Bath & North East Somerset Council

Health & Wellbeing Board

Date: Wednesday, 25th October, 2017
Time: 10.30 am
Venue: Brunswick Room - Guildhall, Bath

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), Jayne Carroll (Virgin Care), Mark Coates (Knightstone Housing), Tracey Cox (Clinical Commissioning Group), Debra Elliott (NHS England), Diana Hall Hall (Healthwatch), Steve Imrie (Avon Fire & Rescue Service), Steve Kendall (Avon and Somerset Police), Bruce Laurence (Bath & North East Somerset Council), Councillor Paul May (Bath and North East Somerset Council), Professor Bernie Morley (University of Bath), Laurel Penrose (Bath College), Jermaine Ravalier (Bath Spa University), Hayley Richards (Avon and Wiltshire Partnership Trust), James Scott (Royal United Hospital Bath NHS Trust), Andrew Smith (BEMS+ (Primary Care)), Sarah Shatwell ((VCSE Sector) - Developing Health and Independence), Jane Shayler (Bath & North East Somerset Council) and Elaine Wainwright (Bath Spa University)

Observers: Cllr Tim Ball and Eleanor Jackson

Other appropriate officers
Press and Public

Marie Todd
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NOTES:
1. **Inspection of Papers:** Papers are available for inspection as follows:

Council's website: https://democracy.bathnes.gov.uk/ieDocHome.aspx?bcr=1

Paper copies are available for inspection at the **Public Access points:-** Reception: Civic Centre - Keynsham, Guildhall - Bath, The Hollies - Midsomer Norton. Bath Central and Midsomer Norton public libraries.

2. **Details of decisions taken at this meeting** can be found in the minutes which will be circulated with the agenda for the next meeting. In the meantime, details can be obtained by contacting as above.

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.

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https://democracy.bathnes.gov.uk/ecCatDisplay.aspx?sch=doc&cat=12942

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Health & Wellbeing Board - Wednesday, 25th October, 2017

at 10.30 am in the Brunswick Room - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

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

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

   (b) The nature of their interest.

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

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

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

6. PUBLIC QUESTIONS/COMMENTS

7. MINUTES OF PREVIOUS MEETING - 6 SEPTEMBER 2017 (Pages 7 - 14)

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

8. INTEGRATION PROGRAMME UPDATE (Pages 15 - 22)

   To consider the attached report which describes the role the two key organisations, B&NES Council and B&NES CCG, could play in the B&NES system in leading the extension and enhancement of integrated commissioning for the benefit of the population and to create a more sustainable approach to Health and Care going forward.

10.40am – 30 mins – Mike Bowden/Jane Shayler

9. BATH AND NORTH EAST SOMERSET VIRTUAL EMPLOYMENT HUB (Pages 23 - 26)

To receive an update on the Economic Strategy Review, which was presented in 2015, along with an introduction to the B&NES Virtual Employment Hub.

11.10am – 30 mins – Ben Woods

10. PREVENTION CONCORDAT

To receive a presentation regarding the creation of a prevention concordat.

11.40am – 20 mins – Jane Shayler

11. HEALTH PROTECTION BOARD ANNUAL REPORT (Pages 27 - 72)

To consider the annual report of the Health Protection Board which documents the progress made on the priorities and recommendations set out in the 2015-16 report; highlights the key areas of work that have taken place in 2016-17 and identifies priorities for the next 12 months.

12 noon – 20 mins – Becky Reynolds

12. FUTURE MEETING DATES

To note that future meetings will take place on the following dates:

Tuesday 30 January 2018 – Kaposvar Room, Guildhall
Tuesday 17 April 2018 – Brunswick Room, Guildhall
Tuesday 26 June 2018 – Brunswick Room, Guildhall
Tuesday 25 September 2018 – Brunswick Room, Guildhall
Tuesday 27 November 2018 – Brunswick Room, Guildhall

Meetings will normally commence at 10.30am.

13. CLOSING REMARKS

To receive closing remarks from the Chair.

12.20pm – 5 mins – Dr Ian Orpen

The Committee Administrator for this meeting is Marie Todd who can be contacted on 01225 394414.

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HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 6th September, 2017, 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
Jayne Carroll	Virgin Care
Mark Coates	Knightstone Housing
Tracey Cox	Clinical Commissioning Group
Jocelyn Foster (in place of James Scott)	Royal United Hospital Bath NHS Trust
Alex Francis (in place of Diana Hall Hall)	The Care Forum – Healthwatch
Bruce Laurence	Bath & North East Somerset Council
Councillor Paul May	Bath and North East Somerset Council
Professor Bernie Morley	University of Bath
Laurel Penrose	Bath College
Hayley Richards	Avon and Wiltshire Partnership Trust
Andrew Smith	BEMS+ (Primary Care)
Jane Shayler	Bath & North East Somerset Council

Also present: Cllr Eleanor Jackson (Observer)

12 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

He explained that two information reports had been circulated to Board members, regarding the Community Pharmacy update and the Local Safeguarding Children's Board Annual Report for 2016/17. These reports were circulated for information only and would not be discussed at this meeting.

13 EMERGENCY EVACUATION PROCEDURE

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

14 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Cllr Tim Ball – B&NES Council (Observer)
Jermaine Ravalier – Bath Spa University
James Scott – Royal United Hospital NHS Trust – Substitute Jocelyn Foster
Sarah Shatwell – VCSE Sector – Developing Health and Independence
Elaine Wainwright – Bath Spa University

15 DECLARATIONS OF INTEREST

Councillor Paul May declared a non-pecuniary interest as a Non-Executive Director on the Board of Sirona.

16 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There was no urgent business.

17 PUBLIC QUESTIONS/COMMENTS

Councillor Eleanor Jackson made a statement regarding the Commissioning Process and stressed the need for full consultation with local residents regarding health projects in their areas.

Dr Ian Orpen stated that he recognised the need for full public consultation. He also highlighted the funding pressures which the NHS was currently experiencing and pointed out that time-pressures in relation to funding were a reality.

A copy of the full public statement is attached as *Appendix A* to these minutes.

18 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting, held on 12 July 2017, were approved as a correct record and signed by the Chair.

19 **SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) UPDATE**

Tracey Cox, Chief Officer, B&NES Clinical Commissioning Group gave a presentation which provided an update on the Sustainability and Transformation Partnership (STP).

- A Five Year Forward View Next Steps document has been published which sets out nine focus areas.
- STPs will evolve into an Accountable Care System which will work as a locally integrated health system, in which NHS organisations, often in partnership with local authorities, choose to take on responsibility.
- Only when the STP is able to demonstrate it is ready for the new system will it cease to exist.
- Collaborative working is very important across the B&NES, Swindon and Wiltshire areas.
- An update was given on each of the following areas:
    - Proactive and preventative care
    - Planned care
    - Acute collaboration
    - Digital
    - Workforce
- James Scott recently stood down as Senior Responsible Officer for the STP and a new Officer will be appointed in the near future.
- Bridget Musselwhite has been appointed as Programme Director for the STP.
- Governance arrangements have also been reviewed and a stakeholder forum has been introduced. The Forum will meet quarterly.
- STP priorities will be reviewed during September and October to ensure that the focus is on the right areas.
- A Communications Manager is now in post and a stakeholder engagement event is planned for October.

The following issues were then discussed:

- Councillor Vic Pritchard highlighted the advantages of the STP. However, he noted the absence of any reference to social care and felt that this was not receiving the profile that elected members would like. Tracey Cox stated that this was a problematic issue nationally and stressed the need for the agenda to be aligned through the development of an accountable care process.
- Alex Francis was encouraged to see that a Communications Manager was now in post. She also noted the importance of considering the different types of stakeholders and groups and the need to take into account the specific audience during the communication process.
- Dr Ian Orpen noted that the alignment of policies across B&NES, Swindon and Wiltshire should minimise any postcode lottery issues.

A copy of the presentation slides is attached as *Appendix 2* to these minutes.

RESOLVED: To note the STP update.

20 **B&NES/SWINDON/WILTSHIRE (BSW) SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) MENTAL HEALTH DELIVERY PLAN**

The Board considered a report which presented the STP Mental Health Delivery Plan. The Plan contained further information on priority actions to deliver the Five Year Forward View for Mental Health across the B&NES/Swindon/Wiltshire area and also set out actions for each constituent part of the STP. The Plan has been informed by the Joint Strategic Needs Assessment, a gap analysis against the Five Year Forward View and by previously identified local priorities, including those in local Mental Health Strategies and Plans.

Mental Health at STP level is implicit and it is important to provide a priority focus in its own right. There has been a powerful partnership approach in preparing the Plan. It was noted that mental health impacts across all service areas and can affect inequalities, life expectancy and other health related issues. Early intervention before a crisis occurs is key along with early help for children and young people.

The evidence showed that if more were invested in mental health services then large savings would be made. This would reduce hospitalisation and improve both physical and mental health. The challenge is to identify where the greatest value can be added and the Plan is intended to provide clear evidence based priorities.

A workshop was held in August which had highlighted the following priority/high impact areas:

- Urgent and emergency care
- Improving transitions
- In-patient access
- Workforce development

The following issues were then discussed:

- Councillor Paul May stressed the importance of employers taking action to improve the health of their employees. Hayley Richards explained that the STP is aware of this issue and that Forums are in place for this area of work. There are also links with the education sector.
- Bruce Laurence explained that some work is already taking place with employers around mental health issues. He noted that mental health is about the way society operates and stated that the Health and Wellbeing Board could take a wider view of this area to improve the resilience of the local population.
- Mike Bowden acknowledged the amount of work that has gone into the production of this Plan.
- Alex Francis pointed out that there is lots of energy and enthusiasm in the voluntary sector for this particular area of work.

RESOLVED: To note the priority actions set out in the Sustainability and Transformation Partnership (STP) Mental Health Delivery Plan.

21 **BETTER CARE FUND PLAN 2017-19**

The Board considered a report regarding the Better Care Fund Plan 2017/19 which set out the vision for integrated services in B&NES up to 2020 and how the Improved Better Care Fund grant monies (iBCF) will be utilised to support the Better Care Fund Plan.

Additional funding has been awarded for adult social care and certain conditions have to be met. Spending will need to demonstrate how it will improve performance against the following four national metric measures:

- Delayed transfers of care
- Non-elective admissions to hospital
- Admissions to residential and nursing homes
- The effectiveness of reablement

One of the main areas of focus is around patients leaving hospital, how well this works and ensuring that best practice is being followed.

The Better Care Fund schemes all have plans and these are aligned where relevant with CCG QIPP schemes and the Council Savings schemes.

The Plan has to be submitted by 11 September 2017 and provisional feedback from NHS England is positive with only a few minor amendments being suggested.

The following issues were then discussed:

- It was noted that the higher level of grant funding in the first year is to support the necessary transformational change.
- Tracey Cox stated that this is a very complex piece of work and is a robust plan.
- Hayley Richards pointed out that there are twice as many delayed transfers for mental health patients than for patients in acute care. She requested that consideration be given as to how this issue might be addressed. The report author agreed to consider this matter in the context of the Better Care Fund Plan.
- Bruce Laurence expressed concerns regarding future projections due to the anticipated decrease in the ratio of economically active people compared to those who are not economically active. This would need to be addressed to avoid difficulties in the future.
- Jane Shayler pointed out that there are a number of schemes that provide for adults of working age such as pre-crisis beds for mental health patients.

RESOLVED:

(1) To strengthen the wording on the Better Care Fund (BCF) Narrative Plan 2017-19 in relation to mental health.

(2) To approve the proposed utilisation of the BCF funds 2017-19 and the utilisation of iBCF grant monies.

(3) To delegate formal sign off of the final submission of the Plan on 11

22 HEALTH OPTIMISATION

The Board received a presentation from Dr Ruth Grabham and Jon McFarlane regarding pre-operative health optimisation.

- It is important for patients to be as fit as possible prior to undergoing surgery. Evidence relating to the effects of smoking and obesity on outcomes has been considered.
- Smokers are 38% more likely to die after surgery and are at increased risk of heart and lung complications, post-surgical infections and poor wound healing. Pre-operative smoking cessation is effective.
- The statistical evidence relating to obesity is more limited. However, there is an overall increased risk of anaesthetic airway complications and surgical site infection for all surgeries.
- It was proposed that prior to surgery GPs would discuss smoking cessation and weight loss with patients as appropriate. Patients would then be offered physiotherapy and advice about weight loss and giving up smoking. Patients would then have three months in which to prepare for surgery.
- There will be a staged approach to the pathway as follows:
    - Stage 1 – Hip and knee replacement surgeries – this will aim to build on the success of the Hip and Knee Programme
    - Stage 2 – Smoking cessation across all surgeries
    - Stage 3 – Weight loss across all surgeries
- This will be introduced from 1 October 2017.
- The proposals will lead to improved patient outcomes following surgery and reduced length of stay in hospital.
- There will be a public engagement process.

The following issues were then discussed:

- Councillor Vic Pritchard noted the strong evidence relating to smoking. It was acknowledged that some patients will not wish to engage and that they cannot be compelled to take part.
- Councillor Paul May stressed the need for publicity about the proposals to raise awareness. Tracey Cox confirmed that further patient engagement is planned prior to the introduction of stages 2 and 3.
- Alex Francis stated that Healthwatch has been involved in this project. She queried the capacity for health organisations to support patients. She also noted the complexity of patients and the many different reasons for certain lifestyle choices such as smoking. It will be important to support healthcare professionals to enable them to carry out these, often difficult, conversations with patients.
- Dr Grabham stated that Virgin Care has the capacity to support patients through this process. The initial conversations with patients will be with their GP who will then make a referral. The referral support service will then provide the necessary support and advice.
- Professor Bernie Morley commented on the data provided and the need to make this as clear as possible to understand.
- Ashley Ayre noted that people are often more willing to make lifestyle

changes at a time of crisis.

- Hayley Richards endorsed the proposals and pointed out that people suffering from a mental illness are often less likely to attend for regular health checks. It will be important to evaluate the impact of intervention on different sectors of the population.
- Bruce Laurence felt that it was very important to give people support and opportunities to improve their health. He noted that this proposal appears to be the right level of "carrot and stick" as it provides an assertive approach while not being mandatory.
- Mark Coates recommended that patients should be asked why they did or did not take up the offer of advice and support.

A copy of the presentation slides are attached as *Appendix 3* to these minutes.

RESOLVED: To fully endorse the pre-operative health optimisation proposals.

23 DATE OF NEXT MEETING

It was noted that the next meeting would take place on Wednesday 25 October 2017.

The meeting ended at 12.35 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**5 October 2017**
TYPE	**An open public for information item**

Report summary table	
Report title	Integration Programme Update
Report author	Jane Shayler
List of attachments	None
Background papers	Report to Health and Wellbeing Board 6 September 2017, *"Better Care Fund Plan 2017-19"*
Summary	The overarching aim of this report is to describe the role the two key organisations, B&NES Council and BaNES CCG, could play in the B&NES system in leading the extension and enhancement of integrated commissioning for the benefit of the population and to create a more sustainable approach to Health and Care going forward. Each organisation has its own constitution and separate accountabilities but has a common interest in the health and wellbeing of local people. There is now an opportunity to strengthen existing joint arrangements to achieve the level and pace of service change and integration needed to meet current and future challenges. This will enable both organisations to provide the seamless health and care which residents need and to meet the sustainability challenge faced by both organisations.
Recommendations	The Board is asked to: • Agree broad support for the proposal to develop an Integrated Commissioning model between the Council and CCG, that is fit for purpose, sustainable and responds effectively to emerging issues and pressures across health and social care; • Note the benefits of this integrated commissioning model as an enabler for delivering the Joint Health and Wellbeing Strategy and improved health and wellbeing outcomes for the people of B&NES; and • Note the links to the early work of the Board in considering the development of an Accountable Care model across Bath & North East Somerset.

Rationale for recommendations	The proposals set out in this report are considered to be key enablers in the commissioning and delivery of more integrated health and care services in line with both national and local policy agendas and plans. It is considered that the development of a more integrated commissioning model will support improved utilisation of resources and a greater focus on and investment in preventative services. It will also make a significant contribution to delivery of the outcomes in the Joint Health and Wellbeing Strategy.
Resource implications	There are no direct resource implications associated with the recommendations in this report for the Health and Wellbeing Board. As set out in the report and, in particular, paragraph 2.2, key benefits of a more integrated commissioning model include effective use of pooled resources, including funding; reduced bureaucracy; more efficient and streamlined systems and processes; and more effective and timely decision-making.
Statutory considerations and basis for proposal	As briefly outlined in the report, both the CCG and Council will retain their statutory responsibilities under the proposed arrangements. However, a more integrated commissioning model will support both organisations in meeting those statutory responsibilities and in achieving improved health and wellbeing outcomes for the people of Bath and North East Somerset and effective utilization of the available resource.

Consultation	A wide range of officers from both the Council and CCG are actively engaged in developing the proposed integrated commissioning model, including subject matter experts from finance, governance, commissioning and organisational development. Proposals are the subject of more detailed reports to be presented to both Council Cabinet and CCG Board in November. Informal briefings have been given to Council Cabinet, CCG Board, Council Strategic Management Team, CCG Executive Team and Council/CCG Joint Commissioning Committee. The Council Section 151 Officer and Monitoring Officer have been consulted in the preparation of this report.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

1.1 Introduction

The overarching aim of this report is to describe the role the two key organisations, B&NES Council and BaNES CCG, could play in the B&NES system in leading the extension and enhancement of integrated commissioning for the benefit of the population and to create a more sustainable approach to Health and Care going forward. Each organisation has its own constitution and separate accountabilities but has a common interest in the health and wellbeing of local people. There is now an opportunity to strengthen existing joint arrangements to achieve the level and pace of service change and integration needed to meet current and future challenges. This will enable both organisations to provide the seamless health and care which residents need and to meet the sustainability challenge faced by both organisations.

The current governance structures require changes for both organisations to be able to implement the necessary changes jointly and at pace. National direction, such as The Integration and Better Care Fund Policy Framework 2017, requires and enables integration between health and care services. Success measures for such are being developed nationally and the Care Quality Commission has the remit to carry out targeted reviews, particularly in relation to integrated arrangements to avoid hospital admission and reduce Delayed Transfers of Care from hospital into community settings.

The Health and Wellbeing Board are asked to comment and provide input in to these proposals to inform the development of a future model for integrated commissioning ahead of discussion at Council Cabinet on 8th November and CCG Board on 9th November.

1.2 Background to and history of Integration in B&NES

The Government is clear within the Better Care Fund Policy Framework for 2017-19 that people need health, social care, housing and other public services to work seamlessly together to delivery better quality care. More joined up services help improve the health and care of local populations and may make more efficient use of available resources.

B&NES Council and the local NHS have a long history of constructive joint working. Joint health and social care structures have been in place in B&NES since 2009, with commissioning arrangements implemented in that year and provider arrangements consolidated by the creation of an integrated health and social care provider in 2011. This was supported by a formal Partnership Agreement that described how the then Primary Care Trust (PCT) and Council would work together to deliver improved outcomes for the population. Joint financial arrangements, primarily pooled budgets, were implemented alongside the original joint structures and have expanded and developed since. Following NHS reconfiguration, the CCG and Council reconfirmed their commitment to joint working and agreed a Joint Working Framework. The commissioning arrangements were reviewed and redesigned in 2013 in response to the creation of the CCG and the reaffirmation of the commitment by both CCG and Council to joint working and to the integrated commissioning and provision of services.

A Partnership Board for Health and Wellbeing (the precursor to the current Health and Wellbeing Board) was established in 2008 to oversee, monitor and make recommendations in respect of the development of strategy and performance management of adult health and social care, children's health and social care and public health.

In B&NES, the journey towards closer integration is set out within the *your care your way* programme. The two organisations worked in strategic partnership over a two year period (2014 to 2016) to review community health and care services through "*Your Care Your Way*". Through a process of extensive engagement with a wide range of partners, including service users, carers, staff and provider organisations this review helped to set out a future vision for health and care services and supported the delivery of services better co-ordinated around the individual to ensure the right care is offered at the right time and in the right place. The review also supported the development of outcomes based commissioning based on those outcomes that are most important to the people and communities of Bath and North East Somerset and against which success can be measured.

1.3 Current arrangements

Established under the Health and Social Care Act 2012, the B&NES Health and Wellbeing Board is the overarching strategic forum where key partners with a role in the health and wellbeing agenda come together to improve local health and wellbeing. The Board is responsible for having oversight of the health and care system and for setting the strategic direction for meeting local health needs. The Board has adopted co-chairing arrangements between the Council and CCG, recognising the value and importance of the shared ambition between these two organisations in promoting good health and wellbeing. These arrangements seek to facilitate real and clear joint ownership for the whole health and care system.

The Health and Wellbeing Select Committee is responsible for scrutinising the planning, provision and operation of local health and care services and for holding local health organisations to account when they are make significant decisions about the future of health care provision in B&NES.

As described in paragraph 1.2, currently the commitment to and arrangements under which the BaNES CCG and B&NES Council work together are described in the Joint Working Framework (April 2013). This document sets out aspirations around common goals and shared working practices. The partnership arrangements are underpinned by formal Section 75 and Section 10 pooled budget agreements.

The operation of joint working arrangements, including the operation of pooled funds and the exercise of functions by either body on behalf of the partner body, is overseen by a Joint Committee for the Oversight of Joint Working. In October 2014 the Joint Commissioning Committee replaced the previous structure, further strengthening governance of our joint commissioning arrangements. The Committee consists of senior managers from BaNES CCG and B&NES Council, and clinical representatives. The overall role of the group is to develop the overarching vision of joint working, review joint strategies, plans, performance and risk and develop integrated commissioning of adult health and social care and children's health services. JCC is a sub-committee of the CCG Board.

Under these arrangements the CCG and Council currently commission a range of community health and care services together and to strengthen these arrangements a number of commissioners are jointly funded by, and are accountable to, both organisations including in relation to the Better Care Fund Plan, for Mental Health, Learning Disabilities and Children's services. There is also a joint finance lead to support joint commissioning and the management of associated pooled budgets. However both organisations believe

that there is a clear opportunity to go beyond the existing joint arrangements to create a single commissioning function in B&NES.

As part of the programme of work to develop the proposed integrated commissioning model a review of the current governance arrangements has been undertaken and further detailed work will continue in the coming weeks. This work includes a review of and revisions to financial reporting, oversight and assurance of pooled funding arrangements, in the context of a significantly expanded Better Care Fund pooled budget as well as the proposed further integration of Council/CCG commissioning arrangements.

At a high-level the proposed revised governance arrangements will be the subject of reports to both Council Cabinet and CCG Board in November 2017.

2.1 Principles to support integrated commissioning

The intent is to seek to develop a model which would ensure that future arrangements are fit for purpose, sustainable and able to respond effectively to emerging issues and pressures across health and social care. In summary the broad principles of such a model would include:

- The two statutory organisations will still exist – BaNES CCG and B&NES Council will continue to remain responsible for and will retain statutory governance and assurance mechanisms. There is not a new organisation being created, instead a new Governance model and ultimately a new leadership and integrated commissioning structure would be proposed which is capable of providing the mechanisms within which the two statutory organisations continue to meet their obligations through extended joint working and financial arrangements.
- The Health and Wellbeing Board and Health and Wellbeing Select Committee will continue to operate as described in the current arrangements
- The model will have an assumption that this is a “partnership of equals” and this will be reflected in design and detail.
- The new model must be capable of adding value. It will need to work differently to better shape and manage pooling of responsibilities, budgets and resource and the harnessing of greater commissioning power. Importantly it will need to reduce, not add to the burden, in terms of governance, process and delivery.
- There will be a need to understand how the new model will connect and work with the wider system leadership at local, regional and national level.
- Creating a united “voice” for Bath and North East Somerset during the current wide scale system reform is seen as the best route to ensure our local interests are best represented and protected.

2.2 Benefits of proposed further integration

- In developing these arrangements attention has been paid to how they will support the effective delivery of the Joint Health and Wellbeing Strategy
- Integrated commissioning arrangements enable achievement of a single vision and shared focus on prevention and early intervention and community solutions to promote independence and a shared commitment to achieve improved health and wellbeing outcomes for the people of B&NES.
- The ability to share risks and benefits associated with the pooling of resources and delivery of the shared vision.
- The opportunity to share information results in more intelligent commissioning and the development of more innovative solutions to meet people’s needs.

- Integrated commissioning enables the effective use of pooled resources, including funding, to ensure the individual's whole needs are at the centre of decision making, resulting in improved outcomes and the ability to target resources to the most effective place in the system to meet need. This avoids potential wasted resource and sub-optimal outcomes.
- It is not always clear to the public which organisation is responsible for the services that they need. Integration of commissioning arrangements between the Council and CCG will mean that it is less important for people in need of health and care advice, support or assistance to know which organisation to refer to as holding the statutory responsibility for meeting their need, as whichever entry point they use the system will be able to support them to the right point.
- By working more closely together to achieve a single vision the CCG and Council would be better able to influence the way that health and care services are delivered for the population through a stronger voice at local, regional and national level.
- There is the opportunity for greater synergy between the adults and children's agenda where transitions can be managed more effectively.
- Providers will benefit from a single commissioning and contracting process for the services commissioned by the Council and CCG.
- More integrated commissioning helps identify gaps in provision as well as overlaps and duplication enabling the development and delivery of seamless pathways from prevention to specialist and acute care and through all life stages.
- Reduced bureaucracy, timely decision-making, ability to identify opportunities to develop shared support and "back-office" functions are all potential benefits of further integration between the Council and CCG.

3.1 Next steps

The proposals for further integration of commissioning arrangements between the Council and CCG still require significant work but can be seen as a natural development of the current joint working arrangements with the aim of further improving outcomes for the local population. These proposals may result in resource reallocation and, possibly, one off costs but also the potential for efficiencies which will help support the longer-term sustainability and resilience of the Council and CCG in meeting their respective statutory responsibilities and those of the local health and care economy.

Proposed phases:

- Description of possible integrated governance model to Council Cabinet on 8th November and CCG Board on 9th November.
- Whilst the broad framework, accountabilities and responsibilities will be described within this initial model, if approved, much more detailed work will be required to test out and map the full set of governance arrangements.
- Options appraisal to look at the optimum organisational model to deliver a B&NES Health and Care Integrated Commissioning Function. Through this commissioning functions and associated teams and individuals from the CCG and Council (People and Communities Directorate) will come together to deliver integrated commissioning as described by the Integrated Governance Model.
- Subsequent phases will look to bring in the broader determinants of health and wellbeing in terms of the other services provided or commissioned by other Council Directorates such as housing, education and leisure facilities as well as the potential for integration of other functions, for example shared back-office services.

4.1 Communications

A communications plan is being developed for key stakeholders to set out the proposals in further detail, highlight the benefits of the proposed model and clarify how key stakeholders can be engaged in future phases. All communications will be jointly undertaken by both the CCG and Council.

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

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**25 October 2017**
TYPE	**An open public item**

Report summary table	
Report title	Bath & North East Somerset Virtual Employment Hub
Report author	Benjamin Woods, Group Manager Economy and Culture
Attachments	None
Background papers	Economic Strategy: http://www.bathnes.gov.uk/sites/default/files/siteimages/Planning-and-Building-Control/Major-projects/ba192_economic_strategy_05.pdf
Summary	The report provides an update since the Economic Strategy Review was presented in 2015 and an introduction to the B&NES Virtual Employment Hub
Recommendations	The Board is asked to agree that: • The Virtual Employment Hub (VEH) approach is supported • Health colleagues are supported to contribute to the VEH process
Rationale for recommendations	The Health & Wellbeing Strategy identifies the priority 'all residents have access to training and employment. Currently, B&NES services who could promote this priority do not all have the same level of information available about what support they can access or about the wider benefits of work to an individual. Employment support and training partners could benefit from a better understanding of the health & wellbeing support available to residents
Resource implications	Funding for the web portal and other external support is via secured S106 development contributions to employment & skills activities. Officer time will come from existing resources. Engagement of health colleagues in the process: likely to be six steering group sessions and possible one-to-one meetings
Statutory considerations and basis for proposal	Councils have the power to address the economic, environmental and social wellbeing of their area. This addresses economic prosperity: public health and inequality
Consultation	
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

1. Context

1.1. The B&NES Health and Wellbeing Strategy recognises the importance of skills development and employment to tackling health inequality. We know that areas with higher rates of poor health correlate with areas of low income which equally correlate with areas of lower educational attainment. The impact of this is illustrated in the Health & Wellbeing Strategy:

"There's life expectancy gaps of over 8 years (and increasing) exist for men living in different parts of B&NES. Just 5 stops on a local bus route."

1.2. The Public Health England 'Health Profile for England' chapter on social determinants of health clearly states that the long-term unemployed have a lower life expectancy and worse health than those in work. Of those people who are out of work and claiming benefits due to ill health, over the last five years the majority have been out of work due to mental health issues at around 51% consistently.

1.3. There is also an increasing body of work nationally which recognises the wider links between the quality of employment and a person's health. The Paper also states: "The workplace can either support health and wellbeing and the health system can actively support people into work in a virtuous circle or the workplace can be unsupportive and health and work systems can work against each other".

2. Opportunities

2.1. Under the umbrella of the Health & Wellbeing Strategy employment support, skills development and health have developed mechanisms for coordination, recognising the synergies between the outcomes that we seek to achieve.

2.2. Since the Health & Wellbeing Board received a report on the Economic Strategy review in 2015 progress has been made against the action plan. A number of areas of progress present a key opportunity for joint working to achieve the outcome set out in the Health & Wellbeing Strategy; for all residents have access to training and employment.

2.3. Enterprise Zones:

- 9500 new jobs in Bath
- 1700 new jobs in the Somer Valley

Businesses locating into Enterprise Zones (EZ) can access certain benefits for being in an EZ area. This includes things like business rate discount, superfast broadband and clustering around key sectors. Offering these benefits to business enables us to have an early conversation with businesses as they think about locating here.

2.4. Devolution:

- Adult Education Budget
- In-Work Progression Pilot
- Work & Health Programme

As one of the local authorities within the West of England Combined Authority (WECA) area we are able to work with WECA on shaping delivery of the devolved skills and employment funding. With direct control of funding, we are able to determine outcomes for the Adult Education Budget locally and work with providers on delivery of those outcomes. We will directly delivery the in-work Progression Pilot in B&NES to help people who are on low pay, low hours and / or unstable contracts to increase their earnings. We can work with the Work & Health Programme provider to ensure that they complement our local area support offer.

2.5. Social Value:

- Construction (development management)
- Procurement
- Licencing

The council has developed a toolkit to ensure that we achieve social value from our own or partner investments in the area. Developers submitting planning applications are required to offer training places to B&NES residents; contracts procured by the Council are subject to similar requirements and through licencing of the new casino we have secured guaranteed interviews for 50 B&NES residents.

2.6. As a large employer:

- Work experience
- Time to Change

Some examples using our own resources as a local large employer are our Work Experience policy which we are beginning to use as a resource to support service users and the Council's Time 2 Change pledge and action plan, written by HR and Organisational Development, to reach our own employees.

2.7. Business Engagement:

The Business Growth team have developed InvestInBath as a communication channel and are building a business engagement strategy. We can use this to deliver key messages. For example, we know that employers are currently operating in a tight labour market, they should therefore be more motivated to talk about accessible employment and accessing a more diverse workforce.

3. Coordination: The Virtual Employment Hub

3.1. Employment support and skills development is currently taking place across B&NES funded via diverse funding streams and although there are efforts in place to coordinate, these can be time consuming and often rely on staff connecting by chance.

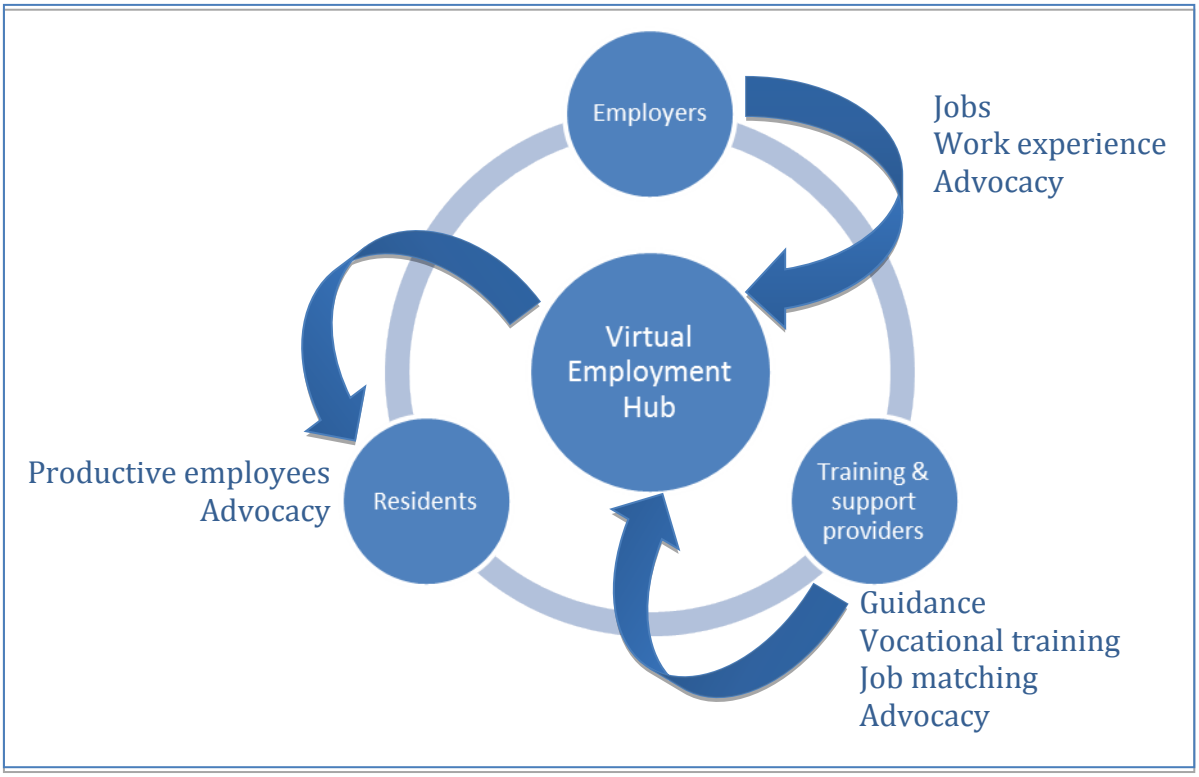
3.2. We have therefore identified an opportunity to coordinate this activity in three ways:

3.3. **Live information**: the Virtual Employment Hub - a web portal which will pull together locally available jobs and the support that residents can use to access those jobs. Currently it can be hard for professional support workers to know what is available for the clients that they are working with; with the planned jobs growth through the development of the Enterprise Zones we need to enable residents to access the support available directly. This web portal will show residents the jobs available and

directly link them to training and employment support that enables them to access those jobs.

3.4. **Joint working:** as part of early discussions with colleagues about the Virtual Employment Hub, it has become clear that as well as better information, service delivery across all partner organisations could benefit from systematic joint working. We are therefore implementing a process to review the approach we currently take to support our residents to access employment and to develop a shared approach across partners which improves signposting across all available services. This approach will be user-led to ensure that the outcomes of our services align with the outcomes that users are seeking to achieve.

3.5. **Communications strategy:** The Virtual Employment Hub will have a 'knowledge' section for residents, one for employers and one for providers. The process of developing joint working will also enable us to develop key messages. These key messages will be developed into a content marketing strategy to increase traffic to the portal and as a communications platform. This involves understanding what the audience is searching for and then optimising the content for search engines and through social media. The marketing industry has identified that this approach delivers 54% more leads on average than traditional marketing and we can use this to deliver key messages to our audiences.



4. Conclusion

4.1. We therefore recommend that the Health & Wellbeing Board supports the proposed approach and endorses the involvement of health colleagues in developing joint working. We value any feedback from the Health & Wellbeing Board either specific to the opportunities identified or on the Virtual Employment Hub proposal.

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

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**25 October 2017**
TYPE	**An open public item**

Report summary table	
Report title	B&NES Health Protection Board Annual Report 2016-17
Report author	Anna Brett, Health Protection Manager
List of attachments	B&NES Health Protection Board Annual Report 2016-17 Appendix 1: B&NES Health Protection Board Terms of Reference Appendix 2: 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 2015-16 report; highlights the key areas of work that has taken place in 2016-17 and identifies priorities for the next 12 months.
Recommendations	That the B&NES Health & Wellbeing Board notes this annual report and supports the following recommended priorities for the Health Protection Board in 2017/18.
Rationale for recommendations	The Health Protection Board is committed to improving all work streams. 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. 1. Assurance: continue to monitor performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary. 2. Support activities to slow the development and spread of

	antimicrobial resistance. 3. Continue to ensure that the public are informed about emerging threats to health. 4. Support the review, development and implementation of all Air Quality Action Plans. 5. Continue to reduce health inequalities in screening and immunisation programmes. 6. Improve the uptake of flu vaccinations in at risk groups, pregnant women, health and social care workers, and carers; and pneumococcal vaccination amongst under 65s at risk and over 65s. 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, particularly the focus on screening and immunisation programmes. 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 for People & Communities 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.

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BATH AND NORTH EAST SOMERSET

HEALTH PROTECTION BOARD ANNUAL REPORT 2016/2017

Specialist Health Protection Areas:

Healthcare Associated Infection (HCAI)

Key Performance Indicators: MRSA & C.difficile

Communicable Disease Control & Environmental Hazards

Key Performance Indicators: Private Water Supplies & Air Quality ManagementAareas

Health Emergency Planning

Key Performance Indicators: Civil Contingencies Act requirements

Sexual Health

Key Performance Indicators: HIV & under 18 conceptions

Substance Misuse

Key Performance Indicators: Hep B vaccination, Hep C testing, Opiates & Non-Opiates

Screening & Immunisation

Key Performance Indicators: National screening programmes & uptake of universal immunisation programmes

Contents

1 Executive summary

1.1 Purpose of the report

This annual report documents the progress made by the Health Protection Board during 2016-17 and highlights key performance indicators, risks, challenges and priorities for the next 12 months in each specialist area.

1.2 Progress on 2015-16 priorities that were implemented in 2016-17

In the last Health Protection Board report 2015-16, 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	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 pneumococcal vaccine	
7	Continue to reduce health inequalities in screening programmes	

1.3 Priorities for 2017-18

The following six priorities have been identified for 2017-18:

1. Assurance: continue to monitor the performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary

2. Support activities to slow the development and spread of antimicrobial resistance

3. Continue to ensure that the public are informed about emerging threats to health

4. Support the review, development and implementation of all Air Quality Action Plans

5. Improve the uptake of flu vaccinations in at risk groups, pregnant women, health and social care workers, and carers; and pneumococcal vaccination amongst under 65s at risk and over 65s

6. Continue to reduce health inequalities in screening and immunisation 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.

Throughout 2016-17 the Board has continued to provide 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. Please refer to Appendix 1 for the Board's Terms of Reference.

Priority 1 from 2015-16 report: Assurance: continue to monitor performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary

RAG: Green

During 2016-17 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 2017-18.

Sections 3 to 10 of 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)

Many healthcare activities are associated with a risk of infection. It is essential that everyone involved makes sure that they keep this risk of infection as low as possible.

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 bacteraemia 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 2016-17 BaNES failed to deliver zero cases of MRSA in all CCG patients, as 2 cases were reported, a decrease from 3 cases in 2015-16.

3.2 Post infection review

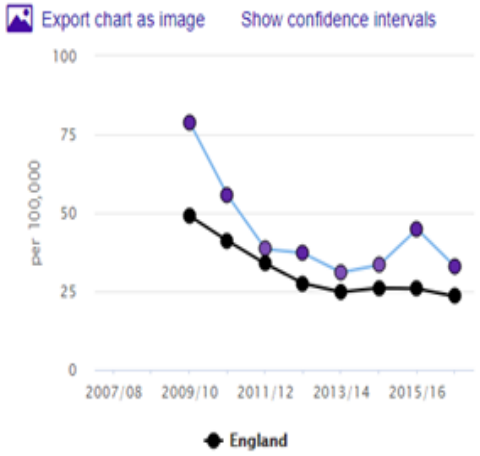
When a local hospital admits a patient and blood cultures are taken at time of admission which results in MRSA bacteraemia the CCG is tasked with completing a Post Infection Review (PIR). PIRs help to ascertain if the infection was most likely acquired in the hospital, in the community or if it may have been acquired in another country or due to lifestyle e.g. drug user with a chaotic lifestyle. The CCG will report if there were any missed opportunities to swab or treat, they will question appropriate prescribing and will carry out hand/environmental hygiene audits. The CCG share the lessons learned to minimise the risk of future cases arising.

3.3 Clostridium difficile infection

In 2016/17 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 61 compared to 83 cases in 2014/15, a decrease of 22 cases.

The number of cases of *C. diff* infection was highlighted and monitored on the Health Protection Board's Risk Log throughout the year. The graph below shows that the general trend of *C.diff* infection has been decreasing since 2009.

All C. difficile rates by CCG and financial year NHS Bath And North East Somerset CCG Crude rate - per 100,000



Period		Count	Value	Lower CI	Upper CI	South Central	England
2009/10	●	137	78.9	-	-	51.6	49.0
2010/11	●	97	55.6	-	-	43.2	41.1
2011/12	●	68	38.5	-	-	39.2	33.8
2012/13	●	66	37.1	-	-	29.4	27.5
2013/14	●	56	31.0	-	-	25.9	24.8
2014/15	●	61	33.4	-	-	22.2	26.1
2015/16	●	83	44.8	-	-	23.8	25.8
2016/17	●	61	32.9	-	-	21.6	23.4

Source: HCAI Mandatory Surveillance Data

Source: Public Health England (2017)

3.4 Reducing antimicrobial resistance (AMR) & *Clostridium difficile* infection

Priority 2 from 2015-16 report: Support the B&NES Antimicrobial Resistance Strategic Collaborative

RAG: Amber

Over this past year the pace of collaborative work to address antimicrobial resistance stepped up a level - nationally, with neighbouring areas, and locally. There has been excellent cross-sector work to reduce health care associated infections, improve infection prevention and control practices, improve prescribing practices, and raise public awareness. In light of this, creating a separate Strategic Collaborative in B&NES was not thought to be a priority in 2016/17. This decision will be revisited in 2017/18.

BaNES CCG has continued to improve antimicrobial stewardship within primary care, across all GP practices, with a reduction in all antibiotic prescribing and particularly broad spectrum antibiotics. This has contributed to a reduction in *C. diff* infection and a reduction in *E. coli* blood stream infections; reducing *E. coli* blood stream infections is now a NHS priority patient safety programme and will be monitored as a key performance indicator at future Health Protection Board meetings.

ANTIBIOTIC GUARDIAN

3.5 Antibiotic Guardian

B&NES had the highest rate of Antibiotic Guardians in England in 2016.

Antibiotic Guardian is a Public Health England (PHE) campaign that was set up in 2014 to raise awareness among the general public of the very real threat posed by antimicrobial resistance. The public can find out more at www.antibioticguardian.com, make a pledge and discover ways they can help stop the spread of infection and help protect antibiotics.

3.6 School projects & public engagement to raise antibiotic awareness

3.6.1 Primary school project

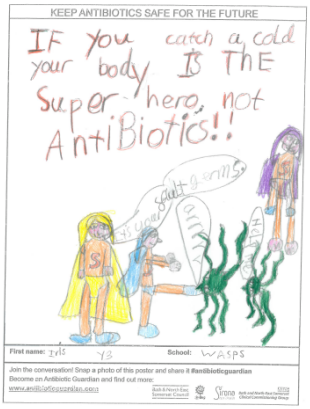
We know that in the year to November 2016, 26 per cent of 0-10 year-olds in B&NES were prescribed antibiotics by their GP at least once. Furthermore, over half of all prescriptions for antibiotics were for respiratory infections such as ear ache, sore throat and cough, which usually get better on their own.

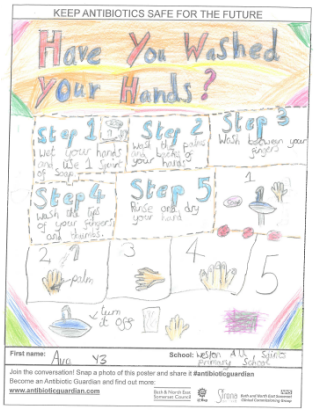
A campaign in B&NES to raise awareness of the importance of using antibiotics appropriately won in the Community Engagement category of this year's national Antibiotic Guardian awards.

The campaign was led by B&NES Council and BaNES CCG with the support of Sirona Care and Health, local public health representatives and national and international science educators. Year 3 pupils designed posters showing how to wash your hands, catch your sneezes and make sure you take antibiotics properly.

The posters were displayed in locations in and around B&NES including sports centres, libraries, pharmacies, GP's surgeries and the Royal United Hospital, and members of the public who saw them were encouraged to upload photos to social media.

The artwork created by the children was informative and fun, and really showed that they understood the concepts they were taught about infection prevention.





Above: 3 winning posters. Below: the 2016-17 Chairman of the Council, Cllr Hale presenting the children with their awards.

3.6.2 Secondary school project

All secondary schools in B&NES were offered a lesson to Year 9 pupils taught by trainee GPs and public health professionals which included key AMR educational messages, self-care messages and information on access to healthcare services. During 2016-17 3 schools took up the offer and the lessons were delivered to approximately 500 pupils.

Supporting activities to slow the development and spread of antimicrobial resistance has been identified as priority 2 for 2017-18.

4 Communicable disease & environmental hazards

Communicable diseases can be passed from animals to people or from one person to another. They can be mild and get better on their own, or develop into more serious illnesses that if left untreated lead to serious illness, long-term consequences or death. They continue to pose a significant burden to health and society. In the UK infectious diseases account for a large proportion of GP visits for children and adults.

There are a range of environmental hazards that can affect our health and wellbeing. Natural hazards include earthquakes, volcanic eruptions and flooding. Human-produced hazards are mainly related to pollution of the air, water and soil.

4.1 Communicable Disease

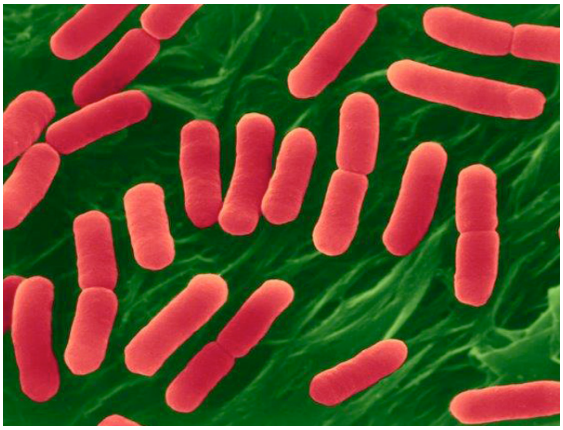
4.1.1 Confirmed or probable cases of infectious disease during 2016-17

The Health Protection Team in 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 403 confirmed or probable cases of infectious disease during 2016-17, all of which needed some degree of follow-up or investigation. This number of cases is as expected for our population size.

There were 7 confirmed cases of Escherichia coli (*E. coli*) Infection, VTEC 0157 in B&NES in 2016-17. We have highlighted below an example of a national *E. coli* VTEC 0157investigation which B&NES Council was involved with.

4.1.2 What is E. coli VTEC 0157?



E. coli bacteria are frequently found in the intestines of humans and animals. There are many different types of *E. coli*, and while some live in the intestine quite harmlessly, others may cause a variety of diseases.

The bacterium is found in faeces and can survive in the environment. *E. coli* bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. *E. coli* bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood.

E. coli O157 infection can cause a range of symptoms, from mild diarrhoea to bloody diarrhoea with severe abdominal pain. On rare occasions, it can also cause more serious medical conditions and can be caught by eating contaminated food or by direct contact with animals with the bacteria. It can also be passed from an infected individual to another person if hand and toilet hygiene is poor.

4.1.3 *E. coli* VTEC 0157 case study

Between June and August 2016 B&NES Council Public Protection Team were involved in the investigation and response to a national outbreak of *E. coli* 0157. The outbreak affected over 160 people throughout the UK, many in the South West. Two people died as a result of the infection. Although the suspected food was not produced in B&NES, close co-operation with a local distributor played a key part in preventing further spread. Approximately 180 hours of Officer's time was spent on this investigation. Although the source was not identified officers were able to assist

in the elimination of most of the suspected food and epidemiological investigations identified mixed salad leaves as the likely cause of the outbreak.

PHE and the Food Standards Agency urged people to remove any loose soil before storing vegetables and thoroughly wash all vegetables and salads that will be eaten raw unless they have been pre-prepared and are labelled 'ready to eat'. These measures may reduce the risk of infection from any *E. coli* contaminated vegetables and salad but will not eliminate any risk of infection completely.

4.1.4 Illegal & under age tattooing

Priority 4 from 2015-16 report: Ensure that the public are appropriately informed about emerging threats to health

RAG: Green

Tattoos pierce the skin repeatedly with one or more needles and insert droplets of ink into the skin. The risks of being tattooed by an illegal tattooist include un-sterilised equipment and poor hygiene standards which could lead to communicable disease transmission risks and complications including:

- Blood-borne disease such as Tetanus, Hepatitis B & C and HIV
- Skin infections
- Allergic reactions to skin dyes

In May 2017 B&NES Council Officers became aware that a group of under 18 year olds were tattooed by someone not registered as a tattooist.

It is illegal to tattoo anyone under the age of 18, even with parental consent. Tattooists are required to register with and be inspected by B&NES Council; it is essential that hygiene standards are met to prevent infection and registered tattooists should always display their registration certificate.

In this situation the Council produced a poster and leaflet (see below) and wrote to all secondary school head teachers and other youth services to ask for support in raising awareness amongst staff, parents and students regarding the dangers of illegal and/or under age tattooing.

Following this work the Council received three referrals; one from Connecting Families and two from Youth Connect relating to underage tattoos.

Public Protection Officers are handing out the literature that was produced to raise awareness to new tattoo businesses when they register.

Above: The illegal tattooing leaflet that was designed to raise awareness

The Council's Public Protection team can investigate reports of un-registered tattooists and the public can report a person tattooing from an unregistered premise or if they are concerned about the hygiene standards of a tattooist.

Continuing to ensure that the public are informed about emerging threats to health has been identified as priority 3 for 2017-18.

4.2 Environmental Hazards

4.2.1 Air Quality Management Areas

Priority 3 from 2015-16 report: 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

RAG: Green

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

B&NES Council have declared 3 AQMAs in Bath, Keynsham and Saltford.

The Council has reviewed air quality throughout B&NES as part of its Annual Status Report; this report has undergone peer review by DEFRA.

4.2.2 Bath Air Quality Action Plan

Stakeholder engagement has taken place prior to the launch of the review of the Bath Air Quality Action Plan which has generated many ideas and comments for inclusion in the consultation document. The plan is currently out for a 3 month public

consultation. There will be 3 informal pop-up sessions in local venues as well as 3 public drop-in sessions in addition to the online information, and one of those drop in sessions will be at the Bath City Conference.

4.2.3 Keynsham and Saltford Air Quality Action Plans

Last year the Board supported the development of AQAPs for Saltford & Keynsham. In 2015 a public consultation reviewed the AQAPs for Keynsham and Saltford before they were formally adopted in May 2016. 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 currently being delivered includes a trial for a one way system in Keynsham High Street with associated monitoring to understand the impact of this change.

4.2.4 Temple Cloud air quality

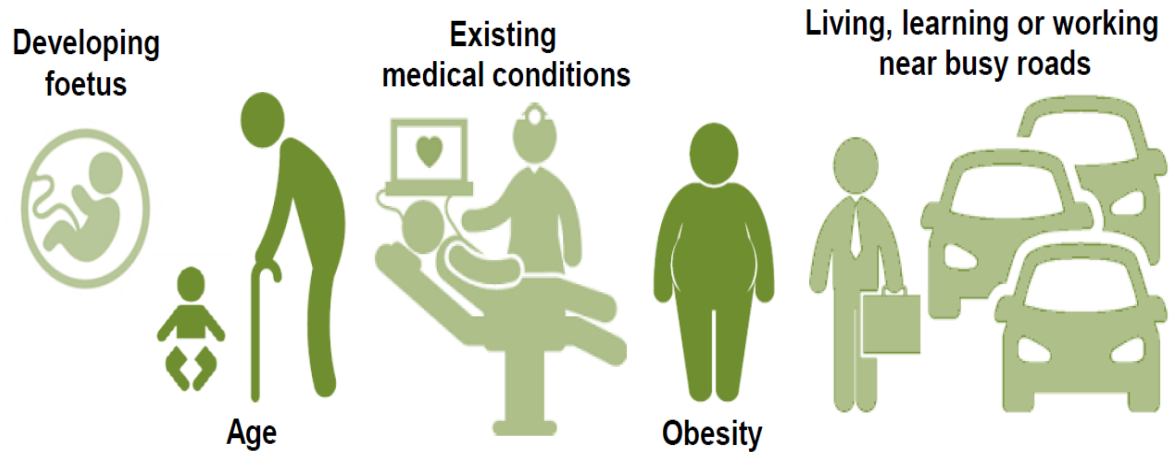
During the last year, monitoring was undertaken in various locations along the A37 between Whitchurch to the north and Farrington Gurney to the south of B&NES. There are some areas which do not comply with the objective standards and the Public Protection Team will be consulting on declaring an AQMA in Temple Cloud. Further monitoring is being continued in other locations to clarify whether there is a need to declare additional areas for non-compliance with the objective standards.

4.2.5 National Air Quality Action Plan

A further development has been the inclusion of Bath in the National Air Quality Action Plan as it is considered that a section of the A4 in Bath will continue to exceed the National Air Quality objective for nitrogen dioxide beyond 2021. The Council has been directed to carry out a feasibility study and develop a business plan which sets out how it will achieve compliance with the air quality objective in the shortest time possible.

4.2.6 Protecting vulnerable groups from air pollution

Air pollution can be harmful to everyone; however there are some factors which make some people more vulnerable:



Two projects working across Council departments are currently taking place which aim to raise awareness amongst vulnerable groups living, working and going to school etc. in AQMAs.

The first project uses Geographic Information Systems (GIS) to map and identify those most vulnerable to air pollution in AQMAs e.g. early years settings, schools and care homes. Research is being carried out to develop and deliver appropriate communication messages to help those identified reduce their exposure to air pollution.

The second is a pilot project working with schools in AQMAs to:

- Develop exposure reduction advice
- Promote active travel to school
- Raise public awareness
- Support behavioural change with school children

Supporting the review, development and implementation of all Air Quality Action Plans has been identified as priority 4 for 2017-18.

5 Health Emergency Planning Resilience & Response

Emergencies, such as road or rail disasters, flooding or other extreme weather conditions, or the outbreak of an infectious disease, have the potential to affect health or patient care. Organisations therefore need to plan for and respond to such emergencies.

5.1 Local Health Resilience Partnership & health protection arrangements

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 local B&NES health partners produced the ‘B&NES Health Protection Incident Response

Plan'. This plan is underpinned with a Memorandum of Understanding agreed by all stakeholders.

Recently in September 2017 the LHRP repeated the review of local health protection arrangements for responding to incidents and outbreaks. Since 2014 real incidents, such as the burst water main incident described below, planning and exercising and close partnership working have all contributed to improved health protection capabilities in B&NES.

The LHRP are currently working to consolidate 5 local authority Health Protection Incident Response Plans into one and this will be tested during a desktop communicable disease exercise in Feb 2018.

5.2 Burst water main incident at Willsbridge

On Wednesday 19 July 2017, 35,000 properties across Keynsham and parts of Saltford and Kelston were without water for over 24 hours when a mains water pipe burst in Willsbridge. Numerous Council departments were involved in the incident which effected vulnerable people, including those in care homes and operation of food businesses and GP practices.

Bristol Water tweeted this image of the burst water main at Willsbridge

A full debrief is due to take place with Bristol Water shortly. In preparation for this local health partners including the Council, Virgin Care and BaNES CCG held their own debrief and reported the following:

What went well?

- Good feedback from Domiciliary Care providers
- Local team work to help affected businesses/vulnerable groups
- Virgin Care business continuity plans and offer of help from District Nurses to vulnerable patients etc.
- Council Public Protection Team supporting high risk food premises
- Out of hours list and contacts
- Red Cross helpful
- B&NES Council were ready to open control room

What didn't go so well?

- Communications with Bristol Water; gravity of importance was not known from outset, anticipated time to regain water varied and changed frequently and poor use of website etc.
- Gaps in Bristol Water's vulnerable person list – lack of capacity to deliver water to vulnerable people/groups
- Major incident called late by South Gloucestershire Council
- Ad hoc notifications internally/with local partners
- Contact with food takeaways could not take place until late afternoon
- Ability to share vulnerable person information
- Public Protection evening work – under resourced/resilience.
- Lack of large containers to transport water

What could be improved and what actions are required?

- Business continuity of Bristol Water:
  - Brief staff in call centre
  - Update vulnerable person list
  - Provide an alternative way of local authority and other partners contacting them in an emergency
  - Provide informed information to public and partners on website, point of water collection at bowsers
- Follow-up with Wessex Water and other utility companies if similar incident occurred
- Process for internal/local partner cascade when not a major incident – initial teleconference
- Care providers services business continuity
- Sharing patient identifiable information – Virgin Care out of hours being able to identify different groups of patients and share information
- Detailed care providers services contact lists required
- Actions/support required in the event of a longer incident e.g. large containers, bottled water supply mutual aid from other water companies Water/voluntary sector
- Communications with PHE and ward Councilors during incidents

5.3 Rest centre & hospital evacuation exercise

The Council and Virgin Care are in the process of planning a part desk top and part live rest centre and hospital evacuation exercise in November 2017.

The Council has a statutory duty to plan and exercise for emergency situations. The Council's rest centre plan has recently been reviewed and needs to be exercised. Virgin Care is required to test their hospital evacuation plans and support the Council with its rest centre plan, so the two have been combined to carry out a joint exercise.

The exercise and associated debrief will highlight any gaps/actions which need to be addressed and implemented for us to be assured that our plans are suitable.

5.4 Health Emergency Planning Resilience & Response risks

The inability to respond to emergencies long term and the absence of a formal out of hours provision for Public Protection have remained on the Board's risk log throughout 2016-17. However the best endeavour out of hours system that Public Protection operate on good will has been tested a number of times and has worked. The likelihood of not being able to respond to an emergency long term has remained low, but as the impact is high the Board has continued to monitor it.

6 Sexual health

Sexual health is an important part of physical and mental health and is a key part of our identity as human beings. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.

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

The most important, and dominant, piece of work overseen and completed during 2016/17 has been the redesign of sexual health services in B&NES as part of the Your Care Your Way (YCYW) programme. The sexual health element of YCYW has resulted in the specification of a new, integrated sexual health service to commence in April 2018, combining elements of the previous Sexual Health and HIV Medicine delivered by Royal United Hospitals NHS Foundation Trust, and the Contraception and Sexual Health service delivered by Sirona Care and Health. We are confident the new service, fully aligned to the YCYW principles of easier access and better

connected community services, will be able to deliver more holistic sexual health provision to B&NES residents.

Linked to this has been the move of the Sexual Health and HIV Medicine service from the main RUH hospital site to new, shared premises with the Contraception and Sexual Health service at the Riverside Clinic in central Bath. The move was completed in June 2017 to help support the development of the clinical space and integrated team working ahead of the launch of the new service in April 2018.

During 2016/17 we carried out a sexual health needs assessment for young people in, and leaving care. The needs assessment highlighted much good practice along with a number of areas for improvement, which have now been adopted into a bespoke action plan.

Finally, much progress made against a number of actions in the sexual heath action plan including an overhaul in the reporting of contraceptive provision in general practice with a specific focus on collating data per contraceptive fitter to ensure each fitter is working within the correct guidelines; supporting the local Female Genital Mutilation (FGM) awareness campaign in collaboration with the Local Safeguarding Adults and Children's Board; targeted work with providers in the Norton Radstock area around compliance with our Sexual Health Advice For Everyone (SAFE) scheme, and a review of the Condom Card (C-card) scheme to assess its compliance with recently issued national good practice. Outstanding actions in the action plan not completed due to time needed to be given to the YCYW process have been reviewed by the Sexual Health Board and will be delivered in 2017/18 where appropriate.

6.3 Challenges

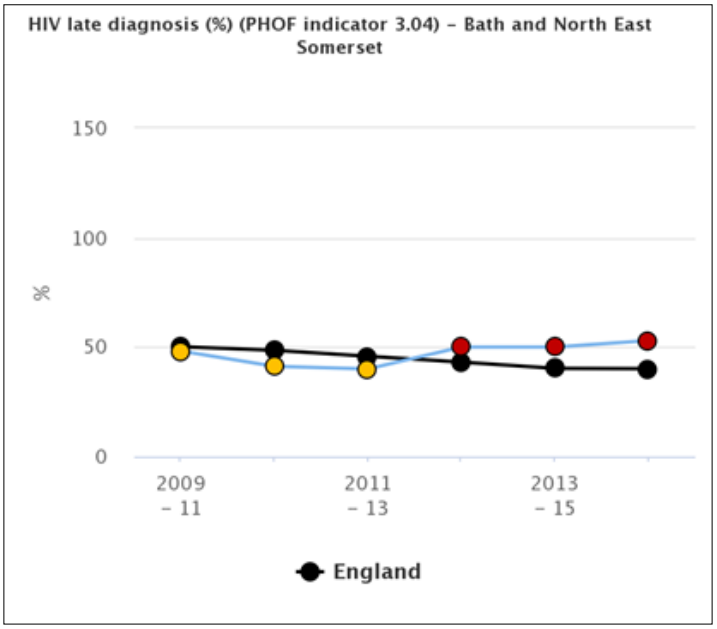
2016/17 has seen further pressure on budgets, including cuts to the public health grant. The Sexual Health Board has supported some tough decisions to reduce the overall spend on sexual health services in B&NES, whilst trying to ensure that actual reductions in service provision is minimised. Some examples include a strategic de-prioritisation of chlamydia screening, the decommissioning of the HIV support service, and the establishment of a maximum age level for provision of free emergency hormonal contraception via community pharmacies. The board recognises that further financial challenges are likely to be a significant factor over the short to medium term, but remains committed to achieving our strategic objectives working with available resources

6.4 Sexual health indicators

The Sexual Health Board has devised an indicator set to assess progress against our three defined outcomes which support our vision. Detailed below are two key indicators from the set which give an important insight into sexual health in B&NES.

6.5 HIV late diagnosis

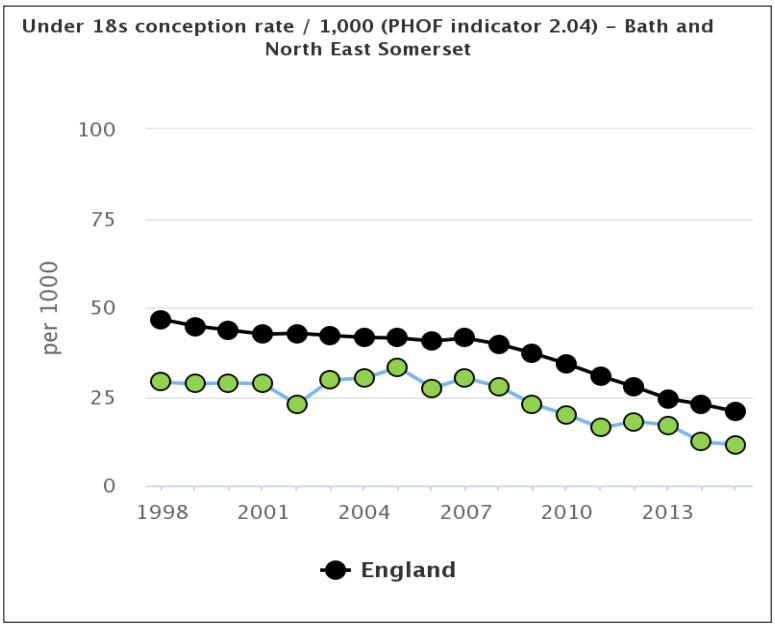
B&NES remains a low prevalence area for HIV infection but ensuring early access to HIV testing is vital to reducing HIV-related mortality and morbidity. People who are diagnosed with HIV at a late stage can have a ten-fold risk of death compared to those diagnosed promptly. The percentage of those diagnosed late with HIV in B&NES was 52.9% over the period 2014 – 2016, slightly higher than the England average. There has been a gradual increase since 2011 – 2013, in contrast to England which has seen a decline as detailed below. This data needs to be interpreted with caution as the rates are based on very small numbers:



Source: Public Health England (2017)

6.6 Under 18s conceptions

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 has continued. From 1998 to 2015 B&NES has reduced its level of teenage conceptions from 29 per 1,000 women aged under 18, to 11.4 per 1,000 women aged under 18 as shown below:



Source: Public Health England (2017)

7 Substance misuse (drugs and alcohol)

Drug and alcohol misuse is a complex issue. Although the number of people with a serious problem is relatively small, someone's substance misuse and their dependency affects everybody around them.

7.1 National public health framework indicators (drug treatment specific);

Two new Public Health Framework sub-indicators have been added since 2016; successful completions of alcohol treatment and deaths from drug misuse:

7.1.1 Successful completions of alcohol treatment

Successful completions of alcohol treatment has been added as an additional sub indictor to reflect the fact that in many areas (including B&NES) drug and alcohol services are increasingly commissioned together and the data that is used to report on access and provision is drawn from the NDTMS data system which reflects that many services users use more than one substance, including alcohol, at any one time.

7.1.2 Deaths from drug misuse

Deaths from drug misuse has also now been including within the national framework as there has been a rising trend in Drug Related Death (DRD) over the last few years; however for B&NES the number of DRD's is too small to be analysed nationally. None the less, reducing DRDs is a key priority for B&NES as the quality and accessibility of treatment services, how deaths are investigated through

systematic reviews of DRD's, and harm reductions such as the roll out of Naloxone are key factors in reducing the number of DRD's.

B&NES is currently undertaking a Needs Assessment 2017-18 which will inform future key priorities. One key area will be the development of 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 Successful completion of drug treatment – non-opiate users

There are declining numbers of people in treatment for non-opiate users than in the previous years. However during 2016-17 the proportion of all non-opiate users in treatment who successfully completed treatment and did not represent within 6 months in B&NES was below the national average of 37.3%. The current performance for B&NES is 25.5%. The Developing Health & Independence charity (DHI) will be focussing on increasing engagement of non-opiate drug users; and maximising successful outcomes for this cohort. This will include changing the treatment offer so that it is more attractive to these clients (many of whom are in full time employment) e.g. shortening the duration of the programme, offering it in the evening etc.

7.3 Reducing health inequalities & substance misuse

A project is currently taking place in B&NES aimed at improving the outcomes of parents in treatment by increasing successful completions. This will be enhanced by providing parent specific group substance misuse interventions, and by collaboratively delivering this at the Children's Centre, children will benefit from this therapy.

7.4 Blood Borne Viruses

B&NES is effective and proactive at supporting appropriate substance misuse clients to be tested for HCV. At the end of 2016-17 only 7% 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 17% without a test.

8 Screening & immunisations

Immunisation remains the safest and most effective way to stop the spread of many of the most infectious diseases. If enough people in the community are immunised, the infection can no longer be spread from person to person.

Screening is a way of identifying apparently healthy people who may have an increased risk of a particular condition. There are six NHS England national screening programmes.

For further information on the vaccines that are routinely offered to everyone in the UK free of charge on the NHS and the ages at which they should ideally be given and the national screening programmes please visit NHS Choices: www.nhs.uk and search screening or vaccinations.

There are no major concerns about the performance of any of our local screening programmes or immunisation programmes in place across B&NES, except those detailed below. For performance data please visit the Public Health England website: http://tinyurl.com/y9c9tby8 and search under indicator keywords.

8.1 Screening programmes & reducing health inequalities

Priority 7 from 2015-16 report: Continue to reduce health inequalities in screening programmes

RAG: Amber

Health inequalities can be described as the differences in health outcomes that exist between groups of people that are to do with where they live or work, the amount of income they have, their education, gender, ethnicity etc. These differences in outcomes can be measured by looking at areas such as: the differences between groups of people in their life expectancy, educational attainment, number of years lived free from a disability, rates of diseases and long term conditions, experience of mental ill health, access to health services, experience of services etc.

8.1.2 Health protection & health inequalities

In May 2016 many partners came together in B&NES for a Health and Wellbeing Board summit to help delegates better understand health and social inequalities in B&NES, and identify ways in which organisations/partnerships/teams could reduce these. At a subsequent Health Protection Board meeting members were asked to think about a number of different questions related to health inequalities and their specialist area of health protection. Each board member then committed to implementing at least one action e.g. a business case is currently being put forward to appoint a screening and immunisation health inequality officer to work across B&NES.

8.1.3 Screening and immunisation health inequality workshop

The Council's Public Health Team and NHS England South (South Central) Screening & Immunisation Team are currently planning a screening and immunisation health inequality workshop in November 2017 aimed at reducing inequalities in uptake of the cervical screening and childhood (0-5 years) immunisation programmes.

Workshop objectives

- Learn more about inequalities in uptake between different population groups
- Increase understanding about barriers to uptake
- Learn about and share good practice in improving uptake
- Identify opportunities to improve access
- Produce a draft list of actions to take forward

8.1.4 Bowel Cancer Screening & Health Inequalities

Work continues through a B&NES, Swindon and Wiltshire-wide Bowel Cancer Screening Health Equity Working Group to increase uptake of bowel cancer screening among men and neighborhoods with lower Index of Multiple Deprivation (IMD) scores and greater ethnic diversity. The first communications campaign aimed at these groups is scheduled for December 2017.

Continue to reduce health inequalities in screening and immunisation programmes has been identified as priority 5 for 2017-18.

8.2 Immunisations

8.2.1 Uptake of childhood immunisations 2016-17

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).

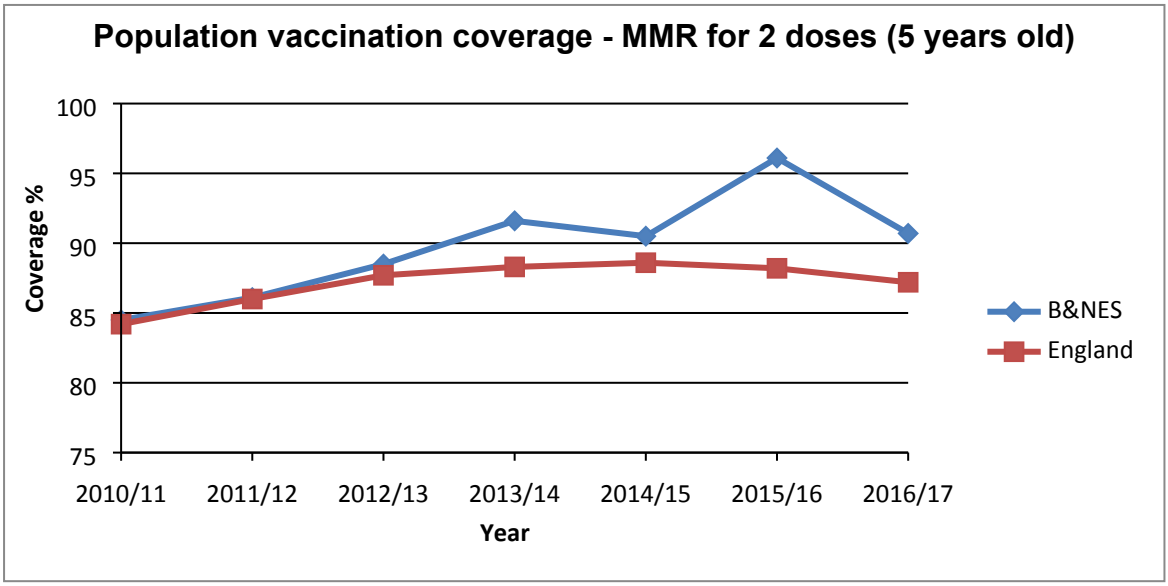
The B&NES uptake across all four quarters in 2016-17 for all childhood immunisations were higher than the England average; however uptake of pre-school booster vaccinations given at 3 years 4 months of age regularly fall below the national 95% target.

8.2.2 Measles, Mumps and Rubella vaccination (MMR)

Priority 5 from 2015-16 report: Improve the uptake of MMR Vaccination in B&NES.

RAG: Amber

The current English routine immunisation schedule for MMR vaccination is for dose one to be given at 12 months of age and dose 2 to be administered at 3 years 4 months. Nationally the data reports MMR (both doses) being received by the time the child turns 5 years of age.



Source: Public Health England (2017)

In last year's Health Protection Board report, priority 5: to increase the uptake of MMR vaccination, was set based on the data that was available until 2014-15.

Since 2015 a substantial amount of local work has taken place aimed at increasing the uptake, this includes working with the Child Health Information System (CHIS) and GP practices and Health Visitors. The graph above shows that uptake of MMR vaccinations (dose two by 5 years of age) steadily increased in B&NES between 2010 and 2014-15, dropped in 2014-15 to just above 90% and then increased substantially in 2015-16 to above 95% only to decrease back down again in 2016/17 to above 90%.

8.3 B&NES Immunisation Group

The B&NES Immunisation Group was established in July 2015 and continues to take 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 reports to the Health Protection Board. Please see Appendix 2 for terms of reference.

As the above MMR data shows the group needs to continue its focus on increasing the uptake of childhood vaccinations and further work is planned, including hosting a health inequality workshop described more below.

Through its monitoring the group became aware that in some secondary school cohorts adolescence/school based vaccinations rates were lower than desired thus putting unvaccinated children and young people at risk and increasing the likelihood of an outbreak in the wider population. Dr Bruce Laurence, Director of Public Health and Dr Ardiana Gjini, Screening & Immunisation Lead, PHE & NHS England South (South Central) therefore wrote a joint letter to head teachers asking for their help in ensuring as many young people as possible have their vaccinations. This included working alongside Virgin Care's School Nursing Service to identify those eligible for each vaccination, by providing student lists and helping to gather as many consent forms as possible.

8.4 Seasonal flu vaccination programme & winter preparedness

Priority 5 from 2015-16 report: 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

RAG: Green

Preparations in B&NES for the impact of flu this winter covers three main areas; vaccination of eligible groups e.g. 65s and over, under 65s at risk, pregnant women, children aged 2-9 and carers; vaccination of health and social care staff and pandemic flu.

8.4.1 Vaccination of eligible groups

Last year across B&NES uptake of the seasonal flu vaccination amongst all of the eligible groups increased from the previous 2015-16 year except in people aged 65 years and over. Vaccination rates of all eligible groups were also above the England average except the under 65s at risk. Two and three year old uptake across B&NES, Gloucestershire, Swindon & Wiltshire (BGSW) was the best in the country, the school programme in B&NES achieved impressive uptake (on average for school years 1,2 and 3 - 69.2%) and Health Care Worker (HCW) uptake also saw significant improvement.

Uptake at CCG level for the 2016-17, 2015-16 and 2014-15 BANES CCG Seasonal flu adult programme; 65s and over, under 65s at risk & pregnant women

Organisation name	No. of practices responding	% practices responding	Year	65 years and over	Under 65 at risk	Pregnant women
BaNES CCG	26	100	**16-17** 15-16 14-15	**71.4** 72.0 72.9	**47.0** 43.0 45.4	**45.7** 44.0 45.7
England			**16-17** 15-16 14-15	**70.4** 71.0 72.8	**48.7** 45.1 50.3	**44.8** 42.3 44.1

Source: ImmForm, 2017

Uptake at CCG level for the 2016-17, 2015-16 and 2014-15 Seasonal flu childhood programme

Org. Name	No. of practices responding 16/17	Year	All aged 2	All aged 3	All aged 4	Year 1 5-6yrs	Year 2 6-7yrs	Year 3 7-8yrs
BaNES CCG	26 (100%)	**16-17** 15-16 14-15	**52.3** 42.6 46.8	**54.2** 47.8 48.3	**44.5** 39.6 39.8	**71.4** 38.5 -	**68.2** 33.7 -	**68.1** - -
England		**16-17** 15-16 14-15	**38.9** 35.4 38.5	**41.5** 37.7 41.3	**33.9** 30.0 32.9	**57.6** 53.6 -	**55.3** 52.1 -	**53.3** - -

Source: ImmForm, 2017

Uptake of seasonal flu vaccination of HCWs by Trust

Organisation	**Uptake (%)**	
	2016-17	2015-16
Royal United Hospital Bath (RUH) NHS trust	68.0	43.6
Avon and Wiltshire Mental Health Partnership (AWP) NHS Trust	66.5	38.4
BGSW Team Health Care Workers(All GP Practices & other organisations e.g. Sirona Care & Health)	54.6	44.8
England	63.2	49.5

Source: ImmForm, 2017

8.4.2 Priorities for the 2017-18 seasonal flu vaccination programme

As the uptake of the flu vaccine in at risk groups & pregnant women is far below the aspirational level (at least 55% in all clinical risk groups, and maintaining higher rates where those have already been achieved) the (BGSW) Flu Planning & Oversight group have agreed that the under 65's at risk and pregnant women will continue to be a priority for the 2017-18 season.

NHS England will continue to incentivise the uptake of flu vaccinations for frontline clinical staff through the CQUIN scheme for 2017-18. More work is needed to dispel flu myths and encouraging reluctant staff to understand the reasons why flu vaccinations are being offered.

8.4.3 Sustainability & Transformation Partnership (STP), Prevention and Proactive Care - Flu & Pneumococcal Work Stream

A STP wide seasonal flu and pneumococcal working group has been established with the aim to increase seasonal flu and pneumococcal vaccination in eligible groups. The group's objectives have been identified as those adding value to the work already planned through existing structures and processes. In year one of the work stream (2017-18) the focus is on increasing flu vaccination uptake in carers and social care staff; this includes surveying all care providers to find out how many are offering staff flu vaccinations, as well as holding focus groups with carers to inform a promotional campaign aimed at carers.

Improve the uptake of flu vaccinations in at risk groups, pregnant women, health and social care workers, and carers; and pneumococcal vaccination amongst the under 65s at risk and over 65s has been identified as priority 6 for 2017-18.

9 Recommendations

The Health Protection Board is committed to improving all work streams. 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 activities to slow the development and spread of antimicrobial resistance.
3. Continue to ensure that the public are informed about emerging threats to health.
4. Support the review, development and implementation of all Air Quality Action Plans.
5. Continue to reduce health inequalities in screening and immunisation programmes.
6. Improve the uptake of flu vaccinations in at risk groups, pregnant women, health and social care workers, and carers; and pneumococcal vaccination amongst under 65s at risk and over 65s.

10 Appendices

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

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

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

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

Appendix 2

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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