Health Scrutiny Committee (sub-committee of the People Scrutiny Commission) Agenda

Date: Monday, 14 March 2022

Time: 10.00 am

Venue: The Council Chamber - City Hall, College Green, Bristol, BS1 5TR

Distribution:

Councillors: Graham Morris (Chair), Jos Clark (Vice-Chair), Brenda Massey, Paul Goggin, Lorraine Francis, Chris Windows, Mohamed Makawi, Amal Ali and Tom Hathway

Issued by: Dan Berlin, Scrutiny Advisor
E-mail: scrutiny@bristol.gov.uk
Date: 4th March 2022

Agenda

1. Welcome, Introductions, and Safety Information

(Pages 4 - 6)

2. Apologies for Absence and Substitutions

3. Declarations of Interest

4. Minutes of Previous Meeting

(Pages 7 - 14)

5. Chair's Business

6. 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 scrutiny@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 Tuesday 8 March.**

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 Friday 11 March.**

7. Public Health Update

For Information

8. NHS System Pressures and Status Update

(Pages 15 - 22)

9. Urgent and Emergency Care - Minors Programme

(Pages 23 - 35)

10. Healthy Weight

(Pages 36 - 104)

11. AWP Patient Reconfiguration

For Information **(Pages 105 - 206)**

12. Work Programme

For Information **(Page 207)**

Public Information Sheet

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

You can find papers for all our meetings on our website at www.bristol.gov.uk.

Changes to how we hold public meetings

Following changes to government rules, public meetings including Cabinet, Full Council, regulatory meetings (where planning and licensing decisions are made) and scrutiny will now be held at City Hall.

COVID-19 Precautions at City Hall (from July 2021)

When attending a meeting at City Hall, COVID-19 precautions will be taken, and where possible we will:

- Have clear signage inviting you to check in to the venue using the NHS COVID-19 app or record your contact details for track and trace purposes.
- Provide public access that enables social distancing of one metre to be maintained
- Promote and encourage wearing of face coverings when walking to and from the meeting
- Promote good hand hygiene: washing and disinfecting hands frequently
- Maintain an enhanced cleaning regime and continue with good ventilation

COVID-19 Safety Measures for Attendance at Council Meetings (from July 2021)

To manage the risk of catching or passing on COVID-19, it is strongly recommended that any person age 16 or over attending a council meeting should follow the above guidance but also include the following:

- Show certification of a negative NHS COVID-19 lateral flow (rapid) test result: taken in the 48 hours prior to attending. This can be demonstrated via a text message or email from NHS Test and Trace.
- An NHS COVID-19 Pass which confirms double COVID-19 vaccination received at least 2 weeks prior to attending the event via the NHS App. A vaccination card is not sufficient.
- Proof of COVID-19 status through demonstrating natural immunity (a positive NHS PCR test in the last 180 days) via their NHS COVID-19 pass on the NHS App.
- Visitors from outside the UK will need to provide proof of a negative lateral flow (rapid) test taken 48 hours prior to attendance, demonstrated via a text message or email.

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- are required to self-isolate from another country
- are suffering from symptoms of COVID-19
- have tested positive for COVID-19 and are requested to self–isolate

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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 scrutiny@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.
- As part of the drive to reduce single-use plastics in council-owned buildings, please bring your own water bottle in order to fill up from the water dispenser.

For further information about procedure rules please refer to our Constitution
https://www.bristol.gov.uk/how-council-decisions-are-made/constitution

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Bristol City Council
Minutes of the Health Scrutiny Committee (sub-committee of the People Scrutiny Commission)

6 December 2021 at 10.00 am

Members Present:-
Councillors: Graham Morris (Chair), Brenda Massey, Paul Goggin, Lorraine Francis, Mohamed Makawi and Tom Hathway

Also in Attendance:-
Councillor Helen Holland, Cabinet Member for Adult Social Care and Integrated Care System; Councillor Ellie King, Cabinet Member for Public Health, Communities and Bristol One City.

Christina Gray, Director for Communities and Public Health, Bristol City Council; Mark Arruda-Bunker Associate Director, Specialised, Secure and CAMHS, Avon and Wiltshire Mental Health Partnership; Dave Jarrett, Area Director, South Gloucestershire and Bristol, NHS Bristol, North Somerset & South Gloucestershire CCG (BNSSG CCG); Nick Goff, Mental Health Programme Manager, BNSSG CCG; Steve Rea, Delivery Director, South Bristol ICP; Kate Groves, Senior External Affairs Manager, BNSSG CCG.

1 Welcome, Introductions, and Safety Information

The Chair welcomed all attendees to the meeting.

2 Apologies for Absence and Substitutions

Councillor Clark sent apologies.

3 Declarations of Interest

The Chair declared that a member of his family had experience of an autism assessment and Child and Adolescent Mental Health Services.

4 Annual Business Report

The Scrutiny Advisor presented the Annual Business Report.

RESOLVED;

That;

- The Scrutiny sub-committee's Terms of Reference be noted;
- The membership of the Committee for the 2021-22 municipal year be noted;
- The Chair, Cllr Morris, and the Vice-Chair, Cllr Clark, be noted;
- The dates and times for meetings in 2021-22, 6th December 2021, 10am, and 14th March 2022, 10am, be noted.

5 Chair's Business

The Chair advised Members that the Suicide Prevention item, scheduled for today's agenda, would be presented to the sub-committee as a scrutiny briefing in January 2022.

The Chair noted that Cllr Massey had received a text from the NHS which advised her she was eligible for a booster, although she had already received one; the Chair shared Cllr Massey's concern that this error, which had happened to others, had provided confusion to the public.

RESOLVED;

That the Director of Communities and Public Health advise the sub-committee whether this was a known error and that it would be addressed.

6 Minutes of Previous Meeting

RESOLVED;

That the minutes of the meeting held on 25 February 2021 be agreed as a true record.

7 Public Forum

Questions:

Ref	Name	Topic
Qs 1 - 2	Jen Smith	Child and Adolescent Mental Health Service

Statement:

Ref	Name	Topic
S1	Jen Smith	Child and Adolescent Mental Health Service

There were no supplementary questions.

The Chair commented that the statement showed that the system was complex and sometimes confusing when children had additional support need; and stated that there was a need for a simplified and better signposted services.

RESOLVED;

That the Public Forum questions and statement be noted.

8 Child and Adolescent Mental Health Services

The Associate Director, Specialised, Secure and CAMHS, Avon and Wiltshire Mental Health Partnership, introduced the report.

- There was a discussion around ethnicity data, and how representative referrals were of Bristol's communities; Members were concerned that proportionally less Black Asian Minority Ethnic children and adolescents had accessed services, and that 630 referrals were from white applicants, and the combined number from Black Asian Minority Ethnic groups was 119.

- The Committee was told that it was recognised that the referral route for young people had not been representative of the diverse communities, and that there was ongoing work and initiatives, which included a Quality Improvement Project, to improve equitable access for all and also to ensure staff were representative of the communities. There had been partnership working, which included work with the Barton Hill Settlement, to improve equitable access.

- There was a further discussion about access to services and referrals and it was agreed there was need for more clarity regarding the relationship between Bristol's demographics and access/referrals.

- Members were advised that, in terms of Black Asian Minority Ethnic representation in recruitment, the organisation had improvements to make, which included positive action to enable Black Asian Minority Ethnic communities in senior leadership roles, and other initiatives which ensured better representation.

- Members noted that North and South areas had more referrals than the Central & East area and were advised that there were no concerns about a lower ability to access services than in the other two areas, that there were more third sector and community pathways in Central & East before the need to access CAMHS.

- Members asked whether building works at the Riverside Unit would prevent access to services and were told that 10 (of the 12 capacity) patients would receive services whilst the works were ongoing, and that there would be close partnership work that would ensure anyone who needed services would receive appropriate services, and that all young people who were not eligible would be monitored by professionals at Tier 3 which included crisis and outreach services.

- It was confirmed that the building works would enable an increased capacity of 16 (12 inpatients and 4 days patients).

- The Committee was advised that there was a national challenge to meet the need for eating disorders; and that there had been a sustained increase in referrals for young people with eating disorders.

- It was recognised that the service required a more sophisticated system to record characteristics, which included Transgender, but that all young people were assessed based on need and the assessment recognised that an individual who identified as Transgender had increased risk of higher need.

- The Chair commended the approach taken in South Bristol, that he observed that there was a positive outreach service and young people were encouraged to talk.

- The was a discussion about access to information and Members were advised that CAMHS, as part of the community health partnership, had a single website which was subject to ongoing improvement, which included the introduction of an ability to self-refer; and that there was investment to enable development. The Committee heard that the website had successfully signposted young people (see https://cchp.nhs.uk), but there was a recognition of the need of further improvement.

- The Chair asked how success was measured and Members were advised that patient reported outcome measures (PROMs) were used**,** which assess the quality of care from the service users perspective, that young people's experience was the most important aspect to measure success and that CAMHS had worked with Barnardo's who had assisted in enabling young people's voices.

- There was a further discussion about the workforce and the Committee was informed that there was significant planned expenditure to support staff, and that there was a national challenge in terms of the health of the workforce.

- The Committee was informed that mental health support teams focused on both primary and secondary schools, are now in place. The first wave of 3 teams would cover schools in South Bristol, East Central Bristol and South Gloucestershire (see https://www.otrbristol.org.uk/what-we-do/mhst/) with a further seven across BNSSG by 2024.

- The Chair commended the report and presentation and thanked the officers involved and all who provided mental health support to Bristol's young people.

RESOLVED;

That;

- Avon & Wiltshire Mental Health Partnership be invited to bring an update to the Committee on its initiatives to improve access to child & adolescent mental health services by Bristol's Black Asian Minority Ethnic communities and ensure a workforce better representative of Bristol's diverse communities.

- The report be noted.

9 Community Mental Health Framework and Integrated Care Partnerships in Bristol

The Area Director (South Gloucestershire and Bristol); Mental Health Programme Manager; and Delivery Director (South Bristol ICP), Bristol North Somerset South Gloucestershire CCG, introduced the report.

The Cabinet Member for Adult Social Care and Integrated Care Systems said that the integration of health and care should be from a bottom-up approach, and what had been seen by the Health & Wellbeing Board, on which the three Integrated Care Partnerships were represented, was good local representation and voice from local communities, and that there had been great enthusiasm from local partners; and that she hoped ICPs would have the opportunity to raise local need and affect ongoing strategy. Also

social prescribing was highlighted as an important role within the development of the ICPs and how communities accessed services.

- There was a discussion about how many GPs there were in relation to population across the area, and Members were advised that the numbers related to GP practices, not the GPs themselves, and that some practices had more GPs in them, which meant more of an even relationship between GPs and population across the area. It was agreed that this needed clarifying and updated statistics would be sent to the Committee.

- There was a discussion around recruitment and retention of the workforce and Members asked what steps would be taken to manage the issues. The Committee was advised that there were workforce shortages and challenges, and that the plan to introduce integrated teams removed the need for a linear referral process, and so resources and time could be freed up.

- There was a recognition that peoples' needs should be met earlier and support mechanisms should be widened with the utilisation for the community and voluntary sector.

- The Director for Communities and Public Health clarified that the proposals for charges in parks only referred to commercial activities, and so would not affect social prescribers.

- A Member of the Committee expressed optimism that the new arrangements would make a positive difference to accessing mental health services, and stated that their experience was one that showed the eligibility criteria for referrals into services was a high threshold, and asked whether the new framework would mean an expectation of more referrals and better and quicker access to services. The Committee was informed that the expectation was now a four week wait for the patient from initial referral; this was a national aspiration embraced locally – the four weeks would be from the point of reach-out for support to an offer of treatment (from a range of offers which included clinical and social prescribing).

- Members were advised that the new framework brought a fundamentally different approach, which included devolved budgets and demanded closer partnership working, a move away from a linear pathway which would increase access where it was needed and improved service.

- The Committee was advised that the framework demanded good partnership working which would recognise the differing factors that affected peoples' mental health, such as access to good housing, food and exercise; that opening up the links across housing, parks and green spaces and healthy eating initiative was integral to the community mental health framework.

- There was a discussion around community engagement and Members asked how communities had been listened to. Members were informed that there had been 40 engagement sessions in the

first half of the year; these had been with professional partners and the voluntary and community sector, as well as with people with lived experiences.

- The Committee was advised that all six Integrated Care Partnerships had people with lived experiences to help shape their plans. Members were also told about groups that focused on specific areas, such as eating disorders, formed to help develop services, co-chaired by professionals and an individual with lived experience.

- The Chair commented that there was not established voluntary groups that represented all communities, and so this should be recognised and arrangements put in place so everyone could have influence if they wanted to; and that there was a need to communicate better with all communities the positive work as set out in the report.

- The Chair commended the inclusion of a need to 'directly and urgently address the inequalities in health outcomes meeting needs earlier to mitigate against disadvantage...' as a key attribute of the draft model of care and asked how the relevant communities were being identified and targeted so as to address the inequalities. Members were told that data was utilised to help inform targeted support, and that tackling health inequalities was forefront of all plans.

- The Committee was informed about the use of 'asset mapping' (which included mapping of community organisations across the area) which would assist in the engagement of diverse groups.

- There was a discussion around transition from CAMHS to adult mental health services, and members were advised that there should not be a hard deadline for transition, that the focus should be on enabling young people to adult services between the ages 16-25, and that there was a need to ensure accessibility for people with learning difficulties and autism, and so the criteria needed to be flexible.

- The Committee was informed that there was a significant piece of work in development an IT system which would join up care records, and that this would be extended to all relevant organisations within the framework.

RESOLVED;

That;

- The number of GP practices with regard to population across the areas be clarified and passed to the Committee;

- The report be noted.

10 Work Programme

The Work Programme was noted.

11 Public Health Update

The Director of Communities and Public Health provided an update on COVID-19.

- The Delta variant was still dominant; it was expected the Omicron variant would become dominant in the next months.

- The public health advice was that, if meeting in groups to cover faces, ventilate rooms and use lateral flow tests. People were encouraged to ensure they test themselves regularly, especially if they plan to meet in groups.

- It was highly likely Omicron will be at least as transmissible if not more so, and so taking precautions was very important.

- The Mayor was about to sign up to a global vaccine equity statement – it was important to recognise that the more people were vaccinated, the safer everyone would be.

Meeting ended at 12.15 pm

CHAIR _____

Health Scrutiny Committee
(Sub-committee of the People Scrutiny Commission)
14 March 2022

Report of: David Jarrett, Area Director, BNSSG CCG

Title: NHS System Pressures and Status Update- BNSSG CCG

Ward: All

Officer Presenting Report: David Jarrett

Contact: David.Jarrett2@nhs.net

Key points:

The attached slide deck provides Members with an update on the current urgent care pressures and work underway to tackle them.

The slide deck will be updated for the meeting.

Healthier Together

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

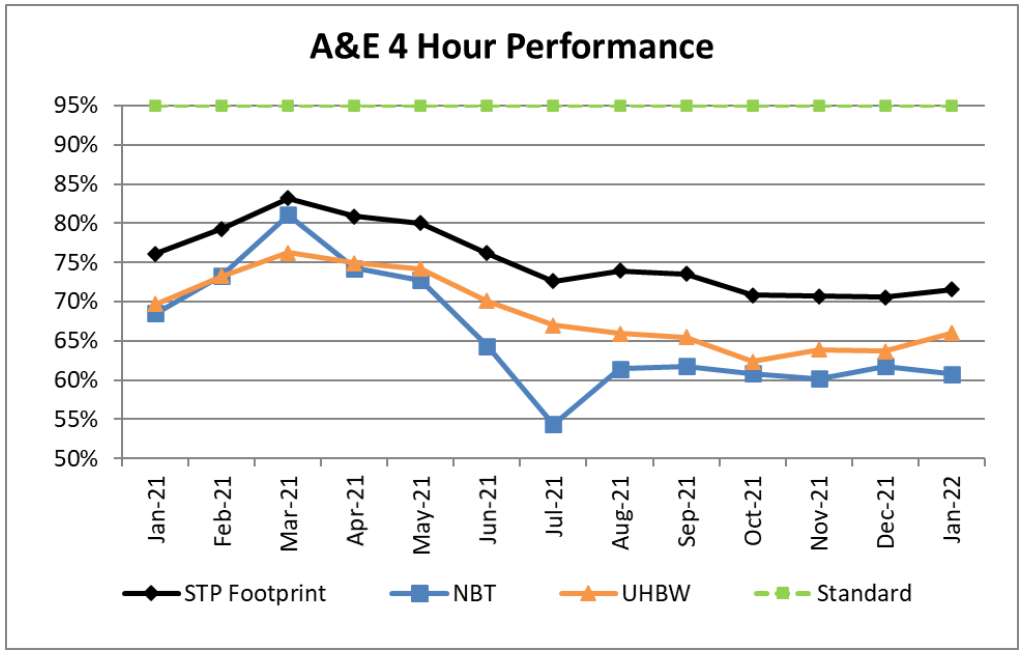
NHS System Pressures and Status Update – BNSSG CCG

Dave Jarrett

Current position and context of Urgent Care System

- BNSSG system is currently in system level Opel 4;
- Still in Level 4 incident in line with national response to Covid-19;
- Omicron bed usage in acutes falling slowly but will become steady state;
- High sickness rates in providers;
- Poor performance in key areas e.g. ambulance handover delays.

BNSSG OPEL 4



Improvement Actions 1

- 4 key transformational areas as part of winter plan:
  - ED minors programme
  - Frailty urgent care including same day emergency care;
  - Improving domiciliary care recruitment rates and retention;
  - Delivery of Discharge to Assess business case.
- Improvement programme for ambulance handovers, with support from national colleagues.
- National improvement team support for health to improve flow across all organisations.

Improvement Actions 2

- As part of Level 4 Covid governance a Winter Pressures Cell established to oversee:
  - Establishment of a care hotel, commissioned until end March 22;
  - Additional Discharge to Assess beds commissioned non-recurrently;
  - System scenario and surge planning: Opel 5 trigger and action cards produced;
  - VCSE support including further support into acutes;
  - Greater access to front door for community equipment.

- Other work on going to improve community same day offer and virtual wards.

Primary Care Access

December - acceleration of the booster programme announced. National guidance provided to primary care stipulating that delivery of the booster programme is the number one priority followed by retaining access to urgent care.

British Medical Association provided prioritisation guidance to practices and the CCG provided communications support to practices so that we could be consistent in explaining to our population that there may be delays for routine appointments

Omicron surge planning – practices reminded to refresh business continuity planning and to refresh continuity planning at scale across Primary Care Networks and localities. Situation reporting reinstated to understand extent of workforce absence in general practice

Winter Access Plan for Primary Care

- National package announced aimed at supporting resilience and additional capacity in general practice
- Local schemes collaboratively developed and included:
  - Same day urgent care access scheme in general practice
  - Digital video remote consultation scheme
  - Mental health first contact scheme
  - Expansion of community pharmacy consultation scheme
  - Development of enhanced access, quality and resilience support offer to work intensively with practices in greatest need
  - Suite of schemes to support health inequalities including additional psychologist, dental and outreach support for homeless people and family centred outreach clinics for those in greatest need in our local communities

Priorities for general practice 2022/2023

- Continued focus on health inequalities and early diagnosis of cancer
- Extended access offer to be developed and delivered across all Primary Care Networks
- Maintaining support for urgent care access and the wider urgent care system
- Focus on chronic disease and long term condition management
- Increasing the workforce through the investment in Primary Care Networks and retaining staff
- Continued support to the covid vaccination programme

Health Scrutiny Committee
(Sub-committee of the People Scrutiny Commission)
14 March 2022

Report of: Jenny Theed, BNSSG / Sirona

Title: Urgent and Emergency Care – Minors Programme

Ward: **All**

Officer Presenting Report: Jenny Theed

Contact: jenny.theed@nhs.net

Key points:

An improved delivery model for patients with urgent conditions which are not life threatening is being developed for the Bristol, North Somerset and South Gloucestershire area.

1. Summary

Urgent and Emergency Care – Minors Programme

This new model aims to reduce the number of people with minor conditions attending Emergency Departments (ED). This will enable ED to concentrate on providing care to patients with life threatening conditions.

The current increased 'minors' demand is contributing to crowding in EDs, extended waiting times, and is impacting clinical outcomes. Annual winter pressures and the ongoing Pandemic are further adding to the pressures.

The CCG has built a case for change (based on research and highlights) highlighting increased demand for Urgent Emergency Care (UEC) particularly for lower acuity needs.

Based on the insight, the treatment pathway has been refreshed and key programme activity includes:

- Targeted communications campaign to encourage patients to access GP / NHS 111 (instead of walking into ED)
- Enhanced 111 service with increased capacity and multi-disciplinary approach to assess and support
- Pharmacy Pilot booking people directly on to dedicated pharmacy consultation slots
- Enhanced Front Door model – pilots to stream patients with minor conditions away from ED

Timings:

- November 2021 onwards – enhanced 111 service
- January 2022 – pharmacy pilot
- February 2022 – communications campaign (TBC)
- March 2022 – enhanced front door pilot

2. Policy

N/A

3. Consultation

a) Internal
N/A

b) External
N/A

Appendices:
None

LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985
Background Papers:

Slide pack attached

Healthier Together

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

Urgent and Emergency Care - Minors Programme Briefing

March 2022

Jenny Theed – Programme Director

Purpose

- To brief the Committee on the development of an improved delivery model for patients with urgent conditions which are not life threatening;
  - Case for change
  - Key changes
  - Benefits realisation
  - Implementation timeframe
  - Communication and engagement undertaken
  - Integrated governance framework

- This work aims to reduce the number of people with minor conditions who are managed within Emergency Departments to enable them to concentrate on providing care to patients with life threatening conditions. It emphasises the central role of primary care in providing urgent care across BNSSG.

Programme Summary (1)

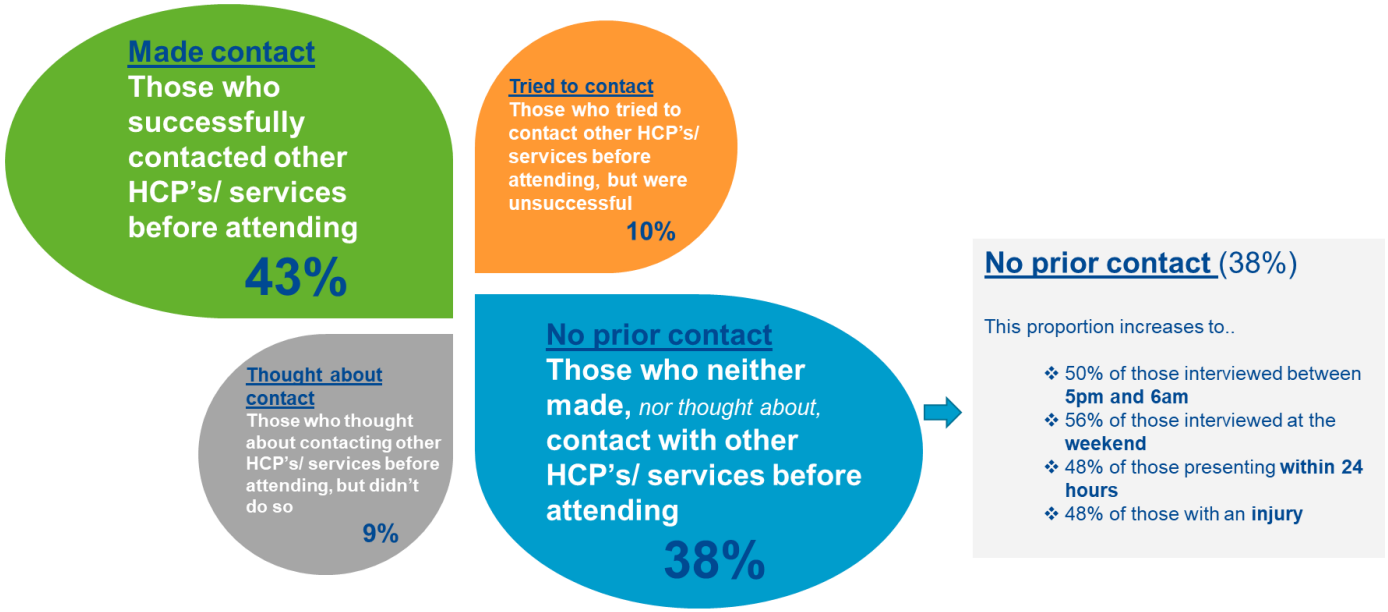
Case for change:

- Increased demand for UEC services, particularly for lower acuity needs.
- This has contributed to crowding in EDs which extends waiting times for patients and negatively impacts clinical outcomes.
- BNSSG have high levels of ambulance handover delays.

BNSSG Gold Command has decided to respond by seeking to radically reduce minor ED demand; streaming away patients with lower acuity conditions who can be safely managed in other settings. This will allow more offloading space for ambulances and more capacity for majors patients.

Insights:

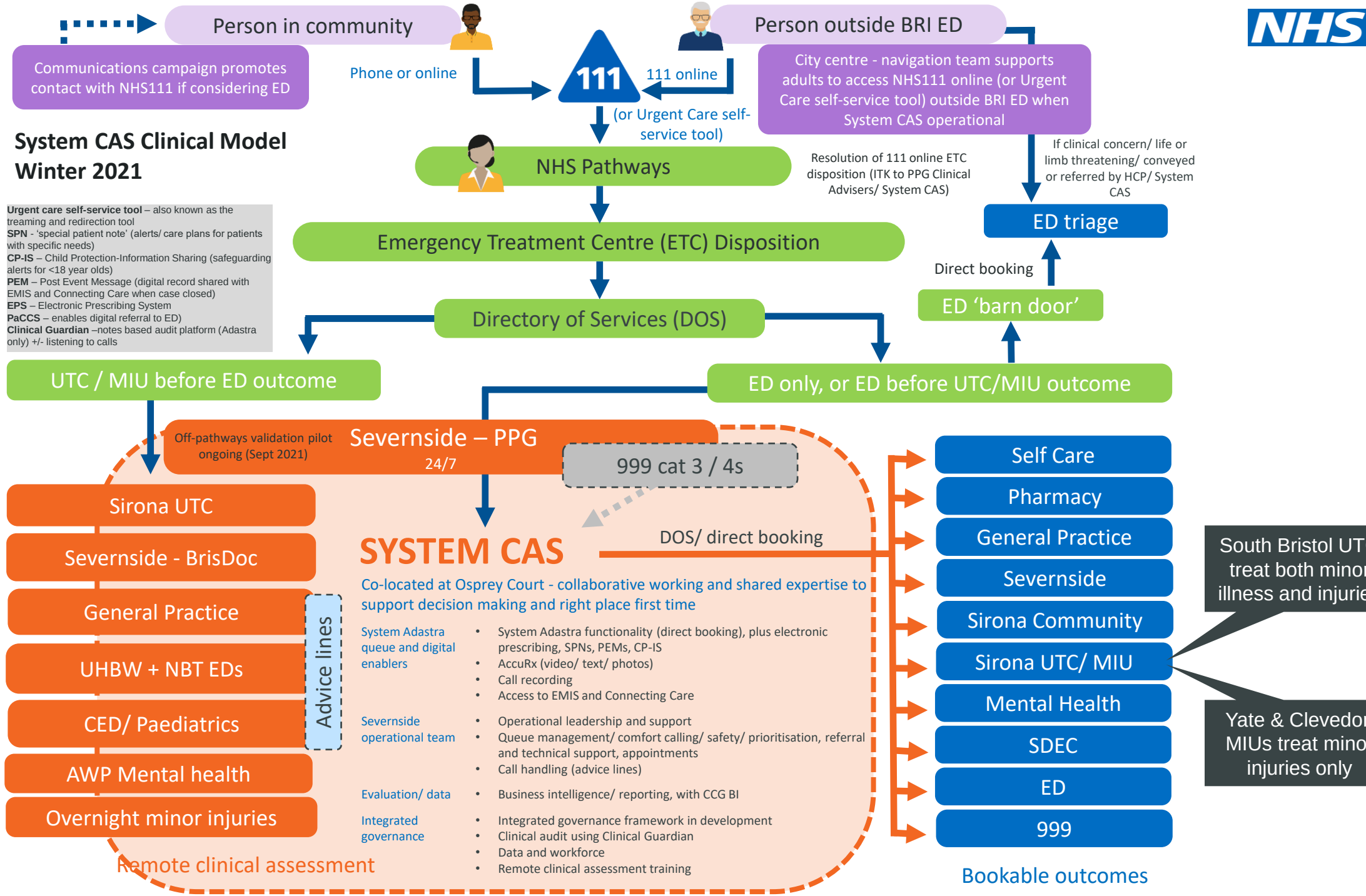
- August 2021 waiting room survey which gathered feedback from patients waiting at ED, MIU and UTC services.
- Over half of patients had made contact, or tried to make contact with an alternative NHS service prior to attending.
- This demonstrates the opportunity for improving the ability of patients in BNSSG to access alternatives to ED for minor acuity needs.



Programme Summary (2)- Key Changes

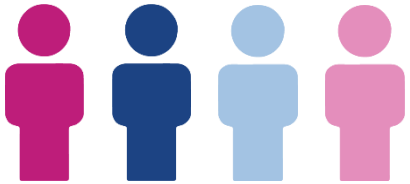
	Targeted Comms Campaign	Enhanced System CAS & 111	Pharmacy Pilot	Enhanced Front Door ED model
Change	Encouraging patients to access their own GP and NHS 111 instead of walking into ED	Multidisciplinary co-located workforce remotely assessing and managing people with urgent needs. If a face to face appointment is needed patients can be referred or directly booked into a wider range of urgent care services.	People directly booked from South Bristol UTC to dedicated Community Pharmacy Consultation Service slots	Pilots in BRI, NBT and Weston EDs of ED streaming tool (EDST) and non-clinical navigators. This will stream patients with minor conditions away from ED to alternative services.
Logic to support the change e.g. data, evidence, insights.	• National evidence base e.g. NHSE comms 111 • BNSSG Insights – citizen panel attitudes to 111 and remote consultation, waiting room interviews Aug 21 • Focus groups - attitudes to 111, message testing • Staff workshop – explored messaging, concerns, etc.	• Routine activity data • Severnside ED 'Validation' Pilot Evaluation, April 2021 • Sirona and Severnside pilot evaluation, Jan 2021 • NHSE Further Faster 111 objective & evidence	• Evidence of impact from GP CPCS scheme • Analysis of UTC walk in presentations demonstrates a number can be managed by pharmacy	• Minors Demand and Capacity BI modelling of projected impact of streaming away minor patients at front door of all 3 EDs • Feedback from other Further Faster 111 sites using the streaming tool already e.g. - Staffordshire Front door streaming tool County Kiosk 111 feedback • BNSSG Insights -Waiting room interviews - Aug 2021 • NHSE Further Faster 111 objective & evidence

System CAS Clinical Model Winter 2021



Urgent care self-service tool – also known as the treaming and redirection tool
SPN - 'special patient note' (alerts/ care plans for patients with specific needs)
CP-IS – Child Protection-Information Sharing (safeguarding alerts for <18 year olds)
PEM – Post Event Message (digital record shared with EMIS and Connecting Care when case closed)
EPS – Electronic Prescribing System
PaCCS – enables digital referral to ED)
Clinical Guardian –notes based audit platform (Adastra only) +/- listening to calls

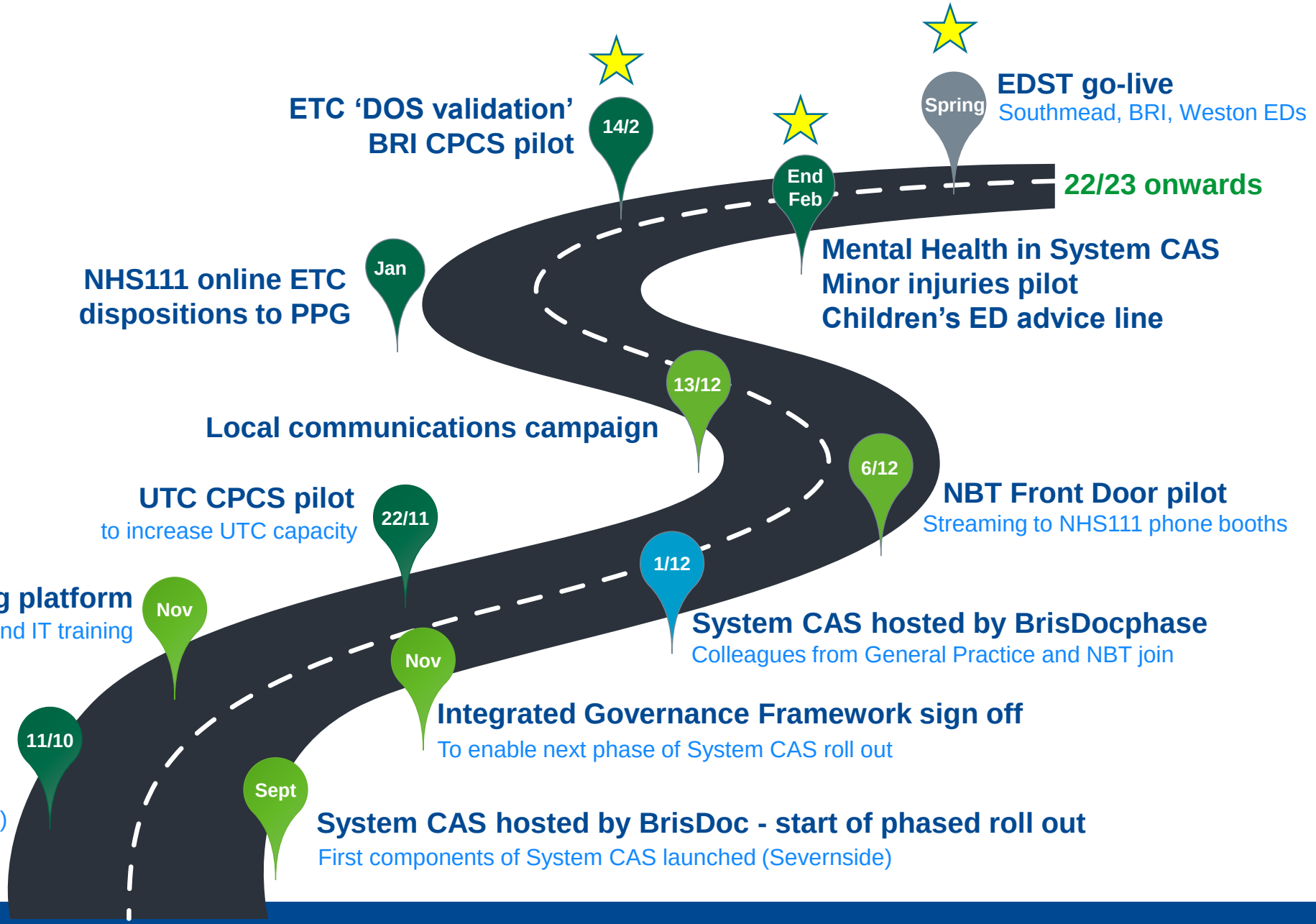
Benefits Realisation



Patient	Staff	System
Improved Experience – Right Place First Time	Improved working environment and experience	Increased ED capacity for majors: reduced ambulance handover delays, better time to assessment
Protected acute services for when you need them	Reduction in violence and aggression	Improved staff recruitment and retention
Less time waiting in waiting rooms	Increased learning and development from multi-disciplinary team working in the CAS	Increased minors capacity in community and remote settings
Improved understanding of how to access urgent care services	Improved experience from working with patients most appropriate for your skillset/ value add	Improved ambulance response times
Fewer transfers between services		Reduce travel, improved air pollution and carbon footprint
More predictable appointments		
Tell story once (supported by digital handoffs of records)		

Implementation Roadmap

‘Perfect weeks’



Communications & Engagement

NHS 111 Advertising Campaign

- Working with marketing agency (AgencyUK)
- Creative concepts agreed
- Media channels include
  - Targeted social media campaign
  - Door drops
- Pre & post campaign evaluation via Citizens Panel

Public Relations

- PR/media Campaign with local news outlets
- Producing videos for social media featuring key Clinicians in system CAS
- Partnership working to promote messaging across partner channels
- Social media campaign
- Publicity materials for system partners and key locations across the system

Insights

- Campaign focus Groups / User testing
- Front Line Staff workshop
- Procuring a social listening tool to support comms evaluation/insight.
- Developing further insight and highly targeted interventions working with specialist behaviour change agency.

Stakeholder Engagement

- Workstream Team inc. partner reps from across system
- Comprehensive Stakeholder mapping
- Initial staff & Stakeholder Briefing w/c 06/12
- Working with Public Health to engage school nurses to support engagement with parents with young children
- Working with Universities to engage students
- Engaging Local MPs

Integrated Governance Framework

A bespoke Integrated Governance Framework (IGF) provides the detailed governance underpinning this novel system-wide endeavour. It includes;

- Lines of responsibility and accountability
- Clinical model,
- Patient journeys,
- Workforce requirements,
- Digital infrastructure.
- Safeguarding
- Training and audit
- Information Governance
- Risk management
- Learning events (incidents);
- Complaints and potential claims.

Questions?

Health Scrutiny Committee
(Sub-committee of the People Scrutiny Commission)
14 March 2022

Report of: Director for Communities and Public Health

Title: Whole systems approach to healthy weight

Ward: All

Officer Presenting Report: Alasdair Wood, Grace Davies, Charly Williams, Bonnie Dimond, Sally Hogg

Contact: alasdair.wood@bristol.gov.uk

Recommendations:
Tackling healthy weight requires action across the entire system, and needs to be viewed as 'everybody's business'.

This report presents for awareness to the HOSC. It outlines the whole systems approach being implemented by the communities and public health team, and examples of the range of work to address healthy weight in the city. Through raising awareness of this approach with city leaders, we aim to embed work to counter healthy weight across the system and in the system leadership.

There is also opportunity for HOSC to input into specific pieces of work which are currently in development; the recommissioning of tier-2 weight management services, and the food equality action plan.

1. Summary

This report aims to provide Members with an overview of the work ongoing by the Communities and Public Health team to tackle unhealthy weight in Bristol for all ages. It provides an overview of how this is being addressed through a 'whole systems approach' to healthy weight. The report includes examples of how this whole systems approach is being applied for children and young people. It then presents two specific examples of projects that form part of this whole system approach: the recommissioning of a tier-2 weight management service for Bristol, and the development of an action plan for food equality.

1.1

2. Context

Background and context in Bristol

The proportion of adults in England who are overweight or living with obesity has seen large increases in the last four decades.[1] Whilst it is important not to create stigma for individuals with excess weight, at a population level this increase is strongly associated with negative health outcomes and reduced life expectancy. Obesity is a risk factor for a range of chronic diseases, including cardiovascular disease, type 2 diabetes, at least 12 kinds of cancer, liver and respiratory disease. Obesity can have a negative impact on mental health. The health risks associated with obesity have been brought into focus by the COVID-19 pandemic; people who are overweight or living with obesity are more likely to be admitted to hospital, to an intensive care unit and, sadly to die from COVID-19.[2]

2.1

Over half of adults in Bristol are overweight or obese (57.3%, CI 55%-59.7%). This is lower than the national average of 62% of all adults in England (CI 62.6%-63.0%)[3]. However, it shows an increase compared to the two previous year's survey: This figure was 54.8% in 2018/19 and 55.6% in 2017/18[4].

2.2

Local data from the Bristol Quality of Life (QoL) survey reveals significant variation and inequality across the city. The 2020/21 QoL survey showed wide variation by

2.3

[1] Patterns and trends in excess weight among adults in England - UK Health Security Agency (blog.gov.uk)

[2] Tackling obesity: empowering adults and children to live healthier lives - GOV.UK (www.gov.uk)

[3] Source: Public Health England (based on 2019/2020 Active Lives survey, Sport England)

[4] JSNA 2020-21: Healthy Weight (adults) (bristol.gov.uk)

ward, with 26% overweight and obese in Cotham compared to 69% in Southmead (see Figure 1). There is an apparent variation between lower rates in more central wards and higher in more outlying ones, particularly in the south of Bristol and relates in part to age and deprivation patterns in the city.[5]

2.4 The Quality-of-Life data highlights the following inequalities in healthy weight in the city:

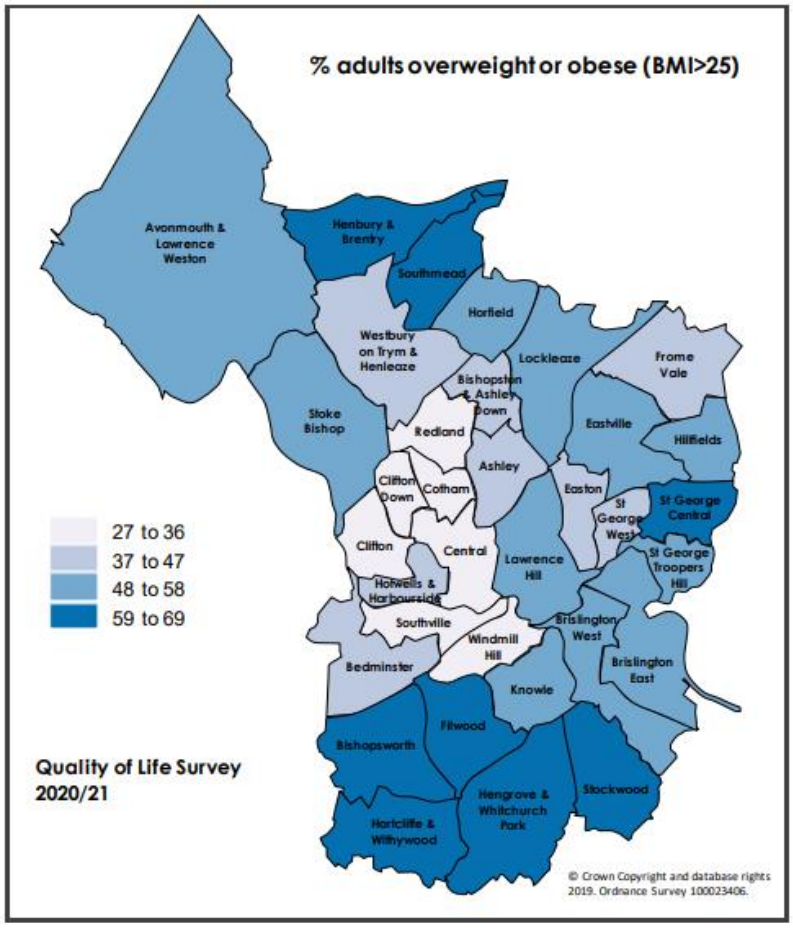


Figure One – percent of adults overweight or obese (BMI >25) in Bristol by ward. Note: this is self-reported data and as such may present an under-estimation.

- **Deprivation** – 64% of adults living in the 10% most deprived areas have excess weight, significantly above the city average (49%). This compares to 40% of adults living in the 10% least deprived areas.
- **Ethnicity** – 38% of White minority ethnic adults had excess weight compared to 77% of Black adults, both of which differ significantly to the city average (49%).
- **Disability** – Significantly more disabled adults (69%) have excess weight compared to the city average (49%)
- **Gender** – Men (54%) are more likely to have excess weight than women (44%), but women are more likely to be obese (BMI ≥ 30)
- **Diet Quality** – Quality of Life data (2019/20) also shows that the lowest levels of fruit and vegetable consumption, and highest levels of excess sugar consumption, are associated with areas of the highest deprivation.
- **Pregnancy** – The percentage of women booking for maternity care with a BMI of 30 or more has increased in Bristol since 2013 (18.8% in 2013 to 20.2% in 2020). Mothers who are overweight or obese are at risk of a range of

[5] JSNA 2020-21: Healthy Weight (adults) (bristol.gov.uk)

complications and poor birth outcomes and are more likely to have children with excess weight or obesity. [6]

There are also significant numbers of children with excess weight in Bristol. Data from the 2019/20 National Child Measurement Programme (NCMP) in Bristol indicates that approximately 1 in 4 (23%) of children in reception (4-5-year-olds)[7] and 1 in 3 (33.9%) of year 6 pupils (10-11-year-olds) have excess weight (are overweight or obese). The prevalence of excess weight in both year groups is similar
2.5 to the national average (23% in reception and 35.2% in year 6)[8]. NCMP is undertaken annually but was scaled back in 2020/21 due to the Covid-19 pandemic, with only a 10% sample undertaken of Bristol schools. Although the sample is not fully representative of the Bristol average, local monitoring of the data suggests an upward trend and widening inequalities. NCMP has now restarted fully for 2021/22. As with adults, there is significant variation in the proportion of children with excess weight across the city, as seen in figure two.

[6] Heslehurst N, Vieira R, Akhter Z, Bailey H, Slack E, Ngongalah L, Pemu A, Rankin J. (2019). The association between maternal body mass index and child obesity: A systematic review and meta-analysis. PLoS Med.11;16(6). Available at: The association between maternal body mass index and child obesity: A systematic review and meta-analysis - PubMed (nih.gov)

[7] In March 2020, NCMP was curtailed in Bristol due to the pandemic. This affected the completion of measurements for reception-aged pupils for the year 2019/20 (year 6 was completed). Bristol average statistics are presented for 2019/20 for this year group but the data should be interpreted with caution due to the relatively low coverage of NCMP that year.

[8] JSNA 2021/22 - Healthy Weight Children (bristol.gov.uk)

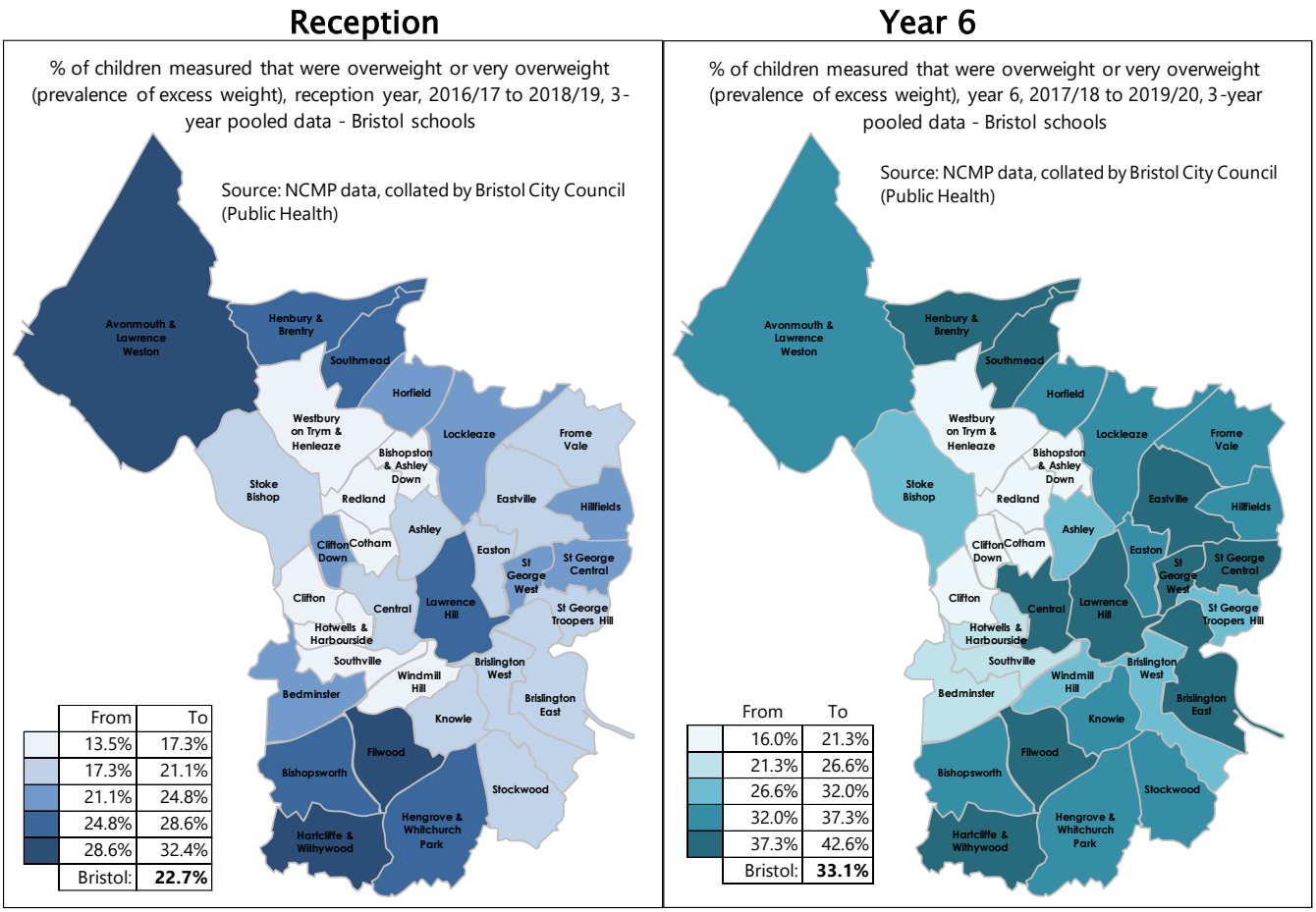


Figure Two – percent of children in Reception and year 6 overweight or obese (BMI >25) in Bristol by ward (NCMP 3-year pooled data – hence the differences between the data in the graphs and the data reported above). The differences between this and the adult data may be explained by the adult data being self-reported.

2.6 The number of children with excess weight is closely associated with a range of inequalities:

- **Deprivation** – there is a consistent association in Bristol between deprivation of area of residence, and prevalence of excess weight in children at both reception and year 6 age.
- **Ethnicity** – for year 6 pupils, Asian, Asian British, Black, Black British, and Mixed Ethnicity pupils have a higher proportion of excess weight than the Bristol average. White pupils have a lower proportion of excess weight than the Bristol average (NCMP data, 2019/20).
- **Diet Quality** – only 28% of primary and 22% of secondary school students reported eating at least five portions of fruit or vegetables on the day prior to being surveyed for the Bristol 'Pupil Voice' survey in 2019. 11% primary and 9% secondary students reported having no fruit of vegetables at all the previous

day. This data is not available at ward data but is likely to show a similar association with deprivation as with adults.

Taking a *Whole System Approach* to healthy weight

The causes of excess weight are complex. At its core, obesity is caused when people consume more calories than they expend through physical activity. This balance of calorie intake and expenditure is impacted by a huge range of interlinking factors,
2.7 many of which are inherent to the way we live our lives. This is sometimes referred to as an 'obesogenic' environment. These interlinked factors include individual genetic factors, social factors, the food options available to people, education on food and diet, food marketing, access to physical activity opportunities, the built environment of our city, transport options, and school or work environments.

There is no one solution that can counter all of these complex causes. The Office for Health Improvement and Disparities (OHID, previously Public Health England) therefore recommends that a *whole systems approach* is needed to tackle obesity.
2.8 There is a growing body of evidence to support the impacts of taking this approach.[9] This means taking a broader approach by working across the entire system. This includes taking actions in the following areas to address all causes that lead to excess weight:

- Healthier **food environment**
- **Schools and childcare** settings
- Increasing **healthy food consumption**
- Creating **healthy workplaces**
- Increasing **active travel**
- Providing **weight management support**
- Promoting **local opportunities** and **community engagement**
- Educating on **healthy eating** and **physical activity**
- Creating an environment that **promotes physical activity**

Bristol have committed to developing a whole system approach and have signed up to the *Local Authority declaration on healthy weight* to provide a framework for this.
2.9 Bristol are also committed to working collaboratively and joining up our approach with our neighbouring authorities, for example through the Bristol, North Somerset and South Gloucestershire (BNSSG) healthy weight Health Integration Team (HIT). This

[9] Whole systems approach to obesity: A guide to support local approaches. Public Health England, 2019.

brings together researchers, public health professionals, clinicians, and the public, to improve how research, policy and practice interconnect, aiming to ultimately help re-shape the unhealthy environments that we live in. Another key facilitator which will allow us to make the system-level changes that are required is through the developing Integrated Care Systems (ICS). These bring together public health, healthcare providers, acute trusts, voluntary and community organisations, and the public to re-think how we provide health and social care services with a focus on prevention and place-based solutions.

Example one – Whole systems work to improve healthy weight in children and young people

2.10 The following provides some examples of current work being undertaken to improve healthy weight in children and young people. These are grouped under the *Local Government healthy weight declaration* categories as an example of how this contributes to a whole systems approach.

Category of action	Example work
System Leadership	- Bristol's Belonging Strategy for children and young people includes key outcomes, priorities and actions on healthy weight, covering healthy weight in pregnancy, breastfeeding and early nutrition, physical activity, healthy eating and reducing all health inequalities. - The Food Equality Strategy and Action Plan contains specific aims relating to food security in children and young people. - The Sports and Physical Activity Strategy aims to halt the rise in levels of childhood and adult obesity by 2025.
Healthy weight promoting environments and settings	- Funding has been secured to deliver healthy weight conversation skills training for midwives and health visitors across BNSSG. - Maternal healthy weight advice and guidance is provided through the 'my pregnancy' app. - Healthy start vouchers and vitamins are promoted and distributed to families to increase uptake.

	- Promoting breast feeding and breastfeeding support services, including targeted one to one support for women in the wards with the lowest breastfeeding rates. - Promoting and protecting optimal infant feeding through ongoing work to support health visitors, Children's Centres and maternity services, to achieve UNICEF Baby Friendly Gold Accreditation. - Free swimming classes for pregnant women at Bristol City Council leisure services. - *This Girl Can* physical activity campaign for women and girls. - Work with Children's Centres, for example in providing Children's Kitchen and Food Clubs. - As part of a BNSSG offer, the School Health Nursing Service has been commissioned to provide Extended Brief Interventions on healthy weight for children and families. - Training for school nurses and other practitioners working with children and families on healthy weight conversation skills and Brief Interventions, as part of a 'Making Every Contact Counts' approach. - The Bristol Healthy Schools programme supports and provides awards for schools that adopt a whole systems approach to healthy weight. - 'Eat Them to Defeat Them' campaign to promote vegetable consumption. - Funding provided to develop the healthy eating element of the national curriculum.
Policies and commercial interventions	- A total citywide ban on unhealthy food advertising is outlined in the 2021 Advertising and Sponsorship policy. - The Bristol Eating Better Award for schools and early years settings, including a policy of no unhealthy food advertising. - Ban on advertising of unhealthy foods within 400m of schools or educational settings. - Restriction of the opening of hot food takeaways within 400m of a school or youth provision. - The Bristol City Council Good Food and Catering procurement policy 2018.

	- Bristol Breastfeeding Welcome Scheme in a range of venues and settings to support mothers to breastfeed in public spaces. - Work to ensure the requirements of the International Code of Marketing Breastmilk Substitutes is implemented.

Example two – Commission of a tier-2 weight management service for Bristol

The NHS defines four tiers of services to address healthy weight (see figure three). Bristol has not had a tier-2 weight management service for the past few years. In

2.11 2021, the Office for Health Improvement and Disparities (OHID) provided one year funding for a tier-2 weight management service to all Local Authorities in England. This funding was only able to be used for services for adults, and not for maternal or children and young people's weight management.

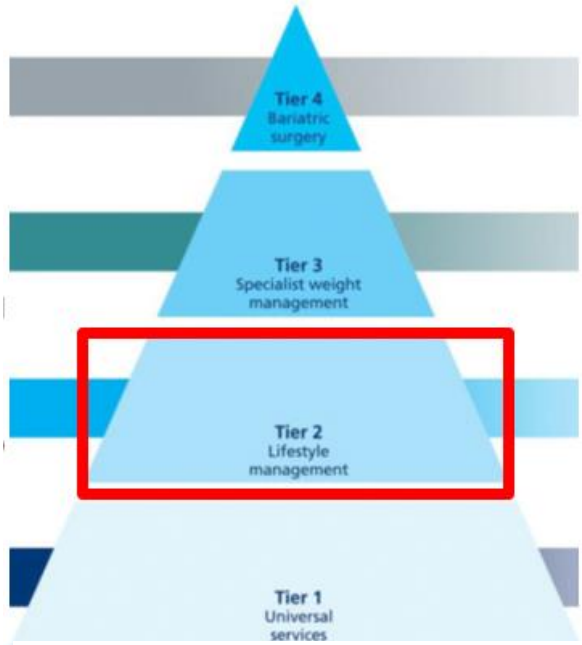


Figure Three – NHS tiers of weight management service

The Communities and Public Health team used this funding to commission a new adult Tier-2 weight management pilot. Recognising the lack of long term sustained impact tier-2 services have had in the past in Bristol, this new service was commissioned to use a community asset-based approach, and a 'test and learn' ethos. This is currently in operation in two areas of the city (Central & East and South Bristol). The current funding runs until June 2022 and includes an

2.12 insight and learning workstream to monitor the delivery of courses within these communities. This will provide evidence based, local delivery that is appropriate to the community and provide opportunities for programmes to be expanded city wide. The provider for this service – BeeZeeBodies, has extensive experience in public health and behaviour change science and provides mental health support with their delivery. An additional insight piece of work will be delivered to evidence how co-design of services with communities can support the development of a whole systems approach to healthy weight.

2.13 OHID have indicated that funding for a further three years is going to become available for these tier-2 weight management services. The Communities and Public

Health Team are taking a proposal to Cabinet to accept this funding. We are also creating a service specification for a three-year service which builds on the same innovative, community co-produced, asset based, and insight driven service. Insights and learning from the one-year pilot will be built into this service specification.

Next steps for the tier-2 weight management commissioning:

- For decision at cabinet meeting in April to seek permission to accept and delegated authority to spend this funding when it arrives.
- Development of the service specification in order to commission a 3-year service once the current contact runs out in June.

2.14

- Continue to work with the current provider to gather insights on the current pilot programme, it's use within the target communities, and the outcomes on weight management.
- Expand the service specification to take a broader all-age approach, for example through the specific focus on family interventions.

Example three – The Food Equality Action Plan

In partnership with Feeding Bristol, the Community and Public Health team have created a **One City Food Equality Strategy for Bristol 2022-2032**. This strategy has been developed to address the acute food insecurity in the city; 1 in 20 households in Bristol face uncertainty about being able to access sufficient food. The issues of food insecurity were exacerbated during the COVID-19 pandemic, and the ongoing

2.15

economic impacts and rise in cost of living mean this issue is set to remain or worsen in the next few years. The strategy recognises the overlap of food insecurity with access to a nutritious diet, and the impacts a poorly functioning food system can have on healthy weight. Many people in the city face multiple barriers to accessing to fresh, good quality, nutritious food, or having the skills or resources to benefit from it. In this way, addressing food inequality is a key strand of work in our whole system approach to healthy weight.

The strategy was developed with input from over 70 stakeholder organisations across the city. A series of 'community conversations' were also held with areas of the city which experience the highest levels of food inequality, as well as specific groups of

2.16

people who face increased risk of food inequality (for example people experiencing homelessness, disabled people, refuges and asylum seekers). A draft strategy was produced and put to public consultation in 2021. The results of this consultation have been incorporated into the final strategy. The strategy was presented and

approved by the Health and Wellbeing board in February 2022. See appendix B for a copy of the final strategy.

2.17 The strategy sets the ambitious aim to strive for food equality for all residents in the city of Bristol. The strategy defines food equality as existing when "all people, at all times, have access to nutritious, affordable, and appropriate food according to their social, cultural and dietary needs. They are equipped with the resources, skills, and knowledge to use and benefit from food, which is sourced from a resilient, fair, and environmentally sustainable food system." The strategy identifies five priority themes to achieve this:

- Fair, equitable access
- Choice and security
- Skills and resources
- Sustainability local food system,
- Food at the heart of decision making.

2.18 The next stage in this process is the development of an action plan, which will set out the specific actions and commitments needed from the council and partner organisations to achieve the vision set out in this strategy. This action plan will be co-produced by stakeholders and 10 'food equality champions' – people with lived experience of food inequality from across the city. The action plan will be embedded in the One City Approach and overseen by a steering group which reports to the Health and Wellbeing Board. The steering group will have representation from various departments of Bristol City Council, as well as representatives from the Voluntary and community (VCSE) sector in the city and the food equality champions. Regular updates will be taken to the health and wellbeing board to monitor progress against the stated aims, as well as the other thematic boards of the One City office to leverage actions across all sectors of the city.

2.19 <u>Next steps for the Food Equality Action Plan:</u>

- Recruitment of 10 food equality champions
- Setting up of the steering group, agreeing appropriate governance and oversight arrangements
- Developing a framework for action using the aims of the food equality strategy
- Developing systems for monitoring and regular reporting back to the overseeing boards
- A communications plan

3. Policy

The work on the whole systems approach to healthy weight relates to multiple policies and priorities within the council. These include:

- The One City Plan
- The One City Climate Strategy (due to the links with the work on sustainability on food)

3.1
- The Sport and Physical Strategy
- The One City Belonging Strategy
- The Local Government declaration on healthy weight
- The Bristol City Council corporate strategy
- The Good Food and Catering procurement policy
- The advertising and sponsorship policy
- The liveable neighbourhoods and parks and green spaces strategy

4. Consultation

a)Internal

4.1 This report was produces by the *healthier people and places* and the *children and young people* teams of the community and public health team in Bristol City Council

b)External

Not applicable

5. Public Sector Equality Duties

5a) Before making a decision, section 149 Equality Act 2010 requires that each decision-maker considers the need to promote equality for persons with the following "protected characteristics": age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Each decision-maker must, therefore, have due regard to the need to:

i) Eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act 2010.

ii) Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it. This involves having due regard, in particular, to the need to --

- remove or minimise disadvantage suffered by persons who share a relevant protected characteristic;

- take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of people who do not share it (in relation to disabled people, this includes, in particular, steps to take account of disabled persons' disabilities);

- encourage persons who share a protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

iii) Foster good relations between persons who share a relevant protected characteristic and those who do not share it. This involves having due regard, in particular, to the need to –
- tackle prejudice; and
- promote understanding.

5b) No equalities impact assessment has been undertaken for this umbrella piece of work of developing a whole systems approach to healthy weight. Addressing inequalities is a core theme underpinning this entire body of work. Insights through data and population health management will be used throughout this process to identify, monitor and address inequalities. Equalities impact assessments have been undertaken on specific pieces of work where it was important as part of a decision-making process. Please find below a link to the impact assessment of the food equality strategy, and in appendix A the equalities impact assessment for the tier-2 weight management pilot.

5.1

https://bristol.citizenspace.com/public-health/one-city-food-equality-strategy-for-bristol/supporting_documents/Equality Impact Assessment Food Equality Strategy Action Plan FINAL signed off.pdf

Appendices:

Appendix A – Equalities Impact Assessment for the recommissioning of the tier-2 Weight Management Service

Appendix B – The One City Food Equality Strategy. Please note – the wording of this copy is the approved final wording but there are some final changes to the design and formatting ongoing.

LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985
Background Papers:

Nil additional to the published references noted in the body of the report.

Equality Impact Assessment [version 2.9]

Title: Commissioning of Healthy Weight Service utilising asset-based community development (ABCD) approaches following 1 year pilot co-design phase	
☐ Policy ☐ Strategy ☐ Function ☒ Service ☐ Other [please state]	☒ New ☐ Already exists / review ☐ Changing
Directorate: Public Health and Communities	Lead Officer name: Grace Davies
Service Area: Public Health	Lead Officer role: Public Health Principal

Step 1: What do we want to do?

The purpose of an Equality Impact Assessment is to assist decision makers in understanding the impact of proposals as part of their duties under the Equality Act 2010.

1.1 What are the aims and objectives/purpose of this proposal?

The DH&SC will grant money for Local Authority Public Health Depts to commission a Tier 2 weight management service. The amount is currently unknown, but it is expected in Spring 2022. The aim of this proposal is to use the grant for the commissioning of a 3 year asset-based community development (ABCD), in line with NICE and Government guidance, and will build on the current pilot work to co-design models that support healthy weight in our communities and reduce health inequalities. It will also include targeted work with families and children, where budget allows.

Key **aims** of the future 3 year service will be to effectively embed support for healthier weight into our most at risk communities, thus reducing the health inequalities associated with excess weight and obesity.

The Community Asset Based approach used in our existing pilot service will also form the basis of future services, ensuring providers use learning from the 'deep listening' pilot work and utilise existing community networks, working closely with the Communities Team and other partners to develop and shape programmes appropriate for that community.

Any service or intervention we develop, or commission, will also reflect the following principles/ambitions;

- A whole systems approach that recognises the wider determinants of healthy weight
- A life course approach; involving adults, families, children, and pregnant and postpartum women in programmes
- A family-based approach
- A preventative approach
- A co-produced approach, monitoring emerging evidence, evaluation and innovation

1.2 Who will the proposal have the potential to affect?

☐ Bristol City Council workforce	☒ Service users	☒ The wider community
☐ Commissioned services	☒ City partners / Stakeholder organisations	
Additional comments:		

1.3 Will the proposal have an equality impact?

☒ **Yes**	☐ **No**

The service or intervention will aim to support the reduction of health inequalities caused by excess weight and obesity. The proposal will aim to have a positive equality impact by targeting priority groups to reduce inequalities through targeted promotion and providing the opportunity to access the service first, for example people/families who live in the most deprived neighbourhoods.

The Community Asset Based approach is a key part of our pilot service and will form the basis of future services, ensuring providers use learning from the 'deep listening' pilot work and utilise existing community networks, continuing to work closely with the Communities Teams to develop and shape programmes appropriate for that community.

There will be selection criteria to assess the Service in line with DH&SC (was Public Health England) requirements, set out in adult weight management service and children and families service guidance.

The service has the potential to change quality of life for the people with overweight and obesity. There is greater potential to have an impact on improving quality of life for groups which are identified to experience inequalities.

Step 2: What information do we have?

2.1 What data or evidence is there which tells us who is, or could be affected?

Data / Evidence Source [Include a reference where known]	**Summary of what this tells us**
https://www.bristol.gov.uk/documents/20182/3849453/JSNA+2019+-+Community+Assets+%28updated+Aug+19%29.pdf/d677de2e-64a0-1539-9675-a411b3abc54b	The Joint Strategic Needs Assessment identifies the higher risk populations in Bristol.
https://www.gov.uk/government/publications/obesity-weight-management-and-people-with-learning-disabilities/obesity-and-weight-management-for-people-with-learning-disabilities-guidance	Weight management guidance for disabled people.
https://www.bristol.gov.uk/documents/20182/34772/HW%20Strategy%20Document_2013_web.pdf/9dcfd365-4f01-46be-aaf3-0874d75c7c33	Reducing health inequalities as part of the One City Deal.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf	Disproportionate effect of COVID 19 on Black, Asian and minority ethnic adults.
Guh et al. (2009) The incidence of co-morbidities related to obesity and overweight: a systematic review and meta-analysis. BMC Public Health. 2009 Mar 25; 9:88. doi: 10.1186/1471-2458-9-88. PMID: 19320986; PMCID: PMC2667420. Available at https://pubmed.ncbi.nlm.nih.gov/19320986/	Co-morbidities associated with overweight and obesity.

Quality of life profiles for Lawrence Hill, Easton, Ashley, Filwood, Hartcliffe and Withywood (linked text).	Ward profiles – Quality of life profiles
JSNA 2021/22 - Healthy Weight Children (bristol.gov.uk)	Joint Strategic Needs Assessment – Healthy Weight (children) profile
Quality of Life 2020-21 — Open Data Bristol	There are marked differences in the extent to which citizens in Bristol self-identify as overweight or obese based on their characteristics and circumstances (including locality and deprivation). This is useful data to compare with health / medical data because there are likely to be ethnic, cultural and class-based differences in the way people recognise and interpret their weight and body shape:

Quality of Life Indicator	**% overweight or obese**
16 to 24 years	30.7
50 years and older	57.2
65 years and older	57.4
Female	42.9
Male	49.7
Disabled	67.2
Black Asian & Minority Ethnic	48.9
White Minority Ethnic	34.5
White British	47.7
Asian/Asian British	37.0
Black/Black British	76.3
Mixed Ethnicity	46.0
White	46.1
Lesbian Gay or Bisexual	45.9
No Religion or Faith	43.5
Christian Religion	51.8
Other Religions	52.1
Carer	54.5
Full Time Carer	61.8
Part Time Carer	52.3
Single Parent	55.5
Two Parent	49.5
Parent (all)	50.2
No Qualifications	63.7
Non-Degree Qualified	60.0
Degree Qualified	39.0
Rented (Council)	73.1
Rented (HA)	56.7
Rented (Private)	39.0
Owner Occupier	46.0
Most Deprived 10%	60.2
Bristol Average	**46.5**
	Source: Quality of Life in Bristol 2020-21

Quality of Life Indicator	**% overweight or obese**
Ashley	36.1

Avonmouth & Lawrence Weston	50.5
Bedminster	43.8
Bishopston & Ashley Down	36.1
Bishopsworth	54.5
Brislington East	52.5
Brislington West	51.0
Central	35.0
Clifton	31.5
Clifton Down	28.9
Cotham	24.9
Easton	42.5
Eastville	48.4
Filwood	62.5
Frome Vale	42.3
Hartcliffe & Withywood	68.0
Henbury & Brentry	52.7
Hengrove & Whitchurch Park	65.4
Hillfields	54.7
Horfield	55.1
Hotwells & Harbourside	33.7
Knowle	48.6
Lawrence Hill	49.4
Lockleaze	52.5
Redland	30.5
Southmead	64.9
Southville	35.8
St George Central	57.7
St George Troopers Hill	54.5
St George West	45.5
Stockwood	57.1
Stoke Bishop	49.0
Westbury-on-Trym & Henleaze	41.5
Windmill Hill	35.1
Bristol Average	**46.5**

Source: Quality of Life in Bristol 2020-21

Additional comments:

Overweight & Obesity in Adults and Children in Bristol

In Bristol more than half of adults and more than a third of children leaving primary school are living with overweight or obesity.

Overweight and obesity is a serious health concern that increases the risk of many other health conditions, including Type 2 Diabetes, cardiovascular disease, joint problems, mental health problems, and some cancers. There are key population groups (adults and children) with significantly increased risk of overweight and obesity:

1. People living with a disability
2. Ethnicity - the prevalence of overweight and obesity (and type 2 diabetes, which is associated with obesity) is much greater amongst adults from Black African, African Caribbean and South Asian background. The most recent 3 years of data show stark differences by ethnicity and gender for year 6 pupils, with female Black and Black British pupils (47%) significantly more likely than any other broad ethnic female group (apart from those of mixed ethnicity), to have excess weight. Asian and Asian British male year 6 pupils (47%) and Black or Black British male year 6 pupils (45%) also have significantly higher prevalence than any other broad ethnic group.
3. Deprivation**:** 64% of adults living in the 10% most deprived areas of the city have excess weight, compared with 40% in the 10% least deprived areas. In year 6 pupils, around 43% of children living in the 20% most deprived areas of city are overweight or obese, compared to well under half that for those living in the least deprived 20% of the city.
   JSNA 2020/21 Healthy Weight Data Profile and JSNA 2021/22 - Healthy Weight Data Children's Profile

2.2 Do you currently monitor relevant activity by the following protected characteristics?

☒ Age	☒ Disability	☐ Gender Reassignment
☐ Marriage and Civil Partnership	☐ Pregnancy/Maternity	☒ Race
☒ Religion or Belief	☒ Sex	☒ Sexual Orientation

2.3 Are there any gaps in the evidence base?

The pilot co-design phase is currently ongoing, establishing relationships with and engaging with the community to influence the co-design of this service with the 'test and learn' approach.

2.4 How have you involved communities and groups that could be affected?

The 1 year pilot co-design phase has initiated discussions with local communities which will support the co-design of this service. It is proposed that the service will take an asset-based community development approach to embed co-design and continuous learning into the service. The Neighbourhoods and Communities Team Managers will also be consulted, involved in the selection of provider and guiding of the co-design of the service.

Weight management is one of the three priorities areas for the 'healthy body' aims of the Bristol Health and Wellbeing Strategy 2020-25, as well as featuring among the aims within the Healthier People & Places programme of the One City Plan (Bristol One City, 2021) and Belonging Strategy (Bristol One City, 2021). It also aligns with themes 1, 4 and 5 of the Corporate Strategy.

A goal of whole-systems approach to healthy weight, embedded across the city, ensuring environments support healthy choices and are accessible and affordable for everyone, by 2033.

The One City Plan aims to use the collective power of Bristol's key organisations by supporting partners, organisations, and citizens to help solve key challenges, which includes improving the mental and physical health of all residents. The weight management service aims to align with this approach.

The adoption of the Local Authority Healthy Weight Declaration in February 2020, together with NHS Partner Pledges, has continued to benefit this whole-systems working. In particular, the workstreams set up to support healthy eating and food equality, are foundational in our approach to supporting healthy weight - linking to community anchor organisations and developing a community-led approach.

2.5 How will engagement with stakeholders continue?

Initial consultations have been carried out with Primary Care Networks prior to this proposal. Major outcomes of the proposal will focus on further consultations, community asset mapping and other community and partner engagement. The service will aim to be embedded within local communities and be able to demonstrate links with local VCSE and statutory partners, notably the new Integrated Care Provider networks and other NHS weight management services.

The 'test and learn' approach to service delivery will ensure utilising client, partner, and stakeholder feedback to continually improve delivery, with the service including co-production with members of the target population. Monitoring and evaluation of the service will be carried out in partnership with commissioners or third parties appointed by commissioners. Furthermore, where a referred service user is not eligible for the service, alternative provision should be sought wherever possible. The provider will develop strong relationships with statutory and community partners who may be able to offer support to those who may not be eligible for this service and will refer or signpost accordingly.

The proposal also aligns with the Council's Corporate Plan. This outlines the Bristol City Council's commitment to working with partners to empower communities and individuals, increase independence and support those who need it.

Step 3: Who might the proposal impact?

3.1 Does the proposal have any potentially adverse impacts on people based on their protected or other relevant characteristics?

Consider sub-categories (different kinds of disability, ethnic background etc.) and how people with combined characteristics (e.g. young women) might have particular needs or experience particular kinds of disadvantage.

Where mitigations indicate a follow-on action, include this in the 'Action Plan' Section 4.2 below.

GENERAL COMMENTS (highlight any potential issues that might impact all or many groups)	
While we have not identified any direct negative impact from the proposal, we aware from the evidence above of existing disparities for Bristol citizens based on their characteristics and circumstances. We will aim to address this where possible by ensuring service delivery is informed by accessible and inclusive co-design principles and ongoing engagement to meet the needs of Bristol's diverse citizens.	
PROTECTED CHARACTERISTICS	
Age: Young People	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	1 in 4 (23.0%) of children in reception year in Bristol (4-5 years old) and 1 in 3 (33.9%) of year 6 pupils (10-11 year olds) have excess weight (are overweight or obese) (2019/20). Data for 2016/17 to 2018/19 indicated a prevalence of around 17% for pupils living in the least deprived 20% of the city, compared to 28% for those living in the most deprived 20% of the city.
Mitigations:	The service will target Bristol Wards with a high proportion of people living in the most deprived areas, taking a whole family approach.
Age: Older People	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	Quality of Life survey shows more people aged 65 and over (56%) have excess weight compared to the city average (49%). People aged 65+ may be less likely to be comfortable using digital services
Mitigations:	The service will target older people. See general mitigations above.
Disability	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	Significantly more disabled adults (69%) have excess weight compared to the city average (49%). Disabled people are likely to face significant additional barriers to accessing services – including physical barriers and communication barriers etc.
Mitigations:	The service will target disabled people and use a range of accessible formats. See general mitigations above.
Sex	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐

Potential impacts:	Men (54%) are more likely to have excess weight than women (44%), but women are more likely to be obese (BMI ≥ 30)
Mitigations:	The service will target overweight and obesity in men and obesity in women using a range of communication methods. to meet the needs of a wide range of Bristol citizens
Sexual orientation	Does your analysis indicate a disproportionate impact? Yes ☐ No ☒
Potential impacts:	
Mitigations:	
Pregnancy / Maternity	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	In Bristol the % of women with obesity (BMI over 30) booking maternity care has gradually increased from 18.8% in 2013 to 20.2% in 2020.
Mitigations:	Following NICE and The Office of Health Improvement & Disparities (OHID) guidance the service will be appropriate for women before, during and after pregnancy and their families.
Gender reassignment	Does your analysis indicate a disproportionate impact? Yes ☐ No ☒
Potential impacts:	
Mitigations:	
Race	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	38% of White minority ethnic adults had excess weight compared to 77% of Black adults, both of which differ significantly to the city average (49%). Some groups may face additional language and cultural barriers to accessing appropriate services.
Mitigations:	The service will target Black, Asian and minority ethnic communities, and White minority ethnic communities (e.g. Polish community). Service delivery will be in a range of accessible formats to meet the needs of a wide range of Bristol citizens
Religion or Belief	Does your analysis indicate a disproportionate impact? Yes ☐ No ☒
Potential impacts:	
Mitigations:	
Marriage & civil partnership	Does your analysis indicate a disproportionate impact? Yes ☐ No ☒
Potential impacts:	
Mitigations:	
OTHER RELEVANT CHARACTERISTICS	
Socio-Economic (deprivation)	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	64% of adults living in the 10% most deprived areas have excess weight, significantly above the city average (49%). This compares to 40% of adults with excess weight living in the 10% least deprived areas.
Mitigations:	The service will target Bristol Wards with a high proportion of people living in the most deprived areas. Service delivery will be in a range of accessible formats to meet the needs of a wide range of Bristol citizens
Carers	Does your analysis indicate a disproportionate impact? Yes ☐ No ☒
Potential impacts:	
Mitigations:	
Other groups [Please add additional rows below to detail the impact for other relevant groups as appropriate e.g. Asylums and Refugees; Looked after Children / Care Leavers; Homelessness]	
Potential impacts:	
Mitigations:	

3.2 Does the proposal create any benefits for people based on their protected or other relevant characteristics?

Outline any potential benefits of the proposal and how they can be maximised. Identify how the proposal will support our Public Sector Equality Duty to:

- ✓ Eliminate unlawful discrimination for a protected group

- ✓ Advance equality of opportunity between people who share a protected characteristic and those who don't
- ✓ Foster good relations between people who share a protected characteristic and those who don't

The ambition of this service is to reduce health inequalities caused by excess weight and obesity between groups where inequalities exist, for example our most and least deprived communities, and between Black, Asian and ethnic minority populations and White citizens in Bristol. This proposal takes the necessary steps to meet the needs of people from protected groups as it will be targeted specifically at people with particular protected characteristics. It also encourages people from protected groups to participate in "public life or in other activities where their participation is disproportionately low". The community conversations and co-design production has the potential to foster good relations between people who share a protected characteristic and those who don't. This proposal also aims to contribute towards the gap in life expectancy between the most deprived and least deprived groups in Bristol is currently 9.6 years for men and 7.2 years for women (Bristol JSNA 2020/2021).

Step 4: Impact

4.1 How has the equality impact assessment informed or changed the proposal?

Summary of significant negative impacts and how they can be mitigated or justified: N/A
Summary of positive impacts / opportunities to promote the Public Sector Equality Duty:
This proposal specifically aims to address the negative impacts of unhealthy weight and will highlight priority groups who may experience inequalities.

4.2 Action Plan

Improvement / action required	Responsible Officer	Timescale
Using this Equality Impact Assessment tool has highlighted the importance of community involvement and stakeholder engagement. We will ensure that the previously outlined co-production actions are adhered to and emphasised.	Service provider	Contract length (3 year)

4.3 How will the impact of your proposal and actions be measured?

Monitoring and evaluation of the test and learn process as well as the outcomes achieved is a priority of this project. The provider must use validated tools when evaluating the service and adhere to the specifications set out by DH&SC for use of this funding. A bid has been made for National Institute for Health & Care Reform (NIHCR) funding to run an evidence-based test and learn evaluation, including effectiveness of the programme and long-term behaviour change effects on the 1 year co-design phase. The evaluation is expected to be university based in partnership with Bristol City Council. We require the awarded provider to work collaboratively with the evaluation and support their requirements if/when they develop. The provider will also be required to link with relevant evaluation supported by the proposed Bristol based Healthy Weight Health Integration Team. Regular monitoring meetings will be held with the provider to make sure that community engagement is met.

Step 5: Review

Equality and Inclusion Team Review: *Reviewed by Equality and Inclusion Team*	**Director Sign-Off:** 
Date: 24/1/2022	Date: 31/1/2022

A One City Food Equality Strategy for Bristol

2022 – 2032

BRISTOL ONE CITY

Food equality exists when all people, at all times, have access to nutritious, affordable and appropriate food according to their social, cultural and dietary needs. They are equipped with the resources, skills and knowledge to use and benefit from food, which is sourced from a resilient, fair and environmentally sustainable food system.

Acknowledgements

Bristol City Council and Feeding Bristol have worked in partnership to oversee the development of the Food Equality Strategy 2022 – 32. We are grateful to the following stakeholders who have helped to shape this document.

91 Ways to Build a Global City
Age UK Bristol
Avonmouth Community Centre
Avon Wildlife Trust – Grow Wilder
Baraka Café
Black South West Network
Borderlands
Bristol Ageing Better
Bristol Citizen's advice
Bristol City Council – City Councillors; Communities and Public Health Division; Children's Services; Families in Focus; Welfare Rights and Money Advice Support Service (WRAMAS); Procurement; Sustainable City; City Libraries.
Bristol Disability Equality Forum
Bristol Food Network
Bristol Food Policy Council
Bristol Food Producers
Bristol Food Union
Bristol Green Capital Partnership
Bristol Homeless Forum
Bristol Horn Youth Concern
Bristol Local Food Fund
Bristol One City Health and Wellbeing Board
Bristol Outreach Services for the Homeless (BOSH)
Bristol Refugee Rights
Bristol Sport Foundation
Bristol Youth and Community Action
BS3 Community
Caring in Bristol
CHAS Bristol
City Funds
Clifton Diocese
Counterslip Cares Food Bank
Eastside Community Trust
Family Action FOOD Clubs
FareShare South West
Heart of BS13
Henbury and Brentry Community Council
High Sheriff of Bristol
Incredible Edible Bristol
inHope
Inns Court Community and Family Centre
Julian Trust
Knowle West Alliance
Lawrence Weston Community Farm
Learning Partnership West
Malcolm X Centre
National Food Service Bristol
North Bristol Foodbank
Playful Bristol
Power to Change
Quartet
Refugee Women of Bristol
Roots Independent Street Team
Sims Hill Shared Harvest
South Bristol advice service
South & East Bristol Foodbank
Southmead Development Trust
Square Food Foundation
St Nicholas of Tolentino Catholic Church
St Werburgh's City Farm
St Werburgh's Community Centre
Super Supper Club
The Children's Kitchen
The Community Farm
The Matthew Tree Project
The MAZI Project
Trinity Centre
University of Bristol
University of the West of England
Urban Agriculture Consortium (UK)
Voscur
WECIL
Wellspring Settlement
Windmill Hill City Farm

Contents

Foreword

Food is essential to all our lives. Not only does it fuel and sustain us, it also plays a crucial role in the fabric of our city. It brings people together, is an expression of culture, binds communities and drives a thriving and vibrant economy. In this way, food plays a central role in the health and well-being of us as individuals and for our communities; and when we are not able to benefit from food in this way, food can become a significant cause and driver of inequality.

It is unacceptable that anyone in Bristol should face uncertainty about being able to access adequate food. Yet we know that one in every 20 households in Bristol face this stress regularly. This is just the tip of the iceberg, and the inequalities in our food system run much deeper. For example, the way in which our food is produced places a huge burden on the environment; significant numbers of people in the city are not able to access fresh and nutritious food, which leaves them at risk of ill health; and when food economies function poorly, people miss out of the significant economic and social value this can bring to themselves and communities.

On top of this, the economic and social impacts of COVID-19 have worsened these issues and left more people struggling to afford or access a nutritious diet. Nationally, the pandemic has caused a sharp rise in the number of people seeking emergency food support, and I want to acknowledge the strong network of voluntary, community and grassroots organisations in Bristol that have done an incredible job meeting this

need, in partnership with the council and many other organisations across the city. This has highlighted the need for us as a city to take urgent action not only to ensure support is available to people when they need it, but also to take a committed and dedicated view to preventing these issues from arising in the first place.

Bristol has made a sustained commitment to improving its food system, and this strategy builds on a number of years of work to make the food system fairer and more sustainable for all. The achievements of this were recognised in Bristol becoming only the second city in the UK to receive 'gold sustainable food city' status in May 2021. This strategy builds on this strong baseline of work, and presents our ambitious plan to strive for food equality for all residents in the city of Bristol within ten years. In it, we present the city's vision of food equality, highlighting the areas we need to address to be able to achieve this aim. This strategy will form the framework for a pragmatic *Food Equality Action Plan*, to be developed in 2022, which will lay out the actions we need to take to achieve each point raised in this strategy. To be able to achieve these aims, food equality needs to be considered as a key priority throughout the wider work of the city, and this strategy has been developed in collaboration with system partners through the One City Approach.

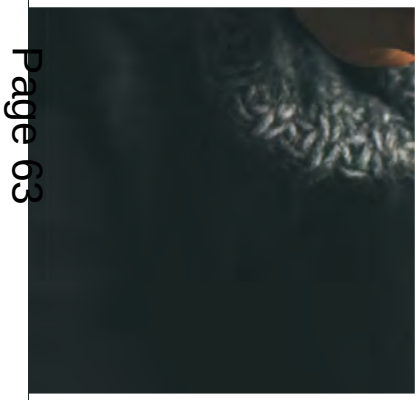
Our ultimate aim is to make Bristol a leading city on issues of food equality, and to become a pioneering city that is leading the fight for food justice. By significantly improving food equality for the people within our own city, we will be able to make positive influence both nationally and internationally on issues that will ultimately make our food system fairer and more equitable for all.

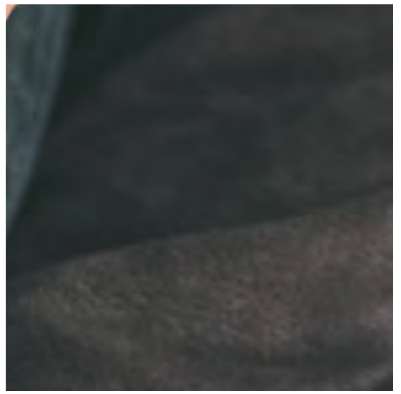
Councillor Asher Craig Deputy Mayor and Cabinet Member for Children, Education and Equalities, and Food Champion.

Executive summary: A vision for food equality in Bristol

Food equality exists when all people, at all times, have access to nutritious, affordable and appropriate food according to their social, cultural and dietary needs. They are equipped with the resources, skills and knowledge to use and benefit from food, which is sourced from a resilient, fair and environmentally sustainable food system.

Our vision for Food Equality – Bristol Food Equality Stakeholder Group, 2021





The *Food Equality Strategy 2022 – 32* is designed to recognise and tackle the issues of rising food inequality in Bristol. Developed out of Bristol's Going for Gold 'Sustainable Food City' campaign,[1] the strategy builds on work and research that has been carried out over the last two decades. The strategy and a subsequent *Food Equality Action Plan* will work alongside other initiatives in the city that seek to tackle poverty and inequality. It will form part of the *One City Bristol Good Food 2030 Action Plan*, which will be focused on creating a fairer, more resilient, and sustainable local food system, benefitting people and the planet.

The need for this new strategy has become even clearer due to the impact of the COVID-19 pandemic, which shone a spotlight on the significant inequality that exists in how people access nutritious, affordable, and sustainably sourced produce, both nationally and locally. Coupled with the impact of Brexit and climate change on our national food system and economy, these inequalities will not only continue to exist, but will intensify if we do not act now to ensure an equitable local food system is established. **It is the most disadvantaged who will feel the impacts first and most severely when faced with food shortages, price increases, and the breakdown of supply chains.**

It was imperative that this strategy was created through a collaboration of key stakeholders throughout the city, including representatives of organisations working both directly and indirectly in all aspects of the food sector, as well as members of the wider community.

Over a period of nine months, we facilitated three stakeholder group meetings and surveys (involving more than 100 individuals representing over 70 organisations) and eight community conversations (involving 38 people) to test and develop the vision for food equality.

Stakeholder group meetings involved discussions on what food inequality looks and feels like, and what the barriers to food equality are. Participants also discussed what the administration and accountability of food equality should be, and how this could be made more inclusive, ensuring the success of the strategy. The community conversations were targeted at five wards that ranked highest on the 2019 index of multiple deprivation and three community groups at high-risk of food inequality (disabled people, people experiencing homelessness, and asylum seekers and refugees) to provide valuable insights and views from those with lived experience of food inequality.

[1] For more information, please see 'Bristol Named Gold Sustainable Food City': www.goingforgoldbristol.co.uk

Edible Fishponds © Gareth Price

Priorities for achieving food equality

The results of these meetings, conversations and background research led to the formation of a vision for food equality in Bristol. This vision was distilled into five priority themes that will be the foundation for positive change, providing the building blocks for this strategy:

Fair, equitable access	Fair access to nutritious and appropriate food.
Choice and security	Choice, empowerment, and a feeling of security.
Skills and resources	People and communities are equipped with the necessary food knowledge, skills and facilities.
Sustainable local food system	A resilient and environmentally sustainable local food system.
Food at the heart of decision-making	Food is at the heart of community, economy, and city planning.

Food Equality Action Plan

The next step in the development of the strategy is to shape a *Food Equality Action Plan* (scheduled for early 2022) based on the priority themes above. This will set out a path for positive change, with clear and accountable actions for achieving the vision of food equality in the city. As part of the stakeholder consultation and community conversations we have begun to develop action plan priorities which will continue to be worked on by a broader group including stakeholders, people from identified communities of interest, and those with lived experience of food inequality.

It is important that the aims of the strategy and action plan are monitored and evaluated. This will use a mixture of qualitative and quantitative measures, some of which already exist and others which will need to be developed.

Appropriate administrative and accountability structures will need to be established and the need for a representative steering group has also been identified. Community-based Food Equality Champions, with lived experience of food inequality, and wider stakeholder group meetings will also be crucial to oversee the delivery and engagement of the strategy and action plan.

The success of this work relies on the *One City* approach, where partners from across the city, including Bristol City Council, take ownership on delivery, development and evaluation of the work needed to make a positive impact to the lives of people who live and work in Bristol. By taking a collaborative and co-produced approach we can significantly increase the chances of success of the strategy.

Definitions: why 'food equality'?

The *Food Equality Strategy* 2022 – 32 addresses inequalities faced across our local food system, including, but not limited to, food insecurity. To reflect the broad focus of this work we have chosen to use the term 'food equality'.

As there is no official definition of food equality, a definition has been developed and co-produced through the stakeholder consultations in development of this strategy. This definition has become our vision for food equality for Bristol.

It is important to recognise that this definition is closely related to definitions of 'food security', 'food justice' and 'food equity', and incorporates the key elements of these terms. It is also important to highlight that these terms often have multiple definitions.

Important and related terms	Definition
Equity	Equity recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome. (The George Washington University, 2020)
Food Insecurity (also referred to as 'household food insecurity' and 'food poverty')	...being unable to consume an adequate quality or sufficient quantity of food for health, in socially acceptable ways, or the uncertainty that one will be able to do so. (Dowler et al., 2001)
Food Security	Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. (Food and Agricultural Organisation, 1996)
Food Justice	Food justice is where everyone has access to nutritious, affordable and culturally appropriate food, which is grown, produced, sold and consumed in ways that care for people and the environment. (Feeding Bristol, 2021)
Food Equity	Food equity is the expansive concept that all people have the ability and opportunity to grow and to consume healthful, affordable, and culturally significant foods. (University of Buffalo, accessed 2021)
Food Sovereignty	Food sovereignty is the right of each nation to maintain and develop its own capacity to produce its basic foods respecting cultural and productive diversity. We have the right to produce our own food in our own territory. Food sovereignty is a precondition to genuine food security. (Via Campesina, 1996)
"Good Food" (as developed by the Bristol Good Food Charter)	Good food is defined as being vital to the quality of people's lives in Bristol. As well as being tasty, healthy and affordable, the food we eat should be good for nature, good for workers, good for businesses and good for animal welfare. (Bristol Good Food Charter, 2012)

Guiding principles

This strategy has been developed using the following underlying principles:

- **Equity is the key consideration at all stages** The inequalities present in our food system and health outcomes are the primary focus of this strategy. To address these inequalities, we need to ensure inclusion of all members of society, and an appropriate focus on those most at risk of social and economic inequality. We strive for **equity**, by which we mean creating a fair and just system which appropriately prioritises the communities and individuals most in need. This focus on equity is what will enable us to drive towards equality across the city.
- **Take a preventative approach** Food inequality should not exist in a just society, and it is not enough to only address the problems of food inequality once they are already established. We need to stop these inequalities developing in the first place. This means taking time to identify all the driving causes of the problem and taking action to prevent them.
- **Take a systems view** The causes of food inequality are part of a complex system of interdependent factors, as are the solutions. We must recognise the complexity of food inequality and create this strategy with a view of how it will fit into, and interact with, this complex system.
- **Take a place-based approach** This empowers communities and incorporates grass root solutions. Building on the activities and assets already in use in localities, instead of attempting to build solutions from scratch. This also needs to consider the specific needs of at-risk groups. By empowering change at a local level, it can influence positive changes across the city.
- **Take an inclusive and transparent approach** Diverse community participation from across the city is fundamental in the development, implementation, and administration of the strategy. This is also key to making it meaningful to the people of Bristol and therefore more successful in achieving food equality.
- **A reflective and flexible approach** This actively seeks feedback and adapts accordingly. Feedback from individuals, communities and stakeholders will be continually sought and fed back into this work, which will help build a sustainable working relationship that can then exist beyond the limits of this strategy.
- **Link the strategy to a pragmatic action plan** This will ensure the goals set out in this strategy are realistic and achievable.

Introduction

Essential to our survival, food is fundamental to all our lives. Intimately connected to expressions of cultural and social identity, what we eat and how we eat are major determinants of our health and well-being.[2] But more than this, the entire food system – from production to consumption – has a social, economic, and environmental impact on our society, our communities, and our lands.

The right to adequate food is a basic human right.[3] Bristol has had significant success over the past years in bringing together partners from across the city to improve all aspects of the food system. This achievement was recognised in Bristol becoming the second city in the UK to receive 'gold sustainable food city' status in May 2021.[4] Yet despite this, we are seeing increasing levels of food inequality across the city.

An estimated 1 in every 20 households experienced severe to moderate food insecurity in 2019/20 (JSNA, 2021) – a statistic that is likely to have increased due to the impact of the COVID-19 pandemic. This figure rises to 1 in every 8 households in certain parts of Bristol, and the stark reality is that people experiencing this form of food inequality are disproportionately from the most deprived areas of the city, or from key at-risk groups. This both reflects and contributes to a much broader range of inequalities experienced by these disadvantaged groups. The most striking example of this is seen in the gap in healthy life expectancy (the number years lived in good health) between the least and most deprived areas of the city which is approximately 16 years.[5] But it is also seen in inequalities in the infrastructure, and access to services and provisions experienced by different people across the city.

This food inequality must be addressed.

The Food Equality Strategy

The aim of the *Food Equality Strategy* is **to strive for food equality for all residents in the city of Bristol** within ten years. Recognising the importance of this issue within our city, this aim is deliberately aspirational and aligns with the targets set out in the *One City Plan*.[6]

Presenting a shared vision for food equality in Bristol, this strategy document explores what drives food inequality nationally and locally and outlines a series of priorities for how the city can work together to achieve food equality.

Drawing on data from previous city-wide work alongside a recent *Food Inequality Needs Assessment for Bristol*,[7] this strategy is co-produced and informed by stakeholder consultations, as well as community conversations with people who have lived experience of food inequality in Bristol.[8] (Full details on the stakeholder consultation and community consultation can be provided on request).

Importantly, this strategy sits alongside a separate Food Equality Action Plan that will be developed based on this strategic vision. This action plan will be co-produced by stakeholders across the city and overseen by a representative steering group. It will contain specific actions and commitments from the council and partner organisations on how we will be able to achieve the vision set out in this strategy.

The benefits to the city from achieving food equality

The purpose of this strategy is to provide the following benefits to our city:

- A more equitable city for all.
- Reduce hunger and food insecurity for residents, recognising and supporting the 'right to adequate food'.
- Reduce health inequalities across the city.
- Reduce the anxiety and other mental health effects caused by food insecurity.
- Reduce the impacts on the NHS and social care system through these improved health outcomes.
- Contribute to city-wide efforts to reduce poverty in Bristol.
- Help develop a thriving and resilient local food economy.
- Build and strengthen connections and communities through food.
- Have a positive impact on our local environment and contribute to the city's commitment to becoming a carbon-neutral and climate resilient city by 2030.
- Help achieve key aims and goals the city has already committed to under the *One City Plan*, the *Bristol City Council Corporate Strategy*, the *United Nations Sustainable Development Goals*, *The Local Authority Declaration on Healthy Weight*, and more.

[2] Dimbleby et al, 2020. National food strategy; part one. Available at www.nationalfoodstrategy.org

[3] www.ohchr.org

[4] 'Bristol Named Gold Sustainable Food City': www.goingforgoldbristol.co.uk

[5] Bristol City Council JSNA Health and Wellbeing Profile 2020/21: Healthy Life expectancy

[6] 'One City Plan 2021: A Plan for Bristol to 2050': www.bristolonecity.com

[7] Publication Pending – available on request from Bristol City Council Communities and Public Health team.

[8] Publication Pending – available on request from Feeding Bristol team.

Background work in Bristol

The strategy builds on extensive work that has sought to make Bristol a more just and sustainable food city for those who live and work here. Over the past ten years, this has included:

- The 2011 report *Who Feeds Bristol*, which explains the food system serving the Bristol area.
- The 2013 *Good Food Plan 2020*, which sought to promote food system change across the city.
- The 2013 review *Food Poverty: what does the evidence tell us?*, which draws together national and local data on food insecurity.
- In 2016, a collective city-wide campaign won Bristol 'silver' status as a Sustainable Food City.
- In 2018, Bristol City Council passed the *Good Food and Catering Procurement Policy*.
- The 2019 report *Bristol food provision and services*, which reviewed available food support in the 10 most deprived wards in Bristol.
- In 2021 the *Advertising and Sponsorship Policy* for Bristol City Council now includes restrictions for food and drinks high in fat, sugar and salt.[9]
- The 2020 city-wide COVID-19 crisis food response. Including reports: *Bristol's COVID-19 Community Food Response* and *COVID-19: Local coordination* delivered emergency food, but food plans must address food insecurity.

This work contributed to Bristol's successful city-wide 'Going for Gold' bid[10] to become only the second place in the UK to achieve the Sustainable Food Places Gold award in May 2021. The 2-year initiative was coordinated by the Going for Gold Steering Group and includes food equality as one of six key themes. This new strategy is a legacy of the *Going for Gold* campaign and is also an integral part of the *One City Bristol Good Food 2030 Action Plan*, which is currently in development.

Importantly, Bristol's *Going for Gold* campaign could not have been successful without the strong network of Voluntary, Community, Social Enterprise (VCSE), grassroots and statutory sector organisations providing essential and innovative support and access for residents across the city. This network has also been crucial to the COVID-19 pandemic food response over 2020 – 21, as well as to the development of this strategy.

Food inequality: causes, impacts, and the national picture

Many of the causes and drivers of food inequality relate to broader social and economic inequality, and in particular poverty and economic disadvantage.[11] A stark example of the interactions between poverty and food inequality is seen in the Department for Work and Pensions (DWP) *Family Resources Survey*, which reported on food insecurity figures in the UK between 2019 – 20, finding that 43 per cent of households who receive Universal Credit experience high or very high levels of food insecurity.[12]

Poverty is a complex issue and with many causes. The impact of living in poverty extends far beyond food inequality, but the two issues are inherently interlinked. For example, people living in poverty may have less resource, capacity and access to facilities and infrastructure which allow them to cook nutritious food from scratch. Many individuals and families may also have to face dilemmas between paying bills or cutting back on food (also known as the 'heat or eat' trade-off).

However, the causes of food inequality are not as simple as just poverty alone. It is a complex issue that is deeply engrained in the economic, social, cultural and environmental structures of our city, and wider society. The following figures highlight key factors driving food inequality, and the far-reaching impact that food inequality can have on individuals and communities.

[9] Full policy available at democracy.bristol.gov.uk

[10] www.goingforgoldbristol.co.uk

[11] House of Lords Select Committee on Food, Poverty, Health and the Environment. *Hungry for change: fixing the failures in food*. Report of Session 2019-20

[12] Department of work and Pensions (2021), Family Resources Survey; financial year 2019 to 2020. Published online 25/03/21, available at www.gov.uk

Figure 1: Summary of the causes and drivers of food inequality. Sources: The 2013 *Food Poverty* report[13] and the 2021 *Food Inequality Needs Assessment for Bristol*[14]

Causes and drivers of food inequality

Economic	Social	Environmental
• Low income, unemployment, and financial hardship. • Poor social welfare provision. • The rising cost of living and reduction of household income in real terms. • High proportion of household income spent on food and other essentials • Over-reliance on supermarkets and a lack of investment in local food economies. • Many economic causes exacerbated by COVID-19 pandemic.	• Lack of access to culturally appropriate food. • Lack of access to equipment and/or fuel for cooking. • Lack of knowledge or skills required to prepare healthy meals. • Lack of access to emergency food support, due to lack of awareness, inability to achieve a referral, poor availability, or social stigma. • Poor regulation of food industry, which incentivises cheaper processed and calorie-dense options. • Marketing of unhealthy foods.	• Reduced availability of growing spaces and allotments. • Food system reliant on industrial-scale farms, importing and transporting food. • Local food supply chains under-utilised. • A lack of locally available affordable and healthy food is associated with poor diet quality.

[13] Maslen, C., Raffle, A., Marriot, S., Smith N. (2013) *Food Poverty. What does the Evidence tell us?* Bristol City Council.

[14] Publication Pending – available on request from Bristol City Council Communities and Public Health team.

Figure 2: Summary of the impacts of food inequality. Sources: The 2013 *Food Poverty* report[15] and the 2021 *Health Needs Assessment of Food Equality in Bristol.*[16]

Impacts of food inequality

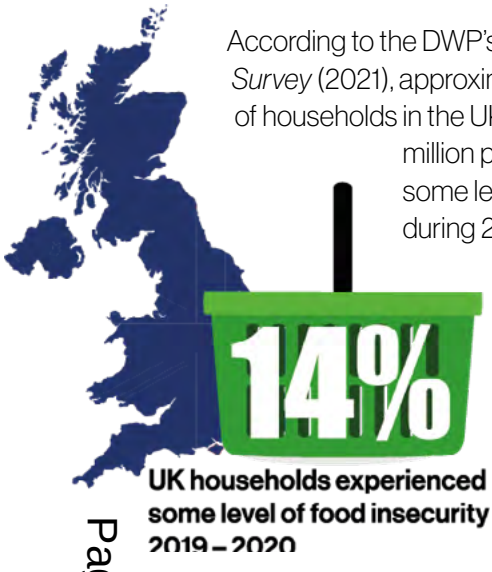
Economic	Social	Environmental	Health
• Fewer employment opportunities in local food economy. • Fewer people working and participating in the economy. • The social, environmental and health effects of food inequality place a significant financial strain on the state, particularly the NHS and the VCSE sector.	• Causes a range of behavioural, academic and emotional issues in children, and can compromise their educational attainment. • Poor quality diets are associated with anti-social behaviour and violence in adults. • Disconnection of people from their local food systems (e.g., food growing)	• Lack of food growing spaces prevents people from growing their own, fresh food. • Carbon emissions result from reliance on non-local and international food supply chains, contributing to climate change. • Food is sourced from industrial-scale agriculture, which negatively affects local ecosystems and biodiversity.	• Food insecurity is strongly associated with poor diet quality and obesity. • Food insecurity has been linked to poor mental health. • Poor diet quality is associated with cardiovascular disease, stroke, Type 2 diabetes, and some cancers. • In children, poor diet quality increases the risks of stunting, iodine deficiency and iron deficiency anaemia.

The poorest individuals and communities are disproportionally impacted. As such, food inequality is a key driver of health inequalities.

[15] Maslen, C., Raffle, A., Marriot, S., Smith N. (2013) *Food Poverty. What does the Evidence tell us?* Bristol City Council.

[16] Publication Pending – available on request from Bristol City Council Communities and Public Health team.

The national picture of food inequality



According to the DWP's *Family Resources Survey* (2021), approximately 14 per cent of households in the UK (equivalent to 9.5 million people) experienced some level of food insecurity during 2019 – 2020 (with 6 per cent experiencing marginal, 4 per cent low, and 4 per cent experiencing very low food security).[17] The distribution of food insecurity across the country was unequal, with the North West and North East having the highest rates. Food insecurity in the South West was reported lower than the national average, with an estimated 5 per cent of households having marginal, 2 per cent having low and 4 per cent very low food security. However, it is important to note that the data from this survey is not available beyond a regional level, and comparison of our local food insecurity in Bristol to this national average is difficult due to different methods and the lack of consistent recording and reporting of this data. It is also difficult to interpret regional data, where the averages may mask significant variations and inequalities.

[17] Department of work and Pensions (2021), Family Resources Survey; financial year 2019 to 2020. Published online 25/03/21, available at www.gov.uk/government/collections/

Impact of the COVID-19 pandemic

The COVID-19 pandemic has made the issue of food inequality, in particular food insecurity, more pressing than ever.

At a national level, it has both exposed and exacerbated some of the long-standing problems of food insecurity which exist in our society. It has also driven a rise in the visibility and discussion of this issue on the national stage, for example in the significant publicity around the campaign spearheaded by the footballer Marcus Rashford around Free School Meals and the problem of food access for children and families.

One of the most visible impacts of the pandemic was that as more households have faced financial pressure from unemployment, under-employment or furlough, there has been an unprecedented rise in households seeking emergency food support. The Trussell Trust (who manage more than half of all food banks in the UK) have reported that between 2019/20 and 2020/21 there has been a 33 per cent increase in food parcels distributed in just one year.[18] And around half of those using food banks were doing so for the first time as a result of unemployment and financial insecurity caused by the pandemic.[19]

Reviewing food insecurity levels during this time, the Food Foundation found that rates of food insecurity have been consistently higher than pre-COVID-19 levels, with those on Universal Credit (UC) especially at-risk. According to their surveys, people who were already claiming UC experienced three times greater levels of food insecurity in the first 6 months of lockdown than the average before the pandemic, despite the £20 uplift to UC.[20]

Importantly, the COVID-19 pandemic has also revealed cracks in our wider food system. It has exposed our over-reliance on supermarkets and long-supply chains, highlighting the severe impact disruption to this model has on food economies at a local and national level; an issue that will be put at further risk of exposure with the impact of Brexit and the indirect impacts of climate change. This does present an opportunity to build a stronger local food system as part of the COVID-19 recovery; one that can both tackle the issues of food inequality and wider issues for workers in the food industry by providing higher rates of job security, pay and financial resilience.

[18] The Trussell Trust. End of Year Stats 2021. Available at www.trusselltrust.org

[19] The Trussell Trust. Local Lifelines. investing in local welfare during and beyond COVID-19. Salisbury: The Trussell Trust. 2020.

[20] The Food Foundation. A Crisis within a Crisis: The Impact of COVID-19 on Household Food Security. London: The Food Foundation. 2021

Food inequality in Bristol

Data from multiple sources has been collected to build a picture of the current state of food equality in Bristol. Full details can be found in the Food Inequality Needs Assessment for Bristol.[21] Headline findings are presented below, each of which must be addressed to achieve the vision for food equality in Bristol.

Food equality shows significant disparity across the city

The effects of food inequality are disproportionality felt within the most deprived areas of the city. While 1 in 20 households (4.2 per cent) across Bristol experienced severe to moderate food insecurity in 2019/20, this rate increased to 1 in every 8 households (12.2 per cent) in the most deprived wards of the city (JSNA, 2021).[22] This inequality mirrors a number of other indicators of food insecurity. For example, up to half of children in some wards of the city are eligible for free school meals, compared to a city-wide average of 1 in every four children.[23] This also relates to the large inequalities in healthy life expectancy (the number of years lived in good health) seen across the city: in 2020, women in the least deprived areas live an average 16.7 years longer in good health. Similarly, men in the least deprived 10 per cent of the city can expect to live 16.3 years longer in good health than those in the most deprived 10 per cent.[24]

Availability of resources across the city is of particular concern. Access to fresh and nutritious food varies considerably between areas, and a report in 2018 found that residents living in some of the more deprived areas of the city had easier access to takeaways than shops selling fresh and nutritious produce.[25]

Unsurprisingly, emergency food support use is higher among those living in more deprived areas of the city, and people living in the most deprived 10 per cent are three times more likely (8.4 per cent)to access food support compared to those in the least deprived areas of the city (0.3 per cent).[26] Significantly, because this data was collected prior to the COVID-19 pandemic, these rates are expected to have increased.

[21] Food Inequality Needs Assessment for Bristol 2021. Publication Pending – available on request from Bristol City Council Communities and Public Health team

[22] Bristol City Council JSNA health and wellbeing profile 2020/21: food poverty/insecurity.

[23] Free School Meal data provided by Bristol City Council, based on 2021 data.

[24] Bristol City Council JSNA Health and Wellbeing Profile 2020/21: Healthy Life expectancy.

[25] Carey et al, 2018, Bristol Food Provision and Services; informating the work of the Feeding Bristol charity, a short summary.

[26] Bristol City Council JSNA health and wellbeing profile 2020/21: food poverty/insecurity.

Certain at-risk groups experience higher rates of food inequality

Certain groups are more at risk of experiencing food inequality. For example, according to the Bristol *Quality of Life Survey* (2020/21), disabled people, full-time carers, single parent households, and those renting from either the council or a housing association were more likely to experience food insecurity.[27]

Key figures from the *Quality of Life Survey* (reporting on 2020/21 figures):

- Almost 1 in 7 disabled people (14.8 per cent) reported moderate to severe food insecurity in the past 12 months, more than three times higher than the Bristol average (4.2 per cent).
- Residents in council housing were 25 times more likely (11.5 per cent) to have used emergency food support than those who owned their own homes (0.46 per cent).
- 13.4 per cent of single parent households reported that they had experienced moderate to severe food insecurity in the last 12 months, compared to only 1.6 per cent of two parent households.

These findings are supported by the recent food insecurity figures published by the Department for Work and Pensions (DWP) through their *Family Resources Survey* and other studies into food insecurity and food bank use.[28]

Further to this, through engagement with stakeholders and community conversations (detailed later in the strategy) other key at-risk groups were highlighted, including those with No Recourse to Public Funds,[29] people experiencing homelessness, and older residents. Notably, all these groups are likely to be under-represented in *Quality of Life* survey respondents.

Diet varies across the city

Diet quality (currently only measured as fruit and vegetable intake) was not only shown to be lower for those in more deprived areas, but also for people living in rented accommodation, for people aged 16 – 25, for those with no further educational qualifications, and those who identified as Black/Black British.[30]

Food inequality is associated with health inequalities in our city

It is difficult to estimate the true impact of food inequality on health outcomes in Bristol. But there are several ways in which food inequality could worsen the health inequalities seen across the city. For example, a healthy diet often costs more than less healthy options,[31] and one of the most direct impacts of food inequality can be lack of access to fresh nutritious food and poor diet quality. This can contribute to excess weight. There are more adults living with excess weight in the more deprived areas of the city: 17.1 per cent of adults in the most deprived areas of the city are classified as obese, compared to only 9.1 per cent in the least deprived areas.[32] A similar pattern is seen in children, with 28 per cent of reception-aged children in the most deprived areas having excess weight compared with 17 per cent in the least deprived areas.[33]

[27] Bristol City Council JSNA health and well-being profile 2020/21: food poverty/insecurity. Available at www.bristol.gov.uk

[28] Loopstra and Lalor, 2017; Prayogo et al., (2017); MacLeod et al., (2018); Garratt (2017).

[29] This refers to migrants who have no entitlement to the majority of welfare benefits.

[30] Bristol City Council JSNA health and well-being profile 2020/21: food poverty/insecurity. Available at www.bristol.gov.uk/documents

[31] www.foodfoundation.org.uk

[32] Bristol City Council JSNA health and well-being profile 2020/21: food poverty/insecurity.

[33] Bristol City Council JSNA health and Well-being profile 2020/21: Health weight (children).

Priority themes for food equality in Bristol

This strategy aims to significantly improve food equality in Bristol over the next decade. It aligns with other key strategies for improving food systems and addressing poverty in the city, as well as many of the aims laid out in the *National Food Strategy*.[34]

This section sets out the priority themes where action needs to be taken to achieve food equality in Bristol. These themes have been co-produced through stakeholder consultation with representation from over 70 different organisations and community conversations with people who have lived experience of food inequality in the city.[35]

Priority theme: Fair, equitable access

Fair access to nutritious and appropriate food. Residents are able to access food that is appropriate for their dietary needs, is culturally appropriate, and affordable.

Priority theme: Choice and security

Choice, empowerment, and a feeling of security. Everyone can make decisions about their relationship with food and are free from the anxiety and stress of food insecurity.

Priority theme: Skills and resources

People and communities are equipped with the necessary food knowledge, skills and facilities. Residents can foster a healthy food culture, have confidence in their ability to access and use food to meet their needs, as well as the facilities and fuel to cook with.

Priority theme: Sustainable local food system

A resilient and environmentally sustainable local food system. The local food system prioritises resilience and sustainability in food production, food waste management, distribution, economy, and environmental resilience.

Priority theme: Food at the heart of decision-making

Food is at the heart of community, economy, and city planning. Food needs and equality are considered in all decision-making – whether developing social support models, new businesses or planning new housing .

Priority theme: Cross-cutting strategic aims

Strategic aims that sit across all the priority themes.

[34]Dimbleby et al, 2020. National food strategy; part one. Available at www.nationalfoodstrategy.org/part-one/

[35]Publication Pending – available on request from Feeding Bristol team.

Priority theme: Fair equitable access

Everyone in the city is able to access food that is appropriate for their dietary needs, is culturally appropriate, and affordable.

Priority theme: Fair equitable access

To achieve this, we must address the multiple barriers that people and communities face which limit their access to sufficient fresh, nutritious food that meets their needs. This includes thinking about how our city and communities are structured, for example the variety, location and accessibility of local food outlets, and the transport options that allow people to access them. It also involves thinking about how we can include the specific needs of individuals and groups at risk of food inequality, including disabled people, people experiencing homelessness, different cultural groups and more.

Nutritious and appropriate food needs to be affordable for everyone, but this should not disadvantage the food producer or retailer. We need to encourage innovative models of food support that allows for better access to nutritious and affordable food in ways that enable choice, retains dignity, and develops empowerment.

As a city, we will:

- **Actively investigate and take stock of the specific issues and barriers to accessing nutritious, appropriate food in the most deprived wards and for at-risk communities of interest.** We need to understand how our current food system and transport infrastructure impacts on food access. Mapping shops, social eating spaces, growing spaces, public transport and community groups and facilities will allow us to take a community-led approach to improving access which makes use of the facilities and assets already available. This must include an awareness of the specific needs of different areas and considering specific access needs for at risk groups including disabled people, refugee/asylum seekers, young people, people experiencing homelessness, and older people.
- **Take time and use a participatory approach to understanding barriers and needs.** Listen to and work with communities to understand specific barriers and needs, and co-create solutions, whilst being mindful of the differences that may exist between localities.
- **Recognise and understand that the definition of 'good access' to food may differ for different communities and take action to address this consideration throughout services.** Ensure emergency food providers and services are able to take into account what types of food are appropriate for different cultural backgrounds and intolerances allergies.
- **Support diversity of shops that increase access to fresh food.** Do this in a manner which will support communities to eat well and encourage a vibrant local food economy.

Priority theme: Choice and security

Everyone can make decisions about their relationship with food and are free from the anxiety and stress of food insecurity.

Priority theme: Choice and security

Eliminating food insecurity is not only a worthy goal but can also prevent a wide range of negative knock-on effects on a person's life, health, and wellbeing. Food insecurity creates anxiety and stress, an issue that was highlighted in the community conversations. While there are a wealth of organisations and schemes providing excellent services addressing food and financial insecurity in the city, many residents are unaware of the support available to them. At all stages it is important to recognise the key role that choice and empowerment can have on people's dignity, perception of and engagement with actions addressing food inequality..

As a city, we will:

- **Empower communities to have a platform to make change.** Take a co-designed approach to actions and accountability to address food equality, which helps ensure the right action is taken and encourages a joint sense of ownership. Use the recruitment of Food Equality Champions (people with relevant lived experience based in the communities of interest) as a framework for a positive example of how this might be done in a collaborative way.
- **Build resilience through prevention.** Take action to help shift the current needs away from a model of emergency food provision to one of prevention. This will help increase dignity and improve food security.
- **Use food as an opportunity to encourage access to other support and services.** Expand access to other support and preventative services that can affect broader positive changes in people's lives, including financial support and mental health services.
- **Increase choice and empowerment in food offers from services and projects that provide food support.** Food provision needs to be adaptive to communities to provide more appropriate choice that matches the need. Part of this requires recognising that additional choice is likely to require investment into and training for food support providers.
- **Reduce the risk of stigma in programmes that address food inequality.** We need to champion solutions that preserve dignity and don't create stigma and recognise the importance of how we create and deliver solutions in and with communities.
- **Maximise income for residents.** Working with welfare support organisations and the broader work in the city to counter poverty, maximise support for people to access unclaimed welfare benefits, and provide financial support and grants schemes, as well as other measures to support income and wages. This includes promoting the Real Living Wage as per the Real Living Wage Foundation.

Priority theme: Skills and facilities

People and communities are equipped with knowledge, skills and facilities.

Priority theme: Skills and resources

Provide the necessary tools to facilitate residents to foster a healthy food culture through increased confidence in their ability to not only access food, but also in having the appropriate knowledge, skills and facilities to be able to use the food that meets their needs. Often a person's ability to be able to prepare a meal is hampered by a lack of facilities at home and in the community, or a lack of knowledge and confidence with food. Education has been a key theme in both the community conversations and the stakeholder consultations, and this applies to all ages from early years through adulthood.

As a city, we will:

- **Address barriers posed by lack of facilities or equipment** which are preventing people in hardship from preparing and cooking food in the most affected areas of the city. This can be either at their own homes, or through local community resources.
- **Build and strengthen facilities and assets already in the community.** Focus on the strengths already in the system and building on them. In this way we can capitalise on the numerous resources already available across Bristol and encourage the development of best practice around the city. This can include community kitchens, growing projects, initiatives from the hospitality sector and more. Creating stronger links between them will create a more resilient network that will pass the test of time.
- **Take specific action to reduce food inequality for children and young people**, recognising the key opportunity that working with both children and young people can have in preventing many further issues for themselves, their families and their communities. Ensure interventions that impact this group receive appropriate consideration and prioritisation.
- **Develop and encourage food related topics and skills education in schools, colleges and early years settings**, embedding into existing community-based programs and initiatives across the city. This needs to include elements of the whole food system, from growing, to buying, to cooking. There is a need to invest in subsidising these projects these projects and initiatives to allow for greater access and skills development.
- **Expand food related education beyond school age**, to cover topics as needed (for example budgeting, growing courses, community cooking classes etc). We will need to adapt these opportunities for specific communities (for example the needs of disabled people may differ from those experiencing homelessness).

Priority theme: Sustainable local food system

A resilient and sustainable local food system.

Priority theme: Sustainable local food system

Resilience and sustainability are considered and prioritised at all stages of the local food system. Through this, we will achieve a positive impact on the environment at a local level, as well as develop resilience in the food system, and create and support careers for people working in the local food economy. Increased prevalence of small-scale farms and community growing have been demonstrated to have links to increased education, more resilient infrastructure and a stronger local economy. Access to growing spaces helps facilitate improved cooking knowledge and education, as well as providing valuable health and wellbeing benefits.

As a city, we will:

- **Work with our county neighbours to build a fair and equitable food system throughout the region.** We need to acknowledge that we cannot grow enough food within the city to feed Bristol. A resilient, local food system will need to be built through co-operation across local authority boundaries, mixing urban, peri-urban and rural food production that supports food justice. This would include growing diverse food, providing work opportunities and paying a fair price for produce.
- **Expand the food growing capacity within the city.** Importantly this must also consider equity in growing spaces across different areas of the city in response to need. Local and ethical growing space and produce needs to be accessible and equitable to people from all communities and backgrounds.
- **Champion food equality when considering land use within the city**, including equitable distribution geographically. This will include the need to review access to and management of allotments and smallholdings as part of the new *Parks and Green Spaces Strategy* and wider issues of city planning.
- **Champion inclusive procurement for public services in the city** which promote local producers and sustainable methods of production, building on the work already undertaken in this area.
- **Continue to reduce food waste**. Food waste occurs at multiple levels in our food system, from production and distribution to household food waste. Excessive waste has a direct impact on food inequality and also has unnecessary environmental impact. We need to minimise waste throughout all levels of this system, and ensure food equality is a key consideration at all stages of this approach. Find innovative ways of reducing and redistributing food surplus.
- **Support and continue to champion food equality in all work streams that allowed Bristol to become a Gold Sustainable Food city**. Ensure that the work of the Food Equality Strategy is constantly fed into and considered throughout the *Bristol Good Food 2030 Action Plan*. This will set out the wider strategic plans for the city's food system, and will bring together action plans on all aspects of the food system.

Priority theme: Food at the heart of decision-making

Food is at the heart of community, economy, and city planning.

Priority theme: Food at the heart of decision-making

We must put food at the heart of our decision-making and recognise that food is a cross-cutting issue. Addressing many of the factors that impact food equality requires close collaboration with multiple partners including the public sector, the private sector, grassroots organisations, and the voluntary and community sector. Food is at the very heart of the lives of individuals and communities, and therefore should be at the heart of decision making across the city. This includes, but is not limited to, working with city planning, transport, housing and licensing decisions, and involves taking opportunities to work across local authority areas to work across local authority areas to reduce food inequality.

As a city, we will:

- **Look at the big picture, and consider the interactions of food equality with the wider system.** When addressing food equality, recognise the integral overlap between food insecurity and the broader work to counter poverty in the city. This includes ensuring the work of the strategy aligns with other council policies to maximise impact. For example, the *Bristol One City Plan 2050*, the *Bristol Corporate Strategy 2018 – 2023*, the *One City Climate Strategy 2020*, *Thrive Bristol, the Parks and Green Spaces Strategy*, the *Fuel Poverty Action Plan*, and the *Bristol Good Food 2030* plan (currently in development).
- **Embed food equality outcomes in all relevant departments and work-streams across the City and the City Council.** The impacts on food equality outcomes should be a key consideration for all departments, and during all relevant decision making in the city. Continue this 'health in all policies' approach in development of the *Food Equality Action Plan*.
- **Use a One City Approach.** Work closely with the One City boards to ensure food equality is embedded into their six thematic boards: Children and Young People, Economy and Skills, Environment, Health and Wellbeing, Homes and Communities, and Transport. Use this Approach to promote and link the work of food equality to have a wide range of city partners.
- **Incentivise investment in the local food economy**, particularly in recognising the impact of COVID-19 on food systems and hospitality sector, and the broader economic impact of the pandemic. Recognise the huge value of volunteers in this sector, but set the culture of hiring from local communities and do not create reliance on voluntary solutions.
- **Work across local authority borders** to address the food inequality that exists within the current food system. Create innovative joint approaches to tackling food inequality with neighbouring local authorities, identifying opportunities to have a positive impact at a broader regional level.
- **Bristol will become a leading city in our approach to addressing food inequality**, and where appropriate be vocal on the national stage in matters where national policy or intervention will have a significant impact on food equality.

Cross-cutting strategic aims

The following strategic aims sit across all the priority themes and will need to be addressed in order to maximise the impact of the strategy through the action plan. Importantly, while this section outlines specific cross-cutting themes that impact each of the priority areas, the priority areas themselves should not be seen in isolation, and should be approached together.

As a city, we will:

- **Listen and respond to the needs of the communities.** Build working relationships with communities throughout the ten-year strategy timeline, actively seeking feedback and modifying our methods and actions for maximum impact. We need to be creative with how we engage with people and communities, so there are a variety of ways people can engage and get involved.
- **Commit to investing in solutions.** Creating fair access to food will require financial investment. We recognise that, currently, there are no funds attached to deliver this strategy, but if the city is making a serious commitment to achieving this aim, it must also be prepared to provide appropriate funding for solutions presented in the Food Equality Action Plan. We must be prepared to take advantage of opportunities presented by the National Food Strategy, and to encourage, facilitate and co-ordinate communities and organisations across the city to apply for available funding to enable positive action.
- **Create a system for monitoring food equality.** Currently data on food equality is available from many indirect and proxy sources. Understanding the impact it has on people's lives, in different areas of the city, or trends over time, can be difficult. To effectively evaluate the impact of the strategy and action plan a protocol for monitoring should be established. This will include a compilation of data from diverse sources, which takes into account data that is only available at a national and a regional level, but also more targeted data and qualitative data which can examine inequalities, trends and the lived experience of those living with food inequality within individual areas of the city. This should include focussed action for groups who are under-represented in our current data sources.
- **Develop an accessible communications strategy** with information on services available to support people experiencing food or financial hardship. This also includes improving communication to workers and volunteers working in food-equality related services. This will take into account accessibility requirements across a range of users, for example, non-technology users and different languages, as well as using a variety of media both through digital, print and physical institutions (e.g., schools and community groups). Provide better visibility and links to promote the work of the numerous schemes already providing support in the city, as well as any new schemes that arise.
- **Take a strong stance on food equality and food justice issues at a regional and national level** with the aim of influencing national policy that affects many of the determinants of food equality. We want Bristol to be seen as a pioneering city that is leading the fight for food justice.

Governance, oversight and delivery

- The strategy is to be embedded in the 'health and well-being' strand of the **One City Approach**.[36] This approach brings together a huge range of public, private, voluntary and third sector partners within Bristol. Through work across six major thematic boards, these partners work together with a shared aim to make Bristol a fair, healthy and sustainable city. Oversight for this strategy is provided by the Health and Wellbeing Board. The strategy and Action Plan will also be a part of the *Bristol Good Food 2030 Action Plan*, which is currently in development and will have oversight from the Environment Board.
- A **Steering Group** will be set up to oversee the implementation of the strategy, who will be report and be accountable to the Health and Wellbeing Board. This group will monitor progress, update the relevant boards, and be dynamic and flexible to achieve the aims of the strategy. This Steering Group will have a representative membership from key partners in

[36] www.bristolonecity.com/about-the-one-city-plan/

the public, private and VCSE sectors in the city, as well as representatives of the key communities and groups most affected by food inequality. Membership will also include 10 Food Equality Champions – people with relevant lived experience – to represent their communities.

- The **Stakeholder Group** with a wide representation of organisations across the city will continue to meet regularly. Keeping the engagement of this group through good communication and working to encourage wide representation from the whole system will be key to the success of achieving the aims of this strategy and the subsequent action plan.

Monitoring and evaluation

Monitoring and evaluation are key to understanding the impact and success of the strategy and action plan. Current data sources are not sufficient to adequately assess this in our city, therefore creating a system which will allow us to monitor this sufficiently is one of our key strategic aims. This may involve making better use of existing data sources, as well as potentially creating new methods of monitoring progress.

Sources of data that will help to inform the state of food equality in Bristol include the national measurement of food insecurity in the DWP *Family Resources Survey*; and local data sources, such as the *Bristol Quality of Life Survey*. Other proxy measures, such as Free School Meal eligibility, Healthy Start Voucher uptake and Universal Credit claims will continue to be used to estimate the impact of food inequality. Work to improve this data will overlap on broader work to counter poverty in the city, and good quality data on food equality may be able to provide significant useful insights to many other areas of work. We will commit to collaboration and ensure relevant data sharing where appropriate.

Establishing a framework for monitoring and evaluating the impacts on food inequality will be a core aim in the action plan, and we will endeavour to create a regular, reliable and representative method of visualising the state and impact of food equality work in our city. Importantly, a key method of monitoring will be continuing to have regular community conversations and seeking regular feedback from affected communities and vulnerable groups.

Risks

This is an ambitious strategy, and we must acknowledge there are risks to achieving the aims sets out in this document.

This strategy will require investment and currently there are no funds attached to achieve its stated aims. Funding will need to be secured through multiple sources, which may include the local authority, Public Health England, and Central Government in alliance with city-wide efforts. An innovative and collaborative approach to funding will be taken.

Achieving this strategy will also involve a significant shift in behaviour, both within organisations and as a society. We need to recognise that these changes will not happen overnight and achieving a sustained shift in our practices will require all people involved to be reflective, open and committed to food equality.

A full risk register will be developed and outlined in the *Food Equality Action Plan*.

[37] https://sdgs.un.org/goals

[38] www.bristolonecity.com/sdgs/

[39] House of lords (2020), Hungry for change: fixing the failures in food. Report of session 2019-2020

National and local policy context

This strategy sits alongside and complements a number of local, national and international policies and strategies to address food inequality. These have been considered in the development of this strategy, and this section highlights the main international and national policies that the aims in this strategy align to.

International – United Nations Sustainable Development Goals. The United Nations Sustainable Development Goals (SDGs) recognise the importance of food security under their goal number two: End Hunger. Specifically, by 2030 they set the aim to "end hunger, achieve food security and improved nutrition and promote sustainable agriculture".[37] Bristol is committed to delivering the SDGs locally, and conducted a voluntary local review to map progress against these goals in 2019.[38]

National Select Committee on Food, Poverty, Health and the Environment: Hungry for change: fixing the failures in food (July 2020). This report looks at the links between food, inequality, public health, and sustainability. It identifies where interventions can be applied, or reinforced, to tackle the serious health, social and environmental damage that is being inflicted by the current food system. This will ensure a healthy and sustainable diet that can be accessed by everyone.[39] It makes a series of recommendations to government that should be included in the government's white paper on the *National Food Strategy*.

National Food Strategy. Published in 2021,[40] this large independent review of the food system in England, covers all aspects of the food system, including food production, farming and trade policy, environmental impact and health impacts. It does not include specific consideration of food inequality, and especially contains little detail on food poverty. Despite this, the recommendations in this strategy would have several positive impacts on food equality in Bristol if they were adopted at a national level. This is especially true in being able to address some of the policy and corporate determinants of food inequality which would be impossible to meaningfully tackle independently at a local level. Initial reaction to this strategy across politics, the media, public institutions and private industry has contained a lot of positive support.[41] The government will produce their White Paper response to this strategy in 2022, at which point the impacts on the *Food Equality Strategy* for Bristol will be reviewed.

Local policy and strategy links

There are a number of strategies and policies in Bristol which are relevant to food equality. Below is a list of some of the key activities and documents. This strategy has been developed with these in mind, and efforts to join up, collaborate, and work alongside these workstreams will continue through the process of creation and delivery.

- **Bristol One City Plan 2050.** Food equality touches on multiple objectives, specifically:
  - By 2021 ensure Bristol is accredited as a gold standard in the *Sustainable Food City Awards* (already achieved) and establish a legacy programme.
  - By 2023 over 50 per cent of fast-food outlets in the city sell healthy alternatives in line with the *Bristol Eating Better Awards*.
  - By 2031 everyone has access to affordable fresh food within a 10-minute walk from their home.
  - By 2036 all schools will produce and grow food for their own use.
- **Bristol Corporate Strategy 2018 – 2023.** Under the section *Empowering and Caring*, give our children the best start in life, and under *Well-being*, tackle food and fuel poverty. This strategy is currently being updated.
- **Bristol City Council Business Plan 2020 – 2021: COVID-19 Recovery Edition.** Under *Key Commitment 1 – Healthy weight declaration* and *Key Commitment 3 – Tackle food and fuel poverty*. These include a commitment to increase the number of food outlets holding a *Bristol Eating Better Award* in priority wards.
- **Thrive Bristol** is a 10-year programme to improve the mental health and well-being of everyone in Bristol, it recognises the mental health impacts of food insecurity.
- **One City Climate Strategy.** Under *Delivery Theme 9: Food* – "Developing a resilient and low carbon food supply chain will contribute to the reduction of Bristol's carbon footprint whilst also improving security to the supply chain and boosting the local food economy. Positive change around Bristol's food culture also

[40] www.nationalfoodstrategy.org/

[41] www.foodmanufacture.co.uk/Article/2021/07/15/National-Food-Strategy-Part-2-reaction

provides an opportunity to engage with children and adults about health, well-being and nutrition as well as different cultures and diets" and "Sustainable and low carbon food options will be available to everyone, respectful of all dietary and cultural requirements, in all future climates."

- **Local Government Declaration on Healthy Weight** – adopted by Bristol City Council in 2020.
- **Recovering from COVID-19** – tackling poverty highlights the importance and overlap of fuel poverty and food poverty work.
- **Shaping Places for Healthier Lives** – £300K successful bid to address food insecurity across Bath, North Somerset and South Gloucestershire over the next three years.
- **The Bristol Eating Better Award** is a free award for food businesses that sell healthier food options and promote sustainability. Also available for schools and early years settings.
- **Mayoral priorities 2021 – 2024**, specifically under the commitment to, "Deliver our climate and ecological plans including £1 billion investment in clean energy, double the tree canopy, and grow sustainable food in every ward."

Extra pic needed here

Summary and next steps

This document presents a joint vision of how we can work to achieve food equality across the city of Bristol. It builds on the significant good work already achieved by the numerous organisations across the city. The priority themes and strategic aims needed to achieve this vision are outlined and have been developed with a large stakeholder input.

This Food Equality Strategy 2022 – 32 will feed into the broader work of the **Bristol Good Food 2030 Action Plan** and will ensure that equality is a key consideration in all decisions relating to food in the city.

A Food Equality Action Plan will be developed to bring together key stakeholders under each strategic area to set commitments for how we will achieve each desired goal, and priorities to address the greatest needs.

A **Food Equality Steering Group** will be set up to monitor and ensure progress against these areas and provide accountability through the **One City Approach** via the relevant boards, and through feedback to the wider stakeholder consultation group. A key measure of success and accountability will be the **ongoing engagement with the residents and communities** affected by food inequality, to ensure the actions taken are co-designed and meet their needs in an equitable manner. Through promotion of this strategy and ongoing collaborative work with partners across the city, we believe we can embed considerations of food equality across all decision making in our city. Following these steps will allow us **to achieve our ambitious aim to achieve food equality for all residents in the city of Bristol.**

Health Overview and Scrutiny Committee
14th March 2022

Work to improve Healthy Weight

Alasdair Wood | Public Health Registrar

Grace Davies | Principal Public Health specialist

Charly Williams | Principal Public Health specialist

Bonnie Dimond | Senior Public Health specialist

Sally Hogg| Consultant in Public Health

Work to improve healthy weight in Bristol

Outline of presentation

- Background of overweight and obesity in Bristol
- Description of a whole systems approach to healthy weight
- An example of three areas of work to address healthy weight in Bristol, and how these fit into a whole system approach
  - Whole systems work to address healthy weight in Children and young people
  - An ‘asset-based community development’ approach to targeted weight management support for Bristol
  - The Food Equality Action Plan

Background and context in Bristol

At a **population level**, increased population weight is associated with:

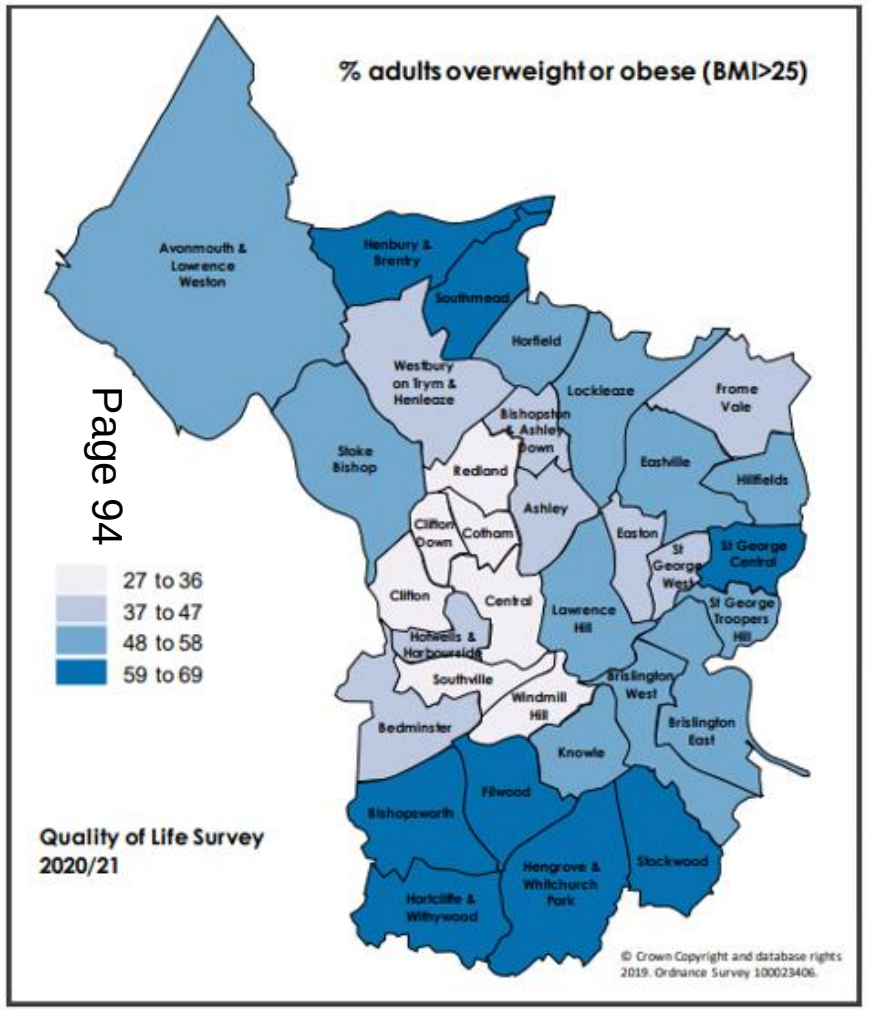
- Reduced life expectancy
- Cardiovascular disease
- Type-2 diabetes
- 12 type of cancer
- Mental health problems
- Worse health outcomes from COVID-19

At the **individual level**, increased weight may be associated with:

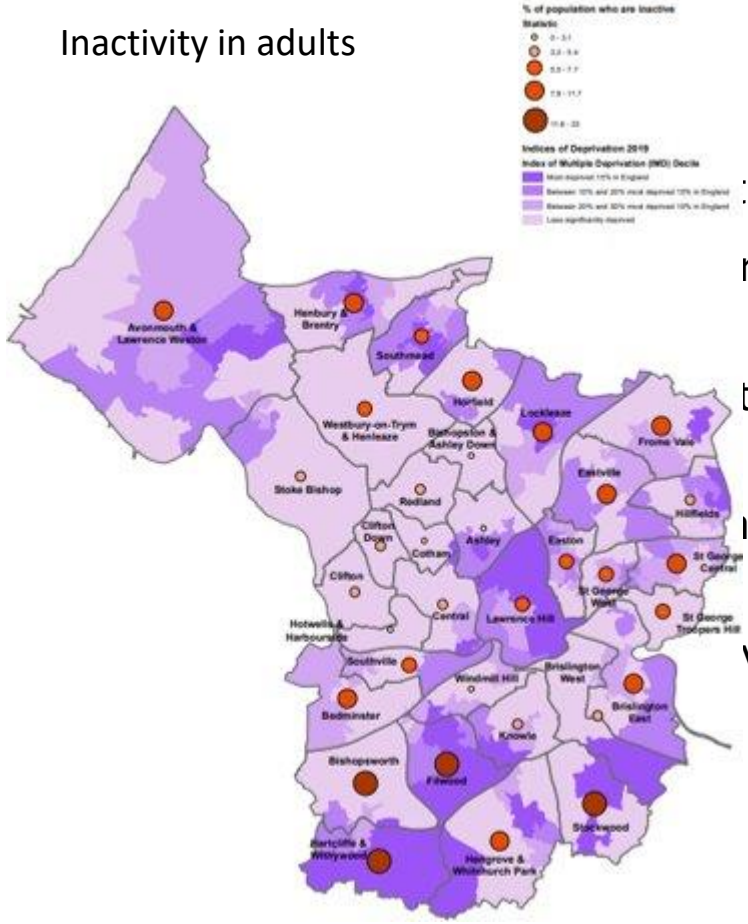
- Weight stigma
- BMI is an imperfect measure not always correlated to health
- Negative physical and mental health outcomes driven by the **stigma**

We need to focus at a population level without perpetuation or worsening stigma

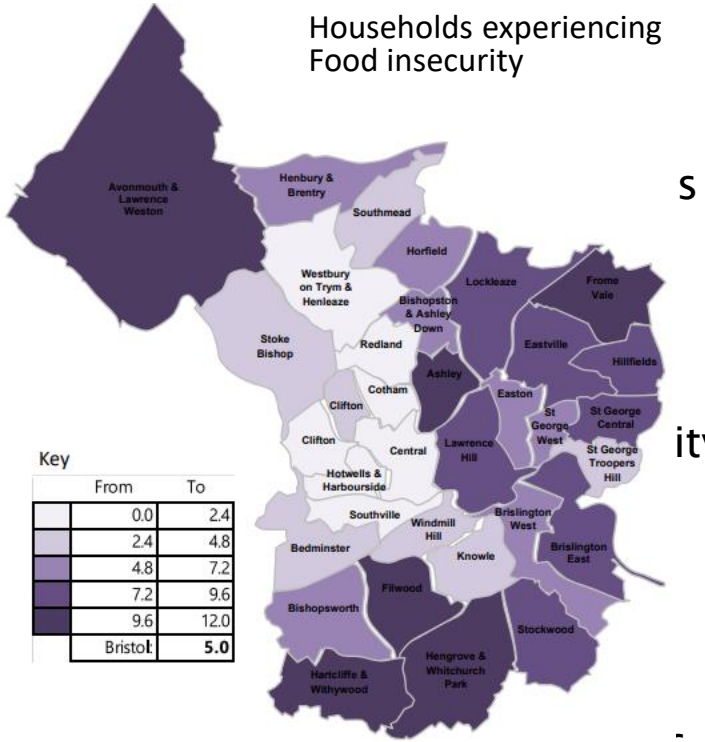
Background and context in Bristol



- **Over half of adults in Bristol are overweight or obese** (57.3%)
- This shows an **increase** compared to the two previous year's survey. (54.8%
- Inactivity in adults



- Households experiencing Food insecurity



- **Maternity** – women booking for maternity care with a BMI of 30 or more increased from 18.8% in 2013 to 20.2% in 2020

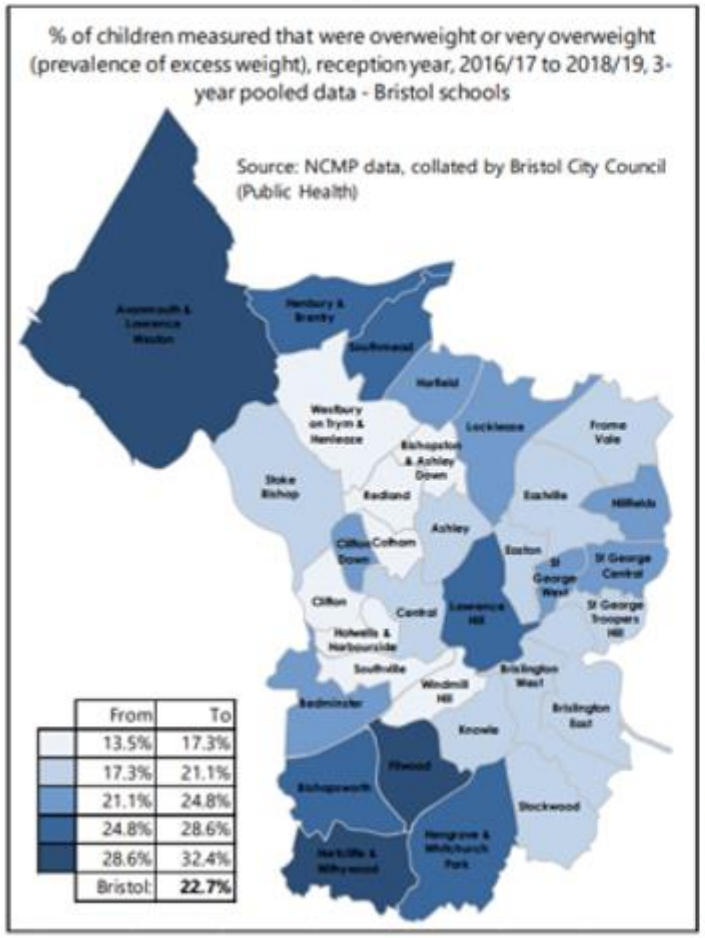
Background and context in Bristol

- The prevalence in Bristol is similar to the national average, but still shows inequalities:
- **Deprivation**
- **Ethnicity** – disparity seen especially in year 6 between white and Asian, Asian British, Black, Black British, and Mixed ethnicity pupils
- **Diet Quality** – only 28% of primary and 22% of secondary school students reported eating at least five portions of fruit or vegetables
- 11% primary and 9% secondary students reported having no fruit of vegetables at all the previous day.

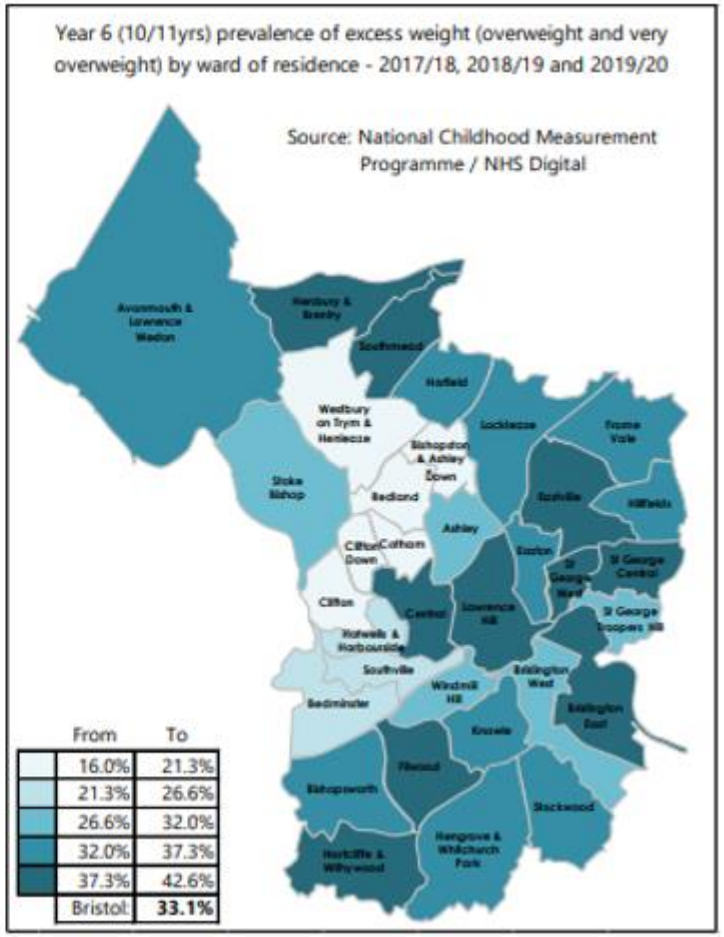
We expect a **worsening of trends** due to the **COVID-19 pandemic** but the data and review is ongoing

Note: Data for children is recorded in a different way than for adults (through the national childhood measuring programme)

Reception

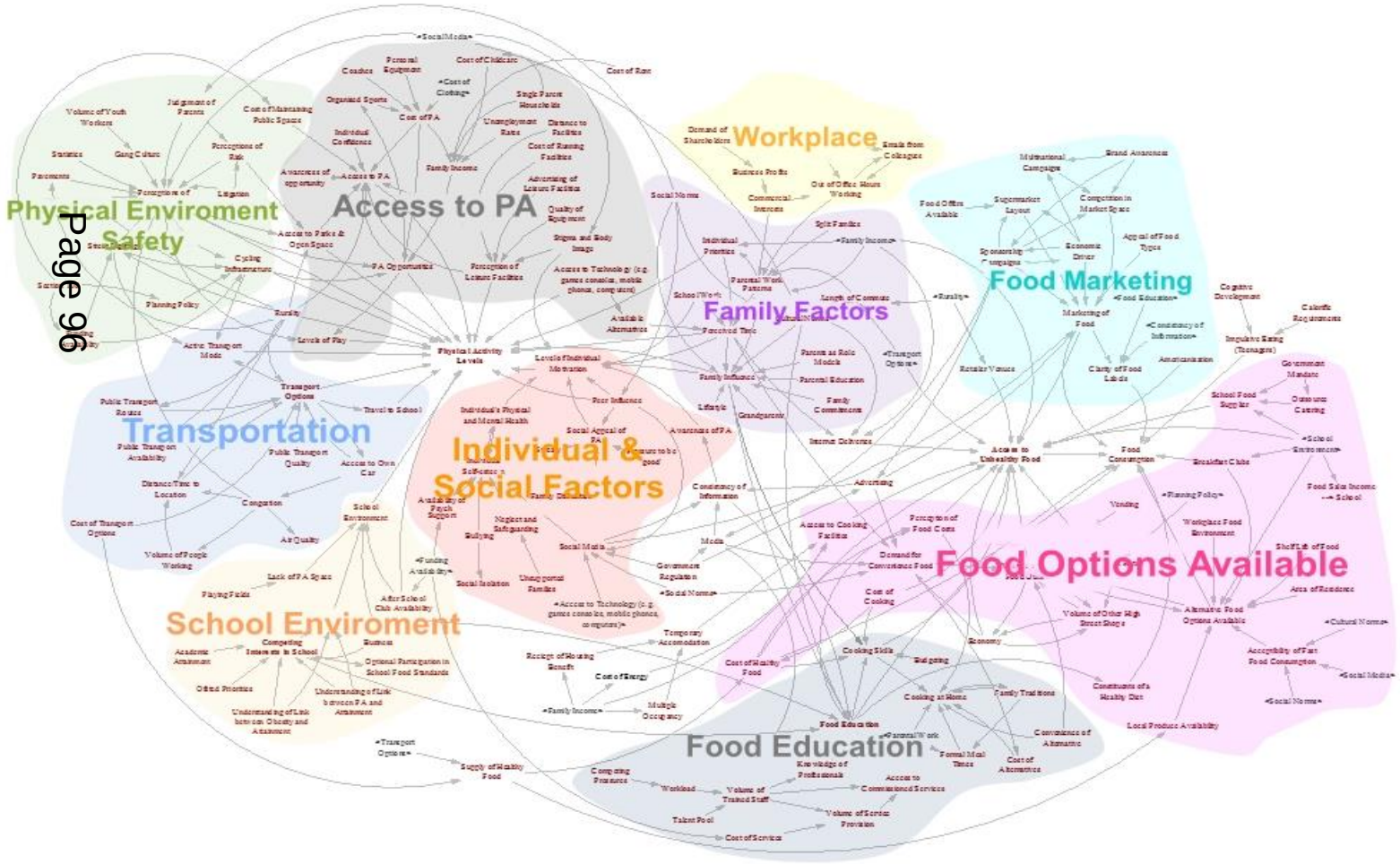


Year 6



How are we going to address this? A whole systems approach

- The causes of excess weight are complex and multifaceted!
- Evidence shows our solutions need to also be taken across the whole system in order to make lasting change

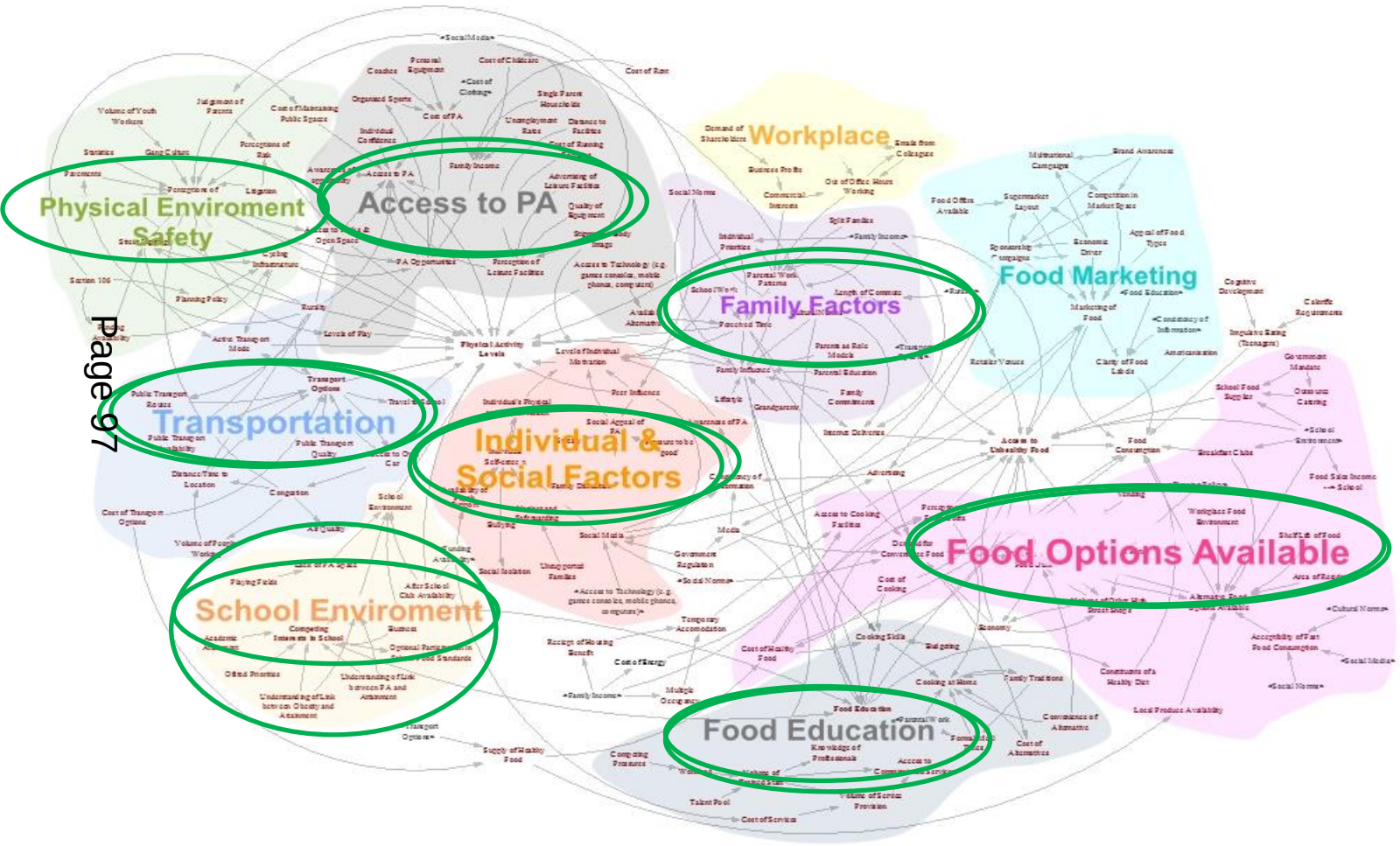


Common activity themes (OHID):

- Healthier **food environments**
- **Schools and childcare** settings
- Increasing **healthy food consumption**
- Creating **healthy workplaces**
- Increasing **active travel**
- Providing **weight management support**
- Promoting **local opportunities and community engagement**
- Educating on **healthy eating** and **physical activity**
- Creating an environment that **promotes physical activity**

System map of causes of excess weight. Source: Health matters: whole systems approach to obesity, Public Health England, 2019

Example One – whole systems work for children and young people

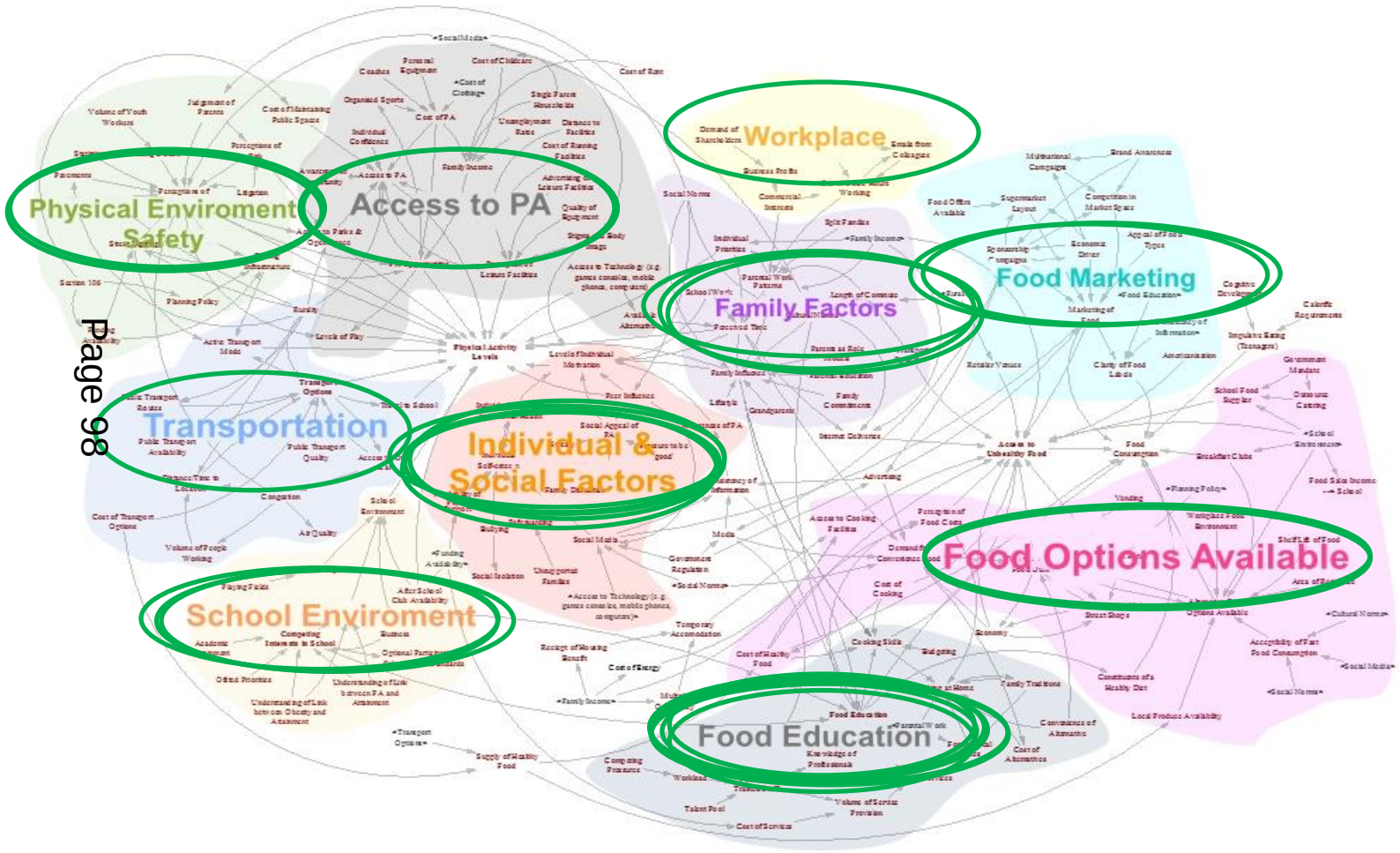


Examples of **Systems Leadership**

- The Bristol Belonging Strategy for Children and Young People
- The Food Equality Strategy
- The Sports and Physical Activity Strategy

System map of causes of excess weight. Source: Health matters: whole systems approach to obesity, Public Health England, 2019

Example One – whole systems work for children and young people

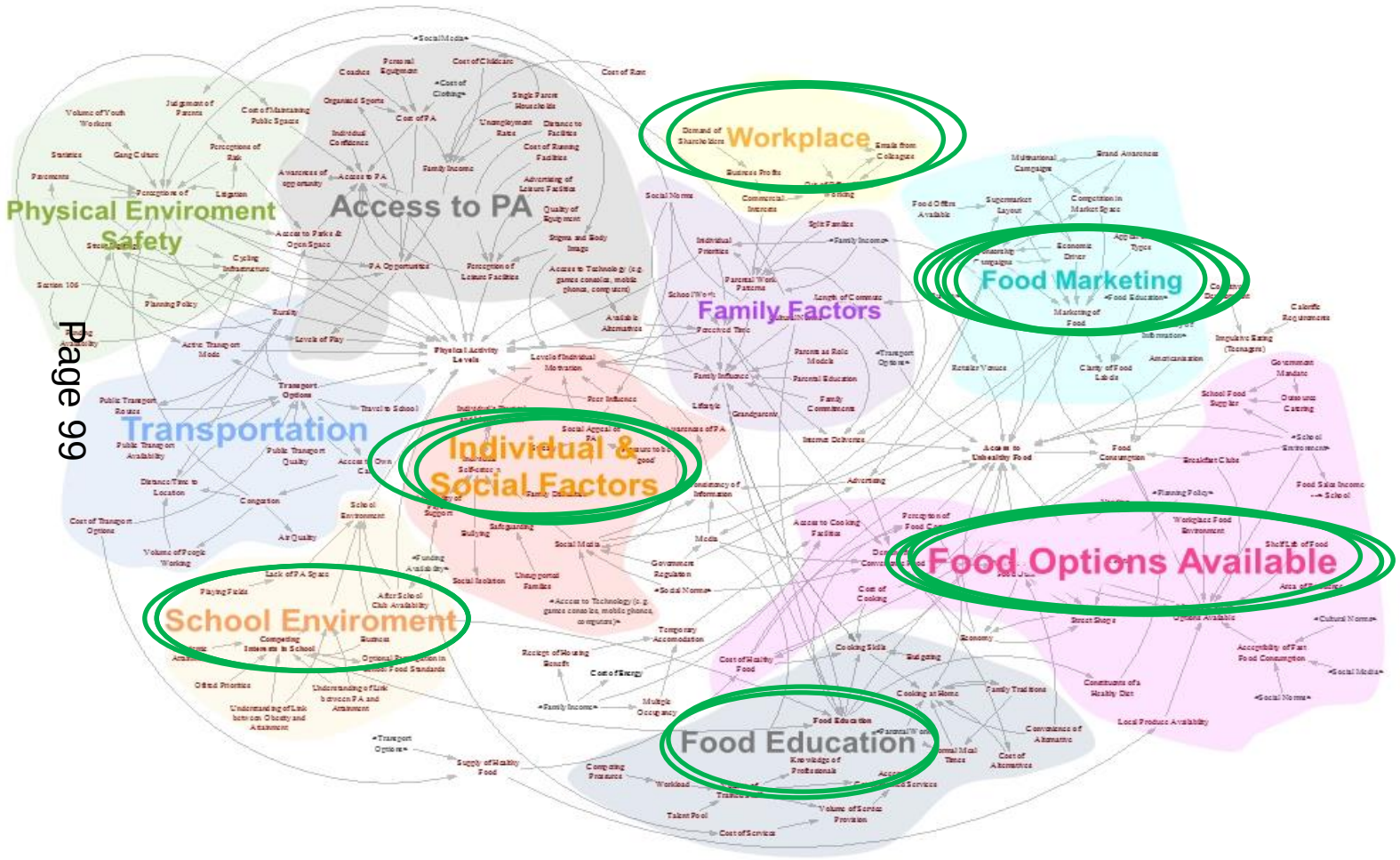


Examples of **Healthy Weight promoting** environments and settings

- Healthy weight conversations skills for midwives and health visitors
- ‘my pregnancy’ app
- Free swimming for pregnant women
- Healthy start vouchers and vitamins
- Promoting breastfeeding and breastfeeding support services
- UNICEF Baby Friendly gold accreditation
- ‘This Girl Can’ physical activity campaign
- School Health Nursing Service – Healthy Weight Extended Brief Interventions
- Bristol Healthy Schools programme
- ‘Eat Them to Defeat Them’ campaign
- Development of national curriculum

System map of causes of excess weight. Source: Health matters: whole systems approach to obesity, Public Health England, 2019

Example One – whole systems work for children and young people

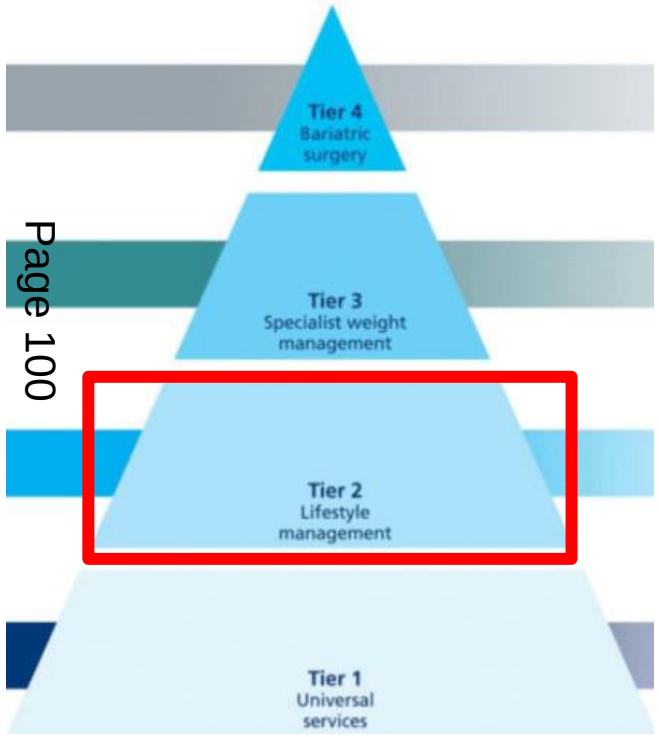


Examples of **Policies and commercial interventions**

- The 2021 advertising and sponsorship policy
- Bristol Eating Better Award – especially for schools and early year settings
- Ban on advertising of unhealthy foods within 400m of a school or educational setting
- Bristol City Council Good Food and catering policy 2018
- Restriction of hot food takeaway within 400m of a school or youth provision
- Bristol Breastfeeding Welcome scheme
- International code of marketing of breastmilk substitutes

System map of causes of excess weight. Source: Health matters: whole systems approach to obesity, Public Health England, 2019

Example two – Tier-2 Weight Management service



- Recently commissioned a pilot service for adult weight management in Bristol - provider **Beezee bodies**
- Taking an innovative approach with four aims:
  - Local engagement and co-production
  - Delivering a high-quality remote weight management
  - Long-term engagement with local people
  - Insight project
- Funding for this project is only for 1 year.
- Targeted in limited areas of the city: Ashley, Easton, Lawrence Hill, Filwood, Hartcliffe & Withywood
- Also focus on Black Caribbean, Black African, and South Asian populations

Example two – Tier-2 Weight Management service

beezee bodies

"I like to listen to people I can relate to someone I know from my community who is regarded as such. Someone who can explain this to me in a simple way or in a language I clearly understand."

"The lack of motivation to prepare home made food means I spend so much money on fast foods which ultimately causes me to gain weight"

Example two – Tier-2 Weight Management

- OHID (formally Public Health England) are now planning to extend funding **for up to 3 years** – but not confirmed yet!
- Our aim if budget allows is:
  - to commission a targeted service for the whole city,
  - A focus on addressing inequality
  - using the same co-produced approach,
  - using the insights gained from the pilot,
  - Expanded to include all ages for example by including a family approach
  - Also expand to include maternity
- Caveat on the amount of money and the stipulations of the grant, dependent on grants made available by Gov, NHS, and other sources
- Due to be presented to **cabinet in April** based on our estimated funding available from these grants.

Example three: One City Food Equality Action Plan

- We know that the food system in Bristol is not equal.
- A **One City Food equality strategy** has been developed in partnership with Feeding Bristol
- Strategy Aim: *To strive for food equality for all residents in the city of Bristol within ten years.*
- Sets out goals to address **food poverty**, whilst also addressing **unequal access** to nutritious food in some areas of the city, the local **food economy**, **skills and education** relating to food, and **environmental sustainability** of our food systems.
- Signed off by the Health and Wellbeing board in February
- Next step is going to be in developing an **action plan** using this strategy as a framework
- **Comms plan** including a 'launch' potentially linking with a food justice event in city hall
- Embedded in the One City approach
- Currently setting up steering groups including 10 **food equality champions** (people with lived experience) to oversee it's development and delivery

FEEDING BRISTOL

BRISTOL CITY COUNCIL

Summary and possible discussion points

- Whole systems healthy weight is everybody's business
- Requires a long-term joined up approach, and changes throughout the system
- The example work presented today contributes to a whole systems approach.

Possible discussion points:

- How can this fit with the work of HOSC, and how HOSC can input further?
- How do we support communities to meet their needs? How do you think this fits with the needs of your constituents across the whole system and for the specific example projects?
- How can HOSC help us achieve this approach together, to leverage the council system and city systems to enable change?

Health Scrutiny Committee
(Sub-committee of the People Scrutiny Commission)
14 March 2022

Report of: Peter Tilley, Deputy Director of Finance, Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)

Title: **AWP Patient reconfiguration**

Ward: All

For Information

Key points:

Briefing note for Bristol City Council HOSC on AWP Patient reconfiguration.

Business case attached (Appendix 1).

Briefing note for Bristol City Council HOSC

AWP Patient reconfiguration

Healthier Together STP (specifically AWP) were awarded £7.5m of capital as part of the STP Wave 3 Capital award in March 2018 to support the relocation of Oakwood adult acute inpatient ward and Mason Place of Safety from their current location on the Southmead Hospital site to Callington Road Hospital in Bristol, pending completion of a full business case.

A full Business Case has now been prepared.

Bristol City Council HOSC is asked to support the submission of the full business case to the Department of Health and Social Care to enable the capital funding to be released and approve that this case does not meet the criteria for a significant service change.

Background

The capital investment would enable core inpatient services (specifically Oakwood adult acute ward and Mason Place of Safety) to be co-located onto the Callington Road site, maintaining overall adult acute bed numbers whilst bringing ward sizes into line with national recommendations, whilst ensuring that treatment is being provided in modern therapeutic environments in line with the latest regulations for mental health inpatient care.

This proposed reconfiguration will remove isolated units and facilitate greater site-based working, enabling an enhanced skill mix of staff to be shared across all units on the Callington Road site, whilst also improving the utilisation of space on site (facilitating improved value for money).

It will also avoid a significant capital requirement (which is currently unidentified) needing to be invested in the existing AWP Southmead estate to mitigate maintenance and patient safety / environmental risks which are escalating year on year.

The completion of the full business case was initially delayed whilst exact requirements around design, build and contracting arrangements were clarified and then worked up – progression of the case was also delayed for a time due to the COVID-19 pandemic as the focus of the Trust switched to ensuring that core services were safely maintained during the pandemic.

The case has now reached a stage where the fundamental requirements from NHS England / Improvement have been satisfied and the latest draft can be shared and discussed with key stakeholders in order to seek support.

Issues surrounding the current location at Southmead Hospital are outlined in Appendix 1. Further information on public engagement, an Equality Impact Assessment, an Options Framework and the Financials are also available.

Appendix 1

The Trust-owned estate at Southmead does not provide well for modern mental health service requirements. The wards are somewhat isolated in their functionalities, leading to poor optimisation of staffing at times. The layout of most wards is poor, with a number of safety issues on the risk register that are difficult to mitigate, and there is a maintenance backlog of circa £3.3 million

The adult inpatient unit at Southmead has many aspects which limit good service delivery. Oakwood Ward has a cramped communal space, very little therapy space, poor observation lines including corridor tee junctions and dog-legs, small sloping gardens with many risks, close adjacent residential houses. A number of safety issues in the ward and gardens mean that high staffing is often required to maintain observation levels. Due to high bed numbers and poor visibility arrangements, interactions with clients are too often focussed around de-escalating issues that have progressed too far before being observed. It is too often necessary to place clients on overt close observation, when a more relaxed slightly distanced observation style would be preferred. The ward is noisy acoustically, and does not feel therapeutic or relaxed.

Oakwood Ward and Lime Ward at Callington Road have 23 beds, which exceeds the recommended ward size for providing safe and effective care. Oakwood is the only acute ward on the AWP Southmead site, with other wards being specialised services. Therefore, staff cross-over is limited, and Oakwood is somewhat stand-alone for staffing resilience.

For two years, a step-down inpatient facility at Larch Unit was able to play a part in reducing delayed transfers of care. However, the service had several limitations. At only 10 beds, it is not optimal in size for staffing ratios, and this is made worse by operating from a building with 2 floors that has very poor layout for observations as it was designed for a lower risk rehabilitation service model. It has been difficult to identify clients suitable for this type of facility that could not in any case be discharged home with suitable care arrangements in the community, which also impacts upon overall occupancy levels.

To address these shortcomings it is proposed to relocate Oakwood to Callington Road site, by creating a new ward in space that was previously office and meeting space. This will enable Oakwood and Lime to be reduced to 19 beds, and also enable the 10 step-down beds to be accommodated as adult acute inpatient beds.

The reconfigured service will be considerably more effective in treating patients, with a more relaxed management style, few “pressure points” in the communal spaces, less opportunity or temptation to engage in negative behaviours such as climbing, self-harm, or aggression. This will resolve the service quality and high-risk issues that currently exist and allow a high standard of care that is much more effective and delivered through an optimal staffing provision.

Mason Place of Safety has a number of environmental safety and robustness issues and inadequate spatial design of some areas. It relocated to Southmead from Callington Road approximately 5 years ago when it became necessary to increase the size of the unit, and space could not easily be made available at Callington Road. It is a small unit not directly adjacent to other Acute wards, which reduces availability of staff when rapid response to incidents is needed.

Mason PoS was designed at a time when PoS services were holding clients up to 72 hours, so included full bedroom facilities, and is configured in a way which does not fully support the current service approach.

The current expectation of assessing clients within a maximum of 24 hours requires a more flexible approach to use of space, improved assessment areas, and revised design to achieve most effective flow of care and use of staff. Due to increases in acuity over recent years, there needs to be improved observation arrangements. The inclusion of a Mental Health Place of Safety close to the Emergency Department of an Acute Hospital also sometimes causes issues with clients presenting un-necessarily at one or other location.

To address these issues the unit will relocate back to Callington Road and be placed immediately adjacent to an Adult Acute ward (Lime Ward) so that staff can be shared between units if required. There will be access between the two units and a common alarm system so that urgent response can be provided to incidents. By relocating to the previous location of Callington Road it is expected that there will be fewer cases with primarily mental health need presenting at Southmead Emergency Department, and there will be fewer cases with primarily physical recovery needs presenting at the Place of Safety. This will be better for clients, and contribute to more efficient Emergency Department and mental health services.

Relocating these services will support staff resilience through the removal of standalone services and through the reconfiguration of ward bed numbers make the environments a more attractive place for staff to work (particularly from a medical perspective). It will also remove significant environmental risks associated with poor general building condition and specific quality and safety risks for patients linked to potential ligature points, low roof lines and garden safety

The proposed reconfiguration will ultimately deliver the same number of beds as are currently available across the two sites, but will increase the number of adult acute beds available (through the repurposing of Larch Ward on the Callington Road site) and bring ward bed numbers back in line with the nationally recommended levels – see table below:

Location	Currently commissioned beds	Proposed commissioned beds at programme end
Oakwood	23	19
Silver Birch	19	19
Lime	23	18
Larch	10	0
New Ward (Woodside)	-	19
Total	**74**	**74**

It is planned that this revised configuration will support a reduced length of stay for patients through an improved therapeutic environment and thus support increased patient throughput. This reduced length of stay will enable more patients to be treated within AWP hosted beds and contribute towards an overall reduction in the use of out of area inpatient beds when demand exceeds available supply. These beds can often be out of region, displacing patients from their local area at a time of acute crisis.

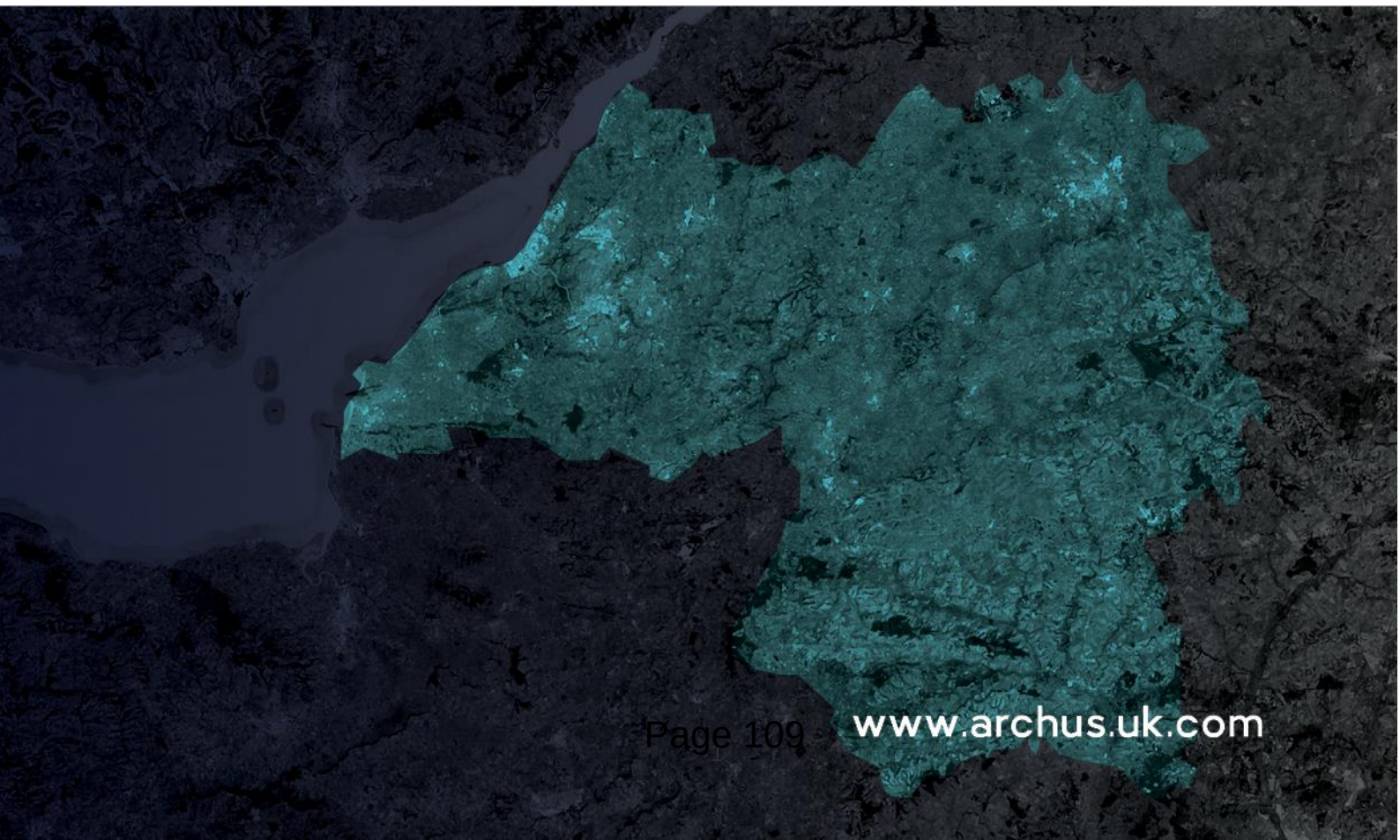
More detail on the expected Patient Experience and Workforce benefits is outlined in the business case.

NHS
Avon and Wiltshire
Mental Health Partnership
NHS Trust

ARCHUS
ADVISORY • INVESTMENT • DEVELOPMENT

Full Business Case
for Mental Health Inpatient Services Reconfiguration for Bristol, North Somerset and South Gloucestershire

DRAFT 2.4.1 February 2022



www.archus.uk.com

TITLE OF SCHEME	Mental Health Inpatient Services Reconfiguration in Bristol, North Somerset and South Gloucestershire	
	Improvement Scheme	
	Reference	
	Organisation issuing the reference number.	NHS England and NHS Improvement South West Region

SPONSORING NHS ORGANISATION(S) (or other such as GP)	Lead Sponsor	NHS Bristol, North Somerset & South Gloucestershire Clinical Commissioning Group

LEAD SPONSOR CONTACT DETAILS		
LEAD OFFICER FOR THE SCHEME	Title	Director of Finance
	Name	Simon Truelove
	Organisation	Avon and Wiltshire Mental Health Partnership NHS Trust
	Office tel.	01225 258281
	Mobile tel.	
	e-mail	simon.truelove@nhs.net
LEAD FINANCE OFFICER FOR THE SCHEME	Title	Head of Financial Accounting, Treasury Management & Finance Systems
	Name	Jayne Williams
	Organisation	Avon and Wiltshire Mental Health Partnership NHS Trust
	Office tel.	01225 258288
	Mobile tel.	
	e-mail	jaynewilliams4@nhs.net
LEAD COMMISSIONER	Title	Director of Commissioning
	Name	Lisa Manson
	Organisation	Bristol, North Somerset and South Gloucestershire CCG
	Office tel.	
	Mobile tel.	
	e-mail	lisa.manson@nhs.net

PROPOSED SOURCE OF CAPITAL Sources of funding to be accessed		BNSSG STP Wave 3 PDC, BNSSG System Capital and AWP Trust Capital					
	CAPITAL/NR REVENUE VALUE AND PROPOSED CASH FLOW OF FUNDING:						
PERIOD FUNDING SOURCE	2020/21 £'000	Current year 2021/22 £'000	2022/23 £'000	2023/24 £'000	2024/25 £'000	2025/26 £'000	Total £'000
Wave 3 PDC	600	677	1,102	2,465	1,977	679	7,500
AWP Trust Capital	0	0	110	610	1,110	1,115	2,945
Total	600	677	1,212	3,075	3,087	1,794	10,445

Contents

Schedule of Tables

Schedule of Figures

Document control

Document Title	Full Business Case for Mental Health Transformation, for Bristol, North Somerset and South Gloucestershire Area
Prepared by	Jayne Williams
Date	February 2022
Checked by	Pete Tilley
Date	February 2022

Version control

Version	Date	Description of change/s	by
0.1	March 2020	Complete review of existing draft and action plan for completion	N Witchalls, J Rowland P May, J Williams
0.2	Apr/May 2020	Sections issued for updating/ongoing updates	Nigel Witchalls
0.3	Jun 2020	Ongoing section updates	N Witchalls, J Rowland, P May
0.4	21/07/20	Issued to AWP peers for review/comment	Nigel Witchalls
0.4	27/07/20	Clinical and Financial Case issued to CCG for review/comment	Nigel Witchalls, Paula May, Pete Tilley, Jayne Williams
0.5	29/07/20	Archus peer review comments added	Ellie Clark
0.6	30/07/20	Review formatting	Kath Leeder
0.7	31/07/20	Final amendments and formatting	Nigel Witchalls, Ellie Clark, Kath Leeder
0.8	04/08/20	Final internal Trust review	Pete Tilley, Jayne Williams
1.0	04/08/20	Issue for Exec Review and governance approval by NHSE/I Regional Team	Nigel Witchalls
2.0	18/10/21	Amendments following NHSE/I feedback and full design and tender process	Pete Tilley, Jayne Williams, Nigel Witchalls
2.1	20/10/21	Submission to NHSE/I for informal review	Jayne Williams
2.2	21/20/21	Submission to BNSSG CCG for review / commissioner approval	Simon Truelove
2.3	28/10/21	Minor amendments following an initial review by the regional capital team	Pete Tilley
2.4	22/12/21	Format review before submission to South Glos HOSC	Pete Tilley

2.4.1	17/02/22	Format review / update ahead of submission to BNSSG SFC / Governing Body	Pete Tilley

1 Executive Summary

1.1 Introduction

The Healthier Together STP submitted a Wave 3 Capital bid to NHS England in May 2017 for additional capital of £7.5 million to support the aim of consolidating inpatient services in the Bristol area on to a single site at Callington Road. A further submission was made in September 2017 where the bid remained unchanged but an initial value for money (VFM) assessment was included. The STP was notified in March 2018 that this bid had been successful (project reference STP39.1d) and subject to submission of an FBC and final VFM assessment, NHS England would fund the associated developments.

This FBC has been developed to support the co-location of all core inpatient services in Bristol on to one site at Callington Road Hospital. The funding is to be made available by way of a NHS STP Wave 3 PDC grant to BNSSG of £7.5 million, together with a sum of £3.0 million, that will be provided through a combination of the AWP NHS Trust internal capital programme and BNSSG system capital, making a total of £10.5 million.

The recurrent revenue benefits associated with this scheme have been assessed at £1.0 million per annum.

This project is aligned with both the STP vision and Trust / CCG's strategies for mental health as a response to the Five Year Forward View for Mental Health and NHS Long Term Plan requirements, as well as its overall approach to the integration of health and social care along with the introduction of Integrated Care Systems (ICSs) and the Community Mental Health Framework (CMHF). The investment will ensure sustainable provision of mental health inpatient services for service users in the Bristol area.

1.2 Strategic Case

1.2.1 The Strategic Context

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is one of the main providers of mental health services in the South West region and has a catchment population of 1.8m. The AWP footprint covers the area of two STPs, and their associated Clinical Commissioning Groups (CCGs): Bristol, North Somerset and South Gloucestershire CCG, and BaNES, Swindon and Wiltshire CCG. These CCGs form two STP footprints: Healthier Together (BNSSG) and BSW (Bristol, Swindon and Wiltshire). These STP's are now forming Integrated Care Systems with other health stakeholders in the area. AWP also provides Specialised mental health services across a regional geography. These services are commissioned by NHS England Specialised Commissioning, NHS England Direct Commissioning and the South West Provider Collaborative.

The Five Year Forward View for Mental Health (2016) and NHS Long Term Plan (2019) set out clear expectations for NHS mental health services over coming years which can be summarised as:

- Increased community-based provision of services
- Reduced reliance on inpatient care, especially out-of-area placements
- More extensive use of technological solutions for delivery of care.

Delivering system change against the current financial situation is a challenge. Prior to the Covid-19 pandemic, the Trust had submitted plans outlining a forecast annual deficit of approximately £9 million over the upcoming

three year period, and very limited annual capital spending limit (CDEL). There are no easy ways to make inroads to improving this situation whilst ensuring that quality and effectiveness are maintained.

In addition to this, the Trust-owned estate at Southmead does not provide well for modern mental health service requirements. The wards are somewhat isolated in their functionalities, leading to poor optimisation of staffing at times. The layout of most wards is poor, with a number of safety issues on the risk register that are difficult to mitigate, and there is a maintenance backlog of circa £3.3 million.

The STP/ICS has agreed that mental health service estate transformation is a priority. This document comprises the Full Business Case (FBC) for the investment required by AWP to progress strategic developments in the Healthier Together STP/ICS. The programme will enable further rationalisation of the Southmead site and re-provision of core Mental Health services in centres of excellence across the region.

1.3 Clinical Quality Case

The Healthier Together STP/ICS aims to deliver the aims of the Long Term Plan and Five Year Forward View through a more integrated approach to physical and mental health care, particularly in community services, underpinned by technological solutions for effective service delivery. AWP is an active member of the BNSSG STP Mental Health and Learning Disabilities Steering Group and Mental Health Programme delivery team and coordinates regularly with local system groups in delivering services to the BNSSG population. The objectives of this Reconfiguration of Mental Health Services programme are to:

- Deliver specialist care in the community;
- Support prevention, early intervention and self-care;
- Create more efficient use of digital solutions and joint estate options at scale;
- Reduce levels of use of hospital beds through a variety of mechanisms;
- Ensure the Trust makes full and effective use of all its available resources, including staff and PFI estate.

Demand and capacity modelling has been undertaken to assess future needs and ensure the programme can meet these. The modelling forecasts the following general trends.

- Population in the region will grow by between 9%-17% depending on demographic group.
- Ward occupancy has been consistently high, above 85%, with a slightly increasing length of stay.
- If current services remain unchanged there would therefore be a notable shortfall in beds available to address demand in 5-10 years time.

It is clearly essential that the effectiveness of the mental health care system must change if the potential capacity requirements are to be contained within the likely available funding flows. To provide care sustainably we need to ensure that:

- The inpatient care and treatment model is of high quality, effective, and enabled by the staffing model and environment.
- Staffing provision is resilient in terms of scale and skill mix, and staff are clearly valued and supported.
- The care environment facilitates effective and safe treatment.

A number of options have been considered as to how to achieve the level of change needed in a sustainable way. The options are considered in the Economic case and conclude that by far the strongest option is to relocate the wards currently situated at Southmead to Callington Road Hospital. This can be achieved by reconfiguring current outpatient and office space at Callington Road, and by restructuring older adult ward services. It is proposed that these services are reconfigured as follows.

- Oakwood adult acute ward at Southmead will relocate to Woodside, Callington Road.
- Mason Place of Safety at Southmead will relocate back to Callington Road (where it was previously situated) adjacent to Lime adult acute ward.
- Oakwood and Lime wards will be configured to have 19 beds instead of the 23 each currently have. The remaining 8 beds will form part of a new ward.
- Larch adult step-down/delayed transfer of care facility will be re-designated as adult acute beds, and together with the 8 beds released by Oakwood and Lime will be formed into a new 18 bed adult acute ward.
- Older adult services will continue to develop enhanced community care service delivery. This has already enabled the closure of Laurel ward (18 beds) through other programmes of work, with inpatient Functional and Dementia care provided from Aspen Ward on Callington Road together with Cove and Dune ward at Weston-Super-Mare. These changes would be made permanent.
- The Eating Disorders unit has been moved to the Blackberry Hill site during the pandemic due to a range of safety risks at Southmead. The option for this service to remain on the Blackberry Hill site remains open moving forward.

These changes will allow the services to operate with effective staffing models from high quality buildings, purpose-designed to meet current environmental standards.

1.4 Economic Case

Following an extensive options appraisal, using the approved HM Treasury Green Book approach of an options framework, the preferred way forward is set out below.

Option 4 - Intermediate Option 2 'preferred way forward'; Reconfiguration of services in alternative estate with significant improvements. This option will co-locate all core inpatient services in Bristol on to the Callington Road site by reconfiguring the PFI accommodation, which is currently inadequately used for high value services, including improvements to support new clinical quality and care drivers. Works will be phased over 4 years and carried out by our PFI partner.

The main advantages associated with this option are that this will enable reconfiguration of wards in size, type, and environmental quality. These changes enable the Trust to increase effectiveness in delivery of inpatient services and improve the patient journey and outcomes. There will also be formal confirmation of a revised structure for older adult services in parallel with improvement of services in the community which reduces the need for inpatient stays and the number of beds required. The programme could also facilitate future land reutilisation for other health service delivery within the STP/ICS footprint on the Southmead site. This

possibility is currently being reviewed by both AWP and North Bristol NHS Trust to ensure the most appropriate solution is obtained for the BNSSG system and that adequate capital funding for any development is in place. It is worth stating that these potential developments can only be facilitated if the programme of works described in this case are fulfilled.

The main economic disadvantage would be the relatively small anticipated increase in unitary charge costs of the PFI contract and associated contractual commitment. This would, however, deliver increased space utilisation efficiency at the Callington Road site, which will then be focussed on clinical inpatient service delivery with reduced low-value administration and office space.

This option was identified as the preferred way forward, as it would meet all of the benefits criteria and enable the Trust to respond to the challenges set out in the Mental Health Five Year Forward View and the BNSSG STP Mental Health Strategy.

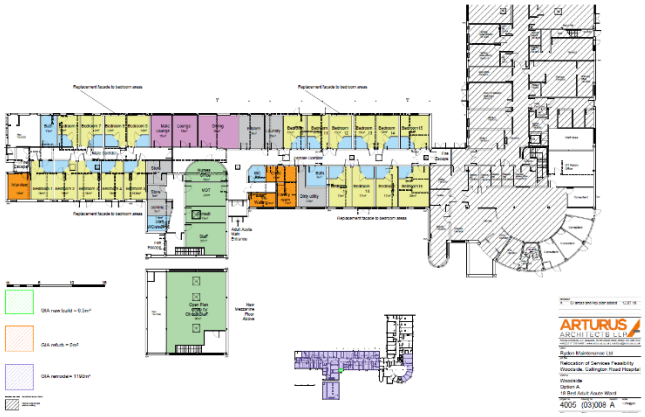
1.5 Commercial case

The commercial considerations arising from this business case are not extensive. The Trust already has a long-term commitment to its PFI estate, and this programme invests in this estate to maximise its use for high value clinical services. Mental health facilities do not offer strong opportunities for retail, and the Callington Road site already has the benefit of an adjacent Tesco. The site land is well-used, and this proposal seeks to maximise occupancy, so there is little opportunity to offer space to others.

The contractual arrangements for delivering the programme of work also have little negotiability. The PFI contract for Callington Road Hospital sets out the variation mechanism, and the Trust has been working together with ProjectCo to develop the design and implementation programme. The proposed developments are shown in Figure 1 overleaf.

The proposed arrangement has some potential for risk transfer, as it converts some existing PFI office and outpatient space to inpatient units. However, these types of inpatient services are already provided at Callington Road and are covered in the PFI contract, so the changes have relatively little risk impact other than normal variation costings that the Trust and ProjectCo are familiar with.

Figure 1 – Proposed Developments at Callington Road



Woodside: new Oakwood ward

Mason Place of Safety and Lime Ward

1.6 Financial case

As part of the assessment of this case, the Trust has considered in full the costs associated with options 1, 2 and 4. Initial capital and revenue modelling has been completed for these options with the Value for Money (VfM) modelling undertaken where recurrent saving opportunities have been identified.

Option 1 "do nothing" is discounted through the options appraisal process due to service compliance and safety reasons. Never-the-less it has to form the baseline for the financial assessment and for the calculation of VFM and payback of option 4, as option 2 would require significant capital resources which are at this stage unidentified. Therefore, the Financial Case considers the Do Nothing option against the Preferred option.

In order to progress with the co-location of services onto the Callington Road site (option 4), the Trust has worked with its PFI provider in order to calculate the fully designed and tendered cost of the necessary

construction works, fees and equipment. The total capital requirement over the six year period will be £10.5 million. The programme will require £7.5 million to be drawn down in the form of STP Wave 3 Public Dividend Capital (this business case) and the balance of £3.0 million will be funded by £2.5 million of BNSSG System Capital and £0.5 million from the Trust capital programme, giving a total of £10.5 million.

Full capital, revenue and Value for Money (VfM) modelling have been completed. This indicates that the recurring system (BNSSG STP) revenue benefit will be £1.0 million from 2026/27.

Following the approval of this FBC, the Trust will allocate £0.5 million of the AWP internal Capital programme to this project. It will also continue to work with BNSSG system partners with regards to potential land and building transfers, as well as other national funding opportunities that may arise, in order to fund the remaining £2.5 million. If neither of these options are deemed suitable, emergency cash funding may be requested to fund the System Capital envelope allocation as there are no prior year cash surpluses available to fund this.

1.7 Management case

1.7.1 Project Management

The project will be managed up to FBC submission by BNSSG: AWP in accordance with PRINCE 2 methodology. The Programme Board has the responsibility to drive forward and deliver the outcomes and benefits of this development.

Members will provide resource and specific commitments to support the project manager to deliver the outline deliverables.

1.7.2 Project key milestones

The delivery of this project will be managed via various phases to ensure that the appropriate services are relocated at the right time. The detailed phasing programme can be found in Appendix A with the key milestones set out in the table below.

Milestone	Completion
FBC submission & approval from NHSE/I	Mar 22
Pre-Construction Process Complete	May 22
Contractor Appointed (PFI)	May 22
Construction Commenced	Jun 22
Phase 1 – Reconfiguration of Larch as therapies hub	Nov 22
Phase 2 – Reconfiguration of Woodside South to create an inpatient unit	May 24
Phase 3a – Reconfiguration of Lime to create a Place of Safety	Feb 25
Phase 3b – Reconfiguration of Silver Birch to create an Enhanced Care Suite	Sep 25

1.8 Recommendation

Avon and Wiltshire Mental Health Partnership NHS Trust request on behalf of BNSSG STP/ICS that this Reconfiguration of Mental Health Services programme is given approval to proceed.

Signed: 

Date: COMPLETED ON SUBMISSION

Simon Truelove, Director of Finance

Senior Responsible Owner
Project Team

2 The Strategic Case

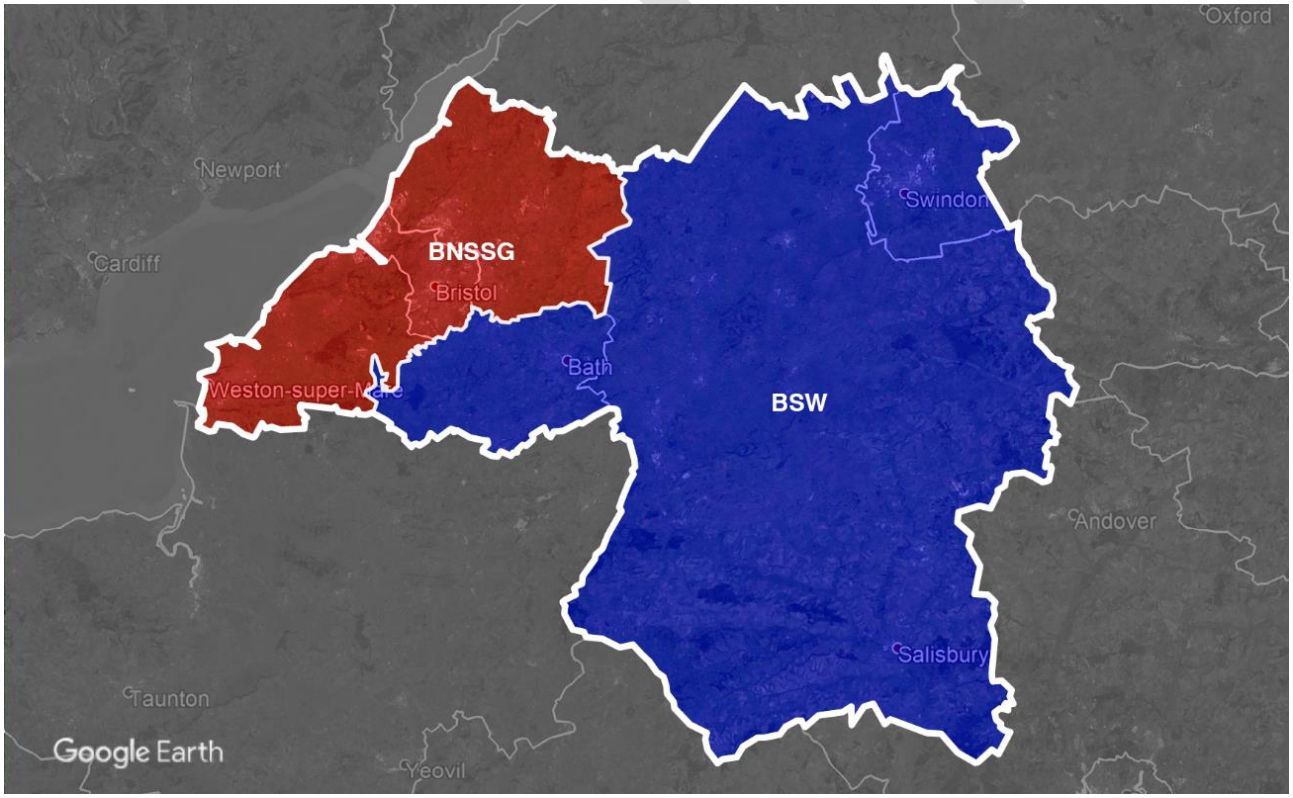
2.1 Introduction

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is the main provider of mental health services in the region including Bath and North East Somerset (B&NES), Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire with a catchment population of 1.8m.

The AWP footprint covers the area of two Clinical Commissioning Groups (CCGs): Bristol, North Somerset and South Gloucestershire CCG & Bath and North East Somerset, Swindon and Wiltshire CCG. These CCGs form two STP footprints: Healthier Together (BNSSG) and BSW (illustrated at Figure 1).

Both STPs are developing coordinated plans to develop their healthcare systems. These STP areas are also progressing more local integrated care planning with Local Authority and health colleagues across the region.

Figure 2 - BNSSG and BSW areas



The Trust purpose is summarised as 'Working together, living our best lives' and the 5 year vision, specifically:

> *"We aspire to give you the best possible care in the right place, at the right time, to help you recover and live your best life"*

In line with the *Five Year Forward View for Mental Health (FYFV)*, NHS Long Term Plan, wider guidance and best practice evidence, AWP is increasingly providing more care and treatment either in people's own homes or in local community settings, enabling easier access to specialist support when required. Where inpatient

treatment is required, lengths of stay will be shorter, with a swift return to community care as much as possible.

AWP also provides more highly specialised mental health services, across a regional geography. These services are commissioned by NHS England Specialised Commissioning alongside the South West Regional Provider Collaborative. The Trust currently provides:

- Inpatient medium and low secure forensic services for men and women, and including more specialist forensic services for people with a co-diagnosis of Learning Disabilities;
- Inpatient Perinatal care for women and their babies;
- Inpatient Child and Adolescent Mental Health Services (CAMHS);
- Inpatient Eating Disorders Services.

AWP is also one of the few remaining providers of NHS inpatient drug and alcohol detoxification services.

This document comprises the Full Business Case (FBC) for the investment required by AWP to progress strategic estates developments in the Healthier Together STP. This will also include some changes in location of services currently commissioned by NHS England. This investment will enable sustainable provision of inpatient mental health care for service users in the BNSSG area and more widely.

2.2 Structure and content of the document

This FBC has been prepared using the agreed standards and format for business cases, as set out in NHS Improvement Capital regime investment and property business case approval guidance for NHS Trusts and Foundation Trusts (NHS Improvement 2016).

The approved format is the Five Case Model plus Clinical Quality Case, which comprises the following key components:

- The strategic case. This sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme;
- The economic case. This demonstrates that the organisation has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money (VFM);
- The commercial case. This outlines the content and structure of the proposed deal;
- The financial case. This confirms funding arrangements and affordability and explains any impact on the balance sheet of the organisation;
- The management case. This demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality.
- The clinical quality case. This is a bespoke section set out by NHS Improvement and is to be completed for all business cases with a patient-facing or clinical aspect.

2.3 Approvals and Support

The Trust has been working with colleagues in the Healthier Together STP to identify sustainable solutions for the NHS estate across BNSSG (see Appendix B for approvals confirmation).

The STP Estates workstream has adopted the following principles [1]to guide the development of proposals:

- Estate meets the demands of the clinical strategy and is delivered in the right place with the right facilities;
- Existing estate is fully utilised;
- Estate is fit for purpose and where not is disposed of;
- Reduction in backlog maintenance;
- Reduction in running costs;
- Co-location with other public sector bodies;
- Locality models will inform infrastructure developments across Bristol, North Somerset and South Gloucestershire.

Over the last 5 years, there has been significant investment in the Health Services Plan, which has enabled the development of the new Southmead Hospital, the closure of Frenchay Hospital, development of central Bristol hospitals including: Bristol Heart Institute, extensions to the Bristol Royal Infirmary, Bristol Royal Hospital for Sick Children, Bristol Haematology and Oncology Centre and closures of the Bristol General and Bristol Royal Infirmary Old Building. These developments have been financed through a combination of public capital, major disposals, prudential borrowing and Private Finance Initiatives (PFI).

Recognising that similar investment and development is required for mental health services, colleagues from the Healthier Together STP have agreed the following priority projects:

- Rationalisation of the Southmead site and re-provision of mental health services located there;
- Part disposal and part development of the Frenchay Hospital site;
- Improve the utilisation of core estate;
- Additional GP facilities in Weston villages and wider Weston/Worle area;
- Reconfiguration of the estate in Thornbury.

Following a review of all capital schemes, all members of the STP agreed that transformation of the mental health estate across the footprint should be the first priority for any future investment. In this context, the Healthier Together STP submitted an initial Wave 3 Capital bid to NHS England in May 2017 for additional capital of £7.5 million to support this aim. The STP was notified in March 2018 that this bid had been successful (project reference STP39.1d) and subject to submission of an FBC and associated Value for Money (VFM) assessment, NHS England would fund the associated developments.

In addition, a number of other Healthier Together priority projects are also being progressed via numerous funding sources, i.e. ETTF funding for the Weston Villages development.

[1] Source: Healthier Together Estates Workbook

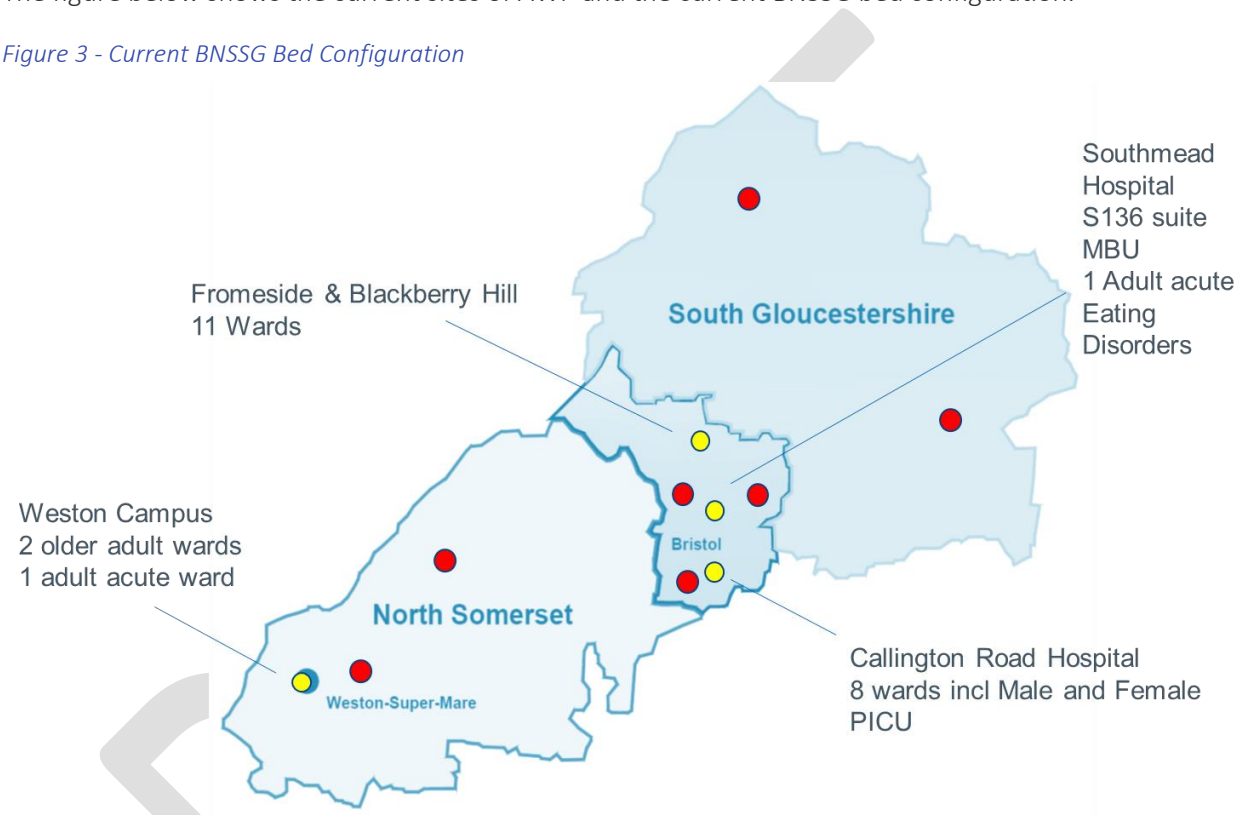
The final draft FBC will be submitted to NHS England and NHS Improvement March 2022. The final FBC will then be submitted to the Department of Health and Social Care following NHS England / Improvement approval.

Strategic Case Part A: the Strategic Context

2.4 Organisational overview

The figure below shows the current sites of AWP and the current BNSSG bed configuration.

Figure 3 - Current BNSSG Bed Configuration



2.5 National context for this case

People with serious mental health problems are also among the most socially excluded within any society, subject to the interlocking and mutually compounding problems of impairment, discrimination, diminished social roles, unemployment and lack of social networks. They, therefore, need services that are well integrated at the point of contact and a health care system that makes sense from their perspective, which fits their differing needs at different points in their journey and that adopts a holistic approach to care.

In response to this recognised gap in provision, NHS England published the Five Year Forward View for Mental Health in February 2016. This set out a new ambition for mental health service provision, with a focus on improving a range of pathways and services in order to deliver more stepped change in mental health care to ensure parity of esteem and improved outcomes for service users. The NHS Long Term Plan, published in January 2019 reinforced this mandate, with a commitment to further investment and improvement in mental health services.

2.5.1 NHS Five Year Forward View for Mental Health

The *Five Year Forward View for Mental Health* covers a whole life span – encompassing improvements in care for children and young people, working age adults and for people in the later stages of their lives. The Department of Health and Social Care has pledged significant levels of investment to enable the *Five Year Forward View* to be delivered at scale and pace, including:

- Additional funding for Child and Adolescent Mental Health Services (CAMHS) to support earlier intervention through establishing CAMHS IAPT services and community based Eating Disorders Teams, as well as significant investment in additional beds in poorly served areas – such as the south west;
- Additional funding for Perinatal Mental Health services to support the creation of specialist community perinatal mental health teams, and the development of inpatient services to ensure that women have easy access to inpatient care when needed;
- Better care for people with common mental illness, with further improvements in access times for IAPT and access to mental health support through primary care;
- 24/7 access to crisis and home treatment teams for people with more severe mental illness, alongside the development of new 'Core 24' services providing better hospital based crisis and liaison services;
- For people with severe mental illness (SMI), improved access to physical health checks – recognising the link between mental health and physical health;
- Trialling new models of care in secure services, ensuring a smoother pathway into and out of secure care, provided as locally as possible to service user need;
- Ensuring closer alignment between health and justice services, with increased investment in liaison and diversion services;
- Delivering a 10% reduction in suicide rates nationally over the 5-year period, through the implementation of integrated suicide prevention strategies.

The *Five Year Forward View for Mental Health* emphasises the need for place-based models of care that support service users to be treated as locally to their home as possible. To achieve this it is expected that mental health services will increasingly be integrated across local systems – either within individual or across multiple Integrated Care Systems and through Provider Collaboratives. The benefits of this approach are that service provision is more seamless and consequently easier to navigate for service users and professionals, meaning that the right service is accessed first time, every time. Services themselves are jointly invested in achieving positive outcomes for service users, often with alliance-based contracts that enable risk and gain to be shared, with any benefits often reinvested into service provision (see section 3.3 for further information on how this project aligns with the AWP service strategy).

2.5.2 NHS Long Term Plan

The NHS Long Term Plan makes commitments to improve the following areas relevant to mental health over a ten-year period.

- Bringing together different professionals to coordinate older adult care better;
- Helping more people to live independently at home for longer;

- Developing more rapid community response teams to reduce need for hospital stays;
- Upgrading NHS staff support to people living in care homes;
- Making further progress on care for people with dementia;
- Helping 380,000 more people get therapy for depression and anxiety by 2023/24;
- Perinatal mental health support for women;
- Spending at least £2.3bn more per year on mental health care;
- Increased funding for children and young people's mental health;
- Bringing down waiting times for autism assessments;
- Providing the right care for children with a learning disability.

The BNSSG STP recently submitted its Five Year Plan in response to NHS Long Term Plan.

2.6 Regional context

AWP is a key partner in the Bristol, North Somerset and South Gloucestershire (BNSSG) System Transformation Partnership (STP) – the Healthier Together STP. A key driver of this case is the need to improve health estate across the region. Major investment has been made in transforming other health provision over the last 5 years under the auspices of the Bristol Health Services Plan. To date this transformation has mainly focused on acute hospital care including the closure of Frenchay Hospital and development of the new Southmead Hospital PFI. Other hospitals across Bristol have had major extensions that have been financed through a combination of public capital, major disposals, prudential borrowing and PFI.

The STP has agreed that mental health service estate transformation is now a priority with this project, which will enable further rationalisation of the Southmead site and re-provision of Mental Health services in centres of excellence across the region. The project itself will change how mental healthcare services are delivered and support the key priority to integrate primary and community care to increase early interventions in both primary and secondary mental health services and deliver improved integration throughout the system to focus on prevention and early access, to provide more community based models close to home, to reduce in-patient admissions and increase quality of care and outcomes for patients and families. This will further help in the management of the known increased demand and acuity and financial sustainability of core and new mental health services.

Over the next 5 years, the Healthier Together STP will work towards the development of a fully operational Integrated Care System (ICS) which will bring together all health and care services, including mental health provision, across the footprint.

Figure 4 - Integrated Care System illustration

2.6.1 Demography and population changes

BNSSG has a mixed demography with areas of high deprivation in Bristol, as well as areas of affluence in South Gloucestershire and North Somerset. In Bristol, self-harm and suicide rates are both higher than the national average. There is a significantly higher number of alcohol related deaths, with a number of people living with alcohol or drug dependency issues.

The population of the BNSSG is in the region of 968,314 (2018). However due to inward migration and increased life expectancy the anticipated population growth in the total population is 4.4% up to 2021. This equates to 43,000 additional residents. Within this overall increase, there is an average increase of 15.9% in the 74-84 age bracket and a 17.7% increase in the over 85s, with a large proportion of this being seen in North Somerset and South Gloucestershire.

The table below shows the predicted increase in population for the BNSSG area forecasted up to 2030.

Figure 5 - Forecast Population growth (up to 2030) BNSSG

Population growth, by local authority area (sourced from ONS, see link below) -- DATA LIMITED TO 2030

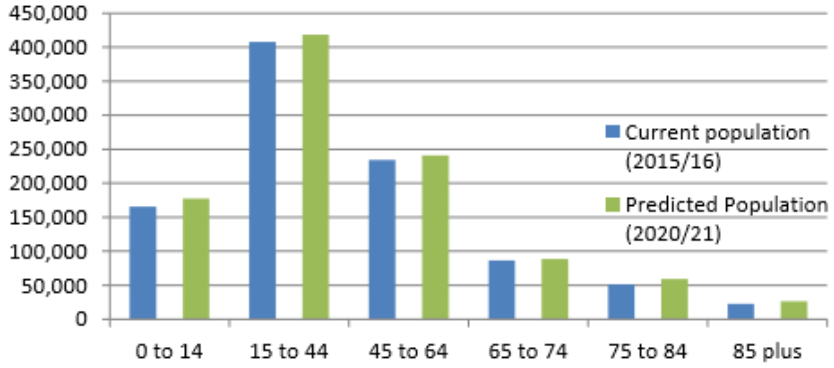
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2

CODE	AREA	AGE GROUP	2016 (000s)	2017 (000s)	2018 (000s)	2019 (000s)	2020 (000s)	2021 (000s)	2022 (000s)	2023 (000s)	2024 (000s)	2025 (000s)	2026 (000s)	2027 (000s)	2028 (000s)	2029 (000s)	2030 (000s)
E06000023	Bristol, City of	All ages	456	461	466	471	475	479	483	487	490	494	498	502	506	510	514
E06000024	North Somerset	All ages	212	213	215	217	219	221	222	224	226	228	230	231	233	234	236
E06000025	South Gloucestershire	All ages	277	279	282	285	287	290	292	295	297	300	302	305	307	310	312
	Total	All ages	944	954	963	972	981	989	997	1006	1014	1022	1030	1038	1046	1054	1062
		Year on year % growth		*1.0%*	*1.0%*	*0.9%*	*0.9%*	*0.9%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.7%*	*0.7%*

Due to the increases seen in the elderly population, AWP needs to plan for population growth – there will be greater numbers of older people with potentially complex health needs. Planned housing developments in the region(s) will also attract additional young families.

The graphic below shows the expected population changes over the next five years by age bands across BNSSG, supporting the anticipated population increase which is predicted to be in the region of 50,000 additional residents in BNSSG.

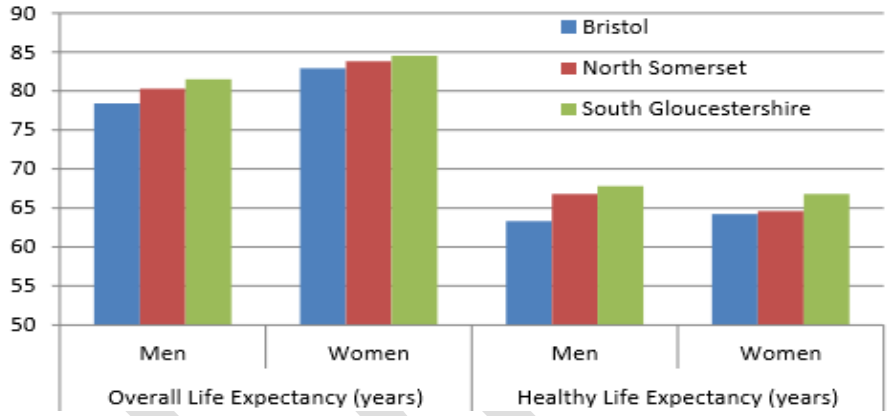
Figure 6 - Predicted population change BNSSG, 2015/16 to 2020/21



2.6.2 Life Expectancy

Life expectancy is the average number of years a person is expected to live based on a range of factors. Healthy life expectancy is an estimate of the years of life that will be spent in good health. To plan health needs, an understanding of the variances is critical. The chart below presents the differences in life expectancy across BNSSG.

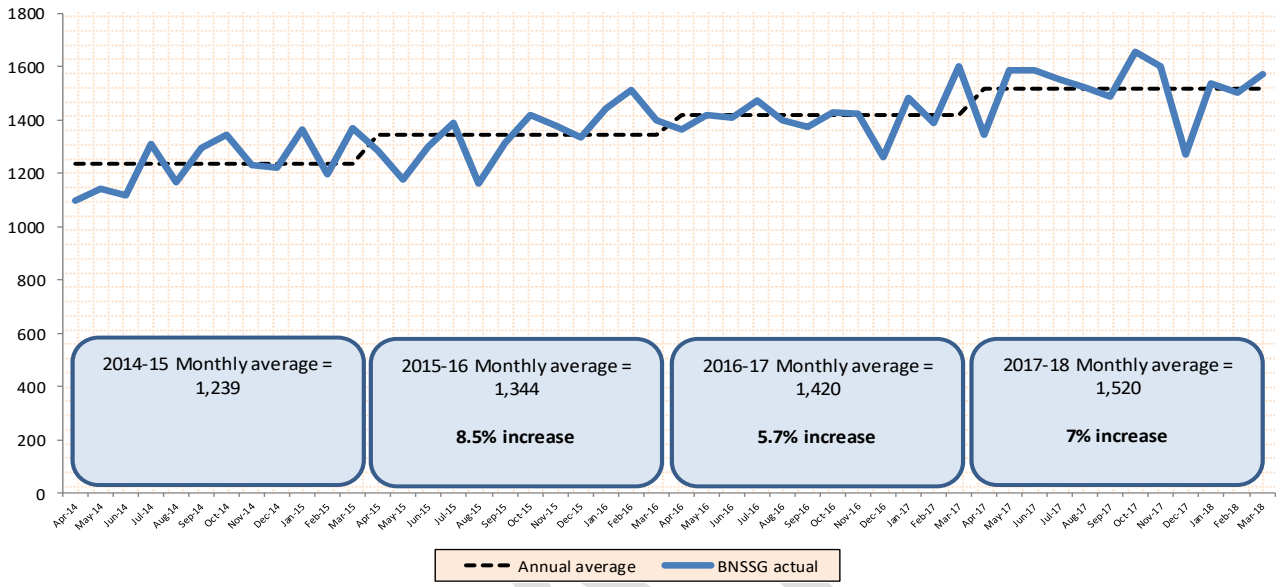
Figure 7 - Overall and Health Life Expectancy BNSSG



2.6.3 Increase in demand for mental health services (above population increase)

Population growth for the catchment is averaging just under 1% per annum. However, patient activity levels are exceeding population growth projections as can be seen in Figure 8 below.

Figure 8 - Patient Activity Levels vs Population Growth Projection



Historic data between the 3 year period 2015 – 2017 inclusive, shows the growth rates have been 8.5%, 5.5% and 7.5% respectively. This additional growth is a result of unmet need and the acknowledged gaps in mental health services nationally as described in Five Year Forward View for Mental Health.

The data and forecasts available to date do not include the changes in demand arising from Covid-19.

2.7 Trust Context and approach to service delivery

The Trust has established four strategic principles, which are the guiding aims for all aspects of service delivery:

- Outstanding Care: To continually improve and provide high quality, safe care to help people to achieve the outcomes that are important to them;
- Outstanding People: Our people make the difference in everything that we do – we will strive to make AWP a great place to learn and work;
- Sustainable services: Services that are properly resourced to meet rising demand and acuity;
- Delivered in partnership: Care as a joint endeavour with patients/family/friends/carers and our partners, including the voluntary sector.

Over the next 5 years, the Trust will transform and develop its services ensuring that:

- It remains a Partnership Trust, pursuing full integration with social care;

- It continues to provide all age mental health care, supporting seamless transition between services;
- Mental health experts are embedded within multi-disciplinary teams, supporting GPs to provide care that meets the physical, mental and social needs of people;
- It follows best evidence to provide more care closer to home;
- Community based alternatives are offered wherever possible to prevent acute inpatient admissions;
- Inpatient wards will be located together to create centres of excellence that offer a wide range of specialist therapies in a safe and supportive building;
- It will work with commissioners and other care providers to develop pathways for specialised and secure services. New care models will mean people access care closer to home, in the least restrictive environment and avoid receiving care away from friends and family;
- Staff, service users and carers are involved in the running of the organisation to improve experience and care quality;
- Where it improves care quality and health, it will provide physical and mental health community care services, either directly or in partnership;
- It will be outward looking, seeking innovative ideas that improve care and through our research portfolio contribute to the national evidence base for mental health care.

The Trust transformation programme has been established to oversee significant changes to the way in which services are provided – both physically and operationally – in order that the Trust is able to provide accessible and responsive mental health care for its populations sustainably. This also focuses on building the necessary partnerships and relationships across both BNSSG and BSW footprints to support longer term delivery of integrated care.

This will take place over the next two years, with a focus on developing new community-based services that will enable more service users to be managed in the community with appropriate levels of support from not only mental health staff, but also housing, social care, and employment services to name but a few.

Existing community-based provision is being transformed in order to ensure that people can access the right service for their needs more quickly. Where advice is required from secondary mental health services, the Trust Primary Care Liaison Service (PCLS) will support early access and advice as need by clients. Community Mental Health Teams (CMHTs) will offer a more consistent service, ensuring that they are able to respond to those service users who need more in-depth support.

As a result of the above changes, inpatient services will be the last point on a longer care pathway with care provided in the right environments to meet service user need. Standard packages of care will be created, ensuring that variation in both care and outcomes are reduced.

The Psychiatric Intensive Care Unit (PICU) pathway is also being reviewed, ensuring that service users have the shortest length of stay that is appropriate for their clinical condition, and are either stepped down into other inpatient services or to community-based support as swiftly as possible.

BNSSG CCG has recently led a review of both inpatient and community rehabilitation services with input from staff across the Trust. This review has concluded that there needs to be a change in the way that rehabilitation

services are provided, with a stronger focus on community-based care and with a consequent shift in the number of inpatient rehabilitation beds required.

Much of this transformation work is intended to mitigate the continued growth in demand for services. At present the Trust is unable to manage within its existing bed capacity and a number of service users (ranging from 20-50 at any one time over the last eighteen months) are placed in out of area beds.

As part of BNSSG System Planning and LTP Activity monitoring, the Trust has committed to a trajectory which will see a significant reduction in the number of out of area placements, with an aim to ultimately achieve and maintain a position of zero out of area placements by the end of the current LTP planning cycle. This trajectory is based upon a culmination of a number of different investments (Community Mental Health Framework, Additional Roles Reimbursement Scheme, Mental Health Investment Standard developments) supporting a position of continued reduction in the number of out of area placements. Although this particular scheme will not deliver additional bed numbers (aside from the conversion of Larch beds from rehab to adult acute) it will support reduced length of stay through an improved therapeutic environment and thus support increased patient throughput.

All of the above programmes of work will have an impact on the Trust estate and its configuration. Wards and their associated environments will need to be able to respond to the potentially higher acuity of service user, ensuring that the right care can be provided first time, every time.

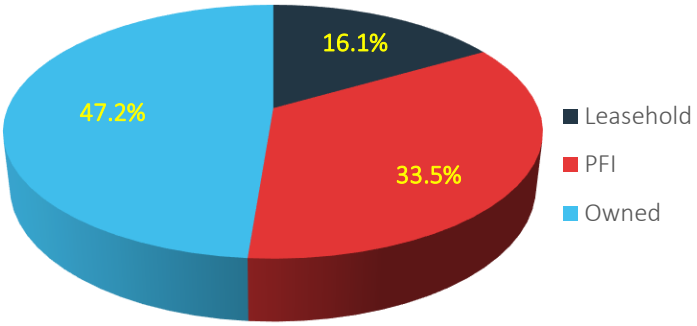
The corporate and clinical strategies are supported by a number of enabling strategies and plans, including Estates, Digital and Workforce. Each of these enabling documents is aligned to the delivery of the wider corporate strategy and will support the Trust in delivering its five-year ambitions. Physical changes to the existing estate are a core component of the first phase of implementation and are central to changes in clinical service provision.

The main inpatient sites in BNSSG at present are as follows (please see options appraisal below for bed numbers, note that Forensic Services inpatient sites are excluded).

- Callington Road Hospital, Brislington – PICU (male & female), Adult Acute, Older Adult (functional and organic), Rehabilitation, Step-down Rehabilitation,
- Southmead Hospital – Adult Acute, Perinatal Mental Health, Health based place of safety (HBPoS), Eating Disorders;
- Long Fox Unit, Weston-super-Mare – Adult Acute, Older Adult (functional and organic);
- Elmham Way – Rehabilitation;
- Whittucks Road, Hanham – Rehabilitation (BNSSG and B&NES).

The BNSSG mental health estate is a mix of freehold, leasehold and Privately Financed (PFI) buildings, in the proportions of floor area shown below. The majority of the Trust's owned estate is in the Bath, Swindon and Wiltshire region. The Trust-owned estate has a total value of approximately £116 million, and the split between PFI, Leased and Owned property is shown below.

Figure 9 - Breakdown of Trust Property Ownership



Some strategically relevant Trust estate performance parameters are indicated in the table below.

Table 1 - Summary of Current Performance

Current Performance	Need to	5 yr. target
Non-clinical occupied space – 33% (Carter <35%)	↓	
Un-occupied space – 9% (Carter 2.5%) Cost £0.6m pa. (Hillview, Long Fox, Southmead, Green Lane)	↓	2.5%
Under-utilised occupied space – 30-50%	↓	
Not fully fit for purpose occupied space – 8.1% (Hillview, Long Fox, St Martins, Applewood) £40-80m	↓	
Operating cost - is moderate, 3rd. quartile for MHTs (allowing for PFI)	↓	2nd quartile
Current locations – reasonable, minimal client complaints	↔	Meet STP aims

Prior to developing the Estate Strategy, the Trust commissioned a Space Utilisation study of key strategic properties across its portfolio, including outpatient and offices space in The Coppice and Woodside buildings on the Callington Road site. This survey found that the buildings were 65% and 73% underutilised respectively.

A number of recommendations have been addressed since then to improve utilisation of these buildings, including room booking management to minimise block meeting room bookings and high percentage of "no shows". However, the proposals set out in this business case will further improve the utilisation in these high value buildings through a re-provision of space to maximise space being utilised for patient care. At the end of the programme of works, the Trust will revisit the space utilisation assessment on the revised configuration as part of the post project implementation to ensure that the space is being more effectively utilised (and thus delivering VFM) and take further steps if required.

In developing the Estate Strategy, the Trust has taken the revised Carter metrics into account and is focused on reducing the amount of space occupied by corporate functions. It also supports the key clinical objectives outlined in the clinical case.

While all the above local strategies support the Trust plans, the full business case will have to follow the Value for Money (VFM) assessment criteria as dictated by Treasury[2]. This requires each organisation to identify the assumptions, lead organisations system revenue, qualitative benefits and risks. The approach to the development of the full business case follows this criterion ensuring the required information is available for the assessment to be made.

Strategic Case Part B: the case for change

2.8 Needs and opportunities for change

In light of national, system and Trust context, the Trust has completed a comprehensive review of its existing estate. In order to deliver the ambitions set out in the Corporate, Clinical and Estates strategies and provide modern, effective mental health services now and in the future, it has been agreed that there needs to be a fundamental review of services across the Bristol footprint. The principle drivers of this change are summarised below.

2.8.1 NHS national strategies for Mental Health

The NHS has presented its Five Year Forward View (2016) and Long Term Plan (2019) for Mental Health. The BNSSG Integrated Care System and AWP strategic approach to clinical service delivery is based on these, and discussed in more detail in Section 3: The Clinical Quality Case. The strategic plans arising from the LTP and FYFV are outlined below.

2.8.2 Inpatient services needs

Existing inpatient services in BNSSG meet a wide range of needs, many of which are covered under headings below. However some service specific issues are:

Higher acuity - One effect of a community focused model of care, with reduced admissions and shorter lengths of stay, is that the overall acuity found in in-patient units might be expected to be higher. The clustering of inpatient units will allow improved resilience and response between inpatient units, and this is essential to successful inpatient service delivery.

Effective care pathways - As inpatient care pathways are improved there will be effective step-up and step-down care systems. Co-locating all of the inpatient wards onto one site will enable more cohesive pathways for our service user group and allow the opportunity for step-up and step-down from community services right through to intensive care, as required.

Single-sex units - To facilitate high quality patient care and support timely and appropriate bed availability the Trust is considering the establishment of some inpatient units as single sex wards. Currently there are single sex bedroom wings with mixed-sex communal areas. This also provides a more appropriate environment for effective step down care transfer from single sex PICU units.

Optimised ward size - It is expected that the Trust will configure inpatient beds on the adult acute wards in BNSSG area to be broadly within the in line with the national standard of between 15 – 18 beds per unit. This will be done without an overall reduction within the adult BNSSG bed base. In order to maintain the current

[2] VFM Allocations Tranche 2

number of actual beds, it would be anticipated that two of the inpatient units in the revised configuration would have 19 beds to meet current demand levels.

2.8.3 Local health system needs

The BNSSG STP will move towards a fully Integrated Care System over the next year. Mental health services will be part of this change, with a focus on:

- Enabling people to live better lives and manage their mental health and wellbeing effectively;
- Ensuring that the system delivers parity of esteem between mental health and physical health, for all ages;
- Adapting service provision to meet the needs of individual communities within the STP footprint;
- Ensuring equity of provision, with standardised care models and reducing variation in outcomes;
- Supporting people with severe mental illness effectively, with the aim to address their more complex needs in the right place, first time.

Mental Health has been identified as one of the 10 priority programmes for the STP, with its plans to improve mental health services in the future set out in its response to the NHS Long Term Plan. This is further supported by the system-wide Mental Health Strategy which has been collaboratively produced by system stakeholders.

Transforming the Trust estate will enable a range of benefits to be realised for the wider health system. Over the last 5 years there has been major estates investment under the Bristol Health Services Plan, however this has largely focused on transforming acute Trust buildings, including: the new Southmead Hospital (financed through PFI), improvements and extensions to the Bristol Heart Institute, the Bristol Royal Infirmary and the closure of Frenchay Hospital. All of these schemes have been financed through a combination of public capital, major land disposals, borrowing and PFI.

The time is now right to take forward similar transformation of the mental health estate. This has been agreed as an STP priority project for the following reasons:

- It will consolidate core mental health services onto two inpatient hubs across BNSSG – creating a clearer identity for mental health provision and delivering financial savings as outlined;
- There will be better utilisation of core health estate, reducing inefficiencies and costs;
- Community services will be enhanced, and will be well-positioned to integrate into the emerging locality model ensuring that mental health and physical health are managed together by appropriately trained professionals;
- There is the potential to release land and buildings at Southmead hospital site for other healthcare use, although noting they will have very limited functional suitability for modern health services and will need considerable investment.

2.8.4 Adopting improving technologies

Over the coming years there will be opportunities and expectations for using technology to work differently with service users. Areas that may have potential to improve efficiency include:

- Video-based consultations
- Text notifications regarding services or appointments

- Email-based communication with service users
- Laptop/PC-based telephoning
- Centralised electronic systems for efficient room bookings, appointments, etc.

These could change the profile of how estate is used, particularly for community services, but will also benefit inpatient services to areas such as therapeutic activities, staff skill set and use of space.

2.8.5 Performance targets challenges

NHS benchmarking for Mental Health has been introduced into the Model Hospital system, and is leading to performance being monitored and targeted on a range of new parameters. In addition existing performance targets are being tightened, such as:

- Reduction in Length of Stay (LoS) via system wide reviews and transformation initiatives generating the most efficient and appropriate use of bed type availability within the BNSSG division and Trust wide bed base;
- Reduction in Out of Area Placements (OOA) – through effective application of discharge management, reduced length of stay and system flow.

2.8.6 Static real-terms budgets

The funding forecast for the services provided by AWP over the period of the Long Term Plan (LTP) is outlined below:

Statement of Comprehensive Income	Annual plan	Long Term Plan		
	20/21	21/22	22/23	23/24
	£'000	£'000	£'000	£'000
Operating income from patient care activities	237,641	242,740	253,839	263,097
Other operating income	9,884	9,486	9,578	9,670
Employee expenses	-195,799	-200,141	-208,565	-215,305
Operating expenses excluding employee expenses	-54,249	-54,215	-56,527	-58,771
OPERATING SURPLUS / (DEFICIT)	**-2,523**	**-2,130**	**-1,675**	**-1,309**
FINANCE COSTS				
Finance income	24	24	24	24
Finance expense	-7,090	-7,948	-8,334	-8,685
PDC dividends payable/refundable	-2,436	-1,610	-1,610	-1,610
NET FINANCE COSTS	**-9,502**	**-9,534**	**-9,920**	**-10,271**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**-12,025**	**-11,664**	**-11,595**	**-11,580**
Add back all I&E impairments/(reversals)	2,500	2,500	2,500	2,500
Remove capital donations/grants I&E impact	16	16	16	16
Adjusted financial performance surplus/(deficit) including PSF, FRF and MRET funding	**-9,509**	**-9,148**	**-9,079**	**-9,064**

To note, the table above has not been amended to reflect outturn for 2020/21 due to the impact of Covid-19 funding and expenditure streams that would skew the alignment across the financial years provided. Also, a revised long term financial plan for the BNSSG system is in the process of being developed, in line with national guidance.

Although income increases over the life of the plan (in line with developments to deliver the outcomes of the mental health FYFV), expenditure also increases, despite nationally mandated levels of efficiencies being delivered, leaving the Trust with a similar level of underlying deficit at the end of the plan period. This comes off the back of a period of relatively static budgets with annual requirements to deliver 2-4% of efficiency savings to enable the Trust to stand still – delivering efficiencies over and above this level in order to fund investment is extremely challenging, hence it becoming inevitable that a more complex investment proposal is now required to meet rising demand with static real-terms budgets.

The anticipated capital plan over the same LTP period is noted below:

Capital Departmental Expenditure Limit (CDEL)	Annual plan	Long Term Plan		
	20/21	21/22	22/23	23/24
	£'000	£'000	£'000	£'000
Self Financed Depreciation	6,110	5,912	6,009	6,078
Less PFI costs	-2,061	-2,110	-2,207	-2,340
Net CDEL excluding PDC	4,049	3,802	3,802	3,738

Given the relatively small capital budget for an organisation of this size / spread and the impact of depreciation / rising PFI costs over the period of the LTP, there is no internal capital flexibility available to fund significant transformational programmes without recourse to national funding streams.

2.8.7 Opportunity for wider benefits

In delivering efficiency improvement strategies, it is expected that some wider public benefits will be realised, such as:

- Improved access to wider ranges of health or public services in a co-ordinated way;
- Potential release of some existing land for future system use

2.8.8 Estate fitness for purpose

The Trust estate in the BNSSG area, which was originally designed in the 1980's -1990's, now has significant fitness for purpose issues as standards for mental health care have moved a long way in recent years. Evidence-based good practice building design is needed which will ensure that:

- The environment is tailored to the needs of patients and visitors;
- The environment is one that can be associated with, and portrays, high quality mental health care;
- Risk presented by non-functionally suitable estate is significantly reduced leading to good regulatory compliance;
- The environment supports efficient and safe care and staffing models.

The Southmead mental health estate has the following main functional suitability design issues:

Mason Place of Safety Unit - Seclusion suite not suitably configured or sized; en-suite cannot be used in high risk situations.

STEPS Eating Disorders Unit - Kitchen and dining room cramped, and with poor storage for food, not ideal for eating disorders. Garden very difficult to observe. Very little provision for single-sex accommodation. Most rooms use the shared bathroom facilities.

Oakwood Adult Acute Ward - No airlock entrance leading to weak security, and very tense management of clients in entrance/dining area. Corridors have many bends and blind spots leading to excessive staffing needs. Highly inadequate communal and therapy space. Some rooms too small for safe client management.

New Horizons Mother and Baby Unit - The unit has only 4 beds. This does not meet current demand, and is also too small to be sustainable in the future. Minimum 8 beds is required. [NB. Considerations on increasing the bed base for this service function are subject to separate discussions and business case].

Site-wide design issues - Rooflines are generally low, but at places have significant falls from height risks.

See Appendix C for more detailed functional suitability information on the Southmead site.

2.8.9 Estate condition and quality

The AWP estate physical condition in the BNSSG area is largely good, because a significant part of the estate is contracted under PFI and is committed to a fully funded high contractual standard of maintenance. However, the estate at Southmead is not in the same position.

Following recent condition surveys, owned estate backlog and impending backlog is stated as £5.5 million, with £1.3 million as Critical Infrastructure Risk (CIR). The AWP Southmead site accounts for £3.3 million of this Backlog and all of the £1.3 million of the CIR. See Appendix D for physical condition survey information split by site.

There is one specific issue that is causing significant risks to Southmead services continuity - the water system of the buildings has become colonized over a long period of time. This affects all wards on the AWP site.

The situation with the water system has been managed to date with replacement of the plantroom water heating infrastructure, frequent planned flushing of taps, and rigorous monitoring of water temperatures. At times it has been necessary to use very costly micro-filters on every tap. This level of activity is not sustainable in the long term and there is still a residual risk of issues flaring up and indeed has done so in 2021. The replacement cost of the full water system has been estimated at £2-2.5 million. Given the existing site functional suitability issues outlined above, this would not be worthwhile investment and would not represent value for money. The removal of Southmead wards from the AWP estate will eliminate these risks to patient care quality and safety, and in financial terms will completely remove the AWP Southmead cost of backlog and impending backlog totalling £3.3 million, of which £1.3 million is Critical Infrastructure Risk. This avoided cost is a significant factor when considering the £10.5 million investment that this business case proposes.

2.9 Strategic Objectives

The general over-arching strategic objectives for this programme, which will enable the Trust to meet the challenges outlined in the Strategic Case, are summarised below.

- Reduction in out of Trust bed placements;
- Reduction in delayed discharges;
- Reduction in waiting times;
- Improved used of space, and specifically PFI building space;
- Improvements in key staffing indicators, such as turnover rates, absence rates and use of agency;
- Reduction in estates risks.

A number of clinical objectives have been identified arising out of these, and are reported in the Clinical Case, Section 3. The investment objectives are presented in detail in the Economic Case, Section 4, and are measurable to enable review (NHSI guidance specifies that investment objectives should be SMART).

The estate development programme also has strategic objectives to deliver quality, effectiveness and efficiency which can under-pin the service delivery objectives (Table 2).

Table 2 – Estate Strategic Objectives and Priorities

Estate priority	Alignment with strategic ambitions	Quality impact	Financial impact	Proposed Measurement
General Objectives				
Maximise the high-value clinical use of PFI estate Maximise the use of owned estate and cost-effective shared estate Minimise, as much as possible, the amount of costly commercially leased accommodation	Contributes towards national Carter targets	Potential disposal of estates that is unfit for modern health services	Reduction in high level backlog maintenance Increased utilisation of expensive estate for high cost clinical services	Movement in CIR / Backlog maintenance position over the period of the development 2020-2026 Continual assessment of space utilisation via PFI estate utilisation survey (including clinical vs non-clinical)
Inpatient hospital sites				
Should operate in clusters of four or five units (or more) with no acute 'standalone' units	Inpatient wards will be located together to create centres of excellence that offer a wide range of specialist therapies in a safe and supportive building	Reduction in use of temporary staff as staff will operate across the site Improved access to on site expertise	Reduction in high cost temporary staff Maximise use of high cost PFI estate Income generation through research portfolio Reduction in costs associated with mitigating known risks (e.g. water system, ligature risks) and backlog maintenance	Agency usage change in hours and £, split by framework/off framework and by key staff groups pre/post implementation (and compared against anticipated improvement trajectory to be developed 1 year before project completion)
Inpatient hospital sites (continued)				

Estate priority	Alignment with strategic ambitions	Quality impact	Financial impact	Proposed Measurement
			Increased ability to attract staff to centres of excellence, and with that enabling access to latest treatments and research based initiatives Reorganisation of the estate will ensure that service users are cared for in the right environment for their needs	Measure movement in recruitment interest / starter and leaver numbers in impacted services across key recruitment categories (Nursing, Medical, Clinical Support) pre and post reconfiguration.
Community service sites				
Will be delivered alongside of a modernised community care model to achieve high client-facing service levels with up to date working practices and technologies. It will also align with the developing wider STP transformation	Mental health experts are embedded within multi-disciplinary teams, supporting GPs to provide care that meets the physical, mental and social needs of people Community based alternatives to inpatient admissions are offered wherever possible. Where it improves care quality and health outcomes, we will provide physical and mental health community care services, either directly or in partnership	More care available closer to home for service users, resulting in reduced travel time and associated impact Service users can access the right service, first time for their needs Admissions are avoided where possible, and where required, service users will have shorter lengths of stay	Minimise the use of high cost commercially leased accommodation, through improved use and sharing of community service sites	Average Adult Acute Inpatient average length of stay tracked over 3 monthly intervals

Estate priority	Alignment with strategic ambitions	Quality impact	Financial impact	Proposed Measurement
Community service sites				
	We will work with commissioners and other care providers to develop pathways for specialised and secure services. New care models will mean people access care closer to home, in the least restrictive environment and avoid receiving care away from friends and family.	Opportunities for sharing of learning and expertise between teams will be maximised		
Support Services Office Space Efficiencies				
The Trust will work within STP / ICS structures to develop transformation plans that achieve the best business practice for the Trust and wider STP stakeholders. This may lead to re-aligned estate needs.	Meets STP Healthier Together and one public estate objectives More efficient use of technology to enable agile working and reduce office requirements	Clinical services are better aligned on single campus sites that offer improved clinical pathways and service efficiencies	Better use of public funds within health economy	To be agreed through BNSSG system approach to transformation / outcome assessment.

While all the above local strategies support the agenda the Trust is planning, the full business case will have to follow the Value for Money (VFM) assessment criteria as dictated by Treasury[3]. This requires each organisation to identify the assumptions, lead organisations system revenue, qualitative benefits and risks. The approach to the development of the full business case follows this criterion ensuring the required information is available for the assessment to be made.

[3] VFM Allocations Tranche 2

3 The Clinical Quality Case

3.1 The Five Year Forward View for Mental Health

The Mental Health FYFV report of 2016 is nearing the end of its planning timescale, but contains some fundamental aims that remain as valid areas for further development today. It will require considerable time and investment to develop and to integrate necessary changes into system service models, such as:

- Reduced out of area placements for inpatient services
- Extended hours service provision for community services
- Enhanced community and home-based treatments
- Multi-agency partnerships for mental health support
- Online mental health services
- Improving some specific types of service.

There have been challenges over the past 4 years such as staffing and financial constraints that have slowed initiatives to improve these areas, but the 2019 NHS Long Term Plan and recent 2020 NHS investment planning is taking steps to accelerate these developments to mental health services.

The recent response to Covid-19 has also emphasised that very developed thinking has been done in these areas over several years, and that a proactive approach to change could embed new ways of working and deliver the long term service models that are needed. This will improve the community service approach and reduce dependency on inpatient beds and associated out-of-area placements, and hence improve the experience and outcomes of service users and carers.

3.2 NHS Long Term Plan

The NHS Long term plan (2019) makes commitments to improve the following areas relevant to mental health over a ten-year period.

- Developing more rapid community response teams to reduce need for hospital stays
- Bringing together different professionals to coordinate older adult care better
- Helping more people to live independently at home for longer
- Upgrading the NHS staff support to people living in care homes
- Making further progress on care for people with dementia.
- Helping 380,000 more people get therapy for depression and anxiety by 2023/24
- Perinatal mental health support for women
- Spending at least £2.3bn more per year on mental health care

The Long Term Plan sets out that the NHS will achieve these by:

- Doing things differently – through local integrated systems of care

- Preventing illness and tackling health inequalities – helping people avoid significant causes of ill health
- Backing the NHS workforce – providing training, apprenticeships, and development routes
- Making better use of data and digital technology – with more convenient digital access and apps, and improved use of digital information for service planning and delivery
- Getting best value for taxpayer investment – reducing duplication, administrative costs, and using NHS buying power.

The Covid-19 pandemic response has demonstrated the ability that the NHS has to move forward in many of these areas, with the rapid introduction of new care approaches, workforce support, apps and video-consultation technology, use of NHS procurement power for new treatment and contracts, and use of highly skilled UK healthcare research capability

3.3 Clinical strategy and commissioning intentions

BNSSG STP/ICS has refreshed its corporate and clinical strategies in response to the Five Year Forward View for Mental Health and NHS Long Term Plan. Through planned system integration and collaboration, the AWP strategy focuses on taking opportunities to benefit the wider system rather than taking a purely service-based approach to development and improvement. Four key values underpin the AWP service delivery strategy.

Figure 10 - AWP Key values

Through implementing these principles, the following clinical developments and enhancements are in progress and will be further supported by this investment:

- The provision of a **more flexible access to mental health services** to ensure patients get the right care at the right time and of the right quality. This will ensure that people facing a crisis have access to mental health care in the same way that they are able to get access to urgent physical health care. Delay in providing care can lead to poorer clinical and social outcomes whereas early intervention services provided by dedicated teams are highly effective in improving outcomes and reducing costs.
- Across BNSSG the services are to extend their reach by delivering services that are flexible and adaptable and recovery focused. Some of these services include early access, street triage, enhanced crisis services, and engagement with families for co-production of service design with 'experts by experience'.
- Provision of an **integrated mental and physical health approach** to care to meet the expectation that people living with severe mental health problems should have their physical health needs met in parity with the general population. Increased access to evidence-based psychological therapies will be developed, and there should be screening and secondary prevention reflecting their higher risk of poor physical health. Also, there is a need that all women have access to perinatal mental health.
- Across BNSSG this collaboration and system integration is setting the clinical direction for all services to follow by its implementation of a centrally placed enhanced physical health care team to support the NHSI collaborative to reduce the mortality gap. It is also providing the flexibility, adaptability and innovation required to introduce new pathways of care including referral by phone options, early access through care reconfigurations and a multi-faceted approach to mental health promotion working with partners, commissioners and NHS England.
- Creating mentally healthy communities is a key priority across BNSSG and ensuring full involvement of service users and staff as partners is demonstrated by the implementation of the Primary Care Liaison provision as a prevention service and an interim provision for people awaiting secondary and tertiary care referrals and admission. The CCG has implemented a multi-professional training programme for staff to enhance experience and assist more people in dealing with early access to services.
- **Children and young people** are a priority group for mental health promotion and prevention, and it is known that early intervention and quick access to good quality care for children and young people is essential. In BNSSG a whole system approach, as described in the Future in Mind and Thrive recommendations, is being implemented which will reduce waiting times and prevent inequalities in access for young people waiting for care. The full implementation of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme has also been commenced.
- The BNSSG **IT strategy** is a key supporting strategy that will drive information linkage across many areas such as public health, education and other sectors, in relation to prevalence, access, experience and outcomes within mental health in order to meet the standards for provision of a published range of benchmarking data. This will provide improved understanding and transparency about mental health expenditure and performance in line with national governance requirements.
- In AWP performance data and benchmarking will be used to inform clinical service developments. The national; minimum data set indicators are reported to the board monthly including a clear set of quality indicators and NHS benchmarking data. A programme has been designed to deliver these activities and a number of clinical and

operational work streams have been established to support their delivery. Each one having a mandate describing the key elements to deliver, how and when they will be delivered and by whom to meet the agreed standards that:

- Decisions will be locally led to ensure developments meet the needs of local populations;
- Care developments will be benchmarked and based on the best available evidence;
- New services will be designed in partnership with people who have mental health problems and with their carers;
- Inequalities will be reduced to ensure all needs are met, across all ages;
- Care delivery will be integrated – spanning people's physical, mental and social needs;
- Prevention and early intervention will be prioritised;
- Care will be safe, effective and personal, and delivered in the least restrictive setting and close to home wherever possible;
- The right data will be collected and used to drive and evaluate progress.

3.4 Clinical Objectives

The strategic drivers outlined in Section 2, together with the NHS Long Term Plan and Five Year Forward View have led to a range of objectives for clinical service improvement over coming years. These are to:

- Implement a 7-day model of care;
- Deliver specialist care in the community;
- Reduce the inappropriate use of hospital beds;
- Create more efficient use of digital solutions and joint estate options at scale;
- Support prevention, early intervention and self-care;
- Reduce the dependency on acute beds;
- Create an acute care collaboration for the best use of hospital capacity and enable further opportunities for growth;
- Ensure the Trust maximises the use of all its available resources, using best practice evidence to deliver innovative new models that support service users and promote recovery.

These objectives are achievable because they are based on enhancing existing elements of the mental health service models that work well and reducing use of aspects which are less effective or efficient and can be measured through a number of metrics. Further detail associated with these objectives is presented in Section 4.3 Economic Investment Objectives, along with the proposed measurement approach. The Covid-19 pandemic response has demonstrated that by doing this programme of work we can further reduce bed use and length of stay, increase the community care offering, increase collaboration, and use physical and IT resources in much better ways.

3.5 Leadership and stakeholder engagement

The Board-approved Communications and Engagement Strategy sets out our internal and external stakeholders. AWP programme leads regularly engage with all of these groups in various ways, some of which are summarised in Section 7. Most of these stakeholders are relevant to the BNSSG Programme, either at the service development stage (covered here), or at the delivery stage (see Section 7).

Table 3 - Key Trust Stakeholders

Internal	External	
1. AWP Staff a. Nurses b. Medical Staff c. Allied Health Professionals d. Occupational Therapists e. House Keepers, Estates and Facilities staff f. Corporate Services g. Executives h. Non-Executive Directors i. Headlight (Trust Charity)	2. Service Users and Carers 3. Local CCGs 4. Acute Trusts 5. Local Authorities 6. BSW STP and BNSSG STP 7. Health and Well-Being Boards 8. Directors of Adult Social Care 9. Directors of Children Services 10. Private Providers 11. Overview and Scrutiny Committees 12. Healthwatch 13. Local Councillors 14. Media – national, local and trade	15. Clinical Networks 16. Members of Parliament 17. Voluntary and Community Sector 18. NHSI 19. Universities, schools and colleges 20. CQC 21. Members of the public 22. Local campaign groups 23. Crime and Disorder Partnerships 24. NHSE 25. Safeguarding Boards

Avon and Wiltshire Mental Health Trust is a core member of the BNSSG Mental Health & Learning Disabilities Steering Group and Mental Health Programme delivery team and coordinate regularly with local system groups in delivering services to the BNSSG population. AWP engage and partner with a wide range of organisations and stakeholders in considering solutions for the challenges that Mental Health services face in the BNSSG area. These include:

- BNSSG Mental Health commissioning (Adult and Older Adult and CAMHS mental health)
- NHSE Specialised Commissioners (Perinatal MBU)
- South West Provider Collaborative (Inpatient Eating Disorders, Secure and LD service)
- Community Health services (gg. Sirona CIC and Devon Partnership NHS Trust in BNSSG area)
- Childrens' Health services (Sirona CIC)
- Acute NHS Trusts (e.g. North Bristol NHS Trust, University Hospitals Bristol & Weston Trust), e.g. for emergency department pressures/Place of Safety/crisis services
- Primary Care providers and networks (therapy and crisis services)
- Local Authority social care and mental health teams (system flow and community services)
- Care providers such as care homes and shelters (mental health liaison services)

- Third Sector organisations that provide support and representation for specific service user groups (e.g. supported living, ethnic support groups, carer groups)

The AWP BNSSG Programme touches on almost all of these areas of activity, and we have engaged widely in developing this programme proposal. AWP have worked through a range of considerations that have influenced and steered this business case to its presented options, such as

- Investment requirements for suitable and sustainable Adult Acute mental health provision
- Issues in level of acuity and resource availability in the Section 136 collaborations around Emergency Departments, Place of Safety and Police services.
- Capacity requirements, safety and community-based care solutions for Older Adult beds
- Options for future locations for Mother and Baby Unit, with a possibility of increasing provision
- Needs of other healthcare organisations in developing their own services, including access to estate.

As part of the engagement process, the issue of whether formal Consultation with the public is required regarding some aspects of the services, given the changes proposed, has been considered in depth in line with the NHS England "Planning, assuring and delivering service change for patients" guidance. The conclusion reached by the Trust and its commissioners is that the reconfiguration does not change the type of services available in each geographical locality. It also still addresses local demand variations, and takes into account performance enhancements in some services, as detailed in other parts of this Section. The distance for relocation of services is relatively small at 7 miles, in a city that is well connected for transport options, and these services are inpatient services that operate across the full city and the BNSSG region. It has also been concluded that the quality improvement benefits associated with this scheme (through improved estate and a more consolidated workforce model) will deliver tangible benefits to patients as compared to the current configuration. Therefore, formal consultation has been determined as not being required for any elements of this programme as the significant change criteria is not met. This assessment that formal consultation was not required for the project was unanimously supported when the business case was presented to the South Gloucestershire Health Overview and Scrutiny Committee on the 26th January 2022.

3.6 Demand for Mental Health Services in BNSSG

Demand and capacity modelling has been considered as part of the scheme to ensure that it is future proofed and can adapt to meet the changing needs of the local population. General factors influencing demand within BNSSG such as population growth are discussed in Section 2. The trends arising from the health planning and demand this data can be summarised as follows.

Population growth

- We are forecasting the population accessing AWP services to increase by 45 thousand to over 1million people by 2030 (9.4% increase).
- 17% increase in older people across the areas is being forecast, which could also increase the demand for mental health services, such as dementia.

Ward occupancy

- Overall occupancy is consistently high across most services, above 85%
- No service is showing a drastic rise in occupancy since 2017, only a steady increase each year
- Highest average occupancy is in PICU at 95% consistently across all wards.

Length of stay

- Adult acute average increase in length of stay (LoS) has risen annually (average 27 to 30 days)
- PICU inpatients is the only service where LoS has increased significantly, from 25 to 36 days on average over 3 years. This could be linked to significant use of out-of-area placements combined with increased patient acuity.

Potential future capacity requirements

A potential future capacity forecast has been produced based on:

- demand continuing to grow but at a reduced rate of 2%;
- 90% occupancy;
- repatriation of 50% for out of area patients.

This shows that by 2030:

- Adults will have a shortfall of just under 52 beds
- PICU will have a shortfall of 9 beds
- Older people with a shortfall of 61 beds
- An overall deficit of 111 beds.

Proposed capacity

It is clearly essential that service models must change if the potential capacity requirements are to be contained within the forecast funding flows. The following factors have been applied to the analysis.

- Planning for a substantial absorption of inpatient activity by enhanced community models of care (such as the Community Mental Health Framework Investment and the Additional Roles Reimbursement Scheme)
- Reducing average length of stay
- Further active management of bed demand and admission/discharge mechanisms particularly for PICU and Older Adult referrals to reduce episodes of care
- Enhanced Assertive Outreach to our most complex clients who regularly present to inpatient services
- Improved personality disorder service pathways to reduce multiple attendances and duplication of care across the care system
- Enhanced primary to secondary mental health interfaces with improved recovery support to reduce repeat referrals

- Dementia Enhanced Service Teams (DEST) to reduce crisis escalation of dementia clients leading to inpatient referrals from care homes and residential settings.

Overall, these factors will contribute up to a 40% reduction in inpatient activity, particularly focused on the older adult cohort, which will help to offset the increased demand of demographic change. Based on these corrections the proposed changes to bed numbers are as follows.

- Adult Acute will retain the same number of beds, with no increase.
- PICU will retain the same number of beds.
- Older people beds will continue at 2021 levels moving forward (these reduced by 18 in 2017 when Laurel Ward closed).

The changes proposed to achieve this have already been considered as part of the Covid-19 response and subsequent surge capacity planning, and this is expected to guide further development in community services to enable demand to be fully accommodated.

3.7 Sustainable Care and Improvement

To provide care sustainably we need to ensure that:

- The inpatient care and treatment model is of high quality, effective, and enabled by the staffing model and environment.
- Staffing provision is resilient in terms of scale and skill mix, and staff are clearly valued and supported.
- The care environment facilitates effective and safe treatment.

Through consolidation and collaboration across the BNSSG footprint, mental health service provision will also improve by following national recommendations to:

- Work in partnership with local stakeholders and voluntary organisations
- Co-produce with clinicians, experts-by-experience and carers
- Consider mental and physical health needs
- Plan for effective transitions between services
- Enable integration
- Draw on the best evidence, quality standards and NICE guidelines
- Make use of financial incentives to improve quality
- Emphasise early intervention, choice and personalisation and recovery
- Ensure services are provided with humanity, dignity and respect.

The challenge for the BNSSG system is to continue to meet the mental health needs of its population, and deliver improvements, in a way that is effective yet affordable and is underpinned by the clear principles described above. A detailed development of community services has commenced, and is being taken forward as a separate workstream. Also needed is a restructuring of inpatient services to improve quality, patient outcomes, and efficiency of delivery.

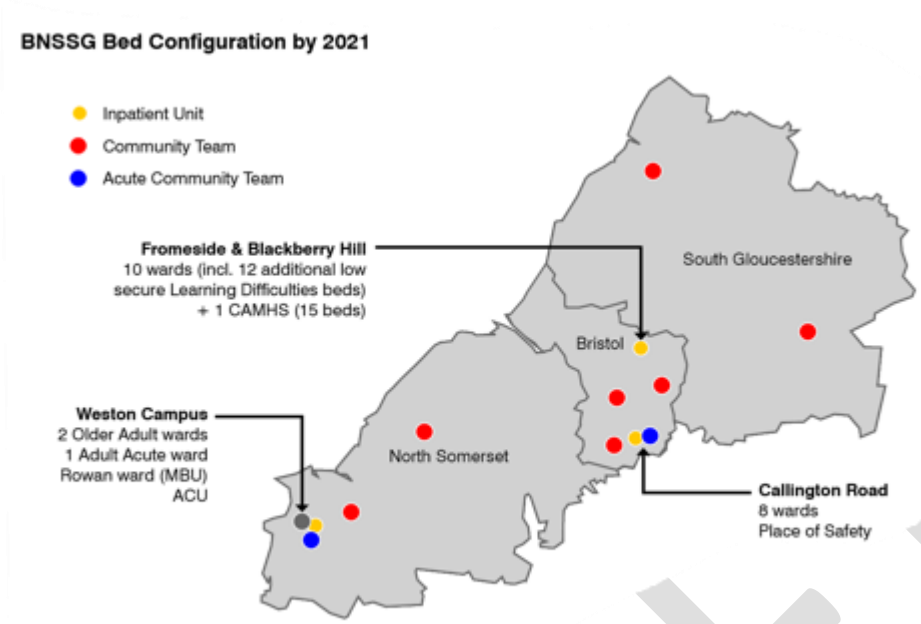
3.8 Proposed Change and its Impact

To achieve these service improvements in a sustainable and effective way, we need wards to be in groups of 4 or more, in safe and well-designed estate that supports the care approach. The options around this are discussed under Section 4, and have concluded that the best option is to consolidate AWP Southmead core inpatient services on to the Callington Road Hospital site.

The proposed transition programme will impact on a number of clinical units, enabling them to operate in more suitable and effective environments.

- In time, as demand rises, a higher proportion of caseload will be seen, and able to remain, in community settings. This applies to both Adult and Older Adult services.
- Oakwood ward will move to Callington Road Hospital;
- Place of Safety clients will be taken by Police to Callington Road Hospital rather than Southmead. (Prior to relocation to Southmead in 2016, the PoS service was previously at Callington Road);
- New Horizons will relocate to an alternative location in due course, this is subject to a separate business case under negotiation with NHSE & I Specialist Commissioning;
- Clifton Ward has temporarily relocated to the Blackberry Hill Hospital site and will be subject to further discussion as to its permanent location outside the scope of this case.
- Some elements of building detail design will improve ability of teams to manage Covid-19 risks and cases.
- It will be necessary for many staff to relocate along with their unit;
- Sections of the Southmead site will be vacant and offered to other stakeholders and in particular North Bristol NHS Trust (NBT) for their potential use;
- Rosa Burden unit will continue in NBT use.

Figure 11 - Proposed Bed Configuration



As a result of this consolidation there will be a total of 8 wards on the Callington Road site, which will provide a good staff skill mix across the site and improved cross-cover. The therapy teams of Southmead and Callington Road will be able to merge and operate as one site service, giving a better range of specialisms and therapies. The redesign of some wards will allow improved therapy provision within wards, and enabling outpatient therapy provision to be updated. In addition, specific wards will receive the following positive changes.

3.8.1 Adult Inpatient Services

The adult inpatient unit at Southmead has many aspects which limit good service delivery. Oakwood Ward has a cramped communal space, very little therapy space, poor observation lines including corridor tee junctions and dog-legs, small sloping gardens with many risks, close adjacent residential houses. A number of safety issues in the ward and gardens mean that high staffing is often required to maintain observation levels. Due to high bed numbers and poor visibility arrangements, interactions with clients are too often focussed around de-escalating issues that have progressed too far before being observed. It is too often necessary to place clients on overt close observation, when a more relaxed slightly distanced observation style would be preferred. The ward is noisy acoustically, and does not feel therapeutic or relaxed.

Oakwood Ward and Lime Ward at Callington Road have 23 beds, which exceeds the recommended ward size for providing safe and effective care. Oakwood is the only acute ward on the AWP Southmead site, with other wards being specialised services. Therefore, staff cross-over is limited, and Oakwood is somewhat stand-alone for staffing resilience.

For two years a step-down inpatient facility at Larch Unit was able to play a part in reducing delayed transfers of care. However, the service had several limitations. At only 10 beds it is not optimal in size for staffing ratios, and this is made worse by operating from a building with 2 floors that has very poor layout for observations

as it was designed for a lower risk rehabilitation service model. It has been difficult to identify clients suitable for this type of facility that could not in any case be discharged home with suitable care arrangements in the community, which also impacts upon overall occupancy levels.

To address these shortcomings it is proposed to relocate Oakwood to Callington Road site, by creating a new ward in space that was previously office and meeting space. This will enable Oakwood and Lime to be reduced to 19 beds, and also enable the 10 step-down beds to be accommodated as adult acute inpatient beds. The reconfigured service will be considerably more effective in treating patients, with a more relaxed management style, few "pressure points" in the communal spaces, less opportunity or temptation to engage in negative behaviours such as climbing, self-harm, or aggression. This will resolve the service quality and high-risk issues that currently exist and allow a high standard of care that is much more effective and delivered through an optimal staffing provision.

3.8.2 Health-based Place of Safety (POS)

Mason Place of Safety has a number of environmental safety and robustness issues and inadequate spatial design of some areas. It relocated to Southmead from Callington Road approximately 5 years ago when it became necessary to increase the size of the unit, and space could not easily be made available at Callington Road. It is a small unit not directly adjacent to other Acute wards, which reduces availability of staff when rapid response to incidents is needed.

Mason PoS was designed at a time when PoS services were holding clients up to 72 hours, so included full bedroom facilities, and is configured in a way which does not fully support the current service approach. The current expectation of assessing clients within a maximum of 24 hours requires a more flexible approach to use of space, improved assessment areas, and revised design to achieve most effective flow of care and use of staff. Due to increases in acuity over recent years, there needs to be improved observation arrangements. The inclusion of a Health Place of Safety close to the Emergency Department of an Acute Hospital also sometimes causes issues with clients presenting un-necessarily at one or other location.

To address these issues the unit will relocate back to Callington Road and be placed immediately adjacent to an Adult Acute ward (Lime Ward) so that staff can be shared between units if required. There will be access between the two units and a common alarm system so that urgent response can be provided to incidents. By relocating to the previous location of Callington Road it is expected that there will be fewer cases with primarily mental health need presenting at Southmead Emergency Department, and there will be fewer cases with primarily physical recovery needs presenting at the Place of Safety. This will be better for clients, and contribute to more efficient Emergency Department and mental health services.

3.8.3 Older Adult Inpatient Services

The older adult inpatient services have benefited from changes over recent years to the community service delivery, which have been enhanced to reduce the need for inpatient stays. As a result of this, a temporary reduction in older adult beds at Callington Road has been possible. Functional and dementia care beds are now offered from Aspen Ward on the Callington Road site, with care for the more complex dementia presentations being focussed at Dune Ward, Long Fox Unit, Weston-Super-Mare. It has not been necessary

to use the beds of Laurel ward for more than 4 years, and recently some beds at Long Fox have also been vacant for short periods.

The Covid-19 pandemic has further embedded this improved way of working, and clearly demonstrated that the enhanced community care model is effective. Risks and disadvantages of inpatient stays can be significantly reduced by care in the community, resulting in better outcomes and much improved patient experience.

Under this programme the reduction in older adult beds at Callington Road will consolidated into a permanent arrangement, to include Long Fox wards as part of the care system. Clients receiving inpatient care will be directed on a needs basis to either Callington Road (Aspen ward) or Long Fox Unit (Cove and Dune wards). Both sites will continue to cater for both functional and organic illness. Those with more complex dementia and frailty and physical health needs are likely to be admitted to Dune ward which is a dedicated Organic ward, located on an Acute hospital site, and is likely to have a community Frailty Hub in the same location. Aspen ward will benefit from the other changes to the Callington site configuration by review of the therapies models, and also the improvements to staffing skill mix and cross-cover on site.

3.9 Patient experience and safety

3.9.1 Quality Impact Assessment

The programme aims to improve the quality of care and the experience of patients requiring mental health care across Avon and Wiltshire mental health services. The service has carried out a full quality impact assessment (Appendix E) as a part of planning for this project which confirms that the proposal will enhance services through opportunity for better access, an improved environment, integrated care systems and a modern suitable environment for patient care. The performance of the project against its deliverable quality indicators will be assessed through patient feedback and outcomes analysis.

3.9.2 Patient experience

The scheme will specifically benefit patients through improved patient experience as a consequence of services being provided in an integrated way and in an improved environment. This includes:

- Ease of access.
- Integrated multi-professional services
- Care being delivered within the community environment and accessible to patient's
- Increased number of services available in an improved clinical environment
- Quality environment with increased privacy and dignity for all.

Consideration has also been given to the required safety, design and flow of the changed environment, to ensure easy access for all patients, providing them with an excellent environmental experience. The design and environment will enhance the ability of staff to work safely and as one team with efficient use of skill mix to support clinical needs of the patients.

An Equality Impact Assessment has been carried out to ensure that service user groups are not significantly adversely affected by the changes (Appendix F).

3.10 Workforce

The workforce within mental health service from a recruitment and retention perspective has been challenging over recent years.

Some areas within the BNSSG footprint have difficulties with the recruitment of qualified staff nurses. This is predominantly within the North Somerset footprint, recruitment into Bristol and South Gloucestershire is easier, as can be seen by our vacancy rate. There is some difficulty in retaining of staff to the inpatient environments as opportunities and progression arises within our expanding community services.

It is also felt that from a demographic perspective future issues could be high as significant numbers of staff within the teams are over 50 years of age. We need a development that provides a more modern and flexible opportunity to secure the future workforce.

By locating all of our inpatient units in Bristol on one site, this allows for economies of scale and sharing of skills and resources and career progression across the site. A single site model will support wards being able to cross cover at times of either high acuity or staffing challenges, helping to reduce the current dependence on temporary staffing in inpatient services. It will also enable support services such as therapies to be consolidated and wrap more consistently around services, improving patient care. These factors will contribute to significant improvements in the quality of care cost and efficiency. This is essential if we are to achieve the Trust target CQC rating of "Outstanding".

A number of national drivers for workforce have been incorporated in the proposal, including:

- Introduction of new roles including associate practitioners, nursing associate roles and physician's associates across BNSSG
- 7-day provision of services – multi-use facilities and ease of access
- Tele-health opportunities and technology advance and utilisation
- Weekend and out of hours' work
- Evidence of national benchmarking and use of workforce analytical tools to meet current and future delivery
- Training and development in new ways of working and inclusion of staff in re-design of services opportunities for more flexible and family friendly working practices.

The opportunities for change will also support a 7 day NHS, providing extended urgent and emergency mental health care services 24 hours a day, as exists for physical health care. Mental health services will be delivered by multi-disciplinary integrated teams, with named, accountable clinicians, across primary, secondary and social care. They will include provision of care for substance misuse issues.

3.11 Design and buildings

Since commencement of the design of the project, engagement has taken place to ensure that the requirements of the developments were discussed with all relevant and appropriate stakeholders. As the scheme progresses each of the agreed groups will have a named lead resource to attend designated meetings and give feedback to all members of their team. This will ensure continuity throughout the decision-making

process to ensure the options are clinically appropriate in terms of change of use and layout of the rooms and adjacencies.

The reconfigured ward areas will provide wards between 15 – 19 beds and will meet all safety standards in regards to health & safety and ligature standards making the facility fit for purpose and meeting the necessary national requirements for patient safety. Further safety improvements are also expected by removing isolation of units and improving resilience of support on the Callington Road site.

By locating on one site further improvements can be made. An enhanced skill mix of staff will ensure that the service is able to 'get the teams right' reducing risk, reducing incidents of aggression by improved de-escalation opportunities, and reducing incidents of self-harm including suicide prevention by improved observation. These will be measurable improvements in experience and outcomes.

Clinical staff expect that by combining services there will be opportunity to further increase their involvement in multi-professional training and research. This ensures that accreditation and national standards are sustained.

The preferred option reflects the importance of flexibility and quality and is informed by the latest design guidance where appropriate. There will be a number of benefits in terms of functionality, quality and efficiencies for patients and staff. The improved environment will be tailored to the needs of patients with mental health needs and will be in line with the provision of high quality and safe care. Regulatory compliance in terms of health and safety and infection control standards will also be met.

The space provided will serve multi-professional working and is designed for future flexibility and clinical effectiveness in care delivery. This will enable new care models to be implemented for operational efficiencies and good patient experience. The environment will also support information technology and record integration supporting joint mental health and physical health approaches.

As part of the design process a schedule of accommodation (SOA) has been prepared (see Appendix G). This has provided an assessment of the space needed based to meet the agreed functionality principles. The SOA will be fine-tuned as part of the phased implementation process to reflect detailed clinical requirement and service flows.

A key aspect of the design is that spaces have been planned to maximise beneficial use. Outpatient space is reduced in order to use it more intensively, and rooms such as meeting, consulting, and supervision rooms have been planned as multi-purpose rooms. Likewise inpatient communal rooms have been designed where necessary to be multi-functional to optimise the use of space in wards. As a result the occupancy level of the Callington Road site is expected to be close to 100%.

Various aspects of the design will enhance overall energy efficiencies, which will help to meet NHS sustainability targets but will also contribute significantly to the care environment and to recovery. Energy-efficient LED lighting will be used, with appropriate dimming and automatic switching. Building temperature control and heat emitters will be improved wherever possible, which will be a significant improvement on the inadequate control at Southmead. The PFI site is in general more energy efficient than the Southmead site which will in any case become surplus, but the design is now based on most recent standards in insulation, lighting, low-carbon heating. The Trust has declared a Climate Emergency, and there is an aspiration to use this programme as an opportunity to deliver net zero carbon for all or part of the Callington Road site, but this will require top-up funding to be secured over the course of the programme.

3.12 Learning and Continuous Improvement

The investment in mental health services supports a culture for continuous improvement giving a clear vision and direction. This programme allows for the delivery of services that can be continuously improved through support of a high-quality environment that meets the needs of patients. The quality of the final developments will be assessed through the design quality indicator review process and the delivery of improved care for patients will be evaluated as part of a post project benefits analysis (see Section 7).

4 The Economic Case

4.1 Introduction

In accordance with the Capital Investment Manual and requirements of HM Treasury's Green Book (A Guide to Investment Appraisal in the Public Sector), this section of the FBC documents the options review process which concludes with the most effective option that best meets the Trust's service needs and optimises value for money.

4.2 Critical success factors

These Critical Success Factors (CSF) have been used alongside the investment objectives for the project to evaluate the long list of possible options. The key CSFs for the proposed project are set out below.

- CSF1: business needs – how well the option satisfies the existing and future business needs of the organisation;
- CSF2: strategic fit – how well the option provides holistic fit and synergy with other key elements of national, STP and Trust strategies;
- CSF3: benefits optimisation – how well the option optimises the potential return on expenditure – business outcomes and benefits (qualitative and quantitative, direct and indirect to the organisation) – and assists in improving overall VFM (economy, efficiency and effectiveness);
- CSF4: potential achievability – the organisation's ability to innovate, adapt, introduce, support and manage the required level of change, including the management of associated risks and the need for supporting skills (capacity and capability). Also, the organisation's ability to engender acceptance by staff and local community;
- CSF5: potential affordability – the organisation's ability to fund the required level of expenditure – namely, the capital and revenue consequences associated with the proposed investment.

4.3 Economic Investment Objectives

The table below sets out the investment objectives which have been identified by the programme team.

Table 4 - Investment objectives

Investment objective	KPI	New / Existing	What it means for service users
Rebalanced bed types to meet demand sustainably	Out of Trust bed day numbers as part of the agreed LTP improvement trajectory Historical DTOC levels vs revised levels Length of stay profile and reduction by cluster group % occupancy over 3 month intervals	Existing	Fewer service users sent out of geographical area for care Care in hospital will be for shorter periods

Investment objective	KPI	New / Existing	What it means for service users
Improved systems for community mental health services, including PCLS, IAPT, Intensive / Crisis teams, Core 24 and Place of Safety, evidenced by improvements in:	Waiting times for emergency assessment Waiting times for urgent and routine assessment Management of admissions process Activity information Waiting times for treatment Waiting times for assessment (psychiatric liaison services) Contacts within each service (street and control room triage) Referrals (street and control room triage) Diversion rate from S136	Existing	Quicker access to right care, resulting in less escalation of symptoms and faster recovery
Increased efficiency of service provision as a result of improvements in:	Improved use of space monitored through ERIC returns Disposes of existing void space Creates disposal opportunity	Existing	Excess space cost savings are invested in improving quality
Improvements in key staffing indicators over fixed time periods, specifically:	Retention rate Sickness/Absence rates Number of shifts covered by Bank Number of shifts covered by Agency Number of shifts managed through cross cover	Existing & new	More consistent care service levels and quality
Reduction of estate risks and backlog maintenance	Reduced value of estate backlog maintenance Reduction in significant estates risks Reduction in estate operating costs (per bed, per m2, per desk)	Existing	Improved quality and safety of estate

4.4 Options Appraisal Framework Approach

In line with Green Book guidance, identification of options for the Project has taken place in two stages:

1 Creation of a long-list of possible options that could meet the investment or spending objectives of the Project;

2 Refinement of the long-list of possible options into a short-list of feasible options for further appraisal, using the options framework.

As per the Treasury Green Book guidance (chapter 5) the options framework as set out in the table below was used to identify the long list options and a preferred way forward.

Table 5 - Options framework

Project	BAU/ Do Nothing	Do minimum	Intermediate 1	Intermediate 2	Do maximum/ Ambitious
1. Service Scope – as outlined in strategic case	1.0 Do nothing – no service change or improvement	1.1 Make minimum improvements to existing services within site and current staffing constraints	1.2 Significant improvements to existing services within existing sites.	1.3 Reconfiguration of services in alternative estate with significant improvements	1.4 Total service redesign, new build facility in new optimal location.
	Discounted	Carried Forward	Carried Forward	Preferred Way Forward	Discounted
2. Service Solution – in relation to the preferred scope	2.0 Beds remain at Southmead campus			2.1 Beds transfer to Callington Road campus	
	Carried Forward			Preferred Way Forward	
3. Service Delivery – in relation to preferred scope and solution	3.0 Local Contractor	3.1 Regional Contractor	3.2 National Contractor	3.3 PFI Partner	
	Discounted	Carried Forward	Carried Forward	Preferred Way Forward	
4. Implementation – in relation to preferred scope, solution and method of service delivery	4.0 Big Bang over 1 year	4.1 Phased over 2 years	4.2 Phased over 2-4 years	4.3 Phased over 4 years	
	Discounted	Carried Forward	Preferred Way Forward	Carried Forward	
5. Funding – in relation to preferred scope, solution, method of service delivery, implementation	5.0 Public PFI	5.1 Mixed Public and PFI	5.2 Private		
	Preferred Way Forward	Carried Forward	Discounted		

4.5 Long List - Identifying a preferred way forward

The long list was appraised using the CSFs and investment objectives, to then identify a preferred way forward. The table below provides the outcome of these reviews, identifying whether the option was carried forward or discounted (see table 6 below for full descriptions).

Table 6 - Summary shortlist of options

Options	1. BAU	2. Do Minimum	3. Intermediate	4. Intermediate – preferred way forward	5. Do Maximum
Project Scope	1.0	1.1	1.2	1.3	1.4
Project Solution	2.0	2.0	2.0	2.1	N/A
Service Delivery	N/A	3.1	3.2	3.3	N/A
Project Implementation	N/A	4.1/4.2	4.2/4.3	4.2	N/A
Funding	N/A	5.1	5.0/5.1	5.0	N/A

The key criteria for short listing were based on the extent to which each option met the investment objectives and CSFs. Option 4 is noted as the preferred way forward; co-locate services onto the Callington Road site, by reconfiguring the PFI accommodation.

Table 7 - Outcomes of options review against objectives & CSFs

Options	Finding
1. Do Nothing /BAU; accept the current position and make no changes to the current estate configuration and accept the associated limitations on clinical models.	This option accepts the current position and make no changes to the current estate configuration. There are no advantages with this option. Implementation costs would be nil, but the revenue costs of operation are higher in the medium-long term (see Option 4 analysis). The main disadvantages are that the Trust would continue to deliver services across a fragmented site with existing vacant and underused buildings. The current water system risk and other backlog issues would not be resolved. These and various other disadvantages of continuing as at present are covered in the Option 4 analysis **This option was discounted** as it does not fit within the Trust's Estate Strategy and approved rationalisation plan and has no clinical benefits or financial benefits. There would be no release of potential surplus land for potential future service development nor any efficiency gains realised.
2. Do Minimum; Undertake remedial works to replace pipework at the Southmead site to address current water system and other compliance issues. Beds remain at Southmead, using a regional/national contractor, phased over 3 years using public and PFI funding.	This option will address the estates compliance issues at the site. The main advantages are that this would enable the Trust to address the some of the existing compliance issues at the site (noting that fitness-for-purpose issues would not be covered). The main disadvantages are that this would not address the poor utilisation. The existing ward configuration does not support the Trust's clinical standards. The costs are prohibitive at £9.1 million due to the extent of the infection throughout the water supply. There would be no release of potential surplus land for future service development or for improved BNSSG System use. **This option was carried forward**, as it does address some of the compliance estate issues and would be potentially affordable and achievable than Intermediate Option 1. However, it does not meet the Trust's Estate Strategy and rationalisation plan and cannot economically address its fitness for purpose and hence estate utilisation issues.
3. Intermediate Option 1; Refurbish the existing buildings at Southmead to address compliance issues and new models of care. Beds remain at Southmead, using a regional/national contractor, phased over 3 years using public and PFI funding.	This option will reconfigure the use of existing buildings to meet the Trust's clinical strategy. The main advantages are that this would enable the services to function within compliant, fit for purpose accommodation. The main disadvantages are that the existing vacant buildings would need to be demolished and re-built on site as they are not fit for purpose. The costs would be prohibitive and the impact on service continuity would be significant during construction. **This option was discounted** as it would be cost prohibitive and would have a significant impact on service continuity. There would be no release of potential surplus land for future service development See figure 12 below for current Southmead buildings.

Options	Finding
4. Intermediate Option 2 'preferred way forward'; Co-locate services onto the Callington Road site by Reconfiguring the PFI accommodation, which is currently inadequately used for high value services, including improvements to support new clinical drivers. Works to be phased over 4 years and carried out by a PFI partner.	This option would take the opportunity of co-locating all inpatient services in Bristol on to the same site at Callington Road Hospital. The main advantages are that this would enable reconfiguration of wards / number of beds - these changes enable the Trust to increase capacity in specific specialities and therefore reduce the usage of out of Trust placements. This serves to both reduce expenditure by reducing external bed usage, but also improve the patient journey and outcomes. This would enable the potential for future land reultilisation for other health provision within the STP Southmead footprint The main disadvantages are the anticipated increased unitary charge costs due to the PFI contract. However, these would be mitigated by improved utilisation efficiency at the Callington Road site, and by the fact that the services to transfer already exist in the contract specification and are already provided at Callington Road. **This option was carried forward, and was subsequently identified as the preferred way forward**, as it would meet all of the benefits criteria and enable the Trust to respond to the challenges set out in the Mental Health Five Year Forward View and the BNSSG STP. See figure 13 below showing all current buildings at Callington Road.
5. Do Maximum; New build facility – Obtain a development site elsewhere within BNSSG, create a purpose built facility while retaining PFI estate.	The Trust could acquire a green field site and construct a new purpose built facility to replace the Southmead site, while retaining the Callington Road PFI site unchanged. The main advantages are that there is no impact on existing services during construction. The main disadvantages are the inherent risks and time associated with the acquisition of a green field site. The costs of implementation would be prohibitive. **This the most ambitious option and was discounted** due to the cost and risks associated with the acquisition of a new green field site and planning permission for a new build facility are significant. This option would meet the business need, benefits realisation, but not the Trust's Estate Strategy or rationalisation plan and it is higher risk regarding affordability and achievability.

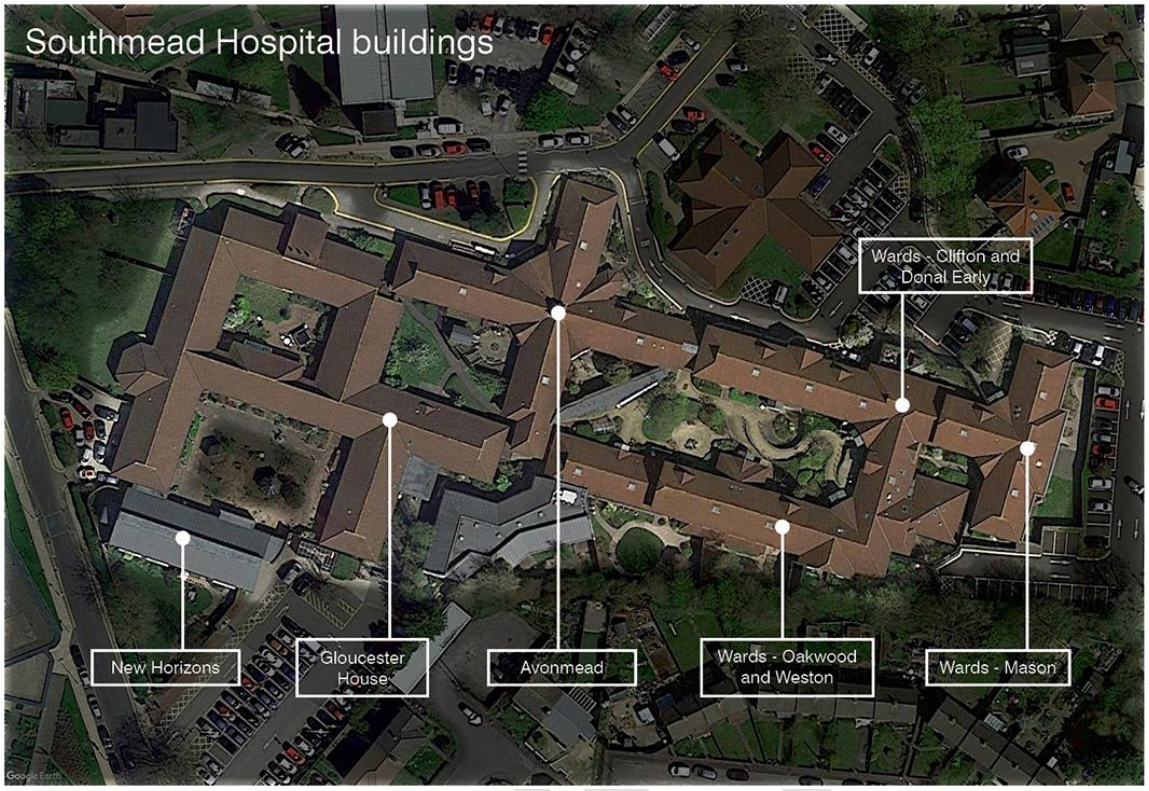


Figure 12 - Current AWP buildings at Southmead site

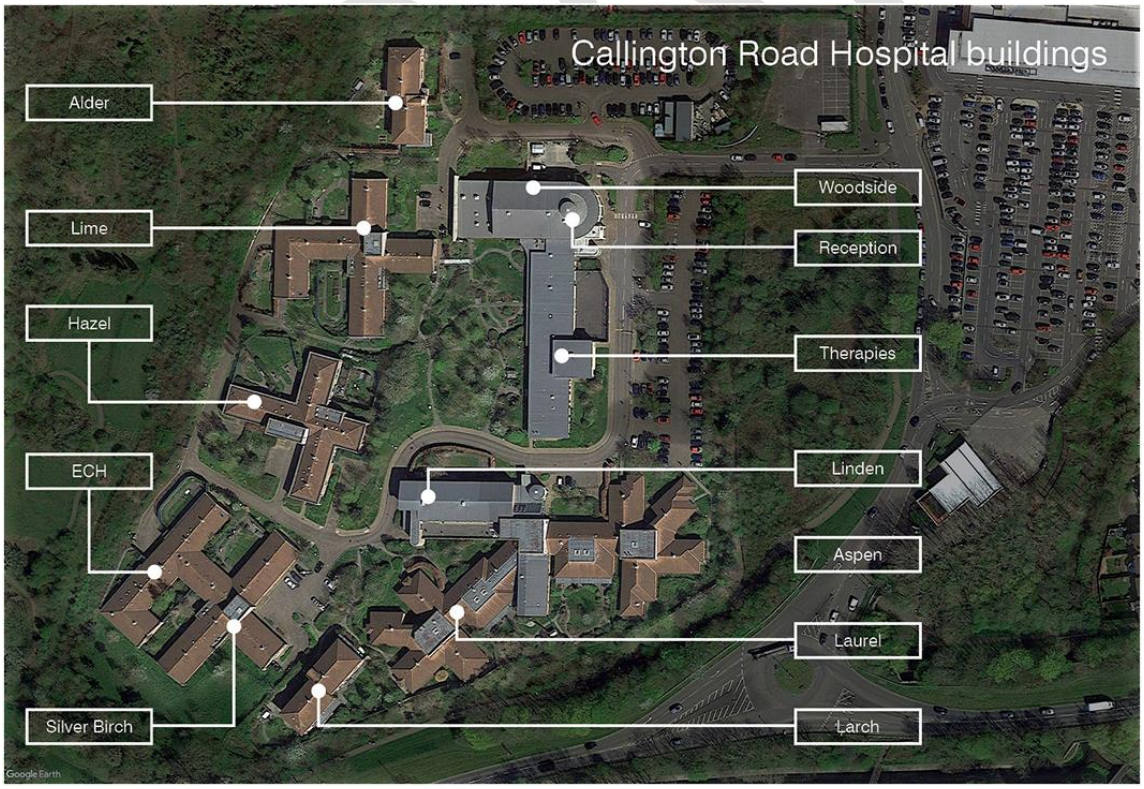


Figure 13 - Current AWP buildings at Callington Road site

4.6 Short List – Identifying the Preferred Option

The long-listed options were subject to further assessment to produce a shortlist, involving a SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) using the CSFs and investment objectives, the outcomes of which are shown in the summary table below.

Table 8 - Shortlisted options summary assessment

Reference to:	Option 2	Option 4
Spending Objectives	Do Minimum	Intermediate
1. Rebalanced bed types to meet demand sustainably	?	√
2. Improved systems for community mental health services	X	X
3. Facilitating improved bed management	?	√
4. Increased efficiency service provision	X	√
5. Improvements in key staffing indicators	X	√
6. Reduction of estate risks and backlog maintenance	?	√
Critical Success Factors		
1. Business need	X	√
2. Strategic fit	X	√
3. Benefits Optimisation	X	?
4. Potential achievability	√	√
5. Potential affordability	X	√
SUMMARY	Possible	Preferred Option

Following the above short-listing process, the Trust determined that there are two principal options to be considered, with one preferred option:

- Option 2 – Do Minimum – Possible: Make minimum improvements to existing services within site and current staffing constraints. This option has significant issues with affordability, effectiveness, and quality, and hence with overall value for money.
- Option 4 – Intermediate – Preferred Option: Reconfiguration of services in alternative estate with significant improvements. This option is to re-configure under-utilised day-service accommodation at Callington Road to enable the co-location of all core inpatient services in Bristol onto the same site. It enables 10 Larch step-down beds to incorporated into other wards on site as Adult Acute provision, and the Larch building to be re-utilised for outpatient services. The re-provision will enable an additional ward to be created at Callington Road that also alleviates excess bed numbers in the current Oakwood and Lime ward configurations.

4.7 Short-listed options - Indicative Costs

4.7.1 Estimating of Costs

Both options have initially been appraised from a current value revenue / capital perspective to assess the financial impact and the likelihood of payback and VFM being delivered. Where the opportunity for payback is identified, the financial benefits appraisal has been undertaken utilising a standard Treasury approved Value

for Money (VfM) template. This utilises all the lifetime costs of the project (both capital and revenue) and then discounts those costs by Treasury inflation assumptions to arrive at a single Net Present Value cost to compare with the qualitative evaluation.

Costs included within the VfM template are based on the revenue and capital costs outlined in section 6 but as required the Treasury Green Book nominal costs as follows:

- VAT is excluded as this is defined as an economic transfer (as per Green Book para 6.7). Where revenue and capital costs outlined in section 6 includes VAT then this has been deducted to arrive at the appropriate figures
- All costs have been expressed at standard prices as at 2021/22 (as per green Book para 5.11). Costs have been forecast on an annual basis over the whole lifetime of the project, which is taken as 20 years, though noting that the remaining lives of the buildings are 40 years.

Timeline

- Year 0 (2020/21) represents the first year in which any investment commences, notably the full design and tendering of the scheme through the Trust PFI provider.
- Year 1 (2021/22) Conclusion of the design and legal works commenced in year 0;
- Year 2 (2022/23) first year of construction, part in use;
- Year 3 (2023/24) second year of construction, part in use;
- Year 4 (2024/25) third year of construction, part in use;
- Year 5 (2025/26) fourth and final year of construction, part in use;
- Year 6 (2026/27) first full year of operation

A 'high level' summary of the options is outlined below, with the full details outlined in Section 6 and within the VFM template in Appendix H.

4.7.2 Option 2 – Do Minimum: remedial works at the Southmead

To keep the AWP Southmead site safe in the long term within a cost effective envelope, there are a number of functional suitability and safety issues that need to be resolved.

The old water circulation system has had serious issues in recent years, and these will be ongoing. The system will require replacement in the short to medium term and will continue to have high running costs in the meantime. The costs to do this were assessed in 2016 and totalled £2.2m and included significant decant issues and potential interruptions to clinical services. In addition to this, there are critical safety and backlog maintenance issues that would require immediate attention should the buildings continue to be in use for the medium to long term. There would be a significant capital requirement in order to complete these works which the Trust is not able to cover from within internal capital resources and so would require a further business case to be completed to secure external capital. As the ward configurations associated with this option would remain broadly per the current "as is" model, no efficiencies would be released and so describing the VFM and payback associated with this scheme would not be possible.

The capital investment would also attract new capital charges which would have no identified revenue funding source leaving this proposal ultimately costing the wider system more than is currently the case.

The capital / revenue costs associated with this option and the correction of the identified issues are summarised in the table below.

Table 9 – Capital Costs for Shortlisted options

Item	Cost (£m)	Notes
Replace water system and physical condition works	4.9	Water system works and physical condition capital works including critical backlog
Functional suitability works	3.5	Costs to rectify functional suitability non-compliances where possible
Decant costs	0.5	Costs to decant patients safely whilst works take place
Critical IT replacement	0.2	Including network upgrades, Wi-Fi and telephony improvements to AWP standard
Total Costs	9.1	

Option 2 - Do-minimum	Revenue cost / efficiencies
	£'000
Annual cost / efficiencies	
Efficiency savings generated	0
Additional capital charges	338
Wider BNSSG system benefit	0
Total	338

As these tables demonstrate, this option requires significant, currently unidentified, capital with additional capital charges and no realisable efficiency savings. Therefore, it does not meet the criteria to undertake a full VFM assessment.

Option 4 – Preferred Option: re-configure under-utilised accommodation at Callington Road to enable the co-location of all core inpatient services in Bristol onto the same site

Under this option, the Trust would re-provide the following services from the AWP Southmead (SMD) site on the Callington Road Hospital (CRH) site:

- Adult Inpatient - Oakwood currently 23 beds;
- Place of Safety – Mason;

This option also enables 10 Larch step-down beds to incorporated into other wards on site as Adult Acute provision, and the Larch building to be re-utilised for an alternative service. The reprovision will enable an additional ward to be created at Callington Road Hospital (CRH) that alleviates excess bed numbers in the current Oakwood and Lime wards:

- Move SMD Oakwood ward to CRH Laurel (to be designated Cherry ward), 19 beds:

- Move Southmead Place of Safety to CRH part of Lime unit, reducing Lime from 23 to 19 beds;
- Therapy rooms to move from CRH Woodside (ground floor) to Larch building;
- New ward to be created in CRH Woodside (ground floor), 19 beds;

The re-provision of the Southmead New Horizons Mother and Baby Unit is being considered by way of a separate stand-alone business case and does not form part of this business case. Day services at Gloucester House will remain on the Southmead campus and may be subject to a separate Community Services review in future.

The reconfiguration option being proposed by the Trust in this case to reconfigure the existing buildings and commissioned bed stock at Callington Road is as follows:-

Table 10 - Current v proposed bed base

Location	Currently commissioned beds	Proposed commissioned beds at programme end
Oakwood	23	19
Silver Birch	19	19
Lime	23	18
Larch	10	0
New Ward (Woodside)	-	19
Total	74	74

This relocation would remove the necessity to spend a material amount of unidentified capital on the Southmead site by significantly reducing both the current backlog maintenance value and the CIR – these be negated in full upon the potential future move of the Mother & Baby Unit from the Southmead site (not included within the scope of this case). It will also maintain the number of adult acute beds currently available, whilst maximising the opportunity to release the following recurrent revenue savings:

Description	Trust £000	CCG £000
Reduction in commissioner income for in-scope services	0	183
Improved Trust contribution (release of environmental staffing pressures)	271	0
Improved overall acute occupancy following closure of Larch reducing OOA numbers	256	256
Gain from overall reduction in capital charges	9	0
	535	**439**

Total Recurent Savings: **974**

Running this preferred option through the VFM template delivers the following high level benefits which remain consistent with the original submission:

	2021/22	2022/23	2023/24	2024/25	2025/26
Revenue savings	511,000	511,000	694,000	694,000	694,000
Initial Capex	10,445,000				
Average annual revenue saving 21/22 - 25/26 (next Spending Review period)	620,800				
Revenue savings as a proportion of initial capex	6%				
Payback period	14				
Return on Investment	116%				

4.8 Non Cash Releasing benefits from the Economic appraisal

The economic appraisal identifies the following non cash releasing benefits;

Number	Benefit Name	Benefit Description
1	Improved theraputic interventions	Delivering higher intensity therapeutic interventions in more specialised units is thought likely to deliver reductions to average length of inpatient stays - beneficial both to patient experience and bed utilisation
2	Removal of isolated services through consolidation	Developing highly specialised inpatient services on sites hosuing multiple inpatient services serves to mitigate clinical risk associated with isolated services
3	Improved staff morale	Improved recruitment and retention associated with benefits of working in a more specialist environment, including high quality training and development programmes.
4	Improved quality standards through consolidation	Quality and safety can be delivered at lower staffing levels than is the case for some of the isolated wards and units thus reducing reliance on short term agency staffing and improving quality and contiunity of care provided to patients
5	Supporting the delivery of the Five Year Forward View (FYFV)	Supports delivery of FYFV for MH aspirations, via creating capacity for new priority service developments, whilst contributing significantly to the parity of esteem agenda. Also frees up estate elsewhere within the STP for future reprovision / redevelopment

4.9 The Preferred Option

The economic assessment of the options indicates that only Option 4 warrants completion of the full VFM assessment, as Option 2 would result in an overall cost to the BNSSG system as well as relying upon currently unidentified capital funding. Therefore, Option 4 is the only option that meets the criteria to be taken forward with clearly identified funding sources. This is to reconfigure PFI accommodation at Callington Road to be able to transfer core inpatient services from the Southmead site.

4.10 Main risks

The following key risks were highlighted in the VFM Assessment in support of the STP allocation.

Table 11 - Summary of Key Risks (VfM Assessment)

Number	Risk description	Mitigation of risk	Risk likelihood after mitigation	Risk impact after mitigation
1	Ensuring that current levels of demand are managed to ensure that the capacity of the consolidated units reflects required capacity and is sufficiently future proofed	Demand and capacity modelling to be implemented alongside expectations for how new models of care will reduce the current and future need for in-patient admission. Leadership teams will work to address any areas causing delay in the care pathways to ensure the new capacity reflects expectations in line with best practice.	Medium	Medium
2	If Overview and Scrutiny Committees and Service User representative groups are not sufficiently engaged in the development of these plans, there is a risk that it will not be possible to implement within the proposed timeframes	A robust communication and stakeholder management plan is in place to ensure sufficient engagement is undertaken.	Medium	Medium
3	Procurement and site development takes significantly longer than planned and lengthens scheme payback period	The phasing of the various components of the scheme has been carefully considered. Robust project management arrangements will be put in place to ensure the PFI partner delivers the required schemes to the agreed programme.	Low	Medium
4	Recruitment and retention of staff remains challenging and the continued use of temporary staff reduces the financial benefits associated with the scheme	Targeted recruitment plan has been implemented alongside BNSSG recruitment and retention strategy. A review of opportunities will take place to advertise new models of care and how further flexible working opportunities and incentives for permanent members of staff can be implemented within the new working environments and across the communtiy and hospital pathways.	Medium	Medium

All risks will be identified and incorporated into the project and Trust Risk Register and managed accordingly as described in more detail in the Management Case section.

4.11 Constraints

The project is subject to the following constraints:

- Final funding approval is currently outstanding: This business case is being presented to NHS England / Improvement for funding to be secured to enable the scheme to move to full development. The business case is fully supported by BNSSG and AWP to move ahead once this is approved in line with the Clinical and Estate Strategy.
- Because the development will take place on an operational site, the sequencing and project timetable will be reserved by the need to fit in with the ongoing clinical needs of the service and maintenance of safe operations at all times.
- The scheme must meet all elements of the programme within the costs identified within the VFM template and to be delivered within 4 financial years, post formal approval. There will also be a need to demonstrate financial sustainability through the implementation of the project.
- Car parking policy and sustainable travel initiatives will need to be considered, as additional parking cannot be included within the premises design and there may be a small impact on the use of off-site parking.

4.12 Dependencies

The project is subject to the following dependencies that will be carefully monitored and managed throughout the lifespan of the scheme.

- Formal approval of funding to meet the requirements of the project
- Full business case approval by NHSE with sign off of the completed technical drawings.

The Five Year Forward View for Mental Health and local STP transformation plans are significant in both scope and scale of change. Whilst the estates transformation set out in this business case focuses on the BNSSG footprint, there are a range of other transformation programmes that must be considered as being interdependent with this programme, as follows.

Table 12 - Interdependencies

Interdependency	Risk	Mitigation
The Estates Programme is reliant on the Trust Transformation Programme delivering its objectives to manage demand and capacity in the system	There is a risk that if the Trust Transformation Programme, particularly to Community services, does not ensure that the Trust can manage within its existing bed base, then additional bed capacity could be required	Detailed modelling and adjustment of ward bed numbers to ensure maximum efficiency Ongoing detailed management and analysis of bed demand through Beds Management processes
Alongside this programme there is a need to relocate the New Horizons MBU, which is the subject of a Spec Comm business case and programme that must run alongside this programme.	If the MBU business case options are required to include Callington Road Hospital as a strong option, this could impact on the detailed ward configurations on site, and hence on timescale and deliverability.	Strong options for the MBU service which meet Spec Comm requirements do exist nearby to the BNSSG footprint and are currently being worked up.
Covid-19 The Response to Covid-19 is leading to relatively minor changes in ways the mental health estate is configured. It is not clear if these changes will affect long-term design principles for Mental Health wards.	If Covid-19 estate principles need to become long-term design principles, then current designs may need to change in the course of this programme.	Design changes for Covid-19 considered to date are relatively minor and can be accommodated. The Callington Road buildings are fairly flexible in configuration. For example they would enable some smaller suites of rooms to be created, or ventilation systems to be introduced.

5 The Commercial Case

5.1 Introduction

The report above has outlined a range of options that have been considered as the long list. The commercial options and opportunities considered in assessing the long list included those below:

- Procurement via tendering (either standard procurement or P22) and funding through PDC;
- Procurement through lease, with significant landlord capital investment;
- Procurement via existing contracts for PFI sites, which includes obligations for Project Co to demonstrate value for money;

Commercial opportunities to lease out space to stakeholder third parties have been taken into account.

The continually developing working arrangements with stakeholders such as third sector providers, Acute or Community hospitals, and Social Services do not currently require a significant inpatient colocation strategy in the medium term. AWP takes an active part in the STP and One Public Estate for BNSSG area, and will identify opportunities as they arise, but these are likely to contribute spoke sites for local community activity rather than the inpatient centres discussed here.

Commercial opportunities for retail and cafés have been considered both for this business case and in the past. For mental health sites there is very little opportunity, due to the requirements of the client group, and the very limited public footfall on site. The primary site in this business case, Callington Road Hospital, has a large Tesco with café immediately adjacent, which further reduces the need for onsite retail.

There is a potential leasing aspect to ongoing discussions about the provision of existing rehabilitation services on Callington Road Hospital. The current position is that the service will continue with AWP in the medium term and, if transferred to others, could operate from its existing location at Callington Road on a leased-out basis. If it was released for other use, the building would very usefully be converted to outpatient use.

The short list of options includes a potential do-minimum option, which has commercial matters to consider. If continuing with Southmead site, AWP would need to continue to lease out parts of the site (Avonmead, Gloucester House), and to find a tenant for the long vacant Weston Ward. This has not proved possible to date, as it is unfit for purpose without major investment, and is poorly located for access by others. It would be a significant cost risk and might need to be leased at a loss just to receive some income and cover the tenant's investment costs.

The preferred short-listed option is to invest in the Callington Road Hospital site, which is good quality estate fully operated under a PFI contract which has approximately 15 years term remaining. The remainder of this section therefore considers how the Callington Road option would be delivered through the PFI contract.

5.2 Design Development

5.2.1 Design principles of the new facility

The redevelopment will provide the following accommodation:

- Ward spaces and bedrooms compliant with relevant mental health guidance such as HBN03
- Therapeutic and relaxing communal space with due attention to spatial design, light, and acoustics
- Safe and suitable clinical space, comprising Treatment and Consultation Rooms,
- Satisfactory staff facilities;
- Toilet and waiting area improvements.
- Adequate administration space;

This will be delivered within a total floor space of approximately 3,500m² GIA.

5.2.2 Operational Design

The design phase has been led by architects Arturus, who are experienced Mental Health design, and appointed by Imagile as ProjectCo through its FM contractor Rydon Maintenance Ltd. No specific derogations from NHS Mental Health guidance have been noted.

The functional space requirements of Callington Road have been determined based on the activity objectives set by the Trust and its Commissioners based on the clinical strategy, and also agreed performance or utilisation assumptions identified with the clinical teams. The identified functional requirement was used to determine the Schedule of Accommodation (Appendix G) and hence prepare 1:200 drawings (Appendix Ii, Iii & Iiii) and replicated in small scale below.

Figure 14 - Callington Road Coppice ground floor plan

Figure 15 - Callington Road Woodside ground and first floor plans

Figure 16 - Callington Road Lime Place of Safety floor plans

5.3 Commercial Feasibility

The AWP PFI contract covers buildings on 5 sites, of which is Callington Road Hospital is the largest. The contract includes 2 mechanisms to achieve design changes within the PFI process. The PFI ProjectCo and associated FM contactor have been very supportive of this proposed procurement and variation and have carried out design work and provided indicative costings for the programme.

5.3.1 Contract Variation

Under this mechanism, the PFI project company (ProjectCo) is instructed to design, build and operate the required building changes, taking all risk as per the base PFI contract. This provision is intended for scenarios such as the current business case, where the property needs to be further developed. It includes an obligation to demonstrate value for money in the construction process.

Benefits

- ProjectCo takes risk as per original contract;
- ProjectCo agrees to adopt the works into the contract as part of their proposal;
- ProjectCo has responsibility to deliver works while keeping the remainder of the site fully operational;
- ProjectCo team has full knowledge of design of existing buildings, enabling best approach to alterations;

- Lifecycle charges for the existing buildings should be reduced by ProjectCo to take account of the new work that the Trust has funded;
- The capital element of the funding can be provided either by the Trust from its sources, or by the PFI provider through the PFI funders although this may carry a high long-term cost.

5.3.2 "Step In" rights

Under this mechanism, the Trust would undertake the work by directly employing all consultants and contractors and delivering the completed project. This mechanism is intended for when ProjectCo does not offer to meet the Trust's need on design or timescales. The Trust has used this approach in the past for urgent pieces of work, where the Trust had already defined the design needed for the improvements, for example where CQC requirements needed to be met. A variation is still required to enable ProjectCo to adopt the new works into its portfolio.

Benefits

The Trust can directly carry out, or influence, the design and timescales, meaning that design liability will rest with the Trust.

5.3.3 Risks (both methods)

ProjectCo may apply significant costs for risk, particularly operating risks such as lifecycle costs and patient damage, and design risks such as ligature reduction issues.

ProjectCo may decline to carry certain types of risk, particularly if new service user groups or expensive solutions are introduced to site. Although risks covered in the existing contract cannot technically be declined, they can be costed so high as to be non-viable.

The timescale to carry out a full formal design variation as part of a PFI contract can be quite lengthy, however this issue has been removed through the utilisation of the early fee draw down to expedite the full design, tender and variation process.

5.3.4 Contracting mechanism to be used

The PFI Contract Variation mechanism offers more advantages, as it is intended for this type of scenario, and would be the method of procurement for works to Callington Road Hospital.

5.4 Full planning approval and lease permissions

The vast majority of the proposed work consists of alterations within the envelope of existing buildings on the Callington Road Hospital PFI site, for which planning approval will not be required. There are two minor extensions required to Lime ward and Woodside to improve amenity space and access points. These are well within the core of the hospital site, minimal in nature, do not increase height, and are not overlooked, and the advice we have received via the PFI / through the early draw down process is that planning permissions will not be an issue. We have recent experience of a far more substantial extension of a similar nature to one of the existing wards on the Callington Road site where planning permission was deemed to be required but was successfully granted with no major issues.

No lease permissions are required. The Callington Road site PFI contractor is supportive of the proposals and the PFI contracting process to deliver the scheme is described in Section 5.

5.5 Procurement Strategy and Implementation Timescales

To implement a Contract Variation to the existing PFI contract the formal procedure is as follows:

- Trust specifies variation and ProjectCo responds with a design proposal, and all costs including operating costs;
- Trust prepares variation paperwork, which is subsequently approved by NHSE/I (transfer of risk approval) and AWP Board and signed;
- ProjectCo prepares detailed specifications in collaboration with Trust, and procures contractor;
- ProjectCo manages works construction to completion and handover.

For a brand new construction this procedure can take 1-2 years if sequential negotiation of each stage is undertaken. However, the Trust has good working relationships with our PFI provider, so we are able to carry out some stages of this process in parallel, with relatively small increases to risk (being mainly consultancy costs for design and works procurement), and by splitting the programme into phases. This leads to a process as follows for each phase:

- Specification and costing, detailed design – 3-4 months
- Preparation of variation and procurement of contractor – 3-4 months
- Contract approval by Board followed by commencement of works – 1-2 months

However, for the initial phase of the proposed programme, there are some funding imperatives that require faster timescales. Some initial work has already been undertaken in completing the strategic planning and in preparing this business case.

The above risks and timescales have been significantly reduced and expedited through the use of the early draw down of fees in order to complete the full design and tender process ahead of the approval of the full FBC. Contract variation completion is now pending the final sign off of this case.

Further details on programme phasing and timescales, which includes the phased procurement timescales, are given in section 7.8. These timescales include allowances for:

- Planning Applications;
- Building regulations compliance process;
- Pre-construction Mobilisation;
- Construction;
- Works commissioning.

5.6 Procurement Process

The procurement process will follow the standard PFI variation process, amended to improve timescales as described above.

5.7 Accountancy Treatment

The PFI estate is currently represented by a capital asset, together with a financial liability. The Trust will follow the guidance in the Group Accounting Manual (GAM) to ensure the relevant accounting treatment is used. The valuation requirements of IAS 16 (Property, Plant and Equipment) and IFRIC 12 (Service Concession Arrangements) will be followed to ensure the accounting transactions are correct.

For this investment to the existing Callington Road buildings, AWP will provide the capital for the investment, sourced from a BNSSG STP Wave 3 PDC capital allocation. As a result, a relatively minor additional PFI liability is expected, and has been included in the financial model. There will be some initial impairment against the capital investment that will be determined by the Trust valuer, in accordance with the GAM (e.g. design costs).The residual investment amount will be added to the Trust balance sheet alongside the existing PFI asset. This will then be depreciated in accordance with IFRS and subject to PDC charges, as per existing PFI assets.

This will involve obtaining a full valuation of the programme of works from the Trust valuer to ensure the net amount after impairment is added to the Trust fixed asset register. Whilst this expenditure is on a PFI site, the works are not funded by the PFI provider and therefore do not add to the PFI debt or to the Trust Unitary Charge. The net asset addition will be added to the Trust asset register and depreciated on a straight line basis over the useful remaining life of the asset which is anticipated to be 40 years. The only minor change to the PFI Unitary Charge will be some small change of use items that have been included in the revenue modelling for the case.

The effect of the capital expenditure, external funding and resulting impairments are all shown in the impact on Statement of Financial Position table in section 6.10.

5.8 Proposed Key Contractual Issues

It is proposed that the PFI variation process will be carried through to manage the following:

- Design and specifications to latest mental health and AWP standards, including current guidance and legislation;
- Consideration of key issues such as fire compliance and ligature risks, including CAS alerts;
- Provision of suitable designs and ownership of design risk;
- Delivery of works within an active operational site, including safe working;
- Management of works costs, and containment of capital cost pressures;
- Clear identification of maintenance and lifecycle revenue cost implications;

Anticipated areas of complexity are:

- Estimating annual cost risk of patient damage;
- Estimating cost of design risk in mental health settings.

5.9 Potential for Risk Transfer

The proposed scheme will be delivered through an existing PFI contract within the existing footprint, so the existing contracted risk transfer arrangements will remain in place.

However, the Callington Road site risk profile for maintenance will change due to converting out-patient space to inpatient units, leading to a revised unitary charge. Conversely, by reducing the number of beds on the Trust-owned Southmead site, the Trust is reducing its directly owned risk. Therefore, a transfer of risk for current Trust business at Southmead could be considered to take place. The services transferring to Callington Road are of a type that is already covered in the PFI contract so will be readily assessed in comparison to existing similar services on site.

5.10 Personnel Implications (including TUPE)

The personnel implications for Trust staff affected by the proposed reductions in Southmead (e.g. clinical, domestic, administration) are covered in the Management Case section 7. These are expected to be minimal overall. The personal circumstances of a few individuals may require detailed attention and potential consideration of redeployment, and some scope exists for suitable opportunities to be offered if necessary on alternative AWP sites nearby.

There will be no TUPE implications for amending the PFI contract as the work is almost all within the footprint of the existing PFI buildings, and does not reduce services.

If this programme proceeds the AWP Southmead site will have significantly reduced mental health service activity in future, and that the site may be mothballed for some time either under AWP ownership or another organisation. Various service contracts will be affected, but no TUPE transfers are expected arising from this programme. The maintenance contract for the site has provision for removing sites from the contract with minimal TUPE effect as it is a multi-site contract with no dedicated staff for any specific site. Other service contracts such as laundry services and security are in a similar situation.

6 The Financial Case

6.1 Introduction

The purpose of this section is to set out firm financial implications associated with the preferred option. It describes the impact on the main financial statements, outlines the efficiency savings released and forms a conclusion on the overall affordability. These costs are robust following the full design and tendering process that has been undertaken with the utilisation of the early fee funding. The remaining risk in this area is that the tender prices provided are only valid until November 2021 and although a further extension is likely to be possible to negotiate, the costs may be subject to further inflation, depending on the time taken to fully approve this FBC.

For the purposes of VfM, payback and Return on Investment, the financial case modelling has to consider the do nothing option against the preferred option in order to accurately assess the full financial impact of any capital investment being made. In reality and as outlined elsewhere in this case, do nothing is not an option given the quality and safety issues associated with the Southmead site, with a do-minimum option at a cost of £9.1 million being the only other option available.

6.2 Capital Costs

The capital costs outlined below are based on estimates provided by the Trust PFI provider, ProjectCo following detailed design work with their contractors. As the Callington Road site is PFI in nature, all construction will be provided through the existing contract that the Trust has in place with ProjectCo. The total cost of the project is £10.5 million, with a breakdown by category being shown in the table below;

	Total capital cost
	£'000
Construction	8,494
Design & PM fees	1,031
PFI related costs	164
Trust fees	206
Equipping	550
Total	**10,445**

6.3 Financing

Construction is anticipated to take place over four years, with the financing requirements shown in the table below. The programme will require £7.5 million to be drawn down in the form of STP Wave 3 Public Dividend Capital and the balance of £3.0 million will be funded by £2.5 million from BNSSG System Capital and £0.5 million from the Trust capital programme over the life of the project, giving a total of £10.5 million.

The vast majority of the payments will go through ProjectCo, with only the Trust fees and equipping being paid for directly by the Trust.

PROPOSED SOURCE OF CAPITAL Sources of funding to be accessed		BNSSG STP Wave 3 PDC, BNSSG System Capital and AWP Trust Capital					
	CAPITAL/NR REVENUE VALUE AND PROPOSED CASH FLOW OF FUNDING:						
PERIOD FUNDING SOURCE	2020/21 £'000	Current year 2021/22 £'000	2022/23 £'000	2023/24 £'000	2024/25 £'000	2025/26 £'000	Total £'000
Wave 3 PDC	600	677	1,102	2,465	1,977	679	7,500
BNSSG System Capital	0	0	0	500	1,000	1,000	2,500
AWP Trust Capital	0	0	110	110	110	115	445
Total	600	677	1,212	3,075	3,087	1,794	10,445

6.4 Revenue model

Detailed modelling has been undertaken at ward and site level in order to fully assess the financial impact of the proposed moves from the Southmead site. The "as is" Income / Expenditure position is outlined below:

AS IS MODEL								
Existing Configuration	**No of beds**	**Income / Proxy Income £000s**	**Direct costs £000s**	**HFM £000s**	**SFM £000s**	**Other £000s**	**Total £000s**	**Contribution £000s**
Southmead Site - In Scope Services								
Oakwood Ward	23	2,212	2,075	55	139	0	2,269	-57
New Horizon MBU	4	1,135	827	14	35	0	876	259
Clifton Ward - Eating Disorders	10	1,610	1,017	37	91	0	1,144	466
Mason Unit - Place of Safety	4	1,010	883	17	35	0	935	75
Total	**41**	**5,967**	**4,802**	**122**	**300**	**0**	**5,224**	**742**
Callington Road - In Scope Services								
Lime Ward	23	2,683	1,851	467	166	0	2,484	199
Laurel Ward	18	2,368	1,553	458	182	0	2,193	175
Larch Unit	10	1,319	856	275	152	0	1,283	35
Total	**51**	**6,370**	**4,261**	**1,200**	**500**	**0**	**5,960**	**410**
Total No. of Beds and Costs	**92**	**12,337**	**9,062**	**1,322**	**801**	**0**	**11,185**	**1,152**

Once all of the ward moves have been completed, the revised Income and Expenditure position looks as follows:

FOLLOWING PROJECT COMPLETION								
Revised Configuration	**No of beds**	**Income / Proxy Income £000s**	**Direct costs £000s**	**HFM £000s**	**SFM £000s**	**Other £000s**	**Total £000s**	**Contribution £000s**
Southmead Site - In Scope Services								
Oakwood Ward	0	0	0	0	0	0	0	0
Clifton Ward & MBU	0	0	0	0	0	0	0	0
Mason Unit - Place of Safety	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Callington Road - In Scope Services								
Lime Ward	19	2,570	1,747	467	166	0	2,380	190
Oakwood Ward	19	2,331	1,739	258	162	0	2,159	173
Cherry Ward	18	3,034	2,169	458	182	0	2,809	225
Mason Unit - Place of Safety	4	1,010	883	17	35	0	935	75
Larch Unit	0	462	0	275	152	0	427	35
Total	**60**	**9,408**	**6,538**	**1,474**	**698**	**0**	**8,710**	**698**
AWP Footprint								
MBU	4	1,135	827	14	35	0	876	259
Clifton Ward - Eating Disorders	10	1,610	1,017	37	91	0	1,144	466
Total	**14**	**2,745**	**1,844**	**51**	**126**	**0**	**2,021**	**724**
Total No. of Beds and Costs	**74**	**12,153**	**8,382**	**1,525**	**823**	**0**	**10,731**	**1,423**

A high level summary of the two key impacts delivered through these changes is outlined below:

Element	**£000**
"As is" Income for in-scope services	12,337
Revised Income for in-scope services	12,153
Net reduction in income released back to commissioner:	**183**

The overall income quantum required from commissioners for the services in the scope of this case are reduced, releasing £0.18m back to BNSSG CCG.

Element	£000
"As is" Trust contribution	1,152
Revised Trust Contribution	1,423
Contribution gain to the Trust	**271**

In addition to the income release back to BNSSG CCG, the overall level of contribution generated by the in-scope services increases by £0.27m. These benefits to the Trust position are released through an overall reduction in capital charges (reduction at Southmead as compared to additional charges incurred due to works at Callington Road) and through an improvement to the contribution generated by Oakwood Ward after relocation – this is realised through the release of additional staffing costs currently being incurred on the ward in its Southmead location due to environmental issues.

Finally, the following capital charge reduction is realised:

	No of beds	Income / Proxy Income	Direct costs	HFM	SFM	Other	Total	Contribution
		£000s	£000s	£000s	£000s	£000s	£000s	£000s
Existing Southmead site capital charges	-	346	0	0	0	320	320	26
New Capital Charges - Callington Road	-	333	0	0	0	309	309	24
							11	-2
							Net change:	9

6.5 Efficiency Savings

As noted in the economic case, additional system savings will be generated through the occupancy gain that is realised through the proposed ward reconfigurations. By replacing the existing 10 Larch step down beds with 10 adult acute beds, an inherent improvement in occupancy will help deliver a net reduction in adult acute out of area placements. This efficiency release is based upon the following:

	Occupancy %
Average Larch Occupancy Jun 19 - Nov 19	76.00%
Average Bristol Acute Occupancy Jun 19 - Nov 19	97.00%
Assumed occupancy gain	21.00%

	Bed Numbers
Larch Bed numbers	10
Bed gain/ OOA reduction based upon Larch bed numbers	2

	£
Average cost per day per OOA placement in 20/21 (inc. Specialling)	£700.00
Total efficiency saving for 2 OOA placements saved in FY	£511,000

This efficiency release is shared on a 50/50 basis by the Trust and the commissioner as any adult acute OOA expenditure currently runs through a contractual risk share arrangement.

The combined recurrent revenue savings generated by all of these changes is summarised below:

Description	Trust £000	CCG £000
Reduction in commissioner income for in-scope services	0	183
Improved Trust contribution (release of environmental staffing pressures)	271	0
Improved overall acute occupancy following closure of Larch reducing OOA numbers	256	256
Gain from overal reduction in capital charges	9	0
	535	**439**

Total Recurent Savings:	**974**

6.6 Capital Charges

In order to accurately calculate the capital charge impact of the programme, the remaining life of the buildings in question have been assumed to be 40 years, based on the latest Trust valuation report. In addition to this, Public Dividend Capital has been calculated on the reducing balance of the net asset addition, at the Treasury rate of 3.5%. In completing the financial analysis for the programme, the following has been taken into account in terms of changes in capital charges;

- Southmead site – assumption that from the point of construction completion, all capital charges from vacated buildings on the Southmead site will be released.
- Callington Road site – an assumption has been made of a 50% impairment of construction costs, to give a net asset addition, upon which new capital charges have been calculated

6.7 Statement of Comprehensive Income impact

The Statement of Comprehensive Income table below has been collated utilising the VfM template and summarising the monetisable benefits for both the Trust and wider system as well as the capital charge net savings for the Trust.

Statement of Comprehensive Income	Annual plan	With BNSSG redevelopment	Additional STP system savings	Movement - Current plan to FY effect
	20/21	25/26	25/26	FY effect
	£'000	£'000	£'000	£'000
Operating income from patient care activities	237,641	237,641		0
Other operating income	9,884	9,884		0
Employee expenses	-195,799	-195,799		0
Operating expenses excluding employee expenses	-54,249	-53,723	438	964
OPERATING SURPLUS / (DEFICIT)	-2,523	-1,997	438	964
FINANCE COSTS				
Finance income	24	24		0
Finance expense	-7,090	-12,313		-5,223
PDC dividends payable/refundable	-2,436	-2,427		9
NET FINANCE COSTS	-9,502	-14,716	0	-5,214
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	-12,025	-16,713	438	-4,250
Add back all I&E impairments/(reversals)	2,500	7,723		5,223
Remove capital donations/grants I&E impact	16	16		0
Adjusted financial performance surplus/(deficit) including PSF, FRF and MRET funding	-9,509	-8,974	438	973
Net system change		973		

6.8 Changes in Income & Expenditure

The changes in income and expenditure shown in the VfM template can be summarised as follows;

- A recurring improved Trust contribution of £0.3 million due to the reduction in temporary medical and nursing staff following the environmental improvement due to the change in site
- A reduced recurring improvement to the STP system of £0.2m due to the remodelling of services

- A total reduction in out of area placements across the system of £0.5m that will benefit the system and the Trust on a 50/50 basis due to the current risk share agreement that is in place
- The capital charge cost to the Trust reduces by £0.009 million per annum as a result of vacating the Southmead site

6.9 Affordability

The VfM template has been completed with full financial modelling to support it. This shows that with the capital expenditure of £10.5 million and monetisable benefits described above, the system would achieve the following financial and economic outturn;

- Revenue savings as a proportion of initial capital expenditure (based on average revenue savings from 2021/22-2025/26) – 6%
- Payback period – 14 years
- Return on Investment – 116%
- Value for money ratio – 1.3

All of the above has been based on an assumption of a project life of 20 years. It was not believed to be appropriate to extrapolate over 40 years as the remaining life of the PFI buildings on the Callington Road site.

6.10 Impact on the Trust Statement of Financial Position

There are a limited number of impacts on the Trust Statement of Financial Position. This summarises to being the required capital expenditure of £10.5 million, with £7.5 million being funded by Public Dividend Capital. The impairment of £5.2 million reduces the asset addition and contra effect to retained earnings due to NHS accounting treatment.

Statement of Financial Position	Annual plan	With BNSSG redevelopment
	20/21	25/26
	£'000	£'000
ASSETS		
Total Non-Current Assets	151,607	156,385
Total Current Assets	13,796	13,796
Total Non-Current Liabilities	-65,109	-65,109
Total Current Liabilities	-15,224	-15,224
TOTAL ASSETS	85,070	89,848
TAXPAYERS EQUITY		
Public Dividend Capital	128,912	138,912
Revaluation Reserve	37,866	37,866
Retained Earnings	-81,708	-86,931
TOTAL EQUITY	85,070	89,848

6.11 VAT Recovery

All construction costs associated with the Trust PFI are considered to be VAT recoverable, with the net cost being shown throughout the financial modelling. This VAT recovery position has been approved and in place since the commencement of the PFI scheme under the Contracted Out Services (COS) scheme. In addition to the PFI element, further recovery is shown in the modelling for professional fees. The only element where no recovery is anticipated is for the group 2 & 3 equipping elements of the programme.

6.12 Contingencies

Included within the capital costs, is a 7.5% risk and contingency element, based on the total net construction cost. This equates to a total cost of £0.6 million and is considered to be appropriate in the current economic climate and given the detailed costing exercise that has been undertaken.

6.13 Optimism Bias

Optimism Bias reflects the tendency for scope change to affect capital cost between estimated capital cost and commissioning. Given the entire construction programme is within the Trust PFI contract and therefore ProjectCo, optimism bias has not been applied as ProjectCo believe that they have accurate costs available for the development over its life. The early draw down of fees has enabled the Trust to engage with its PFI provider to complete a full design and tender process for the scheme ahead of the submission of this FBC. These price agreements remove the required future scope change. The only remaining potential cost change is any inflationary increase that potentially may occur between November 2021 when the tender price is held and the final approval of this FBC. Therefore, due to cost certainty, optimism bias has not been ultilised in this case.

6.14 Equipment Schedule

There is a small amount of equipment included within the capital cost of the programme, as summarised below. VAT is shown as applicable and has been included in the appropriate element of the VfM template.

Group	Phase 1	Phase 2	Phase 3	Total
	£'000	£'000	£'000	£'000
Group 1	83	66	38	**187**
Group 2	31	24	24	**79**
Group 3	83	83	60	**226**
VAT (group 2/3 only)	20	21	17	**58**
Total	**217**	**194**	**139**	**550**

6.15 Land Transactions

As the Trust will be vacating a number of buildings on the Trust owned element of the Southmead site, there will be land and buildings that will be available to be sold or transferred. Discussions are ongoing with North Bristol NHS Trust regarding future building use requirements and potential options for splitting site usage between the two organisations for the benefit of future system service developments.

6.16 Asset Impairments

Based on the recent experience of the Trust with regards to significant construction programmes within PFI buildings, an assumption has been made of a 50% impairment of the total cost of £10.5 million. This in turn therefore reduces the impact on the Trust Statement of Financial Position and ongoing depreciation and cost of capital charges.

6.17 Sensitivity analysis

Sensitivity tests have been considered in relation to the overall affordability of the case and assumed monetisable benefits. Discussions have taken place with systems partners and it is agreed that assumptions made are low risk and are far outweighed by the tangible qualitative benefits delivered. With monetisable benefits being evenly spread, there is not considered to be anything of significant risk that would be detrimental to the successful delivery of the programme. These benefits are very conservative with the assumption of a 20 year lifespan, rather than the whole building lifespan of 40 years.

This has been further supported by the formal tender process that has been conducted, giving good cost certainty and fixed prices to November 2021. The table below demonstrates how conservative both the level of savings and lifespan are in relation to the affordability of the case.

Parameters	Savings as % of capex	Payback period (yrs)	RoI %
FBC - 20 year lifespan with achievable levels of savings	**6%**	**14**	**116%**
Scenario 1 - 20 year lifespan with a 20% reduction in savings	5%	17	73%
Scenario 2 - 25 year lifespan with a 20% reduction in savings	5%	17	110%
Scenario 3 - 25 year lifespan with FBC level savings	6%	14	162%

6.18 Reconciliation between the business case and Value for Money (VfM) assessment

A value for money (VFM) assessment of this development is detailed in Appendix H with payback and ROI metrics. A reconciliation table is provided below to highlight that the key figures outlined in this proposal are consistent with those detailed in the VFM assessment:

Element	Business Case	Where	VFM Template	Where	Variance
	£'000		£'000		£'000
Capital Cost	10,445	Section 6.2 / 6.3 Capital Costs & page 3	10,445	Costs Tab, Cell E46	0
Internal Cash	445	Section 6.3 Financing & page 3	445	Costs Tab, Cell E47	0
System capital	2,500	Section 6.3 Financing & page 3	2,500	Costs Tab, Cell E52	0
DHSC Wave 3 STP PDC	7,500	Section 6.3 Financing & page 3	7,500	Costs Tab, Cell E50	0
Recurrent cash releasing benefits	271	Section 6.5 Efficiency Savings	271	Monetisable benefits, Cell N6	0
Recurrent cash releasing benefits	183	Section 6.5 Efficiency Savings	183	Monetisable benefits, Cell K7	0
Recurrent cash releasing benefits	511	Section 6.5 Efficiency Savings	511	Monetisable benefits, Cell I8 + I9	0
Recurrent cash releasing benefits	9	Section 6.5 Efficiency Savings	9	Financial summary, cell I15	0

7 The Management Case

7.1 Introduction

The Management Case provides a summary of the arrangements which have been put into place for the successful delivery of the proposed scheme outlined in this document, and to secure the benefits sought through the investment.

7.2 Project Management

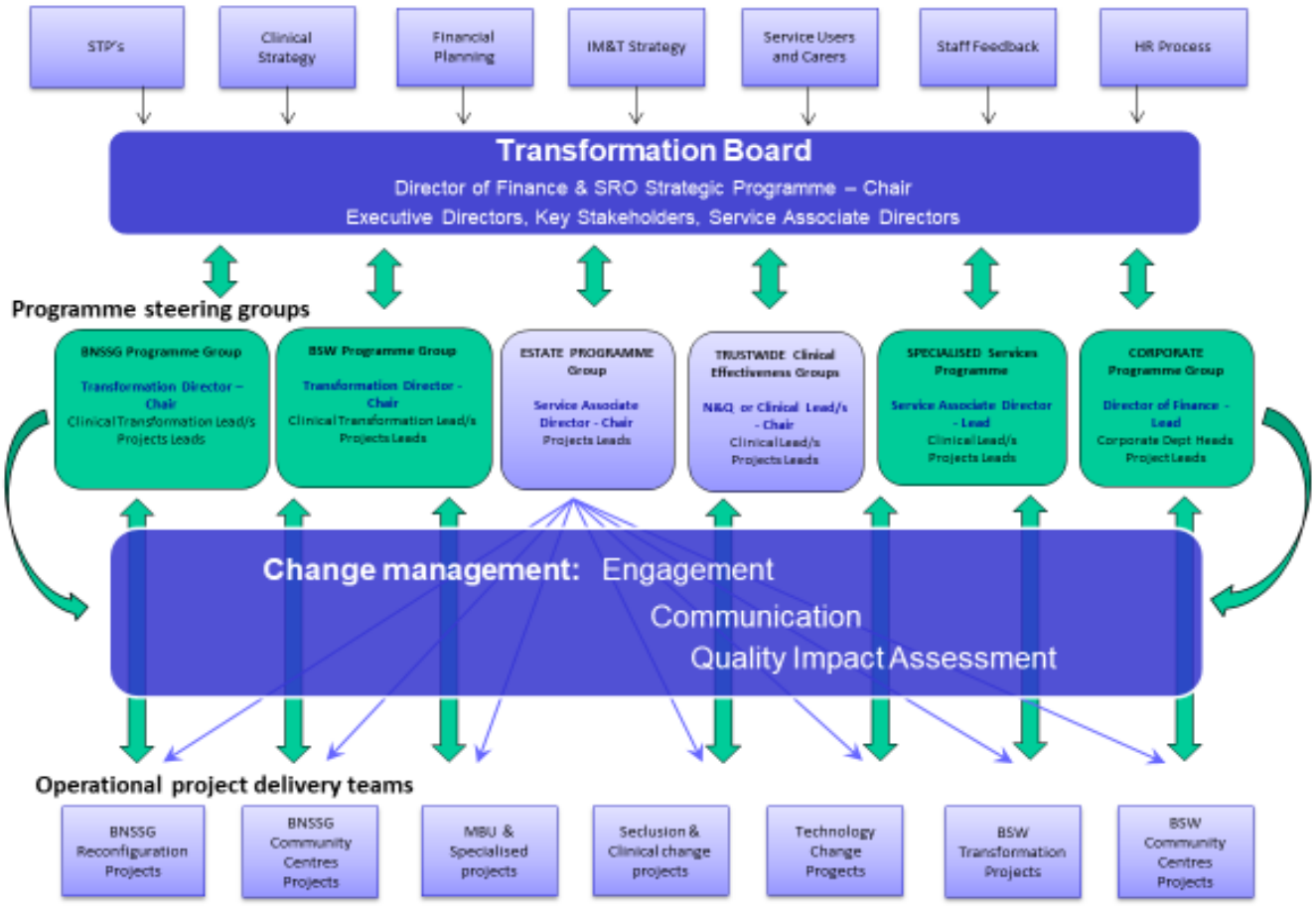
The project will be managed up to FBC submission by BNSSG: AWP with a methodology that is generally aligned with PRINCE 2. The project board has the responsibility to drive forward and deliver the outcomes and benefits of this development.

Members will provide resource and specific commitment to support the Programme manager to deliver the outline deliverables. Project management and design fees of £1.3 million have been identified in the capital funding requirements.

7.3 Project Governance Arrangements

Project Governance arrangements will be established to reflect national guidance and as set out in the Capital Investment Manual 'Managing Capital Projects' (Department of Health); PRINCE2 (Office of Government Commerce); Managing Successful Programmes (Office of Government Commerce/ Efficiency and Reform Group). The project governance structure is shown in the diagram below.

Figure 17 – Programme governance and management structure



7.4 Project Roles & Responsibilities

Key Project delivery roles are described below:

- Senior Responsible Officer (SRO): The SRO has overall responsibility for programme delivery at Executive level and chairs the Programme Board. This role is to be performed by Director of Finance.
- Project Director: The Project Director for each Programme Phase is responsible for the management of the Project. This role will normally be performed by the Chief Operating Officer.
- Senior Users: This role will be performed by Associate Directors within the BNSSG & Specialised Divisions, in addition to the Associate Director for Operations – Estates and Facilities and with responsibility for ensuring that the project maintains alignment with the service and business targets described in the Business Case and working within the terms of reference set by the Project Team.
- Trust Project Manager: The Head of Estates Projects will undertake this role, having day to day responsibility for, the delivery of the projects to meet the parameters described within the business case. The provision of appropriate reports on status to the Project Director. The management of risks and issues and escalation of appropriate matters for executive direction/ approval. Monitoring, co-ordinating and controlling the work of the Project Teams and Working Groups.

- Service Project Manager: Operations Managers within the BNSSG & Specialised Divisions will undertake this role, having day to day responsibility for providing advice on the service brief to the Technical Project Manager and associated team, and for planning and delivery of service and workforce change under the direction of the Senior Users.
- Technical Project Manager: This role will be performed by the PFI partner, Imagile, who will have day to day responsibility for administration of the design and development of the project (within the delegated role permitted by Project Team).

7.4.1 Programme Board

A Programme Board will be set up in Spring 2022, with membership as follows:-

- Senior Responsible Owner (SRO) Director of Finance;
- Project Director – Chief Operating Officer;
- Director of Nursing or nominated Deputy;
- Senior Users - Associate Director of AWP's BNSSG and Specialised Divisions;
- Clinical Director of AWP's BNSSG and Specialised Divisions;
- Associate Director of Operations - Estates and Facilities;
- Head of Programme Management Office;
- Head of Workforce Development;
- Head of Information and Performance;
- Head of IM&T;
- Deputy Director of Finance.
- Head of Estates Projects

Key roles and responsibilities will include:

- Responsibility for delivering the project within the parameters set within the business case;
- Providing high level direction on stakeholder involvement and monitoring project level management of stakeholders;
- Providing the strategic direction for the project;
- Ensure continuing commitment of stakeholder support;
- Key stage decisions;
- Progress monitoring;

Monthly progress reports, including projections of forthcoming key activities and decisions, will be submitted to the Programme Board by the Project Director.

The standing agenda will be as follows:

- Apologies;
- Minutes of Previous Meeting;
- Matters Arising;
- Development Progress Report;
- Recruitment and training;
- Stakeholders and Communications;
- Risk Register;
- Any other business;

- Clinical Service update;
- Service model refinement;
- Date of Next Meeting.

7.4.2 BNSSG Project Group

The membership of the Project Steering Group/ Team is:

Table 13 - Membership of the Project Steering Group/Team

Role	Member
Senior responsible Officer	Director of Finance, AWP
Project Leads	Associate Director of BNSSG and Specialised Divisions
Senior User	Operations Mangers from Bristol, South Glos and Specialised Divisions,
Clinical Leads	Clinical Director s BNSSG and Specialised Divisions
Service Project Manager	Operations Mangers from Bristol, South Glos and Specialised Divisions
Health and Safety Lead	Health and Safety Lead
Project Manager	Head of Estates - Projects
Finance Lead	Dept. Director of Finance/Divisional Accountant
Contractor Project Lead	PFI provider and construction lead to provide representation
N&QD	Dept. Director of Nursing
EFM	Associate Director of Operations - Estates and Facilities
IM&T	Head of IM&T
Consultation and Engagement	Business Development lead
HR	Workforce Development Lead
Communication Plan	AWP Communications Lead

Key roles and responsibilities will include:

- Day to day responsibility for the delivery of the projects to meet the parameters described within the business case;
- Provision of appropriate reports on status to the Project Director;
- Management of risks and issues and escalation of appropriate matters for executive direction/ approval;
- Providing working groups with detailed briefs;
- Monitoring, co-ordinating and controlling the work of the Project Team and Working Groups;
- Drawing together the outputs of the Working Groups;
- Ensure continuing commitment of stakeholders, both internal and external.
- Ensuring the financial sustainability of the programme

The group will meet monthly or more frequently as required in accordance with the phase of the project. The Standing Agenda will be as follows:

- Apologies;
- Minutes of Previous Meeting/Action Log;
- Matters Arising;
- Progress Report;
- Consultation/Engagement process;
- Risk Register and Issues Log;
- Workforce Development;
- Service Development;
- Financial Reports;
- Contract variation to the PFI Contract;
- Impact Assessments.

7.5 Working Groups

Working Groups will be convened to provide advice and direction to the detailed design process in developing this scheme, as and when required. Their role can be summarised as follows:

7.5.1 Design and Build Team

This group will be led by a Trust project manager in conjunction with the PFI partner and will be responsible for:

- Managing design progress and coordination issues;
- Identifying key matters requiring Project Team assistance/ decision making;
- Identifying design risks / issues for management and if appropriate escalation to Project Team.
- There will be representation from Clinical Services, EFM services, IM&T, H&S, Nursing and Quality to ensure the design meets the service specification and is compliant with current standards.
- The outputs will also include:-
- Producing equipment schedules;
- Planning the commissioning of equipment;
- Understanding the transfer requirements of existing equipment/ furniture (as appropriate).

Will represent the needs of hard and soft FM, provide the following support:

- Providing comments to the Technical Project Manager on reviewable design Information;
- Advising on FM related fittings, fixtures and equipping selection as part of the detailed design process;
- Advising on policies and service agreements required to reflect the operation of the scheme;

Will be responsible for ensuring that voice and data requirements are delivered for the scheme, along with advice on equipment which is linked with communications (e.g. CCTV, entry systems, etc.), including:

- It will represent the IM&T requirements addressing any queries from the PFI Partner in relation to the design of cabling and associated works;
- Reviewing any design information in relation to IM&T;
- Planning the transfer and commissioning of voice and data provision from the existing operating locations to the new development.

The end stage of the project will result in the completion, handover and commissioning of the new facility. The Project Team is responsible for providing assurance that the project has been delivered in terms of product and quality in line with the Business Case

7.5.2 Service Development team

This group will be led by the service project managers and will focus on transforming the way in which the clinical services are delivered. This group will comprise of key operational personnel, HR, N&Q, clinical staff and service user representation across the BNSSG footprint.

The remit of the group will include the co-production of service changes and will develop the following work strands:-

- Clinical modelling and profiling;
- Workforce analysis;
- Any specific training gaps and needs analysis;
- Any IM&T interdependencies;
- The devising and updating of relevant operations processes and procedures across the site.

7.5.3 Change Management and Workforce Development team

This group will lead the culture change and staff consultation process and ensure that the workforce is appropriate for the transformed clinical services.

This workstream will determine the revised staffing models required following the Trusts existing Safer Staffing model, taking into account the environmental and layout improvements, whilst also considering the cross-site opportunities for cross cover (through floating shifts, etc). Given the current temporary staffing challenges and the possibility that a small number of staff may not choose to relocate from Southmead, this group will also identify specific roles that need a bespoke recruitment focus and monitor delivery of these. Problematic recruitment areas due to current ward sizes being greater than recommended (specifically Medics) will also get specific attention to ensure a high quality substantive workforce are recruited and established as part of this programme of work. Overall, there is not a material change to the staffing requirements as part of this case – the main benefits are consolidation and environmental improvements which are then expected to increase the attractiveness of these services to staff, increasing substantive fill and reducing overall temporary staffing usage. It will also enable a reduction in staff numbers above budgeted levels which are currently covering for environment issues (such as line of sight challenges and low roof line and garden access).

An analysis of training needs will be undertaken in within this workstream to ensure that existing staff have received relevant development to meet the changing service requirements. Engagement of the existing workforce will be key and the group will ensure that there is specific focus across all workstreams on retaining experienced, skilled and knowledgeable staff.

7.6 Stakeholder Engagement and Communications

In defining the Programme objectives and deliverables and solutions there has been engagement with stakeholders as described in Section 3, the Clinical Quality Case. The implementation of the Programme will

also require good engagement and communication with a range of specific stakeholders to ensure smooth and effective transition between service arrangements, and communication to ensure that all necessary groups are well informed of the changes being delivered.

7.6.1 Engagement for Programme Delivery

Depending on the Phase of the programme, the following stakeholders will require inclusion and information about the programme, and opportunity to have a level of involvement.

- Community Health services (e.g. Sirona CIC, Devon Partnership NHS Trust)
- Acute NHS Trusts (e.g. North Bristol Trust, University Hospitals Bristol & Weston NHS Foundation Trust)
- Primary Care providers and networks
- Local Authority social care and mental health teams
- Care providers such as care homes and shelters
- Third Sector organisations that provide support and representation for specific service user groups
- Police, particularly regarding Place of Safety
- Local and Trustwide staff, and unions

7.6.2 Communications for Programme Delivery

The Project Group will ensure that a communications plan is prepared that considers the needs of:

- Key stakeholders such as identified by the Project Group and Programme Board such as those above
- Service users and carers, as identified by the Service Development team
- Staff and unions, as identified by the Change Management and Workforce Development team.

Specific targeted direct communication to organisations and individuals will be identified, together with more general methods of communication including:

- Trust external website
- Trust internal weekly news and intranet site
- Trustwide Executive Online Staff Briefing (live web-based team brief, currently weekly under Covid-19)
- Trustwide Management Leadership Forum (Skype forum, currently monthly)
- Press briefings where appropriate
- Consideration may be given to social media updates.

7.7 Use of Special Advisors

Special advisors have been used in a timely and cost-effective manner in accordance with the Treasury Guidance. Further appointments will be made as required, to achieve the design planning and building regulations processes etc.

Table 14 - Roles of Special Advisors

Role of Special Advisor	Organisation
Business Case/ Finance Analysis/ Healthcare Planning	Archus
Architects	Imagile

7.8 Project Programme

The delivery of this project will be managed via various phases to ensure that the appropriate services are relocated at the right time. The detailed phasing programme can be found in Appendix A with the key milestones set out in the table below.

Table 15 - BNSSG FBC Key Project Milestones

Milestone	Completion
FBC submission & approval from NHSE/I	Mar 22
Pre-Construction Process Complete	May 22
Contractor Appointed (PFI)	May 22
Construction Commenced	Jun 22
Phase 1 – Reconfiguration of Larch as therapies hub	Nov 22
Phase 2 – Reconfiguration of Woodside South to create an inpatient unit	May 24
Phase 3a – Reconfiguration of Lime to create a Place of Safety	Feb 25
Phase 3b – Reconfiguration of Silver Birch to create an Enhanced Care Suite	Sep 25

7.9 Arrangements to Ensure Benefits Realisation

The realisation of the key benefits realisation plan has been agreed by the programme team to ensure that the measurable benefits are monitored for delivery. It sets out who is responsible for the delivery of specific benefits, how and when they will be delivered and how they will be measured. It also identifies These have been agreed by the project team and are set out in the benefits realisation plan advising the desired benefit, the enablers required to realise the benefit, the baseline measure, who is responsible and the target date by which the benefit will be delivered.

A full benefits review will be included in the Post-Implementation Review process (see below) and see Appendix J for the benefits realisation plan.

7.10 Management of Change

The main changes associated with this programme that need to be managed will be:

- Relocation of inpatient services from Southmead to Callington Road. This will be overseen by the Programme Board, and Stakeholder Engagement plan will include Service Users (Section 7.6). The

Modern Matron/s for the respective ward/s will ensure that due engagement with service users is undertaken at appropriate stages leading up to the relocation.

- Relocation of staff from Southmead to Callington Road. This will be overseen by the Programme Board. The Project Group for each phase will ensure that appropriate staff consultation stages are timed into the programme delivery, to enable smooth and fair transition of employment contracted base. Due to the short distance involved for this relocation, it is considered extremely unlikely that any redundancy situation will arise. Some soft consultation about the need for change has already taken place at various levels within these teams.
- It is not envisaged that any contracts will change in a way that requires TUPE transfers.

7.11 Programme Amendments and Contract Management

Any amendments considered necessary to the programme will be managed through the Project Team and authorising bodies that preside over it based on the governance structure described above, under the chairmanship of the Senior Responsible Officer (SRO). Day to day programme amendment issues will be discussed at the Project Team level and any resultant contract and/ or cost changes will need to be approved in accordance with Trust SFI's.

This work will form part of a contract variation to the existing long standing contract between the Trust and the PFI provider and managed through the existing contract management process via the Joint Liaison Committee (JLC). Principles of the variation have been agreed in advance of the capital sign off (in line with the early draw down of fees request) in order to tender and deliver cost certainty. However, the contract variation can only be formally signed off by both sides once the project has formaly final sign off. This will be enacted as soon as possible after the green light has been received from DHSC.

Contract Management will continue as is (via the JLC) and existing contractual mechanisms and levers will be used where appropriate.

7.12 Risk Management

A risk management framework has been implemented to provide a comprehensive risk assessment and control framework for delivery of the project. This will focus on:

- The risks associated with the delivery of the scheme being developed;
- Risk that is highlighted from the individual Working Group, presented at the BNSSG Project Board meeting and managed through the Trust Board.

The reporting will follow the PRINCE2 process of checkpoint, highlight and exception reports. The condition will be indicated by using red, amber or green (RAG) colour code as outlined below.

Table 16 - Risk register scoring

Score	Probability	Impact
5	Almost certain	Severe
4	Likely	Major
3	Possible	Moderate

Score	RAG	Definition
15 – 20	R	Corrective action urgently required
7 – 14	A	Condition requires corrective action which has been implemented

2	Unlikely	Minor
1	Rare	None

6 or less	G	Condition is on programme or within budget therefore no special action is required

The risk register for the project (Appendix K) will be monitored by the Project Lead and reported monthly to the Transformation Board and Project Team. The focus of risk management will address broadly:

- Non-delivery of project outcomes as defined in stages of the project plan;
- Threats to the completion of the project within cost and time (managed on a day-to-day basis by the Development Project Manager).

7.13 Project Evaluation Reviews (PERs)

The project evaluation review will appraise how well the project was managed and whether or not it delivered to expectations. It is timed to take place during the construction phase and will form part of the post project design evaluation. It will compare the current design assessment undertaken during the FBC project phase with the final operational building.

The arrangements for PERs have been established in accordance with best practice. The Project Team will ensure that a thorough post-project evaluation is undertaken at key stages in the process to ensure that positive lessons can be issued and learnt from the project. These will be of benefit to:

- The Transformation Board and other Project Teams – in using this knowledge for similar capital schemes;
- Other key local stakeholders – to inform their approaches to future projects;
- The NHS more widely – to test whether the policies and procedures used in this procurement have been used effectively;

The evaluation will examine the following elements, where applicable at each stage:

- The effectiveness of the project management of the scheme – viewed internally and externally;
- The quality of the documentation prepared by the Project Team;
- Communications and involvement during key stages;
- The effectiveness of advisers utilised on the scheme;
- The efficacy of NHS guidance in delivery the scheme;
- Perceptions of advice, guidance and support from the NHS England, NHS Property Services and Community Health Partnerships in progressing the scheme.

Formal post project evaluation reports will be compiled by the SRO and Project Lead and reported to the Project Team and Transformation Board to ensure compliance to stated objectives.

7.13.1 Post Implementation Review (PIR)

This review will consider whether the anticipated benefits have been delivered. In addition to the review which takes place shortly after the new service opens, the PIR will take place approximately 2 years later to consider the outcomes against the benefits planned.

Formal post implementation review reports will be arranged by the SRO and Programme Lead and reported to the Transformation Board to ensure delivery of the stated benefits. This will include recommendations on opportunities for improvement, and on learning which can be carried to other programmes.

7.14 Contingency Plans

Contingency plans will be considered by the Programme Board and the Project Team for each Phase, to ensure AWP can continue to deliver an acceptable level of service of its critical activities in the event of any disruption during this projects' development.

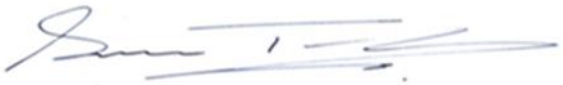
It is not expected that this programme will impact on the ability to maintain a full service as it stands. To achieve this it is planned in phases, with minimal decant required, with each phase having service mechanisms for mitigation of issues. However, various interdependencies with other programmes and the associated risk mitigations are discussed in Section 4.10 and 4.11 of the Economic Case.

8 Recommendation, Endorsements and Approvals

Avon and Wiltshire Mental Health Partnership NHS Trust request on behalf of BNSSG STP/ICS that this Reconfiguration of Mental Health Services programme is given approval to proceed.

This document has been endorsed and approved by the following people:

Scheme or Project Endorsed by;		
Sponsor organisation Director of Commissioning	Organisation	BNSSG CCG
	Position	Director of Commissioning
	Name	Lisa Manson
	Signature	Lisa Manson
	Date	
NHS England Regional Director of Finance	Area	NHS England South West Region
	Position	NHS England Regional Director of Finance
	Name	Kaye Bentley
	Signature	
	Date	
NHS England Regional Director Estates	Region	NHS England South Region
	Position	NHS England Regional Director of Estates
	Name	
	Signature	
	Date	
Prioritisation *(For regional use only)*		
ETTF or Other NHS England / NHS Improvement Programme	Programme	
	Position	
	Name	
	Signature	
	Date	
NHS England Chief Financial Officer	Name	
	Signature	
	Date	

Signed: 

Date: WHEN SUBMITTED

Simon Truelove, Director of Finance, Strategic Programme Senior Responsible Officer
Nigel Witchalls, Head of Estates, Programme Lead

Appendices

A	Phased Programme
B	STP / Commissioner approval for bid
C	Functional Suitability Review
D	Physical Condition Review
E	Quality Impact Assessment (QIA)
F	Equality Impact Assessment (EIA)
G	Schedule of Accommodation – Callington Road
H	Value for Money Template
Ii, Iii, Iiii	1:200 Drawings
J	Benefits Realisation Plan
K	Risk Register
L	BNSSG STP Estates Strategy

ARCHUS

ADVISORY • INVESTMENT • DEVELOPMENT

UK Company Registration No. 6937095

Health Scrutiny Committee Work Programme 2021-22

Meetings in-public

Topic	Date
Health Scrutiny Committee (Sub-Committee of the People Scrutiny Commission)	
Public Health Update	Monday, 6th December 2021, 10am
Children's Mental Health and Child and Adolescent Mental Health Services	
Community Mental Health Framework and Integrated Care Partnerships in Bristol	
Public Health Update	Monday, 14th March 2022, 10am
Healthy Weight	
NHS System Pressures and Status Update	
Urgent and Emergency Care – Minors Programme	
AWP Patient reconfiguration	
Joint Health Overview & Scrutiny Committee	
Stroke Programme	Monday, 15th November 2021, 10.30am
Integrated Care System	