Bath & North East Somerset Council

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Date: 5th March 2015
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To: All Members of the Wellbeing Policy Development and Scrutiny Panel

Councillor Vic Pritchard
Councillor Katie Hall
Councillor Sharon Ball
Councillor Sarah Bevan
Councillor Anthony Clarke
Councillor Bryan Organ
Councillor Kate Simmons
Councillor Neil Butters
Councillor Eleanor Jackson

Chief Executive and other appropriate officers
Press and Public

Dear Member

Wellbeing Policy Development and Scrutiny Panel: Friday, 13th March, 2015

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 13th March, 2015** at **10.00 am** in the **Council Chamber - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
for Chief Executive

If you need to access this agenda or any of the supporting reports in an alternative accessible format please contact Democratic Services or the relevant report author whose details are listed at the end of each report.

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 Guildhall Bath (during normal office hours).

2. **Public Speaking at Meetings:** The Council has a scheme to encourage the public to make their views known at meetings. They may make a statement relevant to what the meeting has power to do. They may also present a petition or a deputation on behalf of a group. Advance notice is required not less than two full working days before the meeting (this means that for meetings held on Wednesdays notice must be received in Democratic Services by 4.30pm the previous Friday)

   The public may also ask a question to which a written answer will be given. Questions must be submitted in writing to Democratic Services at least two full working days in advance of the meeting (this means that for meetings held on Wednesdays, notice must be received in Democratic Services by 4.30pm the previous Friday). If an answer cannot be prepared in time for the meeting it will be sent out within five days afterwards. Further details of the scheme can be obtained by contacting Jack Latkovic as above.

3. **Details of Decisions taken at this meeting** can be found in the 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 are available for inspection as follows:-

   Public Access points – Reception: Civic Centre - Keynsham, Guildhall - Bath, The Hollies - Midsomer Norton. Bath Central, and Midsomer Norton public libraries.

   For Councillors and Officers papers may be inspected via Political Group Research Assistants and Group Rooms/Members' Rooms.

4. **Recording at Meetings**:-

   The Openness of Local Government Bodies Regulations 2014 now allows filming and recording by anyone attending a meeting. This is not within the Council's control.

   Some of our meetings are webcast. At the start of the meeting, the Chair will confirm if all or part of the meeting is to be filmed. If you would prefer not to be filmed for the webcast, please make yourself known to the camera operators.

   To comply with the Data Protection Act 1998, we require the consent of parents or guardians before filming children or young people. For more information, please speak to the camera operator

   The Council will broadcast the images and sound live via the internet www.bathnes.gov.uk/webcast An archived recording of the proceedings will also be available for viewing after the meeting. The Council may also use the images/sound recordings on its social media site or share with other organisations, such as broadcasters.

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

6. THE APPENDED SUPPORTING DOCUMENTS ARE IDENTIFIED BY AGENDA ITEM NUMBER.

7. **Emergency Evacuation Procedure**

When 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.

Wellbeing Policy Development and Scrutiny Panel - Friday, 13th March, 2015

at 10.00 am in the Council Chamber - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

   The Chair will draw attention to the emergency evacuation procedure as set out under Note 6.

3. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

4. DECLARATIONS OF INTEREST

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting. Members are asked to indicate:

   (a) The agenda item number in which they have an interest to declare.

   (b) The nature of their interest.

   (c) Whether their interest is **a disclosable pecuniary interest** *or* an **other interest**, (as defined in Part 2, A and B of the Code of Conduct and Rules for Registration of Interests)

   Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer or a member of his staff before the meeting to expedite dealing with the item during the meeting.

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

6. ITEMS FROM THE PUBLIC OR COUNCILLORS - TO RECEIVE DEPUTATIONS, STATEMENTS, PETITIONS OR QUESTIONS RELATING TO THE BUSINESS OF THIS MEETING

   At the time of publication no notifications had been received.

7. MINUTES (Pages 7 - 22)

8. CABINET MEMBER UPDATE (10 MINUTES)

The Cabinet Member will update the panel on any relevant issues. Panel members may ask questions

9. CLINICAL COMMISSIONING GROUP UPDATE (10 MINUTES)

The Panel will receive an update from the Clinical Commissioning Group (CCG) on current issues.

10. HEALTHWATCH UPDATE (10 MINUTES)

The Healthwatch representative will update the Panel on any relevant issues. Panel members may ask questions.

11. CARE QUALITY COMMISSION - FUNDAMENTAL STANDARDS (20 MINUTES) (Pages 23 - 32)

The Panel are asked to consider a presentation from the Care Quality Commission Inspection Manager for North Somerset & BANES and Swindon Wiltshire Region.

12. DEMENTIA WORK PROGRAMME UPDATE (20 MINUTES) (Pages 33 - 40)

Improving the quality of life for people with dementia is a priority for the Health and Wellbeing Board and the dementia work programme links to two of the CCG's strategic priorities for the next 5 years: 'Long Term Condition Management' and 'Safe, compassionate care for frail older people'. The purpose of this paper is to update the Wellbeing Policy Development and Scrutiny Panel on the dementia work programme.

The Panel is asked to note the work undertaken to date and support the delivery of the work programme.

13. UPDATE ON - NHS 111 SERVICE (20 MINUTES) (Pages 41 - 50)

Panel members received two briefings on the performance of the NHS 111 Service in the Bath & North East Somerset area in 2014. The last briefing reported on progress to improve performance, as well as a range of proposed developments. This briefing paper describes progress made, performance over the winter and how service performance continues to be monitored closely to ensure that it meets the needs of local people.

Panel Members are asked to note the latest performance of the NHS 111 service.

14. NON EMERGENCY PATIENT TRANSPORT SERVICE UPDATE (20 MINUTES) (Pages 51 - 60)

Panel members received briefings on the performance of the Non-Emergency Patient Transport Service in the Bath & North East Somerset area in March 2014, July 2014 and September 2014. The first set of reports set out the challenges being experienced during the mobilisation of the new single provider of this service within the first year of the contract. This briefing explains the progress being made with the service delivery of this contract and explains the actions being introduced within the contract to ensure this service meets the needs of the patients of BaNES.

Panel Members are asked to note the agreed actions and the latest performance of the Non-Emergency Patient Transport Service.

15. REFRESH OF SHAPING UP HEALTHY WEIGHT STRATEGY (20 MINUTES) (Pages 61 - 86)

The Panel are asked to approve the draft ‘Shaping Up’ strategy for further public consultation and that the draft ‘Shaping Up’ strategy to go to Health and Wellbeing Board for final consultation and approval.

16. CHAIRMAN'S SUMMARY

The Chairman, Councillor Vic Pritchard, will use this opportunity to summarise the work that the Panel had done, or had been engaged in, in the last 4 years.

The Committee Administrator for this meeting is Jack Latkovic who can be contacted on 01225 394452.

BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Friday, 16th January, 2015

Present:- Councillors Vic Pritchard (Chair), Katie Hall (Vice-Chair), Sharon Ball, Sarah Bevan, Anthony Clarke, Bryan Organ, Brian Simmons, Neil Butters and Eleanor Jackson

64 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

65 EMERGENCY EVACUATION PROCEDURE

The Chairman drew attention to the emergency evacuation procedure.

66 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Kate Simmons had sent her apologies to the Panel. Councillor Brian Simmons was a substitute for Councillor Kate Simmons.

Councillor Neil Butters informed the meeting that he would have to leave at 12.30pm due to another appointment.

Councillor Simon Allen (Cabinet Member for Wellbeing) had sent his apologies for this meeting.

67 DECLARATIONS OF INTEREST

Councillor Vic Pritchard declared an “other” interest as a representative of the Council on Sirona Care & Health Community Interest Company.

Councillor Katie Hall declared an “other” interest as a representative of the Council on Sirona Care & Health Community Interest Company.

Councillor Eleanor Jackson declared an “other” interest as a representative of the Council on Sirona Care & Health Community Interest Company.

Councillor Tony Clarke declared an “other” interest in agenda item ‘Impact Assessment of Transfer of Endoscopy Services’ as a representative of the Council on the RNHRD Board.

68 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

The Chairman used this opportunity to inform the Panel that he had received a letter from the Royal National Hospital for Rheumatic Diseases (RNHRD) acting Chief Executive, Kirsty Matthews, on the latest developments with the hospital, in particular on acquisition from the RUH Bath.

The Chairman read out the letter and welcomed that the RNHRD had received the lowest possible CQC risk score 2, out of maximum of 92.

69 ITEMS FROM THE PUBLIC OR COUNCILLORS - TO RECEIVE DEPUTATIONS, STATEMENTS, PETITIONS OR QUESTIONS RELATING TO THE BUSINESS OF THIS MEETING

There were none.

70 MINUTES

The Panel confirmed the minutes of the previous meeting as a true record and they were duly signed by the Chairman subject to the following amendment:

- Page 11, 12 lines up in the last paragraph to delete '**not**' so it should read '….was simplified and ….'

The Chairman said that he had not yet received a feedback from an officer on his suggestion at the last paragraph on page 11. Jane Shayler commented that she would arrange for an officer to get in touch with the Chairman on that matter.

71 CABINET MEMBER UPDATE (10 MINUTES)

The Chairman invited Jane Shayler (Director of Adult Care and Health Commissioning) to give an update (attached to these minutes).

Some Members of the Panel had said that the Wellbeing College, and its courses for January and February this year, had been positively received by the Midsomer Norton, Radstock & District Journal.

The Chairman thanked Jane Shayler for an update.

72 CLINICAL COMMISSIONING GROUP UPDATE (10 MINUTES)

The Chairman invited Dr Ian Orpen to give an update (attached to these minutes).

The Chairman commented how winter pressures across the UK had been happening every year and asked why in the past few weeks we had seen A&E departments across the UK under severe pressure with a number of hospitals decided to declare an internal major incident.

Dr Orpen responded there were a number of reasons that had contributed to the pressure on the A&E system. These included a higher than expected number of people turning up at A&E, cold weather leading to higher levels of illness in the elderly population which could often require admissions. There had also been delays in discharging people from hospital when the necessary health or care facilities were not in place. Dr Orpen also said that, on local level, the RUH had not been able to meet its target of seeing 95% of patients within 4 hours although staff had worked incredibly hard to ensure that every patient received the best quality care possible in the circumstances.

Dr Orpen commented that the B&NES System Resilience Group had been carrying out a review of activity levels and plans for the period from 15th December to 12th January to help in understanding the reasons behind system's poor performance and to identify what further actions should be taken to improve things and ensure meeting the 95% target again as soon as possible.

The Chairman commented that some Whitchurch residents chose to go to GP surgeries in Bristol area, as they were closer than surgeries in B&NES area.

Dr Orpen commented that Whitchurch has been on B&NES border with Bristol and it has been covered by the CCG from Bristol. Dr Orpen suggested that, in near future, more GPs would be available in B&NES area.

Councillor Hall suggested that the Panel could have a report on analysis from weather pressures in near future.

Councillor Hall asked about the prioritisation of the most urgent and life-threatening cases in dermatology.

Dr Orpen responded that provision of dermatology services had been currently under review, and commissioners were liaising closely with other providers to offer alternative services to patients with non-urgent conditions. In the meantime, the RUH had written to affected patients to ask them to discuss their condition with their GP and agree next steps.

Councillor Butters asked how much training had been given to the NHS 111 staff.

Dr Orpen responded that the NHS Pathways was a suite of clinical content assessment for triaging telephone calls from the public, based on the symptoms they report when they call. It had an integrated directory of services, which identified appropriate services for the patient's care if an ambulance is not required. Also, clinicians would sit during the training of new staff.

Councillor Jackson commented that the CCG and the NHS England Area Team should work closely with the schools on the 'Primary Care: Preparing for the Future' project.

Councillor Jackson asked if the GP could tell that lump on the skin is benign or not.

Councillor Jackson handed over to Dr Orpen complaints made by hospital transport service users. Councillor Jackson highlighted that people usually complain on a trip from hospital to their homes.

Dr Orpen responded that Children Services had been integrated in the 'Primary Care: Preparing for the Future' project.

Dr Orpen also said that over the time removal of the lump on the skin was not anymore considered appropriate to be carried out by the GP. The GP would make clinical assessment to detect those lumps.

Dr Orpen added that he took note of hospital transport complaints and that he, or his colleague/s, would get back to Councillor Jackson with an answer.

The Chairman thanked Dr Orpen for an update.

73 HEALTHWATCH UPDATE (10 MINUTES)

The Chairman invited Alex Francis (Healtwatch rep) to introduce the report.

The Chairman welcomed the fact that the Healtwatch had been working across the age sector. In the past the Healtwatch, and its predecessor, were mainly linked with adults' health and wellbeing. The Chairman commented that this was the first step in working with children and young people.

Alex Francis commented that she was delighted with the feedback from 28th October event. It has been a good foundation to start with in terms of building positive relationship with children and young people networks.

Councillor Hall also welcomed the report and the event on 28th October. Councillor Hall suggested that the Healtwatch should take a look at the Gem Project which has been designed to help children and adults see learning as something that can enhance their lives. Councillor Hall also suggested that Young Healthwatch Event report should be presented to the Early Years, Children and Young People (EYCY) Scrutiny Panel.

Councillor Organ commented that people had been wary of being open with mental health problems, due to stigma around that subject. Councillor Organ asked if there was anything to encourage people to come forward.

Alex Francis took on board comments from Councillor Hall in terms of the Gem Project and presence at the EYCY Panel. In response to Councillor Organ's comment, Alex Francis also said that there was national campaign called 'Time to Change' which talks about mental health stigma, and which had been signed up by the Health and Wellbeing Board.

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

74 HOMELESSNESS UPDATE (30 MINUTES)

The Chairman invited Mike Chedzoy (Team Manager for Housing Options and Homelessness) to introduce the report.

The Chairman asked about the £239k funding.

Mike Chedzoy replied that Bath and North East Somerset Council had successfully bid for money from a Help for Single Homeless fund, together with North Somerset Council and Bristol City Council, to provide a "rapid response and outreach" service to identify and to assist rough sleepers. The funding of £239k had been allocated between the three authorities and it would run until April 2016. Bath and North East Somerset Council was the lead authority.

The Chairman asked about reconnection of people to their home area.

Mike Chedzoy replied that newly-arrived rough sleepers without any local connection had been reconnected to their home area wherever it was safe and reasonable. This step was to ensure that accommodation available in their home town was not lost and that vital support services continue. Rough sleepers could decline a reconnection which ends their entitlement to local services and could mean they continue to rough sleep.

Councillor Hall praised the fact that numbers of people sleeping rough had been going down and asked where these people were coming from.

Mike Chedzoy replied that people had been coming from nearby areas.

Councillor Jackson highlighted the importance of integrated work with other services and organisations in the area. Councillor Jackson also said that people from rural areas had had problem accessing Julian House due to distance.

Councillor Butters also congratulated on low numbers and asked what proportion of people refused to receive services and help.

Mike Chedzoy replied that he would not have the exact number of people who refused services. Mike Chedzoy also said that people with drug and alcohol problems were usual ones who declined any help from the Council.

The Chairman concluded the debate by saying that, even though this has been an ongoing issue, the report has been encouraging in showing an improvement in terms of rough sleepers.

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

75 IMPACT ASSESSMENT ON TRANSFER OF ENDOSCOPY SERVICES (20 MINUTES)

The Chairman invited Tracey Cox (CCG) to introduce the report.

The Panel debated this matter and concluded that transfer of Endoscopy Services from the RNHRD to the RUH Bath would be a sensible move and, for the benefit of maintaining and improving clinical service, it should go ahead as planned.

The Panel had been satisfied that the patients would continue to have access to an endoscopy service. The proposed transfer would ensure service continuity and patients would benefit from the added assurance of externally accredited standards of care.

It was **RESOLVED** to note the outcome of the various impact assessments which confirm that the effects of this change had been considered to be minimal and that there had been a number of positive aspects to the service change.

It was also **RESOLVED** that the transfer of the endoscopy services should proceed.

76 ACTION ON LONELINESS (20 MINUTES)

The Chairman invited Andy Thomas (Partnership Delivery Group Manager) to introduce the report.

Councillor Bevan commented that loneliness could affect anyone, of any age, and asked what had been done to combat against stigma that loneliness had been associated only to old people.

Andy Thomas agreed that people tend to associate loneliness with age. People could become socially isolated for a variety of reasons such as getting older, weaker, no longer being the hub of their family, leaving the workplace, disability or illness, and the deaths of spouses and friends. Also, living alone does not mean that someone is lonely.

Andy Thomas also explained that there was a distinction between loneliness and social isolation. Social isolation was an objective state. For instance, an individual has four or fewer people they could turn to for support and help. Or, if you were new in town, and knew only two people to turn to for support, you would be considered socially isolated. Loneliness was usually defined as a subjective state. This would mean you might know a lot of people as potential supports, but still would alone.

Andy Thomas added that the Council had been working with a lot of services and organisations on this issue, including the Healtwatch.

Councillor Organ commented that the death of spouse could be one of the biggest reasons for loneliness and that we should stay in touch with those people who lost their love ones. Andy Thomas took that comment on board.

The Chairman praised Village Agents scheme, which was operational in twenty parishes in B&NES, and their work in ‘increase the resilience of people and communities including action on loneliness’ which was one of the Health and Wellbeing Board’s priorities.

It was **RESOLVED** to note the report and to receive a further update at one of future meetings.

77 NHS HEALTH CHECK PROGRAMME UPDATE (20 MINUTES)

The Chairman invited Cathy McMahon (Public Health Development and Commissioning Manager) to introduce the report.

The Chairman commented the NHS Health Check programme was a population wide, primary prevention programme using a systematic approach to identify asymptomatic people aged between 40 – 74 years of age who were then offered a range of tests of risk factors in order to estimate their risk of Cardiovascular Disease (CVD) and deliver interventions to prevent disease occurring. Face to face consultations had included measurements of blood pressure, cholesterol, body mass index (BMI) and where necessary diabetes and kidney disease. Information had been recorded on family history of CVD, ethnicity, smoking, alcohol consumption and physical activity. The results of these investigations had been used to estimate CVD risk over the next 10 years. All individuals were offered specific interventions to reduce or manage this risk. A risk assessment for dementia awareness had been also included for everyone aged 65 – 74.

Councillor Hall commented the NHS Health Check programme had been funded from the Public Health Grant, which was currently ring-fenced until 2016. Councillor Hall asked who would make the decision on where the funding would go.

Cathy McMahon responded that B&NES programme had been commissioned by the Public Health team and delivered through all 27 GP surgeries locally. Programme delivery had been overseen by a Steering Group with representation from a GP (retired), practice managers and the Public Health team.

Cathy McMahon also said that between July 2011 and September 2014, 44,578 people in Bath and North East Somerset were offered a NHS Health Check and 20,080 received a Check. During 13/14 the take up of NHS Health Checks in B&NES was 51.1%, an improvement on 12/13 take up of 45.6% and above the national average of 48%.

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

78 SPECIALIST MENTAL HEALTH SERVICES - INPATIENT REDESIGN IMPACT ASSESSMENT AND UPDATE (30 MINUTES)

The Chairman invited Andrea Morland (Senior Commissioning Manager for Mental Health and Substance Misuse Commissioning) to introduce the report.

The Chairman asked what impact transferring Ward 4 dementia inpatient services from St Martin's Hospital to the Royal United Hospital into a new build specialist mental health unit would have on patients, staff and carers.

Andrea Morland replied that benefits for the proposed changes were: improved inter-team professional working both within AWP and across into the RUH; improved quality of care for older adults with dementia; improved in-patient environments for delivery of care to all mental health and dementia patients; increased access to diagnostics in the RUH; platform for realising “parity of esteem” national agenda; and, potential to increase provision e.g. S136 suite and assessment unit if space allows.

Andrea Morland also said that safe parking for staff, patients and carers could be a potential cause for anxiety. Andrea Morland informed the Panel that discussion with the RUH and transport providers to increase provision would be taking place with emphasis on specific parking for new unit to be provided.

The Panel welcomed the proposed change, taking into consideration the reason for move, business case and also the fact that service users would be safely housed in case of total rebuild of the site.

It was **RESOLVED** to note:

1) The issues as outlined in the impact assessment documentation and embedded documents.
2) The overwhelmingly positive support for the move of Ward 4 by stakeholders, staff and Healthwatch.

It was also **RESOLVED** to **AGREE** that all local engagement, assessment of impact and support had been adequate to enable continued proposal development for a new build mental health and dementia unit on the RUH site.

79 PANEL WORKPLAN

It was **RESOLVED** to note the workplan with the following suggestions:

- ‘Action on Loneliness update’ – for future Panel to include into their workplan
- ‘Public Health update’ – for future Panel meetings as regular item

The meeting ended at 1.40 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Cllr Simon Allen, Cabinet Member for Wellbeing
Key Issues Briefing Note

Wellbeing Policy Development & Scrutiny Panel – January 2015

Your Care, your way

Bath and North East Somerset CCG and **Bath & North East Somerset Council** work closely together to commission community services that are focused on the needs of local people. ***Your care, your way*** is the project that will involve us all in identifying the best way to deliver integrated community services from April 2017 onwards.

Over the coming months we will be engaging with patients, service users, providers and partners to design a model for community services that places the service user at the centre of their care and can adapt to their changing needs in future years. We will build on our strong track record of partnership working between health and social care professionals to commission care that blurs the organisational boundaries between GPs and hospitals, between physical and mental health and between health and social care.

A launch event is taking place at the Bath Assembly Rooms on Thursday 29 January 2015 and this will be the first opportunity to learn more about the project and find out how to be involved in the conversation. We will explain our emerging vision for community services and would like you to share your early thoughts with us. You will have the opportunity to ask questions and to hear different perspectives from commissioners, providers and members of the public.

You will leave the event with a clear understanding of the health and wellbeing outcomes that community services must deliver for the local population. We hope we will inspire you to explore new ways of working together to deliver truly integrated services and support our patients and service users to live healthier and more independent lives.

We expect demand to be high for this event and places are limited. Please book your place and tell us about your areas of interest by registering at yourcareyourway.eventbrite.co.uk by Thursday 22 January 2015.

Better Care Fund Plan

Bath and North East Somerset's Better Care Fund Plan 2015/16-2018/19 has been identified by the Better Care Fund Task Force, comprising Department of Communities & Local Government; Local Government Association; NHS England and the Department of Health as an example of best practice. The full plan can be viewed by following this link: http://www.bathandnortheastsomersetccg.nhs.uk/sites/default/files/BCF%20BNES%20Submission%20Part%201%20Nov%202014_0.pdf

Wellbeing College

We are pleased to announce that the Wellbeing College Web site is now live at www.wellbeingcollegebanes.co.uk

Courses coming up in January and February include:

- Family Cook It
- Computers for Work
- Mindfulness for Carers
- Finding the Balance
- 5 Ways to Wellbeing

The full programme of courses can be seen on the website.

CCG Briefing:
Wellbeing Policy Development & Scrutiny Panel Meeting

Friday 16th January 2015

Winter pressures update

The past few weeks have seen A&E departments across the UK under severe pressure with a number of hospitals deciding to declare an internal major incident. Here in BaNES, last week saw the highest number of ambulance drop-offs at the RUH since records began five years ago. There were 628 drop-offs compared with the usual 500 to 550 – an increase of about 17%. As a result, the RUH has not been able to meet its target of seeing 95% of patients within 4 hours although staff have worked incredibly hard to ensure that every patient still receives the best quality care possible in the circumstances.

There are a number of reasons that have contributed to the pressure on the A&E system. These include a higher than expected number of people turning up at A&E, cold weather leading to higher levels of illness in the elderly population which can often require admissions. There have also been delays in discharging people from hospital when the necessary health or care facilities are not in place. This then results in blockages across the entire health and care system and impacts on the flow of patients through our system.

Dr Ian Orpen is the Chair of the B&NES System Resilience Group which includes representation from all the NHS providers involved in the urgent care system including the RUH, 111, the ambulance service, Sirona and the GP out-of-hours service. This group is carrying out a review of activity levels and plans for the period from 15th December to 12th January to help us understand the reasons behind our system's poor performance and to identify what further actions we can take to improve things and ensure that we are meeting the 95% target again as soon as possible.

Your Care, Your Way launch

The CCG and the Council will be launching their joint review of community health and care services on Thursday 29th January at the Bath Assembly Rooms.

Over 100 people have already signed up to attend the afternoon event to learn more about Your Care, Your Way and to contribute their own early ideas about how community services in B&NES could look like in the future. The event will include representatives from the CCG, the Council, health and care providers, voluntary and community sector organisations and members of the general public.

Following the launch event, we will be spending the months of February and March outreaching to a wide range of groups to talk to them about community services and their vision for the future. This includes events organised in conjunction with the Area Forums in Somer Valley, Chew Valley and Keynsham as well as attendance at the Young People's Equalities Summit in April.

Primary Care: Preparing for the Future

The CCG and the NHS England Area Team are jointly funding a two year project to drive improvements in primary care. B&NES is already one of the best places in the country for getting an appointment with a GP but there is more that can be done.

The Primary Care: Preparing for the Future fund has been provided to our local GP provider organisation, Banes Enhanced Medical Services (BEMS+). Working jointly with the 27 GP practices in B&NES they will be focussing on four key projects:

1. **Focussed Weekend Working** – a targeted service for at risk and vulnerable patients who would benefit from a GP visit on a weekend to prevent avoidable hospital admissions and support earlier discharge.

2. **Information Management and Technology** - interoperability across GP practices using networked telephony software and improved working and flexibility through the use of mobile tablets

3. **Workforce Analysis** - Working with Skills for Health to prepare an analysis of current primary care workforce, identify future challenges and prepare a workforce development and skills mix strategy.

4. **Collaborative working** - Working with Skills for Health to scope opportunities for collaborative working between GP practices enabling them to work in partnership to offer a wider range of services to local communities.

Proposed Endoscopy Changes

A detailed paper has been provided to Wellbeing Policy Development and Scrutiny panel members on the proposed transfer of endoscopy services from the Royal National Hospital for Rheumatic Diseases (RNHRD) when the acquisition of the RNHRD by the RUH is expected to be completed.

Equality, quality and privacy impact assessments have all been completed and confirm that the effects of this change are considered to be minimal and that there are a number of positive aspects to the service change. It is therefore recommended that the transfer of the endoscopy services should now proceed.

Specialist Mental Health Services

A substantial engagement exercise with stakeholders and staff has taken place in relation to the transferring of Ward 4 dementia inpatient services from St Martin's Hospital to the Royal United Hospital into a new build specialist mental health unit.

There has been overwhelmingly positive support for the move of Ward 4 by stakeholders, staff and Healthwatch and it is recommended to Wellbeing Policy Development and Scrutiny panel members that the local engagement, assessment of impact and support is adequate to enable continued proposal development for a new build mental health and dementia unit on the RUH site.

Dermatology

In line with a national trend, the Royal United Hospital has experienced a significant increase in referrals for dermatology services. This sharp increase in demand has resulted in a number of patients waiting to see a specialist. The increase in referrals is largely attributed to the increased incidence of skin cancers nationally and the success of public health campaigns, meaning people are more vigilant about changes to their skin.

In view of the situation, it has been agreed between the RUH and local CCGs to temporarily suspend consultations for patients with non-urgent skin conditions in order to prioritise the most urgent and life-threatening cases.

Ensuring the rapid diagnosis and treatment of serious conditions such as skin cancers is of the utmost importance and we are committed to providing the continued high quality delivery of these important services. We do appreciate that non-urgent skin conditions, whilst not life-threatening, can cause considerable anxiety, discomfort and inconvenience. As such, provision of dermatology services is currently under review, and commissioners are liaising closely with other providers to offer alternative services to patients with non-urgent conditions. In the meantime, the RUH has written to affected patients to ask them to discuss their condition with their GP and agree next steps.

This suspension of service affects patients across Bath and North East Somerset, as well as some patients in Wiltshire, Somerset and South Gloucestershire who have been referred to the RUH.

Diabetes Survey

The CCG's survey of everyone living with Type 2 Diabetes in Bath and North East Somerset will begin in February.

Over 6,000 people with Type 2 diabetes will receive a letter from their GP practice asking them to participate in the survey and they will have the option to complete the survey online or through the post. The results of the survey will be used to improve the different forms of support available to people who have been diagnosed with

diabetes so that they can manage their condition better and avoid complications in the future.

The survey is being delivered in partnership with Bath-based “my Community” who are offering rewards to those who complete the survey. These include free exercise classes, wellbeing evaluations and workshops with nutritional therapists.

Establishment of a Transformation Group in B&NES

Earlier this year the CCG engaged on the development of it’s Five Year Strategic Plan and it was proposed that a Transformation Leadership Board (TLB) would oversee the development of the six transformational priority work streams that the CCG identified: -

1. Prevention, including self care

2. Improving Diabetes Care

3. Musculoskeletal service review and redesign

4. Improving the interoperability of patient records systems

5. Improving Urgent Care

6. Safe Compassionate Care for Frail Older People

It was also proposed that the TLB would oversee progress on the Better Care Fund.

This approach is still envisaged but the TLB will now be called the Transformation Group. It is proposed that the Transformation Group will replace the current sub-committee of the Health and Wellbeing Board (HWB) - the Strategic Advisory Group.

The newly formed Transformation Group will consist of senior commissioning representatives from the CCG and Council, provider representatives from all key provider organisations in B&NES, HWB representatives, a member of Healthwatch, 3rd sector representation and representation from the Local Education Training Board.

The Transformation Group will report directly into the Health and Wellbeing Board and in addition to acting as vehicle for supporting the delivery of the CCG’s 5 Year Strategy and Better Care Fund, will provide a shared space for oversight of our local services and enable active input into the Health and Wellbeing Board's strategic planning. This is a critical enabler in the successful transformation of services in the local system.

The first meeting will take place on 4th February.

Update on RNHRD acquisition

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD) and the Royal United Hospitals Bath NHS Foundation Trust (RUH) continue to make significant progress towards joining together and have secured the necessary approvals from the Board and Council of Governors of each organisation.

On 27th November 2014 at an extraordinary RNHRD Trust Board held in public the Board formally approved the proposed acquisition of the RNHRD by the RUH.

On 2nd December 2014, at an extraordinary meeting of the Council of Governors, held in public, the RNHRD Governors formally approved the RNHRD's application to Monitor for the RNHRD to be acquired by the RUH.

In December 2014, the RUH Board of Directors and Council of Governors approved proposals for the acquisition of the RNHRD.

In January 2015, the RUH and RNHRD will make a joint application to the independent healthcare regulator Monitor to approve the proposed acquisition. Pending their agreement, it is anticipated that the earliest the transaction will take place is the beginning of February 2015.

Patients will continue to be seen and treated at the RNHRD as usual whilst our hospitals work together to deliver the proposed acquisition.

Dry January

The CCG is supporting this year's Dry January campaign with over 24 members signing their name up on the wall in the CCG's offices.

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Fundamental Standards

Jo Bell

Event

February 2015

Our purpose and role

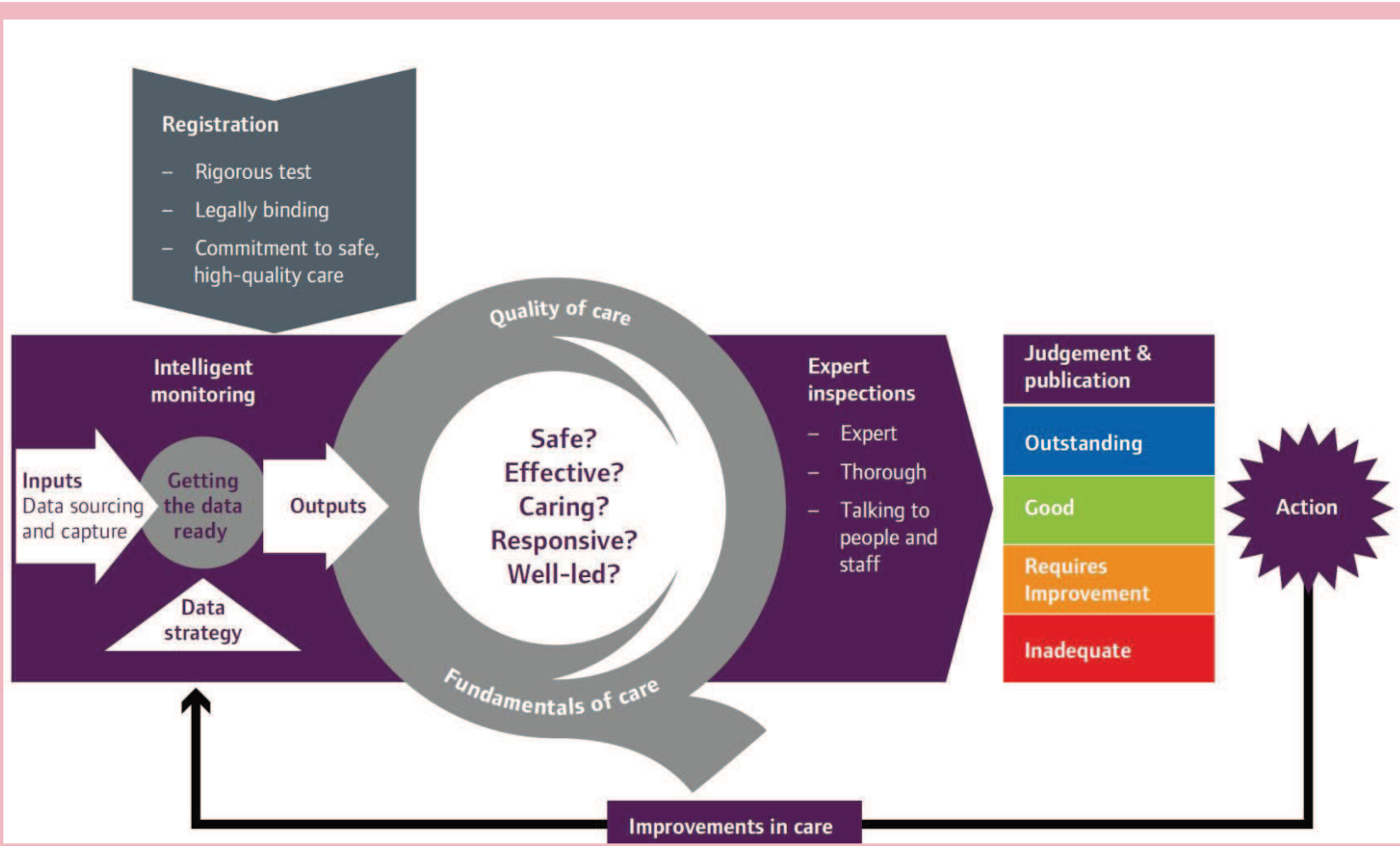
Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care

Our new approach



Fundamental Standards

Current regulations

- Care and welfare of service users
- Assessing and monitoring the quality of service provision
- Safeguarding service users from abuse
- Cleanliness and infection control
- Management of medicines
- Meeting nutritional needs
- Safety and suitability of premises
- Safety and suitability of equipment
- Respecting and involving service users
- Consent to care and treatment
- Complaints
- Records
- Requirements relating to workers
- Staffing
- Supporting workers
- Cooperating with other providers

New Regulations

- Person-centred care
- Dignity and respect
- Need for consent
- Safe care and treatment
- Safeguarding service users from abuse
- Meeting nutritional needs
- Cleanliness, safety and suitability of premises and equipment
- Receiving and acting on complaints
- Good governance
- Staffing
- Fit and proper persons employed

and

- Fit and proper persons requirement for directors
- Duty of candour

When does it all come into effect?

Fundamental Standards

- All providers from April 2015

Duty of Candour

- NHS Trusts from late 2014 and all providers from April 2015

Fit and proper person requirement

- NHS Trusts from late 2014 and all providers from April 2015

Enforcement policy

- All providers from 2015

Overview

Duty of candour	A new requirement to tell people who use services when something goes wrong and to apologise
Fit and proper person requirement	A new requirement that directors and non-executive directors are of good character and properly qualified and capable of doing the job

Duty of candour

Duty of candour

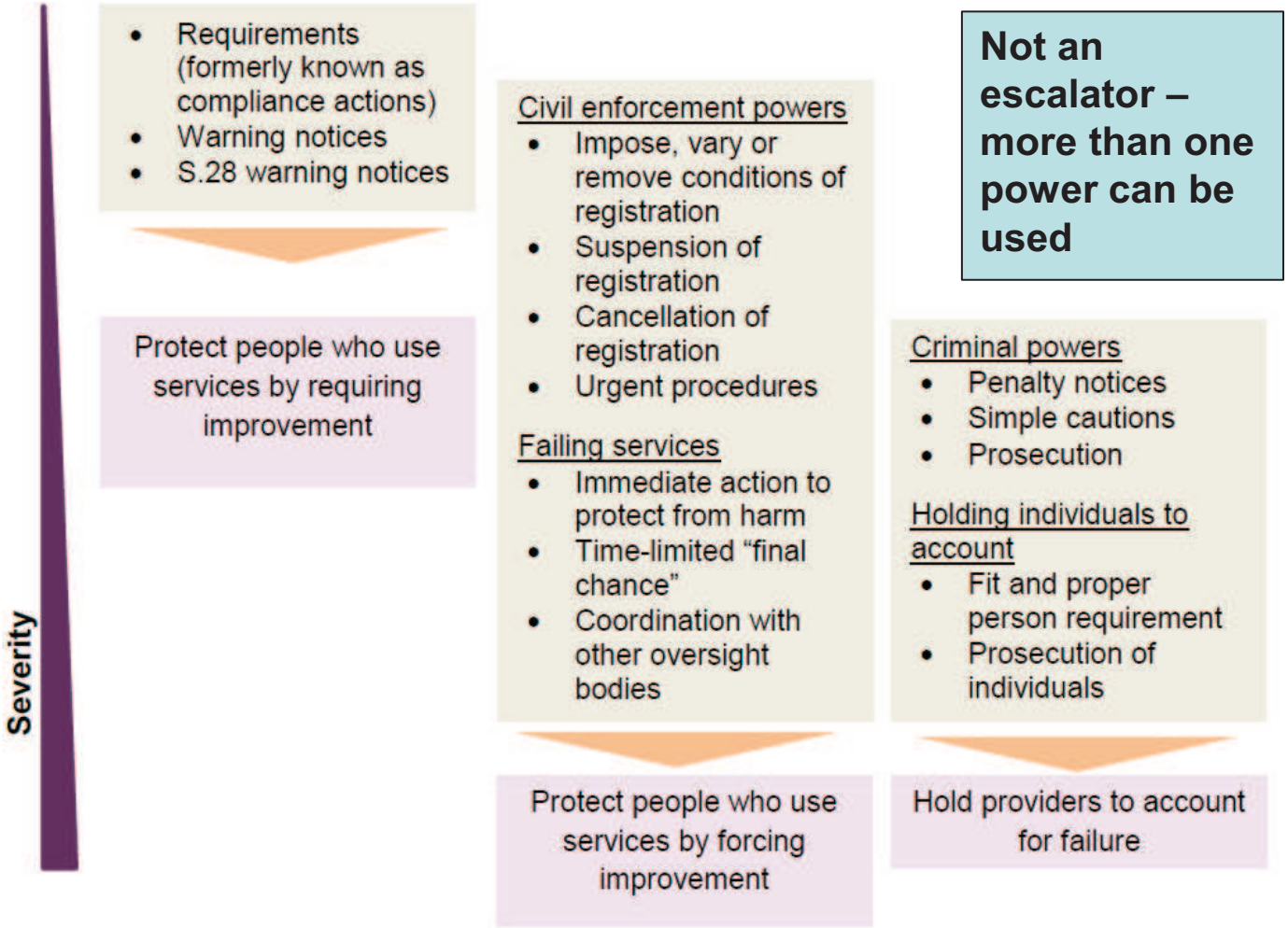
- Providers must be open and honest with people when things go wrong with care and treatment. Providers must give them reasonable support, truthful information and a written apology.
- Providers must have an open and honest culture at all levels and have systems in place for knowing about notifiable safety incidents. The provider must keep written records and offer reasonable support to the patient or service user in relation to the incident.
- A requirement to be candid is already in the NHS contract so, in theory, NHS trusts should already be fostering a culture of openness and honesty. The duty of candour means CQC can take enforcement action against trusts that don't satisfy these requirements.

Fit and proper person requirement

Fit and proper person requirement

- Providers must take proper steps to ensure that their directors (both executive and non-executive) are fit and proper for the role.
- Directors must be of good character, physically and mentally fit, have the necessary qualifications, skills and experience for the role, and be able to supply certain information (including a Disclosure and Barring Service check and a full employment history). Those who are unfit will include individuals on the children's barred list or the adults' barred list. They must not be prevented from holding a director's post under other laws like the Companies Act or Charities Act.

Our enforcement powers



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Bath & North East Somerset Council		
MEETING/ DECISION MAKER:	**Wellbeing Policy Development and Scrutiny Panel**	
MEETING/ DECISION DATE:	**13th March 2015**	
TITLE:	**Dementia Work Programme Update**	
WARD:	**All**	
AN OPEN PUBLIC ITEM		
List of attachments to this report: None		

1 THE ISSUE

1.1 Improving the quality of life for people with dementia is a priority for the Health and Wellbeing Board and the dementia work programme links to two of the CCG's strategic priorities for the next 5 years: 'Long Term Condition Management' and 'Safe, compassionate care for frail older people'. The purpose of this paper is to update the Health and Wellbeing Policy Development and Scrutiny Panel on the dementia work programme.

2 RECOMMENDATION

2.1 The Panel is asked to note the work undertaken to date and support the delivery of the work programme.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 The delivery of the dementia work programme involves a range of commissioning and provider staff. The BaNES Dementia Care Pathway Group meets bi-monthly and the member organisations are requested to send representatives to this meeting.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 Following the publication of the National Dementia Strategy – *Living Well with Dementia* (NDS) in February 2009, the Prime Minister's Dementia Challenge was published in March 2012. The dementia work programme also contributes to the delivery of the following domains of the NHS Outcomes Framework:

1) Preventing people from dying prematurely
2) Enhancing quality of life for people with long term conditions
3) Helping people to recover from episodes of ill health or injury
4) Ensuring people have a positive experience of care
5) Treating and caring for people in a safe environment and protecting them from avoidable harm.

5 THE REPORT

Background

5.1 The Prime Minister's Dementia Challenge, published in March 2012 to build on the National Dementia Strategy, identified three key areas:

1) Driving further improvements in health and care including timely diagnosis and improved care in hospital and in the community;
2) Creating dementia friendly communities that understand how to help; and
3) Better research to improve treatments for people with dementia and if possible, prevent it from occurring in the first place or at least slowing it from progressing beyond a very early phase.

5.2 An annual report was published in May 2014 by the Department of Health setting out the progress made against the Prime Minister's Challenge and setting out the aims for the third and final year.

5.3 The key priority areas are continuing to support improvements to the number of people with dementia being diagnosed and receiving high quality post-diagnosis support; increasing the number of communities and sectors that are working towards becoming dementia-friendly; and focusing on progressing research in the fight against dementia.

5.4 As set out in the Joint Health & Wellbeing Strategy, improving services for people with dementia and their carers remains a priority for the CCG and the Health & Wellbeing Board.

Work Programme Update

5.5 Over the past 12 months, the dementia work programme has focused on the first area for action identified in the Dementia Challenge - driving improvements in health and care services. This can be further broken down to the delivery of:

- Improved dementia diagnosis rates.
- The mobilisation of the Dementia Support Worker service.
- The evaluation of the Dementia Challenge Fund Projects and future commissioning of these services.

Dementia Diagnosis Rates

5.6 The national focus on dementia diagnosis rates has continued throughout 2014/15 and NHS England, in parallel with the Prime Minister's Challenge on

Dementia, set the ambition that two thirds (67%) of the estimated number of people with dementia should have a diagnosis by 31st March 2015.

5.7 This target was chosen because nationally the number of people with a dementia diagnosis seemed low; there was significant variation across CCGs which could not be accounted for by the profile of the local population; and some areas were achieving this rate.

5.8 Although the dementia diagnosis rate in BaNES has been steadily increasing since 2010/11, it seemed unlikely from the outset that the 67% target would be met locally and therefore a local ambition of 60% was agreed.

5.9 Aside from general awareness raising, the following specific initiatives have been undertaken to increase the dementia diagnosis rate:

- Implementation of the Dementia Support Worker service. High quality support and information is essential for people with dementia and their carers but the service also gives health care professionals confidence that after diagnosis, the person can access information, advice and support which is tailored to their needs.
- Practice Support Pharmacists have been checking that all patients who are prescribed dementia drugs have the correct dementia code recorded in their medical notes.
- NHS England introduced an Enhanced Service to incentivise GP practices to increase their dementia diagnosis rate and produced two tools for practices to use to help identify patients who may have memory problems and would benefit from a review.
- Practices were asked to check that all patients diagnosed by the RICE memory assessment service were coded correctly.

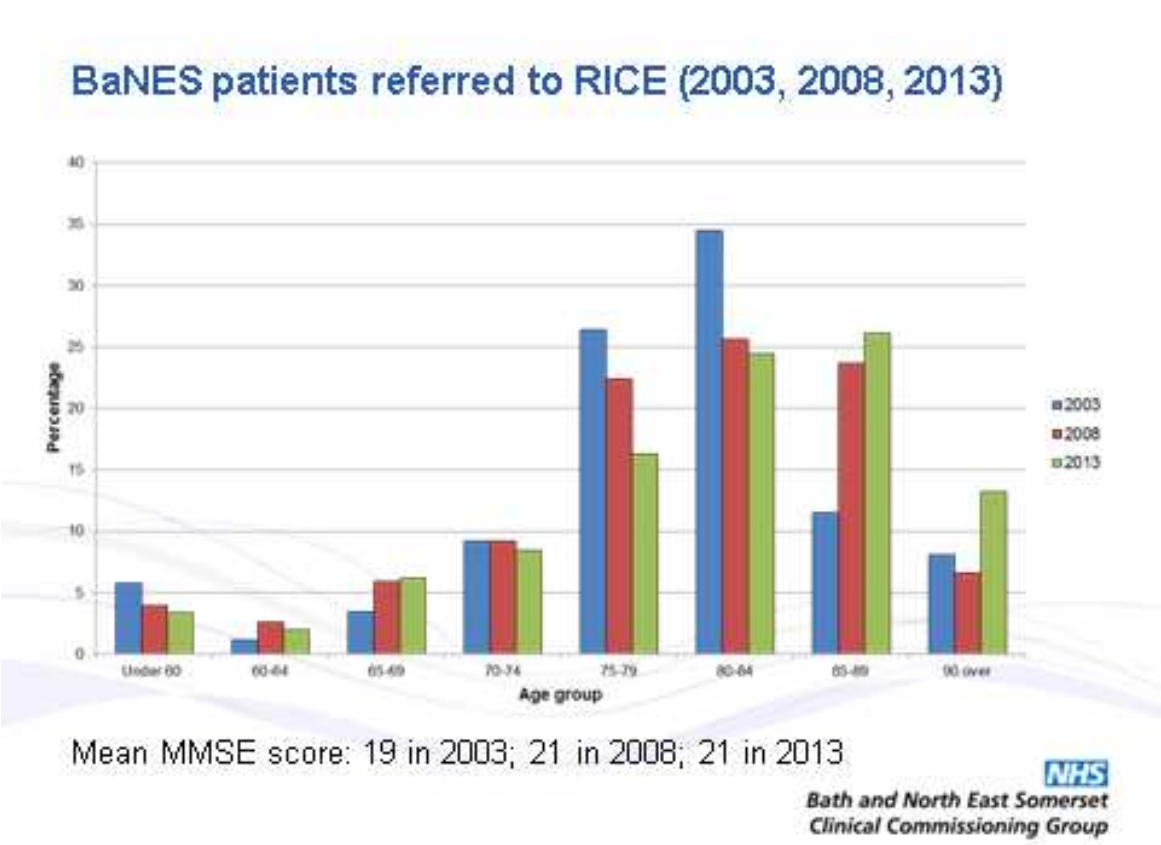
5.10 As at January 2015, the diagnosis rate in BaNES is 57.3% compared to 54.02% in the South of England.

5.11 Only one of the 50 CCG's in the South of England has achieved the 67% target and locally, despite best efforts to improve the diagnosis rate, there are three key reasons why the 67% target is unlikely to be achieved.

5.12 Firstly, the estimated prevalence may not be accurate. The number of people who are expected to have dementia is based on the 2007 Alzheimer's Society Dementia UK report which uses the Expert Delphi Consensus approach based on studies from 1986-1993 in a limited number of areas in the UK and not including any sites in the South West. No allowance has been made for the type of area (e.g. inner city, rural, small town) or any other health factors.

5.13 Secondly, most of the diagnosis rate increase over the last six months has been due to coding corrections and not new people diagnosed with the disease.

5.14 Thirdly, and most importantly, there has been a considerable increase in referrals to RICE over the past few years. This indicates a greater awareness of dementia but the number of new diagnoses is not increasing at the same rate as referrals. This is because over the last decade the patients presenting are older but their memory problems are considered milder as judged by the Mini Mental Score Examination and therefore they are not being diagnosed as having dementia. The chart below shows how the patient profile at RICE has changed.



5.15 The increase in older patients with milder memory problems may be due to the lower rates of smoking, obesity and diabetes than other areas of the country. It is known that smoking, obesity and diabetes are all risk factors for developing dementia and the table below shows that BaNES has significantly lower rates of smoking and diabetes than the England average and the obesity rate is lower than neighbouring areas.

Area	Smoking Prevalence (%)	Obese Adults (%)	Diabetes Rate (%)
England	19.5	23	6.0
Wiltshire	17.2#	22.3	5.4#
Swindon	21.5*	22.6	6.4*
South Glos	17.5	21.1	5.2#
N. Somerset	14.8	22.7	5.5#
Glos	17.5	22.9	6.1*
Bristol	21.3	23.8	4.7#
BaNES	16.7#	19.2	4.6#

#Significantly better than the England average
*Significantly worse than the England average

Source: Health Profile Statistics (2014)

Dementia Support Worker Service

5.16 The CCG commissioned the Dementia Support Worker Service as locally there was insufficient post-diagnostic support available. A restricted tender process was undertaken at the end of 2013 and the contract was awarded to the Alzheimer's Society. The service launched in February 2014 and four Dementia Support Workers plus a Befriending Manager are employed across BaNES.

5.17 The service offers personalised information, support and advice to people with dementia and their carers and helps people to develop a support plan in accordance with their needs. A Dementia Support Worker is regularly based at RICE in order to provide support to the people attending the memory assessment clinics.

5.18 People are able to self refer to the service and a wide range of health and social care professionals are referring into the service as well. Referrals continue to increase and the results of a recent service user and carer survey have been positive.

Dementia Challenge Fund Projects

5.19 The NHS South of England Dementia Challenge Fund was launched in 2012 to provide funding for pilot projects for 12 months. Three of the five bids were successful and although the other two were not successful, the CCG recognised the value of implementing them and therefore agreed to fund them on a 12 month non-recurring basis. The five projects are as follows:

1) *Avon & Wiltshire Mental Health Partnership Trust (AWP): Care Home Support & Assessment Service*

- The provision of advice, education, training and information to care home staff and carers on how they can support people with dementia.

2) *The Carers' Centre & Age UK B&NES: Home from Hospital*

- The provision of a Discharge Liaison Co-ordinator to support people with dementia when returning home following a hospital admission.

3) *Curo: Rural Independent Living Support Service*

- The provision of a rural dementia co-ordinator to help people in rural areas to receive a timely diagnosis of dementia and access appropriate information and support post-diagnosis to help maintain their independence.

4) *RUH CQUIN PLUS: Integrating Hospital & Community Care Pathways*

- The provision of dementia co-ordinators on the wards to improve the pathway between hospital and community services as well as the expansion of the mental health liaison service.

5) *Sirona Care & Health: Memory Technology*

- The provision of memory technology (e.g. orientation clocks, talking tiles) to support people with dementia to maintain their independence.

5.20 Following a review in Autumn 2013, the CCG found that it was difficult to evidence the success of the projects after only six months but concluded that all seemed beneficial and agreed a further 12 months funding from April 2014 to March 2015. A second evaluation of the five projects was concluded in October 2014 and found that there was strong evidence demonstrating the positive impact of three of the projects. Consequently, the CCG has agreed to fund these projects on a recurrent basis. These projects are:

- AWP: Care Home Support & Assessment Service
- The Carers' Centre & Age UK B&NES: Home from Hospital
- Curo: Rural Independent Living Support Service

5.21 With regard to the other two projects, the RUH CQUIN Plus demonstrated some positive impact but not all targets were achieved. The reasons for this are unclear but given that the project has achieved several of the performance measures, including fewer ward moves and increased mental health liaison so 90% of patients are receiving mental health reviews within 24 hours, the CCG has approved funding for a further 12 months funding and a further evaluation will take place.

5.22 The Memory Technology project which is part of the telecare service provided by Sirona was found to be underutilised and therefore no further funding was approved by the CCG for 2015/16. However, the project had a small budget underspend and the CCG has agreed that Sirona can carry this funding forward to enable the telecare service to continue to support people living with memory loss and dementia.

Other Work

5.23 In addition to the above three areas of focus, there are many community groups to support people with dementia and their carers such as Singing for the Brain, Memory Cafes and the Peggy Dodd Day Centre. Guideposts Trust also continue to host the 'Dementia Web' website which provides a range of information and produce the BaNES specific 'Information Prescription'.

5.24 Although the dementia work programme in BaNES has focused on making improvements to health care services over the last 12 months, work on the other two areas for action – building dementia friendly communities and increased research – has progressed.

5.25 A Dementia Friendly Community is one that shows a high level of public awareness and understanding so that people with dementia and their carers are encouraged to seek help and are supported by their community. The Dementia Friends campaign was launched in May 2014 to support the development of dementia friendly communities and the Dementia Friends sessions aim to raise awareness of dementia and improve attitudes towards the condition in order to create a more dementia friendly society. Dementia Friends sessions have been made available for CCG and Council staff based at St Martin's Hospital and Sainsburys (Odd Down) supermarket. Sessions are also planned for staff working in the Council's 'One Stop Shop' and libraries and material has recently been developed nationally to facilitate the delivery of the sessions in schools. The Alzheimer's Society and BaNES Carers Centre are also working with Radstock Town Council to help Radstock become a dementia friendly community.

5.26 With regard to dementia research, BaNES is involved in a six centre research trial 'Goal-Oriented Cognitive Rehabilitation in Early-Stake Alzheimer's Disease' (GREAT) which is being led by RICE. This is a multi-centre single-blind randomised controlled trial which will involve mild dementia patients being recruited and randomised to a cognitive rehabilitation therapy or not with the aim of establishing whether cognitive rehabilitation is successful. The trial is due to end in summer 2016.

Next Steps

5.27 The BaNES Dementia Care Pathway Group will continue to meet on a bi-monthly basis to deliver a work programme which focuses on:

- Better information for people with dementia & their carers
- Improving diagnosis rates
- Improving post-diagnostic support in the community
- Support the development of dementia friendly communities
- Improving care in hospitals
- Improving standards in care homes & domiciliary care
- Supporting people with dementia at end of life

6 RATIONALE FOR RECOMMENDATIONS

6.1 The Health and Wellbeing Policy Development and Scrutiny Panel is receiving this update because the dementia care work programme sits within theme two (Improving the quality of people's lives) of the Joint Health and Wellbeing Strategy, linking to priority seven (Enhanced quality of life for people with dementia).

7 OTHER OPTIONS CONSIDERED

7.1 Not Applicable

8 CONSULTATION

8.1 This report was prepared by the CCG's Commissioning Manager for Long Term Conditions but the member organisations of the BaNES Dementia Care Pathway Group are involved in the delivery of the dementia work programme.

9 RISK MANAGEMENT

9.1 This work programme is managed in line with the CCG's risk management guidance.

Contact person	*Laura Marsh (Tel: 01225 831897)*
Background papers	*None*
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council		
MEETING:	**Wellbeing Policy Development and Scrutiny Panel**	
MEETING DATE:	13th March 2015	**AGENDA ITEM NUMBER**
TITLE:	Update on – NHS 111 Service	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
attachments to this report: Appendix 1: Briefing Paper Appendix 2 : Table showing Summary of Performance for April – August 2014		

1. THE ISSUE

1.1. To update Well-being & Policy Development panel members on the performance of the NHS 111 Service in the Bath & North East Somerset area.

1.2. Panel members received two briefings in 2014. The last briefing reported on progress to improve performance, as well as a range of proposed developments. This briefing paper describes progress made, performance over the winter and how service performance continues to be monitored closely to ensure that it meets the needs of local people.

2. RECOMMENDATION

2.1. Panel members are asked to note the latest performance of the NHS 111 service.

3. FINANCIAL IMPLICATIONS

3.1. None to note as part of this briefing paper.

4. THE REPORT

4.1. The attached report summarises performance and progress to date.

5. RISK MANAGEMENT

5.1. Risk management processes and systems remain in place as part of the NHS 111 governance arrangements to monitor the effectiveness of the service.

5.2. Information on complaints, incidents and feedback from healthcare professionals is collated and reviewed by Care UK and shared with the CCG's Clinical

Governance Lead for NHS 111, Dr Liz Hersch, and with the CCG's Quality Team.

5.3. Commissioners across Avon, Gloucester, Swindon, BaNES and Wiltshire recently reviewed processes for on-going monitoring of the service. We have developed integrated performance and quality monitoring of the service which continues on a monthly basis. Additional assurances are sought by commissioners at anticipated busy times, e.g. Christmas, Easter.

6. EQUALITIES

6.1. An in-depth equality impact assessment was completed by BaNES PCT and commissioning team as part of the process to develop the specification for the 111 Service. The service will continue to be monitored in respect of its impact on different groups of patients.

7. CONSULTATION

7.1. Care UK has been consulted in advance of the presentation of this paper.

8. ISSUES TO CONSIDER IN REACHING THE DECISION

8.1. Not applicable to this report.

9. ADVICE SOUGHT

9.1. Not applicable to this report.

Contact person	*Tracey Cox, Chief Officer B&NES Clinical Commissioning Group. Telephone 01225 831736* *Email : traceycox@nhs.net* *Dr. Elizabeth Hersch, GP and 111 Clinical Governance Lead for B&NES & Wiltshire CCGs.* *Catherine Phillips, Commissioning Manager and Author* *Email: Catherine.phillips4@nhs.net*
Background papers	*None*
Please contact the report author if you need to access this report in an alternative format	

Appendix 1

Briefing Paper – NHS 111 Services in B&NES

1.0 Introduction

The objective of the NHS 111 service is to support the delivery of urgent and emergency care by directing patients to the right service first time with clinical assessment and referral ideally taking place within the same telephone call.

2.0 NHS 111: Current position in BaNES

Although the service experienced a challenging start in February 2013, the development of a rectification plan facilitated steady progress and ultimately, full service commencement in October 2013.

The service continues to experience challenges around recruitment and retention of call handlers and Clinical Advisers which contributes to:

- Delays in call handling
- Higher than necessary ambulance dispatch rate
- Delays in warm transfer (i.e. transfer directly from the original call handler to a clinical advisor) and call back.

Commissioners and Care UK recognise the importance of having experienced and skilled staff to be able to address many of these issues. Care UK is implementing a programme of work to ensure that they recruit and retain the right people and make best use of their skills and time. It is anticipated that this transformation programme will start to have a greater impact during the first quarter of 2015/16.

The programme will help Care UK to fill shifts to facilitate better matching of capacity to call volume forecasting to ensure that the Key Performance Indicators set within the contract are met at all times. Commissioners are working with Care UK to focus these measures, particularly at weekends when call volumes are substantially higher than weekdays.

2.1 NHS 111 monitoring in BaNES

Monthly integrated quality and performance board meetings take place between commissioners and Care UK to monitor progress and outcomes. Additional assurances are sought by commissioners at anticipated busy times, e.g. Christmas, Easter.

The CCG receives daily progress reports against the targets and **Appendix 2** shows performance for the period August 2014 – January 2015 inclusive. The graphs demonstrate an increasing use of the NHS 111 service overall, with distinct peaks at weekends and bank holidays. The graphs depict only BaNES and Wiltshire service usage, but of note is also the total volume of calls received by the call centre. For example, on 27th December, one of the entire Urgent Care System's busiest days,

1196 calls related to BaNES and Wiltshire residents, a 538% variance on the same day last year for our area. The call centre received 7778 calls from across the area, 78% higher than predicted call volumes, despite weekly re-profiling of demand forecasts.

The graphs in Appendix 2 also demonstrate that the service has struggled to match capacity with some of the peaks in demand, resulting in patients waiting longer for their call to be answered and for calls to be returned. Despite the increase in overall call numbers, the service maintained its average disposition rates for ambulance dispatch and referral to Emergency Departments throughout the winter; the difference depicted is between weekends and weekdays.

2.2 Clinical Governance

In addition to performance information, the Integrated Quality and Performance Board meeting receives details about clinical effectiveness, patient safety and patient experience. The monthly report provides updates on call audits carried out, number of complaints and incidents, and feedback from health care professionals as well as other reports e.g. Safeguarding Adults and Children.

All front line staff has 5 of their calls audited each month and feedback is given individually with further training and support as required. Calls audited show strengths of listening, negotiation, professionalism and call control. Further work is required on the skills of asking probing questions to better understand the patient's needs.

A total of 6 complaints were received by the provider from August 2014 to January 2015 (BaNES and Wiltshire combined). Within this period, 84,968 calls were answered by Care UK for BaNES and Wiltshire. Themes included incorrect phone numbers being taken from patients, lack of dental provision and misunderstanding about referral to other services e.g. GP Out of Hours and GP surgeries. There is evidence that the investigations of complaints and incidents are being managed and reported through the monthly quality reports. Commissioners and Quality colleagues continue to seek assurances around the implementation of lessons learned from the complaints process.

3.0 Developments

Currently the service is commissioned locally but to a national specification to ensure a consistent approach to quality across the country. The service is provided across Bristol, North Somerset, South Gloucestershire, Gloucestershire, Swindon, Wiltshire and BaNES by Care UK and commissioners work collaboratively to monitor the service.

3.1 In the last report, a number of developments were identified. Updates on progress are provided here:

3.2 Special Patient Notes (SPNs) provide specific information relevant to a patient with complex health and/or social care needs e.g. patients on the End of Life Care Register. They are visible to GPs in both in- and out- of hours settings, as well as NHS 111, amongst others. Access to good quality SPNs is vital for NHS 111 and GP Out of Hours, to provide the call handler or clinician with knowledge and additional information specific to the patient to facilitate making an informed decision about treatment.

BaNES CCG is actively working with GPs to improve the quality and completeness of SPNs during this financial year and is aiming to further develop the range of conditions for which SPNs might be used to communicate appropriate actions for out of hours services from April 2015.

3.4 Directory of Services (DoS)
The DOS is the application which holds information that describes the services, care or referral available to the patient following an assessment by NHS 111.

BaNES and Wiltshire CCGs now share a full time DOS lead, who is responsible for updating entries on the DOS and profiling new services so that they can be referred to by NHS 111. This will make a difference to the efficiency of the call centre, as well as experience of the patient who is more likely to get sent to the right service at the right time.

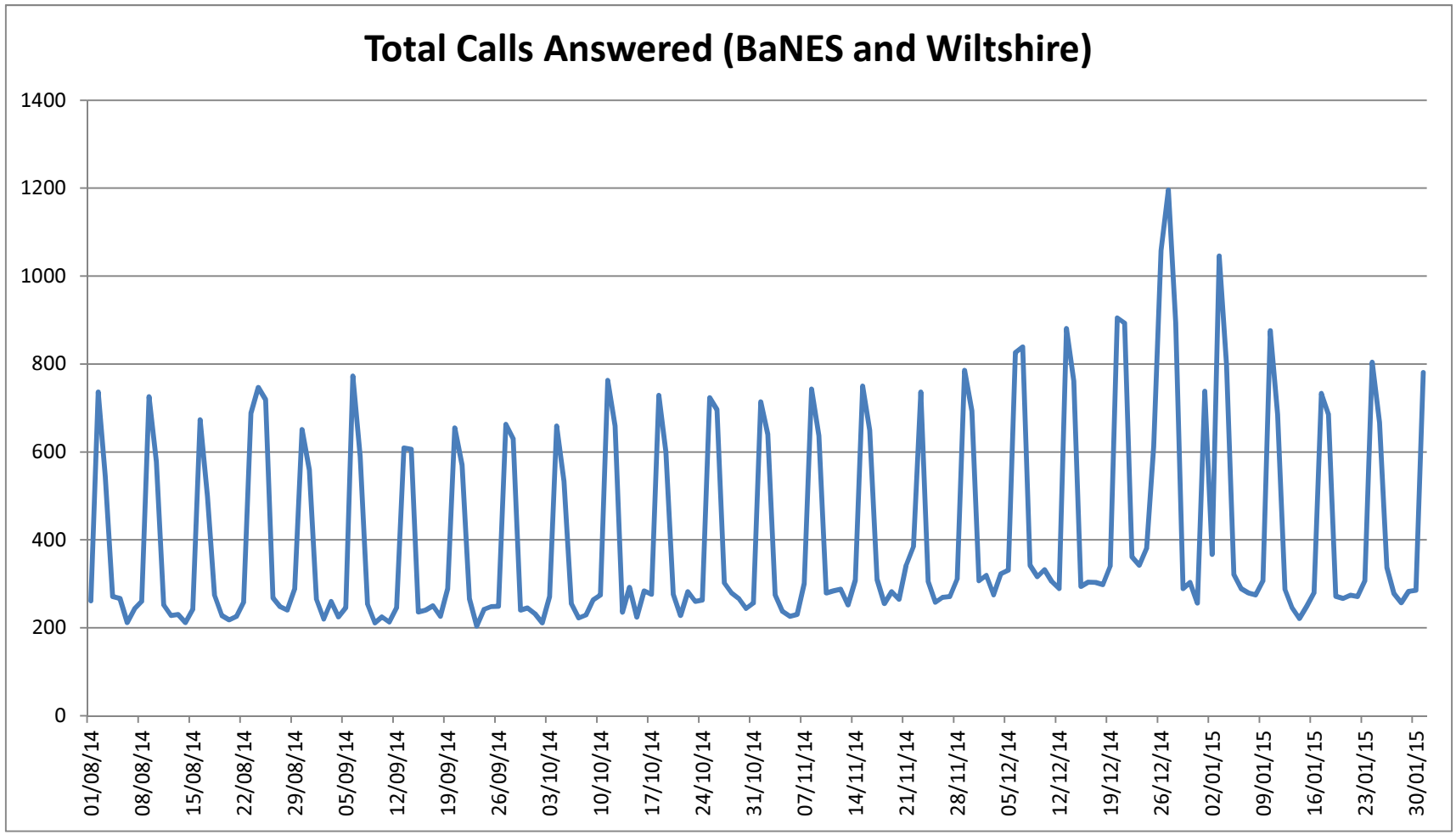
3.6 Contingency Arrangements: Health Care Professionals Line
In March 2013, a contingency process was put in place for health care professionals needing access to the NHS 111 service as part of managing a patient's care pathway.

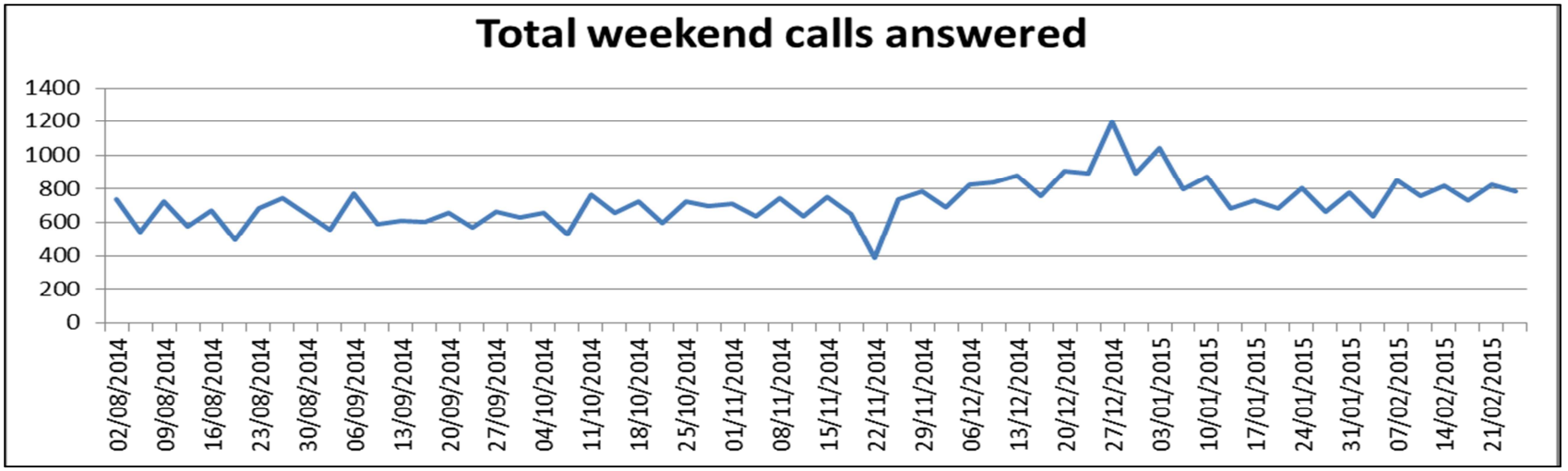
A contractual arrangement remains in place with the GP Out of Hours service to provide the "HCP line", currently continuing until March 2016.

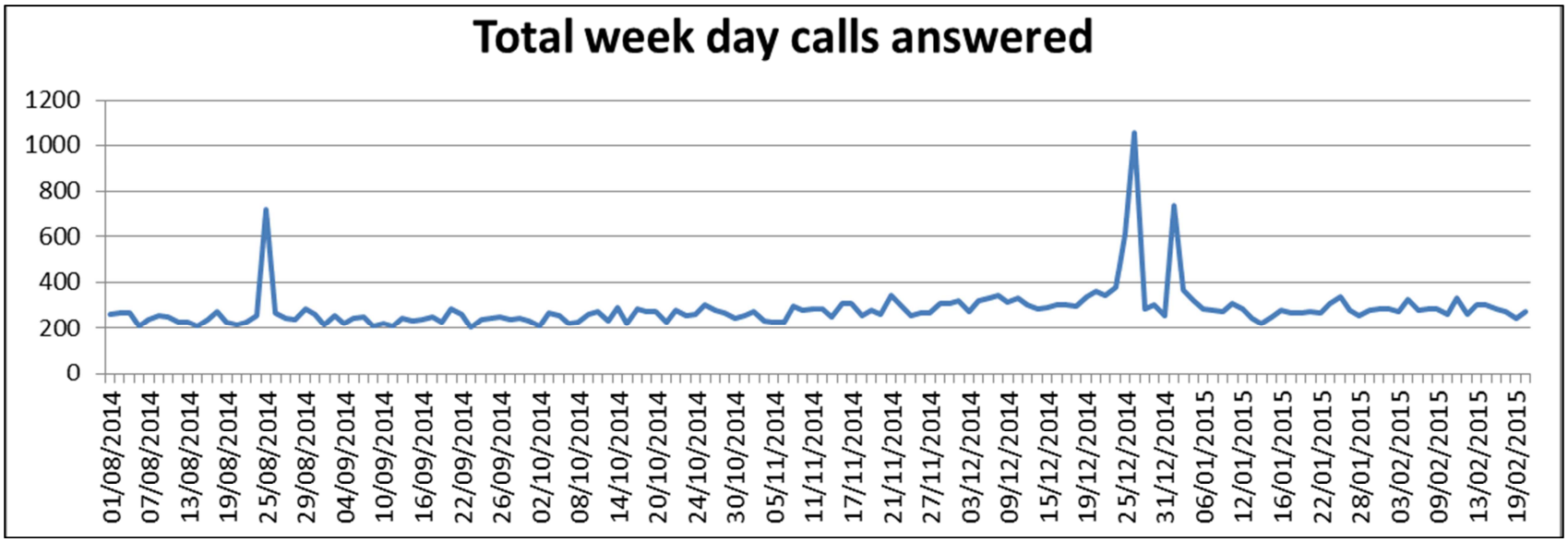
4. On-going reporting to the Well-being & Policy Development Panel
Panel members are asked to confirm whether any further updates on the progress of the NHS 111 service are required at a future date.

Appendix 2

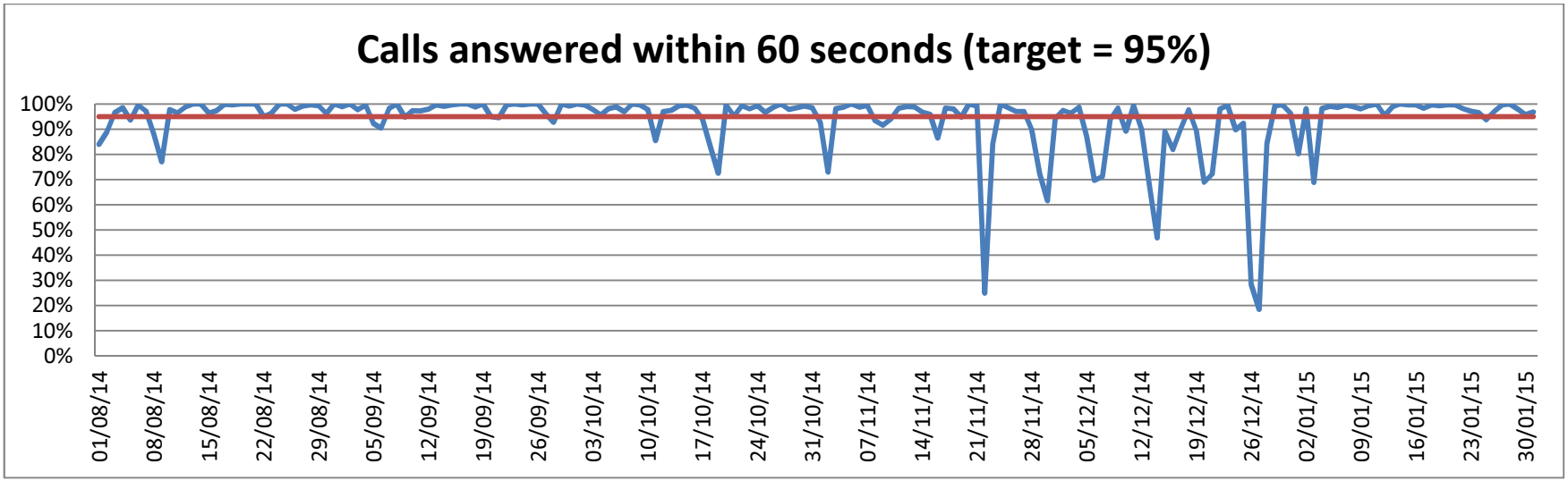
Performance against targets for August 2014 – January 2015 (Source: NHS BaNES and NHS Wiltshire Dashboard, compiled from DailySitReps).







* Peaks depict bank holidays


Calls answered within 60 seconds (target = 95%)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
01/08/14
08/08/14
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22/08/14
29/08/14
05/09/14
12/09/14
19/09/14
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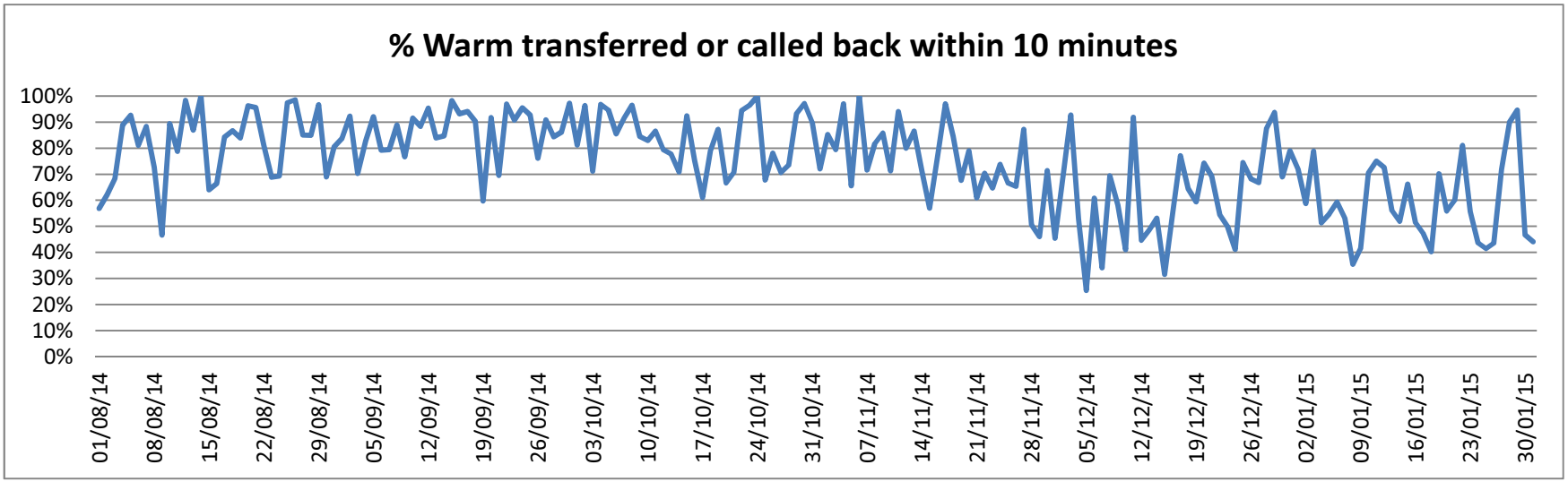
% Warm transferred or called back within 10 minutes
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
01/08/14
08/08/14
15/08/14
22/08/14
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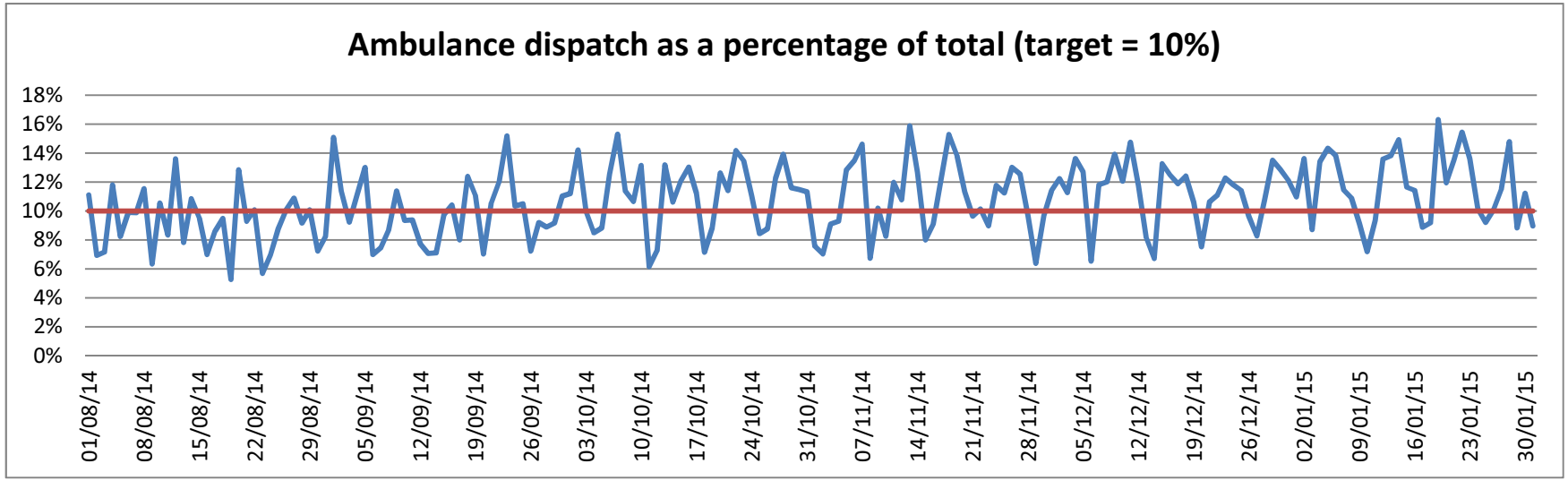
Ambulance dispatch as a percentage of total (target = 10%)
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
01/08/14
08/08/14
15/08/14
22/08/14
29/08/14
05/09/14
12/09/14
19/09/14
26/09/14
03/10/14
10/10/14
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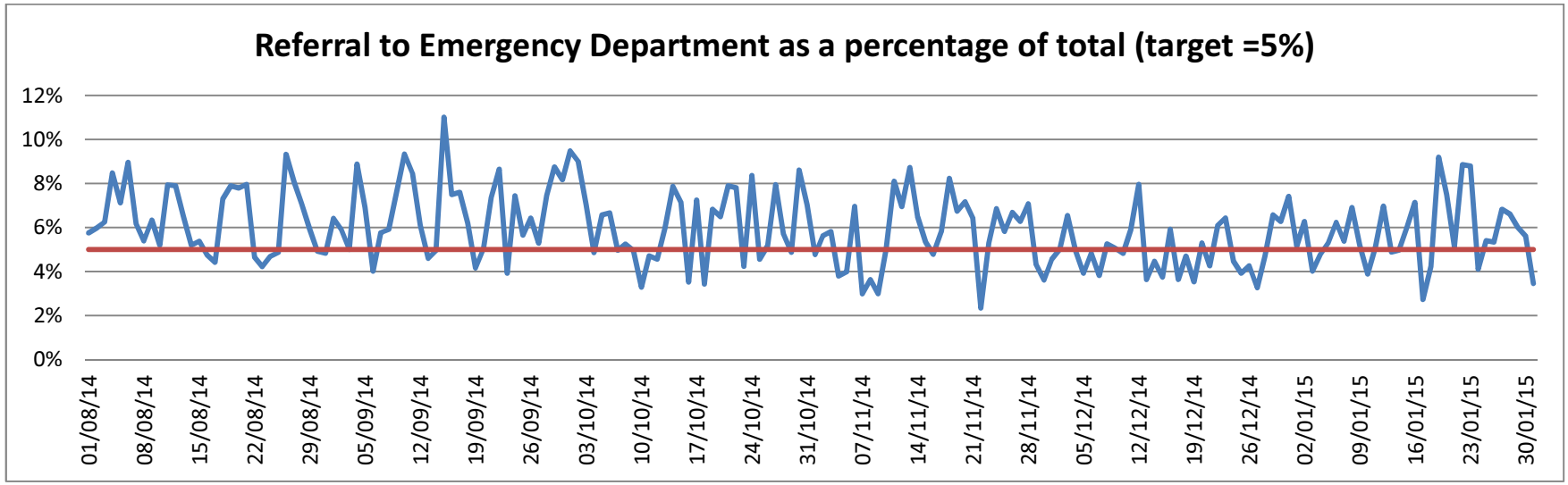
Referral to Emergency Department as a percentage of total (target =5%)
12%
10%
8%
6%
4%
2%
0%
01/08/14
08/08/14
15/08/14
22/08/14
29/08/14
05/09/14
12/09/14
19/09/14
26/09/14
03/10/14
10/10/14
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16/01/15
23/01/15
30/01/15

Bath & North East Somerset Council			
MEETING:	**Wellbeing Policy Development and Scrutiny Panel**		
MEETING DATE:	13th March 2015	**AGENDA ITEM NUMBER**	
TITLE:	Update on – Non Emergency Patient Transport Service		
WARD:	ALL		
AN OPEN PUBLIC ITEM			
attachments to this report: Appendix 1: Briefing Paper Appendix 2: Tables showing Summaries of call volumes and performance for December 2014 and January 2015.			

1. THE ISSUE

1.1. To update Well-being Policy Development and Scrutiny Panel members on the performance of the Non-Emergency Patient Transport Service in the Bath & North East Somerset area.

1.2. Panel members received briefings in March 2014, July 2014 and September 2014. The first set of reports set out the challenges being experienced during the mobilisation of the new single provider of this service within the first year of the contract. This briefing explains the progress being made with the service delivery of this contract and explains the actions being introduced within the contract to ensure this service meets the needs of the patients of BaNES.

2. RECOMMENDATION

2.1. Panel members are asked to note the agreed actions and the latest performance of the Non-Emergency Patient Transport Service.

3. FINANCIAL IMPLICATIONS

3.1 The Non-Emergency Patient Transport Service contract allows for a review of activity and costs at the end of the end of the first year of operation or if activity reaches a specific level in line with this process the contract value is being uplifted by agreement between the CCGs and ATSL.

4. THE REPORT

4.1. The attached report summarises the ongoing issues, the actions taken and the performance to date.

5. RISK MANAGEMENT

5.1. Strong collective risk management processes are in place and monitored by the combined commissioners to support and improve the effectiveness of the service. The key risk to this service is delays in responding to and moving patients within the agreed timeframes.

5.2. Incidents, complaints and feedback from healthcare professionals are collated monthly and formally reviewed by the BaNES, Gloucester, Swindon and Wiltshire (BGSW) Clinical Quality Review Group meeting on a monthly basis.

6. EQUALITIES

6.1. Quality impact assessments have been completed within the collaborative commissioning approach to developing the new Non-Emergency Patient Transport Service Contract specification. The service continues to be monitored to review its impact on all groups of patients.

7. CONSULTATION

7.1. As stated within the report.

8. ISSUES TO CONSIDER IN REACHING THE DECISION

8.1. Not applicable to this report.

9. ADVICE SOUGHT

9.1. Not applicable to this report.

Contact person	*Tracey Cox, Chief Officer B&NES Clinical Commissioning Group. Telephone 01225 831736* *Email : traceycox@nhs.net* *Dominic Morgan, Urgent Care Programme Lead BaNES Commissioning Manager* *Email: dominic.morgan1@nhs.net*
Background papers	*None*
Please contact the report author if you need to access this report in an alternative format	

Appendix 1

Report on Arriva Transport Solutions Ltd Non-Emergency Patient Services For The Wellbeing Policy Development & Scrutiny Panel, Friday 13th March 2015.

1. Introduction

This report builds on those provided to the panel in March 2014, July 2014 and September 2014. The panel asked for a further update as we approach the end of the winter period.

2. Non-Emergency Patient Transport Service Current position in B&NES

Arriva Transport Solutions Ltd (ATSL) was awarded contracts by Bath and North East Somerset (BaNES), Gloucestershire, Swindon and Wiltshire CCGs for non-emergency patient transport in summer 2013; the service went live on 1 December 2013. The NHS-funded Non-Emergency Patient Transport Service (NEPTS) is for those who, due to their mobility or medical needs, cannot travel safely by any other means.

During the first 14 months of the ATSL contract there have been a number of challenges involved in the provision of a NEPTS service to patients across four CCG areas; patients attending four acute trusts within the CCG boundaries and a number of significant patient flows to acute trusts outside the CCG boundaries. The contract replaced a multitude of bespoke service arrangements that had developed over time within the different acute trusts. A significant challenge has been the misalignment of predicted versus actual activity and mobility profiles.

3. Monitoring

Governance, arrangements are now well established.

Contract Performance Boards continue monthly with key risks and issues escalated as appropriate. Performance and activity data is provided by ATSL monthly, by CCG. Additional ad hoc reports are provided on request by the CCG analytics team and ATSL.

CCG Quality leads meet bi-monthly, with commissioning leads and ATSL to review relevant issues. The ATSL Quality Report provides a summary of quality information relating to the delivery of the non-emergency patient transport service across the four CCG areas. A separate Patient Experience Report is produced to sit alongside the Quality Report.

The following are reported as standard bi-monthly:

- Workforce/staffing including sickness and turnover and agency and third party usage
- Training schedules and mandatory training compliance

- Incidents including monthly trend analysis, patient safety and any harm identified, identified actions and learning
- Actions and learning from Serious Incidents
- Infection control including vehicle deep cleaning
- Any Care Quality Commission visits and recommendations
- Safeguarding referrals

The report has been developed along with ATSL and is kept under review. For clarity, any serious incidents are reviewed in real time and the learning from them is shared at these meetings.

ATSL locality managers are based at, and work closely with each hospital trust to address issues and an Arriva escalation process enables healthcare staff to escalate issues as required.

ATSL managers regularly join the daily Strategic Teleconference calls in BaNES to provide information regarding ATSL activity.

Transport Working Groups (led jointly by ATSL and the RUH) meet regularly to address local issues. Specific acute-trust/community hospital level monthly dashboards are in place, which allow the hospital trusts to review their own performance in relation to the booking of transport e.g. the number of bookings made in advance vs. number made on the day, number of aborted journeys by ward/dept. etc. Lead commissioners engage directly with respective hospital trusts to help to address issues.

4. Contractual Developments

Currently the four CCGs who contract with ATSL are in the process of contract rebasing negotiations. This will result in a re-based contract, which will enable the core service to better match known demand; and the cessation of non-recurrent monthly top-up funding, currently used to purchase additional third party resource.

Included within the rebasing are amended contract penalties and incentives for the Key Performance Indicators (KPIs). This will reinforce the focus on the main KPIs which relate to the timeliness of service delivery for both inbound and outbound journeys and a particular focus on the longest-wait journeys. Incentives will also apply to other patient experience measures.

5. Other Developments

ATSL has continued to work with commissioners and acute and community healthcare providers to put in place a number of improvements, including:

- A further roster review to continue to better match resource to demand.

- A mapping of renal dialysis journeys to identify opportunities to reduce travelling distance for some patients and consolidation of journeys for others. There are patients who are transported past one or more dialysis units in order to attend a more distant unit. It is believed this is likely to be at least in

part a consequence of dialysis unit capacity at the time the patient initiates dialysis. There are other cases where dialysis patients travel to/from similar destinations at different times, where possible synchronisation would enable more efficient use of transport resources. The findings are to be shared with renal dialysis service providers to seek opportunities to reduce patient travelling time consistent with patient needs, patient choice, and the operational delivery of the dialysis service.

- Embedding the new in-house complaints team; enabling a better focus on complaint investigation resolution and timeliness.

- A proposed revision to details of how the eligibility question assessment is conducted, which is currently being considered by commissioners.

- A revised internal escalation process to minimise longest wait journeys.

- The provision of a more comprehensive data suite for acute trust transport working groups, enabling trends to be identified and corrective actions to be better targeted.

- Flexible resourcing to enable known variations in demand to be accommodated e.g. over bank holiday weekends or periods of surge.

- Additional communications materials including myth-busting for acute trust staff; a tri-fold information card for patients; a revised script for call handlers to signpost to other services for patients not eligible for the NHS-funded service.

- Weekly escalation of trends, themes and issues to ATSL Locality managers for addressing locally at acute trust level.

6. Next Steps

The RUH has formally notified BaNES and Wiltshire CCG that the current service specification – although developed with their input – may no longer fully reflect the needs of the acute care setting, particularly with regard to the time delay for the on-day element of service (even though in the pre-ATSL scenario, the CCG did not fund any same-day service). After completion of the contract rebasing a further piece of work will be carried out to identify how better to meet acute trusts' needs while remaining within the limits of affordability.

Further work will continue jointly involving ATSL, CCGs, and the RUH to ensure continuous service improvement, particularly in response to lessons learned from complaints and incidents; actions identified at contract review meetings; actions identified at transport working groups; feedback from Healthwatch and other stakeholders. CCG Quality Team staff are now fully embedded within the routine contract management process, ensuring a continuing focus on service quality and patient safety and experience.

7. Conclusion

The introduction of the ATSL NEPTS service has been and remains challenging, but much work has been done to place this service on the right footing and to ensure the right level of resourcing. Operational oversight continues to ensure the service reaches a level where it consistently achieves the required standards. We are assured that ATSL in collaboration between the four CCGs and transport users within the health community are committed to make the necessary improvements.

Appendix 2

Journey volumes and performance against the main contract Key Performance Indicators (KPIs) for December 2014 & January 2015 (Source: Central Southern Commissioning Support Unit – PTS Monthly Reports) and complaints.

Journey Volumes

Contract Year 1

Number of booked Journeys by direction of travel

Direction	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
Inward	1468	1559	1254	1264	1258	1316	1195	1292	1279	1351	1370	1200	15806
Outward	1723	1872	1510	1554	1529	1615	1520	1604	1553	1680	1697	1503	19360
Total	**3191**	**3431**	**2764**	**2818**	**2787**	**2931**	**2715**	**2896**	**2832**	**3031**	**3067**	**2703**	**35166**

Contract Year 2

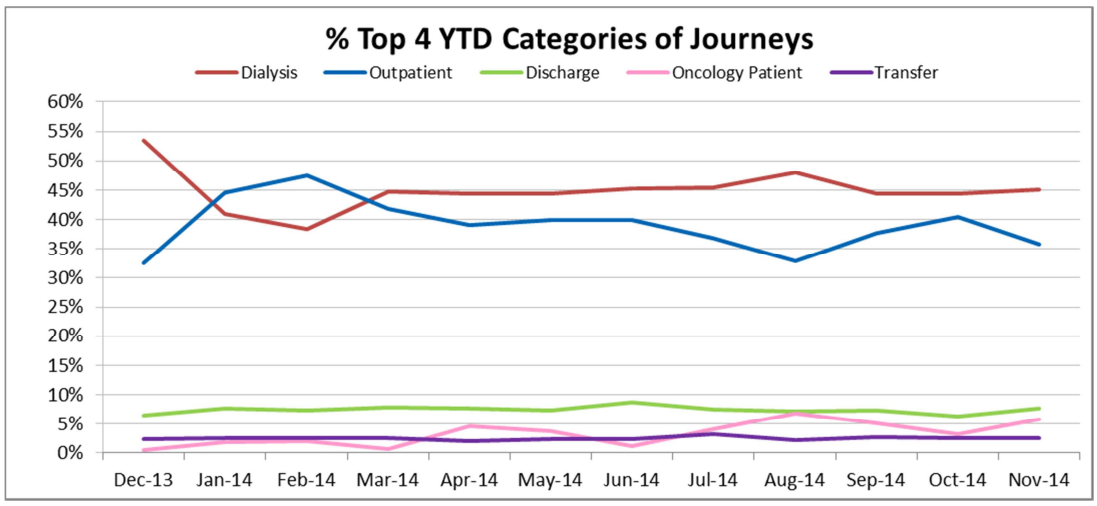
Number of booked Journeys by direction of travel

Direction	Dec-14	Jan-15	YTD
Inward	1388	1241	18435
Outward	1731	1599	22690
Total	**3119**	**2840**	**41125**

Category of Journeys

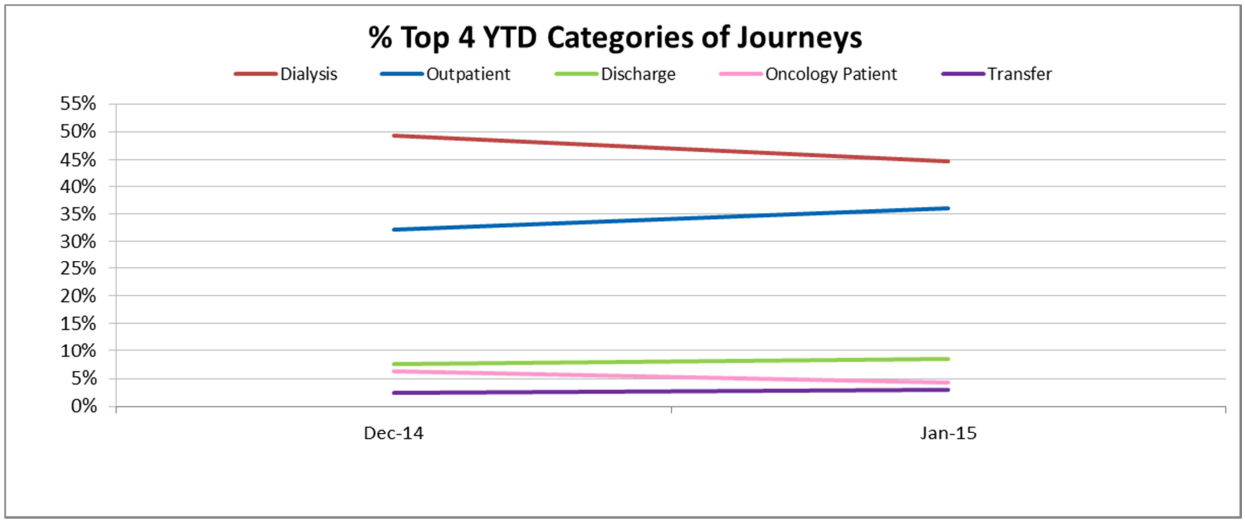
Category of Journey - Percentage of Total Journeys

Category	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
Dialysis	53.46%	40.86%	38.39%	44.68%	44.42%	44.39%	45.30%	45.44%	47.99%	44.34%	44.44%	45.02%	44.92%
Outpatient	32.62%	44.54%	47.50%	41.84%	39.15%	39.95%	40.00%	36.88%	32.91%	37.71%	40.37%	35.81%	39.12%
Discharge	6.58%	7.75%	7.34%	7.81%	7.71%	7.44%	8.77%	7.56%	7.20%	7.42%	6.39%	7.66%	7.45%
Oncology Patient	0.50%	1.89%	2.03%	0.75%	4.63%	3.75%	1.10%	4.18%	6.81%	5.15%	3.33%	5.81%	3.29%
Transfer	2.41%	2.48%	2.53%	2.59%	2.01%	2.46%	2.32%	3.18%	2.22%	2.74%	2.64%	2.55%	2.51%



Category of Journey - Percentage of Total Journeys

Category	Dec-14	Jan-15	YTD
Dialysis	49.44%	44.68%	45.24%
Outpatient	32.13%	36.09%	38.38%
Discharge	7.66%	8.49%	7.54%
Oncology Patient	6.22%	4.23%	3.57%
Transfer	2.44%	3.03%	2.54%



Key Performance Indicators

Key performance indicators (KPIs) are as follows:

PTS01 – Patients travelling less than 10 miles should not spend more than 60 minutes on any one journey.

PTS02 – Patients travelling between 10 and 35 miles should not spend more than 90 minutes on any one journey.

PTS03 – Patients travelling between 35 and 50 miles should not spend more than 120 minutes on any one journey.

PTS04 – Arrival within 45 minutes before or within 15 minutes after scheduled appointment time.

PTS05 – Patients should not wait more than 60 minutes for their outbound journey (Where booked at least a day in advance) from the point of booked ready by the HCP.

PTS06 – Patients will be collected within four hours where booked on the day (within two hours for end of life).

Current KPI Performance

BaNES Yearly KPI Performance (13 months Dec 13 to Jan 15)

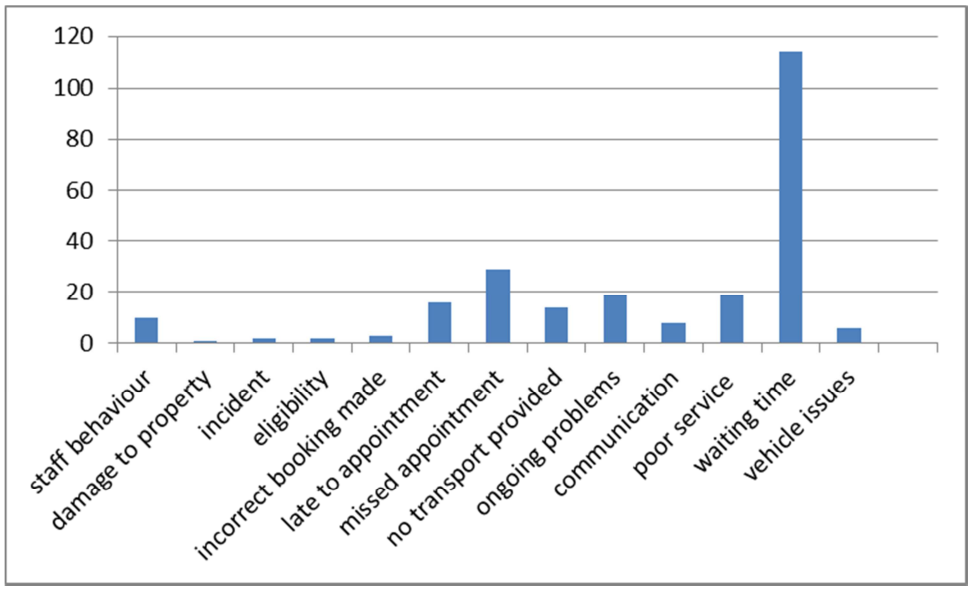
KPI Description	KPI No.	Target	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
<10 miles < 60 minutes on vehicle	PTS01	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
BaNES CCG			94.34%	92.64%	93.12%	94.87%	95.07%	95.66%	94.28%	95.01%	94.73%	94.56%	94.81%	94.69%	95.09%	94.35%
10 - 35 miles < 90 mins on vehicle	PTS02	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
BaNES CCG			93.81%	89.02%	89.12%	93.93%	94.61%	92.15%	90.21%	93.67%	93.25%	94.42%	93.28%	93.82%	93.91%	92.75%
35 - 50 miles < 120 mins on vehicle	PTS03	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
BaNES CCG			100.00%	80.00%	--	80.00%	--	50.00%	100.00%	100.00%	100.00%	66.67%	--	80.00%	--	100.00%
On time arrival -45 > + 15 mins	PTS04	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
BaNES CCG			62.92%	57.28%	68.79%	82.32%	83.62%	78.57%	76.83%	80.11%	82.32%	77.30%	80.14%	77.80%	77.56%	78.55%
60 minute pick up (planned)	PTS05	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
BaNES CCG			64.23%	51.66%	65.24%	75.65%	77.43%	76.76%	71.88%	75.69%	76.75%	70.44%	72.92%	70.92%	74.28%	73.81%
4 hour pick up (on the day)	PTS06	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
BaNES CCG			79.75%	93.75%	90.83%	87.41%	89.19%	87.58%	84.71%	91.86%	90.73%	79.17%	75.63%	77.78%	79.47%	86.72%

Complaints

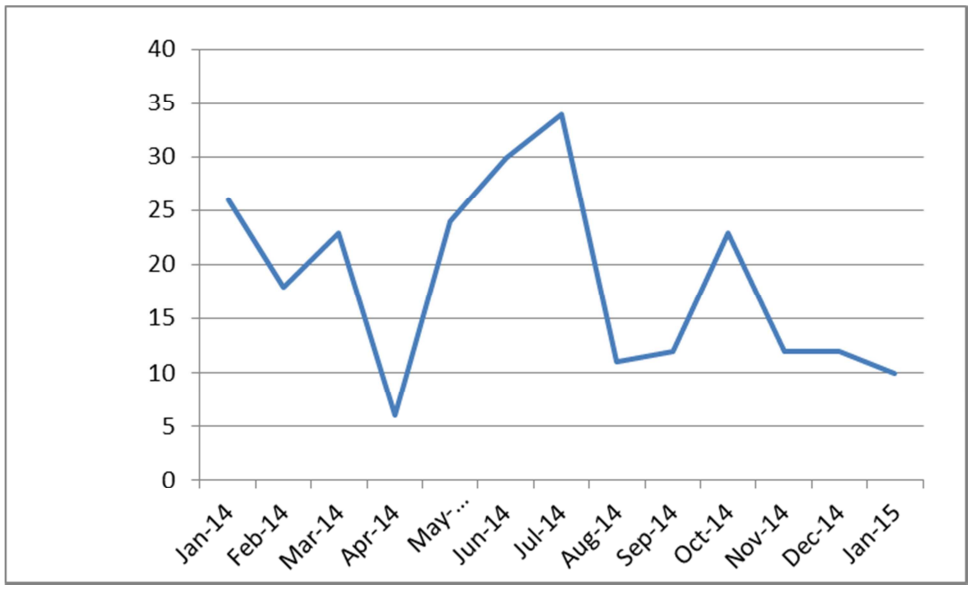
The numbers of complaints have been reducing across the first year of the service and ATSL are continuing to demonstrate the importance they place upon resolving issues and complaints. ATSL has implemented their new complaints process and continue to show their commitment to resolve issues as swiftly as possible and have invested in their customer care team to improve experiences.

Despite these efforts we continue to see the main complaints centred on poor waiting times, followed by late or missed appointments.

Complaint Reason	No
staff behaviour	10
damage to property	1
incident	2
eligibility	2
incorrect booking made	3
late to appointment	16
missed appointment	29
no transport provided	14
ongoing problems	19
communication	8
poor service	19
waiting time	114
vehicle issues	6



Complaints by Month	No
Jan-14	26
Feb-14	18
Mar-14	23
Apr-14	6
May-14	24
Jun-14	30
Jul-14	34
Aug-14	11
Sep-14	12
Oct-14	23
Nov-14	12
Dec-14	12
Jan-15	10



Bath & North East Somerset Council		
MEETING/ DECISION MAKER:	**Wellbeing Policy Development & Scrutiny Panel**	
MEETING/ DECISION DATE:	**13 March 2015**	
TITLE:	**Refresh of Shaping Up Healthy Weight Strategy**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Draft 'Shaping Up' Healthy Weight Strategy		

1 THE ISSUE

1.1 The strategy sets out the priorities for Bath and North East Somerset for tackling obesity which has been determined using existing provision, consultation, research, other strategies and plans and emerging trends and issues. The strategy shows the Council's commitment to improving opportunities to enable people to achieve a healthy weight dependent upon collaboration from all sectors to develop services which promote and facilitate a healthy lifestyle for all our residents

1.2 The successful delivery of the Shaping Up Strategy will be dependent upon collaboration with other key partnerships and the delivery of the 3 other key strategies:

1.3 Fit for Life – getting more people, more active, more often. The strategy leads on local priorities which encourage people to be more active as well as looking at changes to the physical environment, transport and planning.

1.4 Local Food Strategy - will work in partnership with local organisations who lead on environmental sustainability to encourage people to eat more local food, improve access to affordable healthy food as well as helping people to have the right knowledge and skills to be able to have a healthy diet.

1.5 The local NHS Clinical Commissioning Group 5 year plan which highlights the need for prevention and self care, the redesign of diabetes services as well as contributing to the reduction in falls in older people.

2 RECOMMENDATION

2.1 Members approve the draft 'Shaping Up' strategy for further public consultation

2.2 Members approve the draft 'Shaping Up' strategy to go to Health and Wellbeing Board for final consultation and approval

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 The Council will contribute financially to the delivery of the Shaping Up Healthy Weight Strategy from existing resources (both across various Council departments and from the ring-fenced Public Health budgets). The Council will consider the appropriate use of any new funding it secures to support delivery of the recommendations in the strategy.

3.2 Due to the cross cutting nature of this strategy its successful delivery will rely upon the funding and resources identified within supporting strategies (listed below) and a commitment to pool budgets or align resources from supporting strategies for implementation of this strategy:

- CCG strategic plan
- Local Food Strategy
- Fit for Life Strategy
- Transport plan
- Green infrastructure strategy
- Children and young people's plan
- Play strategy
- Built facilities and playing pitches strategy

- Green spaces strategy

3.3 The strategy seeks to influence the work and use of resources of other partners and coordinate work within the sector in order to secure additional budget to deliver the outcomes

3.4 The strategy is designed to encourage more people to achieve and maintain a healthy weight.

3.5 The strategy will help to:

i. **Boost the economy** through reducing sickness absence and worklessness

ii. Meet the Council's new responsibilities in meeting the outcomes identified in the Public Health, NHS and Social Care Outcomes Framework – for example reducing falls in over 65s, increasing physical activity, reducing mortality from cardiovascular disease and increasing the use of outdoor space, improve access to affordable healthy food

iii. Contribute to improving travel flow and air quality – through increasing opportunities for and uptake of walking, cycling, play and other physical activity in our daily lives, reducing sedentary behaviour

iv. Reduce demand on health and social care services – through supporting people to achieve and maintain a healthy weight, increase knowledge and skills of food preparation and food growing as well as creating opportunities for people to live full and independent lives through increasing their activity levels.

v. Increase the use of existing facilities and maximising use of outdoor space – for example increasing use of existing community facilities (e.g. schools), parks and open spaces to encourage people to be more active

vi. Empowering communities - connecting with communities to improve health and wellbeing

vii. Reduce health inequalities - Getting people of all ages and backgrounds to eat more healthily, participate in leisure and sports activities both of which can improve social cohesion and help reduce antisocial behavior.

viii. Widening access to an affordable healthier diet

ix. Increasing pupil attainment – supporting children to have the knowledge and skills to feel emotionally and physically well

x. Improve the provision of and access to good food in the private and public sector through implementation of Workplace Charter, Eat Out Well, the School Food Plan

xi. Contribute to a Healthy and Sustainable Food Culture in supporting the delivery of the local food strategy to increase skills in cooking and growing, as well as increasing public awareness of good food

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 Public Health and Inequalities

5 THE REPORT

5.1 The strategy describes our partnership plans to promote healthy weight and tackle unprecedented levels of obesity. A strategy was initially developed in B&NES in 2005 and subsequently refreshed in 2007 and 2011. This refresh of the strategy is a high-level overview of current issues relating to healthy weight and focuses on what will achieve sustainable change.

5.2 It draws on the main themes from the national Healthy Lives, Healthy People: A Call to Action on Obesity in England as a clear vision for where action can be taken. It also takes into consideration the best practice recommendations as outlined in National Institute for Clinical Excellence (NICE) guidance and briefings relating to diet, nutrition, obesity and physical activity.

5.3 The report makes reference to a number of national and local statistics, by referring to the extensive evidence base for the benefits of activity and by making use of the joint strategic needs assessment to understand the key local issues.

5.4 It presents to Councillors, staff, partners and stakeholders the priorities for tackling obesity up to 2020. It links directly to the Joint Health and Wellbeing Strategy and the Children and Young People's Plan providing more detail on how the Council is working to deliver on the vision to support all resident s to achieve and maintain a healthy weight.

5.5 The need for this strategy is increasingly important at this time when finances are very limited; whilst the needs, expectations and aspirations of our customers and partners are increasing.

6 WHY HEALTHY WEIGHT?

6.1 In England 24.7% of adults are obese (BMI 30 and over), including 2.4% who are severely obese (BMI over 40). The negative health impacts tend to increase with greater levels of obesity. Moderate obesity (BMI 30-35) has been found to reduce life expectancy by an average of three years, while severe obesity (BMI 40-50) reduces life expectancy by eight to ten years.

Obesity Harms Adults

6.2 Locally over half of adults (55.7%) in B&NES are estimated to be overweight or obese, although this is significantly lower than regional and national figures. Rates of recorded obesity are rising in adults in B&NES, but are lower than national rates.

6.3 It is well documented that people who are overweight and obese increase the risk of a range of diseases that can have a significant health impact on individuals. Obesity is associated with type 2 diabetes and hypertension – which are major risk factors for cardiovascular disease and cardiovascular related mortality. Obesity has also been associated with cancer, dementia, disability and reduced quality of life, and can lead to premature death.

Obesity and health inequalities

6.4 The prevalence of overweight and obesity has increased in all communities, demonstrating that the whole population is at risk and a population preventative approach is required. However some sectors of the population are more at risk of developing obesity and its associated complications, contributing to inequalities in health:

- People from deprived areas
- Older people
- People with disabilities
- Some black and minority ethnic groups

6.5 Obesity is also associated with educational attainment. Men and women who have fewer qualifications are more likely to be obese. Around a third of adults who leave school with no qualifications are obese, compared with less than a fifth of adults with degree level qualifications.

Obesity Harms children

6.6 Trends in child obesity are a particular cause for concern. Obesity has been rising rapidly in children in England over the past 20 years – the proportion of children classified as obese has nearly doubled for children aged 4-5 years and increased more than threefold for children aged 10-11 years. However this increase may be starting to level off, as the rate of increase in child obesity has slowed compared to the increases observed between 1995 and 2004.

6.7 Around 1 in 4 (23.2%) Reception aged children (4 to 5 years old) in B&NES are an unhealthy weight, i.e. either overweight or obese. or obese. Around 1 in 11 (8.9%) Reception aged children in B&NES are obese.

6.8 Around 3 in 10 (29.5%) Year 6 aged children (10 to 11 years old) in B&NES are an unhealthy weight, i.e. either overweight or obese. Around 1 in 6 (16.0%) Year 6 aged children in B&NES are obese.

6.9 Half of parents do not recognise their children are overweight or obese. Parental obesity is a significant risk factor for childhood obesity. Therefore, areas with high levels of childhood unhealthy weight and obesity are also likely to have more adult obesity

6.10 Being overweight or obese in childhood and adolescence has consequences for health in both the short term and longer term. Maternal obesity significantly increases risk of foetal congenital anomaly, prematurity, stillbirth and neonatal death. Once established, obesity is notoriously difficult to treat, so prevention and early intervention are very important.

Economic Impact of Obesity

6.11 Independent research earlier this year found that obesity now costs the British taxpayer more than police, prisons and fire service combined.

6.12 The associated costs to society and business could reach £45.5 billion per year by 2050, with a 7 fold increase in NHS costs alone. Previous estimates suggested that the economic cost of obesity locally is approximately £49 million.

6.13 There are significant workplace costs associated with obesity. For an organisation employing 1000 people, this could equate to more than £126,000 a year in lost productivity due to a range of issues including back problems and sleep apnoea.

Vision, Outcomes and Objectives

6.14 Vision for B&NES:
In Bath and North East Somerset healthy lifestyles are the normal way of life and every adult and child is informed, able and motivated and supported to make positive choices regarding nutrition and physical activity.

6.15 Aim:
To focus our combined efforts on lasting societal and environmental changes that enable people to maintain a healthy weight; while informing and empowering people to make healthy choices.

6.16 Outcome:

- All people in B&NES are a healthy weight
- All residents and their families can experience the benefits of being a healthy weight.

How B&NES will promote a healthy weight:

6.17 Achieving a higher proportion of healthy weight in the population is a complex social and public health issue. The evidence is very clear that policies aimed solely at individuals will be inadequate and that simply increasing the number or type of small-scale interventions will not be sufficient to reverse the trend. We need significant effective action to prevent obesity at a population level targeting elements of the obesogenic environment as well as improving nutrition and physical activity in individuals.

6.18 Our key Objectives will be to:

i. Coordinate a holistic integrated weight management pathway for the whole population which promotes self-care, prevention, early intervention and specialist support for both families and individuals

ii. Controlling exposure to and demand for consumption of excessive quantities of high calorific foods and drinks

iii. Increasing opportunities for and uptake of walking, cycling, play and other PA in our daily lives, reducing sedentary behaviour

iv. Increasing responsibilities of organisations for the health and wellbeing of their employees.

v. Develop a workforce that is competent, confident and effective in promoting healthy weight

vi. Influence decision making and policy making to change the environment we live in to facilitate healthy behaviours

6.19 Achievement of these objectives will involve action across the stages of life through pregnancy to older age with a particular focus on families. Action will be at three levels; universal (for whole population), targeted (for those at risk) and specialist (for those who are above a healthy weight)

6.20 Principles underpinning the strategy:

i. Leadership – Has strong local leadership supporting people to embrace change

ii. Partnerships – effective partnership working to optimise the use of resources

iii. Intelligent Interventions - developments are needs led, making best use of available market insight

iv. Advocacy – ensuring local people & key stakeholders understand the benefits of healthy weight

v. Value for Money – ensuring we deliver our priorities in the most effective way

vi. Innovative – uses technology to better engage and connect with people

vii. High quality and Best Practice – Development that meets local need, learning from & improving on the best practice

viii. Holistic – a cross sector commitment contributing to improved health and wellbeing of local people

ix. Targeted – focuses on the inactive, addressing inequalities for underrepresented groups, creating opportunities which are fun, tailored and inclusive

x. Sustainability - ensuring exit routes are in place for participants to ensure impacts and measures are sustained and long lasting and that work is built from the bottom upcreating an asset based community development approach

7 RATIONALE

7.1 The draft strategy has emerged following extensive research. The authority now wishes to undertake a final period of consultation to use this framework to develop the draft into a final document by testing the assumptions and priorities set out in the draft.

8 OTHER OPTIONS CONSIDERED

The draft strategy has emerged following extensive research and consultation which considered a wide range of options.

9 CONSULTATION

9.1 Healthy Weight Strategy Group, Cabinet member for Neighbourhoods, Cabinet Member for Wellbeing, Health and Wellbeing Board, School Health Pupil Survey, local focus groups targeting families general public, focus groups of those who are

using commissioned lifestyle services, a wide range of partners and stakeholders for Healthy Weight.

9.2 Extensive consultation was undertaken as part of the strategy development for the Fit for Life Partnership and the Local Food Strategy, both of which contribute to the development and delivery of the Healthy Weight Strategy.

9.3 Further plans are in place to undertake a formal online consultation of the strategy with the general public, Health and Wellbeing Board network members and Children and Young People's participation group.

10 RISK MANAGEMENT

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

Contact person	*Jameelah Ingram 01225 394073*
Background papers	*List here any background papers not included with this report, and where/how they are available for inspection.*
Please contact the report author if you need to access this report in an alternative format	

References

For more information on local statistics quoted in this report please visit the

Bath and North East Somerset Joint Strategic Needs Assessment Wiki page at www.bathnes.gov.uk/jsna

1. Foresight (2007) Tackling obesities: Future Choices- project report. Government Office for Science.
2. Craig R, Mindell J (eds) (2013) Health Survey for England 2012, London: The Health and Social Care Information Centre.
3. http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/obesity
4. Gatineau M, Dent M (2011) Mental Health and Obesity London: National Obesity Observatory (NOO)
5. Gatineau M, Mathrani S (2012) Alcohol and Obesity: an overview London: NOO
6. http://www.alzheimers.org.uk/site/scripts/news_article.php?newsID=2150

All the national infographics statistics
https://www.noo.org.uk/securefiles/150225_1335//Making_the_case_for_tackling_obesity_reference_sheet_factsheet.pdf

Local Statistics
http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/obesity

Bath & North East Somerset Council

Healthy Weight Strategy Bath and North East Somerset 2015 to 2020

Executive Summary

This document describes our partnership plans to promote healthy weight and tackle unprecedented levels of obesity. A strategy was initially developed in B&NES in 2005 and subsequently refreshed in 2007 and 2011. Since then, obesity has climbed the national public health agenda.

In terms of obesity, the government has made its intention clear: it wants to see the rising rates reversed. Its obesity strategy, 'Healthy Lives, Healthy People: A call to action on obesity in England', which was published in October 2011, set a new target for a downward trend in excess weight for children and adults by 2020:

- **a sustained downward trend in the level of excess weight in children by 2020**
- **a downward trend in the level of excess weight averaged across all adults by 2020.**

This strategy is a high-level overview of current issues relating to healthy weight and focuses on what will achieve sustainable change. It draws on the main themes from the national Healthy Lives, Healthy People: A Call to Action on Obesity in England as a clear vision for where action can be taken. It also takes into consideration the best practice recommendations as outlined in National Institute for Clinical Excellence (NICE) guidance and briefings relating to diet, nutrition, obesity and physical activity

Achieving a higher proportion of healthy weight in the population is a complex social and public health issue. The evidence is very clear that policies aimed solely at individuals will be inadequate and that simply increasing the number or type of small-scale interventions will not be sufficient to reverse the trend. We need significant effective action to prevent obesity at a population level targeting elements of the obesogenic environment as well as improving nutrition and physical activity in individuals.

Our key Objectives will be to:

1. Coordinate a holistic integrated weight management pathway for the whole population which promotes self-care, prevention, early intervention and specialist support for both families and individuals.
2. Controlling exposure to and demand for consumption of excessive quantities of high calorific foods and drinks
3. Increasing opportunities for and uptake of walking, cycling, play and other PA in our daily lives, reducing sedentary behaviour.
4. Increasing responsibilities of organisations for the health and wellbeing of their employees.
5. Develop a workforce that is competent, confident and effective in promoting healthy weight
6. Influence decision making and policy making to change the environment we live in to facilitate healthy behaviours

Contents

Introduction

The evidence is very clear. Significant action is required to prevent obesity at a population level,to avoid creating 'obesity promoting' environments as well as improving nutrition and physical activity in individuals.. This strategy recognises the contributions and combined efforts of all partners to increase the number and proportion of children and adults who are a healthy weight.

"We know that for people at risk, losing just 5-7% of your weight can cut your chance of diabetes by nearly 60%. If this was a pill we'd be popping it – instead its a well designed programme of exercise, eating well and making smart health choices."

What do we mean by the term Healthy Weight and Obesity?

The term 'healthy weight' is used to describe when an individual's body weight is appropriate for their height and benefits their health. Above the healthy weight range there are increasingly adverse effects on health and wellbeing. Weight gain can occur gradually over time when energy intake from food and drink is slightly greater than energy used through the body's metabolism and physical activity.

Obesity is defined as a significant excess of body fat which occurs when energy intake exceeds expenditure over a long period of time. Obesity is known to increase the risk of a range of health problems particularly type 2 diabetes, stroke and coronary heart disease, cancer and arthritis. It is also important to note the immense impact of overweight and obesity on emotional health and quality of life.

Measurement of Healthy Weight, Overweight and Obesity

The recommended measure of overweight and obesity within a population is body mass index (BMI)3. BMI is calculated by dividing body weight (kilograms) by height (metres) squared. In children this is adjusted for a child's age and gender to allow for growth and development. Although it does not directly measure body fat, having a higher than recommended BMI in adulthood increases risk of chronic diseases. Children with BMI in the overweight and obese range are more likely to become overweight or obese adults. BMI is an indicator of health and should be used with caution when exercised when used for individuals as waist circumference is also used a predictor of obesity. Clinical judgement is necessary to assess individual's weight where there is concern.

Table 1: BMI classifications for adults

Classification	BMI Centile
Underweight	>18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	30.0 – 39.9
Morbidly Obese	>40

Source: Nice 2006

Presently there is some debate about the definition of childhood obesity and the best way to measure it. The National Childhood Measurement Programme (NCMP) uses BMI reference charts to classify children which take into account children's weight and height for their age and sex. Children over the 85th centile are considered overweight and those over the 95th centile, obese.

Table 2: UK National Body Mass Index (BMI) percentile classification or child

Classification	BMI Centile
Underweight	≤ 2nd centile
Healthy Weight	2nd centile – 84.9th centile
Overweight	85th centile – 94.5th centile
Obese	≥95th centile

Source: Nice 2006

What Causes Obesity?

The causes of obesity are complex; factors include biology, behaviour, culture, environment and socio-economics.

Personal responsibility is a factor in weight management and a focus on behaviour change can have an impact

Our weight is affected by our habits and beliefs. These in turn affect behaviour around healthy eating and physical activity.

Diet plays a significant role. The UK diet has changed significantly since the 1950s and this may be partly responsible for the rising prevalence of obesity. Both the types and amount of food consumed have changed and there is an increased availability of energy dense convenience foods and an increase in food eaten outside the home.

The high energy density of many of convenience foods (a typical fast food meal contains more than one and a half times as many calories as an average traditional British meal) means that people often unconsciously consume more calories than the body needs. Studies show that there is a tendency to overeat on high fat diets, a phenomenon called 'high-fat hyperphagia' or passive over-consumption of fat. Consuming high sugar foods and drinks has been shown to have a similar effect. Another factor is that portion size is increasing. Evidence from several research studies shows that when faced with larger portions, people eat more[1].

We must also acknowledge the role of environment on our ability to be physically active .

We live in an obesogenic environment whereby more people work in offices whilst fewer people have a physically active job.

We benefit from labour saving devices in the home and rely heavily on cars to get around.

Increased reliance on the car over the last fifty years has contributed to a major decline in walking and cycling.

Concerns about safety, anti-social behaviour and crime may also deter people from being physically active in their local area and parents are wary of letting children walk or cycle to school

Environmental factors affecting our weight include how local housing estates are designed, how we travel to destinations, the accessibility of shops and public services and the availability of good quality sport and leisure opportunities, including parks and open spaces.

Economic factors can influence an individual's ability to choose a diet that is lower in fats and sugars and access opportunities to be physically active.

Low mood has also been linked to obesity. There are also links between social inclusion, wellbeing physical activity and people not feeling fully in control of the food they eat. Social issues are important determinants of obesity in children and adults.

Why is Obesity an issue?

The prevalence of obesity in the UK has increased dramatically over the last 25 years with Britain now being the most obese nation in Europe.

The majority of the adult population 61.9% and 28% of children aged 2- 15 are either overweight or obese and it is estimated that, without clear action, these figures will rise to almost nine in ten adults and two-thirds of children by 2050. While there is some indication that it may be starting to level off among children in England, prevalence remains very high among this group.

People who are overweight have a higher risk of getting type 2 diabetes, heart disease and certain cancers. Excess weight can also make it more difficult for people to find and keep work, and it can affect self-esteem and mental health. Health problems associated with being overweight or obese cost the NHS more than £5 billion every year.

Prevalence is rising

Overweight and obesity in adults is predicted to reach 70% by 2034. More adults and children are now severely obese

Consequences are costly

A high BMI

- **is costly to health and social care**
- **has wider economic and societal impacts**

Obesity is widespread

Two thirds of adults, a quarter of 2–10 year olds and one third of 10–15 year olds are overweight or obese

Health Impact of Obesity

Adults

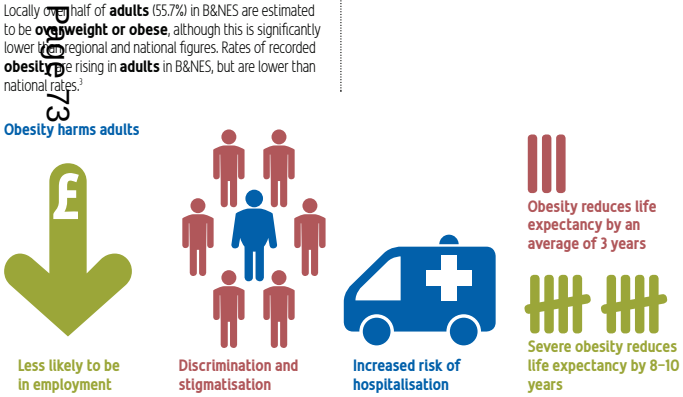
In England 24.7% of adults are obese (BMI 30 and over), including 2.4% who are severely obese (BMI over 40) (Health Survey for England 2012)[2]. The negative health impacts tend to increase with greater levels of obesity. Moderate obesity (BMI 30-35) has been found to reduce life expectancy by an average of three years, while severe obesity (BMI 40-50) reduces life expectancy by eight to ten years.

Locally over half of **adults** (55.7%) in B&NES are estimated to be **overweight or obese**, although this is significantly lower than regional and national figures. Rates of recorded **obesity** are rising in **adults** in B&NES, but are lower than national rates.[3]

It is well documented that people who are overweight and obese increase the risk of a range of diseases that can have a significant health impact on individuals. Obesity is associated with type 2 diabetes and hypertension - which are major risk factors for cardiovascular disease and cardiovascular related mortality. Obesity has also been associated with cancer, disability and reduced quality of life, and can lead to premature death.

Obesity and Inequalities

The prevalence of overweight and obesity has increased in all communities, demonstrating that the whole population is at risk and a population preventative approach is required. However some sectors of the population are more at risk of developing obesity and its associated complications, contributing to inequalities in health.



Mental Health and Obesity

'Obese persons had a 55% increased risk of developing depression over time, whereas depressed persons have a 58% increased risk of becoming obese' The mental health of women is more closely affected by overweight and obesity than that of men. There is also strong evidence to suggest an association between obesity and poor mental health in teenagers and adults. This evidence is weaker for younger children.[4]

Obese persons had a 55% increased risk of developing depression over time

depressed persons had a 58% increased risk of becoming obese

Alcohol and obesity

There is no clear causal relationship between alcohol consumption and obesity. However, there are associations between alcohol and obesity and these are heavily influenced by lifestyle, genetic and social factors. Alcohol accounts for nearly 10% of the calorie intake amongst adults who drink, and most people are unaware of the calorific content of alcoholic drinks. Heavy, but less frequent drinkers seem to be at higher risk of obesity than moderate, frequent drinkers.

Death rates from liver disease have risen by 40% between 2001 and 2012. Whilst alcohol is the most common cause of liver disease, obesity is an important risk factor for liver disease because of its link to non-alcoholic fatty liver disease (NAFLD), which is the term used to describe accumulation of fat within the liver that is not caused by alcohol. It is usually seen in people who are overweight or obese and with rising levels of obesity we would expect to see rising levels of NAFLD. Equally excess body weight and alcohol consumption appear to act together to increase the risk of liver cirrhosis.[5]

Dementia and Obesity

Researchers at the University of Oxford found obesity in mid-life increases the risk of developing dementia. Evidence suggests that people who are obese in their thirties are three times more likely to get dementia[6]

Children

Trends in child obesity are a particular cause for concern. Obesity has been rising rapidly in children in England over the past 20 years – the proportion of children classified as obese has nearly doubled for children aged 4-5 years and increased more than threefold for children aged 10-11 years. However this increase may be starting to level off, as the rate of increase in child obesity has slowed compared to the increases observed between 1995 and 2004.

Being overweight or obese in childhood and adolescence has consequences for health in both the short term and longer term. Maternal obesity significantly increases risk of foetal congenital anomaly, prematurity,stillbirth and neonatal death. Once established, obesity is notoriously difficult to treat, so prevention and early intervention are very important. Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood. Although many of the most serious consequences may not become apparent until adulthood, the effects of obesity - for example, raised blood pressure, fatty changes to the arterial linings and hormonal and chemical changes (such as raised cholesterol and metabolic syndrome) can be identified in obese children and adolescents.

Some obesity-related conditions can develop during childhood. Type 2 diabetes has increased in overweight children. Other health risks of childhood obesity include early puberty, eating disorders such as anorexia and bulimia, skin infections, asthma and other respiratory problems. Some musculoskeletal disorders are also more common, including slipped capital femoral epiphysis (SCFE) and tibia vara (Blount disease).

Disabilities and Obesity

Children and young people with disabilities are more likely to be obese than children without disabilities and this risk increases with age.

Obesity harms children and young people

- Emotional and behavioural
- Stigmatisation
- Bullying
- Low self-esteem

SCHOOL

- School absence

- High cholesterol
- High blood pressure
- Pre-diabetes
- Bone and joint problems
- Breathing difficulties

- Increased risk of becoming overweight adults
- Risk of ill-health and premature mortality in adult life

We may not see ourselves or children as obese

- Adults tend to underestimate their own weight
- Half of parents do not recognise their children are overweight or obese

The media tend to use images of extreme obesity to illustrate articles about obesity

GPs may underestimate their patients' BMI

If we do not recognise obesity we are less likely to prioritise tackling it

Obesity is also associated with educational attainment. Men and women who have fewer qualifications are more likely to be obese. Around a third of adults who leave school with no qualifications are obese, compared with less than a fifth of adults with degree level qualifications.

Part of the reason for this is that levels of educational attainment are linked to levels of inequality and deprivation. People who are socioeconomically deprived tend to have poorer health and lower levels of education. In addition, low achievement at school among obese children may be due to a variety of factors such as poor psychological health, teasing, bullying and discrimination, low self esteem, disturbed sleep, absenteeism and less time spent with friends or being physically active.

Economic Impact of Obesity

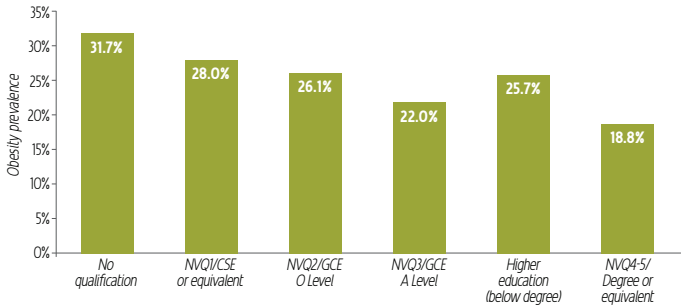
Independent research earlier this year found that obesity now costs the British taxpayer more than police, prisons and fire service combined. It is clear that, as a society, if we are going to continue to deliver world class public services and look after the health of the population as a whole, we are going to have to do more to address this.

The associated costs to society and business could reach £45.5 billion per year by 2050, with a 7 fold increase in NHS costs alone.

Obesity can impact on the workplace in a number of ways. Obese employees take more short and long term sickness absence than workers of a healthy weight. In addition to the impact on individual health and increased business costs due to time off work through associated illnesses, obese people frequently suffer other issues in the workplace including prejudice and discrimination.

There are significant workplace costs associated with obesity. For an organisation employing1000people, this could equate to more than £126,000 a year in lost productivity due to a range of issues including back problems and sleep apnoea.

Adult obesity prevalence by highest level of education (2006-2010)



On current projections costs are likely to increase

Between 2010 and 2030 – health costs are up by

£2bn

- Obesity increases the risk of many serious long term conditions
- More advanced treatments
- Greater life expectancy
- Increasing obesity prevalence
- More people than ever living in ill health

The annual cost of obesity

Cost to wider economy **£27bn**

- Obesity attributed days sickness £16m
- Obesity medication £13.3bn
- Cost to NHS £55.1bn
- Social care £352m

Vision and Strategic Targets

Vision for B&NES

In Bath and North East Somerset healthy lifestyles are the normal way of life and every adult and child is informed, able and motivated and supported to make positive choices regarding nutrition and physical activity.

Aim

To focus our combined efforts on lasting societal and environmental changes that enable people to maintain a healthy weight; while informing and empowering people to make healthy choices.

Outcomes

- All people in B&NES are a healthy weight
- All residents and their families can experience the benefits of being a healthy weight.

To tackle overweight and obesity effectively we need to adopt a life course approach – from pre-conception through pregnancy, infancy, early years, childhood, adolescence and teenage years, and through to adulthood and preparing for older age. There are specific opportunities and challenges at each stage of the life course and action is needed at all ages to avert the short- and long-term consequences of excess weight and to ensure that health inequalities are addressed. Action needs to encompass an appropriate balance of investment and effort between prevention and, for those who are overweight or obese, treatment and support.

Prioritising Local Need

The strategy will focus on the following priority groups

Geographical areas of inequalities:

- Areas of B&NES with the highest child obesity prevalence, as measured through the child measurement programme
- Areas of B&NES with the highest estimated adult obesity prevalence.

Points across the life course where people are more at risk of obesity:

- Women during and after pregnancy
- Early years (0-5years)
- Children aged between 5 and 11 years
- Prevention in adults aged less than 35 years
- Weight management in adults aged over 35 years
- Women following the menopause
- People stopping smoking
- Adults following retirement

Groups who can be more at risk of obesity:

- Looked After Children
- Children and adults living in the most disadvantaged areas of B&NES
- Children and adults with a learning disability
- Black and Minority Ethnic Children
- Adults with depression or other common mental health problems

Bringing together a coalition of partners

Effective local action on obesity requires wide collaboration of partners to work together in order to create an environment that supports and facilitates healthy choices by individuals and families.

The Council already performs a vital leadership role by bringing together partners who can stimulate action on local issues through the Health and Wellbeing Board.

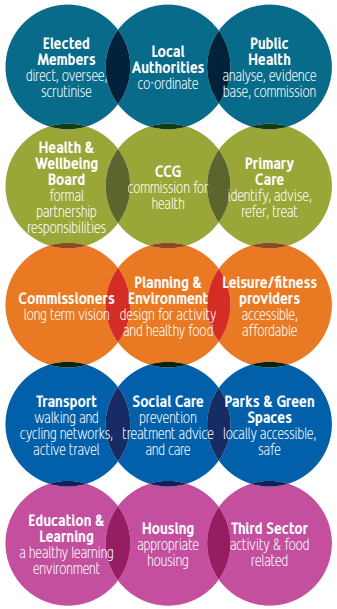
The local Health and Wellbeing Board has set a framework for action.

Priorities have been identified under 3 key themes:

- Theme one: Helping people to stay healthy
- Theme two: Improving the quality of people's lives
- Theme three: Creating fairer life chances

Helping children to be a healthy weight and creating healthy and sustainable places have been identified as local priorities within theme one .

Partnership: the key to success



Local Governance

The successful delivery of the Shaping Up Strategy will be dependent upon collaboration with other key partnerships and the delivery of the other key strategies:

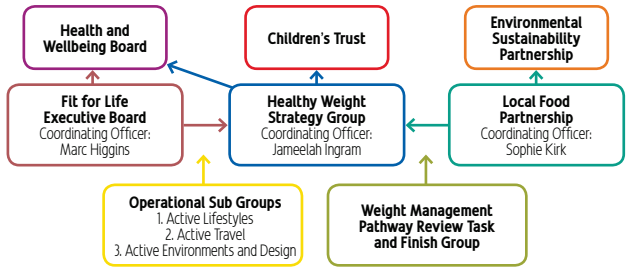
1. Fit for Life – getting more people, more active, more often. The strategy with leads on local priorities which encourage people to be more active as well as looking at changes to the physical environment, transport and planning.

2. Local Food Strategy - working with local organisations who lead on environmental sustainability to encourage people to eat more local food, improve access to affordable healthy food as well as helping people to have the right knowledge and skills to be able to have a healthy diet.

3. It will also have links to the local **NHS Clinical Commissioning Group 5 year plan** which highlights the need for prevention and self care, the redesign of diabetes services as well as contributing to the reduction in falls in older people.

This strategy is governed by the Health and Wellbeing Board and reports also to the Children's Trust Board.

Various groups (including task and finish groups) will be involved in the implementation of the different aspects of the strategy e.g. the School Food Forum, Fit for Life Partnership – Subgroups etc.



Principles underpinning the strategy

1 Leadership – Has strong local leadership supporting people to embrace change

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10 Sustainability - ensuring exit routes are in place for participants to ensure impacts and measures are sustained and long lasting and that work is built from the bottom up creating an asset based community development approach

Implementation and Monitoring of the strategy

The strategy will be supported by an annual action plan. Reporting of outcomes will be via the Healthy Weight Strategy Group to the Health and Wellbeing Board and Childrens Trust Board.

Monitoring the prevalence of healthy weight in children and adults is a requirement of the national Public Health Outcomes Framework as highlighted by the following key performance indicators:

- Excess weight in 4-5 and 10-11 year olds (PHOF 2.6)
- Diet (placeholder) (PHOF 2.11)
- Utilisation of green space for exercise/health reasons (PHOF 1.16)

How B&NES will promote a healthy weight

Achieving a higher proportion of healthy weight in the population is a complex social and public health issue. The evidence is very clear that policies aimed solely at individuals will be inadequate and that simply increasing the number or type of small-scale interventions will not be sufficient to reverse the trend. We need significant effective action to prevent obesity at a population level targeting elements of the obesogenic environment as well as improving nutrition and physical activity in individuals.

Our key Objectives will be to :

1. Coordinate a holistic integrated weight management pathway for the whole population which promotes self-care, prevention, early intervention and specialist support for both families and individuals.

2. Controlling exposure to and demand for consumption of excessive quantities of high calorific foods and drinks

3. Increasing opportunities for and uptake of walking, cycling, play and other physical activity in our daily lives, reducing sedentary behaviour.

4. Increasing responsibilities of organisations for the health and wellbeing of their employees.

5. Develop a workforce that is competent, confident and effective in promoting healthy weight

6. Influence decision making and policy making to change the environment we live in to facilitate healthy behaviours

Achievement of these objectives will involve action across the stages of life through pregnancy to older age with a particular focus on families. Action will be at three levels; universal (for whole population), targeted (for those at risk) and specialist (for those who are above a healthy weight).

1. Universal: Whole population prevention activity

We will work collaboratively with the Fit for Life Partnership and the Local Food steering group to create positive environments which actively promote and encourage a healthy weight in B&NES. This involves transport, the built environment, parks and open space and promoting access to affordable healthy food; as well as interventions such as the Healthy Child Programme, Director of Public Health Award in Schools and Eat Out Eat Well award accreditation scheme with food retailers.

2. Targeted: Community based lifestyle interventions

We will maintain and develop interventions to support individuals and communities most at risk of obesity to intervene earlier and reduce inequalities in obesity. This will include interventions to support individuals and families becoming more active and eating more healthily.

3. Specialist Weight management services

Working together with the NHS to develop and deliver high quality specialist treatment and support to for local residents who are severely obese and have additional complex health needs and where conventional lifestyle support has been unsuccessful. This level of support may include drug therapy, specialist clinical support and in some cases surgery.

OUTCOME FRAMEWORK: ALL PREGNANT WOMEN, CHILDREN AND YOUNG PEOPLE ARE A HEALTHY WEIGHT

Outcome & Indicator

Outcome: All children are a healthy weight

Indicator: National Child Measurement Programme (Overweight and Obesity prevalence of reception/ yr 6)

Breastfeeding prevalence initiation and continuation at 6-8 weeks

Local: Overweight and obesity prevalence of pregnant women at 1st antenatal booking

School Health Survey

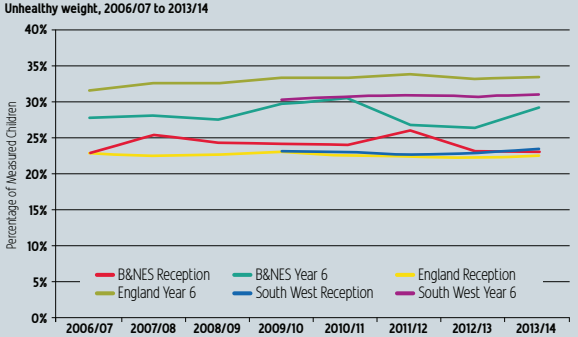
Population: Pregnant women, Children and young people aged under 18

Data issues/gaps:

- Have mechanism to monitor BMI of pregnant women at 10 week booking at RUH but need to obtain data from Bristol trusts also to get B&NES resident population
- Only record obesity prevalence in reception and Yr 6.
- Only measure children in B&NES schools – do not include children who study out of area
- Updated NCMP maps – detailing ward areas with highest rates and with schools mapped for targeting inequalities work.
- Poor physical activity data for children and young people – no national indicator
- Missing – Play and active travel indicators, measuring utilisation outdoor space and facilities.
- Mapping of all service provision in the area needs to be undertaken to identify gaps and areas of duplication
- Linking NCMP with pupil attainment and free school meals data.
- Neighbourhood profiles showing trends dietary behaviour, activity levels and unhealthy weight prevalence in maternal and child health.
- Measuring longer term outcomes (6/12 months for commissioned services).
- Service user feedback on commissioned services.

BASELINE

Unhealthy weight, 2006/07 to 2013/14



Partners

- Local residents
- NHS Primary Care/CCG:
- Health Visiting
- Connecting
- Sirona – Health Visiting, School Nursing, SHINE Weight management, Cook it!, HENRY
- Bath University
- Play Services
- Children's Centres, private nursery and play group settings
- Maternity Services
- Schools
- Director of Public Health Award
- Parks and open spaces
- Sports Clubs
- Sports and Active Lifestyles
- Dietitians
- GPs
- Paediatricians
- Oral Health – Dentists
- Curo
- Youth Connect
- Foodbanks
- School Sports Partnership
- Wesport
- Leisure contractor

OUTCOME FRAMEWORK: ALL PREGNANT WOMEN, CHILDREN AND YOUNG PEOPLE ARE A HEALTHY WEIGHT

Story behind the baseline: (examples of contributory factors)

Around 1 in 4 (23.2%) **Reception aged children (4 to 5 years old)** in B&NES are an unhealthy weight, i.e. either overweight or obese. Around 1 in 11 (8.9%) Reception aged children in B&NES are obese.

Around 3 in 10 (29.5%) **Year 6 aged children (10 to 11 years old)** in B&NES are an unhealthy weight, i.e. either overweight or obese. Around 1 in 6 (16.0%) Year 6 aged children in B&NES are obese.

Trends in childhood unhealthy weight - including overweight and obesity - have been relatively static since the national measurement programme began in 2006/07, i.e. there has been no long-term significant upward or downward shift. This accords with national findings that demonstrate prevalence rates of overweight and obesity may have stabilized between 2004 and 2013.

Age is a significant factor in the levels of obesity among children in B&NES, i.e. increasing with age. **Deprivation and ethnicity** are significant factors in the level of obesity among Year 6 aged children in B&NES.

Parental obesity is a significant risk factor for childhood obesity. Therefore, areas with high levels of childhood unhealthy weight and obesity are also likely to have more adult obesity. 1

Children and young people with disabilities are more likely to be obese than children without disabilities and this risk increases with age (analysis of HSE 2006-2010 for children aged 2-15 with a LLTI)

Research shows that 3 year olds are now experiencing tooth decay – with sugary drinks being a key factor.

75%

There is a 75% uptake of healthy start vouchers by eligible families in Bath and North East Somerset.

Infant Feeding

84% of babies in B&NES are breastfed at birth, higher than regionally (78%) and nationally (74%). At the 6-8 week check this rate has dropped to 65% as of Q2 2013/14, although this is still higher than regional (49%) and national (47%) rates. These rates have been relatively flat over the past few years, but seem to be rising locally.

Within B&NES there is considerable variation in rates of breastfeeding between different areas, with 9 wards having 6-8 week rates of less than 50%, the lowest being 29%. It is difficult to distinguish the influence of geographical deprivation from age of mother from the data in B&NES as some of the most deprived areas, with the lowest rates of breastfeeding, also have the highest numbers of teenage mothers.

Physical Activity

In 2012/13, 41.2% of people in B&NES use outdoor space to exercise for health/reasons, the highest regionally and significantly higher than the national average (1.3%)

Currently no activity data recorded for children and young people

OUTCOME FRAMEWORK: ALL PREGNANT WOMEN, CHILDREN AND YOUNG PEOPLE ARE A HEALTHY WEIGHT

Listening to the public and service users

In 2013 the The Child Health-Related Behaviour Survey in B&NES in 2013 results on healthy eating and activity were similar or better than the national average.

Primary school - 83% of primary school children reported enjoying physical activity at school and in leisure time. They also reported that they are adopting healthy eating behaviours; 98% have breakfast and 32% reported eating 5 or more portions of fruit or vegetables. Approx. 1 in 5 said they would like to lose weight.

Almost half of primary school children (47%) travel to school by car.

Just over 80% of young people say they watched TV, DVD's or videos on the day prior to the survey

93% of our **Primary School** children own a bicycle

Secondary school - 1 in 10 children are skipping meals, with 11% reporting that they did not have lunch on the day before the survey. Fewer secondary school children (21%) are eating their recommended portions of 5 a day. However more secondary children are walking to school (54%) and 75% of respondents are enjoying physical activity 'quite a lot or a lot. 68% (59%) of Year 10 pupils said they worried about at least one of the issues listed 'quite a lot' or 'a lot'.

A focus group of young mums with preschool aged children highlighted issues around availability of good facilities and activities (including for under 3's and for parents) and crèche facilities whilst exercising

A youth focus group highlighted the need for indoor and outdoor spaces to socialise within their age group

A group of disabled people commented that transport is one of the main barriers to participating in activities as well as access issues

A survey by the University of Bath (2012) highlighted that parents have a significant effect on young people's physical activity levels with barriers including: fears of parenting skills being judged, not knowing other parents or workers, cost of services, lack of awareness of services and reacting badly to being told that their child is overweight

A holistic integrated weight management pathway for the whole population which includes prevention, an ethos of taking personal responsibility for the both the health and wellbeing of the family and individuals with the offer of specialist support when needed

Current good practice in B&NES

Maternal Health

- An integrated Tier 2 holistic weight management service is in place for women with an unhealthy weight and/or are smokers

Early Years 0-5

- Free Healthy Start vitamins, fruit and vegetable vouchers for families on low incomes
- Universal preventative healthy weight offer for early years settings
- Director of Public Health Award in early years settings
- All Health Visitors trained in HENRY Core Skills, and using HENRY resources at 3 specific contact points for all familiesMaternal child nutritional guidance developed for early years settings and health professionals
- Health Visiting service accredited Baby Friendly award for health visiting service. Universal Infant Feeding Hubs established in Childrens Centres, supported by peer supporters, Specialist Infant Feeding Support Service pilot underway

OUTCOME FRAMEWORK: ALL PREGNANT WOMEN, CHILDREN AND YOUNG PEOPLE ARE A HEALTHY WEIGHT

- Targeted early years service Tier 1 weight management service for families with children who are an unhealthy weight/live in area where obesity prevalence is high
- Commissioned family cooking skills programme for families with children who are unhealthy weight – includes combined food growing and cooking skills intervention

5-19 Years

- Universal preventative healthy weight offer in primary and secondary schools and FE colleges:
  - *Director of Public Health Award offered to educational settings*
- Excellent participation rates in National Child Measurement Programme (NCMP)
- Telephone support offered to families participating in NCMP programme who have a child who is obese
- A range of commissioned targeted Tier 1 weight management programmes:
  - *6 week cookery courses for families with overweight/obese children aged 0-19 (Cook It!)*
  - *HENRY Healthy Lifestyle parenting programme for under5 year olds*
  - *Healthy Child Programme delivered by school nurse programme*
- Commissioned Tier 2 community based weight management provision:
  - *intervention for children and young people aged 10-17 year olds includes psychological component*
  - *Paediatric dietietic support*

Recommendations to address Gaps/Needs Identified

General from Birth-19:

- Develop a community development building parental capacity approach to self care and prevention for the whole family (including carers and extended family members)
- Increase investment in preventative programmes targeting pregnant women/parents/carers and those planning pregnancy
- Review Parenting Strategy and current programmes delivered across B&NES, ensure approach is consistent and evidence based and measures outcomes
- Continue to provide effective Tier 1 and Tier 2 services for those at risk of unhealthy weights, ensuring that commissioned interventions include psychosocial aspects of being overweight.
- Improve access and retention of current Tier 1 and Tier 2 weight management services – with particular focus on improving access and availability of provision for 5-9 year olds, 14-19 year olds, families with physical and learning difficulties

Maternal Health

- Review commissioning of maternal and child health programmes o ensure a holistic approach to positive parenting, early messaging of importance and benefits of healthy lifestyles for the whole family from Pregnancy onwards.
- Work towards integrated commissioning of preventative (children's) services and Public health

Early Years 0-5

- Increase uptake of healthy start vitamins, and voucher scheme, review universal offer of Vitamins in light of new Guidance
- Introduce healthy lifestyle offer for parents/carers at GP 6-8 week post natal check
- Develop healthy lifestyles offer for connecting families programme
- Strengthen preventative work which supports parent/carers
- Review and improve provision of Tier 1 weight management interventions for families, ensuring services are effective and value for money
- Develop targeted social marketing campaigns for specific at risk groups
- Incorporate healthy lifestyle messaging into all commissioned parenting programmes and 0-5 services.
- Review, update and disseminate maternal health and early years nutritional guidance to all professionals working in children's services
- Develop and disseminate a framework of key messages for all children's services and relevant council wide departments to support the Baby Friendly Initiative
- Review Specialist Infant Feeding Support Service Pilot and identify appropriate commissioner and investment

5-19 Years

- Continue to deliver the National Child Measurement Programme

OUTCOME FRAMEWORK: ALL PREGNANT WOMEN, CHILDREN AND YOUNG PEOPLE ARE A HEALTHY WEIGHT

- Involve and upskill professionals in educational settings in the development of an effective weight management pathway
- Improve the nutritional quality and offer of food in junior and secondary schools and continue to increase uptake of school meals.
- Increase public awareness: Raising the issue of weight with parents, especially reception aged children
- Continue to assess the whole Early Years/school/College environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight and be physically active.
- Review healthy weight pathway to include oral health promotion
- Review School Nurse Service Specification to include the model of delivery of a Universal and targeted offer

Controlling exposure to and demand for consumption of excessive quantities of high calorific foods and drinks

Current good practice in B&NES

- New 5 Year Local Food Strategy and multiagency steering group launched in 2014 to ensure everyone can access good quality, safe, affordable food and enjoy a healthy diet, with more locally produced food that sustains the environment and supports the local economy.
- Supporting local businesses and community organisations to offer healthier options:
- Eat Out Eat Well retailer accreditation scheme- developed to support reward food outlets to offer healthier options
- Participation in national Change4Life Social Marketing campaigns to promote healthy eating messaging including Start4life, 5 A day
- Multiagency School Food Forum ensuring coordinated delivery of national school food plan in primary schools
- Commissioned community family cookery programmes available in areas where childhood obesity rates are highest

Recommendations to address Gaps/Needs Identified

Through the delivery of the local food strategy group we will:

- Greater promotion of national Change4Life programme to deliver key messaging on the dangers of sugary and caffeinated drinks and portion sizes/oversnacking locally
- Partner with street trading team to reduce the number of outlets which offer unhealthy snack and drink in areas close to educational settings and family leisure facilities.
- Reduce the number of new fast food outlets near educational settings.
- Increase the availability of affordable fruit and vegetables in neighbourhoods of high need.
- Increase uptake of healthy start vouchers by eligible families.
- Reduce diet-related inequality by focusing services on low-income residents/families with priority given to children from Black and Minority Ethnic Backgrounds, Children with a physical or learning difficulty and young

Increasing opportunities for and uptake of walking, cycling, play and other PA in our daily lives, reducing sedentary behaviour.

Current good practice in B&NES

New 5 year physical activity strategy: Fit for Life
Established Fit for Life Executive Board and implementation sub groups covering maternal health and children and young peoples

Procurement and proposed modernisation of local council owned leisure facilities

Investment in a range of preventative and community based Tier 1 and Tier 2 interventions including:

Maternal Health

- Best practice research project – Moving on Up project , 12 week postnatal dance programme for women (delivered as part of Passport to Health

Early Years 0-5 years

A range of preventative activities include:

- Director of Public Health award in Early Years settings
- Go By Bike: community based preschool cycling activities
- Wheels for All cycling club for adults and children with disabilities and differing needs

An investment in Tier 1 physical activity offer early years:

- Targeted Healthy Lifestyle Parenting Programme (HENRY)

OUTCOME FRAMEWORK: ALL PREGNANT WOMEN, CHILDREN AND YOUNG PEOPLE ARE A HEALTHY WEIGHT

5-19 years

- Open Access Community play sessions run in areas where NCMP data identifies higher rates of unhealthy weight children
- Family play inclusion workers offer children who are referred between 5 to 13 and their families, tailored play support , developing stronger parenting bonds and linking children to open access play sessions and other play opportunities, SEN/disabled families prioritised
- Play Inclusion Worker model used by Connecting Families
- Promoting healthy lifestyles, especially active play and health eating is integral to the Community Play Specification.
- Commissioned Go By Bike: cycling proficiency and sporting events
- Sport England funded try active programme which uses cycling, walking/running and outdoor fitness to get people more active. Range of community activities offered to 14-19 year olds
- Established everyday active programme of activities offered in primary and secondary school – delivered by schools sports partnership

Tier 2 community based weight management programme (SHINE) for 10-17 offers ongoing rolling physical activity offer for children and young people

- University of Bristol commissioned dance research project to engage Year 7 girls in dance activities after school

Recommendations to address Gaps/Needs Identified

Provide modernised leisure facilities which are make them more attractive, accessible and affordable to young people and families.

Work collaboratively with the Fit for Life partnership to:

- Increase the range of activities and opportunities for children and young people to be active outside of school
- Encourage schools and clubs to work together in increasing participation
- Increase range of community based activities for families with children with a learning or physical difficulty.
- Supporting the sustainability of the Wheels for All cycling inclusion project
- Review and improve provision of opportunity for physical activity available for pregnant women and parents/ carers of small babies / pre-schoolers
- Promote activities which children can do independently and those they can enjoy with their family and friends.
- Work across sectors to increase opportunities for everyday activity and opportunities for play in children, young people and families. Prioritise:
  - *Families in low socioeconomic groups (targeting families with children aged 0-5)*
  - *Children with disabilities and/or who have parents with a disability and*
  - *BME children*
  - *Girls aged 12 upwards*
  - *NEETS*

Assess the whole Early Years/school/College environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight and be physically active.

- Support children and young people's settings to promote physical activity and active play during school hours, evenings, weekends and holidays.
- Support schools to be community hubs providing access to their facilities in their local community to raise awareness and encourage families to be more active
- Continue to work with the school sports partnership to continue to ensure high quality sport and physical activity opportunities are delivered within schools
- Develop effective strategies for increasing activity levels in the key transition points for young people (between primary and secondary school and secondary and further education)

Refresh the Council's play strategy and ensure promoting the opportunity for active play is embedded in all other relevant children's service specifications

Increase the opportunities for active travel for families – considering key transition points – such as starting preschool/school/college/university.

Work with early years and educational settings to continue to encourage a culture of physically active travel, supporting them to provide cycle and road safety training for all children.

Introduce an active travel scheme for schools

OUTCOME FRAMEWORK: ALL PREGNANT WOMEN, CHILDREN AND YOUNG PEOPLE ARE A HEALTHY WEIGHT

- Explore opportunities for co-locating health, leisure and NHS services to offer a holistic approach to supporting families.
- Remove the cost of venue hire for commissioned services operating in public sector venues to enable more families to access services. (Can we include this?)

Increasing responsibilities of organisations for the health and wellbeing of their employees.

Current good practice in B&NES

- NHS Health Checks are on offer to all residents working in children's services who are aged 40 and above
- Commissioned service to deliver Workplace Wellbeing Charter to local businesses
- Eat Out Eat Well – developed to reward food outlets that provide their customers with healthier choices, established for over 2 years, supported range of settings, restaurants (24%), workplace canteens (17%) and Pubs (15%), public sector and educational settings, café and community centres etc.

Commissioned integrated lifestyles hub for local residents to access Tier 1 and Tier 2 community based weight management and physical activity programmes: including:

- Lifestyles advisors -1-1 support
- Slimming on referral (Weight Watchers, Counterweight,
- Passport to Health: Exercise on referral
- Wellbeing walks

Local Sustainability Transport Fund and Highways agency offer a range of workplace active travel incentives in the NHS and Public Sector to include: roadshows, cycle training, pool bikes, electric cars

Recommendations to address Gaps/Needs Identified

- Upskill local public sector workforce so that they are healthier in themselves, reducing sickness absence and improving productivity.
- Through development of the Workplace Wellbeing Charter, support workplaces to provide opportunities for staff to eat a healthy diet and be physically active, through:
  - *active and continuous promotion of healthy choices in restaurants, hospitality, vending machines and shops for staff and clients, in line with existing national guidance*
  - *working practices and policies, such as active travel policies for staff and visitors*
  - *a supportive physical environment, such as improvements to stairwells and providing showers and secure cycle parking*
  - *recreational opportunities, such as supporting out-of-hours social activities, lunchtime walks and use of local leisure facilities.*
- Support the NHS and the Local Authority to be exemplar employers in achieving the Workplace Wellbeing charter and Eat Out Eat Well Gold Status
- Through the delivery of the local food implementation plan enhance the procurement of healthy, nutritional good quality meals by organisations and businesses.
- Workplaces providing health checks for staff should ensure that they address weight, diet and activity, and provide ongoing support to employees.

Develop a workforce that is competent, confident and effective in promoting healthy weight

Current good practice in B&NES

- Investment has been made in training children service' staff in evidence based lifestyle programmes and raising the issue of weight:
  - *The local authority holds the training license for HENRY to enable Health Visitors and Children's Centre staff can raise the issue of weight with parents of babies and toddlers*
  - *The local authority has invested in the evidence based psycho social weight management programme: SHINE. Sirona and the RUH who are providers of the programme have trained midwives and staff working with 10-17 year olds on raising the issue of weight.*
- A NHS/LA working group has been established to develop a coordinated approach to train frontline staff in Making Every Contact Counts (Health Visitors, School nursing)
- RSPPH Level 2 and Level 3 Nutrition training on offer to businesses

OUTCOME FRAMEWORK: ALL PREGNANT WOMEN, CHILDREN AND YOUNG PEOPLE ARE A HEALTHY WEIGHT

Recommendations to address Gaps/Needs Identified

- Secure investment and deliver a coordinated training programme of 'making every contact count' for frontline staff working in the public and voluntary sector.
- Enable all staff to have increased confidence in:
  - *raising the issue of weight*
  - *Promoting Baby Friendly key messages*
  - *competencies to deliver/refer to weight management interventions where appropriate.*

Influence decision making and policy making to change the environment we live in to facilitate healthy behaviours

Current good practice in B&NES

Refreshed transport plans for Bath and Keynsham

Health impact assessed Council's place making plan

Established a Fit for Life Partnership to deliver a 5 year Fit for Life strategy includes key objectives to:

- Improve Active Travel
- Influence Active Design: work with planners to improve our neighbourhoods to offer easy access to a choice of opportunities for physical
- Create Active Environments: ensure leisure facilities and green infrastructure are well used and enjoyed by local residents and visitors.

Recommendations to address Gaps/Needs Identified

Through the delivery of the Fit for Life Partnership:

- Ensure physical activity is a consideration in all policy development that impacts on children and young people
- Map safe routes to school, local play and leisure facilities
- Work with Leisure and Tourism, parks and allotments and open spaces to create opportunities for spontaneous play and maximising opportunities for physical activity.
- Invest in training for planners (urban, rural and transport), architects and designers on the health implications of local plans.
- Protect playing pitches and outdoor opportunities for physical activity from development
- Provide safe open spaces and play areas which are stimulating, challenging and age appropriate for children
- Create family friendly environments that enable opportunities for active play and planned physical activity

OUTCOME FRAMEWORK: ALL ADULTS ARE A HEALTHY WEIGHT

Outcome & Indicator

Outcome: All adults are a healthy weight

National Indicators:
PHOF Excess Weight in Adults (Active People's Survey)

PHOF % of physically active and in active adults (Active People's Survey)

PHOF – Number of people on diabetes register aged 17+ (QOF)

PHOF/CCG – Mortality rates caused by diseases considered preventable (ONS Data)

PHOF/CCGUnder 75 mortality rate from all cardiovascular disease (ONS data)

Population: Adults aged 18+

Data issues/gaps:

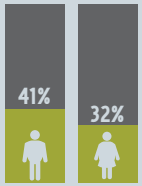
- Poor data quality for measuring prevalence rates as data underreported, locally and nationally.
- Poor physical activity data for adults – active peoples survey – small sample.
- Mapping of all service provision in the area needs to be undertaken to identify gaps and areas of duplication
- Developing indicators which link obesity and sickness absence.
- Explore suitable indicators for measuring the built environment, food and dietary choices, active transport and outdoor space usage.
- Local indicators for measuring use of outdoor space and parks.
- Neighbourhood profiles showing trends dietary behaviour, activity levels and unhealthy weight prevalence need developing.
- Measuring longer term outcomes (6/12 months for commissioned services).
- Capturing data from partners organisations which demonstrate behaviour change
- Developing prevalence rates for lifestyle risk factors and NHS Health Check
- Developing indicators for measuring wellbeing and obesity

BASELINE

Obesity Key Facts:

Over half (58.7%) of adults in B&NES are estimated to be overweight or obese, although this is significantly lower than regional and national figures.

Rates of recorded obesity are **rising in adults** in B&NES but are lower than national rates.



Nationally, men and women have a similar prevalence of obesity, but **men are more likely to be overweight** (41%m compared to 32%f) (2008)[7]

Partners

- Sirona – Healthy Lifestyle Service
- Counterweight
- Bath University
- NHS and Social Care
- Public Sector workforce leads
- Local businesses
- Voluntary sector organisations
- Parks and open spaces
- Sports Clubs
- Sports and Active Lifestyles
- Dietitians
- GP Practices (Diabetic Nurses, NHS Health Check Leads)
- Community Nursing (district nursing/OTs)
- Physios
- CCG Commissioners
- Public Protection – Environmental Health
- Regeneration
- Planners and developers
- Transport leads
- NHS England Specialist Commissioners
- Endocrinologists
- Leisure Contractor
- Wesport

OUTCOME FRAMEWORK: ALL ADULTS ARE A HEALTHY WEIGHT

BASELINE

Obesity prevalence (ages 16+) – B&NES and England GP 16 years + registered populations

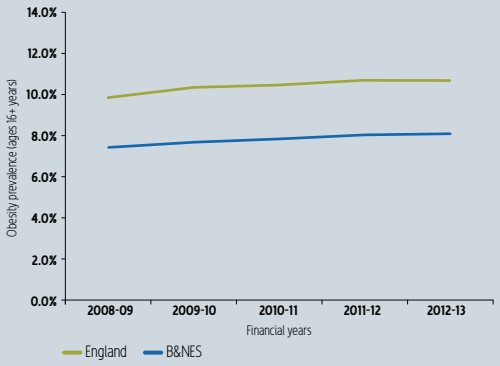


Figure 1 There were 13,446 (2012/13 financial year) people 16 years and over registered as obese in GP practices in B&NES.3

The prevalence of obesity in those 16 years and over in GP practices has been gradually increasing locally and nationally. The prevalence rate in B&NES is significantly lower than England. The national prevalence of obesity (ages 16+) was 9.9% in 2008/09 and 10.7% in 2012/13 (financial year). N.b these figures are for a registered population..

B&NES estimated obesity prevalence to 2030

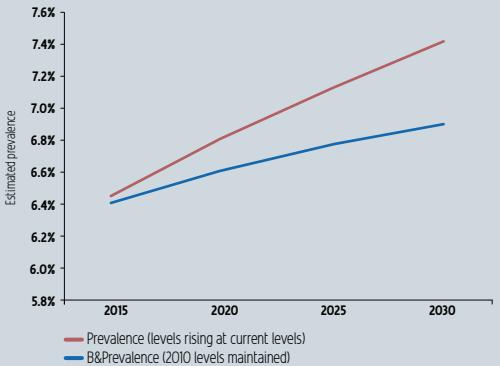


Figure 2 demonstrates the estimated local increase in obesity prevelence up to 2030. If obesity levels continue to rise at the current rate, this would mean an estimated prevalence increase of 27% over the next 16 years from 6.5% (~10,038 persons) to 7.4% (~12,712 persons).

OUTCOME FRAMEWORK: ALL ADULTS ARE A HEALTHY WEIGHT

Story behind the baseline: (examples of contributory factors)

Diet Key Facts

B&NES has a higher than national known level of fruit and vegetable consumption (**30%** compared to **26%**)

Lyncombe has the highest model based estimate percentage of 38% consumption of fruit and veg and of those that are known, Twerton has the lowest at 19% consumption of 5 pieces of fruit and veg a day

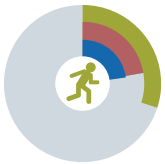
There were large rises in food prices between June 2007 and February 2009. This included a 23% rise in vegetable prices and an 11% rise in fruit prices. All food price rises put pressure on food shopping choices

Percentage consuming 5 fruit and vegetables a day is higher in areas of lower deprivation

There is a relationship between healthy eating and areas with lower incomes. In addition food prices are rising at a signficant rate, with a 23% rise in vegetable prices and 11% rise in fruit prices between 2006 and 2009

Physical Activity - Key Facts

27% of Bath and North East Somerset population undertake 30 minutes of moderate intensity exercise on 3 or more days a week (**22.3% national**, **South West 22.9%**).



43.7% of adults do no sport or active recreation in Bath and North East Somerset

Health costs in Bath and North East Somerset due to inactivity comes to £2.9 million per year.

National research suggests that over half of people living in deprived areas would take more exercise if green spaces were improved

Physical Activity

27% of B&NES population undertake 30 minutes of moderate intensity exercise on 3 or more days a week (22.3% national, South West 22.9%). This rate is higher among men than women both locally and nationally and there is no difference by ethnicity8 (Active People 2011-12)

Sport England indicates that 43.7% of adults do no sport or active recreation in B&NES (South West 48%, National 49.1.1%) and that health costs in B&NES due to inactivity comes to £2.9 million per year

The most popular ways to be active in B&NES are swimming, then cycling, then the gym 9.

Twerton has the lowest adult participation in sport and active recreation (<17.6%) (MSOA 2010, Sport England)

There is significant evidence of health inequalities as the most deprived wards in B&NES (Twerton, Whiteway and Southdown) also have the lowest levels of physical activity and high levels of obesity.

The highest rate of GP referrals for Passport to Health by ward corresponds with the wards with the highest percentages of obese and overweight children, including Midsomer Norton Redfield and Radstock. Keynsham North also has significantly high percentages of obese and overweight children19

The cost of inactivity in B&NES is estimated at £15m.

OUTCOME FRAMEWORK: ALL ADULTS ARE A HEALTHY WEIGHT

Listening to the public and service users

2013 B&NES community survey – 994 respondents said:

The most important factors limiting activity are:

Lack of time (55%), direct costs (40%) and accessible and good quality facilities (26%).

Lacking time to excercise due to home pressures was a factor for 22% of the sample, nationally this is only 5%.

Although 97% state regular activity is either very important or important, slightly under half state they are not undertaking as much activity as they would like (46%), with women currently less satisfied with the amount of activity they are doing.

Leisure centres are most popular facility for those who exercise, yet there is a decrease in satisfaction of current provision.

Cost and time are significant reasons for both male and female respondents for not taking part in more physical exercise

The majority of the sample does not cycle and do not want to (55%).

The top 3 barriers to cycling less than 5 miles are:

(1) Lack of confidence cycling (23%)

(2) Driver behaviour / road safety (20%)

(3) Lack of on road cycle lanes and also no barriers (19%)

A holistic integrated weight management pathway for the whole population which includes prevention, an ethos of taking personal responsibility for the both the health and wellbeing of the family and individuals with the offer of specialist support when needed

Current good practice in B&NES

A Multiagency working group is established to review the adult weight management pathway and provision of existing services

An established weight management exists for adults with an unhealthy weight. Current commissioned activity includes:

- A single point of access integrated lifestyle hub delivered by Sirona Care and Health.

Universal prevention programmes include:

- Community based cookery activities targetting specific groups:
  - *Bath City Farm: mental health service user volunteering projects to improve cooking skills and food growing*
  - *Cookery programmes for social housing tenants delivered Curo*
  - *Wellbeing walks coordinated by Sirona Care and Health*
  - *Feel Good Foods recipe food box scheme for adults with learning difficulties*

OUTCOME FRAMEWORK: ALL ADULTS ARE A HEALTHY WEIGHT

Tailored weight management support is available for overweight/obese individuals

- **Tier 1**
  - *1:1 six week programme with a lifestyle Advisor*
  - *Diabetes education programme*
- **Tier 2**
  - *Slimming on referral scheme - 12 week group based weight loss programme with a commercial provider (Weight Watchers, Slimming World), Counterweight) or*
  - *Referral to 6 month Counterweight weight management programme delivered in 16 GP practices by nurses*
  - *Referral to a dietitian*

Specialist weight management is funded by the NHS England and the Clinical Commissioning Group. Current services for severely obese patient with complex health problems include:

- **Tier 3** multidisciplinary service for individuals delivered by the RUH
- **Tier 4** Bariatric Surgery service
- **Tier 5** Post-operative weight management service

Recommendations to address Gaps/Needs Identified

- Review and develop an improved prevention self care offer which includes the promotion of online tools and social media prioritising specific populations:
  - *Development of a Healthy Lifestyles app for people with learning difficulties*
  - *Develop an online weight management offer for employees*
  - *Adults who have had a health check*
  - *Newly diagnosed diabetic patients*
- Create a weight management care pathway to ensure a single inclusive pathway based on client need and evidence based practice. Develop in partnership with the NHS and the community and voluntary sector.
- Work with partners to embed weight management support within existing social care pathways
- Provide necessary adaptations and carer support for severely obese people to help improve their quality of life
- Continue to provide effective services for those at risk of unhealthy weights, ensuring that commissioned interventions include psychosocial aspects of being overweight.
- Improve access to weight management programmes for :
  - *adults aged 20-25*
  - *People suffering from poor mental health*
  - *Those with a physical or learning difficulty*
  - *Residents who are from a Black or minority ethnic background*
- Review and create a sustainable model for cooking skills for adults or single occupant households
- Develop community outreach model for health check scheme to screen residents who don't access a GP.
- Engage more people in communal activities associated with food such as cooking and growing can contribute to community cohesion and social engagement.

Controlling exposure to and demand for consumption of excessive quantities of high calorific foods and drinks

Current good practice in B&NES

- New 5 Year Local Food Strategy and multiagency steering group launched in 2014 to ensure everyone can access good quality, safe, affordable food and enjoy a healthy diet, with more locally produced food that sustains the environment and supports the local economy.
- Eat Out Eat Well retailer accreditation scheme– developed to support reward food outlets to offer healthier options
- Participation in national Change4Life Social Marketing campaigns to promote healthy eating messaging including Start4life, 5 A day
- Delivery of Nutrition programmes for businesses delivered by Public Protection

OUTCOME FRAMEWORK: ALL ADULTS ARE A HEALTHY WEIGHT

Recommendations to address Gaps/Needs Identified

- Improve access to a healthy and affordable diet prioritising families in low income groups. (Food Strategy)
- Support more people to access, afford and choose good quality, healthy food can enhance the consumption of good food and improve dietary health.
- Seek opportunities for more people to develop skills in food growing and cooking will equip them with the knowledge, skills and confidence to prepare healthy meals.
- Promote healthy eating across all settings (workplace/ health/commercial organisations)
- Commission services which attract adults aged 20-25 year olds.
- Develop and roll out change4life marketing campaigns targeting priority groups
- Increase opportunities for community food growing
- Through the delivery of the local food strategy group we will:
  - *Greater promotion of national Change4Life programme to deliver key messaging on the dangers of sugary and caffeinated drinks and portion sizes/ oversnacking locally*
  - *Increase the availability of affordable fruit and vegetables in neighbourhoods of high need.*
  - *Reduce diet-related inequality by focusing services on low-income residents*

Increasing opportunities for and uptake of walking, cycling, play and other PA in our daily lives, reducing sedentary behaviour.

Current good practice in B&NES

- New 5 year physical activity strategy: Fit for Life
- Established Fit for Life Executive Board and implementation sub groups with a focus on adults
- Procurement and proposed modernisation of local council owned leisure facilities
- Investment in a range of preventative and community based Tier 1 and Tier 2 interventions including:

  Prevention:
  - *Free cycle training for Adults commissioned by council*
  - *Group led wellbeing walks delivered by Sirona Care and Health*
  - *Mass Participation sporting events for example, sport relief mile, half marathon, Tour of Britain*
  - *Development of the Odd Down Cycle Circuit to increase community activities*
  - *Sport England funded Triactive programme – free activities for adults to increase walking, cycling and improve outdoor fitness for the inactive*
- Commissioned Tier 2 twelve week community based exercise on referral scheme offering:
  - ***Community Activators*** *- This programme offers 1:1 support from home/community*
  - ***Facility-based Pathway*** *- 12 weeks of subsidised access to a leisure centre with support from a member of the Passport to Health Team*
  - ***Community Group Exercise Pathway*** *- 12 weeks free access to community group exercise sessions currently taking place in Timsbury, Radstock, Chew Stoke, Keynsham, Twerton and Odd Down. These sessions are offered indoors and outdoors as walking, cycling or simple circuit-based exercise*
- Macmillan funded structured exercise programme for cancer survivors

Recommendations to address Gaps/Needs Identified

Through the delivery of the Fit for Life Strategy:

- In partnership with the NHS review and develop an improved prevention self care offer which includes the promotion of online tools and social media for priority groups including those with long term conditions (diabetes, mental illness cardiovascular disease)
- Modernise leisure facilities and increase opportunities for activities to make them more attractive to women, people with disabilities
- Increase opportunities for low level structured activity needed for obese or those with long term conditions
- Work in partnership with NHS and voluntary sector
- Increase the opportunities for active travel for individuals/families – considering key transition points – such as starting school/new job

OUTCOME FRAMEWORK: ALL ADULTS ARE A HEALTHY WEIGHT

- Review and increase provision of community based activities which attract adults aged 20-25 year olds, women, people with learning/physical difficulties and have a different ethnic origin than white.
- Support development of residential travel plans that promote sustainable/active travel.
- Continue to work with local sports/cycling clubs to attract new members
- Mapping of outdoor leisure opportunities for all.
- Invest in additional marketing campaigns that will inform, support, empower people to make changes to their activity levels.
- Continue to promote Change4Life campaigns
- Increase opportunities for people to access adapted versions of sport aimed at supporting inactive people to be more active such as walking football or 'back into sport' programmes
- Increase number of mass participation events aimed at engaging new people, promoting positive messages and providing education about sport and physical activity
- Promote activities which are holistic and combine improved mental wellbeing and exercise
- Continue to support the B&NES Inclusive Sport and Physical Activity partnership to improve opportunities and access to sport and physical activity for those with disabilities

Increasing responsibilities of organisations for the health and wellbeing of their employees.

Current good practice in B&NES

Investment in development of Workplace Wellbeing Charter accreditation scheme, prioritising public sector workplaces as ambassadors for change

Active Travel Promotion and Incentives for council and NHS workforce:

- Travel roadshows
- Pool Bikes
- Individualised travel plans

Recommendations to address Gaps/Needs Identified

- Upskill local public sector workforce so that they are healthier in themselves, reducing sickness absence and improving productivity.
- Enable staff to have increased confidence in raising the issue of weight and the competencies to deliver weight management interventions
- Increase the opportunities for workplace weight management programmes
- Encourage local workplaces and business to sign up to the Responsibility Deal.
- Through the delivery of the Fit for Life strategy:.
  - *Create opportunities for volunteering to successfully increase people's physical activity and promote good mental health and well-being as well as increasing the potential for employment.*
- Develop a workplace Health Check offer for men
- Through development of the Workplace Wellbeing Charter, support workplaces to provide opportunities for staff to eat a healthy diet and be physically active, through:
  - *active and continuous promotion of healthy choices in restaurants, hospitality, vending machines and shops for staff and clients, in line with existing national guidance*
  - *working practices and policies, such as active travel policies for staff and visitors*
  - *a supportive physical environment, such as improvements to stairwells and providing showers and secure cycle parking*
  - *recreational opportunities, such as supporting out-of-hours social activities, lunchtime walks and use of local leisure facilities.*
- Support the NHS and the Local Authority to be exemplar employers in achieving the Workplace Wellbeing charter and Eat Out Eat Well Gold Status
- Through the delivery of the local food implementation plan enhance the procurement of healthy, nutritional good quality meals by organisations and businesses.
- Workplaces providing health checks for staff should ensure that they address weight, diet and activity, and provide ongoing support to employees.

OUTCOME FRAMEWORK: ALL ADULTS ARE A HEALTHY WEIGHT

Develop a workforce that is competent, confident and effective in promoting healthy weight

Current good practice in B&NES

Investment has been made in training local authority and Sirona voluntary sector service' staff in evidence based lifestyle programmes and raising the issue of weight:

- The local authority holds the training license for Counterweight to enable practice staff to raise the issue of weight with patients and provide weight management support.
- Annual training sessions held for staff undertaking health checks so they are confident in raising the issue of weight
- A NHS/LA working group has been established to develop a coordinated approach to train frontline staff in Making Every Contact Counts (Health Visitors, School nursing)
- RSPPH Level 2 and Level 3 Nutrition training on offer to businesses

Recommendations to address Gaps/Needs Identified

- Secure investment and deliver a coordinated training programme of 'making every contact count' for frontline staff working in the public and voluntary sector.
- Enable all staff working in health, social care and the voluntary sector to have increased confidence in:
  - *raising the issue of weight*
  - *competencies to deliver/refer to weight management interventions where appropriate.*

Influence decision making and policy making to change the environment we live in to facilitate healthy behaviours.

Current good practice in B&NES

- Contribution to the development of the master plan for Bath and the Placemaking through Health Impact Assessment
- Newly Developed transport plan for Bath and Keynsham
- Development of local food policy options for the Placemaking Plan
- Development of allotment management plan and site selection criteria.
- Procurement of new leisure facilities contract
- Contribute to the production of the river strategy

Recommendations to address Gaps/Needs Identified

- Ensure development of the transport plan includes opportunities for individuals and families to travel sustainably and contributing to climate change and traffic calming agenda
- Strengthen partnership with Planning Department to influence the need for residents to be physically active as a routine part of their daily life on new planning applications.
- Invest in training for planners (urban, rural and transport), architects and designers on the health implications of local plans.
- Create environments which support health promoting behaviour.
- Work with Leisure and Tourism, parks and allotments and open spaces to create opportunities for physical activity
- Work with providers of public transport to promote the benefits of travelling sustainably – linking walking and cycling routes with public transport networks
- Work with planners to improve access to food retail outlets and the feasibility of restricting the number of fastfood outlets
- Ensure there is a good supply of resilient, well-managed, maintained and fit for purpose green spaces and playing pitches that meet the needs of the community they serve as well as safeguard against the loss of open space and recreational facilities.
- Maximise on opportunities for integrating walking and cycling routes with art and culture and world heritage sites

OUTCOME FRAMEWORK: ALL OLDER PEOPLE ARE A HEALTHY WEIGHT

Outcome & Indicator

Outcome: All Older People are a healthy weight

National Indicators:
PHOF Excess Weight in Adults (Active People's Survey)

PHOF % of physically active and in active adults (Active People's Survey)

PHOF – Number of people on diabetes register aged 17+ (QOF)

PHOF/CCG – Mortality rates caused by diseases considered preventable (ONS Data)

PHOF – Injuries due to falls in persons over 65

PHOF/CCG – Hip fractures in persons aged over 65

Population: Adults aged 65+

Data issues/gaps:

- Poor data quality for measuring prevalence rates as data underreported, locally and nationally.
- Need to develop age specific local indicators for diet and Physical activity levels
- Poor physical activity data for adults – active peoples survey – small sample.
- Need to capture local voice.
- Mapping of all service provision in the area needs to be undertaken to identify gaps and areas of duplication
- Developing indicators which link obesity and sickness absence.
- Explore suitable indicators for measuring the built environment, food and dietary choices, active transport and outdoor space usage.
- Local indicators for measuring use of outdoor space and parks.
- Neighbourhood profiles showing trends dietary behaviour, activity levels and unhealthy weight prevalence need developing.
- Measuring longer term outcomes (6/12 months for commissioned services).
- Capturing data from partners organisations which demonstrate behaviour change
- Developing prevalence rates for lifestyle risk factors and NHS Health Check
- Developing indicators for measuring wellbeing and obesity

BASELINE

Over half (58.7%) of adults in B&NES are estimated to be overweight or obese, although this is significantly lower than regional and national figures.

Rates of recorded obesity are rising in adults in B&NES but are lower than national rates.

Older age brings greater threats of coronary heart disease, stroke, diabetes, cancer, arthritis and obesity.

Obesity Key Facts:

The number of people who are over 75 is projected to **increase by over 3,000** people (20%) in B&NES

Emergency hospital admissions for accidents in over 65s made up **5% of all emergency admissions** for this age group, with 61% of these being for falls

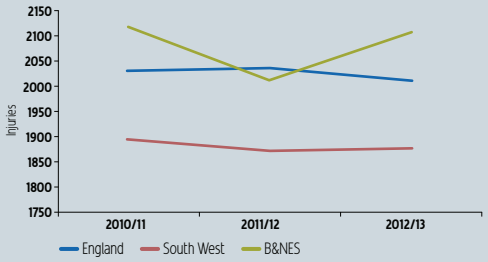
Partners

- Sirona – Healthy Lifestyle Service
- Counterweight
- Bath University
- NHS and Social Care
- Public Sector workforce leads
- Local businesses
- Voluntary sector organisations
- Parks and open spaces
- Sports Clubs
- Sports and Active Lifestyles
- Dietitians
- GP Practices (Diabetic Nurses, NHS Health Check Leads)
- Community Nursing (district nursing/OTs)
- Physios
- CCG Commissioners
- Public Protection – Environmental Health
- Regeneration
- Planners and developers
- Transport leads
- NHS England Specialist Commissioners
- Endocrinologists
- Falls Clinics
- Residential/care settings
- Active Ageing Health Visitors
- Leisure Contractors

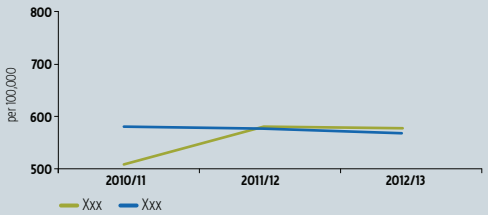
OUTCOME FRAMEWORK: ALL OLDER PEOPLE ARE A HEALTHY WEIGHT

BASELINE

Injuries due to falls in person aged over 65



Hip fractures in persons aged over 65 – standardised rate per 100,000



Story behind the baseline: (examples of contributory factors)

Diet Key Facts

More than 1 in 10 sheltered housing tenants are likely to be at risk of malnutrition (approx 200 in B&NES). Hospital admissions for malnutrition have increased significantly between 2004-6 and 2009-11, but this may relate to improved diagnosis.

Malnourished elderly people run a dramatically increased risk of fracturing their neck of femur, usually by falling due to a lack of strength 17

Older people are often at increased risk of food poisoning and malnutrition; they experience major transitional life events and suffer from medical ailments, which can all affect their food purchase, preparation and consumption behaviours. This in turn can influence their overall health and wellbeing6

An estimated 70,000 premature deaths in the UK could be avoided each year if UK diets matched nutritional guidelines

Malnutrition affects 23% of people under 65. This increases to 32% over the age of 65.

Those who are admitted to hospital over the age of 80 are twice as likely to become malnourished than those under the age of 50

In 2006, the estimated cost of malnutrition to the NHS was £7.3 billion a year10

OUTCOME FRAMEWORK: ALL OLDER PEOPLE ARE A HEALTHY WEIGHT

Story behind the baseline: (examples of contributory factors)

Physical Activity - Key Facts

30% of 65-74 year-olds and **less than 15% of adults aged 75 and over** reported any exercise lasting at least ten minutes during four weeks 5

Older people are not sufficiently active 17 and often fall well below the levels of physical activity recommended to attain healthy aging

A common form of physical activity provision for older people is the community or leisure centre-based group exercise programme 22. Adherence to group based programmes can be as high as 84% 23. However, there is little evidence that such rates are achieved in long-term programmes (≥ 1 year) even though this is necessary for sustained health benefit.

Project OPAL 2627 found that in a sample of 125 males with a mean age of 77.5 years, and 115 females with a mean age of age 78.6 , the number of steps walked per day and the amount of moderate to vigorous activity were significantly lower in participants from more deprived neighbourhoods

Listening to the public and service users

**No age specific data available on JSNA

A holistic integrated weight management pathway for the whole population which includes prevention, an ethos of taking personal responsibility for the both the health and wellbeing of the family and individuals with the offer of specialist support when needed

Current good practice in B&NES

- A Multiagency working group is established to review the adult weight management pathway and provision of existing services
- An established weight management exists for adults with an unhealthy weight. Current commissioned activity includes:
- A single point of access integrated lifestyle hub delivered by Sirona Care and Health.
- Universal prevention programmes include:
  - *Community based cookery activities targetting specific groups:*
  - *Bath City Farm: mental health service user volunteering projects to improve cooking skills and food growing*
  - *Cookery programmes for social housing tenants delivered Curo*
  - *Wellbeing walks coordinated by Sirona Care and Health*
  - *Feel Good Foods recipe food box scheme for adults with learning difficulties*
  - *A pilot between Age UK and Chew Valley Secondary School has been launched to engage older people in schools to share knowledge and skills around cooking and food skills.*
  - *Curo Housing offers lunch club/dinner and dance in Chew Valley for retired residents*
  - *Sirona Care and Health is piloting a Cooking for One course with the Active Ageing Health Visiting service*

Tailored weight management support is available for overweight/obese individuals

- **Tier 1**
  - *1:1 six week programme with a lifestyle Advisor*
  - *Diabetes education programme*
- **Tier 2**
  - *Slimming on referral scheme - 12 week group based weight loss programme with a commercial provider (Weight Watchers, Slimming World), Counterweight) or*
  - *Referral to 6 month Counterweight weight management programme delivered in 16 GP practices by nurses*
  - *Referral to a dietitian*

Specialist weight management is funded by the NHS England and the Clinical Commissioning Group. Current services for severely obese patient with complex health problems include:

- **Tier 3**
  - *multidisciplinary service for individuals delivered by the RUH*
- **Tier 4**
  - *Bariatic Surgery service*

OUTCOME FRAMEWORK: ALL OLDER PEOPLE ARE A HEALTHY WEIGHT

- **Tier 5**
  - *Post-operative weight management service*

Recommendations to address Gaps/Needs Identified

- Review and develop an improved prevention self care offer which includes the promotion of online tools and social media
  - *Adults who have had a health check*
  - *Diabetic patients*
  - *Dementia prevention pathways*
- Create a weight management care pathway to ensure a single inclusive pathway based on client need and evidence based practice. Develop in partnership with the NHS and the community and voluntary sector.
- Work with partners to embed weight management support within existing social care pathways
- Provide necessary adaptations and carer support for severely obese people to help improve their quality of life
- Continue to provide effective services for those at risk of unhealthy weights, ensuring that commissioned interventions include psychosocial aspects of being overweight.
- Improve access to weight management programmes for :
  - *People suffering from poor mental health*
  - *Those with a physical or learning difficulty*
  - *Residents who are from a Black or minority ethnic background*
- Review and create a sustainable model for cooking skills for adults or single occupant households
- Develop community outreach model for health check scheme to screen residents who don't access a GP.
- Engage more people in communal activities associated with food such as cooking and growing can contribute to community cohesion and social engagement.
- Integrate weight management pathways

Controlling exposure to and demand for consumption of excessive quantities of high calorific foods and drinksc

Current good practice in B&NES

- New 5 Year Local Food Strategy and multiagency steering group launched in 2014 to ensure everyone can access good quality, safe, affordable food and enjoy a healthy diet, with more locally produced food that sustains the environment and supports the local economy.
- Eat Out Eat Well retailer accreditation scheme– developed to support reward food outlets to offer healthier options
- Participation in national Change4Life Social Marketing campaigns to promote healthy eating messaging including 5 A day
- Delivery of Nutrition programmes for businesses delivered by Public Protection

Recommendations to address Gaps/Needs Identified

- Through the delivery of the local food strategy:
  - *Improve the nutritional quality of food provision in local hospitals and residential care settings.*
  - *Improve access to a healthy and affordable diet prioritising social housing tenants.*
  - *Support more people to access, afford and choose good quality, healthy food can enhance the consumption of good food and improve dietary health.*
  - *Seek opportunities for more people to develop skills in food growing and cooking will equip them with the knowledge, skills and confidence to prepare healthy meals.*
- Greater promotion of national Change4Life programme to deliver key messaging on the dangers of sugary and caffeinated drinks and portion sizes/oversnacking locally
- Increase the availability of affordable fruit and vegetables in neighbourhoods of high need.
- Reduce diet-related inequality by focusing services on low-income residents
- Review Cooking skills provision for adults or single occupant households

OUTCOME FRAMEWORK: ALL OLDER PEOPLE ARE A HEALTHY WEIGHT

Increasing opportunities for and uptake of walking, cycling, play and other PA in our daily lives, reducing sedentary behaviour.

Current good practice in B&NES

New 5 year physical activity strategy: Fit for Life

Established Fit for Life Executive Board and implementation sub groups with a focus on active ageing

Procurement and proposed modernisation of local council owned leisure facilities

Investment in a range of preventative and community based Tier 1 and Tier 2 interventions including:

Prevention:

- Free cycle training for Adults commissioned by council
- Group led wellbeing walks delivered by Sirona Care and Health
- Development of the Odd Down Cycle Circuit to increase community activities – such as silver cycling for older people
- Mass Participation sporting events for example, sport relief mile, half marathon, Tour of Britain
- Development of the Odd Down Cycle Circuit to increase community activities
- Sport England funded Triactive programme – free activities for adults to increase walking, cycling and improve outdoor fitness for the inactive
- AGE UK funded chair based seated exercise, Tai Chi, guided walks, Fit for the future physical activity programme
- Commissioned Tier 2 twelve week community based exercise on referral scheme offering:
  - ***Community Activators*** *- This programme offers 1:1 support from home/community*
  - ***Facility-based Pathway*** *- 12 weeks of subsidised access to a leisure centre with support from a member of the Passport to Health Team*
  - ***Community Group Exercise Pathway*** *- 12 weeks free access to community group exercise sessions currently taking place in Timsbury, Radstock, Chew Stoke, Keynsham, Twerton and Odd Down. These sessions are offered indoors and outdoors as walking, cycling or simple circuit-based exercise*
- Macmillan funded structured exercise programme for cancer survivors
- Lottery funded wellbeing community activator programmes for older people and/or their carers
- Bath University research study to develop a 12 month intervention to reduce sedentary behaviour in older people (REACT)
- University of West of England mapping current physical activity provision for older people
- Bath University published Promoting physical activity in older adults: A guide for local decision makers

Recommendations to address Gaps/Needs Identified

- Through the delivery of the Fit for Life Strategy
- In partnership with the NHS review and develop an improved prevention self care offer which includes the promotion of online tools and social media for priority groups including those with long term conditions (diabetes, mental illness cardiovascular disease)
- Modernise leisure facilities and increase opportunities for activities to make them more attractive to people with disabilities/long term conditions
- Increase opportunities for low level structured activity needed for obese or those with long term conditions
- Review and increase provision of community based activities which attract adults aged 20-25 year olds, women, people with learning/physical difficulties and have a different ethnic origin than white.
- Support development of residential travel plans that promote sustainable/active travel.
- Continue to work with local sports/cycling clubs to attract new members
- Mapping of outdoor leisure opportunities for all.
- Invest in additional marketing campaigns that will inform, support, empower people to make changes to their activity levels.
- Continue to promote Change4Life campaigns
- Increase opportunities for people to access adapted versions of sport aimed at supporting inactive people to be more active such as walking football or 'back into sport' programmes
- Increase number of mass participation events aimed at engaging new people, promoting positive messages and providing education about sport and physical activity
- Promote activities which are holistic and combine improved mental wellbeing and exercise

OUTCOME FRAMEWORK: ALL OLDER PEOPLE ARE A HEALTHY WEIGHT

- Continue to support the B&NES Inclusive Sport and Physical Activity partnership to improve opportunities and access to sport and physical activity for those with disabilities

Increasing responsibilities of organisations for the health and wellbeing of their employees.

Current good practice in B&NES

- Investment has been made in training local authority and Sirona voluntary sector service' staff in evidence based lifestyle programmes and raising the issue of weight:
  - *The local authority holds the training license for Counterweight to enable practice staff to raise the issue of weight with patients and provide weight management support.*
  - *Annual training sessions held for staff undertaking health checks so they are confident in raising the issue of weight*
  - *A NHS/LA working group has been established to develop a coordinated approach to train frontline staff in Making Every Contact Counts (Health Visitors, School nursing)*
  - *RSPPH Level 2 and Level 3 Nutrition training on offer to businesses*

Recommendations to address Gaps/Needs Identified

- Promote healthy eating in workplace pre-retirement programmes
- Secure investment and deliver a coordinated training programme of 'making every contact count' for frontline staff working in the public and voluntary sector care settings.
- Enable all staff working in health, social care and the voluntary sector to have increased confidence in:
  - *raising the issue of weight*
  - *competencies to deliver/refer to weight management interventions where appropriate*

Influence decision making and policy making to change the environment we live in to facilitate healthy behaviours.

Current good practice in B&NES

- Contribution to the development of the master plan for Bath and the Placemaking through Health Impact Assessment
- Newly Developed transport plan for Bath and Keynsham
- Development of local food policy options for the Placemaking Plan
- Development of allotment management plan and site selection criteria.
- Procurement of new leisure facilities contract
- Contribute to the production of the river strategy

Recommendations to address Gaps/Needs Identified

- Ensure development of the transport plan includes opportunities for individuals and families to travel sustainably and contributing to climate change and traffic calming agenda
- Strengthen partnership with Planning Department to influence the need for residents to be physically active as a routine part of their daily life on new planning applications.
- Invest in training for planners (urban, rural and transport), architects and designers on the health implications of local plans.
- Create environments which support health promoting behaviour.
- Work with Leisure and Tourism, parks and allotments and open spaces to create opportunities for physical activity
- Work with providers of public transport to promote the benefits of travelling sustainably – linking walking and cycling routes with public transport networks
- Work with planners to improve access to food retail outlets and the feasibility of restricting the number of fastfood outlets
- Ensure there is a good supply of resilient, well-managed, maintained and fit for purpose green spaces and playing pitches that meet the needs of the community they serve as well as safeguard against the loss of open space and recreational facilities.
- Maximise on opportunities for integrating walking and cycling routes with art and culture and world heritage sites