Public health outcomes framework and other key indicators

Public health outcomes framework and other key indicators (as at November 2019).
We have particularly chosen indicators to show our areas of greatest challenge.

Period	Indicator Description	England	South West	Bath and North East Somerset	Recent trend
Health Improvement					
2017	Under 18 conceptions (rate per 1,000)	17.8	14.9	13.1	→
2018-19	Reception: Prevalence of overweight (including obesity)	22.6%	22.0%	21.4%	→
2018-19	Year 6: Prevalence of overweight (including obesity)	34.3%	29.9%	25.6%	→
2017-18	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	121.2	128.6	158.1	→
2017-18	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	96.4	99.5	113.8	→
2017-18	Hospital Admissions as a result of self-harm (10-24 years)	421.2	621.0	549.5	–
2015-16/ 2017-18	Admission episodes for alcohol-specific conditions - Under 18's per 100,000	32.9	43.6	47.4	–
2017-18	Percentage of physically active adults	66.3%	70.7%	79.7%	–
2018	Smoking Prevalence in adults (18+) - current smokers (APS)	14.4%	13.9%	11.7%	–
2018-19	Smoking status at time of delivery	10.6%	10.9%	6.8%	→
2017	Successful completion of drug treatment - non-opiate users	36.9%	35.3%	39.1%	→
2018	Cancer screening coverage - breast cancer	74.9%	77.6%	75.3%	→
2014-15/ 2018-19	Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	43.3%	33.7%	62.0%	–
Health Protection					
2018-19	Population vaccination coverage - MMR for two doses (5 years old)	86.4%	90.7%	93.1%	→
2018-19	Population vaccination coverage flu (aged 65 years +)	72.0%	73.4%	73.2%	↑
2016-18	HIV late diagnosis (%)	42.5%	45.1%	25.0%	–
Healthcare and premature mortality					
2016-18	Under 75 mortality rate from all cardiovascular diseases (per 100,000)	71.7	61.9	56.1	–
2016-18	Under 75 mortality rate from cancer (per 1000,000)	132.3	125.6	120.7	–
2016-18	Under 75 mortality rate from liver disease (per 100,000)	18.5	15.9	14.2	–
2016-18	Suicide rate (per 100,000 population)	9.6	11.1	11.0	–
2017-18	Hip fractures in people aged 65 and over	578	564	568	–
Inequalities					
2015-17	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)	9.4	7.5	8.1	–
2015-17	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (female)	7.4	5.8	3.8	–
2017-18	% of children living in poverty (before housing cost). Taken from End Child Poverty campaign 2019.			12.0%	–
2017-18	School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception	56.6%	52.3%	48.2%	↑

Key for recent trends

– Could not be calculated → No significant change ↑ Increasing/getting better ↑ Increaasing/getting worse

Bath & North East Somerset Council

Director of Public Health Report 2019/20

Think Global Act Local

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Think Global Act Local

Contents

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My grateful thanks go to Jenny Willson, Ruth Sampson, Paul Sheehan, Paul Scott, Anna Brett and Joe Prince for contributing chapters to this report and to Sarah Wattley for collating and editing the overall report.

Introduction

Welcome to this year's Director of Public Health report. I hope you will find something in here that is of interest to you.

This has certainly been a momentous year for Britain and for Bath and North East Somerset. If we want everyone to be healthy and to thrive, we need to focus on both the very large political, social, economic and environmental forces that shape the world, as well as the smaller and more local actions and behaviours that affect individuals as they live their lives. This report has chapters that show some of the extremes of that range.

One of the biggest changes this year is that we finally seem to have reached the first crucial "tipping point" in the fight against climate change. That first point is the recognition, amongst the great majority of people and governments, that climate change is real and that it poses a massive and even existential threat to humans across the world. In public health circles it is now considered that climate change poses the very biggest threat to public health of all our current challenges. I am therefore really encouraged by the Council's declaration of a climate emergency and its intention to play a strong role in influencing local perceptions and behaviours. And although this is a truly gigantic and global challenge, the actions of individuals are still important, alongside the actions of governments, industries and world-spanning bodies like the UN.

The chapter in this report on climate change demonstrates the ways in which the actions of the large and small players may interact. Now, I mentioned that we had reached a first tipping point which is about recognition and awareness. Of course there is a second and more difficult point that we need to reach, and that is to summon up the collective will to do what it takes, politically, financially and behaviourally, to make the really big changes that are needed if we are not to reap the full whirlwind of a major increase in average global temperatures toward which we are currently headed. I hope that the Council's stand and consequent actions will be a step in that direction.

Major issues

I have then included two chapters that focus on major issues, where there has been so much success in past years that we have become complacent when we cannot afford to be. The first of these is smoking. We have seen a big decline in smoking rates, and most of us are much less exposed to the sight and the smell of people smoking around us - and indeed rates of smoking related illnesses and deaths are starting to decline. But because smoking now concentrates in communities that are poorer and face many other factors that also work to reduce their health and wellbeing , tobacco remains one of the biggest causes of the gap in life expectancy between the most and the least well off parts of our society. In this chapter we particularly look at E-cigarettes, which have become a major "game-changer" in the last few years in the fight against the damage done to lungs and lives by tobacco.

The second area where success has bred complacency and worse is that of immunisation. Some parts of the UK have struggled to maintain the high levels of vaccination coverage required to give overall protection to the population from the most highly infectious illnesses such as measles.

Thankfully, in Bath and North East Somerset there is a good level of support for vaccinations and rates have remained high, giving us space to focus on those few areas where we need to make extra efforts to ensure easy access.

Every year this report is very selective in what it covers, and therefore misses much out. If I could highlight one more theme that is extremely challenging to the Council, NHS, schools and universities, and to all our communities (and especially, as is so often the case, the poorest) it would be that of the mental health and wellbeing of children and young people. Pressures on young people in this generation are very great, and we are seeing high levels of anxiety, depression and other signs of unease. Some of the causes are general economic and social pressures on families after years of austerity and pressure on many services, the constant presence of social media in young peoples' lives, and perhaps some societal changes that have led to children being given less space to interact on their own terms with other children away from the controlling gaze of adults. Although I have given this subject little attention in the following report I am hopeful that there will be much focus on improving this situation in the coming year, possibly with a strong lead taken by our local Health and Wellbeing Board which represents many important groups with roles to play.

Finally I would highlight the chapter on some of our local and indeed national health inequalities. There are many advantages in public health teams moving in 2013 from the NHS to Local Authorities. Sitting in the heart of the Council I can try to influence colleagues who work on so many of the local factors that impact on people's lives. These include folk who work on leisure and green spaces, transport, housing, regeneration, environmental health, economic development, education and social care.

But another reason that I like working in local government, and perhaps more surprisingly, is because it is a fundamentally political environment. Public health work has a strong focus on attacking the roots of illness and disadvantage and in reducing health inequalities. Now, whether we like it or not, the health of our communities, and also who has better and worse health in our society, inevitably depends, at least to some extent, on how we choose to distribute our country's resources, and how we raise and spend public money on services and infrastructure. And these choices are, in a democratic society, political choices, which are influenced by people's values expressed through their support of different political groups offering different visions of a just and well-ordered world. So with that in mind I would like to make two further and related points to finish my introduction to this report.

Firstly I have been impressed by how much support politicians from all groups in Bath and North East Somerset have given to the idea that we, as a Council, should work to reduce social and health inequalities among our residents, and put real effort into helping those who need it most. That is the good news, and the reason why Bath and North East Somerset has been such fertile soil for the transplantation of my public health team from the health service to local government.

But secondly, and constituting less good news, is that compared to other wealthy and industrialised countries the UK is one of the more unequal in terms of wealth distribution across different sections of our society. We are a less unequal society than that of the United States, but you will see from information in the chapter on health inequalities that our record is not one to be entirely proud of. It is a common belief in the public health profession, and one that I share, that wide socioeconomic and health inequalities are bad for everyone, whether wealthy or poor. As well as being causes of physical and mental ill-health, high levels of inequality contribute to political and social tensions, and are damaging to the fundamental "social contract" that keeps all the different groups that make up a nation working together in relative harmony and signing up to some of the same fundamental principles. And on that basis, it is not at all unreasonable to imagine that some of the political polarisation that we have seen expressed in the UK this year and in other developed countries, are either caused by or at least made worse by real and perceived inequalities, and the distress, anger and sense of injustice that they generate.

Health inequalities are not just about health, in the narrow sense of whether people get ill or live long lives, but are a reflection of the whole of people's life experience, and thus a community that is working to reduce its health inequalities is also working to reduce injustice, social tension and political fragmentation.

Dr Bruce Laurence
Director of Public Health

Climate change and our health

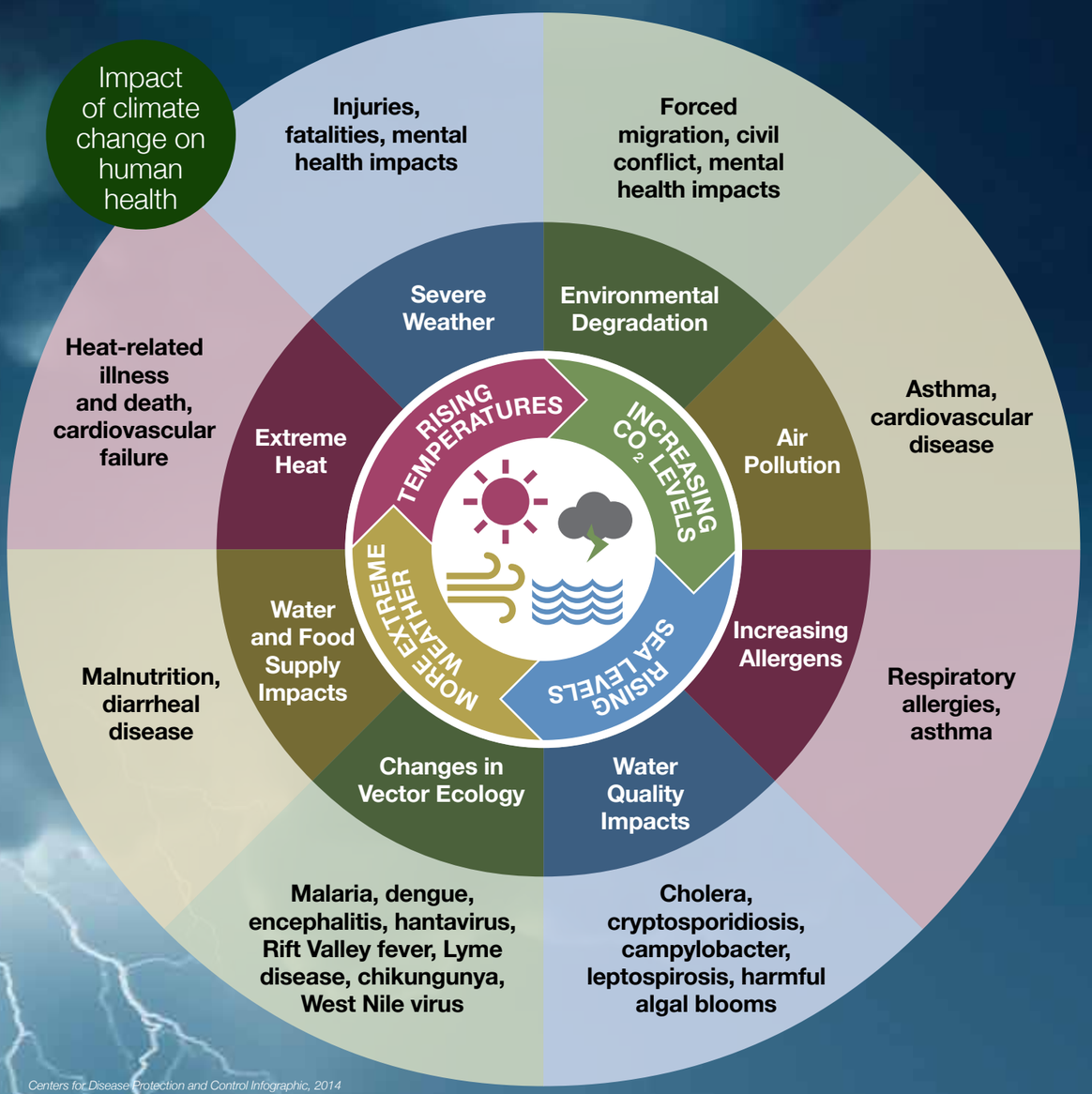
Climate change is a major global issue and is the largest environmental challenge the world has faced. It can have a significant impact on our health, in a variety of ways. Here we look what effect climate change can have on our health and what is being done nationally and locally here in Bath and North East Somerset to address it.

What is climate change and what are the impacts?

Climate change is a change in the earth's climate. It is any long-term, extensive deviation of a regions average temperatures and usual weather patterns that occurs over a considerable period of time. A multitude of evidence has been developed to show that our climate is changing because of the build-up of greenhouse gases resulting from human activity. It is this accumulation of greenhouse gases that traps heat in the earth's atmosphere. The burning of fossil fuels like oil, natural gas and coal and the deforestation of carbon-absorbing forests are all contributing to the rising levels of carbon dioxide (CO_2) in our atmosphere, resulting in what is known as global warming.

The impacts of climate change in the UK may not be as noticeable as they are in the rest of the world, such ocean acidification and ice sheets melting, but there are a number of effects that are being seen across the country including localised flooding.

How does climate change affect our health?



Centers for Disease Protection and Control Infographic, 2014

A World Health Organisation assessment determined that climate change is expected to cause approximately 250,000 additional deaths per year between 2030 and 2050 globally; 38,000 due to heat exposure in elderly people, 48,000 due to diarrhoea, 60,000 due to malaria, and 95,000 due to childhood undernutrition.

Climate change has and will continue to have a vast array of impacts on health. It has been described as the *'greatest public health threat of our time'*. The World Health Organisation (WHO) states that 'Climate change affects the social and environmental determinants of health - clean air, safe drinking water, sufficient food and secure shelter'. Therefore, it affects every aspect of our daily lives.

Climate change effects human health and disease in various ways, we will see some existing health conditions worsen and new health threats will arise. It is important to note that not everyone is at risk in the same way; age, economic resources, and location will all play a role. Those with less resources have less capacity to mitigate the damaging effects of climate change and so inequalities may be magnified as it gets worse.

High temperatures and heatwaves directly contribute to an increase in heat related illness and deaths from cardiovascular and respiratory disease. The elderly are more at risk of cardiovascular and respiratory diseases, and with an ageing population in the UK, this will mean more of our population will become vulnerable. Pollen and other allergen levels also increase in extreme heat, which can then trigger asthma, which affects around 300 million people world wide. The heatwave of summer 2003 resulted in 2000 excess deaths in England and Wales and more than 70 000 deaths across Europe. In 2006 in England, Public Health England (PHE) found that there were an approximated 75 extra deaths per week for each degree of increase in temperature above 25ºC.

Research suggests that the UK is one of the most vulnerable countries in Europe to coastal flooding, and low lying and coastal cities are at particular risk from flooding, as sea levels continue to rise. Floods also cause drownings, physical injuries and damage to homes. Apart from deaths due to drowning, the most substantial health impact from flooding is on mental health. PHE research found that over a third of people who were flooded in 2014 suffered with depression, Post-Traumatic Stress Disorder (PTSD) or anxiety.

Climate change risks to health

In 2016, the WHO defined the most serious public health threats climate change presents to the UK as:

1 An escalation in heat-related illness and death – the 2003 heatwave which caused multiple deaths across England and Europe, is predicted be a 'normal heatwave' by 2040. The number of heat-related deaths in the summer is predicted to increase and cold-related deaths in the winter are predicted to decrease in the UK, due to warmer summers and milder winters.

2 More flood-related illnesses are expected to be seen, with an increase in injury and infection, but the influence of flooding on mental health will be also substantial.

3 An increase in food, water and vector-borne diseases, due to changes in rainfall patterns, flooding, higher temperatures and the resultant droughts. Changes in patterns of disease with an increase in tropical diseases such as malaria will also be seen.

4 Increased levels of air pollution from ozone, particulate matter and prolonged pollen seasons, all of which could escalate levels of respiratory and cardiovascular disease. Between 28,000 and 36,000 air pollution related deaths per year in the UK are associated with particulate matter and nitrous oxides. More than 40 towns and cities in the UK reach or exceed air pollution limits.

5 Sunburn and skin cancer – malignant melanoma has risen by 78% among men and 48% among women from 2003 to 2012 and is now the fifth most common cancer in England, with cases expecting to increase as people spend more time in the sun.

6 Increased demand on healthcare providers to keep services running in extreme weather – flooding, storms and wildfires are all set to become more common and they will all effect vital infrastructure.

7 An increase in health inequalities – a rise in fuel and food prices and a reduction in access to heating, cooling, and green spaces will all affect our disadvantaged groups.

PHE Public Health Matters Blog https://publichealthmatters.blog.gov.uk/2016/08/12/climate-change-and-the-significant-seven/ and the WHO CLIMATE AND HEALTH COUNTRY PROFILE 2015

The UK Climate Change Risk Assessment suggests that current climate projections indicate that heat-related deaths in the UK are likely to increase by 5,000 a year by the 2050s and that floods, whether caused by sea, river or surface water, could impact as many as 3.3m people in the UK by the same date.

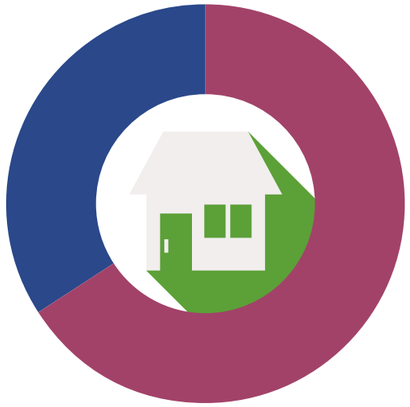
What is being done nationally?

The Climate Change Act in 2008 made the UK the first country to determine a long-term legally binding framework to cut carbon emissions. The Act established a legally binding target to decrease the UK's greenhouse gas emissions by at least 80% in 2050, from 1990 levels, the first country to do this. This has recently been increased to a reduction in greenhouse gases by a minimum of 100%, from 1990 levels. The Act also set up an independent expert body, the **Committee on Climate Change** (the CCC), who report to the Government on levels of emissions and progress on their reduction.

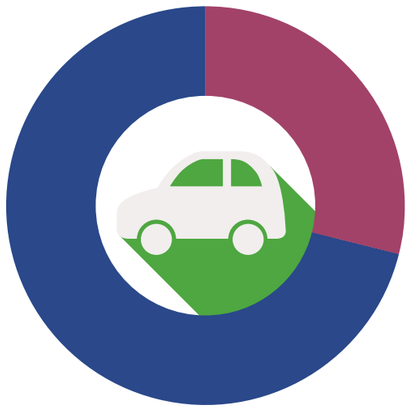
What is being done locally here in B&NES?

B&NES Council declared a Climate Emergency in March 2019, which committed the Council to deliver local leadership to enable B&NES to become carbon neutral by 2030, working across all council functions. A requirement of the Climate Emergency resolution was to produce a progress report six months later and then annually after that. The first progress report was delivered in October 2019. The report highlights some of the vast range of carbon reduction work that had already been carried out by the council before the resolution including; The Energy at Home retrofitting scheme providing in the region of £800K of grants to improve the energy efficiency of local people's homes and the fact the council was the first local authority to roll-out LED street lighting to main roads.

Since the resolution, the Council has created a new Climate Emergency Cabinet post, has worked with Bath University to explore citizen engagement mechanisms and commenced engagement and has created a new Climate Emergency webpage. Vast research has been carried out examining the carbon footprint of the B&NES area, which enabled the council to identify where the area's direct and indirect carbon emissions are coming from. There has also been an initial equalities assessment looking at carbon emissions against household income. This detailed research has led to the identification of three priority areas for action:



1 **Energy efficiency** improvement of existing buildings is required on a large scale as **66% of the area's in-district carbon footprint is from energy use in buildings**. Supporting the prevention and addressing inequalities agendas, domestic retrofitting can assist low income and vulnerable people, a higher portion of who live in the energy inefficient houses.



2 **Transport comprises 29% of the district's footprint** and makes up a large component of the household footprint.

3 **Local Renewable Energy** – the research outlines measures such as electrification of heat and transport, the carbon saving of which is dependent on an sufficient supply of renewable energy.

For more information on the climate emergency, key papers, council meeting minutes and reports, please visit www.bathnes.gov.uk/climate-emergency.

What can I do?

Addressing climate change is everyone's business and every person needs to play a role, no matter how big or small. Each person will contribute to climate change in some way. The majority of the UK's greenhouse gas emissions arise from our production and consumption of energy; driving a car, powering their homes, wasting food or simply boiling a kettle.

It's not about individual blame. We can all do our bit to help tackle climate change; whether that's using the car less, using public transport and walking or cycling more, buying local food, recycle more and using efficient lighting. There are numerous ways we can all be more environmentally sustainable and help tackle the causes of climate change by reducing the amount of carbon emissions our lifestyles produce. Here are some suggestions of what can be done individually:

1. Drive less - walk & cycle more

Reduce the amount of car journeys taken by walking or cycling, car sharing, taking public transport if available and remote working. All of these can help decrease congestion and travel costs, whilst preventing further emissions.

2. Use efficient lighting and energy-efficient electronic devices

By simply replacing light bulbs with the most efficient bulbs, such as LEDs, could save the average household around £35-50 each year. Additional savings can be achieved by purchasing energy efficient models when replacing household appliances; use the Energy Efficiency Rating as a guide. Get home energy advice via the Energy at Home Advice Line www.energyathome.org.uk.

3. Insulate your home

Investing in double glazing, insulating lofts and draft proofing doors and windows are some straightforward measures that result in a large reduction in energy consumption. Loft insulation can save around £100 each year and improving window glazing can save £70-90 per year. A simple measure such as turning the thermostat down by 1°C could save around £50 annually.

4. Turn off electronic devices

Simply turning off your television, computer, lights, microwave and anything else electronic when you are not using them, will save 1000's of kilograms of carbon emissions a year!

5. Food and food waste

Every year in the UK we throw away 7 million tonnes of edible food and from our homes. Food waste that goes to landfill sites decomposes and produces methane, which is one of the greenhouse gases that contribute to climate change. To decrease the amount of food you throw away and save money at the same time visit www.lovefoodhatewaste.com. Alongside this, consider buying local and seasonal food or alternatively grow your own fruit, vegetables and herbs.

6. Reduce, recycle, reuse where possible

Recycling and re-using cardboard, plastic and paper will help reduce carbon emissions and protect the environment. Visit the B&NES Council website for more information.

7. Change your habits at work

Take your good environmental habits with you. Walk, cycle or take public transport where possible, or even care share with colleagues. Shut down your computer rather than just simply logging off and turn off appliances, equipment and lights when you finish using them.

8. And finally… share ideas

Talk to friends, neighbours, colleagues and share ideas on what do to. You could engage with your local school, community group, Parish Council or your employer, share your ideas and work together.

There are also a number of useful suggestions that businesses and organisations can do on the B&NES Council website www.bathnes.gov.uk/climate-emergency.

One vital aspect that is important to acknowledge here is that individuals could make some or even all of these changes to their daily lives, but if a reduction in CO_2 emissions is to happen on any scale that will make a difference to reaching net-zero emissions, then wider system changes need to happen first to create a more supportive environment.

The The Behaviour Change, Public Engagement and Net Zero report recently published for Committee on Climate Change by Imperial College London (ICL) details how behaviour changes such as those listed here could have a large impact on reducing carbon emissions and advises on the policies that can support this. The report highlights that it is imperative that solutions are employed immediately to encourage better consumer engagement. The report emphasises that policy needs to include strategies for enabling consumers to take actions to not only reduce emissions, but also that helps create a societal shift in public engagement.

The ICL report includes recommendations that concentrate on heating, transport and diet. These include the retrofitting of public buildings with low-carbon heating, introduction of reduced-price bus and rail season tickets for part-time workers and financial incentives for lower impact food production and consumption. Further recommendations also include the introduction of an 'escalating Air Miles Levy to discourage excessive flying by the 15% of the UK population estimated to be responsible for 70% of flights'. This would affect the frequent flyers and not the majority of the UK population who will fly once for their annual holiday.

What effect could these changes have on health?

By walking and cycling more, individuals will be increasing their levels of physical activity which will have a huge benefit to their health and wellbeing. Doing regular exercise can help to prevent and manage over 20 chronic conditions and diseases, including heart disease, type 2 diabetes, some cancers and can also help improve mental health.

The effects that climate change could have on widening health inequalities was referenced earlier when we spoke about the impacts on health. It is important to consider whether the individual

changes that people can make listed above, could differ by health and socio-economic status and therefore could making these changes contribute to widening health inequalities further?

The health impacts of climate change will vary among different populations, due to variances in their exposure, vulnerability and their capacity to cope. Inequalities may be amplified as climate change gets worse, as those with less resources often live in more vulnerable areas and have less capacity to alleviate the negative effects of climate change.

The co-benefits of climate change

If individuals were to make some of the changes above, it is vital to acknowledge that their actions would hopefully help to improve their lives, rather than having a negative impact on them. The co-benefits of taking action on climate change are vast including improved air quality, reduced traffic congestion, leading a more active and healthy lifestyle, improved physical health and safer, stronger communities.

The recently published *Ashden Climate Action Co-Benefits Toolkit* describes this clearly and in great detail. It was developed to support local authorities and others on addressing climate change locally, with the aim of the toolkit being to re-define action on climate change to show how it can enhance our quality of life. It explains the wider benefits that can be seen from taking action, including economic opportunity, job creation, improved resilience and improved equity and social cohesion. The image below gives some examples of the multiple co-benefits from climate action.

Multiple co-benefits from climate action – some examples

Action	Carbon	Health	Economy	Equity	Resilience
Insulating homes 	Cuts energy demands and cuts carbon emissions	Reduces fuel poverty as people stay warmer	Creates jobs for local people, and people save money on their energy bills which they may spend locally	Increased access to affordable warmth	Households are better placed to withstand future energy price rises as well as overheating during heatwaves
Car sharing 	Reduced fuel consumption cuts carbon emissions	Reduced NOx improves air quality. Improved wellbeing through social interaction	People save money on their fuel, which they may spend locally. People can make journeys (eg to work) that they may not otherwise be able to do. Reduced congenstion	Brings people together; can reduce isolation and lonliness	Increased resilience to impact of future fuel price rises
Cycling 	Reduced fuel consumption cuts carbon emissions	Reduced NOx from combustion engines improves air quality. Increased activity increases health.	Money saved on petrol. Reduced congestion	Increased connections to local community through cycling initiatvies	Resilience to future increases in fuel costs

Taken from the Climate Action Co-Benefits Toolkit

Tobacco Control

Finding the facts on E-Cigarettes

Smoking remains the biggest preventable cause of cancer in the UK. Further to this smoking is associated with multiple serious health conditions affecting the heart and lungs. Whilst nicotine is the chemical which precipitates addiction, it is the concoction of many other substances present in cigarettes that when burnt and inhaled damage cells. Smoking is more common in deprived areas. This means that it remains a significant driver of health inequalities in the UK.

Electronic cigarettes were developed to mimic the action of smoking and have become increasingly popular in the UK over the past 7 years with an estimated 3.6 million adults currently vaping. This is up from 700,000 back in 2012. By mimicking smoking behaviour and delivering nicotine e-cigarettes have provided an alternative nicotine replacement method to traditional patches and gum. They therefore have innovative potential to help people stop smoking. They are not recommended to be used by non-smokers.

Despite their popularity, public perceptions of the harms of e-cigarettes remain worryingly inaccurate. To help address this here are some key facts about e-cigarettes and what the advice is to help assure people that making the switch from smoking to e-cigarettes is one of the best things you can do to improve your health.

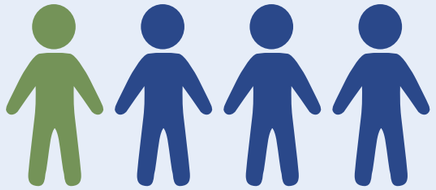
PHOTO © NICAT NASIBLI

Who uses E-cigarettes?

Adults

> Of the 3.6 million current vapers, just under **2 million** are ex-smokers; **1.4 million** are current smokers; and **200,000** are never smokers.

> Vaping is much less common among young people who have never smoked. A large majority of never smokers aged 11-18 (93.8%) in total have either never used an e-cigarette (87.8%) or are unaware of them (6%).



The main reasons given by current vapers for the use of an e-cigarette is to help them to STOP smoking.

After a recent Voicebox survey we know that across Bath and North East Somerset (B&NES) **1 in 4 people** are using E-cigarettes. This is similar to what we are seeing nationally and highlights the importance of sharing consistent information about how they can be used to support people to stop smoking and the role they play in supporting our smokefree places agenda. We are very proud to be commissioning an E-cigarette friendly local Stop Smoking Service across B&NES.

Fact check

E-cig use amongst young people remains low

E-cigarettes are not recommended in any other context other than in stopping smoking. Whilst there is some evidence to suggest that some young people do experiment with vaping, regular use remains low.

E-cig regulations are tighter in the UK

The UK has a far tighter grip on E-cig regulation, as well as strict marketing and advertising laws – unlike the US. The MHRA (Medicines & Healthcare products Regulatory Agency) has a robust yellow card reporting system in place.

Using E-cigs is less harmful than smoking

E-cigs don't contain many of the toxins found in cigarettes, nor do they combust, which means there is no smoke or tar, which are the main cause of disease / illness linked with smoking.

You can use NRT alongise an E-cig

Nicotine withdrawal if not correctly managed by a suitable replacement can cause the desire to smoke to intensify – leading to relapse. Healthcare professionals recommend using E-cigs and NRT together to help mage these cravings.

E-cigarettes and Pregnant Women Pilot Programme

When talking about health it's easy to get lost in numbers and statistics that tell us every detail and enough data to sink a ship. Making the right decisions about our health can sometimes seem overwhelming, even more so when you are pregnant.

The choices women make during pregnancy are not only important to their own health, but also to the health of their baby(s). The impact of this choice can also be seen beyond pregnancy, for example smoking is known to increase the vulnerability of babies to sudden infant death in the first year of life. Historically women's choice of products during a quit attempt has been limited during pregnancy and only nicotine replacement therapy has been available. NRT isn't always suitable for every woman and we were starting to see a dip in women accessing support. We have also seen a recent shift in the number of women enquiring about using e-cigarettes when pregnant.

Our Public Health team has always been confident that E-cigarettes provide a great way to help people stop smoking. It's because of this confidence that we put a small trial together to see if vaping could be used to help support women throughout their pregnancies.

Stopping smoking is especially important during pregnancy as any chemicals / toxins in a pregnant woman's bloodstream will be passed to their baby. An initial six month pilot programme was agreed and set up, in which all pregnant women, referred to our Health in Pregnancy (HIPs) team would be handed out free e-cigarettes as part of their supported quit attempt.

How's it going so far…

The project has got off to a very positive start, with lots of women trying E-cigarettes who otherwise probably wouldn't have engaged with the service. It's what's happening beyond the initial aim of the project that is really exciting. Whilst the aim of the project was to support pregnant women manage to quit smoking, the positive impact the E-cigarettes are having has been seen beyond this on other family members who smoke in the household. It's also been a great starter product, with a selection of women who like using it going on to buy their own suggesting a sustained change in smoking behaviour.

The Public Health team are working with the University of Bath to produce a full evaluation of this project, with the hope of writing up the findings in a published medical journal.

"Incorporating the E-Burn as part of our day to day service has been amazing. We've got something now that is so similar to smoking that even the women who say they have tried everything can't help but give the E-Burn a go. I feel far more invested in supporting pregnant women as I can physically hand it to them during the appointment."

Dawn Powell, Health in Pregnancy Advisor

Illegal Tobacco

It's often cheap tobacco – usually half the tax paid price of legally sold tobacco. Illicit tobacco is defined in the dictionary as being 'disapproved of by society', however there are more specific terms used to describe the types of tobacco products that are often made available. These include;

Counterfeit – fake but made to look like the real thing and may well be in standardised packaging, or made to look like a non-duty paid product.

Non Duty Paid – A genuine brand with foreign labelling in non-standardised packaging, bought from outside the UK and then smuggled back in.

Cheap / other – Manufactured for the black market to look like genuine and established or non-duty paid brands. They are not manufactured to comply with current UK legislation and would not be seen for sale at genuine retail premises.

Things to look out for…

- **Cheaper prices**
- **Foreign health warnings**
- **No picture health warnings**
- **Unusual taste or smell**

Trading Standards South West
ILLEGAL TOBACCO REPORTING
@SWIllegalTobacco
@SWIllegalTobac
SWIllegalTobacco.info
REPORT IT
Illegal tobacco: No ifs ... No butts

Local Activity

There were three main elements of the illegal tobacco campaign that have taken place over the past two years, including brand development, marketing and community events. We wanted to highlight the problem across our local communities and encourage members of the public to come forward with any intelligence they may have on illegal tobacco activity within their neighbourhoods.

We used a range of marketing techniques over this time period, including bus advertising, smartphone 'pop up' adverts as well as face to face roadshow events. Intelligence was received via direct contact with our colleagues in Trading Standards as well as via the Crime Stoppers direct line, who were our partners at the time.

The illegal tobacco brand continues to grow and develop and we have activities planned for the up and coming year. We now also have a brand new reporting mechanism, which is tailored specifically to the South West.

You can report any illegal tobacco sales at: www.swillegaltobacco.info

Campaigns: Stoptober

Last year's Stoptober activities were epic! We love Stoptober as it means we get to do some joint campaign work with our friends at Virgin Care, which for 2018 meant bringing the giant red ball to Twerton Park Football club, the home of Bath City football.

The day was filled with activities including chatting to fans, taking carbon monoxide reading to anyone thinking about quitting and of course signing people up to the 28 day challenge. Who can forget this character as well (left) – our very own Director of Public Health, dressed as a giant cigarette taking on the almighty 'Pig' in a mascot showdown penalty kick out at half time.

Stoptober is estimated to have generated an additional 350,000 quit attempts since it started in October 2012.

Our NEW Tobacco Control Strategy 2019-2024

Our Vision

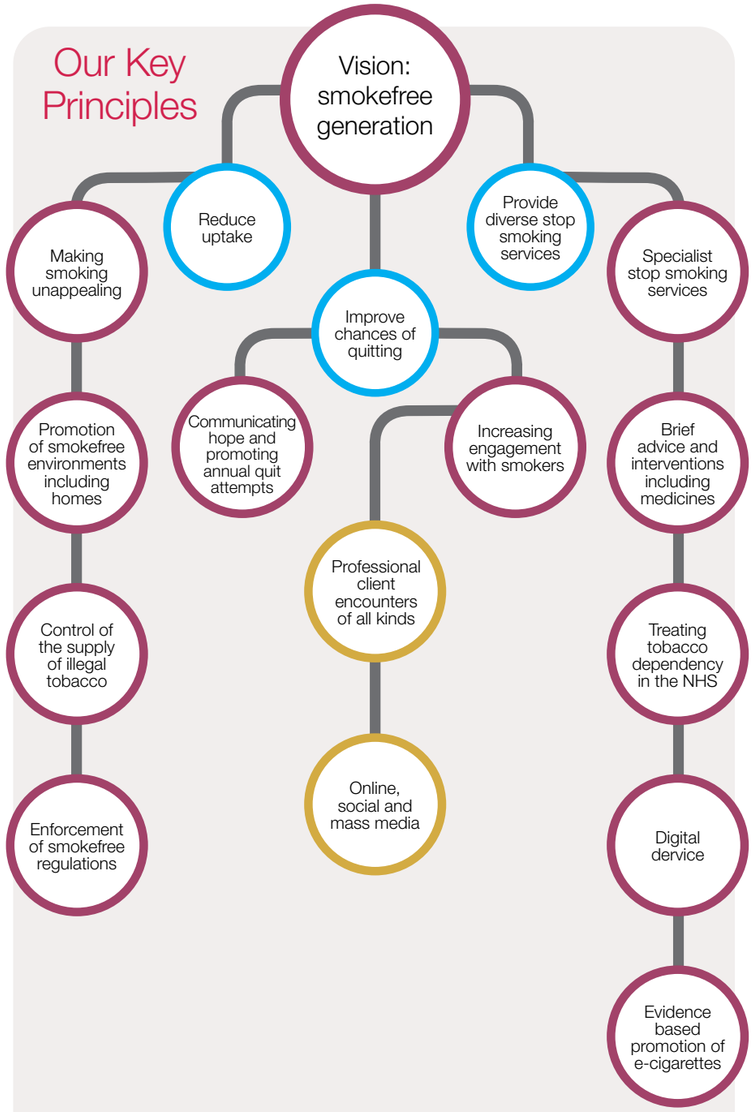
To achieve a smokefree generation in Bath and North East Somerset, which will build healthier, more equal communities by reducing smoking prevalence, exposure to second-hand smoke and illicit tobacco.

Aims

To reduce health inequalities in B&NES by achieving a smoke free generation (5% smoking prevalence) by 2030, in line with national ambitions and local needs. Our new strategy seeks to build on the progress resulting from the previous 2014-2018 strategy by defining how the local authority and its partners will seek to act in an evidence based and needs based way across the next 5 years in order make meaningful impact on:

- Prevention of uptake of tobacco use and relapse into tobacco use
- Protection from the harm of smoking in existing smokers and from second-hand smoke
- Increasing quit attempts and evidence based support to quit

Our Key Principles



Priorities

Smoking prevalence and exposure in these groups represents an important source of health inequality: pregnant women, people with severe mental illness or substance misuse issues, people who are lesbian, gay, bisexual, transgender or questioning (LGBTQ), communities that are more socio-economically deprived, children and young people and gypsy, boater and traveller communities.

Sexual Health in Bath and North East Somerset

What is sexual health?

Sex is an important part of people's lives. It is a fundamental human behaviour as an expression of intimacy and forms an aspect of our identity. As such sex also needs to be understood through our essential human rights to privacy, a family life and living free from discrimination. Like many human behaviours sex isn't without its risks. These risks can result in negative impacts on health, both physically and mentally. Essential elements of good sexual health are relationships free from coercion, where sexual fulfilment can be experienced and enjoyed. For this to happen people need to have access to accurate information to inform decision making, and services need to help people avoid and manage the risk of unintended pregnancy, illness or disease. This is achieved in Bath and North East Somerset (B&NES) through a multifaceted approach to maintain and improving sexual health for our population.

How do we work together to improve sexual health?

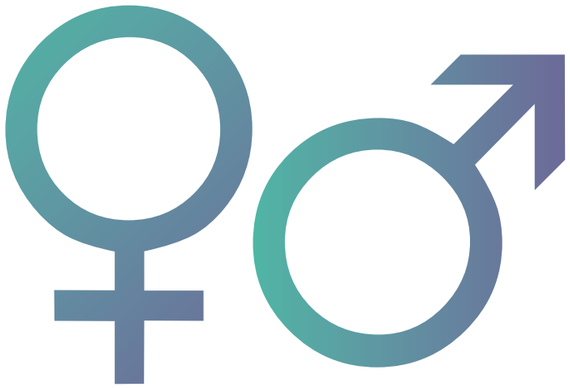
There are two main ways in which the Council seeks to maintain and improve positive sexual health for individuals and communities in B&NES. Firstly by ensuring there are sexual and reproductive health services covering prevention, testing and treatment for individuals and communities. This is not just about the services being present; it involves understanding our population in B&NES and the barriers and facilitators to people accessing services. Secondly, the Council leads on a B&NES-wide Sexual Health plan. Through working together with different organisation an action plan has been developed which is underpinned by three main aims:

1. Being free from sexually transmitted infections (STIs)

2. Being free from unplanned pregnancies

3. Empowering young people to have choice and control over intimate and sexual relationships

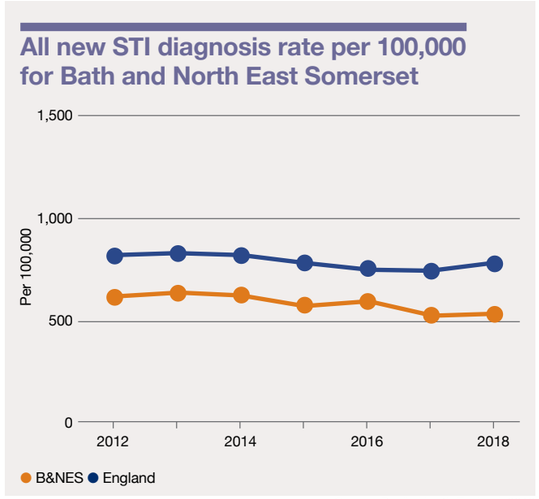
This is emblematic of what is known as a "sex positive" approach. Sex positive means that we approach sexual health with a view that sex isn't something that we should be embarrassed about. It's also about having a positive attitude towards sex and respecting people's sexual preferences. In short, our approach emphasises safe, legal and consensual sexual activities, along with a view that each individual is entitled to receive comprehensive sex education, information and advice to be able to explore sex safely and make informed choices.



Sexually Transmitted Infections (STIs) in B&NES

Generally speaking there are low, stable rates of the STIs in B&NES. The table below shows that from 2012 to 2018 the rate of newly diagnosed STIs amongst B&NES residents have remained consistently below the England average. In 2018 the rate of newly diagnosed STIs in B&NES was 533 per 100,000 population, compared to 633 per 100,000 across the South West region and 784 per 100,000 across England (see graph below).

There are some STIs that are more common amongst different groups. Chlamydia, for example, is the most common STI amongst people aged 15 – 24 in B&NES, which is also the case across England. In another example although the number of syphilis diagnoses in B&NES is very small, and much lower than the England average, from 2012 to 2018 the percentage of people diagnosed with syphilis who identified as men who have sex with men has accounted for around 95% of all total diagnoses.



Source: Public Health England, 2019

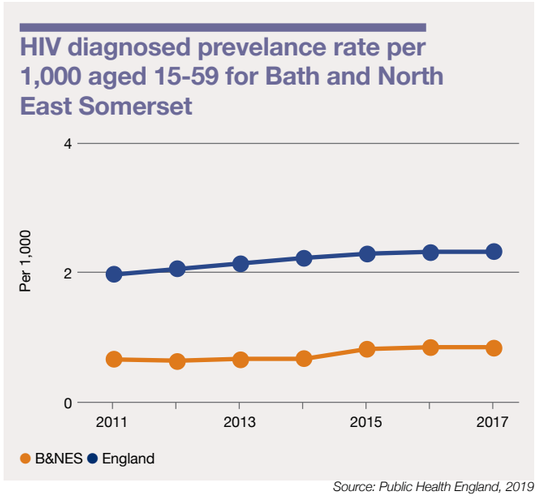
"From 2012 to 2018 the rate of newly diagnosed STIs amongst B&NES residents have remained consistently below the England average."

HIV in B&NES

The narrative around Human Immunodeficiency Virus (HIV) has changed dramatically over time. HIV used to be considered untreatable with serious illness and death occurring shortly after diagnosis. The introduction of anti-retroviral (ARV) treatment in the mid-90s, and the development of these thereafter, has completely revolutionised these outcomes. When HIV is diagnosed quickly and treatment in given and taken, the presence of the virus in an individual's blood stream can become undetectable. This has dramatically improved outcomes associated HIV. When the virus is undetectable individuals no long risk infecting others thus ARVs have also reduced the spread of HIV through populations.

HIV rates in B&NES are very low and have remained low for a while. In 2017 the diagnosed prevalence rate of HIV in B&NES amongst 15 – 59 year olds was 0.86 per 1,000 population, substantially lower than the England rate of 2.32 per 1,000 population (see graph below).

We want to diagnose HIV as soon as possible which involves ensuring individuals have an understanding of what puts them at risk of contracting the virus. HIV infection often has very general and sometimes no symptoms. However the sooner people get tested and start treatment the better their health will be. During 2011 – 2017 there have been less than 10 new HIV diagnoses in B&NES each year. Treatment levels are high with 99% of HIV positive B&NES residents receiving anti-retroviral treatment in 2017.

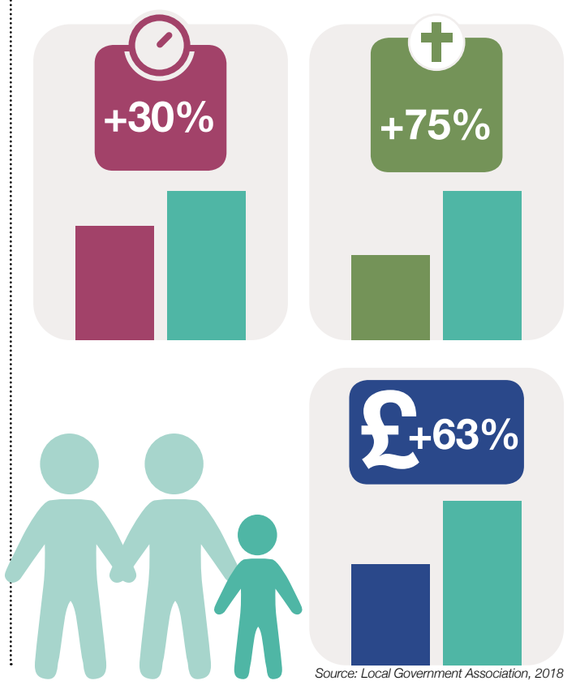


Source: Public Health England, 2019

Teenage conceptions in B&NES

Being a teen parent has impacts on both the teenager parent(s) and the child. Many normal aspects of being a teenager, including education, become challenging in the context of parenthood. National research has found that an estimated 1 in 5 young women aged 16 to 18 who are not in education, employment or training are teenage mothers. The impacts on the child include being more likely to be a low-birth-weight baby and a higher rate of infant death. Child poverty is associated with teenage pregnancies and thus teenage conceptions are both a cause and consequence of health and education inequalities. Although we've had low rates of teenage conceptions in B&NES compared to both the South West and England, keeping it low and giving good support to teenage mothers and their babies remains a priority and a key aspect of reducing health inequalities.

Their children have a **30% higher rate of a low birth weight**, **75% higher rate of infant mortality** and a **63% higher risk of experiencing child poverty**



Source: Local Government Association, 2018

Our services

There are a range of services in B&NES to provide advice, information, testing and treatment for all sexual health, contraceptive and other reproductive health needs.

The Riverside Clinic

The Riverside Clinic in central Bath (with a satellite clinic in Keynsham) offers testing and treatment for STIs, HIV testing, contraceptive fitting and wider care and support including follow up support following sexual assault, outpatient care for people living with HIV and a telephone advice line. Services are available six days a week on a walk-in and appointment basis.

Members of the Riverside Clinic team

Case study #1

In June 2017 our main sexual health service moved from the Royal United Hospital at Combe Park to the Riverside Health Centre in central Bath. The service moved so that we could provide one joined-up, integrated sexual health service for people in B&NES thus facilitating access to services. The team at Riverside Clinic, have undertaken a huge amount of work to ensure that patients can access as many of their sexual health needs as possible, in one location, and in one visit. Integral to this work was consultation with patients and working with local press to disseminate the message of the relocation. The service has also aspired to be innovate and efficient, for example through the introduction of a texting platform for results and reminders. This allows people to have contact with services even when their lives are busy.

Sexual health services can also be accessed through GPs and pharmacies. General practices particularly focus on the provision of contraception such as Long Acting Reversible Contraceptive (LARC) methods. Our community pharmacy colleagues are fundamental in their provision of sexual health advice and facilitation of access to free condoms via C-card; chlamydia treatment, and free pregnancy testing and emergency contraception for women under the age of 25. The great benefit of pharmacy is their open access nature, and the fact that there are pharmacies in many towns and villages across B&NES making them highly accessible.

Case study #2

Alice, aged 18, is a student at Bath Spa University. She had sex with her partner on Friday night but the condom broke and she walked into the pharmacy in a very upset state just before we closed on Saturday afternoon worried that she might be pregnant. I immediately took her into our private consultation room where I tried to calm her down and took details of what happened. She was worried that she might have to go to the Riverside Clinic and wait until Monday to get an appointment. She said that she wanted a pregnancy test but I explained that a pregnancy test would not give an accurate result at this point. I talked through the range of contraceptive options with her and advised her that we could offer her the levonorgestrel pill free of charge as emergency contraception immediately. She asked a number of questions about the medication, so I took time to answer those fully. She became calmer and I asked her whether she would consider ongoing contraception methods. She was receptive and I provided her with some leaflets and details of websites where she could get more information.

I also said that the Riverside Clinic was very close by and could offer her advice and all contraceptive methods free of charge, and advised her how to make an appointment. As a pharmacist it's important to me that we can make an immediate response to patients, dealing with the presenting problem and by doing so preventing future sexual health problems. It's also really important that patients who need a sexual health intervention, especially those who are vulnerable, can access a service without an appointment and outside of "normal" working hours.

School nurses

School nurses provide another element of our B&NES sexual health service through the specialist Clinic in a Box service delivered in a range of school and community settings. The aim of the Clinic in a Box service is to provide information and access to contraception and pregnancy testing. This service aims to reduce the number of teenage conceptions and STIs in young people by enhancing young people's knowledge and access to sexual health services in a non-threatening environment.

Members of the B&NES School Nursing team

C-card

A C-card is a plastic key fob that enables people 13 to 24 years old to receive free condoms. They can be of any sexuality, and do not have to be sexually active. The C-card professional will provides a 10 – 20 minute discussion with the young person about how the scheme works, covering healthy relationships, whether they are ready for a sexual relationship, keeping safe and how to get help and advice. Young people can then show their C-card in over 60 SAFE accredited venues across B&NES and receive a free condom pack plus information and advice on sexual health on each visit to the service.

SAFE

SEXUAL HEALTH ADVICE FOR EVERYONE

Sexual health Advice For Everyone

As well as breaking down barriers to accessing sexual health facilities B&NES also aspires to provide high quality services. SAFE (Sexual health Advice For Everyone) is a quality standard offered to all organisations who provide sexual health advice and information to young people aged 13 to 24. Any B&NES service showing the SAFE logo shows that they've had their services assessed by the Council as being young person friendly.

safebanes.com

Supporting the SAFE brand is our website www.safebanes.com. The site, has been redesigned in collaboration with young people and relaunched in June 2019. It provides information and advice on free condoms via the C-card scheme; contraception; emergency contraception; pregnancy; sexual and gender identity; and relationships and sexual abuse. There is also a searchable map where you can find all of the sexual and reproductive health services across B&NES, plus a professionals-only section containing useful resources and information to support professionals.

Health inequalities

"Most health inequalities are determined by people's social and economic status over the course of their lives."

What are health inequalities?

Health is something we all enjoy and aspire to have. Perhaps this is because it facilitates independence, the ability to work and to enjoy recreational activities. Despite health being something valued by all, some people in our community have worse health than others. A proportion of these differences arise by chance or as a result of genetics and some from individual decisions. However international research shows that most health inequalities are determined by people's social and economic status over the course of their lives. It's not a coincidence that across the country, people living in more deprived areas have lower life expectancy than people living in less deprived areas. In Bath and North East Somerset (B&NES) for example, this difference in life expectancy for a boy born today is 9 years.

Differences like these are seen across different levels of wealth, between men and women, different ethnic groups, people with and without disability and between other marginalised groups and the majority.

Whilst we sometimes focus on differences in adult health, such as the rate of heart disease in adults from high or low income groups, these differences start very early in life and accumulate over the years resulting in different health behaviours and different health outcomes.

It's important to point out that when we describe these inequalities we often talk about averages across groups of people; there will of course be lots of variety within each group. However, taken as an average of each group, lower income and more excluded groups tend to have consistently worse health outcomes. But why?

What influences your health and wellbeing

Many of the things that influence our health and wellbeing are the everyday circumstances we live in. Figure 1 (right) shows the contribution of various factors that influence our health and wellbeing.

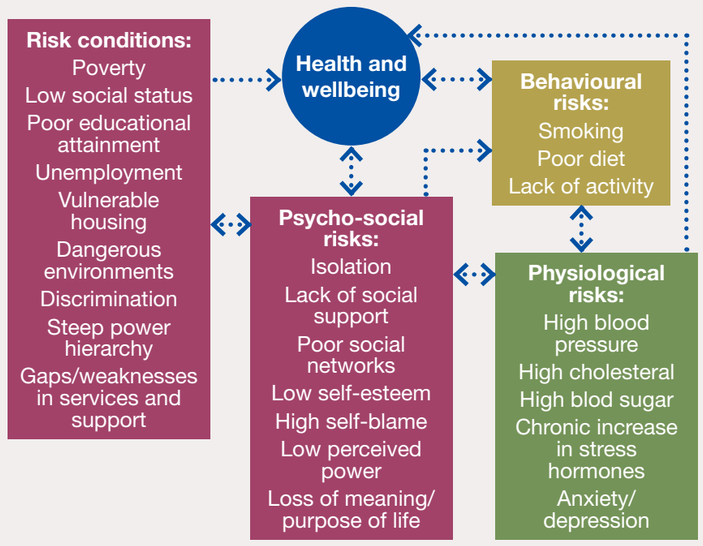
Figure 1: Factors that influence our health and wellbeing

Health behaviours 30%	Socioeconomic factors 40%	Clinical care 20%	Built environment 10%
Smoking 10%	Education 10%	Access to care 30%	Environmental 5%
Diet/exercise 10%	Employment 10%	Quality of care 10%	Built environment 5%
Alcohol use 5%	Income 10%		
Poor sexual health 5%	Family/social support 5%		
	Community safety 5%		

Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank countries by health.

To tackle health inequalities there is a certain amount that can be done by focusing on clinical risk factors (such as high blood pressure) or health behaviours (such as smoking). These can prevent further complications and illness. But to really impact on the underlying influences on these ("the causes of the causes") it's necessary to act on the wider social conditions people live in. Here's a picture showing these influences (figure 2).

Figure 2: Underlying influences of health and wellbeing



Source: Source: NHS Right Care (2018), Equity and Health Inequalities Pack, NHS Bath and North East Somerset CCG, December 2018, available from: https://www.england.nhs.uk/wp-content/uploads/2018/12/ehircp-sw-bath_and_north_east_somerset-ccg-dec18.pdf

Inequalities in B&NES from childhood to older life

School readiness

Across schools in England, children aged four and five years are checked to see if they have reached particular levels of development at the end of the first year of primary school. In B&NES, 73% of children achieve these levels, and that's slightly better than the England average. However, only 48% of local children eligible for free school meals (which is used as an indicator of income) achieve this.

This difference between children in B&NES is a worrying inequality so early in life. Although this number has improved in recent years, rising from only 33% of children in 2014 to 48% in the most recent figures, B&NES still has the lowest achievement amongst this group compared to all other councils in the South West region. These differences are not inevitable and areas of the country that have had more resources for disadvantaged schools have much smaller gaps between these groups.

B&NES Council and local school have been working to support these groups, for example supporting the transition from home to school and promoting uptake of childcare and support for working parents with lower incomes.

73%

In B&NES **73% of primary school children** achieve particular levels of development at the end of first year.

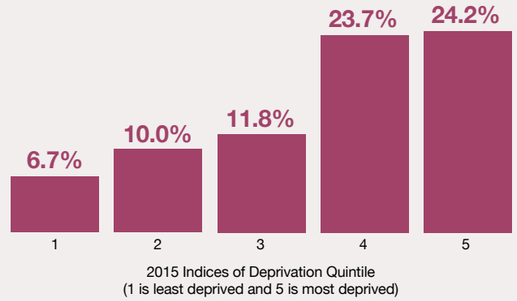
48%

Only **48% of local primary school children eligable for free school meals** achieve particular levels of development at the end of first year.

Child obesity

We see a similar pattern in levels of obesity across children in B&NES. By the time that boys leave primary school in B&NES, about 13% overall are obese. However, there is a notable contrast in obesity levels between boys from our more deprived areas (24% are obese) and boys from our least deprived neighbourhoods (only 7% are obese). This is shown in the chart below, and importantly shows that with each increase in deprivation level across B&NES, the levels of obesity go up as well. When this sort of gradient pattern is observed it strengthens the evidence of an association, in this case between deprivation and obesity in B&NES.

Figure 3: Percentage of children classified as very overweight, 2015/16 to 2017/19, B&NES

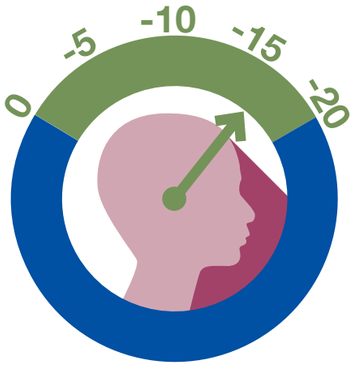


Smoking

Smoking rates in B&NES have fallen in recent years and only 12% of adults smoke overall. This has had a huge positive impact on the health of the population. However, amongst adults in routine and manual occupations in B&NES around 27% of people still smoke – more than double the district rate. Given the impact of smoking on health, this means people in routine and manual occupations are more likely to develop smoking related conditions such as heart disease or some cancers, compared to people in higher skilled professions.

Mental health

Similar patterns of inequality are seen across local hospital admissions for self-harm and to some extent for rates of suicide in our different neighbourhoods. People living with severe mental illness on average have a 15-20 year shorter life expectancy than the general population - mostly due to poor physical health – and also have much lower likelihood of being in employment and living independently.



National picture

Collaboration across sectors to reduce inequalities was demonstrated through the B&NES approach to reducing obesity. By bringing together different players, (transport, housing, voluntarily organization, public health...) B&NES has been able to consider how obesity can be addressed in a complex system.

National response

The key guidance to tackle health inequalities has come from the Marmot Review 2010. This review looked at the key inequality issues and potential policy responses available. These are as follows:

1. **Give every child the best start in life**
2. **Enable all children young people and adults to maximise their capabilities and have control over their lives**
3. **Create fair employment and good work for all**
4. **Ensure a healthy standard of living for all**
5. **Create and develop healthy and sustainable places and communities**
6. **Strengthen the role and impact of ill health prevention**

In B&NES we have led work across all of these themes and have made some progress. However, the negative impacts on living standards for many people since the financial crisis and ongoing cuts to public sector services sometimes set limits on what local efforts can achieve.

Stop press: The influential Marmot report into health inequalities in England has just been updated ten years on. It paints a grave picture. Increases in life expectancy have stalled, people are living more of their lives with significant ill-health, inequalities within and between regions have increased, and thus the importance of combating the roots of social, economic and health inequality is now greater even than it was a decade ago.

Local responses

Despite the complexities of the national picture, Figure 2 (see previous page) shows many social and psycho-social issues that can be directly impacted on by local authorities, business, the third sector and our local communities. These include for example improving skills and in-work progression for people in low paid jobs and ensuring there is sufficient, adequate housing for all people, including those most marginalised. B&NES has seen real improvements in lifestyle risk factors, such as the fall in smoking rates, but these improvements tend to be taken up by the least deprived first which can in turn increase the gap in health outcomes. We need to ensure the support we offer is tailored to the needs of people in a range of circumstances to maximise everyone's opportunity to make healthy choices for them and their families. The NHS has a crucial role to play as well, encouraging and supporting prevention and tailoring treatment to be relevant and accessible for people who may feel other daily pressures more acutely than health risk factors such as obesity, high blood pressure or diabetes.

In it for the long term

Figure 4 below shows the different timescales required to bring about change from these approaches. GPs working with the less affluent patients at their surgery can have a real impact on their health within a few years, potentially preventing conditions such as stroke or heart attacks. Helping people to lead active healthy lives can take longer and the effects may in turn take time to impact. And longest of all, working on the wider social determinants of health is probably the most significant action at the level of whole communities, but the impact on health may take more than a decade to show. Political and professional commitment to these approaches is therefore needed for the long term.

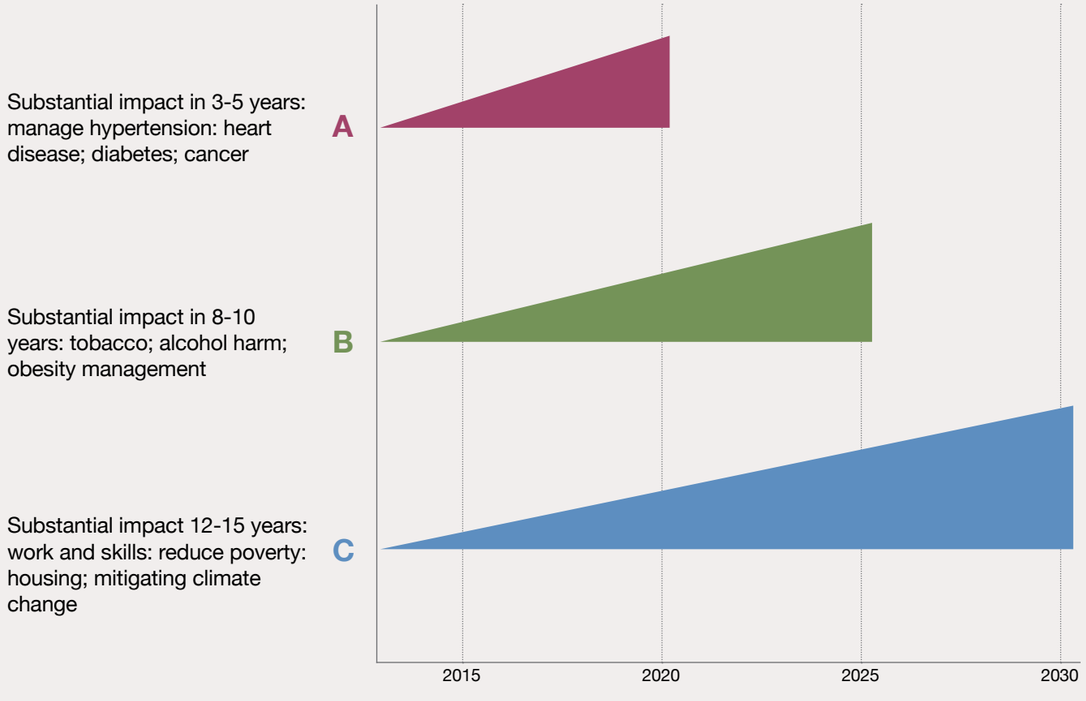
Making progress in reducing inequalities requires working across the system; education, industry, health care, CCG, local authority and understanding the wider drivers that can be influenced locally.

In B&NES the CCG and council are committed to supporting a range of different groups. One example of this is women who smoke during pregnancy. In the tobacco chapter an innovative project involving a smoking cessation intervention for pregnant women in B&NES was described. Delivered by the Public Health team this contributes to the shared goal of reducing health inequalities.

Collaborative working has also been illustrated through projects such as the Narrowing the Gap project in primary schools and the 'UP' project in early years (which aims to help unlock children's potential).

The approach in B&NES goes beyond the immediate to consider how future work undertaken by the local authority might affect people differently. For example, part of the consultation about the clean air zone involved whether its impact would be more excessive on those less well off. It is through a systems approach that inequalities in B&NES will continue to be addressed as we aspire for better outcomes for all.

Figure 4: Different timescales required to bring about change



Childhood immunisation programme & tackling health inequalities in uptake

Why childhood immunisation is important

Some infectious diseases can kill children or cause lasting damage to their health. Children's immune systems need help to fight those diseases; young babies are very vulnerable to infections, so they need to be protected as early as possible. Immunisation gives protection against some infectious diseases stimulating the body to produce antibodies that fight infection. We have a comprehensive program of immunisations in the UK. This provides the opportunity to protect individuals and the those who cannot be immunised (such as those on cancer treatments). Immunisation reduces the spread of disease through the population. Accessing vaccinations, which result in immunisation, can be challenging as people's lives are busy. In Bath and North East Somerset, we are committed to understanding and overcoming these barriers.

When do babies and children get their vaccinations?

The immunisation programme gives vaccines to babies and children at different ages. Routine immunisation for babies begins when they're two months old. For a checklist of the vaccinations and the ages at which they should ideally be given visit: *www.nhs.uk/conditions/vaccinations*

If you're not sure your child has had all their routine immunisations, check their Personal Child Health Record (Red Book), contact your GP practice or speak to your health visitor or school nurse.

There are lots of good reasons to vaccinate including:

- ✔ To protect the individual
- ✔ To protect those around them who cannot receive the vaccine (Herd Immunity)
- ✔ Disease eradication (Smallpox 1980)

What can happen when a child isn't immunised?

Due to the high number of children receiving vaccinations in England over the past couple of decades, many serious childhood infectious diseases have disappeared altogether, like diphtheria, polio or tetanus or been dramatically reduced, such as measles and whooping cough.

However, in some parts of Bath and North East Somerset (B&NES) and the country more widely, vaccination rates in children are lower than needed. Figures released in September 2019 showed vaccination rates for all nine vaccines given to children before the age of five fell in the last year in England and the UK lost its measles-free status in August amid a rising number of cases.

"The two public health interventions that have had the greatest impact on the world's health are clean water and vaccines." (WHO)

Uptake of vaccinations in Bath & North East Somerset

The 95% target for childhood vaccination coverage is recommended nationally to ensure control of vaccine preventable diseases within the UK.

Since 2015 a substantial amount of local work has taken place aimed at increasing the uptake of childhood vaccinations in B&NES. The graph below shows that uptake of MMR vaccinations (dose two by 5 years of age) has steadily increased in B&NES between 2015 and April 2019. Since 2016 uptake has consistently been above both the England and South West average.

However we have not reached the target of 95%. This puts unvaccinated children at greater risk and increases the likelihood of an outbreak in the wider population. In recent months outbreaks of both measles and mumps have occurred in B&NES and surrounding areas. As a result, a number of local initiatives and communication campaigns were launched, mainly aimed at children and young people. The key messages were; to check if you have had two doses of the MMR (measles, mumps and rubella) vaccination and it's never too late to have the MMR vaccination.

Immunisations & tackling health equalities

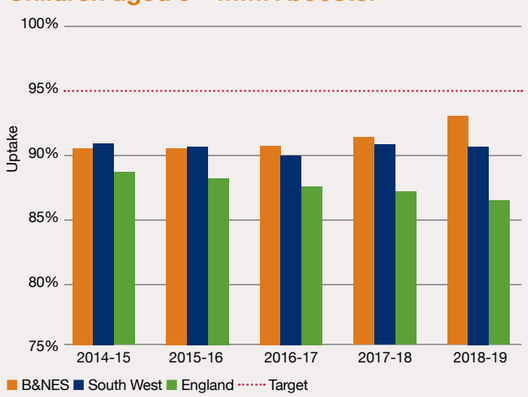
There are areas in B&NES where vaccination uptake is lower than the B&NES average shown in the graph (left). During early 2018 we became aware in B&NES of consistently low uptake for St Michael's Partnership, Twerton and as a result the Council's Public Health Team worked with the Health Inequality Specialist employed by Virgin Care at the time to set up a multi-agency working group in Twerton to address the issue. The group was made up of Health Visitors, Practice Nurses, School Nurses, Early Years Settings, Schools, NHS England & Improvement, Virgin Care Services & B&NES Council.

The data showed that uptake was particularly low (around 75%) for the vaccinations given at 3 years 4 months and reported at 5 years of age. Some of the outcomes of the project included:

- Regular multi-agency meetings
- A shared understanding of the problem
- Training for early years and primary school staff
- An audit of the GP practice & other organisations using NICE (National Institute for Health & Clinical Excellence) guidelines - good practice identified and implemented.
- Closer working between Health Visitors and GP practice – sharing of 'Did Not Attend' lists and discussion at safe guarding meetings
- Development of a childhood immunisations toolkit, including new resources & a 4th birthday card given to children in early years settings
- Outreach immunisations Service Level Agreement to allow practice nurses to give immunisations in other settings if needed

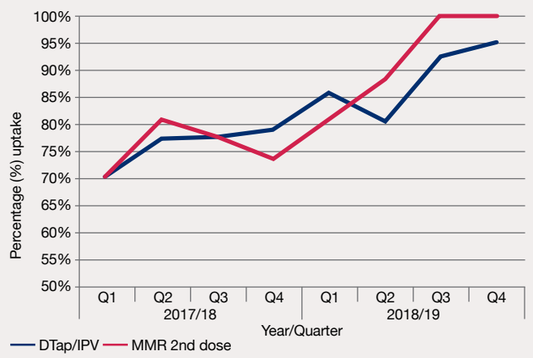
The following data for the two vaccinations; diphtheria, tetanus, pertussis, polio (DTap/IPV) and MMR offered at 3 years 4 months of age (reported at 5 years of age) shows a fantastic improvement in uptake since the project has been running.

Children aged 5 – MMR booster



Data source www.gov.uk/government/collections/vaccine-uptake

Children aged 5 – booster vaccinations St Michael's Partnership, Twerton



Source: IMMFORM