement Framework (Commissioning Framework), Children In Care Councils, democratic processes, strategic development, the Children and Young People's Plan, the Early Help Strategy and through the groups that have been set up to hear the voices of seldom heard minorities.

The framework which provides guidance to help involve children and young people in the commissioning of services is currently being re-drafted. The greatest challenge is to engage young people who are not existing or potential users of a new commission.

CYP Commiss Framework 2015.doc

The local 2014-2017 Participation Strategy sets out the locally agreed definition of participation and identifies the benefits of participation not only to children and young people but also to the adults who work with them, the organisation and services that are provided, and society as a whole. LINK

OHFT CAMHS service, having been the lead provider in the regional CYIAPT collaborative for the last 3 years, has developed effective CYP participation in line with the principles outlined in *Delivering With, Delivering Well* (reproduced in Appendix 4). The CAMHS participation group is usually consulted about pilot developments and is particularly key in suggesting and approving written and digital resources.

A very recent consultation by the local Youth Forum suggests that CYP

- do not always comprehend the range of services available,
- still perceive a stigma around mental health problems and
- would prefer to be informed of self care and further information in a variety of ways.

Further consultation is planned to determine the most appropriate website to host the Transformation Plan and to signpost useful digital resources.

## 7. Transformational Funding

B&NES is served by all elements of the model outlined in Appendix 3. Children’s services are detailed above (Table 4) and are provided by a range of organisations including the LA, Sirona Care and Health, Oxford Health NHS Foundation Trust and smaller voluntary organisations.

Some of the proposals for driving improvement within the Transformation Plan will be cost-neutral, requiring a different way of helping C&YP within existing resources. However, the Government has committed additional monies to local areas based on the standard CCG allocation formula. For B&NES this is £333,463 per year. £95,191 has already been received by the CCG and this must be spent on improving the C&YP Eating Disorders Service. Pending approval of the Transformation Plan, the CCG will receive another £238,272 for 15/16 and thereafter £333,462 per year.

The proposed distribution for 15/16 funding is as follows:

| | | |
|---|---|---|
| 1 | Eating Disorder (includes training) | 95,191 |
| 2 | Therapeutic support for social care (6 months) | 32,500 |
| 3 | development of digital resources incl TP publishing, incl map of medicine | 10,000 |
| 4 | workforce capacity building (Theraplay,Thrive, Attachment Aware etc) | 55,000 |
| 5 | college resilience hubs (includes staff training) | 5,000 |
| 6 | school resilience hubs (includes staff training) | 41,000 |
| 7 | online counselling | 16,000 |
| 8 | school counsellors attending school Hubs | 10,500 |
| 9 | nuture outreach service in primary schools | 40,000 |
| 10 | commissioning capacity (7 months) | 6,021 |
| 11 | CYP/parent/carer consultation/coproduction/ | 5,000 |
| 12 | stakeholder event -launch of resources and co-production of 16/17 plans | 2,250 |
| 13 | support for parents of 'non-engaging' children (scoping) | 5,000 |
| 14 | independent evaluation and consideration of 'single point of access' | 10,000 |
| | | 333,462 |

Funding (once agreed) to implement the plan will be monitored via the national Transformation Plan tracker excel spreadsheet.

## 8. Governance

- The EHWB Strategy Group acts as a sub-group for the Children’s Trust Board and are required to produce 6 monthly reports to the Children’s

Trust Board, LSCB and Health and Wellbeing Board as well as an annual review of performance.

- Formal monitoring of the Transformation Plan will be via a subgroup of the EHWB Strategy Group. Although this group does not include a CYP representative, the CYP Equalities Group will also receive the same 6 monthly report for scrutiny and comment. (This group includes representatives from the various children and young people participation groups and school equalities teams across B&NES including CAMHS service users, Children in Care, Youth Forum and the Member of Youth Parliament)
- There are strong links to the Local Safeguarding Children's Board (LSCB) with the EHWB group's social care representative also being a member of the LSCB.
- The CCG Children's Health Commissioning Project Manager engages with mental health events facilitated by the SW Strategic Clinical Network and the SW CAMHS Operational Delivery Network and contributed to the *Commissioning better CAMHS in the South West*, Oct 2014. This forum will continue to be used to give/receive national guidance and to share ideas, experiences and good practice.

**Appendix 1**

Chief Medical Officer's Annual Report: Our children deserve better: Prevention pays, October 2013
https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

NSPCC - Prevention in mind, All babies count: spotlight on Perinatal Mental Health, June 2013
http://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/spotlight-mental-health-landing_wda96578.html

Public Health England – How healthy behaviour supports children's wellbeing, August 2013
https://www.gov.uk/government/publications/how-healthy-behaviour-supports-childrens-wellbeing

Children and Young People's Mental Health Coalition report 'Overlooked and Forgotten', December 2013
http://www.cypmhc.org.uk/resources/overlooked_and_forgotten_full_report/

Mental health sub-group report of the children's outcomes forum, May 2013
https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results
Closing the Gap, Priorities for essential change in mental health, January 2014 https://www.gov.uk/government/publications/mental-health-priorities-for-change

Baby Bonds, Parenting, attachment and a secure base for children, The Sutton Trust, March 2014
http://www.suttontrust.com/researcharchive/baby-bonds/

Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2004) Mental health of children and young people in Great Britain, 2004. Office for National Statistics. London, HMSO

Egger, H. L. and Angold, A. (2006) Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. Journal of Child Psychology and Psychiatry, 47 (3-4), 313–37.

Kurtz, Z. (1996) Treating children well: a guide to using the evidence base in commissioning and managing services for the mental health of children and young people. London. Mental Health Foundation

## Appendix 2

**Table 1: Protective factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)**

| Individual factors | Family factors | School context | Life events and situations | Community and cultural factors |
|---|---|---|---|---|
| Easy Temperament<br><br>adequate nutrition<br><br>attachment to family<br><br>above average intelligence<br><br>school achievement<br><br>problem solving skills<br><br>internal locus of control<br><br>social competence<br><br>social skills<br><br>good coping style<br><br>optimism<br><br>moral beliefs<br><br>values<br><br>positive self-related cognitions<br><br>physical activity | supportive caring parent<br><br>family harmony<br><br>secure and stable family<br><br>small family size<br><br>more than two years between siblings<br><br>responsibility within the family (for child or adult)<br><br>supportive relationship with other adult (for a child or adult)<br><br>strong family norms and morality | sense of belonging<br><br>positive school climate<br><br>pro-social peer group<br><br>required responsibility and helpfulness<br><br>opportunities for some success and recognition of achievement<br><br>school norms against violence | involvement with significant other person (partner/mentor)<br><br>availability of opportunities at critical turning points or major life transitions<br><br>economic security<br><br>good physical health | sense of connectedness attachment to and networks within the community<br><br>participation in church or other community group<br><br>strong cultural identity and ethnic pride<br><br>access to support services<br><br>community/cultural norms against violence |

**Table 2: Risk factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)**
NB: the following tables list *influences* on the development of mental health problems not the *causes*.

| Individual Factors | Family/social factors | School context | Life events and situations | Community and cultural factors |
|---|---|---|---|---|
| Prenatal brain damage<br><br>Prematurity<br><br>birth injury | having a teenage mother<br><br>having a single parent | Bullying<br><br>peer rejection<br><br>poor attachment to | physical, sexual and emotional abuse<br><br>school transitions | socio-economic disadvantage<br><br>social or cultural discrimination |

| | | | | |
|---|---|---|---|---|
| low birth weight, birth complications | absence of father in childhood | school | divorce and family break up | isolation |
| physical and intellectual disability | large family size | inadequate behaviour management | death of family member | neighbourhood violence and crime |
| poor health in infancy | antisocial role models (in childhood) | deviant peer group | physical illness | population density and housing conditions |
| insecure attachment in infant/child | family violence and disharmony | school failure | unemployment, homelessness | lack of support service including transport, shopping, recreational facilities |
| low intelligence | marital discord in parents | | incarceration | |
| difficult temperament | poor supervision and monitoring of child | | poverty/ economic insecurity | |
| chronic illness | low parental involvement in child's activities | | job insecurity | |
| poor social skills | neglect in childhood | | unsatisfactory workplace relationships | |
| low self-esteem | long-term parental unemployment | | workplace accident/ injury | |
| alienation | criminality in parent | | caring for someone with an illness/ disability | |
| impulsivity | parental substance misuse | | living in nursing home or aged care hostel | |
| alcohol misuse | parental mental disorder | | war or natural disasters | |
| | harsh or inconsistent discipline style | | | |
| | social isolation | | | |
| | experiencing rejection | | | |
| | lack of warmth and affection | | | |

Reproduced from: Commonwealth Department of Health and Aged Care 2000, Promotion, Prevention and early intervention for mental health-a Monograph, Mental Health and Special Programs branch, Commonwealth Department of Health and Aged Care, Canberra. Quoted in Making it Happen (DH 2001)

Pregnancy and early years
School age
Young people
BIRTH
ADULTHOOD
Pre- and post-birth mothers and fathers are supported in promoting their own and their child's emotional health.
All parents are able to access high quality information and advice on children's emotional health, and know where and how to access additional support if necessary.
Vulnerable parents have high quality advice and support to improve parenting skills and confidence, plus access to adult services to address other issues that they are facing.
All vulnerable children have a positive adult role model. Where this is not being provided through the family, structures are in place for other adults (e.g. tutors or mentors) to notice and support that child.
Children and young people have opportunities to play and interact together in high quality spaces, both structured and unstructured. They have access to peer support and mentoring schemes when needed. Personal development opportunities are available to develop interests, skills, confidence and self-awareness and esteem.
Childcare, learning and training takes place in environments that promote emotional health, with staff who understand children's emotional health needs and have the time and skills to develop nurturing relationships. Action is taken to prevent bullying and discrimination. Policies and practice promote a caring, secure and stimulating environment.
Early years provision supports children's personal, social and emotional development.
Children and young people are supported in developing social and emotional skills, with small group support for those requiring additional help.
Children, young people and practitioners have access to information and advice on promoting emotional health and addressing problems.
Those at particular risk of experiencing mental health problems are identified and have access to support from relevant practitioners, including those with mental health expertise where therapeutic support is required. This is co-ordinated with any other services being delivered to the child.
Supporting parents and carers
Supporting friendships, peer relationships and personal development
Promoting emotional health in childcare and learning environments
Information, advice and support when needed

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# CYP IAPT principles in CAMH services – values and standards

**"Delivering With and Delivering Well"**

**Version 2**

### 1.0 Introduction

The children and young people's improving access to psychological therapies project [CYP-IAPT] aims to improve the availability and effectiveness of mental health interventions for children and young people.

This transformation is being effected by:

> Training existing CAMHS staff, in targeted and specialist services, in an agreed, standardised curriculum of NICE approved and best evidence based therapies. This will also increase the range of evidence based treatments / interventions available.
>
> In addition, supervisors and managers will receive training on supervision, service change and development.
>
> Supporting the collection of a nationally agreed outcome framework on a high frequency or session by session basis for all contacts. This routine outcome monitoring [ROM] is actively used to guide treatment / intervention in a collaborative manner with young people and their families.
>
> This outcome data will also be used in the direct supervision of the therapist, to determine the overall effectiveness of the service and to benchmark services. Embedding outcome monitoring across the whole CAMHS will transform how they operate, and how they are commissioned.

### 2.0 Service Quality

CYP IAPT has brought together CAMHS providers from across the statutory and voluntary sectors. At the heart of the programme is a strong emphasis on creating a collaborative approach across these sectors in addition to that with service users. As a result, there is now widespread agreement that the values and qualities embodied by the CYP IAPT programme should be part of a wider drive for change in improving children and young people's access to timely and high quality mental health provision.

CYP IAPT's approach to service quality and accreditation is one that seeks to build on existing quality assurance mechanisms rather than further burden frontline agencies.

The CYP IAPT approach is one which enables not only services that have directly benefited from their engagement in the programme to demonstrate their adherence to its principles and standards, it also encourages and facilitates change across all services providing help to children and young people with their mental health difficulties.

This document sets out an overarching quality framework for CYP IAPT which identifies the key markers underpinning the values and qualities of the programme. These markers are currently recognised in the existing quality assurance and quality processes mechanisms: Quality Network for Community CAMHS (QNCC), Youth Wellbeing Directory with ACE-V Quality Standards (ACE-Value), Choice and Partnership Approach (CAPA) and the Child Outcomes Research Consortium (CORC).

**3.0 Related Accreditations, Service Evaluations and Transformations**

*The Quality Network for Community CAMHS (QNCC)*

QNCC is part of the Royal College of Psychiatrists' Centre for Quality Improvement. Established in 2005, the network sets comprehensive service standards for community based CAMH teams and reviews them through a process of self and peer review. There is an additional subset of standards for teams providing a crisis and/or intensive response. Teams demonstrate their compliance with the standards by providing evidence and collecting feedback from young people, families, staff and professionals from other agencies. The network also provides a framework for services to share best practice and learn from each other through regular national conferences and learning events, an email discussion group and the opportunity to be part of a peer review team.  Services meeting enough standards can be accredited by the College.  The CYP IAPT values and qualities included in this document will be featured in the QNCC standards and for a service to be accredited as excellent, they will need to demonstrate their compliance with all of these.
[www.rcpsych.ac.uk/communitycamhs]

*Youth Wellbeing Directory with ACE-V Quality Standards*

The Youth Wellbeing Directory is a free online resource providing information about child and adolescent mental health service providers across sectors, both large and small. The directory provides commissioners, referrers and service users with a way of searching for services both locally and nationally according to the ACE-V Quality Standards of Accountability, Compliance, Empowerment and Value. Providers who aim to improve the emotional wellbeing and/or mental health of children and young people up to the age of 25 (whether directly; or by supporting their families and caregivers) are able to register their service profile by providing information around the ACE-V quality standards. By registering, providers "put themselves on the map" as committing to these qualities and are able to demonstrate how they are embedding these qualities in their practice The searchable online directory offers a way for potential service-users, referrers and commissioners to collaboratively consider and compare service providers based on quality, and offers the opportunity for service providers to increase recognition of their work. The CYP IAPT values and qualities included in this document map to the ACE-V Quality Standards. [www.youthwellbeingdirectory.co.uk]

*Choice and Partnership Approach (CAPA)*

CAPA is a clinical service transformation model that brings together:

- Collaborative practice: the active involvement of young people and their families
- Goal setting with regular review involving the young person
- Demand and capacity ideas and Lean Thinking
- A new approach to clinical skills and job planning: skill mix layering



It is used widely in the UK, Ireland, Belgium, Holland, New Zealand, Australia and Canada in CAMHS,

Adult mental health, and Child and Adult learning disability. [www.capa.co.uk.]

*Child Outcomes Research Consortium (CORC)*

CORC is a grassroots collaboration of mental health specialists from services providing provision for children and young people with mental health and wellbeing difficulties across the UK and beyond. The collaboration has grown from 4 subscribing organisations in 2004 to over 70. Members collect information from children, young people and families on progress, outcomes and experiences of care received. A small central team of researchers and support staff analyse the pseudonymised data centrally and provide ongoing support and training to members. The data is collected, explained and interpreted with young people in mind and CORC members are committed to using this information to help them reflect on their service provision and to use data to help them improve practice. [www.corc.uk.net]

**4.0 Values and Standards**

These values can be clustered into those that services demonstrate

- in their interactions WITH young people and their families/carers and
- those that are then required to deliver services WELL.

Within each value is an observable behaviour/s that shows the value being enacted well and acts as the standard description for that value.

Evidence to present to meet the standards:
Following each criteria are suggested evidence that a service could present – it anticipated that any service who has recently undergone a quality improvement or service transformation using any of the above four methodologies will have complied evidence as part of this process. This can be utilised to evidence the Values and Standards set out in this document.

Each accreditation / evaluation / transformation organisation listed above has mapped to the standards in their improvement frameworks. All those organisations can support services in developing to meet these standards. The key contacts/websites are shown above.

***Note: The term "Young people" is chosen, for the sake of brevity, to represent young people, children and their families and carers. It is also used to promote the involvement of families and carers, wherever possible, in all these values. The term clinician / practitioner describes staff who deliver interventions to young people and their families.***

# Delivering With

## Section 1: Access and voice

### 1.1 Referral

Clear eligibility criteria and referral processes which are accessible and understandable.

| Behaviour | Possible Evidence |
|---|---|
| Clear information in a variety of formats to help young people and others in contact with them to understand how and when young people can access a service e.g. open access services: phone or drop in, opening times / referral based services: a set of criteria and pathways | Leaflets, website, posters, social media links |

### 1.2 Self-referral

A clear self-referral process is available for all young people (as is appropriate for that service and compatible with local commissioning guidance).

| Behaviour | Possible Evidence |
|---|---|
| 1. Information is available in a variety of formats to support young people to make direct contact<br>2. Clear procedures to ensure young people voluntarily agree to attend the service | Agency information Data on referral activity<br>Feedback from young people Policy on website<br>Numbers of self-referrals<br>A YP story of self-referral |

### 1.3 Access times

A young person and where relevant their parents/carers receive quick access to treatment (access times are in line with any locally agreed targets).

| Behaviour | Possible Evidence |
|---|---|
| 90% of young people wait no more than 6 weeks between Assessment and Treatment [or Choice to Partnership] | Published data<br>Young people's feedback<br>Procedures to enable urgent/fast access to appointments |

### 1.4 Accessible settings

Young people are offered help in accessible and comfortable settings.

| Behaviour | Possible Evidence |
|---|---|

| | |
|---|---|
| 1. Young people are consulted on and offered appointments at times and in locations that suit them best e.g. early evening, youth/community-based centres<br><br>2. Young people are consulted on the design of or improvements to the service's premises and the physical environment, including its signage and information are consistent with the agency's values and principles | Feedback and evidence of young people's involvement and the response made<br>Feedback from young people's<br>Complaints and suggestions<br>Opening times<br>Young people's feedback |

**1.5 Service feedback**

There are clear ways and simple to use means for a young person and/or their family to provide regular feedback or to complain. This feedback should be used in a meaningful manner.

| **Behaviour** | **Possible Evidence** |
|---|---|
| 1. Clear policy and processes for gathering young people's individual feedback on their experience of the intervention offered and the overall service.<br><br>2. Information about making suggestions or complaints about the service is available and displayed in accessible format(s)<br><br>3. Information is available to young people about the actions taken as a result of feedback, complaints and/or suggestions | Published data on young people's experience of the help available<br>Website/leaflets/posters<br>Records of suggestions and complaints and the outcome<br>Website/leaflets/posters |

**1.6 Advocacy & Support**

The availability of independent advocacy and support services are well signposted and young people and/or their families are supported to access the help available.

| Behaviour | **Possible Evidence** |
|---|---|
| 1. The agency provides clear information about all its available services to enable young people to understand the range of help available e.g. information, advice and other support services<br><br>2. Staff listen carefully to young people to understand their needs and ensure they are referred to the appropriate internal or external service (if differentiated)<br><br>3. The agency has effective links with and information about other external bodies relevant to young people's needs to enable effective referral and signposting | Website/leaflets<br>Young people's feedback<br><br>Data on young people's use of internal services<br>Feedback from young people<br>Agency contacts and knowledge of other local agencies<br>Information systems to support referral and signposting |

**1.7 Transitions**

The transition between services will be planned and supportive, with the young person's mental health kept in mind throughout.

| Behaviour | Possible Evidence |
|---|---|

| | |
|---|---|
| 1. Any transfer plan is discussed and agreed with the young person<br><br>2. Where young people agree to an external referral, clear information and processes are implemented to ensure young people actively agree to the exchange of personal information and the agencies to which it may be given | Examples<br>Care Programme Approach (CPA)<br>Policy on consent and information sharing |

## Section 2: Clinical / Intervention Collaboration

### 2.1 Initial assessments

Young people are offered an initial assessment without significant delay

| Behaviour | Possible Evidence |
|---|---|
| An initial assessment / Choice is offered within 6 weeks for 90%of all non-urgent referrals | Service level data<br>Parents/Child feedback |

### 2.2 Holistic

Young people are offered an initial assessment that is fully collaborative and takes a complete view of their lives and mental health. This assessment should include family/carers and friends where appropriate.

| Behaviour | Possible Evidence |
|---|---|
| 1. Young people are offered clear and accessible information to help them understand the purpose of assessment and the information gathered<br><br>2. Assessment / Choice letters includes content concerning bio-psycho-social information and the young person's wishes<br><br>3. Information on the young person's experience of assessment / Choice is regularly collected<br><br>4. Staff are appropriately trained to enable young people to identify their needs, strengths and difficulties | Young person feedback<br>Audit<br>Collated assessment / Choice letters / random audit<br><br>Young people's feedback<br><br>Young people's feedback<br>Training records |

### 2.3 Information

Young people are helped to make informed choices.

| Behaviour | Possible Evidence |
|---|---|
| Young people have access to age and developmentally appropriate information about possible and different interventions and services relevant to their mental health and emotional wellbeing | Website/leaflets /hand-outs<br>Young people's feedback<br>Signposting to relevant website |

### 2.4 Goals

Clinicians involve young people (and where appropriate their parents/carers) in the setting of relevant shared goals.

| Behaviour | Possible Evidence |
|---|---|
| 1. These are noted in the initial assessment / Choice letter<br>2. Goal based outcome measures are used in 90% of cases<br>3. Young people have opportunities to feedback on the process of goal setting | Young person feedback<br>Audit<br>Letters |

**2.5 Interventions**

A choice of approaches/interventions (including those of evidence based practice where relevant) are offered if possible, in line with client preference and goals, and chosen in partnership with the practitioner.

| Behaviour | Possible Evidence |
|---|---|
| 1. Intervention information is provided and discussed<br>2. Used in intervention decision | Young person feedback<br>Audit<br>Data on service/intervention take-up |

**2.6 Goal review**

Where goals are set there is regular review and reflection on goals and progress.

| Behaviour | Possible Evidence |
|---|---|
| A goal based outcome measure is used and reviewed with young people | Young people's feedback<br>Published outcome data<br>Notes audit |

**2.7 Routine outcome measurement**

Young people are asked to give session by session feedback and are involved in reviewing progress, goals and outcomes.

| Behaviour | Possible Evidence |
|---|---|
| At least 3 ROM are used for 90% of YP | Published outcome data<br>Young people's feedback<br>Notes audit |

## Section 3: Strategic/Service Collaboration

**3.1 Strategic collaboration**

Young people (and where appropriate their parents/carers) are involved in all decisions/plans that affect young people. This includes design, planning, delivery and reviewing of services.

| Behaviour | Possible Evidence |
|---|---|

| | |
|---|---|
| Young people are offered a range of opportunities relevant to their needs to encourage and support their involvement and participation in various aspects of the service.<br><br>Young People's feedback is shared with senior representatives at a Trusts/Organisation Board level and comments are acted upon | Website/leaflets<br>Demographic data<br>Reports and data on activities<br>and their outcomes<br>Forum minutes |

**3.2 Publication Collaboration**

Any leaflets, websites or communications aimed at young people are developed in partnership with young people.

| Behaviour | Possible Evidence |
|---|---|
| Agencies have a range of strategies to enable appropriate consultation with all the groups of young people its service is designed to meet | Profile of young people involved<br>Feedback from young people<br>Notes/reports<br>Young person's forum |

**3.3 Training**

Young people and carers are appropriately involved and supported in the design, delivery and/or evaluation of staff training.

| Behaviour | Possible Evidence |
|---|---|
| A training plan describing how young people have been consulted on and involved in its delivery is available | Young people's feedback<br>Training plan<br>Staff feedback |

**3.4 Recruitment**

Young people and/or their parents/carers are involved in and their views taken into account in the recruitment and appointment of anyone in the organisation who has contact with young people.

| Behaviour | Possible Evidence |
|---|---|
| 1. Young People are involved in developing recruitment policies and procedures<br><br>2. Young people are trained and supported to conduct staff appointments | Collated interview panels<br>Feedback from young people, interviewees and staff |

# Delivering Well

## Section 4: Leadership

### 4.1 Leadership team

That there is a leadership team representing multiple aspects of the service e.g. managers, admin and clinicians / practitioners.

| Behaviour | Possible Evidence |
| --- | --- |
| There is a regular cycle of meetings involving all those who lead and manage different areas of the service to ensure collaboration in the design, review and delivery of the annual operational and other plans.<br><br>Transformation is seen as a dynamic process. | Operational plan<br>Data on targets<br>Minutes of meetings |

### 4.2 Team development

There are regular scheduled opportunities for staff to come together for team / service away days to build team relationships, facilitate learning and service development.

| Behaviour | Possible Evidence |
| --- | --- |
| Each team has regular joint development time and opportunities<br><br>Transformation is seen as a dynamic process | Team diary<br>Leadership team minutes Away day notes / agendas Staff feedback |

### 4.3 Training

There is an organisational commitment, resources and time made available for continuing professional development and training.

| Behaviour | Possible Evidence |
| --- | --- |
| Each service has an annual training plan available | Submitted<br>Staff feedback |

### 4.4 Integrated services

There are effective relationships with key local organisations to ensure the holistic needs of young people are met in a timely and appropriate manner

| Behaviour | Possible Evidence |
| --- | --- |

| | |
|---|---|
| 1. Staff develop positive working relationships with external agencies to enhance the overall local service offer to young people<br><br>2. Staff share skills and knowledge to ensure the timeliness and relevance of services and interventions based on an understanding of young people's wishes and needs<br><br>3. Where relevant and agreed with young people, staff ensure an integrated approach with other agencies in the care offered to individual young people | Minutes of meetings<br>Information on local services<br>Referral protocols<br>Referral data<br>Young people's feedback<br>Staff feedback<br>Record of joint training events |

## Section 5: Workforce

### 5.1 Skill mapping

The service has mapped the skills of the individual team members and uses this to inform clinical interventions, training and recruitment.

| Behaviour | Possible Evidence |
|---|---|
| 1. Services map staff skills at least annually, through e.g. supervision, appraisal, the use of core competency frameworks<br><br>2. The information generated actively informs the delivery of its services, operational and training plans | Operational and strategic plans<br>Training plan<br>Recruitment<br>Skills map<br>SASAT |

### 5.2 Interventions

Services offer an appropriate range of treatments, including those recommended by NICE and other evidence based interventions (where relevant).

| Behaviour | Possible Evidence |
|---|---|
| Staff are competent to perform all aspects of their role and responsibilities, including NICE recommended treatments where relevant | Data on outcomes<br>Young people's feedback<br>Staff appraisal and feedback<br>Training records |

### 5.3 Job Planning

Clinicians / practitioners have a clear description of their roles, tasks and capacity for clinical casework, administration, team meetings and supervision.

| Behaviour | Possible Evidence |
|---|---|
| 1. All staff have a job description and individually agreed work plan / capacity plan<br><br>2. Work plans are regularly monitored and reviewed in supervision<br><br>3. The service has a collated team capacity plan | Work plans<br><br>Staff feedback<br>Team / service capacity plan |

### 5.4 Supervision

There are time and resources for clinical and management supervision.

| Behaviour | Possible Evidence |
|---|---|
| 1. The agency has clear policies on the different functions of line and clinical supervision and staff have regular access to both.<br><br>2. Clinical supervision must be available to practitioners at least one hour per month<br><br>3. Management supervision is available to all staff<br><br>4. Supervision is delivered by staff with the appropriate clinical skills and training | Line and clinical supervision policies<br>Notes of supervision<br>Feedback from staff |

### 5.5 Peer group discussion

There are regular opportunities for staff to participate in small group case discussion regarding goals and outcomes.

| Behaviour | Possible Evidence |
|---|---|
| The service ensures time and resources are available for practitioners to discuss interventions on a regular basis | Information for practitioners on PGD meetings<br>Feedback from staff<br>Dates / frequency noted in leadership team minutes |

### 5.6 Appraisal

Young people's/families' views of their experience of the clinical care delivered should be included in staff appraisals.

| Behaviour | Possible Evidence |
|---|---|
| 1. Appraisers are trained to use young people's feedback to help inform individual staff appraisal<br><br>2. Each appraisal involves some feedback from young people on their service experience plus a clinical experience of service review (i.e. direct feedback on specific clinical interactions) | Notes of appraisal<br>Staff and supervisor feedback<br>Submitted<br>E.g. CAPA-ECQ [experience of choice questionnaire]<br>360 degree |

## Section 6: Demand and Capacity

### 6.1 Demand and capacity management

Services can describe their demand and capacity and have systems (IT and others) and process in place to monitor and respond to fluctuations.

| Behaviour | Possible Evidence |
|---|---|

| | |
|---|---|
| 1. There is a continuous record of referrals accepted by team and available assessment / treatment or Choice and Partnership capacity.<br>2. The agency monitors:<br>- all contacts made by young people;<br>- all assessments and interventions offered and taken up<br><br>3. The agency uses this information to help plan and manage the service | Statistical data<br>Notes of management meetings<br>Maps of administrative systems to support process |

**6.2 Flow management**

Services deploy their resources efficiently and effectively to minimise delays in the young person's care and involve full booking wherever possible.

| Behaviour | Possible Evidence |
|---|---|
| 1. The service regularly monitors and reviews:<br>- all initial contacts made to the service<br>- waiting times between initial contact and intervention<br><br>2. The service has procedures for assessing and fast tracking urgent needs<br><br>3. 90% Young people are fully booked (i.e. booked into a specific slot rather than placed on a waiting list) into treatment / Partnership at Assessment / Choice | Data on contacts and take up of assessments and interventions<br>Service policy on managing urgent cases<br>Young people's feedback<br>Maps of administrative systems to support process |

**7.0 Authorship**

This document was written by Dr Steve Kingsbury [Service Development Group], Barbara Rayment [Voluntary Sector], Dr Isobel Fleming [CORC], Peter Thompson [QNCC] and Dr Ann York [Service Development Group Chair] with contributions from Mark Hemsley [Young Person] and Catherine Swaile [CAMHS Commissioner]. The group would like to thank the National Accreditation Council and the Service Development Group for their additional contributions.

**8.0 CYP IAPT Values and Behaviours Summary**

| **Delivering With** | | | |
|---|---|---|---|
| **Section 1: Access and Voice** | | | |
| **1.1** | **Referral** | Clear criteria and referral processes which are accessible and understandable. | |
| **1.2** | **Self-referral** | A clear self-referral process is available for all young people (as is appropriate for that service and compatible with local commissioning guidance). | |
| **1.3** | **Access times** | A young person and where relevant their parents/carers receive quick access to treatment (access times are in line with any locally agreed targets). | |

| | | | |
|---|---|---|---|
| **1.4** | **Access settings** | Young people are offered help in accessible and comfortable settings. | |
| **1.5** | **Service feedback** | There are clear ways and simple to use means for a young person and/or their family to provide regular feedback or to complain. This feedback should be used in meaningful manner. | |
| **1.6** | **Advocacy & Support** | The availability of independent advocacy and support services are well signposted and young people and/or their families are supported to access the help available. | |
| **1.7** | **Transitions** | The transition between services will be planned and supportive, with the young person's mental health kept in mind throughout. | |
| **Section 2: Clinical / Intervention Collaboration** | | | |
| **2.1** | **Initial assessments** | Young people are offered an initial assessment without significant delay | |
| **2.2** | **Holistic** | Young people are offered an initial assessment that is fully collaborative and takes a complete view of their lives and mental health. This assessment should include family/carers and friends where appropriate. | |
| **2.3** | **Information** | Young people are helped to make informed choices. | |
| **2.4** | **Goals** | Clinicians involve young people (and where appropriate their parents/carers) in the setting of relevant shared goals. | |
| **2.5** | **Interventions** | A choice of approaches/interventions (including those of evidence based practice where relevant) are offered if possible, in line with client preference and goals and chosen in partnership with the practitioner. | |
| **2.6** | **Goal review** | Where goals are set there is regular review and reflection on goals and progress. | |
| **2.7** | **Routine outcome measurement** | Young people are asked to give session by session feedback and are involved in reviewing progress, goals and outcomes. | |
| **Section 3: Strategic/service collaboration** | | | |
| **3.1** | **Strategic collaboration** | Young people (and where appropriate their parents/carers) are involved in all decisions/plans that affect young people. This includes design, planning, delivery and reviewing of services. | |
| **3.2** | **Information Collaboration** | Any leaflets, websites or communications aimed at young people are developed in partnership with young people. | |
| **3.3** | **Training** | Young people and carers are appropriately involved and supported in the design, delivery and/or evaluation of staff training. | |
| **3.4** | **Recruitment** | Young people and/or their parents/carers are involved in and their views taken into account in the recruitment and | |

| | | | |
|---|---|---|---|
| | | appointment of anyone in the organisation who has contact with young people. | |
| **Delivering Well** | | | |
| **Section 4: Leadership** | | | |
| **4.1** | **Leadership team** | That there is a leadership team representing multiple aspects of the service e.g. managers, admin and clinicians / practitioners. | |
| **4.2** | **Team development** | There are regular scheduled opportunities for staff to come together for team service away days to build team relationships, facilitate learning and service development. | |
| **4.3** | **Training** | There is an organisational commitment, resources and time made available for continuing professional development and training. | |
| **4.4** | **4.4 Integrated services** | There are effective relationships with key local organisations to ensure the holistic needs of young people are met in a timely and appropriate manner | |
| **Section 5: Workforce** | | | |
| **5.1** | **Skill mapping** | The service has mapped the skills of the individual team members and uses this to inform clinical interventions, training and recruitment | |
| **5.2** | **Interventions** | Services offer an appropriate range of treatments, including those recommended by NICE and other evidence based interventions (where relevant). | |
| **5.3** | **Job Planning** | Clinicians / practitioners have a clear description of their roles and task with appropriate time allocated for clinical casework, administration, team meetings and supervision. | |
| **5.4** | **Supervision** | There are time and resources for clinical and management supervision. Individual supervision must be at least one hour per month. | |
| **5.5** | **Peer group discussion** | There are regular opportunities for staff to participate in small group case discussion regarding goals and outcomes. | |
| **5.6** | **Appraisal** | Young people's views of their experience of the clinical care delivered should be a key part of staff appraisals. | |
| **Section 6: Demand and Capacity** | | | |
| **6.1** | **Demand and capacity management** | Services can describe their demand and capacity and have systems (IT and others) and process in place to monitor and respond to fluctuations. | |
| **6.2** | **Flow management** | Services deploy their resources efficiently and effectively to minimise delays in the young person’s care and involve full booking wherever possible. | |

# Appendix 1: References

## Delivering With

### *Leadership*

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Aarons et al. The organizational social context of mental health services and clinician attitudes toward evidence-based practice: a United States national study (2012) Implementation Science, 7:5

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Alimo-Metcalfe B & Alban-Metcalfe J (2008) Engaging leadership: Creating organisations that maximise the potential of their people. Chartered Institute of Personnel and Development.

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### *Workforce*

Self Assessed Skills Audit Tool produced by Public Health England: SASSAT http://www.chimat.org.uk/resource/item.aspx?RID=103044

CAMHS Workforce Guidance.pdf

### *Demand and capacity and flow management*

York, A & Kingsbury, S. (2013). The Choice and Partnership Approach – A Service Transformation Model. Surrey; CAPA Systems Limited www.capa.co.uk

Capacity activity modelling guidance.p

## Delivering Well

***What Young People's Say***

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Lavis, P., Hewson, L. (2011) How Many Times Do We Have to Tell You? A Briefing from the National Advisory Council about What Young People Think About Mental Health and Mental Health Services, *National Advisory Council for Children's Mental health and Psychological wellbeing*

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***Outcome Monitoring***

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***Importance of the trusted adult***

http://www.counselheal.com/articles/6765/20130918/study-identifies-traits-youth-look-when-trusting-adults.htm

***Collaborative Care***

Collaborative care for depression and anxiety problems (2012) The Cochrane Library Janine Archer[1,*], Peter Bower[2], Simon Gilbody[3], Karina Lovell[1], David Richards[4],Linda Gask[5], Chris Dickens[6], Peter Coventry[7]

https://www.evidence.nhs.uk/document?ci=http%3A%2F%2Fonlinelibrary.wiley.com%2Fdoi%2F10.1002%2F14651858.CD006525.pub2%2Ffull&q=collaborative%20working%20and%20patient%20centered%20care&ReturnUrl=%2Fsearch%3Fq%3Dcollaborative%2520working%2520and%2520patient%2520centered%2520care

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Wolpert, M. (2014) Closing the Gap through Changing Relationships. The Health Foundation

***Advocacy and Support***

Banks, W. (2010) Provision of independent advocacy; as a protective measure to support children and young people to raise safeguarding issues and be involved in decisions about their lives, *Munro Review of Child Protection: Call for Evidence*

Balmer, N.J., Pleasence, P. (2012) The Legal Problems and Mental Health Needs of Youth Advice Service Users: The Case for Advice, *Youth Access*

Sefton M. (2010) With Rights in Mind, *Youth Access.*

***Children and Young People's Rights***

The UN Convention on the Rights of the Child

***Feedback and complaints***

Brown, A., Ford, T., Deighton, J., & Wolpert, M. (2012). Satisfaction in Child and Adolescent Mental Health Services: Translating Users' Feedback into Measurement. *Adm Policy Ment Health*.

The Children's Commissioner (2013) Child Friendly Complaints Processes in Health Services: Principles, Pledges and Progress, *Office of the Children's Commissioner*

***Service User Participation***

A range of online resources to support young people's involvement and participation
http://www.myapt.org.uk/

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## Annex 1: Local Transformation Plans for Children and Young People's Mental Health

*Please use this template to provide a high level summary of your Local Transformation Plan and submit it together with your detailed Plan (see paragraph 5.1.4)*

**Developing your local offer to secure improvements in children and young people's mental health outcomes and release the additional funding: high level summary**

| **Q1. Who is leading the development of this Plan?**<br>(Please identify the lead accountable commissioning body for children and young people's mental health at local level. We envisage in most cases this will be the CCG working in close collaboration with Local Authorities and other partners. Please list wider partnerships in place, including with the voluntary sector and include the name and contact details of a single senior person best able to field queries about the application.) |
|---|
| Lead accountable commissioning body: Bath and North East Somerset CCG.<br><br>Supported by local Children's **Emotional Health and Wellbeing Strategic Group, the multi-agency strategy group that provides strategic direction to local provision**;<br>Membership: Joint LA/CCG Senior Commissioning Manager, Specialist Services , CCG Children's Health commissioner, CAMHS Service manager, CYP Voluntary Sector Network representative, LA Specialist Social Care Service Manager, LA Educational Psychologist, LA 0-11 Outcomes manager, LA 11-19 Outcomes Service Manager, FE College pastoral lead, School Nurse clinical lead, Public Health mental health commissioner, Director of Public Health Award coordinator, Headteacher of Bath & North East Somerset Virtual School for Children in Care<br>, LA Preventative Services commissioner.<br><br>Contact details: Mary Kearney-Knowles<br>Senior Commissioning Manager, Specialist Services,<br>Bath and North East Somerset CCG and Council,<br>Telephone: 01225 394412<br>Email: Mary_Kearney-Knowles@bathnes.gov.uk |
| **Q2. What are you trying to do?**<br>(Please outline your main objectives, and the principal changes you are planning to make to secure and sustain improvements in children and young people's mental health outcomes. What will the local offer look like for children and young people in your community and for your staff?). Please tell us in no more than 300 words |
| B&NES CCG and LA are currently reviewing community health and social care |

services provision, through an innovative programme locally known as Your Care Your Way; http://www.yourcareyourway.org/. Mental health services for children, young people and adults are within the scope of the review. The results of this review, currently in stage 2, will contribute to the future provision of mental health service and to this transformational plan through 2020.

Currently there are a wide variety of support services in Bath and North East Somerset (B&NES) to promote, protect and maintain CYP's mental health. These range from universal to very specialist services and they have a variety of eligibility criteria and referral pathways. The new Transformation Plan will enable commissioners and providers to work even more collaboratively to improve the access and effectiveness of the services on offer and will particularly focus on five main priorities:

1. The consideration and development of a single point of access or 'single front door' to enable practitioners, parents/carers and CYP to contact and thereafter receive, at the earliest opportunity, the most appropriate help.
2. To improve school/college/CAMHS liaison by introducing 'Resilience Hubs' at each school and college. These Hubs will provide opportunities for monthly face-to-face meetings where CAMHS link workers, selected school/college staff, school/college nurses and independent counsellors can meet for consultation, training and mutual support.
3. To increase the level of therapeutic support offered to statutory social workers and parents/carers who are struggling to prevent the breakdown of fostering and adoptive placements. This will take the form of a CAMHS psychologist being seconded to the LA placements team.
4. To further increase the skills of a number of practitioners who work directly with families and schools whose younger children/pupils display behaviours which present barriers to learning
5. To improve the digital guidance for national and local EHWB services. This will include the published Transformation Plan, suggestions for CYP self-care, guidance for referrers etc. all presented in an informative and accessible manner.

**Q3. Where have you got to?**

(Please summarise the main concrete steps or achievements you have already made towards developing your local offer in line with the national ambition set out in *Future in Mind* e.g. progress made since publication in March 2015.) Please tell us in no more than 300 words

Since April 2015 a number of developments to support the transformation plan have begun:

1. *Pilot - Extended CAMHS support: for > 18 y/o's* who were receiving CAMHS interventions when they turned 18 and, although they are particularly vulnerable, do not meet the referral criteria for adult mental health services. This cohort will include, but is not restricted to, Care Leavers and will provide

intensive emotional support.

2. *Pilot - Early Intervention in Psychosis:* Pilot to improve fidelity to the early intervention in psychosis model by building links with CYP substance misuse, developmental disorder, CAMHS, schools and other services.
3. *Pilot - School Based Counselling:* Independent counsellors have been commissioned to provide individual 'drop in' advice sessions and formal counselling sessions at seven secondary schools from September.
4. *Pilot - Resilience Hubs: (*See above) These complement school based counselling and have also started in the new academic year.
5. *Pilot - Mindfulness Pilot:* 32 members of staff from *2* secondary schools have undertaken an 8 week Mindfulness course. 2 staff from each school will now be trained to deliver Mindfulness in Schools sessions/resources directly to young people.
6. *KS4 resource packs:* Mental Health PSHE Resource packs for Key stages 3&4 are being developed in partnership between School Improvement and the CAMHS participation group.
7. *Specialist Family Support and Play re-procurement:* A review has resulted in a new combined service model being procured to provide early intervention with 5-13 years olds with a range of emotional and social issues.
8. *Protocol between CAMHS and police:* has been implemented to reduce inappropriate attendances at the S136 suite.
9. *Pilot - CAMHS self-referral for 16 and 17 y/o's:* is being trialled by provider
10. *ASD support service:* Additional SLT sessions have been commissioned to 'speed' up ASD diagnosis and a new parent support worker will visit families whose children with ASD refuse to attend school.
11. *Eating Disorder Specialist service::* Agreeing new service model with provider and neighbouring CCGs

**Q4. Where do you think you could get to by April 2016?**

(Please describe the changes, realistically, that could be achieved by then.) Please tell us in no more than 300 words

By April 2016 we would expect to have:

1. Published our agreed Transformation Plan
2. Published collaboratively developed digital resources (presently differently for CYP, parents/carers and practitioners) and received feedback evidencing their use.
3. Completed interim evaluations of some of our pilots and made decisions regarding whether or not to continue. To have secured funding for those that should continue.
4. A clinical psychologist providing therapeutic support to the statutory placement team and have collected feedback from the social workers regarding the effectiveness of the secondment.
5. Improved the specialist Eating Disorder Service whilst simultaneously releasing resources to reduce waiting lists for generic specialist CAMHS.

6. Collaboratively agreed the most appropriate Shared Point of Access to services supporting the emotional health and wellbeing of local CYP and hence creating a 'No wrong door' culture.
7. Evidenced the number of CYP who have been 'diverted' from the S136 Place of Safety.

**Q5. What do you want from a structured programme of transformation support?** Please tell us in no more than 300 words

It would be helpful to have good examples of websites and apps from other areas and permission to use similar material where appropriate for our local area.

Likewise it would be helpful to have good examples of Single Point of Access models, including costings, and feedback of how well they work from other areas.

More examples of Key Performance Indicators e.g from the current 15 schools/CAMHS pilots would be helpful to ensure we include sufficient ones to allow us to compare ourselves with other areas.

Plans and trackers should be submitted to your local DCOs with a copy to England.mentalhealthperformance@nhs.net within the agreed timescales

The quarterly updates should be submitted in Q3 and Q4. Deadline dates will be confirmed shortly and are likely to be shortly after quarter end. These dates will, where possible, be aligned with other submission deadlines (eg, for the system resilience trackers, or CCG assurance process).

DCOs will be asked to submit the trackers to england.camhs-data@nhs.net for analysis and to compile a master list

Agenda Item 12

Bath & North East Somerset Council

healthwatch Bath and North East Somerset

NHS Bath and North East Somerset Clinical Commissioning Group

| MEETING | B&NES HEALTH AND WELLBEING BOARD |
|---|---|
| DATE | 28/10/2015 |
| TYPE | An open public item |

| Report summary table | |
|---|---|
| **Report title** | Local Safeguarding Adults Board Annual Report 2014/15 |
| **Report author** | Lesley Hutchinson<br>Telephone (01225) 396339 |
| **List of attachments** | Appendix 1. Local Safeguarding Adults Board Annual Report 2014/15 |
| **Background papers** | None |
| **Summary** | The Local Safeguarding Adults Board (LSAB) Annual Report 2014/15 highlights the work of the Board during the period and information and analysis of safeguarding case activity for the Health and Wellbeing Board to note. The Business Plan 2015-18 is available through the link in the report. |
| **Recommendations** | The Board is asked to:<br>• Note the report and business plan<br>• Raise any queries or concerns on safeguarding activity<br>• Recommend to the LSAB any areas for additional focus and assurance |
| **Rationale for recommendations** | The LSAB contributes to the Health and Wellbeing Strategy 2015-2019 as set out in the section Keeping People Safe (p19). The LSAB is assured to see the inclusion of safeguarding in the revised Strategy and values the partnership with the Health and Wellbeing Board. |
| **Resource implications** | None, however there remain capacity issues caused by the continued increase in safeguarding alerts. The outgoing Independent Chair has asked to have noted their concern about financial and capacity pressures on the statutory, voluntary and independent sectors. |
| **Statutory considerations and basis for proposal** | The Association of Directors of Adults Social Services recommends that LSABs present their Annual Reports to the 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.<br><br>The Care Act 2014 which comes into force on the 1st April 2015 requires LSABs to share their Annual Reports with Health and |

| | |
|---|---|
| | Wellbeing Boards and Healthwatch. |
| **Consultation** | The draft report has been considered by the LSAB. The report has been provided to Healthwatch for comments and will be presented to the Health and Wellbeing Committee in November 2015. |
| **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 2014/15.

1.2 The LSAB Annual Report 2014/15 follows the usual format with a few minor changes to reduce the size of the body of the report which the Health and Wellbeing Board comments upon last year. To that end the Partner Reports have been included in the appendices and the work of the Sub Groups is reported in bullet points.

1.3 The Report:

- contains an overview of changes to national and local policy which have taken place during the period; yet again we have seen a raft of new documents published specific to safeguarding particularly in light of the implementation of the Care Act 2014

- confirms the Boards governance arrangements and changes made within year particular reference is given to Healthwatch joining the Board in the absence of lay member

- sets out the Boards activity during the year and safeguarding case activity with 741 new alerts being made and 49% of these meeting the threshold for progression through the safeguarding procedures

- compares safeguarding case activity with national data; the national data set available for comparison is for 2013/14 however it provides a useful guide. A new comparator on mental capacity has been included though this itself requires further refining to reflect the decision specific nature of mental capacity assessments

- demonstrates the commitment of member agencies through their individual agency reports

1.4 The Business Plan 2012-15 has been completed and signed off with a new three year Plan developed at a workshop in February 2015. The original five domains have been reduced to three for greater focus. The three key priority areas are:

- Multi-Agency Responsibility and Accountability which has eight outcome areas

- Prevention and Early Intervention with three outcome areas

- Responding to and Learning from Abuse and Neglect with six outcome areas

Some of the outcomes are maintained from the previous Plan however a number are new in line with the requirements of the Care Act 2014 and the learning the LSAB has taken from its previous work programme.

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

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# Annual Report

## 2014 – 2015

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

working together for health & well-being

## Chair’s Foreword

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This is my final foreword after four years as independent chair, a role I have been proud to carry out. I have been privileged to work with outstanding colleagues across many agencies and to observe the dedication and professionalism that they demonstrate daily.

This annual report once again shows the vast amount of work that is taking place in Bath and North East Somerset to support, deliver and promote adult safeguarding. The scale and complexity of this work increases year on year and the Care Act has broadened it further. While welcoming the recognition the Act gives to safeguarding it also reminds us that this shifting landscape is hard enough for people involved in the work to comprehend and work with, let for alone people who need support who are trying to navigate the system.

While this is happening all agencies are under unprecedented financial pressure and, increasingly, this will affect the way in which safeguarding services are accessed, delivered, prioritised. Staff in all agencies have dealt with this professionally and with huge commitment to the people who need support. As this pressure mounts it will be increasingly difficult to maintain current standards and activity levels. The Board will need to oversee and understand the impact this is having on people who need support.

The Local Government Association’s peer review of the Board’s work was very helpful. It recognised the work that is being done and also gave some clear pointers for improvement. As well as practical recommendations the review reminded us of the danger of too much process. This annual report stresses the need to understand the difference the Board makes for people who need support. This is not easy as it is not an executive body but it remains an important goal. This review also reminds us to connect with local people and to raise the profile and understanding of safeguarding within the wider population. The work of the Awareness, Engagement and Communications Sub Group is starting to make headway in this area.

Making Safeguarding Personal is a way of ensuring that people who are being safeguarded are at the centre of everything that happens to them. This work has acquired new momentum and is starting to show some results. It is very important that this continues. This work provides a challenge to commissioners and to providers to move away from the way in which they have worked together.

The work on improving ways of sharing information and intelligence between agencies continues. This is a vital area to get right especially for people who experience abuse over time and who are supported by a range of agencies.

I am handing over to Reg Pengelly who also chairs the Children Safeguarding Board. This is a very positive move as it will bring these two vital areas of work closer together, alongside an integrated structure within B&NES Council and the CCG.

Robin Cowen Independent Chair

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## Executive Summary

The Local Safeguarding Adult Board (LSAB) Annual Report 2014/15 marks both an important beginning and end for the Board. An important end because of the departure of Robin Cowen (Independent Chair); an important beginning as we welcome the new chair Reg Pengelly from June 2015 and embrace the Board becoming a statutory requirement from the 1st April 2015 as part of the Care Act 2014.

The Board members have worked effectively throughout the year and have been supported by a wide range of agencies delivering the work programme through the five Sub Groups. Highlights of the key achievements for the year include:

1) Making Safeguarding Personal (MSP) – the Board has given a significant focus to the implementation of MSP in B&NES and has trialled a new arrangement for starting each Board meeting with a case study so it can hear and understand how service users and carers are involved in, and influence safeguarding. Four test bed sites have been in place which has strengthened front line practice and the Board has received routine updates on their progress ensuring the voice of the service user is at the fore.
2) A swift multi-agency response to the Cheshire West Supreme Court judgment was put in place. The judgment sets out the 'acid test' which must now be applied to service users who lack mental capacity to make specific decisions and are subject to the Deprivation of Liberty Safeguards in accordance with the Mental Capacity Act 2005. Each agency quickly identified the service users this would affect and have put in place mechanisms to ensure people's human rights are not affected.
3) The identification of the five areas of collaboration with the Local Safeguarding Children Board – this work will be built upon during 2015/16 with the lead from a new Business Support Manager to be appointed.
4) A positive appraisal from the Local Government Association (LGA). The LGA undertook a peer review of the local safeguarding arrangements and was complimentary about the consistent message delivered by all agencies including everyone wanting to do the right thing and having a robust assurance framework in place.
5) Preparation for the Care Act 2014 coming into force on 1st April 2015.
6) Attendance of 90 stakeholders from a wide variety of organisations at a successful stakeholder event entitled *Safeguarding and the Care Act: Is it Business as Usual?* The LSAB hosted the event and engaged two outstanding speakers: Julie Bailey, of *Cure the NHS,* who talked about *The Experience of Families and Friends in Mid Staffordshire Hospitals, and* Jane Lawson, Independent Consultant, who talked about *Making Safeguarding Personal and the Care Act 2014* who helped set the scene for interesting discussions between partners and for the Board to consider taking forward.
7) The development of a newsletter sharing the Board's news – this goes to all agencies working across B&NES.

Safeguarding case activity - 741 new alerts were raised during the year of which 49% met the threshold to invoke the Multi-Agency Safeguarding Procedures. The number of alerts is 8% higher than the previous year however it is a reduced

increase from previous years which have been as high as 31%. 707 cases were closed during the year.

The profile of the individuals who had been through the safeguarding procedures remained similar to the national picture in terms of age, gender and the primary care and support need. The ethnicity of service users also remained in line with the Boards expectation based on local population data, however the Board is keen to continue to reach out to people from black and minority ethnic communities. The types of abuse suspected also remains in line with the national picture with slightly fewer alerts regarding financial abuse reported. There are fewer 'unknown people' identified as being alleged responsible for the abuse than the national picture indicated and over 80% of service users are already known to services which is higher than the national average and higher than previous years.

The defined outcome of those cases investigated remains consistent with slight variation to the national picture. In B&NES fewer cases are recorded as inconclusive, however more than the national average are not substantiated – this correlates with a higher percentage of cases requiring no further action to reduce risks.

The Board has identified that it wants to further understand and gain assurance on the work undertaken to support people who are referred more than once and agencies are looking into this.

Robin Cowen is keen for the Board to note:

> *'It is evident from this report that demand for safeguarding support continues to increase. At the same time resources are reducing and are likely to further reduce over the next three to four years. This is bound to affect services and is an area that the LSAB will need to monitor closely.'* (September 2015)

Despite competing demands and capacity pressures across the board, the report demonstrates the commitment Board members give to safeguarding people in need of care and support. This is not only evidenced in the partner reports in the appendices to the report, but is also demonstrated by the work provided by non Board partners through the Sub Groups.

The Board has set its priorities for 2015/16 and beyond and will continue to deliver this alongside monitoring the impact on services during financially difficult times. Embedding MSP will remain a key priority as will meeting the new responsibilities for Prevent and Anti-Slavery.

## 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. 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.

1.2 This report summarises the LSAB's activities that has taken place between April 2014 and March 2015. 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 has continued to maintain a high profile during this period locally, regionally and nationally, both in terms of Government initiatives and in the media. We still feel the ripple effect from the impact of Winterbourne View, Mid Staffordshire and various Care Home scandals e.g Orchard View.

2.2 The Care Act 2014, published in May 2014, set out the new statutory arrangements and responsibilities for safeguarding adults (sections 42 to 47 of the Act are specific to safeguarding adults at risk). However, the Act was not implemented until 1st April 2015 and therefore ***No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*** (DH 2000) remained in place as the framework for multi-agency working to safeguard adults at risk until 31st March 2015.

2.3 Schedule 2 of the Care Act 2014 provides specific guidance on the purpose and role of LSABs, which became mandatory under the Act (see Appendix 4). The move to putting safeguarding adults on a statutory footing is welcomed by the LSAB and the Board has given particular focus during this period to try and ensure its arrangements are fit for purpose for 2015 whilst ensuring current arrangements are robust. For this reporting period however it is important to note that ***No Secrets*** remains the framework that agencies were working within.

### 2.4 Who is a 'vulnerable adult'?

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

- 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)*

2.5 **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 unintended (for example, caused by lack of training and ignorance).

2.6 **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. The person responsible for abuse can be a paid worker, another service user, a family member, a friend, a group or a stranger. An organisation can also be responsible.

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

3.1 2014-15 was a significant year for Adult Safeguarding. The focus at both national and regional level has been on supporting organisations to prepare for the introduction of the ***Care Act 2014***, which came into effect on the 1st of April 2015. The Care Act sets out a clear framework for how local authorities and other statutory agencies should protect adults with care and support needs, who are at risk of abuse or neglect. From the 1st of April 2015 ***No Secrets*** is replaced by Chapter 14 (Safeguarding) of the Care Act Statutory Guidance. To meet the requirements of the Care Act, organisations have had to spend time this year (2014/15) making changes to both their policies and their practice, so they are compliant from the 1st of April 2015.

3.2 The Act introduces statutory duties for safeguarding. These include duties on the Local Authority to: make safeguarding enquiries or cause them to be made; to establish a Safeguarding Adults Board in their area that contains - as a minimum - representatives from the Local Authority, Clinical Commissioning Group and the police. There are also duties for the Safeguarding Adults Board which include: arranging for Safeguarding Adult Reviews (SARs) to be undertaken and publishing an annual report and strategic plan.

3.3 One of the most fundamental changes introduced by the Care Act concerns the definition of when these new safeguarding duties apply. The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect. (Care Act Section 42 (1)).

3.4 The ***Care Act Statutory Guidance*** was published in October 2014 and this also contains details of some of the areas that would constitute abuse or neglect (Care Act Guidance 14.17). Many of the areas will be familiar such as physical, financial and sexual abuse. Other areas, such as modern slavery, self-neglect and domestic violence, may not be as familiar in a safeguarding context but have been introduced for the first time. Several publications have been produced this year that support the development of good practice in these areas.

3.5 Domestic Violence: The second edition of ***Adult Safeguarding and Domestic Abuse: A guide to support practitioners and managers*** was produced by the LGA and ADASS in October 2014. Written by Ruth Ingram and Lindsey Pike, this report seeks to improve recognition and understanding of the circumstances in which adult safeguarding and domestic abuse overlap and should be considered in tandem and to contribute to the knowledge and confidence of professionals so they can offer the best support advice and options for resolution to the individuals they are working with.

3.6 Modern Slavery: On the 26th March 2015 the ***Modern Slavery Act 2015*** received Royal Assent. This Act provides provisions to: consolidate and simplify existing offences into a single act; introduce new orders to enhance the court's ability to place restrictions on individuals where this is necessary to protect people from the harm caused by modern slavery offences; create an independent anti-slavery commissioner to improve and better coordinate the response to modern slavery; and introduce a defence for victims of slavery and trafficking.

3.7 During 2014/15 Safeguarding Boards were also asked to review their awareness of Mental Health interventions and the use of restrictive care, recognising if individuals are not supported appropriately in these key areas safeguarding concerns of significant harm can arise. ***Note for adult safeguarding boards on the Mental Health Crisis Concordat*** *(*LGA and ADASS, March 2015). This note draws on the Mental Health Crisis Concordat that was published in February 2014, and recognises the important part Safeguarding Boards can play in sharing information about ways in which people in mental health crisis are proved with treatment and support. It also encourages Boards to benchmark local services against the standards published in the Concordat. The note asks Boards to recognise the link between safeguarding issues and people in a mental health crisis citing a recent analysis of 71 serious case reviews that showed a significant number concerned people in mental health crisis. Some had not received timely assessments, some had not received appropriate services and some were not recognised as carers under stress.

3.8 ***Positive and Proactive Care: reducing the need for restrictive interventions*** (Department of Health 2014). This document provides guidance for all those working in health and social care settings: commissioners of services, executive directors, frontline staff and all those who care for and support people. It was developed as concerns about the inappropriate use of restrictive interventions across health and care settings

were identified by Winterbourne View Hospital (DH 2012), Mental Health Crisis Care: Physical Restraint in Crisis in June 2013 by MIND, and the inspection of inpatient learning disability services by the Care Quality Commission (CQC). The guidance provides a framework within which adult health and social care services can develop a culture where restrictive interventions are only ever used as a last resort and only then for the shortest possible time.

3.9 The Care Quality Commission have published a number of reports this year that have provided useful information and areas of considerations for Safeguarding Adults Board. These include:

- ***Monitoring The Use Of The Mental Capacity Act Deprivation Of Liberty Safeguards in 2013/14*** *(*Care Quality Commission January 2015). This is the fifth report published by the CQC on the use of the Mental Capacity Act 2005 in provider organisations. The report states that: "it is both striking and concerning that we have seen the same themes recurring in our reports over the last five years." These themes include: a lack of recognition amongst providers of when someone was being deprived of their liberty and therefore not seeking authorisation; a wide variation in practice and training in health and social care organisations; a lack of understanding about, and awareness of, the wider Mental Capacity Act 2005 and this continues to be a barrier to good practice; providers failing to notify CQC when they apply for authorisation to deprive someone of their liberty. Since 2011, CQC have received notifications for just 37% of applications to supervisory bodies.

3.10 ***CQC Annual report and accounts 2014/15*** (released July 2015). This report contains information on the outcome of the inspections undertaken by CQC during 2014/15. The report states that across all the inspections undertaken during the year, the area/question where performance was not strong was that of "safety". Of the 2,544 Adult Social Care providers inspected during the year, 1,090 (43%) locations were rated as inadequate or requiring improvement for safety. In the Hospitals directorate, 67 out of 81 (83%) providers/locations were rated as inadequate or requiring improvement. Among GP practices, it was 173 out of 556 (31%). All settings performed best in the area/question on caring. In the Adult Social Care directorate, 2,131 of 2,539 locations were rated as outstanding or good under this question. In the Hospitals directorate, 76 of 81 providers/locations were rated as good or outstanding for caring. For GP practices, it was 539 of 556 providers.

CQC's regulatory approach is changing for 2015/16 – when following each inspection, each service will be rated: Outstanding, Good, Requires Improvement or Inadequate.

3.11 The Annual Report from the Health and Social Care Information Centre, on the ***Safeguarding Adults Return, Annual Report, England 2013/14***, (14 October 2014), also provides useful national performance information. This report details the reporting by Local Authorities of safeguarding concerns. The report states that safeguarding referrals were opened for 104,050 individuals

during the 2013/14 reporting year. 60 per cent of these individuals were female and 63 per cent were aged 65 or over. Just over half (51 per cent) of the individuals had a physical disability, frailty or sensory impairment. For referrals which concluded during the 2013/14 reporting year, there were 122,140 allegations about the type of risk. Of these, the most common type was *neglect and acts of omission,* which accounted for 30 per cent of allegations, followed by physical abuse with 27 per cent. The alleged abuse most frequently occurred in the home of the adult at risk (42 per cent of allegations) or in a care home (36 per cent of allegations). The source of risk was most commonly someone known to the alleged victim but not in a social care capacity, accounting for 49 per cent of allegations. Social care employees were the source of risk in 36 per cent of allegations and for the remaining 15 per cent the perpetrator was someone unknown to the alleged victim. These figures are based on a total of 99,190 allegations recorded for concluded referrals.

3.12 **Making Safeguarding Personal** is mentioned throughout this annual report but no examination of the national picture would be complete without an acknowledgement of the work done on the *Making Safeguarding Personal* programme by the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS). During 2014/15 more Local Authorities signed up to the programme at its various levels and the language of *Making Safeguarding Personal* echoes throughout the Care Act Guidance, ensuring that the good practice in this area continues to develop under the new legislative framework.

3.13 In concluding this section on the national picture, we return to where we began, with the Care Act 2014. The statutory guidance for the Care Act 2014 makes it clear that safeguarding is not a substitute for:

- Provider responsibilities to provide safe and high quality services
- Commissioners regularly reassuring themselves of the safety and effectiveness of the services they have commissioned
- The Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or take enforcement action
- The core duties of the police to prevent and detect crime and protect life and property

3.14 In February 2015 ADASS President David Pearson appeared on Radio 5 Live Investigates programme. In an article he later wrote (ADASS 18th March 2015) about this experience, he stated that what he took away from that programme was:

*That if we do not communicate widely about what the safeguarding system is and the responsibilities of all organisations as we implement the expectations for the Care Act, there is a strong potential for confusion about its responsibilities…it is the responsibility of all these agencies (CQC, Police, Providers and Local Authorities) to co-operate and collaborate in order to maximise the safety of all – not just in residential care, but at home, on the streets and in their communities.*

*It is clear that the very strength of good safeguarding is that it rests with many agencies and the appropriate pooling of their resources and skills can mean the sum of their focused responsibilities being far greater than their individual commitments can allow. This in turn can make it confusing for those who look for clarity and simplicity.*

*How we transfer our understanding of the web of responsibilities for safeguarding into a similar understanding shared with the wider community is a challenge we should all be considering, and applying ourselves to meeting.*

3.15 The challenges for the coming year, at both a national and local level, is to further strengthen the multi-agency approach to safeguarding and ensure that individuals and communities are better informed about all of our responsibility to safeguard adults at risk.

## Section 4: Governance and Accountability

4.1 The principles and functions of the Board have not changed since the previous report and are set out below. The Board have reviewed its Terms of Reference and these were adopted in March 2015 in time for the implementation of the Care Act on the 1st April. However during this period the above were in place:

4.2 **Principles of the Board**

4.3 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

4.4 **Functions of the Board**

4.5 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

4.6 **Structure of the Board and Sub Groups**

4.7 The Board meet on a quarterly basis to carry out its functions; in addition to this, six sub-groups work to deliver the Board's 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
- Making Safeguarding Personal

The Joint Interface Group of Local Safeguarding Children and Adults Boards has only met once during the period; however there have been other activities taking place trying to bring the work of the Boards together which are set out later in the report.

4.8 Terms of Reference for the LSAB and the sub-groups are available on the B&NES Council website.

4.9 **Membership of the Board and Sub Groups**

4.10 Members of the Board are all at a senior level within their organisation and are from the Statutory, Voluntary and Independent sectors. Healthwatch have been trying to recruit two lay members to the Board during the period. Although this has not yet been achieved. Healthwatch have provided a representative for the Board as an interim measure, to go some way to ensuring the voice of service users is heard. The Board have now agreed to recruit lay members in the same way that the Local Children Safeguarding Board does and this process will take place in the Autumn of 2015.

4.11 The nominated sub-group members are from a variety of specialisms to ensure that each group has relevant expertise in order to carry out its role. Some of the sub groups have struggled with attendance this year as agencies have noticed an increase in operational demand. Whilst the Sub Groups have managed to deliver the work programme for 2014/15 they are looking for more consistent attendance in 2015/16. This may also require different ways of approaching the work that is less time-consuming and more focused.

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

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

- **Statutory organisations** including: the Local Authority; NHS B&NES Clinical Commission Group; NHS England; Royal United Hospitals Foundation Trust; 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 – though interim position held by Healthwatch; 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); Healthwatch;

- **Education organisations**: Vacant
- **Council Cabinet member:** Cabinet Member for Wellbeing

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

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

4.15 The Safeguarding Children Board is represented through five statutory organisation members who sit on both the Children 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. During the year the Council brought together adults and children safeguarding under one team with senior manager overseeing both areas – this mirrors CCG arrangements and is hoped to strengthen joint working across the safeguarding system.

4.16 **Role of the Chair and Board members**

4.17 The LSAB is chaired by Robin Cowen. Robin has been the Independent Chair since early 2011 and is contracted for 20 days per year to deliver the following:

- Provide strong leadership and an independent, objective voice for the Board
- Promote the strategic development of the LSAB ensuring the views of service users and carers are incorporated
- Ensure the LSAB works effectively to achieve its vision, objectives, priorities and plans
- Represent the LSAB locally and nationally
- Ensure the LSAB delivers its functions and responsibilities
- Ensure that all local agencies are supported to work together to deliver high quality services that safeguard adults at risk
- Offer mediation, where required, in any dispute resolution in relation to safeguarding adults
- Ensure that any Serious Case Reviews are undertaken rigorously; are consistent with guidance; that lessons are effectively communicated; and that associated action plans are delivered.

4.17 The role of the Board Members is set out in the LSAB Terms of Reference. Each sub-group chair is a core member of the Board.

4.18 **Financial arrangements**

4.19 Each agency continues to contribute 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. B&NES Council continue to facilitate and administer the Board.

4.20 Direct financial contributions are currently made by B&NES Council; NHS Banes CCG, Avon and Somerset Police Constabulary and Avon Fire and Rescue. These contributions go towards the Independent Chairs salary, awareness raising materials and articles, stakeholder events and other meetings / workshops convened by the LSAB. B&NES Council commissions Sirona Care and Health to deliver a range of multi-agency safeguarding training to the voluntary, independent and private sectors.

4.21 **Onward reporting structures**

4.22 The Board shared its Annual Report 2013/14 and Business Plan with the Health and Wellbeing Board who approved the work being focused on.

4.23 As previously mentioned Healthwatch are now a Board member and are aware of the safeguarding work that takes place across the partner agencies. The report will be shared with Healthwatch for comment and feedback will be incorporated into next years report and the Business Plan as required.

4.24 During 2014/15 safeguarding adults data has continued to be reported quarterly to B&NES Council and monthly to the NHS Banes CCG Board. Each Board member retains their own existing lines of accountability for safeguarding and promoting the safety of adults at risk within their organisation.

## Section 5: Achievements of the LSAB during 2014/15

5.1 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 7. The majority of the work takes place within the Sub Groups however the Board itself, through the contribution of all members also completes actions in the Plan.

5.2 Achievements and Outcomes of Sub Groups are set out below, followed by other items the Board has completed.

## Policies and Procedures Sub Group – Chaired by Damaris Howard (Freeways)

**Brief Overview of Function:**
- Ensure that multi-agency policy and procedures commissioned by the Board are developed and reviewed on a regular basis
- Ensure that all multi-agency policy and procedure promotes confidentiality, dignity and effective access to safeguarding for all communities in B&NES

**Key Achievements 2014/15:**
- Completion of the protocol for **Managing Large Scale Concerns**
- Signed off the sub regional **Multi-Agency Safeguarding Adults Policy** and Care Act 2014 complaint **Multi-Agency Safeguarding Adults Procedure**
- Reviewed existing **Self Neglect Policy** which should soon be available in a draft format to trial for six months in line with Care Act changes
- Signed off the **Multi-Agency Mental Capacity Act Policy**
- Signed off the **Multi-Agency Information Sharing Principles**

**Outcomes – What difference have the achievements made?**
- With the new safeguarding policy signed up to by B&NES, Bristol, North Somerset, Somerset and South Gloucestershire there will be greater consistency in the application of adult safeguarding across the sub region for B&NES residents who access services in other areas and Provides which operate across Local Authorities

**Challenges Faced in Delivering the Agenda:**
- Ensuring policies and procedures are Care Act compliant in a short timescale
- Ensuring that policies are disseminated and link to Provider's own policies.

**Priorities for 2015/16**
- Ensure all policies and procedures are Care Act complaint (specifically the **Multi-Agency Self Neglect Protocol** and **Managing Large Scale Concerns**
- Develop a new **Safeguarding Adults Review (SAR)** to replace the Serious Care Review (Pre-Care Act 2014)
- Use the detailed review sheet of all multi-agency policy and procedures and all LSAB and sub group Terms of References to ensure that all are updated in the agreed three yearly cycle unless legislative or practice changes mean this needs to happen sooner
- Consider closing the sub group and setting up short task and finish groups going forward should a new multi-agency policy need to be written.

## Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Quality and Practice Sub Group – Chaired by Lesley Hutchinson (B&NES Council)

**Brief Overview of Function:**

- To ensure health and social care provider agencies across B&NES fully apply the Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards)
- To provide assurance to the LSAB in relation to the quality of MCA application and practice or raise concerns as appropriate

**Key Achievements 2014/15:**

- Developed a swift multi-agency response to the Cheshire West Supreme Court judgment by setting-up a task and finish group. The group quickly got the message out to all providers and identified what needed to be done across the area. The action plan to deliver this was completed
- Ensured the wider MCA remained on everyone's agenda including co-ordinating a response to Lyn Romeo's (Chief Social Worker for Adult Care in England) survey on Social Workers and MCA implementation
- Supported the introduction of Sirona's MCA workbook for care staff as an alternative to more traditional forms of training
- RUH's shared their DoLS audit report and MCA training material with partners
- Discuss various local and a draft national MCA audit tool, with a view to identifying what might work best for B&NES care and health agencies

**Outcomes – What difference have the achievements made?**

- Supported multi-agency understanding across B&NES about the implications of the Supreme Court judgement, which led to a more co-ordinated response and hence maximised our resources
- Monitored the use of advocacy services and fed finding back to the Commissioner

**Challenges Faced in Delivering the Agenda:**

- Ensuring good attendance at meetings in light of other work pressures and changes of personnel
- Not to lose focus of the wider Mental Capacity Act when there is so much attention on the Deprivation of Liberty Safeguards (both the scheme and for those in community settings)

**Priorities for 2015/16**

- Re-visit content of MCA staff training across B&NES
- Request that each represented agency undertake an MCA audit with reference to the recently published ADASS improvement tool
- Reconsider each agency's current methods of communication with the public in terms of ensuring that they know their rights under the MCA as recent research and the House of Lords MCA report have highlighted this as a particular problem.
- Continue to use the MCA Group to ensure that agencies are aware of developments in MCA case law, policy and practice

## Awareness, Engagement and Communication Sub Group – Chairs Sonia Hutchison (Carers Centre) and Karyn Yee-King (B&NES Council)

**Brief Overview of Function:**

- To ensure initiatives commissioned by the Board in relation to service user and carer engagement, involvement and feedback are developed, implemented and evaluated on a regular basis
- To develop and disseminate a range of accessible information in a variety of formats to raise awareness about adult safeguarding, targeting citizens, professionals, service users and carers
- To ensure that the LSAB partners and sub-groups are aware of the needs to promote awareness and that opportunities are taken to support the prevention of abuse

**Key Achievements 2014/15:**

- Service user fact sheets on safeguarding have been developed
- A newsletter has been developed and two editions widely distributed via email
- The first of the annual Adult Safeguarding weeks took place
- 'Keeping You Safe' questionnaire continued to be used and B&NES continued to develop Making Safeguarding Personal. The reports can be found in Appendix 8
- Publications have been sent to every household in B&NES (e.g Connect Magazine)
- Publications sent to a wide range of professionals and organisations including but not limited to, Healthwatch/Care Forum e-bulletin, Interagency e-bulletin, Bath City Conference, 6 C's exhibition at the RUH, Carers' Centre newsletter
- An LCSB representative has joined the sub-group to enable joint working
- The Chair is linked to the National Chairs' network and shares information with the Board and other agencies about safeguarding developments across the country

**Outcomes – What difference have the achievements made?**

- Service users have easy to read information on safeguarding process and purpose
- Professionals and organisation gain regular information from the newsletter
- We know from the small number of service users who have responded that we are making them feel safer
- Increased publicity, ensuring the broadest reach that it is 'everyone's business'

**Challenges Faced in Delivering the Agenda:**

- The Chair from the Carers' Centre took a six month sabbatical; however, the work was very well supported by B&NES Safeguarding Adults Team Manager.

**Priorities for 2015/16**

- Review of how to capture outcomes and service user and carer experiences
- Deliver the areas of collaboration identified by LSAB and LSCB

- Development mechanisms for getting feedback on the effectiveness of the Board
- Ensure lay members' voice is heard
- Embed induction programme for LSAB and sub group members
- Develop new LSAB website independent of the Council site
- Formalise arrangements for disseminating awareness raising information to stakeholders, community and citizens through bi annual newsletter, rolling programme of awareness raising, co-ordination of Adult Abuse week and review all multi-agency safeguarding material in line with the Care Act 2014.

## Training and Development Sub Group – Chaired by Jenny Theed (Sirona Care and Health)

**Brief Overview of Function:**
To maintain an overview of Safeguarding Adults training and development across B&NES and to ensure that high quality training is promoted across all of the organisations which work with adults at risk.

**Key Achievements during 2014/2015:**

- In November 2014, the group organised a very successful Stakeholder Event entitled *Safeguarding and the Care Act: Is it Business as Usual?*
  This Event brought together about 90 stakeholders from many different professional backgrounds and discussions were stimulated by two outstanding speakers: Julie Bailey, of *Cure the NHS,* who talked about *The Experience of Families and Friends in Mid Staffordshire Hospitals, and* Jane Lawson, Independent Consultant, who talked about *Making Safeguarding Personal and the Care Act 2014*
- The Group completed work on the second B&NES Safeguarding Training Self Audit, analysing the responses and providing a report to LSAB in November 2014 and feedback to all those stakeholders who completed the audit (a total of 27 organisations)
- The Group has discussed the implications of the Care Act 2014 and the Supreme Court Judgment regarding changes to the DoLS regime. Both these major changes need to be embedded into training for all relevant staff and this involves changes to the Competency Framework, which will be completed in 2015-16
- 196 independent /voluntary sector staff received training from Sirona Care and Health – this is broken down into 175 Level 2 course attendances and 21 Level 3 course attendances. The table below shows how this is broken down into sectors:

| SA Level | Care Homes / Nursing | AWP | RUH | Dom. Care | Vol. Sector | Indep / Other | B&NES Council | Un-known | TOTAL |
|---|---|---|---|---|---|---|---|---|---|
| **Level 2** | 74 | 1 | 2 | 17 | 64 | 8 | 2 | 7 | 175 |
| **Level 3** | 2 | 3 | 3 | 1 | 10 | 0 | 2 | 0 | 21 |
| **Total** | 76 | 4 | 5 | 18 | 74 | 8 | 4 | 7 | 196 |

**Outcomes – What difference have the achievements made?**

- The Stakeholder Event provided an opportunity for stakeholders from a wide range of organisations to learn about the lessons from events in the Mid Staffordshire Hospitals and how these can be embedded in their own organisations
- The Self Audit exercise has provided a much clearer picture of what 'good practice' in Safeguarding training looks like and a template for organisations to adopt in keeping their staff fully updated
- Significant differences in the approach to training across the agencies were identified, with smaller organisations tending to score higher than larger ones
- Many examples of excellent practice were identified and there were some particularly good examples of training being directed linked to improvements in practice.

**Challenges Faced in Delivering the Agenda:**

- Lack of attendance from partners has continued to be a cause for concern with the exception of four organisations who routinely attend to support the work programme of the group

**Priorities for 2015/16**

- To fully review and update the Competency Framework in line with the Care Act 2014 and other national developments
- To undertake a third Organisational Training Audit, widening the scope of the audit and (if possible) making it an electronic exercise
- To organise and deliver another large-scale Stakeholder Event – focusing on providers and quality of care
- To forge closer links with the LSCB Children training sub group
- To refresh the Group's Terms of Reference in line with national ADASS guidance re Care Act 2014 requirements
- To refresh the Group's Membership to ensure a wider and more consistent representation.

**Quality Assurance, Audit and Performance Management Sub Group – Chaired by Kate Purser (NHS B&NES Clinical Commissioning Group)**

**Brief Overview of Function:**

- To identify learning from the experience of safeguarding adults at risk both local and nationally, and ensure that lessons are used to inform the practice of safeguarding adults
- To develop robust mechanisms which assure the LSAB that good practice to safeguard vulnerable adults is delivered consistently by partner agencies.

**Key Achievements 2014/15:**

- The group undertook regular case note audits to help identify both good practice and areas for improvement
- All LSAB partner agencies undertook a comprehensive Self-Assessment in 2013. During the reporting period, all agencies were asked to review and update these assessments and report actions remaining back to QAAPM
- Reviewed the B&NES LSAB self-assessment tool and feedback was obtained from partner agencies on the efficacy and value of the tool. This will now be implemented.
- Reviewed the Serious Case Review (SCR) for Tinkers Lane in Wiltshire. The lessons learned were identified and used to improve the training and work of GP practices in B&NES
- The SCR for the Orchid View care home in Sussex was also reviewed by QAAPM and the Safeguarding Adults GP lead for B&NES CCG. The SCR's recommendations were considered and key learning identified for B&NES. These will be used to inform future work in QAAPM
- Looked into the source of safeguarding alerts / referrals and reported these to the LSAB for discussion about any organisation that appeared not to be reporting

**Outcomes – What difference have the achievements made?**

- They have helped partners identify areas for development in safeguarding within their organisations
- They have helped B&NES CCG identify areas to improve the knowledge and commitment of GP practices within its area
- They have led to the development of an improved self-assessment audit tool

**Challenges Faced in Delivering the Agenda:**

- This proved to be a challenging year for QAAPM due to organisational changes and capacity issues in key partner agencies. This affected the membership of the group and hence its capacity to undertake its functions in full
- It became apparent that the methodology used for the case file audits did not meet the requirements of the Data Protection Act, and led to a suspension of this function. Advice is being sought on how best to re-introduce this function.

**Priorities for 2015/16**

- To re-establish an audit framework for learning and development in relation to safeguarding cases
- To use the new Self-assessment Tool to review the current position of the partners of the LSAB and to identify areas for development in each
- To establish an framework for learning in safeguarding and establish a process for embedding and evaluating this across partners
- To continue to undertake thematic reviews of safeguarding data as directed by the LSAB and audit the embedding of the learning from them

**Making Safeguarding Personal Sub Group – Chaired by Karyn Yee-King (B&NES Council)**

- Making Safeguarding Personal is a sector led initiative supported by the Local Government Association (LGA) and ADASS. It arose in response to findings from peer challenges, consultation and engagement, which identified the need to develop an outcomes focus to safeguarding work. Making Safeguarding Personal is about engaging with people throughout their safeguarding contact to confirm the outcomes they want to achieve and at the end of the safeguarding episode checking if these outcomes were achieved.

- The approach requires everyone working in safeguarding to focus on the outcomes the individual wants to achieve rather than those the professionals believe is appropriate. It's about a change of mind-set, a willingness (sometimes) to take greater risks and about developing a culture of listening carefully to the service user and letting them, where possible, lead the way.

- In June 2014 the Board gave agreement for B&NES to participate in the Making Safeguarding Personal (MSP) initiative. Four test bed sites were established involving teams from Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and Sirona Care and Health. Each team worked with the adult at risk to ensure that their views and wishes were taken into account from the start of the safeguarding process. They also made sure that the information given and discussions held were accessible for the individual.

- To support the involvement of service users in the safeguarding process, the MSP sub group agreed that the team that received the largest number of referrals the ASIST team, Sirona Care and Health - would pilot an alteration in the procedural timescales. These changes were:

  - Strategy discussion – timescale of 5 days could be extended to a maximum of 10 working days in those cases where more time is required to gather the views and desired outcomes of the adult at risk
  - S42 Enquiry – timescale of 20 days could be extended to a maximum of 30 working days where the situation justifies it e.g. in order to complete a complex investigation.

**Sheila's story**

Sheila is 62 years old and has a mild learning disability. She lives in Extra Care accommodation. Her finances were managed by her brother who only gave Sheila £30 of her £180 benefits every week. Sheila was reported to be badly clothed and had been seen asking people for money to buy toiletries. In addition she had developed large debts.

Staff from various agencies tried unsuccessfully to resolve the matter by discussing the financial issues with Sheila's brother. Due to the concerns of possible financial abuse the situation was identified as a safeguarding matter. The safeguarding process was discussed with Sheila and she said that she wanted to take control of her own money. A mental capacity assessment confirmed that Sheila had the capacity to manage her finances with some support.

Through the safeguarding process, with agencies working together, Sheila was supported to take on the management of her finances. She opened a bank account (although it was a challenge to find a bank that would enable this to happen). Her bills are now paid on time and Sheila enjoys being able to spend her money in that way that she wants.

The police attended one of the safeguarding meetings but considered that there was insufficient evidence to charge her brother with fraud.
The safeguarding process is now finished, but Sheila's case remains open to a worker for the day to day support she needs.

- The MSP sub group monitored the use of these exceptions and found that of the 163 alerts received by the ASIST team between January and the end of March 2015.
    - 9 cases exceeded the recommended timeframes.
    - 8 cases involved the strategy discussion or meeting exceeding the 5 days
    - 1 involved a planning meeting exceeding recommended timeframe by 2 weeks
    - The maximum days exceeded for strategy discussion/meeting was 3 days i.e. strategy discussion or meeting completed on 8th day
    - All reasons provided for use of flexible timeframes cited as need to engage with service user or carer and seek their views, wishes and outcome in preparation for the strategy meeting. The delay for the 1 planning meeting was to enable the service user to attend.
    - 3 cases closed following a strategy discussion at request of service user and alternative plans put in place.

- A request has therefore being made to the Board to adjust the timescales for all safeguarding enquires to support individual involvement.

- The sub group has also requested an audit of the test bed sites and a practitioner survey. The details of these will be shared with the Safeguarding Board in September 2015.

- The importance of safeguarding being person- led and outcome focused is reinforced in the Care Act 2014. The guidance states that individuals should be engaged in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. Given the need to make each safeguarding alert person centred, the MSP sub group felt that the MSP approach now needed to move from a pilot to full compliance by April 2016. A plan is currently being developed to support the implementation, considering the training needs, information requirements and quality assurance framework.

**Harold's Story**

Harold is an 82 year old gentleman who lives alone. He has reduced mobility and uses walking aides to mobilise around the home. Harold is able to clearly express his views and wishes.

Harold's daughter was constantly telephoning and calling at her father's home requesting money and entry in the home, which was affecting Harold's emotional and physical health. He felt frightened and on his guard constantly, worrying that his daughter would turn up at the house at any time. Due to the constant requests for money Harold set up a standing order to his daughter to provide a monthly allowance.

The social worker explained the safeguarding process to Harold and he asked to attend the strategy meeting. He told the meeting that he wanted his daughter to stop coming around to the house and that he would like her to get support with benefits and her health issues. He said that he felt his health was

"…*slipping away due to stress. I feel disappointment. I feel angry and shaken"*

*"my confidence is worn down to nothing. The feeling is of wasting my time and nothing can be done. I just don't feel anything will work"*

Harold was supported to cancel the monthly allowance to his daughter. This was negotiated with Harold all the way through so that he felt he was in control of what was going to happen. He felt that stopping it immediately without any notice wouldn't be fair so settled on a date in the future and allowed the social worker to write to his daughter confirming the date the payment would stop.

Harold's daughter was provided with support with benefits and housing support.

Harold has stated that the safeguarding process has had a positive impact on him; he said that he feels someone is finally listening to him and he has made some progress with his daughter.

The involvement of Harold's neighbour and friend at every safeguarding meeting also enabled the process and as she was present to hear advice about the setting of boundaries she was able to reinforce these outside of the safeguarding meetings.

5.3 **Joint Working with the LSCB**

5.4 For a number of years there has been a joint Interface Group of the LSCB and LSAB. Both Boards have remained committed to driving this work forward however the sub group has not met during this time. The work has been progressed steadily by the Chair of the LSCB Reg Pengelly and LSAB. They have presented opportunities for collaboration to the Health and Wellbeing Board who has approved these.

5.5 During the period the Board Chairs drafted a brief report setting out the five areas for the Boards collaboration. These have either subsumed or replaced the recommendations identified in 2012 which have largely been achieved. These areas and the actions to drive them forward are set out in Appendix 3:

- Communications
- Quality Assurance and Performance
- Policy and Procedures

- Training
- Exchanging Information

5.6 The LSAB Chair has continued to lobby for a Business Support Manager post in line with the LSCB; the post was agreed in principle by the LSAB and funding has been identified with contributions from the Local Authority, Police and CCG. The post will be recruited to in 2015, it will be a joint LSCB / LSAB Business Support Manager role facilitating the joint working opportunities.

5.7 As stated in the Chairs Foreword; Robin Cowen has stood down as the LSAB Chair following four years of service. This is a loss for the LSAB but has enabled it to take the opportunity to create a shared Chair across both Boards. This was one of the recommendations from 2012 by both Boards. Following a selection process the LSCB Chair, Reg Pengelly has been appointed as LSAB Chair and he will take over from Robin Cowen in June 2015.

5.8 In addition to the above changes to support joint working across both Boards the Council has also restructured its arrangements to safeguard children and adults and has brought these under one Head of Service in the People and Communities Department. The Board viewed this on balance as a positive move and welcomed the move towards advancing joint working.

5.9 **Additional Work Carried Out by the LSAB during 2014/15**

5.10 In addition to the work of the sub groups the LSAB has progressed a significant amount of other work during the period:

- The **Serious Case Review** Multi-agency and Single-agency action plans from the previous year have been signed off by the Chair. A report was received regarding the gap analysis into agencies awareness of domestic abuse and the Multi-Agency Risk Assessment Conference (MARAC) process was completed and presented to the LSCB and LSAB. The work on the information sharing arrangements has been assumed within **the Multi-agency Information Sharing Hub Board's (MISH)** work programme and the regional MAPPA coordinator gave a presentation to raise awareness on MAPPA to approximately 50 stakeholders
- The **MISH Board** was formally established in January 2015 following LSAB approval of the commissioned independent report written by Deborah Klee. Terms of Reference have been agreed which dovetail with the overarching Programme Board which Avon and Somerset Police Constabulary lead. Funding has been identified for a Project Lead (0.4FTE) and recruitment will take place in early May 2015. The LSAB agreed that the scope of the local MISH will include adult and children's safeguarding and domestic abuse
- The Board has continued to receive reports on progress of arrangements for safeguarding children / young people in **transitions** however further assurance is required before this can be signed off
- The LSAB held the CCG and Council Commissioners to account and discussed the **assurance mechanisms** that are in place – the Board were satisfied by these arrangements however more is required from NHS England in terms of assurance for safeguarding in their areas of responsibilities.

- The CCG gave an update on the **Quality Surveillance Group** and link to LSAB which Board members found useful and further update reports were requested
- An introduction on the **Crisis Concordat** was provided and the LSAB wanted to understand its role in relation to this and what activity / assurance could be provided in relation to this. It has therefore requested this remain on the agenda and ADASS have encouraged this and provided a checklist for LSABs to consider which it will do in 2015/16 Members considered in detail the impact of the MCA / DoLS **Supreme Court Judgment *P v Cheshire West and Chester Council and another P and Q v Surrey County Council*** which was laid down in March 2014. There are significant implications for providers and potential safeguarding concerns which the Board understood and required updates from all agencies on regarding their response to this and the mitigation to the risks associated with the impacts
- The Board have a draft **Risk Register** now in place which will be finalised in 2015/16, this was developed and led by Avon Fire and Rescue Service
- In addition the Board has reviewed its Business Plan and at the end of the period signed off the 2014/15 plan. During a business development session in February the priorities for the 2015/18 plan were agreed
- As well as signing off specific policies and procedures in order to be Care Act 2014 compliant (including revising the LSAB **Terms of Reference**), the Board considered the impact of the Care Act and changes on the LSAB in order to prepare itself and had discussions about the new **Designated Safeguarding Adult Manager** role which it awaits confirmation from the Department of Health on the actual scope of
- Following feedback from the November stakeholder event the Board now start each meeting with a safeguarding **case study**, the first one was presented in March 2015 by the Learning Disability Service in Sirona Care and Health. The Board will continue with case studies at the beginning of each meeting as it enables the service users voice to consistently be front of mind
- The Board **Performance Indicators** for 2015/16 were approved and each agency report in Appendix 5 demonstrates how partners have performed against the 2014/15 indicators
- A proposal for **appraising the Chair** was also approved and will be implemented for 2015/16
- The Board have continued to receive updates from the work being undertaken by the LSCB and received a copy of the LSCB Annual Report and Work Programme
- The Board has continued to receive routine updates and information from the LSAB Chairs network via the Chair

- Finally the **Local Government Association** undertook a **Peer Review** in March 2015. The scope of the review was twofold it included looking at the following themes which are common to all safeguarding Peer Reviews:

    - Outcomes for and experiences of people who use services
    - Leadership, Strategy and Commissioning

- Service delivery and effective practice, performance and resource management
- Working together – the Safeguarding Adults Board

and also included the specific key questions B&NES wanted a view on:

- Is it clear and understood by all where safeguarding adults' accountability sits?
- How do the individuals/bodies/organisations with accountability for safeguarding adults get assurance and provide upwards assurance?
- Are assurance mechanisms and processes robust, providing genuine *assurance* rather than reassurance?
- Is the system/arrangement future proofed in terms of the Care Act 2014

The headline messages from the review were as follows:

> *'Bath & North East Somerset Council and the Clinical Commissioning Group (CCG) have shown real system leadership in the way integration has been progressed over a period of four years. The development of Sirona as a community interest company providing a wide range of publicly-funded care and support services, including community healthcare, children's healthcare, public health services and adult social care services and generic social work, put you ahead of the curve A strong focus has been maintained on assurance and development of robust processes to support this.*
>
> *All of the partners, managers and staff the Peer Review Team met are clearly committed and enthusiastic to 'get things right' in relation to adult safeguarding, thus providing an opportunity to progress integration at all levels - and with some pace.*
>
> *There is a real importance to ensure the safeguarding prevention and early intervention narrative is 'live' for citizens and practitioners. This would include being clear for those trying to implement it what is understood by 'prevention and early intervention' within the context of your aim to empower people to remain in control of their own lives. Making Safeguarding Personal is starting to offer solutions that will be evaluated to help in understanding the effectiveness of interventions, complement your renewed focus on outcomes and provide a platform for best practice sharing.' (p2 LGA Review Report)*

The Report identified areas of strength in each of the headings and similarly areas for consideration. Overall it was a very positive report and was a tribute to the Boards effective working relationships and assurance mechanisms. There were four areas identified for final consideration:

- Progress at pace the implementation of Making Safeguarding Personal (MSP)

- The Quality Assurance, Audit and Performance Management Sub Group – in line with MSP, could develop more qualitative ways of auditing safeguarding
- Revise the 2 day decision rule in relation to MSP
- Consider how you reaffirm the citizen at the centre of everything you do

The Board have approved an action plan which it considered in June 2015 which addresses each area. Progress against this will be reported in next year's Annual Report.

5.11 **Other Work in Relation to Safeguarding Adults**

- The Council continue to undertake the required Annual Social Care Survey as part of the requirement for the Department of Health in accordance with the ***Adult social care outcomes framework, a subset of Health and social care outcomes frameworks*** and ***Compassionate care in the NHS.***

  In 2014/15 965 people were surveyed and 403 (41.8% responded) this is a slight decrease on last year when 43.5% responded. The results are as follows:

| ASCOF indicator | 2011-12 | 2012-13 | 2013-14 | 2014-15 |
|---|---|---|---|---|
| Proportion of people who use services who feel safe | 68.3 | 65.1 | 70 | 72 |
| Proportion of people who use services who say that those services have made them feel safe and secure | 75.2 | 78.5 | 82 | 85 |

  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 2014/15.

  In 2015/16 a new indicator is being added – the **proportion of completed safeguarding enquiries where people report that they feel safe**. This will be reported on next year and will help demonstrate how effective people believe the safeguarding procedure has been.

- B&NES Council, NHS Banes and the Care Quality Commission have continued to work closely together. The bi monthly meeting has continued and information from inspection and reviews of regulated / commissioned services has been triangulated. This alongside information on safeguarding referrals, complaints to the Council, Serious Untoward Incident reporting and complaints to NHS Banes and whistleblowing to each agency has proved useful to ensure safe, quality services are being provided. The meetings prove useful and helped the early identification of concerns to help prevent abuse from occurring or potentially escalating.

There are 59 care homes in B&NES providing support to people with a range of health and social care needs. There are 15 care homes providing in total 122 beds for people with a learning disability (although not all these places will be taken), with the remaining 44 providing in total 1,487 beds for people with physical and sensory needs, dementia; and mental health needs (although again, not all these places will be taken). The size of the care homes range from the very small (three bedded) to the very large (102).

**Table 1: Summary of CQC Inspections and Council Restrictions**

| | **Nursing homes** | **%** | **Residential homes** | **%** | **Learning Disability /other homes** | **%** |
|---|---|---|---|---|---|---|
| **CQC** | Good | 62 | Good | 75 | Good | 88 |
| | Requires improvement | 38 | Requires improvement | 20 | Requires improvement | 12 |
| | Inadequate | 0 | Inadequate | 5 | Inadequate | 0 |
| **Council** | No restrictions | 57 | No restrictions | 75 | No restrictions | 100 |
| | Place with caution | 24 | Place with caution | 15 | Place with caution | 0 |
| | Embargo | 19 | Embargo | 10 | Embargo | 0 |

The Care Homes work closely with the Council, CCG and CQC to ensure action plans are developed and complied with to improve practice and remove any place with caution or embargo that has been either voluntarily agreed or imposed. The LSAB have asked for annual reports on the above information and have requested analysis on other registered settings from the Council, CCG and CQC.

- Activities to maximise joint working continue to be prioritised with **Community Safety** partners through the **Responsible Authorities Group** (RAG) and its sub groups for example:

  - In March 2014 the RAG made a successful bid was made to the NHS Banes CCG for funds to develop a Domestic Violence and Abuse (DVA) training strategy and delivery plan co-ordinating all partnership DVA training within the B&NES area or training that includes a DVA element. This work will provide quality standards to manage all DVA training and build on the findings of MARAC Gap Analysis 2014 commissioned by LSAB, NHS Banes CCG and Avon and Somerset Police Constabulary

  - The Independent Domestic Violence and Abuse (IDVA) provider (Southside) had provided ad hoc IDVA services in the emergency department at the Royal United Hospital (RUH). The pilot to provide a

more integrated IDVA service at the RUH is now fully operational. This is demonstrating the need through the positive impact on staff confidence in dealing with victims of DVA, also using the skills of the IDVA to engage with victims who might previously have not even been recognised as such. The RUH is now, through the IDVA, fully integrated within the MARAC risk assessment and management process

- The 2014 review of DVA verified that the MARAC process and support for high risk victims works well in B&NES and that there is a clear pathway for these victims, however the same could not be said for low and medium risk victims. The IDVA service now based at the Lighthouse (Avon and Somerset Police Constabulary service), ensures that more survivors of abuse get a timely service. It has seen an increase in the number of DVA victims that are assessed as potentially high risk or even medium risk but in need of early support from an IDVA. The RAG prioritised a portion of the community safety fund to extend the IDVA service to make provision for low and medium risk victims. In quarter 1 of 2014/15 102 new referrals were made to this service

- A great deal of time and support has been dedicated to developing the buddy scheme at Southside as a response to the call from victims for more avenues of support but also survivors who want to 'give something back'. The buddies will each support an IDVA in supporting individual victims, including young victims of DVA, where this intervention is appropriate

- Investment was made in the Identification to Referral and Improved Safety programme (IRIS). IRIS is the GP referral project supporting B&NES Council's commitment to extend the IDVA Service to low and medium risk victims and bring primary care into the pathway of services. The core team to deliver IRIS GP referral scheme have been recruited and trained and work is underway to provide bespoke locally specific and relevant IRIS training for GPs and GP practices

- The Community Safety Fund also provided Somerset and Avon Rape and Sexual Assault Service (SARSAS) core funding in B&NES. The Council has also facilitated links with external funders and business support to enable SARSAS to be established on a more sustainable footing

- Stand Against Racism and Inequality service (SARI) has been commissioned to provide a service to enhance the core Avon and Somerset Police and Crime Commissioner funded race hate crime service to include all victims of hate crime

- Finally, the Prevent Steering Group has continued to meet during the year however with the new enhanced duties the steering group will be reviewed in early 2015/16 to ensure new arrangements are put in place as required. This will be reported on in 2015/16 report.

## Section 6: Analysis of Safeguarding Case Activity 2014/15

6.1 In October 2014 the Health and Social Care Information Centre (HSCIC) published ***Safeguarding Adults Return Annual Report, England 2013-14 Experimental Statistics*** (SAR 2014) 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, however it is important to note that this replaces the previous reporting mechanism Abuse of Vulnerable Adults (AVA), consequently we need to be mindful that some of the data collection is different. The Centre have published the following in relation to this on their website:

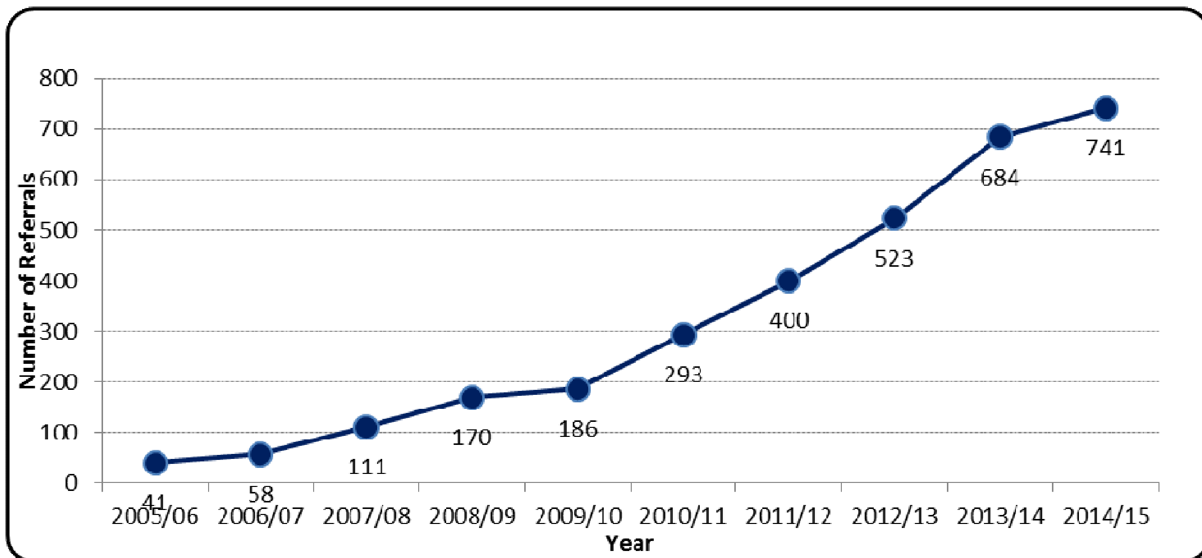
> *It covers the same subject area as the AVA return but is much smaller in size and there are no directly comparable data items. Alerts and action types are no longer collected and demographics are recorded based on counts of individuals rather than referrals.*

This report has used the information provided in the SAR return for 2013/14 to provide useful comparators where it can however the reduction in data items collected – AVA collected 2070 items and the SAR collects 137 should be noted. It is also data that is one year older than the reporting period. Regarding data collection we have continued to collect additional information which we considered important for assurance purposes and this will be used in the report.

6.2 During the reporting period 2014/15 B&NES received 741new alerts. In addition to these there were also 97 service users who had been referred during the previous year, but whom were still being supported through the safeguarding process at the start of April 2014. At the end of March 2015, 131 cases remained open and 707 had been closed (on 31st March 2014, 664 cases were closed; by March 2015 we see an increase of 6% of closed cases).

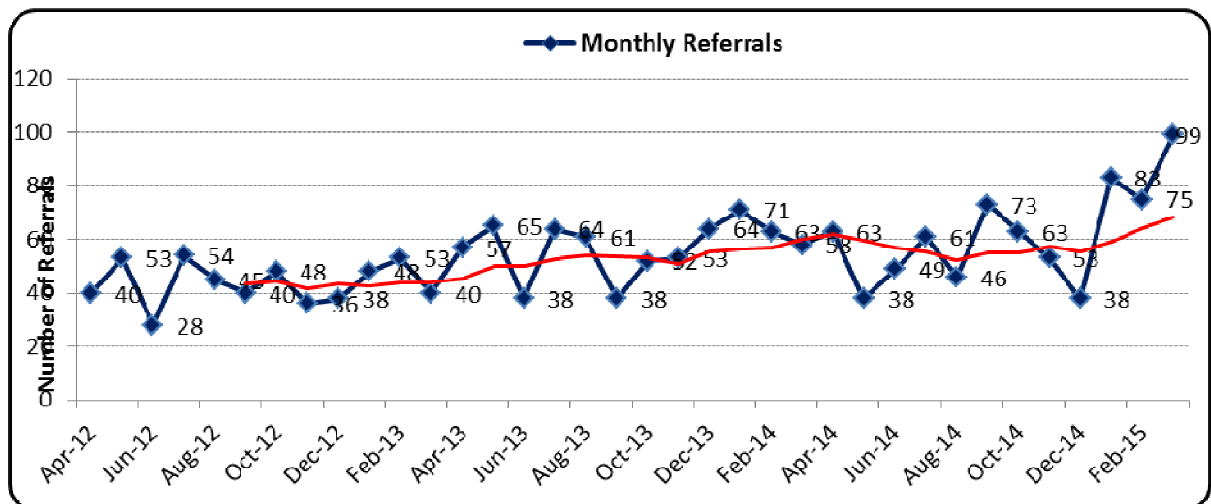
6.3 There was an 8% increase in the number of alerts received from 2013/14 to 2014/15. Whilst recognising that the level of alerts continues to increase, it should be noted that the level of increase in referrals appears to have slowed in comparison with the previous two years when the referral level had increased by 31%. The Chart below shows the rise in alerts from 2005/6 to 2014/15 for B&NES.

6.4 **Chart 1: Number of Safeguarding Alerts 2005/6-2014/15**




6.5 The chart below shows the number of alerts from April 2012- March 2015 by month. The monthly average was 61 alerts. There was a significant drop in the number of alerts received in May and December 2014 , with 38 alerts in both months, whilst March 2015 saw the highest level of alerts – 99. The reason for the spike remains unclear but it may relate to the extra publicity and training which took place in the weeks leading up to the implementation of the Care Act 2014.

6.6 **Chart 2: Monthly Safeguarding Alerts from April 2012/15**




6.7 As the HSCIC no longer collect information on the number of alerts which met the safeguarding referral threshold it isn't possible to compare B&NES performance with other areas. Historically HSCIC have reported that 50% of the alerts reported nationally met the safeguarding threshold and led into the safeguarding process. (HSCIC 2013) In B&NES for 14/15 49% met the threshold. Sirona Care and Health and B&NES Council have continued to work closely on threshold decision making and we have seen further

alignment with a further reduction in threshold challenges made by the Council through the case audits.

6.8 During 2013/14 nationally there were 104,050 safeguarding referrals opened (5% reduction on the previous year). Referrals for the purposes of the HSCIC are those 'where a concern is raised about a risk of abuse and this instigates an investigation under the safeguarding process.' (SAR 2014 p11). In B&NES in 2013/14 there were 389 referrals that met this definition and progressed into the strategy stage. In 2014/15 this had decreased to 378 – this is the first time a decrease has been reported.

6.9 During 2014/15, a total of 64 service users known to Sirona Care and Health were subject to more than one safeguarding referral. The Sirona Safeguarding Adults lead is currently analysing the reasons for these referrals but the principal reasons seem to be:

- Duplicate referrals (ie several referrals about the same incident on or around the same time)
- Repeated episodes of 'service user to service user' abuse – e.g a person with dementia or adult with a learning disability 'hitting out' at another resident in a care home on more than one occasion
- Service users choosing to live a lifestyle which professionals regard as 'risky' and which leaves them more vulnerable to abuse from 'friends' or family members.

Whilst no abuse is acceptable, and all reports are fully investigated, many of the incidents reported were minor and there is no evidence that any of the initial referrals were poorly managed. However, it is always important to learn lessons from such cases in order to minimise the number of people who are subject to abuse or neglect on more than one occasion. A full report is being submitted to the Quality Assurance, Audit and Performance Management Sub Group in December 2015.

6.10 **Table 2:** below sets out the **Safeguarding Alert by Gender and Age**

| No. of Alerts by Gender | | | | No. of Alerts by Age | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 18-64 | | | 65+ | | |
| | 12/13 | 13/14 | **14/15** | 12/13 | 13/14 | **14/15** | 12/13 | 13/14 | **14/15** |
| Male | 192 (36.2%) | 263 (38.4) | **258 (34.8%)** | 107 (20.5%) | 126 (18.4%) | **109 (14.7%)** | 83 (15.9%) | 137 (20%) | **149 (20.1%)** |
| Female | 331 (63.1%) | 421 (61.5%) | **483 (65.1%)** | 123 (23.6%) | 137 (20%) | **144 (19.4%)** | 208 (39.9%) | 284 (41.5) | **339 (45.7%)** |
| **Total** | 523 | 684 | **741** | 230 (44.1%) | 263 (38.4%) | **253 (34.1%)** | 291 (55.9%) | 421 (61.5%) | **488 (65.8%)** |

6.11 The age breakdown by gender is largely similar to previous years though there is a further decrease this year on the number of younger (18-64 years) (10% over the previous two years) adults' referrals and an increase in 65+

age. Nationally 63% of referrals are for adults 65+ and 37% for 18-64 year old, which is similar to the B&NES figures. The percentage of females to males has risen again in the local reporting and is higher than the national picture which shows the number of female referrals at 60% and the number of males at 40%. (SAR 2014, p12)

6.12 The ethnic breakdown of service users at point of alert is as follows: 95% were White British; 1% were Asian/Black/African/Caribbean British and 2% are from other ethnic groups. 1% declined to provide information on their ethnicity. This compares the local census data which shows the population is 90% White British, 3% Asian/Black/African/Caribbean British and 7% from other ethnic groups. The SAR 2014 national data reports 85% of referrals were accounted for as White; 6% were Asian/Asian British and Black/Caribbean/African/Black British, 1% are from other Ethnic groups and 6% were recorded as unknown. (p13). These figures are largely consistent with previous reports from HSCIC. The LSAB has asked the Engagement, Awareness and Communications Sub Group to meet with a range of Black and other Minority Ethnic community groups to ensure people are aware of the support that can be provided.

6.13 Table 2 below shows the break down by service user group for 2012 to 2015. It shows that the proportion of alerts for each service user group has remained relatively consistent with the previous two years, with adults with a physical disability receiving the most alerts. For the first time we have received more alerts from adults with mental illness (by 1%) than adults with a learning disability. At a national level the reporting indicates that adults with a physical disability are the subject of the most referrals at 51% (same as the previous year), adults with a mental illness are the subject of the second highest number of referrals (24%) and learning disability (18%). (p16 SAR 2014)

6.14 **Table 3: Number of Alerts by Service User Group 2012-15**

| Service User Group | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| **Physical Disability** | 289 (55%) | 397 (60%) | 433 (58%) |
| **Mental Health** | 96 (18%) | 111 (17%) | 139 (19%) |
| **Vulnerable People** | 8 (0.2%) | 22 (3%) | 23 (3%) |
| **Learning Disability** | 117 (23%) | 124 (19%) | 133 (18%) |
| **Substance Misuse** | 2 (0%) | 5 (0.8%) | 5 (1%) |
| **Adult Carer** | 2 (0%) | 5 (0.8%) | 8 (1%) |
| **Total** | **523** | **664**[1] | **741** |

6.15 The proportion of alerts by service user group has remained largely consistent over the last three years. There has been a steady reduction in the proportion of learning disabled service users being safeguarded in 2013/14 and 2014/15.

6.16 707 cases were closed during the period – this accounts for 84% of the total number of cases that were supported (741 new alerts and 97 open from the

[1] At the time of the 2013/14 report there were 20 cases with missing data on the abuse type because the case had only recently opened.

previous year). The number of cases that were open on the 31st March 2015 was 131, a 26% increase on last year. This is accounted for by the fact that there was the highest number of alerts in January, February and March 2015 – 83, 75 and 99 respectively.

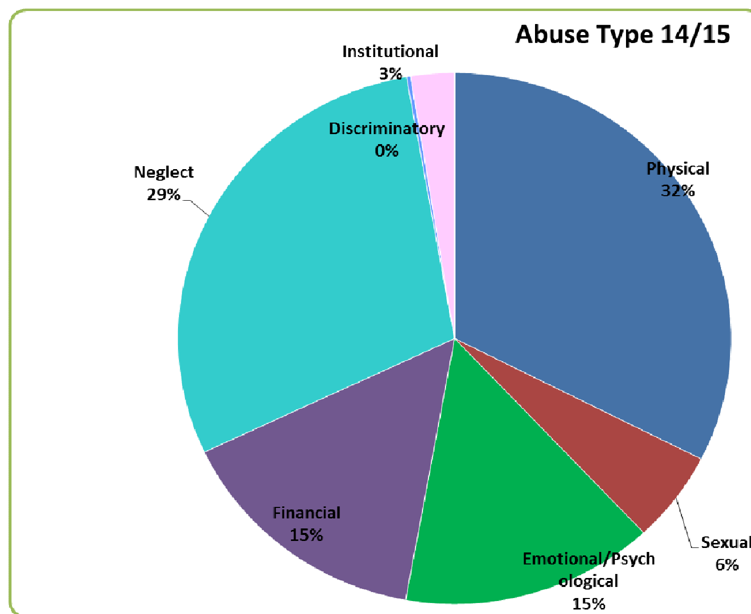
6.17 80.5% of the safeguarding referrals were for service users known to the Council. This is for the first time higher than the national average of 72.5%. This figure is higher than B&NES has historically reported, this is likely to be because we are now reporting on those who meet the safeguarding threshold rather than all those cases alerted which were previously reported. That said, the Board will review the information provided to self funders regarding safeguarding in light of this. 11% of cases were people not known to the Council with physical support needs. With reference specifically to adults with dementia, 33% were previously unknown to the Council. This is higher than the national figure of 21%. (p17 SAR 2014)

6.18 **Table 4: Percentage of Referrals by Abuse Types**

The following table sets out the 'primary referral type' although it should be noted that some service users will experience abuse of more than one type.

| Abuse Type | HSCIC National 2013/14 | B&NES 2012/13 | B&NES 2013/14 | B&NES 2014/15 |
|---|---|---|---|---|
| Physical | **27%** | 33% | 30% | **32%** |
| Emotional | **15%** | 18% | 14% | **15%** |
| Financial | **18%** | 15% | 19% | **15%** |
| Neglect | **30%** | 20% | 28% | **29%** |
| Sexual | **5%** | 10% | 7% | **6%** |
| Institutional | **4%** | 3% | 1% | **3%** |
| Discriminatory | **1%** | 1% | 0.5% | **0** |

6.19 **Chart 3: Abuse Type as Percentage of Safeguarding Referrals 2014/15**

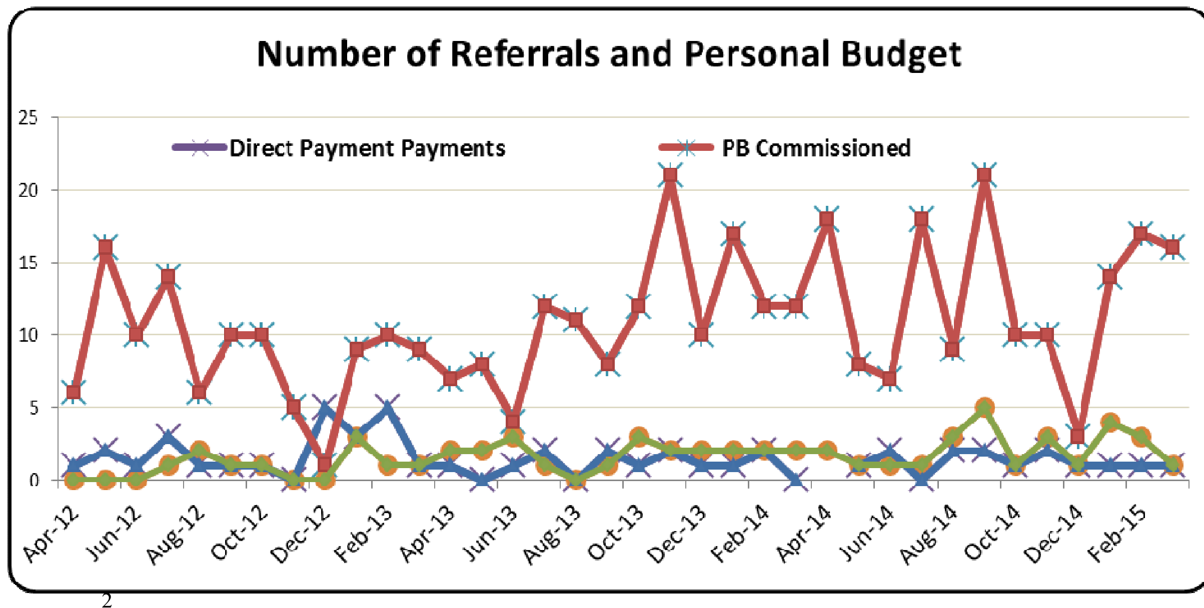



6.20 In comparison to national figures the percentage split of abuse type is broadly similar, with physical abuse being slightly higher but this difference is not sufficient to be a concern for the LSAB.

6.21 B&NES saw an increase of 4% in the number of alerts that are alleged to have taken place in the service user's own home (42% to 46%). The national figure for 2013/14 is 42%, the same as the B&NES figure for that period. The percentages of cases that are alleged to have taken place in care homes (residential and nursing) is 35% for B&NES and 36% nationally for 2013/14 (B&NES reported 39% for 2013/14 period). Nationally 6% of cases are reported to have taken place in hospital settings; B&NES are also reporting 6% for 2014/15. (SAR 2014, p21)

6.22 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 known as a Personal Budget (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 thirdly a PB 'mixed package', which is a combination of the two above. 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.

6.23 **Chart 4: Number of Alerts and Type of Personal Budget**



[2]

6.24 Analysis of the service user's mental capacity has also been included for the first time in this report. The table below sets out the percentage of those at risk who lack capacity and, of those the percentage that received support. In comparison to the SAR 2014 (p27), B&NES reported 25% of service users lacked capacity whereas nationally the figure is 28%. 53% of individuals had capacity where as nationally that figure was 9% lower at 44%. Unknown cases locally are shown as 21% where as nationally the figure is higher at 29%. In terms of the number of service users who received support when they lacked capacity – in all age ranges the percentage is significantly higher than the national picture with on average 49% of individuals identified as lacking capacity provided with support where as in B&NES the average is 73% - support in this context is provided by an advocate, family or friends. (SAR 2014 p29)

6.25 **Table 5: Percentage of those at Risk Lacking Capacity and Receiving Support**

| | Percentage of Concluded Referrals | | | | | Total |
|---|---|---|---|---|---|---|
| **Was the individual lacking capacity** | **18-64** | **65-74** | **75-84** | **85-94** | **95+** | |
| **Yes** | 7% | 1% | 5% | 11% | 1% | **25%** |
| **No** | 25% | 6% | 9% | 11% | 2% | **53%** |
| **Don't know** | 7% | 3% | 6% | 4% | 1% | **21%** |
| **Of those recorded yes how many were provided with support** | 57% | 100% | 74% | 79% | 100% | |

[2] The green line is the number of mixed packages

6.26 **Table 6: Source of Risk 2014/15**

| | Source of risk | | |
|---|---|---|---|
| **Type of risk** | **Social Care Support (paid, contracted or commissioned)** | **Other - Known to Individual** | **Other - Unknown to Individual** |
| **Physical** | 10% | 17% | 3% |
| **Sexual** | 1% | 5% | 0 (0.2%) |
| **Psychological and Emotional** | 6% | 11% | 2% |
| **Financial and Material** | 3% | 11% | 2% |
| **Neglect and Omission** | 18% | 8% | 1% |
| **Discriminatory** | 0 | 0 | 0 (0.2%) |
| **Institutional** | 1% | 0 | 0 |
| **Total** | **39%** | **52%** | **8%** |

6.27 The above table sets out a breakdown by percentage of all closed cases by source of risk and abuse type. Other known to the individual includes for example, other adults in need of care and support; family members and neighbours / friends. The percentage distribution of type of risk by source is outlined in the national SAR 2014 return. The B&NES figures are broadly similar with 35% showing social care as source of risk, 49% other known to the individual but 16% being unknown. Nationally the majority of institutional abuse and neglect cases were alleged to be carried out by social care workers. This is also reflected locally.

6.28 16% of concerns were regarding domiciliary care staff working in people own homes however of these only 15% were substantiated or partly substantiated mainly regarding neglectful behaviour (2% of total). 13% were concerns regarding primary health, secondary health or health care workers of which the majority were alleged to have taken place in hospital settings with a quarter being substantiated or partly substantiated.

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

| Year | % of total cases Police involved in |
|---|---|
| **2014/15** | **38%** |
| 2013/14 | 38% |
| 2012/13 | 27% |

6.30 Avon and Somerset Police are for the second year reported to have been involved in 38% of cases[3].

6.31 The following outcomes were recorded for the 49% cases that were accepted as safeguarding referrals. In the table they are shown in comparison with national data and with local information from previous years.

6.32 **Table 8: SAR 2013/14 and B&NES Comparator Data on the Outcome of Closed Safeguarding Referrals**

| Outcome | SAR data 2013/14 | B&NES 2012/13 | B&NES 2013/14 | B&NES 2014/15 |
|---|---|---|---|---|
| Substantiated | **32%** | 33% | 33% | **33%** |
| Partly substantiated | **11%** | 16% | 17% | **9%** |
| Inconclusive | **22%** | 14% | 14% | **15%** |
| Not substantiated | **31%** | 38% | 32% | **37%** |
| Investigation ceased at individuals request | **3%** | N/A | 4% | **5%** |

6.33 The source of risk shows that the majority of cases which were substantiated were from someone known to the individual. These figures are broadly similar to the national picture reported in the SAR 2014 return as demonstrated in Table 7 above.

6.34 **Table 9: Source of Risk and Case Conclusion**

| | Source of risk | | |
|---|---|---|---|
| **Conclusion** | **Social Care Support** | **Other - Known to Individual** | **Other - Unknown to Individual** |
| **Fully Substantiated** | 11% | 18% | 4% |
| **Partially Substantiated** | 4% | 4% | 1% |
| **Inconclusive** | 6% | 7% | 2% |
| **Not Substantiated** | 19% | 16% | 3% |
| **Investigation Ceased** | 1% | 4% | 0 |

6.35 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:

[3] This figure is from the number of cases that are recorded as either stating yes or no to police involvement and does not include those which were left blank (409 cases)

- 15% of cases action was taken and risk removed (22% national figure)
- 34% of cases action was taken and risk was reduced (35% national figure)
- 7% of cases action was taken and risk remains (8% national figure)
- 44% of cases no action was taken (36% national figure)

6.36 The following outcomes have been recorded for survivors of abuse: 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. In 4% of cases a referral was also made to children social care and, in 3% of cases a child protection plan was in place as well.

6.37 The table on the next page describes the stage within the safeguarding procedure at which the case was terminated and the conclusion of the termination/closure.

6.38 **Table 10: Outcome at Procedural Stage by Terminated Cases from Referral 2014/15**

| Termination Stage | Investig-ation Ceased at Persons Request | Inconc-lusive | Not Substan - tiated | Partly Substan -tiated | Substan -tiated | Total of all stages |
|---|---|---|---|---|---|---|
| **Strategy** | 9 | 13 | 47 | 7 | 21 | 28% (97) |
| **Assessment** | 3 | 6 | 12 | 1 | 6 | 8% (28) |
| **Planning** | 6 | 20 | 39 | 13 | 32 | 32% (110) |
| **Review** | 1 | 14 | 29 | 11 | 55 | 32% (110) |
| **Total of all outcomes** | 5% (19) | 15% (53) | 37% (127) | 9% (32) | 33% (114) | |

6.39 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 as well. 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 resourcing in the Sirona Care and Health and AWP social work teams. It is important to note that in July 2014 Sirona Care and Health restructured their services and have put in place a new Advice, Support, Information and Safeguarding Team (ASIST). This team are responsible for deciding the threshold for all safeguarding concerns and operate as a 'duty service' for all cases with the exception of concerns regarding adults with a learning disability, those known to mental health services and those who the risk is identified in a hospital setting. ASIST and the Council Safeguarding Chairs have developed a good working relationship and routinely discuss how best to respond to

safeguarding issues. The introduction of ASIST has also demonstrated a reduction in the number of cases where the strategy meeting / discussion takes more than 8 days, which is reassuring.

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

| Indicator | Target | % Completed on time from April 14 – Mar 15 | | RAG | Direction of travel from last year |
|---|---|---|---|---|---|
| 1.<br>% of decisions made in 48 working hours from the time of referral | 95% | Sirona C&H | 97%<br>608/624 | | ↔ |
| | | AWP | 98%<br>118/121 | | ↑ |
| | | **Combined** | **97%<br>726/745** | | ↔ |
| 2a.<br>% of strategy meetings/discussions held within 5 working days from date of referral | 90% | Sirona C&H | 93%<br>277/299 | | ↑ |
| | | AWP | 87%<br>69/79 | | ↓ |
| | | **Combined** | **92%<br>346/378** | | ↑ |
| 2b.<br>% of strategy meetings/discussions held with 8 working days from date of referral | 100% | Sirona C&H | 98%<br>293/299 | | ↑ |
| | | AWP | 99%<br>78/79 | | ↔ |
| | | **Combined** | **98%<br>371/378** | | ↑ |
| 3.<br>% of overall activities/ events to timescale | 90% | Sirona C&H | 89%<br>1257/1415 | | ↑ |
| | | AWP | 91%<br>300/329 | | ↑ |
| | | **Combined** | **89%<br>1577/1744** | | ↑ |

6.41 It is important to note that, although the number of concerns has increased, the number that progress through the procedures has decreased as fewer concerns reached the safeguarding threshold. The number of Mental Health cases that progressed to strategy decreased by three on the previous year and Sirona Care and Health cases by eight. This is the first year that cases progressing to strategy and beyond has fallen.

## Section 7 Priorities for 2015/16

7.1 The LSAB met in February 2015 to review the 2012-2015 Business Plan and formulate the next three years plan. The Board agreed to merge the five key areas of focus and reduce these to three. The Board also identified the outcomes it seeks to achieve, these are set out below:

| **Key Priority 1** |
| --- |
| Multi – Agency Responsibility and Accountability |
| **Outcomes** |
| • Core duties in relation to the Care Act 2014 are delivered; quality and outcome of this work is evidenced; service user and carer perspectives influence change in practice; MCA is embedded<br>• Service users and carers are at the centre - Making Safeguarding Personal is embedded in practice<br>• Service users and carers who are self neglecting are supported appropriately<br>• The LSAB understand and are able to effectively respond to domestic abuse, radicalisation, modern slavery, self neglect, adult sexual exploitation<br>• Think Family, become more effective and efficient (continue to develop collaboration with LSCB to improve practice, share learning and reduced duplication of work)<br>• Improved understanding of the consequences and impact on social care and health services caused by the increase in safeguarding cases (links to key priority 3)<br>• Be forward thinking, predicting and responding to safeguarding issues<br>• Development mechanisms for getting feedback on the effectiveness of the Board |
| **Key Priority 2** |
| Prevention and Early Intervention |
| **Outcomes** |
| • The LSAB are assured the stakeholders, community and citizens are aware safeguarding adults is everybody's business<br>• Prevention and early intervention responses are embedded to reduce and remove the risk and impact of abuse<br>• Improved information sharing arrangements to reduce and prevent harm |
| **Key Priority 3** |
| Responding to and learning from abuse and neglect |

| Outcomes |
| --- |
| • Service users and carers are at the centre - Making Safeguarding Personal is embedded in practice<br>• Service users and carers who are self neglecting are supported appropriately<br>• The LSAB understand and are able to effectively respond to domestic abuse, radicalisation, modern slavery, self neglect, adult sexual exploitation<br>• Ensure learning is effective and embedded from SARs<br>• Core duties in relation to the Care Act 2014 are delivered; quality and outcome of this work is evidenced; service user and carer perspectives influence change in practice; MCA is embedded – see also actions in Key priority 1<br>• Ensuring effective and timely responses to themes / issues in a dynamic way |

7.2 The Plan is updated and presented at each Board meeting to ensure the actions are being progressed. New actions are added as required and the Local Government Association recommendations from the Peer Review have also been added. The Plan references some of the opportunities for closer collaborative work with the LSCB (as set out in Appendix 3) however further work is needed on this during the life of the LSCB and LSAB Plans.

7.3 The Business Plan can be found on the link below:

http://www.bathnes.gov.uk/sites/default/files/siteimages/attachment_4_lsab_business_plan_2015-18_update_sept_15.pdf

## Appendix 1: LSAB MEMBERSHIP LIST (as at March 2015)

| NAME | ORGANISATION |
|---|---|
| **ALLEN Cllr Simon** | B&NES Council Cabinet Member for Wellbeing<br>Simon_Allen@bathnes.gov.uk |
| **AYRE Ashley** | Strategic Director People & Communities<br>B&NES Council<br>Email: Ashley_Ayre@bathnes.gov.uk |
| **BELAFONTE Carolyn Det/Supt** | Managing People & Place<br>Avon & Somerset Constabulary Public Protection Unit<br>Email: Carolyn.Belafonte@avonandsomerset.police.uk |
| **BLANCHARD Helen**<br><br><br><br>***[LEWIS Mary - sub]*** | Director of Nursing<br>Royal United Hospital NHS Trust<br>Email: helenblanchard@nhs.net<br><br>Assistant Director of Nursing<br>Email: mary.lewis7@nhs.net |
| **BRUCE-JONES Bill**<br><br><br><br>***[RICHARDS Liz and RHODES Phil - subs]*** | Clinical Director<br>Avon & Wiltshire Mental Health Partnership NHS Trust<br>Email: w.bruce-jones@nhs.net<br><br>Operations Director<br>Email: lizrichards@nhs.net<br><br>Service Manager<br>Email: phil.rhodes@nhs.net |
| **BUTTON Justine** | Inspection Manager ASC North Somerset & BANES and Swindon & Wiltshire<br>Care Quality Commission, South Region<br>Email: Justine.button@cqc.org.uk |
| **CLARKE Dawn** | Director of Nursing & Quality<br>NHS BaNES Clinical Commissioning Group<br>Email: Dawn.clarke6@nhs.net |
| **COWEN Robin** | Independent Chair for LSAB<br>Email: cowen.robin@googlemail.com |
| **DABBS Janet** | Age UK [Chair of Supporting People Forum and rep at LSAB]<br>Email: janetd@ageukbanes.co.uk |
| **DAY Kevin** | Local Delivery Unit Team Leader/ Senior Probation Officer<br>Avon & Somerset Probation Service<br>Email: Kevin.Day@probation.gsi.gov.uk |
| **DIXON Mick** | Head of Risk Reduction and Operational Training<br>Avon Fire & Rescue<br>Email: mick.dixon@avonfire.gov.uk |
| **ELIOTT Kevin** | Patient Experience Manager - Area Team:<br>Bath, Gloucestershire, Swindon & Wiltshire<br>NHS England |

| | |
|---|---|
| | Email: kevin.elliott@nhs.net |
| **EVANS Julie** | Director Customer Services (Housing & Support)<br>Curo<br>Email: Julie.evans@curo-group.co.uk |
| **HALL HALL Diana** | Healthwatch Rep and Interim Lay Members Rep |
| **HOWARD Damaris** | Director, Regulated Services,<br>Freeways<br>Email: damarishoward@freeways.org.uk |
| **HUTCHINSON Lesley** | Head of Safeguarding and Quality Assurance<br>B&NES Council<br>Email: Lesley_Hutchinson@bathnes.gov.uk |
| **HUTCHISON Sonia**<br><br>***[Trumper David - sub]*** | Chief Executive<br>Carers Centre Bath & North East Somerset<br>Email: Sonia.Hutchison@banescarerscentre.org.uk<br><br>Deputy<br>Email: David.Trumper@banescarerscentre.org.uk |
| **LEACH Louise (Dr)** | G.P. Safeguarding Lead<br>BaNES Clinical Commissioning Group<br>Email: Louise.leach1@nhs.net |
| **MANN Kirstie** | "Your Say" Advocacy<br>Email: kirstie@yoursay-advocacy.co.uk |
| **PENGELLY Reg** | LSAB Chair Designate<br>Email: regpengelly@hotmail.com |
| **PURSER Kate** | Adults Safeguarding Lead<br>NHS Bath & North East Somerset, Clinical Commissioning Group<br>Email: kate.purser@nhs.net |
| **ROWSE Janet** | Chief Executive Officer<br>Sirona Care & Health<br>Email: Janet.Rowse@sirona-cic.org.uk |
| **SHAYLER Jane** | Director of Adult Care & Health Strategy & Commissioning<br>B&NES Council<br>Email: Jane_Shayler@bathnes.gov.uk |
| **THEED Jenny** | Director of Operations<br>Sirona Care & Health<br>Email: Jenny.Theed@sirona-cic.org.uk |
| **TRETHEWEY David**<br>Associate Member | Divisional Director, Policy & Partnerships<br>B&NES Council<br>Email: David_Trethewey@bathnes.gov.uk |
| **YEE-KING Karyn** | Safeguarding Adults and Quality Assurance Team Manager<br>B&NES Council<br>[Acting Chair of Awareness & Comms sub-group)<br>Email: Karyn_Yee-King@bathnes.gov.uk |
| **VACANCY** | Representative for care home providers - TBC |

## Appendix 2: Membership List of Local Safeguarding Adults Board Sub Groups (as at March 2015)

**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)
Maggie Hall (Sirona Care & Health)
Kate Purser (NHS BaNES CCG)
D. Heaton (Agincare Domiciliary Care)
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)
Sally Eaton (City of Bath College)
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)
Amanda Lloyd (Avon & Somerset Constabulary)
Roanne Wootten (Julian House)
Fran McGarrigle (AWP)
Neil Boyland (RUH)
Lindsay Smith (Sirona Care & Health) *for info only*
Jenny Shrubsall (Service User) *for info only*

**Awareness, Engagement and Communications Sub Group**
**Meet approx: Bi-monthly**
**Chair: Sonia Hutchison** (Carers' Centre, Bath & NE Somerset)
Karyn Yee-King (B&NES Council – Safeguarding Adults)
Melanie Hodgson (B&NES Council – Information Officer)
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)

**<u>Quality Assurance, Audit & Performance Management Sub Group</u>**
**Meet approx: Bi-monthly**
**Chair: Kate Purser** (BaNES NHS CGG)
Alan Mogg (B&NES Council)
Geoff Watson (Sirona Care & Health)
Mick Dixon/Sarah Allen (Avon Fire & Rescue)
Karen John (Age UK, Bath & NE Somerset)
Dr Claire Williamson (AWP)
Andrew Snee (Curo Group)
Rob Elliot (RUH)
Roger Tipping (Rep from Healthwatch)
Fran McGarrigle (AWP) *for info*

**<u>MCA and DoLS Quality & Practice Sub Group</u>**
**Meet: Quarterly**
**Chair: Lesley Hutchinson (B&NES Council)**
Dennis Little (B&NES Council)
Tom Lochhead (B&NES Council)
Karen Gilroy (B&NES Council/AWP)
Karyn Yee-King (B&NES Council)
Pete Campbell (B&NES Council – Children)
Kate Purser (NHS BaNES CCG)
Maggie Hall (Sirona Care & Health)
Karen Webb (Four Seasons)
Roger Tipping (Rep from Healthwatch)
Benita Moore (Swan Advocacy)
Sally Cook (Swan Advocacy)
Pam Dunn (Carewatch)
Philip Rhodes (AWP)
Gemma Box (RUH)
Justine Button (CQC)

**<u>Making Safeguarding Personal Sub Group</u>**
**Meet: Bi Monthly**
**Chair: Karyn Yee-King** (B&NES Council)
Geoff Watson (Sirona Care and Health)
Maggie Hall (Sirona Care and Health)
Karen Gilroy (B&NES Council / AWP)
Phil Rhodes (AWP)
Steve Marshall (Sirona Care and Health)
Alan Mogg (B&NES Council)

## Appendix 3: LSAB/LSCB Joint Working 2015/16

| Theme | Opportunity | Relevance | Work needed to progress | Anything else? |
|---|---|---|---|---|
| **Communications** | Joint safeguarding advice to public / professionals e.g. via media / newsletters<br><br>Joint conferences / workshops<br>Develop opportunities for joint participation activity | Could be relevant to "Think family", Young carers<br><br>Young carers, disabled, DVA, "Think family | Collaboration between sub groups LSCB / LSAB<br><br>Develop a joint strategy for Comms sub groups would need to be broad to encompass all stakeholders | Joint website links (see Devon)<br><br>Getting other sub groups to link into comms-sharing of sub group minutes<br><br>Most disadvantaged hardest to access<br><br>Joint newsletter |
| **Quality Assurance** | Shared audits where VA and Children are relevant<br><br>Best use of people | Relevant to DVA , Substance / alcohol abuse, mental health (adult and child)<br><br>Voice of adult<br><br>Voice of child<br><br>How do we evidence quality | Design work plans for LSAB and LSCB for some convergence on issues during year<br><br>Quality audits and information governance | Shared learning on process of QA<br><br>Joint audits on occasion using a range of methodology's to audit cases where there might be shared learning<br><br>Family QA work with overarching Information Sharing Protocol |
| **Policy and Procedures** | Assure guidance for adults does not bring conflict with guidance for children (&vice versa)<br><br>Assure guidance is consistent across both | Assurance and QA exercise to be undertaken | May require a joint T&F group to work on this<br><br>Sharing a forward plan of groups agenda | Policy checklist required to be shared with other equivalent sub groups before sign off.<br><br>Sharing of a 'forward plan'<br><br>Could move to a SWCPP style web based guidance<br><br>Application of the MCA<br><br>Shared information sharing protocol |
| **Training** | Actively look for opportunities for bring appropriate aspects of training together (i.e. convergence) | As a first stage, examine opportunities for convergence at Level 2 | May require joint T&F Group to work on this could include looking at ;<br>Signs of Concern/vulnerability | Identify generic key areas where training can be trained together.<br><br>Challenge generic views on |

|  |  |  | Information sharing<br><br>'Think Family' approach<br><br>Challenge generic perceptions of safeguarding | safeguarding<br><br>Continue joint training at Level 2<br><br>Joint work would help to disseminate info on specialist training. Look at developing easier routes to specialist training<br><br>Risk of 'dilution'<br><br>Use of champions to promote knowledge and learning<br><br>Engagement with professionals who need to be made aware of relevance to their area of work<br><br>Linking training to relevant services.<br><br>Joint training on DV and substance misuse |
|---|---|---|---|---|
| **Exchanging Information** | Improved yearly identification of risk and referral | Joint development of MASH or other appropriate tool for this | Joint working group in operation | MISH – all sub groups involved in design<br>IRIS<br>CPIS system<br><br>Culture change in terms of how agencies share information.<br><br>Perpetrators – information and how we share it<br><br>Feedback from referrals<br><br>Strategy minutes |

**Across all themes:**

- **Less confusing for the public and professionals if there is more shared work**
- **Better use of resources, less duplication**
- **Improve knowledge and skills across sub groups of both Boards**

## Appendix 4: SCHEDULE 2 SAFEGUARDING ADULTS BOARDS

**Membership, etc.**

1 (1) The members of an SAB are—

(a) the local authority which established it,

(b) a clinical commissioning group the whole or part of whose area is in the local authority's area,

(c) the chief officer of police for a police area the whole or part of which is in the local authority's area, and

(d) such persons, or persons of such description, as may be specified in regulations.

(2) The membership of an SAB may also include such other persons as the local authority which established it, having consulted the other members listed in sub-paragraph (1), considers appropriate.

(3) A local authority, having consulted the other members of its SAB, must appoint as the chair a person whom the authority considers to have the required skills and experience.

(4) Each member of an SAB must appoint a person to represent it on the SAB; and the representative must be a person whom the member considers to have the required skills and experience.

(5) Where more than one clinical commissioning group or more than one chief officer of police comes within sub-paragraph (1), a person may represent more than one of the clinical commissioning groups or chief officers of police.

(6) The members of an SAB (other than the local authority which established it) must, in acting as such, have regard to such guidance as the Secretary of State may issue.

(7) Guidance for the local authority on acting as a member of the SAB is to be included in the guidance issued for the purposes of section 78(1).

(8) An SAB may regulate its own procedure.

**Funding and other resources**

2 (1) A member of an SAB listed in paragraph 1(1) may make payments towards expenditure incurred by, or for purposes connected with, the SAB—

(a) by making the payments directly, or

(b) by contributing to a fund out of which the payments may be made.

(2) A member of an SAB listed in paragraph 1(1) may provide staff, goods, services, accommodation or other resources for purposes connected with the SAB.

**Strategic plan**

3 (1) An SAB must publish for each financial year a plan (its “strategic plan”) which sets out—

(a) its strategy for achieving its objective (see section 43), and

(b) what each member is to do to implement that strategy.

(2) In preparing its strategic plan, the SAB must—

(a) consult the Local Healthwatch organisation for its area, and

(b) involve the community in its area.

(3) In this paragraph and paragraph 4, “financial year”, in relation to an SAB, includes the period—

(a) beginning with the day on which the SAB is established, and

(b) ending with the following 31 March or, if the period ending with that date is 3 months or less, ending with the 31 March following that date.

**Annual report**

4 (1) As soon as is feasible after the end of each financial year, an SAB must publish a report on—

(a) what it has done during that year to achieve its objective,

(b) what it has done during that year to implement its strategy,

(c) what each member has done during that year to implement the strategy,

(d) the findings of the reviews arranged by it under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year),

(e) the reviews arranged by it under that section which are ongoing at the end of that year (whether or not they began in that year),

(f) what it has done during that year to implement the findings of reviews arranged by it under that section, and

(g) where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.

(2)The SAB must send a copy of the report to—

(a) the chief executive and the leader of the local authority which established the SAB,

(b) the local policing body the whole or part of whose area is in the local authority's area,

(c) the Local Healthwatch organisation for the local authority's area, and

(d) the chair of the Health and Wellbeing Board for that area.

(3) "Local policing body" has the meaning given by section 101 of the Police Act 1996

## Appendix 5: LSAB Indicators for 2015/16

| Indicator 1: Compliance with Procedural Timescale | Target | Reported | By |
|---|---|---|---|
| 1. 1 % of decisions made in 2 working days from the time of referral | 95% | Monthly | AWP and Sirona C&H |
| 1.2 % of strategy meetings/discussions held within 5 working days from date of referral | 90% | Monthly | AWP and Sirona C&H |
| 1.3 % of strategy meetings/discussions held with 8 working days from date of referral | 95% | Monthly | AWP and Sirona C&H |
| 1.4 % of overall activities / events to timescale | 90% | Monthly | AWP and Sirona C&H |
| **Indicator 2: Exception and Breach Reports** | **Target** | **Reported** | **By** |
| 2.1 Breach report on failure to comply with procedural timescale | 100% | Monthly | AWP, Council and Sirona C&H |
| 2.2 Exception reports on repeat referrals | 100% | Monthly | Council |
| 2.3 Exception reports on cases which are Not Determined and Inconclusive | 100% | Monthly | Council |
| **Indicator 3: Quality Audits** | | | |
| 3.1 Report on the findings of case file audits | 15% (total) | Bi Annual Reports | AWP, Council and Sirona C&H |
| **Indicator 4: Service users experience** | | | |
| 4.1 Report on the experience and outcome for the service user (to include involvement in safeguarding arrangements) | N/A | Annually | AWP, Council and Sirona C&H |
| **Indicator 5: Training** | | | |
| 5.1 Relevant staff will have completed SA level 2 training within 6 months of taking up post and/or completed refresher training every 3 years thereafter (the term 'relevant' is defined by CQC) | 90% | Quarterly | LA and CCG commissioned agencies |
| 5.2 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) | 80% | Quarterly | LA and CCG commissioned agencies |
| 5.3 Relevant staff to have undertaken | 95% | Quarterly | LA and CCG |

| | | | |
|---|---|---|---|
| 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) | | | commissioned agencies |
| 5.4 Relevant staff to have undertaken SA level 2 training within 6 months of taking up post (the term relevant here includes staff that have direct contact with vulnerable people). | 80% | Annually | LSAB non CCG and LA commissioned agencies |
| 5.5 New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment | 95% | Annually | LSAB agencies; LA and CCG commissioned agencies |
| **Indicator 6: Safer Recruitment** | | | |
| 6.1 Relevant staff to have an up to date DBS check | 100% | Annually | LSAB agencies; LA and CCG commissioned agencies |
| **Indicator 7: Safe Practice** | | | |
| 7.1 Provide evidence of safeguarding discussions / raising awareness with the agency setting (eg, supervision arrangements to include this) | N/A | Annually | LSAB agencies; LA and CCG commissioned agencies |
| 7.2 DASM / Champion identified for Police, CCG and B&NES Council | 100% | Annually | LA, Police and CCG |

## Appendix 6: Partner Reports 2014/15

| Agency Name: Age UK | | | |
|---|---|---|---|
| **Brief outline of agency function:** Age UK Banes enable older people to exercise choice and live independently within a supportive community. We provide a voice for older people and seek to challenge age discrimination. Together with our staff, and volunteers we work to ensure older people are as healthy, satisfied and independent as possible, and have opportunities to participate and contribute as valued members of their communities. | | | |
| **Achievements during 2014-2015:**<br>• Passed Quality Assessment Framework Inspection<br>• New staff Inducted – 3 Safeguarding training sessions planned. 2 in February 2015, 1 in September<br>• Renewed Flow chart, Safeguarding Policies and Procedures and Code of Conduct<br>• Trustees attended training<br>• New Gifts and Hospitality policy introduced<br>• All JD's to include Safeguarding awareness<br>• New Staff and Volunteer Handbook completed | | | |
| **Performance to LSAB indicators 2014-2015:** | | | |
| **Indicator** | **Target** | **Outturn** | **Comment** |
| New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)*** | 95% | 95% | Induction within 2 weeks, followed by planned mandatory training. Probation process, regular reviews, Supervisions |
| 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 and bank staff to attend training. Training sessions twice a year for new employees and refresher for existing 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 yet happening. To introduce E Learning |
| Relevant staff to have undertaken | 95% | N/A | |

| DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP 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:**

- Inductions
- Regular Supervisions and item agenda
- 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
- Staff Handbook
- Policies and Procedures

**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 ASIST team of any concerns
- Staff given reassurance and support at meetings
- Policies, procedures explained to them and every effort to support them through training, supervisions, meetings.
- Inter-agency communication and awareness
- Staff handbook
- LA updates circulated

**Objectives for 2015/2016:**

- Continue to raise awareness of Safeguarding procedures
- Continue with mandatory training
- Raise the profile of Safeguarding within the Organisation
- Arrange for staff to undertake Mental Capacity Act training – E learning
- Reach 100% target on all training
- Communication with other Agencies to improve awareness

| **Agency Name: Avon & Wiltshire Mental Health Partnership** |
|---|
| **Brief outline of agency function:**<br>Providing primary and secondary mental health services within Bath and North East Somerset as well as B&NES Community Drug and Alcohol Services . |
| **Achievements during 2014-2015:** (in bullet points)<br>• Establishment of a short life working group with local authority colleagues to consider the implementation of the Care Act 2014 and changes required in regard to safeguarding<br>• Review and amendment of the Trust Safeguarding Adults Policy and Guidance to reflect Care Act and statutory guidance and good practice<br>• Review and amendment of service user / carer safeguarding leaflets<br>• The development and launch of Trust Safeguarding Adults ELearning module<br>• Introduction of a Trust wide system to use the improved functionality of RiO within the safeguarding adult modules in order to improve recording. This includes the collection and reporting of outcomes for people subject to safeguarding<br>• Development of bespoke Rio eLearning modules to support staff.<br>• The Trust launched its first annual audit in relation to staff knowledge of Safeguarding Adults, Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs). Overall, findings demonstrated staff have a good understanding of their duties and responsibilities to safeguarding adults.<br>• To support practitioners as well as supervisors to embed effective safeguarding supervision in clinical/management supervision a safeguarding supervision template was developed<br>• The Trust Safeguarding Team developed guidance to further improve staff understanding of safeguarding recording and adverse incident reporting<br>• Safeguarding content on the intranet and internet have been refreshed with simplified pathways to access key content<br>• Implementation of the new regional policy on safeguarding.<br>• Continued participation in multi-agency and partnership initiatives in safeguarding such as the multi-agency safeguarding Hub development (HUB).<br>• Plans developed to hold an afternoon tea event in June 2015 for carers and service users where they will have an opportunity to meet with members of the Adult Safeguarding Team as part of "Stop Abuse Week"<br>• Feedback received from Peer Review Team (Local Government Association ) which indicated that that a strong framework for Making Safeguarding Personal created by the four test bed sites. Two teams within BANES (Recovery and CITT) participated in this |

**Performance to LSAB indicators 2014-2015:**

| 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 locality, in encouraging staff to attend training. Level 1 and 2 + 97% |
| 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% | 97% | |
| 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% | | We do not report specifically on those already in post and their attendance at safeguarding training. They are included in the training figures above |
| Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)*** | 80% | 93% | 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% | | As above |
| Relevant staff to have an up to date DBS checks ***(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** | The Team Manager's (or their delegated safeguarding champion) are responsible for acting as a team reference resource on safeguarding issues, provision of required data, implementation of audits and relevant training planning, cascade of information, safe recruitment and workforce issues, and support and supervision to their team on safeguarding issues | | |

| | |
|---|---|
| | Additionally 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 regular meetings held between AWP and Banes Council with any recommendations cascaded to teams and practitioners
- Any safeguarding issues or updates are shared with Senior Practitioners, Team Managers, Ward Managers and Service Managers at Team Managers meetings. In addition to these, any urgent information is disseminated via email for Team/Service Managers to discuss within their business meetings.
- Individual supervision
- Safeguarding training of staff is monitored through a rolling IQ quality improvement process which is shared within the organisation.
- Staff can access specialist advice and support from the Trust's Safeguarding team for all areas of safeguarding including marac , mappa and prevent

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

The work of the BANES Recovery and CITT teams in relation to Making Safeguarding Personal is being embedded across mental health and drug and alcohol services to ensure that service users and carers are actively involved in the Safeguarding Process. Their views, wishes and expected outcomes from the safeguarding process are elicited to ensure that they feel more empowered and in control of the safeguarding experience. Examples of how this has been achieved have included; has the person that the safeguarding relates to consented to the referral being made and have they said what they wish to happen as a result of the safeguarding process.

If a service user is believed to lack capacity, this is assessed and if they are found to lack capacity, they can be supported by an advocate, family member or friends, depending upon their individual circumstances.

At the end of the safeguarding process they are asked if they feel safer as a result of the safeguarding process and whether the outcomes they specified at the beginning of the safeguarding process have been achieved. All service users are provided with a Feedback Form to ensure that both positive and negative points can be used to improve the safeguarding process.

**Objectives for 2015/2016:**

- Attendance at all meetings we are expected to attend.
- Demonstrating outcomes from training are delivered in practice
- To manage increased demand for safeguarding activity, including safeguarding cases management and enhanced safeguarding governance activity with safeguarding partnerships and commissioners
- Achieving a Named professional who can lead on safeguarding locally.
- Achieving consistent compliance in relation to quality standards
- Embed Making Safeguarding Personal into all aspects of safeguarding

| **Agency Name: B&NES Council** |
|---|
| **Brief outline of agency function:**<br>Responsible for the ensuring the statutory responsibilities for safeguarding adults in need of care and support at risk of abuse are met through quality assuring service delivery of external providers, triangulating information with other agencies to ensure early identification of risks, Chairing individual and large scale safeguarding meetings, administering and facilitating the LSAB meetings, development sessions and the majority of multi-agency Sub Groups, writing and coordinating consultation on multi-agency policy and procedures, organising and facilitating policy launch events and adult abuse week. |
| **Achievements during 2014/2015:**<br>• Reviewed contract monitoring arrangements for all commissioned services in relation to safeguarding<br>• Audited all safeguarding concerns below the safeguarding threshold<br>• Coordinate and facilitate piloting of Making Safeguarding Personal<br>• Facilitate Local Government Association Peer Review receiving positive feedback<br>• Put in place arrangements to ensure safeguarding arrangements are Care Act 2014 compliant<br>• Work proactively with sub regional local authorities to develop joint multi-agency policy<br>• Coordinate Adult Abuse Week |

**Performance to LSAB indicators 2014-2015:**

| Indicator | Target | Outturn | Comment |
|---|---|---|---|
| New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)*** | 95% | 100% | Safeguarding policy and procedure included in induction programme; new staff meet the safeguarding team |
| 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% | 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 ***(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% | 100% | |
| 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% | |
| Relevant staff to have an up to date DBS checks ***(All)*** | 100% | 100% | |
| Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments** | Ensuring safeguarding arrangements are robust is core to all adult care Council staff work. Routinely discussed at each teams Team Meeting. | | |

**Describe how you raise awareness of safeguarding in your agency:**

- Articles in Council Connect
- Invite staff to all LSAB events
- Circulate  LSAB newsletter
- Let staff know of new leaflets etc that are available
- Invited all staff to participate in the LGA Peer Review
- Reviewed Contract and Commissioning arrangements for safeguarding
- Let all staff know about the new LSAB indicators each year
- Holding case law update sessions
- Care Act 2014 training for all staff

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

The Safeguarding and Quality Assurance team have been very proactive in this involving and supporting service users and carers in safeguarding meetings at an operational level through Making Safeguarding Personal

The Council have also responded to any concerns raised from service users via the Keeping Yourself Safe questionnaire.

The Council has also responded to a small number of complaints received about the safeguarding procedure and has amended the procedure to take account of these where needed.

**Objectives for 2015-2016:**

- Ensure all Policies and Procedures are Care Act 2014 compliant – this is a significant amount of work – particularly consulting on the Self Neglect protocol
- Ensure the new arrangements resulting from the Care Act with Sirona Care and Health and AWP work effectively

- Monitor the impact of the new safeguarding duties on the Council and partners
- Implement Making Safeguarding Personal at a pace
- Lead the work with the Anti-Slavery Partnership and participate in the South West pilot
- Review the data provided by the new SAR and determine what other information is required for assurance purposes
- Ensure robust arrangements are in place for the new duty regarding Prevent and Channel
- Ensure the Council public website is reviewed and clearly sets out the new safeguarding arrangements
- Participate in Your Care Your Way and ensure safeguarding and the MCA responsibilities are threaded through
- Deliver the LGA Peer Review action plan
- Continue to facilitate and support the work of the LSAB
- Facilitate Adult Abuse Week

**Agency Name: Bath and North East Somerset 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 2014-2015:**

- 39 potential safeguarding cases referred to Local Authority in 2014/15
- 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
- Carers' Centre represented carers by chairing the Awareness, Engagement and Communications Sub-committee for part of the year, attending the Training Sub-committee and attending the full Board meetings.

**Performance to LSAB indicators 2014-2015:**

| 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% | Compulsory training |
| Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post | 80% | N/A | |

| | | | |
|---|---|---|---|
| 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% | 0% | Staff are currently on waiting list for 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% | N/A | |
| Relevant staff to have an up to date DBS checks ***(All)*** | 100% | 100% | |
| 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. Carers’ Centre supported the Safeguarding week by helping with an event.

**Describe how you have supported service users and carers through the safeguarding adults procedure:**
When there are safeguarding concerns, these are discussed with the Chief Executive and the staff member or volunteer raising the concerns and the safeguarding policy and procedure is followed. Where possible concerns are discussed with carers before a referral is made to the Access Team and if relevant concerns are discussed with referring agencies. Occasionally the Carers’ Centre provides low level advocacy at safeguarding meetings when required. A referral process is in operation 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. X number of referrals came through Chairs.

**Objectives for 2015/2016:**

- Continue to build on representing carers by taking on the vice chair role for the Board.
- Support in recruiting lay members to the Board
- Support Safeguarding Week
- Continue to raise awareness through publications

| Agency Name: Royal United Hospitals Bath NHS FoundationTrust |
| --- |
| **Brief outline of agency function:**<br>The Director of Nursing and Midwifery is the Executive Lead for Adult Safeguarding within the Royal United Hospitals, supported by the Deputy Director of Nursing, Quality and Patient Safety. The adult safeguarding team has continued to develop the support for clinical staff raising concerns.<br><br>Assurance relating to adult safeguarding, Mental Capacity and Deprivation of Liberty Safeguards is provided to the Trust Board by the Safeguarding Adults Forum via the Operational Governance route. The Safeguarding Adults Forum is a multi-agency forum chaired by the Deputy Director of Nursing, Quality and Patient Safety.<br><br>The Royal United Hospitals continues to play an active role within the Wiltshire Safeguarding Adults Board with Executive representation from either the Director of Nursing and Midwifery or the Deputy Director of Nursing, Quality and Patient Safety. There is RUH representation at the Quality Assurance sub group, which is attended by the Senior Nurse, Adult Safeguarding and the Lead for Quality Assurance<br><br>***Safeguarding Adults Team***<br><br>The Safeguarding Adult team consists of 1.8 WTE registered nurses with the support of a 0.8 WTE administrator. When the team receives an alert they review the patient and/or their medical records on the ward and gather the initial information as requested by the Local Authority safeguarding teams. The RUH team provide an immediate response for advice and support to all staff by being available via the bleep system. Each operational safeguarding lead maintains a patient caseload. The Safeguarding Adult team regularly undertake case reviews to support safeguarding processes that have been convened in the community following an episode of care in the RUH, providing the Chair with background information to supplement the process. The team represent the RUH at safeguarding strategy and planning meetings held at the RUH and on occasions at external meetings. |
| **Achievements during 2014-2015:**<br>The RUH is constantly working to improve the adult safeguarding service that it delivers. Achievements during 2014-15 have been:<br>• Appointment of additional Safeguarding Nurse to increase capacity in the team to manage significant increases in activity.<br>• Successful centralisation of the DoLS process including communication process between RUH and local authorities' DoLS administration teams.<br>• Compliant with training targets for the delivery of Adult Safeguarding Level 3; improving compliance for Level 1 and 2.<br>• Adult Safeguarding Level 2 e-learning package launched.<br>• Adult Safeguarding Level 1 e-learning package under development.<br>• Monitoring of adverse and serious incidents.<br>• Reviewed lessons learned from the investigation reports into offences committed by Jimmy Savile in NHS hospitals, to strengthen safeguarding arrangements in the Trust.<br>• Actions required following the Jimmy Savile Investigations - The RUH established a Savile Task and Finish Steering Group in November 2014. The membership has representation from all divisions Estates, Human Resources, Safeguarding Teams and Security. The group has initiated two work streams to capture the current work required following the recently published Lampard report as detailed |

below:
  - Managing access to the hospitals and a focus on the volunteers.
  - Permission to challenge; how staff challenge people who are in the hospitals and wider areas in estates.
  - There are also areas of work that overarch the two work streams; policy review, training and communications.
- Safeguarding Adults Network - The network was established in January 2015; the key objectives of the network are to support practitioners by ensuring lessons learnt from Safeguarding Adult Reviews (SARs), Serious Incidents information is shared, discussed and learning disseminated. Identify and discuss cases to disseminate examples of good practice. Provide membership with consistent information related to organisational priorities related to safeguarding adults.
- Representation from the operational safeguarding nurses at Banes LSAB sub groups.

**Performance to LSAB indicators 2014-2015:**

| **Indicator** | **Target** | **Outturn** | **Comment** |
|---|---|---|---|
| New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)*** | 95% | Level 1 89.4% Level 2 60.1% | |
| 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 ***(LA and CCG Commissioned members only)*** | 90% | 60.1% | |
| 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 ***(Non - LA and CCG Commissioned members only)*** | 80% | As above | |
| Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and CCG Commissioned members only)*** | 80% | 67.4% | |
| 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% | 67.4% | |
| Relevant staff to have an up to date DBS checks ***(All)*** | 100% | 100% | 100% of new staff that have started employment within the organisation have been DBS checked & 100% of relevant employment rechecks have been completed. |
| Safeguarding champions identified for each team ***(All)*** **Describe arrangements** | We do not have safeguarding champions across the organisation. There are Operational Safeguarding Leads who are senior nurses who work across the | | |

| for champions in your agency if not in each team in comments | Trust, promoting, training and supporting staff within the safeguarding arena, and representing the Trust where required. |
|---|---|

Training is one of our challenges therefore the Adult Safeguarding Team have increased the Level 2 face to face training provision from 1 to 3 sessions per month and continue to deliver training at Level 2 on the Induction programme for clinical staff.
The Level 2 Adult Safeguarding e –learning programme has been developed by the Senior Nurse, Adult Safeguarding and was launched during March 2015. Development of Level 1 Adult Safeguarding e-learning programme began in March 2015.
Current delivery against the trajectory agreed with Commissioners means the Trust will achieve 90% compliance with Level 2 training Trust wide by October 2016. The compliance rate will continue to be monitored by the Safeguarding Adults Forum.

**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.
- Poster displaying contact details of Safeguarding Adults team and referral mechanism for patients and carers.
- Awareness raising through training, induction, refresher and ad hoc training.
- Governor Induction
- Working with partnership agencies
- Awareness raising through Adult Abuse Week Events

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

- Engaging and involvement when appropriate in regards to making safeguarding personal
- Operational safeguarding nurses are visible in practice areas both inpatient and outpatient. This visibility encourages robust communication between carers, service users and staff. We encourage a multi agency/disciplinary approach as part of the safeguarding process.
- Periodically learning and sharing from case studies which the Safeguarding Adults team have been involved with.

**Objectives for 2015/2016:**

- To meet training targets for level 2 Safeguarding Adults as per our agreed trajectory.
- To review and build evidence for Care Quality Commission Fundamental Standards Outcome 13.
- Work with Trust Head of Security in regards to restrictive practices Trust wide.
- Working closer with Named Nurse for Children and Named Midwife particularly in relation to Domestic Violence.
- Establish PREVENT training programme in conjunction with children's safeguarding team and security to meet contract compliance targets for PREVENT awareness.
- Compliance with Sections 42-46, Care Act Statutory Guidance 2014.
- Contribute to Making Safeguarding Personal initiatives in partnership with the Local Authorities.

**Agency Name: NHS BaNES CCG**

**Brief outline of agency function:**

- NHS B&NES CCG commissions and performance manages all NHS funded care in Bath and North East Somerset.
- The CCG Director of Nursing and Quality is executive lead for Safeguarding and attends the Local Safeguarding Adults Board meetings.
- The Lead for Quality & Adult Safeguarding chairs the Quality and Assurance sub-group; sits on the MCA & DOLS groups and also attends LSAB board meetings.
- The Lead for Quality & Adult Safeguarding works to ensure that Adult Safeguarding is being effectively delivered in all commissioned services

**Achievements during 2014-2015:**

1. A comprehensive Adult Safeguarding action plan was developed following completion of the LSAB self-assessment in 2013.
2. Collaboration with the Local Authority (LA): This work included:
   - Supporting significant health-related adult safeguarding investigations.
   - Supporting the Council with five large scale investigations.
   - Developing a tool to support the local authority safeguarding leads to ensure that all safeguarding investigation resulting from a pressure ulcer are managed consistently
   - Developing a pressure ulcer matrix jointly with the local authority that was used to help identify themes and patterns from all pressure ulcers that lead to a safeguarding investigation.
3. A small group of CCG staff supported the council with their Local Government Authority (LGA) Peer Review. Documentary evidence was submitted to demonstrate how adult safeguarding is embedded in the CCG and several CCG staff were interviewed by the review team.
4. There were no Serious Case Reviews during 2014/15 however actions from the 2013 SCR were completed in this time.

   Recommendation 5: Promoting awareness of Domestic Violence and Abuse (DVA) and responses to it.
   *CCG Actions:*
   a. The CCG attends the MARAC steering group.
   b. Increasing awareness of domestic abuse was added as a KPI to the 2015-16 Adult Safeguarding Schedule.
   c. A new service to deliver Domestic Abuse training and support to Primary Care (IRIS) has been procured and is now being mobilised.
   d. NICE guidance (PH50 DVA) was reviewed with a view to identifying local gaps.
   e. A successful bid for quality premium money secured £10,000 which will enable the Interpersonal Violence and Abuse Strategic Partnership (IVASP) to prioritise its ambition to develop and roll-out a sustainable DVA partnership training plan.

   Recommendation 12: Consideration to be given regarding provision of a specialist nursing service for older people within primary care. To this effect, the CCG supported the recruitment of a Health Visitor for the Elderly who has now been in post over a year.
5. Adult Safeguarding is a regular agenda on all provider Contract Review Meetings which are always attended by one of the CCG Nursing and Quality Team.

6. The programme of regular supervision with the Safeguarding leads continued during 2014/15.
7. Care Homes are the subject of quarterly reporting to the CCG Quality Committee and continue to be monitored through the following processes:
    a. The Local Authority Contracts and Commissioning Team.
    b. B&NES Adult Safeguarding procedures.
    c. Bi-monthly meetings with the Local Authority, CQC and the CCG
    d. The CCG Nursing & Quality Team continues to support the Local Authority with regular, planned quality assurance visits to BaNES care homes. 14 care homes have been visited during this period.
    e. Nursing Homes forum: This group was developed in order to support care homes to deliver clinically effective, safe and evidence based care. Two one day meetings have been held during the reporting report with at least three planned for 2015-16.
    f. Concerns were raised during 2014-15 regarding two national care home providers:
        - A B&NES home belonging to one of these companies was investigated been under whole home procedures following several safeguarding referrals. During this investigation the CCG raised concerns around their governance/HR processes which were fed back to NHS England.
        - A second care home provider in B&NES was subject to several CQC whistle-blowing allegations during 2014-15. These allegations led to a number of safeguarding investigations which were managed through the whole home investigation process. The CCG actively worked with the Council in promoting improved engagement from this company.
8. *Pressure ulcers:* work has been undertaken to help support providers to reduce new pressure ulcers. These included:
    - A community-wide workshop, held in December 2014, which explored the issue of non-concordance and considered ways to work with patients to help prevent the development of pressure ulcers.
    - A meeting was held with a large provider to discuss themes and learning from pressure ulcer Root Cause Analyse investigations (RCA's).
    - The CCG funded 'Rapid Spread' pressure ulcer improvement programmes in two large providers. Following the introduction of the project in the first provider, there has been a significant reduction in the numbers of hospital-acquired pressure ulcers. The second provider is due to commence their project.
9. *Provider dashboard:* This tool allows an over-view of concerns relating to quality and safety and includes fields such as CQC outcomes and Safeguarding concerns. The dashboard continues to be developed and populated.
10. *Prevent:* is one of the four elements of 'Contest', the government's anti-terrorist strategy. Prevent lays out the public sector responsibility to help prevent the recruitment into terrorism of at risk adults. To support this agenda:
    - Prevent was included in the 2014/15 National NHS Contract and was also added to all provider contracts and the Adult Safeguarding strategy.
    - A pack containing a range of national literature and guidance was sent to all providers in May 2015.
    - Providers were actively encouraged/supported to recruit named Prevent leads and to deliver against the contract.
    - The CCG sits on the B&NES Prevent Steering group

- A local Prevent meeting has been planned to support provider leads in meeting their contractual requirements.
- The CCG attended an NHS England South Central Prevent event in February where the potential impact of the legislative changes was discussed.

11. *Adult Safeguarding schedule*: This forms part of provider contracts and was comprehensively reviewed for 2014/15. The schedule included 6 standards, an annual audit return and 7 Key Performance Indicators (KPI's) against which provider performance was monitored.
12. *Serious Incident, Complaints and Safeguarding committee:* monthly reports are completed to demonstrate current safeguarding activity. Further reports as required are presented to the Quality Committee and have included reports on Pressure ulcers, DoLS and the Care Home review programme.
13. *Deprivation of Liberty Safeguards (DoLS)*: The Supreme Court ruling in March 2014 posed a significant challenge in terms of resources and organisational processes for the local authority and all providers. This risk was added to the organisational risk register & the CCG has supported on-going work via the B&NES Task and Finish group. The ruling was also the subject of a report for Quality committee in June 2015.
14. *Court of Protection:* Following the Supreme Court ruling, Deprivation of Liberty now also applies to clients receiving health or social care in their own homes. The implication of this is that the CCG is responsible for processing DoLS applications for patients receiving health care packages in domestic settings. The CCG attended a seminar to more fully understand implications of the ruling to the CCG and also wrote a report for the CCG. This work continues to be scoped.
15. *Sulis.com* - This website was developed to provide information and to obtain comments/feedback from the local community (both public and professional). The Adult Safeguarding page on this website was reviewed and updated and now contains a comprehensive range of relevant and up to date resources.
16. Two new prompt cards produced by NHS England – Adult Safeguarding and Mental Capacity - were distributed to all providers.
17. A national evidence gathering exercise by NHS England, found that the Mental Capacity Act and Deprivation of Liberty Safeguards have not been implemented consistently. In response, the Bath, Gloucestershire, Swindon and Wiltshire (BGSW) Area Team funded a project with the National Development Team for Inclusion (NDTI) who were asked to explore with service users, their families and key agencies, how well the MCA is utilised in the BGSW area.
18. The named GP for Adult Safeguarding has:
    - Cross-referenced local guidelines for primary care against DoH guidance
    - Held discussions with GP colleagues to clarify training requirements and also around individual safeguarding concerns.
    - Liaised with the Coroner's Office and the LMC regarding death certificates where the patient is subject to a DoLS authorisation.
    - Established an adult safeguarding support meeting for the safeguarding lead GPs with two meetings being held during the reporting period.
    - Reviewed a Serious Case review from a primary care perspective and identifying learning points.
    - Reviewed information about a local care home and comparing with the SCR above.
    - Held two informal lunchtime GP support sessions
    - Distributed regular Adult Safeguarding newsletters to primary care.

19. The Safeguarding Adults Lead and the Named GP have developed a training strategy for primary care and this has been delivered as per the planned programme.

**Performance to LSAB indicators 2014-2015:**

| Indicator | Target | Outturn | Comment |
|---|---|---|---|
| New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)*** | 95% | 68% | This has increased from 0% in 2013/14 and we expect to reach 80% by the end of 2015 |
| 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% | 73% | This has increased from 54% in 2013/14 despite a significant increase in the number of CCG staff. We expect to reach 90% by the end of 2015 |
| 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% | 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 checks ***(All)*** | 100% | 75% | This process is not managed by the CCG and is currently being reviewed |
| 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:**

- As a small organisation, the Adult Safeguarding Lead is able to work closely with all CCG teams to raise awareness of Adult Safeguarding
- The CCG annual report, taken to the CCG Board each year, includes Adult Safeguarding
- Significant safeguarding concerns are also taken to the confidential Board
- Regular reporting to the CCG Quality Committee and Executive Team
- When necessary, Adult Safeguarding matters are communicated via the CCG

Communications team, the staff noticeboard and staff briefings

**Describe how you have supported service users and carers through the safeguarding adults procedure:**
n/a

**Objectives for 2015-2016:**

1. For the CCG together with the Local Authority, to develop a matrix that identifies high risk areas and then allow for action to be taken to address the risks with providers.
2. Continue to develop/refine processes for monitoring safeguarding actions when these relate to health commissioned services.
3. Support clinical teams to improve practice: The CCG and LA to develop a matrix to map out safeguarding referrals in order to allow identification of teams/areas with high numbers of safeguarding concerns.
4. Develop and introduce the Designated Adult Safeguarding Manager role.
5. In collaboration with the Designated Nurse for Children, develop a Clinical Supervision policy and continue to deliver the programme of supervisory visits for provider safeguarding leads.
6. Establish a local Adult Safeguarding Forum for provider safeguarding leads.
7. Review the LSAB protocol for 'Determining Neglect in the development of a Pressure Ulcer.
8. Review the NDTI Mental Capacity Act report and commence work to support the recommendations of the review where relevant to B&NES.
9. Continue to deliver the Prevent agenda locally.

**Agency Name: Curo**

**Brief outline of agency function:**
Curo is a Housing Association with a portfolio of 12,700 homes with a care and support service delivering support for 3000 customers every week.

**Achievements during 2014-2015:** (in bullet points)

- A Social Return On Investment of £12.9 Million from Care and Support services
- Between April 2014 and April 2015 we made 296 safeguarding alerts, the breakdown as follows: 206 Domestic Abuse cases were reported to us, 10 further adult safeguarding cases from Curo (Landlord function).
- In total 80 safeguarding cases were supported in relation to Curo's care and support dept (Curo Choice) made up as follows 49 related to older persons services, 19 related to B&NES Young People services, 2 in step down accommodation.
- We supported 29 multi-agency meetings
- We attended every MARAC meeting
- We attended LSAB regularly, making a full contribution.

- Across Curo colleagues are trained within the first week of their induction and this training is repeated throughout employment.
- We won a national award for our work connected to tackling Domestic Abuse.

**Performance to LSAB indicators 2014-2015:**

| **Indicator** | **Target** | **Outturn** | **Comment** |
|---|---|---|---|
| New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)*** | 95% | 95% | Staff delivering front line support provision have received the training within 3 months of starting employment |
| 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% | 91% | As above, Care and Support staff all complete level 2a training or equivalent within 6 months and have refresher training on an annual basis. This is now a web based training programme. |
| 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 | 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% | 85% | Mental Capacity Act training is not role specific to the care and support posts within Retirement Living. However, mental health training and guidance is delivered on an annual basios to all support team members |

<table>
<tr><td>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)</td><td>95%</td><td>95%</td><td>DOLS training is delivered to all staff. Since the Care Act 2014 all Retirement Living staff have either been present at one of the two team meetings where training was provided or been sent the training material electronically.</td></tr>
<tr><td>Relevant staff to have an up to date DBS checks (All)</td><td>100%</td><td>100%</td><td>Maintained via HR.<br>All staff are DBS checked every 24 months or before taking up position in the organisation for CARE AND Support staff.</td></tr>
<tr><td>Safeguarding champions identified for each team (All) Describe arrangements for champions in your agency if not in each team in comments</td><td colspan="3">Team Champion is Carol Davidson, Team Leader for Older Person's Service<br>Safeguarding Adults Lead Andrew Snee Head of Tenancy Solutions<br>Young Person safeguarding Lead Julie Fisher Head of Operations<br>Overall Safeguarding Lead Harriet Bosnell</td></tr>
<tr><td colspan="4">Describe how you raise awareness of safeguarding in your agency:<br>All staff are trained when in their induction period and have a minimum of annual refresher training.<br>We work closely with CAMHS and Adult mental health services throughout support planning to meet customer need.<br>At each team meeting, local and full team, safeguarding is an agenda item.<br>At wider resident meetings safeguarding is also discussed.<br>We are co-located with the Police at the Keynsham PFD and meet regularly with the IRIS team.<br>We monitor the shared safeguarding log across Curo which we monitor and review.<br>We share top level information with our sheltered housing, supported housing and older persons working group and also at events.<br>We participate in CAF and where possible take the lead.<br>We attend multiple multi agency meetings where cases and themes are reviewed.<br>We sit on the QAAPM group.<br>We have taken part and serious case reviews and share our learning.</td></tr>
<tr><td colspan="4">Describe how you have supported service users and carers through the safeguarding adults procedure:</td></tr>
</table>

Customers are supported at every stage of a safeguarding process.

Colleagues will talk through the procedure, accompany people to appointments, represent at multi-agency meetings and provide any support required.

We have regular residents meetings and share specific data.

We have reviewed our safeguarding policy and procedure with our customers.

**Objectives for 2015-2016:**

- Embed culture of safeguarding outcomes feedback across the organisation.
- Continue shared learning.
- Colleagues will attend multi agency safeguarding training.
- Compliance will be monitored of our training programme.
- Curo working to engage at a committee level and engage more.
- Review SLA's with specialist partners.

**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 can provide domiciliary care and hydrotherapy.

**Achievements during 2014-2015:**

- Relevant training completed for staff member who had 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; a significant number of staff have attended B&NES safeguarding and MCA training.
- Continue to raise Safeguarding / DOLS/ Mental Capacity within regular team meetings and supervisions; use occasion reports to discuss best practice.
- Continue to encourage staff to participate in Safeguarding; discussed in annual service reviews.
- Staff have supported some service users to report concerns themselves to safeguarding.
- Service users have been sign posted to attend abuse awareness courses.
- Staff are regular going though easy read policy to safeguarding with the service users.
- Dignity champions now established on both community and residential services, role relates to championing safeguarding and MCA.

**Performance to LSAB indicators 2014-2015:**

| Indicator | Target | Outturn | Comment |
| --- | --- | --- | --- |
| New staff to undertake safeguarding learning as part of Induction within 3 months of | 95% | 100% | |

| | | | |
|---|---|---|---|
| starting employment ***(All)*** | | | |
| 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% | 96% | We provide annual refresher internally |
| 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% | 96% | 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% | 90% | Provided internally as well as accessing Council training |
| Relevant staff to have an up to date DBS checks ***(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.<br><br>1 in residential service.<br>Dignity champions-safeguarding awareness as part of the role. | | |

**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; discussed in team meetings to look at best practice where behavioural strategies can be recorded.
Annual complaints audit.
Annual safeguarding audit; recording the number of safeguarding referrals made by each service.
Annual service reviews; whole team attend and safety is discussed as part of our business aims.
Bi-monthly visit/report by senior managers; discuss safeguarding issues.
Discussed with service users using our accessible policy, training and resident

meetings.

**Describe how you have supported service users and carers through the safeguarding adults procedure:**
Going through easy read safeguarding policy individually with each service user.

Raising awareness in resident/tenant meetings.

Having a robust complaints procedure that is continually promoted; complaints have increased during the year.

Establishing good relationships with the local police for advisory chats with service users and supporting service users with safeguarding concerns that have been reported.

**Objectives for 2015-2016:**

1. Staff to continue to encourage service users to report to safeguarding and the police themselves.
2. Staff teams to build on reflective practice gained through reviewing occasion reports and the effectiveness of current behavioural strategies with behavioural strategies /risks amended accordingly.
3. Managers to ensure all actions needed to support safeguarding concerns are evidenced on the occasion reports and completion of these actions is recorded where appropriate.
4. Safeguarding/Abuse training for service users to be delivered as part of Annual Service Review actions. Training/discussion to take place within the service. Continue to signpost service users to external courses.
5. Ensure that service users' views/wants are supported/advocated by the service to determine/influence safeguarding outcomes.
6. As a provider we endeavour to promote a culture that encourages candour, openness and honesty at all levels.
7. Maintain yearly refresher training for all staff in safeguarding, MCA and DOLS.
8. Keep abreast of relevant external training to supplement internal training; a significant number of staff have attended B&NES safeguarding and MCA training.

| **Agency Name: Avon and Somerset Constabulary** |
|---|
| **Brief outline of agency function:**<br>Public Protection, Safeguarding people and investigating and detecting crime through policing |

**Achievements during 2014-2015:** (in bullet points)

During 2014/15 Avon and Somerset Constabulary made significant improvements to the operational and strategic response to dealing with incidents involving vulnerable adults, and the safeguarding of adults who are potentially vulnerable.

- In October 2014, the Constabulary introduced a new Operating Model, a 'One Team' approach with the vulnerability of the victim and/or the risk presented by the offender being the key factor in the allocation of the investigation, rather than the crime type.
- On 1 October 2014, the Force introduced its Integrated Victim Care service: "Lighthouse". This new service ensures that vulnerable, intimidated or persistently targeted victims receive a tailored, coordinated and consistent service. Each victim now has a Victim & Witness Care Officer (VWCO) automatically allocated to their case. The VWCO remains allocated to the case from the point of initial report, through the investigation and to the end of any subsequent Criminal Justice process. The VWCO ensures that the victim receives a comprehensive needs assessment, where possible within 24 hours of the crime being reported. The VWCO may share the needs assessment with particular agencies and organisations to ensure the victim has access to support services that may be appropriate for them, as part of a proactive handover package that ensures the needs of the victim are understood, and that they do not have to repeat themselves.
- One Team tasking identifies and highlights the most vulnerable victims and high risk offenders via the Daily Pacesetter which is chaired by a Gold Commander. Investigations work as One Team but with distinct areas of specialism (Protect, Solve and Convict) with Protect incorporating Public Protection investigations. These Investigations teams are made up of a mix of specialisms, but are not 'generic'. Specialist expertise is thereby retained with the ability to task the right resources according to the type of investigation needed, as well as to pool resources when necessary.
- By way of context, the Constabulary recorded 184 Safeguarding Adult Crimes and 351 Safeguarding Adult Incidents in Bath and North East Somerset during 2014/15, increases of 133% and 142% respectively on the previous 12 months. The number of Domestic Abuse Crimes recorded in 2014/15 was 894, representing an increase of 25% on the previous financial year, with 2037 Domestic Abuse Incidents being recorded, an increase of 25% compared with the previous year.

**Performance to LSAB indicators 2014-2015:**

| 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 delivered across the force area. An input is given to all 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 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% | | 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 checks ***(All)*** | 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 to identify and protect vulnerable people | | |

**Describe how you raise awareness of safeguarding in your agency:**

- We want everyone within the Constabulary to know and understand their role and responsibility for victim care, be able to identify vulnerability and recognise the part they play can impact on the victim’s journey through the criminal justice system.
- The Constabulary therefore has an ongoing programme of vulnerability training. In conjunction with SARI, we delivered in November 2014 a

conference entitled 'Policing for Disabled People' to frontline officers which covered: Autism & the Criminal Justice System; Alzheimer's & Dementia; being a wheelchair user – impacts and barriers and how the police service can be accessible; Mental Health; sensory impairments; contributions from Disability Advisory Group (DIAG); and panel discussions with service users.

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

- The North East Safeguarding Coordination Unit acts as the central point of contact for all safeguarding issues and referrals in Bath and North East Somerset, including cases involving vulnerable adults
- The Safeguarding Coordination Unit links patterns in order to proactively safeguard victims, and works directly with partner agencies, including Adult's Social Care and Health. They undertake risk assessments of all incidents and intelligence received, make decisions, partnership referrals and hold strategy discussions.

**Objectives for 2015-2016:**

- Improve multi-agency response to growing safeguarding demands and ensuring that Avon and Somerset remains at the forefront nationally in terms of victim care
- Improve the way agencies share information and identify vulnerability at first point of contact
- Embed learning and improve identification and response to vulnerable victims
- Successfully Implement ACPO's 13 strands of vulnerability
- Successfully communicate & implement the changes from the 2014 Care act to ensure the police work collaboratively with partners to protect and safeguard the most vulnerable adults in our communities

**Agency Name: Sirona Care and Health**

**Brief outline of agency function:**

Community health and social care provider, providing a wide range of services and employing a range of health and social care staff.

**Achievements during 2014-2015:**

- Sirona Care and Health has continued to play a key role within the multi-agency framework set by the B&NES Local Safeguarding Adults Board. Representatives play an important part in the work of the LSAB and all of its sub groups, covering Training and Development; Quality Assurance; Policy and Procedures; Awareness, Engagement and Communications; and *Making Safeguarding Personal.*

- Sirona Care and Health managed a total of 617 Safeguarding Adults referrals in 2014-15 and referred others on to appropriate teams in AWPT.

- In July 2014 we reorganised our teams and created a new ASIST team in order to provide a more robust and consistent response to safeguarding cases.

- Managers carried out a detailed audit of 92 cases and, of these, 69% were considered to have been ‘well’ or ‘very well’ managed in a person-centred way.

- We took a lead role in organising a very successful Stakeholder Event entitled Safeguarding and the Care Act: Is it Business as Usual?

- We took a lead role in organising the area Safeguarding Training Self Audit

- In March 2015 we undertook a series of *Introduction to the Care Act* training courses which included a section on changes to legislation around Safeguarding

- We continued to run level 1, Level 2 and Level 3 Safeguarding Adults courses and to offer a significant number of places to the voluntary and independent sector

- We also run a series of courses on MCA and DoLS.

- We have updated our Safeguarding Adults policies and procedures

**Performance to LSAB indicators 2014-2015:**

| Indicator | Target | Outturn | Comment |
|---|---|---|---|
| New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)*** | 95% | 95% (est) | |
| 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% | 73% | |
| 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% | 59% | |
| Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage*** | 95% | 95% (est) | |

| | | | |
|---|---|---|---|
| ***Care Homes and Hospitals, Sirona and AWP only)*** | | | |
| Relevant staff to have an up to date DBS checks ***(All)*** | 100% | 100% | |
| Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments** | We have approximately 30 Safeguarding champions across the organisation. | | |

**Describe how you raise awareness of safeguarding in your agency:**

- Sirona Care and Health runs regular training courses as described above – these are mandatory for frontline staff
- We have also commissioned specialised training on *Making Safeguarding Personal*
- Role of our Safeguarding Lead in Stop Adult Abuse Week – plus flyers and posters in appropriate buildings
- Regular Champions' meetings
- The Adverse Events process is linked with Safeguarding processes
- Safeguarding is regularly on the agenda in team meetings, senior leadership meetings and at SLT and Board level
- Social work staff and managers have attended specialised training on legislative and practice changes resulting from implementation of the Care Act

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

- Sirona Care and Health employs all the Adult Care and Learning Disabilities social workers and they play a key role in investigating concerns
- We are in the process of implementing MSP principles through training and practice discussions
- There is a gradual increase in the use of advocates
- 69% of cases audited were considered to have been managed 'well' or 'very well' in a person-centred way.

**Objectives for 2015-2016:**

- More focused training around MSP and the Care Act will be delivered to practitioners in 2015-16 and plans are in hand to do this in the Autumn
- Staff training levels (against the 3 – year refresher measure) are still not as good as want and there will be a new campaign to ensure that relevant staff book places on the half-day level 2 course.
- Sirona Safeguarding Adults policies and procedures to be updated again in

line with the Care Act 2014

- Work will be undertaken to improve the information available on the Sirona public website about Safeguarding Adults
- Sirona Care and Health will continue to contribute fully to the work of the B&NES LSAB and its sub groups

| **Agency Name: Avon and Somerset National Probation Service** | | | |
|---|---|---|---|
| **Brief outline of agency function:**<br>National Probation Service | | | |
| **Achievements during 2014-2015:** (in bullet points)<br><br>Transforming Rehabilitation Implementation. | | | |
| **Performance to LSAB indicators 2014-2015:** | | | |
| **Indicator** | **Target** | **Outturn** | **Comment** |
| New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)*** | 95% | 50% | New Training Programme just starting to bed in |
| 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% | 50% | As above |
| 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% | 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 checks ***(All)*** | 100% | 100% | NPS enhanced |
| Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments** | On going see below | | |
| **Describe how you raise awareness of safeguarding in your agency:** | | | |

NPS new approach to include new policy and practice guidance current self assessment and follow QA being undertaken .

Training programme to be further developed which will include fresh set of objectives

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

The role of the NPS is to protect the public, support victims and reduce reoffending. It does this by assessing risk and advising the courts to enable the effective sentencing and rehabilitation of all offenders; working in partnership with Community Rehabilitation Companies and other service providers; and directly managing those offenders in the community, and before their release from custody, who pose the highest risk of harm and who have committed the most serious crimes. In carrying out its functions, the NPS is committed to protecting an adult's right to live in safety, free from abuse and neglect.

This policy statement acknowledges the NPS's responsibility towards safeguarding and promoting the welfare of adults at risk. It recognises the importance of working with people and other organisations together to prevent and stop both the risks and experiences of abuse and neglect, whilst at the same time making sure an individual's well-being is being promoted with due regard to their views, wishes, feelings and beliefs. It also acknowledges the contribution the NPS can make to the early identification of an offender in the community's care and support needs as well as cases where an offender who is a carer needs support.

The focus of this policy statement is on NPS involvement with offenders in the community either as part of a community sentence or on post-release licence. The policy on adult safeguarding in prisons is set out in PSI 16/2015. The policy on adult social care in prisons and ensuring continuity of care into the community is set out in (PI 11/2015 (PSI 15/2015) The latter PI is supplemented by specific guidance on the social care provision for residents in Approved Premises, which will form part of the Approved Premises Manual.

**Objectives for 2015-2016:**

**TBC**

## Appendix 7 LSAB Business Plan 2014/15 outturn

See website

http://www.bathnes.gov.uk/services/care-and-support-and-you/safeguarding-and-legal-information under the Business Plan section.

Or hyperlink:

Safeguarding: information for professionals and practitioners | Bathnes

## Appendix 8 Keeping Yourself Safe Report

**Analysis of Responses from the Safeguarding Adults Service User Feedback Questionnaire 'Keeping You Safe'**

**Reporting Period:** 2014-2015

**Author:**
Karyn Yee-King (B&NES Council) on behalf of LSAB Awareness, Engagement and Communication Sub-Group and MSP Sub-Group

### 1. Purpose of the Report

1.1 The Care Act (2014) has made explicit the need to involve Service Users at all points in the Safeguarding Process and the 'Making Safeguarding Personal' (MSP) approach is now prominent in the Care Act Guidance and is a 'must do'.

1.2 The LSAB has been clear in its commitment to ensuring that these core values and principles are integral in all aspects of the Safeguarding Procedure. Over the last year a Making Safeguarding Sub-Group of the LSAB was formed to act as a springboard to develop the approach in Sirona and AWP.

1.3 The Safeguarding 'keeping you safe' questionnaire was introduced a number of years ago prior to introduction of MSP and was a way of ensuring each service user' is given the opportunity for their voice to be heard, it provides the LSAB and operational practitioners with learning to inform improvement in practice and service delivery.

1.4 However, since the introduction of MSP principles within the Safeguarding process a greater emphasis has been placed on involving the service user or their advocate/carer from the beginning to the end. Their views should be sought and of importance what they would want as an outcome/s to the Safeguarding process and whether this has then been met. Although MSP is a relatively new concept in terms of it being placed on a statutory footing within the Care Act, Banes were involved from the pilot stage in 2013. As a result early findings suggest that the qualitative information on the service user experience is of higher quality and of greater value than the information collated from the Service User Feedback Forms.

1.5 The report contributes to objectives 1.3, 3.1, 3.3, 3.4 and 4.1 of the LSAB Business Plan.

1.6 This report, thereby, seeks to provide a summary of the questionnaires

received within the review period 2014/15. However, in summary it provides evidence to demonstrate that the service user questionnaires in its current format has not had a significant impact on on-going learning and practice development or its effectiveness in determining an outcomes based model of Safeguarding.

## 2. Background

2.1 The involvement of service users by the LSAB occurs via a number of mechanisms:

- Service users are involved and consulted about the development of safeguarding policies and procedures – this is undertaken at a variety of forums for example the 'Keeping You Safe' questionnaire itself was reviewed by the Sirona Care and Health Service User Panel and by Your Say.
- Service users are directly involved in developing new arrangements to keep them safe e.g., Keep Safe areas Keynsham and Midsomer Norton and now progressing and new areas are being considered in Bath as a result of Safeguarding concerns being raised in particular areas of the city.
- The service users' voice is heard through-out the safeguarding procedure including participation in planning meetings and beyond in terms of being consulted as to whether they feel safer as a result of the process, reinforced by changes to the data collection which specifically requires practitioners to have asked this question.
- As a result of the outcomes based model and MSP changes were made to the data collection to ensure that practitioners were considering whether the Service Users' outcome/s had been met.
- As part of the collaborative approach introduced through MSP Service Users at risk are now more likely to be talked to/met before the Strategy meeting in order to elicit their views and wishes. Through this approach there is a higher likelihood that preferred outcomes as expressed by the Adult at Risk could be met by means other than progressing through Safeguarding Adults process. More supportive approaches to risk management have enabled this development.
- Service users are asked to complete 'Keeping You Safe' – a questionnaire that is given to everyone that is referred into the safeguarding process.

2.1 Through the Awareness, Engagement and Communications sub group work continues to appoint lay members to the LSAB Board to ensure a wider perspective is sought. Health watch has progressed the recruitment process but continue to be challenged by the lack of appropriate individuals to take on the role. In lieu of this and to ensure that the LSAB focus remains firmly fixed on the experience of the

Adults at Risk, the MSP sub group alongside Awareness, Engagement and Communications sub group introduced a regular agenda item at the beginning of the LSAB presenting a case study, evidencing an outcome focussed approach.

2.3 The current ‘Keeping You Safe’ questionnaire was implemented in 2011 following a review of the process at the time whereby service users were telephoned for their views. The problems associated with this approach will not be documented here. However, it should be noted that the principles of this previous approach is still embodied in part in the current questionnaire and should be considered in terms of the ‘Next Steps’ in moving forward with service user’ participation. It should also be noted that a further review of the questionnaire was undertaken by the Awareness, Engagement and Communication sub-group this year and changes made to wording with the addition of pictures to ensure accessibility to all. Information was also provided regarding organisations that could be contacted if independent assistance on completion was required.

## 3 Keeping You Safe Questionnaire Distribution

3.1 As stated the questionnaire is distributed to all service users that have been part of the Safeguarding Procedure as outlined in the Bath and North East Somerset Multi Agency Safeguarding Adults Policy and Procedures. It is distributed by Sirona Care and Health and AWP (B&NES) Teams. It is important to note that service users are provided with a SAE to encourage return. The questionnaires are sent to and collated by the Councils’ Safeguarding Adults and Quality Assurance team and since April 2014 I have taken the lead on ensuring that any promotional work that is required is taken forward. I also take the lead on actioning any follow up calls requested by Service Users in their return.

3.2 The questionnaire is sent /given to all service users of closed safeguarding cases where the service user and or their advocate have been aware of a safeguarding referral and subsequent investigation. Closed safeguarding cases for the purpose of this report include from the strategy meeting / discussion stage onwards. Questionnaires are given to service users advocates when they have been assessed as not having the capacity to be involved directly in the safeguarding procedure and actions.

3.3 During the period 1st April 2014 to 31st March 2015 there were 741 new safeguarding referrals (made up of 622 for Sirona Care and Health and 119 for AWP). Of those 378 in total progressed to a strategy meeting (299 for Sirona and 79 for AWP) in that they met the threshold criteria for adult at risk of significant harm.

3.4 26 questionnaires were returned represented a 7% return rate in comparison to 5.9% for 2013/14.

3.5 There were 7 returns for AWP (3 in 2013/14) and 19 from Sirona (20 in 2013/14). This represents a return rate of 9% return for AWP (4% 2013/14) (based on 79 Safeguarding cases) and 6% for Sirona (6% 2013/14) (based on 299 safeguarding cases).

3.6 Safeguarding chairs are encouraged to remind service users if in attendance or staff in lieu of this, at the last Safeguarding Meeting to send out and facilitate return of the questionnaires. This has been particularly encouraged within the AWP teams due to low returns.

## 4. Findings From The Questionnaire

### 4.1 Service User Feedback Returns Per Month

| Month | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. of Returns | 3 | 3 | 0 | 2 | 6 | 2 | 3 | 3 | 1 | 1 | 1 | 1 |

4.2 The results will be analysed at the end of the report. However, this table indicates that there has been a small increase since 2013/14;

4.3 The majority of the individuals completing the questionnaires did not write any additional comments but merely ticked the boxes.

4.4 The individuals returning questionnaires for the LD teams were supported to complete their form by either social workers or support workers. It is unknown whether the majority of the remaining respondents completed their forms independently. Therefore there is a lack of assurance in terms of whether all responses could be considered to be unbiased or autonomous.

4.5 Only 1 respondent requested follow-up but then didn't leave a name or number in order for that to happen.

4.6 All questionnaires were complete unlike 2013/14 where a number of sections were missing.

4.7 The questionnaire comprises of 10 questions and spaces for comments. Collated responses for the individual service users are as follows:

**Q1. Were you clear about the reasons why a worker came to see you?**

| Yes | No | Not Sure | Not answered |
|---|---|---|---|
| 19 (73%) | 2 (8%) | 3 (11.5%) | 2 (8%) |
| 'To say why I was unhappy about a staff member' | ' I did not attend the SG meetings' 'D does not wish to comment' | One respondent commented 'I have dementia' | Although not answered one person stated 'no-one came to see me' (may be that they were spoken to on the phone but answering according to specific of question asked) |

The above information showing that at 73% stating that they knew why they were visited is lower than the 91% for 2013/14.

**Q2 – Were you given clear information about what was going to happen?**

| Yes | No | Don't know | Not answered |
|---|---|---|---|
| 16 (62%) | 3 (11.5%) | 7(25%) | |
| No comments made | 'not sure what to ask' | No comments | |

62% of respondents felt they were given clear information which is lower than 2013/14 with an increase in the number of respondents both saying they didn't feel that they were provided with clear information (11.5% in comparison to 4% in 2013/14) and also those who didn't know if they had been (25% in comparison to 9% in 2013/14). The old adage applies here that one doesn't know if they were given clear information unless one knows what the standard is or what to expect. Work is underway to develop a suite of information leaflets outlining from a service user perspective what they can expect at each stage of the process i.e. when they come to a strategy meeting, planning meeting, preparing for you meeting etc.

**Q3 Were you fully able to express your views throughout our involvement with you**

| **Yes** | **No** | **Not Sure** | **Not answered** |
|---|---|---|---|
| 22 (84%) | 0 | 2 (8%) | 2 (8%) |
| 'made M's life more bearable' | | No comments given | 'I spoke to someone in Bristol about my concerns. Then someone |

| | | | from Bath phoned and asked me a few more questions and gave reasons why they were involved too'. |
|---|---|---|---|

Although 8% answered that they weren't sure whether they had been fully able to express their views they hadn't validated this by providing comments as to the context of why they had responded in this way.

**Q4 Did you (and members of your family where appropriate) feel listened to?**

| Yes | No | Not sure | Not answered |
|---|---|---|---|
| **21 (80%)** | **1 (4%)** | **2 (8%)** | **2 (8%)** |
| 'Yes by 2 phone calls only'<br>'moved to a safe place' | No comments | No comments | No comments |

**Q5 Did the worker fully explain what choices were available to you**

| Yes | No | Not sure | Not answered |
|---|---|---|---|
| 18 (69%) | 2 (8%) | 6 (23%) | 0 |
| 'I would have liked someone to have seen my flat'<br>'I saw the police, I was invited to 4 of the 4 meetings and in hospital for the other' | No comments | No comments | |

A result of 69% is a drop in service user satisfaction around choices being offered as this response stood at 82% for 2013/14. It is of concern that there has once again been an increase in those responding in the negative or 'not sure' category. In any learning can be gleaned from these results it is that chairs and care managers need to document what choices have been discussed with service users and this recorded in the minutes of safeguarding meetings. The risk assessment which is being finalised will also assist with detailing choices in regards to positive risk taking that have been explored with the service user.

**Q6 Were you happy with the outcome of our involvement with you**

| Yes | No | Not Sure | Not answered |
|---|---|---|---|
| 22 (84%) | 1 (4%) | 3 (12%) | |
| 'that it would go no further and that it | No comments made as to place | No comments made | |

| was all finished with in the meeting' | this in context | | |
|---|---|---|---|

An 84% satisfaction rate is very positive considering that a service user will not always feel that their outcomes have been met and how this can skew their perception. For example, we often hear service users or their carers expressing that they want a member of staff sacked when this is not in our gift and gets translated into them feeling that the care manager has not done enough.

**Q7. Did the worker keep you fully informed/updated throughout their involvement with you**

| Yes | No | Not Sure | Not answered |
|---|---|---|---|
| 19 (73%) | 1 (4%) | 4 (15%) | 2 (8%) |
| 'Definitely' And another said 'there was a clear line of written and verbal communication at every stage' A service user with a learning disability said that they were kept fully informed but couldn't recall what they said. Another service user with a Learning Disability gave yes as an answer and stated that their support worker also gave them the information | 'K was unaware of the first meeting i.e. strategy' | No additional comments | 'Just and update after the safeguarding meeting. I would have liked a letter re outcome not just a phone call' |

This is a marginally higher positive response. However, what could be extrapolated is that service users feel they are given information at the beginning of a safeguarding process but perhaps this momentum is not consistent as time goes on and it would be interesting if information were available as to whether those who didn't answer or who were unsure had progressed to either first or second review.
The last comment about not being provided with written information mirrors similar comments made last year. The question needs to be asked as to why the service user was not sent minutes of the relevant safeguarding meeting in which the outcome of the safeguarding should be clearly recorded. Additionally, it may be worth considering formally writing to service users at the completion of the safeguarding summarising what their outcomes were, whether these were met and informing them that Safeguarding Process had ended.

## Q8 Do you feel you were treated with dignity and respect at all times?

| Yes | No | Not sure | Not answered |
|---|---|---|---|
| 23 (88%) | 0 | 2 (8%) | 1 (4%) |
| 'very much so'<br>'very nice'<br>'they were polite' | | No comments to contextualise provided | |

At 88% this is the highest rated affirmative response. This is an excellent result in terms of the engagement and approach workers had with service users, and reflects high satisfaction especially as this is an area that has received a high degree of media attention.

## Q9 By the time you finished seeing your worker, did you feel….

| Outcome | Number of responses 2014/15 | 2013/14 comparator |
|---|---|---|
| Safer | 18 | 12 |
| More informed | 15 | 12 |
| More Independent | 7 | 2 |
| More in control of your life | 13 | 3 |
| More supported | 13 | 10 |
| Enabled to live where you wanted | 8 | 2 |
| That your carer/family were supported | 5 | 4 |
| Other (please specify) | 5 | 1 |
| | | |

There was only one additional comment of:
'Showed happiness and wanted the staff member to work with me again'
'Good experience'
'I felt completely at ease and not judged unfairly at all'.
'As a result I now have a community alarm which makes me feel very safe'
The results within this table appear to be most reassuring in terms of identifying the outcomes for service users

## Q10 Is there anything we could have done better?

There is no tick box option on this question and respondents are requested to comment. All are listed below:

- 'I would like to have been more informed'
- 'The whole process has reassured me'
- 'SB was lovely and very caring. I felt she understood my concerns and was there to help'.

- ‘clear at all times’

**Q11 I would like someone to respond to the comments I have made in this questionnaire**

24 answered no
2 answered yes they would like contact

Follow up was made with the individuals who requested it and they were supported to express further views. The two individuals did not wish to make any further comment about the safeguarding but wanted to request input and advice regarding their care management support.

**5. Conclusion**

5.1 Obtaining any service user feedback within any sector has always proven challenging. This is particularly the case within safeguarding adults for many different reasons from the service user being reluctant to relive the abuse to poor cognition and recall. Our sample continues to be small and not necessarily quantitatively significant. Whilst the importance of seeking service user views cannot be undoubtedly questioned the qualitative value of the analysis to inform practice and service improvements is limited.

5.2 Humphries (2011) found safeguarding outcomes were mostly reactive and needed to be linked more to the aspirations of personalisation, and promotion

Of dignity, choice and control. They found that expected outcomes are rarely defined clearly from the outset, and there is some evidence that service users find intervention to be process-driven rather than person-centred.

5.3 From the limited research available and tentatively supported by feedback from service users both this year and last (including MSP feedback) ‘The value of existing relationships in supporting positive safeguarding interventions, not least because they facilitated effective communication between service users and professionals, was repeatedly highlighted. This would suggest that in the ‘‘age of personalisation’’ care management practice would benefit from the re-introduction of old-style relationship-based social work practices….in order to support effective safeguarding’ (Fyson and Kitson, 2012). The ‘social work practices’ referred to can be delivered in many different ways, improving and sustaining positive outcomes for service users. From early stages of the MSP implementation, evidenced by the audits undertaken, this appears to beginning to be realised.

**6. Recommendations**

**(i)** To propose that the questionnaire is not routinely sent to all service users who have been through the safeguarding process but that the questions asked within the questionnaire are used as prompts within the safeguarding meetings to

elicit service user views on their experience. If not present the chair to task the Safeguarding Adult Lead Worker to elicit these responses and to feed them into the relevant meetings. The aim is for improved quality of information as opposed to a ‘tick-box’ format.

**(ii)** Assurance on the service user experience will be provided by the regular updates to the LSAB on MSP (see draft action/project plan)

**(iii)** To complete new ‘service user friendly’ information sheets on the Safeguarding Process, highlighting what they have the right to expect and our promises to them.

**(iv)** Consider the opportunity for follow up interviews with a sample of those who have been through the process a period of time after closure. There is an absence of research literature on the longer term effects of safeguarding. To seek out areas nationally where this is being done and develop proposal to take this forward if of benefit.

**(v)** To build on the changes that have been made to CareFirst in terms of data collection in relation to outcome measures. To ensure that we continue to work with the Liquid Logic team to build a system that takes account of both quantitative and qualitative information.

**(vi)** Consideration implementing formal closure letter to service users who have been through safeguarding process confirming ending of Safeguarding and summarising outcomes achieved.

**(vii)** Increase referral rates for advocates to support individuals through safeguarding process as this will lead to increase in improvement of sharing of service user experience.

**(viii)** Learn from the MSP pilot and incorporate this into the local process.

**(ix)** Consider ways in which service users taking part in safeguarding meetings can be helped to ‘plan’ for that meeting so that they are enabled to prepare their responses ahead of time.

**References**

DH (2008). Safeguarding Adults: A consultation on the review of the ‘No Secrets’ guidance. London, Department of Health.

Humphries, R. (2011) ‘Adult safeguarding: early messages from Peer reviews.’ The Journal of Adult Protection 13(2).

Fyson, R. and Kitson, D. (2012) ‘Outcomes following adult safeguarding alerts: a critical analysis of key factors.’ Journal of Adult Protection 14(2)

## Appendix 9 LSAB Budget 2014/15

| **2014-15** | |
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| **Income** | |
| BANES NHS CCG | **6000** |
| Avon Fire and Rescue | **1000** |
| Avon and Somerset Constabulary | **1000** |
| B&NES Council | **36057** |
| **Total** | **44057** |
| **Expenditure** | |
| Independent Chair | **12502** |
| MASH - Scoping Commission | **9063** |
| Organisation and Administration | **3090** |
| Room and Equipment Hire | **1700** |
| Training | **17702** |
| **Total** | **44057** |

The income for the LSAB is either an agreed contribution from the partner organisations or identified funds from the council to support the individual activities. The council contribution fluctuates with actual spending.

Bath & North East Somerset Council

healthwatch Bath and North East Somerset

NHS Bath and North East Somerset Clinical Commissioning Group

| MEETING | B&NES HEALTH AND WELLBEING BOARD |
|---|---|
| DATE | 28/10/2015 |
| TYPE | An open public item |

| Report summary table | |
|---|---|
| **Report title** | Establishment of a Bath and North East Somerset Antimicrobial Resistance Strategic Collaborative |
| **Report author** | Elizabeth Beech (Elizabeth.beech@nhs.net) and Ian Orpen (ian.orpen@nhs.net), NHS BaNES CCG |
| **List of attachments** | None |
| **Background papers** | All background papers are in the public domain and are detailed below with hyperlinks. It is not anticipated that Board members will read all or any of these papers, but they have been included should anyone wish to access the strategic documents referred to within this report.<br>• Review on Antimicrobial Resistance http://amr-review.org/<br>• National Risk Register of Civil Emergencies https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419549/20150331_2015-NRR-WA_Final.pdf<br>• UK 5 Year Antimicrobial Resistance Strategy 2013 to 2018 https://www.gov.uk/government/publications/uk-5-year-antimicrobial-resistance-strategy-2013-to-2018<br>• Progress report on the UK 5 year AMR strategy: 2014 https://www.gov.uk/government/publications/progress-report-on-the-uk-five-year-amr-strategy-2014<br>• Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use NG15 August 2015 https://www.nice.org.uk/guidance/ng15<br>• Antimicrobial stewardship - changing risk-related behaviours in the general population http://www.nice.org.uk/guidance/indevelopment/gid-phg89<br>• English surveillance programme antimicrobial utilisation and resistance (ESPAUR) report PHE 2014 https://www.gov.uk/government/publications/english-surveillance-programme-antimicrobial-utilisation-and-resistance-espaur-report<br>• NHS Atlas of Variation 2015 http://www.rightcare.nhs.uk/index.php/nhs-atlas/<br>• Cornwall Antimicrobial Resistance Group set up in response to |

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| | UK Five Year Antimicrobial Resistance Strategy 2013 to 2018<br>Iain Davidson - Cornwall Hospitals NHS Trust; Neil Powell - Cornwall Hospitals NHS Trust<br>PHE Annual Conference 2015 Evidence into action: implementing antimicrobial stewardship initiatives<br>https://www.phe-events.org.uk/hpa/frontend/reg/absViewDocumentFE.csp?documentID=8784<br>• NHS Bath and North East Somerset CCG Annual Report and Accounts 2014-15<br>http://www.bathandnortheastsomersetccg.nhs.uk/documents/annualreports/annual-report-2015 |
| **Summary** | *If we fail to act, we are looking at an almost unthinkable scenario where antibiotics no longer work and we are cast back into the dark ages of medicine" – David Cameron, UK Prime Minister*<br><br>Antimicrobial resistance (AMR) is an increasing global and national problem, predicated to kill an extra 10 million global deaths a year by 2050 – more than cancer. There have been very few new antibiotics developed in the past 30 years and very few are in development at the moment. Therefore stewardship of existing antibiotics is essential to allow us to continue to successfully treat infections now and in the future. Already 25,000 deaths occur every year in Europe due to resistant infections. The UK Government have included AMR in the National Risk Register of Civil Emergencies and have published a UK 5 Year Antimicrobial Resistance Strategy 2013 to 2018. Implementation of this strategy is a Public Health England (PHE) priority, and the NHS need to support PHE deliver this.<br><br>NHS BaNES CCG has been working over the past 18 months to improve the use of antibiotics, and this has been partly successful. However a whole economy wide approach is now required to allow us to effectively implement the key objectives within the UK 5 Year Antimicrobial Resistance Strategy. To do this we need to collaborate throughout the whole of Bath and North East Somerset: to improve the prevention of infection, increase peoples understanding of the risks that resistant infections bring, and encourage behaviour change to reduce the inappropriate use of antibiotics. 80% of antibiotic use is in primary care and the community, and half of this is for respiratory infections, many of which are self-limiting and can be managed with supported self-care, for example from community pharmacies. However, there is also a significant amount of 'unknown' antibiotic use in other areas such as dental care; and the large numbers of tourists visiting Bath bring both resistant bacteria and a variety of imported antibiotics.<br><br>We propose the establishment of a Bath and North East Somerset Antimicrobial Resistance Strategic Collaborative, chaired by the CCG Clinical Chair, reporting to the Health and Wellbeing Board. Membership would include wide representation from NHS and private health care providers, public health, PHE, academic and |

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| | clinical networks, patient and public representation, and local healthcare professional representation. The purpose of the Collaborative is to facilitate implementation of the UK 5 Year Antimicrobial Resistance Strategy key objectives at a local level, in particular;<br>• Improving infection prevention and control practices<br>• Optimising prescribing practice<br>• Improving professional education, training and public engagement<br>• Developing new drugs, treatments and diagnostics<br>• Better access to and use of surveillance data |
| **Recommendations** | The Board is asked to:<br>1. Agree to the establishment of a Bath and North East Somerset Antimicrobial Resistance Strategic Collaborative, chaired by the CCG Clinical Chair, reporting to the Health and Wellbeing Board at 6 monthly intervals<br>2. Support European Antibiotic Awareness Day on 18th November and pledge to become an Antibiotic Guardian at https://antibioticguardian.com/ |
| **Rationale for recommendations** | Antimicrobial resistance (AMR) is an increasing global and national problem, predicated to kill an extra 10 million global deaths a year by 2050 – more than cancer. There have been very few new antibiotics developed in the past 30 years and very few are in development at the moment. Therefore stewardship of existing antibiotics is essential to allow us to continue to successfully treat infections now and in the future. Already 25,000 deaths occur every year in Europe due to resistant infections. The UK Government have included AMR in the National Risk Register of Civil Emergencies and have published a UK 5 Year Antimicrobial Resistance Strategy 2013 to 2018. Implementation of this strategy is a Public Health England (PHE) priority, and the NHS need to support PHE deliver this.<br><br>If AMR continues to develop to the remaining antibiotics we still have, we will lose our ability to provide safe and effective healthcare to our whole population, from child birth to routine elective surgery such as hip replacements, to patients with long term conditions such as diabetes and respiratory illnesses. We therefore need to improve our stewardship of those antibiotics we still have working.<br><br>NHS BaNES CCG has been working over the past 18 months to improve the use and stewardship of antibiotics, and this has been partly successful, as highlighted in the CCG Annual Report. However a whole economy wide approach is now required to allow us to effectively implement the key objectives within the UK 5 Year Antimicrobial Resistance Strategy. To do this we need to collaborate throughout the whole of Bath and North East Somerset. |

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| | A Bath and North East Somerset Antimicrobial Resistance Strategic Collaborative would support wider engagement and more effective implementation of the UK 5 Year Antimicrobial Resistance Strategy at a local level. It will align to recent NICE guidance promoting the value of whole economy antimicrobial stewardship programmes, and support the implementation of Public Health England Local AMR plans.<br><br>There is no existing whole health economy AMR collaborative in Bath and North East Somerset at present, although there is a BaNES CCG led Healthcare Infection Prevention Collaborative that would contribute and report to the proposed AMR collaborative. In addition other topic related working groups, for example the NHS England immunisation planning group, would be invited to contribute. This provides an excellent opportunity to collaborate to deliver the Joint Wellbeing Strategy health outcomes.<br><br>Cornwall have successfully implemented an AMR Collaborative that is demonstrating real gains to local communities; for example winning innovation funding to provide Infection Prevention and Control nursing expertise to work with children in schools who have had disruptive winter infections outbreaks.<br><br>How the recommendations contribute to the delivery of the outcomes in the Joint Health and Wellbeing Strategy:<br>• <u>Preventing ill health by helping people to stay healthy</u><br>Inappropriate antibacterial use can lead to the development of bacterial resistance and infections become harder to treat, particularly in the very young, very frail, and those who are immunocompromised, such as people with cancer. Healthy people can transfer resistant bacteria to other people who are vulnerable. Preventing infection is an essential part of reducing the use of antibiotics, and includes effective use of hand washing, vaccination and self-care. Educational and behavioural change strategies are vital to promoting these activities to the residents of BaNES to help them stay healthy.<br><br>• <u>Improving the quality of people's lives</u><br>The availability of effective antibiotics are essential to keeping people healthy, reducing the burden of ill health associated with long term conditions such as respiratory disease and diabetes. Inappropriate use of antibiotics contributes to the development and spread of resistant infections putting this population at risk of avoidable harm (harm from untreatable and hard to treat infections such as MRSA, and harm from antibiotic associated infections such as Clostridium difficile infection which can be fatal). Inappropriate use includes the use of antibiotics to treat infections caused by viruses (antibiotics do not work for viral infections), self-limiting infections (that will get better without antibiotics), and use of broad spectrum antibiotics when not |

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| | required (narrow spectrum antibiotics should always be used where possible to minimise the development of resistance to broad spectrum antibiotics which are required for serious infections such as blood stream infections, and infections already resistant to usual antibiotics).<br><br>• Tackling health inequality by creating fairer life chances The ESPAUR report shows the volume and choice of antibiotics varies widely throughout England, with higher levels of bacterial resistance reported in areas with higher use of specific antibiotics. National antibacterial prescribing indicators included in the NHS Atlas of variation show wide variation in primary care antibiotic prescribing; NHS BaNES CCG have very high use of key antibiotics (broad spectrum antibiotics; low use is better than high use). |
| **Resource implications** | Resource costs are anticipated to be minimal initially, limited to staff time to attend 4 meetings a year and this would be met by all organisations contributing to the AMR Collaborative. Meeting resources and administrative support could be provided by the CCG. The collaborative will be able to apply and bid for resource funding to support innovation and effective interventions, and may contribute a resource gain for the health economy.<br><br>A successful collaborative is anticipated to increase appropriate self-care of infections, resulting in a reduction in workload for primary and emergency healthcare services. Increased uptake of vaccinations would deliver a reduction in preventable infections in all parts of the economy, resulting in reduced days lost at work and school, reduced workload for healthcare services, and a reduction in avoidable life lost. Avoidance of healthcare acquired infections will reduce harm and associated costs - each Clostridium difficile infection costs the NHS at least £10,000 |
| **Statutory considerations and basis for proposal** | None anticipated |
| **Consultation** | Health care providers and professionals have been informally consulted and expressed support and willingness to contribute to the collaborative. Public Health has been consulted locally and is fully supportive of the initiative. Public Health England has been informally consulted and is supportive and able to contribute. The BaNES CCG led Healthcare Infection Prevention Collaborative has been consulted and discussed the proposal and is fully supportive and has expressed a desire to report its activities to the collaborative. |
| **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. |

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