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

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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

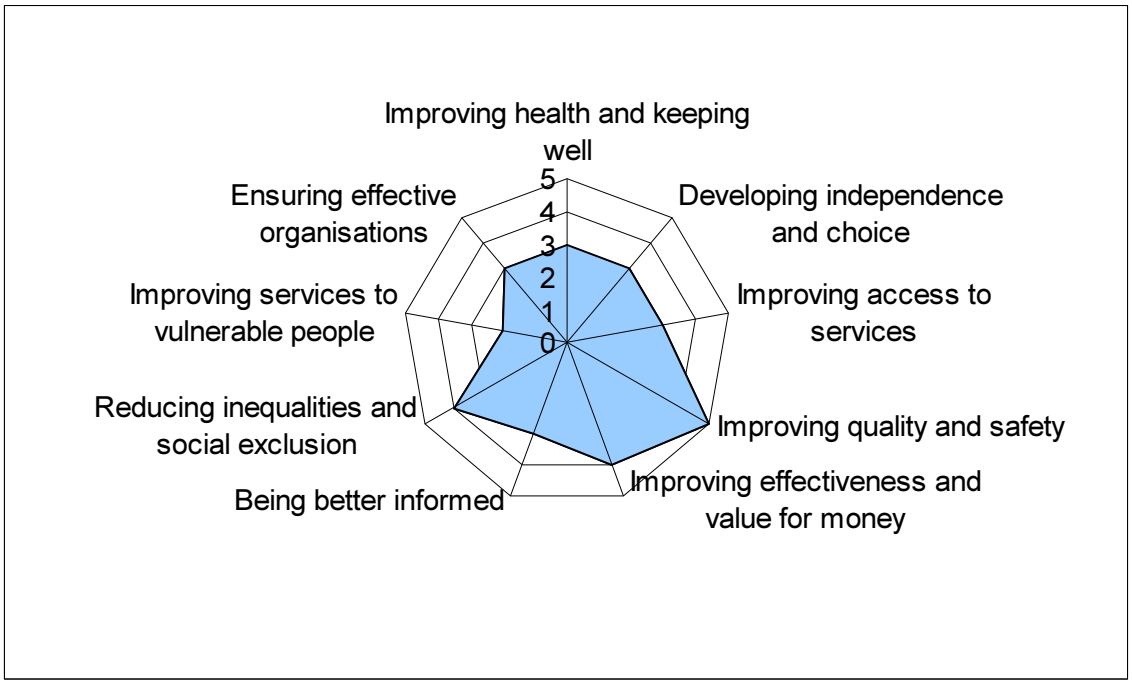
INDEX

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.

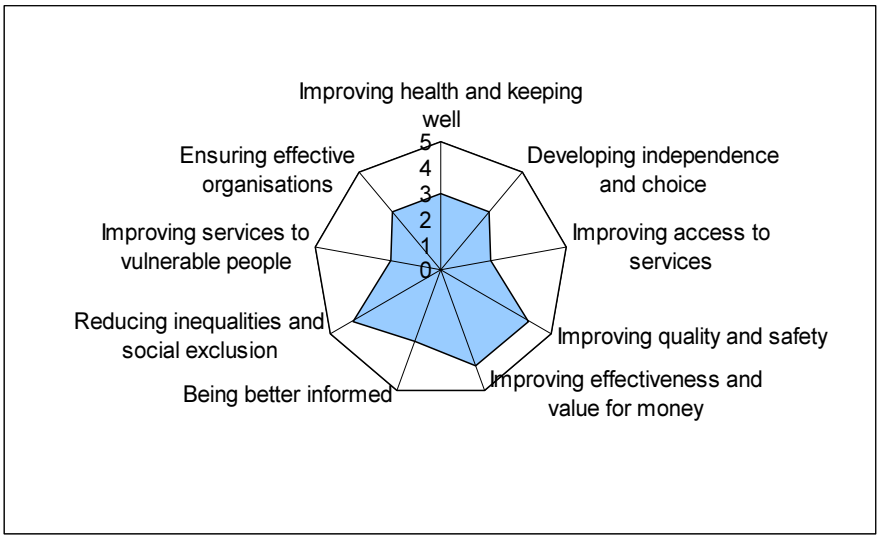
1.1 Performance versus Nine Strategic Goals – Quarter four 2010 - 2011



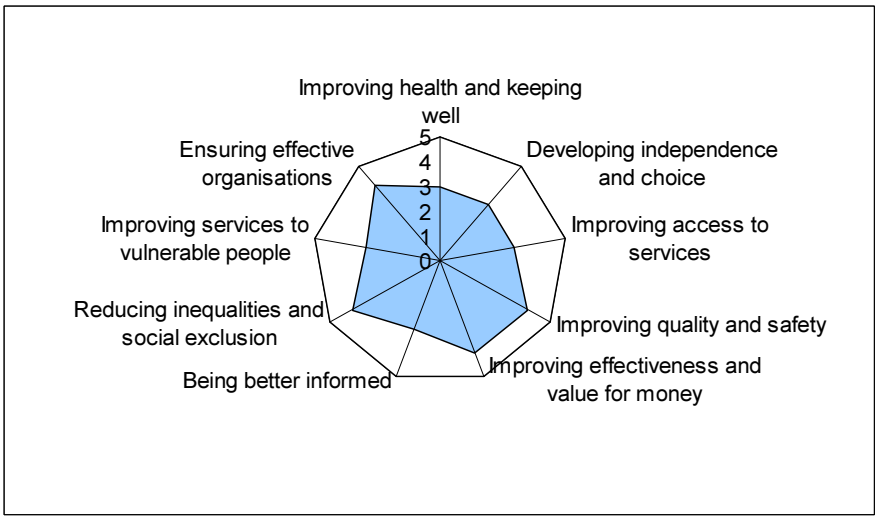
The chart above is a subjective representation of performance against the nine strategic goals, based on aggregate performance versus individual targets attached at Annex 1. Each of the nine strategic goals is represented as a spoke, performance is graded 0-5 (5 being excellent) on each spoke. For example, 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:

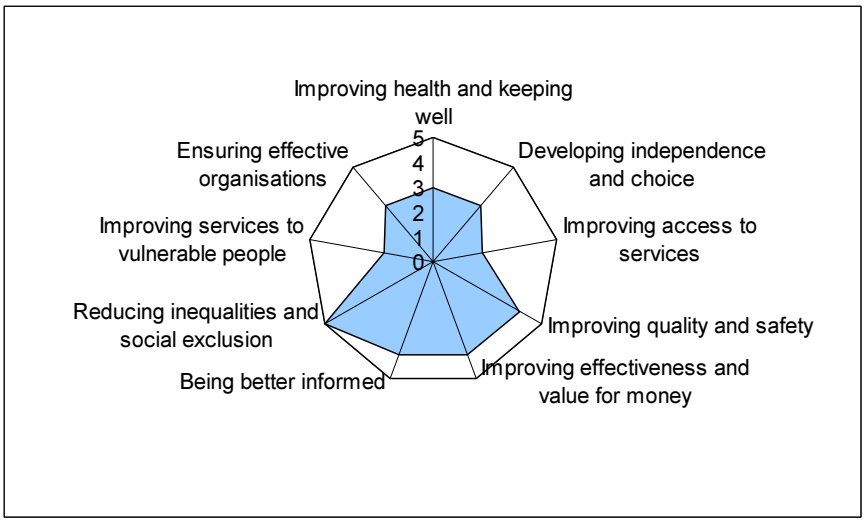
Performance versus Nine Strategic Goals – Quarter one 2010 - 2011



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

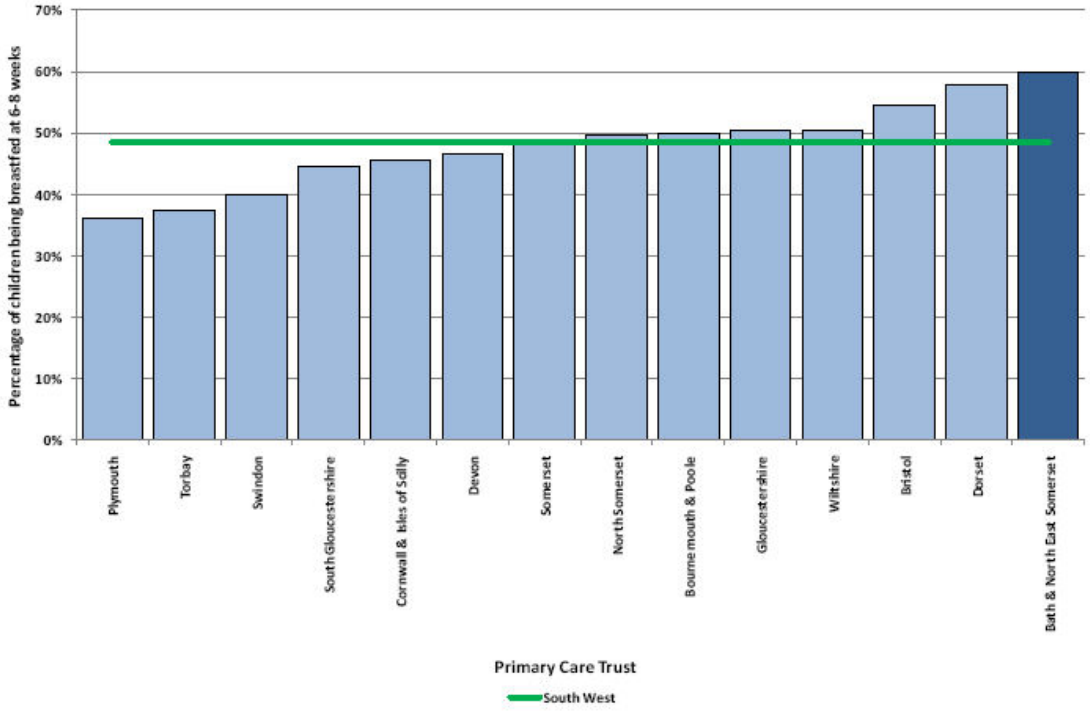
Chlamydia screening has risen from 18.5% uptake to an expected 23% for year end. This is a significant improvement and reflects improved commissioning and delivery of some parts of the service. However, the overall uptake is still too low against a national target of 35% and there was lower than expected 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.

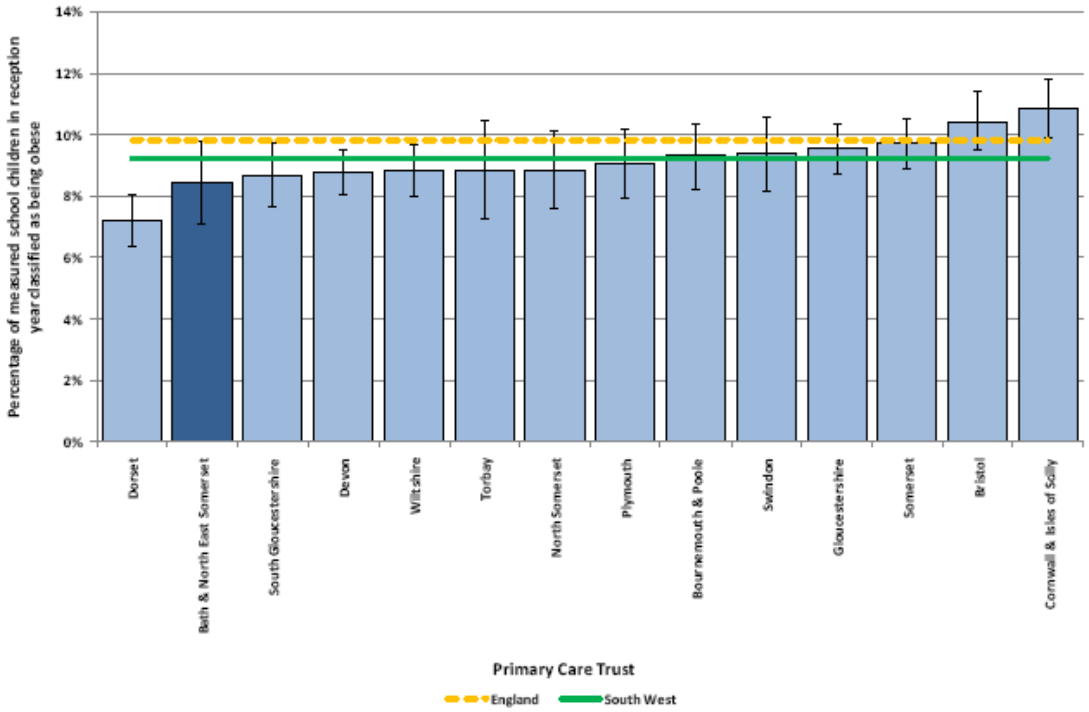
Percentage of children being breastfed at 6-8 weeks, South West PCTs and South West SHA, 2010/11 Q3.



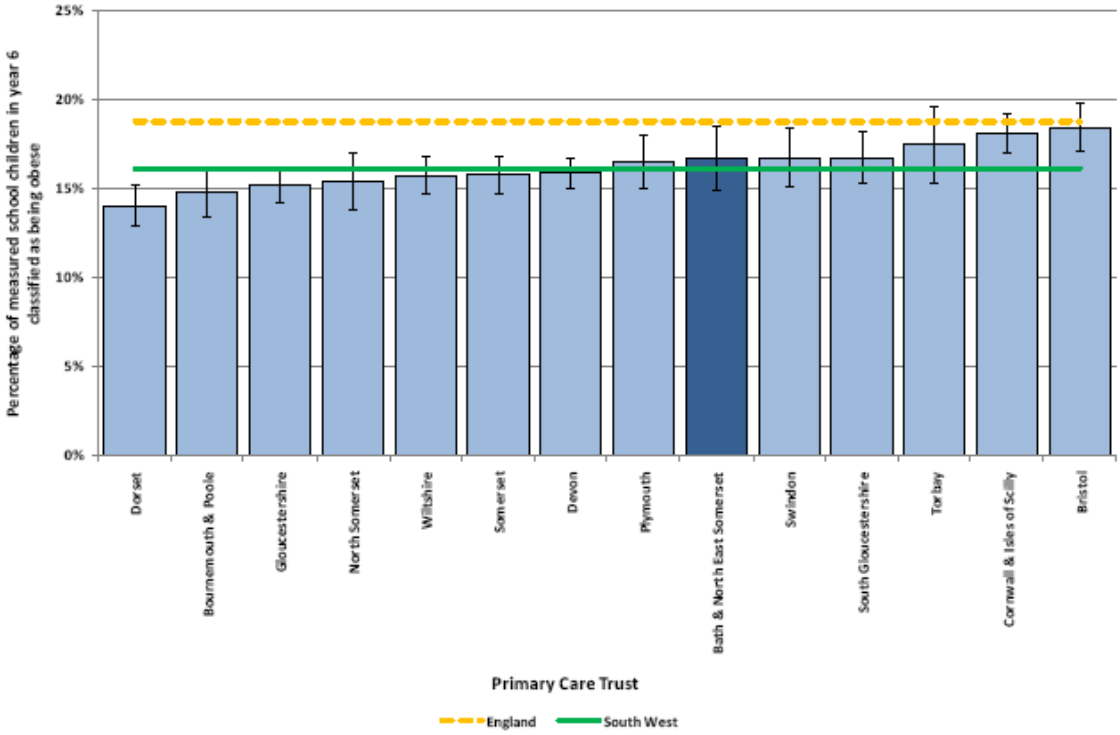
Child obesity

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

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