Annual Report 2018 – 2019

and

Strategic Plan 2018 - 2021


NHS
England


DEVELOPING HEALTH & INDEPENDENCE
DHI


AVON & SOMERSET
CONSTABULARY


Bristol
Gloucestershire
Somerset
& Wiltshire
Community Rehabilitation Company
PROBATION
Operated by Working Links


bridge care
SUPPORTING OLDER PEOPLE


curo


Bath & North East
Somerset Council


AVON
FIRE & RESCUE


virgincare


carewatch
BATH
supporting independence


HM Prison &
Probation Service


healthwatch
Bath and North East
Somerset


Julian House
The home of opportunity


Avon and Wiltshire
NHS
Mental Health Partnership NHS Trust

Carers' Centre
Bath and North East Somerset

Bath College

NHS
South Western Ambulance Service
NHS Foundation Trust

NHS
Bath and North East Somerset
Clinical Commissioning Group

Royal United Hospitals Bath NHS
NHS Foundation Trust

Chair's Foreword

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.

In 2018-19 no Development Sessions took place. A joint Development Session with both the LSCB and LSAB took take place in May 2019 to discuss the new safeguarding arrangements proposed by the safeguarding partners (B&NES Council, Avon & Somerset Police and the BaNES NHS CCG). It was not possible to progress this earlier in 2018-19.
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 1 was 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 Responsible Authorities Group (RAG), known as the Community Safety Partnership in other areas; 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.

Thank you

Val Janson, Interim Independent Chair

B&NES Local Safeguarding Adults Board

Executive Summary

The LSAB has agreed an Executive Summary of the full 2018-19 Annual Report. This has been published as a separate document covering the following areas:

- The role of the LSAB
- The Sub-Groups of the LSAB
- Outcomes and safeguarding activity
- Making Safeguarding Personal

The Executive summary is available on the LSAB website:

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

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Section 1: Local Context for B&NES 2018-19

1.1 Bath and North East Somerset (B&NES) is a Unitary Authority with 188,678 residents. According to the 2017 ONS Mid-Year Population Estimates 16.7% (31,489) of the population are 15 years or under, and 6% (11,444) are 16 - 19 year olds. B&NES has two campus based universities in the Local Authority area which effects the 18-24 population.

1.2 The area has a predominantly White and White British ethnic population, with 95% defining themselves as such. The largest minority ethnic groups in the area are those who define themselves as mixed heritage (2%) and Black (1%). 9.6% of children under 18 are from BME communities.

1.3 Bath is the largest urban settlement in the area, acting as the commercial and recreational centre. It is home to approximately 50% of the population and is one of the few cities in the world to be named a UNESCO World Heritage Site. Keynsham lies to the west of Bath, a traditional market town with a population of almost 9% of the total population of B&NES. Midsomer Norton and Norton Radstock are small historic market towns, located in the south of the area with approximately 6% of the total population split between them. They both have a strong heritage of mining and industry stemming from the North Somerset Coalfield. The rest of the district consists of 69 diverse rural communities of varying sizes and characteristics, including a line of villages along the foothills of the Mendips, the Chew Valley and Cotswolds villages around Bath.

1.4 The area has a mix of affluent and deprived areas, with five small areas being in the most deprived 20% nationally according to the 2015 Indices of Deprivation. Nationally, Child Poverty is increasing, though we have no current reliable data on this locally.

1.5 As at 31st March 2019 (snapshot) the number of people receiving long term support was:

18 to 64:	883
65 & over:	1168

1.6 The number of people who received long term support during the year 2018/19:

18 to 64:	1013
65 & over:	1644

Section 2: Background

2.1 Safeguarding adults has continued to maintain a high profile during this period locally, regionally and nationally, both in terms of Government initiatives and in the media.

2.2 This report covers the fourth year of implementation of the Care Act 2014, the duties outlined in the Act and Chapter 14 (Safeguarding) of the *Care and support statutory guidance* (Department of Health, March 2016 revised from 2014 version).

2.3 The Act introduced statutory duties for adult safeguarding. These include duties on the Local Authority (LA) to:

- make safeguarding enquiries or cause them to be made
- establish a Safeguarding Adults Board in their area that contains as a minimum representatives from the local authority, Clinical Commissioning Group and the Police.

2.4 There are also duties for the Safeguarding Adults Board which includes:

- arranging for Safeguarding Adult Reviews (SARs) to be undertaken
- the publication of an annual report and strategic plan.

2.5 **Who do the safeguarding duties apply to?**

The term vulnerable adult is no longer used in adult safeguarding, instead LA's are asked to apply their duty to make safeguarding enquiries for an adult who:

- *has needs for care and support (whether or not the local authority is meeting any of those needs) and;*
- *is experiencing, or at risk of, abuse or neglect; and*
- *as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.*
  (Care and support statutory guidance 2016, 14.2)

2.6 **What is abuse?**

The following abuse types are included within the Statutory Guidance (section 14.6); financial, psychological, sexual, physical, discriminatory, neglect or acts of omission, organisational, modern slavery, domestic violence and self-neglect. LA's are required to consider these areas under their safeguarding responsibilities; whilst radicalisation is not listed in this section it also constitutes abuse when the person fits the criteria outlined in 2.5 and is at risk of radicalisation and the Guidance reminds us that whilst they include a list of areas the LA must not be limited by these.

2.7 **Where does abuse happen?**

Abuse can happen anywhere, in someone's own home, in a public place, in a care home, in community care or in a hospital. Abusers or 'perpetrators' are often already known by the adult at risk. The person responsible for abuse can be a paid worker, another service user, a family member, a friend, a group or a stranger. An organisation can also be responsible.

2.8 **What does Safeguarding mean?**

Adult safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances. (Care and support statutory guidance 2016, 14.7)

2.9 **Six Key Principles of Adult Safeguarding**

The Guidance describes six key principles of safeguarding. These principles are supported by "I" statements that describe how this principle should be experienced by the adult being supported by safeguarding.

Empowerment - People being supported and encouraged to make their own decisions and informed consent.
I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.

Prevention - It is better to take action before harm occurs.
I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.

Proportionality - The least intrusive response appropriate to the risk presented.
I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.

Protection - Support and representation for those in greatest need.
I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.

Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.

Accountability - Accountability and transparency in delivering safeguarding.
I understand the role of everyone involved in my life and so do they.

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

3.1 The ***Care Act 2014*** was implemented from the 1st April 2015 and B&NES have had new arrangements in place since then to ensure compliance. The Care Act statutory guidance has been updated several times however none of these relate directly to safeguarding arrangements. Work is abreast to clarify when a section 42 enquiry is recorded as such and all Local Authorities will be asked to put this in place during 2019/20.

3.2 The Mental Capacity (Amendment) Act received Royal Assent on the 16th May 2019 following various iterations of the Bill being discussed in 2018/19. We await the accompanying statutory guidance and will provide the detail in the 2019/20 Annual Report and consider the potential impact on the Act for adults at risk and agencies working with the adults.

3.3 In July 2018 the Home Secretary announced the Modern Slavery Act 2015 would be reviewed. In May 2019 the review was published: *Independent review of the Modern Slavery Act* and the Government's response in July 2019. Details of this will be provided in the next reporting period. The Home Office published information for organisation's to help them produce a modern slavery statement.

3.5 There have also been a number of other publications which are aimed at supporting agencies, of note are the following:

- *Safeguarding in general dental practice: a toolkit for dental teams* was published on 3rd April 2019 by Public Health England. The document reinforces the importance of safeguarding in dental teams and helps clarify roles and responsibilities, signposting to other resources and guidance on pathways to report concerns and training requirements.
- In December 2018 the Home Office published *Individuals referred to and supported through the Prevent Programme, April 2017 to March 2018*. Nationally there were 7,318 individuals referred who concerns were raised that they were vulnerable to being drawn into terrorism. 57% were aged 20 years and under the remaining 43% being over 20 years. Approximately 7% of those referred were over 20 years and were discussed at Channel panel. The majority of whom were from London and the West Midlands region.
- On 5th October 2018 the Home Office published guidance on *Domestic abuse: how to get help*. They also published a series of promotional materials in relation to Female Genital Mutilation.

- Finally in January 2019 the Home Office published *Response to an inspection report on Home Office's approach to identifying and safeguarding vulnerable adults*. This sets out what the Border Force are doing in relation to improvement recommendations made from its last inspection to identify and protect vulnerable adults.

- In November 2018 the Association of Directors of Adult Social Services (ADASS) produced an advice not relating to the commissioning of out of area care and support. This advice note highlights the importance of the commissioning and the host authority in relation to sharing information on safeguarding concerns. In October 2018 they also produced guidance on the role of the Safeguarding Adult Board chair including the functions of the role, knowledge and skills.

- In July 2018 ADASS published *Making Safeguarding Personal Outcomes Framework and Report.* LSAB's are recommended to use this Framework as it will help enable SAB's to understand what difference they are making in keeping people safe.

3.6 The *Safeguarding Adult Annual report 2017-18, England* was published in November 2018 setting out key findings from the Safeguarding Adult Return (SAR) data collection provided by all local authorities to help benchmark B&NES data and performance. The information from this report is referred to in section 7 of this Annual Report.

Section 4: Governance and Accountability

4.1 B&NES LSAB is a statutory body established under the Care Act 2014. It is independently chaired and consists of senior representatives of all the principal stakeholders working together to safeguard adults with care and support needs across the area. The Terms of Reference are available on the LSAB website: LSAB Terms of Reference (June 2018)

The membership for the LSAB and sub-groups during 2018 - 19 is set out in Appendix 2.

4.2 B&NES Council is responsible for establishing the LSAB. The accountability of the LSAB and performance of the Independent Chair is delivered via a two stage process. The Annual Report is considered by a Scrutiny Panel made up of Chief Executives of member agencies and including the lead Local Authority Member for Adult Social Care and Health. This Panel convenes soon after publication of the Annual Report and will present challenges to the Chair regarding the effectiveness of the LSAB. In stage two, B&NES coordinates a 360 degree appraisal of the performance of the Independent Chair. Contributors to this process include all representative members of the LSAB. The appraisal includes a commentary from the Chair of the Scrutiny Panel at Stage 1. The process is completed at a meeting between the Independent Chair and LA Chief Executive at which performance and

development goals are set for the following 12 months.

4.3 The Board's statutory objectives as set out in the Care Act 2014 are noted in section 2 and 3 above, its operational functions are specified under Schedule 2 of the Care Act 2014; these are included within the Terms of Reference.

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

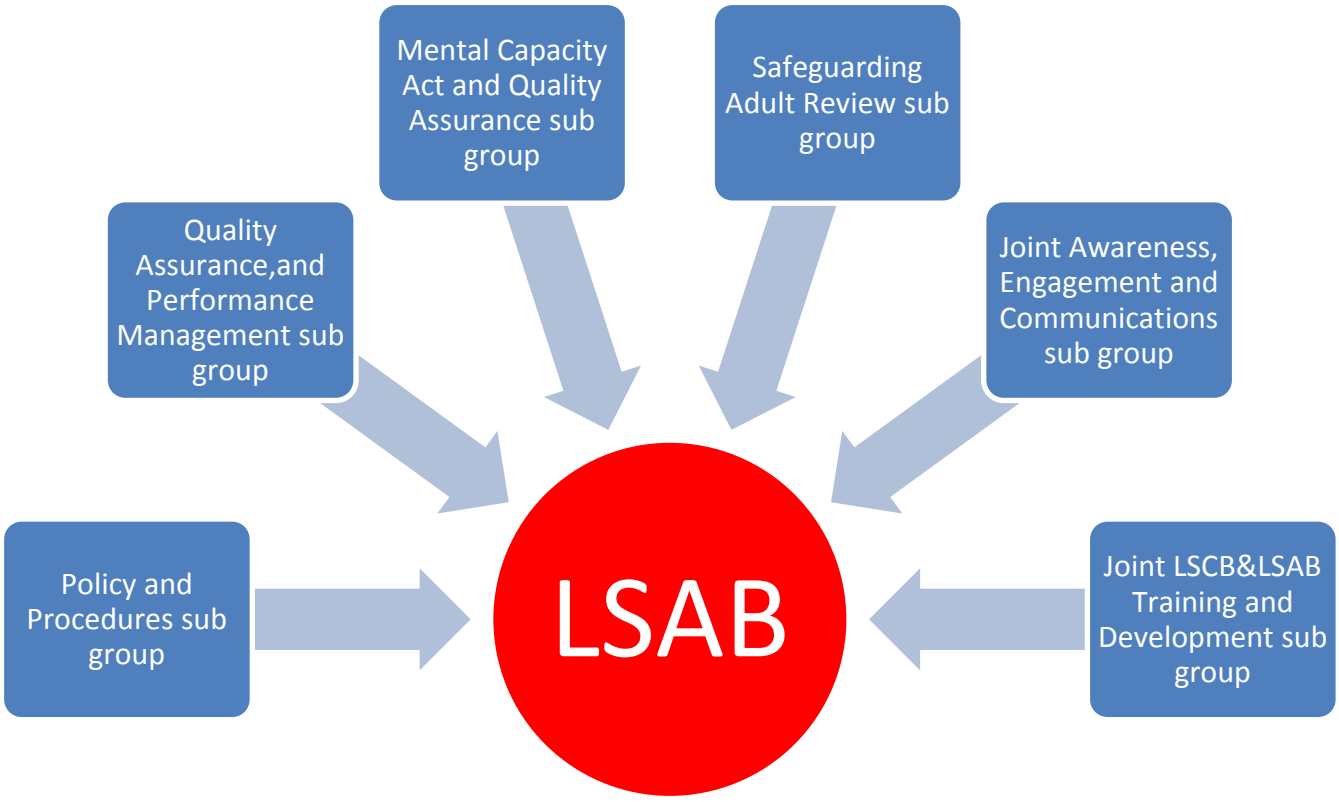
- Safeguarding is everybody's business and the Board will work together to prevent and minimise abuse as doing nothing is not an option
- Everyone has the right to live their life free from violence, fear and abuse
- All adults have the right to be protected from harm and exploitation
- All adults have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

4.5 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

4.6 The LSAB structure is set out below and the work of the sub-groups is explained further in Section 5 of the report.



4.7 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.

4.8 During the period covered by this report, the LSAB has 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. Their views can be found in Section 9.

4.9 The LSAB budget is monitored throughout the year and presented in the Annual Report in Appendix 3. The Board has a Memorandum of Understanding which all partners approved and signed in June 2017 and this includes reference to the contributions made by partner agencies both financially and in kind to ensure that the budget as well as participation and engagement are right for the needs of the LSAB.

4.10 In June 2018 the LSAB finalised a new Board Assurance Framework and in December 2018, the LSAB has approved a new Risk Register for 2018, identifying risks for the LSAB.

4.11 Escalation Policy for Resolving Professional Disagreement

Occasionally situations arise when practitioners/workers in one agency feel that the decision made by a worker from another agency on a child protection or child in need case is not a safe decision. During 2018-19 there have been three occasions reported to the LSCB & LSAB Business Support Manager when the LSAB Escalation Policy has been formally used. There were no recorded occasions in the previous year.

In 2018-19 the LSAB reviewed the Escalation Policy to be joint with the LSCB, relaunch it and reminded agencies, including through the self-neglect Stakeholder Event, of the need to use the Escalation Policy and Proforma to register escalation concerns regarding safeguarding decisions made by other practitioners.

Escalation Policy

- LSAB & LSCB Escalation Protocol (March 2019)
- Escalation Report Proforma (March 2019)

In 2016-17 the LSAB developed a Dispute Resolution Policy for use between Local Safeguarding Children/Adult Board Partners, Sub Group Members and With Other Boards; there is no record of this being used in 2018-19.

Dispute Resolution

- LSCB & LSAB Dispute Resolution Policy

Section 5: LSAB Sub Group Achievements and Priorities

The LSAB has six sub groups as set out in section 4.6 above. 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.

5.1 Awareness, Engagement & Communications sub group (AEC)

The Awareness, Engagement and Communications sub-group's purpose is to:

- To ensure that initiatives commissioned by the Board in relation to service user engagement, involvement and feedback are developed, implemented and evaluated on a regular basis

- To develop and disseminate a range of accessible information in a variety of formats to raise awareness about adult safeguarding, targeting citizens, professionals, service users and carers.
- To develop and oversee engagement, involvement and feedback with/ from carers on behalf of the Board
- To ensure that the LSAB partners and sub-groups are aware of the needs to promote awareness and that opportunities are taken to support the prevention of abuse.

Key achievements for 2018-19

1. The sub-group had a short hiatus during the summer whilst a new Chair was recruited, but has since resumed quarterly meetings and is receiving regular support and representation from a wide number of statutory and voluntary sector partners. We are pleased to continue to have lay representation on this group.
2. We have undertaken a year-long campaign around the themes of neglect and self-neglect, in line with the strategic priorities of the two local safeguarding boards. Best practice guidance and useful resources, including a practitioner briefing sharing learning from a safeguarding adult review undertaken in B&NES, have been shared widely with statutory and voluntary sector partners to raise awareness and understanding of this issue.
3. The sub-group continues its commitment to actively involving members of the public in its work. We have agreed an approach with the Youth Forum to capture the views of children and young people without them having to attend formal meetings, and are working with providers to capture some case study experiences of safeguarding from B&NES residents.
4. Sub-group members worked with safeguarding boards from across the West of England to co-ordinate messages during Stop Adult Abuse Week (June 2018) and provided a resource pack for local partners to engage. The topic of this year's campaign was Mate Crime.
5. The sub-group has promoted emerging safeguarding topics, including 'cuckooing' and county lines, to professionals and the public through the joint adults'/children's newsletter which the group produces and sends out twice a year.

Outcomes – What difference have achievements made?

1. Continued lay member involvement and support from the voluntary sector in the Joint AEC sub-group ensures scrutiny of the Boards' activities and strengthens the public voice.
2. The group's year-long campaign on neglect and self-neglect has supported the targeted training and workforce development that has been delivered to help increase awareness of this topic for both staff and the public.
3. We have continue to feel the benefits of operating a joint AEC group, with good attendance and support from partners organisations and consistency of messages out to both adult and children's services, evidenced by the contributions and response to the joint newsletters. These are now being shared more widely, including through internal communications within some of our largest NHS providers to ensure maximum reach. Improved scrutiny of the Board through supported lay member involvement.

Challenges faced in delivering the agenda

1. Recruitment of a new Chair to lead the work of the group.
2. Capacity of sub group members to complete the work identified.
3. Developing video resources to promote safeguarding issues to the public

Priorities for 2019-20

1. To increase awareness of safeguarding and continue to engage children, young people and adults in our work.
2. To continue the joint campaign around neglect and self-neglect; sharing new learning, best practice and opportunities for professional development as they emerge.
3. To successfully delivery the 2019 Stop Adult Abuse Week campaign, the topic of which is mental capacity, and to lead a day of engagement around mental capacity and self-neglect.
4. To promote safeguarding awareness and issues with the wider community.
5. To continue progressing the actions of both Boards' Strategic Plans.

5.2 Mental Capacity Act & Quality Assurance sub group (MCA&QA)

The MCA/DoLS Quality & Practice Sub Group is a multi-agency group that works to strengthen the partnerships inter agency relationships to support implementation of the MCA including the Safeguards in addition to providing assurances around governance and quality, sharing practice and improving DoLS compliance. As part of this work the group has shared best practice and tools that are used to ensure that health and social care provider agencies across B&NES fully apply the Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards).

The sub-group supports the aim to embed rights and responsibilities of the MCA in mainstream work. The key message is that the MCA applies to everyone who works with and/or cares for an adult who may lack capacity to make specific decisions. Each member organisation of the Board promotes awareness and good practice under the MCA within their services, training and through commissioned services.
The subgroup meets quarterly and reports regularly to the Board.

Key achievements for 2018-19

1. The group has received positive feedback from all the agencies involved which have been able to revise their practice, drawing on the experience and tools that other agencies use.
2. The MCA Group has continued to ensure that agencies are aware of developments in MCA case law, policy and practice.
3. The Group have disseminated information about executive functioning, and MCA and self-neglect.
4. Training has been delivered (by providers and the LSAB) throughout the year in reference to MCA and DoLS.
5. Monitoring of the DoLS back log and associated actions.
6. The group has reviewed any proposed changes in reference to DoLS procedures (that have been recommended).

7. The additional representation from Childrens services has benefitted members in improving their knowledge base and understanding in reference to minors.
8. With a new Chair in place, reviewed the Group's Terms of Reference and update membership.

Outcomes – What difference have achievements made?

1. Supported multi-agency understanding across B&NES, which has led to a more coordinated response and hence maximised our resources.
2. Monitored the use of advocacy services.
3. Received regular feedback from main providers within locality to monitor and raise and discuss issues within the group. Sharing learning and open discussions has benefited group members.

Challenges faced in delivering the agenda

1. Turnover/capacity of staff from some partners / agencies who routinely attend to support the work programme of the group.
2. Risk of losing focus of the wider Mental Capacity Act when there is so much attention on the Deprivation of Liberty Safeguards (both the scheme and for those in community settings).

Priorities for 2019-20

1. Continue to regularly seek assurance from partners on the implementation of MCA and gather findings.
2. Develop MCA Assessment Audit Tool including decisional and executive capacity for all agencies to use and feedback on Practice (by September 2019).
3. Provide progress reports/feedback on delivery of DoLS and community DoLS work (to jointly include health commissioned packages).
4. Provide MCA Awareness training slides including those on mental capacity and self-neglect, for single agencies to use in their training.
5. Review LSAB MA Policies in line with changes to DOLS legislation when appropriate.
6. Complete the actions from the SAR Action Plan.

5.3 Policy and Procedures sub-group

Ensure that multi-agency policy and procedures commissioned by the Board are developed and reviewed on a regular basis.
Ensure that all multi-agency policies and procedures promote confidentiality, dignity and effective access to safeguarding for all communities in B&NES.

Key achievements for 2018-19

1. Reviewed the Self-Neglect Policy and developed a Quick Guide to take into account the learning from the three local Safeguarding Adults Reviews into Self Neglect
2. Reviewed the multi-agency Prevention Strategy
3. Devised a statement on Adult Exploitation.
4. Reviewed the Multiagency Information Sharing Protocol and Consent Policy – re Data Protection Act 2018
5. Reviewed the Multi Agency Procedure and One page flowchart
6. Updated all the relevant MA Policies with the change of Virgin Care Adult Safeguarding Team and telephone number.

Outcomes – What difference have achievements made?
Ensure all multi agency policies are up to date and shared with all LSAB members and providers of services to adults with care and support needs.

Challenges in Delivering the Agenda

1. Capacity of members to complete the work to timescale in addition to the delivery of their own substantive roles
2. Ensuring that the LSAB policies are fully disseminated and link to provider's own policies.

Priorities for 2019-20

1. Policy development of People in a Position of Trust
2. Revise the LSAB Pressure Ulcer Policy in line with NHSI definitions
3. Review the Sub region: Multiagency Safeguarding Policy
4. Review the safeguarding fact sheets
5. Use the detailed review sheet of all multi-agency policy and procedures and all LSAB and sub group Terms of References to ensure that all are updated in the agreed three yearly cycle unless legislative or practice changes mean this needs to happen sooner.
6. Work with the LSCB on further joint policies – for example perinatal mental health
7. Consider closing the sub group and setting up short task and finish groups going forward should a new multi- agency policy need to be written.

5.4 Quality Assurance & Performance Management sub-group (QAPM)

The group is responsible for identifying learning from the experiences of safeguarding adults at risk both locally and nationally and for ensuring that the lessons are used to inform and improve the practice of safeguarding adults.

The group is also responsible for developing robust mechanisms which assure the LSAB that good practice to safeguarding adults is delivered and there is consistency across partner agencies.

Key Achievements 2018-19

1. Monitored the delivery of the groups actions in the Strategic Plan and the Board Assurance Framework throughout the year
2. Successfully revised the safeguarding dashboard so that data is more accessible
3. Ensured the findings from the previous LSAB agencies self assessment documents have been monitored and are being delivered
4. Reviewed audit reports including the repeat referrals audit and the 15% case file audit and approved recommendations to improve practice
5. Ensured the groups actions from the Safeguarding Adult Review action plan are being carried out (including the Mystery Shopping exercise to gather assurance)
6. Received updates in relation to the Multi-agency Safeguarding Hub and how this is progressing from an adult perspective
7. Received the Making Safeguarding Personal Annual Practitioner Survey and had 21 responses which were more positive than the previous one completed

8. Council and Police triangulated Hate Crime data and put in place new systems to send through referrals
9. Reviewed the SAC return and benchmarking information

Outcomes – What difference have achievements made?

1. The group continue to be assured that Virgin Care, AWP and the Council are monitoring incidents of repeat referrals for individuals to reduce the risk
2. Timeliness of safeguarding meetings and activity has significantly improved from the previous year
3. The group continue to be been assured by Virgin Care that service users in out of area placements are safeguarded

Challenges faced in delivering the Agenda

1. Attendance at the group has been variable and this has caused difficulties progressing some areas of work
2. The group has a very large agenda and whilst it is committed to delivering this it is a challenge and a number of priorities have not been achieved eg, development of a multi-agency dashboard and the Review Making Safeguarding Personal arrangements in light of the LGA reports

Priorities for 2019-20

1. Implement changes with regard to recording of section 42 enquiries
2. Implement monitoring of the new Making Safeguarding Personal arrangements as set out by the LGA
3. Review local arrangements regarding rough sleeper death reviews when national guidance is published
4. Monitor the implementation of the Prevention Strategy actions

5.5 Audit Group (a subsidiary of QAPM)

Brief overview of sub group function

The Audit Sub group undertake audits into key areas of safeguarding practice. It identifies areas of practice or procedure that require strengthening and shares examples of good practice. The group also provides a quality assurance function for individual agency safeguarding audits by providing templates for audits undertaken by partner agencies and reviewing the findings. This includes Repeat Referral Audits that reviews people who have been referred into safeguarding more than 3 times in a year. The learning from the audit group is shared with the Quality Assurance and Performance Management Group and with the LSAB.

Key achievements for 2018-19

1. Completion of Audits as required by the LSAB Business Plan for 2018/19 these were audits of safeguarding cases containing concerns relating to: Domestic Abuse (including coercion and control) and Sexual exploitation and an audit of MASH cases.

2. Implementation of the reporting framework for repeat referrals and safeguarding audits undertaken by key partner agencies.
3. Supporting the LSAB SAR Action Plan by reviewing the self-neglect audit template.

Outcomes – what difference have the achievements made?

The audits undertaken have identified a range of findings which have been discussed at the QA&PM Group and actions agreed. The key findings from the year have been:

1. The need for key agencies to be aware of other support available to people outside of safeguarding. This should include an understanding of MARAC, Domestic Support Services and support for those being sexually exploited.
2. That there should be a written S42 enquiry report that details the information provided by all those involved in the enquiry. This action was implemented during the year and completed S42 reports are now required for all concerns that progress to a safeguarding review.
3. To ensure that information is sought from GP surgeries where it is indicated that the person may be in contact with their GP. This applies to both the MASH meetings and safeguarding meetings. This action has been implemented and the Safeguarding Chairs are undertaking some additional assurance to make sure that GP information is sought and the outcome of the request recorded.

Challenges faced in delivering the agenda

Undertaking audits is time consuming and whilst all three LSAB statutory agencies are committed to the work of the group, at the start of the year it was not possible for all agencies to participate in the audits completed this year. This may have led to audits that were less rich as they lacked the insight of one agency, however, the alternative of not undertaking an audit was not acceptable. In the later part of the year the group's membership was stabilised and it is anticipated that all partners will be contributing to the audits in the coming year.

Priorities 2019-20

The sub group is committed to undertaking the following audits:

1. July 19 – Self neglect concerns brought under the safeguarding procedures
2. October 19 – Quality of registered providers referral forms (snapshot for 2-4 week period)
3. January/ February 20 - Toxic Trio
4. The audit group will also consider the repeat referrals audits undertaken by Virgin and AWP in June 19 and December 19
5. Consider additional audits for FGM and adult exploitation depending on cases referred in year.

5.6 Safeguarding Adults Review (SAR) Sub Group

The Safeguarding Adults Review Sub Group is a sub group of B&NES Local Safeguarding Adults Board. The Group's main purpose is to enable the LSAB to undertake reviews of cases that require lessons to be learned, including statutory Safeguarding Adults Reviews (SAR's) as detailed in the Care Act 2014. The group also provides a mechanism for the LSAB to deliver reviews of cases that do not meet the threshold for a statutory review but do meet the criteria for a review under the Boards Safeguarding Adults Review Policy. The group was approved in

December 2015 by the LSAB and started in early 2016.

Key achievements for 2018-19

1. Managing the SARs; this has been a huge undertaking for the group on top of their 'day' jobs
2. Change of chair for the SAR subgroup, minimal impact due to support from Council staff
3. Successfully transferred to the new online reporting
4. Kept on top of SAR action plan which sets out how the actions from the completed SARs will be taken forward.
5. Kept on top of SAR tracker to keep abreast of all the SAR applications and progress on those which meet the criteria
6. Regularly review other SAR reports across the country
7. Regular attendance by a lay member to provide an independent view

Outcomes – What difference have achievements made?

1. The group and SAR panel have identified with SAR authors the learning and improvements agencies in B&NES need to make in order to ensure individuals who self neglect are safeguarded in the future

Challenges in delivering the Agenda

1. This has been a very challenging year for the sub group members and the administrator. The SAR subgroup has had three SAR reviews in quick succession.
2. Independent reviewers are hard to resource and this can be a difficult challenge for the team to find the correct reviewers with the relevant skills.

Priorities for 2019-20

1. Ensure dissemination / awareness raising of SAR outcomes is in place and effective
2. Monitor the completion of the SAR action plans
3. Keep abreast of good practice; review the lessons learnt from other SARs
4. Make sure the SAR agenda is still heard within the new safeguarding arrangements

5.7 Training & Development Sub Group (T&D)

This sub group is responsible for ensuring the continuing development of all staff in order to safeguard and promote the welfare of children and young people and adults at risk. The group focuses on the skills, knowledge and behaviours required for inter-agency working and provides training and development opportunities in order to meet statutory functions and to respond to national and local issues. The group also sets standards and learning outcomes for single agency and multi-agency safeguarding training

Key achievements for 2018 - 19

An extensive LSAB inter-agency training programme was provided across 2018 – 2019 which resulted in:

- 34 LSAB training sessions taking place comprising of 6 different courses
- 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

Strategic Developments

1. A joint strategy aimed to equally support the learning and development of the adult's and children's workforce was approved by both Boards. The strategy was created to reflect the key themes of safeguarding shared by the two workforces and bring together the training provision to achieve a shared understanding of roles and responsibilities and improve effective working together.
2. The training strategy 2018 – 2021 is in line with the LSAB and LSCB business plans and allows training to be responsive to changing need and new priorities. For example additional training and learning opportunities have been provided to support the workforce in identifying and responding to people who Self-Neglect.
3. A new approach to the Training and Development sub group was adopted which streamlined membership and enabled developmental work to be taken forward in a timely and constructive manner. The new structure involved 'Core' members meeting on a quarterly basis, with 'wider' representatives attending the meetings twice a year, acting as a virtual panel to review any work produced by the 'Core' team and also joining specific work streams as required.
4. The new structure has supported the advancement of a number of projects including the formation of a development work plan, the creation and endorsement of Domestic Abuse 'awareness raising' materials, and the revision of trainer observation reports to support QA of training delivery.
5. The charging policy for LSAB training was reviewed and a new tiered system of charging was approved by the Board, ready to be implemented in September 2019. The new system was refined to ensure the charging policy is fair, constantly applied and protects the sustainability of the training programme.
6. The sub group is responsible for overseeing the rigorous evaluation of training, to ensure that it meets the LSAB's statutory duties and responds to national and local issues.

Scrutiny of evaluation forms shows a positive trend in terms of improved confidence and knowledge of course delegates. Evaluations have particularly highlighted an increase in:

- Practitioner's confidence in applying knowledge and skills following training.
- Practitioners advised that they gained a significant understanding of different forms of abuse and the risk factors and indicators associated with abuse.
- Practitioner's understanding of multi-agency roles and improved communication between professionals, including the making of appropriate referrals.
- Practitioner's understanding of legislation, case law, policy and guidance and how to apply this into practice.

Challenges faced in delivering the Agenda

1. Limited expansion has taken place to the variety of inter-agency courses available on the LSAB training programme due to the restricted training budget available.
2. The postponement in the publication of the intercollegiate document for Adults led to a

delay in the revision and approval of training levels and standards. A small working group is currently undertaking this task.

3. Limited expansion has taken place to the modules available in the e-learning library, due to reduced availability of technical support. The possibility of utalising the skills of Digital Learning Design Apprentice is currently being explored to help progress on-line methods of learning.
4. Limited representation on Training & Development Sub Group from statutory bodies.
5. The consideration of the charging proposal by the Boards was delayed to enable refinement of the model to occur. Consequently the Charging Policy was not approved until March 2019.

Priorities for the joint sub-group for 2019-20

1. Build upon the work undertaken between the Adults' and Children's Workforce to further embed a culture and practice of 'Think Family'.
2. Revise and approve training levels for the workforce and review and agree standards and required learning outcomes for 'core' safeguarding courses.
3. Focus on prevention to reduce significant harm and promote improved outcomes for adults with care and support needs and their carers.
4. Provide access to and associated themed learning from Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.
5. Supply additional training and learning opportunities to support the workforce in protecting adults with care and support needs and their carers against the impact of Contextualised Safeguarding.
6. Supply additional training and learning opportunities to support the workforce in identifying and responding to people who self-neglect, and embed the MCA into practice to ensure people who self – neglect are effectively supported and their well-being safeguarded.
7. Implementation of the new tiered system of charging approved by the Board.
8. Expand the online learning opportunities available to the Adult workforce to include the development of a 'learning library'.
9. Adapt working practices to support and respond to changes arising from the replacement of Local Safeguarding Children Boards (LSCBs) with Safeguarding Partners.

5.8 Task and Finish Groups

Joint LSCB and LSAB County Lines Group:

The Joint Task & Finish Group on County Lines was established to address the growing threat of County Lines across Bath & North East Somerset and to ensure a consistent message across all LSCB and LSAB partners. The Group consisted of members from children and adult services as well as commissioners, education, CCG, council and police.

The Group only met on three occasions to undertake specific task of producing a Multi-Agency Briefing.

Key Achievements

1. A Multi-Agency Briefing for all partners to raise awareness across the workforce and with the public on the growing threat and impact of County Lines, how to identify if children, young people or vulnerable adults may be involved and what to do.
2. A set of power Point Slides were also developed to ensure consistent training across the workforce

Outcomes - What Differences have achievements made in relation to Outcomes?

1. All partners and their workforce have an awareness of County Lines and what actions to take.
2. All partners have an understanding of both their role and the role of others in disrupting 'County Lines'
3. There are consistent messages being delivered through training.

Challenges in Delivering the Agenda

1. County Lines, gang culture and violence is a fast moving agenda with perpetrators rapidly changing their modus operandi, thus requiring everyone to be aware of this and share information.
2. Sharing of intelligence is key to disruption and yet some of these young people are not receiving any statutory service input. However Working Together to Safeguard Children, 2018 makes it clear.
   'Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children, whether this is when problems are first emerging' and

   'Information sharing is also essential for the identification of patterns of behaviour when a child has gone missing, when multiple children appear associated to the same context or locations of risk, or in relation to children in the secure estate where there may be multiple local authorities involved in a child's care'

Priorities for the County Lines Task & Finish Group

Further work on County Lines is to be taken forward through the 'Exploitation Sub Group'.

Section 6: Other Relevant Work and Achievements

6.1 **Board Development:** The LSAB usually holds two Business Development Days every year. The purpose of these half–day events is to explore the mechanisms by which the Board undertakes its business and to identify improvements to our effectiveness.

In 2018-19 no Development Sessions took place.

A joint Development Session with both the LSCB and LSAB is due to take place in

May 2019 to discuss the new safeguarding arrangements proposed by the safeguarding partners (B&NES Council, Avon & Somerset Police and the BaNES NHS CCG). It was not possible to progress this earlier in 2018-19.

6.2 **Case Studies:**

At the start of each Board meeting, a case study is presented on the theme of 'Making Safeguarding Personal' (MSP) to ensure that the LSAB hears the voice of the adult with care and support needs and is assured that they are listened to and affect the outcomes of their individual safeguarding case.

During 2018-19, the Board heard cases from B&NES Council Safeguarding Team, Avon and Somerset Constabulary, and Virgin Care; on cases involving:

1. A service user who had mental health and substance misuse issues and who became a victim of 'cuckooing', where drug gangs befriend vulnerable people (particularly those with drug addiction problems) and move into the flat or house and control that individual and use the premises for drug dealing. The support manager for the individual concerned was alerted to the situation and the Police were informed. The service user proactively engaged with the help and support offered, including safeguarding intervention and, together with the Police, the situation was satisfactorily remedied.
2. An elderly man with dementia who had come to the attention of the safeguarding adult's team in June 2017. The man lived with his wife and adult son, but he lacked the capacity to make decisions about his care and accommodation and would often not engage with services.
3. A man who suffered bullying from another housing tenant and how the impact of other issues in his life may have led to his overdose attempt. This case study was a good demonstration of partnership working between all professionals local and voluntary sector

In all cases the Board was assured that the use of MSP had had an impact on the management and process of the safeguarding cases and their outcomes.

6.3 **Presentations:** the Board received the following presentations:

6.3.1 **Analysis from the Complex (Toxic) Trio work**

A representative from B&NES Council attended the LSAB to talk about and gave a PowerPoint presentation to the Board outlining the purpose of the Complex/Toxic Trio project, the methodology used and the key findings.

The purpose of the project was to develop a better understanding of the prevalence of children in B&NES where at least one parent/carer is experiencing one or more of the Toxic/Complex Trio issues, with particular focus on those that are experiencing all three. To identify the support and safeguarding being provided. To identify strengths and weaknesses within the system to help develop more effective, coordinated and targeted support and interventions. To keep children in B&NES safe.

As a result of the project the Council has reviewed their contracts with service providers.

6.3.2 **County Lines**

The Police updated the Board on "County Lines" which is a major risk nationally and locally. There are "County Lines" gangs operating in the area which the Police are aware of and have had some success in breaking up. A multi-agency approach is required, though, to effectively deal with these gangs who prey on vulnerable people, manipulating their way into their lives and where the vulnerable person has a flat, the gangs will move in and use that as a base for drug dealing. It is an invidious activity which has serious impacts on communities.

At the request of the B&NES LSAB, a 'task and finish' group was set up to look at "County Lines" comprising of multi-agency representation and produced a briefing on County Lines.

6.3.3 **Children's' Safeguarding Arrangements**

The Council's Director of Safeguarding and Quality Assurance presented to the Board about the opportunities available to do things differently as a result of legislative changes for Children's Safeguarding Boards (LSCBS) due to Working Together 2018. One proposal is an Executive Group to reduce areas of overlap in work and improve efficiency. This overarching group will include the three statutory partners; the CCG, Police and the Council, and consideration is being given about whether it could combine areas of the LSCB, LSAB and RAG into one Board rather than solely focus on children. This would be of benefit in terms of strengthening the Think Family approach. From the LSCB perspective, the Police, CCG and Council have to inform the Department of Education on any changes to the LSCB before the end of June 2019 and then have implemented these changes by September 2019. There is also potential for new arrangements between the LSCB/LSAB and Responsible Authorities Group (RAG). There have been three meetings so far looking at a new draft model around building one conversation. During these meetings, the group have mapped out the three current Boards and the twenty-two sub-groups, which highlighted a lot of duplication of work. The LSAB member sand sub groups will be invited to a joint development for the 3 boards in May to give feedback on the new proposals, however the decision about any new safeguarding arrangements lie with the statutory partner and not the LSCB, LSAB or RAG.

6.4 **Information received from the LSCB:** As well as the joint working between the Boards as shown in Appendix 7, the Board received the LSCB Annual Report for 2017-18 was shared for information. The Independent Chair has also kept the Board abreast of the Government review on LSCBs that has now been included in the **The Children and Social Work Act 2017** passed in April 2017 and **Working Together to Safeguard Children 2018** which lead to a joint working party across the area and sub region to propose a new joint safeguarding arrangement from September 2019.

6.5 **Work of the MASH** The arrangements for the adult MASH changed in September 2018 to a weekly meeting. The focus of these meetings is: 1) safeguarding concerns that have been raised where it is not evident from the information provided that the person meets the safeguarding threshold. For example, the person does not appear to have care and support needs or it is not evident what abuse they are experiencing. 2) Police notifications

sent to social care – in order to clarify why the information has been passed to social care and what the expectation is in regards to the information shared.

Data

Before the move to the new arrangements, April 18 – end of August 18, the Mash received 6 referrals. From September 2018 to the end of March 2019, 120 referrals where discussed at the MASH meetings. As the data shows the new arrangement has worked well and all agencies have been very engaged and supportive of the work of the MASH.

Audit

In April 2019 the LSAB Audit sub group audited a random number of the cases that had been discussed at the MASH. The aim of the audit was to identify learning to improve the service provided to adults with a level of vulnerability. The recommendations from the audit are currently being implemented and it is anticipated that this will further strengthen our current arrangements.

6.6 **Other Annual Reports:**

Deprivation of Liberty Safeguards (DoLS) Annual Report It is 9 years since the implementation of the Deprivation of Liberty Safeguards. The amount of work has increased and capacity to check DOLS assessments is still an issue, but this is a national problem and not specific to B&NES. The B&NES MCA/DOLS Team have developed a prioritisation and structured process with Mental Health Senior Practitioners checking and signing-off DOLS assessments.

Under Section 3 and Local Arrangements: The team have looked at ways of managing the resources in a more efficient way and now will use 'equivalent assessments' and BIAs to review the backlog awaiting assessment on a monthly basis.

292 DOLS assessments had been completed by end of March 2018.

The 2018-19 DOLS report will show a significant increase in DOLS assessments.

LeDeR Annual Report: This paper on the national LeDeR Report was written by the Commissioning Support Officer for Learning Difficulties LeDeR Local Contact. The officer had also presented this report to the LSCB but was unable to attend the LSAB. Two reviews have been completed locally. The LeDeR Annual Report is a national report and contains no B&NES data. There is a need for more LeDeR reviewers in B&NES so Board members were offered the opportunity to train to become a LeDeR Reviewer,

6.7 LSAB Stakeholder Event:

The LSAB held a Stakeholder event in July 2018 on self-neglect.

At the event the LSAB published a revised Self Neglect Policy and Procedure for health, social care, police and other statutory and voluntary agencies.

The intention is to help everyone – family members, friends and professionals to identify the often hidden warning signs of self-neglect so that support may be offered.

Over 100 local practitioners and managers across a wide range of agencies attended the launch at Somerdale Pavilion in Keynsham, where Key Note speakers included Professor Michael Preston-Shoot, Professor Emeritus at Bedfordshire University and Professor Jill Manthorpe, Director, Social Care Workforce Research Unit, Kings College, London.

Professor Preston-Shoot warned that self-neglect is often hidden from view and can lead to life changing social and health concerns which can sometimes be fatal. He cautioned that even when it is identified, issues of personal choice, mental and physical health difficulties can combine to make it extremely challenging for health, social care and other professionals to effectively offer help to an individual.
Where death or serious injury occurs as a result of self-neglect, it is a duty of a Safeguarding Adult Board, under the Care Act 2014, to commission a Safeguarding Adult Review to understand what happened, how agencies addressed the situation and what lessons can be learned for future practice. Professor Preston-Shoot and Professor Suzy Braye undertook such a Review for the Bath and North East Somerset Safeguarding Adults Board. The full report of SAR John was published on the day of the Stakeholder Event.

The full Report and Board Response on SAR John along with all the PowerPoints and resources shared on the day can be found on the safeguarding website on the following link, just click on the relevant 'drop-downs':
https://www.safeguarding-bathnes.org.uk/adults/local-safeguarding-adults-board/6-safeguarding-adult-reviews

6.8 **'Stop Adult Abuse Week' June 2018:** for the fifth year the LSAB supported this regional event across the old Avon area.

Stop Adult Abuse Week is a partnership between North Somerset, Bristol, Somerset, South Gloucester and Bath and North East Somerset Local Adult Safeguarding Boards. For 2018 a joint Resource and Promotion Pack was designed to help local organisations run social media and other promotional activities and events.
Bath and North East Somerset kicked the week off promoting a Think Family approach through a video https://www.youtube.com/watch?v=cSoBG9B1XnY part 1 and https://www.youtube.com/watch?v=Nnbwq_wHH2k part 2.
A word search was also sent out to promote safeguarding.
Tuesday 12th June the theme was Mate Crime led by Bristol who held a conference on Mate Crime and promoted new leaflets. North Somerset and Somerset led on arrange of key issues including Coercion and Coercive Control, Domestic Abuse, Modern Slavery, and learning from the Mendip House SAR. For all safeguarding issues a range of

resources and suggestions for learning and promotion were included in the resource pack.

6.9 **Work of the Responsible Authorities Group (RAG):** the work that the RAG contributes to safeguarding adults with care and support needs during the year includes the following:

Domestic Homicide Reviews - During 2018-19 the RAG was consulted on one referral resulting in one DHR being commissioned. The outstanding DHR is was significantly delayed due to Pathology delays, Home Office were informed and accepted that this would be out of time.

Hate Crime – The role of the Strategic Partnership Against Hate Crime includes continuing monitoring of hate crime statistics, during 2018/19. Statistics from Stand Against Racism and Inequality (SARI) show that their referrals remain low at 58 representing a B&NES caseload of 35. The majority 30 being race, 3 disability the remaining 1 religion/belief and 1 regarding sexual orientation. Considering the relative size of the B&NES population it's caseload does not appear to be anomalous as SARI opened 37 and 64 cases in North Somerset, and South Gloucester respectively.

Antisocial behaviour in public open spaces generates a significant amount of work for officers. Avon & Somerset Police report that compared with the last 12 months total crime in B&NES is down -4.2% (506 less offences)
ASB down -11.2% (439 less reports)
City Centre crime down -3.8% (120 less offences) ASB -13.9% (171 less reports)
Bath City Outer crime down -0.6% (9 less offences) ASB -3.8% (171 less reports)
Bath City South crime up +4.5% (+51 offences) ASB +4.6% (18 more offences)
Bath City West crime down -5.4% (99 less offences) ASB -9.1% (46 less reports)
Keynsham crime down -12.1% (193 less offences) ASB -24.2% (142 less reports)
North Mendip crime down -16.1% (61 less offences) ASB +3.9% (2 more offences)
Peasedown and Paulton crime down -5.1% (38 less offences) ASB + 7.5% (11 more reports)
Pensford and Chew Valley crime down -6.1% (20 less offences) ASB -24.5% (12 less reports)
Somer Valley crime down -1.4% (18 less offences) ASB -17.1% (20 less reports)

B&NES Inclusive Communities Team work with Public Protection, Police, Housing providers and other services to co-ordinate and run 'days of action' that are evidence based and focus on premises where intelligence may show activity including serious organised crime, money laundering, people trafficking and modern slavery. During the last year no adults were referred into modern slavery referral mechanism.

Modern Slavery: B&NES Council continues to be an active member of the regional anti-slavery partnership and the Avon & Somerset Anti-Slavery Board with an aim to raise awareness of modern slavery amongst all employees and partners, to ensure a multi-agency approach to this issue and to implement the transparency in supply chain provisions of the Modern Slavery Act to prevent modern slavery from occurring in its own supply chain, noting that the Council's Contract Standing Orders already recognise

the importance of preventing modern slavery.

Disrupt – serious and organised crime panel: The group meets regularly to share and compare intelligence on activities of individuals, business and specific locations in order to identify where supporting evidence from partner agencies can secure convictions for serious and organised criminal activity.

Prevent & Channel: The Prevent Steering Group has continued to meet during the year. It has changed its schedule of meetings from quarterly to six-monthly. During 2018-19 eight referrals (4 x child 4 x adult) were made into the Prevent programme; on advice from the Avon & Somerset Police Prevent team just one of these (adult) was progressed to the Channel Panel.

Workshop Raising Awareness of Prevent training continues to be delivered in the Council's corporate training programme.

6.10 **Work of the Domestic Abuse Partnership (DAP)**

A successful bid was made to MHCLG to fund improvements in our refuge provision there are a number of measures but specifically to:

- Ensure women who have hearing impairments are able to access our existing refuge beds
- Provide extra beds for women to escape high risk DVA
- Provide access to accommodation options including refuge beds following contact with the Housing Options Team which is frequently the first point of contact for women with or without their children who are escaping DVA in B&NES

IRIS GP referral scheme

All B&NES GP Practices are now participating IRIS, and continues to receive unprecedented numbers of referrals many of which represent very high risk cases. At the end of the financial year IRIS had 144 referrals as opposed to 106 during the previous year. At any single time 4 % of people reported they had a history of drug misuse, 14% mental health and 8% had attempted or considered suicide.

Violence Against Women and Girls (VAWG) Fund

The additional VAWG funding has helped to support an unprecedented number of victims, especially those with no previous recourse to help. In an attempt to manage demand DAP made an additional bid to the Home Office to secure additional Domestic Abuse Advisor hours and an additional day a week to provide information and advice each week. The Information and Advice Navigator (IAN) dealt with in excess of 340 calls during the year, this service is open to anyone. These callers are victims or frontline staff who previously would not have had easy access to this level of expert information and advice. IAN has been so successful in providing advice but also referrals that a knock on effect is that although there is more capacity in the system an increasing number of people are being identified who need more specialist support. With these increased requests for service there is great concern that the VAWG money will finish in April 2020.

Section 7: Analysis of Safeguarding Case Activity 2018-19

7.1 Summary of Safeguarding Activity 2018/19

7.1.1 During the reporting period 2018/19 B&NES received 1,150 safeguarding concerns (alerts/referrals).

7.1.2 Of these concerns, 325 resulted in support being provided through the safeguarding process.

7.1.3 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.

7.1.4 72% of people fully or partially obtained the outcome they had identified as wanting from the safeguarding process.

7.2 Benchmarking Data

7.2.1 In January 2019 NHS Digital published ***Safeguarding Adults, Annual Report, England 2017-8 Experimental Statistics*** (SA 2018). The report is available to the public as Experimental Statistics, which means the statistics are undergoing evaluation based on returns from all Councils with social care responsibilities.

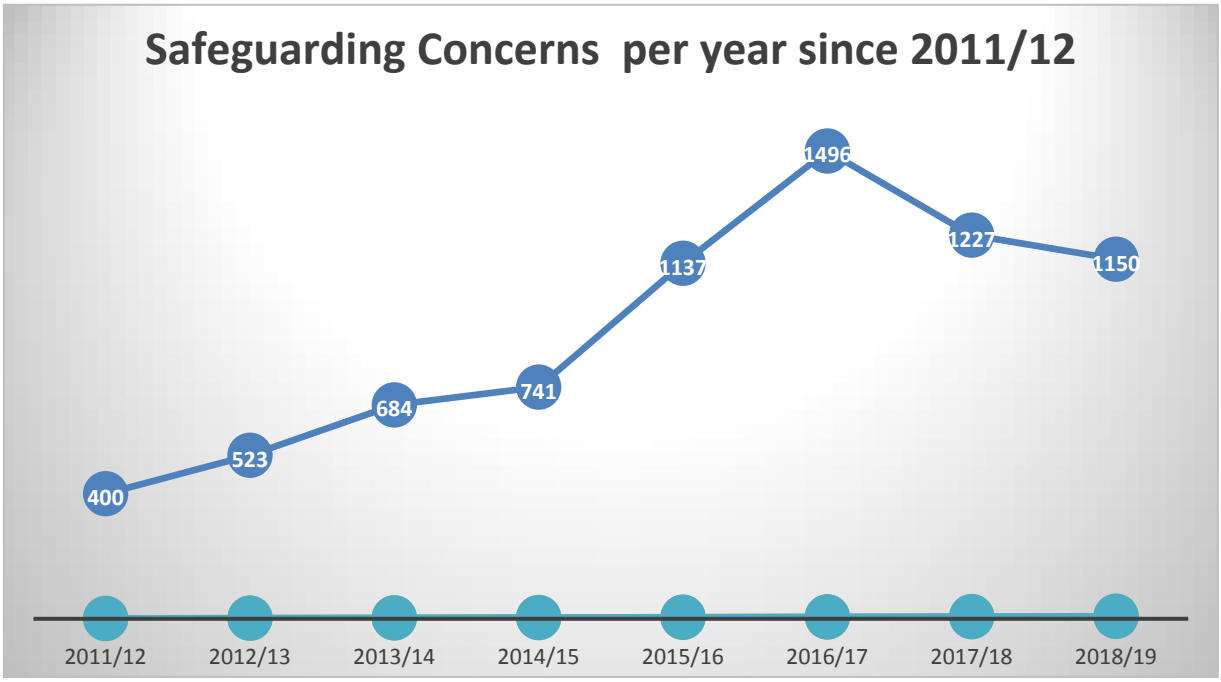
7.2.2 The analysis undertaken in this section has used the information provided by B&NES Council for the Safeguarding Adults Collection (SAC) for 2018/19 together with the information provided in the national Safeguarding Adults Annual Report (SA 2018) to provide useful comparators where appropriate. It must however be noted that the national data used throughout this section is a year older than the information provided by B&NES.

7.3. Safeguarding Concerns received during 2018/19

7.3.1 During the reporting period 2018/19 B&NES received 1,150 safeguarding concerns (alerts/referrals). This is a decrease of 7% compared with last year. In 16/17 there was a substantial increase in concerns with levels decreasing year on year since then. The level of concerns received do, however, continue to remain substantially higher since the Care Act was introduced in 2015.

7.3.2 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.

Diagram 1: Safeguarding Concerns per year since 2011 - 12



7.3.3 The national report (SA 2018) does not report national information on concerns raised, only on enquiries undertaken, it is therefore not possible to compare our results with those of other authorities in all the areas relating to concerns.

7.4 Repeat Concerns

7.4.1 Contained within the figures reported above are a number of concerns that relate to the same individual. These are called “repeat” concerns. Repeat concerns are recorded when a person has more than one safeguarding concern raised with the Council during year. For example it may be someone living in the community has had a concern raised in May regarding possible financial abuse and then another concern in January regarding a medication error.

7.4.2 During 18/19 the 1,150 concerns of abuse or neglect related to 874 people. This means that 24% of concerns were about an individual who had already had at least one other safeguarding concern raised during the year.

7.4.3 The number of people with two or more concerns raised about them has fallen this year. Last year it was reported that 35% of concerns were about the same individual.

7.4.4 Having more than one concern raised does not mean that the person was not appropriately supported after the first concern was raised. It may be that the person did not require safeguarding support, as the issue concerned: individuals who had no care and support needs; those who could protect themselves or individuals that needed an assessment or review of their social care needs. All the repeat concerns are reviewed by lead professionals in Virgin care, AWP and the Council’s Safeguarding and Quality Assurance Team and regular reports are provided to the LSAB’s Quality Assurance sub group.

7.5 Safeguarding Concerns by Gender and Age

Table 1: Safeguarding concerns by Gender, April 2016– March 2019

No. of Concerns by Gender			
	16/17	17/18	**18/19**
Male	378 (38%)	330 (41%)	**330 (38%)**
Female	618 (62%)	468 (59%)	**544 (62%)**
Total	996	798	**874**

7.5.1 As can be noted from the table above, the concern breakdown by gender shows that the number of concerns this year regarding men has decreased as a percentage of the concerns raised. The number of concerns relating to men has remained at the same number as last year.

Table 2: Safeguarding concerns by Age, April 2016 – March 2018

Year	18-64	65-74	75-84	85-94	95+	Not Known	Total
2016/17	383	97	188	256	71	1	**996**
	38%	10%	19%	26%	7%		
2017/18	300	94	189	179	36	0	**798**
	38%	11%	24%	22%	5%		
2018/19	299	80	178	253	64	0	**874**
	34%	9%	21%	29%	7%		

7.5.2 The percentage of concerns raised relating to adults aged 18-64, has fallen slightly this year in comparison with the previous 2 years. The number of concerns relating to people aged 65 – 74 has also decreased .There has, however, been an increase in concerns for adults aged 75-84 and for those aged 85 and over.

7.6 Safeguarding Concerns by Ethnic Breakdown

7.6.1 The ethnic breakdown of service users at point of concern is as follows: 83% were White British; 2.05% were Dual heritage/Asian/Black/African/Caribbean British, 15% declined to provide information on their ethnicity or the information was not known. The number of those declining to provide information regarding their ethnicity or it is unknown has increased substantially this year. Further work on capturing this information when a safeguarding concern is first raised is required and it is anticipated that professionals submitting safeguarding concerns on the new written form will ensure this information is provided. It is of concern that the level of safeguarding issues being raised in relation to people of Dual heritage, Asian, Black, African, Caribbean British, remains low. This is an area that the Board should consider undertaking further work to ensure all people are aware of the support available to them if they are experiencing abuse or neglect.

7.7 Safeguarding Concerns by Primary Support Reason

7.7.1 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.

Table 3: 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

7.7.2 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.

7.8 Moving from Concerns into a Safeguarding Enquiry

7.8.1 A total of 325 concerns moved into a Safeguarding Enquiry during 18/19. This is 28% of the concerns raised. The concerns related to 301 people.

7.8.2 This level of "conversion" from safeguarding concerns into enquiries has slightly decreased further from last year. Last year the conversation rate was 31% whilst the year before the conversion rate was 37%.

7.8.3 The national Safeguarding Adults, Annual Report, England 2017-8 (SA 2018) records that the overall conversion rate at a national level was 38%, however, the report notes that the range of conversion rates varied across local authorities from 3.9% to 100%. The report states that these differences are primarily due to a lack of guidance in relation to the definition of what constitutes a safeguarding enquiry. Work at a national level has therefore been undertaken to provide this definition and it is anticipated that guidance regarding S42 enquiries will be provided by August 2019. It is hoped that this will then lead to a greater standardisation in recording and make comparisons at a national and regional level more feasible.

7.8.4 The South West Safeguarding Network has also undertaken some work in this area. Whilst it identified differences in the way Local Authorities defined the work completed under safeguarding, there was a level of consistency in regard to the decision making and the action needed to protect the person.

7.9 Safeguarding Enquiries

7.9.1 Local authorities are now reporting the number of safeguarding enquiries undertaken rather than "investigations". This new term was introduced in the Care Act in April 2015 with an enquiry being defined as "the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place". B&NES completed 315 statutory enquiries during 18/19.

7.9.2 There are also a number of non -statutory enquiries undertaken every year. These are enquiries that do not meet the Care Act definition for an enquiry but due to the issues raised combined with an identified public interest it was felt appropriate to proceed. These enquiries are usually undertaken when the individual has died but the safeguarding concerns, related primarily to the care provided by an organisation or agency, identify issues that if not considered may continue to impact on people receiving support. For 18/19 10 non-statutory enquiries are included in the overall enquiry figure of 325.

7.10 Safeguarding Enquiries by Abuse Type

7.10.1 The following table sets out the percentage of concluded enquiries by abuse type. The national SA 2018 report this years includes the additional areas of abuse included in the Care Act. The table below therefore includes these additional categories

7.10.2 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.

7.10.3 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.

Table 4: 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%**

7.10.4 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.

7.11 Reported setting of alleged abuse

7.11.1 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).

7.11.2 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.

7.11.3 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.

7.11.4 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.

Table 5: Where the Abuse takes Place 2017-19

	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%

7.12 Source of Risk

7.12.1 The chart below shows the percentage distribution of the source of risk as identified for safeguarding enquiries. This year's return shows a decrease in risks attributable to a person employed as a service provider. The level is, however, higher than that reported as the all England average for 17/18. The source of risk from "persons unknown" has increased this year.

Table 6: Source of Risk 2017- 19

Source of Risk	SA England average 2017/18	B&NES 2017/18	B&NES 2018/19
Service Provider	34%	50%	41%
Other- Known to the Individual	50%	44%	42%
Other - Unknown to Individual	16%	6%	16%

7.13 Mental Capacity and Safeguarding Enquiries

7.13.1 The table below sets out the number of people who went through the safeguarding process that lacked capacity. It also shows how many of them received support to articulate their views and wishes during the process. In 2017/18 B&NES reported 33% of service users lacked capacity. The SA 2018 reported that the England average was 32% of people lacking capacity. The B&NES figure for 2018/19 is both higher than the 2018 England average and the previous year's reporting with 40% of individuals lacking capacity to make decisions related to the safeguarding enquiry.

7.13.2 The number of service users who received support when they lacked capacity, in all age ranges, is significantly higher than the national picture reported in SA 2018 where on average 79% of individuals identified as lacking capacity were provided with

support. In B&NES for 18/19 98% of people without capacity were provided with support. Support in this context is provided by an advocate, family or friends.

Table 7: Percentage of those at Risk Lacking Capacity and Receiving Support

		Percentage of Concluded Referrals					Total
Was the individual lacking capacity	**18-64**	**65-74**	**75-84**	**85-94**	**95+**	**Not known**	
Yes	23	8	30	45	8	0	**114**
No	75	13	25	47	10	0	**170**
Don't know	0	0	0	0	0	0	**0**
Not recorded	1	0	0	0	0	0	**1**
Of those recorded yes how many were provided with support	21	8	26	40	8	9	**112**

7.14 Action taken and risk remaining - Safeguarding Enquiries

7.14.1 The following actions and risk remaining were recorded for concluded safeguarding enquiries for 18/19. This information is shown alongside the national data for 2017/18 (SA 2018) and the local information from 2017/18.

Table 8: Outcome Following Conclusion of Safeguarding Enquiry

	SA National England Average 2017/18	B&NES 2017/18	B&NES 2018/19
Risk identified, action taken	**68.5%**	**99%**	**92%**
Risk identified, No action taken	**4%**	**0.6%**	**0.3%**
Assessment inconclusive, action taken	**6.2%**	**0%**	**0%**
Assessment inconclusive, no action taken	**2.7%**	**0%**	**0%**
No risk identified, action taken	**6.9%**	**0%**	**1.9%**
No risk identified, no action taken	**7.6%**	**0%**	**0.6%**
Enquiry ceased at individuals request	**4%**	**0.4%**	**5.2%**

7.14.2 The B&NES data for 2018/19 does vary significantly from the national data. This change is due to the implementation of the safeguarding recording system which requires that a risk assessment is undertaken and updated at regular periods throughout the enquiry process. The action plan then addresses the risk identified with actions that may range from the provision of advice, support from an advocate or social care services.

7.14.3 The number of enquiries ceasing at the individuals request has increased this year and is more in line with the national average for 17/18.

7.15 Making Safeguarding Personal

7.15.1 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.

Table 9: 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%

7.15.2 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.

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

7.16 Compliance with Local Safeguarding Procedural Timescales

7.16.1 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.

7.16.2 The Board's procedural timescales are:

Table 10: LSAB's Procedural Timescales

Stage	Definition	Target Timescale
1. Concern	Same day but no later than 24 hours after incident of abuse or concern becomes known	Immediate action in cases of emergency but otherwise no later than 24 hours
2. Decision to undertake Section 42 Enquiry	Information gathering by TM (Virgin/AWP) to enable a decision to be made by SA &QA Team (to include where possible views/outcomes for Service User). • Chair will review information gathered and determine whether S42 Enquiry required or NFA under safeguarding adult procedures. May make recommendations	4 working days unless the person is at significant risk in which case the decision must be made sooner
3. Enquiries • Further information gathering/Service User outcomes as required • Planning Meeting • Enquiry Actions	How to proceed with Section 42 Enquiry and who might lead. This is also to give more scope for speaking to the adult at risk, to gather more information and to arrange the meeting.	10 working days, unless the Safeguarding Chair decides it must be held sooner. Timescale for enquiry to be agreed by Chair – dependent on the nature of the enquiry.
4. Safeguarding Plan and Review • Agreeing outcomes and Safeguarding Plan from Section 42 Enquiry • Review	To discuss outcome of Section 42 Enquiry and where necessary, put in place a Safeguarding Plan	Within 5 working days of receipt of written Enquiry Report Not more than 3 months, but dependent on level of risk. To be agreed as part of process.

7.16.3 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.

7.16.4 Reporting has been improved to also provide information relating to the reasons for delays in timescales being met. It is anticipated that next years 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.

Table 11: 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.

Section 8: Priorities for 2019 – 20 and Beyond

8.1 **LSAB Strategic Plan 2018-21**

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

Section 9: Lay Members View

9.1 Below are the views of the two Lay Members supporting the work of the LSAB and giving effective friendly and independent challenge:

'The year has been a positive one for the lay members who, in their third year of office, have progressively achieved a deeper knowledge and understanding of the work of the Board, enabling a higher appreciation of the achievements of the Partners and facilitating stronger challenge where necessary.
Marjorie sits on the Communications & Awareness sub group where she continues to push for ways to bring the strap line 'Safeguarding is everyone's business' to a wider

public. Convincing local media outlets - print and broadcast - is proving difficult but with the current group led by the enthusiasm of its new chairman - Alex Francis - Marjorie feels a breakthrough is close.

As a member of the Training and Development sub group also she agrees that the split into two groups is a more efficient use of time - limited members but is concerned that, too often, the take up of important training sessions offered appears weak.

Amanda continues to lead on the Partnership Reports Audit and also sits with the SAR Sub Group which has proved unusually active since late last year with two live cases at present under review and investigation and three completed.

The new Safeguarding arrangements Partnership to be implemented in September will bring with it new challenges for the lay members, both of whom look forward to the coming year with keen anticipation and a determination to continue their support of both the Authority and the people of B&NES to the best of their ability.

Amanda Cranston and Marjorie Stephinson, LSAB Lay Members

Section 10: Essential information

10.1 The Annual Report is published by the LSAB and has been contributed to and approved by all partner agencies.

10.2 The Report is shared with the Health and Wellbeing Board, LSCB, Responsible Authorities Group (RAG), CCG Board and Council Chief Executive.

10.3 The report can be made available in alternative formats as required and by contacting the LSAB Business Support Manager by emailing Dami_Howard@bathnes.gov.uk

Appendix 1: LSAB Members and Attendance 2018 - 19

Name	Agency	Role
Alex Francis	Healthwatch B&NES	Interim General Manager
Adrian Carr (from Dec 2018)	Dept of Work & Pensions	Partnership Manager
Amanda Cranston	Independent	Lay Member
Andrew Snee	Curo	Head of Tenancy Solutions
Dami Howard	B&NES Council	LSCB/LSAB Business Support Manager
David Trumper (From October 2018)	B&NES Carers Centre	Chief Executive
Debbie Patten	Virgin Care	Head of Adult Social Care & Learning Disabilities
Helen Wakeling	B&NES Council	Safeguarding Lead: Adults & QA
Jayne Davis	Bath College	Deputy Principal Curriculum & Quality
Jane Shayler	B&NES Council	Divisional Director Adult Care, Health, Housing
James Knight	National Probation Service	Senior Probation Officer
Karen Webb (from Sept 2018)	Newbridge Towers	Home Manager
Kirsty Matthews	Virgin Care	Managing Director
Lesley Hutchinson	B&NES Council	Head of Safeguarding and Quality Assurance
Dr Louise Leach	Banes NHS CCG	G.P. Safeguarding Lead
Lynn Franklin (From March 2019)	AWP (Avon and Wiltshire Mental Health)	Head of Safeguarding
Marjorie Stephinson	Independent	Lay Member
Lisa Cheek	RUH	Deputy Director of Nursing, Quality and Patient Safety
Liz Plastow	BaNES NHS CCG	Designated Lead Nurse Safeguarding
Mike Bowden	B&NES Council	Strategic Director People & Communities
Neil Liddington (associate member only)	Avon Fire & Rescue	Area Manager – Risk Reduction
Pam Bourton	Bridgemead Care	Home Manager
Pam Dunn	Care Watch Bath	Operations Director
Phil Rhodes (until December 2018)	AWP (Avon and Wiltshire Mental Health	Community Service Manager (B&NES)
Robert Lake (until Jan 2019)	Independent Chair	Independent Chair
Roanne Wootten	Julian House	Partnerships Manager
Rosi Shepherd	NHS England South	Safeguarding Lead Nurse
Sara Gallagher	Bath Spa University	Head of Student Support
Simon Hester (associate member only)	SWAST	Named Professional for Safeguarding
Steve Kendall	Avon and Somerset Constabulary	Chief Superintendent
Sue Lane	Community Rehabilitation Company	Team Leader
Val Janson (interim Chair from February 2019)	BaNES NHS CCG	Deputy Director of Nursing & Quality
Victoria Caple	Avon and Somerset Constabulary	Partnership Liaison Manager, Lighthouse Unit
(Cllr) Vic Pritchard	Independent	Cabinet Member for Adult Social Care & Health

LSAB Attendance by Agency				
Name	**June 2018**	**Sept 2018**	**Dec 2018**	**March 2019**
Avon Fire & Rescue (associate member only)				
Avon and Somerset Constabulary				
Avon and Wiltshire Mental Health Partnership Trust				
Banes NHS CCG				
B&NES Carers Centre (vacant until Oct 2018)				
B&NES Council				
Bath College				
Bath Spa University				
Care Home Rep				
Community Rehabilitation Company (CRC)				
Dom Care Rep				
DWP (from Dec 2018)				
Executive Lead Member				
Lay Members				
Healthwatch Rep				
Housing Advocate				
Health & Wellbeing Network Advocate				
Named GP				
National Probation Service				
NHS England South				
Virgin Care				
Royal United Hospital				
SWAST (associate member only)				

The above indicates representation only, which is not always from the designated lead from each agency, and not the numbers attending.

Appendix 2: LSAB Sub group members

(note members of task and finish groups are not included)

Joint LSCB & LSAB Awareness, Engagement & Communication sub group	
Member	**Agency**
Alex Francis	Healthwatch (Chair)
Alison Gerrard	B&NES Council
Bev Craney	Swallow
Caroline Latham	Virgin Care
Charlie Farnham	Off The Record
Dami Howard	B&NES Council
David Trumper	Carers Centre
Jane Williams	B&NES Council Comms
Lores Savine	B&NES Council
Mary Kearney-Knowles	B&NES Council
Marjorie Stephinson	Independent Lay Member
Melissa Neill	Virgin Care Comms
June Thompson	RUH, Bath.
Sarah McCluskey	B&NES Council
Sharon Prowse	Freeways
Victoria Parker	Curo
Policy and Procedures sub group	
Member	**Agency**
Val Janson	BaNES NHS CCG (Chair)
Dami Howard	B&NES Council
Dawn Rivers	Julian House
Geoff Watson	Virgin Care
Barrie Fitzpatrick	B&NES Council
June Thomson	RUH
Rebecca Potter	B&NES Council
Simon Eames	Avon and Somerset Constabulary
Steph Stokoe	Avon and Wiltshire Mental Health Trust
Mental Capacity & Quality Assurance sub group	
Member	**Agency**
Lynn Franklin	Avon and Wiltshire Mental Health Trust (Chair)
Christine Ireland	B&NES Council - MCA/DOLS Team Manager
Debra Harrison	Royal United Hospitals, Bath
Geoff Watson	Virgin Care
Karen Gilroy	B&NES Council - Team Manager CITT
Karyn Yee-King	B&NES Council - Principal Social Worker

Karen Webb	Newbridge Towers
Louise Watkins	Swan Advocacy
Matt Dix	Curo
Pam Dunn	Carewatch (Bath) - Domiciliary Care Provider
Phil Rhodes	Avon & Wiltshire MH Partnership
Sarah Box	B&NES Council - Safeguarding Adults Team
Sarah Jeeves	BaNES NHS CCG
Quality Assurance, Audit & Performance Monitoring sub group	
Member	**Agency**
Lesley Hutchinson	B&NES Council (Chair)
Alan Mogg	B&NES Council
Geoff Watson	Virgin Care
Helen Wakeling	B&NES Council
Andrew Snee	Curo
Dami Howard	B&NES Council
Liz Plastow	Banes NHS CCG
Rob Elliott	RUH
Rob Fortune	Avon and Somerset Constabulary
Philip Rhodes	Avon & Wiltshire MH Partnership
Audit Group	
Helen Wakeling	B&NES Council (Chair)
Rob Fortune	Avon and Somerset Constabulary
Liz Plastow	Banes NHS CCG
LSCB & LSAB Joint Training and Development sub-group	
Member	**Agency**
Core Group	
Debra Harrison	RUH (Chair)
Jen Russell	B&NES Council (Vice Chair)
Dami Howard	B&NES Council
Helen Heal	B&NES Council
Justin Charnock	Way Ahead Care
Judith Steele	Virgin Care
Karyn Yee-King	B&NES Council
Liz Plastow	BaNES HHS CCG
Maggie Hall	Virgin Care
Simon Crisp	Avon and Somerset Constabulary
Vicky Christophers	Diocese of Bath & Wells
Wider Group	
Debra Harrison	RUH (Chair)
All of the above members and	

Kevin Clark	B&NES Council
Kitty Crowther	B&NES Council
Dawn Kingman	B&NES Council
Helen Roberts	Virgin Care
Mike Menzies	RUH
Ralph Lillywhite	St Mungo's/Volunteer Network
Roanne Wootten	Julian House
Sue Lee	CAFCASS
Stephanie Pepperd	Step Ahead Training
Safeguarding Adult Review sub group	
Member	**Agency**
Rob Fortune	Avon & Somerset Constabulary (Chair)
Helen Wakeling	B&NES Council
Lesley Hutchinson	B&NES Council
Val Janson/Liz Plastow	Banes NHS CCG
Dami Howard	B&NES Council
Amanda Cranston	Lay Member

Appendix 3: Budget 2018 - 19

	2018 - 19	
	Budget	**Actuals**
Income		
B&NES Council	35,697	34,305
Avon & Somerset Constabulary	5,342	5,346
BaNES NHS CCG	7,000	7,000
Community Rehabilitation Company	500	500
SAR contributions (external from Police and CCG equally)	0	10,929
Training	9.950	23,993
Totals	**48,539**	**58,080**
Expenditure		
Staff Salaries (Business Manager 40% allocation)	20,939	20,348
Independent Chair	6,500	6,500
Organisation and Administration	4,000	1,728
Training (Level 2 Voluntary & Independent sector, Level 3 All sectors)	15,000	10,960
SAR expenditure.	0	16,394
Contracts – ECR online system	1,500	1,500
Room and Equipment Hire	600	650
Totals	**48,539**	**58,080**

The income for the LSAB is either an agreed contribution from the partner organisations or identified funds from B&NES Council to support the individual activities. The Council contribution fluctuates with actual spending.

Appendix 4: Safeguarding Assurance Indicators

The following indicators were approved by the Board in and June 2019 for the following year 2018-19. Partner Reports in Appendix 5 report on those indicators that were agreed by the Board in June 2018 for 2018-19.

LSAB Board Performance Indicators 2019-20 (agreed June 2019)
(Indicators 4,5 and 6 are for B&NES Council, AWP and Virgin Care only)

Indicator 1: Training	Target %	Outcome %
1.1. New staff joining the organisation have undertaken safeguarding adults awareness training within 3 months of starting.	95%	
1.2. Relevant staff have completed SA Level 2 training within 6 months of taking up post and completed refresher training every 3 years thereafter	90%	
1.3. Relevant staff have completed SA Level 3 training	90%	
1.4. Relevant staff have completed MCA/DOLS training within 6 months of taking up post of a level appropriate to their role. (relevant staff includes people that directly provide health and social care or are in a position to make decisions about the service users care and those staff responsible in law for making a DOLS and/or community DOLS application - training must be comparable to B&NES DOLS training)	90%	
1.5. Relevant staff have undertaken Prevent awareness training.	85%	
1.6. Relevant senior staff to have undertaken WRAP training session delivered by an approved trainer.	85%	
1.7. Safeguarding Leads have received Modern Slavery/Human Trafficking awareness training.	100%	
1.8. Relevant staff have received FGM awareness training.	80%	
1.9. Relevant staff have completed domestic abuse awareness training.	80%	
1.10 Relevant staff to have completed self neglect training **N.B. This will increase to 80% in 2020-21**	50%	
Indicator 2: Safer Recruitment	Target	Outcome %
2.1. Relevant staff have an up-to-date DBS check at a level	100%	

appropriate to their role.		
2.2. Two written references to be required before work commences with adults with care and support needs.	100%	
Indicator 3: Attendance at LSAB (members only) 3.1. Your agency's attendance at LSAB Board Meetings.	75% of meetings attended	
Indicator 4: Procedural Timescales	Target	Outcome %
4.1 % Decisions whether to undertake Section 42 Enquiry made in no more than 4 working days from date of referral.	95%	
4.2 % Planning Meetings / Discussions held within 10 working days.	95%	
4.3 % Section 42 Enquiry Reports within Chair's agreed timeframe.	90%	
4.4 % Review meetings held within 5 working days of Enquiry Report being received.	85%	
Indicator 5: Exception and Breach Reports	Target	Outcome
5.1 Breach report completed on procedural timescales.	Report completed	
5.2 Exception report completed on repeat referrals (i.e. cases where there have been 3 or more safeguarding referrals within 12 months).	Report completed	
Indicator 6: Quality Audits	Target	Outcome %
6.1 Report completed on the findings of case file audit.	15% of closed cases audited	

NB: For information about safeguarding adults training refer to the guidance below.

Competency Framework for Safeguarding Adults (April 2016)

Note: the LSAB has agreed that it is each agency's responsibility to determine which of their staff members fall into the category of 'relevant'. For example a social worker, GPs, a nurse, beat officers, staff supporting adults with care and support needs in face- to-face activities would be considered 'relevant'; however an administrator in an office setting who has no contact with adults would not be. The staff to be considered 'relevant' for safeguarding Level 3 or WRAP training need to be determined by each agency, but the expectation is they would have completed the awareness and standard training indicators below and have progressed to the more advanced (e.g. GP Cluster Leads).

Awareness training can be either face-to-face, e-learning or equivalent agencies need to decide. Agencies are asked to note the incremental rise in the PREVENT awareness.

Appendix 5: Partner Reports

Introduction

A new process was introduced last year with the 2017-18 Partner Reports all being read by an audit group prior to the Annual Report being published and a summary of their findings being included in the Report rather than each agency's individual report. The audit group then submitted a full report, to the Quality Assurance and Performance Management sub group (QAPM) and the Training and Development sub group (T&D). The audit group then sent their approved summary to each partner agencies with their QA comments and asked some additional questions which many partners then provided additional information to further explain their partner report.

All 2018-19 partner reports have been quality assured by the group and commented on in terms of:

1. Do the Partners meet the LSAB indicators?
2. Overview of the quality of the reports
3. Highlights of achievements in 2018/19
4. Summary of the Partners objectives for 2019/20

The questions included in this year's Partner Report template were refined from previous years to information needs of the LSAB:

- (For Strategic Plan)
  As an adult service, how many referrals have you made in 2018-19 to B&NES Council Children's Social Care about a child you are concerned about?

- (For Board Assurance Framework - QAPM)
  Number of safeguarding allegations made against your agency staff members in 2018/19.
  Outcomes of these allegations

- (For SAR Action Plan – MCA Group)
  Do you have an MCA Policy? Yes/No
  How often is it reviewed?

- (For SAR Action Plan – MCA Group)
  How the MCA Policy is applied in practice e.g. How are MCA assessments recorded?
  What is your governance process to ensure their quality?

- (For SAR Action Plan – MCA Group)
  How does your agency share an MCA assessment with all other relevant agencies to ensure a consistent understanding and approach to that individual?

Unfortunately, Partner Reports were not received from the following agencies:

- Avon Fire and Rescue Service
- National Probation Service

- Newbridge Towers
- NHS England SE & Central as this is not applicable to their work
- Avon & Wiltshire Mental Health Partnership (AWP). This agency provides a statutory safeguarding function on behalf of the Council and so it is a concern not to have received a report. A representative from AWP was part of the audit group and so was able to give a partial verbal report which was highlighted in the audit.
- South West Ambulance Trust (SWAST submitted their regional Annual Report which was looked at by the QA group but was not specific to the B&NES data or questions.)

1. **Do the Partners meet the LSAB indicators?**

   All agencies that provided data largely met most of the LSAB training indicators. Several, working across boundaries, reported difficulties with providing specific data to the LSAB. B&NES Council and RUH had not fully met all training indicators, and were very close to doing so, but all gave detailed commentary and given the size of the organisations, the audit group were not concerned and could see evidence of efforts made to address this. Virgin Care was now able to provide all the requested training data. The Police were unable to give full training data for B&NES and gave limited commentary to explain this although it had been more detailed elsewhere in the Partner Report.
   Areas that showed a need to increase training were particularly the awareness of FGM, PREVENT, WRAP, Modern Slavery, Domestic Abuse and MCA.
   Not all agencies provided numbers of staff trained as requested, as well as the percentages – this would have given the data a better context.

   Attendance at the LSAB was not fully met by all agencies although many exceeded the 75%. Attendance is an issue for smaller agencies to ensure senior staff at appropriate levels can attend or when staff are called away to attend to other priorities.

2. **Overview of the quality of the reports**

   The feedback given after last year meant that answers given were more specific to safeguarding and/or to B&NES rather than the whole agency. Brief reports usually were succinct and answered the questions but one or two could have given greater detail and assurance. The quality of the answers to the new questions that were asked, was varied.
   Once approved by QAPM and Training subgroups, feedback will be sent to each agency that completed a Partner Report with some receiving additional questions to further explain their responses. Providing this feedback is an addition to the audit process this year and will help to develop the quality of the reports received for 2019 - 20

3. **Highlights of achievements in 2018/19**

   This section of the reports was very thorough. There was evidence of the voice of the adult/carer being listened to in line with making safeguarding personal (MSP).

The QA group was particularly impressed by:
Agencies identifying self neglect champions
MCA recording and governance completed
Internal audit of MCA assessments and processes
Use of policy and guidance form LSAB around self-neglect and MARMs
Internal Modern Slavery Board
Hoarding Project
Bath College – significant improvement in training and evidence of pro-active engagement with safeguarding including supporting students transitioning from child services into adult services
RUH- comprehensive launch of RUH newsletter, opportunities to develop safeguarding supervision alongside clinical supervision and strong evidence of cascading learning from recent SAR's

4. <u>Summary of the Partners' objectives for 2019/20</u>

The objectives identified were generally appropriate and should lead to positive outcomes. They include: developing the Think Family agenda; updating procedures and practice for Liberty Protection Standards (LPS), learning from SARs, mental health training and support; and Self Neglect training.
Not many agencies identified the need to increase MCA training as an objective, despite the recent SARs, and the audit group was concerned by the number of agencies that did not see that as relevant training.

New Questions:

- Referrals from children's services – agencies were not able to provide much evidence of children's services referring a concern about an adult as this was very last minute question and one that they had not been asked to collect data on before. In some agencies, they would refer internally to their own adult safeguarding team and so this would not be easy to identify. Those answers that were received will be shared with the QAPM group.
- Allegations against staff – The answers provided showed proportionate actions appear to have been taken where necessary. The information provided in answer to this question will be shared with the QAPM group.
- MCA Policy, quality assurance, governance and information sharing – Some agencies have a clear MCA policy and review schedule, some have adopted the LSAB one, some have incorporated MCA into their safeguarding policy and some did not answer the question. The responses were not as detailed as had been hoped in order to give assurance and will be shared with the MCA sub group. As these questions are key assurances requested from all LSAB agencies as part of the SAR action plan, questions similar to these will now be incorporated into the MCA audit for partners to complete in the autumn.

Appendix 6: Training Information and Evaluation

Bath and North East Somerset Local Safeguarding Adults Board

Evaluation of LSAB Inter-agency training

(April 2018 – March 2019)

Bath and North East Somerset Local Safeguarding Adults Board.
Evaluation of LSAB Inter-agency training April 2018 – March 2019

Core Business Objectives 2018 – 2019

Our role is to ensure that people who work with who work with adults with care and support needs and their carers are appropriately trained to minimise the risk of abuse or neglect to adults and to safeguard effectively where abuse or neglect has or may have occurred. We review and evaluate the quality, scope and effectiveness of single and inter-agency training to ensure it is meeting local need.

All LSAB training is person centred, evidence based, promotes the need for working in partnership, and informed and governed by issues of equality and diversity.

All LSAB training is accessible to B&NES individuals who work with adults with care and support needs and their carers, and is subjected to regular rigorous review and evaluation.

Delivery in 2018 – 2019

- 34 LSAB training sessions taking place comprising of 6 different courses
- 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.
- 91 Professionals attended LSAB Stakeholder Day on Self - Neglect

Outcomes as reported / evidenced by practitioners

Evaluations highlight an increase in practitioner's confidence in applying knowledge and skills following training, thus being more responsive to adults with care and support needs and their carers.

Practitioners advised that they gained a significant understanding of different forms of abuse and the risk factors and indicators associated with abuse.

Practitioner evaluations identify an increased understanding of multi-agency roles and improved communication and information sharing between professionals, including the making of appropriate referrals.

Evaluations identified that delegates hold a greater understanding of legislation, case law, processes, policy and guidance and how to apply this into practice.

Challenges

Limited expansion has taken place to the variety of inter-agency courses available on the LSAB training programme due to the restricted training budget available.

Minimal progress has taken place with regards to the modules available in the e-learning library, due to reduced availability of specialist and technical support.

The postponement in the publication of the intercollegiate document for Adults led to a delay in the revision and approval of training levels and standards.

Limited representation on Training & Development Sub Group from statutory bodies.

The consideration of the charging proposal by the Boards was further delayed to enable refinement of the model to occur. Consequently the Charging Policy was not approved until March 2019.

The next steps –

- Build upon the work undertaken between the Adults' and Children's Workforce to further embed a culture and practice of 'Think Family'.
- Revise and approve training levels for the workforce and review and agree standards and required learning outcomes for 'core' safeguarding courses.
- Focus on prevention to reduce significant harm and promote improved outcomes for adults with care and support needs and their carers.
- Provide access and associated themed learning from Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.
- Supply additional training and learning opportunities to support the workforce in protecting adults with care and support needs and their carers against the impact of Contextualised Safeguarding.
- Supply additional training and learning opportunities to support the workforce in identifying and responding to people who self-neglect, and embed the MCA into practice to ensure people who self – neglect are effectively supported and their well-being safeguarded.
- Implementation of the new tiered system of charging approved by the Board.
- Expand the online learning opportunities available to the Adult workforce to include the development of a 'learning library'.
- Adapt working practices to support and respond to changes arising from the replacement of Local Safeguarding Children Boards (LSCBs) with Safeguarding Partners.

Introduction

The Local Safeguarding Adult's Board (LSAB) is responsible for ensuring that people who work with adults with care and support needs and their carers are appropriately trained to minimise the risk of abuse or neglect to adults; and to safeguard effectively where abuse or neglect has or may have occurred. The LSAB also needs to review and evaluate the quality, scope and effectiveness of inter-agency training to ensure it is meeting local needs.

This annual evaluation report covers training and other learning and development activities commissioned and delivered through the LSAB from 1 April 2018 to 31 March 2019. Information is provided on attendance, course evaluation, the impact of training onto practice and conclusions about future training and development priorities.

Training Delivery

The development and delivery of the LSAB training programme is overseen by the Children's Workforce Manger, who also makes provision for the effective administration, evaluation and quality assurance of the courses. The LSAB courses are delivered through the Safeguarding Adults Quality Assurance Team, colleagues from other agencies and external trainers.

Training Programme

The programme provided by the LSAB resulted in the provision of 34 training sessions taking place which compromised of 6 different training topics. This compared with 18 training sessions covering 6 subjects across the 2017 – 2018 programme.

A main priority throughout the year has been to supply training and learning opportunities to support the workforce in identifying and responding to people who Self-Neglect. Therefore in addition to the topic being added to the training programme, a stakeholder's event was held to help support the workforce in identifying and appropriately responding to people who self – neglect, 103 professionals booked a place on this event with 91 attending on the day.

For information on attendance on the above training programme please refer to appendix A. (It should be noted that Workshops Raising Awareness of Prevent are included on the council's corporate programme, and are available to all partner agencies.)

E-Learning and online learning material is also available in the following areas:

- Awareness of Forced Marriage
- Domestic Abuse
- Female Genital Mutilation
- Modern Slavery and Human Trafficking
- Making Every Contact Count (MECC)
- Prevent
- Prevent - Channel General Awareness
- Radicalisation

Unfortunately it is not possible to gain the statistics regarding the numbers of the workforce completing all online learning as several of the topics are hosted through different agencies for example the Home Office.

Within the 18 – 19 period limited expansion has taken place to the modules available in the e-learning library, due to reduced availability of technical support, however, work is currently being undertaken on an Adults Safeguarding Module and a Self Neglect Module with the plan that it will be available to the workforce within Q1 of next year's programme. Additionally a link has been added to signpost to a Domestic Abuse Awareness package commissioned by the Domestic Abuse Partnership.

It is hoped that the progression of on-line methods of learning will occur throughout the 2019 – 2020 programme through the possibility of utalising the skills of Digital Learning Design Apprentice.

Course Content

All LSAB training is person centred, evidenced based, promotes the need for working in partnership and governed by issues of equality and diversity.

Person centred: The training courses use a variety of techniques to ensure the needs of the individual remain central to the learning undertaken, including hearing individual stories, recognising the importance of relationship building, sharing and receiving information and confirming the importance of using observation.

The evaluation forms also ask a specific question about how service users will know that a delegates practice has improved, ensuring that all delegates consider the situation from the perspective of the individual with whom they are working.

Evidence Based: The content of the training course is regularly appraised and reviewed to ensure it contains the latest research, reflective practice changes to legislation, practice and policy and the 'lessons learned' on a local and a national level.

Interagency Collaboration: All training is designed and delivered to multi- agency audiences, bringing together people and organisations and promoting the need for interagency working, to effectively safeguard adults at risk.

Equality & Diversity: All training is informed and governed by equal opportunities and reflects the diversity and cultural needs of the individuals and organisations, within Bath & North East Somerset, that have responsibilities for safeguarding and promoting the wellbeing of adults with care and support needs.

To support delegates' engagement in the course content, aid their understanding of the material and assist in transferring the learning undertaken into practice each course incorporates a variety of methods and approaches to ensure a variety of adult learning styles are catered for.

Course Attendance

LSAB training is accessible to all in B&NES who work with adults with care and support needs and their carers.

Bookings for course attendance are reasonable with 68% of courses having over 60% places reserved. A particular challenge was experienced with the number of bookings undertaken

on the Safeguarding Level 2 course where only 49% of available places were taken. Additionally it should be noted that whilst the Self-Neglect course had a 60% booking rate, there were considerably more spaces across the courses that could have been utilised and one session needed to be cancelled due to low bookings.

Low take up rates of courses are monitored and attempts are made to improve attendance through additional advertising of the training and targeting specific areas of the workforce as appropriate. If it is not possible to achieve a minimum booking of 10 delegates, discussion will take place with the course trainer and a decision will be made as to whether the course will be deferred / cancelled. Decisions are informed by cost and time implications and the effect low numbers may have on the quality of group work and overall learning undertaken.

Levels of non- attendance across the training programme are also monitored. It appears that this year has seen an increase in a higher number of individuals who did not attend training after making a booking. This was specifically noticeable in attendance levels on the Safeguarding Level 3 course and the Introduction to MCA.
The increase in non- attendance on these courses is particularly concerning given the sessions are often fully booked months in advance.

For further information regarding course attendance / agency representation please refer to appendices A and B.

Evaluation & Quality Assurance

Through its Training & Development Sub-group, the LSAB is required to evaluate the provision and quality of both single and multi-agency training, ensuring that it is provided within individual organisations, and checking that training is reaching all relevant staff.

Monitoring and Evaluation of Inter-agency training

In order to evaluate the effectiveness of multi-agency training in Bath and North East Somerset, a variety of methods are employed to achieve four goals:

- Ensure the learning outcomes for each course are met, and reflect evidence based ‘best practice’ that keeps the needs of the individual in focus.
- Ensure the continual evaluation by Training Manager to ensure courses are meeting the needs of staff, with transparent overview and accountability to the LSAB training and development sub group.
- Ensure that evaluations inform the planning and development of future training
- Ensure that messages from training are being embedded in practice.

Methods of Evaluation

All courses advertise the learning outcomes expected from participants by the end of the session. The evaluation forms used on half day, full day or two day courses remind attendees of the expected learning outcomes and delegates are asked to scale pre and post course their confidence in these areas. These scores are used to assess the effectiveness of the training in addressing the identified aims and objectives on the day. If a common theme emerges around objectives not being met this will trigger a review of the course content/ delivery style so that adjustments can be made.

Research into the effectiveness of inter-agency training suggests that for participants to gain the most from training they need to be able to make direct links to their own practice, and consider how the knowledge gained in training can improve their practice. All delegates are therefore invited at the end of training to consider an action plan for changing their behaviour in the workplace, and thinking through the impact that this change will have on the people they work with.

Quality assurance on trainers practice is undertaken through consideration of the evaluation forms received from training courses and also through sessions being observed by a member of the Training and Development Sub Group or other appropriate professional. The findings from the session observed are fed back to the trainer with an action plan being developed to address any gaps in provision / delivery identified.

The methods of evaluation used have evidenced an increase in practitioner's confidence in applying knowledge and skills following training, thus being more responsive to adults with care and support needs and their carers,

"I will have increased sensitivity, respect and observational skills"
Senior Day Care Assistant (Level 2)

"I feel more confident on assessing capacity, including and recording Best Interest decisions"
Registered Nurse (MCA Best Interest Decisions)

"Confident in questioning"
Nurse Team Lead (Self Neglect)

"I will now be more confident when conversing with the LSAB"
IDVA (Level 3)

"Will be more confident and can explain why I have come to certain decisions"
Student Social Worker (Introduction to MCA)

"I feel I have confidence to question certain practices in my work place"
Community Support Worker (MCA Best Interest Decisions)

Practitioners advised that they gained a significant understanding of different forms of abuse and the risk factors and indicators associated with abuse.

"I understand Self – Neglect in the context of Safeguarding adults. The signs and symptoms. Legal framework to be guided by and what to do if I think someone is self-neglecting."
Community Nurse (Self – Neglect)
"[I gained] an awareness of organisational abuse"
Senior Day Care Assistant (Level 2)

"Case studies helped understanding of different types of abuse"
Team Leader (Level 3)

"[I understand] indicators of potential victims and understanding different types of modern slavery"
Support Co-Ordinator (Modern Slavery & Human Trafficking)

Practitioner evaluations identify an increased understanding of multi-agency roles and improved communication and information sharing between professionals, including the making of appropriate referrals.

"Interaction from the others in the group was good, we are all from different factions so coming from different points of views and associations with our service users."
Medical Secretary (Level 2)

"Good Multi-agency approach"
Social Worker (Level 3)

"Felt able to discuss and work with others to gain fuller understanding".
Well-being advisor (Self-Neglect)

"I will be able to discuss with individuals comfortably and confidently when needed"
Housing Support Worker (Level 2)

"Useful to have insight from Police Investigator"
Mental Health Student Nurse (Level 3)

"Would not be afraid to raise a concern"
Home Care Support Worker (Level 2)

Evaluations identified that delegates hold a greater understanding of legislation, case law, processes, policy and guidance and how to apply this into practice.

"I have clarity of the process of the section 42 enquiry"
Area Co-ordinator (Level 3)

"A greater understanding between the different regulations and guidance"
Senior Care Worker (Self Neglect)

"Clarity around process and rationale for decision making"
Service Manager (Level 3)

"Updated knowledge on legislation"
Director and facilitator (Level 2)

"I feel my capacity assessments will be more holistic and in-depth"
RMN (MCA Best Interest Decisions)

"Very informative about the issues arising and the legislation"
Care Co-Ordinator (Human Trafficking and Modern Slavery)

The next steps

In evaluating the training that has taken place over the last year and in consideration of the priorities determined by the LSAB and the LSCB in their 2018 – 2021 strategy the following will be the main Training and Development areas of focus:

• Build upon the work undertaken between the Adults' and Children's Workforce to further embed a culture and practice of 'Think Family'.

• Revise and approve training levels for the workforce and review and agree standards and required learning outcomes for 'core' safeguarding courses.

• Focus on prevention to reduce significant harm and promote improved outcomes for adults with care and support needs and their carers.

• Provide access and associated themed learning from Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.

• Supply additional training and learning opportunities to support the workforce in protecting adults with care and support needs and their carers against the impact of Contextualised Safeguarding.

• Supply additional training and learning opportunities to support the workforce in identifying and responding to people who self-neglect, and embed the MCA into practice to ensure people who self – neglect are effectively supported and their well-being safeguarded.

• Implementation of the new tiered system of charging approved by the Board.

• Expand the online learning opportunities available to the Adult workforce to include the development of a ‘learning library’.

• Adapt working practices to support and respond to changes arising from the replacement of Local Safeguarding Children Boards (LSCBs) with Safeguarding Partners.

Appendix A

Training delivery: 1st April 2018 – 31st March 2019

	Course Title	Number of Sessions run	Duration of course	Places Available	Places Booked	Delegates attended	% of places booked	% of places allocated	% actual course take up*
LSAB	Adults Safeguarding Level 2	11	3.5hrs	440	216	194	49	90	44
LSAB	Adults Safeguarding Level 3	4	6hrs	74	83	62	112	75	84
LSAB	Intro to MCA	4	3hrs	69	57	40	83	70	58
LSAB	MCA Full Day	4	7hrs	69	69	56	100	81	81
LSAB	Human Trafficking & Modern Slavery	1	3 hrs	18	11	8	61	73	44
LSAB	Self Neglect	10 (10 courses were offered 1 cancelled due to low numbers)	3.5	250	151	136	60	90	54
LSAB	FGM **	1	2.5 hrs	60	24	20	40	83	33
LSAB	IBA Training ** (Think family)	2	3 hrs	60	26	25	43	96	42

*Attendance based on potential course capacity

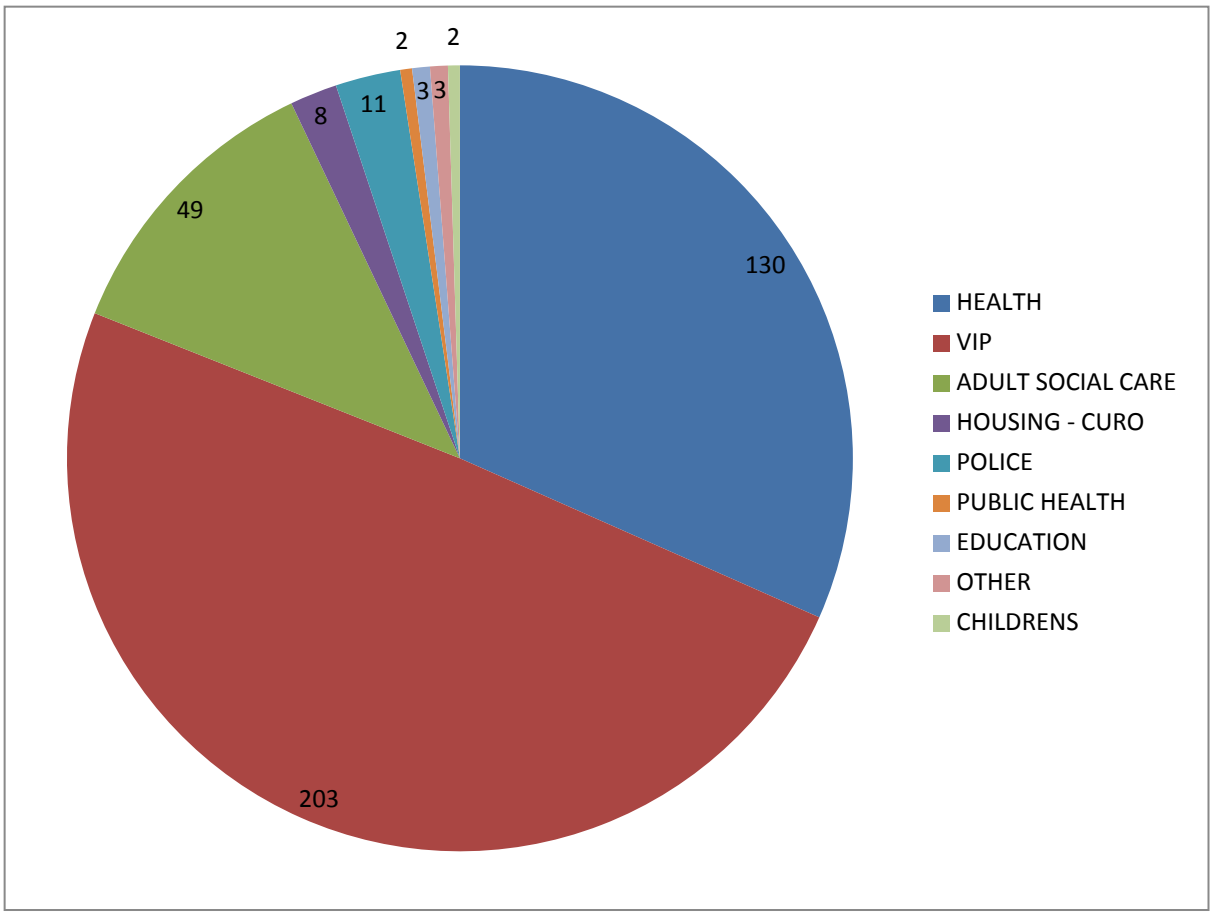
** These course figures have been included within the LSCB statistics and therefore have been included here for information but not included within the LSAB training delivery calculations.

Single Agency Training provided by LSCB training co-ordinator

Organisation / Sector	Course title	Number of sessions run	Delegates attended
Virgin Care	Adult Safeguarding	1	14

Appendix B

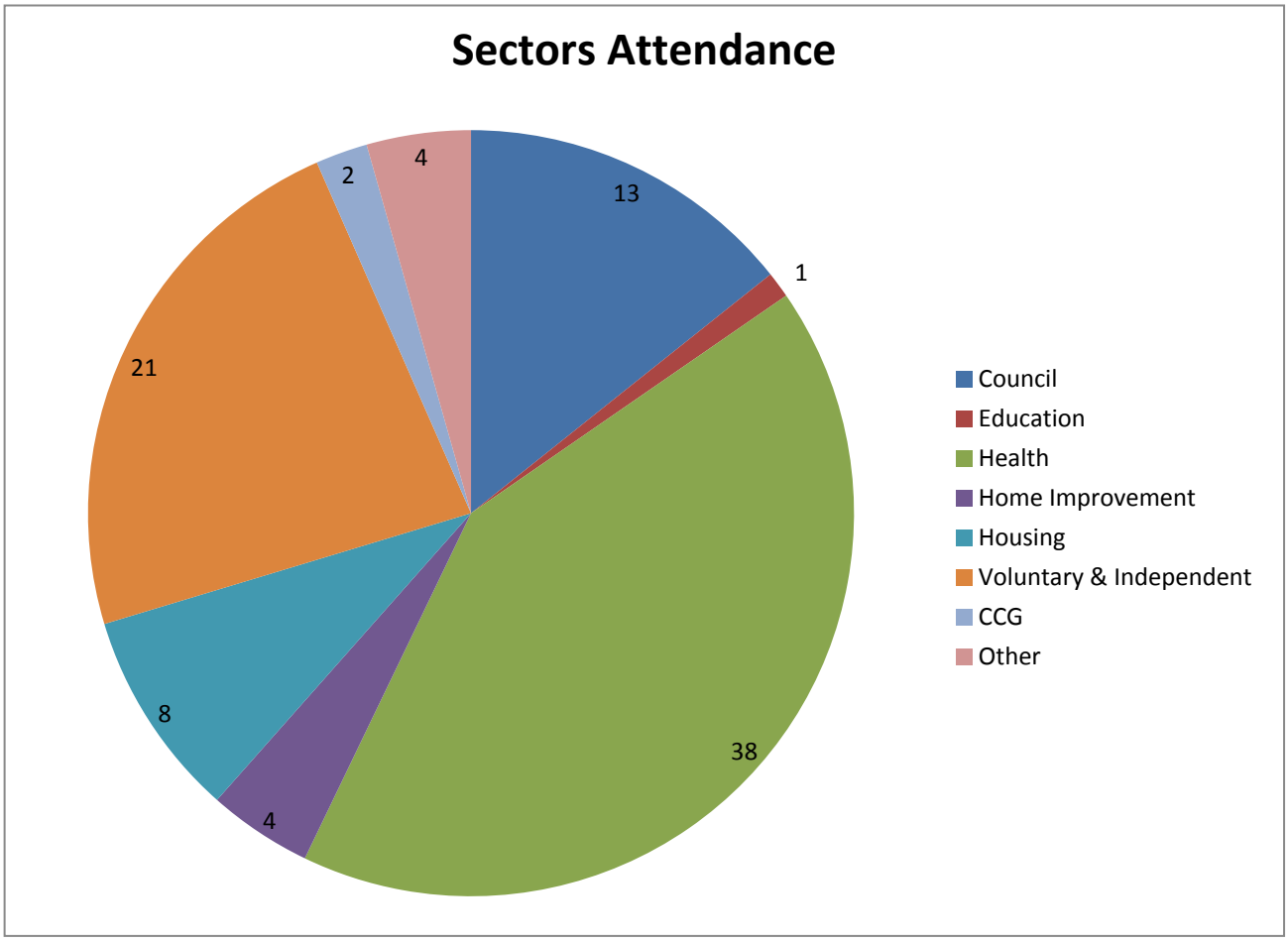
Agency Representation on LSAB Training Programme: 1st April 2018 – 31st March 2019



Agency Code	Number of Attendees
HEALTH	130
VIP	203
ADULT SOCIAL CARE	49
HOUSING - CURO	8
POLICE	11
PUBLIC HEALTH	2
EDUCATION	3
OTHER	3
CHILDRENS	2
TOTAL	411

Appendix 1

Agency Representation of attendance at Self-Neglect Stakeholders event



Agency Code	Number of Attendees
Council	13
Education	1
Health	38
Housing	8
Home Improvement	4
Voluntary & Independent	21
CCG	2
other	4
TOTAL	91