Health and Wellbeing Board

Agenda

Date: Wednesday, 28 February 2024

Time: 2.30 pm

Venue: Bordeaux Room, City Hall, College Green, Bristol

Issued by: Jeremy Livitt, Democratic Services
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Date: Friday, 16 February 2024

Agenda

1. Welcome, Introductions and Safety Information

(Pages 5 - 7)

Please note: if the alarm sounds during the meeting, everyone should please exit the building via the way they came in, via the main entrance lobby area, and then the front ramp. Please then assemble on the paved area between the side entrance of the cathedral and the roundabout at the Deanery Road end of the building.

If the front entrance cannot be used, alternative exits are available via staircases 2 and 3 to the left and right of the Council Chamber. These exit to the rear of the building. The lifts are not to be used. Then please make your way to the assembly point at the front of the building. Please do not return to the building until instructed to do so by the fire warden(s).

2. Apologies for Absence and Substitutions

3. Declarations of Interest

To note any declarations of interest from the Councillors. They are asked to indicate the relevant agenda item, the nature of the interest and in particular whether it is a **disclosable pecuniary interest**.

Any declarations of interest made at the meeting which is not on the register of interests should be notified to the Monitoring Officer for inclusion.

4. Minutes of Previous Meeting held on 14th December 2023

(Pages 8 - 14)

To agree the minutes of the previous meeting as a correct record.

5. Public Forum

Up to 30 minutes is allowed for this item.

Any member of the public or Councillor may participate in Public Forum. The detailed arrangements for so doing are set out in the Public Information Sheet at the back of this agenda. Public Forum items should be emailed to democratic.services@bristol.gov.uk and please note that the following deadlines will apply in relation to this meeting:-

Questions - Written questions must be received 3 clear working days prior to the

meeting. For this meeting, this means that your question(s) must be received in this office at the latest **by 5pm on Thursday 22nd February 2024.**

Petitions and Statements - Petitions and statements must be received on the working day prior to the meeting. For this meeting this means that your submission must be received in this office at the latest **by 12 Noon on Tuesday 27th February 2024.**

Members of the press and public who plan to attend a public meeting at City Hall are advised that you will be required to sign in when you arrive and you will be issued with a visitor pass which you will need to display at all times.

6.	**Integrated Care Partnership Update (Verbal) - Councillor Helen Holland**	**2.35 pm**
7.	**University Hospitals Bristol, Weston NHS Trust and North Bristol NHS Trust moving to "Group Model" - Verbal - Rebecca Dunn, UHBW**	**2.40 pm**
8.	**CQC Assurance Update (Verbal) - Hugh Evans, Bristol City Council**	**2.50 pm**
9.	**BNSSG All Age Mental Health Strategy - Julia Campbell, ICB - Papers Attached**	**3.00 pm** **(Pages 15 - 36)**
10.	**Joint Forward Plan - Cintia Faria, ICB - Paper Attached**	**3.30 pm** **(Pages 37 - 39)**
11.	**Health Protection Annual Report - Jessica Horner and Ashley Bryant, Bristol City Council - Papers Attached**	**4.00 pm** **(Pages 40 - 103)**
12.	**Any Other Business - Local Food Fund and Tobacco Control Work Verbal Updates - Mark Allen-Richardson**	**4.30 pm**

13. Health and Well Being Board Forward Plan - FOR INFORMATION

To note the HWBB Forward Plan. **(Page 104)**

14. Date of Next Meeting

The next Board meeting is provisionally scheduled to be held at 2.30pm on Wednesday 26th June 2024 in the Bordeaux Room, City Hall, College Green, Bristol.

Public Information Sheet

Inspection of Papers - Local Government (Access to Information) Act 1985

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- are suffering from symptoms of COVID-19 or
- have tested positive for COVID-19

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Committee rooms are fitted with induction loops to assist people with hearing impairment. If you require any assistance with this please speak to the Democratic Services Officer.

Public Forum

Members of the public may make a written statement ask a question or present a petition to most meetings. Your statement or question will be sent to the Committee Members and will be published on the Council's website before the meeting. Please send it to democratic.services@bristol.gov.uk.

The following requirements apply:

- The statement is received no later than **12.00 noon on the working day before the meeting** and is about a matter which is the responsibility of the committee concerned.
- The question is received no later than **5pm three clear working days before the meeting**.

Any statement submitted should be no longer than one side of A4 paper. If the statement is longer than this, then for reasons of cost, it may be that only the first sheet will be copied and made available at the meeting. For copyright reasons, we are unable to reproduce or publish newspaper or magazine articles that may be attached to statements.

By participating in public forum business, we will assume that you have consented to your name and the details of your submission being recorded and circulated to the Committee and published within the minutes. Your statement or question will also be made available to the public via publication on the Council's website and may be provided upon request in response to Freedom of Information Act requests in the future.

We will try to remove personal and identifiable information. However, because of time constraints we cannot guarantee this, and you may therefore wish to consider if your statement contains information that you would prefer not to be in the public domain. Other committee papers may be placed on the council's website and information within them may be searchable on the internet.

During the meeting:

- Public Forum is normally one of the first items on the agenda, although statements and petitions that relate to specific items on the agenda may be taken just before the item concerned.
- There will be no debate on statements or petitions.
- The Chair will call each submission in turn. When you are invited to speak, please make sure that your presentation focuses on the key issues that you would like Members to consider. This will have the greatest impact.
- Your time allocation may have to be strictly limited if there are a lot of submissions. **This may be as short as one minute.**
- If there are a large number of submissions on one matter a representative may be requested to speak on the groups behalf.
- If you do not attend or speak at the meeting at which your public forum submission is being taken your statement will be noted by Members.
- Under our security arrangements, please note that members of the public (and bags) may be searched. This may apply in the interests of helping to ensure a safe meeting environment for all attending.
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Bristol City Council
Minutes of the Health and Wellbeing Board

14 December 2023 at 2.30 pm

Board Members Present: Councillor Helen Holland (Chair), Councillor Ellie King (Temporary Chair and Deputy Chair), Eva Dietrich, Hugh Evans, Christina Gray, Tim Poole, Jean Smith, Mette Jakobsen, Rebecca Mear, Heather Williams, Rebecca Dunn, Neil Turney, Tim Poole, Tim Keen, Joe Poole, Julie Bird (substitute for Vicky Marriott - also presenter see below), Steve Rea, Ros Cox (substitute for Colin Bradbury)

Officers in Attendance:-
Mark Allen-Richardson, Karen Blong, Penny Germon, Jeremy Livitt

Presenters
Joanna Copping and Alexandra Humphrey (Agenda Item 6), Julie Bird (Agenda Item 7)

1. Welcome, Introductions and Safety Information

The Chair welcomed all parties to the meeting.

2. Apologies for Absence and Substitutions

Apologies for absence were received from Reena Bhogal-Welsh, Penny Gane, Carol Slater, Colin Bradbury (Ros Cox to substitute) and Vicky Marriott (Julie Bird to substitute).

3. Declarations of Interest

There were no Declarations of Interest from councillors.

4. Minutes of Previous Meeting held on Wednesday 25th October 2023

The minutes of the meeting held on Wednesday 25th October 2023 were agreed as a correct record and signed by the Chair.

5. Public Forum

There were no Public Forum items.

6. Women's Health "Hub" - Joanna Copping, BCC and Alexandra Humphrey, Integrated Care Board

The meeting received a presentation from Joanne Copping and Alexandra Humphrey who made the following points:

Reproductive Outcomes

- Women in the BNSSG area spent longer in poor health than in other areas. In addition, unplanned pregnancies were high and abortions were rising in the area
- Whilst emergency contraception was free for over 25s, there had been a decrease in uptake
- Rates of certain STD's such as gonorrhea had been increasing and condom use had been declining
- Maternity outcomes were variable. Outcomes were worse with certain types of screenings reduced, such as breast cancer
- Whilst rates or cervical cancer had been reduced following HPY vaccination, rates of vaccination and cervical screening were not sufficiently high
- The demand for support for problems caused by menopause was huge. These included heavy menstrual bleeding, endometriosis and incontinence but data was poor since the problem was stigmatised and frequently hidden

System Wide Approach

- There was a focus on sexual reproductive health but currently lots of gaps in the date
- There was a fragmented landscape of commissioning and budgets with public health being responsible for sexual health and NHS England were responsible for screening. Many patients needed help navigating the system
- Consultation concerning sexual health focused on key areas such as access to gynecology
- Work from public health in preventing unplanned pregnancies led to benefits elsewhere (i.e. the health service) and therefore close working was required to achieve effective interventions
- The escalation of costs for care had resulted in variable quality and inequities in access and outcomes
- Women's health strategy needed to embrace diversity and innovation to deal with a shortfall in funding

National Guidance and Women's Health Hub

- The National Health Strategy had been drawn up in 2022 – a definition was provided
- Core Services included issues such as tackling menstrual problems and assessments

- The Health Hub would provide wrap around care so that, when a woman had a coil fitted, she could have a cervical cancer screening at the same time
- These would also provide primary care options rather than requiring an automatic transfer to hospital
- Phase 1 was currently taking place from August to November 2023, Phase 2 – High-level planning from November 2023 to January 2024, Phase 3 provided detailed planning via a working group, Phase 4 in April 2024 was the implementation phase
- A workshop had taken place on 7th December 2023 and had involved a wide range of organisations
- Emerging themes were a follows – long-acting e=reversible contraception, support access to good quality information and education, education training and support for healthcare professionals, involving women in planning and making changes, reducing the service delivery problems of silos of funding and commissioning and the need to harness the collective power of people and organisations for delivery

In response to Board Members' questions, Joanne Copping and Alexandra Humphrey made the following points:

- Whilst there was some additional funding which would recur within gynecology and maternity services, there were gaps within this provision. It was noted that changing the system to make it work better would help to meet probable unmet need and was likely to require more funding. There were a lot of voluntary sector partners who could help with this provision
- Bristol was piloting two sites delivering LARCs (Long-Acting Reversible Contraceptives) in a different way. Whilst some of these practices were working well, others had none at all. Provision of a separate hub, clinic and/or service would help since it would provide women's health care through a clinic in a non-GP setting
- The integration of different services through wider community support was important through a wide range of different hubs
- Whilst there were opportunities for embedded relationships to provide support for certain issues such as HIV, there was also a need to manage expectations given the limited resources available
- The future wider development of hubs would help to provide an approach that was more focused on prevention and was more societal than medical

7. Your NHS Menopause Experience - Julie Bird, Healthwatch

Julie Bird gave a presentation on this issue and made the following points:

- The Health Watch project had started from the end of 2022 to the beginning of 2023
- The project listened to patient voices and assessed their influences and concerns, providing a summary of their conversations and feedback

- Following the hosting of a recent coffee and cake community event, it was noted that there were some information gaps in particular areas such as Hormone Replacement Therapy.
- There was a diverse range of opinions at this event with some welcoming and others mourning the loss of fertility for women. A steering group had been set up concerning HRT to examine alternative approaches
- A workshop had taken place for National Women's Day
- The symptoms of respondents were frequently confused or ignored by GPs with patients often being referred to mental health services when there were other causes of illnesses. Individuals with long term conditions frequently struggled to separate symptoms from pre-existing conditions which made diagnosis harder.
- A number of people from ethnic minorities had requested a hub outside their community. It was important to take into account these cultural differences
- The recommendations of the report included (1) a self-referral specialist hub to provide an initial assessment, (2) ensuring early awareness information is sent to all women in preparation for pre-menopause, (3) the designation of leads in Primary Care Networks to provide specialist advice and guidance, (4) the development of signposting information (5) a mandatory provision of medical and cultural competence training
- The full report was available at www.healthwatchbristol.co.uk

In response to members' questions, Julie Bird made the following points:

- This work had been aired with South Gloucestershire and North Somerset
- Further discussions were required internally as well as with wider networks such as GP surgeries
- There would be a further review in about a year's time

Health Watch agreed to share the report with GPs via One Care (Ruth Hughes) and Katrina Boutin
ACTION: Mark Allen-Richardson and Julie Bird

8. Director of Public Health Report 2023 - Christina Gray, Bristol City Council

Christina Gray introduced this report and made the following comments:

- The fourth Department of Public Health report ("The Power of Us") was the 2023 DPH report
- Whilst all elements of the report built on each other, the starting point was "mental wealth"
- 11 Power of Us case studies had been used to demonstrate the great work being carried out around the city with communities telling stories in their own voices
- The report was a scientific document to provide evidence to show that communities matter and provides a link between peoples' physical and emotional selves when this manifested itself in illness
- The report tackled the issue of why inequality made people sick

- As well as social capital via social peers, vertical integration was a key element in assessing the importance of community relations. Organisations such as VOSCUR and Black South West Network were a key element of this
- Urban and natural Places – This approach needed to enable the way we build our homes and public spaces, parks etc.
- Art, Culture and Well Being – it was important to make people aware of the power of art, including street art. An example was provided of an arts project embedded in a stroke ward which led to all patients starting to dance. Analysis of such projects indicated that these frequently led to better health outcomes
- Resource Allocation – there had been a lot of interest in this through projects such as Ambition Lawrence Weston (a resident-driven organisation striving to make Lawrence Weston an even better place to live and work). A great deal of community work had taken place to develop this including many examples of community assets and through the community resilience fund
- A call to action – This enabled community action and leadership through community owned infrastructure, engagement in networks, an asset-based approach, investing in trust and trusted relationships, the development of collaboration, co-production and shared decision-making

  Board members noted the prevention work associated with this including greater engagement and feedback to improve mental health and wellbeing and to reduce pressure on public services. In addition, it also helped to provide information concerning the networks involved in building key relationships and in the development of a wider structure (such as One City).

  The Committee thanked Christina Gray for her work in producing a very constructive and engaging piece of work with a wide number of organisations involved which provided weight in its assessment.

  Christina Gray explained that, in addition to the general publication on the website, there would be a general mailing with the link.

  It was agreed that the report and ideas from the Bristol DPH report 2023 are exchanged with the South Gloucestershire and North Somerset DPH reports and reported to the ICP **ACTION: Christina Gray to arrange for the exchange of ideas of Bristol DPH with South Gloucestershire and North Somerset DPH reports and consider reporting on all three reports to the ICP**

9. Integrated Care Partnerships - Verbal Update - Ros Cox, Bristol City Council

Ros Cox gave a verbal presentation on the issues discussed at the 29th November 2023 meeting of the Integrated Care Partnership and reported the following:

- A board to board session of the ICP would be taking place on 11th January 2024
- The ICP and ICB would discuss roles and responsibilities with a draft agenda to be circulated to the board. The LGA would facilitate and provide presentations as required

- There would be a trauma informed pledge to sign up to and to assess into organisational plans. There remained concern about how to embed these into the organisational plans.
- A proposal would come back to February 2024 for final sign-off with any required investment and a partnership approach.
- There would be an update concerning the Discharge to Assess Programme
- In August 2023, 170 beds had been saved and patient flow had been much improved
- There was a target to make 5% of the population smoke free by 2030. It was noted that smoking cessation had been a key element of the Development Day with the goal of preventing smoking at health centres and care homes through workforce support

The following points were also noted:

- Additional funding would be provided to Local Authorities on smoking cessation – approximately £2 million on the "Swap to Stop Campaign" for an acute smoking cessation service and maternity service including for workforce health.
- There was considerable debate about the possible introduction of health checks for staff which would be free this winter and the same as for the service received from the GP. There had been very positive feedback on this approach to tackle certain members of staff with poor rates of health since it also helped to retain staff
- This was a 5 year cross governmental programme which would triple current investment

10 Care Quality Commission Assurance - Verbal Update - Mette Jakobsen, Bristol City Council

Mette Jakobsen gave a verbal report on this issue and made the following points:

- Local Government was now subject to the CQC framework which Mette had spent a great deal of time preparing for
- The LGA Peer Review Challenge was an opportunity to test self-assessment and awareness and to learn from it
- In addition, CQC pilots had been launched (5 in total – 4 had been assessed as good, 1 requiring improvement) and CQC Assurance had now been received. Three sites had been announced for the first reviews, none of which were in the South West
- Some of the early feedback from practitioners had been good, indicating a positive relationship with partners and providing good opportunities.
- There had been a number of issues to reflect on and indicating those areas requiring risks and opportunities for further action and to work with other partners
- Whilst the guidance indicated that self-assessment is not a statutory responsibility, they had to be written from the point of view of each group – partners, colleagues, those who receive the service. Since the inspectors would spend more time at any Local Authority which did not carry out a review, it made sense to participate in it.
- Although there were some concerns about process issues, this was likely to be caused by 13 years of a lack of scrutiny of the service. The review had noted positive relationships with the health

system and voluntary care which resulted in a greater productivity for the development and designing of policies. In addition, lived experience had showed a good intention in the approach indicating that it has been a valuable exercise

- A peer visit would also be carried out to provide support and lived experience. Details of an existing peer experience were noted

The Chair pointed out that the report would be released in about 4 weeks' time. It had highlighted the strength of the HWBB. However, the CQC process was tantamount to an inspection and its significance was not yet appreciated for the organisation.

11 Health and Well Being Board Forward Plan

HWBB agreed that the Joint Development Session on Wednesday 27th March 2024 is a joint session with the Homes Board and discussing issues such as damp and mould plus temporary accommodation. **ACTION: Mark Allen-Richardson to add to Work Programme**

Councillor Helen Holland noted that the LGA Peer Pilot Review had highlighted that Bristol City Council Adult Social Care team could improve its relationship with BCC housing.

It was noted that two local acute units would shortly be coming together under a joint chief executive and that a report was required to provide the implications for this. **ACTION: Mark Allen-Richardson to add to Work Programme**

The Board noted that the UK Health Security Agency had impacted a report on climate change. **ACTION: CG to provide to Jeremy Livitt for circulation.**

12 Date of Next Meeting

The Board noted that the next formal Board meeting was scheduled for 2.30pm on Wednesday 28th February 2024 in the Bordeaux Room, City Hall, College Green, Bristol.

Meeting ended at 4.10 pm

CHAIR _____

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

Bristol Health and Wellbeing Board

Title of Paper:	Bristol North Somerset & South Gloucestershire (BNSSG) All Age Mental Health and Wellbeing Strategy
Author (including organisation):	Julia Chappell Senior Business development and Planning Manager Avon & Wiltshire Partnership NHS Trust
Date of Board meeting:	28th February 2024
Purpose:	Decision

1. Executive Summary

1.1. The Bristol Health and Wellbeing Board are asked to endorse the final draft of the Bristol North Somerset & South Gloucestershire (BNSSG) All Age Mental Health and Wellbeing Strategy and plan on a page which are appendixes 1a and 1b to this cover paper. The cover paper summarises the process of, and feedback from, engagement between the first and final draft as well as the edits which have been made as a result.

2. Purpose of the Paper

2.1. The Bristol Health and Wellbeing Board are asked to make a decision to endorse the All Age Mental Health and Wellbeing Strategy which is also being submitted for endorsement to the Integrated Care Partnership Board and the North Somerset & South Gloucestershire Health and Wellbeing Boards.

3. Background, evidence base, and what needs to happen

3.1. All Integrated Care Systems are required by NHS England to have a mental health strategy describing their vision and ambitions for mental health within their system. A system wide mental health strategy brings all partners together to work towards a set of collective priorities. The strategy aligns to the overarching Integrated Care System strategy which identifies mental health as a key priority area. The mental health strategy provides the next level of detail on specific areas of work within the mental health system.

3.2. In late 2022, AWP were asked to lead on the development of a new All Age Mental Health & Wellbeing Strategy on behalf of the system. This would be based on previous co-production completed for a draft strategy developed, but not finalised, between 2018-20.

3.3. A steering group was established to guide the development of the draft. The group included representatives from across the three Local Authorities, the mental health Voluntary and Community Sector alliance, AWP and acute trusts.

3.4. As the draft document was developed, it was shared widely in partnership meetings across the system. A full engagement log detailing the meetings attended and feedback received was kept and reviewed by the steering group.

3.5. In addition to formal partnership meetings, some of which also included people with lived experience, specific meetings were held to share the draft strategy with people with lived experience. These included the Barnardo's Helping Young People Engage (HYPE) Group which has representatives from a number of young people's sub groups, the Independent Futures (IF) group representing people who have experience of multiple disadvantage and the Independent Mental Health Network (IMHN).

3.6. Through this initial engagement process over 300 people had the opportunity to input into the draft.

3.7. This process led to a strategy which;

- Provides a high level overview of the policy context and needs within BNSSG
- Sets out our system vision as 'People having the best mental health and wellbeing in supportive, inclusive, thriving communities'
- Identifies 6 ambitions to help deliver the vision;
  - Holistic care: People of all ages will experience support and care which considers everything that might help them stay well
  - Prevention and early help: People of all ages, their families and carers will get the support they need in the right place and in a timely way, as early as possible.
  - Quality treatment: High quality treatment is available to people of all ages as needed closer to home, so they can stay well in their local communities.
  - Sustainable services: We will have an economically and environmentally sustainable mental health system where maximum benefit is delivered to the Community.
  - Health Inequalities: We will reduce health inequalities by improving equity of access, experience and outcomes throughout people's lives.
  - Great place to work: We will have a happy, diverse, inclusive, trauma-informed and stable workforce across our system.
- Sets out key areas of work required to deliver each of the ambitions above and identifies which metrics will help us know if we have been successful
- Notes that Joint Forward Plans for mental health will be developed annually to progress the priorities identified within the strategy
- Concludes by explaining our system governance and noting that "When all organisations in our system work together to deliver change, the impact can be transformational"

3.8. The draft strategy was endorsed by the Integrated Care Partnership Board on the 28th September and published for an 8 week engagement period on World Mental Health Day, the 10th October.

4. Community/stakeholder engagement

4.1. Alongside the draft strategy being published on the ICB website, a survey monkey was published to give people in BNSSG a chance to further shape the strategy. The survey asked if the strategy was clear and accessible, what was missing from the strategy and what was the key thing people would like to change within the mental health system.

4.2. There were 53 responses were received to the survey monkey. 20 of these were from groups/Organisations (reflecting at least 124 individuals with 7 group responses not confirming how many people took part) and 33 from individuals.

4.3. People who answered as individuals were asked to share their demographic information. An analysis of demographics indicated those who took part were broadly reflective of the BNSSG population in terms of age, ethnicity, sexuality and religion. However, in terms of gender 23 responses were female and only 8 were male. This may reflect the higher number of female staff within the health and social care workforce.

4.4. The themes and changes which have been made as a result are summarised below;

Theme	Edits as a result
The strategy reflects the correct aspirations, but how will it be delivered?	Including graphic on the final page explaining JFP will have detail on projects to deliver the strategy. As described below there will also be a strategy action plan led by the ICB.

Are there enough resources to deliver the strategy and how will this be managed?	An opportunity costs graphic was developed to demonstrate the benefits of investing in prevention. However, it is recognised resources will continue to be a challenge requiring HCIG to prioritise and phase investments over the lifetime of the strategy.
How will you measure impact?	A table with all the detailed metrics we will use has been added as appendix 2 of the strategy.
You need to emphasise social support more	Case studies have been added to show impact of social support and text added to strengthen to highlight the impact of social support.
You need to emphasise multiple disadvantage/dual diagnosis more.	A paragraph to be added to specifically address this and it has been addressed through case studies.
The strategy should recognise the change from the Care Programme Approach to Support Conversations.	Text has been added to explain the move to Support Conversations under our holistic care ambition.
The Strategy talks a lot about children, young people and adults but not enough about older people.	We have added text under holistic care to describe the programme of work being led by our older people's mental health clinical lead across both functional mental ill health and dementia.

4.5. A communications plan has been developed for the roll out of the final strategy and is available upon request.

5. Next Steps

5.1. A strategy action plan is being developed to pick up on the specific, immediate term, commitments within the strategy and ensure that these are being delivered. Once populated, this plan will be shared with the Mental Health Learning Disability and Autism Health and Care Improvement Group (MH LD & A HCIG) for approval and onward monitoring. The HCIG consists of mental health leaders from across the health and care system in BNSSG with Bristol City Council represented by the Director of Public Health

5.2. In the medium to long term, the strategy will be implemented through the NHS Joint Forward Plan (JFP) and its annual refreshes. The 2024/25 JFP has therefore been structured so that all projects are aligned against the six strategy ambitions.

5.3. Finally, a brief cover sheet will be developed for MH LD&A HCIG so that every paper coming for discussion or decision is aligned to the ambitions within the strategy. This will allow the MH LD&A HCIG all work against the ambitions and consider where there may be gaps.

6. Recommendations

6.1. It is recommended that the Bristol Health and Wellbeing Board;

- Endorse the final version of the strategy following the engagement
- Note that the strategy is also being submitted to the North Somerset & South Gloucestershire Health & Wellbeing Boards and the Integrated Care Partnership Board for endorsement.
- Note that the MH LD&A HCIG will implement and monitor the strategy through a combination of an action plan and the annual refreshes of the Joint Forward Plan with an annual report on progress also being share with the Integrated Care Partnership Board.

7. City Benefits

7.1. Having an Integrated Care System wide strategy will improved partnership working and a focus on prevention which is expected to improve mental health outcomes in Bristol and the wider BNSSG area.

7.2. The strategy also contains a specific priority and initial plan to address health inequalities in mental health. This will support groups in the Bristol community who do not currently have equity of access, experience or outcomes from mental health support.

8. Financial and Legal Implications

8.1. Implementing the strategy will have financial implications as it will be the guide through which both new NHS investments and proposals for transformation are viewed. This will be governed by the Mental Health, Learning Disability and Autism Health and Care Improvement Group where the Council are represented by the Director of Public Health.

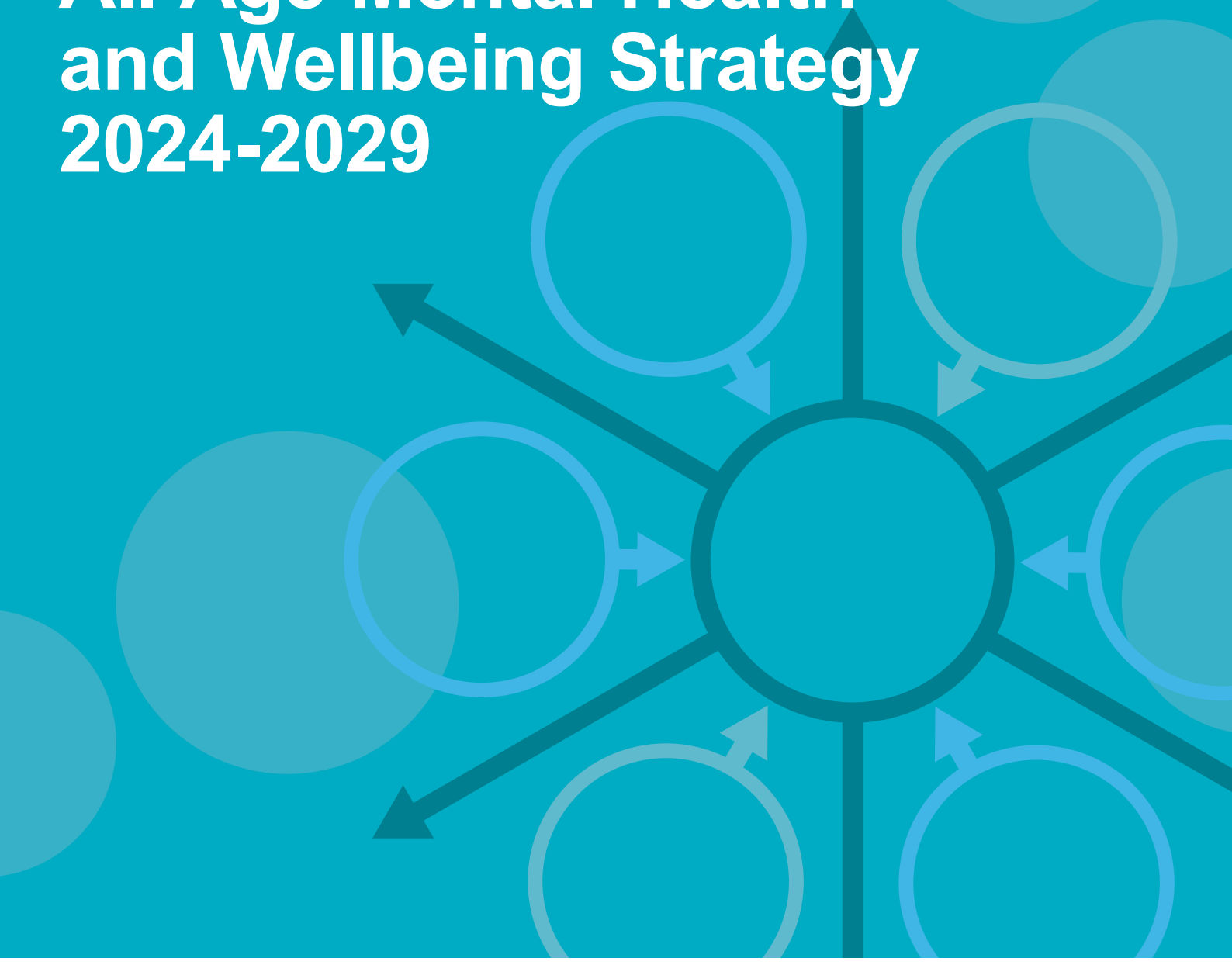
9. Appendices

1. A. BNSSG All Age Mental Health and Wellbeing Strategy – final version
   B. BNSSG All Age Mental Health and Wellbeing Strategy Plan on a Page – final version

Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

Bristol, North Somerset and South Gloucestershire Integrated Care System All Age Mental Health and Wellbeing Strategy 2024-2029



Contents

Introduction

We are delighted to present our All Age Mental Health and Wellbeing Strategy, setting out our partnership approach to improving mental health and wellbeing in the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System. This Strategy is for anyone who wants to understand the vision and ambitions for the future mental health services and support in BNSSG, including the work which will deliver this.

This vision and Strategy has been co-produced and are co-owned by people with lived experience and their families, community representatives, voluntary sector organisations, statutory health and social care providers, wider mental health stakeholders and commissioners.

The Strategy takes an **all age** life course approach, recognising that good mental health is a key principle underpinning wellbeing, and is embedded in family and community life.

This Strategy sets out six key ambitions for more effective **joint-working**. In doing so, it will deliver a five-year vision for our mental health system, driving improvements against key outcomes - supported by detailed delivery plans.

The Strategy takes a **thrive approach,** embracing the spectrum of mental health from thriving through to those who need higher levels of support.

Recognising that mental health is everyone's business, we are committed to becoming a community that **works together,** delivering the best mental health outcomes.

Whilst also delivering a service for people of all ages, that is person centered, trauma-informed, recovery focused and is a place where people want to live and work.

Whilst mental health and wellbeing is our focus, we will strive to deliver **wider social, economic and environmental benefits** as part of this work. In particular, we recognise the absolutely vital role of stable housing in supporting good mental health.

A separate Strategy is being developed with and for people with learning disabilities and neurodiversity, although interdependencies and the need for personalised support have been recognised in this Strategy.

Healthier Together

SECTION 2

The wider context

Our system has developed a document which assesses the health needs of the people who live here; Our Future Health
This has identified that mental health conditions are among the biggest drivers of population health and care needs. This Mental Health and Wellbeing Strategy supports the overarching BNSSG Integrated Care Partnership Strategy. The ICS Strategy prioritises specific projects to support delivering transformation in health outcomes. We will ensure this work aligns with the ambitions within the Strategy and includes priority projects for mental health.

Page 21

Mental health and age

Children and young people (CYP): 75% of children and young people who experience mental health problems aren't getting the help they need.

Students: With social and academic pressures, this is a time of major life transition during the developmental transition to adulthood. Adding in financial stresses and potential negative consequences of digital technology and social media, students are a high risk group for developing mental health and wellbeing problems.

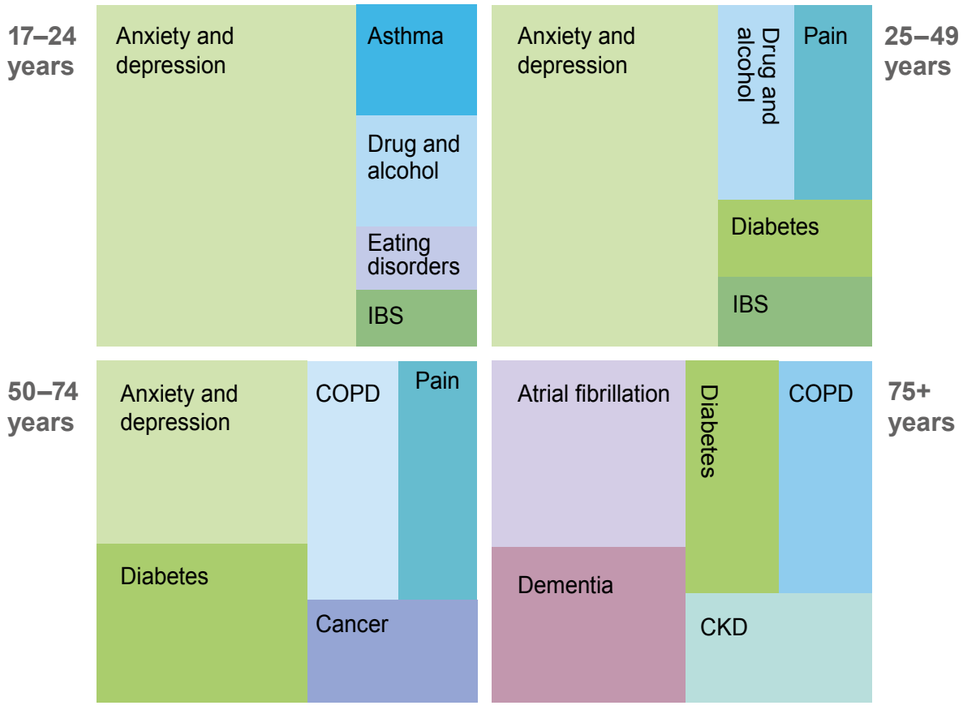
Parenting and mental health: All parents face challenges and there may be additional difficulties if you have a mental health problem. Other stressful life experiences such as money problems or a relationship breakdown can negatively affect mental health.

Later in life: Changes in life as we get older such as retirement, bereavement, loneliness, becoming a carer and physical illness can affect mental health and wellbeing.

Source: Mental Health Foundation 2021.

Our population

The impacts on health through the life course in BNSSG



Source: Our Future Health 2022

The graph above shows conditions that have the greatest impact on the population, shown in four different age groups. The bigger the box within each of the four squares, the bigger the impact of that condition. This only includes people over 16 years old as the tool that has been used to create this graph has only been validated in adults.

Painful conditions are within the top 5 most impactful conditions across the life course (particularly among the over 50s population) within BNSSG. There is significant overlap with mental health issues especially anxiety and depression, and this is unlikely to be resolved through more prescribing or faster access to procedures.

Eating disorders rank in the top five most impactful conditions among 17-25 year olds in BNSSG.

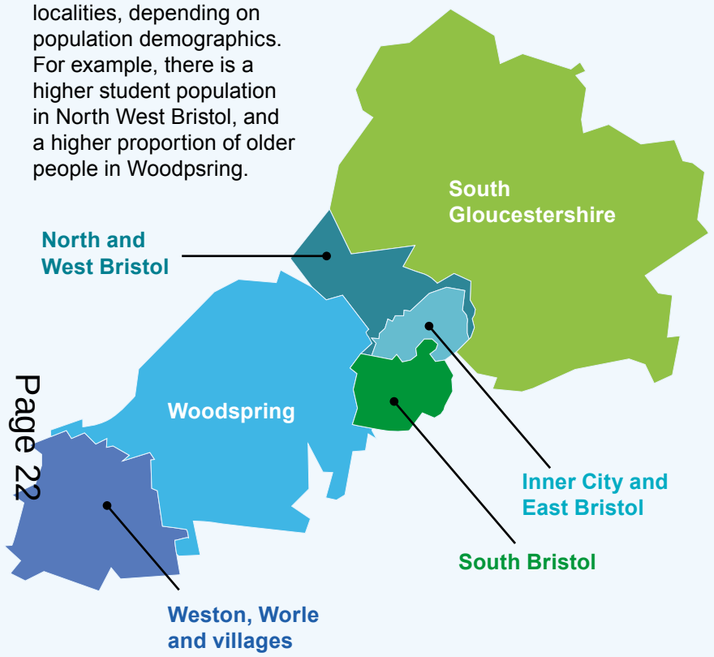
The numbers of children and young people in treatment for eating disorders in BNSSG has increased from 107 in 2017-18 to 367 in 2021-22.

Suicide is uncommon, but a leading cause of years of life lost as it is more common in young people with more years ahead of them.

Suicide is our second biggest cause of years of life lost, after heart disease.

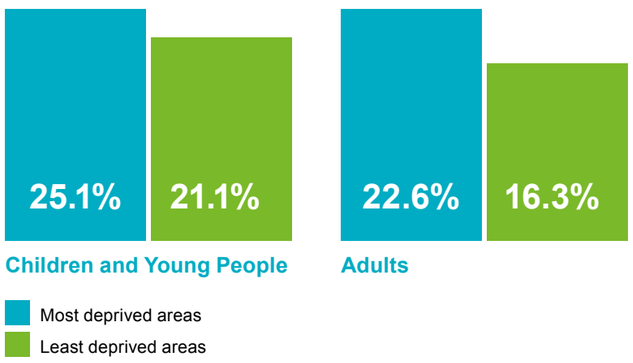
Our population

There are different mental health needs across localities, depending on population demographics. For example, there is a higher student population in North West Bristol, and a higher proportion of older people in Woodpsring.



Mental health in areas of deprivation

People with a mental health need are more likely to be living in the most deprived areas compared to those without.



Source: BNSSG System Wide Dataset Analysis.

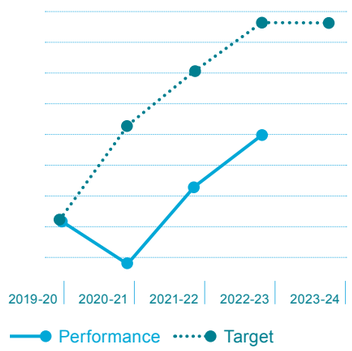
Where are we now?

Long Term Plan for mental health

In 2019, the NHS Long Term Plan (LTP) for mental health was published. This set out ambitious expectations for health systems across the country to deliver significant improvements in all age mental health and wellbeing over the next four to five years.

Significant progress has been made in improving our mental health offer over the past few years. Concentrated work has been completed in line with the NHS LTP, through working with key partners and with increased investment. This progress is demonstrated through our system's improved performance against some of the core national measures highlighted here.

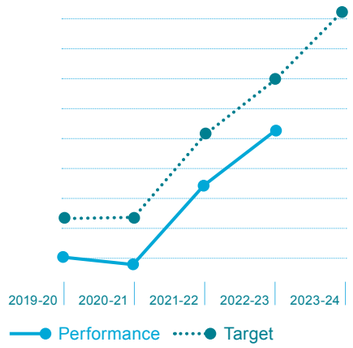
Perinatal Access



Data Source: MHSDS Digital Publication (Indicator MHS91). 2020/21 Performance impacted by Coronovirus Pandemic.

More than £2.7 million has been invested into improving perinatal mental health since 2019, and a brand new Maternal Loss and Trauma service was established in 2023.

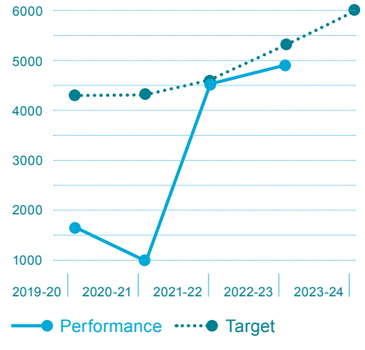
Children and Young People Access



Data Source: MHSDS Digital Publication (Indicator MHS95). 2020/21 Performance impacted by Coronovirus Pandemic.

By 2025 over 50% of school aged pupils in BNSSG will have access to early help delivered by a mental health support team in their school.

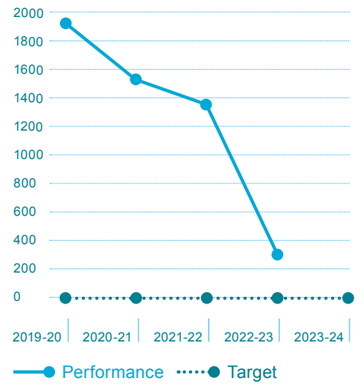
Physical Health Checks for people with Severe Mental Illness (SMI)



Data Source: NHS Stats Physical Health Checks SMI Publication. 2020/21 Performance impacted by Coronovirus Pandemic.

There has been collaborative work across primary and secondary care to help people with SMI access an annual physical health check. We have more work to do to make sure this happens every year.

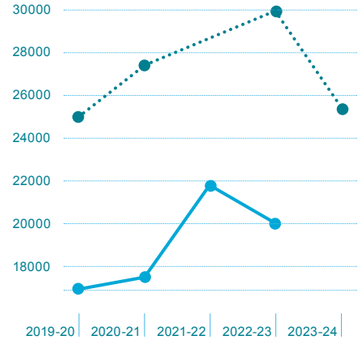
Out of Area Placements



Data Source: Out of Area Placements in Mental Health Services NHS Digital. 2020/21 Performance impacted by Coronovirus Pandemic.

Many staff across organisations in our system have worked intensively to bring people placed in out of area hospitals back to BNSSG to be near their families and communities. Our efforts mean that very few people are now placed out of area unless they have highly specialist needs that cannot be met by local services.

NHS Talking Therapies

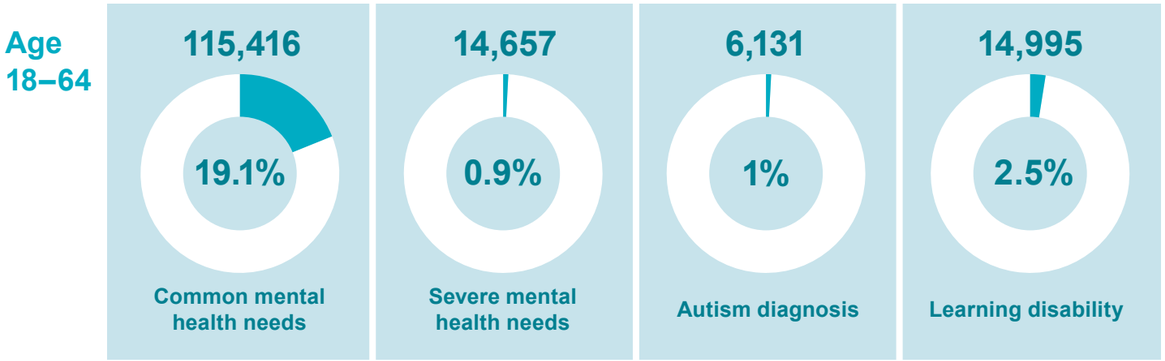


Data Source: Psychologoical Therapies, Reports on the use of IAPT services – NHS Digital (Indicatore MO31). 2020/21 Performance impacted by Coronovirus Pandemic.

As a system we are meeting multiple national NHS Talking Therapies targets, such as those which measure recovery from illness. The NHS Talking Therapies target measures the number of people able to get help from NHS Talking Therapies. Increasing the access to Talking Therapies has been difficult due to a combination of investment and transformation however we are planning to meet the target in 2023/24.

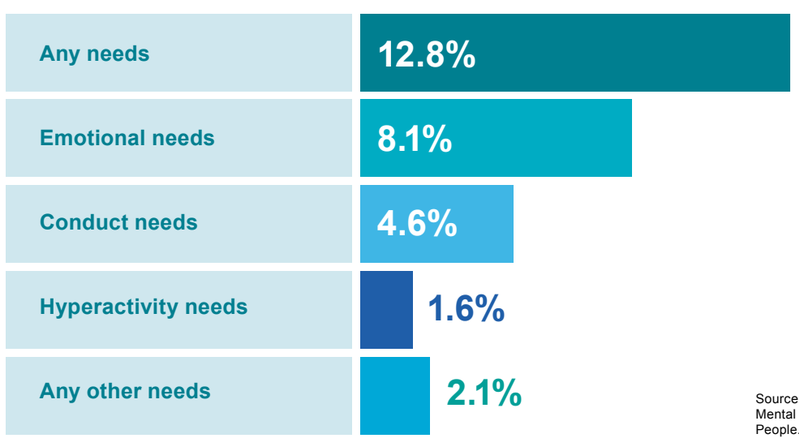
Whilst our system has made significant progress, the performance above also demonstrates that there is much further to go to meet our ambitions and improve care for our population. It is also significant that current national metrics have focused on measuring access to services. A vital part of our next steps as a mental health system will be to embed the measuring of meaningful outcomes and experience measures so that we know what is helping people of all ages the most in their recovery.

Estimated levels of mental health needs, learning disability and autism in adults across BNSSG



Source:
POPPI/PANSI, Institute of Public Care 2020

Estimated levels of metal health need among 5-19 year olds across BNSGG



Source:
Mental Health of Children and Young People. NHS Digital (2017, 2020)

Costs for adults (18+) with a mental health condition in BNSSG

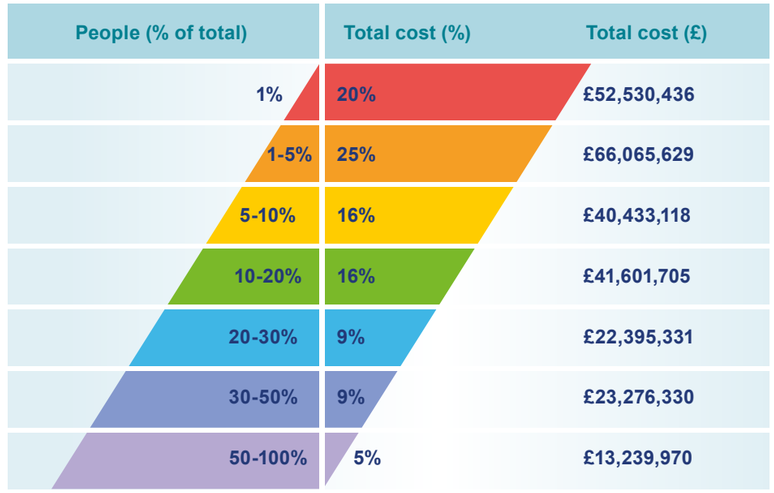
The pyramid diagrams below are designed to show how, currently, very large amounts of funding are spent on a small group of the most unwell people. Our ambition is to create a shift so that more money is invested in prevention to keep people well.

1% of the BNSSG population with a mental health condition flagged in Primary Care or in contact with mental health services account for **20%** of the total costs across the whole system.

For BNSSG this is 1609 people

Annual cost: £52.5m

Average cost per person of £32,648



Costs include admissions and attendances across primary, secondary and community care as well as prescribing (1 year, 2021/22). Some costs are Payment By Results (PBR), some are indicative. Maternity inpatient activity is included because it cannot be separated from outpatients using the system wide dataset

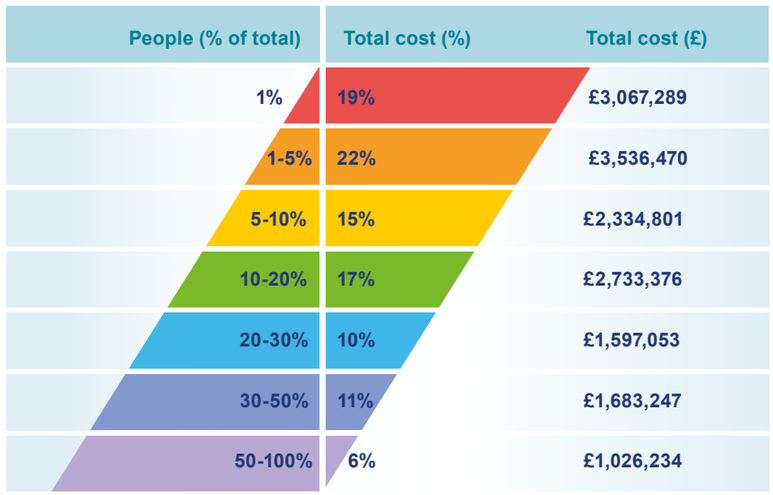
Costs for children and young people aged 0–17 with a mental health condition in BNSSG

1% of the BNSSG population aged between 0 and 17 with a mental health condition flagged in Primary Care or in contact with mental health services account for **19%** of the total costs across the whole system.

For BNSSG this is 116 people

Annual cost: £3m

Average cost per person of £26,442



Costs include admissions and attendances across primary, secondary and community care as well as prescribing (1 year, 2021/22). Some costs are Payment By Results (PBR), some are indicative. Maternity inpatient activity is included because it cannot be separated from outpatients using the system wide dataset. Kooth data is not included as no patient details available and OTR (Off The Record) data is limited as not all records have NHS numbers or costs, so some patients are not included.

Mental health cohort derived from primary care mental health flags, secondary care mental health inpatient stays or any referral or outpatient activity in MHSDS – all reasons, all services, including OTR where NHS number is available. learning disability and autism included.

Opportunity costs for our system

We have analysed examples of average costs within our system to understand what we could buy if we were able to stop using one mental health inpatient bed a year. The diagram below demonstrates that we must focus on prevention because we can help far more people with our resources through this approach.

For the cost for **1 mental health inpatient bed** each year we could pay for:

4 **people** to live in a **residential care home** for a year

6 **people** to live in **supported living accommodation** for a year

17 **people** to have a year round care package of **support at home**

93 **people** to have **Community Mental Health Team support** for a year

187 **people** to have access to a course of **high intensity talking therapies**

883 **people** to access **green social prescribing support**

Sources: AWP RiO, Bristol City Council Social Care purchasing system, BNSSG Green Social Prescribing Programme, VITA Health Talking Therapies Service. N.B. talking therapies is based on an average length of 9 sessions not including assessment.

Community Mental Health Framework

Following the Long Term Plan, the national Community Mental Health Framework for adults and older adults was published in 2019. It set out a fundamental change to the delivery of community mental health services for adults, and young people moving into adult services, with a vision for mental health services which are integrated, personalised and delivered close to home. In line with this vision, the framework also removes the requirement for the Care Programme Approach in favour of much more individual and goal focused care planning for everyone.

As an Integrated Care System we have:

Co-produced and implemented a First Episode Rapid Early Intervention for Eating Disorder (FREED) service and introduced a new Voluntary, Community and Social Enterprise (VCSE) partner, called Sweda, who deliver holistic support closer to home. This quickly offers people more holistic support and has reduced waiting lists by over 50%.

Co-designed, and started to deliver, an integrated model of care for people with difficulties associated with personality disorders, inclusive of complex emotional needs, to address the current gap in provision of specialist interventions at primary care level.

Started providing Mental health and wellbeing Integrated Network Teams (MINTs) for adults across BNSSG. These bring health, social care and VCSE partners together to meet people's diverse needs, offering access to the right mental health support at the right time.

Strengthened our community mental health rehabilitation team and introduced a flexible grants scheme, which has reduced the number of people requiring care outside our local area by 45%.

We have co-designed a new personalised, system based, care planning approach that focuses on creating a team around each person, with enhanced involvement of family and carers. We will use co-produced 'Support Conversations' to ensure that all agencies are working together to support people achieve the outcomes that are important to them.

Increased capacity in primary care, Avon and Wiltshire Partnership's Physical Health Teams and peer support roles to enable more people on GP Severe Mental Illness registers to receive an annual physical health check and have their physical health needs met. This increased provision from 12% (2021) to 62% (2023).

Introduced a range of mental health support accessible to people calling 999 or NHS 111 to make it easier for people to get the support they need when they may be becoming more unwell.

We still have more to do with our community mental health model, such as implementing the new community waiting time of four weeks from assessment to intervention. This will build on the positive progress we have already made.

Prevention concordat

The Prevention Concordat for Better Mental Health was published in 2017 and provides resources for local areas to take an evidence based approach to public mental health and prevention. The Concordat was updated in 2022 to reflect the impact of the COVID-19 pandemic on mental wellbeing. BNSSG Integrated Care System is committed to implementing evidence based prevention at every level of need.

Trauma-Informed System Approach

In January 2023, the Integrated Care Board employed a Trauma-Informed Systems Manager to lead on a programme of work looking to promote and embed trauma-informed practice across Bristol, North Somerset and South Gloucestershire. This programme has provided dedicated resource to further develop a shared language and trauma-informed approach to practice. This helps support organisations and different parts of the system to consider how to recognise and effectively respond to trauma and adversity experienced by individuals, families, communities and staff.

Children and Young People's policy context

Transforming Children and Young People's Mental Health Provision – a Green Paper outlined the Department of Health and Department of Education's commitment to improving and embedding new ways of working across our children's mental health services and education settings. The ambition within the Green Paper was to put schools at the heart of efforts to intervene early and placed significant emphasis on the role education could play in early identification and support.

There are synergies between the Green Paper and Public Health England's Best Start in Life and Beyond which outlines the role that school health nurses and health visitors have in supporting children, young people and their families with a particular emphasis on the high impact areas, one of which is supporting maternal and family mental health and early identification.

The Long Term Plan builds on the commitments within the Green Paper. As a result of this, additional funding and support has been utilised to develop mental health support in schools and colleges across BNSSG. Furthermore, the Long Term Plan has driven, and will continue to drive expansion and transformation.

Locally, significant work has already begun to achieve the aims of the Long Term Plan. This includes:

Mental Health Support Teams in Schools (MHSTs): BNSSG has completed three waves of MHSTs, with 10 teams now available across the geography, in locations which have been chosen on a needs-led based approach. At the end of 2022/23, MHSTs had delivered both individual interactions and wider engagement of the whole school approach in 115 schools.

Crisis: Our local Crisis Outreach and Intervention Teams have been expanded to provide additional support to children and young people presenting in crisis to our local hospitals. There is a 24/7 response line in place, enabling young people requiring a mental health assessment to receive one sooner, and ensuring that appropriate care is received. Furthermore the Crisis Teams provide additional support in the community to help prevent hospital admission and keep young people safe and well at home.

Eating disorders: The capacity of our Specialist Child and Adolescent Mental Health Services (CAMHS) and Acute Emergency Department eating disorder teams have been increased. Alongside this, the recruitment of a CAMHS Home Treatment Team to provide intensive support to children and young people in the community, helping keep them safe and well at home. There have been improvements in joint working across Bristol Royal Hospital for Children and CAMHS teams to ensure that young people are well supported regardless of the setting. This has been further developed through a pilot across the two organisations that helps to support young people in the community, who may otherwise require a specialist eating disorder bed.

Transition: Discussions are being held with key organisations across the system to scope transitions pathways for young people aged 16-25. This work is in its infancy but there is dedicated project management in place looking at options to improve the current pathway for children and young people, ensuring that their transitions are planned for and support is available when needed.

Significant transformation has already taken place across BNSSG, with plans to expand and build on this work to ensure that we are meeting the aims of the Long Term Plan and improve access and provision of services to our children and young people.

Changes to the Mental Health Act

The Mental Health Act 1983 is currently being updated to reflect a shift to less restrictive and more personalised care.

The key changes are expected to be:

People of all ages are detained for shorter periods of time, and only detained when absolutely necessary.

When someone is detained the care and treatment they get is focused on making them well.

People of all ages have more choice and autonomy about their treatment.

Everyone is treated equally and fairly, and disparities experienced by people from minority ethnic backgrounds are tackled.

People with a learning disability and autistic people are treated better in law, and reliance on specialist inpatient services for this group of people is reduced.

Whilst the legislation is still progressing through Parliament, it is clear there will be important implications for our system to consider, such as fully understanding the demographics of our inpatient population so we can target preventative approaches accordingly, as well as ensuring we have the best quality inpatient care and treatment.

Advancing equalities

In September 2020 the national Advancing Mental Health Equalities Strategy was published. It sets out the need for local systems to use a population health management approach to co-produce local solutions to health inequalities within mental health. As part of the Strategy, a Patient and Carer Race Equality Framework is now being rolled out nationally. The framework is a practical tool to help mental health trusts work with ethnic minority communities, and understand what steps the trusts can take to achieve practical improvements. An Equality and Diversity Workforce Improvement Plan covering all NHS services has also been published, setting the ambition of having a diverse and inclusive workforce at all levels.

Locally, we know we must ensure services are accessible to, and inclusive of, specific communities experiencing inequality of access, experience and outcomes. To do this we must improve data capture, embed training and establish culture changes. This will ensure everyone in our system understands the drivers and the impact of health inequalities. Furthermore, the compounding effects of intersection of different needs or characteristics.

> **“I feel like I am not taken seriously by doctors because I am black. I have to exaggerate for them to take what I am saying seriously and for them not to think it’s just because I am black”.**
>
> Young person, BNSSG young people’s Black Minds Matter group

Understanding local need

We have provided a snapshot of information about our local population. Further information can be found through our Local Authority Joint Strategic Needs Assessments for Bristol, South Gloucestershire and North Somerset as well as through ‘Our Future Health’ – the needs assessment supporting our Integrated Care System whole population Strategy.

Complex Multiple Disadvantage

We recognise that data and statistics cannot tell the full story. People who need mental health support will have a wealth of life experiences that impact their mental health. Some of these will be positive and support their mental wellbeing and some will result in trauma that can have a negative impact on mental health. For example, someone may have experienced trauma or domestic abuse which has caused them to be homeless and the impact of that trauma and homelessness may lead people to misuse drugs or alcohol to self-medicate. In addition, people from minority ethnic groups, people who are LGBTQIA+, people with learning or physical disabilities and neuro-divergent people are more likely to experience barriers in accessing mental health support. When they do access mental health support they tend to have a poorer experience and worse outcomes.

The data and needs analysis that we have done does not tell us about peoples real life stories and the complex difficulties that they experience. These experiences are not always well documented and different data sets look only at one kind of need or experience. Different aspects of people’s lives can intersect and compound their trauma and inequality; we want partners in the mental health support system to recognise and understand the complexities of the lives of people and, in so doing, better enable their recovery.

Our whole population

Around **one million** people live across BNSSG

Youngest population is in Bristol with an average age of

30

compared to age

46

in North Somerset and age

40

in South Gloucestershire

74.6 years — **83.2 years**

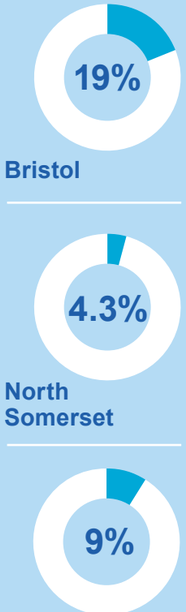
A man living in the most deprived area of Bristol typically lives 9.9 years less than a man living in the least deprived area.

80.3 years — **87.8 years**

A woman living in the most deprived area of North Somerset typically lives 7.9 years less than a woman living in the least deprived area.

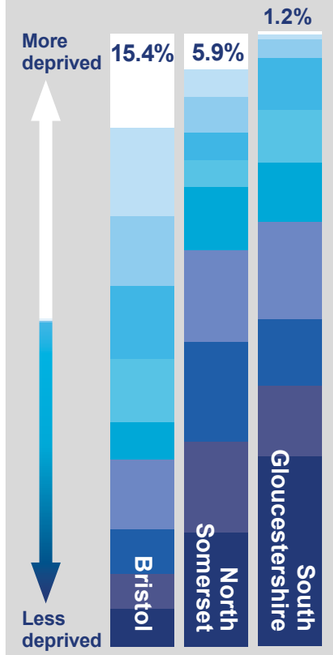
1 ICS | **3 Local Authorities** | **6 Localities**

Minority ethnic groups:



Index of multiple deprivation:

15.4% of people living in Bristol are in areas of high deprivation compared to 5.9% in North Somerset and 1.2% in South Gloucestershire



BNSSG Our Future health (ethnicity statistics updated from 2021 Census)

What do we want to achieve?

Our Integrated Care System vision is:

“Healthier together by working together”

People enjoying healthy and productive lives, supported by a fully integrated health and care system – providing personalised support close to home for everyone who needs it.

Our Integrated Care System vision for mental health is:

“Better mental health for all”

People having the best mental health and wellbeing in supportive, inclusive, thriving communities.

Our mental health ambitions

We are committed to the following priorities, based on the significant co-production to date.

Six ambitions:

1 Holistic care

People of all ages will experience support and care which considers everything that might help them stay well.

2 Prevention and early help

People of all ages, their families and carers will get the support they need in the right place and in a timely way, as early as possible.

3 Quality treatment

High quality treatment is available to people of all ages as needed, closer to home, so they can stay well in their local communities.

4 Sustainable system

We will have an economically and environmentally sustainable mental health system where maximum benefit is delivered to the community.

5 Advancing equalities

We will reduce health inequalities by improving equity of access, experience and outcomes throughout people’s lives.

6 Great place to work

We will have a happy, diverse, inclusive, trauma-informed and stable workforce across our system.

Underpinned by:
Working together to create the wider social and economic conditions to support positive mental health and wellbeing, including investing in a healthy start in life.

For each ambition we have started to develop plans to address them which are described on the following pages. These plans will be developed with further projects and detail added over the lifetime of the Strategy. We expect new information to be added to our Joint Forward Plan as it is refreshed annually. We have also described how we will know we have achieved each ambition; these descriptions all link to a metric that is being measured in the system either through the Long Term Plan, BNSSG ICS Population Outcomes Framework or through something we can qualitatively track.

We are proud of what we have achieved so far

Link Team
(Holistic care)

The Link Team supports people in Bristol who are street homeless and experiencing other challenges like addiction, domestic violence, learning disabilities or neurodiversity. The team bridges the gap ensuring mental health support gets to people, often for the first time in years.

They are a skilled multi-disciplinary team from organisations across Bristol. Support is person-centred and trauma-informed, meaning the team take time to understand a person's past, the social context of their experiences (such as racism), and how this affects their life now.

"He completely took the lead, made a workout plan, and directed the session. It was a great bonding opportunity that strengthened the relationship and also created some equalising of power through role reversal: I was asking questions, he had the answers."

Link team worker

Mental Health in Schools
(Prevention and early help)

AWP has worked with local charity, Off The Record, to provide Mental Health Support Teams in schools in Bristol, North Somerset and South Gloucestershire.

They provide interventions for young people with mild to moderate mental health needs, and help develop a whole school approach to mental wellbeing. This type of support is non-stigmatising for young people and less disruptive to education. Families are included as a key part of the support team and there is access to further services if needed. The service covers approximately half of our schools and colleges, based on need.

"OTR's intervention has had a huge impact – the students have been supported quickly and proactively, and at an early stage."

BNSSG teacher

Integrated Access Partnership
(High quality treatment)

The Urgent Assessment Centre is a pilot crisis service operating 7 days a week between 5pm - midnight. It provides a safe space for people in mental health crisis who are referred from 999, NHS 111 or emergency departments.

Offering holistic mental health assessments to understand needs during a crisis, it provides mental health coping skills, emergency support with housing and finance, and ongoing help. The service provides clear and planned recovery next steps, preventing people feeling alone in a period of crisis. This has meant reductions in police use, ambulance time and those waiting in an emergency department for mental health support.

"I think that it was just the fact that I didn't have to go into hospital. I felt like I could come here and it was a way of calming down without having to spend hours at the hospital for them not to do much. I feel a lot safer going home now."

UAC service user

Green Social Prescribing (GSP)
(Sustainable services)

The BNSSG ICS Green Social Prescribing partnership is one of seven pilot sites helping people access nature to improve health outcomes. Since 2021, more than 3,000 people have been supported to access the natural environment; ranging from mothers experiencing post-natal depression, school age children experiencing anxiety, working adults with low mood and older adults with dementia.

Whether it is care farming, woodland conservation, nature photography, horticulture therapy or open water swimming, there are a range of high-quality interventions available to support our community, which also make a positive contribution to biodiversity. We are also working to offer alternatives to prescribing anti-depressants.

"Wild swimming has helped significantly reduce the quantity and intensity of suicidal thoughts I was having."

Open water swimmer referred via primary care

Women's Health Training
(Advancing equalities)

Womankind and Missing Link, two local charities, were funded by the ICB to deliver women's health training.

The training supported mental health practitioners, staff and volunteers in the NHS and VCSE to better understand the barriers women face in accessing mental health support and the factors affecting their mental health throughout their life.

"Early autism diagnosis is needed to help people understand themselves and mitigate a crisis caused by masking."

Training participant

Staff Support Debriefs
(Great place to work)

Working in mental health services, staff can be exposed to events that can be very distressing and potentially traumatic for them. AWP has implemented Staff Support Debriefs to help staff affected by such situations.

The process involves AWP trained facilitators providing a voluntary session to any staff member affected by a traumatic event. During the session the staff can speak about the event, discuss the impact on them, receive information about trauma responses, and identify further sources of support that may be of benefit.

"It has felt very supportive and I am hopeful it will allow me to move forward without feeling so bad…"

AWP Staff Member

Our holistic care ambition

People of all ages will experience support and care which considers everything that might help them stay well.

What will we do to achieve this:

We will have Mental health and wellbeing Integrated Network Teams (MINTs) established across BNSSG. These teams include a wide range of NHS, local authority, talking therapies and voluntary sector providers. This will deliver a new community based offer including; access to psychological therapies, improved physical health care, employment support, peer support, green social prescribing, personalised and trauma-informed care, medicines management and support for self-harm and co-existing substance use.

These teams will use shared personal wellbeing plans called a 'Support Conversation'. These plans will replace the Care Programme Approach and will capture people's strengths and assets alongside their mental health needs.

We will aim to have the voluntary sector as an equal partner within all our models of care. This ensures that people of all ages get holistic support that is offered at an early point. It also ensures consideration of the social determinants of health such as housing, debt or social isolation.

We will continue to invest in targeted initiatives for groups of the population who are less likely to access physical healthcare, including a specific focus on addressing the mortality gap for people with severe mental illness.

We will ensure our models of care consider the needs of carers. For children and young people, services will consider the whole family and the role of education.

Where people are in an acute physical health hospital and require mental health support, we will ensure holistic care is delivered.

We will know we are making a difference when:

We have Mental health and wellbeing Integrated Network Teams (MINTs) fully established in every locality within BNSSG

Everyone with a severe mental illness has access to an annual health check.

The gap in premature mortality between people with severe mental illness and the general population starts to close.

People of all ages will report experiencing integrated care. We see indicators for crisis presentations reducing.

We will have a dedicated clinical lead for older adults, who is reviewing care pathways to ensure they are accessible to older adults with functional illness, who currently do not always get the support they need.

"Early autism diagnosis is needed to help people understand themselves and mitigate a crisis caused by masking."

Young person,
BNSSG Neuro diverse subgroup

70%

of people who sleep rough have a mental health need

Source: Bristol City Council

45%

of respondents to the latest national health needs audits for homelessness, reported using drugs or alcohol to help them cope

Source: Homeless Link 2022

Our prevention and early help ambition

People of all ages, their families and carers will get the support they need in the right place and in a timely way, as early as possible.

What will we do to achieve this:

There will be clear, publicly accessible information available describing what is available for people of all ages, families and carers close to where they live, work or study and effective signposting to sources of support across the system.

We will ensure we systematically monitor all waiting lists and wait times within the mental health system, including the wider impact of delayed care. We will consider both service re-design and investment to address long waits for support.

Our key NHS early intervention and early life services such as Child and Adolescent Mental Health Services (CAMHS), infant mental health services, specialist perinatal services and Early Intervention in Psychosis (EIP) will meet national performance expectations and will receive particular focus on embedding best practice models of care.

We commit to working together to create the wider conditions for good mental health, including early years work, mental health in schools, thrive approaches, social prescribing, access to employment, debt and housing advice.

We will ensure we work as a trauma-informed system, adapting services to reduce potential unintended negative effects on those who have experienced trauma.

We will develop a dementia Strategy which delivers equity of offer across BNSSG, and seeks to support early diagnosis.

We will know we are making a difference when:

Our NHS services which provide early intervention such as EIP, perinatal mental health (evidenced to improve babies outcomes) and CAMHS will meet or exceed all national NHS performance measures.

We see improvements in everyone's wellbeing.

People of all ages using early intervention or early help will report it is high quality and easy to access.

People of all ages experience service support as being timely.

All service waiting times are in line with national guidance.

We see self harm rates in young people reducing.

"At the moment it feels like you have to get iller to get help so you almost want to get worse to get help. This also creates a fear of getting better because you want to get better but you are scared of losing the support which is helping you if you do"

Young person BNSSG Helping Young People Engage (HYPE) group

During the pandemic

1 in 3

children lived with at least one parent reporting emotional distress

Source: Statistical commentary on UK Household Longitudinal Study wave 11

Our high quality treatment ambition

High quality treatment is available to people of all ages as needed, closer to home, so they can stay well in their local communities.

What will we do to achieve this:

As a system we will take a quality improvement approach to all services and projects. This means all projects and programmes will be required to state the evidence base they are using or, in the case of innovation, expecting to build on and have clear agreed evaluation points. Where there is no evidence base for a service or initiative, the system will refocus resource.

We will proactively work closely with housing providers and employers to support people to live as independently as possible, to improve overall mental health and improve outcomes in treatment and recovery.

We will continue to invest in crisis alternatives such as crisis houses and ensure these are integrated with our clinical support, as well as developing new initiatives such as our Integrated Access Partnership (mental health phone support available through calling NHS 111 or 999).

The ICB, local authorities and other relevant organisations in BNSSG will work with the South West Provider Collaborative (who manage child and adolescent mental health inpatient beds) to minimise the number of children admitted to inpatient settings. We will ensure that where children and young people need to stay away from home, this is as close to where they live as possible and in as homely an environment as possible.

We will use the opportunity of changes to the Mental Health Act, alongside embedding the learning from our local work, to ensure people who require inpatient care have high quality treatment and as short a stay as possible and are supported to be discharged as soon as they are well enough.

As a system we commit to implementing new approaches to working with people who have mental ill-health as part of wider multiple disadvantages.

We will know we are making a difference when:

We have embedded the use and monitoring of 'paired outcome measures' across our system which allow people of all ages using services, clinicians and the wider system to understand which support has most helped someone with their recovery.

Fewer people of all ages are placed in an acute bed outside of our local area.

Fewer people of all ages require an admission to an inpatient ward.

Fewer people of all ages experience a delayed discharge from an inpatient bed.

Fewer children and young people rely on emergency department support when in crisis. Our service models meet national best practice requirements. Our service models meet national best practice requirements.

"My mum can't speak English and when I go to health appointments with her, they don't take her seriously".

Young person, BNSSG young people's Black and Brown Minds Matter group

10%

of children and Young People in BNSSG who have regularly attended Accident and Emergency have done so because of a mental health need

Source: BNSSG System Wide Dataset Analysis 2023

Our advancing equalities ambition

We will reduce health inequalities by improving equity of access, experience and outcomes throughout people's lives.

What will we do to achieve this:

We will invest in our local community groups and grass roots organisations, working in partnership with them to deliver services and support.

We will create opportunities for community led groups to become involved in designing, delivering and evaluating services and grow their organisations.

All work undertaken within the BNSSG mental health system will clearly address health inequalities, and improve equity of access and outcomes.

Our NHS Talking Therapies service will offer specific activities to those previously not reached, enabling everyone in our population to access help early.

We will improve data capture across the system so that we fully understand where gaps in equity exist. This will include supporting our workforce to understand why capturing demographic information is so important. We will then use this data to set out targeted improvement plans.

Co-production will be a feature of all projects, encompassing both a range of partner organisations including Healthwatch as well as people of all ages and backgrounds, families and carers with lived experience. We will specifically seek to understand from people of all ages and backgrounds with lived experience what does or could have helped them stay well. This will also include paid progression opportunities and lived experience leadership roles.

We will have a diverse and inclusive workforce, representative of our population, and equipped with the skills and knowledge needed to address inequalities.

We will know we are making a difference when:

We can demonstrate impactful investment in our local communities.

We have good quality data flowing which lets us know if people of all ages with protected characteristics, or other measure of health inequalities such a socio-economic status, are achieving outcomes at the same level as the rest of the population.

Where inequity of access, experience or outcomes have been identified, there are targeted and time bound improvement plans, which are scrutinised by the ICB's Mental Health, Learning Disability and Autism Health and Care Improvement Group.

For every project in the system there is strong evidence of co-production and measurable action to address health inequalities.

1 in 7

LGBTQIA+ people have avoided health treatment for fear of discrimination

Source: Stonewall 2017

52%

of LGBTQIA+ people have experienced depression in the last 12 months

Source: Stonewall 2017

Around

1 in 5

women have a mental health problem

Source: Mental Health Foundation, 2021

3x

as many men as women die by suicide

Source: Mental Health Foundation, 2021

Black people are

3x

more likely than white people to be sectioned under the Mental Health Act

Commission for Equality in Mental Health, 2020

Our great place to work ambition

We will have a happy, diverse, inclusive, trauma-informed and stable workforce within our system.

What will we do to achieve this:

Alongside learning from the South West Workforce Forum, we will pilot new approaches to staff skill mixes ensuring people are able to use and develop their skills appropriately.

We will seek out proposals from staff about how their work could be done differently.

We will have a focus on staff wellbeing, such as providing staff with access to regular reflective practice and ensuring staff can be supported through experiences of trauma.

We will establish new development opportunities for staff at all levels, including the chance to access career development opportunities across healthcare organisations within BNSSG.

We will establish pathways for young people and adults with lived experience to progress into peer support roles and onwards.

We will actively work with regional and national workforce teams to understand what more we can do, as a system, to contribute towards addressing national workforce shortages.

We will know we are making a difference when:

An increased percentage of mental health staff say they are satisfied with the quality of care they provide.

An increased percentage of mental health staff would recommend their organisation as a place to work.

An increased percentage of mental health staff say they feel their role makes a difference to the people they support /care for.

The health and wellbeing of our staff improves.

We can see more staff from under-represented groups are progressing to senior roles.

There is an increase in lived experience recruitment and progression, to ensure we are making the most of the significant contribution people with experience of mental health services can bring to the workforce.

Spend on agency across the system reduces and is in line with national benchmarks.

Recruitment and retention rates improve and are above national benchmarks.

“You need to create more conversation around these jobs – what makes them good and what impact do they have? Then more people would want to go into these roles and you might get a more diverse workforce”

Young person BNSSG Helping Young People Engage (HYPE) group

78%

is the gap between the employment rate for people in contact with secondary mental health services and the overall employment rate in the South West.

PHE 2021

Our sustainable services ambition

We will have an economically and environmentally sustainable mental health system, where maximum benefit from our actions and services is delivered to the community.

What will we do to achieve this:

We will consider the short and long term social, economic and environmental impact of all investment decisions within our system and act proportionately to address any negative impacts identified.

We will ensure mental health is fully considered in our ICS Digital Strategy, maximising opportunities for digital innovation to improve the efficiency of integrated working for our partners, and reduce the need for people of all ages to repeat their stories.

We will ensure people of all ages have a range of options for accessing services both virtually and in person based on individual needs. For many people, a virtual offer can be more convenient. It also is better for the environment, as well as helping us retain staff who want to work flexibly. Other people may experience digital poverty or may prefer a face-to-face option and so this will also need to be available as close to public transport routes as possible.

We will ensure our new co-created support plans will be shared with people directly via Digital Patient.

We will have sustainable contracting approaches that offer longer term funding, to allow partner organisations to be committed to transformation and support their staff retention. Any procurement exercise will fully consider environmental and social impact as key elements.

We will require new contracts to include commitments to address the climate emergency.

We will know we are making a difference when:

As a system, we can demonstrate the wider social and environmental impact of our services.

We have a clear commissioning and contracting plan supporting the sustainability of our whole system.

We have digital solutions which allow rapid information sharing across partners.

Providers can evidence that they have reduced their carbon footprint.

Providers can evidence local recruitment.

Providers can evidence use of local supply chains.

“Accessing mental health support should be easy – where to start, who to contact. It should be as simple as calling 999 is when there’s an emergency”

Independent Futures (lived experience) group member

£105 billion per year

is the estimated economic and social cost of poor mental health

PHE 2018

Next steps

Forming an Integrated Care System (ICS) represents the best opportunity to deliver urgently needed transformation of our health and social care system. The ICS provides the opportunity to break out of organisational silos, enabling all partners to work together to tackle deeply rooted challenges, drawing together their collective skills, resources and capabilities.

Five key principles which will allow our ICS to thrive:

1	2	3	4	5
Collaboration within and between systems and national bodies	A limited number of shared priorities	Allowing local leaders the space and time to lead	The right support, balancing freedom with accountability	Enabling access to timely, transparent and high-quality data

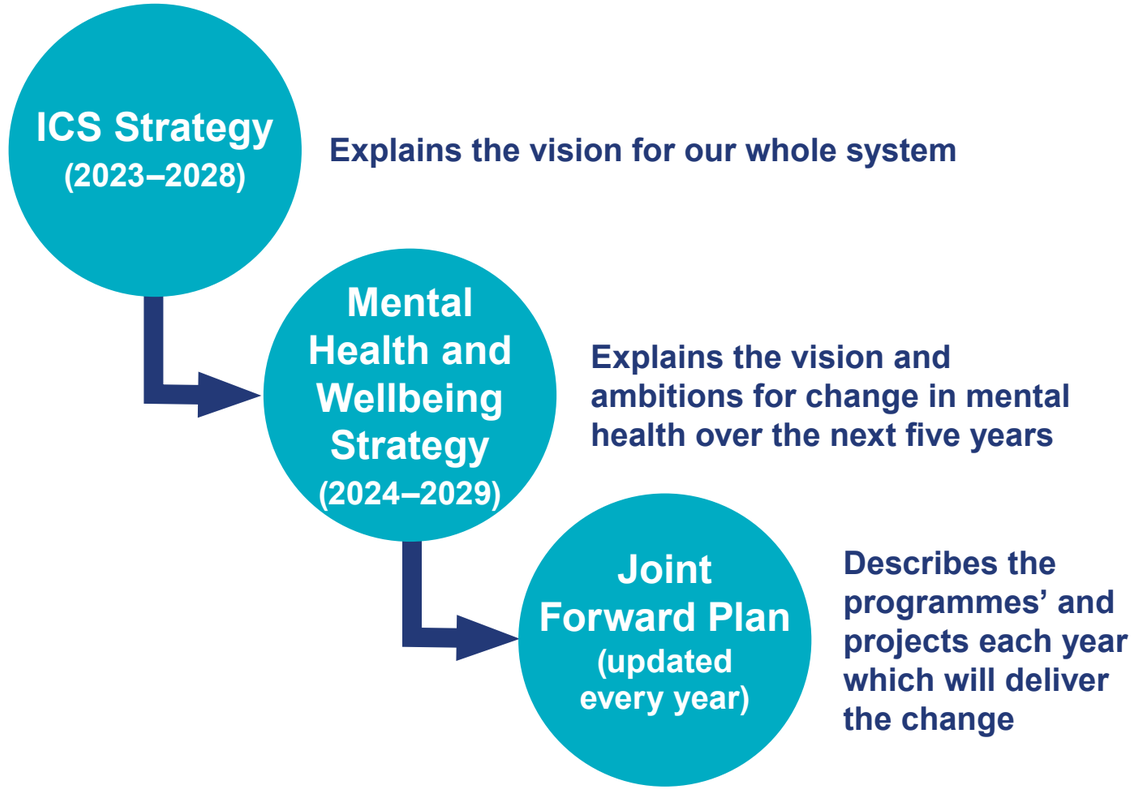
Locally we are absolutely committed to the transformative power of working together to deliver change. There is a Mental Health, Learning Disabilities and Autism Health and Care Improvement Group which oversees the delivery of the vision, ambitions and priorities set out within this Strategy. The Health and Care Improvement Group includes representatives from partners across our system. There is also a Children's Health and Care Improvement Group which provides additional scrutiny on the delivery of work to improve mental health access and outcomes for children and young people.

During 2024–25, the Mental Health, Learning Disabilities and Autism Health and Care Improvement Group will oversee the production of plans to deliver our ambitions. These will form our five year Joint Forward Plan. Each year, our Joint Forward Plan will be updated to demonstrate the progress we have made and include further detail on the projects which will be delivered in that year to meet our aims.

Delivering this Strategy will also require all partners to commit support for key projects, so that we can take a system approach to workforce planning, digital, estates and quality improvement, to make the best use of all our resources.

When all organisations in our system work together to deliver change, the impact can be transformational.

How will the Strategy be delivered?



Glossary

TERM	DEFINITION
Acute care	Acute care is where a patient receives active, short-term treatment for a condition, often staying in hospital.
Assets	This describes things which can support good mental health and wellbeing, such as family, community relationships, social networks, community and neighbourhood services, activities and facilities.
Autonomy	Autonomy is about a person's ability to act on their own values.
BNSSG	Bristol, North Somerset and South Gloucestershire.
Care Programme Approach	A way to create a plan for someone's care and support in secondary mental health services, usually using a standard set of documents. This approach is due to be replaced by new care planning approaches being developed by the Community Mental Health Framework Programme.
Co-produced/Co-owned	This describes how we work with people who use our services to make sure care and the way it is delivered meets their needs, rather than providers deciding this on our own.
Digital innovation	This is about new technologies such as software programmes, apps or use of mobile phones, tablets or computers.
Equalities	Ensuring people have equal rights and opportunities.
Green Social Prescribing	A national programme offering people the opportunity to access wellbeing activities outside and in nature in order to support their mental health and meet other people.
Health and Care Improvement Group	The name of a meeting of different organisations from across BNSSG who come together to make decisions about health and care services in the area. The two Health and Care Improvement Groups most relevant to this document are the Mental Health, Learning Disability and Autsim Health and Care Improvement Group, and the Children and Young People's Health and Care Improvement Group.
Holistic care	A holistic approach means to provide support that looks at the whole person, not just their mental health needs. The support should also consider their physical, emotional, social and spiritual wellbeing.
ICS	Stands for Integrated Care Systems. 42 of these were set up across the country. They are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. Our local ICS is BNSSG.
Inequalities	The state of not being equal, especially in status, rights, and opportunities. We know that some groups of our population currently find it harder to access mental health services than others.
Inpatient care	When a patient is being cared for in hospital rather than at home.
Integrated	Where people work together to deliver something.
Joint Forward Plan	A five year document that every healthcare system is required to produce to describe how they will deliver improvements in local services. It is refreshed annually.
Joint Strategic Needs Assessment	Joint Strategic Needs Assessments are documents held by local public health departments within Local Authorities which set out what the health and social care needs of a local area are.
Legislation	The process of making or enacting laws.
Lived Experience	The knowledge people gain from treatment or going through services. This provides invaluable insight to what services are like for the patient.
Local Authority	A Local Authority, commonly referred to as a Council, is the government body responsible for delivering local services in an area.
Locality Partnership	These are groups of providers and wider partners working together at a local level to delivery care specific to the needs of local populations. In BNSSG there are 6 Locality Partnerships; North & West Bristol, South Bristol, Inner City & East Bristol, South Gloucestershire, Woodspring, Worle & Villages and Weston (both of which are in North Somerset).
Long Term Plan (LTP)	The NHS Long Term Plan 2019-2024 was a policy document published to provide guidance to local areas about the improvements expected in mental health services during this time.
Mental health Integrated Network Team (MINT)	A new type of team around primary care bringing together NHS, social care and voluntary sector organisations (VCSE) to offer quick access to a broad range of support.
Paired Outcome Measures	Tools which are used to understand changes in mental health and wellbeing. Often a set of questions completed at the start and end of a period of support or treatment to understand how much it has helped.
Peer Support	People who have experienced services are uniquely placed to support others who follow in their footsteps, they can explain what to expect and how they felt whilst under the care of a service.
Personalised care	This means service users have choice and control over the way their care is planned and delivered.
Mental Health Act	The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.
Primary care	Healthcare provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment.
Recovery focused	This means working with people to target ways to help their mental ill health get better and achieve the things they want to do as they improve.
Safeguarding	protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility.
Secondary care	This refers to services being provided by health professionals who generally do not have first contact with a service user for example, a hospital rather than a GP surgery.
Severe mental illness (SMI)	Historically Severe Mental Illness was a term used to refer to people who experienced psychotic illnesses, where people may see or hear things which are not real, and/or struggle to think or act clearly. Often, when this term is used for national targets or in data this is the group being referred to. GP 'SMI' registers also only record people who have a psychotic illness. However, the Community Mental Health Framework, introduced in 2019, has widened the scope of the term and has used it to mean a much wider group of conditions and needs using the following definition: "SMI covers a range of needs and diagnoses, including but not limited to; psychosis, bipolar disorder, 'personality disorder' diagnosis, eating disorders, severe depression and mental health rehabilitation needs – some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use".
Social determinants of health	The things outside of our biology which can affect our physical and mental health such as housing, debt, social isolation.
Sustainable	Something that is able to be maintained at a certain level.
Trauma-informed	A program, organisation, or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in individuals, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist retraumatisation. In BNSSG we have adopted 6 trauma-informed principles that underpin our approach: Safety, Trustworthiness & Transparency, Choice & Clarity, Collaboration, Empowerment and Inclusivity.
Voluntary Community and Social Enterprise (VCSE) sector	Organisations which deliver services but do not seek to make a profit from these services. Often services will be free to access but where there is a charge this money will be reinvested into delivering the organisations social or charitable aims.

Metrics to be used to measure impact against priorities

DOMAIN	WE WILL KNOW WE ARE MAKING A DIFFERENCE WHEN	CODE	INDICATOR
Holistic Care	Integrated personalised care teams are established in every locality within BNSSG.	HOL1 HOL2	Number of Primary Care Networks in your system meeting the data flow criteria for transformation. Activity within community mental health services for adults and older adults with severe mental illnesses.
	Everyone with a serious mental illness has access to an annual health check.	HOL3	People with severe mental illness receiving a full annual physical health check and follow up interventions (rolling 12 months).
	We see indicatiors for crisis presentations reducing.	HOL4 HOL5	Rates of total Mental Health Act detentions Rates of restrictive interventions.
	We see the gap in premature mortality between people with serious mental illness and the general population close.	HOL6 HOL7	Severe mental illness mortality gap close. Rate of suicide deaths (persons rate/100K).
	People using services report satisfaction with the practical help they receive.	HOL8	Proportion of DIALOG question 10 responses from 5-7 (fairly, very or totally satisfied).
	People using services report satisfaction with their meetings with mental health professionals.	HOL9	Proportion of DIALOG question 11 responses from 5-7 (fairly, very or totally satisfied).
	People of all ages will report experiencing integrated care.	HOL10	To be developed.
Prevention & Early intervenion	All our NHS mental health services will meet or exceed all national access and wait time standards.	PRE1	A new national approach to monitoring community mental health service waiting times has been released and provisional reporting in place. No wait time expectations have yet been set. We are working on reporting these locally.
	We see improvements in everyone's mental wellbeing.	PRE2 PRE3	ONS wellbeing 4 domains (% low happiness score). CYP Warwick-Edinburgh Wellbeing Score (proportion scoring very low/low.
	People of all ages using early intervention or early help will report it is high quality and easy to access.	PRE4	Adult mental health services use a Patient Reported Experience Measure to check peoples views of services.
	We see self harm rates in young people reducing.	PRE5 PRE6	Self-reported harm in young people . Hospital admissions as a result of self-harm (10-24years).
High Quality Treatment	We have embedded the use of 'paired outcomes measures' across our system which allow people of all ages using services, clinicians and the wider system to understand what support has helped someone with their recovery.	QUA1	Positive change in DIALOG between paired scores for questions 1-8.
	Services demonstrate helping people feel better.	QUA2	Talking Therapies recovery rate.
	Our service models meet national best practice standards.	QUA3 QUA4 QUA5 QUA6 QUA7	EIP services achieving Level 3 NICE concordance. Mental Health Liaison services within general hospitals meeting the "core 24" service standard. Coverage of 24/7 adult and older adult Crisis Resolution and Home Treatment Teams operating in line with best practice. Proportion of discharges from adult acute beds eligible for 72 hour follow up – followed up in the reporting period. Coverage of 24/7 crisis provision for children and young people (CYP) that combine crisis assessment, brief response and intensive home treatment functions.
	Fewer people of all ages are placed in an acute bed outside of our local area.	QUA8	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days for adults requiring non-specialist acute mental health inpatient care.
	Fewer people of all ages require an admission to an acute ward.	QUA9	Mental Health Acute admissions - adult and children.
	Fewer people of all ages experience a delayed discharge from an inpatient bed.	QUA10	Mental Health Trust Reporting.
	Fewer children and young people rely on Emergency Department support when in crisis.	QUA11	Mental Health A&E attendance for children and young people.
Advancing Equalities	We can demonstrate impactful investment in our local communities.	EQU1	We will analyse data from indicator QUA1 by locality and provider.
	We have good quality data flowing which indicates people of all ages with protected characteristics or other measure of health inequalities such a socio economic status are achieving outcomes at the same level as the rest of the population.	EQU2	Mental Health Services Dataset - Data Quality Maturity Index Score.
	Where inequity of access, experience or outcomes have been identified there are targeted and time bound improvement lans which are scrutinised by the Healthcare Improvement Group.	EQU3	Project documentation.
	For every project in the system there is strong evidence of co-production and measurable action to address health inequalities.	EQU4	We will monitor the following five indicators by age, sex, deprivation and ethnicity as a minimum: HOL3 HOL4 HOL5 PRE1 QUA2
Great place to work	An increased % of staff say they are satisfied with the quality of care they provide.	STA1 STA2 STA3	% of NHS staff who say they are satisfied with the quality of care they give to patients/service users. % of NHS staff who say their role makes a difference to patients/service users. Proportion of staff recommending their organisation as a place to be treated or cared for.
	We will improve the health and wellbeing of our staff.	STA4 STA5 STA6 STA7 STA8	Sickness absence rates - working days lost to sickness. Sickness absence rates - annual average. Vacancies. % of NHS staff who say their organisation takes positive action on health and wellbeing. Average reported health and wellbeing (emotionally exhausting, burn out, frustration, exhaustion, tired, time for friends and family).
	Increase in staff who are from underrepresented groups progressing to senior roles.	STA9	There are four data sources we can use to monitor different staffing groups.
	Increase in Lived Experience recruitment and progression to ensure we are making the most of the significant assets people with lived experience can bring to the workforce.	STA10	In development.
	Spend on agency across the system reduces and is in line with national benchmarks.	ST11	In development.
	Recruitment and retention rates improve and are above national benchmarks	STA12	In development.
Sustainable System	As a system we can demonstrate the wider social and environmental impact of our services.	SUS1	In development.
	We have a clear commissioning and contracting plan. supporting the sustainability of our whole system.	SUS2	In development.
	Providers can evidence use of local supply chains.	SUS3	In development.
	Providers can evidence that they have reduced their carbon footprint.	SUS4 SUS5	Measure annual carbon emissions across all scopes. Total financial cost to the system if we were to off-set our carbon emissions at £75 per tonne (all scopes).
	We have a digital solution/s which allow rapid information sharing across partners .	SUS6	Number of staff across different providers using the single mental health patient administration system In development.
	Providers can evidence local recruitment.	SUS7	In development.

Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

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Bristol, North Somerset and South Gloucestershire Integrated Care System All Age Mental Health and Wellbeing Strategy 2024-2029

Our vision

Our vision is better mental health for all. People having the best mental health and wellbeing in supportive, inclusive, thriving communities. Our Strategy describes what we will do to achieve this.

The strategy is 'all age' meaning it covers mental health and wellbeing for our whole population from conception to end of life.

It covers the whole mental health spectrum regardless of whether people have had a formal mental health diagnosis. From people who have good wellbeing, to those who might need more intensive support.

It considers where people may have mental ill health alongside other needs such as learning disabilities, autism or neurodiversity.

It has been co-produced in collaboration with people who have mental ill-heath, and staff in organisations who provide support and treatment, incorporating their valuable insight and experiences.

Where are we now?

Good progress has been made in improving mental health support and care in recent years.

However, we know that there is still much more to do to make sure that everyone gets the support they need, when they need it. Our Integrated Care System gives us the opportunity to work even more closely to help make improvements for people.

How will we get there?

We have chosen six priority areas to help us achieve our vision of 'better mental health for all'. In our full strategy document each of six ambitions has a set of actions that will be taken to support the improvement of our systems' mental health services.

Six ambitions:

1 Holistic care

People of all ages will experience support and care which considers everything that might help them stay well.

2 Prevention and early help

People of all ages, their families and carers will get the early support they need in the right place and in a timely way, as early as possible.

3 Quality treatment

High quality treatment is available to people of all ages as needed, closer to home, so they can stay well in their local communities.

4 Sustainable system

We will have an economically and environmentally sustainable mental health system that delivers maximum benefit to the community.

5 Advancing equalities

We will reduce health inequalities by improving equity of access, experience and outcomes throughout peoples' lives.

6 Great place to work

We will have a happy, diverse, inclusive, trauma-informed and stable workforce within our system.

Underpinning principle: Working together to create the wider social and economic conditions to support positive mental health and wellbeing, including investing in a healthy start in life.

How will we know we have been successful?

We have identified ways to measure impact for each action so we can know whether we are driving positive changes. As a system, we will develop an annual 'Joint Forward Plan' which will be aligned to the ambitions within our strategy and will include more detail on how we will deliver change.

When all organisations in our system work together to deliver change, the impact can be transformational.

Bristol Health and Wellbeing Board

Title of Paper:	**Update to review/development of the Joint Forward Plan**
Author (including organisation):	**Cintia Faria, Integrated Care Board**
Date of Board meeting:	**28th February 2024**
Purpose:	Information and discussion

1. Purpose of the Paper

To provide an update to the process being completed to review and update the Integrated Care System (ICS) Joint Forward Plan (JFP), giving opportunities to all members of the HWB to feedback and contribute as appropriate, evidencing partnership and system-working.

2. Background, evidence base, and what needs to happen

The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England, and their partner NHS trusts and foundation trusts, to produce and publish a Joint Forward Plan (JFP). As well as setting out how the ICB intends to meet the health needs of the population within its area, the JFP is expected to be a delivery plan for the integrated care strategy of the local Integrated Care Partnership (ICP) and relevant joint local health and wellbeing strategies (JLHWSs), whilst addressing universal NHS commitments. As such, the JFP should provide a bridge between the ambitions described in the Integrated Care Strategy developed by the ICP and the detailed operational and financial requirements contained in NHS planning submissions.

The national guidance and principles for development of the Joint Forward Plan includes:

a) The need to be fully aligned with wider system ambitions
b) Supports subsidiarity by building on existing local strategies and plans, as well as reflecting the universal NHS commitments.
c) Delivery focused, including specific objectives, trajectories, and milestones.

The approach we are taking to develop the next iteration of our plan include:

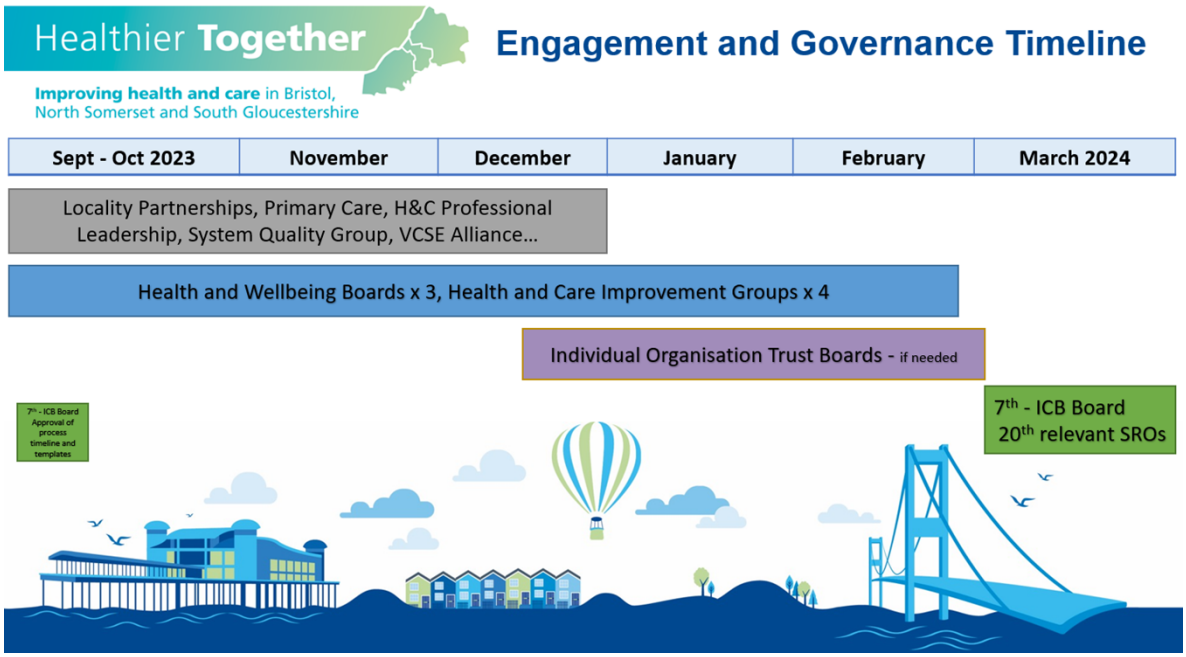
a) Alignment with system operational planning process.
b) Take opportunity to address feedback and lessons identified. We will reduce the contents of the JFP to be published, using a **visual format** that is easier for the public to read and understand; Include an explanation on **how** the plans will **benefit the population** with the new template provided by the planning team)
c) Focus on 5-year deliverables, trajectory and metrics, including assessment of first year delivery (partial assessment due to constraint timeline, update the original table for deliverables and metrics so it can be used internally for planning purposes).
d) Ensuring clearly articulated alignment with **BNSSG strategy, 4 ICS aims** and how plans will support the **outcomes framework**

All the risks, issues, mitigations and opportunities within each plan should be managed within the relevant programme Board, with oversight from the relevant Health and Care Improvement Group. Relevant risk assessments were completed as part of each Programme plan. Please note that all the ICS Programmes are expected to have completed and approved any risk assessment as appropriate. The ICB also provide support for Quality and Equality Impact Assessments. Opportunities to discuss interdependencies and integration between relevant plans delivered by different partners was facilitated by the ICB Planning team at the Planning Day event on 20th November 2023, with a further session facilitated on the 20th of February 2024.

3. Community/stakeholder engagement

The ICB is required to consult with the relevant Local Authorities and health and wellbeing boards, before completing the updates and the review cycle of the JFP every financial year. Please note that the engagement with HWBs has been ongoing throughout the entire process as represented below.

Public consultation is only required if the ICB or its partner trusts are considering a significant change to the plans, therefore, we do not anticipate this to require full formal public consultation. All previous local patient and public engagement exercises and subsequent action have informed the existing JFP, and we anticipate that each programme will continue to complete the relevant consultation required as part of their transformation plans in order to comply with the Public Sector Equality Duty. The Joint Forward Plan also takes account of the Section 149 of the Equality Act 2010 and the NHS Act 2006.



4. Recommendations

It is recommended that HWB members review and provide feedback once the JFP is finally collated and shared with the relevant HWB members (probably by email due to the timescales by March 2024). The Health and Wellbeing Board is welcome to add a sentence to the updated JFP to reflect how the JFP takes proper account of each JLHWS published, a statement of this consultation will be very welcome and should then be included in the updated JFP as appropriate. Any contribution can be sent to the ICB the planning team before the end of February 2024, please email: bnssg.planning@nhs.net

5. City Benefits

There are opportunities within the whole JFP to achieve the 4 aims of the ICS:

a) **Improve outcomes** in population health and health care
b) **Tackle inequalities** in outcomes, experience and access
c) **Enhance productivity** and value for money
d) Help the NHS support **broader social and economic development.**

The JFP include plans to address inequalities in outcomes, experience and access to healthcare. Identifying, understanding, and addressing the drivers of health inequalities within our diverse population is a fundamental reason as to why the System Strategy has been developed.

Within the JFP, there is a chapter dedicated to the System's sustainability, which includes the plan to improve the environmental impact, recognising the pressing urgency to address our carbon footprint, air pollution and the quality of the natural environment. Plans are split into a few workstreams including procurement, estates, travel, transport and air quality, waste and Medicines Optimisation.

The plans are aimed to improve the social impact of health and social care within the system, improving people's wellbeing and health outcomes. The economic implications of the financial and workforce pressures are reflected in the plans with extra narrative provided under the relevant (finance) section.

6. Financial and Legal Implications

All the plans included in our Joint Forward Plan have gone through the relevant System governance route, including Programme Boards, Operational or Oversight Delivery Groups, Health and Care Improvement Groups, System Directors of Finance, etc. Therefore, no financial implications are expected. Please note all decisions made for investment would also have gone through the ICB Board, where Local Authorities are key members.

Bristol, North Somerset and South Gloucestershire Integrated Care Board

Bristol Health and Wellbeing Board

Title of Paper:	Annual Health Protection Report for Bristol
Author (including organisation):	Ashley Bryant, BCC Jessica Horner, BCC Julie Northcott, BCC
Date of Board meeting:	28th February 2024
Purpose:	Oversight and assurance

1. Executive Summary

This annual health protection report covers the period 1st April 2022 to 31st March 2023 (financial year 2022–23). The report provides an overview of health protection in Bristol, highlighting areas of success and key risks requiring priority action for each of the following 11 areas:

- Immunisation
- Screening
- Sexual health
- Healthcare Acquired Infections and Antimicrobial resistance
- Tuberculosis
- COVID-19
- Environmental Health
- Global population health
- Asylum Seeker and Refugee health
- Non-communicable environmental health risks
- Emergency preparedness, Resilience and Response

Key successes and priorities in 2022/23

- Successful continued delivery of COVID-19 vaccination and infection prevention and control across Bristol.
- Abdominal Aortic Aneurysm (AAA) screening and breast cancer screening offer no longer impacted by COVID backlog, however staffing and capacity have impacted delivery of screening functions.
- Tackling the increase of gonorrhoea and STI cases.
- Decreased cases of Clostridium difficile, E.coli, pseudomonas aeruginosa and Klebsiella.

Key priorities for coming year

- To increase uptake of vaccines (child immunisations, flu, COVID-19) and cancer screening offer.
- To focus on recovering the backlog of food inspections.
- Continue to strengthen our preparedness by re-establishing the Local Health Resilience Partnership in light of system level changes.
- Undertake a rapid review of TB for a robust understanding of Bristol's position and need.
- Undertake the recommissioning of integrated sexual health services.
- Increasing screening uptake with a focus on inequalities.

2. Purpose of the Paper

This assurance report provides information to the Health and Wellbeing Board of infectious diseases and environmental hazards across Bristol. It gives detail on key areas of work being undertaken to protect the health of Bristol's population.

3. Background, evidence base, and what needs to happen

Health protection covers an extensive range of exposures, risks, and disease – from air quality to port health, and cancer screening to tuberculosis.

The annual report gathers data from a variety of national and local sources to present an overview of the performance of the city in addressing health protection issues and measures against national and regional targets in line with published strategies. This enables the Health Protection Committee to agree recommendations for a workplan for the coming year across the partnership.

4. Community/stakeholder engagement

Contributions to this report came from the BCC Health Protection team and the wider BCC Public Health team, BCC Environmental Health, BCC Civil Protection, The Office for Health Improvement and Disparities and the UK Health Security Agency (two organisations that replaced Public Health England), the BNSSG ICB (which replaced the BNSSG CCG), and NHS England. The report has been ratified by the Bristol Health Protection Committee and will also be shared with the BNSSG ICS.

5. Recommendations

This report enables the Director of Public Health to provide assurance to the Health and Wellbeing Board (H&WB), that the health of the residents of Bristol is being protected in a proactive and effective way.

The board is asked to approve the report and the approach we are taking.

6. City Benefits

The health protection actions enable the population to be protected from infectious diseases, identify cancer at an early stage and address health emergencies, among other benefits.

Addressing inequalities and inclusion health is an integral part of protecting the health of the whole population.

7. Financial and Legal Implications

Not applicable.

8. Appendices

The full report is available as a separate supplement.

Bristol Health Protection Annual Report 2023

April 2022 to March 2023

Report date: February 2024

Report authors: Ashley Bryant, Public Health Practitioner Apprentice, Bristol City Council

Jessica Horner, Public Health Practitioner Apprentice, Bristol City Council

Contents

Acknowledgements

Our thanks go to Julie Northcott and Monica Koo for their guidance and support in producing this report. Thanks also to the member of the Bristol Health Protection Committee and programme leads for their time and contributions to the report.

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Jessica Horner, Public Health Practitioner Apprentice

08 February 2024

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Acronyms

AAA	Abdominal Aortic Aneurysm
ACH	African and Caribbean Heritage
AMR	Antimicrobial Resistance
AQMA	Air Quality Management Area
ARAP	Afghan Resettlement and Assistance Policy
ASR	Asylum Seeker and Refugees
BBV	Blood Borne Virus
BCC	Bristol City Council
BCG	Bacillus Calmette-Guerin
BDP	Bristol Drugs Project
BNSSG	Bristol, North Somerset and Gloucestershire
BPHA	Bristol Port Health Authority
BSI	Bloodstream infections
CAZ	Clean Air Zone
CCG	Clinical Commissioning Group
CDI	Clostridium difficile (C. difficile) infection
CIPFA	Chartered Institute of Public Finance and Accountancy
COVID-19	Coronavirus

DEFRA	Department for Environment Food & Rural Affairs
DfE	Department for Education
DTaP-IPV	Diphtheria, Tetanus and Pertussis - Inactivated Polio Virus
EHO	Environmental Health Officer
EPRR	Emergency preparedness, resilience and response
FSA	Food Standards Agency
HAZMAT	Hazardous Materials
HCAI	Healthcare associated infections
HEAT	Health Equity Assessment Tool
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ICB	Integrated Care Board
IPC	Infection, Prevention and Control
JCVI	Joint Committee on Vaccination and Immunisation
JSNA	Joint Strategic Needs Assessment
LHRP	Local Health Resilience Partnership
LMIC	Low-Medium Income Country
MenACWY	Meningitis ACWY vaccine
MDR	Multi Drug Resistant
MMR	Measles Mumps and Rubella
Mpox	Monkeypox
MRSA	Methicillin Resistant Staphylococcus Aureus
MSM	Men that have sex with men
MSSA	Methicillin-Sensitive Staphylococcus aureus
NBT	North Bristol Trust
NHSE	NHS England
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
PHE	Public Health England
PPV	Pneumococcal vaccine
PrEP	Pre-exposure prophylaxis
PTSD	Post Traumatic Stress Disorder
PWID	People Who Inject Drugs
RSHE	Relationships and Sexual Health Education
SARS	Severe Acute Respiratory Syndrome
STI	Sexually Transmitted Infections
SW	South West region
TB	Tuberculosis
ToR	Terms of Reference
UHBW	University Hospitals Bristol and Weston
UKHSA	UK Health Security Agency
UNAIDS	Joint United Nations Programme on HIV and AIDS
WHO	World Health Organisation

1. Introduction

This report covers the period of the 1st April 2022 to the 31st March 2023 and provides an overview of infectious diseases and environmental risks to our population. It reports on the health protection priorities, targets, and recommended actions identified by the Health Protection Committee.

The impact of the pandemic continues to be felt throughout our reporting, with ongoing consequences on the availability and interpretation of data for some sections. The reporting of immunisations, screening and TB have continued to be impacted by the delays in data provision. This has been noted in the sections affected and is a risk.

Finally, health protection covers an extensive range of exposures, risks, and diseases – from air quality to port health, and cancer screening to tuberculosis. However, there are many underlying and connecting themes, of which inequality and inclusion is particularly prominent. This year's report acts as a reminder that addressing health inequalities is critical to improving and protecting the whole population.

This report straddles a period when PHE was becoming UKHSA and OHID and the CCG was transitioning into becoming the BNSSG ICB, so both of these terms will be used throughout this report.

Our next assurance report will be produced in December 2024 covering the period from 1st April 2023 to 31st March 2024.

2. Executive Summary

Bristol stands as a dynamic and inclusive city, celebrated for its cultural diversity, vibrancy and energy. However, notable pockets of deprivation serve as drivers for health protection issues.

Distinct demographic differences to other South West local authority areas make it difficult to compare Bristol within this footprint, and therefore comparison with other statistically similar authorities, such as core cities, and national England averages have been used where possible.

The ongoing response and management of COVID-19 has impacted the availability of same data used in this report. The reporting of immunisations, screening and TB have been impacted by the delays in data provision, some of which is expected and will be noted where necessary.

An update on last years' priorities for each section of this report can be found in Appendix B.

Immunisation

The COVID-19 vaccination programme has continued to be delivered in line with the Joint Committee on Vaccination and Immunisation (JCVI) guidance and in addition to routine immunisation programmes.

There was a successful 2022-23 Autumn-Winter programme of flu and COVID-19 vaccinations, including a COVID-19 Spring Booster programme for those at higher risk. As of 29th March 2023, 75% of the population aged 16 years or over had received two doses of the COVID-19 vaccine and 61% have received a third/booster dose.

In terms of seasonal influenza vaccinations there has been a decrease across the categories of; 65 and over, under 65 years and in an at-risk group, 50–65-year-olds and all 3-year-olds. There has been a marginal increase in the uptake of influenza vaccinations for all pregnant women and all 2-year-olds.

Nationally, childhood vaccine coverage in 2022–23 decreased compared to 2021–22, and none of the scheduled vaccines met the 95% target. Bristol presents similarly.

A System-level Maximising Immunisation Uptake Groups has been established and is working to implement an action plan to improve uptake and reduce inequalities of immunisation.

Priorities for the next reporting period

- Implementation of the national vaccination strategy once published.
- To work in collaboration with System colleagues to increase childhood immunisation uptake, particularly MMR.
- To maintain focus on COVID-19 and flu vaccine uptake across all eligible groups.

Screening

Cervical screening coverage remains a key focus for the SW NHSE Vaccination and Screening Team, and further targeted communications is planned to increase uptake of the offer.

The BNSSG bowel screening centre saw an increase in uptake during 2022-23 and continues to extend the eligible age cohort. The Bristol uptake of bowel screening remains below the regional and national levels, despite an increase in screenings this year.

AAA screenings and breast cancer screening offer which was impacted by COVID-19 has now been addressed and the backlog have been offered screening. The Avon breast screening programme took delivery of a new mobile screening unit in March 2023 which will bring additional screening capacity to the programme.

Staffing pressures and capacity within maternity have had varying degrees of impact on some screening functions throughout 2022-23.

The BNSSG Diabetic Eye Screening programme has good performance against its KPIs with an uptake of 81.3%

Priorities for the next reporting period

- To return to and overtake pre-pandemic screening uptake levels, including developing a strategy for cervical cancer elimination.
- To focus on inequalities in screening uptake.

Sexual Health

Bristol continues to see a higher incidence of STIs compared to the South West and England, and although there has been an increase in new STI diagnosis, this remained below pre-COVID-19 pandemic levels. Cases of HIV in Bristol also continued to decrease.

During the 2022-23 reporting period, sexual health services in Bristol responded to the Mpox outbreak and to a significant increase in gonorrhoea cases.

The 2023-2024 period will see the integrated sexual and reproductive health services for BNSSG recommissioned.

Priorities for the next reporting period

- Undertake the recommissioning of integrated sexual health services.
- Continue to monitor and encourage the recovery of STI and HIV testing in Bristol and the subsequent effects on numbers of new diagnoses.
- Support the development of communications materials to raise awareness of the C-Card condom distribution age extension and oversee their dissemination.
- In conjunction with local partners including populations at risk, determine the most appropriate interventions and channels to address the continuing rise in STIs.

Healthcare Associated Infections & Anti-Microbial Resistance

In Bristol, cases of MRSA, C. difficile and E.coli decreased from the previous year. With 21 cases of MRSA, which still remains above the target of 0 cases per year, 79 cases of Clostridium difficile, and 205 cases of E.coli.

This year also saw a decrease in cases of Pseudomonas aeruginosa and Klebsiella but saw an increase in MSSA and antibiotic prescriptions.

Priorities for the next reporting period

- A deep dive into HCAI to gain better insight into drivers of these infections.
    - Focus on MRSA and MSSA.

TB

This year's TB data has been difficult to obtain as only limited information has been published.

However, data from the UKHSA indicates that there has been an increase of TB diagnosis in the Southwest region, and Bristol's 3-year average remains higher than the England average.

The South West TB Control Board was launched in December 2022. The Board is responsible for setting strategic priorities in the South West and facilitate the delivery of the TB Action Plan 2021–2026.

The increased TB incidence, some linked to migration which has grown exponentially in this period, and the complexities in regard to wider risk factors, diagnosis and treatment is creating increased pressure on the local system.

Priorities for the next reporting period

- To undertake a rapid review of TB in Bristol to gain clarity on local profile to support commissioning and delivery.
- Develop a system pathway for those with no recourse to public funds who have TB or other high consequence infectious disease.

COVID-19

From April 2022, free community testing had ceased, and the numbers of tests completed reduced.

In the year from March 2022 to March 2023 there were 115 deaths from COVID-19.

Priorities for the next reporting period

- To continue to promote vaccination as the key preventative measure against severe illness but focussing on further aligning with flu vaccination programme ‘ winter vaccination’ .
- To maintain oversight of epidemiology recognising new variants will emerge and action may be needed.

Environmental Health

There were 585 confirmed cases of notifiable food/water related infections and 148 service requests relating to suspect food poisoning.

Bristol’s annual programme of inspections was impacted by COVID-19, causing a backlog. Inspections remain below the FSA’s expectations, although approached normal capacity despite staffing issues.

Priorities for the next reporting period

- Focus on recovering the backlog of food inspections in addition to programmed visits and anticipated new business registrations.

Global Population Health

There is growing concern of the risk of measles transmission. Bristol, which has an MMR coverage level more similar to London and other cities, is at greater risk.

The COVID-19 pandemic continues to display a negative impact on the essential immunisation programme in a global context. Delivery and strengthening of this programme remains a priority for the World Health Organisation.

Between 2022 and 2023 we saw the international emergence of Mpox, of which Bristol saw very few cases.

Priorities for the next reporting period

- Continued focus on immunisations as a core prevention activity – engagement with underserved communities to narrow the gap in coverage and reduce inequalities.

Asylum Seekers & Refugees

The city of Bristol has continued to welcome and meet the health needs of both asylum seekers and refugees (ASRs) during the reporting period.

The number of ASR is expected to continue to increase in the year 2023–24 which will create additional demand and system pressure on local services.

Priorities for the next reporting period

- Contribute to a local TB action plan so that any gaps in the latent TB screening of asylum seekers and refugees are identified and rectified.

Non-communicable Environmental Health Risks

In November 2022, Bristol's Clean Air Zone (CAZ) commenced. It charges polluting vehicles to enter a zone in Bristol's city centre.

National data indicates that emissions from domestic wood burning have been increasing in the last decade, which increases risks of long-term diseases and deaths.

Priorities for the next reporting period

- Priorities will be reviewed and agreed once the new administration is in place (from May 2024.).

Emergency Preparedness, Resilience and Response

The Emergency Preparedness Response Team (EPRT) responded to 37 incidents throughout the reporting period, including 13 fires, 5 Road Traffic Collisions and two floods. One fire that broke out was on the top floor flat of Twinnell House.

This year, Bristol saw a number of industrial action strikes, including those working in health and the NHS.

A Summer Preparedness Severe Weather Group was established to assess the impacts of heatwaves and high temperatures.

Priorities for the next reporting period

- Continue to strengthen our preparedness by re-establishing LHRP in light of system level changes and developing a clear plan of priorities for the whole health system, including social care.
- Maintain and increase our staff training and exercising of emergency response and capability to act.
- Validate the Recovery Guide and Humanitarian Assistance Guide.
- Review the Corporate Business Continuity Response Framework.

3. Immunisations

3.1 Overview

Immunisations are one of the most significant public health developments in the prevention of infectious disease.[1] The routine vaccine schedule in the UK is available from: https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule/the-complete-routine-immunisation-schedule-from-february-2022 .

[1] ONS (2015) How has life expectancy changed over time? Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/articles/howhaslifeexpectancychangedovertime/2015-09-09

In addition to the routine immunisation programmes, the COVID-19 vaccination programme has continued to be delivered in line with the Joint Committee on Vaccination and Immunisation (JCVI) guidance. In 2022-23 there was a successful Autumn-Winter programme, and a Spring Booster programme for those at higher risk.

Performance and quality indicators are monitored by the NHSE Vaccination and Screening Team, and assurance provided to the Bristol Health Protection Committee.

3.2 Childhood immunisations

Nationally, childhood vaccine coverage in 2022–23 decreased compared to 2021–22, and none of the scheduled vaccines met the 95% target. In Bristol, the uptake of the MMR and DTaP-IPV 2nd vaccines among 5-year-olds is of concern, which was less than 90% (84.3% and 83.1% respectively) (Figure 1). This represents a very slight increase in coverage of both vaccines compared to the last reporting period (2021–22), (Figure 2). However, coverage remains below the pre-2018-19 level.

The UK-wide Measles and Rubella Elimination Strategy[2] was released in 2019 and a South West-wide action plan was developed to support implementation of the plan following a regional conference on measles held in February 2020. Following a pause during the COVID-19 pandemic, the regional strategy has now been updated and is being shared with all stakeholders to ensure a co-ordinated, collaborative approach that includes both local, regional and national objectives and priorities.

2022–23 saw the development of System-level Maximising Immunisation Uptake Groups, led by the NHS England (NHSE) Screening and Immunisation Team, with a key focus on increasing the uptake of childhood immunisations, particularly MMR and pre-school booster vaccines. This group, which has been developed into the Immunisations Strategic Oversight Group in BNSSG, has developed an evidence-based action plan that identifies targeted interventions to improve uptake. In Bristol, this work includes projects to deliver catch up MMR clinics to individuals aged 17-30, working with GP practices to improve uptake, and a comms strategy to support MMR awareness and uptake.

[2] UKHSA (2019) Measles and rubella elimination UK strategy. Available from: https://www.gov.uk/government/publications/measles-and-rubella-elimination-uk-strategy

Figure 1: Childhood Vaccination Coverage in Bristol, South West, and England, 2022–23 [3]

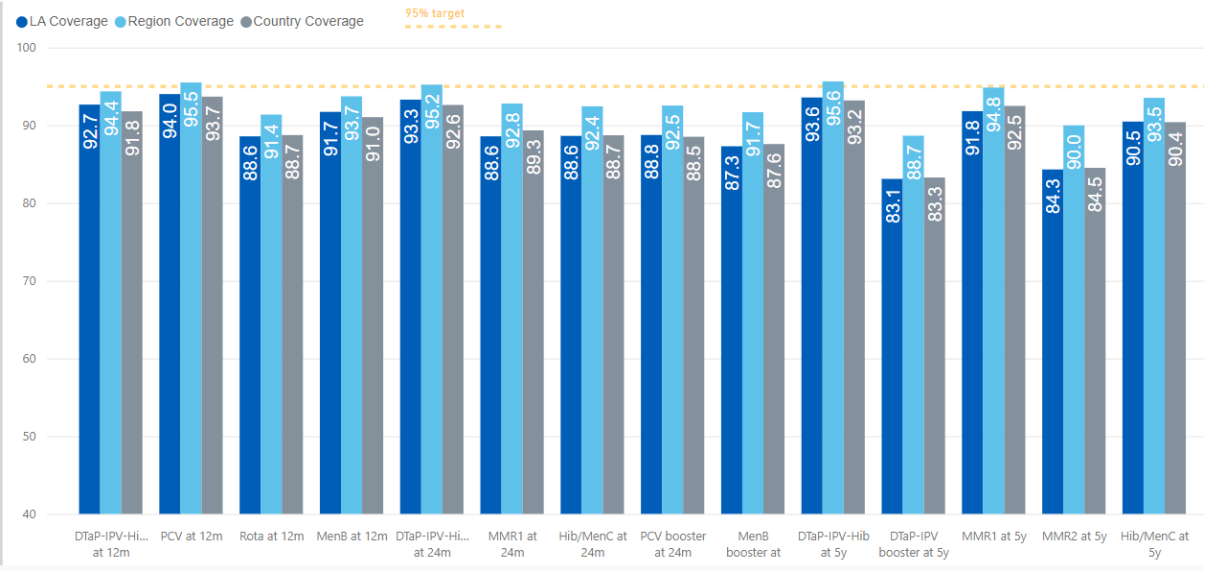
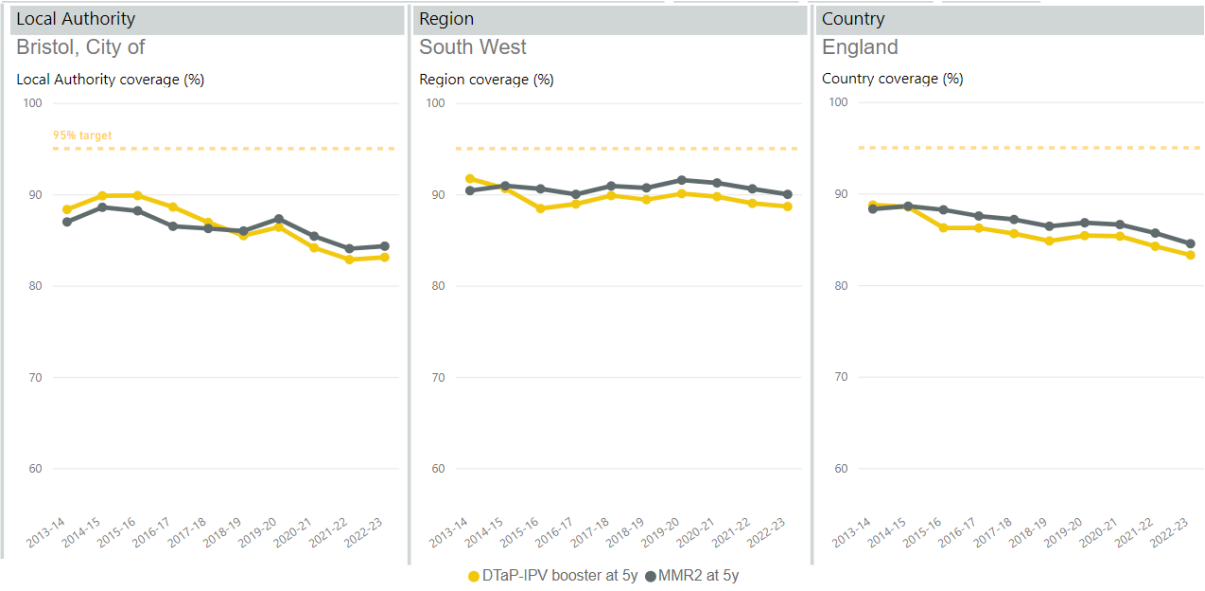


Figure 2: MMR 2nd dose at 5 years and DtaP-IPV booster dose at 5 years in Bristol, South West, and England, 2013–14 to 2022–23 Error! Bookmark not defined.



In addition to the routine childhood vaccination programme, targeted immunisations (hepatitis B, BCG [tuberculosis], and influenza) continue to be delivered to eligible babies. Following large scale changes to the infant BCG programme from September 2021, all providers have changed their models of delivery to deliver to infants at 28 days. These changes have resulted in better data collection and fail-safes being put in place. This is currently being evaluated to ensure a high level of uptake is being maintained.

3.3 School age immunisations

Both the 2020–21 and 2021–22 school aged adolescent immunisation cohorts were affected by the COVID-19 pandemic. There was significant disruption to delivery, due to school closures and high

[3] NHS Digital (2023) Childhood Vaccination Coverage Statistics- England, 2022–23. Available from: Childhood Vaccination Coverage Statistics, England, 2022-23 - NHS Digital

levels of school absence, and capacity was affected by the additional requirement and prioritisation for providers to deliver the COVID-19 vaccine to 12–15-year-olds as well as the extended flu programme in Autumn 2021. In 2022-23 the school aged immunisation services across the region continued to offer both school based and community provision for missed vaccines to previous eligible cohorts, alongside the routine offer to the 22/23 cohorts. This additional offer was completed in March 2023.

Published annual data is not yet available for the 2022–23 cohort.[4] The available provisional monthly uptake data on HPV and ACWY shows good progress was made with recovery of the 21/22 cohort across BNSSG in regard to being offered, however, Bristol uptake is not as high as South Gloucestershire and North Somerset and the teenage booster was noticeably lower in Bristol compared to pre-COVID figures. Continued lower uptake across the adolescent programme has been in evidence for the 2022-23 cohort, which reflects a national picture. With recovery now complete, the focus will be on developing plans with all providers to improve uptake and address inequalities, including continuing to make the offer for all adolescent vaccines to the end of year 11. Following JCVI guidance, which showed comparable efficacy of a single dose compared to 2 doses, a change to the HPV programme from a two dose to a one dose schedule will take effect from September 2023.

3.4 Shingles

The shingles vaccine is offered to people aged 70 to 79 years old. From September 2021, an additional Shingles vaccine (Shingrix®) was introduced for eligible individuals who are immunocompromised.[5]

Shingles vaccination was offered opportunistically up until April 2021. Since then, 70–79-year-olds have been actively invited for a vaccine. [6] In Bristol, vaccine coverage among eligible individuals turning 70–80 years in financial year 2021–22 was 62%, and comparable to the BNSSG estimate of 64% and England estimate of 62%. [7] The annual coverage report for 2022-23 is not yet available.

From 1st September 2023, large scale changes to the shingles programme have been introduced, expanding the eligible population to 60-80 years old in a phased rollout, and over 50 years old for everyone who is severely immunocompromised.

3.5 Pneumococcal vaccine

The pneumococcal vaccine (PPV) protects against serious and potentially fatal pneumococcal infections. The vaccine is offered to adults aged 65 years or over and those with long-term health conditions, such as serious heart or kidney conditions. National vaccine shortages of PPV have historically been an issue and have had a significant effect on coverage, however, it has been reported by NHSE this issue has now been resolved. Bristol data has not yet been published by NHSE for 22/23

[4] Given that data for the 21/22 cohort was published before full activity was completed and therefore not representative of final uptake, it has not been included.
[5] PHE (2021) Shingles immunisation programme: introduction of Shingrix® letter. Available from: https://www.gov.uk/government/publications/shingles-immunisation-programme-introduction-of-shingrix-letter/shingles-immunisation-programme-introduction-of-shingrix-letter
[6] NHS England (2021) Update on vaccination and immunisation changes for 2021–22. Available from: https://www.england.nhs.uk/publication/update-on-vaccination-and-immunisation-changes-for-2021-22/
[7] UKHSA (2022) Shingles vaccine coverage for those becoming 70 to 80 years of age in the year 1 April 2021 to 31 March 2022 as of 23 June 2022. Available from: https://www.gov.uk/government/publications/herpes-zoster-shingles-immunisation-programme-2021-to-2022-evaluation-reports

3.6 Flu vaccine

Seasonal influenza vaccinations happen every year, starting in September and continuing until February. Below is a summary of vaccination uptake for vaccines delivered by GP practices in Bristol.

Table 1 Number of Seasonal Influenza Vaccinations delivered and Uptake as a percentage (1st September 2022- 28th February 2023)[8] [9]

Category	Number of Vaccines Delivered 2021-22	Uptake % 2021-22	Number of Vaccines Delivered 2022-23	Uptake % 2022-23
65 years and over	56,344	83.0%	52,402	80.6%
Under 65 years and in an at-risk category	38,582	50.7%	36,077	49.4%
All pregnant women	2,749	40.2%	6,279	40.3%
All 50–65-year-olds	44,479	53.1%	23,246	28.5%
All 2-year-olds	2,684	48.9%	2,426	49.0%
All 3-year-olds	2,926	51.6%	2,560	49.6%

It is important to note that of the 39 GP practices within Bristol, 38 practices completed the survey, giving a response rate of 97.4%, this is less than the previous year, where 100% of practices completed the survey.

Compared to the previous year, there has been a decrease across the categories of; 65 and over, under 65 years and in an at-risk group, 50–65-year-olds and all 3-year-olds. There has been a marginal increase in the uptake of influenza vaccinations for all pregnant women and all 2-year-olds.

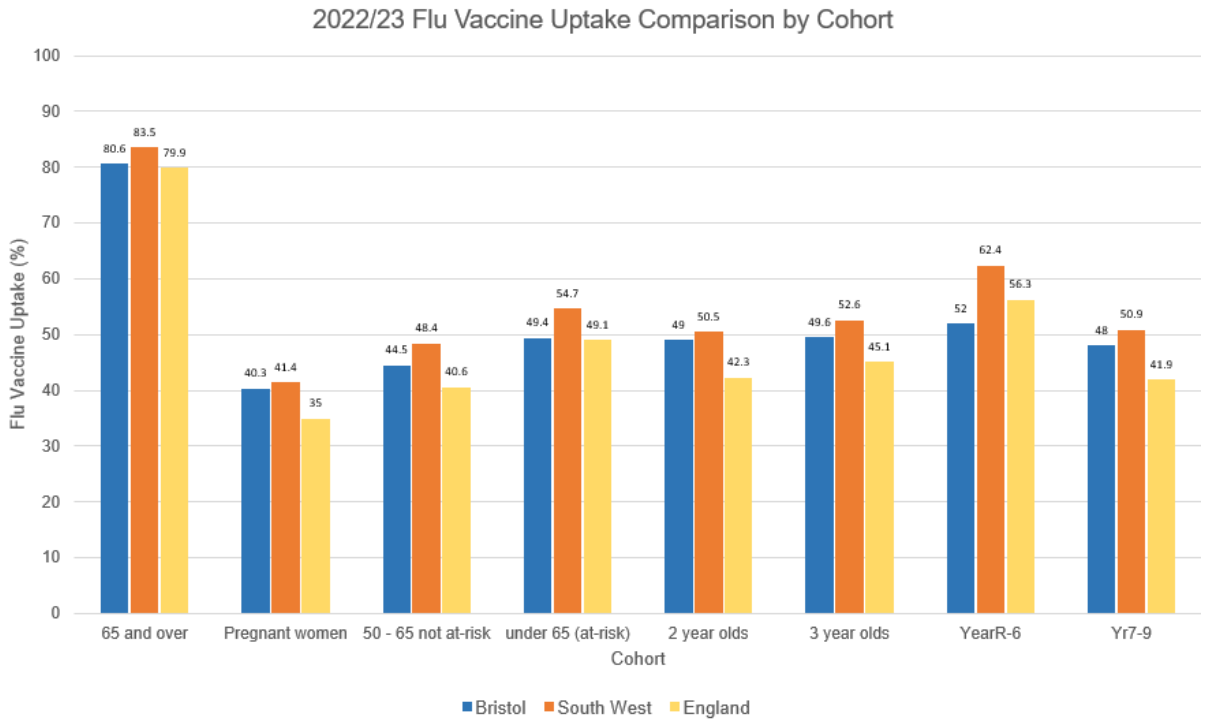
Flu immunisation uptake in Bristol was above the England average in 2022–23 but remained below the SW level. Uptake was highest among 65 and over age group.

Flu vaccine uptake in Bristol was below the South West region average across the eligible cohorts but above the national average for all but the Primary School age group (Figure 3).

[8] UKHSA (2022) Seasonal influenza vaccine uptake in GP patients: winter season 2021 to 2022. Available from: https://www.gov.uk/government/statistics/seasonal-influenza-vaccine-uptake-in-gp-patients-winter-season-2021-to-2022

[9] UKHSA (2023) Seasonal influenza vaccine uptake in GP patients: winter season 2022 to 2023. Available from: https://www.gov.uk/government/statistics/seasonal-influenza-vaccine-uptake-in-gp-patients-in-england-winter-season-2022-to-2023

Figure 3: Flu Vaccination Uptake for eligible groups in Bristol, SW and England, 2022-23[10] [11]



3.7 COVID-19 vaccine

COVID-19 vaccinations began being administered in Bristol on 8th December 2020, as of 29th March 2023, 75% of the population aged 16 years or over have received two doses of the vaccine and 61% have received a third/booster dose. The uptake of the vaccine is much greater in older age groups and diminishes as the ages get younger.

Figure 4: Percentage of population having received 1st, 2nd and 3rd dose of COVID-19 vaccine, broken down into age groups[48].1

	1st dose - Coverage			2nd dose - Coverage			3rd dose - Coverage		
	Bristol	BNSSG	ENG	Bristol	BNSSG	ENG	Bristol	BNSSG	ENG
12yrs+	77%	82%	78%	73%	78%	75%	58%	65%	59%
16yrs+	**79%**	**83%**	**80%**	**75%**	**80%**	**77%**	**61%**	**68%**	**63%**
60yrs+	**93%**	**95%**	93%	**92%**	**95%**	92%	**88%**	**92%**	89%
50-59yrs	**86%**	**90%**	87%	**84%**	**88%**	86%	**75%**	**81%**	76%
40-49yrs	**78%**	**82%**	78%	**75%**	**80%**	75%	**62%**	**68%**	60%
30-39yrs	**73%**	**76%**	70%	**69%**	**72%**	66%	**53%**	**56%**	46%
18-29yrs	**72%**	**75%**	68%	**66%**	**69%**	62%	**45%**	**48%**	38%
16-17yrs	**58%**	**66%**	62%	**45%**	**54%**	49%	**12%**	**15%**	12%
12-15yrs	**45%**	**52%**	46%	**35%**	**41%**	35%	**1%**	**2%**	1%
5-11yrs	**12%**	**14%**	10%	**8%**	**9%**	7%	**0%**	**0%**	0%

Compared to other core cities, Bristol ranks relatively high in terms of 1st dose vaccine coverage (79.3%). Ranking only behind Sheffield and the England average (both 80.4%). When comparing the

[10] UKHSA National Childhood Influenza Vaccination Programme 2022 to 2023. Available from: Seasonal influenza vaccine uptake in school age children: winter season 2022 to 2023 - GOV.UK (www.gov.uk)

[11] Seasonal Influenza vaccine uptake amongst GP patients in England 2022 to 2023. Available from: Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023 - GOV.UK (www.gov.uk)

percentage of the population that have had at least 3 doses of the vaccine the story is the same, Bristol (62.3%) again ranks only behind Sheffield (62.9%) and the England average (63.9%).

Figure 5: Estimated vaccination coverage: 1 or more doses, Bristol, England and English core cities[48].

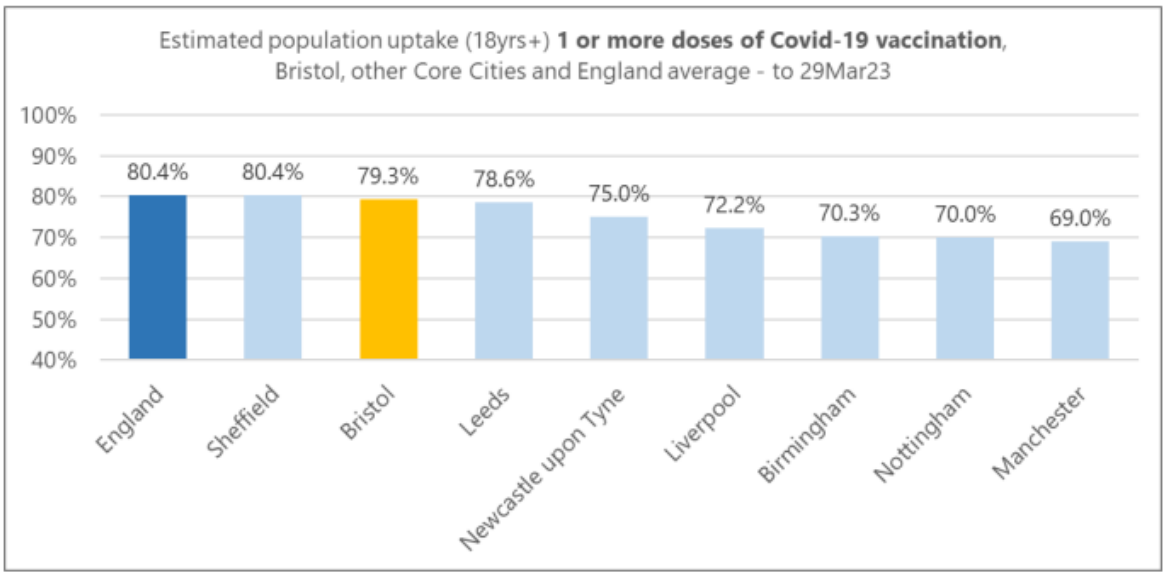
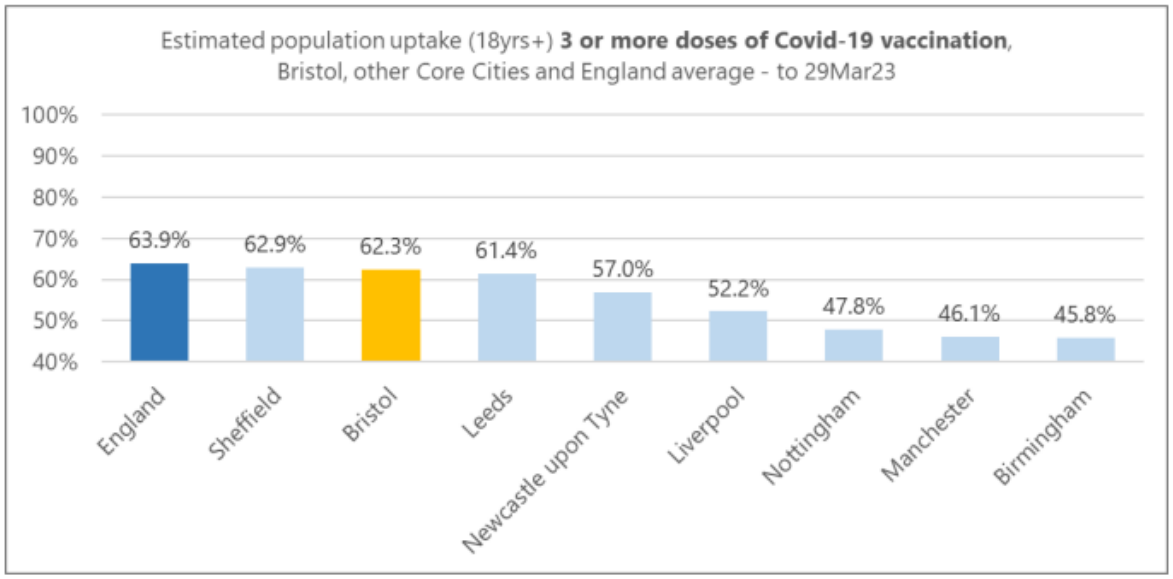


Figure 6: Estimated vaccination coverage: 3 or more doses, Bristol, England and English core cities[48].



When comparing to Chartered Institute of Public Finance and Accountancy (CIPFA) statistical nearest neighbours, which includes some Core Cities but also some additional local authority (LA's), Bristol's uptake for 1 or more dose ranks lower. Being much more in the middle of the table. This is again reflected in the 3 or more doses data.

Figure 7: Estimated vaccination coverage, 1 or more doses, Bristol, England and CIPFA nearest neighbours[48]

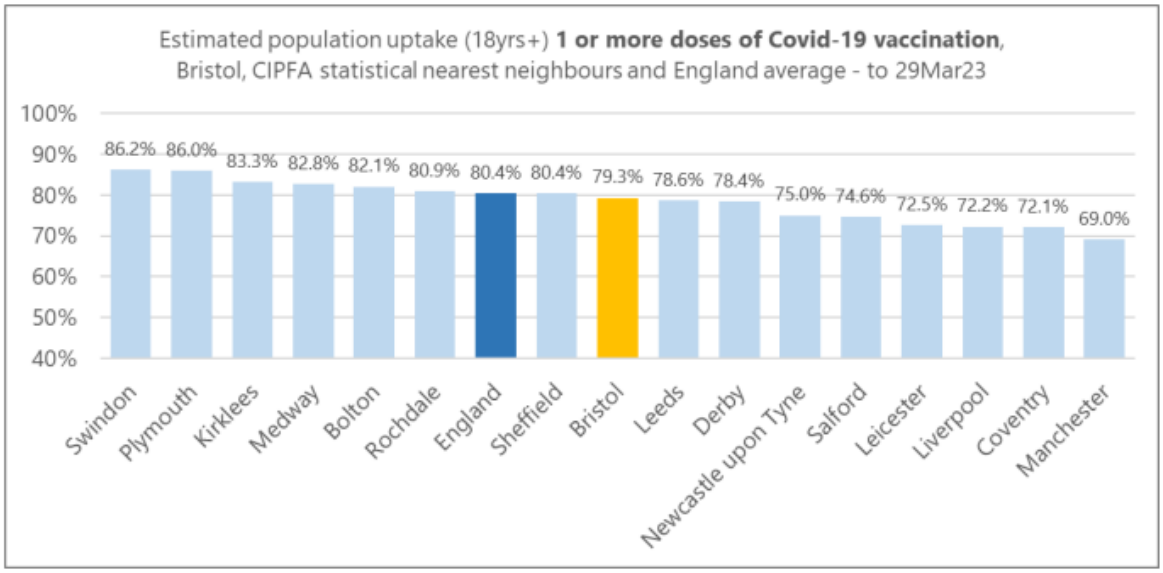
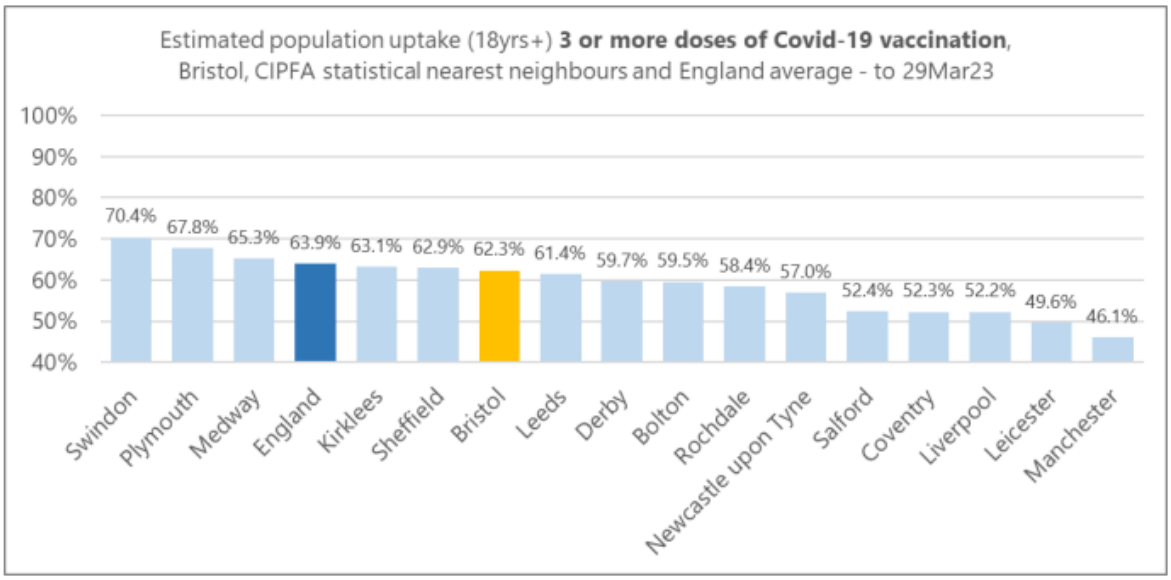


Figure 8: Estimated vaccination coverage, 3 or more doses, Bristol, England and CIPFA nearest neighbours[48]



4. Screening

4.1 Screening programmes

There are currently three national population cancer screening programmes: breast, bowel and cervical screening.

There are eight non-cancer screening programmes: six antenatal and new-born (Foetal Anomaly, Infectious Diseases in Pregnancy, Sickle Cell and Thalassaemia, New-born and Infant Physical Examination, New-born Blood Spot and New-born Hearing) and two adolescent / adult (Abdominal Aortic Aneurysm and Diabetic Eye).

All screening programmes have performance standards relating to uptake, which may be acceptable or achievable (acceptable is a lower target than achievable). [12] Performance and quality indicators are monitored by the NHSE Vaccination and Screening Team, and assurance provided to the Bristol Health Protection Committee.

4.2 Cervical screening

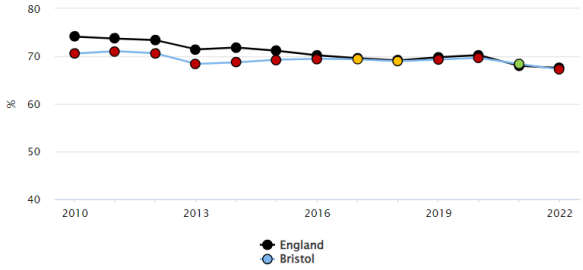
Cervical screening data is broken down into two specific age groups, 25–49 years and 50–64 years.

Based on 2021–22 data, there has been a further slight decline in local and national coverage among 25–49-year-olds with 67% of women and people with a cervix accepting a cervical screen (Figure 9). Among 50–64-year-olds, overall uptake is higher at 73%, again a stable position over the last 3 years, but a downward trend over the last 10 years. It is worth noting that while the percentage coverage is decreasing, in absolute numbers the number of screens taking place has increased across Bristol, due to the rise in size of eligible population.

Increasing cervical screening coverage remains a key focus for the SW NHSE Vaccination and Screening Team this year, and a programme of work is planned to include targeted work with GP practices, and local communications. There have also been examples of local work to increase cervical screening uptake, for example, Caafi Health making telephone calls to eligible individuals to support them to book and attend appointments.

Figure 9 and Figure 10: Cervical cancer screening coverage in Bristol, South West, and England in different cohorts[13]

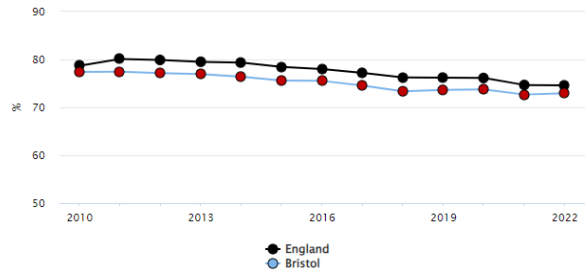
Cancer screening coverage: cervical cancer (aged 25 to 49 years old)



Recent trend: Decreasing & getting worse

Period		Bristol Count	Value	95% Lower CI	95% Upper CI	England
2010		-	70.6%	70.3%	70.9%	74.1%*
2011		-	71.1%	70.8%	71.4%	73.7%*
2012		-	70.6%	70.3%	70.9%	73.4%*
2013		-	68.4%	68.1%	68.7%	71.5%*
2014		-	68.7%	68.4%	69.0%	71.8%*
2015		-	69.3%	69.0%	69.6%	71.2%*
2016		-	69.5%	69.2%	69.8%	70.2%*
2017		-	69.4%	69.1%	69.7%	69.6%*
2018		-	68.9%	68.7%	69.2%	69.1%*
2019		-	69.3%	69.0%	69.6%	69.8%*
2020		-	69.7%	69.4%	69.9%	70.2%*
2021		-	68.4%	68.1%	68.6%	68.0%*
2022		-	67.3%	67.0%	67.5%	67.6%*

Cancer screening coverage: cervical cancer (aged 50 to 64 years old)



Recent trend: No significant change

Period		Bristol Count	Value	95% Lower CI	95% Upper CI	England
2010		-	77.4%	76.9%	77.9%	78.7%*
2011		-	77.4%	77.0%	77.9%	80.1%*
2012		-	77.1%	76.6%	77.6%	79.9%*
2013		-	77.0%	76.5%	77.5%	79.5%*
2014		-	76.4%	75.9%	76.9%	79.4%*
2015		-	75.6%	75.1%	76.1%	78.4%*
2016		-	75.5%	75.0%	76.0%	78.0%*
2017		-	74.5%	74.1%	75.0%	77.2%*
2018		-	73.4%	72.9%	73.8%	76.2%*
2019		-	73.6%	73.2%	74.1%	76.2%*
2020		-	73.8%	73.3%	74.2%	76.1%*
2021		-	72.7%	72.2%	73.1%	74.7%*
2022		-	72.9%	72.5%	73.4%	74.6%*

[12] PHE (2019) NHS population screening standards. Available from: https://www.gov.uk/government/collections/nhs-population-screening-programme-standards

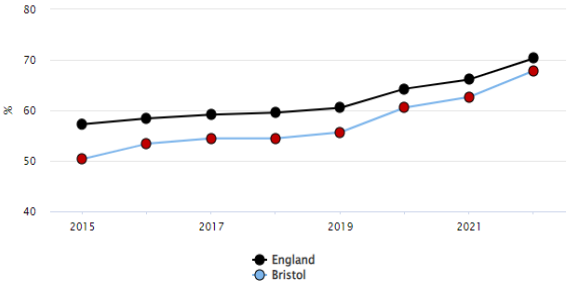
[13] OHID (2022) Fingertips: Public Health Outcomes Framework (cervical cancer screening). Available from: https://fingertips.phe.org.uk/

4.3 Bowel cancer screening

The BNSSG bowel screening centre demonstrated a good performance during 2022-23 despite events such as postal and nursing/doctor strikes causing an impact on the service. The Programme continues to extend the age cohort in line with National policy and now incorporates 54-, 56-, and 58-year-olds. A further extension to 50- and 52-year-olds is planned to go live from April 2024. From July 2023 patients with Lynch Syndrome will be invited into the screening programme and capacity for this has been secured.

Bowel screening uptake in Bristol, the South West, and England in the 60–74-year-old cohort (published data not yet available for other age cohorts) has increased. In Bristol specifically, there has been an increase from 51% in 2014–15 to 67.9% in 2021–22 which meets the achievable standard (Figure 11). Nevertheless, bowel screening uptake in Bristol remains lower than regional and national uptake. Initiatives such as a system wide inequalities group and the completion of a Health Equity Assessment Tool were commenced in 2022 and are ongoing.

Figure 11: Bowel cancer screening coverage in Bristol, South West, and England, 2014–15 to 2021–22 [14]



Recent trend: ⬆ Increasing & getting better

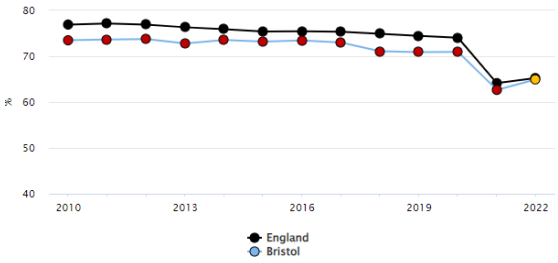
Period		Bristol Count	Value	95% Lower CI	95% Upper CI	South West	England
2015		-	50.3%	49.9%	50.8%	60.5%*	57.3%*
2016		-	53.4%	52.9%	53.8%	62.2%*	58.4%*
2017		-	54.5%	54.0%	54.9%	63.0%*	59.2%*
2018		-	54.5%	54.0%	54.9%	62.9%*	59.5%*
2019		-	55.7%	55.2%	56.1%	63.9%*	60.5%*
2020		-	60.5%	60.1%	61.0%	67.8%*	64.3%*
2021		-	62.6%	62.2%	63.0%	69.9%*	66.1%*
2022		-	67.9%	67.5%	68.2%	74.2%*	70.3%*

4.4 Breast cancer screening

Bristol's breast cancer screening programme achieved recovery, regarding screening offer, in 2022-23 following the pause in screening and subsequent backlog which developed during the COVID-19 pandemic. In line with regional and national trends, uptake for the Avon programme, which covers Bristol, has been below previous years and below the target of 70%. Looking forward into 2023-24 the focus is on increasing uptake and addressing health inequalities. The Avon breast screening programme took delivery of a new mobile screening unit in March 2023 which will bring additional screening capacity to the programme.

[14] OHID (2023) Fingertips: Public Health Outcomes Framework (bowel cancer screening). Available from: https://fingertips.phe.org.uk/

Figure 12: Breast cancer screening coverage in Bristol, South West, and England, 2009–10 to 2021–22 [15]



Recent trend: ⬇ Decreasing & getting worse

Period		Bristol Count	Bristol Value	Bristol 95% Lower CI	Bristol 95% Upper CI	South West	England
2010	●	-	73.5%	73.0%	74.0%	79.5%	76.9%
2011	●	-	73.6%	73.2%	74.1%	79.5%	77.1%
2012	●	-	73.8%	73.3%	74.2%	79.1%	76.9%
2013	●	-	72.8%	72.4%	73.3%	78.9%	76.3%
2014	●	-	73.6%	73.1%	74.0%	78.9%	75.9%
2015	●	-	73.2%	72.7%	73.6%	78.6%	75.4%
2016	●	-	73.5%	73.0%	73.9%	78.3%	75.5%
2017	●	-	73.0%	72.5%	73.4%	78.1%*	75.4%*
2018	●	-	71.1%	70.7%	71.6%	77.6%*	74.9%*
2019	●	-	70.9%	70.5%	71.4%	77.0%*	74.5%*
2020	●	-	71.0%	70.5%	71.4%	76.9%*	74.1%*
2021	●	-	62.7%	62.2%	63.1%	67.7%*	64.1%*
2022	●	-	65.0%	64.5%	65.4%	69.0%*	65.2%*

4.5 Antenatal and new-born screening

The antenatal and new-born screening services covering the Bristol locality area are delivered by North Bristol Trust (NBT) and University Hospitals Bristol and Weston (UHBW). Staffing pressures and capacity within maternity have had varying degrees of impact on some screening functions throughout 2022-23. Screening teams within both Trusts have worked with wider team colleagues and management to provide mitigation for a safe and effective service to patients. Coverage for the ANNB programmes in both NBT and UHBW Trusts has met the acceptable or achievable for 2022-23. Published annual data for the year 2022-23 is not yet available.

4.6 Diabetic eye screening

Diabetic eye screening is offered to anyone with diabetes who is 12 years old or over on an annual basis. The BNSSG DESP programme has a good performance against its KPIs with an uptake of 81.3% (above the 79.0% England average) and above the 75% acceptable target. Interval extension will start being introduced from 1st October 2023 with patients with 2 consecutive results of no pathology (R0M0) being put on a 2-year recall (50% will be put on a 2-year recall in the first year as an even number of patients need to be screened from one year to another). Whilst there is no published data specific to Bristol, provider data at GP and screening centre level has shown that more deprived areas in central Bristol have lower uptake and a higher nonattendance rate, and to address this they have initiated targeted work with this population. This includes involvement in community events to promote screening, provision of an accessible central Bristol clinic in The Galleries, and flexible appointment times such as evenings and weekends.

4.7 AAA screening

Abdominal Aortic Aneurysm (AAA) screening is offered to men during their 65th year. If an AAA is identified in an individual, they are entered into a surveillance programme or referred for assessment for vascular surgery, depending on the size of the aneurysm. The Bath, Bristol and Weston AAA screening programme has now fully recovered, in regard to screening offer, following COVID-19. Latest published data from 2021–22 states that 73% of eligible men in Bristol had received AAA screening within the year they became eligible, higher than the national coverage (70%).[16]

[15] OHID (2023) Fingertips: Public Health Outcomes Framework (breast cancer screening). Available from: https://fingertips.phe.org.uk/
[16] OHID (2022) Fingertips: Public Health Profiles – AAA screening coverage (proportion %). Available from: https://fingertips.phe.org.uk/

4.8 Inequalities and strategy

Inequalities in screening and immunisation uptake (by ethnicity, deprivation, physical or learning disability status) have been previously acknowledged nationally.[17] The NHSE SW Vaccination and Screening Team has a regional Inequalities Strategy for Screening and Immunisation Programmes in the South West, to renew focus on ensuring access for all.

This includes providing training on the use of the Health Equity Assessment Tool (HEAT), supporting all screening providers to use this tool to develop health inequalities action plans, commissioning Learning Disability practitioners in every system to support screening uptake, and bespoke training for screening providers on working with people with severe mental illness.

5. Sexual Health

5.1 Introduction

Bristol continues to see a higher incidence of STIs compared to the South West and England, which is likely to be linked to the greater proportion of young people aged 15-24 in Bristol and to changes in sexual behaviours. Although there has been an increase in new STI diagnoses in the reporting period, this remained below pre-COVID-19 pandemic levels, which was linked to the ongoing recovery in STI testing. During the 2022-23 reporting period, sexual health services in Bristol responded to the Mpox outbreak and to a significant increase in gonorrhoea cases (that has now exceeded pre-pandemic levels locally). New cases of HIV in Bristol continued to decrease and in 2022 the rate was lower than both the South West and England averages. This data is being explored further for assurance purposes.

5.2 Overview

Sexually transmitted infections (STIs) are entirely preventable but can have lasting long-term and costly complications, such as pelvic inflammatory disease, ectopic pregnancy and infertility. Bristol has a relatively young population compared to England and this is predicted to rise. The city is ethnically diverse, has areas of high deprivation, and there is a significant lesbian, gay, bisexual and trans (LGBT) community. These factors mean sexual health is a high priority for Bristol City Council (BCC).

Unity Sexual Health, Bristol's specialist sexual health service, has faced a number of challenges in 2022-23, initially responding to the easing of COVID-19 restrictions, followed closely by the emergence of Mpox in May 2022 onwards. Towards the end of 2022 there was a notable increase in gonorrhoea cases, which continued to rise to levels greater than prior to the pandemic by the end of March 2023. Throughout 2022-23, the service adapted their delivery model to respond to these challenges, offering longer appointment times in response to Mpox to allow for appropriate infection prevention and control measures to be carried out, to deliver vaccinations to those at risk, and towards the end of 2022-23 to increase the number of gonorrhoea treatment clinics to manage the numbers being diagnosed.

5.3 Sexually Transmitted Infections (STIs)

There were 3,948 new STIs diagnosed in Bristol in 2022. This is equivalent to a crude rate of 838 per 100,000 people and is significantly higher than the rate of 489 per 100,000 in the South West region

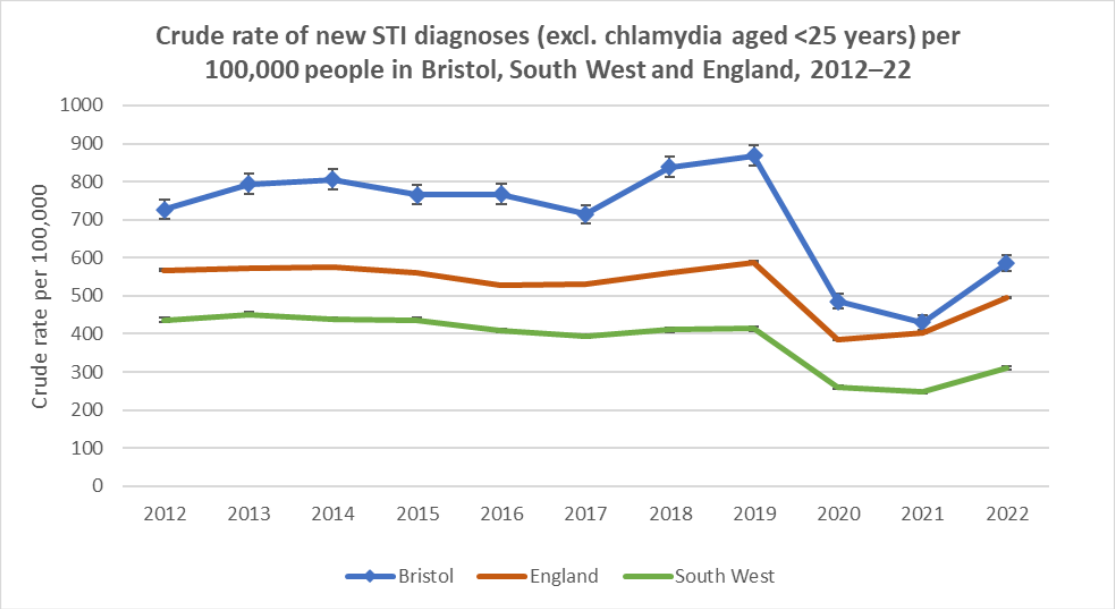
[17] PHE (2020) Screening inequalities strategy. Available from: https://www.gov.uk/government/publications/nhs-population-screening-inequalities-strategy/phe-screening-inequalities-strategy#screening-inequalities-and-the-case-for-action

and 694 per 100,000 in England.[18] Crude rate calculations consider differences in population size, but not population structure. Bristol has the highest rate of STIs in the South West, and much of this difference is likely to be due to a greater proportion of young people in the city compared to the South West and England.

Following significant decreases in STI diagnoses recorded in Bristol in 2020 and again in 2021 during the COVID-19 pandemic, which limited social interactions and restricted access to sexual health services and testing, the number of diagnoses increased in 2022 but did not reach pre-pandemic levels. Levels of STI testing are still recovering following the pandemic, which likely accounts for the lower levels of STI diagnosis still being reported in 2022-23.

A similar pattern is seen when chlamydia cases in under 25-year-olds are excluded (Figure 13). The rate of new STI diagnoses excluding chlamydia in under 25-year-olds was 586 per 100,000 people in 2022. This was a 36% increase compared to 2021, but still lower than pre-pandemic levels and lower than the national average (496 per 100,000).

Figure 13: Crude rate of new STI diagnoses (excl. chlamydia aged <25 years) per 100,000 people in Bristol, South West, and England, 2012–22 (UKHSA)[18]

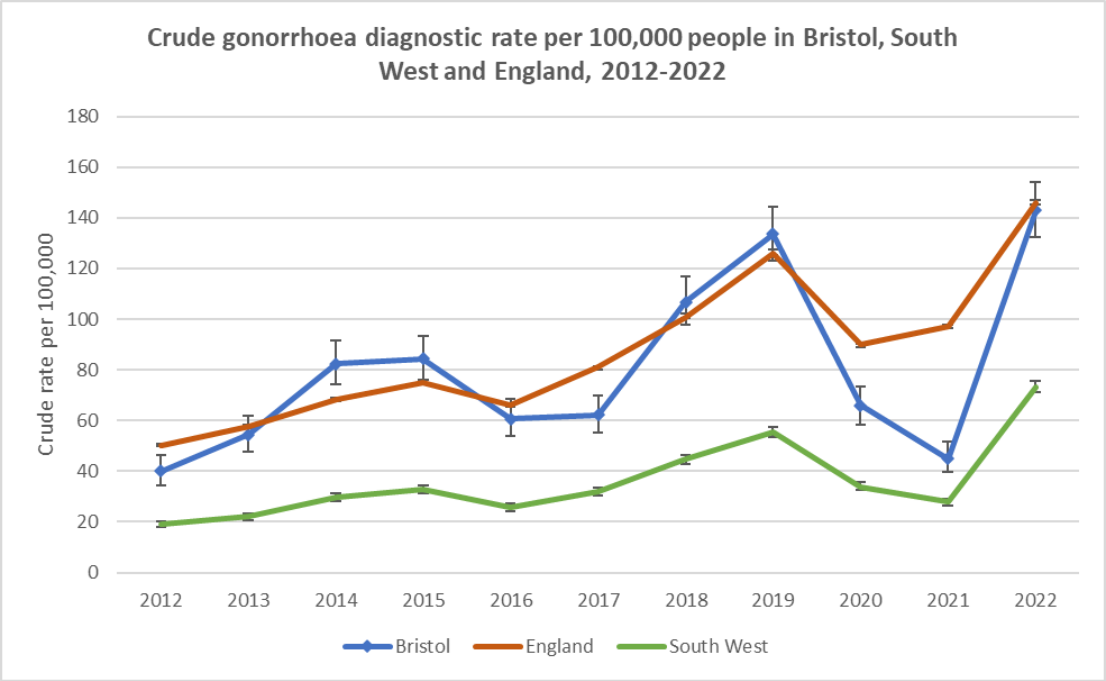


During 2022, both gonorrhoea and syphilis cases in England returned to the high levels reported in 2019 (prior to the COVID-19 pandemic). Gonorrhoea increased in people of all ages, but the rise was highest among young people aged 15 to 24 years. Similar increases were seen in Bristol. In 2022 there were 673 new diagnoses of gonorrhoea in Bristol, compared to 619 in 2019, with a rate of 143 per 100,000 people, similar to England's rate of 146 per 100,000 people (Figure 14). The increase in gonorrhoea seen across the South West led to the UK Health Security Agency (UKHSA) in the South West declaring a regional incident early in 2023. Bristol had the highest number and rate of

[18] UKHSA (2022) Sexual and Reproductive Health Profiles. Available from: https://fingertips.phe.org.uk/profile/sexualhealth/data#page/4/gid/1938133286/pat/6/par/E12000009/ati/502/are/E06000023/iid/93546/age/1/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-ao-0_car-do-0

gonorrhoea cases, with increases seen particularly among heterosexuals aged 19 to 23 years, and among GBMSM aged 24 to 34 years. In relation to syphilis, there were 62 new diagnoses in Bristol in 2022, compared to 69 in 2019, with a rate of 13.2 per 100,000 people, similar to England's rate of 15.4 per 100,000 people. Although syphilis numbers are relatively low, undetected, this infection can have significant health impacts and any increase is a concern.

Figure 14: Crude gonorrhoea diagnostic rate per 100,000 people in Bristol, South West, and England, 2012–22 (UKHSA)[18]



5.4 Mpox (Monkeypox)

Mpox is a rare but high consequence viral infection (MPXV). Mpox does not spread easily between people unless there is very close contact. Spread of Mpox may occur when a person comes into close contact with an infected animal (rodents are believed to be the primary animal reservoir for transmission to humans), human, or materials contaminated with the virus. Mpox has not been detected in animals in the UK. The virus is transmitted through skin-to-skin contact, breathing in the virus through the respiratory tract, or contact with mucous membranes (eyes, nose, mouth, genitals).[19]

Since May 2022, cases of human Mpox have been reported in multiple countries that have not previously had MPXV in animal or human populations, including the UK. Between the 22nd of May 2022 and the end of March 2023, 3,561 cases of Mpox had been identified in the. The majority of these cases have occurred in GBMSM without documented history of travel to endemic countries. At the end of 2022, there had been 13 cases of Mpox in Bristol.[20]

[19] UKHSA (2018) Mpox (monkeypox): background information. Available from: Mpox (monkeypox): background information - GOV.UK (www.gov.uk)
[20] UKHSA (2022) Mpox outbreak: epidemiological overview. Available from: Monkeypox outbreak: epidemiological overview - GOV.UK (www.gov.uk)

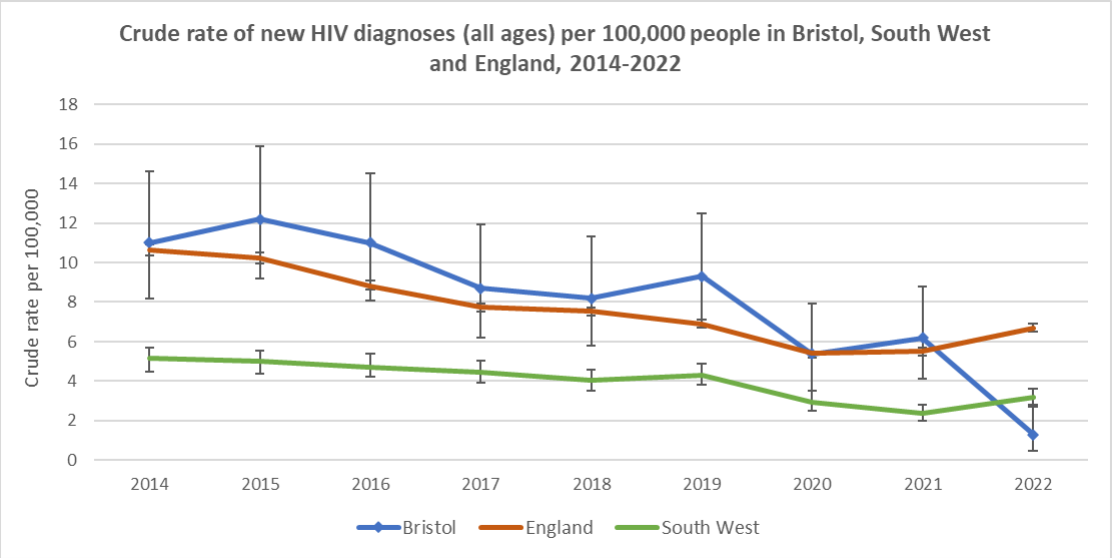
Unity Sexual Health worked closely with the Bristol, North Somerset and South Gloucestershire health system to respond to the spread of Mpox, offering extended appointments to observe all infection prevention and control requirements and supporting the rollout of the vaccination programme.

5.5 HIV incidence in Bristol

Data on fingertips for HIV incidence in Bristol in 2022 is incorrect and therefore it is not possible to update this section accurately. This is being investigated with UKHSA and our HIV treatment provider. The England average is 6.7 per 100,000 (Figure 15). It is important to note that testing coverage in Bristol is poor, with only 38% of eligible people attending specialist sexual health services accepting a HIV test in 2022, having fallen from 68% in 2019. This is likely to have had an impact on the number of new HIV diagnoses. The increasing use of PrEP is also likely to have a positive impact.

Once newly diagnosed, the percentage of people in 2020–22 who started antiretroviral therapy promptly (within 91 days of their diagnosis) was 91%, a little above the England average of 85%.[21] The way this metric is calculated was revised in 2023 and is no longer comparable to historic data.

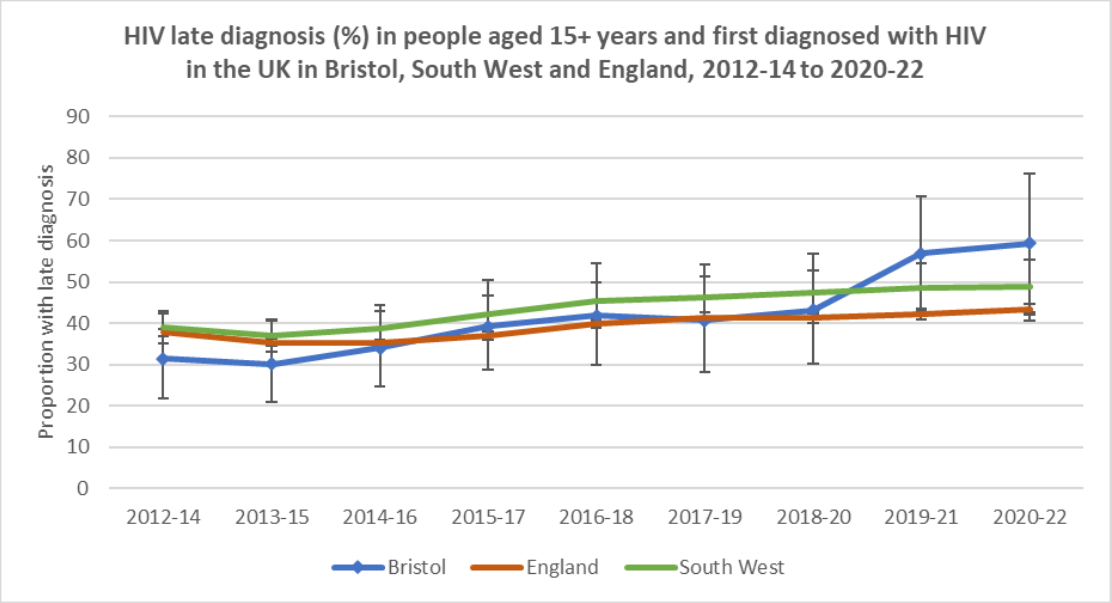
Figure 15: Crude rate of new HIV diagnoses per 100,000 people (all ages) in Bristol, South West and England, 2014–22 (UKHSA). NOTE unreliable Bristol data for 2022.



In Bristol, it is estimated that around 1 in 20 (5%) people are unaware that they are infected with HIV, based on a UKHSA analysis using 2021 data. This increases the risk of poor health outcomes and onward HIV transmission. Between 2020 and 2022 in people aged 15 and over in Bristol with a new HIV diagnosis that was first diagnosed in the UK, 59% had a late diagnosis, which is a slight increase on the combined 2019 to 2021 data and higher than the England average of 43% (Figure 16).

[21] UKHSA (2022) Sexual and Reproductive Health Profiles. Available from: https://fingertips.phe.org.uk/profile/sexualhealth/data#page/4/gid/1938133286/pat/6/par/E12000009/ati/502/are/E06000023/iid/93546/age/1/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-ao-0_car-do-0

Figure 16: HIV late diagnosis in people aged 15+ years and first diagnosed with HIV in the UK in Bristol, South West and England, 2012–14 to 2020-22 (UKHSA)



5.5.1 HIV initiatives in Bristol

Work continued throughout 2022-23 to support the national HIV Action Plan[22], much of which is aligned with the global Fast Track City initiative that BCC signed up to at the end of 2019.[23] The initiative is led by the Bristol Fast Track Cities Steering Group with membership from BCC Public Health, Brigstowe, the University of Bristol, Unity Sexual Health, North Bristol NHS Trust, Terence Higgins Trust, CHIVA and members of the public. The collaborative steering group aims to end HIV stigma and focus on exceeding the UNAIDS 95:95:95 HIV targets:

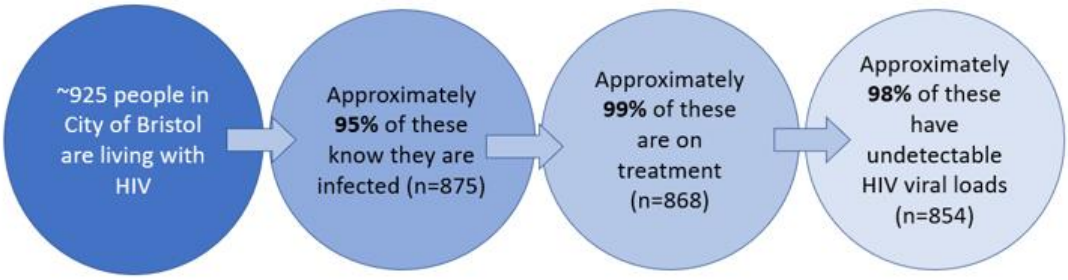
- 95% of people living with HIV knowing their status
- 95% of people with diagnosed HIV on treatment
- 95% of people on treatment with suppressed viral loads

Fast Track Cities performance data is analysed by UKHSA, and at the time of writing, the data for 2022 was not available. Figure 17 below shows Bristol's achievement in 2021 against the three targets.

[22] Department of Health and Social Care (2021) Towards Zero: the HIV Action Plan for England - 2022 to 2025. Available from: https://www.gov.uk/government/publications/towards-zero-the-hiv-action-plan-for-england-2022-to-2025

[23] Bristol One City (2020) Fast Track Cities. Available from: https://www.bristolonecity.com/fast-track-cities/

Figure 17: Bristol HIV Fast Track City performance, 2021 (UKHSA)



In 2022-23, Fast Track City partners undertook a number of initiatives including:

- A pilot of four vending machines in two locations in Bristol, one location in North Somerset and one location in South Gloucestershire for the collection of STI self-sampling kits and HIV self-testing kits. The vending machines aimed to increase access to asymptomatic testing among African and Caribbean heritage communities, young people and GBMSM.[24]
- Commencing a study examining how to improve HIV testing and access to PrEP in GP practices.[25]
- Commencing a project to understand whether it is possible to use pharmacies to deliver PrEP to improve HIV prevention, including identifying the barriers that may stop people from using them.[26]
- Lobbying local MPs about the importance of funding opt-out HIV testing in emergency departments in areas of high HIV prevalence.
- Rolling out of 'Hearts and Minds' training to address stigma amongst healthcare workers.
- Campaigns to address HIV stigma.
- Expanding support to people who find it difficult to engage in HIV treatment.

5.5.2 Common Ambition Bristol (CAB)

Common Ambition Bristol is a co-production project which aims to work with African and Caribbean Heritage (ACH) communities to address the HIV inequalities experienced by this community.

[24] Gobin, M. et al. (2023) P048 Acceptability and Feasibility of Digital Vending Machines to Improve Access to Sexual and Reproductive Health Testing in the West of England: Using a Person-based Approach. Sexually Transmitted Infections [online]. Available from: https://sti.bmj.com/content/99/Suppl_1/A46

[25] National Institute for Health Research. Examining how to improve HIV prevention and testing in GP practices. Available from: https://arc-w.nihr.ac.uk/research/projects/examining-how-to-improve-hiv-prevention-and-testing-in-gp-practices/

[26] National Institute for Health Research. Accessing PrEP through pharmacies to improve HIV prevention. Available from: https://arc-w.nihr.ac.uk/research/projects/accessing-prep-through-pharmacies-to-improve-hiv-prevention/

ACH community members work alongside healthcare, public health and academic partners to develop, test and evaluate interventions to establish effectiveness and acceptability. In 2022-23 there were 4 key strands of work; outreach via ACH businesses including barbers, hairdressers and local shops, promotion of messaging via various sources of ACH relevant media, running an ACH specific sexual health clinic to undertake testing, to commence PrEP, planning a second clinic, and running community events to promote understanding and HIV testing including enabling self-testing.

5.5.3 HIV PrEP

PrEP became available via routinely commissioned NHS sexual health services at the end of 2020. This medication reduces the risk of individuals acquiring HIV. BNSSG were commended in the national press for being one of the first areas in the country to make this provision available via Unity Sexual Health. In 2022-23, 339 people started taking daily PrEP, and a further 212 people started taking event-based PrEP. Of those starting PrEP in 2022-23 in Bristol, take-up was highest in men who have sex with men/transgender women (98%), ages 25-34 years (46%), and people who are White British or White Irish (68%).

5.6 SHIP HIT[27]

The Sexual Health Improvement Health Integration Team (SHIP HIT) is a group of partners who aim to collectively support the development of evidence-based services to improve the sexual health of our population. The SHIP HIT action plan is a comprehensive action plan which includes a number of areas relevant to health protection; improving understanding of sexual health needs, ending sexual stigma, improving STI and HIV testing and using our collaborative network to influence nationally.

In 2022-3 the SHIP HIT continued to support the work of Fast Track Cities and Common Ambition Bristol (see above), and we were involved in a number of other research projects including Emergency Department opt out testing for blood borne viruses (national) , exploring HIV testing barriers for Black African women, PrEP pharmacy delivery, GP HIV testing, STI vending machines evaluation, vaccine uptake in men who have sex with men, and black men's sexual health needs.

5.6 Sexual health needs assessment

A joint sexual health needs assessment for BNSSG was undertaken for the first time in 2022-23 in order to identify unmet need and gaps in service provision that could be impacting on the sexual and reproductive health outcomes of the population. The needs assessment brought together data on sexual health and HIV outcomes, as well as data on service activity and quality. A BNSSG-wide survey was also undertaken to explore the views of the public, service users and professionals. The needs assessment has provided important evidence and recommendations to support future commissioning decisions.

5.7 Relationships and sexual health education (RSHE)

RSHE became statutory in schools in 2020[28], which covers Relationships Education at Key Stages 1 and 2 (primary school), Relationships and Sex Education (RSE) at Key Stages 3 and 4 (secondary school) and Health Education from key stage 1 to 4. All schools are required to deliver 13 modules

[27] Bristol Health Partners. Sexual Health Improvement Programme. Available From: https://www.bristolhealthpartners.org.uk/health-integration-teams/sexual-health-improvement-programme-ship/

[28] Department for Education (2019). Relationships Education, Relationships and Sex Education (RSE) and Health Education. Available From: https://assets.publishing.service.gov.uk/media/62cea352e90e071e789ea9bf/Relationships_Education_RSE_and_Health_Education.pdf

developed by the Department for Education (DfE). This guidance is currently being reviewed and revised guidance is due to be published in 2024.

In Bristol many schools choose to purchase a resource that provides tailored learning aids and teaching materials that are aligned to the curriculum. Within BCC, any queries relating to the delivery of RSHE are directed to the Healthy Schools Team, who encourage schools to be responsive to emerging issues within schools. There is an RSHE Hub available on the Healthy Schools website[29] which shares support and resources related to RSHE topics.

5.8 Future plans

5.8.1. Sexual health recommissioning

The process of recommissioning integrated sexual and reproductive health services for Bristol, North Somerset and South Gloucestershire will begin in 2023-24. Services in scope for recommissioning include:

- STI and HIV testing, STI treatment, HIV prevention including pre-exposure prophylaxis (PrEP), the National Chlamydia Screening Programme, specialist contraception services, and a service for young people, sexual health outreach and health promotion.

BNSSG Integrated Care Board will co-commission abortion services with the integrated sexual health service, and Bath and North East Somerset Council will also co-commission the National Chlamydia Screening Programme with the integrated sexual health service.

The recommissioning process will be led by Bristol City Council and supported by a joint commissioning group with partners from North Somerset, South Gloucestershire Councils and the Integrated Care Board. It will draw on findings from the sexual health needs assessment and from engagement with the public, clinicians and potential providers to develop a sustainable service model that is responsive to the population's needs.

5.8.2. Bristol Fast Track Cities

In 2023-24 Bristol Fast Track cities aims to focus on addressing apparent low uptake of HIV testing amongst sexual health services users and will be repeating the audit which took place in 2022. We will be working with our OHID colleagues to encourage late diagnosis to be considered a serious incident and require investigation, to enable us to better understand why people continue to be diagnosed at a stage which compromises their health. We will undertake a stigma survey in Bristol to better understand the prevalence of stigma and continue educating our health and care colleagues around HIV. We will be exploring workplace policies around blood borne virus (BBV) and how these can be improved to reduce continued stigma, and we will focus on people with HIV who have been lost to follow up. We will continue to work, share and learn from our UK Fast Track city partners and will be developing a bespoke Bristol Fast Track Cities website.

5.8.3. Extending C-Card age range

In 2023-24, Bristol City Council will be increasing the age range of their C-Card condom distribution scheme from 13-19 years old to 13-24 years old. This extension is in response to the gonorrhoea outbreak as Bristol have the highest rates of new gonorrhoea cases in the South West, with the 19-23 age group one of the most impacted. Regular testing and using a condom are key preventative measures being encouraged to curb the spread of gonorrhoea. Ensuring that all young people under

[29] Bristol Healthy Schools. Available from: Bristol Healthy https://www.bristol.gov.uk/council-and-mayor/statistics-census-information/census-2021 Schools

the age of 25 in Bristol can access free condoms is an important intervention that Bristol City Council are putting in place to try and reduce transmission of gonorrhoea and other STIs.

5.8.4 Priorities for the next reporting period

- Undertake the recommissioning of integrated sexual health services.
- Continue to monitor and encourage the recovery of STI and HIV testing in Bristol and the subsequent effects on numbers of new diagnoses.
- Support the development of communications materials to raise awareness of the C-Card condom distribution age extension and oversee their dissemination.
- In conjunction with local partners including populations at risk, determine the most appropriate interventions and channels to address the continuing rise in STIs.

6. Healthcare Associated Infections (HCAI) and Antimicrobial Resistance (AMR)

6.1 Introduction

Healthcare associated infections (HCAI) are more likely to occur in patients who are seriously ill; patients who have repeated courses of antibiotics or invasive devices such as catheters and intravenous cannulas; or patients who inject drugs.

The BNSSG Clinical Commissioning Group (CCG) hosts the Healthcare Associated Infection (HCAI) Group. This is held quarterly and chaired by the CCG's Deputy Director of Nursing & Quality and the BNSSG Antimicrobial Resistance Strategy (AMR) Group which was established to support and enable delivery of the UK 5-year AMR National Action plan 2019–24 and ensure progress towards the 20-year vision to contain and control AMR. The group provides leadership for a system-wide approach for the containment and control of AMR in human health services. Bristol City Council (BCC) Public Health team have representatives at both groups.

6.2 MRSA

Methicillin-Resistant Staphylococcus Aureus (MRSA) is a gram-positive bacterium that is commonly colonised in the human skin and mucosa without causing infection. When invasive infection occurs, usually because the bacterium enters the body via broken skin or medical procedures, it can produce a wide variety of diseases particularly in those with weakened immune systems. This may include minor skin and wound infections and pneumonia, but also result in blood stream infections (septicaemia) and sepsis which can be fatal.

Nationally, there is a 'Zero Tolerance' approach to MRSA Bacteraemia. In Bristol there were 21 cases of MRSA in the reporting period, this represents a decrease from the previous year (28 cases) but remains above the target of zero cases per year. This is a concern and further work is needed to better understand the profile and drivers for this.

The diagnosis of a MRSA bloodstream infection on admission enables timely access and administration of appropriate antibiotics to patients. The Vascular Access Process initiative at UHBW has been one quality improvement programme of work to reduce MRSA/MSSA bloodstream infections.

BNSSG CCG and local authority partners commissioned Bristol Drugs Project (BDP) to roll out a Chlorhexidine programme and implementation during 2019-20. Public Health England supported the Chlorhexidine project. This intervention targeted service users using drugs within Bristol, screening this specific patient cohort for MRSA and providing decolonisation treatment where applicable. In

addition, a trial promoting use of Chlorhexidine wipes to Persons Who Inject Drugs (PWID) commenced in April/May 2021 through our local drug and alcohol services with the aim of reducing risk of infection in injecting site. Due to the challenges of the COVID-19 pandemic a robust evaluation was challenging, and the decision made to extend the project into 2022-23 was made.

6.3 Clostridium Difficile

Clostridium Difficile is a gram-positive bacterium normally found in the gut. In elderly hospitalised patients, especially those with current or recent history, repeated or extended courses of antibiotics can allow the bacterium to grow to abnormally high levels and cause severe diarrhoea and mortality. It is preventable through antibiotic stewardship, high levels of environmental cleaning, and standard infection prevention and control measures by staff.

During 2022-23, there were 79 cases of Clostridium Difficile infection (CDI) in Bristol, compared to 144 cases 2021-22.

Across the ICB, the cases appear to be evenly split over the local authorities, but there is a demonstrable reduction in the Bristol local Authority compared to 2021-22. As an ICB, this benchmark remained above the England and Southwest average per 100,000 populations until more recently. There were three (3) periods of improvement throughout 2022-23 where the assigned cases were below the All England and Southwest average.

BNSSG was a key partner is the South West CDI collaborative group during 2022-23 and actively engaged with system colleagues. The BNSSG Clostridium Difficile working group continued work to embed HCAI-CDI workstream sprint initiatives which includes a review of Vancomycin and community onset CDI during quarter 3 (Oct – Dec 2022).

The ICB are required to undertake systemwide reviews for patients diagnosed with CDI. However, during 2021-22, no community onset case reviews were routinely undertaken due to Data Protection Information governance issues. The lack of case reviews means lost opportunities to ensure patients have received appropriate treatment and a loss of opportunity to share learning with system partners.

6.4 Escherichia coli

Escherichia coli (E. coli) is a gram-negative bacterium found in the intestines of humans and animals. While most strains are harmless, some can become invasive and cause a variety of diseases: healthcare associated E. coli bloodstream infections represent 55% of all gram-negative bloodstream infections.

E. coli cases reduced in frequency when compared to 2021-22. There were 205 cases of E. coli in Bristol this reporting period, compared with 232 last year.

6.5 Other bloodstream infections (BSI)

The number of cases of Methicillin-Sensitive *Staphylococcus aureus* (MSSA), *Klebsiella* and *Pseudomonas aeruginosa* bacteraemia reported within Bristol are noted in **Table 6.5.1**.

Table 2: Number of cases of MSSA, Klebsiella and Pseudomonas aeruginosa bacteraemia in Bristol, 2020–21 to 2022–23

Pathogen	Year		
	2020-21	2021-22	2022-23
Pseudomonas Aeruginosa	33	28	24
Klebsiella bacteraemia	85	86	73

Methicillin-Sensitive Staphylococcus aureus (MSSA)	78	73	93

The most frequently reported primary focus of Klebsiella species bacteraemia during 2021-22 was the urinary tract, constituting 32.8% of cases with a reported primary focus of infection. BNSSG will seek to facilitate shared learning to capture how local improvement has been achieved.

During 2023-24 monitoring of the position for BNSSG against all England and Southwest benchmarking will continue. The BNSSG ICB will encourage partner organisations to review IPC work programmes for 2023-24 and support learning from MSSA reviews.

6.6 Antibiotic prescribing

Antibiotic prescribing and antibiotic resistance are inextricably linked, as overuse and incorrect use of antibiotics are major drivers of resistance. A BNSSG Antimicrobial Resistance Strategy group (recently renamed Infection Prevention and Management Committee) was established in 2020–21 aiming to support and enable the delivery of the national five-year AMR Action Plan[30].

In the winter of 2022–23 there was a significant increase in antibiotics prescribed due to an increase in Group A Streptococcus infections. A 43% increase of antibiotic prescriptions from October 2022 (16,396) to December 2022 (23,488) was seen in Bristol. The largest increase was seen in children aged 0-9 years and was in line with increases seen nationwide. The prescribing rate has since reduced back to expected levels. Despite the winter increase, BNSSG remains the lowest prescriber of antibiotics in children nationally, highlighting good antimicrobial stewardship.

Bristol and BNSSG continued to meet the two nationally set antimicrobial prescribing targets. Antimicrobials per STAR-PU[31] which monitors overall antibiotic prescribing, and the broad-spectrum antibiotics target in 2022–23 (whereby broad-spectrum antibiotics[32] should constitute ≤10% of all prescribed antibiotics).

In hospital settings, the 2022–23 NHS Standard Contract included a requirement to reduce antibiotic consumption of broad-spectrum antibiotics (WHO watch and reserve classification) by 4.5% from a 2018 baseline, measured as Defined Daily Doses (DDD) per 1000 admissions. UHBW met this target and NBT whilst seeing a reduction in the prescribing of broad-spectrum antibiotics did not meet the 4.5% reduction target.

Community antibiotic guidelines continue to be reviewed and updated and stewardship work continues across Bristol. In 2022–23 this included a focus on cellulitis and pyelonephritis pathways with all Bristol practices undertaking an audit on how the diagnosis and prescribing for these two conditions. During World Antimicrobial Awareness Week (18-24th November 2022), there was a focus on the course length of antibiotics, this area of focus is continuing into 23-24 and clinically appropriate short courses can lead to reduced antimicrobial resistance and reduced antibiotic side effects for patients.

[30] UKHSA (2019) UK 5-year action plan for antimicrobial resistance 2019 to 2024 Available from: https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024

[31] Antibiotic prescribing can be measured using Specific Therapeutic Group Age-sex weightings Related Prescribing Units (STAR-PU) weighting, which allows prescribing levels to be adjusted for the number and characteristics of patients registered in the practice.

[32] Cephalosporins, Quinolones and Co-amoxiclav

7. Tuberculosis (TB)

7.1 What is TB?

Tuberculosis (TB) is an infectious disease that most often affects the lungs and is caused by a type of bacteria. It spreads through the air when infected people cough, sneeze or spit. Most infections result in asymptomatic latent TB which is not infectious while 5–10% of cases go onto develop into active TB [33].

Tuberculosis is preventable and curable. Additionally, TB disproportionately impacts underserved and often socially marginalised populations, where the risks of transmission and delayed diagnosis, drug resistance, and mortality are highest.

TB is a public health priority in the UK and globally due to the health, social and economic burden of the disease. While it is preventable through vaccination and is a curable disease with appropriate use of antibiotics, there is a worldwide risk of multi-drug resistant TB (MDR TB) and extensively drug resistant TB (XDR TB).

7.1.1 TB data availability

Availability of timely and recent data for TB notifications, Treatment and Outcomes at a Local Authority level is poor. The most recent data available for this report runs up until the end of 2021. This could be significantly improved to allow for more reactive public health action and better prevention at a local level. Improving data oversight at a Bristol locality level will be a key priority in the year ahead.

7.2 TB Incidence in Bristol

The Tuberculosis in England, 2022 report (data up until end of 2021) indicates that in Bristol, the 3-year average number[34] of TB Notifications and rates reported to UKHSA from 2020-2022 was 43, this represents a rate of 9.2 per 100,000[35] and portrays a slight increase in incidence on recent years.

TB incidence has been decreasing overall in Bristol since 2011, but the rate of decline had been slowing (Figure 18). This latest increase is concerning, particularly in the context that data availability carries a significant delay and we do not know the full local impact of the Covid19 pandemic on TB notifications within the city. Additionally, over the past 18 months Bristol has seen significant migration to the area and more widely the South West.

Responding to TB cases within Bristol requires significant resource from local agencies, with many cases having complexities both medically and socially. So any rise in incidence will add pressure to an already challenged system.

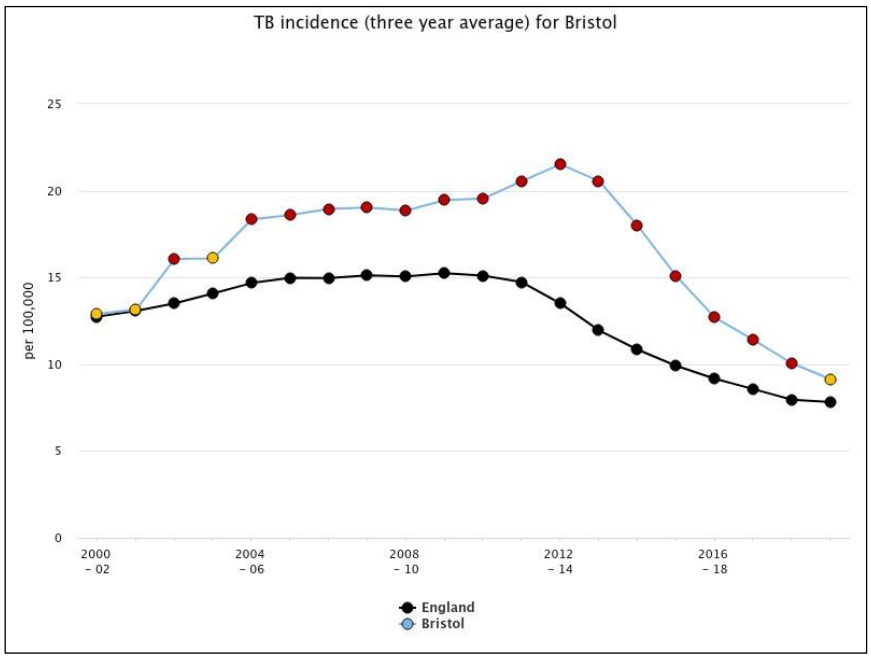
Bristol's 3-year average still remains higher than the England average for the same period (7.3-7.8 per 100,000) and significantly greater than the South West Average (2.9).

[33] WHO (2022) Tuberculosis Fact sheet. Available from: https://www.who.int/news-room/fact-sheets/detail/tuberculosis

[34] UKHSA (2021) Tuberculosis incidence and epidemiology in England, 2021. Available from: tb-annual-report-series- https://www.bristol.gov.uk/council-and-mayor/statistics-census-information/census-20211-supplementary-data-tables.ods (live.com)

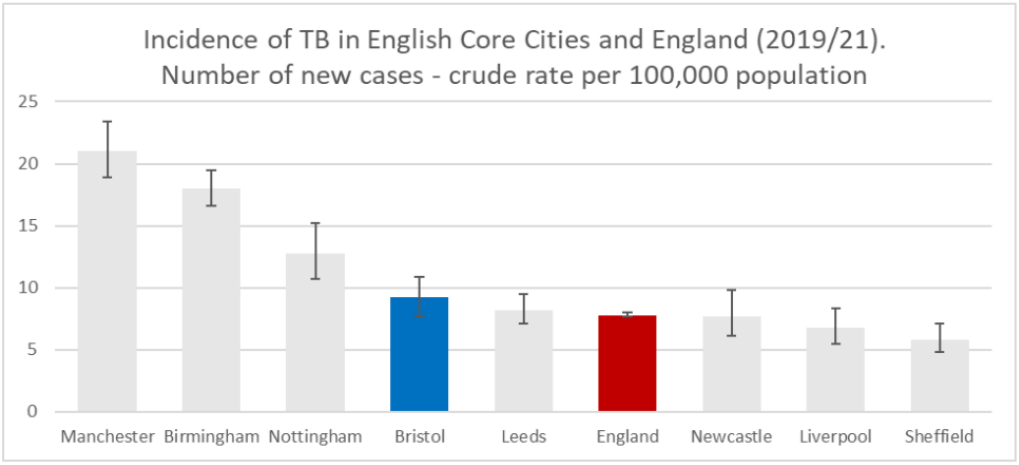
[35]UKHSA (2022) Tuberculosis in England, 2022 report Tuberculosis in England, https://www.bristol.gov.uk/council-and-mayor/statistics-census-information/census-20212022 report (data up to end of 2021) - GOV.UK (www.gov.uk)

Figure 18: Incidence of TB in Bristol and England, 2000/02-2019/21[36]



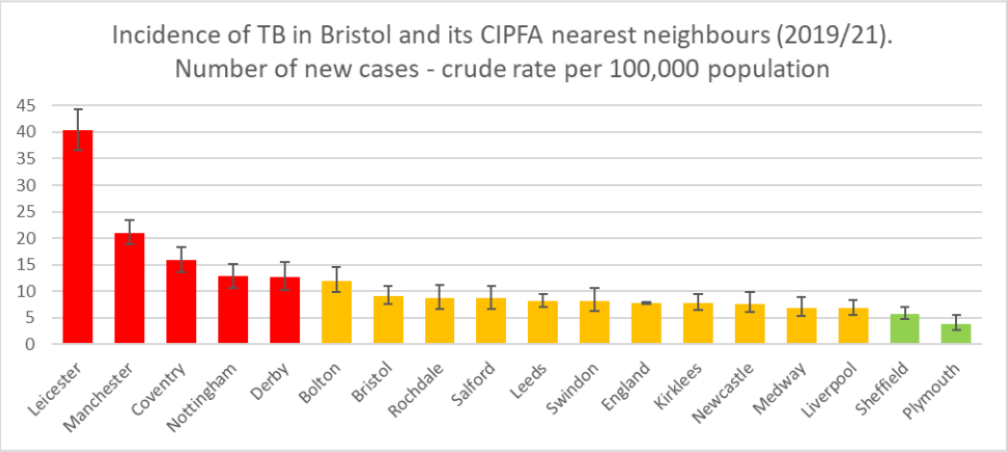
When comparing to English Core Cities, Bristol ranks 4th and when compared against CIPFA nearest neighbours, Bristol ranks 7th in terms of TB incidence (Figure 19 & Figure 20).

Figure 19: Incidence of TB in English Core Cities[36]



[36] OHID Fingertips (2023) Public Health profiles. Available from: https://fingertips.phe.org.uk

Figure 20: Incidence of TB in Bristol and CIPFA nearest neighbours[36]



The red colour-coding indicates rates that are significantly greater than the England average, yellow represents rates that are not significantly different than the England average, green indicates rates that are significantly less than the England average.

Provisional data from quarterly reports, produced by UKHSA suggests that there have been more cases of TB diagnosed in the Southwest in this reporting period than there were last year. (190 in 2022-23 vs 156 in 2021-22)[37].

7.3 TB Treatment

The main treatment for TB is a 6-month course of antibiotics[38], and therefore, due to the nature of TB treatment and testing, data on this is limited. The most up-to-date data available is up until the end of 2021.

In 2021, 42.1% of pulmonary TB cases in Bristol started treatment within two months of the onset of symptoms and 68.4% within four months of symptom onset. This is higher than the proportion of cases starting treatment within two months in England, which is 38%, and equal to the proportion of cases starting treatment within four months in England[39].

There is an established TB service operating across Bristol providing outreach and support to people with active or latent tuberculosis (TB). The team are responsible for identifying and arranging screening for people who've been exposed to TB.

The team also provide information, advice and education about TB to health professionals and the community. The team also lead leads the clinical management of cases and contact tracing, and works with the South West health protection team at UKHSA in response to more complex TB incidents or outbreak situations.

The nurses within the team work closely with TB specialist doctors at the Bristol Royal Infirmary (BRI) and Southmead Hospital to support people who are being investigated or treated for TB. They visit

[37] UKHSA (2023) Number of TB Notifications by UKHSA Region. Available from: https://www.gov.uk/government/statistics/tuberculosis-in-england-national-quarterly-reports
[38] NHS (2023) Tuberculosis (TB). Available from: https://www.nhs.uk/conditions/tuberculosis-tb/
[39] OHID (2023) Fingertips – Public Health Data. Available from: https://fingertips.phe.org.uk/profile/tb-monitoring/data#page/4/gid/1938132814/pat/6/ati/502/are/E06000023/iid/91450/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/tre-do-1

people at home, making sure they get the help they need to complete their courses of treatment and tailoring their support to individual needs. The nurses also arrange TB check-ups for people who have had contact with someone that has an infectious case of TB.[40]

7.3.1 Time to Treatment

In 2020, 35% of pulmonary TB cases in Bristol started treatment within two months of symptoms onset and 57% within four months of symptoms onset. This is lower than the proportion of cases starting treatment in England, at 39% and 68% respectively. No culture-confirmed TB cases were found to be multi-drug resistant (MDR) across the SW in 2020[41].

The number of new cases per year places a notable demand on the health care system. Contact tracing is key to management of TB, and with new testing tools latent TB can be identified (that could otherwise reactivate and cause active disease) and appropriate action taken to support these people.

7.3.2 Enhanced Case Management (ECM)

21 cases of TB within the South West have been recorded as requiring Enhanced Case Management, accounting for 13% of cases. Of these 21 cases, 6 situations required a Level 3 response. Level 3 indicates cases involving patients with very complex clinical or social issues or both affecting treatment and necessitating DOT or video enhanced therapy (VOT) and may include people experiencing homelessness, multidrug resistant (MDR) or rifampicin resistant (RR) TB, those with complex contact tracing or cases in which the involvement of social services is required.[42]

The number of these more complex situations that arise, place significant strain and resource implications on agencies responding to these cases within Bristol, particularly if a case is linked to a vulnerable setting such as a homeless hostel or street homeless population.

7.4 TB Equalities Data

National data for the calendar year ending 2020 indicates that the majority of people with TB born in the UK were White (59%) followed by South Asian (22%) and Black (14%) among those with known ethnicity [43]. However, adjusting for differences in population size, incidence rates were highest among people from non-White ethnic groups being up to 11 times higher than in the White ethnic group.

Similarly in the South West, the most frequently reported ethnic groups of TB cases diagnosed in 2020 were White (50%), Indian (16%) and Black African (15%), but the equivalent incidence rate among non-UK born individuals was 20.3 per 100,000 people, which was substantially higher than the incidence rate among the UK-born population (1.3 per 100,000 people) **Error! Bookmark not defined.**.

Non-UK-born cases were more likely to have received a BCG vaccination for TB prevention than UK-born cases (73% vs 27% respectively), reflecting the fact that the BCG vaccine is not routinely administered in the UK **Error! Bookmark not defined.**.

7.4.1 Asylum Seekers and Refugees

Over the past 18 months there has been significant migration into Bristol and more widely, the South West. This has caused pressure on the local system and presents a potential cause for concern in the future due to the unknown history of TB exposure in some people.

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[40] Tuberculosis (TB) Nurse – Sirona care & health NHS services (sirona-cic.org.uk)

[41] UKHSA (2021) Tuberculosis in the South West: annual review 2021. Available from: https://www.gov.uk/government/publications/tuberculosis-tb-regional-reports

[42] TB treatment in England, 2021 - GOV.UK (www.gov.uk)

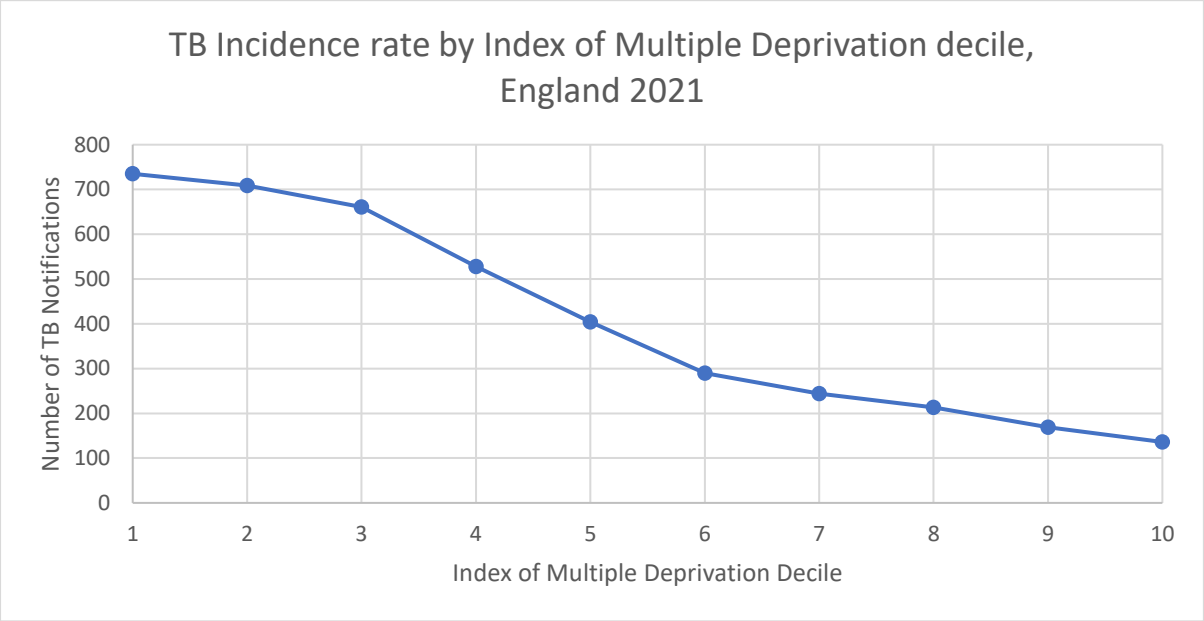
[43] UKHSA (2021) Tuberculosis in England: 2021 report (presenting data to end of 2020). Available from: https://www.gov.uk/government/publications/tuberculosis-in-england-annual-report

There have also been specific official routes to the UK opened for eligible migrants (for example from Afghanistan or Ukraine). As these populations and routes have specific features there are tailored TB screening recommendations for these groups.

7.4.2 Deprivation

National data indicated a social gradient in TB incidence rate for the calendar year ending 2021. The incidence rate of TB in the 10% of the population living in the most deprived areas (IMD decile 1) was over five times greater than the incidence rate of TB in the 10% of the population living in the least deprived areas (IMD decile 10)[Error! Bookmark not defined.].

Figure 21: TB Incidence by Index of Multiple Deprivation Decile[Error! Bookmark not defined.]



Source: UKHSA (2021) Tuberculosis in England: 2021 report (presenting data to end of 2021).

7.4.3 Social risk factors

Social risk factors that are measured among those diagnosed with TB are, current drug and/or alcohol misuse, current experience or a history of homelessness and imprisonment.

Nationally, the number of people notified with TB has decreased in the last decade but the number of people with TB and a social risk factor has remained relatively constant, suggesting that TB control measures have not been as effective in this population.

In 2021, 17 (11%) TB cases in the South West reported one or more risk factors[Error! Bookmark not defined.]. On average, TB cases with social risk factors tended to have shorter delays between symptom onset and treatment but were less likely to complete treatment and more likely to have poorer outcomes compared to those with no social risk factors.

7.5 National strategy and reporting

Substantial work is needed to meet the international WHO End TB targets in the UK, which aim to achieve a 95% reduction in the number of TB deaths and 90% reduction in the incidence rate of TB compared to 2015 by 2035[44].

UKHSA and NHS England jointly published a new Action Plan for TB (2021 to 2026) in 2021, which set out a programme of work to reduce TB incidence and transmission. The TB Action Plan aims to improve the prevention, detection and control of TB in England, focusing on the needs of those most affected by TB whilst recognising the impact and learning of the COVID-19 pandemic [45].

The South West TB Control Board has overall responsibility to set the strategic priorities in the South West and facilitate the delivery of the TB Action Plan 2021–2026 and have representation from across the system. Additionally, the regional UKHSA team produces annual reports and twice-yearly cohort reviews to provide local health intelligence beyond the notification system used for outbreak response and management.

Delivery of the Action Plan's priorities will build on the progress in collaborative working with multi-agency partners (regional OHID, ICS, service providers) in forums such as the South West TB network to address the 5 key priorities outlined in the TB Action Plan.

7.6 Local Priorities

7.6.1 Local Surveillance

The increased TB incidence, some linked to migration which has grown exponentially in this period, and the complexities in regard to wider risk factors, diagnosis and treatment is creating increased pressure on the local system.

It is a key priority that data from local surveillance, and local caseload is timely and is reported into the Health Protection Committee. In the coming year, agencies will work together to ensure that this more localised data is readily available and can be used to initiate interventions and public health action.

With the limited published data we will need to undertake a local rapid review of TB to gain clarity on local profile to support commissioning and delivery. Noting the complexities of migration and for some who have no recourse to public funds we will develop a local pathway across the system.

7.6.1.1 Impact of Covid 19

The impact of COVID-19 on TB control in England is not yet fully quantified: population-wide lockdowns may have reduced TB transmission but due to the disruption of TB services, the number of undetected and untreated TB cases may have increased [46].

Going forward, it is a key priority within Bristol to understand the full impact of the Covid 19 pandemic on TB surveillance and control within the city.

[44] WHO (2015) The End TB Strategy. Available from: https://www.who.int/teams/global-tuberculosis-programme/the-end-tb-strategy
[45] UKHSA (2021) TB Action Plan for England, 2021 to 2026. Available from: https://www.gov.uk/government/publications/tuberculosis-tb-action-plan-for-england
[46] Cilloni L et al (2020) The potential impact of the COVID-19 pandemic on the tuberculosis epidemic a modelling analysis. Available from: https://doi.org/10.1016/j.eclinm.2020.100603

7.6.2 Asylum Seekers and Refugees

Work is required locally to address the risks associated with an increasing migrant population within the city- specifically related to those who have entered the UK via specific official routes (for example from Afghanistan or Ukraine- both countries with a higher national incidence of TB).

Pre-entry screening does not test for latent tuberculosis infection (LTBI) or for extra-pulmonary disease. Migrants from high-incidence countries remain at a higher risk for TB many years after arrival in the UK. Primary care practitioners must therefore remain alert to the signs and symptoms of TB among migrants. This is a priority locally in Bristol to address this.

8. COVID-19 Response

The majority of data within this section has been extracted from Bristol City Council's JSNA for COVID-19.[47]

8.1 Overview

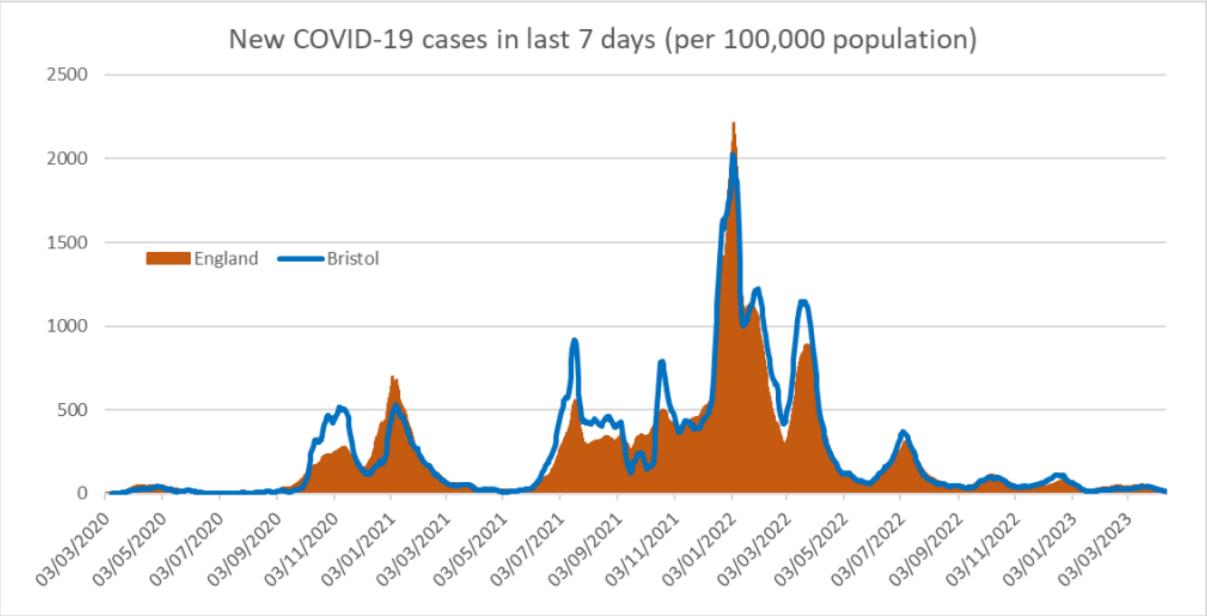
COVID-19 (SARS-CoV-2) is an infectious disease caused by a coronavirus. It was first reported in China in December 2019, the first case reported in the UK happened the following month in January 2020. Bristol reported its first case on 3rd March 2020 and the first reported death within Bristol with COVID-19 was on 27th March 2020. As of April 2023, all legal requirements associated with COVID-19 have been lifted in the UK.

8.2 Cases and Testing

Since January 1st, 2020, there have been 185,502 reported cases of COVID 19 within Bristol (as of 31st March 2023). Figure 22 below illustrates the trend in cases over time. It is important to remember that we can only present reported data, therefore cases may be artificially lower due to testing limitations at certain points of time and/or personal choice regarding testing completion/ reporting.

[47] Bristol City Council (2023) COVID-19 Joint Strategic Needs Assessment. Available from: https://www.bristol.gov.uk/files/documents/1577-jsna-2021-22-covid-19/file

Figure 22: Trends in cases of COVID-19[48]



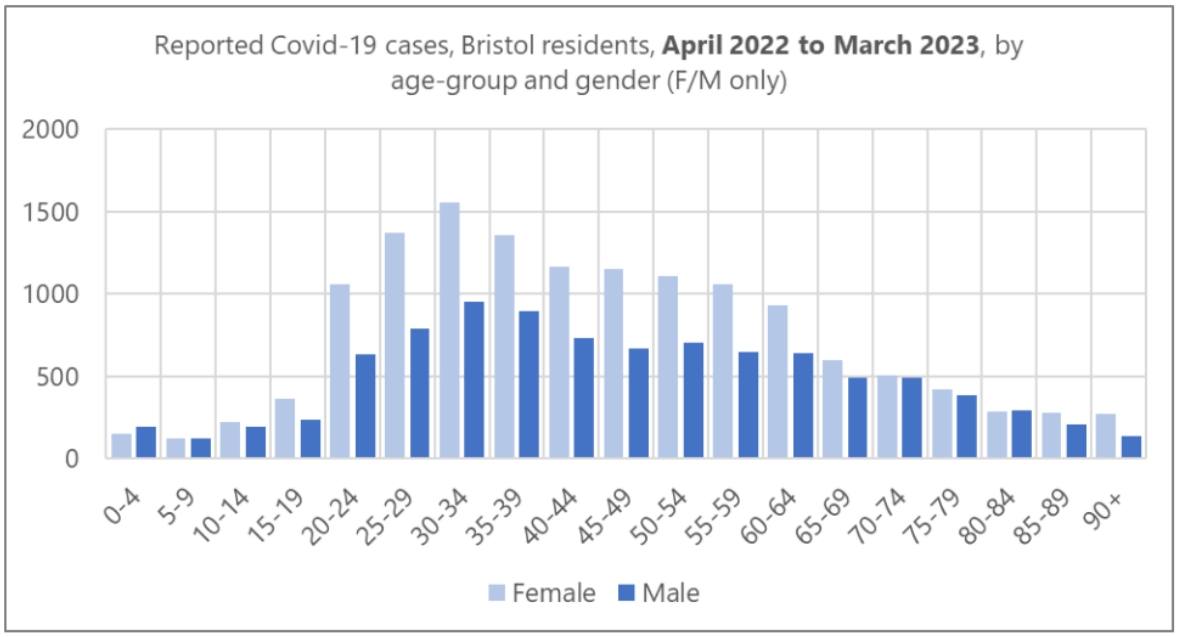
Testing was initially reserved for healthcare staff and patients; therefore, testing (and the number of cases) was artificially low. Free community testing was made available and strongly promoted to the wider population from May 2020 onwards, until April 2022.

During the period of April 2022 – March 2023, that this report covers, free community testing had ceased, and the numbers of tests completed reduced, which limited the level of confidence in COVID-19 rates. Due to the continuing testing across Health and Social Care some data was available locally which showed an expected skew towards working age adults and older people.

There was very little data evidence of COVID-19 infection in children and young people, but testing was not undertaken to assess this. Figure 23 below provides an overview of reported cases, separated by male and female.

[48] Bristol City Council (2023) Joint Strategic Needs Assessment – COVID-19. Available from: https://www.bristol.gov.uk/files/documents/1577-jsna-2021-22-covid-19/file

Figure 23: Total number of COVID-19 cases within Bristol by age group and sex, April 2022 to March 2023[48].

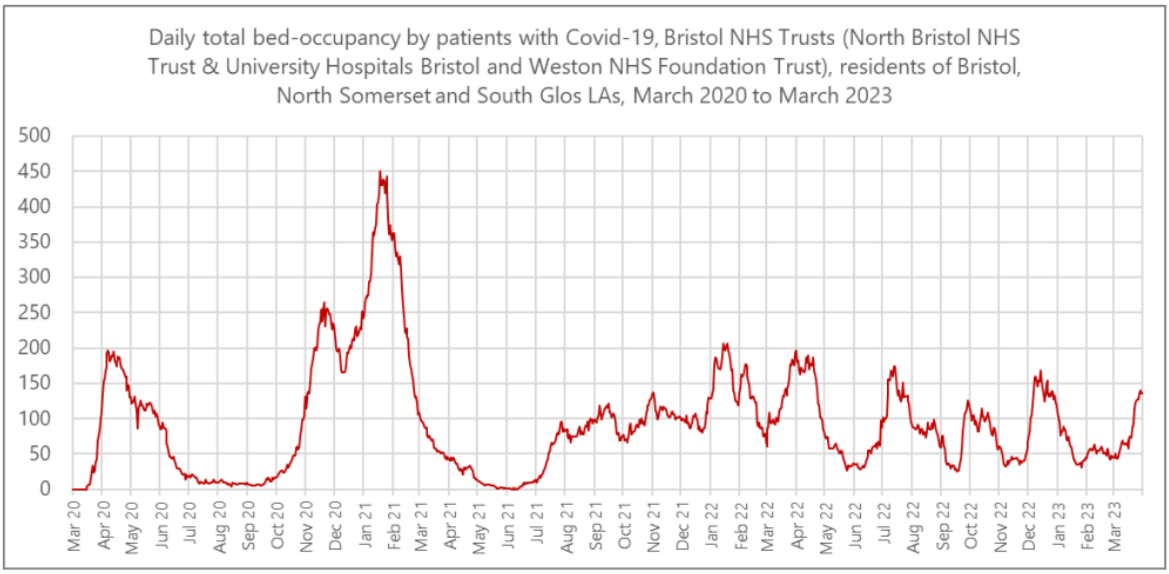


With the reduced level of testing data, the focus on monitoring risk moved to measuring levels of severe illness. Hospital data became increasingly important as an early and reliable metric of the COVID-19 impact.

8.3 Hospitalisations

15,917 people were admitted to hospital with COVID-19 during the period of March 2020 – 31st March 2023. These admissions were to the two main hospitals that serve Bristol (although these hospitals serve a very large area, not just Bristol residents). It is also important to acknowledge that COVID-19 may not have been the primary reason for hospitalisation but was identified through admission testing or due to asymptomatic or symptomatic cases being tested while in hospital. Estimates are that between 20-50% of recorded hospitalised cases of COVID-19 do not have COVID-19 as the primary reason for admission.

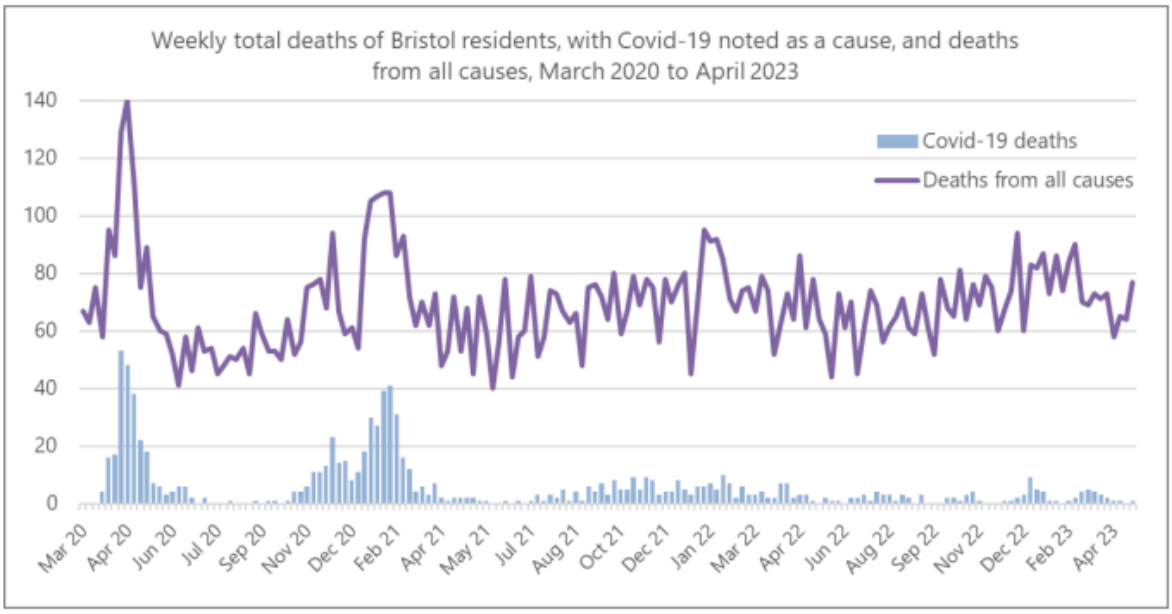
Figure 24: Daily hospital bed occupancy associated with COVID-19 infections across Bristol's two hospital trusts[48].



8.4 Deaths

The method for measuring death caused by COVID-19 in this document, is COVID-19 being cited as the underlying cause of death on the death certificate. From March 2020 to March 2023, 921 residents of Bristol died from COVID-19. Across the three years since March 2020, the mortality of COVID-19 has decreased year on year. In the year from March 2020 to March 2021 there were 613 deaths from COVID-19, from March 2021 to March 2022 this number was 193 and in the year from March 2022 to March 2023 there were 115 deaths from COVID-19.

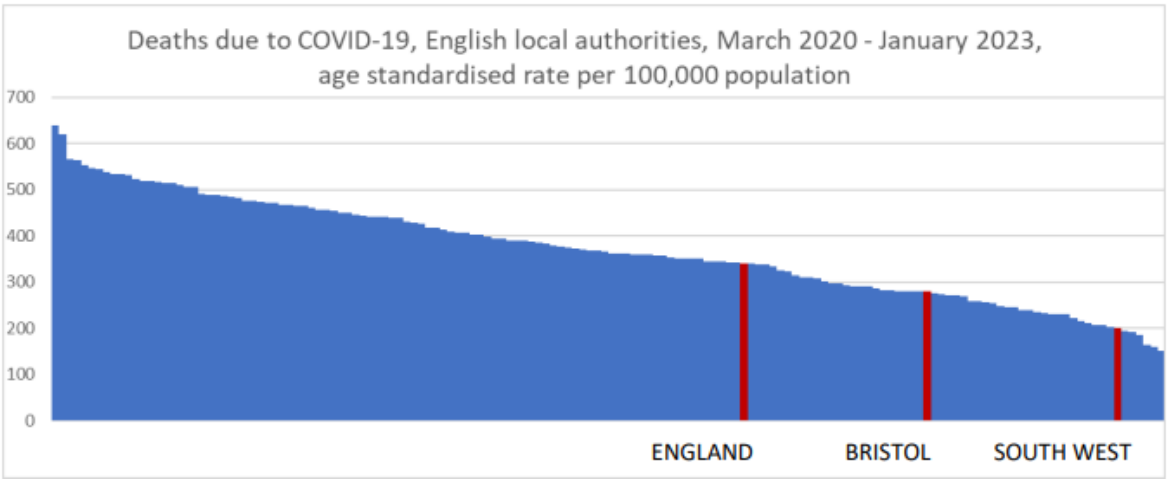
Figure 25: Trend in number of COVID-19 deaths and deaths from all causes registered in Bristol[48].



The demographic of Bristol, with a statistically younger age population than other cities and local authorities, may influence on the low crude mortality rates observed. Bristol has a relatively young population, who are much less likely to be affected by serious illness associated with COVID-19 infection, when compared to a more elderly population. However, by comparing age standardised

mortality rate, which is more reliable in comparisons, we can see that while Bristol was relatively low for total deaths, compared to the other core cities within England, and the England average it had a higher mortality rate than the average for the Southwest of England region.

Figure 26: Age standardised COVID-19 mortality rates, English Local Authorities[48].



8.5 Long COVID

There is no local data or intelligence for long COVID[49] in Bristol.

As of 5th March 2023 there were 1.9 million people living in private households who had self-reported long COVID (2.9% of the population). The greatest prevalence of self-reported long COVID was within people aged 35-69 years, females, people living in deprived areas, those working in social care, those aged 6 years and over who are not working or looking for work.

By applying the same estimates to Bristol using the most recent 2021 Census data which indicated Bristol had a population of 472,500 on census day it can be estimated that approximately 13,700 have self-reported symptoms of long COVID. Fatigue was the most reported symptom (72% of people who self-reported long COVID reported fatigue), this was followed by difficulty concentrating (51%), muscle aches (49%) and shortness of breath (48%).

9. Environmental Health

9.1 Foodborne and Waterborne Illness

Foodborne illness (more commonly referred to as food poisoning) is any illness that results from eating contaminated food/water. Foodborne and waterborne illness can be caused by a variety of different pathogenic organisms at some point in the food chain, between farm and fork. For example, Campylobacter, Salmonella, Listeria, Escherichia Coli 0157, Giardia and Cryptosporidium. Although most cases in the UK are mild, they are unpleasant and result in absences from education or the workplace and place a significant demand on healthcare services. Occasionally foodborne/waterborne illness can lead to complications or even death. Access to safe food and potable water is one of the most fundamental human needs.

[49] Long COVID is described by the Office for National Statistics as “symptoms continuing for more than four weeks after the first confirmed or suspected coronavirus (COVID-19) infection that were not explained by something else”.

In Bristol, there were 585 confirmed cases of notifiable potentially food/water related infections between 1 April 2022 and 31 March 2023. There were also 148 service requests relating to suspect food poisoning for the same period[50].

Bristol City Council (BCC) Public Protection Team works closely with relevant health protection agencies and businesses to minimise the spread of infections and to investigate serious cases/outbreaks throughout the year.

9.2 Food Safety Inspection and Intervention

All food businesses based in the UK are subject to food hygiene laws enforced by local authorities. Businesses can be inspected at any point unannounced, for example if BCC receives complaints, or having become due as part of the annual programme of inspections.

Authorised environmental health officers (EHOs) have the right to enter and inspect food premises unannounced, without appointment to ensure that businesses meet the requirements of food safety legislation. Inspections result in a set of scores which, for most business supplying the final consumer, are published under the Food Standards Agency (FSA) 'Food Hygiene Rating Scheme'.[51]

The Food Standards Agency (FSA) expects 100% of premises to be inspected based on their scoring; BCC has set a local target of 80%. Bristol's annual programme of inspections was impacted by the COVID-19 pandemic and associated restrictions on premises resulting in an increased backlog of outstanding inspections. Towards the end of the previous reporting period (2021–22), 41% of the required inspections/interventions had been achieved, compared to 79% achieved pre-pandemic in 2019–20. Between April 2022 and March 2023, inspections recommenced at approaching normal capacity, although there were some problems retaining and recruiting authorised officers. 2,131 inspections were completed representing 67% of the total due. This remains below the FSA's expectations.

During 2022–23 BCC followed FSA guidance and priority planning in the form of the Local Authority Recovery Plan to focus on the highest risk establishments first. The Plan set out the timescale for authorities to clear the backlog of inspections by the end of March 2023. There was a backlog of 950 visits by the end of 2022–23, which will add to the programmed visits and anticipated new business registrations giving an estimated total of 3,572 visits due by the end of 2023–24.

The 2022–23 compliance rate across food businesses in Bristol was 98% excluding the establishments awaiting first inspection (86% including the unrated). The minority of establishments that fall into the "non-compliant" category are the focus for follow up and action by BCC. Among the non-compliant establishments identified during 2022–23, BCC conducted 186 re-visits, issued 527 written warnings, with 10 voluntary closures or surrenders.

Looking forward, we have recently been making good progress on reducing the backlog, we have engaged contractor EHOs to help with this. We have provided the FSA with quarterly reports and have regular meetings with them as they closely monitor progress as part of their regular monitoring of LA activity. Food inspector capacity during the reporting period was supported through temporary

[50] UK Health Security Agency notifications recorded on BCCs Civica database.

[51] These ratings run from 0-5, with a score of '0' indicating that serious action must be taken immediately to avoid penalties or the closure of the premises. A score of 3-5 is considered "broadly compliant" while a score of 0-2 is considered "non-compliant". Establishments are inspected on a regular basis, with inspection intervals varying from every 6 months to every 36 months. https://www.food.gov.uk/safety-hygiene/food-hygiene-rating-scheme

funding structures. As new grant funding opportunities become available the BCC Environmental Health team will continue to apply for these; any additional funds will be used to employ additional contractors to reduce the backlog as much as possible. Subject to grant funding, the team aims to contract out a further 1,800 inspections for completion by the end of March 2024. This will have a positive impact on reducing the backlog.

9.3 Port Health

BCC is the statutory Port Health Authority for the ports of Avonmouth, Royal Portbury Docks and Portishead marina which are in North Somerset and owned by Bristol Port Company. Bristol Port Health Authority (BPHA) is part of the BCC Public Protection team and is responsible for infectious disease control at the border, inspection & certification of international shipping arrivals and operating the long-established Border Control Post.

The Border Control Point is based at Avonmouth and is operated in liaison with Border Force, the Animal and Plant Health Agency, DEFRA, and the FSA and subject to their regulatory requirements.

A second Border Control Post funded by central Government and the Bristol Port Company has been built at Royal Portbury Docks where the deep-water dock is located, with detailed input and liaison from BPHA regarding the necessary Border Control Post requirements to examine arriving foodstuffs. This facility is currently in the designation process and hopefully will be operative by the end of 2023. The Port Health Authority continues to work with DEFRA regarding the many and frequent changes to proposed import controls regarding EU imports and ongoing funding for these activities.

During the reporting period (April 2022 to March 2023), BPHA was proactive in ensuring the necessary COVID-19 controls (which changed over time) were in place in relation to all ships including cruise ships arriving from international and European destinations. A 24-hour service was introduced at the beginning of the COVID-19 pandemic to provide effective controls at the Port.

Our Port Health Officers continued to liaise with many different partners about the ongoing UK legal COVID-19 requirements and guidance during the reporting period. These partners included Bristol Port Company & Harbourmasters, Importers, Border Force, Public Health England, Shipping agents, Coastguard, Port Police, and the Seafarer Centre Chaplains at Portbury Dock. This involved working on complex COVID-19 cases arriving from various countries and working with relevant agencies to ensure COVID-19 spread was contained, crew and the public protected, and crew changes and self-isolation requirements adhered to.

Other Port Health work includes inspections and sampling of ships including cargo and cruise liners for non-COVID-19 infection control including Legionella, food poisoning, other communicable diseases, and hygiene arrangements including the issuing of International Ships Sanitation Certification. There was a steady record of manifest checks (183 over the reporting period) and checks on Maritime Declarations of Health (1,557 over the reporting period) during the reporting period. The rate and number of actions completed by Port Health officers during this reporting period was impacted by the working restrictions in place due to the COVID-19 pandemic and the many outbreaks and cases of COVID-19 on vessels that were dealt with as a priority by Port Health Officers.

9.4 Contaminated Land

It is recognised that failing to deal adequately with land contamination could cause harm to human health, property and the wider environment. The origin of land contamination is often because of

industrial activities although some areas may be affected by the natural or background occurrence of potentially hazardous substances such as radon, methane or metallic elements.

Bristol was formerly a city of heavy industry, rapidly developing from the eighteenth century, the construction of the floating harbour in 1809 saw a boom in industry alongside the river and overtime this has moved away from the city centre to Avonmouth and other industrial areas. Industries specialising in chemicals, metals (lead and steel) and glass were commonplace. Mineral extraction including coal mining continued until the early twentieth century. In recent years there has been a growth in the waste processing sector.

Contamination becomes a concern when the levels of substances are deemed to be high enough to cause potential risks to human health and/or the environment. The presence of contamination however does not mean an unacceptable risk. Risk exists when there is a complete contaminant linkage involving a:

- **Source** - contaminant on or under the land, any substance which is or may become harmful to persons or buildings, including substances which are corrosive, explosive, flammable, radioactive or toxic.
- **Pathway** - the route by which the contamination reaches the receptor i.e., inhalation or ingestion.
- **Receptor** - people and living organisms in general, groundwater, rivers or the wider environment, ecological systems or property which may be harmed.

The team have three main mechanisms to deal with contaminated land:

- **Development Management Process (Planning and Building Control)**
    - **National Planning Policy Framework 2023** – developers have a duty to ensure the development is fit for the proposed end use, as outlined National Planning Policy Framework (2023) Paragraphs 120, 174, 183-188.
    - **Building Regulations 2010 –** developers have a duty to ensure the building meets the requirements of Approved Document C.
    - We are a consultee for the development management process ensuring that developments are fit for purpose, we work in conjunction with other national bodies such as the Environment Agency with respect to controlled waters and the Coal Authority with respect to coal mining legacy issues.
- **Environmental Damage Regulations 2009**
    - This enables us to act when a current pollution incident occurs from a company.
- **Environmental Protection Act 1990 Part 2A**
    - The council have a statutory duty to assess and inspect land to ensure it is suitable for the current use, these are sites which have the potential to be causing significant harm to human health from historic contamination.

The Pollution Control Team ensures and ratifies the above processes by providing expert evaluation of applications, associated site investigation reports, risk assessments, testing, remediation strategies, unexpected contamination and validation.

The typical number of planning applications where we need to consider contamination (associated site investigation reports, risk assessments, testing, remediation strategies, unexpected contamination and validation etc) runs at approximately 550 per year.

10. Global Population Health

10.1 Zoonosis

Approximately 60% of emerging infectious diseases reported globally are thought to be of zoonotic origin.

Zoonoses are defined as those diseases and infections naturally transmitted between people and vertebrate animals. There are three classes as follows: a) endemic zoonoses which are present in many places and affect many people and animals; b) epidemic zoonoses which are sporadic in temporal and spatial distribution; and c) emerging and re-emerging zoonoses which are newly appearing in a population or have existed previously but are rapidly increasing in incidence or geographical range. Examples of the latter include Rift Valley fever, SARS (severe acute respiratory syndrome), pandemic influenza H1N1 2009, Yellow fever, Avian Influenza (H5N1) and (H7N9), West Nile virus and the Middle East respiratory syndrome coronavirus (MERS-CoV) reported in the recent past.

This increase has been linked to environmental changes, loss of habitat, climate change, loss of biodiversity. It is also recognised that there are now greater levels of contact between humans and animals, and that we live in closer proximity. In addition to the increasing incidence of infectious diseases is the increasing risk of spread.

Infectious diseases have no borders. The COVID-19 pandemic showed how quickly an infection can circle the earth and have devastating impacts. Worldwide people travel for a range of reasons; for holidays, visiting friends and family, to study and work or to flee war, persecution or economic hardship. These journeys create opportunities for infections to spread.

10.2 Vaccine-preventable diseases

Despite many countries making significant development towards immunisation efforts, there are still many outbreaks of vaccine-preventable diseases. Notably measles, which remains to be one of the leading vaccine preventable killer of children, globally[52] . There is growing concern of the risk of measles transmission, London particularly has seen a growth in cases in the early part of 2023. Links to travel to countries with high measles prevalence and low vaccination coverage are then reaching into UK populations with low MMR vaccination protection. Bristol, which has an MMR coverage level more similar to London and other cities, is at greater risk.

The COVID-19 pandemic continues to display a negative impact on the essential immunisation programme in a global context. Delivery and strengthening of this programme remains a priority for the World Health Organisation.

Conflict can lead to greater number of vaccine-preventable deaths due to the disruption of healthcare infrastructure which undermines vaccination programmes. In these turbulent environments focus often shifts away from preventative healthcare, leaving vulnerable populations at heightened risk of vaccine-preventable disease. Furthermore, displacement of populations to refugee camps that have limited medical facilities and limited sanitation may foster the spread of disease.

Inequalities in access to healthcare are observed globally, particularly in relation to immunisations for vaccine-preventable diseases. LMIC (Low-medium income countries) often have poorer vaccine programmes due to a number of economic, systemic and logistical challenges, as a result of reduced

[52] World Health Organization (2023) A new era in the fight against measles and rubella. Available from: https://www.who.int/news/item/22-02-2023-a-new-era-in-the-fight-against-measles-and-rubella

economies and resources. Including the inadequate funding for purchasing vaccines, maintaining cold-chains, and training of healthcare workers. Other barriers include reduced capacity for health education, political instability and difficulty reaching geographically isolated populations.

10.3 Anti-microbial resistance (AMR)

Where bacterial infections occur, antibiotics are often used to treat, however the more we use antibiotics, and use them unwisely, for example for non-bacterial infections, we are increasing the risk of anti-microbial resistance. As described earlier in this report (Section 6.6), this remains a significant public health challenge internationally and work to reduce antibiotic use in human, animal and agriculture remains a priority; Fleming Fund and the Global AMR Innovation Fund.

Global surveillance systems continue to monitor antimicrobial resistance and antibiotic use at a global level.

10.4 Mpox

Between 2022 and 2023 we saw the international emergence of Mpox. Mpox (previously named Monkeypox) is a rare but high consequence zoonotic disease caused by a virus related to smallpox, most commonly found in west and central Africa. Mpox is not highly infectious, it requires close contact between humans or an infected animal. It is however classed as a high consequence infectious disease with potential for high mortality.

More detail about Mpox can be found in section 5.4.

10.5 Climate Change

Climate change is described as "an alteration in the regional or global climate; especially the change in global climate patterns increasingly apparent from the mid to late 20th century onwards and linked largely with increased emissions of carbon dioxide and other greenhouse gases caused by human activity"[53].

Climate change is contributing to a number of different emergencies worldwide, such as wildfires, heatwaves, tropical storms and hurricanes. These weather and climate hazards affect health both directly and indirectly, increasing the risk of deaths, noncommunicable diseases, the emergence and spread of infectious diseases, as well as affecting food availability and quality, contributing to world-hunger foodborne and waterborne diseases[54].

11. Asylum seekers and Refugees

The city of Bristol has continued to welcome and meet the health needs of both asylum seekers and refugees (ASRs) during the reporting period. ASRs are a broad population with some groups requiring more assistance than others based on the circumstances and context of their arrival.

The council's Refugee Resettlement Programme Project Board, chaired by Adult Social Care, has oversight of Resettlement streams of work. A multi-agency group of statutory, community and voluntary partners, chaired by Public Health, continues to coordinate and facilitate the care of those

[53] Oxford English Dictionary, s.v. "climate change (n.)," December 2023. Available from: https://doi.org/10.1093/OED/4530570262

[54] World Health Organization (2023) Climate Change. Available from: https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health

arriving through the Home Office-organised hotel accommodation for ASR. This included an initial accommodation hotel for destitute asylum seekers, and two hotels and 40 apartments for people resettling from Afghanistan (ARAP Afghan Resettlement and Assistance Policy scheme). This group meets regularly to focus on the health and wider needs of the ASR population. The Integrated Care Board also coordinates a health commissioners migrant health group to facilitate planning.

The health needs of the ASR population include a range of physical and mental conditions including post-traumatic stress disorder (PTSD) and trauma. The OHID Migrant Health Guide[55] continued to provide key guidance on health-related policy for health providers serving migrant populations. Health Protection issues dealt with this year include outbreaks of diarrhoea and vomiting, scabies, chicken pox and identification and treatment of TB cases.

Haven Health, a specialist primary healthcare care service for ASRs provided by Sirona Health and Care provides a 'first stop' clinic for new arrivals across the BNSSG area. The Haven offers comprehensive health assessments for those not yet registered with a GP, medical management of current health problems, and screening and immunisations for communicable diseases. Additionally, the Haven facilitates registration with primary care practices and provides information about how to use the NHS and confidential interpreting during consultations. Sirona Health and Care has also provided health visitors, and a school nurse to support this community, as well as the Latent TB team.

The HOPE service provided by Avon & Wiltshire Mental Health Partnership helps ASRs and victims of trafficking who have experienced trauma in adulthood and have a primary diagnosis of PTSD.

Work is ongoing across the council to support people fleeing conflict in Ukraine, they have access to all UK healthcare provision.

The number of ASR is expected to continue to increase in the year 2023–24 which will create additional demand and system pressure on local services. The ARAP accommodation will close in 2023, with many families being rehoused locally, and the initial accommodation will be expanded to include at least one other hotel. This means that our priority is to ensure a continuity of health service for residents being moved, ensuring the resilience of local services, and working with UKHSA to ensure infection prevention measures are in place recognising the regular movement of people across the Home Office hotel estate.

12. Non-communicable Environmental Health Risks

12.1 Air quality

Poor air quality is the largest environmental risk to public health in the UK. Studies have shown that exposure to poor air quality can have an impact on health and wellbeing at all stages of life, from being associated with low birth weight, lung function development in children, increased risk of chronic disease, and acute respiratory exacerbations, to premature death[56].

[55] Office for Health Improvement and Disparities (2023) Migrant health guide. Available from: https://www.gov.uk/government/collections/migrant-health-guide

[56] PHE (2019) Review of interventions to improve outdoor air quality and public health. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/938623/Review_of_interventions_to_improve_air_quality_March-2019-2018572.pdf

Poor air quality is harmful to everyone, but inequalities in exposure (e.g., how close you live to an area of high pollution) and susceptibility (e.g., infants and children, older people, and those with poor lung health) result in health inequalities[57].

International and national actions to improve air quality often focus on particulate matter (PM10), fine particulate matter (PM2.5), and nitrogen dioxide (NO_2) which are major components of urban air pollution[58] and are strongly linked to adverse health effects. There are many other pollutants that are given less prominence, though any efforts to achieve the above targets will likely lead to overall improvements in air quality.

New estimates produced by DEFRA and UKHSA indicate that in 2021, 5.7% of all deaths in Bristol were attributable to long-term exposure to PM2.5 pollution [59]. The proportions of deaths attributable to air pollution vary across the city in relation to pollutant concentrations, from around 7% in some wards to around 10% in others[60]. Concentrations are highest in the centre of the city and therefore so are deaths attributable to air pollution. These mortality rates include both nitrogen dioxide (NO2) and fine particulate matter (PM2.5) based on 2013 pollution data, so are slightly higher than the figure quoted by DEFRA and UKHSA above.

In Bristol, monitoring data shows continued exceedances of the annual mean NO air quality objective close to roadside locations in the city centre and along the main arterial routes. While concentrations of NO are declining, further urgent action is needed to comply with legal limits. Additionally, domestic solid fuel burning (a major source of PM10 and PM2.5) is of increasing concern with limited awareness among the population.

12.2 Road transport and the Air Quality Management Area

Road transport is a major source of particulate matter and nitrogen oxides (of which nitrogen dioxide is one) accounting for 34% of NOX and 12% of PM2.5 emissions in the UK[61]. At busy roadside locations, the contribution of traffic to NO2 can be greater than 80%.

An Air Quality Management Area (AQMA) may be established if health standards (known as objectives) are not achieved or at risk of being not achieved, in line with DEFRA recommendations (Figure 27). Approximately 100,000 people live within Bristol's AQMA, which has been in place since 2001.

[57] DHSC (2017) Annual Report of the Chief Medical Officer, Health Impacts of All Pollution – what do we know? Available from: https://www.gov.uk/government/publications/chief-medical-officer-annual-report-2017-health-impacts-of-all-pollution-what-do-we-know

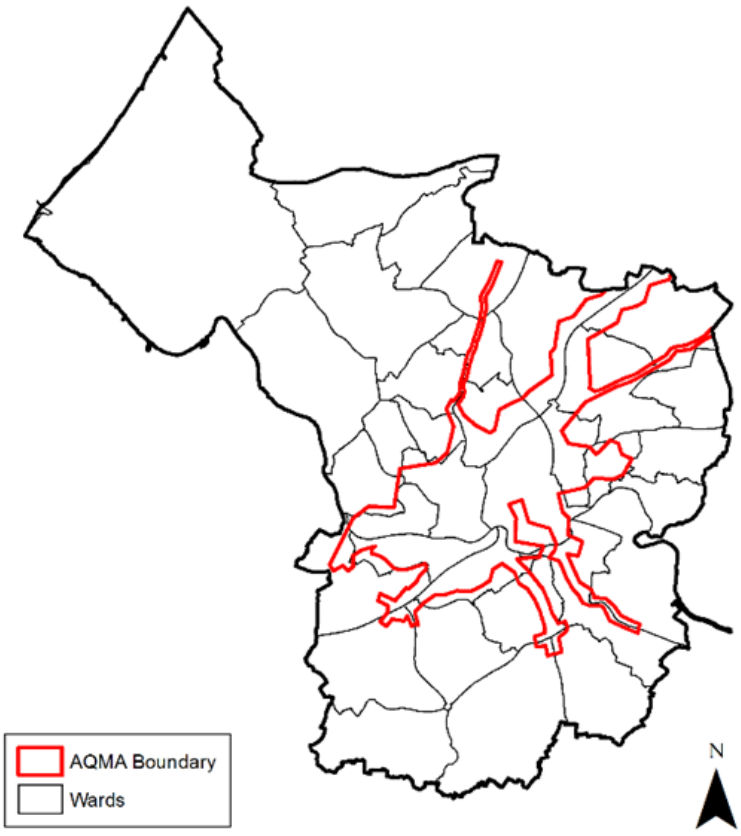
[58] PHE (2018) Health matters: air pollution. Available from: https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution

[59] OHID (2022) Fingertips: Public Health Profiles. Available from: https://fingertips.phe.org.uk/search/air%20pollution#page/4/gid/1/pat/6/par/E12000009/ati/402/are/E06000023/iid/93861/age/230/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

[60] Air Quality consultants (2017) Health Impacts of Air Pollution in Bristol. Available from: https://www.bristol.gov.uk/files/documents/599-health-impacts-of-air-pollution-in-bristol-february-2017/file

[61] DEFRA (2019). Clean Air Strategy 2019. Available from: https://www.gov.uk/government/publications/clean-air-strategy-2019

Figure 27: Map of Bristol's Air Quality Management Area (AQMA) [62]



The AQMA is based around busy road junctions and roads where nitrogen dioxide from the exhausts of vehicles is most concentrated due to the volume of vehicles. Real-time data on local air quality can be visualised and downloaded in the Air Quality Dashboard.

Bristol's Clean Air Zone (CAZ) commenced in November 2022. The CAZ charges polluting vehicles to enter a zone in Bristol's city centre and is predicted to deliver compliance with the NO air quality objective in 2023 and will also lead to small reductions in particulate pollution. Additional air quality monitoring will be carried out to understand the effects of the CAZ, and all air quality monitoring data is published real-time on Bristol's open data portal. Exemptions have been applied to ensure impact on low-income households is mitigated. Further information is available on the Clean Air for Bristol website.

12.3 Domestic fuel burning

Domestic solid fuel burning is a re-emerging area of concern across the UK for particulate matter emissions, especially in wintertime when it may be used to supplement central heating. National data indicates that PM2.5 emissions from domestic wood burning have been increasing in the last decade, and there is increasing evidence regarding PM2.5 and a range of long-term diseases and deaths[63]. Recent evidence shows that domestic combustion accounted for 15% and 25% of PM10

[62] OS data © Crown copyright & database rights 2021 Ordnance survey 100023406

[63] Thangavel P et al., (2022) Recent Insights into Particulate Matter (PM2.5)-Mediated Toxicity in Humans: An Overview. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9223652/

and PM2.5 respectively in the UK in 2020, most of which comes from burning wood in closed stoves and open fires [64].

In Bristol, additional measures are being considered to address PM2.5 emissions from domestic solid fuel burning. For example, the DEFRA air quality grant funded "Slow the Smoke" citizen engagement project which started in 2021 and aimed to raise awareness of solid fuel burning and collect data relating to solid fuel burning in Bristol. This may lead to some improvement in air quality in the study area.

The impacts that exposure to PM10 and PM2.5 have on the human body are severe.
Short term exposure to particulate matter can exacerbate chronic conditions such as asthma, COPD, and bronchitis. In people with cardiovascular disease, short term exposure to PM2.5 can lead to arrhythmias (abnormal heartbeat) and heart attacks. These typically subside once exposure is reduced.
Long term exposure to air pollution and particulate matter can increase a person's risk of developing several conditions such as heart disease, respiratory diseases, lung infections, lung cancer, diabetes and others. There is also the increased risk of premature death from these conditions[65].Furthermore, there is a possible association between exposure to PM2.5 during pregnancy and adverse birth outcomes, such as preterm birth, low birth weight and being small for gestational age[66]

12.4 Pollution control

The BCC Pollution Control team has continued to undertake environmental permit checks of high-risk activities across the city, working closely with the Environmental Agency. In addition, the team is responsible for petroleum licensing for petrol stations and environmental searches relating to property purchases. The team also investigates and makes representation on planning applications relating to contaminated sites to ensure proper remediation is undertaken before redevelopment.

12.5 Lead

Lead poisoning is very rare but can have significant effects on human health. Common places where lead can be found is in soil, old paint (sometimes found in older housing built pre-1950's), and in older lead water pipes. The UK Health Security Agency lowered the concentration for lead from ≥10µg/dL (≥0.48µmol/L) to ≥5µg/dL (≥0.24µmol/L) for children under 16 years and for pregnant women, with effect from 5 July 2021 a reduction to 0.24. Public health intervention is required for anyone testing above 0.24. Since this change, we have seen a small increase in reported numbers of Lead cases in Bristol.

Lead poisoning occurs when lead is ingested or inhaled, with inhalation more common through occupational exposure. Lead poisoning cases in children predominantly occur through ingestion and where Pica behaviour is observed. In the reporting period less than 5 new cases were reported in Bristol. Multiagency work is undertaken with each case to thorough environmental sampling, investigation of other potential sources, putting in mitigations to remove or prevent access to

[64] DEFRA (2022) Emissions of air pollutants in the UK – Particulate matter (PM10 and PM2.5). Available from: https://www.gov.uk/government/statistics/emissions-of-air-pollutants/emissions-of-air-pollutants-in-the-uk-particulate-matter-pm10-and-pm25

65 Health Effects Institute (2020) State of Global Air. Available from: soga-health-effects-factsheet_0.pdf (stateofglobalair.org)

66 Yuan L et al., (2019) Maternal fine particulate matter (PM2.5) exposure and adverse birth outcomes: an updated systematic review based on cohort studies. Available from: https://pubmed.ncbi.nlm.nih.gov/30891704/

identified lead sources and monitoring the individuals blood lead levels until they have returned to a safe level to prevent further harm.

13. Emergency Preparedness Resilience and Response (EPRR)

13.1 National Security Risk Assessment 2022

In November 2022 the next reiteration of the Nationals Security Risk Assessment was published. This was then assessed and localised risks, likelihoods and impacted reviewed.

Bristol City Council identified the risks, hazards, threats most apparent, as either having a lead Local Authority role and responsibility, and/or a localised priority to plan and prepare for.

These were then prioritised by capability, training and exercising gaps against highest scoring risks due to impact and likelihood, giving us the following priority areas;

April 2022 – November 2022

- National/Regional Power Outages
    - IT & Communication Outages
- Recovery Exercise – Terrorism *(deferred due to incidents)*
- Cyber

November 2022 – March 2023

- As above, and also;
    - Major Fire
    - High Temperatures & Heatwaves
- Assess new risks added such as;
    - Incident (grounding/sinking) of a vessel [blocking a major port] – *in a local context.*
- And additional risks under Human, Animal and Plant Diseases such as
    - Major outbreak of plant pest – Argrilus planipennis

Lists not exhaustive.

13.2 Heatwaves

In May 2022 we held our first Summer Preparedness Severe Weather Group, assessing the likelihood and impacts of high temperatures and heatwaves, reflecting such in the Severe Weather Guide, no longer just Winter Weather, and utilising the new Keeping Bristol Cool mapping tool.

It was agreed to continue having both a Summer and Winter preparedness meeting with the Severe Weather Group hereon.

The first Heatwave was declared in July 2022 with surrounding areas falling into RED Weather Warnings and Level 3 and Level 4 Heat Health alerts came into force.

13.3 Special Measures

In June 2022 it was brought to our attention that four of our HRA High Rise Blocks were to go in Special Measures, which requires a mass evacuation instead of a Stay Put Policy.

Tabletop Exercises were held with council Services, Partners and agencies, to prepare for such a scenario.

Capability gaps identified were around transportation of evacuees and access to care and medications.

The number of HRA blocks in Special Measures increased to 38 across Bristol.

13.4 Industrial Action: Health

Numerous partners and agencies undertook a series of Industrial Action Strikes impacting services.

This included medical staff that also supported South West Ambulance Service Trust (SWAST) who continued to have lengthy ambulance delays and long waiting times on calls.

On the night of 15th December, a Major Incident was declared due to a road traffic collision between a bus and a car impacting a property, and the potential for casualties during such strikes within the National Health Service, and the impacts on SWAST.

13.5 Industrial Action: Avon Fire & Rescue Service

In February 2022 there was potential for a localised strike with Avon Fire and Rescue Service. Briefings, planning and preparedness was done to understand the risks and impacts for Bristol, especially as we had a number of blocks in Special Measures.

Industrial Action did not take place on this occasion.

13.6 Incidents

The Emergency Preparedness Response Team (EPRT) responded to 37 incidents throughout the reporting period. This is demonstrated by table 13.6.1.

Table 3: Incidents responded to by the EPRT

Incident	Number
Fire	13
HAZMAT	3
Highways	1
Utility: Water	4
Heatwave	1
London Bridge	1
Bomb Threat	1
Flooding	2
Road Traffic Collisions	5
Death of a Minor (Alert)	1
Protest	1
Community Safety, Crime and Disorder	3

13.7 Debriefs and Lessons Identified

After each exercise and/or incident we have an internal debrief within 2-3 weeks and a multi-agency debrief within 4-6 weeks.

13.8 Ex Safe Nest

Exercise Safe Nest was a Live Emergency Centre exercise in one of our Community Places of Safety.

This gave opportunity to put various staff volunteers and partner agency's' training into practice with setting up a centre, registering evacuees and providing welfare.

Voluntary Agencies British Red Cross, RE:ACT and Maritime Voluntary Service took part, as well as neighbouring Local Authority Emergency Planning Teams.

We also exercised the Tesco Emergency Feeding provision as well as collaborated with Avon and Somerset Police Casualty Bureau and the Disability Equality Forum, walking through potential opportunities to enhance and develop further processes.

13.9 Twinnell House

A fire broke out in a top floor flat of Twinnell House. The initial 999 call received was not for a fire but a fatality on the ground floor. The flat and building behaved as expected under the containment design and fabrication of the flats, however a further two persons required immediate rescue from the external wall of the flat. The building at the time of the fire had a Stay Put Policy.

Lessons were identified about the initial response and decisions made regarding evacuation in a multi-agency debrief and sharing of information on the blocks stay put/evacuation policies have since been shared and continue to be during a period of housing works and improvements.

The internal learning regarding health, community and housing impacts, the media reporting and level of coordinated response and recovery has led to process changes in our Incident Management Guide, Recovery processes and Humanitarian Assistance.

13.10 Avon and Somerset Local Resilience Forum

Bristol City Council remain active members and contributors to the work of the Avon and Somerset Local Resilience Forum, leading on Death Management for Excess deaths and/or Mass Fatality incidents, as well as Chairing and administering the Avon Area Voluntary Agencies Group (AAVAG).

13.11 Local Health Resilience Partnership

In 2022-23 the LHRP which covered Bristol, North Somerset, South Gloucestershire and Somerset (Avon and Somerset LHRP) was restructured to become 2 LHRP's coterminous with the BNSSG ICB footprint and Somerset ICB footprint. The first BNSSG LHRP meeting was in November 2022 with focus on gaining clarity on membership, ToR. Work is needed to develop a clear strategic plan of priorities recognising the whole system, including adults social care.

14. Appendix A: Organisation Roles and Responsibilities

Health protection is a critical domain of public health which seeks to prevent or reduce the harm caused by communicable diseases and to minimise the health impact from environmental hazards and risks. Health protection functions therefore include a broad range of topics, including:

- Vaccination against vaccine-preventable diseases.
- Screening programmes including for the earlier detection of cancer (bowel, breast and cervical) and other conditions (antenatal and new-born, diabetic eye, and abdominal aortic aneurism screening).
- Infection prevention and control in health and social care community settings including antimicrobial resistance.
- Communicable diseases with significant health impact such as sexually transmitted diseases, tuberculosis, and COVID-19.
- Environmental hazards such as food-borne and water-borne diseases and air pollution; and
- Health emergency preparedness and response including the management of incidents relating to communicable disease and chemical, biological, radiological and nuclear hazards.

The roles and responsibilities across organisations involved in health protection are briefly described below.

Bristol City Council
Bristol City Council (BCC) has a statutory duty under the Health and Social Care Act 2012 to be assured that the local health protection system is robust and able to respond appropriately to protect the local population's health, and that risks have been identified, are mitigated against, and adequately controlled. This duty is discharged through the Director of Public Health, who provides information and advice to relevant organisations and the public with an oversight function.

BCC also has defined statutory powers in respect of environmental health and health and safety, including food standards, pollution (including air quality), pest control, and port health (BCC serves as the Port Health Authority at the ports of Avonmouth, Royal Portbury Docks and Portishead marina).

Finally, BCC is a Category 1 responder alongside NHS bodies and emergency services for emergency preparedness and response as set out in the Civil Contingencies Act (2004). BCC is therefore responsible for assessing the risk of emergencies occurring; having emergency plans and business continuity management arrangements in case of emergency; providing advice and assistance 60 to business and voluntary organisations about business continuity management; and maintaining arrangements to communicate information and advice to the public in the event of an emergency.

UK Health Security Agency (formerly Public Health England)
The UK Health Security Agency (UKHSA) is responsible for the investigation and management of public health outbreaks / incidents.

UKHSA have the responsibility to declare a health protection incident, major or otherwise. UKHSA also provides surveillance and early warning systems and expert advice on infectious diseases and environmental hazards as appropriate.

NHS England
NHS England (NHSE) is responsible for the commissioning and implementation of national screening and immunisation programmes across the South West region.

NHSE is also responsible for the co-ordination and support of the Local Health Resilience Partnership (LHRP), which along with preparedness, coordinates any NHS multi-agency response to an emergency.

Integrated Care Board (formerly Clinical Commissioning Group)
The Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) is responsible for commissioning health services across the geographies covered by the three named local authorities. The ICB must ensure through contractual arrangements with provider organisations that healthcare resources are made available to respond to health protection incidents or outbreaks (including screening, diagnostic, vaccination, and treatment services)

15. Appendix B: Update on Last Year's Priorities

Section	Last years' priorities	Update

Immunisations	1. To establish system-level Maximising Immunisation Uptake Groups in 2022–23 to increase childhood immunisation uptake. 2. To maintain focus on COVID-19 and flu vaccine uptake among eligible groups, particularly where there are known inequalities	1. The Maximising Immunisation Uptake Group was established for BNSSG, this has now been superseded by the BNSSG Immunisations Strategic Oversight Group and is focussing on MMR vaccine uptake. 2. COVID and flu have remained priority programmes for the team in order to reduce burden of disease and winter pressures in the healthcare system.
Screening	1. To return to and overtake pre-pandemic screening uptake levels. 2. To focus on inequalities in screening uptake	1. Uptake has increased in Bowel and Breast cancer screening; however we continue to see a decline in cervical cancer screening, which is a continued focus for the team. 2. We have had a strong focus on addressing health inequalities in our screening programmes, strengthening the contractual requirements on health inequalities, with providers completing Health Equity Assessment Tools and developing action plans to increase access. We have delivered HEAT tool training and provided a number of resources. We have commissioned training for screening providers co-designed and co-delivered with people. We have commissioned LD screening liaison practitioners across the region to support people with LD to access screening.
Sexual Health	1. BNSSG Joint Sexual Health Needs Assessment will be conducted and led by BCC public health team. 2. To examine syphilis diagnosis rates in light of recent changes in trends and data reporting methodologies 3. To monitor impact of national changes to chlamydia screening implemented in April 2022 (removing offer of opportunistic screening among men) 4. To support several health promotion campaigns/outreach events led by Unity and Terrence Higgins Trust including a focus on HIV testing, and a SW-wide campaign to encourage access to PrEP	1. A joint BNSSG Sexual Health Needs Assessment was conducted and completed at the end of 2022, led by the BCC PH team. It is due to be published very soon. 2. Syphilis diagnosis rates are regularly monitored and did increase in Bristol following the COVID-19 pandemic but did not reach pre-pandemic levels in 2022. Nationally, cases exceeded pre-pandemic levels in 2022. 3. Chlamydia screening and detection levels are regularly monitored and to improve access to tests and take up of screening, Unity's Chlamydia Screening Team have developed an action plan and will work closely with primary care settings. 4. The BCC PH team supported the development of the PrEP My Way SW-

		wide campaign, which has been live since June 2023.
HCAI & AMR	1. To restart HCAI case review meetings from April 2022 2. To review findings from a pilot study of Chlorhexidine wipes for people who inject drugs which was initiated to reduce the spread of MRSA. 3. To undertake a cohort review of P. aeruginosa bacteraemia to understand local drivers. 4. To undertake two antibiotic prescribing projects (review of cellulitis and pyelonephritis treatment)	1. The end-to-end CDI reviews are currently underway with partner organisations. 2. A briefing paper was prepared. Staff are currently in discussion with BDP to assess any improvement in 2023-24. 3. Due to improvement in case counts, this was not completed. 4. There has been no update on this priority.
TB	1. To continue to closely monitor the case rates in Bristol and work towards increased awareness of TB diagnosis and treatment within GP surgeries, drug and alcohol treatment services and inclusion health groups. 2. To set up a new TB control board in December 2022 3. To seek clarity on the causes of delayed diagnosis and treatment	1. Limited data and regional focus has impacted on our Bristol specific shared understanding of TB incidence, risk factors and impacts both to service user and service delivery. A rapid review is needed to do this and has been agreed to be complete in 23/24 2. Regional TB board was launched and is meeting.
COVID-19	1. Continue to support outbreak management in high-risk settings. 2. Continue to monitor vaccine uptake and the impact of long COVID in Bristol	1. UKHSA have returned to Business as usual and are the lead for outbreaks in high-risk settings, system partners continue to provide local support as needed. 2. Vaccination coverage is monitored through system weekly meetings during winter and other booster periods. 3. There remains limited information regarding long covid in Bristol.
Environmental Health	1. Focus on recovering the backlog of food inspections in addition to programmed visits and anticipated new business registrations	1. This priority remains the same as this continues to be a priority, particularly as the 'second inspection post lockdowns' becomes due for more and more establishments.
Global Population Health	1. The upcoming annual DPH report (September 2023) will focus on the borderless aspect of infectious diseases.	1. This will be reconsidered, as a different topic was prioritised in 2023.
ASR	1. Continue the multi-agency group to support health and wellbeing of the ASR population. 2. System commissioners to undertake funding reviews to ensure that	1. The health of asylum seekers and ARAP resettlement families in the Bristol hotels is supported with the Refugee Resettlement Board, the multi-agency hotels group, and the ICB health group. In 2022-23 planning was undertaken for

	services are sufficient for the increasing ASR population	the opening of a second asylum hotel in April 2023. In additional to this a further asylum hotel opened in summer 2023. The health and wellbeing of the population continues to be supported by multi-agency groups and partnership work. 2. ICB commissioners reviewed the demand on health services caused by the increase in ASR population. The ICB has increased the investment in Haven Health and the AWP Hope Service for 2023-24. The commissioners also increased resources for Health visitors, and four Bristol GP practices that deal with asylum seekers and refugees, the Latent TB service, and Dentaid.
Non-communicable environmental Health risks	1. To refresh the Clean Air Plan for Bristol	1. The Clean Air Plan has not been refreshed, instead reliance was made on the Joint Local Transport Plans (JLTP) to fulfil the statutory duty to have an Action Plan. Whilst the JLTPs did look to reduce emission from traffic, it didn't have a focus on air pollution or consider any other sources of air pollution
EPRR	1. Continue to strengthen the coordination of response by re-establishing LHRP in light of system level changes. 2. Maintain and increase our staff training and awareness of emergency response and capability to act. 3. Update the Corporate Recovery Plan and review and update the corporate business continuity framework with supporting impact assessment and plan templates	No update recorded as a result of the priorities remaining similar for the next reporting period.

16. Appendix C: List of tables and figures

[End of document]

DRAFT Forward Plan as of February 2024

Wednesday 27th March, 2:30-5pm - development session

Joint workshop with the One City Homes Board on:

- Health infrastructure
- Damp and mould
- Supported housing

April – pre-election period

Thursday 23rd May

Development session or public meeting TBC