Annual Report 2018 – 2019

Executive Summary

Sept 2019

1. The Role of the Local Safeguarding Adults Board (LSAB)

B&NES LSAB is a statutory (though independent) Board established under the Care Act 2014. It is independently chaired and consists of senior representatives of all the principle stakeholders working together to safeguard adults with care and support needs across the area. All agencies involved in providing care and support for adults work together to respond in a coordinated way to cases of suspected harm or abuse of adults. We aim to ensure that people's rights are respected in the process of them being offered help and protection.

The Terms of Reference for the LSAB are available on the LSAB website:

LSAB Terms of Reference (June 2018)

The LSAB brings together local statutory and independent sector agencies working with adults with care and support needs at risk of abuse. The LSAB is responsible for ensuring that the Multi-Agency Safeguarding Adults Policy and Procedures are effective and prevent adults from experiencing significant harm.

The Board is committed to ensuring the following principles are practiced:

- 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

Safeguarding is everyone's business

2. The Work of the LSAB

The Board's statutory objectives as set out in the Care Act 2014 are:

a) To develop and publish an Annual Strategic Plan
b) To publish an Annual Report
c) To arrange Safeguarding Adult Reviews (SAR) for any cases which meet the criteria for these to promote effective learning and improvement action to prevent future deaths or serious harm occurring again.
d) Operational functions specified under Schedule 2 of the Care Act 2014

Functions of the Board
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

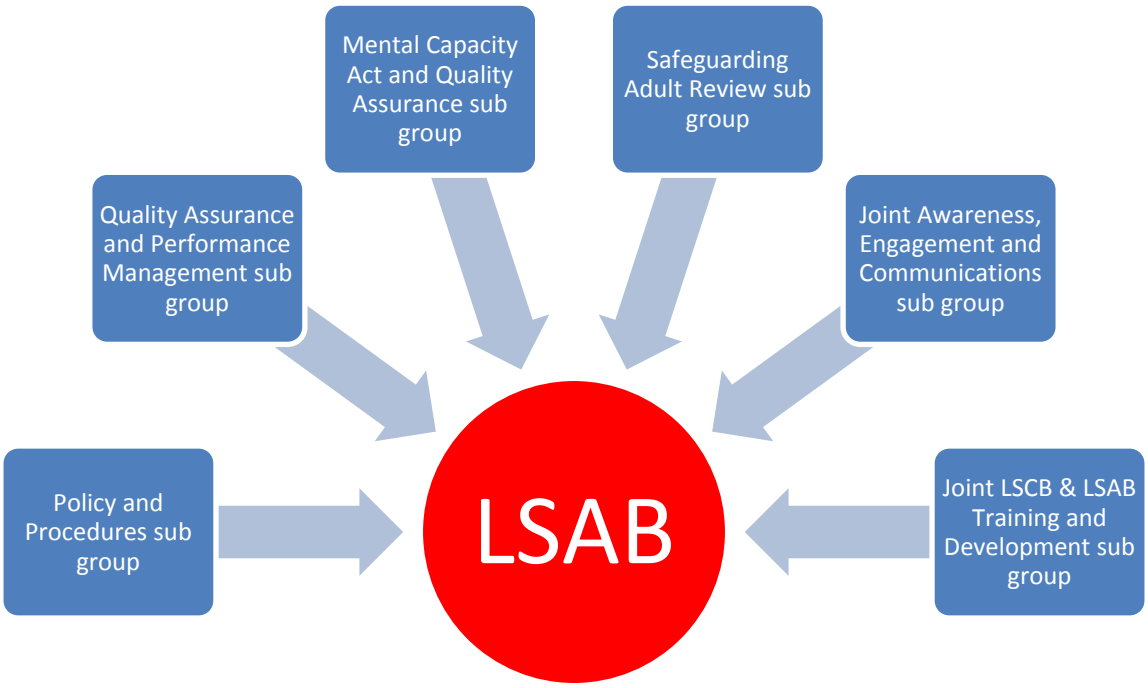
'everybody's business'

- Providing strategic leadership

3. The Sub-Groups of the LSAB

The LSAB has six sub groups as set out below. There is an Audit Group reporting directly into the Quality Assurance and Performance Management Group. The Terms of Reference for each of the sub-groups is available on the LSAB web page: add Audit Group

https://www.safeguarding-bathnes.org.uk/adults/local-safeguarding-adults-board/1-about-board



- Each sub group reports progress on the Board's Strategic Plan 2018-21 on a six monthly basis to the LSAB and contributes to the Chairs' Business Management Group quarterly meeting. Each sub group has a duty to challenge practice within the partnership where it identifies issues of concern.
- The full Annual Report 2018-19 lists the key achievements, challenges and priorities for each sub group in 2019- 20. The report is available on the LSAB Safeguarding website https://www.safeguarding-bathnes.org.uk/
- During 2018, the LSAB partners and Business Management Group developed a new Strategic Plan for 2018-21, this is more outcomes or impact focused and was finalised in June 2018 and then published on the safeguarding website. Sub Groups then report very six months to the Board on their progress on the Strategic Plan actions and the Year One progress is available below:

LSAB Strategic Plan Year One Summary - March 2019

The full version and one page version of the Strategic Plan are also available on the safeguarding website:

LSAB Strategic Plan 2018-21 on a page

LSAB Strategic Plan 2018-21

The new Plan has 5 key outcomes and 12 priorities in order to meet them.

Five Outcomes

- Prevention and early intervention responses are embedded across all partner agencies in order to reduce and, where possible , remove the risk and impact of abuse
- Adults at risk and carers are listened to throughout the safeguarding process. They contribute fully in the development of safeguarding services
- The LSAB is assured that safeguarding is embedded, is delivered to a high standard and is effective across all partner agencies
- A workforce which is skilled, competent and confident in all aspects of safeguarding
- The LSAB is responsive to national changes in practice and legislation and to any changes to the role of the LSCB

4. Outcomes and Safeguarding Activity

- The LSAB have completed three SARs during the period; two have been approved at an extraordinary LSAB in January 2018 where the LSAB agreed not to publish one report at the request of the adult concerned and SAR John was be published in the summer of 2018 as part of the learning on self-neglect along with a revised Self Neglect Policy. The third SAR, SAR Jane, was approved at an extraordinary meeting in October 2018 by the LSAB and published in March 2019.
  The LSAB has collated a master SAR Action Plan in relation to the recommendations from all three SARS into self-neglect and this is monitored regularly by the SAR sub group. Recommendations include:

  - On safeguarding policies and procedures - Revised Self Neglect Policy, simplified guide to Policy; improved dissemination and monitoring of policy impact; provision of self-neglect training;
  - On Making Safeguarding Personal – improve training; on Mental Capacity – undertake audits, develop understanding and knowledge;

- On Assessments and Multi-agency working; on commissioning and on embedding the learning – one year on event etc.

Full information about the SARs in B&NES can be found on the website: https://www.safeguarding-bathnes.org.uk/adults/local-safeguarding-adults-board

Individual Reports and the Board response:
Full Report - SAR John
Board Response
Full Report - SAR Jane
Board Response

The LSAB is also participating in a joint Domestic Homicide Review/SAR with the Responsible Authorities Group this will need Home Office approval before publication but again is hoped to be completed by the end of 2019. Finally another application for a SAR was received but this did not meet the criteria.

- During the reporting period 2018/19 B&NES received 1,150 safeguarding concerns (alerts/referrals).
- Of these concerns, 325 resulted in support being provided through the safeguarding process.
- 72% of all concerns raised did not require a safeguarding response and were either supported through: the provision of information and advice; a social care assessment; action taken by the Council's contracts and commissioning teams or support from another agency.
- 72% of people fully or partially obtained the outcome they had identified as wanting from the safeguarding process.
- In the Board's 17/18 report it was noted that further work has been done to support providers to identify matters that should be raised with safeguarding. It was noted that this led to a fall in the number of concerns referred by providers in the last few months of that year. That trend continued into 2018/19 with providers now referring less concerns and being clearer what matters should be raised as a safeguarding concern.

Safeguarding Concerns by Primary Support Reason

- In 2018/19 there was an increase in the number of people, being referred to safeguarding, with Physical Disability and Learning Disability as their Primary Support reason. Social Support is used for people that may be experiencing drug or alcohol related issues.

Number of Individuals involved in Concerns by Primary Support Reason

Year	Physical Disability	Sensory Support	Support with Memory and Cognition	Learning Disability	Mental Health	Social Support	No support reason	Not Known
16/17	496 42%	24 2%	101 8%	201 17%	161 13%	85 7%	118 10%	6 0.5%
17/18	320 40%	16 2%	125 16%	102 13%	131 16%	91 11%	13 2%	0
18/19	428 49%	17 2%	105 12%	149 17%	96 11%	79 9%	0	0

- There has also been a decrease in the percentage of concerns received relating to people with a Memory Loss and Cognition and Mental Health. This decrease has been raised with the local Mental Health Provider and some additional training is being provided to ensure that safeguarding concerns are raised appropriately and in a timely way.

Percentage of Concluded Enquiries by Abuse Types

Abuse Type	SAR National 2017/18	B&NES 17/18	B&NES 18/19
Physical	**22.2%**	**27%**	**19%**
Sexual	**4.3%**	**6%**	**4%**
Psychological	**13.1%**	**18%**	**22%**
Financial or Material	**14.6%**	**15%**	**15%**
Discriminatory	**0.6%**	**0**	**1%**
Organisational	**4.2%**	**0**	**4%**
Neglect and Acts of Omission	**32.1%**	**22%**	**27%**
Domestic abuse	**4.1%**	**6%**	**5%**
Sexual Exploitation	**0.6%**	**1%**	**1%**
Modern Slavery	**0.2%**	**0**	**0**
Self-Neglect	**4.2%**	**4%**	**1%**

- The figures for 18/19 show an increase in the numbers of enquiries that identified concerns relating to Psychological abuse as well as regarding Neglect and Acts of Omission, in comparison with last year's figures. There is a decrease in concerns related to Physical abuse.
- Last year it was noted that work was needed in regard to discriminatory and organisational abuse require further investigation. It is therefore positive to see that we do now have a level of reporting, albeit small, for these forms of abuse.
- For the second year there are no instances of Modern Slavery recorded in the B&NES data. Assurance has been obtained from the safeguarding teams in key

organisations are that they are aware of the indicators of Modern Slavery and do consider these when undertaking enquiries.

Reported Setting of Alleged Abuse

- The decrease in the number of safeguarding enquiries where the alleged abuse had taken place in the service user's own home, noted in previous reports has continued this year. (44% in 15/16, 37% 16/17, 35% in 17/18, 26% in 18/19).
- It is recommended that the Board considers undertaking some work to ensure that organisations that work with people in the community are aware of safeguarding and how to report them.
- The percentages of enquiries regarding alleged abuse in residential/nursing care homes have decreased in comparison with last year. It is however only slightly higher than the reported England National average for 17/18. The lack of enquiries in Mental Health units and Community Hospitals remains an area where further assurance is required to confirm that safeguarding concerns are being reported appropriately as this remains an areas of concern.
- There has been an increase in the percentage of situations being defined as other – from 5.5% in 17/18 to 20% in 18/19. These situations could include abuse that takes place on the street or in public places, including that experienced by people who are street homeless. This increase reflects the number of people who are street homeless who are being supported through the safeguarding process.

	SA National Average 2017/18	B&NES 2017/18	B&NES 2018/19
Own Home	40%	35%	26%
Community	3%	0.6%	0%
Community Service	4%	4.3%	7%
Nursing Home	17%	21%	12%
Residential Care Home	23%	30%	30%
Hospital - Acute	3%	3%	6%
Hospital - MH	3%	0	0
Community Hospital	2%	0.6%	0
Other	6. %	5.5%	20%

Compliance with Local Safeguarding Procedural Timescales

- Compliance with safeguarding procedural timescales continues to be monitored on a monthly basis by the Council as the Commissioner of safeguarding support from AWP and Virgin care. The LSAB, CCG Board and Council Corporate Performance Team also receive regular performance reports.
- Performance on timescales has improved significantly in 2018/19. It does, however, remain below the Safeguarding Boards expected standards. Performance is discussed at bi monthly meetings with all the key agencies..

Concerns regarding performance have been discussed at the LSAB Quality Assurance Group and shared with the Board.

- Reporting has been improved to also provide information relating to the reasons for delays in timescales being met. It is anticipated that next year's reporting will provide the overall performance and then additional information regarding the reason for the delay. This will support the Board's understanding of why decisions or meetings are being delayed and if further action is required. Initial reporting of this data suggests that there is a level of delay due to other agencies/ professionals or the person themselves not being able to make a meeting within the time frame. The performance data provided below for the key agencies includes delays that are attributable to others and therefore does not provide a clear picture of the number of delays that are really attributable to them.

Performance in Relation to Multi-Agency Procedural Timescales

Indicator	**Target**	**% Completed on time from April 18 – Mar 19**	
1. % of decisions made in 4 working days from the time of referral	95%	Virgin care	88%
		AWP	85%
		SDAS	85%
		Overall	**87%**
2a. % Planning Meetings/Discussions within 10 working days	90%	Virgin care	78%
		AWP	69%
		SDAS	67%
		Overall	**75%**
2b. % of enquiry reports provided to the Chair 5 days before the first review.	100%		Available timescales are set for all review meetings to be held 5 days after a S42 is completed. Therefore the reporting is focused on how many enquiry reports are received 5 days before the meeting, less than 5 days or not received before the meeting.

For further analysis of the safeguarding activity undertaken in 2018-19 please see the full Annual Report on the LSAB website at:

https://www.safeguarding-bathnes.org.uk/adults/local-safeguarding-adults-board/2-annual-report-and-strategic-plan

5. Outcomes for the LSAB

During 2018 and 2019 the LSAB has also:

a) Continued to work closely with the two Lay Members who give a unique, independent and valuable perspective on safeguarding adults with care and support needs. Their work can positively influence the decisions of the Board. So far the Lay Members have given the Board some very effective challenge and are actively engaged in the work of three sub groups, have taken part in the QA of LSAB Partner Reports and are keen to be involved in more.

b) Further strengthened joint working arrangements between the LSAB and the Local Safeguarding Children's Board (LSCB) which are now embedded in each Strategic Plan and the continued work of the joint Communications sub-group and joint training & development sub group.

c) Developed a new Risk Register for 2018-21, identifying risks for the LSAB, and finalised a new Board Assurance Framework.

d) Continued to update and revise a range of key policies and guidance to ensure that the Board continues to be informed through documents that remain up to date and relevant to emerging priorities. In the past twelve months the Board has endorsed and revised a range of documents some of which include:
B&NES LSAB Multi-Agency Safeguarding Adults Procedures (September 2018)
B&NES LSAB MA Safeguarding Adults Procedures Flowchart - One Page (September 2018)
Adult Exploitation Statement (September 2018)
LSAB and LSCB Exploitation and County Lines Briefing (January 2019)
Multi Agency Safeguarding Adults Consent Policy (June 2018)
Multi Agency Information Sharing Protocol (June 2018)
LSAB Multi Agency Prevention Strategy (December 2018)
Safeguarding Adults Review Policy (Amended September 2018)

e) Continued our programme of multi-agency audits within the Quality Assurance, and Performance Management Group and the Audit sub group which take a themed focus and cases are be debated by the core statutory partners as set out in the Care Act 2014. Learning is then shared with managers.

f) Completed and published the third Safeguarding Adult Review (SAR) on self-neglect. Commissioned a new SAR, which is expected to go to the LSAB in September for approval. The LSAB is also participating with the Responsible Authorities Group on a joint Domestic Homicide Review (DHR)/SAR, it requires Home Office approval before publication but is

hoped to be completed later in 2019.

g) Robert Lake unfortunately had to retire in January 2019 as the Independent Chair due to health issues and Val Janson, the Director of Public Health who was the Deputy Chair has stepped up to chair the LSAB in the interim.

h) Safeguarding Training we delivered:

i) The LSAB inter-agency training programme provided across 2017 – 2018 resulted in:

- 34 training sessions taking place which compromised of 6 different training topics.
- 920 Inter-agency training places made available
- 587 Inter-agency training places booked
- 496 Inter-agency training places attended
- 411 professionals trained
- On average over 90% completed evaluations and these are demonstrating impact.
- 99 Professionals attended LSAB Stakeholder Day on Self -Neglect

- The LSAB faces a number of current and future challenges/areas for development:

a) In accordance with other LSABs the resourcing and financing of the Board remains tight and pressured. All partner agencies experience similar pressures on funding, and organisational change creates the potential for additional pressures. This will require ongoing monitoring and management.

b) Working across boundaries in collaboration with other agencies and LSABs to develop a policy responding to Allegations against People in Positions of Trust.

c) Liaising with the LSCB and statutory partners BaNES NHS CGG and Avon and Somerset Constabulary about the development of their new safeguarding arrangements to replace the LSCB from 29 September 2019 in line with Working Together 2018 and the new Statutory Guidance. The overarching view is that the new arrangements should be 'placed based' and focus on B&NES but look to inter agency working across the police area and CCG area looking towards Wiltshire and Swindon. Local plans for the new safeguarding arrangements in B&NES have to be published by 29 June 2019. The LSCB and LSAB may choose to work together as one Partnership.

6. Making Safeguarding Personal

- Since 2016 local authorities have been asked to report on Making Safeguarding Personal outcomes. Information is requested on the number of

people who had been through the safeguarding process, who had been asked what outcomes they wanted from the safeguarding process and if at the conclusion these had been achieved. The reporting in this area was initially voluntary and therefore was not publised in the national reporting. However the SAC 2018 does contain this information, so we are able to look at our performance in comparison with the all England average for the first time this year.

Desired outcomes requested from the individual or their representative and whether these were achieved

Was the individual asked?	National Reporting 17/18	B&NES 17/18	B&NES 18/19
Yes and outcomes expressed	70%	62%	72%
Yes but no outcomes expressed	12.5%	9%	-
No	9.7%	10%	9%
Don't Know	2.4%	8%	18%
Not recorded	5.3%	9%	1%
Where outcomes where expressed were they			
Fully achieved	62.3%	66%	57%
Partially Achieved	29%	30%	41%
Not Achieved	8.5%	4%	2%

- This year's data shows an increase in the percentage of people whose outcomes were asked and expressed. The number of not recorded has decreased which suggests that data reporting has increased.

- The achievement of outcomes where expressed shows a decrease in fully achieved and an increase in partially achieved.

Other MSP work includes:

- A review of all the safeguarding Factsheets including the Easy Read Factsheet is underway and they will be published later in 2019.has been developed by the
- From April 2017 the Council's Safeguarding and Quality Assurance Team contacted a few people every month to obtain their views of their safeguarding process by asking a range of questions during face to face discussions at the end of the safeguarding process. The number undertaken may vary dependent on whether the individual or their representative agrees to the discussion. The annual report of these interviews for 2017-18 was analysed by the Awareness, Engagement and Communications sub group in autumn 2018. 7 of the 21 service

users contacted agreed to be interviewed. Although this figure seems low, other authorities using this approach have reported a similar level of take up.

- The Communications group were disappointed that none of the respondents had been offered the easy read factsheets about the safeguarding process and requested that these were updated and their use encouraged. This action is being progressed currently.
- One respondent felt that the issue had been over dealt with and safeguarding was not necessary. They did, however, acknowledge that they had not realised that issues of poor care were so important.
- Five of the respondents reported that the safeguarding process had been positive and had taken into account their views and wises. One person stated "I am happy and reassured that there is a Safeguarding Team working for the council ….I never knew such a team existed."

- The Communications group will analyse the 2018-19 report later this year.

7. Independent Chair's Closing Summary

The key purpose of the Annual Report is to assess the impact of the work the Board has undertaken to ensure that safeguarding outcomes for vulnerable adults in Bath and North East Somerset are the best they can be. I hope this Executive Summary demonstrates that Bath and North East Somerset safeguarding Adult's Board are steadfast, hardworking and are not afraid to challenge ourselves and our local practice in order to seek better outcomes.Due to unforeseen circumstances our committed and dedicated Chair, Robert Lake resigned from our Board in January 2019. On behalf of all of those involved in or receiving safeguarding services in Bath and North East Somerset, a very big thank you to Robert for all his hard work since taking on the role as Chair in October 2017. As Deputy Chair I have had the privilege of taking over the interim position of Chair of the LSAB and I would like to thank members of the Board, the subgroups and staff from all sectors who do their utmost every day to keep people as safe as possible.

As you will see in the Report much has been achieved in the past year which demonstrates the ongoing commitment and support that agencies place on adult safeguarding. The six sub groups of the Board have a robust and stretching work programme and they hold each other to account at our quarterly business management meetings as well as at the Board.

The Board reviewed the Strategic Plan and agreed priorities for action.

The Board oversaw progress of 3 safeguarding adults reviews, 3 of the reports were approved, and 1was published in the summer of 2018 (1 wasn't published at the

request of an individual) and the 3rd published in March 2019. These all related to self-neglect and we have had a detailed multi-agency action plan which has led to improvements in how agencies work alone and together. Learning events have been held, the self-neglect policy re-written and the implementation of this evaluated.

We developed a new risk register for 2018-2021 and finalised a new Board Assurance Framework. In the past year we have reviewed and approved a range of policies and documents.

Key changes have been made to the ways in which we will work together going forward in Bath and North East Somerset. From September 2019, we are merging the Adults Safeguarding Board, the Children's Safeguarding Board and the Community Safety

Partnership; this is an exciting and innovative model which will enhance the joint working across agencies and with people living in Bath and North East Somerset.

I trust that you have found this Executive Summary informative and readable and I hope it encourages you to at least dip into the full Annual Report. If you have any comments you would wish to raise with me, I can be contacted on vjanson@nhs.net

Thank you