Bath and North East Somerset
Health & Wellbeing Board (Shadow)

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	Date:	1 June 2012

To: All Members of the Health & Wellbeing Board (Shadow)

Members: Tony Barron (Chair of the PCT Board), Councillor Paul Crossley (Bath & North East Somerset Council), Patricia Webb (NHS B&NES), Councillor Nathan Hartley (Bath & North East Somerset Council), Councillor Simon Allen (Bath & North East Somerset Council), John Everitt (Bath & North East Somerset Council), Public Health Officer (NHS B&NES), Ashley Ayre (Bath & North East Somerset Council), Diana Hall Hall, Ed Macalister-Smith (NHS B&NES), Dr Ian Orpen (Clinical Commissioning Group) and Dr Simon Douglass (Clinical Commissioning Group)

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

Other appropriate officers
Press and Public

Dear Member

Health & Wellbeing Board (Shadow)

You are invited to attend a meeting of the Board, to be held on **Wednesday, 13th June, 2012** at **2.00 pm** in the **Council Chamber - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
Committee Administrator

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

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

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

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

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

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

5. **Declarations of Interest**
   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 Board have roles in the Council and PCT:

Ed Macalister-Smith	*Chief Executive NHS Wilts and Chief Execute NHS B&NES*
Ashley Ayre:	*Strategic Director People and communities*

   However, when attending a meeting of the 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.

Health & Wellbeing Board (Shadow)

Wednesday, 13th June, 2012
Council Chamber - Guildhall, Bath
2.00 pm

Agenda

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 member of the Board has roles in the Council and PCT:

   Ashley Ayre: Strategic Director for People and Communities, operating across the Partnership

   The following member of the Partnership Board has roles in BANES and Wiltshire PCT Cluster:

   Ed Macalister-Smith: NHS BANES and NHS Wiltshire Chief Executive

   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. PUBLIC QUESTIONS/COMMENTS

7. MINUTES OF PREVIOUS MEETING

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

8. ORGANISATIONAL UPDATES (35 MINUTES)

   The Board are asked to consider the following verbal updates:

   - Local Healthwatch (procurement) – Derek Thorne
   - Public Health – Public Health Officer

- Public Health Transition Plan

- PCT – Ed-Macalister Smith
- CCG – Ian Orpen
- Council – Ashley Ayre

9. UPDATE REPORTS (20 MINUTES)

The Board are asked to consider the following update reports:

- Children's Safeguarding report (Maurice Lindsay)
- Children's Health Services Commissioning Performance (Liz Price)
- Safeguarding Adults at Risk (Lesley Hutchinson)
- Adult Health and Wellbeing Commissioning Report (presentation from Tracey Cox)

10. CLINICAL COMMISSIONING GROUP (CCG) PLAN (30 MINUTES)

The Board are asked to consider a presentation from Dr Ian Orpen.

11. THE EMERGING PRIORITIES (25 MINUTES)

The Health and Wellbeing Board is responsible for developing a set of strategic priorities that deliver the Boards aim to reduce health inequalities and improve health and wellbeing in Bath and North East Somerset.

The priorities that the Board agrees will form the foundations of the Health and Wellbeing Strategy, as well as inform the Board's work programme over the next few years.

This report introduces the emerging priorities for open discussion.

12. FORWARD HEALTH AND WELLBEING BOARD (SHADOW) DATES

The Board are asked to note the schedule of future meetings:

- Wednesday 19th September 2012 at 2pm in Council Chamber, Guildhall.
- Wednesday 7th November 2012 at 2pm in Council Chamber, Guildhall.
- Wednesday 6th February 2013 at 2pm in Council Chamber, Guildhall.
- Wednesday 17th April 2013 at 2pm in Council Chamber, Guildhall.

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

PARTNERSHIP BOARD FOR HEALTH AND WELLBEING

Minutes of the Meeting held

Wednesday, 8th February, 2012, 2.00 pm

Malcolm Hanney Chair of NHS BANES	-	NHS BANES
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
John Everitt	-	Chief Executive of the Council
Dr Pamela Akerman	-	Acting Joint Director of Public Health
Ashley Ayre	-	Strategic Director for Children's Services
Diana Hall Hall	-	Link Representative
Ed Macalister-Smith	-	NHS B&NES Chief Executive

1 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

2 EMERGENCY EVACUATION PROCEDURE

The Democratic Services Officer drew attention to the evacuation procedure.

3 APOLOGIES FOR ABSENCE

Apologies were received from Councillor Paul Crossley, Dr Ian Orpen, Dr Simon Douglass, Mike Bowden and Derek Thorne. Councillor Simon Allen sent his apology for missing the start of the meeting as he was attending 'Shared Lives' event in the Guildhall (arrived at 2.50pm) and Ed Macalister-Smith informed the meeting that he will have to leave at 3.00pm.

Dr Ruth Grabham was substitute for Dr Orpen and Dr Douglass.

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 Councillor

Ashley Ayre: Strategic Director for people and Communities, operating across the Partnership

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

Ed Macalister-Smith declared the interest as the B&NES and Wiltshire PCT Cluster Chief Executive.

5 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There was no urgent business.

6 MINUTES OF PREVIOUS MEETING

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

7 PUBLIC QUESTIONS/COMMENTS

There were none.

8 MEMBER UPDATES: HIGH LEVEL STRATEGIC UPDATES

Clinical Commissioning Group (CCG) update – Dr Ruth Grabham

- The amendments on the Health and Social Care Bill are now subject to debate in Parliament. Whatever the outcome of the debate the CCG is supportive of Clinically Led Commissioning.
- The CCG is aware that this is a very difficult and stressful time for staff but at the same time staff members are aware of the complexity around the transition. The CCG is in the middle of the consultation process and the next step is a meeting with the other CCGs in the Cluster. The CCG is aware that £25 per head running cost allocation is a much lower allocation than the PCT had in the past but it is manageable.
- Working closely with colleagues and active GP Forum – 10 meetings per year.
- Patient Participation Groups are up and running in each practice.

Healthwatch (procurement) update – David Trethewey

- National implementation date had been pushed back and there is a lot of consultation as to how the Healthwatch should look.

Public Health update – Dr Pamela Akerman

- Public Health is on the agenda for this meeting.
- Finance papers came yesterday evening (Tuesday 7th Feb). There is no firm budget for 2013/14 and broadly what was submitted appears to have been taken on board with some minor elements changed.

PCT update – Malcolm Hanney and Ed Macalister-Smith

- Everyone is under stress and a lot of pressure to achieve objectives.
- There is a lot of anxiety as the Health and Social Care Bill has still not gone

through Parliament.

- PCT Cluster arrangements to be in place by the end of March 2012. Lot of work on co-ordination of local and cluster work.
- National introduction of 111 number.
- Discussion with the Chief Executive from the RUH and forward plans.
- Even though there are pressures to make savings in the NHS (£20bn across the country and 10% inflation pressure in the NHS) it is also necessary to improve quality of care.
- Specialist services, such as Specialist Commissioning, should not be forgotten.

9 PUBLIC HEALTH POLICY UPDATE

The Chair invited Paul Scott (Consultant in Public Health) to introduce the report.

John Everitt informed the meeting that the governance and accountability of the planning process lies with the Partnership Board for Health and Wellbeing.

John Everitt also said that the public health transition plan will require sign off not only from the Chief Executive of the Council and the PCT but also from the Chair and/or Vice Chair of this Board. The Council will provide resources, within reason, for service delivery.

The Chair suggested that Chief Executives, Ashley Ayre, Dr Pamela Akerman and the Board Chair and/or Vice Chair should meet as soon as possible and have off-line discussion about the issue of future status of Director of Public Health (DPH) within Council hierarchy. The Chair also acknowledged that we were very grateful and had been very fortunate to have Pamela Ackerman on an extended period of service as Acting Joint DPH.

Ed Macalister-Smith welcomed the statement from John Everitt about the provision of resources and said that he would be looking forward to get together with John Everitt, Ashley Ayre, Dr Pamela Akerman and the Chair/Vice-Chair of the Board to move forward with the Public Health Transition plans.

It was **RESOLVED** to:

1. Note the report;

2. Ask the officers to take on board comments from the Board Members; and

3. Receive a subsequent update in April 2012 following the submission of the public health transition assurance plan to NHS South of England.

10 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

The Chair invited Jon Poole (Research and Intelligence Manager) to introduce the report.

The Chair suggested that the Local Involvement Network should also be included in discussions as they are part of the Board. Diana Hall Hall and the officers welcomed that suggestion.

It was **RESOLVED** to note the status updates and revised timescales and agree with the proposed outputs.

11 PRIORITISATION FRAMEWORK

The Chair invited Helen Edelstyn (Strategy and Plan Manager) to introduce the report.

John Everitt informed the meeting that the Cabinet will consider 'The Council's Vision and Values' report at their meeting tonight and if agreed, the Council's existing planning and delivery framework will be revised to incorporate the new vision, objective and outcomes so that there is clarity on how this will be delivered.

It was **RESOLVED** to:

1. Note the draft Prioritisation Framework;

2. Agree to establish a 'task group', including Board members, to consider the prioritisation framework and begin work on prioritisation; and

3. Note that the next Board meeting in April will focus on the outputs of the JSNA and begin strategy prioritisation.

12 CHILD PROTECTION ACTIVITY PERFORMANCE REPORT

The Chair invited Ashley Ayre to introduce the report.

John Everitt asked that future reports should provide more information on missed targets, such as indication on how much those targets are missed and what action is being taken on those targets that are in red (including if there were no actions being taken due to the pressure on service). John Everitt informed the meeting that the Care Quality Commission report will be brought before this Board when published.

Ashley Ayre took on board the comments from John Everitt and added that the draft report from the Care Quality Commission has been received and that the Council's response to the report should be ready by Friday 10th February.

It was **RESOLVED** to note the report and receive updated performance reports at each meeting of the Board.

13 ADULT HEALTH AND WELLBEING HIGH LEVEL PERFORMANCE ASSURANCE REPORT

The Chair invited Jane Shayler (Programme Director for Non-Acute Health, Social

Care and Housing) to introduce the report.

Jane Shayler went through the report and drew the Board's attention to improved performance indicators for the 'Proportion of people who have had a stroke who spend at least 90% of their time in hospital on stroke unit'. Jane Shayler added that the pattern on that indicator was seen across the country.

Members of the Board commented that they are pleased that there is joint work with the RUH to improve those figures even more.

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

14 FORWARD PARTNERSHIP BOARD DATES

The Board noted the future dates.

15 ADULT SAFEGUARDING REPORT

The Chair invited Jane Shayler, Janet Rowse (Sirona Chief Executive) and Lesley Hutchinson (Assistant Director for Safeguarding and Personalisation) to introduce the report.

John Everitt commented that Safeguarding referrals seem to have consistent trends and asked if there is a need for additional resources to tackle those referrals as the Partnership Board need a deeper understanding on what the figures and trends mean.

Ashley Ayre commented that there are a number of issues to consider when looking into these figures such as raised awareness, transitional arrangements from children to adults and also about the personal choice where an officer has to make the decision on when to intervene.

Lesley Hutchinson added that there is also much greater complexity of cases going around.

John Everitt commented that the Partnership Board would like to see the evidence as to whether the figures are on the increase because of trends, raised awareness or because of the complexity of cases.

It was **RESOLVED** to note the report and for officers to take on board comments for future reporting.

The meeting ended at 3.20 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board (Shadow)
MEETING DATE:	13th June 2012
TITLE:	Children's Safeguarding Report
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1: Child Protection Performance Indicators	

1 THE ISSUE

1.1 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 2011/12.

1.2 The Report also details progress made in identifying local performance indicators which will provide more evidence of the quality and impact of child protection services for the child and their family, to supplement the national performance indicators which are fundamentally output measures.

2 RECOMMENDATION

2.1 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.

3 FINANCIAL IMPLICATIONS

3.1 There are no direct financial considerations arising from this report.

4 THE REPORT

4.1 Appendix 1 details Bath and North East Somerset's performance in respect of the key performance indicators for child protection activity, as reported to the Local Safeguarding Children Board. The following paragraphs provide a commentary and performance summary in respect of each indicator, together with remedial actions where appropriate. Proposals for local performance indicators and how these will be collected and recorded are outlined in paragraph 4.9.

4.2 Number of children subject to child protection plans

4.2.1 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.

4.2.2 Our thresholds for intervention are monitored by the LSCB's Safeguarding Children Sub Committee and reported to the LSCB. The Children's Service regularly audits thresholds for interventions. These are considered to be appropriately and consistently set and understood by other agencies.

4.2.3 There was a steady increase in the number of children with protection plans throughout 2010/11 with a marked increase in the final quarter – 106 represented the highest number since the late 1990's. The Children's Service 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 some cautious decisions about the need for some protection plans) – and took actions to address these factors which have resulted in an appropriate reduction in the number of children with protection plans throughout 2011/12 and more children in need plans – whilst ensuring that protection plans are in place for all who require them.

4.2.4 The current figure (78) is close to the average for the past five years. Whilst it is likely that the figure for 2010/11 represented a spike within overall figures, it is probable that the current figure will steadily increase over the next few years in line with the recent trends and projected increases in the demands for Children's Social Care Service, and the number of initial and core assessments undertaken and will probably reach 100 – 105 by 2014/15. These trends and projections are in line with comparator authority and national positions.

4.3 <u>Child Protection Plans lasting two years or more (NI 64)</u>

4.3.1 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 effected 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.

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

4.3.3 The improvement noted throughout 2010/11 (which resulted in the end of year figure being only slightly off target), was maintained in 2011/12 and the end of year target achieved. It must be noted that these percentages

represent a small number of children and families. We have processes in place to review the circumstances of each child. Each child protection plan is 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.

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

4.4.1 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.

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

4.4.3 Our performance in this area had been strong for a number of years – exceeding both the national and family of Local Authorities' performance. As noted in previous reports, performance throughout 2010/11 was off target (and above national and comparator positions). Gradual improvements were achieved throughout 2011/12 but the end of year target was not achieved. We are nonetheless now closer to the level of comparator authorities.

4.4.4 Absolute numbers are small but performance did raise questions about the overall effectiveness of the services provided by agencies at the conclusion of child protection plans to prevent risks from re-emerging. Ensuring that these are in place and consistently accessed by families is central to the re-design of Children's Social Care Service currently underway and has been reported to the LSCB. This should effect further improvements in the longer term.

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

4.5.1 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.

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

4.5.3 Our performance is 100% and has been for the previous eight years. The reported performance for 2011/12 (98.5%) represented one case not being received within timescales. There was a child protection plan in place and this has been reviewed.

4.5.4 Although this indicator is no longer 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.

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

4.6.1 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. Revisions to national guidance (Working Together to Safeguard Children 2010) has made explicit the need to ensure that all referrals receive an initial assessment. Work was undertaken throughout 2010/11 to significantly lift performance – this was achieved and exceeded targets – and was built upon in the first three quarters of 2011/12 but slipped in the final quarter.

4.6.2 It is important to note that the numbers of referrals received by social care has not remained static, indeed there has been a substantial increase between 2008-9 and 2011-12. 1140 in 2008-9 to 1750 in 2011-12 i.e. an increase of 53%. In addition the percentage of referrals that are subsequently taken forward to Initial Assessment has risen from 35% in 2008-9 to 74% in 2011-12. This means that the service carried out 400 Initial Assessments in 2008-9 compared to a projected figure of 1295 Initial Assessments in 2011-12. This is a three-fold increase in initial assessment workload with only three additional posts added to the social work workforce during this period.

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

4.7.1 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.

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

4.7.3 Work completed to clear outstanding assessments at the end of 2010/11 meant that the Service was in a stronger position at the beginning of 2011/12 to significantly improve performance. This was achieved for Q1. That strong performance was, however, disrupted by capacity issues in the Locality Team and secondments to the re-design team during Q2 – actions were taken to address these impacts and to lift performance throughout the rest of the year. These were however undermined by staff turnover and vacancies (now resolved) at a time when the service was dealing with a significant increase in the number of referrals for services (see above). Sustaining this level of performance and also improving quality of work cannot be fully disassociated from the level of resource available to carry out this work. We are now progressing plans to establish increased front line manager and practitioner capacity in the teams.

4.7.4 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. The Government is currently considering this recommendation and had committed to providing guidance in Spring 2012 now extended to Autumn 2012. There may be future scope for determining local indicators in terms of timeliness and quality and the service has started to give this matter consideration.

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

4.8.1 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.

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

4.8.3 Work completed to clear outstanding assessments at the end of 2010/11 meant that the Service was in a stronger position at the beginning of 2011/12 to significantly improve performance. This was achieved during the first 3 quarters of 2011/12 but was not maintaining during the 4th quarter as a consequence of the staffing difficulties outlined above. We have used the learning from the Lean Review of Social Care processes to inform the re-design of our front of house services, and the proposed enhanced team will complete all core assessments. This will bring more consistency in both timeliness and quality.

4.8.4 As in the case of Initial Assessments, the number of Core Assessments undertaken has also risen between 2008-9 and 2011-12 from 205 to 307 representing a 50% increase in this workload. Again, this increase has been achieved within existing staffing levels and plans are now in place to increase manager and practitioner capacity in the front of house team.

4.9 The Service is now progressing plans to record and report on the following indicators of performance:-

- Percentage of children seen by the allocated Social Worker within 5 working days of date of the referral
- Percentage of children with whom plans / or services were shared within 7 working days
- Percentage of assessments completed within 10 working days and shared with the child / family
- Percentage of assessments completed within 15 working days and shared with child / family
- Number of days from referral to case closed
- Percentage of closed cases resulting in report referrals within 6 months
- Number and percentage of overall number of children with protection plans for more than 2 years

- Number and percentage of overall number of children with protection plans for whom step down services have been put in place, and received within 6 months
- Number and percentage of overall number of children with repeat child protection plans

Any qualitative measures, to include:-

- Percentage of children reporting that the provision of social care services had made a positive difference to their lives / made them feel safer
- Percentage of parents reporting had made a positive difference to their parenting and their child safer
- Percentage of plans incorporating the child's expressed views and opinions

And also exploring how to report on the effectiveness of services provided to children following the cessation of a protection plan – and thereby avoiding the need for future such plans.

4.10 The Service will present reports showing the performance in the first half of the year to the Board meeting in October 2012.

5 RISK MANAGEMENT

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

5.2 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.

6 EQUALITIES

6.1 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.

6.2 An Equalities Impact Assessment has been completed in respect of the LSCB's Annual Report and Work Programme which incorporates these performance indicators.

7 CONSULTATION

7.1 Cabinet Member; Staff; Other B&NES Services; Service Users; Other Public Sector Bodies; Section 151 Finance Officer; Monitoring Officer.

7.2 Consultation with other BANES Services and other Public Sector Bodies via reports to and discussions at the Local Safeguarding Children Board quarterly meetings.

7.3 Discussed with staff at Team and Management Group meetings and via LSCB Stakeholders' event.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Young People.

9 ADVICE SOUGHT

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

Contact person	**Maurice Lindsay**, Divisional Director - Safeguarding, Social Care and Family Service Maurice_lindsay@bathnes.gov.uk, 01225 396289
Background papers	Previous reports to Health and Wellbeing Partnership Board: most recent 8th February 2012
Please contact the report author if you need to access this report in an alternative format	

Appendix 1: Child Protection Performance Indicators

Child Protection activity / performance indicators	2010/11 England	2010/11 Family	2010/11 Actual	2011/12 Plan	2011/12 Actual	2011/12 Quarterly			
						Q1	Q2	Q3	Q4
1. Number of children subject to child protection plan			Total = 106	N/A	106	104	88	81	78
2. Child protection plans lasting 2 years or more (NI 64)	6.0%	7.0%	10.4%	8%	5.5	8.8	6.3	7.0	5.5
3. Children becoming subject to a child protection plan for a second or subsequent time (NI 65)	13.3%	15.0%	23.5%	12%	15.1	18.2	17.4	14.8	15.1
4. Child protection cases which were reviewed within required timescales (NI 67)	97.1%	96.9%	100%	100%	100	100	100	100	100
5. Referrals to Children's Social Care going on to initial assessments (NI 68)	72.0%	79.2%	73.9%	75%	65**	79.3	73	73.9	65**
6. Initial assessments by Children's Social Care carried out within ten working days of referral (NI 59) *	75.7%	68.2%	67.5%	78%	68.6	83.7	67.6	73.7	68.6
7. Core assessments by Children's Social Care that were carried out within 35 working days of their commencement	75.1%	68.9%	59.3%	80%	71.2	65.2	75.5	79.1	71.2

* Previous performance indicator was for 7 working days ** To be confirmed following data returns.

Note: This table details performance for the 2010/11 and comparisons with England and our family of Local Authorities (most recent national data available): our plans for 2011/12 and actual performance at the end of each quarter and end of year for 2011/12 (colour coded to indicate status of performance to target – Red/Amber/Green)

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board (Shadow)
MEETING DATE:	13th June 2012
TITLE:	Children's Health Services Commissioning Performance
AN OPEN PUBLIC ITEM LIKELY TO BE TAKEN IN EXEMPT SESSION	
List of attachments to this report: none	

1 PURPOSE

1.1 The purpose of this report is to provide information on the performance of People & Community Departments commissioning of children's health services.

2 INTRODUCTION

2.1 This report covers key areas of commissioning activity for children's health services. Appendix 1 contains the following performance data:

- Table 1: National PIs reported to Children's Trust Board about children's health
- Tables 2 and 3: Tier 3 CAMHS contract performance data
- Table 4: Children's health services key PIs 2011/12 (Quarter 1 performance by Community Health & Social Care, from Q3 Sirona Care & Health).

2.2 The commentary in this report covers the following areas of children's health commissioning :

- Disabled children's services
- Emotional health & wellbeing
- Substance misuse
- Contract monitoring including safeguarding compliance.

2.3 The public health indicators are not commented on as these are reported separately.

3 DISABLED CHILDREN

3.1 Work on the provision of a more streamlined/integrated service for disabled children continues in discussion with other agencies. Social Care's "lean review" of their services extended to their disabled children's team but concluded this team should remain with the mainstream social work process. The work by the Transitions Board to promote pathways on transitions has resulted in improvements in the information available for adult services about the young people who may use their services. This work has been led by the transitions champion. The difference in levels of service available for children and adults remains problematic at times but the personalisation agenda extended to younger people should help with parental/carer expectations.

3.2 There are reviews on health services completed or in progress for wheelchair services, occupational therapy and physiotherapy, and speech and language therapy.

3.3 The local wheelchair service review has been taken over by national events. A consultation meeting took place at Threeways School in March 2012, for parents, carers and professionals who were invited to comment on the DoH specifications for wheelchair services in relation to local requirements. The Any Qualified Provider process (AQP) process in B&NES will commence in July 2012 with 2 specifications a) Provision of Equipment & Support and b) Assessment & Provision of Equipment. Both these AQP processes will go live in December 2012.

3.4 The review of children's occupational and physiotherapy services provided by the RUH for both acute and community needs has resulted in a streamlined management structure. Negotiations are underway with special schools to identify additional capacity and funding to meet the children & young people's needs for these services in schools.

3.5 A review of speech and language therapy services identified the need for additional capacity in schools and commissioners are currently negotiating with schools about funding.

3.6 Short break services contracts have been extended by a year to allow time for further review and evaluation of some services before they are re-commissioned again for April 2013. The parents/ carers group continues to play an active part in the review and commissioning process.

4 EMOTIONAL HEALTH & WELLBEING

4.1 Our Tier 3 specialist Camhs and Tier 4 inpatient provider is Oxford Health Foundation Trust (OHFT). The new model services they are providing continue to perform well. Performance targets for waiting times are being met as shown in Table 2 below. From 1st June 2012 Tier 4 in-patient services are being commissioned nationally by the specialised commissioning group.

4.2 Our new primary Camhs service started in September 2011 and has embedded well. Packs of information have been sent to all GP practices and schools about the new service. A training programme for staff on emotional and mental health issues has started. A strategy for working with young people who self-harm drawn up with local agencies and services users was launched in February.

4.3 The emotional health of children in care as measured by NI58 has apparently deteriorated (Table 1). This indicator is the average annual Strengths and Difficulty Questionnaire score for children in care. This questionnaire is completed by foster carers and is then used for reference at the child/young person's annual health

assessment. A low score is good. We have been working to achieve greater completion of SDQs but have a way to go. This will be improved by the changes to the Looked after Children Health Service underway but even with improved take up there are difficulties with this measure as different children are measured each year as they come in (and out) of care. Some additional analysis has been done on the scores of those children who have had an SDQ score for two years or more. The average for these scores has gone down showing an improvement over time.

5 SUBSTANCE MISUSE

5.1 Following the liquidation of the company providing our young people's substance misuse service, Project 28, in November 2011, the service was provided on an emergency basis for a month until the liquidator confirmed the contract end. We then set up the majority of Project 28 services from the same premises managed in house until a new temporary service could be re-commissioned. DHI who also provide adult substance misuse services successfully bid for this temporary contract and the new Project 28 started in February 2012. Both adults and young people's substance misuse services are to be re-commissioned for April 2013. Project 28 has kept the majority of the same staff throughout this period and so the impact of the changes on the young people using the service has been minimal. There continues to be evidence that Project 28 achieves good outcomes.

6 SAFEGUARDING COMPLIANCE

6.1 Following the inadequate judgement by CQC on the health services contribution to the safeguarding inspection in January 2012, an action plan has been agreed with the CQC and SHA. Karen Littlewood our Designated Nurse has taken a lead with providers in considering the child protection concerns. Commissioners have been working with Sirona to address shortfalls identified in the health service for looked after children. A specification for a new model of service has been agreed that includes additional capacity for a Designated Nursed and Designated Doctor for Looked after Children. Funding has been agreed and Sirona are currently recruiting to these posts. Communication systems have also been improved between children's social care and the looked after children's, health service about children coming into care, leavers and placement changes.

6.2 The SHA have booked two days in July to review the CQC action plan.

7 CONTRACT MONITORING ISSUES – SIRONA CARE & HEALTH

7.1 The key indicators scorecard for children's health services (Table 4) shows good performance for the last year.

7.2 Sirona is an early implementer site for the Health Visiting Implementation Plan-A Call to Action. This is a 4 year programme to increase the number of Health Visitors in B&NES by 19. Sirona's implementation plan is going well. The plan includes developing the Family Nurse Partnership model to support young first time parents.

8 CONTRACTING MONITORING ISSUES – ROYAL UNITED HOSPITAL

8.1 Work has started on a pathway into acute paediatric services with RUH Paediatricians and community paediatricians based on information from other areas where advice & guidance has been provided rather than outpatient appointments. Discussions have also taken place with RUH paediatricians and Sirona about reducing hospital admissions/ length of stay by providing more community nursing.

8.2 We currently commission our service for children with diabetes from the RUH and diabetes nurses and dieticians from Wiltshire Community Health Services (now part of Great Western Foundation Trust). Best Practice Tariff, which provides a "year of care" tariff for children with diabetes, will be introduced in B&NES from September this year. The nationally prescribed tariff will provide greater investment in children's diabetes with the objective of gaining earlier control of diabetes to prevent early onset of diabetes related complications. Inpatient care is currently excluded from the tariff. From April 2013 there will be no other currency for paediatric diabetes and the RUH will be expected to be meeting all of the requirements of the tariff by this time.

Contact person	*Liz Price, Acting Divisional Director Children's Health, Commissioning & Strategic Planning*
Background papers	*None*
Please contact the report author if you need to access this report in an alternative format	

Table 1: Be Healthy former National Indicators – financial year

Indicator	England	Region	Previous target	Previous annual result		Target for current reporting year	Latest figure / forecast	
NI 53 Prevalence of breastfeeding at 6-8 weeks from birth a – 6-8 weeks			49% (10/11)	61% (10/11)	G	60% (11/12)	58% (Q4 11/12)	A
b – Recording			95% (10/11)	100% (10/11)	G	95% (11/12)	99% (Q4 11/12)	G
NI 55 Obesity among primary school age children in Reception Year	9.8% (09/10)	9.2% (09/10)	7.5% (09/10)	8.4% (09/10)	R	7% (10/11)	8.4% (10/11)	R
NI 56 Obesity among primary school age children in Year 6	18.7% (09/10)	16.1% (09/10)	12.5% (09/10)	16.7% (09/10)	R	12% (10/11)	16.9% (10/11)	R
NI 58 Emotional and behavioural health of children in care (mean Strengths & Difficulties Questionnaire score – lower scores are better)	13.9 (10/11)	14.8 (10/11, (statistical neighbours)	14.5 (10/11)	15.6 (10/11)	R	14.5 (11/12)	16.1 (11/12 estimate)	R

Tables 2 & 3: B&NES CAMHS monthly performance report

Table 2: B&NES CAMHS community teams

Description	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Activity YTD	Target YTD	Variance	Annual Target
Caseload	337	324	316	271	279	292	268	275	275	275	293	293	293	N/A	N/A	N/A
Inappropriate referrals	24	36	20	28	12	24	32	12	6	4	5	8	211	N/A	N/A	N/A
Direct patient contacts completed	309	351	334	296	252	306	308	360	234	355	291	267	3663	N/A	N/A	N/A
Indirect patient contacts completed	12	41	17	25	14	44	50	108	103	120	76	115	725	N/A	N/A	N/A
Number of discharges	33	48	45	65	41	38	44	52	28	33	33	26	486	N/A	N/A	N/A
% Appointments patient DNA	10%	9%	10%	11%	12%	10%	11%	10%	8%	9%	8%	7%	10%	12%	2%	12%
% Appointments cancelled by patient	8%	6%	7%	8%	8%	9%	7%	7%	9%	14%	13%	13%	9%	N/A	N/A	N/A
% Appointments cancelled by Trust	1%	1%	2%	2%	1%	1%	1%	1%	6%	8%	8%	9%	3%	1%	2%	1%
First to f/up ratio	10	9	8	8	8	7	6	8	9	6	11	7	8	10-12		10-12

Table 3: B&NES CAMHS Outreach Service for Children and Adolescents (OSCA) Team

Description	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Activity YTD	Target YTD	Variance	Annual Target
Caseload	39	43	76	71	116	121	128	132	149	199	178	167	167	N/A	N/A	N/A
Completed Episodes of care	7	22	7	31	14	16	21	18	35	18	26	27	242	N/A	N/A	N/A
Direct patient contacts completed	111	198	216	195	151	165	182	183	130	196	271	218	2216	N/A	N/A	N/A
% Appointments patient DNA	7%	9%	11%	12%	11%	8%	9%	3%	4%	5%	4%	4%	7%	12%	4%	12%
% Appointments cancelled by patient	0%	2%	3%	2%	8%	7%	7%	8%	3%	7%	8%	4%	5%	N/A	N/A	N/A
% Appointments	0%	0%	0%	0%	3%	2%	1%	1%	4%	2%	5%	4%	2%	1%	1%	1%

cancelled by Trust															

Table 4: Sirona Care & Health (Community Health & Social Care) Key Performance Indicators 2011/12

Service	Measure	Q1	Q2	Q3	Q4
Health visitors	% of parents accepted reviews for 2 - 2.5 years old	91%	90%	90%	80%
School nurses	Total Contacts	1399	1203	1921	2163
Children's Learning Disability Nurses	Total Contacts	188	129	150	176
Community Paediatrician	RTT 18 week % seen	99.7%	99.6%	99.6%	100%
Community Paediatric Audiology	RTT 18 week % seen	100%	100%	99.4%	100%
Lifetime - core service	Number of hospital admissions saved	61	36	74	51
Speech and Language Therapy	Children are able to eat and swallow safely and gain adequate nutrition and hydration from food and drink or reach their full potential in speech, language and communication skills. Episodes recorded as recorded as “fully”, “mostly” or “partially”	98.7%	98.9%	99.3%	99.0%

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Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board (Shadow)
MEETING DATE:	13th June 2012
TITLE:	Safeguarding Adults at Risk
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 Safeguarding Assurance and Non Delegation Flow Chart	

1 THE ISSUE

1.1 To update the Partnership Board for Health and Wellbeing on the following areas:

- Safeguarding adults referrals and procedural timescales 2011 – 2012
- Progress of the new safeguarding arrangements with Sirona Care and Health
- Local Safeguarding Adults Board (LSAB) activity

2 RECOMMENDATION

2.1 The Partnership Board for Health and Wellbeing is asked to note the report and make recommendations for any further work required of the LSAB and Commissioner.

3 FINANCIAL IMPLICATIONS

3.1 None

4 THE REPORT

4.1 During 2011 to 2012 safeguarding work has taken place with 431 service users. 31 of these cases were on-going from March 2011 into this financial year and a further 400 new safeguarding adult referrals have been received during April 2011 to March 2012. 354 of these cases have been terminated within the reporting period 2011-2012. (The data reported is from a performance report ran on the 4th May 2012; final data cleansing takes place in June 2012 in preparation for submission to the Department of Health Information Centre and these figures may change slightly once the data report is finalised).

4.2 This demonstrates a continued trend of increased adult safeguarding activity, with a 252% increase in safeguarding adult's referrals over the last five years.

4.3 The outcome of the 354 terminated cases is set out in the table below:

Termination stage	Outcome					
	NFA / No Case to Answer	Not Determined / Inconclusive	Not Substantiated	Partly Substantiated	Substantiated	**Total**
Decision	140	2	1	1	1	**145**
Strategy	22	15	20	10	13	**80**
Assessment	8	6	10	8	12	**44**
Planning meeting	1	8	19	4	8	**40**
Review	5	5	2	7	24	**43**
Total	**176**	**36**	**52**	**30**	**58**	**352×**

×Note there are two cases that have been terminated however the outcome has not been completed on the data record system and could not be provided for the performance report. The case coordinators are in the process of updating the information. (Data produced on 4th May 2012).

4.4 The outcome and termination stage will be analysed by service user group for the annual report; however reports indicate that there has been a significant increase in the number of referrals for adults with Learning Disabilities in comparison to other service user groups.

4.5 **Safeguarding Progress on Procedural Timescale Indicators**

Indicator	Target	% Completed on time from April 2011 – March 2012		RAG	Direction of travel from 2010-2011
1. % of decisions made in 48 working hours from the time of referral	95%	Sirona C & H	99% 328/331		↑
		AWP	97% 58/60		↑
		Combined	**99%** 386/391		↑
2a. % of strategy meetings/discussions held within 5 working days from date of referral	90%	Sirona C & H	94% 175/186		↑
		AWP	100% 43/43		↑
		Combined	**95%** 218/229		↑
2b. % of strategy meetings/discussions held with 8 working days from date of referral	100%	Sirona C & H	99% 185/186		New
		AWP	100% 43/43		New
		Combined	**100% (99.5%)** 228/229		New
3. % of overall activities/ events to timescale	90%	Sirona C & H	93% 688/741		↔
		AWP	95% 151/159		↑
		Combined	**93%** **839/900**		↑

4.6 212 (53%) alleged abuse took place in people's own home; 113 (28%) in care homes and the rest are alleged to have taken place in a range of places including health settings, supported living settings, the alleged perpetrator's home and public places.

4.7 The Council's Safeguarding and Quality Assurance team, Non-Acute and Social Care Commission team and Complaints Manager work closely with the Care Quality Commission (CQC) and triangulate information on safeguarding alerts, complaints, contract issues and CQC notifications in relation to care homes and other registered services in the area to ensure appropriate care is being delivered and action is taken when needed. The Safeguarding Annual Report 11/12 will include a detailed analysis of safeguarding referrals, setting and outcome and compare this to previous years and where possible with other Local Authority areas activity.

4.8 **Update on progress of new safeguarding arrangements with Sirona Care and Health**

4.9 With the launch of Sirona Care & Health on the 1st Oct 2011 came the new assurance arrangements, put in place by B&NES Council, to provide oversight and authorisation of decisions made by Sirona Care & Health regarding safeguarding adults' case coordination. Appendix 1 describes how the new arrangements are delivered.

4.10 A new Safeguarding Adults and Quality Assurance team have been established to deliver the new arrangement within People and Communities. (The Safeguarding Adults and Quality Assurance Team have a broader remit than safeguarding and also deliver assurance for the Council on all cases that Sirona Care & Health have case management responsibility for).

4.11 The new arrangements have:

- provided independence and challenge to safeguarding case coordination through auditing closed cases that do not progress to a meeting, Chairing individual safeguarding meetings and authorising decisions to close cases (this independence, to a certain extent, mirrors the arrangements in child protection cases)

- increased the assurance for the Council regarding the quality of case coordination and delivery of the Multi-Agency Safeguarding Policy and Procedures

- highlighted areas where the Procedures need to be improved and clarified (this is an on-going process)

4.12 Regular meetings are held between the Safeguarding Adults and Quality Assurance team and relevant Sirona Care & Health staff to ensure good partnership working and negotiate solutions on issues as they arise.

4.13 **Local Safeguarding Adults Board activity**

4.14 The Local Safeguarding Adults Board (LSAB) met for its routine meeting in March 2012 and agreed, adopted and /or discussed the following areas of work:

- Adopted a Multi-Agency Learning and Development Framework; this is based on the competencies outlined in the *National Competence Framework (NCF) for Safeguarding Adults (2010)* developed by Bournemouth University and the organisation Learn to Care. The Training and Development sub group of the LSAB will monitor this

- Adopted new Self Neglect Guidance for all LSAB agencies

- Agreed new safeguarding performance indicators for 2012-2013

- Agreed a Safeguarding and Carers action plan which has been developed locally and is based on the recommendations identified in the *Carers and Safeguarding Adults – working together to improve outcomes by ADASS July 2011.*

- Discussed the initial findings of Winterbourne View Serious Case Review

- Discussed the priorities for the Business Plan 2012-2015 which will be presented to the Partnership Board for Health and Wellbeing at its next meeting

4.15 The South West Strategic Health Authority, working in partnership with the SW JIP/ADASS Safeguarding Adults Programme, commissioned an audit of the use of the regional Self-Assessment Quality & Performance Framework and a review of annual reports. The report, *Audit of Safeguarding Adult Boards in the South West Region by Kate Ogilvie (Independent Consultant) (January 2012)* highlights the progress all South West LSAB's (or Partnerships) and makes several references to positive work B&NES has undertaken particularly regarding personalisation. The report recommends ways for all areas to improve their annual reports and these will be taken on incorporated into the B&NES 2011-2012 report.

5 RISK MANAGEMENT

5.1 The Council has a Corporate Risk Register for safeguarding adults that is routinely monitored and addresses risk identified regarding safeguarding activity and management.

5.2 Risks are managed in accordance with Council risk management guidance.

6 EQUALITIES

6.1 An Equality Impact Assessment has not been completed for this report. Equalities are considered and reported on in the safeguarding annual report which will be presented to the Board in September 2012.

7 CONSULTATION

7.1 Cabinet Member; Staff; Other B&NES Services; Community Interest Groups; Stakeholders/Partners; Other Public Sector Bodies; Section 151 Finance Officer; Chief Executive; Monitoring Officer

7.2 The Local Safeguarding Adults Board and the sub groups that report to it discuss and are consulted upon the items contained within the report.

8. ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Human Rights; Impact on Staff;

9. ADVICE SOUGHT

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

Contact person	Lesley Hutchinson (Assistant Director for Safeguarding and Personalisation) (01225) 396339
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

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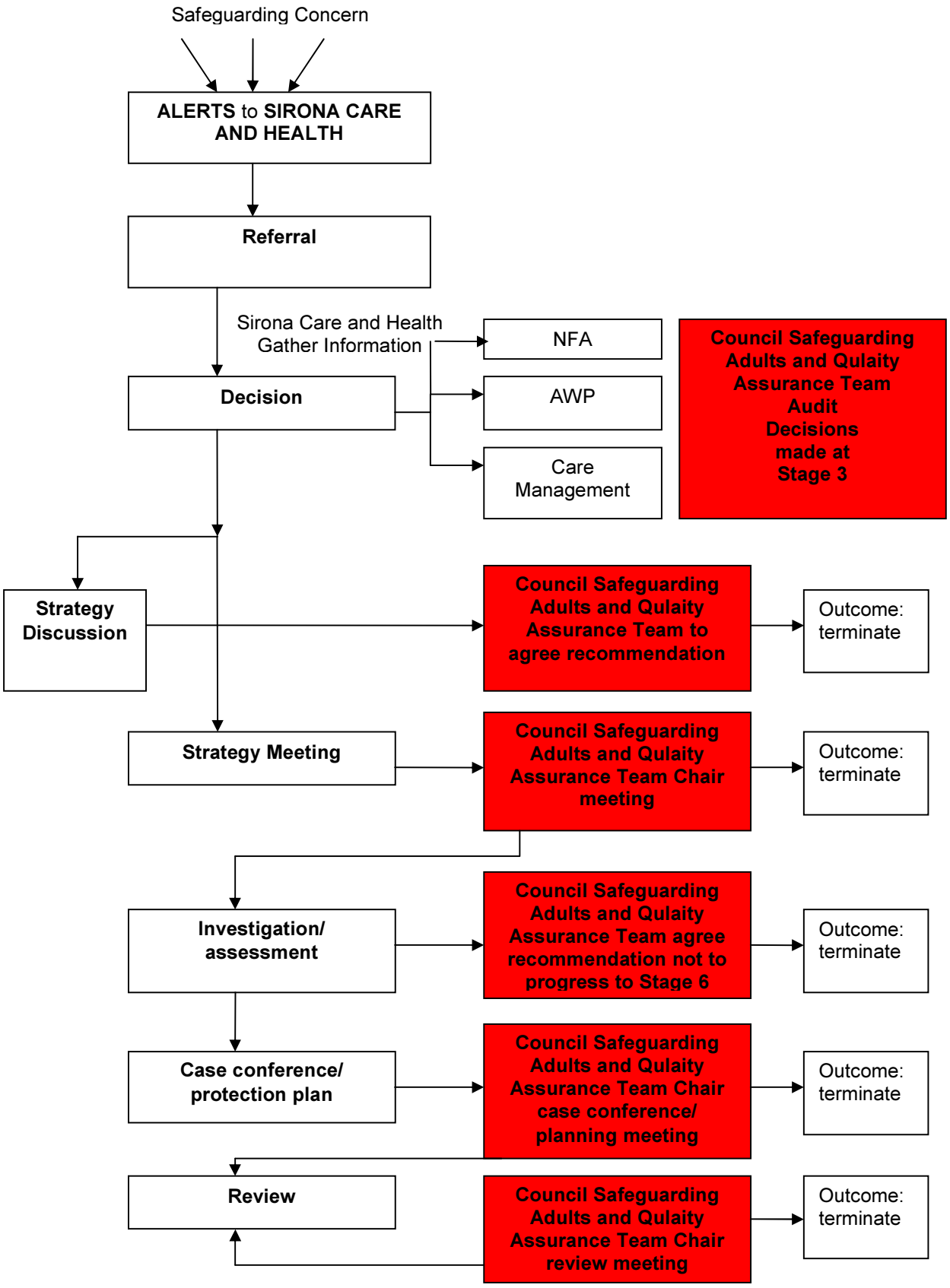
Appendix 1

Safeguarding Adults Assurance / Non Delegation Flow Chart



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Partnership Board for Health and Wellbeing	
MEETING DATE:	8 February 2012
TITLE:	Emerging priorities
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix One: Emerging priorities	

1 THE ISSUE

1.1 The Health and Wellbeing Board is responsible for developing a set of strategic priorities that deliver the Boards aim to:

- Reduce health inequalities and improve health and wellbeing in Bath and North East Somerset

1.2 The priorities that the Board agrees will form the foundations of the Health and Wellbeing Strategy, as well as inform the Boards work programme over the next few years.

1.3 This report introduces the emerging priorities for discussion.

2 RECOMMENDATION

The Partnership Board is asked to:

1) Note and comment on the emerging priorities (appendix 1)

3 FINANCIAL IMPLICATIONS

3.1 Activities defined within this report are to be managed through existing resources within the Council and PCT.

4 THE REPORT

4.1 On 28 May a task group of the HWB, chaired by Cllr Simon Allen, began thinking on a set of strategic priorities for the Health and Wellbeing Board. Discussions were informed by the JSNA update 2012 and need. The output from this session is a set of emerging priorities (set out in appendix 1).

4.2 The emerging priorities are a work in progress; there is still the opportunity to refine, especially as the CCG Plan develops.

4.3 The emerging priorities include 7 aspirational objectives and a series of outcomes focused priorities that will contribute to the delivery of at least 1 of the objectives.

4.3 Once complete these priorities will offer the Board the opportunity to be clear about what it wants to achieve. They will create a strong local voice which will enable us to influence decisions locally and nationally; including the NHS commissioning board. They should

underpin our commissioning plans, in order to make the greatest impact across the health and care system and beyond.

4.4 *'Joint health and wellbeing strategies should prioritise the issues requiring the greatest attention, avoiding the pitfalls of trying to take action on everything all at once. They will not be a long list of everything that might be done; they will focus instead on key issues that make the biggest difference'.* ***(DoH draft JHWS guidance)***

4.5 Next steps

Consultation on the emerging priorities will continue with the CCG and key Council service leads. The task group will meet again on the 2 July to review the emerging priorities – this session will have a particular focus on outcomes.

5 RISK MANAGEMENT

5.1 Risk will form a key consideration in the development of the Boards priorities (the associated risk of 'doing or 'not doing' the priority).

6 EQUALITIES

6.1 Inequality is a key part of the JSNA framework. To reduce health inequality is a key ambition of the Board – around which the priorities are framed.

7 CONSULTATION

4.2 The emerging priorities have been developed in consultation with:

a. *Cabinet Member; Staff; Other B&NES Services; Service Users; Local Residents; Community Interest Groups; Stakeholders/Partners; Other Public Sector Bodies;*

8 ISSUES TO CONSIDER IN REACHING THE DECISION

a. Select from: *Social Inclusion; Customer Focus; Sustainability; Human Resources; Property; Young People; Human Rights; Corporate; Health & Safety; Impact on Staff; Other Legal Considerations*

9 ADVICE SOUGHT

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

Contact person	*Helen Edelstyn (x7951)*
Background papers	*NA*
Please contact the report author if you need to access this report in an alternative format	

Aim of Board: Reduce health inequalities and improve health and wellbeing

Principles of operation

- Strengthen the role of ill-health prevention (throughout the objectives, priority outcomes and delivery)
- Integrate the planning, transport, housing, environmental, social care, social, community and health systems to address the social determinants of health and wellbeing

	Aspirational objectives	Priority outcomes
	1. Promote a healthy lifestyle for all (adults and children) 2. Improve the outcomes and experiences of adults and children who experience mental ill-health 3. Improve the outcomes of families with complex needs 4. Improve the outcomes (health and economic) of people with long term multiple conditions and needs *(including vulnerable groups in our communities such as the homeless, gypsy and travellers, people with learning disabilities)* 5. Enable our aging population to maximise their capabilities, have control over their lives 6. Reduce economic and social inequality which are linked with poor health outcomes 7. Create and develop healthy and sustainable places and communities	• Reduce obesity (children and adult) • Reduce alcohol misuse • Reduce self-harm • Better outcomes for people who experience mental ill-health • Reduce domestic violence ○ Better outcomes for people who experience domestic violence • Better outcomes for people with dementia • Our aging population can live independently (delivered through a new model of care that also manages demand on residential places) • Reduce the variation in life expectancy (between communities, and vulnerable groups)

		• Improve the standard of living through the provision of decent and affordable housing • Better outcomes for people who experience depression