Bath & North East Somerset Council

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Date: 12th September 2013
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To: All Members of the Wellbeing Policy Development and Scrutiny Panel

Councillor Vic Pritchard
Councillor Cherry Beath
Councillor Sharon Ball
Councillor Sarah Bevan
Councillor Lisa Brett
Councillor Eleanor Jackson
Councillor Anthony Clarke
Councillor Bryan Organ
Councillor Kate Simmons

Chief Executive and other appropriate officers
Press and Public

Dear Member

Wellbeing Policy Development and Scrutiny Panel: Friday, 20th September, 2013

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 20th September, 2013** at **10.00 am** in the **Kaposvar Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
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 Jack Latkovic who is available by telephoning Bath 01225 394452 or by calling at the Riverside Offices Keynsham (during normal office hours).

2. **Public Speaking at Meetings:** The 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 Jack Latkovic 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 Jack Latkovic as above.

   Appendices to reports are available for inspection as follows:-

   Public Access points - Riverside - Keynsham, Guildhall - Bath, Hollies - Midsomer Norton, and Bath Central, Keynsham and Midsomer Norton public libraries.

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

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

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

6. **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.

Wellbeing Policy Development and Scrutiny Panel - Friday, 20th September, 2013

at 10.00 am in the Kaposvar Room - Guildhall, 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 (Pages 9 - 18)

8. UPDATE ON NHS 111 SERVICE (30 MINUTES) (Pages 19 - 26)

To update Well-being & Policy Development panel members on the implementation of the new NHS 111 Service to the Bath & North East Somerset area and to report on current performance.

Panel members received a briefing in May 2013 at a time when the introduction of the new 111 service was problematic in B&NES and other parts of the country. The briefing paper explains how the service performance has improved since then.

Panel members are asked to note the latest performance of the 111 service.

9. SAFEGUARDING ADULTS ANNUAL REPORT 2012/13 (15 MINUTES) (Pages 27 - 126)

The Local Safeguarding Adults Board (LSAB) has produced an Annual Report which outlines the work its multi-agency partners carried out during 2012-2013 and includes the updated Business Plan. The report is brought to the attention of the Panel for its consideration with regard to the content of the Annual Report, its analysis and the on-going work of the LSAB.

The Panel is asked to note the Annual Report and Business Plan; raise any queries or concerns on safeguarding activity and recommend areas the LSAB would in its view benefit on focusing on.

10. REPORT FROM THE STRATEGIC TRANSITIONS BOARD (15 MINUTES) (Pages 127 - 146)

This report provides an update on the work and activity of the Strategic Transition Board, noting areas of achievement and highlighting future priorities.

The Wellbeing Policy Development and Scrutiny Panel is asked to note the summary and conclusions of the report.

11. URGENT CARE UPDATE (30 MINUTES) (Pages 147 - 150)

To provide the Panel with an update on urgent care. The Panel is asked to note this report.

12. DRAFT B&NES TOBACCO CONTROL STRATEGY 2013 - 2018 (15 MINUTES) (Pages 151 - 210)

Smoking is still the single biggest cause of premature death and disease nationally and locally. Life expectancy varies in Bath & North East Somerset by up to 6.3 years for men in the most deprived areas and by 3.5 years for women. Smoking accounts for approximately half this difference in life expectancy. The existing B&NES Tobacco

Control Strategy Breathing Free was written in 2006. Significant progress has been made nationally, regionally and locally since then and it is appropriate now to update local strategy in the light of this and set priorities which are in line with the new opportunities for public health and the changing local landscape within public services.

The Wellbeing Policy Development and Scrutiny Panel is asked to agree that:

- The draft B&NES Tobacco Control Strategy is supported and taken forward for endorsement by B&NES Health and Wellbeing Board.
- The Strategy is refreshed in 2016 to update priorities and recommendations to ensure relevance to emerging local, regional and national issues.

13. UPDATE ON DEMENTIA (15 MINUTES) (Pages 211 - 216)

To provide the Panel with an update on improving local services for people with dementia. The Panel is asked to note this update and consider when it would wish to receive a further update.

14. SUPPORT TO AMBULANCE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE (10 MINUTES) (Pages 217 - 220)

A letter from Ambulance JHOSC (Joint Health Overview & Scrutiny Committee) Chair Cllr Clarke was received at the Wellbeing PD&S Panel meeting of July 5th 2013. Cllr Clarke described how the local ambulance organisational infrastructure had recently changed, whereby Great Western Ambulance Service (GWAS) had been acquired by South West Ambulance Service (SWAS) on 1st February 2013. An ambulance JHOSC Panel had previously met to consider issues of concern across the former GWAS area. With the advent of SWAS, Cllr Clarke queried the future scrutiny landscape.

In considering Cllr Clarke's letter, the Panel were minded to request further information to allow them to consider the financial, resource and constitutional implications of the proposals.

The Wellbeing PD&S panel is asked to consider:

- The resource, financial and governance information contained in this report and, in so doing, respond to the questions raised by Cllr Clarke;
- Specifically, whether the Wellbeing Panel supports the continuation of an Ambulance JHOSC for the former GWAS area based on the current model of officer support or;
- As an alternative, would the Panel support the principle of a fixed term arrangement until the new health arrangements are fully established.

15. SPECIALIST MENTAL HEALTH SERVICES UPDATE (20 MINUTES) (Pages 221 - 254)

This paper gives an updated progress report on local mental health community support services and the Primary Care Talking Therapy service.

The report also describes the new locality management structure for the Specialist Mental Health services delivered by the Avon and Wiltshire Mental Health Partnership Trust.

The Wellbeing Policy Development and Scrutiny Panel is asked to note:

- Progress in implementing more service user led, recovery focused community support services and suggested next steps.
- The implementation of the new Primary Care Talking Therapy service.
- The new locality management structure in AWP.

16. PANEL WORKPLAN (Pages 255 - 258)

This report presents the latest workplan for the Panel.

The Committee Administrator for this meeting is Jack Latkovic who can be contacted on 01225 394452.

BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Friday, 5th July, 2013

Present:- Councillors Vic Pritchard (Chair), Katie Hall (Vice-Chair), Sarah Bevan, Lisa Brett, Eleanor Jackson, Anthony Clarke, Bryan Organ, Kate Simmons and Douglas Nicol

Also in attendance:

16 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

17 EMERGENCY EVACUATION PROCEDURE

The Democratic Services Officer drew attention to the emergency evacuation procedure.

18 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Sharon Ball sent her apology to the Panel. Councillor Douglas Nicol was her substitute for this meeting.

Councillor Lisa Brett left the meeting at 11.40am (after agenda item 9).

Councillor Douglas Nicol left the meeting at 11.55am (after agenda item 10).

Councillor Bryan Organ left the meeting at 12:50pm (after agenda item 12).

19 DECLARATIONS OF INTEREST

Councillor Eleanor Jackson declared an 'other' interest as a Council representative on Sirona Care and Health Community Interest Company.

Councillor Vic Pritchard declared an 'other' interest as a Council representative on Sirona Care and Health Community Interest Company.

20 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

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

THIS MEETING

The Chairman informed the meeting that Ms Pat Dawson and Ms Lin Patterson will read their statements.

Ms Pat Dawson read her statement and highlighted the benefit of having Larkhall public toilets open for people who regularly shop in Larkhall and also for those people with medical conditions who cannot shop anywhere, without anxiety, unless they know there are toilets nearby.

Ms Pat Dawson also said that 'public toilets are an asset that should be maintained and not wasted. For the wellbeing, health and hygiene of us all, the Council should keep the Larkhall toilets open. They are an essential amenity with no current alternative to council support. The reversion to the original closure date of April 1st is an acknowledgement that Larkhall needs its toilets'.

A full copy of the statement from Ms Pat Dawson is available on the Minute Book in Democratic Services.

Ms Lin Patterson read her statement and highlighted 'the impact of the policy of the closure of public toilets in Bath upon both physical and mental health and wellbeing.'

Ms Lin Patterson also pointed out on statistics around people in the UK who have urinary problems (according to British Toilet Association).

Ms Lin Patterson concluded her statement by saying that (quote) 'moving the closure from August 2013 to April 2014 is not a reprieve. While it would be lovely if a bog company agreed to subsidise nearly £12k for the toilets, that hope may turn out to be unrealistic, as are all the other schemes considered. Public toilets should be just that, publicly funded through taxes, as these have been since 1907'.

A full copy of the statement from Ms Lin Patterson is available on the Minute Book in Democratic Services.

The Chairman explained that technically there is little that the Panel could do as the decision to close the toilets was part of the Budget proposals though the Panel could have a debate on this matter and, depending on the outcome of debate, make their views/recommendations.

Some Members of the Panel felt that people could use toilets in some other premises, such as pubs and community halls.

Ms Lin Patterson replied that the access to toilets in many of these premises is not user friendly for wheelchairs or for people with mobility issues. Ms Lin Patterson also said that the toilets in New Oriel Hall should not be considered as replacement for public toilets due to the nature of clubs, activities and events running in the hall.

Some other Panel Members felt that the toilets in Larkhall should remain open for the reasons highlighted by speakers.

The Chairman felt that it is Council's responsibility to provide these facilities. The Chairman also said that this Panel doesn't have any power other than make a request to the current Administration to reconsider their decision to close the toilets.

Councillor Eleanor Jackson moved the motion to request from the Administration to reconsider their decision to close the toilets.

Councillor Vic Pritchard seconded the motion.

Voting: 5 in favour and 3 against.

It was **RESOLVED** to request from the Administration to reconsider their decision to close the toilets.

22 MINUTES

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

23 CABINET MEMBER UPDATE (15 MINUTES)

The Chairman invited Councillor Simon Allen (Cabinet Member for Wellbeing) to give an update to the Panel.

The Panel made the following points:

Councillor Bryan Organ said that he didn't entirely agree what the investment, from the pooled health and social care fund, was intended for. Councillor Organ felt that people still need to explain their problems to the health and social care services more than once. Councillor Organ said that there is still a lot of work to improve intervention as 70% of people admitted to Accidents and Emergency were there because of falls. Councillor Organ welcomed the other two bullet points in the 'investment in integration' paragraph.

Councillor Allen responded that at the moment we have situation where information is coming from different sources. It is a novel idea but it seems like a positive way forward making sure that an individual is in control of that information. Councillor Allen agreed with Councillor Organ's view on intervention and falls. It is about educating people now how they are going to live into older age as well as meeting the needs of people who are at that age now. Falls prevention is within Sirona's area and they are doing fantastic job.

The Chairman asked about the Health & Social Care Integration Pioneers application and where it is coming from.

Councillor Allen replied that it is joint application between the Local Authority and BaNES Clinical Commissioning Group (CCG).

The Chairman said it is encouraging that the application is a joint one. The Chairman said that he struggled to understand what the driver for this pioneer project is as there is no financial reward, although if the reward is in the shape of accolades then they still need to persuade certain elements of the Council to engage in this project.

Councillor Eleanor Jackson asked if the Council is monitoring Sirona's system of filling in forms for home care. Councillor Jackson also said that she was having complaints about the cutbacks in BaNES for respite care and asked Councillor Allen to comment on that. Councillor Jackson said that some residents do not want to take MMR vaccines because of their culture or faith and asked Councillor Allen if anything has been done to tackle these perceptions.

Councillor Allen responded that Sirona has complex system and the Council value what they do. They have slightly different way of working but they are also part of the pioneering programme mentioned earlier. In terms of the respite care - Councillor Allen said that all social care services are offered on the basis of the assessment of need. If someone disagrees with the assessment then they can challenge that but the offer of support is based on eligibility criteria. Councillor Allen asked Councillor Jackson to let him know if there are any specific examples on that matter outside the meeting. In terms of MMR vaccines – there is no mandate for people to have vaccines. It is a personal choice though vaccination rates are good (92% of a targeted 95%).

Councillor Lisa Brett commented that it is good that voluntary and partner organisations are involved in the Health & Social Care Integration Pioneers project and asked Councillor Allen to comment on that.

Councillor Allen responded that he finds working with those organisations surprisingly positive.

The Chairman thanked Councillor Allen for the update.

24 CLINICAL COMMISSIONING GROUP UPDATE (15 MINUTES)

The Chairman invited Dr Ian Orpen (Clinical Commissioning Group – CCG) to give an update to the Panel.

Dr Orpen updated the Panel with current key issues within BANES CCG.

The Panel made the following points:

Councillor Katie Hall commented that she was glad that the Harmoni continue to make steady progress on delivering the improved performance. Councillor Hall asked if the improvements in the percentage of calls answered within 60 seconds had been maintained for four weeks in a row.

Dr Orpen replied that the Harmoni did not reach four weeks though the last week was well above projector dates.

Councillor Hall asked how the Harmoni is getting on with the appointment of clinicians.

Dr Orpen replied the recruitment of clinicians continues to be an issue. Harmoni will continue to update the CCG on all issues at their weekly meetings.

The Chairman said that the NHS 111 commencement is national issue and that we cannot commence in isolation. The Chairman asked what will happen if we have successful commencement here but not nationally.

Dr Orpen replied responded that it is national programme. We can launch when we are ready and we are not held back on what is happening nationally. The CCG's view is to commence the NHS 111 when we are ready.

The Chairman said that this could potentially lead to public confusion – for instance someone is here for a visit and can access the NHS 111 and not in the area where they are from.

Dr Orpen agreed with the Chairman and commented that these issues are discussed at national level.

Councillor Hall asked about the working relationship with Somerset CCG, especially during winter.

Dr Orpen responded that there is more work to be done with Somerset CCG.

Councillor Lisa Brett asked about the improvement of extended opening hours of GP surgeries.

Dr Orpen said that the CCG does not have direct involvement in GP opening hours – there is contractual arrangement between GPs and the NHS England.

Councillor Eleanor Jackson asked about the physiotherapy services.
Dr Orpen responded that physiotherapy services are provided by Sirona.

The Chairman said that the Panel will invite Sirona at one of the future meetings so there will be an opportunity for direct questions to them.

The Chairman thanked Dr Ian Orpen for the update.

25 HEALTHWATCH UPDATE (15 MINUTES)

The Chairman invited Pat Foster (The Care Forum General Manager) to introduce the update.

It was **RESOLVED** to note the update

26 SOUTH WEST AMBULANCE JOINT SCRUTINY COMMITTEE STATUS (15 MINUTES)

The Chairman invited Councillor Tony Clarke to give an update to the Panel.

Councillor Clarke updated the Panel on the current status of the Joint Ambulance Scrutiny Committee and the proposals for future arrangements.

The Panel debated this matter and, in principle, expressed their support for the new Joint Ambulance Scrutiny Committee subject to the report/update from the relevant officers in the Council on resources, financial, staffing and governance arrangements.

On a motion from Councillor Bryan Organ, seconded by Councillor Katie Hall, it was unanimously **RESOLVED** that the Panel is minded to support the new Joint Ambulance Scrutiny Committee subject to the report/update from the relevant officers in the Council on resources, financial, staffing and governance arrangements. The Panel requested that the report/update be on September 2013 agenda.

27 ROUGH SLEEPERS (20 MINUTES)

The Chairman invited Mike Chedzoy (Housing Services Manager) to introduce the report.

The Panel made the following points:

The Chairman said that the refurbishment of Manvers Street Hostel was required because it was draconian and only people who were really desperate for accommodation used it. To make individual units on that site there had to be the reduction of existing, shared, units. The Chairman also said that at the last meeting of the Panel it was suggested there had been reduction though it was compensated with the satellite provision elsewhere. The Chairman highlighted the fact in the report that five individuals, who want to engage with the programme, are turned away on nightly basis and those five individuals change each night. In a week that is a considerable number of people. The Chairman concluded by saying that appears to be considerable deficit in the provision for rough sleepers in the city with the prospect to become worse considering the difficult financial situation.

Mike Chedzoy responded that there are some people who do not want help they don't want to engage with the programme. It is their choice and they can't be persuaded to engage.

The Chairman said that we should not just accept when people turn away help from us. Those people should be persuaded to engage and get help.

Councillor Simon Allen said that the Council have accurate figures for rough sleepers - who they are and where they are, and we didn't know that before. When the

previous counts were done it was hard to find anybody. Those people are coming from most complex situations and difficulties, mixture of alcohol and/or drug abuse or other problems in life. The Council had invested in Julian House and now there are more facilities with more privacy in a more usable environment. There are 20 beds in Manvers Street and 9 satellite beds elsewhere and everybody involved are doing a great job. Homelessness is difficult and it is not good thing to have any homelessness anywhere. The report on homelessness is never going to be a good report. The Council is developing Homelessness Strategy which should be coming to the Panel in the next few months.

The Chairman said that figures presented in the report were the worst on record though at the last meeting of the Panel it was reported there were adequate facilities to house homeless people and the problem was contained.

Some Panel Members highlighted the fact that we have a number of non-English people who are homeless, without the means to go back home, and asked if anything has been done to address that situation. They also asked about the wheelchair friendly rooms in Dartmouth Avenue and what has been done to support homelessness in North East Somerset.

Mike Chedzoy responded (see response re: foreign homeless) that Dartmouth Avenue has two rooms accessible to wheelchair users. The homeless people, or rough sleepers, across Bath and North East Somerset are having access to comprehensive services by calling the dedicated hotline no matter where they are.

The Panel asked about the status of the current Homelessness Strategy.

Councillor Allen said that the current strategy will run out by the end of this year. The new strategy will feed into the Joint Health and Wellbeing Strategy.

The Panel welcomed the suggestion from Councillor Allen to have draft Homelessness Strategy at one of their future meetings.

It was **RESOLVED** to:

1. Note the report
2. Receive draft Homelessness Strategy at one of the future Panel meetings.

28 JOINT STRATEGIC NEEDS ASSESSMENT UPDATE (15 MINUTES)

The Chairman invited Jon Poole (Research and Intelligence Manager) to give the presentation.

Jon Poole highlighted the following points in his presentation:

- Domestic abuse profile
- Welfare reform
- Smoking & Healthy Lifestyle Behaviour
- Measles

- Premature deaths

The Panel made the following points:

Members of the Panel welcomed the information provided in the presentation. Some Members of the Panel wanted to debate more on Domestic Abuse subject though they were advised by the officers that Domestic Violence is part of another Scrutiny Panel remit (Economic and Community Development) and that Domestic Violence is on the agenda for the meeting on Thursday 18th July.

It was **RESOLVED** to note the presentation.

29 AN OVERVIEW OF COMMISSIONING SEXUAL HEALTH SERVICES AND INTERVENTIONS IN B&NES (30 MINUTES)

The Chairman invited Daniel Messom (Public Health Commissioning and Development Manager) to introduce the report.

The Panel made the following points:

Some Members of the Panel were disappointed in some of the HIV figures presented in the report and commented that the way to overcome these figures is to test people more regularly against the HIV.

Daniel Messom responded that the Public Health team done a lot of work in educating General Practices on when is appropriate to test. Public Health will be also looking into the HIV Point-of-care rapid testing (fingerprint testing that can be used to give much quicker result). Prevention is the most important aspect in minimising the HIV risks but raising awareness and testing are also critical areas.

The Panel asked about the chlamydia testing with for teenage girls.

Daniel Messom responded that the Council is a part of the National Chlamydia Screening Programme (for 15-25 year old). The Public Health team have done significant work over the last 5 years in this area by introducing testing in the wide range of venues – from General Practices to community pharmacies, youth services, etc. However, this is very challenging thing to do and there is still a lot of work to be done as it is difficult to target specific groups.

Members of the Panel were particularly interested in the Teenage Pregnancy part of the report and felt that the Panel should receive detailed report on this matter.

The Chairman asked about the cross-charging between neighbouring authorities.

Daniel Messom responded that this authority would need to take joined up approach with neighbouring authorities in terms of the cross-charging. The Council is waiting for the sexual health tariff guidance from the government.

It was **RESOLVED** to:

1. Note the report; and
2. Receive a report on Teenage Pregnancy at one of the future meetings.

30 REPORT FROM THE STRATEGIC TRANSITIONS BOARD (20 MINUTES)

It was **RESOLVED** to defer this item for September 2013 meeting.

31 PANEL WORKPLAN

It was **RESOLVED** to note the workplan with the following additions

- Strategic Transitions Board – September 2013
- Joint Ambulance Scrutiny Committee arrangements – September 2013
- Teenage Pregnancy – date to be confirmed
- Homelessness Strategy – date to be confirmed

The meeting ended at 2.15 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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Bath & North East Somerset Council		
MEETING:	Well-being & Policy Development Panel	
MEETING DATE:	20th September 2013	**AGENDA ITEM NUMBER**
TITLE:	Update on NHS 111 Service	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
attachments to this report: Appendix 1: Briefing Paper Appendix 2 : Table showing Summary of Performance for August 2013		

1 THE ISSUE

1.1 To update Well-being & Policy Development panel members on the implementation of the new NHS 111 Service to the Bath & North East Somerset area and to report on current performance.

1.2 Panel members received a briefing in May 2013 at a time when the introduction of the new 111 service was problematic in B&NES and other parts of the country. The briefing paper explains how the service performance has improved since then.

2 RECOMMENDATION

2.1 Panel members are asked to note the latest performance of the 111 service.

3 FINANCIAL IMPLICATIONS

3.1 None to note as part of this briefing paper.

4 THE REPORT

4.1 The attached report summarises performance and progress year to date.

5 RISK MANAGEMENT

5.1 Risk management processes and systems remain in place as part of the clinical governance of the service to monitor the effectiveness of the service. Processes are in place to monitor complaints from patients and feedback from Healthcare professionals. This information is collated and reviewed by Harmoni and shared with the CCG's Clinical Governance lead for 111, Dr. Elizabeth Hersch and with the CCG's Quality Team.

6 EQUALITIES

6.1 An in-depth equality impact assessment was completed by B&NES PCT and commissioning team as part of the process to develop the specification for the 111 Service. The service will continue to be monitored in respect of its impact on different groups of patients.

7 CONSULTATION

7.1 This paper has been prepared in consultation with Harmoni.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Not applicable to this report.

9. ADVICE SOUGHT

9.1 Not applicable to this report.

Contact person	*Tracey Cox, Chief Operating Officer B&NES Clinical Commissioning Group. Telephone 01225 831736* *Email : traceycox@nhs.net* *Dr. Elizabeth Hersch, GP and 111 Clinical Governance Lead for B&NES & Wiltshire CCGs.*
Background papers	*None*
Please contact the report author if you need to access this report in an alternative format	

Appendix 1

Briefing Paper – NHS 111 Services in B&NES

1.0 Introduction

NHS 111 is a nationally mandated service to make it easier for the public to access urgent healthcare services. The concept is a free to call 111 number available 24/7 every day of the year to respond to people's healthcare needs when they:

- need medical help fast, but it's not a 999 emergency
- do not know who to call for medical help or don't have a GP to call
- think they need to go to A&E or another NHS urgent care service
- require health information or reassurance about what to do next

The anticipated benefits of the new service include:

- The provision of a memorable three digit telephone number – 111 – with a national brand and agreed service standards
- improving the patient and carer experience by providing clear, easy access to more Integrated services.
- improving efficiency in the urgent and emergency health care system by connecting patients to the right place, first time.
- Increasing public confidence in the NHS by providing a modern, efficient entry point to the NHS focussed on patient needs

2.0 Launch of NHS 111 in B&NES

Locally, the NHS 111 service provided by Harmoni was introduced on the 19th February 2013. Members will be aware that the early introduction of the service was problematic with poor performance across a range of measures including response times, abandoned calls, referrals to the ambulance service and staff sickness/absenteeism. The key measures that are used to assess the performance of the service include:-

- The total number of calls answered within 60 seconds (target 95%)
- The total number of abandoned calls 30 seconds after the message (target less than 5%).
- The warm transfer rate (95% of calls which require transfer to a Clinical Adviser are done so by 'warm transfer' ie. without calling the patient back)

2.1 Actions to Improve & Current Performance

A rectification plan was produced to improve performance. This included actions to significantly increase the number of Health Advisers and additional Clinical Advisers . Weekly rectification meetings have taken place chaired by commissioners to monitor progress with the production of an agreed weekly dashboard. As a consequence there have been significant improvements in local performance. The table at Appendix 2 shows performance for the Month of August.

2.2 Further roll-out and implementation of the service

On the 28th August 2013 Commissioners made a recommendation that the local service should proceed to the next phase of implementation. There is a national checkpoint process and Harmoni are now ready to proceed through to Checkpoint 5. This means that calls that the NHS direct service will be switched off for patients within B&NES and in other local geographical areas covered by Harmoni and these calls will be re-directed to the 111 service.

2.3 Contingency Arrangements

As a result of Harmoni not meeting KPIs on a consistent basis, in March this year a decision was taken by the Commissioners to implement a local contingency process for health care professionals who may also need to access the 111 service as part of managing a patient's care pathway. On an interim basis Health care professionals are able to by-pass the service and contact Out of Hours providers directly. This reduces the volume of calls directed to the 111 service from clinicians. This contingency currently remains in place.

2.3.1 Clinical Governance

Now that the initial problems associated with the launch of the service have been addressed the process for monitoring Clinical Governance has been reviewed and updated and set out in the Quality Schedule for the contract. This will bring the NHS 111 reporting requirements in line with other providers.

2.3.2 Revised arrangements

A Quality Monitoring Review Group has been established with the remit to ensure that NHS 111 delivers on all contractual terms and conditions relating to quality and patient safety as set out in the Service Specification.

2.3.3 Monitoring process

NHS 111 will be required to provide assurance that they have robust Clinical Governance arrangements in place and that these are embedded across the service via monthly qualitative reports to the Quality Monitoring Review Group. The focus of these reports will be on clinical effectiveness, patient safety and patient and professional experience of the service.

Other assurance will be sought outside of the quality meetings as necessary, including quality visits to establish how the governance arrangements are embedded in practice and how the lessons learned from audits, complaints, incidents and feedback from patients, staff and professionals are used to improve the service.

2.3.4 The NHS 111 Clinical Governance Group

This group was established to ensure that quality and patient safety was at the core of the NHS 111 service and will continue, but will be more seminar based focusing on addressing operational issues across a pathway. This will ensure that the strong clinical focus is retained while addressing issues that impact on patients, clinicians and managers at the interface with the NHS 111 service. In addition, there is also a monthly Avon, Gloucestershire and Wiltshire wide NHS 111 Clinical Leads Group, of which Dr Elizabeth Hersch is a member, and which also aims to improve quality in the whole patient pathway e.g. a review of ambulance dispositions to A&E.

2.3.5 Providing Board Assurance

The Quality Monitoring Review Group will report to the BaNES and Wiltshire CCG Boards via the Strategic Quality Monitoring Committees and will provide regular reports on progress as well as highlighting areas of concern.

3.0 Next Steps

The CCG will continue to work with Harmoni to implement the service locally and ensure that local performance is maintained.

Panel members are asked to confirm whether any further updates on the progress of the 111 service are required at a future date.

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APPENDIX 2

Table showing Summary of Performance for August 2013

Week Commencing	**29/07/13**	**05/08/13**	**12/08/13**	**19/08/13**	**26/08/13**	**02/09/13**
Total Calls Offered	8767	8398	8451	9091	10205	8059
Total Calls Answered	8748	8342	8416	8982	10089	7972
% Calls Answered	99.78%	99.33%	99.59%	98.80%	98.86%	98.92%
% Calls Answered within 60 seconds	99.46%	98.54%	98.94%	95.89%	97.09%	96.70%
% Calls Abandoned after 30 seconds	0.08%	0.23%	0.14%	0.66%	0.38%	0.50%
% Calls Triaged	83.00%	83.45%	84.28%	86.17%	84.13%	86.75%
% Warm Transferred	72.94%	74.73%	78.90%	79.07%	73.79%	79.39%
% Warm Transferred or called back within 10 minutes	86.84%	89.46%	89.69%	92.77%	86.28%	90.72%
Longest Wait for Answer	00:07:06	00:04:33	00:05:38	00:07:09	00:03:49	00:04:48
Longest Wait for First Attempted Call Back	00:15:39	00:11:07	00:12:24	00:06:42	00:08:05	00:06:25
Mean Wait for First Attempted Call Back	00:00:57	00:00:52	00:00:58	00:00:56	00:00:51	00:00:52
Ambulance Dispatch as a Percentage of Total	10.18%	10.06%	11.50%	9.60%	8.92%	9.05%
% Callers Referred to A&E	7.85%	8.03%	7.23%	7.02%	7.10%	7.97%

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development and Scrutiny Panel
MEETING DATE:	20th September 2013
TITLE:	Safeguarding Adults Annual Report 2012/13
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1: Local Safeguarding Adults Board Annual Report 2012/13	

1 THE ISSUE

1.1 The Local Safeguarding Adults Board (LSAB) has produced an Annual Report which outlines the work its multi-agency partners carried out during 2012-2013 and includes the updated Business Plan. The report is brought to the attention of the Panel for its consideration with regard to the content of the Annual Report, its analysis and the on-going work of the LSAB.

2 RECOMMENDATION

The Panel is asked to:

2.1 Note the Annual Report and Business Plan; raise any queries or concerns on safeguarding activity and recommend areas the LSAB would in its view benefit on focusing on.

3 FINANCIAL IMPLICATIONS

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

4 THE REPORT

4.1 The LSAB Annual Report 2012/13 provides

- an overview of changes to national and local policy
- confirms the Boards governance arrangements
- sets out the Boards activity during the year
- provides information on safeguarding activity

- compares safeguarding activity with national data
- demonstrates the commitment of member agencies through their individual agency reports

4.2 Appendix 5 to the report is the Business Plan 2012-2015; a working document that is monitored at each LSAB meeting and new actions are added when required through-out the year.

5 RISK MANAGEMENT

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

6 EQUALITIES

6.1 An Equalities Impact Assessment has not been carried out on the Annual Report itself and is not believed to be required. However an assessment will be carried out on the Business Plan element of this and discussed with the LSAB in December 2013. Equalities issues and impact assessments are carried out on policies and protocols that the LSAB approve.

7 CONSULTATION

7.1 Cabinet Member; Health and Wellbeing Board (discussing on 18th Sept 2013); Staff; Other B&NES Services; Community Interest Groups; Stakeholders/Partners; Other Public Sector Bodies; Section 151 Finance Officer; Chief Executive; Monitoring Officer.

7.2 The LSAB discussed the report in June 2013 and have commented on the content. Appendix 1 Local Safeguarding Adults Board Annual Report includes the comments that have been received post the June meeting.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Human Rights; Corporate

9 ADVICE SOUGHT

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

Contact person	Lesley Hutchinson (Head of Safeguarding Adults, Assurance and Personalisation) (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

2012 – 2013

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Avon and Somerset Probation Trust

AVON FIRE & RESCUE

Three Ways School

AVON & SOMERSET CONSTABULARY

Avon and Wiltshire NHS Mental Health Partnership NHS Trust

Royal United Hospital Bath NHS NHS Trust

curo

Carers' Centre Bath and North East Somerset

Freeways

Bath & North East Somerset ageUK

Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

Sirona care & health

NHS Bath and North East Somerset Clinical Commissioning Group

Chair's Foreword

This has been a tough year and an extremely busy one. On behalf of the LSAB I would like to thank all those staff who are dealing with an increasing workload so professionally while there is such pressure on resources.

LSAB members have also been responding to the aftermath of Winterbourne View, of Mid-Staffordshire, to regulatory demands and to other enquiries while managing a serious case review. Despite all these pressures this Annual Report details a huge amount of work that continues to support and inform safeguarding practice in B&NES.

I would like to thank sub-group members for delivering this programme. I am very clear that the sub-groups drive the LSAB's work and that members do this over and above the 'day-job'. The commitment from partners in B&NES is outstanding and nowhere is this better illustrated than in the sub-groups. It is clear though that people are finding it hard to keep up the momentum and this is shown by falling numbers in some sub-groups. This is a challenge for the LSAB in the coming year.

Looking ahead there are a number of national and local agendas that need attention:

- The Care Bill, which is going through the parliamentary process, is moving LSABs towards statutory status. This is likely to be helpful but is not expected to make a substantial difference to the way in which we already operate.

- The LSAB needs to find better ways to listen to people who use services and to the wider community. We are working with Healthwatch to help us with this.

- One of the learning points arising from the serious case review was the need to improve intelligence sharing. One route towards this may be the development of a Multi-Agency Safeguarding Hub and this is being explored as a possibility. Another learning point was the need to improve links with Domestic Abuse processes and this is being actively pursued with the Responsible Authorities Group.

- The LSAB carried out a survey to see how the work was viewed by Board and sub-group members. This has been very helpful in highlighting areas such as the need to improve communication and to ensure that our work is not too reactive. This will inform our work in the coming year.

- The big task ahead, though, is how to manage increasing demand for safeguarding intervention against diminishing resources. The LSAB needs to take a lead in working with commissioners, providers and a wider audience to understand what this means in practice, how risk is prioritised and shared and how expectations can be managed in this difficult climate.

Robin Cowen. Independent Chair

Contents

Section 1: Introduction

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

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

1.3 This annual report summarises the LSAB's activities that has taken place from April 2012 to March 2013; it highlights the commitment to multi agency working including, the robust performance management and quality assurance mechanisms and achievements of the LSAB.

Section 2: Background

2.1 The LSAB have seen a continued increase during 2012-13 in the profile and scrutiny of multi-agency working to prevent and safeguard adults at risk of abuse.

2.2 ***No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*** (DH 2000) continues to provide the framework for multi-agency working to safeguard adults at risk. In May 2011 the Coalition Government published the ***Statement Of Government Policy On Adult Safeguarding*** which set out the Governments legal position on safeguarding. In July 2012 it published the draft Care and Support Bill; clause 34 to 38 relate specifically to safeguarding adults at risk of abuse or neglect. Whilst the Bill moves through the parliamentary process the Government has published a second ***Statement of Government Policy on Adult Safeguarding;*** this 'acts as a bridge between No Secrets and the duties and powers contained in the draft Care and Support Bill.' (May 2013 p4). It builds on *No Secrets* which will remain as statutory guidance until at least 2014.

2.3 **Who is a vulnerable adult?**

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

and

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

2.4 **What is abuse?**

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

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

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

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

3.1 The profile of safeguarding adults at risk continues to be raised. The Government, the Local Government Association (LGA), the NHS and Association of Directors of Adult Social Services (ADASS) to name but a few organisations have continued to give focus to safeguarding adults at risk through-out 2012-13.

3.2 A significant amount of focus has been placed on understanding what went wrong, the lessons learned and improving services following the BBC Panorama documentary aired in May 2011 **Undercover Care: The Abuse Exposed.** The abuse took place at **Winterbourne View Hospital** managed by Castlebeck – the response to the programme has led to a wealth of investigations, reports and actions being taken to try and ensure the abuse does not occur again, these included:

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

3.3 The criminal investigation was concluded in October 2012 and six people were sentenced to prison and a further five were given suspended sentences. The eleven defendants admitted to 38 charges of either neglect or ill treatment of five people with learning disabilities resident at Winterbourne View Hospital.

3.4 ***South Gloucestershire Safeguarding Adults Board Winterbourne View Hospital - A Serious Case Review*** was published in August 2012. The review was chaired and report written by Margaret Flynn. The report makes a large number of recommendations to be addressed to improve the safeguarding and commissioning arrangements and oversight.

3.5 The CQC published ***Learning Disability Services Inspection Programme - National Overview*** (June 2012). CQC inspected 150 settings of which 145 were included in the analysis for the report. 68 of the inspections were of NHS trusts providing assessment, treatment and secure services; the inspections focused on

Outcome 4: Care and welfare of people who use services and Outcome 7: Safeguarding people who use services from abuse of the Essential Standards. The report made recommendations for providers, commissioners and themselves.

3.6 The DH published ***Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report*** in December 2012 (this followed the interim report that had been published earlier in June 2012). The report sets out the governments final response to the events at Winterbourne View hospital. *'It sets out a programme of action to transform services for people with learning disabilities or autism and mental health conditions or behaviours described as challenging'.* (DH p2) The review drew on:

- *'a criminal investigation with 11 individuals prosecuted and sentenced;*
- *the Care Quality Commission review of all services operated by Castlebeck Care, the owners of Winterbourne View, and the programme of inspections of 150 learning disability hospitals and homes;*
- *the NHS South of England reviews of serious untoward incident reports and the commissioning of places at Winterbourne View hospital;*
- *an independent Serious Case Review commissioned by the South Gloucestershire Safeguarding Adults Board, published on 7 August 2012; and*
- *the experiences and views of people with learning disabilities or autism and mental health conditions or behaviours described as challenging, their families and carers, care staff, commissioners and care providers.'* (p9)

The report makes clear that fundamental change is expected and includes Annex A: Model of Care and Annex B: 63 actions that will be completed between June 2012 and summer 2016 to achieve the change.

3.7 The DH also published ***DH Winterbourne View Review Concordat: Programme of Action*** (December 2012). The concordat sets out the shared commitment to transform services with specific actions which individual partners will deliver to make changes to the care and support for people with learning disabilities. The concordat was agreed by a large range of organisation. Some of the commitments include:

- an end to all inappropriate placements by 2014
- adult who are in specialist autism or learning disability hospital setting will have their care reviewed by 1 June 2013 and if they would be better off supported in the community then they should be moved out of hospital as quickly as possible, and no later than 1 June 2014
- Every area will put in place a locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour which accords with the model of care by April 2014.

3.8 In addition to the activity resulting from Winterbourne View a range of other significant reports, legislative changes and guidance notes were produced during the year including ***Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*** Francis R (February 2013) The Stationary Office of the Government. This report outlines conditions of 'appalling care' delivered between 2005 and 2008; it identifies warning signs and makes a set of recommendations for change. Francis states '...*The extent of the failure of the system shown in this report suggests that a fundamental culture change is needed.* (p5)

3.9 The ***Health and Social Care Act 2012 chapter 7*** was passed changing the way health services are commissioned and making clinicians responsible, putting them

at the centre of commissioning. The Act allows the separation of NHS deliver and changes the focus of public health making it accountable within Local Authorities. Section 194 of the Act requires local authorities to establish a health and wellbeing board.

3.10 The ***Draft Care and Support Bill*** (now known as the Care Bill) was presented to Parliament in July 2012 the draft bill builds on the recommendations of the Law Commission's review report ***Law Commission No. 326 Adult Social Care*** and consolidates the large number of adult care legislation into one Bill; however it also sets out radical reform of the social care system and includes provisions to enable the recommendations of the Dilnot Commission to be included. Clauses 34 to 38 apply specifically to the safeguarding adults at risk of abuse or neglect.

- 34 Enquiry by local authority – '...*it must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case'* (34 (1)) (p51)
- 35 Safeguarding Adults Boards – placed on a statutory footing
- 36 Safeguarding adults reviews
- 37 Abolition of local authority's power to remove persons in need of care
- 38 Protecting property of adults being cared for away from home

3.11 In addition to the Bill the Government set out a radical agenda for reform in its White Paper, ***Caring for our future: reforming care and support*** (July 2012). The White Paper set out how different the social care system needs to be with a series of 'I' statements expressing what the service user will be saying. It sets out how it is going to keep people safe and links directly to the delivery of the Care Bill above.

3.12 The ***Domestic Violence, Crime and Victims (Amendment) Act 2012*** came into being with amendments to the 2004 Act, broadening the remit to section 5 relating to the *'...causing or allowing of a child or vulnerable adult to suffer serious physical harm.'*

3.13 The ***Welfare Reform Act 2012*** was approved, this comes into force in April 2013 bringing about a range of radical changes to welfare benefits and introducing a Universal Credit. It is not clear what the impact of these reforms will be on vulnerable people at the moment.

3.14 The **Disclosure and Barring Service (DBS)** became operational in December 2012. It was established under the **Protection of Freedoms Act 2012.** The DBS *helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).* The DBS are responsible for:

- processing requests for criminal records checks
- deciding whether it is appropriate for a person to be placed on or removed from a barred list
- placing or removing people from the DBS children's barred list and adults' barred list for England, Wales and Northern Ireland (from the DBS Website)

3.15 ADASS and the Local Government Association (LGA) have produced a range of guidance documents during the year for example:

- ***Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services*** (March 2013)*;* this builds on the *Safeguarding Adults: Advice Note* published in April 2011. The document sets out the vision for adult safeguarding; provides evidence of what works; focuses on the requirement to achieve good outcomes and identifies Top Tips in Priority Areas (including tips for Safeguarding Adults Boards). It also draws attention to safeguarding adults reviews, personalisation, legal powers and workforce.
- ***Adult safeguarding: Standards and Performance Summary*** (July 2012); This document summarises the work of the LGA, ADASS and safeguarding leads in terms of performance monitoring. It states that... *'Safeguarding is a dominant theme in the overall performance of adult social care. It has a disproportionate significance in terms of impact. Addressing the safeguarding dimensions of improvement is therefore critical for sector based improvement itself.'* (p1) This is a summary document to the full report which sets out a suite of safeguarding standards and competencies, focuses on outcomes and the learning from peer reviews and challenges.

3.16 Other documents the LGA have been involved in developing include

- ***Safeguarding Adults Briefing from the LGA for Prospective Police and Crime Commissioners*** Williams C (April 2012). This briefing sets the context for adult safeguarding; poses questions for the Chief Constable and recommends ways for the PCC to engage with Councils.
- LGA and Research in Practice for Adults jointly produced the ***Councillor's Briefing – Adult Safeguarding*** (March 2013). This guide replaces the previous briefing and sets out the role of Councillor's in relation to adult safeguarding; poses key questions and actions and the legislative framework that supports this.
- LGA, NHS Confederation and Age UK produced ***Delivering Dignity Securing dignity in care for older people in hospitals and care homes*** (February 2012) which sets out 37 recommendations on how to improve dignity in care and highlights the importance of five 'Always' events for dignity in care: *'...1. Always treat those in your care as they wish to be treated – with respect, dignity and courtesy; 2. Always remember nutrition and hydration needs; 3. Always encourage formal and informal feedback from older people and their relatives, carers and advocates, to improve practice; 4. Always challenge poor practice at the time – and learn as a team from the error; 5. Always report poor practice where appropriate – the people in your care have rights and you have professional responsibility.'* (p12)

3.17 Other documents ADASS has been involved in or commissioned includes:

- ***Out-of-Area Safeguarding Adults Arrangements*** ADASS (December 2012).This document sets out the safeguarding responsibilities for both the host and placing authority for service users that are subject to safeguarding arrangements when placed out of area.
- ***Prisoners and Safeguarding*** (April 2012) author Robin Cowen. The report identifies that prisoners are not excluded from *No Secrets.* Her Majesty's Inspectorate of Prisons (HMIP) recognises the need to address this.

- ADASS, ADCS and The Children's Society collaborated to produce the following document: ***Working Together to Support Young Carers and Their Families - A Template for a Local Memorandum of Understanding [MoU] between Statutory Directors for Children's Services and Adult Social***

Services (August 2012). The MoU focuses on young carers and how the two directorates (including LSCB and LSAB) can work together.

3.18 Social Care Institute for Excellence (SCIE) has produced:

- ***Serious Safeguarding Abuts Reviews: Guidance note on options for London*** Bestjan S (April 2012). Although this is an options appraisal and proposal for London it sets out a range of different approaches to undertaking reviews to enable lessons to be learnt as it recognises that *'Traditional SCRs can be very costly, with some exceeding £15,000, while some practice learning models costing a fraction, of a few thousand pounds may achieve better outcomes. Thus, there is a clear case for change and alternative safeguarding review model options, which are both robust and more efficient than more traditional approaches.'* (p1)
- ***Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare commissioners*** (November 2012). This sets out the new arrangements for DOLS from April 2013 primarily that the NHS commissioners will transfer their supervisory body responsibility to the Local Authority for hospitals.

3.19 The DH published the following document:

- ***The Adult Social Care Outcomes Framework 2013-14*** (November 2012) and also the Health and Social Care Information Centre produced the ***Abuse of Vulnerable Adults in England 2011-12 Final Report, Experimental Statistics*** (March 2013) used in the later section of the report and consulted on
- ***New Safeguarding Powers*** in October 2012.

3.20 Numerous articles of interest have been published in the Journal of Adult Protection however of specific interest is ***Adult Safeguarding and the role of housing*** Parry I Vol.15 No.1 2013. The paper identifies and encourages good practice in adult safeguarding by housing providers.

3.21 The Local Government Ombudsman published the following document in July 2012 ***Adult Social Care, LGO the Single Point of Contact for Complaints.*** The report highlights four key areas identified from investigations of complaints one of which specifically deals with protecting vulnerable adults. The report summarises two case studies it has investigated and its findings to help improve service delivery and share the lessons learned widely.

3.22 The Government published in October 2012 ***Channel: Protecting vulnerable people from being drawn into terrorism. A guide for local partnerships*** setting out the way it expects partners to work together and prevent vulnerable people being drawn into terrorism. ***The South West Channel Guidance for Multi Agency Statutory Partners A multi-agency approach to safeguarding those at risk of radicalisation*** written by NHS South of England (West and Central) Prevent Coordinator, Probation, Police Leads and the Regional Channel Coordinator (November 2012) puts the Government document into local procedures. It is a regional document which sets out the referral criteria, referral procedure to activate someone through the Channel procedure. Channel is the multi-agency procedure designed to safeguard individuals who may be vulnerable to being drawn into terrorism; **Channel** is a key strand of the Prevent Strategy and **Prevent** is one of the four strands of **CONTEST** the Strategy for Countering Terrorism

3.23 ***Advocacy: a voice for our future a case study report*** Voluntary Organisations Disability Group was published by VODG (October 2012). The report describes what independent advocacy looks like '...*how accessible it is, how it can be applied and how it contributes to the quality of life, rights and safeguarding of otherwise vulnerable people.'* (p6). Page 18 of the report showcases how KeyRing safeguarding and provide support in advocacy.

3.24 The NHS Commissioning Board in preparation for new governance structures produced ***Arrangements to secure children's and adult safeguarding in the future NHS - The new accountability and assurance framework – interim advice*** (September 2012). The framework states... '*Safeguarding Adults Boards already work effectively with health bodies. The draft Care and Support Bill proposes putting SABs on a stronger, statutory footing, better equipped both to prevent abuse and to respond when it occurs. It is intended that CCGs and the NHS CB will become statutory members of SABs.'* (p9)

Section 4: Governance and Accountability

4.1 Principles of the Board

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

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

4.3 Functions of the Board

4.4 The Board has responsibility for:

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

4.5 Structures of the Board

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

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

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

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

4.8 **Membership of the Board and sub groups**

4.9 Members of the Board are at a senior level within their organisation and are from the Statutory, Voluntary and Independent sectors. There is a carers specific representative; however since the decommissioning of Bath People First the LSAB no longer have a service user representative. The Board has been discussing how the voice and involvement of service users can now be achieved and this issue is yet to be resolved.

4.10 The sub-group members are from a variety of specialisms to ensure the group has relevant expertise in order to carry out its role. For example, the Quality Assurance, Audit and Performance Management group representative from the Police is their Lead for the Investigations Team; the Awareness, Engagement and Communications group has the Service User Facilitator from Sirona Care and Health responsible for a service user panel and expert in engagement and the Training and Development sub-group has a representative from the domiciliary care providers to help identify the needs of this sector.

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

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

- **Statutory organisations** including the: Local Authority; Primary Care Trust; Clinical Commission Group; Royal United Hospital; Royal National Hospital for Rheumatic Diseases; Avon and Somerset Constabulary; Avon and Wiltshire Mental Health Partnership NHS Trust; B&NES Avon Fire & Rescue Service; Avon & Somerset Probation Trust; Care Quality Commission
- **User led and Carers organisations** currently there is not a provider representing the voice of service users; the Carers Centre represents the voice of carers and carer organisations
- **Private, Independent and Voluntary sector organisations** including: Four Seasons Health Care, representing local care homes; 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)
- **Education organisations**: Threeways School
- **Council Cabinet member**: portfolio holder for B&NES Council Social Care, Health and Housing

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

- Local Safeguarding Children's Board
- Department of Work and Pensions

- Divisional Director for Tourism, Leisure and Culture, B&NES Council
- South West Ambulance Service

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

4.15 Role of the Chair and Board members

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

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

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

4.18 Financial arrangements

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

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

4.21 The LSAB have agreed to commission a Serious Case Review (SCR) during this financial year. The SCR will not be completed until 2013-14 however the independent chair was funded by B&NES Council and the report writer was funded primarily by NHS Banes and partly by B&NES Council.

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

4.23 Onward reporting structures

4.24 The Board has continued to report via B&NES Council commissioning to the Partnership Board for Health and Wellbeing (PBH&WB).

4.25 Safeguarding activity during 2012-13 continued to be reported quarterly to B&NES Council and monthly to the NHS Banes Board. Each Board member retains their own existing lines of accountability for safeguarding and promoting the safety of adults at risk within their organisation.

4.26 The Cabinet signed off the LSAB Annual Report for 2011-12 and Business Plan.

Section 5: Achievements During 2012-13 of the LSAB

5.1 Achievements and Outcomes of LSAB and Sub-groups Work during 2012-13

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

5.2 Policy and Procedure sub-group

5.3 The Director of Regulated Services at Freeways representing the Health and Wellbeing Partnership Network on the LSAB continued to chair the sub-group during 2012-13.

5.4 The group has undertaken the following work:

- Developed the following multi-agency documents for the LSAB's consideration and approval:
  (i) ***Protocol for Determining Neglect in the Development of a Pressure Ulcer*** – the existing protocol was rewritten and approved by the LSAB in June 2012
  (ii) ***LSAB Guidance on Service User Involvement*** - this was approved in September 2012
  (iii) Drafted a response on behalf of the LSAB regarding the proposed ***New Safeguarding Powers*** and sent this to the Department of Health in October 2012
  (iv) Reviewed the ADASS ***Inter-Authority Protocol for Safeguarding Adults*** (June 2012) and recommended a statement be added to clarify the arrangements in B&NES; this has since been superseded by a final version which ADASS circulated in December 2012 and the LSAB approved this.
  (v) Reviewed and finalise new ***Multi-Agency Safeguarding Adults Procedures*** which were approved by the LSAB in December 2012 for implementation in April 2013
- The group have also continued to try and progress the Multi-Agency Trigger Protocol; work has been slow on this and the LSAB have discussed it on several occasions. A workshop was held at the end of January 2013 with a good turn out from multi-agency partners including Children Services. The workshop

focused on what the current arrangement for sharing information and triggers for local agencies were; what needed to be developed to create a comprehensive multi-agency approach to this thus enhancing preventative responses and reviewed the barriers to developing this. The LSAB plan to hold another session in the autumn to progress this further.

- The group has prompted the LSAB to review its Terms of Reference which was completed in September 2012.

5.4 Safeguarding and Personalisation sub-group

5.5 The group disbanded in June 2012; it reviewed progress against the South West Regional ***Safeguarding and Personalisation Framework*** (revised January 2011). The group achieved all but two of the recommendations it hoped to achieve from the Framework. One area that continues to remain a gap is the establishment of Risk Enablement Panels; B&NES Council, AWP and Sirona do not currently offer these, however all are confident they could arrange a meeting with a specific service user and their advocate to discuss their 'support plan' if the service user wanted to make a challenge about not being enabling to take a risk which they felt they wanted to and were able to manage. The second area related to CRB checks for Personal Assistants working in households with children. Legal advice has been sought regarding this and although good practice to do so, it cannot be a mandatory requirement. Therefore to try and reduce / prevent risk, care managers and direct payment support agencies such as the Shaw Trust positively promote safer recruitment practices to all service users employing PA's and highlight the potential risks especially to households with children. CRB checks continued to be required for PA's to disabled children.

5.6 Mental Capacity Act and Deprivation of Liberty Safeguards Quality and Practice Group

5.7 The Assistant Director for Safeguarding and Personalisation at B&NES Council continued to chair the sub-group during 2012-13.

5.8 The group has undertaken the following work:

- Reviewed its Terms of Reference and moved from being known as an implementation group for the MCA to having a greater focus on quality assurance of practice. Children Services and the Police have been identified as key stakeholders and the group have requested representatives be identified. The objectives within the Terms of Reference are now in line with the actions identified in the Business Plan
- Presented an annual report specifically to the LSAB on the ***Deprivation of Liberty Safeguards (DOLS) 2011/12*** in September 2012; this identified that applications had significantly increased on previous years and were more in line with the numbers we would expect to see within the B&NES population. It also highlighted areas for improvement and noted the lack of applications from hospital settings with the exception of the RNHRD who had made appropriate applications to other placing authorities. RUH, Sirona and AWP agreed to look into this and provide assurance on staff awareness of DOLS
- Requested formal involvement and attendance from the Independent Mental Capacity Advocacy Service. SWAN Advocacy successfully won the tender for this service in February 2013 and began attended the group in March 2013;

SWAN Advocacy have been proactive and have highlighted areas they could usefully work with the group to provide assurance

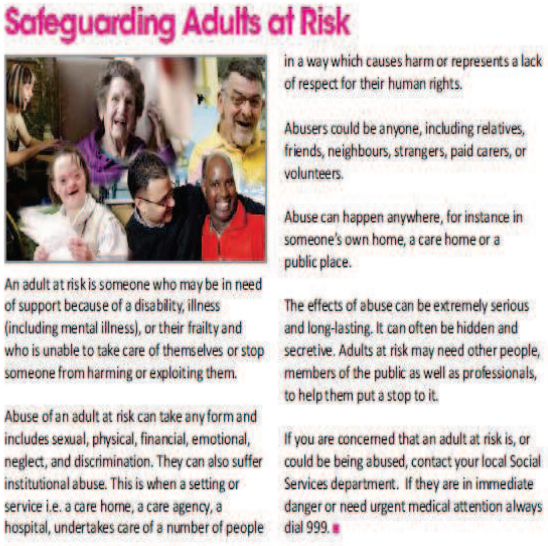
- Reviewed the Mental Capacity Act (MCA) and DOLS training programme offered to stakeholders by the Council for 2013-2014 and a new programme will be available with two new courses being offered.
- Provided bespoke training sessions on the MCA throughout the year for example two sessions at the RUH
- Started the process of gathering information from agencies on the mechanisms they have in place for assuring themselves that the MCA is being delivered in practice within their agency. Several agencies have undertaken audits which they will share with the group once reports are finalised
- Committed to developing a draft set of performance indicators that will enhance those on training already in place to provide assurance on the MCA and DOLS; these will be presented to the LSAB for discussion by December 2013
- Continued to share information on case law activity, discuss areas of good practice and raised awareness
- Continued to monitor the number of DOLS applications the Local Authority and PCT has received; 59 applications were received during 2012-13 and all have been completed within the required timescale. This is a significant increase on 2011-12 and a specific annual report will be discussed at the September 2013 LSAB meeting

5.9 Awareness, Engagement and Communication sub-group

5.10 The group was chaired for the first half of the year by the Deputy Director for Nursing (Medicine) at the RUH and passed to the Chief Executive of the Carers Centre for the second half.

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

- Written its Terms of Reference
- Reviewed and progressed the ***Carers and Safeguarding Adults – working together to improve outcomes (*ADASS, 2011)** Action Plan
- Reviewed and localised **Whistleblowing Guidance** (building on the guidance document Bristol providers and Council Safeguarding Team have produced). This was circulated to all stakeholders
- Identified that the ***Health and Community Guide Health and Community Information for Everyone*** did not reference safeguarding adults at risk; contacted the publisher and wrote the content (see above) for the national publication and also advertised in the specific publication for Bath; this was distributed to a number of local GP surgeries and is free to download
- Ran a specific adult safeguarding stall at Bath City Conference (May 12)
- Reviewed and recommended the ***NHS South of England Safeguarding Adults booklets*** to local health providers and commissioners
- Published a variety of adverts and statement on safeguarding adults throughout the year for example, in the RUH Insight magazine; Friends of the RUH Guide and B&NES Council Connect magazine which goes to every household in B&NES



Safeguarding Adults at Risk

An adult at risk is someone who may be in need of support because of a disability, illness (including mental illness), or their frailty and who is unable to take care of themselves or stop someone from harming or exploiting them.

Abuse of an adult at risk can take any form and includes sexual, physical, financial, emotional, neglect, and discrimination. They can also suffer institutional abuse. This is when a setting or service i.e. a care home, a care agency, a hospital, undertakes care of a number of people in a way which causes harm or represents a lack of respect for their human rights.

Abusers could be anyone, including relatives, friends, neighbours, strangers, paid carers, or volunteers.

Abuse can happen anywhere, for instance in someone's own home, a care home or a public place.

The effects of abuse can be extremely serious and long-lasting. It can often be hidden and secretive. Adults at risk may need other people, members of the public as well as professionals, to help them put a stop to it.

If you are concerned that an adult at risk is, or could be being abused, contact your local Social Services department. If they are in immediate danger or need urgent medical attention always dial 999.

- Continued to have safeguarding adults information on the one hour loop series on Council TV in B&NES Council offices, leisure centres and libraries to raise awareness
- Continued to discuss safeguarding adults at a variety of forums and groups for example the Domiciliary Care Services group
- Explored how to best engage service users in the strategic aspect of the work on safeguarding – the LSAB continue to consider this however did not reach a conclusion during 2012-13
- Held a workshop in January 2013 to develop a calendar of opportunities to routinely and strategically disseminate information for citizens, providers and publications. Additional organisation representatives attended and a large number of events, print and web opportunities were identified

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

Safeguarding - leaflets, posters and articles | Bathnes

5.13 The service user feedback questionnaire was rolled out to all service users that had been supported by Sirona Care and Health through stage 4 onwards of the safeguarding procedure. An easy read pictorial questionnaire was also designed with service user input and the Complex Health Needs Service of Sirona Care and Health. 12% (21) **Keeping You Safe** questionnaires were returned evidencing a positive response with:

- 81% of the respondents stated they were clear about the safeguarding process itself
- 86% of respondents felt able to express their views throughout the process
- 90% of respondents said that they did feel listened to
- 76% of respondents were happy with the outcome of the involvement
- 85% stated they were treated with dignity and respect

5.14 One respondent did not have a positive experience answering all questions negatively with No or Not Sure; in one of the comments boxes they stated *'No*

control of what was to happened to me'. This respondent did not leave their contact details.

5.15 Of the 21 returns, six service users completed the questionnaire themselves; three completed it with support; four were completed on the service users behalf by their support worker; four were completed by the service users son or daughter; three did not complete this section of the form and one ticked the box to say it had been completed by someone on their behalf but didn't say who that was.

5.16 Training and Development sub-group

5.17 The Operations Director of Sirona Care and Health continued to chair the sub-group during 2012-13.

5.18 The group has struggled for membership, however despite this has undertaken the following work:

- Rolled out the **Multi-Agency Staff Development Framework.** LSAB and sub-group member agencies; carers and domiciliary care agencies have been asked to audit arrangements in this area and were asked to return completed audits with fully year data for 2012-13; findings will be reported to the LSAB in the autumn of 2013
- Identified the need for additional MCA/DOLS courses and new sessions are now available
- Started discussion with the LSCB about developing a suite of level three workshops that stakeholders could attend, potential themes include:
    - Hate crime/Mate crime
    - Domestic abuse
    - Financial abuse

5.19 Sirona Care and Health continue to be commissioned to provide level 2 and 3 courses to the voluntary and independent sector. The figures in the table below set out the number of staff trained in level 2 and from which organisation they are from.

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

Agency	Course Title – Safeguarding Adults....			
	Level 2 (inc Children)	Level 2 – Awareness	Level 3 – Investigation	Total
AWP		3	4	7
GP Surgery	1	2		3
Voluntary / Independent	29	156	10	195
North Bristol Trust		7		7
NHS Other		6		6
Other B&NES	1	10		11
PCT Commissioning		2	1	3
Council Commissioning		5	4	9
Council Provider		2		2
Sirona Care and Health		652	42	694
Grand Total	**31**	**845**	**61**	**937**

5.21 Table 2: Agency Type and Number of Staff Trained at Level 2 by Sirona Care and Health by 2010-13

Organisation Type	No. Staff Trained 2010-11	No. Staff Trained 2011-12	No. Staff Trained 2012-13
AWP	2	3	3
Independent and Voluntary Sector Providers	331	160	150
General Practices	12	12	1
NHS Other	22	4	4
PCT Commissioning	6	10	2
PCT Provider other	0	2	0
Sirona Care and Health	380 (Health staff) 359 (Social care staff)	585	652
Council	8	10	7
North Bristol Trust	0	2	1
Other	0	3	0
Total	**1120**	**791**	**168**

5.22 Organisations across B&NES also provide their own staff training and these figures are not captured in this report. For those agencies the Council have a contract with, training figures are reviewed as part of the review process.

5.23 Bespoke workshops/training sessions were provided for staff employed by Independent Contractors (GPs, Optometrists, Pharmacists and Dentists). Three workshops were run for all four groups to attend and 47 staff attended; the sessions were run by NHS Banes and the Council. Feedback from these sessions was largely positive with some areas for improvement. A further workshop was held specifically for GPs. This was run by the NHS Banes, Council and BGPERT (B&NES GP Education, Research and Training Group). All courses covered the MCA and Safeguarding Adults. Feedback from this session was less good and the workshop would need to be changed significantly if the session were to be run again.

5.24 A bespoke workshop was also held for the Strategic Domiciliary Care providers at their request. It was well attended and had positive feedback. *'Thanks for the workshop today it was very informative'* (Care South).

5.25 Sirona Care and Health are in the process of designing investigation training in partnership with the Police; it is hoped this will be available in 2012-13.

5.26 The Council worked in partnership with other sub regional authorities to deliver a training / awareness raising session with Care and Support West members. Areas that were address included safeguarding threshold particularly medicine errors and pressure ulcers.

5.27 During the year Bath People First (ULO) members delivered safeguarding training to a range of organisations in B&NES including: SWALLOW; Greenhill House (Leonard Cheshire Homes); Carers Centre; local services provided by Dimensions (UK); Bath Mind; Lynwood House (Voyage Care); Shared Lives Scheme, Carrswood and Connections Day Centre (Sirona Care and Health). The training was bespoke to each organisations needs but largely covered the following areas:

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

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

5.28 Yoursay Advocacy Service also delivered bespoke training to a supported living provider and service users in receipt of the service; this was as a result of a high number of safeguarding alerts being received about the service users in one particular block of flats. The alerts related to a range of abuse that was occurring in the community and Yoursay focused on keeping safe and hate crime.

5.29 Quality Assurance, Audit and Performance Management sub-group

5.30 The group has continued to be chaired by the Assistant Director for Quality and Performance Management from NHS Banes.

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

- Continued to undertake multi-agency case file audits. This process has highlighted both gaps and good practice, both have been fed back to relevant organisations (three cases were from the RNHRD; one from Fire and Rescue Services; one from Curo; one from Sirona Care and Health and one from the Police)
- Monitored the progress of the action plan developed in response to the Somerset LSAB ***Serious Case Review into Parkfields Care Home*** by Margaret Sheather (May 2011)
- Assessed the findings of the LSAB agencies responses to the ***South West Self-Assessment Quality and Performance Framework for Safeguarding Adults*** (ADASS SW 2010) dashboard and reported this to the Board
- Revised the groups Terms of Reference and these are now available on the public web site
- Reviewed safeguarding referral data sources to ensure there were no obvious gaps in providers making alerts and that information triangulated between agencies
- Commenced work on developing a risk register for the LSAB; reviewed a risk register from Wiltshire and present a draft to the LSAB in March 2013; this will be finalised in June 2013
- Reviews a report from Sirona Care and Health on **Safeguarding Adult Referral Audit** – this is a repeat snapshot audit of the alerters perceptions of the duty teams (at Sirona Care and Health) call handling skills. Findings were positive for example; 100% of respondents thought that that the call handler listened well to their alert. The snapshot is carried out on all alerts made in October 2012 and builds on the snapshot undertaken in October 2011; improvements were evident from the responses provided
- Considered the B&NES Council Children and Family Services Ofsted report and potential impact on adults safeguarding i.e: could this be said of adult safeguarding delivery? Areas identified for improvement are being addressed by the Joint Interface group of the LSCB and LSAB

- Undertook a **survey of LSAB and sub-group members views of the effectiveness of the LSAB**. All LSAB and sub-group members were asked to complete an on-line survey. The Survey Monkey questionnaire went to 66 people with 40 responses (60% response rate). There were a lot of positive comments and some areas for improvement identified for example:
  - There is a really good understanding of the role of the LSAB (39/40 gave positive responses)
  - The role of the LSAB and subgroups is clear to most respondents (33/40)
  - There was a mixed view in relation to the effectiveness of LSAB in working together to prevent and minimise abuse, the LSAB members reported more positively than the subgroup

- 49% of all respondents felt that service users and carers could be more involved in aspects of safeguarding planning
- Almost half of respondents didn't know whether lessons learnt from SCRs are shared effectively across B&NES

The LSAB has considered the findings and are looking at ways to improve in the areas that require this

- Routinely discussed and updated itself on new information regarding Winterbourne View
- Analysed responses to questions posed to LSAB agencies about their approach to **whistleblowing** to provide the Board with assurance that whistleblowing was taken seriously and responded to appropriately. Five questions were asked:
  - Have you got a Whistleblowing Policy in place?
  - When was your Whistleblowing Policy last reviewed?
  - How is the Whistleblowing Policy shared with staff and when was this last done?
  - In the last 24 months how often has the Whistleblowing Policy been invoked?
  - How do you learn from Whistleblowing incidents and what is the evidence that the learning has made a difference?

  11 of the LSAB member agencies returned responses. Each agency has a policy in place that relates to whistle blowing however a small number of agencies use a different name rather than calling it a whistleblowing policy, for example, Fire & Rescue Service have a Confidential Reporting Code, the RUH have a Raising Concerns Policy and Police have a Professional Standards Reporting Policy. Agencies report that the majority of policies have been reviewed within the last two years; one was reviewed over three years ago and two are under review at the moment. Most agencies include a focus on whistleblowing as part of new staffs' induction programmes and have the Policy and Procedures available on their intranets. Two agencies have whistleblowing posters in key locations and a small number of agencies discuss it at staff meetings, during supervision and include it in staff training. Agencies have a variety of mechanisms in place for evidencing that the learning from whistleblowing events has made a difference.

5.32 Joint Interface Group of Local Safeguarding Children and Adults Boards

5.33 The group was convened in September 2012 and is Chaired by the Assistant Director for Safeguarding and Personalisation at B&NES Council.

5.34 The group was formed following a joint LSAB/LSCB development day earlier in the year. The purpose of the group is to identify areas for streamlining joint working and sharing resource and expertise and strengthening any areas of service delivery to improve outcomes for households. The group has been progressing seven areas that the Boards approved joint working on:

- **Training and development** – sharing training programmes and extending the reach; developing a suite of sessions that meet the needs of both the LSCB and LSAB such as domestic abuse; IMR writing; Disability training and investigators training and merging the Training and Development sub-groups together

- **Learning opportunities** – Boards to routinely share learning and actions identified from management reviews, inspections, SCRs etc to develop practice
- **Trigger Protocol / Intelligence Gathering / Information Sharing** – improving current information sharing between children and adults services
- **Communications and Awareness Raising** – the LSCB do not have a group working on this are; they are planning to learn from the adults group and plan to develop a joint communication plan
- **Chairing arrangements** – LSCB and LSAB to look at the opportunity for a single chair. The LSAB have asked the LSCB to scope the interest and skills of those applying for the role of chair of the LSCB
- **Transition of Children to Adult Services** – review how safeguarding is considered during transitions and in the work of the Transitions Board
- **Safer Recruitment of Personal Assistants for Adults and Children** – the legal responsibilities for children and adults in terms of safer recruitment are different and awareness needs to be raised for households with children where the adult (not child) is in receipt of social care and employs a Personal Assistant.

5.35 Additional Work Carried Out by the LSAB During 2012-13

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

- Received routine updates from the work being undertaken by the LSCB and received copies of the LSCB Annual Report 2011-12 and 2012-13 and Work Programme
- Received routine updates and information from the LSAB Chairs network via the Chair
- Reviewed and revised the LSAB Terms of Reference
- Approved the new LSAB Business Plan for 2013-15 (**Appendix 5 o**f the report)
- Received a progress update on the actions from the recent serious case review (SCR) and approved a new **Serious Case Review Protocol** which builds on the lessons learned from carrying out the SCR
- Commissioned a new SCR. The SCR report was discussed by the LSAB in April 2013 and recommendations will be included in 2013-14 Annual Report
- Received several briefing papers on adult safeguarding in NHS provision in B&NES highlighting issues and areas of focus and the changes that were being brought about from the PCT ceasing and the CCG forming in April 2013; CCG members joined the Board during 2012-13 to ensure continuity and understanding of the work of the Board. It also received an assurance update on the B&NES position in relation to the recommendations of the South Gloucestershire ***Winterbourne View Serious Case Review*** from NHS Banes and a briefing on the findings and recommendations of the ***Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009,*** Robert Francis QC (House of Commons report published February 2013). NHS Banes also held a conference on Dignity in November 2012 where the document ***Delivering Dignity Securing dignity in care for older people in hospitals and care homes*** (NHS Confederation, LGA and Age UK) was discussed. B&NES Council helped fund the event at which the guest speaker Michael Mandelstam (author and specialist in adult social care) did a though provoking presentation on 'Daring to Fight for Dignity'; safeguarding adults was one of the topics discussed

- Agreed the LSAB safeguarding indicators for 2012-13 (each agencies has reported progress on these in section 7 of the report) and also approved the 2013-14 indicators
- Discussed the ***South West SAB Audit report*** which sites B&NES LSAB in several areas of good practice for others to look at
- Approved the **Deprivation of Liberty Safeguards Annual Report 11/12** noted in 5.8 of the report
- Considered the issues faced regarding **Forced Marriage / Honour Based Violence** a representative from Julian House presented the issues for the LSAB
- Received policy and legislative updates on the following:
  - ***Caring for our future: reforming care and support*** (DH July 2012)
  - Reforming the law for adult care and support: the Government's response to Law Commission report 326 on adult social care
  - ***Consultation on New Safeguarding Powers*** (DH July 2012)
  - **ADASS / LGA *Safeguarding Adults Advice and Guidance to DASS*** (March 2013)
- Received brief information on the ***Welfare Reform Act 2012*****,** this is being discussed in greater detail in June 2013 and ***Channel: Protecting vulnerable people from being drawn into terrorism:*** *A guide for local partnerships* (Home Office, Gov 2012), and on the changes to the Criminal Record Bureau checks and the **Disclosure and Barring Scheme**
- Received an update on the **South West ADASS Safeguarding Programme** at which a B&NES Council Team Manager has the roll as the representative for the South West Safeguarding Adults Leads Group
- Received information on the **West Sussex Judicial Review**
- Discussed the most effective way to engage service users in the work of the LSAB. The Chair met with the Service User Panel of Sirona Care and Health to discuss this and the Board considered a paper from the Service User Facilitator at Sirona Care and Health and considered the views of Yoursay Advocacy Service; this is still in discussion and the LSAB approach has not been finalised. The current proposal is to approach Healthwatch to look at what they can offer by way of support with this
- Received routine safeguarding activity reports on the number of referrals and performance to procedural timescales; also received copies of the safeguarding reports presented to the Health and Wellbeing Board
- Were consulted on the draft **B&NES Suicide Prevention Strategy;** the Director for Public Health (interim PCT) presented the draft strategy and the LSAB made recommendations about the areas to be included from an adult safeguarding perspective
- Started to routinely agree the **key messages** that the LSAB wanted to share with all local stakeholders and disseminate these after each meeting by way of a chairs report
- Started a conversation on the boundaries and scope of the role of the LSAB in commissioning activity. The LSAB plan to take this work further and define its involvement more clearly in the commissioning cycle at its awayday in 2013
- Took part in a Home Office Safeguarding Project which took the form of a peer audit; the Home Office have commissioned a national audit into Force areas looking at the partnership working between the Police, Community Safety Partnership, LSCB and LSAB. B&NES was chosen as the area the Home Office team wanted to visit for the Avon and Somerset Constabulary area. A programme of visits was put together and the peer audit team attending part of

the LSAB meeting which discussed a case study which Fire and Rescue Services had identified a safeguarding alert and all partners worked together to reduce the risk to the service user and others in the multi-occupancy building. The team also met with B&NES Networks (CIC) who wrote the team a script about hate crime and three members of the Network showed the team around Community Safety Zones in Keynsham.

Community Safety Zones are safe places in the Community to go to when you are out and about if you are the victim of Hate Crime.

The Home Office lead for the visit wrote to us quickly after the visit to say, '...this is the first time that a Local Authority has allowed us to meet community members like Networks and arrange for them to talk to us and explain their experiences and thoughts. We felt thoroughly honoured to be with such lovely people and proud to share the time to visit a Safe Zone area and talk to the local shop keepers involved in the scheme- stamping out Hate Crime is a priority for us all. It was a very powerful experience and we would like to pass on our sincere thanks to everyone we met. Thank you Networks.' (April 2013)

- Held an Awayday in October 2012 which focused on two areas:
  - Prevention and working with Community Safety and the Responsible Authorities Group (RAG); the Group Manager for Policy and Partnerships (B&NES Council) gave a presentation on the work of the RAG and the work of the Council to enhance community safety and facilitated a session on the type of preventative work the LSAB could undertake and commit to as part of the Business Plan
  - The findings, lessons and recommendations from the reports into what happened at Winterbourne View Hospital. Presentations were given by a member of the SCR panel; CQC and health and social care commissioners

The away day was extended to LSAB sub-group members and key Council and PCT staff

5.38 Other Work in Relation to Safeguarding Adults

- B&NES Council adult care commissioners were asked to speak at a national conference **on Safeguarding adults in care homes and other residential settings: Promoting prevention through quality, dignity and collaborative working** and delivered a presentation on Incorporating Quality Assurance in the Commissioning Process; the presentation covered the positive impact on assurance the integration of health and social care has had on both commissioning, micro commissioning and delivery of services

- B&NES Council Risk and Assurance Service audited the mechanisms of control the Council Safeguarding Adults and Quality Assurance team have in place for safeguarding adults; the auditor found the team to have excellent mechanisms in five areas and good mechanisms in one area it assessed as outlined below:

Assurance Summary **The key control objectives used to review the framework of internal control are recorded below. For each control objective we have considered the risks and internal controls in place and operating, based on audit review / testing.**	**Assessment of controls in place and operating to ensure achievement of control objectives**
An up to date Safeguarding Policy is in place with clear procedures documented and disseminated to the appropriate agencies/organisations.	Excellent
Assurance is obtained from organisations commissioned by the Council to support and protect vulnerable adults, which confirms appropriate safeguarding training is provided.	Excellent
The role and responsibilities of the Local Safeguarding Adults Board is clearly defined.	Excellent
Procedures are in place to ensure all alerts are correctly recorded and the 'Procedure for Safeguarding Adults' is effectively and accurately applied in all cases.	Good
Procedures are in place to identify reoccurring alerts/ themes by service user and agency/ organisation, and action taken where appropriate.	Excellent
Procedures are in place to monitor alerts in respect of clients who are receiving services commissioned outside the authority.	Excellent

Three areas of weakness were identified:

- Formalised and documented procedures for auditing of Stage 3 closed cases and Chairing arrangements for cases proceeding through the Safeguarding Adults procedures have not been agreed with AWP.
- Minutes from Strategy and Case Conference/Planning meetings, which clearly record actions and details of the investigations are not always attached in CareFirst prior to the case being closed
- The LSAB have yet to formally adopt the ADASS 'Out of Area Safeguarding Adult Arrangements' which came into effect in December 2012.
  All are being addressed and will no longer be weaknesses from June 2013.

➢ The Council undertake an Annual Social Care Survey as part of the requirement for the Department of Health in accordance with the ***NHS Outcomes Framework 12/13*** (DH Dec 2011). In 2011-2012 1073 people were surveyed (figures for 2012-13 are not available for oublic release until July 2013); 445 (41.5%) responded to the survey and the results are as follows:

- Outcome 4a The proportion of people who use services who feel safe: 68%
- Outcome 4b The proportion of people who use services who say that those services have made them feel safe and secure: 75%

Those respondents who have stated they do not feel safe are contacted to see it they need any additional help or review of their situation.

➢ Sirona Care and Health, the RUH, B&NES Council and NHS Banes have commenced a piece of work to try and streamline safeguarding and root cause

analysis (RCA) investigations and reduce duplication of investigations and reports. All parties are working together closely on this as they recognise we need to reduce the demand on staff time and pressure on the system where 'we' can.

- B&NES Council have worked closely with NHS Banes to ensure safeguarding adults and children is monitored as part of the new NHS 111 contract delivered locally by Harmoni.
- B&NES Council, NHS Banes and CQC have worked closely meeting on a bi monthly basis to discuss inspection and review findings of regulated services and triangulate this with any information received from reviews, safeguarding alerts and complaints to the Council and Serious Untoward Incident reporting and complaints to NHS Banes and whistleblowing to each agency. The meetings have proved useful and helped the early identification of concerns to help prevent abuse from occurring or potentially escalating.

- Community Safety and safeguarding prevention has continued to be a focus for the LSAB during the year and the following has taken place:
  - The LSAB has ensured routine attendance at MARAC and MAPPA meetings
  - The Councils Assistant Director for Safeguarding and Personalisation and members of the Safeguarding Adults and Quality Assurance team are represented on a range of RAG working groups such as: Interpersonal Violence and Abuse Strategic Partnership (IVASP); Partnership Against Hate Crime (PAHC); MARAC Steering Group; MARAC Provisions meeting; Door Step Crime forum; Prevent Steering Group. Specific presentations on adult safeguarding have also been made at the RAG.
  - The IVASP action plan 2012-2015 now explicitly makes the link between Safeguarding and domestic abuse. MARAC training is being delivered to practitioners to raise their awareness of the dynamics of domestic violence as it has been established that particularly older and the more vulnerable victims may not recognise that they are victims.
  - Safeguarding data has been shared with IVASP to be included in the new Domestic Violence Problem Profile which will be published in the autumn of 2013. Strong links have been made both through IVASP and within this document to Safeguarding. Discussions with and analysis of data supplied by Safeguarding underpin the analysis and findings relating to vulnerable people.
  - The Community Safety Plan has been extended to 2014. On behalf of B&NES the RAG has adopted the Police and Crime Commissioners, Crime Plan for B&NES 2013-2017 of the 4 priorities 3 are focused on work which impacts on safeguarding:
    - Anti-Social Behaviour – focusing on the risk to the most vulnerable and repeat victims
    - Domestic Violence and abuse – particularly amongst those most vulnerable to harm
    - Ensure victims are at the heart of the criminal justice system
  - The LSAB Chair has met with the Police and Crime Commissioner to discuss the interface with safeguarding
  - A successful bid was made to the Police and Crime Commissioner for funding for 2013/14 to :
    - Maintain the IDVA service and link with the range of services provided by Southside Family project, this includes the their 4 newly set up community hubs and the family support service

  - Develop a single victim support service in B&NES to provide a one stop shop and advocacy service for victim of crime including the most vulnerable
- Community Safety Zone in Radstock, Midsomer Norton and Keynsham continue to operate and a third party reporting process to facilitate and increase reporting of hate crime for people with learning disabilities experiencing Hate Crime incidents when out and about in their community has been developed. As well as offering further training to members of schemes in Radstock, Midsomer Norton and Keynsham a briefing pack was developed and delivered to the police to ensure that new staff can be briefed in house. Refresher training has been offered to all members of the existing schemes.
- The Village Agents provide a link between individuals and organisations that are able to provide help and support. This community run initiative continues to grow, for example the Village Agents for the Chew Valley have secured new funding that will enable a greater number of parishes to be covered.
- A monthly bulletin has been developed by the Stronger Communities Team to assist in the dissemination of community and information of community interest, it is distributed to the range of networks in Keynsham and the Chew Valley. Recent news items included details of the 'Stop Abuse' work in B&NES and the Sirona's new service to support victims who may be suffering mental illness. LSAB Key Messages are also shared through the bulletin

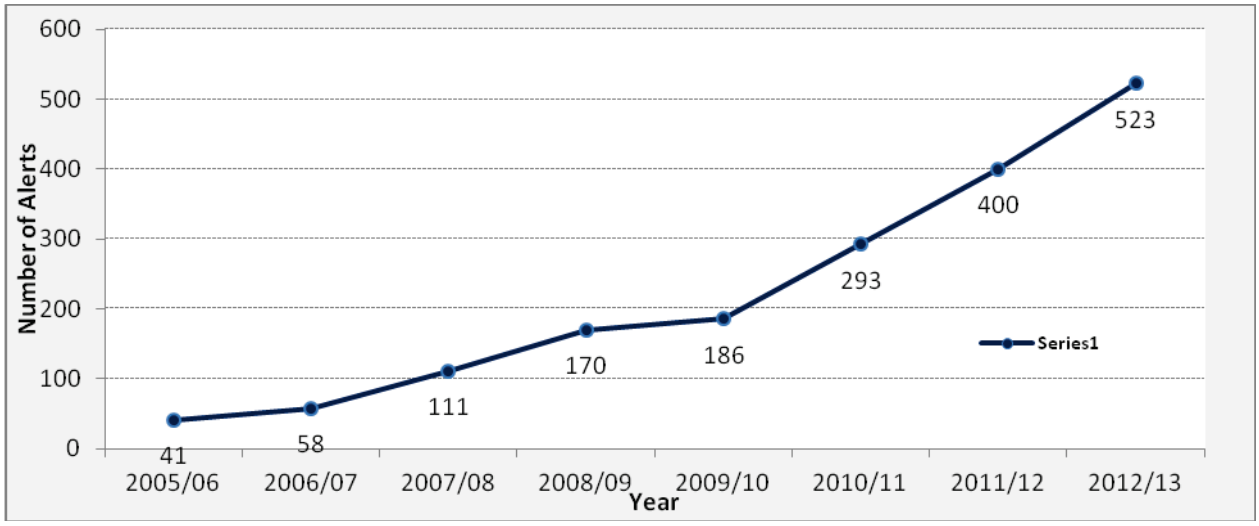
Section 6: Analysis of Safeguarding Case Activity (2012-13)

6.1 In March 2013 the NHS Information Centre (NHSIC) published ***Abuse of Vulnerable Adults in England 2011-12: Final Report, Experimental Statistics*** (the report is available to the public as Experimental Statistics, which means the statistics are undergoing evaluation and is based on returns from 152 Councils). Previously the South West Region ADASS group had commissioned benchmarking information however we are not aware this has been done for 2012-13. Therefore the NHSIC report is the only source of comparator data available to inform analysis of the B&NES position and this is a year old. The NHSIC data for 2012-13 will not be available until March 2014.

6.2 The NHSIC report shows there was a 44% (p9) increase in the number of alerts for 2010-11 and 2011-12 and reports an 11% increase on referrals (cases that are progressed through the Safeguarding Procedure i.e where the coordinator decides the person is a vulnerable adult and the threshold of significant harm has been met) for the same period with 108,000 new referrals made in England. When comparing B&NES data from 2010-11 and 2011-12 there was a 37% increase in the number of alerts (7% lower than the national increase) and there was an 18% increase in the number of referrals that progressed through the safeguarding procedure (7% higher than the national increase). This may indicate that the number of alerts are not all being identified and that the threshold applied in B&NES is lower than in other areas. LSAB agencies are looking at thresholds and a number of discussions have taken place better the Council and Sirona Care and Health regarding this. The LSAB has also discussed the difference between 'sub optimal care' and safeguarding.

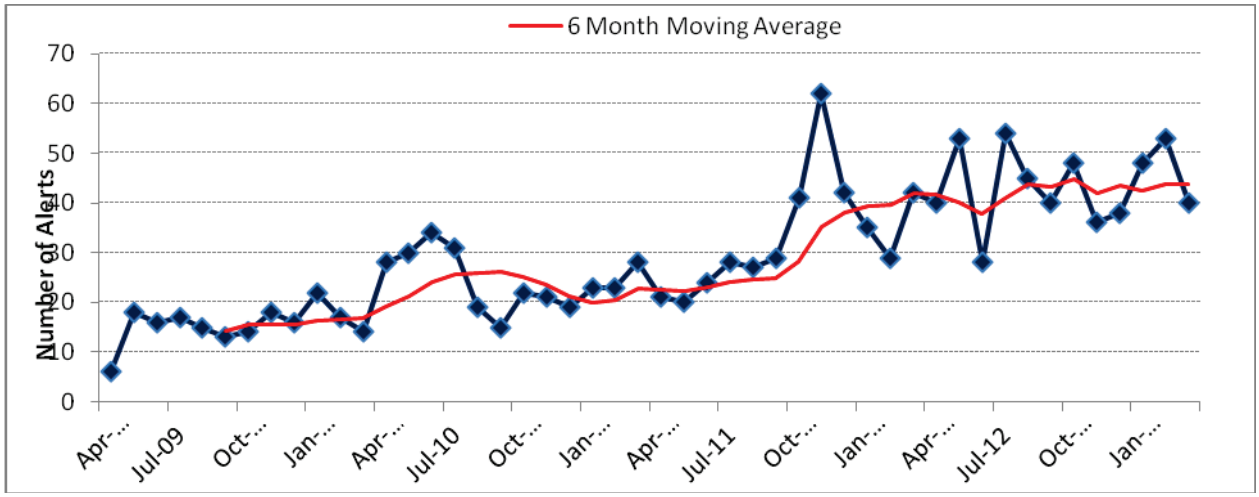
6.3 B&NES received 523 new alerts during 2012-13 and also supporting 51 service users through the safeguarding procedure who had been referred during the previous year. At the end if the March 2013, 110 cases remained open and 464 had been closed. This is a significant increase in the number of cases remaining open from previous years. The increase in the number of alerts received from 2011-12 to 2012-13 was 31%. The Chart below shows the rise in alerts from 2005-13.

6.4 Chart 1: Number of Safeguarding Alerts 2005-13



6.5 The chart below shows the number of alerts from April 2009-13 by month. There was a significant drop in the number of alerts received in June 12 compared to other months in the period. It is not clear why that is.

6.6 Chart 2: Monthly Safeguarding Alerts from April 2009 – 13



6.7 Alerts that were received more than once for an individual service users were at 23% of the total number of alerts during 2012-13 – these are known as 'repeats'. The repeats are for service users who were previously subject to safeguarding in the reporting period. 54 service users had more than one alert; of these service users 82% had two; 16% had three and one service user had four alerts. Adults with learning disabilities were the group with the highest number of repeats (46%) followed by adults with a physical disability (39%) and then adults with a mental health need (13%). The figure for learning disabled service users is significantly

higher than the national picture, the NHSIC report 30% repeats for adults with a learning disability (less than B&NES); 40% of repeats are for adults with a physical disability (similar to B&NES) and 25% for adults with mental health needs (higher than for B&NES) (p22). 34% of the cases for adults with a learning disability were in the age group 18-64 and were substantiated. It is likely that these relate largely to a large scale investigation being undertaken by B&NES Council and Sirona Care and Health and also relate to work identified through the current serious case review.

6.8 There have been three large scale investigations carried out during the period; two have been closed and the providers complied with comprehensive action plans that were monitored through the Councils commissioning and contract leads and CQC and the other is on-going. Large scale investigations involve a significant amount of work for all parties and increase the pressure on the safeguarding system. The Council and Sirona Care and Health have been mindful of the West Sussex Review when undertaking these. Two different models have been tested to carrying out a large scale investigation and the Policy and Procedures sub-group are developing a Large Scale Protocol which will be considered by the Board in 2013-14.

6.9 Table 3 below shows the gender and age of the service user referred for consideration under the Safeguarding Policy and Procedures. The percentage of male and female for 2012-13 is very similar to previous years however we can see a slight increase year on year of more females than males; this gender profile is also similar to the national picture for 2011-12 which shows 61% of women and 39% of men are referred.

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

No. of Alerts by Gender				**No. of Alerts by Age**					
				18-64			**65+**		
	10-11	11-12	**12/13**	10-11	11-12	**12/13**	10-11	11-12	**12/13**
Male	113 (38.6%)	148 (37.2%)	**192 (36.2%)**	57 (19.5%)	91 (22.9%)	**107 (20.5%)**	56 (19.1%)	57 (14.3%)	**83 (15.9%)**
Female	180 (61.4%)	250 (62.8%)	**331 (63.1%)**	54 (18.4%)	81 (20.4%)	**123 (23.6%)**	126 (43%)	169 (41.5%)	**208 (39.9%)**
Total	293	398	**523**	111 (37.9%)	172 (43.2%)	**230* (44.1%)**	182 (62.1%)	226 (56.8%)	**291* (55.9%)**

Note: the date of birth is missing from two service users records, these are open cases.

6.11 The age breakdown by gender is similar to previous years though there is a slight increase in the number of younger (18-64 years) females to males and a slightly reduced number of older age (65+) female to male referrals. The national picture shows that the number of female referrals is rising in each age group: *'The number of referrals for females was higher than males in every age group and the proportion of females increases as age increases'* (NHSIC 2013 p13).

6.12 For 2012-13, 85% of the alerts that were for men were from the white British ethnic group and 91% of alerts for women were from that group. Overall 7% of service

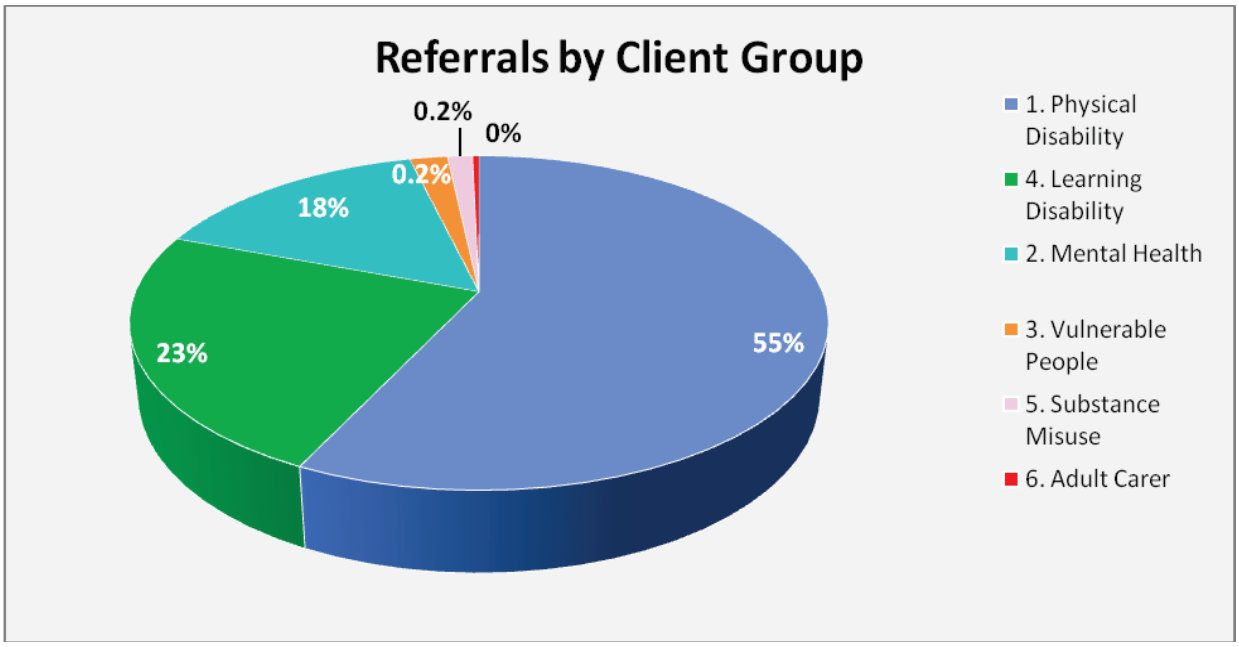
users were of non white British ethnicity. A full breakdown of alerts by gender, age and ethnicity for 2012-13 can be found in **Appendix 4**. The NHSIC reported that 89% of all referrals were for vulnerable adults belonging to the white ethnic group. (p17).

6.13 Table 4 below shows the break down for 2010-11; 2011-12 and 2012-13. It shows that the proportion of alerts for each service user group has remained consistent with last year and that adults with a learning disability continue to receive more alerts than for adults with a mental illness. B&NES has improved the categorisation of adults from last year and identified more service users with a specific group rather than categorising them as 'vulnerable people'.

6.14 Table 4: Number of Referrals by Service User Group 2010-13

Service User group	2010-11	2011-12	2012-13
Physical disability	151 (51%)	221 (55%)	289 (55%)
Mental health	83 (28%)	65 (16%)	96 (18%)
Learning disability	55 (19%)	90 (23%)	117 (23%)
Substance misuse	2 (1%)	4 (1%)	8 (0.2%)
Vulnerable people	1 (0%)	17 (4%)	11 (0.2%)
Adult carer	1 (0%)	3 (1%)	2 (0%)
Total	**293**	**400**	**523**

6.15 Chart 3: 2012-13 Referral Breakdown by Service User Group



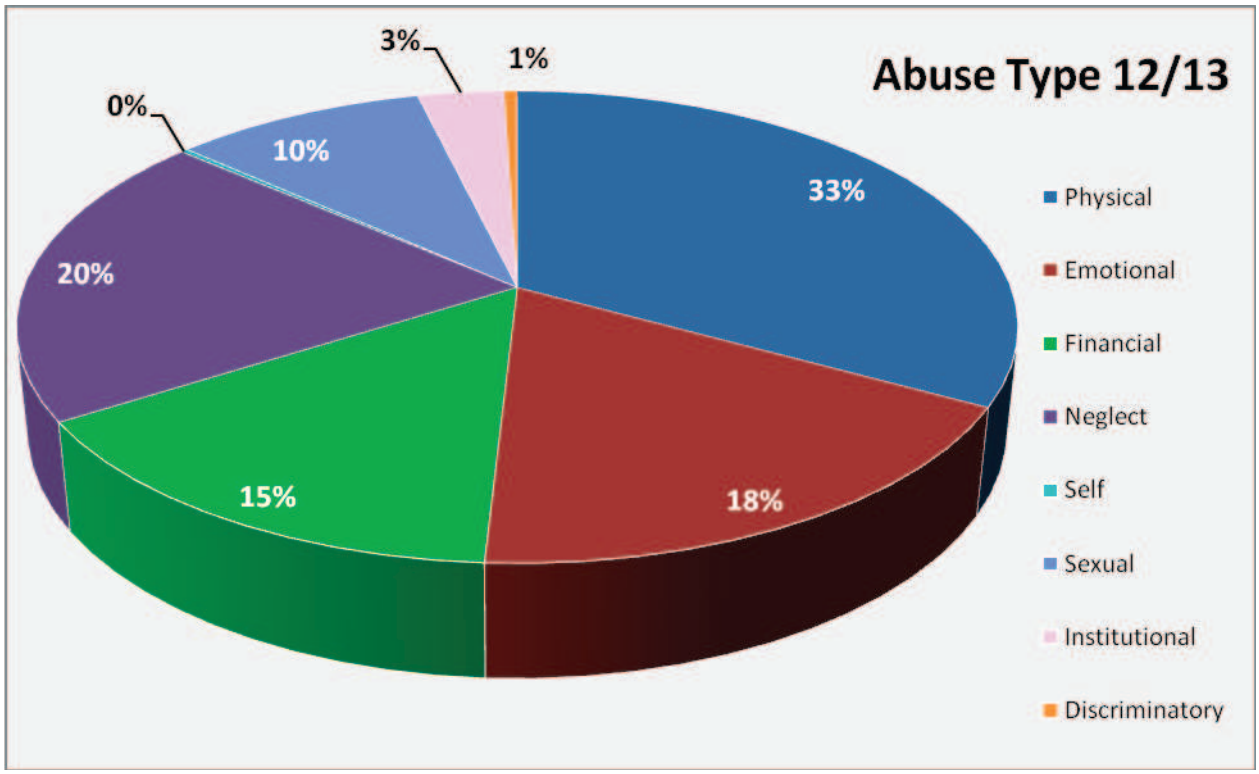
6.16 The data indicates a proportionate increase in the number of mental health referrals, this was predicted as the percentage increase in the actual number of mental health cases in 2011-12 (65) to 2012-13 (96) is a significant increase of 48% from 2011-12. When compared to NHSIC data the client group referrals as a percentage of all referrals are slightly different from the national average which shows physical disability being 49%, lower than B&NES but still the highest group; mental health being 24%, higher than B&NES (18%) and second highest and learning disability being 21%, slightly lower than B&NES (23%) and third highest

nationally. There has been a large scale investigation of a learning disabled provider which will have impacted on this figure.

6.17 464 cases were terminated/closed during the period; a **31%** increase.

6.18 55% of the referrals for safeguarding adults were for service users known to the Council. This is below the national average. 9% of cases being for service users that are placed in B&NES from out of area. However, when this is compared to the number of service users that were funded by health, social care or another authority the figure is 67% with 12% being self funders and 21% not in receipt of a service at the time of the referral made. The data needs to be analysed further to ensure the a correct understanding of what it is indicating.

6.19 Chart 4: Nature of Abuse at Referral Stage 2012-13



6.20 Physical abuse has remained the highest alleged abuse type. Neglect is the second highest; this is the first time neglect has come above emotional abuse (third highest) and financial abuse (fourth highest). The percentage of neglect cases has however remained the same as last year at 20% as indicated in the chart above. There has been a large rise in the proportion of physical abuse (10% increase). This is largely in line with the national picture for 2011-12. The NHSIC reported proportions are included in the table below.

6.21 Table 5: B&NES and NHSIC Abuse Types

Abuse Type	NHSIC National	B&NES
Physical	29%	33%
Emotional	16%	18%
Financial	19%	15%
Neglect	26%	20%
Sexual	5%	10%
Institutional	4%	3%
Discriminatory	1%	1%

6.22 The national picture also shows neglect as being the second abuse type in 26% of cases. This was the case in 2010-11 as well. The increase in neglect is thought to be down to the impact of Winterbourne View and the Mid Staffs with people being much more aware.

6.23 Table 6: below sets out the **Source of Alert** for B&NES for 2012-13 and compares this with the NHSIC data for 2011-12

Alert Source	B&NES 2011-12	NHSIC 2011-12 Average	B&NES 2012-13
Social care staff (all)	41%	44%	49%
Health staff	31%	22%	23%
Family Member/ Friend/ Neighbour/ Self Referral	8%	11%	9%
Police	3%	5%	4%
Other (including housing, CQC, education)	17%	18%	15%
Total	**100%**	**100%**	**100%**

6.24 The table demonstrates a high number of social care referrals than the previous year and a lower number of health staff referrals however the figure is in line with the national picture for health.

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

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

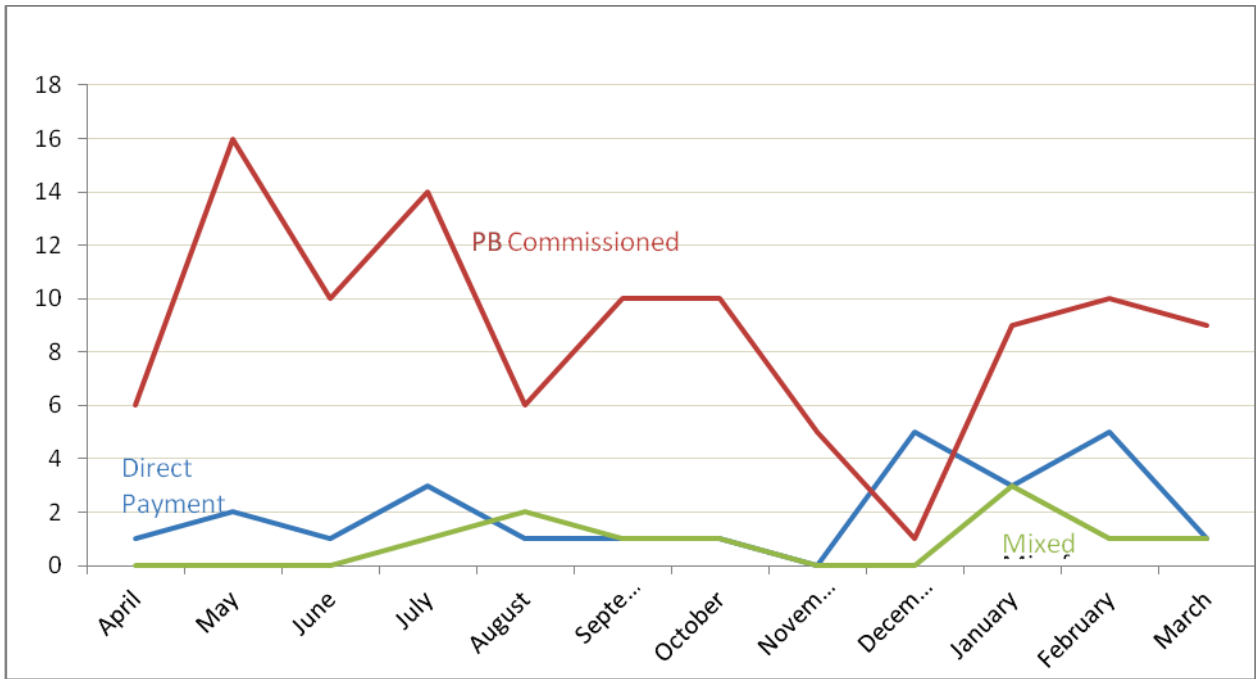
6.26 There has been a 5% increase in the police involvement in cases during the year. Three cases have resulted in criminal prosecutions, this is more reassuring as the figure dropped for 2011-12; 16 have required police action and two resulted in a referral to MAPPA for the perpetrators. Avon and Somerset Police have restructured during the period and have implemented a new process to manage alerts within their organisation.

6.27 In B&NES, 36% of alerts were for abuse that is alleged to have taken place in the service user's own home, this is a significant decrease on last year. In contrast there has been an increase in the number of cases that are alleged to have taken place in care homes (residential and nursing both permanent and temporary placements included) at 38%. This is a new picture for B&NES and is also different to the NHSIC data report showing 40% of referrals were for people in their own home and 36% were for people living in care home settings. The LSAB is not overly concerned by this as the percentages are not too dissimilar. Analysis of the alerts shows that some care home providers are very proactive in raising safeguarding alerts in their own setting. For all other locations such as the perpetrators own home, hospital settings, supported living settings and so on, B&NES figures are similar to those provided on average in the NHSIC 2011-12 report.

6.28 The majority of service users who live in the community and are supported by adult social care receive the funding for the social care through the Councils personal budget process (PB). There are three types of PBs: a PB Direct Payment, where the service user purchases their own social care to help them remain at home with; a PB Commissioned package, where Sirona Care and Health or AWP organise the social care package and purchase this from agencies the Council has a contract with and the third is a PB mixed package, which is a combination of each of the two above.

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

6.30 Chart 5: Number of Alerts and Personal Budget



6.31 The relationship between the alleged perpetrator and the vulnerable adult is set out in Table 8 below. The findings are similar to those reported last year with 'other professionals' being the highest number of alleged perpetrators and 'other family member' being the second highest. B&NES reporting shows a lower number of cases where the alleged perpetrator is unknown than the national average.

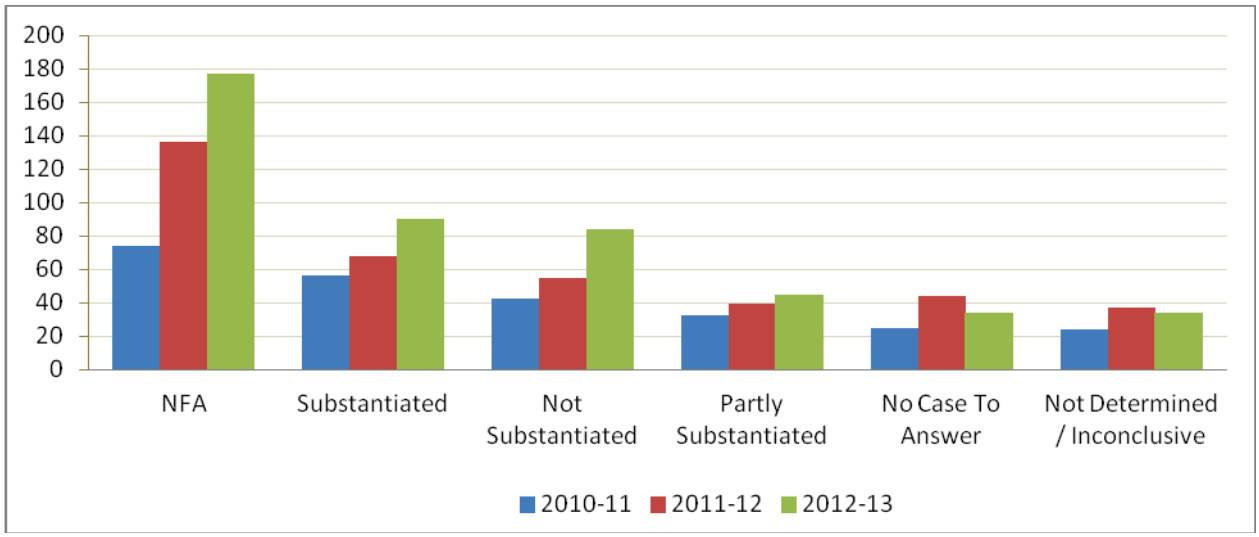
6.32 Table 8: Relationship of Victim with Alleged Perpetrator at Alert

Alleged Perpetrator	B&NES 2011-12	NHSIC 2011-12	B&NES 2012-13
Other professional	28%	36%	34%
Other family member	24%	16%	14%
Other	8%	7%	10%
Self abuse	9%	-	-
Not known	7%	13%	7%
Partner	8%	6%	11%
Other vulnerable adult	5%	13%	12%
Neighbour/friend	9%	6%	10%
Stranger	1%	2%	2%

6.33 21% of alleged perpetrators were residential care staff; 5% were health care staff and 4% were domiciliary care staff.

6.34 464 safeguarding alerts were terminated/closed during the reporting period. Of these 19% were substantiated (same as 2011-12) and 10% were partly substantiated. In 7% of cases there was not enough evidence to confirm whether or not the abuse had taken place and the outcome was not determined and inconclusive. This is reflected in chart 6 below.

6.35 Chart 6: Outcome of Safeguarding Cases 2010-13



6.36 The Abuse of Vulnerable Adult (AVA) return for the Information Centre takes a different cut of information for terminated/closed cases from that above and looks at the cases with one of the following four outcomes: substantiated, not substantiated, partly substantiated and not determined. It excludes cases that were alerted to the local authorities but that did not meet the threshold of meeting the criteria of a vulnerable adults thought to be at risk of significant harm. The category No Further Action in the chart above refers to those cases that largely did not meet the threshold of significant harm and do not progress through the safeguarding procedure beyond stage 3; however the outcome of No Case To Answer needs more unpicking as to what is measured and how far through the procedure this case progresses. This was a recurring problem from last year, however for the 2013-14 collections the outcome definitions have changed again so the issue will be resolved.

6.37 Table 9: NHSIC Average Outcomes 2011-12 Compared to B&NES 2012-13

Outcome	NHSIC 2011-12	B&NES 2012-13*
Substantiated	31%	33%
Partly substantiated	11%	16%
Not determined and inconclusive	31%	14%
Not substantiated	28%	38%

*Includes only cases that have met the threshold of vulnerable adult and at risk of significant harm; thus excludes the outcome of No Further Action.

6.38 NHSIC data shows that learning disabled service users have the highest number of substantiated cases (p39) this is also the case in B&NES with 33% of substantiated cases being for adults with a learning disability; this also echo's the information on repeat referrals and learning disability. Commissioners are aware of the pressure on the Sirona Care and Health team supporting adults with learning disabilities and the resource required in these safeguarding cases.

6.39 There were more cases of physical abuse substantiated than any other category; followed by financial abuse, neglect and then emotional abuse. However when you compare the percentage of alerts by abuse type, rather than by total number of

alerts; financial abuse has the highest number of substantiated cases for example 40% of financial abuse cases were substantiated and 33% of physical abuse cases were substantiated; 28% of emotional abuse cases and 28% of neglect cases were substantiated during 2012-13.

6.40 For cases where the alleged perpetrator was a professional worker, 17% were substantiated; where 'other family members' were identified as the alleged perpetrator, 13% were substantiated; where partners were identified, 19% of cases were substantiated and where a neighbour / friend was the alleged abuser, 33% were substantiated. In 50% of cases where another vulnerable adult was the alleged abuser the case was substantiated. National data available did not provide a comparator for this specific information.

6.41 There are 16 types of **actions** listed in the AVA return that can be **taken to support the victim**, these include things such as referral to MARAC; increased monitoring; no further action; civil action; removed from property; referral to court and so on. More than one action can be undertaken.

6.42 27% of all actions taken were to increase monitoring of the victim, this is identical to that reported in the NHSIC 2011-12 report (p41). The NHSIC also report that in 30% of cases no further action was taken to ensure the victims was safeguarded; however this is the action in 39% of cases in B&NES. The NHSIC reports that in 3% of cases there was an action to change management of finances, this occurred in 2% of B&NES cases. In 4% of cases it was reported nationally that the action was to move to 'increased or different care' whereas in B&NES this was 8% of the actions undertaken. This is lower than the recorded level from 2011-12 when in 10% of cases this action was taken.

6.43 **Advocacy** support through specialist advocacy services was provided in 4% of cases during the procedure. The **Independent Mental Capacity Act Service** supported 3% of the service users.

6.44 The LSAB commissioned a **Serious Case Review** in May 2012; the review is progressing and the outcome will be reported in the Annual Report for 2013-14.

6.45 The DH and B&NES monitor the number of **protection plans** in place during the period.

The term protection plan is used to refer to the agreed actions placed on the care plan of a vulnerable adult following an investigation into an allegation of abuse. The plan should document:

- *what steps are to be taken to assure the future safety of the vulnerable adult;*
- *what treatment or therapy the vulnerable adult can access;*
- *modifications in the way services are provided (for example moving to same gender care or placement);*
- *how best to support the individual through any action they take to seek justice or redress; and*
- *any on-going risk management strategy required where this is deemed appropriate.* (NHSIC 2013 p44)

6.46 From the number of protection plans that were offered / required, 86% were accepted; 12% could not be accepted due to the vulnerable adult being unable to

consent and 2% were declined. This is a very different picture to that reported nationally where '*Of all protection plans that were offered in 2011-12, 57 per cent were accepted, 22 per cent were declined and for 21 per cent of plans, the vulnerable adult was unable to consent.'* (NHSIC 2013 p45)

6.47 There are 18 types of **actions** listed in the AVA return **for the perpetrator**; these include things such as criminal prosecution/formal caution; community care assessment; removal from the property or service; referral to Protection of Vulnerable Adults list/Independent Safeguarding Authority; disciplinary action; continued monitoring; exoneration and no further action.

6.48 There can be more than one action recorded for the perpetrator. 'No action' was 44% of all actions taken for the perpetrators, the national figure is 36%; 19% of the actions were taken 'to continue to monitor the perpetrator and the situation,' the national figure for this is similar at 18%. 1% of cases resulted in criminal prosecution/formal cautions and a further 6% in police action this is consistent with the NHSIC report which shows 5% and 1% respectively (p47). Disciplinary action accounted for 5% of actions in B&NES and this is the same as the national picture at 5%. 2% of alleged perpetrators were exonerated in B&NES and nationally (p47). B&NES figures are almost identical to national ones with the exception of the no further actions reported.

6.49 The findings of the 'Keeping You Safe' questionnaire (5.13 above) describes the service user experience of the Safeguarding Procedure.

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

6.51 Table 10: Outcome at Procedural Stage for Terminated Cases 2012-13

Termination stage	Outcome						Total
	NFA	No Case to Answer	Not Determined/ Inconclusive	Not Substan-tiated	Partly Substan-tiated	Substan-tiated	
Decision	177	6	0	7	0	2	192 (41%)
Strategy	0	22	6	35	10	15	88 (19%)
Assessment	0	1	4	15	2	17	39 (8%)
Planning meeting	0	5	11	16	18	23	73 (16%)
Review	0	0	13	11	15	33	72 (16%)
Total	177	34	34	84	45	90	464

6.52 The percentage of cases closed at the decision stage remains the same as the last period at 41%; however there are fewer cases closed at Strategy and Assessment stage than the previous year with more closed at review and planning. Therefore a greater number of investigations are being carried out in comparison to the previous year. This is also impacting on the whole systems ability to maintain and manage

the safeguarding procedure; the Police, RUH, Council, Sirona Care and Health and AWP have all particularly reported the impact of this during 2012-13.

6.53 Compliance with safeguarding procedural timescales continues to be monitored on a monthly basis by the Commissioner. The LSAB, Health and Wellbeing Partnership Board, PCT Board and Council Corporate Performance Team receive regular reports on this. The table below describes progress against the procedural timescales during the period. Sirona Care and Health, AWP and the Council have performed less well than last year, however still well given the increase in alerts and those cases progressing through the safeguarding procedure with no additional resource. Of particular concern however is 2b and % of strategy meetings held within eight days from the referral. Sirona Care and Health have looked into each of the seven cases it is responsible for and have plans in place to try and prevent this occurring again and have contacted multi-agency partners when necessary to ensure cooperation. The two breaches for AWP are being looked into to understand what happened.

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

Indicator	Target	% Completed on time from April 12 – Mar 13		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% 414/427		↓
		AWP	91% 87/96		↓*
		Combined	**96% 501/523**		↓
2a. % of strategy meetings/discussions held within 5 working days from date of referral	90%	Sirona C&H	91% 215/237		↓
		AWP	98% 85/87		↓
		Combined	**93% 300/324**		↓
2b. % of strategy meetings/discussions held with 8 working days from date of referral	100%	Sirona C&H	96% 226/237		↓
		AWP	99% 86/87		↓**
		Combined	**96% 312/324**		↓
3. % of overall activities/ events to timescale	90%	Sirona C&H	88% 910/1035		↓
		AWP	90% 257/285		↓
		Combined	**88% 1167/1320**		↓

* The data above was correct at the time of writing however each breach has now been reviewed and all were data inputting errors and should show as 100% and green.
** The case has been examined and the dates of the meeting have been incorrectly input. Performance was correct at the time of reporting however the dates have been corrected and should show as 100% and green.

6.55 Sirona Care and Health and AWP have been vigilant in working with the Commissioner to examine each breach. There is a lot of evidence from the breach reports to indicate that there can be practical and best practice reasons for timescales to be breached, for example when all parties are not able to attend a strategy meeting within five days or when an investigation report cannot be completed within 28 days as information is outstanding. The agencies are looking into a different way to present the data above and express those which are considered (by the Commissioner and either Sirona Care and Health or AWP) to be a 'valid' breach. This will provide greater assurance to the LSAB and Council.

6.56 The new arrangements with Sirona Care and Health and the Council have been in place for 18 months in March 2013. Both agencies have worked closely to try and ensure a consistent approach is applied and operational staff have met on a quarterly basis to do this. Safeguarding performance meetings are also held monthly to keep abreast of the latest position.

6.57 The same chairing arrangement is being rolled out to AWP from April 2013 so that one system is in place. AWP and the Council have worked closely during the year to ensure the smooth transition for this. Safeguarding performance meetings are also held with AWP on a monthly basis to keep abreast of the latest position.

6.58 All partner agencies have felt capacity pressures brought about by the increase in the number of cases alerted and the number that progress through the procedure having reached the threshold of a vulnerable adult being at risk of significant harm. Partners are working together to try and streamline processes so as not to duplicate reporting and investigations. The LSAB recognise the need to finalise the risk register in relation to the capacity pressures.

Section 7: Partner Reports

7.1 LSAB partner organisations have provided information outlining the specific safeguarding adults activity they have undertaken in 2012-13 and their achievements on the LSAB indicators.

Agency Name: Avon & Somerset Probation Trust (ASPT)

Brief outline of agency function:

To protect the public and reduce reoffending by contributing to a fair and effective criminal justice system
- To provide justice for victims of crime and local communities
- To provide punishment and reform for offenders
- To develop our business and professional skills to be a provider of choice in a competitive market
- To provide value for money for the taxpayer

Achievements during 2012-2013: (in bullet points)

Avon and Somerset Probation Board are constantly working to improve on the services we deliver and the Business Plans and Annual Reports are available on our website which provide evidence of our future plans and achievements during 2012/13.

Performance to LSAB indicators 2012-2013:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	95%	Mandatory

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 PCT Commissioned members only)***	85%	85%	Mandatory and included in PPDAs
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 PCT Commissioned members only)***	80%	80%	As above
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and PCT 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 CRB check ***(All)***	100%	100%	Enhanced CRBs completed on all staff
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**			Save Guarding Leads held at ACO/or Team Leader Roles
Describe how you raise awareness of safeguarding in your agency: Policy, Practice and Training			
Objectives for 2013-2014: Under review due to The MOJs Transforming rehabilitation agenda.			
Agency Name: Age UK Banes			
Brief outline of agency function: To provide services and activities for older people to help remain independent in their own homes and give them a voice in the community. To provide day services, Information &Advice, Home from Hospital, Home Response, Befriending, Wellbeing services ie. Fit as a Fiddle, Tai Chi, Trading, Toe nail cutting service.			
Achievements during 2012-2013: (in bullet points) • 7 recorded safeguarding incidents reported • 1 safeguarding case referred on to the safeguarding strategy meeting with positive outcome.			
Performance to LSAB indicators 2012-2013:			
Indicator	**Target**	**Outturn**	**Comment**
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	100%	

Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and PCT Commissioned members only)***	85%		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 PCT Commissioned members only)***	80%	90%	
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and PCT Commissioned members only)***	80%	90%	
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 CRB check ***(All)***	100%	100%	
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**		Yes	Safeguarding champion identified for the organisation, recording and reporting procedures in place.

Describe how you raise awareness of safeguarding in your agency:

- Team Meetings
- Regular supervisions and appraisals
- On induction of new members to the organisation
- Training for staff and volunteers
- Working in partnership with other agencies

Objectives for 2013-2014:

- Continue to raise awareness, and make sure that Safeguarding is on the agenda at every team meeting, and highlight at every appraisal.
- Increase our training to 100% target

Agency Name: NHS B&NES Clinical Commissioning Group

Brief outline of agency function:

From April 2013, clinical commissioning groups (CCGs), led by GPs and other clinicians, are responsible for commissioning most local healthcare services. The focus remains on improving outcomes and driving up standards of care for the population as a whole, but with an emphasis on tackling health inequalities. As a commissioner, the duty of NHS Bath and North East Somerset CCG is to promote and enable greater choice for patients which may result in a greater range of providers in some areas of healthcare, where commissioners consider that this will improve quality of care.

It is the responsibility of the CCG and every healthcare professional to ensure that

people in vulnerable circumstances are not only safe but also receive the highest possible standard of care.

The Director of Nursing and Quality in NHS B&NES is executive lead for Safeguarding and attends the Local Safeguarding Adults Board meetings.
The Senior Manager for Quality chairs the Quality and Assurance sub-group
The Adult Safeguarding Lead attends sub-group meetings as required

Achievements during 2012-2013: (in bullet points)

- The PCT and CCG safely maintained and progressed their safeguarding responsibilities and activities during the transition from PCT to CCG
- The CCG became a fully authorised CCG on 1st April 2013 with no conditions imposed for safeguarding
- Appointment of CCG Director of Nursing and Quality with executive responsibility for Adult Safeguarding- post commenced 11th February 2013
- Recruitment of substantive Adult Safeguarding Lead who took up post in March 2013
- CCG Quality Committee established with reports on safeguarding a standing agenda item
- Updating relevant Safeguarding Adults policies and procedures in line with the new Clinical Commissioning Groups and recent NHS England guidance
- The review of Serious Incident reports and working with providers to improve practice based on 'lessons learnt'
- Delivery of three Primary Care safeguarding adults awareness events Jan-March 2013
- Attendance at bi-monthly CQC Cause for concern meetings. This is an opportunity to share intelligence and raise flags on services which cause concern.
- Joint workings with B&NES Council Safeguarding Team to ensure concerns relating to NHS providers are managed in a responsive and efficient manner.
- Review of Serious Case Reviews, both local and national.
- Adult safeguarding indicators for all providers agreed at LSAB in March 2012 and now form part of all contracts. These indicators provide assurance, through evidenced reporting, of compliance with the multi-agency safeguarding adults policy and procedures and are monitored by the Quality & Safeguarding Team
- Bi-monthly meetings with BANES Council Safeguarding Team

Performance to LSAB indicators 2012-2013: The CCG is a newly formed statutory organisation. PCT training indicators for 2012-2013 are not applicable

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%		
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 PCT Commissioned members only)***	85%		
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	80%		

(Non - LA and PCT Commissioned members only)			
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and PCT Commissioned members only)***	80%		
Relevant staff to have undertaken DOLS training within 6 months of taking up post ***(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP only)***	95%		
Relevant staff to have an up to date CRB check ***(All)***	100%		
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**	B&NES CCG has a substantive Adult Safeguarding Lead		

Describe how you raise awareness of safeguarding in your agency:

- Ensure appropriate safeguarding performance indicators are included within commissioning for health contracts
- Working jointly with the Local Authority to support safeguarding activity relating to healthcare
- There is a clear line of accountability for safeguarding which is reflected in CCG governance arrangements, and the CCG has arrangements in place to co-operate with the local authority in the operation of the Local Safeguarding Children Board and the Safeguarding Adults Board
- There is a monthly Quality Committee, which is a sub-Committee of the Board, receives Adult Safeguarding reports
- There is senior management commitment (including Board level lead) and a clear line of accountability within the CCG ensuring that awareness at all levels is raised

Objectives for 2013-2014:

- Ensure the CCG Board is fully appraised of safeguarding priorities and that Board members and CCG staff receive appropriate training
- Further strengthen partnership arrangements to promote cross-boundary / multi-professional working
- Safeguarding procedures will be aligned to other core aspects of quality and governance structures. A clear statement of the CCG's responsibilities will be available to staff
- To establish, in collaboration with the Local Area team, a Safeguarding training programme for Primary Care
- To develop a Safeguarding Network for Primary Care to improve knowledge and disseminate learning and best practice
- To continue to contribute to the work of the LSAB and its sub-groups
- To promote awareness of Safeguarding issues throughout the organisation
- Monitor the progress of the LSAB Business Plan 2013/14 and ensure actions are completed as requested and in a timely manner
- Consider arrangements for user involvement; obtain specialist advice to scope how this may be developed
- Implement process to receive quarterly reports on all clinical incidents raised within NHS provider services and screen for safeguarding concerns

- Establish a process for updating the CCG on safeguarding adults activity.
- Develop mechanisms to monitor FNC/CHC. The Rosewell SCR recommended that joint monitoring of nursing homes should take place.
- Plan and deliver programme of supervisory visits for provider safeguarding leads
- Develop CCG intranet & internet safeguarding page
- Obtain & disseminate/distribute NHS England leaflets for LD & Adult Safeguarding
- Develop Adult Safeguarding measures for quality dashboard
- Develop thematic appraisal for results of pressure ulcer RCA's & implement action plan accordingly
- Review Francis report in line with adult safeguarding
- Consultation & implementation of MCA & DOLS indicators
- Develop matrix to monitor outcomes of safeguarding interventions when relating to health
- Monitor implementation of agreed actions following safeguarding interventions
- Develop community-wide pressure ulcer project

Agency Name: Avon and Somerset Constabulary

Brief outline of agency function:

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

Achievements during 2012-2013: (in bullet points)

- Setting up of three geographically based Safeguarding Co-ordination Units (SCUs) with centralised management and overview including one on the Northern area located at Keynsham
- Formation of a Safeguarding Vulnerable Adults strategic and working group led by an Assistant Chief Constable and the Head of Public Protection
- Identification of all premises across the force area where vulnerable people reside (including vulnerable children) and the introduction of appropriate flagging markers to identify them within crime recording systems
- Establishment of a network of Safeguarding Champions across the force area made up of front-line Constables and Police Community Support Officers who help and support the Public Protection Unit to identify and protect vulnerable people

Performance to LSAB indicators 2012-2013:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%		Safeguarding Vulnerable Adults training is being developed for the force area. An input is given to student police officers during initial training and an e-learning awareness package has been produced which is aimed at all staff who may come into contact with SA issues
Relevant staff to have completed	85%		N/A

Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and PCT Commissioned members only)***			
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 PCT Commissioned members only)***	80%		Further in-depth specialist training for PPU and other appropriate staff is in progress
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and PCT 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 CRB check ***(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 and support the PPU to identify and protect vulnerable people

Describe how you raise awareness of safeguarding in your agency:

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

Objectives for 2013-2014:

- Co-location of multi-agency services within SCUs –

1. Bristol SCU currently multi-agency in police premises although still developing

with the aim to include Health and Adult Social Care and to move more towards joint investigations
2. Southern SCU co-location planned for beginning of September 2013 in Council offices at County Hall, Taunton
3. Aim to develop a co-located multi-agency Northern SCU during 2013/14

- Finalise and implement level 2 SA training for specialist PPU investigations officers

- Continue to build relationships between SCUs and Mental Health services and develop work with the National Autistic Society to improve the understanding and awareness of staff when dealing with Adults within the Autistic Spectrum. Similar relationships are also being formed with the National Dementia Society

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. We also support volunteering and employment opportunities as well as providing domiciliary care and hydrotherapy.

Achievements during 2012-2013: (in bullet points)

- We have worked with a group of service users to replace our previous safeguarding policy with an accessible version – 'Keeping Safe in Freeways'
- In our floating support service 9 of 14 alerts have been investigated and this has prevented sexual abuse, domestic abuse and financial abuse. In 4 cases the police were involved with the perpetrators of the financial abuse.
- 1 service user disclosed an alleged rape from 15years ago. This was found to have been dealt with appropriately at the time but the service user was offered counselling and psychology support as a result
- 1 service user made an allegation against a member of staff for how they were spoken to and supported which resulted, after investigation, in the termination of their contract
- 1 member of staff whistleblew internally about a colleague for the way they behaved towards service users, after suspension and investigation the case was unfounded
- Worked with NHS Bristol and a group of our service users to support the production of an awareness pack for people with learning disability to have greater understanding of abuse and especially domestic violence and abuse.

Performance to LSAB indicators 2012-2013:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	100%	
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and PCT Commissioned members only)***	85%	100%	It is an organisational requirement that all staff in the services are updated annually

			in safeguarding
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 PCT Commissioned members only)***	80%	90%	
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and PCT Commissioned members only)***	80%	95%	
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%	
Relevant staff to have an up to date CRB check ***(All)***	100%	100%	All staff have a CRB check every 3 years
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**			Each service is prioritising the development of champions that will be chosen by their manager to promote safeguarding. At present senior managers lead on safeguarding within the organisation

Describe how you raise awareness of safeguarding in your agency:

Induction: CIS, observation, probation period

Ongoing continuous professional development: Annual training (various methods- team training sessions, supervision discussions, staff meetings, coaching, reflection sheet on safeguarding concern form. Attendance on forums and updates disseminated through the organisation.

Accredited qualification pathway: Diplomas levels 3-5.

Occasion/incident reports and the follow up actions.

Annual complaints audit.

Annual safeguarding audit; recording the number of safeguarding referrals made by each service.

Bi-monthly visit/report by senior managers; discuss safeguarding issues.

Worked with NHS Bristol to support the production of an awareness pack for people with learning disability to have greater understanding of abuse and especially domestic violence and abuse.

Objectives for 2013-2014:

Management to ensure all staff have annual updates in safeguarding, MCA and DOLS (where applicable) training, both in house and by external agencies.

All new staff to continue to receive MCA and DOL's training within 6 months of taking

up their post as part of their induction process.

Safeguarding champions to be selected and recognised in each service by the end of June 2013 and link to existing selected dignity champions.

Develop safeguarding training for our service users and promoting staff supporting service users to report their concerns directly to LA or others with the aim of empowerment and independence.

Agency Name: Carers Centre

Brief outline of agency function:
The Carers' Centre is the leading agency for carers in Bath and North East Somerset working with over 2000 carers providing information, advice and support to carers. Each carer is offered a Carers' Assessment with an individual support plan and an emergency plan and card. A regular breaks programme is provided to refresh and renew carers to improve their well-being to be healthy in their caring role. Training is provided to ensure carers are safe in their caring role and to gain new skills to have a life of their own. Counselling and befriending is available to support carers to stay mentally well.

Achievements during 2012-2013: (in bullet points)

- Took over chair of the Local Safeguarding Adults Board Awareness, Engagement and Communications Sub-Group
- Article in Newsletter 5000 copies circulated to over 2000 carers in public venues and to local professionals.
- Article sent via E:bulletin to over 600 people
- All safeguarding alerts have been recorded and the progress has been recorded from the perspective of the carer
- Training has been provided to carers about safeguarding
- 622 Carers' Assessments were carried out providing carers with a support plan to increase resilience and ensure safeguarding issues are considered routinely and areas are planned to ensure carers are safe including an emergency planning.
- Regular training provided to all staff and volunteers at the Carers' Centre
- Safeguarding is a standing agenda on staff and volunteer supervision

Performance to LSAB indicators 2012-2013:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	100%	
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and PCT Commissioned members only)***	85%	100%	
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(Non - LA and PCT Commissioned***	80%	100%	

members only)			
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and PCT 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 CRB check ***(All)***	100%	100%	Now DBS
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**			CEO at the Carers' Centre is the champion and encourages on-going awareness raising in the organisation

Describe how you raise awareness of safeguarding in your agency:
At the Carers' Centre safeguarding is a standing agenda item at supervision. New updates are shared through team meetings and Management Committee meetings. Articles are shared through the newsletter and e:newsletter at least annually which all carers registered received and has a circulation of 5000.

Objectives for 2013-2014:
Continue to action and monitor the Carers and Adult Safeguarding Plan

Agency Name: Sirona Care and Health

Brief outline of agency function:

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

Achievements during 2012-2013: (in bullet points)

- Total of 438 referrals (Sirona cases) received and investigated - an increase of 30% over last year. An additional 104 cases received and referred on to AWP (grand total of 542 cases)
- A small number of 'whole service' investigations were carried out, including a large series of investigations involving a care home where a total of 18 separate strategy meetings have taken place so far
- Sirona played a key role in undertaking a Serious Case Review, initiated in June 2012
- Sirona continued to play a key role within the multi-agency framework, with representatives playing an important part in the work of the LSAB and all of its sub-groups, covering Training and Development, Quality Assurance, Policy and Procedures and Awareness, Engagement and Communications
- Targets relating to timescales for investigations, although not quite on target, were close to target despite the significant increase in cases
- Figures for 'staff up-to-date with Safeguarding training' were significantly improved over last year's figures

- Feedback received from service users who have been subject to the Safeguarding procedures was largely positive and outcomes from Safeguarding cases were mainly good
- An audit of referring agencies revealed a high level of satisfaction with the way referrals were managed
- We provided Safeguarding Adults training to 241 non-Sirona staff, mainly from the independent sector.

Performance to LSAB indicators 2012-2013:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	60%	
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 PCT Commissioned members only)***	85%	78%	
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 PCT Commissioned members only)***	80%	N/A	
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and PCT Commissioned members only)***	80%	35%	
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%	76%	
Relevant staff to have an up to date CRB check ***(All)***	100%	100%	
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**		Champions meet quarterly with Maggie Hall, Safeguarding Adults Co-ordinator	We have a total of 36 Champions across the organisation. While this does not equate to a Champion in every team, it is a widely representative group.

Describe how you raise awareness of safeguarding in your agency:

- It is expected that Safeguarding issues are raised at all team meetings and in the course of all supervision sessions involving front-line staff
- Safeguarding Adults issues are routinely reported on at Quality Committee and at Board level
- Safeguarding training is mandatory for all front-line staff
- Good links are in place between the Complaints process, the Adverse Event

reporting system and safeguarding
- Our Safeguarding Adults Co-ordinator provides advice and support to staff and attends MARAC meetings etc
- Our Professional Lead for Social Work monitors outcomes and co-ordinates issues relating to performance and training; also attends MAPPA meetings

Objectives for 2013-2014:

WORKPLAN FOR 2013/14

The key workstreams planned for 2013/14 are:

- To update all our Safeguarding Adults policies and procedures in line with the new, revised multi-agency policies and procedures
- To launch the newly-updated Mental Capacity Act guidelines and ensure that all front-line staff are fully aware of their responsibilities under the MCA.
- To continue to support the Safeguarding Champions Group
- To amend the Safeguarding Adults input into the Sirona induction programme to ensure that it is more closely aligned with Safeguarding Children training
- To update the Level 2 Safeguarding Adults training programme in line with national and local developments and align it more closely with Safeguarding Children training
- To extend the Safeguarding Adults training programme with a new one-day course on undertaking investigations with the police
- To ensure that all front-line staff are up-to-date with their Safeguarding training
- To continue to contribute fully to the work of the LSAB and its sub-groups
- To contribute fully to the work of MAPPA and MARAC within B&NES
- To continue a dialogue with B&NES Council colleagues around reaching a better consensus on 'risk' and 'thresholds' and to continually improve our practice based on 'lessons learnt' from the recent SCR and other cases
- To ensure that awareness of Safeguarding issues permeates the organisation from senior managers and Board level through to front line staff in every area and setting

Agency Name: Royal National Hospital For Rheumatic Disease

Brief outline of agency function:

Founded in 1738 the Royal National Hospital for Rheumatic Diseases (RNHRD), also known as 'The Min' a reference to its original name 'The Mineral Water Hospital', is a specialist hospital in central Bath with an international reputation for research, and expertise in specialist rehabilitation for complex long-term conditions. The core services the hospital provides are in rheumatology, pain management, Chronic

Fatigue Syndrome/ME (CFS/ME). The Trust has a small but internationally known Clinical Measurement department with access to advanced equipment and technology, and a diagnostic endoscopy service.

Achievements during 2012-2013: (in bullet points)

- Improvement and maintenance in compliance with training targets
- Reorganisation of Safe guarding structure following the loss of specialist staff.
- Introduction of new specialities groups within the Trust with vulnerable adults.
- Development of supervision policy
- Reorganisation of the meeting structure to include safeguarding children and the psychosocial group.
- New links with the deputy designated nurse from commencement of new post.
- Completion of the DNA audit.

Performance to LSAB indicators 2012-2013:

Indicator	**Target**	**Outturn**	**Comment**
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	100%	
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and PCT Commissioned members only)***	85%	82%	Changes in the orientation programme to allow time for staff to complete induction and e-learning on safe guarding 2a and b to improve compliance. Refresher is set every 3 years
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 PCT 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 PCT Commissioned members only)***	80%	100%	This training takes place as part of induction and covers safeguarding Children, Safeguarding Adults, Mental Capacity Act, DOLS. It refers to the legislation, the signs of abuse, the action required of an employee who has concerns, and the requirements of the MCA and DOLS
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%	79%	79% of relevant staff have undertaken level 2 DOLS training at end of quarter 4, this equates to 16 out of a possible 19. 1 member of this group has left the Trust; the remaining 3 members of staff are

			booked to complete this training by the end of May. Due to the closure of the Neuro rehabilitation service the number of staff requiring this training will decrease from April 2013.
Relevant staff to have an up to date CRB check ***(All)***	100%	100%	
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**	Yes	10 champions	A Safeguarding co-ordinator has been developed to support safeguarding in the Trust. This role will cover adults and children as the named nurse. The Director of Clinical Practice and Operations is the executive with responsibility for safeguarding.

Describe how you raise awareness of safeguarding in your agency:
The Clinical Supervision Policy has been ratified and includes explicit reference to the discussion of safeguarding DoLs issues in addition discussions take place during regular patient MDT meetings within all services.
There is disseminating of lessons learnt and change practice accordingly through the Safeguarding Committee for Adults and Children.
There is high priority on achieving compliance with training among the staff.
There is an awareness week being organised by the named nurse for October 2013.
Plan to raise profile of CCG safeguarding representatives by holding Q&A sessions.

Objectives for 2013-2014:

1. Achieve compliance in the training targets for safe guarding.
2. Review training guidelines for all safeguarding across all professional groups
3. Increase reporting of all safeguarding discussions/concerns
4. Develop Q&A sessions for staff with CCG safeguarding representatives
5. Organise an awareness week in Oct 2013.
6. Review and update the policy on Safeguarding adults.

Agency Name: Curo

Brief outline of agency function:

- We are the largest social landlord in the Bath area providing 12,000 homes.
- We are a major local provider of older people's services.
- We provide homes and support services to general social housing residents, young people and teenage parents, older people in sheltered housing, homeless people, shared owners and leaseholders.
- We provide services to other housing associations.
- We let private market-rented properties.
- We have developed more than 1,700 homes since 2002 and are due to complete 1,473 homes by 2016.
- We have a foyer where, in addition to accommodation, we provide training for young people.

Achievements during 2012-2013: (in bullet points)
We have had some serious cases and have played a full part in the progression of the cases and have also taken a close look at the details of the case so that colleagues can learn from these.

We have taken the lead in a serious case which has involved us obtaining an injunction against a perpetrator which protects out 1900(approx.) sheltered residents.

We have looked at the use of concern cards for trade staff so that safeguarding concerns can be highlighted

We have looked at our pre tenancy process and made changes so that the full picture and needs of a prospective tenant is captured and looked at so that services can be tailored to the individual person.

We have started regular meetings across the business looking at individual safeguarding cases and concerns that are highlighted are raised and discussed.

Increased training for staff which included adults children and domestic violence as a result staff are much more confident in their approach to best practise in safeguarding

By staff being more observant to potential safeguarding issues we have been able respond more rapidly to reduce risk

Extremely proactive partnership relationship between safeguarding team and OPS, which has enabled us to challenge two safeguarding decisions made by social workers last year (social workers not considering referrals as safeguarding decisions overturned)

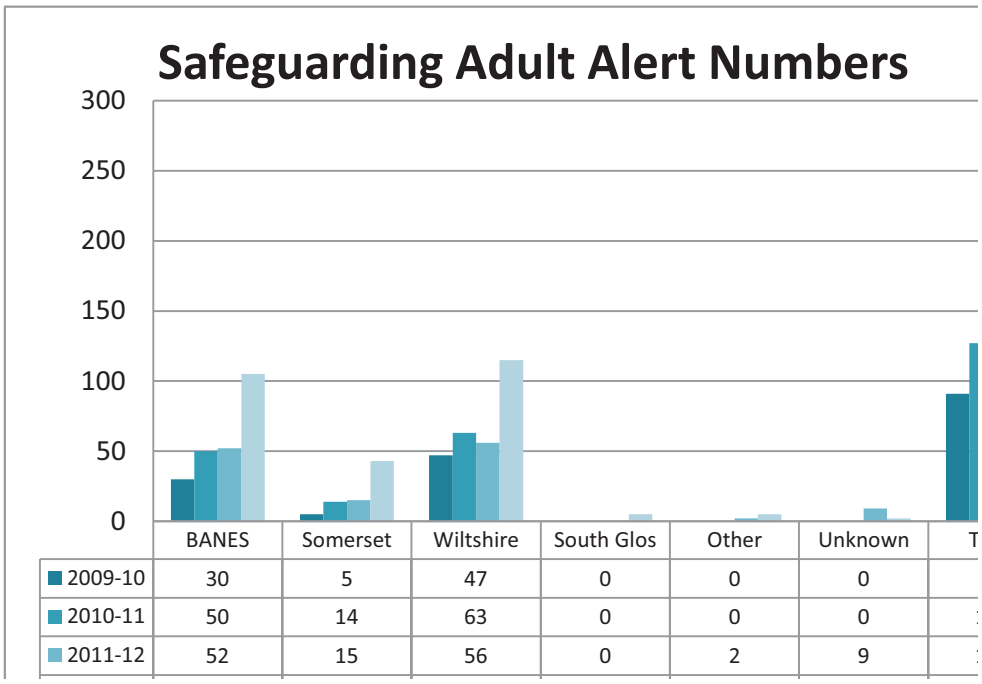
Performance to LSAB indicators 2012-2013:

Indicator	**Target**	**Outturn**	**Comment**
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	100%	
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and PCT Commissioned members only)***	85%	100%	
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(Non - LA and PCT Commissioned members only)***	80%	n/a	
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and PCT Commissioned members only)***	80%	100%	Time taken to access course is a concern
Relevant staff to have undertaken DOLS training within 6 months of taking up post	95%	n/a	

(LSAB Members that manage Care Homes and Hospitals, Sirona and AWP only)			
Relevant staff to have an up to date CRB check ***(All)***	100%	100%	
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**		yes	Champions identified. All cases of a safeguarding nature are highlighted to the champion for quality assurance etc.
Describe how you raise awareness of safeguarding in your agency: Safeguarding awareness is discussed at every 1:1 and every team meeting. It is a permanent agenda item. Safeguarding awareness is also discussed at wider team meetings and briefings across the business.			
Objectives for 2013-2014: More joined up approach across Curo for safeguarding (Shared information). This process has already begun. To continue to develop staff skills and knowledge in safeguarding For Curo to become recognised as an organisation for identifying and working with appropriate multi disciplinary agencies to reduce risk of safeguarding Play a full part in the delivery of cross agency safeguarding training. Full roll out of concern cards for trade staff so that safeguarding queries can be highlighted at an early stage. Pre tenancy process pilot to be continued as business as usual so that safeguarding situations can be identified at an early stage.			
Agency Name: South West Ambulance Service			
Submitted their annual report for assurance purposes but were unable to complete the annual report pro-forma for inclusion			
Agency Name: Royal United Hospital			
Brief outline of agency function: Acute Care Provider			
Achievements during 2012-2013: (in bullet points) • Awareness of adult abuse and protection continues to increase across the organisation. • Successfully run “Deprivation of Liberty Safeguards” (DoLS) workshops for senior staff. • Compliant with training targets for the delivery of Adult safeguarding Level 1 • Development and delivery of Adult Safeguarding “refresher” training at Level 2 • Half day induction training for all registered staff aligned to BANES /Sirona			

training matrix level 2

- Following CQC inspection in September 2012, the RUH is compliant with outcome 7.
- Positive outcome from the South West Partnership Dementia Peer Review in January 2012. The Trust was highly commended for being Dementia friendly.
- CRB checks compliance is 100% for all new staff.
- Root cause analysis undertaken on 100% of the most serious pressure ulcers at grade 3 and 4.
- Further development and growth of the existing Safeguarding "database"
- Establishment of a DoLS "database".
- Development of and work against the Safeguarding Adults Work plan for 2012-13. This was written in alignment with the Self-Assessment Quality & Performance Framework for Adult Safeguarding, CQC essential standards for quality and safety, Training Matrix - BANES LSAB and RUH
- Over the past 4 years there has been a consistent rise in the number of alerts made to the Operational safeguarding leads.



Performance to LSAB indicators 2012-2013:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	Level 1 83.7% Level 2 70.3%	We do not separate out induction and refresher compliance for non-clinical staff
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed	85%	Induction 70.3% Refresher	Working towards RUH target trajectory which

refresher training every 2 years thereafter ***(LA and PCT Commissioned members only)***		8.4% Overall 33.1%	was shared with PCT at quarterly meeting.
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 PCT Commissioned members only)***	80%	As above	
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and PCT Commissioned members only)***	80%	70.3%	
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%	Enhance DoLS training 30.3%	Further training has taken place since March 2013 aim to be compliant by Q.1
Relevant staff to have an up to date CRB check ***(All)***	100%	100%	100% of new staff that have started employment within the organisation have been CRB checked
Safeguarding champions identified for each team ***(All)*** **Describe arrangements for champions in your agency if not in each team in comments**			We do not have safeguarding champions across the organisation. There are Operational Safeguarding Leads who are senior nurses who work across the Trust, promoting, training and supporting staff within the safeguarding arena, and representing the Trust where required.

Describe how you raise awareness of safeguarding in your agency:

- Trust intranet web pages for DoLS, MCA and Safeguarding Adults.
- Adult safeguarding on Trust internet for public to access
- Safeguarding Adults, DoLS, MCA leaflets.
- BANES Abuse posters are displayed in outpatient and inpatient areas, PALS and in the corridors.
- BANES Adult safeguarding information article run in Summer 2012 & Spring 2013 INSIGHT Magazine (Quarterly staff and public magazine)
- Awareness raising through training, induction, refresher and ad hoc.
- Governor Induction

Objectives for 2013-2014:

- To meet our training objectives for levels 2 and 3 as per our internal trajectory.
- Improved utilisation and interrogation of the safeguarding adults and DoLs "data bases", which will report into the Trusts Safeguarding Adults Forum.
- Randomised case note review to be undertaken quarterly and reported into Trusts Safeguarding Adults Forum
- Update Safeguarding Adults work plan for 2013-14 and work towards completing these objectives.

Agency Name: Avon and Wiltshire Mental Health Partnership NHS Trust

Brief outline of agency function:

Avon and Wiltshire Mental Health Partnership NHS Trust ('AWP') are the organisation that provides services for people with mental health needs, with needs relating to drug or alcohol dependency and mental health services for people with learning disabilities in the B&NES area. They also provide secure mental health services and work with the criminal justice system.

It also has the specific responsibility for providing services relating to safeguarding for adults at risk who meet the relevant criteria, and includes safeguarding adults at risk from avoidable harm; ensuring effective preventative mechanism are in place and providing a good quality local safeguarding service.

Achievements during 2012-2013:

This was a year of significant change and development in the roles undertaken by AWP to safeguard adults throughout 2012/13 in B&NES.

AWP continued to play an active role in the Safeguarding Adults Board and its work. AWP attended the Board on a regular basis. AWP also has a variety of staff involved in some of the Board's sub groups.

The Trust has continued to seek to improve its delivery of safeguarding in practice, with revision of the policy and guidance to practitioners, revised documentation to support safeguarding alerts and referrals, better access to information for staff on the intranet and service users and the public on the Trust Website, and significant updates to the training of practitioners.

AWP has reviewed its services in light of the Winterbourne View Hospital reviews and developed an action plan against the relevant recommendations. It is also considered and is developing actions arising out of the recommendations from the Francis Report on Mid-Staffordshire.

The Trust has maintained compliance with Outcome 7 (Safeguarding) of the CQC Essential Standards in all CQC inspections of teams in B&NES during 2012/2013.

The Trust was continued to ensure that its staff is trained in their role to safeguard adults, with the target of 80% of staff being trained on a 2 year cycle at Alerter level (level 2) being maintained during 2012/2013.

AWP has maintained a good level of performance in management of alerts during 2012/2013, and has undertaken audits of the quality of the management of

safeguarding alerts in B&NES and other local authority areas, that have contributed to the development of the policies and systems to support effective safeguarding by practitioners.

Performance to LSAB indicators 2012-2013:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	100%	
Relevant staff to have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and PCT Commissioned members only)***	85%	85%	
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 PCT Commissioned members only)***	80%	N/A	
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and PCT Commissioned members only)***	80%	63%	This is a combined training with DOLS
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%	63%	
Relevant staff to have an up to date CRB check ***(All)***	100%	100%	
Safeguarding champions identified for each team ***(All)***			We have LA safeguarding leads

Describe how you raise awareness of safeguarding in your agency:

- It is expected that Safeguarding issues are raised at all team /workstream and ward clinical meetings and in the course of all supervision sessions involving front-line staff
- Safeguarding training is mandatory for all front-line staff
- all staff have awareness of safeguarding via policy procedure and training

Objectives 2013-2014

AWP will use the current changes in its organisational structure from the 1/4/2013 to improve the direct relationship between its local services and the safeguarding adult partnership and Board in 2013/2014., and will be taking forward a number of key actions, including:

- Moving to a revised contracted system to manage safeguarding alerts, with all safeguarding referrals being chaired by the Local Authority's Safeguarding Team

- Developing systems capturing risks and concerns, to assist triangulation and identify risks, and themes.
- The Trust is implementing the Francis report action plans
- Demonstrating compliance with the safeguarding adult requirements set out in the new NHS contact for 2013/2014
- Developing joint understanding of application of clinical management and safeguarding thresholds with key partners in differing mental health inpatient units
- Rolling out and implementing changes within the revised multi agency safeguarding procedures due in 2013/2014, particularly in relation to the active involvement of the person in their own safeguarding.

Agency Name: Avon Fire and Rescue

Brief outline of agency function:

Avon Fire and Rescue provides an emergency response to a wide variety of adverse events such as fires, road traffic collisions, chemical spillages and rescues from water and lifts. This list is not exhaustive. In addition we also undertake a huge amount of education within the community. This ranges from visiting homes to provide safety advice and assist with escape plans in the event of fire to going into schools and colleges across all age ranges to deliver bespoke education on fire, road and water safety.

Achievements during 2012-2013:

Completed all the items contained within the improvement plan following the self-assessment and writing of an IMR for a serious case review.

Reviewed service policy on child protection which culminated in Service policy and guidance on safeguarding children, young people and vulnerable adults.

Provided e-learning (level 1) to over 70% of current staff. Level 2 and 3 training delivered to 10% of appropriate staff / managers as detailed within the Policy and Guidance. Senior officers have received and in-depth briefing around expectations, role and responsibilities and the associated risks for dealing with safeguarding.

Staff are more proactive and aware of safeguarding and are more readily alerting other agencies to safeguarding issues.

We have identified a lead senior officer to attend all safeguarding boards across the Service area. This has ensured consistency in approach, and safeguarding is very much at the forefront of our thoughts when crossing thresholds of homes and schools and colleges.

Performance to LSAB indicators 2012-2013:

Indicator	Target	Outturn	Comment
New staff to undertake safeguarding learning as part of Induction within 3 months of starting employment ***(All)***	95%	100%	All new staff have completed level 1.
Relevant staff to have completed	85%	100%	Service managers

Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter ***(LA and PCT Commissioned members only)***			and people with increased contact with vulnerable people have received level 2 and 3.
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 PCT Commissioned members only)***	80%		Not available
Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post ***(LA and PCT 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 CRB check ***(All)***	100%		Not available
Safeguarding champions identified for each team ***(All)***			

Describe how you raise awareness of safeguarding in your agency:

Following the publication of a new standard operating procedure all staff will be undertaking e-learning programme at level 1. Other appropriate managers and staff (firesetters) have undertaken level 2 and 3. The Area Managers is designated as the Service lead and while a steep learning curve has been able to redesign a proportion of that role recognising the importance of safeguarding to a Fire and Rescue Service. Assign officers to follow up on alerts and where necessary advise other officers to attend meetings such as the MARAC.

Report on a regular basis to the Fire Authority, the number of alerts and actions taken with partner agencies.

Objectives for 2013-2014:

1. Following the roll-out of the initial training we will strive to increase staff awareness of local practises by working with all LSB's.
2. Deliver local training to station personnel and managers.
3. Continue to learn and to contribute to the agenda and priorities of the LSAB.
4. Want to be fully embedded in to all LSAB's across the Service area and to be recognised as a partner of choice.

Section 8: Priorities for the Coming Year 2013-14

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

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

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

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

- **Domain 2: Responsibility & Accountability**

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

- **Domain 3: Access & Involvement**

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

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

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

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

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

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

8.3 The local plan has taken into account actions recommended from national guidance including those specified following Winterbourne View and Mid Staffs; LGA / ADASS advice and guidance note and the findings of the Serious Case Review and prioritised its work in relation to these.

8.5 The local objectives and actions proposed by the LSAB to fulfil the domains and outcomes are set out in Appendix 5 and will be monitored by the LSAB and sub-groups routinely to ensure they are achieved. The details of the plan will be reviewed annually.

Author:

Lesley Hutchinson
Head of Safeguarding Adults, Assurance and Personalisation
B&NES Council
Health and Wellbeing Partnership
June 2013

Appendix 1

LOCAL SAFEGUARDING ADULTS BOARD
Membership as at March 2013

NAME	ORGANISATION
Cllr ALLEN Simon	Cabinet Member for Wellbeing (B&NES)
CLARKE Dawn	Director of Nursing & Quality (Designate) NHS B&NES CCG
COWEN Robin	Independent Chair. B&NES LSAB
DABBS Janet	Rep for Provider Forum Age UK, Bath & North East Somerset
DAY Kevin	Senior Probation Officer, Avon & Somerset Wiltshire Probation Service
DEAN Mark + Fran McGarrigle as sub	Head of Public Protection & Safeguard, Avon & Wiltshire Partnership Mental Health NHS Trust
EVANS Julie	Director of Customer Services (Housing & Support), CURO (formerly Somer Community Housing Trust)
GOODFELLOW Janet	Regional Manager, Four Seasons Health Care
HOWARD Damaris	Director, Regulated Services, Freeways
HUTCHISON Sonia	Chief Executive Officer, Carers Centre (B&NES)
HUTCHINSON Lesley	Assistant Director Safeguarding and Personalisation B&NES Council
JANSON Val	Assistant Director of Performance and Quality (Commissioning) NHS B&NES
KENT-LEGER Sophie	Assistant Head Teacher Threeways Special School, B&NES Council
Dr LEACH Louise	B&NES Clinical Commissioning Group Representative
LEWIS Mary	Assistant Director of Nursing (Medicine), RUH
McDONALD Rayna	Director of Operations & Clinical Practice Royal National Hospital for Rheumatic Diseases
MANN Kirstie	Manager, Your Say Advocacy
ROWSE Janet	Chief Executive, Sirona Care and Health (formerly Community Health and Social Care Services)
SHAYLER Jane	Programme Director for Non-Acute Health, Social Care & Housing B&NES Council
SMITH Sue	Clinical Standards Manager, GWAS (Associate Member of LSAB)
TAYLOR Karen	Compliance Manager, CQC South West Region
THEED Jenny	Director of Operations, Sirona Care & Health
TOZER Clare	Personal Assistant to Lesley Hutchinson & Notetaker for LSAB B&NES Council
TRETHEWEY David	Divisional Director Policy & Partnerships, B&NES Council
WESSELL Geoff + DCI Philip Polet as sub	Det Superintendent PPU Avon & Somerset Constabulary

Appendix 2

Membership List of Local Safeguarding Adults Board sub-groups (at March 2013)

Safeguarding Adults Training and Development sub-group
Meet: Bi-monthly
Chair: Jenny Theed
Sue Tabberer (B&NES Council)
Dennis Little (B&NES Council)
Karyn Yee-King (B&NES Council)
Geoff Watson (Sirona Care & Health)
Maggie Hall (Sirona Care & Health)
Manager (Agincare Domiciliary Care)
Amanda Pacey (RNHRD)
Simon Ibbunson (RNHRD)
Jane Davies (RUH)
Belinda Lock (Way Ahead)
Clare Gray (Shaw Trust)

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)
Caroline Latham (Sirona Care & Health) sub for Maggie Hall
Amanda Lloyd (Avon& Somerset Constabulary)
Lynne Scragg or Mark Pennington (City of Bath College)
Sally Cook or Hana Kennedy (Bath MIND)
Roanne Wootten (Julian House, Bath)
Helen Jenkins (Specialist Drug & Alcohol Service, Bath)
Jenny Shrubsall (Service User)
Fran McGarrigle (AWP)
Neil Boyland (RUH)
Jane Davies (RUH)

Awareness, Engagement and Communications sub-group
Meet approx: Bi-monthly
Chair: Sonia Hutchison (Carers' Centre, Bath & NE Somerset)
Lesley Hutchinson (B&NES Council)
Camilla Freeth (B&NES Council)
Melanie Hodgson (B&NES Council)
Maggie Hall (Sirona Care & Health)
Martha Cox (Sirona Care & Health)
Damaris Howard (Freeways)
Kirstie Mann (Your Say Advocacy)
Helen Robinson-Gordon (RUH)
Mary Lewis (RUH)
Gareth Sharman (AWP)
Bev Craney (Swallows Charity)

Quality Assurance, Audit & Performance Management sub-group
Meet approx: Bi-monthly
Chair: Mary Monnington/Val Janson
Lesley Hutchinson (B&NES Council)
Alan Mogg (B&NES Council)
Geoff Watson (Sirona Care & Health)
Marc Anderson (Avon Fire & Rescue)
Mike Williams (Avon & Somerset Constabulary PPU)
Janet Dabbs (Age UK, Bath & NE Somerset)
Amanda Pacey (RNHRD)
Fran McGarrigle (AWP)
Sarah Seeger (Curo Group)
Rob Elliot or Sue Leathers (RUH)

Mental Capacity Act Local Implementation Group
Meet: Quarterly
Chair: Lesley Hutchinson (B&NES Council)
Dennis Little (B&NES Council)
Karyn Yee-King (B&NES Council)
Tom Lochhead (B&NES Council)
Teresa Kippax (Interim Safeguarding Adults Lead, NHS BANES Cluster)
Dr Louise Leach (B&NES CCG)
Jenny Theed (Sirona Care & Health)
Louise Russell (RNHRD)
Amanda Pacey (RNHRD)
Pam Dunn (Carewatch)
Alan Metherall (AWP)
Gemma Box (RUH)
Karen Webb (Four Seasons)

Safeguarding & Personalisation sub-group
[This sub-group was disbanded June 2012 – last meeting was 29th May 2012]
Meet: Quarterly
Chair: Lesley Hutchinson (B&NES Council)
Alan Mogg (B&NES council)
Dennis Little (B&NES Council)
Dave Mehew (B&NES Council, Audit)
Karyn Yee King (AWP / B&NES Council)
Geoff Watson (Sirona Care and Health)
Jenny Shrubsall (Independent Service User)
Clare Gray (Shaw Trust)
Meri Rizk (B&NES People First)
Roanne Wootten (Julian House)

Joint Interface Group LSCB/LSAB
Chair: Lesley Hutchinson (B&NES Council)
Jenny Theed (Sirona Care and Health)
Sonia Hutchison (Carers Centre)
Mark Dean (AWP)
Maurice Lindsey (B&NES Council)
Sophia Swatton (B&NES CCG)

Appendix 3: LSAB SAFEGUARDING INDICATORS 2012-13

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

Other Mechanisms for Assurance:

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

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

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

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

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

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

- 85% of relevant health and social care staff will have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter (the term relevant here excludes staff without direct contact with patients / service users and certain other categories – eg support staff, Children's Health staff)

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

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

.

Annually: ALL LSAB Members and LA / PCT Commissioned Services

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

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

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

- Safeguarding champions identified for each team

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

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

Appendix 4 Breakdown of Alert by Gender, Age Band and Ethnicity 2012/13 (All Cases)

Gender	Ethnicity	18-44	45-64	45-65	65-74	75-84	85+	Grand Total	% of Female / Male Alerts
Female	Asian/Brit-Indian					1		1	0.3%
	Asian/Brit-Pakistan					1		1	0.3%
	Black/Brit-Carib					2		2	0.6%
	Black/Brit-Other Black					1		1	0.3%
	Chinese						1	1	0.3%
	Info not yet obtained		1			11	2	14	4.2%
	Mix Other					1		1	0.3%
	Mix White/Black Carib					4		4	1.2%
	Other Ethnic group					1		1	0.3%
	White British	11	5		8	240	36	300	90.9%
	White Irish					2		2	0.6%
	White Other					2		2	0.6%
Female Total		**11**	**6**		**8**	**266**	**39**	**330**	**100.0%**
Male	Asian/Brit-Other Asian					3		3	**2%**
	Black/Brit-Carib						1	1	**1%**
	Declined to say					1		1	**1%**
	Info not yet obtained	1			1	12	1	15	**8%**
	Mix White/Asian					1		1	**1%**
	Mix White/Black Carib		2					2	**1%**
	Other Ethnic group					1		1	**1%**
	White British	10	11	1	6	126	10	164	**85%**
	White Irish					1		1	**1%**
	White Other					3		3	**2%**
Male Total		11	13	1	7	148	12	192	**100%**
Grand Total		22	19	1	15	415	51	523	

Appendix 5

Business Plan

April 2012- March 2015

Contents Page

Chair's foreword

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

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

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

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

Robin Cowen

Independent Chair

LSAB 2012

1. Introduction

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

2. Aims & Objectives of the LSAB

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

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

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

3. Terms of Reference

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

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

4. Monitoring Arrangements

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

5. Business Planning and Strategic Goals for 2012 - 2015

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

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

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

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

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

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

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

Domain 1: Prevention & Early Intervention

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

Domain 2: Responsibility & Accountability

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

Domain 3: Access & Involvement

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

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

Domain 4: Responding to Abuse & Neglect

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

Domain 5: Training and Professional Development

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

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

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

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

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

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

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

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

Domain 1. Prevention & Early Intervention Outcome 1: a pro-active approach reduces risks and promotes safe services whilst ensuring independence, choice and control.					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
1.1 Assure that information is shared appropriately and in a timely manner within and across partner agencies	A. Review LSAB and single agency information sharing protocols (relate to Trigger Protocol). Identify key areas for information sharing	03/13	P&P group / LSAB agencies	**June 13:** Following SCR this needs to be a priority. We hope to prepare a simple protocol based on work done to date to share patterns of concern and soft intelligence, and bring this to the LSAB in Oct. Request move timescale to 10/13	A
	B. Carry out multi-agency audits routinely and report gaps and good practice to LSAB to help improve and shape future practice	Quarterly on going	QAAPM group	**June 13:** Adopted new methodology for audit process in May meeting, discussed 2 cases. Learning points identified. Safeguarding lead for Sirona and LA to work together to agree methodology for future meetings.	G
	C. Develop and implement an effective Triggers Protocol (including both Commissioners and Providers triggers)	03/13	P&P group	**June 13:** Slow progress to date; needs LSAB focus Risk is the lack of capacity to develop and implement across key agencies. Plan to prepare a process linked to Sharing info protocol and bring to Oct Board. Request move timescale to 10/13 LSAB need to agree how to take this forward as now part of a wider	A

				discussion following SCR recommendations – this will impact on work of the group	
1.2 Ensure Carers needs are supported	A. Implementation and review of Carers Action Plan	12/12	AEC group	**June 13:** Action plan reviewed in June. Carers Centre updating plan.	G
	B. LSAB partners to support and promote joint working with carers centre	12/12	AEC group	Carers Centre has met with Sirona, Curo and AWP and has begun discussions on how to work more effectively together.	A
1.3 Support service users to identify risks and to reduce and prevent abuse occurring	A. Monitor service user feedback from safeguarding process	06/13	AEC group	**June 13:** Report completed, LSAB agenda item for June 13. **Apr 13:** 6 month review requested. Review report has been prepared by Sirona and is being considered at the April 13 Meeting	G
	B. Promote through training, development and effective supervision, an ethos of choice and control by achieving the right balance between safeguarding action and proactive risk enablement	12/12	T&D group	Update required	
	C. Develop further service user feedback opportunities	09/14	AEC group	**June 13:** Work is ongoing and meeting with Healthwatch to discuss. Discussion took place at January 13 meeting and being brought to March	A

				13 LSAB meeting for decision of the way forward	
1.4 Work more closely with the LSCB to ensure areas of cross over are addressed; eg Transitions and Mental Health	A. Establishment joint LSAB / LSCB working group	9/12	LSCB and LSAB working group	Completed	G
	B. LSCB/LSAB chairs and B&NES Council Strategic Director for People and Communities to make proposals to both Boards	03/13	LSAB / LSCB	Completed **June 13:** working group continue to meet and progress recommendations approved by LSAB and LSCB **Mar 13:** Working group met at the beginning of Sept and have agreed a set of recommendations which will be proposed to the LSAB and LSCB at December meetings for consideration	G
1.5 Assurance that robust lessons learned arrangements are in place (including learning from SCRs, case law and other review documents)	A. Review lessons learned guidance that LSAB agencies and sub-groups have in place	06/13	QAAPM group	**June 13:** No agencies submitted lessons learned guidance for discussion. Continue to add national safeguarding reviews to agenda for discussion locally	A
	B. Draft multi-agency lessons learned guidance	12/13	P&P group	**June 13:** No progress as not a current priority. Request timescale extended to 12/14	R
	C. Ensure recommendations	12/12	QAAPM	**June 13:** Commissioning Team action	G

	from Winterbourne View and Francis Report are being considered and actioned and risks fully understood; ensure included in contract monitoring		group	plan in place to ensure that local actions relating to Winterbourne View are completed. Francis report presented to QAAPM at last meeting.	

Domain 2. Responsibility & Accountability Outcome 2: There is a multi-agency approach for people who need safeguarding support					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
2.1 Develop and improve links with Clinical Commissioning Groups (CCGS)	A. Provide joint training events for Practice and District Nurses	12/12	Sirona Care and Health and CCG	Update required	
	B. Monitor CCG actions from SCR recommendations and lessons learned	On going	QAAPM group	**June 13:** Early engagement with CCG and Medical Director involved; Commissioner attended CCC with report on SCR and involvement required; report to LSAB on allocation of resources in June 2012	G
	C. Provide training for independent contractors	03/13	Council and PCT	**June 13:** Four workshop were provided to independent contractors during quarter 4 2012-13	G
2.2 Formalise accountability arrangements between the LSAB, commissioner and commissioned	A. Draft guidance note as required setting out the Commissioner and LSAB responsibilities	12/12	Council to draft for LSAB discussion	**June 13:** LH and RC finalising details of session on this – considering LSAB Away day **March 13:** Discussion paper presented to the LSAB and workshop planned **Dec 13:** Initial discussion with LSAB Chair and Dept People and	A

Domain 2. Responsibility & Accountability Outcome 2: There is a multi-agency approach for people who need safeguarding support					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
services				Communities taken place; P&C leadership team agreed to develop draft for 01/13; timescale of 12/12 will slip until Jan 13 though work is in progress	
2.3 LSAB agencies to complete self - assessment annually to demonstrate continuous development	A. Identify areas for improvement from partner agencies and LSAB through annual self-assessment and include progress in annual report	06/12	QAAPM group	**June 13:** Self-assessments completed and analysed by June 12, further self-assessment to be completed in next year's business plan	G
	B. Incorporate areas for improvement into LSAB Business Plan annually	12/12	QAAPM group	**June 13:** On-going action for next business plan	G
2.4 Assure LSAB sub-groups are meeting the strategic objectives of the LSAB	A. Review sub-group Terms of Reference	06/12	All sub-groups	Completed	G
2.5 Assure that learning	A. Monitoring of progress on addressing action points in	09/12	QAAPM group	Completed	G

Domain 2. Responsibility & Accountability Outcome 2: There is a multi-agency approach for people who need safeguarding support					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
identified in SA annual reports are addressed	annual report 10/11				
	B. Incorporate and monitor learning from 11/12 annual report into Business plan	10/12	Council Commissioning Lead	Completed	G
2.6 Assure that Whistle blowing arrangements are robust	A. Whistle blowing statement to be included in revised multi-agency policy	12/12	P&P group	**June 13:** Statement now in new policy which is to be presented to LSAB in June for approval	A
	B. Review LSAB and sub-group agencies whistle blowing policies and procedures and report back to LSAB	12/12	QAAPM	**June 13:** No further action required at this stage **Dec 12:** reviewed feedback from agencies on whistle blowing questions posed by LSAB – assurance provided	G
	C. Disseminate Whistle blowing best practice guidance widely	09/12	AEC group	Completed Request for good practice example to balance the bad practice example – to be included when document reviewed	G

Domain 2. Responsibility & Accountability Outcome 2: There is a multi-agency approach for people who need safeguarding support					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
2.7 Assurance that the work of the LSAB is incorporated into commissioned	A. Confirmation of how safeguarding and MCA/DOLS indicators are monitored in commissioned services contracts	12/12	Council and PCT Commissioning	Complete – LSAB indicators in contracts and reviewed in accordance with contract review frameworks ie, quality meetings or review visits	G
	B. Propose mechanisms to improve reporting and monitoring arrangements	03/13	Council and PCT Commissioning	**June 13:** Work is in progress on this. Request move timescale to 03/14 **Dec 12:** Initial conversation taken place about the development of an overarching health and social care assurance framework (including children services for safeguarding) building on adults assurance framework that currently exists.	A
	C. Monitor implementation of above mechanism	09/13	QAAPM group	**June 13:** action not yet due will slip to accommodate above if LSAB agree	
	D. Develop / review assurance arrangements regarding MCA practice (5.1 ToR)	12/12	MCA group	**June 13:** Group have reviewed arrangement in place and are now receiving agencies assurance reports for evidence – report back to LSAB in	A

Domain 2. Responsibility & Accountability Outcome 2: There is a multi-agency approach for people who need safeguarding support					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
				Oct on review findings Request move timescale to 10/13 to report the review of the arrangements and 03/14 to develop / propose any new arrangements that might improve position **Mar 13:** New IMCA provider in place and attending group to provide assurance **Dec 12:** Gather MCA figures on annual basis; new tender for IMCA	
	E. Propose MCA / DOLS indicators for LSAB	03/13	MCA group	**June 13:** Group developing new assurance measure – draft proposals being taken to agencies. Request move timescale to 03/14 **Mar 13:** Early discussion has taken place, initial thoughts include: no. of IMCA referrals, DOLS application and process to timescale; safeguarding cases where formal capacity assessments have been undertaken	A

Domain 3. Access & Involvement Outcome 3: People are aware of what to do if they suspect or experience abuse Outcome 4: Local practice and the commissioning of services and support are informed by feedback and satisfaction levels of those who have had experience of the safeguarding process					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
3.1 Ensure service users and alerters have a positive response from professionals through-out the Safeguarding procedure	A. Monitor and review service user experience questionnaire responses (linked to outcome 1)	12/12	AEC group	**June 13:** paper to LSAB; completed	G
	B. Review audit of 'front door' response to safeguarding alerts	12/12	Sirona report to QAAPM	**June 13:** Audit received, positive results noted and shared with LSAB; will be repeated in Oct 2014	G
3.2 Assure a systematic approach to providing safeguarding and MCA information and updates to all people / communities is in place ***(disseminating)***	A. Develop a calendar of opportunities to routinely and strategically disseminate information for i) citizens ii) providers iii) publications	06/13	AEC and MCA group	**June 13:** draft calendar developed. To be finalised by next LSAB. Request timescale be changed to 10/13 **Mar 13:** Workshop held in Jan 13 with additional organisations invited. A thorough list of all communication opportunities at events, in print and web links were collated.	A

Domain 3. Access & Involvement Outcome 3: People are aware of what to do if they suspect or experience abuse Outcome 4: Local practice and the commissioning of services and support are informed by feedback and satisfaction levels of those who have had experience of the safeguarding process					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status RAG Score**
3.3 Assure that mechanisms are in place for service user and carers feedback to inform improvements to policy, practice, commissioning and service development ***(personalised; sharing)***	A. Monitor effectiveness of service user feedback questionnaire process and responses	12/12	AEC group	**June 13:** paper to LSAB in June 13 completed	G
	B. Evidence of continual improvement in response to feedback and involvement of service users *(requested from AEC group)*	03/13	QAAPM group	**June 13:** report being discussed with LSAB in June 13; QAAPM group to consider report and agree how they will achieve this. Request timescale change to 10/13 due to slip in AEC group reporting	

3.4 Service users and carers who have been through the safeguarding process to provide peer and mentoring support to other service users and carers	A. Develop a work programme to progress this objective including reviewing the support available Consider Advocacy and Adult Safeguarding document from ADASS	06/15	AEC group	**June 13:** Advocacy and Adult Safeguarding document from ADASS was considered at June 13 meeting Will look at the review of current feedback and consider future needs and opportunities. A new IMCA provider is starting and the group will introduce themselves to identify professional support available. Not due until 06/15	A
3.5 Raise awareness of discriminatory abuse	A. Agree awareness raising activities specifically for this type of abuse	03/13	AEC group	**June 13:** linked to 3.2a draft calendar developed. To be finalised by next LSAB. Request timescale be changed to 10/13 **Mar 13:** Will be considered in setting calendar of events at April 13 meeting.	A

Domain 4: Responding to Abuse & Neglect Outcome 5: People in need of safeguarding support feel safer and further harm is prevented					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
4.1 Assure that service users and carers where appropriate, are fully involved and participate at every stage of the safeguarding process and robust evidence that best interests decisions are made where necessary and clearly recorded *(personalised; sharing)*	A. Develop person centred procedures on service user involvement to be available and used by all LSAB partners ensuring service users and carers are treated with dignity	09/12	P&P group	**Dec 12:** completed service user involvement policy approved	G
	B. Implement and monitor guidance	12/12	QAAPM group	**June 13:** will be discussed at next meeting Request timescale be changed to 03/14	R
	C. Request 15% sample audit of cases undertaken by AWP and Sirona Care and Health include a section on compliance with this and demonstrate it is achieved	05/13 for report	QAAPM group to consider audit report	**June 13:** Audits not presented to May 13 meeting however both AWP and Sirona have presented reports to commissioner in June QAAPM group to consider at next meeting	A
	D. Include this in the Carers Action plan in Domain 1.	09/12	AEC group	Complete	G

Domain 4: Responding to Abuse & Neglect Outcome 5: People in need of safeguarding support feel safer and further harm is prevented					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
4.2 Assure that multi-agency policies and procedures are reviewed and best practice guidance is developed (including responses to vulnerable perpetrators) *(personalised; sharing)*	A. Ensure multi-agency policy and procedure review dates are set and list is reviewed on an annual basis	03/13	P&P group	Completed 06/12	G
	B. Ensure each multi-agency documents are reviewed on a bi-annual basis	06/12 – 03/15	P&P group	**June 13:** In progress. We have 3 due for review by the end of the year – consent, thresholds and media/comms – need to identify lead reviewers for these.	A
	C. Recommend good practice guidance, policies and procedures be written resulting from new information provided nationally, locally from SCRs, quality assurance information from audits and lessons learned information	06/12 – 03/15	QAAPM and P&P group	**June 13:** QAAPM group routinely do and is now regular agenda item	G
				June 13: Ongoing dependant on SCR action plan and work around improved information sharing/triggers	A

4.3 Ensuring a robust process for the management of large scale investigations	A. Develop large scale investigation guidance and procedures with a clear definition	12/12	P &P group	**June 13:** Overdue - Work being undertaken. Request timescale be changed to 12/13	A
Domain 5: Training and Professional Development Outcome 6: Staff are aware of policies and procedures, their practice safeguards adults and promotes understanding of harm					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
5.1 Ensure organisational commitment to support the development of safeguarding adults and MCA competence in the workforce	A. Roll out audit to LSAB and sub-group agencies, carers organisations and Dom Care partners	09/12	T&D group	Audit tool has been circulated with new framework document to all partnership agencies	G
	B. Review Audit Tool (Multi-agency Staff Development Framework) to include MCA	09/13	T&D group	Not due by June 13	
	C. Report audit findings to LSAB	09/13	T&D group	Not due by June 13	
	D. Propose further roll out to other commissioned services	12/13	T&D group	Not due by June 13	
	E. Develop requirements for Chief Executives, Elected Members and Board members	12/12	T&D group	**June 13:** Poor attendance at the group and work not progressed. Request timescale move to 12/13	A

5.2 Assure that LSAB training targets are achieved	A. Set up a system for LSAB training target reporting (including MCA, DOLS and SA training)	06/12	LSAB	**June 13:** Annual report on the agenda for June meeting and training performance included for 12-13 **Mar 13:** LSAB Annual Report proforma includes training target reporting **Dec 12:** Discussed by LSAB however difficult to implement	G
5.3 Ensure safeguarding and risk assessment training is delivered and available to service users and carers	A. Ensure training request is included in Carers Centre service specification	09/12	Council Carers Lead Commissioner	Completed	G
	B. Ensure service user training is provided through appropriate agency	09/12	Council Commissioner	**Mar 13:** Delivery of training is included in LD specification for Your Say and for direct payment users through Shaw Trust; Bath People First have funding to deliver this for all service user groups as well *however this is not commissioned against a service spec and the agency is currently reviewing its viability and there may be a future gap*	G

Domain 5: Training and Professional Development Outcome 6: Staff are aware of policies and procedures, their practice safeguards adults and promotes understanding of harm					
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Agency / Officer**	**Progress**	**Status** RAG Score
5.4 Assure that training meets LSAB standards and competencies set out in the Staff Development Framework are delivered and that service users and carers are involved in delivery where possible	A. Review training provided by Sirona Care and Health and all LSAB agencies	12/12	T&D group	**June 13:** Analysing findings from the training audit – will report to the LSAB in Oct 13. Request timescale extend to this for section on all LSAB agencies **Mar 13:** Completed review of Sirona's training	A
	B. Work with the carers centre and support carers to deliver safeguarding training	03/14	T&D group	**June 13:** This objective has not been progressed by the training subgroup and will be picked up as a priority for 2013/14 to work with the Carers' Centre to support service users to participate in SA training delivery.	
	C. Work with service user representative to support service users to participate in SA training delivery	To be agreed	T&D group	As above	
	D. Propose level 4 training in Staff Development framework to LSAB	03/13	T&D group	See 5.1 response above	R

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

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

7. Review and monitor arrangements with Emergency Duty Team	B&NES Council Non Acute Contract and Commissioning Team	In discussion; Monitored by People and Communities Department
8. Review the monitoring and recording arrangements for safeguarding procedures that have been carried out for B&NES service users living outside B&NES geographical boundary	B&NES Council Safeguarding Adults and Practice Development Team	Monitored by People and Communities Department
9. Secure support from B&NES Council Research and Development Team to ascertain whether B&NES referral rates are within an expected range	B&NES Commissioning	Monitored by People and Communities Department

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy and Development Scrutiny Panel
MEETING DATE:	20th September 2013
TITLE:	**Report from the Strategic Transitions Board**
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 – Main Report and supporting Appendices.	

1 THE ISSUE

1.1 This report provides an update on the work and activity of the Strategic Transition Board, noting areas of achievement and highlighting future priorities.

2 RECOMMENDATION

The Wellbeing Policy Development and Scrutiny Panel is asked to agree that:

2.1 The summary and conclusions of the report are accepted by the panel

3 FINANCIAL IMPLICATIONS

3.1 There are no direct financial implications of this report. However, the work of the Strategic Transition Board as highlighted in the report will have an impact on the Council's medium term service and resource planning. Developing person centred approaches to improving transition planning for young people is expected to enable people to maximise their independence as they move into adulthood,

4 THE REPORT

4.1 The Strategic Transition Board was originally established in 2007 following a review commissioned from an independent organisation – Lifestyles – to review transition processes for the transfer of young adults (all client groups) from Children's to Adult services.

In summary the report found a number of barriers to effective service delivery including:

lack of strong leadership and commitment to transition planning processes,

no strategic overview

Mixed criteria for accessing services

Lack of understanding of roles and responsibilities of the different sectors and agencies involved in the transition

Lack of resources and clear, collated and easily accessible information and communication systems.

Lack of person centred planning and user involvement

4.2 The board's original remit was to implement the recommendations from the Lifestyles review and a workplan was put in place to address the issues above.

In 2008/09 a three year National Transition Support programme was launched, which aimed to raise the standards of transition support and provision in all local areas. Support was provided to all local authority areas to meet their statutory requirements and minimum standards in transition and go on to develop good practice, as one of the 5 work streams that made up the DCSF/DH Aiming High for Disabled children agenda to transform disabled children's services.

4.3 Over the course of the three year programme Bath and North East Somerset moved from Band 3 (the lowest rating, noting need for high support) through to Band 1(the highest rating), as the improvements being driven by the Strategic Transition Board were recognised by the National Transition Support team. During this period the workplan of the Strategic Transition Board was regularly amended to reflect the emerging recommendations from the National Transition Programme and the yearly self assessments. The workplan has been continued and is overseen by the Board. Responsibility for implementing the plan sits with a 'core group' of the

board which is currently chaired by the Senior Commissioning Manager for adults with learning disabilities and PSI.

4.4 Further detail is contained within the main report attached as Appendix 1 and supporting appendices.

5 RISK MANAGEMENT

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

6 EQUALITIES

6.1 An Equalities Impact Assessment was initially completed when the Board was established.

7 CONSULTATION

7.1 *Overview & Scrutiny Panel*

7.2 Consultation with the Wellbeing Policy and Development Scrutiny Panel carried out as a result of receiving this report.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Young People; Human Rights; Corporate; Impact on Staff; Other Legal Considerations

9 ADVICE SOUGHT

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

Contact person	*Mike MacCallam 01225 396054*
Background papers	
Please contact the report author if you need to access this report in an alternative format	

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Wellbeing Policy and Development Panel – 20th September 2013
Agenda Item 16

Title: Report from the Strategic Transitions Board

Purpose: To provide an update on the work and activity of the Strategic Transition Board, noting areas of achievement and highlighting future priorities.

NB – The Wellbeing Policy Development and Scrutiny Panel received a previous report regarding transitions in January 2012. It is understood that membership of the panel has changed significantly since January 2012 and therefore this report repeats previous information for new panel members and additionally provides an update regarding progress since the first report.

Background:
The Strategic Transition Board was originally established in 2007 following a review commissioned from an independent organisation – Lifestyles – to review transition processes for the transfer of young adults (all client groups) from Children's to Adult services.

In summary the report found a number of barriers to effective service delivery, including:

- lack of strong leadership and commitment to transition planning processes,
- no strategic overview
- Mixed criteria for accessing services
- Lack of understanding of roles and responsibilities of the different sectors and agencies involved in the transition
- Lack of resources and clear, collated and easily accessible information and communication systems.
- Lack of person centred planning and user involvement

The board's original remit was to implement the recommendations from the Lifetstyles review and a workplan was put in place to address the issues above. Terms of reference and Objectives of the board were established, which are attached as Appendix 1. The Board is currently chaired by Jane Shayler, Deputy Director Adult Care, Health and Housing, supported by Mike MacCallam, Senior Commissioning Manager for Adults with Learning Disabilities and Adults with Physical and Sensory Impairments.

In 2008/09 a three year National Transition Support programme was launched, which aimed to raise the standards of transition support and provision in all local areas. Support was provided to all local authority areas to meet their statutory requirements and minimum standards in transition and go on to develop good practice, as one of the 5 work streams that made up the DCSF/DH Aiming High for Disabled children agenda to transform disabled children's services.

Each local authority was required to complete a yearly Self Assessment Questionnaire (SAQ) to capture their position in relation to a number of key transition indicators set by the National programme. The SAQ was also the tool the Transition

Support Programme used to measure progress made by local areas and to determine how well local areas were meeting statutory requirements and guidance in relation to transition. Data from the SAQ was then used by DCSF and DH to make decisions about what support would be offered to local areas in the following year.

Over the course of the three year programme Bath and North East Somerset moved from Band 3 (the lowest rating, noting need for high support) through to Band 1(the highest rating), as the improvements being driven by the Strategic Transition Board were recognised by the National Transition Support team. During this period the workplan of the Strategic Transition Board was regularly amended to reflect the emerging recommendations from the National Transition Programme and the yearly self assessments. The workplan has been continued and is overseen by the Board. Responsibility for implementing the plan sits with a 'core group' of the board which is currently chaired by the Senior Commissioning Manager for adults with learning disabilities and PSI.

Key milestones and achievements of the Strategic Transition Board.

1 Transition Protocol

Bath and North East Somerset, via the Strategic Transitions Board, has published a revised Protocol for Transition Planning for young people with additional needs age 14 to adulthood (in part as a result of the work and support that had been received from the national transition team).

This protocol covers young people with statements of special educational needs (SEN) and their parents / carers. It sets out the expectations of relevant agencies in Bath and North East Somerset throughout the transitions process so they are clear what the specific responsibilities of each agency will be at each stage. It also aims to ensure that these young people and their parents / carers have the right information to make informed decisions throughout the transition planning process.

The protocol also explains the roles of schools, Bath & North East Somerset's Children and Families services, Connexions, Adult Care/ Learning Difficulties /Mental Health services, Health services and Housing services in working together to support young people and families with additional needs and special educational needs in the transition to adulthood.

The protocol emphasises the importance of person centred approaches to transition planning and developing this has been a key priority for the STB.

2. Appointment of Transition Champion

To support the implementation of the transition protocol and in particular to promote person centred approaches to transition planning, Bath and North East Somerset created the post of a Transition champion, first appointed in June 2010 and originally funded through Sure Start grant. From April 2011 this post has been funded through combined commissioning between children's and adult social care.

The postholder has been a key figure in developing revised approaches to transition planning, and is highly thought of, particularly within the two special schools Fosseway and Three Ways, where the majority of students with a Statement of Need (SEN) attend. As a direct result of working with the Transition Champion, both schools have now built preparation for transition planning into their school curriculum and are adopting a revised transition planning process which is aimed at improving outcomes for their students and providing better information for commissioners of adult care to assist with service planning and delivery (see item on Database below for more information).

Update July 2013:
The Transition Champion, now titled Transition Project Officer has recently agreed to 'case manage' 10 students from Fosseway School and Three Ways School through their next transition review. This will enable the project officer to model good practice and provide direct leadership around the transition pathway to the staff of the schools, and develop examples of outcomes from what a 'good' transition pathway can look like.

3. Implementing the Bath and North East Somerset Transition Pathway
Bath and North East Somerset has agreed a revised approach to transition planning which places greater emphasis on supporting each young person and their family to be better prepared for their transition review, and to have had the opportunity to have thought in a more person centred way about their own needs, wishes and aspirations for the future. (See Appendix 2 at the end of this report).

The aim is to produce a transition support plan that is framed around the 'pathways' of Getting A Life. Getting a Life was a three-year cross government project (April 2008 to March 2011), set up to show best practice and drive change so that young people with a severe learning disability could live full lives when they leave education. It focused on what needs to happen during the vital transition period between ages 14 and 25. Although the programme has now ended, it was cited in the Green paper *Support and Aspiration: A new approach to special educational needs and disability (2011)* as a model of best practice that had produced good outcomes for young people. An illustrative example of the pathways to Getting a Life is included as Appendix 3 at the end of this report.

Update July 2013:

An 'away day' was held in October 2012 to introduce the B&NES Pathway to a wide audience of stakeholders including mainstream and special schools, families and carers, local Council staff, representatives from further education, the Connexions service. A secondary purpose of the day was to agree actions needed to support a three year strategic transition plan for implementing Getting A Life, which is overseen by the Strategic Transitions Board.

To support the transition pathway all schools have now been requested by the Council's SEN team to use One Page Profiles with SEN students as a part of their individual transition review, and submit copies of the One Page profile with a copy of

the transition plan (yr 9 – age 14+ - and above) to the SEN team. Early evidence is that the majority of plans *are* being supported by a One Page profile, which is very encouraging.

A (real) illustrative example of a One Page profile and feedback from the SENCO at Norton Radstock school is attached as Appendix 4 to this report.

In addition, all secondary schools are now introducing a revised format for the yearly transition review/transition plan. The new format complements the B&NES pathway, and guides people towards considering outcomes within the four pathways of Getting A Life. It is intended that in time this information can then be used by commissioners within adult health and social care to assist with the planning and commissioning of services. The new transition plan has only been recently introduced and as yet no analysis has been completed to measure how successfully this has been implemented. Many schools undertake transition reviews in the Autumn term and therefore it is intended to complete a mini audit with all schools at the end of the calendar year.

Furthermore, all secondary schools (bar one) have now had at least one person trained (SENCO; Learning Support Assistant) in using the B&NES Transition Pathway, person centred approaches use of the new transition plan paperwork.

4 Training Strategy

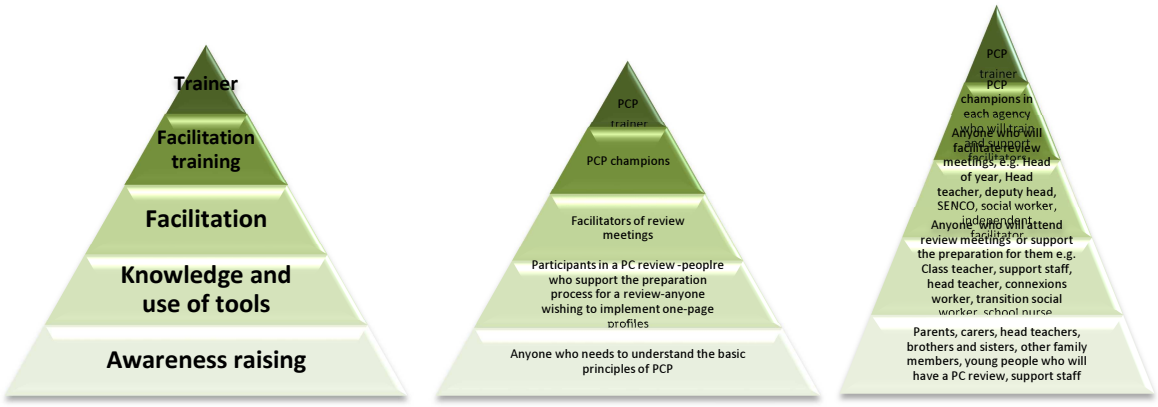
It is evident that young people, families and carers are often ill prepared for the changing model of adult social care with its particular emphasis on personalised approaches, independent living, and use of personal budgets.

The Board has recognised that driving significant change in the way that people are supported through the transition planning process is a major undertaking and a training programme has been developed and implemented to support young people, families, and professionals from all agencies with this.

The purpose of the training strategy is to embed person centred planning (PCP) across all support services in Bath and North East Somerset as a mechanism to support transition for children and young people from 14 - 25 who are disabled, or identified as having a special educational need. This includes all statutory, private and voluntary sector providers and all mainstream secondary schools, special schools and colleges in Bath and North East Somerset. The strategy aims to build internal capacity to ensure that ongoing training for PCP is self-sustaining and effective mechanisms exist to support and develop high quality single planning processes.

In summary the training strategy identifies 5 levels of training from Level 1 awareness raising through to Level 5 where individual staff are trained as PCP trainers – thus building a sustainable training and development programme for B&NES. There is little cost involved as the majority of training is delivered by the Transition Champion. The strategy is illustrated in Table 1 and Table 2 below.

Table 1 Illustration of training strategy



What level of training is required? Who would need this level of training? Which people might be involved?

Table 2 – Training Participation at each level

Level 1: Awareness raising • **Who needs it?** Anyone who needs to understand the basic principles of PCP • Parents, carers, head teachers, brothers and sisters, other family members, young people who will have a PC review, support staff
Level 2: Knowledge and Use of tools • **Who needs it?** Participants in a PC review • Anyone who will attend review meetings e.g. Class teacher, support staff, head teacher, connexions worker, transition social worker, school nurse, therapists
Level 3: Facilitation • **Who needs it?** Facilitators of review meetings • Anyone who will facilitate review meetings, e.g. Head of year, Head teacher, deputy head, SENCO, social worker, independent facilitator, Class Teacher
Level 4: Facilitation Training • **Who needs it?** PCP champions • PCP champions in each agency who will train and support facilitators
Level 5: Trainer Training • **Who needs it?** PCP trainer

Update July 2013

Work will continue to roll out the training programme particularly at levels 1 and 2, and in schools. In addition further support will be offered to young people and families to build understanding of local options, particularly around housing, employment and personalisation. As an example we are in the process of organising seminars to better explain what supported living actually means, what can you use personal budgets for etc, to help people prepare ahead of transition planning. The next seminar event is scheduled for the 17th September 2013.

5 Information

For some time it had been acknowledged that there is an unsatisfactory provision of information available to young people and their families with regard to transition and transition planning. The core group is currently working with a web author to establish a single point of contact on the public website to hold a range of up to date and useful information, which is expected to be developed in shadow form by April 2012. This will then be tested with a range of stakeholders, including schools, carers, and the participation group referred to above before going live at a point later in the year.

Update July 2013:

Bath and North East Somerset has produced 'Preparing For Adulthood – A local guide' – which is a local directory for young people, families and carers and other key partners, and provides local information about each of the four pathways of Getting A Life, in addition to a range of further information. This guide has been very well received and has received positive feedback from Parent Carers Aiming High (PCAH), a local group of parents and carers who are also represented at the Strategic Transition Board

The Council has also established a specific webpage for Transition which has links to the guide plus other relevant information and is easily accessed via the Public website – link below.

http://www.bathnes.gov.uk/services/children-young-people-and-families/transition-adulthood

6. SEN Reforms

The Green paper *Support and Aspiration: A new approach to special educational needs and disability (2011)* contains a series of reforms for supporting children with a Statement of Educational Need (SEN), many of which will impact on children and young people as they move into adulthood. A local working group has been established to oversee local service redesign and implementation of the reforms, with multi- agency representation including membership from commissioners with Adult Health and Social Care. A key focus for the group is to secure the engagement of agencies, including Health, Social Care and Education in ensuring that responsibilities in delivering the reforms, particularly around the requirement for a single Education Health and Care plan for statemented children through to age 25, are clearly understood and locally adopted. A stakeholder event is being planned for September 2013 to support this focussed piece of work.

In addition, a draft and comprehensive revised SEN Code of Practice has been published for formal consultation later in 2013 to provide information and guidance around implementing the SEN reforms – this has been considered by members of the Strategic Transitions Board and initial feedback is currently being collated.

7 Transition and Safeguarding

The Strategic Transitions Board has been asked by the Local Safeguarding Adults Board and the Local Safeguarding Childrens Board (LSAB/LSCB) to review local procedures relating to safeguarding and joint working around children and young people aged 16+, including the need to ensure that planning around any individual subject to safeguarding procedures is properly undertaken between services, and that information sharing protocols are clarified. This work is underway and a briefing will be provided to both the LSAB and LSCB at meetings in September and October 2013.

8 Transition into Adulthood – Operational procedures

A Transitions 'Operations Panel' meets four times a year to oversee the transition of young people and the transfer of social work care management responsibility from childrens to adult services. The purpose of the panel is to ensure that young people who will be eligible for social care services as an adult are identified within 6 months of their 16th birthday, and allocated to an appropriate team/case manager no later than their 17th birthday.

This panel has led to a significant improvement in joint working between children's and adult services and enabled better planning and commissioning of services for young people in adult services, particularly for people with LD and Autism. The Operations Panel is further supported by a secondary panel comprising Senior Commissioning Managers from Adult Health and Social Care, who will make the final decision regarding allocation if a person has a range of complex needs that cannot be easily met by one service. This ensures that all young people who are transferring to adult social care can be identified and transferred prior to their 17th birthday.

Within Bath and North East Somerset there is no dedicated transitions team or specific transitions social workers, and case management can be accepted by any qualified social worker within the adult care/mental health/learning disability teams. As far as possible individual social workers from the adult teams will begin joint working with their counterparts in children's services and with relevant agencies, i.e schools, colleges at the earliest opportunity to improve transition outcomes for each young person.

As an illustrative example, there are currently 299 young people with a Statement of Need in year 9 or above. Of these, approximately 100 have learning disabilities and/or autism, are the responsibility of B&NES and will be eligible for services as an adult. This equates to approximately 15 cases each year 'transitioning' into adulthood, to be case managed by the LD and Autism social work teams.

9 Summary and Conclusions

There has been a continuous programme of development around improving transition planning and transitions outcomes for young people both at strategic and operational level.

A new Transitions pathway has been introduced for B&NES, based on Getting A Life Pathways and using person centred approaches to transition planning.

This is supported by the introduction of revised transition plan documentation which is being introduced in all schools.

The Transition Project officer is leading on improving practice in the use of person centred approaches by case managing 10 students from two special schools.

Improvements have been made to the provision of information and advice to young people and their families with the setting up of a Transition webpage on the Council public website and the publication of a local guide – 'Preparing for Adulthood'.

Immediate priorities for the next twelve months include: establishing a local framework for implementing the SEN reforms; auditing the implementation of the revised transition processes across all schools in the autumn of 2013.

Mike MacCallam

Senior Commissioning Manager

Appendix 1

Bath and North East Somerset

Strategic Transition Board

1. Purpose

To ensure that appropriate and effective arrangements are in place to meet the needs of young people with physical and/or learning disabilities and/or with mental health problems aged between 14 – 25, as they move from childhood to adulthood.

2. Objectives

2.1 To develop a transition protocol and local transition pathway covering the transition from childhood to adulthood that ensures that appropriate transition planning and assessments of young people with disabilities approaching adulthood are in place and that the planning and commissioning of services to support young people is undertaken.

2.2 To ensure that transition processes are multi agency, addressing all of a young person's needs using a person centred approach and that the transition plan is meaningful, detailing the young person's aspirations and how they can be supported to achieve them.

2.3 To ensure all young people have the opportunity to reach their potential and maximise quality of life, participation in education, training or employment and independence.

2.4 To identify and plan to meet training needs for professionals working within the transition process

2.5 To ensure that schools have mechanisms in place to share information to aid planning and commissioning services to meet future demand

2.6 To oversee development of the personalisation agenda for young people through the transition stage.

2.7 To ensure that there are clear and effective transition processes for young people with identified health needs including mental health so that health needs continue to be met in adulthood

2.8 To examine how service provision can be improved and developed and to make recommendations as required.

2.9 To monitor the effectiveness of multi-agency working, including role of lead professional, in relation to the policies, procedures and protocols and to resolve issues and problems where identified.

2.10 To ensure provision of clear and accessible information for all about the transitions processes, future options and progression routes relating to young people and their families.

2.11 To ensure high quality transition service across Bath and North East Somerset is provided and to receive reports on service provision as requested by the board.

2.12 To establish any groups/action groups and board believes will be required to sustain and promote the transitions policy. The terms of reference of these groups will be determined by the board.

2.13 To champion work on transitions across all services.

2.14 To establish mechanisms to ensure that disabled young people and their families have a voice and that their views are communicated appropriately.

2.15 To ensure that services meet the whole needs of each young person taking into account ethnic origin, culture, religion, sexuality, gender and language, as well as social and emotional needs.

2.16 Linking into sub-regional work and sharing sub-regional learning

3. Working arrangements and conduct

3.1 The Bath and North East Somerset Strategic Transition Board will report annually to the Children's Trust board and to the Partnership Board for Health and Wellbeing, and any other relevant Boards/Partnerships as required. This reporting function will be the responsibility of the chair of the Strategic Transition Board.

3.2 The Board may invite non-members to attend Board meetings as appropriate, or to co-opt members to undertake work as required. Should a Board member be unable to attend when s/he has an item on the agenda, then a representative may attend on his/her behalf for that item.

4 Membership

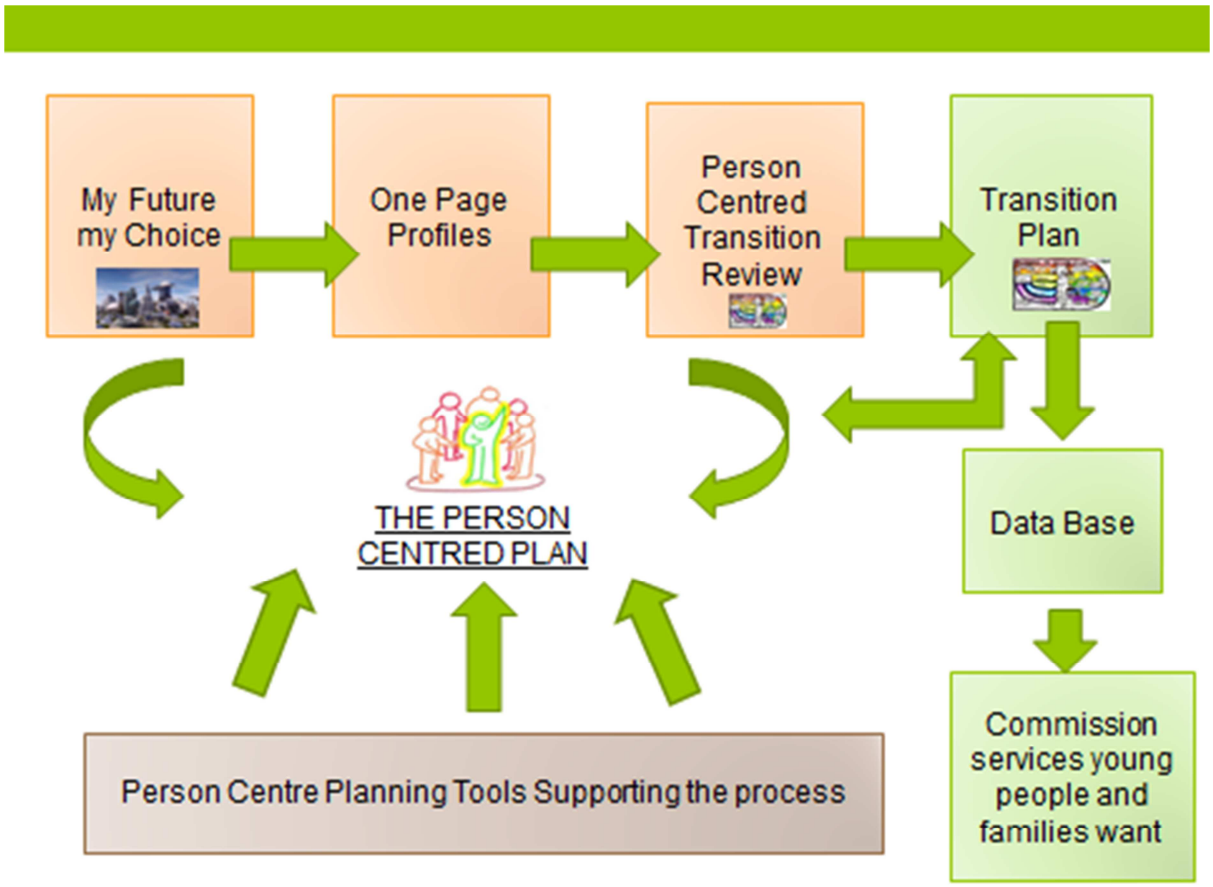
- Children's Social Care
- Joint Health and Social Care Provider
- Acute Health Providers – Children's and Adult services
- Connexions
- Mental Health Joint Commissioning
- Learning Difficulties Joint Commissioning
- Joint Children's commissioner
- Education Liason Manager
- FE Providers
- Mental Health – AWP
- Child & Adolescent Mental Health Services
- Shared Commissioning Services
- Special Schools
- Mainstream schools
- Third Sector/Voluntary organisations
- Disabled young people and parents/ carers
- Supported employment
- Advocacy Services

5. Frequency of meetings

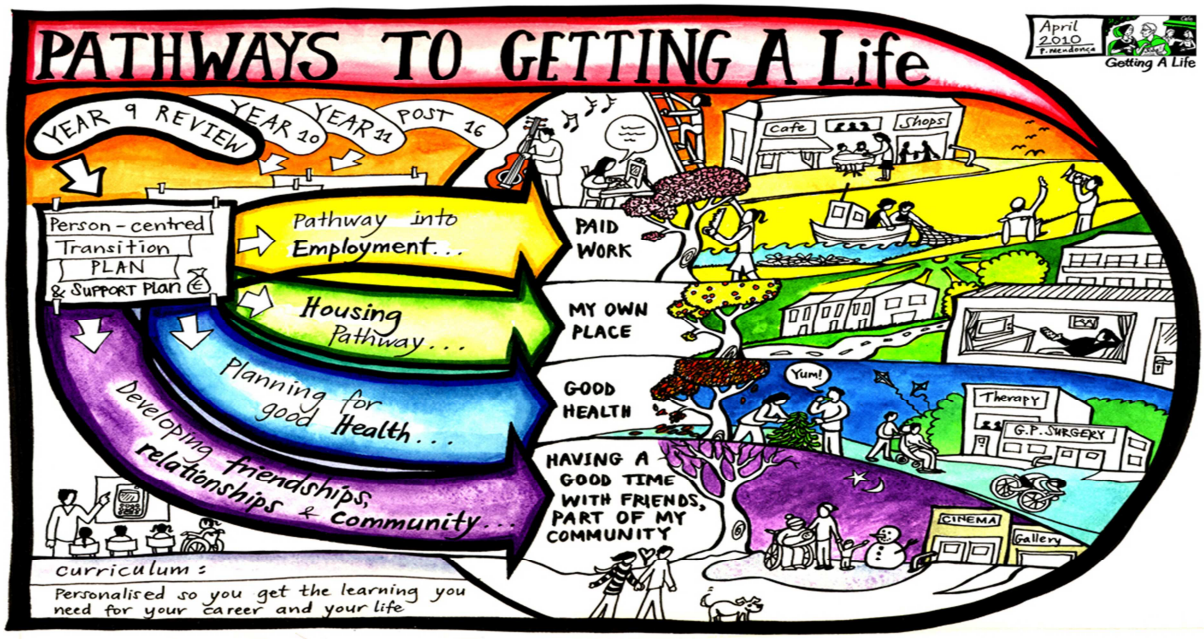
5.1 The Board will meet on at least 4 occasions each year. Additional meetings may be required as agreed by the Board.

The terms of reference, objectives and outcomes of the Board will be reviewed annually.

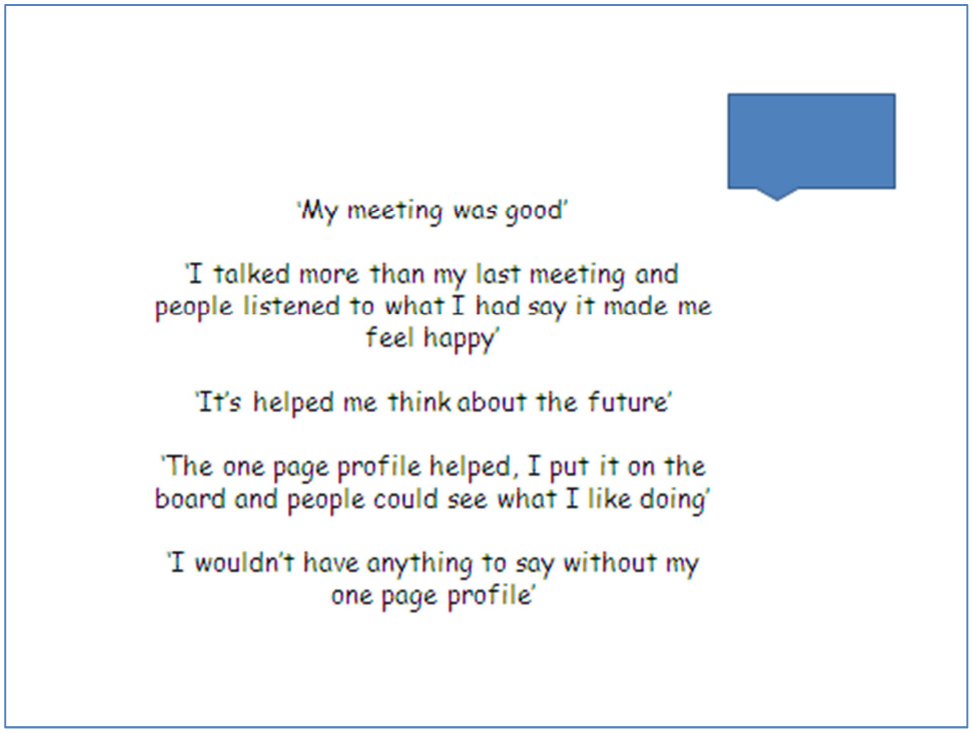
Appendix 2 Transition Pathway



Appendix 3 Illustration of Pathways to Getting a Life



Appendix 4 – Example One Page Profile



'The Person Centred approach has been valued by all the young people we have worked with.

In particular there has been a shift in emphasis to a broader celebration of the strengths, values and achievements of the whole person.

This has made for a much more positive and meaningful experience for both the young person and their parents.

Professionals working with the child (and often parents too) have discovered much they did not know.

It has created an atmosphere that allows for more honest and open discussions of the challenges faced.

The prior work done before the meeting with a trusted adult has been a key part of the process.

Following the meeting young people, like XXXX, have been much keener to discuss and refer back to the meeting; they really feel it was 'their meeting'.

It has supported the development of them taking responsibility for their future.

I have been impressed with how the young people have risen to the challenge of taking responsibility, meeting and greeting guests, presenting and participating'

Rachel Appell SENCO Norton Radstock School May 2012

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	Friday 20th September 2013
TITLE:	Urgent Care Update
WARD:	All
AN OPEN PUBLIC ITEM	
List of attachments to this report: No attachments	

1. THE ISSUE

To provide the Panel with an update on urgent care.

2. RECOMMENDATION

The Panel is asked to note this report.

3. FINANCIAL IMPLICATIONS

There are no financial implications in relation to this update.

4. THE REPORT

In November 2012, the Panel agreed the proposal recommended by the PCT and CCG to relocate the GP-led Health Centre to the RUH to create an Urgent Care Centre (UCC) following a public engagement process on the plans to redesign urgent care services.

One of the key messages from the public engagement process in 2012 about the proposed changes was GP access, in particular the ability for patients to get through on the phone to their GP practice and to get a same day appointment.

As a result the CCG implemented an urgent care incentive scheme (known as a local enhanced service) which each practice in BaNES agreed to take part in. The scheme enables practices to gain additional non-recurring funding for delivering improvements in the way they respond to patients with urgent care needs over and above their core contract funding.

This incentive scheme, which started in October 2012 and finishes at the end of March 2014, is aimed at making sustained changes in urgent primary care access. The scheme has required practices to take part in the Primary Care Foundation's audit tool which has enabled them to analyse performance on a number of key factors for managing access and urgent care, including:

- ease of access by phone

- consultation rates
- patient experience
- balance of same day and book ahead appointments
- use of telephone consultations
- home visits
- workload by staff group and;
- variation in response by the reception team.

The first six months of the incentive scheme required each practice to undertake the audit and develop action plans in response to the findings. It also required them to complete a baseline patient survey about access with a final survey to be completed in March 2014 to compare the results and the impact of any changes made. Overall the plans have a strong focus on appointment availability and telephone systems.

Subsequently the CCG invited Dr David Carson from the Primary Care Foundation to the BaNES GP Forum Plus meeting in June to present the audit findings as well as share his expertise and knowledge about the importance of primary care in the urgent care system. Dr Carson, who was a GP for ten years and spent four years developing GP out of hours services and emergency care policy and performance for the Department of Health, is well known for a number publications, including 'Raising Standards for Patients: New Partnerships in Out-of-Hours Care' (known as the 'Carson Report) and 'Urgent Care in General Practice.'

His presentation was thought provoking as it challenged some preconceived views and ideas. It also challenged some misconceptions about the management of urgent primary care all of which stimulated discussions in the practice clusters during the meeting resulting in some of the practices revising their action plans.

During July and August 2013 practices were asked for a brief update on progress with their plans. Every practice reported changes to their current systems in line with their actions. However, it is still too early to demonstrate the impact of these changes on patient satisfaction with primary care access.

The Panel may also be interested to note that in August 2013, NHS England launched a 'Call to Action' to stimulate debate in local communities about the future of general practice and how best to develop general practice services. NHS England has published an on-line survey on their website which is open for comments and feedback until 10th November 2013.

Urgent Care Centre Update

At the beginning of May 2013, the CCG, with the support of Central Southern Commissioning Support Unit, published the tender advert for the UCC on Supply2Health. The tender also included the re-commissioning of other BaNES urgent care services on the basis that the contract for these services ends on 31st March 2014.

- GP out-of-hours home visiting service
- GP out-of-hours face to face consultation service at Paulton Hospital
- GP out-of-hours medical cover to Paulton Hospital and St Martin's Hospital run by Sirona Care & Health CIC
- The homeless primary care service based at Julian House.

The CCG is currently in the procurement process and as such cannot disclose any information about who will run the services as it is commercially sensitive. However, the contract is expected to be awarded in November.

5. RISK MANAGEMENT

A risk assessment is not necessary in respect of this update report.

6. EQUALITIES

An equalities impact assessment is not warranted in respect of this update report.

7. ENGAGEMENT & CONSULTATION

All practices are engaged in taking forward the incentive scheme which requires them to undertake patient surveys.

8. ISSUES TO CONSIDER IN REACHING THE DECISION

Not relevant.

9. ADVICE SOUGHT

It wasn't necessary to seek advice from either the Council's Monitoring Officer (Council Solicitor) or the Section 151 Officer (Strategic Director – Resources & Support Services) on the contents of this update report.

Contact person	Corinne Edwards, Senior Commissioning Manager for Unplanned Care & Long Term Conditions, NHS Bath & North East Somerset, Tel: 01225 831868
Background papers	Primary Care Foundation, *Urgent Care: a practical guide to transforming same-day care in general practice*, May 2009 NHS Bath & North East Somerset Clinical Commissioning Group's *Integrated Commissioning Plan*, September 2012
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development and Scrutiny Panel
MEETING DATE:	20th September 2013
TITLE:	Draft B&NES Tobacco Control Strategy 2013 - 2018
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Draft B&NES Tobacco Control Strategy 2013 – 2018 B&NES CLeaR Peer Assessment for Excellence in Tobacco Control June 2013	

1 THE ISSUE

1.1 Smoking is still the single biggest cause of premature death and disease nationally and locally. Life expectancy varies in Bath & North East Somerset by up to 6.3 years for men in the most deprived areas and by 3.5 years for women. Smoking accounts for approximately half this difference in life expectancy. The existing B&NES Tobacco Control Strategy *Breathing Free* was written in 2006. Significant progress has been made nationally, regionally and locally since then and it is appropriate now to update local strategy in the light of this and set priorities which are in line with the new opportunities for public health and the changing local landscape within public services.

2 RECOMMENDATION

The Wellbeing Policy Development and Scrutiny Panel is asked to agree that:

2.1 The draft B&NES Tobacco Control Strategy is supported and taken forward for endorsement by B&NES Health and Wellbeing Board

2.2 The Strategy is refreshed in 2016 to update priorities and recommendations to ensure relevance to emerging local, regional and national issues.

3 **FINANCIAL IMPLICATIONS**

3.1 Each year in B&NES it is estimated that smoking costs society £39.9 million including the cost of lost productivity due to early death, sickness absence and smoking breaks as well as cost of NHS care, domestic fires and litter.

3.2 Annually smokers in B&NES spend approximately £45.3 million on tobacco products, approximately £1,700 per smoker per year. This contributes roughly £34.5 million in duty to the exchequer leaving an estimated annual funding shortfall of £5.5million. This shortfall is even greater if the lost tax revenue from illicit tobacco, which funds the activities of organised criminal gangs, is added into the equation.

3.3 Tobacco Control Investment in Bath & North East Somerset 2012/13

Specialist Support to Stop Smoking services[1]		375,138
Smoke Free South West Regional Programme[2]		79,032
Tobacco Control activity (inc. ASSIST programme)[3]		72,000
	Total £	**526,170**
Medication via GP's and Pharmacists[4]		260,647

The above investment is funded by Public Health Grant (£526,170) and B&NES Clinical Commissioning Group (£260,647).

3.4 Stop smoking services are one of the most cost effective interventions in public health care**,** and evidence shows that people are four times more likely to quit smoking if they have support.[5] Treating nicotine dependence produces a good return on investment compared to the cost of treating a wide range of smoking related chronic conditions. Preventing young people from taking up smoking in the first place reduces long term costs to health and social care through avoidance of treatment and care of people with diseases such as lung cancer, coronary heart disease, chronic obstructive pulmonary disorder and stroke for example.

3.5 The cost per 4 week quitter[6] in B&NES for 2010/11 was £480 per person compared to a South West average of £548 (CO validated & self-reported, including medication).[7]

[1] Specialist Stop Smoking support services are delivered through GP surgeries, pharmacies, GWH maternity services, Avon & Wiltshire Partnership NHS Trust and Sirona Care and Health.
[2] All local authorities in the South West collectively fund Smoke Free South West to undertake campaign, advocacy and professional network services. B&NES contribution is currently 40.5p per head of population.
[3] ASSIST is an evidence based peer education programme in Secondary Schools. Other Tobacco control work includes Smoke Free Play areas, smoke free policy work, training for staff and local campaign co-ordination.
[4] All medications to support cessation are funded by B&NES Clinical Commissioning Group
[5] Godfrey et al (2005) The cost-effectiveness of the English smoking treatment services: evidence from practice. Addiction, Volume 100, Issue s2
[6] A 4 week quitter is defined as a treated smoker whose quit status at four weeks from their quit date (or within 25 to 42 days of the quit date) has been assessed either face-to-face or by telephone, text, email or postal questionnaire.
[7] Willis N Options appraisal of Stop Smoking Service Delivery in South West. Commissioned by South West Directors of Public Health (March 2012)

3.6 The NHS threshold for cost effective interventions is £20,000 per Quality Adjusted Life Year (QALY) gained[8]. Support to stop smoking interventions typically cost £1080 per QALY and are considered one of the best buys in terms of public health.

3.7 Across the Avon area (Bristol, B&NES, South Gloucestershire, North Somerset) NHS Public Health departments invest over £3.8 million in tobacco control programmes annually, including specialist support to stop services.

3.8 By comparison, the Avon Pension Fund currently invests £11.8 million in Imperial Tobacco and British American Tobacco.[9] This is one area where Local Authorities with their new responsibilities for Public Health have an opportunity to look strategically at how money is invested to effectively support public health policy.

3.9 The recommendations contained in the draft Strategy can be delivered within the current Public Health Grant. The recommendation relating to Harm Reduction policy, in response to newly issued NICE Harm Reduction guidance (June 2013), could have financial implications for B&NES Clinical Commissioning Group (CCG) as the guidance recommends extending the provision of Nicotine Replacement Therapy to people for longer periods of time than currently prescribed and to people who would find it hard to give up smoking abruptly. Therefore the extent to which these guidelines can be adopted locally will need to be agreed with the CCG.

4 THE REPORT

4.1 Our vision is for a Smoke Free Bath and North East Somerset, where children and young people grow up free from the harms caused by tobacco.

4.2 Smoking related deaths and diseases in B&NES are lower than the English average and smoking prevalence is less than South West and England rates. However there are still over 23,000 smokers in B&NES, the majority from disadvantaged communities.

4.3 Smoking rates are much higher amongst people with mental health problems and people who work in routine and manual jobs in B&NES. There are higher rates of smoking amongst young pregnant women in B&NES and those who live in poorer areas. Young people are three times more likely to take up smoking if people in their family smoke. The cost of smoking exacerbates inequalities as poorer families are more likely to smoke. This leads to a demand for illegal tobacco which brings organised crime into communities and enables young people to have access to cheap tobacco. Tobacco control is central to any strategy to tackle inequalities according to Marmot (2010).

4.4 This draft B&NES Tobacco Control Strategy aims to reduce health inequalities by:

- Preventing young people from starting to smoke
- Encouraging smokers to quit

[8] A QALY is a standard and internationally recognised method to compare different drugs and treatments to measure their clinical effectiveness. A QALY gives an idea of how many extra months or years of life of a reasonable quality a person might gain as a result of treatment. Cost effectiveness is measured as £ per QALY, if a treatment costs more than £20,000-30,000 per QALY, then it would not be considered cost effective.

[9] http://www.avonpensionfund.org.uk/financeandinvestments/faqs.htm#1

- Reducing the harm from smoking through exposure to toxins from second hand smoke and harm to existing smokers

Local action will focus on achieving these aims through the following evidence based strands of Tobacco Control:

- Multi agency partnership working
- Normalising smoke free lifestyles
- Reducing exposure to second hand smoke
- Restricting supply of tobacco
- Helping people to quit
- Ensuring effective communications and marketing

4.5 The B&NES Tobacco Action Network is currently chaired by Public Health and has a membership representing the key stakeholders and service providers in the area. This includes Public Protection, Maternal and Child Health services, specialist cessation support providers, Fire & Rescue, school & youth services and mental health services.

4.6 The role of the TAN is to support workforce development, intelligence gathering, co-ordination of communications and marketing and the promotion of evidence based practice across the tobacco control community. The Tobacco Action Network will develop an Action Plan to take forward the recommendations within the Strategy and will oversee its monitoring and evaluation.

5 RISK MANAGEMENT

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

6 EQUALITIES

6.1 An EqIA has been completed. No adverse or other significant issues were found.

7 CONSULTATION

7.1 Ward Councillor; Cabinet Member; Policy Development and Scrutiny Panel; Staff; Other B&NES Services; Service Users; Local Residents; Community Interest Groups; Youth Council; Stakeholders/Partners; Other Public Sector Bodies; Section 151 Finance Officer; Chief Executive; Monitoring Officer

7.2 The B&NES Tobacco Action Network organised a multiagency workshop in May 2012 to review performance and priorities. Twenty people attended representing a range of professions/bodies including School/College Nursing, Maternity Services, District Nursing, Trading Standards, Specialist Stop Smoking Team, Local Pharmaceutical Committee, Smoke Free South West and Councillor representation from Wellbeing PDS. The issues raised in this workshop formed the outline for the draft Strategy.

7.3 The draft Strategy was then circulated for consultation amongst a wide range of professional groups including: Children’s Trust Board Healthy Lifestyle Sub Group, Young People’s Substance Misuse Group, Trading Standards, Children’s

Centres, Health Visiting team, Avon Fire Service, Avon & Wiltshire Partnership, Local Pharmaceutical Committee, Public Health and Sirona Care and Health.

7.4 From Jul – Oct 2012 the draft Strategy was available to the public on the B&NES Council website consultations page. Representatives from the DAFBY Young People's group were consulted face to face and the document was also circulated via other networks including Bath Racial Equality Council and B&NES Care Forum.

7.5 Action on Smoking and Health (ASH) developed a model for Peer Assessment of Excellence in Tobacco Control (CLeaR) during this period and the Tobacco Action Network decided to use this as a way to test assumptions and gain some objective feedback on our performance and future plans. The CLeaR model focuses on three areas; Vision and Leadership, Challenging your services and Results and provides a structured, evidenced based approach to achieving excellence in local tobacco control. Following a self-assessment exercise in Spring 2013, a Peer Assessment Day took place in June 2013. The assessment team included representation from Smoke Free South West, ASH and North Somerset Council.

7.6 The external assessors report accorded closely with our self-assessment and made some recommendations for additional areas of improvement. These have been included in the recommendations in the draft Strategy.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Human Resources; Property; Young People; Human Rights; Corporate; Health & Safety; Impact on Staff;

9 ADVICE SOUGHT

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

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

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Bath & North East Somerset Council

Smoke Free
Bath & North East Somerset

Draft
Tobacco Control Strategy
2013 - 2018

B&NES Tobacco Action Network
August 2013

Contents Page

Executive Summary

Smoking is still the single biggest cause of premature death and disease nationally and locally. Life expectancy varies in Bath &North East Somerset by up to 6.3 years for men in the most deprived areas and by 3.5 years for women. Smoking accounts for approximately half this difference in life expectancy.

Smoking related deaths and diseases in B&NES are lower than the English average and smoking prevalence is less than South West and England rates. However there are still over 23,000 smokers in B&NES, the majority from disadvantaged communities.

The Governments' Tobacco Control Plan (2011) sets targets for reducing smoking prevalence amongst pregnant women, young people and adults by 2015. This focus is reflected in the Public Health Outcomes framework which have become the responsibility of Local Authorities to deliver from April 2013.

There is strong local leadership and resourcing of tobacco control initiatives in B&NES and a comprehensive programme of evidence based work on tobacco control. The challenge locally is to deliver a co-ordinated population wide tobacco control programme whilst effectively targeting resources to reduce the significant inequalities in smoking prevalence within our communities.

This B&NES Tobacco Control Strategy aims to reduce health inequalities by:

- Preventing young people from starting to smoke
- Encouraging smokers to quit
- Reducing the harm from smoking through
    - exposure to toxins from second hand smoke and
    - harm to existing smokers

This will be achieved through a co-ordinated multiagency approach focussing on the following key strands of tobacco control:

- Multi agency partnership working
- Normalising smoke free lifestyles
- Reducing exposure to second hand smoke
- Restricting supply of tobacco
- Helping people to quit
- Ensuring effective communications and marketing

Recommendations for action (2013 – 2015) across all of these strands have been drawn up in consultation with a wide range of key stakeholders and will form the Tobacco Control Action Plan which will be overseen and monitored by the B&NES Tobacco Action Network.

Background

The World Health Organisation (WHO) Framework Convention on Tobacco Control is a treaty designed to reduce the health and economic impacts of tobacco globally. To date 175 countries have bound themselves to delivering on the Framework including the UK, which signed up in 2004.

The WHO Framework commits countries to a range of actions including reducing demand for tobacco through price and tax measures and non-price measures such as regulation of tobacco products and protection from exposure to tobacco smoke. It also includes actions to reduce supply of tobacco via illicit trade and sales to and by minors.

Specifically Article 5.3 of the WHO Framework aims to protect public health policies from the commercial and other vested interests of the tobacco industry. This applies to all levels of Government, national and local, and aims to encourage transparency and accountability amongst government officials and employees and avoid conflicts of interest.

The Marmot review (2010) states that tobacco control is central to any strategy to tackle health inequalities and to any prevention strategy[1]. It identified the driver of health inequalities as social inequalities created by differences in living standards, occupation and education for example. One of Marmot's key proposals linked to reducing cardiovascular disease and cancers is:

'Reduce smoking in the most marginalised groups by focusing on price and availability, while providing stop smoking services targeted to help the poorest groups quit'.

In March 2011 the coalition Government launched Healthy Lives, Healthy People: A Tobacco Control Plan for England with the aim of '*achieving a demonstrable reduction in inequalities by improving the health of the poorest fastest by prioritising smoking'.*[2] The Plan aligns with the key strands of the WHO Framework and references the findings of Marmot.

The Plan states that measures need to be active at local, regional, national and international level to be effective and sets out how the Plan fits with the localism agenda.

National targets have been set to reduce smoking levels amongst young people, pregnant women and the general population and are also part of the new Public Health Outcomes Framework from April 2013.

[1] Marmot (2010) Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010

[2] Department of Health (2011) Healthy Lives: Healthy People: A Tobacco Control Plan for England

National Targets

- To **reduce adult (aged 18 or over) smoking prevalence to 18.5% or less** by the end of 2015 (from 21.2%)

- To **reduce rates of regular smoking among 15 year olds to 12% or less** (from 15%) by the end of 2015

- To **reduce rates of smoking throughout pregnancy to 11% or less** (from 14%) by the end of 2015 (measured at time of giving birth)

From April 2013 local authorities have responsibility for achieving the public health outcomes for smoking. In order to ensure smoking prevalence continues to decline, a strategic multi layered approach is recommended which ensures all elements of the six internationally recognised strands of tobacco control are being addressed including:

- Making smoking less affordable
- Reducing exposure to second hand smoke
- Stopping the promotion of tobacco
- Regulating tobacco products more effectively
- Helping smokers to quit
- Producing effective communications for tobacco control

The Tobacco Control Plan identifies key opportunities with the move of public health to local authorities including improved compliance with regulations, tailoring services such as cessation support to local need and enhanced opportunities to engage local communities in the development and delivery of local initiatives. Equally there are significant opportunities to embed smoke free policies across the broad spectrum of local authority responsibilities.

The existing B&NES Tobacco Control Strategy *Breathing Free* was written in 2006. Significant progress has been made nationally, regionally and locally since then and it is appropriate now to review local strategy in the light of this and set priorities which are in line with the new opportunities for public health and the changing local landscape within public services.

Strategic Vision

Our vision is for a smoke free Bath and North East Somerset, where children and young people grow up free from the harms caused by tobacco.

This B&NES Tobacco Control Strategy aims to reduce health inequalities by:

- Preventing young people from starting to smoke
- Encouraging smokers to quit
- Reducing the harm from smoking through
    - exposure to toxins from second hand smoke and
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Local action will focus on achieving these aims through the following key strands of Tobacco Control:

- Multi agency partnership working
- Normalising smoke free lifestyles
- Reducing exposure to second hand smoke
- Restricting supply of tobacco
- Helping people to quit
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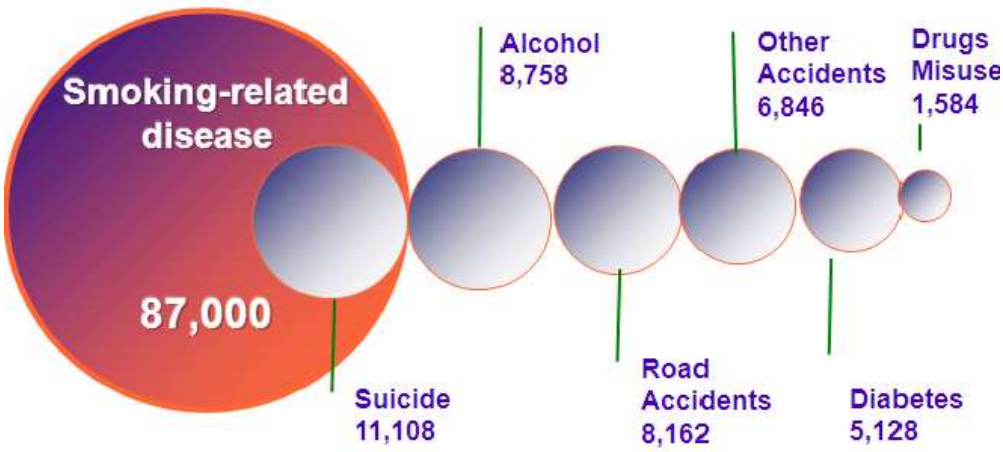
The current picture of smoking in B&NES

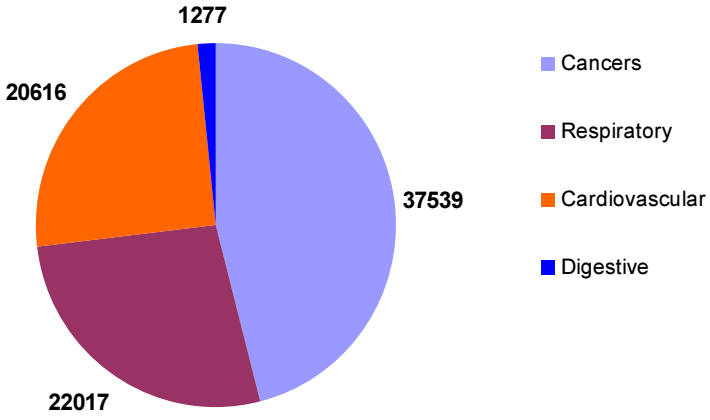
Smoking is still the single biggest cause of premature death and disease nationally and locally. Smoking related deaths are more numerous than the next 6 most common causes of preventable death combined (drug use, road accidents, preventable diabetes, suicide, other accidents and falls and alcohol abuse).[3]

Figure 1 Causes of preventable death annually



The top 3 causes of mortality in B&NES are diseases of the circulatory system (heart etc.), followed by neoplasms (Cancer), and respiratory diseases (lungs)[4]. These diseases (in particular, heart attack, stroke, lung cancer and chronic obstructive pulmonary disease (COPD)) are responsible for the majority of smoking related deaths (see figure 2).

Figure 2 Smoking attributable deaths from major causes (England 2009)[5]



Total deaths 87,000

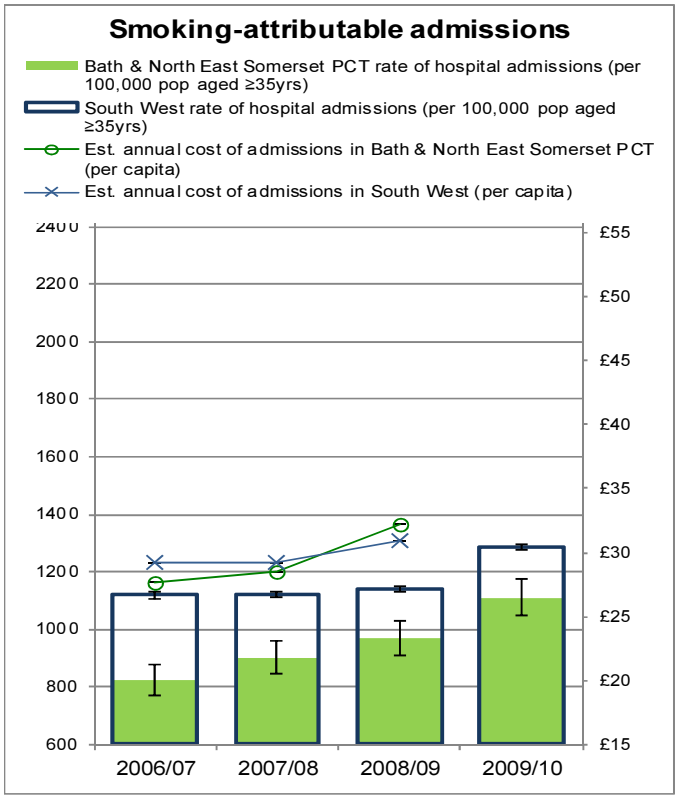
[3] Department of Health (2011) Healthy Lives Healthy People: A Tobacco Control Plan for England
[4] Joint Strategic Needs Assessment, Bath and North East Somerset Draft (March 2012)
[5] NHS Information Centre (2009), Statistics on smoking: England 2009 available at www.ic.nhs.uk/webfiles/publications/smoking09/statistics_on_smoking_england_2009.pdf

Life expectancy varies in B&NES by up to 6.3 years for men in the most deprived areas and by 3.5 years for women. Smoking accounts for approximately half the difference in life expectancy. Smoking related diseases such as cardiovascular disease and lung cancer are more prevalent in disadvantaged communities.

300 people die prematurely in B&NES due to smoking related diseases each year. One in two smokers will die from a smoking related cause and life time smokers will lose approximately 10 years of life.

Smoking related deaths and diseases in B&NES are lower than the English average, with the exception of stroke which is in line with England average[6]. Smoking attributable hospital admissions are rising, this is considered to be a consequence of people living longer with chronic conditions (see figure 3).

Figure 3 B&NES Smoking Attributable Hospital Admissions 2006/7 – 2009/10



Overall smoking prevalence amongst adults in B&NES is 16.4%, this equates to 23,308 smokers 18 years and over[7]. This is lower than national (21%) and South West prevalence (19%). Local data suggests 56% of B&NES smokers want to give up.[8]

[6] Local Tobacco Control Profiles for England (2011) www.lho.org.uk
[7] Integrated Household Survey ONS Smoking prevalence by region and local authority April 10 – March 11 www.lho.org.uk
[8] Bath and North East Somerset Council (2010) Voicebox 18 Survey, in-house analysis

Nationally smoking prevalence has been declining steadily since the 1960's. However the downward trend has stalled in recent years and now seems to be levelling out, with little change in prevalence rates since 2008. Experience from other countries indicates that smoking prevalence can be reduced even more. Australia, Sweden and parts of the USA have reduced smoking prevalence to 15%, 15% and 11.9% respectively. Australia has the lowest prevalence of smoking amongst 14 –17 year olds in the world at 2.5%.

Research has shown that the decline in smoking rates in the UK has slowed since the start of the economic recession. [9] Prevalence has reduced across all social gradients however the gap between the socio economic groups has stayed constant. Smoking is becoming more engrained in specific communities and there has been a shift in smoking behaviour with a rise in use of Hand Rolling Tobacco (HRT), 53% of smokers in the South West roll their own, the highest rate in the UK.

Smoking in pregnancy

Tobacco smoke contains over 4,000 chemicals many of which can cross the placental barrier and have a direct toxic effect on the foetus.[10] Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy. Smoking during pregnancy also increases the risk of infant mortality by an estimated 40%.[11]

Smoking amongst pregnant women in B&NES is currently 9.4% compared to a national level of 12.7%. However there are marked differences in levels of smoking amongst younger women who are pregnant and those who live in different areas of B&NES. For example, 35% of under 18's who are pregnant in B&NES smoke and there are much higher rates of smoking amongst pregnant women in the Radstock (32%) Twerton (22%) and Keynsham (15.4%) children centre catchment areas compared to other areas of B&NES.

Children and young people

Very few adults take up smoking for the first time. Two thirds of smokers say they began before they were legally old enough (18 years) to buy cigarettes and 9 out of 10 before the age of 19 [12]. Nicotine addiction starts in adolescence.

National surveys show that the proportion of secondary school pupils who have ever smoked continues to decline.[13] In 2010, 27% of 11 – 15 year olds

[9] West R, Brown J Fidler J (2012) Key findings from the Smoking Toolkit Study presentation www.smokinginengland.info
[10] Royal College of Physicians (March 2010) Passive Smoking in Children
[11] Department of Health: 2007 Implementation plan for reducing health inequalities in infant mortality
[12] http://ash.org.uk/localtoolkit/docs/cllr-briefings/Children.pdf
[13] NHS Information Centre; Smoking, drinking and drug use among young people in England in 2010. National Centre for Social Research

had smoked at least once, compared to 53% in 1982. Smoking increases with age, becoming more prevalent as children progress through secondary school, and more girls are smoking than boys.

Regular smoking is associated with other risky behaviours such as drinking alcohol and taking drugs. Cannabis, which is commonly smoked with tobacco, is the most commonly used drug amongst Year 10 pupils in B&NES, with 9% reporting using it within the last month.

Those young people who have truanted from school or been excluded at some point are more likely to be regular smokers. Children are three times more likely to smoke if their parents smoke and the vast majority of 16yr old regular smokers live in a household with at least one other smoker. The younger the age of uptake of smoking, the greater the harm is likely to be because early uptake is associated with subsequent heavier smoking, higher levels of dependency, a lower chance of quitting, and higher mortality.

The local Secondary School age survey (Yr 8 and 10) in B&NES[14] reported that:

- 24% of pupils said they have tried smoking in the past or are smoking now
- 8% said they smoke regularly or occasionally (compared to 9% in national sample)
- 6% smoked at least one cigarette during the last 7 days (compared with 9% of national sample)
- 12% of year 10 boys and 21% of year 10 girls said that they smoke 'occasionally' or 'regularly'
- 13% of B&NES primary school pupils think they may smoke when they are older compared to 10% of the national survey.

The two Further Education Colleges in Bath & North East Somerset have carried out similar surveys of health related behaviours amongst students, including smoking. A Bath City College survey in spring 2013 involving 325 students indicated that 28% of students smoke (80% of which is hand rolling tobacco) and 21% started smoking when they joined the College. The majority of smoker (65%) said they wanted to quit.

Second hand smoke

Second hand smoke is made up of the smoke emitted from the burning end of a cigarette or other tobacco product, in combination with smoke exhaled by the smoker. It contains a number of toxins and is carcinogenic to humans. Evidence shows that exposure to second hand smoke causes death, disease and disability in children and adults. A 2010 report from the Royal College of

[14] NHS B&NES (2011) Primary and Secondary Health Related Behaviour Survey: Bath & North East Somerset

Physicians estimates that exposure to second hand smoke impacts the health of children in the UK each year in the following ways[15]:

- around 20,500 new cases of lower respiratory tract infection in children under the age of 3 years
- 121,400 new cases of middle ear disease in children of all ages
- 22,600 new cases of wheeze and asthma
- at least 200 cases per year of bacterial meningitis
- 40 sudden infant deaths

This report also concludes that passive smoking is a significant contributor to the levels of health inequalities in terms of incidence of these diseases across socio economic gradients.

Local survey data tells us that 33% of B&NES 11 – 15 year olds say at least one person regularly smokes indoors in their home[16]. This is lower than the national comparator (40%) but still a significant number exposed to second hand smoke and smoking behaviours.

Routine and manual workers

The percentage of people in routine and manual jobs who smoke in B&NES is 26% (2011/12) compared to 30.2% regionally and 30.3% nationally and B&NES average of 16.4%.[17] Smokers from lower socio economic groups are no less likely to try to give up smoking, however they are less likely to succeed.[18] This suggests that some groups face social and economic barriers that may inhibit their ability to quit.

Mental health and smoking

Smoking rates are much higher amongst people with mental health problems than the general population. Research has found that people with depressive episodes, phobias or obsessive compulsive disorders were twice as likely as those without these conditions to smoke. Also smokers with mental health problems are heavier and more dependent smokers than the general population.[19] There is evidence to suggest that smoking is a factor in the onset and worsening of mental health conditions, specifically depression and anxiety related problems.[20]

[15] Royal College of Physicians: March 2010 Passive smoking in Children
[16] NHS B&NES (2011) Primary and Secondary Health Related Behaviour Survey: Bath & North East Somerset
[17] Local Tobacco Profile (2010) www.lho.org.uk
[18] Kotz D, West R. Explaining the social gradient in smoking cessation: it's not in the trying, but in the succeeding. *Tob Control.* Feb 2009;18(1):43-46.
[19] NHS Health Development Agency (2004) Smoking in patients with mental health problems
[20] McNally L (2009) Quitting in mind. A guide to implementing stop smoking support in Mental Health settings. London Development Centre

Smoking and ethnicity

Smoking rates amongst ethnic groups are generally lower than the population as a whole. However rates vary considerably between ethnic groups and amongst men and women within ethnic groups. Higher rates of smoking are found in men in Black Caribbean (37%) Bangladeshi (36%) Chinese (31%) and White Other (30%) populations. These differences could be explained by socio economic differences between groups. Smoking rates among women are low with the exception of Black Caribbean (24%) and White Irish (26%) populations.[21]

Bath and North East Somerset is less ethnically diverse than the UK as a whole but more so than the South West. 88% of residents are likely to define their ethnicity as White British. White Other (3.66%) is the most significant non White British ethnicity by volume which is likely to include EU Accession state residents (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia), followed by "Asian Indian" (1.97%), "Chinese/Other ethnic background" (0.96%), "Black African" (0.9%) and White Irish (0.7%).[22]

Evidence shows that minority ethnic groups in England are as ready to quit smoking as the general population, however fewer have made an attempt to stop through using professional support. Whilst the black and minority ethnic population in B&NES is 7.66% only 2.8% of people accessing cessation support services during 2011/12 were from these groups. Those from BME groups setting a quit date were also less likely to successfully quit (36% quit rate) compared to the other groups (52%).

Smoking related fire deaths and casualties

Nationally, smokers' materials (i.e. cigarettes, cigars or pipe tobacco) were the most frequent source of ignition causing accidental dwelling fire deaths, accounting for over a third of all accidental dwelling fire deaths in 2010-11. For every 1,000 accidental dwelling fires (where smokers' materials were the source of ignition), 35 people were killed in 2010-11. Since 2000-01, such deaths have become increasingly less common and there has been a downward trend in the figures for most of the decade.[23]

Avon Fire & Rescue reported a 13% reduction of primary fires in 2010/11 (2,295 reduced to 2,004) and a 12% reduction in fire related injuries. There were 12 primary fire deaths in the Avon area in 2010/11(1.1 per 100,000 population) this is higher than the South West rate (0.7 per 100,000). Of these deaths, 4 involved smoking materials. During 2011/12, there were 5 primary fire deaths in the Avon area, none of these were caused by smoking materials.

[21] Millward D and Karlsen S Tobacco Use among Ethnic Minority populations and cessation intervention. A Race Equality Foundation Briefing Paper May 2011 www.better-health.org.uk
[22] B&NES JSNA Technical Summary Document 2012 www.bathnes.gov.uk/jsna
[23] Fire Statistics Great Britain 2010/11 Communities and Local Government http://www.communities.gov.uk/publications/corporate/statistics/firestatsgb201011

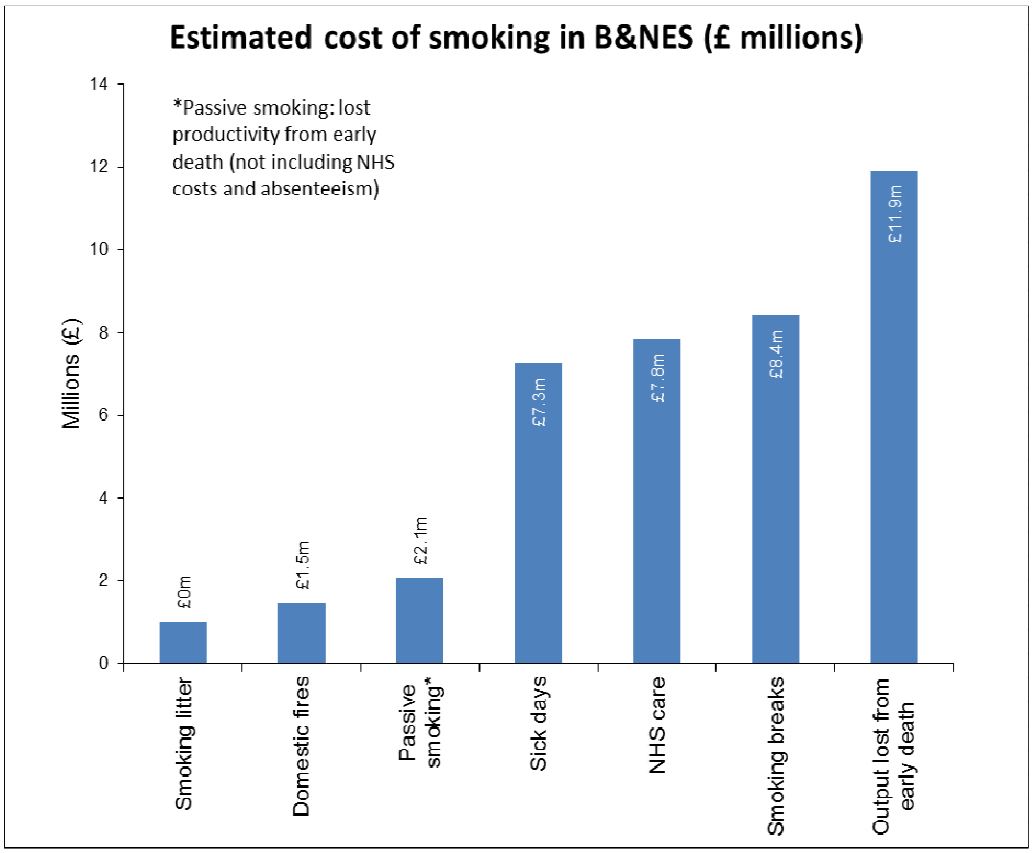
The financial costs of smoking

Whilst tax on tobacco contributes £10 billion annually to the Treasury, the true costs to society from smoking are far higher, at £13.74 billion.[24] This cost is made up of the cost of treating smokers on the NHS (£2.7 billion) but also the loss in productivity from smoking breaks (£2.9 billion) and increased absenteeism (£2.5 billion); the cost of cleaning up cigarette butts (£342 million); the cost of fires (£507 million), and also the loss in economic output from the deaths of smokers (£4.1 billion) and exposure to second hand smoke (£713 million).

Using the above figures the ASH (Action on Smoking and Health) Ready Reckoner was used to estimate the overall economic burden of smoking in B&NES (see figure 4). [25]

Each year in B&NES it is estimated that smoking costs society £39.9 million. Annually smokers in B&NES spend approximately £45.3 million on tobacco products, approximately £1,700 per smoker per year. This contributes roughly £34.5 million in duty to the exchequer leaving an estimated annual funding shortfall of £5.5million.

Figure 4 Estimated costs of smoking in B&NES



Note above figures based on 2011 estimated smoking population in B&NES of 25,600.

[24] Featherstone H & Nash R (2010) Cough Up; Balancing tobacco income and costs in society. Policy Exchange

[25] http://ash.org.uk/localtoolkit/R9-SW.html

Across the Avon area (Bristol, B&NES, South Gloucestershire, North Somerset) NHS Public Health departments invest over £3.8 million in tobacco control programmes annually, including specialist support to stop services[26]. See Appendix 1 for a breakdown of B&NES Tobacco Control investment for 12/13.

By comparison, the Avon Pension Fund currently invests £11.8 million in Imperial Tobacco and British American Tobacco.[27] This is one area where Local Authorities with their new responsibilities for Public Health have an opportunity to look strategically at how money is invested to effectively support public health policy.

What works in Tobacco Control?

There are six internationally recognised strands of tobacco control which have become the core of tobacco control policies worldwide:

- Making smoking less affordable
- Regulating tobacco products more effectively
- Reducing exposure to second hand smoke
- Stopping the promotion of tobacco
- Helping people to quit
- Producing effective communications for tobacco control

The most effective policies are those aimed at changing behaviour on a population level through regulation and enforcement, reinforced by co-ordinated local action and support for individuals in quitting.

Making smoking less affordable

Research has consistently shown that cigarette price increases, through taxation, reduce tobacco consumption. The UK now has the most expensive cigarettes in the EU apart from Ireland. The average cost of a pack is now £7.46. Even though the price is high, tobacco is still more affordable now that it was in the 1960's relative to income[28]. High prices can deter children from smoking, since young people do not possess a large disposable income and have been shown to be more price sensitive than adults.

Regulating tobacco products more effectively

Illegal tobacco

The public health benefits of taxation are undermined by illegal supply and in times of recession people are looking for cheaper alternatives, fuelling the market for illegal tobacco. It is estimated that 147 million packets of illegal

[26] Costs include Specialist Support to Stop Services, Medication, Smoke Free South West Programme, ASSIST programme costs and Tobacco Control co-ordinators.
[27] http://www.avonpensionfund.org.uk/financeandinvestments/faqs.htm#1
[28] Nash R, Featherstone H. Cough Up. Balancing tobacco income and costs in society Policy Exchange Research Note March 2010

cigarettes are smuggled into the South West every year and over half of all hand rolled tobacco is counterfeit.[29]

Whilst there has been a significant reduction in the illicit tobacco market in the UK since 2000, from 21% to 11% of the cigarette market and from 61% to 49% for hand rolling tobacco, illicit tobacco still represents a significant proportion of consumed tobacco especially within poorer communities.[30]

Around one fifth of the South West smoking population admit to purchasing illicit tobacco. Smokers buy from a wide variety of outlets. These range from independent shops to houses in local communities, pubs/clubs, markets and ice-cream vendors selling illicit tobacco to children. This illegal trade has a direct impact on the profits of legitimate retailers.

Routine and manual workers are more likely to use illicit tobacco and the majority of smokers from disadvantaged and poorer backgrounds agree that illegal tobacco makes it affordable for them to smoke. Smuggling therefore contributes to widening health inequalities. Smuggling is usually one part of wider organised crime and is used to fund other criminal activities.[31] The same channels previously used for dealing Class A drugs are now being used for illicit tobacco due to its profitability and relatively low risk in terms of punishment when caught.

The South West Region's coalition of Trading Standards (SWERCOTS) have identified an intelligence gap in relation to understanding the illicit tobacco trade in the region.

Under age sales

Legislation introduced in the UK in 2007 increased the legal age of purchase of tobacco products from 16 years to 18 years. This did contribute to a drop in the proportion of 11 – 15 year olds who said that they bought cigarettes in shops, however 2010 national data showed that a high proportion (58%) of 'regular' smokers in this age group still report purchasing cigarettes from shops.[32] In B&NES, 9% of those who smoke say they got them from a shop and 41% say they got them from friends.[33]

Proxy purchase, when someone else buys cigarettes on behalf of children, is commonly reported amongst 11-15 year olds. This is usually done by older friends or strangers. At present it is not illegal to buy cigarettes for children in this way.

Section 5 of the *Children and Young Persons (Protection from Tobacco) Act 1991*[34] requires every local authority to consider a programme of enforcement

[29] Smoke Free South West (2010) NEMS Market Research
[30] HMRC (2011) Tackling Tobacco Smuggling – building on our success
[31] LACORS 2010, Illicit Tobacco: An introductory guide for enforcement agencies. Local Government Association
[32] NHS Information Centre; Smoking, drinking and drug use among young people in England in 2010. National Centre for Social Research
[33] NHS B&NES (2011) Primary and Secondary Health Related Behaviour Survey: Bath & North East Somerset
[34] http://www.legislation.gov.uk/ukpga/1991/23/contents

at least every 12 months. Trading Standards officers carry out test purchases of cigarettes using young people 16 years of age or younger. On average 15% of test purchases lead to an illegal sale. Figure 5 below shows the type of premises where illegal sales occur.[35]

Figure 5 Test Purchases in retail premises leading to illegal sales by type

Test Purchases made in retail premises	
Type	% of illegal sales
Petrol Station Kiosk	23
Small retailer	18
Independent Newsagent	18
Off Licence	13
Large retailer	10
National newsagent	9

Fire safer cigarettes

In November 2011 European Union legislation was introduced requiring cigarette manufacturers to comply with a new fire safety standard BS EN 16156:2010. All cigarettes now sold in the EU must comply with this standard of reduced ignition propensity which means that, once lit, the cigarette goes out if it is not actively smoked. Cigarettes now have special bands at intervals down the length of the cigarette paper so that they extinguish themselves when they are not puffed on which dramatically cuts the risk of fire. It is estimated that this legislation could cut the number of smoking related fires and fire deaths by two thirds. In 2010, Finland became the first EU country to require fire safer cigarettes reducing the number of smoking related fire deaths by 40% in one year.[36] The trade in illicit tobacco could undermine these benefits as illegal cigarettes are unlikely to comply with EU product safety standards and therefore are a greater fire risk.

Reducing exposure to second hand smoke

Smoke Free legislation introduced in 2007 in England has been highly effective in reducing exposure to second hand smoke in work and public places. It has also resulted in significant reduction in the number of hospital admissions for heart attacks[37]. There has also been an increase in the number of homes with smoking restrictions since the Smoke Free legislation was introduced. Experience in other countries demonstrates that extension of the legislation to cars, parks, beaches and other public areas could prove popular and effective.

[35] Local Government Group (2011) Tobacco Control Survey 2010/11. A report of council trading standards service activity
[36] RIP Coalition; http://www.firesafercigarettes.org.uk
[37] Sims M, Maxwell R, Bauld L & Gilmore A. The short-term impact of smokefree legislation in England: a retrospective analysis on hospital admissions for myocardial infarction. BMJ 2010;340:2161

A recent survey showed wide spread public support in the South West for going completely smoke free on hospital grounds (62%), in play areas (76%) and in cars carrying children under 18 months (80%).[38]

Tobacco control activities are increasingly about the protection of children. Safeguarding children from exposure to tobacco is fundamental to preventing them becoming smokers in the long term and protecting their health. The best way to protect children from the harms of tobacco is to get those around them to quit. This protects them from second hand smoke at home and in the car and also reduces their exposure to smoking behaviour, which role models healthy lifestyles.

'Young people are more likely to smoke if their parents smoke. If you stop adults from smoking then more young people wouldn't want to smoke'

DAFBY member

Research suggests that knowledge about smoking is a necessary component of smoking campaigns but by itself does not affect smoking rates. It may result in a postponement of initiation as part of a whole school smoke free policy.

Stopping the promotion of tobacco

UK Legislation in 2002 (Tobacco Advertising and Promotions Act) has banned most direct and indirect advertising of cigarettes. Also a point of sale display ban in supermarkets came into force in April 2012 and will be enforced in small retailers from 2015. However there are still many areas of media where smoking imagery is still widely used and seen by young people specifically in TV programmes, films, on the internet, through video games and in music videos. Local feedback from members of Democratic Action for Youth in B&NES (DAFBY) confirms the power of the media in making smoking attractive.

'Films make smoking more noticeable than cigarette packets – they give smoking a good image. You see people smoking and think about doing it (especially when it's one of your) role models' DAFBY member

The packaging of cigarettes and other tobacco products is also key to communicating brand identity and favourable imagery to children about smoking. It is interesting to note that the tobacco industry have begun to specifically target the branding of hand rolling tobacco at young people.

The Government is currently considering whether or not to legislate for plain packaging of tobacco products in the UK, as is the case in Australia. Research suggests that plain packaging would increase the impact of health

[38] ASH (2011) Tackling Tobacco: Public Opinion in the South West http://ash.org.uk/localtoolkit/docs/R9-SW/PO-R9-SW.pdf

warnings, reduce false and misleading messages that one type of cigarette is less harmful than another, and reduce the attractiveness of products to young people.[39]

Helping people to quit smoking

Stop smoking services are one of the most cost effective interventions in public health care**,** and evidence shows that people are four times more likely to quit smoking if they have support.[40] Treating nicotine dependence produces a good return on investment compared to the cost of treating a wide range of smoking related chronic conditions.

Harm reduction for smokers

Smokers have an almost universal regret about having started smoking and the majority want to give up, and make many attempts to quit[41].

Whilst there are health harms associated with all tobacco use, smoking tobacco is by far the most hazardous to health. If people are unable to quit nicotine altogether it has been argued that they can reduce harm by stopping smoking to get nicotine and use a safe pharmaceutical nicotine product instead.[42] As those from disadvantaged communities are more likely to smoke, are heavier smokers and their children are more likely to be exposed to second hand smoke and start smoking younger, it can be argued that harm reduction approaches will contribute to reducing inequalities in health.

NICE has recently published guidance on tobacco harm reduction. While recognising that quitting smoking is always the best option for smokers, the NICE guidance supports the use of licensed nicotine containing products (NCPs) to help smokers not currently able to quit to cut down and as a substitute for smoking, where necessary indefinitely. This guidance does not cover tobacco containing products or E cigarettes as they are currently not licensed.

On 12th June 2013 the Medicines and Healthcare Products Regulatory Agency (MHRA) announced its intention to regulate nicotine containing products, such as E cigarettes, as medicines. Electronic cigarettes that are currently on the market will not be required to obtain a medicine license until the proposal in the European Commission's revised Tobacco Products Directive is agreed and transposed into law. The revised Directive is expected to be adopted in 2014 and to come into effect in 2016.

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[39] University of Stirling (2011) Plain Tobacco Packaging: A Systematic Review

[40] Godfrey et al (2005) The cost-effectiveness of the English smoking treatment services: evidence from practice. Addiction, Volume 100, Issue s2

[41] Chapman S Freeman B. Markers of the denormalisation of smoking and the tobacco industry. Tobacco Control 2008: 17 25 - 31

[42] Royal College of Physicians (2007) Harm reduction in nicotine addiction: Helping people who can't quit

Producing effective communications for tobacco control

In the context of a holistic tobacco control approach mass media campaigns have been shown to drive quit attempts both nationally and regionally. They educate about harms, set the agenda for discussion locally, change beliefs and attitudes and increase quit intentions and attempts. Television is the prime media for maximum audience penetration but this also needs to be backed up by local press and publicity to reinforce messages. Equally campaigns need to be on-going, sustained and of sufficient intensity and reach to be effective.

B&NES Tobacco Control Activity

Multi agency partnership working

The B&NES Tobacco Action Network is currently chaired by Public Health and has a membership representing the key stakeholders and service providers in the area. This includes Public Protection, Maternal and Child Health services, specialist cessation support providers, Fire & Rescue, school & youth services and mental health services. It has been in existence since 2002 however momentum and leadership has varied over this time.

The role of the TAN is to support workforce development, intelligence gathering, co-ordination of communications and marketing and the promotion of evidence based practice across the tobacco control community.

The TAN is currently meeting quarterly. Membership of the TAN has been static for the last 2 years and engagement from local authority councillors, leaders and local employers with this agenda has been opportunistic to date. The links with the wider Health and Wellbeing Strategy and reporting structure need to be clarified and formalised to ensure strategic engagement and support for the work of the group.

The B&NES Children & Young People's Plan has recently consulted on a number of 'narrowing the gap' indicators for children's health and wellbeing. Two smoking related indicators have been adopted for monitoring by the Children's Trust Board. These are smoking at time of delivery for young pregnant women compared with those over 25 years and the percentage of year 10 pupils who smoke by gender. These indicators will help to raise the profile of inequalities in these areas and track progress over time.

Action on Smoking and Health (ASH) developed a model for Peer Assessment of Excellence in Tobacco Control (CLeaR) during 2012/13 and the B&NES Tobacco Action Network decided to use this as a way to test assumptions and gain some objective feedback on our performance and future plans. The CLeaR model focuses on three areas; Vision and Leadership, Challenging your services and Results and provides a structured, evidenced based approach to achieving excellence in local tobacco control.

The Peer Assessment Day took place in June 2013. The assessment team included representation from Smoke Free South West, ASH and North Somerset Council.

The external CLeaR Report accorded closely with our self-assessment and made some recommendations for additional areas of improvement. These have been included in the relevant sections below:

Recommendations

- Clarify governance arrangements for Tobacco Control Strategy and Tobacco Action Network in line with the Health and Wellbeing Board structure.

- Council to consider an organisation wide policy in line with WHO Framework Convention on Tobacco Control to provide guidance for staff and members and protect work on Tobacco Control from the vested interests of the tobacco industry.

- Broaden engagement with the Tobacco Action Network to include Council members, clinical input, representation from the Clinical Commissioning Group/primary care and Universities.

- Increase capacity and skills development in tobacco control locally

- Develop, agree and monitor local targets for tobacco control that contribute to narrowing the gap in health inequalities locally.

- Increase the engagement and involvement of young people in activities of the Tobacco Action Network.

Normalising smoke free lifestyles

National Institute for Health & Clinical Excellence (NICE) recommended smoking prevention interventions within school settings are implemented in B&NES. Smoking education is provided to all pupils through the structured Personal Social and Health Education (PSHE) programme in schools and a whole school approach to tobacco control is supported as part of the Director of Public Health Award launched in May 2012 (previously Healthy Schools Award and Healthy Schools plus programme). The two further education colleges in Bath & North East Somerset are working towards becoming health promoting colleges through the Director of Public Health Award

NHS B&NES also commission an evidence based initiative to support children and young people to resist the temptation to take up smoking. ASSIST is a peer led programme in secondary schools (year 8) which has been shown to

prevent uptake of smoking up to 2 years after implementation[43]. This programme is currently in its third year of operation in B&NES, with the majority of schools having taken part at least once. The programme is not suitable for smaller schools and not adapted for special schools therefore an alternative is needed to ensure equity of access to this programme.

Recommendations:

- Ensure all secondary schools in B&NES undertake the ASSIST programme (or equivalent) annually including how the approach can be adapted so that smaller schools and special schools can participate.

- Carry out regular baseline surveys of health related behaviours in Schools and Further Education Colleges to inform local action and monitor progress

- Provide on-going support to Further Education Colleges in developing a whole college approach to becoming Smoke Free

- Incorporate the principles of a Smoke Free Environment into local authority Play Policy and other relevant policies

Reducing exposure to second hand smoke

Tobacco control services are commissioned via Sirona Care & Health to support implementation of the Smoke Free Homes, Play Areas and Hospital settings. Settings are supported through policy development, training, guidance and links to national and regional campaigns. Avon Fire and Rescue service also support implementation of the Smoke Free Homes campaign.

B&NES Council Public Protection teams support on going enforcement of Smoke Free legislation in local workplaces, public spaces and entertainment venues.

Recommendations:

- Implement further training for frontline staff in health and social care to deliver brief interventions on smoking and second hand smoke to support embedding of Smoke Free Homes Programme (including Family Nurse Partnership)

- Develop and evaluate the Smoke Free play areas project across B&NES

- Work with the Royal United Hospital to ensure effective implementation of Smoke Free policy and practice

[43] Campbell R et al. (2008) An informal school based peer-led intervention for smoking prevention in adolescence (ASSIST); A cluster randomised control trial Lancet 2008 371:1595 - 1602

- Undertake work with mental health service providers on the development of Smoke Free Policies

Restricting supply of tobacco

B&NES Trading Standards receive a low level of complaints about illegal sales of tobacco, either under age or illicit, compared to other products such as alcohol or knives. They run test purchasing and product testing in response to complaints within existing resources.

Very little information about illicit tobacco is passed on to trading standards by the public or other agencies and local trading standards are keen to work collectively with professionals and community members to improve intelligence to inform local action.

Recommendations

- Improve local professionals and community understanding of the illegal tobacco trade and its impact on communities

- Improve local intelligence from professionals and the community regarding the sale of illicit tobacco and under age sales

- Increase the awareness and engagement of young people in test purchasing process

- Increase engagement of local communities in tackling the issue of illegal tobacco and under age sales.

Helping people to quit

Smoking cessation services are currently provided across B&NES through a Specialist Support to Stop service and through GP surgeries, pharmacies, maternity services and mental health services. In total, over 120 professionals have been trained across B&NES to provide stop smoking support services.

Since 2009 in B&NES, over 2000 people each year access the smoking cessation support services and set a quit date. This is approximately 8% of the smoking population, above the Department of Health recommended 5% but still only a small proportion of those smoking. Numbers of people using cessation services are rising year on year however the quit rate has been declining year on year, falling from 62% to 52% in 2011/12. This is a trend mirrored across the South West region. Nationally the average quit rate is 49%.

B&NES local services are effective in reaching people across the social gradients however people from black and minority ethnic groups and young people are under-represented and those in the most deprived areas of

B&NES are less successful at quitting than other service users, suggesting further support is needed for some groups to access the service, and to improve outcomes for others.

Recommendations

- Target cessation services more effectively at disadvantaged groups including those with mental health conditions, young women who are pregnant, black and minority ethnic groups and those in routine and manual jobs.

- Ensure access to cessation services is widened via a wider range of settings including further education colleges, workplaces, dentists, pharmacists, secondary care and voluntary and community organisations

- Explore the feasibility of providing online and text based support for quitters

- Improve access to brief interventions in secondary care

- Increase availability of group based cessation support

- Develop a policy on approaches to harm reduction for smokers in line with NICE guidance.

Ensuring effective communications and marketing

Alongside local implementation of national campaigns, the 14 Local Authorities (previously PCT Public Health Departments) across the South West have collectively commissioned Smoke Free South West to deliver social marketing campaigns across the region. This collective commissioning arrangement has been in place since 2008/09 with the aim of delivering consistent and co-ordinated messages to change social norms and promote smoke free policies, whilst benefitting from economies of scale. This model of sub national service in combination with local tobacco control activity has been evaluated in the USA and shown to be effective in speeding up reductions in prevalence rates.[44] To date Smoke Free South West has focussed on key cross cutting issues which benefit from being co-ordinated over a larger footprint including illegal tobacco, smoke free policies, smoke free homes, hand rolling tobacco and plain packaging.

[44] Health Economics Research Group (Dec 2011) Building the case for Tobacco Control; The evidence base report. Commissioned by Smoke Free South West, Tobacco Free Futures, Fresh North West

Recommendations:

- Continue to commission a range of social marketing campaigns on key issues including smoke free homes and cars, hand rolling tobacco, illegal tobacco and plain packaging.

- Co-ordinate local communications work with national and regional campaigns to maximise impact

- Continue to promote opportunities to quit via National No Smoking Day, Stoptober and pharmacy health promotion campaigns

- Evaluate the impact of the Bath City College Social Marketing project and disseminate learning to other settings.

Summary of recommendations 2013 – 2018

Multi agency partnership working

- Clarify governance arrangements for Tobacco Control Strategy and Tobacco Action Network in line with the Health and Wellbeing Board structure.

- Council to consider an organisation wide policy in line with WHO Framework Convention on Tobacco Control to provide guidance for staff and members and protect work on Tobacco Control from the vested interests of the tobacco industry.

- Broaden engagement with the Tobacco Action Network to include Council members, clinical input, representation from the Clinical Commissioning Group/primary care and Universities.

- Increase capacity and skills development in tobacco control locally

- Develop, agree and monitor local targets for tobacco control that contribute to narrowing the gap in health inequalities locally.

- Increase the engagement and involvement of young people in activities of the Tobacco Action Network.

Normalising smoke free lifestyles

- Ensure all secondary schools in B&NES undertake the ASSIST programme (or equivalent) annually including how the approach can be adapted so that smaller schools and special schools can participate

- Carry out regular baseline surveys of health related behaviours in Further Education Colleges to inform local action and monitor progress

- Provide support to Further Education Colleges in developing a whole college approach to becoming Smoke Free

- Incorporate the principles of a Smoke Free Environment into local authority Play Policy and other relevant policies

Reducing exposure to second hand smoke

- Implement further training for frontline staff in health and social care to deliver brief interventions and Smoke Free Homes campaign (including Family Nurse Partnership)

- Develop and evaluate the smoke free play areas project across B&NES

- Work with the Royal United Hospital to ensure effective implementation of Smoke Free policy

- Undertake work with mental health service providers on the development of Smoke Free Policies.

Restricting supply

- Improve local professionals and community understanding of the illegal tobacco trade and its impact on communities

- Improve local intelligence from professionals and the community regarding the sale of illicit tobacco and under age sales

- Increase the awareness and engagement of young people in test purchasing process

- Increase engagement of local communities in tackling the issue of illegal tobacco and under age sales.

Helping people to quit:

- Improve access to brief interventions in secondary care

- Target cessation services more effectively at disadvantaged groups including those with mental health conditions, young women who are pregnant, black and minority ethnic groups and those in routine and manual jobs.

- Ensure access to cessation services is widened via a wider range of settings including further education colleges, workplaces, dentists, pharmacists, secondary care and voluntary and community organisations

- Explore the feasibility of providing online and text based support for quitters

- Increase availability of group based cessation support

- Develop a policy on approaches to harm reduction for smokers in line with NICE guidelines

Ensuring effective communications and marketing for tobacco control

- Co-ordinate local communications work with national and regional campaigns to maximise impact

- Continue to promote opportunities to quit via National No Smoking Day, Stoptober campaign and pharmacy health promotion campaigns

- Commission a range of social marketing campaigns on key issues including smoke free homes and cars, hand rolling tobacco, illegal tobacco and plain packaging.

- Evaluate the impact of the Bath City College Social Marketing project and disseminate learning to other settings.

Local structure for delivery, monitoring and reporting

The Tobacco Action Network will develop an Action Plan to take forward the recommendations within the Strategy and will oversee its monitoring and evaluation.

The TAN will monitor and report on progress on the following indicators on a quarterly basis:

- Smoking amongst pregnant women (smoking at time of delivery)
- Number of 4 week quitters – Target for 13/14 = 1049

The following indicators are reported annually or bi annually:

- Smoking prevalence amongst adults (Integrated Household Survey)
- % of smoking population accessing specialist support (Target 13/14 = 8%)
- Smoking prevalence amongst young people (B&NES School Health Education Unit Survey)

Two narrowing the gap indicators have been incorporated into the Children's Plan:

- smoking at time of delivery for pregnant women under 25 years compared with those over 25 years
- the percentage of year 10 pupils who smoke by gender

As B&NES is performing better than the England average for all of the above indicators our ambition will be to be in the top quartile in the South West and/or amongst the group of local authorities with similar deprivation profiles, where data is available at this level. Where data is not available at local authority or regional level national comparators will be used.

The TAN will report progress on the Action Plan annually to the Health and Wellbeing Board.

Link to other strategies

This Strategy supports and contributes to the overarching aims within the following B&NES Strategies:

B&NES Corporate Plan & Sustainable Communities Plan (2011- 2026)

Health and Wellbeing;

- To help individuals achieve their potential by improving health and wellbeing and reducing inequalities within our communities

Stronger communities

- Creating communities where everyone contributes and everyone takes responsibility

Safer Communities

- Building communities where people feel confident about carrying out their daily activities, inside and outside the home

Children and young people

- All children and young people will do better in life than they thought they could

B&NES Community Safety Plan (2009-2012)

- through reduction in criminal activity and cleaner streets.

B&NES Children and Young People's Plan (2011 – 2014)

- Providing children and young people with a safe environment, including empowering children and young people to recognise and manage risks
- Reducing health, education and social inequalities in specific groups of children and young people and specific geographical areas.
- Promoting healthy lifestyles for children and young people.

B&NES Health and Wellbeing Board – Strategy (2013)

The Board aims to:

- Reduce health inequalities and improve health and wellbeing in Bath and North East Somerset

Theme areas:

- Helping people to stay healthy (prevention)
- Improving the quality of people's lives (quality of life)
- Fairer life chances (health inequality/Life expectancy)

Glossary

Smuggling
The unlawful movement of genuine or fake products from one tax jurisdiction to another, without the payment of tax.

Boot legging
When individuals or small groups travel to the EU or Russia for example and buy cheap tobacco in lesser quantities and bring it back to the UK for resale.

Counterfeit (fake)
The manufacture of illegal tobacco products using the trademark of others. Tax is rarely paid on counterfeit products.

Illicit Whites
In recent years a novel type of large scale smuggling has emerged with cigarettes often termed 'illicit whites' or 'cheap whites'. These cigarettes are marketed on price and typically produced legally but intended for smuggling into countries where there is no prior legal market for them. An example of this is "Jin Ling", manufactured outside the EU but the second most seized illegal brand within the EU in 2008.

Quit rate
A smoker is considered to have quit if they have not smoked a cigarette in the four week period since setting a quit date (-3 to +14 days). This is validated by a Carbon Monoxide monitoring test.

Smokeless Tobacco
Smokeless tobacco is not a single product, but rather a summary term for a range of different tobacco products which deliver nicotine without combustion. Smokeless tobacco products differ substantially in their risk profile in approximate relation to the content of toxins in the tobacco.

Smoking prevalence

Local and regional smoking prevalence is generated from the Integrated Household Survey (IHS) April 2009 to March 2011. The IHS is a composite survey including questions from a number of Office for National Statistics (ONS) social surveys to produce a dataset of "Core" variables. The surveys are the General Lifestyle Survey (GLF), Living Cost and Food Survey (LCF), the Opinions Survey (OPN), Annual Population Survey (APS), English Housing Survey (EHS) and Life Opportunities Survey (LOS). Figures are the number of persons aged 18+ who are self-reported smokers in the sample covering the population of England, including a subset of the routine and manual group. Smoking status is defined as self-reported "current smoker", "ex-smoker" or "never smoked". Prevalence is also generated in the routine and manual group

Appendix 1

Tobacco Control Investment in Bath & North East Somerset 2012/13

Specialist Support to Stop Smoking services	375,138
Medication via GP's and Pharmacists	260,647
Smoke Free South West Regional Programme	79,032
Tobacco Control activity (inc. ASSIST programme)	72,000
Total £	**786,817**

The above investment is funded by Public Health Grant (£526,170) and B&NES Clinical Commissioning Group (£260,647).

Please note costs above do not include tobacco control activities carried out as part of frontline staff job roles e.g health visitors, midwives etc. Costs associated with enforcement activities carried out by Trading Standards officers are also not included in the above.

Benchmarking

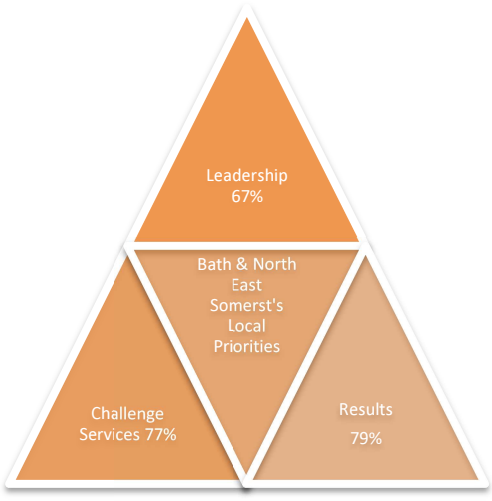
The cost per 4 week quitter in B&NES for 2010/11 was £480 per person compared to a South West average of £548 (CO validated & self-reported, including medication). This figure does not include Tobacco Control Activity or Smoke Free South West costs but does include commissioning costs.[45]

[45] Willis N Options appraisal of Stop Smoking Service Delivery in South West. Commissioned by South West Directors of Public Health (March 2012)

CLeaR Thinking

CLeaR Model Assessment for Excellence in Local Tobacco Control

Bath and North East Somerset Council
10th June 2013



Bath and North East Somerset's CLeaR scores as a % of the total available in each domain

CLeaR Context

CLeaR is an improvement model which provides local government and its partners with a structured, evidence-based approach to achieving excellence in local tobacco control.

The model comprises a self-assessment questionnaire, backed by an optional challenge and assessment process from a team of expert and peer assessors. The purpose of the assessment is to test the assumptions organisations have made in completing the questionnaire and provide objective feedback on performance against the model.

The report also provides a number of recommendations (CLeaR Messages) and the assessors suggestions for revised scores accompanied by detailed feedback on specific areas of the model (CLeaR Results). In addition we suggest some resources you may find useful as you progress your work on tobacco control (CLeaR Resources).

CLeaR in Bath and North East Somerset

Cathy McMahon invited the CLeaR team to pilot the CLeaR assessment process in Bath and North East Somerset as a benchmarking exercise for the tobacco control alliance, to assist with development of the CLeaR model and to inform the updated Tobacco Control Strategy.

This report summarises conclusions of the CLeaR Assessment team following their visit and a series of interviews on 10th June 2013. It sets Bath and North East Somerset's challenge in context, providing information on the economic impact of smoking in BANES.

In carrying out the CLeaR assessment we built on the Tobacco Control Alliance's insights into areas that needed improvement, as recognised in their self-assessment questionnaire.

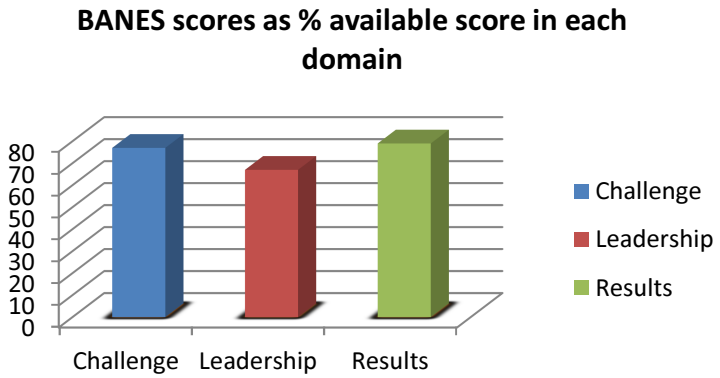
Special thanks go to Cathy for her assistance in co-ordinating responses to the self-assessment and organising the assessment visit.

Thanks also go to all those who gave their time to be interviewed by the CLeaR team; their willingness to engage with the process, honesty and integrity were greatly appreciated.

- Cllr Simon Allen, Chair, Bath and North East Somerset Council Health and Wellbeing Board
- Dr Ian Orpen, Chair, Bath and North East Somerset Clinical Commissioning Group
- Dr Bruce Laurence, Director of Public Health, B&NES Council
- Paul Scott, Public Health Consultant, B&NES Council
- Denice Burton, Ast Director, Public Health, B&NES Council
- Judy Allies, Director of Public Health Award Co-ordinator, B&NES Council

- Sarah Heathcote, Public Health Development and Commissioning Manager, B&NES Council
- Sue Green, Service Manager, Public Protection, B&NES Council
- Suzanne McCutcheon, Education and Enforcement Manager, Public Protection, B&NES Council
- Robin Wood, Team Leader, Trading Standards and Health and Safety, B&NES Council
- Friederike Hamilton, Health Visitor, Sirona Care and Health
- Sally Mitchell, School Nurse, Sirona Care and Health
- Dawn Powell, Specialist Stop Smoking Midwife, Great Western Hospital Trust
- Martyn Price, Manager, Lifestyle Services, Sirona Care and Health
- Ann Young, Specialist Stop Smoking Advisor, Sirona Care and Health
- Ruth Sampson, Tobacco Control Lead, Sirona Care and Health
- Daniel Cattanach, Communications and Media Officer, B&NES Council

CLeaR Messages



CLeaR Domain	Max score	Self-assessment score	CLeaR Assessment score
Challenge Services	78	55	60
Leadership	60	37	40
Results	28	20	22

Your insights (we observed the following which matched with your self-assessment)**:**

- Your alliance involves a wide range of partners, as demonstrated by those who took part in the assessment. You have an existing tobacco control plan and are working to update this.
- You have an existing comprehensive range of activities with more work being developed.
- You have a comprehensive communication plan and evidence of utilising the range of communication media to good effect. You have also identified new opportunities to be developed from within the Local Authority such as via internal communication channels.

Your strengths (as observed by the peer assessment team)**:**

- Bath and North East Somerset benefits from the strong leadership and support of councillor Simon Allen who chairs the Health and Wellbeing Board
- A good understanding of the current position of tobacco control in BANES was demonstrated as well as knowledge of some weak areas and plans to tackle them.
- Strong work with young people is being undertaken across the range of ages.
- Provider Healthy Lifestyle Services provide a quality Stop Smoking Service as part of an integrated approach to health.

Opportunities for development:

Whilst tobacco control could be considered implicit in the work to reduce Health Inequalities as set out in the Health and Wellbeing Strategy, there is a need to make it more explicit in order not to lose the focus on tobacco control.

There needs to be a clear formal governance framework for the Tobacco Control Strategy and a formal reporting mechanism for the Tobacco Action Network.

The development of SMART targets for the Tobacco Control Strategy will help in monitoring achievements.

Transition provides an opportunity to build a broader consensus for tobacco control across a wide range of council functions and partnership agendas (for instance, highlighting the contribution tobacco control makes to priorities such as community safety, children and young people, and economic prosperity.) You have identified other partners whose engagement in the TAN would be beneficial (eg CCG and wider Local Authority Members).

Regular data sharing and reviews of progress by the TAN will ensure learning from innovation is recognised and embedded in partner work.

A local scrutiny inquiry could be helpful to engage elected members.

Signing up to the Local Government Declaration on Tobacco Control would signal clear leadership in this area throughout the Authority.

An organisation policy in line with article 5.3 of the WHO `Framework Convention on Tobacco Control would show exemplary corporate leadership on tobacco control and would provide a clear steer for departments on any working with the tobacco industry.

Strengthening the focus on engaging with the illicit tobacco issue specifically in local communities and close working with Trading Standards would help to raise awareness of the issues and drive intelligence.

There is strong work being undertaken with young people for example with the Director of Public Health Award and the Health Education Survey. This work should be continued to discourage the uptake of smoking by young people and drive down smoking prevalence over the long term.

The comprehensive approach would benefit from further engagement with other consultants and clinical leads at the RUH and in Primary Care.

Brief intervention training around second hand smoke would support the embedding of the Smokefree Homes Programme with relevant partners (eg Health Visitors, Children's' Centre staff).

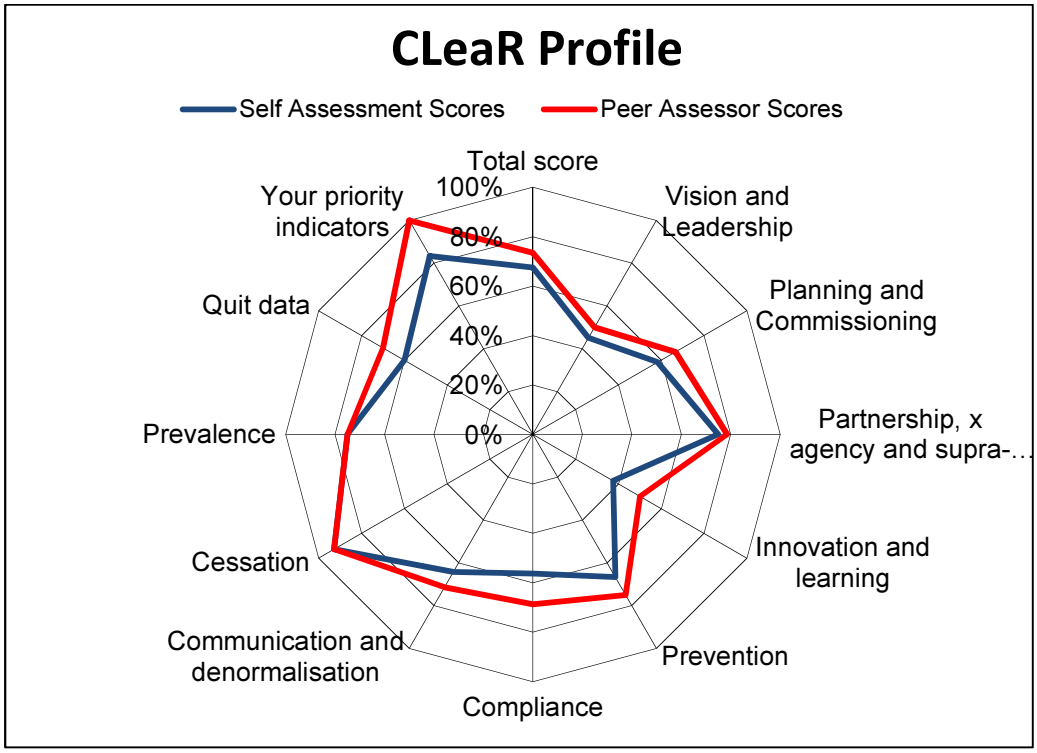
More robust data for measuring Smoking at Time of Delivery (SATOD) should be provided by the move of Maternity Services to a new IT system.

CO screening for all pregnant women should be an ambition and the mandatory recording on the new maternity database should help to achieve this in the future. This will also help to assure that all pregnant smokers are identified.

There are opportunities to make greater use of corporate communications which you identified and which will make a positive contribution to future work.

CLeaR Results

The chart below shows (in blue) Bath and North East Somerset's original self-assessment scoring, as a % of available marks in each section and (in red) the CLeaR team's assessment results. The results of the peer assessment accorded closely with the self-assessment, with the peer assessment identifying some additional areas for improvement.



Detailed comments on your assessment are as follows

Clear Theme	Your score	Our score	Max	Comments
Leadership				
Vision and leadership (including WHO FCTC)	9	10	20	B&NES has an integrated holistic approach evidenced in the Health and Wellbeing Board Draft Strategy. However, we felt that the lack of tobacco as a clear defined objective is both a concern and a missed opportunity to maintain the focus on this important area. The executive member for Wellbeing was

				a strong advocate for tobacco control. Other members are noted as being supportive of the tobacco control agenda. A Scrutiny inquiry could be a useful tool here in further engaging members. We saw evidence of engagement with clinical leadership and understand there is support from the Clinical Commissioning Group who will be consulted on the Tobacco Control Strategy. Further engagement with other consultants and clinical leads at the RUH and in Primary Care would also be beneficial to a comprehensive approach. We felt the support to staff and plans for a smokefree campus are strong evidence of B&NES Council's ambitions to act as an exemplar in supporting staff to stop using tobacco. A policy in line with article 5.3 of the WHO `Framework Convention on Tobacco Control would show exemplary corporate leadership on tobacco control.
Planning and commissioning	7	8	12	We saw evidence of a comprehensive Draft Strategy which will be signed off at Council Cabinet level via the Health and Well Being Board and other relevant partners. The development of SMART targets will help in monitoring achievements against the Strategy.
Partnership, cross-agency and supra-local working.	21	22	28	An active Tobacco Action Network was evidenced through the self- assessment and by the participants who took part in the assessment visit. B&NES is actively involved in existing regional networks including for the sharing of best practice and in collaborative working across the South West. We felt that you showed strong evidence of relevant partners being accountable for the delivery of targets.

				You have identified other partners whose engagement in the TAN would be beneficial (eg CCG and wider Local Authority Members)
Challenging Your Services				
Innovation and learning	3	4	8	We saw evidence of the sharing of both local innovation and data through several networks. The revived TAN and continued engagement with the South West Action Group should provide B&NES with a good forum to continue this practice allowing all groups to share from it. We scored higher in this area as active membership of the SW Action Group and Professional Network meetings had not been included. Regular data sharing and reviews of progress by the TAN will ensure learning from innovation is recognised and embedded in partner work.
Prevention	8	9	12	B&NES has a comprehensive programme of work with young people across the age groups with excellent engagement with schools and Bath City College and a range of other programmes and awards to support this agenda. Brief intervention training around second hand smoke would support the embedding of the Smokefree Homes Programme with relevant partners (eg Health Visitors, Children's' Centre staff).
Compliance	9	11	16	B&NES engages with other organisations across the South West to amplify regulatory work through collaborative working (eg SFSW, SWEROTS). We scored higher in intelligence gathering and handling and a risk based approach to reflect the collaborative work that B&NES supports through SFSW with the Regional Intelligence Unit and the use of Crimestoppers.

				A policy in line with article 5.3 of the WHO `Framework Convention on Tobacco Control would protect your work on illicit tobacco from the vested interests of the tobacco industry.
Communications and denormalisation	9	10	14	We saw good examples of work around communication and denormalisation and scored your approach to communication of tobacco control issues higher to reflect the comprehensive approach through partners and the current Communication Plan. There are opportunities to make greater use of corporate communications which you identified and which will make a positive contribution to future work.
Cessation	26	26	28	The Stop Smoking Service has some strong examples of good practice. Incentives for NHS providers are evidence through the CQUIN in the Maternity Contract and the LES for primary care providers. CO screening for all pregnant women should be an ambition and the mandatory recording on the new maternity database should help to achieve this in the future. This will also help to assure that all pregnant smokers are identified.
Results				
Prevalence	9	9	12	Smoking prevalence data for B&NES shows an improving trend across the standard measures with local work to address the lack of prevalence data in young people. The move of Maternity Services to a new IT system will provide more robust data for measuring SATOD.
Quit data	6	7	10	Whilst your local quit rate data is compared to National and Regional averages, the fall since 2009/10 should be addressed to ensure quality and cost effectiveness of service.

				More locally relevant criteria for setting the local quit target will assist in targeting services.
Local Priorities	5	6	6	B&NES local priorities will contribute to reducing the negative impacts of tobacco use on the population. Although the SHEU survey which will give a very localised indication of progress in reducing exposure of young people to tobacco smoke, B&NES has benefited in this area from its collaborative working with the Smokefree South West Smokefree Homes Programme which has shown a significant decrease in smoking in the home across the South West (decrease from 22% in 2011 to 13% in 2013).

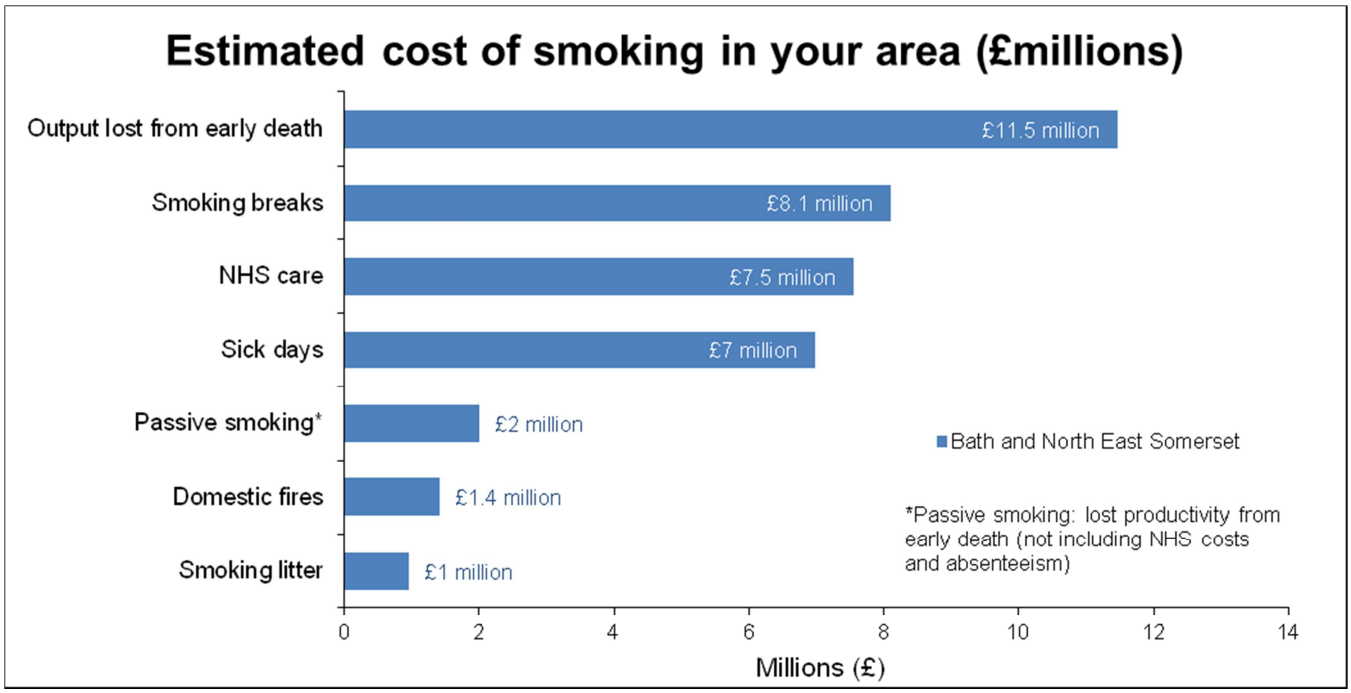
CLeaR Opportunities

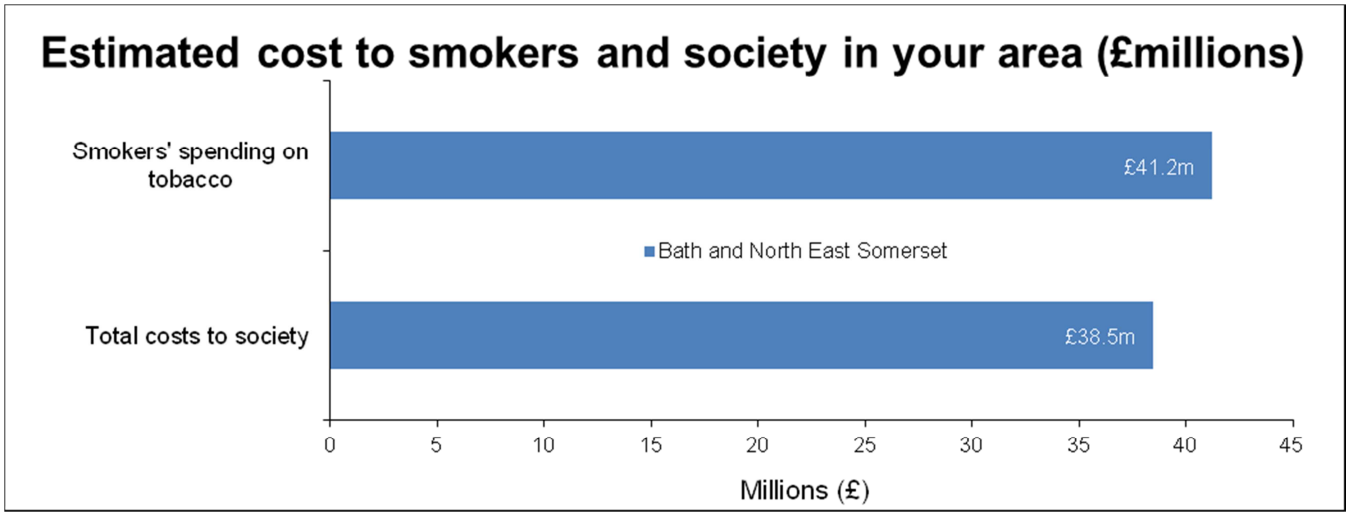
Bath and North East Somerset's estimated smoking population is **23,300** people.

If the wider impacts of tobacco-related harm are taken into account, it is estimated that each year smoking costs society in Bath and North East Somerset **£38.5m**. In addition the local population in Bath and North East Somerset spend an estimated **£41.2m** on tobacco related products.

As smoking is closely associated with economic deprivation this money will be disproportionately drawn from Bath and north East Somerset's poorest citizens and communities.

See www.ash.org.uk/localtoolkit/ for more details





CLeaR Resources

Information on the business case for tobacco control, and a toolkit of resources for Directors of Public Health, local authority officers and members can be found at http://www.ash.org.uk/localtoolkit

Further local information on the business case for tobacco can be found at http://www.brunel.ac.uk/about/acad/herg/research/tobacco

A helpful toolkit for conducting effective overview and scrutiny reviews can be found at http://politiquessociales.net/IMG/pdf/CfPSPeelingonionfin_1_1_.pdf

In relation to communications, you may find it useful to review “A social marketing approach to tobacco control: a guide for local authorities"

www.idea.gov.uk/idk/aio/21028178

Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control also contains a useful chapter on communications.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_084848.pdf

A copy of the tobacco advocacy toolkit can be obtained from Ian Gray – email I.Gray@cieh.org

A briefing on investment and local authority pension funds - http://ash.org.uk/files/documents/ASH_831.pdf

NICE guidance on smoking and tobacco http://www.ash.org.uk/stopping-smoking/for-health-professionals/nice-guidance-on-smoking

The NCSCT have a range of resources which may interest you – see for instance

NCSCT Training and Assessment Programme (free) - developed for experienced professionals working for NHS or NHS commissioned stop smoking services who want to update or improve their knowledge and skills - as well as newcomers to the profession, who can gain full NCSCT accreditation.

http://www.ncsct.co.uk/training

Very Brief Advice on Smoking – a short training module for GPs and other healthcare professionals to help increase the quality and frequency of Very Brief Advice given to patients who smoke.

http://www.ncsct.co.uk/VBA

Very Brief Advice on Second-hand Smoke - a short training module designed to assist anyone working with children and families to raise the issue of second-hand smoke and promote action to reduce exposure in the home and car.

http://www.ncsct.co.uk/SHS

NCSCT Streamlined Secondary Care System (cost available on request) a whole hospital approach to stop smoking support for patients

(More information – http://www.ncsct.co.uk/delivery/projects/secondary-care - contact Liz.hughes@ncsct.co.uk)

NCSCT Provider Audit - is a system of national accreditation designed to support local stop smoking service commissioners and providers to demonstrate whether the support they provide meets minimum standards of care and data integrity. This aims to complements any existing internal quality assurance processes whilst its independent nature provides external assurance of quality and performance.

(More information - http://www.ncsct.co.uk/delivery/projects/audit-of-local-stop-smoking-services - contact Isobel.williams@ncsct.co.uk)

CLeaR next steps

Thank you for using CLeaR.

Having completed your self-assessment and CLeaR assessment, you will now be awarded CLeaR accreditation until May 2014. This gives you the right to use the CLeaR logo and automatic entry to the CLeaR awards which will be held for the first time in 2013.

In the meantime we invite you to:

- share the report with partners and stakeholders, and develop actions based on the recommendations;
- contact us if you'd like to discuss commissioning further support for tobacco control;
- take up CLeaR membership and train members of your staff as peer assessors, to enable you to participate in, and learn from, other assessments in your region;
- repeat self-assessment in 12 month's time to track how your score improves; and
- consider commissioning a CLeaR re-assessment in 2014.

Contacts

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Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Equality Impact Assessment / Equality Analysis

Title of service or policy	B&NES Tobacco Control Strategy 2013 - 2018
Name of directorate and service	Public Health
Name and role of officers completing the EIA	Cathy McMahon, Public Health Development and Commissioning Manager
Date of assessment	30th August 2013

Equality Impact Assessment (or 'Equality Analysis') is a process of systematically analysing a new or existing policy or service to identify what impact or likely impact it will have on different groups within the community. The primary concern is to identify any discriminatory or negative consequences for a particular group or sector of the community. Equality impact Assessments (EIAs) can be carried out in relation to service delivery as well as employment policies and strategies.

This toolkit has been developed to use as a framework when carrying out an Equality Impact Assessment (EIA) or Equality Analysis on a policy, service or function. It is intended that this is used as a working document throughout the process, with a final version including the action plan section being published on the Council's and NHS Bath and North East Somerset's websites.

1.	**Identify the aims of the policy or service and how it is implemented.**	
	Key questions	**Answers / Notes**
1.1	Briefly describe purpose of the service/policy including • How the service/policy is delivered and by whom • If responsibility for its implementation is shared with other departments or organisations • Intended outcomes	The B&NES Tobacco Control Strategy will be overseen by the Tobacco Action Network, a multi-agency alliance of local stakeholders including commissioners and providers of tobacco control activity. Responsibility for its delivery is shared across a range of stakeholders however overall responsibility for delivery of public health outcomes in relation to smoking will move to the local authority from April 2013. Intended outcomes of the Strategy are: Reduction in smoking prevalence amongst adults Reduction in smoking prevalence amongst young people Reduction in smoking prevalence amongst pregnant women
1.2	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement?). • How much room for review is there?	The existing B&NES Tobacco Control Strategy *Breathing Free* was written in 2006. Significant progress has been made nationally, regionally and locally since then and it is appropriate now to review local strategy in the light of this and set priorities which are in line with the new opportunities for public health and the changing local landscape within public services. This Strategy is a refresh of the 2006 B&NES Tobacco Control Strategy Breathing Free and has been written in response to the Governments Tobacco Control Plan 2011.

1.3	Do the aims of this policy link to or conflict with any other policies of the Council?	This Strategy supports and contributes to the overarching aims within the following B&NES Strategies: B&NES Corporate Plan & Sustainable Communities Plan (2011- 2026) Health and Wellbeing; • To help individuals achieve their potential by improving health and wellbeing and reducing inequalities within our communities Stronger communities • Creating communities where everyone contributes and everyone takes responsibility Safer Communities • Building communities where people feel confident about carrying out their daily activities, inside and outside the home Children and young people • All children and young people will do better in life than they thought they could B&NES Community Safety Plan (2009-2012) • through reduction in criminal activity and cleaner streets. B&NES Children and Young People's Plan (2011 – 2014) • Providing children and young people with a safe environment, including empowering children and young people to recognise and manage risks • Reducing health, education and social inequalities in specific groups of children and young people and specific geographical areas.

		• Promoting healthy lifestyles for children and young people. B&NES Health and Wellbeing Board Strategy (2013) The Board aims to: • Reduce health inequalities and improve health and wellbeing in Bath and North East Somerset Theme areas: • Helping people to stay healthy (prevention) • Improving the quality of people's lives (quality of life) • Fairer life chances (health inequality/Life expectancy)

2. Consideration of available data, research and information

Monitoring data and other information should be used to help you analyse whether you are delivering a fair and equal service. Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data** (including ethnicity, gender, disability, religion/belief, sexual orientation and age)
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **external inspections** or audit reports

	Key questions	Data, research and information that you can refer to
2.1	What is the equalities profile of the team delivering the service/policy?	Consideration of equalities issues and addressing health inequalities form part of the Contracts of all service providers delivering services related to Tobacco Control.
2.2	What equalities training have staff received?	Staff are required to have generic equalities training as part of their mandatory induction training and to supplement this with additional training in specialist areas where appropriate.
2.3	What is the equalities profile of service users?	Overall smoking prevalence amongst adults in B&NES is 16.4%, this equates to 23,300 smokers 18 years and over. Smoking amongst pregnant women in B&NES is 12.3% compared to a national level of 13.2%. There are marked differences in levels of smoking amongst younger women who are pregnant and those who live in different areas of B&NES. For example, 35% of under 18's who are pregnant in B&NES smoke and there are much higher rates of smoking amongst pregnant women in the Radstock (32%) Twerton (22%) and Keynsham (15.4%) children centre catchment areas compared to other areas of B&NES. Smoking prevalence increases with age and more girls are smoking than boys. 12% of year 10 boys and 21% of year 10 girls said that they smoke 'occasionally' or 'regularly'. 33% of B&NES 11 – 15 year olds say at least one person regularly smokes indoors in their home[1]. This is lower than the national comparator (40%) but still a significant number exposed to second hand smoke and smoking behaviours.

[1] NHS B&NES (2011) Primary and Secondary Health Related Behaviour Survey: Bath & North East Somerset

		The percentage of people in routine and manual jobs who smoke in B&NES is 26% (2011) compared to 29% regionally and nationally. Smoking rates are much higher amongst people with mental health problems than the general population. Whilst the black and minority ethnic population in B&NES is 7.66% only 2.8% of people accessing cessation support services during 2011/12 were from these groups. Those from BME groups setting a quit date were also less likely to successfully quit (36% quit rate) compared to the other groups (52%). This is an area for improvement in the strategy.
2.4	What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps?	The Specialist Stop Smoking Service collect on-going feedback from clients using the service. There are high levels of satisfaction with the service from users. Lost to follow up client feedback is also being sought in an attempt to understand more about why people leave the service. Work is underway to better understand the needs of BME groups in terms of service delivery. Satisfaction with the Young People's Programme (ASSIST) is collected from schools who participate.
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	An extensive consultation has been carried out amongst professional and interest groups locally on the Strategy. We have talked directly to Young People via the DAFBY Group to better understand their perspective on issues such as plain packaging. We have made a recommendation in the Strategy to improve the engagement of young people in the delivery of the Strategy as a result.
2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	Ensure that specific strategies are used to engage effectively with minority groups and vulnerable clients.

3. Assessment of impact: 'Equality analysis'			
	Based upon any data you have considered, or the results of consultation or research, use the spaces below to demonstrate you have analysed how the service or policy: • Meets any particular needs of equalities groups or helps promote equality in some way. • Could have a negative or adverse impact for any of the equalities groups		
		Examples of what the service has done to promote equality	**Examples of actual or potential negative or adverse impact and what steps have been or could be taken to address this**
3.1	**Gender** – identify the impact/potential impact of the policy on women and men. (Are there any issues regarding pregnancy and maternity?)	Specialist support is commissioned to help pregnant women to stop smoking. The DPH Award for Schools and colleges offers evidence based support to tackle smoking amongst young people including data on smoking levels amongst boys and girls specific to the school setting. All Schools are offered the Assist Programme every year – an evidence based peer support programme to prevent uptake of smoking.	Targeting pregnant women who smoke will have a positive effect on the health of the baby and the woman. Reducing smoking in young people should benefit girls more than boys as more girls smoke than boys Potential for work targeting girls specifically to reduce prevalence in this group.
3.2	**Transgender –** – identify the impact/potential impact of the policy on transgender people		Reducing smoking prevalence will benefit the whole community in terms of reducing exposure to second hand smoke in homes and in public spaces
3.3	**Disability** - identify the impact/potential impact of the policy on disabled people (ensure consideration of a range of impairments including both physical and mental		Reducing smoking prevalence will benefit the whole community in terms of reducing exposure to second hand smoke in homes and in public spaces

	impairments)		
3.4	**Age** – identify the impact/potential impact of the policy on different age groups	Specialist support is commissioned to help pregnant women to stop smoking. The DPH Award for Schools and colleges offers evidence based support to tackle smoking amongst young people including data on smoking levels amongst boys and girls specific to the school setting. All Schools are offered the Assist Programme every year – an evidence based peer support programme to prevent uptake of smoking.	Reducing smoking in young people will have a positive impact on their long term health in later life. Reducing smoking amongst adults will have a positive impact on their life expectancy and quality of life. Equally reducing smoking in adults will benefit the health of children by reducing exposure to second hand smoke in the environment. Reducing smoking in pregnancy will have a positive impact on the health of babies and mothers
3.5	**Race** – identify the impact/potential impact on different black and minority ethnic groups	Healthy Lifestyle services are looking at ways of engaging more effectively with BME groups, including developing specific marketing materials and links to local groups.	Making smoking cessation services more accessible to ethnic minority groups will help to reduce health inequalities in these groups.
3.6	**Sexual orientation -** identify the impact/potential impact of the policy on lesbians, gay, bisexual & heterosexual people		Reducing smoking amongst adults will have a positive impact on their life expectancy and quality of life. Young people and adults who are lesbian, gay, bisexual or heterosexual are more likely to suffer from mental health issues and more likely to smoke heavily.
3.7	**Religion/belief** – identify the impact/potential impact of the policy on people of different religious/faith groups and also upon those with no religion.		The policy will not have any negative impact on people of different religious/faith groups as it will have a positive impact on adults and children regardless of religion or belief.

3.8	**Socio-economically disadvantaged** – identify the impact on people who are disadvantaged due to factors like family background, educational attainment, neighbourhood, employment status can influence life chances	Support services are offered in workplaces that employ higher proportion of routine and manual workers. Equally clinics are offered in a range of community centres to enable access to all. Specialist services work with Big Issue and DHI to support those with complex needs.	Targeting routine and manual workers with support services will help to reduce the healt h inequalities experienced disproportionately by this group as they are more likely to smoke and smoke heavily. A harm reduction approach will also enable support to be given to those who find it difficult to give up smoking abruptly.
3.9	**Rural communities** – identify the impact / potential impact on people living in rural communities		Looking at options to increase the accessibility of support services including text/telephone support and online support will enable more people from rural areas to access the services.

4. Bath and North East Somerset Council & NHS B&NES
Equality Impact Assessment Improvement Plan

Please list actions that you plan to take as a result of this assessment. These actions should be based upon the analysis of data and engagement, any gaps in the data you have identified, and any steps you will be taking to address any negative impacts or remove barriers. The actions need to be built into your service planning framework. Actions/targets should be measurable, achievable, realistic and time framed.

Issues identified	Actions required	Progress milestones	Officer responsible	By when
A range of equalities issues have been identified through the consultation process of developing the Strategy - these include gender issues, working with BME groups, supporting people with mental	The Tobacco Action Network will form an Action Plan based on the recommendations within the Strategy	A range of indicators including those relating to narrowing the gap re; inequalities have been identified within the Strategy and will be monitored by the TAN	Cathy McMahon	On going

health problems and targeting areas of deprivation.				

5. Sign off and publishing

Once you have completed this form, it needs to be 'approved' by your Divisional Director or their nominated officer. Following this sign off, send a copy to the Equalities Team (equality@bathnes.gov.uk), who will publish it on the Council's and/or NHS B&NES' website. Keep a copy for your own records.

Signed off by: Bruce Laurence (Divisional Director or nominated senior officer)
Date: 10/09/2013

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	Friday 20th September 2013
TITLE:	Update on Dementia
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: No attachments	

1. THE ISSUE

To provide the Panel with an update on improving local services for people with dementia.

2. RECOMMENDATION

The Panel is asked to note this update and consider when it would wish to receive a further update.

3. FINANCIAL IMPLICATIONS

There are no financial implications to this update report.

4. THE REPORT

The Panel last received an update report in November 2011. This report therefore provides an update on progress made locally since then.

Following the publication of the National Dementia Strategy – *Living Well with Dementia* (NDS) in February 2009, the Prime Minister's Dementia Challenge was published in March 2012. This identified three key areas:

- Driving further improvements in health and care including timely diagnosis and improved care in hospital and in the community;
- Creating dementia friendly communities that understand how to help and;
- Better research to improve treatments for people with dementia and if possible, prevent it from occurring in the first place or at least slowing it from progressing beyond a very early phase.

An annual report was published in May 2013 by Department of Health setting out the progress made against the Prime Minister's Challenge and the aims for 2015.

Local Priorities

Improving services for people with dementia and their carers remains a priority for the CCG and the Health & Wellbeing Board as set out in the Joint Health & Wellbeing Strategy.

BaNES Dementia Care Pathway Group continues to meet on a bimonthly basis to take forward the local priorities which are as follows:

- Improving diagnosis rates
- Improving post-diagnostic support in the community
- Improving care in hospitals
- Improving standards in care homes & domiciliary care
- Better information for people with dementia & their carers
- Supporting people with dementia at end of life
- Reducing use of antipsychotics
- Support the development of dementia friendly communities
- Increase availability of dementia nursing home beds

Progress Made to Date
Since the last update, the following progress has been made:

Memory assessment pathway for primary care – the pathway has been reviewed and revised to ensure that GPs know who and where to refer patients to ensure they receive a timely diagnosis. Diagnosis rates in BaNES were below the South West average and although this might be partly to do with the coding of patients in primary care, there is clearly room for improving them. The CCG has set a target of reaching 53.5% by the end of 2013/14 and target of 60% by the end of 2014/15. Currently the rate is around 46%. A number of dementia awareness sessions were also held at the Research Institute for the Care of the Elderly (RICE) for GP practice staff including administrative staff. The sessions covered dementia, diagnosis and signs to look for; patients scenarios and; information about RICE and the memory clinic experience.

Improving diagnostic support in the community – this was identified as a local gap in service provision and although the Alzheimer's Society currently provides a community development worker to support people with dementia and their carers in BaNES, the pathway group recognised the need to expand this offer. As a result funding was secured from the CCG to develop this service and it is currently out to tender. Dementia cafes and singing for the brain is offered in various locations in BaNES with other community developments underway to support people with dementia and their carers.

Improving care in hospitals – national funding for pilot projects to improve care environments was made available earlier this year and the RUH was successful in its application for capital investment to refurbish Combe Ward, one of their wards in the older people's unit. Building work has started and is due to be completed in September 2013. The redevelopment will also include a garden area for patients.

Better information for people with dementia and their carers – providing accurate and timely information has been a major focus of the pathway group. Guideposts Trust has supported and developed a dementia web which provides a range of information on-line from diagnosis through to end of life care. They also provide a 24/7 helpline and produced an 'after diagnosis' handy guide which is BaNES specific. As well as this development, the Council has updated and produced the new older people's directory and care services directory.

Supporting people with dementia at end of life – Dorothy House provided three two day dementia training courses for registered practitioners and care homes.

Primary care audit of use of antipsychotic medicines – a local audit of the use of antipsychotics in primary care was initially carried out in June 2011, the results of which showed that 91 patients over the age of 65 were on antipsychotic drug (10.5%). A follow up audit in January 2012 showed that this had reduced to 77 patients (7.9%). Data suggests from across the South West that less than 10% is achievable.

Dementia friendly communities – A dementia friendly community is one that shows a high level of public awareness and understanding so that people with dementia and their carers are encouraged to seek help and are supported by their community. On 17th April 2013, Cllr Simon Allen, Cabinet Member and Chair of Health & Well-being Board launched an exciting initiative to put BaNES at the forefront of care for people with dementia. A number of key leaders in the field of dementia in BaNES came together under the chairmanship of Simon Knighton from Sirona Care & Health to consider how to make this a reality. Following the first meeting a virtual forum was created by Cllr Allen to encourage everyone to share their thoughts and ideas through the Freedcamp portal as well as the creation of a newsletter to keep everyone informed of developments.

Dementia nursing home beds – discussions with developers to stimulate interest in sites to increase the number of dementia nursing homes continues. To date, we have identified three potential development partners and are engaged in discussions about four potential sites. Work also continues with existing dementia nursing homes in BaNES to increase the availability of complex dementia care (ie where clients have significant elements of behaviour that requires specialist care and/or a large element of physical nursing care due to disease progression).

Research – BaNES is involved in a six centre research trial 'Goal-Oriented Cognitive Rehabilitation in Early-Stake Alzheimer's Disease' (GREAT) which is being led by RICE. This is a multi-centre single-blind randomised controlled three year trial which started earlier this year. This will involve 480 mild dementia patients being recruited and randomised to a cognitive rehabilitation therapy or not with the aim of establishing whether cognitive rehabilitation is successful.

Dementia Challenge Fund Projects

The NHS South of England Dementia Challenge Fund was launched in 2012 in response the PM's Challenge with the aim of funding pilot projects for 12 months. Five applications were submitted via the CCG, with one submitted jointly with Wiltshire CCG. Three of the bids were successful and although the other two were not successful, the CCG recognised the value of implementing them and therefore agreed to fund them on a 12 month non-recurring basis. The successful bids were as follows and totalled £455k:

- Sirona Care & Health: Technology Libraries
- RUH CQUIN PLUS: Integrating Hospital & Community Care Pathways
- Curo: Rural Independent Living Support Service

The other two bids were as follows and totalled £137k:

- The Carers' Centre & Age UK B&NES: Home from Hospital
- Avon & Wiltshire Mental Health Partnership Trust (AWP): Care Home Support & Assessment Service

Technology Libraries – Sirona Care & Health is working with a number of partners including Bath Institute of Medical Engineering to offer technology to support people with dementia to maintain independence. The launch of the library was held on 3rd April 2013 and an independent website went live on 12th July 2013 to show case the products available (http://memorytechnologylibrary.co.uk).

Integrating Hospital & Community Care Pathways – this project is aimed at improving the pathway between the hospital and community services as well as expanding the mental health liaison service. Three dementia co-ordinators are now in post and working on the wards. The older adults' mental health liaison team has moved to seven day working mid-July 2013.

Rural Independent Living Support Service – Curo is working with people in rural areas to achieve timely diagnosis of dementia. A rural dementia co-ordinator has been appointed who at the beginning of February 2013 organised two community events to raise awareness of dementia. The co-ordinator is working in partnership with the Village Agents in the Chew Valley area. A memory café has also been established in Peasedown St John.

Home from Hospital – The Carers' Centre & Age UK's project is working very closely with the RUH project to support people with dementia when returning home. A discharge liaison co-ordinator has been appointed for the project and is available Monday to Friday at the RUH who works closely with the carers' officer. Greeting cards have been produced and designed to leave with patients when visiting the wards for the carers to be contacted by either the discharge liaison co-ordinator or the carers' officer.

Care Home Support & Assessment Service – AWP has put in place a new service providing advice, education, training and information to care home staff and carers on how they can support people with dementia. An experienced occupational therapist with teaching experience from AWP is leading on this project and has been working with Dorothy House on end of life care.

Next Steps
The key next steps are as follows:

- Subject to the tender process, the mobilisation of the community dementia support worker should begin later this year.

- The pathway group will complete a self-assessment against the NICE quality standards – Supporting People to Live Well with Dementia – which were published earlier this year. The quality standards apply to all social care settings and services working with and caring for people with dementia.

- The dementia challenge fund projects are in the process of being evaluated. Once the evaluation has been completed a report will be presented to the CCG to inform decision making about the on-going commissioning and recurring funding of these services in 2014/15.

5. RISK MANAGEMENT

A risk assessment is not necessary in respect of this update report.

6. EQUALITIES

An equalities impact assessment is not warranted in respect of this update report.

7. CONSULTATION

The B&NES Dementia Care Pathway Group has been the vehicle for engaging and consulting on the dementia action plan. The group includes the following organisations:

Alzheimer's Society
Avon & Wiltshire Mental Health Partnership Trust (AWP)
Age UK B&NES
Curo Housing
Dorothy House Hospice
Guideposts Trust
Research Institute for the Care of Older People (RICE)
Royal United Hospital Bath NHS Trust (RUH)
Sirona Care & Health C.I.C
Support for People with Alzheimer's (Peggy Dodd)
Somerset Care & Repair
The Carers Centre

8. ISSUES TO CONSIDER IN REACHING THE DECISION

Not relevant.

9. ADVICE SOUGHT

It wasn't necessary to seek advice from either the Council's Monitoring Officer (Council Solicitor) or the Section 151 Officer (Strategic Director – Resources & Support Services) on the contents of this update report.

Contact person	Corinne Edwards, Senior Commissioning Manager for Unplanned Care & Long Term Conditions, NHS BaNES CCG, Tel: 831868
Background papers	National Dementia Strategy, Department of Health, February 2009 Prime Minister's Dementia Challenge, March 2012 and subsequent annual reports in 2012 and 2013
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development and Scrutiny Panel
MEETING DATE:	20 September 2013
TITLE:	Support to Ambulance JHOSC
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: None	

1 THE ISSUE

1.1 A letter from Ambulance JHOSC (Joint Health Overview & Scrutiny Committee) Chair Cllr Clarke was received at the Wellbeing PD&S Panel meeting of July 5th 2013. Cllr Clarke described how the local ambulance organisational infrastructure had recently changed, whereby Great Western Ambulance Service (GWAS) had been acquired by South West Ambulance Service (SWAS) on 1st February 2013. An ambulance JHOSC Panel had previously met to consider issues of concern across the former GWAS area. With the advent of SWAS, Cllr Clarke queried the future scrutiny landscape.

1.2 In considering Cllr Clarke's letter, the Panel were minded to request further information to allow them to consider the financial, resource and constitutional implications of the proposals

2 RECOMMENDATION

The Wellbeing PD&S panel is asked to consider:

2.1 The resource, financial and governance information contained in this report and, in so doing, respond to the questions raised by Cllr Clarke;

2.2 Specifically, whether the Wellbeing Panel supports the continuation of an Ambulance JHOSC for the former GWAS area based on the current model of officer support or;

2.3 As an alternative, would the Panel support the principle of a fixed term arrangement until the new health arrangements are fully established.

3 FINANCIAL IMPLICATIONS

3.1 Financial implications

(1) Bristol City Council provides lead scrutiny officer support to the existing JHOSC arrangements, and have indicated they are minded to continue doing so, hence minimal financial impact to B&NES in this regard.

(2) B&NES Council Democratic Services Officers provide clerking/minute taking to the JHOSC meeting on a rotational basis. This last happened in 2010 and 2012 (1 meeting in each year). The time commitment to support this activity is approx. 2 days for each meeting (approx £555). In addition, Democratic Services Officers may have some general communication and interaction between the JHOSC and Panel Members. The cost of this is minimal, at most approx. 1hr per month.

(3) B&NES Policy Development & Scrutiny Officers also support JHOSC in a limited way. This could include liaison with officers of the lead authority, circulating minutes and contact with panel members. These tasks would take a minimal amount of time, with at most approx.1hr per month.

(4) Cllr Clarke reports that SWAS Foundation Trust are prepared to provide support to JHOSC. As this support is unquantified, it is difficult to acknowledge how this may impact on B&NES financially.

4 THE REPORT

4.1 Cllr Clarke's letter discusses a number of working arrangements for Ambulance JHOSC. If the scrutiny model were to remain on a regional basis similar to that used under the GWAS era, existing Terms of Reference contained in the Constitution would be sufficient to accommodate this way of working as they include the principle of establishing joint scrutiny arrangements.

5 RISK MANAGEMENT

5.1 The risks associated with this proposal are minimal.

6 EQUALITIES

6.1 There are no specific equalities considerations that relate to this issue.

7 ADVICE SOUGHT

7.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) has had the opportunity to input to this report and has cleared it for publication.

Contact person	Jo Morrison, Democratic Services Manager / Liz Richardson, Lead Policy Development & Scrutiny Project Officer
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development and Scrutiny Panel	
MEETING DATE:	September 2013	**AGENDA ITEM NUMBER**
TITLE:	**Specialist Mental Health Services update**	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix 1 – Bridging the Gap – B&NES Peer research report (Exec Summary). Appendix 2 – Mental Health Community Services re-design draft flow chart Appendix 3 – Creativity Works - Executive summary of activity 2012-13 Appendix 4 – List of Mental Health Quartet grants 2011-13 Appendix 5 – CCG Board presentation – Primary Care Talking Therapies		

1 THE ISSUE

1.1 This paper gives an updated progress report on local mental health community support services and the Primary Care Talking Therapy service.

1.2 The report also describes the new locality management structure for the Specialist Mental Health services delivered by the Avon and Wiltshire Mental Health Partnership Trust.

2 RECOMMENDATION

The Wellbeing Policy Development and Scrutiny Panel is asked to note:

2.1 Progress in implementing more service user led, recovery focused community support services and suggested next steps.

2.2 The implementation of the new Primary Care Talking Therapy service.

2.3 The new locality management structure in AWP.

3 FINANCIAL IMPLICATIONS

Continuing re-design of mental health community support services is taking place in the context of the overarching savings requirements of the council for the supporting people and communities programme. Whilst the re-design for mental health support services concentrates on delivering longer term efficiencies through better use of the existing budget (previous savings having been released at the beginning of the re-design 2 years ago), following the sector reviews and final proposals we will clarify whether any further savings can be delivered.

4 THE REPORT

4.1 Mental Health Community Support services update

In our original strategy for redesigning community support services we stated that from 2011-12 – 3013-14 we wanted to focus on better facilitating:

- the development of personalised services
- the expansion of peer led and localised support activities
- the centralisation of local information accessible to all
- access to the intensive support needed for people to remain in their own homes
- engagement with creative and practical activities that develop confidence and skills
- individual's access to mainstream community education, training, leisure and employment opportunities

Our key aim has been to work with a recovery and solution focused approach to supporting people where contact is based on identifying and building on people's strengths and sense of hope for the future. To this end we have successfully worked with local providers to set up and deliver:

4.1.1 Building Bridges to Wellbeing Project/Community Options

This service, currently delivered by both St Mungo's and Sirona Care and Health has been very successful in:

- Establishing a peer facilitation and support network for service users called New Hope.
- Supporting New Hope to carry out and produce a peer research paper on what matters to local people with mental health problems (Appendix 1).
- This work is now integral to shaping an updated mental health commissioning strategy (in development).
- Continuing to support people through short and long term provision of groups and one-to-one support (85 people 06-13)
- Helping individuals access mainstream activities and opportunities
- Enabling service users to shape services and events (e.g. membership of Wellbeing Forum, Acute Care Forum, setting up World Mental Health day events)

Next steps: We wish to further support the development of peer networks, facilitation and mentoring. We are in discussion with service providers about this including the strengthening of social prescribing (Appendix 2)

4.1.2 Creative Engagement Activities

- Closely aligned to the above teams Creativity Works have continued to offer a range of creative opportunities as well as working very hard to help people establish their own projects.
- We envisaged that the arts could support people in the process of recovery from on going mental health problems, anxiety and depression through a wide range of creative projects including arts, crafts, creative writing etc. Participants could learn new skills, build confidence and make friends and be encouraged to continue the work themselves, supporting groups to become independent and self supporting.

- This has been successful e.g. the new art collective Tiny Monuments exhibition and the resultant Arts Award at the International Conference for Culture, Health and Wellbeing held in Bristol plus an award from Bath & North East Somerset Council for Outstanding Work with Children and Families for the project My Time My Space which supports women with low mood and postnatal depression (Appendix 3)

Next steps: we wish to continue these activities linked to peer support networks (see above) and the B&NES Wellbeing College – see 4.1.8.

4.1.3 Access to Quartet grants

- Quartet is a Charitable Foundation for the Bath & NE Somerset area, which holds funds and disburses them in the form of grants to charities, social enterprises and individuals against agreed criteria with the donors.

- We have donated mental health monies annually to Quartet to set up an endowment which provides seed funding for social enterprises, service user led groups and activities to provide the impetus and means to start or develop a service or group.
- This has provided an opportunity for peer groups to become established when they might otherwise have been denied the opportunity due to lack of capital or resources, as many service users are reliant on benefits. The Building Bridges and creative arts teams have supported people/groups to access this opportunity (Appendix 4).

Next steps: to continue with this community capacity building opportunity

4.1.4 Mental Health Re-enablement services

- The re-enablement service, delivered by Sirona Care and Health, works with residents who are experiencing mental health problems and who are eligible for social care under the terms of the local authority's eligibility criteria. The service works with people for up to 8 weeks and is free of financial contributions.
- The team works closely with AWP's Specialist teams and enables people to avoid admission into hospital as well as leave hospital appropriately, safely and as promptly as possible. The overall objectives are; to help people to remain living at home, to achieve maximum independence, to prevent hospital admissions (or re-admissions) and when appropriate, to reduce the level of care needed.
- The team also encourages people who have lost their skills for daily living, to re-learn them (or to acquire new skills), to build up their confidence and to enable them to be as independent as possible within their own homes.
- Kings College London have contacted the team to discuss being part of wider piece of research as currently we appear to be one of only two such services in the country.

Next steps: to investigate the possibilities of accessing a short stay, bed-based respite facility as part of this model.

4.1.5 Floating Support Services

Social Care funded Floating Support services are provided both as part of Supported Living accommodation and within the community. This service is chargeable.

4.1.5.1 Community Floating Support

- Since 2011-12 commissioners have retained within Sirona a social care funded Community Floating Support service for people with more complex social care support needs. This enabled retention of the skills and expertise of the pre-

existing social support teams and enabled us to measure the impact of personal budgets and the reablement service on local provision.

- This has resulted in being able to move staff into the reablement team in order to respond to demand as we have right-sized the provision.
- This team also offers a telephone support service which has been very popular and a floating support service that is funded by Supporting People monies and concentrates on housing/tenancy related support needs.
- Floating support services are also provided by other 3rd sector organisations via individuals' personal budgets for social care support and via supporting people funding for housing related support.

Next steps: Review the possibility of encouraging a village agent type of approach to delivering this support for the rest of the life of the Sirona contract.

4.1.5.2 Accommodation based Supported Living provision

- Whilst also providing floating support to people in their own homes- as above – some 3rd sector providers deliver more intensive support to people within accommodation units that the providers also manage. This is called Supported Living provision.

Next steps: We are currently working with providers to better understand their implementation and costing models for these services so that they represent good value for money as well as stability of accommodation for service users as we move forward with a more nuanced approach to individual budgets.

4.1.6. Work Development Team

- The team has continued to work well with the specialist mental health teams as well as with the Primary care talking therapy service. It hosts vocational advice network meetings (membership of 24 organisations) as well as training and holding advice sessions with the mental health teams.
- There has been an increase since 2012-13 in the numbers of clients seen for job retention support which often requires the team to work with the employers as well as the employee.
- A key area of concern for the team has been to support clients who have been in "permitted" work placements/experience who may be affected by the welfare reforms.

Next steps: Continue with plan of working with the Learning Disability commissioner to create an inclusive employment development service iduring 2014-15.

4.1.7. Advocacy services

- Access to advocacy services is a key component of mental health service provision.
- Following a re-commissioning process advocacy services for people under the requirements of the Mental Health or Mental Capacity Acts is now provided by Swan Advice centre.
- Bath MIND offer general advocacy support to people contacting them directly.

4.1.8 New development – B&NES Wellbeing College

We are currently working with the Public Health team to fund a project to develop a Wellbeing College to support local people to develop their confidence and ability to manage their conditions and maximise their wellbeing. We are extremely grateful to local providers and service users for coming up with and developing this idea.

The Wellbeing College will have a focus on providing courses which help people manage their long term conditions and mental health, develop a healthy lifestyle and achieve wellbeing. The work of the College will be integrated with mainstream

community activities and education in its broadest sense and will provide an umbrella concept for the delivery of many of our existing groups etc.

Through a "college" approach a range of educational courses and access to resources can be made available for people to understand their conditions, share their experiences, learn ways to manage their conditions, build their skills, support one another and take control. It is based on the premise that people can learn how to take care of themselves and others through education.

The College will enable participants to have more independent and fulfilling lives by positive access to a wide range of opportunities that include social, leisure, sport, health, work, training and volunteering.

Next steps: A specification for the two year pilot, delivered through existing resource, is currently being finalised.

4.2 Primary Care Talking Therapy service update

- As previously reported the CCG re-commissioned its GP based counselling services and the Improving Access to Psychological Therapies (IAPT) into a single Primary Care Talking Therapies service.
- The Avon and Wiltshire Mental Health Partnership Trust were the successful bidders for the service (Appendix 5).
- The new service started on August 1st and is currently running its consultation on staffing structures for transferring staff as well as seeing new and waiting clients as part of its transition plan.
- The commissioners are working very closely with AWP to ensure integration of the service with the primary care liaison service and successful short and longer term implementation of the specification. This is being most helpfully supported by the new AWP locality specific management team for B&NES who are absolutely committed to working in partnership with other organisations and practitioners to deliver services. The team is:
    - Dr Bill Bruce-Jones – Clinical Director
    - Liz Richards – Managing Director
    - Claire Williamson – Head of Professions

  (Please note the new locality structure is in line with the previously reported Fit for the Future programme of change in AWP that committed to restructuring to ensure locally responsive operational activity and on-going quality and performance improvement.)

5 RISK MANAGEMENT

5.1 Risks associated with redesign are being managed as part of the Supporting People and Communities and the Primary Care Talking Therapies implementation programmes.

6 EQUALITIES

6.1 Equality impact assessments have been reported previously. Not applicable to this update.

7 CONSULTATION

7.1 There is on-going consultation (sector reviews) taking place with community providers through a series of events.

7.2 All mental health developments taking place in conjunction with the Mental Health Wellbeing Forum and service users.

7.3 AWP are working closely though formal HR processes with all staff on the implementation of the new services model.

7.4 No specific consultation has been undertaken on the contents of this update.

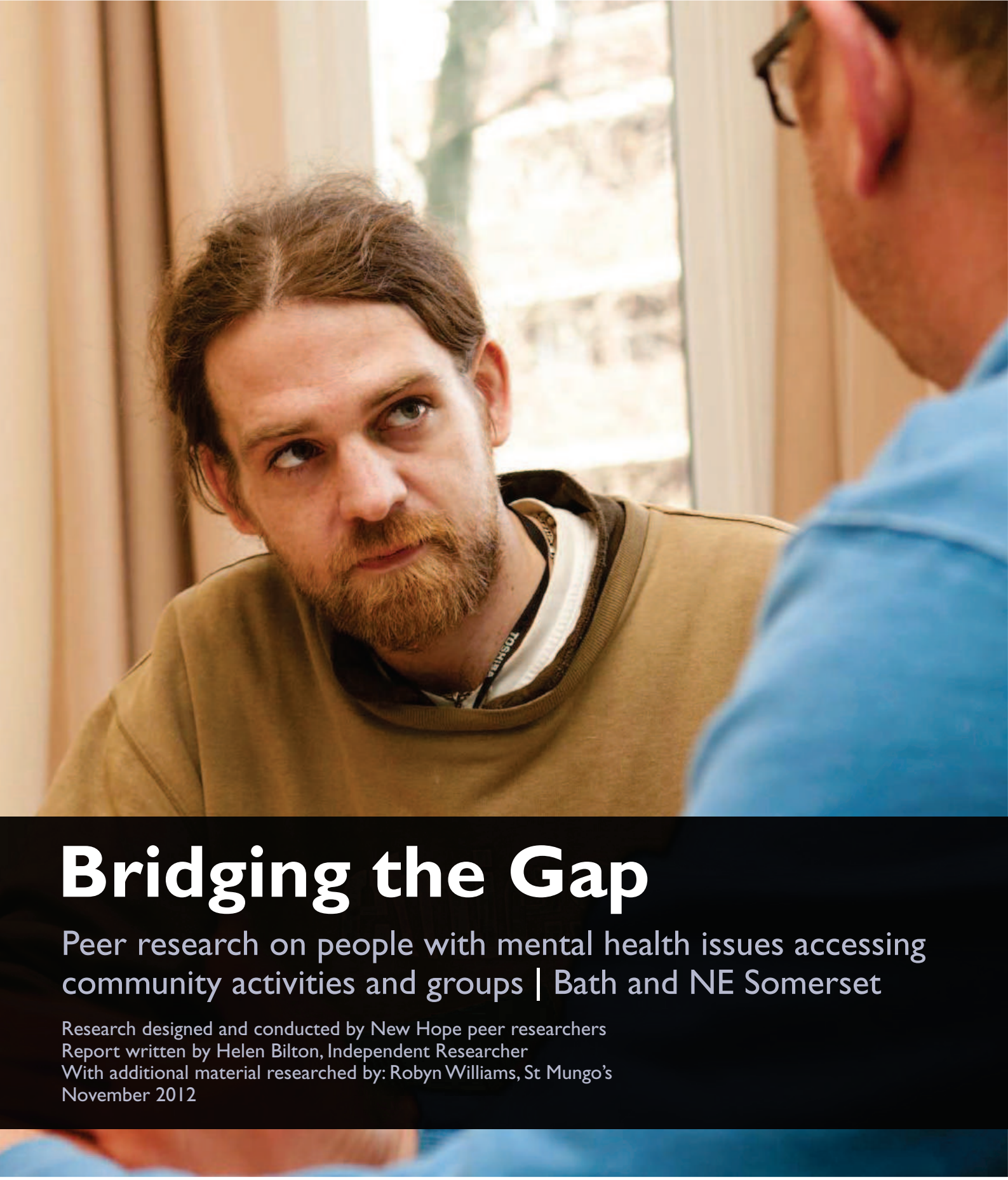
8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Human Resources; Health & Safety; Impact on Staff

9 ADVICE SOUGHT

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

Contact person	Andrea Morland, Associate Director Mental Health and Substance Misuse Commissioning 01225 831513
Background papers	*Equity & Excellence: Liberating the NHS (DH 2010)*, sets out ambitions to make primary care the nexus of health care planning, commissioning and delivery, with acute/secondary care services restricted for those with the most severe conditions. Care close to home is emphasised, as is a focus on clinical outcomes and the patient experience. *The Transforming Community Services (DH 2010)* program states that Community services are changing to provide better health outcomes for patients, families and communities and to become more efficient; by providing modern, personalised, and responsive care of a consistently high quality that is accessible to all. *Bath and North East Somerset Joint Mental Health Commissioning Strategy 2008-2012 (currently under review for 2013-18)*
Please contact the report author if you need to access this report in an alternative format	



Bridging the Gap

Peer research on people with mental health issues accessing community activities and groups | Bath and NE Somerset

Research designed and conducted by New Hope peer researchers
Report written by Helen Bilton, Independent Researcher
With additional material researched by: Robyn Williams, St Mungo's
November 2012

Introduction

This report examines what helps and what hinders people affected by mental health issues when accessing groups and support which would improve their overall wellbeing. The research was carried out by St Mungo's peer researchers who are clients and carers affected by mental health issues themselves. These researchers were particularly keen to research access to peer support groups and statutory mental health services. However the findings and recommendations can be applied to any form of group or service.

Method

St Mungo's commissioned this peer-researched qualitative study in early 2012 in order to find out what needs to be done to build bridges between people with mental health issues in B&NES and services, groups and activities that could support improvements in their wellbeing. Through the peer research process and interviews with 42 service users with experience of mental health issues (including some carers) the five New Hope peer researchers identified the problems and came up with suggested solutions.

It should be noted that the majority of people interviewed were already accessing groups and have support networks in place. However most had been more isolated at times in their lives; the report examines this experience.

Structure of the report

We organised our findings around six 'gaps'; areas where there was clearly room for improvement and where we could recommend bridges to better wellbeing.

The 'gaps' take many forms showing that there is simply no one-size-fits-all approach to improving access. The six gaps are:

1. Improving wellbeing in general
2. Connections between people
3. Statutory services
4. Motivation
5. Accessing services
6. Finding out about services

1. Improving wellbeing in general

We took it as a base assumption that good wellbeing is a desirable goal. In our background research we looked into many different studies which showed that wellbeing involves not just feelings of happiness but elements of functioning well both personally and in society[1]. We also found evidence for the crucial point that wellbeing and mental illness can be separated; that it is possible to have lived experience of poor mental health and good wellbeing (and the opposite).

Sociologist Corey Keyes argues for a "dualcontinua" model of mental health. In this approach, mental health and wellbeing are conceptualised as being separate dimensions from mental illness, allowing for the possibility that people with no mental health issues can still have low wellbeing "languishing" (in Keyes' terminology) whereas, conversely, those with significant mental health difficulties may also experience high wellbeing.[2]

The first thing we did in our study was to find out whether people had good or poor wellbeing, and what factors they felt affected their wellbeing. This is an important background to the subsequent sections on increasing participation in community activities; it provides the ultimate reason behind the work. If wellbeing were static or already optimised then there would be no reason to continue looking at improved access to community activities.

We looked at ratings of wellbeing against a definition devised by our own peer researchers:

Someone who has good wellbeing has a clear mind and feels safe, self-confident and happy. They have a sense of purpose and positive connections with other people and the community around them.

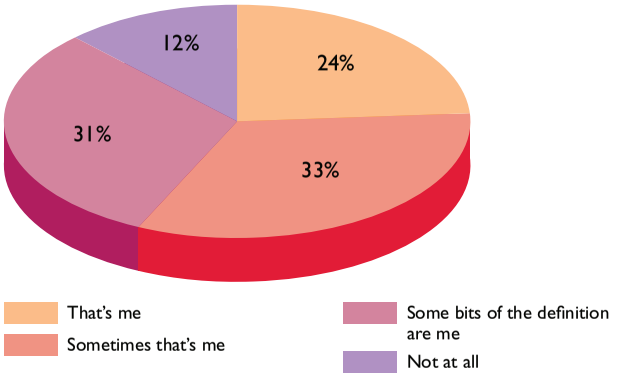
[1] Sources of this information are e.g. :
nef (2009) *National Accounts of Wellbeing: Bringing real wealth onto the balance sheet.* nef: London, 2009 http://www.neweconomics.org/publications/national-accounts-well-being
Foresight Mental Capital and Wellbeing Project (2008) *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century.* Government Office for Science: London, 2008 http://www.bis.gov.uk/foresight/our-work/projects/published-projects/mental-capital-and-wellbeing/reports-and-publications
Jahoda, M. (1958) *Current Concepts of Mental Health.* Basic Books Inc: New York, 1958 http://archive.org/stream/currentconceptso00jaho#page/n5/mode/2up
BNES Joint Commissioning Board *Mental Health Commissioning Strategy 2008-2012* http://democracy.bathnes.gov.uk/Executive/WL/2007/071221/01E1733zAnnex1.pdf

[2] nef (2011) *Five Ways to Wellbeing: New applications, new ways of thinking.* nef: London, 2011 http://www.neweconomics.org/publications/five-ways-to-wellbeing

We asked them to define their current wellbeing against this definition in general terms and also on a scale of 1-10. We discovered an average rating at present of 6.6 compared to 2.03 at respondents' worst ever point. Respondents wellbeing was overall three times higher now than at its worst, but still a long way from being at its optimum.

The real interest, however, came from the findings about how wellbeing fluctuates over time, and also how only parts of the definition apply as you can see in the following graph:

How much does our definition of wellbeing sound like you



For example:

Not like me. Have a sense of purpose, not a clear mind, don't feel safe or self-confident. Happy sometimes, connections with people with same condition as me. Find connections with people outside mental health difficult.[changes in the nature of wellbeing].

When I'm in a bad state, having one of my bad parts I can change very, very rapidly, change from positive and outgoing and suddenly pull back in, withdraw, don't speak to anyone, don't trust myself, don't believe in anything, I'm argumentative, I can go from being reasonably OK to suicidal in a matter of hours. [time-based changes].

We found that the parts relating to 'confidence' and 'connections with people and the community' were the areas that people were most likely to struggle with.

Our own work bears out the key point that good wellbeing and mental illness can co-exist; there are many examples of people who, despite suffering with a diagnosed mental illness, still rate their wellbeing highly. For example:

Since I've been in Bath I feel very confident, getting better rather than up and down. [Woman who lives in mental health supported housing who rated her current wellbeing as 10/10].

Does improve and change. May not know when it's gonna happen. When things are bad something positive generally comes out of it. [Man who suffers from depression who rated his current wellbeing as 10/10].

We asked our respondents directly how their wellbeing affects their day-to-day lives. We found that without exception wellbeing affected their ability to do things.

When I'm feeling really down my get up and go gets up and goes without me.

My level of wellbeing affects whether I go out or not. Bus service is terrible anyway but if I'm bad I just sit around in my pyjamas all day, not bothering to get dressed.

My level of wellbeing affects me massively. When its good I want to do all things. When bad it affects everything, all relationships, lifestyle.

My wellbeing can dip all of a sudden then I shy away from people and turn reclusive. I can sometimes control it, other times not.

Totally affected by my level of wellbeing. How I feel changes on what I feel I can do, its very, very important.

So, increased overall wellbeing is clearly a desirable goal and strongly related to activity and 'doing'. If we turn our definition on its head we would discover that what destroys wellbeing is having an unclear mind (i.e. feeling mentally ill), feeling unsafe/ insecure, unconfident, having no sense of purpose and being isolated from other people. Therefore the means to raise wellbeing involve tackling these issues. Subsequent sections address issues of statutory support, connecting with others, and participation in purposeful groups and activities. Each of these sections relate to the different components of our definition of wellbeing.

Recommendations for bridging the wellbeing 'gap'

- Build your service on a base assumption that improving wellbeing for people living with mental health issues and their supporters is both possible and worthwhile.
- Flexibility and continuity are the key to meeting the needs and aspirations of people who have variable mental health. This is particularly important for people rejecting support because of their low mental health (see 'Motivation').

2. Connections between people

People *need* connections. Our research shows that loneliness, isolation and disconnection exacerbate (even cause) mental health problems and impede wellbeing. We have already seen respondents were likely to feel their wellbeing was less good in the area of social connections and the need for positive, meaningful connections with others is rippled throughout the entire dataset.

We found that the people in our study highly valued their social networks and 78% had good support from either family or friends. The top answer to 'What helps the most' was basically 'connections with other people', e.g.

[What helps me most is] knowing people are there for support. Knowing that I am not alone even though it feels like it sometimes.

[What helps me most is] human contact.

[What helps me most is] having someone to talk to.

[What helps me most is] Talking, being listened to, being noticed. Knowing someone will share load/ understand what you are going through. Speaking to someone with MH problems.

[What helps me most is] Talking, medication is important but talking more so.

A couple of stories from our interviews are particularly poignant in showing how the simplest friendly action can have a profound impact on someone else. This woman doesn't feel like she has any friends but..

I'm a member of the WI although I haven't been to a meeting for a long time. The woman who runs it rang me to see why they hadn't seen me for a while and we got chatting. I told her I was due to go to the dentists and she offered to take me and she did. I offered her petrol money and she said ' You don't take petrol money from friends'. I was just so pleased that she said I was her friend, it really gave me a lift.

This woman, when asked what helps her the most says:

I would love to have a letter every day. I had an invite to a wedding the other day from an old friend, that was nice, made me feel nice – at least she hasn't forgotten me. You don't think people are thinking about you but they are.

We looked into the reverse of connection – loneliness and isolation[3] – with one of our questions 'Why do you think people with mental health issues often end up isolated?' Responses mainly split into two camps. One group said it's the nature of the illness; some mental illnesses make you want to retreat from the world, become apathetic to doing things or isolate yourself through fear, shame or low confidence. The other group of responses blames other people – people don't understand, stigma, judgement and fear.

Stigma or lack of understanding came through strongly with 69% of respondents saying that the attitude of others had a negative effect on their wellbeing. One of our interviewees said that:

[people become isolated because of] stigma, tend to keep to themselves because of how they're feeling. They disengage, I won't 'inflict' myself on others. Worry that others will think you're odd, worry about how you come across. Can make you less able to interact, depending on the issues.

Examples from the wider literature show that good social relationships are a protective factor for mental health and wellbeing. For example, a WHO report about the social factors involved in health concludes:

Social support helps give people the emotional and practical resources they need. Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health. Supportive relationships may also encourage healthier behaviour patterns. [..] People who get less social and emotional support from others are more likely to experience less well-being, more depression ... In addition, bad close relationships can lead to poor mental and physical health.[4]

A Mental Health Foundation report shows the far-reaching effects of loneliness and concludes that:

If loneliness is persistent or recurring, the person finds it even harder to relate to others. One of the paradoxes of loneliness is that it leaves people less able to forge the relationships which they crave[5].

Client-led groups and user involvement

There is a clear case to be made for user-led groups of clients with similar health issues, and peer support[6]. 53% of our respondents agreed or strongly agreed that they liked to be with other people with similar problems and only 13% disagreed. Many respondents said that they wanted to see more support groups, that such groups were what helped them most and that being with others with the same problems would help them feel more supported. This comment from someone attending a group for people with depression illustrates:

I don't talk a lot about my problems here but we're all pretty much in the same boat. I do like the company, reassuring to know you're not on your own, some of us go out for tea afterwards and carry on talking, not just about depression.

and this person would like more groups that bring together people with similar mental health issues:

A way of socialising – meeting other with similar issues. "There might be someone else like me", I would like to meet someone with the same diagnosis.

[3] It's fascinating that we used the word 'isolation' ourselves and not loneliness. Loneliness has such dreadful connotations in our society, we're almost scared to use the word. But also, isolation is something we do to other people (think prison, hospitals) and it is clear from the data that everybody has their part to play in reducing isolation/ loneliness.

[4] Wilkinson, R. and Marmot, M. (eds) *The Solid Facts (2nd Edition): Social Determinants of Health.* WHO Europe: Denmark, 2003 http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf

[5] MHF (2010) *The Lonely Society.* MHF: London, 2010 http://www.mentalhealth.org.uk/content/assets/PDF/publications/the_lonely_society_report.pdf

[6] See also, for example, Tait, L and Lester, H. 'Encouraging user involvement in mental health services' *Advances in Psychiatric Treatment* (2005), vol. 11, 168–175 at http://apt.rcpsych.org/content/11/3/168.full.pdf for an academic review of evidence.

People also talked about greater user involvement under 'what would you like to change about the services you use?' and 'What support would you like to enable you to access a new group?' For example:

[I would like to change services by having] more members to become involved in running things and making decisions. Staff to remain to take responsibility through. More frequently for longer hours.

[I would like to change services by having] more client-based groups where clients have greater input.

[To access a new group I would need] Something like Bath Survivors Network – the idea is we run it ourselves for people like us.

[What would help me feel more supported is] a group for mental health. As a group can get more access to services. Finding groups is hard.

There are two benefits with user involvement. One is the clearly identified benefit of meeting other people who have similar problems. The other is to do with autonomy and the fact that self-managed groups are effective in achieving the aims of service users. Client-led groups also link in to issues about motivation and access. We will see, when we look at these later in the report, that groups based around a common purpose are the most likely to succeed in improving wellbeing, and that most clients have a desire to 'put something back' and are therefore potentially motivated by being involved in setting up and running groups.

Recommendations on how to build connections between people

- Create accessible group and activity opportunities for people, that provide a sense of purpose, build confidence and reduce isolation
- Develop opportunities for people with similar health or caring issues to spend meaningful time together and peer support opportunities
- Maximise client involvement, including in service design, review and implementation
- Train staff and volunteers to model friendly, welcoming behaviour from the top-down. Even the tiniest of gestures can make a big difference to someone struggling with low wellbeing.

3. Statutory services

We looked at the support received from professionals because this was seen by our peer researchers and interviewees as a key factor in underpinning improved wellbeing. Respondents showed that if statutory services are not providing appropriate support, people feel 'stuck' and unable to improve their wellbeing.

Our respondents said they needed the bedrock of professional mental health support to rely on.

We looked at the support received from statutory services: 33% said that what would make them feel more supported was better professional support; 38% said that they wanted more services to be available; and 75% said they'd encountered delays or difficulties in getting someone to help them. Overall respondents reported that services need to improve.

Tried getting CPN (many years ago) was self-harming, unable to get support. Don't bother trying to get help from CMHT any more.

When first diagnosed – wrong tablets – tired/ sleepy and took a long time to convince doctor that the tablets were wrong.

Over medication and insufficient diagnosis, not enough support and groups to try and get back to normal life. Not just medicating.

Partner encountered problems when I had an episode – making phone calls – getting someone to help. Dr very unhelpful, I had left the house, the police were phoned and they picked me up. I was put in a police cell for nine hours. Episodes always seem to happen out of hours.

Over half of respondents who had been discharged had a negative experience of the discharge process, with 20% who had been discharged saying they had felt abandoned. One person made the point that services in general need to pay attention to endings and what happens when the group/activity stops:

Informal support ending – can be really damaging, no exit strategy. Rejection. Volunteers, e.g. when they go, just disappear.

Mental health crises are frightening and can be serious so we also asked about where people would turn in a crisis. We found that most people would contact their GP in a crisis but one in seven didn't know who to go to. Additionally there was a lot of distrust displayed regarding the statutory crisis team, particularly in terms of its reliability out-of-hours.

Have crisis team's number and did phone them recently and they were worse than useless. So [in a crisis I'd contact] probably no one. Next day I'd phone the GP but by then the crisis is probably over. I do have a couple of friends I could call but it depends what time of day it is and whats happening. I don't like to bother people.

Frightened to contact anyone, you'd be banged up immediately. They have terrible trouble with mental health services in this area.

Have no faith that the crisis team would answer their phone – making you more desperate.

When it works, this is what good support looks like:

Rang GP last November and got dealt with very quickly and also rang my consultant.

Good CMHT – current ones all turn up – good.

Suggestions from respondents:

At evenings and weekends there is less help than during week but needed more.

If the services were more open to honest discussion about what is going on – feels like banging your head on a brick wall.

A lot more frank information out there in much more publicly and upfront ways – e.g. about drugs and effects.

If you try and complain or address the issues, services close up and make you feel you're out of line. Acknowledgement on their part, genuine equal partnership, respect for you as the carer, respect for the family members, respect for the fact that you know yourself better than any professionals ever going to.

We have seen earlier that the people we interviewed typically had below-optimum wellbeing. When this is combined with poor mental health, this can easily create a gap between what people expect of services and what, realistically, those services can provide. We did find that as people's wellbeing increases it is likely to reduce their need for statutory services. In other words, whilst statutory services are clearly needed as a solid underpinning, their role is less critical as wellbeing improves and people are able to function better and manage their mental health more effectively. What also know from our research that people have strong opinions on statutory services and a variety of positive and negative experiences. People feel passionately about improving mental health services but find it hard to feed back their experiences:

[What would help me feel more supported is] knowing the system is being improved, so others don't have to go through the same issues with no support. Mental health services also need to take into account the impact on other family members.

Things do need change. There is a gap in the help process. Ground needs to be made in helping.

We call on statutory service providers to utilise this valuable feedback via the independent voluntary sector organisations who work with people affected by mental health issues. We also call for further research to be done to explore the issues of what statutory services could and should provide.

As with the previous section, individual social networks are seen as most important for replacing and complimenting a person's experience of statutory support. All these people rated their wellbeing as eight or higher – they are coping:

One thing that helps a lot that I've put into place is having a network of other people so its not just me who is responsible for my mum.

I find it very disturbing when she's psychotic – now with CPN and community living team and friends and neighbours, it really helps not being the only one.

[What helps me most is] Meeting friends and socialising. Seeing the counsellor. Getting away – visiting family.

Since I've been here I don't think I've needed support. If I got really ill I'd talk to Mary.

Building relationships between statutory mental health teams, people with mental health issues, their carers, supporters and peers is essential.

Recommendations for statutory services

- Develop closer working relationships between statutory mental health services and community organisations
- People's individual support networks consist of a mix of statutory and informal. Statutory services need to work as closely as possible with the individual's friends and family as they will be there when statutory services are not
- Statutory services need to request and utilise feedback from current and former services users via voluntary organisations
- Discharge is a particularly critical point where support is needed and statutory services need to ensure people don't feel 'abandoned'. Peer support could be especially valuable here
- Promote positive stories/outcomes you've had.

For all services, (especially) including informal groups

- Pay attention to exit strategies and don't allow people to end up feeling abandoned. Understanding and information will go a long way.

4. Motivation

Throughout our interviews we heard people talking about lack of confidence, fear, low self-esteem, apathy and tiredness. But we also realised that, despite this, most of our interviewees did actually do at least some things to fill their time. We needed to look in a bit more detail about what makes people get up and do things.

There is a known link between mental health issues and low motivation[7]. There is also a body of evidence to lead us to the key conclusion that 'doing' is important and motivation can be raised as a *result* of 'doing' rather than the other way around. Mastery of something – be it music, sport, an educational subject, arts or crafts or building a friendship, is an important psychological tool for improving wellbeing.[8]

The key motivating factors in our data were doing things people are interested in, and a desire to 'give something back'. For the first of these, we gave people a list of statements to see what level of agreement there was:

Table 1: General statements

Statement	% of agree + strongly agree
I find it easier to attend groups that have a purpose that I'm interested in	95%
When supporting people with mental health issues it is important to pay attention to details	89%
I like informal groups, more like meetings with friends	81%
I think there should be groups especially for older people	76%
I like to be with people in general, regardless of their mental health status	73%
I like groups in general	71%
Walking into a room full of strangers is intimidating	71%
I think there should be groups especially for younger people	68%
I find it hard to cope with full-on commitment to groups	55%
I think there should be women-only groups	55%
I like to be with other people who have mental health issues	53%
I think there should be men-only groups	48%
I like formal, structured groups	45%
Most people have a good understanding of mental health issues	15%
I like groups where I don't know anyone	12%

7 For example in:
nef (2011) *Five Ways to Wellbeing: New applications, new ways of thinking.* nef: London, 2011 http://www.neweconomics.org/publications/five-ways-to-wellbeing
Mental capital and wellbeing – making the most of our selves in the 21st Century. Executive summary final report. 2008.
http://www.bis.gov.uk/assets/foresight/docs/mental-capital/mentalcapitalwellbeingexecsum.pdf

8 Same resources

As you can see, the top most-agreed-with statement, for which support was almost unanimous, is 'I find it easier to attend groups that have a purpose that I'm interested in'. Whilst on the surface this might seem rather obvious it is actually very important to understand that motivation really is that simple – people will do stuff that they're interested in. There is more in the next section on the actual kinds of things that our respondents said they were interested in.

Another important finding is that almost half of our respondents are already involved in voluntary work, driven by the desire to fill their time and to 'give something back'.

[what helps most is] my structured lifestyle. Get up at 6, have a structure. It's nice to get up even if we have something wrong with us. Keep busy, do something for someone else. I feel very supported with the people I work with. All the young people teach me so much. It's almost unbelievable how much they teach me. At City farm – I'm a trained cook and she's not but she's better than me so we're connected. Support is getting on with people, in a way.

My sense of pride/ self-respect is tarnished by being on benefits – restored by putting something back to community e.g. playing piano at old people's home. Having self-respect is very important.

This woman's story vividly illustrates the varied and multiple factors that motivate her, including the support she gives back to other women:

I've enrolled on a three year Masters related to mental health issues. My mother was bipolar, my brother committed suicide, he was schizophrenic with a personality disorder. I don't like to subscribe to labels, I like to be unjudgemental. I'm a carer for my daughter who is 14 and hearing impaired, and my mother. Since I had her I've had post natal depression so I've had all kinds of psychiatric drugs which I know a lot about now, trying to come off them and never want to go back on. I love reading, I read loads both books and the internet. I walk a lot with dog. Hanging out and socialising with friends, lots of friends. I run a women's support group, informal helping women to link up together and help each other, supporting each other to achieve our hopes and dreams. Wednesday nights, we meet in a pub.

Recommendations to do with motivation, for service providers

- Flexible services, as recommended under the 'wellbeing' heading will accommodate people's fluctuating motivation
- Design services to overcome low motivation – attractive, based around people's aspirations, easy to use. People will be attracted above all by the 'purpose' of the group but may be put off by barriers – use the recommendations of the next two sections to ensure your services are easy to use and known about
- Develop involvement and volunteering opportunities for and with people affected by mental health issues. People want to get involved, so ensure your offer is as good as it can be.

5. Accessing services

In many ways this is the real crux of this research. The researchers took a look at the wide range of activities that people are currently involved in and then looked at what they would like to do but feel they can't and discovered some large gaps. We then looked at what specifically was preventing people from participating in the things they wanted to do.

This chart shows what our respondents are already doing:

Clearly this shows a wide range of activities and dispels the common myth that people with mental health issues spend all day in front of the TV.

We found that ordinary, everyday mainstream activities such as talking, socialising, faith, music, creativity, sport and work were what people were seeking. Getting together with other people who have mental health issues was also seen as important, as is involvement in setting up and managing activities and groups (see Section 2).

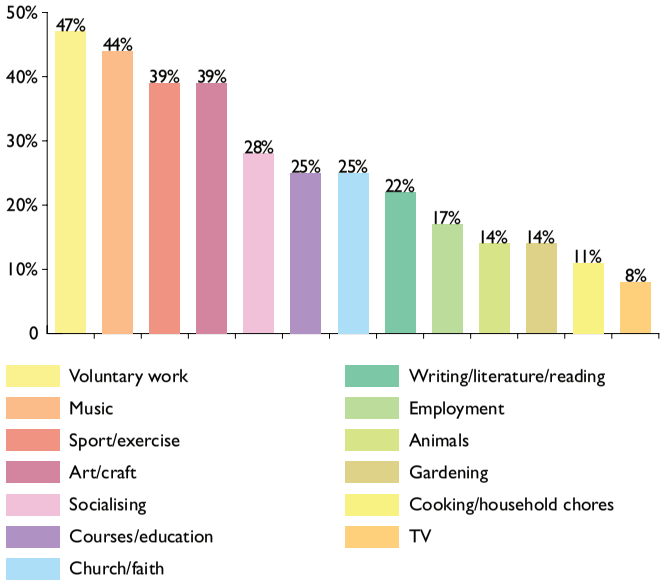
The purpose of the group is only one aspect; there are also other characteristics of a group such as the age or gender of people it is aimed at, or whether it is aimed at people with a particular mental health issue.

There is some support in figure 1 for groups targeting particular demographic groups – groups for older people get the most support (remembering that most of our interviewees were themselves older). We have already looked at the positive value of groups for people facing similar mental health issues under 'connections with people'.

Purely social groups are also considered valuable. There was considerably more support for 'informal groups, like meetings with friends' (81%) than 'formal, structured groups' (45%) in figure.

[I do go to a] social support group. Ladies group, meeting with friends – it did have support worker. 10 years - 6 people.

Activities respondents are currently involved in



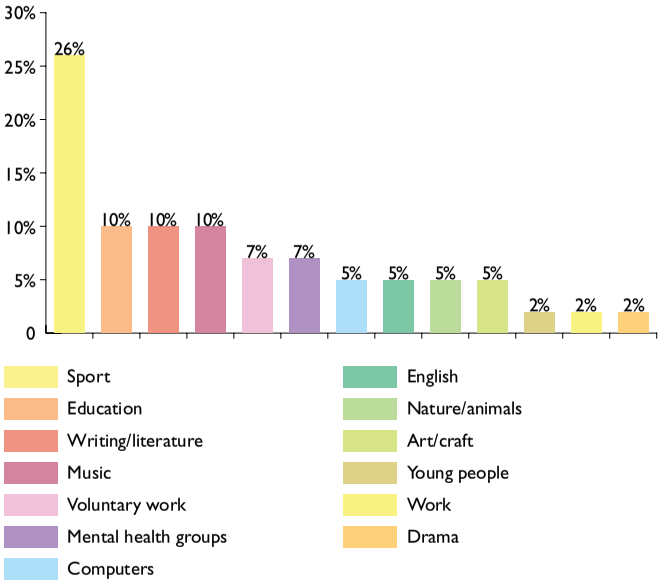
The key to getting people involved is to offer things they are interested in. What is very clear is that the purpose of the group does not have to be 'improving wellbeing'; that will naturally follow from people doing things they are interested in. Part of the remit of Bridges to Wellbeing is to get people involved in mainstream groups not just specialist mental health groups and the data proves this would be valuable – for example a specialist mental health allotments group simply may not be viable in terms of numbers or finance, but enabling someone with mental health issues to attend a mainstream group is much more achievable.

Most of our respondents had some kind of activity that they wanted to do more of but felt that there were things stopping them. The chart below shows what they wanted to do.

Sport overall came out as the most common activity that people wanted to get involved with but couldn't. Usually people mentioned quite specific things rather than the general categories – cycling, allotments, singing etc. Of course to an extent these things are localised – what may be hard to access in some areas may be easy in others.

We then asked specifically about the barriers which prevent people from participating once they have identified an activity they'd like to try (how to find out about groups and activities is dealt with in the next section, and we looked at low motivation as a barrier in the previous section).

Activities that respondents would like to try but can't



Barriers to participation ranked in order of importance

1=	Cost
1=	Transport
3	Confidence
4	lack of groups to go to
5	Mental health issues get in the way
6=	Unfit/no energy/tired
6=	Lack of time
8	Lack of knowledge about groups

What is interesting here is that the top factors are not psychological but highly practical – cost and transport.

Many people with mental health issues are on extremely low incomes or managing on benefits due to being unable to work. Cost is also linked to transport which, whether driving or buses/ trains, costs money. Many mainstream groups cost quite a bit to take part in.

I'd like to find another pottery group – doesn't have to be professional but access to clay and kiln is expensive. I find sculpting and pottery very therapeutic. I would also like to go to poetry reading group – but it's the cost of getting there and accessing the group that means I can't.

Mainstream art groups costly. MH/SU groups are free – maybe should encourage to attend mainstream.

A lot of it comes to travel, and cost. I wouldn't mind salsa dancing but you need black shoes and they're expensive.

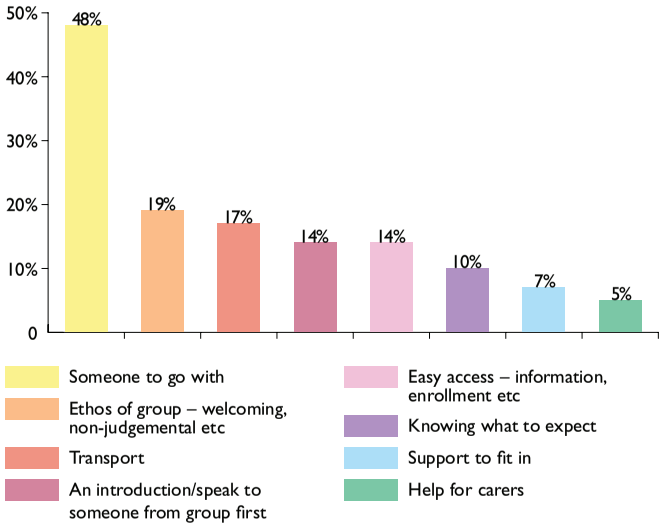
Music lessons – used to have them but they are too expensive. Would like to see a group which teaches music/ musical instruments (not just music therapy).

Transport problems are wider than just money, though. Parts of B&NES are extremely rural and transport can be hard to come by. This woman explains how her physical health problems prevent her from reaching an activity which would be ideal for her:

Also I used to be into gardening but with fibromyalgia I can't do

that any more, just look and weep. Got a little dog, keeps me going. There is a gardening group with raised beds in Bath but I can't get to it. I have a mobility scooter but can't get it on the buses.

Support people need to enable them to start new groups



Cost and transport are barriers to everyone, or at least they have the potential to be. Additionally, people with mental health issues and/or low wellbeing may have low motivation and poor resilience which means that they find it harder to overcome these barriers by themselves.

Confidence is a key barrier. We know from several other areas of the data that confidence is often lacking in our respondents. We asked a further specific question which asked what support people would need to attend a group for the first time. The results are pretty conclusively in favour of someone to accompany them, once again repeating our finding that connections between people are vital. However, the ethos of the group and ease of access are also very important.

This extract from one of our interviews shows how one woman learned the value of support and now offers it to others:

A few years ago I was much more timid. Still helps now to make contact with the person running a new group, nice to know what it's about, what to expect, talk to someone on the phone. With my own group I offer to transport or accompany new people because I think it's important and can be terrifying.

Offering any potential newcomers a lift in this way this solves several problems all in one go, transport, the need for someone to go with and an introduction to the group.

Recommendations for service providers on breaking down the barriers to their services

- **Cost.** Think about ways you can reduce, offset or subsidise the cost of your activities to make it more manageable for people on low incomes. Look for any grants that may be available or offer income-based charging scales. Consider ways in which you could get people to connect with each other and share the costs, or let people pay 'in kind', by contributing in some other way
- **Transport.** Consider how people will get to your group or activity, ensure there is access to good public transport, look into transport schemes in your area or organise lift sharing, this has the added benefit of putting people in contact with each other
- **Someone to go with.** Half of our respondents said they'd like someone to accompany them the first time they attend a group. Where appropriate, allow people to bring a friend to the first session, or support them to find someone who can accompany them. Befriending schemes are useful in matching up people in need of support with someone who can help
- **Be welcoming.** Train your staff and volunteers to be welcoming, friendly and non-judgemental and encourage them to explain the group clearly to newcomers.

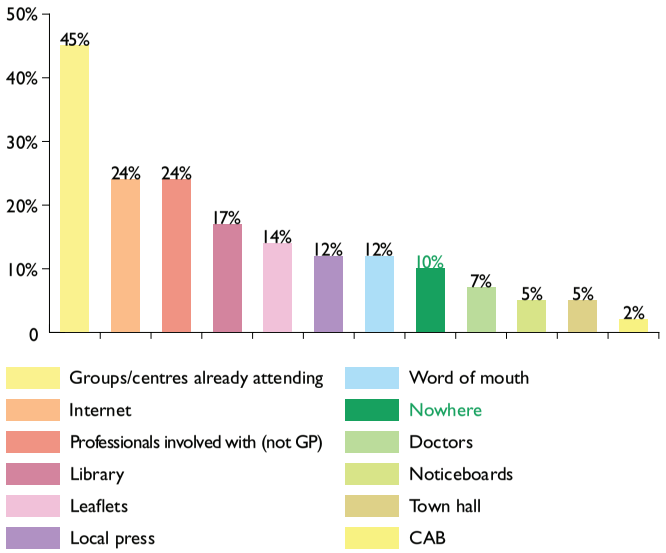
[9] For example http://www.bathnes.gov.uk/healthandsocial/communitytransport/Pages/MiniBusSchemes.aspx

6. Finding out about services and activities

Finding out about available services and activities is such an important potential barrier that we separated it out into a section of its own. We asked our respondents to tell us where they go to find out about things to do.

We found that one in ten respondents had no idea where to look for information about things to do and by far the most common way to find out was at groups or places the individual is already attending. Although, as these are very much the kinds of activities that this project is looking at, it does rather beg the question of how people found out about *them* in the first place. We assume that it was through some of the other means mentioned – support professionals, the internet, library, leaflets, press/ leaflets and their doctors.

Where do people find out about things to do



Looking more closely at this information, we also found that person-to-person delivery of information seemed to work best, especially as people with mental health issues may not actively seek information.

Things are put in front of me rather than me seeking it and this means I mostly meet other people with mental health issues. Pros and cons.

Once again we see the essential need for connections with other people – we see 'word of mouth' and 'professionals' on our list and we can be fairly sure that a lot of the information-passing-on that people get in drop-ins and other groups is personally presented rather than just picked up on a poster. And our categories hide

some of the other ways in which people need other people to find out about activities – for example, one person said they 'get others to check the internet'. Carers need information about activities too (for themselves and the person they care for) – it is no good offering information just to the ill person if it will never get to their carer.

Some interviewees expanded further on problems they'd encountered finding information:

Things are hidden away in pamphlets where nobody ever gets to them.

Not really anywhere for Mind, could call at head office. No drop-in centre [for information] really – could go to Hayhill if you knew about it.

Tried voluntary bureau in library but not very helpful. Internet is best bet (Lets Get to It).

The use of the internet is an interesting area – clearly not the most popular but used by about a quarter of respondents (24%). We asked a specific question about whether respondents have ever used a database on the internet called WellAware[10] which aims to provide information about local services. 98% of respondents had never used it, although three people had heard of it. The one person who had used it found it wooden.

The implications for service providers is that simply providing leaflets in information bureaux etc is not likely to reach potential users with mental health issues, more creative ways are needed.

Recommendations for informing people about services

- People find out about groups and activities from other people. Ensure that information about your service is available. Encourage word of mouth, perhaps by encouraging existing members to talk about their experiences at different places
- Do not rely exclusively on any one format, and particularly not the internet. Leaflets, noticeboards and local press are definitely useful but limited in their reach
- People very frequently find out about groups and activities at the places they already attend, and from professionals involved in their support – target these
- Remember that people with mental health issues may not proactively seek out information at all, they may only react to information provided to them. Don't always expect people to look for information about your service/group, get out there and deliver it to them
- Make sure your information reaches carers too.

10 http://www.wellaware.org.uk/ Accessed 19/6/12

Conclusion

This report aimed to find out what needs to be done to build bridges between people with mental health issues in B&NES and services, groups and activities that could support improvements in their wellbeing.

Through the peer research process and interviews with 42 service users (including some carers) we established the issues and came up with recommendations for solutions.

We organised our findings around six 'gaps'; areas where there was clearly room for improvement. In summary the gaps were:

1. Improving wellbeing.
2. Connections between people.
3. Statutory services.
4. Motivation
5. Accessing services
6. Finding out about services

The research showed that what may not be a barrier to someone without a mental health issue in accessing a service may present a significant obstacle to someone *with* a mental health issue because their motivation might be low and therefore they do not have the requisite inner resources to overcome it.

What we also found was that the gaps are all intertwined with each other; in particular, a strong theme which came out of the data is that overarching all of the 'gaps' is the need to improve connections between people. There are many, many things we can and should be doing towards improving wellbeing for those affected by mental health issues in B&NES but building social relationships, networks and ties underpins anything else you might do.

We found that people are motivated by interest, by enjoying something and by getting something out of it (including a very strong desire to 'put something back' into society). Offering opportunities for people to do things they are interested in, and building ways for as many people as possible to access them, *is* working towards improving wellbeing.

In conclusion, we say that our study found below-optimum wellbeing amongst our study population and identified many areas where changes could be made to achieve better wellbeing. We found that there is no magic silver bullet which will instantly transform people's lives; instead a wide and deep ranging approach is needed, reaching across 'service' boundaries and being prepared to delve into profound topics such as loneliness, friendships, community, motivation, client involvement, what really works and what wellbeing actually means. Whilst there are no quick-fixes there are undoubtedly things that can be done in the short-term, quickly and cheaply, which would work towards wellbeing goals. And, in addition, there are medium-to-long-term adjustments which need to be made to systems, structures and attitudes which will make the lasting difference. Our evidence suggests that the benefits of making these changes and building the bridges to wellbeing would be immense.

St Mungo's Bridges to Wellbeing

The Bridges to Wellbeing service works with people with low to moderate mental health needs in Bath and NE Somerset. The aim is to enable people to have more independent and fulfilling lives by developing peer support networks and groups. It supports and collaborates with:

New Hope

A forum for those who have been affected by mental health issues (inclusive of clients, carers and supporters) who are involved in improving local groups and services and reducing stigma surrounding mental health.

Mission: To reduce stigma surrounding mental health issues and to be actively involved in improving local services used by those effected by mental health issues.

Aim: To use the skills and talents of group members to improve the experience of living with mental health issues in B&NES, empowering those who get involved and inspiring others

Together New Hope and St Mungo's Bridges to Wellbeing provide:

- **Training** – including recovery and recovery star, safeguarding, boundaries, self development, facilitation and mentoring skills. Wherever possible this is co-delivered.
- **Grants** – Anyone affected by mental health issues can apply for funding to set up a group. The clients, staff and commissioner panel, have allocated £4000 to five groups – Tiny Monuments, 12 O'clock club, Speaking Circles training, Creative Individuals, Mulberry House FC. Other groups in development include: Keep Safe Keep Sane for carers, Personality Disorder Support and Surfing.
- **Volunteering opportunities** – Including: Planning and delivering World Mental Health day; Peer research; Designing and running a What's On website; Peer mentoring; Co-facilitation of groups, meetings and events.
- **Support** – One to one and group support to clients setting up groups, activities and delivering training and all clients involved in New Hope.

To find out more or get involved
Tel: 07825 115 775 **Email:** rlillywhite@mungos.org

For more information please contact:
St Mungo's, Griffin House, 161 Hammersmith Road, London W6 8BS

Tel: 020 8762 5500 Fax: 020 8762 5501
Email: info@mungos.org www.mungos.org

Registered Charity No. 1149085
Company No. 8225808
Housing Association No. LH0279

St Mungo's

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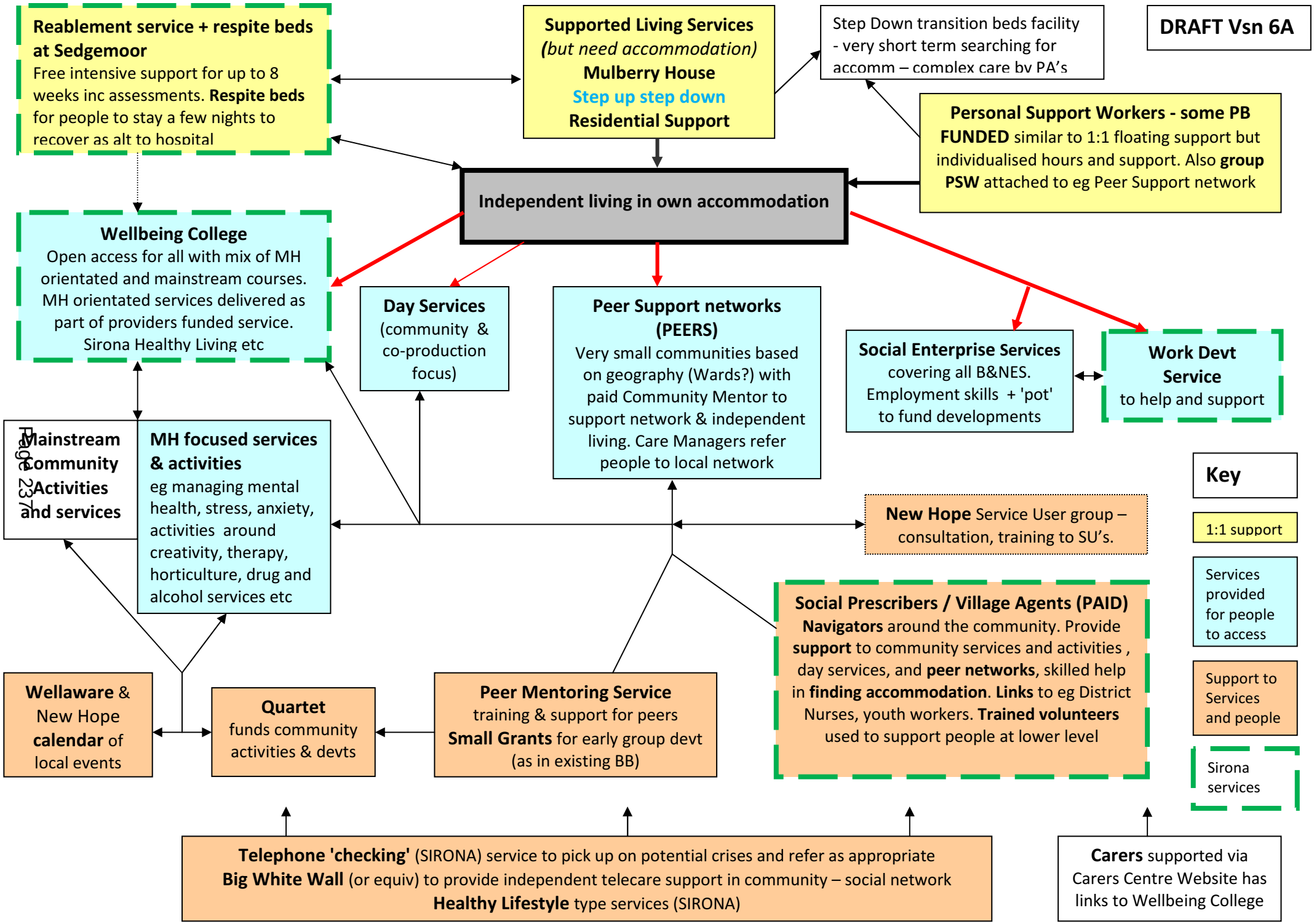
DRAFT Vsn 6A
Reablement service + respite beds at Sedgemoor
Free intensive support for up to 8 weeks inc assessments. Respite beds for people to stay a few nights to recover as alt to hospital
Supported Living Services
(but need accommodation)
Mulberry House
Step up step down
Residential Support
Step Down transition beds facility - very short term searching for accomm – complex care by PA's
Personal Support Workers - some PB FUNDED similar to 1:1 floating support but individualised hours and support. Also group PSW attached to eg Peer Support network
Independent living in own accommodation
Wellbeing College
Open access for all with mix of MH orientated and mainstream courses. MH orientated services delivered as part of providers funded service. Sirona Healthy Living etc
Day Services
(community & co-production focus)
Peer Support networks (PEERS)
Very small communities based on geography (Wards?) with paid Community Mentor to support network & independent living. Care Managers refer people to local network
Social Enterprise Services
covering all B&NES. Employment skills + 'pot' to fund developments
Work Devt Service
to help and support
Mainstream Community Activities and services
MH focused services & activities
eg managing mental health, stress, anxiety, activities around creativity, therapy, horticulture, drug and alcohol services etc
New Hope Service User group – consultation, training to SU's.
Social Prescribers / Village Agents (PAID)
Navigators around the community. Provide support to community services and activities , day services, and peer networks, skilled help in finding accommodation. Links to eg District Nurses, youth workers. Trained volunteers used to support people at lower level
Wellaware & New Hope calendar of local events
Quartet
funds community activities & devts
Peer Mentoring Service
training & support for peers
Small Grants for early group devt (as in existing BB)
Telephone 'checking' (SIRONA) service to pick up on potential crises and refer as appropriate
Big White Wall (or equiv) to provide independent telecare support in community – social network
Healthy Lifestyle type services (SIRONA)
Carers supported via Carers Centre Website has links to Wellbeing College
Key
1:1 support
Services provided for people to access
Support to Services and people
Sirona services

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Creativity Works' Mental Health Creative Support Service - Executive Summary
April 2012 – March 2013

The Mental Health Creative Support Service [MHCSS] **provides a person-centred process of engagement and progression, which supports people with mental health needs in B&NES to take up opportunities in the community and support their transition from using mental health services to community, based activities.**

The Mental Health Creative Support Service delivered 10 creative projects across B&NES to over 100 people and 7 events, which reached an audience of over 570 people. Support of 6 creative peer-support groups, 5 of which developed this year has involved 43 people in volunteer roles and promoted greater connections with community and culture. Participants on the creative courses said they were very satisfied with the service and that it had helped them make connections with community and culture and develop social networks.

Working with 13 experienced artist facilitators in a wide variety of art forms from creative writing, to visual arts and dance has enabled people to express themselves in different ways and feedback shows that taking part has increased participants confidence, self esteem and promoted positive identity. Increased learning of new skills in creative thinking and creative arts has inspired wider aspirations and motivation and as a result outcomes have included people taking up new leisure interests, volunteering opportunities, returning to work and starting up businesses. With opportunities to share and profile work through celebrations, exhibitions and events at community and cultural events a sense of pride has been developed amongst participants and has helped reduce stigma around mental health issues promoting personal and encouraging stories in a positive light. These events have given the wider public opportunities to share their feelings about mental health and offered them a sense of support and inspiration.

The effectiveness of creative mental health support is shown through the 6 creative peer support groups that have continued to develop. Benefits to individuals include supporting each other's creative aspirations and plans for the future, teamwork and shared decisions, enabling support through difficult times and helping to move ideas on. The groups help address social isolation and bring a new sense of purpose, which boosts motivation and aspirations. Participant volunteers in new creative groups have taken on roles such as fundraising, planning and booking venues to enable their networks to establish and keep connected.

There are greater connections with statutory, community and cultural organisations as a result of the creative groups and they are greatly valued by those that attend and other community organisations. The 'voices' of people with lived experience of mental health are enabling and influencing the design of new groups and services so helping to meet the requirements of local people with mental health issues.

Outcome	Outputs	Benefits of the Service
Outcome 1 **Increased numbers of people with mental health problems have better access to community services and activities, which meet their needs and improve their health and wellbeing**	**Project Outputs** • **13 new creative projects** across Bath & North East Somerset • **125 sessions** April 2012 – March 2013 • **107** total enrolments, 760 total attendances • **3 projects** attracted further to support vulnerable families • **Participants voices** and needs influence the delivery of the MHCSS • **121 people** say they are very satisfied with the service • **96% of participants** very satisfied and satisfied with the service **Celebration and Event Outputs** • **7 events delivered** • **26 sessions delivered at events** • **Involved 26 participant volunteers in various roles at events** • **Delivered to an audience of 577 people over the 7 events**	*Gave me a target to attend each week * Good to meet other people * Doing something with your hands takes off the pressure. It's therapeutic without feeling like therapy * It introduces you to something different you haven't done before. Builds your confidence up which is a big thing * It took me 3 weeks to pluck up the courage to come. Now I look forward to it each week * Knowing that I'm not alone with my mental illness * We're getting value for money rather than paying for care coordinators * I wouldn't go to a group where there was a specific label of mental health. I don't want to be labelled * I'm proud to be who I am and what I've been through * Helped give a structure to my week and a place to meet people * I do more exercise at home because of this * Finding myself again and developing after being institutionalises and long hospital admission*
Outcome 2 **Increase in peer support groups available**, which assist service users to become self-supporting. **Communities develop initiatives that address local issues**, providing local solutions to local needs.	**Outputs - New peer support groups** • **5 new creative peer support groups start up** • **43 people** involved in the set and management **of 6 creative peer support groups** • **7 groups** supported to apply for **new funding** through the St. Mungo's fund and Quartet • **6 successful fundraising bids by new peer support groups** • **1 person supported to enable a personal development course** • Creativity Works successful in a Quartet bid to support volunteers • Participants and artists help shape a creative service and new volunteer roles • The reduction of use in Community Mental Health Services • Rise in number of participants who access education, training,	• *Hearing each other has been really interesting. It has turned us into a really nice group. We have got on well and talk to each other about our group.* • *Encouragement, feedback and picking out areas that are strongest in our work* • *Endings can be perceived as beginnings – the desire to continue – build, grow, this energy creates something new* • *Would be good to build on what we've done and try new activities.* • *We could show work by the council offices. Would like to have an exhibition'* • *Getting myself out and about and meeting people*

	employment and volunteering • Creative projects have impact on individuals and their families as peer support groups strengthen positive experiences, social support networks and raise aspirations	• *Having review meetings with everybody – very good*
Outcome 3 **Evidence of the number of people aware of Wellaware** (and other signposting facilities),	**Mapping of Creative Activity in B&NES** • Mapping of creative art forms in B&NES informs furthers community opportunities for participants. • Mapping knowledge shared with St. Mungo's to help update a local website built by volunteers • Extra funding attracted from Arts and Health South West to enable a B&NES wide mapping of creative organisations • Number of people who said they have heard of Wellaware = 1 , not heard of Wellaware = 12 (See full report Appendix 1. A Research Report on Arts and Wellbeing Practice within Bath and North East Somerset September 2012)	
Outcome 4 **People are supported and encouraged to take up volunteering opportunities** in a social context **Indicator** Increased number of volunteers	**Outputs** • 43 people become involved in running volunteering their time to run their own new peer support groups • 10 people are supported in volunteering roles to organise World Mental Health • In partnership with St. Mungo's a programme of training devised to support artists and participants/ service users.	
Further Outcomes: **Project Partnerships** **New partnerships have supported the referrals into the creative projects and the**	**Partnership Organisations:** AWP Recovery Teams, Older People Liaison Team and Therapies Team Bath Library Bath Literature Festival Bath College Community Learning Service	**Referral Organisations:** Creativity Works Through my GP New Routes Word of mouth

delivery of projects and events across B&NES	First Steps Children's Centre Keynsham Children's Centre New Routes, The Care Forum Radstock Children's Centre Sirona, Community Options Team Sirona Health Visiting Teams St. Mungo's Building Bridges Service	Hay Hill Psychological Therapies Service Through social worker Sirona Health Visitors Community Options Team AWP Genesis DHI Julian House
Digital Development	• Creative Mapping feeds into the St. Mungo's local mapping website • Creative projects include the following Blogs: ○ **My Time My Space Keynsham** blog - http://elementalanita.wordpress.com a private review of the project process made by the artist and shared with participants ○ **My Time My Space Radstock** blog - http://mytimemyspaceradstock.blogspot.co.uk/ a private review of the project process made by the artist and shared with participants ○ **Black Dog**: www.theblackdogresidency.tumblr.com	

For detail see full **Creativity Works' Mental Health Creative Support Service Report, April 2012 – March 2013**

Philippa Forsey, Creativity Works Wellbeing and Arts Project Manager, April 2013
philippa@creativityworksforeveryone.co.uk 01761 438852 www.creativityworks.org.uk

QUARTET funding Programme **Name:** B&NES Supporting Communities **(45 records)**		
	£49,767.20	
Age UK Bath & North East Somerset		For a garden/allotment project, allowing older people of 50 years plus to enjoy gardening in a space that they may not have at home
Age UK Bath & North East Somerset		For staff costs to expand the groups befriending services to its members who are housebound and living alone
Art at the Heart of the RUH		To run a pilot programme consisting of 24 sessions of creative writing, reading and interactive storytelling activities for patients on one of the Older Peoples Units at the RUH
BANES Football Club		For football coaching and venue hire to continue training sessions for people with a mental health/learning disability
Bath City Farm		To supply and install wooden structure with turf roof to enable members to continue with word work activities in all weather
Bath City Sound		For capital items for the groups new studio at the Aquaterra complex in the centre of town
Care & Repair Somerset		For staff costs and room hire for reading sessions
Care & Repair Somerset		For staff costs and room hire for reading sessions, for the extension of pilot project based in community cafe in the deprived town of Radstock
Care Forum		For the town hall rental for a community arts and health project for people suffering anxiety, depression and isolation
Chew Valley Community CIC		To provide a dedicated Village Agent to address the unmet needs of the older population
Chew Valley Monday Club		Towards catering costs for the group
Creativity Works (nesa)		For staff costs to help facilitate and train volunteers to support new

	creative groups in B&NES, including group management, signposting, help with funding bids etc
Foxhill Point Community Group	For gentle exercise classes (exercise tuition provided by Community Learning) and reminiscing sessions for over 60's, both projects aimed to improve mental health and wellbeing
Genesis Trust	For a new PC to be used by staff and service users
Greenlinks (Supported by Bath Mind)	Towards a trained horticulturist to deliver training on basic elements of horticulture to the regular group of members and for a trained therapeutic horticulturist to support volunteers who are not so far along their recovery
Inspirational Art & Craft Group	For tutoring costs and capital items for ongoing creative art sessions for adults suffering mental health issues
Julian House	For members of the SEEDS group will carry out a piece of research across Bath and North East Somerset to better understand and represent the views and experiences of women who have/are experiencing domestic abuse
Julian House	For a series of six week yoga courses for homeless, socially excluded and vulnerably house service users
Mothers For Mothers	For continuation of the groups service supporting women and their families in B&NES
Mothers For Mothers	to train volunteers and bring postnatal illness counselling service to B&NES
New Hope/Bath Mind/St Mungo's/Soundwell/Care Forum/Creativity Works For Everyone	Towards venue costs for an event to improve the confidence and wellbeing of individuals affected by mental health issues
New Hope c/o St Mungo's	For 10 memberships for the groups members to access the Big White Wall mental health forum 24/7

Positive Action on Cancer	To fund the venue rental costs for counselling service at the Southside Family Centre in Twerton, Bath
Read Around Bath	Towards co ordinators salary to develop the reading service for the socially isolated and vulnerable people in the Banes area
Read Around Bath	For co ordinators salary to extend groups reading services for the socially isolated
Somerset and Wessex Eating Disorders Association (SWEDA)	To bring a desperately needed specialist primary care eating disorders service to Bath
Soundwell Music Therapy Trust	Towards various new instruments, drums, melodean, Celtic Harp etc
Soundwell Music Therapy Trust	Towards weekly music therapy workshops in Bath for people suffering from Dementia and their carers
Southside Family Project	For Southside staff costs to support new initiative -setting up a Hub group on Foxhill Estate, Bath
St Mungos	For a double cross country skier as part of the required gym equipment for the group to establish a new outdoor green gym
SWALLOW	For expansion of the incredibly popular Boogie Nights dance classes
SWALLOW	To run a relaxation and yoga course for both members (people with learning disabilities) and staff to learn a variety of stress management techniques
SWALLOW	for support workers for football sessions for members
Tiny Monuments	This funding will enable the Tiny Monuments group to build their own creative, collaborative project for and managed by people with and recovering from mental health issues
Writing Space c/o Creativity Works	For staff costs and publicity costs to generate more members

Local services grant panel 2011-2013

Using Bridges to Wellbeing finance a panel meets 6 times a year and is made up of New Hope members, B&NES commissioner, St Mungo's staff and staff from Creativity works or Soundwell. Over the last year the panel has allocated £8819 to the following eight groups:

1. **12 O'CLOCK CLUB**
   The group meets weekly at a tea shop in Radstock and go to places of cultural interest. The group improves the self-confidence of its members who do things as a group which they wouldn't do alone and provides something positive to look forward to. Having a group which is regular and constant provides a structure to the week of those involved which they find helpful for their well-being.
2. **Creative individuals**
   This group began as a writing group within Hayhill social support group and supported by Creativity works. The funding enabled this group to move to the library, progress as a more independent group with more input into the direction and progress of the group and utilising a tutor every other week rather than every week.
3. **Speaking Circles**
   The course creates a safe space that supports participants to be able to face the fear of being in groups and public speaking & as a result improving their self confidence. Three hour session once a week for 4 weeks, with an experienced trainer who received very positive feedback from the seven participants including "Couldn't have felt more comfortable with John" Four participants particularly liked the practical tips they got on the course. The next course is being planned at the moment.
4. **Tiny Monuments**
   A mixed media, collaborative arts project based in Bath for individuals to express opinions about their life experiences in a positive way. There are 14 regular members who meet weekly. The group recently exhibited at Bath Literature Festival and two members have also had their work published. This group is supported by Creativity works.
5. **Mulberry House FC**
   St Mungo's Mulberry House residents and staff applied for funding, did the promotion and put on a very successful event that also included teams from Julian House, Community Options and Percy Community Centre the event also included food and was a great success and all teams are looking forward to the next events on 10th April and 19th June .
6. **Surfing**
   The funding is enabling a group of up to11 people per session to enjoy a day out at Woolacombe, some of this group will be having surfing lessons; sessions start on 17th May. The group's aims are to improve confidence; create friendships and bonds;

increase social networks; get a new hobby; learn something; offer escapism; be by the sea, and surfing. The group have booked transport, completed a risk assessment, and started promotion etc

7. **Sing & Smile**
   The sessions offer an opportunity to sing songs from around the world, and develop your voice in a relaxed and friendly atmosphere. This group meets weekly in Bath and is supported by Creativity works
   “Helps people feel good after the session having a long term effect on wellbeing” (Group member feedback)

8. **Breathing Space**
   To maintain and develop a pre-existing therapeutic art group in Keynsham, for local people who experience severe anxiety, depression and social isolation, with the aim of alleviating and overcoming our conditions through creative activity and social interaction. This group is supported by Creativity Works

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Bath & North East Somerset Council

NHS Bath & North East Somerset Clinical Commissioning Group

Primary Care Talking Therapies

Andrea Morland and Sue Blackman

Date: 25/07/2013

Healthier, Stronger, Together

Background and Overview

NHS Bath & North East Somerset Clinical Commissioning Group

Recommissioning rationale

- IAPT contract due to end and model needed strengthening for long term conditions
- Counselling provision needed re-tender because:
  - Variation in quality/quality assurance across B&NES
  - Information governance issues
  - Counselling approach limited to within practice – apart from Southside (St Michaels)
  - Outcomes information inconsistent
- Bring all approaches together in a single NICE compliant service

NHS Bath & North East Somerset Clinical Commissioning Group

Background to LIFT Psychology

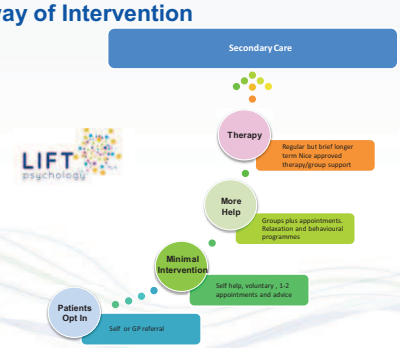
- Developed by GPs and psychologist Liz Howells in Swindon many years ago
- Based on a belief that counselling approaches are well suited to managing distress
- Adapted range of support and intervention to include national IAPT programme
- Taken up by all GP practices in Swindon and Wiltshire
- Also delivering services in Bristol and South Gloucestershire

LIFT psychology

NHS Bath & North East Somerset Clinical Commissioning Group

Focus of the service

Pathway of Intervention

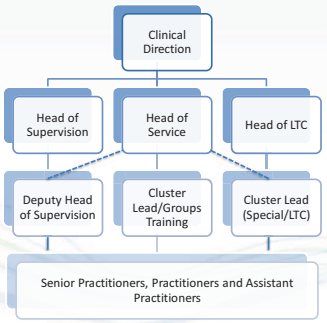


Delivery

- Locally based services –
  - prefer GP practice appointments where possible
- Dedicated phone line
  - for booking appointments
- Wide range of psychological courses
  - delivered in local venues
  - with live website booking
- Extended hours

Links

Workforce

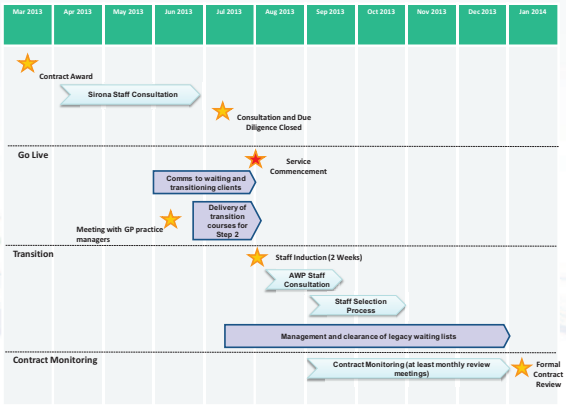


NHS Bath & North East Somerset Clinical Commissioning Group

Transition and Comms Plan

NHS Bath & North East Somerset Clinical Commissioning Group

Implementaion Overview



Procurement Lessons Learnt

- Assessment/scoring methodologies to be scenario tested
- Clarity of intention around financial values
- Emphasis on added value contribution from providers to be factored into assessment
- Potential end results of tendering to be scenario tested/risk assessed for impact and local relationship dynamics
- Resultant range of commissioning risk management plans to be formulated for action.

NHS Bath & North East Somerset Clinical Commissioning Group

Implementation Lessons Learnt

- Early engagement at Executive Level between providers is key to setting the aspirations and strategy for the transition:
- Inclusive and consultative approach with outgoing provider
- Dedicated, experienced Project Management resource
- Regular project reviews and integration of work streams
- Early identification of communication strategy and plan to be shared with commissioners – especially when there are multiple affected providers (GPs)
- Early staff/counsellor engagement and provision of timely information

NHS Bath & North East Somerset Clinical Commissioning Group

Comms Plan

Event	Format	Recipients	Frequency	Date	Lead
Contract Award	Letter	Bidder (AWP)	N/A	28th March 2013	CCG
Notification re Change of Services	Letter	Counsellors and Practice Managers	N/A	8th April 2013	CCG
GP Forum Plus	Face to face	GP Practice Managers	N/A	16th April 2013	CCG/AWP
GP Practice Manager Meeting	Face to face	GP Practice Managers	N/A	19th June 2013	CCG/AWP
GP Practice Manager Briefing	Letter	GP Practice Managers	N/A	19th June 2013	CCG
Referral notification for GP Practices	Letter	Service Users	N/A	26th June 2013	AWP
GP PCTT Service Overview	Letter	GP Practice Managers	N/A	26th June 2013	AWP
Low Intensity Waiters Letter	Letter issued via PCMIS	Clients awaiting LI	N/A	1st July 2013	Sirona
HI Intensity Waiters Letters	Letter issued via PCMIS	Clients awaiting HI	N/A	3rd July 2013	Sirona
Update newsletter	PDF	B&NES Stakeholder (TBC)	Bi Weekly	15th July 2013	AWP
Contract Launch (Stakeholder) Letter	Letter	B&NES Stakeholders (TBC) eg MP's	N/A	17th July 2013	CCG
Reactive Media Statement	Press Release	As required	N/A	17th July 2013	CCG
LIFT GP Practice Leaflets	Leaflet	Service Users	N/A	1st August	AWP
LIFT Website for B&NES (plus links from CCG website)	Web	Service Users	N/A	1st August	AWP
Scrutiny Panel	Face to face	Panel Members	N/A	September 2013	CCG

NHS Bath & North East Somerset Clinical Commissioning Group

Next steps

Waiting List Management
- *In Progress*
- Delivery and completion of appropriate stepped care for all transitioning clients including appropriate intervention for all existing Hi Intensity waiters

Contract Launch
- *1st August*
- Communication to key stakeholders to coincide with contract signature

Staff Induction
- *1st to 12th August*
- Two week induction and training for all transferring staff

AWP Consultation
- *Commencing 5th August and completion expected October 2013*
- Appointment of transferring staff to permanent positions and embedding of AWP structure

NHS Bath & North East Somerset Clinical Commissioning Group

Bath & North East Somerset Council

NHS Bath & North East Somerset Clinical Commissioning Group

Thank you!

Any questions?

Healthier, Stronger, Together

Bath & North East Somerset Council

WELLBEING PDS FORWARD PLAN

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 Jack Latkovic, Democratic Services (01225 394452). 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), Riverside (Keynsham) and at Bath Central, Keynsham and Midsomer Norton public libraries.

Wellbeing PDS Forward Plan

Bath & North East Somerset Council

Anticipated business at future Panel meetings

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 20TH SEPTEMBER 2013				
20 Sep 2013	**Wellbeing PDS**	**NHS 111 update**	Tracey Cox, Dr Liz Hersch and Russell Kelsey (Harmoni)	
18 Sep 2013 20 Sep 2013	**HWB** **Wellbeing PDS**	**Safeguarding Adults Annual Report 2012-2013**	Lesley Hutchinson Tel: 01225 396339	Ashley Ayre Jane Shayler
20 Sep 2013	**Wellbeing PDS**	**Report from the Strategic Transitions Board**	Mike MacCallam Tel: 01225 396054	Jane Shayler, Ashley Ayre
20 Sep 2013	**Wellbeing PDS**	**Urgent Care - 6 month update**	Dr. Ian Orpen	Ashley Ayre, Jane Shayler
20 Sep 2013	**Wellbeing PDS**	**Tobacco Control Strategy**	Bruce Laurence Tel: 01225 39 4075	Bruce Laurence
20 Sep 2013	**Wellbeing PDS**	**Dementia Strategy update**	Corinne Edwards	Ashley Ayre, Jane Shayler

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
20 Sep 2013	**Wellbeing PDS**	**South West Ambulance Service Joint Scrutiny arrangements**	Emma Bagley Tel: 01225 396410	
20 Sep 2013	**Wellbeing PDS**	**Mental Health Services update (including Talking Therapies)**	Andrea Morland	Ashley Ayre, Jane Shayler
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 22ND NOVEMBER 2013				
22 Nov 2013	**Wellbeing PDS**	**Neuro-rehab services update**	Specialised Commissioning Team - Dr Lou Farbus; Clinical Commissioning Group - Tracey Cox	Jane Shayler, Ashley Ayre
22 Nov 2013	**Wellbeing PDS**	**Update on the future of the RNHRD**	The RNHRD	
22 Nov 2013	**Wellbeing PDS**	**Alcohol Harm Reduction Scrutiny Inquiry Day**	Emma Bagley	
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 17TH JANUARY 2014				
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 21ST MARCH 2014				
FUTURE ITEMS				

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
	Wellbeing PDS	**Dentistry (requested by the Panel on 28.01.13)**		
	Wellbeing PDS	**Teenage Pregnancy**		
18 Sep 2013 Not before 19th Sep 2013	**HWB** **Wellbeing PDS**	**Homelessness Strategy**	Sue Wordsworth Tel: 01225 396050	Ashley Ayre
	Wellbeing PDS	**The RUH status update**		
	Wellbeing PDS	**Home Care (requested by Cllr Jackson on 28.01.13)**		
	Wellbeing PDS	**NHS Healthchecks**		

The Forward Plan is administered by **DEMOCRATIC SERVICES**: Jack Latkovic 01225 394452 Democratic_Services@bathnes.gov.uk