

Health and Wellbeing Board Agenda



BRISTOL CCG

Date: Wednesday, 16 August 2017

Time: 2.30 pm

Venue: The Writing Room, Floor 1, City Hall, BS1 5TR

Distribution:

Mayor Marvin Rees, Dr Martin Jones, Alison Comley, John Readman, Julia Ross, Cllr Asher Craig, Cllr Helen Godwin, Cllr Claire Hiscott, Cllr Helen Holland, Becky Pollard, Vicki Morris, Elaine Flint, Keith Sinclair, Steve Davies, Justine Mansfield and Pippa Stables

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Date: Tuesday, 8 August 2017



Agenda

1. Welcome, apologies and introductions 2.30 pm

2. Public forum - must be about items on the agenda

Written questions (must be about items on the agenda):

Written questions may be submitted in advance of the meeting by a member of the public or a member of Council. These must be about items on the agenda for this meeting. A maximum of 2 written questions per individual can be submitted. The deadline for receipt of questions for the 16 August Health and Wellbeing Board is **5.00 pm on Thursday 10 August**. These should be emailed to democratic.services@bristol.gov.uk

Please note: wherever possible (bearing in mind the limited time available in advance of the meeting for the preparation of replies), a written reply will be provided to a question at the meeting, and the questioner will then receive an opportunity to ask one supplementary oral question per question submitted.

Petitions and written statements (must be about items on the agenda):

Members of the public and members of the Council may submit a petition or submit a written statement to the Health and Wellbeing Board. These must be about items on the agenda for this meeting.

The deadline for receipt of petitions and statements for the 16 August Health and Wellbeing Board is **12.00 noon on Tuesday 15 August**.

These should be e-mailed to democratic.services@bristol.gov.uk

Please note: details of all petitions / statements submitted by the deadline will be sent to Board members in advance of the meeting. Subject to time, anyone who has submitted a petition / statement will be given an opportunity to briefly present their petition / statement at the meeting.

Maximum time allocation for public forum – 30 minutes

3. Declarations of interest

4. Minutes of previous meeting - 28 June 2017 - to be confirmed (Pages 4 - 9) as a correct record



- 5. Key decision - Substance misuse and sexual health services currently delivered in primary care** **2.40 pm**
(Pages 10 - 111)

- 6. Better Care Fund and Improved Better Care Fund Plan 2017-19** **2.55 pm**
(Pages 112 - 119)

- 7. BNSSG STP update** **3.10 pm**
(Pages 120 - 124)

- 8. BNSSG CCG's Operational Plan 2017-19** **3.30 pm**
(Pages 125 - 270)

- 9. Emotional health and wellbeing transformation plan refresh** **3.50 pm**
(Pages 271 - 288)

- 10. Health and wellbeing roundtable discussions** **4.05 pm**
(Pages 289 - 294)

- 11. Update - Bristol Community Links service** **4.15 pm**
(Pages 295 - 298)

- 12. Information item - Big drink debate update**
(Pages 299 - 349)

- 13. Information item - Pharmaceutical Needs Assessment update**
(Pages 350 - 351)



Minutes of the Health and Wellbeing Board

28 June 2017 at 2.30 pm



Board members present:-

Marvin Rees, Alison Comley, John Readman, Cllr Asher Craig, Cllr Claire Hiscott, Cllr Helen Holland, Becky Pollard, Vicki Morris, Elaine Flint, Keith Sinclair, Steve Davies, Richard Lyle (for Julia Ross)

1. Welcome, apologies and introductions

Attendees were welcomed and introduced themselves.

Apologies were received from Martin Jones, Julia Ross, Councillor Helen Godwin and Linda Prosser.

2. Public forum

It was noted that no public forum business had been submitted to this meeting.

3. Declarations of interest

There were no declarations of interest.

4. Minutes of previous meeting - 12 April 2017

RESOLVED:

That the minutes of the meeting of the Board held on 12 April 2017 be confirmed as a correct record.

5. Key decision - Adult substance misuse treatment service recommissioning

The Board considered a report seeking approval of a commissioning strategy (appendix A of the report), which would enable the Council, as lead commissioner, to progress to invitation to tender and contract award.

Peter Anderson, Safer Bristol Manager presented the report.



Main points raised/noted:

- a. In re-commissioning adult substance misuse treatment services, the aim was to support vulnerable citizens to access health interventions that supported their health and wellbeing needs. The intention was to commission a new service with a total value of £8.7m. It was anticipated that the new service would be in place by December 2017.
- b. It was noted that VOSCUR had raised an issue in relation to the financial standing appraisal (appendix 6 of the report). There was a concern that expecting a bidder to have a turnover of 1.5 times the annual contract value might exclude some organisations from being able to bid. In connection with this point, it was clarified that the authority needed to assess the capacity issue of whether any bidder had the resources to carry out the work and whether a bidder would be over-dependant on the contract. The authority would generally expect a bidder to have a turnover of 1.5 times the current contract value but each bid would be carefully assessed and the risk level to the authority professionally assessed in each case. However, work was taking place to review the financial evaluation so as not to exclude smaller organisations.
- c. Keith Sinclair asked a question relating to carers in terms of the reduction in resources and the impact of not being able to commission a service across the whole area and how these would be mitigated. The Mayor and Board members noted these concerns, and it was noted that these issues should be considered and addressed as necessary as part of the process leading to invitation to tender.
- d. It was noted that an equalities impact assessment impact of the proposal had been carried out (appendix E of the report). A cumulative equalities impact assessment had not been carried out (i.e. assessing this proposal in the context of relevant service changes elsewhere which may impact on this service). However, in developing the commissioning strategy, very detailed consultation had taken place with a wide range of partners, as detailed in the report.
- e. In terms of the needs assessment relating to this service, it was noted that Bristol had an estimated 5,400 opiate and/or crack users, a higher level than in other core cities. Bristol also had a relatively higher proportion of clients with very complex needs.

Having noted and taken account of the above, the Mayor then took the following key decision:

That the commissioning strategy (Appendix A of the report) be approved, enabling the Council, as lead commissioner, to progress to invitation to tender and contract award.

6. Better Care Fund - planning and governance update

The Board considered a report setting out the key changes within the Better Care Fund planning framework for 2017-19 and the amended governance arrangements for monitoring the Better Care programme in Bristol.

Becky Pollard, Director of Public Health and John Readman, Strategic Director – People presented the report.

Main points raised/noted:

- a. In terms of the new Better Care policy framework, Better Care plans would be 2 year plans. There was a reduction in the number of national conditions with a new condition introduced for managing transfers of care.
- b. As per the details included at appendix 3 of the report, a number of important projects /strong work were being taken forward through the Better Care fund, e.g. 7 day social care in ED, and the disabled facilities grant project.
- c. Work was taking place on the implementation of the new Improved Better Care Fund and would be reported to the Board for sign-off.



d. The revised governance structure as proposed was currently appropriate but, given the changing health landscape (nationally and locally), would need to be kept under review.

At the conclusion of the discussion, the Board

RESOLVED:

- 1. That the changes to the Better Care Fund policy framework be noted.**
- 2. That the detail included in the report about the additional grant to be included in the Better Care Fund be noted.**
- 3. To approve the principle of a BNSSG narrative plan, as proposed in the report.**
- 4. To approve the revised governance structure for monitoring Bristol's Better Care programme, but noting that the position will be kept under review.**

7. Joint Strategic Needs Assessment - update

The Board considered a report providing an update on progress and plans for the Bristol Joint Strategic Needs Assessment (JSNA).

Joanna Copping, Consultant in Public Health and Nick Smith, Strategic Intelligence and Performance Manager presented the report.

Main points raised/noted:

- a. Work was progressing on the development of the priority JSNA chapters. 5 had been published and a number of others would be published in the next few months once signed-off by their reference groups (as per the details set out in Appendix A of the report).
- b. The Board was updated on the significant changes made to the JSNA web page (hosted on the Council's web site), aimed at improving its accessibility. The new web page is available from this link: www.bristol.gov.uk/jsna There was also a new online Open Data Platform for Bristol which will include JSNA data-sets with new dashboards to be developed to improve data visualisations.
- c. Due to budget pressures, the Quality of Life survey (which provides a key source of local, ward level data for the JSNA) is using new, on-line focused methodology for 2017. There is a risk that the response rate could fall significantly; therefore, additional publicity had been issued and a targeted mailing will now be carried out to mitigate this risk.
- d. It was noted that further to the discussion that had taken place at the December 2016 Board meeting, there remained a challenge around accessing ethnicity and other equalities data, as this was not always available as routine data. In discussion, concerns were expressed about the level of risk / consequences for health services in terms of the gaps in equalities data. It was noted that this is a national issue although there is also scope to start improving local processes. It was agreed that a letter should be sent to NHS England seeking a progress update on the work being undertaken on a national basis around recording ethnicity data (Public Health to draft a letter on behalf of the Mayor). As part of that letter, an offer should be included stressing that Bristol would be willing to participate in any pilot work in this area. It was also agreed that the JSNA steering group should establish an Equalities data sub-group to review the ethnicity data gaps and identify further resource and capacity, in the expectation that partners will be involved in taking necessary actions to assist the sub-group.
- e. The CCG would like to see more data available at GP cluster level. VCS partners agreed this would be useful to improve targeted work. This may be feasible to develop via the new Data Open Platform.



RESOLVED:

That the report and the above information be noted, and that the action points identified in point d. above be progressed accordingly, plus the scaling up of the Quality of Life survey promotion to be carried out to ensure it is useful for the city.

8. Health and wellbeing - roundtable discussions

The Board considered a report providing an update on the outcomes and developments that were emerging from recent Health and Wellbeing roundtable discussions hosted by the Mayor.

Becky Pollard, Director of Public Health presented the report.

Main points raised/noted:

a. 3 roundtable discussions had been set up on behalf of the Mayor to explore how to strengthen local health system leadership across the city. The workshops had involved Board members and local provider and commissioning health system leaders. 2 workshops had been held to date; a third facilitated workshop would be held on 13 July to draw together key outcomes and a proposed way forward.

b. The Mayor stressed that, linked with the development of a long term strategic city plan, it was essential for the Board to address the following issues:

- What is our view of what a healthy Bristol population will be/look like in the next 10 – 25 - 50 years?
- What sort of leadership do we need to deliver this?
- What is the role of this Board in achieving this?

It was essential for the Board to invest in a longer term “health view” / direction for Bristol’s population.

c. It was important to link / engage with schools in terms of their health and wellbeing role (e.g. around young people’s mental health and wellbeing) bearing in mind school capacity issues. It was suggested that schools should be represented at the next roundtable session on 13 July.

d. The importance of co-production moving forwards was stressed, including maximising appropriate voluntary sector contributions, linking in with the longer term direction.

e. The opportunity should be taken to link up partnerships that were already working successfully.

f. Given the changing health landscape nationally and locally, consideration should be given to the most appropriate way of ensuring provider representation on the Board moving forwards.

At the conclusion of the discussion, the Board

RESOLVED:

That the report and the above information be noted, noting also that a third roundtable session is being held on 13 July and that a report on the outcomes / proposed forward plan for health system leadership will be presented for discussion at the next meeting of the Board on 16 August 2017.

9. Thrive Bristol - delivering a citywide approach to mental health and wellbeing

The Board considered a report providing an update on plans to develop a citywide mental health and wellbeing programme. The report included an overview of the “Thrive” model and proposed developing a “Thrive Bristol” programme, led by city leaders and co-produced with individuals and groups across the city.



Leonie Roberts, Consultant in Public Health and Victoria Bleazard, Mental Health and Social Inclusion Programme Manager presented the report.

Main points raised/noted:

- a. There was positive support from Board members generally for the principle of developing a Thrive programme in Bristol.
- b. The “Thrive” brand was welcomed.
- c. The proposed collaborative partnership approach, embracing inclusion and co-production was strongly welcomed and supported.
- d. It was suggested that addressing the mental health and wellbeing of young people should one of the key priorities. It was noted that in presenting their manifesto at the Bristol Full Council meeting earlier that week, members of the Bristol Youth Council had identified young people’s mental health and wellbeing as one of their key priorities.
- e. The mental health and wellbeing of older people was also a priority area.
- f. It would be essential to include a focus on preventative approaches in relation to mental health and wellbeing, e.g. taking into account the evidence around trying to ensure the best possible start in life for children and how a child’s experiences during their first 1,000 days of life impacted on their future wellbeing.
- g. It would be important to learn from the models and experience elsewhere of taking forward Thrive programmes (e.g. West Midlands and also Thrive London and Black Thrive), and apply best practice accordingly. The views of local communities about their needs must also be taken into account.
- h. It would also be important to link the programme in with other related initiatives, e.g. work being taken forward on tackling loneliness and social isolation; and also take into account relevant aspects of the current “Your Neighbourhood” consultation outcomes.
- i. There was an opportunity for the approach to be applied across the wider BNSSG footprint.
- j. Consideration should be given to looking to bring new partners “to the table” in terms of the contribution they can potentially make around this agenda, e.g. the newly established West of England Combined Authority.
- k. The Mayor indicated his strong support for the approach and also commented that, in terms of the longer term strategic view of health leadership, as discussed earlier at the meeting, the Board should be aiming to ensure leadership and full support across partners for positive initiatives such as the Thrive programme. Bristol as a city should aim to have the most healthy and well workforce in the country into the future.

At the conclusion of the discussion, taking account of the above, the Board

RESOLVED:

To adopt and support the delivery of a “Thrive Bristol” programme to address the Board’s key priority to improve mental health and wellbeing across the city; and that further work be now progressed to identify the vision and key focuses of a Thrive programme and related actions.

10. Progress update - Bristol alcohol strategy

The Board considered a report providing a progress update on the delivery of the Bristol Alcohol Strategy.

Leonie Roberts, Consultant in Public Health presented the report.

Main points raised/noted:



a. The multi-agency alcohol strategy group was continuing to deliver actions in the strategy action plan, the overall aim being to reduce alcohol consumption in the city and reduce the harm associated with drinking alcohol.

b. These actions had included:

- Delivering the Bristol Big Drink Debate, using a variety of techniques including focus groups, on-line surveys, workshops and social media to engage individuals and communities about the impacts of alcohol consumption.
- Developing a system approach to alcohol related liver disease treatment.
- Working with schools to reduce alcohol use along young people and promote awareness about alcohol harm among families; and training staff in more than 30 community pharmacies (many of these were located in areas of high deprivation) to provide opportunities for local people to gain awareness about alcohol use.

c. The multi-agency partnership actions had enabled “join-up” with other key agendas, e.g. reducing anti-social behaviour and the harmful effects of alcohol consumption had a positive impact on community safety. Feedback from the police had indicated that the approach adopted to encourage safer alcohol consumption in venues (including Queen Square) during last year’s Bristol Harbour Festival had seen a reduction in cases of anti-social behaviour at the event.

RESOLVED:

That the report and the above information be noted.

Meeting ended at 4.25 pm

CHAIR _____



Agenda Item 5

Health and Wellbeing Board Report - Key Decision Date: 16 August 2017

Title: Substance misuse and sexual health services currently delivered in primary care	
Ward: Citywide initiative	Cabinet lead: Councillor Asher Craig
Author: Thara Raj and Annette Billing (Sexual Health) Katherine Williams (Substance Misuse)	Job title: Consultant in Public Health and Public Health Principal Contracts and Commissioning Manager (Safer Bristol)
Revenue Cost: £2,961,000 (based on sexual health spend of £474,000 per annum and substance misuse spend of £1,500,000)	Source of Revenue Funding: <i>The Public Health Grant funds the majority of these services. BCC General Fund provides a revenue contribution for substance misuse services. Sexual health services are partly funded through a transfer from NHS England.</i>
Capital Cost: £	Source of Capital Funding: n/a
One off <input type="checkbox"/>	Saving <input type="checkbox"/>
Ongoing <input checked="" type="checkbox"/>	Income generation <input type="checkbox"/>
<p>Finance narrative:</p> <p><i>With regards to substance misuse, as previously approved by the HWB, Safer Bristol are commissioning a new service with a total annual value of £8.7m. The new service will be in place by December 2017. The pooled budget is funded by contributions from the General Fund, Public Health, CRC Partnership Funding and neighbouring local authorities. RS23 £20k budget reduction for 17/18 has been confirmed achieved.</i></p> <p><i>With regards to Sexual Health, Public Health intends to recommission existing sexual health services that are currently delivered in GP practices and pharmacies with a new contract to be in place from 1 October 2017. The total financial value of these services is planned to remain consistent as per current arrangements with total planned expenditure of £474k per annum. This financial commitment will remain for the proposed duration of the contract until March 2019.</i></p> <p><i>These services are currently budgeted for within the divisional budget ring-fenced for the Public Health grant. Also included here is £68k of income to be received from NHS England to support the services to be recommissioned. There is currently no documented agreement with NHS England regarding these funds and this must be addressed by Public Health prior to commencing procurement.</i></p>	
Finance Officer: Jemma Prince, Finance Business Partner	

<p>Summary of issue / proposal: Current contracts for sexual health and substance misuse services with GP practices and community pharmacies have been extended to 30 September 2017. Approval is sought to commission these services by continuing to contract with GP practices and pharmacies that can fulfil the requirements of the service specification on the existing terms.</p>
<p>Summary of proposal & options appraisal:</p> <ul style="list-style-type: none"> • In June 2017 the Health & Wellbeing Board approved the substance misuse commissioning strategy which included the model of service delivery, procurement approach and funding as defined in the attached Commissioning Strategy (Appendix A). Primary Care is an integral part of the treatment system in delivering opiate substitute prescribing, alcohol detox prescribing and supervised consumption services. Without primary care the model would not be viable. • Local authorities have a mandated responsibility to provide, or make arrangements to secure the provision of open access sexual health services in their area. • Soft market testing and dialogue with other authorities has resulted in the conclusion that the only viable providers of this service are those currently doing so. Having explored all of the options, the considered view is that a procurement process could not save money, achieve efficiencies or deliver any service improvements. Furthermore a procurement process could in fact damage relationships with primary care providers who may perceive the process as unnecessary and could

result in reduced service provision in key locations (both are issues that have been experienced by other local authorities). There would also be the drain on BCC officer time in running the procurement process. For these reasons, it is recommended that the existing contracts be extended.

Recommendation(s) / steer sought: all recommendations must make clear the intended outcome

For the sexual health and substance misuse services that are currently delivered in GP practices and pharmacies to continue to be commissioned by Bristol City Council through the award of 18 month contracts to primary care providers.

Delegated authority for the Director of Public Health to award the contracts is requested.

City Outcome: *What is the proposed outcome for the city and how does this contribute to the Corporate Plan?*

The Mayor's Vision as articulated in the Corporate Strategy 2017 to 2022 is for Bristol to be a city in which services and opportunities are accessible and where life chances and health are not determined by wealth and background. Investing in accessible sexual health services will contribute to this outcome by preventing sexually transmitted infections and unintended pregnancies. Investing in substance misuse services will support vulnerable citizens to access health interventions that support their health and wellbeing needs, as well as contributing towards a safer city. The focus on early help and prevention will improve people's quality of life and avoid the need for higher cost care and support.

Health Outcome summary: The services are designed to improve the public health outcomes of the residents of Bristol, and will contribute to three indicators in the Public Health Outcomes Framework: under-18 conceptions; chlamydia diagnoses (15–24-year-olds); people presenting with HIV at a late stage of infection; successful completion of drug treatment (opiate users and non opiate users); successful completion of alcohol treatment; and deaths from drug misuse.

Sustainability Outcome summary: Measures on sustainability will be incorporated into the tender process, for example, a requirement to ensure that clinical waste is disposed of using sustainable methods.

Equalities Outcome summary: Services will be focused on people who already experience inequalities associated with their age, gender, ethnicity, sexuality, disability and economic status. The NICE research evidence about how to tackle health inequalities in the most cost effective way points to the importance of improving the range of contraceptive choices available in order to reduce unplanned pregnancies and to offer STI testing, targeted at specific groups at most risk.

Impact / Involvement of partners: *What is the impact on key partners? What engagement have they had?* : The proposal has been discussed at relevant meetings with key stakeholders. Colleagues from primary care, health and social care, housing, criminal justice, education, mental health, neighbouring authorities, VOSCUR and Public Health England have been engaged.

Consultation carried out: A formal 12 week consultation on substance misuse services took place, finishing on 6 April 2017. The sexual health services were considered as part of a wider public consultation on sexual health services last year, ahead of the tender for the integrated sexual health service. Although these services were not in scope, the incorporation of primary care into the new sexual health system was evaluated as part of the tender.

Legal Issues: These are Schedule 3 services, for which the threshold is £589,134. Above this threshold, the Public Contracts Regulations 2015 normally require that an advert is placed in the OJEU and that a fair and transparent procurement process is run. Subject to the point below, the direct award of these contracts would not comply with the legislation; however any pharmacy or GP surgery that wished to provide the services would, provided that it met the minimum criteria, be awarded a contract due to the nature of the expenditure being dictated by patient choice. The nature of the market is such that there should theoretically be no prospective challenger to a direct award, given that there would be no barrier to a qualified bidder being awarded a contract. I understand from the client that the only real risk in this regard is that a larger organisation may wish to effectively act as a middle manager in this regard. Given that we have no additional funding available, this would rely upon them convincing pharmacies/GPs to accept a lower amount in return for their acting as go between.

Legal Officer: Eric Andrews

Policy/Comms Officer: Not applicable

DLT sign-off	SLT sign-off	Cabinet Member sign-off
Alison Comley 28 th June	Cabinet Agenda Conference 19 th July SLT Sexual Health 6 th June SLT Substance Misuse 16 th May	Councillor Asher Craig 13/7/2017

Please note that appendices A, B and E attached to this paper relate to sexual health primary care services, for substance misuse services please refer to the key decision paper from 28 June 2017 HWB:

<https://democracy.bristol.gov.uk/ieListDocuments.aspx?CId=213&MId=2675&Ver=4>

Appendix A – Further essential background / detail on the proposal	YES
Appendix B – Details of consultation carried out - internal and external	YES
Appendix C – Summary of any engagement with scrutiny	NO
Appendix D – Risk assessment	YES
Appendix E – Equalities screening / impact assessment of proposal	YES
Appendix F – Eco-impact screening/ impact assessment of proposal	NO
Appendix G – Exempt Information	NO

Appendix A

Commissioning of primary care delivered contraception & STI services

1.1 Purpose of the paper

The purpose of this paper is to provide background information for the key decision on the future commissioning of the sexual health services currently delivered by GP practices and community pharmacies. The services relates to the provision of contraception and STI services that are designed to improve the sexual health outcomes of the residents of Bristol as required under the Health and Social Care Act 2012.

Discontinuing this service would have an adverse effect on the health of the citizens of Bristol. If this service were to cease there would be a dramatic reduction in the access to contraception and sexual health services, which would lead to a rise in unplanned pregnancies and sexually transmitted infections which would further exacerbate health inequalities. Sexual ill health is not equally distributed within the population, and strong links between deprivation and STIs, teenage conceptions and abortions. There are particular sub groups that are most vulnerable, which include looked after children, care leavers, men who have sex with men, people involved in sex work, homeless people and some BME communities.

The project team have considered a range of different approaches for procuring these services. The relative benefits and risks of each approach have been appraised, and evaluated according to a set of key criteria. This process has confirmed that there are a number of complex legal, financial and policy considerations that need to be taken into account in procuring these services. This process concluded that the direct award of contract continues to be the most straightforward way of ensuring we have continuity of these mandated services. The involvement of primary care in key as a patient's GP and pharmacist are often the pathway into specialist sexual health services. Continuing to commission services in primary care will help to ensure smooth patient pathways and ensure that services are provided in convenient locations within communities that Bristol residents trust and already access for their general healthcare needs.

1.2 Current arrangements for commissioning these services from primary care

Bristol City Council currently commission GP practices and community pharmacies to provide sexual health services that fall outside of their NHS contracts commissioned by NHS England. This involves the fitting of contraceptive implants and intrauterine contraception (known as long acting reversible contraception or LARC methods), chlamydia screening and treatment, emergency contraception for young people and condom distribution. The services are commissioned through separate contracts with 48 individual GP practices and 94 pharmacies across Bristol. Since the local authority became responsible for commissioning these services in 2013, the contracts have been directly awarded on an annual basis at the start of the financial year. The contract covers a range of public health services including drug and alcohol services, health checks and stop smoking services.

1.3 What are the key reasons for commissioning these services?

There are a number of local and national drivers for commissioning these services:

Mandated public health services

Under the Health and Social Care Act 2012 there is a statutory requirement that open access sexual health services are provided /commissioned by the local authority. Additionally, local government responsibilities for commissioning most sexual health services and interventions are further detailed in The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013¹. Regulation 6 requires local authorities to provide, or make arrangements to secure the provision of open access sexual health services in their area. Regulation 6 states that:

(1) Subject to paragraphs (4) and (5), each local authority shall provide, or shall make arrangements to secure the provision of, open access sexual health services in its area—

- (a) By exercising the public health functions of the Secretary of State to make arrangements for contraceptive services under paragraph 8 of Schedule 1 to the Act (further provision about the Secretary of State and services); and*
- (b) by exercising its functions under section 2B of the Act—*
 - (i) for preventing the spread of sexually transmitted infections;*
 - (ii) for treating, testing and caring for people with such infections; and*
 - (iii) for notifying sexual partners of people with such infections.*

(2) In paragraph (1), references to the provision of open access services shall be construed to mean services that are available for the benefit of all people present in the local authority's area.

(3) In exercising the functions in relation to the provision of contraceptive services under paragraph (1)(a), each local authority shall ensure that the following is made available—

- (a) advice on, and reasonable access to, a broad range of contraceptive substances and appliances; and*
- (b) advice on preventing unintended pregnancy.*

(4) The duty of the local authority under paragraph (1)(a) does not include a requirement to offer to any person services relating to a procedure for sterilisation or vasectomy, other than the giving of preliminary advice on the availability of those procedures as an appropriate method of contraception for the person concerned.

(5) The duty of the local authority under paragraph (1)(b) does not include a requirement to offer services for treating or caring for people infected with Human Immunodeficiency Virus.

Cost effectiveness of sexual health services and future savings to local authority and NHS budgets

There is strong national evidence that investment in sexual health services will reduce future costs to local authorities as well as the NHS. Prompt access to high quality sexual health services will reduce the onward transmission of sexually transmitted infections (STIs) and unintended pregnancies, both of which will prevent a future upturn in expenditure for Bristol City Council.

¹ <http://www.legislation.gov.uk/ukxi/2013/351/regulation/6/made>

Unplanned pregnancies

The health costs of unintended pregnancies will have direct consequences on NHS budgets, including abortions, miscarriages, still births and live births depending on the outcomes of the pregnancy. However it should be noted that Bristol City Council has jointly commissioned an integrated sexual health service with the CCG for Bristol residents which includes all termination of pregnancy (abortion) services. As a joint investment between the local authority and the NHS there is an element of risk share which is of benefit to both parties, and it is not the intention of either commissioner to claw back in year savings. However with increasing financial pressures we will continue to have discussions with the CCG, NHS England and other partners to inform a broader risk sharing approach across Bristol so that savings to the wider system as a result of Bristol City Council's investment, through this contract, is recognised and understood. Additional costs for children's health services will have an impact on services commissioned by the local authority (health visitors and school nurses) as well as NHS commissioners.

The Advisory Group on Contraception have produced a cost calculator which models the costs of unplanned live births to public sector budgets beyond healthcare costs.² This includes spend on education, housing, personal social services and social welfare. The tool, which is recognised as being very conservative in its methodology, estimates that 367 live births per annum in Bristol are unplanned pregnancies, which is associated with an additional public sector spend of £1,143,475 per annum (see table).

Select Local Authority :		Deprivation Sector ⁶ :		Total Population ⁴ :	
Bristol, City of UA		Red		442,474	
	Local Authority Bristol, City of UA	Region South West	Regional L.A. Average South West	National England	
Live births ^{1&3} :	6,442	58,403	1,622	661,496	i
Estimated number of unplanned pregnancies resulting in live births ^{1&3} :	367	3,329	93	37,705	i
Total estimated education cost per annum ² :	£532,060	£4,823,646	£133,990	£54,634,562	i
Total estimated housing cost per annum ² :	£127,615	£1,156,951	£32,138	£13,104,090	i
Total estimated personal social services cost per annum ² :	£60,312	£546,783	£15,188	£6,193,091	i
Total estimated social welfare cost per annum ² :	£423,489	£3,839,336	£106,648	£43,485,867	i
Total estimated public sector cost per annum ⁴ :	£1,143,475	£10,366,715	£287,964	£117,417,610	i
Total estimated public sector cost per annum per capita ⁴ :	£2.58	£1.91	£1.91	£2.16	i
Additional savings associated with 5% reduction in unplanned pregnancies resulting in live births :	£57,174	£518,336	£14,398	£5,870,881	
Additional savings associated with 10% reduction in unplanned pregnancies resulting in live births :	£114,348	£1,036,672	£28,796	£11,741,761	

Teenage pregnancies place a significant additional pressure on local authority budgets. Although Bristol has made significant progress in reducing its teenage pregnancy rates over the last decade, reducing spending on emergency contraception and long acting reversible contraception has the potential to reverse the progress that has been made. This risks an increase in young women and children experiencing disadvantage, living in poverty, with poor education and employment prospects. Also important, children born to teenage mothers are more likely to become teenage parents themselves and so perpetuate the cycle of disadvantage.

² The impact of unplanned pregnancies on local authority budgets cost calculator can be downloaded from <http://theagc.org.uk/useful-resources/>

Messages on delaying sexual activity continue to be integral to the strategy to reduce teenage pregnancies, but it is widely recognised that abstinence only approaches are not effective. Instead, front line professionals who work directly with the most vulnerable young people, such as foster carers, school nurses and youth workers, receive training to ensure they have the skills to deliver the right support and guidance to young people, and to signpost to sexual health services as appropriate.

Also important in terms of longer-term economic effects of unintended pregnancy is the impacts on earnings potential of mothers aged over 20 who have already completed their education.

Long acting reversible contraception (LARC), which includes intrauterine contraception, implants and injectable contraceptives, has a lower failure rate than all other methods and is the most cost-effective contraception available. A local authority with a population of 400,000 could save up to £790,000 per year by improving access to LARC and reducing unintended pregnancies.³

Sexually transmitted infections

Data on recent trends in STIs from Public Health England, show that the number of new STI diagnoses is continuing to increase in Bristol, which reflects that national picture. Young people aged 15 to 24 experience the greatest burden of STI diagnoses, which is in part due to ongoing unsafe sexual behaviours. STIs can have lasting long term and costly complications if not treated and are entirely preventable. The current primary care services which support young people's STI testing and condom use are important evidence based prevention strategies which aim to reduce the transmission of chlamydia and other STIs, including HIV. Without these services, Bristol is likely to see an increase in transmission of STIs which will put a significant financial pressure on the specialist sexual health service, Unity, which is commissioned by Bristol City Council to treat STIs. In addition, there will be increased costs resulting from Bristol residents attending open access sexual health services in other local authorities (BCC are invoiced for these attendances).

National policy

In March 2013 the Department of Health published a "Framework for Sexual Health Improvement in England" which set out the Government's ambition to improve sexual health and wellbeing of the whole population. Whilst acknowledging that some elements of sexual health have already improved in recent years, the framework highlights important issues that still need to be addressed. This includes the need to:

- continue to work to reduce the rate of sexually transmitted infections (STIs) using evidence-based preventative interventions and treatment initiatives
- reduce unwanted pregnancies by ensuring that people have access to the full range of contraception, can obtain their chosen method quickly and easily and can take control to plan the number of and spacing between their children
- ensure joined-up provision that enables seamless patient journeys across a range of sexual health and other services – this will include community gynaecology, antenatal and HIV treatment and care services in primary, secondary and community settings

The Public Health Outcomes Framework published by the Department of Health in 2012 which sets out the national & local strategic direction for public health, includes three indicators for local authorities in relation to sexual health services:

³ Figure from NICE LARC Guidance <https://www.nice.org.uk/guidance/cg30>

- Reduction in under 18 conceptions
- Chlamydia diagnoses in young people (15 to 24 year olds)
- Reduction in numbers of people with HIV diagnosed at a late stage

NICE Guidance

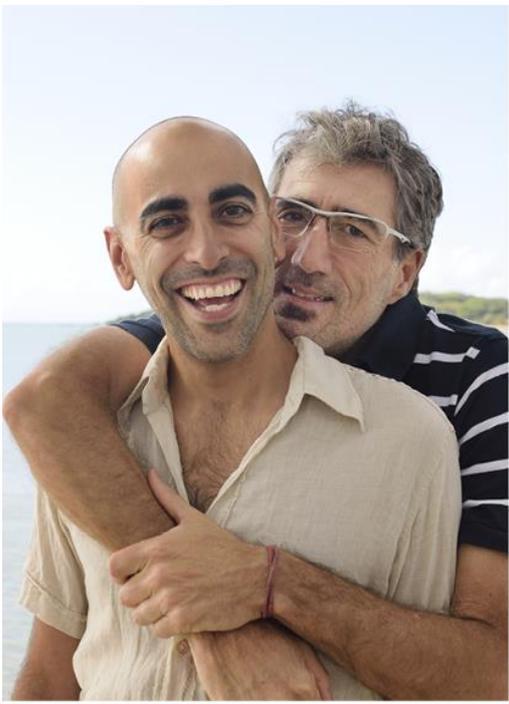
Guidance from NICE (2014) states that, while all methods of contraception are effective, LARC methods such as contraceptive injections, implants, the intra-uterine system or the intrauterine device (IUD) are much more effective at preventing pregnancy than other hormonal methods, and are much more effective than condoms.⁴ This is because the effectiveness of barrier methods and oral contraceptive pills depends on their correct and consistent use. By contrast, the effectiveness of LARC methods does not depend on daily concordance. NICE Guidance on contraceptive services for under 25s recommends that local arrangements should be put in place to ensure all young women can easily obtain free oral emergency contraception.⁵

NICE has recently released guidance on preventing sexually transmitted infections (STIs) through condom distribution schemes⁶. The guidance, published this year, recommends that local authorities consider providing free condoms as part of existing services that are likely to be used by those most at risk, with GP practices and community pharmacies being cited as specific examples of services. Young people aged between 16-24 are at particular risk of STIs, with most diagnoses of chlamydia and genital warts being found in this age group. Condoms are the best way to prevent most infections being passed through sex, and increasing their availability has the potential to significantly reduce STI rates.

⁴ <https://www.nice.org.uk/guidance/cg30>

⁵ <https://www.nice.org.uk/guidance/ph51>

⁶ <https://www.nice.org.uk/guidance/ng68>



Sexual Health Matters

A report on the consultation to improve sexual health in Bristol, South Gloucestershire and North Somerset



Contents

1	Introduction	3
2	Executive Summary	5
2.1	Overview	5
2.2	Key themes	5
2.3	Conclusions.....	10
2.4	Recommendations	11
3	Survey.....	13
3.1	Introduction	13
3.2	Methodology.....	13
3.3	Respondents.....	15
3.4	Key findings.....	16
4	Focus groups	45
4.1	Introduction	45
4.2	Methodology.....	46
4.3	Focus group profiles.....	48
4.4	Summary of findings	48
4.5	Acknowledgements	67
5	Other feedback received from local stakeholders	68
	Appendix A: Scope of the Reprocurement	71
	Appendix B: Focus Group Facilitator Brief.....	73
	Appendix C: Brook Young People’s Survey Findings	77

1 Introduction

A new procurement of sexual health services across Bristol, North Somerset and South Gloucestershire is due to begin in April 2016 with any new provider arrangements starting in April 2017. It is planned that the procurement will cover a wide range of sexual health services commissioned by both local authorities and clinical commissioning groups in these areas. More detail on the scope of the procurement can be found in Appendix A.

Commissioners recognised that an essential step in the design of the new service was a period of public consultation on a set of draft plans. This took place from 1 November 2015 to 31 January 2016. The aim was to better understand the needs and preferences of a wide range of current and potential service users as well as those interested in protecting and improving sexual health and wellbeing across our whole population. This included seeking the views of people who are at higher risk of poor sexual health outcomes so that the new service can effectively tackle health inequalities.

The feedback received through the consultation will be used to shape the final service specification and other tender documents that bidders will be asked to respond to. It will influence the assessment questions asked of potential providers around the quality and suitability of the services they propose. Commissioners will be looking for a clear link between the needs and views of local residents and the plans put forward by potential providers.

About this report

A wide range of feedback was received during the consultation period. In particular, views were expressed through three key methods:

- 1) An online and printed survey
- 2) A series of focus group discussions targeting groups at higher risk of poor sexual health outcomes

- 3) A number of public events, discussion forums and a survey facilitated by local stakeholders

The first section of this report – the Executive Summary – combines the key themes that emerged from all of these consultation methods to give an overview of key issues, challenges and recommendations for change.

A more detailed review of each of the consultation methods is available in sections three to five of the report. A series of other supporting documentation can be found in the appendices, such as detail on the scope of the procurement. The consultation website www.sexualhealthconsultation.co.uk will remain live until the contract has been awarded. The draft service specification, sexual health needs assessments for each local area and full consultation report will be available on the website.

2 Executive Summary

2.1 Overview

This section of the report brings together the findings from all consultation activity on the planned Bristol, North Somerset and South Gloucestershire sexual health procurement. It organises that feedback into key themes that must guide the detail of the tender documentation and the way in which potential bidders are assessed for the suitability and quality of the services that they propose.

It is recognised that this process of identifying key themes will inevitably simplify what is a very complex area of health and wellbeing. A wide variety of views were expressed taking in the needs and preferences of many people with different perspectives on what is needed to protect and improve sexual health and wellbeing. However, it is also the case that many of the issues that people spoke about reinforced each other and set down some fundamental principles of what services should look like and how they should respond to people's needs.

This summary is intended to highlight those key themes for a wide range of audiences and allow debate about how best to respond to them. However, it is important that both commissioners and potential providers of services should also read through the detail of all consultation activity to be clear on what a successful sexual health system should look like.

2.2 Key themes

(A) Understanding the population and prioritising prevention

Meeting the complexity of needs and preferences within the population

A clear theme that emerged from the consultation is the importance of seeing the wide range of population needs for sexual health services and support. Any service

or mix of services must be based on a good understanding of how people want to engage with a service and their preferences for how it should be delivered if they are to experience good outcomes. Potential providers should draw on the published evidence, local sexual health needs assessments and views expressed in the consultation to ensure they have sensitivity to the needs of different groups.

Issues mentioned by respondents included:

- ensuring services are provided in an open, non-judgemental and empathetic way
- providing information and advice in culturally sensitive ways
- working with/through organisations that have reach and credibility with the groups whose needs are being addressed
- delivering services through staff and resources that are representative of the population groups that they serve.

The draft service specification for the new sexual health service already identifies a number of key population groups at risk of poor outcomes and feedback from these groups has emphasised the need to look at their issues in detail with no assumptions about how needs can be met or adopting a one size fits all approach.

Education and prevention – schools, relationships and a sex positive approach

Respondents frequently emphasised the benefits of preventing problems before they start and creating the right environments for young people to develop confidence and knowledge to be able to manage their own sexual health effectively. This includes helping young people to learn about sex and relationships in school and providing support services that are relevant to the issues that they face. Building the right partnerships with schools and young people's services is considered essential to make this happen.

There were many mentions of concern about how young people and indeed others form their beliefs and confidence about different types of relationships. Building self-

esteem, learning respect for others and having the skills to manage risk and consent well were all mentioned as areas where consistent improvements are needed. As well as educating people, especially young people, about risk, a number of respondents mentioned the need to emphasize that relationships and sex should be healthy and enjoyable. However, there were also some who expressed concern about service access or advice without parental input.

(B) Good and fair access to services

People need a range of access points

In what could be seen as an echo of the points made about the complexity of different population needs, it is clear that access needs to be provided through a variety of routes. The benefits of specialist services, particularly for those who are vulnerable or who have complex needs, were recognised by many participants. They are seen as a valued resource and one that should be easy to access when in need. Having specialist support in central locations is seen as helpful for transport access and important for some population groups, for example, sex workers or homeless people.

Many people spoke about wanting choice to access services either by home or work location, particularly if opening times are limited to work hours. For some, services easily access by public transport are seen as important whilst others, for example, young people and those living in deprived areas are looking for services within easy walking distance.

Local services in GPs and pharmacies are mentioned as important as are the links between these local access points and more specialist services. Some are more comfortable accessing services through GPs than others, based on a preference for specialist staff or worries about anonymity. However, good training for local clinicians and reception staff was identified as a means of increasing confidence in the benefits of using these services.

Other community access points, in particular services for young people, were also identified as providing an essential function. Again, these services need to be provided by suitably trained staff who have credibility with the population groups that they are there to serve.

There were some concerns about the purpose and scope of having online and telephone based support. In particular, it was emphasised that some may not be able or comfortable in accessing support in this way, there were also concerns about confidentiality and the skills of those providing advice and signposting. It was also stressed that there are occasions where face-to-face contact is essential to fully understand and respond to a range of needs. The issue of how test results could be notified is also an area where people have concerns. Any online or telephone support needs to take account of these issues.

A number of respondents mentioned the benefits of having weekend and evening opening hours to ease their access to services.

Some were clearly interested in using technology to help manage their own sexual health and access to services, with young people and those living with HIV particularly confident in this area. Promotion of these resources needs to appeal to the target audience and use channels that are relevant, for example, Grindr for men who have sex with men. The issue of having a 'brand' for sexual health was confusing or concerning for some, with some questioning the need to move beyond a trusted NHS or specialist provider identity. Any approaches to promoting new services would need to be well researched and communicated with the public.

Provide outreach to vulnerable groups

Improving the quality of main sexual health services is considered a constant challenge but even with the highest standards many feel it is essential that services actively reach out to those who need support the most.

The importance of engaging with young people in the locations, forums and language that appeals to them was frequently emphasised. Linked to this point, but also encompassing other population groups, many emphasised the need to work

with the voluntary and community sector in understanding and responding to different communities' needs. There was an emphasis on maintaining and building on progress made through these links. Some respondents also spoke about the benefits of peer support, for example, BME groups and those living with HIV.

As well as specific sexual health services or clinical treatment points, the importance of working alongside other agencies that support those in need was often mentioned. For example, ensuring high standards around sexual health advice and needs in areas like drug and alcohol support, mental health, homelessness advice, and working with those that support people with learning disabilities. As mentioned around dedicated sexual health services, it was felt that having an extended workforce reflecting the character of all communities can help people to engage and trust the advice and support that is being offered.

(C) Quality of support

Visible, useful information meeting needs of different groups

The need for better messages and advice around prevention has already been noted and part of this effort is seen as a need to make sexual health a more visible topic for everyone to engage with. This is seen as important not just for access to services but also to challenge any potential stigma and attitudes that may increase risk to self or others, for example, consent, domestic violence or safeguarding.

A more visible service could also assist people to access services that they value, for example quick routes to testing. Any promotion of services should take into account the needs of different population groups, for example, reflect the needs of adults over 25 and their lifestyles e.g. entering a new relationship for the first time in many years.

Confidential, trusted and empathetic services – reflect people they serve

Confidentiality was a consistent theme through many responses with respondents clearly stating that this is a 'must do' for any sexual health service and the credibility of any arrangements must be obvious and trusted by any potential service user.

The quality of staff training, both within main sexual health and other linked services, has already been highlighted. For some groups having support from same sex staff was also deemed important, for example, sex workers. Having safe and informal spaces for people to access without judgement was identified as a key requirement, particularly for those with complex needs and risks to manage. Awareness around the needs and preferences of specific groups was identified many times for example, the LGBT community, BME groups or people with learning disabilities.

(D) Other considerations

For some respondents there was concern that any changes to services through procurement could lead to charges for services. There was also some confusion over why services provided through the NHS would be put out to tender in this way. It is important that any final documentation or information for the public is clear about why procurement of services is a legal requirement of local commissioners and to emphasise the fact that services will continue to be provided free at the point of delivery.

2.3 Conclusions

Many of the themes identified through the consultation chime with the issues identified through the sexual health needs assessments carried out for each local authority. Those were used to develop the original service specification which will now be reviewed against this more detailed feedback.

When looking at responses to the questionnaire, at least three out of four people agreed with the principles put forward in each of the questions so there was broad agreement. However, it is important that the issues that people highlighted are reflected in the final versions of the documents and assessment process used in the tender for sexual health services.

2.4 Recommendations

For commissioners:

- There is a need to be clear on expectations of service access times e.g. extended or 24 hours, plus the approach for booked versus drop-in appointments
- It is essential that service users/the public can be involved in both assessing the proposals of potential providers and have ongoing input into service delivery
- Through the online questionnaire people have suggested a list of potential questions for providers to be asked through the procurement process. These should be reviewed and used
- Be clear on why commissioning is happening the way it is including requirements around public procurement and address any confusion on the relationship with mainstream health services and concerns about charging
- Carefully assess any potential provider(s) on their ability to engage with local specialist agencies and those that have reach into the population groups that require information and support

For potential providers:

- There is a need to demonstrate a clear understanding of how to meet the service needs of different population groups either through working directly with those individuals or through organisations that have reach and are credible particularly with those at higher risk of poor sexual health outcomes

- Respondents were very strong around the need to support young people both through specialist services and ensuring all support is young people friendly. Any potential provider would need to clearly articulate its offer to young people and why it would be effective
- Although people support young people's services don't forget the needs of older adults and many highlighted ongoing needs such as new relationships, online dating etc.
- For online services there must be highly assured confidentiality and data security arrangements plus the ability to effectively signpost people elsewhere if they do not want to access support in this way, for example a preference for face-to-face help
- Any proposed phone service must have highly trained and effective empathetic staff in order to build confidence in this service
- If someone doesn't have a good experience of using services what is their alternative? How can someone find an effective way into the system with advocacy on their behalf?
- Any information produced and promoted to the public needs to be relevant to the audience it is aimed at; be clear on who this is targeting and not adopt a one size fits all approach as this will undermine credibility

For wider consideration:

- Recognise the strength of feeling about the importance of prevention. This is a theme that goes beyond the scope of just this procurement and addresses the chance to influence all opportunities to improve education and support around positive sexual relationships. There is a need to work with key partners to do this, for example, schools.

3 Survey

3.1 Introduction

It was felt that the best way to reach the widest range of people would be through an online consultation. A new website was developed for this purpose www.sexualhealthconsultation.co.uk which included background information about sexual health services and their procurement, as well as the online survey. A paper version of the survey was also made available upon request which could be returned to a freepost address.

The survey was based on the principles in the draft service specification, and included questions on prevention, the development of online and telephone based technologies, ensuring high quality services and ensuring good access to services. The survey also gave respondents the opportunity to suggest questions that could be posed to potential provider(s) when the bids are evaluated. The final question asked about service priorities given the limited finding that is available. For those who wanted more detail, the draft service specification and the needs assessments from Bristol, North Somerset and South Gloucestershire were also made available on the website under the section on further information.

The survey was open for 12 weeks from 9 November 2015 through to 31 January 2016.

3.2 Methodology

The survey was publicised widely through a variety of networks, including the circulation of 5000 promotional postcards (containing a QR code) across the area. This included:

- Local authority public consultation websites and staff intranet
- Facebook advertising targeted at under 25s
- Press releases in Bristol, North Somerset and South Glos

- Ask Bristol email
- Distribution of 5000 promotional postcards
- GP surgeries and pharmacies
- Sexual health service users
- Libraries and Childrens Centres
- Secondary schools and colleges
- Youth Mayors
- Healthwatch
- Youth services
- Twitter
- E-mail equalities groups
- E-mail young people's sexual health network
- E-mail PSHE teachers
- Care Forum

Answers to the quantitative questions were automatically analysed by the survey software. Qualitative answers were downloaded onto an Excel spreadsheet and analysed thematically. This involved systematic reading of the data, allocating codes to potential themes and subthemes, and then re-analysing the data to ensure all answers were attached to the codes generated. Themes emerged from the data and as systematic re-reading of the data occurred, some themes were condensed.

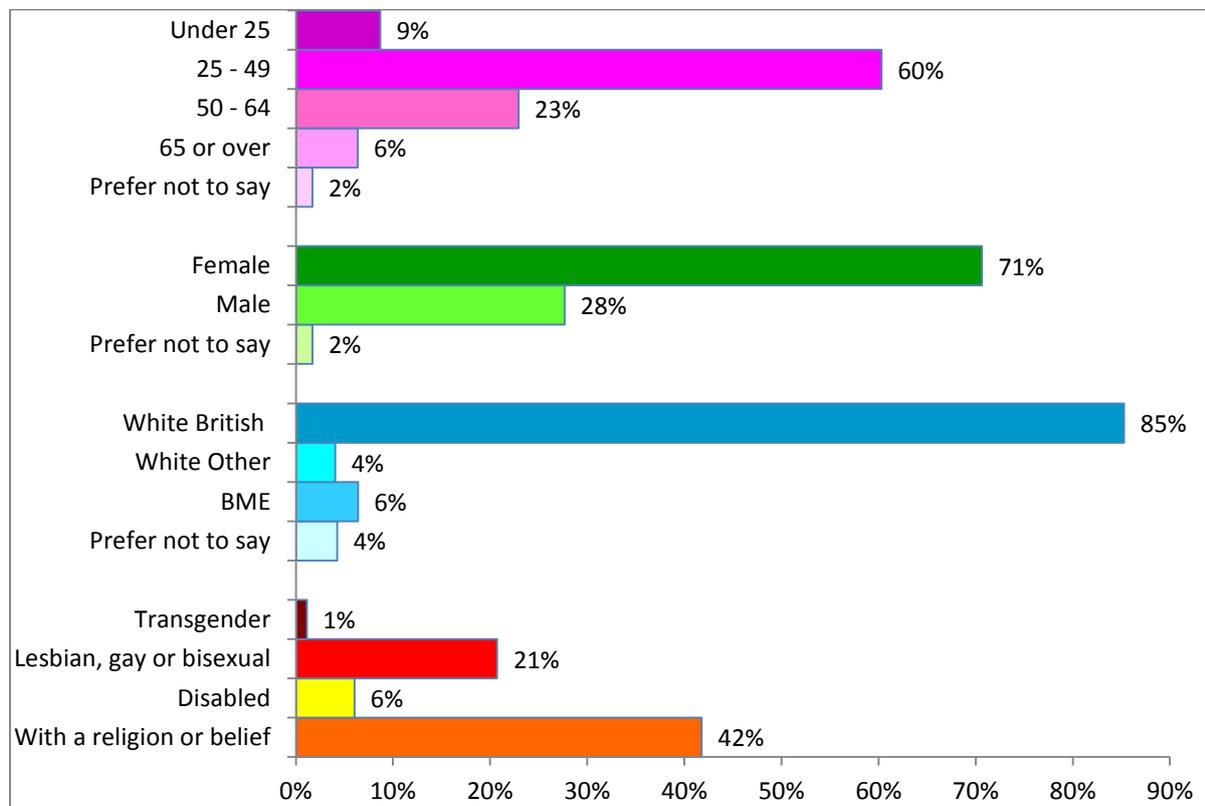
Themes were grouped to provide coherence to reading of the results and to form a basis for development of the recommendations. A team of three people worked on the coding in order to ensure consistency in the themes identified.

It is important to note the limitations of the survey. The results represent the views of those people who took part. As an open public consultation, no sampling techniques to produce representative research were used – the response is self-selecting as anyone with an interest could take part, and is therefore not statistically representative.

3.3 Respondents

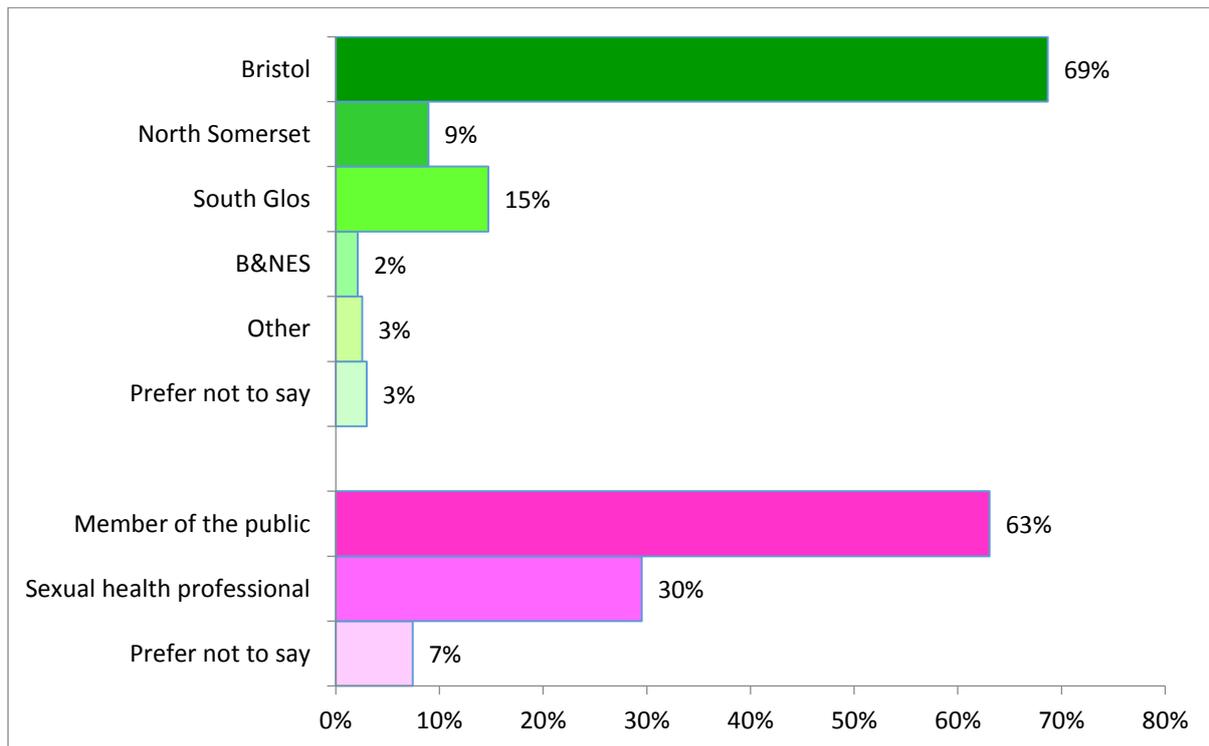
In total, 484 people responded to the survey. A summary of their demographic and equality characteristics are shown in the following chart. In general there was good representation across the local population, although young people under 25 and men were under represented in the sample. Following the mid-point consultation review, additional attempts were made to increase responses from these groups during the consultation through targeted promotion of the survey. Young people also took part in focus groups (see section 4 for more detail).

Demographic and equalities characteristics of respondents



Place of residence and professional interest in the consultation are shown in the following chart. This demonstrates an over representation of Bristol residents in relation to population, and also over representation of professionals involved in the provision of sexual health services, although this would be expected given the nature of the consultation and the direct impact on this group.

Place of residence and background profile of survey respondents



3.4 Key findings

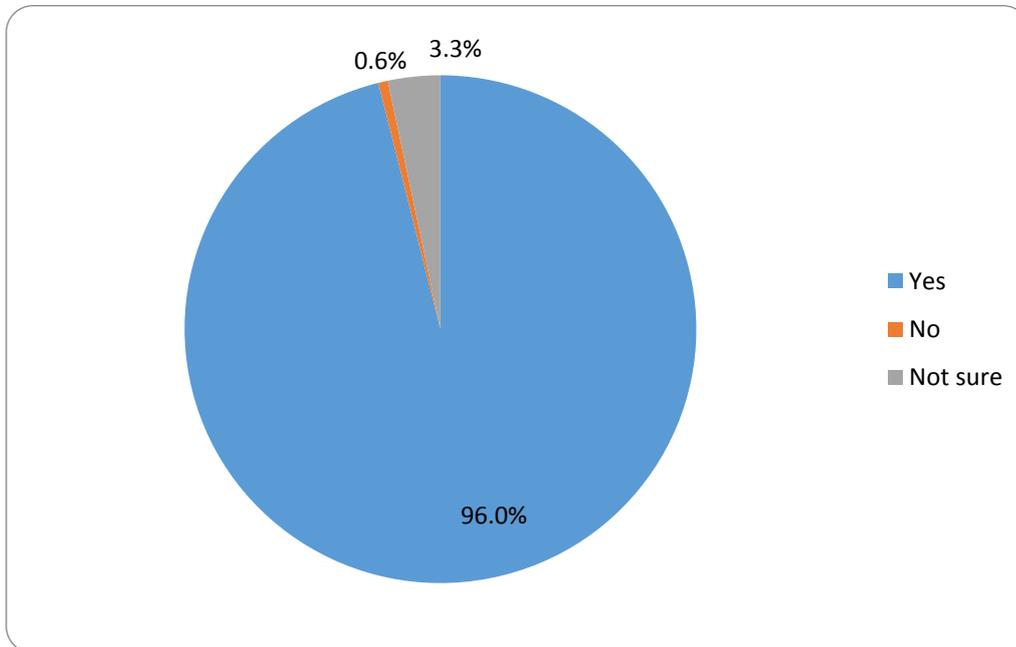
(A) Promoting positive, safe and healthy relationships

Question 1 was about the principle of prevention. Respondents were told that we would like to stop problems before they start. This means:



How many people agreed with this approach?

479 people answered this question, 96.0% (460 people) agreed with this approach, 0.6% (3 people) did not agree and 3.3% (16 people) were not sure.



If people answered 'no' or 'not sure' what reasons did people give?

From the responses given (21 people replied with 463 not answering this question):

(Please note: The bullet points below are set out in order with the most commonly mentioned theme discussed first, moving down to the least frequently mentioned theme)

- There was a strong emphasis on meeting the needs of different population groups for any service to be successful, for example, the LGBT+ community or people with disabilities. Any services must understand and reflect the complexity of sexual health needs in our population.

“My impression is that this approach seems focussed on issues relevant to young age straight sex (resisting peer pressure / intervening early). I suggest further consideration to adequately encompass specific issues relevant to gay sex and sexual activities of older people.”

- Respondents also discussed the need to promote healthy, respectful relationships including enjoyment of sex not just management of risk.

“I agree with them all, especially peer pressure, however I think there should be something about consent, healthy relationships and respecting and understanding consent.”

“Well it all sounds a little too formal. A happy life is not just down to your services. Freedom to enjoy responsible sex as well.”

- People felt there is a need for education about risk to ensure people are well informed and to influence behaviour but any service must also recognise the limitations of getting people to change behaviour

“Prevention is about informing people what STI are out there, how they are spreading, the rate they are spreading, and then inform people how to avoid getting an STI.”

- Prevention is also dependent on good access to this type of advice within sexual health services

“The above statements fail to mention the importance of ease of access to clinical services, the importance of early treatment and the importance of partner notification.”

Is there anything else we should consider?

From the responses given (115 people replied with 369 not answering this question):

- The most commonly mentioned factor was the need to educate young people including through strong partnerships with schools

“Clear PSHE in all schools and FE colleges around consent and health relationships.”

“More projects and courses that would help prevent teenage pregnancy and YP engaging in sexual relationships too young.”

- Respondents also put a strong emphasis on flexible, easy access to services including extended hours including complementing this with appropriate outreach services

“Ensure that there is a good ratio between targeted services for those most at risk of poor sexual health outcomes.”

- A high number of people picked up on tackling attitudes and behaviours that can lead to poor sexual health outcomes such as low self-esteem, risk of coercion, lack of understanding around different sexual identities etc.

“As well as ensuring young people have the right skills and confidence - knowing how and where to access services.”

“I am surprised that abusive relationships are not explicitly mentioned.”

- The importance of understanding and providing for a range of different sexual health needs was emphasised such as younger and older age group needs, making services relevant to LGBT+ or BME audiences and providing support or information in audience specific approaches

“Making sure that by giving the right information includes accessible easy read information for people with learning disabilities.”

- Building on this point about understanding of needs there was also emphasis on equality of access to services to meet all of the community’s needs

“It is important to provide services which are accessible - geographically, psychologically and at the right time in the day.”

“While we need prevention this can't be to the detriment of specialist high end services. Without responding to those with most chronic need effectively we will endanger the health of others.”

- A less frequently mentioned but identifiable theme was the benefits of a proactive, visible service using evidence based approaches

“Prevention is important, but it requires a proactive approach - people are less likely to seek help and advice before a problem arises. This means that the visibility of available advice and services must be high, actively promoted, and convenient to access.”

- Another less frequently mentioned theme within this question (but mentioned elsewhere) was concern that the people working with the public have the right skills and use the right channels of communication to be credible with each audience in order to effect change

“Early stage preventions should be more closely linked with other services such as mental health, substance abuse, and any other factors which often result in higher levels of risk.”

“Equal and true access of services for young people from all backgrounds, gender, geographical areas, sexuality i.e. working with sports clubs and similar to enable boys and young men to access information and services that are vital to their development.”

- The need for confidentiality to maintain user confidence was also mentioned

“Ensuring that all young people (and adults for that matter) have access to confidential services regardless of race, ethnicity or religion.”

(B) Managing your own sexual health

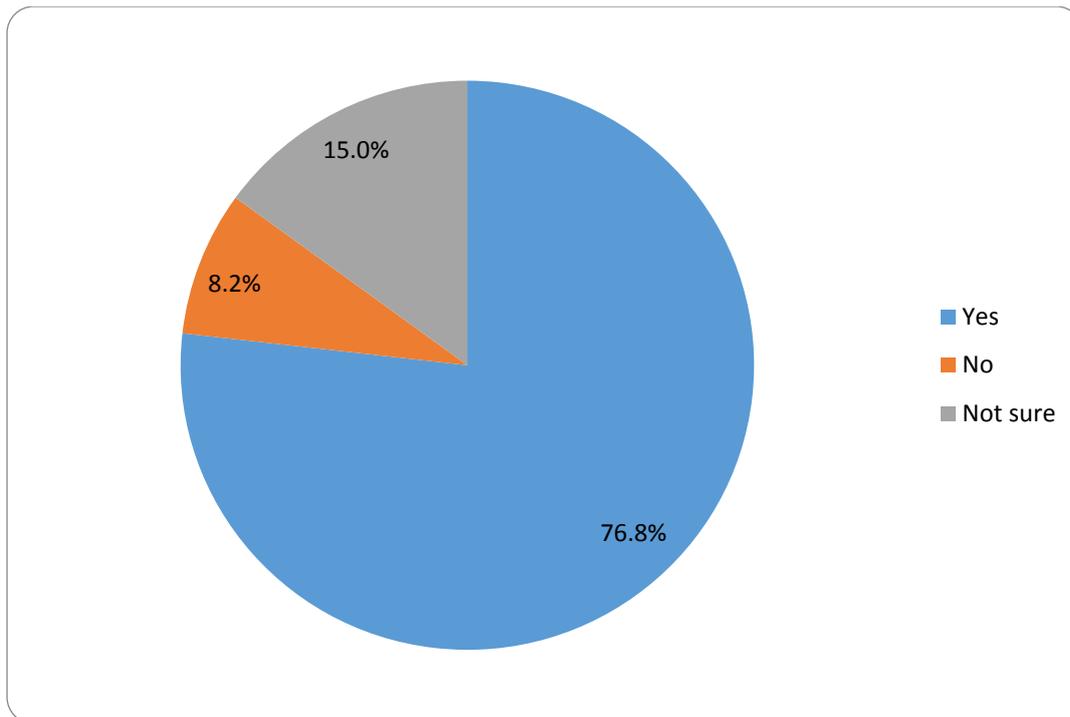
Question 2 was about the development of online and telephone based technologies and their increasing potential to provide more joined up support. Respondents were

told that we would like to:



How many people agreed with this approach?

474 people responded to this question. Of these 76.8% (364 people) agreed with this approach. 8.2% (39 people) did not agree and 15.0% (71 people) were not sure.



If people answered no or not sure what reasons did people give?

From the responses given (111 people replied with 373 not answering this question):

- The most common concerns were that online and telephone services would limit or replace opportunities for face to face consultations. Many felt that personal contact and conversations with skilled staff are essential for picking up on issues such as sexual exploitation, domestic abuse and safeguarding. There were particular concerns for high risk and vulnerable groups, who may not know or understand what their needs are without talking to someone. The importance of young people being able to talk to a person they know and trust was highlighted.

“I think it's extremely important to make sure receiving results online doesn't become a replacement for people being able to speak to someone face to face - not everyone receives information best in that way.”

“In my experience, and peers experience, face-to-face support has been much more significant than any online or telephone based services, especially when issues are more serious.”

- There was some disagreement that a strong brand should be developed. Reasons given were that spending money on branding would be taking away from the investment that should be made into improving the quality and effectiveness of the service. Also that branding sounds too corporate, and that the NHS brand is already a strong brand that people have confidence in. There were also concerns that it would be difficult to create a brand that would be appropriate for the full range of service users.

“Honestly who cares about a "brand" for sexual health services? Money is wasted promoting style over substance, let's concentrate on the services themselves?”

- For some, there was uncertainty about what a 'single point of contact' means, and worries that it means sexual health services would only be available in one place by one provider. These respondents felt that a range of services should be available in a variety of places to support patient choice, including GP practices and local clinics. They also expressed concerns that people may be less likely to access services without adequate choice being available.

“I have concerns that one single contact point might mean some people will not get in contact for fear of bumping into people they don't want to see, or going back to the same place they had a difficult time.”

“Patients will approach different organisations for different issues and nothing should be built into the system that will discourage this.”

- There were worries expressed that a single approach would not recognise that specialised services and targeted approaches are required in order to reach specific communities. Specific equalities groups mentioned included men who have sex with men, young people and people with learning disabilities.

“If it is all grouped as one not all people will feel comfortable accessing the services as it could never cater for everyone's needs. Talking about sexual health is about building up trust- something which I believe can only be done with specific services which have a reputation for providing this confidential service.”

“Creative solutions and services are required to support vulnerable and marginalised people who may be disengaged from mainstream services.”

“A single point of access may mean a 'one size fits none' situation. If you have a single point of access you may exclude those who will only access single sex services or young people specific services.”

- There were reservations about whether online and telephone services are appropriate, particularly for certain groups who are at high risk of poor sexual health outcomes. Although there were positive comments that online services would be convenient and would increase access for many, it was pointed out that not everyone has internet access. Health literacy is poor amongst certain groups and online services would not be able to ensure patients understand what they need and are being told. In relation to online booking of appointments, the importance of retaining the option of regular drop-in clinics alongside was emphasised.

“Booking systems don’t always work for young people with chaotic lives - often those most at risk of poor sexual health outcomes. Regular drop-in clinics may be more appropriate for young people.”

“A lot of my client group struggle with literacy, not sure how they would manage if they had to do everything by phone, or on computer, rather than be able to ‘drop in’.”

- Specific concerns were raised about whether online testing kits delivered to home addresses would be appropriate for certain groups. Examples were given of people with mental health issues and substance misuse issues who may have difficulties using the kits. There were also concerns around confidentiality for young people who still live at home, and for under 16s where there may be safeguarding concerns.

“The ability to get free/confidential tests online would only appeal to the small minority of worried well patients - a large proportion of patients like the contact with a doctor/nurse as they want to be able to ask questions.”

- Concerns about online security and the confidentiality of personal data, especially in relation to test results being made available online. Particular concerns were expressed about confidentiality for people who may have a controlling partner.

“I would be concerned about the potential for online test results to be hacked/externally accessed.”

“This could be utilised by forceful partners to ensure their partner checks their results with them watching.”

- Discomfort with online results for STI tests, particularly for those who test positive, without the opportunities to provide support and explanation.

“My only concern would be people receiving abnormal results online without immediate access to a healthcare worker for advice or support.”

Is there anything else that we should consider?

110 people answered, and 374 people did not answer this question.

- There should be links to the online services from sites that target groups are already using.
- The brand should be one or two words and easy to remember so that it will easily come to mind when it is needed
- All providers under the brand need to demonstrate the same commitment, expertise and accessibility
- Cost effectiveness of online testing kits should be considered, and a pilot conducted before rolling out more widely
- Really good information needs to accompany the offer of online testing kits
- There should be an option to collect testing kits from a service as well as having them delivered to the home address
- There is already a good amount of sexual health information available online from national websites such as NHS Choices. Adding to this at the local level will make it more confusing for people to understand the best source of information on the right contact
- The telephone line should not include automated messages such as "press 1 for... please hold" as this can make people more agitated, reducing the ease of getting help."
- Online services should be targeted at low risk individuals so that higher risk individuals can attend services and receive better, more in depth care
- Online services will be easier for users and may attract people who would be embarrassed to ring for an appointment
- The single point of access needs to be properly staffed and include clinical support to answer questions and ensure that the correct appointment can be booked and pre-appointment advice can be given

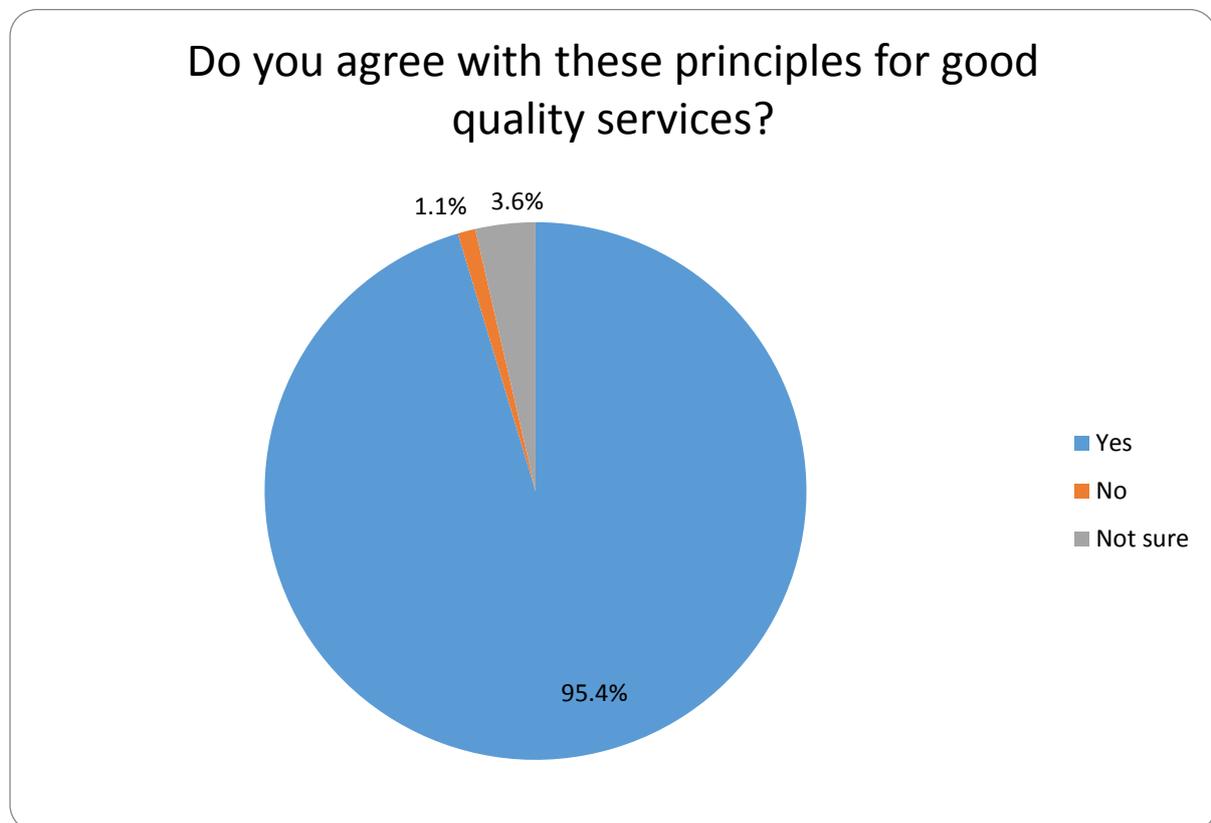
(C) Developing high quality services

We want to develop high quality support. We think this means a service that is:



How many people agreed with these principles?

475 people answered this question, of whom 95.4% (453 people) agreed with the principles, 1.1% (5 people) disagreed and 3.6% (17 people) were not sure.



If people answered ‘no’ or ‘not sure’ what explanations did people give?

21 people left comments and 463 people skipped this question.

The varied comments reflected the wide range of themes within this question:

- A few people pointed out the safeguarding caveats and limitations to the principle of “always confidential”

“A service cannot be ‘always confidential’. There are times when confidentiality must be breached – e.g. when there are safeguarding concerns or there are statutory duties to report (e.g. Female Genital Mutilation in under 18s). Staff would need to be clear on the guidelines.”

- Other points may be summarised as follows:
 - Clarification needed on what “tested to high standards” means
 - Support for healthcare professionals needed
 - Need to provide all levels of service in one place/hub
 - A quick service is important, with less waiting
 - Specialist (not just skilled) support needed for minority groups
 - Need to ask young people their thoughts on this
 - Involve staff as well as public in development of services

“I would want the service to be able to not only discuss but also provide all treatment options - including all reversible contraception options.”

Is there anything else we should consider in relation to quality?

71 people left answers to this question and 413 skipped this question.

Responses again reflected the wide range of areas within the Quality section. There were a few themes more frequently mentioned (between 5 and 10 times):

- The needs of young people were specifically raised. In summary the three key points made were:
 - More education/behaviour change work is needed for young people
 - Accessible young-people friendly services are important
 - Services and commissioners must ask and listen to young people's views

“While the staff may not judge, it will be essential to make a comfortable environment so (young) people are comfortable talking about sexual health.”

“It is a skill to provide quality services for young people. It is essential to have specialists to ensure quality sexual health prevention work is available to young people.”

- The need for health professionals to be well trained in equality and diversity issues was also specifically raised, with particular reference being repeatedly made to the need for better understanding of LGBT+ needs and of those suffering from domestic abuse

“Ensuring staff are educated with respect to different needs of different groups e.g. bisexual, gay, lesbian, trans, disabled, different ethnic groups etc.”

“Bristol and surrounding area are particularly well known as hubs of LGBT+ support, I would like the doctors and extended services to reflect that.”

- Another equally frequently mentioned theme was the need for outreach services and support, with an emphasis on how important face-to-face services are for more vulnerable groups. It was suggested a few times that the voluntary sector have much expertise and should be included in supporting vulnerable groups

“As well as saying 'will never judge people' perhaps another box about vulnerable populations, e.g. 'trying to reach and help the most vulnerable people in our area'.”

“Users who do not feel safe and confident may not even be able to disclose the nature of their needs. Therefore trust relationships and face-to-face contact with skilled, sensitive and informed advisers is paramount.”

“Consider that there may be voluntary organisations who are skilled and trained at providing some of these services - not everything need necessarily be provided by statutory organisations.”

- Some of the other (less frequently repeated) themes within comments were
 - The need for more integrated services, providers working closely in partnership, smooth patient pathways and combined with support.

“A comprehensive offering that takes care of the patient holistically (advice, support, clinical services, counselling etc.) and strives for continuous improvement”
 - The question of how quality will be measured and whether training will be available for staff to assure this
 - Whether the public will be adequately involved in evaluating and developing services
 - Will services reach out to older and more vulnerable people

“I feel older people should be considered here, and the specific communication needs of those with vulnerabilities and a history of self-neglect who may be at particular risk.”
 - Access needs to be local and convenient with shorter waiting times
 - The workforce make-up should reflect that of the community

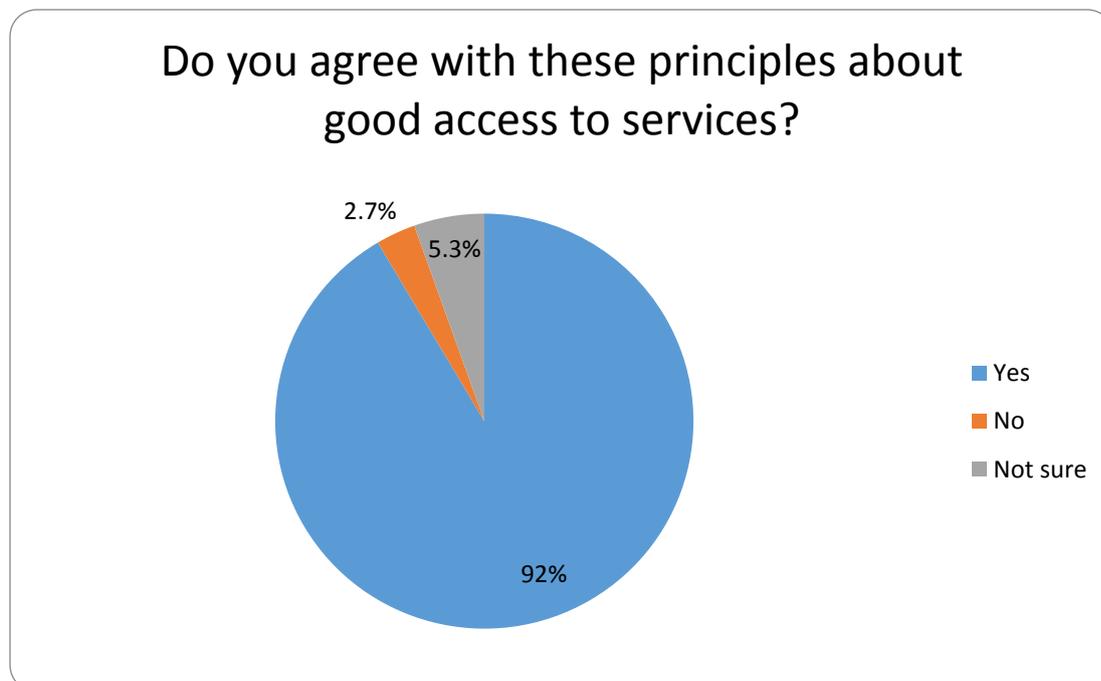
(D) Accessing services easily

We believe this is about getting people to the right support in the right place at the right time. This means:



How many people agreed with these principles?

474 people answered this question, of which 92% (436 People) agreed, 2.7% disagreed (13 people) and 5.3% (25 people) were not sure.



If people answered no or not sure what reasons did people give?

From the responses given (33 people replied with 451 not answering this question):

- From the responses received the most frequently mentioned theme was that a choice of access points for services is essential.

“I would prefer to go to a specialist contraception centre and see a nurse who is specifically trained rather than go to my GP.”

“Patients should be able to choose what type of service they want to attend - this might not be the service that is closest to home - they might want to travel to specialist centres - this should be their choice”

“Some clients prefer not to attend close to home for reasons of confidentiality, for example, young people, people with STI, people who have risk of HIV.”

- There are concerns about restricting access in specialist centres as people may present with complex needs that can only be understood with that interaction and this also requires a strong emphasis on professional skills development

“How do you safely identify those with a clear need without attending a 'specialist centre' sometimes?”

“Providing services as close to home as possible has potential to dilute skill, expertise and resources.”

- Allow for routine local provision but ensure there is outreach for those least likely to access services

“Who are the group that don't often access support? Will this include men? Will support and advice be located in pop up places like festivals i.e. harbourside/ make Sundays special.”

- Some said it is good there is support for young people but there is also a need to respond to other groups

“Young people’s services in schools is an excellent idea. However, many people need access to sexual health services, and the services should be appropriate for all users, not just young ones.”

Is there anything else we should consider?

From the responses given (80 people replied with 404 people not answering this question):

- The most common factor mentioned by respondents was the need to have a choice of access points

“I have noticed that people can be willing to travel for a service that meets their needs and treats them with respect.”

“People’s choice of where to attend may be influenced by work location as well as place of residence - this should be taken into account.”

“Flexibility in accessing services to include on-line, telephone, face to face and postal options.”

- Another frequently mentioned area is that there should be support for those in greatest need to access help effectively

“There should be more / better sexual health services for those groups not accessing GPs or other services e.g. those exiting the criminal justice system, minority groups etc.”

“High risk groups - professionals will need a very good understanding of their health needs, support needed - e.g. Mental health, street sex working, substance misuse, young people, women from BME groups within the community, rough sleepers, understanding their diverse and complex needs - and having an approach that reaches the marginalised groups within the community.”

- A number of respondents also mentioned the benefit of extended (evening/weekend) hours

“Late opening of clinics would be particularly useful”

- People agree there should be specific support for young people but not exclusively without addressing adults’ needs

“I think it is excellent that there are specific provisions for young people but I have been turned away from a walk in clinic in the centre of Bristol for being over 25. People should never be turned away and told to use another service miles away.”

“Not everyone who needs sexual health services is young!”

- Ensure quality and safety in everything including through good professional training and resourcing

“This only works if the services are properly resourced both in terms of training the staff & funding the work and premises and unsociable opening hours if you are hoping to offer these to improve access.”

“Quality and safety is top priority.”

- Some expressed a view that there is an ongoing need for central locations for access and ability to deal with a range of needs.

“It is easier for most clients to access town centre vs having limited services in local areas, due to limited transport from outskirts of town.”

“It is important to remember that some of the key specialities of the service are its holistic approach and opportunities to link various health aspects...The importance of retaining this aspect in more routine services such as contraception should be recognised.”

(E) Getting the right people for the job

The fifth question related to the evaluation of the bids received. It was explained that these services are currently provided by a range of different organisations on behalf

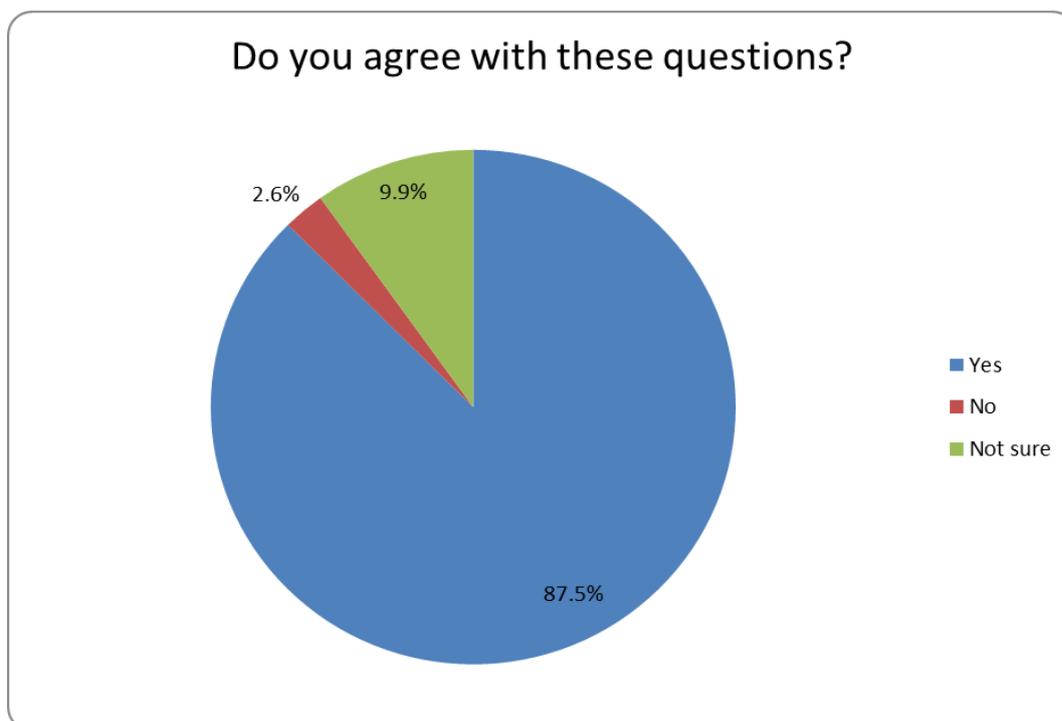
of the councils and the NHS. We will be inviting all organisations who think they can offer these services the chance to provide them in the future. Each organisation will have to put together a detailed proposal for us to assess.

Some of the things we will ask them are:



How many people agreed with these questions?

465 people responded to this question. Of these 87.5% (407 people) agreed with this approach. 2.6% (12 people) did not agree and 9.9% (46 people) were not sure.



If people answered no or not sure what reasons did people give?

From the responses given (52 people replied with 432 not answering this question):

- The most common concern was that the services would be provided by private companies and that profit would be put before people’s needs. Many of these respondents felt that NHS organisations should provide the service.

“I hope the offering of these services to external partners is not leading to privatisation and that these services will not run at a profit by taking more money from the NHS than they need.”

- Particular concerns were expressed about the question on how the service will offer value for money. Some asked how this would be measured, and also how this would be prioritised in relation to the other questions. There were worries that this would mean cuts to services, and that saving money would be considered to be more important than the quality of the service.

“As long as it doesn’t mean by value for money the cheapest. In the long run the cheapest doesn’t mean good value when taking everything into account.”

- A number of people pointed out that the questions did not cover the expertise of the staff providing the service and how well their training would be supported. Related to this, some respondents pointed out that staff should be easy to relate to and inclusive in their approach.

“I feel you should also ask how they train and keep educated the people that work in these organizations - how they ensure inclusivity and understanding of particular issues to LGBTQI+ BME and less abled people.”

- Some people felt that the question on the friendliness of services should be expanded to include all ages, and not just young people. Others criticised the question for not going far enough for young people.

“I think it is important that you find out how they will also make their services friendly to older people who may be using the service for the first time and maybe more inhibited/anxious than a younger person.”

“Ensuring services are young people friendly is more than simply having a young people friendly 'kite-mark'.”

- A small number of people expressed concerns about the model for tendering sexual health services and particularly whether smaller organisations would be disadvantaged and lose out to larger organisations if all services are joined together under one single lot.

“Some user groups need more specialist services and these could be tendered out separately, with the result being 2 or 3 excellent services. Communication can still take place between all the services, but sometimes smaller is better. Large organisations usually result in more waste and can be more inefficient by virtue of their size, despite the perceived savings from reduced HR/ secretarial/ admin departments etc.”

- There were a number of questions raised by the respondents about the procurement process and whether it is necessary.

- There were a small number of concerns that in the future services will not be free.

What other questions did respondents suggest that we ask?

From the responses given (98 people replied with 386 not answering this question):

- The most frequently suggested questions related to how the provider(s) would support staff and how they would ensure staff had the appropriate expertise and training to deliver high quality services. This included staff working directly for the provider as well as others in the sexual health system such as students and GPs. For example:
 - *“How will they support and value their staff”*
 - *“How they train their staff to deliver high quality, evidence based services?”*
 - *“How will they support the training of medical/nursing students, GP trainees, specialty trainees.”*
 - *“How will they support professional development of their staff?”*
 - *“You should be asking how they will train the future sexual health workforce to ensure a long-lasting, high quality service.”*
 - *“How can they ensure that wherever patients access they get high quality care?”*
- Questions about how the provider(s) would identify, engage and support vulnerable and at risk people were also frequently suggested. For example:
 - *“How will organisations ensure that they are truly providing a service accessible to those in greatest need?”*
 - *“How will they assess whether a young person is particularly vulnerable emotionally or mentally, or at risk of exploitation? What support will they offer in such situations?”*

- *“Ask questions about how vulnerable people i.e. sex workers, victims of abuse and rape, people at risk of/experiencing domestic violence and abuse, can be best supported to take control of their sexual health and access the services they need.”*
- *How they will help people who present with challenging behaviour, but still need and deserve a suitable sexual health service?*
- Related to this, a number of questions were about how the provider(s) would address equality and diversity issues. Questions about how they would ensure they were accessible to all ages were particularly prominent. For example:
 - *“How they will make their service accessible to people with learning disabilities?”*
 - *“How will they handle religion-based ethical issues?”*
 - *“What will they do to engage with community/ethnic groups who are less likely to engage?”*
 - *“How would they deal with specific issues related to LGB and Trans communities?”*
 - *“How will they make the services available to all ages young and old?”*
 - *“How will they make their services user friendly for older people? Older people are at significant risk and are seeing infection rates rising - and these people may be intimidated or otherwise feel inadequate by entering a venue with lots of colour, posters of young people and indeed waiting rooms with lots of young people in them.”*
- There were a number of questions suggested about ensuring patient privacy and confidentiality. For example:
 - *“Service providers should be asked to explain how they intend to upkeep patient confidentiality and protect the sensitive personal data to which they would have access.”*

- *“How will sensitive data be stored?”*
- A few suggestions related to how the provider(s) have and would ensure patient and public involvement. For example:
 - *“I'd like to see evidence that they've spoken to young people about their proposal.”*
 - *“How will they engage the public in planning the service?”*
- Some of the suggested questions were about how the provider(s) would work with partners to ensure a joined up approach. This included partnerships both within the sexual health system and with the wider workforce:
 - *“How will they work with schools, youth clubs, social workers not just health? Advertising shouldn't just be online, needs to be in person, with people visiting places and meeting the nurses?”*
 - *“How they will work in partnership with other organisations as no one organisation can be all things to all people.”*
 - *“How they will make sure that all health services are provided in a joined up approach, e.g. HIV testing, diagnosis and treatment.”*
- Other suggestions for questions (only mentioned by one respondent) included:
 - *“How will they ensure an evidence based approach is adopted/followed?”*
 - *“How they will ensure women who need an abortion can access this service in a timely, safe and compassionate manner?”*
 - *“What makes their service different or the best?”*
 - *“What are they doing that is innovative/ at the top of their game?”*
 - *“How will the service provider work towards long term solutions in which the service can be reduced in the future?”*

- *“How will they ensure there is effective signposting for which service is relevant for each person - e.g. GP vs online advice vs specialist centre?”*

(F) What factors are most important?

The sixth question was about prioritisation. It was explained to respondents that we need to make best use of the limited funding we have available. To do this we need to be clear about our service priorities.

What did people think should be our priorities in terms of sexual health?

From the responses given (413 comments were left and 71 people skipped this question):

Four key themes stood out within this large response, with a number of other concerns also raised.

The following themes were most frequently mentioned:

- **Young people**

Approximately a quarter of responses under this section mentioned the needs of young people, focusing mainly on the need for education and prevention work, especially around healthy relationships and consent, and the need for young people-friendly services, including access within non-clinical settings e.g. schools.

“Much better education for young people which does not patronise or shame them.”

“Accessible and well promoted services for Young People”

“High quality services for young people, to build their confidence and engage them in health services.”

“Sex and Relationship Education for young people - SRE Road shows.”

“Providing easily accessible, non-judgemental friendly services particularly for young people.”

- **Prevention and education**

Approximately a quarter of responses under this section emphasised the importance of prevention work to improve sexual health outcomes. Suggestions repeated included providing better sexual health promotion and publicity, better information about reducing risk of sexually transmitted infections and HIV.

“Prevention via education and publicising whatever services emerge out of the review so that people know how and where they can receive help.”

“Identifying 'repeat visitors' to clinics and helping identify the underlying causes for their sexual behaviour which mean they need to come back.”

“Prevention of one unplanned/ unwanted child saves society large costs, as well as human suffering.”

“Prevention strategies that change behaviour.”

- **Reaching vulnerable groups**

Approximately a quarter of responses emphasised the importance of education and sexual health services reaching out to people who may find it harder to access health centre or clinic-based services or are at higher risk of poor sexual health outcomes for various reasons.

“Reaching those most at risk and for reasons unknown do not access mainstream services. For example we need reach people in catchment area who are HIV positive but do not know this.”

“Education on risk and prevention targeted at specific vulnerable groups.”

“Ensuring minority groups within society have easy accessible services and the high risk groups are able to engage in the service provisions on offer.”

“I want you to focus what money there is in tackling the areas that cause people the most pain and suffering.”

- **Rapid access to comprehensive services**

Approximately a quarter of comments left to this question on priorities referred to the need for easy and timely access to sexual health services, with rapid access to testing and treatment of STIs most frequently mentioned. Some people mentioned the need for telephone consultations and online routes to testing within their comments on access.

“Accessibility. For someone who works full time it is incredibly difficult and inconvenient to get tested regularly.”

“One stop service for all sexual health needs. The latest testing techniques - including faster HIV screening. The ability to book appointments online and / or be provided with at home testing kits for those who ‘know the drill’.”

“Allowing people who want to schedule regular appointments to do so easily - online or over the phone.”

- Comments on the following issues were also included in the answers to this question:
 - The importance of services being confidential and non-judgemental
 - Access to Long Acting Reversible Contraception and free condoms alongside STI testing
 - Having services that are local
 - All services available in one place
 - Training for GP practices (e.g. in STI testing) to improve local access
 - Faster HIV testing and self-testing for STIs
 - Better contraceptive support following abortion

(G) Other considerations

The final question was an opportunity for respondents to raise any other topics they wanted to have their say on.

Was there anything else people wanted us to consider?

191 people left comments and 293 skipped this question.

A wide range of themes were covered within the comments here. Many are well represented within comments on other sections of the survey, but it should be noted that some people clearly chose to re-emphasise a point they felt strongly about here.

The previously mentioned themes of **access to education and services for young people, reaching out to vulnerable groups**, and the need to offer **easy access to services within a range of settings** including specialist clinics, GPs and young people-friendly are raised again here.

“Accessibility has been mentioned but very important, also sex education in schools is vital.”

“Reaching out to most vulnerable groups such as trafficked people, sex workers, people who have English (or not at all) as an additional language, rape victims and the young.”

“Easy access for all patients, i.e. close to work or home or school etc. i.e. in the community. Use technology for young people.”

Approximately a quarter of the comments under this question expressed some **concern about potential loss of access to services**. The range of comments included concerns about almost all services and settings, including specialist, GP, young-people specific and school-based services. Comments reflected a common desire to see reducing resources spent wisely, based on evidence and local need, and involving the local people.

“To evaluate previous contracts to determine their effectiveness, cost and lessons learned.”

“Prevention could be viewed as a key aim, however, it is also important to consider relationship-building with service-users through community and peer support, specific support groups, and educational projects for young people.”

“It is important that the service is under one roof and splitting it up will lead to disjointed care.”

Some of the themes within these comments that were less frequently mentioned, but are perhaps not well represented in comments in other sections of the survey include:

- Importance of links with psychosexual services
- Importance of links with other services such as mental health and drug and alcohol services
- Issue of access to services by people with English as a second or other language, in sign language, and for people with learning difficulties or disabilities
- Services targeting boys and young men
- How services are going to address the wider determinants of ill-health e.g. poor self esteem
- Gender and diversity issues/needs
- How quality training will be provided for specialists and GPs
- Access to abortion in places where access to Bristol city centre is difficult
- Importance of anonymity and confidentiality.

4 Focus groups

This section of the report was written by The Care Forum (TCF).

The full report can be found at

<http://www.thecareforum.org/pageconsultation-on-the-recommissioning-of-sexual-health-services-in-bristol-south-gloucestershire-and-north-somerset.html>.

4.1 Introduction

As part of the recommissioning process for sexual health services in Bristol, South Gloucestershire and North Somerset a series of focus groups were conducted in order to understand the views of seldom heard groups on what is important in delivering sexual health services in the region. The Care Forum (TCF) and Healthwatch delivered these focus groups and 12 were conducted between November 2015 and early January 2016. These views were collated and analysed in this report, which was completed in January 2016.

The Care Forum (TCF) is an independent voluntary and community sector infrastructure organisation working in Bristol, Bath & North East Somerset, South Gloucestershire, North Somerset and Somerset. TCF aims to:

- Support communication, consultation and networking with the voluntary and community sector (VCS)
- Promote partnership working with the VCS
- Empower adults and young people to voice issues about local social and community care services
- Provide information and advice about voluntary and statutory sector health and well-being services

Healthwatch listens and engages with people who use health and social care services across the region to help improve the design and delivery of services.

Healthwatch champions the consumer interest of all those who use local health and social care services, and provides independent feedback to commissioners and providers.

4.2 Methodology

In total 12 focus groups were conducted over a period of eight weeks. A series of five questions taken from the project plan were used as the basis of the focus group, which also used two activities in order to get information on what issues were most important, and which opening times and locations would be most appropriate for the services. The facilitator's brief, used in the focus groups, is attached to this report as an appendix and shows the questions and activities used to gather the information in the report. At the start of each focus group each participant was given an information sheet explaining the project, and given an opportunity to ask any questions. Participants were also asked to sign a consent form to adhere to basic research ethics and were able to withdraw consent and leave the focus group at any time.

The focus groups themselves gathered useful data but there were some difficulties with their delivery. We were unable to reach two of the target groups using this research method. These groups were **Children in Care** and **Care Leavers**. Attempts were made to organise focus groups with both of these groups but these did not occur, due to difficulties finding willing organisations, or of recruiting possible participants in the time frame of the project. In the case of **Children in Care** TCF were able to engage this group with other means (see below). **Care Leavers** also had some engagement through a meeting and discussion with the Bristol Children in Care Council. In a third case, we conducted a focus group with Eden House, an organisation that works with **Young Offenders** and **Sex Workers**, though the participants did not specifically identify themselves as **Young Offenders**, and were not included in the analysis as this. **Care Leavers** and **Young Offenders** are two groups who will need further engagement in order to properly understand their views.

In addition to the focus groups a number of other methods were used in order to encourage more engagement with the recommissioning process, including groups who were not engaged through the focus groups.

The methods that were conducted in addition to the focus groups included:

- Distributing 1000 postcards linking to sexual health recommissioning website.
Postcards were given to:
 - The Lighthouse, who work on the street with homeless and sex workers
 - Withywood Centre – Community health team and the local food bank
 - Hartcliffe Young Mothers Group
 - Healthwatch Bristol meeting
 - 100 postcards sent to children in care in South Gloucestershire by South Gloucestershire Council
 - Postcards given to University of West England.
 - Postcards given to Brigstowe Project
 - Postcards given to Off The Record
 - Postcards given to Youth Moves
 - Postcards given to Developing Health and Independence
 - Postcards given to The Hive
 - Feedback gathered from the Children in Care Council (Bristol)
 - Consultation discussed on Bristol Community FM 'Wellbeing Show' run by Healthwatch 8/12/2015
 - Sexual Health Recommissioning event on the 15/12/2015 at The Vassall Centre
 - South Gloucestershire Children and Young People's Mental Health and Emotional Wellbeing event 14/12/2015
 - Professionals at Joint Strategic Needs Assessment
 - Professionals at the prevention and self-care task group
 - Ministry of Defence wives group (The Hive) in South Gloucestershire
- Information going out in info sheets and emails sent out to networks linking to the sexual health commissioning website
- Tweets from The Care Forum and Healthwatch linking to the sexual health commissioning website

- Focus group materials sent out to other organisations (such as Brook, Off The Record etc) for them to carry out their own focus groups.
- Email sent by The Care Forum out to 42 organisations with link to the survey.

4.3 Focus group profiles

12 focus groups were conducted with a total of 82 participants. There were 36 women and 46 men. 20 individuals were BME, 23 identified as LGBT and 7 individuals had learning disabilities. 7 individuals stated they had experience of homelessness, 10 had experience of substance abuse and 15 individuals stated they had a mental health issue.

4.4 Summary of findings

The findings for this report will be presented in two stages. The first is a table showing the important issues and themes raised by each group in the focus groups and the second is a more in depth look at each group and issues they raised in the sessions, analysed by the different themes identified in the table.

Important issues

The following table summarises the issues raised by each group in the focus groups that were conducted. The issues raised are based on the following colour scheme:

Red = Issue very important/immediate priority

Amber = Issue somewhat important/less urgent priority

Green = Issue not very important/non urgent

The urgency of each issue was assessed due to either the urgency with which it was raised, or by the frequency, or in some cases both. This was recorded by staff conducting the focus groups and was corroborated with the information gained from activity 2, in which focus groups were asked to list their three main priorities for sexual health services.

As discussed in the Methodology section it was not possible to engage with all the different groups in the focus groups. Groups not engaged and not included in the table are **Children in Care** and **Care Leavers** and **Young Offenders**.

x-axis = group, y-axis = theme

	People living with HIV	Substance misusers	Sex workers	Men who have sex with men	Homeless people	Young People	People with learning disabilities	People with mental health issues	Black Minority Ethnic	Deprived areas
Accessibility	Red	Red	Red	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Red
Information	Yellow	Red	Yellow	Yellow	Red	Yellow	Yellow	Yellow	Yellow	Yellow
Education	Red	Yellow	Yellow	Red	Yellow	Red	Red	Yellow	Yellow	Red
Privacy/ confidentiality	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
Autonomy/ control	Yellow	Green	Red	Green	Green	Yellow	Red	Red	Green	Green
Specialist needs/services/ integration	Red	Red	Red	Red	Red	Red	Red	Red	Red	Yellow
Staff training/ professionalism	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red

Page 67

	People living with HIV	Substance misusers	Sex workers	Men who have sex with men	Homeless people	Young People	People with learning disabilities	People with mental health issues	Black Minority Ethnic	Deprived areas
Representative staff	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Green	Yellow	Red	Red
Technology/self-management	Red	Green	Yellow	Yellow	Green	Red	Yellow	Yellow	Yellow	Yellow
Layout of clinics	Yellow	Yellow	Yellow	Red	Yellow	Yellow	Green	Yellow	Green	Green
Opening times/locations	Green	Yellow	Yellow	Green	Yellow	Yellow	Green	Green	Yellow	Green
Transport	Green	Green	Yellow	Yellow	Green	Yellow	Yellow	Green	Yellow	Yellow
Peer support	Red	Red	Green	Yellow	Yellow	Yellow	Green	Yellow	Green	Yellow
Awareness of social/cultural/economic/gender/sexuality needs	Yellow	Yellow	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Red	Yellow

In depth analysis (by theme)

Accessibility:

Immediate Priority:

- Individuals with HIV stated that access was often difficult and that waiting times for appointments were often too long, particularly at drop ins, making it difficult to structure other priorities, such as employment. It was felt that there were plenty of services, but they needed longer opening times.
- It was suggested by individuals with HIV that there should be some kind of fast track system for people who need regular appointments, so they don't need to wait a long time.
- Individuals with HIV also stated that it was important to have one person to help guide people through services and serve as a point of contact.
- Substance misusers spoke of hearing many 'horror stories' about accessing treatment and felt that people needed to be reassured that they would be treated with respect when accessing treatment. They spoke of needing to be able to access treatment through specialist organisations which they used, or with a GP that they felt comfortable talking to.
- Men who have sex with men (MSM) felt that it would be useful to be able to access testing and treatment at other services, such as at blood donation centres, in order to destigmatise accessing sexual health treatment.
- MSM also stated that it was important to plan service locations integrated with transport in order to ensure more isolated people can access treatment.
- People in deprived areas stated that it was very important for services to be located close by, ideally within walking distance, or to have cheap and regular transport.
- Sex workers spoke of the need to access treatment, sometimes 24 hours a day. They stated it would be useful to be able to access treatment (like emergency contraception) from services such as 24 hour supermarkets.

Normal Priority:

- People with mental health issues spoke of the importance of being able to access treatment at a local GP, or with a clinic who they trusted, and could feel comfortable with.
- Homeless people stated that it was often difficult to access any treatment due to their circumstances. Individuals worried about being judged when accessing services. It was stated that being able to access sexual health services through specialist organisations would be helpful.
- Young people felt it would be easier to access appointments if they could book them online, or through a sexual health app, and also get appointment reminders via text.
- In one focus group with young people it was asked whether it would be useful for services to be located in schools. Participants felt that this could lead to rumours and bullying, and felt this would be a problem.
- People with learning difficulties felt that it would be useful to have more accessible materials, such as 'easy read' material, and leaflets that explained issues with pictures. It was also stated by participants that they felt it would be helpful to have assistance from support staff in accessing services.
- Black and Minority Ethnic (BME) people stated it would help access if staff at clinics were more diverse, representing the community they served, so that a service would feel more welcoming to BME individuals.

Information:

Immediate Priority:

- Substance misusers spoke of how important access to information was. It was felt that it was important to display information in appropriate locations for different client groups. This also included places which might not be seen as 'traditional' in order to access harder to reach groups.
- In the focus groups with individuals who were, or had been, homeless it was deemed important to have more access at specialist centres and to have professionals attend homeless centres as it was sometimes difficult to access other treatment centres.

Normal Priority:

- People with HIV stated that most of the useful information they had gained came from peer support, through people met at organisations like Brigstowe Project or Terrence Higgins Trust. People suggested that it would be beneficial to use peer support more frequently to spread information to people.
- MSM stated that it would be useful to have information displayed in non-traditional locations that may be used by the community, such as massage parlours or LGBT bars.
- Sex workers stated that they felt they often received conflicting information from different professionals, which often led to confusing situations.
- Sex workers also felt that it was important to have information in a variety of formats, including different languages.
- Young people stated it was important to have up-to-date, modern information about sex and relationships, including LGBT, transgender and other types of relationship, including through peer support. It was deemed as important to not just be heteronormative.
- Young people also stated that it was important to use language and terminology that they understood.
- People with learning disabilities stated that they wanted access to more information which they often felt was being held from them. Many individuals stated that they felt excluded from sexual relationships and wanted to know more. One person stated he was actively discouraged from finding out more about sexual relationships.
- People with learning disabilities also stated it would be essential to have information presented in an understandable format, as they often felt confused about terminology and issues.
- BME individuals in the focus groups spoke of the need for culturally appropriate information, and for information to come from peers to make it more accessible.
- Individuals from deprived areas spoke of the need to have more information available. One participant stated that very little information was on display in local GP clinics etc.

- People with mental health needs did not raise any specific issues with information, but stated that it would be useful to have information in more locations and for it to be appropriate for different groups.

Education:

Immediate Priority:

- People with HIV stated that they felt ‘top down’ education wasn’t working. Participants in the room stated that peer education they had experienced was very beneficial. Suggested that further peer support groups be set up as soon as possible.
- MSM and people with HIV both stated in their focus groups that it was key for there to be education around issues such as chemsex.
- People with learning disabilities had mixed experience of sex education when they were young. Some had had very good education, others had not had any. All stated that they found it useful to have refresher courses on both sexual education and wider education on relationships. Participants stated that it would be useful to have support staff assist them access courses.
- People with learning disabilities also felt that it was useful to have sex education in smaller groups so as to allow for more time to understand the issues and to ask questions, something that may be difficult in larger groups.
- Educational materials appropriate for people with learning disabilities (easy read for example) would be extremely useful for ‘self-education’
- Young people also stated that they felt early education as vital and stated that they felt having ‘peer support’ or education from other young people would help them to relate to the education better.
- Participants who identified they came from deprived areas stated that they also felt education was key, but noted that they felt there was a lack of available resources for them to access.

Normal Priority:

- In the focus group with substance misusers it was felt that the most effective education would be with children, before they became teenagers. It was felt that

professionals should regularly speak to year 6 or 7 children about sex and healthy relationships.

- Sex workers stated that they felt they were aware of sexual health issues, but that it would be important for young people to be educated more. It was also important to educate elderly people who have had no sexual education and who are starting new relationships.
- Individuals with mental health issues also emphasised the importance of education for young people.
- BME individuals stated in focus groups that there needed to be more peer education for individuals from different cultures, who may have different religious or cultural needs. It was felt that they had been judged by professionals and needed more sensitivity.
- The participants in the focus groups who had experienced homelessness talked about how they felt education was important for young people, but stated that accessing education would not be possible during times when homeless.

Privacy/confidentiality:

Immediate Priority:

- Confidentiality was deemed to be an important issue for individuals with HIV. Several participants spoke of attending appointments where the door was left open and people in reception could see in.
- MSM individuals stated that they felt specialist organisations (such as Terrence Higgins) were better at maintaining privacy and confidentiality than the NHS and that the NHS should follow their example.
- Young people stated that they worried about confidentiality and people at school finding out. Many young people disagreed with the idea of having services with school nurses, and instead preferred to access treatment through services like Brook.
- People with learning disabilities spoke of issues over privacy in their sexual relationships. Some spoke of being discouraged/prevented from engaging in sexual relationships by family and admitted they had engaged in sex in public, and had sometimes been caught, damaging their privacy.

- Homeless people in the focus groups spoke of it being difficult to have privacy in a sexual relationship given their circumstances. They also stated that it was important to have privacy when they visited clinics.
- Sex workers stated that they felt services often weren't very private and spoke of occasions where they had used booths rather than private rooms.
- Sex workers also felt that they would feel more confident about privacy if were able to speak to staff of the same gender as them.
- Substance misusers also stated that confidentiality was vital, and some stated that bad experiences with privacy had made it more difficult to return to services.
- People from deprived areas stated they felt it was important to have a good relationship with staff in clinics in order to feel confident about asking for treatment.
- People with mental health issues stated that they felt they needed to have "confidence in confidentiality" due to some bad experiences individuals had experienced.
- BME individuals spoke of confidentiality being important and how it may help to speak to people from the same community. It was deemed important that staff represent the community they serve as closely as possible.

Autonomy/control:

Immediate Priority:

- Sex workers felt that they needed to be more in control of accessing treatment and of being able to choose who they spoke to in the event of needing regular treatment.
- People with learning disabilities felt that they were actively encouraged to not have a sex life. Several individuals in the focus group stated that family and some support staff had discouraged them from sexual relationships. It was felt that this removed their autonomy. One individual stated: "People interfere and try to put you off all the time."
- People with mental health issues stated that they would like more control over the delivery of their care and wanted to be able to choose which staff they spoke

to about their issues. They wanted to be able to express a preference over seeing someone regularly if necessary.

Normal Priority:

- Young people felt that they had a good level of self-management, and felt that to some extent they could regulate their sexual health with technology though they did still want access to professional help.
- People with HIV stated they were able to self-regulate their own health to some extent using specialist online websites but felt they would prefer more peer support groups to help them.

Non Urgent Priority:

- This was not a major issue for people who lived in deprived areas.
- This was not an issue which was important for substance misusers.
- This was not an issue for MSM individuals.
- This was not an important issue for individuals who had experienced homelessness and who instead preferred access to treatment and advice at clinics.
- This was not an issue for BME individuals.

Specialist needs/services/integration:

Immediate Priority:

- Sex workers spoke about the need for specialist services. Participants stated that there were issues such as trafficking, rape, abuse, controlling relationships etc. Services should be able to spot this, and provide counselling. It was felt that signposting alone was not adequate.
- BME individuals spoke of the need to have services delivered by BME communities. One participant (an African woman) stated that she felt it was “important to have black led organisations involved in service delivery or to have BME community workers”.

- People with HIV spoke about how it was important to integrate specialist HIV services into wider sexual health services. It was strongly felt that clinics should refer people to peer support groups.
- MSM participants spoke of the need to have workers who representative of the community, and stated it would be good to have lesbian, gay, bisexual and transgender (LGBT) staff, or organisations.
- Homeless people felt they should be able to access sexual health services at homelessness organisations.
- Some young people felt it would be useful to have access to sexual health services at places like school or college. However, some disagreed and felt this would lead to bullying. It was felt by all the young people that it was important to work closely with organisations that support young people.
- People with learning disabilities stated they would sometimes need help from support staff to access treatment, and would like organisations that work with individuals to be part of services.
- People with mental health spoke about how sexual health services could be integrated with mental health services as issues could be related. For example, risky behaviour in a manic episode could lead to a sexually transmitted infection (STI).
- Substance misusers also stated service integration was important as issues of drug use and sexual health can be related. One participant discussed chemsex and the link between taking drugs and risky sexual behaviour.

Normal Priority:

- Individuals from deprived areas stated that having well linked services would be beneficial and help them access treatment.

Staff training/professionalism:

Immediate Priority:

- People with HIV stated that they had experienced negative issues with staff. They felt judgements had been made their lifestyles. It was suggested that staff, from reception to senior doctors, be given more training to address this.

- People with HIV also stated that a simple step, of asking about general wellbeing, at the start of an appointment was something positive when it was done in clinics.
- MSM also spoke of occasions when they felt judged by staff. They felt it was important to train staff to make the services more welcoming.
- Homeless people, or people had experienced homelessness, in the focus groups spoke about how they may not feel welcome in a clinic.
- Young people stated that they felt staff training was important, and some individuals raised the issue of specialist training for LGBT issues.
- Young people also stated that they felt it would be beneficial to have staff who were the first point of contact to be knowledgeable about sexual health issues and services.
- People with learning disabilities felt that it would be beneficial to have staff who were trained to support them. It was felt that reception staff sometimes used “long words” or “spoke too fast” and it was confusing or difficult to understand.
- Substance misusers stated that they felt it was important to have well trained staff, who understood issues of drug and alcohol abuse.
- Sex workers felt that staff needed to be “understanding” of their issues and “empathetic” of their situation.
- People with mental health issues also stated that they felt it was important to have staff who understood them, from the first point of contact through to treatment.
- BME individuals felt that it was important to have staff who understood the different cultural and social needs of different communities in Bristol.
- Individuals from deprived areas felt that staff needed to be welcoming and understanding of their issues.

Representative staff:

Immediate Priority:

- BME individuals felt that the best way to have staff who understood cultural and social issues would be to recruit staff from the communities they serve, and to make them as demographically representative as possible.

- Individuals from deprived areas stated that they felt it was important to have staff who were demographically representative, and who understood the communities they served.

Normal Priority:

- People with HIV stated that it would be good to promote sexual health nursing amongst different communities in order to be representative.
- MSM felt that it was important for staff to be representative of the communities they worked in.
- Sex workers felt that it was important to have access to staff of the same gender in clinics so they could feel more comfortable and open.
- Substance misusers stated that it was important to have staff from a variety of backgrounds who could relate to different people.
- Young people felt that it important for staff to be representative, and particularly highlighted LGBT issues.
- People with mental health issues stated it would be helpful to have staff who were from different communities to respond to different communities.
- Homeless people stated that staff who had understanding of different communities would provide better treatment. This could be achieved with more representative staff.

Non Urgent Priority:

- People with learning disabilities did not feel that this was a major issue for them, though stated they felt it was important to have staff trained to understand the issues they faced.

Technology/self-management:

Immediate Priority:

- People with HIV spoke of using web resources to help self-manage. Resources such as myHIV or <http://www.hiv-druginteractions.org/> were stated to be good examples and it was suggested that these be promoted.

- It was also stated by people with HIV that it would be useful to have specific apps to be able to book appointments.
- Young people stated that they were comfortable using apps to regulate their own sexual health and gather information. They also spoke of being able to use texts to book appointments etc. However, they stated that they recognised that not all would be capable of using these technologies.

Normal Priority:

- MSM stated that it would be beneficial to have advertising for sexual health services through applications used in the community, such as Grindr/Tinder that may be used to seek sexual partners.
- MSM individuals also stated that they wanted a text message system for drop-ins, or an app which will allow people to walk away from a clinic rather than sit waiting for a long time and be given a 15-20 minute notice to return.
- People from deprived areas stated that they knew people who might struggle to access information online. Many participants stated that they would personally be able to use online services, but may have concerns with confidentiality.
- Sex workers stated that they had the skills to use online services to gather information or book appointments, but raised concerns about confidentiality.
- Sex workers also stated that information on the internet needed to come from “trusted sources” as a lot of information online can be “scaremongering”.
- People with learning disabilities stated that they often had issues getting online if they lived in supported housing. Websites are blocked on shared computers, to stop pornography, but this can also block information websites. Participants stated that they wanted to find a good site to get accurate information.
- People with mental health conditions stated they had no issue with using online information, but stated information needed to be accurate and well-advertised.
- BME people stated no concerns about using online information, but also stated it needed to be accurate and easy to find online.

Non Urgent Priority:

- Participants in the substance misuser focus groups stated that online information was not a priority for them in a service.

- Homeless people stated that they did not prioritise online information and would often find it hard to be online other than using shared computers.

Layout of clinics:

Immediate Priority:

- MSM individuals stated that the layout of clinics needed to be changed to make them friendlier with relevant magazines – people in the room felt that the clinics were ‘too sterile’ and did not feel welcoming.

Normal Priority:

- People with HIV stated in the focus groups that they felt clinics did not feel welcoming in their layout. Some participants spoke of clinics in Brighton which were excellent, and who had a more ‘informal’ atmosphere.
- Sex workers also felt that clinics have an informal feel, and not be too clinical. More choice of magazines would be good.
- Substance misusers also stated they would prefer more informal settings in clinics.
- Homeless people stated that they found it difficult to go into clinics sometimes as they felt they could be unwelcoming.
- Young people felt that clinics should be friendlier to them, with more appropriate reading materials.
- People with mental health conditions also spoke of needing a friendlier, more welcoming environment.

Non Urgent Priority:

- People with learning disabilities did not prioritise the layout of clinics.
- BME people felt that clinics should be laid out to be more welcoming but did not feel it was a main priority.
- People in deprived areas felt that clinics needed to be welcoming, but that other issues were more important.

Opening times/locations:

Normal Priority:

- Substance misusers felt that it was important to have services available within walking distance and to be open in the evenings.
- Sex workers felt that some treatment needed to be accessible 24 hours, such as getting contraception at any time.
- Homeless people felt that the waiting times for treatment were very long because opening hours were not long enough.
- Young people felt that weekends were the best time for services to be open.
- Some BME participants stated that they felt opening times needed to be in the evenings or weekends, and also have appointments that can be done over a lunch break.

Non Urgent Priority:

- People with learning disabilities did not feel this was a priority issue for them
- People with HIV did not feel opening times was a major issue for them, though felt that lunch break appointments would be ideal for many people.
- MSM individuals felt that it would be good to have services located in organisations like Terrence Higgins Trust.
- Individuals with mental health conditions did not raise any issues with opening times or locations, but stated that more evening and weekend appointments may be useful.
- Individuals from deprived areas did not have any specific needs for opening times, but stated they generally attended appointments between 9am - 5pm.

Transport:

Normal Priority:

- People with learning disabilities stated that they found it important to have support in learning new transport routes, so if clinics were moved they would need help to access them.

- Sex workers felt that it would be best to have services located in the city centre so that they would be accessible by public transport.
- MSM individuals stated that it was important to have good public transport to clinics all week, weekends can be slow.
- Young people stated a preference for services to be within walking distance, or within easy reach of buses.
- BME individuals stated a preference for good public transport links to services.
- Individuals from deprived areas preferred to have transport within walking distance.

Non Urgent Priority:

- Individuals with HIV did not have a priority for transport, as this was not an issue for any of the participants. All stated they felt there were many services around the city they could access through public transport or car.
- Substance misusers stated they felt public transport was important, but did not have any major issues accessing clinics.
- Homeless individuals expressed a preference for services within walking distance, but it was not a particular issue for individuals.
- Individuals with mental health conditions did not express any issues over transport, though thought public transport should be integrated into plans for locating new services.

Peer support:

Immediate Priority:

- People with HIV strongly felt that peer support would be a vital thing to use in sexual health treatment, particularly for those diagnosed with serious conditions. It was felt that peer support had been vital for patients.
- Substance misusers also felt that peer support would be vital, as others who had experience with substance misuse would understand the issues they faced.

Normal Priority:

- MSM felt that peer support groups could also be useful for individuals who were LGBT or had other specialist needs for services.
- Homeless people in the focus groups felt that it would be useful to speak to other patients who had experience of homelessness, and knew how to access services.
- Young people felt it would be helpful to get advice on sexual health from other young people, and to share experiences of treatment.
- People with mental health issues felt it would be useful to speak to other patients who had experience of mental health issues, and knew how to access services.
- Some of the individuals from deprived areas mentioned that peer groups could be useful to learn about different sexual health services.

Non Urgent Priority:

- Sex workers did not feel that this was a priority issue for them, and instead stressed the need for trained and diverse staff.
- People with learning disabilities did not feel that this was a priority for them and preferred access to more formal education sessions.
- BME individuals did not feel that this was a major priority, feeling diverse staff was more important.

Awareness of social/cultural/economic/gender/sexuality needs:

Immediate Priority:

- Sex workers felt that staff at clinics needed to be more aware of diverse social, economic, cultural, gender and sexuality needs as they sometimes felt judged by staff.
- BME staff felt that there needed to be concerted efforts to make sure staff were aware of cultural, social and economic needs in the communities they served.

Normal Priority:

- People with HIV stated that they felt it was important to have reception staff who had an understanding of their issues, as well as other groups in society. One individual stated that he was on Employment Support Allowance (ESA), and was advised to “eat better” at appointments, even though he struggles to afford food – he found this offensive.
- Substance misusers felt that staff needed to show cultural awareness.
- MSM felt that doctors at clinics needed to be more aware of their sexuality.
- Young people felt that there needed to be a greater awareness of LGBT issues amongst staff.
- People with learning disabilities felt that staff needed to be trained in awareness of different needs in society.
- Individuals from deprived areas stated that they felt reception staff needed more awareness on various cultural and social issues, and put a particular emphasis on LGBT issues.
- Individuals with mental health issues felt that all staff, from reception to clinic doctors, needed more awareness of the various needs of people in community, including issues such as economic status and culture, in order to be more understanding of patients.
- Participants who had experienced homelessness felt there needed to be more understanding of the issues facing homeless people, particularly economic.

4.5 Acknowledgements

The Care Forum, Healthwatch and the three councils involved in the project would like to thank all participants in the focus groups for their time and opinions as well as all staff and volunteers who conducted, or assisted with the organisation and facilitation of the focus groups.

5 Other feedback received from local stakeholders

Information on the consultation was shared with a wide range of networks through a number of key methods:

- Cascade e-mails with an introduction to the consultation and link to the online questionnaire sent to different networks of interested professionals and local stakeholder groups
- Articles in external or internal newsletters issued by interested organisations e.g. corporate communications from the local authorities
- A media release issued in each of the local authority areas designed to increase publicity around the opportunity
- Attendance at a number of meetings or forums where there was the opportunity to discuss the consultation and planned procurement with interested groups and individuals (a full list of events is listed at the end of this section).

Set out below is a summary of the main attendances at local events. These can be categorised into three key categories:

1. *Internal discussions at the commissioning organisations* – this included attendance at senior leadership team meetings. Feedback included direction on how to run the procurement process effectively (Bristol City Council) and the need for equality of access and developing an integrated community service model with primary care (Bristol Clinical Commissioning Group).
2. *Working with the Voluntary and Community Sector (VCS) to engage a wider range of community groups* – this was achieved through events run by the Care Forum in North Somerset and Bristol/South Gloucestershire. Some of the themes identified in these discussions were ensuring prevention is a priority, the need to help people find the right help quickly and a desire to work closely with the VCS to reach and support those in need. There was also a request for clarification on how the procurement would be lotted into different services, greater explanation of the system leadership role and concerns that young people and people with learning disabilities had not engaged with the online survey.

3. *Specific events for potential providers* – these opportunities to explain and clarify the commissioners' intentions were held in each month of the consultation process. Attendees wanted more information about how the procurement would be run, identified challenges in responding to the timescale for developing proposals and had some concerns about how services could be coordinated in a new system. The last event reflected the position to move GP and pharmacy services out of scope of the procurement and this raised questions about how you can build an integrated approach across different commissioning pathways.

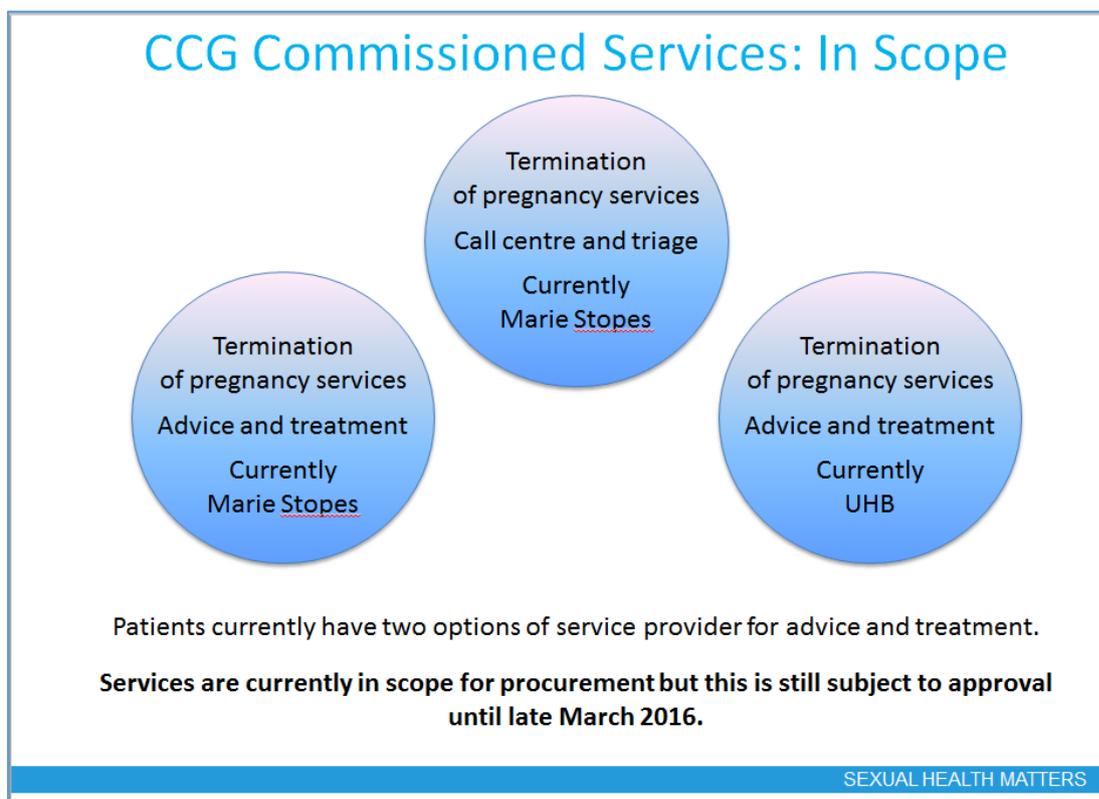
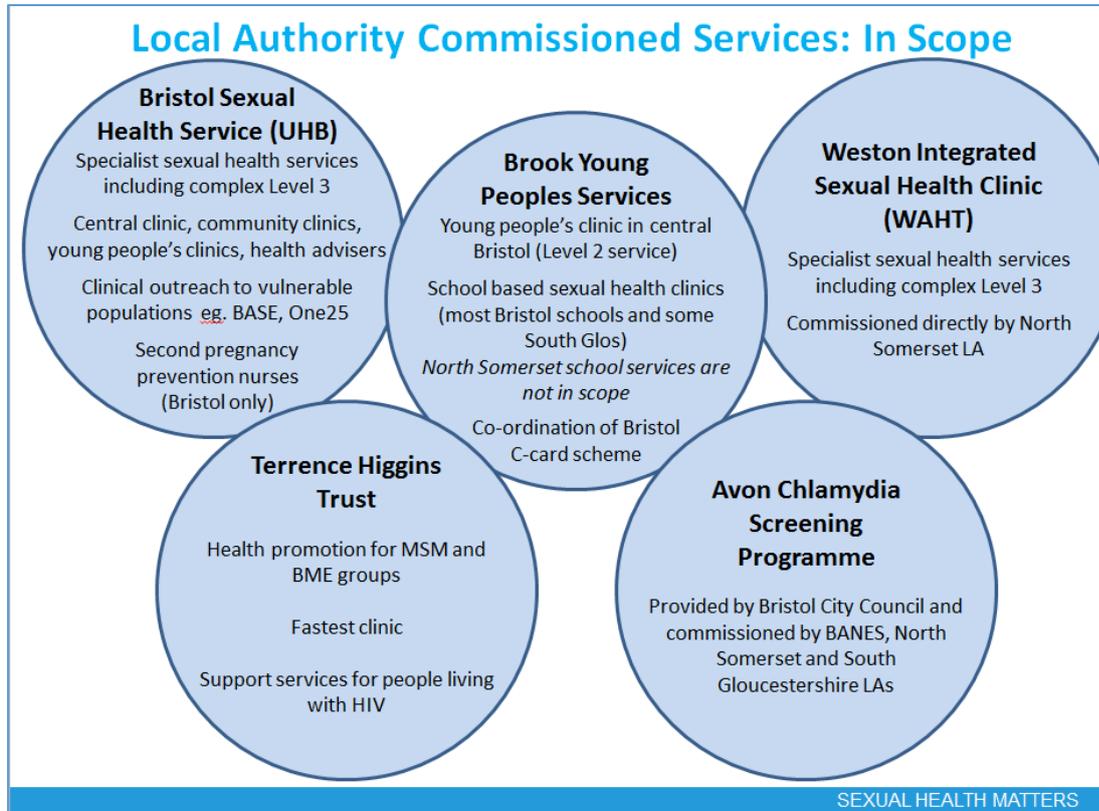
In addition to these planned events, Brook (which provides specialist support for young people's sexual health needs) also developed their own survey to ask for views from young people aged 11-25. They expressed concern about the low numbers of responses from this population group to the main survey. The detail of their responses can be seen in Appendix C. In summary, the main conclusions were:

- Young people want a specialist service for those under 25
- This should include drop-in sessions as a priority with a small number of bookable appointments (which are more popular with those slightly older in this group)
- They would like services to open through the week in the afternoon and evening and Saturdays
- Support should be accessible in schools (favoured by 11-16 year olds), in local communities (popular with all ages) and in the centre of town (favoured by 17-24 year olds)
- If young people are to use services they need to be accessible, young people friendly, confidential and have a short wait
- If services are hard to get to, make people wait too long, break confidentiality, are judgemental or rude then young people will not use them
- Services should always be understanding, non-judgemental and friendly

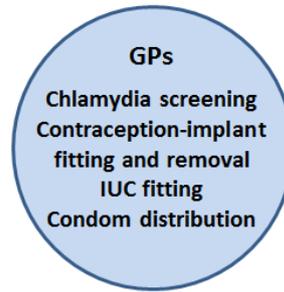
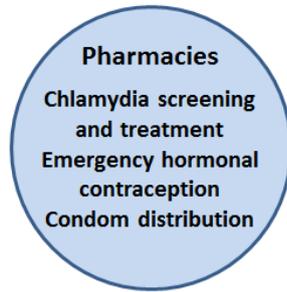
List of key events

Meeting title	Date	Audience
Bristol Health and Wellbeing Board	9/8/15 & 16/12/15	Local councillors, senior officers of CCG and BCC, and voluntary sector representation
Marketing warming event	10/11/2015	All potential providers and community stakeholders
Care Forum North Somerset: Children and Young People's Mental and Sexual Health	09/12/2015	Voluntary and community sector organisations and providers in North Somerset; service users
South Gloucestershire Clinical Operational Executive	10/12/2015	Clinical Commissioning Group officers and practices
Care Forum Bristol and South Gloucestershire: Briefing and networking event	15/12/2015	Voluntary and community sector organisations and providers in Bristol and South Gloucestershire; service users
Primary Care Event	16/12/2015	Primary Care Managers and Clinicians; specialist clinicians
Bristol Clinical Commissioning Group Governing Body	17/12/2015	Members of the Governing Body (private session)
South Gloucestershire Practice Managers Group	07/01/2016	Practice managers
Bristol Neighbourhoods Scrutiny	11/1/2016	Local councillors and senior BCC officers
Procurement event	20/01/2016	All potential providers

Appendix A: Scope of the Reprocurement



Local Authority Commissioned Services: Out of Scope



These services will not be included in the procurement bundle for April 2016.

Commissioners will be looking to negotiate new commissioning arrangements and agreements with GPs and pharmacies individually on a local basis.

Bidders must be able to clearly demonstrate how primary care will be incorporated into the new sexual health system.

Appendix B: Focus Group Facilitator Brief

Ground rules for focus group and potential scenarios

In order to ensure that the focus group runs as well as possible, and to ensure that participants are as comfortable as they can be the following rules should be discussed at the start of each focus group:

1. The focus group is confidential. No personal information is required from participants. We want to know about health care services, rather than their personal experiences. If they wish to share these, they are free to do so.
2. Ask all participants to respect each other's confidential information. Assure participants that any personal information given will not appear in the research report at the end of the project.
3. All information given will be anonymised. No links between a participant and their views will be made in the final report.
4. Ask participants to understand that some people may have had difficult experiences in relation to sexual health, and to be understanding of these issues.
5. Reiterate that the focus group is entirely voluntary, any participant is free to leave at any time without giving a reason. If a participant chooses not to speak, then that is also their right.

Running order to the session

1. The initial 10-15 minutes of the focus group should allow the participants to make a drink and get settled and will then involve a brief description of the project, collecting consent forms and establishing the ground rules.
2. Do around 30-35 minutes of questions (1-3).
3. 10-15 minutes for activity 1.
4. 10 minute toilet/drink break
5. Do around 30-35 minutes of questions (4 & 5).
6. Spend 10 minutes concluding the focus group by reiterating points on confidentiality and anonymity, summarising what was discussed and asking if anything has been missed.

7. Give participants the following email address if they wish to give further feedback or comments: DeanAyotte@thecareforum.org.uk

minutes for activity 2

Questions and prompts (tick these off as they are discussed)

1. *What do you think the priorities should be for a service when trying to promote positive, safe and healthy relationships?*
2. *How would you like to manage your own sexual health?*

Prompt: Ask about accessing services online

Prompt: What services would be appropriate to different people? E.g. people in areas with poor transport, people whose first language is not English?

3. *What would make it easier to access services?*

Prompt: Opening times, access to services locally, transport access, appropriate services for different groups.

4. *What do you think makes a high quality service?*

Prompt: High skilled workforce, adaptable, friendly staff, confidential etc...

Prompt: The use of technology to help patients.

Prompt: Is it important to have integrated services?

Prompt: How can a service be made welcoming for vulnerable people, young people etc.

Scenario: If it is appropriate, and if participants are struggling to understand these prompt questions, give an example of a hypothetical service user and ask what might be important to them.

5. *When you seek help over sexual health, what other information would be good for you to have access to?*

Prompt: Signposting to other health services, information on Health and Wellbeing

Activities

Activity 1:

Use a 'Likert scale' around the room. Place A4 labels around the room with the following labels:

Easy.

Possible.

Difficult.

Impossible.

Ask the participants the following questions:

1. If you found yourself needing treatment, how easy would it be for you to get to Bristol City Centre between 9am and 6pm, between Monday and Friday?
2. If you found yourself needing treatment, how easy would it be for you to get to Weston Super Mare between 9am and 6pm, between Monday and Friday?
3. If you found yourself needing treatment, how easy would it be for you to get to a clinic within 5 miles of your home between 9am and 6pm, between Monday and Friday?

Take each of these questions in turn. For each one ask the participants to go and stand next to the label which best describes their situation. Then, ask the participants if any of them are willing to explain why they have chosen their label and write down the responses.

Then, do the same for the following question:

4. How easy would it be for you to get to an appointment at the following times?
 - 7am – 8.30am Mon-Fri

- 9am – 6pm Mon-Fri
- 6pm – 8pm Mon-Fri
- 9am – 1pm Saturday
- 9am – 6pm Saturday
- 10am – 4pm Sunday

Activity 2:

Have participants answer the following question:

What 3 things about sexual health services are most important to you?

Have participants write their answers onto a post it note and stick them onto a piece of A3 paper by the door when they leave.

Appendix C: Brook Young People's Survey Findings

Overview: In response to the low number of young people completing the consultation survey run by the commissioners, Brook developed their own online and paper survey for young people aged 11-25. Questions were broadly based on the questions in the focus group guide. The survey was promoted to every young person attending the Brook clinic and Brook school drop-ins, as well as during education based workshops being run by Brook in schools and external youth groups. The survey ran during December 2015 and January 2016. Brook shared the data from 392 respondents with the commissioners and the results are presented below. They include qualitative and quantitative results. Graphs and charts were supplied by Brook, but all other analysis was done by the commissioners.

From the responses received, the most common preferences expressed by young people were for:

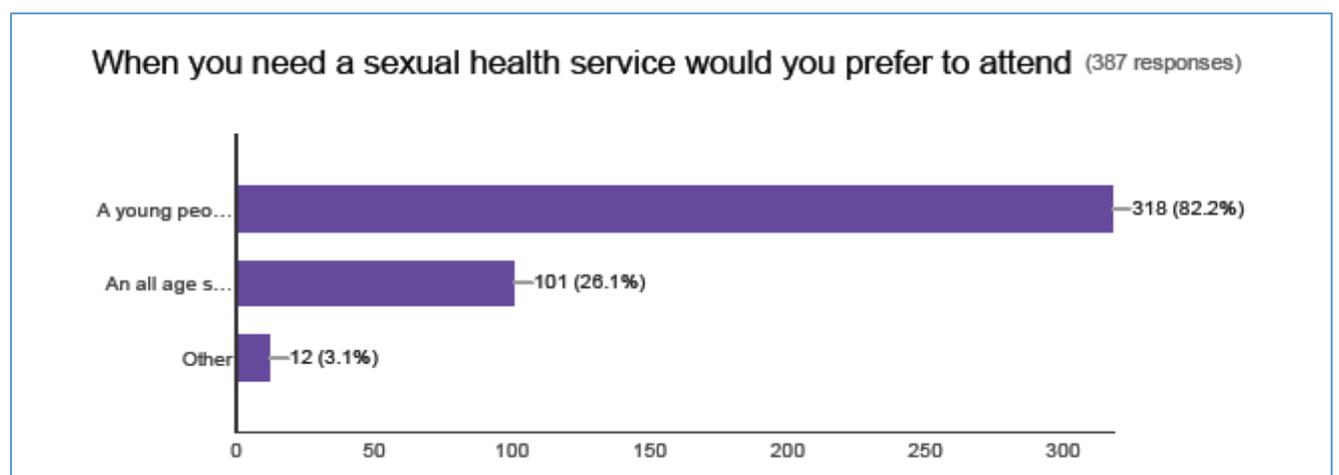
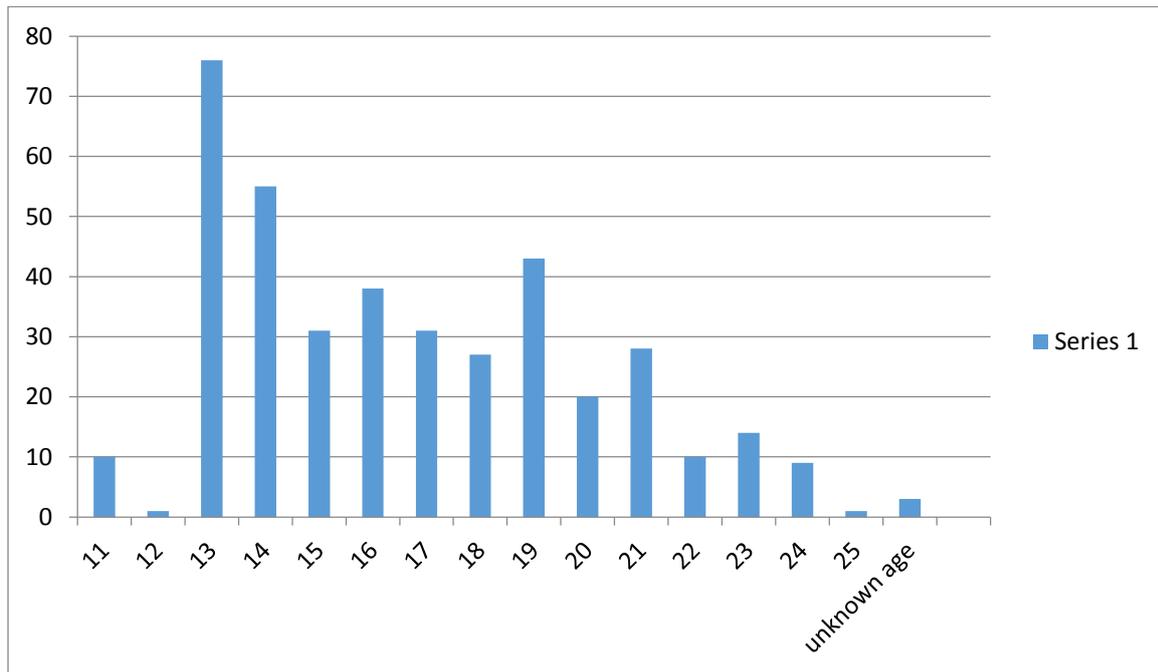
- A **young people's sexual health service** - just for under 25s - which offers;
- **Drop-in sessions** as a priority with a small number of bookable appointments (preferred by older users).
- It will be open **Monday – Friday afternoons** and **evenings** and **Saturdays**.
- Accessibility is key and a range of settings should be available including:
 - **Drop-ins in school and college** (favoured by 11-16 year olds)
 - **Local services in the community** (most popular option, all ages)
 - **Centre of town services** (favoured by 17-24 year olds)
- Young people are most likely to use sexual health services if they are:
 - **Accessible**
 - **Young people Friendly**
 - **Confidential**
 - Have a **short wait** (whether appointment or drop-in)
- If services are **hard to get to**, are too **busy** or make young people wait, **break confidentiality** and are **rude**, **judgemental** and **unfriendly**, service users will not use them.
- Staff at young people's clinics must be:
 - **Understanding**

- Non-judgemental
- Friendly

Results

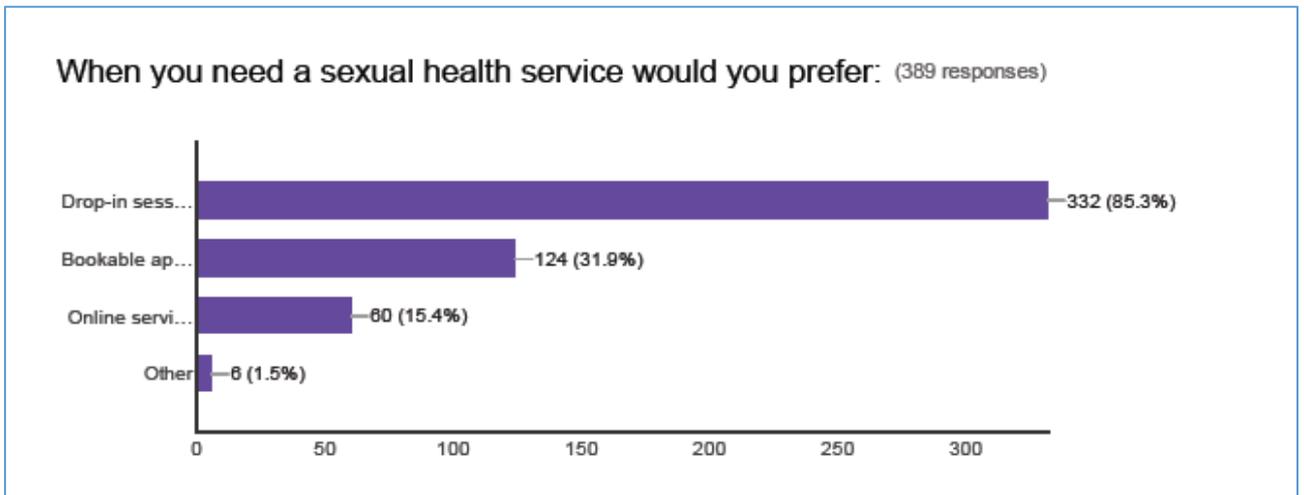
In terms of demographics, only age was collected.

How old are you?



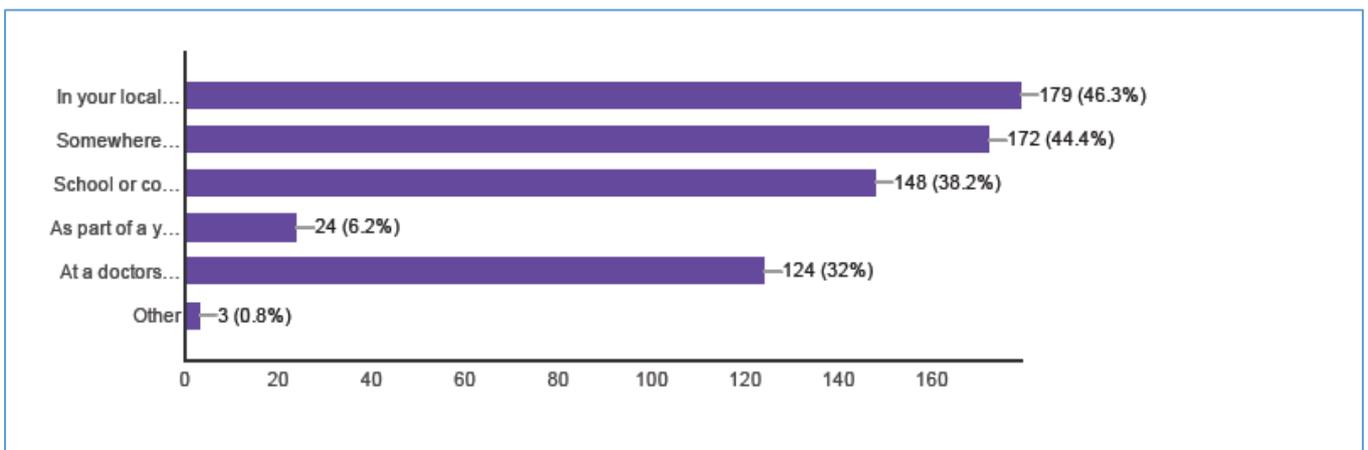
The majority of young people surveyed prefer to attend a young people's sexual health service that is just for under 25s, however, when looking at age, 23 and 24

year olds preferred to access all age services that are young people friendly. A small minority were happy with the option to attend either a young people’s service or an all age (but young people-friendly) service.



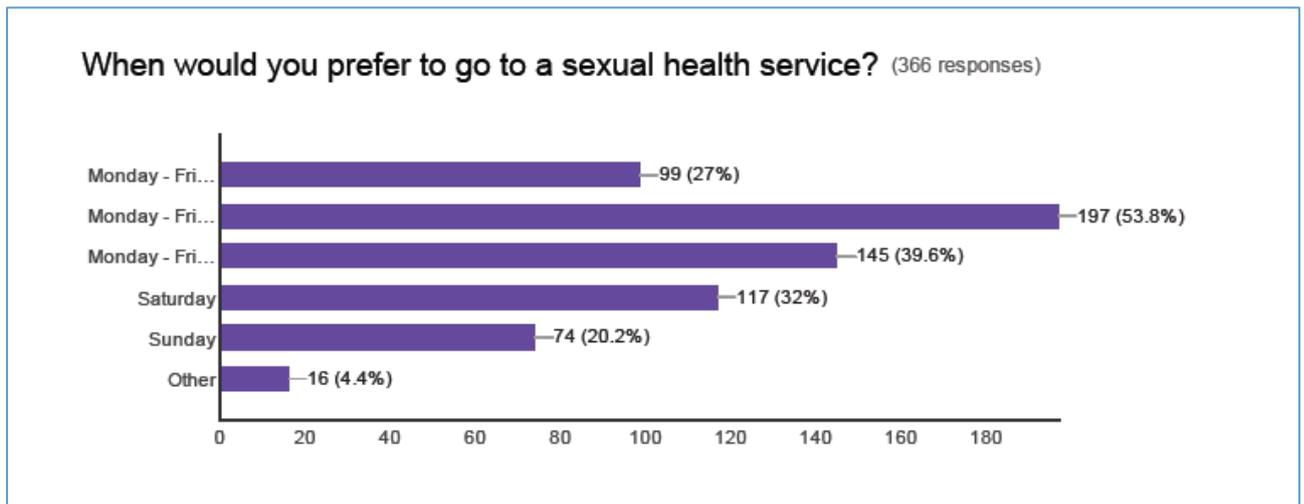
While drop-in sessions were the overall preferred option, answers differed slightly by age. The younger age groups preferred the option of drop-ins while the older the age, the more likely they were to choose both the option of a drop-in and appointments.

Where would you prefer to access a sexual health service:



Most young people surveyed chose multiple options in terms of venue, highlighting their desire for maximum choice and accessibility – echoed in other questions. Overall, having sexual health services in their local community/ near to their home was the most popular. There was, however, a trend in terms of age, with 11-16 year

olds favouring services in schools/ colleges and locally and 17-24 year olds preferring local and central services.



The majority of young people surveyed chose a mix of options in terms of opening times, with no particular mix favoured. This highlights, again, the importance of choice and accessibility to young people. While the most popular time slot overall was Monday – Friday afternoons, Monday-Friday evenings and Saturdays were also very important.

A thematic analysis was used to analyse the final 3 questions of the survey as the questions were open answers meaning young people could write as they pleased.

What would make you more likely to use a sexual health service?

Young people are more likely to use a service which is:

Accessible: The service would need to be close or easy to get to, preferably close to a bus stop. The service could also be in school or at their GP surgery. It was important that the service be open weekends and later in the week and that clients were seen quickly once they were there.

Young people friendly: This included being for young people only, friendly, clean, have a welcoming receptionist, be non-judgemental, make the service user feel happy and safe. The professionals at that service should be nice, relaxed and trustworthy. The actual waiting area should be relaxed, have music but also be discreet.

Confidential: This was particularly important to young people. It meant the service and staff being trustworthy, upholding confidentiality and not telling the family/parents that the young person had visited.

Short waits: This was a key issue for young people completing the survey.

Additional but less occurring factors: That drop-ins and appointments are offered, that there are pregnancy tests, condoms and self-test kits to take away and a range of contraception on offer. That there is a wealth of good information and advice and that it is well promoted.

What would prevent you from using a sexual health service?

There were a few key barriers that would stop a young person using a sexual health service, echoing the above list and therefore highlighting their importance in any service design. Young people would be prevented from using a service that:

Was not accessible: This included services that were hard to get to, had too long a wait or were too busy, made young people book in advance, didn't have opening times in the evening or weekend, didn't offer a range of services. *The two most important barriers were: Hard to get to and long waiting times.*

Did not offer or uphold confidentiality: This was a key and common answer and included a number of people saying they were worried their parents would know they attended.

Not young people friendly: Young people described this as a service having an unwelcoming atmosphere, staff being rude or unfriendly, it being a very loud environment or hostile. They mentioned a fear of staff being judgemental or that adults were using the service too. *The key issues that came up the most were staff being judgemental or unfriendly.*

Additional but less occurring factors: That their own embarrassment might be a barrier to accessing services.

What should staff be like at a sexual health service?

In terms of the key features for staff at sexual health services the most important factors were:

- Understanding staff
- Non-judgemental
- Friendly

Less occurring features included: Being kind, wearing casual clothing, being positive, being confident, trustworthy, polite and helpful.

APPENDIX D

Risk	Risk type	Cause	Consequence	Initial Risk			Actions to address risk	Revised Risk		
				Impact Severity (1-4)	Probability (1-6)	Risk Score		Impact Severity (1-4)	Probability (1-6)	Risk Score
Current providers do not apply/are not awarded resulting in geographical gaps in access to the services	operational	Current primary care providers are not willing to agree to involvement in contract delivery due to additional pressures in primary care	Reduced access to, and engagement with, services with impact on health inequalities	3	3	9	CPG agreement to direct award contracts enables proactive targeting of providers Support proposed to enable registration with ProContract	2	1	2
The service is not affordable within the approved budget envelope	financial	Increased demand for services due to demographic changes and increased needs within the population	Unable to maintain mandatory responsibility to maintain open access sexual health services Individuals unable to access substance misuse treatment resulting in increased health inequalities	3	3	9	Retain current tariffs for existing services and negotiate rates for new elements. Be prepared to manage budget through measures such as caps on activity, targeted rather than universal provision, or by removing some elements of the service. Contracts to include the ability to manage activity centrally when necessary	3	1	3
Direct award decision is challenged	legal	External provider wants to provide services	Necessary to run a competitive procurement process open to all providers	3	2	6	Contract duration and termination clause allows a compliant process to be initiated in a short time-frame	1	1	1
Insufficient capacity in non-primary care substance misuse services	financial	Over-allocation of budget to primary care services	Lack of availability of Complex Needs, residential rehab and community based psychosocial services reducing outcomes for the city	3	3	9	Only 18 month contract and delivery model will be evaluated to ensure most effective use of public funds and that the allocation is proportionate to demand Primary care provision targeted at priority areas for substance misuse (alcohol and heroin treatment)	3	1	3

Bristol City Council Equality Impact Assessment Form

(Please refer to the Equality Impact Assessment guidance when completing this form)



Name of proposal	Procurement of sexual health services currently delivered in GP practices and pharmacies across Bristol
Directorate and Service Area	Public Health – Sexual Health
Name of Lead Officers	Thara Raj and Annette Billing

Step 1: What is the proposal?

Please explain your proposal in Plain English, avoiding acronyms and jargon. This section should explain how the proposal will impact service users, staff and/or the wider community.

1.1 What is the proposal?

The proposal relates to the procurement of the sexual health services that GP practices and community pharmacies currently deliver through contracts with Public Health Bristol. The current contracts run until 30 September 2017. The services relate to the provision of contraception and STI testing and treatment, and are designed to improve the sexual health outcomes of the residents of Bristol as required under the Health and Social Care Act 2012. Local authorities have a mandated responsibility to provide, or make arrangements to secure the provision of open access sexual health services in their area.

During 2016/17 Bristol Public Health procured a new integrated sexual health service in collaboration with North Somerset and South Gloucestershire local authorities and the accompanying CCGs. The contract was awarded to University Hospitals Bristol NHS Foundation Trust (UHB) as lead provider, with UHB subcontracting to a number of local NHS trusts and national voluntary sector providers, including Brook and Terrence Higgins Trust. The service which was launched in June 2017 operates under the brand name 'Unity'.

The primary care sexual health services were not included in the scope of the tender for the integrated sexual health service. This decision followed an open consultation with key stakeholders and advice from legal and procurement teams. It was agreed that a separate process needed to be followed which allowed the local authority to comply with European Union (EU) law by

ensuring a fair and transparent process.

While the current delivery of sexual health services contains many examples of achieving positive and innovative outcomes, there is a need for improved outcomes in several areas:

- The Chlamydia Screening Programme needs to target higher risk people more effectively, this will be evident if the diagnosis rate increases.
- Rising rates of sexually transmitted infections need to be addressed.
- Reductions in teenage pregnancy rates need to be sustained.
- Better access to long acting reversible methods of contraception (implants, intrauterine devices and injections) will reduce unintended pregnancy, abortion and repeat abortion.
- Some groups are at higher risk of poor sexual health, and this inequality must be reduced.
- Bristol is now considered a high prevalence area for HIV and continues to have a high rate of late HIV diagnosis

Future sexual health services will need to adapt to changes in society. The new integrated sexual health service is responding to the opportunities provided by online technology, trends in risky sexual behaviour, and emerging groups at high risk. Primary care services will play a key part as important access points across the city for the delivery of non-specialist services where required. Populations are predicted to rise while pressure on budgets will require an increased focus on prevention and delivering cost effective services.

The aim is to provide an integrated sexual health service network delivering a high quality, cost effective, timely and equitable sexual health service to the population of Bristol, improving outcomes and reducing inequalities.

Step 2: What information do we have?

Decisions must be evidence-based, and involve people with protected characteristics that could be affected. Please use this section to demonstrate understanding of who could be affected by the proposal.

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

In addition to the Department for Health *Framework for Sexual Health Improvement* (2013) information and data, which shows the national picture, Bristol Public Health undertook a comprehensive local needs assessments ahead of the tender for integrated sexual health service . This is available to be read in conjunction with this EqIAA at <https://www.bristol.gov.uk/policies-plans-strategies/joint-strategic-needs-assessment-jsna>

Issues identified through the needs assessment process on Bristol include:

- Bristol's population is growing and also becoming more ethnically diverse, particularly in younger age groups; therefore services need to be able to be flexible to meet increasing demand and to be accessible to diverse population needs.
- High diagnosis rates of syphilis, gonorrhoea and genital warts have been observed in Bristol. Whilst this is in part due to improved testing it is also likely to be due to increased infection rates in the population.
- Teenage pregnancies in Bristol have shown a steep decline since 2007 and are now similar to the national average. The efforts to reduce these rates need to be sustained.
- Long Acting Reversible Contraception uptake remains low, particularly in young people. Conversely oral emergency contraception use is high amongst young people. As LARC methods are more effective forms of contraception, consideration should be given to increasing uptake.
- The diagnosed prevalence rate of HIV in Bristol is over 2 per 1000 residents aged 15-59 years, meaning that Bristol has now passed the threshold for increased HIV testing.
- Bristol has a higher rate of late diagnosis of HIV than that seen nationally. Heterosexuals and Black Africans are at higher risk of late diagnosis.
- There is some evidence of low uptake of services for BME and LGBTQ groups. Services need to ensure they are accessible to all high risk and equalities groups and promote their services appropriately.

- Future plans and services need to reflect the needs of key population groups who have been identified with a higher risk of poor sexual health outcomes, particularly vulnerable young people, MSM, people with learning difficulties, certain BME groups, people involved in sex work, homeless people.
- Evidence suggests that both locally and nationally sexual health behaviours are becoming more risky. Changing cultures have led to emerging needs such as the practice of chemsex (use of injecting drugs to increase sexual pleasure), sexual exploitation, forced marriage, female genital mutilation, sexual harassment, sexual bullying and sexism. Sexual health professionals need to be responsive to these emerging needs.
- There is a concern about the increasing sexualisation of society particularly the effect on young people. Strategies should be developed to prevent the harmful effects of this trend.
- Reducing the late diagnosis of HIV needs to be addressed across the area. Key to this is encouraging regular testing amongst high risk groups including MSM and Black Africans.
- The downward trend in the numbers of teenage conceptions needs to be maintained.
- The rising rates of STI diagnoses need to be addressed through increased prevention efforts, including improved access to STI testing and condoms in order to reduce further transmission of infection. MSM, BME and deprived groups are disproportionately affected by STIs and these inequalities need to be addressed.
- The numbers of repeat terminations should be reduced. Increasing the knowledge, awareness and access to contraception options would improve this situation.
- There are some concerns regarding data quality and issues around comparing data across different providers.

Local service provision might be improved through the following:

- Marketing of services should take advantage of technological developments such as social media, text and online booking and triage.
- An improved system of collecting data that allows the inclusion of complex individual details.
- A coherent branding and dedicated website for sexual health promotion and services, with marketing targeted specifically for high risk groups.

The service specification is key to ensuring that the new services are designed and delivered in the most effective ways to meet the needs of those requiring access to services. The development of the service specification is key to ensuring that the new service meets the needs of the whole community, but in particular to ensure that providers find appropriate ways to reach the most vulnerable local groups and individuals.

2.2 Who is missing? Are there any gaps in the data?

A further needs assessment analysis will review the uptake of current services by people with protected characteristics.

2.3 How have we involved, or will we involve, communities and groups that could be affected?

Commissioners recognised that an essential step in the design of the new integrated sexual health service was a period of public consultation on a set of draft plans. This took place from 1 November 2015 to 31 January 2016. The report is included in Appendix B. The consultation considered sexual health services as a whole, including those currently available in GP practices and community pharmacies.

The aim was to better understand the needs and preferences of a wide range of current and potential service users as well as those interested in protecting and improving sexual health and wellbeing across our whole population. This included proactively seeking the views of people who are at higher risk of poor sexual health outcomes so that sexual health services can effectively tackle health inequalities.

The feedback received through the consultation will be used to shape the service specifications for the services currently delivered by GP practices and

community pharmacies. It will influence the minimum requirements asked of potential providers around the quality of the services they would deliver.

A wide range of feedback was received during the consultation period. In particular, views were expressed through three key methods:

- 1) An online and printed survey
- 2) A series of focus group discussions targeting groups at higher risk of poor sexual health outcomes
- 3) A number of public events, discussion forums and a survey facilitated by local stakeholders

The Care Forum Focus groups with Vulnerable Groups

In addition to the general public survey above, the councils jointly commissioned a voluntary sector organisation The Care Forum to organise and facilitate focus groups with representatives of specific vulnerable populations at higher risk of poor sexual health outcomes. Those with protected characteristics who participated included:

- Men and women
- Black and minority ethnic residents
- Those who identified as LGBTQ+
- Individuals with learning disabilities
- Young people

A great many points were made about access to services through these focus groups, and many of which were echoed in the public consultation survey report.

Brook Young people's own survey

In addition to these planned events Brook developed their own survey, the findings of which were then cross-checked with the other data collected. In the main, the findings were consistent with the concerns about young people's needs heard through the public survey.

Step 3: Who might the proposal impact?

Analysis of impacts on people with protected characteristics must be rigorous. Please demonstrate your analysis of any impacts in this section, referring to all of the equalities groups as defined in the Equality Act 2010.

3.1 Does the proposal have any potentially adverse impacts on people with protected characteristics?

The main negative impact of the proposal affects everyone, as the main risk to public services is shrinking budgets. The risk to people with protected characteristics could be higher, but this risk could be mitigated within the requirements of the services to target particular groups at highest risk of poor sexual health outcomes.

3.2 Can these impacts be mitigated or justified? If so, how?

Mitigation is being undertaken through specific requirements to consider these groups in the service specification. The service priority will be to ensure the needs of vulnerable groups are met. The ability of providers to do this effectively will be measured through contract monitoring and evaluation.

3.3 Does the proposal create any benefits for people with protected characteristics?

The new integrated sexual health service specification requires Unity to ensure that “the sexual health of young people and vulnerable groups will be prioritised in the sexual health system and across the network.” Unity will create the links to ensure that where appropriate vulnerable groups access sexual health service in primary care settings. The term ‘young people’ refers to those aged under 25. The term vulnerable groups refers to those listed below. These groups may change over the duration of the contract so should be reviewed on a regular basis.

- Homeless
- Looked after children
- Care leavers
- People with learning disabilities
- Commercial sex workers
- Substance misusers
- Asylum seekers
- Lesbian, gay, bisexual, transgender and other minority sexuality- or gender-identified people
- Men who have sex with men
- Some ethnic groups, including black Africans and Gypsy and Travellers
- People living in areas of multiple deprivation
- Trafficked people
- Offenders
- Those experiencing or at high risk of sexual exploitation, coercion or violence.
- People living with HIV

There is some overlap in needs of those described in the National Framework for Sexual Health Improvement as 'vulnerable groups' at higher risk of poor sexual health outcomes and those 'protected characteristics' described in the Equality Act.

The proposed services may benefit the groups with protected characteristics in the following ways:

General:

- The service shall be inclusive for the populations of Bristol with staff trained to ensure services are targeted and delivered to communities and individuals regardless of age, ethnicity/race, religion, gender, disability or sexuality who might be at risk of sexual ill health.
- The services will be centred on service users and delivered in a non-judgemental, culturally sensitive and empathetic manner.
- Information to promote the services will need to be appropriate for those at risk, particularly young people and vulnerable groups, and should be developed in close collaboration with these groups. A tailored and segmented approach will be used in developing information and educational material to take account of the diverse needs of these groups.
- Through strong leadership and effective management, the sexual health system will ensure young people and vulnerable groups are prioritised throughout the system.

Specific:

1. Age – some of the services will be specifically offered to young people, such as emergency contraception in community pharmacies, in recognition that some young people may otherwise services. Also, the service will need to ensure that information, advice and services are differentiated for different age groups, in particular for younger and older people.
2. Disability – access to services will improve through a requirement to consider those with specific access requirements, and to ensure all services have made reasonable adjustments in order to comply with equalities legislation. Increased awareness of need through equalities training and any additional support required will be provided by the service.
3. Gender reassignment – the service specification will require staff to receive equalities training and also specific training around transgender/ CIS equalities awareness and monitoring.

4. Marriage and civil partnership – no specific benefit other than that covered by equalities training
5. Pregnancy and maternity – all services will be required to meet equalities and employment standards, as employers and as service providers, in relation to supporting women to have a healthy pregnancy and breastfeed. Relevant outcomes from these services are for lower rates of unintended pregnancies, and specifically to sustain the reduction in teenage pregnancies.
6. Race – the integrated sexual health service requires the providers to consider tailored methods of reaching black and minority ethnic groups, and in particular black Africans who are at higher risk of HIV. These groups may in turn be signposted to GP practices, pharmacies and other providers as appropriate.
7. Religion or belief - see 'general' points above. Training for staff will include religious diversity and the need for equal access regardless of religion or culture.
8. Sex – Services will be accessible to men and women, and training will be provided to staff on the specific needs of women and men who experience domestic abuse or sexual exploitation.
9. Sexual orientation – feedback from the public further increased the requirements within the evaluation criteria for the new integrated sexual health service. This in turn will have a positive impact on the accessibility of primary care services in order to meet the needs of LGBTQ+ people.

The process of awarding contracts will require each provider providing assurance that they meet the minimum requirements to deliver the service. Among many other requirements, the council will require evidence that the provider operates in accordance with the Equality Act 2010 and the s.149 Public Sector Equality Duty.

3.4 Can they be maximised? If so, how?

Benefits can be maximised through the regular analysis of data (e.g. data covering service-user satisfaction, outcomes etc.) in order to inform and ensure continuous improvement in delivery. Having a sound relationship with providers will enable us to have a dialogue about continuous improvement i.e. what works for different people, how can we meet the needs of those who are not being engaged, what can be done to engage them, what skills can be developed amongst the workforce to ensure they are equipped to recognise and meet the needs of service-users where we know that needs will be

different etc..

Commissioners are constantly communicating with their equivalents from other areas of the country to ensure that local equalities practices are improved by learning from other good practice.

Contract monitoring will include regular feedback about equalities. If performance is not adequate then officers managing the contract will take action to ensure improvement.

Step 4: So what?

The Equality Impact Assessment must be able to influence the proposal and decision. This section asks how your understanding of impacts on people with protected characteristics has influenced your proposal, and how the findings of your Equality Impact Assessment can be measured going forward.

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

The feedback from the following have been combined with the analysis from this equality impact assessment to ensure the procurement process, and in particular the **service specification** and the minimum requirements criteria contain robust requirements relating to equalities:

- The local sexual health needs assessment
- The public consultation on sexual health services
- The Care Forum focus groups
- Other stakeholder engagement (including Brook's survey)

4.2 What actions have been identified going forward?

Amendment of service specification

Amendment of minimum requirements criteria

Contract monitoring will include robust requirements for the provider to collect appropriate data relating to equalities. This will be analysed by commissioners to ensure services are meeting the requirements within the service specification that relate to equalities.

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

Through the evaluation of minimum criteria during the tender process.

Through service contract monitoring from the start of the new sexual health services contract, including regular service user and potential service user feedback.

Service Director Sign-Off: Becky Pollard Director of Public Health	Equalities Officer Sign Off: Simon Nelson Equalities and Community Cohesion Officer
Date:	Date:



Bristol

Clinical Commissioning Group

Bristol Health & Wellbeing Board

Better Care Fund & Improved Better Care Fund Plan 2017/19	
Author, including organisation	<p>Daniel Knight, Better Care Manager - Joint appointment between Bristol CCG and Bristol City Council</p> <p>Terry Dafter, Interim Service Director Adult Social Care – Bristol City Council</p> <p>Lindsay Winterton, Interim Principal Commissioning Manager – Bristol City Council</p>
Date of meeting	16 th August 2017
Report for information and decision	

1. Purpose of this Paper

The purpose of this paper is twofold. The first is to provide the Health and Wellbeing Board with an overview of the direction of travel for the Better Care Fund in Bristol and to also delegate authority to sign off the final plans to the co-chairs as it is a requirement of NHS England (NHSE) that the local plans are signed off by Health and Wellbeing Board.

The HWB is asked to note and consider the following:

- **For information** – to note the direction of travel for the Better Care Fund in Bristol
- **For Approval** – Delegate authority to HWB co-chairs to sign off final Better Care Bristol plans

2. Executive Summary

The Better Care Fund (BCF) was established in 2014. Its aim is to promote integration, protect social care services (with a health benefit) and address system issues such as urgent admissions to hospitals and managing transfers of care.

We are currently finalising Bristol’s Better Care Fund plan for 2017/19. The delay in the BCF guidance has meant that there is now a tight deadline issued by the NHSE to submit local areas plans by September 11th 2017.

At the time of writing this report the guidance of how plans must meet the Key Lines of Enquiries (KLOE’s) has not yet been issued, therefore we are unable to finalise the Better Care Bristol plan.

The next step following Bristol’s submission of the BCF plan will be to obtain a formal agreement around the fund between the CCG and Bristol City Council in the form of a Section 75 agreement

**A Section 75 Agreement is a way of formally pooling resources across organisations. Each contribution can be put into this pooled fund with a stipulation of how it can be used. Pooling money in this way does not mean that it, for example, the Disabled Facilities Grant can be used to offset an overspend in a hospital*

3. Better Care Bristol overview

The Better Care Fund (BCF) is described on the DoH website as “one of the most ambitious ever programmes across the NHS and Local Government. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.”

In Bristol the total fund is made up of three elements, which include CCG funding, DFG and the new grant for Adult Social Care badged as the Improved Better Care fund (iBCF). The table below outlines the total amount for the next two years.

	CCG Minimum Contribution	DFG	iBCF	Total
2017/18	£29,004,585	£2,651,566	£9,055,887	£40,712,038
2018/19	£29,555,673	£2,881,793	£5,761,433	£38,198,899

Each year, we are required to submit an annual plan that is agreed through HWB which sets out the targets and how the money is to be spent. This year, The NHSE requires a two year plan to be submitted by September 11th 2017.

Better Care Bristol has aligned the plans to the four themes agreed by the Health & Wellbeing Board, which have been informed by the Joint Strategic Needs Assessment (JSNA). These four themes are that Bristol will be a city:

- That is filled with healthy, safe and sustainable communities and places
- Where health and wellbeing are improving
- Where health inequalities are reducing
- Where people get high quality support when and where they need it

Under these themes a number of priorities have been agreed, which underpin our Better Care Bristol programme. These priorities are to support people to live healthy and independent lives, have timely and easy access to high quality and efficient public services, supported by thriving and connected communities. The priorities will be achieved by:

- Building social capital
- Developing community assets and voluntary action
- Improving community cohesion and perceptions of safety
- Addressing poverty and social isolation, particularly in older age

The Better Care Bristol programme contains a number of innovative and transformational projects. In 2016 work to refresh Better Care Bristol's Vision took the learning from our key achievements to shape the work to facilitate Bristol's plans for integration. Some key achievements have been;

Increasing Social care in acute trust on weekends

Funding from Better Care Bristol has enabled Bristol City Council to successfully implemented Saturday working for Social care teams and Brokerage in both University Hospitals Bristol (UHB) and North Bristol Trust (NBT). Additionally we have implemented an Enhanced Brokerage Service to support Bristol patients in NBT and UHB to quickly move patients on to appropriate longer term services (mainly home care and care homes).

We have a Social Care Practitioner present in ED's in both UHB and NBT who are avoiding admissions and reducing length of stay and are seeing around 10 patients per week and working in partnership with REACT.

Discharge to Assess (D2A)

The main achievements within our Discharge to Assess project have been:

Pathway 1 – In summary the length of stay (LOS) had been reduced on the pilot wards by reducing the front loaded actions conducted in hospital and moving these out to the patient's own home as part of the "meet and greet" community assessment. A project brief has been submitted seeking to make changes based on this learning across the integrated rehab and reablement service. This is now being progressed by Bristol Community Health and Bristol City Council colleagues. A wider transformation piece incorporating this learning has just launched under the STP Discharge and DTOC Reduction workstream.

Pathway 2 – D2A Pathway 2 has been opened up at South Bristol Community Hospital (SBCH) to include patients with complex renal dialysis requirements.

Pathway 3 – This Pathway is no longer a transformation workstream, and the Standard operating procedure (SOP) has been signed off as business as usual, with embedded practices, committed social care case management and well established block booked provision.

PAM's

Bristol CCG successfully bid for Patient Activation Measure (PAM) licenses and are currently finalising their PAM plans for 2017/18. The plans span over a 5 year period (2016/2021), with Bristol community Health taking the lead within the first year to utilise PAMs. In Bristol we will develop some small cohorts of patients where PAMs can be used, not only as an evaluation tool, but to help tailor services around the patients. Bristol recognises the value and importance of working alongside our South Gloucestershire and North Somerset partners. A BNSSG PAM implementation Group has been set up to help the three CCGs work collaboratively to reduce duplication and share best practice.

Moving Forwards

As reflected above, Better Care Bristol has delivered some valuable transformational projects and created links with other work streams. This is positive, but when we reflect even if all projects achieve excellent results the totality will not lead to the transformational shift we need to make to address the challenges of our health and social care system.

Bristol's Better Care two year plan for 2017/18 and 2018/19 should be considered as a continuation of the plans submitted in 2016/17. The Better Care Bristol plans focus solely on schemes funded from the Better Care Fund, this approach will allow Better Care Bristol to clearly focus on driving integration between Bristol CCG and Bristol City Council.

National Conditions

Condition 1 - Plans to be jointly agreed

Plans will be signed off by the Better Care Bristol Commissioning Board and by the Health & Wellbeing Board. The Section 75 agreement will be presented to the Better Care Commissioning Board for final approval ahead of the Health & Wellbeing Board for final sign off.

The Better Care Bristol plans will also include the additional iBCF funding which has been proposed by both Bristol City Council and Bristol CCG, which will be formally agreed by the Better Care Bristol Commissioning Board.

Plans will be shared and agreed with local acute trusts and Social Care providers who will be impacted by the plans.

Condition 2 - NHS Contribution to adult Social care is maintained in line with inflation.

In 2017/18 the CCG's minimum contribution to adult Social Care increased by £169k to a total of £9.627m which was an increase of 1.79% on the 2016/17 fund, as in previous years, Bristol CCG has allocated additional funds to Social Care.

In 2018/19 the CCG's minimum contribution will increased by 1.9% on 2017/18 Social Care allocation to a total of £9.809m and again, Bristol CCG will allocated additional funds to adult Social Care.

Condition 3 – Agreement to invest in NHS commissioned out of hospital services.

The Bristol plan continues to expand on a number of services including providing a 7 day service, Discharge to Assess and Intermediate Care. A full list of schemes that contribute to this National Condition is listed below;

Out of Hospital Services	
Scheme name	OOH Service
Early and Preventative interventions and reduction in hospital admissions in primary care	
Community Services	Y
Adaptations (DFG)	
Carers	
Intermediate Care	Y
Prevention & Maximising Independence (Home Care)	Y
Care Act implementation	
7 Day Working	Y
Section 117	Y
Care Home Support Team	
Investment in Primary Care (GPST)	
Investment in Primary Care (GPSU)	
Discharge to Assess	Y
Community Equipment	Y
Care Home support team - provider training improvement	
Homeless Discharge	
Totals investment for Out of Hospital Services (Estimated figures)	£20,954,455

Condition 4 – Managing Transfers of Care

Bristol CCG in partnership with Bristol City Council will be continuing to deliver the Discharge to Assess (D2A) which has been enabling discharge from local acutes, in addition to this the Enabling Discharge Programme has a main focus on delivering the High Impact Change model and has strong links to the Better Care Programme.

National Metrics

As part of the Better Care Bristol Plan we will continue to measure ourselves against the four National metrics. Local areas are no longer required to report the performance of the previous local metrics. A recent review and mapping

exercise of the schemes within the neighbouring CCG's previous plans highlights a consistent approach to meeting the Better Care Fund performance metrics and we are will work together to align work streams to maximise the impact to achieve the below metrics.

The schemes that contribute to each metric can be seen in the table below;

Metrics				
Scheme name	DTOC	NEA	Admissions to Residential Homes	Effectiveness of Reablement
Early and Preventative interventions and reduction in hospital admissions in primary care	Y	Y	Y	
Community Services	Y	Y	Y	Y
Adaptations (DFG)			Y	Y
Carers		Y	Y	Y
Intermediate Care	Y	Y	Y	Y
Prevention & Maximising Independence (Home Care)	Y	Y	Y	Y
Care Act implementation	Y	Y	Y	Y
7 Day Working	Y	Y		Y
Section 117	Y	Y		Y
Care Home Support Team	Y	Y		Y
Investment in Primary Care (GPST)		Y	Y	
Investment in Primary Care (GPSU)		Y	Y	
Discharge to Assess	Y	Y	Y	Y
Community Equipment	Y	Y	Y	Y
Care Home support team - provider training improvement		Y		Y
Homeless Discharge	Y	Y		Y
Totals investment for each metric (Estimated figures)	£25,508,039	£27,931,755	£25,879,507	£25,272,965

Non-elective Admissions

In previous years, the Non-elective Admissions target aligned with Bristol CCG's operational plans and no further reduction was applied. This approach will continue into the 2017/19 using the BNSSG operational plan.

Admissions to residential care homes

Performance against the reduction in care homes admissions across Bristol has been on a positive trajectory throughout 2016/17, with Bristol CCG investing heavily into schemes that contribute to achieving this metric. This will continue into 2017/19 with the schemes shown above which will contribute to achieving this metric.

Effectiveness of re-ablement

Bristol CCG have remained consistent with the performance against keeping people at home for 91 days after discharge. Although Bristol fell slightly short of this target, it had shown a significant improvement on previous years.

Delayed transfers of care (DTOC)

In previous years the DTOC target aligned with Bristol CCG operational plan. NHSE have mandated a DTOC trajectory for Bristol to achieve a level of 4.5% (Delayed Transfers of Care (delayed days) from hospital per 100,000 population, aged 18+) by September 2017 and reducing to 3.5% DTOC rate in March 2018.

This target will be achieved by the schemes listed in the above table.

Bristol City Council Improved Better Care Fund Initial Allocation Proposal

The following outlines the initial indicative proposals for the Improved Better Care Fund. These proposals follow consultation with stakeholders but are still subject to Bristol City Council governance processes and wider engagement with partners.

The proposals have been produced ensuring they relate to the guidance associated with the fund:

- Stabilising the care market
- Protecting Adult Social Care
- Adult Social Care that supports the NHS deliver
- Avoidance of unnecessary admissions to hospital;
- Improving patient flow after admission;
- Ensuring prompt discharge from hospital either for further social care assessment or into a sustainable on-going care setting (community, residential or nursing) when patients are medically optimised.
- Our Plans are in line with the Adult Social Care Strategic Plan and the 3 tier model

Adult Social Care Strategic Plan 2016 - 2020



Figure 1: Bristol's strategic approach to adult social care

The main initiatives that the additional money will be used for can be summarised below;

	Initiative 1	Initiative 2	Initiative 3	Initiative 4	Initiative 5
Initiative Name	Development of a new market strategy for Bristol.	Managing demand for services.	Increased independence for vulnerable adults through review and market management	Collaborative use of technology	Collaborative working across the Region to improve patient flow and gain efficiencies
Initiative Description	Increased capacity in the sector especially in home support. A more balanced market including a defined role for in-house services. A workforce strategy that attracts more people into social care as a career option A revised price structure and framework that stabilises the market	Implementation of the 3 tier model of care delivery. An action plan (following diagnostic) implementing a strategic approach to assistive technology Creating a more asset based approach to demand Development of an Information Advice and Guidance reformed system	Accommodation strategy for vulnerable people Improved operational arrangements with housing providers Greater range of housing options for vulnerable young people thereby assisting hospital discharge especially with respect to mental health services	Mobile working introduced for all social work and reablement staff Greater engagement with the Connecting Care programme Engagement with NHS Digital on transfers of data to nursing homes Integrated approach to first contact with the Council	Continued work on Section 136 Development of strategic shared approach to hospital admissions and discharges Collaboration on market management approaches including price paid for care

Conclusion

The Better Care Bristol programme, including the Improved Better Care Fund will remain to consist of schemes that focus on joining and aligning services across Health and Social Care, with a large focus being on the forth BCF National Condition, Managing Transfers of Care.

It is apparent that through the Better Care Fund, both nationally and locally, Delayed Transfers of Care will be closely scrutinised with the Government planning a review of DTOC performance in November with a view of reducing 2018/19 iBCF funding for poor performing areas.

As previously stated there is an expectation to achieve a DTOC level of 4.5% by September 2017. This will be a challenge for both Health and Social Care to achieve this as at the end of March 2017 the DTOC position was 8.8% due to Mental Health delays now being included. Work is already underway to address this issue, including the creation of a Mental Health Enabling Discharge Board, to monitor and address blockages within the system.



Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation partnership (STP) update	
Author, including organisation	Laura Nicholas, BNSSG Programme Director University Hospitals Bristol NHS FT
Date of meeting	16 August 2017
Report for Information	

1. Purpose of this Paper

The purpose of this paper is to update the Health & Wellbeing Board on progress with the BNSSG

2. Executive Summary

- The STP is the 15 member partnership leading a BNSSG wide health & care transformation plan in response to the NHS Five year forward view.
- The partnership has now implemented a governance infrastructure, has some new leaders in place and made progress on a number of care pathway redesign projects.
- The BNSSG STP was assessed as “in need of most improvement” in national rankings published on 21 July, but now has the right infrastructure in place to accelerate its rate of progress
- A refresh of the STP is under way which will refocus current plans on areas of greatest opportunity and impact. New priorities will be agreed by end of August
- The STP is also developing plans in the following areas:
 - A strategic case for change
 - A new model of integrated care
 - A commissioning context document to inform Weston sustainability planning
 - Workforce development, in response to funding received from Health Education England (HEE)

3. Context

The STP has been created to generate strategic transformation plans in BNSSG, in response to the NHS strategy – The NHS Five Year Forward View. The BNSSG STP plan has been in development since March 2016. An outline plan submission was made to NHS England in October 2016 in response to national guidance. Since then local partners have worked on establishing the core governance arrangements for the partnership. Work on planning content development was paused between November 2016 and May 2017, whilst more the more immediate priority of developing financial turnaround plans for 2017/18 was undertaken. Work on longer term transformational plans has now recommenced. Progress is described in the rest of this paper.

4. STP Progress update

4.1 Introduction

Since our plan submission in October last year, the STP team has been putting in place the key governance arrangements we need to formalise our collaborative working. We have created a sponsoring board comprising the Chief Executives of our 15 partner organisations (or their representatives) to be chaired by our new independent chair which will oversee the STP going forward. We also have an executive management group consisting of the senior responsible officers (SROs) of each of our main work streams. This group will direct and support the STP work programme. These arrangements and the arrival of new and strengthened leadership (see 4.2 below), will allow us now to accelerate the pace of development of the STP plans.

We are making progress in some of our programmes, including development of a new stroke pathway, redesign of diabetes services and respiratory pathways. We have also made progress on plans for locally integrated care based around GP practice clusters.

STP national rankings - The results of a national assessment of STPs were published by NHS England on 21 July. STPs were assessed on a range of performance, financial and leadership metrics and placed into one of 4 categories. The BNSSG STP was rated category 4 – in need of most improvement - along with 4 other STP footprints. This is disappointing, but not unexpected given the size of our challenge and some of the turbulence we've experienced in recent months. The sponsoring Board discussed the results which are a point in time initial assessment. They acknowledged the result and felt that the changes we are now putting in place around the STP, particularly the new leadership team coming into the CCGs, the joint planning work around in-year delivery; robust governance and leadership for the STP and developing a more focussed work programme will all significantly improve the chances of our future success. There was a real determination to ensure that the next assessment will show material improvement.

4.2 Leadership Developments

- We are very pleased to welcome Sir Ron Kerr, who joins us as Independent Chair of the STP. Ron was most recently the Chief Executive of Guy's and St. Thomas's Hospitals NHS Foundation Trust in London, but also brings a wealth of senior experience over 30 years in both executive and non-executive roles in all parts of the NHS. Sir Ron will Chair the STP Sponsoring Board and support Robert Woolley in the senior leadership of the Partnership.
- Julia Ross Joined us as the new Chief Executive across the 3 BNSSG CCGs on 5 May. Julia was most recently Chief Executive of North West Surrey where she was also the lead Chief Executive for the Surrey Heartlands STP. Julia is now in the process of recruiting her single senior leadership team – announcements will have been made by the time of today's meeting.
- Laura Nicholas started as the Programme Director for the BNSSG STP in April, taking over from Martin Harris. Laura comes to us from the NHS in Devon where she was Director of Strategy for NEW Devon CCG and programme Director for the wider Devon STP.

4.3 STP Refresh

The Partnership agreed in June to undertake a refresh of previously agreed STP projects and programmes. The objectives of the refresh are:

- To agree, mandate and support a core programme of work that needs to be delivered during 2017/18 at the system level that will be led or facilitated by the core STP team, working with partner organisations and resourced to produce specifically agreed deliverables.
- To agree what further development work needs to take place to progress the scale and pace of transformational change plans for the BNSSG system

The overall approach and early outputs of the refresh were agreed by the Sponsoring Board on 26 July and on 8 August the Executive Group undertook a prioritisation exercise to agree the forward work programme for the remainder of 2017/18. The outputs of this were not available at time of preparing this paper but will be agreed by the sponsoring board at its meeting on 30 August.

- As part of the refresh process we will also be reviewing our communications and engagement approach. There are two key elements to this. First is the intention is to ensure that we communicate regularly with partner and stakeholders regularly as our programme of work takes shape and second, ensure that there is meaningful engagement and involvement in the emerging programmes of work set out in section 4.4 below. We intend to build a more innovative and thorough approach to involvement building on some of the leading edge work already going in the Bristol area. A revised communications & engagement work stream will be established in September to take this work forward.

4.4 Key Planning developments

In addition to some of the pathway developments mentioned above The STP is now also beginning to tackle the following :

- i) *Case for change* - We have started work on a high level “case for change” for the STP. This work builds on the initial analysis in the STP June and October submissions and will give us a clearer, more detailed and quantified system understanding of the challenges we face from the perspectives of population health needs; health inequalities and how our current spending and activity patterns relates to these, the overall quality and safety of provision and how efficient and productive our provider system is. (i.e. linked to the 3 key aims of the five year forward view – population health, quality & safety and finance and efficiency). The output will be used to identify opportunities for improvement that will drive development of plans to address the challenges. We will also use its findings to help us to develop a public facing narrative on the BNSSG system challenges and opportunities to transform care and services. A draft of this product will be available towards the end of this year, in time to inform our plans for 2018/19.
- ii) *New model of care* - Work will start in September on consolidating a single articulation of a new model of care for BNSSG. Again, the need for this was set out in the STP submission, but we need to develop the thinking, based on local challenges and opportunities, to ensure that it can provide a consistent strategic framework for further service and pathway redesign. The work will be led by the current Integrated community and primary care (IPCC) work stream as it builds on the out of hospital cluster and multidisciplinary team initiatives already in development, but with input from a wider range of other stakeholders including secondary care, voluntary sector and local authorities.
- iii) *Weston sustainability* - A draft commissioning context document has been in development by the CCGs over the last 2 months. This is an important part of the process for developing a service solution for the North Somerset population who use Weston Hospital services. The document sets out the key population health needs and health inequalities for these communities and a direction of travel for future service provision in all sectors, not just the hospital. This is a significant step forward and it will be used to help co- design the whole local system of care with both local communities and service providers. The document will be reviewed at the Weston Sustainability Board meeting on 15 August, and will be made public in due course.
- iv) *Workforce planning developments* - In July, the STP received £686k additional funding from Health Education England to support our workforce transformation plans. The Local Workforce Action Board (LWAB) is overseeing development of plans and proposals to which these funds will be allocated. High level priorities include: Developing our workforce planning and redesign capability; earmarking funding for developing training packages we know will be needed to support new ways of working; developing a more

flexible workforce and enabling staff to improve overall population health through greater focus on prevention and self-care.

6. Working with our local authority colleagues

- The 3 BNSSG local authorities are named key partners to the STP and executives from all 3 sit on our sponsoring board representing both social care and public health. This representation is key to ensuring alignment across health and social care strategic planning.
- We will continue to develop our relationships and work with the 3 HWBs as a means to achieving alignment of our plans. As the STP vision for transformed care becomes clearer, we will work with officers to jointly develop more specific deliverables. Early areas for joint work with LAs include designing the model of provision for the Weston Community; developing the broader integrated care model; developing a prevention strategy for the STP and exploring opportunities around workforce planning and design. The refresh will also identify some more focussed work on mental health.
- Our case for change work will form an important part of the overall strategic framework for the STP and we will begin work in September to develop a public narrative for the STP. We would like to use the expertise in local authorities to help us to do this as well as ensuring that the 3 OSCs are engaged in this and other plans, as they emerge.
- Robert Woolley and Julia Ross are meeting the 3 LA OSC chairs to provide an update to them on progress with STP and delivery of in-year plans on 17 August

7. Conclusions

Whilst progress on the BNSSG to date has been limited by shorter term priorities, the new governance and leadership arrangements we now have in place will enable us to significantly increase the pace of progress. The STP refresh is the first key step in enabling this.

8. Recommendations

The Board is asked to note the report.

Laura Nicholas
BNSSG STP Programme Director
07 August 2017

Bristol Health & Wellbeing Board

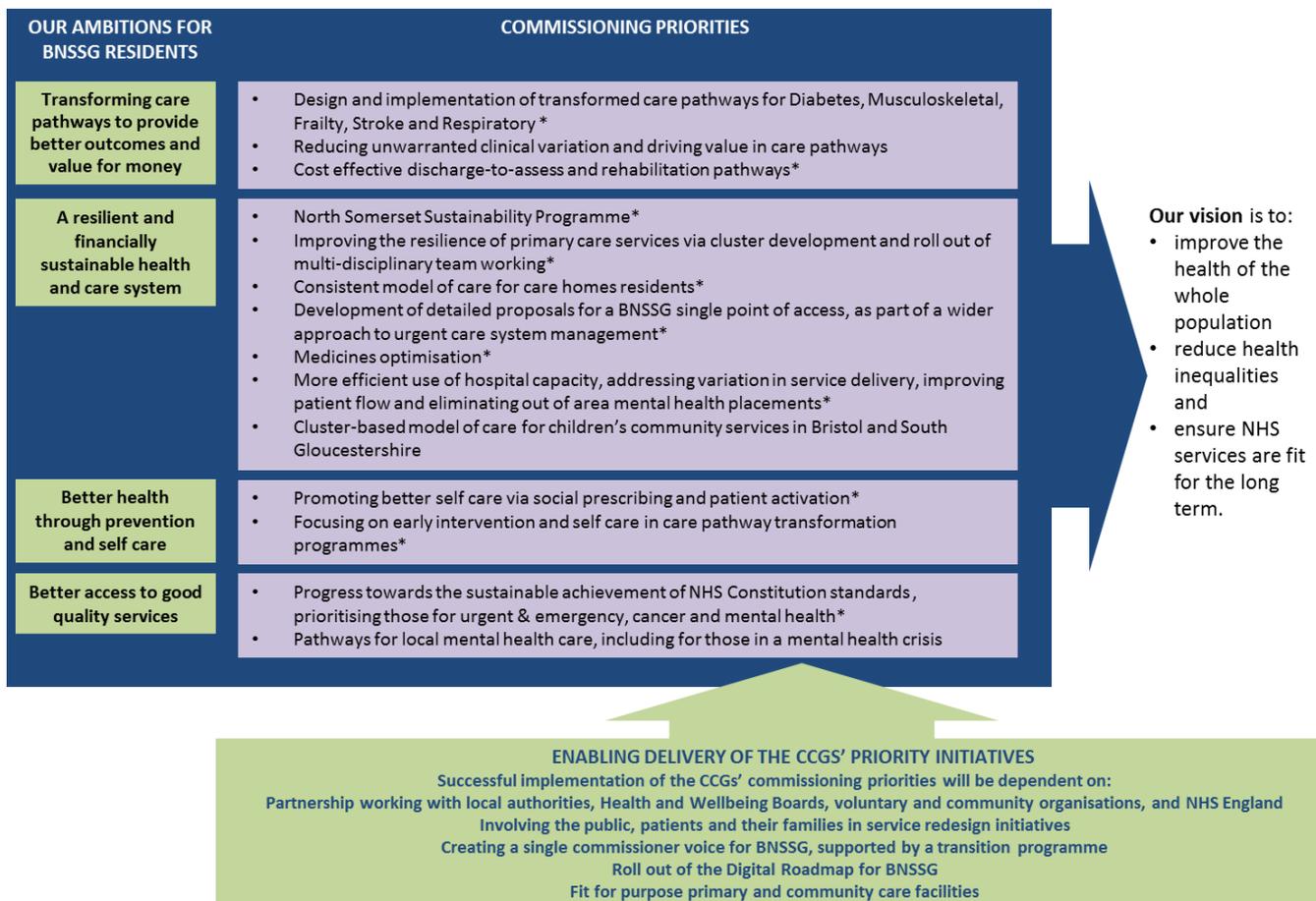
BNSSG CCGs' Operational Plan 2017-19	
Author, including organisation	Julia Ross – Chief Executive BNSSG CCGs Jennifer Norman – Head of Planning and Business Support BNSSG
Date of meeting	16 August 2017
Report for Information/Discussion	

1. Purpose of this Paper

This paper is to provide the Health and Wellbeing Board with an update on the Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups' (CCGs) Operational Plan 2017-19.

2. Executive Summary

The CCGs' operational plan is summarised in the 'plan on a page', which is reproduced below.



3. Context

NHS England published its Five Year Forward View in 2014, which described how the NHS needed to become more sustainable in order to address the anticipated challenges over the coming five years.

Building on this, in December 2015 NHS England published further guidance called “Delivering the Forward View: NHS planning guidance 2016/17 – 2020/212. This guidance comprehensively set out a number of aims, must do’s and elements that NHS organisations must deliver against to enable them to become sustainable organisations by 2021. The required response was the same as the previous year, with the production of two separate but connected plans:

- a five year Sustainability and Transformational Plan (STP), place based and driving the Five Year Forward View; and
- a one year Operational Plan for 2016/17, consistent with the emerging STP.

On 31 March 2017, NHS England published updated guidance in the form of ‘Next Steps on the Five Year Forward View’. This provided a review of nationwide progress toward delivering the Five Year Forward View (FYFV) published in 2014, and set out priorities for its delivery as part of the next phase in 2017.

The refreshed FYFV supplements the NHS England 2017-19 planning guidance published September 2016, and contains a number of specific requirements for 2017-18 all of which have been factored into the BNSSG Operational Plan attached in appendix one.

BNSSG CCGs are providing this paper to share their joint operational plan with HWB members.

4. Main body of the report

The BNSSG Operational Plan highlights the key programmes of work across the BNSSG system, together with the outcomes we expect to achieve. These, along with our CCG strategic objectives and priorities are summarised in the ‘Plan on a Page’.

Priorities

Priorities have been identified with reference to the requirements of our local BNSSG population, the Five Year Forward View and NHS England planning guidance. This guidance includes nine ‘must do’ priorities, which have been woven through the delivery of our programmes.

Ensuring successful delivery of the plan is also in part through its alignment to the Sustainability and Transformation Partnership Plan (STP). Participating in developing the STP with a variety of stakeholders across multiple

organisations, has enabled us to produce a credible plan that has factored in the views of a number of stakeholders.

In delivering our priorities:

- We continue to work as part of the BNSSG Sustainability and Transformation Partnership
- Our focus in 2017/18 will be on those initiatives that support delivery of the system financial recovery plan
- We have established a system-wide control centre and PMO delivery mechanism to ensure accountability clarity and maintain momentum

Financial background

The BNSSG system faces significant financial challenge during the planning period 2017-2019. The combined CCGs' financial position for 2016/2017 was an in year deficit of £38m, which contributed to a cumulative deficit of £55m being carried forward into 2017/18.

The CCGs have been working with providers on a system-wide financial recovery plan, identifying CCG required savings of £83.2m in 2017/18 with a full year effect of £106.7m in 2018/19, leaving a residual gap of £16.8m in 2018/19 to achieve the control totals in both financial years. A process is in place for continuous identification and delivery to support this achievement and to identify a further £17m of savings to deliver a 1% surplus in 2018/19 and restore financial resilience to the health commissioning system in future years.

In addition the combined cost improvement programme for the main healthcare providers totals £75m to reach established control totals for 2017/18 alone; this does not achieve financial balance across the sector at this point.

Overall the financial position is extremely challenged across the BNSSG healthcare landscape. Our total allocation for health is £1.15bn for local commissioning. If specialised commissioning is added to this a total of £1.5bn is available to spend at our local providers and on care for our local population. We consistently spend well in excess of this amount.

Engagement

On Wednesday 19 July, seven proposals requiring patient and public involvement were published on the BNSSG CCG websites. These are accompanied by proposal summaries, online feedback facilities and surveys where required. Further information can be found here www.bristolccg.nhs.uk/get-involved/nhs-service-proposals/

As we move forward we will be implementing a new approach to engagement through patient centred co-design. This will ensure that people who use services are part of the work we do to design new services or re-assess existing ones. We are also establishing a BNSSG-wide Patient & Public Engagement Forum as a formal part of our governance infrastructure reporting directly into our Governing Bodies.

5. Key risks and Opportunities

A high level assessment of risks and mitigations is included in the attached document. Risk identification and risk management is undertaken through the BNSSG programme control centres.

6. Implications (Financial and Legal if appropriate)

National policy “must-dos” include the financial imperative to:

- deliver both individual CCG and provider organisational and local system control totals
- achieve local targets to moderate demand and improve provider efficiency

At the same time other national policy directives are increasing the financial pressure on local health systems in terms of the scale and pace of savings delivery through the System Financial Recovery Plan.

The delivery of planned savings will rely heavily on system -wide collaboration to manage costs and demand within the funding available through a combination of:

- transformation of organisational configuration and service design
- improved management of continuing health care (CHC) processes
- significant reduction in current growth trends for both GP prescribing and CHC
- significantly improved provider efficiency
- enhanced governance and control in relation to demand reduction and efficiency improvement programmes

7. Evidence informing this report.

The key themes and priorities to improving health and wellbeing have been identified using evidence pulled together from the respective Bristol, North Somerset and South Gloucestershire Joint Strategic Needs Assessments (JSNA).

The BNSSG STP Sponsoring Group recently considered a case for change to address the JSNA knowledge gap for the BNSSG STP footprint. Whilst this case for change is progressed, it has been agreed that work to produce one BNSSG JSNA will take place with immediate effect.

8. Conclusions

The BNSSG CCGs remain committed to engaging with partners through the BNSSG CCGs Chief Executive, and through the three new Area Director roles, as we progress our operational plan.

9. Recommendations

HWB members are asked to

- (1) Note the BNSSG CCG Operational Plan for 2017-19.
- (2) Agree to receive further updates as work progresses.

10. Appendices

Appendix 1 BNSSG CCG Operational Plan

BNSSG Operational Plan 2017 - 2019

Contents

- Planning for BNSSG Sustainability and Transformation
 - Our population
 - Plan on a page
 - Our strategic approach
- Financial Planning
- Quality and Safeguarding
- Performance Management
- Approach to Work Programmes
- CCG Priorities: 2017 – 19
- Enabling Programmes
- Operational Plan Risks and Mitigations
- Glossary of acronyms

Planning for BNSSG Sustainability and Transformation

Page 132

Introduction

Bristol, North Somerset and South Gloucestershire is a vibrant, dynamic area with a growing and diverse population of nearly one million people. Known for its high quality of life and standard of living, Bristol, North Somerset and South Gloucestershire's population continues to grow year on year. This is as a result of a relatively high birth rate, more people moving into the area each year, and growing life expectancy.

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups have committed to work together to commission high quality health services and ensure value for money. In acknowledgement of this, a single accountable Chief Executive Officer has been appointed for the BNSSG CCGs. Our vision remains to improve the health of the whole population, reduce health inequalities and ensure NHS services are fit for the long term.

We want to continue to modernise care and treatment to make it truly designed around patients, efficient and in line with modern life. If a treatment or test can take place in a GP surgery or health centre near a patient's home rather than in hospital, then that is better for the patient and the health system. If patients can request follow-up appointments after treatment only if they feel they need them, rather than by automatic invitation, it saves them and the system valuable time and money.

As well as modernising systems and treatments to improve care, we also need to make the best possible use of resources and return the local health system to financial balance. This will allow us to protect the widest possible range of healthcare services for the broadest possible population.

This Operational Plan highlights the key programmes of work across the BNSSG system, together with the outcomes we expect to achieve. These, along with our CCG strategic objectives and priorities are summarised in the 'Plan on a Page'. We look forward to feedback and comments from patients and the public.

Our Population

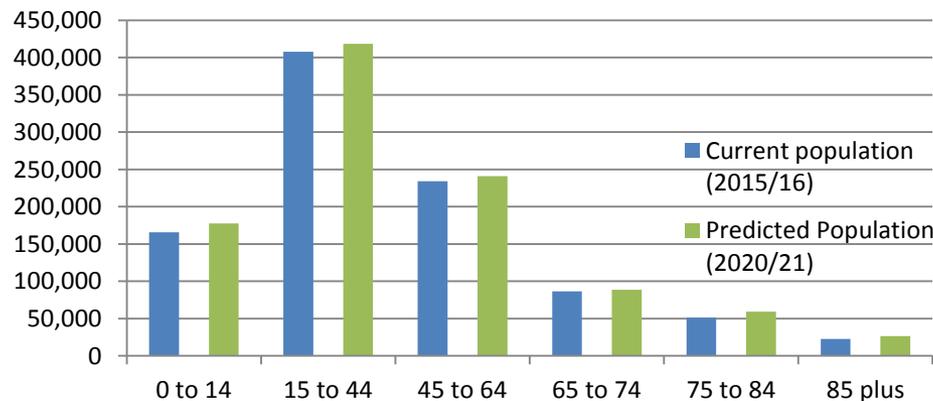
A growing and ageing population

The total population across BNSSG is 968,314, with 17.5% (164,613) of the population in BNSSG living in the most deprived areas of England. As commissioners we need to plan for population growth as a result of planned housing developments that will attract young families as well as greater numbers of older people who may have complex health needs.

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

Page 134

**Predicted Population Change in
BNSSG 2015/16 to 2020/21**

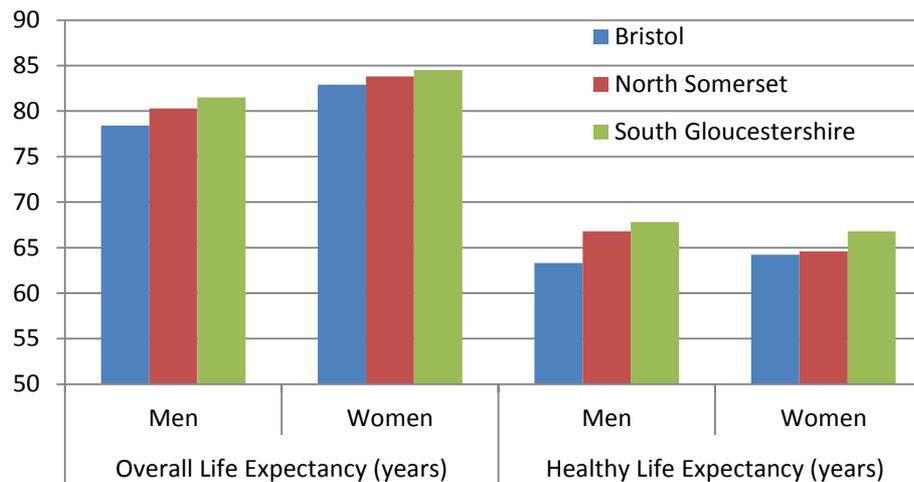


Life Expectancy

Understanding differences in 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. The below graphic presents the differences in life expectancy across BNSSG.

Overall and Healthy Life Expectancy Across BNSSG



As well as differences in life expectancy between men and women, we know there are significant differences in life expectancy depending on where people live and their personal circumstances. As commissioners we need to focus on closing this gap in life expectancy.

Health Equality

Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact because they result in people who are worst off experiencing poorer health and shorter lives. The Joseph Rowntree Foundation estimates that poverty costs the NHS £29bn per year (equivalent to 25% of the entire NHS budget in England).

It has been demonstrated that people in lower socio-economic groups are more likely to have a greater prevalence of severe and enduring mental and physical health problems. Children living in poverty suffer more than anybody else. More than one in five children starting primary school in England are overweight or obese. Obesity leads to serious increased risk of lifelong health problems including type 2 diabetes, heart disease and cancer. Based on data for 2012-2014, in males the leading causes of the inequality gap are cancers, circulatory diseases, respiratory diseases and digestive disorders, and for females respiratory diseases, circulatory and cancers.

As commissioners our approach to addressing health inequalities is to ensure health services are equitable and address the specific needs of our most deprived communities.

Health Needs

Increasing health needs

The health needs of a population reflect the numbers of people suffering from different types of illness. Looking only at the numbers of patients currently being treated for a disease does not show the true prevalence and impact on the population's health. At any given time, there are many people who have a disease but are not aware of it because they have not yet been diagnosed. A robust and well-researched disease prevalence model can help commissioners to assess the true needs of their community, calculate the level of services needed and invest the appropriate level of resources for prevention, early detection, treatment and care.

Disease prevalence methodology was used to forecast the expected increase in disease prevalence for various causes of death for Bristol, North Somerset and South Gloucestershire including: cardiovascular disease, chronic obstructive pulmonary disease, Dementia, Diabetes, and Obesity.

BNSSG Plan on a Page

Page 138

**OUR AMBITIONS FOR
 BNSSG RESIDENTS**

COMMISSIONING PRIORITIES

Transforming care pathways to provide better outcomes and value for money

- Design and implementation of transformed care pathways for Diabetes, Musculoskeletal, Frailty, Stroke and Respiratory *
- Reducing unwarranted clinical variation and driving value in care pathways
- Cost effective discharge-to-assess and rehabilitation pathways*

A resilient and financially sustainable health and care system

- North Somerset Sustainability Programme*
- Improving the resilience of primary care services via cluster development and roll out of multi-disciplinary team working*
- Consistent model of care for care homes residents*
- Development of detailed proposals for a BNSSG single point of access, as part of a wider approach to urgent care system management*
- Medicines optimisation*
- More efficient use of hospital capacity, addressing variation in service delivery, improving patient flow and eliminating out of area mental health placements*
- Cluster-based model of care for children’s community services in Bristol and South Gloucestershire

Better health through prevention and self care

- Promoting better self care via social prescribing and patient activation*
- Focusing on early intervention and self care in care pathway transformation programmes*

Better access to good quality services

- Progress towards the sustainable achievement of NHS Constitution standards , prioritising those for urgent & emergency, cancer and mental health*
- Pathways for local mental health care, including for those in a mental health crisis

Our vision is to:

- improve the health of the whole population
- reduce health inequalities and
- ensure NHS services are fit for the long term.

Page 139

ENABLING DELIVERY OF THE CCGs’ PRIORITY INITIATIVES

Successful implementation of the CCGs’ commissioning priorities will be dependent on:
 Partnership working with local authorities, Health and Wellbeing Boards, voluntary and community organisations, and NHS England
 Involving the public, patients and their families in service redesign initiatives
 Creating a single commissioner voice for BNSSG, supported by a transition programme
 Roll out of the Digital Roadmap for BNSSG
 Fit for purpose primary and community care facilities

**BNSSG Sustainability and Transformation Partnership initiatives that the CCGs will prioritise for delivery in 2017-19*

Our Strategic Approach (1)

Working in the BNSSG Sustainability and Transformation Partnership to Deliver the Five Year Forward View

Every health and care system in England is required to create their own local blueprint for implementing the Five Year Forward View (5YFV). Published in October 2014, the 5YFV is NHS England's national vision for future health services that sets out how the NHS should change so that it can successfully meet the challenges of a growing and ageing population within available resources. The aim is to enable a place-based approach to planning for local health and care systems, encompassing all services commissioned by CCGs and NHS England, and also self-care, prevention and social care, reflecting Joint Health and Wellbeing Strategies. This reflects the need for system-wide involvement and commitment for the successful delivery of major service redesign and transformation.

The BNSSG CCGs have worked with NHS provider organisations in the area, including representatives of GP practices, and the three local authorities to develop a Sustainability and Transformation Partnership (STP). Initial, outline plans developed by the BNSSG STP were published on the websites of the STP organisations – including the BNSSG CCGs – in November 2016. The BNSSG health system has agreed to develop a single sustainability and transformation approach for the services provided to a population of over 900,000 people. It reflects a commitment jointly made by the leaders of health and social care services in BNSSG to a collective effort to transform services and improve outcomes for this population.

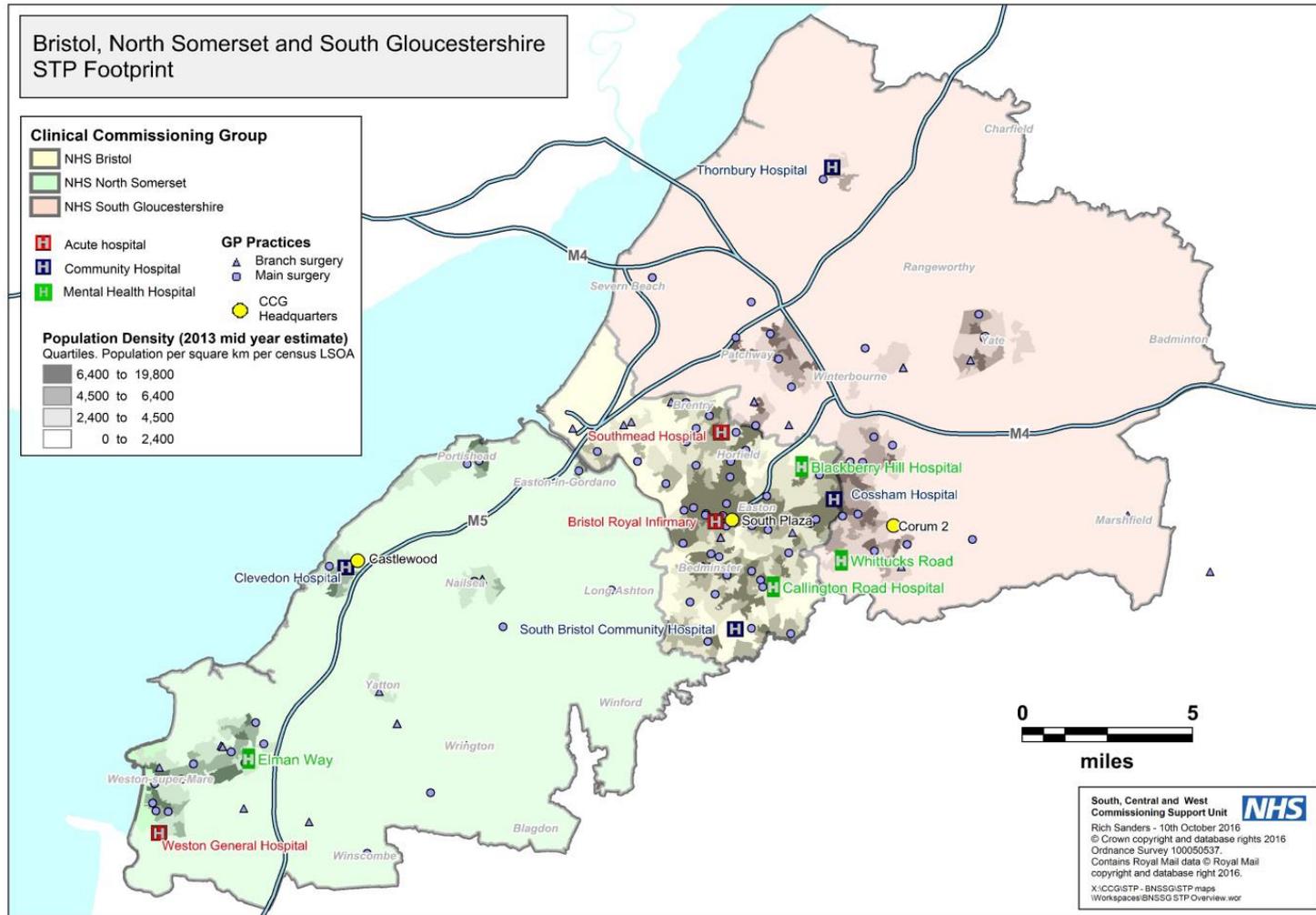
Our Strategic Approach (2)

The NHS as a whole faces a very challenging period financially with a need to identify significant efficiency savings, while continuing to meet growing health needs and continue to secure quality improvements. The 2017-18 budget for NHS services in Bristol, North Somerset and South Gloucestershire is £1.15 billion, but health spending in our area is exceeded this budget and there is a growing deficit. If spending continues at its current rate, the deficit will continue to grow, putting the future of health services at risk. Substantial change may be needed if increasing health needs are to be successfully met in future. There is therefore a focus in 2017-19 on system financial recovery, which has been a key driver underpinning our approach to the development of the work programmes and priorities described in this document.

Page 141

The BNSSG STP plans build on existing plans and learning nationally and locally. This includes the work of BNSSG CCGs to roll out the models of care proposed in the 5YFV:

- Work is already well underway to deliver the new care models for Modern Maternity Services, and Urgent and Emergency Care Networks;
- The learning from the successful enhanced health in care homes model in South Gloucestershire of care is being used to inform a BNSSG model of enhanced care for care home residents;
- The BNSSG STP vision and BNSSG GP Primary Care Strategy reflect the Multispecialty Community Providers model of care; and
- The Viable Smaller Hospitals model of care is informing the North Somerset Sustainability Programme.



The BNSSG Sustainability and Transformation Partnership has 16 member organisations

Commissioners: the BNSSG CCGs and NHS England (Specialist and Primary Care)

Providers: University Hospitals Bristol NHS FT, North Bristol NHS Trust, Weston Area Healthcare NHS Trust, Avon & Wiltshire Mental Health Partnership, South Western Ambulance Service, Bristol Community Health, Sirona Care and Health, North Somerset Community Partnership
Primary Care Provider - One Care (BNSSG) Ltd

Local Authorities: Bristol City, North Somerset and South Gloucestershire

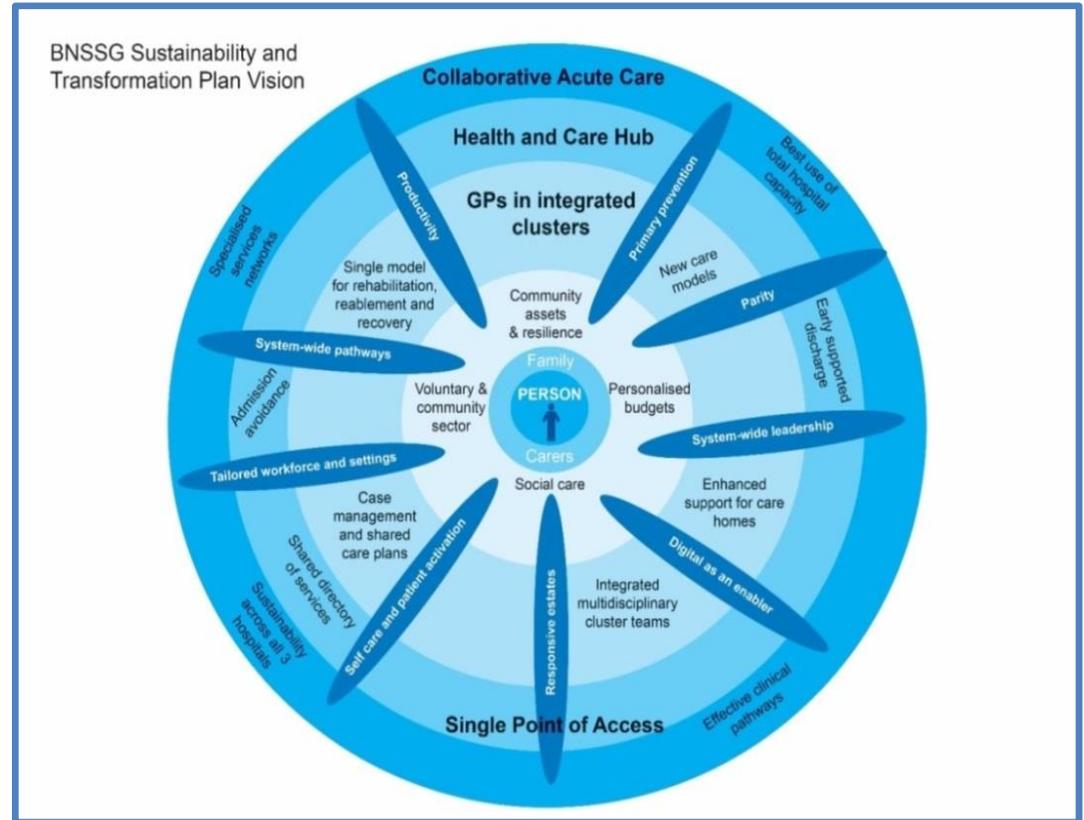
The BNSSG Sustainability and Transformation Partnership Model of Care

Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

The BNSSG Sustainability and Transformation Partnership (STP) has developed a model of care which lies at the heart of the system wide plans under development for transforming services.

The model of care starts with people in families and communities; with individuals encouraged and enabled to care for themselves; services delivered locally by integrated teams focused on the needs of the individual; and simplified access points to acute care and specialised services.

The STP has developed its model of care through three major transformational work streams: Prevention, Early Intervention and Self-Care; Integrated Primary and Community Care; and Acute Care Collaboration. Mental health is explicitly integrated within the three work streams.



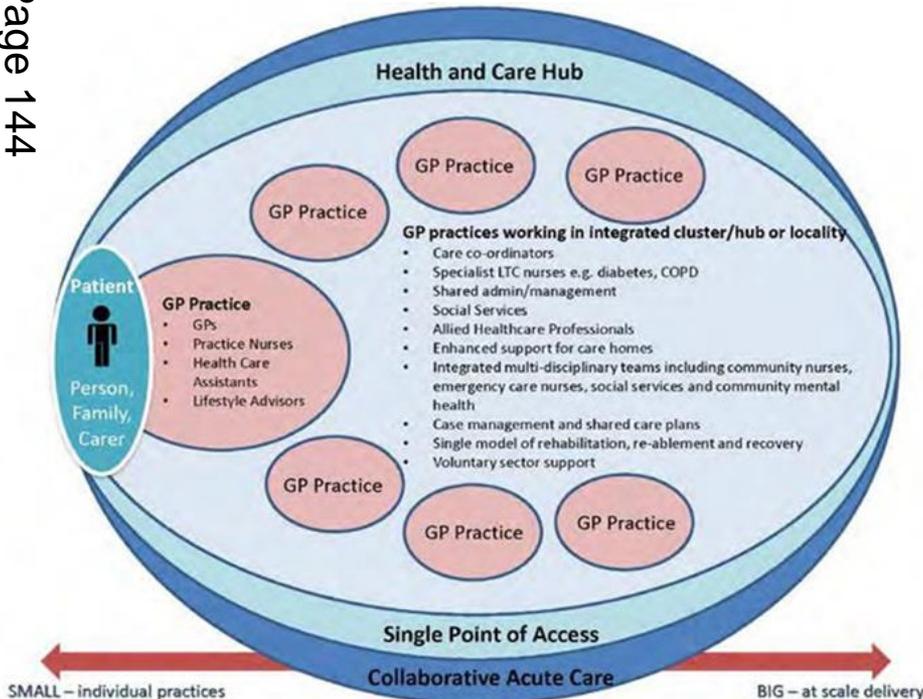
The work of these work streams and enabling programmes has been set out in the submission made to NHS England in October 2016, which is available on the websites of STP member organisations.

Our New Model of Primary Care (1)

Active collaboration between healthcare providers and the people they care for will sit at the heart of primary care. This patient-focused, multi-specialty approach will require collaboration between professionals and stronger integrated approach both within and across organisational boundaries to ensure that both personalised and continuity of care is provided and the need to go to hospital is reduced.

Our model will build on the traditional strengths of our 'expert GPs' who will continue to deliver equitable, personalised and continuity of care, proactively targeting services at, and working with, the population with complex on-going needs such as the frail elderly and those with chronic conditions.

Page 144



By working at scale, primary care providers will ensure consistent, resilient, high quality and safe care with all patients having access to a range of core services but allowing the flexibility to develop services that meet the specific needs of their population. Instead of a 'one size fits all' model, we will work to determine the best solution based on local need and circumstances. The term 'at scale' describes a locality or cluster of practices working together across a larger area to produce efficiencies and therefore increase sustainability.

Our New Model of Primary Care (2)

Increasingly the general practice teams will be supported by specialist nurses, mental health workers, pharmacists, physicians' associates, healthcare assistants and other healthcare professionals. Building on the tradition of hosting services such as the diabetic retinal screening and mental health services, the teams will be capable of offering more services locally.

An integrated approach will provide the capacity for greater continuity of care through better case management and greater use of shared care plans and a single model of rehabilitation, reablement and recovery. This will benefit those with complex care needs including those who are particularly vulnerable, frail or elderly, the housebound, those in care homes and patients who are in need of end-of-life care.

General practice teams will work collaboratively with, and be closely aligned to, community services and social care. There will be a general shift of appropriate work and resources from acute hospitals where it can be demonstrated that funding would be freed up and it would deliver safe and quality care more efficiently.

Transforming Out of Hospital Care: Health and Social Care Integration

The BNSSG CCGs have made significant progress towards the integration of our health and social care systems both individually and as part of the Sustainability and Transformation Partnership (STP).

At present, the CCGs each operate a joint commissioning model with their respective local authorities with arrangements that support the alignment of commissioning intentions and pooled budgets. As part of the wider BNSSG CCGs' transition programme to create a single commissioning voice and to support the further development and delivery of the STP's Integrated Primary and Community Health Care plans, in 2017-19 the BNSSG CCGs are working towards greater alignment in their joint commissioning arrangements, including for Better Care Fund plans. The approach will be based on achievements to date and the areas for improvement that have been identified. The three local authorities are also working to deepen their co-operation and recently commissioned a review of the opportunities for increased collaboration across the local authority adult social care departments.

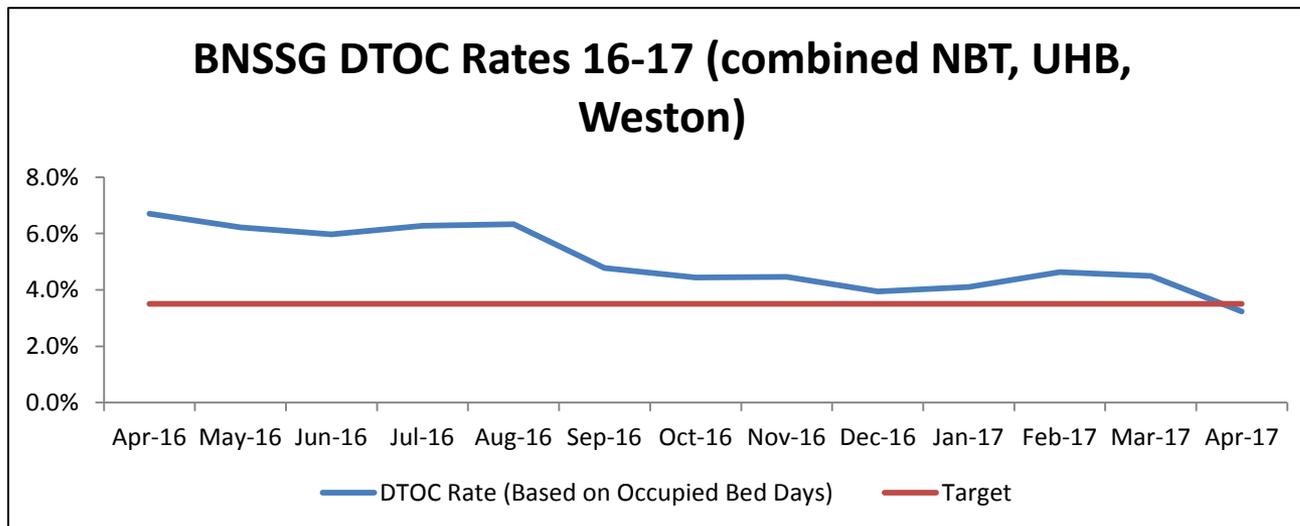
Integrating Health and Social Care

The STP's Integrated Primary and Community Health Care plans underpin our vision for the integration of the BNSSG health and social care system with the aim to improve peoples' care through:

- Early intervention and management to keep people as well as possible
- Enabling independence ,enabling patients to enjoy the best possible quality
- Plans for 17-18 include :
- Integrated models of care at primary and community level with care planning and coordination provided via multi-disciplinary teams
- Integrated health and care hub providing a single standard service offer across BNSSG

Page 147

Progress to date has resulted in significantly reduced Delayed Transfers of Care (DTOCs) across BNSSG :



Financial Planning

Page 148

BNSSG Financial Picture

The CCGs face significant financial challenge during the planning period 2017-2019. The combined financial position for 2016/2017 was a deficit of £55.3m which resulted in an underlying deficit of £58m being carried forward into 2017/18.

The CCGs have been working with providers on a system-wide financial recovery plan, which has identified CCG savings of £83.2m in 2017/18 with a full year effect of £106.7m in 2018/19, leaving a residual gap of £16.8m in 2018/19 to achieve the control totals in both financial years. There is a process in place of continuous identification and delivery to support this achievement and to identify a further £17m of savings to deliver a 1.9% surplus in 2018/19 and restore financial resilience to the commissioning health system in future years.

It is important to note that many of these savings are high risk and that the residual risk in 2017/18 is estimated to be in the order of £22.5m (1.9%). The CCGs are committed to reducing this residual risk by application of the above process and robust cost containment strategies.

The following diagram shows the Income and Expenditure for 2017/2018 and 2018/2019:

page 149

Income and Expenditure	2017/18	2018/19
	£m	£m
Baseline expenditure	1189.5	1161.2
In Year Growth in Expenditure:		
Growth in activity/demand	39.2	44.9
Reinstate Reserves	6.0	0.3
Tariff Inflation	1.1	1.2
HRG4+ Impact	5.4	
Specialist Commissioning Transfer	(1.1)	
RTT	4.9	
	1245.0	1207.6

Page 150

Baseline Allocation	1131.2	1154.0
Growth in Allocation	24.3	24.9
HRG4+ Allocation	(0.3)	
Specialist Commissioning Transfer	(1.3)	
	1154.0	1178.9

Financial Gap Before Savings	91.0	28.7
Identified Savings	83.2	46.4
(Deficit)/Surplus	(7.8)	17.7
Control Total	(8.0)	(1.8)

Note: This represents the in year position and excludes any debt repayment in either year.

Financial Allocation

- Five year allocations were published in December 2015, with confirmed allocations from 2016/2017 to 2018/2019 and indicative allocations from 2019/2020.
- 2017/2018 and 2018/2019 allocations have been reconfirmed, with additional allocations received to fund a change in tariff to HRG4+ and to fund the transfer of some specialist activity back to the CCG from NHS England.
- It is important to note that the CCGs have an outstanding historic debt repayment of £55.2m in 2017/2018 which will increase to £68.4m in 2018/2019 based on current plans and is deducted from the allocation in each year.
- The CCGs have received programme growth of 2.1% in 2017/2018 and 2.2 in 2018/2019. Running cost allocations have increased by 0.2% which represents a real terms reduction after inflation as the allowance per head of population is reduced on a sliding scale each year.

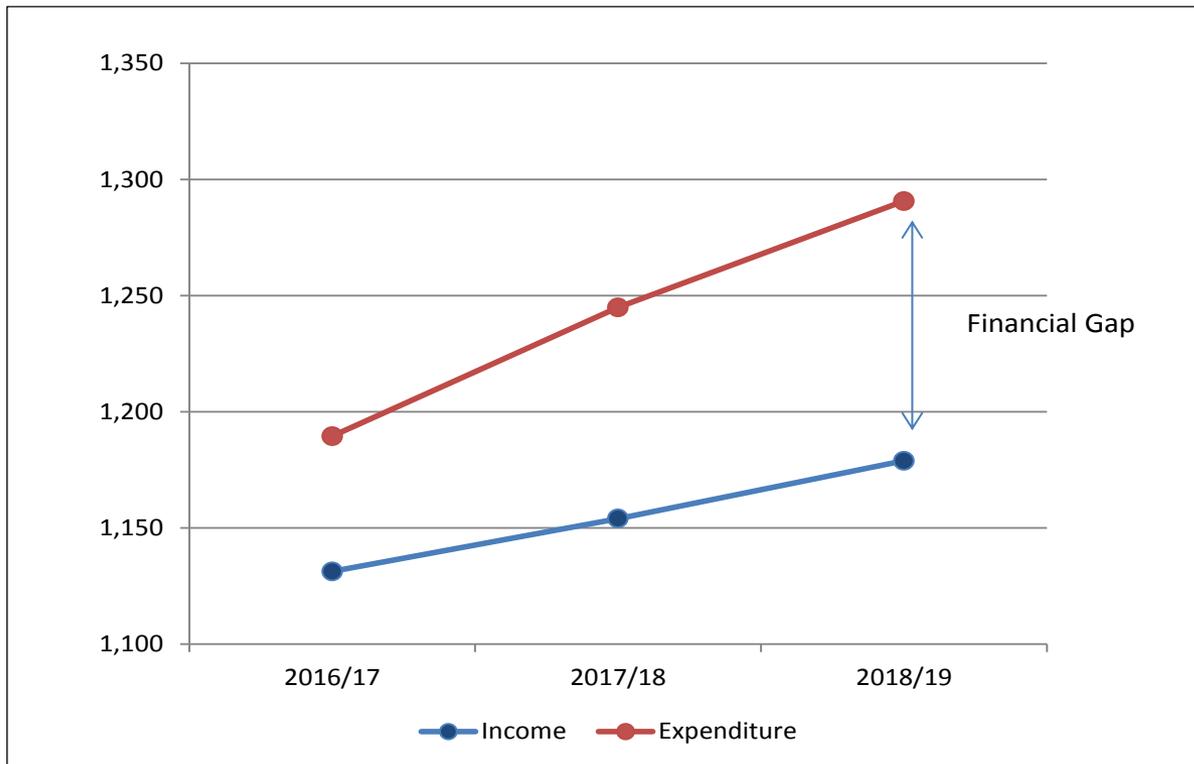
Resources	2017/18	2018/19
	£m	£m
Recurrent Baseline Allocation	1,110.6	1,134.9
Growth	24.3	24.9
Total Recurrent Allocation	1,134.9	1,159.8
Non Recurrent Allocations		
HRG4+ Tariff Impact	(0.3)	(0.3)
Transfers to specialist Commissioning	(1.3)	(1.3)
Total Non- Recurrent Allocation	(1.6)	(1.6)
Running Cost Allocation	20.6	20.7
Total Allocation	1,154.0	1,178.9
Historic Debt Repayment	(55.2)	(68.4)

Ensuring Affordability (1)

CCGs have been notified that they need to reduce the deficit from £58m in 2016/17 to £8m in 2017/18 and £1.8m in 2017/18 and 2018/19 to meet the aggregate CCG control total in each year.

The chart below shows the projected growth in the gap between income and expenditure over the next 2 years if no savings are delivered.

Page 152



Ensuring Affordability (2)

To achieve the control total in each year requires savings of £83.2m in 2017/2018 and £26.9 in 2018/2019, a total of £110.1m. Schemes have been identified which once implemented for a full 12 months will achieve savings of £106.7m leaving a residual gap of £3.4m to deliver the required control total in each year. Work is ongoing with providers to identify this balance and optimally further savings of £19.5m in order to restore a commissioner surplus in 2018/19.

Page 153
It is imperative that we implement our share of the system financial recovery plan, working with providers, to deliver the above.

There is a shared recognition with providers of the magnitude of both commissioner savings and provider cost improvement plans and work is continuing to assure total alignment.

Planning Assumptions

The key financial assumptions on which plans for 2017/18 and 2018/19 are based include the following growth assumptions:

- Acute growth of 2.3%
- Prescribing growth of 5.4% and 4.5% respectively
- Mental health growth of 1.9% in each year
- Community growth of 3.7% and 3.4% respectively
- Continuing healthcare growth of 5.3% and 5.0% respectively

The total cost impact of natural growth is estimated at £36.4m in 2017/18 and £35.0m in 2018/19

Plans are based on national tariff assumptions of 2.1% inflation offset by 2.0% provider efficiency giving a net tariff uplift of 0.1% and a financial cost pressure of £1.1m in 2017/18 and £1.2m in 2018/19

The implementation of the HRG4+ based tariff creates an estimated cost pressure of £5.6m in 2017/18 built into plans

Reserves which were fully utilised in 2016/17 have been reinstated in 2017/18 totalling £17.1m including

- 0.5% CCG contingency reserve
- 0.5% reserve for CCG non- recurrent use only
- 0.5% system reserve to be released only subject to agreement with NHSE

Overall System Financial Position

Financial Position

- Commissioner requirement of £82m savings to deliver £8m deficit control total
 - Initial Turnaround process identified £65m *commissioner* savings
 - The new System Financial Recovery Plan (SFRP) process has identified additional savings opportunities of £17m
 - A number of these schemes do not release full costs from a provider perspective and therefore further cost reductions of £3.8m are required to achieve system control totals
- The system has identified back office, estates and a system approach to bank & agency to deliver £3.8m system savings
- Provider CIPs total £75m to achieve control totals

Page 155

System Financial Recovery Plan

- £26.0m deliverable by CCGs
- £11.7m in contracts with a focus on PIFU & MSK
- £13.4m in provider subsidies outside PbR contract
- £14.8m in year through system transformation and pathway redesign
- £17.3m SFRP savings
- £3.8m Back office, estates and system approach to bank & agency to eliminate the provider impact of the SFRP savings

SFRP Risk Mitigation

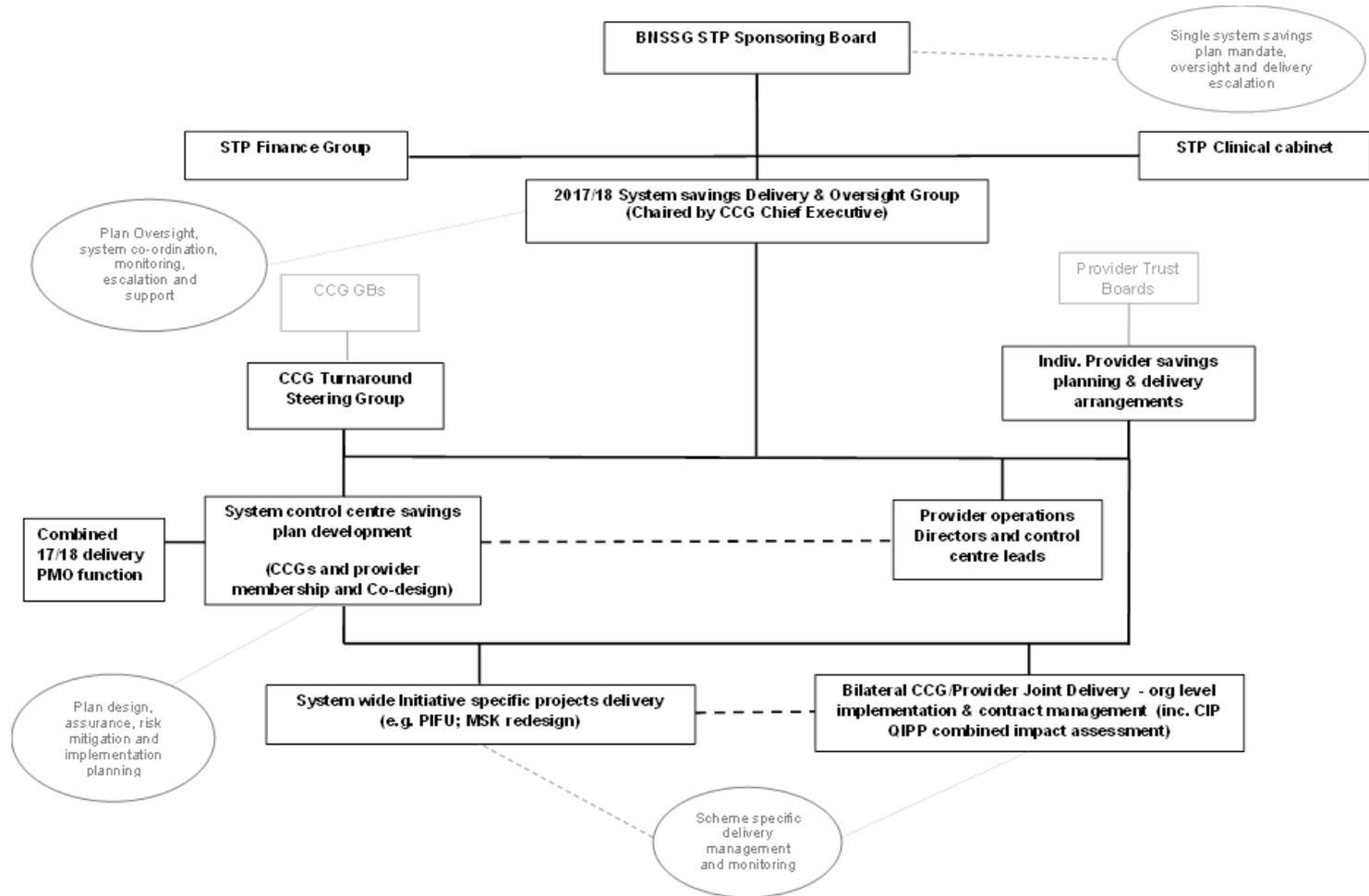
- CEOs' joint sponsorship of System Financial Recovery Plan
- Agreed principles
 - Single system plan approach on open book basis
 - Avoid cost shifting
 - Secure STF and avoid RAB impact

Page 156

Single joint process

- Control centres now focussed on joint system delivery
- Regular weekly DoF and DoOps meetings to manage system delivery
- Clear alignment of STP & Turnaround
- New System project mandate process
- Specific risk assessment of entire system plan underway by System CFOs

The Governance arrangements for the management of the System Financial Recovery Plan are:



Quality and Safeguarding

Page 158

Our approach to Quality and Safeguarding

- We are committed to ensuring local, sustainable and high quality services for our population.
- We have a shared vision for quality and safeguarding. We have sought to define this for our patients and partners so we can work together in ensuring *the right care is delivered in the right place at the right time*.
- Our definition describes three areas:
 - **Safety**, where high quality care is delivered in a safe environment and where those at risk are protected
 - **Clinical effectiveness**, where high quality care reflects the best available evidence on what works.
 - **Patient experience**, where high quality care gives someone an experience of treatment and recovery that is as positive as possible, including acknowledging their wants or needs, and treating them with compassion, dignity and respect.

Page 159

We will undertake robust quality assurance for our local providers, where appropriate involving our social care and multi-agency partners, to ensure that services offer *'high quality for all'*, i.e. services that our safe, clinical effective, responsive to patient's needs and offer a positive patient experience and are well-led.

- We will do this by:
 - Ensuring all patients have access to high quality care delivered in a timely and effective way embracing the approach *'the right care in the right place at the right time'*
 - Ensuring active patient and public participation to inform CCG decision making
 - Ensuring learning from national guidance and reports, including statutory safeguarding reviews, is identified and implemented where appropriate being built into CCG assurance processes
 - Ensuring quality is at the heart of any transformation or improvements to health services
 - Ensuring that quality is everyone's responsibility and ensuring that effective mechanisms are in place to proactively monitor, triangulate and ensure continuous improvement

Quality Priorities

Priorities	We will achieve this by doing...	And by when...
Improving quality of services within all local providers	Monitoring of harm free care data and promote improvements in the overall quality, safety and experience of care	March 2018
	Assisting providers to develop a culture where learning from patient safety incidents and from patient experience is embedded in everyday practice	March 2018
	Development of a framework for monitoring quality in nursing homes in partnership with social care and regulatory organisations	
Active involvement in service redesign to ensure quality is addressed at all stages to reduce/mitigate negative impact on patients and service users	BNSSG Quality team to be active members in all project planning discussions and design key stages Ensuring Quality and Equality Impact Assessments are embedded into project planning cycles	July 2017

Quality Priorities

Priorities	We will achieve this by doing...	And by when...
Develop systems and processes for quality monitoring in primary care services	Developing a Primary Care quality dashboard to provide assurance on quality performance	March 2018
	Mirroring existing systems and processes ensure evidence of learning from incidents (and Significant Event Audits), serious incidents and complaints within Primary Care is shared and embedded	
	Working with AHSN colleagues to promote a safety culture in the primary care setting through the use of tools and training in quality improvement methodology	
Develop a multiagency approach across BNSSG to support the achievement of CCG infection control targets	Developing a BNSSG care pathway, agreed with all partner agencies for achieving zero MRSA cases	August 2017
	Working collaboratively to achieve the reduction in E coli cases and C Diff across the healthcare communities	March 2018

Safeguarding Priorities

Priorities	We will achieve this by doing...	And by when...
Greater aligned systems and processes for quality assuring safeguarding adults and safeguarding children and embedding these within the wider quality agenda	Safeguarding quality metrics included in BNSSG quality schedule with monthly reporting included in provider quality dashboards which report to monthly provider quality subgroups	July 2017
Work in partnership with the three Local Authorities and Police to respond to the recommendations of the Wood Review in respect of Safeguarding Children Boards and Safeguarding Adults Boards in respect of domestic homicide reviews	Strategic safeguarding lead to attend Avon wide multiagency meeting to shape the new safeguarding arrangements and represent health	July 2017
	Strategic safeguarding lead to interface with National Home Office team to ensure CCG meets statutory requirements for DHR	July 2017

Page 16

Improving Performance

Improvement and Assessment Framework



Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

Clinical Commissioning Groups are assured by NHS England against their delivery of the Improvement and Assessment Framework.

The attached tables summarise our current performance against the national Improvement and Assessment Framework

Our programmes are aligned to these areas and are working towards improving performance.

Page 164

IAF Key Metrics	Bristol	North Somerset	South Gloucestershire
Cancer	Needs improvement	Needs improvement	Needs improvement
Diabetes	Greatest need for improvement	Needs improvement	Greatest need for improvement
Maternity	Needs improvement	Needs improvement	Greatest need for improvement
Mental Health	Needs improvement	Needs improvement	Needs improvement
Learning Disability	Needs improvement	Needs improvement	Needs improvement
Dementia Care	Top Performing	Performing Well	Performing Well
Good GP Satisfaction	86.6%	86.7%	85.8%
GP workforce	1.02/1,000 pts	1.00/1,000 pts	1.08/1,000 pts
Electronic Referrals	65.2%	86.0%	62.6%
A&E	83.3% (UHB)	77.7% (Weston)	88.3% (NBT)

Domain	Bristol	North Somerset	South Gloucestershire
Better Health	Requires improvement	Requires improvement	Requires improvement
Better Care	Requires improvement	Requires improvement	Requires improvement
Sustainability	Requires improvement	Inadequate	Inadequate
Leadership	Requires improvement	Inadequate	Inadequate
Overall	Requires improvement	Inadequate	Inadequate

Delivering Constitutional Standards

The BNSSG CCGs' performance in ensuring constitutional standards are met for local residents is closely tied to that of our main acute providers: NBT, UHB and Weston. We have robust contract mechanisms in place for managing provider performance in achieving these standards consistently, together with a supporting infrastructure of system-wide partnerships for managing the flow of patients in and out of hospitals. The attached table summarises our current performance against the national Improvement and Assessment Framework. A description of how we are approaching performance improvement against our most challenging standards is outlined in the following slides

Our programmes are aligned to these areas and are working towards improving performance

Key indicator	March 2017 Performance	2017/18 & 2018/19 Plan
Referral to treatment time – incomplete pathways	90.6% - below the 92% standard	90.6%
Referral to treatment time – diagnostic pathways	1% - Meeting standard	Meet the 1% breach standard
Cancer 62 day to treatment	83.8% - below the 85% standard	Meeting the 85% standard
Other cancer standards	Achieved 5/7 standards across the full year	Plan to achieve all standards
A&E treatment in 4 hours	Significantly below the 95% standard at all providers (see previous page)	Improve to meet local assurance expectations
Psychological therapy access	Below standard	Bristol – to meet standard across the 2 years North Somerset – meet and maintain from October 17 South Gloucestershire – improve through each year to reach the standard at the end of the year
Dementia	Achieving in Bristol & North Somerset, below standard in South Gloucestershire	Maintain achievement in Bristol & North Somerset, South Gloucestershire meet standard in Sept 2017

A&E Treatment in 4 Hours

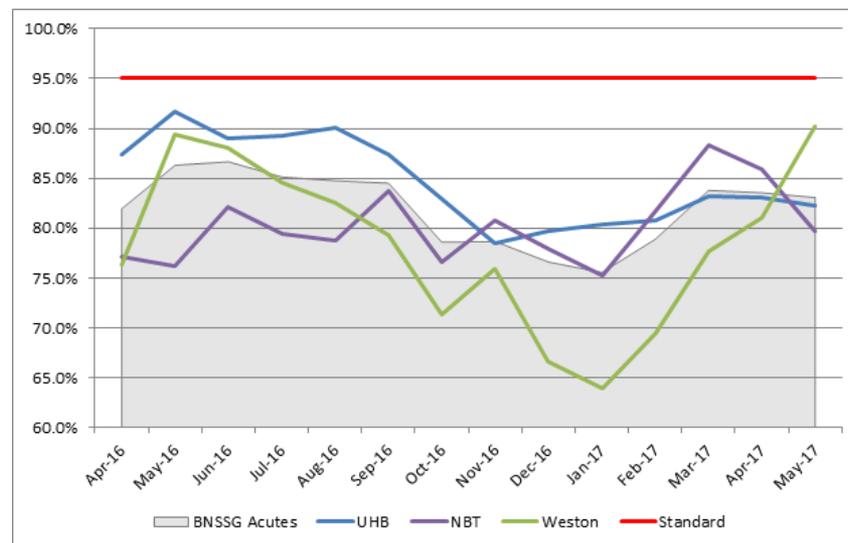


Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

BNSSG 16/17 Performance

	UHB	NBT	Weston	BNSSG Acutes
Apr-16	87.3%	77.1%	76.3%	82.0%
May-16	91.7%	76.2%	89.3%	86.3%
Jun-16	89.0%	82.2%	88.1%	86.7%
Jul-16	89.3%	79.4%	84.6%	85.1%
Aug-16	90.0%	78.8%	82.6%	84.8%
Sep-16	87.3%	83.7%	79.3%	84.5%
Oct-16	82.9%	76.6%	71.3%	78.6%
Nov-16	78.5%	80.7%	75.9%	78.7%
Dec-16	79.6%	78.0%	66.6%	76.6%
Jan-17	80.4%	75.3%	63.9%	75.6%
Feb-17	80.7%	81.7%	69.5%	78.9%
Mar-17	83.3%	88.3%	77.7%	83.8%
Apr-17	83.0%	85.9%	81.1%	83.6%
May-17*	82.3%	79.8%	90.2%	83.1%

*until 21st May



Our Approach for 2017/18:

- Create an Urgent & Emergency Care Delivery Plan for STP including a 4 hour performance recovery plan that is linked to the system diagnosis and breach analysis (by end Q1)
- Take forward the following key initiatives:
 - 111/ OOH – Fast track progress towards a clinical hub (revised model Q3/4)
 - Admission Avoidance – Progress with ED streaming and frailty at the front door (Q3 onwards)
 - Hospital flow – Full implementation of the SAFER initiatives and strengthening Ambulatory Emergency Care provision (ongoing)
 - Enabling discharge – Implementation of ‘trusted assessor’ across BNSSG, strengthening D2A pathways, therapy integration and consistent review of stranded patients

Referral to treatment time – Incomplete Pathways



Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

16/17 Performance

Stable BNSSG RTT position throughout 2016/17. Year end position of 90.92%.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
BNSSG	90.5%	90.5%	90.5%	90.6%	90.4%	90.4%	90.4%	90.6%	90.3%	90.7%	90.6%	90.9%

BNSSG RTT Performance 16/17 – Sub-Speciality

Treatment Function Name	Sum of %<18wks
Neurosurgery	75.05%
Trauma & Orthopaedics	82.92%
General Surgery	83.55%
Neurology	90.16%
Other	90.18%
Gynaecology	90.85%
Gastroenterology	91.54%
Cardiology	92.45%
Thoracic Medicine	93.05%
Plastic Surgery	94.27%
Urology	95.82%
Ophthalmology	96.14%
Cardiothoracic Surgery	96.75%
ENT	97.24%
Dermatology	97.26%
Rheumatology	97.51%
General Medicine	98.51%
Geriatric Medicine	98.65%
Oral Surgery	100.00%
Grand Total	90.64%

Our Approach for 2017/18:

- In line with 'Next Steps on the 5YFV' and as part of system financial recovery plan, we plan to maintain performance at 2016/17 level
- RTT Programme Board in place with delivery plan
- Implement BNSSG Referral Management Service
- All BNSSG T&O referrals now managed via Referral Management service to support patient choice, in line with system capacity
- Implementation of revised clinical policies in orthopaedic surgery
- Redesign clinical pathways in MSK , Ophthalmology and DVT services to reduce demand on hospital services
- Delivery of Elective Care Transformation Programme's High Impact Interventions

Cancer 62 Day Treatment

16/17 Performance

- 2 week wait: BNSSG CCGs as a whole achieved standard, although Q4 decline in performance at WAHT
- Consistent achievement of 31 day standard since September 2016
- 62 day wait standard not consistently achieved despite system-wide CQUIN.. Significant progress is being made and monitored through improvement plans in each Trust
- National Transformation bids for Early Diagnosis being resubmitted which will further aid work towards achieving the target

62 Day Cancer standard

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	2016/17
NBT	83.65%	83.46%	85.21%	84.35%	86.52%	81.05%	78.26%	88.66%	90.08%	88.79%	87.50%	89.24%	85.66%
UHB	76.36%	70.65%	70.81%	72.94%	84.45%	80.48%	79.53%	85.20%	81.52%	84.66%	79.03%	81.22%	79.26%
WAHT	88.68%	81.25%	70.00%	75.47%	75.41%	72.58%	76.56%	75.71%	86.67%	73.33%	71.43%	83.05%	77.59%
BNSSG Trusts	81.70%	78.65%	78.25%	79.69%	84.45%	79.93%	78.48%	85.79%	86.56%	85.79%	82.84%	85.60%	82.44%

Our Approach for 2017/18:

- Continue to refine & hold providers to account for shared timed pathways including robust monitoring of Trust improvement plans
- Performance management of trusts in delivery of actions through contractual processes eg RAPs
- CCG facilitated cancer managers breach resolution meetings in place monthly
- Work with Cancer Alliance to adopt wider system best practice

Dementia

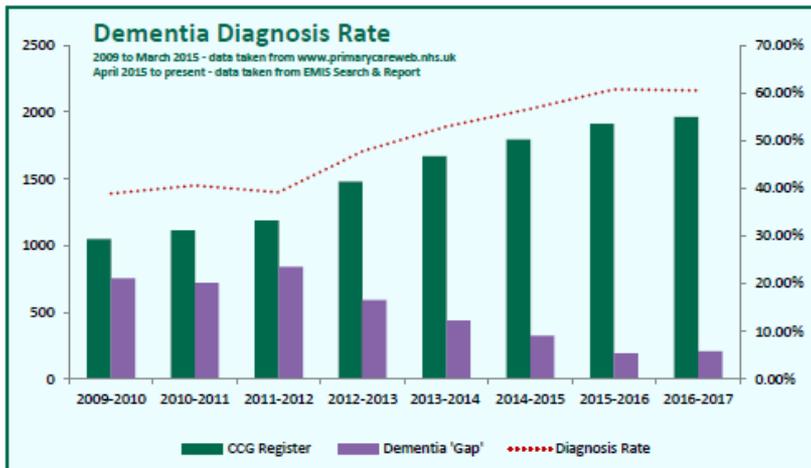
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

16/17 Performance

- Bristol CCG rating ‘top performing’, and South Gloucestershire and North Somerset CCGs ‘performing well’ on the IAF scorecard
- Good performance across BNSSG (81%, 77.4% and 78.1% respectively) in maintaining care plans
- Bristol CCG achieved the diagnosis target, with a diagnosis rate of 73.2% (up from 65.2% in April 2016). Now best performing CCG in South West Region.
- No change in South Gloucestershire diagnosis rate which remains below target. Approach to diagnosis recognised as best practice and CCG clinical lead appointed to the national NHSE CCG Improvement and Assessment Framework expert panel for Dementia
- North Somerset diagnosis rate steadily improved in 2016/17, and in March 2017 reached 64.2%. AWP Memory Assessment Service now seeing 91% of patients within 4 weeks

Page 169

South Gloucestershire position:



Our Approach for 2017/18:

- Continue to engage with GP practices, including to improve data collection
- Work with national team on measurement methodology
- Ongoing programme to raise awareness in wider community, and encourage people to come forward for diagnosis

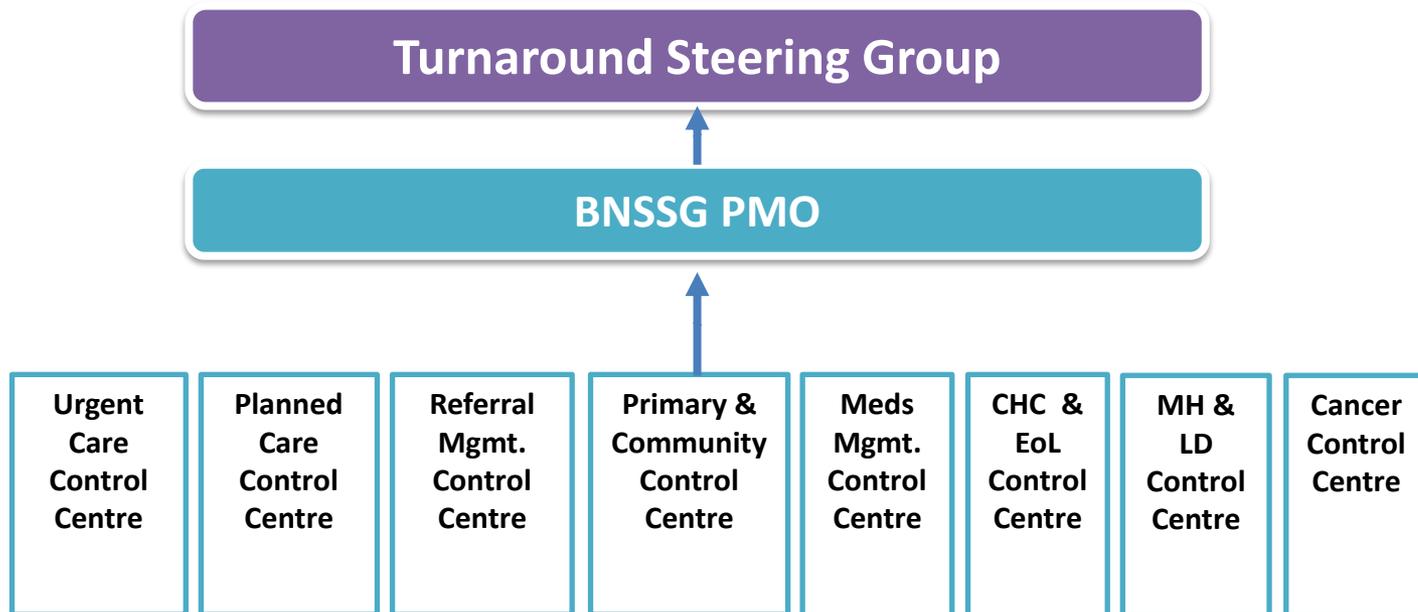
Delivering our 2017-19 Priorities

BNSSG Delivery Mechanism

BNSSG CCGs have set up a process to ensure oversight of the delivery of the Operational Plan. The Executive Team require clear insight into progress against the System Financial Recovery Plan to deliver £83.2m of savings. These processes are set up to monitor the design, implementation, and delivery of system plans to achieve our deficit control total.

The savings are developed and delivered through Control Centres supported by a robust Programme Management Office and software programme.

Page 171



Delivery and RightCare

RightCare is a value, quality and evidenced-based approach. RightCare is a national programme designed to improve people's health. It helps the NHS and local health economies deliver better value for patients, the public and tax-payers. RightCare is designed to increase the value from our resources. It facilitates and supports clinical commissioning through an approach based on understanding the variation in costs and outcomes in the health system.

NHS RightCare has something to offer the whole health economy. It gives everyone the opportunity to concentrate on their population's health and identify and focus on the key areas that will maximise value for patients, the population and the tax payer."

In January 2017, a financial recovery process was implemented by the three CCGs in order to develop a single set of proposals for achieving reductions in expenditure to meet the agreed control total. We have significantly overhauled planning processes across BNSSG to align business planning and financial recovery across the 3 CCGs as part of this process. It was decided that the rigorous and evidence-informed RightCare approach would be embedded in our processes. RightCare uses a number of tools such as *Commissioning for Value*, Deep Dive packs and the Atlases of Variation to help commissioners, service providers and health professionals deliver the best healthcare.

NHS RightCare Approach - Maximising value

PHASE 1

Where to Look

Highlighting the top priorities and best opportunities to increase value by identifying unwarranted variation.

PHASE 2

What to Change

Designing optimal care pathways to improve patient experience and outcomes.

PHASE 3

How to Change

Delivering sustainable change by using systematic improvement processes.

Key ingredients **Indicative & Evidential Data**

Key ingredients **Clinical Leadership & Engagement**

Key ingredients **Effective Improvement Processes**

Delivery and RightCare

The financial recovery process has been progressed through 8 Control Centres which have been established on a BNSSG system-wide basis. Senior Responsible Owners (SROs) for each Control Centre have been identified to lead the development of ideas and work up of those ideas into detailed proposals for consideration by the Executive Management Team prior to respective Governing bodies.

There are 8 planned cycles between April 2017 and April 2019, with each cycle running from an initial Ideas phase through to Implementation and Delivery. Commissioning for Value and other benchmarking tools are key pieces of information for Control Centres to develop ideas for savings.

Each Control Centre will have relevant Commissioning for Value (CfV) Deep Dive packs which will help to link CfV opportunities with current system spend. Control Centres will be expected to use the generic RightCare methodology and approach for everything they do.

Delivery and RightCare

We have opted for a model in which plans are rigorously assessed for viability and impact by panels of experts covering finance, operations, quality, public health, research, evidence and evaluation.

Control Centre plans are subject to detailed assessments which scrutinise financial savings, the activity impacts on Providers, an initial screening for impacts on both quality and equality, together with a draft project plan for implementation. SROs are held accountable for delivery against them. We believe that our face to face assessment centres provide a forum for a deeper understanding, better discussions and more open challenge to plans.

A working group consisting of Business Intelligence, Finance and GP Evidence Fellows have developed a standard Deep Dive methodology for Commissioning for Value. These packs are issued to each Control Centre, along with suggestions for further investigation and will be used to inform the next planning cycle.

Infrastructure for Delivery and Reporting

Design and Review

The PMO has been working with Control Centres on the design and submission of Ideas and Plans in 8 week cycles. To date, there are 76 plans in Verto from Cycle 1 and 21 plans from Cycle 2. In the last 4 weeks, the PMO has been working closely with Control Centres to ensure that plans have detailed timelines for delivery with sequential milestones and well-described tasks so that we can monitor progress in implementation.

Implementation

Fully completed Plans when approved are then moved into the Implementation phase. The detailed milestones of the project allow the PMO to track progress against timeline for delivery on a weekly basis.

BNSSG Reporting Processes

A new reporting process is being established between BI, Finance and the PMO on the recognition that the legacy and discrete BI and Finance processes that existed in the 3 CCGs needed to be aligned to the Design, Review and Implementation activities that drive system savings.

Infrastructure for Delivery and Reporting

Reporting

The PMO have worked with BI and Finance colleagues to create a process which aligns reporting functions into a critical path which will deliver a consolidated monthly report to the Executive Team. The new process will deliver the first BNSSG CCG monthly consolidated report for EMT and TSG at the end of July.

Page 177 reporting structure for BNSSG Executive Management Team has been developed that will describe:

- Savings achieved to date by Control Centre
- Run rates
- Identified savings against planned savings by Control Centre
 - Variance from planned activity and financial impacts
 - Slippage against implementation milestones
 - Gateway Reviews of plans
 - Key risks and issues
 - Ideas and Plans pipeline
 - Exception reports

BNSSG Work Programme 2017 – 19

Page 178

BNSSG Work Programmes

We have identified priorities for the plan with reference to the requirements of our local BNSSG population, the Five Year Forward View and the NHS England planning guidance. This guidance includes the nine ‘must do’ priorities, which have been woven through the delivery of our programmes. Ensuring successful delivery of the plan is also in part through its alignment to the STP. In developing the STP with a variety of stakeholders across multiple health functions and bodies, this has led to a credible plan that has factored in the views from a number of specialties and health professions.

In delivering our priorities:

We will work as part of the BNSSG Sustainability and Transformation Partnership to deliver these priorities

The focus in 2017/18 will be on those that support the delivery of the system financial recovery plan

A system-wide control centre delivery mechanism will ensure accountability clarity and maintain momentum

Cancer	Cardiovascular	Children & Maternity	Community Services	Continuing Healthcare
Dementia	Diabetes	End of Life	Frailty	Learning Disabilities
Mental Health	North Somerset Sustainability	Planned Care	MSK	Referral Management
Respiratory	Stroke	Transforming Primary Care	Urgent and Emergency Care	Enabling Programmes

Cancer

Aim: The aim is to ensure more cancers are prevented, diagnosis is made earlier, treatment is carried out within national guidance timeframes, patients live well with and beyond cancer and patient experience is improved.

Current State : Inequalities with high rates of premature cancer mortality (compared to England) for lung, breast and colorectal cancer in particular, due in part to inequalities, such as gender and deprivation, leading to poor awareness of how to prevent cancer, lower screening uptake, lower proportions of early diagnosis of cancer and increased health risk behaviours (smoking, being overweight, alcohol, poor diet etc.). Due to the changing demographics there will be an increase in the number of cancers diagnosed in the coming years, diagnostic and pathway capacity planning will need to anticipate this.

Objectives:

- Implement the cancer taskforce recommendations with a particular focus on prevention, early diagnosis, improving patient experience and living well and beyond cancer
- Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

Cancer

Prevention

- Increasing uptake of screening for Bowel, Breast and Cervical cancers through working with PHE to distinguish the roles of primary care, community services, the voluntary sector, the CCG and PHE.
 - Reducing levels of obesity in the population, specifically targeting those with a long term condition
 - Reducing smoking prevalence in adults and preventing uptake of smoking in young people
 - Increasing levels of physical activity in the population, specifically targeting those with a long term condition
- Increasing understanding and knowledge of the signs and symptoms of cancer – supporting PHE campaigns on raising awareness of cancers

Early diagnosis

- Working with Public Health England and GP practices to improve uptake of cancer screening programmes where uptake is poor.
- Continue to work with Public Health to further understand the cancer outcomes for the BNSSG population at various levels; support activities around helping people to help themselves be well; understand more about how our commissioning activities and the arrangements we have with a range of providers can support early diagnosis
 - Deliver on cancer constitutional targets in particular 62 days, and with a focus on ensuring sufficient diagnostic capacity
 - Implementation of NICE guidance
 - Implement stratified follow-up pathways as per the planning guidance
 - Commission the recovery package

Cancer Programme Summary

Aims and expected outcome of programme

Implement the cancer taskforce recommendations with a particular focus on prevention, early diagnosis, improving patient experience and living well and beyond cancer.

Deliver on cancer constitutional targets in particular 62 days, and with a focus on ensuring sufficient diagnostic capacity.

Risk and mitigations

Performance against the national 62 day cancer standard remains volatile across BNSSG. The work plan is focussed on addressing the issues and monthly performance monitoring meetings are in place.

- Working across multiple organisations as part of the SWAG Cancer Alliance delays decision making and the required pace for work to be carried out. BNSSG STP Cancer Working Group is managing priorities.

National Must Do

- STP
- Finance
- Primary Care
- Urgent & Emergency
- Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- Improving Quality

Five Year Forward View requirements

- Urgent & Emergency Care
- Primary Care
- Cancer
- Mental Health
- Integrating Care Locally
- Funding and Efficiency

STP Priorities

- Preventing illness and injury
- Providing care closer to home
- Personalised care

Financial summary

- It is not currently possible to unpick a financial summary for cancer
- Work is carried out on individual initiatives to understand where possible relevant activity and finance information

Cancer Programme Priorities

Priorities	We will achieve this by doing...	And by when...
To consistently achieve the 85% NHS Constitutional Standard for 62 day waits.	<ul style="list-style-type: none"> • Performance monitoring of the timed pathway work. • Collaborative working between Trusts and monthly commissioner facilitated breach analysis meetings. • Improvement plans in each Trust • Delivery against the 10 high impact cancer actions (July 2015) • Cancer 62 day rapid recovery plan (NHSI South Region) 	The ambition is to achieve this by July 2017.
Improving earlier diagnosis of cancer with a focus on ensuring sufficient diagnostic capacity	<ul style="list-style-type: none"> • Review diagnostic demand and capacity and model impact • Monitor waiting times for diagnostic tests by modality • Collect and monitor diagnostic reporting times in radiology, endoscopy and pathology 	This extensive piece of work will be carried out in a phased approach from July 2017.
Ensure all patients living with and beyond cancer (LWWBC) have access to the elements of the recovery package	<ul style="list-style-type: none"> • Complete a cost benefit analysis • Design new model for delivery and commissioning of LWWBC • Implement risk stratified follow-up pathways as per the planning guidance 	<p>May – November 2017 2018/19</p> <p>Phased 17/18 and 18/19</p>

Cardiovascular

BNSSG CCGs have identified cardiovascular disease (CVD) as an area of care where there is a significant population health need.

We need to do more to improve outcomes; reduce health inequalities and; use opportunities to develop ways of working and commissioning that will improve efficiency, value and quality of care across BNSSG.

The CVD programme work is at the early stages of development and we have identified three GP clinical leads to lead and take forward this work.

CVD Programme Summary

Aims and expected outcome of programme

- Identification of clinical priorities
- Self-care and secondary prevention
- Establish Heart Failure pathway across BNSSG
- Exploration of re-commissioning of ECG reporting and ambulatory ECG provision across BNSSG
- Community IV diuretics for heart failure
- Consistent HF pathways across BNSSG
- Cardiac rehabilitation for heart failure patients
- Scope pathway work for acute chest pain clinic across BNSSG

Page 185

Risk and mitigation

The main risk at this time is that the programme does not progress at the pace needed. The mitigation is that the programme is now clearly part of BNSSG CCGs operational plan and therefore the raised profile should ensure that sufficient resources and organisational support are dedicated to it.

Financial summary

To be determined as part of the development of the programme.

National Must Do

- ✓ STP
- Finance
- Primary Care
- ✓ Urgent & Emergency
- ✓ Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- Urgent & Emergency Care
- Primary Care
- Cancer
- Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- Personalised care

CVD Programme Priorities

Priorities	We will achieve this by doing...	And by when...
<p>Identify the clinical priorities for this CVD programme, particularly describing the scope of the work as aspects of CVD are being progressed through other separate programmes</p>	<p>A focussed piece of work using available data and information and the views of commissioning and provider clinicians and managers to gain agreement.</p>	<p>End of July 2017</p>
<p>Develop a robust and achievable programme of work in partnership with providers</p>	<p>A formal piece of programme development to provide clarity on what will be achieved, why and by when and what resources (time, etc.) are needed to achieve the desired outcomes.</p>	<p>End of August 2017</p>

Children and Maternity

The Children, Young People and Maternity programme continues to focus on prevention, early intervention and timely access to services within a framework of partnership working. Re-commissioning activity in community children's health services has enabled commissioners to have a good understanding of the experience of children, young people, parents and carers in accessing universal, targeted and specialist services. It has also enabled us to identify priorities for service development.

The focus of the Five Year Forward View is primarily on Children and Young People's Mental Health, and this has been reflected in our STP plans. In 17/18 we will continue to implement our Emotional Health and Wellbeing Transformation Plan, improving access to CAMHS services, including specialist Eating Disorder services, and increasing capacity within our system for earlier support through counselling and resilience building work in schools and community settings.

With our partners we are also making progress with the national agenda for maternity services with the implementation of our Maternity Strategy and the establishment of a Local Maternity System in order to plan and deliver consistent, high quality and cost effective maternity services to the local population. We will implement the Saving Babies Lives Care Bundle. Building on the success of our new Specialist Perinatal Mental Health Team, we will develop integrated pathways including more open access community support.

Children and Maternity cont:

Improvements to services for children and young people with Special Educational Needs and Disabilities (SEND) are underway but there is much work still to do to ensure that all young people in BNSSG are supported to fulfil their potential. We will continue to work with our partners in Local Authorities, schools and community health services to make these improvements, including implementing Integrated Personalised Commissioning.

For children and young people with long term conditions or complex health needs, we will work within the emerging community cluster model to provide better community care helping to avoid unnecessary admissions to hospital, including nursing provision for end of life care.

Our aspiration of delivery high quality children's services needs to be supported by modernisation in information management for community children's health services. We will pursue this through the STP Digital Road Map.

Children and Maternity Programme Summary

Aims and expected outcome of programme

We will work with partners to secure improvements in the quality of our services - access, responsiveness, effectiveness, patient experience and integration. In 17/18 we will focus on emotional health and wellbeing, perinatal mental health, SEND and developing our Local Maternity System.

We will support quality and safety through a Digital Road Map for community children's health services.

National Must Do

- ✓ STP
- Finance
- Primary Care
- Urgent & Emergency
- Planned Care & RTT
- Cancer
- ✓ Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- Urgent & Emergency Care
- Primary Care
- Cancer
- ✓ Mental Health
- ✓ Integrating Care Locally
- Funding and Efficiency

Risk and mitigation

- Workforce – significant recruitment difficulties in CYP MH services. BNSSG wide working on workforce planning. Providers working to develop new professional roles
- Digital road map requires capital investment.

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

Financial summary

- Emotional Health and Wellbeing Transformation funding supports implementation of BNSSG plans 2015-2021.
- Capital funding required for developments in electronic records.

Children and Maternity Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Improve emotional health and wellbeing of children and young people	Implement Emotional Wellbeing and Transformation Plan	2021
Improve the quality and safety of maternity services, enhancing choice, patient experience and maternal and infant health	Develop a Local Maternity System and Maternity Commissioning Strategy for BNSSG	LMS implementation by September 2017
Enable children and young people with long term conditions, disabilities or complex health needs to remain at home as much as possible	Develop community children's nursing service	December 2017
	Develop cluster model for community delivery	January 2018
	Develop Children's Continuing Care Policy	November 2017
Modernise information management in community children's services	Digital road map (STP)	March 2018

Community Services

Across BNSSG we recognise that we want to remove complexity that has resulted from responding to policy directives, develop simple patterns of services that respond rapidly and work across the system to facilitate discharge and prevent admissions and have a consistent approach across BNSSG

We are committed :

- To ensure effective use of system wide resources to support community and primary care services respond to both the growth in care homes, residential and Extra Care Housing and the increasing complexity of need
- To ensure that those who do not need a medical response are provided with age appropriate relevant alternatives
- Implementation of aligned approaches in recognition of frailty as a clinical diagnosis and a pathway of prevention or intervention
- To align our out of hospital services with urgent care work stream
- To Foster MDT working and clear accountability for individuals and integrated working with jointly local authority partners
- Managing Length of Stay and any subsequent Delayed Transfers of Care including using single assessments across BNSSG
- Deliver equity and aligned access across BNSSG

Community Services Programme Summary

Aims and expected outcome of programme

Working together across health and social care to develop high quality, affordable, out of hospital care, including providing an alternative to the Emergency Department, supporting hospital discharge, and keeping people well once they return home

Page 192

Risk and mitigation

- Workforce to deliver--Review of workforce would need to be undertaken looking at different ways of working
- Impact on LAs of savings both within NHS plans and local Authority plans ----Ensure BCF reviews both financial and quality impact assessment on any joint working
- Impact of ongoing estate capacity --Estates review across BNSSG

National Must Do

- ✓ STP
- ✓ Finance
- Primary Care
- ✓ Urgent & Emergency
- Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- Primary Care
- Cancer
- Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

Community Services Programme Summary

Financial summary

There is a recognition that CCGs need to address the deficit, achieve financial balance in BNSSG and create a credible financial plan for achieving in-year savings . The programme will :

- Work closely with community providers to review equity and resource across BNSSG understanding both the CCGs QIPP programme and requirements on local providers
- Review recent IBCF funding against Better Care Funding guidance to ensure there is agreement to invest in out of hospital services and support reduction in local DTOC.
- Ensure plans are affordable and achieve value for money – asking whether the intervention improves productivity or provides a more cost-effective response than other ways of delivering the care patients need.
- Work with providers to ensure the resilience and sustainability of core services

Community Services Programme Priorities

Priorities	We will achieve this by doing...	And by when...
1. To develop capability and capacity in the community so that people with complex needs spend less time in hospital following an acute admission	Confirm scale and scope of BNSSG commissioning programme for community rehabilitation	August 2017
	Establish alignment with existing local programmes (e.g. discharge to assess, community wards, 3Rs, stroke, vascular, T&O)	August 2017
	Create a single demand and capacity model for community rehabilitation to inform operational decision making and long term planning, including in relation to community inpatient capacity	September 2017
	Establish financial model and funds flow requirements, to include tariff unbundling where indicated	September 2017
	Agree BNSSG commissioning programme for community including in-year, medium and long term priorities	September 2017

Community Services Programme Priorities

Priorities	We will achieve this by doing...	And by when...
2 .To develop and enhance integrated Health and Social care services across BNSSG to support patients at home. Including working closely across STP to deliver People Centred Integration	To Foster MDT working and clear accountability for individuals and integrated working .	September 2017
	Working closely with physical health, mental health, social care and voluntary sector	Ongoing
	Increase the Social Care staff presence within wards and within ED and Medical Assessment Units	August 2017
	Design a single and consistent 7 days a week Hospital Discharge process to operate in each of the three main acute hospitals in the BNSSG STP area	September 2017
	Develop and pilot “Trusted Assessor” arrangements	October 2017
	Undertake an analysis of care/nursing home placements made on discharge from hospital by each of the three local authorities and CHC funded placements made by the three CCG’s in the STP area.	October 2017
	Development of community services that offer opportunities for pooled budgets and joint commissioning.	August 2017

Community Services Programme Priorities

Priorities	We will achieve this by doing...	And by when...
3. Reduction in variation in Community Services practice across BNSSG	To work closely with community providers to review shared assessment process and complex care pathways . Support community teams with specialist medical input and use of shared skill sets across providers.,	October 2017
	Development of generalist skills across community services to manage multiple co morbidities	October 2017
4.Implementation of BNNSG Frailty programme	See details of Frailty work programme	March 2018
	Implementation of aligned approaches in recognition of frailty as a clinical diagnosis and a pathway of prevention or intervention	December-2017

Continuing Healthcare

Focus of the Continuing Healthcare (CHC) programme is on:

- Compliance with NHS operating model and quality assurance framework for CHC in relation to 3 month and annual review
- Reducing number of individuals waiting for CHC assessment in an acute setting to achieve the NHSE Quality Premium of 15% of assessments in hospital 2017/19
- Ensuring people eligible for CHC Fast track care / placements receive care in a timely manner
- Alignment of CHC related policies for example CHC commissioning policies
- Establishing a robust clinical governance structure to ensure high quality care for individuals eligible for CHC
- Market supply and management of care homes
- System wide approach to PHB's for those eligible for CHC to achieve NHS PHB expansion trajectory

CHC Programme Summary

Aims and expected outcome of programme

Align BNSSG approach to Continuing Healthcare and improve processes of assessment, decision making, local resolution, and the commissioning of care provision. Achieve greater control over CHC spend.

Risk and mitigation

Page 198

- Local Authority engagement in agreeing process changes to increase out of hospital CHC assessment, mitigated by early engagement in change process
- Care providers agreeing to aligned approach to care procurement, mitigated by early engagement in change conversation
- Changes to the National Framework for CHC, unable to mitigate but BNSSG CCG'S are development partners in NHSE Strategic Improvement programme

National Must Do

- STP
- Finance
- Primary Care
- Urgent & Emergency
- Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- Improving Quality

Five Year Forward View requirements

- Urgent & Emergency Care
- Primary Care
- Cancer
- Mental Health
- Integrating Care Locally
- Funding and Efficiency

STP Priorities

- Preventing illness and injury
- Providing care closer to home
- Personalised care

Financial summary

- BNSSG budget 2017/8 £70.420m (CHC £51.404m, FNC £18.016m)
- Savings £4.642 FYE, £3.326 PYE

CHC Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Align operational approach to CHC referral , assessment and eligibility determination	<ul style="list-style-type: none"> • Agreeing standard operating procedures with all partners • BNSSG CCGs to cease funding 28 days after CHC ineligibility is determined (not funding during appeal) 	<p>October 2017</p> <p>July 2017</p>
Agree BNSSG approach to commissioning care for individuals eligible for continuing healthcare funding	<ul style="list-style-type: none"> • Implementation of BNSSG CHC Commissioning strategy • Delivering a robust approach to care procurement that improves control over CHC package spend 	<p>July 2017</p> <p>October 2017</p>
Personal Health budget expansion for individuals eligible for Continuing Healthcare and CHC Fast Track	<ul style="list-style-type: none"> • To embed a consistent approach to associate risks and expenditure • Reviewing all current PHBs • Implementing Fast Track PHBs to improve hospital discharge and reduce excess bed day spend. 	<p>October 2017</p>

Page 199

Dementia

BNSSG will build on the progress made delivering an increased dementia diagnosis rate for our population. BNSSG will seek to improve access and provision of post diagnostic support for people with dementia, thereby reducing variance across the system.

Our priorities are:

- LTC, Prevention and Self-Care – develop a whole system pathway for dementia, building on best practice within BNSSG
- Improvements in post diagnostic support i.e Dementia navigator/ adviser / support worker role – bid to Heath Foundation for scaling up funding to deliver a BNSSG Dementia service or joint funding to develop a Dementia service (SG)
- Continued commitment to GP education and support
- Further support to care homes to improve care for people with dementia – development of a BNSSG care home PID
- Work with the acute hospitals to improve the patient pathway and timely discharge
- To reduce emergency hospital admissions and short stay admissions
- Joint working with the 3rd sector to deliver aims of the STP
- Developing a shared approach to carer involvement across BNSSG – move towards a trusted assessor model
- To use Rightcare data to guide current and future priorities
- To explore alternatives to acute inpatient provision for people with dementia

Dementia Programme Summary

Aims and expected outcome of programme

Long Term Conditions, Prevention and Self-Care – build on best practice to develop a whole system pathway for dementia. This will include revisions to the use of inpatient care and different models of long term nursing care for people with complex dementia presentations.

Page 201

National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent Emergency
- Planned Care & RTT
- Cancer
- ✓ Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- Cancer
- ✓ Mental Health Locally
- ✓ Integrating Care
- ✓ Funding and Efficiency

Risk and mitigation

- Pressure on primary and social care resources may reduce opportunities for pre-emptive and preventative interventions

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- Personalised care

Financial summary

- The economic case for further investment in dementia services is currently being developed.

Dementia Programme Priorities

Priorities	We will achieve this by doing...	And by when...
<p>LTC, Prevention and Self-Care – develop a whole system pathway for dementia, building on best practice</p>	<p>e.g. Improvements in post diagnostic support i.e Dementia navigator/ adviser / support worker role – bid to Heath Foundation for scaling up funding to deliver a BNSSG Dementia service or joint funding to develop a Dementia service (SG)</p>	<p>By April 2018</p>
<p>Continued commitment to GP education and support</p>	<p>Support GP’s to continue primary care diagnostic pathway</p>	<p>Ongoing work</p>
<p>Further support to care homes to improve care for people with dementia – development of a BNSSG care home PID</p>	<p>Implementing better support to care homes including shared care arrangements with secondary care providing specialist input</p>	<p>Started September 2016</p>
<p>Work with the acute hospitals to improve care the patient pathway to reduce emergency hospital admissions and short stay admissions</p>		<p>Work began in 2015, second phase begins April 2018</p>

Diabetes Transformation Programme

Five Year Forward View:

- We will 'get serious about prevention' of type 2 diabetes by implementing the National Diabetes Prevention Programme
- Commission a new care model for diabetes that is person focussed, not organisation focussed, tailoring care for people with diabetes.
- We will improve the quality of care by commissioning on outcomes, an integrated diabetes service

Sustainability and Transformation Plans:

Deliver the vision of the Integrated Primary and Community Care workstream of the Sustainability and Transformation Plan

Page 203

Benefits:

- More people with diabetes able to manage their own care effectively
- A reduction in the health inequality of outcome for people with diabetes
- More effective use of resources across the health care and supporting system to improve outcomes for people with diabetes
- More specifically, a reduction in preventable complications and the associated cost both to the person with diabetes and to the health and social care system
- Commissioning on outcomes, not activity

Diabetes Programme Summary

Aims and expected outcome of programme

Commission diabetes care on an outcomes basis across BNSSG. This will cover the all types of diabetes for all people who live in BNSSG. Creating one integrated diabetes team which provides tailored care that wraps round the patient.

National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- Urgent & Emergency
- ✓ Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- Cancer
- Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

Page 204

Risk and mitigation

- Risk: The ability of providers to collaborate and transform diabetes services within the year.
- Mitigation: Concerted engagement of all tiers of clinical and managerial staff within providers.

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

Financial summary

- New contracting models will be used to ensure an integrated outcome focussed service is commissioned.

Diabetes Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Treatment Targets: using NHS England funding we will work with primary, community and secondary care providers to improve care of diabetes patients.	<ul style="list-style-type: none"> • Fund practice staff to attend a diabetes course • Implement virtual clinics and advice and guidance to review and manage patients • Fund an additional Diabetes Specialist Nurse in BNSSG 	From June 2017
National Diabetes Prevention Programme: We will roll out this programme of courses across BNSSG, including an NHS Digital pilot of an online course.	<ul style="list-style-type: none"> • Plan a phased roll out across our geography • Work with Living Well, Taking Control our service provider • Pilot Diabetes UK Know Your Risk tool 	From June 2017
STP Diabetes Transformation Programme: We will write an outcome based service specification for commissioning locally.	<ul style="list-style-type: none"> • Defining our vision; procurement approach; outcomes and service specification • Work collaboratively with STP providers to commission transformed services 	By the end of August 2017 April 2018

Page 20 of 25

End of Life

- To agree and implement an integrated approach to End of Life care.
 - Enable multi-disciplinary assessment and treatment, providing seamless care for people at end of life.
 - To provide easily accessible, locally appropriate support for G.P's and hospitals, to prevent admission, expedite discharge and deliver peoples' wishes at the end of life.
 - To provide information and guidance to service users and carers to support self- management and self-care, and support for GPs (and MDTs) in their roles as complex case managers.
- To improve co-ordination of care from both a patient and carers' perspective
- To achieve a % reduction on the 2015/16 rate of the number of non- final emergency admissions for people identified as at End of Life across BNSSG.
- To achieve a % reduction on the 2015/16 rate of patients dying in hospital for BNSSG.
- To increase the number of people that have had the opportunity to discuss and agree their preferences for their end of life care.

End of Life Programme Summary

Aims and expected outcome of programme

Ensure high quality end of life care services are available, through integrated services which embed best practice according to individual need, so that people at the end of their lives have a 'good death'

National Must Do

- ✓ STP
- Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- Planned Care & RTT
- ✓ Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- ✓ Cancer
- Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

Page 20

Risk and mitigation

System engagement and interconnect ability of IT systems are key enablers. Strategies are in place to achieve this.

STP Priorities

- Preventing illness and injury
- Providing care closer to home
- Personalised care

Financial summary

Savings identified £2.5m but in engaging in significant system-wide change it is acknowledged that this is intended to develop further

End of Life Programme Priorities

Priorities	We will achieve this by doing...	And by when...
<ul style="list-style-type: none"> To agree and implement an integrated approach to End of Life care. 	Establish an End of Life Programme within the BNSSG STP.	In place
<ul style="list-style-type: none"> To achieve a % reduction on the 2015/16 rate of the number of non-final emergency admissions for people identified as at End of Life across BNSSG. 	Deliver projects aimed at: Increasing information sharing through use of EPaCCS information system: <ul style="list-style-type: none"> - to GPs - to other providers 	December 2017 May 2018
<ul style="list-style-type: none"> To achieve a % reduction on the 2015/16 rate of patients dying in hospital for BNSSG. 	Seamless pathway for patients / family and carers. Supporting patient to have choice of place of death and advanced care planning	April 2018
<ul style="list-style-type: none"> To increase the number of people that have had the opportunity to discuss and agree their preferences for their end of life care. 	Define the project to support care at home (includes care homes)	July 2017
<ul style="list-style-type: none"> To explore the best use of palliative care services in the community 	Link pathway to include hospice and secondary care	July 2017

Frailty

Vision and principles

BNSSG CCGs will further develop community frailty services to ensure patients receive timely, appropriate care closer to home. BNSSG acute services will prioritise the frailty programme and develop system working to deliver seamless care to this cohort of patients. The interface between community and acute frailty will be further developed to support wider partnership working.

We aim to do this though applying core principles of :

Page 209

Reducing variance in practice across the system i.e. MDT and cluster based working across BNSSG

Replicating best practice within BNSSG and developing a single model of care for community frailty i.e. developing a skilled workforce within care homes and frailty competency training

Focus on developing frailty teams in the community, shifting activity from secondary care to the community

- Focus on progressing enhanced healthcare in care homes - development of a BNSSG Care Home programme
- Acute Frailty and Community Frailty established as separate workstreams.
- Continue to engage and further develop partnership/interface working with the Acute Trusts (NBT/UHB/Weston) and Community providers (Sirona/Bristol Community Health and North Somerset Community Partnership)
- Confirm governance arrangements and links with STP

Frailty Programme Summary

Aims and expected outcome of programme

- Improved patient outcomes following delivery of care for frail patients closer to home.
 - To transfer more funding for care of the elderly into the community and closer to the patients home.
- Clear patient pathways for frail patients
Reduced hospital admissions
Reduced hospital admissions from care homes

Page 210

Risk and mitigation

- Challenges to system/provider engagement across BNSSG – delivery demands the improved system thinking
- Management resource to support delivery of entire frailty programme

Financial summary

Savings - reduction in admissions to hospital for frail elderly patients. To explore service redesign opportunities to deliver BNSSG frailty community services.

National Must Do

- ✓ STP
- Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- Cancer
- Mental Health
- ✓ Integrating Care Locally
- Funding and Efficiency

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- Personalised care

Frailty Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Delivery of a BNSSG Care Home Programme	Finalising BNSSG Care Home PID and delivery of each identified workstream e.g. enhancing health in care homes	Management resource identified. Delivery will start in September 2017, timescales to be finalised by care home delivery board.
MDT cluster based working	Supporting STP IPCC priority of delivering MDT Cluster based working across BNSSG	Timescales are aligned to STP IPCC workstream
Develop an out of hospital service for frail elderly patients	Ensuring consistency across BNSSG to deliver out of hospital community based provision	Timescales September 2017 to March 2018

Learning Disabilities

- Our key focus remains the delivery of the Transforming Care Plan (TCP) for all ages. This will ensure that we have less people with learning disabilities (PWLD) and/or autistic spectrum conditions (ASC) in long term hospital placements. Our TCP plan will reduce the current number of PWLD and/or ASC in hospital to a number within the national activity guidelines. We will also put in place the right care and support to reduce the number of people who may be admitted to hospital placements in the future. This will be supported via the delivery of Care and Treatment Review (CTR) programme to adults and children and young people in collaboration with NHSE

Page 212

Our other key priority remains improving the physical and mental health of all PWLD. This includes ensuring that our local health services are accessible to PWLD and that reasonable adjustments to access are made where necessary. Specific actions relate to improving the rate of annual health checks to 75% and supporting health professionals to implement the recommendations of the confidential inquiry into premature mortality for people with a learning disability (CIPOLD)

- We will work with partners to develop Improved pathways for early identification of people with a learning disability and or autism at risk of involvement with criminal justice services
- In partnership with children and young peoples services, we are improving transitions services for PWLD including increased provision of personal health budgets and a broader range of care and support options for people with complex needs

Learning Disabilities Programme Summary

Aims and expected outcome of programme

Delivery of a Transforming Care Plan for all ages reducing the number of people receiving long term care in hospital settings. Ensuring that there are effective community services to support people with learning disabilities with mental illness and/or challenging behaviour

To reduce the number of PWLD who die earlier than they should through preventable and treatable illnesses

Risk and mitigation

- The proposed transfers of patients from specialised commissioning to the CCG's may create cost pressures
- Care Costs for PWLD continue to increase

Financial summary

- Further financial assessment is required to understand the impact of proposed NHSE changes to the TCP programme, particularly the transfer of responsibilities to CCG's

National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- Urgent & Emergency
- Planned Care & RTT
- ✓ Cancer
- ✓ Mental Health
- ✓ Learning Disabilities
- Improving Quality

Five Year Forward View requirements

- Urgent & Emergency Care
- ✓ Primary Care
- ✓ Cancer
- ✓ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

Learning Disabilities Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Transforming Care Partnership work	Discharging current patients from hospital back to community settings. Avoiding new patients taking their place by providing evidence based community interventions and alternatives to hospital care	The CCGs are working to a 3 year plan and trajectory with milestones between 2016 and 2019
Improving the health of PWLD	Ensuring that PWLD have equitable access to healthcare and that avoidable deaths are reduced including increasing the rate of annual health checks provided by primary care	An improvement trajectory is currently being developed with NHSE with milestones n 17-18 and 18-19
Effective partnership working across the criminal justice pathway	Building effective relationships with the Police , probation and courts to identify high risk individuals at risk of criminality and subsequent hospitalisation	The CCGs are working to a 3 year plan and trajectory with milestones between now and 2020

Mental Health

- We are currently undertaking a process to establish how local services can work more effectively across BNSSG. This involves reviewing models of care, service configuration, estate our contractual relationship with key providers. This is to ensure services remain of high quality are resilient and are affordable
- A key element of this is crisis and acute care including S136 and the Emergency Department offer re liaison psychiatry. Would also require the reprofiling of services to deliver more planned care and home treatment

Page 215

Suggested increase in psychological talking therapies

Developing a sustainable and equitable approach to the application of S117 aftercare

- NHSE working with NICE to help facilitate faster access to new digital therapies
- Better mental health care for new & expectant mothers including expanded specialist perinatal MH teams
- Expansion of physical health checks for people with severe mental illness to reduce health inequalities

Mental Health Programme Summary

Aims and expected outcome of programme

Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages

To develop a sustainable and affordable model of mental health care across the BNSSG footprint

Page 216

National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent Emergency
- Planned Care & RTT
- Cancer
- ✓ Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- Cancer
- ✓ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

Risk and mitigation

- Referral and activity patterns within mental health have seen significant variation in recent years
- Ongoing need to address quality concerns across a range of mental health services

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

Financial summary

- There remains a high level of cost volatility within MH services including structural cost pressures within the provider and cost improvement requirements within the system wide financial plan

Mental Health Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Develop and implement a sustainable footprint wide delivery model for mental health	System wide financial plan is driving required change and outline configurations and options are now being discussed and tested	Completion by April 2018
Page 20 17 Crisis and acute care including S136 and interface with urgent care. Corresponding shift to if possible doing less crisis work and more planned home treatment	Revision and reconfiguration of current services following review process	Completion by April 2018
Expansion of physical health checks for people with severe mental illness to reduce health inequalities	Working with primary care with pilot work in Bristol then rolled out across BNSSG. CQUIN includes smoking cessation linked to public health work	Starting in September 2017, work will be ongoing for initial 2 year period
Sustainable approach to Section 117 aftercare	Plan in place and outline methodology identified. Currently negotiating with Local Authorities as to how it should be implemented	Started April 2017 completion by April 2018

North Somerset Sustainability Programme

- Looking at the sustainability of Weston General hospital in a system-wide context
- Clarifying what the wider out-of-hospital model should look like for North Somerset bringing together:
 - Weston Primary Care Transformation Programme, supporting Primary Care resilience & population growth
 - STP MDT Programme (integrated cluster-based working), and how this could potentially be piloted in Weston
 - STP Pathway Programmes (Stroke, Diabetes, Respiratory)
 - Local initiatives (e.g. Weston care homes)
- Identifying other opportunities to address population need and/or support the sustainability of North Somerset
- Ensuring all of this can be delivered within the financial envelope

North Somerset Sustainability Programme

Aims and expected outcome of programme

Develop a sustainable configuration of services at Weston General Hospital.

National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- ✓ Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- Cancer
- Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

Page 219

Risk and mitigation

- Reputational issues affect recruitment and retain the appropriate clinical staff for the required model
- UHB Partnership agreement

STP Priorities

- Preventing illness and injury
- ✓ Providing care closer to home
- Personalised care

Financial summary

Weston Area Health Trust have a challenging financial position, even when off-set by current commissioner subsidies that pay above national and local tariffs.

North Somerset Sustainability Priorities

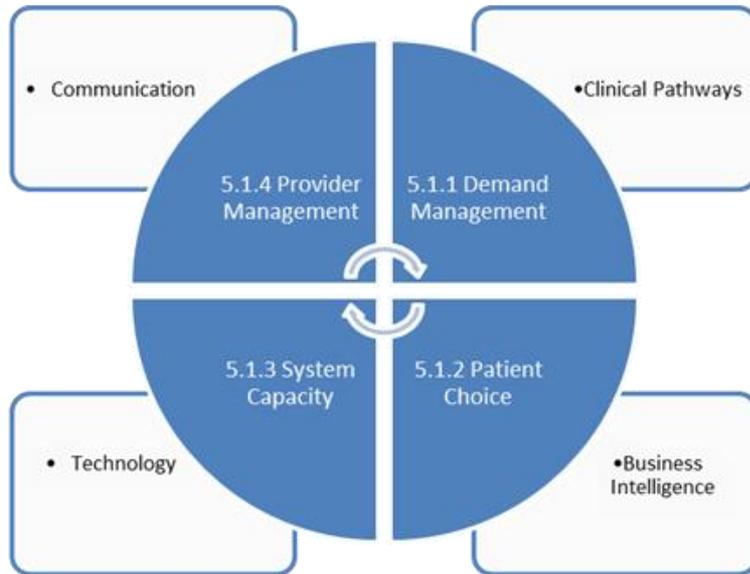
Priorities	We will achieve this by doing...	And by when...
Commissioning context	Engaging with key partners to ensure a clear and comprehensive vision of the service model and pathways supporting Weston General Hospital	July 2017
Business Case for a sustainable model of care at Weston General Hospital	Working closely with UHB and WAHT as they respond to the Commissioning Context document and develop a detailed business case for service reform	Autumn 2017
Public engagement and consultation	Use the agreed business case to build on earlier engagement work (learning from Health Watch North Somerset's review) to consult with the public on the options for a sustainable future for WGH	Winter 17/18

Planned Care

Vision and Principles

BNSSG CCGs aim to provide planned care services designed around patients with greater integration and equality of access, supporting the principle of right care, right place, first time.

Page 221



We aim to do this though applying core principles of:

- Embedding prevention and self-care along the planned care pathway, reducing or delaying the need for treatment where appropriate
- Providing care closer to home and in the community with key decision making being driven from Primary care to help patients manage their health choices.
- Enabling residents to be able to access the right health care at the right time
- Providing patients with an informed choice of provider
- Continuously seek to improve patient experience and clinical outcomes.
- Minimising waste and maximising value by moving care into different settings and reducing procedures with low clinical value
- Working with the wider health and social care community to enhance the patient journey

Planned Care

Objectives

- Supporting planned care strategy to ensure all patients in BNSSG are seen and treated in the community where appropriate, with specialist support where appropriate at the right time in the most appropriate setting
- To develop widespread use of Patient Initiated Follow up for appropriate patients, reducing unnecessary appointments for patients and making best use of hospital capacity
- Through our system wide RTT Delivery Board, manage our elective care contracts, tariffs and activity to deliver the best value to the BNSSG health system
- Continue with the development of clinically developed access policies to ensure funds are used in areas of greatest clinical need and reducing activity for procedures of the least clinical benefit
- Develop and deliver a commissioning strategy for Eye Care across BNSSG
- Commission a standardised, consistent, community based, best value pathways for MSK, DVT and Chronic Liver Disease for all BNSSG patients
- Maintain our current performance against the Referral to Treatment, incomplete Pathways standard through demand management and pathway redesign

Benefits and impact

- Care and treatment provided in community settings where appropriate
- Reduction in patients required to attend a face to face appointment when alternatives are available
- Ensuring best value from our current contracts
- Ensuring available funding is used to provide the maximum benefit for patients
- Supporting financial recovery

Planned Care Programme Summary

Aims and expected outcome of programme

Support the planned care strategy to ensure all patients in BNSSG are seen and treated in the community where appropriate, with specialist support where appropriate at the right time in the most appropriate setting

Page 223

National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- Urgent & Emergency
- ✓ Planned Care & RTT
- ✓ Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- Urgent & Emergency Care
- ✓ Primary Care
- ✓ Cancer
- Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

Risk and mitigation

- Engagement of all providers – ongoing communications in place
- Timescales challenging – ensuring resources are allocated to support delivery

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

Financial summary

- Savings identified = £15.7m

Planned Care Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Clinical Pathways – Developing consistent best value and community based pathways	Focus on MSK , Ophthalmology, DVT and Chronic Liver Disease	Phased delivery, starting July 2017, with key dates in November 17 and April 18
Outpatient Services – developing alternatives to face to face follow - up at scale across BNSSG providers	Supporting widespread use of Patient Initiated Follow ups, and supporting providers to introduce other alternatives, such as telephone appointments	Phased roll out throughout 17/18. Expectations for projects and delivery to start July 2017.
Clinical policies – ongoing development, review and implementation of BNSSG wide clinical policies to ensure patients access clinically appropriate treatment	Implementation and roll out of further clinical polices for orthopaedic procedures , fertility and CPAP devices. Designation of key procedures to 'IFR' request only. Rolling programme of development of new policies	Started from April 2017, and ongoing throughout 17/18

Page 24

Planned Care - Musculoskeletal Clinical Pathways

The Musculoskeletal (MSK) Clinical Pathways programme will create a model of MSK care that will integrate and streamline the delivery of services, providing an aligned service for anyone who has an MSK condition in BNSSG. It will enable a greater proportion of patients to self-manage and have their care managed in a community setting. The review will include all MSK services including Core Physio, Enhanced Physio, Podiatry, Orthotics, Orthopaedics, Pain and Rheumatology Services

Ranges of benchmarking indicators have identified that Trauma and Orthopaedic services and the broader MSK pathway are outliers against a number of key performance and outcome metrics. There is also a complex network of service provision across BNSSG with multiple acute and community providers for T&O/MSK services. These drivers have indicated that there are significant opportunities within the T&O/MSK pathway and its associated delivery model to make significant improvements and a streamlining of services for patients within the region, as well as opportunities to address the notable issues of sustainability within the current services

The project will establish whether a different provider model is required (which may include consideration of a lead provider model) and the optimal service delivery model

The project will also review the current provision of services for patients who have suffered a fractured neck of femur to ensure the same level of service is provided across BNSSG

Musculoskeletal Services – Summary

Aims and expected outcome of programme

Develop vision and clinical model for future provision of MSK services across BNSSG . Enabling a great proportion of patients to self-manage and create a sustainable model of MSK services for our population

National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- ✓ Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- Urgent & Emergency Care
- ✓ Primary Care
 - Cancer
 - Mental Health
 - ✓ Integrating Care Locally
 - ✓ Funding and Efficiency

Page 226

Risk and mitigation

- Demand for MSK services continues to outstrip demand
- Model of care remains financially unsustainable
- Whole MSK pathway to be recommissioned to contain demand and cost

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- Personalised care

Financial summary

- Right Care opportunity of £7m across BNSSG CCGs

Musculoskeletal Services – Priorities

Priorities	We will achieve this by doing...	And by when...
Delivering a financial sustainable model of MSK Services across BNSSG	Development of clinical model and service specification to facilitate commissioning of sustainable service	Clinical Model to be developed by Sept 17 and Service Specification by Dec 17
Addressing significant variation in management of patients in MSK interface services	MSK interface services policies and pathways to be aligned across BNSSG to ensure equity of provision	Single referral form and equity of diagnostic access to be delivered by July 17
Optimal model of Fractured Neck of Femur services across BNSSG .	Current services benchmarked and services developed to reduce length of stay and improve access to theatre.	Community rehabilitation services to be available for patients from December 17.

Referral Management

Objectives:

- Establishing a BNSSG referral support system, providing administrative support, clinical triage and commissioner based referral data collection
- Support referrers to ensure patients are referred at the right time to the right place first time
- Providing education, pathway information and support to GP referrers through IT referral support tools, development of local pathways, referral peer review and education
- Addressing significant variation in referral practice and variation in internal hospital referral practice
- Roll out of advice and guidance supported by the BNSSG referral service in line with 17/18 CQUIN

Page 228

Benefits and impact

- Commissioner control and knowledge over all activity referred into secondary care
- Ensuring patients are referred into secondary care at the right time, and access the correct services first time
- Supporting primary care management as appropriate
- Reduction in significant variation, and reduction in procedures referred and undertaken which do not meet funding criteria, supporting financial recovery

Referral Management Programme Summary

Aims and expected outcome of programme

Establish a BNSSG referral support system, providing administrative support, clinical triage and commissioner based referral data collection

National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- Urgent & Emergency
- ✓ Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- Urgent & Emergency Care
- ✓ Primary Care
- Cancer
- Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

Page 229

Risk and mitigation

- Support from primary care – communications in place
- Impact less than planned – has been trialled and impact demonstrated in CCG localities

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- Personalised care

Financial summary

£1.1m saving identified through 17/18

Referral Management Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Establishing a single system for referral triage, data collection and primary care support	Integration of current referral support systems into a single BNSSG service available for all practices	July 17, with trajectory for all practices using the service by December 17
Addressing significant practice variations at speciality level	Develop statistical reporting tools for practices, and clinically triaging all referrals where variation is high	July 17
Roll out of Advice and Guidance to key specialities	Introduced to Providers through national CQUIN, and following national timescales in 17/18	A&G to be offered by selected specialties by March 18 in line with national CQUIN

Respiratory

The BNSSG Respiratory Programme will support the updated Five Year Forward View in the following ways:-

- 'Improving A&E performance': plans to improve the care of people with respiratory conditions in primary care and the emphasis on self care should reduce the number of people attending A&E with an exacerbation
- 'Strengthening access to high quality GP services and primary care' and 'integrating care locally': the integrated respiratory service being developed will improve the quality of the respiratory care provided in primary care and provide teams without walls, making the most effective and efficient use of respiratory specialists across the whole patient pathway

The BNSSG Respiratory Programme will support the national must-dos in the following way:-

- 'Moderate demand growth and increase provider efficiencies': we are working to introduce virtual pulmonary rehabilitation and to provide one pulmonary rehabilitation offer across BNSSG to help people self manage their condition and reduce their need for services and provide efficiencies and economies of scale between the providers of PR
- 'New models of acute service collaboration and more integrated primary and community services': we are working with all six acute and community providers and the STP cluster/MTD working programme to design and implement an integrated respiratory service across primary, community, secondary care and the voluntary sector
- 'Streamline elective care pathways including through outpatient re-design and avoiding unnecessary follow-ups': to release capacity in secondary care to enable their respiratory specialists to have capacity to support primary care we are working with secondary care to ensure the new to follow up ratio for outpatient appointments is in the top 45th percentile by reducing unnecessary follow ups and implementing patient initiated follow ups

The impact of this work to improve the care received in primary care and to improve self care will be to reduce the number of A&E attendances, reduce the number of hospital admissions, reduce lengths of stay, increase the number of people who receive their care at home or close to home, increase the number of people who stop smoking or reduce the harm from smoking and improve the care people with respiratory conditions receive at the end of their life

Respiratory Programme Summary

Aims and expected outcome of programme

- Agree and implement an integrated approach to both acute and chronic respiratory disease management.
- Improved early identification of COPD, self-management and intervention to improve wellbeing of patients with respiratory disease.
- Enable multi-disciplinary assessment and treatment, providing seamless care for people with respiratory conditions.
- Agree care pathways and implement an integrated MDT model of care across providers.
- To reduce non-elective admissions and outpatient appointments
- Ensure that for this cohort of patients' admission to hospital is minimised but when it does happen their length of stay is as short as possible
- Improve the patient experience.
- Maximising a patient's physical and psychological health through lifestyle advice and education on medication, exercise and breathlessness.
- To upskill primary care services to ensure potential to support the patient population is maximised.
- Ensuring medicines optimisation so the most cost effective therapy is provided at the right time without compromising care whilst reducing admissions
- Agree performance measures

Page 232

National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- ✓ Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- Cancer
- Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

STP Priorities

- ✓ Preventing illness & injury
- ✓ Providing care closer to home
- ✓ Personalised care

Risk and mitigation

There is a risk that there is not enough capacity in primary and community care to take on the additional care of patients with a respiratory condition that we may want in a new model of care.

Financial summary

The in –year savings highlighted in the Right Care data pack have been over estimated and are unlikely to be made The Respiratory Programme is expected to release savings in 2018/19. The exact amount of savings are currently uncertain. A Business Case is being written which will include the detailed savings expected. the ambition for the project in the first year has been influenced by the turn around projects and consequent lack of funding

Respiratory Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Improving the care of people with respiratory conditions in primary care	Testing respiratory specialist led virtual clinics and diagnostic hubs in conjunction with the STP work on primary care cluster and MTD working	We will work to the STP Cluster/MTD working timescale. We would like to have tested the new model in one cluster of practices per CCG by the end of the 17/18 financial year
Ensuring equity of respiratory services across BNSSG	We plan to ensure there is:- <ul style="list-style-type: none"> • hot clinics provided at all three acute trusts • Early supported discharge provided across BNSSG 	We will produce a Business Case to try and establish both of these services for the North Somerset population from the start of 2018
Improving the depth and breath of pulmonary rehabilitation across BNSSG	We will do this by: <ul style="list-style-type: none"> • Offering virtual PR via MyCOPD • Providing one PR programme across BNSSG • Offering shorter education sessions for people newly diagnosed with COPD 	We plan to start offering MyCOPD by the end of 2017. We are aiming to provide one PR programme and supplement the PR programme with shorter education sessions, offered face to face and virtually by April 2018

Stroke

- **Programme** – There are 30+ deaths that can be saved each year (RightCare 2016). Services as they are currently structured do not meet the national Cardiovascular Network guidance, or the requirements of the NHS England (NHSE) business case and the NHSE requirement for STP. Areas where stroke services have been transformed have seen significant reductions in mortality and morbidity from stroke. Aligned with NHSE’s 2016-17 Business Case, networks for life changing and life threatening conditions, including stroke
- **Prevention** – Preventable risk factors for stroke, including high blood pressure, atrial fibrillation, and Transient Ischaemic Attack can be better identified and managed to reduce the strokes in all three CCGs. This will also reduce the incidence of strokes, heart attacks, heart failure and vascular dementia (NHSE’s 5YFV and NHSE’s 2017/18 Business Case)
- **Acute Care** – Not achieving all the necessary stroke standards (Sentinel Stroke National Audit Programme) and none of the three trusts meet the criteria for acute stroke care and the seven day standard in England (NHSE, 2016). Stroke services are among the five services that NHSE requires to be centralised to reduce mortality (NHSE’s Transforming Urgent and Emergency Care Services). Improving A&E performance, patients directed from A&E to HASU
- **Rehabilitation and Living with Stroke** – Life expectancy is increasing and the number of patients living and surviving with stroke is increasing. Current model - most specialist stroke rehabilitation is provided within the acute trusts, adding to current issues of capacity. New model proposes patients transferring out to community as soon as medically fit for discharge, providing care closer to home wherever possible

Stroke Programme Summary

Aims and expected outcome of programme

- Prevent ill health and reduce demand
 - Implement new models of care
 - Support and improve general practice
 - Achieve and maintain performance against core standards
- Achieve national clinical priorities by 2020
- Improve quality and safety
- Use technology and accelerate change
- Develop the necessary workforce
- Achieve and Maintain financial balance

Page 235

National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- Urgent & Emergency
- Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- Cancer
- Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

Risk and mitigation

- Lack of Public Engagement in centralisation – mitigated by involvement of patient in co-design prior to public consultation
- Capacity (NBT)– movement of services to UHB

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

Financial summary

- A full financial and workforce analysis is near completion

Stroke Programme Priorities

Priorities	We will achieve this by doing...	And by when...
<p><u>Prevention</u> – Identification of preventable risk factors for stroke, including high blood pressure, atrial fibrillation, and Transient Ischaemic Attack to be better identified and managed. This will reduce the incidence of strokes, heart attacks, heart failure and vascular dementia</p>	<p>Providing training to primary and community care and additional capacity (funded by AHSN) to see additional patients for AF and hypertension. Provide education for GPs and practice staff to identify TIAs and refer urgently to TIA clinics (via CEPN) TIA clinics will be available 7 days a week</p>	<p>Pilot in September 2017, full roll out envisaged for January 2018</p>
<p><u>Acute Care</u> – To achieve the necessary stroke standards (Sentinel Stroke National Audit Programme), to improve quality and necessary stroke specialist workforce. Stroke services are among the five services that NHSE requires to be centralised to reduce mortality and increase efficiency</p>	<p>Centralisation of acute care services on one site. Assessment by stroke specialist staff at A&E/HASU and swift transfer to ASU for continued stroke care and assessment for transfer to community</p>	<p>At the same time as provision is in place in community. Date to be determined by STP approval and NHSE Assurance</p>
<p><u>Rehabilitation</u> – To provide a single specialist stroke service covering Acute Stroke Unit (ASU) and community, enabling seamless transfer from acute services to care closer to home</p>	<p>A multidisciplinary health and social care team to provide a seamless stroke rehabilitation service across ASU and community dependent on patient needs not service criteria. All patients not needing acute hospital care to receive rehab out of hospital with home as the default</p>	<p>Pilot to start following approval to progress from STP and NHSE</p>

Transforming Out of Hospital Care: Primary Care

The CCGs are co-commissioners of primary care with NHSE (South Gloucestershire CCG has yet to apply for formal co-commissioning responsibilities). The BNSSG CCGs, together with NHS England, have developed a BNSSG GP Primary Care Strategy which is the local blueprint for implementing the **General Practice Forward View (GPFV)**. This focuses on primary care sustainability and transformation, with the aim of ensuring a resilient and thriving primary care service at the heart of an integrated health and social care system. This will mean a sustainable, effective and accessible primary care, with primary care being a more attractive career choice.

The BNSSG GP Primary Care Strategy considers what is important to and for the population of BNSSG using intelligence from primary care patient surveys, local stakeholder events and public health statistics. It considers the challenges facing the primary care system in BNSSG and provides a vision for the future from both a patient and system perspective.

Sustainable primary care is fundamental for delivering the BNSSG STP vision. A new model of care has been developed that draws on national best practice, including the learning from the vanguard models for multi-specialty community providers. Across BNSSG, pilot schemes funded by Prime Minister's Challenge Fund (now renamed the General Practice Access Fund) have been in place to test working at scale and delivery of areas included within the ten high impact actions, this includes back office functions, finance functions, service delivery and IT capabilities.

Transforming Out of Hospital Care: Primary Care

Within the STP footprint and as part of the CCGs' shared operational plan under development, two areas have been agreed as priorities for work to improve sustainability: Weston and South Bristol. Change managers have been employed by NHSE to work with practices within these areas to develop and support implementation of a programme of work which will deliver a sustainable solution.

The majority of practices across BNSSG are now aligned to cluster delivery models which facilitate multi-disciplinary team working and the development of further initiatives. There is also the need to support those patients in care homes and BNSSG will build on the work that is already happening.

page 238

OUR VISION

A resilient and thriving primary care service which is the heart of an integrated health and social care system centred around the patient and carer

A responsive system that delivers needs-based high quality, equitable and safe care

Primary Care Programme Summary

Aims and expected outcome of programme

To deliver against the BNSSG primary care strategy and FYFV aligned to STP requirements

National Must Do

- ✓ STP
- Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- Cancer
- Mental Health
- ✓ Integrating Care Locally
- Funding and Efficiency

Page 239

Risk and mitigation

Sustainability: recruitment difficulties and an ageing workforce are major concerns for primary and community care providers. BNSSG wide workforce planning is required to address the high level of risk and a CCG primary care workforce lead has recently been appointed provide a focus for this.

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

Financial summary

Plans for investment of the anticipated FYFV funding are being developed following allocation of the initial sum.

Primary Care Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Prepare plans for NHS approval to allow full delegated responsibility for primary care and support delivery of the priorities below	Establish a transition working group to provide robust project support and governance to the process	Before March 2018 (as quickly as national requirements allow)
Building Primary Care Resilience & Transforming Care	Build on work already underway to utilise resilience funding to deliver practice sustainability and enable delivery of out of the hospital care programme	Invest the £3 per head to support primary care to fully operationalise cluster /locality based models and MDT working by March 2019
	Agree clear commissioning intentions which effectively deliver against FVfV allocations	September 2017
Promote and develop inter-professional team working in order to achieve multidisciplinary service delivery	Develop a comprehensive primary and community workforce plan, including introducing new career pathways	November 2017
	Provide training which is consistent across BNSSG, supporting delivery of clinically effective intervention and reducing unwarranted variation	March 2018
To ensure delivery of GP improved access in a way which supports a whole system approach to urgent and out of hours care	Review existing model and ensure targets are met at both BNSSG and CCG level.	Ongoing

Urgent and Emergency Care

The delivery of high quality and accessible urgent care services is an important priority for Bristol, North Somerset and South Gloucestershire (BNSSG). With the development of the Sustainability and Transformation Planning process, BNSSG perceive this to be an opportunity to become more aligned as a system. The BNSSG Urgent Care Strategy needs to ensure coherence across the prevention and self-care, Integrated Primary Care and the Acute Care Collaboration groups of the STP. This will provide the opportunity for the Urgent Care leads to develop shared pathways, unified care and further system alignment to avoid variation in standards. Our aim as commissioners of care is to ensure that urgent care services in the future are delivered in a seamless integrated way to best meet the needs of our local population

Underpinning the strategy will be a system wide programme for implementation by way of the Urgent Care STP Delivery Plan. The delivery plan will translate the strategy into a reality for the local population, and will deliver the required changes to the urgent care system for it to be sustainable, responsive and with high clinical quality outcomes

Urgent Care 5 Year Forward View (5YFV) 7 priorities:

- NHS 111 Online
- NHS 111 Calls
- GP Access
- Urgent Treatment Centres
- Ambulances
- Hospitals
- Hospital to Home

Urgent and Emergency Care Programme Summary

Aims and expected outcome of programme

To clearly articulate and deliver our vision for Urgent and Emergency Care, including the creation of a BNSSG Strategy, an STP Delivery Plan and a Performance Recovery plan to bring performance back in line based on intelligence around causes for breaches and system delays.

National Must Do

- ✓ STP
- ✓ Finance
- Primary Care
- ✓ Urgent & Emergency
- Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- Improving Quality

Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- Primary Care
- Cancer
- Mental Health
- Integrating Care Locally
- Funding and Efficiency

Page 242

Risk and mitigation

- Clinicians resist cultural and model changes – Clinical Lead to take responsibility for driving work stream level engagement with clinicians across the system.
- Inadequate infrastructure to deliver the specialist care required. Develop ideal workforce model and utilise available capital money and STF to develop existing estates, ensuring the BNSSG Urgent Model of care is sustainable and of high quality

STP Priorities

- Preventing illness and injury
- Providing care closer to home
- Personalised care

Financial summary

- Apply the principle of one health economy budget and ensure a high quality urgent care service is delivered within financial envelope.

Urgent and Emergency Care Programme Priorities

Priorities	We will achieve this by doing...	And by when...
To place Primary Care at the forefront of urgent care provision.	Primary care will be supported to develop, change and bring to the system approaches for multidisciplinary team working, care planning, clinical risk management and same day urgent primary care.	March 2018
Patients waiting no longer than 4 hours in ED, this will be demonstrated through the achievement of the 95% standard	Implement the requirements of the NHSE Urgent Care 5 year Forward View. Including ED Streaming to Primary Care, Improved flow through hospitals and the wider system.	March 2018
Deliver a standardised UEC service provision across BNSSG.	Align Urgent Care provision in line with Urgent Treatment Centre service specification to reduce variation and increase uniformity.	March 2019
7 day services - Clinical outcomes are the same regardless of the day of the week.	Develop 7 day service models of care to ensure patients receive the same urgent care response over 7 days and are not unnecessarily delayed in hospital at weekends.	March 2018
Ensure that we deliver against the 7 pillars of the urgent care five year forward view.	Delivery Plan in draft with detailed action against how each priority will be delivered. Governance structure in place including STP A&E Delivery Board and associated work streams with Executive and clinical leads.	March 2018

Page 243

Enabling Programmes

Page 244

Procurement approach

The CCGs ensure full compliance with all procurement regulations (including Public Contract Regulations 2015 and Procurement, Patient Choice & Competition Regulations 2013).

The procurement approach to the commissioning of healthcare services at the CCGs is decided upon on a case by case basis, and is based on an objective, evidence-based assessment of what will deliver improved, more outcomes focussed pathways and clinical care and agreed service specifications.

Page 245
When making an overarching decision on whether to contest a specific healthcare service, the CCGs consider as a minimum the following key points:

- Transparency, Equity and Proportionality as per our EU Treaty duties
- Choice, Competition or Integration as per the PPCC Regs 2013
- Value, Market, Continuity, Stability and Urgency as per the PCR2015
- Equality and Engagement as per the Public Sector Equality Duty and the Health & Social Care Act 2012

The CCGs have a strong, strategic relationship with their procurement team, and advice and support is sought on a case by case basis in moulding the above key consideration in to a formal decision-making case for each commissioning exercise.

Procurement timetable

Area of care	Service specification approved	New contracts (variations) drafted	New contracts (variations) agreed
Diabetes	By end Sept 2017	By end Dec 2017	By end Feb 2018
Respiratory	By end Sept 2017	By end Dec 2017	By end Feb 2018
Deep Vein Thrombosis	By end July 2017	By end Nov 2017	By end Dec 2017
Skin	By end Oct 2017	By end Jan 2017	By end March 2018
Eye Care	During 2018/19	During 2018/19	During 2018/19

Timescales subject to change

Communications and Engagement

Commitment

We are committed to delivering clear, open communications and engagement with:

- Patients, carers, service users and members of the public
- NHS providers and workforce
- Community and voluntary sector providers and partners
- Local authority and political partners
- Local and regional media

Page 247

Principles

Communications and engagement activity will be carried out with the following principles:

- Open
- Responsive
- Relevant
- Timely
- Two-way and ensuring there are mechanisms to feedback to the BNSSG CCGs
- Proportionate and appropriate to the project

Outcomes

Principle outcomes include ensuring that the needs of our population are met by listening and involving people in our decision making. We will meet our statutory and legal duties on engagement and public consultation - as set out in the Health & Social Care Act 2012 and Local Authority Regulations 2013 and our duties under the 2010 Equality Act - to engage protected characteristic groups and also to meet accessible information regulations.

Communications and Engagement (2)

Our aim is to ensure public confidence and trust so that we:

- Reflect the needs and aspirations of local people in our prioritisation and decision making
- Design pathways of care and health services that work for the people who use and operate them through co-design
- Enable and empower people to take control of their own health; and support the friends, families and communities who care for them
- Value our stakeholders and keep people informed and involved in everything we do

• Page 248

We will achieve this by:

- Creating a citizen led approach through a systematic, structured user centered design model
- Co-design services with our stakeholders and service users
- Embedding shared decision making and informed self-care in clinical pathway design
- Providing regular and ongoing communication tools for use by all partners
- Ongoing stakeholder, citizen and service user engagement
- Core decision-making meetings in public

Our Commitment to Engagement

- We are committed to engagement being at the heart of our work.
- We will continue to listen and act upon patient, carer, service user and public feedback at all stages of the commissioning cycle because of the evident added value of commissioning services that are informed by the experiences and aspirations of local people.
- Our commitment to engagement is supported at a national level in legislation, and in the NHS constitution.

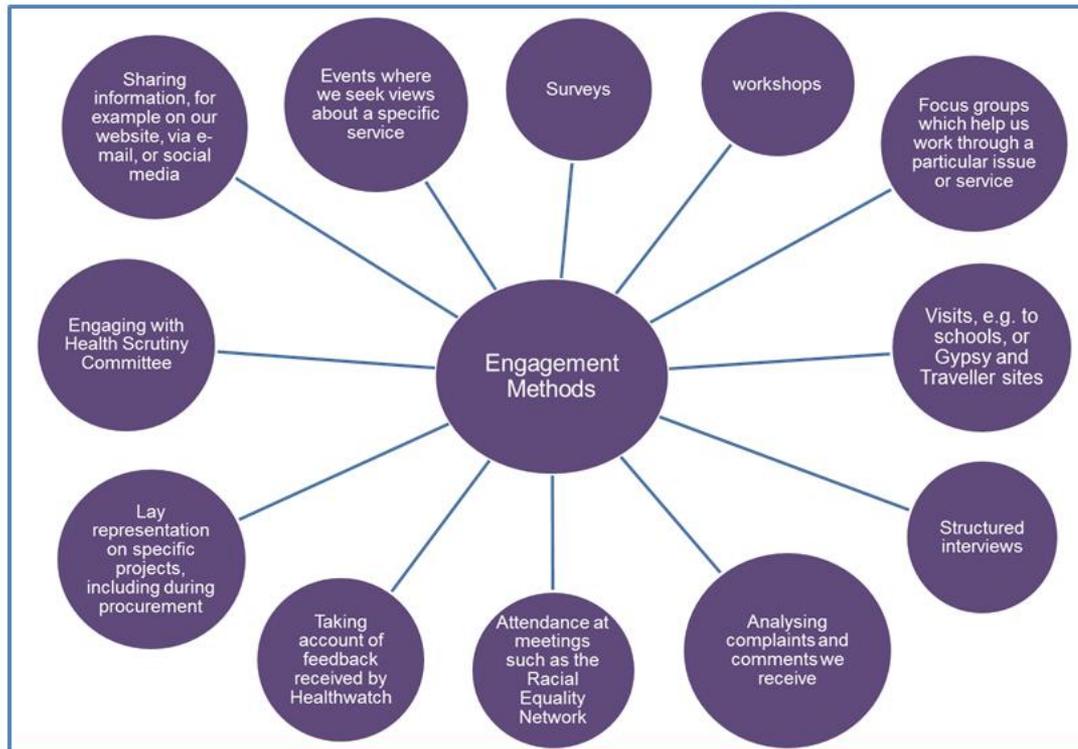
Page 249

Public sector equality duties also outline how we must have due regard to the need to eliminate discrimination and harassment, advance equality of opportunity and foster good relations between those who share a protected characteristic and those who do not share it.

- This means it is important that when we undertake engagement we take account of the differing needs of our diverse population.
- Our commissioning intentions for 2017 to 2019 were shaped using evidence from feedback the BNSSG CCGs regularly receive from patients and public
- We published our draft commissioning intentions, inviting comment from patients and public, as well as key stakeholders including: Health and Wellbeing Boards; local Healthwatch organisations and local umbrella organisations for the BNSSG voluntary and community sector

How we Engage

We will continue to offer proportionate and appropriate engagement opportunities using a range of methods as illustrated below, enabling patients and the public to continue to engage with us in a meaningful way



Timeline for Engagement

- Our operational plan comprises of programmes of projects aimed at improving service delivery for patients, carers and service users; creating efficiencies where necessary; and re-designing healthcare along pathways of care that minimise variation across our BNSSG area.
- Projects are carefully assessed to determine which ones will both benefit from and require engagement and involvement with the public. This assessment includes ensuring that the timeframe for engagement allows people sufficient opportunity to become meaningfully involved if they wish to.
- Some projects, that have will no impact on the range of services that people receive, or the manner in which they are delivered, do not require public engagement and involvement.

The projects that do require public engagement and involvement range from very small scale ones, impacting on tens of people, to very large scale ones affecting larger parts of our BNSSG population. Timeframes will vary according to the scale of the project between a minimum of four weeks for those small scale projects to 12 or more weeks for larger scale projects needing formal consultation.

- **Timeframes for each project will be published within the project documentation and on the 'Get Involved' section of our websites.**
- Some projects will commence engagement and involvement following publication of this operational plan.
- We will aim to group projects together that are linked in some way so that we do not create consultation fatigue within our population.

BNSSG Organisational Development (1)

Our Aim

Much work has been done to prepare for organisational change in response to an external Capacity and Capability Review commissioned by NHS England in 2016. This included the appointment of a single accountable Chief Executive Officer for the BNSSG CCGs. The aim of the organisational change programme is to embed a clear sense of purpose and identity that enables the three CCGs in BNSSG to operate together as a single entity, with all its energy focused on delivery on behalf of the population we serve.

Outcomes

- Page.252
- Articulation of shared ambition and vision, underpinned by a single set of organisational values, including a statement of what we want to be known and recognised for as commissioners
 - Tangible sense of positive shared commitment to the above within the whole clinical and corporate leadership community, including Members and Governing Bodies, underpinned by a robust governance and decision-making framework
 - Clarity of role and purpose throughout the workforce, supported by an emerging proactive, appreciative and developmental culture that enables people to believe in themselves, serve the population, and act as positive advocates for BNSSG
 - A systematic approach to identifying and articulating our success on a regular basis, and identifying and learning from the things that don't work
 - Clear evidence that the commissioners are taking their rightful place as system leaders across BNSSG, orchestrating change on behalf of the people we serve
 - Confidence of the Regulators that BNSSG CCGs are in a strong position for delivery, discharged from regulations pertaining to capacity and capability

BNSSG Organisational Development (2)

Our Organisational Development Programme in 2017/18 will:

1. Build a compelling and unified ambition, underpinned by a shared vision and set of values to guide our work, creating a strong sense of the role and purpose of BNSSG commissioners as system leaders and advocates of the local population.
Establish the operating model that will enable delivery of our ambition, vision and values, including the appropriate infrastructure for:
 - Governance and decision making
 - Clinical leadership
 - Corporate leadership and management
 - Establishing 'the way we do things around here' – culture by design
3. Supporting people through change throughout the organisation through:
 - Board development
 - Clinical leadership development
 - Corporate leadership development
 - Staff and team development

Page 253

Risks and mitigations

Risks

- Loss of skilled staff due to uncertainty and anxiety about organisational change.
- Inability to balance the competing needs of delivering on the operational plan with the need for organisational change and development
- Inability to deliver the scale of cultural and behavioural change required
- Inability to assure regulators sufficiently to discharge legal directions

Mitigations

- Appoint single Executive team as quickly as possible to stabilise the workforce
- Appoint a Transition Director to lead the change programme
- Commission experienced consultancy support for delivery of the OD programme

Digital

Our **2016 Local Digital Roadmap** is not simply a point in time assessment of ‘what to do next’ but a continuation of a long and proud journey. We initiated our award winning **Connecting Care** programme and began the journey of breaking our organisational ‘silos’ to benefit our population long before the *Five Year Forward View* described the high priority of ‘interoperability’.

Our health and care community faces many challenges that we need to address if we are to sustain and improve our system for the future. We understand that technology has a key part to play in helping our region meet its financial challenges – as well as improving efficiency, enabling better care and quality, and closing the wellbeing gap.

In particular the CCGs are committed to:

- Clinical systems – ensuring real-time capture and access to clinical records, regardless of location
- BI and Performance – to provide data, information, knowledge and wisdom in support of the planning, commissioning in and management of care
- Informatics Infrastructure – which is reliable and securely accessible from any location
- Strategic Interoperability – to provide appropriate sharing of clinical information between multiple organisations involved in the health and social care of our patients
- Capability and capacity – so that there is internal and external expertise to support the ongoing running of systems and solutions, as well as research and development in opportunities for new solutions
- Agile working – to drive the most efficient and productive working arrangements across the whole workforce as part of improved health and wellbeing at work

Digital Programme Summary

Aims and expected outcome of programme

The ability to operate efficiently, share information and support people is a key priority. Five building blocks for change are:

1. Primary Care at scale – focus on maximising digital across GP practices and Out of Hours services.
2. Paperless by 2020 – Embedding digital records in acute, community, mental health and social care.
3. Connecting Care – Information sharing to include putting citizens at the heart of their ‘personal health records’.
4. The Information Engine – fully utilising our electronic data to power our planning and delivery engine.
5. Infrastructure and support – ensuring we do all of the above on a solid, efficient infrastructure and delivery mechanism.

Page 255

National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- Planned Care & RTT
- Cancer
- Mental Health
- Learning Disabilities
- ✓ Improving Quality

Five Year Forward View requirements

- Urgent & Emergency Care
- ✓ Primary Care
- Cancer
- Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

Risk and mitigation

- Funding - Whilst it is always possible to be more innovative and more prudent with existing funds, it is also true that adequate funding is needed going forward. Investment funds will require additional savings from system transformation
- Capacity – having enough of the right people with the right skills and the ‘space’ to deliver. We need robust workforce planning and organisational commitment to staff involvement

STP Priorities

- Preventing illness and injury
- Providing care closer to home
- ✓ Personalised care

Financial summary

- Excellent IT enables delivery of excellent services. Total system spend on IT services is estimated to be in excess of £20m per annum. Further opportunities for system wide procurement planned. Any additional investment will need to deliver improved productivity and financial savings.

Priorities	We will achieve this by doing...	And by when...
Primary Care at scale	<p>Better access to better information about primary care and community services.</p> <ul style="list-style-type: none"> • More 'digital consultations' • Improved quality of care through read/write access to patient record via EMIS. • Efficiencies in primary care through an improved telephony solution • Increasing reporting and management information in primary care. Eg Radiography Imaging • Establishing new ways to support improved self-care 	2017-2019
Paperless 2020	<p>Faster, more reliable transmission of information throughout our system.</p> <ul style="list-style-type: none"> • mobile working and extended use of Wifi • e-prescribing/ telemedicine / wearable devices; • clinical decision support / pathway visibility • Reduced risk to people through errors caused by e.g. missing paper notes, transcription errors. • Financial benefits through the reduction in the costs associated with the management of paper records. 	2017-2019
Connecting Care	<p>To expand on the progress already made in BNSSG with the Connecting Care interoperability platform. This is the natural foundation on which to build access for people to their own health information.</p> <ul style="list-style-type: none"> • document sharing across BNSSG including discharge summaries; end of life care coordination; • development of personal health record capability including self-care via digital solutions; • radiology images and reporting; • piloting of NHS England approved apps and technology on a national tariff basis 	2017-2019
Information Engine	<p>Successful bid to begin building on existing data flows from acute and community, including Primary Care data sets to inform the design of new models of care and population analytics to inform commissioning of different care pathways</p>	2017-2019
Infrastructure & Support	<p>Includes implementation of a single domain for Primary Care to improve operational networking and workforce mobility; hardware and software refresh programmes to support transition to cloud based computing; user testing for NHS Mail 2 deployment in 2017; and operational workflow enhancements including telephony modernisation</p>	2017-2019

Page 256

Estates

The strategic goals of the CCG estates programme for BNSSG are:

- **Transformation of services** by providing fit for purpose accommodation aligned with new models of care, with a specific focus on integrated primary care and community health and care services operating at scale
- **Recovering and sustaining system wide financial balance** by optimising use of existing 'fit for purpose' estate, eliminating void, and disposal of surplus estate which is no longer fit for purpose

Estates

Aims and expected outcome of programme

The development of a system wide strategic estates programme for BNSSG will be a key enabler for delivery of the Operational Plan and also contribute towards the development to a strategic approach to asset management across the local public sector (One Public Estate). The strategic estates programme will also closely aligned with the local Digital Roadmap.

Risk and mitigation

Risk: Scale and complexity of the task delays realisation of benefits

Mitigation: Consider phased approach with emphasis on benefits that can be delivered in the operational plan timescale

Risk: Estate plan duplicates or contradicts STP estates plan

Mitigation: Ensure Estates Programme aligns to or merge with STP plan

Risk: Current national estate delivery models for NHSPS and CHP

Mitigation: Working with NHSPS and CHP to develop new pilots to enable different models for estate funding and contract management arrangements that support delivery of our plans

National Must Do

- ✓ STP
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Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
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- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

STP Priorities

- Preventing illness and injury
- ✓ Providing care closer to home
- Personalised care

Financial summary

To be undertaken as part of the stocktake process during Quarter 2

Estates Programme Priorities

Priorities	We will achieve this by ...	And by when...
Stock take of primary care and community estate to establish baseline	A rapid stock take of current estate including location, cost, utilisation and quality	July 2017
Analysis of current and future service requirements and map how these align to existing estate to reduce voids or future estates requirements	Work with local STP partner organisations and with national NHS PS and CHP to agree future estate requirements to support the Operational Plan. To include consideration and alignment with existing local schemes and opportunities.	October 2017
Agree a strategic estates programme	Agree a strategic estates programme including in-year, medium and long term priorities for delivering the aims and expected outcomes of the programme	January 2018

Medicines Optimisation (1)

Sustainable and Transformational improvement in medicines optimisation will deliver cost savings, improve efficiencies, maximise benefits from medicines including cost avoidance, and improve patient outcomes reducing variation across the system.

The benefits include the following, (with the assessment in the Carter efficiencies, that for every £1 that is spent on medicines optimisation there is a £5 benefit to the NHS).

- Cost savings; e.g. Biosimilar implementation results in reduced medicines expenditure; better management of medicines results in reduced wastage
- Cost avoidance; e.g. Improved medicines optimisation results in reduced admission and readmission rates and reduced length of stay
- Patient harm reduction; e.g. medicines safety improvements have a direct impact on avoidance of harm and therefore also result in cost avoidance
- Service efficiencies; e.g. service centralisation in order to focus attention on medicines optimisation
- Ensure appropriate and best use of resources, through strong formulary and guideline adherence,.
- Delivery of STP Medicine Optimisation programme and operational projects to deliver financial requirement

This links to national NHS Strategies and action plans; Carter Review of hospital services, Right Care, NICE Medicines Optimisation Guideline.

Medicines Optimisation (2)

Prescribing

Prescribing growth is assumed to be about 5% nationally and therefore is an initial starting point to set local budgets before then locally adding a savings target, which reduces the actual percentage uplift on budgets and therefore significant savings need to be realised to achieve allocated budget and a reduced growth target.

Growth on prescribing can fluctuate year on year and can be dependent on a number of factors including capacity and ability to deliver local savings plans, fluctuations in Category M Drug Tariff prices, volatility and unpredictability of No Cheaper Stock Obtainable (NCSO), patent expiries, and introduction of new drugs including NICE Technology Appraisals.

In 2016/17 prescribing growth compared to the previous year was negative for the first time for many years and was -1.01, -1.76 and -1.65 for Bristol, North Somerset and South Glos respectively.

The savings required for 2017/18 require another year of negative growth. Comprehensive savings plans are in place to achieve this and require some big changes, including reviewing what is available on prescription, waste and more capacity invested in processes to ensure cost effective prescribing is maximised.

Medicines Optimisation Programme Summary

Aims and expected outcome of programme

Continue to engage commissioner and provider colleagues across BNSSG through the BNSSG Joint Formulary Group, the BNSSG Drugs & Therapeutics Committee and BNSSG NICE College, to identify and commission for unmet need, highlight unwarranted variation, and implement evidence based medicine and innovation into practice, and challenge medicines use that is not safe or cost effective.

Page 26/28

Risk and mitigation

- Capacity of medicines management teams to deliver programme at pace required mitigated by prioritisation to ensure effective delivery and identification of additional project support required
- GP engagement and impact on primary care workload mitigated by ensuring strong clinical leadership and relationships with practices
- Lack of public understanding where services might be delivered differently mitigated by effective public engagement from the outset

National Must Do

- ✓ STP
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Five Year Forward View requirements

- Urgent & Emergency Care
- ✓ Primary Care
- Cancer
- Mental Health
- Integrating Care Locally
- ✓ Funding and Efficiency

STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- Personalised care

Financial summary

Effective delivery of the programme to ensure that the medicines management allocation is met across BNSSG

Medicines Optimisation Programme Priorities

Priorities	We will achieve this by doing...	And by when...
<p>Commissioners in BNSSG will work together to improve patient outcomes through better use of medicines, ensuring that innovation and evidence-based care is embedded into routine practice through medicines optimisation.</p> <p>We will identify and commission for unmet need, highlight unwarranted variation, and implement evidence based medicine and innovation into practice, and challenge medicines use that is neither safe or cost effective.</p>	<p>To apply Right Care medicines data on variation to BNSSG to focus on areas for improvement and implement changes , aligning with other work programmes across the care pathway e.g. Stroke prevention, Breast cancer.</p> <p>BNSSG Joint Formulary Group, the BNSSG Drugs & Therapeutics Committee and BNSSG NICE College. Collaboratively implement the first BNSSG Paediatric Joint Formulary. Engage with Regional Medicines Optimisation Committee</p> <p>Continue to develop evidence based, cost effective BNSSG prescribing guidance and clear pathways of care, to reduce admissions and demand on health care.</p> <p>Continue to commission the same prescribing support tool for use in GP practices across BNSSG, share resource to monitor and manage the system.</p> <p>Through good relationships and working directly with all prescribers ensure cost effective prescribing.</p> <p>Ensure that those services that we commission to reduce unnecessary referral, admission, or prescribing activity continue to improve quality, productivity and outcomes and align across BNSSG.</p> <p>Ensure that those services that we commission from community pharmacists to provide better access to healthcare closer to home continue to improve quality, productivity and outcomes and where possible align across BNSSG</p> <p>Work at local level in collaboration with NHS England, contractors and providers to identify, learn from and reduce medication errors</p>	<p>2017-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

Medicines Optimisation (2) Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups

Priorities	We will achieve this by doing...	And by when...
<p>Continue to develop methods to achieve better value for money for the local NHS on high cost 'pass through' drugs excluded from the PbR tariff, ensuring outcomes are achieved in line with NICE Technologies.</p>	<p>Biosimilars. Work with medical teams (eg GI, Rheumatology, Dermatology) and patients to implement the more cost-effective biosimilar pharmaceutical products & manage the transfer to these drugs where clinically appropriate.</p> <p>Establish an embedded pharmacist in acute services to ensure robust management of high cost drugs and appropriate medicines optimisation in care pathway design. Introduce the use of BlueTeq across all trusts to aid assurance that drugs are used in line with NICE TA or local pathways.</p> <p>High Cost Drugs. Review the use of the most expensive drugs and ensure they are being used appropriately and consider if improvements could be made.</p>	<p>2017-18</p> <p>2017-18</p> <p>2017-18</p>
<p>Continue to address patient care issues that relate to medicines use, where these occur at the interface between primary, secondary, community and local authority.</p>	<p>E-Referrals. Use available technology to transfer discharge information to community pharmacists to provide follow up care for patients taking complex medicines.</p> <p>Improve the patient experience (timely supply of medicines) when attending for out-patient appointments or day case admissions.</p>	<p>2017-18</p> <p>2017-18</p>
<p>Medicines are optimised in primary care, minimising medicines waste</p>	<p>Compliance Aids. Work more closely with colleagues in all care settings to rationalise the use of multi-compartment compliance aids.</p> <p>Commissioning Options. Conduct options appraisals on the prescribing in the areas of Stoma and Continence with view to upscale; creating efficiencies and introduce a consistent service to patients.</p> <p>Community Providers. Seek to devolve budgets directly to areas responsible for prescribing certain medicines and appliances prescribed</p> <p>Repeat Prescriptions management service pilot. To manage repeat prescription services in order to avoid provision of unnecessary medicines and reduce wastage.</p>	<p>2017-18</p> <p>2017-18</p> <p>2017-18</p> <p>2017-18</p>

Page 264

Medicines Optimisation (3)

Priorities	We will achieve this by doing...	And by when...
<p>Patient centred care and medicines optimisation for people with Long Term Conditions, leading to improved patient outcomes.</p> <p>Avoidance of adverse drug reactions, especially among vulnerable groups such as the frail, or elderly</p>	<p>Polypharmacy (GP guidance & care homes). Review medicines being taken by the frail elderly, particularly within the care home context, in order to ensure that all medicines are necessary and appropriate.</p>	2017-18
	<p>Enhance and continue to commission pharmaceutical support for patients in care homes and patients in their own homes.</p>	2017-18
	<p>De-Prescribing. Identify and agree medicines that are considered to have no proven benefit and implement de-prescribing protocols.</p>	2017-18
	<p>Enhanced multidisciplinary working e.g. Integrated respiratory service, Diabetes specialist nurse service.</p>	2017-18
<p>Ensuring appropriate use of antibiotics in both primary and secondary care, given the concerns around antimicrobial resistance and risks of healthcare associated infections.</p>	<p>Antimicrobial stewardship activities in line with national policy to reduce overall antibiotic prescribing and the percentage that are broad spectrum, utilising TARGET resources and local guidelines. Work with clinicians in primary and secondary care to achieve the 2017-19 Quality Premium and CQUINS.</p>	Ongoing
<p>Ensure that valuable NHS resources are not consumed by the prescribing of items that do not represent good value for money, or are not a priority for investment</p>	<p>Support patients to self care where appropriate and implement national guidance on reducing the use of drugs of limited clinical value</p>	2017-18

Page 265

Operational Plan Risks and Mitigations

Key risks to the delivery of the BNSSG Operational Plan have been identified through the work programmes. Risks are assessed against probability (likelihood) and impact (consequence) and mitigating actions put into place to manage any unacceptable risks. Summary over-arching risks and mitigations that have been identified include :

Risk Area	Risk	Mitigating Actions
Strategic	That commissioning plans required to deliver the operational plan impact adversely on longer term strategic priorities and objectives	<ul style="list-style-type: none"> • Work closely with partners to understand the impact of short-term plans on longer term priorities. • Ensure alignment with system financial recovery plans and strategic commissioning priorities
Operational	Growth and activity exceed levels within commissioned plans	<ul style="list-style-type: none"> • Robust monitoring of activity levels delivered and waiting time performance against contracted levels. • Ensure patients are signposted to the most appropriate point of care
Operational	Insufficient provider capacity to deliver commissioned activity.	<ul style="list-style-type: none"> • Plans and contracts to reflect IHAMs activity assumptions and risk assessment of this • Whole system demand and capacity planning to be undertaken • Robust monitoring of provider capacity across BNSSG • Manage demand for elective activity through further development of access protocols and commissioning policy
Operational	Contractual arrangements with providers don't allow shift of resources between providers to support transformational plans.	<ul style="list-style-type: none"> • Develop risk sharing arrangements between providers that encourage them to shift resources that support transformational change • Explore alternative contractual arrangements that incentivise risk sharing

Risks and Mitigations

Risk Area	Risk	Mitigating Actions
Operational	Non-Delivery of constitutional standards with particular risk around 4hr A&E , RTT and 62 Day Cancer Pathway.	<ul style="list-style-type: none"> • System wide recovery plans developed for all core standards • Recovery plans performance managed through BNSSG Delivery Boards • Aligned Performance , Activity and Financial reporting embedded across BNSSG • Utilisation of external expert support where required e.g. ECIP and IMAS
Workforce	Risk to sustainability of Primary Care due to workforce pressures leading to increasing patient demand elsewhere in the system	<ul style="list-style-type: none"> • As co-commissioners of Primary Care close working with NHSE has resulted in scoping and identification of vulnerable practices • Development work will focus on sustainability
Financial	Non- Delivery of BNSSG Financial Control Total	<ul style="list-style-type: none"> • System Financial Recovery Plan developed and approved between commissioners and providers • System Financial Recovery governance structure implemented to oversee delivery of plan

Page 267

Risks and Mitigations

Risk Area	Risk	Mitigating Actions
Workforce	Clinical workforce constraints across Primary and Secondary Care result in inability to deliver transformed services	<ul style="list-style-type: none"> • The Director of Nursing and Quality chairs a quarterly group with HEE, the universities who provide training to staff groups in North Somerset, to discuss the on-going CPD needs of the workforce and the new models of education required for pre-registration students. Additionally this is discussed at the CCG's QIG. • BNSSG Clinical Workforce Strategy to be developed
Operational	Risk to collaborative relationships across BNSSG due to rapid and substantial changes to the way services are delivered.	<ul style="list-style-type: none"> • Clear narrative about why change is needed • Close working with partners across BNSSG • Early Local authority engagement • Increased engagement with all members of the People and Communities Board • Involve providers in development of plans • Robust Communications and Engagement Strategy and detailed plans for resourcing and delivering these.
Quality	Risk that proposed commissioning plans negatively impact quality of services provided	<ul style="list-style-type: none"> • All plans reviewed through Quality Impact Assessment and Equality Impact Assessment • On-going quality and equality monitoring through delivery governance

Page 268

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups

Acronym	Description	Acronym
A&E	Accident and Emergency	MDT
A&G	Advice and Guidance	MH
AWP	Avon and Wiltshire Mental Health Partnership	MSK
BCF	Better Care Fund	NBT
BCH	Bristol Community Health	NHS
BNSSG	Bristol, North Somerset and South Gloucestershire	NHSE/I
CAMHS	Child and Adolescent Mental Health Service	NSCP
CCG	Clinical Commissioning Group	NICE
CFO	Chief Financial Officer	OT
CfV	Commissioning for Value	PbR
CHC	Continuing Healthcare	PCF
CIP	Cost Improvement Plan	PCN
CNS	Clinical Nurse Specialist	PHE
CCQI	Commissioning for Quality and Innovation	PIC
CV	Cardiovascular	PIFU
CYP	Children and Young People	PTS
D2A	Discharge to Assess	PWLD
DQIP	Data Quality Improvement Plan	QIPP
DTOC	Delayed Transfers of Care	QOF
DVT	Deep Vein Thrombosis	QP
ED	Emergency Department	RSS
ERS	Electronic Referral System	RTT
FYFV	Five Year Forward View	SEND
GP	General Practice/Practitioner	SIRONA
GPFV	General Practice Forward View	SFRP
HASU	Hyper-acute Stroke Unit	SPA
HRG	Healthcare Resource Groups	STF
IAPT	Improving Access to Psychological Therapies	STP
IBD	Irritable Bowel Disease	TCP
IHAM	Indicative Hospital Activity Model	T&O
LA	Local Authority	UHB
LMS	Local Maternity System	WAHT
LoS	Length of Stay	WiC
LTC	Long Term Condition	YTD
MCP	Multispecialty Community Provider	

MDT	Multi-Disciplinary Team
MH	Mental Health
MSK	Musculoskeletal
NBT	NHS North Bristol Trust
NHS	National Health Service
NHSE/I	NHSE England/Improvements
NSCP	North Somerset Community Partnership
NICE	National Institute for Health and Care Excellence
OT	Occupational Therapy
PbR	Payment by Results
PCF	Primary Care Foundation
PCN	Prescribing Clinical Network
PHE	Public Health England
PIC	Patient Initiated Contact
PIFU	Patient Initiated Follow Up
PTS	Patient Transport Service
PWLD	People with Learning Disabilities
QIPP	Quality Innovation Productivity and Prevention
QOF	Quality and Outcomes Framework
QP	Quality Premium
RSS	Referral Support System
RTT	Referral To Treatment
SEND	Special Educational Needs and Disabilities
SIRONA	Sirona Care & Health
SFRP	System Financial Recovery Plan
SPA	Single Point of Access
STF	Sustainability Transformation Fund
STP	Sustainability and Transformation Partnership
TCP	Transforming Care Plan
T&O	Trauma & Orthopaedic
UHB	University Hospitals Bristol
WAHT	Weston Area Health Trust
WiC	Walk In Centre
YTD	Year to date

Final page



Bristol Health & Wellbeing Board

Bristol Children and Young People’s Emotional Health Transformation Refresh - 2017	
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Author, including organisation	Rebecca Cross NHS Bristol CCG/ Bristol City Council
Date of meeting	16 th Aug 2017
Report for Information/Discussion	

1. Purpose of this Paper

This is the second draft refresh of the original Children and Young People’s Emotional Transformation Plan. We are seeking engagement with the Health and Wellbeing Board regarding the transformation of our Bristol CAMHS and services for children with emotional health needs, with due regard to national and local priorities.

Health and Wellbeing Board agreed to delegate sign off of the original plan to NHS Bristol CCG Clinical chair, so process of sign off in October is to be agreed.

2. Executive Summary

The Emotional Transformation Plan includes information relating to achievements over the last year and plans for 2017/18. This includes Eating Disorders services, Crisis outreach services and workforce development plans.

3. Context

In summer 2015, the Departments of Health and Education published a joint five year strategy ‘Future in Mind’¹ to transform services for children and young people’s emotional health and wellbeing.

The vision for 2015 to 2020 is to ensure that every child, everywhere, receives the right support, as early as possible. It’s much broader than just Children and Adolescent Mental Health Services (CAMHS) and includes working with

¹ Future in Mind, 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

schools, the local authority, universal and primary services such as GPs and school nurses, as well as the voluntary and community sector.

In July 2016, NHS England published 'Implementing of the Five Year Forward View for Mental Health'². This guidance identified new areas for us to focus on and this has again been included in our plans for 2017/18. This plan does not include our work on perinatal mental health, as that is covered elsewhere

4. Main body of the report

The key headlines of the plan are:

- Priority across BNSSG to improve access and waiting times for children and young people who need evidence based interventions for diagnosable mental health conditions, providing parity of esteem with physical services.
- Building resilience through the delivery of training to non-specialist workforces to improve capacity and capability to support children and young people in community settings
- Services are part of the children and young people's Improving Access to Psychological Therapies Collaborative, but this needs to be developed in both specialist and wider children and young people's workforce
- Work towards a sustainable 24/7 urgent and emergency mental health service
- Provide community eating disorder services, compliant with access targets and independently accredited
- Improve access to and quality of perinatal and infant mental health care
- Deliver improved access to mental health support to children and young people at risk of or in the early stages of criminal justice involvement
- Ensure data quality and transparency - increase digital maturity to support interoperability of healthcare records

5. Key risks and Opportunities

The additional transformation funding comes from NHS England to NHS Bristol CCG however it is not ring-fenced and health is subject to a system

² Implementing the Five Year Forward View for Mental Health
<https://www.england.nhs.uk/mentalhealth/taskforce/>

financial recovery process that may result in the expected allocation this year and in the future not being available.

Due to pressures on local authority funding there may be future reductions to allocations of funding to children and young people's mental health services.

6. Implications (Financial and Legal if appropriate)

See above for future risks.

7. Evidence informing this report.

The plan was informed by an original needs assessment that is currently being revised.

Children, young people were engaged in the development of the original plan and have been involved in the development of various service improvements and initiatives.

The nationally defined model of eating disorder services is evidence based.

The Partnership Outreach Service for children who present at the emergency department with mental health needs is currently being evaluated.

8. Conclusions

The plan includes the nationally required components such as

- previous year's spend and this year's budget.
- Progress in developing Eating disorder and Crisis outreach home treatment services.
- Workforce data

9. Recommendations

Health and Wellbeing Board to

- feedback on draft 2017 Emotional Transformation Plan refresh.
- agree mechanism of sign off.

10. Appendices

Draft Children and Young People Emotional Transformation Plan Refresh v.6.



***Draft Children and young people's
emotional health and wellbeing
transformation plan refresh 2017/18
v.6***

October 2017

Contents

1. Introduction	2
2. What have we achieved since our last transformation plan in 2016/17? ..	3
3. What are we planning in 2017/18?	8
3.1 Eating disorders	9
3.2 Crisis care and inpatient treatment	9
3.3 Developing the workforce	10
4. Where are we now?.....	10

DRAFT

1. Introduction

In summer 2015, the Departments of Health and Education published a joint five year strategy 'Future in Mind'¹ to transform services for children and young people's emotional health and wellbeing.

The vision for 2015 to 2020 is to ensure that every child, everywhere, receives the right support, as early as possible. It's much broader than just Children and Adolescent Mental Health Services (CAMHS) and includes working with schools, the local authority, universal and primary services such as GPs and school nurses, as well as the voluntary and community sector.

In July 2016, NHS England published 'Implementing of the Five Year Forward View for Mental Health'². This guidance identified new areas for us to focus on and this has again been included in our plans for 2017/18. This plan does not include our work on perinatal mental health, as that is covered elsewhere.

This plan also links closely with our local Sustainability and Transformation Plan and contributes to the Integrated Assessment Framework. The key headlines are:

- Priority across BNSSG to improve access and waiting times for children and young people who need evidence based interventions for diagnosable mental health conditions, providing parity of esteem with physical services.
- Building resilience through the delivery of training to non-specialist workforces to improve capacity and capability to support children and young people in community settings
- Services are part of the children and young people's Improving Access to Psychological Therapies Collaborative, but this needs to be developed in both specialist and wider children and young people's workforce
- Work towards a sustainable 24/7 urgent and emergency mental health service
- Provide community eating disorder services, compliant with access targets and independently accredited
- Improve access to and quality of perinatal and infant mental health care

¹https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Children_Mental_Health.pdf

²<https://www.england.nhs.uk/mentalhealth/taskforce/>

- Deliver improved access to mental health support to children and young people at risk of or in the early stages of criminal justice involvement
- Ensure data quality and transparency - increase digital maturity to support interoperability of healthcare records

The Mayor of Bristol, Marvin Rees has continued to make the emotional wellbeing of children and young people a priority. It is also one of four priorities in Bristol's Strategy for Children, Young People and Families 2016³ – 2020. In addition, the Youth Mayors have included reducing stigma and focusing on male mental health as part of their manifesto⁴. This transformation plan has been developed with the involvement of the Health and Wellbeing Board and the Children and Families Board and has been informed by a recent JSNA chapter on children's mental health (add link when published - www.bristol.gov.uk/JSNA).

We are actively engaged with Public Health's development of an all-age mental health strategy. This is an opportunity to build on our work to date and ensure a wide range of stakeholders are also involved with the development of this programme of work.

We also work closely with colleagues across the region and play an active part in the Strategic Clinical Network. Nationally we learn from other areas with similar issues or that have implemented innovative ways of delivering services.

We will keep engaging with a variety of stakeholders to develop our plans over the course of the programme, which runs until 2020. If you would like to get involved or let us know your thoughts, please contact the team at bristolccg.cypehbristol@nhs.net or on 0117 900 2533.

2. What have we achieved since our last transformation plan in 2016/17?

We have continued to develop and implement our programme of transformation since we published our last transformation plan refresh in October 2016⁵.

This has built on our work since 2015 and builds on our vision of ensuring that every child, everywhere, receives the right support, as early as possible and taken steps to make this a reality.

³ www.bristol.gov.uk/cyf

⁴ https://www.bristol.gov.uk/en_US/youth-council-youth-mayors

⁵ <https://www.bristolccg.nhs.uk/library/emotional-health-and-wellbeing-news/>

Since our last plan was published, we have progressed on a number of fronts:

- **CASCADE training**

In association with the Anna Freud Centre, CASCADE training was undertaken and completed by 94% of schools in Bristol between January and May 2017. Bringing together mental health leads in schools and CAMHS to embed long term collaboration and integrated working, the Bristol training, run across six area-based cohorts, also incorporated key staff from Early Help, educational psychology, safeguarding in education, Public Health teams, commissioned providers and more.

CASCADE training was previously successfully delivered across 22 Clinical Commissioning Groups as part of the Joint Department of Education and NHS England schools link pilot, testing a single point of access in schools and mental health services⁶.

Bristol has led the way in becoming the first city in England to offer the training to all of its school settings; primary, secondary and special. 93% of delegates found the training helpful and, as a requirement of attendance, schools were asked to identify a mental health lead for their setting.

- **Training**

The following additional training has also been commissioned and delivered:

- Social care and Early Help staff; 402 Bristol City Council Social Care practitioners have undertaken training to support prevention and early intervention in relation to CYP emotional distress and trauma with a particular focus on self-harm and suicidal ideation.
- School nurses, sexual health nurses & Youth Offending Team practitioners; Up to 48 practitioners from across the three professions are undertaking two-day Mental Health First Aid training in autumn 2016.
- Parenting; 96 parents have completed Incredible Years training which has robust evidence of decreasing challenging behaviours in children under 10, as well as increasing parental confidence and use of evidence based parenting skills.
- Mental Health First Aid: 126 Youth Workers across the city have been trained in Youth Mental Health First Aid.

⁶ <https://www.gov.uk/government/publications/mental-health-services-and-schools-link-pilot-evaluation>

- **Youth Mental Health First Aid training**

Secondary school staff in Bristol have been some of the first to receive Youth Mental Health First Aid (YMHFA) Training as part of the YMHFA First Aid in Schools programme. This follows a commitment made by the Prime Minister in January 2017 to provide the training to at least one member of staff in every state secondary school in the country over the following three years.

Bristol Metropolitan Academy, Orchard School Bristol and Bridge Learning Campus each hosted a one day course between June and September 2017 for up to 16 staff per course. Training was organised on a locality basis and included input from CAMHS Primary Mental Health Professionals. The course focused on supporting delegates to provide mental health support to pupils on a first aid basis in order to facilitate early intervention and recovery. The training aimed to further enhance the skills and understanding of those who had already attended CASCADE training as mental health leads for their settings.

- **Online directory**

Following feedback from stakeholders, we launched an online directory⁷ of local and national services and resources in May 2017 on the NHS Bristol CCG website. This is for use by children and young people, their families as well as a wide range of professionals.

The aim is to have a single, searchable source of information of different services, as well as NHS commissioned providers such as CAMHS, Off The Record and www.kooth.com. It will be updated on a quarterly basis to ensure the information is kept up to date. It is also available on the GP referral support tool and can be printed as an A5 booklet.

- **Online counselling and support**

We have continued to commission our successful online counselling and support service for all 11-18 year olds at www.kooth.com. This service has been widely promoted across secondary schools and colleges by an Involvement and Participation Worker.

Uptake has been higher than originally anticipated and the service has been welcomed by schools and GPs. We are continuing to ensure the service is part of an integrated, system wide pathway.

⁷ <https://www.bristolccg.nhs.uk/your-health-local-services/help-and-support/young-peoples-emotional-health/>

We plan to extend the pilot until March 2018, with the potential to be included in the newly commissioned Community Children's Health Partnership from April 2018.

- **Working with GPs and primary care**

The information available on the GP referral support tool has been reviewed and updated. This provides GPs and other primary care staff with information on how to signpost and support children and young people and their families to a wider range of services and resources than just those commissioned by the NHS. It also includes a link to our newly developed online directory⁸.

It also includes a crisis risk screen tool which was developed by CAMHS and GPs. This supports GPs in assessing children and young people who present in mental health crisis and in providing an appropriate level of response.

- **NHS 111**

We have also improved the information available on NHS 111 so that when members of the public or professionals contact them, they can be made aware of additional local services such as www.kooth.com and Off The Record, as well as CAMHS and primary care.

- **Working with schools**

The extensive reach of the CASCADE Training enabled commissioners to liaise closely over a period of time with many Bristol schools. Emergent was the need for a Bristol Schools' Mental Health Network. Transformation commissioners along with other key local authority and health colleagues are now working collaboratively with schools to develop this work. A one day Supporting Mental Health & Wellbeing Conference for Schools was successfully delivered on 27th September incorporating:

- CASCADE Celebration Workshop; developed to showcase the emotional health and wellbeing work and approaches of a number of Bristol schools, led by the Anna Freud Centre.
- Launch of the Bristol Schools' Mental Health Network.
- Launch of the new Public Health Bristol Healthy Schools' Award Mental Wellbeing Badge. Schools are encouraged to sign up and work towards achieving the badge which is focussed around a 'whole school approach' to mental health. It is comprised of a set of standards, developed in partnership with Bristol schools and in line with NICE guidance. The award is part of a wider Bristol Healthy Schools award

⁸ <https://www.bristolcgg.nhs.uk/your-health-local-services/help-and-support/young-peoples-emotional-health/>

and is endorsed by Bristol's elected Mayor. Supporting this programme are 10 recently appointed pilot Heads of Mental Wellbeing from Bristol primary, secondary and special schools across the city.

Feedback from the conference was (*insert*). All Bristol primary, secondary and special school settings were encouraged to attend the day, with X number/percentage participating.

- **Self-harm**

This is a manifestation of emotional distress rather than a primary disorder, commonly this includes difficult personal circumstances, past trauma (including abuse, neglect or loss), or social or economic deprivation together with some level of mental disorder.

Self-harm is rising across the UK and has the highest rate in Europe, estimated at 400 per 100 000 people (JSNA *add footnote link when published*). Rates of self-harm are higher for young people who have a diagnosed mental health disorder but self-harm isn't restricted to people with mental health disorders. Risk factors for self-harm, aside from age and gender, are similar to the risk factors for all mental health problems. The risk of self-harm increases with the number of stressful life events a child is exposed to, the socio-economic position of the family and parenting factors such as high levels of punishment and high levels of family conflict (JSNA).

The Partnership Outreach Service (CAMHS/ Off the Record/ UHB/ Early Help Family Support) commenced Sept 2015 and an evaluation is in progress. This service and the Central Intake Team provided assessments for children who present with urgent mental health needs primarily to the Emergency Department and provides an outreach service for those not engaged in a service.

These two teams have recently merged to form the CAMHS Triage, Assessment and Outreach Team. GPs are now referring to this service rather than the child presenting to the Emergency Department.

The number of children accessing these services has increased across Bristol and South Gloucestershire from 315 in 2014 to 364 in 2015 and 391 in 2016.

The initiatives above all aim to contribute to reducing self-harm but nationally it is increasing due to a range of issues including the impact of social media.

In addition, suicidal ideation and self-harm training was run for social care and Early Help staff to support identification and to enhance the support of Practice Leaders within the teams. Practice Leaders are now developing an assessment tool and are clear about their roles:

- Leading on practice

- Equipped in completing initial assessments of a child or young person's health and social care needs
- Producing the assessment tool
- Developing and supporting safety plans and risk assessments with children, young people and their families.
- Mentoring staff
- Offering a network of support
- Sharing knowledge and skills within their service
- Linking with multi-agency partners when required

3. What are we planning in 2017/18?

In NHS England's 'Implementing the Five Year Forward View for Mental Health', there was a new objective that in 2017/18 at least 30% of CYP with a diagnosable mental health condition receive treatment from an NHS-funded community mental health service.

We have calculated these figures for our child and young people population in Bristol using the newly available data from the refreshed JSNA chapter on children and young people's emotional health and wellbeing.

Based on activity figures from our providers (CAMHS, Off The Record, www.kooth.com), 30.4% of Bristol children and young people with a diagnosable mental health condition received treatment from an NHS-funded community service in 2016/17.

- **SEND children's needs**

A multi-agency deep dive workshop included social care and education with health as part of a wider whole system review of services for children with autism and social communication and interaction needs. This workshop focussed on identifying the needs of those at risk of hospitalisation, home or out of area school or social care placements with a view to if and how these needs could be met locally.

Bristol and South Gloucestershire CCGs and Local Authorities submitted a bid to NHS England as part of the Bristol, North Somerset and South Gloucestershire (BNSSG) Transforming Care Partnership Plan. The pilot is to extend our Positive Behaviour Support Service to meet the needs of children and young people with ASD/ Asperger's without a moderate or severe learning disability in order to reduce out of area and costly social care and education placements, also hospital inpatients.

New training relating to autism should be available for CAMHS from Jan 2018 as part of the Increasing Access to Psychological Therapies (IAPT).

- **Data reporting**

We are continuing to work closely with our providers to ensure comprehensive and high-quality data is submitted to the Mental Health Minimum Data Set⁹. We are focusing on improving both the quality and quantity of the information available about service delivery and who is being seen. This intelligence will allow us to make more informed and transparent commissioning decisions in the future.

3.1 Eating disorders

By 2020/21, evidence-based community eating disorder services for children and young people will be in place across Bristol. We are working towards ensuring that 95% of children in need receive treatment within one week for urgent cases, and four weeks for routine cases.

New NICE guidelines for the treatment of eating disorders were published in May 2017¹⁰. We will ensure that eating disorders services in Bristol reflect the recommendations made.

Our CAMHS provider now has extra staff in post (WTE 1.8 including therapists and psychiatry input), which have been funded by transformation monies. They are continuing to develop a model of care that covers BNSSG and are a member of the Quality Network for Community CAMHS – Eating Disorders¹¹.

We have also funded a research project with stakeholders to get a better understanding of how we can improve primary care for children and young people with eating disorders via Bristol Health Partners¹². This involves exploring with patients, their families and GPs how children and young people with eating disorders can best be supported by primary care providers.

3.2 Crisis care and inpatient treatment

We are working with colleagues in NHS England and across our Sustainability and Transformation Plan footprint to develop a collaborative plan for commissioning pathways including inpatient beds. The intention is to develop appropriate community services and potentially home treatment to reduce the need for inpatient admissions, especially in out of area facilities.

We developed an initial BNSSG wide collaborative commissioning plan with our local NHS England's specialised commissioning team by December 2016.

⁹ <http://content.digital.nhs.uk/mhds>

¹⁰ <https://www.nice.org.uk/guidance/ng69/chapter/Recommendations>

¹¹ <http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/childandadolescent/communitycamhsqnc/gncc-ed.aspx>

¹² <http://www.bristolhealthpartners.org.uk/health-integration-teams/eating-disorders/projects-and-activities>

Since then, we have engaged with NHS England to explore how we can develop and improve services further.

We are also working in partnership with the Local Authority, the police and hospitals to get a better understanding of the needs of children and young people in crisis, and identify if there are gaps in the services provided.

3.3 Developing the workforce

In Bristol we are part of Wave 2 of the South West CYP Improving Access to Psychological Therapies (CYP IAPT) Collaborative Programme. This year we have supported staff from CAMHS, Off The Record and the Local Authority parenting team to take part in the clinical training programmes.

This has included NHS Bristol making a financial contribution to the salary support costs of CYP IAPT training from our transformation funding.

In December 2016 we also produced an initial BNSSG wide joint workforce plan in collaboration with our providers and other commissioners across BNSSG. This includes promoting and integrating the principles and values of CYP IAPT throughout the wider workforce, as well as other specialist training.

This includes trauma recovery model training for a range of practitioners in Bristol working with vulnerable and complex children and young people, which is taking place in autumn 2017. This training was funded by NHS England Health and Justice Collaborative Commissioning.

'Strengthening the Circle' training, funded by Health Education England is also being delivered in Bristol in autumn 2017. This training aims to strengthen the skills, confidence and competence of the joint agency non-specialist workforce – those who provide the circle of support around individual vulnerable children and young people.

We are also exploring options for delivering Mental Health First Aid training to primary schools.

4. Where are we now?

Please see the table below for how much we spent in 2016/17 and plans for 2017/18:

Description	Actuals			Planned
	2014-15 Bristol CCG	2015-16 Bristol CCG	2016-17 Bristol CCG	17-18 Bristol CCG
Main block CAMHS	4,467,377	4,557,362	4,334,741	4,450,300

Total Block	4,467,377	4,557,362	4,334,741	4,450,300
Other				
Off the record	50,895	60,215	62,360	91,215
Crisis Outreach	400,000	61,724	-	-
CHC Children's	311,365	421,225	291,422	292,168
ED and transformation	-	869,411	1,028,551	1,013,949
CYP IAPT	-	51,250	196,750	101,250
Total other CAMHS	762,260	1,463,825	1,579,082	1,498,582
Combined Total	5,229,637	6,021,187	5,913,823	5,948,882

Bristol City Council Spend and Budget

	14/15 - Actual Spend	15/16 - Actual Spend	16/17 - Actual Spend	17/18- Budget
CAMHS	864,595	878,516	992,854	907,780
Social Care - Positive Behaviour Support Service (PBSS)	30,000	30,000	30,000	30,000
MTFC	0	93,781	105,255	96,401
Troubled Families	49,534	72,836	148,000	162,689
Early Years - Emotional Needs	9,063	12,642	23,708	23,708
SEN - PBSS	30,000	30,000	30,000	30,000
Youth Services - Counselling			84,000	84,000
	983,192	1,117,775	1,402,751	1,323,512

There are other funding sources that include emotional health but these have not been possible to disaggregate such as Healthy Schools Programme or social care or educational support.

Please see the tables below for details of the workforce and activity of our specialist providers in 2016/17:

CAMHS Workforce 2016/17

Specialised CAMHS

Position	WTE	NHS Band
Admin & Clerical	1.4	3
Admin & Clerical	0.6	4
Assistant Psychologist	0.5	5
Nurse	3.8	7
Psychologist	2.4	7
Nurse Manager	0.4	8a
Psychologist	0.55	8a
Psychotherapist	0.8	8a
Psychotherapist	1.1	8b
Psychologist	0.6	8c

WTE total = 12.15

Bristol East and Central CAMHS

Position	WTE	NHS Band
Admin & Clerical	1.49	2
Admin & Clerical	2.25	3
Admin & Clerical	1.5 (0.5 = CIT)	4
Nurse band	1.00	6
Nurse band	1.8	7
PMHS/PIMHS	3	7
Clinical Psychologist	1.71	7
Family Therapist	1.35	8a
Psychotherapist	1.00	8a
Psychologist	0.6	8a
Psychologist	0.61	8c
Psychiatrist consultant	1.6	

WTE total = 17.91

Bristol North CAMHS

Position	WTE	NHS Band
Admin & Clerical	1.37	2
Admin & Clerical	2.24	3
Admin & Clerical	0.8	4
Psychologist	1.9	7
Nurse	1.3	7
PMHS/PIMHS	4	7
Psychologist	1.6	8a
Family Therapist (ED)	0.6	8a
Family base treatment	1	7

(ED)		
Consultant Psychiatrist (ED)	0.2	
Psychologist	0.7	8b
Psychotherapist	0.9	8a
Psychotherapist	1.0	8b
PMHS	1.0	8a
Psychiatrist Consultant	0.6	

WTE total = 19.21

Bristol South CAMHS

Position	WTE	NHS Band
Admin & Clerical	1.6	2
Admin & Clerical	2.6	3
Admin & Clerical	1.81	4
Occupational Therapist	0.6	7
Psychologist	3.25	7
Nurse	1.79	7
PMHS/PIMHS	4.4	7
Psychologist	0.63	8a
Family Therapist	0.7	8a
Psychotherapist	1.09	8b
Psychotherapist	1.0	8d
Nurse	1.0	8a
Psychiatrist consultant	2.4	

WTE total = 22.87

CAMHS activity 2016/17

Total number of referrals for year	1900
Total number accepted	1379
DNA rate	6%

Off The Record workforce 2016/17 (including NHS funded staff)

WTE	NHS Band Equivalent
19	-
4.2	4
27.6	5
2	5/6
7	6
4	7
1	8b

WTE total = 62

Off The Record activity 2016/17

Total number of referrals to OTR	1536
Total number seen in CCG services	815 (409 counselling + 246 pop-up + 160 groupwork)
DNA rate for CCG funded services	11.2%

Kooth – **workforce?** Xenzone to provide by 7th August to match approach in other CCG plans

Kooth activity 2016/17

Total number of referrals to Kooth (registrations)	1441
Total number seen in CCG services – review wording	364
DNA rate for CCG funded services	N/A



Bristol Health & Wellbeing Board

Health and Wellbeing Roundtable Discussions	
Author, including organisation	Becky Pollard, Director of Public Health, Bristol City Council
Date of meeting	16 th August 2017
Report for Information and Discussion	

1. Purpose of this Paper

To update the Bristol Health & Wellbeing Board (HWB) on the outcomes and developments which are emerging from recent Health and Wellbeing Roundtable Discussions hosted by the Mayor of Bristol, Marvin Rees.

2. Executive Summary

Three roundtable discussions have been set up on behalf of the Mayor of Bristol to explore ways to strengthen local health system leadership across the city.

These workshops have engaged with local provider and commissioning health system leaders and members of the HWB. The specific aim and purpose of these discussions are to:

- Explore current health and wellbeing system leadership and delivery in Bristol;
- Map existing Health and Wellbeing systems leadership networks in Bristol;
- Consider and define the role of the HWB for Health and Wellbeing in Bristol in light of current arrangements.

The scope of the workshops includes:

- What do we want from the health system in Bristol?
- What does the health system leadership need to deliver for Bristol?
- What systems leadership is needed for health in Bristol?

- What is the role of the HWB in Bristol?
- What is the way forward with Health and Wellbeing in Bristol?

A third roundtable discussion took place on the 13th July 2017. It was hosted by Marvin Rees with local health and social care systems leaders and HWB members. This session aims to discuss Health and Wellbeing outcomes identified from the workshops and to agree a way forward to strengthen health system leadership across the city.

A small Task and Finish group of leaders set up on behalf of Marvin Rees (Mayor) for the HWB will further update the HWB in September 2017 with a HWB vision and refresh proposal.

3. Context

The Health and Social Care Act 2012 set out a statutory duty for unitary local authorities and clinical commissioning groups across England to set up local Health and Wellbeing Boards to improve the health and wellbeing of their local populations.

The Bristol HWB was established in 2013 and is currently co-chaired by the Mayor, Marvin Rees and Dr Martin Jones, Clinical lead for Bristol Clinical Commissioning Group (CCG). It is made up of local health and social care commissioners and representatives of the community and voluntary sector. At present, the Board does not include representatives from NHS providers.

Since 2013, the strategic landscape for health and social care commissioning has changed considerably, in particularly with the establishment of joint working across Bristol, North Somerset and South Gloucestershire (BNSSG) CCGs and with the introduction of BNSSG Sustainability and Transformation Plan (STP). In light of these changes, the Mayor invited local health system leaders and members of the HWB to review local system leadership to ensure most effective partnership working arrangements are in place to improve health and wellbeing and reduce health inequalities.

Bristol City Council commissioned Joe Simpson from the Leadership Centre to facilitate a series of group discussions and provide feedback to the Mayor and the HWB. The first of three events took place on the 3rd May 2017 for local NHS and social care providers. The second event took place for HWB members on 12th May 2017.

A third and final event took place on the 13th July for all health and system care leaders to review outcomes of all discussions and agreed a way forward.

Appendix 1 sets out invitees for all discussion events for information.

4. Main body of the report

The group discussed Systems leadership for H&W in Bristol, the purpose and role of the HWB, future membership, and Bristol's H&W vision.

Key themes arising:

- City place based health leadership rather than organisational leadership;
- Stakeholder relationship with the HWB in terms of H&W strategy and governance;
- H&W vision to improve health and wellness, resilience and recovery across the Bristol population making fewer demands of the NHS, not just to alleviate sickness through health services;
- HWB role in developing the City Plan;
- HWB role in developing a communications plan with H&W stakeholders;
- Short, medium and long term health visions to be set out by the HWB.

Action points:

- A small group consisting of seven senior representatives from Acute services, Commissioning, Adult Social Care, VCS, Public Health, NHSE, and PHE should be set up as a Task and Finish group to notify stakeholders of the review outcomes;
and
- Appoint a HWB lead to oversee the H&W refresh;
- Discuss and agree stakeholder contribution towards the HWB lead costs and admin;
- Agree HWB membership and TOR;
- Introduce new HWB members to the HWB at the next available opportunity;
- The H&W Task and Finish Group vision arrangements should include:
 - Governance and decision making matrix for the H&WB
 - List of H&W stakeholders
 - List of key H&W strategies
 - Short term, medium term and long term H&W population targets for Bristol.

5. Key risks and Opportunities

These discussions provide an opportunity to explore and further develop Bristol's Health and Wellbeing Vision to improve health and wellbeing of the local population.

6. Implications (Financial and Legal if appropriate)

N/A

7. Evidence informing this report.

N/A

8. Conclusions

The outcomes of these roundtable discussions will provide evidence and direction in how we can develop the role of the HWB and inform the development of a new City Plan for Health and Wellbeing for Bristol.

9. Recommendations

- Consider the outcomes of these roundtable discussions
- Support the Task and Finish Group in moving forward

10. Appendices

Appendix 1 – List in invitees to the three roundtable events

Attendees – 1st Workshop – 3 May 2017

Mayor Marvin Rees – Bristol City Council

Martin Jones – Clinical lead, Bristol Clinical Commissioning Group

Robert Woolley – Chief executive, University Bristol Hospital Trust

Andrea Young – Chief executive, North Bristol NHS Trust

Julia Clarke – Chief executive, Bristol Community Health

Anna Klonowski - Chief executive, Bristol City Council

Alison Comley- Strategic Director of Neighbourhoods, Bristol City Council

John Readman - Strategic Director of People, Bristol City Council

Becky Pollard – Director of Public Health, Bristol City Council

Julia Ross- Chief Executive, BNSSG CCG

Hayley Richards- Chief Executive, AWP

Joe Simpson – Director, Leadership Centre, (Facilitator)

In attendance - Mark Jefferies, Public Health, Bristol City Council

Attendees – 2nd Workshop – 12 May 2017

Marvin Rees, (Mayor)

Alison Comley, Strategic Director, Neighbourhoods

Becky Pollard, Director, Public Health

Councillor Asher Craig, BCC

Councillor Helen Holland, BCC

Andrea Young – Chief executive, North Bristol NHS Trust

Elaine Flint, Voluntary and Community Sector representative

Dr Pippa Stables, Inner city & east Bristol locality group

Justine Mansfield, North & West Bristol locality group

Mike Hennessey, Director, Care Support and Provision

Vicki Morris, Health Watch representative

Councillor Gill Kirk, BCC

Steve Davies, South Bristol locality group

Joe Simpson – Director, Leadership Centre, (Facilitator)

In attendance – Anne Addison, DA to Becky Pollard, BCC

Attendees - Third Workshop – 13 July 2017

Mayor, Marvin Rees, – Co – Chair, Health and Wellbeing Board, BCC

Cllr Asher Craig, Deputy Mayor

Alison Comley, Strategic Director, Neighbourhoods

Becky Pollard, Director of Public Health

Joe Simpson – Director, Leadership Centre, (Facilitator)

David Relph, Director, Bristol Health Partners

Keith Sinclair, Carers Support Centre, Health Watch

Terry Dafter OBE, Service Director (Care and Support – Adults – Interim)

Vicki Morris, Health Watch representative

Robert Woolley, CEO, UHB NHS Trust

Dr Hayley Richards, CEO, AWP

Julia Clarke, CEO Bristol Community Health

Cllr Helen Godwin, Cabinet Member for Children and Young People

Cllr Helen Holland, Cabinet Member for Adult Social Care

Cllr Claire Hiscott, Cabinet Member for Education and Skills

Elaine Flint, Voluntary and Community Sector representative



Bristol Health & Wellbeing Board

Update - Bristol Community Links service	
Author, including organisation	Sonia Moore, Early Intervention & Targeted Support (Adults) Manager, Bristol City Council
Date of meeting	16 th August 2017
Report for Discussion	

1. Purpose of this Paper

To inform Health and Wellbeing Board members of the current review of in-house day services to adults (known locally as Bristol Community Links service).

To request feedback on the proposed changes that are currently part of the 'Your Neighbourhoods' public consultation from HWB members.

To identify potential opportunities for increased partnership working and stimulate a discussion about how we can further develop existing city-wide and community initiatives linked to this service (e.g. in relation to dementia care).

2. Executive Summary

Bristol Community Links service is Bristol City Council's in-house day service provision for vulnerable adults. Following the Full Council decision to apply savings of £1.3million to the Bristol Community Links service (approximately one third of the previous budget), a public consultation is in place to review the delivery model of the service.

The full consultation information, and proposals for consideration can be found at the following link: <https://bristol.citizenspace.com/bristol-city-council/yourneighbourhood/>

3. Context

In order to deliver the Corporate Budget agreed by Full Council on 21st February 2017, the Bristol Community Links service needs to deliver budget savings of £1.2 million, as well as generate £100k of income during the period

2017-2020. Proposals for how these savings could be achieved are currently part of the 'Your Neighbourhoods' 12 week public consultation.

Any changes for existing users of the service will be undertaken on an individual basis through an assessment of their social care needs.

4. Main body of the report

The current provision of Bristol Community Links was created in 2013, following a previous review of BCC's in-house day centre provision.

Operating from 3 building-based centres in the North, South and Central areas of the City, it offers building-based day care for people with complex personal care needs, as well as access to the community. Supporting in the region of 130 people at any one time, across the 3 centres, the service supports people with Learning Disabilities, Dementia, and Physical / Sensory Impairments. All the people who attend the centres have been through an assessment of their care needs by Adult Social Care, and have been deemed eligible for a package of care, funded by the Local Authority.

In addition, there are also 3 separate drop-in centres that offer low level ad-hoc support to people that otherwise live independently in the community. Approximately 130 people access the drop-in service (although this varies).

Following the decision to reduce the budget for the service by approximately one third, a period of co-design involving a wide range of stakeholders took place. This feedback, combined with market analysis of the private provider market, informed the current proposals included in the public consultation.

The key outcomes for the future service are:

- To promote and support independence for vulnerable people, with a particular focus on access to paid employment
- To enable reliable support for carers to enable them to continue their caring role
- To support the delivery of the Three Tier model of care, taking a whole city approach to early intervention, to enable people to develop skills and enhance their lives
- To ensure that the service delivery model is sustainable for the future, including the flexibility to respond to any changing market, political and budgetary conditions.

5. Key risks and Opportunities

Risks

- Dependency on the provider market – both in terms of capacity and pricing
- Capacity to complete adult social care reviews

- Not duplicating existing initiatives but taking a whole city approach to ensure that people's needs are met.

Opportunities

- Partnership working with external provider market and voluntary and community organisations
- Helping to join up existing city-wide and community initiatives – for example around Dementia care, social prescribing, advice provision and so on)
- Shared use of space – either through offering space to other organisations within the BCL buildings, or through BCL providing services from other locations
- Dementia care – ambition to develop Bristol as a centre of excellence by working in partnership with dementia specialists and schemes across the city, e.g. universities, health providers, support for carers and so on.

6. Implications (Financial and Legal if appropriate)

N/A

7. Evidence informing this report.

What evidence have you used to inform:

- Evidence of need and the case for change (eg. **JSNA**, activity data, patient feedback, national directive etc)

The requirement to reduce the budget was agreed by Bristol City Council in February 2017.

The implementation of the Care Act has led to a new focus on services for Vulnerable Adults. BCC has adopted the Three Tier model approach to support for people, and as such it is timely to review the approach to this specific service.

- Evidence of effectiveness of proposed solution/initiative/new service

Following the Full Council decision to allocate a £1.2m savings target to the Community Links service, many conversations have taken place across the City to really understand the value of the current service, and identify areas where these savings could be achieved.

This consultation process is allowing discussion of the proposals with a range of stakeholders, to test the model and identify where any

changes to these proposals should be made. Following the consultation phase, a final model will be established.

8. Conclusions

As this is still part of a public consultation phase, this report does not offer specific conclusions. However any input from members of the HWB will be added to the wide ranging feedback already gathered to inform the final delivery model.

A decision on the proposed service model will be taken by Bristol City Council's Cabinet. This is currently scheduled for 5th December 2017.

9. Recommendations

That the Health & Wellbeing Board members consider the proposals outlined in the Consultation, and offer feedback and suggestions based on their own knowledge and experience. In particular for members to consider:

- Do you agree in principle with the consultation proposals and direction of travel?
- Do you see scope for you / your organisation to explore working with us in partnership to develop the new model? (If so please pass on your name so our project team can contact you for further discussions.)
- Are you aware of any other plans that you / your organisation may have to develop something similar?

10. Appendices

N/A



Bristol Health & Wellbeing Board

Bristol’s Big Drink Debate	
Author, including organisation	Public Health Bristol
Date of meeting	16 th August 2017
Report for information	

1. Purpose of this Paper

To present the findings of the Big Drink Debate to the HWB highlighting findings that will inform future alcohol harm reduction activity.

2. Executive Summary

Please see the executive summary in the Bristol’s Big Drink Debate report which is attached at Appendix 1.

3. Context

The harm caused by alcohol is a significant concern for public, primary and secondary health and statutory services in Bristol. Alcohol-related hospital admissions in Bristol are significantly higher than the England average for both men and women and alcohol-related deaths in men are significantly higher than the national average (28.5 per 100,000; national 16.1), and are rising. Bristol City Council has identified alcohol as one of the Public Health priorities and has developed a strategy to reduce alcohol consumption in the City. Public Health has identified alcohol as a priority lifestyle behaviour and is working with partners to reduce the harm caused.

4. Main body of the report

Please see attached report at Appendix 1.

5. Key risks and Opportunities

Please see attached report at Appendix 1.

6. Implications (Financial and Legal if appropriate)

The recommendations in the report indicate the implications for future work related to changing attitudes to alcohol consumption in Bristol. These are limited to public health policy, commissioning and the design of health improvement interventions.

7. Evidence informing this report.

The report is a presentation of new evidence about attitudes to alcohol in Bristol.

8. Conclusions

The work undertaken under the banner of the *Big Drink Debate* will help to shape our efforts to reduce the harm caused by alcohol. It suggests we should link concerns about weight gain with alcohol-harm-reduction messages and broadcast messages that emphasise the normality of drinking within the Chief Medical Officers (CMO) Guidelines for low risk drinking. The high proportion of people drinking within CMO limits supports our intention of working with businesses and licensees to help them expand their range of no and low alcohol options.

9. Recommendations

That the Health and Wellbeing Board considers the detail of the Big Drink Debate report and considers its implications.

10. Appendices

Appendix 1: Bristol's Big Drink Debate 2016/17: What do you think about alcohol?

Bristol's Big Drink Debate 2016/17



**BRISTOL'S
BIG DRINK
DEBATE**

**What do you think
about alcohol?**

The **Big Drink Debate** takes place from **Monday 14 November 2016** to **Monday 30 January 2017**.
It's *your* chance to tell us about ways we could be helping to reduce harmful drinking in the future.

Complete the survey at:
www.bristol.gov.uk/bristolsbigdrinkdebate

Follow the live debate on Twitter:
[#bristoldrinkdebate](https://twitter.com/bristoldrinkdebate)



Contents

1.	SUMMARIES.....	3
1.1	EasyRead Summary	4
2.	INTRODUCTION.....	5
3.	METHODS	6
3.1	Survey.....	6
3.2	Twitter	8
3.3	Community outreach	8
3.4	Focus Groups.....	8
4.	RESULTS.....	9
4.1	Where the responses were from	9
4.2	Who the responses were from	10
4.2.1	Gender.....	10
4.2.2	Ethnicity.....	11
4.2.3	Age	11
4.2.4	Economic status	11
4.3	What the respondents said.....	11
4.3.1	How much do people drink?	12
4.3.2	How often do people drink?	14
4.3.3	Where do you prefer to drink?	14
4.3.4	Where is it acceptable to be drunk?	14
4.3.5	Is drinking a problem in Bristol?.....	15
4.3.6	Retail of alcohol	16
4.3.7	Attitudes to drinking	17
4.3.8	What would encourage people to drink less?	18
4.3.9	What worries people about drinking	19
4.3.10	Other comments about alcohol.	19
4.4	#bristoldrinkdebate.....	22
4.5	Focus Group Feedback.....	23
5.	DISCUSSION.....	24
6.	RECOMMENDATIONS.....	27

Appendix 1: Data

Appendix 2: Sample size calculations

Appendix 3: Survey questions

Appendix 4: Twitter questions used to prompt debate

Appendix 5: List of outreach activities

Appendix 6: Focus Groups / Group Discussions

1. SUMMARIES

The Debate reached thousands of local residents through variety of media coverage and nearly 2000 individuals took part in the survey. It directly engaged with nearly 2,000 people with many more being made aware of the activity and the issues relating to alcohol on which it concentrated by media coverage that it attracted.

Attitudes and opinions about alcohol and its effect on individuals and society were gathered through focus groups, community outreach, social media activity and a paper and web-based survey. The target number of survey responses (1,065) was achieved, enabling us to make statements about the population of Bristol with a 3% margin of error at a 95% confidence level. However there was imperfect stratification of the sample, resulting in the over-representation of adults aged 25-49 and the underrepresentation of young people and the self-employed.

The proportion stating they thought that 'drinking is a problem in Bristol' was potentially quite concerning, given that only just over half (52%) thought that it is. With 23% answering 'don't know', there appears to be a case for raising awareness of the negative impacts that alcohol is having.

15% of all respondents stated they "Never" drink, the Joint Strategic Needs Assessments (JSNA) estimates 16% of the Bristol population (16+) abstain from drinking. The age range 40-49 had the highest percentage of those that did not drink. A large proportion of the sample drink very infrequently. 48% of our respondents drink once a week or less. 49% reported they drink twice a week or more. The snapshot provided by the survey suggests the high level of official concern about emergency admissions due to alcohol-related harm may be due to the harm caused to a relatively small proportion of the population.

The majority of participants reported they drink within Chief Medical Officer Guidelines. The average consumption across all respondents was 1-2 units on a Weekday (36.84% of the total sample) and 3-4 units (24.64% of the total sample) at the weekend. However over 15% reported drinking above CMO guidelines (more than 2-3 units per day) during the week. The percentage rose to over 54% at weekends. 17% of respondents reported an alcohol related injury or illness.

The survey intended to find out opinions on how best to encourage people to drink less. The fact that 'wanting to lose weight' is listed as the third most encouraging factor is notable. Linking alcohol consumption with weight gain will influence the choices of a substantial proportion (between c. 30-50%) of the population. Weight gain was reported as a consequence of drinking that respondents worried about relatively frequently. The high profile of 'financial commitments' suggests that further price increases may provide encouragement to reduce consumption.

The social impact of alcohol concerns people and implies that future campaigns might focus on the antisocial nature of excess drinking, as opposed to the harm that individuals who drink too much may experience. This needs further testing with target audiences - particularly men - who's acceptance of being so drunk as to be out of control is substantially different from women.

The Big Drink Debate achieved its goal of raising the issue of society's relationship with alcohol and involving people in the debate about the benefits and harms caused by drinking and has given us some pointers towards future action that may be required.

1.1 EasyRead Summary

Drinking too much alcohol is bad for you and lots of people are made ill every year.

We want to help people think about how much they are drinking and called our project "Bristol's Big Drink Debate".

Nearly 2,000 people told us what they thought about drinking alcohol.

People came to groups where we talked about alcohol. And 1,065 people who live in Bristol completed our survey. But too few young people sent in their survey forms and we had many more replies from people aged 25-49. This means we have to be careful about how we use the survey results.

People told us that:

- Half of them think that people drinking alcohol is a problem
- They are worried about alcohol making them gain weight
- They think that the National Health Service (NHS) is badly affected by alcohol
- Half of them drink less than once a week
- They are worried about how much alcohol costs
- More men than women think it's OK to be drunk
- Nearly 1 in every 5 people had been made ill or have been injured because of drinking alcohol
- They did not think there were too many places to buy alcohol

We will use what people told us to help people drink less alcohol. This will help them stay healthier for longer.

2. INTRODUCTION

The harm caused by alcohol is a significant concern for public, primary and secondary health and statutory services in Bristol. Alcohol-related hospital admissions in Bristol are significantly higher than the England average for both men and women and alcohol-related deaths in men are significantly higher than the national average (28.5 per 100,000; national 16.1), and are rising. Bristol City Council has identified alcohol as one of the Public Health priorities and has developed a strategy to reduce alcohol consumption in the City. Public Health has identified alcohol as a priority lifestyle behaviour and is working with partners to reduce the harm caused.

Bristol's Big Alcohol Debate was an initiative to get people thinking and talking about alcohol by using a variety of techniques such as online survey, focus groups, workshops, public displays, social media and other communication activity.

Bristol's Big Alcohol Debate was launched on 14th November 2016 and ran to 30th January 2017.

It aimed to inform actions to create an environment and a social consensus about acceptable drinking behaviour and a culture that creates a less harmful relationship with alcohol. More specifically, we aimed to:

1. Understand individual's experience of alcohol related harm in Bristol;
2. Gain an understanding of citizen's knowledge of and attitude to alcohol;
3. Understand the acceptability of drinking behaviour among different groups;
4. Gain the views of the local communities on strategies to address the problems caused by alcohol, and
5. Get people talking about alcohol.

The majority of responses were captured by the online survey site. A variety of other opportunities for participation in the Debate were also provided, especially in localities with diverse and disadvantaged communities in order to engage these communities in thinking and talking about their relationship with alcohol and encourage them to complete the survey to ensure representativeness of responses.

Data from the online survey (Appendix 1) and focus groups (Appendix 6) will be used to support the Alcohol Strategy and future intervention work by the Public Health team.

3. METHODS

The initiative involved a variety of techniques to involve people in thinking and talking about alcohol. These include an online survey, a Twitter campaign and direct community engagement.

3.1 Survey

The survey (see Appendix 3) comprised of 16 questions developed by the Alcohol Strategy Workstream 1 group. It was made available to the public on the council's website and to ensure accessibility, it was also made available in paper format. 1,000 paper copies were made available to libraries, pharmacies and community centres. The link to the online questionnaire was circulated by Public Health and the council's Public Relations team to local organisations and stakeholders and advertised on the Council's internet and intranet sites. The debate was also promoted on Bristol's Customer Service Points TV screens, advertised to members of the Bristol Citizens' Panel, (a representative panel of 2,000 Bristol citizens), Ask Bristol (the Council's consultation hub) and promoted on BCFM, a community radio station. Posters were circulated and displayed in community venues and 1,000 drinks coasters with the Big Drink Debate logo and URL for the survey were distributed to community venues, bars and pubs.

Sample size

The Big Drink Debate's aims were wider than just the production of survey responses, but the survey was a large part of the initiative and was helpful in achieving the aim of getting people talking about alcohol and their relationship with it.

Initially, planning discussions identified an aspiration of being able to compare responses from different wards of Bristol to identify variation in attitudes and behaviours between them, but we calculated that the numbers of responses required to allow this level of comparative analysis would exceed 33,000.

Using mid 2015 population figures for Bristol¹, we used www.surveymonkey.com/mp/sample-size-calculator to calculate the number of responses required to enable us to make statements about the population of Bristol, (see Appendix 2: Sample size calculations). This produced a target figure of 1,065 which would enable us to make statements within a 3% margin of error and at 95% confidence level.

Stratifying the sample

In an attempt to control and understand the bias to which surveys of this kind are subject and to help ensure the sample is truly representative of the Bristol population, we stratified the sample by age, ethnicity and employment status. In all

¹ www.bristol.gov.uk/documents/20182/33904/Population+of+Bristol+July+2016/858ff3e1-a9ca-4632-9f53-c49b8c697c8c

cases, the sample sizes necessary to enable comparison within the layers within each sub-population (comparison between attitudes of different age groups for example) were beyond the maximum response rate we could sensibly envisage, so we did not design the survey to enable us to compare with statistical confidence the attitudes of (for example) employed vs self-employed people or (for example) the different levels of consumption of alcohol between the different age groups in the sample. We have included some discussion about differences that are apparent from the responses, but these comments should be viewed with caution.

Incentives to respond

We incentivised participation in the survey with the offer of entry into a prize draw for all those completing the survey. The prizes were three shopping vouchers for exchange at Cabot Circus, (the largest City Centre Shopping Mall) valued at £100, £75 and £50.

How representative is the sample?

Assuming the population of Bristol is homogenous, within the specified confidence intervals and margin of error the 1,065 sample is sufficiently large to be representative of Bristol's tenants and residents. But the population is not homogenous and the stratification we employed in an attempt to account for the variation in ethnicity, age and employment status was only partly successful. Our analysis of the responses shows that young people, the self-employed and men are under-represented and employees, women and people aged 25-49 are over-represented in our sample. And not all questions were answered by all 1,066 people who returned the survey. This will increase the margin of error.

We did not randomise the sample of individuals from whom we sought a response from within each strata. Bias will have arisen in various ways which should be considered when reading the results. Selection bias arose due to the way in which the electronic links to the Survey Monkey site (which hosted the survey) were circulated. This led to 72% of respondents were fulltime or part-time employed. It is likely that Bristol's largest employers, the NHS and local authority accounted for a disproportionately large number of the employed respondents because of the subject matter and the fact that the survey was designed and promoted by the local authority.

Recall bias is a common problem with self-reporting and alcohol consumption is known to suffer from this problem because people find it difficult to recall accurately the volume and frequency of their drinking and may in some cases be reluctant to personally acknowledge and / or report their level of consumption. Evidence shows surveys typically produce underestimates of alcohol consumption of approximately 40-50%².

The survey as presented was clearly not impartial on the subject of alcohol consumption. The association with 'public health' and the discussion of 'harm' and

² www.ncbi.nlm.nih.gov/pubmed/25486405

ways to minimise the harm caused by drinking will have created a tendency for some responders to answer in ways that they believe the questioner is hoping for, or which are socially acceptable.

The significance of these effects will vary depending on the questions and issues at stake, but they do limit the statements we can make based only on these results.

3.2 Twitter

A Public Health Twitter account was opened to assist the debate with the hashtag, #bristoldrinkdebate to categorise the Tweets. The Twitter account was advertised on all promotional materials and at events and presentations. Tweets were posted weekly to prompt debate and promote the survey. We encouraged discussions around alcohol by posing questions or suggesting new interventions to reducing harm from drinking in Bristol. Some were controversial to instigate debate (Appendix 4). The account was also used to promote Dry January 2017 and share alcohol related articles which were published during the consultation period.

3.3 Community outreach

To promote the debate and to engage with parts of our community that may not appreciate online survey forms or social media we visited community centres and groups across Bristol (Appendix 5). Promotional materials, paper copies of the surveys, demonstration models and other materials to promote the new Chief Medical Officer's guidelines and Dry January 2017 were displayed and given out.



3.4 Focus Groups

To add to the sample, we engaged with over 300 members of the public face-to-face in focus groups and community engagement activities. Focus groups were used to complement the debate, to ensure we engaged all parts of Bristol and to help generate concepts to supplement the material gathered from the surveys and Twitter. Seven Focus Groups / Group Discussions were held (Appendix 6). Groups were run in areas of high deprivation, with young people, older people and with BME

communities. As we collected comments from participants, a number of ideas and concepts emerged repeatedly from the discussions and these are presented in section 4.5 below.

4. RESULTS

The survey generated 1,642 responses. All responses from outside Bristol and where the postcode was unknown were removed. Partial postcodes were included, if we could definitely identify the entry as being within the Bristol City Council area.

Table 1: Number of responses

Total number of responses	1645
Ward Identified (Full Postcode)	910
Bristol (Partial Postcode)	156
Responses from outside Bristol	317
Postcode withheld	262
Sample	1066

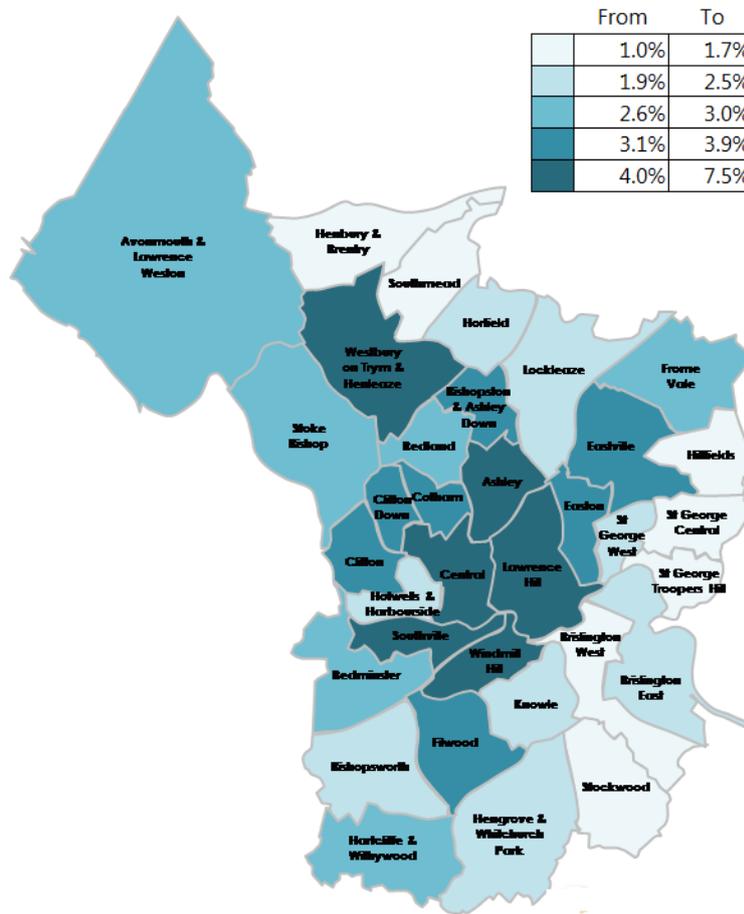
The target number of responses (1,065) was achieved, enabling us to make statements about the population of Bristol. These statements must be read in the light of the qualitative aspects of the sample, (see 3.1 above).

4.1 Where the responses were from

The debate attracted interest from residents across Bristol, with each ward represented to some degree. Map 1 demonstrates distribution of replies.

Map 1: Responses to survey by Ward of residence.

The mapping application used split the wards into 5 equal membership quintiles, each with 20% of the wards in them. This range is more precise, i.e. the colours reflect a true absolute range of values, the quintiles tend to make it easier to differentiate the wards in terms of higher and lower, while not being so influenced by extreme values at either end of the scale.



4.2 Who the responses were from

Demographic details of respondents are included in Appendix 1.

4.2.1 Gender

The population of Bristol is split almost exactly 50/50 by gender, meaning our sample slightly over represents the views of females, who comprise 55% of our respondents.

Table 2: Gender of respondents

Male	434 (41.85%)
Female	568 (54.77%)
Prefer not to say	35 (3.38%)

4.2.2 Ethnicity

79% of our respondents were White British, which is almost exactly the proportion of White British in the population of Bristol, (78%).

There is a minor overrepresentation of people who are not White British in our sample. This is likely to be due to specific outreach work done with inner city communities. Initially responses from the Black / African / Caribbean / Black British communities were too low and we worked with Public Health teams based in the inner city that had good links with these communities to raise the response rate.

4.2.3 Age

Our responses are not representative of Bristolian tenants and residents by age. They over-represent the views of people aged between 25 and 49, who comprised 54.6% of our sample but only 38% of the population. The views of people aged under 25 are under-represented. This is perhaps understandable given the differences in legal status with respect to alcohol purchase and consumption, but is nevertheless a bias in the sample that has to be noted.

4.2.4 Economic status

Our sample is over-represents the views of the employed and unemployed and slightly under-represents the views of the self-employed.

Table 3: Responses by economic status

	Target number of responses	Actual number of responses
Unemployed	31(2.9%)	39 (3.71%)
Self employed	82 (7.7%)	60 (5.7%)
Employees	466 (43.8%)	772 (72.4%)

4.3 What the respondents said

We have presented the results at Appendix 1 and in sections 4.3.1 to 4.3.10 we have highlighted some of the responses.

4.3.1 How much do people drink?

We asked: “How many units of alcohol do you consume when you are drinking?” and “How many units of alcohol were drunk on a weekday and at weekends”?

Results are shown in Table 5.

Table 4: How many units of alcohol do you consume?

n=907		Answered	893 (98.46%)
	Week Day	Weekend	
	Response Total	Response Total	
1-2	329 (36.84%)	195 (21.84%)	
3-4	205 (22.96%)	220 (24.64%)	
5-6	80 (8.96%)	198 (22.17%)	
7-9	34 (3.81%)	154 (17.24%)	
10+	22 (2.46%)	130 (14.56%)	

The highest response to this question was from age group 30-39 (23.35%). Age ranges up to 29 reported similar drinking levels. From age 30 onwards, levels of reported drinking start to lower at weekends as demonstrated in Table 5: Units consumed when drinking.

Table 5: Units consumed when drinking

Age Range	Highest % of units reported	
	Weekday	Weekend
18-24	1-2 Units (36.9%)	5-6 Units (26.19%)
25-29	1-2 Units (36.11%)	5-6 Units (27.78%)
30-39	1-2 Units (43.4%)	3-4 Units (26.41%)
40-49	1-2 Units (28.9%)	3-4 Units (18.48%)
50-59	1-2 Units (33.52%)	1-2 Units (27.37%)
60+	1-2 Units (33.64%)	1-2 Units (34.55%)

The majority of participants reported they drink within Chief Medical Officer Guidelines; consumption reported was 1-2 units on a Weekday (36.84%) and 3-4 units (24.64%) at the weekend. However over 15% reported drinking above CMO guidelines during the week, over 14 units per week. The percentage rose to over 54% at weekends.

We also asked, “Why do you drink?”. The highest response to this question was, “To socialise” (82.76%) as their reason to drink.

To gain an understanding of citizen’s attitude of alcohol and compare the drinking behaviour among different groups, we compared reported drinking levels of the genders. We found they didn’t noticeably differ during the week. However Men reported drinking slightly more than women at weekends, where on average women reported 3-4 units and men reported drinking 5-6 units.

Qualitative assessment of the responses indicate that generally, those who are concerned less about the impact of drinking in Bristol are consuming more.

4.3.2 How often do people drink?

We asked: “How often do you have an alcoholic drink?”

Frequency	Response (Number and %)
Never	159 (15.04%)
Monthly or less	134 (12.68%)
2-4 times per month	231 (21.85%)
2-4 times per week	400 (37.84%)
5+ times per week	133 (12.58%)
No answer	9 (0.8%)
Total	1057 (99.1%)

The sample answering this question (1057) gives a 4% margin of error at a 95% confidence level. This means that if we asked the same question to the same number of Bristol tenants and residents 100 times, 95 times their answers would tell us that between 11% and 19% of people never drink. The five times the answers lie outside this range will be due to random chance.

The age range 40-49 had the highest percentage of those reporting they do not drink.

48% of our respondents drink once a week or less. Approximately the same proportion drink more than twice a week.

4.3.3 Where do you prefer to drink?

We asked: “Where do you prefer to drink?”

Overwhelmingly, the two most commonly reported locations were ‘at home’ (91%) and in a ‘pub / bar’ (94%).

This result provides useful guidance for targeting our future work and interventions to help influence drinking patterns and behaviour.

4.3.4 Where is it acceptable to be drunk?

We asked: “Where do you think it is acceptable to be drunk, to the extent of losing control of one’s behaviour or faculties?”

70% of our respondents thought that it is not acceptable to be out of control due to alcohol anywhere. Applied to the population of Bristol it may be an overestimate given the over-representation of older people and underrepresentation of younger people in the sample.

There were differences in the attitudes to being drunk between the genders (see Table 6).

Table 6: Acceptability of being drunk

% that responded "Not acceptable anywhere"		
All responses	Male	Female
70.03%	59.53%	73.4%

4.3.5 Is drinking a problem in Bristol?

We asked: *Do you think drinking is a problem in Bristol?* and the responses are presented in Table 7.

Table 7: Do you think drinking is a problem in Bristol?

Answered by 1054 (98.87%)	
Is drinking a problem in Bristol?	Number (%)
Yes	557 (52.85%)
No	251 (23.81%)
Don't Know	241 (23.34%)

Responses to this question were assessed to explore the association between whether respondents believed Bristol had a drinking problem and their drinking behaviour. The numbers of responses are insufficient to calculate robust association, but it appears that the frequency with which people drink is unaffected by their view of whether Bristol has a drink problem or not and *vice versa*. However, those that do not think drinking is a problem in Bristol reported higher levels of drinking at weekends. Comparing other responses, those that thought there was a drinking problem in Bristol were also likely to agree that alcohol should be less visible in retail outlets and there were too many retail outlets selling alcohol where they live.

The following are examples of the comments made by participants that think drinking is a problem in Bristol.

"The amount of glass (alcohol related) found on the streets of Bristol in the early morning, particularly weekends and is totally unacceptable. It is dangerous for kids and animals in particular."

"Too many very drunk stag and hen parties with public nudity and inflatable dolls/penises even in broad daylight. Harbourside is to be avoided at night, especially but not exclusively at weekends. King Street is a disgrace not just in the evenings, but the following mornings with litter strewn across the street plus food waste and vomit. The licensing needs to be sorted out - it's too much."

"I really don't like going out in the city centre any more. It seems to have got worse over the last 10 years. I've sat on the bus or walked past people who are visiting the city from abroad and overheard horrified conversations about the scenes I've described above."

Respondents that referred to having experience of alcohol issues personally, or with friends or family, were more likely to believe Bristol has a drinking problem. They also reported lower drinking levels and a healthier attitude to alcohol.

Those that confirmed they do not believe drinking is a problem in Bristol were more positive about alcohol. There were still some negative comments about alcohol, but they were more likely to promote drinking “in moderation” or criticise the debate.

“As long as a person's drinking does not negatively influence anyone else they should be allowed to do what they want to.”

“The lines of questioning in this survey appear to be based on the underlying principle that drinking is bad - it only focused on the perceived "negative" effects, what the respondent thought was "unacceptable", what measures would make the respondent reduce", etc - the clear standpoint being that alcohol consumption is a bad thing. Most people drink sensibly and responsibly and in these circumstances, alcohol can be a pleasurable experience without significant side-effects - but the survey fails to address this. I would suggest, for this to genuinely be a "debate", such obvious bias from our Public Health team should be less evident.”

“It is important to recognise the positive health benefits that are provided by a welcoming local community pub, to the mental health of single people who would otherwise have limited opportunities for socialising.”

“Not a problem, there are far more important things to worry about in Bristol.”

4.3.6 Retail of alcohol

We included two questions about the retail of alcohol: “*Do you think there are too many retail outlets that sell alcohol where you live?*” and “*Should alcohol be less visible in retail outlets and only in one section?*”

Table 8: Visibility of alcohol in shops

Alcohol should be less visible in retail outlets and only in one section?	
Answered by 1055 (98.97%)	
Agree	551 (52.23%)
Disagree	362 (34.31%)
Don't Know	142 (13.47%)

Table 9: Too many shops selling alcohol?

Do you think there are too many retail outlets that sell alcohol where you live?	
Answered by 1051 (98.59%)	
Yes	377 (35.87%)
No	575 (54.71%)
Don't Know	99 (9.42%)

The results do not demonstrate a high degree of concern about the availability of alcohol, although this may vary considerable at a local level and between groups of respondents who considered there to be a problem with drinking in Bristol and those who did not. Overall respondents are not convincingly supportive of proposals to reduce the visibility of alcohol in shops where it is sold.

4.3.7 Attitudes to drinking

We asked “*Which of the following situations do you think are acceptable / not acceptable?*”

Hypothetical alcohol-related scenarios were tested for acceptability. All of the scenarios describe level of drinking that are in excess of the UK Chief Medical Officers’ guidelines. Some scenarios were seen as more acceptable than others, indicating how attitudes to alcohol consumption are influenced by more than the quantity of alcohol being consumed.

Table 10: Does situation affect acceptability?

Answered by 1049 (98.4%)			
	Acceptable	Not acceptable	No Opinion
A person in their 20s or 30s drinking a bottle of wine when out with friends.	696 (67.12%)	221 (21.31%)	120 (11.57%)
A man in his 20s or 30s drinking 8 pints of lager or beer when out with friends.	394 (38.03%)	487 (47.01%)	155 (14.96%)
Two couples out for dinner drinking three bottles of wine between them.	583 (56.27%)	319 (30.79%)	134 (12.93%)
A person over 18 regularly drinking two glasses of wine, five nights a week.	402 (38.95%)	467 (45.25%)	163 (15.79%)
A 14 year old having a glass of wine with a family meal	625 (60.44%)	299 (28.92%)	110 (10.64%)
Taking a day off work because of a hangover	54 (5.2%)	922 (88.74%)	63 (6.06%)
Taking a day off school, college or university because of a hangover	67 (6.49%)	902 (87.32%)	64 (6.2%)

4.3.8 What would encourage people to drink less?

We asked: “Which of the following would encourage you to drink less?” and presented the options listed in Question 9, Appendix 1.

The top results are presented in Table 11.

Table 11: What would encourage you to drink less?

Answered by 895 (83.96%)	
Option	Response Total
Change in health status / diagnosed with health condition	618 (69.05%)
To be more healthy	537 (60.00%)
Wanting to lose weight	459 (51.28%)
I don't enjoy it anymore / as much	436 (48.72%)
Became or planning to become pregnant	337 (37.65%)
Financial commitments	278 (31.06%)
Not able to meet family commitments / responsibilities	230 (25.7%)
Impact on pastimes and recreation / sports commitments	218 (24.36%)
Not able to meet work / study commitments	213 (23.8%)

The fact that 'Wanting to lose weight' is listed as the third most encouraging factor (and by over half of the respondents) is notable, given the low profile that calorific content of alcoholic drinks is afforded by marketing and branding materials. This response might be explained in a number of ways: awareness of the calorific content of alcohol might already be high; the concern might also be explained by a perception that consuming alcohol has an adverse impact on weight loss activities that burn calories; the respondents may be reflecting a generic concern about their weight in their responses to this question and drinking may be associated with eating in ways that tend towards weight gain.

We asked "*Do you think that information on the number of calories contained in an alcoholic drink would influence the amount you drink?*" 57% of respondents replied "no" with 35% saying "yes" and 7% "don't know". The "no's" included those who do not drink at all.

Considering these two questions, it seems likely that linking alcohol consumption with weight gain will influence the choices of a substantial proportion (between c. 30-50%) of the population.

The high profile of 'financial commitments' suggests that further price increases may provide encouragement to reduce consumption.

4.3.9 What worries people about drinking

We asked: "*Have you ever worried about any of the following?*" and listed a number of possibilities asking individuals to rank the frequency with which they worried about the factor from 'never' to 'all the time' on a sliding scale from 1-5. 907 people answered this question and the percentages reported below are of this number.

The factor generating the highest number of 'all the time' responses was 'Costs to the NHS' at 40.3%. We should be cautious of this result, as stated above due to the nature of circulation of the online survey we believe a large number of responses are from NHS staff. 366 respondents worried about this at a level of 4-5. The next most frequent concerns were "Children and young people drinking in parks or on street corners" and "People being drunk and rowdy in public" (for both, 31% worried with 4-5 level of frequency). "Drinking alcohol will make me put on weight" was the next most frequent worry. 29.8% of people worried 'all the time' or at level 4 about putting on weight. Respondents expressed the lowest levels of concern about "The negative impact on my job" and "The negative impact on my friends and family", for which 84% and 77% of responses were 1's and 2's.

4.3.10 Other comments about alcohol.

We asked "*Do you have any other comments you'd like to make about alcohol?*"

We received 340 other comments, the comments can be categorised under the following themes.

- Social context / Alcohol / drinking is a social norm
- Licensing/Legislation is required

- Pricing/Minimum pricing
- Negative Personal or Family History
- Binge Drinking / Anti-social behaviour is a problem
- More Education needed is necessary
- Comment about the impact on NHS/Services
- Referred to alcohol as a drug

The following are examples of comments received, which demonstrate common attitudes to social acceptability, availability of alcohol, experiences of alcohol issues and legislation.

Social context / Alcohol / drinking is a social norm

“Our society makes (heavy) drinking seem attractive, socially acceptable and the only way to have a good time. People who do things they shouldn't because of drink are seen as funny, heroes or are let off the hook because they were drinking. People who don't drink are treated as strange killjoys.”

“It has become socially acceptable to become a social alcoholic in this country, in fact almost a national duty to become one. This must stop, through the education of young people, that the long term effects of alcohol are not attractive big or clever.”

Licensing/Legislation is required

“Too many licenced venues, too close together. Overlong opening hour and too many sales promotions in supermarkets and retail 'outlets'.”

“I think that we should reduce the number of 24 hour licensing, maybe make licensed premises in Bristol pay towards policing and clean up.”

Pricing/Minimum pricing

“Bad cheap alcohol should be less readily available - make it difficult for 'budget booze ' type shops to become established”

“Minimum unit pricing is a proven and effective strategy for reducing alcohol relate harm. It has the greatest impact on those who currently consume amounts of alcohol that are detrimental to their health and wellbeing. It has been shown to save lives and should be introduced without further delay.”

Negative Personal or Family History

“I was brought up with one alcoholic parent. It is important young people are taught about the negative impacts of all drugs - smoking, drinking and healthy eating - as a package! However, we are a university city and there is only so much the council can do in isolation. I also disagree with punishing respectable drinkers because of the behaviour of a minority (the prohibition did not work, neither will hiding alcohol in shops.) issues with alcohol in the UK, are predominately a UK issue. In Europe, alcohol abuse exists but is less prevalent - due to culture.”

“My family history of alcoholism has a big effect on my own relationship with alcohol. Their openness about it is a part of that.”

Binge Drinking / Anti-social behaviour is a problem

“The white British culture historically has not encouraged responsible drinking as children grow up, as on the continent, therefore teenagers start to binge as soon as they are aware of it. The behaviour of young people in town centres all over the country, drunk and making the areas they are in unpleasant for others who may be out for dinner or other activities, is unacceptable.”

“A distinction needs to be made between safe "normal" drinking practice and excessive/anti-social drinking. It is the latter which is so destructive and society needs to be made to understand what is "normal" compared with when drinking gets out of control and develops into a bad habit. I spend a lot of time in France. Binge drinking and drinking to excess is very rare there (although it appears to be on a slight upwards trend), yet most people drink wine with their meals. The distinction between the 2 drinking "situations" is very clear in France.”

More Education needed is necessary

“More education about alcohol and the affects it has on physical and mental health, needs to be provided as young people reach adolescence and the positive and negative effects of alcohol so that young people can make up their own minds about how they want to live, the impression they want to give out and the effects on their health.”

“It has become socially acceptable to become a social alcoholic in this country, in fact almost a national duty to become one. This must stop, through the education of young people, that the long term effects of alcohol are not attractive big or clever.”

Comment about the impact on NHS/Services

“I find it shocking how much the NHS has to spend its time and funds on alcohol-related treatments. While I think it's right they do so if necessary, I'd support higher taxes on alcohol to go towards this.”

“Alcohol consumption is out of hand (and I'm someone who has enjoyed drinking in her lifetime), and causes untold damage to individuals, communities, costing NHS, police etc. too much time and money.”

Referred to alcohol as a drug

“Alcohol is seen as an accepted drug in society, but it can result in worrying issues.”

“Alcohol should be band it is a legal drug and it wrecks peoples and family lives 3 men in my family were alcoholics - and all they care about is were the next drink is coming from not there family's like they should ”

4.4 #bristoldrinkdebate

A Twitter account was set up to support the debate and we gained over 100 followers during the course of the debate. The account was more likely to be followed by organisations than individuals. The number of followers was relatively low; but some of those that did follow us in turn had thousands of followers. They supported the debate by re-tweeting our tweets and encouraging their followers to participate.

Twitter became a successful way of directing participants to the online survey. 10.6% of respondents came from Twitter or social media. It was the 4th highest way respondents stated where they had heard about the online survey. Appendix 1 includes a table of how all respondents found the survey.

We posted weekly tweets to encourage discussions around alcohol, by posing questions or suggesting new interventions to reduce harm from drinking in Bristol. Twitter followers were generally not enticed by these tweets; we didn't see very much debate online.

4.5 Focus Group Feedback

We used formal and informal focus groups to help generate concepts to complement the data gathered from the surveys and Twitter. Appendix 6 gives further details of the groups we ran. Nearly 100 Bristol residents were directly involved in this way. Staff mainly attended existing meetings to run sessions, it was found to be more efficient and beneficial to attend established groups rather go through the lengthy process of recruiting individuals to participate. The following themes developed.

- Alcohol is socially acceptable

Many participants highlighted how socially acceptable they considered heavy drinking and public drunkenness to be.

- The British drinking culture/Europe

Many participants compared British drinking culture to drinking on the continent, believing it would be better if we adopted a similar culture in this country to resolve some of the issues caused by alcohol.

- Street drinking and antisocial behaviour

All groups voiced concern about antisocial behaviour caused by alcohol. In particular groups based in Stapleton Road and Avonmouth were concerned about how street drinking was affecting their neighbourhoods. We found there was a difference in the type of public drinking and antisocial behaviour. Participants from Stapleton Road complained about drunken behaviour, violence and crime. However in Avonmouth, their concerns were about excess noise and litter caused in public parks. The people drinking in public spaces in Avonmouth were identified as Eastern European shift workers gathering at the end of their working day to socialise and drink. Stapleton Road street drinkers were described as marginally housed or homeless, with alcohol and other substance dependence.

- Other comments, which were repeated at focus groups
 - Alcohol is fine, as long as it is in moderation
 - Alcohol is too easily to obtain
 - Alcohol shouldn't be available 24/7
 - Alcohol is too cheap
 - Alcohol is the main social lubricant in our society, but what are the alternatives for socialising, especially for men?
 - Lack of community and social support is exacerbating issues.
 - Closure of Public Houses is causing people to drink more at home, behind closed doors.
- Younger person's groups

We held very informal focus groups at two youth groups; it was felt the survey may not be entirely appropriate to under 18's. Additional questions were devised using the Key Stages 3/4 resource pack to supplement discussions with these groups.

We asked the participants to Agree or Disagree with the following statements:

- Everybody drinks alcohol.
- Drinking alcohol makes you look cool.
- Less younger people are drinking alcohol.
- A party's no good without alcohol.
- There's no point in drinking, unless it's to get drunk.
- It's OK for 'boys' / 'girls' to get drunk.
- The more you can drink the more respect you get from others.
- There are no consequences to getting drunk.
- You should always look after your mates when they are drunk.

Overwhelmingly the views expressed by the youth groups were that "everybody drinks alcohol" and they noted that alcohol wasn't hard to obtain for underage drinkers. Many explained how their parents purchased alcohol for them; it was described as a form of harm reduction. The parents would buy them alcohol so they knew what their children were drinking and it wasn't stronger drinks.

There was no noticeable difference in attitude between the genders, both boys and girls drank to get drunk and have a good time.

We found generally that knowledge of alcohol was very varied. Those with a mature outlook had discussed alcohol with their parents. Whilst others had no understanding of the health impacts of alcohol or that alcohol had calories.

Generally, attitudes towards alcohol were hedonistic with no concern for any consequences. But participants were very open to discussing the issues and why Public Health is promoting low-risk drinking.

5. DISCUSSION

The Big Drink debate had 5 aims. The extent to which each aim was met has been varied.

1. Understand individual's experience of alcohol related harm in Bristol.

The survey results gave us some insight into what people living in Bristol think about alcohol and alcohol use. The strength of the conclusions we can draw is tempered by the nature of the survey and the analysis that has been possible on the responses. The work with individuals who gave us their views through the focus groups and the survey has provided a colourful snapshot from those individuals who chose to participate.

The survey and engagement exercise covered a much wider field than just alcohol related harm, but has highlighted that just over half of respondents thought that Bristol 'has a drink problem'.

Respondents focused on the night time economy and the anti-social behaviour rather than the impact on an individual's health.

2. Gain an understanding of citizen's attitude to alcohol.

The questions allowed us to elaborate on Bristol's attitude to drinking and drunkenness.

The proportion stating they thought that 'drinking is a problem in Bristol' was potentially quite concerning, given that only just over half (52%) thought that it was. With 23% answering 'don't know', there appears to be a case for raising awareness of the negative impacts that alcohol is having.

A number of people referred to the "European" way of drinking as being appropriate. This does not take into account the health harms associated with alcohol.

Over 60% of respondents said it was acceptable for a 14 year to have alcohol with their meal.

From focus group and survey work we have found that concerns about alcohol's impact on healthcare services are a significant concern. Prior to the survey, the assumption was that in Bristol more people would have expressed concern about impacts on individual health and reductions in quality of life and ultimately life expectancy. While it is possible that respondents to this question conflated individual health impacts with impact on the NHS, concern about wider societal impacts was also reflected in the response to the question about acceptability of drinking in different scenarios. Responses established that the least acceptable of the scenarios was taking time off work, school, college or university as a result of drinking too much, irrespective of the quantity consumed. Therefore it may be that focussing future campaigns on wider social impacts will have an impact on people's attitude to drinking. For this to be true, we would have to assume that people who reported being concerned about social impacts are also drinking at harmful levels and we would need to explain why "The negative impact on my job" and "The negative impact on my friends and family", were the 'worries' people thought about with the lowest frequency.

3. Understanding the acceptability of drinking behaviour among different groups.

The sample is not large enough to draw conclusions about variation between specific groups, however our analysis found some interesting comparisons. The Debate enabled us to divide the sample into two groups, based on their beliefs whether Bristol has a drink problem or not.

Responses to this question were analysed to see if would demonstrate a difference in attitudes to alcohol in Bristol. We explored the association between whether respondents believed Bristol had a drinking problem and their responses to other questions.

Comparing responses, what stood out most was that those that believe there is a problem tended to agree that there are too many retail outlets that sell alcohol where there live and alcohol should be less visible in retail outlets and only in one section.

Comparing genders, females were more likely to state there is a problem. We looked at other comments to see if we could gain insight into why they would think this. The majority of the comments criticised how socially or culturally acceptable drinking and drunken behaviour is and challenged attitudes towards excessive alcohol consumption. The comments were also more likely to describe negative personal or family experiences of alcohol.

4. Gain the views of the local communities on strategies to address the problems caused by alcohol.

The Big Drink Debate provided some useful reflections on strategies to address alcohol problems. Regarding restriction of supply, the survey revealed that a low proportion of respondents (36%) believed that there were too many alcohol outlets locally. More people supported the idea of restricting the visibility of alcohol where it is sold.

One of the leading responses to the question about 'what would encourage you to drink less' related to financial considerations. This indicates that Bristol does not appear to be different from the country as a whole in so far as alcohol pricing is considered to be an effective means to restrict demand.

The survey did not invite comments on early intervention and treatment services.

5. To get people talking about alcohol.

Nearly 2,000 people were directly involved in the Big Drink Debate through the survey, focus groups and by visiting stalls at outreach events.

While the "Twitterstorm" we hoped to stimulate did not materialise to the degree that we had hoped, around 100 people became followers of #bristoldrinkdebate.

The press coverage that the debate generated will have reached a large but unquantifiable number of people in Bristol and beyond.

6. RECOMMENDATIONS

Public health campaigns

- Ensure local public health campaigns to reflect the issues identified in this debate and evidence based guidance. This could include focusing on health impact of alcohol and weight gain
- Consider communicating the fact that nearly half of the population on average drink no more than once a week. This will help re-normalise low levels of drinking and challenge erroneous perceptions that the majority are drinking a lot of alcohol frequently.
- Target interventions and campaigns at the at risk groups such as men
- Develop ways of further engagement with the public so there is a continuous debate about the issues linked to alcohol consumption. Include people who do not live but study and work in the City.

Community safety

- Public health to work with licensing to explore how to work with licensed premises to encourage alcohol free drinks and tailored evidence based interventions.
- Continue partnership with organisations to reduce the impact on quality of life of anti-social behaviour caused by drinking

Further research

- Explore the possibility of a larger sample to enable more detailed analysis to be completed
- Gain an understanding of the attitudes of children and young people.

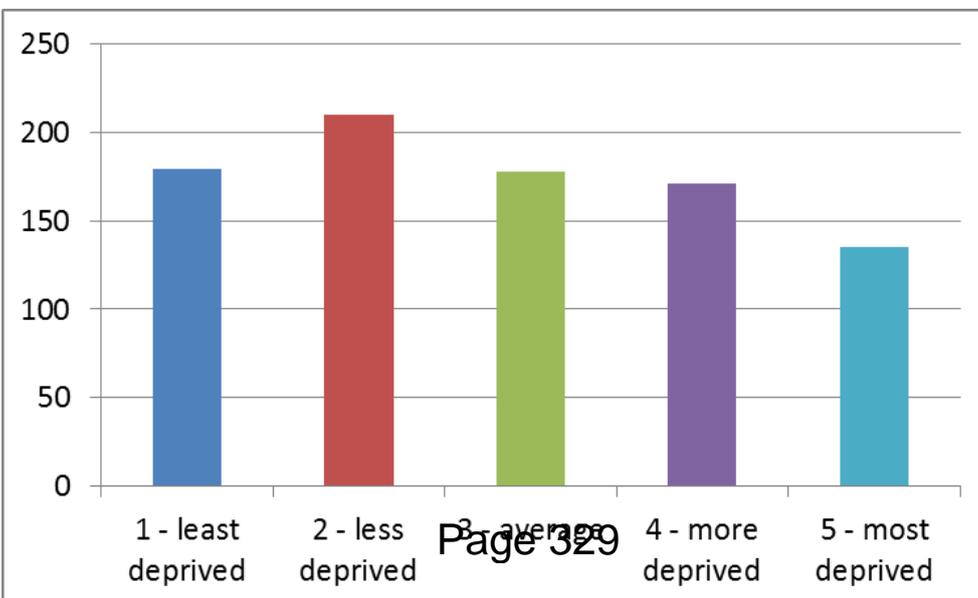
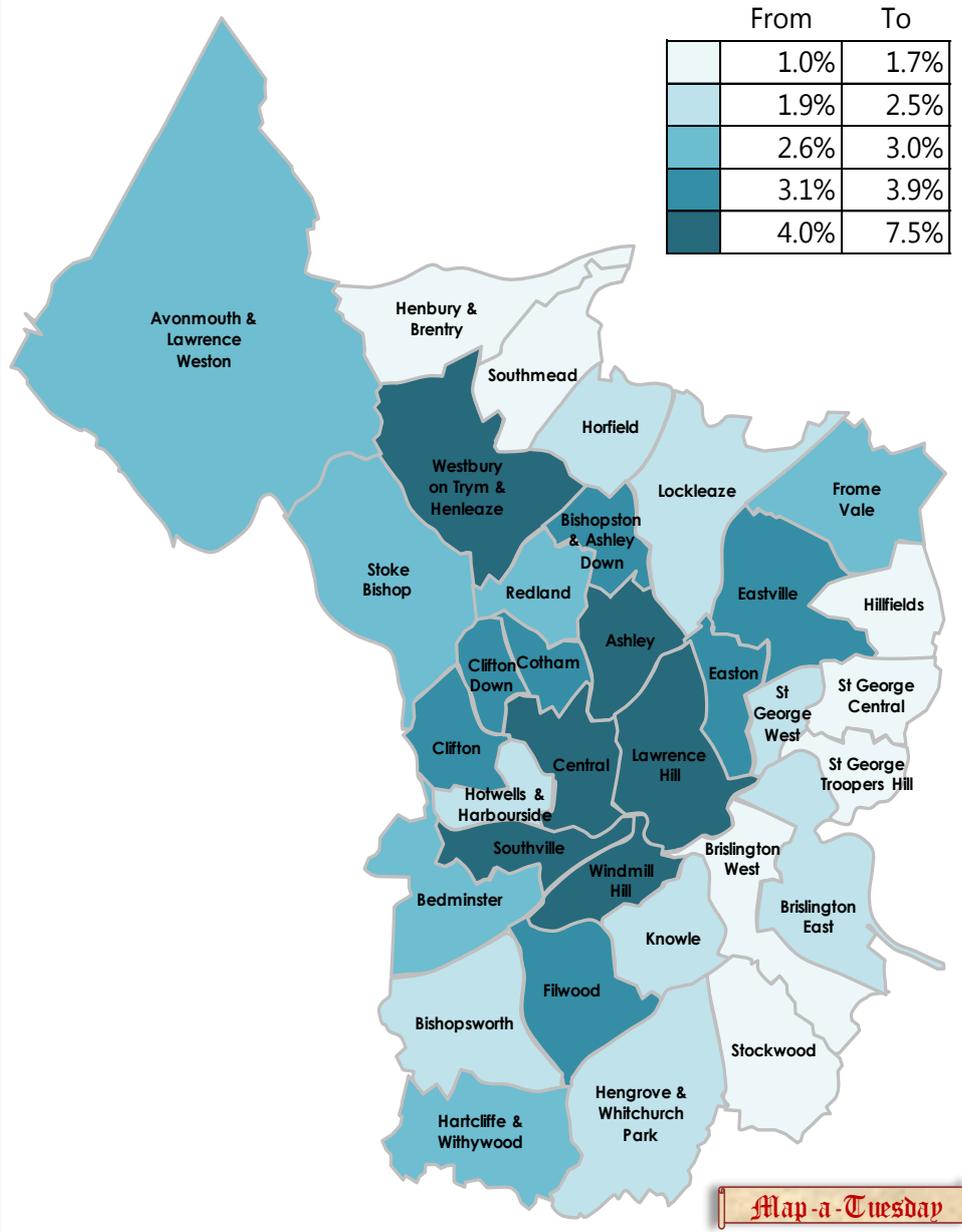
Appendix 1: Data

Results from the survey

The survey generated 1642 responses. The data was filtered to ensure presentation of the attitudes of Bristol residents. Using all postcode information provided, all entries from outside Bristol and where the postcode was withheld were removed from the data file. Partial postcodes were included, if they could be definitely identified as being from within the Bristol City Council area.

Total number of responses	1642
Ward Identified (Full Postcode)	910
Bristol (Partial Postcode)	156
Postcode withheld	317
Responses from outside Bristol	262
Sample	1066

Responses to survey by ward of residence (% of all responses with postcode that can be matched to a Bristol ward of residence, n = 896)



1. How often do you have an alcoholic drink?		
n=1066	Answered	1057 (99.15%)
		Response Total
Never		159 (15.04%)
Monthly or less		134 (12.68%)
2-4 times per month		231 (21.85%)
2-4 times per week		400 (37.84%)
5+ times per week		133 (12.58%)

2. How many units of alcohol do you consume when you are drinking?		
n=907 (1066-159 Never)	Answered	893 (98.46%)
	Week Day	Weekend
	Response Total	Response Total
1-2	329 (36.84%)	195 (21.84%)
3-4	205 (22.96%)	220 (24.64%)
5-6	80 (8.96%)	198 (22.17%)
7-9	34 (3.81%)	154 (17.24%)
10+	22 (2.46%)	130 (14.56%)

3. Where do you prefer to drink? (Tick all that apply)		
n=907 (1066-159 Never)	Answered	748 (82.47%)
		Response Total
Pub / bar		701 (93.72%)
At home		684 (91.44%)
Friend's house		459 (61.36%)
Café or restaurant		458 (61.23%)
Relative's house		213 (28.48%)
Dance club / nightclub		176 (23.53%)
Sports club		40 (5.35%)
Out and about (on the street, parks, malls, etc.)		36 (4.81%)
At work		11 (1.47%)
Don't know		0
Other: 25 (3.34%)		

4. Why do you drink? (Tick all that apply)		
n=907 (1066-159 Never)	Answered	905 (99.78%)
		Response Total
To socialise		749 (82.76%)
To relax and unwind		661 (73.04%)
To forget my worries and concerns		135 (14.92%)
To get drunk		118 (13.04%)
To give me confidence		112 (12.38%)
Because of work-related stress		100 (11.05%)
Because all my friends do		80 (8.84%)
To relieve boredom		65 (7.18%)
Because of personal issues (for example, relationships)		53 (5.86%)
Because there's nothing else to do.		27 (2.98%)
Other: 148 (16.35%)		

5. Do you think that information on the number of calories contained in an alcoholic drink would influence the amount you drink?		
n= 908	Answered	896 (98.68%)
Yes		318 (35.49%)
No		513 (57.25%)
Don't Know		65 (7.25%)

6. Have you ever worried about any of the following? Scale from 1-5, 1 being never, 5 being all the time.					
n= 1066	Answered			907 (85.08%)	
	1	2	3	4	5
The negative effects it could have on my health?	165	221	283	182	49
Drinking alcohol will make me put on weight?	211	191	220	199	72
If I drink too much or too often, I might become dependent?	369	202	165	101	47
The way alcohol affects my behaviour?	257	255	210	120	47
Violence caused by people drinking where you live?	338	220	153	94	77
People being drunk and rowdy in public?	135	208	260	180	106
The costs to the NHS?	150	151	227	214	152
Children and young people drinking in parks or in the street corners?	143	221	231	177	108
Alcohol related litter in my community?	192	247	197	148	99
The negative impact on my job?	606	159	72	26	17
The negative impact on my friends and family?	508	192	93	47	40

7. Which of the following would encourage you to drink less? (Tick all that apply)		
n= 1066	Answered	895 (83.96%)
		Response Total
Change in health status / diagnosed with health condition		618 (69.05%)
To be more healthy		537 (60.00%)
Wanting to lose weight		459 (51.28%)
I don't enjoy it anymore / as much		436 (48.72%)
Became or planning to become pregnant		337 (37.65%)
Financial commitments		278 (31.06%)
Not able to meet family commitments / responsibilities		230 (25.7%)
Impact on pastimes and recreation / sports commitments		218 (24.36%)
Not able to meet work / study commitments		213 (23.8%)
Decided I was too old to drink so much		156 (17.43%)
Encouraged by family or friends		154 (17.21%)
Personal safety reasons		139 (15.53%)
Seen health promotion advertising		58 (6.48%)
Support from my employer		29 (3.24%)
Friends and family are drinking less		25 (2.79%)
Decided I was too young to drink so much		25 (2.79%)
Don't know		28 (3.13%)
Other: 88 (9.83%)		

8. Whose responsibility should it be to introduce children and young people to ideas about a sensible and healthy approach to drinking alcohol? (Tick all that apply)		
n=1066	Answered	1062 (99.62%)
Parents / carers / families		1041 (98.02%)
Schools / colleges		823 (77.5%)
Media/advertising		636 (59.89%)
Health services		613 (57.72%)
Universities		580 (54.61%)
Youth services		531 (50%)
Social services		371 (34.93%)
Friends		328 (30.89%)
Employers/employment services		246 (23.16%)
Other: 40 (3.77%)		

9. Do you think drinking is a problem in Bristol?

n=1066	Answered	1054 (98.87%)
Yes	557 (52.85%)	
No	251 (23.81%)	
Don't Know	246 (23.34%)	

10. Alcohol should be less visible in retail outlets and only in one section?

n=1066	Answered	1055 (98.97%)
Agree	551 (52.23%)	
Disagree	362 (34.31%)	
Don't Know	142 (13.47%)	

11. Do you think there are too many retail outlets that sell alcohol where you live?

n=1066	Answered	1051 (98.59%)
Yes	377 (35.87%)	
No	575 (54.71%)	
Don't Know	99 (9.42%)	

12. Which of the following situations do you think are acceptable / not acceptable?			
n=1066	Answered		1049 (98.4%)
	Acceptable	Not acceptable	No Opinion
A person in their 20s or 30s drinking a bottle of wine when out with friends.	696	221	120
A man in his 20s or 30s drinking 8 pints of lager or beer when out with friends.	394	487	155
Two couples out for dinner drinking three bottles of wine between them.	583	319	134
A person over 18 regularly drinking two glasses of wine, five nights a week.	402	467	163
A 14 year old having a glass of wine with a family meal	625	299	110
Taking a day off work because of a hangover	54	922	63
Taking a day off school, college or university because of a hangover	67	902	64

13. Where do you think it is acceptable to be drunk, to the extent of losing control of one's behaviour or faculties?	
n=1066	Answered 1029 (96.53%)
Not acceptable anywhere	721 (70.07%)
At home	284 (27.6%)
Family member / relative's house	161 (15.65%)
Friend's house	181 (17.59%)
Pub / bar	90 (8.75%)
Café or restaurant	21 (2.04%)
Dance club / nightclub	92 (8.94%)
Sports club	21 (2.04%)
At work	13 (1.26%)
Out and about (on the street, parks, shopping centres, etc.)	24 (2.33%)
Don't know	15 (1.46%)

14. Have you ever had an alcohol related injury or illness that required medical treatment?

n=1066	Answered	1054 (98.87%)
Yes		182 (17.27%)
No		866 (82.16%)
Don't Know		6 (0.6%)

15. Would you feel comfortable challenging a friend or member of your family about their drinking?

n=1066	Answered	1053 (98.78%)
Yes		653 (62.01%)
No		255 (24.22%)
Don't Know		145 (13.77%)

Where did you find out about this survey?		
n=1066	Answered	1036 (97.18%)
Ask Bristol e-bulletin	185 (17.86%)	
Via work	127 (12.26%)	
Word of mouth	114 (11%)	
Social media	109 (10.52%)	
Via Public Health Staff	111 (10.71%)	
Library	53 (5.12%)	
Via Email	44 (4.25%)	
BCC, The Source	43 (4.15%)	
Advertisement	39 (3.76%)	
Bristol City Council Website	36 (3.47%)	
NHS - email circulated	28 (2.7%)	
GP Practice/Health Centre	23 (2.22%)	
Media	22 (2.12%)	
Via Email Footer	17 (1.64%)	
University Email	16 (1.54%)	
Pharmacy	12 (1.16%)	
Voscur	8 (0.77%)	
Bar/Public House	6 (0.58%)	
CAMRA	6 (0.58%)	
Our City email	6 (0.58%)	
UHBristol newsbeat	6 (0.58%)	
BDP	4 (0.39%)	
Citizenspace	3 (0.29%)	
Via Email	22 (2.12%)	
Other	16 (1.54%)	

Demographic Data

What is your gender?		
n=1066	Answered	1037 (97.28%)
Male	434 (41.85%)	
Female	568 (54.77%)	
Prefer not to say	35 (3.37%)	

What is your age group?		
n=1066	Answered	1053 (98.78%)
Under 15	1 (0.09%)	
15-17	7 (0.66%)	
18-24	98 (9.31%)	
25-29	115 (10.92%)	
30-39	244 (23.17%)	
40-49	224 (21.27%)	
50-59	214 (20.32%)	
60 or older	135 (12.82%)	
Prefer not to say	15 (1.42%)	

What is your ethnicity?		
n=1066	Answered	1050 (98.5%)
Asian / Asian British	15 (1.43%)	
Black / African / Caribbean / Black British	44 (4.19%)	
Mixed / multiple ethnic groups	17 (1.62%)	
Other ethnic group	10 (0.95%)	
White British	831 (79.14%)	
White Other	86 (8.19%)	
Prefer not to say	47 (4.48%)	

What is your sexual orientation?		
n=1066	Answered	1036 (97.18%)
Heterosexual	826 (77.48%)	
Lesbian, gay or bisexual	86 (8.07%)	
Prefer not to say	124 (11.63%)	

Are you transgender?		
n=1066	Answered	952 (89.31%)
Yes	4 (0.42%)	
No	871 (91.49%)	
Prefer not to say	77 (8.09%)	

Do you consider yourself to be a disabled person?		
n=1066	Answered	957 (89.77%)
Yes	70 (7.31%)	
No	818 (85.48%)	
Prefer not to say	69 (7.21%)	

Do you have a religion or belief?		
n=1066	Answered	972 (91.18%)
Yes	258 (24.20%)	
No	614 (57.6%)	
Prefer not to say	100 (9.38%)	

Occupation?		
n=1066	Answered	1052 (98.69%)
Employed full-time	600 (57.03%)	
Employed part-time	162 (15.4%)	
Retired	94 (8.94%)	
Self-employed	60 (5.7%)	
In training / education	42 (3.99%)	
Unemployed	39 (3.71%)	
Apprentice	2 (0.19%)	
Other	26 (2.47%)	
Prefer not to say	27 (2.57%)	

Appendix 2: Sample size calculations

Group	Population size	% (and number) required for 1,065 sample to be representative of Bristol	Sample size giving 95% CI and 3% margin of error representative of the group	Sample Method/Strategy
Population of Bristol	449,300	n/a	1065	All
			1065	
Age				
0-15?	83,800	18.6% (198)	1054	Work Children and Young people team. Engage with our Neighbourhood team's
16-24	70,500	15.7% (167)	1052	
25-49	170,500	38% (404)	1061	Engage with our network of groups and individuals.
50-64	65,300	14.5% (154)	1050	
65+	59,300	13.2% (141)	1049	Engage with our network of groups and individuals, including Bristol Older People's Partnership board.
Sample size enabling comparison between age groups			5,266	
Ethnicity				
White British	333,432	78% (830)	1064	Engage with our Neighbourhood team's and network of groups and individuals.
Black African and Black Other inc Somali	19,007	4.4% (47)	1011	
Pakistani	6,863	1.6% (17)	924	
Caribbean	6,727	1.6% (17)	922	
Indian	6,547	1.5% (16)	918	
Chinese	3,886	0.9% (10)	838	
Sample size enabling comparison between ethnic groups listed above			5,667	
Economic activity www.nomisweb.co.uk/reports/lmp/la/1946157348/report.aspx?town=bristol#tabempunemp				
Unemployed	13,400	2.9% (31)	989	Engage with our

Group	Population size	% (and number) required for 1,065 sample to be representative of Bristol	Sample size giving 95% CI and 3% margin of error representative of the group	Sample Method/Strategy
Self employed	34,400	7.7% (82)	1036	Neighbourhood team's and network of groups and individuals.
Employees	196,700	43.8% (466)	1062	
Sample size enabling comparison between employment groups listed			3,087	

Appendix 3: Survey questions

1. How often do you have an alcoholic drink?

- Never (*Jump to question 8*)
- Monthly or less
- 2-4 times per month
- 2-4 times per week
- 5+ times per week

2. How many units of alcohol do you consume when you are drinking?

(One alcohol unit is equal to a single measure of spirit, e.g. whisky (ABV 40%), or a third of a pint of beer or cider (ABV 5-6%) or half a standard (175ml) glass of red wine (ABV 12%))

	Week Day	Weekend
1-2		
3-4		
5-6		
7-9		
10+		

3. Where do you prefer to drink? (Tick all that apply)

- At home
- Relative's house
- Friend's house
- Pub / bar
- Café or restaurant
- Dance club / nightclub
- Sports club
- At work
- Out and about (on the street, parks, malls, etc.)
- Don't know
- Other Please specify:

4. Why do you drink? (Tick all that apply)

- To relax and unwind
- To socialise
- To forget my worries and concerns
- To get drunk
- To relieve boredom
- To give me confidence
- Because all my friends do
- Because of work-related stress
- Because of personal issues (for example, relationships)
- Because there's nothing else to do
- Other Please specify:

5. Do you think that information on the number of calories contained in an alcoholic drink would influence the amount you drink?

- Yes
- No
- Don't Know

6. Have you ever worried about any of the following?

(Never, Sometimes, Always)

- The negative effects it could have on my health
- Drinking alcohol will make me put on weight
- If I drink too much or too often, I might become dependent
- The way alcohol affects my behaviour
- Violence caused by people drinking where you live
- People being drunk and rowdy in public
- The costs to the NHS
- Children and young people drinking in parks or in the street corners
- Alcohol related litter in my community
- The negative impact on my job
- The negative impact on my friends and family

7. Which of the following would encourage you to drink less?

(Tick all that apply)

- Became or planning to become pregnant
- Wanting to lose weight
- Change in health status / diagnosed with health condition
- To be more healthy
- Personal safety reasons
- Friends and family are drinking less
- Decided I was too young to drink so much
- Decided I was too old to drink so much
- Not able to meet family commitments / responsibilities
- Encouraged by family or friends
- Financial commitments (mortgage, car, household expenses, etc.)
- I don't enjoy it anymore / as much
- Impact on pastimes and recreation / sports commitments
- Seen health promotion advertising
- Not able to meet work / study commitments
- Support from my employer
- Don't know
- Other

8. Whose responsibility should it be to introduce children and young people to ideas about a sensible and healthy approach to drinking alcohol? (Tick all that apply)

- Parents / carers / families
- Friends
- Employers/employment services
- Schools / colleges

- Universities
- Youth services
- Health services
- Social services
- Media/advertising
- Other

9. Do you think drinking is a problem in Bristol?

- Yes
- No
- Don't Know

10. Alcohol should be less visible in retail outlets and only in one section.

- Agree
- Disagree
- Don't Know

11. Do you think there are too many retail outlets that sell alcohol where you live?

- Yes
- No
- Don't Know

12. Which of the following situations do you think are acceptable/not acceptable? (Acceptable / Not acceptable / No Opinion)

- A person in their 20s or 30s drinking a bottle of wine when out with friends.
- A man in his 20s or 30s drinking 8 pints of lager or beer when out with friends.
- Two couples out for dinner drinking three bottles of wine between them.
- A person over 18 regularly drinking two glasses of wine, five nights a week.
- A 14 year old having a glass of wine with a family meal.
- Taking a day off work because of a hangover.
- Taking a day off school, college or university because of a hangover.

13. Where do you think it is acceptable to be drunk, to the extent of losing control of one's behaviour or faculties?

- Not acceptable anywhere
- At home
- Family member / relative's house
- Friend's house
- Pub / bar
- Café or restaurant
- Dance club / nightclub
- Sports club
- At work
- Out and about (on the street, parks, shopping centres, etc.)
- Don't know
- Other

14. Have you ever had an alcohol related injury or illness that required medical treatment?

- Yes
- No
- Don't Know

15. Would you feel comfortable challenging a friend or member of your family about their drinking?

- Yes
- No
- Don't Know

Do you have any other comments you'd like to make about alcohol?

Appendix 4: Twitter questions used to prompt debate

01 st October 2016	Public Health Twitter account live
12 th October 2016	Debate Launch Tweet: Do you think Bristol has a problem with alcohol
19 th October 2016	Tweet: Is counting units the easiest way to monitor how much you drink?
26 th October 2016	Tweet: Do you think there should be a minimum unit price for alcohol?
02 nd November 2016	Tweet: Should alcohol advertising on TV and in cinemas be banned?
09 th November 2016	Tweet: Would it be a good idea if alcohol was only sold in standardised plain packaging?
16 th November 2016	Tweet: Should the age that you can buy alcohol be raised from 18 to 21?
23 rd November 2016	Tweet: Do you think all alcohol should carry health warnings, similar to those on cigarettes?
30 th November 2016	Tweet: What if drink companies were banned from sponsoring local public events?
7 th December 2016	Tweet: Should happy hours and special offers on alcohol be banned?
14 th December 2016	Tweet: Is Bristol drinking within national recognised guidelines?
21 st December 2016	Tweet: Is too much alcohol drunk at Christmas?
28 th December 2016	Tweet: How much is "Too Much"?

Appendix 5: List of outreach activities

Stapleton Road

A major thoroughfare in Bristol, it is known for being culturally diverse with varied shops, cafes and restaurants.



Bartonhill Settlement

Barton Hill Settlement provides services, facilities and community development to Barton Hill and surrounding areas of East Bristol.

Easton Community Centre

Easton Community Centre provides facilities and services for people who live or work in Easton, Bristol BS5.

Greenway Centre

Greenway Centre is a local community hub and business centre in north Bristol, in Southmead run by the Southmead Development Trust as a centre for the community, as well as providing business facilities.

Withywood Centre

The Withywood Centre is a multifunctional community asset run by South Bristol Church and Community Trust.

Hartcliffe Health Centre

A family practice situated in Hartcliffe, South Bristol.

Computershare, The Pavilions

A “global financial administration company” with 1000+ staff, based in South Bristol.

Appendix 6: Focus Groups/Group Discussions

Stapleton Road

Members of the community recruited by Inner City Health Champions.

- 8, Male and, 25-49, Asian / Asian British & Black / African / Caribbean / Black British.

Fit and Fab, Knowle West Health Park

A women's support group, based in South Bristol

- 8 members, Female, 30-60, White British.

The Station Youth Hub, Central Bristol

- 14 members and staff. Male and Female, 15-30, White British, Asian / Asian British & Black / African / Caribbean / Black British.

Knitting Group, Avonmouth Community Centre

- 12 members, Female, 40+, White British.

Icon Films

Icon Films is an internationally established production company based in College Green, Bristol.

- Presentation and discussions with 10 Staff.

Knowle West Men's Platform, Men's Breakfast Group

Springfield Allotments, Knowle West

- Informal discussions with group

Hanham Youth Club, Bristol

Hanham Youth Centre is the busiest youth centre in Bristol and South Gloucestershire, with more than 500 young people coming here every week.

- 21 Members, Male & Female, 12-17, White British.

Agree / Disagree Questions for Youth Clubs?

- Everybody drinks alcohol.
- Drinking alcohol makes you look cool.
- Less younger people are drinking alcohol.
- A party's no good without alcohol.
- There's no point in drinking, unless it's to get drunk.
- It's OK for 'boys' / 'girls' to get drunk.
- The more you can drink the more respect you get from others.
- There are no consequences to getting drunk.
- You should always look after your mates when they are drunk.



Bristol Health & Wellbeing Board

Pharmaceutical Needs Assessment Update	
Author, including organisation	Barbara Coleman Public Health Programme Manager, BCC
Date of meeting	16 th August 2017
Report for Information	

1. Purpose of this Paper

The purpose of this briefing is to update the Health & Wellbeing Board on the progress in producing the revised PNA.

2. Executive Summary

The HWB is required to produce a Pharmaceutical Needs Assessment every three years. The purpose of the PNA is to inform commissioners and NHS England of the health needs of the local population and whether there are any gaps or access issues in respect of community pharmacies.

The document is going out to consultation between 4th September and 27th November 2017. The final draft document will be available to members prior to this date.

3. Key risks and Opportunities

Key issues arising from the health needs assessment include:-

- Planned and recent increases in dwellings across Bristol (6,737) and the peripheral area (South Gloucester) – 7,715
- Decrease in numbers of pharmacies since last PNA (1 less in Bristol North and West Locality)
- Increased population levels 437,500 in 2013 to 454,900 in 2017 (increase of 4,000 persons per annum

6. Implications (Financial and Legal if appropriate)

There are no financial or legal implications arising from this report.

7. Evidence informing this report

What evidence have you used to inform:

- Population demography and health needs were derived from the Bristol JSNA (updated 2017)
- Data on opening hours and numbers of pharmacies were provided by NHS England (June 2017)
- Current service provision was provided from NHS England, Bristol CCG and the public health team in Bristol City Council
- Housing developments data were provided from Strategic Planning BCC and South Gloucestershire
- Bristol Citizen's Panel survey
- Young People's Mystery Shopping
- Data on complaints / incidents from Healthwatch and BCC teams

8. Conclusions

A small area of Bristol (Charlton Mead 400n population) falls outside of 1.6m walking distance by 0.4 km. Bristol has 93 pharmacies, 31 in each locality area. There were no gaps identified currently in provision of pharmacies across Bristol and in terms of opening hours. The PNA steering group will be reviewing the information and responses received so far, to be included in the final draft for consultation.

9. Recommendations

Health & Wellbeing Board are asked to note the position. The final report will come to the board for agreement in February 2018, following a full consultation and updated to reflect feedback from key stakeholders.