Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Bath and North East Somerset Health & Wellbeing Board

Democratic Services Riverside, Temple Street, Keynsham, BS31 1LA	Direct Line:	01225 394452
	Ask For:	Jack Latkovic
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	Date:	10 September 2013

To: All Members of the Health & Wellbeing Board

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

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

Other appropriate officers
Press and Public

Dear Member

Health & Wellbeing Board

You are invited to attend a meeting of the Board, to be held on **Wednesday, 18th September, 2013** at **2.00 pm** in the **Kaposvar Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
Committee Administrator

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

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

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

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

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

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

5. **Declarations of Interest**

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

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

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

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

7. **Emergency Evacuation Procedure**

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

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

Health & Wellbeing Board

Wednesday, 18th September, 2013
Kaposvar Room - Guildhall, Bath
2.00 - 4.00 pm

Agenda

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

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

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

   (b) The nature of their interest.

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

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

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

6. PUBLIC QUESTIONS/COMMENTS

7. MINUTES OF PREVIOUS MEETING

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

8. JOINT HEALTH AND WELLBEING STRATEGY (10 MINUTES) Helen Edelstyn

   The Board is asked to:

   1.1 Approve the Joint Health and Wellbeing Strategy

   1.2 Note the Equality Impact Assessment carried out on the Joint Health and Wellbeing Strategy

   1.3 Note that a final Joint Health and Wellbeing Strategy will be submitted to Council on 14 November for final approval.

9. JOINT STRATEGIC NEEDS ASSESSMENT UPDATE (20 MINUTES) — Jon Poole

This report provides an update to the Joint Strategic Needs Assessment base and summarises findings of recent research conducted on the Bath and North East Somerset community.

The Board is asked to:

- Note the findings of the report and consider the impact of any new findings on local policy.
- Promote the JSNA web-site www.bathnes.gov.uk/jsna

10. HEALTH AND WELLBEING NETWORK FEEDBACK - PLACEMAKING PLAN DISCUSSION ON 24TH JULY 2013 (10 MINUTES)

The Board will receive a feedback from Pat Foster on the last public engagement session held on 24th July 2013.

11. PLACEMAKING PLAN (20 MINUTES)

This report provides an update on progress with the Council's Placemaking Plan, and highlights opportunities to embed Health and Well Being considerations into the document.

The Board is asked to note the progress that is being made with the Placemaking Plan and that there are opportunities to link with Public Health Objectives.

12. HOMELESSNESS STRATEGY (15 MINUTES) — Sue Wordsworth

Following stakeholder engagement and a review of national policy Housing Services has drafted a new Homelessness Strategy that reflects national guidance and a review of the local evidence base and priorities. This draft Strategy is now being opened up to wider public participation and to seek input and endorsement from key stakeholders including the Health & Wellbeing Board.

The Health and Wellbeing Board is asked to:

- Comment on the draft Homelessness Strategy 2014-18;
- Endorse the statement on page 5 of the draft Strategy: "The Health and Wellbeing Board will champion the homelessness agenda in Bath and North East Somerset;
- Endorse the Homelessness Strategy Communications Plan 2013.

13. BATH AND NORTH EAST SOMERSET CHILDREN AND YOUNG PEOPLE'S PLAN (CYPP) (15 MINUTES) — Mike Bowden

The Children Trust Board and Bath and North East Somerset Local Authority have jointly

agreed to the development of a new Children and Young People's Plan (CYPP) 2014-2017.This plan will be a non-statutory plan building on previous plans. It will clearly define the commissioning intentions for the delivery of services. The new plan will be aligned to the Health and Well Being Strategy 2013.

The Board is asked to agree the priorities and the proposed timeframe for the next CYPP 2014-2017.

14. SECTION 256 AGREEMENT AND FUNDING ALLOCATION 2013/14 (5 MINUTES) — Jane Shayler

Over the past four years, funding from the Department of Health has been passed, via local NHS commissioners (previously the Primary Care Trust, now, following NHS Reform, a combination of the Clinical Commissioning Group and NHS England Area Team). Funding streams have included: additional support funding for social care; improving and sustaining performance on access (primarily to hospital services); and reablement support. Each funding stream has typically come with guidance about use of the funding, which has informed the development of local agreements between the NHS and Local Authority about use of the funding. These agreements are termed "Section 256" Agreements as they are made under the terms of Section 256 of the National Health Service Act 2006.

Following NHS Reform, a proportion of the funding for 2013/14 is covered by a Section 256 Agreement between the Clinical Commissioning Group (CCG) and Council. The majority of funding is covered by a similar Agreement between the NHS England Bath, Gloucester, Swindon and Wiltshire Area Team (the Area Team) and the Council. Details of the funding allocation and agreed use of this funding is covered in section 3 of this report and in the Appendices to this report.

In the June 2013 spending round covering 2015/16 a national £3.8 billion "Integration Transformation Fund" was announced. This fund, established by the Department of Health, is to be held by local authorities and will include funding previously transferred by local NHS commissioners to the Council under Section 256 Agreements.

The Board is asked to:

- Note the agreed use of Section 256 funding in 2013/14;
- Note proposals in relation to the 2015/16 Integration Transformation Fund and, in particular, the key role of Health & Wellbeing Boards in agreeing plans for the use of this fund.

15. HEALTHWATCH BATH AND NORTH EAST SOMERSET - UPDATE (10 MINUTES)

This report provides an update on key Healthwatch Bath and North East Somerset progress during its implementation phase over the last 5 months as well as planned next steps.

The Board is asked to note the Healthwatch B&NES update.

16. SAFEGUARDING ADULTS ANNUAL REPORT 2012/13 (10 MINUTES) — Lesley Hutchinson

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 updates Business Plan. The report (including the business plan) requires the approval of the Health and Wellbeing Board.

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

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

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HEALTH & WELLBEING BOARD (SHADOW)

Minutes of the Meeting held

Tuesday, 30th April, 2013, 2.00 pm

Councillor Paul Crossley	-	Bath & North East Somerset Council
Councillor Simon Allen	-	Bath & North East Somerset Council
Ashley Ayre	-	Bath & North East Somerset Council
Dr. Ian Orpen	-	Member of the Clinical Commissioning Group
Dr Simon Douglass	-	Member of the Clinical Commissioning Group
Councillor Dine Romero	-	Bath & North East Somerset Council
Pat Foster	-	Healthwatch

1 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting. The Chair and every other Board Member introduce themselves to the present public.

2 EMERGENCY EVACUATION PROCEDURE

The Democratic Services Officer drew attention to the evacuation procedure.

3 APOLOGIES FOR ABSENCE

Apologies were received from Jo Farrar (Council Chief Executive) and Paul Scott (Acting Director of Public Health).

4 DECLARATIONS OF INTEREST

There were none.

5 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There was no urgent business.

6 PUBLIC QUESTIONS/COMMENTS

The Chair invited Pamela Galloway (Secretary of the Warm Water Inclusive Swimming and Exercise – WWISE) to address the Board with her statement.

Pamela Galloway explained that she was speaking on behalf of B&NES residents who, because of disability or short and/or long term health conditions, need access to warm water pools to exercise and swim so they can help, and/or maintain, their health and fitness.

Pamela Galloway described the needs of those residents and the necessity for the adequate facilities in local leisure centres.

Pamela Galloway concluded that the WWISE network applaud the Council's strategy for the provision of leisure facilities for health outcomes, not just for recreation, and welcomed that the draft Health and Wellbeing Strategy placed emphasis on enabling everyone to live healthy and fulfilling lives, reducing health inequalities and improving the health of local people and communities.

A full copy of the statement from Pamela Galloway is available on the Minute Book in Democratic Services.

The Chair thanked Pamela Galloway for her statement.

The Board asked what would be suitable water temperature for people who need warm water pools and whether the access to pools is acceptable.

Pamela Galloway responded that lot of people from the WWISE network feel that 30°C is still too cold for them so they were asking for anything between 31°C and 33°C. Pamela Galloway also said that currently many people who use warm water pools are excluded from using their local leisure centres because the water is too cold for them and/or the facilities do not meet their access needs.

The Board suggested that the WWISE network should have their facts and figures (water temperature, number of users, accessibility needs and similar) ready and forwarded to the Cabinet Member for Neighbourhood and also to Jon Poole (Research and Intelligence Manager).

7 MINUTES OF PREVIOUS MEETING

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

8 FEEDBACK FROM PROVIDER ENGAGEMENT SESSION - VERBAL UPDATE (10 MINUTES)

The Chair introduced this item by saying that the first Public Engagement Session of the Health and Wellbeing Board (Shadow) happened earlier in the day and invited Helen Edelstyn (Strategy and Plan Manager) to summarise the session.

Helen Edelstyn said that 35 organisations were at the session today, which was more than expected and showed that participants and stakeholders are willing to engage in this kind of event.

Helen Edelstyn informed the Board that the main focus of the session was on the draft Joint Health and Wellbeing Strategy consultation, with the emphasis on the equality issues. The responses from the session will be summarised in one document and sent to all participants.

The Chair said that the Public Engagement Session was quite successful considering that 35 organisations were present at the session, and that they

engaged quite well in the consultation.

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

9 **OUTLINE JOINT HEALTH AND WELLBEING STRATEGY (20 MINUTES)**

The Chair invited Helen Edelstyn to introduce the Strategy by giving the presentation to the Board.

Helen Edelstyn highlighted the following points in her presentation:

- The Strategy – intentions
- Theme 1 – Helping people to stay healthy
- Theme 2 – Improving the quality of people's lives
- Theme 3 – Creating fairer life chances
- Consultation
    - Public consultation runs from 30th April until 7th June this year
    - The Strategy will go to the Full Council in September 2013 for final approval

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

Members of the Board welcomed the layout of the Strategy. They felt that the Strategy was easy to read and in the accessible format.

The Board also welcomed the start of the consultation pointing out that it is the right time for it.

Members of the Board debated what other issues should be addressed in the Strategy and suggested that the Strategy should also include the following:

- More information on the work towards reduction of health and wellbeing inequalities
- More information about parts of B&NES with income deficiencies
- Specification on dementia current and future figures
- Focus on the deprivation and complex families
- Focus on the smoking cessation
- More transparency on the financial pressure over the next 4 to 5 years

Councillor John Bull said that he expected more on children's centres in the Strategy. The Board replied that pages 6 and 7 of the Strategy cover work with partners and the purpose of the Strategy is to set its strategic intentions rather than going into details.

The Chair closed the debate by saying that the Joint Health and Wellbeing Strategy is a broad framework to start solving particular issues. This is an excellent first step and the Board will be committed to the open dialogue with the communities.

The Chair invited the Board to formally launch the consultation on the Strategy.

The Chair also suggested that details (names and email addresses) of all Board Members should be included in the Strategy along with the general contact email.

It was **RESOLVED** to:

1) Welcome and approve the Joint Health and Wellbeing Strategy (subject to suggestions made by the Board in the debate).
2) Launch the consultation on the Joint Health and Wellbeing Strategy and include Board Members' details.

10 **ENHANCED QUALITY OF LIFE FOR PEOPLE WITH DEMENTIA: DEMENTIA FRIENDLY COMMUNITIES - VERBAL UPDATE (30 MINUTES)**

The Chair invited Corrine Edwards (Clinical Commissioning Group) to give a presentation named 'Enhancing the quality of life for people with Dementia in B&NES'.

Corrine Edwards highlighted the following points in her presentation:

- Prime Minister's Challenge
- Driving improvements in health and care
- Creating dementia-friendly communities
- Belter research
- NHS Outcomes Framework
- B&NES population projections
- What is happening in health, social care and housing?
- Our priorities
- What have we achieved so far?
- Next steps

A full copy of the presentation from Corrine Edwards is available on the Minute Book at Democratic Services.

Members of the Board welcomed the presentation and highlighted the importance of creating dementia-riendly communities. Members of the Board in particular emphasised the significance of raising the awareness and understanding across society and encouraging more companies to commit to being dementia friendly.

Dr Ian Orpen shared his experience as General Practitioner by saying that it is not straightforward helping people with dementia as most of the people are hiding the syndrome.

Members of the Board agreed with all priorities set in the presentation, and highlighted the importance of the following:

- Improving standards in care homes and domiciliary care
- Better information for people with dementia (and their carers)
- Increase availability of dementia nursing home beds; and
- Supporting people with dementia at end of life.

The Board felt that end of life planning, with people who have early signs of

dementia, needs to be discussed at that stage, whether with the specialist or family members/carers, as those conversations are not easy at a later stage.

The Chair concluded the debate by asking for a report with the general update on Dementia in six months' time.

It was **RESOLVED** to note the presentation and to receive a general update on Dementia in six months' time.

11 HEALTH AND WELLBEING BOARD TERMS OF REFERENCE (10 MINUTES)

The Chair invited Helen Edelstyn to introduce the report.

Members of the Board commented that apart from a couple of minor points (i.e. National Commissioning Board is now called NHS England) they were happy with the document before them.

It was **RESOLVED** that the Board agreed with the Terms of Reference for the Bath and North East Somerset Health and Wellbeing Board.

12 JOINT STRATEGIC NEEDS ASSESSMENT VERBAL UPDATE (20 MINUTES)

The Chair invited Jon Poole to give a presentation.

Jon Poole highlighted the following points in his presentation:

- Helping People Stay Healthy
    - Measles
    - Multiple unhealthy lifestyle behaviours
- Improving the Quality of people's lives
    - Strategic Housing Market Assessment
    - Welfare Reforms
- Fairer life chances
    - Child poverty
    - Teenage pregnancy

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

Members of the Board thanked Jon Poole for providing this information in his presentation.

Members of the Board commented that figures on fairer life chances and new child poverty figures in deprived areas need to be addressed in detail.

The Chair felt that one of the jobs that this Board will have is to think how to fix these issues and how to reduce figures across the whole area.

Ashley Ayre added that there are quite a lot of initiatives happening at the moment within the education and schools area, such as Healthy Schools Initiative funded by the Public Health, and also the work of the Skills and Employment agency.

The Chair closed the debate by requesting more information on the initiative mentioned by Ashley Ayre in the next Joint Strategic Needs Assessment update.

It was **RESOLVED** to note the presentation and for officers to take on board requirements for the next update.

13 **LOCAL HEALTHWATCH WELCOME AND INTRODUCTION - VERBAL UPDATE (15 MINUTES)**

The Chair invited Pat Foster (Healthwatch Bath and North East Somerset) to give the presentation.

Pat Foster gave a presentation in which she informed the Board that the Care Forum, as a 'body corporate', has been awarded the Healthwatch Bath and North East Somerset contract. Local Healthwatch will be quite different from the Local Involvement Network – there will be no host organisation to support Healthwatch as The Care Forum is a company able to employ staff.

Pat Foster also outlined the powers and duties of the local Healthwatch, what had happened since the contract with The Care Forum had been signed, Healthwatch governance and the flowchart explaining what particular groups and individuals are in Healthwatch.

Pat Foster concluded her presentation by saying that the local 01225 number will be soon operational.

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

Members of the Board welcomed the presentation from Pat Foster. Members of the Board asked how the Healthwatch will ensure that volunteers would present the views of the community group/s and not their own personal, views.

Pat Foster replied that the Healthwatch want to have everyone views on board. Volunteers will be listed directly from the community groups. The other difference between the Local Involvement Network (LINk) and the Healthwatch is that LINk was network of individuals whilst Healthwatch will be network of groups.

Dr Ian Orpen asked to be noted that the Clinical Commissioning Group's Patient and Public Forum is not there to duplicate the work of the Healthwatch.

The Chair concluded by saying that he was very pleased that the Healthwatch Bath and North East Somerset is now formally established and that they will have two seats on the Health and Wellbeing Board.

It was **RESOLVED** to note the presentation from Pat Foster.

The meeting ended at 3.45 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board
MEETING DATE:	18th September 2013
TITLE:	Joint Health and Wellbeing Strategy
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix One: Joint Health and Wellbeing Strategy Appendix Two: Joint Health and Wellbeing Strategy appendix Appendix Three: Equality Impact Assessment	

1 THE ISSUE

1.1 As set out in the Health and Social Care Act 2012, the Bath and North East Somerset Health and Wellbeing Board is responsible for developing a Joint Health and Wellbeing Strategy which will deliver the Board's aim to:

a) Reduce health inequalities and improve health and wellbeing in Bath and North East Somerset

1.2 The Strategy offers the Health and Wellbeing Board the opportunity to create shared leadership across the health, social care and wellbeing systems to deliver better health and wellbeing outcomes locally.

1.3 This report seeks approval of the final strategy.

2 RECOMMENDATION

The Board is asked to:

2.1 Approve the Joint Health and Wellbeing Strategy

2.2 Note the Equality Impact Assessment carried out on the Joint Health and Wellbeing Strategy

2.3 Note that a final Joint Health and Wellbeing Strategy will be submitted to Council on 14 November for final approval.

3 FINANCIAL IMPLICATIONS

3.1 There are no direct financial implications arising from the publication of the Bath and North East Somerset Joint Health and Wellbeing Strategy. However, the

priorities of the Strategy should form a key consideration in the commissioning and allocation of health, social care and wellbeing resources.

4 THE REPORT

4.1 The Joint Health and Wellbeing Strategy sets out the Health and Wellbeing Board's strategic intentions for improving health and reducing health inequalities in Bath and North East Somerset.

4.2 The Health and Wellbeing Board will deliver these priorities through strong local leadership across the NHS, public health and social care systems and by jointly planning and delivering services.

4.3 Over time more detailed delivery plans will be adopted, setting out Board action on priorities such as helping children to be a healthy weight or creating dementia friendly communities.

Joint Health and Wellbeing Strategy priorities

4.4 A development group of the Health and Wellbeing Board undertook a process of rigorous prioritisation to reach agreement on the priorities within the JHWS. The process was not easy and included a lengthy assessment of local health and social care need over the course of a year. As a result the Board are confident that the priorities for action set out in this Strategy are right for improving people's health and reducing health inequality.

4.5 The priorities are not an exhaustive list of everything that the Council and NHS are doing to meet local health and wellbeing need; but rather a small set of priorities for the Health and Wellbeing Board to really focus on and make a difference.

4.6 The Joint Health and Wellbeing Strategy sets out three important themes and priorities. These are:

a) <u>Theme 1 – Helping people to stay healthy</u>
   - Helping children to be a healthy weight
   - Improved support for families with complex needs
   - Reduced rates of alcohol misuse
   - Create healthy and sustainable places

b) <u>Theme 2 - Improving the quality of people's lives</u>
   - Improved support for people with long term conditions
   - Reduced rates of mental ill-health
   - Enhanced quality of life for people with dementia
   - Improved services for older people which support and encourage independent living and dying well

c) <u>Theme 3 – Creating fairer life chances</u>
   - Improve skills, education and employment
   - Reduce the health and wellbeing consequences of domestic abuse
   - Increase the resilience of people and communities including action on loneliness

Consultation on the draft Joint Health and Wellbeing Strategy

4.7 A formal consultation period on the draft Joint Health and Wellbeing Strategy was launched on 30 April and ran until 7 June 2013.

4.8 Consultation responses were received from a range of stakeholders including the Health and Wellbeing Board, health and social care providers, VCSE organisations, members of the public and service users. Many of the responses were positive and welcomed the development of a Joint Health and Wellbeing Strategy to reduce health inequalities and improve health and wellbeing in B&NES.

4.9 Some of the issues from the consultation included:

a) Need to strengthen what is meant by health inequality locally
b) Need to strengthen the link with sport and leisure
c) More clarity on how the themes and priorities will be delivered
d) Need to better articulate the journey – why these priorities and how are they going to shape commissioning
e) Need a greater focus on mental illness and wellbeing amongst young people
f) It's not in an accessible or easy read format

4.10 Cllr Simon Allen presented the draft Joint Health and Wellbeing Strategy to the Wellbeing Policy Development and Scrutiny Panel on 17 May. The minutes from the Scrutiny meeting state:

The Panel welcomed the Health and Wellbeing Strategy and felt that, around the rest of the key areas in the Strategy, the action on reducing social isolation and loneliness is a particularly important issue to be addressed through the Strategy.

Some Panel Members suggested that the Council could look at the Bristol Light Box Happiness Project (provides supportive environment for socially isolated people) as one of ways to tackle loneliness. Councillor Allen welcomed the suggestion.

4.11 These consultation responses have informed and shaped the development of the final Joint Health and Wellbeing Strategy, which has been approved by:
- B&NES Council Cabinet (10 July 2013)
- B&NES CCG Board (25 July 2013)

4.12 It is scheduled to be presented to B&NES Council on 14 November for final approval.

4.13 A copy of the Joint Health and Wellbeing Strategy is included as Appendix One and Appendix Two.

4.14 A copy of the Equality Impact Assessment carried out on the Joint Health and Wellbeing Strategy is included as Appendix Three. This will also inform the ongoing delivery of the strategy and equality considerations will play a key part as more detailed action against the Board's priorities is developed.

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 To reduce health inequality is a key ambition of the Board around which the priorities in the Joint Health and Wellbeing Strategy are framed.

6.2 A draft Equality Impact Assessment has been completed and is attached as Appendix Three. Equality considerations will also play a key part as more detailed plans setting out action on the strategic priorities are developed.

7 CONSULTATION

7.1 A formal consultation period was carried out on the draft Joint Health and Wellbeing Strategy (summary of feedback presented above). This consultation was promoted through mechanisms including local news sources, B&NES Council and CCG website, Healthwatch B&NES e-bulletin, social media and online networks.

7.2 Consultation responses were received from a range of stakeholders including the Health and Wellbeing Board, health and social care providers, VCSE organisations, members of the public and service users.

7.3 Health and Wellbeing Board meetings are held in public and are publicised online. Regular engagement sessions are also held prior to the formal Board meetings in order to feed in the views and comments from key stakeholders and service users.

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; 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	Helen Edelstyn (01225 477951)
Background papers	
Please contact the report author if you need to access this report in an alternative format	

Joint Health and Wellbeing Strategy

Bath & North East Somerset - *The* place to live, work and visit

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

healthwatch Bath and North East Somerset

Foreword

Bath and North East Somerset can and should be a place where everyone is enabled to lead healthy and fulfilling lives. Achieving this is no easy task. Everything local public services do must aspire to the goal of improving the health and wellbeing of local people and communities.

I am fully committed to reducing health inequalities in Bath and North East Somerset and to ensuring that, through this Joint Health and Wellbeing Strategy, I put in place plans which improve the health of local people and communities.

I cannot deliver this alone and it will be essential to work in partnership with health, social care and broader 'wellbeing' services to improve the health and wellbeing of local people. Already, some organisations across Bath and North East Somerset have come together through the new Health and Wellbeing Board and are working together on this Joint Health and Wellbeing Strategy.

Through this strategy, the Health and Wellbeing Board will lead a joined up approach to local services that support and protect people's health and wellbeing. Its focus is on encouraging people to stay healthy, improving the quality of people's lives and on making sure that everyone has a fair chance of living well.

Over the past 2 years I have met many local people and organisations. I have listened to the views and experiences of local health and social care service users. This experience has helped me to understand what works well and areas that need to improve. Local knowledge forms a central part of this Joint Health and Wellbeing Strategy and in creating future plans for local health and wellbeing services.

No one should underestimate my determination to make a difference. This Joint Health and Wellbeing Strategy will not only help people who are unwell but will work to integrate local services from housing to parks and leisure; to prevent ill health and make sure that people live well.

Councillor Simon Allen
Chair, Bath and North East Somerset Health and Wellbeing Board

Who is responsible for health and wellbeing?

The Health and Wellbeing Board is the body responsible for improving the health and wellbeing of people in Bath and North East Somerset. It provides strong and shared leadership and is the principle point of integration between the newly reformed health system and social care.

The Council is required by Government to have a Health and Wellbeing Board. The Health and Wellbeing Board is made up of senior officers from the Council, local councillors, GPs from NHS Bath and North East Somerset Clinical Commissioning Group, the Director of Public Health, Bath, Gloucestershire, Swindon and Wiltshire Area Team and Healthwatch Bath and North East Somerset.

The Health and Wellbeing Board has assessed the health and wellbeing needs of people in Bath and North East Somerset (adults, young people and children) through the Joint Strategic Needs Assessment process. You can find out more about the Bath and North East Somerset Joint Strategic Needs Assessment at www.bathnes.gov.uk/jsna. This Joint Health and Wellbeing Strategy sets out the priorities for action based on the health and wellbeing needs identified in the Joint Strategic Needs Assessment.

A process of rigorous prioritisation was undertaken by the Health and Wellbeing Board to reach agreement on the priorities within this Joint Health and Wellbeing Strategy. The process was not easy and included a careful assessment of local health and social care need. As a result of this process, the Health and Wellbeing Board are confident that the priorities for action set out in this strategy are right for improving people's health and reducing health inequality in Bath and North East Somerset.

The priorities are not an exhaustive list of everything that the Council and NHS are doing to meet local health and wellbeing need; but rather a small set of priorities for the Health and Wellbeing Board to really focus on and make a difference.

The Health and Wellbeing Board faces the enormous challenge of responding to the priorities set out within this strategy at a time of financial austerity. This will require the Council and NHS to think differently about how the priorities are delivered and how care is commissioned locally. This includes a shift away from care in hospitals towards a more preventative approach that promotes self-care and is much more personalised and co-ordinated around the needs of the individual. The Health and Wellbeing Board will deliver this change through strong local leadership across the NHS, public health and social care and by jointly planning and delivering services.

The Health and Wellbeing Board sits within the Bath and North East Somerset local partnership framework and works alongside leaders from all of the local public sector agencies to ensure a joined-up approach to local service delivery.

There is a history of good working relationships between health and social care partners in Bath and North East Somerset which has led to more joined up services and improvements in care and support for local people.

This is the first Joint Health and Wellbeing Strategy for Bath and North East Somerset. It is a 5 year strategy that will be reviewed in 2015.

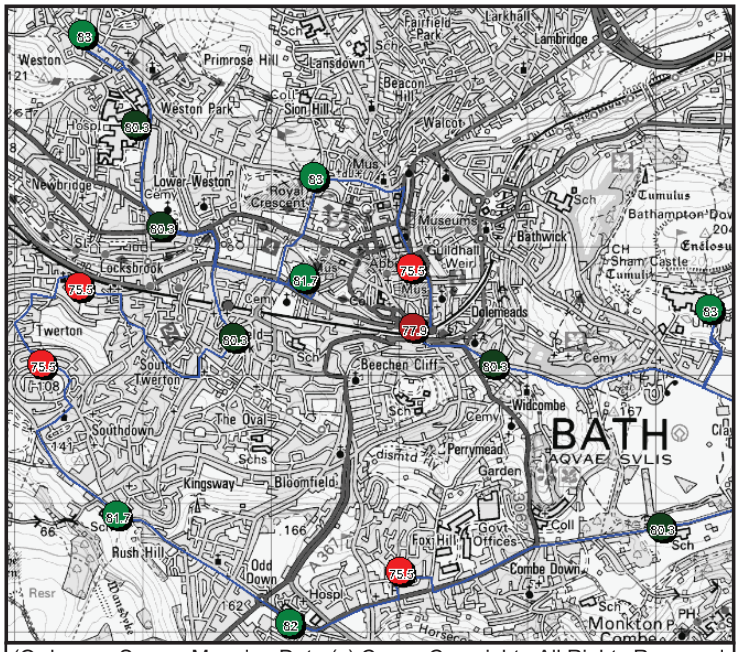
Why does Bath and North East Somerset need a joint health and wellbeing strategy?

The World Health Organisation defines health as “a state of complete physical, mental and social wellbeing”. People with good health are able to have control of their lives, live life to the full and participate in their communities.

Unfortunately people and communities experience inequality in health. This can be due to differences in where they live, social group, gender and other biological factors. These differences have a huge impact, because they result in some people experiencing poorer health and shorter lives.

Health inequality exists in Bath and North East Somerset. The Joint Strategic Needs Assessment shows that good health is unequally shared and inequalities exist between different geographical areas, communities, social and economic groups in Bath and North East Somerset. For instance we know that, for men, life expectancy varies by up to 7 years along the stops of the number 20a/c bus route in Bath. People living in Twerton have a lower life expectancy than those who live just 5 bus stops away.

Life expectancy for men in small areas surrounding bus stops on the 20a/c route in Bath City



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The Health and Wellbeing Board is committed, through this strategy, to tackling these health inequalities. This Joint Health and Wellbeing Strategy sets out a framework for partnership action against three themes:

Theme one:
Helping people to stay healthy
Theme two:
Improving the quality of people’s lives
Theme three:
Creating fairer life chances

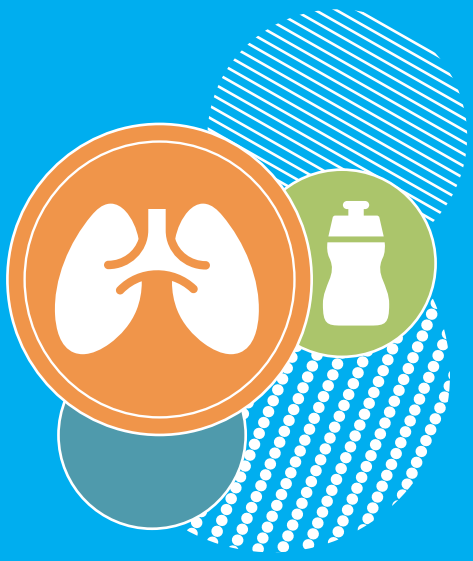
In 2010 Sir Michael Marmot published ‘Fair Society Healthy Lives’ and set out an evidence based approach to reducing health inequalities in England. This Joint Health and Wellbeing Strategy is guided by the principles set out within the Marmot report.

How will we deliver this strategy

Part two of this strategy sets out the priorities for action and describes the Health and Wellbeing Board's high level intentions for delivery.

Part three is appendix one and provides a summary of our first steps to delivery, and relevant national outcomes. It is not intended to be a static or full delivery plan but rather one that will be updated as the Health and Wellbeing Board develops and promotes the services and activities that can make a difference.

Over time more detailed delivery plans will be adopted, setting out action on specific priorities such as helping children to be a healthy weight or creating dementia friendly communities.



Our work locally, through this Health and Wellbeing Strategy, is set against a national performance programme. This includes national frameworks for action for adult social care, children's social care, public health, and the NHS. The delivery of these frameworks will continue to be extremely important. The relevant national outcomes for this strategy are set in Part three (appendix one).

About Bath and North East Somerset

In the Census there were

176,000

Residents in Bath and North East Somerset

And

196,000

Patients registered with Bath and North East Somerset GPs

Approximately **20%** of households could be experiencing **fuel poverty**

Hospital admissions for fractures appear to **double** in snowy weeks compared with other fair weather week

1/3 Children

are an unhealthy weight at year 6 (age 10/11)

An estimated

£16,000,000

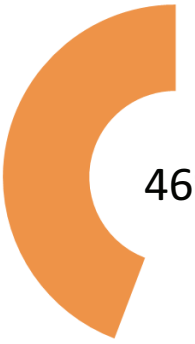
is spent on our most complex families every year

7,021 adults are dependent on alcohol

Find out more:
www.bathnes.gov.uk/jsna

The population is aging, we think there will be over **2.5x** as many people aged 80+ by 2026 compared with1981

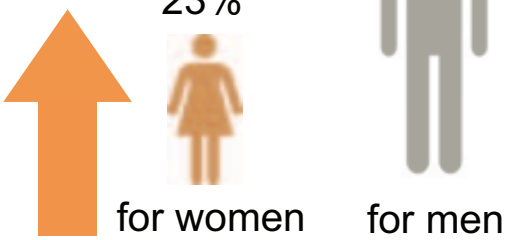
73,000 people in the area have at least one long-term health condition



of people with a mental health condition have a long term health condition

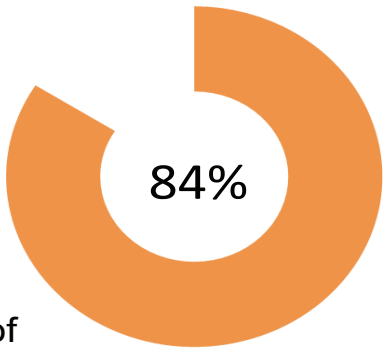
of people with a long term physical health condition have a mental health condition and

By 2025 we expect **dementia** to increase by:



for women

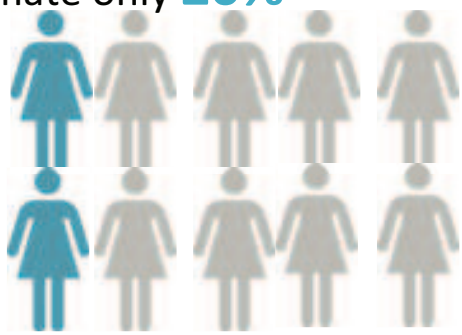
for men



of residents are **satisfied with the area as a place to live**

Estimates suggest that only one in four of the **3,419** people with a learning disability are known about by local services

We estimate only **20%**



of **domestic abuse** incidents are reported to the authorities

1,289 **people in 2030**

The prevalence of Autistic Spectrum Disorders (ASD) in B&NES is estimated to rise

1,166 **people in 2010**

Hospital admissions for alcohol are **3x** higher for residents in our lowest income communities

Our vision for health and wellbeing

Our vision is to reduce health inequality and improve health and wellbeing in Bath and North East Somerset by:

Helping people to stay healthy

Improving the quality of people's lives

Creating fairer life chances

These 3 themes set our framework for action. Part two of this strategy describes some of the things we are doing to deliver these themes.

The Health and Wellbeing Board has also agreed a set of cross-cutting principles. These are:

- Strengthen the role and impact of ill-health prevention
- A commitment to public, patient and provider engagement
- A commitment to add value through strong local leadership and a 'whole system approach' to health and wellbeing through:
  - integrating the NHS, social care and public health systems
  - influencing planning, transport, housing, environment, economic development and community safety in order to address the wider determinants of health and wellbeing
  - High quality service delivery within the resources available including low cost and no cost options, and reducing waste through a whole system approach

Wellbeing refers to the wider social, physical, psychological, environmental and economic factors which affect our lives and our health. In order to improve the wellbeing of people in Bath and North East Somerset, the Health and Wellbeing Board is committed to working with non-traditional health and social care partners in areas such as economic development, sustainability, transport and housing.

Theme One

Helping people to stay healthy

The priorities set out within this section aim to prevent ill health, reducing the need for more costly interventions later in life and to help people to live well.

Helping children to be a healthy weight

Over 26 per cent of Bath and North East Somerset's 11-12 year olds are of an unhealthy weight and 14 per cent are obese. Childhood obesity is associated with a range of health problems and it has been linked to low self-image, low-self-confidence and depression. Children who are obese are more likely to be obese as adults and this increases the risk of developing a range of chronic diseases such as heart disease and diabetes.

At its most simple, children become an unhealthy weight when the energy from the food and drink they eat is greater than the energy they burn off with day to day activity. A huge range of issues affect what we choose to eat and whether we keep active. For example, is it cheaper to buy foods high in fat and sugar? Or are there opportunities where we live for children and families to get outside and play?

So helping children to be a healthy weight means encouraging children and families to make healthy choices. It also means making changes to the local environment to make those choices easier. The Health and Wellbeing Board will work with partners, including the Children's Trust Board and Public Health, to develop action to help children to be a healthy weight. This will include a coordinated plan to address the many reasons why a child becomes overweight.

Improved support for families with complex needs

There are around 200 families with complex needs living in Bath and North East Somerset. These families can experience some of the following problems: unemployment, domestic abuse, children in care or on the edge of care, mental ill health, and substance misuse.

Families with complex needs place significant demands on the criminal justice, health, welfare, housing and social service systems. The Government estimates that each family costs an average of £75,000 each year. This is an annual total in Bath and North East Somerset of £16,000,000.

The Health and Wellbeing Board is taking steps through our Connecting Families programme to help these families enjoy the same life chances experienced by others. The Connecting Families programme will do this by addressing the causes of anti-social behaviour, supporting children back into education, supporting people back into work and encouraging families to take responsibility for their own lives.

Case Study

Food for Life Partnership

Southdown Community Infants School – roast dinner day 2012.

Parents, members of the local community, school staff and pupils enjoy a locally sourced, seasonal and healthy roast dinner as part of Food For Life Partnership's Roast Dinner Day.

Reduced rates of alcohol misuse

Since 2002, alcohol related hospital admissions in Bath and North East Somerset has risen by 12 per cent. Approximately 800 11-15 year olds are thought to be drinking to get drunk every week and over 29,000 people are considered 'risky' drinkers and are threatening their health because they are drinking too much.

Alcohol is one of the three biggest lifestyle factors for disease and death in the UK after smoking and obesity. It causes alcohol-related violent crime and its impacts on communities, children and young people are clear.

The Health and Wellbeing Board wants to tackle the problems caused by drinking irresponsibly, tackle the health consequences associated with excessive alcohol consumption, and encourage people to drink sensibly. The Health and Wellbeing Board will work in partnership with the Clinical Commissioning Group, the local Police and Crime Commissioner, Public Health, the Childrens Trust Board and our Universities to lead co-ordinated action to reduce the harms caused by alcohol misuse.

Create healthy and sustainable places

People's physical and mental health is affected by the quality of housing, access to green space, air quality and the environments in which they live.

The Health and Wellbeing Board will work in partnership with local organisations who lead on environmental sustainability to encourage people to eat more local food, increase access to the natural environment, encourage people to walk, cycle or use public transport rather than drive their cars and encourage people to insulate their homes and stay warm.

The Health and Wellbeing Board is committed to making sure that there are accessible homes for those who need them. For many people with learning difficulties, mental ill-health or physical needs this means enabling them to have greater choice and control over where they live, adapting existing provision and encouraging the development of suitable affordable housing options. The Health and Wellbeing Board will work in partnership with housing services and providers to support and encourage improvements to homes and neighbourhoods.

Regular physical activity, sport and exercise help people to stay healthy. It reduces the risk of developing heart disease, stroke, high blood pressure, and osteoporosis and helps to control weight. The Health and Wellbeing Board will work in partnership with sport and leisure commissioners and providers to make sure that leisure facilities are accessible and to encourage people to be active.

Theme Two

Improving the quality of people's lives

This theme aims to improve the quality of people's lives by supporting people who are unwell to look after themselves, and to help them and their carers to live as normal a life as possible.

Improved support for people with long term health conditions

There are over 73,000 people in Bath and North East Somerset with at least one long term health condition. Older people in particular often live with several long term health conditions at the same time.

A long term health condition is a condition that lasts a year or longer, impacts on a person's life, and may require ongoing care and support. The best way to support people with conditions like these is to help people to manage their conditions and live healthily, so that they stay well and are less reliant on medical interventions, including hospital stays.

The Health and Wellbeing Board will work in partnership with the Clinical Commissioning Group to deliver a coordinated response to long term health conditions that helps people to manage their conditions and stay well. This will be achieved through timely diagnosis and a package of support including helping people with long term health conditions to feel empowered and confident to self-manage their conditions, personalised care plans, by supporting carers and primary and community care. The use of new and developing technologies will also be explored which may support people to live more independently.

Reduced rates of mental ill-health

Within Bath and North East Somerset, approximately 18 per cent of our local population have experienced mental ill-health which includes depression and anxiety. A local health and social care voluntary group identified mental ill-health as the second largest health concern for local residents, after dementia.

Co-ordinated action to prevent suicide, repeat self-harm and support for people with mental ill-health will be developed by the Health and Wellbeing Board alongside partners including health services, social care, schools and communities. This includes services that support and build emotional wellbeing in children and young people.

Case Study

Independent Living Service

The local Independent Living Service won the prestigious National Housing Federation Community Impact Award in 2012. For many, the service has been an alternative to residential care through simple adjustments that make life easier from home adaptations and shopping deliveries to money advice.

Enhanced quality of life for people with dementia

There are 1022 people registered in Bath and North East Somerset who have dementia, and this number is expected to increase as our older population grows. Dementia can have a big impact on a person's behaviour and their lives. It can make them feel anxious, lost, confused and frustrated. These behaviours can make it difficult for people with dementia to lead normal lives.

The Health and Wellbeing Board is committed to improving the care and experience of people with dementia and their carers through a package of support including better diagnosis, improving care in hospital, improving standards of care in homes and domiciliary care, better awareness and support in the community.

The Health and Wellbeing Board will work in partnership with health, social care, communities, business and other local services to champion 'dementia friendly communities' in Bath and North East Somerset. This initiative will focus on improving the experience of people with dementia in local communities by raising local understanding about dementia. This may be as simple as training local bank staff in how to better help people with dementia to access their bank accounts.

Improved services for older people which support and encourage independent living and dying well

Our population is changing as people are living for longer. Statistical projections suggest that by 2026 people aged over 75 will represent 11 per cent of the local population, compared with 9 per cent in 2011. This will increase the demand for services that help older people to stay healthy, active and independent for as long as possible. The Health and Wellbeing Board will lead coordinated action to ensure fair, good quality, accessible and integrated services for older people.

High quality person centred care for those people at the end of their lives is an important part of this priority. In partnership with hospitals, hospices, social care, carers, families and communities, the Health and Wellbeing Board will promote services that make sure people are supported and treated with dignity and respect at the end of their lives.

Theme Three

Creating fairer life chances

This theme aims to reduce health inequalities across Bath and North East Somerset by creating fairer life chances and making sure that everyone has the opportunity to live well.

The surroundings where we grow up and live, our social and economic group and our local community all have effects on our health and wellbeing. Social inequality has a significant relationship with a wide range of health and social care problems including reduced life expectancy and long term health conditions.

Improve skills, education and employment

Key to creating fairer life chances for all is ensuring that our local communities have access to good quality education and employment opportunities. Educational outcomes and employment status have a significant impact on physical and mental wellbeing.

To achieve fairer life chances, investment in early years is crucial. Working with our Children's Trust Board, we are committed to working with schools and colleges to maximise the choice and diversity of opportunities for young people, and to ensure that they are supported to succeed.

The Health and Wellbeing Board will work in partnership with the Bath and North East Somerset Economic Partnership, the Bath and North East Somerset Learning Partnership and the West of England Local Enterprise Partnership to build a strong economy supporting the skills development necessary to create more local job opportunities, promote job creation, ensure appropriate jobs are available, improve connections between employers and job seekers, and support the network of apprentices, interns, and undergraduate placement schemes.

Reduce the health and wellbeing consequences of domestic abuse

Domestic abuse represents a significant proportion of crime within Bath and North East Somerset. The health and wellbeing consequences of domestic abuse are wide-reaching and well acknowledged and include physical harm and disability, depression, low self-esteem, drug and alcohol abuse, child abuse, poverty, social exclusion and homelessness. It can have both immediate and long-term consequences for the victim, and can also have wider impacts on family, friends and the wider community.

Health services are often the first point of contact for people who have experienced domestic abuse. They can play an important role in preventing violence by intervening early, providing treatment and referring victims on to other services. The Health and Wellbeing Board will work with health, social care and police to promote early, swift and prompt intervention to make sure victims of domestic abuse get the care and support they deserve.

Case Study

Village Agents - transforming services for older people in Chew Valley

Older people in the Chew Valley area at risk of social isolation meet with friends and local services as part of the Village Agents Scheme.

Increase the resilience of people and communities including action on loneliness

Our local surroundings and social environment play an important part in our health and wellbeing. There is a link between loneliness and isolation and a range of health and wellbeing issues such as high blood pressure, depression and heart disease, particularly amongst the aging population.

There are a number of groups which may be particularly vulnerable to social isolation and loneliness including young care-leavers, those with mental ill-health and the older population. The Health and Wellbeing Board is committed to working with partners to support services and activities which keep local people connected, such as community volunteering can help address issues of loneliness and isolation helping older people play a greater and more empowered role in community life.

Joint Health and Wellbeing Strategy

Appendix 1

Bath & North East Somerset - *The* place to live, work and visit

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

healthwatch Bath and North East Somerset

Part Three - Delivering our priorities

This section provides a summary of our first steps to delivery, and relevant national outcomes. It is not intended to be a complete delivery plan but rather one that will be updated and evolve as the Health and Wellbeing Board develops and increases its influence over the services and activities that can make a difference.

Over time more detailed delivery plans will be adopted, setting out action on specific priorities such as helping children to be a healthy weight or enhanced quality of life for people with dementia.

THEME 1: HELPING PEOPLE TO STAY HEALTHY			
Joint Health and Wellbeing Strategy Priority	Joint Strategic Needs Assessment evidence	Examples of local partnership deliverables and joint activity	National outcome measures
Helping children to be a healthy weight	Higher rates of overweight children starting school 25.9% of children in reception year are of an unhealthy weight (overweight and obese) compared to 22.6% nationally	Halt the rise in childhood overweight and obesity (CYPP) Promote and support healthy lifestyles for children and young people (CYPP) Make sustainable travel options (e.g. walking and cycling) accessible and available as part of a healthy lifestyle choice for all. (ES&CC Strategy) Develop a B&NES strategic approach to local food, to increase production and engagement in growing, reduce carbon emissions and make cheaper, healthier fresh food more accessible for key groups (ES&CC Strategy) Implementation of Shaping Up Strategy Encourage the creation of high quality compensatory play provision that is accessible, local, free from unacceptable levels of risk, yet stimulating and challenging (B&NES Play Policy)	Excess weight in 4-5 and 10-11 year olds (PHOF 2.6) Diet (placeholder) (PHOF 2.11) Utilisation of green space for exercise/ health reasons (PHOF 1.16)

THEME 1: HELPING PEOPLE TO STAY HEALTHY			
Joint Health and Wellbeing Strategy priority	Joint Strategic Needs Assessment evidence	Examples of local partnership deliverables and joint activity	National outcome measures
Improved support for families with complex needs	There are 220 families in B&NES experiencing a range of complex needs The Government estimates that each family costs the public sector an average of £75,000 each year	Implementation of Connecting Families Programme (Key deliverables: Family members in work; Children and young people in the families regularly attending school; Reductions in youth crime and anti-social behaviour ; Reduction in domestic abuse within the families; Reduction in mental ill-health within the families; Reduction in the numbers of children admitted to care / staying in care; Increase in effectiveness and timeliness of child protection; Reduction in substance abuse)	Children in poverty (PHOF 1.1) 16-18 year olds not in education, training or employment (PHOF 1.5) People with mental illness or disability in settled accommodation (PHOF 1.6) Sickness absence rate (PHOF 1.9) Fuel poverty (PHOF 1.17) Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm (ASCOF 4) Under 18 conceptions (PHOF 2.4)
Reduced rates of alcohol misuse	The average year on year increase in admissions attributable to alcohol is 12%, compared with 8% for the South West (since 2002/03) Estimates suggest that B&NES has 7,021 people aged 18-64 dependent on alcohol People living in the most deprived areas are over 4 times more likely to be admitted to hospital for alcohol specific conditions than those living in the least deprived areas	Implementation of Alcohol Harm Reduction Strategy for B&NES (Key aim: to prevent the harm arising to individuals, families and society from alcohol misuse in B&NES and to treat, rehabilitate and care for those who misuse alcohol) Promote and support healthy lifestyles for children and young people; Reduce substance misuse (CYPP) Reduce alcohol specific related admissions (CCG Local Priority Measure – CCG Quality Premium) Minimise the harm that drug and other substance misuse causes to society, communities, families and individuals (Community Safety Partnership priority)	Alcohol-related admissions to hospital (PHOF 1.18)

THEME 1: HELPING PEOPLE TO STAY HEALTHY

Joint Health and Wellbeing Strategy priority	Joint Strategic Needs Assessment evidence	Examples of local partnership deliverables and joint activity	National outcome measures
Create healthy and sustainable places	People living in areas with high levels of greenery are thought to be 3 times more likely to be physically active and 40% less likely to be overweight or obese There is a link between air pollution and an increased risk of death and hospital admission Access to the natural environment can have positive effects on mental health	Reduce health, education and social inequalities in specific groups of children and young people and specific geographical areas; Ensure all children access a range of recreational activities (CYPP) Promote and support healthy lifestyles for children and young people (CYPP) Sustainable Development Management Plan (in development) (CCG Plan) Recognise the links between mental and physical health and access to the natural environment and open spaces (ES&CC Strategy, Green Infrastructure Strategy, Green Spaces Strategy) Promote the opportunity for health and social care providers to benefit from local energy projects (ES&CC Strategy) Increase community resilience to climate change impacts (ES&CC Strategy) Public Protection (Key areas: Food safety; Environmental monitoring; Health improvement; Health and safety; Public safety) Plan for development that promotes health and wellbeing (Core Strategy) Implementation of Housing and Wellbeing Strategy (Key priorities: Tackle fuel poverty and climate change by making homes warmer and more energy efficient; Make homes safer and healthier; Increase the supply of new affordable housing) Implementation of Tobacco Control Strategy (Key aims: 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)	Utilisation of green space for exercise/ health reasons (PHOF 1.16) Diet (placeholder) (PHOF 2.11) Recorded diabetes (PHOF 1.17) Excess weight in adults (PHOF 1.12) Proportion of physically active and inactive adults (PHOF 1.13) Air pollution (PHOF 3.1) Public sector organisations with board-approved sustainable management plans (PHOF 3.6) Everyone enjoys physical safety and feels secure (ASCOF 4A) Excess winter deaths (PHOF 4.15) Fuel Poverty (PHOF 1.17) Reduce air pollution and meet the national air quality objectives in the three Air Quality Management Areas in Bath, Saltford and Keynsham (Environmental Services)

THEME 2 : IMPROVING THE QUALITY OF PEOPLES LIVES			
Joint Health and Wellbeing Strategy priority	Joint Strategic Needs Assessment evidence	Examples of local partnership deliverables and joint activity	National outcome measures
Reduced rates of mental ill-health	Admissions for self-harm are higher for both men and women in B&NES (229 per 100,000) compared to the national average (198 per 100,000) for 2009/10 There has been a steady increase in the number of suicides per year since 2005. Rates in men are higher than rates in women High rates of depression and high levels of self-harm amongst young women	Promote children and young people's emotional health and resilience (CYPP) Mental health services (Key priorities: Reconfiguration in adult mental health inpatient services; Review mental health care pathways and services to improve health and social care outcomes; Improve mental health and wellbeing in Primary Care) (CCG Plan) Delivery of Primary Care Liaison Service by AWP and B&NES Council to support people with mental ill health, provide a gateway into secondary mental health services as well as signposting to other services	Hospital admissions as a result of self-harm (PHOF 2.10) Emotional wellbeing of looked after children (placeholder) (PHOF1.8) Suicide (PHOF 1.10)
Enhanced quality of life for people with dementia	Dementia is expected to increase by 23% for women and 43% for men between 2010 and 2025 Feedback from the LINk survey (2009) suggested that Dementia and Alzheimer's were the conditions of most concern to the community Black, minority and ethnic communities experience lower levels of awareness of problems such as dementia Over 50% of nursing home residents experience dementia	Long term conditions and frail elderly (Key priorities: Redesign of clinical pathways to improve clinical outcomes; Increase & ensure patient satisfaction; Deliver care closer to home) (CCG Plan) Implementation of Dementia Local Action Plan (key priority areas: Better diagnosis; Improving care in hospitals; Improving standards in care homes and domiciliary care; Better information for people with dementia and their carers; Better support for carers; Providing support in the community; Supporting people with dementia at end of live; Reducing use of antipsychotics)	Dementia and it's impacts (placeholder) (PHOF 1.16) Dementia – a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life (ASCOF 2F)

THEME 2 : IMPROVING THE QUALITY OF PEOPLES LIVES			
Joint Health and Wellbeing Strategy priority	Joint Strategic Needs Assessment evidence	Examples of local partnership deliverables and joint activity	National outcome measures
Improved services which support and encourage independent living and dying well	B&NES has a higher than average number of people aged 65 and over who are permanent residents of residential and nursing care homes (92 people per 10,000, 2009/10) Most people (63%) express a wish to die at home; however, only 20% actually do (22.2% B&NES vs. 20.3% nationally)	End of life care (Key priorities: Deliver improved care coordination for people at end of life; Achieve and sustain national and local performance) (CCG Plan) Support people with dementia at end of life (Dementia Local Action Plan)	Health related quality of life for older people (placeholder) (PHOF 1.13) Permanent admissions to residential and nursing care homes, per 1,000 population (ASCOF 2A) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B) Delayed transfers of care from hospital, and those which are attributable to adult social care (ASCOF 2C) B&NES Local Action Plan to support implementation of the National End of Life Care Strategy
Improved support for people with long term health conditions	The prevalence of long term health conditions, including cancer, is rising (in line with national and regional rates) Long term health conditions make up a significant proportion of NHS spend There is a 60% higher prevalence of long term conditions in deprived areas Heart conditions, cancer, lungs and diseases of the digestive system are the most common forms of death (in line with national)	Long term health conditions and frail elderly (Key priorities: Redesign of clinical pathways to improve clinical outcomes; Increase & ensure patient satisfaction; Deliver care closer to home) (CCG Plan) Improve the efficiency of provision of disabled facilities in partnership with Sirona and Curo Housing Association (Housing Services) Implementation of Tobacco Control Strategy (Key aim: Encouraging smokers to quit)	Employment for those with a long-term health condition including those with a learning difficulty / disability or mental illness (PHOF 1.8) Proportion of people who use services who have control over their daily life (ASCOF 1B) Overall satisfaction of people who use services with their care and support (ASCOF 3A) The proportion of people who use services and carers who find it easy to find information about support (ASCOF 3D) The proportion of people who use services who feel safe (ASCOF 4A) The proportion of people who use services who say that those services have made them feel safe and secure (ASCOF 4B)

THEME 3: CREATING FAIRER LIFE CHANCES			
Joint Health and Wellbeing Strategy priority	Joint Strategic Needs Assessment evidence	Examples of local partnership deliverables and joint activity	National outcome measures
Improve skills and employment	4.4% of current 16-18 year olds are NEET (December 2012). Numbers have increased over time, although remain lower than similar areas and nationally There are higher rates of people claiming out of work benefits in some areas of B&NES	Reduce health, education and social inequalities in specific groups of children and young people and specific geographical areas (CYPP) Support all young people to engage in employment, education and training from 16-19 (CYPP) Implementation of Economic Strategy for B&NES (Key objective: Improve the prosperity and wellbeing of B&NES residents through a more productive, competitive and expanded economy by 2026) Primary Care (Key priorities: new patient pathways that result in a shorter time in the system and return to work/education) (CCG Plan) Mental Health Services (Key priorities: Maintain of performance for people in specialist mental health services in settled accommodation and employment) (CCG Plan) Learning Difficulties (Key priorities: Increase number of people living in their own homes and gaining paid employment) (CCG Plan) Support people to find employment, training and volunteering schemes through joint initiatives with Homelessness Partnership service providers and DWP (Housing Services)	16-18 year olds not in education, employment or training (PHOF 1.5) Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness (PHOF 1.8) Proportion of adults with a learning disability in paid employment (ASCOF 1E) Proportion of adults in contact with secondary mental health services in paid employment (ASCOF 1F) Under 18 conceptions (PHOF 2.4)

THEME 3: CREATING FAIRER LIFE CHANCES			
Joint Health and Wellbeing Strategy priority	Joint Strategic Needs Assessment evidence	Examples of local partnership deliverables and joint activity	National outcome measures
Reduce the health and wellbeing consequences of domestic abuse	Domestic abuse is a significant volume of crime in B&NES Women are more likely to be victims of domestic abuse compared with men (78% women, 21% men victims) Men offenders made up 79% of all recorded perpetrators of domestic abuse crimes between 2012-12	Implementation of Interpersonal Violence and Abuse Strategic Partnership - Violence Against Women and Girls Action Plan Provide children and young people with a safe environment, including empowering children and young people to recognise risks (CYPP) Protection from violence, maltreatment, neglect and sexual exploitation (CYPP) Tackle domestic and sexual violence, particularly towards women and children (Avon and Somerset Police and Crime Plan) Provide support, advice and refuge to victims of domestic abuse in partnership with commissioned service providers (Housing Services)	Domestic abuse (placeholder) (PHOF 1.11) Violent crime (including sexual violence) (placeholder) (PHOF 1.12) Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm (ASCOF 4)
Increased resilience of people and communities including action on loneliness	Just over half of the people who live alone have regular contact with friends and family	Implementation of the Village Agent Project Implementation of B&NES Young Carers Strategy (Key objectives: Young carers will be able to access the Young Carers local project that provides safe, quality support to those children who continue to be affected by any caring role within their family; Young carers will have the same access to social/leisure opportunities as their peers) Implementation of B&NES Plan for Public Library Services (Mission Statement: Help everyone to achieve their goals and boost their wellbeing; work with partners to offer accessible, affordable and relevant resources for learning, reading and enjoyment; create opportunities for people to become involved with community life)	Social connectedness (placeholder) (PHOF 1.18) Proportion of people who use services and their carers, who reported that they had as much social contact as they would like (ASCOF 1L)

CYPP - Children and Young People's Plan
CCG Plan - Clinical Commissioning Group Plan
ES&CC Strategy - Environmental Sustainability and Climate Change Strategy

PHOF - Public Health Outcomes Framework
ASCOF - Adult Social Care Outcomes Framework

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	Joint Health and Wellbeing Strategy
Name of directorate and service	Strategy and Performance, Strategy and Plan Team
Name and role of officers completing the EIA	Helen Edelstyn – Strategy and Plan Manager Andrea Wolfenden – Programme and Strategy Officer
Date of assessment	July 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.

The Joint Health and Wellbeing Strategy is based on a substantial amount of equality analysis which has been collected through the Joint Strategic Needs Assessment. This document summarises some of the key equality considerations highlighted through this assessment process as well as demonstrating the impacts that the strategy will have on different equalities groups.

1.	**Identify the aims of the policy or service and how it is implemented.**	
	Key questions	**Answers / Notes**
1.1	Briefly describe the purpose of the service / policy	Bath and North East Somerset Council has a legal duty, as set out in the Health and Social Care Act 2012, to produce and publish a Joint Health and Wellbeing Strategy. The strategy sets out local priorities for action based on the health and wellbeing needs identified in the Joint Strategic Needs Assessment. The Health and Wellbeing Board is the body responsible for developing and delivering this strategy and is made up of senior officers from the Council, local councillors, GPs from NHS B&NES Clinical Commissioning Group, the Director of Public Health, Bath, Gloucestershire, Swindon and Wiltshire Area Team and Healthwatch B&NES. Further details on the B&NES Health and Wellbeing Board can be found here: www.bathnes.gov.uk/health-wellbeing-board
1.2	Provide brief details of the scope of the policy or service being reviewed	Through this strategy, the Health and Wellbeing Board is committed to creating a shared leadership across the health and social care systems to deliver better health and wellbeing outcomes locally. The overarching aim of the strategy is to improve health and wellbeing and reduce health inequalities and it is therefore vital that the strategy is fair and doesn't discriminate against any groups of people. The strategy sets out a framework for partnership action against three theme areas: • Helping people to stay healthy

		• Improving the quality of people's lives • Creating fairer life chances The priorities identified within these themes are not an exhaustive list of everything that the Council and NHS are doing to meet local health and wellbeing need; but rather a small set of priorities for the Health and Wellbeing Board to really focus on and make a difference. This will be the first Joint Health and Wellbeing Strategy for B&NES. It is a 5 year strategy and will be reviewed in 2015. It is a high level strategic document which sets out the Health and Wellbeing Board's priorities over the coming years; more detailed action plans will be developed against each of the priorities and further equalities analysis will be undertaken as a key part of this.
1.3	Do the aims of this policy link to or conflict with any other policies of the Council?	Health and wellbeing issues have links with most of the work the Council does and are not limited to health and social care services alone. The Board is keen to work with non-traditional partners including economic development, sustainability, transport and housing and this strategy highlights key links that exist between the Board's priorities and the work of other service areas. Appendix One to the strategy sets out some of the key examples of local partnership activity, recognising the policies, services and plans already in place or developing which will impact on the Board's priorities (e.g. Children and Young People's Plan, Environmental Sustainability and Climate Change Strategy). Through this strategy, the Board will be influencing the planning, commissioning and delivery of local services to ensure that they meet the needs of communities within B&NES. The priorities of the Strategy should form a key consideration in the allocation of local health, social care and wellbeing resources.

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?	The Joint Health and Wellbeing Strategy has been developed by the Health and Wellbeing Board, in consultation with local groups, organisations, service users and residents. The newly established Healthwatch Bath and North East Somerset, who have two seats on the Health and Wellbeing Board, will take part in the ongoing development of the strategy. Healthwatch B&NES have a responsibility to be accessible to all as well as representing the views of local people at the Board through varied and inclusive engagement. The equalities profile of the Health and Wellbeing Board is currently unknown; an equality monitoring exercise will be carried out with Board members in order to determine their equalities profile.
2.2	What equalities training have	Strategy and Plan team members have received training on equality issues, including

	staff received?	equality impact assessments. An equalities update briefing is also noted on the Health and Wellbeing Board Forward Plan to be scheduled at a future meeting.
2.3	What is the equalities profile of service users?	All residents of Bath and North East Somerset will be users of services covered under the remit of the Health and Wellbeing Board. The Joint Health and Wellbeing Strategy is grounded in an evidenced understanding of the local population and its needs, through the Joint Strategic Needs Assessment process. The Joint Strategic Needs Assessment provides detailed profiling information by different equality characteristics which are summarised in Section Three of this document.
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?	A formal consultation period on the draft Joint Health and Wellbeing Strategy was launched on 30 April and ran until 7 June 2013. Consultation responses were received from a range of stakeholders including the Health and Wellbeing Board, Wellbeing Policy Development and Scrutiny Panel, health and social care providers, VCSE organisations, members of the public and service users. Many of the responses were positive and welcomed the development of a Joint Health and Wellbeing Strategy to reduce health inequalities and improve health and wellbeing in B&NES. Feedback also suggested that people found the draft strategy clear and easy to understand. Issues highlighted through the consultation included: • Need to strengthen what is meant by health inequality locally • Need to strengthen the link with sport and leisure • More clarity on how the themes and priorities will be delivered • Need to better articulate the journey – why these priorities and how are they going to shape commissioning • Need a greater focus on mental illness and wellbeing amongst young people

		• It's not in an accessible or easy read format Responses received during this consultation period have informed and shaped the development of the final Joint Health and Wellbeing Strategy.
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom?	The EIA is a 'living document' and will be continuously updated as necessary. Consultation will be undertaken with members of the Health and Wellbeing Board as well as the Council's Equality Team on this EIA.
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?	Equality considerations will play a key part as more detailed plans setting out action on the strategic priorities are now developed. Healthwatch B&NES will also feed in their ongoing engagement and consultation with local people to Health and Wellbeing Board discussions, ensuring that local views and knowledge are represented and championed. The Health and Wellbeing Board holds regular engagement sessions with local residents, groups, providers and organisations and is keen that these are accessible, fair and representative. The Joint Health and Wellbeing Strategy is available in a range of languages, large print, Braille, on tape, electronic and accessible formats, through contacting Policy and Partnerships – Tel: 01225 477188 or HWB@bathnes.gov.uk. An easy read version of the strategy is also being developed.

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	The Joint Strategic Needs Assessment highlights that health inequality exists within B&NES across different geographic areas, communities, social and economic groups. To reduce this inequality (and promote equality) is a key ambition of the Health and Wellbeing Board around which the priorities in the Joint Health and Wellbeing Strategy are framed. The Strategy sets out the Board's high level priorities and intentions for delivery over the next 5 years and encompasses all groups of people. However, specific characteristics will need to be considered as the Board develops more detailed action plans for delivery. For instance, we know that 78% of all recorded victims of domestic abuse crimes are women (compared with 21% of victims who are male) and in order to achieve the Board's priority to reduce the health and wellbeing consequences of domestic abuse, targeted actions aimed at reducing this will be developed. Other priorities such as helping children to be a healthy weight and reducing rates of mental ill health, especially in people in under-represented groups, will also require more targeted plans to be developed.
Examples of actual or potential negative or adverse impact and what steps have been or could be taken to address this	The priorities set out within the Joint Health and Wellbeing Strategy are not an exhaustive list of everything the Council and NHS are doing to meet local health and wellbeing need. However, the Health and Wellbeing Board will be focusing on these over the next 5 years as areas where they can make a real difference. It will be important that issues and needs not identified as a priority within this strategy are still

		highlighted to the Board and action taken where appropriate. A regular Joint Strategic Needs Assessment update is scheduled at Board meetings to ensure that any new or emerging issues are highlighted to members. An annual review will also be developed and presented to the Board which will summarise whole-system performance against health and wellbeing service delivery in B&NES and highlight any new and emerging JSNA evidence, service quality and delivery, patient and public voice, and performance.	
		What the Joint Strategic Needs Assessment has told us	**How the findings align with the Joint Health and Wellbeing Strategy**
3.1	**Gender**	• In line with national trends, life expectancy for women (84) is greater than for men (80), although the gap is expected to narrow as the population ages. • There are significant differences between the genders in vulnerability to health and wellbeing factors including mental health, heart disease, mortality, service use, domestic abuse and physical activity. ○ Nationally, 50% of all women and 25% of men will be affected by depression at some time in their life ○ The leading causes of death from cancer for women are breast, lung, upper gastro-intestinal, bowel and ovary. The leading causes of death from cancer for men are lung, upper gastro-intestinal, bowel and prostate. Rates for other forms of cancer are roughly equal across the genders, barring gender-specific types ○ Female victims made up 78% of all recorded victims of domestic abuse crimes, equating to 1422 incidents, compared to the 21% of victims who were male (389 incidents). ○ The gap between the proportion of boys and girls achieving 5+ A*-C including English and maths is 13.8% with the girls outperforming the boys ○ Nationally, 21% of men and 12% of women indicate that	The following strategic priorities have been designed to address these needs: • Reduced rates of mental ill health • Reduce the health and wellbeing consequences of domestic abuse • Improve skills, education and employment

		they undertake 30 minutes of moderate intensity exercise on 3 or more days a week	

3.2	**Pregnancy and maternity**	• There has been an increase in complex and high risk pregnancies, higher numbers of older women, women with a high Body Mass Index and women with pre-existing medical conditions
		• Rates of premature and still births are lower in B&NES than nationally
		• Approximately 30% of pregnancies in the UK are unplanned
		• Teenage conception rates in B&NES are approximately 17 per 1,000 15-17 year old females, significantly lower than national (33 per 1,000) and regional (28 per 1,000) rates
		  ○ Of these conceptions 59.2% led to abortion, this is higher than the previous year and higher than both regional (47.9%) and national (49.3%) figures.
		  ○ A high percentage of all abortions are carried out between 3-9 weeks (81%), which suggests good early access to abortion services4
		  ○ Nearly half of teenage mothers are not in employment, education or training.
		• At 83% a higher proportion of local babies are breastfed at birth than regionally or nationally
		  ○ There is some relationship with socio-economic inequality and lower breastfeeding rates
			Whilst issues based on pregnancy and maternity are not explicitly referenced in the strategy, they will be a key consideration in the delivery of the Board's priorities. For instance, in creating fairer life chances and improving skills, education and employment.

3.3	**Transgender**	• 19% of trans people have been physically attacked and 38% experienced physical intimidation and threats because of their gender identity • Nationally, 97% of transphobic crime goes unreported • 80% of trans people have experienced emotional, physical or sexual abuse from a current or former partner based on a rejection of their trans identity • 64% of trans people have experienced domestic violence and	Strategic priority: • Reduce the health and wellbeing consequences of domestic abuse

		abuse, compared to 29% of non-trans respondents. • Trans and non-gendered individuals may face particular barriers to participation in physical activity	
3.4	**Disability** (both physical and mental impairments)	<u>Physical impairments</u> • Estimates suggest that there are nearly 8,500 people with a moderate or severe physical disability and nearly 2,500 who have a severe physical disability living in B&NES. • There are over 73,000 people in B&NES with at least one long term health condition • Nearly half of sufferers with long-term conditions surveyed in 2011 felt that they were able to manage their condition • Emergency bed days for long-term conditions are consistently lower than regional and national levels <u>Mental impairments</u> • Estimates suggest that 16% of the working age population have a common mental illness • Recorded prevalence is generally below the national average, with the exception of depression. ○ B&NES GP practices have higher recorded rates of depression (12.8% of adults) than nationally (11.2%). • 89% of users of less intensive mental health services are satisfied with the service they receive • At £32m, the cost of treating mental health issues is largely in line with national and regional averages. • Mental illness is the leading cause of disability worldwide	Strategic priorities: Theme Two - Improving the quality of people's lives • Improved support for people with long term health conditions • Reduced rates of mental ill-health
3.5	**Age**	<u>Children and young people</u> • Approximately 12% of children in B&NES live in poverty, with 34% in Twerton, 25% in Southdown and 21% in Radstock. • Children on free school meals in B&NES were significantly lower performing than nationally for English and Maths. • Young people are at particular risk of homelessness and 50% of	Strategic priorities: • Helping children to be a healthy weight • Reduced rates of alcohol misuse • Reduced rates of mental-ill

		homelessness applications in B&NES are from people aged under 25. • In 2009 data suggests that B&NES was worse than nationally and regionally with respect to children who had reported they had been drunk one or more times in the last 4 weeks (20% BANES, 15% England). • 1/3rd of 11-12 year olds and a quarter of 4-5 year olds in B&NES are an unhealthy weight • The percentage of school children with Autism Spectrum Disorder in B&NES is higher than the regional average and is in the second highest quintile nationally (8% B&NES, 6% nationally). • Rates of mental health related outpatient attendances for children and adolescents in B&NES were above national and regional averages in 2009/10 and 2010/11. <u>Older people</u> • By 2021 the numbers of over 75's in the population are projected to increase by 20% (approximately 3,200 people). ○ In particular the percentage of older men in the population is projected to increase • Dementia cases are expected to increase by 23% for females and 43% for males between 2010 and 2025 in B&NES (1916 females, 1225 males) • Malnutrition affects 23% of people under 65. This increases to 32% over the age of 65. • Those who are admitted to hospital over the age of 80 are twice as likely to become malnourished than those under the age of 50 • 30% of 65-74 year-olds and less than 15% of adults aged 75 and over reported any exercise lasting at least ten minutes during four weeks • Overall higher ratings of were reported by younger and older people, and lower ratings are reported by those in the middle years	health • Enhanced quality of life for people with dementia • Improved services for older people which support and encourage independent living and dying well • Increased resilience of people and communities including action on loneliness Where particular needs have been identified, priorities within the strategy are targeted at specific age groups (such as helping children to be a healthy weight and enhancing quality of life for people with dementia). However, groups of all ages feed in throughout the strategy.

3.6	**Race**	• Approximately 10% (17,500 people) of the B&NES population are non-white-British. • The second most common ethnicity is 'Other White' and this population group is increasing. • 71% of hate crime is ethnicity related. • There are a disproportionate number of children in care from BME groups. • Ethnicity is not recorded for many health conditions so information for equalities monitoring is not normally available at a local level. • Significantly lower wellbeing was recorded by people of a non-white ethnicity across the range of questions	The strategy sets out to improve the health and wellbeing of all people within B&NES and remove any barriers to healthy lifestyles. The needs of particular racial and ethnic minority communities will be considered in the development of detailed action plans.
3.6	**Sexual orientation, marriage and civil partnership**	• There are likely to be approximately 9,000 adult residents of B&NES who are lesbian, gay or bisexual. • LGB groups are more likely to be vulnerable to adverse health and wellbeing outcomes compared to the general population, including: hate crime, domestic violence, shorter life expectancy, higher rates of smoking, poorer sexual health, higher rates of self-harm and suicide, school absenteeism and homelessness. • Married people, those in civil partnerships and cohabiting couples had higher reported ratings of wellbeing across all domains when compared to single and widowed people.	Strategic priorities: • Reduce the health and wellbeing consequences of domestic abuse • Reduced rates of mental ill health
3.8	**Religion/belief**	• 56.5% of people in B&NES consider themselves Christian • A large proportion (32.7%) state they have no religion • In B&NES, 7% of reported hate crimes are related to faith/religion	The strategy sets out to improve the health and wellbeing of all people within B&NES and remove any barriers to healthy lifestyles. The needs of different faith groups will be considered in the development of detailed action plans.

3.9	**Socio-economically disadvantaged**	• B&NES is one of the least deprived authorities in the country, ranking 247 out of 326 English authorities • It is ranked 49 out of 56 Unitary Authorities. Despite these relatively low levels of social inequality, there are small geographical areas with notable issues and differences in deprivation • Locally, we have seen that the issue of socio-economic inequality is related to a wide range of factors across the life-course • There are significant variations in life expectancy related to socio-economic inequality. For someone living in the most deprived area of B&NES, they can expect to die at a younger age than someone in the most affluent area of B&NES (7.5 years for men and 4.9 years for women). • According to the End Child Poverty report approximately 12% (4056 children) of children in B&NES live in poverty. This compares to 14% in North Somerset, 17% in West Somerset and 11% in Wiltshire. There are wide variations in this figure across different wards in B&NES from under 5% to 34% • Unemployed people scored significantly low on "happy yesterday" and "worthwhile" when measuring levels of wellbeing.	The overarching aim of the Health and Wellbeing Board is to reduce health inequality and improve health and wellbeing in B&NES and will feed into all of the priorities in the strategy.
3.10	**Rural communities**	• ONS estimates for 2009 suggest that 14% of the local population live in dispersed rural areas or villages, this compares to 10% for England as a whole and 20% for the South West.	Strategic priorities: • Create healthy and sustainable places • Increase the resilience of people and communities including action on loneliness The strategy sets out to improve the health and wellbeing of all people within B&NES. Varied and unique communities exist across

			B&NES and different approaches may be required depending on local issues.

3.11	**Students**	• Between 1995/96 and 2008/9 the number of students in these higher education institutions rose from 10740 to 21540 (101%).
		• The student population is not equally distributed across the area, both Universities have a notable proportion of students living 'on-campus' and student housing is also found throughout the City.
		• Analysis in 2011, of areas with high levels of community capacity (the ability of a community to take self-directed action), discovered that some areas with a high proportion of student residents had lower levels of capacity. However, these communities were also considerably more likely to be active users of Social Media.
		• Research for the National Union of Students in Scotland highlighted a range of issues surrounding student mental health:
		  ○ Exams and examinations and future careers were a big cause for concern, with nearly all students interviewed reporting that exams caused more stress than expected.
		  ○ Having enough money to get by was highlighted as a cause of stress for 70% of students, and working a paid job was considered a cause of stress for 50%
		  ○ Alternatively, 30% of students felt comfortable asking their institution for help or support, while 80% reported that stigma related to mental health issues would be the primary barrier.
			There are two large and growing universities within B&NES and the Health and Wellbeing Board recognises that there is a significant student population with our area. Services and initiatives will need to be conscious of the needs and issues of students.
			
			The needs of the student population will be considered in the development of detailed action plans.

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	Officer responsible	By when
The strategy and accompanying documents needs to be accessible to all groups.	Develop an easy read version of the strategy and promote that the document can be made available in a variety of accessible formats upon request.	Strategy and Plan Team	TBC
The priorities set out in the Strategy need to be monitored through the delivery and performance of services and experiences of service users.	An annual review will be produced and made publicly available.	Strategy and Plan Team	2014
Lack of evidence around need does not mean that risks or issues are not present. Data collection on a range of equalities dimensions is incomplete and there are acknowledged gaps in the JSNA (e.g. there is currently very little data on Romany gypsies and Irish travellers in B&NES).	With the emerging connecting Data Project ensure that all stakeholders are aware of the value in monitoring equalities data. Ensure that commissioned research meets gaps in knowledge. Ensure decision makers are aware of the need to include all new intelligence in the JSNA process.	JSNA Project Team	Ongoing
Engagement between the Health and Wellbeing Board and local residents, groups, providers and organisations needs to be accessible, fair and representative.	Monitor attendance at future Board engagement session to ensure appropriate representation of different groups and ensure it is as inclusive as possible.	Strategy and Plan Team / Healthwatch B&NES	Ongoing
The equalities profile of the Health and Wellbeing Board is unknown. The Board will schedule an equality update briefing.	An equality monitoring exercise will be carried out with Health and Wellbeing Board members to determine their equality profile and brief them on key equality considerations.	Strategy and Plan Team / Equalities Team	TBC

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: Helen Edelstyn (Divisional Director or nominated senior officer)
Date: 15 July 2013

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board
MEETING DATE:	18th September 2013
TITLE:	Joint Strategic Needs Assessment Update
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix One: JSNA Update Briefing	

1 THE ISSUE

1.1 This report provides an update to the Joint Strategic Needs Assessment base and summarises findings of recent research conducted on the Bath and North East Somerset community.

2 RECOMMENDATION

The Board is asked to:

2.1 Note the findings of the report and consider the impact of any new findings on local policy.

2.2 Promote the JSNA web-site www.bathnes.gov.uk/jsna

3 FINANCIAL IMPLICATIONS

3.1 There are no direct resource implications of this report, however the findings will be included in data used to supplement the Equalities Impact Assessment of council budget proposals and the wider JSNA will be promoted as a tool to support effective commissioning.

4 THE REPORT

4.1 The aim of the JSNA is to create a single strategic evidence base for understanding local lives, local communities and local services. This means we are broadening the traditional scope of the JSNA to look beyond trends in health and social care to examine the broader social and environmental determinants of wellbeing.

4.2 The JSNA has tried to get a balance between statistical data and information from consultation and engagement activity as well as reflecting local performance.

4.3 A briefing note detailing notable updates to our knowledge and an assessment of how they change what we already know are attached as Appendix 1.

4.4 As part of the ongoing development of the JSNA we have moved it online into a 'wiki' format. This means that updates will be available as soon as they are published. Further communications on this subject will follow.

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 Findings from this update increase our knowledge about the needs associated with a range of equalities characteristics:

(1) Age – Particularly younger people (updated childhood obesity data, Youth Justice Entrants)

(2) Gender – Differences between male and female experiences of domestic abuse

(3) Gypsies and Travellers – Increased understanding of health needs

6.2 Specific sections summarising key JSNA findings against each key equality dimension will be updated as new findings emerge

7 CONSULTATION

7.1 *Cabinet Member; Staff; Other Public Sector Bodies;*

7.2 Consultation has been made in line with corporate guidance and has also been sought from the multi-agency JSNA project team

8 ISSUES TO CONSIDER IN REACHING THE DECISION

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

9 ADVICE SOUGHT

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

Contact person	Jon Poole, Research & Intelligence Manager
Background papers	**www.bathnes.gov.uk/jsna**
Please contact the report author if you need to access this report in an alternative format	

New Research, Facts and Figures
JSNA Update September 2013

News

The JSNA is online
The JSNA is now available as a 'wiki' – this is a way of getting information quickly onto the internet; this means that a range of research professionals in the area can get the JSNA updated as quickly as possible. For more information visit:

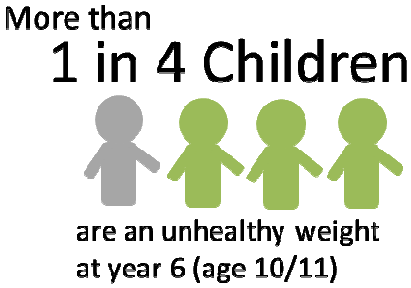
(To be launched at meeting)

New Research

Childhood Weight

In the 2011/12 school year, 26.1% of reception aged children and 26.8% of year 6 children attending schools in B&NES had an unhealthy weight (overweight or obese).

The rate in reception is significantly higher than the national rate of 22.6% and is the highest recorded to date. However, the year six rate is significantly lower than the national rate of 33.9%.



How does this change what we already know?

The rate of unhealthy weight amongst reception year children has already been highlighted as a priority of the Health and Wellbeing Board and this new information further demonstrates the significance of this issue, particularly amongst reception year children.

Domestic Abuse Profile

A new study on Domestic Abuse in the authority area has been produced with the local Crime and Disorder reduction partnership. Key findings are that Domestic Abuse is likely to affect 1 in 5 men and 2 in 5 women over the course of their lives. It costs public services £17.1m each year, £3.7m to health services alone. There is significant evidence of under-reporting.

Younger men are more likely than any other group to be perpetrators according to crime statistics, however safeguarding reports also show increases in cases against older people.

How does this change what we already know?
This profile updates a previous study conducted in 2011 and provides more detail on this issue; it can provide more information to support development of the Creating Fairer Life Chances priority of the Health and Wellbeing Board.

Gypsy Traveller Health Needs Assessment

Findings of a new study suggest that Gypsies and Travellers experience different needs to that of the population as a whole. These needs are characterised by increased risk factors across a range of issues including mental ill-health, physical disabilities and lifestyle factors such as smoking. For example, Traveller and Gypsy Traveller women are more than twenty times more likely to experience the death of a child than the population as a whole.

These needs are often coupled with a reluctance to engage with public services.

How does this change what we already know?
This research increases our understanding of the unique nature of these communities, in the absence of much hard demographic information increases the importance of ensuring services are, where appropriate, targeted to these communities.

Public Health Outcomes Framework

As in previous years the majority of indicators suggest that overall health in Bath and North East Somerset is in line with or significantly better than the national figures other than in a number of cases of which notable new outliers are discussed below.

- **Proportion of the population affected by noise.** The outcomes framework uses an estimation to calculate the proportion of the population affected by noise in the local area. This model projects forward from figures provided as far back as 2005 and calculates that 8.1 per 1000 population will be affected by noise. However, local figures suggest a different picture, with 6.2 people per 1000 affected. This is significantly lower than the reported national figure of 7.2.

- **First Time Entrants to the Youth Justice System**. In common with local authorities across Avon and Somerset the proportion of first time entrants to the youth justice system remains high, however this is in the context of a 13% reduction since 2011 and a low re-offending rate compared to national and regional rates.

- **Excess weight in 4-5 year olds** is significantly higher than the national average, this issue is discussed in more detail above.

YOUR RESEARCH MISSING? – If you know of any new research about Bath and North East Somerset (on any subject) that we're missing or if you want to know more about any of the topics contained in this report, please get in touch: research@bathnes.gov.uk or ring 01225 477230

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board
MEETING DATE:	18th September 2013
TITLE:	Feedback from the Health and Wellbeing Network Meeting 24th July 2013
AN OPEN PUBLIC ITEM	
List of attachments to this report: None	

1 THE ISSUE

1.1 On the 8 May Bath and North East Somerset Council released the Placemaking Plan Launch document. Its aim is to generate discussion and ideas for developing places and communities in Bath and North East Somerset. This includes aspirations for key development sites.

1.2 The Health and Wellbeing Network meeting on 24th July was an opportunity for groups with an involvement or interest in health and social care to hear more about the Placemaking Plan and to consider how the community might work together to plan key development sites that promote health and wellbeing.

2 RECOMMENDATION

2.1 The Board is asked to:

- Note the key recommendations from health and wellbeing provider discussion on the Placemaking Plan:
    - Safeguard - Safeguard Health and Wellbeing Board interests in the development of new communities; protecting growth and making sure that it is the right growth for people against the backdrop of planning policy and housing numbers
    - Influence - Develop a clear relationship and pathway so that the Health and Wellbeing Board can influence the Cabinet Member for Planning and strategic planning processes
    - Based on local understanding – Know the people we are building houses and communities for (including older people); what do they want, what do they need and ensuring wrap around health and social care is available for any new communities. Also ensuring that planning processes are transparent to communities including building on credit unions.

- Learn - 'Listen to communities and work collaboratively'. Keep and build on the current networking, seek inspiration from elsewhere and consult widely with local communities, groups and stakeholders on new development and proposals.

- Capacity - There are many existing resources and services that can be better used. Assets such as older people, volunteers, and existing 'neighbourliness', all represent opportunities and the current provision of services must also be understood as an asset.

- Balance - Build on existing links and services. Developments must find a balance between financial benefits and longer term social/health benefits. Any development needs to rebalance the health inequalities for those who find it hard to engage or access services.

3 THE REPORT

3.1 The Healthwatch Bath and North East Somerset Health and Wellbeing Network meeting was held on Wednesday 24th July 2013. 51 people from local groups with an involvement or interest in the subject attended the event to discuss the Placemaking Plan. In groups delegates discussed the following questions:

3.2 **What wellbeing issues do providers feel need to be addressed by development – how does 'place' affect wellbeing?**

During the discussion it emerged that the identity of 'place' develops from the local population and that identity can go back a long way. The need to balance development and preservation was recognised but Bath must be a living city that meets people's needs into the future. If people have to spend a lot of time in their homes they need to be able to access all of their needs including feeling safe (especially for mental health), shopping, noise and transport in and out of their community.

It was felt that engagement should start with local champions to help reconnect people and that environmental issues can impact on health provision. The accessibility, including affordability, of community services and facilities was stressed. The concept of 'community commissioning', linking development and wellbeing by fostering integrated, connected and sustainable communities, was also discussed.

3.3 **What are the implications for providers of health and wellbeing services in maintaining and providing services to these developing communities? What services will they need?**

The affordability and accessibility of services and facilities is an issue for both local people and local service providers. A lack of infrastructure (including bungalow style buildings and transport links for example) coupled with reductions in funding could make service provision prohibitive in some places.

Developments to the physical environment should be matched with supporting appropriate service development, such as additional staff and training, in order to effectively extend existing provision. This range of existing local provision must be

understood, and supported. Maintaining local shops was an example, but also access to GPs, schools and open spaces.

The group agreed that good local community involvement, and joining up residents and providers, is needed, as medical healthcare providers are not always engaged with the community. It was discussed that a range of services and support is required to provide for physical, emotional and mental wellbeing. It was also highlighted that good signposting and an understanding of local economies and context is important.

3.4 **What do providers feel are the key issues the Health and Wellbeing Board should look at when considering the Placemaking Plan?**

- Safeguard – Safeguard Health and Wellbeing Board interests in the development of new communities; protecting growth and making sure that it is the right growth for people against the backdrop of planning policy and housing numbers

- Influence - Developing a clear relationship and pathway so that the Health and Wellbeing Board can influence the Cabinet Member for Planning and strategic planning processes

- Based on local understanding – Know the people we are building houses and communities for (including older people); what do they want, what do they need and ensuring wrap around health and social care is available for any new communities. Also ensuring that planning processes are transparent to communities including building on credit unions.

- Learn - 'Listen to communities and work collaboratively'. Keep and build on the current networking, seek inspiration from elsewhere and consult widely with local communities, groups and stakeholders on new development and proposals.

- Capacity - There are many existing resources and services that can be better used. Assets such as older people, volunteers, and existing 'neighbourliness', all represent opportunities and the current provision of services must also be understood as an asset.

- Balance - Build on existing links and services. Developments must find a balance between financial benefits and longer term social/health benefits. Any development needs to rebalance the health inequalities for those who find it hard to engage or access services.

Contact person	Pat Foster Care Forum General Manager – Healthwatch B&NES
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:	Health and Wellbeing Board
MEETING DATE:	18th September 2013
TITLE:	Placemaking Plan
AN OPEN PUBLIC ITEM	
List of attachments to this report: Placemaking Plan Launch Document	

1 THE ISSUE

1.1 This report provides an update on progress with the Council's Placemaking Plan, and highlights opportunities to embed Health and Well Being considerations into the document.

2 RECOMMENDATION

The Board is asked to note:

2.1 The progress that is being made with the Placemaking Plan and that there are opportunities to link with Public Health Objectives.

FINANCIAL IMPLICATIONS

2.2 The production of the Placemaking Plan is being met within the Local Development Framework budget.

2.3 The fulfilment of this objective should contribute positively to the financial implications associated with the health and well being agenda.

1 THE REPORT

1.1 The purpose of the Council's Placemaking Plan is to facilitate the delivery of key development sites and to ensure up to date planning policies that are used in the determination of planning applications. The Placemaking Plan will complement the strategic framework provided in the Core Strategy.

1.2 The plan is intended to be produced in a collaborative way drawing on the principles set out in the Council's Local Engagement Framework. This will ensure that B&NES work closely with local communities and other key stakeholders to identify valued assets for protection, opportunities for development and necessary infrastructure requirements.

1.3 The Placemaking Plan is guided by the strategic objectives contained within the Council's emerging Core Strategy. Of particular relevance to the Health and Well Being Board is Objective 6 which seeks to 'plan for development that promotes health and well being':

(1) Enabling more opportunities for people to lead healthier lifestyles and have a greater sense of well-being through facilitating active modes of travel, encouraging social interaction and designing high quality, safe streets and spaces.

(2) Promoting and delivering local employment, training and regeneration opportunities that can contribute to a reduction in the health and social inequalities across the District encouraging and facilitating increased local food production.

(3) Ensuring the timely provision of social and physical infrastructure, including health, welfare, spiritual, recreational, leisure and cultural facilities.

1.4 With regards to this final point it will be necessary to commission research to assess the impact of new development proposals on existing health facilities such as doctor's surgeries and dentists. This will highlight the requirement for developers to provide additional facilities or to make a s106 contribution towards the enhancement of existing facilities.

1.5 This assessment work could form part of the JSNA (Joint Strategic Needs Assessment) and inform the Councils/NHS Joint Health and Wellbeing Strategy, as well as the emerging Placemaking Plan and the Council's Infrastructure Delivery Plan.

The Launch document

1.6 The Placemaking Plan Launch Document was approved by Cabinet on 8th May 2013, and is available for public comment until 20th September 2013. The Launch Document is the first stage in the production of the Placemaking Plan, and its purpose is to stimulate discussion and to facilitate collaboration and joint working at an early stage in the process. The Launch Document sets out the proposed scope of the Placemaking Plan, the key issues to be addressed and an overview of how B&NES will work in collaboration with local communities.

Programme

1.7 The next stage in the production of the Placemaking Plan is the production of the Preferred Options document. This will be informed by

(1) the outcomes of the current consultation on the Launch Document;

(2) informal discussions with different stakeholder and interest groups;

(3) workshops with Parish Councils.

1.8 It is intended that the Preferred Options document will be approved for a further public consultation process in spring 2014, however progress will be influenced by the programme and resource commitments required for the Core Strategy. This is currently under examination, with the public hearings due to resume on 17th September.

1.9 The Placemaking Plan, in being part of the statutory planning framework, needs to undergo a rigorous production and scrutiny process. This involves taking it through an examination process. It is therefore envisaged to adopt the Placemaking Plan in mid 2015.

2 RISK MANAGEMENT

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

3 EQUALITIES

a) An EqIA has not been completed as the launch of the Placemaking Plan represents the first stage in its preparation and no policy direction is being proposed at this stage. The Placemaking Plan will be prepared in the context of the parent document, the Core Strategy, for which an EqIA has been completed.

b) An EqIA will need to be undertaken for the Placemaking Plan and public health inqualities can be integrated into this.

4 CONSULTATION

4.1 The introduction to the launch document sets out the proposed approach to public engagement. The Plan must also be prepared in a way which fulfils the duty to co-operate, including consultation with prescribed consultees.

5 ISSUES TO CONSIDER IN REACHING THE DECISION

5.1 Social Inclusion; Customer Focus; Sustainability; Human Resources; Property; Young People; Human Rights; Corporate; Health & Safety; Impact on Staff; Other Legal Considerations

6 ADVICE SOUGHT

6.1 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	*Stephen George (01225) 477524.* *Stephen_george@bathnes.gov.uk*
Background papers	*Placemaking Plan Launch Document*
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board
MEETING DATE:	18 September 2013
TITLE:	Draft Homelessness Strategy 2014-2018
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1: Draft Homelessness Strategy 2014 – 2018 Appendix 2: Homelessness Review and Evidence Base Appendix 3: Homelessness Strategy Communications Plan	

1 THE ISSUE

1.1 Following stakeholder engagement and a review of national policy Housing Services has drafted a new Homelessness Strategy that reflects national guidance and a review of the local evidence base and priorities. This draft Strategy is now being opened up to wider public participation and to seek input and endorsement from key stakeholders including the Health & Wellbeing Board.

2 RECOMMENDATION

The Health and Wellbeing Board is asked to:

2.1 Comment on the draft Homelessness Strategy 2014-18 attached as Appendix 1;

2.2 Endorse the statement on page 5 of the draft Strategy: “The Health and Wellbeing Board will champion the homelessness agenda in Bath and North East Somerset.

2.3 Endorse the Homelessness Strategy Communications Plan 2013, attached as Appendix 3.

3 FINANCIAL IMPLICATIONS

3.1 There are no direct financial implications arising from this report. The resource implications of the proposed Homelessness Strategy will be considered prior to formal agreement by the Cabinet Member.

4 THE REPORT

Why we need a Homelessness Strategy

4.1 In the last three years nearly 300 families and single people in Bath and North East Somerset were homeless and had a priority need to be helped to find secure and settled accommodation by the Council. The scale of homelessness would be considerably worse without a programme of early interventions and support services provided by Housing Services and a host of third sector agencies for vulnerable and non-priority need homeless people.

4.2 The effect of homelessness and the impact of losing a home can ripple through a family affecting everyone within it for the worse and for some single people, can ultimately lead to rough sleeping or 'sofa surfing', moving from pillar to post with no settled home from which to rebuild a life. Homelessness is closely associated with youth, mental ill health and poor health, low income, social and educational deprivation. Having an effective homelessness prevention strategy makes a big difference to many vulnerable people.

4.3 Having a Homelessness Strategy means that we review our interventions, plan ahead and engage with our local Homelessness Partnership to tackle the main causes of homelessness and have appropriate support in place for everyone who needs it. The government expects us to have an up to date strategy and it is a statutory responsibility to have one in place.

Timescales

4.4 In line with other local authorities we produce a Homelessness Strategy every five years. The new strategy covers the period 2014-2018 and it is planned to have it accepted by the Cabinet Member for Wellbeing as a Single Member Decision in December 2013.

Summary of the Strategy

4.5 The Strategy is closely aligned with national guidance and identifies local priorities emerging from an evidence base of local homelessness and prevention services.

4.6 A review and Evidence Base of local homelessness characteristics was carried out in 2013. Twelve local priorities were extracted from local trends and performance for the three financial years from April 2010 to March 2013. Activities to directly address the local priorities are incorporated into the strategy's action plan.

4.7 National guidance was produced by the government in 2012 and urges local authorities to focus on widening responsibility for prevention activities to all services. It sets out ten local challenges and these are built into the strategy's

action plan so that by achieving them we will deliver an improved service and aim to achieve the government's Gold Standard Service target.

Why we need further Consultation

4.8 Consultation has been carried out with internal and external stakeholders via one to one discussions, round table meetings and a conference event. A Communications Plan shows timescales and full list of stakeholders.

4.9 The proposal is to launch an open public and consultation on the Council's website for six weeks from 25th September to 6th October. The purpose of the consultation is that the effectiveness of the five year Homelessness Strategy depends on partnerships with key stakeholders and continuing work to address the equalities impacts of homelessness. The Strategy will be finalised after this wider consultation has been completed and comments from the Health and Wellbeing Board and Wellbeing Policy Development and Scrutiny Panel have been taken into consideration. The consultation will be aimed at:

- Key stakeholders who will be invited to comment on the Action Plan and make recommendations about their contribution to it.

- Equalities Groups and stakeholders who will be invited to comment on the Strategy, Local Priorities and Action Plan and make recommendations on new equalities impacts in addition to those already identified in the Bath and North East Somerset JSNA 2012 Equalities Summary.

5 RISK MANAGEMENT

5.1 A risk assessment related to the issue and recommendations has not been undertaken, since the Board is being asked to comment on the draft Strategy and to endorse plans for the next phase of consultation.

6 EQUALITIES

6.1 An EqIA has not been completed for at this stage. A full equalities assessment of the proposed Homelessness Strategy will be undertaken following the proposed open public consultation and before a decision to formally adopt the Strategy.

7.1 Cabinet Member; Other B&NES Services; Stakeholders/Partners (as summarised in Appendix 3); Section 151 Finance Officer; Chief Executive; Monitoring Officer

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Young People; Human Rights; 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	Sue Wordsworth Tel 01225 396050
Background papers	Making Every Contact Count (Department for Communities and Local Government 2012) Bath and North East Somerset JSNA 2012 Equalities Summary
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Appendix 1

DRAFT HOMELESSNESS STRATEGY 2014-2018

Preventing homelessness and making every contact count

HOMELESSNESS STRATEGY 1
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Not place any young person aged 16 or 17 or families in Bed and Breakfast 16

EXECUTIVE SUMMARY

Bath and North East Somerset contains some of the least affordable areas of the country for housing. House prices, in some areas of the region, have stayed high despite a national trend for a slowdown in the market. There are continued problems of affordability of housing for many Bath and North East Somerset residents. The local area covers around 20kms of countryside from west to east and is serviced from the city of Bath and the principal towns of Keynsham and Midsomer Norton and Radstock.

The overall stock of social housing has remained broadly the same as it was in 2001 and is now around 14% of all housing. It has been estimated that 3,400 new affordable homes are needed between now and 2031 in Bath and North East Somerset to meet the needs of people who can't afford market housing. Our housing delivery programme expects to achieve significant new provision within the next five years; however we cannot rely solely on the delivery and distribution of new housing to resolve the needs of all homeless people.

Demand for private rented accommodation, particularly amongst single people who are homeless or at risk of becoming homeless, greatly outstrips supply. Reforms mean that single people aged 35 or younger will only be entitled to shared accommodation rates of Housing Benefit so we are anticipating an increased demand for shared housing. Levels of homelessness and main reasons for homelessness have not changed substantially since 2010.

There are considerable challenges for the Council in tackling homelessness. In developing this Strategy we consulted with public, partners and local stakeholders many of whom have been actively involved in our local Homelessness Partnership, to listen to their views and concerns and we identified local issues from evidence based information. This has helped us to put together a detailed Action Plan to support the Homelessness Strategy and respond to local needs.

Looking Ahead

Much has been achieved to address our aims since the last Homelessness Strategy. However, with continuing demands and challenging circumstances, much more remains to be done and we are planning ahead and will work in partnership with others who can help deliver solutions. We have prioritised the government's 'gold standard' for homelessness prevention and aim to achieve it within the next five years, building on our past success and responding to the impacts of changing housing markets and social and welfare reform.

Our major challenges include:

- Demand for housing currently outstrips supply High housing costs both for rent or purchase

- Increased pressures on household incomes Meeting the needs of all residents across the whole geographical area
- Meeting the needs of households with complex needs
- Increasing problems in accessing private rented and temporary accommodation for homeless and potentially homeless households
- Developing solutions to future funding constraints
- Improving communications, knowledge and managing expectations

Strategic Priorities

During the course of this Homelessness Strategy we plan to:

Strengthen our corporate commitment to prevent homelessness through the influence and scrutiny of the Health and Wellbeing Board

Work with extended partnerships to tackle the underlying causes of homelessness such as low income and worklessness which affect the most disadvantaged people in our communities

Improve pathways into accommodation for homeless people with co-existing mental health and substance misuse needs, locally targeted offenders, families, non-statutory homeless and young people.

Work with registered providers of social housing to support them to help their tenants to manage budgets and behavior and prevent evictions; and to review how we can free up family homes.

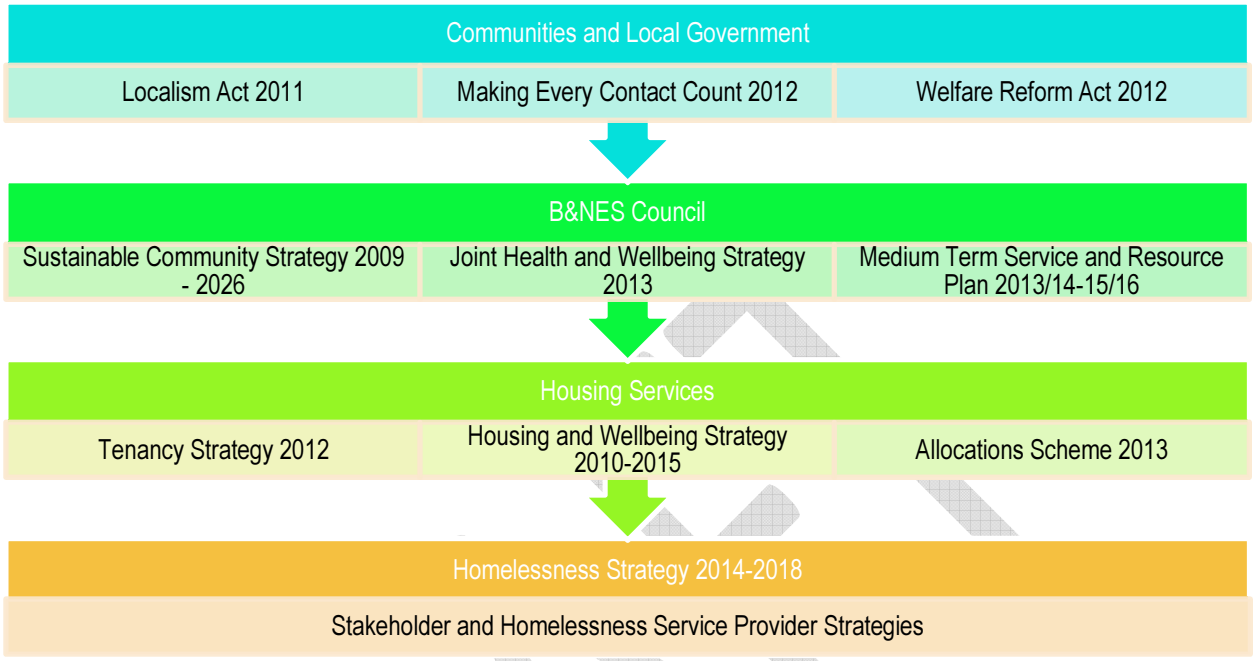
Commission housing related support providers to support vulnerable householders to sustain and manage their tenancies in the private sector

Be able to say that we never use B&B for homeless young people or families (except in an emergency, and then for less than 6 weeks).

Cabinet Member for Wellbeing

[Date]

SHARED AIMS AND OBJECTIVES



MAKING EVERY CONTACT COUNT

Making Every Contact Count 2012. (Department for Communities and Local Government , 2012) is the government's report on preventing homelessness. The government's vision statement which underpins our local strategy is:

> 'There is no place for homelessness in the 21st Century. The key to delivering that vision is prevention - agencies working together to support those at risk of homelessness.'

The government has been explicit in widening responsibility for homelessness prevention to all local services. The vision within the report requires an integrated approach at local level and a commitment to making every contact with a vulnerable person count. Funding and resources will be targeted on early intervention initiatives for groups most at risk of homelessness and cross cutting themes.

The cross cutting themes:

- Agencies working together to target those at risk of homelessness
- Identifying and tackling the underlying causes of homelessness as part of housing needs assessments by referral to appropriate support

- Local authorities co-ordinating access to services for vulnerable people; multi agency action, case work, agencies responding flexibly
- Increasing access to the private sector; supporting people to remain in private sector tenancies
- A focus on youth homelessness.

The government has evaluated what is already working well and has used this to set a Gold Standard for delivery of homelessness prevention services that aims to protect the most vulnerable when they face losing their home and save money by reducing the need for emergency support such as bed and breakfast accommodation. The Gold Standard gives local authorities 10 challenges to overcome and these form the framework of this strategy's Action Planning. Over the next five years our aim is to meet all of the government's challenges within our local context and priorities, and deliver a Gold Standard homelessness service.

WELFARE REFORM

Welfare Reform Act 2012 is the governments' legislative framework for the biggest change to the welfare system for over 60 years. Changes include Universal Credit which is a new single payment for people who are looking for work or on a low income and changes to Housing Benefit. The Act aims to give people on benefit increased personal responsibility for money management and improved incentives to work. The Draft B&NES Strategic Housing Market Assessment 2013 has assessed that the possible impacts of the Act could mean that:

- Private sector landlords may be less likely to want to let tenancies to low income households and this could lead to a reduction in private renting supply;
- Working age social housing tenants on Housing Benefit with spare rooms may fall into debt and risk homelessness;
- Demand for and supply of shared accommodation (Houses in Multiple Accommodation) may increase because single people aged 34 years or younger on Housing Benefit will be unable to afford self-contained accommodation;
- The rate of single person household formation rates may increase because of a financial incentive for adult children to leave home leaving non-working age parents to receive higher Housing Benefit contributions.

These and other issues have been incorporated into the Action Plan.

LOCALISM

Localism Act 2011 includes measures for ensuring that social housing is made available to people with greatest housing need. It introduced flexible tenancies for social housing, changes to securing accommodation for homeless people and protection of local social housing assets. In response to the

Localism Act local authorities were required to set out a Tenancy Strategy as a framework for local registered providers of social housing to manage these flexibilities and local expectations. The Council has also implemented a new Allocation Scheme to meet local needs better.

B&NES Tenancy Strategy 2012 explains why and under which circumstances, private sector tenancies may be used to accommodate homeless and priority need households and why social sector tenancies will no longer be allocated as homes for life. As a result of the Localism Act, social housing for non-retirement age households will generally be let on one year introductory or starter tenancy followed by a minimum five year fixed term tenancy. Landlords will be able to review the tenant's housing need at the end of a fixed term period and decide whether or not to continue the tenancy depending on housing demand and tenant resources.

The intention is to increase mobility within the sector and enable households to access social housing when they need it most. However, it is acknowledged that the flexibilities could lead to more 'revolving door' homelessness if tenants with less security of tenure are evicted for not being able to sustain a tenancy within the first year and the issue is addressed in the Action Plan.

B&NES Allocation Scheme 2013 is the way that social housing is allocated within the area. Following a full review in the light of new government guidance the local scheme is restricted to households that need to live in the district and is subject to means testing. The scheme is customer lead and housing applicants, including current social housing tenants, must actively search and bid for properties that they want to move to. It gives priority to applicants based on their housing needs and this includes their medical and welfare requirements. People who are statutorily homeless and social housing tenants who need to move out of homes that are too large for their needs also have priority.

HEALTH AND WELLBEING

The Joint Health and Wellbeing Strategy 2013 provides the big picture about current and future health and wellbeing needs of the Bath and North East Somerset population and was informed by the Joint Strategic Needs Assessment. Its principal objective is to narrow the health and inequalities gap in the local population by improving the lives of those worst affected:

> The Joint Strategic Needs Assessment shows that health is unequally shared and inequalities exist between different geographical areas, communities, social and economic groups in Bath & North East Somerset.

The **Health and Wellbeing Board** will champion the homelessness agenda in Bath and North East Somerset. It will do this by joining up work with schools, local commissioners, including the Police and Clinical Commissioning Group and local delivery partners to intervene earlier to tackle underlying problems and to ensure that those at risk of homelessness and/or violence and harassment get access to integrated and responsive services. This Homelessness Strategy will directly contribute to the Health and Wellbeing Board's priority themes:

- Helping people to stay healthy
- Improving the quality of people's lives
- Creating fairer life chances

SUPPORTING PEOPLE

Supporting People & Communities

The Council's Medium Term Service and Resource Plan (MTSRP) 2013/14-15/16 includes savings from the Supporting People and Communities budget, which incorporates work on homelessness.

In the short term the Council's reserves and commercial sources of income, together with its long term financial plans and efficiencies, put it in a relatively strong position. There are also key demographic changes, with a projected 40% increase in the older population by 2026 creating a significant additional financial pressure and an increase of the entire population of 12% by the same date. In this context, the Council is faced with meeting increasing levels of need with shrinking resources and this does mean the focus of the money available will be on the most vulnerable groups of people to support their independence and wellbeing and delaying or eliminating the need for more acute, higher cost services. Services commissioned from community and independent sector organisations will reflect this principle, with higher access thresholds being applied.

Since planning to meet the requirements of the MTRSP, Central Government has published its Spending Review for 2015/16, the full implications of which are yet to be fully assessed by the Council. Since February 2013, Supporting People and Communities (SP&C) have been implementing theme-based sector reviews with the intention of finding the required savings through a strategic approach rather than a top-slicing exercise, minimising wherever possible the impact on service users. Commissioned services were looked at within the following groupings:

- Advice, Information & Advocacy
- Housing related support
- Community Services
- Day Services

Using data on performance, utilisation and demand, feedback from providers and stakeholders (including service users) and intelligence on duplication of provision, the reviews aim to inform the development of commissioning plans for 2014/15 onwards. SP&C will continue to focus on prevention and early intervention as the cost benefit of this approach has been clearly evidenced (ref 'The Cost Benefit of

Housing Related Support in Bath and North East Somerset. Sitra 2011). Services commissioned will provide quality and choice, they will work in partnership, be person centred, outcome focused, accessible, and promote independence. They will, necessarily, be targeted at the most vulnerable groups of people.

CONSULTATION

We held a consultation event in early 2013 for key stakeholders to consider our local challenges and contribute to forming our local priorities. These ideas reflect a common purpose amongst our stakeholders and underpin the Action Plan:

Practical: build practical responses to support people to manage with less money; and work sub-regionally to support needs of single homeless people. Practical responses should include shared housing for single people, access to private rented housing and lodgings.

Communicating Together: work 'smarter' and avoid duplication so that everyone understands the current offer/help available from all relevant council services and partner agencies and our front-line staff have access to information / know who and how to refer customers onto services.

Financial Inclusion: make best use of all the available resources, for example by expanding "drop in's" using the Forwards Work Clubs, which aim to help people with mental health challenges, learning disabilities and higher functioning autism to find and stay in work. Expansion could enable a Job Centre Plus adviser and service users such as care leavers and people with disabilities to attend.

Joined up: Join up to share consistent messages and resources and a more strategic approach linking up all stakeholders. Create positive messages about getting into work and promote a shift of mind-set among people affected and those supporting them. Investment in job readiness/ promote employment as an option, overcome self-imposed barriers, create self-belief.

Open Public Consultation

Outcomes (to be completed)

STRATEGIC ACHIEVEMENTS

The Homelessness Strategy 2008-2013 set out strategic priorities to improve information and understand need better, for partnerships to prevent homelessness more efficiently and to broaden the range of housing options for homeless people. Our approach to preventing homelessness has resulted in some excellent examples of good practice for example:

Partnerships targeting those at risk of homelessness

Housing and Mental Health Commissioners have pooled resources to fund a specialist mental health worker to provide housing advice. Our Support Gateway was commissioned by Supporting People and enables better partnership work amongst provider organisations that help people who need support or risk becoming homeless. Julian House, who support rough sleepers, have set up a reporting line and website so that local residents can ask them to look after or get in touch with the homeless.

Identifying and tackling the underlying causes of homelessness as part of housing needs assessments

The Council's Housing Options and Homelessness team refer young people to a newly commissioned Family Mediation service. The service works with vulnerable households to find safe and practical solutions to keep families together and help young people move to independence in a planned way. The innovative Supported Lodgings Scheme means that young people and care leavers can live in a supportive home until they are ready to move on into other housing options.

Increasing access to the private rented sector

The Homefinder Scheme, in conjunction with a Deposit Bond Scheme and in partnership with floating support providers, has been helping people into private tenancies for several years now. The successful Scheme, in conjunction with an advice service for private landlords on fulfilling their legal responsibilities, means that hundreds of families have been able to move into safe and suitable private sector housing.

TWELVE LOCAL PRIORITIES

Based on the Homelessness Strategy Evidence Base 2013 which is a collection of data and trends from 2010 – 2013, twelve local priorities have been identified. These priorities are linked to the Gold Standard challenges and the governments cross cutting themes in the Homelessness Strategy Action Plan. By working together on these priority actions we aim to make a difference to the lives of homeless people and vulnerable people who risk being homeless.

PEOPLE

Priority 1: Support social housing tenants to budget monthly income by targeting welfare and money management advice in areas of high density social housing.

Bath and North East Somerset is a popular place to live and most people who live here enjoy a good standard of living. Within the area, however, are distinct geographical locations where there are high densities of social housing and greatest likelihood of multiple deprivations. Two in every three social housing tenants are in receipt of either full or part Housing Benefit for housing costs. Under welfare reforms, Housing Benefit payments will be rolled into a single Universal Credit payment.

Priority 2: Prevent homelessness amongst young people by providing advice and assistance to help them find and keep shared housing.

Leaving the home of parents, friends or relatives is the main reason for homelessness locally. The resident population has increased by 4% since 2001 and a significant proportion is young adults aged 15-24, many of them students, living in the area (17% compared to 13% nationally). Young people are newly independent and relatively inexperienced at managing household expenses and finding and keeping a roof over their heads. This age group is affected by the changes to Housing Benefit and will only be entitled to shared housing rates until the age of 35. Living in shared housing can create a number of challenges including learning to live compatibly and sharing responsibility with others. Failure to find and keep shared housing may increase the number of homeless young people.

Priority 3: Understand how to meet the housing aspirations of older social housing residents so that they can live safely, well and with independence and to free up family sized social housing.

The resident population in B&NES is getting older and, since 2001 the greatest increases in the ageing population are within the very old (23% increase in age 85+). The age profile of social housing tenants is significantly older than nationally (50% of social rented sector tenants are retirement age compared to 31% nationally). However the demand for social housing is greatest from working age population (90% of households on the Housing Register). The supply of family sized social rented housing is not meeting demand (61% of average annual lettings are 2+ bed homes). We must have a good understanding of how to meet the housing aspirations of older social housing residents so that they can live safely, well and with independence and to free up family sized social housing.

HOUSING

Priority 4: Prevent repossession of mortgaged homes by targeting mortgage rescue advice and assistance at low income households.

Owner occupation is the main housing tenure in the area (67%). We are seeing gradual increases in rates of mortgage repossession locally and as the economy is squeezed owner occupiers with lower incomes and with less employment security, will find it harder to pay housing costs. Typically, these mortgagors will have less or no capital resources and will risk becoming homeless without good advice and assistance that helps them to keep their home. Mortgage Rescue, which is provided locally by South West Homes, is a Government scheme designed to help some of the most vulnerable households facing repossession to stay in their homes and is subject to a range of eligibility criteria.

Priority 5: Protect housing standards and conditions in low cost private rented housing.

There has been no significant expansion in the provision of social housing locally and up until now the number of private rented sector tenancies has been increasing. The allocation of social housing is now targeted at those with greatest statutory housing need and we can expect the demand for lower cost private rented housing increase amongst those with non-statutory housing needs. People with lower incomes will be seeking lower cost housing in lower cost areas and landlords willing to let to Housing Benefit recipients.

Priority 6: Prevent social housing evictions by reviewing pre-eviction protocols and providing intensive first year tenancy support.

Social housing will be let more intensively to those with greatest housing needs and new tenants will also have less security of tenure as the pattern is for them to have an initial one year starter tenancy followed by a fixed term tenancy reviewed at the end of 5 years. There are signs that the impact of these changes could increase the number of failing social housing tenancies and 'revolving door' homelessness.

PREVENTION

Priority 7: Prevent homelessness due to domestic violence by identifying households at risk and intervening with support.

Domestic violence and/or violence or harassment is the third most common reason for becoming statutorily homeless amongst people who have a priority need for housing. Rates of homelessness applications and acceptances have remained fairly consistent since 2010 and the incidence of domestic violence as a reason for becoming homeless is unchanged since the previous review of homelessness based on 2003-2008 data.

Priority 8: Provide suitable temporary accommodation and stop using B&B except in emergencies and then for less than 6 weeks.

The combination of early and effective homelessness prevention services and provision of a range of good quality suitable temporary accommodation means that we only place 16 households, of which 4 are young people, (annual average 2010 -2013) in B&B each year. Although we try to avoid the use of B&B it can sometimes be used for people with complex needs or homelessness applications and 13 households (2 families, 3 young people and 8 singles aged 25+) have spent longer than 6 weeks in B&B. We accept that lliving in B&B is not a good option for families with children, young people or those with a mental or physical disability.

Priority 9: Develop the Homefinder private sector access scheme to improve access to shared accommodation.

The success of our homelessness prevention depends on tenancy advice and access to private sector tenancies. Our private sector access scheme, Homefinder, has helped to secure an average 69 tenancies every year for the last 3 years with an average tenancy length of 19 months). The scheme is very good at facilitating private sector tenancies for families but only 1% of properties rented through the scheme are shared accommodation and demand for this type of housing is likely to increase.

Priority 10: Ensure that services for rough sleepers meet local needs, particularly of women and older homeless, and review provision for out of area homeless depending on outcomes of SP&C sector reviews.

Demand for the Nightshelter and associated services for rough sleepers are high. The total number of people using B&NES Nightshelter is increasing every year and doubled from 2011/12 (75) to 2012/13 (146). Only a small proportion of service users are women however the number of women using the service trebled from 2011/12 (9) to 2012/13 (27). Around 60 % of service users are aged 36 or older. More than half of new service users come from other areas and the percentage of out of area service users is increasing every year.

SUPPORT

Priority 11: Prevent blocking of supported accommodation and advice services by improving pathways and options for people with high needs or assessed risk.

Housing related support and advice is commissioned from several agencies. There is always a high level of demand for these services and waiting lists can be long particularly for accommodation based services.

Priority 12: Improve access to advice, information and support for people living in rural areas and with complex needs.

Loss of private rented accommodation is the second greatest reason for becoming statutorily homeless amongst people who have a priority need for housing. Access to advice and homelessness prevention services is not always easy for service users living in villages and rural areas and service users with high needs or assessed risk whose needs are more complex to meet.

ACTION PLAN – 2014 2018

CROSS CUTTING THEMES				
Agencies working together to target those at risk of homelessness	Identifying and tackling the underlying causes of homelessness as part of housing needs assessments by referral to appropriate support	Local authorities co-ordinating access to services for vulnerable people; multi agency action, case work, agencies responding flexibly	Increasing access to the private sector; supporting people to remain in private sector tenancies	A focus on youth homelessness.

GOLD STANDARD

Adopt a Corporate commitment to prevent homelessness which has buy in across all local authority services

What we will do:

1. Highlight the need for corporate commitment to take homelessness prevention to the next level by consulting and informing to raise awareness about the causes, impact of homelessness and the cross cutting themes and to showcase what we are already doing well.
2. Prevent homelessness due to domestic violence by identifying households at risk and intervening with support (local priority 7)
3. Reduce the harms caused by alcohol misuse and prevent suicide or repeated self-harm by intervening with support for homeless people.
4. Prevent homelessness due to low income and worklessness by ensuring that our local communities have access to good quality education, volunteering and employment opportunities
5. Prevent youth homelessness by producing an evidence-based document which sets out effective local approaches

With:

- ✓ Health and Wellbeing Board
- ✓ Health and Social Care, Police, Youth Services
- ✓ Local Authority Senior Managers who are managing services that may come into contact with homeless people for example, street cleaners/waste collectors to raise awareness about what they can do, including sign-posting to services
- ✓ Elected Members for example policy makers and Ward Councillors who may come into contact with a constituent who is homeless or at risk of homelessness
- ✓ Cabinet Members
- ✓ Registered Social Landlords

Actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs

What we will do:

6. Create a positive message about getting into work
7. Review pathways into employment for people with mental or physical disability
8. Make use of District Flexible Support fund to find work for people on benefit
9. Explore options for supporting individuals facing multiple disadvantages that are some distance from the labour market (such as homeless rough sleepers) on a 'payment by results' basis

With:

- ✓ Jobcentre Plus,
- ✓ Work Choice Providers
- ✓ Voluntary Sector
- ✓ Local Training and Education Providers
- ✓ Registered Social Landlords

Offer a Housing Options prevention service to all clients including written advice

What we will do:

10. Offer a comprehensive prevention service, with advice and support for single people as well as families in need and take steps to improve the service through Peer-led Practitioner Prevention Partnership developed by the National Homelessness Advice Service.
11. Support social housing tenants to budget monthly income by targeting welfare and money management advice in areas of high density social housing (local priority 1)
12. Prevent social housing evictions by reviewing pre-eviction protocols, providing intensive first year tenancy support (local priority 6)
13. Prevent working age social housing tenants who claim Housing Benefit and have spare rooms from getting into debt and becoming homeless by providing early interventions

With:

- ✓ Registered Social Landlords
- ✓ Homelessness Service Providers and Commissioners
- ✓ Partnership Local Authorities

Adopt a No Second Night Out model or an effective local alternative

What we will do:

14. Review provision for out of area homeless depending on outcomes of SP&C sector reviews (local priority 10)
15. Ensure that services for rough sleepers meet local needs, particularly of women and older homeless

With:

- ✓ Homelessness Service Providers and Commissioners
- ✓ Supporting People & Communities

Have Housing pathways agreed or in development with each key partner and client group that include appropriate accommodation and support

What we will do:

16. Prevent blocking of supported accommodation and advice services by improving pathways and options for people with high needs or assessed risk (local priority 11) for example by
    - Meeting the accommodation needs of locally targeted offenders by having clear processes in place (using the published Integrated Offender Management key principles to set out the advantages of a wide partnership involvement).
    - Improving hospital admission and discharge for homeless people by having clear processes in place (Improving Hospital Admissions and Discharge for People who are Homeless 2012, a joint report from Homeless Link and St Mungos. Commissioned by the Department of Health)
17. Prevent homelessness amongst young people by providing advice and assistance to help them find and keep shared housing (local priority 2).

With:

- ✓ lead agencies for delivering local initiatives and accommodation pathways in relation to young people, ex-offenders and people with drug, alcohol mental health needs
- ✓ Supporting People & Communities
- ✓ Royal United Hospital
- ✓ Clinical Commissioning Group
- ✓ Police Services

Develop a suitable private rented sector offer for all client groups, including advice and support to both client and landlord

What we will do:

18. Develop the private sector access schemes to improve access to shared accommodation (local priority 9).
19. Protect housing standards and conditions in low cost private rented housing (local priority 5).

With:

- ✓ Private rented sector landlords and lettings agencies

Actively engage in preventing mortgage repossessions including through the Mortgage Rescue Scheme

What we will do:

20. Prevent repossession of mortgaged homes by targeting mortgage rescue advice and assistance at low income households (local priority 4) for example by improving the Council's web information pages to enable better self-help for residents in mortgage difficulty

With:

- ✓ South West Homes

Have a homelessness strategy which sets out a proactive approach to preventing homelessness and is reviewed annually to be responsive to emerging needs

What we will do:

21. Annually review emerging needs and homelessness strategy
22. Improve access to advice and information about local welfare provisions to reduce hardship
23. Improve access to advice, information and support for people living in rural areas and with complex needs (local priority 12) for example by providing a central IT resource with service directory, FAQs and flowcharts for homelessness information key topics (how to keep a private or social tenancy; family mediation; debt and rent payment advice)

With:

- ✓ Health and Wellbeing Board
- ✓ Homelessness Partnership
- ✓ Revenue and Benefits

Not place any young person aged 16 or 17 or families in Bed and Breakfast (unless in an emergency and for no longer than 6 weeks)

What we will do:

24. Understand how to meet the housing aspirations of older social housing residents so that they can live safe, well and with independence and to free up family sized social housing (local priority 3)
25. Provide suitable temporary accommodation and stop using B&B except in emergencies and then for less than 6 weeks (local priority 8)

With:

- ✓ Mediation Service
- ✓ Supported Lodgings Service and Providers
- ✓ Registered Social Landlords

Contact person	Sue Wordsworth Planning and Partnership Manager Housing Services Bath & North East Somerset Council Tel: 01225 396050 E-mail sue_wordsworth@bathnes.gov.uk www.bathnes.gov.uk/housing
CUSTOMER SERVICE EXCELLENCE CSE	Please contact Housing Services if you need to access this document in an alternative format

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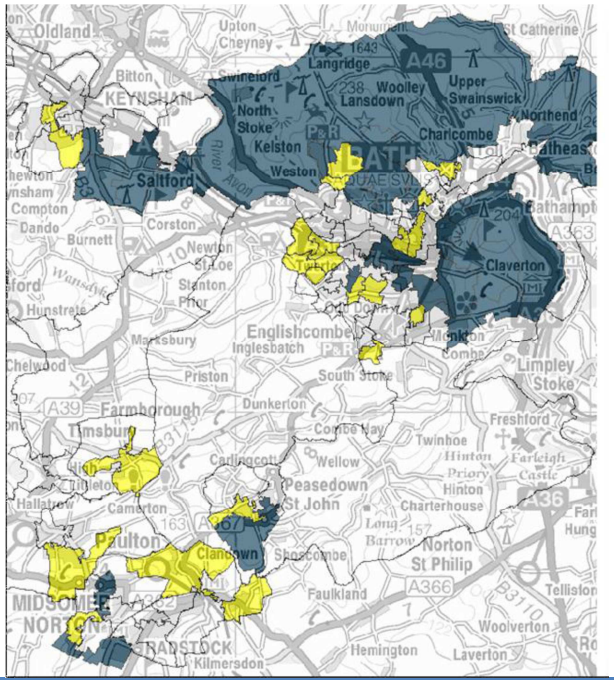
Appendix 2

Summary of key facts

Number	%	increase since 2001	
176,000		7,000 (4%)	TOTAL POPULATION
		23%	Very old (aged 85+)
	17%		Population aged 15-24 (compared to 13% nationally)
	9%		Black and Minority ethnicity (compared to 13% BME homeless acceptances)
20,000			People using advice and information commissioned services every year
73,500			TOTAL HOUSEHOLDS
49,400	67%		Owner occupied
12,500	17%	4%	Private rented
10,600	14%	0%	Social rented
3,000	4%		Households on Social Housing Register
	61%		Family sized 2 or 3+ bed Social Housing Lettings average per year
	90%		Working Age Households on Social Housing Register
	50%		Social Rented Sector Tenants of retirement age (compared to 31% nationally)
7,000	66%		Housing Benefit Recipients in Social Rented Sector (Claims) (compared to 24% in Private Rented Sector)
367			HOUSEHOLDS PREVENTED FROM HOMELESS Council Prevention Service average per year
90			TOTAL HOMELESS HOUSEHOLDS Statutory Duty Acceptances average per year
16			Homeless Households placed in B&B (4 staying for longer than 6 weeks) average per year
	77%		Homeless because leaving the home of parents/relatives or friends, leaving a private tenancy, leaving home because of violence or harassment.
	59%		Homeless have a priority need because of dependent children or being pregnant.

<table>
<tr><th>PEOPLE</th><th>Source</th></tr>
<tr><td>Population
Total population 176,000 of which 6,000 live in a communal establishment.
The total population has increased by 7,000 since 2001
All usual residents aged 16 and over 146,439
The population has increased by 4% since 2001. There is a large student age population (17% of the population is aged 15-24 compared to 13% in England and Wales).
The age and sex profile remains largely consistent over time and is in line with national and regional levels.
The population is getting older, with increases in the 40-49, 60-69 and 80+ age ranges matched by a reduction in the 30-39 age ranges. The most elderly age range (85+) has increased by 23% 2001 (900). The proportion of people aged 75-90+ is higher in B&NES than in the South West or nationally.</td><td>ONS Census 2011</td></tr>
<tr><td>Households
Total households 73,515
Average household size 2.3 persons</td><td>ONS Census 2011</td></tr>
<tr><td>Ethnicity
The BME population has low rates of Gypsy and Irish Traveller and high rates of Chinese compared to south west and national populations.

<table><tr><td>B&NES
White 91%
Mixed 1.6%
Asian 2.6%
Black 0.8%
Other 0.4%</td><td>National
White 84.6%
Mixed 2.2%
Asian 7.5%
Black 3.4%
Other 1%</td></tr></table></td><td>ONS Census 2011</td></tr>
<tr><td>Unemployment
39% of working age population is economically inactive.</td><td>ONS Census 2011</td></tr>
<tr><td>Age of tenants in social housing
Curo tenants (the largest social landlord in B&NES) have an older age profile than nationally - 50% are retirement age or older compared to 31% of social housing tenants nationally.</td><td>Curo 2013</td></tr>
<tr><td>Income of Social Housing Tenants
The median gross income for households (nationally) in social housing in 2007/08 was £10,900, compared with £23,320 for households across all tenures.</td><td>Communities and Local Government. Survey of English Housing, Preliminary Report: 2009.</td></tr>
<tr><td>Unemployment in social housing
Rates of unemployment are high amongst social housing tenants:
Nationally, 60 per cent of social housing tenants are economically inactive (31 per cent are retired and 29 per cent are otherwise economically inactive).</td><td>Communities and Local Government. Survey of English Housing, Preliminary Report: 2009.</td></tr>
<tr><td>Housing Benefit in social housing
62% of Curo tenants are in receipt of full or part Housing Benefit.</td><td>Curo 2013</td></tr>
</table>

Benefits The number of households on low incomes in the private rented sector continues to increase, reflecting wider, national trends. 2680 (Oct 2009) to 3170 (May 2012) private rented sector housing benefit claims. Around 50% who claim incapacity benefit claimants claim for mental health issues. It is thought that around 893 individuals currently claiming employment support allowance/ incapacity benefit will be found —fit to work and a further 386 placed in the —Work Related Activity Group under the new Work Capability Assessment.	B&NES Strategic Housing Market Assessment 2013 B&NES in-house analysis
Teenage pregnancy The conception rate in 15-17 year olds from Bath and North East Somerset is 16.2 in every 1,000 females. This is considerably lower than both the national rate of 30.7 and the regional rate of 27.3. It reflects a 44% reduction from the baseline figure of 29.	ONS Census 2011
NEET The West of England performs relatively well in terms of participation of 16 and 17 year olds in learning. In 2010, 97% of the area's 16 and 17 year olds were recorded as participating in education and training, a figure significantly above both the South West and the national average (both 91%). Within the West of England, Bristol (102%) and BANES (100%) recorded the largest proportion of young people as staying on in education and training. This may be due to a combination of: high staying on rates; a low estimate of the local population; and/or large numbers of independent school pupils being attributed to these areas (but not to the population estimate).	West of England Local Enterprise Partnership
Deprivation Overall, Bath and North East Somerset is one of the least deprived authorities in the country, ranking 49 out of 56 Unitary authorities. But there are marked geographical differences, for example between those least likely to suffer multiple deprivation (grey) and those most likely to suffer multiple deprivation (yellow).   

Qualifications ONS Census 2011

Usual residents aged 16 and over with no qualifications 25,140 (17%) compared to England (22%)

Economic prospects % ONS Census 2011

		B&NES	South West	England
			Region	Country
Worklessness: Economic Activity	Economic Activity Rate; Aged 16-64 (Males); 16-59 (Females)	78.4	78.4	76.5
Worklessness: Economic Activity	Employment Rate; Aged 16-64 (Males); 16-59 (Females)	73.6	73.4	70.5
Worklessness: Economic Activity	Unemployment Rate; Aged 16-64 (Males); 16-59 (Females)	6.1	6.4	7.9
Benefits Data Indicators: Working Age Client Group	All People of Working Age Claiming a Key Benefit	9	13	15
Benefits Data Indicators: Working Age Client Group	Jobseeker's Allowance Claimants	2	2	4
Benefits Data Indicators: Working Age Client Group	Incapacity Benefits Claimants	5	6	7
Personal Insolvency Statistics	New Personal Insolvencies	23.9	30.4	26.7

<table>
<tr><th>HOUSING</th><th>Source</th></tr>
<tr><td>Tenure
The dominant form of housing tenure continues to be owner occupation (67%), although the private rented sector has grown significantly across the last decade (up +4.4% since 2001).
Owner occupied 66.7% (49,436)
Social rented 14.4% (10,614)
Private rented 17% (12,447)</td><td>ONS Census 2011</td></tr>
<tr><td>Empty Homes
238 dwellings vacant for up to 12 months (2008)
650 long term vacant dwellings (2008)</td><td>ONS Census 2011</td></tr>
<tr><td>House prices
House prices effectively doubled between 2001-2012. Prices have been rising since 2011 and are currently outperforming national trends.</td><td>B&NES DRAFT Strategic Housing Market Assessment 2013</td></tr>
<tr><td>Affordability
Affordability declined 2003-2007 but then improved to 2009. More recently, affordability has declined again and (in 2012) is almost back to the peak of the market in 2007.</td><td>B&NES DRAFT Strategic Housing Market Assessment 2013</td></tr>
<tr><td>Rents Local Housing Allowance Rates April 2013

<table><tr><th>LHA room category</th><th colspan="2">BRMA</th></tr><tr><td></td><td>Bath</td><td>Bristol</td></tr><tr><td>Shared accommodation</td><td>£71.54</td><td>£66.04</td></tr><tr><td>1 bedroom</td><td>£129.23</td><td>£115.38</td></tr><tr><td>2 bedrooms</td><td>£159.20</td><td>£144.23</td></tr><tr><td>3 bedrooms</td><td>£183.46</td><td>£167.31</td></tr><tr><td>4 bedrooms</td><td>£286.15</td><td>£224.05</td></tr></table></td><td>B&NES Council Revenues and Benefits 2013</td></tr>
<tr><td>Student accommodation
The policy framework enables the growth of on campus and in-city teaching and research space and also the provision for additional on-campus student bed spaces, enabling growth in the overall number of students. This approach seeks to limit future losses of (private sector) family accommodation to student housing.</td><td>B&NES Core Strategy Proposed Changes 2013</td></tr>
<tr><td>Housing Benefit
Housing Benefit Recipients in Social Rented Sector (Claims) 7,220
Housing Benefit Recipients in Private Rented Sector (Claims) 2,970</td><td>ONS Census 2011</td></tr>
<tr><td>Benefit Reform
The potential impact of Benefit Reform on the Private Rented Sector is currently unknown. Potentially, there could be reduced household formation rates which may reduce the number of households seeking affordable housing. However, some changes in the LHA could see formation rates rise.
The supply of private rented dwellings may change significantly, especially for households on lower incomes.
The total number of housing benefit claimants in the private rented sector is unlikely to fall, but their locations will change to lower priced areas.
Alternatively, where landlords do not accept the lower rents, more properties may return to</td><td>B&NES DRAFT Strategic Housing Market Assessment 2013</td></tr>
</table>

'pure' market housing and out of reach to households on Housing Benefit.
Local authorities may be pressed to find housing solutions for increasing demand from households who cannot resolve their own needs - homelessness presentations and overcrowding may also rise further.

Discretionary Housing Payments — B&NES Housing Revenues and Benefits

Applicants who receive housing or council tax benefit that does not cover the whole of their rent or council tax bill can apply for a Discretionary Housing Payment. A Discretionary Housing Payment is intended to be a short-term measure to help relieve poverty or difficult circumstances.

	DHP Government Contribution 2013/2014
Bath & North East Somerset	£243,479

Possession Claims — Department for Communities and Local Government

Total annual Orders for Possession (landlord and mortgage) decreased by -19.6% (205) in 2010/11. Regionally they decreased by -9.8% and nationally they decreased by -10.2%. Annual mortgage claims for possession have increased by a 4% change from 2009/10 to 2010/11 all other claims and orders for possession have decreased.

Evictions from social housing — Curo 2013

44 households have been evicted from Curo tenancies in the previous 3 years (April 2010-March 2013). All evictions have been on grounds of rent arrears. Last year, the rate of evictions from Curo tenancies doubled (22).

Housing register — B&NES Housing Services

A new Allocations Scheme implemented in 2013 has reduced the number on the register to 3176 (May 2013) by rejecting applications from people with means to obtain market housing or who have no local connection. Need is greatest for one and two bedroom accommodation.

Bedroom need	Working Age	Sheltered	Total May 2013
1 bed	1456 (51%)	312	1768
2 bed	892 (31%)	9	901
3 bed	358(13%)		358
4 bed	109(4%)		109
5 bed	40(1%)		40
Total	2855	321	3176

Social housing stock — ONS Census 2011

Affordable housing is effectively at a standstill position with limited net increase in stock. (14.4% is social rent which is almost the same as in 2001).

Lettings — Department for Communities and Local Government CORE

The table below shows lettings of social housing for 2009-2011. Overall numbers of lettings have been increasing every year and numbers of lettings to low income households (as seen by increasing number qualifying for housing benefits).

The numbers of Assured Tenancies have been declining every year and conversely the numbers of starter/introductory tenancies have been increasing every year.

GENERAL NEEDS LETTINGS	2009	2010	2011
not statutory homeless	592	621	652
Statutory homeless (owed duty)	42	54	57
TOTAL	**634**	**675**	**709**
Number qualifying for housing benefits	396	443	486
Letting accommodation size			
1 bedroom	272	246	265
2 bedroom	245	302	317
3+ bedroom	117	127	127
Tenancy Type			
Assured	197	188	153
Other/Secure	6	2	6
Starter/Introductory	431	485	550

Housing need – Gypsies, Travellers and Travelling Showpeople
The Planning Policy Team is currently working on producing a Gypsies, Travellers and Travelling Showpeople Site Allocations Development Plan Document (DPD). This will allocate land suitable for development as Gypsy, Traveller or Travelling Showpeople sites in accordance with our local evidence base.

B&NES Gypsies, Travellers and Travelling Showpeople Site Allocations DPD 2013

New homes
Addendums 1a and 1b of the BANES SHMA set out the objectively assessed need for housing. A range of outputs are presented to illustrate the sensitivity of the results to the assumptions that are made.

The Proposed Changes to the BANES Core Strategy seek to deliver 12,700 homes between 2011 and 2029. Of these 3,100 will be social rented/intermediate. The Core Strategy is currently in a process of public examination and therefore these figures do not yet form part of the adopted Development Plan for BANES.

B&NES Strategic Housing Market Assessment 2013 (Addendums 1a and 1b)

B&NES Core Strategy Proposed Changes 2013

New affordable homes
The Core Strategy seeks to secure at least an average of 30-40% of all large housing sites for affordable housing, subject to location in the district. A policy is included aimed at ensuring that new residential development provides a range of housing types and needs, to help support mixed and inclusive communities and to respond to demographic change.

B&NES Core Strategy Proposed Changes 2013

PREVENTION

Use of B&B

B&NES Housing Services

Over the last 3 years an average of 4 families and 12 single people have been placed in B&B per annum. Of the single people an average of 4 young people have been placed in B&B per annum.

Over the last 3 years 13 households (2 families, 3 young people and 8 singles aged 25+) have spent longer than 6 weeks in B&B.

	2010/11		2011/12		2012/13	
	Households	Resident 6 weeks plus	Households	Resident 6 weeks plus	Households	Resident 6 weeks plus
Families in B&B	1	0	3	1	8	1
Singles in B&B (16 - 24)	5	1	4	1	3	1
Singles in B&B (25+)	9	1	6	3	9	4
TOTAL	**15**	**2**	**13**	**5**	**20**	**6**

Acceptances

Department for Communities and Local Government

Homelessness applications and acceptances have remained fairly consistent since 2010 locally, regionally and nationally. B&NES has a higher acceptance rate (57.1%) than the South West (50.9%) and nationally (44.9%). Some authorities count prevention cases as homeless applications and this may contribute to the difference in local and national rates.

The ethnicity of homeless acceptances is 87% white and 13% BME. (Rates of homelessness for BME groups are higher than in resident population).

Decisions

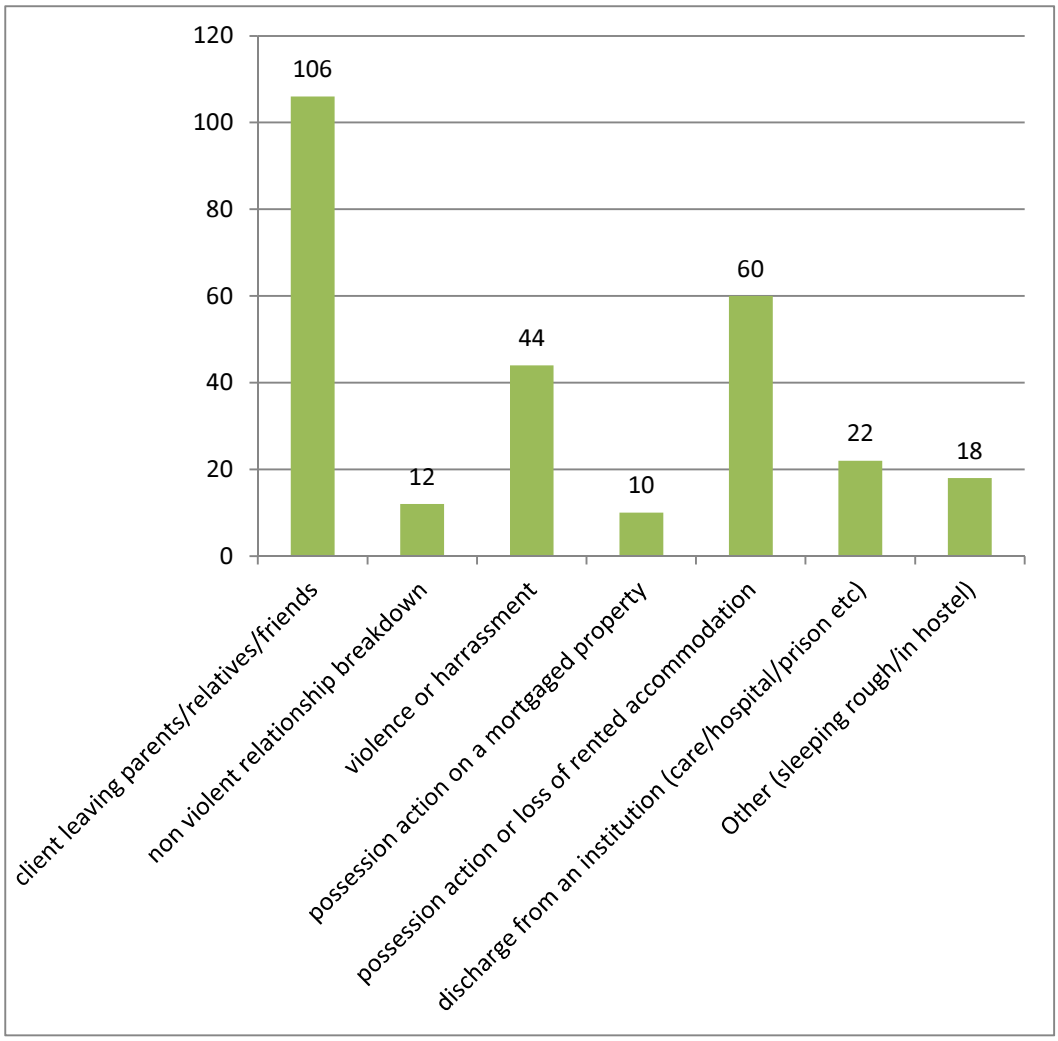
Department for Communities and Local Government

Over the last 3 years 60% of a total 451 homelessness applications were full duty acceptances, 9% were homeless but without priority need and 31% were either not homeless or other decision made.

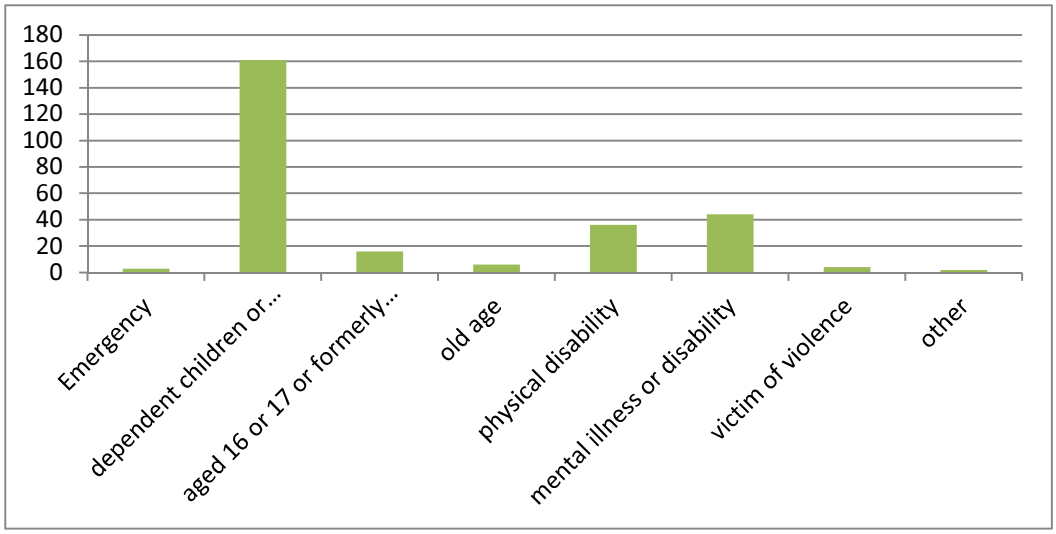
Over the last 3 years 272 families and single people have been homeless with priority need which means the council must secure them settled accommodation. The main reasons for this type of homelessness is leaving the home of parents/relatives or friends, leaving a private tenancy and violence or harassment. They remain the same main reasons as found in the homeless review carried out in 2008.

The main reasons for having a priority need are having dependent children or being pregnant, having a mental or physical disability and being a young person aged 16 or 17 or a care leaver.

Main reasons for homelessness April 2010 – March 2013



Main reasons for priority need April 2010 – March 2013



Prevention

Department for Communities and Local Government

Over the last 3 years 1105 families and single people have been given advice by the local authority that has meant they can stay in their home.

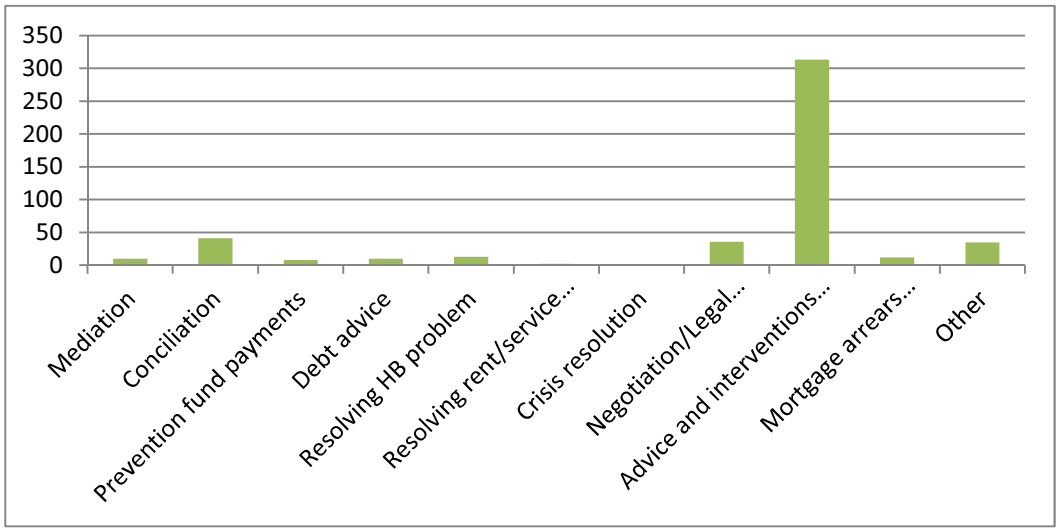
Access to Advice and Prevention Services has improved with agencies sharing use of One Stop Shop in Bath and area offices.

Housing Services have experienced an increase in demand for tenancy advice from students (validity of tenancy agreements/non return of deposits).

The main intervention used to prevent homelessness is advice that enables people to keep their private or social tenancy. Mediation and conciliation and debt and rent payment advice are other important factors.

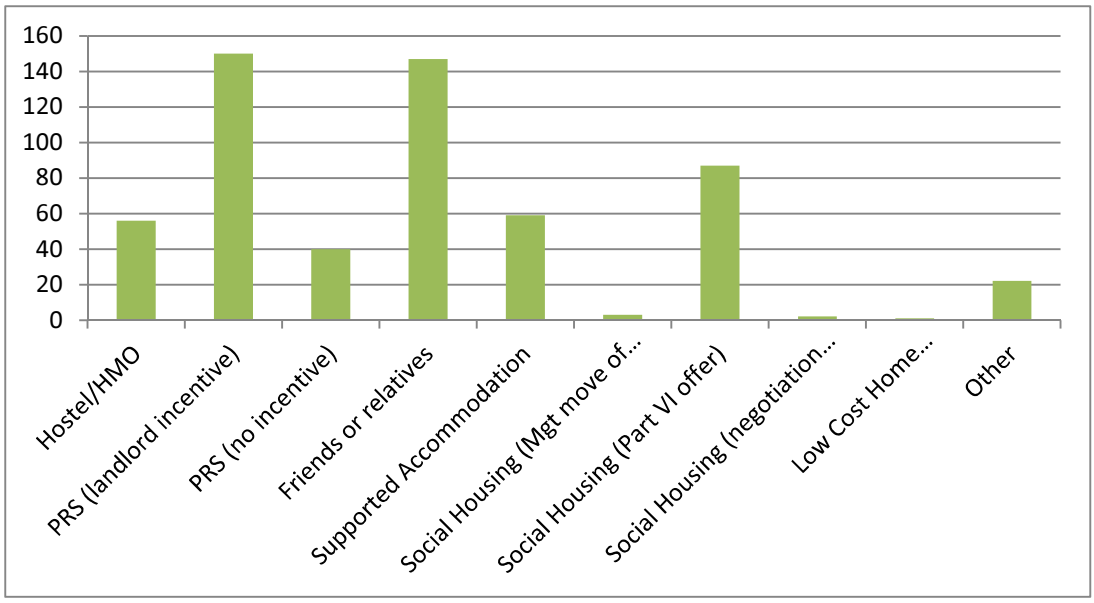
The main types of alternative accommodation secured by advice seekers are private rented using landlord incentive scheme, staying with friends or relatives and social housing or hostel.

Main homelessness prevention interventions April 2010 – March 2013



Main types of alternative accommodation secured April 2010 – March 2013

Department for Communities and Local Government



Private Sector Access Schemes (Homefinder and Pinboard)

B&NES Housing Services

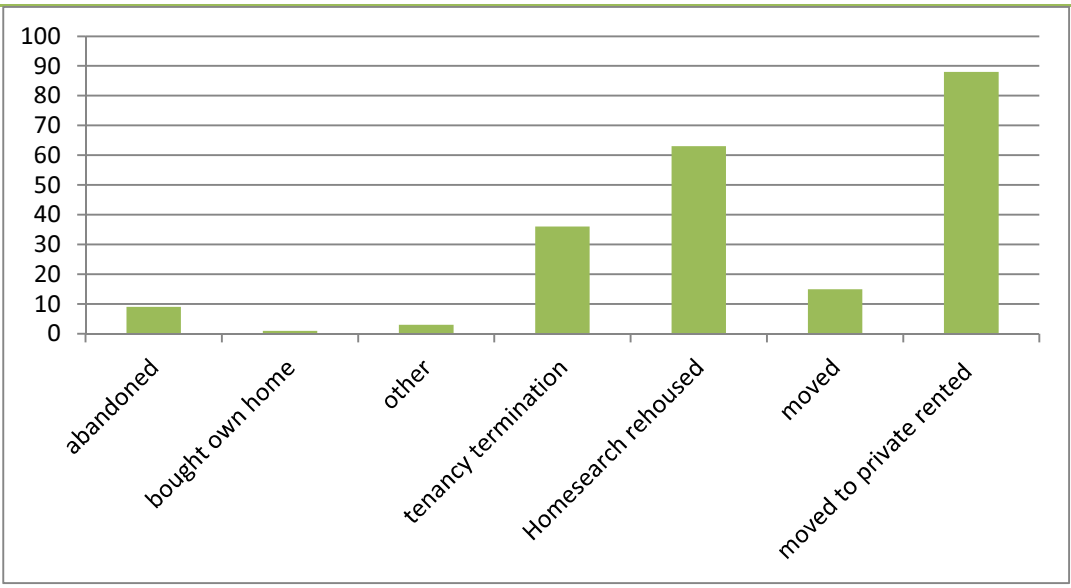
The Homefinder Scheme has been operating since 2005. There are currently 164 ongoing tenancies created via the scheme (June 2013). Over the last 3 years an average of 69 private sector tenancies have been facilitated annually. The average tenancy length is 19 months (15 months on those that have ended, 24 on those that are still ongoing). 42 tenancies have continued for 3 years or more (10 tenancies have continued for 5 years).

2012/2013 61 new tenancies
2011/2012 82 new tenancies
2010/2011 59 new tenancies

62% of ongoing tenancies accommodate families
37% of ongoing tenancies accommodate singles/couples with no dependents
1% of ongoing tenancies accommodate sharing singles/couples (non related)

80% of tenants leaving Homefinder Scheme tenancies moved on to private or social sector housing options.

Reasons for ending Homefinder Tenancy



The Pinboard Scheme is funded by the DWP Local Housing Allowance Transition fund (£10,000 year 2012/13 and £10,000 year 2013/14) and is managed by DHI.

Specifically targeted at single18 to 35 year olds entitled to the single room rate only, but open to over 35s as well, to allow a sensible mix of youth and maturity, and in order to promote/facilitate the use of shared houses, this project seeks to identify potential house sharers, bring them together, vet them and introduce them to a "tenant matching" service to prepare them for and assist them with future tenancies.

SUMMARY OF OUTCOMES FROM YEAR 1: APRIL 2012 TO APRIL 2013

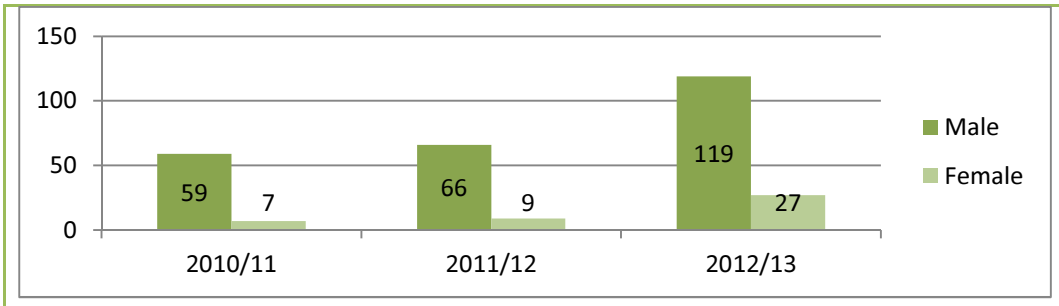
Clients registered with the service	34
Clients housed	15
Through the project	9
Elsewhere	6
Clients assessed and currently undergoing matching	16
Clients disengaged, assessed not suitable, or awaiting assessment/matching	18

Rough sleepers

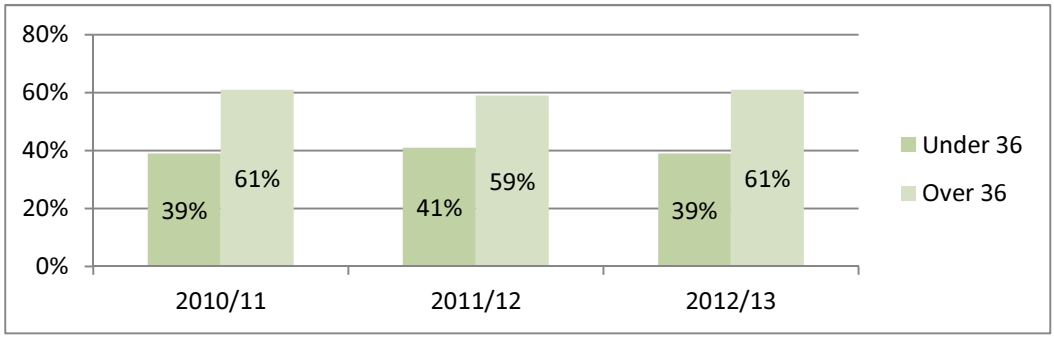
22 rough sleepers (B&NES Rough Sleeper Count 2012)
Numbers have increased by 25% because of new national approach to counting. (Instead of counting the number of people sleeping rough on a single night and using limiting definitions, the new approach is to count on the basis of informed data from rough sleeper outreach services.)

The total number of people and of women using B&NES Nightshelter is increasing every year

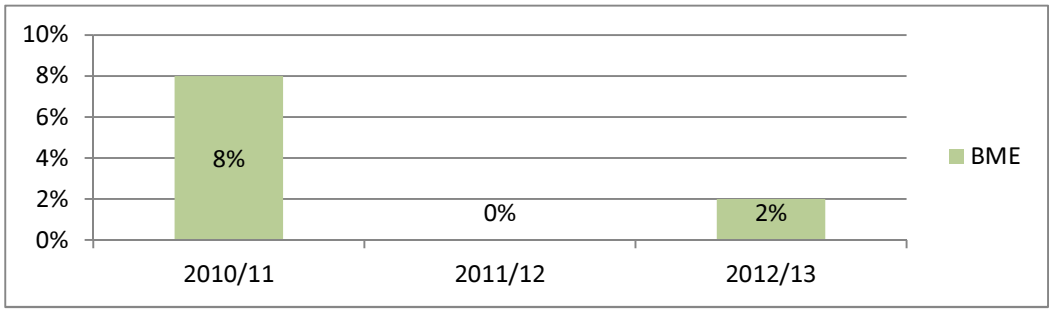
B&NES Supporting People



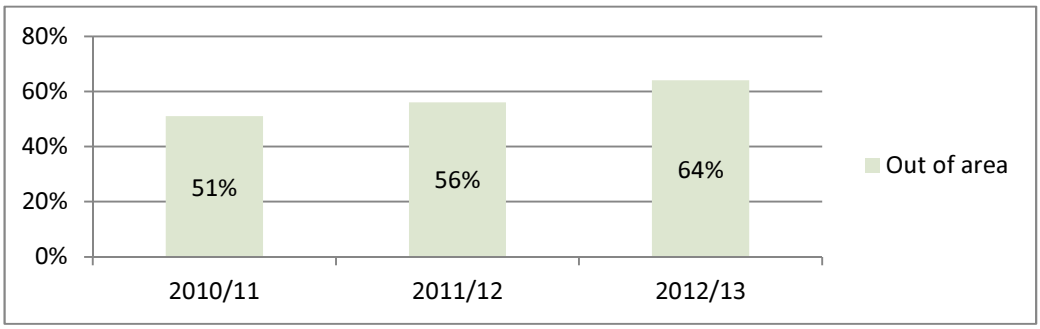
The age distribution of service users is consistent, around 60% are aged 36+



The proportion of BME users is in line with resident population.



More than half of service users are out of area and the percentage of out of area service users is increasing every year



SUPPORT

Advice and information commissioned services

17 providers are commissioned to prevent homelessness through provision of advice and information services for debt/benefits, tenancy sustainment and finding safe accommodation.

More than 20, 000 people used the services in 2012/13.

Demand is high and long waiting lists and lack of transport to office locations mean that some people have difficulty accessing services.

B&NES Supporting People

Supported housing projects

There are 243 accommodation based supported housing units funded by the Council through government grants (£1.4 million spend 2012/13).

In summary there is provision for 38 families, 118 singles/couples with no dependents, 87 young people and young families.

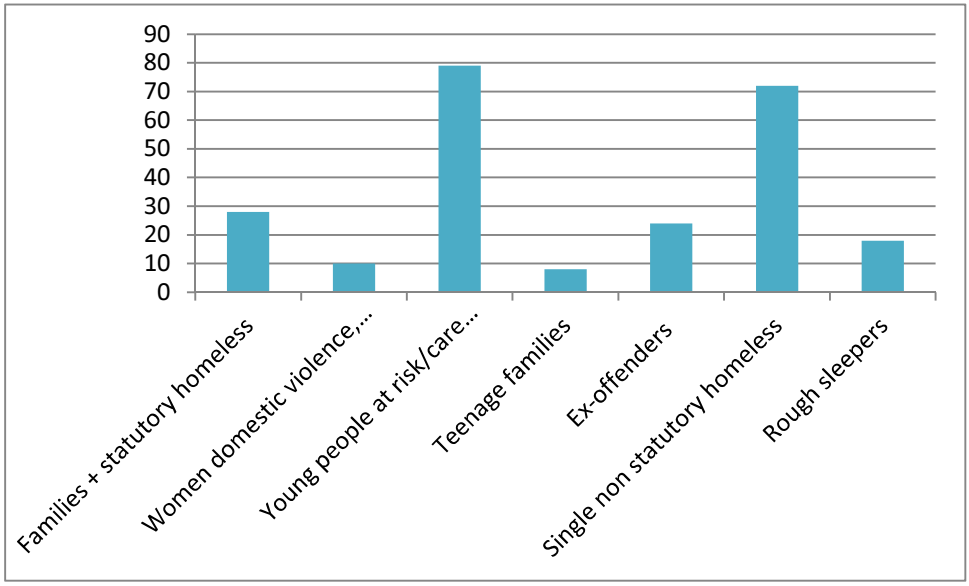
Access to accommodation based services is via the Gateway which provides a single point where service users can apply for a wide range of support services to help them live independently, or prevent homelessness.

Demand for Supported Housing is high and there is a waiting list (132 June 2013). Demand from young people is increasing.

Service users with high needs/risks have difficulty accessing accommodation based services.

B&NES Supporting People

Supported Housing for Homeless People by Client Group



Provider	Service		UNITS
Curo	Somer Temporary A	Families, singles and couples with support needs	11
Curo	Temporary Accomn	Families, singles and couples with support needs	17
Julian House	Peter House	Offenders or people at risk of offending	8
Developing Healt	1 Barton Buildings	Offenders or people at risk of offending (Dry House)	6
Developing Healt	Burlington Street (E	Offenders or people at risk of offending (Dry House)	10
Julian House	Julian House Night	Rough sleepers	18
Bath Mind	Lambridge Place	Single people with mental ill health	4
Bath Mind	Marlborough Lane	Single people with mental ill health	6
Bath Mind	Wellsway 103	Single people with mental ill health	3
St Mungos	Mulberry House & I	Single people with mental ill health	13
Julian House	Barnabas House ar	Single people with mental ill health/substance misuse	12
Solon South We	Rackfield House	Single people with mental ill health/substance misuse	20
Stonham (Home	Percy Place	Single people with mental ill health/substance misuse	4
Stonham (Home	The Paragon	Single people with mental ill health/substance misuse	10
Stonham (Home	Newbridge Road	Single people with mental ill health/substance misuse (women)	4
Julian House	Libra Project	Women domestic violence/mental Ill health/substance misuse	2
Next Link	Domestic Abuse S	Women domestic violence, mental Ill health/substance misuse	8
B&NES Support	Emergency units	Young people at risk/care leavers	2
B&NES Support	Supported Lodgings	Young people at risk/care leavers	20
Curo	Bath Foyer	Young people at risk/care leavers	31
Curo	Cleveland Supporte	Young people at risk/care leavers	6
Curo	Pathways	Young people at risk/care leavers	14
Curo	Temporary Hostels	Young people at risk/care leavers	6
Curo	Cleveland Teenage	Young people with dependents at risk/care leavers	2
Curo	Teen Parents Servi	Young people with dependents at risk/care leavers	6
			243

Floating support

New Floating Support contracts are commissioned for total hours provided at any one time (allowing more flexibility for the service).

B&NES Supporting People

Provider	Service	Client group	HOURS
Curo	Mediation Service	Young people at risk of homelessness	42
Developing Health & Independence	REACH	Families, Ex offender or People at risk of offending, with Drug / Alcohol Problems, Rough Sleeper, Young people at risk/ leaving care, Single Homeless with Support Needs	246
Next Link Domestic Abuse Services	Next Link	Domestic Violence	35.75
Rethink	Rethink	People with mental ill health/ dual diagnosis	67.5
Second Step Housing Association	Second Step	People with mental ill health/ dual diagnosis	90

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HOUSING SERVICE PROJECT COMMUNICATION PLAN	
Project Name	Homelessness Review and Strategy 2014-2018
Project Manager	Sue Wordsworth

1. Purpose

This is the communications plan for the Homelessness Review and Strategy 2014-2018. This document sets out how stakeholders (and providers) will be:

- informed about the commissioning proposals
- able to comment on the commissioning proposals
- able to influence service design

2. Communication objectives

The objectives of this communications plan are to ensure that:

- all stakeholders are aware of the reasons for developing the commissioning proposals and the advantages and disadvantages of available options
- accurate information about the project in appropriate formats is available
- stakeholders have the opportunity to comment on the proposals
- that consultation feeds into the design of the tender specification
- it is clear when communication includes the opportunity for consultation and involvement.
- the objectives of consultations and the way in which the results of consultation will be considered by the Council are clearly stated.

3. Scope of communication

The communications are based around the distribution of a commissioning strategy and its key messages. Consultation will include key stakeholders and equalities groups and stakeholders.

All consultation shall comply with the requirements of legislation, Codes of Practice and other guidance as appropriate.

4. Intended audience

The intended audience includes:

- older people
- younger people
- homeless persons
- people with disabilities
- service users
- voluntary groups that work with homeless and those at risk
- councillors
- local commissioners and funders
- partners (e.g. housing associations)
- local authority staff and agencies who refer clients to these services

5. Key messages associated with the project

The key messages for this project are:

- What – Evidence Base for local homeless characteristics
Draft Homelessness Strategy Action Plan
Local Priorities
Equalities Impacts
- Why – 5 year strategy to prevent homelessness and protect vulnerable people
- Who – stakeholders and partners
- When – Strategy to be in place 2014-2018

6. Stakeholders

- Agencies that lead co-ordinated action to reduce the harms caused by alcohol misuse;
- Connecting Families Team

- Frontline SP&C homelessness sector provider organisations
- Health and Social Care services
- Homelessness Partnership
- Jobcentre Plus,
- lead agencies for young people, ex-offenders and people with drug, alcohol mental health needs
- Local Authority senior managers and members
- Local Training and Education Providers
- Mediation Service
- mortgage rescue advice and assistance
- Police Services
- private rented sector
- Registered Providers (social housing)
- Service Users and ex-service users
- Services that coordinate action to prevent suicide repeated self-harm and support for people with mental ill health.
- Services that ensure that our local communities have access to good quality education, volunteering and employment opportunities;
- Supported Lodgings Service and Providers
- Voluntary Sector (services for homeless)
- Work Choice Providers
- Youth services

7. Measuring and evaluation

The communications and consultation will be measured by:

- the ability to meet specified deadlines
- the level of the response to the survey
- the attendance at stakeholder and provider days
- feedback on the clarity of the commissioning strategy

8. Communication channels

One to one discussions, round table meetings, conference event, open public website consultation.

9. Communication Plan

Homelessness Strategy Communications Timescales		Tasks
07 Feb 2013	Homelessness Partnership (Strategy Group)	Plan conference and strategy outline
14 Mar 2013	Homelessness Partnership (wider group) Stakeholder Agencies (list of delegates below)	Welfare Reform conference (establishing local priorities)
29 Apr 2013	Supporting People & Communities	Agree Strategy structure
00 May 2013		**Research Evidence Base & review national policy**
05 June 2013	Housing Options & Homelessness	Local Priorities consultation
00 June 2013		**Prepare Draft Strategy**
03 July 2013	Homelessness Partnership (Strategy Group) (list of members below)	Draft Strategy consultation
06 Aug 2013	Planning Services	Evidence Base consultation
18 Sept 2013	Health and Wellbeing Board	Approve launch of open public consultation
20 Sept 2013	Wellbeing Policy Development and Scrutiny	Alert to open public consultation period
25 Sept 2013	Open Public Website (6 weeks) to 06 Nov 2013	Draft Strategy consultation
06 Nov 2013	Health and Wellbeing Board	Update on consultation
00 Nov 2013		**Equalities Impacts Assessment**
00 Nov 2013		**Risk Assessment**
22 Nov 2013	Wellbeing Policy Development and Scrutiny Panel	Draft Strategy scrutiny and recommendations
	Strategic Directors Group	Guidance for single member decision
	Informal Cabinet	Guidance for single member decision
00 Dec 2013	**Single Cabinet Member**	**Decision**

Homelessness Partnership (Strategy Group)		
Organisation	**Role**	**Name**
B&NES Council	Cabinet Member for Wellbeing	Cllr Simon Allen
B&NES Council	Cabinet Member for Homes and Planning	Cllr Tim Ball
B&NES Council	Connecting Families	Paula Bromley
B&NES Council	Divisional Director, Customer Services, Revenues & Benefits	Ian Savigar
B&NES Council	Planning & Partnerships Manager	Sue Wordsworth
B&NES Council	Substance Misuse & Communities Manager	Carol Stanaway
B&NES Council	Supporting People Manager	Ann Robins
B&NES Council	Team Manager Housing Services	Mike Chedzoy
Bath Abbey	Homelessness Initiative Manager	Kerry Headen
CAB	Operations Manager	Gill Whitehead
Clean Slate Training and Employment	Managing Director	Jeff Mitchell
Curo	Director of Neighbourhoods	Julie Evans
Curo	Head of Care and Support	Janet Errington
Genesis Trust	Director	Paul Solly
Julian House	Operations Director	John Isserlis
REACH	Service Manager	Nik Brown
Stonham Housing Association	Senior Client Service Manager	Alan Docherty

Welfare Reform Conference 14 March - Preparing for Change List of Delegates		
Organisation	**Role**	**Name**
Avon and Somerset Police	Anti-Social Behaviour Manager	Tim Harris
Avon and Somerset Police	Rough Sleeper Co-ordinator	Elizabeth Parry
B&NES Council	Approved Mental Health Practitioner, Mental Health Services (Social Care & Health)	Tom Lochhead
B&NES Council	Cabinet Member Homes and Planning	Cllr Tim Ball
B&NES Council	Cabinet Member Wellbeing	Cllr Simon Allen
B&NES Council	Change for Children and Independent Quality Assurance Manager, Learning & Inclusion Service	Mary Kearney-Knowles
B&NES Council	Childrens Centre Co-ordinator	Peter Roberts
B&NES Council	Community Support Worker, Work Development Team	Suzanne Morys

B&NES Council	Deputy Team Manager, Children in Care and Moving On Team	Beverley Coles
B&NES Council	Divisional Director, Customer Services, Revenues & Benefits	Ian Savigar
B&NES Council	Housing Adviser	Andrew Stevens
B&NES Council	Housing Advisor Mental Health and Learning difficulties	Tracy Pullen
B&NES Council	Manager, Family Information Service	Jackie Fielder
B&NES Council	Planning & Partnerships Manager	Sue Wordsworth
B&NES Council	Substance Misuse Project Officer, Non Acute & Social Care	Louise Spencer
B&NES Council	Supporting People Manager	Ann Robins
B&NES Council	Team Leader Customer Services	David Hammond
B&NES Council	Team Manager Housing Services	Mike Chedzoy
B&NES Council	Team Manager, Disabled Children's Team	Nora Ryan
B&NES Council	Worklessness Programme Manager, Skills and Employment	Harun Kennedy
Bath Abbey	Homelessness Initiative Manager	Kerry Headen
Clean Slate Training and Employment	Managing Director	Jeff Mitchell
Crisis Welfare Network	Project Manager	Michael Fothergill
Curo	Director of Neighbourhoods	Julie Evans
Curo	Head of Care and Support	Janet Errington
Curo	Welfare Reform Implementation Officer	Hayley Stockham
Department for Work and Pensions	Partnership Manager	Val Baker
Genesis Trust	Director	Paul Solly
Genesis Trust	Lifeline Centre Manager	Gloria
Julian House	Operations Director	John Isserlis
MIND	Community Outreach Support and Development Leader	Jude King
REACH	Support Co-ordinator	Ben McFarland
Sirona Care and Health	Lead Social Worker	Geoff Watson
Stonham Housing Association	Senior Client Service Manager	Alan Docherty
SW Advice Network	Housing Adviser	Fiona Anderson

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board
MEETING DATE:	18th Sept 2013
TITLE:	Bath and North East Somerset Children and Young People's Plan (CYPP)
AN OPEN PUBLIC ITEM	
List of attachments to this report: None	

1 THE ISSUE

1.1 The Children Trust Board and Bath and North East Somerset Local Authority have jointly agreed to the development of a new CYPP 2014-2017.This plan will be a non-statutory plan building on previous plans. It will clearly define the commissioning intentions for the delivery of services. The new plan will be aligned to the Health and Well Being Strategy 2013.

2 RECOMMENDATION

The Board is asked to agree:

2.1 The priorities and the proposed timeframe for the next CYPP 2014-2017

3 FINANCIAL IMPLICATIONS

3.1 There are no direct financial implications arising from this report. The service developments in the Children and Young People's Plan for 2014/17 will be funded from existing budgets. The next CYPP will need to be delivered against agreed priorities within existing budgets across the Children Trust Board

4 THE REPORT

The priorities identified for the 2014-2017 Children and Young People Plan have been identified following feedback from the Pupils Parliaments events, which took place in June 2013.

The 3 key priorities that have been identified are: -

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

The next plan will: -

- Be aligned with other strategies for Health and Wellbeing, Department of Public Health, B&NES Core Strategy
- Be a strategic document that will inform Commissioners & Providers by clearly setting out our statutory duties and outline our commissioning intentions
- Reflect geographical delivery of services
- Maintain its focus on outcomes for more vulnerable children but should also be clear on the Early Help Offer
- Manage expectations, within available resources.
- Be available as an accessible summary document for Children and Young People, Parents & Carers

Timetable

- CYPP steering group and sub groups will meet regularly to oversee the development of the plan between April 2013 and March 2014
- Consultation with Children and Young People and Parents and Carers has taken place between June and August 2013. The Parent & Carers consultation has included both an on line consultation and a targeted approach.
- Leads to be identified for writing the sections of the draft CYPP during September/October 2013
- Following discussion at Children's Trust Board Stakeholder Event on Nov 7th , the draft CYPP plan will be presented to the Children Trust Board business meeting in December 2013.
- Draft CYPP 2014-2017 to go out for an additional 1 month consultation in January 2014
- Final CYPP 2014-2017 to be published 1 April 2014

5 RISK MANAGEMENT

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

5.2 Although the Children and Young People's Plan (CYPP) 2014-2017 is not a statutory document there would be a significant risk to the delivery of services and reputation of the Council if an effective CYPP were not put in place.

5.3 There is a significant risk to the reputation of the Council, the Children Trust Board and the Sustainable Community Strategy if the Children and Young People Plan key priorities are not delivered.

6 EQUALITIES

6.1 Equalities impact assessments will be carried out within each of the priorities and any policies which stem from this work.Once the plan has been approved a new EqIA will be completed

7 CONSULTATION

7.1 *Executive Councillor; Overview & Scrutiny Panel; Staff; Other B&NES Services; Schools :Service Users; Youth Council; Stakeholders/Partners; Other Public*

Sector Bodies; Section 151 Finance Officer; Chief Executive; Monitoring Officer, Children Trust Board, Voluntary and Community Sector

7.2 Consultation on the development of the vision, values and priorities 2014-2017 has taken place with the Children's Trust Board, Children and Young People in and out of school, parents and carers, the voluntary and community sector during the period June 24th to August 31st 2013.

7.3 The final draft CYPP 2014-2017 will be put on the public website for further consultation in January 2014.

7.4 The final CYPP 2014-2017 will subsequently be included on the agendas for Early Years, Children and Youth Policy Development and Scrutiny panel, Cabinet and the Health & Well Being Board.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Young People; Human Rights.

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 Bowden - Deputy Director - Children and Young People, Strategy and Commissioning*
Background papers	CYPP 2011-2014 http://www.bathnes.gov.uk/sites/default/files/sitedocuments/Children-and-Young-People/children_and_young_peoples_plan_2011-2014.pdf JSNA www.bathnes.gov.uk/jsna
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:	Health and Wellbeing Board
MEETING DATE:	18th September 2013
TITLE:	Section 256 Agreement and Funding Allocation 2013/14
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 – "Section 256" Funding Allocation & Investment Appendix 2 – NHS England Area Team Funding Allocation and Agreed Use Appendix 3 – BaNES CCG Funding Allocation and Agreed Use Appendix 4 - Local Government Association and NHS England 'Statement on the health and social care Integration Transformation Fund'	

1 THE ISSUE

1.1 Over the past four years, funding from the Department of Health has been passed, via local NHS commissioners (previously the Primary Care Trust, now, following NHS Reform, a combination of the Clinical Commissioning Group and NHS England Area Team). Funding streams have included: additional support funding for social care; improving and sustaining performance on access (primarily to hospital services); and reablement support. Each funding stream has typically come with guidance about use of the funding, which has informed the development of local agreements between the NHS and Local Authority about use of the funding. These agreements are termed "Section 256" Agreements as they are made under the terms of Section 256 of the National Health Service Act 2006.

1.2 Following NHS Reform, a proportion of the funding for 2013/14 is covered by a Section 256 Agreement between the Clinical Commissioning Group (CCG) and Council. The majority of funding is covered by a similar Agreement between the NHS England Bath, Gloucester, Swindon and Wiltshire Area Team (the Area Team) and the Council. Details of the funding allocation and agreed use of this funding is covered in section 3 of this report and in the Appendices to this report.

1.3 In the June 2013 spending round covering 2015/16 a national £3.8 billion "Integration Transformation Fund" was announced. This fund, established by the Department of Health, is to be held by local authorities and will include funding previously transferred by local NHS commissioners to the Council under Section 256 Agreements.

2 RECOMMENDATION

The Board is asked to:

2.1 Note the agreed use of Section 256 funding in 2013/14;

2.2 Note proposals in relation to the 2015/16 Integration Transformation Fund and, in particular, the key role of Health & Wellbeing Boards in agreeing plans for the use of this fund.

3 FINANCIAL IMPLICATIONS

3.1 In 2013/14, £2.612m and £1.4m will transfer from the Area Team and CCG to the Council under Section 256 Agreements;

3.2 Funding allocations for 2014/15 and 2015/16 are yet to be confirmed and guidance about the use of this funding and transfer arrangements are yet to be published. However, the Bath and North East Somerset allocation of the £3.8 billion Integration Transformation Fund is likely to be at least as much as current levels of funding and may be significantly more.

4 THE REPORT

4.1 Broadly, Section 256 funding is intended for use in addressing pressures in the health and social care system, including those arising from demographic change; reducing admission to and length of stay in hospital; and to fund community based interventions that prevent an escalation of people's need and support them to live as independently as possible, in the community for as long as possible. The Appendices to this report set out further background detail and agreed use of Section 256 funding for the current year.

4.2 Bath and North East Somerset has a good track-record of investment of Section 256 funding in early intervention and preventative services and to achieve system change with the aim of achieving longer-term sustainability in the health and social care system. However, as pressure on public resources increases, it is likely to become increasingly difficult to achieve an appropriate balance between responding to immediate pressures in the system including, for example, increases in avoidable hospital admissions; whilst also investing in a longer-term strategic approach to achieve best value, sustainability and, most importantly, better outcomes for service users and carers.

4.3 The June 2013 Spending Round announcement signalled changes to Section 256 funding; most significantly, a pooled £3.8 billion Integration Transformation Fund (ITF), which will come into effect in 2015/16 but for which planning will need to start this year. The joint Local Government Association and NHS England Statement on the health and social care Integration Transformation Fund attached as Appendix 4 provides a helpful summary.

4.4 Of particular note for the Board are paragraphs 11, 12 and 17 of the Statement, which, briefly, confirm that in order to access the ITF, each locality will be asked to develop a local plan by March 2014 and that plans for the use of the pooled monies will need to be developed jointly by CCGs and local authorities and signed off by each of these parties and the local Health and Wellbeing Board.

5 RISK MANAGEMENT

5.1 Section 256 funding allocations are usually been confirmed on an annual basis in December or early January with detailed guidance also issued at this time of year with the express intention that this funding is used during that financial year. This, at least in part, reflects the fact that at least a proportion of the funding has been allocated on a non-recurring basis for use in relation to winter pressures. The timing of issue of funding allocations and guidance and a lack of certainty about year-on-year funding levels makes it difficult for the CCG and Council to plan and commission services to make the most effective use of Section 256. This lack of clarity could, also, lead to market instability, with providers unable to plan and develop services and recruit and/or train staff to respond to changes in commissioning intentions.

5.2 In order to minimise and mitigate risks it is important that the CCC and Council continue to work together to agree joint plans for the use of the funding that are in line with both organisations' priorities and strategic objectives and, also, to communicate these plans in a timely way to providers. It is also important to clearly articulate and monitor the outcomes, milestones and performance measures associated with this funding.

5.3 A risk assessment related to the issue and recommendations has not been undertaken on the contents of this report, which is not seeking decisions from the Board at this stage.

6 EQUALITIES

6.1 An Equalities Impact Assessment has not been completed because this report is not seeking decisions and use of Section 256 funding reflects commissioning plans and strategies, which are subject to the appropriate equalities impact assessments.

7 CONSULTATION

7.1 In respect of use of 2013/14 funding allocations specific consultation was undertaken with: Cabinet Member; Stakeholders/Partners; Other Public Sector Bodies; Section 151 Finance Officer; Monitoring Officer

7.2 Consultation to inform plans for use of future funding will be undertaken with a range of stakeholders through targeted engagement events and presentation to appropriate governing bodies, including CCG Board and Health & Wellbeing Board.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Human Resources; Young People; Human Rights; Corporate; Other Legal Considerations

9 ADVICE SOUGHT

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

Contact person	Jane Shayler, Telephone: 01225 396120
Background papers	
Please contact the report author if you need to access this report in an alternative format	

Appendix 1

'Section 256' Funding Allocation & Investment 2013/14

1. Background

1.1 In 2010/11 and 2011/12, the Department of Health allocated funding to the Primary Care Trust (PCT) for use in developing reablement services and to mitigate "winter pressures". In both years, this funding was transferred, in full, by the PCT to the Council under a Section 256 agreement.

1.2 In December 2011 and January 2012 the Department of Health confirmed further National funding allocations, including £150m additional support for social care and £100m for improving and sustaining performance on access.

1.3 NHS South of England (more commonly referred to as the Strategic Health Authority) confirmed in January 2012 that the additional support funding for social care should be transferred to the local authority for investment in social care which benefits the health system and was in addition to the funding which was agreed through the 2011/12 planning process for use on prevention, community equipment, telecare, crisis response, maintaining [social care] eligibility, reablement and mental health – all areas of investment evidence to help mitigate pressures in the system.

1.4 In line with the relevant guidance, the use of these funding streams was agreed for 2012/13. The agreed local distribution of funding is consistent with the plans and priorities of the CCG, Council and Health & Wellbeing Board and supports integrated service delivery by Sirona and other partners. At the December 2012 meeting of the Clinical Commissioning Committee (which from April 2013 became the Clinical Commissioning Board) both the transfer and use of Section 256 funding was agreed in principle subject to confirmation of the 2013/14. At the meeting, it was confirmed by the CCG's Director of Finance, that the 2013/14 allocation had been confirmed and was £674,000 more than anticipated. It was agreed at the CCC meeting that this additional funding should be used to increase access to reablement services on the basis that such services are evidenced to reduce individual need for long term packages of care and, also, help to smooth pressures in the urgent care system, with people less likely to reach crisis point. Subsequently, changes in funding flows meant that the larger proportion of 2013/14 allocation flowed through the Area Team rather than the CCG. However, the Area Team agreed to honour the distribution of funds agreed at by the CCC and this use of Section 256 monies is reflected in the Agreements between the CCG and Area Team with the Council as set out in Appendix 2 and 3.

2. Investment and Outcomes

2.1 Investment

Section 256 monies investment, includes five extended research pilots as follows:

- Integrated Health & Social Care Reablement – delivered through a partnership between Sirona CIC and Way Ahead Domiciliary Care Agency;
- Handyperson Services & Minor Adaptations – delivered by Care & Repair Home Improvement Agency;
- Step Down Accommodation, Care & Support – delivered through a partnership between Sirona CIC and Curo Housing Group;
- Intensive Home from Hospital Support – delivered through a partnership between Age UK and Care & Repair HIA;
- Telehealth (focused on heart failure admission avoidance).

2.2 Section 256 monies are also funding additional capacity in/expansion of services as follows:

- Increased activity in Sirona Care & Health – built into the contract to offset pressures arising from demographic change;
- Older Peoples Independent Living Service, which was launched in January 2011and recently won a national award has been accessed by more than 200 people so far;
- Additional extra care housing;
- Support to Carers;
- Transitional Care Beds;
- Emergency Out-of-Hours Domiciliary care;
- Reablement;
- Hospital based Social Work service, Occupational Therapy and Speech Therapy;
- Personal Budgets.

2.4 Outcomes

A strategic approach has been taken to the investment of s256 funding with the aim of both responding to pressures arising from demographic change and, also, building greater sustainability into the health and social care system.

2.5 Key outcome measures agreed by the CCC to monitor the effectiveness of s256 funding are:

- Support achievement of locally agreed Delayed Transfer of Care (DToCs) target of 1% for acute beds and 5% within community hospitals;
- Support reduction in Length of Stay (LoS) for Non-Elective Admissions (NELs) and within community hospitals;
- Support weekend discharges;
- Support avoidance of unnecessary emergency hospital admissions and readmissions;
- Improve support to carers;

- Prevent admissions to residential care & escalations in community care packages; and
- Increased support and assistance for older people to living independently for longer.

2.6 As with investment in all preventative and early intervention services, it is difficult to evidence the outcomes achieved from use of s256 funding. However, Delayed Transfers of Care (DTOC) is a key outcome measure for the effectiveness of services designed to enable people to leave hospital and return “home”. During the period of integrated working, including agreed investment of s256 funding, B&NES Acute DTOC position has, consistently outperformed Wiltshire’s position.

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Appendix 2

NHS England Area Team Funding Allocation and Agreed Use

Proposal	£'000s	Health benefit
Handyperson Services & Minor Adaptations (Care & Repair) - Home Safety Checker and subsequent arrangement of essential adaptations to repairs to enable an older or disabled person to be discharged from hospital and return home safely	50	Support avoidance of unnecessary emergency hospital admissions and readmissions
Step Down Accommodation, Care & Support (Curo Housing & Sirona) - provision of mobility standard flats with care and support to enable step-down from hospital and support return home	100	Support achievement of locally agreed Delayed Transfer of Care (DToC) target of 1% for acute beds and 5% within community hospitals
Medicines management community support	100	Support avoidance of unnecessary emergency hospital admissions and readmissions
Mental Health Liaison Service to strengthen the assessment, support and care planning that avoids hospital admission, facilitates people to stay in or return to their care home as quickly as possible	100	Support the reduction in Length of Stay (LoS) for Non-Elective Admissions (NELs) and within community hospitals
Intensive Home from Hospital Support (Age UK & Care & Repair)	50	Prevent admissions to residential care & escalations in community care packages
Telehealth (Sirona) - focused on heart failure admission avoidance	75	Support avoidance of unnecessary emergency hospital admissions and readmissions
Winter pressures 12/13+	150	Support achievement of locally agreed Delayed Transfer of Care (DToC) target of 1% for acute beds and 5% within community hospitals
Sirona Care & Health - Service Developments (contractual commitment)	350	Support achievement of locally agreed Delayed Transfer of Care (DToC) target of 1% for acute beds and 5% within community hospitals
Sirona Care & Health - Transformation & Organisational Change (contractual commitment)	260	Increased support and assistance for older people living independently for longer

Proposal	£'000s	Health benefit
Social Care Placement and Personal Budgets - the increasing complexity and acuity of people being supported to live in the community is giving rise to cost pressures associated with higher staffing levels and/or skill-mix and, therefore placement and care package unit costs	782	Increased support and assistance for older people living independently for longer
Housing renewal - financial assistance to older and disabled people to make essential improvements to their homes, including addressing trip hazzards, fire-safety, home security, home energy efficiency	120	Prevent admissions to residential care & escalations in community care packages
Independent Living Service - National award winning service tailored to individual needs, which can make the difference between someone staying in their own home and having to leave to go into residential or nursing care	100	Increased support and assistance for older people living independently for longer
Income maximisation service - to assist older and disabled people to maximise their income from welfare benefits and enable them to fund or partially fund care and support	100	Increased support and assistance for older people living independently for longer
Strategic planning capacity	65	Prevent admissions to residential care & escalations in community care packages
Waking Nights - out of hours and emergency domiciliary care services to both facilitate hospital discharge or to provide emergency care to individuals whose normal carer is unavailable (including because they have their own health crisis)	210	Prevent admissions to residential care & escalations in community care packages
TOTAL	**2,611,907**	

Appendix 3

BaNES CCG Funding Allocation and Agreed Use

Proposal	**£'000s**	**Health benefit**
Carers	234	To provide sustainable support to those carers providing care to service users with Health needs, so reducing the need for admission or social care services
Voluntary Organisations	266	To contribute on behalf of the CCG to those voluntary organisations that provide direct or indirect support for the delivery of the Health & Social Care Agenda
Local Reablement	900	To provide funds locally to support and enhance local reablement, in addition to the national funding. So as to provide investment funds and support those services which will reduce the demand on Secondary Care Services, or reduce the length of stay in such services.
TOTAL	**1,400**	

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Statement on the health and social care Integration Transformation Fund

Summary

1. The June 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand pressures on services. In this context the announcement of £3.8 billion worth of funding to ensure closer integration between health and social care was a real positive. The money is an opportunity to improve the lives of some of the most vulnerable people in our society. We must give them control, placing them at the centre of their own care and support, make their dignity paramount and, in doing so, provide them with a better service and better quality of life. Unless we seize this opportunity to do something radically different, then services will get worse, costs to taxpayers will rise, and those who suffer the most will be people who could otherwise lead more independent lives.

2. The funding is described as: "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". We are calling this money the health and social care Integration Transformation Fund (ITF) and this note sets out our joint thinking on how the Fund could work and on the next steps localities might usefully take.

3. NHS England, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) are working closely with the Department of Health and Department for Communities and Local Government to shape the way the ITF will work in practice. We have also established a working group of CCGs, local authorities and NHS England Area Teams to help us in this process.

4. In '*Integrated care and support: our shared commitment*' integration was helpfully defined by National Voices – from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me". The ITF is a means to this end and by working together we can move toward fuller integration of health and social care for the benefit of the individual.

5. Whilst the ITF does not come into full effect until 2015/16 we think it is essential that CCGs and local authorities build momentum in 2014/15, using the additional £200m due to be transferred to local government from the NHS to support transformation. In effect there will need to be two-year plans for 2014/15 and

2015/16, which must be in place by March 2014. To this end we would encourage local discussions about the use of the fund to start now in preparation for more detailed planning in the Autumn and Winter.

Context: challenge and opportunity

6. The ITF provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in adult social care. The ITF is an important opportunity to take the integration agenda forward at scale and pace – a goal that both sectors have been discussing for several years. We see the ITF as a significant catalyst for change.

7. There is also an excellent opportunity to align the ITF with the strategy process set out by NHS England, and supported by the LGA and others, in *The NHS belongs to the people: a call to action*[1]. This process will support the development of the shared vision for services, with the ITF providing part of the investment to achieve it.

8. The ITF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work CCGs and local authorities are already doing, for example, as part of the integrated care "pioneers" initiative and Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

Background

9. The June 2013 Spending Round set out the following:

2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8 billion pooled budget to be deployed locally on health and social care through pooled budget arrangements.

10. In 2015/16 the ITF will be created from the following:

£1.9 billion existing funding continued from 14/15 - this money will already have been allocated across the NHS and social care to support integration
£130 million Carers' Breaks funding.
£300 million CCG reablement funding.

[1] http://www.england.nhs.uk/2013/07/11/call-to-action/

c. £350 million capital grant funding (including £220m of Disabled Facilities Grant).
£1.1 billion existing transfer from health to social care.
Additional £1.9 billion from NHS allocations Includes funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill. Includes £1 billion that will be performance-related, with half paid on 1 April 2015 (which we anticipate will be based on performance in the previous year) and half paid in the second half of 2015/16 (which could be based on in-year performance).

11. To access the ITF each locality will be asked to develop a local plan by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related £1 billion will be met. This plan will also set out how the £200m transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

12. Plans for the use of the pooled monies will need to be developed jointly by CCGs and local authorities and signed off by each of these parties and the local Health and Wellbeing Board.

Conditions of the full ITF

13. The ITF will be a pooled budget which will can be deployed locally on social care and health, subject to the following national conditions which will need to be addressed in the plans:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health;
- ensure a joint approach to assessments and care planning;
- ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached; and
- agreement on the consequential impact of changes in the acute sector.

14. Ministers have agreed that they will oversee and sign off the plans. As part of achieving the right balance between national and local inputs the LGA and NHS England will work together to develop proposals for how this could be done in an efficient and proportionate way.

Conditions of the performance-related £1 billion

15. £1 billion of the ITF in 2015/16 will be dependent on performance and local areas will need to set and monitor achievement of these outcomes during 2014/15 as the first half of the £1 billion, paid on 1 April 2015, is likely to be based on performance in the previous year. We will be working with central Government on the details of this scheme, but we anticipate that it will consist of a combination of national and locally chosen measures.

Delivery through Partnership

16. We are clear that success will require a genuine commitment to partnership working between CCGs and local authorities. Both parties need to recognise the challenges they each face and work together to address them.

- Finding the extra NHS investment required: Given demographic pressures and efficiency requirements of around 4%, CCGs are likely to have to re-deploy funds from existing NHS services. It is critical that CCGs and local authorities engage health care providers to assess the implications for existing services and how these should be managed;
- Protecting adult social care services: Although the emphasis of the ITF is rightly on a pooled budget, as with the current transfer from the NHS to social care, flexibility must be retained to allow for some of the fund to be used to offset the impact of the funding reductions overall. This will happen alongside the on-going work that councils and health are currently engaged in to deliver efficiencies across the health and care system.
- Targeting the pooled budget to best effect: The conditions the Government has set make it clear that the pooled funds must deliver improvements across social care and the NHS. Robust planning and analysis will be required to (i) target resources on initiatives which will have the biggest benefit in terms outcomes for people and (ii) measure and monitor their impact;
- Managing the service change consequences: The scale of investment CCGs are required to make into the pooled budget cannot be delivered without service transformation. The process for agreeing the use of the pooled budget must therefore include an assessment of the impact on acute services and agreement on the scale and nature of changes required, e.g. impact of reduced emergency activity on bed capacity.

Assurance

17. Local Health and Wellbeing Boards will sign off the plans, which will have been agreed between the local authority and CCGs. The HWB is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process. The plans will then go through an assurance process involving NHS England to assure Ministers.

Timetable and Alignment with Local Government and NHS Planning Process

18. Plans for use of the pooled budgets should not be seen in isolation. They will need to be developed in the context of:

- local joint strategic plans;
- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term strategic plans as part of the NHS Call to Action)
- the announcement of integration pioneer sites in October, and the forthcoming integration roadshows.

19. The outline timetable for developing the pooled budget plans in 2013/14 is broadly as follows:

- August to October: Initial local planning discussions and further work nationally to define conditions etc
- November/December: NHS Planning Framework issued
- December to January: Completion of Plans
- March: Plans assured

Next Steps

20. NHS England and the LGA and ADASS will work with DH, DCLG, CCGs and local authorities over the next few months on the following issues:

- Allocation of Funds
- Conditions, including definitions, metrics and application
- Risk-sharing arrangements
- Assurance arrangements for plans
- Analytical support e.g. shared financial planning tools and benchmarking data packs.

Carolyn Downs
Chief Executive
Local Government Association

Bill McCarthy
National Director: Policy
NHS England

8 August 2013

NHS England Publications Gateway Ref. No.00314

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Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board
MEETING DATE:	18th September 2013
TITLE:	Healthwatch Bath and North East Somerset - Update
AN OPEN PUBLIC ITEM	
List of attachments to this report: None	

1 THE ISSUE

1.1 This report provides an update on key Healthwatch Bath and North East Somerset progress during its implementation phase over the last 5 months as well as planned next steps.

2 RECOMMENDATION

2.1 The Board is asked to:

- Note the Healthwatch B&NES update

3 THE REPORT

3.1 During the implementation phase over the last 5 months we have been setting up operational systems and have a full staff compliment now in place. We have been working with Healthwatch England to set up the communication and branding using the national branding guidelines and have a website with social media, leaflets and information banners. We have joined the Healthwatch England Advisory group looking into complaints and are working closely with the organisation SEAP (Support, empower, advocate and promote) to ensure we can signpost any complaints received through Healthwatch to them.

3.2 The Healthwatch governance is well on its way and the first two meetings of the Healthwatch Advisory group have taken place. The Advisory group will set the strategic agenda for Healthwatch and will include new volunteers.

3.3 Volunteer recruitment and induction has begun and volunteer training is being planned with enter and view training being set up for September.

3.4 During the implementation phase it has been important to engage with the emerging NHS structure as Healthwatch will only be effective in improving services from the point of the service user and communities if it is embedded in and engages

with individuals and communities at different levels and in different ways. We have met with NHS England, the NHS B&NES CCG, the Local Authority including Public Health and the NHS Trusts to establish a relationship where Healthwatch can influence commissioning at both a strategic level and commissioning plans for particular services.

3.5 Wellaware is the information and signposting service for Healthwatch, which is a new function within Healthwatch to provide a service to the public. We have been in discussion with other services so that we can build relationships and don't duplicate.

3.6 As a staff team we have been planning the engagement strategy which will allow us to reach individuals and communities including children, young people and adults who are seldom heard or seldom involved to hear their health and social care issues and concerns.

3.7 The Healthwatch B&NES launch event will be on 23rd September at Somerdale Lodge and Claire Pimm, a committee member from Healthwatch England, and Cllr Simon Allen, Chair of the Health and Wellbeing Board, will be joining us. The launch will give an update to stakeholders and volunteers. Using the media we will also be reaching out to alert the general public to Healthwatch Bath and North East Somerset and stressing that their views on health and social care underpin everything that Healthwatch Bath and North East Somerset does.

Contact person	Pat Foster, The Care Forum General Manager, Healthwatch B&NES
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board
MEETING DATE:	18th September 2013
TITLE:	Safeguarding Adults Annual Report 2012/13
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 updates Business Plan. The report (including the business plan) requires the approval of the Health and Wellbeing Board.

2 RECOMMENDATION

The Board is asked to agree that:

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

3 FINANCIAL IMPLICATIONS

3.1 None, however there are capacity issues caused by increased safeguarding 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; Overview & Scrutiny Panel (discussing on 20th 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	

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

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Section 1: Introduction

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

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

1.3 This annual report summarises the LSAB's activities that has taken place from April 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

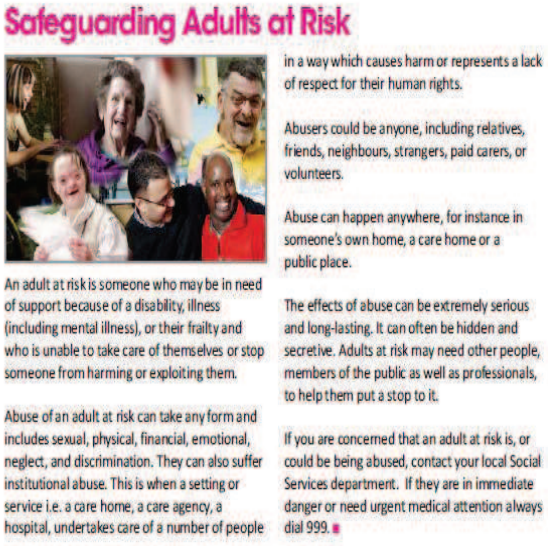
- Reviewed the Mental Capacity Act (MCA) and DOLS training programme offered to stakeholders by the Council for 2013-2014 and a new programme will be available with two new courses being offered.
- Provided bespoke training sessions on the MCA throughout the year for example two sessions at the RUH
- 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

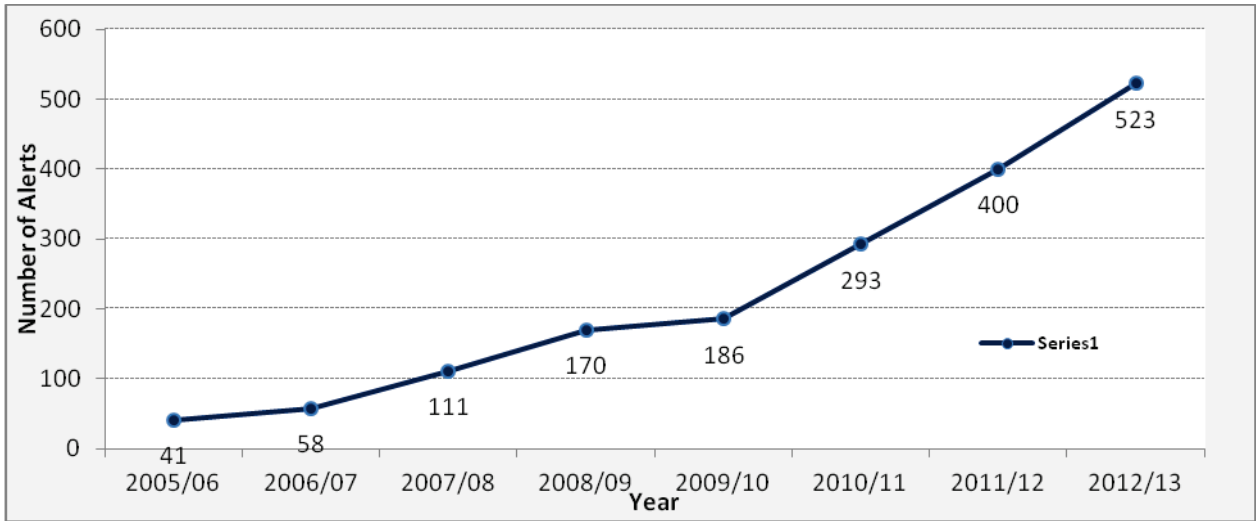
Section 6: Analysis of Safeguarding Case Activity (2012-13)

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.

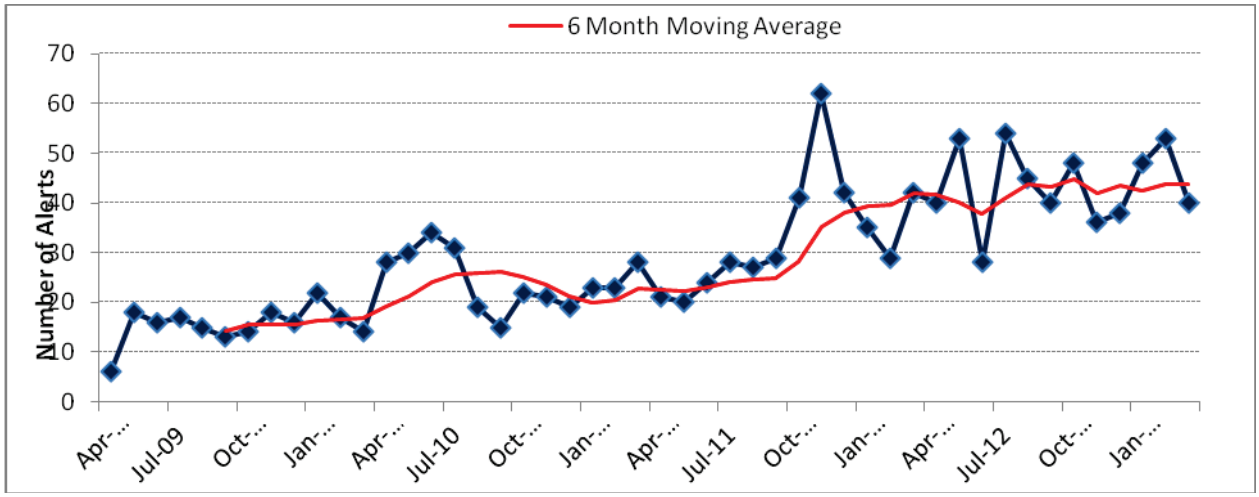
6.3 B&NES received 523 new alerts during 2012-13 and also supporting 51 service users through the safeguarding procedure who had been referred during the previous year. At the end if the March 2013, 110 cases remained open and 464 had been closed. This is a significant increase in the number of cases 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

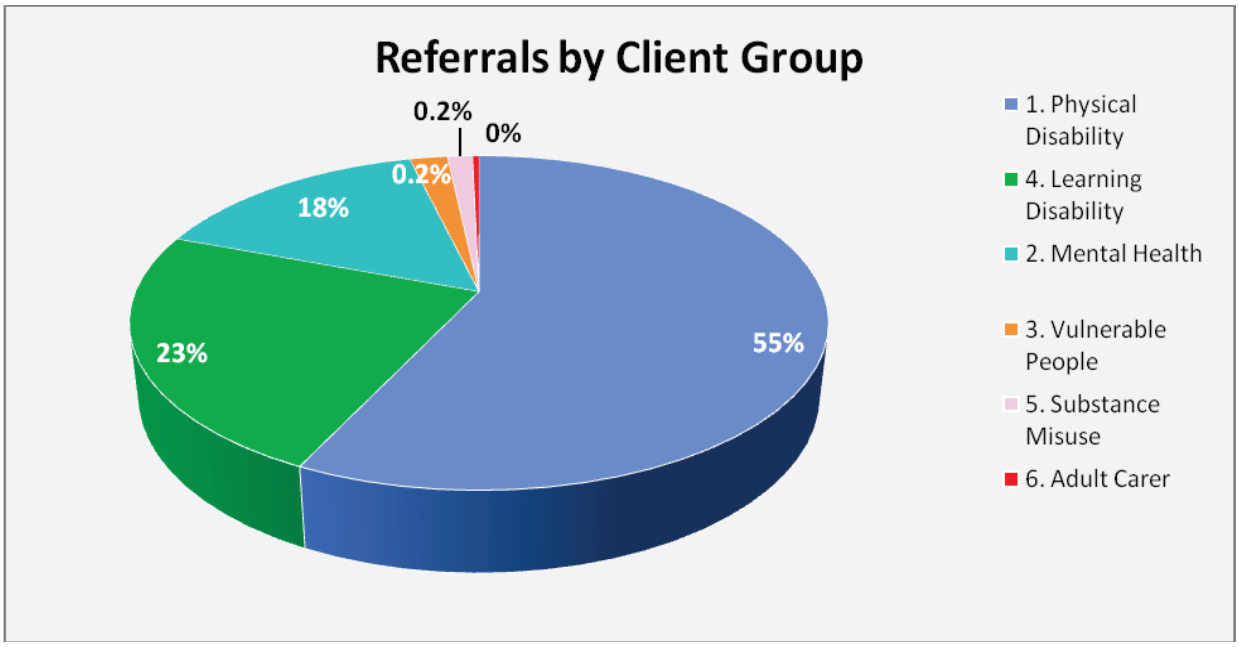
users were of non white British ethnicity. A full breakdown of alerts by gender, age and ethnicity for 2012-13 can be found in **Appendix 4**. The NHSIC reported that 89% of all referrals were for vulnerable adults belonging to the white ethnic group. (p17).

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



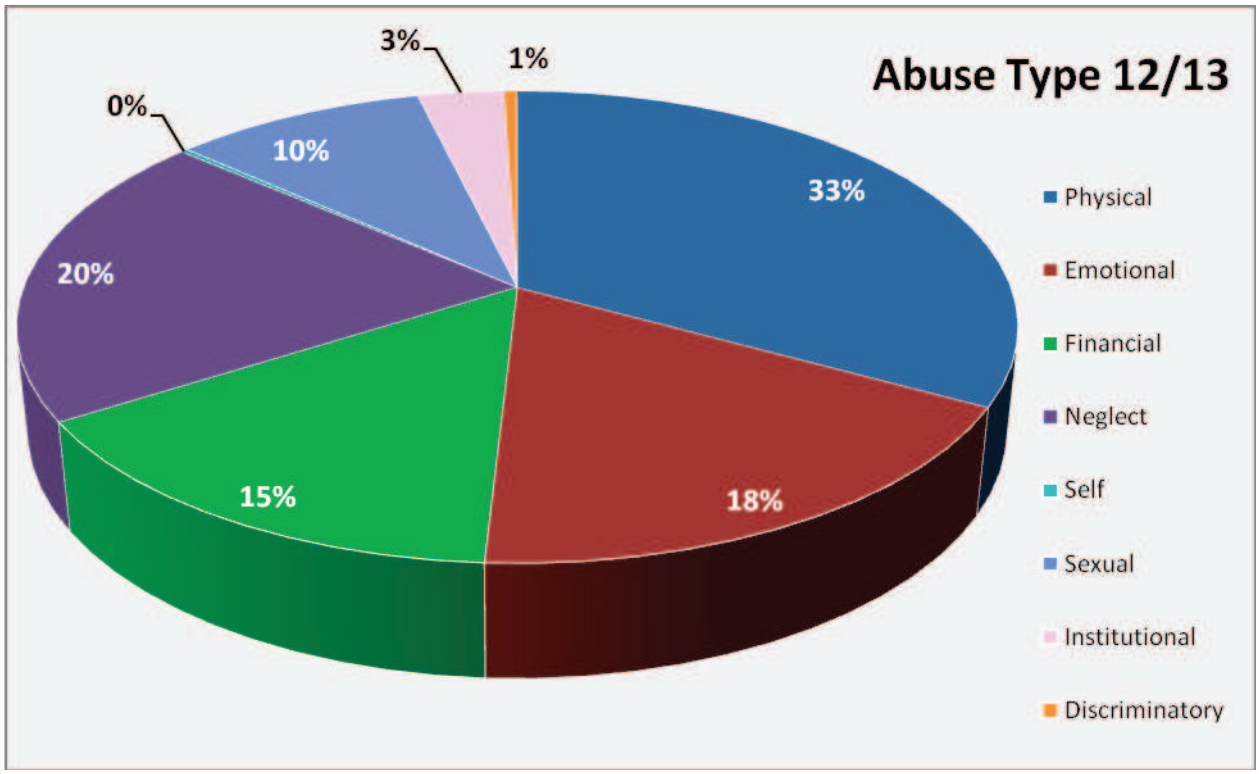
6.16 The data indicates a proportionate increase in the number of mental health referrals, this was predicted as the percentage increase in the actual number of mental health cases in 2011-12 (65) to 2012-13 (96) is a significant increase of 48% from 2011-12. When compared to NHSIC data the client group 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%

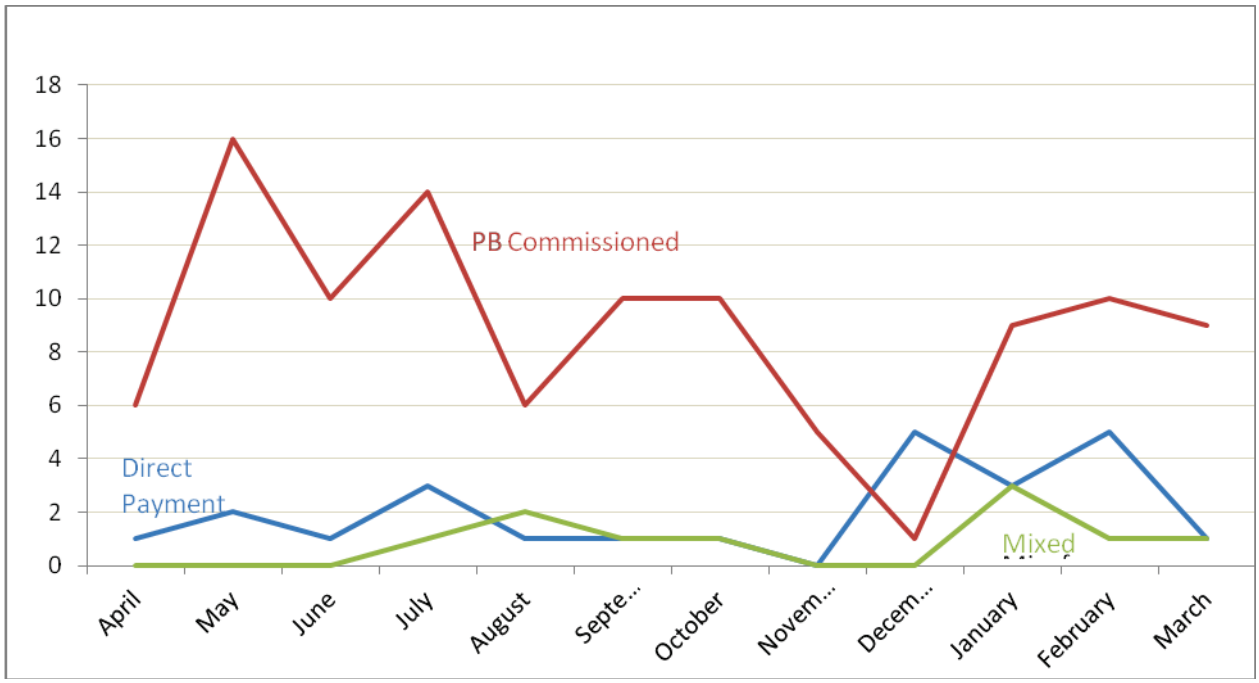
6.26 There has been a 5% increase in the police involvement in cases during the year. Three cases have resulted in criminal prosecutions, this is more reassuring as the figure dropped for 2011-12; 16 have required police action and two resulted in a referral to MAPPA for the perpetrators. Avon and Somerset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

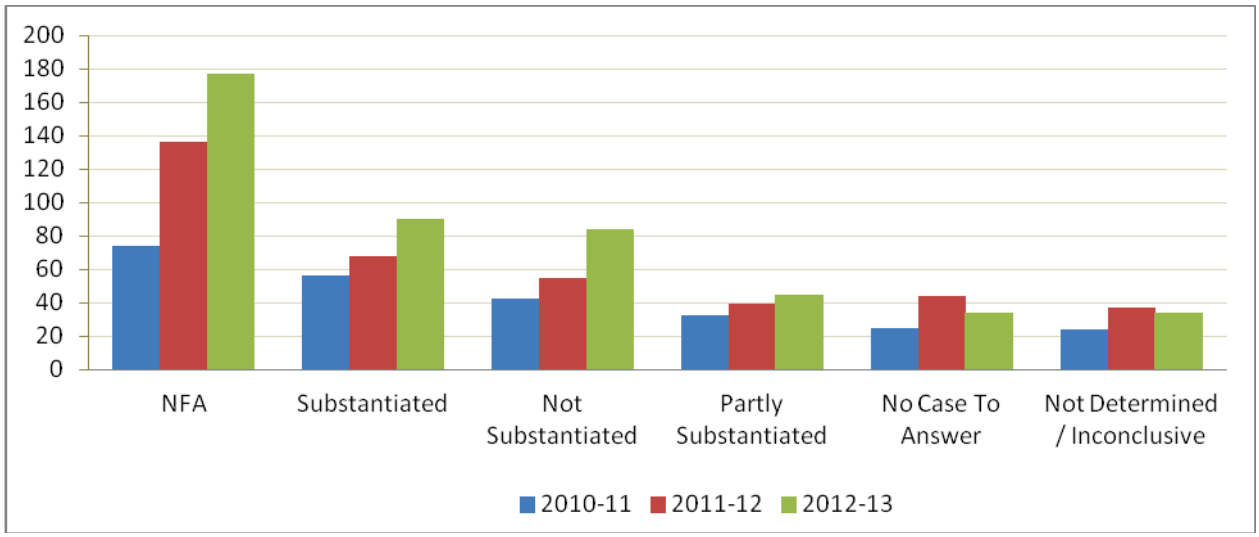
6.32 Table 8: Relationship of Victim with Alleged Perpetrator at Alert

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

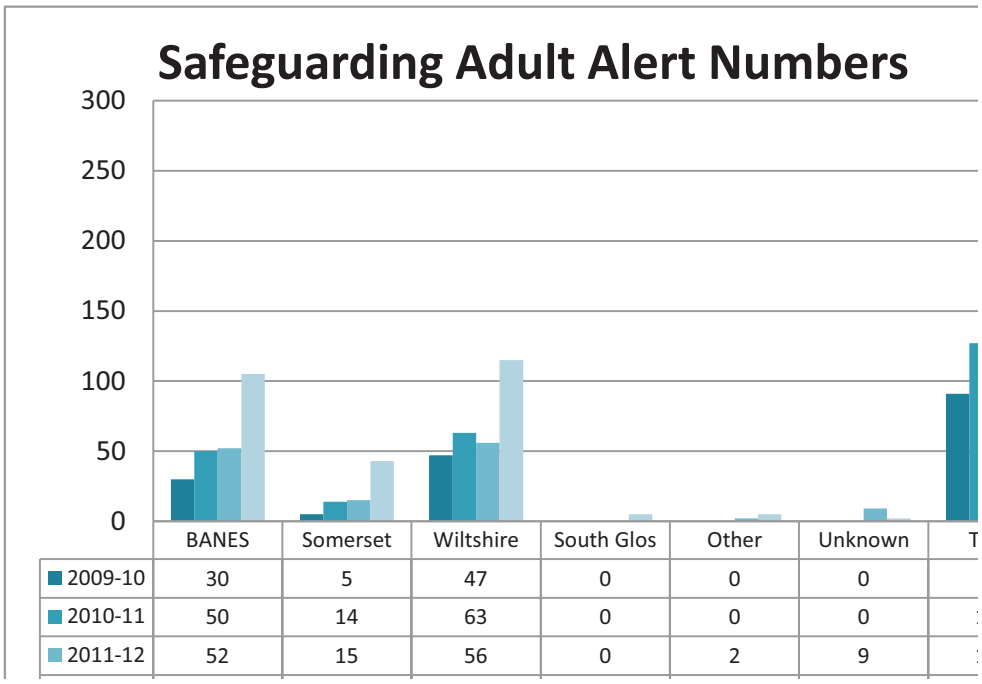
Brief outline of agency function:
Acute Care Provider

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

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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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