Bath & North East Somerset Council

Democratic Services
Guildhall, High Street, Bath BA1 5AW
Telephone: (01225) 477000 *main switchboard*
Direct Line: 01225 394458 Fax: 01225 394439
Web-site - http://www.bathnes.gov.uk

Date: 16th November 2015
E-mail: Democratic_Services@bathnes.gov.uk

To: All Members of the Health and Wellbeing Select Committee

Councillor Francine Haeberling
Councillor Karen Warrington (Substitute for Councillor Geoff Ward)
Councillor Bryan Organ
Councillor Paul May
Councillor Eleanor Jackson
Councillor Tim Ball
Councillor Lin Patterson

Cabinet Member for Adult Social Care & Health: Councillor Vic Pritchard

Chief Executive and other appropriate officers
Press and Public

Dear Member

Health and Wellbeing Select Committee: Wednesday, 25th November, 2015

You are invited to attend a meeting of the **Health and Wellbeing Select Committee**, to be held on **Wednesday, 25th November, 2015** at **10.00 am** in the **Kingston Room - Pump Room, Bath.**

The agenda is set out overleaf.

Yours sincerely

Mark Durnford
for Chief Executive

If you need to access this agenda or any of the supporting reports in an alternative accessible format please contact Democratic Services or the relevant report author whose details are listed at the end of each report.

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 Mark Durnford who is available by telephoning Bath 01225 394458 or by calling at the Guildhall Bath (during normal office hours).

2. **Public Speaking at Meetings:** The Council has a scheme to encourage the public to make their views known at meetings. They may make a statement relevant to what the meeting has power to do. They may also present a petition or a deputation on behalf of a group. Advance notice is required not less than two full working days before the meeting (this means that for meetings held on Wednesdays notice must be received in Democratic Services by 4.30pm the previous Friday)

   The public may also ask a question to which a written answer will be given. Questions must be submitted in writing to Democratic Services at least two full working days in advance of the meeting (this means that for meetings held on Wednesdays, notice must be received in Democratic Services by 4.30pm the previous Friday). If an answer cannot be prepared in time for the meeting it will be sent out within five days afterwards. Further details of the scheme can be obtained by contacting Mark Durnford as above.

3. **Details of Decisions taken at this meeting** can be found in the 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 Mark Durnford as above.

   Appendices to reports are available for inspection as follows:-

   Public Access points – Reception: Civic Centre - Keynsham, Guildhall - Bath, The Hollies - Midsomer Norton. Bath Central, and Midsomer Norton public libraries.

   For Councillors and Officers papers may be inspected via Political Group Research Assistants and Group Rooms/Members' Rooms.

4. **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.

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

6. THE APPENDED SUPPORTING DOCUMENTS ARE IDENTIFIED BY AGENDA ITEM NUMBER.

7. **Emergency Evacuation Procedure**

When 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 and Wellbeing Select Committee - Wednesday, 25th November, 2015

at 10.00 am in the Kingston Room - Pump Room, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

   The Chair will draw attention to the emergency evacuation procedure as set out under Note 6.

3. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

4. DECLARATIONS OF INTEREST

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

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

   (b) The nature of their interest.

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

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

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

6. ITEMS FROM THE PUBLIC OR COUNCILLORS - TO RECEIVE DEPUTATIONS, STATEMENTS, PETITIONS OR QUESTIONS RELATING TO THE BUSINESS OF THIS MEETING

   At the time of publication no notifications had been received.

7. MINUTES - 30TH SEPTEMBER 2015 (Pages 7 - 20)

8. CLINICAL COMMISSIONING GROUP UPDATE

The Panel will receive an update from the Clinical Commissioning Group (CCG) on current issues.

9. CABINET MEMBER UPDATE

The Cabinet Member will update the Panel on any relevant issues. Panel members may ask questions.

10. PUBLIC HEALTH UPDATE

Members are asked to consider the information presented within the report and note the key issues described.

11. HEALTHWATCH UPDATE

Members are asked to consider the information presented within the report and note the key issues described.

12. RNHRD - SERVICE MOVES, ENGAGEMENT & CONSULTATION (Pages 21 - 30)

This paper has been prepared to ensure that the B&NES Health and Wellbeing Select Committee are kept up-to-date with proposals to relocate Royal National Hospital for Rheumatic Diseases (RNHRD) clinical service from their current location at the Mineral Hospital site to ensure sustainable high quality service delivery.

13. DIRECTORATE PLAN FOR PEOPLE & COMMUNITIES (Pages 31 - 60)

This report presents the People and Communities Directorate Plan to the Panel for initial consideration and feedback as part of the Council's service planning and budget development process.

14. LSAB ANNUAL REPORT (Pages 61 - 160)

This report is brought to the attention of the Select Committee for its consideration with regard to the content of the Annual Report, its analysis and the on-going work of the LSAB.

15. SELECT COMMITTEE WORKPLAN (Pages 161 - 164)

This report presents the latest workplan for the Select Committee. Any suggestions for further items or amendments to the current programme will be logged and scheduled in consultation with the Chair of the Select Committee and supporting officers.

The Committee Administrator for this meeting is Mark Durnford who can be contacted on 01225 394458.

Bath and North East Somerset Council

HEALTH AND WELLBEING SELECT COMMITTEE

Minutes of the Meeting held

Wednesday, 30th September, 2015, 10.00 am

Bath and North East Somerset Councillors: Francine Haeberling (Chair), Bryan Organ, Paul May, Eleanor Jackson, Tim Ball and Lin Patterson

Officers : Jane Shayler (Deputy Director of Adult Care, Health and Housing Strategy and Commissioning), Bruce Laurence (Director of Public Health), Dr Ian Orpen (Clinical Chair, B&NES CCG), Jo Lewitt (Public Health Development and Commissioning Manager), Sue Blackman (Your Care, Your Way Programme Manager), Denice Burton (Assistant Director of Health Improvement), Alex Francis (Healthwatch B&NES Project Coordinator) and Mike MacCallam (Senior Commissioning Manager)

Cabinet Members in attendance: Councillor Vic Pritchard, Cabinet Member for Adult Social Care and Health

18 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

19 EMERGENCY EVACUATION PROCEDURE

The Chair drew attention to the emergency evacuation procedure.

20 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Geoff Ward had sent his apologies to the Panel.

21 DECLARATIONS OF INTEREST

Councillor Paul May declared an other interest as he is Sirona board member.

22 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

23 ITEMS FROM THE PUBLIC OR COUNCILLORS - TO RECEIVE DEPUTATIONS, STATEMENTS, PETITIONS OR QUESTIONS RELATING TO THE BUSINESS OF THIS MEETING

There were none.

24 MINUTES - 29TH JULY 2015

The Democratic Services Officer reminded the Select Committee that at the last meeting they were asked to make nominations to the South Western Ambulance Service (North Area) Joint Health Overview and Scrutiny Committee and that at the meeting Councillor Geoff Ward was nominated to take up one of the three nominations available.

Following the meeting the Democratic Services Officer said that he had received communication from Councillor Tim Ball that he would like to take up one of the nominations and therefore the Democratic Services Officer asked that this be confirmed by the Select Committee.

The Panel duly agreed to his nomination.

The Panel confirmed the minutes of the previous meeting as a true record and they were duly signed by the Chair.

25 CLINICAL COMMISSIONING GROUP UPDATE

Dr Ian Orpen gave the Select Committee an update on behalf of the Clinical Commissioning Group (CCG), a summary is set out below.

He informed them that Bath and North East Somerset ranks top for preventing people from dying prematurely. He said that the latest data released on 23rd September that measures the number of years of life lost (per 100,000 registered patients) from conditions that are usually treatable shows we are the best performing CCG in England.

Councillor Eleanor Jackson said that she was concerned about an inequality within some areas of the Council.

Dr Ian Orpen replied that it would be a challenge to maintain these current figures and that they would seek to tackle inequality.

Councillor Lin Patterson asked how B&NES currently performs on winter deaths.

Dr Bruce Laurence replied that he felt that we perform well on this matter these days.

The Director of Adult Care and Health Commissioning added that a great deal of energy efficiency work had been carried out on older properties and the homes of elderly people.

Councillor Tim Ball asked if within a future report that some of those inequality factors could be addressed and thought given to as to how those concerned can seek to elongate their lives.

Dr Ian Orpen said that 85% of health outcomes are down to the individual, their lifestyle and employment, but acknowledged the role that they have to play.

He explained to the Select Committee that there is ongoing poor performance in terms of delivering against the national target for A&E waiting times. He said that the

position for August 2015 was 86% compared to the national target of 95% of patients in A&E to be seen within four hours. He added that not many areas reach the 95% target.

Councillor Tim Ball asked if the four hour period was broken down into categories at all as he had always felt that any children or those with serious injuries had been seen swiftly.

Dr Ian Orpen replied that he felt that the figures relating to patients arriving at A&E were quite stable, but that the complexity of conditions had increased. He added that on average patients were staying around half a day to a day longer in hospital. He stated that there was never a handover delay between ambulances arriving at the RUH.

Councillor Paul May asked if there was an issue with patients being discharged from A&E.

Dr Ian Orpen replied that the RUH had low numbers in terms of delayed transfer of care.

He informed the Select Committee that the CCG supported the roll out of the new Meningitis B vaccine to protect babies from the disease. He stated that GPs now offer the vaccine alongside other routine infant vaccines at two months, four months and 12 months of age. He added that in August the CCG also promoted availability of the new Meningitis W vaccine for teenagers.

He said that two CCG employees had been selected as finalists in the 'Excellence in Healthcare Analytics' category of the E-Health Insider Awards for their work on collating and analysing local data for patients with Type 2 diabetes. The winner will be announced on 1 October 2015.

He added that the CCG had also been shortlisted for a Health Service Journal (HSJ) Healthcare Award in the 'Commissioning for Carers' category in recognition of its collaborative working alongside the Council and Bath Carers' Centre. The winner will be announced on 18 November.

The Chair thanked Dr Orpen for his update on behalf of the Select Committee.

26 CABINET MEMBER UPDATE

The Cabinet Member for Adult Social Care & Health, Councillor Vic Pritchard addressed the Select Committee.

He wished to add his congratulations to Curo for the work they did with regard to the case of Legionnaires' disease.

He said that he would try to make progress on the publication of the AWP - Joint Health Scrutiny Working Group report.

He said that he wished to expand on his response at the previous meeting on how the Health & Wellbeing Board differed from the Health & Wellbeing Select

Committee. He said that the Select Committee would scrutinise the role of the NHS and that they have the power to refer matters direct to the Secretary of State.

Councillor Tim Ball asked if the cuts to Public Health budgets are deeper than expected how this impact would be mitigated.

Councillor Pritchard replied that measures are in hand for the expected level of cuts and that he would be addressing the LGA on the matter of removing ring fenced funding to attempt to protect it.

Councillor Eleanor Jackson agreed that it was important to protect the ring fenced funding and welcomed his attempts to progress the AWP report.

The Director of Adult Care and Health Commissioning assured the Select Committee that the specific actions identified by the CQC, including those relating to potential ligature points were addressed as a matter of urgency.

Councillor Paul May commented that he hoped the Council would look to minimise cuts to frontline services within the Health & Social Care budget.

The Chair thanked Councillor Pritchard for his update on behalf of the Select Committee.

27 PUBLIC HEALTH UPDATE

Dr Bruce Laurence addressed the Select Committee, a summary is set out below.

Improving fitness and health in older people

He explained that Retirement in ACTion (REACT) is funded by the National Institute for Health Research. REACT is a UK study based on a successful US programme called LIFE. It is designed to support older adults to become more active. It is being run by the University of Bath in conjunction with others and Bath will be one of the pilot sites.

He said that a 12 month programme would be delivered in leisure centres and health clubs. Participants will be offered group sessions (15-20 per group) targeting cardiovascular, strength, co-ordination and flexibility. It includes a focus on socialising opportunities and enjoyment and promotes local activities to sustain long term impact.

He added that a pilot REACT study would start in Spring 2016 to test the recruitment and measurement strategies. 180 people (60 in Bristol/Bath) will take part across the three centres. The main trial would begin in Autumn 2016.

Sexual Health Needs Assessment

He shared some of the findings with the Select Committee.

B&NES is a low prevalence area for gonorrhoea with 27 infections per 100,000 population in B&NES in 2013, compared to 55 per 100,000 in England), genital herpes (38 per 100,000 in 2013, compared to 60 per 100,000 in England) and genital

warts (123 per 100,000 compared to 137 per 100,000 in England); In 2013, B&NES had a very low incidence of syphilis (5 per 100,000 compared to 6 per 100,000 in England)

Chlamydia detection rates in B&NES are below the recommended rate of 2,300 chlamydia diagnoses per 100,000 15 to 24 year olds

B&NES has a low level of under 18 conceptions, and low level of teenage conceptions when compared to statistical neighbours (18 per 1,000 females aged 15-17 in B&NES in 2013, 21.7 per 1,000 females in statistical neighbours and 28 per 1,000 females in England)

B&NES has a lower rate of abortions than both the regional and national comparators (12.7 per 1,000 women aged 15-44 in 2013, compared to 14 per 1,000 women aged 15-44 in the South of England, and 16.1 per 1,000 women aged 15-44 in England)

He said that five key themes for improvement, with associated actions had been identified as detailed below:

1. Strengthening intelligence and research: including investigating in greater depth the sexual health needs of and service provision for vulnerable and at risk cohorts; and improving the content of sexual health data;

2. Strengthening sexual health service provision: including examining ways to increase the numbers of young people attending GUM and CaSH services; increasing the level of chlamydia testing amongst under 25s; increasing the level of LARC provision amongst women; and improving understanding of the strengths and areas for development in school-based relationships and sex education provision

3. Strengthening prevention and promotion: including developing the SAFE branding scheme; improving website access to information about services; and ensuring all sexual health media and communications campaigns are clearly targeted and evaluated

4. Working with recent technologies: including reviewing and developing the use of new technologies amongst sexual health service providers

5. Strengthening training and development: including developing the Sexual Health Training Programme and holding regular networking events for all of those involved in sexual health across B&NES

Alcohol and drug treatment progress

He informed them that PHE have commended B&NES for their rate of successful completions for ‘alcohol only’ clients, for its hospital alcohol liaison service and also for work on blood-borne virus testing and immunisation.

Flu campaign beginning

He explained that this has become a complex campaign, now including 8 groups. Over 65s, pregnant women, various young children’s groups, carers, health and

social care workers, those living in residential homes, clinical at risk groups (ie people with heart, lung and other diseases that make them particularly vulnerable to flu at any age)..

Adults will now be able to get vaccinated through pharmacies as well as GPs. Good example of combined efforts of NHSE, PHE providers and the Council.

He said there was a focus on flu because of the impact on individuals, health and social care system and the economy.

Public Health Budgets

He stated there was still no final confirmation of in year cuts and that they were awaiting the comprehensive spending review as guide to the longer term budget. He added that there was much speculation on whether the public health grant will lose its ring-fence or not, and if it does what will happen in terms of mandation of services.

Councillor Paul May asked how people would be recruited for the REACT study.

Dr Bruce Laurence replied that this would be done via a number of routes and that they were working with partners as part of the recruitment process.

Councillor Paul May said that he was pleased to see the low figures regarding the Sexual Health Needs Assessment. He asked if any specific work had been carried out with the universities.

Dr Bruce Laurence replied that they do have a good dialogue with them and Bath City College and that comprehensive services were available at all sites.

Councillor Tim Ball asked if a future update could expand on how we deal with the trauma of incidents involving alcohol and drugs.

Councillor Eleanor Jackson commented that whilst there had been a national trend that showed a reduction in alcohol consumption in young people there was an increase in the use of Ketamine and other legal highs. She added that there was also an increase in the number of patients aged 55+ reporting to the RUH with alcohol related incidents.

She said that all concerned should be commended for the low teenage pregnancy figures and called for services in this area to not be cut.

Dr Bruce Laurence replied that in terms of legal highs he felt that we still only know a small amount about these drugs. He added that the services related to teenage pregnancy had been well invested in and that he looked to maintain those services.

The Director of Adult Care & Health Commissioning added that the trends relating to legal highs can change quickly. She suggested that the Select Committee receive an update at a future meeting from the Senior Commissioning Manager, Mental Health and Substance Misuse.

The Chair commented that loneliness in older people was also a problem that needed to be considered.

Dr Bruce Laurence replied that this was one of the priorities of the Health & Wellbeing Strategy.

The Chair asked how Shingles was monitored currently.

Dr Bruce Laurence replied that there was a phased project in place that offered vaccination to those aged either 70 or 79.

Councillor Eleanor Jackson commented that she was aware of a number of recent cases of Scarlet Fever.

Dr Bruce Laurence replied that there had been a slight increase over the last few years, but in all cases it had been treatable.

He then addressed the Select Committee regarding a recent case of Legionnaires' disease in Radstock.

He explained that B&NES has a number of procedures in place to investigate a case of Legionnaires' disease:

- Public Health England Health Protection Unit have a 24/7 Acute Response Centre including out of hours provision.
- B&NES Council also have a 24/7 contact system including an out of hours contact centre, on-call Emergency Planning Officer and Public Protection & Public Health out of hours contact help list.
- Procedures to investigate a single case or an outbreak of Legionnaires' disease are included in the Communicable Disease Incident & Outbreak Response Framework - an Avon & Somerset Local Health Resilience Partnership document and the B&NES Health Protection Incident Response Plan (draft) which has consolidated a number of documents/procedures.
- There are a number of other related guidance documents including the Health & Safety Executives guidance on managing legionella in hot and cold water systems.

He stated that the case in Radstock had been identified towards the end of August 2015 and explained the timeline of events to the Select Committee.

He praised Curo's approach to the incident with regard to testing a large number of properties nearby.

Councillor Eleanor Jackson wished to also commend Curo for their actions as this incident involved 46 flats being investigated. She asked if there had been a delay between the patient being admitted to hospital and the property being cleaned.

Dr Bruce Laurence replied that the Environmental Health Officer went to the property immediately upon receiving notification and had decided after investigating that there was no further risk to other residents.

The Chair thanked him for his update on behalf of the Select Committee.

28 HEALTHWATCH UPDATE

Alex Francis, Healthwatch B&NES Project Coordinator addressed the Select Committee, a summary is set out below.

Preventing ill health by helping people to stay healthy

She said that work was progressing with Julian House to understand the experiences of local homeless people and how we can help them to improve their health. She explained that a survey has been drafted by Healthwatch and is now being agreed with Julian House staff. The survey includes questions about a range of health and social care services in addition to the commissioned in-house medical service provided at Manvers Street Hostel and Julian House's own services, namely the hostel and homeless discharge work at the Royal United Hospital Bath. She said that they hope to run the survey during the autumn.

Improving the quality of people's lives

She informed them that Healthwatch regularly receives feedback regarding primary care and that this feedback varies greatly, but often includes:

- Concerns about waiting times for appointments;
- The need for more information and signposting to voluntary and community-based services to help people manage their health independently; and more recently,
- Concerns about new housing developments and the provision of primary care services in areas where there is already a perceived strain on resources, for example, Foxhill and the Mulberry Park development

She said that Healthwatch also hears positive comments regarding primary care services, for example:

- The group said that Newbridge Surgery has a really easy telephone appointment system for practice nurses and GPs. The GPs aren't always able to call back on the same day but you get allocated a day and time slot.
- Commentator said that St. Chads is a great surgery. They provide staggered GP surgery start times to cover 7am - 8pm. The surgery also has a Friends group that raises funds for the surgery.

She explained since April 2015, people have been able to rate and review health and social care services via the online Healthwatch B&NES feedback centre. She added that Healthwatch is seeing a steady increase in use of this feedback centre by members of the public, patients and their families/ carers and that a new feature has now been added to the website which enables providers to respond to feedback about their services.

She said that Healthwatch has also heard feedback from members of the public regarding the relocation of services from the RNHRD to the RUH. All feedback regarding the relocation of services to the RUH will be shared with the Trust and NHS BaNES Clinical Commissioning Group Quality Group.

Tackling health inequality by creating fairer life chances

She stated that Healthwatch is working with B&NES Council, St Mungos Broadway and the B&NES Health and Wellbeing Network amongst others, to develop a Mental Wellbeing Charter. The charter is linked to 'Think Local, Act Personal', a national initiative which helps organisations to make personalised services truly person-centred.

She said that the Mental Wellbeing Charter has been drafted and will be discussed with service users, carers and their families through a series of community-based focus groups to ensure that it truly reflects their expectations and aspirations. She added that these will take place during October and November and that discussion had already begun with mental health and wellbeing service providers, both statutory and voluntary/ community sector, to build on the Charter and help implement it across their work.

Councillor Tim Ball asked if as part of her work she was able to visit localities to gather information from the seldom heard.

Alex Francis replied that she does visit a number of groups as part of her role and was happy to do so by request.

Councillor Lin Patterson asked if they had done any work within the travelling community within B&NES.

Alex Francis replied that staff had received culture and awareness training regarding this work area.

Councillor Paul May thanked her for a very good report and for the important role that Healthwatch plays. He offered to invite her to a future board meeting of Sirona. He asked if within a future report there could be a section on Primary Care / Tertiary Care.

Councillor Bryan Organ commented that he was pleased that the issues of exercise and loneliness in relation to older people were being addressed.

The Chair thanked Alex Francis for her update on behalf of the Select Committee.

29 TRANSFER OF COMMISSIONING OF HEALTH VISITING AND FAMILY NURSE PARTNERSHIP SERVICES TO THE COUNCIL

The Assistant Director of Health Improvement and the Public Health Development and Commissioning Manager gave a presentation to the Select Committee regarding this item. A copy of the presentation will be available online as an appendix to these minutes and a summary is set out below.

- From 1st October local authorities will take over responsibility for commissioning 0-5 services (Health Visiting and Family Nurse Partnership) from NHS England.

- A 0-5 Transition Board has been planning for and overseeing the handover to ensure a smooth transition and has in place a risk assessment to identify and mitigate any risks associated with this transfer. The provider (Sirona Care and Health) have an agreed transition plan in place and are ready to safely manage the shift from “registered” to “resident” population.

- The contract and the novation agreement have been signed and the Public Health commissioning team are fully prepared to take on their contractual responsibilities and report on the mandatory elements within the core Health Visiting service and aspire towards continuous service improvement, in partnership with other Children’s Services commissioners.

Transition Issues

- Contractual status / Your Care Your Way

- 18 Month Stability Period

- Ring fenced public health budget
  £7.183 million plus additional estimated
  £2.774 million per year for HV and FNP (including commissioning costs)

- Savings review

National Health Visiting Core Specification

- Delivery of the Healthy Child Programme;

- Assessment and intervention when a need is identified; and

- On-going work with children and families with multiple, complex or safeguarding needs in partnership with other key services including early years, children’s social care and primary care.

- 5 mandated touch points

- 6 high impact areas

Transforming the service

The transformed service is described as the 4-5-6 model. Health Visitors and family nurses deliver this service and are a vital link between primary care and early years.

4 Levels of Service

Your community
Universal
Universal plus
Universal partnership plus

5 Universal Health Reviews

Antenatal health promoting visits;
New baby review;
6-8 week assessment.
3-4 month visit (local additional offer)
1 year assessment (9-12mths)
2-2½ review

6 High Impact Areas

Transition to parenthood
Maternal mental health
Breastfeeding
Healthy weight / nutrition and physical activity
Minor illness and accidents
Health and wellbeing / development

Family Nurse Partnership

This service is provided to 69 young families and will give support to them until the child is 2 ½ years old.

0-5 Sector Led Improvement

Aims to:

- Share learning and develop practice for 0-5 year old services both within and outside of the council including developing leadership to:
- Embed family-centred approaches to improve outcomes
- Implement evidence based practice to improve 0-5 and family outcomes
- Transform and integrate 0-5 and 5-19 services
- Evaluate early years' service improvement

Councillor Bryan Organ said that he was pleased that transition arrangements were now a priority.

The Director of Adult Care and Health Commissioning replied that transition planning had hugely improved under the Joint Commissioning Manager for Learning Disabilities.

Councillor Paul May asked if the staff involved saw the transfer as an advantage.

The Public Health Development and Commissioning Manager replied that the majority were very happy as it provided more opportunities to work with parents.

Councillor Paul May asked if safeguarding was integrated across the service.

The Director of Adult Care and Health Commissioning replied that the Head of Safeguarding & Quality Assurance does work closely with the Director of Nursing.

Councillor Tim Ball commented that this needs to be a seamless transfer from the point of view of the families and asked how this has been explained to them and is there a central contact point.

The Assistant Director of Health Improvement replied that Sirona have led on this work and have developed individual transition plans. She said that it was the role of the Health Visitor to communicate the changes.

Councillor Tim Ball said that some people may not engage with their Health Visitor and he asked to be assured that this is recorded and acted upon.

The Assistant Director of Health Improvement replied that the Family Nurse Partnership has a never give up policy and will always look to build relationships. She said that Health Visitors will also endeavour to carry out their required checks.

Councillor Lin Patterson asked how many families will be affected by the transfer.

The Assistant Director of Health Improvement replied that 637 families were involved with 562 transferring out of B&NES and 75 transferring in.

Councillor Lin Patterson asked if the associated budget would transfer to the Council.

The Assistant Director of Health Improvement replied that they were not expecting there to be a reduction in the budget.

The Select Committee **RESOLVED** to:

i) Note the commissioning responsibilities being transferred to the Local Authority on 1st October 2015 and the progress made to ensure a smooth transfer.

ii) Note the functions of the Health Visitor and Family Nurse Partnership services and the important contribution they make towards outcomes for children and families.

30 YOUR CARE, YOUR WAY: CONSULTATION BRIEFING

The Your Care, Your Way Programme Manager and the Senior Commissioning Manager gave a presentation to the Select Committee, a summary is set out below.

The Making Plans document has been circulated detailing the four models and fourteen priorities with a view to developing a top five priorities.

Currently in phase 2 of 4 – Design & Specify. Provide an outline of the business case in November / December 2015.

The need for change is because of an ageing population, an increased demand, public expectation and a lack of money.

The current provision is £69.24m to over 60 providers for 400 services.

Vision – We will have health and care services in the community that **empower** children, young people and adults to live happier and healthier lives. Supporting people to access services when they are needed in as **seamless** a way as possible, navigators will assist individuals to access pathways of care and support.

There are attributes and challenges with all four possible models and whichever one is chosen we will look to providers to work more collaboratively.

Model 1 – Focus on conditions

Model 2 – Focus on circumstances

Model 3 – GP led Wellbeing Hubs

Model 4 – Community led Neighbourhood Teams

We will try to address loneliness and isolation through this review.

New technology is to be embraced and apps may be used in future work.

Councillor Paul May asked if GP's and providers used any common IT systems as he felt that a fully integrated system was required.

The Your Care, Your Way Programme Manager replied that there were two in use in the main.

Councillor Tim Ball said that in terms of budgets we must make sure that we have the ability to deliver what we are consulting on.

The Your Care, Your Way Programme Manager replied that we have been clear to providers on the financial challenges of the future.

The Senior Commissioning Manager added that money was not the main driver behind this review and that a significant budget exists. He said that the review was a challenge to think about the best model that we can provide.

Dr Ian Orpen stated that doing nothing was not an option and that this was a real opportunity for change. He said that he had heard a lot of positive feedback so far.

Councillor Paul May said that it was very welcome to see such a customer focus to the review.

The Your Care, Your Way Programme Manager reminded those present that the consultation was open until 30th October.

The Select Committee **RESOLVED** to:

i) Note the content and approach, for consultation, the document attached as Appendix 1 : Making Plans - Consultation Document Phase Two and;

ii) Acknowledge the proposals for market engagement as set out in Section 5 of this report.

31 SELECT COMMITTEE WORKPLAN

The Director of Adult Care and Health Commissioning reminded the Select Committee that during the course of the meeting they had requested an update on information relating to Alcohol and Substance Misuse.

Councillor Paul May asked if specialist services could have an input into the RUH items in November.

Councillor Eleanor Jackson reiterated her previous request to have involvement from the Governors of the RUH. She also asked for the AWP - Joint Health Scrutiny Working Group report to be added to the workplan.

The meeting ended at 1.20 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Bath & North East Somerset Council		
MEETING/ DECISION MAKER:	**Health & Wellbeing Select Committee**	
MEETING/ DECISION DATE:	**25th November 2015**	EXECUTIVE FORWARD PLAN REFERENCE:
TITLE:	**Royal United Hospitals Bath NHS Foundation Trust update on the proposed Royal National Hospital for Rheumatic Diseases clinical service relocations**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: None		

1 THE ISSUE

This paper has been prepared to ensure that the B&NES Health and Wellbeing Select Committee are kept up-to-date with proposals to relocate Royal National Hospital for Rheumatic Diseases (RNHRD) clinical service from their current location at the Mineral Hospital site to ensure sustainable high quality service delivery.

2 RECOMMENDATION

The committee are asked to: Note this update, note next steps and the opportunities for patients, carers and the public to influence any service change proposal that we will bring to scrutiny for their endorsement.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

In order to ensure the continued sustainability of the services currently provided at the Mineral Hospital site the ability to fully integrate and align services on a single site was a core component of the original business case for the acquisition of the RNHRD by the Royal United Hospitals Bath (RUH). It will improve efficiency and effectiveness, improving patient experience and ensuring continuity of care, quality of service delivery as well as increasing value for money from the public purse. Clinicians continue to be integral to planning the future of their services to ensure the delivery of high quality effective services.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

Patient and Public Engagement (PPE) activities will be conducted in line with the Government's Consultation Principles for Public Bodies (October 2013), the Equality Act (2010) and Section 242, Subsection (1B)(b) of the Health Act 2006 (as amended).

5 THE REPORT

See following paper.

6 RATIONALE

This paper has been prepared to ensure that the committee are kept up-to-date with the integration of the two hospitals post-acquisition, and proposals to relocate RNHRD clinical services from their current location.

7 OTHER OPTIONS CONSIDERED

As part of original business case for acquisition of the RNHRD options were considered in relation to services continuing on the Mineral Hospital site or relocating services. The ability to fully integrate and align services on a single site, when clinically appropriate, was a core component of the original business case for acquisition and sustainability of services.

8 CONSULTATION

In addition to the service related public engagement and consultations outlined in this report, the RUH is working with the Local Health Economy (LHE) Forum, whose membership includes Executives from B&NES, Wiltshire and Somerset Clinical Commissioning Groups (CCGs), NHS England, RUH Governor and patient representation, to agree the process for communication and engagement activities to support the potential relocation of clinical services over the next three years.

To support this activity, the RUH has established an LHE Communications Working Group (which is comprised of RUH and NHS England and CCG communications and engagement leads and a patient representative) to ensure all service related PPE is conducted in line with the Government's Consultation Principles for Public Bodies (Oct 2013).

9 RISK MANAGEMENT

An integration programme governance structure is in place to ensure that any programme issues are identified and, if required, added to the RUH risk register.

Contact person	*Clare O'Farrell, Associate Director for Integration, RUH* *Tracey Cox, Chief Officer, NHS Bath and North East Somerset Clinical Commissioning Group*
Background papers	*Update to Health and Wellbeing Select Committee 29th July 2015*
Please contact the report author if you need to access this report in an alternative format	

Royal United Hospitals Bath NHS Foundation Trust Update on the proposed Royal National Hospital for Rheumatic Diseases clinical service relocations

1. Introduction

The Royal National Hospital for Rheumatic Diseases (RNHRD) was acquired by the Royal United Hospitals Bath (RUH) on the 1 February 2015 in order to resolve its long standing financial challenges and to preserve the valued services currently provided at the Mineral Hospital Site (also known as The Min). To support this work a Local Health Economy Forum, comprised of representatives from the senior management teams of the RUH, NHS England and various CCGs, has worked with the RUH over the past few years to ensure that plans for the acquisition were widely supported and in line with future commissioning intentions.

Throughout the acquisition process, which has spanned a number of years, the RUH has clearly stated its intention to relocate services from the RNHRD's Mineral Hospital site to the RUH site or, where clinically appropriate and to maximise patient benefit, to suitable community settings. The relocation of services from the Mineral Hospital site will allow a number of promised benefits to be realised for the patients and communities served, principally:

- **Integration**: Improved integration of services and skills will support further expansion of shared care models, particularly for patients with multiple, and complex long term conditions. In time, this is expected to lead to further development of new service models in areas such as therapies and self-management in line with the national direction of travel. Access to specialist expertise and diagnostics will also be extended.

- **Sustainability**: Through integration of service models and closer working with community partners, services will be sustainable for the future, both financially and operationally. All clinical services are expected to continue in line with commissioner requirements.

  The ability to fully integrate and align services on a single site was a core component of the original business case for acquisition and sustainability of services. It will improve efficiency and effectiveness, maintaining patient experience and quality of service delivery as well as increasing value for money from the public purse.

- **Profile and people**: The profile and brand of the RNHRD is both nationally and internationally recognised. This will continue to be maintained and further developed as part of the RUH to ensure that high quality, innovative service models are supported and in turn, promote further research investment in the local area that will ensure the strong track record of and ability to recruit high calibre staff can continue.

- **Service development:** The plans for the future development of services have been produced jointly with clinical teams. These plans take into account both local concerns such as ensuring the development and delivery of a long-term strategy for valued local amenities e.g. hydrotherapy, as well as the wider direction of travel from commissioners, focusing on:

  - Delivering innovative and outcomes oriented care for patients across our community.
  - Reducing reliance on bed-based models of care where appropriate and safe.
  - Increasing self-care through empowering our patients and supporting them with community based delivery.
  - Delivering quality and operational performance standards across all services, aligned with national best practice.
  - Through delivery of all of the above, containing the costs of service provision now and in the future to enable services to better keep up with increased demand.

- **Research and Development:** The combined organisation has the second largest R&D portfolio amongst medium-sized hospitals in the NHS.

  Bringing together the expertise and diverse research areas through the acquisition has resulted initially at a simple level in the pure addition of the studies of both hospitals whilst maintaining recognition of both RUH and RNHRD brands. The joining and co-location is however expected to also provide significant growth in research as bid writing, research culture and fund management are further strengthened alongside access to a larger population for clinical trials.

- **Environment:** It is recognised that whilst the Mineral Hospital building is highly regarded by the patients it serves; in the longer term it is not a suitable or cost effective base for high quality service provision.

It is expected that services will continue to be delivered from the existing building for up to three years post acquisition. During this time, work will be undertaken with local people and patients as part of wider estates plans at the RUH to identify and develop purpose designed environments which benefit patient experience and wellbeing whilst supporting improved efficiency and effectiveness of delivery through appropriate scaling, workflow design and co-location with other services. Opportunities for branding of elements of the new estate will also ensure that the long-term legacy of the RNHRD can be protected.

2. Current position & future proposals

As outlined in our previous report to the committee on the 29 July 2015, the plans for relocation of services, including identification of suitable new accommodation or new buildings, is being managed through the RUH 'Fit for the Future' redevelopment programme. The RUH seeks to ensure this programme provides the best possible opportunities for engagement and consultation with our key stakeholders including patients, employees, public and healthcare partners to inform estate development plans.

In order to develop the accommodation required for service relocation over the three year period outlined in the original principles of acquisition, the RUH Board of Directors is required to sign off an outline business case for estates development investment in early 2016. To achieve this, it is important for the Board to understand whether the general principle of service relocations is accepted.

3. Consultation and engagement

Feedback from patients, carers, staff, healthcare partners and the wider community has been captured over a number of years and used to develop a set of overarching principles, as outlined in the July 2015 report to the Health Select and Wellbeing Select Committee, to guide the RUH through and beyond the acquisition process. Communications activities spanning this period include; ensuring information about the acquisition and plans for the future has been, and continues to be, available on the RUH and RNHRD websites and displayed around the hospital sites, briefings to key stakeholder groups such as B&NES CCG's 'Your Health Your Voice' patient engagement group, B&NES CCG forums for GPs, updates to scrutiny bodies, formal public Trust meetings such as RUH and RNHRD AGMs, Annual Members days, and inclusion in Trust communications and newsletters including @RUHBath and Insight. Common themes from feedback received throughout the process to date can be attributed to the following areas:

- Brand and reputation of the RNHRD
  - *"It is vital to retain this centre of excellence, recognised across the world for its medical expertise and research."*
- Continuation of services

    - *"Because the work they do at The Min has helped me significantly, we don't want to lose these services."*
    - *"Brilliant caring hospital-calming and supportive to all patients – and excellent staff."*
- Specialist expertise of the RNHRD clinical teams
    - *"Please value the very special work that this institution has done over centuries, and enable it to go from strength to strength."*
- Research and development
    - *"…The research and staff have got my rheumatoid arthritis into remission. Preserve excellence."*
- Heritage and history
    - *"The Min's heritage must be preserved."*
- Travel and access
    - *"The only downside to coming to the RNHRD is the parking, although parking at the RUH is not much better, but they have a larger parking area."*

In addition throughout the year, and as previously highlighted to the committee in the July 2015 report, there have been a number of focus groups with patients, charitable organisations and other key stakeholders to inform the RUH redevelopment work. Currently activities have focused on requirements for the RNHRD and RUH therapies and Cancer builds. Wider feedback obtained from these activities also support the common theme of travel and access. The groups discussed access to the department and how they would like the hydrotherapy, gym and changing areas, outpatient and waiting areas, to look and feel. The outputs from these sessions will be shared with the architect to influence the design. There will also be events for patients to feedback on designs for all RNHRD services including, therapies (incorporating hydrotherapy) rheumatology and pain services.

3.1 Current position - A planned and phased approach
A phased approach to support the next part of Patient and Public Engagement (PPE) relating to the continued integration of the two hospitals is considered most appropriate by the LHE Forum, providing general context of the full relocation at the outset but planning and completing each programme of PPE service by service. The RUH is working with CCG and NHS England Engagement leads, and patients to ensure PPE is carried out in line with the Government's Consultation Principles for Public Bodies (October 2013). We are currently in the first phase of activities (September 2015 – April 2016) and progress and feedback to date are outlined below:

i) **Context setting and overarching communications** September 2015–end November 2015 (NB: general feedback will be continued to be captured throughout).

In order to ensure that feedback gained during engagement activities can inform the RUH estates development programme and meet the timeframe for investment decision making (early 2016). On the 17 September 2015 the RUH launched this initial period of broad engagement on relocating all services.

Key activities undertaken to date include:

Activity	Purpose
Information on proposals to relocate services and rationale for change is on both the homepage of the RUH and RNHRD websites. http://www.ruh.nhs.uk/about/service_relocations/index.asp?menu_id=9	Ensure patients, and the public are aware of proposals, the rationale for change and highlight how people can influence the proposal and encourage feedback.
Dedicated email address for feedback established ruh-tr.haveyoursay@nhs.net	Provide a dedicated channel for stakeholder feedback.
Information about the proposals to relocate	Wider circulation of information regarding proposals and

services from the Mineral Hospital site is available on the homepage of B&NES CCG website.	signposting for further details and opportunities to feedback directly to the CCG or the RUH.
B&NES CCG Annual General Meeting 17 September 2015.	RUH Chief Operating Officer presented proposals to relocate RNHRD clinical services from their current location along with potential timings for relocations and inviting feedback on proposals. The slides and the minutes from this meeting are available on B&NES CCG website: http://www.bathandnortheastsomersetccg.nhs.uk
Media coverage in the Bath Chronicle http://www.bathchronicle.co.uk/Children-s-services-Min-Royal-United-Hospital/story-27838934-detail/story.html	Raise awareness of proposals, approximate timescales and outlining that the Paediatric Rheumatology and Fatigue services will be the next to relocate.
B&NES GP Forum 24 September 2015.	B&NES CCG Clinical Chair update on proposals
RUH Annual General Meeting 30 September 2015.	RUH Chief Executive, outlined proposals for RNHRD service relocations and invited feedback on proposals. Presentation from Clinical lead for the Paediatric Fatigue service outlined proposal and rationale for service relocation. Information stands relating to service relocations and the RUH estates redevelopment programme were available and manned during the event. Opportunities to discuss proposals and ask questions or provide feedback anonymously through a feedback box. The slides and the minutes from this meeting are available on the RUH Website www.ruh.nhs.uk
Information available around the Mineral Hospital site outlining the proposals to relocate service, the rationale for change and inviting feedback.	Ensure that patients and visitors to the Trust are aware of proposals and provide reassurance that they will still have access to services and will be looked after by the same clinical teams. Highlight channels for feedback.
September issue of the RUH staff Newsletter @RUHBath, available to all staff and is publically available across the Trust.	Information about service relocations and where to find further information.
Friends of the Min Annual General Meeting 16 October 2015.	RUH Chairman presented proposals and service relocations and potential timescales.

Feedback captured as a result of these communications activities continue to relate to the main themes of feedback obtained throughout the acquisition process: co-location of services, access and parking and continuation of services, as outlined earlier in this report.

ii) Consultation and engagement on proposals to relocate the Paediatric Rheumatology and Chronic Fatigue (CFS/ME) services (October 2015 – January 2016)

Focused clinical and patient and public engagement on the relocation of the Paediatric Rheumatology and Paediatric Chronic Fatigue (CFS/ME) Services from the Mineral Hospital site is currently underway.

Scale and scope

In 2014/15 the Paediatric Rheumatology service served approx. 30 patients from B&NES, with the Paediatric Fatigue service serving 55 patients from B&NES over the same period. Activity information for each of these services is highlighted in the tables below:

Paediatric Rheumatology

CCG	2013/14	2014/15	2015/16
	Number of Patients	Number of Patients	Number of Patients
NHS WILTSHIRE CCG	41	53	24
NHS BATH AND NORTH EAST SOMERSET CCG	27	30	11
NHS SOMERSET CCG	12	13	7
NHS SOUTH GLOUCESTERSHIRE CCG	2	4	0
NHS GLOUCESTERSHIRE CCG	2	2	0
NHS BRISTOL CCG	1	2	1
NHS SWINDON CCG	1	1	1
All CCGs	**91**	**111**	**49**
All Specialised	**41**	**42**	**30**
All Commissioner types	**129**	**150**	**79**

Paediatric Fatigue Services

CCG	2013/14	2014/15	2015/16
	Number of Patients	Number of Patients	Number of Patients
NHS WILTSHIRE CCG	47	72	58
NHS GLOUCESTERSHIRE CCG	32	68	56
NHS SOMERSET CCG	34	53	50
NHS BATH AND NORTH EAST SOMERSET CCG	46	55	44
NHS BRISTOL CCG	21	38	26
NHS SOUTH GLOUCESTERSHIRE CCG	18	35	16
NHS NORTH SOMERSET CCG	22	22	24
NHS SWINDON CCG	8	11	8
All Commissioner Types	**291**	**461**	**333**

Key activities undertaken to date include:

Activity	Purpose and feedback captured
Letter from RUH Commercial Director (dated 6 October 2015, circulated to the Health & Wellbeing Select Committee via Policy Development and Scrutiny Project Officer).	Provide an update on proposals, timings and activity information for the two paediatric service relocations, and provide the opportunity to suggest any questions the committee would like asked during PPE.

Service specific information about the proposals to relocate the paediatric rheumatology and CFS services is available on the RUH and RNHRD websites	Ensure that current and future patients are aware of proposals and opportunities to feedback and influence.
Information about the Paediatric service relocations is available in the outpatient area at both the Min and RUH children's unit.	Raise awareness amongst current patients.
Wc 16 November 2015, online service specific questionnaire available on RUH and RNHRD websites.	Capture feedback on proposals.

In addition to the activities outlined above there will be:

- Letters and questionnaires sent to current patients of both services to outline proposals, and the rationale for change and encourage feedback to identify what is important to maintain or improve in relocating the services, and also reassure patients that they will still have access to the service and be cared for by the same clinical teams.
- an engagement event in the dedicated children's area at the RUH to capture feedback from patients, carers, staff and other interested stakeholders on the proposals to relocate the services and enable them to see the proposed future location for these services
- A media release issued to raise awareness of the proposals, channels for feedback and to advertise the engagement event.
- Social media activity to raise awareness to proposals and invite feedback
- November issue of the RUH staff Newsletter @RUHBath, (available to all staff and publically available across the Trust) will outline information about Paediatric service relocations, how to feedback and where to find further information.
- Winter edition of Insight, the RUH Community Magazine issued to approx. 8,000 stakeholders at the end of November will include information about proposals, rationale for change and invite feedback.

Formal consultation on the Paediatric service relocations will close on the 6 January 2016. Feedback from these consultation and engagement activities will be brought to the January 2016 Health and Wellbeing Select Committee.

Opportunities to engage with the RUH throughout the programme of proposed service improvements will be available on the RUH and RNHRD websites throughout, and advertised on the websites of relevant CCGs and NHS England.

4. Next steps & approvals

In order to develop the accommodation required for service relocation over the three year period outlined in the original principles of acquisition, the RUH Board of Directors is required to sign off an outline business case for estates development investment in early 2016. To achieve this, it is important for the Board to understand whether the general principle of service relocations is accepted.

It is likely that most service relocations e.g. paediatric services will be simply a change of site (similar to the transfer of the endoscopy service from the RNHRD to the RUH site which took place following appropriate engagement earlier this year). However, where clinically appropriate and to maximise patient benefit, suitable community settings could also be considered.

We will continue to update members of the Health and Wellbeing Select Committee as work progresses, and we will invite committee members to any public meetings we may hold as part of engagement activities.

Appropriate impact assessments will be completed following patient and public consultation and engagement activity as required and will form part of any future updates to Scrutiny Committees.

The committee is asked to note this update, note next steps and the opportunities for patients, carers and the public to influence any service change proposal that we will bring to scrutiny for their endorsement.

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Bath & North East Somerset Council	
MEETING:	**Health & Wellbeing Select Committee**
MEETING DATE:	**25 November 2015**
TITLE:	**People and Communities Directorate Plan 2016-2020**
WARD:	All
AN OPEN PUBLIC ITEM	
List of attachments to this report: • Appendix 1: People and Communities Directorate Plan o Annex 1: Summary of functions of the Division o Annex 2: Directorate budget summary (headline numbers) o Annex 3: Draft Capital Programme 2016/17 to 2019/20 o Annex 4: Finance & Resource Impacts	

1 THE ISSUE

1.1 This report presents the People and Communities Directorate Plan to the Panel for initial consideration and feedback as part of the Council's service planning and budget development process.

2 RECOMMENDATION

The Panel is asked to:

2.1 Comment on the draft People and Communities Directorate Plan and;

2.2 Identify any areas of feedback the panel would like to refer to the relevant Portfolio holders and Cabinet for further consideration as part of the service planning and budget development process.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 The resource implications are contained within the draft Directorate Plan and its appendices.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 This report sets out the framework for the service planning and budget processes which lead up to the statutory and legal requirement for the Council to

set a budget in February 2016. Proportionate equality analysis is being carried out on the proposals within the Directorate Plans.

5 THE REPORT

Introduction

5.1 A new Corporate Strategy was agreed by Cabinet at their meeting on 4th November 2015. It sets out the 2020 beautifully inventive vision and the Council's direction of travel over the next four years. It is shaped by and will deliver the 'Putting Residents First' manifesto commitments.

5.2 Three new Directorate Plans have also been developed. They will flow from the Corporate Strategy and set out both the strategic and financial ambitions of each Directorate and how they will deliver the Corporate Strategy commitments.

5.3 The Directorate Plans will replace Medium Term Service and Resource Plans (MTSRPs). They include, as appendices, the Directorate budget summary and details of growth and savings proposals.

Performance management

5.4 The Council will be undertaking a corporate approach to performance management in order that we can understand how we are delivering on our commitments. Performance management will be against the 4 corporate priorities (a focus on prevention, a strong economy and growth, a new relationship with customers and communities and an efficient business) as well as the outcomes in the Directorate Plans.

November PDS process

5.5 During November, the draft Directorate Plans will be presented to the Policy Development and Scrutiny (PDS) Panels. Each PDS Panel will be engaged in this process and Panels should only concentrate on the parts of the plan relevant to their own remit.

5.6 This Panel is asked to consider the implications of the draft People and Communities Directorate Plan and make recommendations to the relevant portfolio holder(s) and Cabinet. Where the panel wishes to either increase expenditure or reduce savings targets alternatives should be proposed.

5.7 At the meeting, the lead for each Directorate Plan will highlight those aspects of the plan that are directly relevant to the panel. The table below maps the remit of this panel to the related Directorate Plan:

Health and Wellbeing Select Committee remit	Directorate Plan
• Adult health and social care • Public Health (Improving health and reducing health inequalities) • Health Scrutiny • Healthwatch • *[When relevant - Health, commissioning and planning (Children)].*	• People and Communities Directorate Plan

Next steps

5.8 A number of Budget Fair meetings have been scheduled during November in order to provide people with the opportunity to hear about the Council's financial plans for the next four years. There will be an opportunity to ask questions and feed into the discussions on the budget proposals. Further details about these events can be found here: http://www.bathnes.gov.uk/services/your-council-and-democracy/budgets-and-spending/budget-fair-consultation-2014

5.9 Following this, Cabinet will consider the feedback received and prepare the Directorate Plans for final consideration at the January PDS meetings (before being presented to Cabinet and Council for agreement in February 2016).

6 RATIONALE

6.1 The Council is required to set a budget which identifies how its financial resources are to be allocated and utilised.

6.2 The attached draft People and Communities Directorate Plan sets out the context and process for the directorate's service and financial planning.

7 OTHER OPTIONS CONSIDERED

7.1 The Directorate Plans set out a package of options that reflect the Council's Corporate Strategy, and its overarching visions and values.

8 CONSULTATION

8.1 The Directorate Plans flow from the Corporate Strategy which was developed in consultation with Cabinet and Council officers. They also build on our 2020 vision which was developed in consultation with the Council, NHS, police, local businesses, fire service and voluntary sector.

8.2 Council meetings have been held with officers and cabinet members during the development of these directorate plans. Five Budget Fair meetings have also been scheduled during November in order to give partners, stakeholders and members of the public the opportunity to consider and give feedback on the range of proposals included within the plans.

9 RISK MANAGEMENT

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

Contact person	Ashley Ayre, Strategic Director People and Communities / Helen Edelstyn, Strategy and Plan Manager (01225 477951)
Background papers	4th November 2015 Cabinet report: B&NES Corporate Strategy 2016-2020 • http://democracy.bathnes.gov.uk/documents/s38764/E2779%20Corporate%20Strategy%20cover%20report.pdf

	• http://democracy.bathnes.gov.uk/documents/s38765/E2779z Appendix%201%20-%20BNES%20Corprate%20Strategy%202016-2020.pdf
Please contact the report author if you need to access this report in an alternative format	

Bath and North East Somerset Council – People and Communities Directorate Plan

Introduction

There are three Directorate Plans covering the Councils three directorates.

This is the People and Communities Directorate Plan.

The four corporate priorities set the framework for the activity in this Plan. These priorities are:

- A strong economy and growth
- A focus on prevention
- A new relationship with customers and communities
- An efficient business

This Plan is not an exhaustive list of everything that the People and Communities Directorate is doing; but rather a summary of key activity that the directorate will focus on over the next four years to deliver the corporate priorities and Council vision.

The People and Communities Directorate has a contribution to make to each of the four corporate priorities and therefore to the Council and Public Service Board vision. Through our ongoing work and transformational projects, we will specifically enhance wellbeing across our area. For children and young people, this includes work to support engagement and enjoyment in play and learning, to help them explore, understand and manage risk in their world, and to be personally secure and confident. For adults, this includes supporting people to be mentally and physically well, addressing barriers to wellness and enabling people to fully participate in work and leisure.

Our Customer Service Excellence Award specifically recognises that People and Communities staff work hard to reach out and respond to those who are hardest to reach. Through continuing this focus and working in partnership, we can promote wellbeing and help those who need us most to actively engage with their communities and the world of work.

This Plan also sets out how the People and Communities Directorate will manage its budget to deliver planned activity. It replaces the Medium Term Financial Plan which has been prepared in the past.

This Plan sits collaboratively underneath the Councils Corporate Strategy and provides a clear line of sight between the two.

PART ONE – CORPORATE OVERVIEW

Strategic context

The Bath and North East Somerset 2020 vision sets out our overarching aspirations for the future including good health and wellbeing, economic growth, financial sustainability, an effective transport system and an efficient, well run Council. The vision was developed in partnership with the NHS, police, local business, education, the fire service and the voluntary sector.

'Bath and North East Somerset will be internationally renowned as a beautifully inventive and entrepreneurial 21st century place with a strong social purpose and a spirit of wellbeing, where everyone is invited to think big – a 'connected' area ready to create an extraordinary legacy for future generations'

We are already making good progress in working towards this vision. We are a national leader in the integration of health and social care services for both adults and children and our relationship with the NHS continues to grow. Educational outcomes are good at every level and local unemployment is low at less than five per cent. Our Connecting Families programme, working with vulnerable families, is one of the most successful in the country and the Roman Baths is one of the top most visited heritage sites in the UK.

However, we know that we need to do even more in order to be financially sustainable and deliver high quality services into the future. The landscape for public services continues to change and over the next four years we will need to adapt to a growing local population, reduced funding from central government and new legislation that will change the way we deliver some services.

These changes, coupled with an increasing demand for many services means that we need to transform the way we deliver some services, whilst holding onto our commitment to excellence. We have identified four corporate priorities for achieving this as we move towards our 2020 vision:

- A strong economy and growth
- A focus on prevention
- A new relationship with customers and communities
- An efficient business

If we get this right we will be able to continue to provide exemplary public services for local residents.

Financial context

The previous Medium Term Service and Resource Plans covered the 3 year period of 2013/14 – 2015/16 and were in line with both budget priorities and the Council's policy framework.

Since the national and local elections in May 2015 the Government has not provided any information on local government funding beyond 31 March 2016, although the Chancellor announced an Emergency Budget Statement on 8 July 2015. This will be followed by a Spending Review leading to the Financial Settlement for Local Government around Christmas 2015.

We therefore cannot be certain about local government funding from 2016/17 onwards, although we can expect the financial challenge facing the public sector to continue throughout the period of the next parliament from 2016/17 to 2019/20.

Whilst the scale and speed of funding reductions are not yet clear, there are a number of factors which we can identify that will impact on our funding going forwards:

- Continuing reductions in the national control total for local government funding – we assume this will be around 40% over the next four years with an element of front loading.
- A significant increase in employer's national insurance contributions to fund the new national pension arrangements – equivalent to £2.4M in cash terms.
- The ongoing impact of new legislation including the Care Act 2014 and the cost of adult social care.
- The need to provide for future pay inflation.
- The potential impact of changes to interest rates and the revenue cost of meeting the Council's full borrowing requirement.
- The level of inflationary and demographic cost pressures.

The initial Financial Planning work to look at the future scale of this financial challenge for the Council originally estimated that the likely savings, or additional income required, would be around £38M for this 4-year period. The position has been reviewed in light of both local and national decisions and announcements resulting in a reduction in the estimated financial planning target to just over £30M. Given the scale of savings already achieved in the current Medium Term Financial Plan and Budget, it is likely that future savings will require some prioritised changes to Council services.

As part of this, the decision of Council to make a contribution of £1.5 million from reserves to meet an on-going revenue budget gap in the 2015/16 budget has been addressed during the current financial year.

It is too early to accurately predict the full financial impact of the Government's Spending Review and related financial risks, although these have been assessed and may give rise to further savings requirements.

A rigorous process is being applied to support the development of the Council budget and medium term financial planning process going forwards, including a review of both the Council's revenue budgets and the current Approved Capital Programme.

The Cabinet will therefore seek to put in place new Directorate Plans setting out a new Medium Term Financial Plan to cover the four years from 2016/17 to 2019/20 and will consider a range of options to make savings, explore new models of service delivery, deliver innovation and efficiency, and generate additional income.

A Strategic Review is taking place to do just this, covering the four corporate priorities:

- A strong economy and growth
- A focus on prevention
- A new relationship with customers and the communities
- An efficient business

The Review considers spending across the Council to ensure efficiency savings and income generation opportunities are maximised ahead of reductions to Council services.

The specific proposals for this Directorate for addressing the Medium Term Financial Plan are set out in Appendix 4 – Finance & Resource Impacts.

PART TWO – DIRECTORATE PLAN

Directorate summary

The People and Communities Directorate led by the Strategic Director-People and Communities provides:

- A strategic lead for Council in terms of: integration of local authority and health services; the provision of public health services and interventions that improve health and wellbeing and reduce inequality; the understanding of and response to local demographic shifts in terms of services for adults with short or long term/chronic conditions, older people and those with mental health needs; the understanding of and response to the needs of children, young people and families where there are issues of parental incapacity or neglect; the capacity, development and effectiveness of the early learning, schools and wider education systems to promote best outcomes for all children; the effectiveness of multi-agency activity to safeguard and protect the welfare of all children, young people and adults.
- A delivery lead for health improvement and health protection incorporating: promoting healthy lifestyles and minimisation of unhealthy choices, education programmes, Health Visiting, family nurse Partnership and School Nursing services, Sexual Health services, the NHS Health Check programme and local oversight of the screening and immunisation programmes for children, young people and vulnerable adults.
- A delivery lead for Adult Care and Community Health incorporating: all eligible adults under the Care Act 2014, provision of residential and nursing care, re-ablement, domiciliary care, community mental health services, drug & alcohol treatment, rehabilitation and preventative support, and social work services for people with learning disability or mental health needs and those in intensive supported living and extra care services. The provision of preventative services which prevent, reduce or delay care and support needs and slow the escalation of costs in meeting individual care and support needs. Delivery of services which support the effective functioning of the wider NHS system and prevent unnecessary hospital admissions or delays to discharge from hospital. Securing either directly or through commissioning of the services required to discharge all duties.
- A delivery lead for all services required for children and young people under the Children Acts 1989 and 2004 incorporating: Children “in Need”, Child Protection and Safeguarding, Children In Care and Looked After, Care Leavers, Corporate Parenting, Disability, Troubled Families, Youth Offending, Youth Services and Careers Advice and Guidance, Virtual School for LAC, Fostering, Adoption and Permanence, “Off-line” Safeguarding and Assurance. Securing either directly or through commissioning of services to discharge all duties.
- A delivery lead for services required through various Education Acts (1988, 2006, 2010, 2012) incorporating: Admissions (primary and secondary), School Place Planning

(mainstream and special), Early Years, Childcare and Day Care planning and sufficiency, Education, Health and Care (SEND) services and assessment (0-25 years), Children Missing Education, Educational Psychology, School Standards and Improvement, Schools finance, Home to School Transport, Early Help and Preventative services (0-19 years).

- A delivery lead for all safeguarding services and coordination of all multi-agency safeguarding work for children and adults including the work of the Local Safeguarding Children's Board and Local Safeguarding Adults Board, Management of Allegations against staff, Independent Reviewing and Independent Child Protection Conference Chairing services and commissioning of all services to support and advocate on behalf of service users.

The Directorate has four Divisions with each led by a Divisional Director, note that individual titles vary due to statutory requirements and the integrated nature of the majority of senior posts with the Clinical Commissioning Group. A chart summarising the functions of each Division is attached. It also shows which Cabinet portfolio holder and Policy Development and Scrutiny Panel they report to.

The Directorate has a high degree of integration with the Clinical Commissioning Group which places both Council and CCG in a strong position in relation to delivery of the strategic vision of the Public Services Board, the NHS Five Year Forward View, national moves towards integrated care and health viewed through the lens of austerity. Our local Better Care Fund plan has been identified nationally as a best practice exemplar. We share a commissioning structure and our method of commissioning has helped to shape the corporate model.

The Directorate structure was developed with further integration in mind and was the first of the wider departmental restructures within the Council bringing together Adult Social Care, Community Health, Children's Social Care and Education and integrating the transferring Public Health function. The original structure also included Housing and Skills and Employment functions which moved across to the Place Directorate in 2014. At this time there was a complete re-structuring of the management structure to deliver the required savings in management.

Over the period of the previous MTSRP the Directorate reduced expenditure across all functions with the exceptions of Public Health which has a ring-fence in place to aid transition from the NHS to local government. The future of that ring-fence will be dealt with in the next national comprehensive spending review. The Directorate has also utilised a range of mechanisms to manage demand and costs so that overall cash limits could be met. All service areas with the exception of Substance Misuse and Over 65 care benchmark at or below comparator authorities. The benchmarking for Adult Care and Health has been skewed because the amount of NHS funding managed by the Council (including pooled budgets) and which is therefore included in the data. When this is removed spend aligns with statistical neighbours other than for over 65 care.

Main report: Directorate intentions

The next four years will be immensely challenging, however, there are a number of opportunities for innovation in service development and delivery and we will use these opportunities to re-shape our services and relationships with service users and partners. The Directorate's strategic intentions are set out below against the Council's four corporate priorities.

- **A strong economy and growth**

We will:

- Continue our nationally recognised Connecting Families programme to support workless families to gain training and employment with a view to permanent entry to the employment market.
- Continue to target those young people most at risk of becoming NEET so that we support them into education, training or employment and prevent long term unemployment and dependency.
- Continue to secure education, training and employment opportunities for our Care Leavers so that we maintain good outcomes into adulthood.
- Commission specialist skills and employment support for those adults less able to access the employment market due to ill health or disability.
- Continue to challenge and support schools to promote progression and attainment and ensure that young people leave education with an aptitude for study and training and with good employability skills.

- **A focus on prevention.**

We will:

- Deliver our Early Help Strategy for children, young people and families promoting early identification of need and swift intervention to prevent long-term ongoing need emerging.
- Deliver a new Behaviour and Alternative Provision Strategy to support children with social, emotional and behavioural needs to promote their integration, learning and achievement and prevent exclusion from school and education.
- Deliver a new Special Educational Needs Strategy to support children with SEN through local integrated provision and local attached and specialist provision with a view to expanding local options and reducing the need for external independent placements.
- Continue to challenge learning settings and schools to promote educational excellence for all children through targeted interventions and shared best practice with a specific focus upon closing the gap for those children most likely to suffer educational under achievement.

- Work with all local schools, trusts and partners to build a shared plan for their future development based upon collaboration and cooperation and recognising the changing role of the LA so that we promote best outcomes for all children and young people.
- Continue the development of the LSCB and our children's safeguarding functions so that we have robust and effective systems in place to protect children including in those areas of emerging knowledge and practice such as Child Sexual Exploitation, Radicalisation, Female Genital Mutilation and social media.
- Review our services for those children and young people most likely to become Looked After particularly those aged 12-15 years to determine if there are other ways to meet need and improve outcomes.
- Review our community-based children's services to ensure they are effective and integrated (part of Your Care Your Way-see below) so that we optimise spend and outcomes in this area.
- Redesign and re-commission health improvement services (part of Your Care Your Way) to be more efficient and effective.
- Re-commission community based contraceptive and advisory services.
- Implement a new, fully integrated Community Services model for community health and care services across B&NES resulting from the Your Care Your Way consultation with communities, partners and providers.
- Develop and implement an Older People Five Year Strategy which goes beyond health, care and housing to encompass all of the services which impact upon older people's lives and which if aligned and sign-posted more effectively can positively manage demand and escalation of need.
- Implement the Care Act 2014 including the new case management and information system (Liquidlogic), new financial management and contribution guidelines, new advice and information duties, etc.
- Re-provide a B&NES Mental Health Unit which combines specialist acute mental health, dementia assessment and treatment wards so that we develop a provision which is "future-proofed" and able to deliver high quality in-patient care for acute mental illness and dementia.
- Continue the development of our Local Safeguarding Adults Board and our adult safeguarding functions so that we have robust effective systems in place to protect adults including in those areas of emerging knowledge and practice such as financial abuse, radicalisation, etc.

- **A new relationship with customers and communities.**

We will:

- Continue to develop feedback and engagement systems with service users so that the voice of children, young people, adults and families influences our practice and provision.

- Review children's social care services to determine if we can develop new models of working which build upon our success in Connecting Families, strengthen early help and reduce reliance on "statutorily-based" interventions.
- Continue to develop Personalisation, Person-Centred planning and personal budgets to enable individuals and families to take control of their health and care.
- Work with the Resources Directorate to develop advice and information services which are timely and customer-centred.
- Develop further links with Area Forums and look for ways to enable communities to live healthier lives using their own assets and resources.

- **An efficient business.**

We will:

- Use contract management mechanisms and re-commissioning where necessary to deliver cost effective services and reduce "outlier" areas of spend.
- Complete a business support review across the Directorate to deploy business support to priority areas.
- Complete a series of demand management reviews to ensure that our direct operations and commissioned services are as cost effective and efficient as possible.
- Work with the Resources Directorate to consider opportunities for traded services.
- Work with the Place Directorate to review transport spend and strategy (Community and Home to School Transport elements).

Risk

The capacity of the Directorate is already stretched, the management structure was rationalised in 2013 with the loss of three Divisional Director posts. The Directorate faces massive legislative change to be implemented over the next 4-5 years across the whole spectrum of functions.

There will be a need for some short term investment in extra capacity and external specialist advice to review some of our operations and to help with service re-design.

The services provided are becoming more targeted and there is the need to ensure that as this trend continues we are aware of, recognise and plan for any equalities-related issues.

The Directorate operates in a wider demographic and societal system which is shifting rapidly and which has huge implications for the services directly delivered or commissioned and therefore for the budgets which fund these activities. The population is ageing and older people have increasingly complex medical and care needs. The number of children in need, those in need of Child Protection and those Looked After are increasing nationally and locally whilst

timescales for interventions are being shortened as a result of legislation. Volumes of demand are increasing causing an increase in workloads.

There is an underlying structural underfund within the adult social care budget which has been a factor for several years. This has been offset by savings on other specific adult social care budgets and call down of ear marked reserves. However, as the demands associated with the Care Act 2014 build-up, this underlying structural issue will crystallise and will require the Council to rectify via investment or other mitigation.

There is also a pressure emerging from SEN and Disability reforms. As this has been implemented the threshold for education, health and care assessment has drawn in more children and young people, creating a significant increase in workload that cannot be managed within existing resources. Government have not allocated sufficient 'new burdens' funding. The service is assessing the financial impact and will clarify this for final budget reports in February 2016.

Against this backdrop, much of our effort over the span of this plan will be in the area of demand management and service efficiency. There is therefore a risk that external factors could undermine some plans for the budget. However, the Directorate will keep all plans under review and seek to mitigate any risks.

Performance management

Key performance measures are included within the three statutory Outcome Frameworks for which the Directorate is responsible these being:

- Public Health
- Adult Social Care
- Children (Social Care and Education)

These will be reflected in performance reporting for the priorities within this plan.

PART THREE: DIRECTORATE RESOURCE PLAN

The Directorate's financial strategy is to deliver the changes set out in the previous section in accordance with the budget summary and impact statement attached.

Each Divisional Director carries responsibility for the delivery of their budget proposals and is accountable to the Strategic Director-People and Communities.

In terms of workforce it is expected that there will be a small reduction in posts across the service and within those services we commission from third parties, this will become clearer as we enter into negotiations with relevant providers. The Directorate will require access to some

external expertise to deliver some of the required work around demand management and service review - this is factored into the financial plans attached. Over time there will be a requirement for skills development within the workforce as the emphasis of our work with individual's shifts.

Property aspects of our priorities will be factored into planning in discussion with the Section 151 Officer and the Resources Directorate.

Appendices

These appendices support the approval of the Councils 4 year financial strategy.

- Directorate budget summary (headline numbers)
- Draft Capital Programme 2016/17 to 2019/20
- MTFP - Service impact statements (linked to strategic review templates)

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Appendix 1

Summary of functions of each People and Communities Division

1. Adult Care and Health

Jane Shayler, Director – Adult Care & Health Strategy & Commissioning

Councillor Vic Pritchard, Cabinet Member for Wellbeing

- Commissioning of Community Health Services
- Commissioning of Adult Care Services
- Commissioning of Adult Mental Health Services
- Commissioning of Substance Misuse Services
- Better Care Fund
- LA role in health system resilience (seasonal planning)
- Adult Safeguarding and Assurance
- Local Safeguarding Adults Board
- Deprivation of Liberty (DoLS) Safeguards
- Approved Mental Health Practitioner Service

  Includes: Older People, Learning Disabilities, Physical Disabilities, Long Term Chronic Conditions, Residential Care, Nursing Care, Domiciliary Care

Scrutiny

- Health and Wellbeing Select Committee (Councillor Francine Haeberling, Chair)
- Health and Wellbeing Board (Dr Ian Orpen, Clinical Commissioning Group Chair and Councillor Vic Pritchard – Co Chairs)

2. Public Health

Dr Bruce Laurence, Director – Public Health

Councillor Vic Pritchard, Cabinet Member for Wellbeing

- Commissioning of Children's public health services
- Commissioning of Adult public health service
- Sexual Health Services
- Health improvement and health Inequalities
- Emergency Planning and Resilience
- Health visiting and Family Nurse Partnership
- Advice, consultancy and guidance to Clinical Commissioning Group
- Advice, consultancy and guidance to Local Authority
- Health Intelligence (Joint Strategic Needs Assessment)

Scrutiny

- Health and Wellbeing Select Committee (Councillor Francine Haeberling, Chair)
- Health and Wellbeing Board (Dr Ian Orpen, Clinical Commissioning Group Chair and Councillor Vic Pritchard – Co Chairs)

3. Children and Young People Strategy and Commissioning

Mike Bowden, Director CYP and Health Strategy and Commissioning

Councillor Michael Evans, Cabinet Member for Children's Services

- Strategic Planning for schools (Admissions, Transport, Place Planning, Capital Strategy)
- School Improvement and Achievement
- Virtual School for Looked After Children
- Commissioning of preventative and early help services for CYP and families
- Commissioning of specialist care services for CYP and families
- Commissioning of Child Health Services
- Commissioning of CYP Mental Health Services
- Specialist Educational Needs Policy and Planning
- CYP Safeguarding Assurance (including Independent Reviewing Services (LAC), Independent Child Protection Chairing Service and Local Authority Designated Officer function)
- Local Safeguarding Children Board

Scrutiny

- CYP Policy Development and Scrutiny Panel (Councillor Lisa Brett, Chair)
- Health and Wellbeing Board (Dr Ian Orpen, Clinical Commissioning Group Chair and Councillor Vic Pritchard – Co Chairs)

4. CYP Targeted and Specialist Services

Richard Baldwin, Divisional Director, Targeted and Specialist

Councillor Michael Evans, Cabinet Member for Children's Services

- Child Protection Services
- Children in Need Services
- Looked After Children's Services (including Fostering Care and Residential Care)
- Adoption and Permanence Services
- Youth Connect
- Connecting (Troubled) Families
- Early Years and Children's Centre Services
- Early Help and Preventative Services
- Youth Offending Services
- Vulnerable Learners (Children Missing Education, SEN Services, Hospital and Reintegration, Educational Psychology, Alternative Provision)
- Disabled Children's Services
- Care Leaving Services

Scrutiny

- CYP Policy Development and Scrutiny Panel (Councillor Lisa Brett, Chair)
- Health and Wellbeing Board (Dr Ian Orpen, Clinical Commissioning Group Chair and Councillor Vic Pritchard – Co Chairs)

Appendix 2 – Analysis of Headline Numbers

Service	2015-16				2016-17 Budget					
	Gross	Income	Net Budget		Growth	One off changes	Savings	Gross	Income	Net
	£'000	£'000	£'000		£'000	£'000	£'000	£'000	£'000	£'000
Childrens Services	**161,037**	**(131,901)**	**29,136**		**411**		**(79)**	**161,369**	**(131,901)**	**29,468**
Children, Young People & Families	14,725	(2,308)	**12,417**		311			15,036	(2,308)	12,728
Learning & Inclusion	8,480	(1,458)	**7,023**		45			8,525	(1,458)	7,068
Health, Commissioning & Planning	31,170	(128,136)	**(96,966)**		55		(79)	31,146	(128,136)	(96,990)
Schools Budgets	106,662		**106,662**					106,662		106,662
Adult Services	**103,107**	**(40,043)**	**63,064**		**1,736**	**(157)**	**(2,197)**	**103,883**	**(41,437)**	**62,446**
Sirona Care & Health	18,888	(2,490)	**16,398**		31		(221)	18,698	(2,490)	16,208
Adults Substance Misuse (DAT)	3,051	(2,500)	**550**		1		(450)	2,602	(2,500)	102
Management Information & Support System	263	(58)	**204**		3			266	(58)	207
Adults & Older People-Mental Health Commissioning	11,529	(3,179)	**8,350**		294		(265)	11,564	(3,185)	8,379
Supporting People & Communities Commissioning	8,038	(2,595)	**5,443**		6	(157)		7,887	(2,595)	5,292
Adult Care Commissioning	1,242	(131)	**1,110**		10			1,252	(131)	1,120
Older People & Physically Disabled Purchasing	15,529	(5,873)	**9,657**		498		(379)	15,658	(5,882)	9,776
Fairer Charging Income		(2,033)	**(2,033)**		(5)				(2,038)	(2,038)
Learning Difficulties Commissioning	22,823	(6,938)	**15,885**		825		(348)	23,302	(6,940)	16,362
Physical Disability, Hearing & Vision	3,934	(372)	**3,562**		64			3,998	(372)	3,626
Public Health	8,864	(8,864)					(534)	9,702	(10,236)	(534)
Better Care Fund	7,540	(4,732)	**2,809**					7,540	(4,732)	2,809
Safeguarding	1,406	(276)	**1,130**		8			1,414	(276)	1,138
Total for People & Communities Cashlimits	**264,144**	**(171,944)**	**92,200**		**2,147**	**(157)**	**(2,276)**	**265,252**	**(173,338)**	**91,913**

2016/17 DIRECTORATE PLAN GROWTH ASSUMPTIONS		16/17 Growth £'000
Pay costs - 1% per annum; inclusive of any incremental increases and other staff related inflation		189
Inflation & contracts		745
Increase in demand for Children in Care placements		120
Increase in number of eligible Care leavers		50
Legal costs re Care		30
Demographic Growth in Adult Services		1,013
TOTAL GROWTH		**2,147**

Appendix 3 – Draft Capital Programme 2016/17 – 2019/20

1. Existing Programme Items

	Costs				Total 5 Year Funding			
Project Title	**Total 2016/2017**	**2017/18 Onwards**	**Total 5 Year Cost**		**Borrowing/ Capital Receipts**	**Grants/ External Funding**	**RIF / Development Funding**	**Comments**
	£'000	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	
Children's Services								
Full Approval								
Paulton Junior School - Basic Need	400	65	465		0	465		
Bishop Sutton Primary School - Basic Need	402	0	402		0	402		
Ensleigh - New Primary School	2,112	1,274	3,386		0	3,386		
Provisional Approval								
Schools Basic Need Grant	6,694	0	6,694		0	6,694		Annual detailed Project Plan Required
Schools Capital Maintenance Grant	2,000	0	2,000		0	2,000		Annual detailed Project Plan Required
Sub Total - Children's Services	**11,608**	**1,339**	**12,947**		**0**	**12,947**	**0**	
Adult Social Care								
Sub Total - Adult Social Care	**0**	**0**	**0**		**0**	**0**	**0**	
TOTAL PEOPLE & COMMUNITIES	**11,608**	**1,339**	**12,947**		**0**	**12,947**	**0**	

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Appendix 4

Bath and North East Somerset Council
People and Communities Directorate Plan - 2016/17 to 2019/20

Finance & Resource Impacts

This appendix sets out the proposals for which there are specific financial, staff or property implications. The focus is on 2016/17 but indicative headline amounts are set out for future years.

2016/17

Type of Service Change

1. Income Generating Opportunities – People &Communities

Proposal

- There are no proposals for 2016/17.

Impact

- nil

Investment required

- nil

Type of Service Change

2. Innovation and Efficiency - People &Communities

Proposal – 2016/17 items only

- Schools Capital 50k. - Our ongoing work to ensure we are as efficient and business-like as possible in the way we function, whilst remaining child- and customer-focused will include some changes in funding arrangements for the schools capital team, with a proportion of their time being appropriately charged to the relevant capital projects.

- Substance misuse 450k - The proposals will involve contract re-negotiation and overall are likely to impact on provider organisations with some reduction of staff in those organisations
- Sirona Care and Health Contract 200k - Review and, potential further redesign, of adult social care services to ensure maximum efficiency, effectiveness and best value. May involve negotiation of contractual changes. Potential implications for staffing, including changes in roles. Links to joint Council/CCG review of community services.
- Sexual Health portfolio 50k - This sum is made up of adjustments to various services within the portfolio which will be achieved without comprising delivery
- Health improvement programmes 261k -Again, this sum is made up of a number of services and work is already under way to work with providers to improve efficiency
- Public Health intelligence work and remodelling public health programme spend 13k - This will be achieved through in-house teams rather than contracting with NHS organisations

Impact

- The impact on staff numbers is estimated at between 8-10 council staff plus indirect impacts on provider organisations

Investment required

- It is anticipated that some resources will be required to support the changes required including redundancy, finance and legal support and procurement advice. The total required is estimated to be £250k
- The One Council Review method and team which requires project by project funding. To allow for the latter an initial notional allocation of £100K has been made which, depending on its level of success, may need to be repeated throughout this 4 year programme.

Type of Service Change

3. Growth Avoidance – People &Communities

Proposal – 2016/17 items only

- Adult Social Care Demographic Growth – Older People over 65 -£333k
- Adult Social Care Demographic Growth – Mental Health over 65 -£190k
- Adult Social Care Demographic Growth – Learning Disabilities- £348k
- Adult Social Care Demographic Growth – Mental Health Adults of Working Age- £75k
- Adult Social Care Demographic Growth – People with Physical Disabilities - £46k

- Greater targeting of prevention and early-intervention services may impact on access to such services for those people with lower level needs. There is also likely to be a reduction in the range and type of services offered and, therefore, the options given to individuals over the type of service put in place to meet their assessed, eligible care and support needs. Proposals will involve renegotiation of contractual arrangements with providers with potential impacts for providers as a consequence.

- Adult Social Care Demographic Growth – Social Work & Safeguarding Activity (Sirona Contract) - £21k
- Potential impact on staff work load both in Sirona and in the Council's Adult Safeguarding and Quality Assurance team.

Impact

- No specific staffing issues from council employees but impact on provider organisations and service users as budgets utilised to support clients are contained.

Investment required

- An investment is required to support the changes needed, including re-negotiation of contractual arrangement with providers estimated at £250k to provide Project capacity, finance support, Procurement/contracting advice.

Type of Service Change

4. Service Redesign – People and Communities

Proposal

- Music Service. £29k. -Our ongoing work to ensure we are as efficient and business-like as possible in the way we function, whilst remaining child- and customer-focused will include some remodelling of the way the music service operates to make it more self-sustaining and reduce reliance on Council revenue funding.

- Healthy lives, healthy people: community small grants scheme £22k **-** There will inevitably be a reduction in service as this sum is made available to voluntary organisations to help them achieve various public health related goals

Impact

- The staffing impact is approximately 1- 1.5 FTE staffing

Investment required

- nil

Summary – 2016/17

People and Communities – Revenue – Recurring Net Savings Targets - Summary	**2016/17**
	£000's
Income Generation	0
Innovation and Efficiencies	1,024
Growth Avoidance	1,013
Service Redesign	51
Total	**2,088**

People and Communities – One Off Revenue Investment to Enable Savings	**2016/17**
	£000's
Income Generation	0
Innovation and Efficiencies	365
Growth Avoidance	100
Service Redesign	0
	465

Summary - 2017/18 to 2019/20

Targets have been established for the following 3 years broken down into broad headings and to be refined following;

- Further consultation
- Development of business cases

People and Communities - Revenue - Recurring Savings Targets	**2017/18**	**2018/19**	**2019/20**
	£000's	**£000's**	**£000's**
Income Generation			
Innovation and Efficiencies	488	160	1,000
Growth Avoidance	1,265	1,263	1,263
Service Redesign	28	0	0
Totals	**1,781**	**1,423**	**2,263**

The levels of capital and revenue investment in future years will be established in the light of consultation on proposals for future years. It is not possible to estimate all of these until more work has been done on the right solutions with appropriate internal and public consultation. Sufficient balances will need to be available set aside in reserves to enable this.

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Bath & North East Somerset Council		
MEETING/ DECISION MAKER:	**Health and Wellbeing Select Committee**	
MEETING/ DECISION DATE:	**25th November 2015**	EXECUTIVE FORWARD PLAN REFERENCE:
TITLE:	**Local Safeguarding Adult Board Annual Report 2014/15**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix 1. Local Safeguarding Adults Board Annual Report 2014/15		

1 THE ISSUE

1.1 The Local Safeguarding Adults Board (LSAB) Annual Report 2014/15 is highlights the work of the Board during the period. The Report is brought to the attention of the Select Committee for its consideration with regard to the content of the Annual Report, its analysis and the on-going work of the LSAB.

2 RECOMMENDATION

2.1 The Committee is asked to:

- Note the report and business plan
- Raise any queries or concerns on safeguarding activity
- Request any additional areas of focus you would like assurance from the LSAB on

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 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.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 The Association of Directors of Adults Social Services recommends that LSABs present their Annual Reports for scrutiny to the relevant scrutiny panel. The LSAB recognises that this is good practice and welcomes the Health and Wellbeing Committees views on the Report.

5 THE REPORT

5.1 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 Committee to note. The Business Plan 2015-18 is available through the link in the report. It 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 made reference to 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.

5.2 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

5.3 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.

6 RATIONALE

6.1 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.

7 OTHER OPTIONS CONSIDERED

7.1 None

8 CONSULTATION

8.1 The draft report has been considered by the LSAB. The report has been provided to Healthwatch for comments and was presented at the Health and Wellbeing Board in October 2015.

9 RISK MANAGEMENT

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

Contact person	Lesley Hutchinson Telephone (01225) 396339
Background papers	None
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

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:

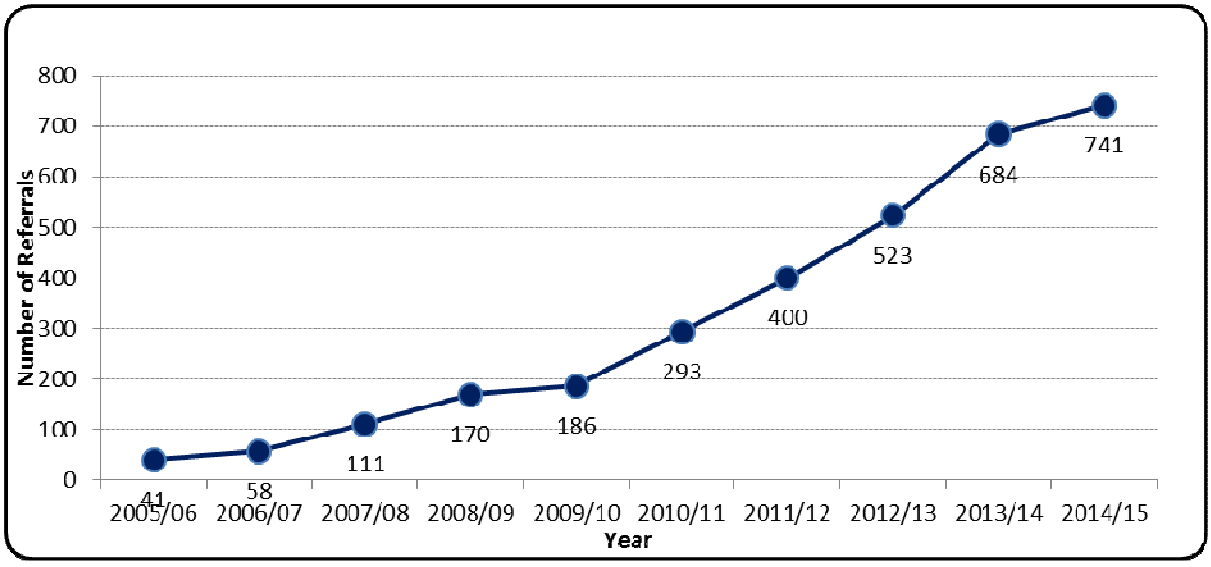
> *It covers the same subject area as the AVA return but is much smaller in size and there are no directly comparable data items. Alerts and action types are no longer collected and demographics are recorded based on counts of individuals rather than referrals.*

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).

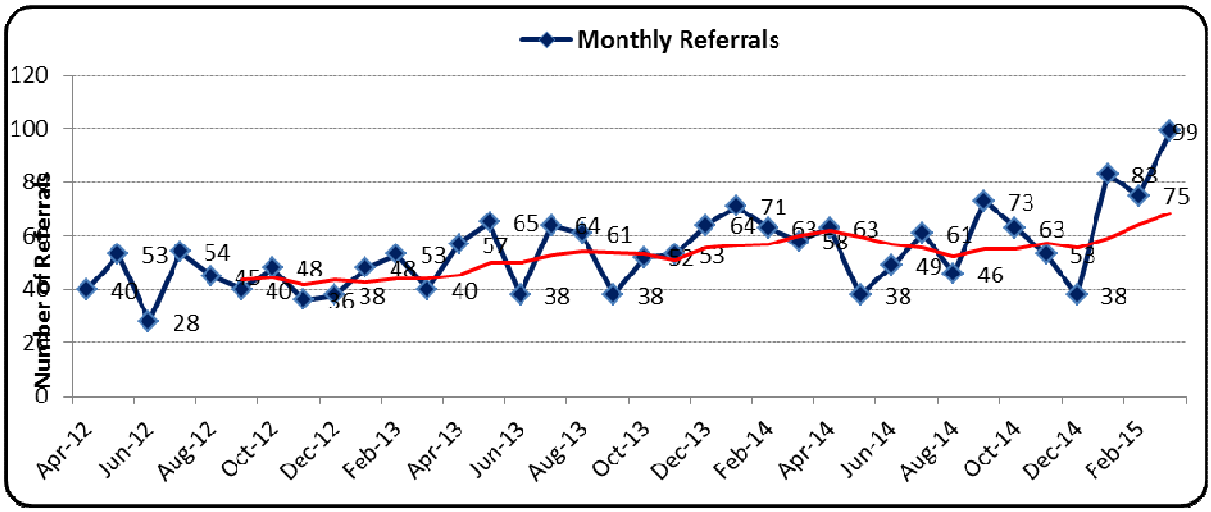
6.3 There was an 8% increase in the number of alerts received from 2013/14 to 2014/15. Whilst recognising that the level of alerts continues to increase, it should be noted that the level of increase in referrals appears to have slowed in comparison with the previous two years when the referral level 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.

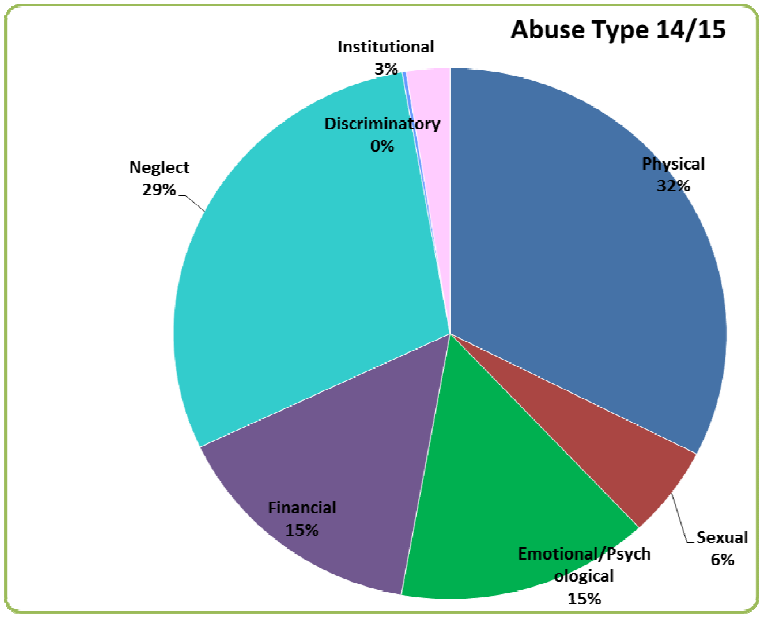
6.17 80.5% of the safeguarding referrals were for service users known to the Council. This is for the first time higher than the national average of 72.5%. This figure is higher than B&NES has historically reported, this is likely to be because we are now reporting on those who meet the safeguarding 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**

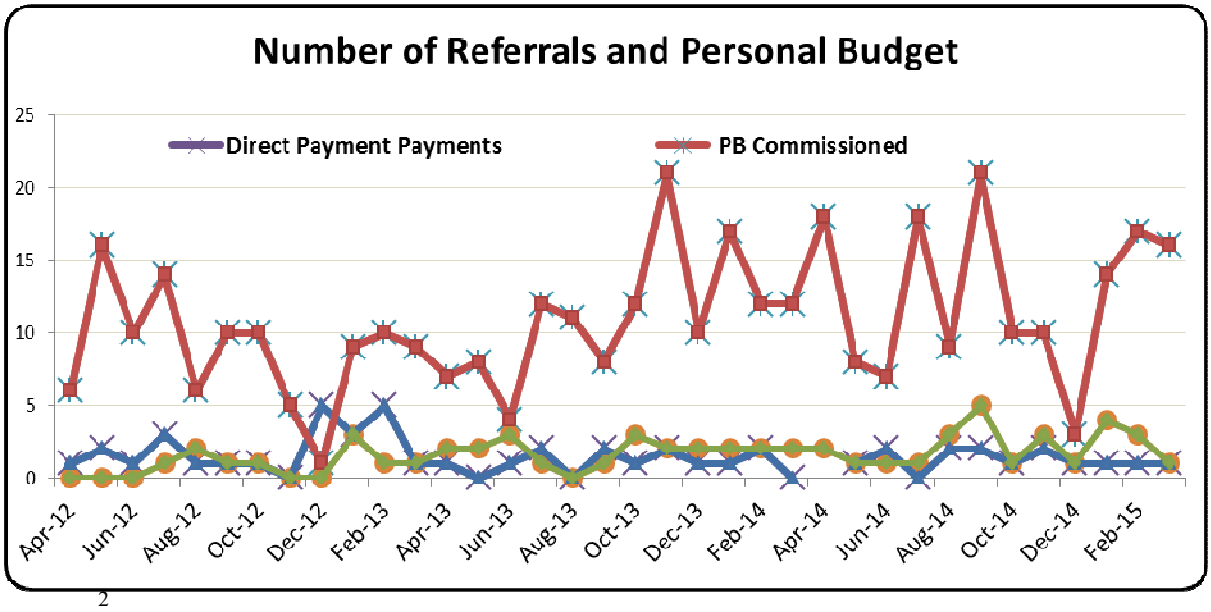


6.20 In comparison to national figures the percentage split of abuse type is broadly similar, with physical abuse being slightly higher but this difference is not sufficient to be a concern for the LSAB.

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. % of decisions made in 48 working hours from the time of referral	95%	Sirona C&H	97% 608/624		↔
		AWP	98% 118/121		↑
		Combined	**97% 726/745**		↔
2a. % of strategy meetings/discussions held within 5 working days from date of referral	90%	Sirona C&H	93% 277/299		↑
		AWP	87% 69/79		↓
		Combined	**92% 346/378**		↑
2b. % of strategy meetings/discussions held with 8 working days from date of referral	100%	Sirona C&H	98% 293/299		↑
		AWP	99% 78/79		↔
		Combined	**98% 371/378**		↑
3. % of overall activities/ events to timescale	90%	Sirona C&H	89% 1257/1415		↑
		AWP	91% 300/329		↑
		Combined	**89% 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 • Service users and carers are at the centre - Making Safeguarding Personal is embedded in practice • Service users and carers who are self neglecting are supported appropriately • The LSAB understand and are able to effectively respond to domestic abuse, radicalisation, modern slavery, self neglect, adult sexual exploitation • Think Family, become more effective and efficient (continue to develop collaboration with LSCB to improve practice, share learning and reduced duplication of work) • 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) • Be forward thinking, predicting and responding to safeguarding issues • 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 • Prevention and early intervention responses are embedded to reduce and remove the risk and impact of abuse • 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 • Service users and carers who are self neglecting are supported appropriately • The LSAB understand and are able to effectively respond to domestic abuse, radicalisation, modern slavery, self neglect, adult sexual exploitation • Ensure learning is effective and embedded from SARs • 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 • 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 Simon_Allen@bathnes.gov.uk
AYRE Ashley	Strategic Director People & Communities B&NES Council Email: Ashley_Ayre@bathnes.gov.uk
BELAFONTE Carolyn Det/Supt	Managing People & Place Avon & Somerset Constabulary Public Protection Unit Email: Carolyn.Belafonte@avonandsomerset.police.uk
BLANCHARD Helen ***[LEWIS Mary - sub]***	Director of Nursing Royal United Hospital NHS Trust Email: helenblanchard@nhs.net Assistant Director of Nursing Email: mary.lewis7@nhs.net
BRUCE-JONES Bill ***[RICHARDS Liz and RHODES Phil - subs]***	Clinical Director Avon & Wiltshire Mental Health Partnership NHS Trust Email: w.bruce-jones@nhs.net Operations Director Email: lizrichards@nhs.net Service Manager Email: phil.rhodes@nhs.net
BUTTON Justine	Inspection Manager ASC North Somerset & BANES and Swindon & Wiltshire Care Quality Commission, South Region Email: Justine.button@cqc.org.uk
CLARKE Dawn	Director of Nursing & Quality NHS BaNES Clinical Commissioning Group Email: Dawn.clarke6@nhs.net
COWEN Robin	Independent Chair for LSAB Email: cowen.robin@googlemail.com
DABBS Janet	Age UK [Chair of Supporting People Forum and rep at LSAB] Email: janetd@ageukbanes.co.uk
DAY Kevin	Local Delivery Unit Team Leader/ Senior Probation Officer Avon & Somerset Probation Service Email: Kevin.Day@probation.gsi.gov.uk
DIXON Mick	Head of Risk Reduction and Operational Training Avon Fire & Rescue Email: mick.dixon@avonfire.gov.uk
ELIOTT Kevin	Patient Experience Manager - Area Team: Bath, Gloucestershire, Swindon & Wiltshire NHS England

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

Quality Assurance, Audit & Performance Management Sub Group
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*

MCA and DoLS Quality & Practice Sub Group
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)

Making Safeguarding Personal Sub Group
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 Joint conferences / workshops Develop opportunities for joint participation activity	Could be relevant to "Think family", Young carers Young carers, disabled, DVA, "Think family	Collaboration between sub groups LSCB / LSAB Develop a joint strategy for Comms sub groups would need to be broad to encompass all stakeholders	Joint website links (see Devon) Getting other sub groups to link into comms-sharing of sub group minutes Most disadvantaged hardest to access Joint newsletter
Quality Assurance	Shared audits where VA and Children are relevant Best use of people	Relevant to DVA , Substance / alcohol abuse, mental health (adult and child) Voice of adult Voice of child How do we evidence quality	Design work plans for LSAB and LSCB for some convergence on issues during year Quality audits and information governance	Shared learning on process of QA Joint audits on occasion using a range of methodology's to audit cases where there might be shared learning 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) Assure guidance is consistent across both	Assurance and QA exercise to be undertaken	May require a joint T&F group to work on this Sharing a forward plan of groups agenda	Policy checklist required to be shared with other equivalent sub groups before sign off. Sharing of a 'forward plan' Could move to a SWCPP style web based guidance Application of the MCA 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 ; Signs of Concern/vulnerability	Identify generic key areas where training can be trained together. Challenge generic views on

			Information sharing 'Think Family' approach Challenge generic perceptions of safeguarding	safeguarding Continue joint training at Level 2 Joint work would help to disseminate info on specialist training. Look at developing easier routes to specialist training Risk of 'dilution' Use of champions to promote knowledge and learning Engagement with professionals who need to be made aware of relevance to their area of work Linking training to relevant services. 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 IRIS CPIS system Culture change in terms of how agencies share information. Perpetrators – information and how we share it Feedback from referrals 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:

- Passed Quality Assessment Framework Inspection
- New staff Inducted – 3 Safeguarding training sessions planned. 2 in February 2015, 1 in September
- Renewed Flow chart, Safeguarding Policies and Procedures and Code of Conduct
- Trustees attended training
- New Gifts and Hospitality policy introduced
- All JD's to include Safeguarding awareness
- 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:
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)

- 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
- Review and amendment of the Trust Safeguarding Adults Policy and Guidance to reflect Care Act and statutory guidance and good practice
- Review and amendment of service user / carer safeguarding leaflets
- The development and launch of Trust Safeguarding Adults ELearning module
- 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
- Development of bespoke Rio eLearning modules to support staff.
- 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.
- To support practitioners as well as supervisors to embed effective safeguarding supervision in clinical/management supervision a safeguarding supervision template was developed
- The Trust Safeguarding Team developed guidance to further improve staff understanding of safeguarding recording and adverse incident reporting
- Safeguarding content on the intranet and internet have been refreshed with simplified pathways to access key content
- Implementation of the new regional policy on safeguarding.
- Continued participation in multi-agency and partnership initiatives in safeguarding such as the multi-agency safeguarding Hub development (HUB).
- 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”
- 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:

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:

- Reviewed contract monitoring arrangements for all commissioned services in relation to safeguarding
- Audited all safeguarding concerns below the safeguarding threshold
- Coordinate and facilitate piloting of Making Safeguarding Personal
- Facilitate Local Government Association Peer Review receiving positive feedback
- Put in place arrangements to ensure safeguarding arrangements are Care Act 2014 compliant
- Work proactively with sub regional local authorities to develop joint multi-agency policy
- 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:

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.

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.

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

Safeguarding Adults Team

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:

The RUH is constantly working to improve the adult safeguarding service that it delivers. Achievements during 2014-15 have been:

- Appointment of additional Safeguarding Nurse to increase capacity in the team to manage significant increases in activity.
- Successful centralisation of the DoLS process including communication process between RUH and local authorities' DoLS administration teams.
- Compliant with training targets for the delivery of Adult Safeguarding Level 3; improving compliance for Level 1 and 2.
- Adult Safeguarding Level 2 e-learning package launched.
- Adult Safeguarding Level 1 e-learning package under development.
- Monitoring of adverse and serious incidents.
- Reviewed lessons learned from the investigation reports into offences committed by Jimmy Savile in NHS hospitals, to strengthen safeguarding arrangements in the Trust.
- 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

Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP only)***	95%	95%	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.
Relevant staff to have an up to date DBS checks ***(All)***	100%	100%	Maintained via HR. All staff are DBS checked every 24 months or before taking up position in the organisation for CARE AND Support staff.
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**	Team Champion is Carol Davidson, Team Leader for Older Person's Service Safeguarding Adults Lead Andrew Snee Head of Tenancy Solutions Young Person safeguarding Lead Julie Fisher Head of Operations Overall Safeguarding Lead Harriet Bosnell		

Describe how you raise awareness of safeguarding in your agency:
All staff are trained when in their induction period and have a minimum of annual refresher training.
We work closely with CAMHS and Adult mental health services throughout support planning to meet customer need.
At each team meeting, local and full team, safeguarding is an agenda item.
At wider resident meetings safeguarding is also discussed.
We are co-located with the Police at the Keynsham PFD and meet regularly with the IRIS team.
We monitor the shared safeguarding log across Curo which we monitor and review.
We share top level information with our sheltered housing, supported housing and older persons working group and also at events.
We participate in CAF and where possible take the lead.
We attend multiple multi agency meetings where cases and themes are reviewed.
We sit on the QAAPM group.
We have taken part and serious case reviews and share our learning.

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

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. 1 in residential service. 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:
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: National Probation Service			
Achievements during 2014-2015: (in bullet points) 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' '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' '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' 'very nice' '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	
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

HEALTH AND WELLBEING SELECT COMMITTEE

This Forward Plan lists all the items coming to the Panel over the next few months.

Inevitably, some of the published information may change; Government guidance recognises that the plan is a best assessment, at the time of publication, of anticipated decision making. The online Forward Plan is updated regularly and can be seen on the Council's website at:

http://democracy.bathnes.gov.uk/mgPlansHome.aspx?bcr=1

The Forward Plan demonstrates the Council's commitment to openness and participation in decision making. It assists the Panel in planning their input to policy formulation and development, and in reviewing the work of the Cabinet.

Should you wish to make representations, please contact the report author or Mark Durnford, Democratic Services (01225 394458). A formal agenda will be issued 5 clear working days before the meeting.

Agenda papers can be inspected on the Council's website and at the Guildhall (Bath), Hollies (Midsomer Norton), Civic Centre (Keynsham) and at Bath Central, Keynsham and Midsomer Norton public libraries.

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
25TH NOVEMBER 2015				
25 Nov 2015	**HWSC**	**RNHRD - Service moves, engagement & consultation**	Jocelyn Foster Tel: 01225 824963	Tracey Cox
17 Nov 2015 25 Nov 2015	**CYP PDS** **HWSC**	**Directorate Plan for People & Communities**	Jane Shayler Tel: 01225 396120	Strategic Director - People
28 Oct 2015 25 Nov 2015	**HWB Board** **HWSC**	**LSAB Annual Report**	Lesley Hutchinson Tel: 01225 396339	Strategic Director - People
27TH JANUARY 2016				
27 Jan 2016	**HWSC**	**RUH / RNHRD Integration**	Jocelyn Foster Tel: 01225 824963	Tracey Cox
27 Jan 2016	**HWSC**	**RUH Site Development Presentation**	Jocelyn Foster Tel: 01225 824963	Tracey Cox

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
27 Jan 2016	**HWSC**	**The Strategic Direction of the RUH**	Jocelyn Foster Tel: 01225 824963	Tracey Cox
27 Jan 2016	**HWSC**	**AWP - Joint Health Scrutiny Working Group**	Andrea Morland, Jane Shayler Tel: 01225 831513, Tel: 01225 396120	Strategic Director - People
27 Jan 2016	**HWSC**	**Introduction to NHS Specialised Services**	Dr Lou Farbus, Head of Stakeholder Engagement, Specialised Commissioning	
30TH MARCH 2016				
30 Mar 2016	**HWSC**	**Alcohol / Substance Misuse Update**	Andrea Morland, Carol Stanaway Tel: 01225 831513,	Strategic Director - People
25TH MAY 2016				
20TH JULY 2016				
ITEMS YET TO BE SCHEDULED				
	HWSC	**Non-Emergency Patient Transport Service**		Strategic Director - People

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
	HWSC	**NHS 111 update**		Strategic Director - People
	HWSC	**Loneliness report - update**		Strategic Director - People
	HWSC	**Dentistry - after May 2015**		Strategic Director - People
	HWSC	**Homecare Review update (for May 2017)**		Strategic Director - People

The Forward Plan is administered by **DEMOCRATIC SERVICES**: Mark Durnford 01225 394458 Democratic_Services@bathnes.gov.uk