HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Tuesday, 17th April, 2018, 10.30 am

Dr Ian Orpen (Chair)	Member of the Clinical Commissioning Group
Councillor Vic Pritchard	Bath & North East Somerset Council
Mike Bowden	Bath & North East Somerset Council
Tracey Cox	Clinical Commissioning Group
Steve Kendall	Avon and Somerset Police
Bruce Laurence	Bath & North East Somerset Council
Kirsty Matthews	Virgin Care
Councillor Paul May	Bath and North East Somerset Council
Professor Bernie Morley	University of Bath
Laurel Penrose	Bath College
James Scott	Royal United Hospital Bath NHS Trust
Dr Andrew Smith	BEMS+ (Primary Care)
Jane Shayler	Bath & North East Somerset Council
David Trethewey (in place of Ashley Ayre)	Bath & North East Somerset Council
Observers:	Cllr Eleanor Jackson Cllr Robin Moss

48 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

49 EMERGENCY EVACUATION PROCEDURE

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

50 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Ashley Ayre – B&NES Council – substitute David Trethewey
Mark Coates – Liverty
Alex Francis - Healthwatch
Stuart Matthews – Avon Fire and Rescue Service
Hayley Richards – Avon and Wiltshire Partnership
Sarah Shatwell – Developing Health and Independence
Elaine Wainwright – Bath Spa University

51 DECLARATIONS OF INTEREST

There were no declarations of interest.

52 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There was no urgent business.

53 PUBLIC QUESTIONS/COMMENTS

Cllr Lin Patterson addressed the Board regarding the environment and the positive effects that nature can have upon health. She referred to Local Plans and the importance of "building with nature" to include green spaces in developments. Cllr Patterson supported the charter put forward by the West of England Nature Partnership and hoped that the Health and Wellbeing Board would sign up to this.

54 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 30 January 2018 were approved as a correct record and signed by the Chair.

55 TOPIC/CASE STUDY: DEMENTIA

The Board received a presentation from representatives of the Alzheimer's Society which provided an overview of dementia services and support available in the B&NES area. The presentation covered the following matters:

- Information regarding the Alzheimer's Society
- Dementia statistics in Bath and North East Somerset – the diagnosis rate in the area is 61.9% which is well below the target set by NHS England (66.7%) and below the West of England average (67.3% and the South West average (62.2%)
- The percentage of residential care and nursing home beds rating as good or outstanding is only just over half as compared with 62.4% across the South

West region.

- The Alzheimer's Society delivers many services and projects to help people with dementia in the B&NES area. There are a number of support workers who aim to eradicate the social isolation for those people with dementia.
- Local Authorities have a great impact on the experience of residents with dementia and it was noted that B&NES Council has made a commitment to becoming more dementia friendly.
- There are 850,000 people living with dementia in the UK and this number is set to rise to 1 million by 2021.
- The Government is due to release a Green Paper over the summer and this provides an opportunity to affect the future of social care in the UK. The Alzheimer's Society will be campaigning to ensure it reflects the needs of people with dementia.

The following issues were then discussed:

- Tracey Cox stated that the CCG is working to improve diagnosis figures in line with NHS targets.
- James Scott pointed out that the RUH undertakes a lot of work with the Alzheimer's Society and the Research Institute for the Care of Older People (RICE) including research regarding dementia. This is an important issue for the RUH which is aiming to become the most dementia friendly hospital in the country. With the increasing age expectancy this will become more and more important.
- Steve Kendall reported that the police service has contact with a growing number of people suffering from dementia. More training in this area would be welcomed by the Police Service.
- It was noted that "dementia friends" can help to give confidence when interacting with people with dementia.
- Jane Shayler stated that the Council is aware of the below average number of care home beds which were rated as good or outstanding and informed the Board that action is being taken to improve this. This statistic could be linked to the high cost of living in the B&NES area which in turn leads to rising staffing costs and recruitment difficulties. The Council is working closely with the Care Quality Commission on this issue.
- It was noted that the Alzheimer's Society can provide courses for staff working in care homes.

RESOLVED: To note the information provided in the report and presentation.

56 **INTEGRATED CARE SYSTEM UPDATE**

Tracey Cox, Chief Officer of B&NES CCG, gave an update regarding the Integrated Care Partnership. The following matters were covered in the presentation:

- Sustainability and Transformation Partnerships, Integrated Care Systems (ICSs) and Integrated Care Organisations are different ways of delivering integration.
- ICSs are key to sustainable improvement in health care by creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS.

- The role and membership of the ICS Partnership Board (which is a sub-group of the Health and Wellbeing Board).
- Progress so far – there is no shared consensus on a "vision". However a key theme of a recent event was "we want to get on with it" with a strong desire to generate a plan for action. There was also agreement that B&NES is a workable footprint in terms of size and geography.
- An initial set of draft principles that the Leadership Team may wish to adopt in order to guide their actions and behaviours.
- Actions identified at the Leadership Event e.g. .targeting specific areas such as "stranded and super stranded patients", resource sharing and having honest conversations where needed to facilitate collaborative working.
- The vision set out in the Health and Wellbeing Board draft statement of intent is "One Health and Wellbeing system that enables people to live happier, healthier lives."
- The Draft Statement of Intent sets out three clear aims:
    - Shared leadership of a sustainable health and wellbeing system which is innovative and affordable.
    - Ill health is prevented.
    - Putting people at the heart of reform.
- Next Steps:
    - The CCG to identify some dedicated transformation capacity to support the development of ICS arrangements.
    - A further meeting of the ICS Board to progress actions and confirm the vision.
    - Priority actions – development of a Memorandum of Understanding and mapping of organisational activities in priority areas of Frailty, MDT working and stranded patients.

James Scott stressed the importance of getting on with this, in particular the actions relating to stranded patients which was a major issue for the RUH.

Andrew Smith stated that the work appeared to be quite reactive, needs a more integrated approach and noted that it would be helpful to link in with existing projects.

Tracey Cox confirmed that a gap analysis was taking place to address these concerns.

A copy of the presentation slides is attached as *Appendix 1* to these minutes.

RESOLVED: To note the update regarding the Integrated Care Partnership Board.

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

Tracey Cox gave an update regarding the Sustainability and Transformation Partnership (STP). The presentation covered the following matters:

- National Context
- STP priorities for 2018/19
- Delivery channels
- Ways of working

- STP Financial Recovery Plan

It was noted that there is a need to strengthen community care. This sector faced challenges as a result of demographic change leading to an aging population. There were also recruitment and retention challenges in the care professions.

Cllr Pritchard stressed the importance of social care and the role of the Council in the health and wellbeing of its population. It was important to align the agendas of health and social care.

The financial context showed that the STP is currently a facing a shortfall of £30m. A financial recovery plan has been put in place to address the deficit and to identify ways to close the gap.

Cllr Pritchard queried whether the financial position put the whole STP at risk as three different local authorities are involved. Tracey Cox confirmed that the position across the three authorities was variable but there was a shared consensus and the authorities could take action together.

James Scott explained that the fundamental issue for the STP is to add value. Most work would be place based and the majority of work will take place in the B&NES area.

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

RESOLVED: To note the update on the Sustainability and Transformation Partnership.

58 **SAFE AND WELL INITIATIVE**

Neil Liddington, from the Avon and Fire Rescue Service, gave a presentation regarding the "Safe and Well" initiative. The presentation covered the following matters:

- Historical context
- Relevant literature
- Current national situation
- Current situation at Avon Fire and Rescue Service
- What can be done working together
- Projects currently underway (such as slips, trips and falls hazard assessment, dementia checks/mental health, social isolation/loneliness)
- Potential issues
- Requirements
- Next steps

It was noted that the Fire and Rescue Service can add value to health and wellbeing services. Funding is available to develop four packages working alongside an app developer. The Fire and Rescue Service was keen to identify which of the 4 unitary areas in the Avon locality wished to work on which project and also a named contact for each authority.

It would also be important to evaluate this initiative to identify what success should look like. Discussions could also take place on future collaborative working on issues such as healthy lifestyles.

Board members acknowledged that there was a good deal of commonality between the different services. This is an excellent offer from the Fire and Rescue Service and further discussions will now take place to clarify how this can be taken forward.

Bruce Laurence stated that this is a generous offer and noted that a great deal of planning will be required. It is important to choose a theme that will add value and will provide positive outcomes against existing priorities.

The presentation slides are attached as *Appendix 3* to these minutes.

RESOLVED:

(1) To note the information provided regarding the Safe and Well initiative.

(2) To agree that Tracey Cox, Bruce Laurence and Kirsty Matthews discuss the best way to progress this matter.

59 PROPOSED CHARTER FOR JOINT ACTION ON IMPROVING HEALTH AND WELLBEING THROUGH NATURE

This item was withdrawn from the agenda and will be considered at a future meeting.

60 DIRECTOR OF PUBLIC HEALTH REPORT 2017

Bruce Laurence, Director of Public Health, presented his 2017 report. The report included the following areas:

- Active living – including active lifestyles, active travel, active design and active environments
- Children's mental health – the importance of getting the best start in life
- Air quality – what is being done locally and what individuals can do
- Domestic abuse – community prevention, early disclosure and help, support for victims, working with perpetrators and developing the workforce
- Health and work – including in-work poverty and getting back to work
- A day in the life – details of a day in the life of a school nurse
- Public health outcomes framework and other key indicators – top ten public health problems:
    - Environmental damage
    - Poverty, inequality and lack of opportunity
    - Poor diet
    - Inactivity
    - An ageing population with unmet needs
    - Shortage of affordable housing
    - Children's mental health and adverse childhood experiences
    - Tobacco, alcohol and other drugs
    - Reduced social cohesion, mutual intolerance and hardening politics
    - Deteriorating public services

The Board thanked the Director of Public Health for his excellent report. Cllr Paul May welcomed the specific chapter on children and young people. He highlighted the need to focus more on the large number of university and college students living in the community. Bernie Morley from Bath University explained that the Student and Community Partnership provide a useful link regarding community and social issues relating to students.

A copy of the presentation slides is attached as *Appendix 4* to these minutes.

RESOLVED:

(1) To note and endorse the annual report of the Director of Public Health 2017.

(2) To invite representatives from the Student and Community Partnership to attend a future meeting of the Board.

61 **CLOSING REMARKS**

The Chair thanked everyone for attending the meeting. Members were also asked to view and score the posters submitted by school pupils as part of the Clean Air Project being run by the Public Health Team.

It was noted that the next meeting will take place on Tuesday 26 June 2018.

The meeting ended at 12.25 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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Integrated Care Partnership Board Update

B&NES H&WB Wednesday 17th April 2018

Integrated Care Alliance Board Update

- National Context
- Local Context :-
  - The B&NES Integrated Care Alliance Board
  - Progress so far
- Next steps

MT1

STPs, ICSs and ICOs are different ways of delivering integration

NHS England

‘Integrated **care**’ is a term used to describe accountability for using a defined set of resources to provide the best possible quality of care and health outcomes for a defined population. There are different ways to deliver this.

Sustainability & Transformation Partnerships (STPs)

STPs are a **partnership** between NHS commissioners, NHS providers, GPs, local government and patient groups. Through this partnership they will develop – and oversee the delivery of – shared plans for improving system-wide quality, health outcomes and efficiency.

Integrated Care Systems (ICSs)

ACSs are evolved versions of STPs that bring together **collaborations** of commissioners, providers and local authorities that take collective responsibility for managing resources, quality improvement and population health, enabling them to deliver faster improvements in services.

Integrated Care Organisations (ICOs)

ACOs are provider organisations that are given **contractual** responsibility for most or all of the health and care services for the local population and for associated resources. Development of ACOs relies on a strong underlying approach to care design, engagement and collaboration.

Slide 3

MT1 A lot of info here. Tracey has alternative slide or split across two slides? AC=different organisations from health and care system working together to improve health outcomes..
May Tamsin, 29/01/18

The national picture

- *"Integrated Care System"* – collective term for both devolved health and care systems and for those previously designated "shadow accountable care systems."

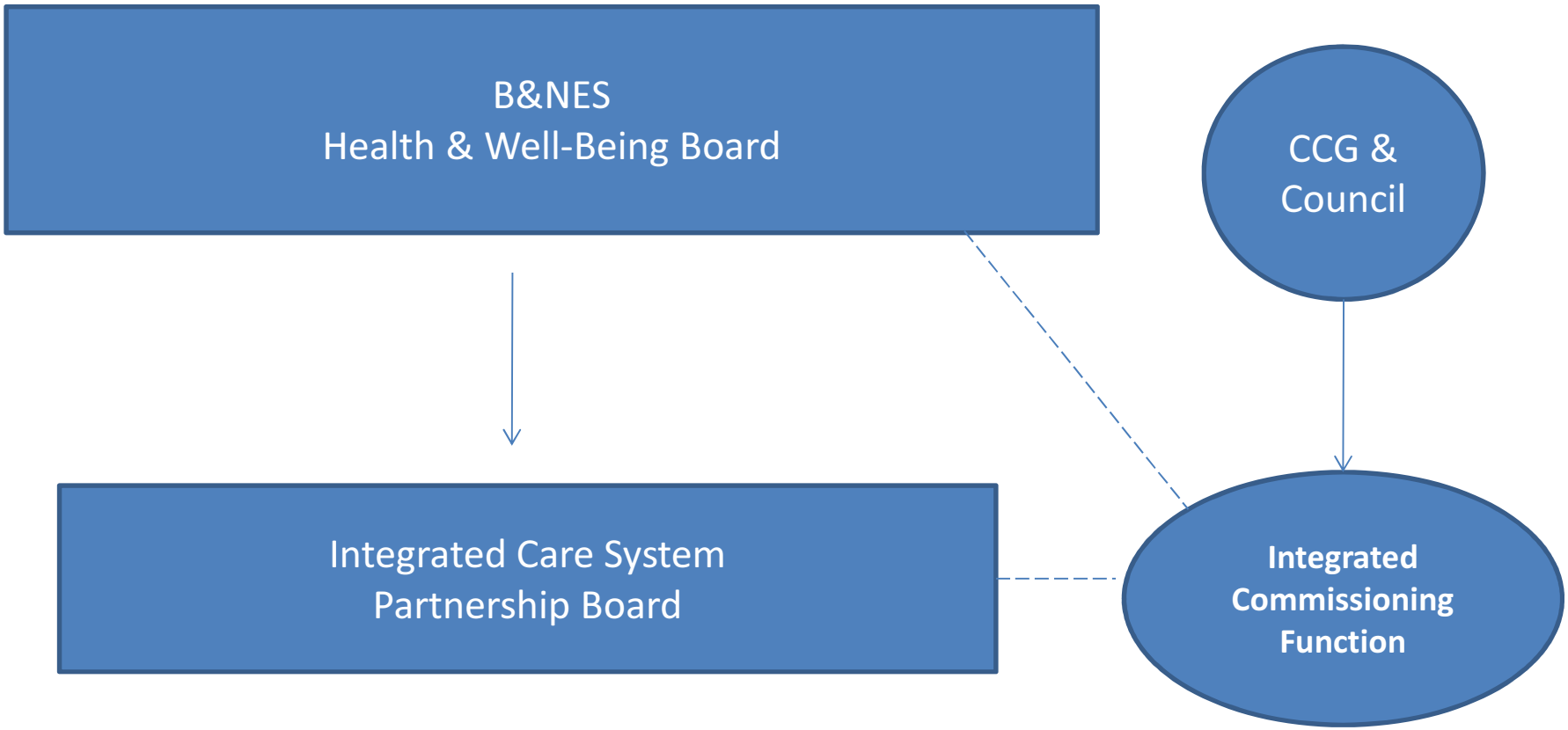
- 10 systems nationally (first wave):-

1. South Yorkshire & Bassetlaw
2. Frimley Health and Care
3. Dorset
4. Bedfordshire, Luton & Milton Keynes
5. Nottinghamshire
6. Blackpool and Fylde Coast
7. West Berkshire
8. Buckinghamshire
9. Greater Manchester (devolution deal)
10. Surrey Heartlands (devolution deal)

ICSs are key to sustainable improvement in health care by:

- Creating more robust cross –organisational arrangements to tackle the systemic challenges facing the NHS
- Supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation
- Delivering more care through re-designed community and home based services, including in partnership with social care, the voluntary and community sector
- Allowing systems to take collective responsibility for financial and operational performance and health outcomes

The local picture



Membership of Board

- *Tracey Cox, Accountable Officer (BaNES CCG)*
- *Ian Orpen Clinical Chair (BaNES CCG)*
- *Jane Shayler, Director of Integrated Health & Care Commissioning, B&NES CCG & Council*
- *Dr. Bruce Jones Director of Public Health, B&NES Council*
- *Councilor Vic Pritchard, Elected Member, B&NES Council*
- *Dr. Andrew Smith, BEMS +GP Representative (on behalf of primary care)*
- *Dr. Gareth Bryant LMC Representative (on behalf of primary care)*
- *James Scott, Chief Executive, Royal United Hospitals, Bath NHS FT*
- *Kristy Matthews, Managing Director, Virgin Care*
- *Nicola Hazel, Clinical Director, Avon & Wiltshire Mental Health Partnership*
- *Sarah Shatwell, Operations Director, DHI, Voluntary Sector Representative*
- *Morgan Daly, Healthwatch*

Role of the ICS Partnership Board

- Confirm the local vision for an ICS for B&NES
- Develop a Memorandum of Understanding (MOU) with relevant partner organisations
- Develop a roadmap for progressing towards an integrated care arrangement
- Agreed the set of transformational work streams to support delivery of the vision

Progress so far

- 2 facilitated development sessions held (10th Jan & 21st March)
- Series of 1:1 interviews have been conducted with System Leaders to gather thoughts on the development of the Integrated Care System in B&NES
- No shared consensus on a “vision”
- However, a key theme of the event was ‘*we want to get on with it’,* with a strong desire to minimise the time spent on revisiting the vision and to quickly generate a plan for action
- Agreement that B&NES is a workable footprint in terms of size & geography
- Some suggested Principles and Actions identified

Principles (Draft – for consideration)

The following are an initial set of draft principles that the Leadership Team may wish to adopt in order to guide their actions and behaviours:

- We will adopt a common narrative which unites us and explains our ambition.
- Our methodology will be based on the principle of the ‘three conversations’ approach.
- We will include non-traditional voices in the development of our Integrated Care System
- We will adopt innovative approaches and learn from others.
- The decisions we take will be based on their benefits to the whole system and we will work together to manage the impact on individuals, teams and organisations.
- We will simplify processes, remove duplication and stop those activities that do not provide value to our integrated system.
- We will identify how we can use our collective resources to support the development of our integrated care system.
- We will take personal ownership and hold each other to account for the improvement of health and wellbeing within B&NES.

Actions

The following actions were identified at the Leadership Event:

- Adopt/ adapt the 'Your Care Your Way' narrative & H&WB draft statement of Intent as the basis for the Integrated Care System (ICS).
- Agree how the ICS Leadership Group will operate, how frequently it will meet and which existing groups need to be aligned or stopped/changed to support the integration agenda.
- Quickly collate a plan which captures the current Top 5 change activities in each organisation and enables us to prioritise the activities we wish to continue and those we wish to stop
- Target some specific areas:
  - Stranded & super stranded patients – Can we do any more to accelerate their transition out of the RUH? What can we learn from them about the upstream interventions that would make a difference in the future?
  - Multi-disciplinary Team (MDT) working – How can we build on the progress made to date and extend the approach both in terms of participation in MDTs and geographic spread?
  - Frailty – How can we accelerate/expand our work on frailty?

Actions

- Resource sharing – identify areas where capacity within the system could be used differently to support integration (e.g. Comms & Engagement Teams, Information Analysts, Transformation resources)
- Identify low value/wasted energy in our current ways of working and eliminate it
- Identify news stories that demonstrate progress and generate hope (but are realistic in the context being experienced by front line teams) and develop collective mechanisms for sharing these with stakeholders.
- Establish a knowledge sharing mechanism (Kahootz?) and implement it as a mechanism for supporting the ICS Leadership Group and process.
- Have honest conversations where needed to facilitate collaborative working.
- Technology and analytics opportunities for improvement/joint working to be identified

Vision – H&WB Draft Statement of Intent

"One Health and Wellbeing system that enables people to live happier, healthier lives"

H&WB Draft Statement of Intent

- 3 key aims:-
  - Shared leadership of a sustainable health & wellbeing system which is innovative & affordable
  - Ill health is prevented
  - Putting people at the heart of reform

Next steps

- CCG to identify some dedicated Transformation capacity to support the development of ICS arrangements

- Further meeting of ICS Board to progress actions and confirm the vision

- Priority actions – development of an Memorandum of Understanding & mapping of organisational activities in priority areas of Frailty, MDT working and stranded patients

Sustainability & Transformation Partnership Update

B&NES H&WB Wednesday 17th April 2018

BaNES, Swindon and Wiltshire STP update

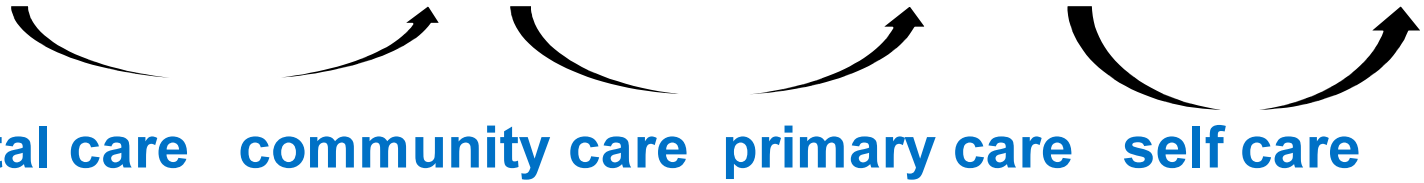
- National Context
- STP Priorities for 2018/19
- Ways of Working
- STP Financial Recovery Plan

The role of Health and Wellbeing boards – Central to strong leadership

BaNES, Swindon and Wiltshire working together

The national context in which STPs are working….

- Working in systems / partnerships / alliances will be the norm – policy development at national level ongoing moving from competition as the driver
- Local authorities are in the driving seat for wellbeing – levering improvements through full portfolio of activities (transport, education, planning, leisure, economic development)
- Wellbeing defined as both physical and mental wellbeing
- Health services support health and wellbeing through continued shift in emphasis



The national context in which STPs are working….

- Pattern of provision of care and commissioning of care may change
- Providers taking ‘lead provider’ responsibilities and undertaking tactical commissioning
- Commissioners working differently – health and social care integration
- Alignment of NHS commissioners to give stronger strategic commissioning voice through single STP wide commissioning where appropriate

Priorities for 2018/2019

Develop and start to implement an integrated transformation programme to:

- **Improve mental health and well-being services**

- **Improve the health and well-being of older people**

Implement a programme of transformation to improve maternity services

Priorities for 2018/2019

- **Establish an STP financial strategy in support of individual organisations' financial plans to achieve the most appropriate use of resources and financial balance**

- **Develop and implement a programme of change that will result in three integrated placed based commissioning and provision systems 'Integrated Care Alliances' (B&NES, Swindon and Wiltshire)**

- **Creating an STP wide commissioning & strategic planning function for the wider STP footprint 'Integrated Care System' where this makes sense for patients**

- **Implement a digital strategy**

Priorities for 2018/2019

Develop a STP estates strategy to ensure both the effective utilisation of the NHS and local authorities estates and appropriate patient/user environments

Establish an STP workforce strategy to reflect the national NHS workforce strategy including social care

Deliver the next stage of the NHS Five Year Forward View

Delivery channels

Direct STP Leadership	STP Oversight	System-level Commissioning lead	CCG lead	Provider Lead	Local Authority Lead
ACS development including Population Health	System-level commissioning at scale (leading to ACS)	FYFV – Cancer (alliances)	System-level commissioning at scale (leading to ACS)	Specialty Reviews – demand, capacity and costs	Proactive and Preventative Care (HWB)
Well-being and Health of Older People (scope to be defined)	Integrated care development (provision)	FYFV – Mental Health	Integrated Care Alliance development	GIRFT	Savings
Mental Health and Well-being (scope to be defined)	Place based commissioning integration	Better Births Delivery Plan (LMS)	Place based commissioning integration with Local Authorities	Model Hospital	Place based commissioning integration with CCGs
STP Financial Recovery Plan including support services	FYFV (UEC, Mental Health, Primary Care and Cancer)	Planned Care – demand management and clinical policies	Right Care	CIPs	
STP Digital strategy and delivery roadmap	Proactive and preventative Care (HWB)		FYFV – Urgent and Emergency Care (A&E Delivery Boards)		
STP Workforce strategy and delivery roadmap	Provider collaboration opportunities		FYFV – Primary Care (CCGs)		
STP Estates Strategy	Better Births Delivery Plan (LMS)		QIPP		
STP Comms and Engagement Strategy and delivery	System performance				
Knowledge management and ways of working	Right Care / GIRFT / Model Hospital / Specialty reviews				

How we work

- Challenge is how to align levers in the STP to a 'system first' culture – a full partnership across health & social care commissioners and providers – with a mixed economy of public, private, third sectors

- We need to recognise that there is a different level of expectation in terms of the STP's role for NHS organisations and for LAs which may require a 'two stream' approach over assurance and delivery of financial savings

- The STP has no direct authority, therefore it can only succeed within the current governance arrangements when all partners commit to 100% delivery of financial and performance standards – the system cannot succeed if any one partner fails in this scenario

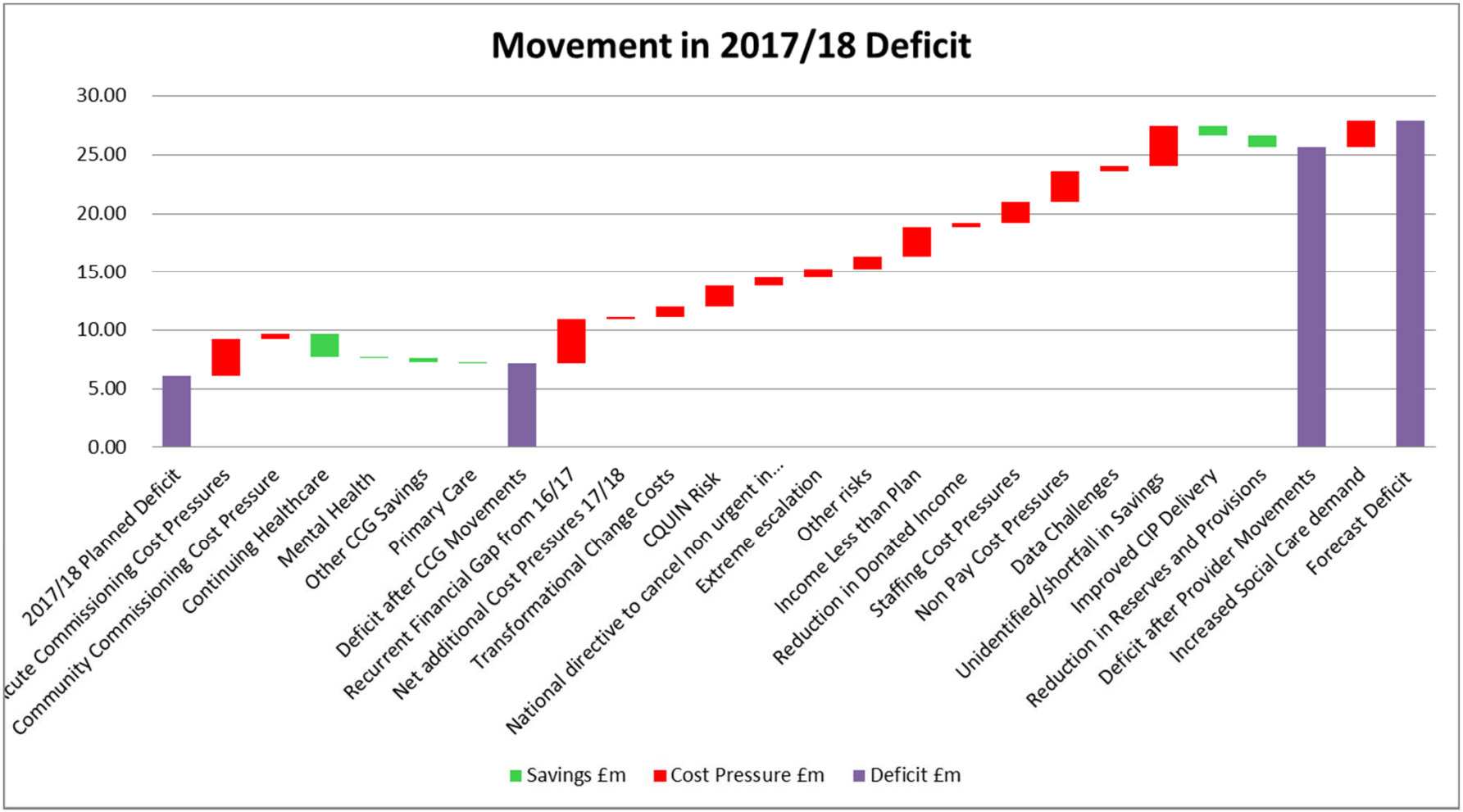
- However, in many STPs we are seeing its partners explicitly passing authority to it through nominated Directors – pooled sovereignty – so that it can make decisions to the benefit of the system (within the scope of NHS Act 2006)

- Working in a system-first way requires an openness and transparency – an MOU on information sharing MOU has been signed by Chief Executives and Chairs (Leaders)

- We may need to review methods of payment and contracting to facilitate system working learning from others who have already made this journey

The Money

The Financial Ask – 2017/2018 Bridge



Financial Recovery Plan – Principles

- Based on organisations continuing to deliver local savings to the same value as in 2017/18 the STP faces a combined financial pressure of circa £50M in 2018/19

- The STP will work to facilitate financial balance for the system but cannot itself deliver savings. All savings will be identified within partner organisations' financial plans and focus of service transformation.

- The STP will establish a Financial Recovery Plan as the first year of a three year financial strategy that will identify opportunities for further cost reductions by working across geographical and organisational boundaries.

- All savings will accrue to organisational bottom lines on a where they are generated / there they fall basis. As organisations are at different levels of financial distress the 'ask' may vary.

Financial Recovery Plan – Principles

- The objective is that the STP achieves its overall financial plan and that each organisation also achieves its financial plan.
- All partner organisations agree that there will be an 'open book' approach to sharing financial information.
- Full CIP and QIPP plans will be available to partners to share opportunities for learning and to identify any 'cost shifting' schemes. Any such schemes should be agreed with any partner bearing the consequences of such a shift.
- An MOU will be signed by all partners to commit to the above way of working

Financial Improvement Programme – scope

Optimising provider productivity and performance

- GIRFT / Model Hospital – identification of best practice in STP, standardisation to best practice, improvement to best practice nationally
- Right Care - identification of best practice in STP, standardisation to best practice, improvement to best practice nationally
- Review of CCG and provider improvement projects to identify opportunities for spread and standardisation (e.g. BaNES falls intervention team)
- Workforce efficiency opportunities
  - Shared bank
  - Apprenticeships
  - Role alignment and re-design (domiciliary workers, support workers, apprenticeships, nursing assistants, others)
- System-wide demand / capacity and cost mapping

Removing duplication

- Back office / support services reviews – easy / medium / hard services to integrate or rationalise
- Clinical Viability Service reviews – clinically led reviews across high cost and/or specialities with limited capacity to identify options to rationalise / share / change care model. Including looking outside the STP to other clinical networks

BSW STP

Any questions?

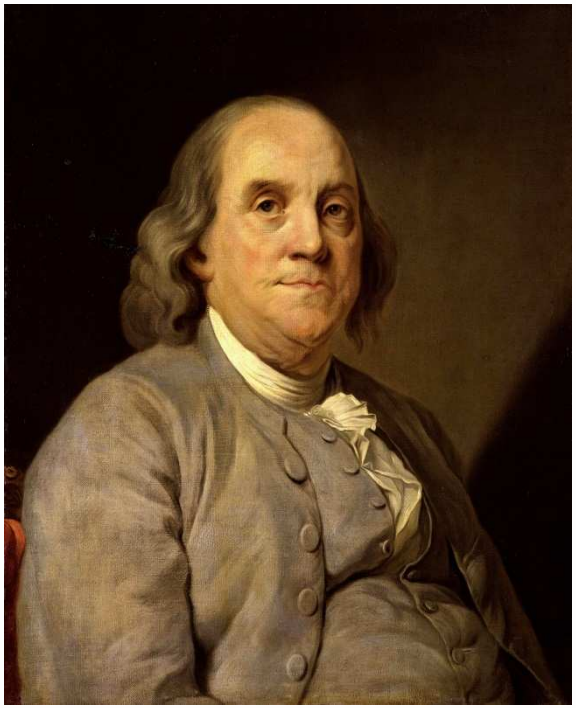
More than one way to safe a life

Collaboration opportunities between AFRS and Health

PREVENTING PROTECTING RESPONDING

Introduction

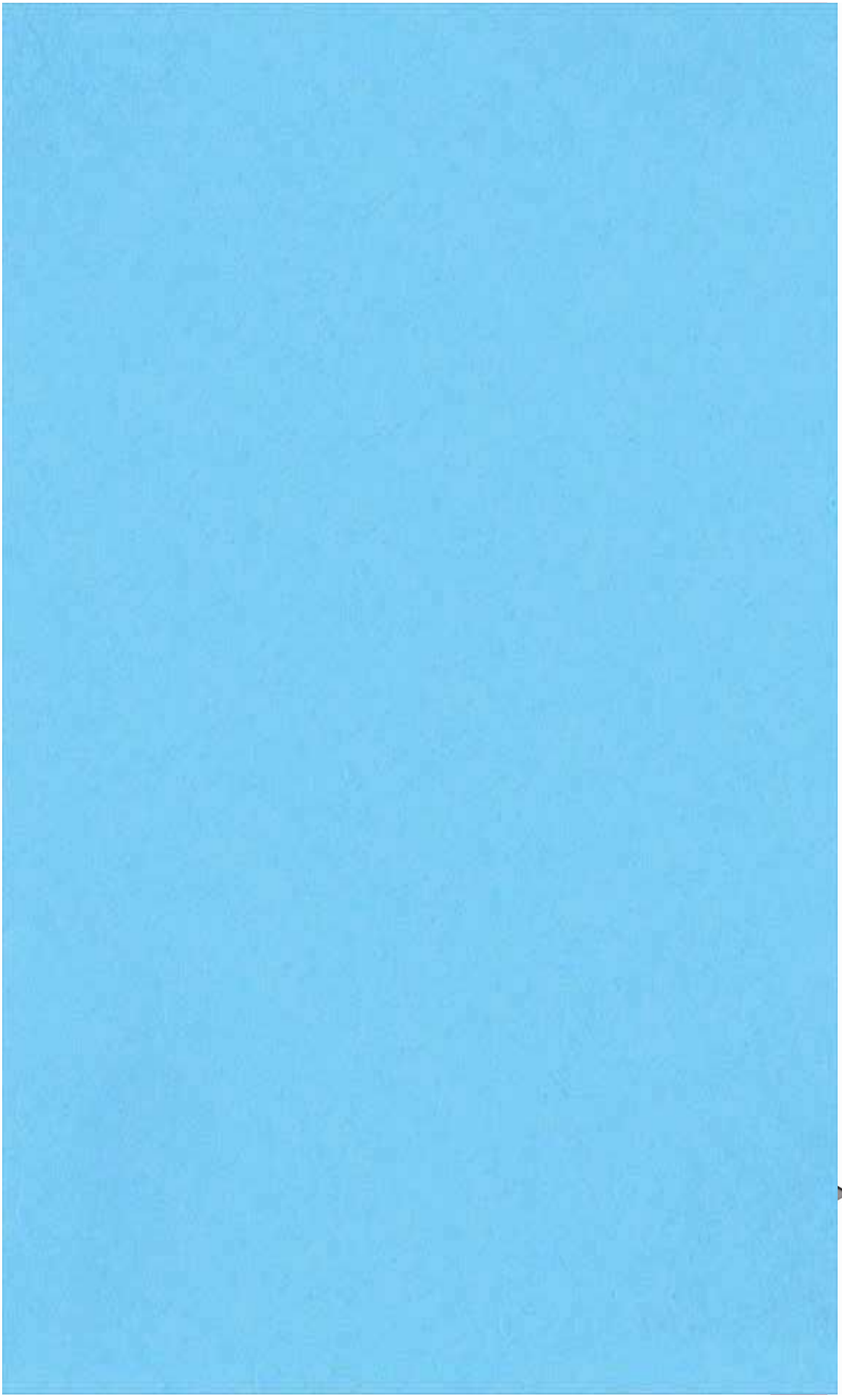
- Avon Fire & Rescue Service
- Technical Fire Safety
- Vulnerable Adults
- Children and Young People
- Partnerships

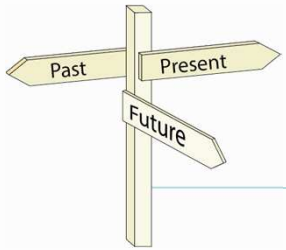


"An ounce of prevention is worth a pound of cure"

(Benjamin Franklin)

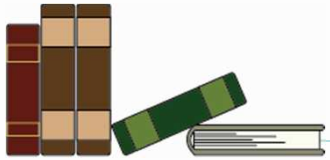
1736





Historical context

- Reduced response totals (approx 50% Reduction of Fire incidents Over 10 years)
- Prevention and protection success over this period
- Brand context/Professional capability
- Government agenda on blue light and public sector collaboration



Relevant literature

- The care act
- NHS five year forward view
- Sustainability & transformational partnerships (BNSSG)
- Fire & health consensus statement
- JSNA
- Fit for the future (public health people)
- Evaluation of the impact of fire and rescue interventions
- Home safety assessments and their role in the improvement of health and wellbeing
- Working together (NHS England)

Current situation nationally

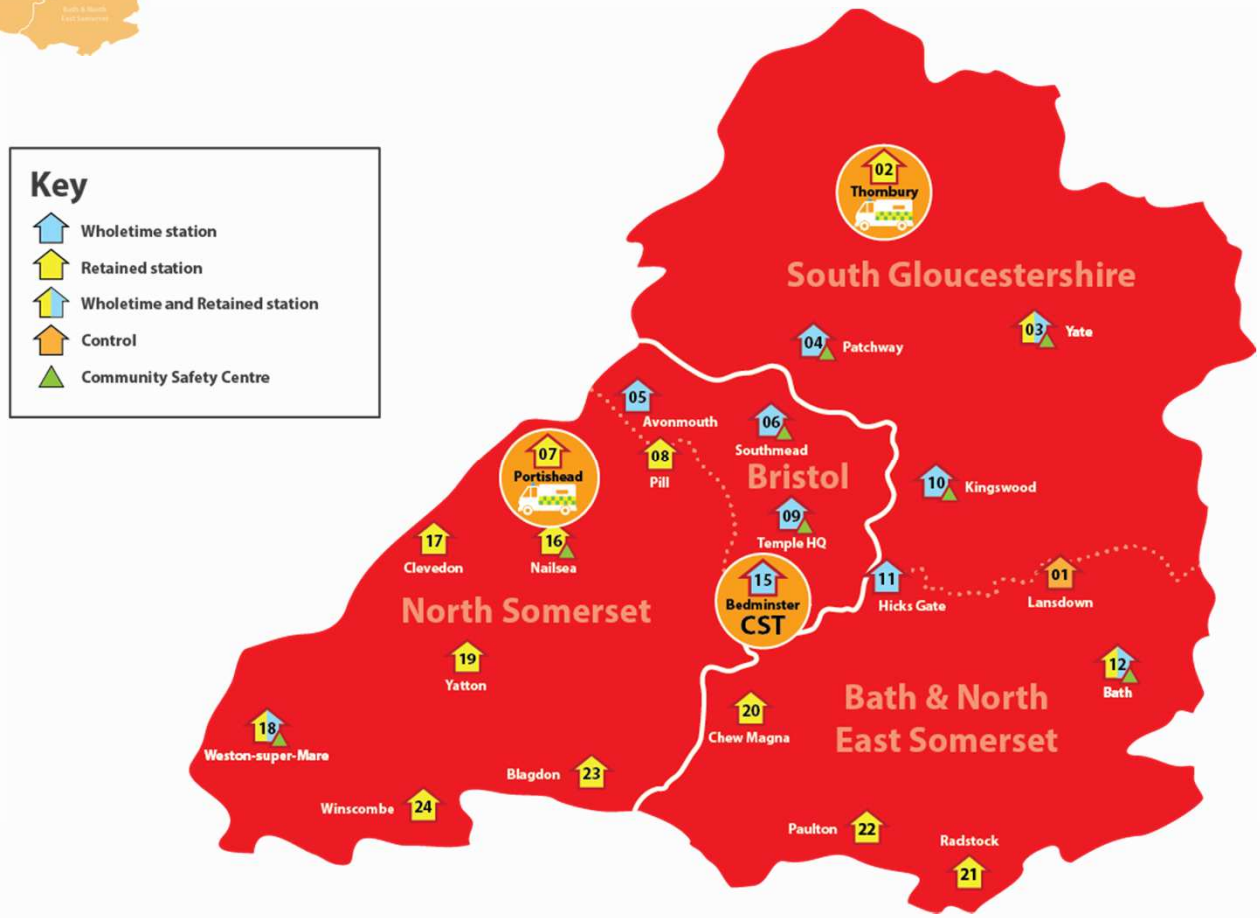
(Aligned to the NHS five year forward statement)

- 44 FRS working independently with Health
- 670,000 Home Fire Safety Checks annually
- Slips, trips and falls prevention
- Social isolation/loneliness
- Dementia
- Alcohol/smoking cessation
- Winter warmth/fuel poverty
- Diabetes*

Current Situation AFRS

- 10,000 Home Fire Safety Visits annually approximately
- AFRS already working with SWAST 02/07
- Falls prevention pilots North Somerset
- One Model South Bristol
- Tele care referral process in Bristol
- First Contact scheme South Glos
- Sirona referral process in B&NES
- Mental health M.O.U. (with Police)

AF&RS station map



What we can do together

"Slow down to go faster"

- Aligned to the areas of need after discussions with CCG
- Primary, Secondary, Tertiary (NHS model of prevention)
- Prevention, Protection, Response (Order of priority)
- Proofing pilot
- Adds value to community safety
- Sustainable

Projects

- S.T.F and hazard assessment (Place)
- S.T.F and hazard assessment (Person)
- Alcohol and smoking cessation
- Dementia checks/Mental health
- Reducing Winter deaths/Fuel poverty
- Social isolation/loneliness
- Blood donation clinic locations

Projects

- Falls response protocol
- Referral and Information sharing protocol
- Assisted living interventions
- Red 1&2 assistance (RDS Expansion)

Potential issues

- Development of packages
- Moving from project to business as usual
- Increased referrals/Workload brought about by offer
- Transition from fire service to others? (on longer term interventions)
- Evaluation tools required by health
- Training of F.S staff (Initial and maintenance)

Potential issues

- Who else should be involved, ie Police
- Funding issues (Equipment/training)
- Boundary's i.e. Wiltshire CCG
- Information exchange

Requirements

- Who else should be consulted?
- Referral mechanisms to be setup by GPs reference FRAT scores
- Information sharing protocols
- What models of intervention are required by health? (ie. FRAT/Audit C/MECC)
- Training of pilot fire service personnel
- What information is required for evaluation by health?
- Who are the points of contact at strategic, tactical and operational level?

What next

- MOU set up between interested party's
- Trial period evaluation process
- Regular review periods
- Discussion on future collaborative working (i.e. healthy lifestyles)

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Director of Public Health Report 2017

Bruce Laurence

Bath and North East Somerset – *The* place to live, work and visit

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Direct

What is health?

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Contents

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Can you limit your sitting and sleeping to just 23 ½ hours a day?

The strategy sets out a framework for partnership action under 4 key themes:

Active Lifestyles

More people are participating in physical activities which are fun and sociable and help to build and strengthen communities.

Active Travel

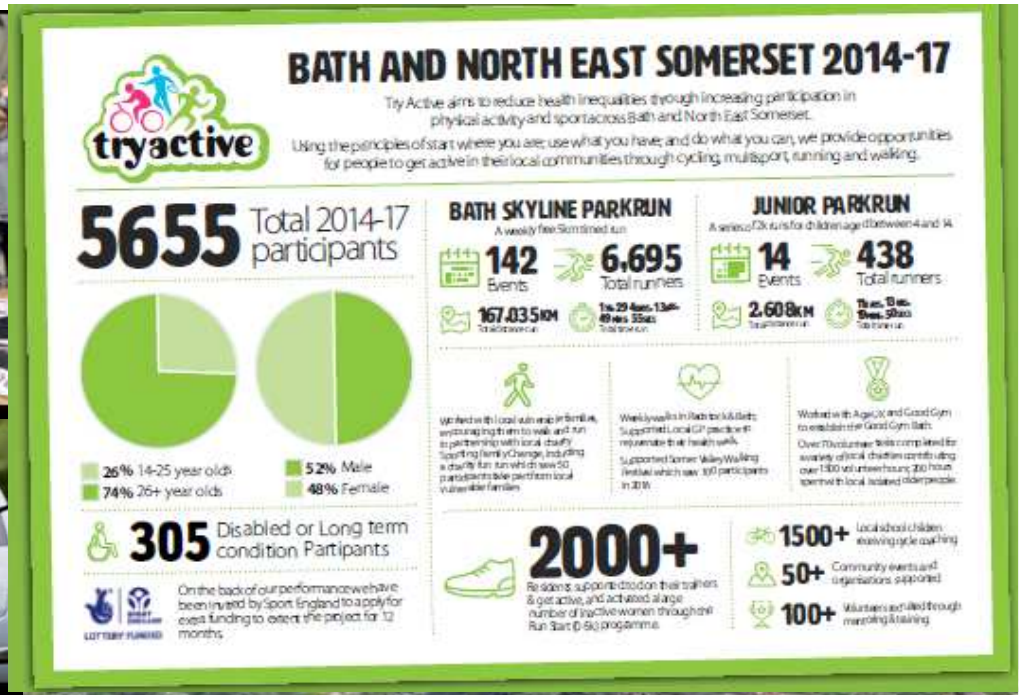
More people are walking or cycling as a means of getting around as part of everyday life.

Active Design

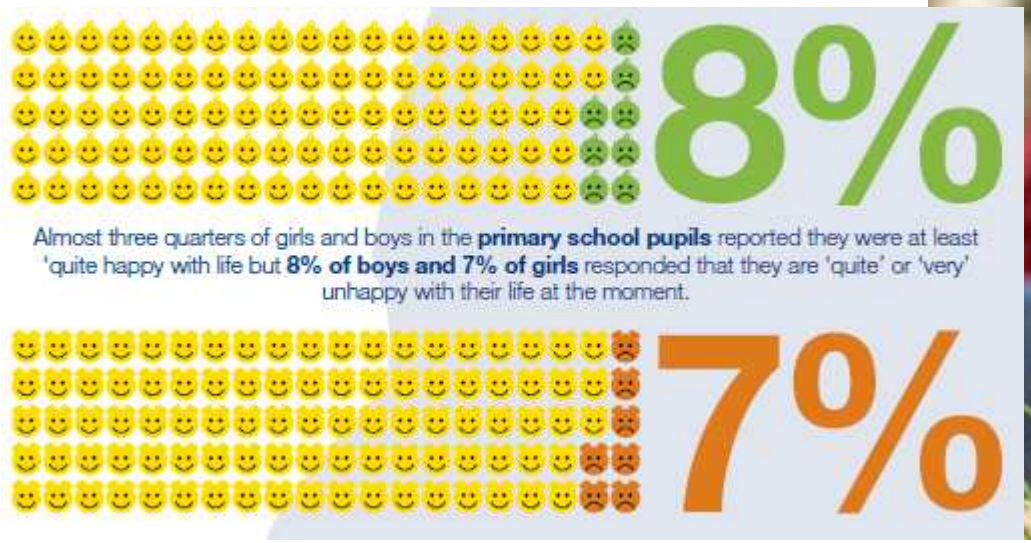
Our neighbourhoods are designed to offer easy access to a choice of opportunities for physical activity enabling communities to be more active and healthy.

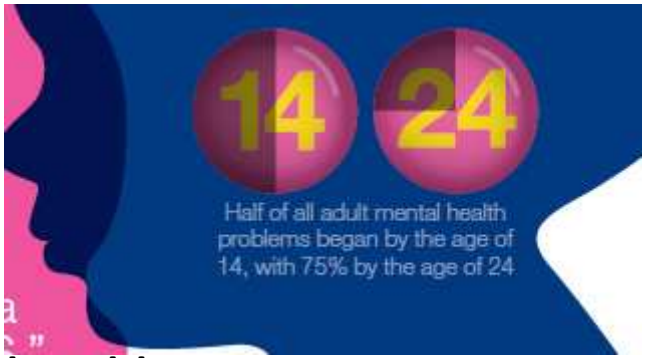
Active Environments

Our leisure facilities and green infrastructure are well used and enjoyed by local residents and visitors.



The mental health of children and young people





- Infancy: The Best Start in Life

Early help Board

Health Visiting

Family Nurse Partnership

Parenting strategy

Mindfulness

Positive Mental Health Resource Packs

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Tackling air pollution

What are we doing locally?

Air Quality Action Plans

Promoting active travel and less reliance on cars

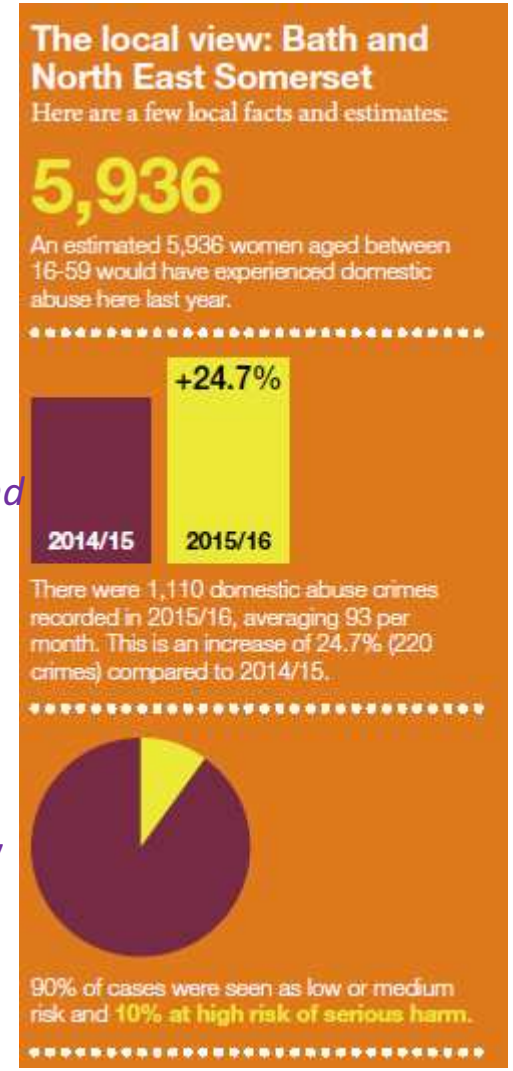
What can I do?

Travel choices

Domestic

Behavioural

I came to you on the advice of my health visitor after the event that ended my relationship, where I had endured 12 years of physical and emotional abuse and bullying from my ex-partner and his family. When I came to you I was mentally exhausted and was about to shut down, I knew I needed to make the final break and get legal help to get an injunction to keep myself and my family safe from harm.



Strategic objectives

1. Community Prevention
2. Early disclosure and help
3. Support for victims
   - Southside
   - Julian house
   - Voices
   - Police - Lighthouse
4. Work with perpetrators
5. Developing the workforce

Health and work

- What is a good job?
- In-work poverty
- Worklessness + poverty
- Workforce and workplace health- physical and mental
- Support to families
- Helping young people
- Building skills
- Staying in work
- Getting back to work

Young people with disabilities account for 7% of the 16 - 24 population and are **16% of the total 'not in education, employment or training' group.**[14]

1 in 3

By 2020 it is estimated that **1in 3** British workers will be **over the age of 50 years.**

£7bn

Estimated costs in lost productivity through unemployment and sickness related to alcohol

Bath & North East Somerset Council

A day in the life of a School Nurse

Public health outcomes framework and other key indicators

Public health outcomes framework and other key indicators (as at November 2017)

PHOF Reference/ Source	Period	Indicator Description	England	South West	Bath and North East Somerset
Health Improvement					
2.04	2015	Under 18 conceptions (females 15-17, rate per 1,000)	20.8	16.8	11.4
2.06i	2015-16	Prevalence of overweight (including obese) in 4 to 5 year olds	22.1%	21.9%	22.6%
2.06ii	2015-16	Prevalence of overweight (including obese) in 10 to 11 year olds	34.2%	30.3%	27.9%
2.07i	2015-16	Hosp admissions, unintentional and deliberate injuries 0 - 4 years per 10,000	129.6	135.2	159.0
2.07i	2015-16	Hosp admissions, unintentional and deliberate injuries 0 - 14 years per 10,000	104.2	105.0	119.6
ChiMat	2015-16	Hospital admissions as a result of self-harm (10-24 years old)/100,000	430.5	597.8	487.6
ChiMat	2013/14 -2015/16	Hospital admissions for alcohol-related conditions, under 18s per 100,000	37.4	46.8	53.2
2.13i	2015/16	Proportion of physically active adults	64.9%	68.6%	68.5%
2.14	2016	Smoking prevalence in adults	15.5%	13.9%	13.6%
2.03	2016-17	Smoking status at time of delivery	10.7%	11.3%	7.1%
2.15ii	2016	Successful completion of drug treatment - non opiate users	37.1%	35.3%	23.1%
2.20i	2015/16	Cancer screening coverage within three years - breast cancer	75.5%	78.3%	76.1%
2.22iv	2013-14/ 2016-17	Take up of the NHS Health Check Programme – health check take up	48.9%	49.0%	50.2%
Health Protection					
3.03x	2015-16	MMR take-up age 5 (2 doses)	88.2%	90.6%	96.1%
3.03xiv	2016-17	Population vaccination coverage flu aged 65 years and over	70.5%	70.9%	71.4%
3.04	2014-16	People presenting with a late stage HIV infection	40.1%	42.9%	52.9%
Healthcare and premature mortality					
4.04i	2014-16	Under 75 mortality rate from cardiovascular diseases (per 100,000)	73.5	63.4	57.0
4.05i	2014-16	Under 75 mortality rate from cancer (per 100,000)	136.8	128.2	122.2
4.06i	2014-16	Under 75 mortality rate from liver disease (per 100,000)	18.3	14.7	17.5
4.10	2014-16	Suicide rate (per 100,000 population)	9.9	10.8	10.0
4.14i	2015-16	Hip fractures in over 65s (per 100,000)	589	598	534

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My top ten public health problems

- Environmental damage: climate change, pollution, loss of bio-diversity
- Poverty, inequality, lack of opportunity.
- Poor diet + too little knowledge, motivation + opportunity to change
- Inactivity
- An ageing population with unmet needs. Loneliness and isolation
- Shortage of housing that people can afford
- Children's mental health and ACEs
- Tobacco, alcohol and other dangerous drugs
- Reduced social cohesion, mutual intolerance and hardening politics.
- Deteriorating public sector and services.
- What are yours…?