Bath & North East Somerset Council

NHS Bath and North East Somerset

Bath and North East Somerset Partnership Board for Health and Wellbeing

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	Our Ref:	
	Date:	7 June 2011

To: All Members of the Partnership Board for Health and Wellbeing

Malcolm Hanney	- Chair of the PCT
Councillor Paul Crossley	- Leader of the Council
Dusty Walker	- PCT Non Executive Director
Patricia Webb	- PCT Non Executive Director
Councillor Nathan Hartley	- Deputy Leader of the Council and Cabinet Member for Early Years, Children and Young People
Councillor Simon Allen	- Cabinet Member for Wellbeing
Jeffrey James	- Chief Executive, NHS B&NES
John Everitt	- Chief Executive of the Council
Dr Brian Conway	- Chair of Professional Executive Committee, PCT
Dr Pamela Akerman	- Acting Joint Director of Public Health
Ashley Ayre	- Interim Strategic Director People's Services and Public Health

Other appropriate officers
Press and Public

Dear Member

Partnership Board for Health and Wellbeing

You are invited to attend a meeting of the Board, to be held on **Wednesday, 15th June, 2011** at **2.00 pm** in the **Elwin Room, Bath Royal Literary and Scientific Institution, 16-18 Queen Square, Bath BA1 2HN.**

The agenda is set out overleaf.

Yours sincerely

Col Spring
Committee Administrator

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

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

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

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

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

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

5. **Declarations of Interest**
   Board Members do not need to declare an interest in their ex-oficio status on the Board. If they have a closer involvement with any specific issue (via membership of a Sub-Committee for example), consideration would need to be given to whether a declaration was needed, and advice sought from the Monitoring Officer if necessary.

   The following members of the Partnership Board have roles in the Council and PCT:

Malcolm Hanney:	*Chair of the PCT and Deputy Leader of the Council*
Jeffrey James	*Chief Executive NHS Wilts and Chief Execute NHS B&NES*
Ashley Ayre:	*Interim Strategic Director People's Services and Public Health, operating across the Partnership*
Dr Pamela Akerman	*Joint Director of Public Health, operating across the Partnership*

   However, when attending a meeting of the Partnership Board, each member is attending in the role shown on the invitation to attend the meeting, which is on the first page of the papers for the meeting.

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

7. **Emergency Evacuation Procedure**

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

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

Bath & North East Somerset Council

NHS Bath and North East Somerset

Partnership Board for Health and Wellbeing

Wednesday, 15th June, 2011
Elwin Room, Bath Royal Literary and Scientific Institution, 16-18 Queen Square, Bath BA1 2HN
2.00 - 4.00 pm

Agenda

Note: The Partnership Board Meeting will have been preceded by a meeting of the Health and Wellbeing Network. Feedback from this meeting will be reported verbally to the Partnership Board under Item 9

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

   Board Members do not need to declare an interest in their *ex officio* status on the Board. If they have a closer involvement with any specific issue (via membership of a Sub-Committee for example), consideration would need to be given to whether a declaration was needed, and advice sought from the Monitoring Officer if necessary.

   The following members of the Partnership Board have roles in the Council and PCT:

   Malcolm Hanney: Chair of the PCT and Councillor

   Ashley Ayre: Interim Strategic Director for Children's Services and Public Health, operating across the Partnership

   Dr Pamela Akerman: Joint Director of Public Health, operating across the Partnership

   However, when attending a meeting of the Partnership Board, each member is attending in the role shown on the invitation to attend the meeting, which is on the first page of the papers for the meeting

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

6. MINUTES OF PREVIOUS MEETING

   The Minutes of the previous meeting will be confirmed as an accurate record

7. PUBLIC QUESTIONS/COMMENTS

STRATEGY AND POLICY

8. RUH FOUNDATION TRUST CONSULTATION - PRESENTATION — RUH Team

9. HEALTHWATCH - STATUS REPORT — Derek Thorne

10.	HEALTH AND WELLBEING BOARD GOVERNANCE	David Trethewey
11.	INTERIM COMMISSIONING ARRANGEMENTS	Ashley Ayre, Jeff James
12.	ALCOHOL HARM REDUCTION STRATEGY	Dr Pamela Akerman

PERFORMANCE AND RISK MANAGEMENT

13.	ADULT SAFEGUARDING PERFORMANCE	Lesley Hutchinson
14.	ADULT HEALTH AND SOCIAL CARE COMMISSIONING PERFORMANCE	Tracey Cox
15.	CHILD PROTECTION ACTIVITY PERFORMANCE	Maurice Lindsay
16.	CHILDREN'S SERVICE COMMISSIONING PERFORMANCE	Ashley Ayre
17.	CHILDREN'S TRUST BRIEFING REPORT	Ashley Ayre

GOVERNANCE AND OTHER BUSINESS

18.	FORWARD PARTNERSHIP BOARD DATES	Col Spring

The Board will be asked to note the schedule of future meetings

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

Bath and North East Somerset Council

NHS Bath and North East Somerset

PARTNERSHIP BOARD FOR HEALTH AND WELLBEING

Minutes of the Meeting held

Wednesday, 9th February, 2011, 2.00 pm

Councillor Francine Haeberling	-	Leader of the Council
Councillor Malcolm Hanney	-	Chair of the PCT
Councillor Vic Pritchard	-	Cabinet Member for Adult Social Services and Housing
Dusty Walker	-	PCT Non Executive Director
Patricia Webb	-	PCT Non Executive Director
Janet Rowse	-	Acting Chief Executive of the PCT
John Everitt	-	Chief Executive of the Council
Dr Brian Conway	-	Chair of Professional Executive Committee, PCT
Dr Pamela Akerman	-	Acting Joint Director of Public Health

1 WELCOME AND INTRODUCTIONS

The Chair was taken by Councillor Francine Haeberling, Leader of the Council. The Chair welcomed everyone to the meeting.

2 EMERGENCY EVACUATION PROCEDURE

The Chair drew attention to the evacuation procedure as listed on the call to the meeting.

3 APOLOGIES FOR ABSENCE

Apologies had been received from Councillor Chris Watt and from Ashley Ayre. Mike Bowden (Divisional Director, Health Commissioning and Strategic Planning) attended as substitute for Ashley Ayre.

4 DECLARATIONS OF INTEREST

The following members of the Partnership Board hold dual roles in the Council and PCT:

Malcolm Hanney: Chair of the PCT and Deputy Leader of the Council
Janet Rowse: Acting CEO and Strategic Director, Adult Health and Social Services
Mike Bowden: Divisional Director, Health Commissioning and Strategic Planning, operating across the Partnership
Dr Pamela Akerman: Acting Joint Director of Public Health, operating across the Partnership

There were no other declarations of interest.

5 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There was no urgent business.

6 **MINUTES OF PREVIOUS MEETING**

Patricia Webb observed that she had sent her apologies to the meeting but these had not been recorded. It was also observed that in Item 9, the name of Ian Orpen had been spelled incorrectly. The Democratic Services Officer agreed to amend the Minutes in two places. The Minutes (as amended) were approved as a correct record.

7 **PUBLIC QUESTIONS/COMMENTS**

There were none.

8 **FEEDBACK FROM HEALTH AND WELLBEING SEMINAR (VERBAL)**

Derek Thorne gave a verbal report of the Seminar. The seminars were by consensus proving increasingly effective. The morning seminar had been attended by 60 people and had discussed the public health reorganisation and re-enablement. There had been a strong message that the new Health and Wellbeing Board should be transparent and should be responsive to comments from the public.

Board members were impressed by the wide ranging feedback, particularly relating to disadvantaged groups. They agreed that the relationship with voluntary and community groups would be critical to success.

The Board agreed to NOTE the verbal report.

9 **TRANSFORMING COMMUNITY SERVICES (VERBAL UPDATE)**

Janet Rowse gave a verbal update of events since November, when the Council and the PCT Board had both approved the direction of travel for community health and social care services to become a social enterprise. Both partners had sought further assurances about the financial sustainability to be demonstrated within the business case.

The Department of Health required that by the end of March, the Partnership must have a viable business case; an organisation established; and a Chair and Chief Executive identified. The business case had been submitted to the Strategic Health Authority in late December. Since then there had been internal scrutiny to test the sustainability of the proposals and further updating of the financial plans. It was anticipated that the report would be presented to PCT Board and to Council on February 17th. The SHA would consider the case at their Board meeting in March; it is the SHA who determine from the NHS perspective whether or not to approve the establishment of the Social Enterprise. The advertisements for Chair and Chief Executive had already been placed and recruitment to both posts was anticipated to take place before the end of March in line with the national timetable.

John Everitt said that the priority must be to establish further engagement with staff. It was clear, for example, that staff were very keen that the new organisation must be not for profit.

Malcolm Hanney observed that the proposals would be a huge change. It was

essential to ensure continuity of performance and quality. The timescales were particularly challenging.

The Board agreed to NOTE the verbal update.

10 NHS REFORM AGENDA AND OPERATING FRAMEWORK 2011-12

Janet Rowse introduced the report. She explained that the consortium of all 27 GP practices had been approved as part of the pathfinder programme although there would be a formal licensing process to go through at a later stage. Discussions were on going about the future shape of commissioning for health and social care and the other components of the new architecture of the NHS were also being planned jointly with Council colleagues. Full details of the Operating Framework had been included in Appendix 1 of the report.

The Board agreed to NOTE the report.

11 NEW STATUTORY DUTIES FOR LOCAL AUTHORITIES

David Trethewey (Divisional Director, Policy and Partnerships) introduced the report. The authority had been recognised as an "early implementer" for the establishment of the new style Health and Well Being Board because of the excellent progress already made towards integration. He had attended a meeting with other authorities at the Department of Health on 13th December and would be attending another meeting the next day, the aim being to share lessons learned amongst the authorities. He explained in response to a question from a Board member that in paragraph 2, where it referred to four main functions, the fourth function should have been listed as "strengthening engagement and involvement", which had been expanded in paragraph 8 of the report.

Janet Rowse emphasised the importance of keeping patient safety and safeguarding at the heart of the work of the Partnership and this was echoed by other members.

Malcolm Hanney said he felt strongly that integration had worked for the Partnership and had delivered benefits; and that it would be important under the new arrangements to keep this at the forefront of thinking. Others agreed with his comments.

Janet Rowse said that the Board needed to give thought to timing and to links with other changes taking place. She felt that the new Health and Well Being Board should be in place by April if this were possible. The Chair and other Board members agreed this approach.

The Board agreed:
(1) To NOTE the report;
(2) To hold an initial seminar style meeting with the likely membership of the new style Health and Well Being Board in April in order to determine how the new Board might be constituted.
(3) To expect the new style Board to become operational in shadow form from June

12 HEALTHY LIVES HEALTHY PEOPLE - STRATEGY FOR PUBLIC HEALTH

Dr Pamela Akerman introduced the report and explained that the main consultation period on the strategy for Public Health and the funding arrangements would end at the end of March although for some questions the closing date was 8th March.

Paul Scott (Assistant Director, Public Health) gave an indication of the timescales: Consultation, as had been explained, would close on 31st March.
John Everitt asked, from a strategic perspective, whether it was possible to act in advance of the statutory deadlines for the transfer of public health functionality. He asked for more structured information about the risks and advantages of moving earlier. Paul Scott agreed to provide this to a future meeting.

Malcolm Hanney said the proposed approach must be fully tested but that the Partnership was already well advanced in is readiness.

Janet Rowse suggested that it may be possible to resolve staffing issues in the short term through existing Partnership secondment arrangements in order to effect the staff transfer as soon as possible. But she also indicated that the transfer of resources was more complex and it would probably be better to wait for further guidance before transferring resources between organisations. However, the evidence of excellent collaboration so far made her confident that there would be no cause for disagreement between the partners at a local level.
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The Board agreed to NOTE the report.

13 SHAPING UP - HEALTHY WEIGHT STRATEGY

Helen Erswell (Public Health Commissioning Manager) introduced the report. Its aim was to reduce obesity, particularly by promoting self-care. The aims and themes of the strategy were explained in the report at page 65.

Members welcomed the strategy and said it was an excellent basis for promoting health.

The Board agreed:
(1) To RECOMMEND to the Cabinet Member for Adult Social Services and Housing that he approve the strategy on behalf of the Council;
(2) To RECOMMEND to the Health and Social Care Committee that it approve the strategy on behalf of NHS B&NES.

14 ADULT SAFEGUARDING PERFORMANCE

Lesley Hutchinson (Assistant Director, Safeguarding and Personalisation) introduced the report. She referred to a number of indicators in the report and updated the Board on some latest developments. There had been some concern over the performance of Avon and Wiltshire Mental Health Trust, but the Trust was now working to an action plan to address the problems. The advertisement for Independent Chair of the Local Safeguarding Adults Board had been published.

John Everitt said that the Board would need to see the AWP action plan.

Dr Brian Conway referred to Indicator 4 (case file audits) and asked that in future, the board could be told what lessons had been learned and what changes made as a result of the audits.

Members agreed that, since the Partnership was able to set its own targets, it would be appropriate to reconsider the targets so that they were realistic and in line with other authorities in the region.

The Board agreed:
(1) To NOTE the reported Safeguarding case coordination activity
(2) To NOTE the update from the Local Safeguarding Adults Board of December 2010
(3) To NOTE the Care Quality Commission Assessment of Adult Social Services Performance for 2009/10
(4) To NOTE the Community Health and Social Care Service Internal Audit of safeguarding cases

15 ADULT HEALTH AND SOCIAL CARE COMMISSIONING PERFORMANCE

Janet Rowse apologised that papers circulated were several months out of date, and as an alternative to using the data provided, gave a verbal report outlining current performance issues. She made particular reference to progress made in achieving stability in the urgent care system. This has been achieved by the whole system working together, including moving GPs into Accident and Emergency, reducing length of stay in acute and community hospitals, effective whole system infection control measures and improving discharge procedures.

The report from the Care Quality Commission on the stroke service had been very positive.

Waiting times for access to social care were within target and waiting times for hospital care would be within target by the end of March.

Patricia Webb congratulated the team and its partners for achieving such an improvement, particularly over the winter months. She had received increasingly good feedback from patients at the RUH about their experience and care.

Board Members felt that the positive message must be communicated to the public, who need to have confidence in their local health service, and that the message should be that the Partnership expects to maintain the successes into the future.

The Board agreed to NOTE the verbal report.

16 COMMUNITY HEALTH AND SOCIAL CARE DELIVERY PERFORMANCE

Jo Gray introduced the report and updated some of the recent figures. She particularly noted that the community hospitals had moved to 7-day therapy and this had led to an improvement in care. The service was very keen to encourage patient feedback and this had now been embedded into staff thinking and was being requested after every event.

Patricia Webb was thrilled at the large patient feedback and said it had been a long-term aim to achieve the current levels. Jo Gray observed that as a consequence of this, the safeguarding agenda was being enhanced.

The Board agreed to NOTE the report.

17 CHILD PROTECTION ACTIVITY PERFORMANCE

Mike Bowden (Divisional Director, Health Commissioning and Strategic Planning) introduced the report and pointed out that the performance reported on page 195 was measured against the existing indicators.

The Board agreed:
(1) To NOTE the report;
(2) To ASK the Divisional Director, Safeguarding, Social Care and Family Service, to submit updated performance reports and each meeting of the Board.

18 CHILDREN'S SERVICE COMMISSIONING PERFORMANCE

Mike Bowden (Divisional Director, Health Commissioning and Strategic Planning) introduced the report. He referred particularly to paragraph 3.2 relating to wheelchairs and acknowledged that this had been a longstanding problem. He said that the planned recommissioning of wheelchair services had been put on hold awaiting the recommendations of the national advisory group. In the interim, work was being done to address the local issues.

Board members expressed a number of concerns about the longstanding problems with the wheelchair service and asked to be kept informed of progress on resolving the local issues and once the national advisory group had reported.

The Board agreed to NOTE the performance described in the report.

19 CHILDREN'S TRUST BRIEFING REPORT

Mike Bowden (Divisional Director, Health Commissioning and Strategic Planning) introduced the report. He explained that although the government is expected to repeal the legislation relating to Children's Trusts, the Trust had decided that it still wished to operate, on a non-statutory basis, to continue the benefits which had been achieved. The new NHS governance arrangements would need to take this into account.

The Board agreed to NOTE the range of key issues covered in the report.

20 FORWARD PARTNERSHIP BOARD DATES

The Board was aware that the next scheduled meeting would be during a local election campaign but the consensus was that an informal meeting of the Board, with guests from those who might be included in the new arrangements, would be helpful as a first step towards a new shadow Board. The invited guests would include Health Watch.

John Everitt reminded the Board that any decisions about governance changes

would have to be agreed by the Council AGM, scheduled for June. He advised caution during the local election campaign.

The Board agreed to NOTE the list of forward dates.

The meeting ended at 4.10 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Partnership Board for Health and Wellbeing Report
Date: 15th June 2011
Report Title: HealthWatch Status Report
Agenda Item: 9
List of attachments to this report: None

Summary

Purpose

1 To update the Board on progress towards the establishment of HealthWatch and to report on the themes resulting from the current consultation exercise.

Recommendation

2 The Partnership Board for Health and Wellbeing is asked to comment on the information presented within the report, to note the key issues and to support the direction of travel indicated.

Rationale

3 HealthWatch will play a key role in the future operation of health and social care. The Partnership Board will need to be aware of the developments towards the establishment of HealthWatch and to have the opportunity to shape the development of the final service.

Other Options Considered

4 None

Financial Implications

5 The funding envelope for HealthWatch has not yet been established and will need to be identified before the procurement process commences.

Risk Management

6 There are risks that the councils duty to establish a service is not met or that stakeholders are not engaged sufficiently in the design and establishment of the service leading to lack of ownership and support. Project management is underway and consultation taking place to control and manage these risks.

Equality issues

7 HealthWatch aims to engage all sections of the community to be influential in shaping services and working towards reducing inequalities.

Legal Issues

8 Establishing HealthWatch is a duty of B&NES council under the legislation outlined within the Health and Social Care Bill currently going through parliament.

Engagement & Involvement

8 A managed consultation is currently underway involving all key stakeholders and is commented on within the report. A public webpage provides all information and is inviting comment and participation from the public. This report has been viewed by the Council monitoring officer and section 151 officer.

Partnership Board for Health and Wellbeing Report
Date: 15th June 2011
Report Title: HealthWatch Update
Agenda Item: 9

The Report

Background

1 The current health and social care reforms are centred on the fundamental principle that patients and the public must be at the heart of everything our health and care services do.

2 The Government has acknowledged that there have been a number of different arrangements for involving people in health and social care over recent years and has expressed an intention to build on what is working well but also establish new structures that will bring even greater benefits. As part of this intent the Health and Social care Bill currently going through parliament has provision in it for the establishment of HealthWatch.

3 HealthWatch is being described as an evolution from the existing Local Involvement Networks (LINK) and is expected to give people real influence over decisions made about local services; it will support individuals as well as engaging communities.

4 The Local Authority has a duty to commission HealthWatch. Subject to Parliamentary approval both HealthWatch England and local HealthWatch will be introduced from July 2012.

5 It is the intention to tender for the provision of HealthWatch in B&NES. An engagement process is underway following which a service specification will be developed and will be published in September.

Purpose of HealthWatch

6 HealthWatch covers health and social care. It can be best described as a consumer champion. Its role is to champion the views and experiences of patients, people using services, carers and the wider public.

7 The Health and Social Care Bill specifies 2 elements to the proposed structure

- **HealthWatch England:** A national body operating within the care quality commission providing leadership to local HealthWatch and advising the NHS commissioning Board.
- **Local HealthWatch:** Acting as consumer champion for local people regarding health and social care services.

8 HealthWatch England is currently being developed through the department of health and is not the subject of local engagement. The design and structure for local HealthWatch is currently being considered by Local Authorities and their healthcare partners across England.

Function of HealthWatch

9 Local HealthWatch has 3 principle responsibilities:

- **To Influence:** Helping shape the planning of health and social care services
- **To inform:** Providing information about health and social care services and supporting people in choice.
- **To advocate:** Acting as a watchdog pursuing peoples interests with local providers.

10 HealthWatch is different from Link and has new responsibilities. HealthWatch will need to do all that Link currently does and has the same powers that Link currently enjoy. It also has new duties to provide information and support people in choice. HealthWatch will also have a seat on the new Health and Wellbeing Boards and will operate as a Health and Wellbeing Board member.

Local development to date

11 The Partnership Board held a seminar on 20th April 2011 and received a presentation on the outline vision for HealthWatch. This initial vision had been developed through officer engagement, a review of the current and emerging guidance, consultation with Link, the involvement of other stakeholders and participation in the south west network of local authorities and health commissioners.

12 The partnership Board approved the outline vision and supported the intention to further engage with local people and principle stakeholders.

This engagement has been underway during May and will continue throughout June and July. Further consultation has taken place with Link and a stakeholder day gathered views from a varied group of interested parties including third sector, healthcare providers, GPs, commissioners and representatives from other areas where similar developments are taking place. The Health and Wellbeing network held a workshop session focussing on the topic and addressing detailed questions.

13 This engagement has consolidated the vision and provided some principles by which further development of the service design can be progressed.

The vision for HealthWatch in B&NES

14 HealthWatch will:

- Deliver the 3 operational functions of influencing, informing and local advocacy
- Operate as a network or brand bringing together the existing infrastructure of engagement and support in B&NES and consolidating it
- Outreach in communities to be inclusive and accessible to all groups e.g. adults, children, minorities,users,carers & patient groups
- Deliver information & choice through a signposting function
- Establish a common agenda of priorities & work alongside partners on those priorities
- Work within a triangle of activity and influence with effective linkages between commissioners, Overview and Scrutiny and the HealthWatch community.

Key issues

15 During the consultation key issues are becoming clear. Principle points are included below.

16 The principle purpose of HealthWatch is to represent and champion the consumer voice. Delivering the vision is dependent upon strong relationships developing between HealthWatch, overview and scrutiny, commissioners and providers. HealthWatch will have a seat on the Health and Wellbeing Board and it is anticipated that HealthWatch will also have a formalised role on the Overview and Scrutiny Panel. These developments will ensure HealthWatch is an active and inclusive partner in shaping ideas and decision making.

17 There is recognition that we do not want HealthWatch to be a separate entity which is stand alone. To do so would duplicate existing involvement structures and would not achieve the potential for collaboration and add value. There is already an existing structure of stakeholder, advice and advocacy groups and it is intended that HealthWatch acts as a coordinating force to bring the inputs from these groups together and to consolidate the consumer voice for health and social care. Some opinions are emerging that suggest HealthWatch may operate as a brand or kite mark whilst other views favour a managed network.

18 A clear consensus from the consultation to date is the recognition that HealthWatch needs to operate in a modern and accessible way. Expectations include an emphasis on electronic media to promote access and involvement and to reach out into communities, constituencies and localites so that engagement is as comprehensive as possible within the resources available.

19 It is expected that HealthWatch will initiate creative ways to be inclusive of all sectors and will move away from a formalised culture which can restrict involvement, to a more open and creative culture that will be attractive to potential users.

20 HealthWatch is for adults and children and it is recognised that the new model must embrace both and achieve effective linkages across both. Adult services and children's services have both evolved engagement and consultation structures that meet individual needs. Alignments across both structures need to be further explored and established.

Next Steps

21 Following the meeting of the Health and Wellbeing Network and the meeting of the Partnership Board a further meeting of the stakeholder group is planned for July 5th. This will consolidate the views and opinions of the engagement process confirm the vision and key principles and identify the outline information for the specification. The specification will be drafted during July with the procurement process commencing in September.

22 The aim is to award the contract in March and for the service to commence in July 2012

Contact person/Author	Derek Thorne
Responsible Director	Ashley Ayre
Background papers	The HealthWatch Transition plan: DH Publication

If you would like this document in a different format, please contact the author

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Partnership Board for Health and Wellbeing Report
Date: 15 June 2011
Report Title: Health and Wellbeing Board Governance
Agenda Item: 10
List of attachments to this report: None

Summary

Purpose

1 To outline the principles for the terms of reference of the shadow health and wellbeing board and facilitate more focused discussion on the aims and intentions of the board.

Recommendation

2 The board is asked to consider and agree the principles for the terms of reference of the shadow health and wellbeing board.

Rationale

3 An agreed terms of reference is central to the professional operation of the shadow health and wellbeing board.

Other Options Considered

4 None

Financial Implications

5 None

Risk Management

6

Equality issues

7 The principles for the terms of reference propose that a key aim of the shadow health and wellbeing board is to 'promote equality, health and wellbeing'

Legal Issues

8 An agreed term of reference is a requirement of the shadow health and wellbeing board.

Engagement & Involvement

8 Principles for the terms of reference were discussed at a workshop attended by partnership agencies provide. This report has been viewed by the Council monitoring officer and section 151 officer.

Partnership Board for Health and Wellbeing Report
Date: 15 June 2011
Report Title: Health and Wellbeing Board Governance
Agenda Item: 10

The Report

1. Introduction

1.1 Bath and North East Somerset (B&NES) is an early implementer of a shadow health and wellbeing board. Over the past year it has developed a strong working relationship with partners and begun to focus on joint plans and strategic commissioning; the board will be building from a position of strength.

1.2 At a meeting of the Partnership Board for Health and Wellbeing on the 9 February it was agreed that Partnership Board would transition to the shadow health and welling board through 2011/12.

1.3 On 20 April the partnership held a workshop to explore changing national expectations and to agree the next steps. Invitations to the workshop were extended to the Link and the B&NES GP Consortia. Principles for the future governance of the Board were discussed at length and will form the basis of the Terms of Reference. *(The meeting report from the 20 April is attached at Appendix 1.)*

2. Principles for the Terms of Reference

2.1 The following paragraphs outline the principles for the shadow health and wellbeing board. They also aim to create more focused discussion on the aims and intentions of the shadow health and wellbeing board.

2.2 This paper does not include issues related to meeting conduct and standard council protocols, which will be added to the full terms of reference. This paper simply aims to set out the principles for the shadow health and wellbeing board.

3. Statement of purpose

3.1 By working together the board will aim to:

- prevent ill health
- promote equality, health and wellbeing
- improve service quality
- deliver best value
- provide leadership and champion health and wellbeing in B&NES

3.2 The board will work to understand what makes a difference by responding to identified need and by listening to, and learning from, people. Joint strategic planning will be informed by this need and form the foundations of the health and wellbeing strategy.

3.3 The board will work to ensure that health and wellbeing services in B&NES:

- use resources effectively
- develop innovative joint responses

3.4 To achieve these aims the board will work collaboratively with partners to join up areas of commissioning across the NHS, social care, public health and other areas related to health and wellbeing.

4 Roles and responsibilities

4.1 The board will be responsible for:

- developing a joint strategic needs assessment (JSNA)
- preparing the health and wellbeing strategy
- considering whether the commissioning arrangements for social care, public health and the NHS are in line with the health and wellbeing strategy
- considering whether the GP Consortia's commissioning plan has given due regard to the health and wellbeing strategy
- reporting formally to the NHS Commissioning Board, GP Consortium, council leadership if local commissioning plans have not had adequate regard to the health and wellbeing strategy

4.2 The board will seek to influence the strategic planning of the NHS, social care, public health and other health and wellbeing agencies (including the voluntary sector) in B&NES through the promotion of the JSNA and health and wellbeing strategy.

4.3 The board will promote joint working and use the NHS Act 2006 flexibilities to increase joint commissioning, pooled and aligned budgets (where appropriate), to support the effective delivery of key outcomes of the health and wellbeing strategy.

4.4 The board will listen to and learn from people, service users and providers and it will ensure that they inform the JSNA, the health and wellbeing strategy and the on-going strategic performance management of key outcomes.

4.5 The health and wellbeing board will strategically performance manage against the key outcomes of the health and wellbeing strategy.

4.6 Responsibility for the scrutiny of health and wellbeing will continue to lie with the council's Healthier Communities and Older People Overview and Scrutiny Panel.

5. Scope

5.1 The boards' scope shall be:

- Adult services (commissioning and service delivery)
- Children services (commissioning and service delivery)
- Public health (commissioning and service delivery)

(Further detail on scope is attached in Appendix 2 Scope. This is the current scope of the Partnership Board for Health and Wellbeing).

6. Accountability

6.1 During the transitional period accountability remains with the Primary Care Trust and the council; as per the current Partnership Board arrangements.

6.2 Responsibility for adult and children safeguarding sits with the council leadership and the council Director for People Services; safeguarding is not a responsibility of the health and wellbeing board. The board will receive annual performance updates from

the Local Safeguarding Children Board and Local Safeguarding Adult Board in the form of their annual reports.

6.3 The board and the Local Strategic Partnership (LSP) will need to consider options and agree a way forward for a local governance framework. The LSP is currently reviewing the way it works; how it relates to the health and wellbeing board will form part of this review. Options for a local governance framework will be tabled at a future meeting of the Partnership.

7. Membership

Membership of the board is:

- B&NES Primary Care Trust (PCT) x 3 (Chief Executive, Chair of PCT Board, Non-Executive Director)
- B&NES Council x 5 (Director of Public Health, Director of People Services, Leader, Councillor x 2)
- GP Consortia x 2
- Health Watch x 2
- Finance advisor (nature of membership to be agreed)

7.1 It was agreed at the 20 April workshop that health and wellbeing 'providers' will not be represented on the shadow health and wellbeing board.

7.2 A number of options for the appointment of the Chair are set out below (this list is not exhaustive):

- Option one: the existing arrangement, whereby the role of Chair alternates annually between the Leader of the Council and Chair of B&NES PCT.
- Option two: the board appoints a Chair on an agreed term.

7.3 The board may also appoint a Vice Chair to support the role of the Chair.

7.4 Membership of the shadow board is not fixed and will be reviewed as the health and social care changes develop.

8. Wider engagement

8.1 By working together the board will:

- Listen to and learn from people, service users and providers
- Engage with communities and networks including the Health and Wellbeing Network
- Engage with and listen to service users and other interested parties through Health Watch

8.2 The board will support a twice yearly meeting of the Health and Wellbeing Network; members will be encouraged to attend.

8.3 The council's overview and scrutiny function offers an opportunity for broader engagement on key issues.

9. Business management

9.1 Board meetings will alternate between business management meetings and less formal workshops. The workshops will be focused on priorities (as identified in the health and wellbeing strategy) and other key issues as they arise. The board may invite external speakers to the workshops to inform discussion and decision-making.

9.2 Board meetings shall generally be held in public. Closed sessions of the board may take place to allow for more informal discussion.

9.3 The board will develop a forward plan, which will be regularly reviewed.

9.4 The board will meet 6 times per year (bi-monthly).

9.5 The board may establish sub-groups or time-limited project groups to lead on issues such as the joint strategic needs assessment, joint commissioning and health inequalities.

Contact person/Author	Helen Edelstyn, x7951
Responsible Director	David Trethewey
Background papers	Appendix 1, Workshop Report Health and Wellbeing Workshop 20 April Appendix 2, Scope of Services (Partnership Board for Health and Wellbeing)

If you would like this document in a different format, please contact the author

Appendix 1:
Health & Wellbeing Board Workshop
20th April 2011
Keynsham Town Hall, Council Chamber

Attendance

MEMBERS PRESENT	
Cllr Malcolm Hanney	Chair PCT
Cllr Francine Haeberling	Leader of Council
Cllr Vic Pritchard	Cabinet Member for Adult Social Services & Housing
Cllr Chris Watt	Cabinet Member for Children's Services
Dusty Walker	Non-Executive Director of the PCT
Patricia Webb	Non-Executive Director of the PCT
Janet Rowse	Acting Chief Executive of the PCT and Director of Adult Social Care and Housing
John Everitt	Chief Executive of the Council
Ashley Ayre	Strategic Director of Children's Services
Mike Bowden	Divisional Director Health Commissioning and Strategic Planning
Diana Hall Hall	B&NES Link
Mike Vousden	B&NES Link
Dr Ian Orpen	GP Commissioning Consortium
Derek Thorne	Assistant Director Communications and Corporate Affairs, B&NES PCT
Helen Edelstyn	Strategy & Plan Manager, Policy & Partnerships
Luke Byron-Davies	Partnership Development Officer, Policy & Partnerships
Susan Bowen	Funding & Programmes, Policy & Partnerships
Cllr Adrian Inker	Chair, Health & Social Care O&S Panel, B&NES Council
John Whapshott	Funding & Programmes, Policy & Partnerships
Paul Scott	Assistant Director Public Health, NHS B&NES / B&NES Council
Jo Gray	Managing Director Community Health and Social Care services

Apologies received from:
David Trethewey, Divisional Director, Policy & Partnerships
Dr Pamela Akerman, Acting Joint Director of Public Health

Welcome from the Chair
Cllr Malcolm Hanney welcomed and introduced the participants to the workshop.

Agenda Item 1
Planning for the Health and Wellbeing Board

JE referenced the local election and noted that outcomes from the workshop would need to be reviewed following the election on 5 May.

Helen Edelstyn presented on the White Paper and Government proposals for Health and Wellbeing Boards. The presentation referenced the Bath and North East Somerset position and progress made since the B&NES Health & Wellbeing Partnership Board was set up in 2008. Some of this progress includes:

- Strong grip on safeguarding
- Join-up of Children and Adult service delivery
- Joint Planning, Managing decision-making and joint accountability within the partnership
- Influencing and steering strategic development
- Embracing public involvement through the Health and Wellbeing Network

Overall the workshop felt that B&NES was building from a position of strength. The discussion focused on the overall purpose of the Board and it was agreed that the Board should continue to focus on strategic commissioning and high-level joint working between the relevant agencies on health and wellbeing matters.

The meeting discussed the breadth of 'health and wellbeing' and noted that this could include many additional service areas and issues. Concern was expressed that broadening the remit could mean that the agenda became unmanageable and it would be difficult to focus on the issues that matter most to Health and Wellbeing. It was felt that the remit and scope of the Board should reflect the scope of the existing Partnership Board for Health and Wellbeing.

Other key points from the open discussion:

- Health and wellbeing scrutiny will continue to lie with the Council's Healthier Communities and Older People Overview and Scrutiny Panel.
- The Board should drive and oversee join-up between the agencies and service areas, including a joint operational plan.
- Acknowledged that the Board will have a role in overseeing performance but that this would be high-level and strategic.
- Acknowledged the need to ensure join-up with the Sustainable Community Strategy and other strategic partnerships.
- Board meetings will be held in public, with scope for informal non-decision making meetings and workshops held in private.

Membership

The meeting discussed the membership of the Health and Wellbeing Board. It was suggested that the membership should be relatively limited and composed of representatives from the PCT (including Chair, Chief Executive and representative(s) of GP Consortia), Council (Leader, Cabinet Members for Children and Adults, Chief Executive, Director of People Services), the Joint Director of Public Health and Health Watch. There was an acknowledgement that the Board would also need finance input and the mechanism for this would need to be considered. It was agreed that organisations that provide a health and wellbeing service ('providers') should not be members of the Health and Wellbeing Board but would be invited as and when appropriate to attend.

The meeting discussed the role of HealthWatch. Diana Hall Hall and Mike Vousden expressed their concern regarding the Government proposal that HealthWatch should be a Board member, which would include a role in Board decision making. Their concern was how this decision making role will impact and potentially conflict with the role of HealthWatch as a consumer champion promoting choice and complaints advocacy. The meeting discussed

options to mitigate this conflict including Health Watch as a non-voting member of the Board. However, the meeting acknowledged that the key benefit of HealthWatch as a Board member would be to help ensure that views and feedback from patients are an integral part of strategic thinking.

Other key points from the open discussion

- Representation from the voluntary sector, potentially delivered through the Health and Wellbeing Network and HealthWatch.

Next steps

- Develop the Terms and Reference for the Shadow Health and Wellbeing Board, including membership.

Agenda Item 2

HealthWatch

Derek Thorne presented on proposals for HealthWatch. The presentation outlined the role of HealthWatch and the B&NES position. The key points from the presentation were:

- Role of HealthWatch is broader than the role of the Link and will include advice and information, and the support of patient choice.
- DH has announced additional funding for HealthWatch but the funding level has not yet been declared.
- B&NES vision for HealthWatch - to act as a network embracing and enhancing existing infrastructure of engagement and to work alongside partners on a common agenda of priorities.

The meeting supported the outline vision for HealthWatch.

The meeting discussed the timetable and the need to establish HealthWatch by April 2012; it was acknowledged that this is a tight timetable. Derek Thorne noted that there is an opportunity for B&NES to be a HealthWatch pathfinder and that there is limited risk or impact on the procurement timetable associated with pathfinder status. John Everitt noted support in principle for pathfinder status but suggested this be on terms that suit B&NES.

Next Steps

- Confirm support for HealthWatch pathfinder status on terms that suit B&NES.
- Develop the contract specification for HealthWatch and procure.

Appendix 2:

SCOPE OF SERVICES (Partnership Board for Health and Wellbeing)

1. Adult Services

a) Commissioning

The strategic planning, commissioning and procurement of health, social care and housing services for adults, including the support and performance management of practice based commissioning, across the following range of services:

- Health services for the whole population including acute care, primary health care and other community services
- Older people services
- Mental health services for adults of working age
- Services for adults with physical and sensory impairments
- Services for adults with learning difficulties
- Strategic housing services for the whole population including Supporting People Services

b) Service delivery

- Intermediate care, community based and other services through the integrated locality teams for older people and people with physical and sensory impairments, including social work and care management services
- Primary Health Care services not included in the above
- Mental health services for older people and people of working age in partnership with the Avon & Wiltshire Partnership NHS Trust
- Community based and other services for people with learning difficulties
- Acute services for adults
- A range of health services including diatetics, continence services, maternity services, dentistry, opticians and pharmacy services
- A range of housing services, including homelessness and housing advice, and housing private sector renewal services.

2. Children Services

a) Commissioning

The strategic planning, commissioning and procurement of strategic education, health, and social care services for children, across the following range of services:

- Early Years, Schools, inclusion support and extended services
- Health services for children including acute services and therapy services
- Mental health services for children
- Social care services for children and families
- Youth services

b) Service delivery

- Locality based services for children and families, including extended services and a range of support services listed below

- Early Years and education services for children, including school improvement services, educational psychology and other inclusion support services
- Health services for children and families (including those provided by health visitors and school nurses) and child health administration services and therapy services
- Social care services, including social work and care management services, fostering and adoption services, disabled children services, child protection, Looked After children and Leaving Care services
- Youth Services and the Youth Offending Service

3. Public Health

a) Commissioning

Assessing the health needs of the local population; strategic planning, commissioning and procurement of services which will help to promote the health and well-being of the population and reduce health inequalities including:

- Services and initiatives to deliver priority health improvement objectives including those in the Local Area Agreements and 'Choosing Health'
- Drugs and alcohol services through the Responsible Authorities Group's pooled budget
- A range of health improvement services in partnership with Children's Services

b) Service delivery

- Public Health advice to health and care services
- Health Promotion services
- Smoking Cessation services
- Health visiting (public health component)
- Health protection services in association with the Health Protection Agency

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Partnership Board for Health and Wellbeing Report

Date: 15 June 2011

Report Title: Interim Commissioning Arrangements

Agenda Item: 11

List of attachments to this report: None

Summary

Purpose

1 To update the Partnership Board on the interim arrangements for the continuation of integrated commissioning of care and health services within Bath and North East Somerset from 1 June 2011

Recommendation

2 To note the report

Rationale

3 These arrangements have been discussed and agreed between senior officers from NHS B&NES, The Council and the GP Commissioning Committee and the Chair of the NHS B&NES Board and Cabinet Member for Wellbeing. Formal agreement of the NHS B&NES and Restructuring Implementation Committee of the Council will also be required

Other Options Considered

4 "None"

Financial Implications

5 Over the rest of the financial year 2011-12 work will be undertaken to apportion budgets and spend in line with the emergent structures that will replace the Primary Care Trust. There will be some small in-year transfers to reflect the movement of a small number of key staff into new positions to support the interim arrangements.

Risk Management

6 These proposals prevent the risk of a 'fracturing' of our integrated commissioning and provision services during the transitions related to NHS reforms and Council re-structuring.
The proposals enable all key agencies to ensure that we retain sufficient senior leadership expertise and capacity to deliver the required changes whilst retaining an absolute focus on safety and safeguarding of customers/clients/patients

Equality issues

7 The proposals will maintain our focus on equalities issues during the transition.

Legal Issues

8 The proposals for the interim arrangements can be delivered through the existing partnership arrangements between NHS B&NES and the Council, using section 113 of the Local Government Act 1972.

Engagement & Involvement

9 The Chief Executive of NHS B&NES and the Council have been consulted as have the Chair of the GPCC and the Cabinet Member for Wellbeing, Chairman of NHS B&NES Board. This report has been viewed by the Council monitoring officer and section 151 officer.

Partnership Board for Health and Wellbeing Report
Date: 15 June 2011
Report Title: Interim Commissioning Arrangements
Agenda Item: 11

The Report

1. Purpose

1.1 The current context is in flux as National Government considers amendment of the proposed Health and Social Care Bill which will bring into being a range of new local and national health commissioning and service delivery structures including the emergent of role of GP-led Commissioning Consortia. The Council has also embarked on a major change programme to deliver its vision of a 'Core' Council.

1.2 Both PCT & Council (with cross party support) agree the benefit of integrated commissioning of health and social care services. During the life of the Partnership to date it is clear that alignment around community based health and social care has been particularly beneficial to:

- Care pathway design & achievement of improved patient / user outcomes – e.g. stroke services, reablement
- System health – particularly the stabilisation of urgent care systems
- Effective joint agency planning & resource application – with demonstrable advantage to both health & social care budgets – eg control of individual placement & package expenditure

1.3 In the face of uncertainty and wishing to preserve the options for future decision making when the landscape becomes clearer, we wish to put in place interim arrangements that preserve the benefits to integration to date, and lay the foundation for even greater integration of adult and children's services, and for interventional and preventative services.

1.4 In this context we are looking for a solution that is simple, clear and "fit for purpose" rather than the final design.

1.5 In the current context it is particularly important that the lines of accountability are clear. There needs to be a clear line of accountability from the DASS & DCS to the Council CEO, and there needs to be clear line of accountability from the PCT CEO to the PCT Board for the commissioning of all NHS services.

1.6 The newly forming Health & Well Being Partnership Board provides a helpful new structure to oversee the formation of these interim arrangements and to ensure that they add value for local people.

2. Progress to date

2.1 An outline “Route Map” for commissioning has been developed and has been used as a prompt for debate amongst group leaders, O&S, GP Consortium and PCT Board & the integrated commissioning team.

2.2 There is general agreement to the concept of integrated commissioning, and growing acceptance that this is particularly important for community health & social care, and that it may therefore be possible / desirable to have different solutions for the commissioning of community as opposed to hospital based services.

2.3 It is fully recognised that there are inter-dependencies between the commissioning and operation of community-based and hospital-based/acute services. The proposals recognise this and seek to ensure that sufficient capacity is in place to enable specific work streams to be delivered and to ensure that these inter-dependencies are recognised in the development of new local, regional and national commissioning structures.

3. Proposed Way Forward

3.1 The Acting Strategic Director for People Services within the Council (Ashley Ayre) will hold the two statutory roles of Director of Children's Services and Director of Adult Social Services, this role will also take responsibility for Housing.

3.2 Jo Gray will report to Ashley in her new role as Divisional Director for Adult Safeguarding, Care and Practice Development

3.3 The commissioning of Acute NHS Services will be aligned with the Cluster and therefore Tracey Cox, Programme Director for Acute Services and team will be part of the PCT Cluster. However, the close working relationship of Tracey Cox and her team will be crucial to the delivery of the QIPP agenda.

3.4 Public Health services are expected to transfer to the Council as part of the NHS reforms. In anticipation of this (and recognising that Public Health is already part of the Council / NHS Partnership) the intention is for line management of the PCT public health team to be brought under the Acting Strategic Director for people Services in the next few months. At this point, Pamela Akerman, the Acting Joint Director of Public Health will report to the Acting Strategic Director for People Services. Until the formal transfer to the council in April 2013 Public Health will continue to be accountable to the NHS B & NES Board.

3.5 NHS Bath and North East Somerset and the GPCC have agreed that the commissioning of Community Health Services should be orchestrated through the Acting Strategic Director for People Services until the GPCC are in a position to confirm and implement their future commissioning structures. The Acting Strategic Director (Ashley Ayre) will be accountable for these services to the PCT Cluster CEO (Jeff James) and therefore to the PCT Board.

3.6 In relation to the above, Jane Shayler, Programme Director for Non-Acute Care, Social Care and Housing and team will report to the Acting Strategic Director for People Services

3.7 All other commissioning staff within NHS Bath and North East Somerset i.e. Finance, Information, Medicines management, Primary Care Commissioning and Corporate Services will also be within the Cluster.

3.8 These decisions will have to be formally agreed by the NHS B&NES Board and the Council in due course.

3.9 It is proposed that the existing partnership arrangements between the Council and NHS B&NES are sufficient to enable the interim management arrangements described for community health service commissioning and Public Health, using section 113 of the Local Government act 1972 to make named senior council managers available to perform functions on behalf of the PCT and vice versa.

3.10 There will be no changes to the location of colleagues although there will be some re-alignment of line management which will be discussed with individual colleagues. The arrangements described above are transitional: there will be further changes associated with the finalisation of the Health Bill and the implementation of the Council Change Programme. Until the final structures become clear there will be no changes in employer for any individual.

3.11 The intention is to establish the principle of even greater integration in the commissioning of community health, social care, public health and housing services for adults and children. In setting this up we need to be very careful not to “disintegrate” the commissioning relationship between acute and community based services and to get the balance right as to what is done locally and what is done at Cluster level. It will be very important, despite changes in line management, for commissioning colleagues to continue to work closely with each other to ensure that together we build on the achievements to date and maintain an integrated system of care that supports local people.

Contact person/Author	Ashley Ayre
Responsible Director	Ashley Ayre
Background papers	

If you would like this document in a different format, please contact the author

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Partnership Board for Health and Wellbeing Report
Date: 15 June 2011
Report Title: Draft Refreshed Alcohol Harm Reduction Strategy for B&NES 2010-12
Agenda Item: 12
List of attachments to this report: None

Summary

Purpose

1 Alcohol misuse causes much harm in B&NES. An interagency group have refreshed the previous alcohol harm reduction strategy. Our goal is to prevent the harm arising to individuals, families, and society from alcohol misuse in B&NES and to treat, rehabilitate and care for those people who misuse alcohol. The draft strategy outlines where we would like to be with alcohol-harm reduction, harmonises with current local and national polices and plans, identifies the key needs, gaps, and priorities, and spells out the key initial actions we need to take. Stakeholders have identified 24 developmental service and organisational priorities for reducing the harm caused by alcohol misuse in B&NES.

Recommendation

2 The Partnership Board for Health and Wellbeing is asked to agree the key priorities and actions and to recommend that:

- The cabinet member for wellbeing approves the strategy
- The Health and Social Care Committee approve the strategy on behalf of the PCT Board.
- The final strategy is adopted by all stakeholder agencies and partnerships (LSP, DHI, AWP, B&NES Council, NHS B&NES, RUH, GWAS, Police, and Probation Service)

Rationale

3 We need to agree our values, gaps, needs, and priorities so that we can assuredly decide the actions and their associated timescales to tackle alcohol related harm. We need a multi-agency multi-sectoral set of actions that are proportionate to needs and affordable. It helps if all the agencies are following the same strategy. The Responsible Authorities Group and the Children's Trust Board have both signed up to the Strategy.

Other Options Considered

4 None.

Financial Implications

5 A spend-to-save business case and action plan based on this draft strategy is being produced that will include actions covering the short term (within 3 months), medium term (up to one year), and long term (over one year). All resource changes will be identified.

Risk Management

6 The risks are from not working in a concerted multi-agency manner to tackle alcohol-related harm. These include not optimising on the benefits from resources committed and fewer people being helped.

Equality issues

7 We will ensure that access to services is the same for all regardless of age, sex, disability, ethnicity, sexuality, or religion. Men, young people, and the socio-economically deprived are more at risk from alcohol-related harm.

Legal Issues

8 None known

Engagement & Involvement

8 All stakeholder agencies (including police, NHS, council, probation, and business representatives) have been involved in contributing to the strategy. Citizens and users have informed workshops. This report has been viewed by the Council monitoring officer and section 151 officer.

Contact person/Author	Philip Milner, Public Health Consultant 01225 831451
Responsible Director	Pamela Akerman, Acting Joint DPH
Background papers	None

If you would like this document in a different format, please contact Philip Milner

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Draft Refreshed Alcohol Harm Reduction Strategy for Bath and North East Somerset for 2010 to 2012

The previous strategy was produced in 2006

Authors:

Philip Milner	Public Health Consultant
Jodie Smith	Project Officer (Alcohol Harm Reduction)
Carol Stanaway	Substance Misuse Joint Commissioning Manager
Pamela Akerman	Acting Joint Director of Public Health

With contributions from:

Andy Thomas, Group Manager Partnership Delivery, B&NES Council

Simon Ellis, Chief Inspector Operations, Bath and North East Somerset District Police

Paul Scott, Assistant Director of Public Health, NHS B&NES

Jane Shayler, Programme Director, Non-Acute Health, Social Care & Housing

November 2010

Avon and Somerset Probation Trust

Royal United Hospital Bath NHS Trust

Avon and Wiltshire Mental Health Partnership NHS Trust

Contents

Summary

Our goal is to prevent the harm arising to individuals, families, and society from alcohol misuse in B&NES and to treat, rehabilitate and care for those people who misuse alcohol. The draft strategy outlines where we would like to be with alcohol-harm reduction, harmonises with current local and national polices and plans, identifies the key needs, gaps, and priorities, and spells out the key initial actions we need to take. Our vision is that local children and adults know about the physical and social effects of alcohol and take actions to drink sensibly and those who experience problems as a result of their own or other's drinking know where to seek help and will receive appropriate help in a timely fashion.

The draft strategy considers the 5 Year B&NES Strategic Plan 'Improving Health & Wellbeing in Bath & North East Somerset', the B&NES Community Safety Plan and the Responsible Authorities Group, and the B&NES Sustainable Community Strategy as well as national drivers such as the UK Government 2010 June Budget Statement, the Big Society, the Police Reform and Social Responsibility Bill, and the new mandatory drinking code.

The alcohol-harm reduction needs and gaps in services and organisation for B&NES were identified through routine information indicators, meetings, communications, and specific consultations. The only problem identified in B&NES by the North West Public Health Observatory Local Authority Alcohol Profile was a high proportion of staff working in bars. The total cost in B&NES of the harm arising from alcohol-use disorders is some £45.0 million a year. Research shows that for every £1 spent on treatment, the public sector saves £5. We need to gather the information on the current resourcing of local alcohol-harm reduction services urgently and evaluate how effective services are being delivered.

Current local services, groups and partnerships tackling alcohol related harm are described. The services are assessed against the models of care recommended and research evidence.

The overall governance of this Alcohol Related Harm Reduction Strategy will be through the Bath and North East Somerset Health and Wellbeing Partnership Board. The community safety aspects of the Strategy will be reported to the Responsible Authorities Group.

Stakeholders have identified 24 developmental service and organisational priorities for reducing the harm caused by alcohol misuse in B&NES. The top developmental ones are with the numbers indication priority:

Service developments

1. There is a need to increase alcohol treatment capacity for people in B&NES who misuse alcohol.

2. The identification of people in B&NES who misuse alcohol and are offered brief interventions needs consolidating in primary care and rolling out to other settings.

3. We need to find out if we are doing enough to identify, risk reduce, and support children of problem drinkers.

Organisational developments

4. There is a need for a B&NES Alcohol Harm Reduction Implementation Group or Annual Stakeholder Forum for checking progress.

5. We need a code spelling out the clear and consistent messages around alcohol and the behaviour expected of B&NES citizens and visitors that the local statutory agencies expect.

6. We need to identify the key local indicators and information sources for alcohol misuse priorities as part of our Joint Strategic Needs Assessment and report the position yearly.

7. We need a comprehensive care pathway for people with alcohol misuse in B&NES that is clear to users, citizens, commissioners, and providers.

8. We need to contribute to the Big Society initiative and engage local communities and citizens on reducing alcohol related harm.

There is an urgent need for officers of the key stakeholder agencies to produce a spend-to-save business case and action plan based on this draft strategy and its associated workshop. These should include actions covering the short term (within 3 months), medium term (up to one year), and long term (over one year).

Recommendations

The Bath and North East Somerset Health and Wellbeing Partnership Board, the Responsible Authorities Group, and the Children's Trust are asked to:

- adapt and adopt this draft Alcohol Harm Reduction Strategy and to agree the key priorities and initial actions and to require a detailed business plan with costings;
- receive Alcohol Harm Reduction Business and Action Plans within 3 months;
- promote the final strategy adoption by all stakeholder agencies and partnerships (LSP, DHI, AWP, B&NES Council, NHS B&NES, RUH, GWAS, Police, and Probation Service).

1 Purpose and Scope

1.1 Our goal is to prevent the harm arising to individuals, families, and society from alcohol misuse in B&NES and to treat, rehabilitate and care for those people who misuse alcohol

1.2 The strategy outlines where we would like to be with alcohol-harm reduction, harmonises with current local and national polices and plans, identifies the key needs, gaps, and priorities, and spells out the key initial actions we need to take.

1.3 The scale of alcohol harm covered is the same as in the Alcohol Harm Reduction Strategy for England.[1] This covers health, crime and disorder, work problems, and family/community problems.

1.4 The Strategy is aimed to cover people of all ages (children and adults) who live, work or visit Bath and North East Somerset.

1.5 The strategy considers the services and partnerships available to prevent and reduce alcohol-related harm and treat, rehabilitate, and care for those who misuse alcohol

1.6 The outcomes we are seeking to achieve are:

- Increasing the number of people drinking sensibly within the daily safe limits (men should consume no more than 3-4 units daily and women 2-3 units daily)
- Decreasing the physical and emotional harm arising in people who misuse alcohol
- Decreasing the crime and disorder arising in people who misuse alcohol
- Decreasing the impairment at work arising in people who misuse alcohol
- Decreasing the amount of family and community harm related to alcohol misuse
- Preventing children and young people and adults from misusing alcohol

[1] Cabinet Office Prime Minister's Strategy Unit. The Alcohol Harm Reduction Strategy for England. London; Cabinet Office, 2004.

2 Vision

2.1 In Bath and North East Somerset we recognise that drinking is associated with a range of harms to individuals and wider communities. We will work together to reduce alcohol-related harms within our communities and better monitor the effects of alcohol on our community so that we can more effectively target our actions.

2.2 We will work to ensure that:

- information on the physical and social effects of alcohol is widely disseminated and appropriately targeted
- those who suffer problems as a result of their own or other's drinking know where to seek help and we will endeavour to provide appropriate help in a timely fashion

2.3 We will ensure that access to services is the same for all regardless of age, sex, disability, ethnicity, sexuality, or religion.

2.4 We will work to promote a culture where drinking is seen as an adjunct to having an enjoyable and sociable time and not as an end in itself. We recognise that drinking alcohol can form an enjoyable part of socialising and we will seek to encourage the development of a variety of venues where drink is available in settings that promote enjoyment.

2.5 We will actively seek in implementing this vision to balance the interests of drinkers with those who are directly or indirectly affected by the behaviours and actions of drinkers.

2.6 There will be no presumption in favour of a 'right to drink'.

2.7 We will not tolerate the use of drunkenness as an excuse for anti-social, violent or other criminal behaviour and will intervene to prevent this at every opportunity.

2.8 We will work to ensure that licensees understand their obligations and that they work in partnership with other agencies to promote the responsible consumption of alcohol and provide a safe and secure environment in which to drink.

2.9 We will work to ensure that drinkers understand that they have an obligation to respect themselves and others.

2.10 Drinkers should respect themselves:

- By understanding the effects of alcohol and by taking steps to protect themselves
- By always knowing how much they have drunk and keeping within recommended alcohol consumption levels
- By knowing where to get help if their drinking becomes a problem to themselves or others.
- By behaving courteously to staff in licensed premises, those working in the night-time economy, and to those who live and work near licensed premises.
- And others by not using alcohol as an excuse to behave in ways that they otherwise would not – harassment, violence, vandalism, littering and fouling the streets.

2.11 We will work to provide alternatives to alcohol as a diversion for young people and we will assist parents to take responsibility for establishing positive approaches to alcohol in their children as a part of effective parenting.

3 Context

3.1 Local partnership priorities, policies and plans

3.1.1 The 5 Year Strategic Plan 'Improving Health & Wellbeing in Bath & North East Somerset'

The 5 Year Strategic Plan for 2010/11 – 2014/15 of the Bath & North East Somerset Health and Well Being Partnership identified that alcohol misuse is one of the leading causes of death and disability in B&NES. Commissioning priorities were specified as:

- Continue to provide primary prevention & education/Healthy Schools programme
- Commission brief interventions at RUH A&E
- Increase drug treatment capacity
- Strengthen Purple Flag scheme to reduce antisocial behaviour
- Strengthen partnership to reduce irresponsible promotions

The outcomes sought are:

- Reduce potential for long term organ damage
- Reduce mental illness as result of dependency
- Reduced A&E attendances and hospital admissions
- Reduction in antisocial behaviour and crime

Primary prevention and education is progressing in schools, brief interventions have been commissioned at the RUH, and the Purple Flag Scheme has become exemplary. But the alcohol treatment capacity has not been increased and irresponsible promotions continue.

3.1.2 The Community Safety Plan and the Responsible Authorities Group

The impetus to tackle alcohol-related harm has come from the B&NES Community Safety Partnership, the Responsible Authorities Group, that identified tackling Substance Misuse (including alcohol) as one of its key objectives. The priority for the PCT from the Community Safety Plan is to minimize the harm that substance misuse causes to society, communities, families and individuals (NI-40). We have also identified how each priority helps to deliver the designated targets within the Local Area Agreement. Priority Actions against alcohol misuse will also contribute to the Partnership's objectives of reducing the fear of crime within the local community and tackling anti-social behaviour.

3.1.3 The Sustainable Community Strategy

The Sustainable Community Strategy sets out what type of place Bath & North East Somerset should become. An important component of this is to influence wider Local Strategic Partnership partners. Top priorities for local residents include the need for activities for teenagers, reducing the level of crime, cleanliness of streets, and the level of pollution. Alcohol misuse can impact adversely on all of these.

3.2 National partnership priorities, policies and plans

3.2.1 UK Government 2010 June Budget Statement

The UK Governments current budget plans are to make government and the public sector more efficient as well as reducing their expenditure as an aid to reducing our national budget deficit. For the statutory agencies this means doing more for less as well as less of the lower priority activities. All public agencies have to make savings currently. So any spending on new priorities will have to come from savings or other services.

3.2.2 The Big Society

The UK Government's aim is to not only create the largest co-operative or mutual in Britain, but to create a mutual that is Britain. Every citizen can be a shareholder, contribute, and receive help and rewards. The Big Society is a society in which we as individuals do not feel small. The Big Society Network is an organisation being set up by frustrated citizens for frustrated citizens, to help everyone achieve change in their local area. The aim is to create a new relationship between Citizens and Government in which both are genuine partners in getting things done, real democracy using all the human and technology tools.

3.2.3 The Police Reform and Social Responsibility Bill

The new coalition national government says that it will do more to tackle alcohol-related harm than its predecessor. In the 25 May 2010 Queen's Speech on the Police Reform and Social Responsibility Bill the main benefit for reducing alcohol related-harm was the proposal for increased powers on licensing to tackle alcohol-fuelled crime and disorder. Main elements cover overhauling the Licensing Act to give local authorities and the police much stronger powers to remove licenses from, or refuse to grant licenses to, any premises that are causing problems; banning the sale of alcohol below cost price; and allowing local councils to charge more for late-night licenses to pay for additional policing, giving them powers to shut down shops or bars persistently selling to children, and doubling the maximum fine for selling to children to £20,000.

3.2.4 New mandatory drinking code

Under a new mandatory drinking code irresponsible promotions including "all you can drink for £10" deals, women-drink-free deals and speed drinking competitions are banned. Other deals that are made unlawful are "dentists' chairs" where drink is poured directly into the mouths of customers making it impossible for them to control the amount they are drinking. In a third measure bars and clubs will be forced to ensure that tap water is available, free of charge, for all drinkers. Two remaining conditions came into force on 1 October 2010 as part of the mandatory code include requiring bar staff check the ID of anyone who looks under 18 and ensuring that small measures of beer, wine and spirits are on offer to customers, so they have the choice to drink less. Bar and club owners who fail to comply with the new code risk losing their licence, a fine of up to £20,000 and six months in prison. Enforcing these new measures will have to wait until the guidance from the Home Office is published.

4 Identified needs

4.1 Alcohol-related harm indicators

The North West Public Health Observatory publishes an alcohol profile yearly in September for each PCT and/or local authority.[2] The one for 2010 for B&NES is shown below in Figure 1. Performance in B&NES is red for % of staff working in bars. The hospital specific admissions for alcohol for women and the mortality rates for males from alcohol harm are high but not outlined as red. Positively for the key priority of the Health and Well Being Partnership we are much lower than the average for hospital admissions for alcohol-related harm (shown as green against NI 39 in Figure 1). In 2008/09 for B&NES the directly age and sex standardised rate of hospital admissions for alcohol-related harm was 1,384.7 per 100,000 population. This figure is just below the national and regional averages and ranks B&NES 153rd out of 326 local authorities in England. There is no more readily accessible timely local information on alcohol misuse. Such information should cover the local priorities for alcohol harm-reduction such as reducing disorder in the night time economy and ensuring that services for alcohol misusers are effective. The local health services in secondary care including the emergency department should routinely record alcohol status in all cases where alcohol is a contributory factor and respond accordingly. A key priority therefore as part of our Joint Strategic Needs Assessment is to identify the key local indicators and information sources for alcohol misuse priorities and to report the position on these indicators yearly.

4.2 The costs of alcohol harm in B&NES

4.2.1 Health Care Costs

Alcohol-use disorders, either directly or indirectly, increases the work burden on all aspects of health and social care. The following NHS services are heavily used because of alcohol-use disorders: inpatients, A & E departments and ambulance services, mental health services, outpatients, GPs and other primary care services, drugs dependency services, and alcohol dependency services.[3] Cost breakdown of alcohol-use disorders shows a major strain on NHS hospitals. We estimate that up to £5.0 million is spent yearly on health care for alcohol-use disorders in B&NES.[3]

4.2.2 Costs of the results of alcohol-specific crime

The costs of alcohol-related crime nationally fall into three main categories:[3] Costs

- incurred in anticipation of crime
- incurred as a consequence of crime
- incurred in response to crime

We estimate that up to £21.3 million was spent yearly as a result of crime related to alcohol-use disorders in B&NES.[3]

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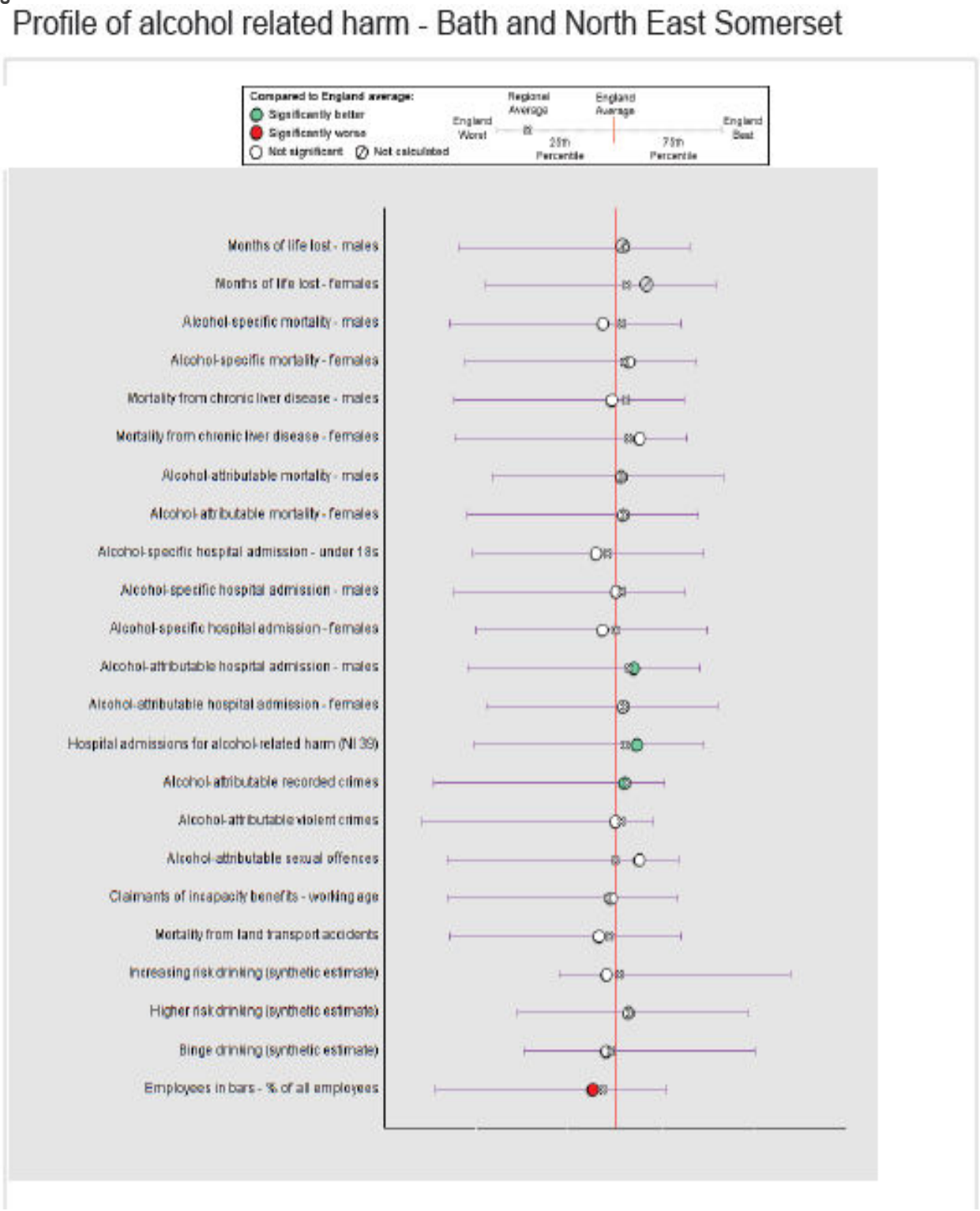
[2] North West Public Health Observatory Local Authority Alcohol Profiles 2010. http://www.nwph.net/alcohol/lape/LAProfile.aspx?reg=k

[3] Leontaridi R. Alcohol misuse: how much does it cost? London; Cabinet Office Strategy Unit, 2003.

Figure 1: Profile of alcohol-related harm for B&NES in 2010



4.2.3 Workplace and Wider Economy Costs

Alcohol-use disorders affect workplace activity and hence incur costs to the economy in three major ways nationally. Alcohol-related working days and hence economic output are lost through:

- Alcohol-related unemployment and early retirement
- Alcohol-related premature deaths

- Alcohol-related absenteeism

We estimate up to £18.7 million is lost yearly due to the economic output reduction caused by alcohol-use disorders in B&NES.[3]

4.2.4 Costs to families and society

The government and researchers have so far been unable to estimate the costs to families and society of alcohol-use disorders because of the incompleteness of appropriate data. There are undoubtedly major costs incurred here though. There are also all the costs of the homeless and the children living in poverty from alcohol-use disorders.

4.2.5 Total yearly costs of alcohol-use disorders

The total cost in B&NES of the harm arising from alcohol-use disorders is some £45.0 million a year.[3]

4.3 Costs & effectiveness of local alcohol harm reduction services & interventions

The direct cost of a brief intervention delivered to hazardous or harmful drinkers was calculated to be only £20 in 1993.[4] A recent WHO study estimated that the cost effectiveness of brief interventions for hazardous and harmful drinking is approximately £1,300 per year of ill-health or premature death averted.[5] This is nearly equivalent to the cost-effectiveness of smoking cessation interventions which is about £1,200. Recent studies suggest that alcohol treatment has both short and long term savings. Analysis from the UKATT Study suggests that for every £1 spent on treatment, the public sector saves £5.[6] The provision of alcohol treatment to 10% of the dependent drinking population within the United Kingdom would reduce public sector resource costs by between £109m and £156m each year.[7] In a Scottish study, alcohol treatment reduced long-term health care costs by between £820 and £1,600 per patient (2002/3 prices).[7]

The costs to society of the harm from alcohol misuse are clear. The crucial question is whether we can reduce these costs by spending on alcohol-harm prevention and treatment. The totality of the funding tackling alcohol-harm reduction in B&NES directly is not known.

Gap 1: Identify how much we are spending on all services targeted directly at reducing alcohol-related harm (Evidence: Refresh consultation)

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[4] Freemantle N, Gill P, Godfrey C et al. Brief Interventions for alcohol problems: a review. Addiction 1993;88:315-335.

[5] Hutubessy R, Chisholm D, Tan-Torres Edejer T, WHO-CHOICE. Generalized cost effectiveness analysis for national-level priority-setting in the health sector. Cost-effectiveness and Resource Allocation 2003;1:8.

[6] UKATT Research Team. Cost effectiveness of treatment for alcohol problems: findings of the randomised United Kingdom Alcohol Treatment Trial (UKATT). BMJ 2005;331;544-48.

[7] NHS National Treatment Agency. Alcohol-use disorders Interventions: Guidance on developing a local programme of improvement. London: Department of Health, 2005.

4.4 Local stakeholder views

4.4.1 Report of the B&NES Alcohol Harm Reduction Strategy Stakeholder Event

Some of the key points made in December 2005 that are still relevant were:

- There is a need for a strategic alcohol group (Progress: not done)
- Clear and consistent messages around alcohol help to set the tone locally (Progress: not done)
- No clear local picture of the existing level of provision nor of the level of need (Progress: partly done)
- A comprehensive treatment pathway needs to be developed locally (Progress: not done)
- Agencies need to develop a coordinated approach to evidence gathering if the review process of the new Licensing Act is to be used (Progress: partly done)
- Consideration should be given to establishing a wider alcohol forum of stakeholders to ensure co-ordination of actions and be responsible for monitoring the effects (Progress: not done)

4.4.2 Alcohol Use and Attitudes among Vulnerable Young People in Bath and North East Somerset in 2004

Some of the key points made that are still relevant were:

- Many participants had friends that they felt had severe problems with alcohol and that they were concerned about
- Most felt that there was no one they could trust to talk to about alcohol misuse
- Several girls, as well as boys commented on the link between alcohol and violence
- Most of the discussions around substance misuse showed that participants felt there was little they could do to help others with a perceived problem, since those with a problem have to recognise it as an issue in the first place
- When asked what advice the young people would like to give to the DAAT, some felt they should be left alone, that no amount of intervention will make any difference, and others that drugs education could play a role but that they did not want advice

4.4.3 Feedback from B&NES Drugs and Alcohol Action Team Awayday in 2010

The key points made were in participants' words:

- There is a high demand on alcohol treatment services
- Review alcohol harm outside of Bath city centre as well
- Have clear alcohol referral and treatment pathways
- There is a lack of funding for alcohol harm reduction services
- Alcohol and drug use are very often interconnected
- The best solution for harm reduction is more housing assistance and more bed and breakfast placements
- What is the difference in levels of harm between young & older binge drinkers?
- When should alcohol education begin? Is there too young an age?
- Is public transportation enabling binge drinking?
- There should be a commitment to alcohol policies in the workplace (public sector should set the standard)

4. Identified needs

4.4.4 Feedback to current strategy

The following items mentioned have been recurring in the work to refresh the strategy:

- A full care pathway should be developed locally with all the routes into treatment and provision at different levels of need
- There is a need for a B&NES alcohol implementation group
- Clear and consistent messages around alcohol and expected behaviours will help to set the tone locally
- Agencies need to develop a coordinated approach to evidence gathering if the review process of the new Licensing Act is to be used
- Review alcohol harm outside of Bath city centre as well
- There is a high demand on alcohol treatment services
- Publicise better the successes in B&NES in reducing alcohol-related harm

4.4.5 Alcohol Harm Reduction Strategy Workshop 6 October 2010 (Appendix 2)

The Alcohol Harm Reduction Strategy Workshop considered the draft strategy so far and commented on supply chains for service delivery and prevention, gaps identified and priority actions. These are summarized in Appendix 2. There were particular focuses on children and young people, health, disorder, society, and workplace as well as mapping delivery outcomes and working better together. Other specific outputs sought were: What is working well and not working as well as it should be? How can the system be improved to improve outcomes? What can we offer to others in the system? What is the ambition for Alcohol Harm Reduction? Good practice example sharing; How can we work together smarter? How can we increase community participation? What are participants going to do to help this happen? and What new joint projects can we implement? The workshop was very valuable for describing the actions needed. Participants were also asked to rank the draft priorities emerging from the strategy so far. The top eight out of the 24 gaps in organisational and service developments identified were:

1. There is a need to increase alcohol treatment capacity for people in B&NES who misuse alcohol.

2. The identification of people in B&NES who misuse alcohol and are offered brief interventions needs consolidating in primary care and rolling out to other settings.

3. There is a need for a B&NES Alcohol Harm Reduction Implementation Group or Annual Stakeholder Forum for checking progress.

4. We do not know if we are doing enough to identify, risk reduce, and support children of problem drinkers.

5. We need a code spelling out the clear and consistent messages around alcohol and the behaviour expected of B&NES citizens and visitors that the local statutory agencies expect.

6. Identify the key local indicators and information sources for alcohol misuse priorities as part of our Joint Strategic Needs Assessment and report the position yearly.

7. A comprehensive care pathway for people with alcohol misuse in B&NES that is clear to users, citizens, commissioners, and providers needs elaborating.

4. Identified needs

8. Contribute to the Big Society initiative and engage local communities and citizens on reducing alcohol related harm.

5 Current services and models of good practice

5.1 Current services for alcohol-related harm

5.1.1 Health and social services

5.1.1.1 All the general practices (Tier 1) in B&NES offer services covering alcohol misuse in primary care. All the local community pharmacies can offer advice, counselling and signposting to people who misuse alcohol.

5.1.1.1.2 Social Services staff is in a position to work with vulnerable people and their families and identify those who misuse alcohol and offer advice, counselling and signposting.

5.1.1.1.3 The Emergency Department at the Royal United Hospital in Bath will see many people attending who misuse alcohol. These attendees can be offered brief interventions through New Highway. The ambulance service also carries many people who misuse alcohol.

5.1.1.1.4 The AWP Mental Health Trust provides services for people with mental health problems, most of which can be made worse by alcohol misuse.

5.1.1.1.5 There are three providers contracted to provide specialised alcohol treatment services in B&NES. These are New Highway (Tiers 1 & 2 - used to be Bath Alcohol and Drug Advisory Service); the Developing Health and Independence (Tiers 1, 2 & 3 - used to be Drugs and Homeless Initiative (DHI); and Specialist Drug and Alcohol Services (Tier 3 & 4 - SDAS). Of these, New Highway and DHI are voluntary sector providers and SDAS is a statutory agency that currently operates as part of the AWP Mental Health Trust. At any time these agencies will be treating around 150 – 160 clients in total and the interventions offered will usually last for about 3 months or so.

Gap 2: There is a need to Increase alcohol treatment capacity for people in B&NES who misuse alcohol (Evidence: HWBP Plan, research evidence on cost effectiveness, & numbers with alcohol-related problems or dependency and those having treatment)

5.1.1.1.6 At the moment outcome data for all individual clients using the specialised alcohol treatment services are not collected, analysed and reported to the commissioners to see how well services are working. The alcohol treatment services need to use a standardised assessment process for clients and report to the commissioners on the health outcomes achieved quarterly. The other alcohol-harm reduction providers should also openly publish regularly their outcomes so that their effectiveness can be assessed. We can then estimate whether we can invest to save.

Gap 3: Evaluate how effective alcohol harm reducing local services are and set up systems that routinely report their effectiveness (Evidence: Refresh consultation)

5.1.2 Criminal justice services

<u>Police (Appendix 1)</u>

The aim of the Police is to work together with partner agencies and the community to

minimise the harm caused by alcohol in terms of crime, health, anti-social behaviour and violence, thereby improving public safety and public confidence.

Probation Service

Other Criminal Justice Service (e.g. magistrates)

Public Protection Team & Licensing Services (B&NES Council)

The Public Protection Service has a key role both as a regulatory service and as an educator. The service's lead role includes licensing, trading standards, health and safety at work, and health improvement.

The Licensing Team administers the processes for licensing premises, agencies, and individuals to sell and/or serve alcohol and the review of such licenses (Appendix 1).

Trading Standards (B&NES Council) (Appendix 1)

The Trading Standards Team works to restrict the sale of alcohol to people under the age of eighteen.

Youth Offending Team (Appendix 1)

The Youth Offending Team (YOT) assesses the young people who offend to see if they misuse alcohol and refer for specialist intervention from health staff if necessary. The YOT tries to break the cycle of offending and alcohol misuse and build self esteem. Members of the YOT may also provide low-level educational interventions.

Criminal Justice Steering Group

5.1.3 Workplace services

Health@Work of B&NES PCT and Council (Appendix 1)

Health@Work works with businesses to minimise the harm arising to their employees through alcohol misuse related to the work setting.

Occupational Health Departments

Occupational Health Departments in businesses and large agencies provide support to employees about alcohol misuse.

5.1.4 Family and community services

Youth Service

Bath & NES Youth Service through its professional youth workers in local youth hubs and projects carries out a range of informal educational programmes to increase awareness, knowledge and understanding of a sensible drinking message and the health risks caused by alcohol misuse.for young people aged 11-25 years old, focusing on those aged 13-19 years.

Other services

There are a variety of other services supporting families and communities in reducing the harm from alcohol misuse. These include:

- Project Officer (Alcohol Harm Reduction)
- Voluntary sector including Julian House, Street Pastors, and Pubwatch
- Bath Rugby Club

5. Current services and models of good practice

- Community Safety Partnership (B&NES Council)
- Schools - PSHE & Drugs Consultant
- Colleges/Universities
- PCT (Health Promotion Specialists & Health Trainers)
- Project 28 (Outreach Workers)
- Children & Young People Substance Misuse Partnership
- School Nursing

5.2 Models of care for alcohol misuse - MOCAM[8]

5.2.1 The 'MOCAM' approach promoted by the National Treatment Agency is to offer different levels of intervention and treatment based on the level of need of an individual with an alcohol misuse problem - the 'stepped care' approach. However, there is not a simple relationship between the severity of an individual's drink problem and his or her readiness to access or receive services. Hence, the challenge in implementation is to offer appropriate levels of care that are readily accessible when an individual seeks help and to facilitate movement between different levels of service as clients' needs change.

5.2.2 A holistic approach to alcohol misuse treatment is required involving partnership working, with a range of agencies coordinating their input for any client. This means conducting needs assessments early on in the treatment process and using these to plan care. Care may involve a range of inputs such as: offering support to individuals as they prepare to enter treatment; offering appropriate treatment for alcohol misuse and other health needs; and providing support to address wider social issues that contribute to or exacerbate alcohol misuse (e.g. housing, financial problems).

5.2.3 Tier 1 services are likely to be provided principally in general practice and other front-line health, social services, and other settings, many will be provided as a part of routine care. These interventions will focus on assessing an individual's level of drinking, providing education and alcohol awareness and will offer targeted brief interventions to drinkers but will also act as a referral route into more specialised services.

5.2.4 Tier 2 services are similar to those in Tier 1 but are targeted at those with a higher level of need. They require practitioners to have specific training in dealing with alcohol issues. They focus around more intensive engagement with a client. Settings in which such services are provided include General Practice and Community Health facilities but extend to specific open access or drop-in alcohol services and may include some services offered by specialist providers as well as those offered by self help groups. These services will engage with clients who may require a step up to more intensive treatment as well as those who are receiving ongoing support following intensive treatment.

5.2.5 Tier 3 services are those provided in community settings generally by specialised alcohol service providers but consist of specialised assessment of alcohol related needs and the planning and co-ordination of packages of care addressing them. These include

[8] DH/National Treatment Agency for Substance Misuse. Models of Care for Alcohol Misusers. June 2006.

intensive support and the use of psycho-social therapies, as well as interventions such as supported detoxification and treatment with drugs to assist with alcohol withdrawal.

5.2.6 Tier 4 Services are in-patient or residential treatments offered as part of planned care package. The elements of care are similar to those in Tier 3 services but differ only in the setting in which they are delivered.

5.3 Care pathways

Evidence-based care pathways for alcohol withdrawal and alcohol liver disease are available from the Map of Medicine, which provides care pathways for the NHS.[9]

5.4 National Institute of Clinical Excellence Public Health Guidance No. 24

On the basis of the best available evidence on preventing the development of hazardous and harmful drinking, this guidance identifies the policy and practitioner options that are most likely to be successful in combating such harm.[10]

Policy

The three policy recommendations made are:

- Consider introducing a minimum price per unit
- Revise legislation on licensing to ensure protection of the public's health
- Ensure children and young people's exposure to alcohol advertising is as low as possible by considering a review of the current advertising codes

Licensing

The recommendation on local licensing includes identifying and taking action against premises that regularly sell alcohol to people who are under-age, intoxicated or making illegal purchases for others; undertaking test purchases; and ensuring sanctions are fully applied to businesses that break the law on under-age sales, sales to those who are intoxicated and proxy purchases.

Resourcing

The recommendation on resourcing states chief executives of NHS and local authorities should prioritise alcohol-use disorder prevention as an 'invest to save' measure.

Practice

The 7 practitioner recommendations made cover:

- supporting children and young people aged 10 to 15 years
- screening young people aged 16 and 17 years
- extended brief interventions with young people aged 16 and 17 years
- screening adults
- brief advice for adults
- extended brief interventions for adults

[9] Map of Medicine. http://eng.mapofmedicine.com/evidence/map/index.html

[10] National Institute of Clinical Excellence Public Health Guidance No. 24 on preventing the development of hazardous and harmful drinking http://www.nice.org.uk/nicemedia/live/13001/49024/49024.pdf

5. Current services and models of good practice

- referral to specialists

6 Gap analyses of needs versus services and service quality

6.1 Prevention

6.1.1 Alcohol Harm in B&NES

6.1.1.1 Numbers of 'problem' drinkers in B&NES

6.1.1.1.1 There is no locally derived data recording drinking behaviour. Reliable estimates of these can be derived, however, by applying national and regional surveys of drinking behaviour to the local population. But in the longer term locally derived data are required to enable us to monitor both the geographical spread of drinking problems across the local area and the effectiveness of the interventions needed.

Gap 4: Identify the key local indicators and information sources for alcohol misuse priorities as part of our Joint Strategic Needs Assessment and report the position on these indicators yearly (Evidence: Refresh consultation)

6.1.1.1.2 There were estimated to be within B&NES:

- 20.4% of people aged between 16 and 74 years locally who are hazardous drinkers and 3.8% problem drinkers in 2007[11]
- more than 29,335 people who are 'risky' drinkers (hazardous) - threatening their health because they are drinking too much or are binge drinking
- 5,464 people in B&NES will be drinking at a problem level that is causing them to experience physical or psychological harm but will not be dependent upon alcohol
- Around 5,177 people will have problems in both controlling their drinking and in continuing to function effectively and will be dependent on alcohol.[12] This group is at real risk of significant health problems. Around 575 people of this dependent group will have significant problems in both controlling their drinking and in continuing to function effectively and 143 people of them will be severely dependent upon alcohol and have a wide range of associated problems – medical and mental health problems associated with drinking; dependence upon other drugs; and social problems.
- About 20% of children aged 11-15 years who drank on average 12.7 units weekly[11] and around 800 children (11-15 year olds) who were drinking to get drunk weekly

6.1.1.1.3 Most of the 10,600 local people who have physical and/or psychological problems caused by alcohol misuse or are dependent will not be receiving health services to help them.

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[11] The NHS Information Centre. Alcohol Statistics. NHS Information Centre, 2009. http://www.ic.nhs.uk/webfiles/publications/alcoholeng2009/Final%20Format%20draft%202009%20v7.pdf

[12] Drummond C, Oyefeso A, Phillips T et al. Alcohol Needs Assessment Research Project (ANARP). London; Department of Health, 2005.

6.1.2 Young people

6.1.2.1 Children of parents who drink

Parents who drink place their children at risk of harm. The conflict and disruption to family life associated with having a family member who misuses alcohol is associated with problems in children's emotional and psychological development. The impact on children of parental drinking can vary with both the pattern of drinking and whether one or both parents are drinkers. Children's lives are more disrupted where parents engage in binge drinking or have sustained consumption than where drinking occurs principally at evenings or weekends. Children's concerns are over violence in the home and the safety of a non-drinking parent or their own safety where violence is directed against them: disruption to their own lives associated with the wider family consequences of drinking. Although children often collude in denial of a parent's drinking to those outside the family this may be motivated by a desire to protect a family identity and be associated with children assuming roles as carers and mediators.[13]

Gap 5: We do not know if we are doing enough to identify, risk reduce, and support children of problem drinkers. (Evidence: Refresh consultation)

6.1.2.2 Children and Young People and their drinking habits

6.1.2.2.1 Many children and young people drink alcohol regularly in B&NES.[11] Youngsters mainly obtain alcohol from their parents, friends and relatives and also see these as an important source of advice on drinking behaviour. Other important sources of alcohol education were seen as teachers and through the media.

6.1.2.2.2 Underage drinking is declining but those underage people who do drink are drinking more.[14] Drinking behaviours can be established in very early adulthood for many and a small group of young adults have already established patterns of drinking that are harmful in the longer term. Those who binge drink at young ages are more likely to return to binge drinking as adults and this pattern of drinking continues into their 40's.[15]

6.1.2.2.3 Within Bath and North East Somerset specialised alcohol services for children and young people up to 19 years of age are provided through Project 28 based in central Bath. It was established as a drugs service but has expanded to accommodate children with alcohol problems in response to demand. Referrals are currently at a rate of 5-6 per month for primary alcohol misusers (around 15 referrals a month are for children abusing alcohol with other drugs). Referrals come through self-referral, via the Youth Offending Team and through Social Services. On average there are around 30 clients receiving treatment for alcohol problems. The main modalities offered to clients with alcohol

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[13] Alcohol Concern. Putting the children first. http://www.alcoholconcern.org.uk/home

[14] Public Health Commission. Key Facts: Alcohol. http://www.publichealthcommission.co.uk/pdfs/PHCMeetings/C&S-KeyfactsAlcohol.pdfhttp://www.publichealthcommission.co.uk/pdfs/PHCMeetings/C&S-KeyfactsAlcohol.pdf

[15] BJMH Jefferis, C Power and O Manor Adolescent drinking level and adult binge drinking in a national birth cohort.. *Addiction* 2005;100:543-9..

problems are one–to-one counselling and family work and diversionary activities. One key aspect to the work is supporting the parents and carers of young problem drinkers. The Project offers intensive aftercare during vulnerable periods for those withdrawing despite limited capacity to do so. However the Project also offers brief and minimal interventions to clients on a drop-in basis and provides advice and training in harm reduction to professionals working with children and young people and to clients. Project 28 has developed the Young Person's Brief Intervention tool & plans with Department of Health Innovations Funding for its future use.

6.1.2.2.4 A sub group of the DAAT with responsibility for young people meets regularly. The group feels that there is a need to maintain or expand the current approaches to tackling anti-social behaviour in young people and to maintain action on under-age sales. We do not know how to convey alcohol harm reduction messages to children and young people in an accessible way through mediums other than schools.

Gap 6: We do not know the best way to engage with young binge drinkers and to get them to adopt risk reducing strategies when out drinking. Evidence: Previous strategy)

Gap 7: Is there enough appropriate provision for the treatment of alcohol misuse in children and young people? (Evidence: Previous strategy)

6.1.3 Students

6.1.3.1 Bath plays host to 20,000 students in its higher and further education institutes and the vast majority of these are aged 18-24 years and are at high risk from both hazardous drinking and alcohol-related crime. The night time economy in Bath has targeted the student market by offering entertainments during the early and mid week. There is concern that this may increase students' risk of harm through drinking at hazardous levels and may artificially extend the period and amount of environmental disturbance in the city centre.

6.1.3.2 Student leaders have begun to call time on mass drinks promotion at the University of Bath, as the students' union hardens its stance on binge drinking. The union wants to enhance town-gown relations and ensure the safety of each new intake of students. The student union president has been working closely with the Federation of Bath Residents' Associations and wants to stop those bars which entice students with the offer of cheap alcohol. It wants to keep students on its campus as much as possible during Freshers' Week and is restricting the number of city bars and clubs appearing at its Freshers' Fair.

The students' associations have run other campaigns in B&NES to increase students' awareness of the impact of their behaviour on the local community such as the "Sssh!" campaign that encouraged them to disperse quietly from pubs and clubs for local residents.

6.1.3.3 Students are a particularly vulnerable group. The student period marks the transition into independence for many young adults. They are vulnerable to peer pressure and the need to be seen to conform to perceived social norms. Many are away from home and established social and support networks for the first time and may not know

where to turn when problems emerge. Educational institutions and students' associations have a difficult role in providing pastoral and welfare support while at the same time fostering independence. The Student Community Partnership, a partnership between the University of Bath, Bath Spa University and Bath & North East Somerset Council is an ideal forum for developing a policy on the promotion of alcohol to students locally to ensure consistency of approach.

Gap 8: All agencies should support the Student Community Partnership in developing a policy on the promotion of alcohol to students locally (Evidence: Previous strategy and consultation refresh)

6.1.4 Workplace

6.1.4.1 Drinking outside of work may impinge on an individual's ability to perform and to hold down a job. Many safety critical industries recognise this and put in place policies that seek to ensure that alcohol is not consumed at work and that employees take care to ensure that their ability to perform at work is not affected by drinking. However, workplace alcohol policies can also play an important role in educating the working population about how to minimise the harmful effects of alcohol and can be a route into effective treatment for some problem drinkers. Employers will introduce alcohol policies if they are clear that they stand to benefit in business terms from their implementation. Whereas large employers may have sufficient resources within their human resources and occupational health departments to develop and implement effective workplace policies, smaller and medium sized businesses may require external facilitation and support. In the workplace the manifestations of alcohol misuse are likely to be increased absenteeism, under-performance and loss of productivity among individuals and teams containing problem drinkers, accidents in the workplace, and ultimately loss of employment. Employers that fail to adequately address the issue of problem drinking may face additional penalties through the loss of highly trained personnel. In most instances it is more cost effective to intervene to address the problems associated with alcohol misuse than to deal with the consequential costs of ignoring them.

6.1.4.2 As part of the Health@Work scheme which has an alcohol element within its core topics staff of the PCT and Council have delivered sessions to employee groups about employer concerns about drinking excessively.

6.1.4.3 Workplace alcohol policies that are well-designed will ensure that:

- there is clarity among all staff about acceptable behaviour for drinking and work and that managers and staff are clear about their rights and responsibilities
- appropriate procedures are put in place to be followed where a problem is identified
- a culture is promoted where managers and supervisory staff have the confidence to raise the issue of their or an employee's alcohol problem early and are equipped with the tools to appropriately address the problem
- such referrals will be handled sensitively and lead to the provision of assistance rather than to disciplinary proceedings

Gap 9: We do not know the extent or quality of workplace alcohol policies among large employers within B&NES. (Evidence: Previous strategy) A survey would establish the level and content of such polices and provide a spring board for work with medium and smaller businesses. The results of such a survey could be published and examples of model practice be promoted locally.

Gap 10: We do not know how the introduction of workplace alcohol policies could best assist in the promotion of harm reduction messages nor how to best pilot such approaches. (Evidence: Stakeholders events and Refresh consultation)

Gap 11: We do not know how current occupational health departments deal with people who misuse alcohol. (Evidence: Refresh consultation) Should a provider be commissioned to receive referrals from them?

6.1.5 Partnership

We know that statutory agencies are facing budgetary problems. In these circumstances partnership working arrangements are very important. We want to know:

- how to cope with fewer resources?
- how much resource is currently spent and how effective is it?
- what each stakeholder group wants from another?
- how can we work together smarter?
- what are the recent successes
- what new joint projects can we undertake?

Gap 12: We need more strengthened partnership work on reducing alcohol related harm. (Evidence: Refresh consultation)

The Big Society challenges us to engage better with local citizens and communities. We know that identifying local leaders and networks and working with them can reap benefits.

Gap 13: How can we contribute to the Big Society initiative and engage local communities and citizens on reducing alcohol related harm? (Evidence: Refresh consultation)

There is no group looking at the generality of alcohol related harm locally and thus no group with the responsibility for ensuring that actions from the strategy are implemented.

Gap 14: There is a need for a B&NES Alcohol Harm Reduction Implementation Group or Annual Stakeholder Forum for checking progress (Evidence: Stakeholders events and Refresh consultation)

6.2 Treatment

6.2.1 Opportunistic screening and brief interventions

6.2.1.1 A key plank for improving the detection and management of alcohol problems in various settings is the implementation of a programme of “opportunistic screening”. This refers to actions that seek to use encounters with health services and other agencies as an opportunity to assess the level of an individual’s drinking and any harm that may be associated with it and to offer appropriate interventions. It requires front-line care

practitioners to be alert to the presentations that are associated with alcohol and to be confident in their ability to assess the client appropriately and to intervene effectively – either themselves or through appropriate referral. Front-line includes:

- social services department
- homelessness services
- antenatal clinics
- police settings e.g. custody cells
- probation and prison services
- education and vocational services
- occupational health services

6.2.1.2 A number of validated tools exist that allow health and social care professionals to assess alcohol consumption in a range of settings. These are simple to administer within existing workload. However, practitioners will require training in identifying presentations associated with an underlying alcohol disorder and the administration and interpretation of the appropriate screening tools. Tools that can be used include the full AUDIT questionnaire or its abbreviated form (e.g. FAST) in primary care. The use of the TWEAK and T-ACE questionnaires is recommended in antenatal settings.[16]

6.2.1.3 The introduction of screening needs to be coupled with the provision of effective interventions for those identified as having an alcohol problem without which there is little point in identifying a problem. Many of those with an identified need will appropriately be treated in Tier 1 services by receiving brief or time limited interventions. However, opportunistic screening will also identify a small but significant number of drinkers with problems that will require more specialised interventions. Brief interventions have not been shown to be effective in patients who have identified that they have a drinking problem and have actively sought help with this but they can be effective in drinkers who are drinking at harmful levels where this is picked up through opportunistic screening.

6.2.1.4 Brief interventions incorporate a variety of techniques but they share the central concept that they can be delivered by non-specialist staff in a range of settings. The issues raised on implementation of opportunistic screening and brief interventions relate to a perceived lack of capacity to undertake this work allied to a lack of confidence in the ability of staff to deliver them.

6.2.1.5 Collecting data for those receiving treatment through General Practice has now become possible through identifying hazardous, problem and dependent drinkers and offering them brief interventions or onward referral to specialist services. This good start needs consolidating in primary care and rolling out to other settings.

Gap 15: The identification of people in B&NES who misuse alcohol and are offered

[16] Raistrick D, Heather N, Godfrey C. Review of the effectiveness of treatment for alcohol problems. London: National treatment Agency, 2006. http://www.nta.nhs.uk/programme/national/docs/Review_of_the_Effectiveness_of_Treatment_for_Alcohol_Problems.pd

brief interventions needs consolidating in primary care and rolling out to other settings through multi-sectoral training (Evidence: Local alcohol services data and National Good Practice NICE Guidance)

6.2.2 Vulnerable and hard-to-reach populations

The Probation Service is currently offering counselling to clients aged 18 years and above in B&NES on Probation assessed by DHI and offered 4-8 sessions to explore motivation, build commitment or maintain gains. In 2009-10 a much higher percentage of B&NES clients misuse alcohol (50%) than in the South West (36%) or England and Wales (32%). This service is working well but is limited to those with problems arising from their alcohol misuse and does not cover people with alcohol dependency. Nevertheless the screening tool used has identified large numbers with dependency for whom no service can be offered.

Gap 16: People with alcohol dependency with Probation Services cannot access specialised health services currently. (Evidence: Local data & Refresh consultation)

6.2.3 Care pathway for people misusing alcohol

There are parts of a care pathway that are used by individual specialised health care providers. But there is no comprehensive local care pathway that covers all the settings where people present with alcohol misuse and indicates options available at key points.

Gap: 17 A comprehensive care pathway for people with alcohol misuse in B&NES that is clear to users, citizens, commissioners, and providers needs elaborating (Evidence: Previous strategy, Stakeholders events, and Refresh consultation)

There are also Gaps 2 and 3 identified above that cover treatment capacity and evidence.

6.3 Enforcement

6.3.1 Licensing (Appendix 1)

6.3.1.1 The licensed trade in B&NES is being encouraged to be more socially responsible through the LEG (Licensing Enforcement Group) and in the future through the Bath Night Watch scheme. It is also intended that supermarkets and off-licences become part of Bath Night Watch initiative as the cheap availability of alcohol which is purchased in bulk has led to 'pre-loading' before going out into the city (as well as hidden harm in those drinking in the home) and is a contributing factor to alcohol-related anti-social behaviour.

6.3.1.2 It has become increasingly realised that cheap alcohol through off-licence premises is available and young people drink at home first and then go out. There is a need to involve off-licence sales as well as on-licence sales to assist with reducing harm. Nationally certain chains such as Tesco are now starting to acknowledge a certain responsibility - but locally there needs to be greater communication with Sainsburys, Morrisons and others. The Police could ask offenders who have been intoxicated with alcohol about where they secured their alcohol when they were drunk.

Gap 18: How best to engage the off-licence retailers to promote responsible sales

and take up of alcohol-harm reduction training? (Evidence: Refresh consultation)

6.3.2 Test purchasing

There is a history of targeted test purchasing to gauge the level of sales to underage purchasers within B&NES. This has been led by Trading Standards Officers from B&NES council with Police support. The level of compliance of on-licensed premises has generally been high. However, during the most recent round of test purchasing the key issues were with off-licences and supermarkets. Intelligence-lead test-purchasing is a vital component in regulating/restricting the supply of alcohol to young persons. Such enforcement activities have an important part in reinforcing wider messages about responsible retailing and in attempting to regulate the supply of alcohol to children.

6.3.3 Cumulative Impact Policy Area

6.3.3.1 The Bath and North East Somerset Community Safety and Drugs Partnership produced a report demonstrating that, in Bath City Centre, certain areas (such as Bath City Centre) experience a significant amount of alcohol-related crime. Having consulted with those individuals and organisations listed in the Licensing Act 2003, the Council resolved, on 13th September 2007, that the evidence contained within the report was sufficient to justify the preparation of a policy on the cumulative impact of a significant number of licensed premises concentrated in one area for inclusion in the Council's Statement of Licensing Policy.

6.3.3.2 The effect of adopting a cumulative impact policy is to create a rebuttable presumption that applications for new premises licences, club premises certificates or variations will be refused if relevant representations are received. If the application is not to be refused then the applicant will have to demonstrate that the operation of the premises will not add to the cumulative impact already being experienced.

Gap 19: Agencies need to develop a coordinated approach to evidence gathering if the review process of the new Licensing Act is to be used (Evidence: Stakeholders events and Refresh consultation)

6.3.3.3 The Bath Night Watch scheme is a culmination of Bath and North East Somerset Council, Bath Pub Watch and the Police working together to promote the four licensing objectives as one co-ordinated stakeholder group. We are grateful to those licensees who have joined as ‘working hard to make Bath city centre a better place’.

6.3.3.4 The Licensing Authority will expect all licensed premises within the Cumulative Impact Area to take a socially responsible approach by participating in schemes like 'Bath Night Watch', or similar, which improve issues of alcohol-associated anti-social behaviour in and around city centre licensed premises at night.

Gap 20: We need to consider alcohol harm and cumulative impact policy areas outside of Bath city centre (Evidence: Stakeholders events & Refresh consultation)

6.3.3.5 The Licensing Authority also encourages all premises, outside the cumulative impact area, to take a similar approach, which would improve the issue of alcohol-associated anti-social behaviour outside the city centre at night.

Gap 21: We need to encourage full participation by all licensees in initiatives that promote public confidence in Bath as a safe and enjoyable place to visit? (Evidence: Refresh consultation)

6.3.3.6 Not all pub and club licensees participate in initiatives that promote public confidence in Bath as a safe and enjoyable night out. For example there are irresponsible alcohol promotions. The partnership initiatives cost money to maintain them. The new mandatory code of practice for licensees and the new Police Reform and Social Responsibility Bill will probably help in securing extra funding to tackle these problems.

Gap 22: We need to share equitably the costs of developing and maintaining such schemes with those who may benefit from them.

6.3.4 Night Time Economy

Since the original strategy was produced there is now a Night Time Economy Steering Group in B&NES who are tacking the alcohol-fuelled harm arising then. Successes from the Group's work cover policing and the night time economy, boosting public confidence, and reducing disorder and include

- The existence of the "cumulative impact policy area" in Bath City Centre
- The development of the Partners and Communities Together (PACT) meetings and process where alcohol issues can be discussed
- Discussions on work to improve transport links
- The work undertaken with students through the Student Community Partnership on developing a policy on the promotion of alcohol to students and the campaigns run
- The provision of street and taxi marshals and portable toilets
- Purple Flag Award. The award was based on past, present and proposed initiatives and is the new national "gold standard" recognising the safest and most appealing cities at night. The award also acknowledges the diversity of entertainment and hospitality that Bath has to offer.

Gap 23: There is a need to better communicate to the general public and all stakeholder agencies the good local work that is tackling alcohol-related disorder in B&NES (Evidence: Refresh consultation)

6.3.5 Public Order and Crime

6.3.5.1 Drink driving

Drinking alcohol impairs an individual's ability to perform complex motor tasks such as driving. Drink driving places other road users at risk, a risk they have a right to expect to be protected from. Nearly 1 in 5 of those killed on the roads in 2008 (580 deaths) in Great Britain were over the legal blood alcohol limit.[17] Men are over 2 times more likely than

[17] Reported Road Casualties Great Britain: 2008 - Annual Report.
http://www.dft.gov.uk/pgr/statistics/datatablespublications/accidents/casualtiesgbar/rrcgb2008

women to have a positive breath test for alcohol after being involved in a motor accident leading to injury.[17] Those aged 17-24 are more than 1½ times more likely to have a positive breath test after an accident than older drivers.[17] Although many drivers are convinced that they can tell when they have 'had enough' before driving there is evidence to suggest that ability to drive is impaired at levels well below the present legal limit for driving. There is a consensus among safety and motoring organisations that the only safe approach is not to drink any alcohol before driving. There appears to be a growing resistance to the "don't drink and drive" message. Avon and Somerset's Road Policing Unit launched its annual summer drink-drive campaign in June 2010. The stopped 27,689 vehicles; breathalysed 1,819 people; and arrested 139 people (7.6% of those breathalysed). This compared with rates of arrests for drink-driving for England and Wales that were around 8-9% of those breathalysed. The Police are considering providing systematic yearly information to stakeholder agencies on those breathalysed and those subsequently arrested for drink driving so that the progress against drink driving can be monitored.

6.3.5.2 Public order

6.3.5.2.1 The Police would like a consensus to emerge from the public and other statutory agencies about what is acceptable behaviour in B&NES. They would like to see clear and consistent messages around alcohol and the behaviour expected of B&NES citizens and visitors that will help to set the tone locally. They would like to see agencies and the licensed trades support the Police in mounting educational activities detailing the risk of alcohol-related harm and promoting strategies and behaviours for reducing that risk. In the last 5 years through the yearly Voicebox surveys about 30% of local citizens have said that drunk and rowdy behaviour is a fairly big or very big problem in their local area.

6.3.5.2.2 Great Western Ambulance Service estimates that 70% of their ambulance attendances on Friday and Saturday evenings and nights are related to alcohol misuse. They also estimate that a member of staff is assaulted weekly during these attendances. Their staff on these occasions also faces verbal abuse, threats of violence, and general disorderly behaviour as well.

Gap 24: We need a code spelling out the clear and consistent messages around alcohol and the behaviour expected of B&NES citizens and visitors that the local statutory agencies expect. (Evidence: Stakeholders events & Refresh consultation)

7 Governance and monitoring system

7.1 The overall governance of this Alcohol Related Harm Reduction Strategy will be through the Bath and North East Somerset Health and Wellbeing Partnership Board. The community safety aspects of the Strategy will be reported to the Responsible Authorities Group.

7.2 We can monitor the problems related to the harm arising from alcohol misuse in B&NES through the Local Alcohol Profiles produced by the North West Public Health Observatory yearly. We are also planning to identify the key local indicators and information sources for alcohol misuse priorities as part of our Joint Strategic Needs Assessment and report the position on these indicators yearly to the Health and Well Being Partnership, the Responsible Authorities Group, and the Children's Trust.

7.3 As part of this Strategy development we will produce the initial action areas that we should prioritise. If we create a B&NES Alcohol Harm Reduction Implementation Steering Group they can be responsible for working up a more complete action plan with initial (within 3 months), medium term (within a year), and longer term (over a year) detailed actions, timescales, lead postholder and agency. Progress on this action plan will be reported to the Health and Well Being Partnership, Responsible Authorities Group, and the Children's Trust quarterly.

8 Development priorities and recommendations

8.1 Development priorities

Stakeholders have identified 24 service and organisational priorities for reducing the harm caused by alcohol misuse in B&NES. The service priorities will need their costs and funding sources identifying in a business case justifying a spend-to-save approach with BANES data and include actions and then decisions taken on their relative priority by the decision-making boards. The organisational priorities will need the time of staff to bring about the organisational development. The top developmental service and organisational priorities identified by stakeholders responsible for developing this draft strategy are (the numbers reflect stakeholder views of priority):

Service developments

1. There is a need to increase treatment capacity for local people who misuse alcohol.
2. The identification of people in B&NES who misuse alcohol and are offered brief interventions needs consolidating in primary care and rolling out to other settings.
4. We need to find out if we are doing enough to identify, risk reduce, and support children of problem drinkers.

Organisational developments

3. There is a need for a B&NES Alcohol Harm Reduction Implementation Group reporting to Health and Wellbeing Partnership Board and the Responsible Authorities Group.
5 We need a code spelling out the clear and consistent messages around alcohol and the behaviour expected of B&NES citizens and visitors that local statutory agencies expect.
6. We need to identify the key local indicators and information sources for alcohol misuse priorities as part of our Joint Strategic Needs Assessment and report the position yearly.
7. We need a comprehensive care pathway for people with alcohol misuse in B&NES that is clear to users, citizens, commissioners, and providers.
8. We need to contribute to the Big Society initiative and engage local communities and citizens on reducing alcohol related harm.

There is an urgent need for officers of the key stakeholder agencies to produce a business case and action plan through the Responsible Authorities Group and the Joint Commissioning Group. This should include actions covering the short term (within 3 months), medium term (up to one year), and long term (over one year).

8.2 Recommendations

1. The Bath and North East Somerset Health and Wellbeing Partnership Board, Responsible Authorities Group, and Children's Trust are asked to:

- adapt and adopt this draft Alcohol Harm Reduction Strategy and to agree the key priorities and initial actions and to require a detailed business plan with costings;
- receive Alcohol Harm Reduction Business and Action Plans within 3 months;
- promote the final strategy adoption by all stakeholder agencies and partnerships (LSP, DHI, AWP, New Highway, B&NES Council, NHS B&NES, RUH, GWAS, Police, Probation Service).

Glossary

One unit of alcohol is 10 ml by volume of pure alcohol, for example half a pint of ordinary strength beer, lager or cider (3-4% alcohol by volume) but there are one and a half units of alcohol in a small glass (125 ml) of ordinary strength wine (12% alcohol by volume).

Those who drink hazardously are individuals who are placing themselves at risk of harm through their drinking behaviour (more than 5 units per day for men and 3 units per day for women).

Those who drink harmfully are those individuals who are already experiencing physical or mental harm as a direct result of their drinking.

Those who drink in a dependent manner are those individuals who demonstrate behaviour that prioritises drinking alcohol over other, previously more important, behaviours.

A working definition of binge drinking is those men who drink more than 8 units and those women who drink more than 6 units in a single drinking session.

AUDIT, the Alcohol Use Disorders Identification Test, is used to identify persons with hazardous and harmful patterns of alcohol consumption. The AUDIT tool was developed by the World Health Organization as a simple method of screening for excessive drinking and to assist in brief assessment. It consists of 10 questions. There are various derivatives of this tool such as AUDIT-C designed for use in specific circumstances.

The FAST questionnaire has a similar purpose to the AUDIT one but was designed by University of Wales College of Medicine, Middlesex University, and the Health Development Agency to be used more quickly, for example in emergency departments. It consists of 10 questions.

The TWEAK alcohol screening test is a short, five-question test which was originally designed to screen pregnant women for harmful drinking habits. It was developed by the Research Institute on Addictions at Buffalo, New York, Department of Obstetrics/Gynaecology and Wayne State University.

T–ACE is a modification of the CAGE screening tool, an early quickly applied tool. T_ACE has been validated for use to detect a range of alcohol use, including risk drinking in pregnancy. It is recommended for use within antenatal settings within SIGN Guideline 74.

Appendix 1: Current services for alcohol-related harm

Health services

Primary care

There were 3,052 newly-registered patients in 2009-10 in general practice who had the FAST or AUDIT-C questionnaire. Of these 198 underwent a fuller assessment using a validation tool. There were 146 hazardous drinkers who received a brief intervention from their general practices and 23 who were referred.

Specialised alcohol misuse services providers

Clients are put in touch with the specialised alcohol misuse services providers through a variety of mechanisms. New Highway acts as the usual initial point of assessment and clients usually self refer, with GP referral being the second most common route. New Highway offers an alcohol management service where a client's motivation to address their problem drinking can be assessed and goals for change agreed. Where more intensive interventions are required then New Highway usually refers on to one of the other providers. DHI tends to see clients that have been referred from other agencies and provides a counselling service as well as providing services to those who have been through a programme of detoxification and are abstaining from alcohol. For these services, after care and relapse prevention are key parts of the overall package. SDAS sees the smallest number of clients but those with the most complex needs and receives referrals from a wide range of agencies. Their services at present include those with a forensic element (where treatment has been mandated by the Courts); those where clients have severe mental health problems and those where others are deemed to be at risk from the behaviour of the client. As an example of the numbers accessing self-help groups, Alcoholics Anonymous in B&NES has 17 meetings each week.

Criminal justice services

Police

The Police achieved their aim the following strategy:

1 Working collaboratively with Licensees to address issues arising from the night-time economy including ensuring that the licensed premises are making good use of CCTV, using licensed doorstaff, being part of the Pubwatch scheme if appropriate, co-operating with regular checks by the Police Officers, Police staff and other agencies.
2 Using the monthly multi agency Licensing Enforcement Group meetings to organise and carry out regular multi agency visits to licensed premises to check and test licence conditions.
3 Using intelligence and analysis to identify crime hotspots and problem premises and respond to these through additional proactive patrols at high risk periods, ensuring that Officers have sufficient knowledge of the legislation and their powers in relation to alcohol related crime and nuisance. Run operations when appropriate and

necessary, such as Operation Tonic (breath tests – drink/drive) throughout the festive period, and Operation Relentless.

4 Increasing the level of young people's education and awareness in relation to responsible levels of drinking and the effects of alcohol through lessons delivered by the Youth Strategy Officer and PCSOs in schools and colleges. Working jointly with Project 28, Off The Record, Youth Offending Team and the B&NES School Alcohol contact Jodie Smith to re-enforce those messages.

Youth Offending Team (YOT)

For a number of young people who offend, alcohol plays a significant part in their offending; they may have offended under the influence of alcohol or offended in order to acquire alcohol. The YOT may also learn in its work with young people that their parents have had issues with alcohol misuse and this has influenced the full family functioning.

The YOT assesses every young person using the assessment tool Asset and ensures that a screening is done about substance misuse amongst other health needs. If the young person needs a specialist intervention from health staff they are referred directly by the seconded staff member. Members of the YOT are also able to provide low-level educational interventions once they have been appropriately trained.

The aim of the YOT is that, by intervening early in the cycle of offending and alcohol misuse they can help prevent the development of further, entrenched offending and enable the young person to build their sense of self-esteem and focus on positive activities.

Public protection

The Public Protection Service has a key role within the local authority both as a regulatory service and as an educator. The service takes a lead role in B&NES in terms of air and water quality, licensing, food safety and standards, trading standards, health and safety at work, health improvement and animal health and welfare. The strong links Public Protection have forged with local business through their ongoing advisory role have been linked with the alcohol harm reduction agenda through the health development officer role working together, particularly with the licensing and trading standards (under age sales) officers. Through this role the service led on gaining the purple flag for B&NES - the new "gold standard" that recognises great entertainment and safe and welcoming hospitality areas at night.

Trading Standards (B&NES Council)

The Trading Standards Team conduct a programme of test purchasing using underage volunteers to check whether on or off licences will sell alcohol to the volunteers. A failed test can result in the seller receiving a fine, a review of the licence to sell alcohol or for criminal proceedings to be instituted against the licence holder or company. Follow up visits by officers are conducted to examine refusal systems used and practical advice is offered on any necessary improvements.

Licensing Services

Appendix 1: Current services for alcohol-related harm

Bath & North East Somerset Council is the local Licensing Authority following the introduction of the Licensing Act 2003. The Council aims to promote a range of cultural activities within Bath & North East Somerset and uses licensing as one means of achieving this. A formal Statement of Licensing Policy is published by the Council detailing its approach to licensing and is available at: http://www.bathnes.gov.uk/NR/rdonlyres/3745A5C2-25A1-46C8-AE32-B72D4017E34A/0/StatementofLicensingPolicy2008.pdf

In discharging its duties the Council seeks to promote the four licensing objectives:

1. The prevention of crime and disorder
2. Public safety
3. The prevention of public nuisance
4. The protection of children from harm

Licensed premises must also submit an operational schedule at the time of applying for a licence detailing how they will address each of the four objectives in the day-to-day running of their premises. As from April 2010 owners of bars and pubs were banned from offering 'all you can drink' alcohol promotions, drinking games and free drinks for women, or face six months in jail.

The Licensing Team administers the licensing process including dealing with applications for licences, and arranging hearings for contested ones. Once a premises licence has been granted the team accepts valid representations that call for a review of the licence which enables problems to be aired and the licence to be amended if necessary. Certain premises have conditions attached to them, many of which assist to reduce harm to the public. The team works in conjunction with its other enforcement partners e.g. police & fire to ensure that these conditions are complied with, and inspecting premises where there is a history of alcohol-related problems.

The Licensing Committee considered a report on the review of the cumulative impact policy and resolved to continue with the policy. The Council's Statement of Licensing Policy is due to be reviewed again in 2010 where the need to continue with the cumulative impact policy will be considered. A copy of the reports, together with the Minutes of the meetings, can be seen at any of the Council's libraries or on the Council's web site at the following address - http://www.bathnes.gov.uk/business/LicencesStreetTrading/Pages/default.aspx .

The licensing authority expects the applicant to address the issues surrounding cumulative impact in their operating schedule in order to rebut such a presumption. The Council's Statement of Licensing Policy also contains a range of measures that the Council, as licensing authority, would wish to be included on a premises licence application within the cumulative impact area would depend on the nature and type of premises within the application and would need to be individual to that premises, examples are:-

- CCTV at the premises to be properly maintained
- Security Industry Authority (SIA) door staff

- Toughened or plastic glass, no bottles
- Free calls to taxi firms for departing customers at the end of the night
- Outside areas to be cleared at a reasonable time (time to be stated)
- Signs to be displayed at each exit to encourage patrons to minimise noise and not to congregate in the street at close
- To contribute to the street marshal scheme
- To be a member of the local Pub Watch
- No open containers of alcohol to leave the premises
- To supervise entry and exit of the customers from the premises at busy times
- Facilities for people to dispose of cigarette ends and provisions for reducing noise from people smoking outside the premises
- A limit on the number of customers permitted on the premises at one time
- A requirement that the public spaces in the premises should be predominately seated

This list is not exhaustive, and is only intended to provide a brief description and guide to applicants.

Workplace

Health@Work

Health@Work works with businesses to minimise the harm arising to their employees through alcohol misuse related to the work setting. It:

- provides employees with information on the effects of alcohol and local sources of support
- ensures that the workplace policy makes it clear that employees are not allowed to consume alcohol at work or during working hours before attending work
- ensures that the workplace policy includes information about the level of support, including counselling or professional help, that an employee will receive if alcohol misuse is recognised
- reviews access to alcohol within the organisation, for example, at social functions or in social facilities

Family and community services

Youth Service

Through its programmes the B&NES Youth Service try to ensure that all young people receive appropriate, information and advise about alcohol and its harms and ways of reducing these. We also provide a wide variety of positive activities that act as an alternative to divert them from activities related to substance misuse including alcohol that put young people at risk.

Appendix 2: Products of Alcohol Harm Reduction Strategy Workshop 6 October 2010

Supply chain for domestic violence	Gaps	Actions
GP, A&E, employer, police, Southside, family worker can help Related: shame, pride, partner, booze, school, neighbours, friends, licensee, employer Employer – reputation risks, occupational health, alcohol policies	A&E last resort / cry for help GP failing? Getting from Domestic Violence victim to booze cause Early intervention missed 'Triggers' not assessed Cultural bias to ignoring domestic violence Cultural shift Community Alcohol Partnerships run by local people for their specific area/problem Strategy to work with licensees on being socially responsible Strategy framework to provide "bucket" of tools to help local task & finish groups Clear strategic statement to set future approach, led by Health and Wellbeing Partnership	Work with GP commissioning of alcohol services Check if children presenting 'symptoms' of parents' alcohol problems and domestic violence I being picked up in schools? Ensure staff in Walk in centres have domestic violence training and knowledge to link to the alcohol being a contributory cause Domestic violence flags work well if that's identified. Who makes the links to the cause, booze? Maximise GP risk assessments Help schools set up screening and early intervention of kids drinking Awareness training for GPs and risk assessment training to get full picture Education at schools to try and break the cycle by starting with cultural shift in children Work with stronger communities department to gain links to local groups, parishes Locally based tasking across all agencies Build on case studies to identify process changes across all agencies Follow the money to address/prove outcomes/needs/savings Better recording of data so all agencies can get the big picture Set up community alcohol partnerships – local solution for local problems
Prevention GP – Husband / Wife Police – anti-social behaviour (ASB) – domestic report Education (children acting out) Registered Social Landlord		

Appendix 2: Products of Alcohol harm reduction strategy workshop 6 October 2010

Supply chain for health	Gaps	Actions
Thinking about your drinking campaign	Brief intervention training for all frontline staff	Brief intervention training for frontline staff
Teachers, counsellors, neighbours; family friends; primary care nurse picks up at screening	Work on alcohol in with Primary Care to do more Engaging primary care at a strategic level	
Refer to secondary care, statutory services → care support, national help lines, AA	Ensure good signposting information available Are all agencies and professionals up-to-date?	Work on alcohol in with Primary Care to do more
School aged children can get help from school counsellor/nurse	Use education in schools for sensible drinking	Ensure good signposting information available
Childline, teachers → Signposting	For people to feel comfortable about having meaningful conversations about change (non-specialist staff)	Ensure up-to-date information on services & signposting is available & agencies know about it
Voluntary sector (New Highway –single point of contact) DHI (e.g. for abstinence)	Change the culture of our society in relation to drinking	Evaluate dry house provision
Can use community level communication (posters in libraries etc)	For those in helping roles to be able to access quality brief intervention training	Ensure better coordination of services
Can use digital communication	Dry-house will only serve the tip of the iceberg Need a better co-ordination of services – one overarching group to maximise resources	Ensure alcohol service providers use standardised forms and give commissioners outcomes information
Prevention	Improve links between hospital, mental health and alcohol services	Ensure that there are good links between hospital and alcohol services
Developing a culture of moderate drinking through education	Better intelligence on alcohol and standardised outcome forms	Maximise opportunities for community volunteers for alcohol
Brief intervention training for frontline staff	We do not maximise opportunities for community volunteers	Train volunteers
Add targets on alcohol in Primary Care so it gets flagged at consultation; ‘pop up’ reminder	Train volunteers in key issues – signposting, harm minimisation, brief intervention.	Develop policy for volunteers
Important that interventions are holistic i.e. capturing precursors such as loss etc	Boost profile of volunteer bureau at Green Park Expand DHI counselling service started by volunteers	Ensure local agencies are up-to-date on alcohol services information
Signposting	Volunteering notice boards at universities / FE colleges. Recruit young people for evening outreach.	Engage primary care at strategic level

Appendix 2: Products of Alcohol harm reduction strategy workshop 6 October 2010

Supply chain for health	**Gaps**	**Actions**
Do all key agencies and professionals have the correct and up to date information they need? Important for support and information to be easily accessible for family, friends, community members as they are likely to be pivotal in helping to identify and support problem drinkers and possibly at risk themselves	Promoting the benefits of volunteering Develop over-arching policy/strategy for working with volunteers across alcohol agencies in B&NES Ensure local agencies/organisations who have contact with key groups e.g over 50s have sufficient support, information and training. This will need co-ordination – pilot and evaluate this mode	

Supply chain for disorder		
Supply chain for residents	**Gaps**	**Actions**
Area for drunk & incapable person	Police ↔ University communications (confidentiality) Banning orders	Explore data sharing protocol for Police-University communications
Police Ambulance	Residents still concerned about noise, abuse, violence, urination, vomit	Explore how schools can introduce education on alcohol early
A & E department Social services Custody services Mental health services	Licensing process Too many young people drunk More education needed – Early Intervention – Schools Alcohol Priority	Explore more support funding for added resposne services Check what happens in Custodial Care at the end
Prevention	More support (funding) for added response services (to support fast ambulance etc)	Check what happens in A&E Dept on future services
Elected member ASB order for persistence Environmental services for noise	Custodial care In police cell – end stage – referral? A&E → care beyond – referral – follow up? Test purchasing for drunken people (in pubs) Court – attendance referral to AA / New Highway etc	Explore test purchasing for drunken people in pubs Explore referral to New Highway/AA from court attendance
Police PACT meetings Supermarkets off licence sales Licensing Enforcement Group	If relevant more focus on alcohol as well as drugs – mental health services Balancing – merging agendas: enforcement with health and care aspects	Explore support for Alcohol Steering Group Explore if community activators can be expanded
Supply chain for drunk person Street pastors A&E if serious health consequences	Targeted actions needed (Holistic approach, greater priority is need for alcohol, priority of resources) Need Alcohol Steering group	Improve signposting and support pathways to access help and initiatives

Appendix 2: Products of Alcohol harm reduction strategy workshop 6 October 2010

A&E advice	More Community Activators	
University support for student if serious	Signposting and support Pathways to access help and initiatives	
Prevention	Knowing your community better	
Education (early) – shift cultural norms		
Support parents (health influence on children's drinking)	Identifying – Local Community Activists (positive influence on community) e.g. S families, strengthening communities (parenting skills)	
Student support at University	Community empowerment in the first place to enable it to happen	
Acceptability of getting drunk to excess – Challenge social norms	More initiatives: Tenants forum – old post office / pilot Keynsham (health and Wellbeing)	
Street Marshals	Access Communities	
FAST ambulance		
Supply chain for workplace	**Gaps**	**Actions**
Supply chain for employee misusing alcohol	Lack of information for staff and employers	Chamber of commerce could provide information, support
Noticing employee → Line Manager		
Policy / Code of Conduct	Lack of support especially in small businesses	Scoping what's happening in large employers (policies, HR)
Human Resources department	Lack of policies / codes	Develop template polices and business case
Occupational Health department	Acceptability of bingeing (work do)	Find ways of supporting SMEs (small amd medium size employers)
Training all staff	Template policies	Use Bath Chamber of Commerce, Residents Associations, PACT, Parish Councils and Councillors, Regenerate, & Media (Chronicle, Radio etc) to improve engagement
Peer conversation	Cost implications and business case for Occupational health	
Risk assessment	Health at work projects	
	Need for an alcohol forum that is the umbrella for all the different projects and schemes and provides leadership	
	Bringing all licensees and off licences together	
Prevention	Nee more community engagement	
Policy/Code of Conduct/Acceptable	Fostering Community Vision for acceptable alcohol code	

Appendix 2: Products of Alcohol harm reduction strategy workshop 6 October 2010

Behaviour	of behaviour	
Health at work projects		
Supply chain for children & young people	**Gaps**	**Actions**
Prevention/treatment	Better links to A&E so that young people can get harm reduction information and advice	Assist services to measure extent of problem and impact
School Nurse Team	More brief interventions (using drink/think)	Promote pathways and services
PSHE and Drug Consultant	Consistent message	Use Schools Health Education Unit survey in local schools
Diversionary Activities: Sports and Active leisure team	Perception of what constitutes a 'problem' – how do we educate people / change attitudes towards drinking?	For community engagement use good examples - M+, OTR
Project 28 & Outreach Team	Alcohol can be very cheap and affordable	Use intergenerational mentoring
Off The Record (OTR)	Parental attitude to drink – 'All children do it'	Roll out drink/think tool
Fairbridge	Media promotes alcohol as socially acceptable	Support new projects - Drama project, PCSO training, new drug education resource
Prince's Trust	Insufficient weight of law to prosecute under age sales	
Family therapy	Develop a clear message which aims to achieve attitudinal change	
Mentoring Plus (M+)	A message which encourages sensible drinking and gets Young people to look after their friends.	
Children Missing Education Officer	Clearer information sharing protocols	

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Partnership Board for Health and Wellbeing Report
Date: 15th June 2011
Report Title: Adult Safeguarding Performance
Agenda Item: 13
List of attachments to this report:

Summary

Purpose

1 To present an update on adult safeguarding performance and activity in B&NES and to draw the Board's attention to any new issues of concern. The performance and activity section is provided jointly by NHS and Bath Council Commissioning Services and Community Health and Social Care Services.

Recommendation

2 The Partnership Board for Health and Wellbeing is asked to note the following:

- Update on adults safeguarding performance indicators from April 2010 to March 2011
- Proposed new performance indicators for 2011 to 2012
- Update from Local Safeguarding Adults Board March 2011 meeting
- Government Policy Statement on Safeguarding Adults

Rationale

3 For the Partnership Board for Health and Wellbeing to be assured that adult safeguarding delivery arrangements in B&NES are developing and improving.

Other Options Considered

4 None

Financial Implications

5 None

Risk Management

6 As noted in each report the Balanced Scorecard indicators seek to assure the Board that the Local Authority (responsible for the coordination of safeguarding cases and the provision and commissioning of safe services) and the PCT (responsible for the provision and commissioning of safe services) has robust monitoring arrangements in place.

New indicators are proposed for 2011/12 to provide the Board with this assurance.

Equality issues

7 All Local Safeguarding Adults Board agencies are expected to review their safeguarding policies to ensure equality and diversity issues are incorporated. This is also a requirement from Care Quality Commission.

Legal Issues

8 None

Engagement & Involvement

9 The Local Safeguarding Adults Board and the sub groups reporting to it are made up of a wide range of commissioned services and partner agencies. Service users are involved in some aspects of the work and Board members recognise the need to develop further engagement and involvement in safeguarding.

The Board continues to look at ways to strengthen the engagement and involvement of service users; CH&SCS are supporting this with capacity from the Service User Involvement Facilitator. This report has been viewed by the Council monitoring officer and section 151 officer.

If you would like this document in a different format, please contact the author

Partnership Board for Health and Wellbeing Report
Date: 15th June 2011
Report Title: Adult Safeguarding Report
Agenda Item: 13

The Report

Background

1. As outlined in the summary report above the Partnership Board for Health & Well Being seek assurance at each meeting that adult safeguarding arrangements in B&NES are robust and that issues of concern are brought to its attention with plans to address these.

Key Points

2. The report highlights four key areas:

- Update on adults safeguarding performance indicators from April 2010 to March 2011 (note the final figures for 2010/11 will not be available until they have been quality checked in June 2011)
- Proposed new performance indicators for 2011 to 2012
- Update from Local Safeguarding Adults Board March 2011 meeting
- Government Policy Statement on Safeguarding Adults

2.1 Update and commentary on adult safeguarding performance and activity in B&NES

2.1.1 Indicator 1: Percentage of referrals that have recorded outcomes (April 10 – March 11)

The data reports for the full year need to be finalised and sent to the DH in July 2011, in the meantime the most up to date figures available show 293 new safeguarding referrals were received during April 2010 to March 2011. As noted in previous reports this is a significant increase on previous years; in 08/09 there were 165 referrals received and in 09/10 186. The increase in referrals demonstrates that adult safeguarding is understood more widely.

39 safeguarding cases were ongoing from the 31st March 2010, therefore up to and including existing March 2011 data 332 safeguarding cases have or are being coordinated by CH&SCS and AWP.

Of these 332 cases, 270 have been closed during April 2010 to March 2011.

(It is important to note that in April 11 the DH Information Centre have set out very prescriptive definitions of what a safeguarding 'alert' and 'referral' includes; once the existing safeguarding data has been quality checked the reported figures may be presented differently; however to date we have had 293 new cases that have been considered in terms of needing safeguarding intervention).

The table below sets out the outcome for each case once terminated:

Case Terminated at the following Stage	Outcome						
	No Further Action	No Case to Answer	Not Determined/ Inconclusive	Not substantiated	Partly Substantiated	Substantiated	Total
Stage 3 Decision not to progress safeguarding process	69	5	1	1	1	0	77
Stage 4 Safeguarding Strategy discussion and / or meeting	0	22	12	17	15	23	89
Stage 5 Assessment/ investigation	0	0	6	12	10	9	37
Stage 6 Planning meeting	0	0	4	4	8	11	27
Stage 7 Review meeting	0	0	6	11	8	15	40
Total	69	27	29	45	42	58	**270**

The Board continues to seek assurance that the cases that have a recorded outcome of Not Determined and Inconclusive are safe. The Board can be assured that exception reports have been discussed between CH&SCS, AWP and the Commissioner for each of these cases. Following discussions about each case, three were found to have an incorrect outcome designated, and had met the criteria for partially substantiated; this has been corrected. All other cases were correctly designated and support has been, and / or continues to be, offered / provided, to the service users to ensure their safety; ongoing monitoring is in place. CH&SCS have developed a reporting template to ensure staffs provide consistent information in the exception reports.

2.1.2 Indicator 2 - Percentage of cases completed within procedural timescales

The table below sets out CH&SCS and AWP safeguarding case coordination performance in accordance with procedural timescales from April to March 2011. The target for 98% of all cases to be managed in accordance with timescales remains in place for this period. The final column of the table shows the direction of travel in performance from the last report in February 2011.

The following performance target ranges have been set:
Green >98%
Amber 80 – 97%
Red <80%

Procedural Descriptor		Data Source	Target	10/11 YTD % and actual number of cases			Since Feb 11
				April 10 - March 11			
				Total no. outside of timescale	Total no. that could be completed on time	% comp-leted on time	
2a	No. of decisions made within 2 days of referral	CH&SC Services	**98%**	6	216 (1 referral received March 31st)	97%	↔
		AWP		10	57	82%	↑
		Both		**16**	**273**	**94%**	↑
2b	No. of strategies discussions/ meetings held within 5 days of referral	CH&SC Services	**98%**	15	135	89%	↑
		AWP		6	63	90%	↑
		Both		**21**	**198**	**89%**	↑
2c	No. of assessment / investigations completed in 28 days of referral	CH&SC Services	**98%**	11	67	84%	↑
		AWP		12	39	69%	↑
		Both		**23**	**106**	**78%**	↑
2d	No. of planning meetings held within 2 weeks of completed assessmen	CH&SC Services	**98%**	1	41	98%	↑
		AWP		12	38	68%	↔
		Both		**13**	**79**	**84%**	↑

	t						
2e	No of reviews held within 12 weeks of planning meeting	CH&SC Services	**98%**	2	31	94%	↑
		AWP		3	18	83%	↑
		Both		**5**	**49**	**90%**	↑

CH&SCS and AWP Combined Performance Overview

The above data is the most accurate combined data set available to date, showing combined performance as amber in four areas and red in one. The direction of travel is improving in all areas except for two where it has remained the same from the previous report. 87% of all cases have been completed in accordance with procedural timescales; this is an improvement of 6% from the last report.

CH&SCS Case Activity

CH&SCS performance has improved considerably throughout the year and this is demonstrated in 2d being on target; 2a being 1% below target and 2e being very close to target also.

When taking all five stages into account CH&SCS currently report 92% of case activity taking place in accordance with procedural timescale.

AWP Case Activity

There remains on going issues with both the data entry for AWP safeguarding cases onto Care First and the performance against procedural timescales; this situation is not sustainable and provides a risk to the level of assurance the Board can be given regarding AWPs management of safeguarding cases. B&NES Commissioners are coordinating a workshop for AWP and the six Local Authorities that commission AWP services to look at a number of issues surrounding safeguarding case coordination; at the workshop a solution to the data entry problem will be sought as will a remedial action plan to address procedural timescale concerns.

AWPs performance has improved from the last report in four of the five areas. AWP are now amber in three of the five stages and remain red in the other two. When all five stages are taken into account, AWP currently report that 78% of case activity adheres to procedural timescale. The remedial action plan is crucial to ensure that adherence to timescales is improved.

AWP are currently looking into why they are recording a higher number of strategy discussions/meetings (2b) than decisions made (2a) as this is very unusual, a possible reason is that some of the information on decisions (2a) has not been provided. The quality of the data needs to be accurate before submission to the Department of Health, AWP are looking into this and have a deadline of the 2nd June 2011 to correct it by.

2.1.3 <u>Indicator 3 – Percentage of identified repeat referrals</u>

During this 12 month period there have been 28 occurrences of service users being referred for safeguarding more than once. 20 of the 28 cases have been reviewed to date to ensure

the service user is in receipt of ongoing support and that plans are in place to try and ensure further repeat referrals are not made. The other eight cases will be reviewed and assurance provided in the Safeguarding Adults Annual Report.

2.1.4 Indicator 4 – Case file audits (2 per month)

Case file audits continue to be carried out each month and are proving a useful tool to improve the quality of the work delivered and the recording of it. CH&SCS recently undertook a larger scale audit and identified five areas for improvement:

- Staff did not consistently follow the safeguarding procedure as set out
- A number of cases appeared to have been closed prematurely despite on going support being provided
- Service user and carer engagement in the procedure was mixed; in some cases excellent involvement was seen and in other it was not clear
- Notes of meetings and finalised investigation reports were not always provided and observation recordings were not always clear. Again there is evidence of excellent practice, however this is not consistent in all cases

The larger scale audit has proved valuable to drive the delivery of consistent and good practice and has led to a set of improvement recommendations that will be rolled out during 2011/12.

2.1.5 Indicator 5 - for all 'relevant' staff to have CRB checks each LSAB agency will provide details of this for inclusion in the Annual Report. This indicator is expected to be achieved.

2.1.6 Indicator 6 - % of 'relevant' staff to have undertaken mandatory safeguarding training.

CH&SCS are responsible for providing and reporting training on the number of 'relevant' adult health and social care staff that have undertaken adult protection training and refresher training during the last two years.

In March 2011 the following was reported:

- 96% adult social care staff were trained against an end of year target of 97%.
- 67% of health staff have been trained against an end of year target of 80%.

CH&SCS are rolling out a new safeguarding e-learning tool. (Note: finalised end of year figures will be available in June 11)

2.1.7 Indicator 7 - safeguarding champions to be nominated for each team

CH&SCS and AWP have confirmed there are safeguarding champions in all services.

2.2 Proposed New Performance Indicators for 2011 to 2012

The proposed safeguarding indicators below have been drafted and were presented to the LSAB in March 2011. Several LSAB agencies have already commented on these and the final agreement is sought by the middle of June 2011. If accepted these will be the indicators used to assure the LSAB and the PBH&WB about safeguarding arrangements in B&NES. The indicators are separated out into qualitative and quantitative measures.

2.2.1 Proposed new procedural timescale indicators 11/12

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

Monthly: AWP and CH&SC only

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

Annually: AWP and CH&SC only

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

Quarterly: LSAB and Local Authority / PCT commissioned agencies who deliver Health and social care services

- 97% of relevant social care staff will have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter (the term 'relevant' is defined by CQC)

- 80% of relevant health staff will have completed Safeguarding Adults 2a training within 6 months of taking up post and/or completed refresher training every 2 years thereafter (the term relevant here excludes staff without direct contact with patients / service users and certain other categories – eg support staff, Children's Health staff)

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

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

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Annually: All LSAB members and LA / PCT commissioned services

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

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

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

- Safeguarding champions identified for each team

Annually: LSAB agencies / non Local Authority and PCT commissioned services whose primary role is not health and social care delivery

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

2.3 Update from the Local Safeguarding Adults Board (LSAB)

The LSAB met in March 2011, outlined below are the key items for noting:

- An Independent Chair was successfully recruited and chaired the latter half of the meeting.

- The Policy and Procedure sub group are developing a range of guidance documents for practitioners including one on Thresholds, Consent and Neglect.

- Two workshops on Risk Enablement, Safeguarding and Support Planning ran in May 11 for CH&SCS and AWP staff and LSAB members. .

- A five week course for service users has been ran by the Shaw Trust and Bath People First to discuss safeguarding, risk assessment and enablement, choice and control. The course is currently being evaluated and the evaluation will be shared with the LSAB in July 11.

- 19 Deprivation of Liberty Safeguards (DoLS) applications were received during April 2010 to March 2011, in comparison to 3 for 2009/2010. The DoLS process and quality of assessments has been reviewed. The findings are that the quality of assessments is to a high standard and that processes are understood locally through they need to be published for transparency. Full analysis of the DoLS applications is being presented to the LSAB in July 2011.
- The Quality Assurance, Audit and Performance Management group: proposed that the LSAB adopt the South West Quality Audit Framework, which they did and this will be used during 2011/12; proposed a set of new performance indicators which are outlined above and undertook its third multi-agency case file audit and feedback the findings of this to the LSAB. This is proving a useful exercise and lessons learned are being shared with managers to improve practice.

- The Awareness, Engagement and Communication group presented a proposal for improving involvement and gathering feedback from service users, this is being considered more widely with regard to the impact on practice and will be reconsidered in July 2011.
- The Multi Agency Safeguarding Training group reported progress on the implementation of the training Strategy and requested Partner agencies consider pooling training funding. LSAB members have been asked to provide a view on this by July 2011.

2.3 Government Policy Statement on Safeguarding Adults

On the 16th May 2011 the Government produced a statement of policy on Safeguarding Adults.

'The Government's policy objective is to prevent and reduce the risk of significant harm to vulnerable adults from abuse or other types of exploitation, whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion.
The Government believes that safeguarding is everybody's business with communities playing a part in preventing, detecting and reporting neglect and abuse. Measures need to be in place locally to protect those least able to protect themselves. Safeguards against poor practice, harm and abuse need to be an integral part of care and support. We should achieve this through partnerships between local organisations, communities and individuals.
The State's role in safeguarding is to provide the vision and direction and ensure that the legal framework, including powers and duties, is clear, and proportionate whilst maximising local flexibility. This framework should be sufficient to enable professionals and others to take appropriate and timely safeguarding action locally while not prescribing how local agencies and partnerships undertake their safeguarding duties.' (DH Gateway Reference 16072 16.05.11)

They have set out the following principles:

Empowerment - Presumption of person led decisions and informed consent. Protection - Support and representation for those in greatest need. Prevention - It is better to take action before harm occurs. Proportionality – Proportionate and least intrusive response appropriate to the risk presented.

Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. Accountability - Accountability and transparency in delivering safeguarding (DH 16.05.11)

The Government have confirmed that 'No Secrets' (DH 2000) will remain as the statutory guidance for safeguarding adults until 2013 and intends to legislate for Local Safeguarding Adults Boards, making existing Boards statutory. We await further guidance on this, however have been preparing the B&NES LSAB for this. In addition to the recently published Law Commission report of its review of adult social care law recommends making LSAB's statutory.

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Responsible Director	*Janet Rowse (Acting Chief Executive and Strategic Director Adult Social Care & Housing)*
Background papers	*None*

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Partnership Board for Health and Wellbeing
Date: 15 June 2011
Report Title: Adult Health & Social Care Commissioning Performance
Agenda Item: 14
List of attachments to this report: March End of Year Scorecard

Summary

Purpose

1 To provide the Board with information on current performance and quality including the financial position within the commissioning arm of the Adult Health and Social Care and Housing Partnership.

Recommendation

2 The Partnership Board for Health and Wellbeing is asked to note the performance as described in the report.

Rationale

3 The Partnership Board oversees the activities of the Health and Wellbeing Partnership and needs to be made aware of performance to enable the role and function of the Board to be delivered.

Other Options Considered

4 None

Financial Implications

5 The financial position is included fully within the report.

Risk Management

6 Risk management processes for the council and PCT have now been integrated.

Equality issues

7 Equalities targets and standards are included within the performance framework.

Legal Issues

8 None identified

Engagement & Involvement

9 This report has been viewed by the Council monitoring officer and section 151 officer.

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Bath & North East Somerset Council

NHS Bath and North East Somerset

working together for health & well-being

Adult Health & Wellbeing Performance Assurance Report

Report for Month 12 March 2011
(Presented in May 2011)

Annual Report for 2010-2011

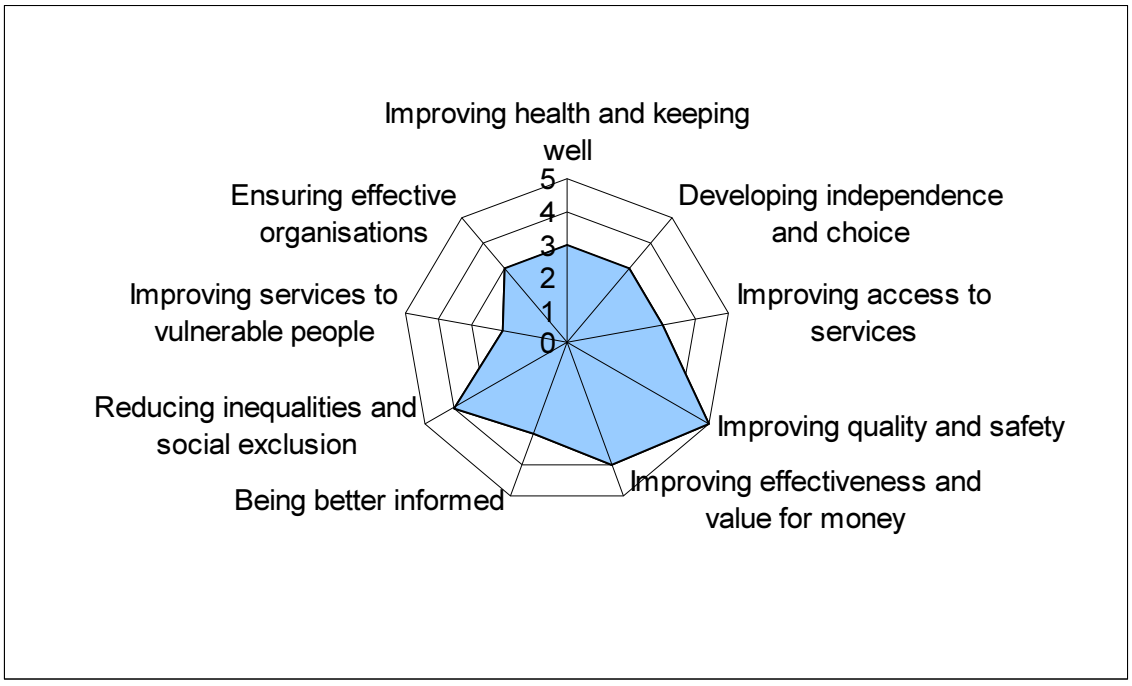
INDEX

1.0 STRATEGIC PERFORMANCE (Scorecard at Annex 1)

This report highlights our performance against the 9 strategic goals during the year from April 2010 to March 2011. This report differs from our usual monthly report in that we are reporting performance across a range of performance indicators for health, social care and housing rather than those that were selected for our monthly exception scorecard. As we focus on the strategic goals in this report we have not split the report by strategic performance and operational performance this time. Next month, the report will focus on operational performance in the usual way. We were not subject to any national external reviews this year as the Care Quality Commission (CQC) stopped undertaking the Annual Health Check and the Annual Social Care Assessment process. We continue to review our performance against other organisations for health, social care and housing targets and as more benchmarking information is produced we will include this in the monthly performance report.

This section of the report summarises the congruence of our current performance with our 9 strategic goals. These goals are intended to deliver our vision of local people achieving their full potential through improved health and well being. Where appropriate this section of the report outlines actions in hand to improve strategic performance.

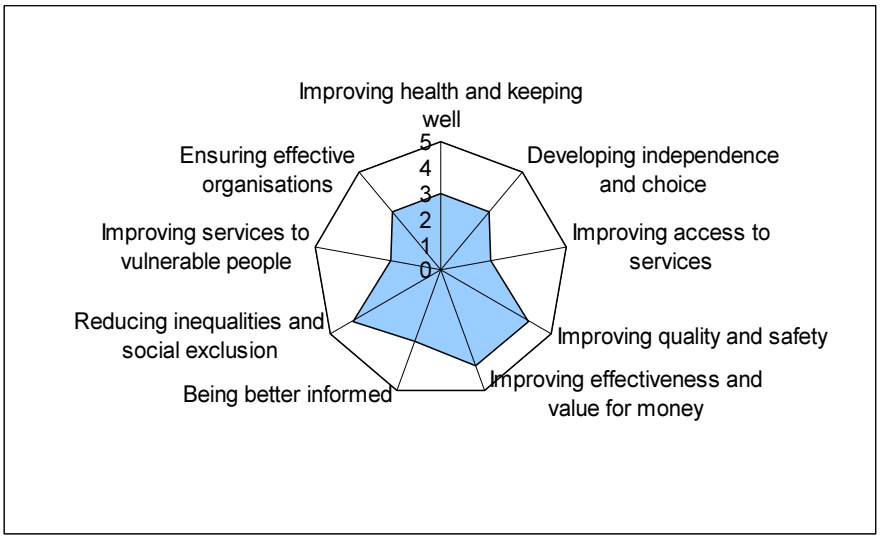
1.1 Performance versus Nine Strategic Goals – Quarter four 2010 - 2011



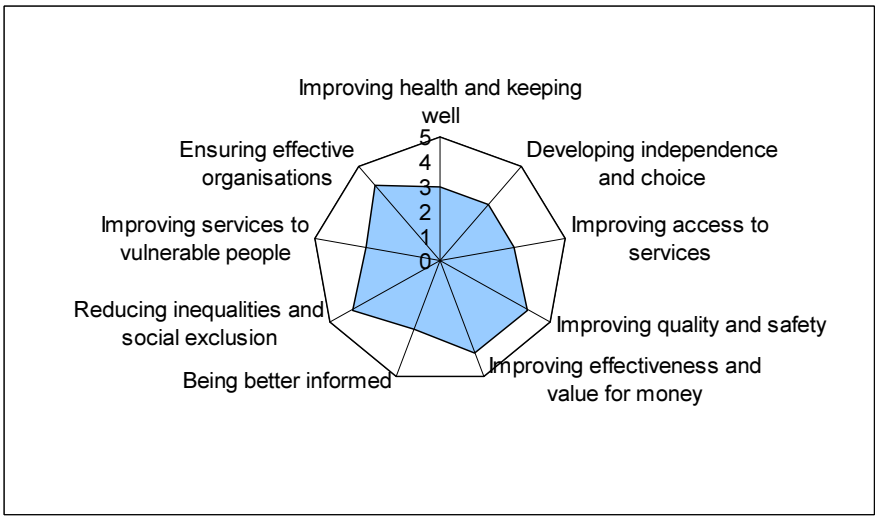
The chart above is a subjective representation of performance against the nine strategic goals, based on aggregate performance versus individual targets attached at Annex 1. Each of the nine strategic goals is represented as a spoke, performance is graded 0-5 (5 being excellent) on each spoke. For example, in the chart above improving quality and safety is graded as 4/5, indicating good performance. The chart above reflects the position at the end of December 2010.

The charts below show the performance over the last three quarters:

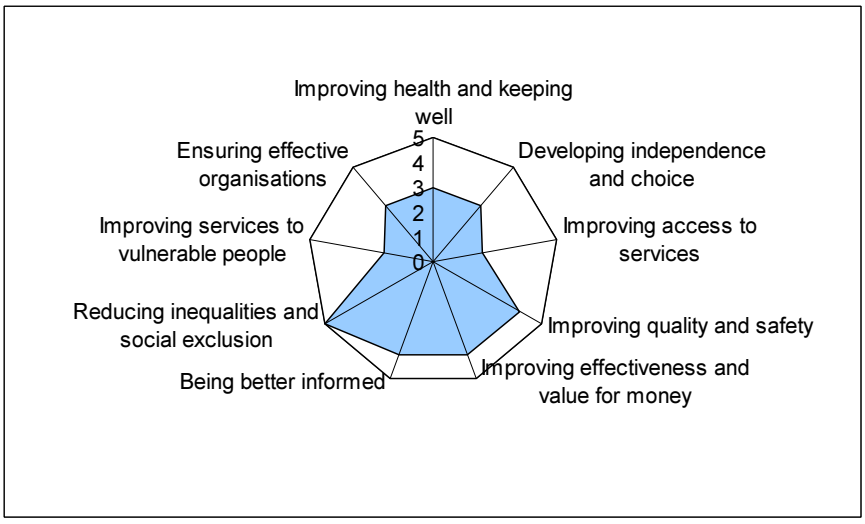
Performance versus Nine Strategic Goals – Quarter one 2010 - 2011



Quarter two 2010 - 2011



Quarter three 2010 - 2011



1.2 The 10 World Class Commissioning Outcomes

The performance review below is based on data used for the Year 3 assurance process for each outcome. The actual data collection period to which this relates will vary by indicator. Year 3 targets are part of our planned trajectory towards the aspirations set out in our strategic plan for achievement by 2015 (year 6).

	Target (Yr 3)	Actual (Yr 3)	Actual (Yr 2)	RAG	Progress since year 2
1a. Reducing health inequalities by 10% by 2015 (Male)	**5.4**	**6.3**	**5.6**	**10-11 Outcome against trajectory**	⇔
1b. Reducing health inequalities by 10% by 2015 (Female)	**3.5**	**3.5**	**3.6**	**10-11 Outcome against trajectory**	⇩
2a. Improving life expectancy by 1 year by 2015 (Male)	**80.1**	**80.3**	**79.7**	**10-11 Outcome against trajectory**	⇧
2b. Improving life expectancy by 1 year by 2015 (Female)	**83.5**	**83.9**	**83.2**	**10-11 Outcome against trajectory**	⇧
3. Increase rate of smoking cessation by 6% by 2015, with focus on deprived communities	**767**	**756 Provisional**	**757**	**Predicted outcome will be met**	⇧
4. Halt the upward trend in obesity in childhood for year 6 children by 2015, with focus on deprived communities	**15.88**	**16.7**	**15.88**	**10-11 Outcome against trajectory**	⇩
5. Coronary Heart Disease (CHD) controlled blood pressure (to exceed current best in country by 2015)	**90**	**89.88%**	**89.5**		⇧
6. Reduce deaths from Cardio Vascular Disease (CVD) by 10% by 2015	**54.7**	**46.97**	**56.2**	**10-11 Outcome against trajectory**	⇧
7. By 2011, increase to 80% the proportion of stroke patients spending 90% of their IP stay on a stroke unit	**80%**	**53.85%**	**18%**		⇧
8. Increase the percentage of all deaths that occur at home to 23% by 2015	**20**	**21.9%**	**18.97**		⇧
9. Increase the proportion of carers receiving a 'carer's break' or a specific carers' service from 14% to 25% by 2015	**18**	**20.7**	**14**		⇧
10. Reduce the number of emergency admissions as a result of a fall in people age 65+ by 150 per year by 2015	**957**	**752**	**994**	**752**	⇧

Commentary on World Class Commissioning outcomes
The year end report has shown positive performance against most of the World Class Commissioning indicators. Details regarding the indicators are as follows;

- Life expectancy targets and the health inequalities for females have been met although the male target has not and the gap in male life expectancy has risen in the last calendar year available (2009). . The B&NES gap for male inequality in life expectancy whilst significantly lower than the England average gap is not significantly different to the regional map. A dedicated plan to identify appropriate actions to reduce this gap further needs to be developed but is being slowed due by capacity issues. This is a complex multi factorial indicator which will be a key focus of the Health and Wellbeing Strategy.
- The smoking cessation target is expected to be met as the figure provided is provisional with data being collected until early June.
- There has been no change since the last report regarding obesity in year 6 children. Actions to reduce obesity through prevention in early years and promoting breastfeeding continue. The national Child Measurement Programme may change format from 2012/13 to one which measures healthy weight rather than obesity.
- The Coronary Heart Disease (CHD) controlled blood pressure target was very narrowly missed by less than 1 percent which represents excellent performance.
- The stroke target is not being met as the Sulis Unit is currently not deemed as being a stroke rehabilitation unit which affects the performance of this indicator significantly.
- The percentage of deaths that occur at home and the reduction of emergency admissions as a result of a fall targets have both been met
- The carer's outcome is expected to improve further as the carers break project data is not yet included.

1.3 Equalities update

We have strengthened our performance in equalities. Improved leadership and policy frameworks are ensuring that effective systems are in place for building equalities considerations into service planning. Guidance, support and training have been targeted towards ensuring equality impact assessments are comprehensive and focused. As a result, equalities work is increasingly well embedded. Equalities impact assessments have been undertaken against the Medium Term Financial Plan and the Integrated Business Plan for the development of a social enterprise. An impact assessment against the PCT's QIPP plans is being finalised

The Single Equality Scheme has been an efficient and effective way to work across organisational boundaries in assessing the impact of service provision on diverse groups. Our Joint Needs Assessment work continues to be combined with equality mapping, giving us detailed data to help us target groups who are vulnerable to discrimination in our population or who are at higher risk of poor health and social outcomes and to make sure we secure services that are accessible and responsive to individual needs.

A Health Fair took place in February 2011 to increase the awareness of ethnic minority senior citizens of the services available to them. As well as a variety of stalls on health services, there were various speakers on the day. The day was successful in taking proactive action with this minority group.

2 OVERVIEW OF STRATEGIC OBJECTIVES

At the end of year, we are able to see which areas are performing well against targets and which ones require action to improve performance. The scorecard in Annex 1 shows our monthly and quarterly performance against targets, and these are set out under each of the 9 strategic objectives. All indicators/ targets are monitored within the Intervening for Success framework by the work stream leads. This report gives sets out key issues for the end of year within the Partnership's Strategic Objectives.

2.1 Strategic Objective one: Improving Health and Keeping Well

Summary of annual performance
This strategic objective includes most of the Public Health indicators. The areas to highlight are the achievement of the smoking targets where both the Vital Sign and World Class Commissioning targets have been met and the breastfeeding rates which are the highest in the region. Chlamydia screening is still a concern and although the end of year target was not met, performance has improved at 23% from the 09/10 outturn of 18.5% and could rise further when the final end of year data received. The childhood immunisation rates have all improved from the 09/10 outturn and work is still ongoing to achieve the WHO targets of 95%.

The stroke indicator also falls within this strategic objective. The RUH trajectory for people spending at least 90% of their time on a stroke unit has been met at year end but due to the Sulis Unit not currently being deemed as being compliant with the definition of a stroke rehabilitation unit performance was not met in this area. A paper is being separately considered by the May Professional Executive Committee to recommend that the unit is considered compliant for 2011-12 based on the Commissioning team's latest assessment of the definition of stroke rehabilitation services.

There is positive news in this financial year concerning the number of drug users in effective treatment as the target has been met this year. The target was not met in 09/10 which had financial consequences.

Performance against targets and actions planned

Smoking
The smoking target for the Vital Sign and the World Class Commissioning for 2011/12 has been achieved. The percentage of women smoking at delivery is better than expected and has also achieved the target.

The year to date figures below show the performance across the B&NES population broken down by deprivation quintile. The service is predominantly being used by people from the more deprived parts of the district which is excellent given the role of cigarette smoking in driving inequalities in life expectancy. The quit rate shows that the best performance was amongst people in the most deprived fifth of the population. The second most deprived group had a lower quit rate than average, but it is unclear why that was.

Quintile	Percentage of quitters coming from each quintile	Quit rate (% of people who succeed in their 4 week quit attempt)
1st (Most Deprived)	29.2%	64.9%
2nd	24.6%	45.9%
3rd	18.1%	56.4%
4th	18.4%	56.6%
5th	9.7%	55.2%
Total	100%	
Average		56.2%

Performance for inequalities is now more focused on routine and manual workers rather than people living in particular wards (although there is an overlap). The year to date figures are shown below:

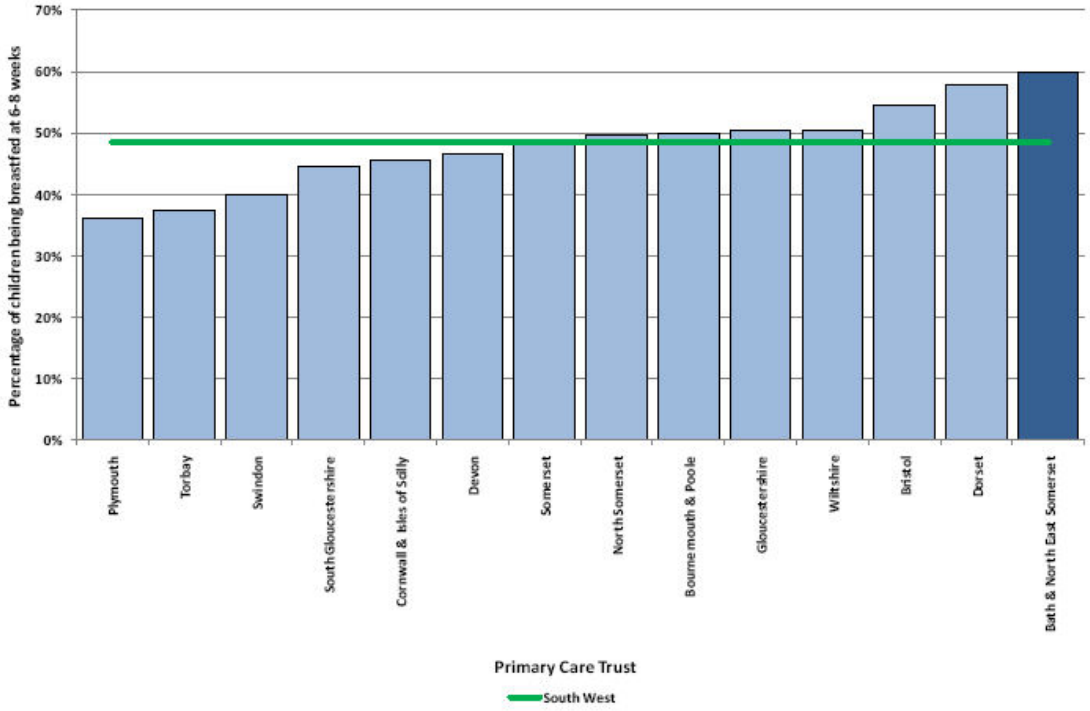
Quarter	Percentage of total quits that are from routine and manual workers	Quit rate amongst routine and manual workers
Q1	33.3	56.6
Q2	24.3	46.4
Q3	30.8	60.8
Average for PCT		56%

Chlamydia
Chlamydia screening has risen from 18.5% uptake to an expected 23% for year end. This is a significant improvement and reflects improved commissioning and delivery of some parts of the service. However, the overall uptake is still too low against a national target of 35% and there was lower than expected performance from a number of core providers including CASH, school nurses and general practice and a higher than expected number of screens came from the Healthy Lifestyle Team outreach service.

Chlamydia screening is no longer a vital sign target for 2011-12 and within the Public Health Outcomes Framework currently being consulted on, it is proposed that an indicator of positivity rates rather than coverage is used in the future. The final framework will be published in August. It is, therefore proposed, that the B&NES team continue to commission on the basis of achieving at least a 25% uptake and review the approach later in the year.

Breastfeeding
Breastfeeding rates in B&NES are the highest in the region.

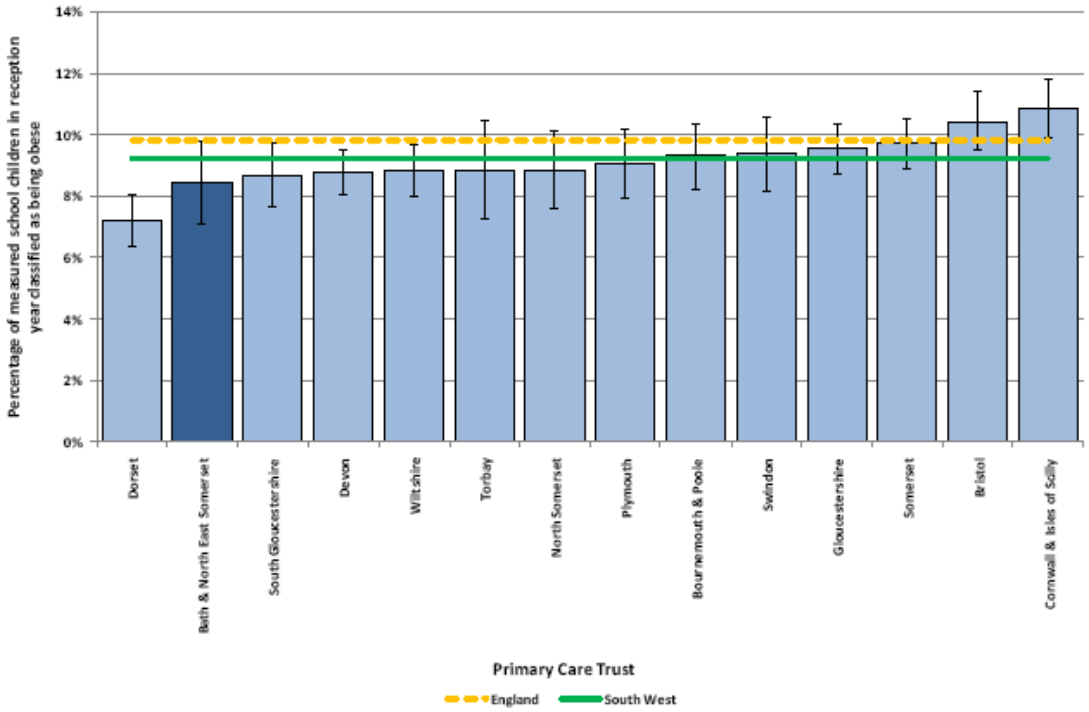
Percentage of children being breastfed at 6-8 weeks, South West PCTs and South West SHA, 2010/11 Q3.



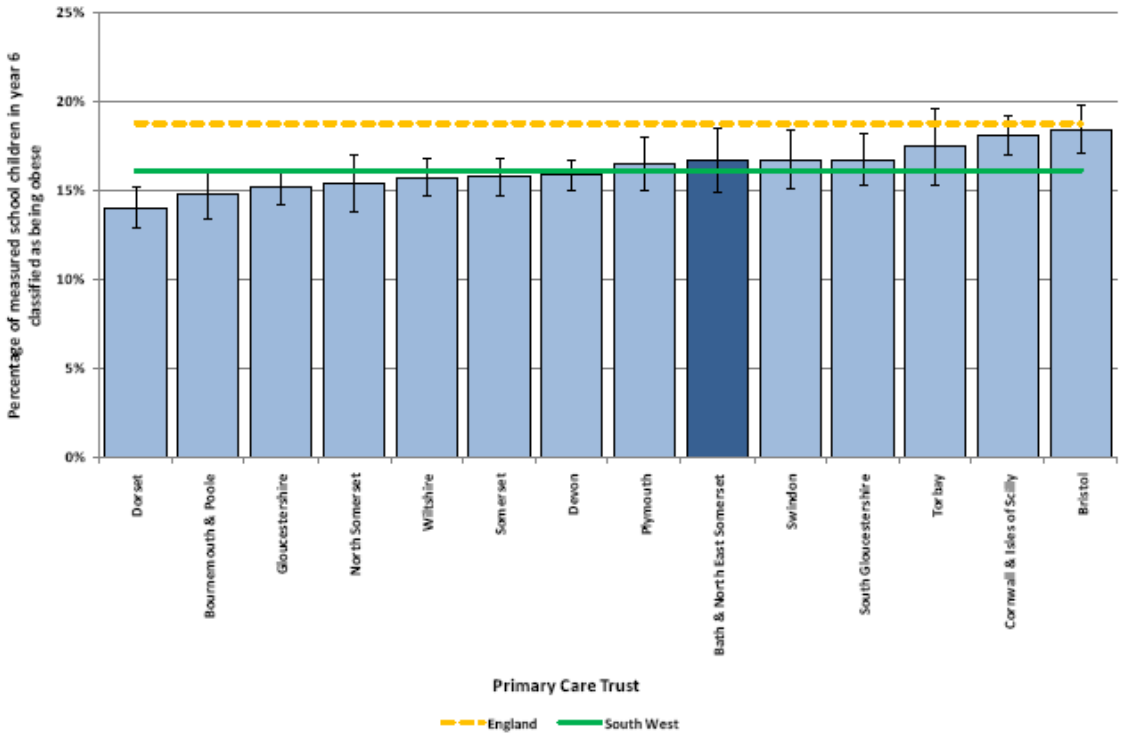
Child obesity

B&NES is underachieving against regionally set child obesity targets. In context, the charts overleaf show that prevalence of obesity amongst reception aged children in B&NES is lower than virtually all other parts of the region. Prevalence of obesity in children leaving primary school (year 6) is similar to the average for the region.

The percentage of children defined as obese, Reception year, South West PCTs, South West SHA and England, 2009/10.



The percentage of children defined as obese, Year 6, South West PCTs, South West SHA and England, 2009/10.



Suicide
Suicide rates have been shown as amber on the scorecard. The 2009 figures were actually lower than the previous year; however, they contribute to a 3 year average which showed an overall increase. If rates continue as at present, we will meet our target of reducing death rates by 20% from 1995-7 to 2009-11. Overall, B&NES experiences a lower than national and regional average rate of suicide.

Mortality
The B&NES all ages, all causes, mortality rate is red on the scorecard against the Vital Sign target but the current rate is significantly better than the regional and England rates.

Immunisations
End of year data shows marginal increases for all of the child immunisation programmes. Most notable was for MMR by age 2, which is encouraging. However, significantly more needs to be done to achieve the WHO target of 95% uptake for all of these immunisations. A meeting has been arranged in June with Children's Services to specifically address next steps in the commissioning, development and performance management of immunisations.

Stroke
Achievement of the 90% target includes patients transferred from an acute stroke unit to community stroke units, i.e. the super-spell. The Sulis Unit is currently deemed as not compliant with the definition of stroke rehabilitation units, albeit there appears to be no national definition and criteria. The actions identified are to seek an external peer review of the existing stroke in-patient

commissioning arrangements and to seek the PEC's support of reporting compliance against the national target in the event there appears to be no national definition. 50% of higher risk patients for Trans ischaemic attacks (TIA's) to be treated within 24 hours exceeded the year end target.

Screening programmes
Screening programme for people in B&NES have complex commissioning arrangements, often led by partners PCTs, with input from the Strategic Health Authority regarding performance and quality issues

Programme	Performance issues
Bowel	Performance is in line with national programme and B&NES fine in terms of capacity and reporting times.
Breast	Uptake and results reporting ok. Uptake needs to improve to meet 2012/13 standards. Planned intention to start offering screening to younger women before March 2011 is not going to be achieved.
Cervical	Uptake and results reporting ok.
Antenatal and newborn (including Down's syndrome, fetal abnormalities, infectious disease, sickle cell and thalssaemia)	Programmes are all now in place, offering tests in line with NICE standards.
Newborn hearing	Performance has improved across the board and compares well against regional peers.
Retinal screening	Performance has remained good throughout 2011/12 despite some challenges in staff capacity and a change in management from RUH to Bristol Community Health Services.
AAA screening	This planning group is signing off the final business case before being submitted for DH funding, anticipated in March 2011. Screening is planned to start in October 2011, subject to DH funding.

2.2 *Strategic Objective 2: Developing Independence and Choice*

Summary of annual performance

The indicators contained within this strategic objective have had mixed outcomes. The indicators show that vulnerable people are being supported to achieve and maintain independent living. In January 2011 the Older People's Independent Living Service OPILS was successfully launched by Somer Community Housing Trust, supported by B&NES which offers older and disabled people a tailored package of support aimed at maximising independent living skills, building and maintaining confidence and preventing the need for more intensive care and support. Other positive areas to report are that the end of year target has been met for the proportion of all deaths that occur at home and the reduction of emergency admissions as a result of a fall. However, we are not meeting the target for people being admitted to permanent residential and nursing care and the measures used to demonstrate that sufficient numbers of individuals are being supported to live independently.

Performance against targets and actions planned

Admissions of People to Permanent Residential & Nursing Care – people aged 65+ per 10,000 population

Although this indicator has been dropped nationally, we have chosen to retain it locally. Permanent admissions to residential care for over 65s has risen slightly since June/July 2010 with the average monthly number of admissions being slightly elevated at 24 when compared to last year's figure of 22. Analysis of issues influencing residential admissions has shown that despite demographic pressures and a significant reduction in delayed transfers of care the observed increase is relatively small. The 2010/11 target has been revised to a rate of 80 to better reflect current demographic and reasonable demand, and there continues to be close monitoring of admissions.

Adults aged 18-64 admitted on a permanent basis in the year to residential or nursing care per 10,000

The 2010/11 outcome related to 14 admissions throughout the year, slightly higher than anticipated due to complex needs in learning difficulties and mental health. There is continued close monitoring of admissions.

People supported to live independently through social services (all ages). Excluding grant funded services

The 2010/11 target was that more than 2800 people were supported to live independently. The year end position shows 2353 but the baseline population data has been amended as per Department of Health guidelines, which has resulted in a drop in performance although the target has not been amended. The target has now been dropped by the Department of Health and there will be outcome monitoring of all social care referrals to replace this indicator.

End of life Care

We improved our overall performance against this target this year; from an out turn position for 09-10 of 18.97% to 21.9%. This exceeded the year end target of 20%.

2.3 Strategic Objective 3: Improving Access to Services

Summary of annual performance
The Health Community continues to demonstrate excellent performance against the 4 hour target with performance at 98.3% for the year end at the RUH and 99.2% including the MIU. The RUH has been rated 2nd nationally in terms of its A&E performance against this measure. Each year we set local challenging targets for Delayed Transfers of Care performance indicators and although these were not met, the Department of Health target of delays per 100,000 populations has been met. Norovirus outbreaks had an impact on delays during February and March and there is continuing focus in this area. The ambulance performance deteriorated significantly in December due to the threat of industrial action which resulted in higher sickness levels in the Avon sector which has contributed to the indicators underperforming. All cancer targets have been met at year end. Performance has been met with the referral to treatment pathway of 18 weeks or less for non-admitted patients but the admitted patient target has not been met. The issue of an 18 week backlog at our local provider, the RUH, has been an ongoing concern throughout the year. There has been significant work to improve this position and a further action plan is being closely monitored to improve performance by the end of Quarter 1 of 2011/12.

Performance against targets and actions planned
Primary Care
Dental
The dental access local target was not met but performance has improved by 5% from the 2009/10 outturn. Available NHS capacity has not been fully used this year and targets are expected to be achieved in 2011-12.

Access to GP Primary Care targets
The extended Access target in 2010/11 was met with 100% of practices offering extended access. Information on performance against other GP Primary Access targets such as access to a healthcare professional within 24 hours are not yet available but historically NHS B&NES has performed well in these areas.

Timeliness of Social Care Assessments and Packages
The 2010/11 target was for 90% of assessments to be completed within 30 days. The year end position is 79.3%. Following the inclusion of the OT assessments a drop in overall performance was seen, however, this has steadily improved from 65% with the remedial action plan in place. There will be adjustments made to OT workflow to ensure the backlog of assessments does not recur.

Delayed Transfers of Care local targets
As expected, Norovirus outbreaks had an impact on this area, but the continued focus on reducing delays has identified mental health liaison and assessment capacity as a key issue for the RUH and the community hospitals. The actions identified are to seek the PEC's support in prioritising the use of the re-ablement & the winter pressures funding to be transferred to the local authority to invest in mental health liaison services. This is being discussed at the May meeting of the Professional Executive Committee.

Ambulance Response Times
Performance deteriorated significantly in December due to the threat of industrial action resulting in higher sickness levels in the Avon sector. The year end activity (incidents with response) was 3% over the contracted level. From April 2011 there is the implementation of re-categorisation to Category A (red 1 & 2) and Category C (green calls 1, 2, 3 & 4) and the new ambulance clinical indicators. The development of crew referral to the clinical

desk is subject to agreement of the GWAS contract. Both are likely to impact on delivery against performance standards for 2011-12.

Cancer: subsequent treatment (radiotherapy) within 31 days
This target came into effect from January 2011 after a year of shadow monitoring. RUH performance was below target for most of 2010/11 because of a shortage of radiotherapy capacity. However, additional capacity was agreed with commissioners and put in place from February 2011. Performance has improved and is being sustained into April and May. Q4 performance for RUH whole trust and B&NES population was 94.7% (target 94%).

The percentage of admitted patients with RTT of 18 weeks or less
The RUH continues to struggle to meet the 18 week RTT target both in terms of % of patients waiting longer than 18 week against the previous target of 90% (dropped as a national indicator by DH but still monitored and performance managed by SHA) where expected annual performance was 80.5%. This continues to be a priority area for performance management in 2011-12.

Diagnostic tests: number of patients waiting longer than 6 weeks for a diagnostic test
Performance against this target, which also incorporates patients choosing to wait longer than 6 weeks, has been stable for most of 2010/11 with occasional breaches in children's hearing services. Total numbers have been affected by breakdowns in RUH machinery which led to cancellations of scopes and significant impact of the national bowel cancer campaign recently which led to 16 breaches in March against previous monthly figures of 1-9. There is pressure across all providers following the bowel screening campaign with both 2 week wait referrals and routine referrals for colonoscopies increasing. It would be helpful to work with the Consortium and ASWCS cancer network to provide support to GP on referrals. We need to ensure that capacity issues as a result of advertising campaigns are fed back through Cancer Network. This target is not included in the Outcomes Framework for 2011/12.

Cancelled operations: The percentage of cancelled operations not rebooked within 28 days
The year end performance was slightly below standard at 5.8% compared to a target of less than 5% of was largely driven by poor performance in the first few months of 2010/11. The RUH are compiling an action plan to ensure improvement against this target for 2011-12, with plans to be linked to bed modelling and winter planning.

PCT booking: ensure every hospital appointment is booked for the convenience of the patient
PCT overall performance fell from 83% in 2009/10 to 65% in 2010/11. This is driven by the lack of direct booking to the PCT's main provider, the RUH, and reservations amongst GPs about use of Choose and Book. The Choose and Book team have also been providing support to the18 week programme and ISTC utilisation by managing waiting list transfers although numbers are decreasing. The move to direct booking at the RUH which should come into effect from July 2011 should mean direct booking is possible and therefore that our utilisation rates will increase. This continues to be an important issue for patient satisfaction although this target is not included in the Outcomes Framework for 2011/12.

Deliver the share of patients who need it to have access to Crisis Resolution Home Treatment each year
We performed very well against this target, with year end performance at 373 against a target of 265.

2.4 Strategic Objective 4: Improving Quality and Safety

Summary
We have further developed the quality assurance programme in the past year; and whilst we currently report on only a few indicators and targets (infection control, mixed sex accommodation), providers have reported positive engagement with us as lead commissioners and through ensuring a number of processes are effectively managed through the year outcomes for patients have improved and this is demonstrated through the quality scorecards that we have developed with all providers where we are the lead commissioner.

The scorecards are monitored and developed through the Quality Review process and contain a number of indicators that are measures of quality of care, for example, infection rates, death rates, patient feedback, complaints response timescales, staff sickness etc. In addition to the Quality meetings, and review of quality/ safety indicators, we also carry out quality assurance visits.

During the year, we carried out approximately ten quality assurance visits to different providers including the RUH, RNHRD and CHSCS, in addition, the infection, prevention and control nurses carried out visits to our provider sites and decontamination visits are underway with dental practices.

We review all complaints and incidents that are reported to the PCT PALs Team where there may be a clinical quality concern and take action as necessary. For example, carry out a quality visit. We work with other teams within commissioning as requested for example, safeguarding concerns.

Within the year, we have set up quality monitoring processes with additional primary care providers such as Assura and large dental practice providers.

Quality strategy
During the year, the Quality Team has drafted a Quality Strategy. This encompasses the quality processes described above but we have agreed a list of outcomes measures in order to demonstrate improvements to patient care. We are specifically identifying areas that we can influence through the quality agenda. We have worked with public health on the indicators chosen to ensure that we link to the JSNA and so to the Heath & Wellbeing agenda. Our next step is to work with the GP consortia to agree the Strategy and to develop our ambition to improve clinical engagement in the coming year.

Infection, Prevention and Control
The RUH have achieved their stretch target of five with only two MRSA infections this year. All of the other infection control targets were met for the RUH and PCT. There have been several outbreaks of Norovirus in the RUH and Community hospitals which were effectively contained but nevertheless still impacted negatively on other performance areas. The Department of Health have directed that acute hospitals are now required to monitor MSSA and E Coli surveillance and we are reviewing the numbers at the Quality review meetings. Targets have not been set for these two indicators as yet.

Eliminating Mixed Sex Accommodation
National reporting of mixed sex accommodation sleeping accommodation breaches was mandatory for acute NHS Trusts, and community Trusts from January 2011. This became mandatory for Foundation Trust from April 2011. The RUH, BANES, CHSCS, and the RNHRD are all reporting nationally as required. All three have reported zero

breaches to date. A matrix for justified and unjustified breaches in line with the published DH guidance has been agreed. These are included in the provider contracts for 2011/12.

Risk Management
The new commissioning risk register is now fully operational. It has recently been agreed that the baseline for corporate risks has now increased from 12 to 15 so that only high risks (red risks) are Corporate Risks. The Corporate risk register is reviewed monthly by the Professional Executive Committee.

CQUIN schemes for 11-12
The CQUIN schemes with Dorothy House, CHSCS and the RNHRD have been agreed but still to be finalised with the RUH. These will be monitored and reported in future reports.

We consistently monitor serious incidents (SI's) and never events and are pleased to report that we have no never events in the year. When a serious incident occurs, providers inform us of the incident and details of actions taken whilst they begin a detailed investigation. We review the investigation result and monitor their progress against actions agreed until the actions are completed. We now meet the standards set by the SHA for managing SI's, this has been a challenge at times but providers have improved their processes for undertaking investigations and reported the outcomes in a timely way.

Serious Incidents
A review of all serious incidents reported in 10-11 has been undertaken. We discuss serious incidents at each provider quality meeting and review and monitor actions. In addition, all root cause analysis reports for every SI are reviewed by two members of the quality team. We do this against the quality review template published by the National Patient Safety Agency (NPSA). Once we have reviewed the RCA report we feedback comments or recommendations to the provider. This process, whilst robust, does introduce delays in the system and we (commissioners) keep SI's open until we have assurance that the provider has completed all relevant actions.

Revised guidelines issued required all Trusts to grade incidents from 0-2 from October 2010. Zero- the least serious and for notification only and grade 2 the most serious for example, maternal deaths, child protection, never events. The SHA review all Grade 2 incident reports and feed back comments on the quality of RCA's.

We ensure that processes for reporting and investigating serious incidents are agreed within the contract with each provider. From 2011, there is the potential to recover costs of aspects of patient care to the provider when a never event occurs. Decisions on cost recovery will be made on a case by case basis.

Wider learning following Serious Incidents
We have processes in place to share learning from SI's across our community, and we disseminate any learning from SI's from other areas that we feel is relevant to our providers. All serious incidents that relate to infection issues are reviewed by the community infection control group. Learning from incidents is discussed and good practice shared. We are working with the SHA to set up a day's training on root cause analysis, we aim to particularly focus on areas that affect the whole community and where the interface between services can impact on outcomes such as pressure ulcers and look at ways of sharing learning across the community.

Annual Review of Serious incidents

We are in the process of compiling an annual report of serious incidents and this will be shared with PEC once completed and will contain some qualitative and quantitative detail

Commissioner SI's for 10-11
We reported 2 SI's in the year, they related to theft of controlled drug at dispensing practice and an issue at a care home which is being investigated as a serious case review

Community Health and Social Care Services -Total number of SI's in 2010-11
CHSCS reported 13 SI's in the year, of these 9 were pressure ulcers grade 3 or above, 3 were ward closures due to infection and 1 was an unexpected death.

Royal United Hospital- total number of SI's in 10-11
The RUH has reported 21 Incidents in the year, of these, 2 were drug related incidents 5 ward closures, 5 pressure ulcers, 2 communicable disease and infection issues, 3 breaches of information, 1 related to NICU, 1 related to vCJD ,1 system failure and 1 communication issue

RNHRD -total number of SI's in 10-11- Zero

2.5 Strategic Objective 5: Improving Effectiveness and Value for Money

Summary
As reported in last months report the 2010/11 outturn position for the Partnership is an under spend of £3,081k. The PCT key finance performance indicators for 2010/11 were (5a of scorecard) to deliver a surplus of £2.685m and in doing so (5b of scorecard) achieve planned savings of £11.1m. Draft accounts have been submitted to the Department of Health showing a surplus of £2.685m, these are currently the subject of audit; the final submission is due in early June. The savings target has been achieved through a combination of actions including delivering savings of £4m, not proceeding with planned expenditure of £6.6m and new income of £0.6m. The Social Care and Housing Budget under spent by £396k.

It should also be noted that the PCT delivered against its management savings target of £600k in 2010/11, resulting in a net reduction of 15.8wte or 19 posts.

Prescribing
The comparative primary care rolling growth performance of NHS B&NES in 2010/11 compared to others in the Cluster and the SHA is favourable and indicates that our GP have still had a good year in keeping prescribing growth below Cluster, SHA and England averages. However, performance was disappointing and with hindsight the expectations of continued lower primary care prescribing growth of about 1% was over ambitious.

NHS B&NES	3.57%
NHS Wiltshire	3.9%
NHS SW	4.17%
NHS England	3.79%

The performance for High Cost Drugs continues to be challenging with a 24% over performance against financial budget in 2010/11. Significant work has been developed over the year to improve our health communities horizon scanning process to support better prediction on high cost drug growth. The position demonstrates the challenging position of getting secondary care clinicians to support stronger control on PBR exempt High Cost Medicines and is shared across many Commissioning Communities. There will have been a local SHA under spend on the Cancer Drugs Fund of £110k which will help offset the over performance of the High Cost Drugs budget.

For 2011-12 the medicines Management Team will:

- Set a more realistic plan for 2011/12 for prescribing growth
- Continue to develop the work programme to understand and manage the high cost drugs budget utilising the contracting process, home delivery and other levers

2.6 Strategic Objective 6: Reducing Inequalities and Social Exclusion

Housing – summary of annual performance
The housing service met both of their national indicators for the number of affordable homes delivered (NI155) and the number of households living in temporary accommodation (NI156).

Other Performance
Adaptations given through the Disabled Facilities Grant (DFG's) are consistently effective. They produce significant health gains and prevent accidents and admissions to hospitals and residential care. Research has shown major improvements in quality of life and independence for grant recipients. Disabled children and their siblings benefit in development, education and social contact. Carers suffer less stress and have reduced likelihood of back injury.

A recent national benchmarking exercise with 16 other authorities provided very positive results on Housing Services performance demonstrating that: our unit administrations costs were the second lowest in the data set; that we deal with the second highest level of demand; and that at the time our time taken to complete work was also good with only 4 authorities being quicker. However, what is now clear is that overall process time performance has declined since 2008/09. The document, commissioned by the Department of Communities & Local Government suggests that we should aim to complete most adaptations within 30 weeks of date of enquiry to the Council. At present only 30% of DFGs are completed within this time frame. There is an action plan in place to improve this performance whist maintaining service quality.

2.7 Strategic Objective 7: Improving Services to Vulnerable Groups

Summary of annual performance
Carers are continuing to receive support with the Carers Give Us a Break Demonstrator Site Project. The performance target is not showing as being met but this indicator is likely to improve significantly once the carers break data is included. The national indicators (NI145, 146, 149, and 150) for people with learning difficulties and mental health in settled accommodation and in employment have not been met largely due to the number of assessments or reviews not taking place and data recording. Details of this are given below. There has been a significant improvement in Safeguarding performance with Procedural Timescales and safeguarding training targets.

Performance against targets and actions planned

Carers receiving a service or advice and information as an outcome of an assessment or review (NI135)
The target in this area would have been met with the CHSCS but lower performance with AWP has brought performance down. However, it should be noted that the Carers Breaks data is not yet included in the outcome figure and this could make a significant improvement to this indicator with an estimated outturn of 30% which would achieve the 25% target. Further scrutiny and remedial actions with AWP have been identified.

Adult and older clients receiving a review as a percentage of those receiving a service (PAF D40)
63% of clients have received a review against a target of 80%. A total of 3,410 annual reviews have been completed during the year with CHSCS completing 78% of this total. Performance data does not capture unscheduled reviews which make up a significant proportion of review activity, particularly during winter months (Dec-March) when planned review activity falls to accommodate this. There will be further scrutiny and remedial actions in relation to AWP's performance for 2011-12.

Assessment and Reviews of adults with learning difficulties
The outturn percentage of adults receiving an assessment or review in 2010/11 was 69% - a figure which has been declining month on month. Significantly the number of assessment or reviews completed each month has steadily worsened since the reconfiguration of the LD community service in October 2010. This has been a consistent issue throughout 2010/11, and remedial actions taken to date do not appear to have produced significant results. A more rigorous reporting and monitoring schedule is to be introduced with CHSCS from April 2011.

Adults in settled accommodation
Despite a working knowledge that there are approximately 63% of people with LD living in settled accommodation, performance against NI145 has remained below target, due to the ongoing under achievement of targeted number of assessment and reviews each month. The year end target of 63% has not been achieved for this reason.

The number of people reported as in settled accommodation has risen from 123 (31.5%) to 138 (38%). In April 2010 there were 149 adults with LD living in registered care, representing 34% of people receiving a service. This figure has reduced by 1 to 148 in April 2011 (38%). Two registered care schemes – River Street (Dimensions) and Maple Grove (CHSCS) were due to have deregistered by March 2011 which would have meant a further reduction to the registered care population of 22 people. However both schemes have been delayed and will not now de-register until June 2011.

16 new supported living placements were made in 2010/11 of which 3 were moves on from registered care. 2 people were supported to purchase their own home through shared ownership with Advance Housing.

2 registered care homes deregistered in 2010/11, creating 7 further supported living placements.

The number of people living in supported living has dropped from 121 (28%) in April 2010 to 98 (25%) in April 2011. This is due to a number of factors including: 2 deaths; 2 moves into nursing care; a large number of people living in Out of Area supported living placements being accepted as Ordinarily Resident in their place of residence.

The forecast for 2011/12 indicates a rise of 32 new supported living placements and a corresponding reduction of 25 registered care placements.

Adults with LD in employment

There has been no recent movement in the % figure for adults with in LD in employment, however, overall in 2010/11 the actual number of adults in paid employment has risen from 13 (3.3%) to 22 (6%), an increase of 9 people from April 2010, due to the success of schemes such as Project Search and a targeted approach to support more people into employment.

Annual Health Checks for adults with learning disabilities

As previously reported a Strategic Ambition for NHS South West was to provide an Annual Health Check to all people registered with a learning disability with their General Practitioner by 31 March 2011. This has been further supported nationally with the availability of the direct enhanced service.

Information published at the end of July 2010 identified that across NHS South West an average of 55% of people with a learning disability had received an annual health check by 31 March 2010. In Bath and North East Somerset the figure was 47% - slightly lower than with the SW average. The outturn for 2010/11, based on submissions from primary care, indicates that the percentage of adults with learning disabilities who have received a health check in 2010/11 has risen to 70%. There has been a significant improvement from 2009/10.

In particular it is noted that:

- 20 practices improved their performance in 2011/11
- 9 practices completed health checks for more than 90% of their patient register, including 5 practices who completed 100%
- Of the 9 practices who submitted a nil return in 2009/10, only two did so again in 2010/11. The average completion rate for the remaining 7 practices was 66%.

Personal Budgets

The total number of adults receiving a personal budget at the end of March 2011 was 88 people – representing 21% of all adults receiving a service, and 36% of those aged 18-64. This figure has risen from a total in April 2010 of only 19 people and reflects the strategy of transferring funding to a personal budget system for all people not living in registered care. However, the total number of people (18-64) who have had an assessment or review and are recorded as living in settled accommodation at the end of March 2011 was 147, all of whom should have been transferred to a personal budget. It remains unclear as to why there is a 'lag' in the system which delays the accurate reporting of the number of people transferring onto a personal budget, and this will be continue to be monitored in 2011/12.

Adults in contact with secondary mental health services in settled accommodation and employment (NI149 and 150)
As reported in last months performance reports these two indicators have dipped at the end of the year as a result of alignments being made to meet national recording changes that, in effect widened the cohort of people from which to count (denominator) and narrowed the definition of who could be counted (numerator).

Assertive Outreach Caseload Total
In preparation for wider mental health adult service redesign in 2011-12, the Avon, Wiltshire Partnership (AWP) Mental Health Trust undertook a review of its nationally prescribed service models - of which Assertive Outreach is one. This was to ensure that the service users being counted as 'in receipt' of Assertive Outreach services fully met the eligibility criteria set out in the Policy Implementation Guide 2003. The imperative was to do this for year end and before the transition to RiO (a new computer system).

For some service users, this meant transferring/stepping them down from the list of those 'in receipt' of Assertive Outreach back to Community Mental Health Teams, where their care is more appropriately provided. This work resulted in a decrease in the Assertive Outreach caseload count at the end of the year, compared to the count in the previous quarter but is a more clinically appropriate and accurate count of the AO caseloads across the Trust.

Currently, the caseload total for May 2011 is 65.

Sickness/absence rates for AWP
Whilst performance was at target for the majority of the year, winter (norovirus) related sickness saw the first rise of sickness levels to above target levels. New sickness monitoring arrangements in AWP have been implemented and levels of staff sickness will be closely monitored through the performance meeting. (Especially in order to monitor the effect of increased pressure on resources within the health sector and whether this has an effect of staff health.)

Substance Misuse
During 2010-11 further progress was made on key performance indicators.

The following targets were achieved at year-end:

- NI40 (Number of Problematic Drug Users (PDUs) in treatment): Target 594, Actual 603;
- 95% of clients entered treatment within three weeks;
- 84% of all adult clients were retained in treatment for 12 weeks;
- 99% of new clients had a General Health Care Assessment completed;
- 100% of new clients had a Care Plan;
- 99% of new clients were offered Hepatitis B vaccinations;
- 97% of previous or current injecting clients were offered a Hepatitis C test;
- 87% of new clients had a TOP (Treatment Outcome Profile) survey completed at the start of treatment;
- 100% of clients had a TOP survey completed when they exited treatment.

The substance misuse treatment system underperformed in four areas. To achieve performance the system must:

- Increase the number of all adult drug users entering treatment to meet the increasing prevalence of changing drugs of choice/dependence being used by younger clients, and to maximise funding (PbR).

- Enable more clients to recover by increasing the number of clients leaving treatment drug-free.
- Improve clients health and wellbeing by increasing the number of adult substance misusers who have Hepatitis B vaccinations.
- Increase take-up and improve recording of TOP surveys to measure client outcomes.

Safeguarding

Safeguarding Performance when Applied to 11/12 Procedural Timescales Targets:

No performance ranges are set.

Indicator	**Target**	**% Completed on time April – Mar 11**		
1. % of decisions made in 48 working hours from the time of referral	95%	CH&SCS	97%	
		AWP	84%	
		Both	**91%**	
2a. % of strategy meetings/discussions held within 5 working days from date of referral	90%	CH&SCS	89%	
		AWP	90%	
		Both	**90%**	
2b. % of strategy meetings/discussions held with 8 working days from date of referral	100%	CH&SCS	NA	N/A
		AWP	NA	N/A
		Both	**NA**	N/A
3. % of overall activities/ events to timescale	90%	CH&SCS	92%	
		AWP	79%	
		Both	**86%**	

CHSCS and AWP Combined Performance Overview
As reflected in Table 1 combined performance has improved in 3 of the stages, remained the same in 1 and decreased in 1 (2a). There are no reported breaches for either service for March, although there are 3 reported for AWP which occurred in Jan 11. The final position with regard to safeguarding case coordination performance for 10/11 will not be available until June 11.

CHSCS Case Coordination Activity
CHSCS performance continues to improve with no timescale breaches in March 11; this is the fourth month this has occurred throughout 2010/11. Overall performance has improved in 3 of the timescale stages and remained the same in 2.

AWP Case Coordination Activity
There is a backlog of cases from AWP that need to be input onto Care First, some of the backlog has been cleared, hence changes to the performance figures, however some remain outstanding and AWP have not provided support with the data entry. The

information available shows that AWP have improved in 3 of the stages, remained the same in 1 and decreased in 1 – this was due to a delay in the decision to progress the safeguarding referral in Jan 11. The delay was caused by miscommunication between CHSCS and AWP. The accuracy of the AWP figures is currently being looked into as it not possible for 55 referrals to be accepted and 59 strategy meetings/discussions to have taken place.

AWP Remedial Action Plan
Despite repeated requests AWP have not provided a remedial action plan and have stated that they would like to discuss the performance concerns at a workshop arranged by B&NES in June 11. The workshop will be attended by AWP and the 6 Local Authorities they hold a contract with. Despite repeated requests to meet prior to this AWP have not been able to do so; a further request will be made.

The percentage of relevant staff that have undertaken safeguarding training
There are 2 local targets set for this:

Target	Actual to date (April 10 – March 11)
97% of relevant social care staff	96%
80% of health staff	67%

CHSCS are aware that they need to improve the position regarding health staff and are looking at capacity to do this.

2.8 Strategic Objective 8: Being Better Informed

We work with the patients and the public in a number of ways such as the Health and Wellbeing network,. This is a virtual community of people who take an interest in the planning and delivery of health, social care and housing services. We also hold stakeholder events throughout the year. These are called Our Healthy Conversations

Specific and targeted involvement activities took place during the year. We held a three month engagement and a three month consultation on the plans for Right Care Best Value. This exercise helped to shape the direction of service change and confirmed the priorities and concerns of local people.

Groupings of patients and the public also joined with managers in other areas of service development and change. In the autumn of each year we produce a public report detailing all the involvement activities undertaken and their impact.

Public issues
We completed a review on the provision of specialist surgery for gynaecological cancer, affecting a small number of patients with complex conditions. Initial proposals to move this service to Bristol were not supported by all patients and led to different views amongst clinicians. The PCT took account of peoples concerns and worked hard to reach a resolution. A decision was reached in early 2011 to enhance and strengthen the service provided at the RUH and withdraw the proposal for a move. Throughout the process a stakeholder group of patients, people and representatives from local LINKs worked through the debate.

External partners
During the year in addition to our engagement work with the public we also worked closely with Bath and North East Somerset Local Involvement Network (B&NES LINk) responding to the issues and items of interest they raised with us and providing them with information to help in their role of acting as the voice of people who use health and care services. We also had regular involvement with B&NES Overview and Scrutiny Panel, attending public meetings, providing reports and working with councillors during the year on issues raised.

Communications
Involvement with the public is also facilitated through our ongoing communications programme. Throughout the year we produce public communications through the media, our website, targeted distributions and campaigns and regular information published in 'Council Connect', the B&NES Council newsletter sent to every household four times a year.

Patient advice and liaison service
One of the ways in which patients and local people engage with local health services is via the patient advice and liaison service (PALS). This gives people the opportunity to ask questions about local health services, find out information, get any concerns sorted out quickly and put forward their views in order to influence the development and delivery of services. As well as contacting the PALS central office at NHS B&NES, people can find out about and access PALS from health service staff and via their GP practices, pharmacists, dentists, opticians and local voluntary sector partners.

The year on year trend of increased use of the PALS service continues with a 7% increase on last year. Most people contact PALS because they need information or advice, as well as wanting PALS to help them sort out any concerns they may have. The most common information requests we received during the year were for issues concerning how to register with an NHS dentist and signposting to clinical services. There

has been a small increase in requests for signposting to translation services for clinical consultations. During the year PALS responded to 686 enquiries. 32% for information, 30% concerns, 20% advice and assistance. 17% covered compliments.

Social care clients receiving self directed support
Within our annual scorecard the Partisanship includes the measure of the number of social care clients receiving Self Directed Support. The target has been met against the CQC 30% target for the number of clients receiving support per 100,000 population. However the LAA target measuring the rate of clients receiving self directed support was narrowly missed.

2.9 Strategic Objective 9: Effective Organisations

NHS reform

2010-11 has been a particularly challenging year for the organisation due to a significant period of transition. We are in a period of major NHS reform. In July, the Department of Health released a consultation paper on wide-ranging NHS changes through a programme entitled Equity and Excellence- Liberating the NHS. Following the consultation period, a second paper was published in December confirming the intention to press ahead with reform and setting out the legislative framework and next steps. The announcements included the disestablishment of PCTs from April 2013, the creation of GP consortia to lead the future commissioning of the NHS, a stronger role for local authorities in the overview and management of local healthcare and the furthering of arrangements for healthcare providers to operate as independents, foundation trusts or social enterprises.

The aims of the reforms are stated as putting patients right at the heart of the decisions about their care, putting clinicians in the driving seat on decisions about services and focusing on delivering health outcomes that are comparable with, or even better than, those of our international neighbours. All of these aims are consistent with the values of NHS B&NES. Management arrangements were quickly reconfigured to respond to the challenges of the reforms and at the end of the year we have made very good progress in preparing for the structures of the future. This work will continue throughout 2011 and 2012.

GP commissioning

One of the key areas of reform is to bring into being GP consortia as a way of ensuring the future commissioning of the NHS is led by clinicians. Consortia are expected to take over from PCTs in April 2013. Since the announcements made by the Government, managers and clinicians have worked closely with local GPs to help establish a strong foundation for a GP consortium in B&NES.

Transforming community services

A key feature of the year has been the work undertaken to separate community health and social care provider services from the commissioning arm of the PCT and to establish a stand-alone organisation. Consultation was undertaken with staff, the public and other partners and in November, B&NES Council and the PCT approved a direction of travel to establish a Social Enterprise comprising the existing B&NES Community Health & Social Care Service.

Whilst there are no formal indicators as part of the Partnership's score card against this strategic objective, there are a number of measures and indicators that can be used to determine the effectiveness of organisations.

Staff wellbeing

The Health and Wellbeing partnership recognises that on occasions a member of staff may feel unwell or suffer from a serious health condition which may prevent them from being able to fulfil their duties or attend their work. The partnership aims to offer support throughout these periods, treating people appropriately and sensitively. We also aim to balance sickness absence with minimising disruption at the work place through adopting a fair monitoring and review system that will also contribute to creating a healthy workplace. Our current sickness absence rate is currently 3.41%. Average sickness absence rate across NHS organisations stands at 4.25%.

All members of staff and their immediate families can access a range of services provided by the Employee Assistance Programme (EAP). The EAP includes the service of an

information line and short term counselling and support. (4 sessions per individual). Services are free and strictly confidential. The service is well used and we have received positive feedback.

End of Report

This report was prepared by:-

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Board report line	2010/2011 Indicators	Indicator Number	Workstream	Lead	2009/10 Outturn	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	2010/11 outturn	Cumulative/ Average/ Actual data	Year end target	Direction compared to last year	Risk on Register
	Strategic Objective: 1. Improving Health, Keeping Well																					
1a	Number of 4 week smoking quitters who attended NHS stop smoking services - cumulative	**NI123 Care Quality Commission**	Staying healthy	HE	Actual 1240 Plan 1005	Actual 51 Target 27	Actual 84 Target 47	Actual 164 Target 146	Actual 248 Target 247	Actual 341 Target 298	Actual 416 Target 440	Actual 507 Target 468	Actual 572 Target 519	Actual 679 Target 665	Actual 754 Target 715	Actual 847 Target 795	Prov actual 1118 Target 1016	Prov actual 1118 Target 1016	C	Number of quitters 1016	↓	
1b	Number of 4 week smoking quitters who attended NHS stop smoking services - cumulative (rate per 100,000 population)	**WCC**	Staying healthy	HE	838			Actual 110.8			Actual 281.1			Actual 458.8			Prov actual 756	Prov actual 756	C	767	↓	
1c.	Percentage of 15-24 year olds tested outside of GUM or screened in any setting for Chlamydia. (NB: only provisional quarterly figures available. Actuals at year end will be slightly higher).	**VSB 13 Care Quality Commission NI 113**	Staying healthy	DM	Prov. 18.5% Target 25%			Prov. 4.7% Target 8.8 %			Prov. 9.5% Target 16.8%			Prov. 14.0% Target 25.9%			Prov. 23% Target 35.0%	Prov. 23% Target 35.0%	C	35%	↑	✓
1d.	Breastfeeding at 6-8 weeks: recording (coverage)	**VSB11 NI53**	Staying healthy	JL	Actual 95% Target 90%			Actual 96.4% Target 95%			Actual 96.7% Target 95%			Actual 98.6% Target 95%			Actual 100% Target 95%	Actual 99% Target 95%	Ac	95.1%	↑	
1e.	Breastfeeding at 6-8 weeks: breastfeeding (prevalence)	**VSB11 NI54**	Staying healthy	JL	Actual 58% Target 45%			Actual 57.8% Target 49.1%			Actual 57.4% Target 49.1%			Actual 60.0% Target 49.1%			Actual 61.0% Target 49.1%	Actual 60.1% Target 49.1%	Av	49.1%	↑	
1f.	Proportion of people who spend at least 90% of their time on a stroke unit	**VSA 14 WCC**	Unplanned Care	CE	26.00%			54.69%			55.00%			44.80%			53.85%	53.85%	Av	83%	↑	
1g	Proportion of people who spend at least 90% of their time on a stroke unit - RUH	**VSA 14**	Unplanned Care	CE	25.5%	Actual 30.6% Plan 32%	Actual 35.1% Plan 35%	Actual 72% Plan 45%	Actual 58.1% Plan 50%	Actual 61.7% Plan 55%	Actual 73.5% Plan 60%	Actual 77.8% Plan 65%	Actual 71.0% Plan 70%	Actual 84.8% Plan 75%	Actual 67.9% Plan 80%	Actual 61.9% Plan 80%	Actual 80% Plan 80%	Actual 80% Plan 80%	Ac	80%	↑	✓
1h.	50% of higher risk TIA cases to be treated within 24 hours	**VSA 14**	Unplanned Care	CE	20.93%			73.68%			62.50%			41.67%			80.00%	80.00%	Av	67%	↑	
1i.	All-age all cause mortality rates for men and women (2007-09)	**(NI120) VSB 01**	Staying Healthy	PS	2008/09 492.06													Actual 495.66	Ac	481	↓	
1j	Mortality rate per 100,000 (directly age standardised) from all circulatory diseases at ages under 75 (07-09)	**(NI121) VSB 02 CQC National Priority/LAA**	Staying healthy	PS	2008 46.26													Actual 46.97	Ac	46.04	↓	
1k	Mortality rate per 100,000 population under 75 from cancer (07-09)	**(NI122) VSB 03**	Staying healthy	PS	2008 97.22													Actual 98.96	Ac	97.44	↓	
1l	Healthy life expectancy at age 65	**NI 137**	Staying Healthy	PS	19.0m, 21.3f 05-07													19.3m, 21.4f 2007-09	Ac	15.3	↑	
1m	Improved life expectancy by 1 year by 2015 (Male)	**WCC**	Staying Healthy	PS	79.7													80.3 2007-09	Ac	80.1	↑	
1n	Improved life expectancy by 1 year by 2015 (Female)	**WCC**	Staying Healthy	PS	83.2													83.9 2007-09	Ac	83.5	↑	
1o	Reduced Health Inequalities by 10% by 2015 (Male)	**WCC**	Staying Healthy	PS	5.6													6.3 2007-09	Ac	5.4	↓	
1p	Reduced Health Inequalities by 10% by 2015 (Female)	**WCC**	Staying Healthy	PS	3.6													3.5 2007-10	Ac	3.5	↑	
1q	Coronary Heart Disease (CHD controlled blood pressure (to exceed current best in country by 2015	**WCC**	Primary Care	JG	89.5%	52.62%	61.30%	68.73%	74.42%	77.04%	79.93%	82.22%	84.52%	85.62%	86.22%	88.32%	89.88%	89.88%	Ac	90%	↑	
1r	Reduce deaths from Cardio Vascular Disease (CVD) by 10% by 2015	**WCC**	Staying Healthy	PS	56.2													46.97%		54.7	↑	
1s	To reduce the proportion of women who smoke at the time of delivery by 0.5% from the 2005/6 baseline (13.5%) by 2010/11.	**DoH monitoring**	Staying healthy	HE	10.40%													10.00%			↑	
1t	BMI measurements of children in reception and year 6 classes	**WCC**	Staying healthy	JL	13.40%													Known January 2012		12.50%		

Bath & North East Somerset Council

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NHS Bath and North East Somerset

Board report line	2010/2011 Indicators	Indicator Number	Workstream	Lead	2009/10 Outturn	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	2010/11 outturn	Cumulative/ Average/ Actual data	Year end target	Direction compared to last year	Risk on Register
1u	Percentage of reception year children recorded as obese	WCC VSB09(12-14)	Staying healthy	JL	Actual 8.43% Plan 7.48%													Known January 2012		7.01%		
1v	Percentage of year 6 children recorded as obese	WCC VSB09(12-14)	Staying healthy	JL	Actual 16.7% Plan 12.5%													Known January 2012		12.00%		
1w	Rate of hospital admissions for alcohol related harm per 100,000 population	VSC26 NI39	Staying healthy	PA	1385 full yr, 339 Q4			Prov. Actual 385			Prov. Actual 397			Prov. Actual 396			Due September 2011	Due September 2011		366		
1x	No. of drug users in effective treatment. Effective treatment for all clients in contact with tier 3 or 4 services with a mordality start date who are retained in treatment for 12 or more weeks from their triage date or have a planned discharge	VSB14 NI40	Mental Health	CS	581			581			607			601			603	603	AC	594	↑	
1y	Suicide and Injury of undetermined Intent: mortality rate (2007-09)	VSB 04	Staying healthy	PS	5.6 (2006-08)													6.5		6 by 2009-11, known in early 2013	↑	
1z	Improving Health and Reducing Health Inequalities - Emotional health and well being and child and adolescent health services (CAMHS) (4 indicators can each score 1 to 4)	VSB12 NI50 NI51	Mental Health	LP	15															Not known		
1za	Percentage of women aged 47 to 49 and 71 to 73 offered screening for breast cancer within last 3 years	VSA09	Staying healthy	PS	N/A													0.00%				
1zb	Percentage of women receiving cervical cancer screening test results within two weeks	VSA15	Planned Care	HM	84.50%													99.70%			↑	
1zc	Percentage women aged 25-49 screened within 3.5 years and 50-64 screened within 5 years	CQC national priority	Staying healthy	PS	80.80%													80.20%			↓	
1zd	Guaranteed access to GUM clinic within 48 hrs of contacting a service	CQC Existing Commitment 09/10	Planned Care	HM	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	Ac	100%	⇔	
1ze	Percentage of children aged 1 immunised for DTaP/IPV/HIB	VSB10	Staying healthy	CP & MF	95.6%			96.1%			97.1%			96.1%			94.7%	96.1%	Ac	97%	↑	
1zf	Percentage of children aged 2 immunised for PCV	VSB10	Staying healthy	CP & MF	90.3%			89.9%			92.6%			91.7%			91.0%	91.7%	Ac	95.1%	↑	
1zg	Percentage of children aged 2 immunised for Hib/MenC	VSB10	Staying healthy	CP & MF	91.2%			91.5%			92.6%			91.7%			91.2%	91.7%	Ac	95.1%	↑	
1zh	Percentage of children aged 5 immunised for DTaP/IPV/Hib	VSB10	Staying healthy	CP & MF	90.0%			91.6%			90.0%			89.7%			90.1%	90.1%	Ac	95.1%	↑	
1zi	Percentage of children aged 2 immunised for MMR	VSB10	Staying healthy	CP & MF	87.6%			88.4%			91.1%			90.3%			89.0%	90.3%	Ac	95.1%	↑	
1zj	Percentage of children aged 5 immunised for MMR	VSB10	Staying healthy	CP & MF	84.1%			83.6%			86.1%			84.5%			84.9%	84.5%	Ac	95.1%	↑	
1zk	Percentage of females aged 12-13 immunised for HPV	VSB10	Staying healthy	CP & MF	73.2%			73.20%										76.30%	Ac	90%	↑	
	Strategic Objective: 2 Developing Independence and Choice																					
2a	Admissions of people to permanent residential and nursing care - people aged 65+ per 10,000 population	LAA Stretch (PAF C72)	Unplanned Care	SS	95	142	128	107	99	96	93	97	96	94	95	95	data not available	95	Ac	less than 60	⇔	
2b	Adults aged 18-64 admitted on a permanent basis in the year to residential or nursing care per 10,000 population	C73	Unplanned Care	SS	1.3	3.2	3.2	2.5	2.4	2.1	1.8	1.5	1.3	1.4	1.5	1.3	data not available	1.3	Ac	less than 1.2	⇔	
2c	People supported to live independently through social services (all ages). Excluding grant funded services.	NI 136	Unplanned Care	SS	1951	1755	1780	1790	1787	1812	1852	1864	1878	1897	1890	1808	1822	1822	Ac	more than 2800	↓	

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2c(2)	People supported to live independently through social services (all ages). This is an estimated total based on current figures above and 08/09 GFS figures	NI 136	Unplanned Care	SS	2486	2285	2310	2321	2317	2343	2382	2395	2409	2428	2420	2338	2353	2353	Ac	more than 2800	↓	
2d	Achieving independence for older people through rehabilitation/intermediate care	NI 125	Unplanned Care	CE	90%	87%	89%	90%	89%	89%	91%	92%	93%	93%	93%	94%	94%	94%	Ac	90%	↑	
2e.	Number of vulnerable people achieving independent living	NI 141	Unplanned Care	CE	70.60%			63.3%			67.6%			68.9%			75.00%	75.00%	Av	65%	↑	
2f	People with long-term conditions supported to be independent and in control of their condition	NI 124 VSC11 LAA	Unplanned Care	CE	83%	Annual GP survey														85%		
2g	The extent to which older people receive the support they need to live independently at home	NI 139 LAA	Unplanned Care	CE	2008 33.4%	No place survey taking place but question in Voicebox.																
2h	End of life care - Proportion of all deaths that occur at home.	NI 129 WCC	Unplanned Care	ST	18.97%	23.2%	18.0%	24.2%	24.2%	21.2%	20.7%	21.4%	21.8%	22.2%	21.6%	24.0%	18.5%	21.9%		20%	↑	
2i	Number of vulnerable people who are supported to maintain independent living	NI 142	Unplanned Care	SS	98.2%			98.3%			97.3%			98.2%				98.4%		98.2%	↑	
2j	To reduce emergency admissions as a result of a fall in people aged 65+ by 150 per year by 2015	WCC	Unplanned Care	ST	994	60	73	62	66	52	74	69	51	78	57	47	63	752		957	↑	
	Strategic Objective: 3 Improving Access to Services																					
3a	Timeliness of social care assessment.	NI 132	Long Term, End of Life, Older People	SS	90.90%	72.8%	74.4%	75.1%	75.5%	73.5%	74.0%	73.8%	73.7%	74.4%	76.0%	77.7%	79.3%	79.3%	Ac	more than 90%	↓	
3b	Timeliness of social care packages.	NI 133	Long Term, End of Life, Older People	SS	92.90%	90.2%	88.8%	89.0%	90.9%	89.3%	90.2%	90.6%	88.5%	89.0%	90.0%	90.1%	90.4%	90.4%	Ac	more than 95%	↓	
3c	All cancers: Subsequent treatment within 31 days - (PCT population)	VSA 11/12	Planned Care, Cancer and Maternity	HM	95.77% Surgery	100% Surgery	96.6% Surgery	96.3% Surgery	100% Surgery	96.2% Surgery	100% Surgery	100% Surgery	91.7% Surgery	92.6% Surgery	96.0% Surgery	95.7% Surgery	100% Surgery	96.9% Surgery	N	Surgery 94%	↑	
3c	All cancers: Subsequent treatment within 31 days - (PCT population)				97.14% Drug Treatment	100% Drug Treatment	100% Drug Treatment	100% Drug Treatment	100% Drug Treatment	93.3% Drug Treatment	100% Drug Treatment	100% Drug Treatment	93.3% Drug Treatment	100% Drug Treatment	97.9% Drug Treatment	100% Drug Treatment	100% Drug Treatment	98.8% Drug Treatment	N	Drug treatment 98%	↑	
3d	All cancers: Overall treatment within 62 days - (PCT population) (original plan)	VSA 13	Planned Care, Cancer and Maternity	HM	86.67%	85.2%	97.1%	91.3%	90.9%	88.5%	85.7%	91.7%	85.0%	89.3%	96.0%	100.0%	89.7%	90.5%	Av	85%	↑	
3d	Treatment within 62 days for patients identified through screening programmes (PCT population)				96.55%	100.0%	No data available	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.1%	Av	90%	⇔	
3d	Treatment within 62 days for patients identified through consultant upgrades (PCT population)				93.33%	100.0%	No data available	100.0%	100.0%	100.0%	No data available	100.0%	No data available	0.0%	100.0%	100.0%	No data available	93.3%	Av	90%	⇔	
3e	All cancers: two week wait - (PCT population) (Original Plan)	Care Quality Commission	Planned Care, Cancer and Maternity	HM	94.40%	92.6%	97.4%	94.3%	93.1%	93.4%	96.6%	95.3%	92.8%	95.9%	90.0%	97.5%	93.2%	94.4%	Av	93%	⇔	
3f	All cancers: Subsequent treatment within 31 days - PCT) (Original Plan)	VSA 11/12	Planned Care, Cancer and Maternity	HM	98.09%	97.8%	100.0%	98.8%	98.6%	98.7%	100.0%	98.9%	96.6%	100.0%	100.0%	100.0%	97.0%	98.8%		96%	↑	
3g	Subsequent treatment within 31 days, Radiotherapy - (PCT) (Original Plan)	VSA 12	Planned Care, Cancer and Maternity	HM	93.02%	55.6%	63.6%	51.7%	71.9%	82.6%	64.7%	85.3%	96.2%	85.0%	88.5%	100.0%	96.3%	94.7%		94%	↓	

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3h	Two week wait for urgent referral for breast symptoms other than suspected cancer (PCT population)	**VSA 08**	Planned Care, Cancer and Maternity	HM	98.09%	97.4%	94.3%	96.2%	99.2%	97.7%	98.9%	98.9%	99.0%	100.0%	100.0%	98.9%	99.2%	98.4%		93%	↑	
3i	Percentage of admitted patients with a referral to treatment pathway of 18 weeks or less	**VSA 04**	Planned Care, Cancer and Maternity	HM	Actual 74.55% Plan 90%	Actual 75.34% Plan 90%	Actual 82.1% Plan 90%	Actual 91.8% Plan 90%	Actual 93.2% Plan 90%	Actual 92.4% Plan 90%	Actual 88.6% Plan 90%	Actual 85.3% Plan 90%	Actual 85.7% Plan 90%	Actual 86.7% Plan 90%	Actual 80.1% Plan 90%	Actual 80.5% Plan 90%	Actual 80.3% Plan 90%	Actual 80.3% Plan 90%	Ac	Monthly target	↑	✓
3j	Percentage of non- admitted patients with a referral to treatment pathway of 18 weeks or less	**VSA 04**	Planned Care, Cancer and Maternity	HM	Actual 98.11% Plan 95%	Actual 98.38% Plan 95%	Actual 98.6% Plan 95%	Actual 99.0% Plan 95%	Actual 98.4% Plan 95%	Actual 97.6% Plan 95%	Actual 97.5% Plan 95%	Actual 98.1% Plan 95%	Actual 94.6% Plan 95%	Actual 96.4% Plan 95%	Actual 96.1% Plan 95%	Actual 96.0% Plan 95%	Actual 97.2% Plan 95%	Actual 97.2% Plan 95%	Ac	Monthly target	↓	✓
3k	Supporting measures for VSA 04: number of diagnostic waits >6 weeks (currently includes those who choose to wait longer than 6 weeks)	**VSA 04**	Planned Care, Cancer and Maternity	SB	Actual 77 Plan 0	Actual 0 Plan 0	Actual 4 Plan 0	Actual 4 Plan 0	Actual 1 Plan 0	Actual 9 Plan 0	Actual 2 Plan 0	Actual 1 Plan 0	Actual 3 Plan 0	Actual 5 Plan 0	Actual 1 Plan 0	Actual 0 Plan 0	Actual 16 Plan 0	Actual 46 Plan 0	C	0	↑	
3l	Supporting measures for VSA 04: Activity levels for 15 diagnostic tests	**VSA 05**	Planned Care, Cancer and Maternity	SB	Actual 50289 Plan 41591	Actual 3786 Plan 3716	Actual 3778 Plan 3716	Actual 4246 Plan 3716	Actual 4025 Plan 3716	Actual 3963 Plan 3716	Actual 4085 Plan 3716	Actual 3919 Plan 3716	Actual 4304 Plan 3716	Actual 3649 Plan 3716	Actual 4346 Plan 3716	Actual 4068 Plan 3716	Actual 4435 Plan 3716	Actual 48604 Plan 44592	C	more than 44592	↓	
3m	Reduce delayed transfers of acute care to a minimal level - RUH (Currently this includes all RUH data not just BANES residents)	**Local indicator**	Unplanned Care	CE	3.2%	N/A	3.3%	2.6%	1.5%	3.3%	4.1%	3.0%	3.0%	2.7%	2.8%	4.5%	3.6%	3.1%	Ac	1% local target	↑	
3n	Reduce delayed transfers of acute care to a minimum level - RUH (B&NES residents only-monthly average)	**Local indicator**	Unplanned Care	CE	2.0%	2.4%	2.0%	1.3%	1.9%	2.3%	2.7%	2.6%	0.9%	1.9%	2.9%	1.9%	1.5%	2.0%	Ac	1% local target	⇔	
3o	Reduce delayed transfers of care to a minimal level - Community Health and Social Care Services (monthly average)	**Local indicator**	Unplanned Care	CE	16.0%	10.3%	9.1%	9.5%	9.5%	12.7%	11.6%	7.8%	8.6%	8.9%	11.2%	17.0%	8.3%	10.4%	Ac	local target agreed 5%	↑	
3p	Reduce delayed transfers of care to a minimal level - AWP (Mental Health)	**Local indicator**	Mental Health	AM	23.0%	5.7%	5.4%	5.0%	6.4%	9.6%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	Ac	Less than 7.5%	↑	
3q	Average weekly rate of delayed transfers of care from all NHS hospitals, acute and non-acute, per 100,000 **18+** population (includes mental health)	**Care Quality Commission NI131**	Unplanned Care	CE	13	9	7	6	8	12	13	6	6	10	10	10	8	8.8	Ac	15 for 08/09, 09/10 not yet set	↑	
3r	Ambulance Trusts to respond to 75 % of Category A calls within 8 minutes (GWAS)	**Care Quality Commission**	Unplanned Care	CE	75.0%	78.3%	78.1%	76.3%	77.6%	75.8%	74.4%	74.9%	73.8%	64.7%	72.2%	73.9%	77.8%	74.3%	Av	75%	↓	✓
3s	Ambulance Trusts to respond to 95 % of Category A calls within 19 minutes (GWAS)	**Care Quality Commission**	Unplanned Care	CE	95.1%	96.0%	96.0%	94.9%	95.7%	95.2%	95.4%	94.7%	94.9%	90.3%	94.6%	95.0%	96.6%	94.8%	Av	95%	↓	✓
3t	Ambulance Trusts to respond to 95% of Category B calls within 19 minutes (GWAS)	**Care Quality Commission**	Unplanned Care	CE	90.7%	93.2%	93.8%	91.8%	92.5%	92.8%	91.7%	91.4%	91.6%	84.6%	90.7%	91.6%	91.1%	91.4%	Av	95%	↑	✓
3u	Four hour maximum wait in A&E from arrival to admission, discharge or transfer. RUH (all RUH data not just BANES residents).	**Local indicator**	Unplanned Care	CE	95.2%	97.0%	98.8%	98.7%	99.1%	99.3%	99.1%	98.4%	99.2%	97.8%	98.5%	97.8%	95.6%	98.3%	Av	98%	↑	✓
3v	Four hour maximum wait in A&E from arrival to admission, discharge or transfer. Combined RUH and Minor Injury Units	**Care Quality Commission**	Unplanned Care	CE	97.7%	98.8%	99.4%	99.4%	99.6%	99.7%	99.6%	99.3%	99.6%	99.0%	99.2%	99.0%	98.0%	99.2%	Av	98.0%	↑	✓
3w	% Cancelled operations breaching the 28 day rule (RUH figures only) These percentages are a month in arrears due to data collection.	**Care Quality Commission (target for acute only)**	Planned Care	HM	15.60%	20.6%	15.8%	7.4%	11.8%	0.0%	0.0%	0.0%	9.1%	3.6%	4.8%	3.0%	1.0%	5.8%	Av	Less than 5%	↑	
3x	PCT Booking - Ensure every hospital appointment is booked for the convenience of the patient	**Local indicator**	Planned Care	HM	83.0%	66%	71%	70%	66%	66%	62%	65%	68%	53%	62%	67%	65%	65%	Av	more than 90%	↓	

Board report line	2010/2011 Indicators	Indicator Number	Workstream	Lead	2009/10 Outturn	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	2010/11 outturn	Cumulative/ Average/ Actual data	Year end target	Direction compared to last year	Risk on Register
3y	Deliver local share of patients who need it to have access to a Crisis Resolution Home Treatment each year (cumulative) (For the purpose of performance assessment, this target is taken to be equivalent to the number of separate episodes of home treatment)	Care Quality Commission Existing Commitment	Mental Health	AM	Actual 283 Target 265	Actual 27 Target 22	Actual 63 Target 44	Actual 91 Target 66	Actual 125 Target 88	Actual 158 Target 110	Actual 183 Target 133	Actual 224 Target 155	Actual 252 Target 177	Actual 283 Target 199	Actual 315 Target 221	Actual 346 Target 243	Actual 373 Target 265	Actual 373 Target 265	C	265	↑	
3z	Diabetic retinopathy screening.	CQC Existing Commitment	Unplanned Care	KG	105%			102%			100.3%			100.7%			102.3%	102.3%			↓	
3za	A three-month maximum wait for revascularisation	CQC Existing Commitment	Unplanned Care	CE	100%	100%	100%	100%	100%	100%												
3zb	Thrombolysis 'call to needle' of at least 68 per cent within 60, minutes , where thrombolysis is the preferred local treatment for heart attack	CQC Existing Commitment	Unplanned Care	CE	Low numbers													N/A				
3zc	Patient experience of access to primary care - Able to get appointment same day or in next 2 weeks	VSA06	Primary Care	JG	85.5%	Primary Care Annual Survey																
3zd	Patient experience of access to primary care - Able to get an appointment more than 2 full weekdays in advance	VSA06	Primary Care	JG	84.6%	Primary Care Annual Survey																
3ze	Patient experience of access to primary care - Satisfied with GP opening hours	VSA06	Primary Care	JG	86.0%	Primary Care Annual Survey																
3zf	Supporting measures for VSA06: Extended opening hours for GP practices, Increased capacity in primary care	VSA07	Primary Care	JG	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			⇔	
3zg	For women to have a health and social care assessment of needs, risks and choices by 12 weeks of pregnancy.	VSB 06 NI 126	Planned Care	SB		Data lagged by 2 quarters		86.30%			92.10%			lag			lag	92.10%	Ac			
3zh	Improving Access: Access to Personalised and Effective Care - Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period	VSB18	Primary Care	JG	Actual 94006 Plan 112920	Actual 94006 Planned 94328	Actual 95174 Planned 95286	Actual 95531 Planned 96459	Actual 95908 Planned 97556	Actual 96131 Planned 98850	Actual 96937 Planned 100036	Actual 97455 Planned 10171	Actual 97957 Planned 102534	Actual 98797 Planned 103694	Actual 99042 Planned 104734	Actual 99672 Planned 105791	Actual 100550 Planned 106690	Actual 100550 Planned 106690	Ac		↑	
3zi	The number of emergency bed days per head of weighted population	NI134	Unplanned Care	CE	7899	5240	6430	7067	6206	6604	6840	7048	6945	7159	6938	6500	7200	7200		No target set but improvement on previous year	↑	
3zj	Ambulance conveyance rate to A&E	VSC14	Unplanned Care	CE	66%	67.2%	66.1%	66.3%	65.5%	66.2%	67.4%	66.9%	67.3%	65.1%	66.7%	67.2%	67.4%	66.9%		Target not set as not selected as local vital sign	↑	
~	**Strategic Objective: 4 Improving Quality & Safety**																					
4a	MRSA number of infections - RUH	VSA 01	Quality	ML	Actual 17 Target 19	Actual 0 Target 0	Actual 0 Target 1	Actual 0 Target 1	Actual 0 Target 0	Actual 0 Target 1	Actual 1 Target 0	Actual 0 Target 1	Actual 1 Target 1	Actual 0 Target 0	Actual 0 Target 0	Actual 0 Target 0	Actual 0 Target 0	Actual 2 Target 5	C	less than 5	↑	✔
4b	MRSA number of infections - PCT	VSA 01	Quality	ML	Actual 10 New target	Actual 3 Plan 0	Actual 1 Plan 1	Actual 0 Target 0	Actual 0 Target 1	Actual 0 Target 1	Actual 1 Target 0	Actual 0 Target 1	Actual 0 Target 0	Actual 0 Target 0	Actual 0 Target 1	Actual 0 Target 1	Actual 0 Target 0	Actual 5 Plan 6	C	less than 6	↑	✔
4c	Clostridium Difficile - RUH (all ages monthly target post 48 hours)	Care Quality Commission VSA 03	Quality	ML	Actual 113 Plan 127	Actual 3 Plan 4	Actual 5 Plan 5	Actual 8 Plan 5	Actual 4 Plan 8	Actual 3 Plan 4	Actual 6 Plan 4	Actual 5 Plan 4	Actual 6 Plan 3	Actual 2 Plan 5	Actual 3 Plan 6	Actual 4 Plan 7	Actual 4 Plan 8	Actual 53 Plan 63	C	less than 63	↑	✔
4d	Clostridium Difficile - PCT	Care Quality Commission VSA 03	Quality	ML	Actual 138 Plan 174	Actual 13 Plan 7	Actual 5 Plan 9	Actual 6 Plan 6	Actual 7 Plan 10	Actual 3 Plan 6	Actual 19 Plan 9	Actual 11 Plan 10	Actual 7 Plan 11	Actual 7 Plan 12	Actual 3 Plan 13	Actual 8 Plan 11	Actual 7 Plan 15	Actual 96 Plan 119	C	less than 119	↑	✔
4e	Deliver local share of national target (7,500) new cases of psychosis served by early intervention team per year	CQC Existing Commitment	Mental Health	AM	Actual 39	Actual 10 Target 5	Actual 6 Target 2	Actual 10 Target 3	Actual 10 Target 5	Actual 12 Target 7	Actual 14 Target 10	Actual 15 Target 12	Actual 15 Target 13	Actual 16 Target 15	Actual 17 Target 17	Actual 19 Target 18	Actual 21 Target 20	Actual 21 Target 20	C	20	↓	
~	**Strategic Objective: 5 Improving Effectiveness & Value for Money**																					

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5a	Progress against 11m savings plan	New local indicator	All	TC/ JS	New for 10/11		Actual 1480 Plan 1851	Actual 2340 Plan 2502	Actual 3382 Plan 3702	Actual 4125 Plan 4629	Actual 5363 Plan 5554	Actual 6480 Plan 6480	Actual 7406 Plan 7406	Actual 8332 Plan 8332	Actual 9256 Plan 9256	Actual 10183 Plan 10183	Actual 11109 Plan 11109	Actual 11109 Plan 11109	C	11,108	New	New
5b	On track for control total	New local indicator	All	TS	New for 10/11		Actual 448 Plan 448	Actual 672 Plan 672	Actual 895 Plan 895	Actual 1119 Plan 1119	Actual 1342 Plan 1342	Actual 1556 Plan 1556	Actual 1790 Plan 1790	Actual 2014 Plan 2014	Actual 2240 Plan 2240	Actual 2461 Plan 2461	Actual 2685 Plan 2685	Actual 2685 Plan 2685	C	2,685	New	New
-	**Strategic Objective: 6 Reducing Inequalities & Social Exclusion**																					
6a.	Number of affordable homes delivered (gross)	NI 155	Housing	GS	151			Actual 35 Target 30			Actual 48 Target 64			Actual 105 Target 64			Actual 160 Target 157	Actual 160 Target 157	C		↑	
6b	Number of households living in Temporary Accommodation	NI 156	Housing	GS	19	21	16	24	34	37	41	34	32	27	28	30	29	29		37	↓	
6c	Tackling fuel poverty – people receiving income based benefits living in homes with a low energy efficiency rating	NI 187	Housing	GS	09/10 met	Annual survey																
6d	Conception rate per 1,000 females aged 15-17 (% change from baseline).	VSB08 NI112	Staying Healthy	DB/L P/HM	26% 2008													22% 2009	Ac	40% by 2008	↑	
6e	Services for disabled children	NI054	Childrens Services	LP	64%	Parents Survey														Not set		
6f	Data quality on ethnic group	CQC Existing Commitment			87.41%																	
-	**Strategic Objective: 7 Improving Services to Vulnerable Groups**																					
7a	Carers receiving a service or advice and information as an outcome of an assessment or review- cumulative target	NI 135 WCC	Long Term, End of Life, Older People	SS	22.6% AWP included	3.1% AWP included	5.1% AWP included	6.9% AWP included	8.5% AWP included	9.9% AWP included	11.2% AWP included	12.7% AWP included	14.2% AWP included	15.7% AWP included	16.5% AWP included	18.4% AWP included	19.5% AWP included	19.5% AWP included	Ac	more than 25%	↓	
7a(2)	Carers assessed and getting services or information YTD including estimated voluntary services	NI 135 including estimated vol services WCC	Long Term, End of Life, Older People	SS	21.9%	4.7%	6.6%	8.4%	10.0%	11.3%	12.5%	14.0%	15.5%	17.0%	17.7%	19.7%	20.7%	20.7%	Ac	more than 25%	↓	
7b	Adult and older clients receiving a review as a percentage of those receiving a service - cumulative target	Local indicator (D40)	Unplanned Care	SS	76%	Actual 15% Plan 8%	Actual 28% Plan 16%	Actual 36% Plan 20%	Actual 42% Plan 30%	Actual 46% Plan 35%	Actual 51% Plan 40%	Actual 53% Plan 47%	Actual 55% Plan 54%	Actual 58% Plan 61%	Actual 60% Plan 67%	Actual 66% Plan 73%	Actual 63% Plan 80%	Actual 63% Plan 80%	Ac	80%	↓	
7c	Percentage of adults with learning difficulties in settled accomodation	NI 145	Learning Difficulties	MM	35.30%	Actual 19.4% Plan 5.3%	Actual 27.4% Plan 11%	Actual 31.2% Plan 16%	Actual 34.4% Plan 21.5%	Actual 33.5% Plan 26%	Actual 34.6% Plan 31.5%	Actual 36.0% Plan 37%	Actual 36.7% Plan 41.6%	Actual 35.8% Plan 47%	Actual 38.4% Plan 52%	Actual 38.0% Plan 58%	Actual 34.9% Plan 63%	Actual 34.9% Plan 63%	Ac	63%	↓	
7d	Adults with learning difficulties in employment	NI 146	Learning Difficulties	MM	4.6%	3.2%	3.2%	2.2%	4.8%	5.1%	6.3%	7.1%	6.9%	6.8%	6.7%	6.1%	5.2%	5.2%	Ac	5.5%	↑	
7e	Adults in contact with secondary mental health services in settled accommodation	NI 149 LAA	Mental Health	AM	Actual 90 Plan 70	Actual 70% Target 91%	Actual 91% Target 91%	Actual 92% Target 91%	Actual 92% Target 91%	Actual 92% Target 91%	Actual 92% Target 91%	Actual 92% Target 91%	Actual 92% Target 91%	Actual 92% Target 91%	Actual 92% Target 91%	Actual 76% Target 91%	Actual 78% Target 91%	Actual 78% Target 91%	C	More than 91	↓	
7f	Adults in contact with secondary mental health services in employment	NI 150	Mental Health	AM	17%	16%	18%	18%	18.0%	19%	19%	20%	19.5%	20.0%	21.0%	18.0%	18.0%	18.0%	Ac	20.0%	↑	

Board report line	2010/2011 Indicators	Indicator Number	Workstream	Lead	2009/10 Outturn	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	2010/11 outturn	Cumulative/ Average/ Actual data	Year end target	Direction compared to last year	Risk on Register
7g	Safeguarding adults training - Social Care	CQC Self Assessment	Safeguarding Adults	LH	TBC									91.0%			96.0%	96.0%	Ac	97.0%	↑	
	Strategic Objective: 8 Being Better Informed																					
8a	Social care clients receiving Self Directed Support (DP's & IB's). Rate per 100,000 population	NI 130 LAA	Unplanned Care	SS	521	Actual 428 Plan 450	Actual 472 Plan 495	Actual 524 Plan 535	Actual 572 Plan 579	Actual 619 Plan 622	Actual 656 Plan 665	Actual 712 Plan 708	Actual 763 Plan 751	Actual 794 Plan 793	Actual 836 Plan 836	Actual 874 Plan 879	Actual 919 Plan 922	Actual 919 Plan 922	Ac	922	↑	✔
8b	Percentage of social care clients receiving Self Directed Support.	NI 130 CQC	Unplanned Care	SS	17.9%	Actual 21.3% Plan 15%	Actual 22.2% Plan 17%	Actual 23.8% Plan 19%	Actual 25.4% Plan 21%	Actual 26.6% Plan 23%	Actual 27.3% Plan 25%	Actual 28.7% Plan 26%	Actual 29.6% Plan 27%	Actual 30.1% Plan 28%	Actual 30.4% Plan 29%	Actual 32.7% Plan 29%	Actual 31.6% Plan 30%	Actual 31.6% Plan 30%	Ac	30%	↑	✔
8c	Self reported experiences of patients and users	VSB 15 CQC National Priority		DT	397.86	Patient Survey																
8d	National NHS Staff Survey based measures of job satisfaction	VSB17 CQC National Priority		AP	3.64869	Staff Survey																
8e	Self reported experiences of social care users	NI 127	Unplanned Care	JS		Home Care User Survey																
	Strategic Objective: 9 Effective Organisations																					

There are no performance indicators within this strategic objective

Key

⇧	Improved performance compared to previous month
⇩	Fall in performance compared to previous month
⇔	No change in performance compared to previous month
C	Cumulative
Ac	Actual
Av	Average

Traffic lights:

Red: Major cause of concern as a key target likely to be missed by a significant margin

Amber: Performance is not a major cause of concern, although target may not be fully met

Green: Target is expected to be met

Note: These traffic lights are internal judgements on progress, not official DH bandings.

NHS
and
erset

Annex 1

Comment
Final data mid June - numbers will increase.
Final data mid June - numbers will increase.
Final data late June - numbers will increase.

Annex 1

Comment
Could change with end of year figures

NHS
and
erset

Annex 1

Comment
Could change with end of year figures in June 11 as Carers Breaks data not yet added.

Bath & North East Somerset Council

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Working together for health & wellbeing

Partnership Board for Health and Wellbeing Report
Date: 15th June 2011
Report Title: Child Protection Activity Performance Report
Agenda Item: 15
List of attachments to this report: None

Summary

Purpose

1 To provide the Board with a progress report in respect of the key indicators of child protection activity, as included in the Annual Report and Business Plan of the Local Safeguarding Children Board (LSCB). Progress is shown in relation to previous years and in comparison with other Local Authorities and is reported at the end of each quarter. This report details the position at the end of the fourth quarter for 2010/11.
Following discussion at the previous Board meetings, work is progressing to identify indicators which will reflect outcomes for children rather than simply report on process issues. This work will need to take into account the recommendations of the Munro Review of Child Protection (final report published 10th May 2011) and any subsequent scope for reporting on locally identified performance indicators which may follow from the Implementation Panel formed by Central Government to consider its response to Munro's recommendations. Locally, the Children's Social Care Service is taking forward work to record and collate qualitative feedback from child, parents and other professionals to illustrate whether and how work has made the child safer.

Recommendation

2 The Partnership Board for Health and Wellbeing is asked to note the report and actions being taken and receive updated performance reports at each meeting of the Board. Future reports will detail performance in relation to outcomes rather than process indicators.

Rationale

3 Considering the report represents good practice and illustrates the corporate commitment to safeguarding children, and provides a basis for holding the LSCB to account and being challenged by the LSCB in matters of safeguarding.

Other Options Considered

4 None

Financial Implications

5 There are no direct financial implications arising from this report.

Risk Management

6 The risks associated with ensuring effective safeguarding arrangements are assessed and managed by the LSCB (which receives quarterly performance reports) and its constituent members. Within the Council, these issues are identified within the Service Risk Register.

Equality issues

7 Promoting diversity and supporting individual identity and recognising and valuing the racial and cultural diversity of Bath and North East Somerset's communities and a commitment for anti-discriminatory practice are values underpinning the work of the LSCB.

Legal Issues

8 There are no legal issues requiring consideration.

Engagement & Involvement

9 The LSCB and its constituent members receive and review quarterly performance reports. This report has been viewed by the Council monitoring officer and section 151 officer.

Child Protection activity / performance indicators	2008/09 England	2008/09 Family	2008/09 Actual	2009/10 Plan	2009/10 Actual	20010/11 Plan	2010/11 Quarterly			
							Q1	Q2	Q3	Q4*
1. Number of children subject to child protection plan			Total = 78	N/A	Total = 71		73	74	81	106
2. Child protection plans lasting 2 years or more (NI 64)	6	8.3	15.7	7	18.9	8	18	20.9	12.5	10.4
3. Children becoming subject to a child protection plan for a second or subsequent time (NI 65)	13	13.1	7.7	12	11.4	10	21.9	22.1	25.6	21.6
4. Child protection cases which were reviewed within required timescales (NI 67)	99	98.9	100	100	100	100	100	100	100	100
5. Referrals to Children's Social Care going on to initial assessments (NI 68)	64	75	35	50	51.2	50	67.9	72.8	72.6	81.5
6. Initial assessments by Children's Social Care carried out within seven working days of referral (NI 59) *	72	59.6	55.1	77	67.6	77	34.9	40.1	45.6	62.6 **
							48.2 – For 10 working days	53.6	61.3	63.5
7. Core assessments by Children's Social Care that were carried out within 35 working days of their commencement	78	77.6	75.5	80	78.5	80		33.1	37.6	58 **

* The new NI is 10 working days but we are required to report on performance in 7 working days and 10 working days for 2010/11 only.

** As confirmed in the CIN census for 2010/11

Partnership Board for Health and Wellbeing Report
Date: 15th June 2011
Report Title: Child Protection Activity Performance Report
Agenda Item: 15

The Report

1. The table above details the performance for 2008/09 and comparisons with England and our family of Local Authorities (most recent national data available): our performance for 2009/10: the targets set for 2010/11 and our performance at the end of the fourth quarter of 2010/11 (colour coded to indicate status of performance to target – Red/Amber/Green) – and therefore the performance at year end.

Commentary, Performance summary and remedial actions where appropriate

Number of children subject to child protection plans

2. This is not a national performance indicator, but a significant indicator of child protection activity, though it should be interpreted with caution. A child protection plan is made following a multi-agency case conference and assessment that a child is at continuing risk of significant harm or impairment of health and development. Early intervention and the provision of services can result in a child's needs to being met any earlier stage, thereby preventing the escalation to risk of significant harm and the need for a child protection plan – resulting in a smaller number/percentage of children with plans. On the other hand, small numbers could be the result of inappropriately high thresholds for intervention. Our thresholds for intervention are monitored by the LSCB's Safeguarding Children Sub Committee and reported to the LSCB. The Children's Service recent audit of our thresholds for interventions and concluded that these are appropriately and consistently set. We keep this under regular review. The recent (January 2011) Ofsted unannounced annual inspection of contact, referral and assessment arrangements in Children's Social Care once again found the thresholds to be appropriate and consistently implemented. There has been a steady increase in the number of children with protection plans throughout 2010/11 with a marked increase in the final quarter – 106 represents the highest number since the late 1990's. The Children's Service has investigated this position and determined that the increase has been the result of a combination of factors (the complexity of new cases and risks being identified: cases where long standing but low level concerns have increased to become risks of significant harm: the quality of some assessments and multi-agency evaluations of the risk of harm resulting in cautions decisions about the need for some protection plans) – and has taken actions to address these factors which are likely to result in an appropriate reduction in the number of children with protection plans and more children in need plans – whilst ensuring that protection plans are in place for all who require them.

   It is worth noting that neighbouring Local Authorities Children's Service have also reported a significant increase in their numbers of protection plans during 2010/11.

Child Protection Plans lasting two years or more (NI 64)

3. This national performance indicator is used to indicate the effectiveness of the child protection plan in eliminating and significantly reducing the risk of significant harm – and is based upon research evidence that this is most likely to be achieved within a two year period. If not, the Local Authority should consider whether action is required to remove children from care in which they are assessed as being a continuing risk of significant harm. There are circumstances in which plans may exceed 2 years – for example when there have been changes in household composition that required further assessments: when addressing issues of neglect and improvements in parenting are being affected but further improvements are required and the assessment is that these can be achieved; when working with parents whose mental health difficulties impact upon their parenting.

4. For this performance indicator, a low score is indicative of good performance.

5. Improvement noted at the end of the third quarter in the percentage of children with protection plans lasting more than 2 years has been maintained, and the end of year figure is slightly off target – and represents a small number of children and families. We have processes in place to review the circumstances of each child. Each child protection plan has been reviewed by a multi-agency case conference, and the decision to continue with child protection plans quality assured by the LSCB's Safeguarding Children Sub Committee.

Children becoming subject to a child protection plan for a second or subsequent time (NI 65)

6. This national indicator is used to measure the effectiveness of child protection plans in eliminating risks of significant harm – i.e. the risks have been eliminated, do not reappear and necessitate a further child protection plan. In practice, this is determined by the quality of services provided and work undertaken with parents and child(ren) through the plan: the quality of assessment of risks of significant harm and actions taken: the provision and accessibility of any support services subsequent to the child protection plan.

7. For this performance indicator, a low score is indicative of good performance.

8. Our performance in this area had been strong for a number of years – exceeding both the national and family of Local Authorities' performance.

9. As noted in previous reports, performance during 2010/11 has been off target (and is above national and comparator positions) but numbers are small. We continue to audit all cases to ensure that there are not any shortfalls in services that have contributed to the need for further protection plans. Further work is required to ensure the continuation of appropriate services to children at the end of the protection plan – reports have been submitted to the Children's Trust Board and the LSCB to promote this.

Child protection cases which were reviewed within timescales (NI 67)

10. It is important that all child protection plans are reviewed (by multi agency case conferences) to ensure that they are being implemented and remain appropriate to a child's needs and assessed risk of significant harm. Also to determine whether any further actions are required. Child protection plans must be reviewed within 3 months of the initial case conference and within (at least) six monthly intervals thereafter.

11. For this performance indicator, a high score is indicative of good performance.

12. Our performance is 100% and has been for the past seven years.

13. Although this indicator will cease to form part of the National Indicator set for safeguarding, however, we will continue to monitor this area of performance given its importance in underpinning good and timely planning.

Referrals to Children's Social Care going to initial assessments (NI 68)

14. It is important that the Council responds to and addresses concerns in a timely and efficient way and ensures that all referrals to Children's Social Care be followed up where appropriate. This indicator is a proxy for several issues – the appropriateness of referrals coming into social care, which can show whether local agencies are working well together: and the thresholds which are being applied in Children's Social Care at a local level. The revised national guidance within Working Together to Safeguard Children 2010 has necessitated changes in practice and new targets will be set for subsequent years. Working Together makes explicit the need to ensure that all referrals receive an initial assessment. We have identified some inconsistencies between duty managers but are now on course with greater clarity, helped by new process mapping exercise. We anticipate improved performance and working towards 100%. The lift in performance has been maintained throughout 2010/11 and will be built upon in 2011/12.

Initial assessments by Children's Social Care carried out within seven working days of referral (NI 59) – now ten working days of referral

15. Initial assessments are an important indicator of how quickly services can respond when a child is thought to be at risk of serious harm or thought to be a child in need. As the assessment involves a range of local agencies, this indicator also shows how well multi-agency arrangements are established. The child or young person must be seen, and their wishes and feelings taken into account, within the completion of the initial assessment.

16. For the performance indicator, a high score is indicative of good performance.

17. Our performance has steadily improved during the course of 2010/11 but we have still missed our end of year target. As stated in the table the new standard for this PI is 10 working days but we have been required to report on 7 working days as well for 2010/11 only. Clearing a backlog of outstanding assessments impacted adversely on our performances for the first quarter which was significantly below target. Additional staffing resources were allocated to address these positions and to track completion throughout the 7 and 10 day period. Corrective actions have lifted week-to-week performance (especially in respect of new indicators of 10 working days) and this has been underpinned by early work within the lean review of social care processes to improve response rates and quality as well as timeliness. Work to ensure that there are no outstanding assessments at the end of the performance year should put us in a stronger position at the beginning of 2011/12 to significantly improve performance. The appropriateness of prescribed timescales for initial assessments was considered within the work of the Munro Review Group (national review of social work and child protection) with whom we have been actively engaged – and Munro has recommended that the timescale is dropped and the focus is upon the quality of assessments as a continuous process.

Core assessments by Children's Social Care Services that were carried out within 35 working days of their commencement (NI 60)

18. Core assessments are an in depth assessment of a child and their family, as defined in the Framework for Assessment of Children in Need and their Families. There are also the means by which section 47 (child protection) enquiries are undertaken following a strategy discussion. It is important that the Council investigates and addresses concerns in a timely and efficient way, and that those in receipt of an assessment have a clear idea of how quickly this should be completed. Successful meeting of the timescales can also indicate effective joint working where multi-agency assessment is required.

19. For this performance indicator, a high score is indicative of good performance.

20. Corrective actions to lift performance in respect of the timeliness of completion had by the end of the year effected significant improvements, but the end of year target has not been attained. This was unlikely due to a backlog from 2009/10 that adversely impacted that year's performance. Actions have been taken to avoid that impacting upon 2011/12's performance.

21. The Lean Review of social care processes has identified actions which will improve future performance, and has focused upon the quality of core assessments as well as timeliness – finding it to be strong in some areas but variable in others. Enhanced training and supervision arrangements have been put in place to address this. This work will be underpinned by the work of the Quality Improvement Manager (to be appointed shortly).

22. The appropriateness of prescribed timescales for core assessments was considered within the work of the Munro Review Group (national review of social work and child protection) and Munro has recommended that the timescale is dropped and the focus is upon the quality of assessments as a continuous process.

Contact person/Author	**Maurice Lindsay**, Divisional Director – Safeguarding, Social Care and Family Service Tel: 01225 396289 Email: Maurice_Lindsay@bathnes.gov.uk
Responsible Director	Ashley Ayre, Strategic Director – Children's Service
Background papers	

If you would like this document in a different format, please contact Maurice Lindsay

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Partnership Board for Health and Wellbeing Report
Date: 15th June 2011
Report Title: Children's Service Commissioning Performance
Agenda Item: 16
List of attachments to this report: None

Summary

Purpose

1 The purpose of this report is to report on the current performance of Children's Service commissioning of children's health services.

Recommendation

2 The Partnership Board for Health and Wellbeing is asked to note the performance as described in this report.

Rationale

3 The Partnership Board has a role in monitoring the performance of Children's Services commissioning of children's health services. This report gives an overview of performance.

Other Options Considered

4 Not applicable to this report

Financial Implications

5 None directly relating to this report

Risk Management

6 Any areas of risk are highlighted in the report

Equality issues

7 Any equality issues are addressed in the report.

Legal Issues

8 None identified

Engagement & Involvement

9 Performance reporting is made public through this report which is available to the public and stakeholders. This report has been viewed by the Council monitoring officer and section 151 officer.

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Partnership Board for Health and Wellbeing Report
Date: 15th June 2011
Report Title: Children's Service Commissioning Performance
Agenda Item: 16

The Report

1. Purpose

1.1 The purpose of this report is to provide information on current performance on children's service commissioning relating to health services.

2. Introduction

2.1 This report covers the key areas of commissioning activity for children's health services including :

- Disabled children's services
- Emotional health & wellbeing
- Sexual Health /Teenage pregnancy
- Substance misuse
- Safeguarding compliance in provider services
- Immunisations
- Contract monitoring

2.2 Updates on the national performance indicators which are reported to the Children's Trust Board about health are included with this report but the public health indicators that are reported separately are not commented on except for immunisations. This report updates information given in the report to the Health & Wellbeing Board in February 2011.

3. Disabled Children

3.1 The Care Quality Commission reviewed all health provision for disabled children and young people through an on line questionnaire in January and the results are expected after June.

3.2 Statutory regulation about the provision of short breaks for parent /carers of disabled children come into force on 1 April 2011. This regulation ensures assessment of carers for short breaks, a range of provision of short breaks and an annual public statement by the local authority about services. The budget for disabled children's short breaks was reduced by 25% in the Early Intervention Grant. We have maximised the opportunities for joint commissioning with other services such as play and have been able to re-commission across the range of services.

3.3 The re-commissioning of wheelchair service has been put on hold pending the results of two pilot projects arranged by a National Advisory Group which has been set up to look at how wheelchair services should be provided in the future. One of the pilot projects is in the South West and is being run by the Strategic Health Authority. Efforts to address specific complaints and general issues with the current wheelchair service provider are ongoing. Regular meetings between adult and children's commissioners and the provider are taking place to try to improve waiting times and customer service whilst we are waiting for the SHA/National Group to complete their work.

3.4 Work on the provision of a more integrated service for disabled children has slowed whilst the implications of commissioning and provider split are considered in children's social care. External advice has been commissioned to ensure we capture the best practice in our plans.

3.5 Work has been completed on the Continuing Health Care pathway for children and young people. The Children's Continuing Health Care Assessor Nurse started in March and she will be testing out the pathway and helping train the multi-agency panel

3.6 Transitions remain a difficult issue for families with disabled children. Children's Services has identified the need for a cultural shift so that staff working with disabled young people are aware of the personalisation agenda and can work with young people to increase their independence into adulthood where there are not the same level of support services. Parental expectations remain high for their children so they remain critical of public services.

3.7 In March 2011 the PCT adopted the Every Disabled Child Matters Charter and this will be subject of a single member decision report asking the Council to do the same now the elections are over.

4. Emotional Health & Wellbeing

Our tier 3 specialist CAMHS and tier 4 inpatient provider have changed their name to Oxford Health Foundation Trust (OHFT). The new model services they are providing continue to embed well. Performance targets for waiting times are being met.

The procurement process for our tier 2 targeted primary child and adolescent mental health service for children and young people continues. It is hoped to award the contract from August 2011.

5. Sexual Health / Teenage Pregnancy

5.1 The 2009 conception rate is 22.8; a reduction from the 2008 rate of 26.1.

5.2 The PCT's Sexual Health Strategy led by Public Health now includes the promotion of strategies to prevent teenage pregnancy. A reduction in funding allocated to teenage pregnancy work has mirrored the reduction in national emphasis. Remaining funding is

focussing on creating a sustainable training programme.

5.3 The 2009 conception rate is not due to be released until February. Unconfirmed figures indicate our rate will be reduced from the 2008 rate of 26.1. This downward trend is due to our local sexual health brand, SAFE, and continued partnership working and training is successful in ensuring young people are accessing preventative sexual health services and professionals working with young people are confidentially signposting to relevant services.

6. Drugs and Alcohol Services

6.1 The Young Person's Substance Misuse Needs Assessment and Treatment Plan have both now been submitted to the National Treatment Agency and feedback has been positive. There is evidence that Project 28 achieves good outcomes (in 2009-10, 50 out of 57 young people left treatment either drug free or as an occasional user).

6.2 Project 28's contract has been extended for a further year but on a slightly reduced budget (-£5k). The reduction is a result of cuts to the Safer Stronger Communities Fund. Frontline services have not been affected this year but further cuts to this budget are anticipated in 2012/13 (40% /£36k). This cannot be absorbed without loss of staff / provision.

6.3 Department of Health funding for the Alcohol and Sexual Health Project ended 31st March 2011. A funding application has been made to Comic Relief with a view to continuing / extending the scope of this project, the main focus being the development of the Drink/Think tool (an alcohol brief intervention tool for young people).

7. Children in Care

7.1 The emotional health of children in care remains consistent (NI58 Table 2.1). We have asked the CHSCS to provide an annual report on the health of children in care as part of their contracted performance reporting.

8. Safeguarding Compliance

8.1 All providers had to give the SHA an assurance about their compliance with safeguarding standards. Our three main local providers RUH, RNHRD and CHSCS were all able to report compliance.

8.2 Jenny Theed is covering the role of Designated Nurse since Mary Lewis's departure. Jill Chart our named Nurse has also agreed to provide safeguarding training for primary care in conjunction with adult safeguarding training.

9. Immunisations

9.1 HPV immunisations within the current academic are unlikely to reach the target of 90% for the year. The School Nurses are attempting to vaccinate 1260 girls in Cohort 8 (in both maintained and private schools). By the end of March 77% had received their 3rd dose, 86% had received their second and 88% their first dose.

9.2 There will be a bit of 'catch-up' by the school nurses in April and May and then GPs will provide a safety net for outstanding immunisations.

9.3 This years percentage is already higher than last years final figure but will not reach the very high 90% target. **Note** the 10/11 vital sign for HPV is already known - 76.3% (this is for academic year 2009/10).

9.4 Other childhood immunisations: There is remarkably little change from last years annual results. We have not hit any of the (high) VSB targets that we set for 10/11. Nevertheless only those for MMR - first and second dose are more than 5% off target. MMR first dose shows an improvement from 87.6% (09/10) to 89.3% (10/11) but still not as high as 08/09 (91.8%). Further awareness-raising measures are planned.

9.5 Main issues continue to be

- data discrepancies between Child Health systems and GP practices,
- payments to GPs are complicated and do not reflect each vaccination which has been given at the optimum time.
- some GP practices administering vaccines more effectively than others (for whatever reason).
- some parents remaining 'hard to reach',

10. Contract Monitoring Issues - Community Health & Social Care Services

10.1 The key indicators scorecard for children's health services is attached and completed as far as possible.

10.2 CHSCS has become an Early Implementer of the new Health Visitor Programme. This is seen as advantageous in terms of support from the national programme.

11. Contract Monitoring Issues – Royal United Hospital

11.1 The occupational health and physiotherapy review has still not started pending the appointment of an Independent Chair and changes of staffing at the RUH. We are working with RUH to clarify how this will be progressed.

11.2 Work has started on a pathway into acute paediatric services with RUH paediatricians and community paediatricians based on benchmarking information from other areas where many referrals could be managed within the community. We are currently looking at local figures.

1

Table 2: Be Healthy National Indicators – financial year

Indicator	DD	England	Region	Target 09/10	Result 09/10		Target 10/11	Result / forecast 10/11	
NI 51 Effectiveness of child and adolescent mental health services (CAMHS) (Self-evaluation score out of 16, higher scores are better) *(LAA designated target, 2008/9-10/11)*	MB	15 (09/10)	15 (09/10)	15	15	G	16	-	
NI 52 Take-up of school lunches a – primary	MB	41.4 (09/10)	30.5 (09/10)	34.4%	36.6%	G	38%	Not yet available	
NI 52 Take-up of school lunches b – secondary	MB	35.8 (09/10)	27.5 (09/10)	31.2%	29.9%	R	32%	Not yet available	
NI 53 Prevalence of breastfeeding at 6-8 weeks from birth a – 6-8 weeks	PA			45%	56.95% (Q4)	G	49.1%	61%	G
b – Recording	PA			90%	94.8% (Q4)	G	95.1%	100%	G
NI 55 Obesity among primary school age children in Reception Year	PA	9.8% (09/10)	9.2% (09/10)	7.9% (08/09)	8.0% (08/09)	R	7.5% (09/10)	8.4% (09/10)	R
Dec 2010 comment: 07/08 data was unreliable so the increase that year may be indicative of data quality. Rate has increased from 06/07 data by 0.08%. Strategy going through Overview and Scrutiny and Health & Wellbeing Partnership in Jan/Feb. Healthy Weight Pathway nearing completion. Frontline staff receiving training and key service specs now include indicators of identifying and managing weight with families and referrals to relevant services. Prevention and weight management services continue to be commissioned and reviewed for children and families. Services continue to be commissioned and reviewed to increase breastfeeding rates and within Early Years and Schools.									
NI 56 Obesity among primary school age children in Year 6	PA	18.7% (09/10)	16.1% (09/10)	13.0% (08/09)	13.4% (08/09)	R	12.5% (09/10)	16.7% (09/10)	R
See comment for NI 55 above.									
NI 58 Emotional and behavioural health of children in care (mean SDQ score – lower scores are better)	MB	14.2 (09/10)	15.1 (09/10)	15	14.9	G	-	Not available until July	

National Indicators cancelled and no longer monitored

- **NI 50** - % of children whose emotional health is good **(**based on responses to TellUs Survey)
- **NI 54** - Parental satisfaction with services for disabled children (based on DCSF survey results) (%)
- **NI 57** Children and young people's participation in high-quality PE and sport (DCSF funded School Sport Survey)

Contact person/Author	Liz Price, Head of Commissioning. Children's Service
Responsible Director	Ashley Ayre, Director of Children's Service
Background papers	None

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Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Partnership Board for Health and Wellbeing Report
Date: 15 June 2011
Report Title: Children's Trust Briefing Report
Agenda Item: 17
List of attachments to this report: None

Summary

Purpose

1 The purpose of this report is to provide an update on the key issues being addressed by the Children's Trust Board.

Recommendation

2 The Partnership Board for Health and Wellbeing is asked to note the range of key issues covered.

Rationale

3 Providing opportunity for the Partnership Board to be informed on items considered by the Children's Trust fulfils the remit of the Board to oversee the Children's agenda within the Partnership.

Other Options Considered

4 Not applicable to this report

Financial Implications

5 None directly relating to this report

Risk Management

6 Any areas of risk are highlighted in the report

Equality issues

7 Any equality issues are addressed in the report.

Legal Issues

8 None identified

Engagement & Involvement

8 As set out in the body of the report. This report has been viewed by the Council monitoring officer and section 151 officer.

Partnership Board for Health and Wellbeing Report
Date: 15 June 2011
Report Title: Children's Trust Briefing
Agenda Item: 17

The Report

1. The Children's Trust Board (CTB) met on 17 March 2011

2. In March, the Board received a final draft CYPP 2011-2014 from the CYPP sub-group: the CTB made final comments on the draft plan, agreed the front cover, (winning poster from the design competition at Bath College) and agreed the publication and distribution of the CYPP. The CYPP 2011-2014 was published on April 21st 2011 and is available on the Bath and North East Somerset Council's public website , on : http://www.bathnes.gov.uk/councilanddemocracy/policiesplans/cypp/Pages/default.aspx

   The CTB will host a stakeholder event on July 14th at the Fry Club, Carter Room, Keynsham, from 9.00 to 2 pm, to launch the plan. Representative of all agencies across the Children Trust, the LSCB and the Health & Wellbeing Board will be invited to attend.

   Partners will receive a briefing pack on the CYPP and will be asked to promote the plan across all services/agencies/schools and consider how they will engage with children, young people, parents and carers in the delivery of the plan .Hard copies of the plan will also be available on the day

3. In March, the CTB also received updated reports from the chairs of the strategy groups on their membership and terms of reference (to deliver on the agreed priorities in the CYPP), the LSCB annual report for 2010-2011, LSCB Independent Chair's report which highlighted multi-agency attendance at LSCB business meetings as an area for improvement and the Quarter 3 Performance Report .CTB also received a report on the public health consultation.

4. The CTB next meet on June 9th 2011. This is a development session which will focus on: the impact of changes on all agencies: map out risks regarding changes and the potential opportunities: consider how the emerging Health & Wellbeing Board will link with the CTB and impact of the Munroe Report.

5. The next CTB business meeting is September 15th 2011.

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Responsible Director	Ashley Ayre 01225 394200 Chair of Children's Trust Board
Background papers	None

If you would like this document in a different format, please contact the author

Partnership Board for Health & Wellbeing

TIMETABLE OF FUTURE MEETINGS

2011

MEETING DATE/TIME	VENUE
Wednesday 15th Jun 2011 2pm	***Elwin Room Bath Royal Literary and Scientific Institution 16-18 Queen Square, Bath***
Wednesday 14th Sep 2011 2pm	***Council Chamber, Guildhall, Bath***
Wednesday 16th Nov 2011 2pm	***Council Chamber, Guildhall, Bath***

2012

MEETING DATE/TIME	VENUE
Wednesday 8th Feb 2012 2pm	***Council Chamber, Keynsham Town Hall***
Wednesday 18th Apr 2012 2pm	***Kaposvar, Guildhall, Bath***
Wednesday 13th Jun 2012 2pm	***Council Chamber, Keynsham Town Hall***