Bath & North East Somerset Council

NHS Bath and North East Somerset

Bath and North East Somerset Health & Wellbeing Board

Democratic Services Guildhall, High Street, Bath BA1 5AW	Direct Line:	01225 394452
	Ask For:	Jack Latkovic
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	Date:	17 March 2015

To: All Members of the Health & Wellbeing Board

Members: Councillor Paul Crossley (Bath & North East Somerset Council), Dr Ian Orpen (Member of the Clinical Commissioning Group), Ashley Ayre (Bath & North East Somerset Council), Councillor Simon Allen (Bath & North East Somerset Council), Bruce Laurence (Bath & North East Somerset Council), Councillor Dine Romero (Bath & North East Somerset Council), Jo Farrar (Bath & North East Somerset Council), Morgan Daly (Healthwatch Representative), Diana Hall Hall (Healthwatch representative), John Holden (Clinical Commissioning Group lay member) and Tracey Cox (Clinical Commissioning Group)

Non-voting member Julia Davison (NHS England - Bath, Gloucestershire, Swindon and Wiltshire Area Team)

Observers: Councillors John Bull and Vic Pritchard

Other appropriate officers
Press and Public

Dear Member

Health & Wellbeing Board

You are invited to attend a meeting of the Board, to be held on **Wednesday, 25th March, 2015** at **10.00 am** in the **Brunswick Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
Committee Administrator

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

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

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

3. **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.

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

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

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

6. **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.

(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.

7. Attendance Register:

Members should sign the Register which will be circulated at the meeting.

8. Emergency Evacuation Procedure

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

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

Health & Wellbeing Board

Wednesday, 25th March, 2015
Brunswick Room - Guildhall, Bath
10.00 am - 12.00 pm

Agenda

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

3. APOLOGIES FOR ABSENCE

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.

   (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 CHAIR

6. PUBLIC QUESTIONS/COMMENTS

7. MINUTES OF PREVIOUS MEETING

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

8. BATH AND NORTH EAST SOMERSET PHARMACEUTICAL NEEDS ASSESSMENT 2015-18 (15 MINUTES)

   The Bath and North East Somerset Health and Wellbeing Board has an obligation to produce a Pharmaceutical Needs Assessment (PNA) for the area by 1st April 2015.

   Following a 70 day consultation process, the PNA Steering Group has now prepared a Pharmaceutical Needs Assessment document for consideration and approval by the Board prior to publication.

   The Board is asked to:

   - Consider and adopt the key findings set out in the Bath and North East Somerset

Pharmaceutical Needs Assessment 2015-18

- Agree the proposed arrangements for maintaining and keeping the PNA up to date, including an annual PNA Steering Group review meeting
- Agree that representatives of the Health and Wellbeing Board meet with the Avon Local Pharmaceutical Committee through an informal intelligence-sharing meeting
- Confirm which of option 1 and 2 should be adopted for responding to notifications of new pharmacy applications from NHS England.

9. REFRESH OF THE HEALTHY WEIGHT STRATEGY (15 MINUTES)

The Board is asked to:

- Approve the strategy subject to public consultation
- Agree the governance of the strategy

10. DEMENTIA WORK PROGRAMME UPDATE (15 MINUTES)

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 B&NES Health and Wellbeing Board on the dementia work programme.

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

11. DIABETES CARE PATHWAY REDESIGN (15 MINUTES)

Diabetes is the long term condition with the fastest rising prevalence and in order to manage the increasing demand, the diabetes care pathway is being redesigned.

This work is one of the CCG's strategic priorities for the next 5 years and the purpose of this paper is to inform the B&NES Health and Wellbeing Board on the model and provide an update on project progress.

The Board is asked to:

- Note the project work undertaken to date; and
- Support the development and delivery of the new pathway.

12. BATH AND NORTH EAST SOMERSET JOINT HEALTH AND WELLBEING STRATEGY (25)

The first Bath and North East Somerset Joint Health and Wellbeing Strategy (JHWS) was published in November 2013.

The approval of the CCG 5 year strategic plan, publication of NHS England's 'The 5 Year Forward View', publication of the first Health and Wellbeing Board annual report and work on a new Council vision and corporate plan means a lot has changed since this date. The Strategy needed to be refreshed in order to reflect this change.

The Board is asked to:

- Comment on and adopt the refreshed B&NES Joint Health and Wellbeing Strategy

13. HEALTHWATCH BATH AND NORTH EAST SOMERSET UPDATE (10 MINUTES)

The Board is asked to agree that:

- It notes the feedback received through issues and concerns and through the Network, including an update on a research project conducted by Healthwatch within the Royal United Hospital.
- It considers and notes the proposal for a model of Healthwatch work which maximises resources available within the overall Healthwatch project and local partners.

14. BETTER CARE FUND (BCF) SECTION 75 AGREEMENT (15 MINUTES)

The changes to the previously submitted Bath and North East Somerset BCF plan were agreed by the Health and Wellbeing Board on the 17th September 2014, this led to the plan being approved and recognised as an example of best practice through the NHS England national assurance process.

The submitted plan has had no changes to planned schemes; however the Council and CCG have reviewed its emergency admissions target and reconsidered this target to take into account 2014/15 pressures in acute trust non-elective activity.

There is now a requirement to formalise the arrangement and ensure that there is a documented agreement in place outlining funding transfers, governance and risk share arrangements under Section 75 of the NHS Act 2006.

The Board is asked to:

- Note the financial summary of BCF schemes and the 2015/16 funding transfers
- Support the changes to the target for reductions in emergency admissions
- Agree entering into the draft section 75 agreement with delegation to the Co-chairs of the Health and Wellbeing Board and CCG's Chief Officer for agreement of the final agreement before signing.

15. TWITTER QUESTIONS

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

Bath and North East Somerset Council

NHS Bath and North East Somerset

HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 21st January, 2015, 10.00 am

Councillor Paul Crossley	Bath & North East Somerset Council
Dr Ian Orpen	Clinical Commissioning Group
Ashley Ayre	Bath & North East Somerset Council
Councillor Simon Allen	Bath & North East Somerset Council
Bruce Laurence	Bath & North East Somerset Council
Councillor Dine Romero	Bath & North East Somerset Council
Jo Farrar	Bath & North East Somerset Council
Diana Hall Hall	Healthwatch representative
Ronnie Wright	Healthwatch representative
John Holden	Clinical Commissioning Group lay member
Tracey Cox	Clinical Commissioning Group

Co-opted Non-Voting Member:

Julia Davison	NHS England - Bath, Gloucestershire, Swindon and Wiltshire Area Team

61 WELCOME AND INTRODUCTIONS

Dr Ian Orpen informed the meeting that he would Chair this meeting of the Board according to co-Charing agreement approved at the last Board meeting.

The Chair welcomed everyone to the meeting.

62 EMERGENCY EVACUATION PROCEDURE

The Democratic Services Officer drew attention to the evacuation procedure as listed on the call to the meeting.

63 **APOLOGIES FOR ABSENCE**

Pat Foster had sent her apologies for this meeting. Ronnie Wright (Healthwatch) was her substitute for this meeting.

64 **DECLARATIONS OF INTEREST**

There were none.

65 **TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR**

The Chair informed the meeting that he had agreed to include a briefing (attached to these minutes) from Council officers regarding a response to the recent pressures at the RUH and the fact that £325,000 had been awarded in extra money to support social care.

The Chair suggested that the Board should consider this document under ‘Commissioning Intentions’ agenda item rather than at this point of the meeting.

The Board agreed to consider this document as part of the ‘Commissioning Intentions’ item.

66 **PUBLIC QUESTIONS/COMMENTS**

There were none.

67 **MINUTES OF PREVIOUS MEETING**

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

68 **YOUR SAY ADVOCACY NETWORK UPDATE (30 MINUTES)**

The Chair invited Kirsty Mann and Kate Hurden from ‘Your Say Advocacy’ and Mike McCallum to give the presentation to the Board.

The Board welcomed the presentation. Members of the Board had felt that work of the Your Say Advocacy Network with people who had learning disabilities had been quite inspirational.

Bruce Laurence asked what would be key messages from the Your Say Advocacy to the Board.

Kirsty Mann replied that people with learning difficulties had experienced everything that any other vulnerable group had been experiencing but they do have different needs. For instance they would need more time at the GP to fully understand what they were told.

Dr Orpen commented that an issue of GP appointments for people with learning difficulties was a valid point.

Councillor Crossley commented that the new library in Keynsham had had positive feedback from the Network and asked if there had been any other development work across the area where the Network could be involved.

Kirsty Mann replied that there were other developments across the area in which the Network could have an input.

Councillor Allen commented that the Board should receive regular updates from the Network on their partnership conversations.

Jo Farrar commented that she was pleased that the Network had been involved in the new development in Keynsham and, as a result of that, they were invited to become Partners in the One Stop Shop.

Councillor Romero asked if the Network had been involved in consultation run by the Council.

Kirsty Mann responded that the Network would want to be involved in consultations run by the Council. Kirsty Mann added that the One Stop Shop in Keynsham was a good example how the Network were involved from the beginning of development.

Ashley Ayre asked if the Network had had any links with the special schools and colleges.

Kirsty Mann responded that the Network had had link with the main learning disability special needs school though not with mainstream schools. Kirsty Mann added that there have been some links with colleges but not as strong as the Network would want to have.

Ronnie Wright suggested that the Network should get in touch with the Healthwatch who could amplify their messages on their website and also on their networking events.

Dr Orpen invited the Network to give a presentation to the CCG Board. Kirsty Mann took that offer on board.

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

69 MAKING IT REAL IN BATH AND NORTH EAST SOMERSET (15 MINUTES)

The Chair invited Wendy Sharman (Transformation & Strategic Planning Manager) to give the presentation to the Board.

Wendy Sharman highlighted the following points in her presentation:

- What is Personalisation?
- What does Personalisation mean to us?
- Making it Real

- Markers for Change
- Risk enablement – feeling in control and safe
- Making it Real in Bath and North East Somerset
- Our proposal

A full copy of the presentation is available on the Minute Book in Democratic Services.

Tracey Cox commented that 'Making it Real' action plan appears to have massive agenda and asked if conversation with commissioners and large providers took place.

Wendy Sharman responded that the CCG B&NES, together with the Council, had supported the application. Wendy Sharman also said that draft programme structure and action plan for 'Making it Real' would be communicated with large area providers, like Sirona and the RUH Bath.

Councillor Allen supported 'Making it Real' action plan. He added that the proposed structure for B&NES would result in fully embedding co-production and the principles of 'Making it Real' throughout the decision making processes of Bath & North East Somerset Council Adult Social Services. It would do this by eventually establishing a 'Making it Real Implementation Group' supported by working groups. The Implementation Group would sit alongside the Care Act Implementation Board and would share a number of work streams with that Board.

Bruce Laurence and Tracey Cox commented that there should be caution on the aspiration of the 'Making it Real' action plan. Wendy Sharman replied that it was good to set high goals in order to motivate ourselves and others.

Ronnie Wright commented that the Healthwatch, together with Wendy Sharman and her team would talk more about the Personalisation and 'Making it Real' plan.

It was **RESOLVED** to endorse:

- The commitment to Making it Real
- The proposal to develop a 'Making it Real' action plan
- The principles of co-production which this will entail
- The draft programme structure and draft action plan

The Board **RESOLVED** to receive six monthly progress reports.

70 **ANNUAL COMMISSIONING INTENTIONS (35 MINUTES)**

The Chair invited the following officers to give their presentations (as per attached report):

- NHS England – Julia Davison
- B&NES Council – Jane Shayler
- B&NES CCG – Tracey Cox
- Public Health – Bruce Laurence

John Holden commented that he was very encouraged with presentations. John Holden noted that Tracey Cox had said that commissioning intentions had gone to providers by end of November 2014, which seemed to be consistent with ordinary process to get things in place by April 2015, though he wasn't quite sure when the material from the NHS England had been received. If material was received in December 2014, how could the CCG encompass items from the NHS England presentation?

Tracey Cox replied that the guidance did not come out until 23rd December. However, the CCG always caveat commissioning intentions for that subsequent guidance that was likely to be issued. The good thing was that there were only few surprises with new guidance, and everything else has been pretty much expected.

Councillor Allen welcomed increased focus on mental health and also that care and quality within the urgent care system had been maintained. Councillor Allen added that the most positive thing was joint commissioning of primary care between the Council and CCG.

Jo Farrar said that she was pleased with comments from Julia Davison that B&NES had been setting directions for other places in the UK. Jo Farrar said that the Board should receive a report in near future on why we do work well and how we would take that to the next level, from strategic point of view.

The Chair agreed with the comment from Jo Farrar and supported her suggestion for a report on why do we work well in comparison to others.

It was **RESOLVED** to note the presentation and to receive a report on why we work well in comparison to other authorities.

71 HEALTHWATCH B&NES: MAKING EVERY CONTACT COUNTS (10 MINUTES)

The Chair invited Ronnie Wright to introduce the report.

It was **RESOLVED** to note the outcomes of the meeting.

72 PUBLIC HEALTH ANNUAL REPORT (5 MINUTES)

The Chair invited Bruce Laurence to introduce the report.

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

73 LOCAL SAFEGUARDING CHILDREN'S BOARD UPDATE (15 MINUTES)

The Chair invited Reg Pengelly (Independent Chair of the Local Safeguarding Children's Board - LSCB) to introduce the report).

Ashley Ayre complemented Reg Pengelly as the Chair of the LSCB. Ashley Ayre also said that there had been an ongoing work on recruiting lay members of the LSCB. The LSCB had worked very hard on ensuring clear accountability.

Ashley Ayre also informed the Board that Reg Pengelly had been appointed as the Chair of the Local Safeguarding Adult Board.

Councillor Allen commented that independence of the LSCB was important and that it should stay as independent body.

Councillor Romero suggested that Reg Pengelly should provide further update to the Health and Wellbeing Board at one of the future meetings.

It was **RESOLVED** to note the report and to receive further update regarding the work of the B&NES Local Safeguarding Children Board (LSCB).

74 **TWITTER QUESTIONS (5 MINUTES)**

The Chair informed the meeting that there had been three questions from Twitter.

NOTE: Questions from Twitter had been asked without prior notice so responses from the Board were provided at the meeting.

1. @AnalogueAndy asked *'#ZeroSuicide in the news. More than 4,700 deaths in 2013. What does the Board think it needs to do?*

   Bruce Laurence, Director of Public Health, said:

   'The work done in Detroit was very strong and I have read about it in some detail, but there is a significant difference in that the target was reached there not in the whole population of the city but in a section of the population enrolled in a particular health insurance scheme which will therefore exclude some of the most needy and vulnerable who aren't covered and that will also ensure that everyone is known to services. The NHS has responsibility for the whole population including the most vulnerable and needy and some who will not be known to any services. But the work done there is impressive and we can try to learn from it.

   Suicide is a major problem and there is some evidence that it increases in times of economic stress. To a large extent suicide is an indication of long term and exceptional stress, but sometimes it can be more impulsive with much less reason to suspect that there might be a danger.

   Suicides are tragic to the families affected and we treat every suicide seriously and audit to see if each suicide could have been avoided.

   Sometimes people are in contact with services but often, in maybe around half of cases, they are not so to manage suicide is not just about picking up and managing risks among those who come to the attention of services, but also about looking at the health and wellbeing and particularly mental health of all residents.

   This then brings in contributions of many, starts with good early years development and support to young families, education and training, jobs and benefits, housing and therefore this involves all of our services state, voluntary and indeed society as a whole.

We know that loneliness and social isolation are important and paradoxically the connectivity of the internet has negative as well as positive influence. It can create strong supportive relations and networks that protect people from stress and isolation but can also allow bullying and there are websites that actively encourage dangerous behaviour.

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It involves some of what we have heard this morning about personalised care and the idea that people need control of the support that they get to best meet their needs. Perhaps one of the most important things that the Detroit experience has shown is the power of coordinating different services around individuals thought to be at high risk.

Some of the more specific areas where we are strengthening services that impact on mental health are the increased access to talking services for people who have anxiety and depression, drug and alcohol treatment services and the wellbeing college which has been mentioned already and that is designed to be a strong entry point through which people can be engaged in a discussion and pointed to all the already existing services.

One final point is that it isn't always clear that people, and especially young people, always understand how dangerous some activities are and we need to find ways to have a better dialogue with young people around this to make them aware of danger without doing anything to promote what we are seeking to avoid, which is quite a challenge to us.

We have a suicide strategy that tries to pull these diverse threads together.

Meanwhile we will continue to look at each suicide and learn lessons that might help for the future.

I am not sure that we can really achieve zero suicides and we have had targets over the years to concentrate minds and efforts, but it is a noble aspiration and we must always be aiming to reduce rates to the minimum.

2. @AnalogueAndy asked *'Active travel, walking and cycling have key role to play in prevention. What is the Board doing to support it?'*

   Jo Farrar, B&NES Council Chief Executive said:

   '*The Board is very aware and encourages active lifestyles, as you can see from the Health and Wellbeing Strategy, and as a Council, who works with partners that sit around this table, we use that Strategy to develop quite important work for the local area. To highlight two – one is our Fit for Life Strategy, which is our leisure strategy, and we are soon to re-commission our Leisure Services at the heart of our strategy, promoting walking and cycling as a way to keep fit and remain healthy; and two, another key strategy, is Transport Strategy for Bath which we just consulted on and where we put big emphasis on walking and cycling to get around and recognising Bath as a city known to be good to walk around. We will soon be expanding Transport Strategy and we will be looking at Keynsham area and then wider North East Somerset area.'*

Dr Orpen added *'Study showed that 20 minutes of walking each day could have a significant impact on your health and wellbeing'*.

3. @AnalogueAndy commented *'Market testing sounds like euphemism for privatisation. Board must ensure pounds are spent as intended – not to boost companies' profits*.'

   Tracey Cox (B&NES CCG Chief Operating Officer) said:

   'The CCG and Local Authority are embarking on engagement process at the moment with our stakeholders about future of community services and we are looking at the latest what data tells us about the needs of our local people. We don't know yet what the outcome of that process will be and it is likely that it will be potentially a range of options so once we are at the end of that process we may decide that some bits of our services do need to be put out to the market for re-procurement, but we may decide that others don't. So, there is a range of potential options and outcomes and obviously, due course, we will keep the HWB informed on progress. If you think about national direction of travel, and what we want – we want capable providers that are able to integrate services, and able to provide really good quality outcomes for our patients. When we go to the market, and we test our providers, the price element is often not one of the major factors. At the CCG Board we do some preliminary work to think about relative weight and balance of all of the criteria that we will use to evaluate providers against. The money, perhaps, takes lower priority than people might anticipate.

   It isn't about the lowest cost service – it is about the right service.'

   Dr Orpen added *'To endorse that the money is not the driver; it is the quality of the service. If you have a quality service then you will get the best outcomes.'*

The meeting ended at 12.15 pm

Chair ....

Date Confirmed and Signed ....

Prepared by Democratic Services

Bath & North East Somerset Council

healthwatch Bath and North East Somerset

NHS Bath and North East Somerset Clinical Commissioning Group

MEETING	B&NES HEALTH AND WELLBEING BOARD
DATE	25/03/2015
TYPE	An open public item

Report summary table	
Report title	**Bath and North East Somerset Pharmaceutical Needs Assessment 2015-18**
Report author	Joseph Prince, Senior Public Health Research & Intelligence Officer (01225 394070) Presented by Paul Scott, Assistant Director of Public Health
List of attachments	Appendix One: Draft Bath and North East Somerset Pharmaceutical Needs Assessment 2015-18
Background papers	NA
Summary	The Bath and North East Somerset Health and Wellbeing Board has an obligation to produce a Pharmaceutical Needs Assessment (PNA) for the area by 1st April 2015. Following a 70 day consultation process, the PNA Steering Group has now prepared a Pharmaceutical Needs Assessment document for consideration and approval by the Board prior to publication.
Recommendations	The Board is asked to: • Consider and adopt the key findings set out in the Bath and North East Somerset Pharmaceutical Needs Assessment 2015-18 (Appendix 1) • Agree the proposed arrangements for maintaining and keeping the PNA up to date, including an annual PNA Steering Group review meeting • Agree that representatives of the Health and Wellbeing Board meet with the Avon Local Pharmaceutical Committee through an informal intelligence-sharing meeting • Confirm which of option 1 and 2 should be adopted for responding to notifications of new pharmacy applications from NHS England.
Rationale for recommendations	It is a statutory requirement to publish a PNA for Bath and North East Somerset by 1st April 2015.
Resource implications	The Bath and North East Somerset Pharmaceutical Needs Assessment 2015-18 has been managed within existing Council

	capacity and budgets. The key findings contained within the PNA will help inform the future commissioning and delivery of local pharmacy services by NHS England, Clinical Commissioning Group and Council.
Statutory considerations and basis for proposal	The Health and Social Care Act 2012 established Health and Wellbeing Boards and transferred responsibility to develop and update Pharmaceutical Needs Assessments from Primary Care Trusts (PCTs) to HWBs. The requirements for a PNA are set out in the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.
Consultation	In order to test the findings set out in the draft Bath and North East Somerset Pharmaceutical Needs Assessment 2015-18, a 70 day consultation period was undertaken – starting on 8th December 2014 and ending on 15th February 2015. A range of methods were used to promote the consultation period including: • A letter to key stakeholders inviting feedback (including HWB members, Wellbeing Policy Development and Scrutiny Panel members, neighbouring authorities, CCG colleagues, dispensing doctors and those on the pharmaceutical list, Ward Councillors, Connecting Community Forum Chairs, key officers, providers and community groups) • An online questionnaire and promotion through Twitter • A number of local e-bulletins, newsletters and websites • Presented for discussion and feedback at a number of meetings (Independent Equality Advisory Group, Your Health Your Voice, Joint Commissioning Committee). In addition to the range of feedback collected through meetings and emails, 26 responses were submitted to the consultation questionnaire from a range of people (including members of the public, commissioners, GP's, pharmacy providers and community organisations).
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.

THE REPORT

Background – purpose of the PNA

1.1 Responsibility for developing and updating Pharmaceutical Needs Assessments (PNA) was transferred to Health & Wellbeing Boards in 2012 as a result of the Health and Social Care Act - previously a responsibility of Primary Care Trusts. The B&NES Health and Wellbeing Board has a statutory obligation to produce a PNA for the area by 1st April 2015.

1.2 The PNA is a statement from the B&NES Health and Wellbeing Board which assesses local pharmaceutical related health need and describes the provision of pharmaceutical services across the area. It reflects the needs of the local population which are described in detail in the B&NES Joint Strategic Needs Assessment. It also considers whether the level of provision will be right for local communities over the next 3 years.

1.3 The PNA will be used by NHS England when making decisions on pharmacy applications, articulating what the pharmacy needs look like across B&NES so that that there is a clear understanding of what service provision is required (for example - whether there is a need for a new pharmacy in a proposed location, or whether current provision is adequate). However, it is the role of NHS England through the application process and not the PNA, to assess what the best delivery mechanism for a pharmacy service would be.

1.4 The PNA will also contribute to the delivery of local strategic priorities set out in the Joint Health and Wellbeing Strategy and Clinical Commissioning Group plans, highlighting opportunities where pharmaceutical services can be better targeted to meet local need and enable greater health independence, self-care and self-management, as well as help to reduce health inequalities. Findings from the PNA will also be used to help inform future plans and strategies.

1.5 The PNA will also inform interested parties of the pharmaceutical needs in the area so that services can be planned, developed and delivered in the most suitable way for local people.

Health and Wellbeing Board responsibilities

1.6 Publishing the PNA by April 1st 2015
A draft Pharmaceutical Needs Assessment 2015-18 for Bath and North East Somerset is attached as Appendix One.

The document identifies a number of key findings which the Board is asked to consider and adopt:

- Key Finding 1: Necessary Services are defined as all Essential Services (as defined in 1.1.6 of the PNA)
- Key Finding 2: Current pharmaceutical provision in B&NES, including out-of-hours provision, appears to be sufficient to meet the needs of the population from the three Bath GP clusters of Bath West, Bath East and Bath Central, and the Norton Radstock GP cluster. Furthermore, there appears to be sufficient pharmaceutical provision during the day until at least 18:30 Monday to Saturday that serve the Chew/Keynsham GP cluster

- Key Finding 3: There is a gap in the provision of easily accessible local community pharmaceutical services that serve the Chew/Keynsham GP cluster in the evenings after 18:30 Monday to Saturday, and on Sundays
- Key Finding 4: Within existing pharmaceutical provision there is an identified gap in the number of community pharmacies that currently do not have wheelchair accessible 'closed' consultation rooms
- Key Finding 5: It is anticipated that current pharmaceutical service provision from existing pharmacies will be able to cope with the demand from new populations for the coming few years. This will be reviewed during 2017/18 (at the latest)
- Key Finding 6: There are various locally commissioned pharmaceutical services that could potentially be expanded or improved, these include: an expanded role in testing for a greater range of common STIs; improved signposting for people with substance misuse problems for BBV testing; pharmacies working with a greater range of partners; and individual pharmacies providing a greater range of commissioned services in order to provide a holistic package of care
- Key Finding 7: There are various other locally commissioned services that could potentially be commissioned, for example, an NHS Health Checks Service
- Key Finding 8: There are no known planned additional 'Other Services' (as defined in 1.2.5 of the PNA) that could significantly alter the need for pharmaceutical services in B&NES.

1.7 Maintaining and keeping the PNA up to date

If the Health and Wellbeing Board identifies any significant changes to the availability of pharmaceutical services following publication of its PNA, it is required to make the necessary updates (either through revision to the PNA if deemed appropriate or through a supplementary statement). As a minimum, a new PNA must be published every 3 years.

In addition, the Health and Wellbeing Board is required to keep a map up to date of the provision of NHS pharmaceutical services within the area.

1.8 To meet this requirement, it is recommended that the PNA Steering Group holds an annual review meeting in order to consider whether anything has substantially changed since the publication of the PNA document and to update one another on key work being undertaken which may impact on our understanding of local pharmaceutical services and need.

1.9 In addition, it is proposed that representatives of the Health and Wellbeing Board meet with the Avon Local Pharmaceutical Committee (LPC) through an informal intelligence-sharing meeting in order to consider pharmacy related activity and issues in B&NES and discuss the role pharmacy could play in supporting key priorities identified in the Joint Health and Wellbeing Strategy.

1.10 NHS England notifications about pharmacy applications

Upon receiving a pharmacy application (to amend or open a pharmacy premises), NHS England notifies interested parties of the application and Health and Wellbeing Boards are included as part of this. NHS England invites written representation to be made within 45 days of circulation of the application.

Two options are presented for responding to such notifications and the Health and Wellbeing Board is asked to comment on its preferred option.

Option 1

1.11 It is proposed that representatives from the following teams be given delegated authority for responding to consultations on pharmacy applications on behalf of the B&NES Health and Wellbeing Board:

- Public Health team, B&NES Council
- Research and Intelligence team, B&NES Council
- Strategy and Plan team, B&NES Council
- Ward councillor(s) impacted by application
- BaNES NHS CCG
- Healthwatch B&NES

Upon receipt of an application, it will be circulated to the above contact list for feedback and a single response to NHS England will be co-ordinated by Strategy and Performance.

As part of this process, all those included will be asked to highlight any potential conflicts of interest which may arise in response to an application.

If a clear response cannot be easily identified and agreed electronically, the above group will be invited to meet to discuss and co-ordinate a response.

Option 2

1.12 It is proposed that a board member, such as the Director of Public Health, be given delegated authority for coordinating application responses back to NHS England, on behalf of the B&NES Health and Wellbeing Board.

As part of this process, Public Health will be responsible for circulating applications electronically within 7 days of receipt to representatives from the below teams for their input and feedback before preparing any response:

- Public Health team
- Research and Intelligence team
- Strategy and Plan team
- Ward councillor(s) impacted by application
- BaNES NHS CCG
- Healthwatch B&NES

As part of this process, all those consulted will be required to highlight any potential conflicts of interest which may arise in response to an application.

If a clear response cannot be easily identified and agreed electronically, the above group will be invited to meet to discuss and co-ordinate a response.

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

healthwatch Bath and North East Somerset

NHS Bath and North East Somerset Clinical Commissioning Group

Bath and North East Somerset

Pharmaceutical Needs Assessment

2015 to 2018

Final Version

12th March 2015

Bath & North East Somerset PNA: At a Glance

This document sets out an assessment of need for pharmaceutical services in Bath and North East Somerset (B&NES) for the period 2015 to 2018. Producing this assessment is the responsibility of the B&NES Health & Wellbeing Board.

Chapter 1 sets out the regulatory background, how pharmaceutical services are defined and the process for producing the assessment.

The health and wellbeing needs of the local population, in relation to pharmaceutical services, are set out in chapter 2. Alongside this are the priorities of the B&NES Joint Health & Wellbeing Strategy and the NHS BaNES Clinical Commissioning Group (CCG) Five Year Strategic Plan.

Current provision of local pharmaceutical services is outlined in chapter 3. This chapter highlights provision across the different areas of B&NES, including distribution, accessibility, dispensing activity and wider health services. Variations and current gaps in provision are identified, as well as potential gaps in the future due to population and housing growth. Future opportunities for pharmaceutical services are also considered.

Chapter 4 summarises the eight key findings of the report. These are as follows:

1) Necessary Services are defined as all Essential Services (as defined in 1.1.6).
2) Current pharmaceutical provision in B&NES, including out-of-hours provision, appears to be sufficient to meet the needs of the population from the three Bath GP clusters of Bath West, Bath East and Bath Central, and the Norton Radstock GP cluster. Furthermore, there appears to be sufficient pharmaceutical provision during the day until at least 18:30 Monday to Saturday that serve the Chew/Keynsham GP cluster.
3) There is a gap in the provision of easily accessible local community pharmaceutical services that serve the Chew/Keynsham GP cluster in the evenings after 18:30 Monday to Saturday, and on Sundays.
4) Within existing pharmaceutical provision there is an identified gap in the number of community pharmacies that currently do not have wheelchair accessible ‘closed’ consultation rooms.
5) It is anticipated that current pharmaceutical service provision from existing pharmacies will be able to cope with the demand from new populations for the coming few years. This will be reviewed during 2017/18 (at the latest).
6) There are various locally commissioned pharmaceutical services that could potentially be expanded or improved, these include: an expanded role in testing for a greater range of common STIs; improved signposting for people with substance misuse problems for BBV testing; pharmacies working with a greater range of

partners; and individual pharmacies providing a greater range of commissioned services in order to provide a holistic package of care.

7) There are various other locally commissioned services that could potentially be commissioned, for example, an NHS Health Checks Service.
8) There are no known planned additional 'Other Services' (as defined in 1.2.5) that could significantly alter the need for pharmaceutical services in B&NES.

Acknowledgements

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Special thanks to all those who responded to the consultation

Acknowledgement to:

Other PNA’s, of which some aspects of our PNA are based.

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Glossary of Terms

Bordering pharmacy	A pharmacy situated within 3 miles of the Bath and North East Somerset border.
Controlled localities	Those which have been determined to be 'rural in character' by NHS England in accordance with guidelines set out in the National Health Services (Pharmaceutical Services) Regulations.
Clinical Commissioning Group (CCG)	The Health and Social Care Act 2012 gives commissioning responsibility to CCGs, formed from groups of GP practices in its geographical area of responsibility. These groups of GP Practices, working with other healthcare professionals and in partnership with local communities and Local Authorities are responsible for commissioning the majority of NHS services for patents within their local communities. They have a duty to work with Local Authorities in relation to health and adult social care, early years services, public health, etc.
CCG 5 Year Strategic Plan	CCGs are required to develop a 5 Year Strategic Plan which describes how local health services need to change over the five years to meet people's needs and also how this will be achieved. The NHS Bath and North East Somerset Clinical Commissioning Group 5 Year Strategic Plan is available online here: www.bathandnortheastsomersetccg.nhs.uk/
Core Strategy	The Core Strategy is a key policy document for the area that puts in place a strategic planning framework to guide change and development in the area over the next 20 years and beyond. The Bath and North East Somerset Core Strategy is available online here: http://www.bathnes.gov.uk/services/planning-and-building-control/planning-policy/core-strategy-examination
Dispensing doctor(s)	GPs practicing in rural areas that provide dispensing services to NHS patients in addition to the usual range of medical services.
Dispensing appliance contractor(s)	A specific sub-set of contractors who supply, on prescription, appliances such as stoma and incontinence aids, dressings and bandages and cannot supply medicines.
Fraser guidelines	Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year olds without parental consent. But since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.
Health and Wellbeing Board (HWB)	The Health and Social Care Act 2012 established Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. HWBs are established and hosted by Local Authorities.

Indices of multiple deprivation (IMD)	A measure of deprivation that includes a range of combined information relating to income, employment, education, health, skills and training barriers to housing and services and crime.
Ischaemic heart diseases	Ischemic Heart Disease (also known as Coronary Artery Disease) is a condition that affects the supply of blood to the heart (and may result in a heart attack).
Joint Strategic Needs Assessment (JSNA)	The Joint Strategic Needs Assessment (JSNA) is designed to be the single portal for facts, figures and intelligence about our local area, its communities and its population. The B&NES JSNA is available online in a 'Wiki' format here: www.bathnes.gov.uk/jsna
Joint Health and Wellbeing Strategy (JHWS)	The Joint Health and Wellbeing Strategy sets out the priorities for action based on the health and wellbeing needs identified in the Joint Strategic Needs Assessment. A process of rigorous prioritisation was undertaken by the Health and Wellbeing Board in order to reach agreement on the priorities outlined within the Joint Health and Wellbeing Strategy. The priorities are not an exhaustive list of everything that the Council and NHS are doing to meet local health and wellbeing need; but rather a small set of priorities for the Health and Wellbeing Board to really focus on and make a difference. The Bath and North East Somerset Joint Health and Wellbeing Strategy is available online here: www.bathnes.gov.uk/health-wellbeing-board
Local Pharmaceutical Committee	Local Pharmaceutical Committees (LPCs) represent all NHS pharmacy contractors in a defined locality. LPCs are recognised by local NHS primary care organisations and are consulted on local matters affecting pharmacy contractors.
Minor Ailments Services	Accredited pharmacists may provide some medicines without a prescription for the treatment of conditions such as athlete's foot, conjunctivitis, cold sores, hay-fever, cystitis, thrush, impetigo, ring worm, oral thrush, eye infections and uncomplicated urinary tract infections in females aged 16-65. Unless they are exempt from charges, patients pay the normal NHS prescription charge.
NHS Health Check	The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk.
Neighbouring Health and Wellbeing Board	A term used within the PNA when, for example, a HWB is consulting on their draft PNA and needs to inform the HWBs which border their HWB area.

Pharmaceutical Services Negotiating Committee (PSNC)	The Pharmaceutical Services Negotiating Committee (PSNC) is recognised by the Secretary of State for Health as the representative of community pharmacy on NHS matters.
Palliative Care	The active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments.
Parenteral	Parenteral drug administration means any non-oral means of administration, but is generally interpreted as relating to injecting directly into the body, bypassing the skin and mucous membranes. The common parenteral routes are intramuscular (IM), subcutaneous (SC) and intravenous (IV).
Patient Group Directions (PGDs)	Patient Group Directions provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine to a pre-defined group of patients, without them having to see a prescriber. However, supplying and/or administering medicines under PGDs should be reserved for situations in which this offers an advantage for patient care, without compromising patient safety.
Primary Care Trust (PCT)	Primary care is the first point of contact for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists. Previously, all this was managed by a local primary care trust (PCT). PCT's used to work with local authorities and other agencies that provide health and social care locally to ensure that the local community's needs were being met. The PCT ensured that there were enough services for people within their area and that these services were accessible. On 1st April 2013, PCTs ceased to exist. Their functions have been taken over by Clinical Commissioning Groups (CCGs) and NHS England. They share the responsibilities of commissioning services for their local communities.
Pharmacy contractor (inc. community pharmacies and distance selling pharmacies)	Healthcare professionals working for themselves or as employees who practice in pharmacy, the field of health sciences focusing on safe and effective medicines use. Within this category are: • Community pharmacies (which mainly provide pharmaceutical services from high street premises, supermarkets or adjacent to doctor's surgeries) • Distance-selling pharmacies (which provide pharmaceutical services remotely through the patient placing an order by post, telephone or over the internet and the medication being delivered to the patients' home).

Pharmaceutical Services	In relation to the PNA these include: essential services, advanced services and locally commissioned services (known as enhanced services) commissioned by NHS England. These services are available from pharmacy contractors (pharmacies), dispensing appliance contractors, dispensing GPs and local pharmaceutical services (LPS) contractors.
Stoma	A stoma, or ostomy, is a surgically created opening on the abdomen which allows stool or urine to exit the body. There are 3 main types of stoma – colostomy, ileostomy and urostomy.
Suicide and mortality of undetermined intent	Deaths of this nature are recorded by coroners. A verdict of suicide should is only recorded if there is clear evidence that the injury was self-inflicted and that the deceased intended to kill him/herself. If there is any doubt about the intentions of the deceased either an accidental or an open verdict is recorded.
Voicebox Resident Survey (B&NES)	The large scale Voicebox Resident Survey aims to provide an insight into Bath and North East Somerset and its local communities and to capture resident's views on their local area and council services. The questionnaires are posted to a random selection of addresses within the local authority area. Selected respondents also have the opportunity to complete the survey online.

List of Abbreviations

AUR	Appliance Use Reviews
B&NES / BaNES	Bath and North East Somerset
BBV	Blood Borne Viruses
BMI	Body Mass Index
CaSH	Contraception and Sexual Health Services
CCG	Clinical Commissioning Group
DAC	Dispensing Appliance Contractors
DHI	Developing Health and Independence Charity
DRUMS	Dispensing Reviews of the Use of Medicines
ED	Emergency Department
EHC	Emergency Hormonal Contraceptive
EPS	Electronic Prescription Service
GP	General Practice
GUM	Genitourinary Medicine
HWB	Health and Wellbeing Board
IMD	Indices of Multiple Deprivation
INR	International Normalised Ratio
JSNA	Joint Strategic Needs Assessment
LPS	Local Pharmaceutical Services
LSOA	Lower Super Output Area
LTC	Long term health condition
MMR	Immunization vaccine against measles, mumps, and rubella
MUR	Medicines Use Reviews
NAAT	Nucleic Acid Amplification Tests (for chlamydia and gonorrhoea)
NHS	National Health Service
NMS	New Medicines Service
NRT	Nicotine Replacement Therapy
NSP	Needle and Syringe Programmes
ONS	Office of National Statistics
PCT	Primary Care Trust
PNA	Pharmaceutical Needs Assessment
PoC	Point of Care
PSNC	Pharmacy Services Negotiation Committee
RTI	Respiratory Tract Infection
SAC	Stoma Appliance Customisation
STI	Sexually Transmitted Infection
UCC	Urgent Care Centre

Chapter 1: Background and Process

1.0 Introduction

This chapter introduces the legislative and regulatory background to this Pharmaceutical Needs Assessment (PNA) and describes the process undertaken, including the methodology adopted, to produce it.

1.1 Background

1.1.1 Introduction

The PNA is a statement from the Bath and North East Somerset Health and Wellbeing Board which assesses local pharmaceutical related health need and describes the provision of pharmaceutical services across Bath and North East Somerset (B&NES). The PNA also considers whether the level of pharmacy provision will be right for local communities over the next three years. Finally, it is intended to help decision makers in the commissioning of future services.

The responsibility for the development, publishing and updating of PNAs became the responsibility of Health & Wellbeing Boards (HWBs) as a result of Section 206 of the *Health and Social Care Act 2012*[1] which amended Section 128 of the *National Health Service Act 2006*.[2]

The PNA reflects the needs of the local population which are described in detail in the B&NES Joint Strategic Needs Assessment (JSNA)[3] and summarised in Chapter 2 of this document.

1.1.2 Regulatory Background

B&NES published its first and most recent PNA in 2011, under a now superseded regulatory regime.

The new regulatory basis for developing and updating a PNA is set out in *The National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013*[4] (hereafter referred to as "*The Regulations*"). *The Regulations* require Health and Wellbeing Boards to produce and publish their new PNA by 1st April 2015, and publish a revised assessment as soon as is reasonably practicable after identifying significant changes to the availability of pharmaceutical services.

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[1] *Health and Social Care Act 2012*, c.7, available at: http://www.legislation.gov.uk/ukpga/2012/7/contents
[2] *National Health Service Act 2006*, c.41, available at: http://www.legislation.gov.uk/ukpga/2006/41/contents
[3] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics
[4] *The National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013*, No. 349, available at: http://www.legislation.gov.uk/uksi/2013/349/contents/made

The Regulations were amended by the *National Health Service (Pharmaceutical and Local Pharmaceutical Services) (Amendment and Transitional Provision) Regulations 2014*[5] on 1st April 2014. This PNA has considered these amendments, but the 2013 Regulations have been referenced throughout.

1.1.3 Purpose

The PNA will be used when making decisions on pharmacy applications, articulating what the pharmacy needs look like across Bath and North East Somerset so that that there is a clear understanding of what service provision is required (for example - whether there is a need for a new NHS pharmacy in a proposed location, or whether current provision is adequate).

Pharmaceutical services are an integral part of the wider health and social care provision locally. As part of this, this PNA will contribute to the delivery of local strategic priorities set out in the Joint Health and Wellbeing Strategy and Clinical Commissioning Group plans, highlighting opportunities where pharmaceutical services can be better targeted to meet local need and enable greater health independence, self-care and self-management, as well as help to reduce health inequalities. Findings from the PNA will also be used to help inform future plans and strategies.

The PNA will also inform interested parties of the pharmaceutical needs in Bath and North East Somerset so that services can be planned, developed and delivered in the most suitable way for local people.

1.1.4 Scope

The PNA encompasses pharmacy contractors[6] and dispensing appliance contractors[7] within B&NES, as well as pharmaceutical services provided by dispensing GP practices in the area. In addition, a small number of pharmacies which are outside of the B&NES district, but are close enough to the boarder to likely be regular suppliers of services to B&NES residents, are included (highlighted in Chapter 3). In particular, this applies to the Chilcompton Branch Surgery (of St Chads GP Practice), located across the border in Somerset.

In accordance with *The Regulations* this PNA does not cover dispensing of medicines which takes place at a number of acute and urgent care prescribing centres in the area (see 3.1.4).

[5] *The National Health Service (Pharmaceutical and Local Pharmaceutical Services) (Amendment and Transitional Provision) Regulations 2014*, No. 417, available at: http://www.legislation.gov.uk/uksi/2014/417/contents/made

[6] Defined in 1.1.6.

[7] *Ibid*.

1.1.5 Definition of Pharmaceutical Providers

The Pharmaceutical List is maintained by NHS England and contains a list of providers which have been given permission to provide pharmaceutical services. The list is made up of the following:

A. **Pharmacy Contractors** – pharmacists or a body cooperate that employs a pharmacist. Within this category are community pharmacies (which mainly provide pharmaceutical services from high street premises, supermarkets or adjacent to doctor's surgeries) and distance-selling pharmacies (which provide pharmaceutical services remotely through the patient placing an order by post, telephone or over the internet and the medication being delivered to the patients home).

   At the time of finalising this post-consultation report (3rd March 2015), within B&NES, there are 39 pharmacy contractors – 38 are non-distance selling and one is distance selling (The Bath Pharmacy Company). Of the 38 non-distance selling pharmacies, 8 are believed to be co-located alongside GP practice premises.

B. **Dispensing Appliance Contractors (DAC)** – a specific sub-set of contractors who supply, on prescription, appliances such as stoma and incontinence aids, dressings and bandages and cannot supply medicines.

   At the time of finalising this post-consultation report (3rd March 2015), there are no DACs located in B&NES.

C. **Dispensing Doctors** – medical practitioners authorised to provide drugs and appliances in designated rural areas known as 'controlled localities'.

   At the time of finalising this post-consultation report (3rd March 2015), there are five dispensing GP Practices in B&NES, two with branch surgeries, including one with a branch surgery across the border in Somerset.

D. **Local Pharmaceutical Services (LPS) Contractors** – who provide a level of pharmaceutical services in some areas. An LPS contract allows NHS England to commission community pharmaceutical services tailored to specific local requirements. It provides flexibility to include within a single locally negotiated contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements set out in *The Regulations*. All LPS contracts however, must include an element of dispensing.

   At the time of finalising this post-consultation report (3rd March 2015), there are no LPS contractors in B&NES.

1.1.6 Definition of Pharmaceutical Services

NHS England is the only organisation that can commission NHS Pharmaceutical Services. Therefore, they are responsible for managing and performance monitoring the Community Pharmacy Contractual Framework.

Services defined as pharmaceutical services, and provided by **pharmacy contractors**, are as follows:

A. **Essential Services**[8] – which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service. These services are nationally negotiated and must be provided from all pharmacies:
   - Dispensing of medicines;
   - Repeat dispensing;
   - Safe disposal of unwanted medicines;
   - Promotion of healthy lifestyles;
   - Signposting;
   - Support for self-care;
   - Clinical governance; and
   - Electronic Prescription Service (EPS).

B. **Advanced Services**[9] – services community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation, as necessary. They are negotiated nationally and any contractor may provide:
   - Medicines Use Reviews (MURs);
   - New Medicines Service (NMS);[10]
   - Appliance Use Reviews (AURs); and/or
   - Stoma Appliance Customisation (SAC).

C. **Locally Commissioned Services (known as Enhanced Services)**[11] – these are negotiated locally by NHS England Area Teams and may only be provided by contractors directly commissioned by NHS England. They can include:
   - Anticoagulant Monitoring Service
   - Care Home Service
   - Disease Specific Medicines Management Service
   - Gluten Free Food Supply Service

[8] Schedule 4 of *The Regulations*.
[9] Parts 2 and 3 of *The NHS Act 2006, the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013*.
[10] This service is temporarily commissioned and is currently under review nationally.
[11] Part 4 of the *NHS Act 2006* and the *Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013* [available from: https://www.gov.uk/government/publications/pharmaceutical-services-advanced-and-enhanced-services-england-directions-2013]

- Independent Prescribing Service
- Home Delivery Service
- Language Access Service
- Medication Review Service
- Medicines Assessment and Compliance Support Service
- Minor Ailments Service
- Needle and Syringe Exchange Service*
- On Demand Availability of Specialist Drugs Service
- Out of Hours Service
- Patient Group Direction Service*
- Prescriber Support Service
- Schools Service
- Screening Services (such as chlamydia screening)*
- Stop Smoking Service*
- Supervised Administration Service*
- Supplementary Prescribing Service
- Emergency Supply Service[12]

The responsibility for public health services transferred from Primary Care Trusts (PCTs) to local authorities with effect from 1st April 2013. Where services marked (*) are currently commissioned by local authorities, they are not considered enhanced or pharmaceutical services. However, NHS England is permitted to commission them from pharmacy contractors if asked to do so by a local authority. In this case, if commissioned by NHS England, they are enhanced services and fall within the definition of pharmaceutical services.

NHS England does not currently commission any public health services from pharmacy contractors in B&NES.

1.1.7 Locally Commissioned Services

Other organisations – Clinical Commissioning Groups (CCGs) and Local Authorities being most likely – are also able to commission services from community pharmacies which are not considered part of the NHS Pharmaceutical Services, but meet a particular pharmaceutical need. These are described as 'Locally Commissioned Services' and it is important that these are considered as part of a review of pharmacy need in order to acquire a full picture of current provision. Examples of these services which B&NES commissions locally include sexual health services, smoking, drugs and alcohol services.

[12] Added by *The Pharmaceutical Services (Advanced and Enhanced Services) (England) (Amendment) (No. 2) Directions 2013* [available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266023/pharmaceutical_services_directions_amendment_2013.pdf]. The underlying purpose of this service is to ensure that, in cases of urgency, patients, at their request, have prompt access to drugs or appliances which have previously been prescribed for them in an NHS prescription but for which they do not have an NHS prescription.

1.1.8 Non-Commissioned Added Value Community Pharmacy Services

Community pharmacy contractors can also provide services directly to patients that are not commissioned by NHS England, Local Authorities or CCGs – they are free to decide whether to charge for these services as part of their business model. An example of an added value service provided by some pharmacies within B&NES is the provision of a home delivery service to patients.

1.1.9 Key changes since the last Pharmaceutical Needs Assessment

There have been a number of key developments since the publication of the last B&NES PNA in 2011.

Demographic changes, such as the projected increase in the number of older people in B&NES, are likely to affect local pharmaceutical service provision, for example, leading to an increase in the number of prescription items being dispensed and an increased demand for services targeted to an older population. Health needs also change over time and pharmaceutical services need to reflect this and make sure they are meeting the needs of a changing population.

There have also been a number of pharmacy changes since the last PNA publication with a number of pharmacies closing and new pharmacies opening. Overall, pharmacy provision has increased from 2011 when the last PNA was published – in 2011 there were 36 pharmacy contractors and in 2014 this had increased to 39 pharmacy contractors (including Chew Pharmacy, which opened on 23rd February 2015). Further detail on the specific pharmacy changes can be found in the pharmaceutical services chapter (3.3.1).

An Urgent Care Centre at the Royal United Hospital Bath was opened in 2014.

Adoption of the Bath and North East Somerset Core Strategy in 2014 will also impact on future demand for pharmaceutical services.[13] The Core Strategy sets out the vision for spatial development within the area until 2029 and the strategy identifies a housing requirement of approximately 13,000 new dwellings that it is seeking to deliver. The provision of pharmaceutical services will need to reflect this and respond to potential changes in demand and need.

[13] B&NES (2014), *Bath and North East Somerset Core Strategy: Part 1 of the Local Plan*, July 2014, available at: http://www.bathnes.gov.uk/services/planning-and-building-control/planning-policy/core-strategy-examination

1.2 Content

Regulation 4 and Schedule 1 of *The Regulations* set out the minimum requirements for a PNA. A PNA is required to include the following:

1.2.1 Necessary Services – current provision (Sch. 1, Para. 1)

Current provision of 'necessary' pharmaceutical services within the B&NES area (or outside of the area, but which contribute towards meeting the need for pharmaceutical services in the area) are defined as:

- All Essential Services (defined in 1.1.6; provision is detailed in 3.3 and accessibility is detailed in 3.5.3).

Necessary Services are defined in 4.1.1.

1.2.2 Necessary Services – gaps in provision (Sch. 1, Para. 2)

Any pharmaceutical services which are not currently provided within the B&NES area but which the local Health and Wellbeing Board has identified as needing to be provided (currently or in the future).

Gaps in the provision of Necessary Services are outlined in 4.1.2.

1.2.3 Other Relevant Services – current provision (Sch. 1, Para. 3)

Any other pharmaceutical services provided within the B&NES area which aren't necessary to meet the need but have secured improvements, better access or affect the assessment of need (or outside of the area but which have an impact on the B&NES area).

For the purpose of this PNA, 'Other Relevant Services' are defined as:

A. Non-Commissioned Services

- Collection of prescriptions from GP practices (outlined in 3.5.3[B]); and
- Delivery of dispensed medicine (outlined 3.5.3[B]).

B. Commissioned Services

- Medicines Use Reviews (outlined in 3.5.5[B]);
- New Medicine Service (outlined in 3.5.5[B])Advanced Service: Appliance Use Reviews (outlined in 3.5.5[B]); and
- Stoma Appliance Customisation Service (outlined in 3.5.5[B]).
- Specialist Drugs (Palliative Care) Enhanced Service (outlined in 3.5.5[C]);
- Sexual Health Services (3.5.6[A]);
- Smoking Cessation Services (3.5.6[B]); and
- Substance Misuse Services (3.5.6[C]).

1.2.4 Improvements and better access – gaps in provision (Sch. 1, Para. 4)

Any pharmaceutical services not currently being provided but which would secure future improvements to pharmaceutical services (common examples of this include major industrial, communications or housing developments).

These gaps are outlined in 4.1.3.

1.2.5 Other Services (Sch. 1, Para. 5)

Any NHS services provided or arranged by the Health and Wellbeing Board, NHS Commissioning Board, a CCG, an NHS Trust or an NHS Foundation Trust which affect current or future need for pharmaceutical services (for example, a large health centre providing a stop smoking service).

Other services that might potentially impact on the future need for pharmaceutical services are outlined in 2.4.

1.2.6 How the assessment was carried out (Sch. 1, Para. 6)

An explanation of how the PNA has been carried out including: (i) how the localities used within the PNA have been determined; (ii) how the different needs of different localities within the area have been taken into account, as well as the different needs of people in the area who share a protected characteristic; and (iii) a report on the consultation that has been undertaken.

A description of the PNA process is outlined in 1.3.

1.2.7 Maps (Sch. 1, Para. 7)

A map (kept up to date in so far as is practicable[14]) identifying the premises at which pharmaceutical services are provided in the area.

This requirement is met by the provision of Figure 6.

1.3 Process

1.3.1 Introduction

B&NES's Health & Wellbeing Board has established a PNA Steering Group to oversee the process of developing a new PNA. Members of this PNA Steering Group include representation from B&NES Council, NHS BaNES CCG, NHS England and Avon Local Pharmaceutical Committee (LPC).

[14] Regulation 4(2) of *The Regulations* requires the HWB to keep the above map up to date, in so far as is practicable.

1.3.2 Methodology

The Department of Health's PNA Information Pack,[15] designed to support local authorities with regards to their responsibilities in developing a PNA, has been used as a guide for the methodology adopted in this PNA.

The content of this PNA will be produced by means of a structured analysis of complex and comprehensive data sources in order to identify the following:

- health and pharmaceutical needs of the population (Chapter 2);
- current local provision of services (Chapter 3); and
- gaps in provision of pharmaceutical services (Chapter 4).

Data and information will be taken from a wide variety of sources; including national data sources, B&NES's Joint Strategic Needs Assessment (JSNA), a PNA Questionnaire, and others.

The methodology adopted in this PNA differs from the previous PNA (carried out in 2011), which made decisions about provision and need based on where pharmacies were physically located. Rather than always assume that members of the public use only those pharmacies that are located close to where they live, this PNA takes into account current dispensing behaviours of those people registered with GP practices located in the BaNES CCG area. This will mainly include those people normally resident in B&NES. However, the BaNES CCG population also include people who are registered with a B&NES GP, but who are normally resident in areas outside of B&NES. Likewise, it will exclude those people who are normally resident in B&NES, but who are registered with non-B&NES GP practice.

As has been stated, this PNA covers the BaNES CCG GP registered population. Therefore, the use of strict geographical boundaries has not been followed in this PNA. Instead, health need and pharmacy provision have been mapped in relation to the GP registered population in the current five NHS BaNES CCG GP clusters[16] (Figure 1):

1) Norton Radstock GP cluster;
2) Chew/Keynsham GP cluster;
3) Bath East GP cluster;
4) Bath West GP cluster; and
5) Bath Central GP cluster.

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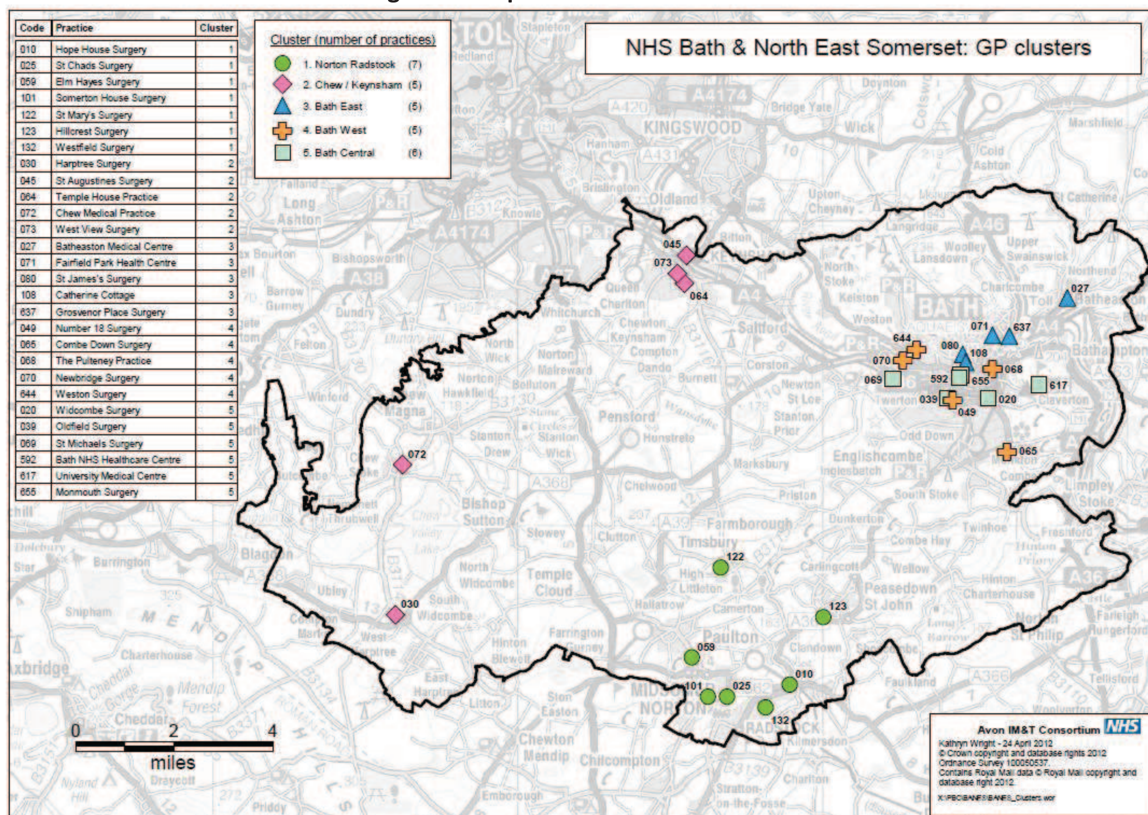
[15] Department of Health (2013), *Pharmaceutical Needs Assessments: Information Pack*, available at: https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

[16] NHS BaNES CCG is structured so that its individual practices are currently grouped into five GP clusters. Each cluster has an elected CCG Board member to represent the views of the cluster at Board level. The clusters act as a liaison between individual practices and the CCG Board and Executive to ensure that local needs are highlighted and met. A GP practice cluster does not have a physical boundary and should not be compared with, or aggregated up to, other geographically based boundaries used for the analysis of healthcare data.

Each GP cluster has a population of between 30,000 and 50,000 (Table 1). The CCG intends to utilise this model to develop community based services in the future.

Consideration has also been given to pharmaceutical providers located outside of the B&NES boundary (Figure 6) that are close enough to the boarder they are likely to be regular suppliers of services to B&NES residents and BaNES CCG GP registered patients.

Figure 1: Map of BaNES CCG GP Clusters



Code	Practice	Cluster
010	Hope House Surgery	1
025	St Chads Surgery	1
059	Elm Hayes Surgery	1
101	Somerton House Surgery	1
122	St Mary's Surgery	1
123	Hillcrest Surgery	1
132	Westfield Surgery	1
030	Harptree Surgery	2
045	St Augustines Surgery	2
064	Temple House Practice	2
072	Chew Medical Practice	2
073	West View Surgery	2
027	Batheaston Medical Centre	3
071	Fairfield Park Health Centre	3
080	St James's Surgery	3
108	Catherine Cottage	3
637	Grosvenor Place Surgery	3
049	Number 18 Surgery	4
065	Combe Down Surgery	4
068	The Pulteney Practice	4
070	Newbridge Surgery	4
644	Weston Surgery	4
020	Widcombe Surgery	5
039	Oldfield Surgery	5
069	St Michaels Surgery	5
592	Bath NHS Healthcare Centre	5
617	University Medical Centre	5
655	Monmouth Surgery	5

Source: NHS BaNES CCG.

Note: Weston Surgery is now known as Rush Hill & Weston Surgery.

The use of these GP clusters in the methodology adopted for this PNA is a departure from the strict boundary based geographical approach adopted in the previous PNA for B&NES.

1.3.3 People with Protected Characteristics

In accordance with *The Regulations*, this PNA will highlight the demographics and health needs of people in B&NES who share a '*protected characteristic*'. Under the Equality Act 2010[17] the following nine characteristics are known as '*protected characteristics*':

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;

[17] *Equality Act 2010*, c.15, available at: http://www.legislation.gov.uk/ukpga/2010/15

- pregnancy and maternity;
- race;
- religion or belief;
- sex; and
- sexual orientation.

1.3.4 Consultation

A. PNA Questionnaire

In order to ensure appropriate stakeholder engagement in the development of the PNA, views were sought from pharmaceutical providers through an on-line survey process organised and run by Avon LPC[18] during August 2014. Survey responses were collected from 38 pharmacy contractors (including the distance selling pharmacy, but excluding the new Chew Pharmacy that opened after the survey process was complete). The results of this survey are outlined in the Pharmaceutical Services chapter (Chapter 3).

B. Statutory Consultation

In addition, a statutory 70-day consultation (extended by ten days from the statutory 60-day minimum to allow for the Christmas and New year break) of the draft PNA was carried out during the period Monday, 8th December 2014 to Sunday, 15th February 2015. This consultation sought the views of key stakeholders and members of the public on whether they agreed with the contents and key findings in the pre-consultation draft PNA. The feedback from this consultation has informed this final published PNA document.

To promote the consultation a number of methods were used, including the following:

- A letter to key stakeholders highlighting the consultation period and inviting feedback (including B&NES HWB, Wellbeing Policy Development and Scrutiny Panel, neighbouring authorities, NHS BaNES CCG, dispensing doctors and those on the pharmaceutical list, Ward Councillors, Connecting Community Forum Chairs, key officers, providers and community groups).
- Online questionnaire on the B&NES Council website[19] and promotion through B&NES Council Twitter account.[20]
- A number of local bulletins and newsletters (including HWB update bulletin, Healthwatch B&NES bulletin, GP Newsletter and NHS BaNES CCG Staff Bulletin).

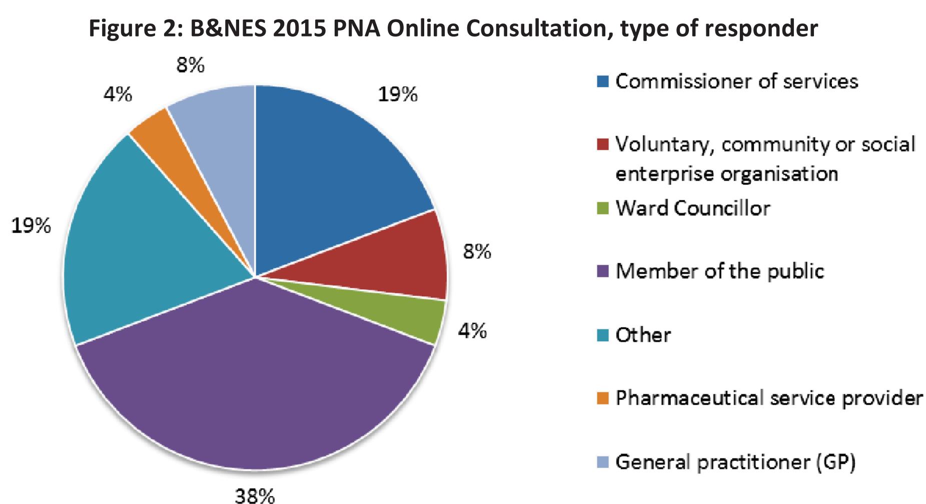
[18] Commissioned by B&NES.
[19] http://www.bathnes.gov.uk/consultations/bnes-pharmaceutical-needs-assessment-2015
[20] https://twitter.com/bathnes

- Websites (including B&NES Council, NHS BaNES CCG and Avon LPC).
- Presented for discussion and feedback at a number of meetings, including: the Independent Equality Advisory Group (IEAG) on 13th January 2015; Your Health, Your Voice on 12th February 2015; and the Joint Commissioning Committee (JCC) on 29th January 2015.

During the period of the statutory consultation there were 26 responses to the online questionnaire.

There was a broad range of respondents to the online questionnaire, including from commissioners of services, members of the public and healthcare professionals (Figure 2).

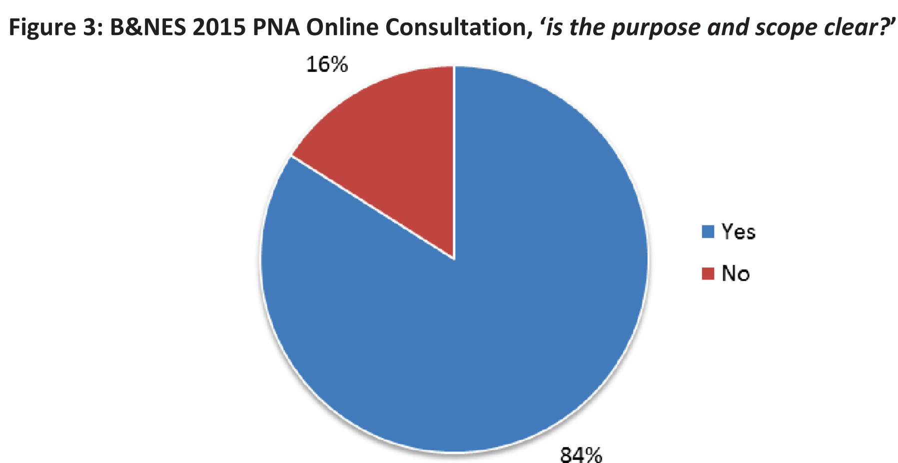
Figure 2: B&NES 2015 PNA Online Consultation, type of responder



Source: B&NES online consultation analysis tool.

Feedback from the online questionnaire shows that 84 per cent of responders thought that the purpose and scope of the draft PNA was clear (Figure 3).

Figure 3: B&NES 2015 PNA Online Consultation, '*is the purpose and scope clear?*'



Source: B&NES online consultation analysis tool.
Question: Is the purpose and scope clear?

In addition to these online responses, feedback was collected through a number of meetings and emails.

The following is a list of the main themes from the consultation responses:

- Accessibility and equality considerations – including issues of varying levels of provision for disabled access, potential language barriers, access issues experienced by different groups (e.g. LGBT, gypsy and traveller communities) as well as availability of consultation room space within pharmacies.

- Pharmaceutical service provision in Keynsham and Chew Valley – including recognising the impact of new housing developments on pharmacy provision, the role of dispensing doctors in service provision, out-of-hours provision and extending opening hours (particularly on Sunday and bank holidays).

- Pharmaceutical service provision in Bath – particularly out-of-hours provision.

The responses to the statutory consultation are discussed in greater detail in section 2.3.

C. Voicebox

A local community Voicebox survey has also been carried out. The fieldwork for this closed in mid-December 2014. It asked local residents about their use and views of pharmaceutical services in the area. The results of this survey were not available in time for the publication of this PNA and will feed into the process of on-going development of the PNA (1.3.6).

1.3.5 Governance

The B&NES Health and Wellbeing Board is the statutory body with overall responsibility for ensuring that the JSNA and PNA are produced for the local area. Production and on-going development of the PNA will follow a similar governance process as the JSNA, i.e. the Health and Wellbeing Board will act as project sponsor for the work and the PNA Steering Group will oversee the on-going development of the PNA and ensure that all requirements are being met.

1.3.6 Ongoing Review Process

The ongoing process to update the B&NES JSNA and B&NES Health and Wellbeing Strategy will be mindful of any implications for pharmacy provision, and where relevant, this document will be reviewed sooner than the three year time frame for this PNA (1st April

2015 to 31st March 2018). For example, a fundamental redesign of the Community Pharmacy Contract, which is expected following NHS England's '*Call to Action*'.[21]

In particular, the following additional pieces of evidence gathering and/or analysis have already been identified in this PNA document for completion following publication on or before the 1st April 2015:

- Analysis of the pharmaceutical questions asked in the most recent local community Voicebox survey (1.3.4[C]);
- Requesting and analysing out-of-hours prescribing activity in Bath and North East Somerset (3.5.3[A]); and
- Co-location of pharmacies with GP practices (3.2.2).

Where additional gaps in pharmaceutical service provision are identified as a result of this additional analysis, and any further analysis or new information, then a Supplementary Statement to this PNA will be presented to the B&NES Health & Wellbeing Board for approval.

[21] NHS England (2013), *Improving Health and Patient Care Through Community Pharmacy – A Call to Action*, December 2013, available at: http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pharm-cta/

Chapter 2: Context

2.0 Introduction

This chapter summarises the demographic characteristics and locally identified health needs of Bath and North East Somerset's (BaNES) Clinical Commissioning Group (CCG) GP registered and resident populations that are relevant to the commissioning of pharmaceutical services in B&NES.

Following the methodology adopted in this PNA (outlined in 1.3.2), this chapter will cover the demographics and health needs of the local CCG GP registered population, sub-grouped by the five GP clusters. Where there is no reliable and robust data available for the local CCG GP registered population the demographics of the local resident population will be used as a proxy.

2.1 Demographics

2.1.1 BaNES CCG GP Registered Population[22]

Table 1: BaNES CCG GP Registered Population by age and GP Practice Cluster (March 2014)

Age Group	BaNES CCG	Norton Radstock	Chew /Keynsham	Bath East	Bath West	Bath Central
0-14	29,861	8,620	6,012	4,388	6,383	4,458
15-24	31,920	5,625	4,275	5,360	4,400	12,260
25-64	101,121	25,566	19,505	16,312	21,251	18,487
65-84	31,260	8,428	7,702	4,657	6,695	3,778
85+	5,498	1,282	1,267	810	1,483	656
Total	**199,660**	**49,521**	**38,761**	**31,527**	**40,212**	**39,639**

Source: NHS BaNES CCG.

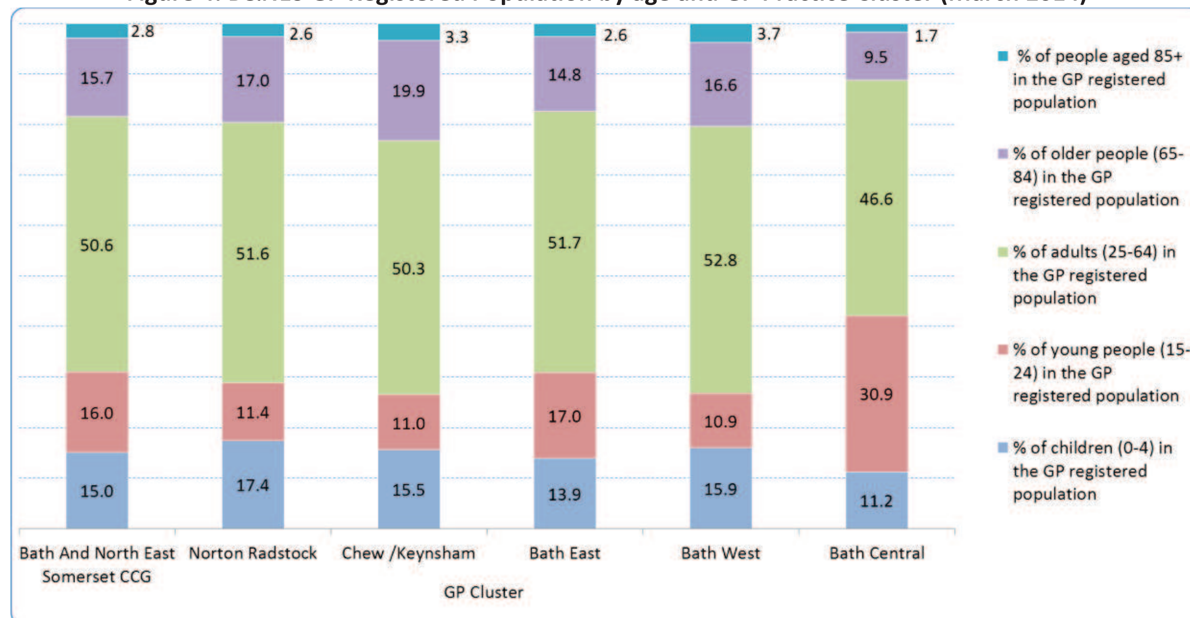
- The BaNES CCG GP registered population – 199,660 as at March 2014 (Table 1) – is slightly higher than the resident population (180,097 as at mid-2013).[23] The GP registered population is greater than the residential population because GP catchment areas are not coterminous with local authority boundaries, and some include substantial areas within neighbouring local authorities.[24]

[22] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/gp-practice-population

[23] Office for National Statistics (2014), *mid-2013 Annual Mid-year Population Estimates*, available at: http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/2013/stb---mid-2013-uk-population-estimates.html

[24] At the time of writing this report it is understood that NHS BaNES CCG will soon be starting a data cleansing exercise to improve the accuracy of their GP registered population. This is likely to result in a lower GP registered population in the future.

Figure 4: B&NES GP Registered Population by age and GP Practice Cluster (March 2014)



Source: NHS BaNES CCG.
Note: Due to rounding, may not add up to 100 per cent.

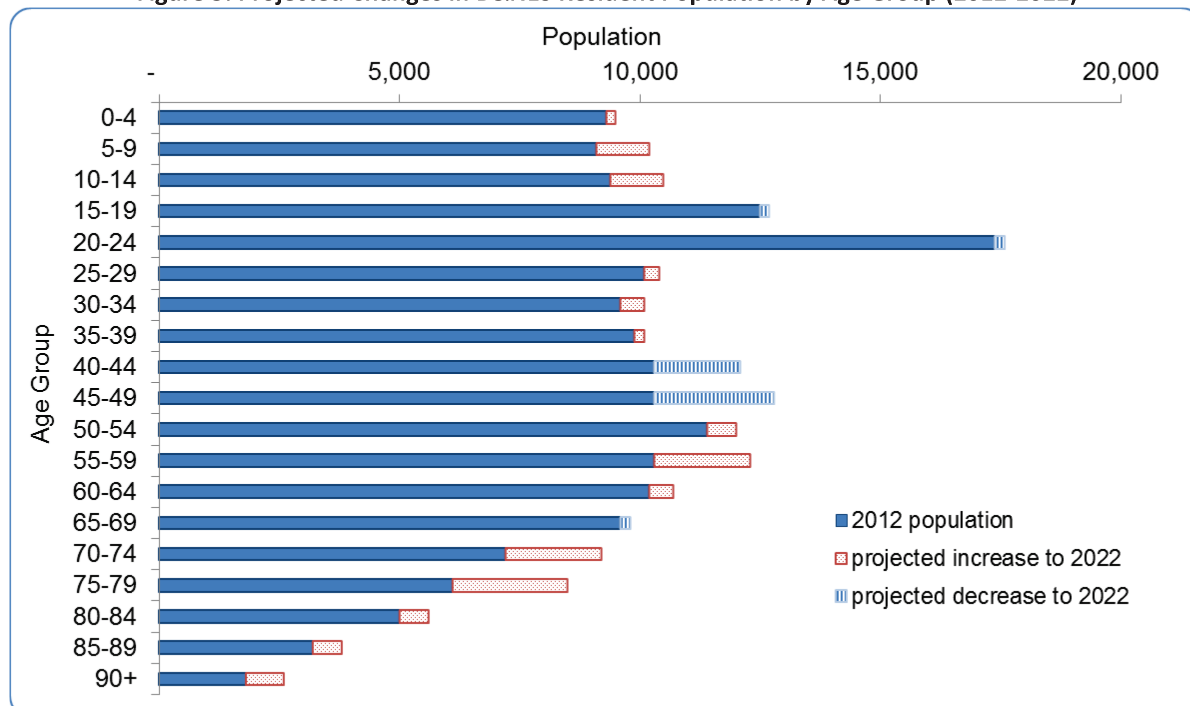
- One of the most notable demographic characteristic is Bath Central GP cluster's large population of young people aged 15-24 – (12,260) nearly a third (30.9 per cent) of the total GP registered population in the Bath Central GP cluster (Table 1 and Figure 4). A large proportion of these young people will be from the resident student population in B&NES.[25]
- Norton Radstock GP cluster has the highest number (8,620) and proportion (17.4 per cent) of 0-14 year olds registered with a GP (Table 1 and Figure 4).
- Chew/Keynsham GP cluster has the greatest concentration of older people (19.9% are aged 65-84 and a further 3.3% are aged 85 and over) (Table 1 and Figure 4).
- Bath West GP cluster has the highest number (1,483) and proportion (3.5 per cent) of GP registered people aged 85 and over (Table 1 and Figure 4).

2.1.2 Projected Future B&NES Resident Population[26]

There are no reliable CCG based figures available for determining the projected population in the future. However, the Office for National Statistics (ONS) sub-national resident population projections for B&NES[27] have been used as a proxy for the BaNES CCG GP practice population.

[25] There are two universities located within the border of B&NES – University of Bath and Bath Spa University.
[26] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/population-change
[27] Office for National Statistics (2014), *2012-based Subnational Population Projections for England*, available at: http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html

Figure 5: Projected Changes in B&NES Resident Population by Age Group (2012-2022)



Source: Office for National Statistics (2014), *2012-based Subnational Population Projections for England*, available at: http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html

Note: These ONS population projections are based on projecting forward past trends and do not take into account changes in the population due to changes in policy, for example, planned future housing developments.

- Between 2012 and 2022 the resident population of B&NES is projected to increase by approximately 8,100 people (or 8.1 per cent). This projected population increase comes from a combination of a natural increase in the population (excess of births over deaths) and net positive internal and/or international migration.
- The largest projected increase in the number of residents between 2012 and 2022 is in those aged in their 70s (Figure 5) – a projected increase of approximately 4,400 people (from 13,300 to 17,700 people, or 33 per cent).
- The largest projected increase in the proportion of residents between 2012 and 2022 is in those aged 90 and over (Figure 5) – a projected increase of 44 per cent (from 1,800 to 2,600 additional people).
- For the decade from 2012 there is projected to be an increase in the 5-14 school aged population (Figure 5), as the relatively high birth rate of the late 2000s and early 2010s starts to work its way through.
- There is projected to be a fall in the population of those aged in their 40s (Figure 5) – from 24,900 in 2012 to 20,600 in 2022, a reduction in this economically active population sub-group of 4,300.
- Taken together, these projected changes will have an impact on the total dependency ratio – the number of people aged 0-15 and 65 and over compared to

the number of 16-64 working age population – rising from 7 dependents to 13 in 2012, to 9 dependents to 11 in 2037.

2.1.3 Planned Future Population Changes (BaNES CCG GP Registered Population)

The ONS population projections outlined in 2.1.2 do not take account of population changes due to policy, i.e. they exclude increases in the population due to planned new housing development. Bath & North East Somerset's Adopted Core Strategy is the main planning document for guiding and managing new development in B&NES from 2011 to 2029.[28] It proposes the building of c.13,000 new homes between 2011 and 2029 (including c.3,300 affordable housing units).

The following analysis assumes that all the housing that is planned in Bath & North East Somerset's Adopted Core Strategy during the decade from 2011 to 2021 will be delivered. There are many factors that could make this assumption invalid. Nor do these figures take into account what has already been delivered, in terms of already completed dwellings, between 2011 and now.

Table 2: 10 Year Housing Growth Modelled Estimates, GP Practice Clusters (2011 to 2021)

Housing Growth	Bath Central	Bath East	Bath West	Chew/ Keynsham	Norton Radstock
Households 2011	14,436	12,164	15,247	13,191	17,167
New Dwellings to 2021	1,313	745	1,514	3,355	1,602
% Growth	9	6	10	25	9

Notes: (i) Calculations assume that the same proportion of households is allocated to GP Clusters as there are people for each electoral ward. (ii) For this analysis dwelling and households are assumed to be the same, even though in reality they are slightly different. (iii) Household projection figures are based on B&NES's Adopted Core Strategy. (iv) Estimates do not take account of the type of dwelling unit that will be delivered on each site (so it is not presently possible to turn this model into direct population growth forecasts).

- Chew/Keynsham GP cluster is expected to witness the greatest housing growth up to 2021 – a 25 per cent increase in the decade from 2011, delivering an estimated 3,355 dwellings (Table 2). Keynsham will be a key growth area in the future, particularly to the south west and south of Keynsham, where there is planned growth of around 700 new homes during the decade up to 2021. Situated in Keynsham North ward, there will be up to 700 new homes on the finished Somerdale site, with 350 new homes planned during the decade 2011 to 2021.
- At the Bath Western Riverside redevelopment site – mainly feeding into the Bath Central GP cluster – there are plans to deliver some 1,250 new homes during the decade from 2011.

[28] B&NES (2014), *Bath and North East Somerset Core Strategy: Part 1 of the Local Plan*, July 2014, available at: http://www.bathnes.gov.uk/services/planning-and-building-control/planning-policy/core-strategy-examination

- The Old Print-Works site (Polestar) in Paulton – mainly feeding into the Norton Radstock GP cluster – is expected to deliver some 550 new homes between 2011 and 2021.
- Redevelopment of the former MoD sites of Foxhill and Ensleigh are expected to add an additional 330 homes each between 2011 and 2021 – the former mainly feeding into Bath West GP cluster, and the latter mainly feeding into Bath East GP cluster.

It is anticipated that current pharmaceutical service provision from existing pharmacies will be able to cope with the demand from these new populations for the coming few years. This PNA will be reviewed by 2018 (at the latest) and the development completion dates for these sites run beyond this time. This is reflected in the key findings (4.1.3).

2.1.4 Ethnicity (B&NES Resident Population)[29]

There are no reliable CCG based figures available for determining the Black and Minority Ethnic (BME) population. However, the resident population BME statistics for B&NES have been used as a proxy for the BaNES CCG GP practice population instead.

- The 2011 Census showed the population of Bath & North East Somerset to be 90 per cent White British and ten per cent other ethnicities.
- Approximately 17,500 residents of B&NES are classified as non-White-British in 2011. Of this non-White-British group, those classified as White non-British (i.e. including 'Other White', White Irish, and Gypsy or Irish Traveller) made up nearly half (approximately 7,750 residents). It is likely that a large proportion of this group will be economic migrants from the Eastern European EU-Accession states, particularly Poland.[30] However, people are increasingly coming to seek employment opportunities from southern European states, for example, Spain.[31]
- There were approximately 4,500 people of Asian or Asian British descent living in B&NES in 2011. The largest ethnic Asian group is Chinese, accounting for approximately 2,000 people in 2011, with a large proportion likely to be from the resident student population.
- In 2011 there were 58 residents who classified themselves as White Gypsy, Traveller or Irish Traveller.[32] In January 2014 50 caravans were counted in B&NES. Gypsy Travellers have significantly poorer health status and significantly more self-reported

[29] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/ethnicity

[30] There were 217 (out of a total of 1,424) National Insurance Number (NINo) allocations to adult overseas nationals from Poland during 2013/14.

[31] There were 223 (out of a total of 1,424) National Insurance Number (NINo) allocations to adult overseas nationals from Spain during 2013/14.

[32] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/travellers-and-gypsy

symptoms of ill-health than other UK-resident, English speaking ethnic minorities and economically disadvantaged white UK residents.[33]

- B&NES has a relatively high number of resident 'Boaters', mainly moored along the Kennet and Avon Canal. In 2012 a local health survey was carried out, and from crude observations of other localities in which 'Boaters' reside, the demographics of live-aboard 'Boaters' is thought to primarily comprise of: young single women (under 30); young couples with children and without children under the age of five; and older males. There is a high proportion of 'Boaters' in B&NES without access to long-term moorings. This may reflect the significant shortage of affordable moorings.

2.1.5 Deprivation (BaNES CCG GP Registered population)[34]

The most up-to-date Indices of Deprivation (ID) available at the time of writing this report is from 2010.[35] B&NES is ranked 247th out of 326 English authorities, and 49th out of 56 Unitary Authorities, in terms of relative deprivation. Despite these relatively low levels of social inequality, there are small geographical areas with notable issues – with the following five Lower Super Output Areas (LSOA) areas within B&NES being within the most deprived twenty per cent of the country: Twerton West, Whiteway, Twerton, Fox Hill North and Whiteway West.

Table 3: Average Indices of Deprivation (ID) Score, GP Practice Clusters (2010)

Indicator	BaNES CCG	Norton Radstock	Chew /Keynsham	Bath East	Bath West	Bath Central
Deprivation score (ID)	12.0	11.9	10.0	11.4	11.9	14.5

Source: Public Health England (2014), *National General Practice Profiles*, available at: http://fingertips.phe.org.uk/profile/general-practice

Note: Derived from 2012 BaNES CCG GP Practice population.

Bath Central GP Cluster has the most deprived profile of GP registered people (with an average ID score of 14.5) (Table 3). This is mainly due to St Michael's Surgery (with an ID average score of 27.9) being part of the Bath Central GP cluster, who's patients, on average, come from the most deprived areas of B&NES.

[33] Parry, G. et. al. (2004), *The Health Status of Gypsies & Travellers in England*, University of Sheffield: School of Health and Related Research, available at: https://www.shef.ac.uk/scharr/research/publications/travellers

[34] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/socio-economic-inequality

[35] Department for Communities and Local Government (2011), *English indices of deprivation 2010*, available at: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010

2.2 Locally Identified Health Needs

This section summarises key relevant locally identified health needs; first, for the BaNES CCG GP registered population (i.e. following the methodology adopted for this PNA); then, for the B&NES resident population (i.e. where reliable and robust data is not readily available at CCG GP practice level). Finally, the themes in the local Joint Health and Wellbeing Strategy, and the priorities in the local CCG Five Year Strategic Plan, are summarised.

2.2.1 Locally Identified Health Needs (BaNES CCG GP Registered Population)

This sub-section presents a selection of ten GP cluster aggregated indicators from the national GP Practice Profile. These indicators are grouped into two categories: (i) disabilities and long-term health conditions; and (ii) emergency hospital admissions.

A. Disability and Long-Term Health Conditions[36]

Table 4: Locally Identified Health Needs, GP Clusters, Disability/Long-Term Conditions (1)

Indicator	Date	BaNES CCG	Norton Radstock	Chew /Keynsham	Bath East	Bath West	Bath Central
% of registered GP population with a long-standing health condition	2012/13	51.0	53.5[H]	51.8[H]	53.3[H]	50.3	46.0[L]
% of registered GP population with health-related problems in daily life	2011/12	45.0	47.9[H]	44.2[L]	43.8[L]	43.7[L]	44.8

Source: Public Health England (2014), *National General Practice Profiles*, available at: http://fingertips.phe.org.uk/profile/general-practice

Notes: (1) GP cluster figures are highlighted for statistical significance against overall BaNES CCG GP practice population: where (H) indicates significantly higher than BaNES CCG and (L) indicates significantly lower than BaNES CCG (at the 95 per cent level of significance). (2) For detailed definitions go to source.

Caution: due to probable bias, these figures are not necessarily representative of the whole of the BaNES CCG GP registered population. A likely more reliable indication of the 'true' prevalence of people with long-term health conditions and disability in B&NES is from the 2011 national Census (2.2.2)

- People registered at GP practices in the Norton Radstock GP cluster report significantly higher rates of long-standing health conditions and health related problems in daily life compared to those registered with all GPs in B&NES (Table 4). This suggests that people registered with GP practices in the Norton Radstock GP cluster have the greatest level of health needs.
- People registered at GP practices in Chew/Keynsham GP cluster appear to have the most significant long-term health needs (Table 5). However, these significantly higher rates are likely to be due to an older population profile and are an indication of the likely higher demand for health services.

[36] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/ill-health-and-disability

- Adults registered at GP practices in Norton Radstock GP cluster are estimated to have the highest prevalence of diabetes – 5.7 per cent (significantly higher than the BaNES CCG rate of 4.6 per cent).
- People registered at GP practices in Bath Central GP cluster appear to have significantly lower prevalence rates of long-term health conditions. However, these significantly lower rates are likely to be due to a younger population profile (Table 5). It is likely that inclusion of the University Medical Centre in Bath Central GP practice cluster is masking some of the health needs of this population (Table 5).

Table 5: Locally Identified Health Needs, GP Clusters, Disability/Long-Term Conditions (2)

Indicator	Date	BaNES CCG	Norton Radstock	Chew /Keynsham	Bath East	Bath West	Bath Central
% of GP registered population estimated prevalence: **CVD** (all ages)	2011	9.8	10.0	11.2^H	9.6	10.6^H	7.3^L
% of GP registered population estimated prevalence: **CHD** (all ages)	2011	4.2	4.4	5.0^H	4.1	4.6^L	2.9^L
% of GP registered population estimated prevalence: **COPD** (all ages)	2011	2.1	2.2	2.3	2.1	2.2	1.7^L
% of GP registered population estimated prevalence: **hypertension** (all ages)	2011	24.2	24.8	27.2^H	24.9^H	25.8	18.2^L
% of GP registered population estimated prevalence: **stroke** (all ages)	2011	2.0	2.0	2.3^H	1.9	2.2	1.4^L
% of GP registered population with **Diabetes**: QOF prevalence (aged 17+)	2012/13	4.6	5.7^H	5.4^H	4.0^L	4.3	3.2^L

Source: Public Health England (2014), *National General Practice Profiles*, available at: http://fingertips.phe.org.uk/profile/general-practice

Notes: (1) **CVD** – Cardio-Vascular Disease; CHD – Coronary Heart Disease; COPD - Chronic Obstructive Pulmonary Disease. (2) The Quality and Outcomes Framework (**QOF**) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. (3) For detailed definitions go to source. (4) GP cluster figures are shaded for statistical significance against overall BaNES CCG GP practice population: where (H) indicates significantly higher than BaNES CCG and (L) indicates significantly lower than BaNES CCG (at the 95 per cent level of significance).

- The most common long-term health condition among B&NES GP registered patients is hypertension (high blood pressure) – 25,395 patients having been diagnosed as at 2012/13.

B. Emergency Hospital Admissions

Table 6: Locally Identified Health Needs, GP Clusters, Emergency Admissions

Indicator	Date	BaNES CCG	Norton Radstock	Chew /Keynsham	Bath East	Bath West	Bath Central
Emergency admissions rate (per 1,000)	2010/11	76.1	78.1	77.0	77.8	81.3 H	65.3 L
Emergency admissions for chronic conditions rate (per 1,000)	2010/11	12.3	13.0	12.0	12.4	12.9	10.9

Source: Public Health England (2014), *National General Practice Profiles*, available at: http://fingertips.phe.org.uk/profile/general-practice

Notes: (1) For detailed definitions go to source. (2) GP cluster figures are shaded for statistical significance against overall BaNES CCG GP practice population: where (H) indicates significantly higher than BaNES CCG and (L) indicates significantly lower than BaNES CCG (at the 95 per cent level of significance).

- During 2010/11 people registered at GP practices in Bath West GP cluster had significantly higher rates of emergency hospital admissions when compared to the overall comparable rate of emergency hospital admissions across BaNES CCG (Table 6). This could partly be due to Bath West GP cluster having the highest number and proportion of people aged 85 and over (Figure 4). This older age group are more likely to have complex co-morbidities that place greater demands on acute health services (as well as primary care).
- During 2010/11 people registered at GP practices in Norton Radstock and Bath West GP clusters had highest rates of emergency hospital admissions for chronic conditions (although neither rate is significantly different from the overall comparable B&NES rate) (Table 6).

2.2.2 Locally Identified Health Needs (B&NES Resident Population)

Indicators from the resident population for B&NES have been used as a proxy for the BaNES CCG GP practice population in the following analysis.

Mortality[37] and Life Expectancy[38]

- The all-cause mortality rate for B&NES is lower than national. Furthermore, there has been a continued long-term fall in all-cause mortality rates, both nationally and locally.
- In England and Wales in 2013, cancer was the most common broad cause of death (29 per cent of all deaths registered) followed by circulatory diseases, such as heart disease and strokes (28 per cent of all deaths registered). During 2008 to 2010 the leading causes of death in B&NES were from circulatory diseases (e.g. heart disease) and cancer.

[37] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/major-causes-mortality

[38] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/life-expectancy

- The performance of the UK in terms of premature mortality – generally considered to be deaths of those aged under 75 – is persistently and significantly below the mean of the original 15 members of the European Union, Australia, Canada, Norway, and the USA.
- The top three causes of premature mortality in B&NES are ischaemic heart diseases; suicide and mortality of undetermined intent; and cancer of trachea, bronchus and lung. In terms of premature mortality, B&NES compares well to **England** on all measures. However, compared to **similar authorities**, B&NES comes out second worst for liver disease (which is the only major disease category in which premature mortality is increasing) and worse than average for cancer and overall premature mortality.
- As a result of falling mortality rates, life expectancy is continually improving. Life expectancy at birth is significantly higher in B&NES for both men (80.6 years in 2010-12) and women (84.4 years in 2020-12) compared to the national and regional figures. However, there are significant variations in life expectancy related to socio-economic inequality. For someone living in the most deprived area of B&NES, they can expect to die at a younger age than someone in the most affluent area of B&NES – seven years earlier for men and four years earlier for women.

Long-term Health Conditions (LTCs)[39]

- Long-term conditions or chronic diseases are conditions for which there is currently no cure, and which are managed with drugs and other treatment, for example: diabetes, chronic obstructive pulmonary disease, arthritis and hypertension.
- In the 2011 census 12,267 residents of B&NES reported that their day-to-day activities were limited a lot through a long term illness or disability. This represents seven per cent of the local population, lower than rates for both the South West and England & Wales.
- People with LTCs are more likely to be elderly and live in deprived areas.
- People with LTCs are likely to be taking medication, often several medications. These people have a particular need to understand the role medicines play in managing their conditions in order to gain maximum benefit and reduce the potential for harm.
- Many people with LTCs also receive a number of different medications for co-morbidities. There is a need for these people to be given assistance with the adherence of taking their medication.

[39] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/ill-health-and-disability

Mental Health and Mental Illness[40]

- Mental illness is the largest single cause of disability and represents 23 per cent of the national disease burden in the UK.
- There is a very significant overall treatment gap in mental healthcare in England, with about three-quarters of people with mental illness receiving no treatment at all.
- Estimates suggest that 16 per cent of the working age population of B&NES have a common mental illness.
- The estimated prevalence of adults (18+) with depression in B&NES in 2011/12 is 13.2 per cent, significantly higher than national (11.7 per cent).
- Suicide rates in B&NES have been increasing since 2005-07, from 5.1 per 100,000 population (26 deaths), to 10.2 per 100,000 population (54 deaths) during the period 2011-13.[41]
- Hospital admissions as a result of self-harm among 10-24 year olds during 2012/13 in B&NES (456.1 per 100,000 population) is significantly higher than national (346.3 per 100,000 population).[42]

Dementia[43]

- The strongest evidence for possible causal associations with dementia are those of low education in early life, hypertension in midlife, and smoking and diabetes across the life course.
- Twenty-two per cent of death certifications in B&NES mention dementia, or a related condition, as opposed to national levels of 17 per cent.
- Largely as a consequence of an ageing society, dementia cases in B&NES are expected to increase by 23 per cent for females and 43 per cent for males between 2010 and 2025 – amounting to an estimated 1,916 females and 1,225 males with dementia by 2025 (up from an estimated 1,549 females and 853 men in 2010).

Smoking[44]

- Smoking is the primary cause of preventable illness and death. Smoking causes around 80 per cent of deaths from lung cancer, around 80 per cent of deaths from bronchitis and emphysema, and about 17 per cent of deaths from heart disease.

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[40] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/mental-health-and-illness
[41] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/suicide-and-mortality
[42] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/self-harm
[43] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/dementia
[44] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/smoking

- The proportion of adults smoking in B&NES is falling, and the latest prevalence rate is 14.5 per cent (21,153 smokers aged 18+), which is lower than the England rate of 18.4 per cent (2013 data). However, the rate of smoking among routine and manual occupation groups is higher, at 21.1 per cent.
- In B&NES one in ten (10.1 per cent) women smoke at the time of delivery.

Alcohol[45]

- Excess alcohol consumption is associated with cardiovascular disease, cancers of the digestive organs, breast cancer, and suicide.
- Hospital admissions for alcohol related conditions (broad measure) in B&NES are rising, but remain lower than regional and national rates.
- People living in the most deprived areas of B&NES are significantly more likely to be admitted for an alcohol related condition compared to those living in the least deprived areas.

Substance Misuse[46]

- Prevalence estimates show that B&NES has a lower than national average of opiate and/or crack users in the population (842, or 7.1 per 1,000 15-64 year old population, compared to 8.9 per 1,000 15-64 year old population nationally).

Healthy Weight[47]

- Over half (56 per cent) 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.
- In the 2012/13 school year, nearly one in four (23.2 per cent) of Reception aged children (4-5 year olds) attending schools in B&NES had an unhealthy weight (overweight or obese), higher than national and regional levels.
- In the 2012/13 school year, just over one in four (26.4 per cent) of Year 6 aged children (10-11 year olds) attending schools in B&NES had an unhealthy weight (overweight or obese); significantly lower than national and regional levels. Generally speaking, national and local trends in childhood unhealthy weight have been levelling out.
- Keynsham (particularly Keynsham South) and Midsomer Norton/Radstock areas consistently have higher levels of unhealthy weight and obesity than other areas in B&NES. As parental obesity is a risk factor for childhood obesity, these

[45] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/alcohol
[46] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/substance-misuse
[47] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/obesity

geographical areas are also likely to have relatively high levels of adult overweight and obesity.

- More deprived areas in B&NES have higher rates of obesity and unhealthy weight than less deprived areas, for year 6 this difference is significant for both obesity and unhealthy weight.

Diabetes[48]

- People with diabetes are at risk of a range of health complications, including cardiovascular disease, blindness, amputation, kidney disease and depression.
- The prevalence rate of diabetes mellitus in those 17 years and over has been steadily increasing locally and nationally.
- There is a gap between expected and observed prevalence rates of diabetes in B&NES. In 2008/09 there were 6,432 people living with diagnosed Type 1 or 2 diabetes, but a further 2,864 people are expected to have Type 1 or 2 diabetes.
- Because of the impact of obesity on type 2 diabetes, the rising prevalence of obesity has led, and will continue to lead, to a rise in the prevalence of diabetes. The local resident based prevalence of diabetes is forecast to rise from 6.3 per cent in 2012 (approximately 9,598 people) to 7.4 per cent by 2030 (approximately 12,712 people), a 32 per cent increase over the next 16 years (due to the large margins of uncertainty the modelled prevalence by 2030 could be between 5.3 per cent and 13 per cent).

Sexual Health[49]

- Rates of Sexually Transmitted Infections (STIs) in B&NES are low compared to regional and national rates. However, these low rates could relate to testing not reaching the most in need.
- Chlamydia testing is lower than recommended levels. However, this may relate to the high student population, who may receive testing at their home GP. There are also known on-going local issues with data quality (which are being resolved).
- Nationally, Men who have Sex with Men (MSM) display a disproportionate burden of ill-health – they are the group most affected by HIV, they are at greater risk of mental ill health problems, and display proportionately higher rates of unhealthy behaviours and lifestyles.
- Although HIV prevalence in B&NES is low (0.66 infections per 1,000 population aged 15-59 years, compared to 2.1 per 1,000 in England), almost half of those who are diagnosed with HIV during 2010 – 2012 (46%) were diagnosed late – defined at having a CD4 count below 350 cells/mm^3 within 90 days of diagnosis. Late

[48] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/coronary-heart-disease
[49] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/sexual-health

diagnosis is an important predictor of HIV-related morbidity and short-term mortality. People diagnosed late have a eleven-fold increased risk of death within one year of HIV diagnosis compared to those diagnosed promptly (3.8 percent vs. 0.35 percent).

Screening and Immunisation[50]

- Overall vaccination rates for childhood vaccinations are better than regional and national rates.
- MMR Vaccination coverage is good, but still lower than recommended targets. Over 500 people had catch-up vaccinations following the 2013 measles epidemic, but up to 1,400 children aged 10-16 may still not be vaccinated against measles.
- Whooping cough vaccinations amongst pregnant women are low, at 40 per cent.

2.2.3 B&NES Joint Health and Wellbeing Strategy[51]

There are three main themes identified in B&NES Joint Health and Wellbeing Strategy:

Theme 1 - Helping people to stay healthy

- Helping children to be a healthy weight.
- Improved support for families with complex needs.
- Reduced rates of alcohol misuse.
- Create healthy and sustainable places.

Theme 2 - Improving the quality of people's lives

- Improved support for people with long term health conditions.
- Reduced rates of mental ill-health.
- Enhanced quality of life for people with dementia.
- Improved services for older people which support and encourage independent living and dying well.

Theme 3 – Creating fairer life chances

- Improve skills, education and employment.
- Reduce the health and wellbeing consequences of domestic abuse.
- Increase the resilience of people and communities including action on loneliness.

[50] B&NES JSNA web-link: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/vaccine-preventable

[51] Bath and North East Somerset Council (2013), *Joint Health and Wellbeing Strategy*, available at: http://www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/working-partnership/health-and-wellbeing-board

2.2.4 BaNES CCG Five Year Strategic Plan[52]

NHS BaNES CCG has developed a five year strategic plan that sets out six key priorities for the coming years:

1. **Care for older people**: to ensure older people are not lonely and isolated at home, as this will mean they are less likely to need to go to hospital.
2. **Self-care and keeping well (prevention)**: doing more to stop people getting unwell, i.e. when people take good care of themselves they need less medical treatment.
3. **Diabetes care**: there are more people with diabetes and there is a need to think about new ways to help people to have the support and care they need closer to their homes.
4. **Musculoskeletal services**: need to make sure there are good services that treat bones and muscles, joints and tendons to keep bodies working well.
5. **Patient record systems**: need to get better at sharing information in order to get better medical care and treatment.
6. **Urgent care**: need to ensure everyone knows how urgent care services work so people see the right medical professional at the right time.

2.3 Responses to Statutory Consultation

Section 1.3.4[B] listed the main themes from the consultation responses. These responses are considered in more detail in this section.

2.3.1 Accessibility and equality considerations

Responses were received from range of organisations, groups (including B&NES's Independent Equality Advisory Group) and individuals (including a ward councillor) that highlighted accessibility and equality considerations. Examples included: lack of wheelchair access to some pharmacy premises and consultation rooms; language barriers between pharmacy staff and members of the public; a need for more convenient modes of delivery of pharmaceutical services to the local traveller, gypsy traveller and boater communities; ensuring there is wide use of Induction Loop Systems so that people with hearing difficulties can access pharmaceutical services; delivery services for prescriptions to people in rural areas; lack of data about the confidentiality of some consultation areas within pharmacy premises; the tailoring of sexual health services to the LGBT community; and a lack of advertising (particularly on the premises) of what services pharmacies provide.

Whilst the remit of the PNA means it is not able to address some of these responses, they have been noted and included so that commissioners of pharmaceutical services within

[52] Bath and North East Somerset Clinical Commissioning Group (2014), *Five Year Strategic Plan*, available at: http://www.bathandnortheastsomersetccg.nhs.uk/news/five-year-strategic-plan

B&NES can take them into consideration in future commissioning decisions and service improvements.

The issue of lack of wheelchair access to some pharmacy consultation rooms is highlighted in sub-section 3.5.3[C] and is reflected in the key findings (4.1.2).

The issue of lack of private consultation space is highlighted in sub-section 3.5.4[A].

2.3.2 Pharmaceutical service provision in Keynsham and Chew Valley

A variety of different responses were received regarding the identified gap in the provision of pharmaceutical services in the Chew Valley area that were highlighted in the consultation draft of the PNA. A new community pharmacy opened in Chew Magna on 23rd February 2015. As a result, there is no longer a gap in the provision of pharmaceutical services serving the Chew Valley area and this is reflected in the finalised key findings (4.1.2).

Responses were also received that highlighted a lack of locally accessible community pharmaceutical services serving the Chew/Keynsham GP cluster during the evenings after 18:30 and on a Sunday. This is particularly the case since the closure of the 100-hour 'in-store' Co-Op pharmacy in Keynsham during 2014. Whilst there has been an application approved by NHS England and the commencement of one hour of Sunday opening (on a Supplementary Hours basis[53]) in Saltford, there still remains a lack of easily accessible out-of-hours pharmaceutical services serving the Chew/Keynsham GP cluster (3.5.3[A]). Therefore, there remains an identified gap in easily accessible out-of-hours pharmaceutical services for this area (4.1.2).

Finally, responses were received to the key finding in the draft consultation PNA that there may not be sufficient local pharmaceutical services in Keynsham to meet the expected increase in demand from new housing development. Over the three year life of this PNA (1st April 2015 to 31st March 2018) existing pharmacy provision appears to be sufficient to cater for the new housing development that is planned to take place across B&NES (2.1.3). However, this issue will need to be revisited by at least 2017/18, i.e. in time for preparation of a new PNA. This is reflected in the finalised key findings (4.1.3).

2.3.3 Pharmaceutical service provision in Bath

There were a number of responses received that indicated a perceived lack of out-of-hours late night pharmacy provision, especially in Bath. Whilst opening hours of at least one central Bath community pharmacy runs to 21:00 Monday to Friday, 20:00 on Saturday and 17:00 on Sunday (3.5.3), it is considered prudent to gather and examine the evidence to establish whether there is a demonstrable gap in the provision of out-of-hours late night pharmaceutical provision in central Bath. As a result, this work will take place following

[53] A pharmacy has the right to amend hours, so long as 90 days notice is given to NHS England.

publication of this PNA and a Supplementary Statement will be issued should a gap in the provision of locally accessible late night pharmacy provision be demonstrated (1.3.6).

2.3.5 Miscellaneous

There were a number of responses highlighting planned future housing development in the Midsomer Norton/Radstock area of B&NES. This has been considered in 2.1.3 and reflected in the finalised key findings (4.1.3).

There was a response that highlighted accessibility issues for urgent palliative care drugs, particularly at busy times in central Bath (3.5.5[C]). It is understood that whilst the NHS BaNES CCG chose the pharmacies for ease of access as one of its key criteria, the CCG is willing to hear requests for additional capacity for this service.

One response referred to the lack of consideration of the benefits that co-locating pharmacies with GP practices can bring. This is referred to in a new sub-section (3.2.2) and will be considered in a further piece of work to be carried out following publication of this document (1.3.6).

The previously identified DAC in B&NES highlighted in the consultation draft PNA was incorrect. It has been confirmed by NHS England that there is no DAC in B&NES and this fact has been corrected in the final PNA (1.1.5[B] and 3.1.3).

Finally, a number of other factual and typographical errors were highlighted by several responders. These have all been corrected.

2.4 Other Services

There are no known planned additional 'Other Services' (as defined in 1.2.5) that could significantly alter the need for pharmaceutical services in B&NES.

Chapter 3: Pharmaceutical Services

3.0 Introduction

This chapter provides an overview of current pharmaceutical services provided across Bath and North East Somerset (B&NES). Commentary is provided on the number of service providers located in B&NES, their dispensing activity, accessibility, and the services that they provide and are willing to provide. The services currently provided are either commissioned through the national pharmaceutical contract or commissioned locally by NHS BaNES Clinical Commissioning Group (CCG) or B&NES Council. There are currently no local services commissioned by NHS England.

3.1 Pharmaceutical Service Providers

3.1.1 Pharmacy Contractors

There are currently 39 pharmacy contractors in B&NES (including the new Chew Pharmacy, which opened on 23rd February 2015) – 38 of these pharmacy contractors are non-distance selling community pharmacies and one is a distance selling pharmacy (The Bath Pharmacy Company). The 39 pharmacy contractors can be categorised as large multiples, small multiples and independents (Table 7).

Table 7: Categorisation of Pharmacy Contractors in B&NES

Multiple or Independent	Pharmacy Name (where a multiple)	Number	Percentage
Large Multiples	Boots (7) Lloyds (7) Sainsbury's (1) Best Way National Chemist Ltd* (1) Superdrug (1)	17	43%
Small Multiples	Jhoots (2) Dudley Taylor (3) Day Lewis (1) Shaunak Pharmacy Ltd. (1) The John Preddy Co. Ltd. (1)	8	21%
Independents	Lifestyle Pharmacy (1) A. H. Hale Ltd. (1) Chew Pharmacy (1) [*opened 23rd February 2015*] Wellbeing (Keynsham) Ltd. (1) Larkhall Pharmacy (1) TANS Pharmacy Ltd. (1) Hawes Whiston and Co. (1) Midsomer Pharmacy (1) Wellsway Pharmacy (1) Widcombe Pharmacy (1) Bathampton Pharmacy (1) Hounsell and Greene (1) Pulteney Pharmacy (1) The Bath Pharmacy Co. Ltd. (the distance selling pharmacy) (1)	14	36%

Note: * bought out the Cooperative pharmacies.

3.1.2 Dispensing GP Practices

There are five dispensing practices in B&NES, which operate across six different sites, though one of these – Chilcompton (a Branch Surgery) – is outside the B&NES border, in Somerset County Council area. All five dispensing practices serve rural populations across the south and south west of B&NES.

The dispensing practices are as follows:

- Chew Medical Practice.
- Elm Hayes Surgery.
- Harptree Surgery (provides a dispensing service at both the Harptree site, and its branch surgery in Cameley).
- St Chads Surgery (only the branch surgery, Chilcompton, has a dispensing service, which is located in Somerset County Council).
- St Mary's Surgery.

3.1.3 Dispensing Appliance Contractor

There is no pharmacy in B&NES registered as a Dispensing Appliance Contractor (DAC).

3.1.4 Other Pharmacy Provision

Dispensing of medicines also takes place in hospitals and the Urgent Care Centre (UCC) within B&NES. These include:

- The RUH and UCC, Bath (Royal United Hospitals Bath NHS Foundation Trust);
- The Royal National Hospital for Rheumatic Diseases, Bath (Royal United Hospitals Bath NHS Foundation Trust);
- St Martin's Hospital, Bath (Avon and Wiltshire Mental Health Partnership NHS Trust);
- CircleBath, Peasedown St John, Bath; and
- BMI Bath Clinic, Combe Down, Bath.

The dispensing services within these hospitals are not directly commissioned by NHS BaNES CCG or NHS England and are excluded from the PNA assessment because they do not fall within *The Regulations*. Each hospital will have its own dispensing arrangements in place.

3.2 Location of Pharmacies

3.2.1 Geographical Location

Figure 6 shows the geographical location of the pharmacy contractors and GP dispensing practices across B&NES.

The majority of pharmacy contractors in B&NES are located in Bath City Centre, with 22 of the 38 non-distance selling community pharmacies (58 per cent) located in the wards that

make up Bath City Centre.[54] The remaining 16 non-distance selling community pharmacies (42 per cent) are located in the areas of Keynsham, the urban and rural areas around Midsomer Norton and Radstock, and the village of Chew Magna. When the four GP dispensing practices located in B&NES,[55] and the one dispensing branch surgery (in Cameley), are taken into account, the proportion of pharmacies outside of Bath City Centre increases to 49 per cent (as they are all outside Bath City Centre).

3.2.2 Co-location

Of the 38 non-distance selling pharmacies located in B&NES, 8 are believed to be co-located alongside GP practice premises.[56]

There are potential benefits to co-locating pharmacies with GP practices, for example, ease of access to pharmaceutical services for patients visiting primary care practitioners and greater opportunity for community pharmacists to integrate with other primary care staff. However, there are also potential benefits of having a pharmacy in a separate location, for example, if it makes it more accessible by a greater range of transport options and being closer to other amenities.

As part of the on-going review process of this PNA (1.3.6), evidence of the benefits of co-location will be considered further.

3.2.3 Deprivation

Figure 7 shows the geographical location of the pharmacy contractors and GP dispensing practices across B&NES in relation to the relative level of deprivation for B&NES.

Indices of Deprivation: the most deprived areas are those where residents are more likely to be living in poverty, and as a consequence, are more likely to experience a lack of basic necessities and poorer outcomes. For example, poorer health (including disability) outcomes and living environments; lower unemployment, ill health or family circumstances); educational attainment and qualifications; and household incomes, higher crime, and barriers to housing and other services. These distinct dimensions of deprivation are measured separately and have been combined into a single overall measure called the Indices of Deprivation (2010). It is this measure that is displayed geographically in Figure 7 and which allows comparison of deprivation between areas in B&NES.

Twelve of the 38 non-distance selling community pharmacies (32 per cent) and one GP dispensing practice are located in the most deprived fifth of Lower Super Output Areas (LSOAs) areas of B&NES (Figure 7). Five community pharmacies and the distance selling pharmacy are located in the least deprived quintile of Lower Super Output Areas (LSOAs) areas of B&NES, i.e. those areas where people experience a range of better outcomes.

[54] Abbey, Bathwick, Combe Down, Kingsmead, Lambridge, Lansdown, Lyncombe, Newbridge, Odd Down, Oldfield, Southdown, Twerton, Walcot, Westmoreland, Weston and Widcombe wards.

[55] St Chads GP practice in B&NES does not have a dispensing service (only the branch surgery in Somerset has this).

[56] (1) Widcombe Pharmacy; (2) Bathhampton Pharmacy; (3) Hounsell & Green Pharmacy; (4) Jhoots Pharmacy, Newbridge; (5) Pultney Pharmacy; (6) Lloyds Pharmacy, Combe Down; (7) Lloyds Pharmacy, Paulton; and (8) Lloyds Pharmacy, Keynsham.

3.3 Pharmacy Provision

3.3.1 Benchmarked Pharmacy Provision

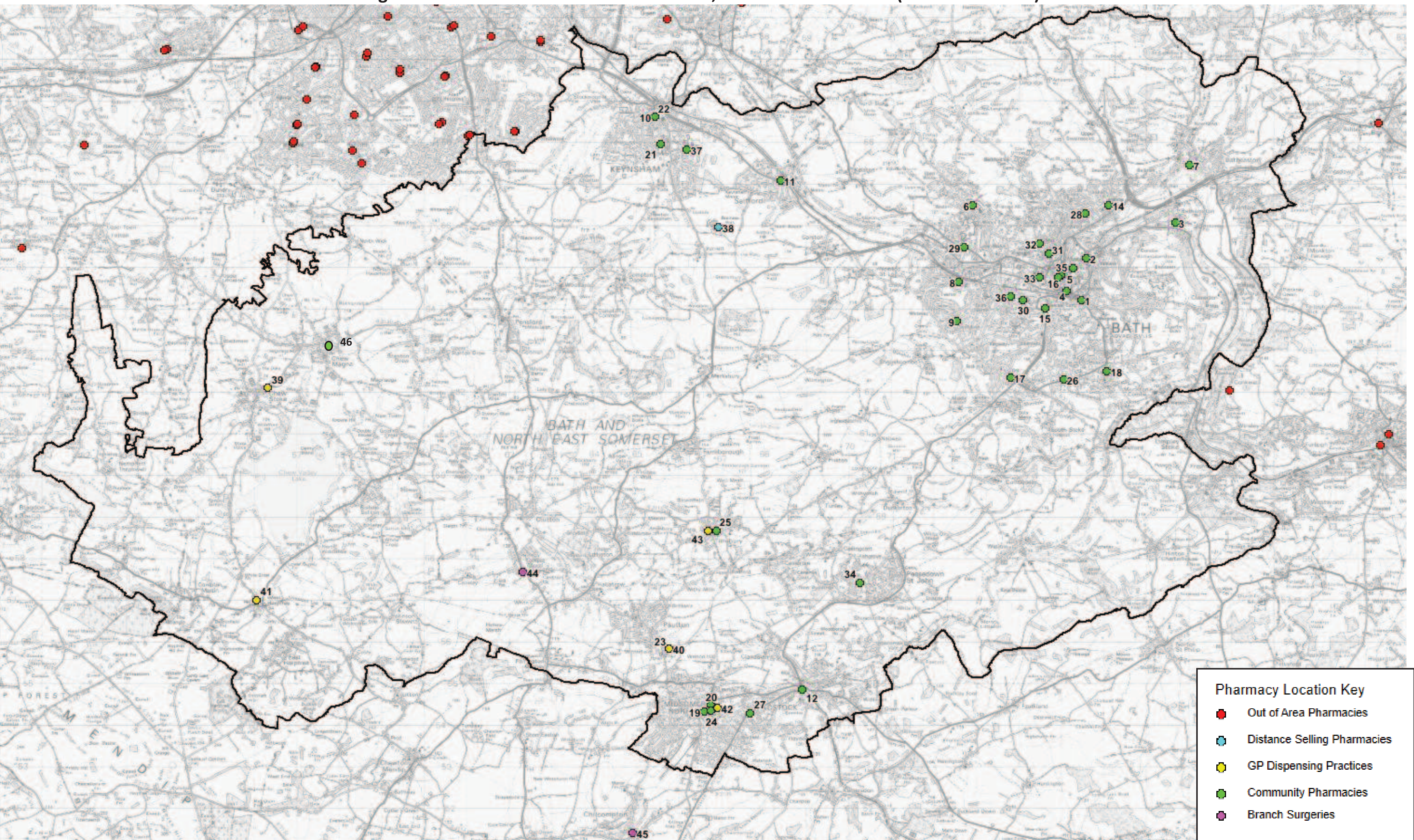
Table 8: Pharmacy Contractors, B&NES and Neighbouring Authorities (31st March 2013)

Primary Care Trust (PCT)	Number of Pharmacy Contractors	Population (000's) Mid-2011[1]	Pharmacy Contractors (per 100,000 population)
England	**11,495**	**53,107**	**22**
South West	**1,048**	**5,301**	**20**
Bath and North East Somerset	**39**	**176**	**22**
Bristol Teaching	96	428	22
North Somerset	42	203	21
Somerset	102	532	19
South Gloucestershire	54	263	20
Wiltshire	74	474	16

Source: Health and Social Care Information Centre (2013), *General Pharmaceutical Services in England: 2003-04 to 2012-13*, available at: http://www.hscic.gov.uk/catalogue/PUB12683
Notes: (1) ONS mid-2011 populations taken from the former Primary Care Trust (PCT) geographies.

In 2013 B&NES had 22 pharmacy contractors per 100,000 population (Table 8). This is the same rate of pharmacy contractors per 100,000 population as at the time of finalising this post-consultation document. This is also the same as the England average (22 per 100,000 population) and higher than the South West average (20 per 100,000 population). Neighbouring areas vary in provision, from 22 pharmacy contractors per 100,000 population in Bristol, to 16 pharmacy contractors per 100,000 population in Wiltshire.

Figure 6: B&NES Pharmaceutical Providers, Location of Premises (November 2014)



Note: it is advisable to print this map in colour.

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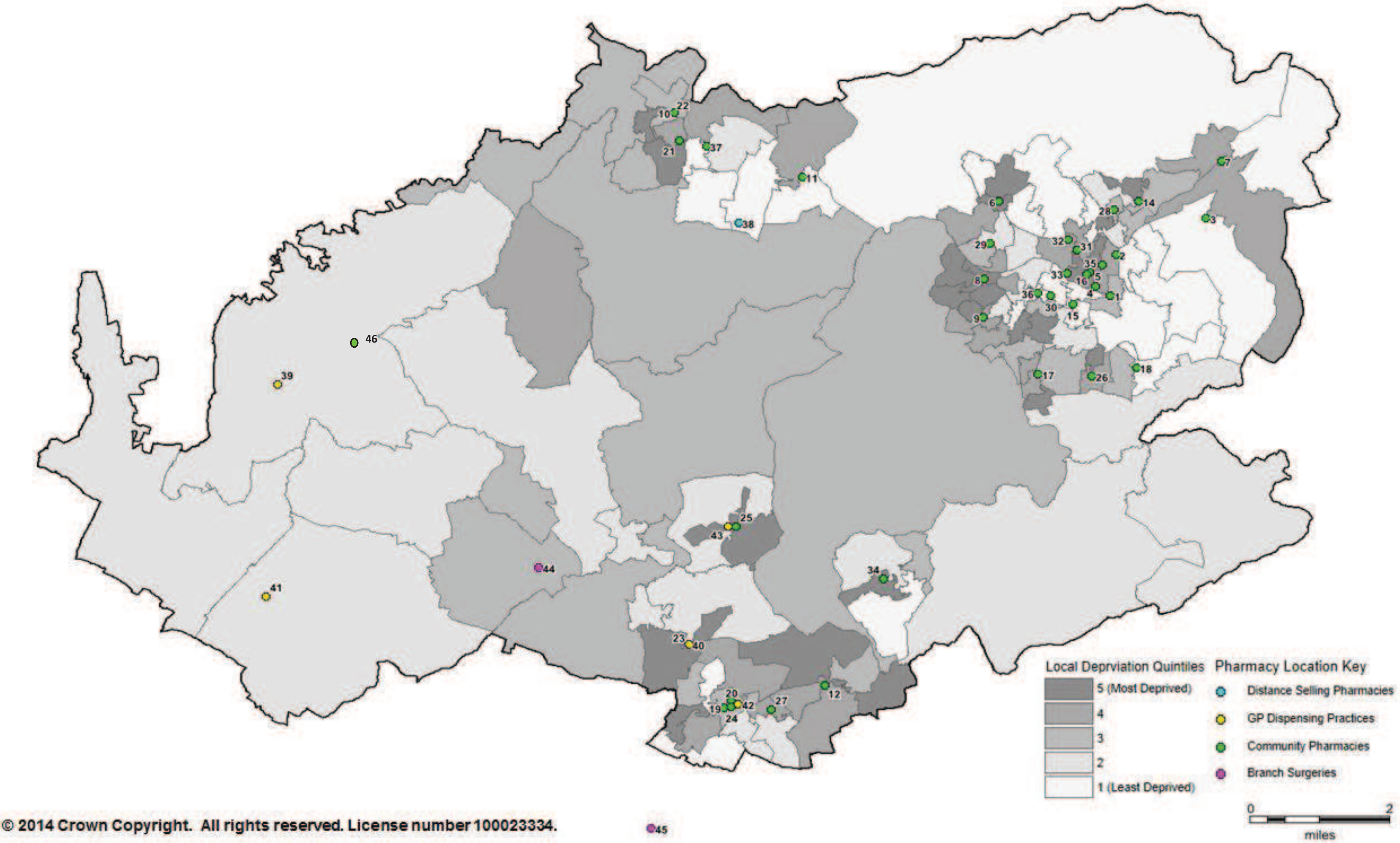
Figure 7: B&NES Pharmaceutical Providers, Local Relative Deprivation (November 2014)



Key to Maps

1	Widcombe Pharmacy	11	Day Lewis PLC (Saltford)	21	Lloyds Pharmacy (Keynsham Health Centre)	31	Jhoots Pharmacy (Brock Street)	41	Harptree Surgery
2	Pulteney Pharmacy	12	Clement Parmacy (Radstock)	22	Lloyds Pharmacy (High Street, Keynsham)	32	Hawes Whiston and Co. (St James Square)	42	St Chads Surgery
3	Bathampton Pharmacy	13	A.H.Hale Ltd (Argyle Street)	23	Lloyds Pharmacy (Paulton)	33	Sainsburys Pharmacy (Green Park Station)	43	St Mary's Surgey
4	Boots (Southgate Centre)	14	Larkhall Pharmacy	24	Midsomer Pharmacy (100-hour)	34	Shaunak Pharmacy Ltd (Peasedown)	44	Harptree Surgery
5	Boots (Westgate Street)	15	Wellsway Pharmacy	25	TANS Pharm Ltd (Timsbury)	35	Superdrug (Westgate Street)		(Cameley Branch)
6	Boots (Weston)	16	Lifestyle Pharmacy (Westgate Street)	26	Dudley Taylor Pharmacy (Combe Down)	36	The John Preddy Company Ltd (Oldfield Park)	45	St Chads Surgery
7	Boots (Batheaston)	17	Lloyds Pharmacy (Odd Down)	27	Westfield Pharmacy (Dudley Taylor)	37	Wellbeing (Keynsham) Ltd (Chandag Road)		(Chilcompton Branch)
8	Boots (Twerton)	18	Lloyds Pharmacy (Combe Down)	28	The Co-operative Pharmacy (Fairfield Park)	38	The Bath Pharmacy Company Ltd (Internet Pharmacy)	46	Chew Pharmacy
9	Boots (Southdown)	19	Lloyds Pharmacy (Chesterfield House, Midsomer Norton)	29	Jhoots Pharmacy (Newbridge Hill)	39	Chew Medical Practice		
10	Boots (Keynsham)	20	Lloyds Pharmacy (Norton House, Midsomer Norton)	30	Hounsell and Greene (Upper Oldfield Park)	40	Elm Hayes Surgery		

3.4 Dispensing Activity

3.4.1 National Dispensing Activity

National data indicates that in England during 2012/13 there were close to a billion scripts issued and dispensed (Table 9). Since 2001 there has been a year-on-year growth of around four to five per cent in the number of items being prescribed.[57] Almost 60 per cent of all prescriptions are for those over the age of sixty.[58]

3.4.2 Benchmarked Dispensing Activity

During 2012/13 the former B&NES PCT had an average prescribed items dispensed per month, per pharmacy, of 6,410 (Table 9). This was the third lowest in the South West, with the highest rate in Plymouth (at 8,170 items per month), and the lowest rate in Bournemouth and Poole (at 5,960 items per month). B&NES PCT's 6,410 items dispensed per month, per pharmacy, is also lower than both the England average of 6,630; and the South West average of 7,200.

During 2012/13 the former B&NES PCT had an average prescribed items dispensed per month, per person, of 1.42 (Table 9). This is similar to the national average of 1.43 items, and the same as the South West average. This suggests that use of pharmacies for dispensed medicines by B&NES residents is about average when compared to national and regional figures.

As the average items per month are below the national and regional averages, and residents' use of pharmacies for dispensed medicines is average, it could be assumed that the current proposed number of pharmacy contractors across B&NES (i.e. 39 with one additional community pharmacy in the Chew Valley) is sufficient to meet current need. Furthermore, this number of proposed pharmacy contractors in B&NES could cope with a further increase in prescription items. An increase such as this may occur if the population increases or the population gets older, both of which are predicted to happen in the years leading up to 2020 (see 2.1.2).

3.4.3 Dispensing Activity in B&NES

Data taken from ePACT[59] for the year 1st April 2013 to 31st March 2014 can be used to show where prescriptions issued by NHS BaNES CCG GPs were dispensed (Figure 8). During 2013/14 the vast majority of all prescriptions issued by NHS BaNES CCG GPs – totalling 3.69 million scripts – were dispensed by pharmacy contractors located within B&NES (81 per cent). An additional 14 per cent were dispensed by the five GP dispensing practices and one per cent by non-dispensing GPs. Only 3.5 per cent were dispensed by pharmacies outside of B&NES (Figure 8).

[57] NHS England (2013), *Improving Health and Patient Care Through Community Pharmacy – Evidence Resource Pack*, December 2013, available at: http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pharm-cta/
[58] *Ibid*.
[59] ePACT.net is an application which allows authorised users at CCG/Trusts and National users to electronically access prescription data.

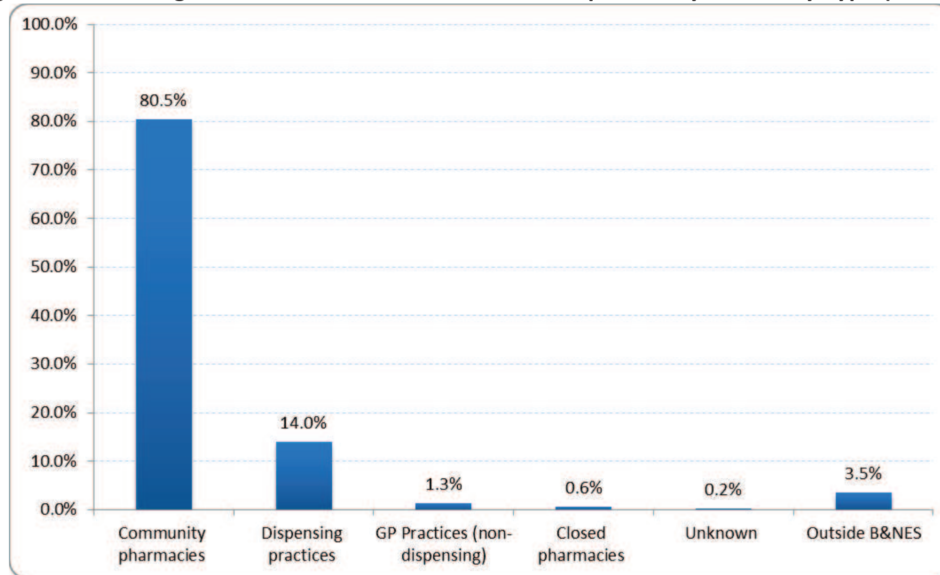
Table 9: Pharmacy Contractors (31st March), Prescription Items Dispensed per month and population, South West, 2012-13

Name	Number of pharmacy contractors as at 31st March 2013 (A)	Prescription items (000's) dispensed per month 2012-13 (B)	Population (000's) mid-2011[1] (C)	Average prescribed items dispensed per month, per person [(B)/(C)]	Pharmacies per 100,000 population [(A)/(C)x100]	Average prescribed items (000's) dispensed per month, per pharmacy [(B)/(A)]
ENGLAND	**11,495**	**76,191**	**53,107**	**1.43**	**22**	**6.63**
SOUTH WEST	**1,048**	**7,546**	**5,301**	**1.42**	**20**	**7.20**
Bath and North East Somerset	**39**	**250**	**176**	**1.42**	**22**	**6.41**
Bournemouth and Poole	74	441	332	1.33	22	5.96
Bristol Teaching	96	733	428	1.71	22	7.64
Cornwall and Isles of Scilly	94	713	536	1.33	18	7.59
Devon	147	1,076	748	1.44	20	7.32
Dorset	82	606	414	1.46	20	7.39
Gloucestershire	111	818	598	1.37	19	7.37
North Somerset	42	311	203	1.53	21	7.40
Plymouth Teaching	52	425	257	1.65	20	8.17
Somerset	102	690	532	1.30	19	6.76
South Gloucestershire	54	338	263	1.29	21	6.26
Swindon	42	330	215	1.53	20	7.86
Torbay Care Trust	39	265	131	2.02	30	6.79
Wiltshire	74	551	474	1.16	16	7.45

Source: Health and Social Care Information Centre (2013), *General Pharmaceutical Services in England: 2003-04 to 2012-13*, available at: http://www.hscic.gov.uk/catalogue/PUB12683

Notes: (1) ONS mid-2011 populations taken from the former Primary Care Trust (PCT) geographies.

Figure 8: Percentage of BaNES CCG Prescribed Items Dispensed by Pharmacy Type (2013/14)



Source: NHS BaNES CCG.

3.5 Analysis of PNA Questionnaire

3.5.1 Introduction

The following information has been gained from a questionnaire **completed and submitted by 38 of the 39 pharmacy contractors in B&NES** (Chew Pharmacy could not take part as they opened after the completion of the analysis), known as the **2014 PNA Questionnaire** (Annex). The questionnaire used was developed by the Pharmacy Services Negotiation Committee (PSNC) to support the PNA process.[60] B&NES's five GP dispensing practices were also surveyed – three responded to the PNA Questionnaire and two responded by telephone only.

3.5.2 Methodology

Picking up on the methodology discussion in Chapter 1 (1.3.2), for some pharmacies, dispensing activity suggests that the vast majority of their customers come from the GP cluster close to where the pharmacy is located. Where this is the case, analyses of the responses to the PNA Questionnaire link the services provided by, and accessibility of, that pharmacy with the GP cluster in which it is located. This is predominantly the case for those pharmacies located close to the GP practices that make up the Norton Radstock and Chew/Keynsham GP clusters (Table 10).

For those pharmacies that serve customers across a number of GP cluster's, which applies to many pharmacies in Bath City Centre, pharmacies have been allocated to a GP cluster providing they dispense at least ten per cent of their total dispensing activity[61] to that GP cluster. So, for example, a pharmacy in central Bath can be allocated to more than one GP cluster (Table 10).

[60] Available at: http://psnc.org.uk/contract-it/market-entry-regulations/pharmaceutical-needs-assessment/

[61] Based on analysing local ePACT data for 2013/14.

Table 10: Number of Pharmacy Contractors Serving GP Clusters

	B&NES	Bath Central	Bath West	Bath East	Norton Radstock	Chew/ Keynsham
Number of pharmacy contractors serving B&NES and each GP cluster	**38**	16	21	15	8	5

Note: a pharmacy contractor will appear in more than one GP cluster when the threshold of ten per cent of a pharmacy's total dispensing activity has been reached. For example, if a pharmacy's total dispensing activity is split 80 per cent from Bath Central GP cluster practices, 12 per cent from Bath West GP cluster practices, and the remaining 8 per cent from Bath East GP cluster practices; then this pharmacy will be allocated to the Bath Central and Bath West GP clusters.

The GP cluster that each pharmacy contractor has been allocated to is detailed in Appendix 1.

3.5.3 Accessibility of Pharmaceutical Services

There are several aspects to assessing the accessibility of pharmaceutical services that will be considered in this sub-section. Firstly, there is opening times, and whether people are able to access pharmacies at times to suit them. Secondly, there is distance to a pharmacy, and how many people are not within a reasonable distance[62] of a pharmacy. Thirdly, there is the issue of how accessible pharmaceutical services are to people with disabilities. Finally, there are potential accessibility issues to people whose first language is other than English.

A. Opening hours

Appendix 1 shows the detailed opening times of the 38 pharmacy contractors in B&NES who took part in the 2014 PNA Questionnaire.

Figure 9 shows the location of pharmacy contractors and GP dispensing practices in B&NES, along with their opening pattern by days of the week. Also shown on this map is a half and one mile distance radius around each pharmacy location point.

There is one 100-hour pharmacy in B&NES, which is open for 100 hours each week, serving the Norton Radstock GP cluster (Table 11). Four community pharmacies are open seven days a week; all serving the Bath Central, Bath West and Bath East GP clusters (Table 11). A further 26 pharmacies (68 per cent) are open six days a week (Monday to Saturday); with eight open for the whole day on a Saturday and 18 open for half the day on a Saturday (Table 11). Seven pharmacy contractors (18 per cent) operate Monday-Friday only (Table 11).

All GP dispensing practices are open during the week before 09:00 and are open until at least 18:00. Two GP dispensing practices are open on Saturday mornings (one alternate Saturday mornings only) (Table 11).

[62] The University of the West of England (UWE) WHO Collaborating Centre for Healthy Urban Environment's adopts half- and one-mile buffers as standard.

Table 11: B&NES Pharmacies – Opening Hours

	B&NES	Bath Central	Bath West	Bath East	Norton Radstock	Chew/ Keynsham
Pharmacy Contractors						
100-hour Pharmacy	1	0	0	0	1	0
7-days a week	4	4	4	4	0	0
All-day Saturday	8	3	3	3	3	2
Half-day Saturday	18	6	7	7	4	3
Monday to Friday only	7	3	7	1	0	0
GP Dispensing Practices						
Half-day Saturday	2				1	1
Monday to Friday only	3				3	0

Source: B&NES 2014 PNA Questionnaire.
Note: refer to Appendix 1 for detail.

- **Monday to Friday opening**

All of the pharmacies are open between the hours of 09:00 until 17:30 from Monday to Friday. Twenty one pharmacies (54 per cent) open before 09:00. The majority (74 per cent) are open beyond 17:30, with most closing at 18:00 and five pharmacies open beyond 18:00. Fifteen pharmacies (39 per cent) are closed during the lunch hour; seven are closed for half an hour at some point between 13:00 and 14:00, seven for the full hour between 13:00 and 14:00, and one pharmacy is closed for an hour and a quarter.

During the week there is no pharmacy open beyond 21:00 serving the three Bath GP clusters. During the consultation period there were several responses highlighting a perceived lack of late night opening hours, especially in Bath (2.3.3). This will be considered as part of an update to this PNA (1.3.6).

There is no community pharmacy that is open beyond 18:30 that serves the Chew/Keynsham GP cluster. There are community pharmacies open beyond 18:30, but they are located across the border in South Gloucestershire and Bristol City Council – approximately 3½ miles away in Longwell Green (open until midnight) and approximately 2½ miles away in Stockwood (open until 23:00) respectively. During the consultation there were several responses received that made a strong case for easily accessible out-of-hours pharmaceutical provision in this area (2.3.2). This is reflected in the key findings (4.1.2).

Every Wednesday evening there is a GP dispensing practice open until 19:30 that serves the Chew/Keynsham GP cluster.

- **Saturday opening**

Thirty-one community pharmacies (82 per cent) are open on a Saturday, with eight (21 per cent) open all day (including the 100-hour pharmacy) and 18 (47 per cent) open for half the day. There are at least two pharmacies serving each GP cluster that are open all day.

The majority of pharmacies that are open on a Saturday open at 09:00 (though nine open earlier), and either close at 13:00 (if open for half the day), or at 17:30 (if open for the full day). Of the six pharmacies that are open beyond 17:30, three are open until 18:00, one until 19:00, one until 20:00, and the 100-hour pharmacy is open until midnight. The 100-hour pharmacy serves the Norton Radstock GP cluster, while the other five serve Bath Central, Bath West and Bath East GP clusters.

On a Saturday there is no pharmacy open beyond 20:00 serving the three Bath GP clusters. During the consultation period there were several responses highlighting a perceived lack of late night opening hours, especially in Bath (2.3.3). This will be considered as part of an update to this PNA (1.3.6).

All of the pharmacies that serve Norton Radstock and Chew/Keynsham GP clusters are open for at least a half day on Saturday. The two dispensing practices that serve the Chew/Keynsham GP cluster are open on Saturdays between 09.00 and 12.00 (one on alternative Saturdays only). There is no easily accessible local community pharmacy open beyond 17:30 on a Saturday that serves the Chew/Keynsham GP cluster. This is also a gap identified by respondents to the consultation (2.3.2) and is reflected in the key findings (4.1.2).

- **Sunday opening**

Five community pharmacies (13 per cent) are open on a Sunday, including the 100-hour pharmacy. The 100-hour pharmacy serves Norton Radstock GP cluster, whilst the other four pharmacies serve Bath Central, Bath West and Bath East GP clusters. The 100-hour pharmacy is open from 8:00 until midnight on a Sunday, whilst the opening hours for the other four pharmacies are 10:30 to 16:30 for one pharmacy, and 11:00 to 17:00 for the other three pharmacies.

On a Sunday there is no pharmacy open beyond 17:00 serving the three Bath GP clusters. During the consultation period there were several responses highlighting a perceived lack of late night opening hours, especially in Bath (2.3.3). This will be considered as part of an update to this PNA (1.3.6).

Apart from one Supplementary Hour[63] between 13:00 and 14:00, there is currently no local easily accessible community pharmacy or dispensing practice serving the Chew/ Keynsham GP cluster that is open on a Sunday. This has been the case since the 'in-store' Co-Op community pharmacy in Keynsham closed in 2014. This is also a gap in provision identified by respondents to the consultation (2.3.2). Whilst this gap in Sunday provision has been highlighted in the key findings (4.1.2), further work could be carried out in order to determine the demand for prescription dispensing services on a Sunday in this area (1.3.6).

B. Distance to pharmacies

Figure 10 shows the location of pharmacies, dispensing practices and bordering pharmacies (within 3 miles of the B&NES boarder) and the residential areas that are within a half and

[63] A pharmacy has the right to amend hours, so long as 90 days notice is given to NHS England.

one mile of them. The majority of people living in Bath, Radstock and Midsomer Norton are within one mile of their nearest pharmacy or dispensing practice.

Figure 10 also shows areas where residents need to travel more than a mile to reach their nearest pharmacy or dispensing practice, mainly those living in the rural areas to the south and south east of Bath. This includes those living in the villages of:

- Marksbury;
- Englishcombe;
- Bishop Sutton;
- Pensford;
- Farmborough;
- Corston;
- Stanton Drew;
- Norton Malreward;
- Norton Hawkfield;
- Hinton Charterhouse; and
- Wellow.

As public transport in these rural locations is limited, the majority of people are likely to travel by car to access pharmacies and dispensing practices. Therefore, those people that do not drive or have a car are limited in terms of being able to easily access a pharmacy or dispensing practice. This is a particular concern for older and younger people, and people with disabilities, who are less likely to have their own means of independent transport. However, many of the pharmacies, and all of the GP dispensing practices, do offer a delivery service for dispensed medicines, either to resident's homes, or a secure local community location (e.g. village hall, shop). However, the issue of collection should be overcome through the advent of the Electronic Prescription Service (3.5.5[A]).

- **Bordering pharmacies**

  B&NES shares borders with five other unitary local authorities – Wiltshire, Somerset, South Gloucestershire, North Somerset and Bristol City. There are a large number of pharmacies within three miles of B&NES, i.e. to the north-north-west towards Bristol (Figure 10). There are fewer pharmacies within three miles of B&NES located to the south and east.

- **Collection of scripts and delivery of dispensed medicines**

  All 38 pharmacies (100 per cent) said that they collect scripts from GP Practices, which should soon no longer be an issue, due to the roll-out of the Electronic Prescription Service (3.5.5[A]). Eighty-one per cent of pharmacies (31) say they will currently deliver dispensed medicines to peoples' homes. Twenty-two of these pharmacies said that they can deliver to any customer, and one said they restrict the service to the elderly and housebound. All of the pharmacies restrict to some extent on a geographical basis, for example, they will only deliver within a certain distance of the pharmacy, or within specific wards. Three of the pharmacies that deliver dispensed medicines to customers' homes said that they charge for this service. Only one pharmacy would not be willing to provide a '*Home Delivery*' service.

GP dispensing practices also operate delivery services (3.5.7).

C. Access for people with disabilities

Table 12: B&NES Pharmacy Contractors – Accessibility of Consultation Rooms

Accessibility of Consultation Room(s)	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew/ Keynsham	
	No.	%	No	%	No.	%	No.	%	No.	%	No	%
With wheelchair access	26	74	11	79	14	74	10	71	7	88	5	100
Without wheelchair access	9	26	3	21	5	26	4	29	1	13	0	0

Source: B&NES 2014 PNA Questionnaire.
Note: pharmacies without consultation rooms are not included.

Of the 35 pharmacies that stated that they have a consultation room available to deliver services (3.5.4[A]), 74 per cent (26) stated that they are accessible by wheelchair (Table 12). Seven of the eight pharmacies that serve Norton Radstock GP cluster, and all of the pharmacies that serve the Chew/Keynsham GP cluster, have consultation rooms that are accessible by wheelchair (Table 12). The largest proportion of pharmacies that do not have wheelchair accessible consultation rooms serve the Bath East GP cluster (Table 12).

The issue of lack of wheelchair access to some consultation rooms was raised by several respondents to the consultation (2.3.1). This issue is reflected in the key findings (4.1.3).

D. Access for people that speak a language other than English

Table 13: B&NES Pharmacy Contractors – Languages Spoken

Language spoken	B&NES	Bath Central	Bath West	Bath East	Norton Radstock	Chew/ Keynsham
Polish	2		1		1	
Italian	1		1			
Spanish	4	2	2	1	3	
Portuguese	1				1	
German	2	1	1	1	1	
French	2	1	1		1	
Greek	1		1			
Mandarin	1		1			
Cantonese	2		2			
Guajarati	3	1	1	1	1	1
Hindi	3	1	1	1	1	1
Swahili	2	1	1	1		1
Arabic	1				1	

Source: B&NES 2014 PNA Questionnaire.

Thirteen non-English languages are spoken by pharmacy staff across the 38 pharmacies in B&NES. The different languages spoken in B&NES, and in pharmacies that serve the different GP clusters, are shown in Table 13. Seven of the languages spoken are European, with one Eastern European (Polish). Some of the consultation responses reflected the need for NHS England and pharmacies to better publicise the services they provide, or example, languages spoken by staff in pharmacies.

3.5.4 Facilities Provided

This section describes the facilities that pharmacies and dispensing practices in B&NES have. The facilities do to some extent determine what services the pharmacy (or dispensing practice) is able to provide. For example, pharmacies need to have a consultation room to be able to provide the majority of Enhanced and Locally Commissioned Services.

A. Onsite Consultation Room

Thirty-five of the 38 pharmacy contractors (92 per cent) have a consultation room available to use. One of the three pharmacies that do not have a consultation room is the distance selling pharmacy (as expected). One of the other two pharmacies has plans in place to have a consultation room available in the next 12 months, and the other is currently in negotiations to have a consultation room available. These two pharmacies serve the Bath Central, Bath West and Bath East GP clusters.

All 35 pharmacies have consultation rooms that are ‘closed’ so that private consultations can take place. This is an issue that was raised by respondents to the consultation (2.3.1). It is therefore encouraging to see that all of the remaining non-distance selling pharmacies have plans in place to secure a ‘closed’ consultation area.

All of the dispensing practices have access to a consultation room, and all are accessible by wheelchair.

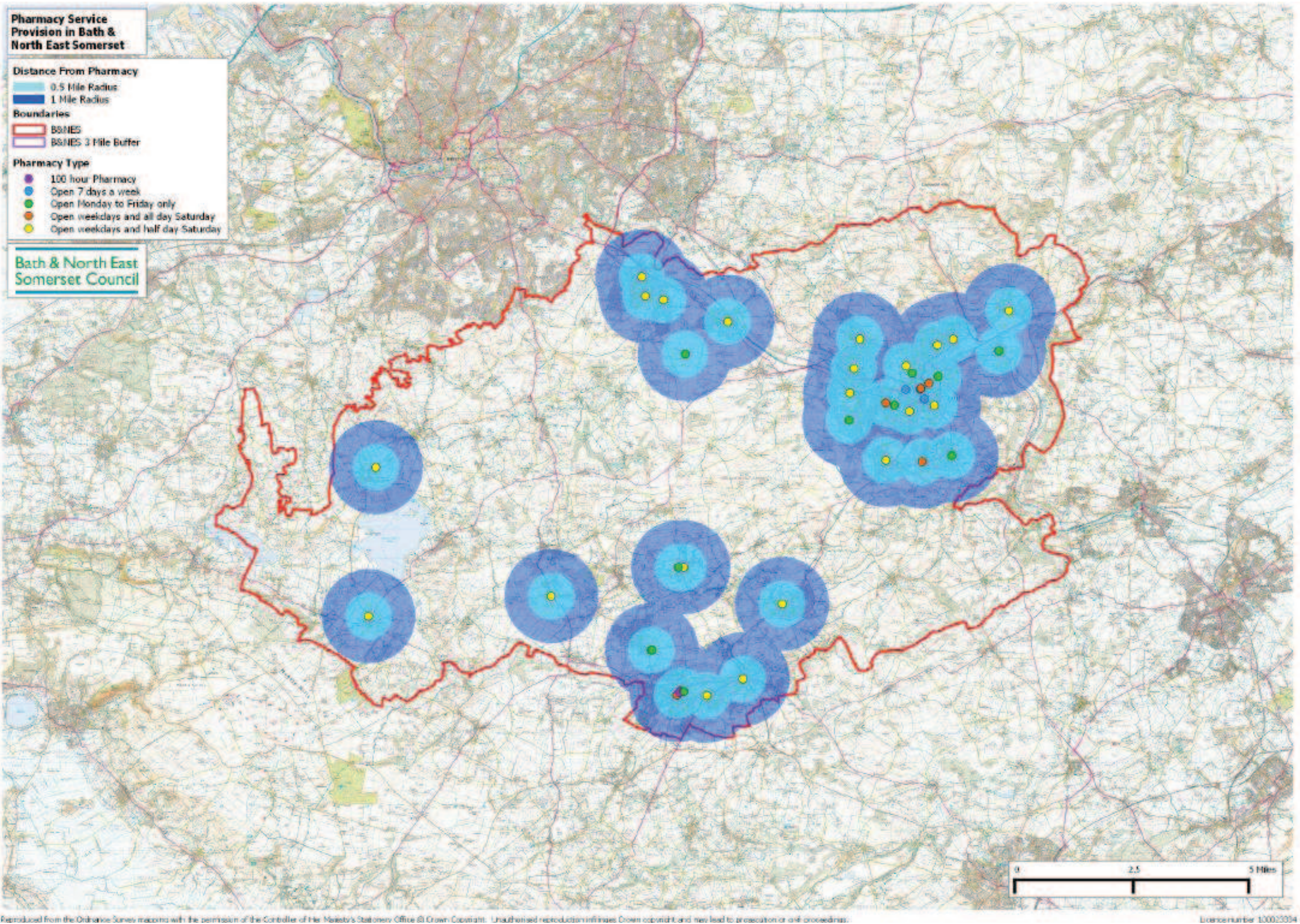
B. Off-site consultations

Thirteen of the 38 pharmacies (34 per cent) are willing to undertake consultations in patients’ homes, or other suitable sites.

C. Hand-washing/toilet facilities

There are hand-washing facilities in 33 of the 38 pharmacies (87 per cent), the majority of which are within the consultation rooms. One of the five pharmacies that do not provide hand-washing facilities is the distance-selling pharmacy. All five dispensing practices have hand-washing and toilet facilities available.

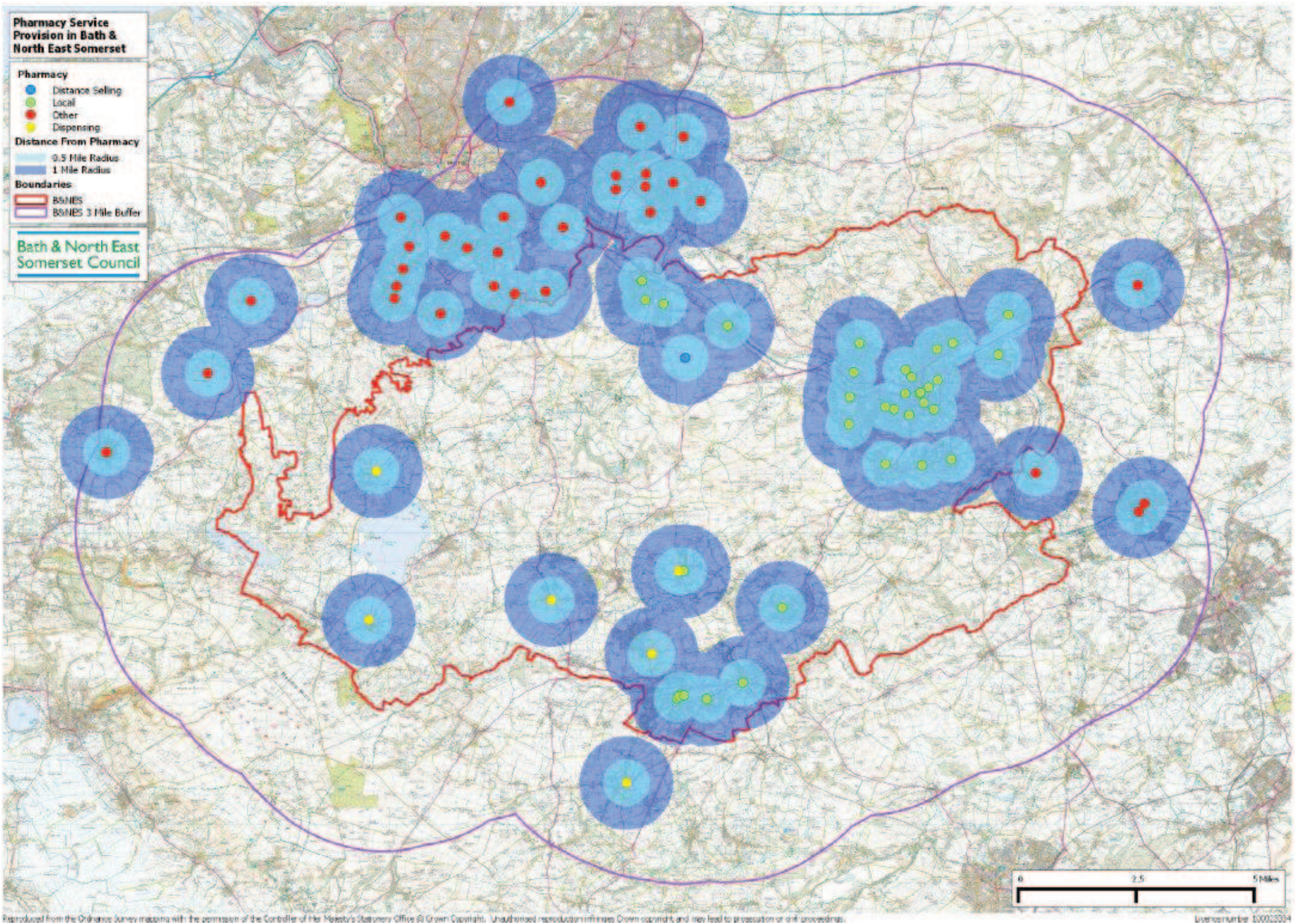
Figure 9: Opening Hours and Distances of B&NES's Pharmacy Contractors and GP Dispensing Practices



Source: B&NES GIS team.

Note: uses information provided by the B&NES 2014 PNA Questionnaire.

Figure 10: Distances from Pharmacy Contractors and GP Dispensing Practices



Source: B&NES GIS team.

Note: standard distances taken from The University of the West of England (UWE) WHO Collaborating Centre for Healthy Urban Environment.

3.5.5 NHS Pharmaceutical Services Provided by B&NES's Pharmacy Contractors

Pharmacy contractors provide three tiers of NHS Pharmaceutical Services (introduced in 1.1.7). They are as follows:

A. Essential Services

Essential services are those services that every community pharmacy providing NHS pharmaceutical services must provide. Essential services are described by the PSNC as:

- **Dispensing** – the safe supply of medicines or appliances. Advice is given to the patient about the medicines being dispensed and how to use them. Records are kept of all medicines dispensed and significant advice provided, referrals and interventions made.

- **Repeat dispensing** – the management of repeat medication for up to one year, in partnership with the patient and prescriber. The patient will return to the pharmacy for repeat supplies, without first having to visit the GP surgery. Before each supply the pharmacy will ascertain the patient's need for a repeat supply of a particular medicine.

- **Disposal of unwanted medicines** – pharmacies accept unwanted medicines from individuals. The medicines are then safely disposed of.

- **Promotion of Healthy Lifestyles (Public health)** – opportunistic one to one advice is given on healthy lifestyle topics, such as stopping smoking, to certain patient groups who present prescriptions for dispensing. Pharmacies will also get involved in six local campaigns a year, organised by NHS England. Campaign examples may include promotion of flu vaccination uptake or advice on increasing physical activity.

- **Signposting patients to other healthcare providers** – pharmacists and staff will refer patients to other healthcare professionals or care providers when appropriate. The service also includes referral on to other sources of help such as local or national patient support groups.

- **Support for self-care** – the provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families. The main focus is on self-limiting illness, but support for people with long-term conditions is also a feature of the service.

- **Clinical governance** – pharmacies must have a system of clinical governance to support the provision of excellent care; requirements include:

    - provision of a practice leaflet for patients
    - use of standard operating procedures
    - patient safety incident reporting to the National Reporting and Learning Service
    - conducting clinical audits and patient satisfaction surveys
    - having complaints and whistle-blowing policies
    - acting upon drug alerts and product recalls to minimise patient harm
    - having cleanliness and infection control measures in place.

- **Electronic Prescription Service (EPS)** - enables GPs and practice nurses to electronically send a prescription to a patient's chosen pharmacy for dispensing. The system makes the

prescribing and dispensing process more efficient and convenient for patients and staff. In addition, EPS can help to reduce wastage of medicines by allowing pharmacy more opportunities to help patients use their medicines more effectively as well as reduces risks of disruption to the supply of medicines to patients.[64]

As these are services which must be provided by all pharmacists, analysis of their availability is, *de facto*, an analysis of the distribution (3.3) and accessibility (3.5.3) of the services which are necessary to meet the need for pharmaceutical services.

B. Advanced Services

Advanced services are services pharmacy contractors and Dispensing Appliance Contractors can provide, subject to accreditation. They include the following:

- **Medicine Use Review (MUR) service** (Table 14) – a medicine check-up service, which is useful for people who regularly take several prescription medicines, or are on medicines for a long-term illness. Thirty-three of the 38 pharmacies in B&NES (87 per cent) provide a MUR service. This includes all of the pharmacies that serve the Norton Radstock and Chew Keynsham GP clusters. There is also good coverage in the pharmacies that serve Bath Central, Bath West and Bath East GP clusters, with between 81 and 93 per cent providing an MUR service. Of those pharmacies that serve the Bath West GP cluster, 19 per cent of pharmacies (4 out of 21) do not provide a MUR service. However, three of these four pharmacies state that they will be providing an MUR service to Bath West GP cluster customers "*soon*", and one is the distance-selling pharmacy. Eighty-nine per cent of pharmacies (34) stated that they would be willing to provide the *Medicines Use Review Plus (MUR Plus)* service if it was to be commissioned locally. This includes pharmacies serving all five GP clusters in B&NES.

Table 14: B&NES Pharmacy Contractors – Medicine Use Review (MUR) Service

Medicine Use Review (MUR) service	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew/ Keynsham	
	No.	%	No	%	No.	%	No.	%	No.	%	No	%
MUR	33	87	13	81	17	81	14	93	8	100	5	100
No MUR	5	13	3	19	4	19	1	7	0	0	0	0

Source: B&NES 2014 PNA Questionnaire.

- **New Medicine Service (NMS)** (Table 15) – is a service offered to people when they are prescribed a medicine to treat a long-term condition for the first time. The pharmacist will support them to use the medicine safely and to best effect. Thirty-one of the 38 pharmacies in B&NES (82 per cent) provide a NMS. This includes all of the pharmacies that serve the Norton Radstock and Chew Keynsham GP clusters. Of those pharmacies that serve the Bath West GP cluster, seven (33 per cent) do not provide a NMR service. However, four of these pharmacies state that they will be providing a NMR service to Bath West GP cluster customers "*soon*", and one of the pharmacies that serve this cluster is the distance-selling pharmacy.

[64] At the time of writing this report (March 2015), EPS has been rolled out in 20 of the 27 GP practices in the NHS BaNES CCG area, with over 40 percent of prescriptions being transferred electronically from GP practices to community pharmacies. This roll-out is expected to be complete by the summer of 2015.

Table 15: B&NES Pharmacy Contractors – New Medicine Service (NMS)

New Medicine Service (NMS)	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew/ Keynsham	
	No.	%	No	%	No.	%	No.	%	No.	%	No	%
NMS	31	82	11	69	14	67	13	87	8	100	5	100
No NMS	7	18	5	31	7	33	2	13	0	0	0	0

Source: B&NES 2014 PNA Questionnaire.

- **Appliance Use Reviews (AURs) service** (Table 16) – an appliance (medical device) check-up service, which is useful for people who use a medical device, such as stoma bags. Twenty-two pharmacies (58 per cent) provide an AUR service, with between three and eight pharmacies providing this service to each GP cluster. Two further pharmacies state that they will be providing this service "*soon*"; one of these serves the Norton Radstock GP cluster, and the other serves the Bath West GP cluster.

Table 16: B&NES Pharmacy Contractors – Appliance Use Reviews (AURs)

Appliance Use Reviews (AURs)	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew/ Keynsham	
	No.	%	No	%	No.	%	No.	%	No.	%	No	%
AUR	22	58	7	44	8	38	5	33	4	50	3	60
No AUR	16	42	9	56	13	62	10	67	4	50	2	40

Source: B&NES 2014 PNA Questionnaire.

- **Stoma Appliance Customisation (SAC) service** (Table 17) – involving the customisation of a quantity of more than one stoma appliance. The aim of the SAC service is to ensure proper use and comfortable fitting of the stoma appliance and to prolong the duration of its use. Eleven pharmacies (29 per cent) provide a SAC service. There are at least two pharmacies that provide this service to each GP cluster, with four pharmacies providing the service to the Bath West GP cluster and four to the Norton Radstock GP cluster. One pharmacy that serves the Norton Radstock GP cluster states that it will be providing this service "*soon*".

Table 17: B&NES Pharmacy Contractors – Stoma Appliance Customisation (SAC) Services

Stoma Appliance Customisation (SAC)	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew/ Keynsham	
	No.	%	No	%	No.	%	No.	%	No.	%	No	%
SAC	11	29	2	13	4	19	2	13	4	50	2	40
No SAC	27	71	14	88	17	81	13	87	4	50	3	60

Source: B&NES 2014 PNA Questionnaire.

- **Dispensing Reviews of the Use of Medicines (DRUMs)** – whilst not an 'Advanced Service', dispensing GP practices who opt to participate in a Quality Scheme which is commissioned by NHS England must provide DRUMs to "*…help patients understand their therapy and to identify any problems that they are experiencing and, where appropriate, suggest possible solutions*."[65]

[65] Information on DRUMs were not collected from GP dispensing practices.

C. Enhanced Services

Enhanced services are services that are commissioned locally by either, NHS England,[66] or Clinical Commissioning Groups (CCGs). The following enhanced services are commissioned by NHS BaNES CCG:

- **Specialist Drugs (Palliative Care) Enhanced Service** (Table 18) – involves commissioning (usually a small number of) pharmacies to keep in stock certain specialist medicines (used in palliative care or to treat severe infections) so that they can be made available on receipt of a valid prescription. These medicines are often required at short notice and may not normally be stocked by pharmacies. NHS BaNES CCG currently commissions five pharmacies to provide this service. A further 24 pharmacy contractors would be willing to provide a Specialist Drugs (Palliative Care) Enhanced Service, whilst nine would not. There is at least one pharmacy contractor serving each GP cluster that is commissioned to provide this service. However, one response was received during the consultation period that expressed a view that the pharmacies involved in the specialist drugs enhanced service are not easily accessible to patients/carers or nurses, particularly on a busy Saturday in the centre of Bath (2.3.3).

Table 18: B&NES Pharmacy Contractors – Specialist Drugs (Palliative Care) Enhanced Service

Palliative care scheme	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew/ Keynsham	
	No.	**%**	**No**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No**	**%**
CP	5	13	2	13	2	10	2	13	2	25	1	20
WA	12	32	6	38	8	38	5	33	0	0	2	40
WT	11	29	3	19	5	24	3	20	3	38	1	20
WF	1	3	1	6	1	5	1	7	0	0	0	0
PP	0	0	0	0	0	0	0	0	0	0	0	0
N	9	24	4	25	5	24	4	27	3	38	1	20
Total No.	**38**		**16**		**21**		**15**		**8**		**5**	

Source: B&NES 2014 PNA Questionnaire.
Note: CP – currently providing NHS funded service; WA – willing and able to provide if commissioned; WT – willing to provide if commissioned, but training required; WF – willing to provide if commissioned, but facilities adjustment required; PP – currently providing private service; N – not able or willing to provide. Percentages may not add up to 100 per cent due to rounding.

- **Emergency Supply of Repeat Medicines** – NHS BaNES CCG are mobilising a new service to support patients accessing emergency supplies of repeat medication as a first port of call from community pharmacies by removing financial barriers. This service will support patients not to inappropriately attend the out-of-hours doctor service or hospital Emergency Departments to meet the need for emergency supplies of medicines that they have run out of. NHS BaNES CCG is anticipating a good uptake of this service, which should be fully mobilised by end of March 2015.

[66] NHS England does not currently commission any enhanced services in B&NES.

3.5.6 Services Commissioned by B&NES Council (Public Health)

B&NES commissions pharmacy contractors to provide a number of sexual health, smoking cessation and substance misuse services. These are set out as follows:[67]

A. Sexual Health Services

Community pharmacies in B&NES are commissioned to deliver contraceptive and sexual health services through a two tiered model.

Tier 1 services are:

- The supply of condoms free of charge to young people under 24 years old, as part of the B&NES C-Card scheme;
- The supply of pregnancy tests free of charge to women under 24 years old; and
- The supply of free chlamydia testing kits to clients under 25 years old.

Tier 2 services are all of the Tier 1 services defined above, and:

- The supply of emergency hormonal contraception free of charge to women aged over 13 year old under a Patient Group Direction (PGD); and
- The supply of free treatment for chlamydia infection for people under 25 years old under a Patient Group Direction (PGD), and their partner(s) where appropriate.

The vast majority of pharmacies deliver the Tier 2 service (27 pharmacies), with three pharmacies delivering the Tier 1 service. All pharmacies offering either Tier 1 or Tier 2 services are expected to offer the service for a minimum of five days per week. Pharmacies deliver services in compliance with the Fraser Guidelines and Department of Health guidance on confidential sexual health advice and treatment for young people aged under-16, in line with the B&NES Sexual Health Policy. In addition, many pharmacies are also SAFE[68] accredited. Currently 22 of the 30 pharmacies delivering sexual health services are SAFE accredited. There is an on-going programme to ensure that all pharmacies become SAFE accredited.

- **Chlamydia testing**: according to questionnaire responses (Appendix 2), 50 per cent of pharmacies (19) are currently providing chlamydia testing, a further one pharmacy is willing and able to provide the service, and 15 pharmacies willing to provide the service, but with training. Only three pharmacies are not willing to provide the service and these provide to the Bath Central, Bath West and Bath East GP clusters, where there is already good provision. Current provision is lowest in Norton Radstock, where only 25 per cent of the pharmacies serving Norton Radstock GP cluster provide the service.

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[67] Where relevant, the PNA Questionnaire responses have been validated with Local Authority records. This is relevant to the sexual health, smoking cessation and substance misuse services described.

[68] SAFE is a quality standard branding scheme offered to all organisations in B&NES who provide sexual health information and services to young people. The SAFE accreditation is given to pharmacies that can demonstrate they: (i) are accessible to young people regardless of disability, gender, ethnicity, sexuality, locality or financial situation; (ii) provide up to date information and resources on a range of sexual health and relationship issues for all young people; (iii) are confidential; (iv) are friendly, welcoming and comfortable places for young people to be; and (v) are encouraging and supportive of opportunities for young people to help services to continue to improve and develop, in both what services are provided and how they are provided.

- **Chlamydia treatment**: 82 per cent of pharmacies (31) are accredited and contracted to provide the chlamydia treatment service, though only 47 per cent (18) have actively been providing this service over the last six months. This latter figure is similar to the questionnaire response (Appendix 2), where 17 pharmacies have stated that they are currently providing the service. However, only two pharmacies stated that they are not willing to provide the service, and these provide to the Bath GP clusters, where there is already good provision.

- **Emergency Hormonal Contraceptive (EHC)**: 82 per cent (31) of pharmacies are accredited and contracted to provide the EHC service, and 67 per cent (25) have been actively providing this service over the last six months. This latter figure is similar to the questionnaire response (Appendix 2), where 26 pharmacies have stated that they are currently providing the service. Only one pharmacy is not willing to provide an EHC service, and they provide to the Bath Central and Bath West GP clusters, where provision is already 69 and 71 per cent respectively.

- **Contraception Service (C-Card Scheme)**: 82 per cent of pharmacies (31) are accredited and contracted to provide the EHC service, and 47 per cent (18) have actively been providing it over the last 6 months. According to questionnaire responses (Appendix 2), only two pharmacies are not willing to provide this service and they serve the Bath GP clusters. No pharmacies that serve the Chew/Keynsham GP cluster are actively providing the C-Card Scheme.

No pharmacies stated that they are providing sexual health services privately.

B. Smoking Cessation Services

Smoking cessation services that can be provided by community pharmacy include the provision of stop smoking support services and nicotine replacement therapy (NRT) supply. The Stop Smoking Service supports people who want to stop smoking through one to one support and advice and facilitates access to, and where appropriate supply of, pharmacotherapy and aids. The service will also refer clients to specialist services where appropriate. The NRT service involves the supply of NRT to clients receiving support from the Specialist Stop Smoking Service who have been issued with a voucher for supply of NRT.

- **Stop Smoking Service**: the majority of pharmacies have signed up to deliver the stop smoking service though levels of activity are fairly low. However, activity in delivering this service has increased year on year since 2009, and during 2013/14 approximately 13 per cent of four week quitters in B&NES used the pharmacy stop smoking service. According to the survey responses from B&NES pharmacy contractors (Appendix 2), 26 (68 per cent) are currently providing the stop smoking service, and only five have chosen not to sign up.

- **NRT Supply Service** - 36 pharmacies in B&NES have signed up to deliver the NRT supply service, though not all the pharmacies are generating NRT supply activity. This suggests that not all pharmacies are actively providing this service to smoking cessation service clients, even when they have signed up to the service. According to the survey responses from B&NES pharmacies (Appendix 2), 24 (63 per cent) of pharmacy contractors are

currently providing the service, seven have chosen not to sign up. However, there is provision across the GP clusters.

C. Substance Misuse Services

Substance misuse services that pharmacies can provide include the Needle and Syringe Programmes (NSP), supervised administration (consumption), and sharps disposal. The first two of these are commissioned by B&NES Council.

- **Needle and Syringe Programmes (NSP)**: eight pharmacy contractors in B&NES currently provide a needle exchange service. The majority of these eight serve the Bath GP clusters, with two pharmacies that serve Norton Radstock and Peasdown. The pharmacy service supplements the two NSPs delivered by DHI from bases in Midsomer Norton and Bath City Centre. NSPs are targeted based on need, i.e. which pharmacy clients wish to use for needle exchange, to ensure that all injecting drug users have easy access to clean works and return used works for safe disposal to reduce the incidence of Blood Borne Viruses and to keep the community safe. According to survey responses from B&NES pharmacies (Appendix 2), 10 (26%) currently provide a needle exchange service. However the majority of pharmacies are willing to provide the service, with only seven stating that they would not wish to deliver the service.

- **Supervised Administration (Consumption)**: according to survey responses from B&NES pharmacy contractors (Appendix 2) a much higher proportion (84%) are currently providing the supervised administration service. Only two pharmacies stated that they would not wish to deliver this service. Clients choose which pharmacy they wish to attend for supervised consumption or to collect their prescription from (if they are on take home medication). There is excellent coverage in B&NES.

3.5.7 Services Provided by GP Dispensing Practices

All GP dispensing practices in B&NES provide a wide range of services for their registered patients.

3.5.8 Services Pharmacy Contractors are Willing to Provide

Table 19: Pharmacy Contractors Willing to Provide a Service

Name of Service	Percentage of Pharmacy Contractors serving B&NES and GP Clusters Willing to Provide Service (Not Currently Commissioned)					
	B&NES	Bath Central	Bath West	Bath East	Norton Radstock	Chew Keynsham
SUBSTANCE MISUSE SERVICES						
Sharps disposal	82% - 31 pharmacies	69%	71%	80%	88%	80%
LONG TERM CONDITIONS						
Long-term Conditions (combined responses)	95% (36)	88%	86%	93%	100%	100%
OTHER HEALTH PROMOTION SERVICES						
Obesity Management	87% (33)	69%	71%	87%	100%	100%
Supplementary prescribing therapeutic areas	61% (23)	63%	57%	67%	50%	40%
NHS Health Check	63% (24)	69%	62%	73%	38%	60%
SCREENING SERVICES						
Alcohol	82% (31)	69%	67%	73%	88%	100%
Cholesterol	89% (34)	81%	76%	87%	100%	100%
Diabetes	92% (35)	81%	81%	93%	100%	100%
Gonorrhoea	66% (25)	63%	57%	67%	63%	60%
Helicobacter Pylori (breath test)	71% (27)	75%	67%	80%	63%	60%
Glycated Haemoglobin (HbA1c)	66% (25)	63%	57%	67%	63%	60%
Hepatitis	66% (25)	63%	57%	67%	38%	60%
HIV	66% (25)	56%	52%	67%	38%	60%
VACCINATION SERVICES						
Seasonal Flu	79% (30)	75%	71%	87%	75%	80%
Childhood Immunisations	71% (20)	75%	67%	80%	63%	60%
Human Papilloma Virus (HPV)	76% (29)	75%	67%	80%	75%	80%
Hepatitis-B	76% (29)	75%	67%	80%	75%	80%
MEDICINES ASSESSMENT AND COMPLIANCE SERVICE						
Medicine Review Service	92% (35)	88%	81%	87%	100%	100%
Medicines Management and Support	76% (29)	75%	71%	73%	75%	60%
Domiciliary MAR Carers Chart	82% (31)	75%	71%	80%	75%	100%
ON DEMAND AVAILABILITY OF SPECIALIST DRUGS						
Directly Observed Therapy	82% (31)	69%	67%	73%	100%	80%
Out of Hours Service	58% (22)	50%	57%	73%	50%	40%
OTHER SERVICES						
Anticoagulant Monitoring	92% (35)	81%	86%	87%	100%	100%
Anti-viral distribution Service	95% (36)	88%	90%	87%	100%	100%
Care Home Service	82% (31)	81%	76%	87%	75%	80%
Medicines Use Review Plus	89% (34)	81%	76%	87%	100%	100%
Minor Ailments Service	92% (35)	81%	81%	93%	100%	100%
Phlebotomy Service	66% (25)	69%	62%	73%	50%	60%
Prescriber Support Service	66% (25)	69%	62%	73%	50%	60%
Schools Service	66% (25)	69%	62%	73%	50%	60%
Access Language Service	61% (23)	63%	57%	73%	50%	40%

Source: B&NES 2014 PNA Questionnaire.

Note: includes the following responses: WA – willing and able to provide if commissioned; WT – willing to provide if commissioned, but training required; WF – willing to provide if commissioned, but facilities adjustment required; and PP – currently providing private service.

Where services are not commissioned as enhanced services by NHS England, the CCG, or as local services by the Local Authority, pharmacies were asked in the PNA questionnaire about their willingness to provide a service. Table 19 summarises B&NES pharmacy contractors' willingness to provide services currently not commissioned.

The services that are pharmacies in B&NES are willing to provide (if commissioned), and which are more likely to be commissioned in England under local arrangements, are described below.

A. Minor Ailments Service

Accredited pharmacists may provide medicines without a prescription (including some Prescription-Only Medicines, under the authority of a Patient Group Direction) for the treatment of: athlete's foot, conjunctivitis, cold sores, hay-fever, cystitis, thrush, impetigo, ring worm, oral thrush, eye infections and uncomplicated urinary tract infections in females aged 16-65. Unless they are exempt from charges, patients pay the normal NHS prescription charge. Minor Ailments services are often commissioned by pharmacies serving more deprived communities. Community pharmacy minor ailment schemes are currently commissioned at a local level, but there has been a call to shift this to a national level.

The **final report of the evaluation of Pharmacy based Minor Ailment schemes**, which provides some evidence into the effectiveness (patient and cost) of community pharmacies managing minor ailments, was published earlier this year.(i) Main points are as follows:

- Consultations for minor ailments are a burden to health care providers; 18 per cent to 37 per cent of GP consultations are for minor ailments.
- Musculoskeletal pain was the most dominant minor ailment presenting in Emergency Departments, while upper RTIs were the most dominant in GP practice. Globally, pain is the most common reason for presenting to ED.
- Healthcare professionals cannot agree what constitutes a minor ailment, so patients probably do not know either in terms of access to appropriate care.
- Community pharmacies deliver equivalent health outcomes at a lower cost when compared with GP and ED services.
- Patients rated convenience as the major influence on choosing where to present with minor ailments, with community pharmacies rated most convenient.
- But community pharmacy minor ailment services demonstrated large variability in quality of consultation and communication skills and this needs to be addressed with education and training.

Recommendations for policy suggest co-location of pharmacies alongside EDs and GP practices; campaigns to raise public awareness of community pharmacy Minor Ailment schemes; urgent need to address the deficiencies in communication and consultation skills of pharmacists and their staff.

(i) Royal Pharmaceutical Society (2014), *Community Pharmacy Management of Minor Illness*, Final Report to Pharmacy Research UK, available at: http://www.rpharms.com/pressreleases/pr_show.asp?id=2342

There are currently no pharmacies providing a Minor Ailments service in B&NES, though 92 per cent (35) pharmacies are willing to provide the service. Three pharmacies are unwilling to provide a minor ailment service – all serving the three Bath GP clusters.

B. Obesity Management Service

Accredited pharmacy staff initiate discussion with adults, who appear to be overweight, about the health risks of overweight and obesity, offer to determine their Body Mass Index (BMI) and waist measurement, and undertake a risk assessment. Appropriate advice, support and referral are provided to those at risk of ill health due to overweight or obesity to help them to modify their lifestyle and risk.

Eighty-seven per cent (33) of B&NES pharmacies (across all GP clusters) would be willing to provide an obesity management service, whilst five are unwilling.

C. Sharps Disposal Service

Pharmacies distribute sharps bins to patients who are prescribed medicines which require parenteral administration or appliances for point of care testing, which consequently result in the production of sharps. Pharmacies subsequently provide a disposal service for these patient generated sharps in order to facilitate its safe disposal. Patients will return filled and sealed sharps bins to the pharmacy.

Eighty-two per cent (31) of pharmacies in B&NES would be willing to provide a sharps disposal service, and this includes pharmacies that serve all GP clusters. Seven pharmacies do not wish to provide this service.

D. Vaccination Services

Seventy-nine per cent (30) of pharmacies in B&NES would be willing to provide a seasonal influenza vaccination service, and this includes pharmacies that serve all GP clusters. Seventy-six per cent (29) of pharmacies are willing to provide a Hepatitis-B vaccination service, which could be used (as appropriate) in conjunction with services offered to clients receiving sexual health and/or substance misuse commissioned services.

E. NHS Health Checks

Accredited pharmacy staff provide a vascular risk assessment and management service for people in the target group (people aged 40-74 years of age who have not had a previous diagnosis of vascular disease) in order to improve awareness of their vascular risk and how to minimise or manage that risk. People who are found to be at moderate or high risk will be offered appropriate interventions and referral where required. Where pre-existing disease is suspected or identified, the person is referred to their GP surgery for further tests.

Sixty-three per cent (24) of pharmacies in B&NES would be willing to provide an NHS Health Check service, and this includes pharmacies serving all GP clusters. Twelve pharmacies are currently not willing to provide this service.

F. Screening services

The majority of pharmacies in B&NES are willing to provide the screening services listed in Table 19, and this includes pharmacies serving all GP clusters. Some screening services (e.g. alcohol screening) are now included within the NHS Health Check locally.

G. Anticoagulant Service

Anticoagulation monitoring involves the pharmacy testing the patient's blood clotting time to determine the International Normalised Ratio (INR), which measures the delay in the clotting of the blood caused by warfarin. The pharmacist will make recommendations about dosage, and provide support and advice to the patient on the use of their anticoagulant therapy, including referral to other primary or secondary care professionals where appropriate.

Ninety-two per cent (35) pharmacies in B&NES would be willing to provide an anticoagulant service, and three would not wish to provide it.

3.6 The Future of Community Pharmacies

All of the identified services that pharmacies provide, along with those they indicate they are willing to provide, need to be seen against a drive for community pharmacies to play an even greater role at the heart of a more integrated out-of-hospital service. This forms part of a wider '*Call to Action*'[69] that NHS England launched in July 2013; following which community pharmacies are set to work with general practice to play a stronger role in delivering better integrated health service that supports better outcomes for patients. The stated aims for community pharmacies are as follows:

- develop the role of the pharmacy team to provide personalised care;
- play an even stronger role at the heart of more integrated out-of-hospital services;
- provide a greater role in healthy living advice, improving health and reducing health inequalities; and
- deliver excellent patient experience which helps people to get the most from their medicines.

3.7 Potential Future Local Commissioning Opportunities

The following outline the potential future local commissioning opportunities identified by B&NES Council that could meet locally identified unmet need.

3.7.1 Sexual Health Services

With the development in testing technologies such as HIV Point of Care (PoC) testing, and NAAT testing for chlamydia and gonorrhoea, there is the potential for community pharmacies to play a bigger role in testing of common STIs in the future. Pharmacies can link to wider CaSH and Genitourinary Medicine (GUM) services in ensuring that potential treatments for these STIs can also be offered. This already happens with treatment for chlamydia infection (3.5.6[A]) and this could be extended to other common STIs, ensuring services are delivered to wherever is convenient to the patient.

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[69] NHS England (2013), *Improving Health and Patient Care Through Community Pharmacy – A Call to Action*, December 2013, available at: http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pharm-cta/

Other identified gaps in the provision of local sexual health services may be identified in a soon to be published B&NES Sexual Health Needs Assessment.

3.7.2 Substance Misuse Services

B&NES has made the Needle and Syringe Programmes very accessible. However, this means that most injecting drug users now use pharmacies to obtain needles and the drug agencies are missing the opportunity to test/re-test for Hepatitis-C and immunise against Hepatitis-B. This will include training with pharmacies on Blood Borne Viruses (BBV) and seeking their help in signposting/referring NSP clients to the treatment agencies for BBV testing, immunisation and harm reduction advice.

3.7.3 Smoking Cessation Services

Whilst coverage of local smoking cessation services is high across B&NES, activity rates are relatively low (3.5.6[B]). There is a need to explore ways of increasing these relatively low activity rates.

3.7.4 NHS Health Checks

B&NES Council is currently working with one pharmacy and a local GP surgery to test out a joint working approach to delivery of the NHS Health Checks. This is an area of need identified by the NHS Health Check Steering Group, which is looking for ways of increasing uptake of the NHS Health Check in the local community. Other areas have successfully used pharmacy providers to deliver this service.

3.7.5 Partnership Working

There are a range of services that community pharmacies could develop closer links with, including GP practices, local schools and youth clubs. This would complement the existing locally commissioned health services in these venues, and also ensure a more joined-up approach to health care.

3.7.6 Holistic Working

A number of pharmacies could supply a more holistic package of services. For example, a number of pharmacies state (in their questionnaire responses) that they currently provide NRT, but not a smoking cessation service, and vice versa.

Chapter 4: Conclusion

4.0 Introduction

In compliance with Regulation 4 and Schedule 1 of *The Regulations*, this chapter identifies gaps in pharmaceutical services in B&NES where current or future unmet need for pharmaceutical services has been identified.

4.1 Key Findings

4.1.1 Necessary Services: definition

Key Finding 1: Necessary Services are defined as all Essential Services (as defined in 1.1.6).

4.1.2 Necessary Services: gaps in provision

A. Essential Services

As already stated in 3.5.5, analysis of the provision of essential services is, *de facto*, an analysis of the distribution and accessibility of the services.

Key Finding 2: current pharmaceutical provision in B&NES, including out-of-hours provision, appears to be sufficient to meet the needs of the population from the three Bath GP clusters of Bath West, Bath East and Bath Central, and the Norton Radstock GP cluster. Furthermore, there appears to be sufficient pharmaceutical provision during the day until at least 18:30 Monday to Saturday that serve the Chew/Keynsham GP cluster.

During the week there is no local community pharmacy in B&NES that is open beyond 18:30 that serves Keynsham (3.5.3[A]). Furthermore, there is no local community pharmacy in B&NES that is open for longer than one hour on a Sunday that serves Keynsham (3.5.3[A]).

Key Finding 3: there is a gap in the provision of easily accessible local community pharmaceutical services that serve the Chew/Keynsham GP cluster in the evenings after 18:30 Monday to Saturday, and on Sundays.

In view of a possible future expanded role for pharmacy contractors, particularly in providing a greater role allied to the Primary Care sector (3.6), there is a need for all community pharmacies, as a minimum, to comply with the requirements of the 2010 Equality Act, including the physical access requirements (3.5.3[C]).

Key Finding 4: within existing pharmaceutical provision there is an identified gap in the number of community pharmacies that currently do not have wheelchair accessible 'closed' consultation rooms.

4.1.3 Improvements and Better Access: gaps in provision

Assuming planned future housing development takes place as provided for by the local adopted Core Strategy, this would lead to additional predicted population growth (i.e. over and above increases due to projected current population trends). This predicted population growth is likely to be greatest in the Keynsham area (2.1.3).

Key Finding 5: It is anticipated that current pharmaceutical service provision from existing pharmacies will be able to cope with the demand from new populations for the coming few years. This will be reviewed during 2017/18 (at the latest).

Section 3.7 identified various Enhanced Services and locally commissioned services that could be expanded, improved or newly commissioned.

Key Finding 6: there are various locally commissioned pharmaceutical services that could potentially be expanded or improved, these include: an expanded role in testing for a greater range of common STIs; improved signposting for people with substance misuse problems for BBV testing; pharmacies working with a greater range of partners; and individual pharmacies providing a greater range of commissioned services in order to provide a holistic package of care.

Key Finding 7: there are various other locally commissioned services that could potentially be commissioned, for example, an NHS Health Checks Service.

4.1.4 Other Services

As stated in 2.4:

Key Finding 8: there are no known planned additional 'Other Services' (as defined in 1.2.5) that could significantly alter the need for pharmaceutical services in B&NES.

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Appendix 1: B&NES Pharmacy Contractors (GP cluster allocation and opening times)

Key
Purple - 100 hr pharmacy
Blue - Open 7 days a week
Yellow - Open weekdays and all day Saturday
Orange - Open week days and half day Saturday
Green - Open Monday to Friday only

Note: Chew Pharmacy in Chew Magna opened on 23rd February 2015. Chew Pharmacy is not included in this list.

Pharmacy	Address	GP cluster(s) serve	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Midsomer Dispensing Limited (Midsomer Pharmacy)	98 High Street, Midsomer Norton BA3 2DE	Norton Radstock	08:00 - 20.00	08:00 - 20.00	08:00 - 20.00	08:00 - midnight	08:00 - midnight	08:00 - midnight	08:00 - midnight
Boots Pharmacy	1 Newark Street, Southgate, Bath, BA1 1AT	Bath Central, Bath West, Bath East	08:00 - 19.00	08:00 - 19.00	08:00 - 19.00	08:00 - 20.00	08:00 - 19.00	08:00 - 19.00	11:00 - 17.00
Boots Pharmacy	33-35 Westgate Street, Bath BA1 1EL	Bath Central, Bath West, Bath East	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	10:30 - 16.30
Sainsburys Instore Pharmacy	Green Park Station, Green Park Road, Bath, Somerset, BA1 2DR	Bath Central, Bath West, Bath East	08:00 - 21.00	08:00 - 21.00	08:00 - 21.00	08:00 - 21.00	08:00 - 21.00	08:00 - 20.00	11:00 - 17.00
Lifestyle Pharmacy Ltd.	15 Westgate Street	Bath Central Bath West, Bath East	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	9.00 - 18.00	11.00 - 17.00
Lloyds Pharmacy	Chesterfield House High Street, Midsomer Norton, Bath	Norton Radstock	08:30 - 17.30	08:30 - 17.30	08:30 - 17.30	08:30 - 17.30	08:30 - 17.30	08:30 - 17.30	Closed
Lloyds Pharmacy	54 High Street, Keynsham, Bristol	Chew Keynsham	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	09:00 - 17.30	Closed
Lloyds Pharmacy	Norton House, High Street, Midsomer Norton, Bath	Norton Radstock	08:00 - 20.00	08:00 - 20.00	08:00 - 20.00	08:00 - 20.00	08:00 - 20.00	09:00 - 17.30	Closed
Lloyds Pharmacy	Elm Hayes Health Centre, Clansdown Road, Paulton, Bristol	Norton Radstock	08:45 - 18.00	08:45 - 18.00	08:45 - 18.00	08:45 - 18.00	08:45 - 18.00	08:45 - 17.30	Closed
Boots Pharmacy	40 High Street, Keynsham, Bristol BS31 1DX	Chew Keysham	08:30 - 17.30 Closed 13.00 - 14.00	08:30 - 17.30 Closed 13.00 - 14.00	08:30 - 17.30 Closed 13.00 - 14.00	08:30 - 17.30 Closed 13.00 - 14.00	08:30 - 17.30 Closed 13.00 - 14.00	08:30 - 17.30 Closed 13.00 - 14.00	Closed
Superdrug Pharmacy	30-32 Westgate Street, Bath, Somerset, BA1 1EL	Bath Central, Bath West, Bath East	08:30 - 17.30 Closed 14.00 - 14.30	08:30 - 17.30 Closed 14.00 - 14.30	08:30 - 17.30 Closed 14.00 - 14.30	08:30 - 17.30 Closed 14.00 - 14.30	08:30 - 17.30 Closed 14.00 - 14.30	09:00 - 17.30 Closed 14.00 - 14.30	Closed
The Bathwick Pharmacy (A.H. Hale Ltd.)	8 Argyle Street, Bath, Somerset, BA2 4BQ	Bath Central, Bath West, Bath East	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09.00 - 18.00	Closed
The John Preddy Co. Ltd.	41 Moorland Road, Bath	Bath Central, Bath West, Bath East	09:00 - 17.30 Closed 13.00 - 14.00	09:00 - 17.30 Closed 13.00 - 14.00	09:00 - 17.30 Closed 13.00 - 14.00	09:00 - 17.30 Closed 13.00 - 14.00	09:00 - 17.30 Closed 13.00 - 14.00	09:00 - 17.00 Closed 13.00 - 14.00	Closed

Purple - 100 hr pharmacy
Blue - Open 7 days a week
Yellow - Open weekdays and all day Saturday
Orange - Open week days and half day Saturday
Green - Open Monday to Friday only

Pharmacy	Address	GP cluster(s) serve	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Shaunak Pharmacy Ltd Pharmacy (Peasedown)	15 Bath Road, Peasedown St John, Bath BA2 8DH	Norton Radstock	09:00 - 18.00 Closed: 13.00-14.00	09:00 - 18.00 Closed: 13.00-14.00	09:00 - 18.00 Closed: 13.00-14.00	09:00 - 18.00 Closed: 13.00-14.00	09:00 - 18.00 Closed: 13.00-14.00	09:00 - 13.00	Closed
Jhoots Pharmacy	Newbridge Road Surgery, 129 Newbridge Hill BA1 3PT	Bath East	08:30 - 18.00 Closed 13.00-14.00	08:30 - 18.00 Closed 13.00-14.00	08:30 - 18.00 Closed 13.00-14.00	08:30 - 18.00 Closed 13.00-14.00	08:30 - 18.00 Closed 13.00-14.00	09:00 - 13.00	Closed
Lloyds Pharmacy	Keynsham Health Centre, St. Clements Road, Keynsham	Chew Keynsham	08:30 - 18.30	08:30 - 18.30	08:30 - 18.30	08:30 - 18.30	08:30 - 18.30	09:00 - 13.00	Closed
Boots Pharmacy	125 High Street, Weston, Bath BA1 4DF	Bath Central, Bath West, Bath East	09:00 - 18.00 Closed 13.30 - 14.00	09:00 - 18.00 Closed 13.30 - 14.00	09:00 - 18.00 Closed 13.30 - 14.00	09:00 - 18.00 Closed 13.30 - 14.00	09:00 - 18.00 Closed 13.30 - 14.00	09:00 - 13.00	Closed
Boots Pharmacy	201 London Road East, Batheaston, Bath BA1 7NB	Bath East	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00 Closed 13.00-14.00	09:00 - 13.00	Closed
Your Local Boots	84-85 High Street, Twerton, Bath BA2 1DE	Bath Central, Bath West	09:00 - 18.00 Closed 13.30 -14.00	09:00 - 18.00 Closed 13.30 -14.00	09:00 - 18.00 Closed 13.30 -14.00	09:00 - 18.00 Closed 13.30 -14.00	09:00 - 18.00 Closed 13.30 -14.00	09:00 - 13.00	Closed
Chandag Road Pharmacy	47 Chandag Road, Keynsham, Bristol, Bristol, BS31 1PW	Chew Keynsham	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	09:00 - 13.00	Closed
Day Lewis Pharmacy	497 Bath Road, Saltford, Bristol, Bristol, BS31 3HQ	Chew Keynsham	08:30 - 18.00 Closed 13.00 - 14.00	08:30 - 18.00 Closed 13.00 - 14.00	08:30 - 18.00 Closed 13.00 - 14.00	08:30 - 18.00 Closed 13.00 - 14.00	08:30 - 18.00 Closed 13.00 - 14.00	09:00 - 13.00	Supplementary Hours from 13:00 to 14:00
Dudley Taylor Pharmacy Ltd (Clement)	7 The Street, Radstock, Bath	Norton Radstock	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	08:30 - 13.30	Closed
Westfield Pharmacy (Dudley Taylor)	9 Elm Tree Avenue, Radstock, Somerset, BA3 3SX	Norton Radstock	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 13.00	Closed
Larkhall Pharmacy	1 St. Saviours Road, Bath, Somerset, BA1 6RT	Bath East	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 15.00	Closed
Timsbury Pharmacy (Tans Pharmacy)	High street timsbury, bath	Norton Radstock	09:00 - 18.00 Closed 13.00 - 14.00	09:00 - 18.00 Closed 13.00 - 14.00	09:00 - 18.00 Closed 13.00 - 14.00	09:00 - 18.00 Closed 13.00 - 14.00	09:00 - 18.00 Closed 13.00 - 14.00	09:00 - 12.30	Closed

Purple - 100 hr pharmacy
Blue - Open 7 days a week
Yellow - Open weekdays and all day Saturday
Orange - Open weekdays and half-day Saturday
Green - Open Monday to Friday only

Pharmacy	Address	GP cluster(s) serve	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Lloyds Pharmacy	88 Frome Road, Odd Down, Bath	Bath Central, Bath West, Bath East	09:00 - 17.30	09:00 - 17.30	09:00 - 17.30	09:00 - 17.30	09:00 - 17.30	09.00 - 13.00	Closed
The Co-operative Pharmacy	3 Claremont Terrace, Campden Road, Bath BA1 6EH	Bath East	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09.00 - 13.00	Closed
Dudley Taylor Pharmacy Ltd	87 Bradford Road BATH	Bath Central, Bath West, Bath East	09:00 - 17.30 Closed 13.00 - 13.30	09:00 - 17.30 Closed 13.00 - 13.30	09:00 - 17.30 Closed 13.00 - 13.30	09:00 - 17.30 Closed 13.00 - 13.30	09:00 - 17.30 Closed 13.00 - 13.30	9.00 - 13.00	Closed
Hawes Whiston and Co.	38 St. James's Square, Bath, Somerset, BA1 2TU	Bath West, Bath East	09:00 - 17.30 Closed 13.15 - 13.45	09:00 - 17.30 Closed 13.15 - 13.45	09:00 - 17.30 Closed 13.15 - 13.45	09:00 - 17.30 Closed 13.15 - 13.45	09:00 - 17.30 Closed 13.15 - 13.45	8.45 - 13.00	Closed
Wellsway Pharmacy	2 Hayes Place, Bath, Somerset, BA2 4QW	Bath Central, Bath West	09:00 - 17.30 Closed 13.00 - 14.00	09:00 - 17.30 Closed 13.00 - 14.00	09:00 - 17.30 Closed 13.00 - 14.00	09:00 - 17.30 Closed 13.00 - 14.00	09:00 - 17.30 Closed 13.00 - 14.00	09.00 - 13.00	Closed
Widcombe Pharmacy	4a Widcombe Parade, Bath, Somerset, BA2 4JT	Bath Central	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	08:30 - 18.00	09.00 - 14.00	Closed
Jhoots Pharmacy	28 Brock Street, Bath BA1 2LN	Bath West, Bath East	09:00 - 18.00 Closed 13.00-13.30	09:00 - 18.00 Closed 13.00-13.30	09:00 - 18.00 Closed 13.00-13.30	09:00 - 18.00 Closed 13.00-13.30	09:00 - 18.00 Closed 13.00-13.30	Closed	Closed
Lloyds Pharmacy	Combe Down Surgery, Combe Down House, The Avenue, Combe Down	Bath West	08:30 - 18.30	08:30 - 18.30	08:30 - 18.30	08:30 - 18.30	08:30 - 18.30	Closed	Closed
Your Local Boots	100 Mount Road, Southdown, Bath BA2 1LN	Bath Central, Bath West	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	09:00 - 18.00	Closed	Closed
Bathampton Pharmacy	27 Holcombe Lane, Bathampton, Bath, Somerset, BA2 6UL	Bath West	08:45 - 17.30 Closed 12.45 - 14.00	08:45 - 17.30 Closed 12.45 - 14.00	08:45 - 17.30 Closed 12.45 - 14.00	08:45 - 17.30 Closed 12.45 - 14.00	08:45 - 17.30 Closed 12.45 - 14.00	Closed	Closed
Hounsell and Greene	45 Upper Oldfield Park	Bath Central, Bath West	08.30 - 18.00	08.30 - 18.00	08.30 - 18.00	08.30 - 18.00	08.30 - 18.00	Closed	Closed
Pulteney Pharmacy	35 Great Pulteney Street, Bath, Somerset, BA2 4BY	Bath West	08:30 - 17.45	08:30 - 17.45	08:30 - 17.45	08:30 - 17.45	08:30 - 17.45	Closed	Closed
The Bath Pharmacy Company	Unit 20, Burnett Business Park, Gypsy Lane, Gypsy Lane, Bristol, Bristol, BS31 2ED	Bath Central, Bath West	08:30 - 17.30 Closed 13.00 - 13.30	08:30 - 17.30 Closed 13.00 - 13.30	08:30 - 17.30 Closed 13.00 - 13.30	08:30 - 17.30 Closed 13.00 - 13.30	08:30 - 17.30 Closed 13.00 - 13.30	Closed	Closed

Appendix 2: PNA Questionnaire Responses (services commissioned by B&NES Council)

SEXUAL HEALTH SERVICES

Chlamydia testing	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew Keynsham	
	No.	**%**	**No**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No**	**%**
CP	19	50	9	56	11	52	10	67	2	25	3	60
WA	1	3	0	0	1	5	0	0	0	0	0	0
WT	15	39	4	25	6	29	3	20	6	75	2	40
WF	0	0	0	0	0	0	0	0	0	0	0	0
PP	0	0	0	0	0	0	0	0	0	0	0	0
Not willing to provide	3	8	3	19	3	14	2	13	0	0	0	0
	38		**16**		**21**		**15**		**8**		**5**	

Chlamydia treatment	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew Keynsham	
	No.	**%**	**No**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No**	**%**
CP	17	45	6	38	9	43	7	47	5	63	2	40
WA	8	21	5	31	6	29	4	27	0	0	1	20
WT	11	29	3	19	4	19	3	20	3	38	2	40
WF	0	0	0	0	0	0	0	0	0	0	0	0
PP	0	0	0	0	0	0	0	0	0	0	0	0
Not willing to provide	2	5	2	13	2	10	1	7	0	0	0	0
	38		**16**		**21**		**15**		**8**		**5**	

Contraceptive service (not EHC) E.G. Condom-card scheme	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew Keynsham	
	No.	**%**	**No**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No**	**%**
CP	6	16	3	19	3	14	5	33	0	0	0	0
WA	18	47	7	44	9	43	8	53	5	63	2	40
WT	12	32	4	25	7	33	1	7	3	38	3	60
WF	0	0	0	0	0	0	0	0	0	0	0	0
PP	0	0	0	0	0	0	0	0	0	0	0	0
Not willing to provide	2	5	2	13	2	10	1	7	0	0	0	0
	38		**16**		**21**		**15**		**8**		**5**	

NB. Updated above questionnaire data information using Pharma Outcomes data

SEXUAL HEALTH SERVICES

Emergency Hormonal Contraceptive (EHC)	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew Keynsham	
	No.	**%**	**No**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No**	**%**
CP	26	68	11	69	15	71	11	73	6	75	3	60
WA	2	5	1	6	1	5	1	7	1	13	0	0
WT	9	24	3	19	4	19	3	20	1	13	2	40
WF	0	0	0	0	0	0	0	0	0	0	0	0
PP	0	0	0	0	0	0	0	0	0	0	0	0
Not willing to provide	1	3	1	6	1	5	0	0	0	0	0	0
	38		**16**		**21**		**15**		**8**		**5**	

SMOKING CESSATION SERVICES

Stop Smoking Service	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew Keynsham	
	No.	**%**	**No**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No**	**%**
CP	26	68	8	50	13	62	9	60	6	75	4	80
WA	1	3	0	0	0	0	0	0	1	13	0	0
WT	6	16	4	25	4	19	4	27	1	13	0	0
WF	0	0	0	0	0	0	0	0	0	0	0	0
PP	0	0	0	0	0	0	0	0	0	0	0	0
Not willing to provide	5	13	4	25	4	19	2	13	0	0	1	20
	38		**16**		**21**		**15**		**8**		**5**	

NRT vouchers	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew Keynsham	
	No.	**%**	**No**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No**	**%**
CP	24	63	11	69	15	71	10	67	4	50	3	60
WA	1	3	0	0	0	0	0	0	1	13	0	0
WT	5	13	1	6	1	5	2	13	2	25	0	0
WF	1	3	0	0	1	5	0	0	0	0	0	0
PP	0	0	0	0	0	0	0	0	0	0	0	0
Not willing to provide	7	18	4	25	4	19	3	20	1	13	2	40
	38		**16**		**21**		**15**		**8**		**5**	

Needle and Syringe Programmes (NSP)	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew Keynsham	
	No.	**%**	**No**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No**	**%**
CP	10	26	6	38	6	29	4	27	2	25	1	20
WA	10	26	1	6	2	10	3	20	4	50	2	40
WT	9	24	1	6	5	24	3	20	2	25	1	20
WF	2	5	1	6	1	5	0	0	0	0	1	20
PP	0	0	0	0	0	0	0	0	0	0	0	0
Not willing to provide	7	18	7	44	7	33	5	33	0	0	0	0
	38		**16**		**21**		**15**		**8**		**5**	

Supervised Administration (Consumption)	B&NES		Bath Central		Bath West		Bath East		Norton Radstock		Chew Keynsham	
	No.	**%**	**No**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No**	**%**
CP	32	84	14	88	17	81	12	80	8	100	4	80
WA	1	3	0	0	0	0	0	0	0	0	1	20
WT	2	5	0	0	1	5	2	13	0	0	0	0
WF	1	3	0	0	1	5	0	0	0	0	0	0
PP	0	0	0	0	0	0	0	0	0	0	0	0
Not willing to provide	2	5	2	13	2	10	1	7	0	0	0	0
	38		**16**		**21**		**15**		**8**		**5**	

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PharmOutcomes®

Pharmaceutical Needs Assessment Questionnaire

Date of completion: 05-May-2014

Pharmacy Name
Primary identification

Postcode [Search]

Address

Trading Name

Is this a Distance Selling Pharmacy? ◯ Yes ◯ No
(i.e. it cannot provide Essential Services to persons present at the pharmacy)

Pharmacy email address
If no email write no email

Pharmacy telephone

Pharmacy fax

Pharmacy website address
If no website write no website

Can we store the above information and use this to contact you?

Consent to store ◯ Yes ◯ No

PNA Easy Guide

To help complete please download the Easy Guide

PSNC Template Document

To help fill in this PharmOutcomes service you may find it useful to download the questions, fill them in offline and then complete the service. Click here to download the PDF and here to download the Word doc.

- Core hours of opening

Enter **No Core Hours** if closed.
Help completing this section click here

Monday Open	Time (24 hour clock)	Monday Close	Time (24 hour clock)
		Monday Lunchtime (from - to)	Text box
Tuesday Open	Time (24 hour clock)	Tuesday Close	Time (24 hour clock)
		Tuesday Lunchtime (from - to)	Text box
Wednesday Open	Time (24 hour clock)	Wednesday Close	Time (24 hour clock)
		Wednesday Lunchtime (from - to)	Text box
Thursday Open	Time (24 hour clock)	Thursday Close	Time (24 hour clock)
		Thursday Lunchtime (from - to)	Text box
Friday Open	Time (24 hour clock)	Friday Close	Time (24 hour clock)
		Friday Lunchtime (from - to)	Text box
Saturday Open	Time or "no core hrs"	Saturday Close	Time or "no core hrs"
		Saturday Lunchtime (from - to)	Text box
Sunday Open	Time or "no core hrs"	Sunday Close	Time or "no core hrs"
		Sunday Lunchtime (from - to)	Text box

- Total hours of opening (Core + Supplementary)

Please complete your full hours of opening
If closed please enter **Closed**
Help completing this section click here

Monday Open	Time (24 hour clock)	Monday Close	Time (24 hour clock)
		Monday Lunchtime (from - to)	Text box
Tuesday Open	Time (24 hour clock)	Tuesday Close	Time (24 hour clock)
		Tuesday Lunchtime (from - to)	Text box
Wednesday Open	Time (24 hour clock)	Wednesday Close	Time (24 hour clock)
		Wednesday Lunchtime (from - to)	Text box
Thursday Open	Time (24 hour clock)	Thursday Close	Time (24 hour clock)
		Thursday Lunchtime (from - to)	Text box
Friday Open	Time (24 hour clock)	Friday Close	Time (24 hour clock)
		Friday Lunchtime (from - to)	Text box
Saturday Open	Text box	Saturday Close	Text box
		Saturday Lunchtime (from - to)	Text box
Sunday Open	Text box	Sunday Close	Text box
		Sunday Lunchtime (from - to)	Text box

Consultation Facilities

Consultation areas should meet the standard set out in the contractual framework to offer advanced services

Is there a consultation area?

- ○ Available (including wheelchair access) on the premises
- ○ Available (without wheelchair access) on premises
- ○ Planned within next 12 months
- ○ No consultation room available
- ○ Other [ ]

If Other please specify

Where there is a consultation area

Is this enclosed? ○ Yes ○ No ○ N/A

N/A if no consultation room

Off-site arrangements

- ○ Off-site consultation room approved by NHS
- ○ Willing to undertake consultations in patients home/ other suitable site
- ○ None apply
- ○ Other [ ]

If Other please specify

Hand washing and toilet facilities

What facilities are available to patients during consultations?

Facilities available

- ☐ Handwashing in consultation area
- ☐ Hand washing facilities close to consultation area
- ☐ Have access to toilet facilities
- ☐ None

Tick all that apply

Information Technology

Is the pharmacy EPS* R2 enabled?

- ○ Yes, EPS R2 enabled
- ○ Planning to become EPS R2 enabled in the next 12 months
- ○ No current plans to provide EPS R2

EPS R2: Electronic Prescription Service Release 2

Information is often distributed to pharmacies as email attachments or via websites. Please indicate whether you are able to use the following common file formats in your pharmacy:

File format types

- ☐ Microsoft Word
- ☐ Microsoft Excel
- ☐ Microsoft Access
- ☐ PDF
- ☐ Unable to open or view any file formats

Please tick all that apply

Essential Services (appliances)

In this section, please give details of the essential services your pharmacy provides.

Does the pharmacy dispense appliances?

- ○ Yes - All types, or
- ○ Yes, excluding stoma appliances, or
- ○ Yes, excluding incontinence appliances, or
- ○ Yes, excluding stoma and incontinence appliances, or
- ○ Yes, just dressings, or
- ○ None
- ○ Other [ ]

If Other please specify

Advanced Services

Please give details of the Advanced Services provided by your pharmacy.
Please tick the box that applies for each service.

Yes - Currently providing
Soon - Intending to begin within the next 12 months
No - Not intending to provide

Service			
Medicines Use Review service	☐ Yes	☐ Soon	☐ No
New Medicine Service	☐ Yes	☐ Soon	☐ No
Appliance Use Review service	☐ Yes	☐ Soon	☐ No
Stoma Appliance Customisation service	☐ Yes	☐ Soon	☐ No

Commissioned Services

Use this section to record which Local services you currently deliver or would like to deliver at your pharmacy. These can be Enhanced Services, commissioned by the NHS England Area Team, Public Health Services commissioned by a Local Authority or CCG services.
Please tick the box that applies for each service.

CP - Currently Providing NHS funded service
WA - Willing and able to provide if commissioned
WT - Willing to provide if commissioned but would need training
WF - Willing to provide if commissioned but require facilities adjustment
PP - Currently providing private service
If you are not willing or able to provide please leave blank.

Service					
Anticoagulant Monitoring Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Anti-viral Distribution Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Care Home Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Chlamydia Treatment Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Chlamydia Testing Service	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP
Contraception Service (not an EHC service)	☐ CP	☐ WA	☐ WT	☐ WF	☐ PP

Local Authority Commissioned Services

List services already commissioned in your locality here

Disease Specific Medicines Management Service:

Service	Options
Allergies	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Alzheimer's/dementia	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Asthma	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
CHD	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Depression	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Diabetes type I	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Diabetes type II	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Epilepsy	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Heart Failure	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Hypertension	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Parkinson's disease	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Other (please state - including funding source)	[text box]

Area Team Services
List your Area Team commissioned services here

End of Disease specific Medicines Management Service options.

Service	Options
Emergency Hormonal Contraception Service	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Gluten Free Food Supply Service	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP (i.e. not supply on FP10)
Home Delivery Service	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP (not appliances)
Independent Prescribing Service	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Therapeutic areas covered (if providing)	[text box]
Language Access Service	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Note: This is not the NMS or MUR service.

Service	Options
Medication Review Service	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Medicines Assessment and Compliance Support Service:

Service	Options
Medicines Management Support Service:	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP i.e. the EL23 service (previously the Vulnerable Elderly / Adults Service)
DomMAR Carer's Charts	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

End of Medicines Assessment and Compliance Support options.

Service	Options
Minor Ailments Scheme	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
MUR Plus/Medicines Optimisation Service	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Therapeutic areas covered (if providing)	[text box]
Needle and Syringe Exchange Service	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Obesity management (adults and children)	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

On Demand Availability of Specialist Drugs Service:

Service	Options
Directly Observed Therapy	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
If yes state which medicines	[text box]
Out of hours services	○ CP ○ WA ○ WT ○ WF ○ PP
Palliative Care scheme	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

End of On Demand Availability of Specialist Drugs Service options

Patient group directions

Many Local Services involve the supply of a POM using a PGD. please list those provided by the pharmacy in the text box below but indicate who commissions the service by ticking the boxes below and annotating each service name with the key:

AT=Area Team
LA=Local Authority
CCG=Clinical Commissioning Group
Pr=Offers a Private Service

Service	Options
Patient Group Direction Service	☐ AT ☐ LA ☐ CCG ☐ Pr Not including EHC (see separate question)

Please list the names of the medicines available if providing PGD services

Service	Options
Medicines available	[text box]
Phlebotomy Service	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Prescriber Support Service	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Schools Service	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Screening Service:

Service	Options
Alcohol	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Chlamydia	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Cholesterol	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Diabetes	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Gonorrhoea	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
H. pylori	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
HbA1C	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Hepatitis	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
HIV	☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Other Screening (please state - including funding source)	[text box]

End of screening service options

Seasonal Influenza Vaccination Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Other vaccinations

Childhood vaccinations ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

HPV ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Hepatitis B ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
(at risk workers or patients)

Travel vaccines ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Other (please state - including funding source)

End of Other vaccinations options

Sharps Disposal Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Stop Smoking Service:

NRT Voucher Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Smoking Cessation Counselling Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

End of Stop Smoking Service options

Supervised Administration ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
Of methadone,buprenorphine etc.

End of Supervised Administration Service options

Collection and Delivery services

Does the pharmacy provide any of the following?

Collection of prescriptions from surgeries ◯ Yes ◯ No

Delivery of dispensed medicines - Free of charge on request ◯ Yes ◯ No

Delivery of dispensed medicines - Selected patient groups
List criteria

Delivery of dispensed medicines - Selected areas
List areas

Delivery of dispensed medicines - chargeable ◯ Yes ◯ No

Languages

One potential barrier to accessing services at a pharmacy can be language. To help the local authority better understand any access issues caused by language please answer the following two questions:

What languages other than English are spoken in the pharmacy

What languages other than English are spoken by the community your pharmacy serves

Supplementary prescribing ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP

Which therapy area

Vascular Risk Assessment Service ☐ CP ☐ WA ☐ WT ☐ WF ☐ PP
NHS Healthchecks

Healthy Living Pharmacy

Is this a Healthy Living Pharmacy

◯ Yes
◯ Currently working towards HLP status
◯ No

If Yes, how many Healthy Living Champions do you currently have? Full Time Equivalents

Almost done

If you have anything else you would like to tell us that you think would be useful in the formulation of the PNA, please include it here:

Other

Please tell us who has completed this form in case we need to contact you.

Contact name

Contact telephone

For person completing the form, if different to pharmacy number given above

Thank you for completing this PNA questionnaire.

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Bath & North East Somerset Council

healthwatch Bath and North East Somerset

NHS Bath and North East Somerset Clinical Commissioning Group

MEETING	B&NES HEALTH AND WELLBEING BOARD
DATE	25/03/2015
TYPE	An open public item

Report summary table	
Report title	Refresh of the Healthy Weight Strategy
Report author	Jameelah Ingram tel: 01225 394073
List of attachments	Draft Shaping Up – Healthy Weight Strategy
Background papers	N/A
Summary	Strategy is signed off and ready for public consultation.
Recommendations	The Board is asked to: • Approve the strategy subject to public consultation • Agree the governance of the strategy
Rationale for recommendations	A Healthy Weight 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. The local strategy contributes to the HWB priority and outcome: • Priority: **Helping children to be a healthy weight** • Outcome: **All pregnant women, children and young people are a healthy weight** **The strategy also contributes to the wider inequalities agenda identified in the Joint Health and Wellbeing Strategy:** 1. **Boost the economy** through reducing sickness absence and worklessness 2. 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 3. 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 4. 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 5. 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 6. Empowering communities - connecting with communities to improve health and wellbeing 7. 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 8. Widening access to an affordable healthier diet 9. Increasing pupil attainment – supporting children to have the knowledge and skills to feel emotionally and physically well 10. 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 11. 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.
Resource implications	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. 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 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.
Statutory considerations and basis for proposal	It is a mandatory responsibility of every local authority to monitor levels of excess weight in reception and year 6 children.
Consultation	The draft strategy has emerged following extensive research and consultation which considered a wide range of options To date the following consultation has been undertaken: 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. 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. 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.
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.

THE REPORT

1.1 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.

1.2 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.

1.3 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.

1.4 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.

1.5 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.

2 WHY HEALTHY WEIGHT?

2.1 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

2.2 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.

2.3 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

2.4 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

2.5 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

2.6 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.

2.7 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. Around 1 in 11 (8.9%) Reception aged children in B&NES are obese.

2.8 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.

2.9 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.

2.10 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

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

2.12 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.

2.13 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

2.14 Vision for B&NES:
In Bath and North East Somerset all residents have the opportunity to have a healthy lifestyle and every adult and child is informed, able and motivated and supported to make positive choices regarding nutrition and physical activity.

2.15 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.

2.16 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:

2.17 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.

2.18 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. Control exposure to and demand for consumption of excessive quantities of high calorific foods and drinks

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

iv. Increase 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.

2.19 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).

2.20 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 up creating an asset based community development approach.

2.21 The strategy recommends taking an integrated life course approach to addressing obesity. Key recommendations from each life course are summarised below:

Outcome 1: All pregnant women, children and young people are a healthy weight:

2.22 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. Improving access and availability of provision for 5-9 year olds, 14-19 year olds, families with physical and learning difficulties.

2.23 Develop a community development building parental capacity approach to self-care and prevention for the whole family (including carers and extended family members).

2.24 Continue to deliver the National Child Measurement Programme.

2.25 Work collaboratively with the Fit for Life partnership to:

- Encourage more pregnant women, children and young people to be more active as part of everyday life, removing barriers to participation

- 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

- 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

- Through the delivery of the Fit for Life Partnership: Ensure physical activity is a consideration in all policy

- Create family friendly environments that enable opportunities for active play and planned physical activity development that impacts on children and young people

- Improve the nutritional quality and offer of food in junior and secondary schools and continue to increase uptake of school meals.

2.26 Through the local food partnership:

- Greater promotion of national Change4Life programme to deliver key messaging on the dangers of sugary and caffeinated drinks and portion sizes/over snacking locally

- 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

- Support the NHS and the Local Authority to be exemplar employers in achieving the Workplace Wellbeing charter and Eat Out Eat Well Gold Status.

Outcome 2: All Adults are a healthy weight

2.27 Continue to provide effective services for those at risk of unhealthy weights, ensuring that commissioned interventions include psychosocial aspects of being overweight.

2.28 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

2.29 Review and develop an improved prevention self-care offer which includes the promotion of online tools and social media prioritising at risk populations.

2.30 Development of a Healthy Lifestyles app for people with learning difficulties.

2.31 Develop an online weight management offer for employees:
- Adults who have had a health check
- Newly diagnosed diabetic patients

2.32 Through collaboration with the local food partnership:

- Support more adults 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.

2.33 Work in partnership with the Fit for Life Partnership to:

- 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 residents and/or those with long term conditions

- 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

- 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.

2.34 Enable staff to have increased confidence in raising the issue of weight and the competencies to deliver weight management interventions.

2.35 Increase the opportunities for workplace weight management programmes.

2.36 Work with leisure and tourism, parks and allotments and open spaces to create opportunities for physical activity.

2.37 Ensure development of the transport plan includes opportunities for individuals and families to travel sustainably and contributing to climate change and traffic calming agenda.

2.38 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.

Older People

2.39 Create a weight management care pathway to ensure a single inclusive pathway based on client need and evidence based practice.

2.41 Work with partners to embed weight management support within existing social care pathways.

2.42 Review and create a sustainable model for cooking skills for adults or single occupant households.

2.43 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.

2.44 In collaboration with the Fit for Life Partnership:

- Invest in additional marketing campaigns that will inform, support, empower people to make changes to their activity levels

- 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 and reduce social isolation

- Increase the opportunities for low level structured activity needed for obese or those with long term conditions

- Review and explore the potential of increasing the number of community based rehab programmes

- Support development of residential travel plans that promote sustainable/active travel.

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:

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- **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. Control exposure to and demand for consumption of excessive quantities of high calorific foods and drinks
3. Increase opportunities for and uptake of walking, cycling, play and other PA in our daily lives, reducing sedentary behaviour
4. Increase 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

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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?

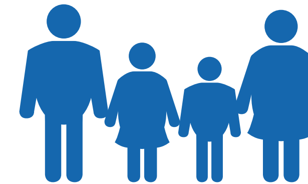
The prevalence of obesity in the UK has increased dramatically over the last 25 years with Britain now being the most obese nation in Europe.

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

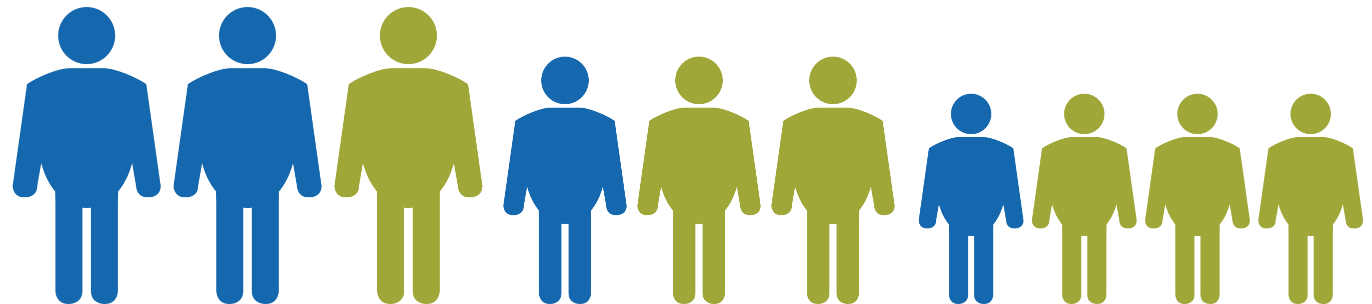
Overweight and obesity in adults is predicted to reach 70% by 2034. More adults and children are now severely obese



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]

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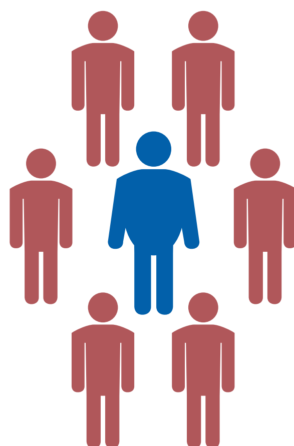
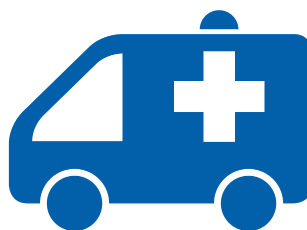
It is well documented that people who are overweight and obese increase the risk of a range of diseases that can have a significant health impact on individuals. Obesity is associated with type 2 diabetes and hypertension - which are major risk factors for cardiovascular disease and cardiovascular related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

Obesity harms adults

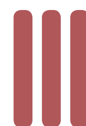
Less likely to be in employment



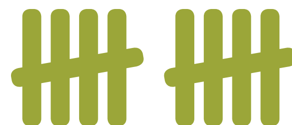
Discrimination and stigmatisation



Increased risk of hospitalisation



Obesity reduces life expectancy by an average of 3 years



Severe obesity reduces life expectancy by 8–10 years

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

Depression, anxiety and other forms of mental illness are more common in obese individuals than in the general population. Obesity may trigger psychological issues such as eating disorders, distorted body image, and low self-esteem. Other mental health effects of obesity include social discrimination – people often judge and mistreat individuals who are overweight. Depression may also lead to reduced physical activity and increased appetite including binge eating. Activity limitations due to obesity or related chronic illnesses may also increase the risk of depression by reducing involvement in physically rewarding activities.

'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]

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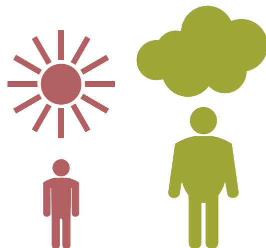
Obese persons had a 55% increased risk of developing depression over time

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.

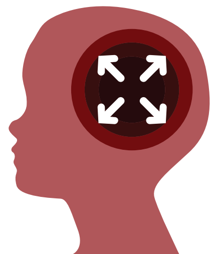
Being overweight or obese in childhood and adolescence has consequences for health in both the short term and longer term. Maternal obesity significantly increases risk of foetal congenital anomaly, prematurity,stillbirth and neonatal death. Once established, obesity is notoriously difficult to treat,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

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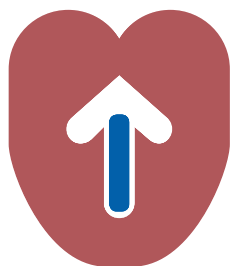
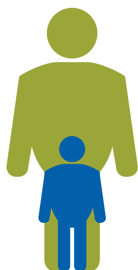
- School absence



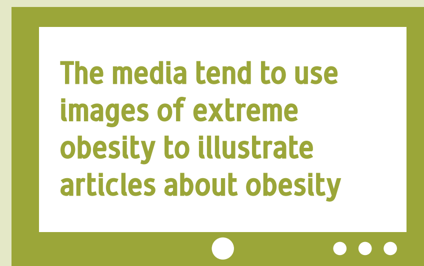
- High cholesterol
- High blood pressure
- Pre-diabetes
- Bone and joint problems
- Breathing difficulties



- 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



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

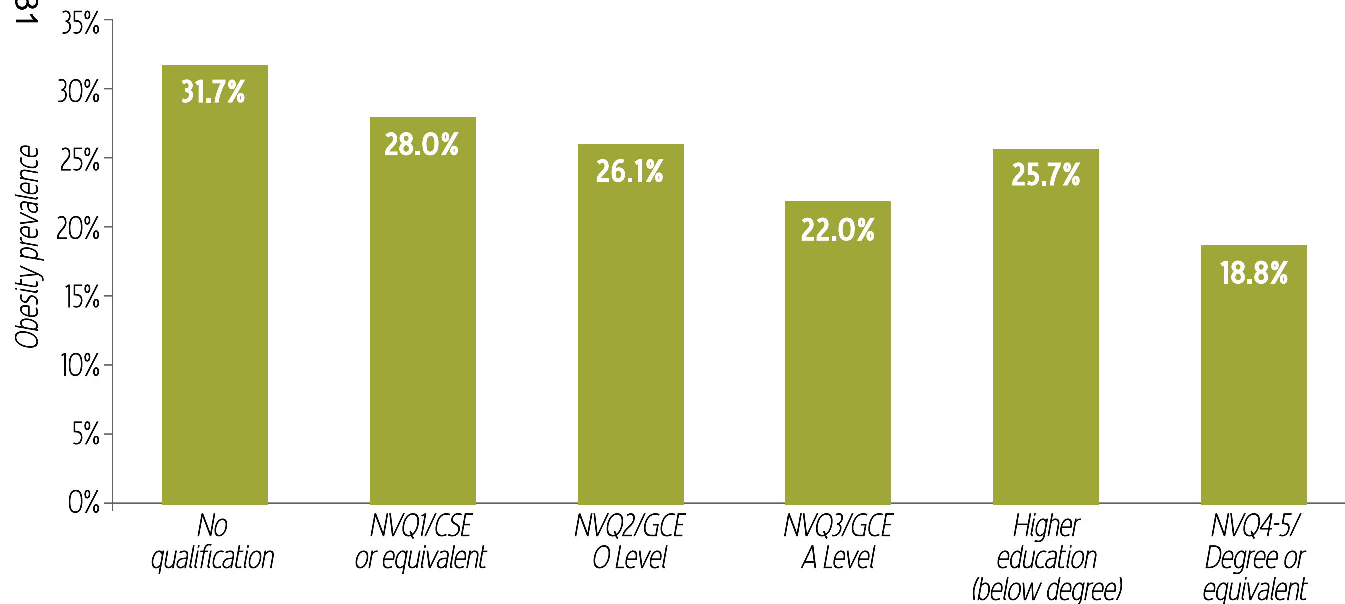
Independent research earlier this year found that obesity now costs the British taxpayer more than police, prisons and fire service combined. It is clear that, as a society, if we are going to continue to deliver world class public services and look after the health of the population as a whole, we are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

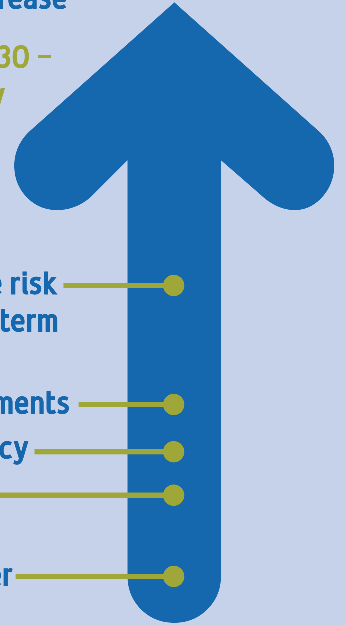
Adult obesity prevalence by highest level of education (2006-2010)



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 all residents have the opportunity to have a healthy lifestyle 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.

Outcome:

- 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.

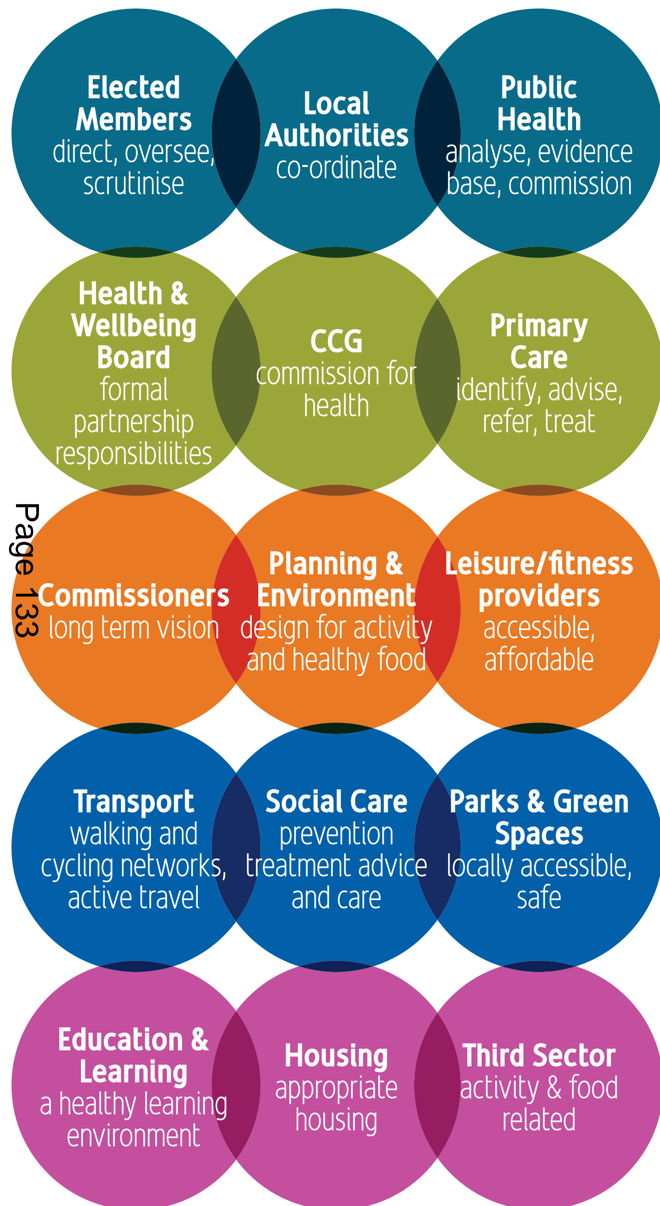
The local Health and Wellbeing Board has set a framework for action.

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



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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:

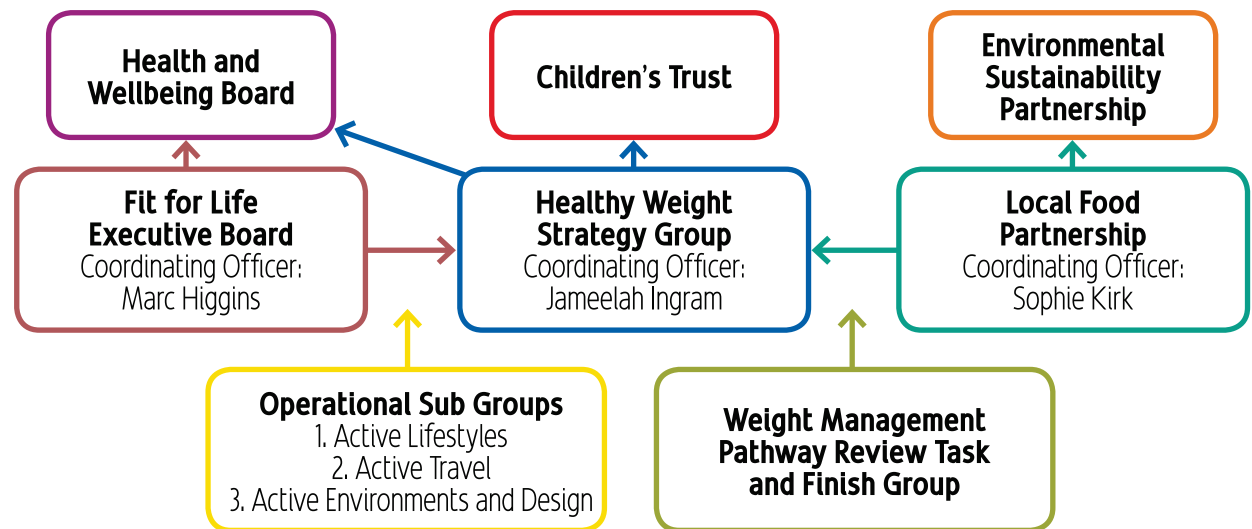
1. Fit for Life – getting more people, more active, more often. The strategy with leads on local priorities which encourage people to be more active as well as looking at changes to the physical environment, transport and planning.

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

2 Partnerships – effective partnership working to optimise the use of resources

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

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

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

6 Innovative – uses technology to better engage and connect with people

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

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

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

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

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

4. Increase 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.

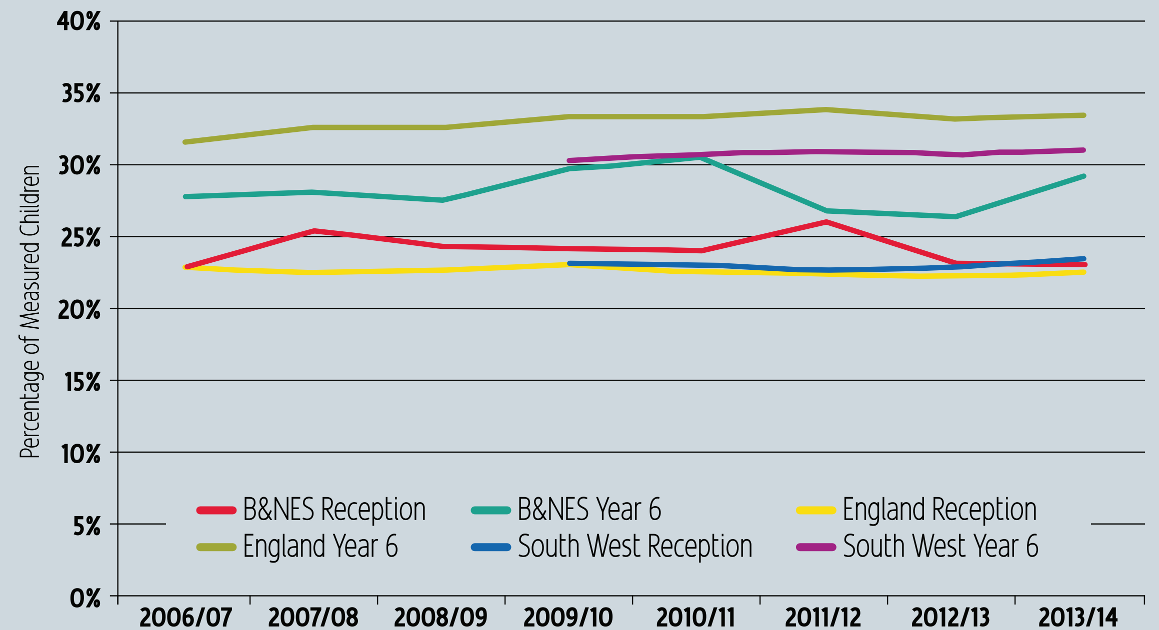
Mapping of all service provision in the area needs to be undertaken to identify gaps and areas of duplication

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.



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

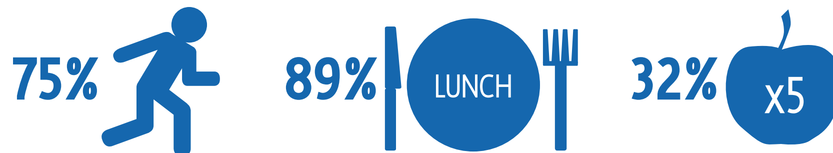
Listening to the public and service users

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
- Involve and upskill professionals in educational settings in the development of an effective weight management pathway

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

- 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

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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 multigancy 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 Start4llfe, 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
- Work collaboratively with the NHS and community partners to develop an integrated holistic pathway for those clients who have a diagnosed eating disorder
- Work with partners to promote body image and esteem in children and young people

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

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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

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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.

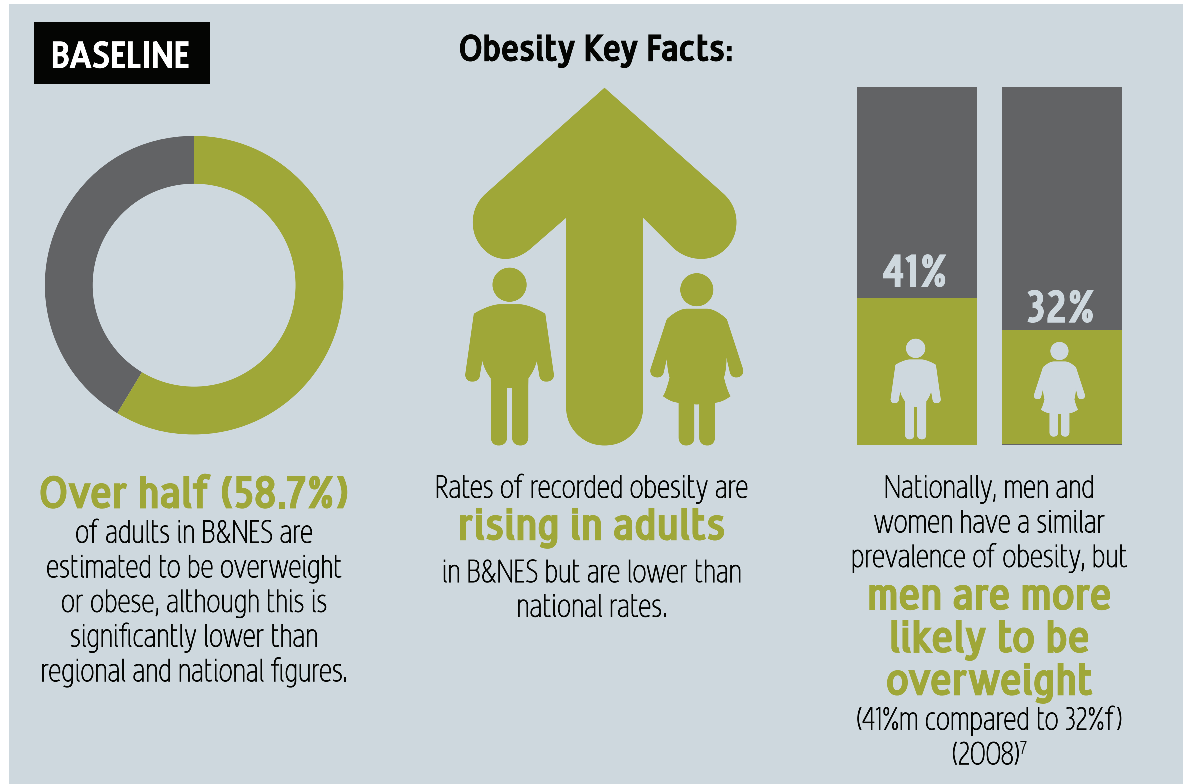
Neighbourhood profiles showing trends dietary behaviour, activity levels and unhealthy weight prevalence need developing.

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



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

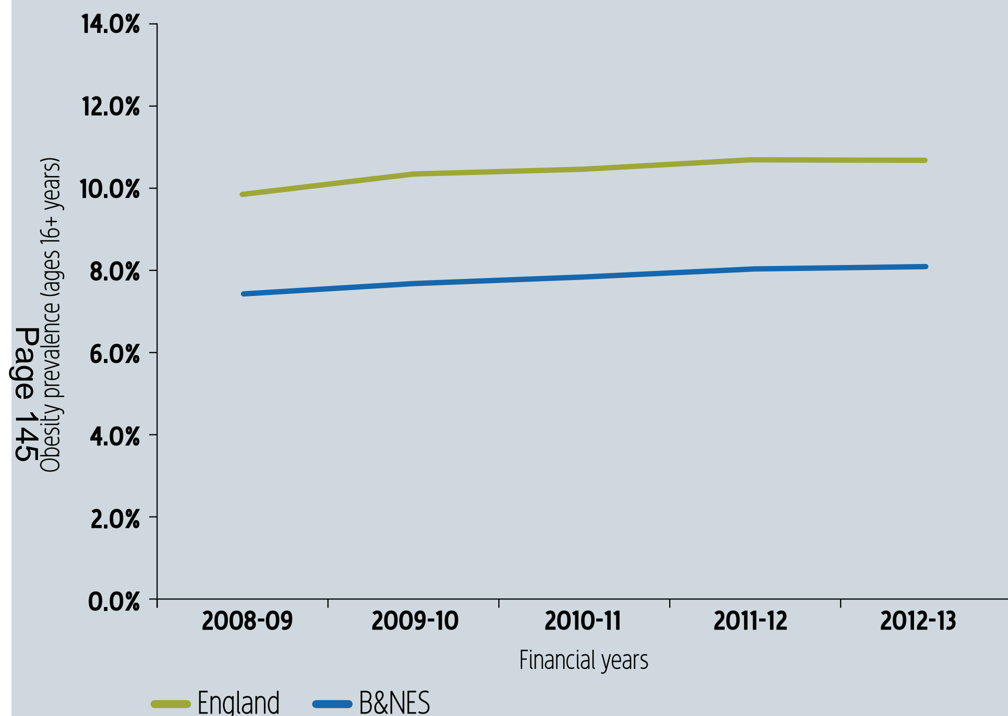


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Figure 1 There were 13,446 (2012/13 financial year) people 16 years and over registered as obese in GP practices in B&NES.3

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

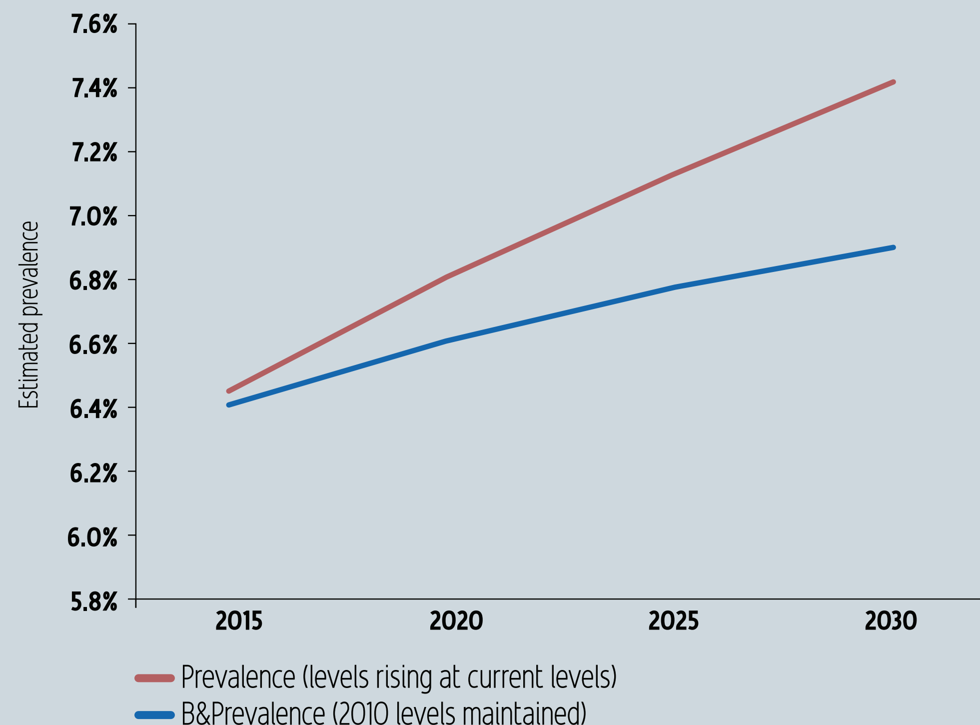
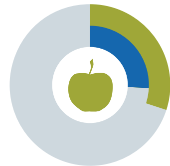


Figure 2 demonstrates the estimated local increase in obesity prevelence up to 2030. If obesity levels continue to rise at the current rate, this would mean an estimated prevalence increase of 27% over the next 16 years from 6.5% (~10,038 persons) to 7.4% (~12,712 persons).

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 signfiicant rate, with a 23% rise in vegetable prices and 11% rise in fruit prices between 2006 and 2009

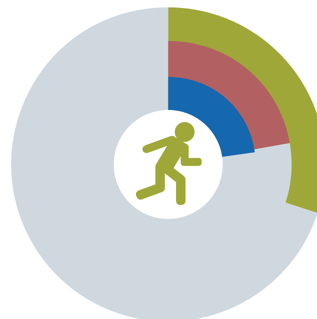
Physical Activity - Key Facts

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:

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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** Bariatic 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.
- Work collaboratively with the NHS and community partners to develop an integrated holistic pathway for those clients who have a diagnosed eating disorder
- Work with partners to promote body image and esteem in adults
- Partner with the NHS and voluntary sector to develop a strategy to prevent disordered eating

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+

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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

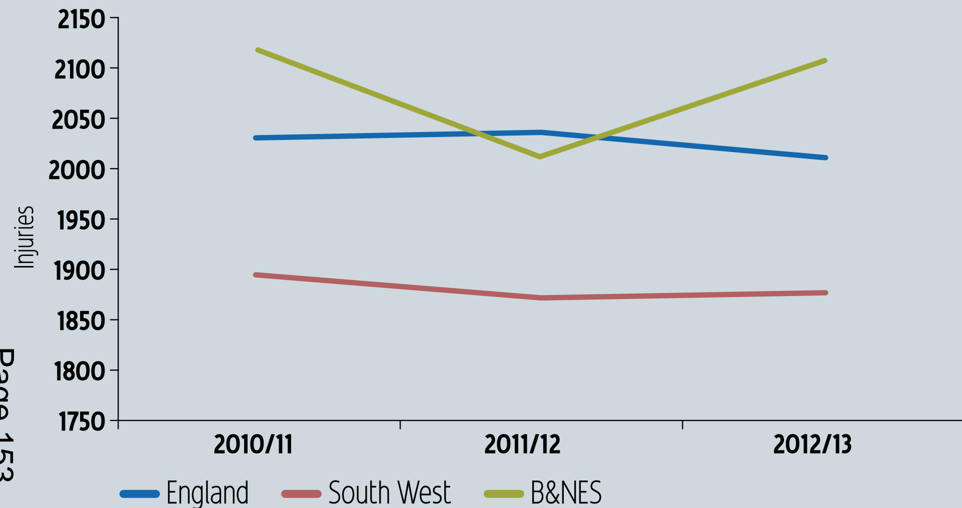
Emergency hospital admissions for accidents in over 65s made up **5% of all emergency admissions** for this age group, with 61% of these being for falls

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



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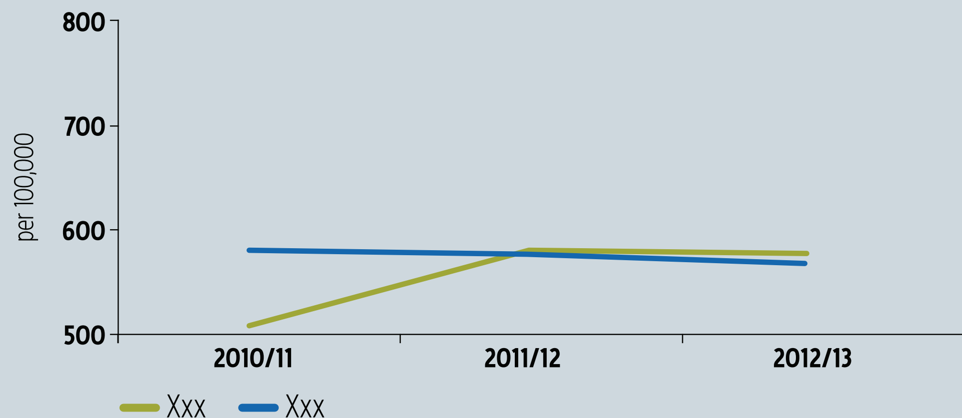

Story behind the baseline: (examples of contributory factors)

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

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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

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

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Local Statistics
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Bath & North East Somerset Council

healthwatch Bath and North East Somerset

NHS Bath and North East Somerset Clinical Commissioning Group

MEETING	B&NES HEALTH AND WELLBEING BOARD
DATE	23/05/2015
TYPE	An open public item

Report summary table	
Report title	Dementia Work Programme Update
Report author	Laura Marsh, Commissioning Manager for Long Term Conditions (BaNES CCG)
List of attachments	None
Background papers	None
Summary	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 B&NES Health and Wellbeing Board on the dementia work programme.
Recommendations	The Board is asked to note the work undertaken to date and support the delivery of the work programme.
Rationale for recommendations	The Health and Wellbeing Board 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).
Resource implications	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.
Statutory considerations and basis for proposal	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.
Consultation	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.
Risk management	This work programme is managed in line with the CCG’s risk management guidance.

THE REPORT

Purpose

1. The purpose of this paper is to provide the Health and Wellbeing Board with an update on the work programme around improving local services for people with dementia and their carers.

Background

2. 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. This 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.

3. 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.

4. 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. 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

6. 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

7. 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.

8. 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.

9. 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.

10. 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.

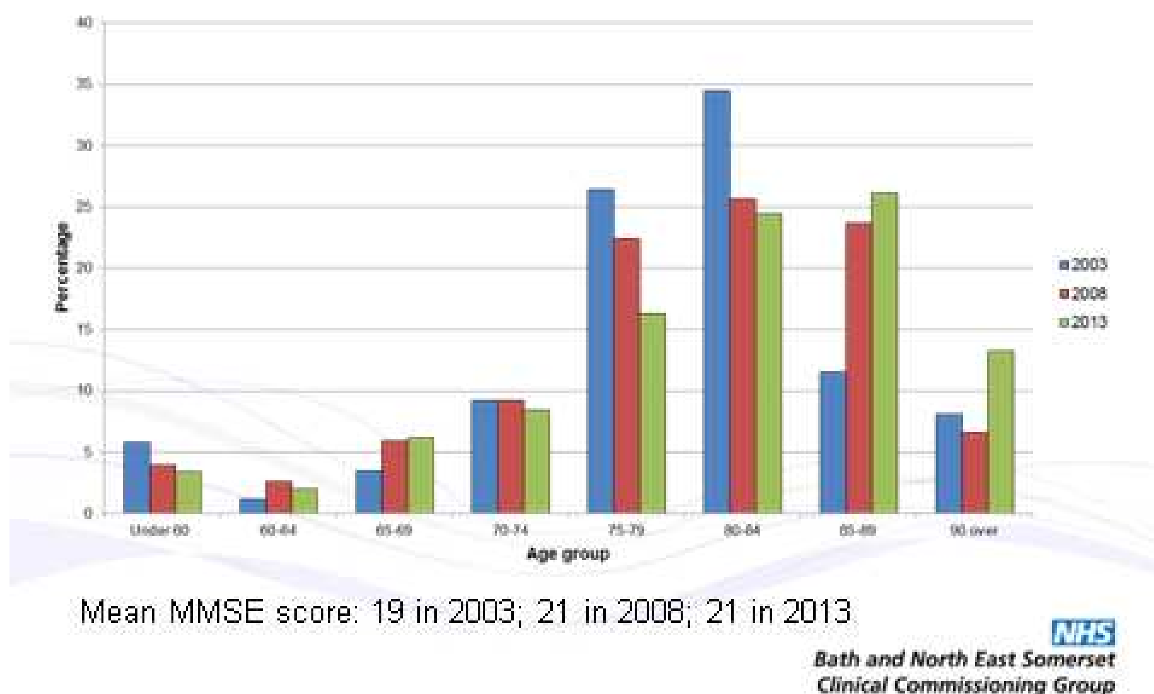
11. As at January 2015, the diagnosis rate in BaNES is 57.3% compared to 54.02% in the South of England.

12. 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.

    12.1 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.

    12.2 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.

    12.3 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.



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

13. 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.

14. 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.

15. 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

16. 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.

17. 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:
    1) AWP: Care Home Support & Assessment Service
    2) The Carers' Centre & Age UK B&NES: Home from Hospital
    3) Curo: Rural Independent Living Support Service

18. 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.

19. 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

20. 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'.

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

22. 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 Sainsbury's (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.

23. 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

24. 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

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NHS Bath and North East Somerset Clinical Commissioning Group

MEETING	B&NES HEALTH AND WELLBEING BOARD
DATE	25/03/2015
TYPE	An open public item

Report summary table	
Report title	Diabetes Care Pathway Redesign
Report author	Laura Marsh, Commissioning Manager for Long Term Conditions (BaNES CCG)
List of attachments	Appendix 1 – Proposed Diabetes Pathway
Background papers	None
Summary	Diabetes is the long term condition with the fastest rising prevalence and in order to manage the increasing demand, the diabetes care pathway is being redesigned. This work is one of the CCG's strategic priorities for the next 5 years and the purpose of this paper is to inform the B&NES Health and Wellbeing Board on the model and provide an update on project progress.
Recommendations	The Board is asked to: • Note the project work undertaken to date; and • Support the development and delivery of the new pathway.
Rationale for recommendations	The Health and Wellbeing Board is receiving this update because the diabetes care pathway redesign work sits within theme two (Improving the quality of people's lives) of the Joint Health and Wellbeing Strategy, linking to priority five (Improved support for people with long term health conditions).
Resource implications	The delivery of this project requires input from the members of the diabetes pathway redesign group as well as support from other CCG staff including representatives from the finance, informatics, communications and quality teams. Clinicians who deliver diabetes care will also need to be engaged and partake in the new ways of working.
Statutory considerations and basis for proposal	There are no statutory considerations but the project will contribute 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.
Consultation	The initial pathway redesign scoping work was undertaken by the Commissioning Manager for Long Term Conditions and CCG Medical Director. However, to develop the pathway further a diabetes care pathway redesign group was formed, whose members include: • Commissioning Manager for Long Term Conditions (CCG) • Medical Director (BaNES CCG) • Consultant in Diabetic Medicine (RUH) • Diabetes Specialist Nurse Team Leader (GWH) • Chief Executive (BEMS+) • GP representative • Practice Nurse representative • Podiatry Professional Lead (Sirona) • Dietetics Professional Lead (GWH) In order to progress the self-care element of the pathway, it is proposed that the membership of the group is expanded to include: • Public Health representative (BaNES Council) • Diabetes Education Lead (Sirona) • Health and Wellbeing College representative (Sirona) • Senior Commissioning Manager for Mental Health (BaNES CCG)
Risk management	This work programme is managed in line with the CCG's risk management guidance.

THE REPORT

Purpose

1. The redesign of the diabetes care pathway is one of the CCG's strategic priorities for the next 5 years and the purpose of this paper is to inform the B&NES Health and Wellbeing Board on the model and provide an update on project progress.

Project Background

2. The Joint Health and Wellbeing Strategy sets out a framework for partnership action to reduce health inequalities and improve health and wellbeing. The strategy comprises three themes and the diabetes care pathway redesign sits within theme two (Improving the quality of people's lives), linking to priority five (Improved support for people with long term health conditions).

3. Long Term Conditions are also a strategic priority for the CCG and initially diabetes is the focus because there are increasing numbers of people, particularly younger adults, developing type 2 diabetes and this is going to have a considerable impact on primary, community and secondary care services in the future unless the pathway is redesigned.

4. The aim of the project is to redesign the diabetes care pathway so that services are delivered by the most appropriately skilled person in the most appropriate setting and the system can manage the increasing demand. This will be done by taking a whole system approach; stressing the prevention and self-care agenda by upskilling primary and community care providers and working in partnership with specialists in diabetes care.

5. The rationale for change is as follows:
    - Fastest rising prevalence of any long term condition – local prevalence is increasing by 5% per year
    - Increasing numbers of people aged 45 and under being diagnosed with type 2 diabetes
    - Referrals to secondary care diabetes services are increasing by 7% each year
    - Up to 20% of all inpatients at the RUH now have diabetes
    - 10% of NHS budget nationally is spent on diabetes. 80% of that is spent on managing complications.

6. The increasing prevalence of diabetes is a national problem and so several CCGs have already reviewed and redesigned their diabetes services. Work undertaken elsewhere shows that integrated care programmes tend to have a positive effect on glycaemic control and other clinical measures in the long term. They have also been proven to particularly benefit patients with poor glycaemic control and patients who live in rural areas. Integrated care is more effective when they enable high quality care to be provided in primary care settings but this requires changing and expanding team roles, particularly in primary care, and ensuring adequate and appropriate support from secondary care specialists.

7. With regard to effective self-management, diabetes education programmes that adopt a psychological/motivational approach, focussing on empowering patients to set goals and solve problems, have been shown to be more effective. There is also evidence to suggest that education programmes which include exercise content are more likely to improve glycaemic control and automated telephone systems for patients to report information have a positive effect on patients' adherence and clinical outcomes. Finally, it has been proven that beliefs about treatment effectiveness, seriousness of diabetes and beliefs about control of the disease are strong indicators of self-management behaviours and in particular beliefs about treatment effectiveness are stronger predictors of behaviour than belief about the disease.

The Model

8. Following a review of the available evidence, including models elsewhere in the country, it has been concluded that a vertical integration model (i.e. integration between primary and secondary care services) with a package of interventions aimed at supporting self-management being an integral part of the initial management of the disease would be most suitable for use in BaNES.

9. A diagram of the model can be seen in Appendix 1 and the two key features of the new model are:
    - Greater support on diagnosis with the aim of improving self-care and therefore reducing the likelihood of complications developing
    - Better integrated continuing care so even with increasing numbers of people with diabetes, patients receive specialist input (when needed) in a timely manner.

Project Update

10. Since the CCG's Operational Leadership Team approved the model and project approach, the following progress has been made:

Mobilisation of the Diabetes Care Pathway Redesign Group

11. This is predominantly a provider group whose members are clinicians providing diabetes services and the purpose of this group is to help develop a patient focussed and evidence based pathway. To date, this group has been involved in the design of the overall pathway and has agreed the detail of the 'Continuing Care' element of the pathway, which is to be tested in one cluster from Spring 2015 before being rolled out across BaNES. It is intended that the membership of this group will expand when the project starts to focus on progressing the self-care element of the pathway.

Connecting Data Work

12. The Council received funding from the Cabinet Office to facilitate a 'Connecting Data' programme and the Council and CCG are working in partnership with the University of Bath to better understand current patient pathways. The work involves using patient NHS numbers to link service use and HbA1c results and the emerging findings show that:
    - 32% of patients with diabetes also have depression
    - 14% more women than men have depression and diabetes (statistically significant)

- Women with diabetes tend to be older than men with diabetes
- Attendance on DESMOND group education courses is positively correlated with improved HbA1C and fewer hospital admissions
- On average over the last 5 years, hospital admissions cost £600 more for patients who haven't attended a DESMOND group education course.

The next stage of this work will include looking at the impact of the Conversation Maps education courses as well as the use of the Diabetes Specialist Nurses. However, this work is more complex than anticipated so it will not be complete by the end of March 2015 as originally hoped.

Patient Survey

13. To complement the 'Connecting Data' work, a survey for all patients with type 2 diabetes has been developed in conjunction with the University of Bath and this was sent out to patients via GP practices at the end of January 2015. The purpose of this survey is to better understand patients' perceptions of their diabetes and their opinions on the care they receive. The survey also seeks to collect a range of demographic information, including NHS number, which will allow the CCG to join up their responses with their use of services and HbA1c. This level of detail has not previously been sought from patients but the necessary Information Governance processes have been followed and providing personal information is optional. It is anticipated that the survey findings will help the CCG understand the needs of different population groups within the population of patients with type 2 diabetes and will therefore ultimately help shape the 'supported self-care' offer to patients.

Continuing Care Element of the Pathway

14. The Pathway Redesign Group has developed the 'Continuing Care' element and helped clarify the roles of primary care, secondary care and the community diabetes team.

15. The main change from the current configuration of services is the creation of the Community Diabetes Team comprising of a Consultant Diabetologist, a Diabetes Nurse Facilitator (specialist nurse) and the practice's lead GP and Practice Nurse for diabetes with input from podiatry and dietetics as required. The Community Diabetes Team will meet regularly to discuss the care of patients with more complex needs. However, the Community Diabetes Team meetings will also provide an opportunity for education updates and audit at a practice and cluster level.

16. As a minimum the Community Diabetes Team for each practice will meet twice per year but the Diabetes Nurse Facilitator will be making additional visits to practices. However, it is anticipated that the practices within each cluster will 'pool' their sessions so they can benefit from more frequent direct contact with the consultant. 'Pooling' sessions should also mean that the most complex patients can be discussed from each practice, removing the inequality to patients of allocating the limited specialist resources to individual practices equally. I.e. Equal allocation would mean that the practices with a larger proportion of patients with diabetes would receive proportionately less time per patient than a practice with a smaller diabetes register. The alternative would be allocating practices a set number of sessions per year based on their population but due to the limited specialist resources available, this would mean some practices would receive such little time that the impact would be extremely limited.

17. It is proposed that the 'Continuing Care' element will be implemented in April/May 2015 (dependent on start date of new Diabetes Nurse Facilitator) in the Bath West cluster initially so that any lessons can be learnt before it is rolled out to the other four clusters. The CCG/Council Joint Commissioning Committee supported the approach and agreed some funding to support the implementation of this new way of working at the committee meeting in December 2014.

Diabetes Specialist Nursing and Dietetics Services

18. BaNES CCG is an associate to Wiltshire CCG's contract with GWH Community, the provider of the Diabetes Specialist Nursing and Dietetics services across BaNES and Wiltshire. This contract is due to end in 2016 and therefore BaNES CCG needs to ensure continuity in service provision after the contract ends. The options for this are currently being explored.

Next Steps

19. The next steps are:
    - Mobilise the 'Continuing Care' element in one cluster initially
    - Complete the 'Connecting Data' work and analyse the results of the patient survey
    - Continue the development of the pathway (i.e. supported self-care)
    - Fully explore the options to ensure continuity in service provision for the Diabetes Specialist Nursing and Dietetics services once the current contract ends.

20. The Health and Wellbeing Board is asked to note the project work undertaken to date and support the development and delivery of the new pathway.

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Bath and North East Somerset
Clinical Commissioning Group

Appendix 1 — Proposed Diabetes Pathway

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NHS Bath and North East Somerset Clinical Commissioning Group

MEETING	B&NES HEALTH AND WELLBEING BOARD
DATE	25/03/2015
TYPE	An open public item

Report summary table	
Report title	Bath and North East Somerset Joint Health and Wellbeing Strategy
Report author	Helen Edelstyn, Strategy and Plan Manager (01225 477951)
List of attachments	Appendix One: Draft B&NES Joint Health and Wellbeing Strategy
Background papers	NA
Summary	The first Bath and North East Somerset Joint Health and Wellbeing Strategy (JHWS) was published in November 2013. The approval of the CCG 5 year strategic plan, publication of NHS England's 'The 5 Year Forward View', publication of the first Health and Wellbeing Board annual report and work on a new Council vision and corporate plan means a lot has changed since this date. The Strategy needed to be refreshed in order to reflect this change.
Recommendations	The Board is asked to: • Comment on and adopt the refreshed B&NES Joint Health and Wellbeing Strategy
Rationale for recommendations	As set out above, a number of recent developments including the approval of the CCG 5 Year Plan, publication of NHS England's 5 Year Forward View and the LGA Health and Wellbeing Board peer review held in 2014 mean that it is timely to undertaken a light touch refresh of the Joint Health and Wellbeing Strategy.
Resource implications	There are no direct financial implications arising from the publication of the Bath and North East Somerset Joint Health and Wellbeing Strategy. However, the priorities of the Strategy should form a key consideration in the commissioning and allocation of health, social care and wellbeing resources.
Statutory considerations and basis for proposal	The Health and Social Care Act 2012 requires that local authorities, through the Health and Wellbeing Board, develop a Joint Health and Wellbeing Strategy which meets the needs identified in the Joint Strategic Needs Assessment.
Consultation	As part of the light touch refresh of the Joint Health and Wellbeing Strategy, internal consultation has been undertaken with the

	Council Senior Management Team, JHWS priority leads as well as key Council and CCG officers. Consultation has also been undertaken with the Joint Commissioning Committee, B&NES Public Services Board and the Voluntary, Community and Social Enterprise Sector Reference Group.
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.

THE REPORT

Purpose

1.1 The Health and Social Care Act 2012 requires that local authorities, through the Health and Wellbeing Board, develop a Joint Health and Wellbeing Strategy which meets the needs identified in the Joint Strategic Needs Assessment. The first Bath and North East Somerset Joint Health and Wellbeing Strategy (JHWS) was published in November 2013.

1.2 The approval of the CCG 5 year strategic plan in 2014, publication of the NHS 'The 5 Year Forward View', publication of the first Health and Wellbeing Board annual report and work on a new Council vision and corporate plan meant that it was timely to refresh the Joint Health and Wellbeing Strategy.

Scope of the refresh

1.3 The 3 themes and 11 priorities of the Joint Health and Wellbeing Strategy were still considered to be relevant; the Health and Wellbeing Board remains confident that the 3 themes and 11 priorities are the right ones to reduce health inequality and improve health and wellbeing in Bath and North East Somerset. The 3 themes and 11 priorities are:

Theme one: Preventing ill health by helping people to stay healthy
Priority one: Helping children to be a healthy weight
Priority two: Improved support for families with complex needs
Priority three: Reduced rates of alcohol misuse
Priority four: Create health and sustainable places

Theme two: Improving the quality of people's lives
Priority five: Improved support for people with long term conditions
Priority six: Promoting mental wellbeing and supporting recovery
Priority seven: Enhanced quality of life for people with dementia
Priority eight: Improved services for older people

Theme three: Tackling health inequality by creating fairer life chances
Priority nine: Improved skills and employment
Priority ten: Reduce the health and wellbeing consequences of domestic abuse
Priority eleven: Take action on loneliness

1.4 The focus of the refresh therefore was:

- To be clearer on outcomes
- To set out our expectations for the health and wellbeing system in the future (including investing in prevention)
- To be clearer on how we are tackling health inequalities
- To strengthen the relationship between the Joint Health and Wellbeing Strategy and CCG 5 year plan 'Seizing Opportunities'
- To strengthen the relationship between the Joint Health and Wellbeing Strategy and Council vision / emerging corporate plan
- To update needs evidence

1.5 The refresh of the Joint Health and Wellbeing Strategy also considered recommendations made by the Local Government Associations Health and Wellbeing Board peer review which took place in January 2014. One of these recommendations was for the Health and Wellbeing Board to better articulate what the local health and wellbeing system to look like in 5 years' time. This recommendation has been addressed in the refreshed JHWS.

1.6 The refreshed Joint Health and Wellbeing Strategy adopts the Council's *'beautifully inventive'* vision:

'Bath and North East Somerset will be internationally renowned as a beautifully inventive and entrepreneurial 21st century place with a strong social purpose and a spirit of wellbeing, where everyone is invited to think big – a 'connected' area ready to create an extraordinary legacy for future generations'.

1.7 It states that '*the strategy will help us to work towards this vision; by reducing health inequality and improving health and wellbeing in Bath and North East Somerset.'* The Joint Health and Wellbeing Strategy is a key strategy in the Council's Strategy framework.

1.8 As the priorities of the Joint Health and Wellbeing Strategy have not changed, it has been a simple review and refresh exercise and a full public consultation has not been carried out. Full public consultation on the original Joint Health and Wellbeing Strategy took place in the spring of 2013. Comments have been sought however from a wide range of internal stakeholders including officers from across the Council and CCG, the Public Services Board and the Joint Commissioning Committee.

1.9 The final strategy will be designed and available in different formats – e.g. strategy on a page – to ensure wide communication of key messages and content. It will also be accompanied by a delivery plan that will set out further detail on the delivery of the priorities.

1.10 The refreshed Joint Health and Wellbeing Strategy is attached at Appendix One. This is an early concept of the designed version and further refinement will take place as appropriate before final publication.

Timescale and next steps

Activity	**Time**
Consultation on light touch refresh of JHWS (PSB, SMT, CCG / Council officers, stakeholders and partnership groups).	January / February 2015
Updated draft strategy presented for approval to the B&NES Health and Wellbeing Board	25 March 2015
Presented to B&NES Cabinet and Council	TBC (June and July 2015)

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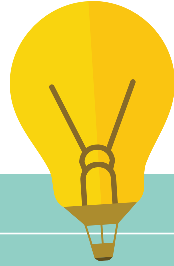
Bath & North East Somerset Council



Joint Health and Wellbeing Strategy

Our vision for 2020

'Bath and North East Somerset will be internationally renowned as a beautifully inventive and entrepreneurial 21st century place with a strong social purpose and a spirit of wellbeing, where everyone is invited to think big – a 'connected' area ready to create an extraordinary legacy for future generations'.

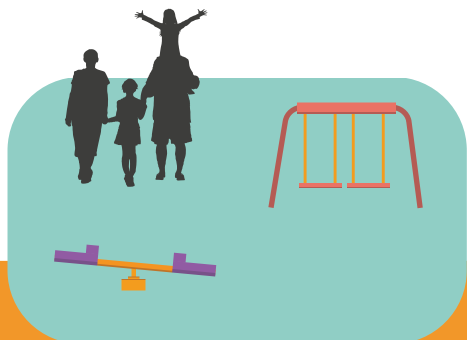
This vision was developed by the Bath and North East Somerset Public Service Board; a partnership made up of leading public, business and voluntary sector organisations in Bath and North East Somerset including the Council and the Clinical Commissioning Group.

This strategy will help the Health and Wellbeing Board work towards the delivery of this vision; by reducing health inequality and improving health and wellbeing in Bath and North East Somerset.

"B&NES will be internationally renowned as a beautifully inventive and entrepreneurial 21st century place with a strong social purpose and a spirit of wellbeing."

The framework

Three themes and eleven priorities set the framework for action:



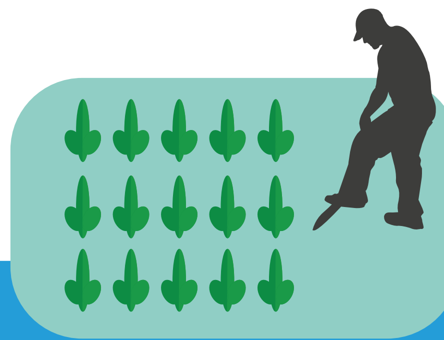
Theme 1
Preventing ill health by helping people to stay healthy

Priority 1
Helping children to be a healthy weight

Priority 2
Improved support for families with complex needs

Priority 3
Reduced rates of alcohol misuse

Priority 4
Create healthy and sustainable places



Theme 2
Improving the quality of people's lives

Priority 5
Improved support for people with long term conditions

Priority 6
Promoting mental wellbeing and supporting recovery

Priority 7
Enhanced quality of life for people with dementia

Priority 8
Improved services for older people

Theme 3
Tackling health inequality by creating fairer life chances

Priority 9
Improved skills and employment

Priority 10
Reduce the health and wellbeing consequences of domestic abuse

Priority 11
Take action on loneliness

Foreword by Councillor Simon Allen

Bath and North East Somerset Health and Wellbeing Board has a significant role to play in developing a local health and wellbeing system that delivers high quality care for all and supports us to lead healthy, sustainable lives.

To achieve this, our local health and wellbeing system will need to adapt to meet new challenges; we live longer, nearly a quarter of people who live in Bath and North East Somerset drink too much and we are increasingly overweight or obese.

I am fully committed to building a sustainable local system and to addressing the challenges we face. To do this we need to get serious about preventing avoidable disease which is putting pressure on our local health system and support people to take more responsibility for their health and care.

This is the second Joint Health and Wellbeing Strategy. It sets out the Health and Wellbeing Boards aspirations for the future and how it will be better. This includes more investment in ill health prevention, integrated health and social care services and care tailored to meet the needs of the individual.

Over the past 2 years I have met many local people and organisations. I have worked closely with Healthwatch Bath and North East Somerset and I have listened to the views and experiences of patients and carers. This experience has helped me to understand what works well and the importance of a person centred approach to care.

No one should underestimate my determination to make a difference. This Joint Health and Wellbeing Strategy will not only help people who are unwell but will work to create a sustainable and healthy future in Bath and North East Somerset.

Councillor Simon Allen

Co-Chair, B&NES Health and Wellbeing Board

Foreword by Dr Ian Orpen

NHS Bath and North East Somerset Clinical Commissioning Group is an equal partner in the Bath and North East Somerset Health and Wellbeing Board. We play a pivotal role in bringing front line clinical expertise to the Board and in helping to realise joined up health and social care services and person centred care.

Together with Bath & North East Somerset Council and through the Health and Wellbeing Board we provide leadership to make innovation and change happen locally. Our aspiration is to have an even higher performing local care system.

To do this we will need to implement new models of care that support people and organisations to innovate, set and adopt national best practice, recognise the potential of providers as an important source of innovation and create a culture that values learning.

The Health and Wellbeing Board plays a unique role at the heart of our local health system that can make this change happen. It offers us the opportunity to think differently about health and social care in the future. It also provides us a powerful voice to influence broader 'wellbeing' services such as leisure, housing and the economy, which are an important part of preventing poor health.

I am fully committed to the Health and Wellbeing Board, and to turning our aspirations into practice. Through this Joint Health and Wellbeing Strategy, and the Clinical Commissioning Group's five year Strategic Plan we will put in place services which improve the health of local people and communities.

Dr Ian Orpen
Co-Chair, B&NES Health and Wellbeing Board

Introduction

Bath & North East Somerset Council and NHS Bath and North East Somerset Clinical Commissioning Group have a shared legal duty to have a Health and Wellbeing Board and to publish a Joint Health and Wellbeing Strategy (JHWS).

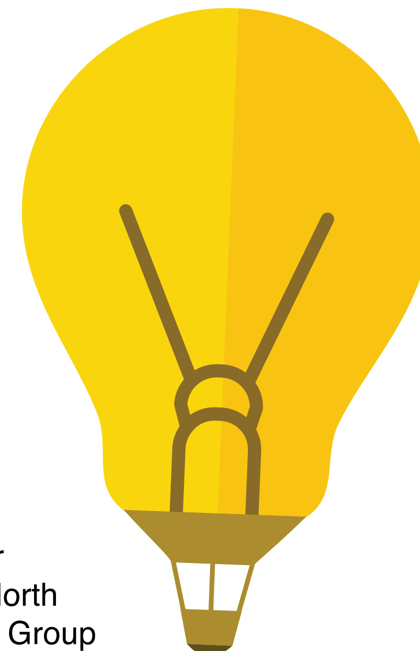
The Health and Wellbeing Board is the body responsible for improving the health and wellbeing of people in Bath and North East Somerset. It provides strong and shared leadership and is the centre point of our local health and social care system.

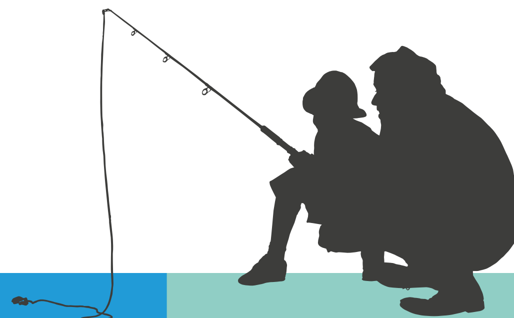
The Joint Health and Wellbeing Strategy sets out how the Health and Wellbeing Board will improve local health; by assessing the evidence, setting the strategic direction and deciding how to make the best use of collective resources. It also ensures that local commissioning plans are coordinated and coherent and that we work together with our communities to deliver outstanding care and health services to local people.

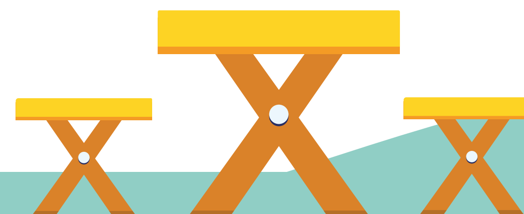
Three themes and 11 priorities set the framework for targeted action in the Strategy. They are not an exhaustive list of everything that the Council and NHS are doing; but rather a set of priorities for the Health and Wellbeing Board to really focus on and make a difference over the next few years.

The Joint Health and Wellbeing Strategy sits collaboratively along side the NHS Bath and North East Somerset Clinical Commissioning Group's 5 Year Strategy 'Seizing Opportunities'.

Seizing Opportunities 'to lead our health system collaboratively through the commissioning of high quality, affordable, person centred care which harnesses the strength of the clinician led commissioning and empowers and encourages individuals to improve their health and wellbeing' (NHS Bath and North East Somerset Clinical Commissioning Group 5 Year Strategy: Seizing Opportunities).







Making a difference

Bath and North East Somerset Health and Wellbeing Board is already making a difference through:

- Strong leadership of the local health and social care system
- Supporting health and care organisations to invest in preventative services such as the new re-ablement and rehabilitation service reducing unplanned hospital admissions.
- Building relationships that are delivering innovative services such as the IRIS Project which is helping GPs identify and help victims of domestic abuse
- Influencing plans for transport, housing and business growth to ensure the environment around us helps us to live well. For the first time health and wellbeing is a cross cutting theme in the Bath and North East Somerset Economic Strategy and also the Core Strategy which guides the council's future housing development plans.
- Promoting the need to focus on groups with the worst health outcomes
- Giving health and care organisations the space to think differently about system change and new models of delivery
- Working to ensure our local care and health service is fit for the future through the Transformation Group (a group of health and social care providers).

There is already a great deal of work underway which is helping to change lives. We will build on this work, learn from others nationally and internationally and use the Joint Health and Wellbeing Strategy to drive forward improvements in our local health and social care system.

A patient centred approach to heart failure care

Heart failure is the most common cause of readmission to the Royal United Hospital in Bath. In the past professionals treated specific aspects of care but often in isolation from each other. A heart failure group was set up to develop a patient owned 'Heart Failure Passport'. The passport includes all the key information about a patient's condition including their treatment plans, all medications and end of life planning where appropriate. So, if a patient sees a healthcare professional who isn't part of the heart failure team all their vital information is easily available.

In addition to this, an investment has been made in telehealth technology so that patients can monitor their weight and better monitor their heart condition. Community heart failure nurses have also been given greater access to a consultant cardiologist and other cardiology professionals. This has enabled the team to share valuable lessons which has enhanced the care experience and improved the outcome for patients.

Building on a strong partnership

There is a strong history of partnership between the Council and NHS which has led to the integration of many local health and social care services.

In October 2011 Sirona Care and Health was created to provide integrated health and social care; it was one of the first independent organisations in the country to include both health and social care professionals. It continues to provide a wide range of care and support services, including community care and community health services, mental health support and children's health care.

The Health and Wellbeing Board is committed to extending and further developing integration arrangements - where these create better outcomes for local people - over time and through funding sources such as the Better Care Fund.

Over the next year the Health and Wellbeing Boards partnership with health and social care providers and Healthwatch will be further developed. The newly formed Transformation Group will be one way this is achieved. The Group will build on the energy and expertise of major health and social care providers, involving them in decisions about the future of health and social care services, and achieving local health and social care goals together.

Improving GPs identification of domestic abuse

IRIS is a domestic abuse training and referral programme that provides support for patients in General Practices, who have lived with, or are still living with domestic abuse. The project provides domestic abuse awareness raising training to a range of practice staff, from GPs to receptionists and helps them to deal proactively with victims of domestic abuse. Research by Healthwatch Bath and North East Somerset suggested that improved support for victims of domestic abuse in General Practices would be welcomed locally.

‘A complete revelation. By becoming more aware of the signs and symptoms that suggest abuse – long term anxiety and depression, repeat visits to the surgery for minor symptoms, unexplained gynaecological problems – I become much more aware of patients who were living with abuse and the negative impact that this was having on their health outcomes.’ (GP national IRIS programme).

(IRIS is commissioned in partnership between Bath and North East Somerset Clinical Commissioning Group and the Office of the Police and Crime Commissioner)

Reducing health inequalities

The World Health Organisation defines health as "a state of complete physical, mental and social wellbeing". People with good health are able to have control of their lives, live life to the full and participate in their communities.

Unfortunately people and communities experience inequality in health. This can be due to differences in where they live, social group, gender and other biological factors. These differences have a huge impact, because they result in some people experiencing poorer health and shorter lives.

Health inequality exists in Bath and North East Somerset. The Joint Strategic Needs Assessment shows that good health is unequally shared and inequalities exist between different geographical areas, communities, social and economic groups in Bath and North East Somerset. For instance we know that, for men, life expectancy varies by up to 8 years along the stops of the number 20a/c bus route in Bath. People living in Twerton have a lower life expectancy than those who live just 5 bus stops away.

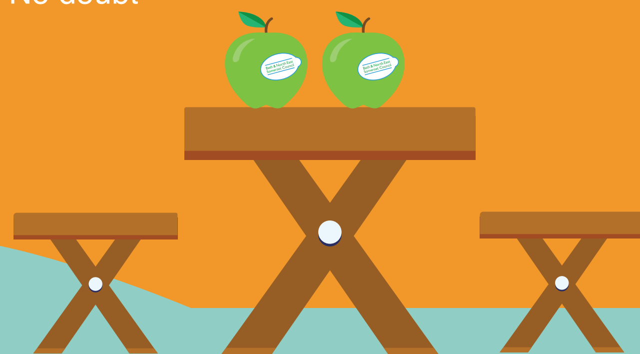
The Health and Wellbeing Board is committed, through this strategy, to tackling these health inequalities. In 2010 Sir Michael Marmot published 'Fair Society Healthy Lives' and set out an evidence based approach to reducing health inequalities in England. This Joint Health and Wellbeing Strategy is guided by the principles set out within the Marmot report.

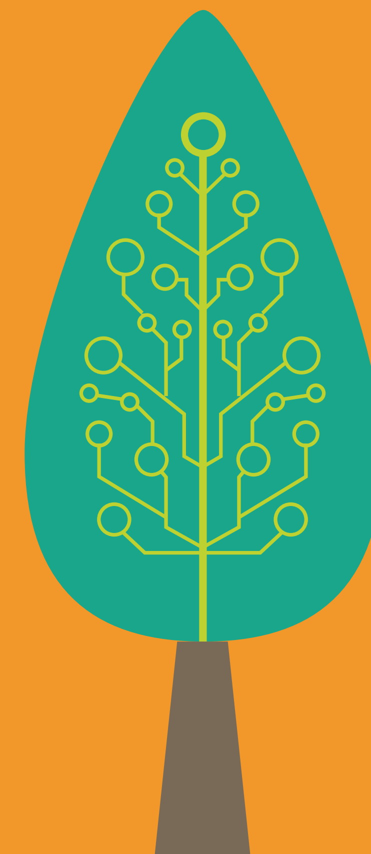
Helping families to eat healthily

'Cook It' is a free 6 week cooking skills course for parents and carers, with crèche facilities provided. M, a busy mum from Bath, joined the course because she wanted to cook healthy meals for her children but her lack of confidence in the kitchen meant she was frightened to try new recipes.

"I know so many mums complaining that they do not have time to cook because it takes a long time and it is too complicated and I totally understand them because I used to feel that way. Having the chance to have a practical lesson with all the ingredients and recipes ready for us to cook was great for me to see that if I get organised before I start cooking, then making a recipe can be a great experience. The best of all is that my family diet has changed a lot for the better. No doubt about this."

"Having the chance to have a practical lesson with all the ingredients and recipes ready for us to cook was great for me to see that if I get organised before I start cooking, then making a recipe can be a great experience."





Getting serious about ill health prevention

The failure to address increases in avoidable ill-health caused by obesity, alcohol misuse and smoking is putting a huge pressure on the future of our local health service.

The UK performs poorly on several important health problems compared to our European peers including coronary heart disease, stroke and lung cancer. We need to do more to tackle the underlying risk factors of these conditions and help people to be healthy by stopping smoking, being more active, drinking less alcohol and becoming a healthy weight.

‘If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness’ (NHS 5 Year Forward View, October 2014)

Through the Health and Wellbeing Board we will develop a more coherent approach to public health that recognises that we all have a part to play in preventing ill-health. We need to refocus policies and services across a wide range of stakeholders from local community groups to schools to produce a whole system approach that gives priority to securing health and reducing health inequality.

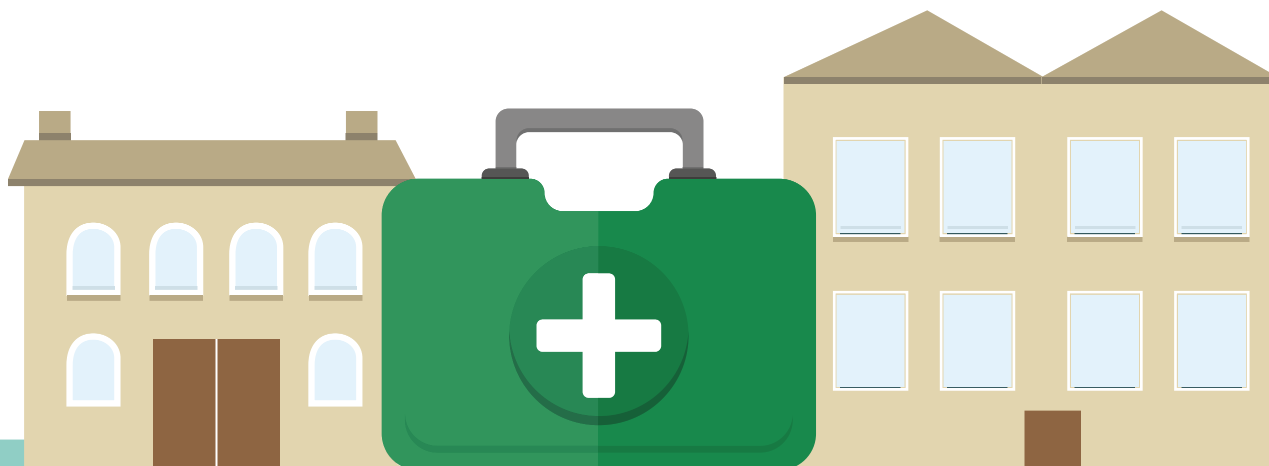
NHS Bath and North East Somerset Clinical Commissioning Group is leading the development of a ‘Prevention, including Self Care’ work programme that will compliment a broader approach to ill health prevention. The programme focuses on areas of higher deprivation and enables people to take greater responsibility for their health.

Where we are now

For many years the focus has been caring for people when they are ill, not keeping them healthy.

Changes in our local population - people are living longer with more complex and sometimes avoidable conditions - means that this is no longer a financially sustainable strategy.

We are beginning to think differently about how health and social care works locally. This includes a shift away from care in hospitals towards a more preventative approach that helps people to help themselves. We are investing in new care models that support and encourage people to be more informed and involved in their own care such as the new diabetes care pathway, but we need to do more to make our local health service really sustainable in the future.



Where we want to get to

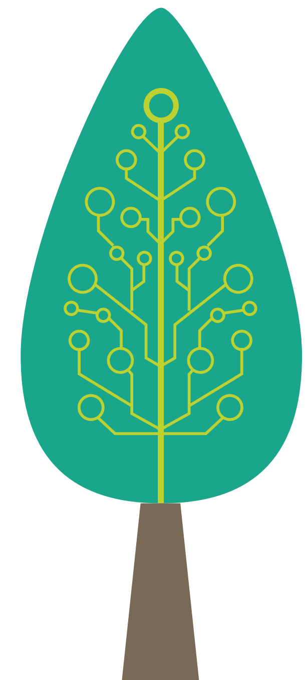
A future that empowers people to take much more control over their own health and care.

Numbers of coronary heart disease, stroke and lung cancers are down because we are helping people to be healthy through exercise, by eating healthy foods and drinking less alcohol. Our local public health system - from healthy eating programmes in schools to exercise clubs for the over 60's – supports health and wellbeing.

We are slowing disease progression and reducing demand for specialist services because more people are helped to get involved and take responsibility for their own care. This in turn reduces the demand on our urgent care system.

The divide between GPs and hospitals, between physical and mental health, and between health and social care is dissolved. 'A future that no longer sees expertise locked in too often out-dated buildings, with services fragmented, having to visit multiple professionals for multiple appointments and endlessly repeating details' (NHS Five Year Forward View).

We have strengthened the long term financial sustainability of the health and wellbeing system through a shift in investment to prevention, which over time has reduced the demand on more costly ill health treatment services. We have created financial efficiencies which mean we can take advantage of the new opportunities science and technology offers patients, service users and carers.



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JM is 66, his wife had just passed away, he was starting to feel a little lost, lonely and was beginning to drink more. He was at risk of depression, and an alcohol related condition. He was signed posted by a helpful neighbour to a local social group, which regularly invited care professionals to talk about health. Through the group and the information he received JM accessed a range of health and social care services. He also joined an over 60's exercise group and is got involved with a local community garden. These experiences have helped him to feel more positive. He is drinking less and his future is good.

Without investment in community programmes that intervene early and support people's wellbeing, JM would probably have needed a more costly health treatment for depression or alcohol related condition.

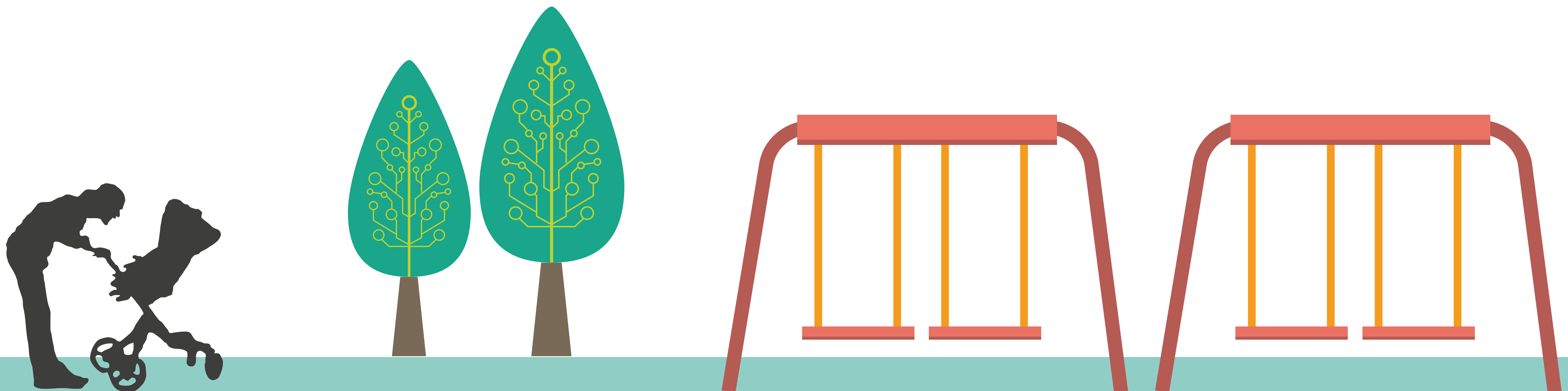
Children and young people

Children and young people are an important part of this Joint Health and Wellbeing Strategy and are included in each of the three themes and eleven priorities from the complex families programme to reducing alcohol misuse.

The Health and Wellbeing Board will continue to work in partnership with the Children's Trust Board and support the delivery of their plans for Children and Young People. The Children and Young People's Plan 2014-2017 is working to deliver 3 key outcomes:

- Children and young people are safe
- Children and young people are healthy
- Children and young people have equal life chances

These outcomes are aligned with the Health and Wellbeing Strategy and are reviewed on an annual basis by the Health and Wellbeing Board.



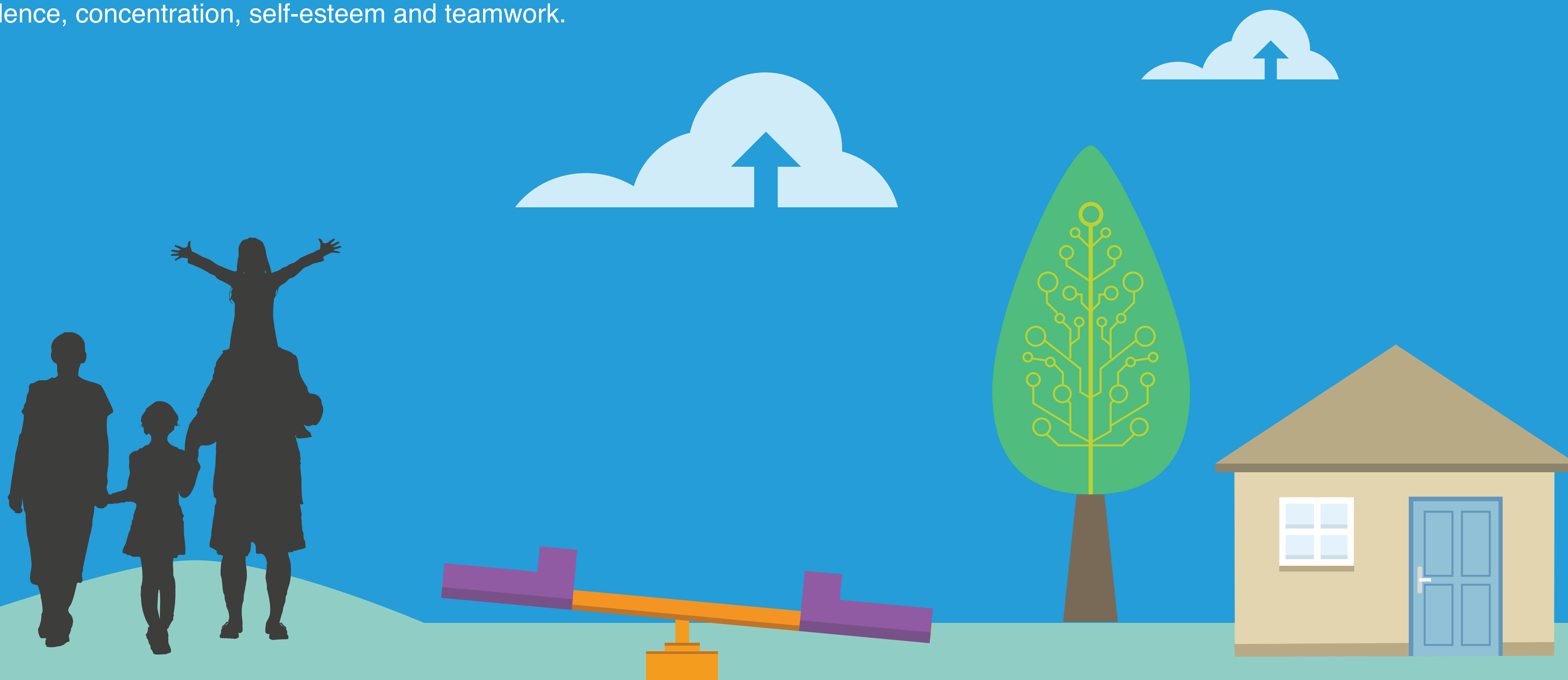
Promoting children's emotional health

B&NES Children and Young People's Plan 2014-2017: 'All children and young people have good emotional wellbeing and resilience'

8 children from a Year One / Two class were chosen as having a particular emotional, behavioural or self-esteem issue. Bath & North East Somerset music service arranged for the pupils (with the rest of their class so there was no stigma of selection) to receive 15 weeks of high quality Djembe drumming tuition. Children were provided with a highly supportive environment to improve: creative exploration, confidence, concentration, self-esteem and teamwork.

The drumming lessons gave children a chance to work collectively to achieve something very special and memorable. The project has allowed some of the pupils with emotional issues to shine and raised the profile of music.

'It was amazing to see pupil X leading his class at Fun Day. A year ago this would be unthinkable'. Mr Stevens (Class Teacher).



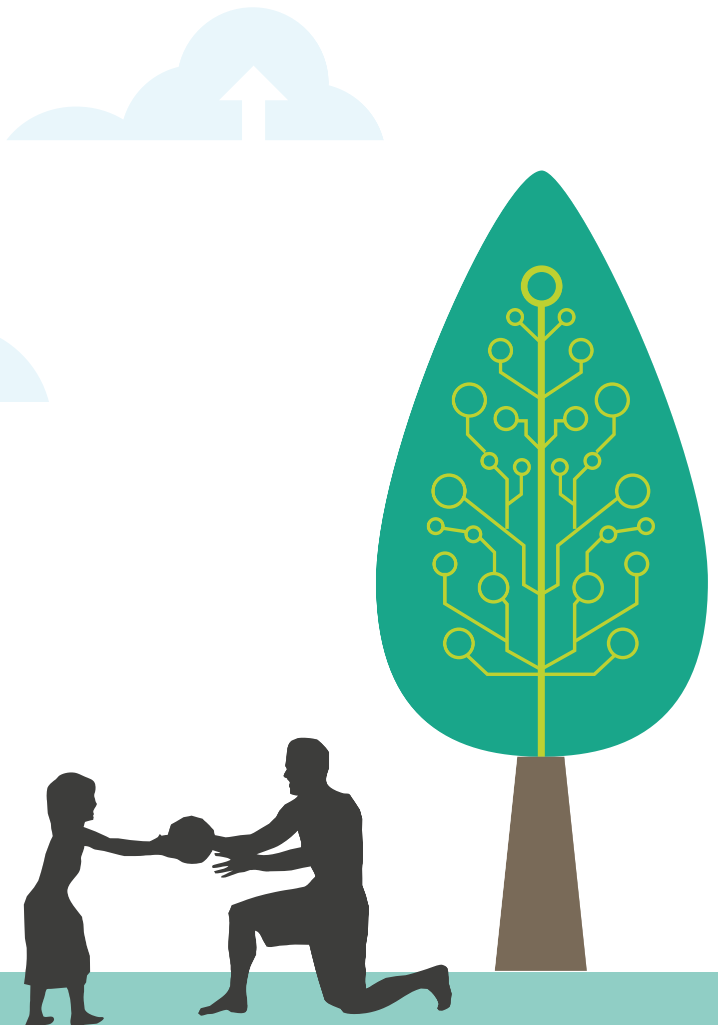
Keeping people safe

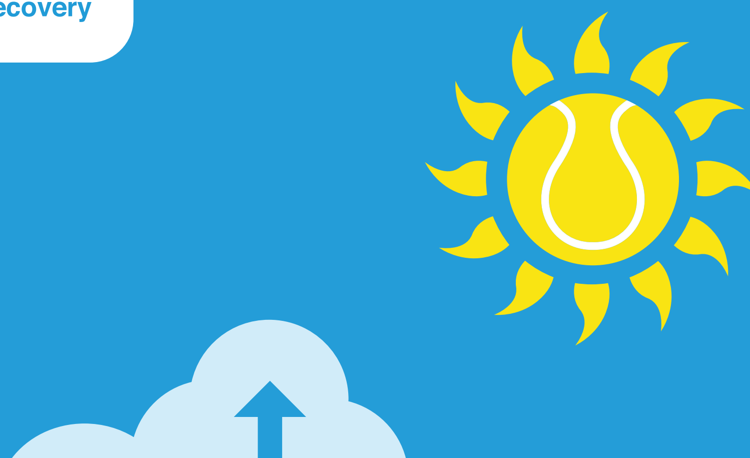
Delivering good quality care and keeping people safe is the business of the Health and Wellbeing Board. Protecting people's health, wellbeing and human rights and enabling them to live free from harm, abuse and neglect is vital.

The Health Wellbeing Board will work in partnership with the Local Safeguarding Adults Board and the Local Safeguarding Children Board to make sure that vulnerable children, young people and adults at risk of harm are protected and kept safe.

The Local Safeguarding Adults Board and the Local Safeguarding Children Board report their annual plans and performance reports to the Health and Wellbeing Board. There is also shared membership amongst the Boards which ensures a joint and seamless approach to delivering health and wellbeing and safeguarding priorities.

"We will make sure that vulnerable children, young people and adults at risk of harm are protected and kept safe."



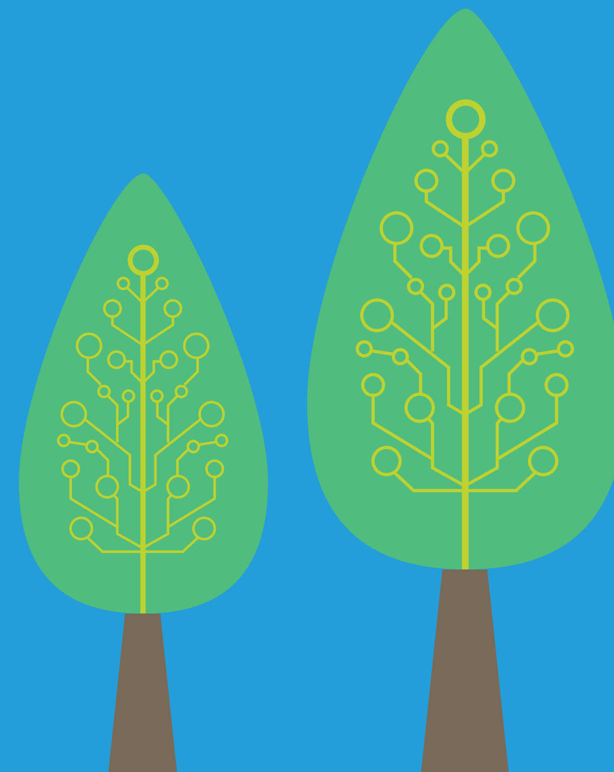


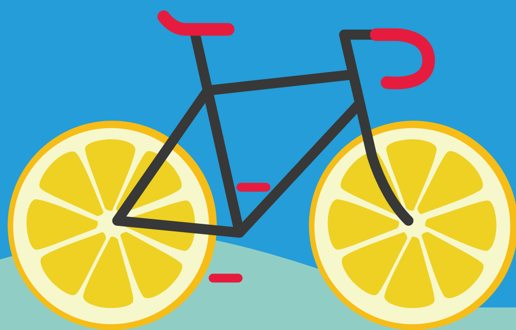
Getting active

NW is a local Mum who has had a lot on her plate in recent years including caring for her father in law, managing a part time job as well as a home and 3 children. Nw had started to feel low and didn't feel as though she was coping as well as she could, which in turn knocked her confidence and self-esteem. When N's doctor suggested referring her to the Lifestyle Service to help manage her weight and get more active she jumped at the chance.

N started the Passport to Health exercise programme in November 2012, using the gym 3 days a week with guidance and support. Three months on and N's confidence and self-esteem have increased dramatically and her friends and family are glad to have the "old N" back. N has noticed she is less anxious and panicky and has stopped taking medication to help control her nerves.

"Passport to health was the best thing for me; I am pleased with the help that I have received from the team on controlling my weight and helping me with my fitness."





The local resident population is 180,700

And there are nearly 20,000 more registered patients than residents.

Healthy life expectancy is high, compared to national and regional rates. ♂=65 ♀=69

But...

Life expectancy gaps of over 8 years (and increasing) exist for men living in different parts of B&NES.

Just 5 stops on a local bus route.

2014 estimates suggest there are:

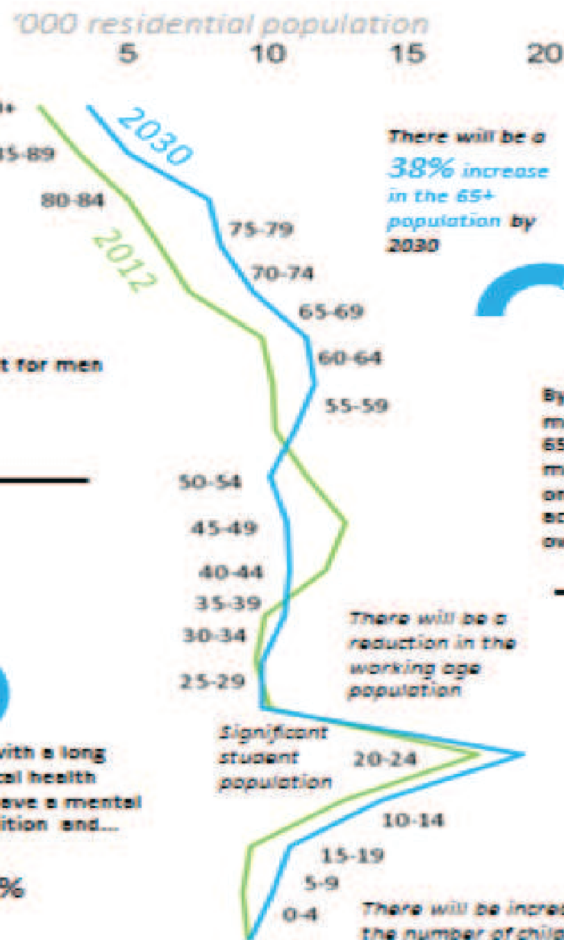
- 19,000 people with a common mental health disorder
- 1,300 people with a psychiatric or personality disorder
- 2,500 with a severe physical disability
- 2,500 people with a learning disability
- 1,500 with autism spectrum disorder

30% of people with a long term physical health condition have a mental health condition and...

46% of people with a mental health condition have a long term health condition.

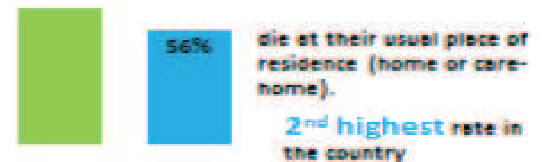
Suicide and undetermined deaths doubled between 2005-07 (26) and 2011-13 (54).

Self harm rates amongst males increased by 38% between 2010/11 and 2011/12



There will be a 38% increase in the 65+ population by 2030

There are ~2000 deaths per year, Of these... 67% want to die at home and...



56% die at their usual place of residence (home or care-home).

2nd highest rate in the country

By 2030 5,000 more people aged 65+ unable to manage at least one self-care activity on their own

Estimated diagnosis rate of people with dementia

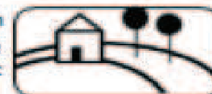
1 in 10 people aged over 18 define themselves as a carer.

155 young carers known to services.

In 2011/12 1 in 3 young people from a low income family achieved 5 or more GCSEs at A*-C

Compared to 2 in 3 for young people not on free school meals

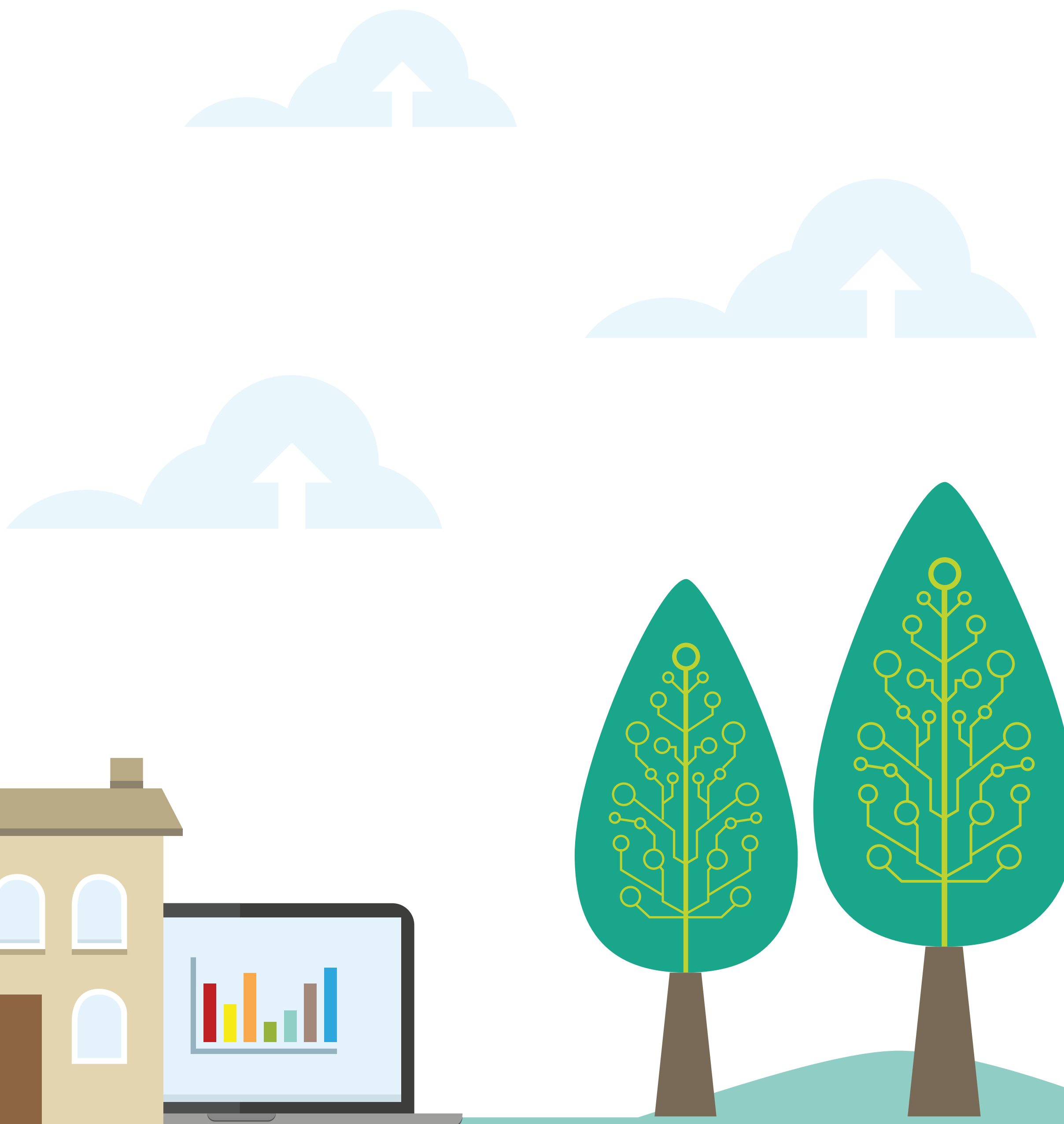
36% of our population live in rural areas without reasonable access to GP facilities by public transport



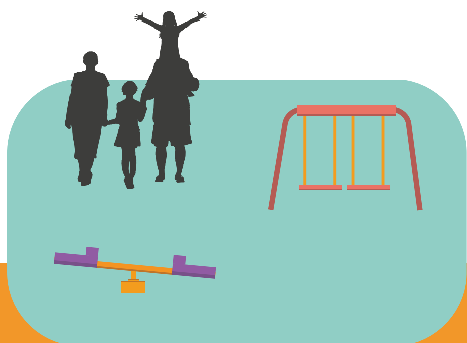
December 2014
research@bathnes.gov.uk

Find more facts, figures and research at www.bathnes.gov.uk/jsna

The following pages set out the three themes and eleven priorities of the Joint Health and Wellbeing Strategy. They are not an exhaustive list of everything that the Council and NHS are doing; but rather a set of priorities for the Health and Wellbeing Board to really focus on and make a difference over the next few years.



The themes and priorities



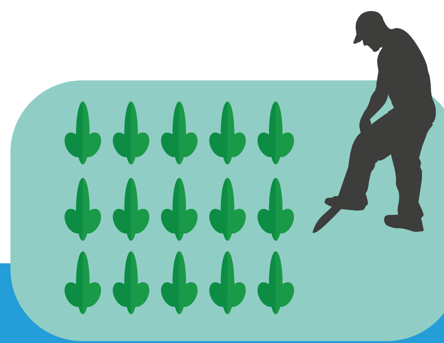
Theme 1
Preventing ill health by helping people to stay healthy

Priority 1
Helping children to be a healthy weight

Priority 2
Improved support for families with complex needs

Priority 3
Reduced rates of alcohol misuse

Priority 4
Create healthy and sustainable places



Theme 2
Improving the quality of people's lives

Priority 5
Improved support for people with long term conditions

Priority 6
Promoting mental wellbeing and supporting recovery

Priority 7
Enhanced quality of life for people with dementia

Priority 8
Improved services for older people

Theme 3
Tackling health inequality by creating fairer life chances

Priority 9
Improved skills and employment

Priority 10
Reduce the health and wellbeing consequences of domestic abuse

Priority 11
Take action on loneliness

Theme one: Preventing ill health by helping people to be healthy			
Priorities	**Outcome**	**Examples of current service delivery**	**Measures**
Priority one: Helping children to be a healthy weight	All pregnant women, children and young people are a healthy weight	• Integrated weight management pathway for the whole population • Control exposure to and demand for consumption of excessive quantities of high calorific food and drinks • Increase opportunities for uptake of walking, cycling, play and other physical activity • Establish lifelong habits and skills for positive behaviour change through mental health and early life interventions • Increase responsibilities of organisations for the health and wellbeing of their employees • Develop a workforce that is competent, confident and effective in promoting healthy weight • Influence decision and policy making to create healthy environments	• Excess weight in 10-11 year olds • Level of exercise undertaken (school health survey) • Number of people who start breastfeeding and who continue at 6-8 weeks • Excess weight of pregnant women at 1st antenatal appointment
Priority two: Improved support for families with complex needs	Families with complex needs are enabled to turn their lives around by making positive changes	Work intensively with 700+ families, including: • A dedicated worker for families • Practical hands on support • Persistence backed up by sanctions • An agreed outcome plan • Working to address family issues using a whole family approach	• Criminal and anti-social behaviour rates • Domestic violence rates • School attendance rates • Number of family members are helped on a pathway back to work • Reduce the requirement of a child protection or child in need plan, keeping children safe • Number of positive health and wellbeing outcomes
Priority three: Reducing alcohol related harm	Children grow up free from alcohol related harm Communities are safe from alcohol related harm People can enjoy alcohol in a way that minimises harm to themselves People can access support that promotes and enables sustained recovery	• Training programmes for frontline staff and screening introduced into the NHS Health Check Programme • Holistic approach to promoting health and wellbeing across educational settings • Resources developed for children and young people including an alcohol drama project for secondary schools • Integrated commissioning model for Adult and children's treatment services • Alcohol Liaison service at the Royal United Hospital	• Number of alcohol specific hospital admissions of under 18 year olds • Number of alcohol related hospital admissions 18+ • Rate of night-time economy related crime and disorder • Number of people successfully leaving treatment with no return within 6 months
Priority four: Creating healthy and sustainable places	A built and natural environment which supports and enables people in our communities to lead healthy and sustainable lives	• Fit4Life – an active living strategy for B&NES which delivers on leisure, travel and active environments • Maximise health improving opportunities in our most deprived areas through the refresh of the Open and Green Spaces strategy • Expansion of the B&NES Energy@Home scheme • Local food action plan to improve local food production, provision and access to good food, and healthy and sustainable food culture.	• Rates of cycling and walking • Access to high quality open and green spaces • Local food production rates • Numbers of energy-efficient, safe and affordable homes • Number of mitigation measures to reduce the impacts of climate change and environmental hazards • Influence of the local planning system

Theme two: Improving the quality of people's lives			
Priorities	**Outcome**	**Examples of current service delivery**	**Measures**
Priority five: Improved support for people with long term conditions	Improved coordination of holistic, multi-disciplinary long term condition management (initially focused on a redesigned diabetes care pathway)	• The Community Cluster Team model – a model of care which facilitates the proactive case management of 'at risk' patients through improved partnership working between primary care and community teams • The community Bladder and Bowel Service - undertaking more preventative work and initiatives to raise awareness • The expansion of the Parkinson's Disease multi-disciplinary team at the Clara Cross Rehab Unit and the Early Supported Discharge service for Stroke patients	• Number of patients with diabetes receiving all care processes each year • The amputation rate per 1000 people with diabetes does not increase over the next 5 years • Number of patients with a diabetic foot care emergency referred to a multi-disciplinary team within 24 hrs • Ongoing monitoring of national indicators from NHS Outcomes Framework to improve quality of life for people with long term conditions
Priority six: Promoting mental wellbeing and supporting recovery	Emotional health and wellbeing is promoted and people are supported to talk about and seek help for mental health problems	• Emotional health and wellbeing is being promoted through the Director of Public Health Award for schools and the Wellbeing College for adults as well as the Children and Young People's Emotional Health and Wellbeing Strategy • B&NES Health and Wellbeing Board have signed a pledge committing to end discrimination against people who experience mental health problems and have developed an action plan for delivering this. • Continued work to improve in-patient pathways of care • Multi-agency action plan delivering the Emotional Health and Wellbeing Strategy for children and young people • A range of actions to reduce the risk of self-harm or suicide	• Parity of Esteem embedded for physical and mental health • Support for people in a mental health crisis is embedded across all sectors • Accommodation options for adults with serious mental health problems in B&NES are improved • Employment options for adults with serious mental health problems in B&NES are improved • Stigma about mental health is reduced and wellbeing is promoted
Priority seven: Enhanced quality of life for people with dementia	Increased dementia diagnosis rates and improved post-diagnostic support for people with dementia	• A Dementia Support Worker service for people who are diagnosed with dementia • Integrated hospital and community pathways for patients • Dementia Friends sessions for CCG and Council staff and now offered to other organisations including Bath Sainsbury's store • A Rural Independent Living Support Service to help people living in rural areas access services and a Home from Hospital service to support discharge from hospital • Care Home Support and Liaison to help care homes better care for residents with dementia	• Dementia diagnosis rate • Performance indicators for the Dementia Support Worker service including being offered an appointment date within 4 weeks, being provided with information and guidance and a survey of service user experiences
Priority eight: Improved services for older people	Integrated, safe and compassionate pathways for older people	• Re-design of adult community services (with more emphasis on supporting people to maintain and regain skills and independence, short term services which promote people's recovery and less emphasis on longer term packages of care which may create dependency). • An integrated reablement and rehabilitation service • Personalised care planning supported by the Think Local Act Personal and Making It Real initiatives • End of life care planning and sharing of these wishes appropriately with all who care for the individual, recognising that this is an issue across the age range	• Monitoring of a range of national indicators including: o Quality of life o Proportion of service users who have control over their daily life, receive self-directed support or payments and have as much social contact as they would like o Permanent admissions of older people to residential and nursing care homes o Delayed transfers of care from hospital o Satisfaction of service users with their care and support and proportion who feel safe and secure o Whether individuals are able to fulfil their wishes in terms of their location at end of life

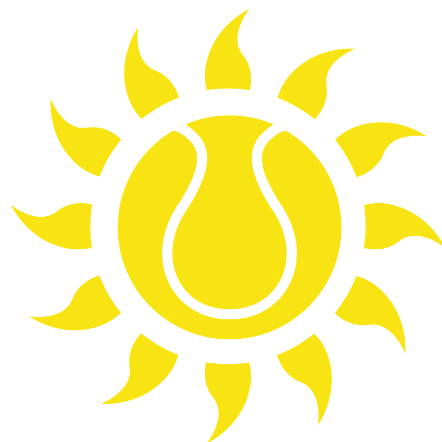
Theme three: Tackling health inequality by creating fairer life chances			
Priorities	**Outcome**	**Examples of current service delivery**	**Measures**
Priority nine: Improved skills and employment	All residents have access to training and employment	• Apprenticeship schemes across the public sector • A programme of work to support skills and employment in the core sectors including care, retail and hospitality • Work experience placements in construction sites across Bath and North East Somerset • A programme of work to support care leavers into employment training or education	• JSA claimant count (including a reduction in long term claimants) • Numbers of Not in Education Employment or Training
Priority ten: Reduce the health and wellbeing consequences of domestic abuse	People are free from domestic abuse	• A multi-agency approach to assessing and responding to high risk cases • IRIS (Identification and Referral to Improve Safety) GP referral scheme • Successful local projects including IDVAs and perpetrator programmes • Innovative, high-quality local training on domestic abuse	• Development of a local perpetrator programmes • Extension of domestic abuse training to more front-line services, and inclusion in relevant commissioning • More emphasis on preventative approaches, particularly for young people • Improved and earlier reporting of domestic abuse
Priority eleven: Take action on loneliness	Everybody has a network	• Independent Living services delivered in local communities • A wide range of locally-based projects including the Village Agent Scheme (operating in 20 parishes) and "The Hub in a Pub" in Chew Stoke (a joint initiative providing services and support to older people living in the Chew Valley).	• Number of "on the ground" projects to tackle loneliness in local areas, building on local community links and networks • Loneliness is addressed through key strategies, plans and commissions • Loneliness is targeting through projects and support in areas of identified need

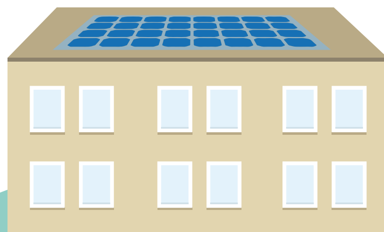
Wellbeing refers to the wider social, physical, psychological, environmental and economic factors which affect our lives and our health.

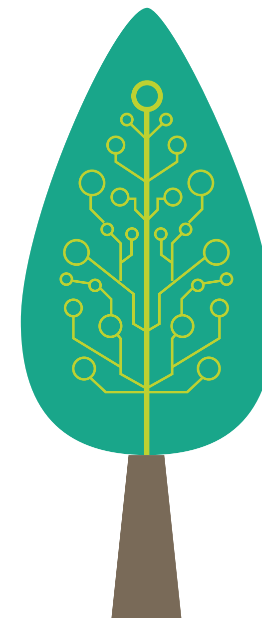
You can find out more about the Bath and North East Somerset Joint Strategic Needs Assessment at **www.bathnes.gov.uk/jsna**

You can find out more the about the Bath and North East Somerset Children and Young People's Plan 2014-2017 at **www.bathnes.gov.uk/cypp**

This document can be made available upon request in a range of languages, large print, Braille, on tape, electronic and accessible formats from Strategy and Performance: **01225 396390** or **HWB@bathnes.gov.uk**







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Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

healthwatch Bath and North East Somerset

MEETING	B&NES HEALTH AND WELLBEING BOARD
DATE	25/03/2015
TYPE	An open public item

Report summary table	
Report title	Healthwatch Bath and North East Somerset Update
Report author	Ronnie Wright / Morgan Daly T: 0117 958 9333
List of attachments	None
Background papers	Health and Wellbeing Network meeting notes February 5 2015 and Healthwatch Bath and North East Somerset Issues and Concerns Quarterly Report available at www.healthwatchbathnes.co.uk
Summary	What are the trends identified through issues and concerns brought to Healthwatch Bath and North East Somerset in the past quarter, what has Healthwatch Bath and North East Somerset learned through its Health and Wellbeing Network and how does Healthwatch propose to respond.
Recommendations	The Board is asked to agree that: • It notes the feedback received through issues and concerns and through the Network, including an update on a research project conducted by Healthwatch within the Royal United Hospital. • It considers and notes the proposal for a model of Healthwatch work which maximises resources available within the overall Healthwatch project and local partners.
Rationale for recommendations	Public, patient and provider engagement is a principle for the Health and Wellbeing Board underpinning the Health and Wellbeing Strategy. Understanding people's needs and experiences and coproducing services and plans with them is key to many of the Health and Wellbeing Strategy's priorities including improving support for families with complex needs, creating healthy and sustainable places, improving support for people with long term conditions, reducing rates of mental ill-health and improving services for older people which support and

	encourage independent living and dying well.
Resource implications	
Statutory considerations and basis for proposal	
Consultation	The research project has been agreed by the Advisory Group of Healthwatch Bath and North East Somerset
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.

THE REPORT

- Co-production has been described as: “A way of working where… people who use services, family carers and service providers, work together to create a decision or service which works for them all. The approach is value driven and built on the principle that those who use a service are best placed to help design it.” And: “A relationship where professionals and citizens share power to plan and deliver support together, recognising that both have vital contributions to make in order to improve quality of life for people and communities.”

- This report will demonstrate how Healthwatch Bath and North East Somerset is ensuring that the ideals of coproduction are informing how we work with voluntary and community sector partners, The Health and Well Being Network, members of the public, patient groups and statutory partners to achieve meaningful benefit for local people.

- The Health and Wellbeing Network meeting held on Wednesday 5 February, which looked at coproduction, was attended by 30 people. The meeting was mainly in the form of small discussion groups. Following two short DVDs on co-production the groups considered their responses to the DVDs. They also discussed their own experiences of co-production locally: What worked well? What difficulties were there? How could issues be overcome?

- The meeting revealed that there are many different examples of coproduction projects locally. In summary some of the key themes that emerged from the discussions were:
    - How can we make sure that involvement would work – how do we make sure a balanced view is heard.
    - What should the policy be on reward and recognition for people who get involved and what support might they need.
    - There are issues related to contracting and coproduction – there can be too much of a focus on outputs and contracts can be so tightly controlled as to not allow flexibility in meeting a person’s needs.
    - Providers need more information about other providers’ roles and capabilities.
    - There needs to be a recognition of the tiered nature of coproduction.
    - There needs to be a recognition that coproduction takes time.
    - It would be good to coproduce our own local definition of coproduction.

- One example of local initiatives to take forward coproduction is partnership work with a number of local organisations including St Mungos Broadway to develop and promote coproduction and progression opportunities. This is only one example of the broad range of work currently being undertaken and the Board is commended to read the full report to get an overview of the scope of the coproduced work already being done by local groups.

- Healthwatch will continue to consult patients, members of the public, voluntary sector groups and The Health and Well Being Network within Bath and North East Somerset during 2015/16 using consultation methodologies informed by learning around coproduction. This will result in findings that are representative of the views of a large cross-section of society.

- Healthwatch is also currently engaged in a research project, designed to recruit a cohort of patients within the RUH who will be surveyed as they move from inpatient care back into primary or residential care. An update on the findings of this research project will be provided to the Board in the near future.

- Planned and ongoing Healthwatch consultation work will dovetail with Health and Well Being Network themes, and will be tailored to address the key theme of loneliness and isolation, an area of specific interest as allocated by the Health and Well Being Board. An example of this can be seen in the current project Healthwatch is conducting within the Royal United Hospital - the findings of which will be important in the understanding of how isolation can arise, and could be addressed, following inpatient care within a secondary care setting. The results of this research project will be discussed, and conclusions drawn, in partnership with the Health and Well Being Network. A report will then be provided to the Health and Well Being Board, with recommendations, coproduced with the Network.

Please contact the report author if you need to access this report in an alternative format

Bath & North East Somerset Council

healthwatch Bath and North East Somerset

NHS Bath and North East Somerset Clinical Commissioning Group

MEETING	B&NES HEALTH AND WELLBEING BOARD
DATE	25/03/2015
TYPE	An open public item

Report summary table	
Report title	Better Care Fund (BCF) Section 75 agreement
Report author	Jane Shayler – Director, Adult Care and Health Commissioning Andy Rothery – Finance Business Partner
List of attachments	• Appendix 1: Financial Summary of BCF funded schemes • Appendix 2: Emergency Admissions Summary Revisions • Appendix 3: Draft Section 75 Agreement
Background papers	• Report to the Health and Wellbeing Board (HWB), 17th September 2014 • BCF Plan Submission: http://www.england.nhs.uk/wp-content/uploads/2014/12/bcf-bath-prt1.pdf
Summary	The changes to the previously submitted Bath and North East Somerset BCF plan were agreed by the Health and Wellbeing Board on the 17th September 2014, this led to the plan being approved and recognised as an example of best practice through the NHS England national assurance process. The submitted plan has had no changes to planned schemes; however the Council and CCG have reviewed its emergency admissions target and reconsidered this target to take into account 2014/15 pressures in acute trust non-elective activity. There is now a requirement to formalise the arrangement and ensure that there is a documented agreement in place outlining funding transfers, governance and risk share arrangements under Section 75 of the NHS Act 2006.
Recommendations	The Board is asked to: • Note the financial summary of BCF schemes and the 2015/16 funding transfers • Support the changes to the target for reductions in emergency admissions • Agree entering into the draft section 75 agreement with delegation to the Co-chairs of the Health and Wellbeing Board and CCG's Chief Officer for agreement of the final agreement before signing.
Rationale for	The Health and Wellbeing Board in March 2014 approved and

recommendations	endorsed BaNES's Better Care Plan 2014/15-2018/19 and the associated schemes to be funded from the Better Care Fund in the context of the local vision for and delivery of integrated care and support. This local vision is aligned with and makes a significant contribution to delivery of the outcomes in the Joint Health and Wellbeing Strategy as follows: Theme One - Helping people to stay healthy: • Reduced rates of alcohol misuse; • Creating healthy and sustainable places. Theme Two – Improving the quality of people's lives: • Improved support for people with long term health conditions; • Reduced rates of mental ill-health; • Enhanced quality of life for people with dementia; • Improved services for older people which support and encourage independent living and dying well. Theme Three – Creating fairer life chances: • Improve skills, education and employment; • Reduce the health and wellbeing consequences of domestic abuse; • Increase the resilience of people and communities including action on loneliness. A requirement of NHS England is that the contents of the agreement need to be overseen by the Health and Wellbeing Board, through this strategic oversight the HWB is required to approve entering into the section 75 agreement. Physical signing of the agreement is the responsibility of BaNES CCG Chief Officer / Chief Finance Officer and Council Section 151 Officer. As the agreement is in draft form there may be changes in the final document, it is therefore necessary to seek delegation of HWB for approval of the final agreement.
Resource implications	The proposed use of the funding and subsequent financial transfers is set out in Appendix 1 of the report. There is an element of risk around the pay for performance period that is addressed in the report and schedule 3 of the Section 75 agreement. On an annual basis and in accordance with each organisation's financial planning processes and decision making, adjustments are likely to be made to BCF funded schemes; model(s) of service; and/or capacity. Revisions will take account of i) evidence of the outcomes delivered by the schemes; ii) the principles and conditions of use of the BCF, including any future revisions; iii) any changes in the statutory obligations of either or both of the organisations; and iv) best value. The treatment of Overspends and Underspends and associated

	Financial governance has been documented in Schedule 1 of the agreement and in the body of the report. The overarching aim of BCF funding is to act as a key enabler of the delivery of integrated services that support and safeguard older and vulnerable people to remain independent through timely interventions that contain, stabilise, decrease and/or de-escalate risks, care and support needs. Also, to continue to reduce unnecessary and unplanned admissions. This requires a shift in focus and of resources to the "front end" of the pathway/system to place greater emphasis on prevention and early intervention. This strategy is critical to responding in a sustainable way to the increasing volume, complexity and acuity of older people and those with long term conditions whilst also achieving the best possible outcomes for individuals. In the longer term this strategic shift of resources is likely to require a reduction in the proportion of funding to acute and specialist health in order to fund sufficient capacity and capability in community services.
Statutory considerations and basis for proposal	This report is recommending entering into the agreement that will allow BaNES to meet its statutory requirement for the Better Care Fund transfer under Section 75 of the NHS Act 2006. Under section 223G of the NHS Act 2006 (as amended most recently by the Care Act 2014), NHS England has the power to set conditions around the payment of funds to CCGs.
Consultation	Key contributors to this report are: • Director, Adult Care and Health Commissioning; • Council Section 151 Officer; • CCG Chief Finance Officer; • Strategic Business Partner – Joint Commissioning (Council & CCG); • CCG Chief Officer; • Senior Commissioning Managers (Council & CCG); The local vision for integrated care and support and associated plans have been developed and endorsed by a broad range of partners, including representatives from: provider organisations; primary care; VCSE (Voluntary, Community and Social Enterprise) sector organisations; Healthwatch BaNES; the HWB; the CCG, the Council, including Public Health; and NHS England.
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. Any arising financial risks have been recorded by both CCG and Council in line with Schedule 3 of the Section 75 Agreement.

THE REPORT

1 BACKGROUND

1.1 In June 2013, the Government announced £3.8bn pooled fund across health and social care services from 2015/16 to ensure better integration and improvements for the lives of some of the most vulnerable people in our society. Locally for BaNES this is a pooled fund of £12.049m that delivers ambitious schemes across the Health and Social Care pathway.

1.2 Following the 17th September HWB the BaNES plan was “Approved with support” after the Nationally Consistent Assurance Review (NCAR) process and included as an example of best practice on the NHS England website. The BaNES plan demonstrated how it will meet the BCF national conditions of:

- Plans to be jointly agreed
- Protection for social care services (not spending)
- As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- Agreement on the consequential impact of changes in the acute sector

1.3 The plan has been jointly developed and supported through the HWB, to enable the schemes to be delivered 2015/16 there is the requirement to have the pooled funding agreement in place that meets section 75 of the NHS Act 2006.

1.4 The September submission of the plan had a revision to the reporting metrics, this was the introduction of the metric of reductions of total emergency admissions with the national ambition of a 3.5% reduction in 2015 against a 2014 actual baseline. As the BCF is not new money, much of it will have to be re-invested from existing NHS services. To strengthen the framework a payment for performance element was introduced to allow CCGs to withhold funds where the emergency admissions targets are not achieved, this will allow CCGs to fund the cost of the additional emergency admissions.

1.5 Through the CCG’s 2015/16 operational planning process there has been the opportunity to review the BCF existing 3.5% target reduction that was included in the BaNES BCF plan. This has allowed BaNES to review actual 2014/15 activity and aligned its BCF plan reductions with the CCG operational plan and associated QIPP schemes that sit within or alongside the BCF.

2 SUPPORTING INFORMATION

2.1 Section 75 Agreement

The draft section 75 agreement will formalise the 2015/16 transfer of Better Care Funding from BaNES CCG to the Council. The document will give both organisations assurance around the use of funding in line with the BCF plan and outline joint governance and reporting requirements. The section 75 agreement uses an amended Bevan Brittan template that has been provided for Councils

and CCGs as a BCF resource on the NHS England website. Some of the key elements in the agreement cover:

Funding Transfers

The BCF schemes and associated budgets are detailed in Appendix 1, this summary shows the total BCF funding for BaNES at £12.049m across CCG and Council commissioned schemes. The Council will act as lead commissioner on a large number of schemes, this is building on existing joint commissioning arrangements that have a good track record of delivery.

The total value of the Council commissioned schemes is £9.94m with £0.958 of scheme funding direct from the Department for Communities and Local Government (DCLG) and the Department of Health (DoH), this funding is ring-fenced to capital schemes for the Disabled Facilities Grant (DCLG) and Social Care IT investment (DoH). The revenue transfer from BaNES CCG is £8.98m, the table details the £0.756m that is held in relation to the payment for performance fund.

The total value of CCG commissioned schemes is £2.11m, this is funding NHS Commissioned out of hospital services.

Commissioning Arrangements

The schemes within the BCF build on existing joint commissioning arrangements and will be closely aligned to the CCG's 5 Year Strategic Plan, 2015/16 operational plan, NHS England Five Year Forward View and the Joint Health and Wellbeing Strategy. In 2015/16 it is unlikely that contractual arrangements will change and will follow existing contract procedure rules and frameworks within BaNES CCG and Council.

Governance Arrangements

The BCF governance builds on the joint arrangements that are in place, delegated decision making for approved schemes will sit within the existing budgetary control framework for the lead commissioning organisation.

Joint reporting will be taken at regular intervals to the Joint Commissioning Committee giving details of scheme expenditure against agreed budgets and individual performance outcomes against the national BCF metrics and locally agreed scheme specific KPI's. When required any changes to existing agreed schemes and use of BCF funding will be a joint decision of the committee.

Wider engagement for reporting against the Better Care fund will be taken through the newly established Transformation Group. The Transformation Group reports directly into the Health and Wellbeing Board and provides a forum supporting the delivery and implementation of *'Seizing Opportunities',* BaNES CCG's 5-Year Strategy and shared system oversight of the Better Care Fund.

To allow the HWB to carry out its strategic oversight role appropriate information will be reported on an annual or quarterly basis.

The Joint Committee for the Oversight of Joint Working may review the joint working aspects of the BCF.

Finance Reporting Arrangements

Financial monitoring will be incorporated into the existing monthly budget monitoring and reporting arrangements in place in both CCG and Council. Specific reporting on the Better Care Fund will be taken regularly to the Joint Commissioning Committee to assure both partners that the financial objectives set out in the Better Care Fund plan are being achieved.

The Joint Commissioning Committee shall be notified of any projected underspends through the Better Care Fund financial monitoring arrangements. The treatment of underspends should be retained within the Better Care Fund with its use agreed by the Joint Commissioning Committee or delegated to the Pooled Fund Manager.

Unless the parties shall agree otherwise all underspends shall at the end of the financial year shall belong to the Council and be earmarked for future Better Care Fund scheme expenditure. The use of underspends will be agreed by both partners.

As with underspends the Joint Commissioning Committee are to be notified of any projected overspends, In the event of a scheme overspending, the funding of overspends will be reviewed by the Joint Commissioning Committee against the overall Better Care Funding available and follow the decision making set out in clause 5.5 of this agreement.

The funding of overspends would be at the discretion of the Joint Commissioning Committee and or delegated to the pooled fund manager if the funding could be met from within existing delegated budgets. If the funding cannot be met from the available pooled fund and available resources the funding request will be subject to Council and CCG approval processes

Performance Reporting Arrangements

There will be BCF specific reporting in the form of a monthly dashboard that will focus on the delivery against the national metrics as follows:

- Total Emergency Admissions
- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed transfers of care from hospital per 100,000 population
- Patient / Service user experience
- Local Measure

The BCF performance dashboard will form part of the reporting taken to the Joint Commissioning Committee to provide oversight of performance outcomes.

The BCF dashboard will be supported by scheme specific monitoring that will be incorporated into contract performance management arrangements with the providers who are delivering the schemes. A number of BCF metrics will also be reported through the Council's corporate performance arrangements that focus on the Adult Social Care Outcomes Framework (ASCOF).

Risk Share Arrangements

The Section 75 agreement outlines the Council and CCG's approach to risk sharing in relation to the performance element of the fund and the treatment of any overspends. These are summarised as follows:

In relation to the payment for performance element, if target reductions in emergency admissions are not met the CCG has the ability to withhold the performance element of the fund, in line with BCF guidance. Priority will be given to funding the cost of emergency admissions above planned levels, to enable acute providers to meet the cost impact of delivering this activity, and to support management of the operational and capacity risks associated with greater than planned activity.

However, schedule 3 of the section 75 agreement outlines a Council and CCG supported approach to risk management, informed by their joint commitment to supporting effective integrated working. Both parties would wish to continue funding the initiative associated with the at risk funding, providing it is proving successful against key metrics and outcomes, even if the specific target relating to reduced emergency admissions is not being achieved.

2.2 Emergency Admissions 2015/16 Reductions

The revised BCF guidance issues on the 25th July 2014 set an expectation of a national reduction in emergency admissions of 3.5%; this was reflected in the BaNES re-submission of the BCF plan in September.

In light of the increased pressures on acute trusts in BaNES and nationally there has been the opportunity to revisit these targets and revise the 2015/16 target in light of actual activity for the submission of the CCG 2015/16 operational plan.

Appendix 2 shows the actual 2013 & 2014 activity levels for emergency admissions that have been used for the CCG activity planning. This shows an increase of 3% in emergency admissions in the 2014 BCF period. The information is presented in the BCF monitoring period which is calendar year Q4 2014/15 – Q3 2015/16.

Before applying scheme reductions this current level of activity has been assumed in 2015/16 with additional growth of 0.65%, the growth assumptions are based on a model that has been agreed with the RUH.

The CCG has carried out a detailed review of all schemes that will impact on emergency admissions and aligned them to Quality, Innovation, Productivity and Prevention (QIPP) financial targets in the operational plan. The planned reductions are aligned to the 2015/16 financial year with target reductions of 382 admissions.

This gives gross reductions of 1.9% across the BCF reporting period and 2.5% for the 2015/16 financial year. When taking into account growth in 2015/16 the net reductions are 0.5% across the BCF period and 1.9% for 2015/16.

These targets have been carefully considered by both the CCG and Council and reflect scheme reductions that take into account current pressures whilst

providing a manageable level of reductions. They have also been shared with providers through the Transformation Group.

3 NEXT STEPS

3.1 Section 75 Agreement sign off

Following the agreement of the HWB the section 75 agreement will be finalised and shared with the Co-chairs of the Health and Wellbeing Board and CCG's Chief Officer for agreement on behalf of the HWB, the authorised signatories for entering into the agreement are the Council Section 151 officer and the CCG Chief Officer / Chief Financial Officer.

The local reporting requirements have been defined in the report and the section 75 agreement. It is anticipated that there will be a requirement from NHS England for a Better Care Fund report in the form of a quarterly reporting template, and a year-end reporting template, will be issued jointly by NHS England and DCLG or LGA to CCGs and LAs to use.

Please contact the report author if you need to access this report in an alternative format

Appendix 1

Table 1 – Scheme summary and financial breakdown

BCF Revenue Schemes					**Lead Commissioner**		**Total**
Scheme Name	**Area of Spend**	**Please specify if Other**	**Provider**	**Source of Funding**	**BaNES CCG**	**B&NES Council**	**2015/16 (£000)**
1. Extended Hours Service	Other	Scheme covers integrated care and support across health and social care.	Charity / Voluntary Sector	CCG Minimum Contribution		559	559
2. Handyperson, Step Down and Intensive Home from Hospital	Other	Scheme covers integrated care and support across health and social care.	Charity / Voluntary Sector	CCG Minimum Contribution		342	342
3. Older People's Independent Living Service	Social Care		Charity / Voluntary Sector	CCG Minimum Contribution		100	100
4. Integrated Re-ablement & Rehabilitation	Other	Scheme covers integrated care and support across health and social care.	Charity / Voluntary Sector	CCG Minimum Contribution		500	500
5. Rural Support Service	Social Care		Charity / Voluntary Sector	CCG Minimum Contribution		208	208
6. Social Care Pathway Re-design Council	Social Care		Charity / Voluntary Sector	CCG Minimum Contribution		1,000	1,000
6. Social Care Pathway Re-design CCG	Community Health		Charity / Voluntary Sector	CCG Minimum Contribution		1,000	1,000
7. Care Act Implementation	Social Care		Local Authority	CCG Minimum Contribution		481	481
8. Integrated Care & Support	Community Health		Private Sector	CCG Minimum Contribution	2,008		2,008
9. Protection of Social Care	Social Care		Private Sector	CCG Minimum Contribution		4,141	4,141
10. Increased capacity in the Approved Mental Health Practitioner Service & DOLS	Mental Health		Local Authority	CCG Minimum Contribution		150	150

11. Social Prescribing	Mental Health		Charity / Voluntary Sector	CCG Minimum Contribution	100		100
12. Mental Health Re-ablement Beds	Mental Health		NHS Mental Health Provider	CCG Minimum Contribution		100	100
13. Increased capacity in the Learning Disabilities Social Work Service	Mental Health		Charity / Voluntary Sector	CCG Minimum Contribution		168	168
16. Support for Carers	Social Care		Charity / Voluntary Sector	CCG Minimum Contribution		234	234
17. Community Cluster Model	Commun ity Health		Charity / Voluntary Sector	Additional CCG Contribution		-	
Total					**2,108**	**8,983**	**11,091**

BCF Capital Schemes					**Lead Commissioner**		**Total**
Scheme Name	**Area of Spend**	**Please specify if Other**	**Provider**	**Source of Funding**	**BaNES CCG**	**B&NES Council**	**2015/16 (£000)**
14. Disabled Facilities Grant	Social Care		Local Authority	Local Authority Social Services		552	552
15. Social care capital	Social Care		Private Sector	Local Authority Social Services		406	406
Total					**-**	**958**	**958**

Better Care Fund Total					**-**	**9,941**	**12,049**

Table 2 – Financial details (and timescales)

Total amount of revenue funding to be transferred from BaNES CCG to B&NES Council and amount in each year:

Funding Stream	**Year**	**£**	**Invoicing Dates**
Section 75 Transfer	2015/16	£8,227,404	On or shortly after 1st April
Payment for Performance	2015/16	£755,596	Quarterly from 1st April
Total		**£8,983,000**	

Appendix 2

Emergency admission summary revisions

Table 1

Emergency admissions quarterly actuals and 2015 forecast

Quarter	2013	2014	2015	% Increase / -Decrease
Q4 Jan - Mar	3,609	3,730	3,840	2.96%
Q1 Apr - Jun	3,634	3,670	3,656	0.65%
Q2 Jul - Sep	3,614	3,621	3,682	0.65%
Q3 Oct - Dec	3,737	4,100	4,046	0.65%
Total	**14,594**	**15,121**	**15,224**	
Percentage Change		**3.06%**	**1.22%**	

Table 2

Revised emergency admissions with growth adjustments and Quality, Innovation, Productivity and Prevention (QIPP) reductions

Financial Year	Quarter	2014	Growth Adjustments	QIPP Allocation	2015	% Increase / -Decrease
14/15	**Q4 Jan - Mar**	3,730	138		3,868	3.70%
15/16	**Q1 Apr - Jun**	3,670	24	-95	3,599	-1.93%
15/16	**Q2 Jul - Sep**	3,621	24	-95	3,550	-1.96%
15/16	**Q3 Oct - Dec**	4,100	27	-96	4,031	-1.68%
BCF Period Total		**15,121**	**213**	**-286**	**15,048**	
15/16	**Q4 Jan - Mar**	3,868	25	-96	3,797	-1.84%
Financial Year Total		**15,259**	**100**	**-382**	**14,977**	
BCF Period Percentage Change			**1.41%**	**-1.89%**		**-0.48%**
Financial Year Percentage Change			**0.66%**	**-2.50%**		**-1.85%**

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Bath and North East Somerset Clinical Commissioning Group

Bath & North East Somerset Council

APPENDIX 3 – Draft Section 75 Agreement

Dated 2015

BATH AND NORTH EAST SOMERSET COUNCIL

and

NHS BATH AND NORTH EAST SOMERSET CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES

BETTER CARE FUND AGREEMENT

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THIS AGREEMENT is made on day of 2015

PARTIES

(1) **BATH AND NORTH EAST SOMERSET COUNCIL** of The Guildhall, High Street, Bath, BA1 5AW (the **"Council"**)

(2) **NHS BATH AND NORTH EAST SOMERSET CLINICAL COMMISSIONING GROUP** of Kempthorne House, St Martins Hospital, Clara Cross Lane, Bath, BA2 5RP **(the "CCG")**

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the Unitary Local Authority area of Bath and North East Somerset.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act for the population registered with GP practices located within Bath and North East Somerset.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will to pool funds and align budgets as agreed between the Partners. This agreement will not impact on the existing agreements under Section 75 of the 2006 NHS Act that are in place.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives as set out in the Bath and North East Somerset Better Care Fund Plan.

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services.

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

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1 DEFINED TERMS AND INTERPRETATION[1]

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 5 setting out the Partners plan for the use of the Better Care Fund.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 00:01 hrs on 1st April 2015.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price [means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment].

Default Liability *means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract) to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.*[2]

[1] Definitions should be finalised once main body of Agreement is finalised.
[2] Further consideration will always be needed on this.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(f) any form of contamination or virus outbreak; and

(g) any other event, in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification. [3]

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund [and for each Aligned Fund the Partner that will host the Aligned Fund]

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other is exercise of both the NHS Functions and Council Functions through integrated structures.

Joint Commissioning Committee means the Joint Commissioning Committee established by the CCG and Council (People and Communities Department) responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

[3] Here and in the definition of NHS functions the widest definition is used; this needs to be cut down in the relevant specification so that the purpose must be fulfilled by use of the function

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Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause [8.4].

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause [7.3].

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

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Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause [10].

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Performance Payment Arrangement means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

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1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM[4]

2.1 This Agreement shall come into force on the Commencement Date[5].

2.2 This Agreement shall continue until it is terminated in accordance with Clause [21].[6]

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.[7]

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4 Consider the term and arrangements for dealing with termination.

5 Parties to consider and confirm whether existing partnership arrangements (Section 75 or otherwise) will be affected by this Agreement.

6 Parties will need to consider how termination will work in relation to this Agreement given that it is unlikely that the CCG/Council would be able to terminate a Better Care Pooled Fund.

7 This is on the basis that the Agreement is a framework arrangement so the details of each Service will be set out in the relevant Scheme Specification.

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3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES[8]

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

4.1.1 Lead Commissioning Arrangements;

4.1.2 Integrated Commissioning;

4.1.3 Joint (Aligned) Commissioning

4.1.4 the establishment of one or more Pooled Funds in relation to Individual Schemes (the "Flexibilities")

4.2 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints. [9]

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners.

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8 This Agreement has been drafted to cover a range of flexibilities to incorporate the framework approach. Drafting here will need to reflect any lead commissioning arrangements.

9 Parties should always check that the proposed services can be delegated before incorporating.

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5.3 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme in the form set out in Schedule 1 shall be completed and agreed between the Partners. The initial scheme specification summary is set out in schedule 1 part 2

5.4 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to business case approval by the Joint Commissioning Committee where costs are within the identified funding agreement, subject to meeting both Council and CCG contracting procedures. For new schemes or changes to existing schemes that are in excess of the pooled fund but within existing delegated responsibilities and budgets, business case approval will be given by the Joint Commissioning Committee. In the event the funding requirement is in excess of the available pooled fund and available resources for new or existing schemes these will be subject to Council and CCG approval processes.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

6.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

6.4 The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

6.5 Each Partner shall keep the other Partners and the Joint Commissioning Committee regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

6.6 The Joint Commissioning Committee will report back to the Health and Wellbeing Board as required by its Terms of Reference.

Appointment of a Lead Commissioner[10]

6.7 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.7.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.7.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.7.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

[10] Parties should consider overarching obligations on Lead Commissioners, including whether any further duties will be assigned to the Lead Commissioner.

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6.7.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.7.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.7.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.7.7 undertake performance management and contract monitoring of all Service Contracts;

6.7.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

6.7.9 keep the other Partner and the Joint Commissioning Committee regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

6.7.10 reporting on the financial and performance monitoring of the Better Care Fund will be incorporated into the Council and CCG's monthly reporting cycle that will provide updates to Council Cabinet, CCG Board,Health and Wellbeing Board and Joint Commissioning Committee.

7 ESTABLISHMENT OF A POOLED FUND[11]

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in the Scheme Specifications.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in a Pooled Fund may only be expended on the following:[12]

7.3.1 Schemes specified within Schedule 1

7.3.2 Amended or new Schemes within the pooled fund that have been approved through the Joint Commissioning Committee with additional approval where required.

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.[13]

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[11] Pooled Funds can be used for Lead Commissioning or Integrated Commissioning arrangements. Furthermore, each Service, can have different Lead Commissioners. The host arrangements for pooled funding is for ensuring that there is streamlined management and accountability of the Pooled Funds with the Host Partner being the accounting body and having responsibility for appointing a Pooled Fund Manager.

[12] This dictates what can be funded out of the Pooled Fund and, therefore, what would constitute an overspend if it exceeded the amount in the Pool. Money spent on other things would be in breach of this agreement and, therefore not recoverable by the Host Partner.

[13] This links liabilities of the Host Partner for default to the indemnity provisions.

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager in respect of each Individual Service where there is a Pooled Fund shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.5 reporting to the Joint Commissioning Committee as required by Joint Commissioning Committee and the relevant Scheme Specification;

8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

8.2.7 preparing and submitting to the Joint Commissioning Committee Quarterly reports (or more frequent reports if required by the Joint Commissioning Committee) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Joint Commissioning Committee to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as required by it.

8.3 In carrying out their responsibilities as provided under Clause [8.2] the Pooled Fund Manager shall have regard to the recommendations of the Joint Commissioning Committee and shall be accountable to the Partners.

8.4 The Joint Commissioning Committee may agree to the viring of funds between Pooled Funds.

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9 NON POOLED FUNDS[14]

9.1 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in the relevant Scheme Specification. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

9.2 When introducing a Non Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

9.2.1 which Partner if any[15] shall host the Non-Pooled Fund

9.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.4 [Both Partners shall ensure that Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification]

9.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

9.5.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the CCG Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year; and

9.5.2 the Health Related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification.[16]

10.2 Financial Contributions will be paid as set out in the each Scheme Specification.

10.3 With the exception of Clause [13], no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Joint Commissioning Committee minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS[17]

11.1 The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources

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[14] These are funds that are notionally held in a joint fund but are not a pooled fund.
If there are Lead Commissioner/Integrated Commissioner arrangements, the funds need to be held but they will be separately accounted for. The Lead Commissioner will still be responsible for managing the fund effectively.

[15] The non pooled fund can be a virtual pool with contributions identified but held separately. Transfers between partners for non pooled funds need to be made by S76/256 of the 2006 Act.

[16] Parties need to deal with the fact that some services will not have pooled funds. In respect of this, parties should decide how the invoicing/payment arrangements will work and whether this will vary from service to service.

[17] As set out in this Clause 11, these arrangements will need to be considered on a scheme by scheme basis. Consider whether there are any practical arrangements that could be set out as overarching principles.

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necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The partners have agreed risk share arrangements as set out in schedule 3, which provide for financial risks arising within the commissioning of services from the pooled funds and the financial risk to the pool arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

12.2 Subject to Clause [12.2], the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Joint Commissioning Committee in accordance with Clause 12.4.

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Joint Commissioning Committee is informed as soon as reasonably possible and the provisions of Schedule 3 shall apply.

Overspends in Non Pooled Funds

12.5 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an overspend in relation to a Partners Financial Contribution to a Non-Pooled Fund or Aligned Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Joint Commissioning Committee.

12.6 Where there is a Lead Commissioning Arrangement the Lead Commissioner is responsible for the management of the Non-Pooled Fund and Aligned Fund. The Lead Commissioner shall as soon as reasonably practicable inform the other Partner and the Joint Commissioning Committee.

12.7 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of the Performance Payment Arrangement.

13 CAPITAL EXPENDITURE[18]

Neither Pooled Funds or Non Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

14 VAT

The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.[19]

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[18] Once the arrangements are confirmed, a reference to s. 256 grants can be included if relevant.
[19] Partners to consider their respective positions regarding VAT.

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15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the Councils Independent External Auditors to make arrangements to certify an annual return of those accounts under the Local Audit and Accountability Act 2014.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 163, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Joint Commissioning Committee.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for

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Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in schedule 6.

19 GOVERNANCE

19.1 Integrated arrangements are overseen by the Health and Wellbeing Board (HWB), which recognises the contribution of joint working in delivering optimal outcomes at best value, within the wider remit of the HWB. The HWB has a sub-group (the Strategic Advisory Group) of large providers, whose remit includes collaboration on whole system solutions for care and support.

19.2 The operation of joint working arrangements, including the operation of pooled funds and the exercise of functions by either body on behalf of the partner body, is overseen by a Joint Committee for the Oversight of Joint Working. This is constituted as a joint committee of the CCG and Council with membership at elected member/Board member level and reports to the HWB, Council and CCG.

19.3 The Joint Commissioning Committee has a formal governance and operational leadership role across health, social care and public health commissioning in respect of strategic planning, performance management and decision-making. The Committee is a formal Committee of the CCG Governing Body and is accountable to Cabinet Members within the Council, and has a reporting line to the Joint Committee for the Oversight of Joint Working.

19.4 The terms of reference of the Joint Commissioning Committee are as set out in Schedule 2

19.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.6 The Joint Commissioning Committee shall be responsible for the overall approval of the Individual Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

20 REVIEW

20.1 Save where the Joint Commissioning Committee agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund, Non Pooled Fund and Aligned Fund and the provision of the Services within 3 Months of the end of each Financial Year.

20.2 Subject to any variations to this process required by the Joint Commissioning Committee, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2

20.3 The Partners shall prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Joint Commissioning Committee and Health and Wellbeing Board and may be presented to the Joint Committee for the Oversight of Joint Working.

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20.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than [3] Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

22.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.[20]

22.5 Upon termination of this Agreement for any reason whatsoever the following shall apply:[21]

22.5.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.5.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.5.3 the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

22.5.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

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20 Consider whether this obligation is acceptable to the Partners.

21 These provision sets out a suggested approach to what happens if the Agreement terminates particularly where there are contracts still in place. The Partners will need to address this in each service contract and also in the individual Scheme Specifications.

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22.5.5 the Joint Commissioning Committee shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.5.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.6 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 The parties will use their best efforts to negotiate in good faith and settle any dispute that may arise out of or relate to this Agreement.

23.2 In the event of a dispute between the Parties in connection with this Agreement the Parties shall refer the matter to the representatives nominated by the Parties who shall endeavour to settle the dispute informally between themselves.

23.3 In the event that the representatives cannot resolve the dispute between themselves within reasonable period of time having regard to the nature of the dispute then it shall be referred in the first instance to a formal meeting of the CCG's Head of Commissioning Development and the Council's Director, Adult Care and Health Commissioning.

23.4 In the event that the CCG's Head of Commissioning Development and the Council's Director, Adult Care and Health Commissioning cannot resolve the dispute between themselves within a reasonable period of time having regard to the nature of the dispute it shall be referred to the Chief Officer of the CCG (or his/her nominated deputy) and the Strategic Director People and Communities Department of the Council (or his/her nominated deputy) to resolve.

23.5 In the event that the dispute is still unresolved within a reasonable period of time with regard to the nature of the dispute and having followed the procedure in Clauses 23.1 to 23.4 above, the Parties may refer the matter to such body or person to act as mediator as they may choose in order to attempt to settle it by mediation in accordance with the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure ("the Model Procedure").

23.6 To initiate the mediation, a Partner must give notice in writing ("ADR notice") to the other Partner requesting mediation.

23.7 The procedure in the Model Procedure will be amended to take account of

23.7.1 Any relevant provisions in the Agreement

23.7.2 Any other agreement which the Parties may enter into in relation to the conduct of the mediation ("Mediation Agreement")

23.8 The costs of the Mediation will be met by the Parties jointly unless otherwise agreed

23.9 As a final resort either Partner may refer the matter to the courts

24 FORCE MAJEURE[22]

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that

[22] Consider whether the suggested procedure (including the definition of Force Majeure Event and timescales) is acceptable.

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Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than [sixty (60) days], either Partner shall have the right to terminate the Agreement by giving [fourteen (14) days] written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY[23]

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and

[23] Confidential information and the sharing of information will need to be considered since the partners have different rules that apply.

within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in schedule 7, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act.

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 sent by facsimile, at the time of transmission;

29.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the [ ];

Tel: [ ]
Fax: [ ]
E.Mail: [ ]

and

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29.3.2 if to the CCG, addressed to [ ];

Tel: [ ]
Fax: [ ]
E.Mail: [ ]

30 VARIATION [24]

No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

[24] The Partners may find it helpful to set out a procedure for agreeing to add a new scheme to the framework arrangement.

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35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

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IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement[25]

SIGNED for and on behalf of)
BATH AND NORTH EAST SOMERSET)
COUNCIL by

Authorised
Signatory……………………………………...

Signed for on behalf of **NHS BATH AND NORTH EAST SOMERSET CLINICAL COMMISSIONING GROUP**

Authorised
Signatory………………………………………

[25] Partners to confirm execution blocks

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SCHEDULE 1 – BCF SCHEME SPECIFICATION

Part 1 – Services Schedule

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement. Table 1 gives the financial breakdown of the Better Care Fund Schemes with the Lead Commissioner identified

Table 1 – Scheme summary and financial breakdown

BCF Revenue Schemes					**Lead Commissioner**		**Total**
Scheme Name	**Area of Spend**	**Please specify if Other**	**Provider**	**Source of Funding**	**BaNES CCG**	**B&NES Council**	**2015/16 (£000)**
1. Extended Hours Service	Other	Scheme covers integrated care and support across health and social care.	Charity/Voluntary Sector	CCG Minimum Contribution		559	559
2. Handyperson, Step Down and Intensive Home from Hospital	Other	Scheme covers integrated care and support across health and social care.	Charity/Voluntary Sector	CCG Minimum Contribution		342	342
3. Older People's Independent Living Service	Social Care		Charity/Voluntary Sector	CCG Minimum Contribution		100	100
4. Integrated Re-ablement & Rehabilitation	Other	Scheme covers integrated care and support across health and social care.	Charity/Voluntary Sector	CCG Minimum Contribution		500	500
5. Rural Support Service	Social Care		Charity/Voluntary Sector	CCG Minimum Contribution		208	208
6. Social Care Pathway Re-design Council	Social Care		Charity/Voluntary Sector	CCG Minimum Contribution		1,000	1,000
6. Social Care Pathway Re-design CCG	Community Health		Charity/Voluntary Sector	CCG Minimum Contribution		1,000	1,000
7. Care Act Implementation	Social Care		Local Authority	CCG Minimum Contribution		481	481
8. Integrated Care & Support	Community Health		Private Sector	CCG Minimum Contribution	2,008		2,008
9. Protection of Social Care	Social Care		Private Sector	CCG Minimum Contribution		4,141	4,141
10. Increased capacity in the Approved Mental Health Practitioner Service & DOLS	Mental Health		Local Authority	CCG Minimum Contribution		150	150
11. Social Prescribing	Mental Health		Charity/Voluntary Sector	CCG Minimum Contribution	100		100

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Scheme Name	Area of Spend	Please specify if Other	Provider	Source of Funding	BaNES CCG	B&NES Council	2015/16 (£000)
12. Mental Health Re-ablement Beds	Mental Health		NHS Mental Health Provider	CCG Minimum Contribution		100	100
13. Increased capacity in the Learning Disabilities Social Work Service	Mental Health		Charity/Voluntary Sector	CCG Minimum Contribution		168	168
16. Support for Carers	Social Care		Charity/Voluntary Sector	CCG Minimum Contribution		234	234
17. Community Cluster Model	Community Health		Charity/Voluntary Sector	Additional CCG Contribution		-	
Total					**2,108**	**8,983**	**11,091**

BCF Capital Schemes					**Lead Commissioner**		**Total**
Scheme Name	**Area of Spend**	**Please specify if Other**	**Provider**	**Source of Funding**	**BaNES CCG**	**B&NES Council**	**2015/16 (£000)**
14. Disabled Facilities Grant	Social Care		Local Authority	Local Authority Social Services		552	552
15. Social care capital	Social Care		Private Sector	Local Authority Social Services		406	406
Total					**-**	**958**	**958**

Better Care Fund Total					**-**	**9,941**	**12,049**

Table 2 – Financial details (and timescales)

Total amount of revenue funding to be transferred from BaNES CCG to B&NES Council and amount in each year:

Funding Stream	**Year**	**£**	**Invoicing Dates**
Section 75 Transfer	2015/16	£8,227,404	On or shortly after 1st April
Payment for Performance	2015/16	£755,596	Quarterly from 1st April
Total		**£8,983,000**	

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2. Financial Governance Arrangements

2.1 Financial Management

Budget Approvals / Sign Off

For funding where the Council is the lead Commissioner the delegated authority for the approval of scheme expenditure will sit with the pooled fund manager or their delegated officers with budget management responsibilities.

For funding where the CCG is the lead Commissioner the delegated authority will sit within the existing financial governance arrangements for the lead commissioner whose commissioning portfolio will cover the specific scheme.

2.2 Audit Arrangements

The Better Care Fund will be internally audited as part of the B&NES 2015/16 audit plan for the People and Communities Directorate

The external audit will fall within the annual audit of accounts for both the Council and CCG

2.3 Financial Management

All BCF expenditure will be committed through existing financial systems that are in place in BaNES CCG and Council and follow existing system controls for the authorisation of expenditure

Financial monitoring will be incorporated into the existing monthly budget monitoring and reporting arrangements in place in both CCG and Council. Specific reporting on the Better Care Fund will be taken regularly to the Joint Commissioning Committee to assure both partners that the financial objectives set out in the Better Care Fund plan are being achieved.

The Joint Commissioning Committee shall be notified of any projected underspends through the Better Care Fund financial monitoring arrangements. The treatment of underspends should be retained within the Better Care Fund with its use agreed by the Joint Commissioning Committee or delegated to the Pooled Fund Manager.

Unless the Parties shall agree otherwise all underspends shall at the end of the financial year shall belong to the Council and be earmarked for future Better Care Fund scheme expenditure, the application to be agreed between the Parties in accordance with the mechanisms set out in this document

As with underspends the Joint Commissioning Committee are to be notified of any projected overspends, In the event of a scheme overspending, the funding of overspends will be reviewed by the Joint Commissioning Committee against the overall Better Care Funding available and follow the decision making set out in clause 5.5 of this agreement.

Through the application of clause 5.5 funding of overspends would be at the discretion of the Joint Commissioning Committee and or delegated to the pooled fund manager if the funding could be met from within existing delegated budgets. If the funding cannot be met from the available pooled fund and available resources the funding request will be subject to Council and CCG approval processes

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3. VAT

For the purposes of this Agreement it is deemed that this is a non-business activity and VAT is not chargeable to the CCG from the Local Authority.

The Parties will follow all current and subsequent legislation and guidance on payments and VAT including in the Department of Health's "Guidance on the Health Act Section 31 Partnership Agreements" issued in 2000.

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PART 2 – AGREED SCHEME SPECIFICATIONS

Detailed scheme descriptions are included in the BCF plan submission:
http://www.england.nhs.uk/wp-content/uploads/2014/12/bcf-bath-prt1.pdf

BCF Investment	Project Ref	2015/16 spend (Minimum) £	Description	National Conditions						Outcomes and Metrics					
		Recurrent		Develop and agree a joint Better Care plan	Protection for social care services (not spending)	Support the development of 7-day services	Better data sharing between health and social care, based on the NHS number	Where funding is used for integrated packages of care, there is an accountable lead professional	Engage with all providers likely to be affected by the use of the fund	Admissions to residential and care homes	Effectiveness of reablement	Delayed transfers of care	Avoidable emergency admissions	Patient / service user experience	Local Metric
Protection for adult social care services	BC01	1,575,397	Alongside the expansion of the Integrated Re-ablement Service and investment in related voluntary sector services, these schemes aim to transform the adult social care system to deliver an integrated service that will support and safeguard older and vulnerable people to maximize their independence.	✔	✔		✔	✔	✔	✔	✔	✔	✔		
7 day working	BC02	350,000	Increased capacity within the Hospital Social Work Service and within the Integrated Re-ablement Service to provide seven day operational cover means that discharges from our acute and community hospitals can take place every day of the week.	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	
Care Bill Implementation	BC03	46,955	Supporting the system change's associated with the implementation of the Care Bill	✔				✔							
Integrated reablement	BC04	500,000	The Integrated Re-ablement Service is set to expand to widen access to individuals who may historically have been directed into the Adult Social Care pathway. The inclusion of social care staff within the integrated service will mean that those requiring Community Care Assessments have access to this as part of their re-ablement journey, thus avoiding the need for handover delays for those who require longer term care.	✔	✔			✔	✔	✔	✔	✔	✔	✔	✔
Integrated reablement and hospital discharge	BC05	209,000	As above	✔	✔			✔	✔	✔	✔	✔	✔	✔	✔
Prevention and early intervention	BC06	100,000	Low level housing related and social support, including assistance with shopping and domestic tasks, pop-in visits and a range of assistive technology enhances wellbeing and a sense of community safety amongst the older population and aims to delay or reduce the need for higher end and/or statutory services.	✔	✔			✔		✔	✔	✔	✔	✔	
Integrated care and support	BC07	2,008,000	Supporting the continuation and expansion of existing jointly commissioned and managed services through the pooling of resources, where they have historically demonstrated qualitative and quantitative benefits to Health & Social Care.	✔	✔		✔	✔	✔	✔			✔	✔	✔
Admission avoidance	BC08	208,000	Providing integrated re-ablement in care homes and extra care schemes not only maintains the independence and functioning of residents but also develops a culture of care which is based on recovery and rehabilitation rather than escalation and dependency.	✔	✔			✔	✔	✔	✔	✔	✔	✔	✔
Hospital discharge	BC09	341,648	Bespoke units of step down accommodation facilitate timely discharge for patients who, following illness or surgery are unable to return home immediately. This may be due to the unsuitability of their accommodation in terms of access for therapy input and/or equipment.	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	
Disabled Facilities Grant	BC10	552,000	Mandatory Disabled Facilities Grants (DFGs) are available from local authorities, subject to a means test, for essential adaptations to give disabled people better access to essential facilities within the home. The legislation governing DFGs in England and Wales is the 1996 Housing Grants, Construction and Regeneration Act.	✔	✔		✔	✔		✔	✔		✔	✔	

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BCF Investment	Project Ref	2015/16 spend (Minimum) £	Description	National Conditions						Outcomes and Metrics					
		Recurrent		Develop and agree a joint Better Care plan	Protection for social care services (not spending)	Support the development of 7-day services	Better data sharing between health and social care, based on the NHS number	Where funding is used for integrated packages of care, there is an accountable lead professional	Engage with all providers likely to be affected by the use of the fund	Admissions to residential and care homes	Effectiveness of reablement	Delayed transfers of care	Avoidable emergency admissions	Patient / service user experience	Local Metric
Social care capital	BC11	406,000	Capital funding to contribute towards social care community projects	✔	✔			✔		✔	✔		✔	✔	
Support for carers	BC12	234,000	Support those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages	✔				✔		✔	✔		✔	✔	
Social Care Pathway Redesign	BC13	2,000,000	The project aims to deliver an integrated adult social care pathway which places greater emphasis on prevention, early intervention & rehabilitation, thus reducing and/or delaying the need for more complex health and social care interventions.	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Mental Health Reablement	BC14	100,000	Providing a 3-bedded Adult of working age pre-crisis/respite facility to be run by Sirona Care and Health in conjunction with their Mental Health reablement (only one of two in the country) and Community Support services to enhance early intervention.	✔	✔		✔		✔		✔		✔	✔	✔
Increased capacity in the Approved Mental Health Practitioner Service & DOLS	BC15	150,000	Over the last three years there has been an annual increase of approximately 30% in the total numbers of Mental Health Act assessments completed in B&NES. The increase in the number of assessments completed locally reflects the national picture. Increasing the AMHP Service will have a positive impact on the Councils duty to fulfil its requirements. There has also been a 27:1 increase in DOLS applications; this will enable the duty to be fulfilled for hospital and care homes.	✔	✔	✔	✔	✔		✔			✔		
Increased capacity in the Learning Disabilities Social Work Service	BC16	168,000	Post Winterbourne View, and in line with national requirements, a more rigorous framework for placement reviews, particularly for people with challenging behaviour and/or complex needs is required. To deliver these outcomes provider investment in the LD service covering safeguarding and reviews will help meet statutory requirements.	✔	✔			✔	✔	✔			✔	✔	
Adult Social Care demographic change & Preventative Services	BC17	3,000,000	Due to demographic change and the associated increase in demand, complexity and acuity of the needs being met, additional funding is required to ensure the national condition of protection for adult social care services is met. Funding will be transferred to support demand pressures on existing services, including those commissioned to meet assessed, eligible adult social care need, ensuring successful client outcomes will be achieved.	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔
Community Cluster Model	BC18		The overarching aim of the new model is to deliver integrated community teams which are aligned to the five practice clusters in BaNES in order to respond in a sustainable way to the increasing volume, complexity and acuity of older people.	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔
Social Prescribing	BC19	100,000	Social Prescribing to enable clinicians and health workers redirect suitable patients away from the NHS and towards opportunities in their local community	✔		✔		✔						✔	✔
Total		**12,049,000**													

SCHEDULE 2 – GOVERNANCE

1 Joint Commissioning Committee

1.1 The terms of reference of the Joint Commissioning Committee is as followings:

JOINT COMMISSIONING COMMITTEE

NHS Bath and North East Somerset

Clinical Commissioning Group

Terms of Reference

1 Introduction

The Joint Commissioning Committee is established in accordance with NHS Bath and North East Somerset Clinical Commissioning Group's Constitution, Standing Orders and Scheme of Reservation and Delegation, Bath & North East Somerset Council's Scheme of Delegations and the Joint Working Framework Agreement.

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the NHS Bath and North East Somerset CCG's Constitution and Standing Orders and Bath & North East Somerset Council's Scheme of Delegations.

The Committee is authorised by the CCG Governing Body and Bath & North East Somerset Council to act within its terms of reference. All Members and employees of the NHS Bath and North East Somerset CCG and relevant officers of Bath & North East Somerset Council are directed to co-operate with any request made by the Committee.

2 Membership

2.1 The Committee shall be appointed by both parties to the joint working arrangements as set out in the Group(s) Constitution and may include individuals who are not on the Governing Bodies.

2.2 The Chair and Vice Chair of the Group will rotate every 6 months between the NHS Bath and North East Somerset CCG Accountable Officer and the Bath & North East Somerset Council Strategic Director for People and Communities.

2.3 The core membership of the Committee (the "core membership") shall consist of:

2.3.1 NHS Bath and North East Somerset CCG Accountable Officer

2.3.2 NHS Bath and North East Somerset CCG Chief Financial Officer

2.3.3 NHS Bath and North East Somerset CCG Director of Commissioning and Service Transformation

2.3.4 Bath and North East Somerset CCG Medical Director

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2.3.5 Bath and North East Somerset CCG Director of Nursing

2.3.6 Bath & North East Somerset Council Strategic Director for People and Communities

2.3.7 Bath & North East Somerset Council Deputy Director, Adult Care, Health & Housing Strategy & Commissioning

2.3.8 Bath & North East Somerset Council Deputy Director for Children & Young People, Strategy & Commissioning

2.3.9 Bath & North East Somerset Council Director of Public Health

2.3.10 Bath & North East Somerset Council Finance Manager (People and Communities

2.3.11 In attendance:
Bath & North East Somerset Council and Bath and North East Somerset CCG Strategic Finance Business Partner, Joint Commissioning

2.4 Clinical Membership:
CCG GP Cluster leads may be invited to attend when significant decisions affecting clinical services are required

2.5 Non-Core membership:
In addition, other members of staff from the CCG, Bath & North East Somerset Council and the Commissioning Support Unit (CSU) may be asked to attend meetings to support the business being discussed.

3 Secretary

3.1 The Secretary shall record the minutes of all meetings of the Committee and be provided by the CCG.

4 Quorum

4.1 A quorum shall be:

Joint business service agenda:	Two members of the CCG and two members of the Council
CCG business service agenda:	Three members of the CCG and two members of the Council
Council business service agenda:	Three members of the Council and two members of the CCG
CCG Clinical Service agenda:	Three members of the CCG one of whom shall be clinical as per 2.4 and two members of the Council

5 Frequency of meetings

5.1 Meetings shall be held monthly.

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6 Remit and responsibilities of the Committee

6.1 The Committee shall through its joint business service agenda:

6.1.1 Develop the overarching vision and development of further joint working between the CCG and Council and make recommendations to the CCG Board and Council Cabinet/relevant Cabinet Member(s).

6.1.2 Review joint service strategies, plans and performance and risk across the partnership.

6.1.3 Review savings and delivery plans by both organisations to ensure a shared understanding, to agree areas for an integrated approach and to mitigate against any negative impacts.

6.1.4 Develop integrated commissioning e.g. through exploring further options for pooled budgets and sharing of commissioning support functions.

6.1.5 Provide a forum for delegated decision-making on specific commission and/or oversight of decisions being recommended to other decision-making bodies.

6.1.6 Recommend to the Governing Body and Council Cabinet/Cabinet Member(s), the strategic, business and financial plan for the CCG and Council taking into account the input of the committees and the Clusters;

6.1.7 Ensure that both parties are aware of and complies with their legal and statutory obligations, and operates in a safe and legally compliant manner, taking appropriate professional advice where necessary;

6.1.8 The management of day to day risks and issues are the responsibility of the individual organisations. Matters of significance to the partnership arrangements will be discussed by this group, which will report to the CCG Board and the Joint Oversight Committee for joint working and Health & Wellbeing Board as appropriate;

6.1.9 Delegate responsibility for identifying, securing and aligning the necessary resources needed to deliver the strategic objectives of the CCG, Council and the partnership, including:

(a) building and maintaining flexible teams;

(b) resourcing different streams of work differently and flexibly;

(c) drawing on the range of different skills and resources available to the Group, including Commissioning Support Services;

(d) negotiating, entering into and managing contracts with third parties for the Group;

6.1.10 Recommending to the Governing Body and Council Cabinet/Cabinet Member(s) a financial strategy to include any risk sharing or management arrangements;

6.1.11 Monitoring provider contract performance, QIPP plans and overall use of resources, including recommending to the Governing Body QIPP business cases for approval and release of reserves;

6.1.12 Monitoring financial performance in relation to key national targets and the NHS Outcomes Framework and Council performance monitoring regimes as they relate to the partnership.

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6.1.13 Oversee effective delivery of commissioning support services to the CCG. The day to day responsibility sits with the CCG Executive Group.

6.1.14 Manage and co-ordinate the overall communication and consultation process for the CCG and Council's health and social care commissioning activities.

6.1.15 Be responsible for the organisational development of the CCG and the Council's partnership arrangements, identifying and implementing opportunities for further integration.

6.1.16 Ensure that the Governing Body and Council Cabinet/Cabinet Member(s) are well supported in their work

The Committee shall through its clinical service agenda:

6.1.17 lead the development of primary care strategy

6.1.18 monitor Cluster performance against their duties and responsibilities as Members of the Group and identify potential areas for development support;

6.1.19 be responsible for the operational delivery of agreed strategy, including strategic commissioning intentions, translating the clinical and innovation strategy determined by the Governing Body and Cabinet;

7 Sub Committees

The committee is authorised to establish sub committees and short life groups as appropriate to deliver the responsibilities detailed above.

8 Accountability and decision making powers

The Group shall in accordance with its respective Standing Orders and Scheme of Reservation and Delegation:

8.1 Report on its decisions and recommendations, where appropriate, to the CCG Governing Body and Cabinet/Cabinet Member(s). The submission to the CCG Governing Body shall include details of any matters in respect of which actions or improvements are needed.

8.2 The Committee will report annually to the CCG Governing Body and the Joint Oversight Committee in respect of the fulfilment of its functions in connection with these terms of reference.

8.3 The CCG's annual report shall include a section describing the work of the Joint Commissioning Committee in discharging its responsibilities.

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9 Policy and best practice

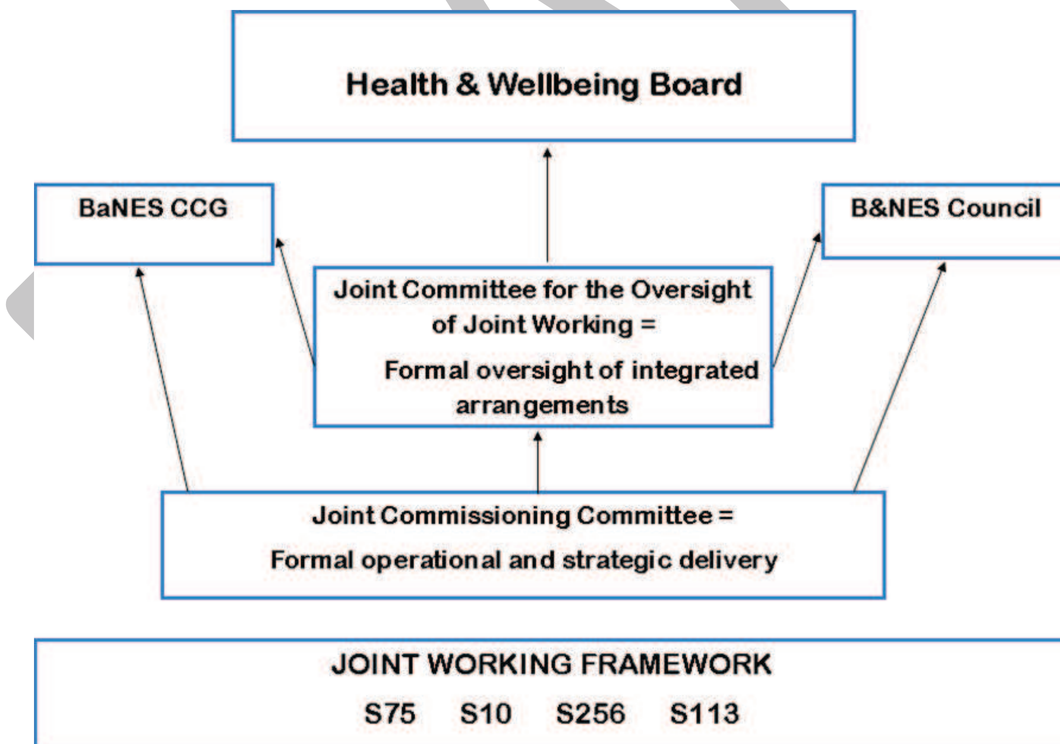
9.1 The Committee is authorised by the Governing Body and Council Scheme of Delegations instruct professional advisors and request the attendance of individuals and authorities from outside the Group with relevant experience and expertise if it considers this necessary for or expedient to the exercise its functions.

9.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

10 Conduct of the Committee

The terms of reference of the Committee shall be reviewed by the Governing Body and Council Officers in accordance with the Council's Scheme of Delegations at least annually. Minor changes to the terms of reference can be made without a full update of the CCG Constitution.

The diagram below shows the joint governance structure with reporting to both B&NES Council and CCG.



SCHEDULE 3– RISK SHARE AND OVERSPENDS

1 To the extent that the pay for performance element of the Better Care fund is not available to the Pooled fund the partners have agreed :-

Both CCG and Council may wish to continue funding Better Care Fund schemes in the event of not achieving the emergency admissions targets.

The basis for funding scheme cost pressures as a result of no pay for performance transfer is as follows:

If there are non-committed funds from within the pooled fund these will be earmarked to mitigate the reduction in pay for performance funding transfer.

Scheme reductions will be considered with a review of the performance and outcomes of schemes with the view to reduce funding or stop investing in schemes that are not achieving their intended outcomes.

Where the non-achievement of the emergency admissions targets has created a CCG cost pressure in funding acute activity the CCG will fund 100% of the first £250k of over activity from its planned contingency for over performance above planned levels in non-elective admissions. This will allow the pay for performance funding to transfer to the Council to fund BCF schemes.

In the event that the CCG's £250k planned contingency for over performance is fully committed against non-achievement of emergency admission reductions the Council and CCG will each bear 50% of the BCF pay for performance cost pressure arising from under performance of the emergency admissions target.

In the event that the CCG's total planned contingency has to be fully utilised to fund wider system pressures the CCG's Chief Finance Officer and Councils Chief Finance Officer will hold the right to review the outlined risk share arrangement and agree how to fund cost pressures from the non-delivery of emergency admissions.

<u>Overspend</u>

The financial treatment of overspends has been outlined in Schedule 1 under Finance Governance Arrangements, the additional actions below act as guidelines when considering overspends:

(a) The Joint Commissioning Committee shall consider what action to take in respect of any actual or potential Overspends

(b) The Joint Commissioning Committee shall acting reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends which may include the following:

(c) whether there is any action that can be taken in order to contain expenditure;

(d) whether there are any underspends that can be vired from any other fund maintained under this Agreement;

(e) how any Overspend shall be apportioned between the Partners, such apportionment to be just and equitable taking into consideration all relevant factors.

(f) The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends.

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(g) Subject to any continuing obligations under any Service Contract entered into by either Partner, either Partner may give notice to terminate a Service of Individual Scheme where the Scheme Specification provides and where the Service does not form part of the Better Care Fund Plan.

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SCHEDULE 4 – PERFORMANCE ARRANGMENTS

Individual Better Care Fund schemes listed in the plan identify key performance indicators to be applied to each scheme. For all BCF schemes that will be incorporated into contract performance management arrangements with the providers who are delivering the schemes.

In line with the Finance reporting arrangements outlined in schedule 1 BCF performance will be reported through a monthly performance dashboard and taken to the Joint Commissioning Committee for review. This dashboard will focus on the delivery against the national metrics forecast as part of the BCF submission. The metrics are as follows, with details on the forecast and relationship to BCF schemes in the table below:

- Total Emergency Admissions
- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed transfers of care from hospital per 100,000 population
- Patient / Service user experience
- Local Measure

Metric	Definition	% forecast change 14/15	% forecast change 15/16	How will schemes contribute to this?
Non Elective Admissions	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	-0.3%	-1.9%	•The key schemes that will drive the 2015/16 change are all aimed at the frail elderly : The Social Care Pathway Re-design (scheme 6) will assess and provide packages to service users more quickly, the Community Cluster Model (scheme 17) will focus on patients / service users already in poor health and pull together health and care services to specifically focus on keeping the patients / service users well enough to stay out of hospital. •Other schemes will also act as enablers but are not expected to have additional direct impacts. • Enabling schemes include: Extended Hours Services (scheme 1), Hospital Discharge - Handyperson, Step Down and Intensive Home from Hospital (scheme 2), Older People's Independent Living Service (scheme 3), Integrated Re-ablement & Rehabilitation (scheme 4), Rural Support Scheme (scheme 5), Integrated Care & Support (scheme 8), Mental Health Re-ablement Beds (scheme 12)
Residential admissions	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	-3.9%	-8.2%	• The Extended Hours Services (scheme 1) are expected to save 10% on the June 2014 rate of 11, an additional 1.1 admissions per month (for 6 months in 2014/15 and full year 2015/16). • In 2014/15 Integrated Re-ablement & Rehabilitation (scheme 4) is also expected to save 10% on the June 2014 rate of 11, an additional 1.1 admissions per month (for 6 months in 2014/15 and full year 2015/16). • There is an assumption there is no overlap between these savings and that other contributing schemes would significantly overlap with these schemes. • Enabling schemes include Hospital Discharge - Handyperson, Step Down and Intensive Home from Hospital (scheme 2), Older People's Independent Living Service (scheme 3), Rural Support Scheme (scheme 5), Social Care Pathway Re-design (scheme 6), Mental Health Re-ablement Beds (scheme 12), Increased Capacity in the Learning Disabilities Social Work Service (scheme 13), The Community Cluster Model (scheme 17). NB. The metrics use the figures rounded down.

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Metric	Definition	% forecast change 14/15	% forecast change 15/16	How will schemes contribute to this?
Delayed transfers of care	Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	14.6%	-13.5%	At this time specific impacts have not been quantified for the individual schemes but the strongest drivers will be: • The Extended Hours Services (scheme 1) will move services to 7 days with extended hours. • The Hospital Discharge - Handyperson, Step Down and Intensive Home from Hospital service (scheme 2). • Integrated Re-ablement & Rehabilitation service (scheme 4). • Social Care Pathway Re-design (scheme 6) and Protection of Social Care (scheme 9). • Enabling schemes include Hospital Discharge - Handyperson, Step Down and Intensive Home from Hospital (scheme 2), Older People's Independent Living Service (scheme 3), Rural Support Scheme (scheme 5), Integrated Care & Support (scheme 8), Increased Capacity in the Learning Disabilities Social Work Service (scheme 13)
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	0.9%	0.8%	This metric relates directly to the Integrated Re-ablement & Rehabilitation service (scheme 4) and the Extended Hours Services (scheme 1) . It will supported by a range of enabling services including: • The Hospital Discharge - Handyperson, Step Down and Intensive Home from Hospital service (scheme 2). • Social Care Pathway Re-design (scheme 6) and Protection of Social Care (scheme 9). • The Community Cluster Model (scheme 17)
Patient/Service User Experience metrics	I am extremely satisfied' or 'I am very satisfied' or 'I am very happy with the way staff help me, it's really good' ASCOF 3A measure but for over 65s only	1.4%	2.0%	This survey is sent to random sample of everyone receiving support in the year from the adult social care service including almost all the schemes within the Better Care Fund.
Local metric	Proportion of high risk people being case managed via Intensive Community Support and Intensive Community Tracking (Community Cluster teams) with an integrated personalised care plan and lead accountable professional. Snapshot at period end.	5.8%	5.5%	The Community Cluster Model (scheme 17)

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SCHEDULE 5 – BETTER CARE FUND PLAN

The Bath and North East Somerset Council / CCG Better Care Fund plan can be found here:

http://www.england.nhs.uk/wp-content/uploads/2014/12/bcf-bath-prt1.pdf

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SCHEDULE 6 – POLICY FOR THE MANAGEMENT OF CONFLCITS OF INTEREST

NHS England has provided statutory guidance for CCGs titled 'Managing conflicts of interest: statutory guidance for CCGs', last updated Dec 2014.

It sets out how CCGs should manage conflicts of interest. It contains specific provisions in relation to co-commissioning primary care services but the guidance is relevant to CCG responsibilities generally. The guidance applies equally to jointly commissioned services.

The guidance is available at this link – http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf

Conflicts of interest arising for the Better Care Fund will be managed in line with this guidance.

The Bath and North East Somerset Council policy on Conflicts of Interest is:

It is important that all potential conflicts of interests are properly identified and recorded and that a record of appropriate action taken is made. This will assist in maintaining public confidence and assist in achieving the Council's commitment to tackle fraud and corruption within or external to the organisation.

It is the responsibility of the Council to ensure that all staff are made aware of their duties and responsibilities arising from Section 117 of the Local Government Act 1972.

This requires individuals to declare any financial interest, whether direct or indirect, in any existing or proposed contract.

The Council's Employee Code of Conduct states that:

- Employees must declare to the Chief Executive or their Director any financial or non-financial interests that they consider could conflict with the Council's interests (e.g. Chair of a voluntary group receiving financial assistance from the Council)

- Employees should declare to the Chief Executive or their Director membership of any organisation not open to the public without formal membership and commitment of allegiance and which has secrecy about rules or membership or conduct.

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SCHEDULE 7 – INFORMATION GOVERNANCE PROTOCOL

The CCG and Council have a corporate governance structure that ensures the principles of the Data Protection Act are adhered.
Both organisations submit a self-assessment using the NHS Information Governance Toolkit and so ensure that staff training and awareness of Information Governance issues pervade throughout each organisation and jointly commissioned areas.

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