Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

Bath and North East Somerset Health & Wellbeing Board

Democratic Services Lewis House, Manvers Street, Bath, BA1 1JG	Direct Line:	01225 394414
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	Date:	4 October 2016

To: All Members of the Health & Wellbeing Board

Members: Dr Ian Orpen (Member of the Clinical Commissioning Group), Councillor Vic Pritchard (Bath & North East Somerset Council), Ashley Ayre (Bath & North East Somerset Council), Mike Bowden (Bath & North East Somerset Council), Tracey Cox (Clinical Commissioning Group), Morgan Daly (Healthwatch Manager: B&NES and Somerset), Debra Elliott (NHS England), Councillor Michael Evans (Bath & North East Somerset Council), Diana Hall Hall (Healthwatch representative), John Holden (Clinical Commissioning Group lay member), Bruce Laurence (Bath & North East Somerset Council), Councillor Tim Warren (Bath & North East Somerset Council),

Non-voting member

Observers: Councillors Tim Ball and Eleanor Jackson

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, 12th October, 2016** at **10.30 am** in the **Brunswick Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Marie Todd
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 Marie Todd who is available by telephoning Bath 01225 394414 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 Marie Todd 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, 12th October, 2016
Brunswick Room - Guildhall, Bath
10.30 am - 12.30 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. MINUTES OF PREVIOUS MEETING - 7 SEPTEMBER 2016 (PAGES 7 - 14)

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

6. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

7. SUSTAINABILITY AND TRANSFORMATION PLAN (STP) BRIEFING (PAGES 15 - 20) — James Scott

   The report outlines the progress made since the programme was established in April 2016 and next steps towards delivering both the next phase of the plan development and commencement of the system-wide transformation work to be outlined within it.

   The Board is asked to note the report, and consider how best the Health and Wellbeing Board can further support the development of the Sustainability and Transformation Plan.

8. DEMENTIA FRIENDLY COMMUNITIES (PAGES 21 - 22) — Becky Reynolds

   Organisations on the Board are asked to become members of the B&NES Dementia Action Alliance, thus signing up to becoming dementia friendly organisations.

9. BANES HEALTH PROTECTION BOARD ANNUAL REPORT 2015-16 (PAGES 23 - 70) — Becky Reynolds

The annual report documents the progress made by the Health Protection Board on the priorities and recommendations made in the 2014-15 report; highlights the key areas of work that have taken place in 2015-16 and identifies priorities for the next 12 months.

10. ANNUAL DIRECTOR OF PUBLIC HEALTH REPORT: GET FRESH - HEALTH AND WELLBEING IN BATH AND NORTH EAST SOMERSET (PAGES 71 - 88) — Bruce Laurence

The annual Director of Public Health (DPH) report is an independent report from the DPH on the state of public health in the area. The report seeks to highlight the biggest public health priorities for the area and demonstrate some of the work that is happening to address those priorities. The Health and Wellbeing Board is asked to note and endorse the report.

11. CLOSING REMARKS/TWITTER QUESTIONS

The Committee Administrator for this meeting is Marie Todd who can be contacted by telephoning Bath 01225 394414

Bath and North East Somerset Council | **Bath and North East Somerset CCG**

HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 7th September, 2016, 10.30 am

Councillor Vic Pritchard (Chair)	Bath & North East Somerset Council
Dr Ian Orpen	Member of the Clinical Commissioning Group
Ashley Ayre	Bath & North East Somerset Council
Mike Bowden	Bath & North East Somerset Council
Tracey Cox	Clinical Commissioning Group
Councillor Michael Evans	Bath & North East Somerset Council
Diana Hall Hall	Healthwatch representative
John Holden	Clinical Commissioning Group lay member
Bruce Laurence	Bath & North East Somerset Council
Councillor Tim Warren	Bath & North East Somerset Council
Councillor Tim Ball	Bath & North East Somerset Council (Observer)

13 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting. He welcomed, in particular, Ashley Ayre attending in his new role as Chief Executive and Mike Bowden, attending in his new role as Strategic Director, People and Communities.

14 EMERGENCY EVACUATION PROCEDURE

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

15 APOLOGIES FOR ABSENCE

Apologies for absence were received from Rob Gibbs, GMB and Councillor Eleanor Jackson (Observer).

16 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

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

There was no urgent business.

18 **PUBLIC QUESTIONS/COMMENTS**

There were no public questions or comments.

19 **MINUTES OF PREVIOUS MEETING - 8 JUNE 2016**

The minutes of the previous meeting were approved as a correct record and signed by the Chair subject to the following amendment:

Minute 1, line 1 “Councillor” Ian Orpen be amended to read “Dr” Ian Orpen.

20 **HEALTH INEQUALITIES INQUIRY DAY**

Paul Scott and Becky Reynolds presented feedback on the Health Inequalities Inquiry Day which had taken place on 11 May 2016.

- The event had focussed largely around the findings from the 2010 review of effective action to tackle health inequalities in England led by Professor Sir Michael Marmot.
- There had been good feedback from the day. People had enjoyed the opportunity to work across different service areas. They had also been very positive about hearing experiences from a local GP and local service users.
- There was excellent feedback about the workshop format from attendees.
- Concrete outcomes from the day were felt to be important.
- Some people had completed pledge cards and these would be followed up in six months’ time to find out if actions had been carried out.

The event had involved six Marmot evidence based themed workshops and the following priorities had been identified by participants:

- Pregnancy and Early Years – it was important for agencies to join up children and adult services and also to strengthen emotional health and wellbeing. Wiltshire currently used a tool to assist with improving emotional health and wellbeing and this would be investigated for the BANES area.

- Education and Life-Long Learning – Children receiving free school meals were much less likely to be “school ready” in their first primary school year. It was also considered to be important to encourage uptake of free nursery provision available for two year olds from disadvantaged circumstances.

- Fair Employment – It was important for BANES and its partners to agree the definition of a quality job and to work with public sector partners to use combined leverage to create and monitor delivery of quality jobs.

- Healthy and Sustainable Communities – The availability of affordable housing in the BANES area was an issue for many people.

- Ill-Health Prevention – There was a need to improve access to transport in the area especially in rural locations. A transport review was suggested along with improved co-ordination of transport services. It was also important to be more creative about accessing funding schemes through outside agencies.

- Inequality in Access to Health Services – An asset based community approach was required taking into account the strengths of the local population. The difficulties of seeing a GP were acknowledged and it would be advantageous to view GP practices as a hub providing a range of different services.

The following other issues were also identified on the day:

- Having a shared vision to reduce inequalities across all services and organisations.
- Better join-up between different agencies.
- More proactive and tailored support.
- Building on strengths and assets within communities.
- Making every contact count.
- Employers working together.

Dr Orpen stated that he had found the day inspiring with a great deal of energy in the room. Health inequalities were a very important area and this was everyone's responsibility. The role of the Health and Wellbeing Board was being reviewed and its strategy being defined more clearly. Health prevention was an important role for the Board. He felt that update reports on this issue should be brought back to the Board in six, rather than twelve, months' time.

Tracey Cox stated that it was very important to set out actions to address health inequalities. She was currently providing information for the health commissioners and was happy to facilitate any cross-referencing as required.

In response to a question from Councillor Tim Ball officers confirmed that wider attendance would be helpful for any future sessions.

Councillor Tim Warren welcomed the work that had taken place and stressed the importance of building on this. He suggested that a report could be taken to the Public Services Board to update its members on the Inquiry Day.

Bruce Laurence noted that the Inquiry Day had ranged from a very strategic level to hearing individual experiences. He informed the Board that Universities were very interested in the issue of health inequalities and the work that had been carried out. It would be important to challenge agencies to consider their role in addressing the issues raised.

Morgan Daly stated that Healthwatch could encourage commitment to this work. In the medium and long term it would be important to assess progress against the

strategy. He felt that the outcomes from the day were an excellent piece of work.

Mike Bowden stated that ownership of the issues raised could be shared with the commissioners.

Councillor Vic Pritchard commended the work undertaken and the enthusiasm generated from the Inquiry Day and stressed the need to ensure that outcomes were monitored.

It was **RESOLVED:**

(1) To note the work undertaken on health inequalities.

(2) To challenge partners on the Health and Wellbeing Board, and partnerships reporting to the Board, to demonstrate explicit plans and actions for the identification of and reduction in health inequalities amongst their client groups.

(3) To receive a report in 6 months' time on progress since the inquiry day.

(4) To receive an update in 6 months' time from the Public Services Board on their work to address local health inequalities.

21 YOUR CARE YOUR WAY UPDATE

The Board received a presentation from Sue Blackman, Project Lead, regarding Your Care Your Way. The presentation covered the following issues:

- On 18 August 2016 the preferred bidder to provide community services within BANES was announced as Virgin Care. This decision had been made on the basis of a number of assessments by both professionals and community champions.

- The following issues had been taken into account during the assessment:
    - Services
    - Payment
    - Quality
    - Reporting and Information
    - Contract Management
    - Governance
    - Capability

- The contract is a standard NHS contract.

- The capability of the bidders had been tested, CQC reports had been examined and financial viability had also been investigated.

- The preferred bidder stage structure consisted of 6 workstreams as follows:
    - Commissioning
    - Communication
    - Workforce

    - Estates
    - Finance
    - Information Management and Technology

- The key messages from the Virgin Care bid were leadership, ability to drive transformational change, co-design of services and a valued workforce. The bid demonstrated a joined-up approach to care and prevention, plans to develop multi-disciplinary teams, single care and support plans and self-management. There were also plans to use village agents in rural areas with a care co-ordination centre as a single point of access.

- The Virgin Care bid demonstrated that in areas where they are running services their workforce had felt valued and the company had a track record of managing transition well, engaging volunteers and using technology to provide an integrated care record. They had clear strategies for the adoption of assistive technologies.

A high level road map had been produced and this was circulated to the Board members.

- The service model proposed by Virgin Care identified key contributions to delivering the priorities that people have said are important to them:
    - Provide more joined up care
    - Consider the whole person
    - Focus on prevention
    - Reduce social isolation
    - Build community capacity
    - Guide people through the system
    - Value the workforce and volunteers
    - Share information more effectively
    - Embrace new technology

- Key dates for the project were:
    - 9 September 2016 – Working assumptions around scope of the prime provider to be released.
    - 25 October 2016 – Preferred bidder stage completed.
    - 10 November 2016 – Full business case to governing bodies

- The mobilisation stage would then take place from November 2016 to April 2017.

- Some indications around the transformation roadmap included:
    - Year 1 - consultation and co-design.
    - Year 2 - mobile working and launch of innovation fund
    - Year 3 – move to paperless working practices

- There would also be an innovation fund which services could bid for.

Members of the Board then asked questions regarding the bid and the contract as follows:

- Is this privatisation of the community care service? Virgin Care is a limited company providing services in the same way that other independent providers provide NHS services. The best service and most capable provider were required that reflected the vision outlined in the specification. There is a proposed cap on management costs and due diligence had confirmed Virgin Care to be compliant with UK tax requirements. As part of the contract any surplus generated would have to be reinvested back into the community.
- What would happen to the existing staff? Where appropriate frontline staff would transfer to Virgin Care but the details were still being worked through at this early stage in the process.
- Will there be any cuts to budgets or services? Will there be an impact on existing service providers? The bids had been assessed on the basis of who would provide services most effectively and efficiently. Virgin Care had demonstrated a clear stratification approach to ensure that the effectiveness of services can be accurately assessed and that funding is directed to the appropriate pathways of care. Cuts to the services were not expected although it was recognised that there are some overlaps with current provision and these are expected to be addressed as part of the transformation. There would be challenges due to the nature of transformational change. It should also be noted that there is an expectation to look at the whole system including secondary care and determine how funding can be most effectively utilised.
- Is a 3 year transition period too long a timescale? There has to be a balance. About 20 services need to safely transition and this must take place at a comfortable pace for staff and the business. It was important not to destabilise the existing health economy.

Morgan Daly and Diana Hall Hall from Healthwatch hoped that their organisation would continue to be used in the future. Healthwatch had some concerns around smaller providers and voluntary sector organisations. Some members of the public also had significant concerns about the forthcoming changes. Healthwatch would be interested to hear from anyone who has concerns and would provide feedback to the Board in due course.

Tracey Cox stressed that the 2 year process was not solely about Virgin Care and that it would be important for all those involved in healthcare provision to continue to bear in mind the 9 strategic themes that have been agreed.

Bruce Laurence stated that the approach to recommissioning had been very thorough.

Dr Ian Orpen noted the very detailed approach and the excellent link-up with the Health and Wellbeing Board. He acknowledged that there was some public anxiety about the planned changes.

Councillor Tim Warren asked whether the roadmap could be made available to all Councillors and the public. Sue Blackman stated that she would look into this.

***(Note:** The roadmap referred to within the Your Care Your Way presentation will be updated during due diligence and used to carry out roadshows with the public and staff and stakeholders. It will therefore be released as soon as due diligence has*

been completed).

The Health and Wellbeing Board commended Sue Blackman and her team and also Jane Shayler and her team on the excellent work they had carried out on this project.

RESOLVED: To note the update.

22 LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2015-16 AND BUSINESS PLAN 2015-18

Reg Pengelly, Independent Chair of the BANES Local Safeguarding Children's Board (LSCB) presented its Annual Report and Business Plan. He explained that the LSCB was a statutory body which was not accountable to any particular group. He explained that a 360 degree feedback system to feed back on the performance of the Independent Chair with an annual multi-agency "Challenge and Review" Panel was now in place. It was noted that the LSCB was supported by a number of sub-groups who carried out a great deal of work and Mr Pengelly congratulated these groups and thanked them for their support.

The following issues from the report were highlighted:

- A multi-agency safeguarding hub would be set up to provide more robust handling of issues and more effective risk assessment.
- Mr Pengelly was also Chair of the Local Safeguarding Adults Board which strengthened the link between the two bodies. A pilot training group had been established to provide training for both groups.
- A schools audit had been carried out to find out how effective safeguarding processes were in local schools. Every school in the BANES area had responded and advice from the LSCB had been provided where necessary. LSCB members had also visited some schools. The aim was to repeat this exercise and to build on it in future years.
- There was a large amount of data in the report. A sub-group of the LCSB audited routine cases and outcomes. The Board aspired to strengthen this data in the future.
- There had been an increase in children with child protection plans. Figures tend to fluctuate year on year and the Board would continue to monitor these figures. 149 children were currently "looked after" in BANES and this was consistent with national figures.
- No serious case reviews had taken place this year. Some local reviews had taken place.
- A fundamental review of the role and functions of LCSBs had been carried out by Alan Wood. The Government has now published a brief response to this and it may result in changes to the way serious case reviews are carried out. There would be a meeting in October to discuss future changes to the LSCB structure.
- Mr Pengelly paid tribute to those member agencies such as the Health and Wellbeing Board who had not withdrawn funds or staff in spite of their own funding pressures.
- With the disbandment of the Children's Trust Board it would be helpful to establish a system of mutual challenge with the Health and Wellbeing Board.

The Board then asked questions as follows:

- Are there any particular emerging themes that threaten children's safety? Mr Pengelly responded that one of the main issues was child sexual exploitation although the main risks to children were from within their own families.
- In response to a question from John Holden it was confirmed that in future the executive summary of the report would be printed at the front of the document.
- How is the LSCB addressing Autistic Spectrum Disorder (ASD)? There was work taking place under the CAMHS transformation plan, some work with schools was being carried out and the CCG transformation fund was also involved with this issue.

Dr Ian Orpen supported the idea of multi-agency safeguarding hubs and noted that any resulting training would require some time commitment.

Ashley Ayre explained that OFSTED dictated a good deal of the report content and noted that it covered a huge range of work. He pointed out that often the longer a child had a child protection plan in place the less effective the outcomes were and noted that schools also tracked child protection plans. He commended the work undertaken by Reg Pengelly and Lesley Hutchinson in order to produce this report.

Councillor Vic Pritchard summed up the debate by highlighting the good work carried out by the LSCB and commended its aspiration to obtain an excellent rating.

RESOLVED to note the report.

The meeting ended at 12.10 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	**12/10/2016**
TYPE	**An open public item**

Report summary table	
Report title	Sustainability & Transformation Plan (STP) Briefing
Report author	James Scott, Senior Responsible Officer, B&NES, Swindon & Wiltshire STP
List of attachments	None
Background papers	None
Summary	The Health and Wellbeing Board is a key stakeholder in the BSW Sustainability and Transformation Plan. This briefing updates the Board on the progress of the BSW STP and enables it to comment on the merging priorities within the draft plan.
Recommendations	The Board is asked to note and comment on the briefing content.
Rationale for recommendations	None
Resource implications	None
Statutory considerations and basis for proposal	No statutory considerations applicable
Consultation	No formal consultation has been undertaken.
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.

B&NES HWB Update – September 2016

Purpose of Report

The challenges faced by the NHS and social care services over the next planning period have been well documented both nationally and locally. In early 2016 NHS England established 44 Sustainability and Transformation Plan (STP) footprints as a vehicle for developing local solutions to the key demographic, quality and financial challenges.

This report outlines the progress made since the programme was established in April 2016 and next steps towards delivering both the next phase of the plan development, and commencement of the system-wide transformation work to be outlined within it.

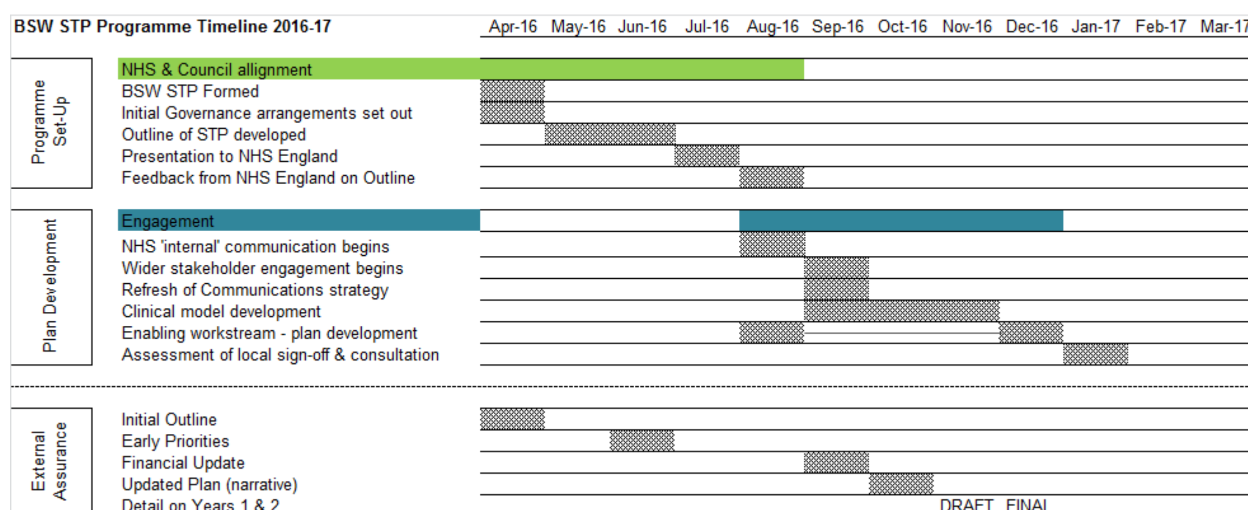
The Board is asked to note this report, and consider how best the Health and Wellbeing Board can further support the development of the STP.

Context

The STP is an NHS–led programme that aims to gain collective ownership of the challenges facing health and social care in the future. There's a firm belief that these challenges will only be overcome through working in partnership and collaboration with citizens, councils, and the voluntary sector and independent sectors.

The BSW footprint posted a near break-even position in 2015/16 (deficit of -£6m) and was therefore not required to develop a detailed and comprehensive five year plan until earlier this year.

The timeline below outlines the two initial phases of the programme in terms of setting up the programme and gaining organisational alignment across the NHS.



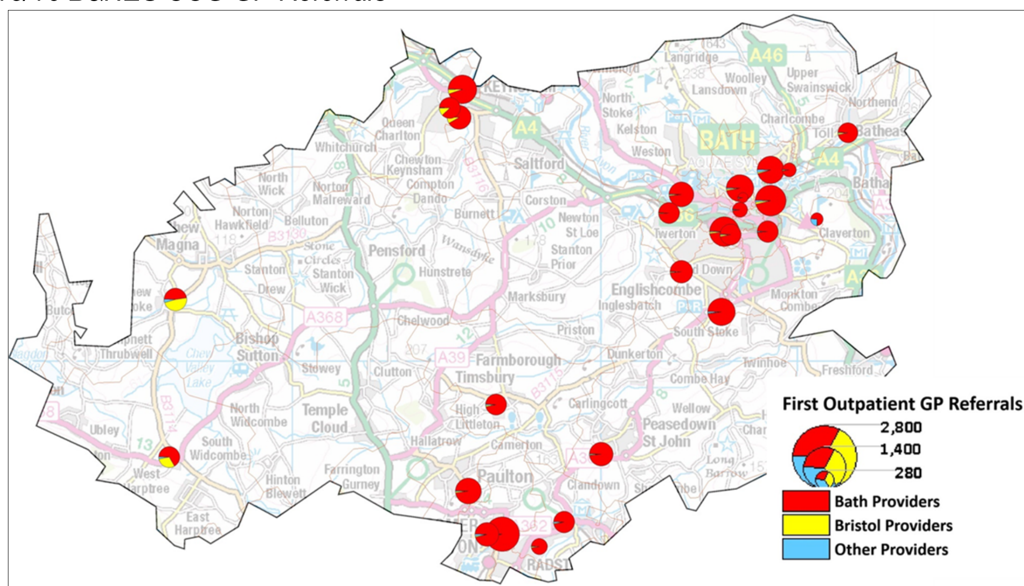
Whilst our local situation is much stronger than many other STP regions across England, our work during June confirmed that our current models of care are unaffordable due to our population levels rising, growing (proportionately) older, and the rising cost of care delivery.

If we took no action to improve how we deliver our services, the gap between the cost of providing these services and the income/funding available will be c£300m/year by 2020/21, making services unviable and impacting on quality and outcomes for patients.

It is predicted that efficiencies can be gained by bringing together all care providers to focus on the needs, and the voice, of citizens – reducing duplication, standardising pathways and ensuring that we work together to address workforce gaps across urgent and planned care pathways.

There has been some debate as to the alignment of CCGs and STP footprints. The rationale for the inclusion of B&NES within the Bath, Swindon & Wiltshire footprint is driven by patient flow and the fact that the vast majority of B&NES referred activity flows within B&NES (see map below), and the RUH catchment (and the main provider) is fairly evenly split across B&NES and Wiltshire (with only small amounts of activity in Somerset and South Glos).

Map 1: 2015/16 B&NES CCG GP Referrals



(source B&NES CCG)

Progress since June

An outline of a B&NES, Swindon and Wiltshire Sustainability and Transformation plan was shared with NHSE at the end of June 2016. That version of the Plan set out a strategic direction of travel for the footprint structured around five early priorities:

1. Create locality based integrated teams supporting primary care
2. Shift the focus of care from treatment to prevention and proactive care
3. Redefine the ways we work together to deliver better patient care
4. Establish a flexible and collaborative approach to workforce
5. Enable acute collaboration and sustainability

Following our submission the STP team met with NHSE and a variety of national bodies in July to discuss and review the plan. NHSE acknowledged that our Plan was at an embryonic stage yet fed back positively on the initial content.

Within the programme, Workstreams have been working during July and August to establish governance structures, with all workstreams having established Programme Boards and developed draft programme plans that were shared at our engagement event on the 13th September.

<u>The emerging care models</u>

The STP emerging vision is to place the citizen at the heart our health and social care system.

The STP seeks to facilitate the development of an effective and responsive integrated community service provision that can deliver the care patients need closer to home, whilst maximising their

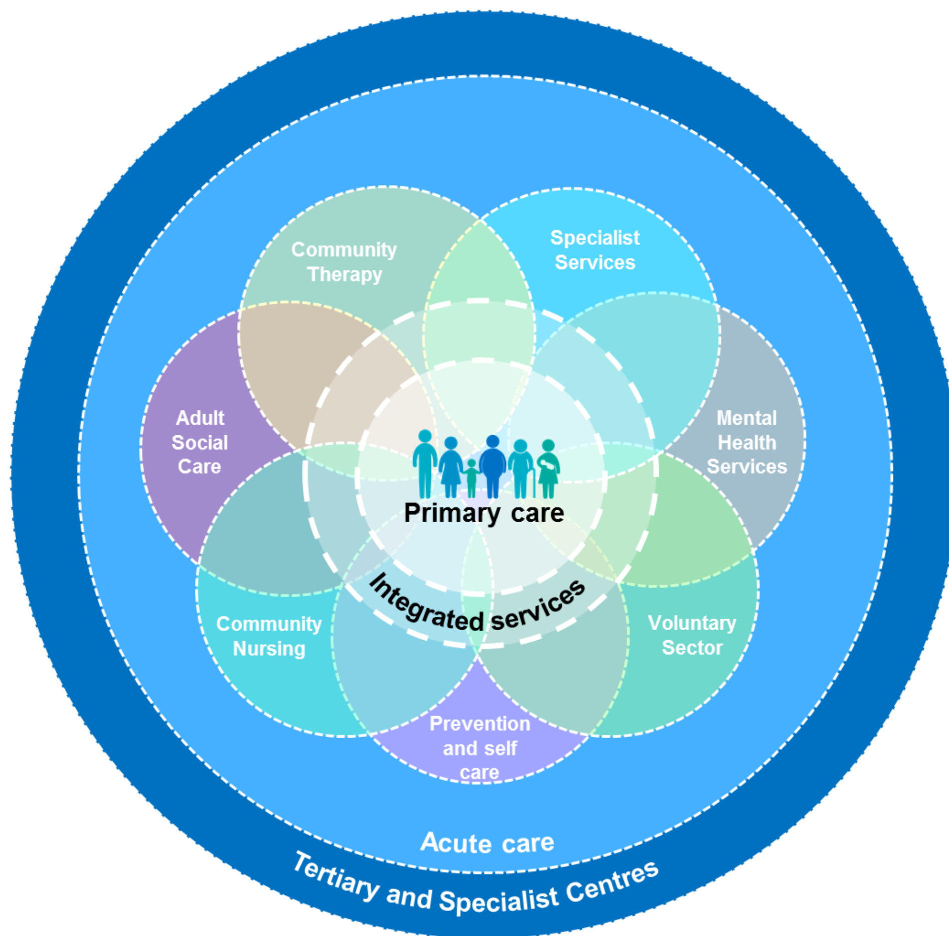
wellbeing, ability to manage their own health, and reduce the need for secondary and specialised services.

The proposed models will support earlier intervention, joined up social and health care planning, crisis management, enhanced self-care options, clearer sign posting, more tiered access to urgent care services, and clinically evidenced triage and treatment.

A key principle for the STP is to utilise and maximise the benefits of working at a footprint level whilst at all other times ensuring that services are tailored to meet the needs of local citizens. Our commitment to this way of working is articulated as 'design once; implement locally'.

Whilst the establishment of primary care cluster/federations models is being led by the CCGs in line with already established local plans and the General Practice Forward View, the STP workstreams are focusing on the following to help facilitate the creation of this integrated, wrap around community service.

A draft pictorial representation of our emerging model is set out below:



The initial priorities being assessed through the three care workstreams and three enabling workstreams are as follows:

Urgent and Emergency Care	○ Improving NHS 111 call handling – better sign posting, clinical triage. ○ Expansion of Ambulatory Care pathways, alternative care pathways to ED. ○ Expanding Geriatrician models (community / front door) – rapid assessment and reducing decompensation. ○ Mental health liaison and crisis services – supporting patients to be treated in the most appropriate settings.

Planned Care	○ Demand management – clinically appropriate thresholds, evidence based, the 'right treatment, at the right time'. ○ Reduced clinical variation, parity of access for all. ○ Outcome based ○ Capacity planning to tailor services to demand from the system as a whole, increasing flexibility. ○ Networked models – sharing best practice and resources. ○ Pre and post-operative support to enhance recovery and outcomes.
Preventative and Proactive Care	○ Tackling obesity – addressing the long term impact of unhealthy lifestyles. ○ Reducing social isolation, and improving wellbeing. ○ Frailty assessments and support to help the elderly maintain independence. ○ Self-management of long term conditions – improving confidence, reducing demand on services, and reducing patients at risk of developing co-morbidities. ○ Diabetes prevention programme
Workforce	○ Shared approach and aligned training to improve consistency. ○ Identifiable, improved, employment offer to help attract and retain the best staff. ○ Joint workforce planning – considering workforce as a whole, with organisations assessing how they can support each other in high pressure areas. ○ Staff health & wellbeing – recognition of the importance of maximising our most valuable resource
Estates	○ Maximise estate utilisation across the patch – reduce inefficiency and expenditure of existing resources. ○ Align secondary care, primary care and local authority estate to ensure a whole footprint approach is taken and resources shared. ○ Consolidate to allow for modernisation and improved efficiency. ○ Ensure optimum location – closer to patients' home wherever possible.
Digital	○ Real-time, integrated health records across health a social care – to allow for faster, informed and join up decision making with less duplication. ○ Collaboration on in-house developments and analytics – to reduce expenditure, ensure consistency and interoperability, and spread best practice. ○ Support clinical workstreams with self-care apps development, widening access to tele-health etc.

Stakeholder Engagement

There has been publicity over recent weeks as to the level of detail within the public domain regarding STPs. Those areas of the country that have been experiencing material financial deficits have been developing their plans over the last 12-24 months and may therefore have quite specific plans for certain services such as A&E units and acute/hospital provision.

Within the BSW footprint however we have an opportunity to engage our stakeholders from the beginning in the redesign of clinical models to ensure that the future services meet the needs of citizens in a cost-effective way.

We held an engagement event on the 13th September to start a conversation with organisations from the voluntary and independent sectors as we are mindful of both the vital role they play in care planning and delivery and the current uncertainties within that sector resulting from recent community procurement processes.

Through that event we are seeking to build their involvement in the redesign of our clinical models alongside the use of citizen and patient involvement. As our care models emerge – and as we start to model our funding envelope alongside them – we will review the scale of the changes and

the need for formal consultation. As an STP we are firmly committed to formal consultation where it is required and through dialogue with statutory bodies.

We view the 13th September event as the start of a series of engagement events over the next 12 months that we will be holding to update key stakeholders on the evolution of our clinical models in addition to utilising existing engagement and communication channels within B&NES.

In addition we have launched our Clinical Group that comprises professions from a broad spectrum of disciplines within health and social care. This Group will help ensure that the clinical workshops are focusing in on high impact areas and that any proposed changes are evidence based and co-designed with patients.

Next Steps

- Next iteration of the Plan to be shared with NHS England on the 21st October.
- Development of Plan content throughout Sept to November.
- Refinement of enabling plans (such as Estates, Digital and Workforce) alongside the clinical models.

Presenter name James Scott
Title Senior Responsible Officer
Organisation BSW STP

Report Author: David McClay, STP Programme Director, BSW STP

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	12/10/2016
TYPE	An open public item

Report summary table	
Report title	Dementia Friendly Communities
Report author	Anne-Marie Stavert, Commissioning & Contracts Officer, BaNES Council Becky Reynolds, Consultant in Public Health, BaNES Council
List of attachments	None
Background papers	http://www.dementiaaction.org.uk/assets/0001/1915/National_Dementia_Declaration_for_England.pdf
Summary	There are currently over 800,000 people living with dementia in the UK and this figure is set to rise. Bath Dementia Action Alliance comes under the umbrella of the national Dementia Action Alliance (DAA); a movement intended to improve the lives of these people with dementia and their carers. Through the local alliance, communities, businesses and services can be made more accessible and less discriminating to those living in BaNES with dementia. Organisations represented on the Health and Wellbeing Board are invited to become members of the BaNES Dementia Action Alliance (DAA). Membership involves signing up to the National Dementia Declaration for England and submitting a short Action Plan (to be updated quarterly on-line) that sets out three actions that the organisation would do to contribute to delivering better quality of life for people living with dementia and their carers. Once a member, the organisation would be given a page on the DAA's website www.dementiaaction.org.uk, with a link on the local BaNES DAA website. A simple action may be to raise awareness of dementia together with frontline and commissioning staff, so they have the chance to increase their knowledge about dementia and provide/commission services that are accessible to people with dementia. An hour free session is available to help with this. We can also suggest many other actions which have been put forward by people with dementia that they say would help them. More information about BaNES DAA can be found at: http://www.dementiaaction.org.uk/local_alliances/17986_bath_north_east_

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	somerset
Recommendations	Organisations on the Board are asked to: • Become members of the B&NES DAA, thus signing up to becoming dementia friendly organisations. Through small changes we can make a positive difference to the quality of life of people living with dementia, and their carers.
Rationale for recommendations	By joining the B&NES DAA, organisations are making visible their commitment to improving the service/support for our customers living with dementia. We can use the alliance to share ideas, get support and work together. The recommendations specifically helps to address the following priority in the Health and Wellbeing Strategy: • Priority 7: Enhanced quality of life for people with dementia. To a lesser extent the recommendations also support the following two priorities from the strategy: • Priority 4: Create healthy and sustainable places • Priority 11: Take action on loneliness
Resource implications	No financial resource implications are anticipated at this time. Minimal time would be needed to make the application. Some time may need to be made available to implement the actions agreed.
Statutory considerations and basis for proposal	Apart from ensuring the best customer experience and helping people to remain as independent for as long as possible, our actions will also help to ensure that the Council, the CCG and other organisations on the Health and Wellbeing Board are compliant with the Equality Act 2010, which recognises dementia as a disability.
Consultation	Anne-Marie Stavert, Commissioning & Contracts Officer, BaNES Council Becky Reynolds, Consultant in Public Health, BaNES Council Chair of the BaNES DAA
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.

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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	12/10/2016
TYPE	An open public item

Report summary table	
Report title	B&NES Health Protection Board Annual Report 2015-16
Report author	Anna Brett, Health Protection Manager
List of attachments	App 1: B&NES Health Protection Board Annual Report 2015-16 App 2: B&NES Health Protection Board Terms of Reference App 3: B&NES Immunisation Group Terms of Reference
Background papers	N/a
Summary	In April 2013 the Health and Social Care Regulations changed the statutory responsibility for health protection arrangements. B&NES Council acquired new responsibilities with regard to protecting the health of their population. Specifically the Director of Public Health (DPH), on behalf of the local authority has to assure himself that relevant organisations have appropriate plans in place to protect the population against a range of threats and hazards and to ensure that necessary action is being taken. The Health Protection Board was established in November 2013 to help fulfil this role. This annual report documents the progress made by the Health Protection Board on the priorities and recommendations made in the 2014-15 report; highlights the key areas of work that has taken place in 2015-16 and identifies priorities for the next 12 months.
Recommendations	That the B&NES Health & Wellbeing Board notes this annual report and the following priorities for the Health Protection Board for 2016/17. 1. Assurance: continue to monitor performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary. 2. Support the B&NES Antimicrobial Resistance Strategic Collaborative 3. Continue to ensure that the public are informed about emerging threats to health. 4. Support the review of the Bath Air Quality Action Plan and support the implementation of the actions in the Saltford & Keynsham Air Quality Action Plans

	5. Increase the uptake of MMR vaccination in B&NES 6. Improve the uptake of flu vaccinations in at risk groups, pregnant women, children and health care workers & support the STP work-stream to run collective campaigns for the influenza and pneumococcal vaccine 7. Continue to reduce health inequalities in screening programmes
Rationale for recommendations	The priorities have been jointly agreed by all Board members as key issues that need to be addressed in order for the DPH, on behalf of the local authority to be assured that suitable arrangements are in place in B&NES to protect the health of the population. This is systematically carried out by monitoring key performance indicators, maintaining a risk log and through intelligence, debriefs of outbreaks and incidents and work plans of the Local Health Resilience Partnership & Local Resilience Forum which are based on Community Risk Registers. The recommendations contribute to the delivery of these outcomes in the Joint Health and Wellbeing Strategy: Theme 1 - Helping people to stay healthy: Create healthy and sustainable places, by improving the air quality in B&NES. Theme 3 – Creating fairer life chances by increasing the resilience of people and communities, by ensuring preparedness for outbreaks of diseases and environmental incidents and hazards as well as ensuring individuals immunity to a number of diseases through immunisation and protect the wider population through herd immunity.
Resource implications	None
Statutory considerations and basis for proposal	This is a statutory role of the Director of Public Health acting on behalf of the Secretary of State. A number of the priorities will help to address health inequalities. In particular improving uptake of flu vaccination in at risk groups and improving coverage of MMR vaccination. Improving air quality in B&NES will directly impact and health and inequalities, sustainability and the natural environment.
Consultation	Dr Bruce Laurence, Director of Public Health B&NES Council Becky Reynolds, Consultant in Public Health B&NES Council Cllr Vic Pritchard, Cabinet Member Adult Social Care & Health Mike Bowden, Strategic Director, People & Communities Department B&NES Council Richard Morgan Chief Financial Officer nominated representative B&NES Council Maria Lucas, Monitoring Officer, B&NES Council
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

See attached.

Please contact the report author if you need to access this report in an alternative format

BATH AND NORTH EAST SOMERSET

HEALTH PROTECTION BOARD ANNUAL REPORT 2015/2016

Specialist Health Protection Areas:

Healthcare Associated Infection (HCAI)
KPIs: MRSA / C.difficile

Communicable Disease Control & Environmental Hazards
KPIs: private water supplies / air quality management areas

Health Emergency Planning
KPIs: Civil Contingencies Act requirements

Sexual Health
KPIs: chlamydia diagnoses, HIV & under 18 conceptions

Substance Misuse
KPIs: hep B vaccination, hep C testing, opiates & non-opiates

Screening & Immunisation
KPIs: national screening programmes & uptake of universal immunisation programmes

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1 Executive summary

1.1 Purpose of the report

This annual report documents the progress made by the Health Protection Board during 2015-16 and highlights key performance indicators, risks, challenges and priorities for the next 12 months in each specialist area.

1.2 Terms of reference & review of working arrangements

The Terms of Reference and working arrangements of the Board were reviewed during the June 2015 Board meeting.

The scope of the Board remained unchanged. A great strength of the Board was highlighted as enabling colleagues to understand more about each other's roles and responsibilities thus improving working relationships which is important when people work together to manage an incident or outbreak.

An area to develop further is the inclusion of providers where the topic under discussion is relevant to them. The terms of reference were amended to reflect this change - please see Appendix 1.

1.3 Progress on 2014-15 priorities that were implemented in 2015-16

In the last Health Protection Board report 2014-15, the Board committed to improving all work streams and identified seven priorities to be addressed in order for the Director of Public Health (DPH), on behalf of the local authority, to be further assured that suitable arrangements are in place in B&NES to protect the health of the population.

The progress made on each priority has been RAG rated below and more detail of the progress made with each priority is detailed within the report.

No.	Priority	Progress
1	**Fully operationalise health protection plans in B&NES**	
2	**Help to ensure resilience of health emergency planning in B&NES**	
3	**Support the development of Air Quality Action Plans (AQAPs) for Saltford & Keynsham**	
4	**Improve uptake in all childhood immunisation programmes**	
5	**Improve the uptake of flu vaccination in target groups**	
6	**Assurance: continue to monitor performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary.**	
7	**Ensure that the public are appropriately informed about emerging threats to health**	

1.4 Priorities for 2016-17

The following seven priorities have been identified for 2016-17:

1. Assurance: continue to monitor the performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary
2. Support the B&NES Antimicrobial Resistance Strategic Collaborative
3. Support the review of the Bath Air Quality Action Plan and support the implementation of the actions in the Saltford & Keynsham Air Quality Action Plans
4. Continue to ensure that the public are informed about emerging threats to health
5. Improve the uptake of MMR vaccination in B&NES
6. Improve the uptake of flu vaccinations in at risk groups, pregnant women, children and health care workers & support the STP work-stream to run collective campaigns for the influenza and pneumocal vaccine
7. Continue to reduce health inequalities in screening programmes

2 Introduction

The Health Protection Board was established in November 2013 to enable the Director of Public Health to be assured on behalf of the local authority that relevant organisations have appropriate plans in place to protect the population against a range of threats and hazards and to ensure that necessary action is being taken.

It provides a forum for professional discussion of health protection plans, performance, risks and opportunities for joint action and ensures strong relationships between all agencies are maintained and developed to provide a robust health protection function in B&NES.

Priority 6 from 2014-15 report: Assurance: continue to monitor performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary

RAG: Green

During 2015-16 the Board continued to monitor key performance indicators for each specialist area and was generally very well assured that relevant organisations do have appropriate plans in place to protect the population. A small number of risks were identified throughout the year and logged, describing the mitigation that was in place for each one. These are described and discussed throughout the report.

Assurance: continuing to monitor performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary has been identified as priority 1 for 2016-17.

Sections 3 to 9 in this report go on to describe the performance, risks, challenges and priorities in each specialist health protection area:

3 Infection prevention & control - health care associated infection (HCAI)

NHS BaNES Clinical Commissioning Group (CCG) assures itself that Infection Prevention & Control is in place in provider organisations through:

1. Quality schedules - zero tolerance of MRSA & minimise rate of *Clostridium difficile (C.Diff).*
2. Commissioning for Quality and Innovation (CQUIN):
3. Site visits of major providers

The CCG monitors the number of cases of healthcare acquired *MRSA* & *C. diff* infection as part of their contract with providers.

3.1 MRSA blood stream infections

The government continue to set the challenge of demonstrating zero tolerance of healthcare acquired MRSA through a combination of good hygiene practice, appropriate use of antibiotics, improved techniques in care and use of medical devices, as well as adherence to all best practice guidance.

In 2015/16 BaNES failed to deliver zero cases of MRSA in all CCG patients, as 12 cases were reported, an increase from 2 cases in 2014/15.

A root cause analysis of every case of MRSA is carried out and any lessons learned are implemented to minimise the risk of future cases arising.

3.2 Clostridium difficile infection

In 2015/16 the national target for *C. diff* infection was 47 cases for all B&NES CCG patients. The total number of cases of *C. diff* was 237 compared to 61 cases in 2014/15.

The number of cases of *C. diff* infection was highlighted on the Health Protection Board's Risk Log throughout the year.

By looking at the complete patient journey, BaNES CCG, the B&NES HCAI collaborative and HCAI *C.Diff* meetings chaired by the Quality and Safety Manager at NHS England South Central identify actions they can take to reduce *C. diff* infections. Actions include focussing on appropriate anti-microbial prescribing and stewardship, discussing local issues in primary care as well as acute and community care, looking at the *C. diff* trajectories and managing reviews in lapses of care.

3.3 Reducing antimicrobial resistance (AMR)

Antibiotics are drugs used to treat bacterial infections in both humans and animals. However, bacteria can change and find ways to survive the effects of antibiotics. This has resulted in antibiotics losing their effectiveness. The more we use antibiotics and the way that we use them can increase the chance that bacteria will become resistant to them. This is known as antimicrobial resistance.

Modern medical and veterinary practice relies on being able to use antimicrobials to prevent and treat infections in humans and animals. Antibiotics have many important uses such as treating and preventing infections and reducing the risk of potentially life threatening complications in surgery, chemotherapy and transplantation.

The reality is that infections are increasingly developing that are resistant to the drugs we have available. This means that antibiotics are losing their effectiveness at

an increasing rate. Without them many common and vital medical procedures such as gut surgery, caesarean section, setting bones, joint replacements and chemotherapy could become too dangerous to perform.

So what can be done to prevent antibiotic resistance? There are many things that need to be done to cut down on unnecessary use of antimicrobials and increase the supply of new drugs. In B&NES we are working across health and education organisations to improve the way we use antibiotics, making sure that they are not wasted on viral illnesses like colds, coughs and flu. This work will fit within the work plan of the B&NES Antimicrobial Resistance Strategic Collaborative that is being established to implement the UK 5 Year Antimicrobial Resistance Strategy.

Supporting the B&NES Antimicrobial Resistance Strategic Collaborative has been identified as priority 2 for 2016-17.

3.4 Antimicrobial resistance programme in schools

To support European Antibiotic Awareness Day (18 Nov 2016) and World Antibiotic Awareness Week (14-21 Nov 2016) in B&NES, a poster competition is being run for Year 3 pupils in all B&NES primary schools. There are 4 categories: hand washing, flu vaccinations, antibiotics don't work for coughs, cold and flu and 'Catch it, Bin it, Kill it' – preventing the spread of infection. Judging of the posters will take place early Jan 2017 and the winning posters will be displayed between Jan and March within the local community to raise AMR awareness.

All secondary schools in B&NES will be offered a lesson to Year 9 pupils taught by trainee GPs and pharmacists which includes key AMR educational messages, self-care messages and information on access to healthcare services.

4 Communicable disease & environmental hazards

4.1 Confirmed or probable cases of infectious disease during 2015-16

The Health Protection Team in Public Health England (PHE) South West works in partnership with external stakeholders including the Public Health and Public Protection teams based at B&NES Council to deliver an appropriate co-ordinated response to infectious disease cases, outbreaks and incidents.

PHE reported that in B&NES there were 476 confirmed or probable cases of infectious disease during 2015-16, all of which needed some degree of follow-up or investigation. This number of cases is as expected for our population size.

There were 6 confirmed cases of Legionellosis in B&NES in 2015-16. We have highlighted below an example of a typical operational investigation into a near classic case of Legionellosis.

4.2 What is Legionellosis?

Legionellosis is a respiratory disease caused by a type of Legionella bacteria. The severity of legionellosis varies from mild febrile illness (Pontiac fever) to a potentially fatal form of pneumonia (Legionnaires' disease) that can affect anyone, but principally affects those who are susceptible due to age, illness, immunosuppression or other risk factors, such as smoking. Water is the major natural reservoir for Legionella, and the bacteria are found worldwide in many different natural and artificial aquatic environments, such as cooling towers; water systems in hotels, homes, ships and factories; respiratory therapy equipment; fountains; misting devices; and spa pools.

4.3 Legionellosis case study

An elderly member of the public (the 'case') was admitted to hospital with Pneumonia. The case was found to be suffering from chronic obstructive pulmonary disease, coronary heart disease and, Legionellosis. The laboratory results sparked off an out-of-hours response from both Public Health England and B&NES Council Public Protection/Environmental Health staff, on a Friday evening. [The lack of formal out of hours provision for the Council's Public Protection & Health Improvement Service is a long standing risk on the Board's risk log; however the Council's emergency contacts list and a cascade 'best endeavour' approach that has been adopted worked on this occasion].

Whilst very ill the case was interviewed in hospital. Information gathered on the initial surveillance form suggested that during the incubation period, the case had had very limited exposure to environments outside the home where there might have been exposure to water aerosols containing legionella bacteria, the transmission route of Legionellosis. The person had used a home shower, visited a local hand car wash, attended a local club to pursue a hobby, and attended hospital as an out-patient.

On Saturday morning the case's home, the hand car wash, and the immediate environment were surveyed for obvious aerosol risks with a view to putting precautionary restriction in place to protect public health. However, no obvious risks were found. On Saturdays no laboratory support is available to receive and process water samples so none were taken.

After the weekend full in-depth inspections of these locations were carried out together with water sampling. The case's home was inspected, and Legionella management plans and water systems of the car wash were scrutinised and found to be satisfactory.

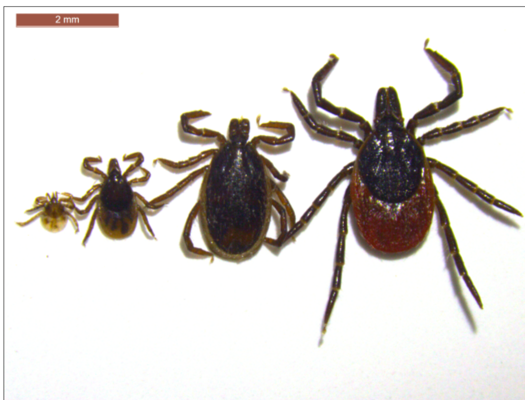
Interviewing the case to verify the information gathered by the surveillance form revealed that the case regularly attended a specific venue to take part in a hobby. Officers were dispatched to the venue where the water systems, including the

sprinkler system for the green and shrubs, all proved to be well maintained and managed.

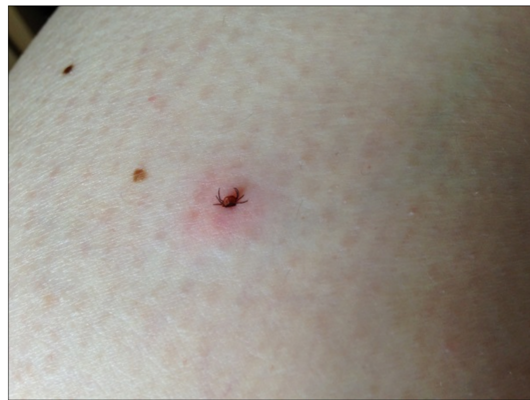
Clearance of the all the water systems in the investigated locations suggest the cause was incidental exposure of this isolated susceptible individual to an infectious water aerosol of unknown origin.

4.4 Ticks & Lyme Disease

Ticks are small spider-like creatures that can be found where there are deer, small mammals or wild birds. They tend to prefer damp, shady dense vegetation, leaf litter and long grass but can also be found in woodland, open country, public parks or gardens. They don't jump or fly, but live on vegetation and climb onto animals or people as they brush past. They can be found throughout the year, but are most active between spring and autumn.



Castor Bean Tick (Ixodes Ricinus) All Stages



Tick Biting

Ticks can pass on a bacterium which can lead to an illness called Lyme disease in an estimated 2000-3000 people each year in England and Wales. Symptoms of Lyme disease include flu like illness and a rash, however, the infection can be treated effectively with antibiotics if caught in the early stages.

4.4.1 Tick Awareness

Priority 7 from 2014-15 report: Ensure that the public are appropriately informed about emerging threats to health

RAG: Green

This 'tick awareness' work is an example of one way that the public are appropriately informed about emerging threats to health.

The understanding and knowledge about ticks is increasingly nationally and locally, so B&NES Council Public Health team are currently encouraging residents and visitors to become 'tick aware' to continue enjoying outdoor activities with the knowledge and confidence of how to manage ticks should they come into contact with them. A poster and leaflet has been produced in collaboration with Public Health England and contains all the key messages. The key messages are:

1. Know what ticks look like, where they can be found, and practise prevention behaviours to help avoid tick bites

2. Check your clothes and body regularly for ticks when outdoors and when you return home

3. Remove ticks as soon as possible with tweezers or a tick removal tool. Once removed apply antiseptic to the bite area and keep an eye on it for any changes

Parish Councils are being sent copies of the publicity materials asking them to display the posters on their noticeboards and also to use other ways that they have to pass on the information to their residents. For areas of Bath not covered by a Parish Council other ways to make the information available are being utilised. GP practices and Pharmacies have also been asked to display the materials.

Further information about ticks can be found on the Council's Public Health webpages: http://www.bathnes.gov.uk/services/public-health/latest-health-messages/tick-awareness

Continuing to ensure that the public are informed about emerging threats to health has been identified as priority 3 for 2016-17.

4.5 Air Quality Management Areas

Priority 3 from 2014-15 report: Support the development of the Air Quality Action Plans (AQAPs) for Saltford & Keynsham

RAG: Green

B&NES Council is legally required to review air quality and designate air quality management areas if improvements are necessary under Part IV of the Environment Act 1995 and the Air Quality Management regulations. Where an air quality management area is designated, an air quality action plan describing the pollution reduction measures must then be put in place in pursuit of the achievement of the Air Quality Strategy and objectives in the designated area.

B&NES Council have declared 3 Air Quality Management Areas (AQMAs) in Bath, Keynsham and Saltford.

The Council has reviewed air quality throughout B&NES as part of its Annual Status Report and at the time of writing this is being submitted to DEFRA for peer review, before being published.

Last year the Board supported the development of Air Quality Action Plans (AQAPs) for Saltford & Keynsham. In 2016 a public consultation reviewed the air quality action plans for Keynsham and Saltford before they were formally adopted in May 2015. The actions fall under the following themes:

- Alternatives to private vehicle use
- Policy guidance and development control
- Promoting low emission transport
- Promoting travel alternatives
- Public information
- Transport planning and infrastructure
- Traffic management
- Vehicle fleet efficiency

One action being delivered in the next 12 months includes a trial for a one way system in Keynsham High Street with associated monitoring to understand the impact of this change.

An AQAP for Bath has been in place for some time and will be reviewed in 2016. The team has already started to update our information in relation to the sources of pollution and have engaged with stakeholders over this review to ensure that all views and ideas are properly considered.

Supporting the review of the Bath Air Quality Action Plan and support the implementation of the action in the Saltford & Keynsham Air Quality Action Plans has been identified as priority 4 for 2016-17

5 Health Emergency Planning

Priority 1 from 2014-15 report: Fully operationalise health protection plans in B&NES

RAG: Amber

During the spring of 2014 the Local Health Resilience Partnership (LHRP) carried out a review of local health protection arrangements for responding to incidents and outbreaks as part of a national audit. In B&NES a number of capabilities and gaps in funding and resources were found. As a result the LHRP produced a strategic document entitled 'Communicable Disease Incident Outbreak Control Plan' and recommended that each Local Authority produce an operational plan with a directory of response activities identifying which organisation has lead responsibility and resources and skills to deliver each activity.

To help inform the operation plan a series of scenario based workshops were held, where all partners came together to discuss very practical issues. A number of debriefs from real incidents or outbreaks have also been used. All the information has been pulled together in a useful document entitled 'B&NES Health Protection Incident Response Plan'. This plan is underpinned with a Memorandum of Understanding agreed by all stakeholders.

Priority 1, to fully operationalise health protection plans in B&NES, remains rated as amber to allow these plans to be fully tested and reviewed during future outbreaks/incidents.

Priority 2 from 2014-15 report: Help to ensure resilience of health emergency planning in B&NES

RAG: Amber

In order to ensure the effectiveness of emergency planning, preparedness and response it is essential that all organisations in the health community work together in a coordinated way.

Due to the re-organisation and recruitment in the Council's Communications Hub and Emergency Planning Team the inability to plan/exercise and the inability to respond to emergencies long term has been on the Health Protection Board's risk log for some time. A substantial amount of work and training has been done in this area and as a result the inability to plan and exercise was removed from the risk register in March 2016.

Whilst the likelihood of the inability to respond to an emergency long term has been reduced, it remains on the Board's risk log, as there is still a need to train further Council staff to ensure that a suitable response to an outbreak or incident could be maintained for a long period of time if necessary.

The World War II Bomb incident, Ebola debrief and Pandemic Flu exercise described below, are all examples of situations where resilience of the health emergency planning system in B&NES was tested and of how planning and exercising takes place and is put into practice.

5.1 World War II Bomb Incident

On Thursday 12 May 2016, contractors unearthed a shell from beneath the surface of a former school playground in Lansdown Rd, Bath. A multi-agency response was put into action, including many services of B&NES Council e.g. emergency planning and highways. A 300 metre exclusion zone was set-up and residents in the zone were advised to evacuate. B&NES Council, Sirona Care & Health and the Red Cross worked to set-up a rest centre for residents who chose to evacuate.

All agencies worked together to remove the device and get everything back to normal.

5.1.1 What went well?

Preparedness

- Emergency Planning team preparedness and training before incident
- Bronze & Silver training of senior Council staff before the incident
- Key plans updated before the incident and previous work taken place to engage with the voluntary sector and confirm the Rest Centre Plan with Sirona Care & Health

During the incident

- Control room opened, roles and responsibilities assigned, key officers identified and contacted, link between Portishead (Gold), Lansdown (Bronze) and Lewis House (Silver Control) established, media and communications channels set up and worked well
- Rest Centre set up (using Rest Centre Plan) and link with Sirona/Red Cross established. Transport and food for Rest Centre arranged
- 250 tons of sand arranged to remove bomb
- Police assisted with road closures
- Trained staff in place to log incident
- Handover between shifts worked well and enough resilience in system for duration of incident (2/3 days)

5.1.2 What didn't go well and could be improved?

- There was a delay in the time that the Police first notified the Council about the incident, which meant the Council could not respond as quickly as they would have like
- The Police decided to evacuate to Lansdown Racecourse, however the Council was not asked for their assistance in the first instance
- Shut down of the incident was not fully completed.
- Personal mobiles were being used during the incident due to lack of signal etc
- There was not one Control Room number, so calls were coming into the Council's control room via different channels, making tracking and logging calls difficult

All lessons identified will be tracked as actions by the Board.

5.2 Ebola Debrief

With the outbreaks of Ebola officially over in West Africa and the threat to the UK subsided, structured debriefing sessions were held across Public Health England South West geographical area to assess how robust agency response plans were.

The response to the risk of Ebola was a good example of how the LHRP can be responsive to support emergent response requirements. NHS England South (South West) and PHE ran a table top exercise for LHRP partners to identify gaps in their response arrangements and provide the opportunity to identify and escalate common issues.

Some recommendations could be closed down locally e.g. internal practices in acute trusts, identifying training leads and sharing lessons identified, but other issues required national escalation;

- Timely cascade of the algorithm
- National communications for staff (eg on personal protective equipment)
- National call centre arrangements
- PHE Porton (laboratory) capacity challenges

One action that Directors of Public Health were asked to put in place through their Health Protection Boards was to ensure all areas are covered by communicable disease outbreak plans on a Local Authority footprint which cover roles and responsibilities for all responding organisations including primary care. As described in 3.3 above, this has been completed.

5.3 Pandemic Flu Exercise

A LHRP Pandemic Flu table top exercise was undertaken in November 2015. There was good engagement from partners and the exercise report was shared with the

LHRP. Outcomes of the exercise were as expected; they highlighted that the response to a flu pandemic will be much more challenging than in 2009 (Swine Flu Pandemic) with reduced estate footprint, resources and bed base in acute trusts.

Following the exercise the strategic LHRP Pandemic Flu Response Framework was completed in December 2015 to support the delivery of an effective response in the event of an Influenza Pandemic.

6 Sexual Health

6.1 Sexual Health Strategy and Action Plan

The Sexual Health Strategy was ratified in autumn 2015 and runs to 2018. It built upon the recommendations of the 2015 Sexual Health Needs Assessment. The strategy sets out three population-level outcomes:

- Outcome 1: Sexually active adults and young people are free from STIs
- Outcome 2: Sexually active adults and young people are free from unplanned pregnancies
- Outcome 3: Young people are supported to have choice and control over intimate and sexual relationships

A number of indicators have been developed which help us identify progress against these three outcomes. These indicators are reported quarterly to the Sexual Health Board, see 6.5-6.8 below. The Sexual Health Action Plan flows from the strategy and sets out a range of measures to improve sexual health across B&NES.

6.2 Achievements

There are a number of achievements that have occurred as a result of the development of the strategy. The level of data coming from providers has improved which has enabled a more accurate picture of certain sexual health issues in B&NES to be gained, such as rates of chlamydia infection and the range of qualifications and skills in primary care for those who deliver Long Acting Reversible Contraception (LARC) to B&NES service users.

Service provision has been strengthened by developing a more peripatetic model for the Clinic in a Box service, which delivers outreach sexual health services in schools and youth clubs.

Sexual health services in the Chew Valley area have increased and have been developed and co-location of Contraception and Sexual Health (CaSH) Service, and Genitourinary Medicine (GUM) service into a central Bath location is underway.

6.3 Challenges

Although data improvement has been seen in some services, work continues with other providers to ensure accurate, detailed data is available to support our planning to improve sexual health, especially for more vulnerable groups.

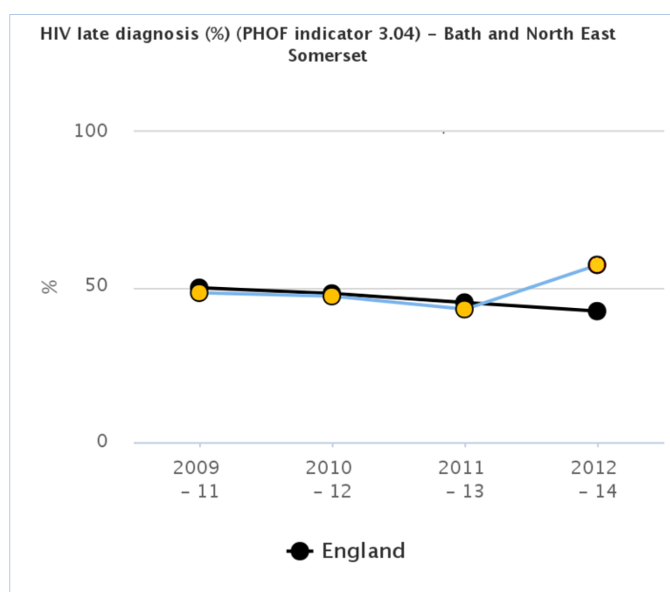
The number of people with HIV who are diagnosed late in B&NES has increased slightly.

As part of the wider financial climate affecting B&NES Council some services have been decommissioned and/or reduced as a result of reduced public health budgets. This includes new age restrictions on those who can access free emergency hormonal contraception (EHC) from pharmacies and a deprioritisation of chlamydia testing outside mainstream sexual health services for those under 25 years old.

6.4 Sexual Health Indicators

As detailed above the Sexual Health Board has devised an indicator set to assess progress against our three defined outcomes which support our vision.

6.5 HIV late diagnosis



Source: Public Health England, 2016

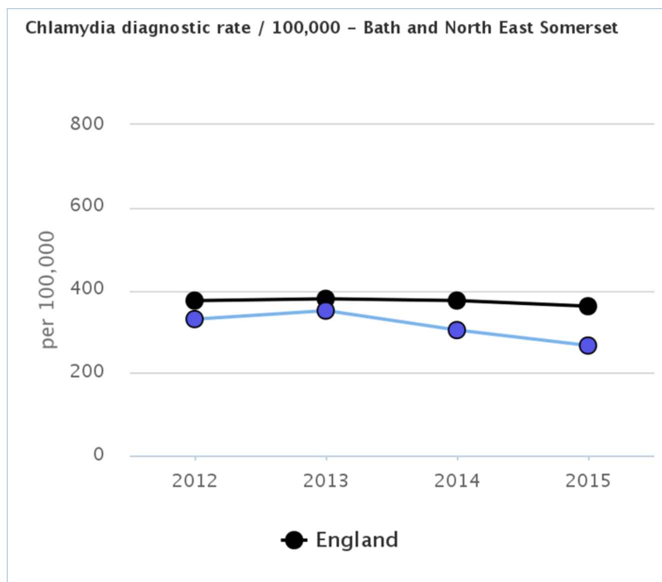
If HIV is diagnosed early it can be successfully treated and people with HIV can live to near-normal life expectancies in good health. Early diagnosis also means that the risk of HIV being passed on as a result of people being unaware of their HIV status is reduced. Although B&NES is generally a low prevalence area for HIV, as can be seen in the chart below, the percentage of people diagnosed late with HIV increased during 2012-2014, although this increase is not statistically significant.

Work is being undertaken with colleagues at the Department of HIV and Sexual Health at the RUH to review these cases and examine what actions might need to be taken to reduce late diagnoses in the future.

6.6 Chlamydia diagnosis

Another helpful indicator is the rate of chlamydia diagnoses amongst young people aged 15-24. We know from national and local data that people in this age range are

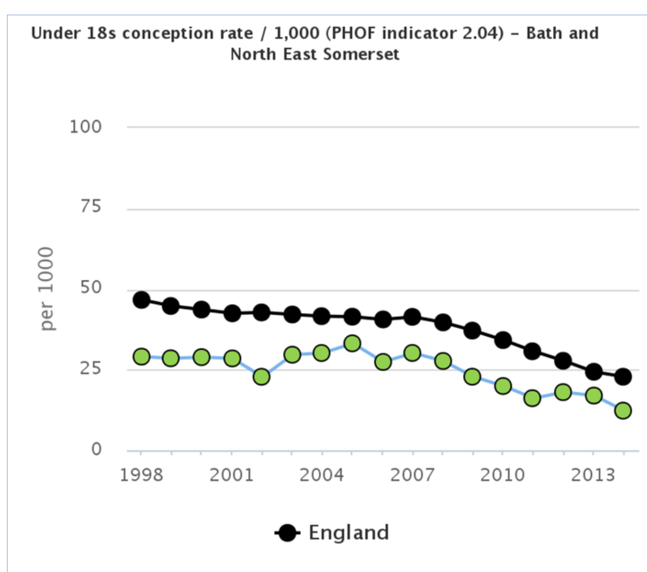
more likely than other ranges to experience chlamydia infection, and as such it can be helpful proxy measure of the sexual health of this cohort. The chart below details that the diagnostic rate per 100,000 people aged 15-24 in B&NES has dropped since 2012:



Source: Public Health England, 2016

Although that may be an indicator of low rates of chlamydia infection, it will be important to ensure in future that the offer of chlamydia screening to this cohort is maintained within core services, as any reduction in testing numbers may have an effect on the numbers of those subsequently diagnosed.

6.7 Under 18s Conceptions



Source: Public Health England, 2016

A final helpful indicator is that of the number of conceptions under the age of 18. Low levels of teenage conceptions can be an indicator of good access to contraceptive and sexual health services, and good education provision that enables young people to be aware of the risks and potential adverse implications of unprotected sex. B&NES has historically had a consistently low rate of teenage conceptions which continues on a downwards trend as shown.

The continuing reduction in under 18 conceptions gives B&NES one of the lowest rates in England.

7 Substance Misuse

7.1 Drug Performance Year End 2015-16

The substance misuse indicators in the public health outcomes framework (PHOF) aim to improve client outcomes through increased successful completions from treatment and prevention of re-presentations (through relapse).

Nationally, PHOF performance has declined since 2014/15. The chart below shows performance in B&NES for opiate clients (indicator 2.15i) and non–opiate clients (indicator 2.15ii) for the year ending 2015/16. Opiate clients' outcomes are slightly lower than the national comparators (6.8 % national), with non –opiate clients' outcomes slightly above the national average (37.3%).

Source: Public Health England, 2016

The key national Health Premium Incentive Scheme (HPIS) indicator has been confirmed as 'successful completion of drugs treatment' (with combined data for opiate and non-opiate users).

Public Health Outcome Framework		2015-16	
Indicator 215i		*Indicator 2.15ii*	
Opiate clients		*Non -opiate clients*	
6%	Similar	39%	Similar

Note: Similar = Similar to England

Public Health England has recently announced the expansion of the substance misuse indicators. As well as the opiate (2.15i) and non-opiate (2.15ii) indicators, there will be two new additional indictors as detailed below:

2.15iii – Successful completions of alcohol treatment. B&NES is monitoring outcomes for clients in alcohol treatment and this will now form part of the PHOF.

2.15iv – Deaths from drug misuse. Public Health England produced a report 'Understanding and preventing drug-related deaths'

The report highlights a number of principles for action by local authorities, drug treatment providers and others, including:

- coordinate whole-system approaches that can address health inequalities and meet complex needs, with better access to physical and mental healthcare, and to other support which could include housing and employment.
- improve access to good quality drug treatment, especially for those not currently in treatment who are harder to reach, for example, through outreach and needle and syringe programmes
- maintain a personalised approach to drug treatment and recovery support, tailored to the user's needs, according to national guidelines
- ensure that the risk of death is properly assessed and understood, addressing any identified poor practice

B&NES is currently developing an approach to reduce drug related deaths which includes, developing a strategy to widen the availability of Naloxone (prenoxad). (Naloxone is the emergency antidote for overdoses caused by heroin and other opiates/opioids such as methadone and morphine) and responding to complex treatment resistant drinkers (often known as 'Blue Light' clients because they require frequent ambulance or police attendance).

7.2 Blood Borne Viruses

Hepatitis B (HBV) and Hepatitis C (HCV) are blood-borne viruses (BBVs), transmitted via infected blood and are known to be the leading cause of liver disease worldwide. Preventing BBVs is a Local Authority responsibility to 'promote the economic, social and environmental wellbeing of communities'.

Injecting drug use continues to be the most important risk factor for people in the UK who have chronic HCV infection.

B&NES is effective and proactive at supporting appropriate clients to be tested for HCV. At the end of 2015/16 only 8% of injecting drug users in B&NES (engaging in drug treatment) had not been tested for HCV. This is substantially above the national performance of 19% without a test.

8 Immunisations

A full report with in depth information about all childhood, adolescence and school based and adult immunisations can be found here: http://www.bathnes.gov.uk/services/public-health/public-health-strategies-and-policies

8.1 Childhood immunisation programmes – Focussing on Measles, Mumps & Rubella Vaccination (MMR)

Priority 4 from 2014-15 report: Improve the uptake in all childhood immunisation programmes

RAG: Amber

8.1.1 Uptake of childhood immunisations 2015-16

The World Health Organisation (WHO) has set vaccination coverage targets at global and WHO regional levels, which have been adopted by the Department of Health at national and local levels. The 95% target for childhood vaccination coverage is recommended nationally to ensure control of vaccine preventable diseases within the UK routine childhood vaccination programmes, with at least 90% coverage in sub-national areas such as local authority or CCG areas. This relates specifically to diphtheria, tetanus, pertussis, polio, Haemophilus influenza type b (Hib), measles, mumps and rubella (MMR).

The B&NES uptake across all four quarters in 2015/16 for all childhood immunisations were higher than the England average; however uptake of pre-school booster vaccinations fell below the national 95% and MMR dose 2 at 5 years has been struggling to stay above 90% (see 3.6.3 below).

8.1.2 MMR Vaccination

Although MMR vaccine uptake rates in England are currently among the highest in Europe, an increase is still needed to reach the WHO's 95% target for MMR vaccination.

The measles immunisation gap in England equates to approximately 24,000 children in England every year (2,000 a month) who are not currently receiving MMR vaccination at the scheduled time (from 12 months of age) and who remain susceptible to the diseases the vaccine protects against.

The current English routine immunisation schedule is for dose one to be given at 12 months of age and dose 2 to be administered at 3 years 4 months.

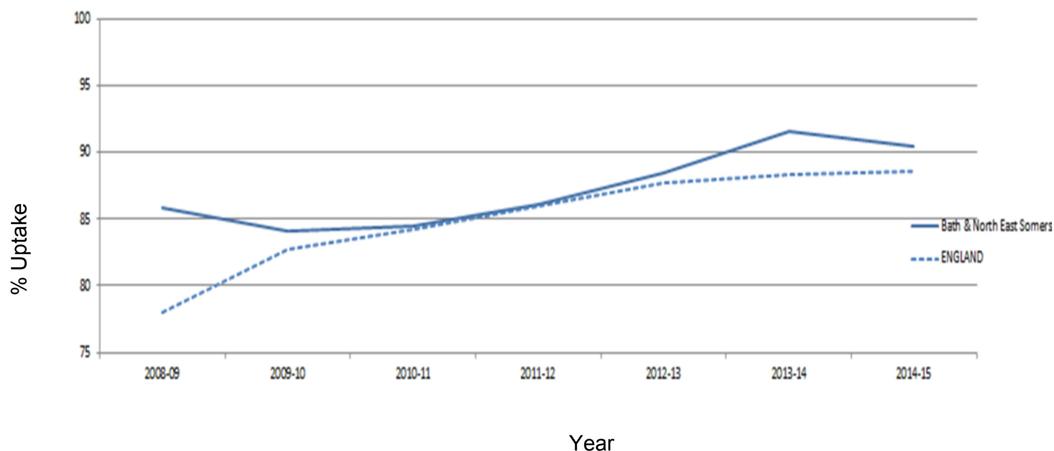
Why is PHE focusing on MMR Vaccination?

- The cessation of rubella screening in pregnancy and the number of babies being born with congenital rubella syndrome (3 cases in the last 18 months).
- Public Health England (PHE) is reminding teenagers and young people to make sure they are vaccinated against measles after new cases were reported across England. These are primarily aged 14 years to 40 years and have an unknown or incomplete MMR status.

- A significant number of these cases, linked to music festivals and other large public events, have been reported since June 2016. This follows an increase in measles over the year with 234 cases confirmed between January and June 2016, compared with 54 for the same period last year. There have been 38 suspected measles cases reported in people who attended events in June and July 2016.

8.1.3 The B&NES situation & what is happening locally?

Uptake of MMR Dose 2 by 5 years old in B&NES 2008-2014



The graph above shows that uptake of MMR vaccinations (dose to by 5 years of age) steadily increased in B&NES between 2010 and 2014, however since 2014 has been gradually dropping to around 90%.

The B&NES Immunisation Group (see below 8.2), B&NES Council Public Health Team and NHS England South (South Central) Public Health Commissioning Team have been supporting PHE to implement a programme of work to increase the uptake of MMR vaccinations; the work includes:

- Practice Nurse workshops & Practice Nurse training
- B&NES Immunisation Group & Childhood Immunisation Working group
  - Revise invite letter
  - Working with Child Health Information System (CHIS) & health visitors to review systems/processes
  - Promotional material and campaigns
- Briefing at Practice Managers meeting and call to action for GP practices:
  - For children less than 5 years, work with CHIS to keep recalling the child in to receive their MMR vaccination and use a flagging system to prompt discussions with parents
  - Notify the heath visitor that the conversation has taken place, enabling the health visitor to contact the parent/carer to follow up on the conversation.

Inform the health visitors of any children who are overdue their MMR dose 2, thus allowing health visitors the opportunity to contact the family about this
- For children and adults over 5 put a mechanism in place to offer the vaccination on an opportunistic/self-referral basis
- Consider promoting MMR in the waiting room
- Ensure reception staff are aware of the drive to vaccinate so that they may have a factual conversation with the patient when they are booking in

Increasing the uptake of MMR vaccination in B&NES has been identified as priority 5 for 2016-17.

8.2 B&NES Immunisation Group

The B&NES Immunisation Group was established in July 2015 due to concerns about uptake of MMR vaccination and consensus that local coordination of all stakeholders would be beneficial. The group reports to the Health Protection Board. Please see Appendix 2 for terms of reference.

It was deemed necessary to have one operational group with the responsibility for taking a system-wide overview of organisations and other stakeholders contributing to B&NES immunisation programmes with the aim to protect the health of the local population, reduce health inequalities and minimise and deal promptly with any threats that may occur.

The group provides a structured approach to monitoring, identifying & mitigating risks and updating action plans relating to immunisation programmes. It works collaboratively to exchange information, share knowledge and good practice, and provide practical solutions to improving and strengthening local immunisation programmes.

The group also aims to seek assurance that immunisation services in B&NES are compliant with the Department of Health guidelines and ensure that all national and local immunisations programmes are delivered safely, effectively and in a timely manner to all B&NES residents.

One of the first priorities of the B&NES Immunisation Group was to discuss the performance of the childhood immunisations programmes to see what could be done to make improvements see 8.1.3 above. The group has had a focus on school based immunisations, immunisations given during pregnancy and immunisation training of practice nurses. The inadequate provision of and access to immunisation training for Practice Nurses has been identified as a risk on the Board's risk log. An immunisation training audit completed by NHS England South (South Central) Public Health Commissioning Team highlighted a number of areas of concern which are being addressed. Two dates for childhood immunisation training have since been

arranged in late September and early November 2016 and a MMR, seasonal flu vaccination and others immunisations question and answer session has been arranged with Practice Nurses in October 2016.

8.3 Seasonal Flu Vaccination Programme

Priority 5 from 2014-15 report: improve the uptake of flu vaccinations in target groups

RAG: Red

In 2015-16 uptake of flu vaccination in B&NES did not improve in any of the target groups compared to the previous 2014-15 year. The table below shows that for each eligible group the decrease was small and in all cases except the under 65s at risk was above the England average.

The uptake in 5 & 6 year olds was also lower than the England average due to it being a GP based programme. In 2016-17 flu vaccination will be delivered in school for Years 1, 2 & 3 and the uptake is expected to increase in line with pilots that have been carried using similar models in different areas.

B&NES uptake of seasonal flu vaccination 2014-15 & 2015-16

Eligible Group	B&NES Uptake 2015-16 (%)	B&NES Uptake 2014-15 (%)	England Average Flu Vaccine Uptake 2015-16 (%)
65 and over	72.0	72.9	71.0
Under 65 (at risk only)	43.0	45.4	45.1
All Pregnant Women	44.0	45.7	42.3
All aged 2	42.6	46.8	35.4
All aged 3	47.8	48.3	37.7
All aged 4	39.6	39.8	30.0
All aged 5	38.5	N/a	53.6
All aged 6	33.7	N/a	52.1

8.4 The 2016-17 seasonal flu programme and action to be taken

Eligible groups & vaccine uptake ambitions for 2016/17

a) **Children (2, 3 & 4 year olds & School Years 1,2 & 3)** – 40-65% across all cohorts and settings

b) **Under 65 year olds in clinical risk groups and pregnant women** – At least 55% in all of the groups, and maintaining higher rates where those have already been achieved.
c) **Aged 65 and over** – 75%
d) **Healthcare workers –** 75% (a Trust-level ambition to reach a minimum of 75% uptake and an improvement in every Trust)
e) **Carers**
f) **Those in long-stay residential care**

A number of recommendations for the delivery of the seasonal flu vaccination programme in B&NES, Gloucestershire, Swindon & Wiltshire have been prioritised and focus on the childhood programme, under 65 year olds in clinical risk groups, pregnant women and health care workers. A full report on the seasonal flu vaccination programme 2015-16 and recommendations for the 2016-17 season can be found here: http://www.bathnes.gov.uk/services/public-health/public-health-strategies-and-policies

8.5 Sustainability & Transformation Plan

B&NES, Swindon and Wiltshire CCGs with local NHS and other partners are working together to create a Sustainability and Transformation Plan (STP). The purpose of the STP is to deliver vision in NHS England's Five Year Forward View:

- improve the health & wellbeing of our local population
- improve quality of local health & care services
- deliver financial stability & balance throughout the local health care system

The priorities are being assessed and developed through three care work-streams and three enabling work-streams.

- Urgent and Emergency Care
- Planned Care
- Preventative and Proactive Care
- Workforce
- Estates
- Digital

Running collective campaigns for influenza and pneumococcal vaccinations is one strand of work within the Prevention and Proactive Care work-stream. Key stakeholders from across B&NES, Swindon and Wiltshire are currently putting together a Project Initiation Document to get this underway.

Improving the uptake of flu vaccinations in at risk groups, pregnant women, children and health care workers & supporting the STP work-stream to run collective campaigns for the influenza and pneumococcal vaccine has been identified as priority 6 for 2016-17.

9 Screening programmes & reducing health inequalities

There are no major concerns about any of the screening programmes in place across B&NES. A full report with in depth information about all screening programmes can be found here: http://www.bathnes.gov.uk/services/public-health/public-health-strategies-and-policies

This report highlights some of the good work which is taking place in Bowel Screening.

9.1 Bowel screening programme & people with learning disabilities

People with learning disabilities have a considerably shorter life expectancy and poorer health than the population as a whole, yet are less likely to access health care. They also have a higher than average chance of health problems such as obesity and poor diet which are associated with bowel cancer. It is therefore really important that we do all that we can to help people with learning disabilities take advantage of the preventive health services that we have to offer.

The bowel screening test has been found to be difficult for people with learning disabilities to complete due to difficulties with reading invitations, getting to appointments and fear of the process. A project has been established in B&NES to help this group of people to complete these tests and access the other NHS screening programmes that they are eligible for. This is a joint project between B&NES Council, BANES Clinical Commissioning Group, Sirona Care & Health and NHS England South (South Central) Public Health Commissioning Team.

With the support of these different organisations, Sirona's community learning disability nurses have been working with people with learning disabilities and their support workers to produce easy read resources and visual aids, increase knowledge of the bowel screening programmes, and therefore reduce anxiety and fear linked to the test.

Picture: Sirona Care & Health's Community Learning Disabilities Nurses

9.2 Bowel Health Equity Audit

A review of equity in the Bowel Cancer Screening Programme in Bath and North East Somerset, Swindon and Wiltshire (BSW) has just been completed. It considers the first stage of bowel cancer screening, the faecal occult blood (FOB) test. The review describes patterns of uptake by age, gender, local deprivation and local ethnic diversity. This review is intended to provide greater detail about who is and isn't taking up the offer of screening. It is the first health equity audit of this local programme.

The review makes a number of recommendations for local consideration:

- Consider ways of increasing uptake among men and neighbourhoods with lower IMD scores and greater ethnic diversity.
- Work with the Screening Programme Centre to encourage GP practices to access and act on screening results.
- Discuss activity with the programme centre, providers and the commissioner so that capacity can be managed.

Continuing to reduce health inequalities in screening programmes has been identified as priority 7 for 2016-17.

10 Screening & Immunisation Incidents

Incidents requiring investigation in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from incidents to minimise the risk of the incident happening again. When an incident occurs it must be reported to all relevant bodies.

Between April 2015 and March 2016 there were a total of two screening incidents and four immunisation incidents in Bath & North East Somerset. There were no serious incidents.

10.1 Screening incidents

The two screening incidents occurred within the Foetal Anomaly Screening Programme (FASP) provided by the Royal United Hospital (RUH). Both incidents were appropriately investigated with lessons learned, and have since been closed.

The first incident related to a late booking for the 20-week scan for a pregnant mother moving from Bath to Swindon. The scan was conducted at 21 weeks and the result was normal with no adverse effects. To mitigate the risk of this incident

recurring training was arranged for all midwives on how to book patients in at other hospitals for their scans.

The second incident related to a handwritten transcription error of a pregnant mother's date of birth. This led to a recalculation of Downs' screening risk, which remained a low-risk value. There were no adverse effects. To mitigate the risk of this incident recurring the RUH have now made it mandatory to use demographic stickers in place of handwritten details, which should be confirmed when the patient is present.

10.2 Immunisation incidents

There were four incidents when vaccines were exposed to temperatures outside of the required range; these are referred to as breaks in the cold chain. The incidents occurred within four separate general practices. Each incident was appropriately investigated with lessons learned, and have since been closed.

A vaccine administration error was also reported when two doses of adult pneumococcal vaccine (PPV) were administered after a fridge had failed (breaching cold chain limits). Clinical advice was taken and confirmed that there were no risks to the patients receiving the vaccines, but that the efficacy of the doses may be compromised. Both patients were invited to receive another dose of PPV a month after the original.

Vaccines for the national immunisation programmes are provided free of charge to practices. The cost of vaccine wastage results in a significant and largely avoidable financial burden that needs to be reduced both locally and nationally.

In the 2015-16 financial year the cost of vaccine wastage due to the four cold chain events in Bath & North East Somerset was £15,221.69, representing a loss of 537 doses. Causes for the cold chain incidents reported are outlined below.

Cause of cold chain incident	No. of incidents reported (April 2015-March 2016)
Fridge equipment failure not due to power loss	2
External power supply problem (power cut)	1
Fridge switched off in error	1

An audit of all cold chain incidents reported across BGSW in the 2015/16 financial year revealed that the potential vaccine wastage cost was more than £82,000.

The NHS England South (South Central) Public Health Commissioning Team shared the results of their audit with GP practices and included useful hints and tips for maintaining the cold chain and reducing vaccine wastage, as well as links to national guidance. They also produced fridge magnets that offer a reminder to staff on the steps to take to maintain the cold chain.

It is hoped that these measures will be used to strengthen cold chain processes within BGSW and help to minimise the cost of vaccine wastage in future.

11 Recommendations

These recommended priorities have been agreed by the Board as key issues to be addressed in order for the DPH, on behalf of the local authority, to be further assured that suitable arrangements are in place in B&NES to protect the health of the population.

The process on reaching the priorities has been informed through monitoring key performance indicators, maintaining a risk log and through intelligence, debriefs of outbreaks and incidents and work plans of the LHRP & LRF which are based on Community Risk Registers.

1. Assurance: continue to monitor performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary
2. Support the B&NES Antimicrobial Resistance Strategic Collaborative
3. Continue to ensure that the public are informed about emerging threats to health
4. Support the review of the Bath Air Quality Action Plan and support the implementation of the actions in the Saltford & Keynsham Air Quality Action Plans
5. Increase the uptake of MMR vaccination in B&NES
6. Improve the uptake of flu vaccinations in at risk groups, pregnant women, children and health care workers & support the STP work-stream to run collective campaigns for the influenza and pneumococcal vaccine
7. Continue to reduce health inequalities in screening programmes

Appendix 1: B&NES Health Protection Board Terms of Reference (see attached document)

Appendix 2: B&NES Immunisation Group Terms of Reference (see attached document)

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Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Bath and North East Somerset Health Protection Board

Terms of Reference

Reporting to:	Bath and North East Somerset Health and Wellbeing Board
Health Protection Group authorised by:	Bath and North East Somerset Health and Wellbeing Board
Responsible Directorate:	Public Health Directorate, Bath and North East Somerset Council (B&NES)
Approval date of TOR:	June 2014
Review date of TOR:	Dec (6 month review)

Document history (author)

Draft Version (JG):	July 18th
Draft version (comments incorporated prior to first meeting of HP Board) JG	October 29th 2013
Draft version 2 (comments included from Nov 4th HP Board and subsequent formatting and collating some functions listed in section 2) BR, JG	Dec 12th 2013 and Feb 13th 2014
Draft version (BR) Amends made following changes agreed at previous Board meeting	Jun 9th 2014
ToR reviewed by Board	June 2015

1. Purpose

From April 2013 the Health and Social Care Regulations change the statutory responsibility for health protection arrangements. Upper tier and unitary local authorities acquired new responsibilities with regard to protecting the health of their population. Specifically local authorities are required, via their Directors of Public Health (DPH), to assure themselves that relevant organisations have appropriate plans in place to protect the population against a range of threats and hazards and to ensure that necessary action is being taken.

Following the introduction of multiple new NHS commissioning organisations and agencies involved in health protection, it is necessary to have one Board with the responsibility for coordinating the health protection responsibilities of those bodies locally. Thus threats to local health in Bath and North East Somerset (B&NES) should be minimised and dealt with promptly. This responsibility will be with the Health Protection Board, whose membership consists of commissioners, regulators and other organisations as described below.

The Board will take a system-wide overview of organisations and other stakeholders contributing to health protection in B&NEs and provide a whole system overview.
The purpose of the Health Protection Board would be to provide assurance, to B&NES local authority and the Health and Wellbeing Board, in regard to the adequacy of prevention, surveillance, planning and response with regard to the health protection issues that affect B&NES residents. It would also provide a route should there be specific health protection concerns, from a variety of stakeholders.

a. The purpose of the Health Protection Board is to ensure co-ordinated action across all sectors to protect the health of the people of B&NES from health threats, including major emergencies.
b. It supports the Director of Public Health (DPH) to carry out statutory responsibility to protect the health of the community through effective leadership and coordination, ensuring appropriate capacity and capability to detect, prevent and respond to threats to public health and safety.
c. The Health Protection Board will provide strategic direction and assurance on matters relating to health protection policy, risks and incidents.
d. All agencies will work collaboratively to exchange information and share knowledge and work together for the purpose of protecting the public's health.

2. Functions

a. To provide a forum for professional discussion of health protection plans, risks and opportunities for joint action
b. To ensure that effective arrangements are in place and are implemented, to protect B&NES people, whether resident, working or visiting B&NES.
c. To ensure effective health protection surveillance information is obtained, assessed and used appropriately so that appropriate action can be taken where necessary.
d. To ensure that public health threats requiring local intervention are identified,

analysed and prioritised for action to protect public health.

e. To ensure that systems are in place for cascading major health protection concerns outside of this meeting.
f. To ensure that health threats are prevented through implementation of relevant local and national guidance and regulations to protect public's health.
g. To ensure that appropriate plans and policies exist to coordinate responses to public health activities, emergencies and threats in relation to the scope identified in section 4.
h. To ensure appropriate response to environmental hazards and control, biological, chemical, radiological and nuclear, including air and water quality, food safety, contaminated land incidences.
i. To agree relevant risks and performance measures that will be overseen by the Board.
j. To ensure appropriate governance for all health protection activities and programmes.
k. To establish local health protection assurance system and support organisations to deliver against the health protection outcomes (part of public health outcomes framework).
l. To receive reports that demonstrate compliance with, and progress against, health protection outcomes.
m. To ensure appropriate response to service challenges, major incidents and outbreaks – although the Board would only need to be alerted to serious incidents, such as mismanagement of a programme, closure of a ward due/MRSA.
n. To provide health protection (including emergency preparedness, resilience and response (EPRR)) assurance on regular (to be determined) basis to B&NES Health and Wellbeing Board and any other relevant local bodies via the Director of Public Health.
o. To ensure strong relationships between all agencies are maintained and developed to provide a robust health protection function in B&NES.
p. To quality-assure and risk-assure health protection plans on behalf of the local authority[i] and provide recommendations regarding the strategic and operational management of these risks.
q. To ensure health protection intelligence is integrated into the Joint Strategic Needs Assessments e.g. individual reports and annual report.
r. To enable / ensure systems are fit for purpose in achieving the desired outcomes, especially in managing the interdependencies between organisations and programmes.
s. To manage emerging health protection risks in delivering effective commissioning and provision of health and social care.
t. Reporting progress and forward planning:
    - To review quarterly performance monitoring against agreed outcomes and standards
    - To identify risk and mitigation of those risks in review of progress and action to be taken. Escalate to the Health & Wellbeing Board, as appropriate.
    - To produce an annual report for the Health & Wellbeing Board
    - To produce an annual work programme to ensure effective health protection risk

review

Relation to other areas for cross-boundary issues

Relationships are in place with other areas for cross-boundary issues. Areas that do not have Health Protection Boards will be developing structures that can be linked in the future if required.

3. Accountability

a. The Health Protection Board will report to B&NES Health and Wellbeing Board (HWBB).
b. The DPH is accountable to the Chief Executive of B&NES Council for discharging health protection duties of the local authority.

4. Scope

The scope of the Health Protection Board is to minimise hazards to human health, and to ensure that any threats are promptly dealt with. Geographically, the scope covers the population of B&NES resident and non-residents who visit (links will be established with professionals in other areas as appropriate). Thematically, the scope covers the following health protection areas in the Health Protection Assurance Framework for B&NES:

a. Vaccination & immunisations
b. Infection prevention and control (IPC) related to healthcare associated infections
c. Alcohol, drugs and substance misuse
d. National screening programmes
e. Sexual health
f. Communicable disease control including TB, blood-borne viruses, gastro-intestinal (GI) infections, seasonal and pandemic influenza
g. Emergency preparedness, resilience and response
h. Public health advice regarding the planning for and control of pollution
i. Sustainable environment
j. Environmental hazards and control, biological, chemical, radiological and nuclear, including air and water quality, food safety, contaminated land
k. New and emerging infections, including zoonoses but not animal health

The scope of the Board would not be limited to those mentioned above.

It is anticipated that each of the health protection programme areas is likely to have its own programme board, already, but this may not be the case in all areas. These programme boards will be monitoring the commissioned services and performance managing the providers, as well as dealing with challenges and risks that arise. It is anticipated that the chair or other representative from those boards would attend the Health Protection Board as part of the assurance process.

5. **Strategic Linkages:** to receive minutes and/or update from relevant committees/groups
a. Local Health Resilience Partnership b. Joint Commissioning Group: for drugs and substance misuse in relation to hepatitis and HIV/AIDS c. Public Health England: for surveillance data and outbreak control d. Infection Control Collaborative meeting on relation to infection prevention and control re health care associated infections e. Local Strategic Committee for Vaccination and Immunisation (this is not been formed yet but is being considered) f. NHS England: Local Screening Committees g. Environmental Health Liaison group h. Seasonal flu planning i. Sexual Health Programme Board j. Any other groups whose work remits are linked to the health protection assurance framework.

6. **Membership of Health Protection Group**
a. DPH/Public Health Consultant Health Protection lead - (Chair) b. B&NES Council Cabinet Member for Wellbeing c. Public Health England: Health Protection - Consultant in Communicable Disease, or their representative d. Area Team Head of Public Health Commissioning or their representative e. Area Team Consultant for Screening and Immunisation or their representative f. Area Team Director of Operations and Delivery who is Deputy Co- Chair Local Resilience Forum, or their representative g. Emergency Planning Officers Group in B&NES: Emergency Planning lead h. Environmental Health lead for Air and Water Quality and Food or their representative i. CCG Director of Nursing and Quality (Director of Infection Prevention and Control-DIPC) j. Representative from Substance Misuse Joint Commissioning Group k. Representative from Sexual Health Programme Board l. Representative from other groups/programme areas, where needed, to make sure all areas of risk represented m. Representative from health and wellbeing board – a committee member not the chair It is expected that core members will attend all meetings and representation will be from the appropriate senior level. Where they cannot, an appropriately competent deputy, with the relevant skills and delegated authority, should attend in their place. Attendance of core members to board meetings will be monitored and reported in the

annual reports of the Board.

7. Co-option of members

Other Leads of health protection elements maybe co-opted as and when appropriate.

8. Declarations of Interest

If any member had an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussion. The Chair will have the power to request that member to withdraw until the Health Protection Board has given due consideration to the matter.

All declarations of interest will be minuted.

9. Deputising

All members must make every effort to attend. If members are unable to attend they must send formal apologies, otherwise they will be recorded as 'did not attend'. Deputies should attend only when necessary.

10. Quorum

Chair or Deputy; and at least 3 other members from different agencies.

11. Frequency of meetings

3 monthly.

12. Agenda deadlines

Items to be received two weeks prior to meeting.

Agenda to be circulated one week prior to meeting.

13. Minutes

Minutes will be circulated within two weeks of the meeting.

Minutes will be circulated to all members of the Health Protection Board.

14. Urgent matters
Any urgent matters arising between meetings will be dealt with by Chair's action after agreement from three other members of the group.

15. Administration
Health Protection Manager and Secretarial support. Directorate of Public Health, B&NES.

16. Attendance
Members (or their nominated deputies) are required to attend a minimum of 3 out of 4 meetings annually.

17. TOR review
TOR will be reviewed at 12 months usually, but at 6 months in first 2 years.

References

DH (2012a) “The new public health role of local authorities”, Gateway reference 17876 published October 2012

Local Government Association, (2013) “Health and Wellbeing boards: a practical guide to governance and constitutional issues” published March 2013

DH (2012b) “ Health protection and local government” published Sept 2012, gateway reference 17740 (this document does not describe the final arrangements for health protection – as when it was produced national legislation had yet to be completed.)

DH, et al (2013) “Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public Health functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013” May 2013, DH, PHE, LGA

Bath & North East Somerset Immunisation Group
Terms of Reference

1. Background

From April 2013 the Health and Social Care Regulations changed the statutory responsibility for health protection arrangements.

Responsibility for commissioning all universal immunisation programmes was passed to NHS England Area Teams as a seconded function from Public Health England who also provides the public health and system leadership capacity in the way of seconded / embedded workforce (Screening and Immunisation Teams, SIT). All B&NES universal immunisation programmes are commissioned by NHS England South (South Central), formally the Bath, Gloucestershire, Swindon and Wiltshire (BGSW) NHS England Area Team supported by the PHE Centre for Avon, Gloucestershire and Wiltshire (AGW). The programmes commissioned are part of the Section 7a agreement between the Secretary of State for Health and NHS England, all programmes are commissioned against a national Service Specifications (Part c of the S7a), subject to local agreements on appropriate additional initiatives.

Upper tier and unitary local authorities also acquired new responsibilities with regard to protecting the health of their population. Specifically local authorities are required, via their Directors of Public Health (DsPH), to assure themselves that relevant organisations have appropriate plans in place to protect the population against a range of threats and hazards and to ensure that necessary action is being taken. The B&NES Health Protection Board was established in 2013 with the responsibility for coordinating the local health protection responsibilities and whose membership consists of commissioners, regulators and other organisations involved in health protection in B&NES.

The implementation of the H&SC Act has come with its challenges, and the screening and immunisation public health leadership and its commissioning has been nationally acknowledged one of the key risks. Some of the issues in this relation explicitly: access of appropriate , timely and reliable data specifically enabling small area analysis; clarity of roles and responsibilities on incident management; working arrangements across NHS England and PHE etc.

NHS England and Public Health England are currently undergoing further re-structuring and NHS England and Clinical Commissioning Groups are implementing co-commissioning or delegated commissioning which is likely to impact on the commissioning and oversight of routine immunisation programmes.

2. Purpose & Scope of the Group

It is necessary to have one operational group with the responsibility for taking a system-wide overview of organisations and other stakeholders contributing to B&NES immunisation programmes with the aim to protect the health of the local population, reduce health inequalities and minimise and deal promptly with any threats that may occur. Please see Appendix 1 for a list of all the immunisation programmes that this group will cover. At this time programmes which consider individual risk factors such as travel vaccinations will not be covered in the scope of this group.

The group will provide a structured approach to monitoring, identifying & mitigating risks and updating action plans relating to immunisation programmes. It will work collaboratively to exchange information, share knowledge; good practice and provide practical solutions and ideas to for the purpose of improving and strengthening local immunisation programmes.

The group will also aim to seek assurance that immunisation services in B&NES are compliant with the DH guidelines and ensure that all national and local immunisations programmes are delivered safely, effectively and in a timely manner to all B&NES residents.

3. Functions

- Seek assurance that all established universal immunisation programmes are implemented and reported in line with national standards.

- Review performance and monitoring of achievement of national or local targets of the immunisation programmes listed in Appendix 1 in line with local and national reporting standards.

- Identify risks or potential risks in meeting immunisations targets or provision of immunisation services in a timely way so actions can be taken by relevant parties to mitigate risks.

- Seek assurance that vulnerable groups such as looked after children; members of the travellers community, people with learning difficulties and the homeless are identified and steps taken to meet their special needs.

- Monitoring the implementation of local and national initiatives to improve uptake of immunisations e.g. the new NICE guidelines

- Sharing of best practice on implementing, maintaining, improving and developing immunisation programmes with providers of immunisation services.

- The development of a programme of work, incorporating the requirements of all other action plans, which identifies the necessary resources required

- Audit of existing and new immunisation programmes as necessary

- Horizon scanning for new immunisation programmes and additions or changes to existing programmes.

- Ensure that actions identified following outbreaks of infectious disease are implemented where appropriate.

- Review immunisation incidents across B&NES to identify trends, to reduce future incidents and identify lessons learned to be implemented.

- Seek assurance that health professionals are suitably qualified and competent to deliver immunisation programmes and disseminate training information and opportunities.

4. Accountability/Authority & Data Sharing

The B&NES Immunisation Group reports to the B&NES Health Protection Board which directly reports to the B&NES Health and Wellbeing Board. Any identified risks should be escalated to the B&NES Health Protection Board and recorded on the Board's risk log and escalation process followed.

Concerns about performance of achievement against national or local targets of immunisation programmes should be referred to NHS England South (South Central) Screening & Immunisation Team for appropriate action to be taken.

Practice level data should not be distributed outside of the meeting and is not for publishing.

5. Membership and Quoracy

Membership of the B&NES Immunisation Group shall be the named leads responsible for ensuring objectives are delivered. A quorum shall be at least four members which must include 1 Local Authority Public Health representative, 1 NHS England South (South Central) Screening & Immunisation team representative and at least 2 representatives from providers. Each member is required to attend at least two of the three scheduled B&NES Immunisation Group meetings and substitute representatives are acceptable as part of the quoracy.

The Co-Chairs of the B&NES Immunisation Group is the Consultant in Public Health on behalf of the Director of Public Health and Screening & Immunisation Manager, NHS England South (South Central) on behalf of the Screening & Immunisation Lead.

Other core members of the B&NES Immunisation group are

- Screening & Immunisation Coordinator, NHS England South (South Central)
- Health Protection Manager, Bath & North East Somerset Council
- Community Consultant Paediatrician
- Child Health Records Department lead
- School Nursing Service
- Primary Care Representative (General Practitioner, Practice Manager or Practice Nurse)
- Health Visitor Representative
- AGW PHEC Representative
- Midwifery Representative
- Infection Control Representative (Sirona)
- Local Pharmaceutical Committee Representative

6. Frequency of Meetings

Meetings shall be held not less than three times a year.

7. Review Arrangements

The terms of reference and effectiveness of the group should be reviewed after 12 months.

Review History

Version	**Approved Date**	**Review Date**
V1	April 2015	April 2016
V2	April 2016	April 2017

Appendix 1

The immunisation programmes that this group will cover are:

Neonatal Hepatitis B immunisation programme

Neonatal BCG immunisation programme

Respiratory syncytial virus (RSV) immunisation programme

Immunisation against diphtheria, tetanus, poliomyelitis, pertussis and Hib

Meningitis C (MenC) immunisation programme

Hib / MenC immunisation programme

Pneumococcal immunisation programme

DTaP/IPV and dTaP/IPV immunisation programme

Measles, mumps and rubella (MMR) immunisation programme

Human papillomavirus (HPV) immunisation programme

Td/IPV (teenage booster) immunisation programme

Seasonal influenza immunisation programme (Although most discussion should be directed to the NHS England South (South Central) Flu Planning & Oversight Group).

Shingles routine and catch-up programme

Pertussis (pregnant women) vaccination programme

Rotavirus immunisation programme

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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	12/10/2016
TYPE	An open public item

Report summary table	
Report title	Annual Director of Public Health report: Get Fresh – Health and Wellbeing in Bath and North East Somerset
Report author	Bruce Laurence 01225 394075
List of attachments	The Annual Director of Public Health Report
Background papers	Contains information from JSNA pages on Council Website
Summary	The report is to be presented for information and endorsement, but there are no key decisions to be made
Recommendations	The Board is asked to agree that: • The board approves the annual report • The board agrees that the areas of focus in the report reflect current public health priorities in Bath and North East Somerset • The board endorses the importance of preventive and health protection services to the residents of Bath and North East Somerset
Rationale for recommendations	The annual DPH report is an independent report from the DPH on the state of public health in the area. As there is now so much easily accessible local and national information on health indicators, the report seeks to highlight the biggest public health priorities for the area and demonstrate some of the work that is happening to address those priorities. In general the priorities in this report closely align with the priorities in the health and wellbeing strategy.
Resource implications	There are no direct resource implications associated with this report although it does inform discussions about future funding priorities
Statutory considerations and basis for proposal	Details of any relevant considerations regarding equalities, crime & disorder, sustainability, natural environment, planning, human rights, children, public health & inequalities. It should also specify the legal power or duty that authorises the decision to be made
Consultation	N/A
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

The full report is attached to the papers and is available to download from the Council's website.

Please contact the report author if you need to access this report in an alternative format

Bath & North East Somerset Council

Report of the Director of Public Health 2016

GET FRESH:

Health and Wellbeing in Bath and North East Somerset

Bath and North East Somerset – *The* place to live, work and visit
www.bathnes.gov.uk

FRESH

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Introduction

Welcome to the 2016 Director of Public Health report. I am here to find ways to help residents become healthier, in body and mind, and avoid, where possible, developing the diseases that prevent us living happy and fulfilled lives.

On average, people in Bath and North East Somerset are some of the healthiest in the UK. But we still face all the challenges that beset any community, and throughout life many of our residents face health problems and disabilities. Our "average" situation reflects a large number of people doing excellently well, but also many with far less positive experiences, and if you are one of those it is little comfort that you live in a healthy area.

Whenever there is a discussion about people's lifestyles, avoidable illness and health inequality in the media, whether about obesity, alcohol or smoking, you will usually hear two broad sets of views.

The first is that our job as health professionals is just to give people the facts about healthy behaviours and then they will use that knowledge, or not, as they wish. If they don't want to take responsibility for their health that is their choice, and anyway we pay for the NHS to treat us, whatever the causes of our illnesses. Beyond that basic education, it is no business of the state to tell anyone how to live their lives.

The second set of arguments are that people's choices are heavily influenced and restricted by the nature of their wealth and position in society, their upbringing and education, advertising, the environment and the economy as well as characteristics such as genetics, sex, ethnicity and disability. In recent years "behavioural economics" has given us a more sophisticated understanding of the psychological influences on our behaviour. On the basis of all these points, the argument goes, a just society needs to work actively to shape itself to provide the best possible opportunities for people to thrive and to "make the healthy choices the easy ones".

There are many refinements to this picture. One is that children are not free to make choices separately from their parents, and society has a responsibility to support them more actively until they are able to do so. Another is that the country pays dearly for the treatment of preventable illness and so there is a shared interest in a healthy population. Yet another is that health inequalities on too great a scale are damaging to the health of all members of the community, even the better off, and that a healthy society therefore needs to take active steps to reduce health inequality and its causes.

We see some of these arguments play out in political and policy debates in the media, and they tend to become very polarised and heated. But as with most of the big questions in life, reality is far more complex and messy than any simple viewpoint can capture. What I hope to show in this report is that we can achieve the most for our residents by balancing all of these views and finding ways both to help individuals make good choices, and to shape the local environment, in the widest sense, to make those choices easier.

Working in the Council and with the local NHS puts me and my team in an excellent position to play this role, and there is widespread commitment of all the major organisations in Bath and North East Somerset to this work.

So many different things affect our health and wellbeing that it can be hard to identify clear priorities. I have therefore used the short word "FRESH" in this report as a mnemonic to help me identify and explain what they are. Our health can be improved at any time in life, from before birth to the very end, and much of the way we work practically is built around a lifelong approach, starting with helping young families, then school age children, working age adults and older people in retirement.

Part of the report will focus on an important meeting this year, run for our Health and Wellbeing Board, to focus on the health inequalities that we have in our communities, and the work that many organisations and groups can do to narrow the gaps between different parts of our community.

If we are to improve people's health, we need accurate information, both about the health of our residents and also about what actions and services are most likely to provide effective support. You will find much information summarised in the report, and much more is available on the Council's website particularly on the Joint Strategic Needs Assessment (JSNA) pages for those who want to dig deeper.

But behind these figures are real people, families and communities, and in this report you will also see some of their stories and challenges, and hear about the support that we are able to give to them. This year we have also listened to the public, and what they think is important about their health, through the pages of the Bath Chronicle. I thank the editor of that paper for allowing us to do this.

I hope you find it interesting and readable, and if anyone wants to speak to me about anything in the report please get in touch on my email at bruce_laurence@bathnes.gov.uk

Dr Bruce Laurence
Director of Public Health

"On average people in Bath and North East Somerset are some of the healthiest in the UK. But we still face all the challenges that beset any community, and throughout life many of our residents face health problems and disabilities."

"Behind these figures are real people, families and communities, and in this report you will also see some of their stories and challenges, and hear about the support that we are able to give to them."

What is FRESH?

Health and Wellbeing is affected by many different influences – from our genetic make-up, how and where we live, the people we spend time with, the education we receive and the work we do. The Public Health team works within the council and in partnership with a wide variety of other agencies to provide a variety of preventative services to the local population, but also builds on their skills and knowledge to ensure that all services aim to promote physical and mental health and wellbeing and to reduce inequalities experienced by different groups within the population.

Five priority areas have been identified by the Public Health team which represent the most significant challenges to the health and wellbeing of residents in B&NES and priorities which the team believe can make the biggest difference using the skills and resources that we have. These priorities are expressed using the acronym 'FRESH'.

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Food and Fitness

Obesity, inactivity and poor diet are at the root of so many of our disabling and deathly diseases like heart disease, strokes, diabetes and many cancers. These diseases can also have a major impact on an individual's mental health. We invest in services that help people of all ages to eat well, exercise more and achieve a healthy body weight.

Relationships and Resilience

Human connections within families and communities along with good mental health are essential for our overall wellbeing. The Public Health team works with others to ensure that those people who are most vulnerable in our community are able to express their health and social needs. We also invest in specific services to promote good mental health and to improve access to other services for those who might most easily be excluded. We work with others to find ways of reducing social isolation and loneliness.

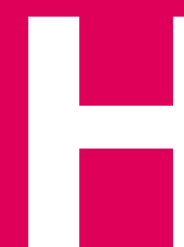
Early Encouragement

It is well documented that a good start in life, with sufficient love and skilled care will improve a child's prospects into adulthood and old age. Therefore providing help to young families and to children's developing minds and bodies are some of society's most fundamental duties. Two of the Public Health teams' largest and most important investments are in the health visiting and school nursing services. These support families from before birth to the end of adolescence, helping to prevent problems before they start, support those in greater need and enable children to fulfil their potential.

Sex and Substances

Positive sexual relationships are important to most people's overall wellbeing; and human society has always existed with a variety of mood-altering drugs, from tobacco and caffeine to cannabis and other drugs. Together these are the pleasurable but potentially risky activities where Public Health intervention can reduce the likelihood of harm. A major area of service provision funded from the Public Health budget is our comprehensive range of sexual health services, advice to young people, easily accessible contraception, and other valuable services. Another large chunk of our budget goes on the prevention and treatment of addiction to tobacco, alcohol and the other legal and illegal drugs.

Hometowns and Habitats



Our housing, the economy, transport links, the natural environment and workplaces impact heavily on our health and wellbeing. The Public Health team have made strong links to teams such as Public Protection, Transport and Regeneration, and has made a contribution to areas as diverse as air pollution, health and the built environment, active transport planning and the health impacts of climate change.

Food and Fitness

We want everyone to be able to enjoy good quality, safe, affordable food and a healthy diet. The Bath and North East Somerset Food Partnership has been set up to oversee the B&NES Local Food Strategy and to co-ordinate action on food issues. We are working on more locally produced food that sustains the environment and supports the local economy too. Take a look at our short Local Food Film to find out more about the work of the partnership. Here are some examples:

Bath and North East Somerset wins Prestigious Sustainable Food Cities Award

Bath and North East Somerset has won the Silver Sustainable Food Cities Award for its work in tackling key food health and sustainability issues such as food poverty, cooking skills, public-sector food and waste. It is one of just 9 local authority areas in the UK to win the prestigious award.

Councillor Martin Veal (Conservative, Bathavon North), Cabinet member for Community Services said **"The Sustainable Food Cities Award recognizes the work of a wide range of organisations including Bath Area Growers who have set up new community gardens in Bath and Community @ 67 who have set up a local food co-operative and lunch club in Keynsham. We're particularly proud of the Local Food Partnership's efforts to improve public-sector food procurement, increase cooking, growing and healthy eating in schools and to support people to develop cooking skills".**

For more information please view the Sustainable Food Cities Award Application or visit www.bathnes.gov.uk/localfood

FOOD AND FITNESS

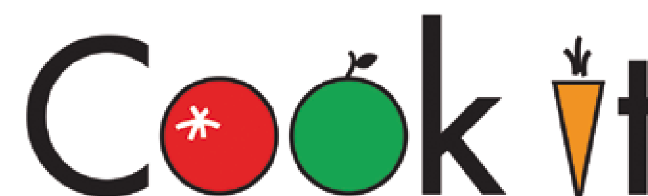
School Food Forum

The Forum supports a whole school approach to food and aims to provide healthier food for children. It has helped schools to meet the new school food standards and increase school meal uptake by 20% between 2013 and 2015. It also supports schools to meet healthy eating requirements in the Director of Public Health Award including cooking, growing, healthy eating and farm visits.

Check out our short film to find out more about food in our local schools!

Public sector food

B&NES Council has developed a new partnership with local food distributor, Fresh Range, to provide fresh, local and sustainable food in schools and other outlets. The new partnership will allow a wide range of local farmers and businesses to supply the Council's school food service, providing fresh food for children and helping to support local businesses and reduce food miles. The Council currently holds the Soil Association's silver Food For Life Catering Mark for its school meals. This provides an independent endorsement that meals served are freshly prepared, free from trans fats and additives, promote healthy eating and are produced from local, organic and sustainably sourced ingredients.



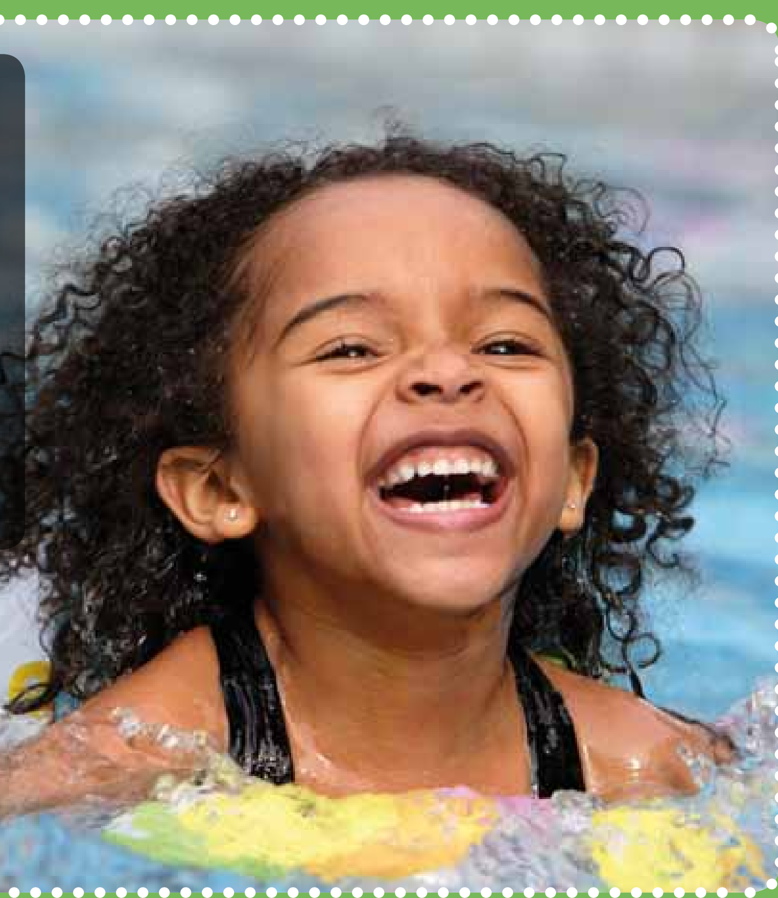
'Cook It' Service

If we want families to eat well it is essential that people have basic cooking skills. The Cook It Service is a free practical cooking course for parents, carers and pregnant women which targets those at greatest need and focuses on affordable, quick and nutritious meals that can be prepared on a budget. The Cook It Service has worked with over 150 local families during the financial year 2015/2016.

Eat Out, Eat Well Award

The "Eat Out Eat Well Award" is designed to encourage restaurants and take-aways to provide their customers with healthier choices and to support them to reduce the fat, salt and sugar content of food prepared. The award scheme is open to all types of food outlets including restaurants, cafes, take-aways and work settings. There are currently 82 businesses in B&NES with an "Eat Out Eat Well Award" and there is a target of enlisting 20% of high street food outlets by 2019.

Food and Fitness



Our modern sitting down and labour-saving lifestyles are doing us great harm and physical activity is truly one of the miracle cures that we can use to improve body and mind. The local Fit for Life Partnership is made up of a range of local organisations who work together to get –and keep- B&NES moving. We have had a busy year. Some of the highlights include:

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A well established Tryactive programme - This project with Bath Rugby Foundation uses cycling, running and outdoor fitness to get people active and healthier.

Improved Sportivate Youth engagement projects at Southside and Peasedown St John - Sportivate is a nationwide campaign providing opportunities for teenagers and young adults (aged 14-25) to receive coaching in a sport of their choice and guide them into regular participation within their community.

Wheels for All Cycling Projects - An inclusive programme enabling disabled and non-disabled children and adults, with a wide range of social, emotional, physical and learning requirements, to engage in and enjoy cycling.

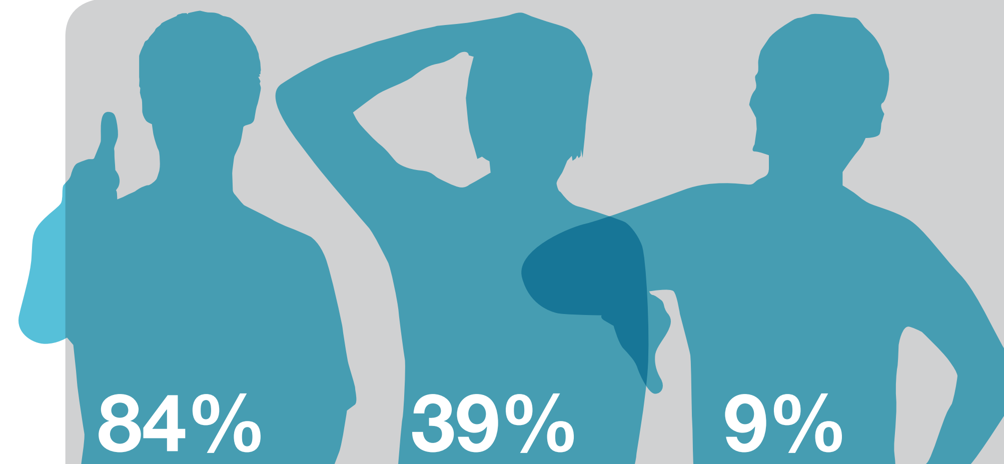
The launch of "**This Girl Can Swim**" at Culverhay Sports Centre - This Girl Can Swim is a national campaign developed by Sport England and a wide range of partnership organisations. It is a celebration of active women up and down the country who are doing their thing no matter how well they do it, how they look or even how red their face gets.

Advice about eating well, moving more and health checks are available as part of the national One You campaign: http://www.bathnes.gov.uk/services/public-health/one-you

Relationships and Resilience

How we feel affects our health. Across the UK 10% of older people live with chronic loneliness[1] and loneliness can be as bad for our health as smoking[2].

According to the Voicebox Residents Survey 2014[3], most people living in Bath and North East Somerset are satisfied with their lives and their relationships. Some people though do not have a quality of life that they would hope for:



84%

84% of residents reported high levels of satisfaction with their life.

39%

But 39% felt anxious "yesterday", higher than the regional average.

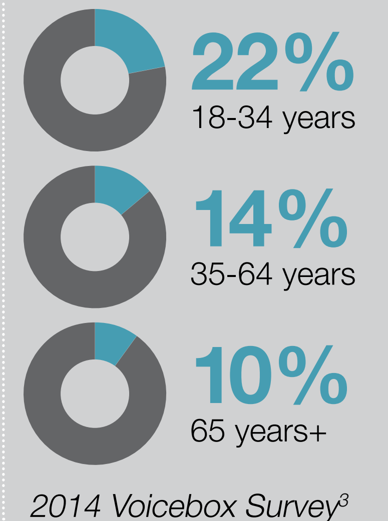
Office for National Statistics Wellbeing Survey, 2013/14[4]

9%

9% of people said they were not satisfied or not sure if they were satisfied with the kinds of relationships they have.

B&NES Voicebox survey for adults in 2014

Younger people in Bath and North East Somerset are most likely to feel they had no one outside their family they could depend on…



2014 Voicebox Survey[3]

More information is available from http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/wellbeing and http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/loneliness-and-isolation

The good news is that research shows there are basic steps we can take to feel better: connecting with others, being active, taking notice of our surroundings, learning something new and giving to others.

These principles form the heart of our work to support the wellbeing of everyone in Bath and North East Somerset. Reducing isolation is a particular priority of our Health and Wellbeing Board. Here's a flavour of our local projects:

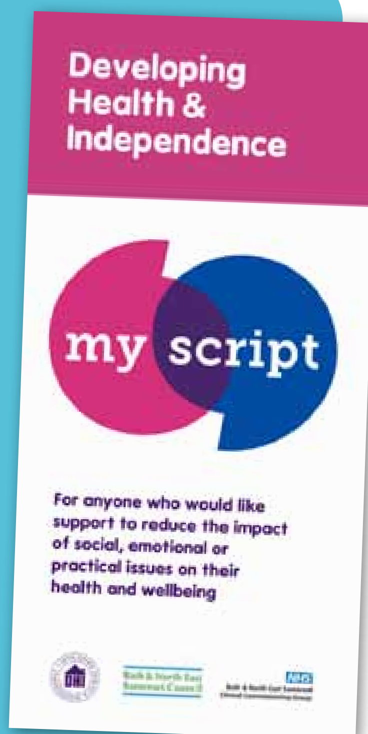
Keynsham Older People's Group, a joint initiative with Age Concern. A friendly group of older people meets in Keynsham. Members enjoy outings, such as trips to the Lifeskills Centre and MShed Museum in Bristol, Bath's Holburne Museum, as well as talks by visiting speakers. The group is free to join, members just bring along a small item for the raffle table.

The Lunch Bunch meet in the Midsomer Norton and Radstock area each month for a pub lunch.

The Hub in a Pub at Chew Stoke, a joint initiative between The Stoke Inn, Age UK, Council and City of Bath College. It provides services and support to older people living in the Chew Valley. The 'Gadget Busters' IT scheme is one of many activities.

See http://www.ageuk.org.uk/bathandnortheastsomerset/activities-events/ or call 01225 484510 for more information.

'MyScript' social prescribing



Health services have a key role in helping people stay mentally and physically well. However, a pill or an operation is not always the best medicine. 'MyScript' is for people who have been in contact with their GP about physical and/or mental health issues who showed an interest in finding out how art, exercise, nature or social activities might help them to feel better.

The service finds out more about peoples current situation and suggests opportunities in the community which might be fun or helpful. The help does not stop there, the team can encourage and support people to attend these opportunities as they are aware that it can feel daunting to try something new.

Nearly 300 people used the service in the first year. Your GP can refer you to the service, so the first step is to talk to them about it. You can fill in a self-referral form (www.dhi-online.org.uk/do/bath/my-script-social-prescribing/) and hand it in to the reception at your Bath and North East Somerset GP surgery. Volunteers are always welcome, to discuss volunteering contact Richard Brookes on 01225 310077.

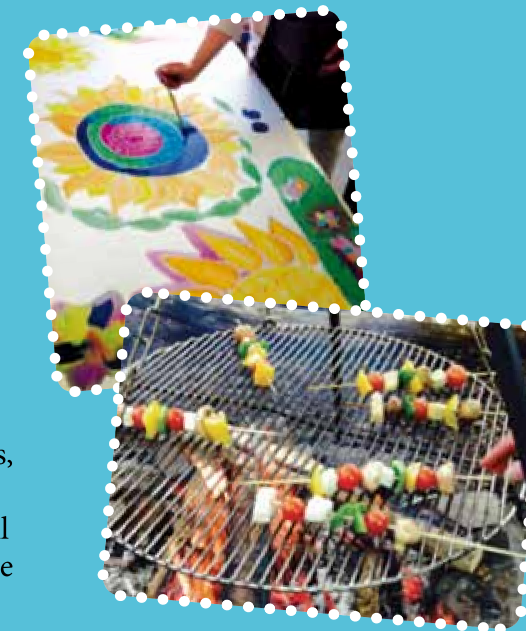
GoodGym

Runners with a strong community spirit to match their strong legs are paired with an older person who would like a runner to visit for a chat. The runner benefits from a cup of tea and encouragement for the return run! GoodGym runners undertake other activities for the community too.
https://www.goodgym.org/areas/bath

The Wellbeing College

The College provides activities and courses in community venues across the area. These aim to improve wellbeing by helping people to learn something new and meet new people. Everyone is welcome and most courses are free. Examples include:

- Woodland wellbeing – a course providing an opportunity to spend two hours in the woods with nature
- Learning about computers in a small supportive group
- Traditional upholstery for beginners
- Gentle yoga – a course very popular with older people



People attend for a number of reasons. Some simply want to start a new hobby or improve their fitness, others are anxious, depressed or lonely and want to do something to feel better. Courses are listed at www.wellbeingcollegebanes.co.uk or call 01225 831820 to speak to an advisor who can help you decide which courses would suit you best.

Feedback from the Wellbeing college

"I was so glad I made the effort last week, even in the rain. It was an achievement. It's really good for me to be doing something different and for myself."
Woodland course

"This course has given me the confidence in myself to approach exercise again"
Gentle Yoga

"Helps me in more ways than I could put into words. Everything about me just feels better. I feel like me, I feel free"
Nature Nurture course

"It has been amazing, I've never laughed so much. Great fun, met some great people and have been able to do things I never thought I would be able to"
Fun Circus Skills

Early Encouragement for Children and Young People

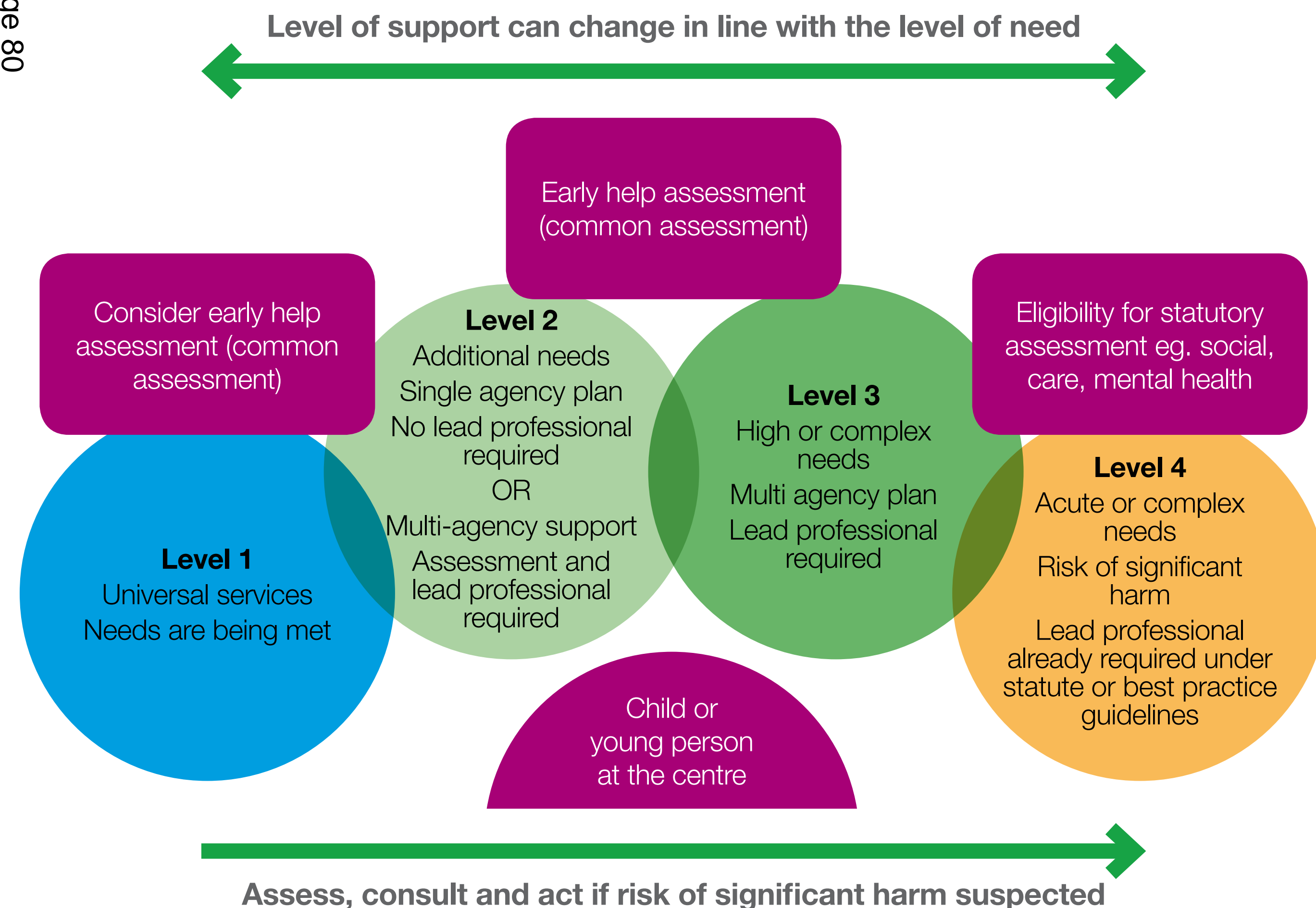
Giving every child the best start in life is crucial. Public Health has been involved in a range of work to strengthen early encouragement in terms of both early help and working with early years.

Early Help offer strengthened

Early Help means providing effective support to children and young people as soon as needs start to be identified, and to bring about change to prevent these from escalating and leading to poor outcomes. Early Help may occur at any point when needs arise, from pre-birth through to the teenage years and at any stage in adulthood.

Organisations have joined together to strengthen the prevention approach with an Early Help offer for children and young people. 2016 saw the launch of the Bath and North East Somerset Early Help Strategy[5].

Early help is an approach, which should take place across the spectrum of need, from universal services for everyone, through to targeted and specialist services (see fig **)



Early Years - Health visiting becomes part of Council services

Bringing up children is a daunting responsibility for anybody, and our health visitors give valuable advice and support to all our families. In October 2015, the commissioning of services for children between the ages of 0-5 was transferred to local authorities, including the health visitor service.

Now that the council has this responsibility there are great opportunities to work more closely with other services like housing, nurseries and children's centres, as well as local GPs. Our 4-5-6 model shown here explains how health visitors work with young families.

Figure ** 4-5-6 model

4
- Community
- Universal services
- Universal plus
- Universal partnership plus

5 **Contacts / touch points**
- Antenatal health promoting visits
- New baby review
- 6-8 week assessment
- 3-4 month visit (local additional offer)
- 1 year assessment (9-12 months)
- 2-2½ review

6 **High impact areas**
- Transition to parenthood
- Maternal mental health
- Breastfeeding
- Healthy weight / nutrition and physical activity
- Minor illness and accidents
- Health and wellbeing / development

Targeted provision – Family Nurse Partnership

The Family Nurse Partnership (FNP) is an extra programme giving intensive support to our youngest mothers. This is a tried and tested approach started in the USA 30 years ago.

The programme focuses on attachment, relationships and psychological preparation for parenthood, helping to overcome adverse life experiences which very young mothers have often faced themselves so that their babies have a great start. Locally there is a team of 5 staff who can see up to 80 families up until their child is 2 years old.

What's changed?

- Health Visitors have been training and now ask all parents about alcohol and substance misuse
- Baby feeding hubs have seen a significant increase in numbers attending
- Health Visitors have started to deliver 'Hello Baby' antenatal courses in Children's Centres.

CASE STUDY

"A day in the life of a Family Nurse from Family Nurse Partnership"

It's Tuesday, nothing special really, just another day…

The Family Nurse in B&NES will see three clients today, one is 14 years old and pregnant; the second is 17 years old with a newborn infant and a partner in prison; and the last client of the day is a 19 year old care leaver who is single with a 22 month old toddler. It's just another day.

With the pregnant client, the Family Nurse will discuss and explore fetal development, nutrition and exercise, smoking and substance use, housing and benefits, plans for the future, healthy relationships and domestic abuse, infant feeding, labour and birth – to name but a few. All the time, affirming strengths and developing the client's increasing knowledge and desire to 'get it right' for her unborn. It's just another day.

With the client with the newborn, the Family Nurse will further explore and build upon all the topics covered in pregnancy. S/he will deliver programme content and complete assessments relating to child health and development – physical, social and emotional – and explore how to support the infant's learning at each stage of development. Not forgetting support around safe sleeping, feeding and introducing solids, immunisations, childhood illnesses and safety. It's just another day.

with the client with the child in toddlerhood (12-24 months) the Family Nurse will further explore and build upon all the topics covered in pregnancy and infancy, with the added blessing of a toddler joining in. S/he will deliver programme content that promotes learning for the client and child. They will explore the importance of play on development and explore the challenges of, and responses to, normal toddler behaviour. S/he will also prepare the client for a positive ending, when they say goodbye and the client will access universal services themselves. It's just another day.

Throughout all of this, the development of a trusting, therapeutic relationship between client and Family Nurse is an intervention in itself. For clients who have experienced many losses and been let down many times, this relationship, and the ability to test its strength and still have the Family Nurse there, has a significant impact on the client's ability to build trusting relationships in the future. It's just another day.

Throughout all of this, the Family Nurse is acting as advocate for the client and child, in often very complex, chaotic and vulnerable circumstances. S/he will work with other agencies to best meet the needs of the individual client and child; including Social Care, Domestic Abuse Agencies, Police, Probation, Mental Health Services, Housing, and other Health Services. It's just another day.

Throughout all of this, the attachment and interaction between the client and child is continually observed and supported with tools and activities, with the key objective of positive interaction and secure attachment. For the clients who have not had positive interactions or secure attachments in their own lives up to the point of becoming a parent themselves, this is a great achievement in breaking the inter-generational cycle. It's just another day.

Just another day in the life of a Family Nurse is a true example of Early Help in action, working every two weeks with women aged 19 and under expecting their first child, from early pregnancy until the child's second birthday.

"The development of a trusting, therapeutic relationship between client and Family Nurse is an intervention in itself."

Sex and Substances

Drugs

Figures appear to indicate that the numbers of opiate and/or crack users in the 15-64 population in Bath and North East Somerset have increased over recent years.

There has also appeared to have been an increase in availability and use in the new psychoactive substances (NPS), previously known as 'legal highs' that appear to be commonly available. In order to halt the spread of these new drugs The New Psychoactive Substance Act came into force on the 26th May 2016. This new act will stop UK websites or headshops from selling NPS's, and will also stop the selling of Nitrous Oxide (NOS) which is often referred to as laughing gas.

Bath and North East Somerset substance misuse team has been proactive in increasing knowledge of new psychoactive substances and Ketamine harm. In response to requests, further training is being delivered in schools, youth clubs and colleges to show the physical changes to the body that, for example, ketamine produces. The Avon and Somerset Police Drug Strategy Manager also delivered training in B&NES on drug trends and NPS's with over 50 professionals attending.

Jason's experience of treatment from Project 28.

Project 28 offer support and assessment services for young people in the BANES area with problematic substance misuse needs.

Jason came to Project 28 at the age of 14 confused with low self-worth and no direction. His journey was not an easy one but he stuck with it reaching goals and keeping to appointments. Support through school for Jason was essential for his treatment and he often said how important it was to have someone to talk to and somewhere to go. More agencies became involved as Jason's needs began to be revealed. Jason finished school, passing his exams and has just completed his first year of college passing Level one in plumbing. He is proud and excited by life and has learned to talk about his feelings. Other key agencies that supported Jason were Child and Adolescent Mental Health Services (CAMHS) and Youth Connect.

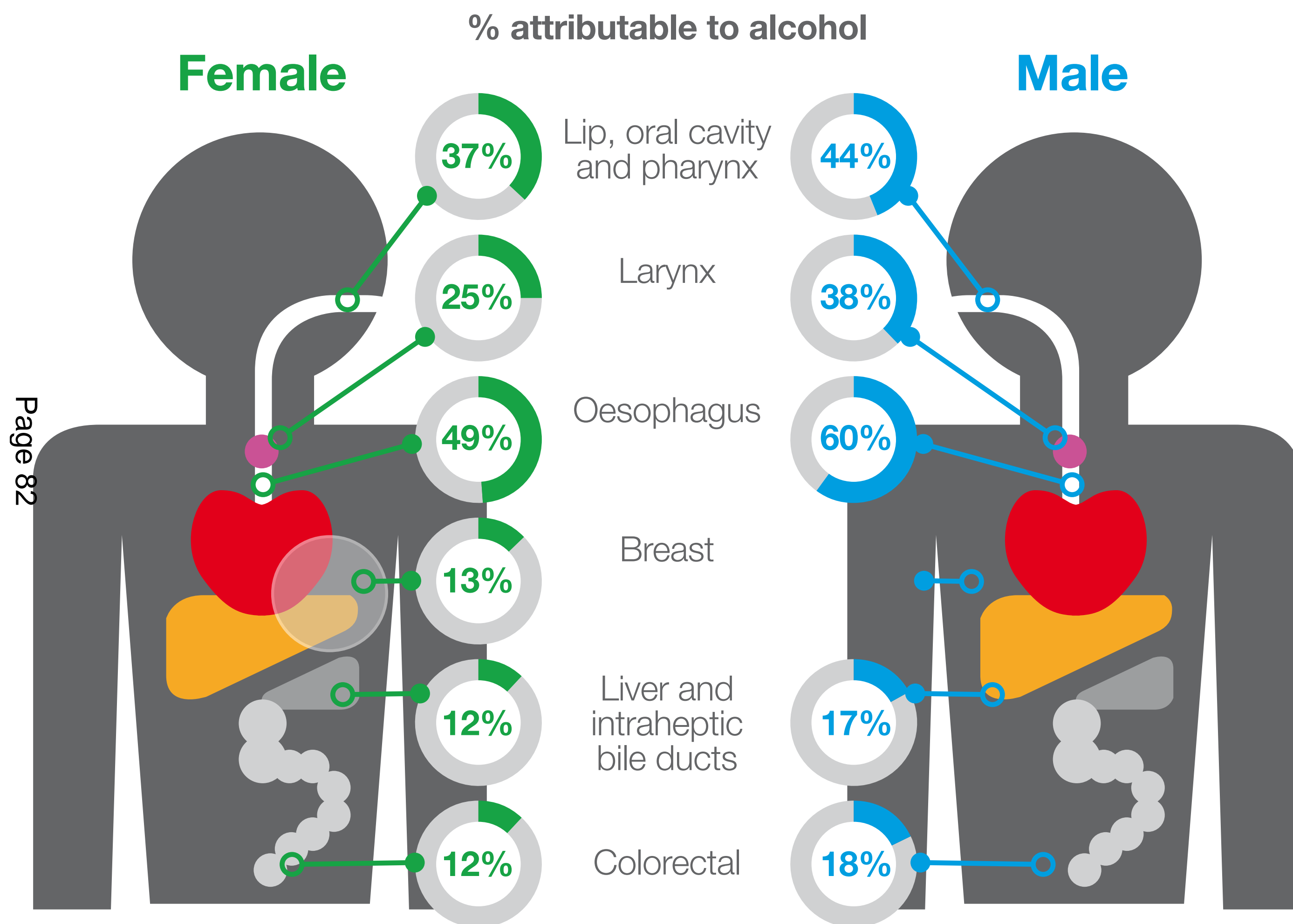
Discharged in July 13, Jason completed treatment and remains drug free.

Alcohol

A study commissioned by Public Health Action on behalf of 11 local authorities in the South West revealed that one in three adults are drinking too much alcohol, consuming it at levels that pose an increasing or higher risk of damaging their health. 83% of those drinking above the Government's recommended guidelines underestimated their drinking, seeing themselves as 'moderate' or 'light' drinkers and 69% (7 out of 10) were not concerned about how much they drink[6].

According to the 2015 Child Health and Wellbeing Survey the proportion of 12-15 year olds reporting drinking alcohol has declined, for example, the numbers who reported drinking alcohol in the last week: 15% of boys in 2015 compared to 24% of boys in 2013 and 12% of girls compared to 21% of girls in 2013[7].

Alcohol consumption is a risk factor for many types of cancer



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Treatment services for the young:
48% of young people in drug and alcohol treatment services drink alcohol. When leaving treatment, 95% of young people have successfully completed treatment, with only 3% re-presenting.

Treatment services for adults:
The number of people seeking help with alcohol misuse has almost doubled in the last three years. The number of people who have successfully completed their programme is consistently high at between 46% – 50%. This is above the national average.

Young Peoples Sexual Health Services

It is really important that young people develop their sexual awareness and behavior in the context of supportive and respectful relationships. We must help them to stay safe while still young, and learn how to form successful long term relationships in adult life. Our modern highly sexualized society presents some real challenges and pressures, and so our sexual health services focus very much on the importance of relationships and respect, young people's rights to control their bodies and be sexually active or not as they choose, and helping them in practical ways to be safe and avoid risks of unwanted pregnancies and sexually transmitted infections. Around 10 years ago the rate of teenage pregnancy in Bath and North East Somerset increased. Evidence highlights that the most important factors in reducing teenage pregnancies are making access to contraception services easier1 (complemented by high quality relationships and sex education starting before young people become sexually active). Therefore services were redesigned to change the locations, methods of communication and timings of clinics to suit young people. Teenage pregnancies have decreased by 55% within the last 5 years.

Clinic in a Box

Clinic in a Box is a mobile service delivered by experienced school nurses who offer confidential advice and support, and provide condoms, contraception, pregnancy testing and information on sexual health, contraception and relationship issues to young people. All resources are easily transportable in a mobile container, hence its name. Lots of time was spent talking to young people about the best locations for the clinics. Many different locations were trialed and at present the clinics are located in:

- Secondary schools
- Youth clubs
- Further education colleges
- Youth offending team

The service operates on a flexible system where locations can be changed to meet emerging need, which further enhances the mobile nature of the service.

Text a nurse service

Another service which the school nurses provide to young people is the 'text a nurse' service. This provides young people with access via text message to a nurse for sexual health advice and support.

Some recent text enquires which have been answered this way:

'Help I can't remember if my dentist said that I should stop taking the pill as I am on antibiotics'

'Are you in school today as I have forgotten to take my pill and don't know if I need the morning after pill'

Homes and Habitats

Our health and wellbeing does not exist in isolation. Where and how we rest, work and enjoy leisure activities influences and is influenced by our health. Our environment is critical to our ability to become and remain, physically and mentally healthy. One of the priorities of the B&NES Health and Wellbeing Strategy is to create healthy and sustainable places.

Housing and health

Affordable:

Achieving affordable housing is a challenge in B&NES. B&NES has the 15th highest rents outside London for English Housing Market Areas.[8] As part of the Council's development plans it will be overseeing the building of 13,000 new homes across the district over the coming decade. This includes supporting development of affordable housing options including specialist and supported housing.

Warm:

Living in cold conditions can harm your health. The efficiency of the heating system, home insulation, affordability of heating and the affect which cold has on an individual due to age or medication, all play a part in whether people become ill due to the cold. An estimated 1 in 8 households in B&NES are in "fuel poverty", meaning that they struggle to keep their houses warm as well as pay all their other bills (DECC, 2013). This is more than the regional and national averages.

Warm & Healthy Homes Fund Grant (advertised as Warm Homes Grant in B&NES)
B&NES Council have a new Warm Homes Grant for those struggling to heat their homes delivered in partnership with the national charity National Energy Action (NEA). This is aimed at residents at risk of fuel poverty and promoted by health and social care staff as well as others working with this group. It can fully fund a heating system and home insulation and includes a home visit for energy efficiency advice.
People can access it through the website www.energyathome.org.uk

Since the fund started in November 2015, there have been 66 home visits to offer advice. Approximately 1 in 5 of these homes so far are receiving home improvement works to improve the energy efficiency. 35 local frontline staff who have contact with groups who are at risk from living in cold homes have been trained to identify fuel poor households and raise awareness of the effects of cold and damp housing on health.

Energy at Home scheme
B&NES Energy at Home scheme is available to all residents and can help them to:

- Use less energy and get the best deal on their energy bills
- Make energy saving home improvements e.g. new boilers and heating controls insulation, efficient glazing renewable technologies
- Access grants to cover the full cost or part of the cost of installation
- Find accredited installers

T: 0800 038 5680
E: advice@energyathome.org.uk
W: www.energyathome.org.uk

Healthy places to live

The B&NES Placemaking Plan sets out how new homes, employment opportunities, schools and travel infrastructure will be developed over the coming decade up to 2029. It includes a variety of policies that will help promote walking and cycling, local food, green spaces, new jobs and affordable housing.

One area included in this plan is the redevelopment of the Foxhill MOD site, now known as Mulberry Park, and the wider Foxhill estate in the southern edge of Bath. This project, led by the housing provider Curo, has the potential to develop of up to 1300 new homes and will include open spaces, a school, community facilities and improved transport infrastructure. It includes the opportunity to redevelop some of the existing housing stock that over time has become poor quality. All of these plans can help to promote the long term health of people living in the area.

Healthy places to work

Local businesses that ensure their workers are in good health are more productive. Last year we worked with a range of organisations, to help improve the health and wellbeing of their employees. They used a national toolkit, the Workplace Wellbeing Charter, to look at how they could promote a healthier environment at work. We provided expert advice on leadership, absence management, health and safety and signposting to local services and lifestyle support for staff. We also tested out delivery of NHS Health Checks on a trading estate targeting male employees, to raise awareness of the risk of cardiovascular disease in a group of people who may be at high risk of this disease.

Examples of businesses that achieved a Charter Award last year include:

- Madison Oakley Estate Agents who reviewed team terms and conditions and organised activities to promote physical activity;
- Bakers of Bath sent staff on health and safety training and ran a Sugar Swaps campaign. They achieved an Eat Out Eat Well Award for supporting people to make healthier choices when eating out;
- DKA Architects focused on using internal media to promote healthy lifestyle services for staff.

B&NES Council and Sirona CIC also sponsored a new category in the 2015 Bath Chronicle Business Awards: The Best Place to Work Award. The Award celebrated businesses that have taken steps to improve the health and wellbeing of their staff. Storm Consultancy won the category; mainly for their work to support the mental wellbeing of their staff through team building activities and flexible working.

Active environments

The council's Fit for Life Strategy sets out plans to improve leisure facilities in Bath and Keynsham. It also commits to protecting playing pitches and enhancing parks and natural play spaces for children and families.

CASE STUDY

A B&NES resident who has benefited from the Warm & Healthy Homes Fund Grant* through the housing services team.

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Mrs Clarke is 87 years old and on guaranteed pension credit. She lives alone in a three storey detached house. The property had an old oil boiler which kept breaking down, putting her at risk of excess cold. To keep herself warm she used a portable heater in the kitchen and an electric fire place in the living room. She applied for a warm home grant after contacting the Council's Energy at Home advice service.

I inspected the property on 22 January 2016. A couple of weeks after my inspection I received an email from Mrs Clarke's daughter, to say that Mrs Clarke had fallen and was admitted to hospital with some injuries. This fall might have been related to excess cold. Cold impairs movement and sensation, and a lowered body temperature affects mental functioning, such that falls are more likely in the cold. People over 60 years old are more vulnerable than others.

I requested Eco Residential, our contractor to provide us with quotes for a boiler replacement and installation.

During my inspection I noticed two other hazards: fire, as the property had no working smoke alarms and also falls on stairs because there were no handrails by the external stairs.

I asked Mrs Clarke's daughter to contact an occupational therapist to arrange an assessment. I also contacted the Avon Fire and Rescue Service to organise a fire safety visit and provide the customer with some smoke alarms for an early warning in case of fire and also reduce the risk of potential fire spread.

Eco Residential replaced the boiler and installed Thermostat Radiator Valves. The customer was very pleased with our service and happy that she will not have to struggle with the cold any more.

Written by Piotr Toporowski, Assistant Environmental Health Officer

"I also contacted the Avon Fire and Rescue to organise a fire safety visit and provide the customer with some battery smoke alarms."

**Delivered in partnership with the national charity National Energy Action (NEA)*

Protecting the Health of the Bath and North East Somerset population

Screening for bowel cancer

Bowel cancer is the fourth most common cancer in the UK. If it's detected at an early stage, before symptoms appear, it's easier to treat and there's a better chance of surviving it.[9]

The faecal occult blood (FOB) test is available to everyone aged 60-74. Every two years home test kits are sent through the post and check for the presence of blood in a stool sample, which could be an early sign of bowel cancer.

Taking part in the test reduces the chances of dying from bowel cancer. However, all screening involves a balance of potential harms, as well as benefits. It's up to the individual to decide whether or not to have it.

For further information please visit http://www.nhs.uk/conditions/Cancer-of-the-colon-rectum-or-bowel/Pages/Introduction.aspx

Why is it important to offer support to people with learning disabilities to take up screening?

People with learning disabilities have a considerably shorter life expectancy and poorer health than the population as a whole, yet are less likely to access health care. They also have a higher than average chance of health problems associated with bowel cancer – such as obesity and poor diet. It is therefore really important that we do all that we can to help people with learning disabilities take advantage of the preventive health services that we have to offer.

The bowel screening test has been found to be difficult for people with learning disabilities to complete due to difficulties with reading invitations, understanding how to complete the kit and fear of the process. A project has been established in Bath and North East Somerset (B&NES) to help this group of people to complete these tests. This is a joint project between B&NES Council, BANES Clinical Commissioning Group, Sirona Care & Health and NHS England, South (South Central) Public Health Team.

As part of this project, Sirona's community learning disability nurses have been working with people with learning disabilities and their support workers to disseminate easy read resources and visual aids, increase knowledge of the bowel screening programmes, and therefore reduce anxiety and fear linked to the test.

CASE STUDY

Dimensions, Bath

Dimensions are a national organisation providing support for people with learning disabilities and autism. In Bath, Dimensions have a supported living home, providing 24hour support with 12 support workers to 15 residents. The support ranges from help with shopping, days out, cooking and some personal care. 2 residents in this home are in the age group for bowel screening eligible and a number of others are approaching 60 so will become eligible soon.

Last year a number of the support workers helped one of the residents, Mrs P, to complete the bowel screening kit. All post is opened jointly by the resident and their support worker. When the invite and kit arrived Mrs P said that she didn't want to complete the test and the letter and kit was left on the side for a while. Over a few months the support workers were able to explain more about bowel screening and why it was important. In time she was able to decide that she wanted to go ahead and complete the kit.

The support from the staff enabled Mrs P to complete the kit. There were a few challenges along the way with inconclusive samples and difficulties with collecting the stools needed, however, Mrs P was pleased to have completed the kit and relieved to have received a reassuring result. Both the support workers and Mrs P now feel more confident about completing the kit when the next invite arrives in 2 years' time.

This case study has prompted some sharing of learning and easy read leaflets with other support workers who are best placed to help someone with a learning disability. Sirona Care and Health's Community Learning Disability Nurses are able to help with the dissemination of information and advice and have already been doing some of this work with supported people and their support workers.

Enjoy the Countryside and 'Be Tick Aware'

B&NES Council Public Health Team are encouraging residents to become 'tick aware' to continue enjoying outdoor activities with the knowledge and confidence of how to manage ticks should they come into contact with them.

Ticks are small spider-like creatures that can be found where there are deer, small mammals or wild birds. They tend to prefer damp, shady dense vegetation, leaf litter and long grass but can also be found in woodland, open country, public parks or gardens. They don't jump or fly, but live on vegetation and climb onto animals or people as they brush past. They can be found throughout the year, but are most active between spring and autumn.

Ticks can pass on a bacteria which can lead to an illness called Lyme disease in approximately 2500 people per year. Symptoms of Lyme Disease can include flu like illness and a rash, however, this can be treated effectively with antibiotics if caught in the early stages.

Tick Awareness

Know what ticks look like, where they can be found, and practice prevention behaviours to help avoid tick bites.

1. Take simple steps to avoid coming into contact with ticks

- walk on clearly defined paths
- avoid dense vegetation
- wear light-coloured clothing so ticks are easier to spot and brush off
- use repellents such as DEET

2. Check your clothes and body regularly for ticks when outdoors and when you return home.

3. Remove ticks as soon as possible with tweezers or a tick removal tool. Once removed apply antiseptic to the bite area or wash with soap and water and keep an eye on it for several weeks for any changes.

4. If you have been bitten by a tick or recently spent time outdoors and develop flu-like symptoms, contact your GP or dial NHS 111.

PROTECTING THE HEALTH OF THE BANES POPULATION

Mission Critical: Reducing Antimicrobial Resistance

Can you imagine a time when antibiotics do not work anymore? Modern medical and veterinary practice relies on being able to use antimicrobials to prevent and treat infections in humans and animals. Antibiotics are a particular type of antimicrobial that work against bacteria and have many important uses such as treating and preventing infections and reducing the risk of potentially life threatening complications in surgery, chemotherapy and transplantation.

The grim reality is that infections are increasingly developing that are resistant to the drugs we have available. This means that antibiotics are losing their effectiveness at an increasing rate. Without them many common and vital medical procedures such as gut surgery, caesarean section, setting bones, joint replacements and chemotherapy could become too dangerous to perform.

So what can be done to prevent antibiotic resistance? There are many things that need to be done to cut down on unnecessary use of antimicrobials and increase the supply of new drugs. In B&NES we are working across health and education organisations to improve the way we use antibiotics, making sure that they are not wasted on viral illnesses like colds, coughs and flu.

Individuals also have a vital role to play to slow down resistance. They can:

- take antibiotics exactly as prescribed and never share them with other people
- have the recommended vaccinations offered by the NHS
- try treating the symptoms of infections that our bodies are good at fighting off on their own, like coughs, colds, sore throats and flu for five days rather than going to the GP
- encourage children to understand more about antibiotics - visit the ebug website (www.e-bug.eu)
- regularly wash your hands, especially if you have a cold or the flu

Antibiotic Guardian is a Public Health campaign to raise awareness and engagement with this important issue. You can have a look at the web site at http://antibioticguardian.com, and pledge to become an Antibiotic Guardian too.

Health Inequalities in Bath and North East Somerset

What is a health inequality?

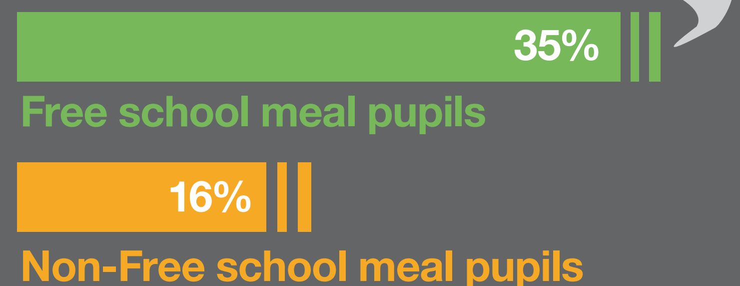
Health inequalities are preventable and unjust differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. Other causes of health inequality are many and include disabilities, mental health problems, adverse circumstances like domestic abuse or worklessness, homelessness and for some conditions differences between ethnic groups.

Some of these factors such as ethnicity or sex may be fixed. Others, such as the type of employment people have; where people live, study, work and play; or the food people eat, are less fixed. But even when fixed characteristics cause risk, their effects can be modified.

Some local examples

A boy born in the **least deprived area** can expect to live **9 years longer** than one born in **the most deprived area**

A much higher proportion of year 8 and 10 **Free School Meal pupils** said that **people regularly smoke cigarettes around them**



Fewer children from **low income** homes are **school ready**

What is being done to try to tackle them?

The Health and Wellbeing Board arranged a summit on May 11th to explore health inequalities within BANES. This day provided an opportunity for approximately 80 people from diverse workplaces and backgrounds – from head teachers, GPs, charity workers council staff and CCG commissioners, to discuss the issues and identify potential areas for improvement.

The Director of Public Health for Coventry attended to discuss the work that this council has done to reduce health inequalities by harnessing the efforts of many different organisations and groups. Workshops were undertaken to discuss inequalities in education, employment, access to health services and ill health prevention.

Outcomes from the Inequalities Day Summit:

The day provided a platform to explore ideas and identify areas where improvements could be made. Examples of work to take forward included:

- To encourage the uptake of free child care available for 2 year olds from disadvantaged circumstances
- To improve the identification of people requiring employment support and to improve the communication between job seekers, training providers and employers through a single point of contact
- To facilitate the change of attitudes and stigma towards health and social issues
- To address the long length of time that people with low to moderate mental health needs have to wait for a mental health assessment
- To improve coordination and awareness of community activities amongst the public and professionals
- To better understand the health needs of people who have the greatest health issues and to determine whether they are able to attend the services they need.

The next steps

The steering group from the summit are presenting the recommendations collated on the day to the September Health and Wellbeing Board.

Public Health Headlines in the Bath Chronicle

The Bath Chronicle

What are the people of Bath and North East Somerset interested in in relation to their health. This year we thought we might get an idea by scanning the columns of the Bath Chronicle, and we are grateful to the editor for supporting us. We didn't have to look for long to find quite a range of interesting articles

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21/4/16

'How just a short bus ride can take you from riches to poverty'

Twerton has FOURTEEN times more children living in poverty than another area of Bath just three miles away. A shocking 28% of children in Twerton come from low-income families, compared with just 2 per cent in affluent Bathwick.

21/4/16

'KEEP ON RUNNING IN PARK FOR FREE, ENTRANTS ASSURED'

Park run to be kept free in bath after the South Gloucester council ruling to start charging an entry fee

28/04/16

'VISION OF A SPORTING CHANCE FOR EVERYONE'

Redevelopment of Bath Leisure centre

12/05/16

'Merger of surgeries 'will help maintain the quality of care'

Merger of St James' and Catherine Cottage surgeries in Bath

12/05/16

'Clinic move to the benefit of patients'

Sexual health clinic services, currently located in the RUH, to move to central Bath

19/05/16

'HUNDREDS SIGN UP TO HELP DEFEAT DEMENTIA'

Volunteers across Bath are signing up to take part in various research studies with 'Join Dementia Research'

19/05/16

'Show how much fun greens can be'

Freshford pre-school has signed up to a scheme encouraging pupils to eat more fruit and vegetables. First local pre-school to sign up to Riverford New Veg for Schools programme – show young people how to prepare family meals and understand the need for a balanced diet. Preschool is working towards the BANES healthy early years award

Public health indicators:

Although many of our health outcomes are good in Bath and North East Somerset, we've identified areas where more work needs to be done.

Public health outcomes framework and other key indicators (as at August 2016)

PHOF Reference/ Source	Period	Indicator Description	England	South West	Bath and North East Somerset
Health Improvement					
2.04	2014	Under 18 conceptions (females 15-17, rate per 1,000)	22.8	18.8	12.3
2.06i	2014-15	Excess weight (overweight and obesity) in 4 to 5 year olds	21.9%	22.3%	23.5%
2.06ii	2014-15	Excess weight (overweight and obesity) in 10 to 11 year olds	33.2%	30.5%	27.3%
2.07i	2014-15	Hospital admissions, unintentional and deliberate injuries 0 - 4 years per 10,000	137.5	145.8	157.3
2.07i	2014-15	Hospital admissions, unintentional and deliberate injuries 0 - 14 years per 10,000	109.6	111.1	110.6
ChiMat	2014-15	Hospital admissions as a result of self-harm (10-24 years old)/100,000	398.0	537.9	422.0
ChiMat	2010/11 -2012/13	Alcohol specific admissions to hospital aged under 18s per 100,000	42.7	51.2	68.2
2.13i	2014	Proportion of physically active adults	57.0%	59.4%	64.0%
2.14	2014	Smoking prevalence	18.0%	16.9%	15.6%
2.03	2014-15	Smoking status at time of delivery	11.4%	11.9%	10.0%
2.15ii	2014	Successful completion of drug treatment - non opiate users	39.2%	33.4%	37.9%
2.20i	2015	Cancer screening coverage - breast cancer	75.4%	78.6%	75.6%
2.22iv	2013-14/ 2014-15	Take up of the NHS Health Check Programme – health check take up	48.9%	46.6%	50.4%
Healthcare and premature mortality					
4.04i	2012-14	Under 75 mortality rate from cardiovascular diseases (per 100,000)	75.7	65.3	53.2
4.05i	2012-14	Under 75 mortality rate from cancer (per 100,000)	141.5	130.5	117.4
4.06i	2012-14	Under 75 mortality rate from liver disease (per 100,000)	17.8	14.5	14.5
4.10	2012-14	Suicide rate (per 100,000 population)	8.9	10.1	8.9
4.14i	2012-14	Hip fractures in over 65s (per 100,000)	571	570	604
Inequalities					
0.2iii	2012-14	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)			7.8
0.2iii	2012-14	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (female)			4.8
1.01ii	2013	Child poverty, under 16s	18.6%	14.8%	11.7%
1.02i	2014-15	% of Receptiion Year FSM pupils achieving a 'Good Level of Development'	51.2%	49.0%	53.9%

KEY: Significance to comparable England figure

Significantly better *Not significantly different* *Significantly worse*

			England	South West	Bath and North East Somerset
Health Protection					
3.03x	2014-15	MMR take-up age 5 (2 doses)	88.6%	90.9%	90.5%
3.03xiv	2014-15	Population vaccination coverage flu aged 65 years and over	72.7%	72.4%	72.9%
3.04	2012-14	People presenting with a late stage HIV infection	42.2%	44.1%	57.1%

KEY:

<90% target *>90% target* *<75% target* *<25% to 50% target* *>50% target*

SOURCES | **PHOF:** http://www.phoutcomes.info/ | **ChiMat:** http://www.chimat.org.uk/
Marmot: http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx

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