Health and Wellbeing Board

Agenda

BRISTOL CCG

Date: Wednesday, 25 October 2017

Time: 2.30 pm

Venue: Committee Room 9, First Floor - City Hall, College Green, Bristol, BS1 5TR

Distribution:

Board Members: 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, Dr Steve Davies, Dr Justine Mansfield and Dr Pippa Stables

Copies to: Terry Dafter (Service Director - Care and Support - Adults), Claudette Campbell (Democratic Services Officer), Nancy Rollason (Service Manager Legal) and Sarah Sharland (Legal Officer)

Issued by: Claudette Campbell, Democratic Services
City Hall, College Green Bristol BS1 5TR
Tel: 0117 9222 342
E-mail: democratic.services@bristol.gov.uk
Date: Tuesday, 17 October 2017

Agenda

1. Welcome, Introductions and Safety Information **2.30 pm**

2. Apologies for Absence and Substitutions

3. Declarations of Interest

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

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

4. Minutes of Previous Meeting

To agree the minutes of the previous meeting as a correct record. **(Pages 4 - 16)**

- Note the minutes of the meeting of the 16th August 2017
- Note the minutes of the meeting of the 14th September 2017

5. Public Forum

Up to 30 minutes is allowed, please note Public Forum items **must** be about matters on the Agenda.

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

Questions - Written questions must be received 3 clear working days prior to the meeting. For this meeting, this means that your question(s) must be received in this office at the latest by 5 pm on Thursday 19th October 2017.

Petitions and Statements - Petitions and statements must be received on the working day prior to the meeting. For this meeting this means that your submission must be received in this office at the latest by 12.00 noon on Tuesday 24th October 2017.

6.	**Key Decision - Healthy Weight Strategic Plan - Wendy Parker**	**2.40 pm**
		(Pages 17 - 51)
7.	**Welcoming Refugees and Asylum Seekers Strategy and Needs Assessment - Anne James, Commissioning Manager Refugees**	**2.55 pm**
	To provide input to the Action Plan	**(Pages 52 - 110)**
8.	**Thrive Bristol - Victoria Bleazard, Mental Health and Social Inclusion Programme Manager**	**3.10 pm**
	To consider and agree draft programme	**(Pages 111 - 128)**
9.	**Health Protection Annual Report - Thara Raj Consultant in Public Health**	**3.25 pm**
	To receive the annual report and provide comments	**(Pages 129 - 173)**
10.	**Better Lives, Adult Social Care Transformation Programme**	**3.40 pm**
	To receive a presentation from Stephen Beet, Care & Support Adults, that will update and provide an opportunity for engagement	**(Pages 174 - 175)**

Bristol City Council
Minutes of the Health and Wellbeing Board

16 August 2017 at 2.30 pm

Board Members Present: Mayor Marvin Rees, Dr Martin Jones, John Readman, Julia Ross, Asher Craig, Claire Hiscott, Helen Holland, Vicki Morris, Elaine Flint, Keith Sinclair, Steve Davies, Justine Mansfield and Pippa Stables

Officers in Attendance:-
Sarah Sharland (Legal Officer) and Claudette Campbell (Democratic Services Officer)

1. Welcome, apologies and introductions

- Dr Martin Jones took the Chair welcomed those present and led introductions.
- Apologies were noted from Alison Comley and Becky Polland with Thara Raj attending as her representative.

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

The following were noted:

- Question 1 Judith Brown, Chair Bristol Older People's Forum and Deputy Chair Bristol Ageing Better – Agenda item 10 HWB roundtable discussions update
- Question 2 Viran Patel – Agenda item 7 STP update and Agenda item 8 CCG operational plan
- Statement from BCC Labour Councillors – Agenda item 7 STP update

3. Declarations of interest

None

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

That the minutes of the meeting held on the 28th June 2017 be confirmed as a correct record and signed by the Chair.

5. Key decision - Substance misuse and sexual health services currently delivered in primary care

The Board considered a report on a key decision in relation to substance misuse and sexual health services that are currently delivered in primary care.

Thara Raj, Public Health Consultant (Health Protection and Sexual Health) presented the report on behalf the Director of Public Health. The Board were reassured that the conclusion drawn in the report was based on proper explorative work and the review of services and service providers. The report outlines the modifications to be made in respect of the existing service.

Main points raised / noted:

a. Vicki Morris requested the inclusion, in the performance indicators, the requirement to undertake demographic monitoring about service provision and to note emerging gaps in the community.
b. Dr Stables – supported the decision explaining that as a practitioner, she is aware that patients come with multiply problems. The issue of substance misuse and sexual are often interrelated. Posed a question as to whether the decision could have been considered by the Board at a previous meeting.
    - Members were assured that the decision was held in abeyance to allow the feasibility study to take place and feed into the final decision.
c. GP's working together in clusters would positively impact the delivery of this service.
d. Mayor Rees suggested that services and service providers should work towards an outcome that resulted in a community being given tools to develop the ability to be self-supporting into the future. Suggesting that this outcome should form part of the service provider's key performance indicators.
    - Action: Mayor Rees to meet with Thara Raj.
e. Steve Davies commented that historically South Bristol had issues with GP recruitment and retention. The area is now in a more stable position with the move towards cluster-working, that shares the overall burden of service delivery, they can now look towards improving sexual health care so the report and proposed decision was welcomed.

Having noted and taken account of the above, the Mayor delegated the decision making to Cllr Craig who took the following key decision:

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

contracts to primary care providers; and that delegated authority be given to the Director of Public Health to award the contracts.

6. Better Care Fund and Improved Better Care Fund Plan 2017-19

The Board considered a report providing an overview of the direction of travel for the Better Care Fund in Bristol and which sought delegated authority for the co-chairs to sign-off the final Better Care Bristol plans.

John Readman, Strategic Director People, introduced the report and briefed the Board.

The plan periodical requires updating and a refresh to reflect directions given by government and to stay in line with wider partners developments, such as the STP (Sustainability and Transformation partnership) agreement and the NHS 5 year forward plan together with considering the continuing alignments across the region. The New Improved Better Care Fund now includes proposal for managing additional funds allocated from central government.

Main points raised / noted:

a. Cllr Holland drew the Board's attention to the current 'proud to care' campaign. A theme of the campaign was the recruitment and retention of professionals working in the care industry. The industry suffered a 33.3% turn over. The care sector accounted for 15% of the employment market. This was an opportunity to implement change; to transform services; to manage the bonus of additional funding; being mindful that any money would taper off over 3 years.
b. Cllr Craig was concerned about the potential impact of collaborative working with partners and regional Authorities on Bristol residents. Assurance was sought that the resources earmarked for Bristol would be protected and used for the benefit of its residents. Clarification was sought on how this would be managed.
c. Julia Ross (Chief Executive for BNSSG CCG) assured the Board that Better Care Fund was focussed on Bristol and would be spent in the Bristol area. The work tobe undertaken would consider the wider health needs, identifying gaps and how to fill these. Conversations would be had with neighbouring authorities on how funds were managed and its link to the STP. Meetings had taken place with the leading Chief Executives of the health authorities to share good ideas and note risks to service provision.
d. Dr Martin Jones shared that joint working across regions had resulted in favourable discharge numbers.
e. Dr P Stables commented that with the reorganisation of GP practices in clusters conversations would identify areas where service provision overlapped and then progress towards solutions to support care needs.

f. Action: John Readman invited the Board to contact him direct with any suggestions before the 25th August. This would allow them to be feed into the process before the mid-September deadline.

At the conclusion of the discussion, the Board

RESOLVED:

1. **To note (as per the report) the direction of travel for the Better Care Fund in Bristol.**
2. **To delegate authority to the Board co-chairs to sign off the final Better Care Bristol plans.**

7. BNSSG CCG's Operational Plan 2017-19

The Board considered a report providing an update on progress with the BNSSG CCG Operational Plan 2017-19.

Julia Ross, Chief Executive, BNSSG CCGs presented the report and addressed the Board commenting as follows:

- Acknowledging the challenges that exist for the public sector and its objective to meet the needs of the wider population.
- The aspiration was to enable people to keep well within community settings.
- That the quality of services in Bristol remain good but that there were areas of challenge none more than meeting national waiting times standards.
- A watching brief on staff resource to anticipate any further challenges.
- That the tensions between the short term and long term strategy would be managed.
- The Plan supported the ambition to deliver better care across areas but particularly highlights needs of those with Diabetes, Musculoskeletal frailty, Stokes and respiratory patients.
- Changing how care is delivered via new ways of working such as Cluster based model.
- Acknowledging the advantages of the voluntary sector and the positive contribution from locally delivered services.
- Communication and engagement needs to be transformed improving the way we talk to the local population. Move towards community participation in budget setting. The co-design of services with the community.
- Effort would be made to pool resources and skills & talents to better respond to the wider needs of the community.

Main points raised / noted:

a. Keith Sinclair requested that any work undertaken included primary care professionals and those partners who are expert in care.
b. Mayor Rees commented that in addition to the best quality services to support a healthy population it was essential that policy leaders devised strategies that impacted on the health

service's ability to deliver successfully. Acknowledged the link between failed LA strategies and impact on health. Encourage all to consider how the social needs of society can be met to support the health strategy.

c. Improved communication would result in a greater understanding of health services strategy and to allow development around community needs.

At the conclusion of the discussion, the Board

RESOLVED:

1. **To note the BNSSG Operational Plan 2017-19 together with the above comments.**
2. **That further updates be received as work progresses.**

8. BNSSG STP update

The Board considered a report providing an update on progress with the BNSSG STP.

Robert Woolley, Chief Executive, UHB NHS Foundation Trust presented the report and addressed the Board commenting as follows:

- Noted the general frustrations expressed by Councillors and others in respect of the lack of progress. Agreed that progress in establishing the STP partnership had not been as robust as it was hoped.
- Clarified that the STP Partnership was a partnership of 15 independent statutory bodies created to form a collective vision and coordinate work to move forward that vision. The partnership included the LA regional Officers. The principles of the partnership were sound but progress had been slow.
- Acknowledged the frustration on how the STP was established by closed door NHS initiative. That they had failed to undertake proper public engagement and have yet to meet Health Scrutiny colleagues.
- The STP initiative had been rated 4 and unfortunately the lowest rating across the sector.
- The situation was now more positive with the appointment of Sir Ron Kerr as the Chair and Julia Ross as the Chief Executive across 3 BNSSG CCGs.
- The STP Board had met twice, initially to set up and to monitor progress. The Board is committed to public engagement. Acknowledged the direction of travel of funding for health and social care and are committed to transformation to manage the reduce funds available for service provision. That he reality of the situation and the enormity of the task was not underestimated by the Board.

Main points raised / noted:

a. Elaine Flint requested the inclusion of the voluntary sector whose knowledge gleaned from community engagement would be a valuable source of intelligence for the STP Partnership.

b. Robert Woolley welcomed the offer confirming that they were now in a position to move to wider engagement.
c. Action: Mayor Rees drew attention to Penny Germon's positive work in the community. He invited contact to discuss opportunities for engagement with the local community. Reminded all that Councillors were available to liaise with their communities on issues arising from the work of the STP partnership.
d. Cllr Craig welcomed public engagement, requesting transparency from the partnership in all areas, including decisions where public engagement was not required. Assurances were given that when and where possible, appropriate engagement would be undertaken.

At the conclusion of the discussion, the Board

RESOLVED:

To note the report together with the above comments.

9. Emotional health and wellbeing transformation plan refresh

The Board considered a report on the second draft refresh of the Children and Young People's Emotional Health Transformation Plan.

Rebecca Cross, Children's Health Commissioning Manager presented the report and addressed the Board commenting as follows:

- Drew the Boards attention to the references in the plan that met the nationally required components such as progress in developing Eating Disorder and Crisis Outreach Service; Workforce data; previous year spend and future budget.
- Shared that there had been an increase in the number of children accessing CAMHS.
- Links had been established with schools to engage children at all stages of development. Work continued to pilot access to services out of hours and provide a range of services to support 24/7 service delivery.
- That the Care Quality Commission inspection of children's mental health would take place on the 18th September 2018.

Main points raised / noted:

a. The question was asked how the increase in the numbers of children accessing CAMHS should be viewed.
b. The increase was a combination of improved data collection. The increase in demand followed the promotion of the service. In addition schools are taking steps to better assess children's mental health.

c. Cllr Hiscott viewed the collaborative work with schools, good news and sought clarification on the results.
d. Confirmation was provided that data exist on the effectiveness of the project. Initial observation demonstrated that parents and carers of children felt less stigmatised accessing mental health care via other avenues.
e. Mayor Rees welcomed the work and the report, noting the work being done to review the existing services to integrate and to expand.
f. The figures provided for those failing to attend appointments (DNA) at CAMHS of 6% of those referred, was questioned. The Board was assured work was being done to test the accuracy of that figure.
g. Cllr. Holland reaffirmed the benefits of children's centres and the contribution made in this area by allowing parents to access assistance in a less invasive manner.
h. Members were assured that impact of the funding challenges faced by all health partners would be assessed in relation to the possible jeopardy to families.
i. CQC Thematic Review – The Board were advised that the Inspectors would meet with Martin Jones as representative of the Board.

At the conclusion of the discussion, the Board

RESOLVED:

To note the update report together with the above comments.

Agreed that authority to sign off the final report would be delegated to John Readman Strategic Director People.

10 Health and wellbeing roundtable discussions

The Board considered a report providing an update on the outcomes and developments emerging from the recent health and wellbeing roundtable discussions hosted by the Mayor.

John Readman Strategic Director People presented the report and addressed the Board.

- Section 4 of the Report noted the key themes and actions that had arisen from the workshops.

Mayor Rees commented:

- That the intention was to review the collective offer of Health services and the Authority.
- The intention to identify 'what the City needs'; How to influence the City into better health; Thus positively impacting the financial cost of the Health Authorities in their delivery of service to a Healthy City.
- Reviewing Board membership to ensure the main Health providers are represented.

- Investigating ways to connect political ambitions with health perspective across all the authority's service provision.
- The addition of primary care and secondary care providers would strengthen the work of the Board.

RESOLVED:

To note the update report together with the above comments, and to support the task and finish group that will be taking forward this work.

11 Update - Bristol Community Links service

The Board considered a report providing an update on the current review of in-house day services to adults, known locally as Bristol Community Links service.

Sonia Moore, Chief Executive, Bristol Community Links service presented the report.

Main points raised / noted:

a. The saving of a 3rd of the services budget would result in a tough decision- making process as to the future look of the service provision.
b. The Board members were requested to share knowledge of the consultation with their associated organisations.
c. Dr Stables offered to meet with the project team to provide the GP's perspective.

At the conclusion of the discussion, the Board

RESOLVED:

To note the report together with the above comments.

12 Information item - Big drink debate update

The Board noted a report providing an update on the findings of the Big Drink Debate.

13 Information item - Pharmaceutical Needs Assessment update

The Board noted a report providing an update on the revised PNA.

Meeting ended at 4.30 pm

CHAIR _____

Bristol City Council
Minutes of the Health and Wellbeing Board

14 September 2017 at 2.00 pm

Board Members Present: Alison Comley, Asher Craig, Helen Godwin, Claire Hiscott, Becky Pollard, Vicki Morris and Elaine Flint

Officers in Attendance:-
Claudette Campbell (Democratic Services Officer) and Nancy Rollason (Service Manager Legal)

1. Welcome, apologies and introductions

Cllr Asher Craig Chaired the meeting and welcomed those present and led introductions.

The following apologies were noted:

- Mayor Marvin Rees
- Dr Martin Jones
- John Readman
- Julia Ross – substitute Justine Rawlings
- Cllr Helen Holland
- Keith Sinclair

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

None

3. Declarations of interest

Board Members Elaine Flint & Vicki Morris ask for it to be noted that the organisation they represented may be involved in the commissioning process.

4. Key decision - Bristol Behaviour Change for Healthier Lifestyles Programme

It was clarified that this was a Bristol City Council key executive decision to be taken by Cllr Craig in the forum of the HWB and that Cllr Craig had delegated authority from the Mayor to do so.

The Board considered a report on a key decision in relation to the Public Health strategy to commission and procure a new contract to deliver changes to the lifestyle behaviours of Bristol residents.

Sally Hogg and Viv Harrison Consultants in Public Health presented the report and briefed the Board.

- The Strategy had been presented to the Board in October 2016, followed by a request to launch the consultation in April. The outcomes of the consultation had been feed into the programme model. The service specifications were now complete and the next step was the procurement process.

Main points raised / noted:

a. Justine Rawlings substitute for Julia Ross CCG – posed a number of questions and raised a number of concerns summarised below;
    - Acknowledged the drive around cost containment, with 15% reduction in funding reassurance sought that new model would deliver on expected outcomes
    - Noted and welcomed the move towards digital approach
    - Sought information on the impact of implementing the programme model, intended and unintended consequence, had they been scoped out.
    - Information on the impact on GP's practice
    - Information on the mitigation strategy to manage outcomes
    - The reason for such a challenging time line for delivery
    - Information on how the model benefited service providers and service users
    - Sought assurance around numbers
    - Questioned whether the CCG leaders have seen and understood the model and the potential impact

b. Becky Pollard DPH – provided the following assurances;
    i. Referred the Board to Appendix E – completed Equality Impact Assessment. Confirmed the wide reaching engagement that had taken place with providers and stakeholders. The message and the drive to work together had been shared and promoted.
    ii. The time line had been impacted by the 2017 June general election, that limited a number of activities during the pre-election period. The procurement window had narrowed as a result and it was imperative that the commissioning process concluded before the end of the current provider's contract.
    iii. The consultation process had included a representative from the CCG therefore it was a concern that that input had not been shared with strategic leaders.
    iv. The detail of the programme model would be released to all at the same time. Bidders Day was an opportunity to receive information on the detail.
    v. Confirmation that Health providers had been included in the consultation.

c. Vicki Morris – shared that she attended a STP steering group, focused on steering the work STP would do with Institute of Voluntary Action Research. The attendees were unaware of the prevention remit of Public Health and the possible duplication if their worked focused on that area

instead of 'self-care'. The opportunity was taken to inform the group of the Healthy Lifestyle service.

d. The Officers provided assurances that;
    i. The report considered the impact of the programme acknowledging that further consideration would need to be given to the question of 'unintended consequences'.
    ii. The programme would centre on supporting users by adopting the principle of 'inform me', 'Enable me', 'Support me'. Research undertaken found that people who were reluctant to engage with authority would access information on line.
    iii. Offered to share the background research with the CCG.
    iv. Confirmed that a representative from the CCG was present during the consultation process.
    v. Provided reassurance that during the consultation process full investigation had been conducted resulting in the proposed model.
e. Alison Comley, Strategic Director provided reassurance that Public Health would continue to work with all Partners including the CCG on communicating financial expectations and to develop mitigation protocol surrounding the model. That the programme being commissioned fell to Public Health and the failure in communicating the programme with CCG Strategic Leaders had been noted.
f. Nancy Rollason, Solicitor and Legal Advisor, sought clarification from the Board through the Chair as to whether there was any fundamental disagreement with the proposal that Cllr Craig needed to take into consideration when coming to her decision. Clarification was also sought as to whether the recommendation should be amended so that in addition to agreeing the tender process that authority would be delegated to Becky Pollard Director of Public Health to award the final contract.

The Chair, Cllr Asher Craig, after taking into consideration the contents of the report and outcomes of consultation as well as the discussion at the meeting took the following key decision;

That the Commissioning Strategy be approved as set out in the Report, and authority be delegated to the Director of Public Health, to progress to invitation to tender and in consultation with Cllr Craig and the section 151 Officer, award the contract.

5. Information item - Pharmaceutical Needs Assessment update

Information Item

Meeting ended at 2.50 pm

CHAIR _____

Health and Wellbeing Board Report / Key Decision **Date: 25.10.17**

Agenda item:

Title: The Healthy Weight Strategic Plan	
Ward: All	**Cabinet lead: Councillor Asher Craig**
Author: Sally Hogg/Wendy Parker	**Job title: Consultant in PH/PH Principal**

Revenue Cost: £3,000	**Source of Revenue Funding:** Public Health ring fenced grant
Capital Cost:	**Source of Capital Funding:**
One off ☒	**Saving** ☐
Ongoing ☐	**Income generation** ☐
Finance narrative: £3000 has been allocated for Bristol Design work, to support the Great Weight Debate conference and to fund the website required for the public consultation. The £3,000 is currently included in the forecast outturn for 2017/18.	
Finance Officer: Wendy Welsh, Finance Manager	

Summary of issue / proposal: *one sentence*
To update on the Healthy Weight Strategic Plan and to ask if it is necessary to go out to public consultation.

Summary of proposal & options appraisal: *Insert bullet points on the issue to be discussed.*

- Healthy weight is one of three key priorities of the Health and Wellbeing Board. This strategic plan sits under the health and wellbeing board strategy.
- A city wide approach is essential to meet the challenging target of halting the rise in overweight and obesity year on year.
- As a city we need to be innovative and challenging, working with a range of partners across the city to change current perceptions about 'healthy weight' and make healthy food and physical activity affordable, accessible and sustainable for all Bristol residents.
- The Big Bristol Challenge – a starting point to engage residents in a community approach to behaviour change encouraging residents to accept a challenge, for example, to 'walk the world' (24,901 miles; 40,075 km) or lose 100,000 pounds in weight, working together as a whole community.

Recommendation(s) / steer sought: *all recommendations must make clear the intended outcome*
Does the Healthy Weight Strategic Plan need to go out to public consultation? As this plan is unlikely to adversely impact the residents of Bristol, a steer is sought on whether we need to go to public consultation.

City Outcome: *What is the proposed outcome for the city and how does this contribute to the Corporate Plan?*
To reduce health inequalities and other factors, for example, the economy, associated with overweight and obesity.

Health Outcome summary: Reverse the trend for the increasing prevalence of overweight and obesity by 2022. (PH Outcome Framework)

Sustainability Outcome summary:

Equalities Outcome summary: To reduce the prevalence of overweight and obesity in our most deprived wards at a greater rate than our least deprived wards.

Impact / Involvement of partners: *What is the impact on key partners? What engagement have they had?*

Ensuring our city promotes healthy lifestyles leading to a healthy weight requires involvement of multiple

partners including health and social care, workplaces, sport and recreation, the food industry, the voluntary sector, education and early years as well as council colleagues in transport, environment and regulation. The Healthy (Great) Weight Steering Group is evolving to ensure we have a wide range of partners who are able to contribute towards reducing overweight and obesity in Bristol. The 23rd May saw the launch of the Great Weight Debate at which we had a broad range of individuals and groups. In addition we have conducted two public surveys and a public consultation is planned.
Consultation carried out: *where has this concept be discussed – partners / Scrutiny etc* A 12 week public consultation is being planned through the BCC consultation team (Matthew Rhymer). The strategy will also be shared with other stakeholder groups such as the Learning City Partnership, Youth Council, Citizen's Panel, GP cluster meetings and community groups.

Legal Issues: *A consultation is required where there is a statutory duty to consult, or it would be fair to consult (usually where the Council has promised it will consult, or there is a practice of consulting in relation to an issue, or where there will be a serious impact on persons as a result of a decision the Council is taking).* *If the view is taken a consultation is required, the proposal(s) must be clearly set out, and* • *The consultation must be at a time when proposals are still at a formative stage.* • *The consultation must give sufficient reasons for any proposal to permit of intelligent consideration and response. Those consulted should be aware of the criteria that will be applied when considering proposals and which factors will be considered decisive or of substantial importance at the end of the problem.* • *Adequate time must be given for consideration and response.* • *The product of consultation must be conscientiously taken into account in finalising any proposals.* *If this is not possible, the consultation should be reconsidered.*
Legal Officer: *Sinead Willis, Solicitor*
Reputational Issues: *– low risk because it's an obvious thing to tackle based on stats*
Policy/Comms Officer: *Bridget Aherne, Interim Head of Public Relations, Consultation and Engagement*

DLT sign-off	**SLT sign-off**	**Cabinet Member sign-off**
Di Robinson (on behalf of Alison Comley) 9th August 2017	Anna Klonowski, 22nd August 2017	Cllr Asher Craig 17the August 2017

Appendix A – Further essential background / detail on the proposal	**YES**
Appendix B – Details of consultation carried out - internal and external	Choose an item.
Appendix C – Summary of any engagement with scrutiny	Choose an item.
Appendix D – Risk assessment	Choose an item.
Appendix E – Equalities screening / impact assessment of proposal	Choose an item.
Appendix F – Eco-impact screening/ impact assessment of proposal	Choose an item.
Appendix G – Exempt Information	Choose an item.

A Strategic Plan for Healthy Weight in Bristol

Our mission: A healthy weight for all citizens of Bristol by 2028

Our vision: Healthy weight is a collective responsibility & a healthy choice is the easy choice

Our strategy: Develop a Bristol City wide approach to creating healthier behaviour in a healthier environment

BRISTOL CITY COUNCIL

Contents

Forward

by the Chairs of the Health and Wellbeing Board and the Director of Public Health

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1. Introduction

The Healthy Weight Strategic Plan is to address the rising prevalence of overweight and obesity in Bristol. It sets out our city wide approach for prevention and early intervention of overweight and obesity. This approach will involve a wide range of stakeholders and partners across the city.

1.1 Background

Diet-related ill health in the UK is estimated to lead to approximately 70,000 premature deaths annually, which represents around 12 per cent of the total number of deaths. Evidence shows that poor diet has the highest impact on the NHS budget, costing around £6 billion per year, a figure which is greater than alcohol consumption, smoking and physical inactivity.

Marmot (2010) identified that inequalities in health in England existed across a range of social and demographic indicators, including income, social class, occupation and parental occupation, level of education, housing condition, neighbourhood quality, geographic region, gender and ethnicity. This applies to Bristol city too. In England obesity is closely associated with social and economic deprivation across all age ranges and is increasing in prevalence. Whilst Bristol has a lower overall prevalence of overweight and obesity than the England average it is significantly higher in areas of social and economic deprivation in the city.

The Bristol City Council's corporate strategy highlights our priorities for the next five years as building resilience in the council and the city, together with a focus on intervening early for those most at risk of escalating needs. It outlines the council's increasingly important role as an enabler and facilitator to achieve our goals. The plan emphasises the need for a commitment to work with people and organisations to tackle inequality and focus on the fundamentals; more homes; decent jobs and a stronger economy; less congestion and cleaner air; and enhanced health and wellbeing.

The causes of weight gain are a complex combination of our individual biology and psychology, the environment we live in and societal and cultural influences. In order to achieve our ambitious mission and to address health inequalities we need collective action across each of these factors at a local, regional and national level. This will only be possible through a collaborative, partnership approach across agencies.

1.2 A Whole Systems Approach to Healthy Weight

We are establishing a Bristol Whole Systems approach to healthy weight. This approach requires leadership from the top, with Bristol City Council holding the ring and engaging partners across the city including health, local authority, business, education and child care, sport and recreation, community groups, charities, universities; government agencies; families and individuals. But it goes beyond collaboration and individual contributions of each organisation and focuses on how the system works as a whole to make the solution "more than the sum of its parts". This approach needs to be challenging and to take bold action if we are to achieve our goal of a healthy weight for all.

Signing the Local Authority Declaration for Healthy Weight will indicate that Bristol City Council is prepared to take the lead in this approach.

A map of the Bristol system has been presented in *Figure 1*.

1.3 Our Objectives

Our partners have all committed to achieving a whole systems approach to healthy weight in Bristol by implementing the objectives identified by this strategic action plan *(Appendix 1).* This strategy is underpinned by an annual action plan that will detail each action and who is responsible.

1.3.1 Our Strategic Objectives:

- To build a more effective, sustainable, system-wide approach to implement changes
- To influence the regional and national agenda to promote healthy weight

1.3.2 Our Prevention Objectives:

- To create an environment which promotes healthy weight
- To give all children the best start in life and address the generational cycle of lifestyle factors in families and individuals.
- To address causes that put particular groups at greater risk of obesity

1.3.3 Our Early Intervention Objectives:

- To offer effective support for families and individuals who want to lose weight.

There are a set of overarching outcomes that will be monitored to show improvements in the healthy weight targets for Bristol *(Appendix 2).*

1.4 Key Commitments

The key commitments and actions have been identified through consultation with Bristol citizens and professionals as well as a review of the evidence of best practice provided by our local Joint Strategic Needs Assessments, the National Institute for Health and Care Excellence (NICE), the Local Government Association (LGA), the Department of Health (DH) and Public Health England (PHE).

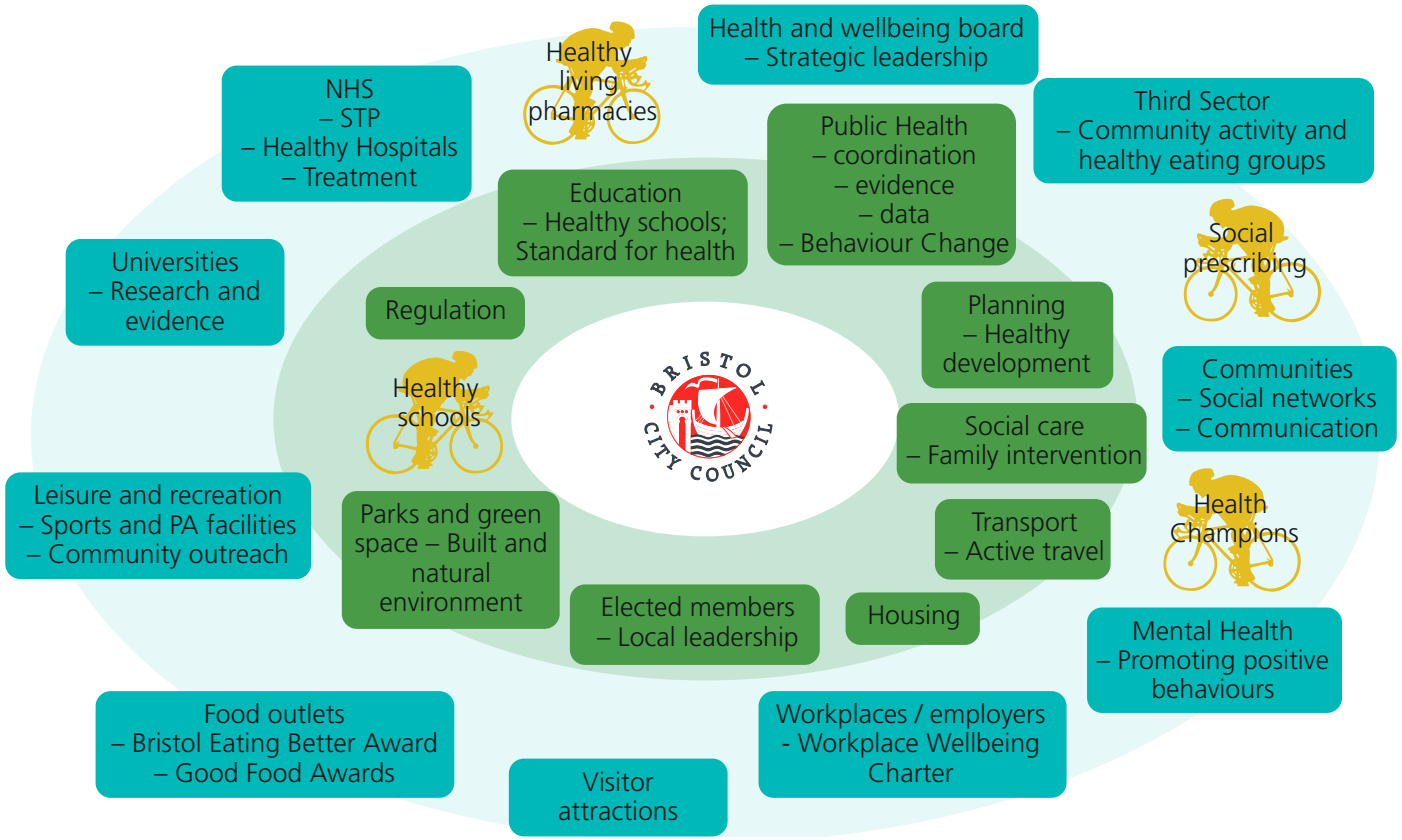
Figure 1:

Bristol's whole system for healthy weight

Co-creating an action plan towards healthier lifestyles

Opportunities for co-creation:

- Everyone's priority
- Consistent messages
- Share knowledge & avoid duplication
- Cross sector partnerships e.g. leisure and schools



Our mission:
A healthy weight for all citizens of Bristol by 2028

Our vision:
Healthy weight is a collective responsibility & a healthy choice is the easy choice

Our strategy:
Develop a Bristol City wide approach to creating healthier behaviour in a healthier environment

On average in every 100 adults in Bristol 58 are overweight (BMI >25); 41 are healthy weight (BMI 18.5-24.9) and 1 is underweight (BMI <18.5)

1.5 In-Scope

In its simplest form reaching and maintaining a healthy weight depends on the amount of calories (energy from food and drink) eaten against the amount of calories (energy from activity) used. *Appendix 3* describes a healthy weight and the preferred nutrition and physical activity recommendations to be used with this strategic plan.

This strategic plan is intended to address the breadth of modifiable issues which contribute to healthy weight across the life course, from conception, through childhood to old age.

The strategy focusses on preventable weight gain and early intervention to reduce overweight and obesity.

There is a two way relationship between weight and mental health. People who suffer from anxiety and depressive disorders are at greater risk of being overweight. Being overweight can also lead to low self-esteem and poorer mental wellbeing. Conversely, taking regular exercise and eating a nutritious, balanced diet can make people feel better, have more energy and boost mental wellbeing. Taking part in exercise groups and clubs can also reduce social isolation which can affect people's mental wellbeing. There is also emerging evidence that stress and poor sleep are also risk factors for weight gain.

Promoting sugar smart as part of healthy weight will also improve oral health as a diet high in sugar not only contributes to overweight but also poor oral health and dental decay.

Many of the opportunities for increasing physical activity and improving diet have a positive impact on the environment. For example travelling by foot or bike instead of by car reduces harmful emissions, causing air pollution and road traffic collisions. Improving the built and natural environment can make streets safer and more welcoming, improve social interaction and support local businesses. A reduction in road traffic would also reduce noise pollution.

Reducing consumption of processed and take-away foods can reduce the impact of excess packaging, food miles and energy used in processing. This could also improve the environment by creating less litter.

1.6 Out of Scope

There are some medical conditions and treatments which can cause people to gain weight. This strategic plan will not address these. However it is recognised that people experiencing weight gain for these reasons, still require support to help them manage the weight gain. Professionals need to be aware of their role in supporting and signposting people to the appropriate support available.

As well as the health risks associated with being overweight, there are also important health risks of being underweight. However the reasons and causes of underweight differ to those of overweight and therefore this is not addressed by this strategic plan. It is recognised as an important issue however and the Government's Emotional Health Transformation Plan: Future in Mind, specifically highlights this issue. Work is underway to implement the recommendations of this report and has been aligned to this strategic plan.

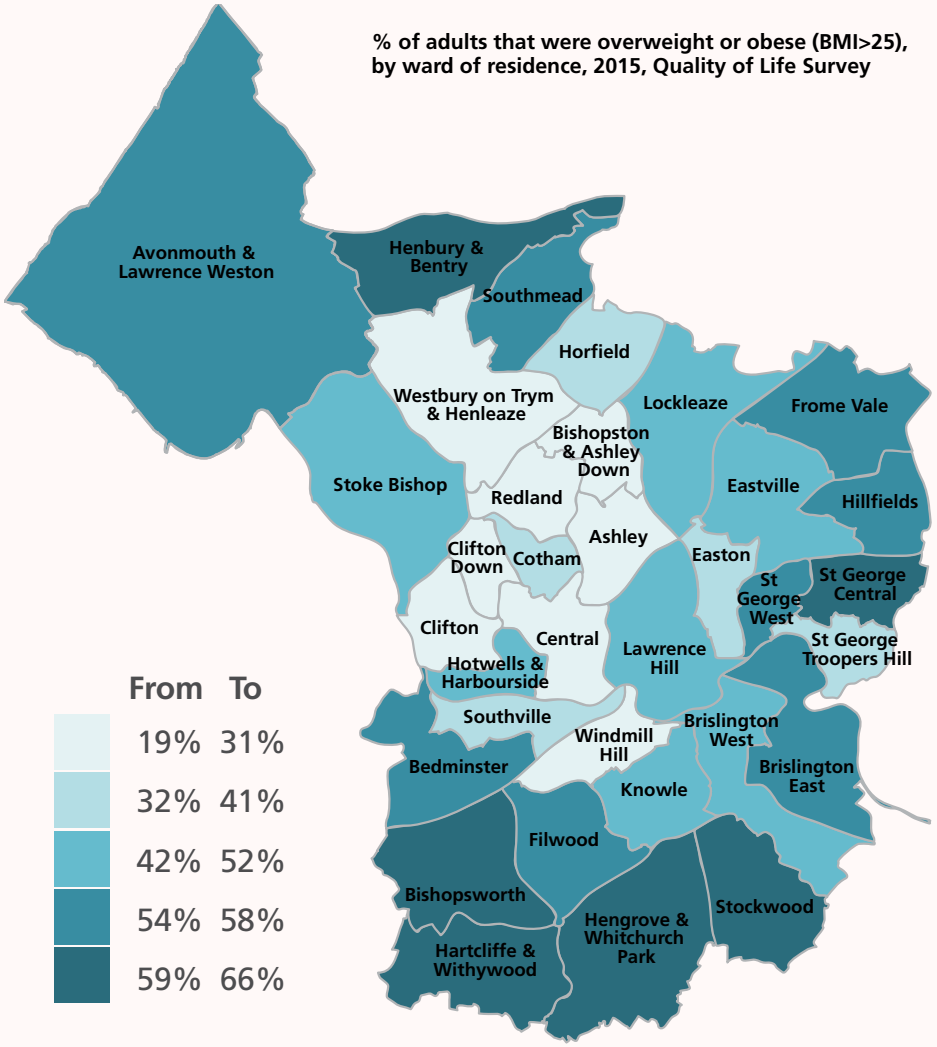
2. The case for change

Healthy weight

- The World Health Organisation considers the rising levels of obesity seen globally to be one of the most serious health challenges of the 21st century.[1]
- In adults, obesity reduces life expectancy by an average of 3 years, and severe obesity by 8-10 years.[2]
- Being overweight or obese increases your risk of:
  - Type 2 diabetes
  - Cardiovascular diseases
  - Some cancers
  - Sleep apnoea
  - Asthma and other respiratory conditions
  - Osteoporosis and musculoskeletal problems
  - Discrimination and stigmatisation, leading to depression and anxiety.
  - People who are overweight and obese are also less likely to be in employment and more likely to require sickness absence from employment or education.
- Obesity is currently estimated to cost the wider economy £27 billion.[2]

- The measure usually used to assess weight is the body mass index (BMI), a person's weight (in kilograms) divided by the square of his or her height (in metres). A person with a BMI of 30 or more is generally considered obese. A person with a BMI equal to or more than 25 is considered overweight. A BMI of between 20 and 25 is considered a healthy weight.
- The percentage of people in Bristol who were overweight and obese increased from 56.9% in 2012-14 to 57.8% for 2013-15. Some wards have much higher levels of overweight than others.[3]

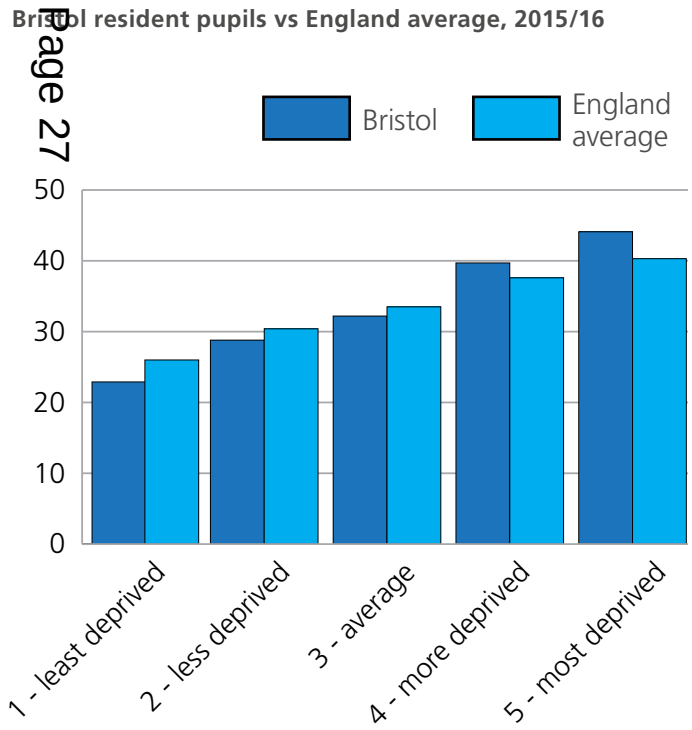
Figure 2: Percentage of respondents who are overweight and obese by Bristol ward area, Bristol Quality of Life Survey 2015



Facts and stats

- The most deprived children in Bristol are significantly more likely to be overweight or obese than in England as a whole.

Childhood excess weight prevalence (% of those measured), by deprivation quintile, year 6 (10/11yrs), Bristol resident pupils vs England average, 2015/16

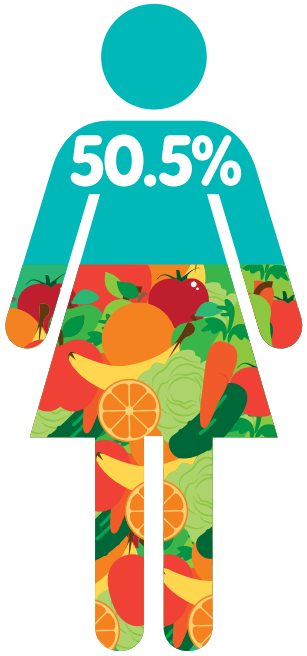


Physical activity

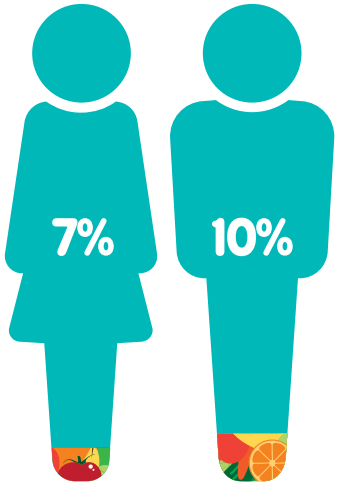
- 16.8% adults in Bristol are physically inactive. Men are more likely to achieve the recommendations for physical activity than women.[4]
- Physical activity in 13-15 year olds nationally fell from 28% meeting the government recommendations in 2008 to 14% by 2012. [5]

Healthy Eating

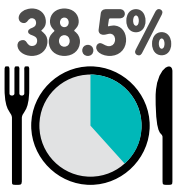
- 50.5% of adults in Bristol meet the 5-a-day fruit and vegetable recommendation. Women are significantly more likely to achieve the recommendation than men.[3]



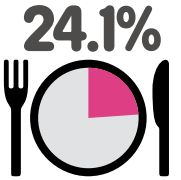
- 25% of year 8 and 10 (secondary) pupils are getting their 5-a-day, 31% of those in years 4 and 6 (primary). [6]



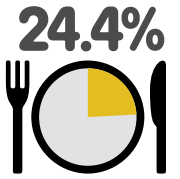
- In Bristol, the following proportion of people eat out once per week: [6]



Sit down meal out



Café style take away



Fast food take away

- Families who eat their main meal together are more likely to come from deprived areas (Quintiles 4&5)

3. What you've told us (from our Sugar Smart survey)

We received 1,200 responses from across the city to our Sugar Smart survey, whilst this is not a true representation of the city's views on healthy weight; it provides a snapshot of public opinion:

Healthy weight

- 77% of you told us healthy weight should be a high or top priority for Bristol.
- 75% of you were worried about being or becoming overweight yourselves.
- You would like more information on the risks of being overweight and the benefits of a healthy lifestyle.

Physical activity

- You told us you would like more opportunities for children and adults to walk or cycle as part of their daily travel, by creating safer routes that are away from roads, have a good quality surface and are well lit.
- You'd like more places for children and adults to be active in.
- You'd like more exercise groups in parks and community spaces. They need to be affordable, held at convenient times (for example in evenings and on weekends), be family friendly, accessible and disabled friendly and well-advertised.
- You'd like better deals for gyms and leisure centres.
- You'd like more opportunities for children and young people to be active at school.
- You'd like us to reduce the number of cars on the roads and improve pollution, for example through a congestion charge.

Healthy Eating

- You told us you'd like more support for adults and families to cook healthier food, for examples through courses on cooking from scratch and budgeting. They need to be held at convenient times (for example in evenings and on weekends).
- You'd like cooking, budgeting and healthy eating skills to be taught in schools and that they should consider including parents.
- You'd like healthy food and drink options to be more affordable.
- You'd like free drinking water to be easily available.
- You'd like to see a reduction in the amount of marketing and advertising of high sugar food and drink.
- You'd like more action to be taken in schools to limit sugary items and reduce sugary drink intake among pupils.

4. Achieving our strategic objectives

4.1 Build a more effective, sustainable, system-wide approach to implement changes

1 Use the Whole Systems Approach to develop a Healthy Weight Strategic Plan for Bristol which is led by the Health and Wellbeing Board.

2 Establish a broad network of stakeholders to deliver the healthy weight strategic plan for Bristol.

3 Ensure professionals are aware of the causes and support available to people to maintain a healthy weight, linking with the Making Every Contact Count programme.

4 Be innovative and ambitious with our programme, using evidence based approaches where possible and contributing to the knowledge base through research and evaluation.

5 Ensure emotional health and wellbeing is embedded into the delivery of this strategy.

To make a meaningful difference to levels of obesity we need challenging, ambitious and innovative approaches across the spectrum of causes.
To do this we plan to:

- Sign the Local Authority Declaration on Healthy Weight *(Appendix 4)*
- Use a Whole Systems Approach to Healthy Weight
- Commit to leading a city wide strategic plan.
- Establish a steering group (Great Weight Group) with a broad network of stakeholders that have a role in promoting healthy weight
- To set challenging goals and raise expectations of achievement
- To produce an annual report for the Health and Wellbeing Board and Children and Families Board Partnership that provides an update on progress against the outcome measures and highlights case studies of successful interventions

There is one main action plan *(Appendix 1)* based on our strategic objectives and there will be a more detailed action plan with SMART objectives developed every 12 months.

4.2 Influence the regional and national agenda to promote healthy weight

6 Work with Public Health England, the West of England Partnership and across our STP footprint to develop consistent messages and approaches to promote healthy weight.

Influence the national agenda to implement evidence based policy to promote healthy weight.

Although there is a lot we can do locally, many initiatives to promote healthy weight need to happen at a regional and/or national level. We are committed to using our influence to steer the national agenda and contribute to the evidence base to inform regional and national policy.

CASE STUDY: Bristol Standard for Health

Bristol Standard is a self-evaluation framework has been supporting quality improvement in early year's settings in Bristol and other local authorities for over 20 years. This year we have piloted an extended model for settings to consider ten relevant public health priorities known as the Bristol Standard for Health. The model provides practitioners with a framework to acknowledge/evidence what they are doing already on a health topic, then reflect and identify where to go next by setting targets. It is an innovative development as there is no other framework available that covers the breadth of health priorities. They include nutrition, physical activity, oral health and emotional health amongst others.

CASE STUDY: Outdoor Events Policy

Public Health Bristol has developed a set of Standards and Guidance to ensure Outdoor Events hosted in Bristol promote healthy lifestyles. This policy includes requirements around ensuring the provision of free drinking water and committing to at least two out of seven Sugar Smart actions.

4.3 Create an environment which promotes healthy weight

8 Improve the built and natural environment to encourage physical activity.

9 Ensure spatial planning processes support promoting a healthy weight.

10 Improve the food environment so the healthy choice is the easy choice.

11 Ensure the public sector food environment sets an example of healthy and sustainable food procurement.

12 Enable and empower workplaces to be competent, confident and effective in promoting healthy weight.

Over recent decades our lives have become more sedentary due to the proliferation of cars, mechanisation and desk-based jobs. This has been coupled with easy access to high energy convenience food and drinks. We want to create an environment where healthy food is the easy choice and exercise can be integrated into everyday life.

CASE STUDY: Playing Out
Playing Out is a Community Interest Company which was set up to enable children to play out freely and safely on the streets where they live, increasing their physical activity levels and improving wellbeing and sense of belonging in their communities; encouraging walking, cycling and children's independent mobility in the city; bringing communities together and re-defining residential streets as playable, liveable public spaces. More information is available on their website **www.playingout.net**.

A total of 921 sessions have taken place, with an average of 20 children per 2 hour session, this equals over 30 000 active play hours. The University of Bristol undertook research to evaluate the impact of playing out sessions. Measures of moderate to vigorous physical activity were taken using accelerometers and GPS monitors on a sample of 105 children. Results found that sessions significantly increased children's time spent outdoors and physical activity levels, increasing by 16 minutes for every hour spent outdoors.

CASE STUDY: Sugar Smart Bristol
Bristol is the first city in England to become 'Sugar Smart'. The programme is working in a variety of settings (schools, colleges, universities, workplaces, food outlets, visitor attractions, sport and leisure facilities) to support changes to the food on offer as well as developing resources and promotional material to promote Sugar Smart messages to the public such as reading the labels, swap sweet snacks for fruit and swap fizzy drinks for water. This is being evaluated in a variety of different ways including through master's student dissertations at the University of Bristol.

CASE STUDY: Sustainable Food City
The Sustainable Food Cities Award is designed to recognise and celebrate the success of those places taking a joined up, holistic approach to food and that are achieving significant positive change on a range of key food issues. Bristol currently holds the Silver Sustainable Food City Award but we are working towards achieving Gold in the coming years.

CASE STUDY: Bristol Eating Better Award
The Bristol Eating Better Award is a free award scheme publicising food businesses that are taking some action to offer food that is healthier and more environmentally friendly. The scheme is currently being piloted in a few cafes and take-aways across the City. An evaluation of the scheme is being conducted by the University of Bristol. More information is available at **www.bristol.gov.uk/food-business/bristol-eating-better-award-scheme**.

4.4 Give all children the best start in life and address the generational cycle of lifestyle factors in families

13 Engender healthy lifestyles throughout life with evidence based early intervention during the critical 1001 days of a child's life, from conception to age 2.

14 Ensure early years, schools and other education settings make the environment health promoting and teach the skills for life required to lead healthy lifestyles.

If children are overweight in childhood they are much more likely to be overweight as adults. From the moment a baby is conceived, their environment and experiences affect their behaviour and preferences into adulthood. There are key opportunities during childhood where it is possible to intervene to promote healthy lifestyles, establish positive behaviours and build emotional wellbeing that they will maintain throughout life.

CASE STUDY:
Mayors Award for Healthy Schools

The Healthy Schools Team works with schools to assess the whole school environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight, eat healthily and be physically active, in line with existing standards and guidance. This includes policies relating to building layout and recreational spaces, catering (including vending machines) and the food and drink children bring into school, the taught curriculum (including PE), school travel plans and provision for cycling, and policies relating to the National Healthy Schools Programme and extended schools. The team have expanded this award to now include healthy nurseries.

CASE STUDY: Fit and Fed

School holidays have become hard for low income families. Research shows many children on free school meals, or low income families are hungry, isolated and inactive in the holidays. A poor diet, lack of activities and limited social engagement leaves them poorly prepared to return to school. Bristol is one of 16 communities across the UK piloting Fit and Fed, providing physical activity programmes and a meal for children in the most deprived areas.

"I am so pleased and happy with the service that has been provided over the last 6 weeks. Without this my children would have been stuck in the house with nothing to do as I am housebound and in a wheelchair. My children have enjoyed coming, enjoyed playing, enjoyed joining in with all the activities that was provided, also the lunches that have been provided for children have been a godsend....."

4.5 Address causes that put particular groups at greater risk of obesity

15 Enable and empower communities to improve individuals and families' relationship with food.

16 Enable and empower communities to improve individuals and families' physical activity levels.

17 Ensure sport and recreational clubs and groups are inclusive and accessible to all.

18 Ensure interventions are targeted towards vulnerable groups at highest risk of overweight.

People from lower socio-economic groups and Black, Asian and Minority Ethnic groups are at much greater risk of being overweight and therefore we need to target interventions and support at those groups who need it most. In order to achieve this, interventions need to be accessible and culturally appropriate. Often people experience barriers to being physically active such as time, the cost of recreational clubs and groups (including kit and transport to them) and a perception that 'sport' is elitist and not for them. We need to address these barriers and ensure everyone has the opportunity to be physically active in a way that suits them.

CASE STUDY:
European City of Sport 2017

European City of Sport has been about raising awareness of the sport and physical activity opportunities available across Bristol. Our website and social media accounts share information enabling organisations to publicise their activities and successes with us and to share with the wider population. The 'Are You Game?' campaign had 80 organisations offering over 100 free different sessions of activity that people could access between May and September. The legacy will be an ongoing 'First Session Free' offer from organisations across Bristol and an on-line physical activity and sports directory. The key aim is to promote physical activity opportunities and encourage participation whether incorporating it into a more active lifestyle or more formal participation.

CASE STUDY:
Young Chef and Young Baker Award

Bristol Healthy Schools launched these awards in 2014, to celebrate the fact that practical cooking skills were back in the curriculum for Key Stages 1 - 3. The aim was to get young people excited about the idea of cooking from scratch; growing food and helping others to get involved. The awards promote health and wellbeing, with a focus on being Sugar Smart and creative on a budget. There has always been huge interest and hundreds of applications to enter for these awards. Feedback on the awards from entrants includes:

'Being a finalist in the Young Chef competition made me realise I am good at something'
'Cooking is good fun, it helps me destress. I get nervous about SATS and this helps me think about other things'
'For the first time ever students in the lower years look up to me! I can help them learn to cook too'
'Weighing food to bake with helps me with my Maths'

From Parents / Carers:

'This experience is such a great one for any young person'

From Teachers:

'We have seen this competition impact on Childrens cooking and growing skills but also on confidence and self-esteem'.

4.6 Offer effective support for children and adults who want to lose weight

19 Provide a behaviour change programme which will enable individuals and families to take action to reduce their weight through provision of information, guidance and coaching.

The focus of this strategy is on preventing people becoming overweight and intervening early by making healthy lifestyles the easy choice. However we recognise that some people will need specialist support to lose weight, for example the severely obese and those with additional needs.

CASE STUDY:
Core Cities Sport England Grant

The aim of this project is to address health inequalities for inactive people in areas of deprivation through increased awareness, better use of community assets and motivators, and improved access and increased participation.

In tackling inactivity we want to reduce health inequalities through better understanding of particular community groups, influencing their behaviours, attitudes and motivations towards physical activity. This will help to achieve personal aims, such as meeting friends, having fun, keeping a healthy weight and feeling safe, through physical activity.

This behaviour change model approach will work towards a pathway of opportunities to ensure that people currently taking less than 30 minutes physical activity a week adopt everyday habits which move them towards the recommended levels beneficial for health i.e. the move from sedentary to participation.

5. How are we going to get there?

This strategy is the beginning of a journey, not the end. The next steps are implementing this strategic plan.

Healthy Weight is one of the top three priorities of Bristol's Health and Wellbeing Board. They have tasked the Great Weight Group with achieving these objectives over the next five years.
www.bristol.gov.uk/social-care-health/get-involved-in-the-great-weight-debate

In order to deliver the objectives we will continue to engage communities and partners in the Great Weight Debate, taking a whole systems approach and creating a social movement. We will do this through local engagement events and public surveys.

The work will not stop after the five year duration of this strategic plan; however that will be a sensible point for us to reflect back on progress, evaluate our achievements against our objectives and refresh our strategy in light of any changes.

6. How will we know when we're there?

The strategic action plan *(Appendix 1)* will be monitored against the overarching outcomes *(Appendix 2)* each year.

The annual action plans will contain more detail about individual projects with SMART (specific; measurable; achievable; realistic and timely) objectives that will also be monitored.

The results of this monitoring will be highlighted in the annual report for the Health & Wellbeing Board, and Children & Families Board Partnership.

6.1 Evaluation

Evaluation of the strategic plan will be continuous and will include feedback from stakeholders and participants.

6.2 Appendix 1: Strategic Action Plan

Summary of the actions and key commitments identified above.

Reference number	Action to achieve change	Key Commitments	Success measure	Timeframe
Priority	**BCC signs the Local Authority Declaration on Healthy Weight**			
1	**Build a more effective, sustainable, system-wide approach to implement changes**			
1.1	Develop a Whole Systems approach to Healthy weight in Bristol that is challenging and bold and is underpinned by a comprehensive healthy weight strategic plan which is led by the Health and Wellbeing Board	• To set challenging goals and raise expectations of achievement interventions. • To produce an annual report for the Health and Wellbeing Board and Children and Families Partnership Board that provides an update on progress against the outcome measures and highlights case studies of successful	Annual action plan developed with challenging objectives Production of annual report	March 2018 March 2019 March 2020 March 2021
1.2	Establish a broad network of stakeholders to deliver the healthy weight strategic plan for Bristol	• Establish a Steering Group (Great Weight Group) with a broad network of stakeholders that have a role in promoting healthy weight.	Range of stakeholders engaged with delivering objectives in the action plans	Annual

Reference number	Action to achieve change	Key Commitments	Success measure	Timeframe
1.3	Develop training programmes to ensure professionals; families and individuals are aware of the causes of obesity and the support available to residents to reach and maintain a healthy weight, linking with the Making Every Contact Count programme (MECC)	• Invest in the health literacy of local residents to make informed healthier choices.	Range of programmes supporting health literacy and uptake of places	Annual
1.4	Be innovative and ambitious with our programme using evidence based approaches where possible and contributing to the knowledge base through research and evaluation	• Create, develop and implement 'The Bristol Challenge' – a population challenge supporting healthy weight	Uptake of Bristol Challenge by the residents of Bristol	April 2018
1.5	Ensure emotional health and wellbeing is embedded into the delivery of this strategic plan	• To work with the Thrive programme to ensure emotional health and wellbeing is included in all interventions	Annual report Measure of emotional health and wellbeing as part of Thrive programme	Annually
2	**Influence the regional and national agenda to promote healthy weight**			
2.1	Work with Public Health England Obesity Network, West of England Partnership and the Bristol, North Somerset and South Gloucestershire Sustainability Transformation Plan to develop consistent messages and approaches to promote healthy weight.	• Support local, regional and national campaigns such as Change 4 Life; Sugar Smart Bristol and One You. • Promote innovative local schemes and their evidence of effectiveness regionally and nationally.	Evidence of input to regional and national campaigns. Evidence of sharing information to support external schemes	Continuous

Reference number	Action to achieve change	Key Commitments	Success measure	Timeframe
2.2	Influence the national agenda to implement evidence based policy to promote healthy weight	• Respond to regional and national consultations and engagement processes to develop healthy weight policy. • Support action at national level to help local authorities reduce obesity prevalence and health inequalities in our communities.	Evidence of response to national consultations Evidence of work supporting national programmes	Ongoing
3	**Create an environment which promotes healthy weight**			
3.1	Improve the built and natural environment to encourage physical activity	• Link plans to Active Travel and public transport		
3.2	Ensure spatial planning processes support promoting a healthy weight	• Advocate plans with our partners including the NHS and all agencies represented on the Health and Wellbeing Board, Healthy Cities, academic institutions and local communities to address the causes and impacts of obesity • Promote use of open spaces for physical activity		2018

Reference number	Action to achieve change	Key Commitments	Success measure	Timeframe
3.3	Improve the food environment so the healthy choice is the easy choice	[8] • Engage with local food businesses to encourage an increase in the availability, accessibility and affordability of sustainable and healthy food and drink across the city. • Increase public access to fresh drinking water at venues across Bristol	Number of businesses with Bristol Eating Better Awards Number of businesses linked into Refill	Annually
3.4	Ensure the public sector food environment sets an example of healthy and sustainable food procurement	• Review and improve the Food supply contract to enable more healthy and sustainable food procurement for all BCC contracts • Develop and implement new healthy and sustainable food and catering standards to apply to all BCC Catering contracts • Protect our children from inappropriate marketing by the food and drink industry such as advertising and marketing in close proximity to schools; 'giveaways' and promotions within schools; at events on local authority controlled sites.	New food supply contract in place that supports healthy and sustainable food procurement. Standards embedded into all BCC Catering contracts	March 2018

Reference number	Action to achieve change	Key Commitments	Success measure	Timeframe
3.5	Enable and empower workplaces to be competent, confident and effective in promoting healthy weight	[9] • Support the health and well-being of local authority staff and increase knowledge and understanding of unhealthy weight to create a culture and ethos that normalises healthy weight	Workplace health programmes in place to support staff	
4	**Give all children the best start in life and address the generational cycle of lifestyle factors in families.**			
4.1	Engender healthy lifestyles throughout life with evidence based early intervention during the critical 1001 days of a child's life: from conception to age 2.	• Promote the importance of a healthy start in life through breastfeeding; healthy eating and physical activity in the first 1001 days of life • Engage the wider family. • Focus resources in areas of higher deprivation, including increasing access to healthier foods. • Promote the Healthy Start Scheme along with Oral Health targeted to high risk families	Breastfeeding initiation rates increase Support for pregnant women to maintain a healthy weight throughout pregnancy Uptake of Healthy Start scheme by eligible families	Annually
4.2	Ensure early years, schools and other education settings make the environment health promoting and teach the skills for life required to lead healthy lifestyles	[13] [11] [18] • Ensure schools provide a healthy environment through the Healthy Schools Award Scheme. • Engage the parents; wider family and community • Bristol Standards	Number of schools achieving Mayors Award Number of Early Years settings completing the Bristol Standard Increased number of children achieving 60 minutes physical activity daily	Annually

Reference number	Action to achieve change	Key Commitments	Success measure	Timeframe
5	**Address causes that put particular groups at greater risk of obesity.**			
5.1	Enable and empower communities to improve individuals and families' relationship with food.	[19] • Provide guidance for hot food takeaways, specifically in areas around schools, parks and where access to healthier alternatives are limited through the Bristol Eating Better Awards	Uptake of Bristol Eating Better Awards Improve skills and knowledge around food and food preparation Better informed about budgeting	
5.2	Enable and empower communities to improve individuals and families' physical activity levels	• Develop a supportive infrastructure and a range of opportunities (including social prescribing) to enable people to engage in community activities that promote healthy lifestyles; and communicate these opportunities across all communities.	Increased uptake of a range of sport and physical activities	Ongoing
5.3	Ensure physical activity, sport and recreational clubs and groups are inclusive and accessible to all	• Continue to improve access to all Council leisure centres and swimming pools particularly for those with highest health needs.	Increased uptake by eligible families and individuals	

Reference number	Action to achieve change	Key Commitments	Success measure	Timeframe
5.4	Ensure interventions are targeted towards vulnerable groups at highest risk of overweight and obesity	[18] • Provide opportunities to engage the public in health promoting behaviours • Tailor information and support to groups at higher risk of overweight or obesity through activities provided by the Behaviour Change Programme.	Range of targeted interventions Increased uptake by vulnerable groups	Annual from 2018-2021

Reference number	Action to achieve change	Key Commitments	Success measure	Timeframe
6	**Offer effective support for children and adults who want to lose weight.**			
6.1	Provide a behaviour change programme which will enable individuals and families to take action to reduce their weight through provision of information, guidance and coaching.	• To implement the Behaviour Change Programme to provide a range of support for individuals and families by building capacity in the community for physical activity and healthy eating initiatives. • The Healthy Weight Nurses will continue to support children and families with highest health needs. • Ensure signposting to the Behaviour Change Programme is available through the NHS Health Check, the National Child Measurement Programme feedback and the pregnant women booking appointment.	As described in the service specifications for for the Behaviour Change programme and for the Healthy weight nurses	

Appendix 2: Outcomes

The strategy will be monitored against a set of measurable outcomes. Some of these outcomes will need monitoring over a longer term than others due to the speed of change and we may want to add more as the work programme develops. These have been presented below:

*Sources: Public Health Outcomes Framework (PHOF) **www.phoutcomes.info**

Quality of Life Survey (QoL) **www.bristol.gov.uk/qualityoflife**

National Child Measurement Programme (NCMP) **fingertips.phe.org.uk/profile/national-child-measurement-programme**

Indicator	Source*	Frequency of reporting	Bristol value (2015/16)	England Average (2015/16)
Primary outcome measures				
Excess weight in adults	PHOF	Annual	57.8%	64.8
Reduce the percentage of children in reception class (4-5 yrs) with height and weight recorded who are overweight or obese.	PHOF	Annual	22.9%	22.1
Reduce the percentage of children in Year 6 class (10-11yrs) with height and weight recorded who are overweight or obese.	PHOF	Annual	35.6%	34.2
Increase levels of physical activity in Bristol.	QoL	Annual	65.3%	
Increase levels of physical activity in areas of deprivation in Bristol	QoL	Annual	56%	
Increase the number of people recorded as consuming 5-a-day fruit and vegetable portions.	PHOF/QoL	Annual	50.50%	
Utilisation of outdoor space for exercise/health reasons	PHOF	Annual	10.8%	17.9

Indicator	Source*	Frequency of reporting	Bristol value (2015/16)	England Average (2015/16)
Reduce the gap between the ward with the highest rates of adult overweight or obesity and the ward with the lowest.	QoL	Annual	66% in Hengrove & Whitchurch Park vs 19% in Hotwells & Harbourside Difference of 47% points	
Sustained reduction in percentage of children in the most deprived quintile who are recorded as overweight or obese in Reception Year (4-5 years)	NCMP	Annual		
Reduce the percentage of children in the most deprived quintile who are recorded as overweight or obese in Year 6 (10-11 years)	NCMP	Annual		
Reduce the percentage of adults recorded as overweight or obese in the 10 wards with the highest levels of overweight or obesity	QOL	Annual	Hengrove & Whitchurch Park 66% Hartcliffe & Withywood 66% Stockwood 65% St George Central 59% Henbury & Brentry 59% Bishopsworth 59% Brislington East 58% Southmead 57% Hillfields 56% Avonmouth & Lawrence Weston 56%	
Increase the number of people recorded as actively travelling to work	Active People			

Indicator	Source*	Frequency of reporting	Bristol value (2015/16)	England Average (2015/16)
Give all children the best start in life and address the generational cycle of lifestyle factors in families.				
Breastfeeding prevalence in children with a known feeding status at 6 to 8 weeks who were exclusively or partially breastfed	PHOF	Quarterly	63.7%	49.6%
Number of early years settings with the healthy eating and physical activity health priorities of the Bristol Standard for Health framework	Public Health	Annual		n/a
Number of drinking water fountains		Annual	1	
Number of school settings have achieved the Mayor's award	Public Health	Annual	18 Primary 1 Special 1 PRU 1 Secondary	n/a
Percentage of children measured as overweight or obese that are signposted to support at their 2 year integrated health check.	Public Health	Annual		n/a
Referrals to and uptake of the local National Diabetes Prevention Programme (NDPP)	?			
Decayed, Missing and Filled Teeth (DMFT) in 5 year old children	Oral Health Profile - Public Health England	Annual	1.12 (2014/5)	0.84 (2014/5)
Hospital admissions for tooth extractions in 0-19 year olds	PHOF	Annual		
Self-reported wellbeing – people with a low worthwhile score	PHOF	Annual	4.4	3.6
Fraction of mortality attributable to particulate air pollution	PHOF	Annual	4.40%	

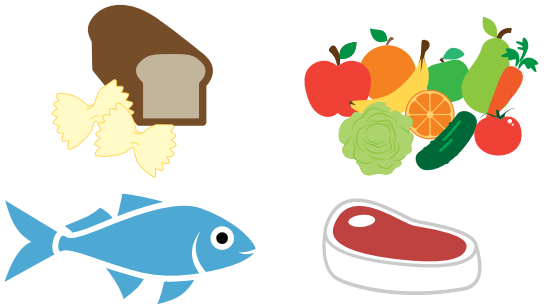
Appendix 3: Guidelines

Our recommendation is that the Eatwell Guide is used as the basis for all nutrition information being delivered to the public:
www.gov.uk/government/publications/the-eatwell-guide

For physical activity these are the recommendations to use:
www.gov.uk/government/news/new-physical-activity-guideline

The following recommendations summarise the guidance on healthy eating:

- Base your meals on starchy carbohydrates
- Eat lots of fruit and vegetables (minimum of 5-a-day)
- Eat more fish – including a portion of oily fish
- Cut down on saturated fat
- Eat less salt – no more than 6g a day for adults
- Drink more water; keep hydrated
- Don't skip breakfast
- Limit red and processed meat to 70g per day.
- Eat less sugar – keep to recommendations for amount of sugar/day



Recommended government guidelines for physical activity are:

Pre-school children who can walk unaided (under 5s)	Be physically active daily for at least 180 minutes (3 hours), spread throughout the day
	Minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).
5-18 years	60 minutes of moderate to vigorous intensity physical activity per day
	Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week.
	Minimise the amount of time spent being sedentary (sitting) for extended periods.
Adults	150 minutes of moderate aerobic activity such as cycling or fast walking every week

Definitions of Healthy Weight:
Health risk categories for adults: Health Survey for England/ NICE

	Low	High	Very High
	Men <94cm Women <80cm	Men: 94-102cm Women: 80-88cm	Men: >102cm Women: >88cm
Underweight (<18.5kg/m²)	Underweight (Not applicable)	Underweight (Not applicable)	Underweight (Not applicable)
Healthy weight (18.5–24.9kg/m²)	No increased risk	No increased risk	Increased risk
Overweight (25–29.9kg/m²)	No increased risk	Increased risk	High risk
Obese (30–34.9kg/m²)	Increased risk	High risk	Very high risk
Very obese (>40kg/m²)	High risk	Very high risk	Very high risk

These criteria are lower for people from Black, Asian and Minority Ethnic groups (BAME)

Measuring and interpreting BMI in children: Public Health England

Measuring an individual child		Measuring a population of children (NCMP)	
<0.4th centile	Very underweight	<2nd centile	Underweight
<2nd centile	Underweight	>2 – <85th centile	Healthy weight
>2 – <91 centile	Healthy weight	>85th centile	Overweight
>91st centile	Overweight	>95th centile	Obese
≥98th centile	Obese		
>99.6th centile	Severely obese		

Appendix 4: The Local Government Declaration on Healthy Weight

The 14 commitments:

- Engage with the local food and drink sector (retailers, manufacturers, caterers, out of home settings) where appropriate to consider responsible retailing (such as not selling energy drinks to under 18s), offering and promoting healthier food and drink options, and reformulating and reducing the portion sizes of high fat, sugar and salt (HFSS) products;

- Consider how commercial partnerships with the food and drink industry may impact on the messages communicated around healthy weight to our local communities. Funding may be offered to support research, discretionary services (such as sport and recreation and tourism events) and town centre promotions;

- Review provision in all our public buildings, facilities and 'via' providers to make healthy foods and drinks more available, convenient and affordable and limit access to high-calorie, low nutrient foods and drinks (this should be applied to public institutions such as schools, hospitals, care homes and leisure facilities where possible);

- Increase public access to fresh drinking water on local authority controlled sites;

- Consider supplementary guidance for hot food takeaways, specifically in areas around schools, parks and where access to healthier alternatives are limited;

- Advocate plans with our partners including the NHS and all agencies represented on the Health and Wellbeing Board, Healthy Cities, academic institutions and local communities to address the causes and impacts of obesity;

- Protect our children from inappropriate marketing by the food and drink industry such as advertising and marketing in close proximity to schools; 'giveaways' and promotions within schools; at events on local authority controlled sites;

- Support action at national level to help local authorities reduce obesity prevalence and health inequalities in our communities;

- Ensure food and drinks provided at public events include healthy provisions, supporting food retailers to deliver this offer;

- Support the health and well-being of local authority staff and increase knowledge and understanding of unhealthy weight to create a culture and ethos that normalises healthy weight;

- Invest in the health literacy of local citizens to make informed healthier choices;

- Ensure clear and comprehensive healthy eating messages are consistent with government guidelines;

- Consider how strategies, plans and infrastructures for regeneration and town planning positively impact on physical activity;

- Monitor the progress of our plan against our commitments and publish the results.

Local commitments can be added.

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Documents available in other formats:
If you would like this information in another language, Braille, audio tape, large print, easy English, BSL video or CD rom or plain text please contact: xxxxxxxxxxx

BD8688 Designed Bristol Design, Bristol City Council September 2017

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Refugee and Asylum Seekers in Bristol	
Author, including organisation	Anne James Commissioning Manager- Refugees Bristol City Council
Date of meeting	25 October 2017
Report for Information	

1. Purpose of this Paper

To invite City Partners to contribute to the Welcoming Refugees and Asylum Seekers Action Plan

2. Executive Summary

The Mayor of Bristol pledged to promote Bristol as a City of Sanctuary and for Bristol to be a welcoming city with a clear strategy for supporting refugees. The Welcoming Refugees and Asylum Seekers Strategy is included as Appendix 1. The Refugee and Asylum Seekers Needs Assessment and Current Activities is included as Appendix 2.

The Strategy has four priorities, one of which is to e*nsure a wide range of city partners (businesses, voluntary sector groups, universities, health and other agencies) work together to make Bristol a City of Sanctuary.* This report has been brought to the Health and Wellbeing Board to engage with partners who can contribute towards making Bristol a City of Sanctuary.

The Refugee and Asylum Seeker Partnership Board (RASP) will oversee the implementation of the strategy. Membership will consist of champions for key refugee and asylum seekers needs: Housing, Information, Advice and Guidance, Employment, Health, Young People, Destitution. Can the Health and Wellbeing Board nominate a representative to sit on the new Board who can champion health needs of asylum seekers and refugees in the city?

3. Key risks and Opportunities

Welcoming refugees generally implies an initial investment, typically of public funds, which can longer term bring opportunities to the city:

- Higher-skilled refugees (and refugees' highly skilled children) can provide different and complementary skills to fill gaps in the labour market and enhance locals' productivity. A third of recent refugees in Sweden are graduates; more than two-thirds of those have skills which match graduate job vacancies.
- Enterprising refugees start businesses that create wealth, employ locals, make the economy more dynamic and adaptable, and boost international trade and investment. Sergey Brin, who arrived in the US as a child refugee from the Soviet Union, co-founded Google, now America's second most valuable company.
- People who have been uprooted from one culture and exposed to another tend to be more creative, while studies show that diverse groups outperform like-minded experts at problem solving.
- Ageing societies with a shrinking native working-age population can benefit from the arrival of younger refugees.
- Migrants in general tend to be net contributors to public finances; in Australia refugees become so after 12 years.
- Globally, remittances from migrants are three times the amount of development money from the all the world's governments. Supporting refugees does indeed pay back to countries of origin improving global stability.

If the city 'does nothing' to welcome refugees then, at best, it is harder for refugees to benefit from networks and opportunities in the city. At worst, the risks of not welcoming refugees would be an increase in community tension, which may potentially lead to disorder or threaten the peace and stability of communities.

6. Implications (Financial and Legal if appropriate)

N/A

7. Evidence informing this report.

The evidence base is detailed in Appendix 2 : Bristol Asylum Seekers and Refugees Needs Assessment and Current Activities 2017

8. Conclusions

Bristol is an international city that looks towards people and cultures beyond its boundaries. It is a diverse, creative, innovative and open city,

made up of communities from around 120 countries around the world who speak over 90 languages. The Welcoming Asylum Seekers and Refugees strategy and action plan will make a step-change in the co-ordination and development of the city's approach towards refugees and asylum seekers living in Bristol.

9. Recommendations

The Health and Wellbeing Board partners are asked to consider

- What is your organisation's role in welcoming asylum seekers and refugees?
- How can your organisation provide more accessible job opportunities for refugees?
- How can your organisation contribute towards creating a safe city of sanctuary, towards greater understanding and towards greater economic and social inclusion of asylum seekers and refugees?
- Which HWB organisation is best placed to champion health needs on the Refugee and Asylum Seekers Partnership Board?

10. Appendices

Appendix 1 Bristol Welcoming Asylum Seekers and Refugees Strategy and Action Plan 2017 - 2020

Appendix 2 Bristol Asylum Seekers and Refugees Needs Assessment and Current Activities 2017

Bristol: A City of Sanctuary

Welcoming Asylum Seekers and Refugees Strategy

Action Plan 2017 - 2020

Final draft

Lead officer: Commissioning Manager - Refugees

For further information, please contact anne.james@bristol.gov.uk

This document should be read in conjunction with the Bristol Refugee and Asylum Seeker Needs Assessment 2017

1 Purpose

In 2016 the Mayor of Bristol pledged to promote Bristol as a City of Sanctuary and for Bristol to be a welcoming city with a clear strategy for supporting refugees. This strategy is being developed in partnership with Strategic Partnerships and refugee service organisations, and when implemented, will realise our commitment to welcome, respect, and build a culture of welcome in our own services, and to supporting inclusivity across every sphere of society in our City.

Bristol is a City of Sanctuary; this Strategy brings together what the many partners in Bristol can do to make Bristol a welcoming city for asylum seekers and refugees. The Strategy defines the city's principles and priorities, which will bring an additional focus and direction to the work in the city. The strategy will underpin and support the many different organisations and activities in the city which work to welcome refugees and asylum seekers. A governance structure will be developed to review progress against the action plan and enable the strategy to evolve organically.

The strategy is based on the Refugee and Asylum Seeker Needs Assessment 2017, which has collated information on what is needed in the city and what is in place to meet these needs. The Strategy and action plan will determine how resources should be configured to better meet the needs of refugees and asylum seekers.

The Action Plan sets out what the council will do to promote Bristol as a welcoming city. Appendix 1 details the activities undertaken by a number of statutory and community organisations. Appendix 2 detail the pathways for UASC and adult asylum seekers.

This final draft will be endorsed by the Cabinet.

2 Background

City of Sanctuary is a mainstream, grassroots movement. It works by creating opportunities for relationship between local people and those seeking sanctuary, and by offering a positive vision of a culture of hospitality for those in need of safety.

Bristol City of Sanctuary, as part of this network, is an organisation made up of people and organisations who work in different ways to make the city a place of welcome and safety for people seeking sanctuary from violence, war and persecution. In support of this work, and building on a long history of providing welcome and safety to refugees, Bristol City Council formally adopted a motion in November 2010 stating that we would

> "celebrate and welcome the diversity that makes up our city, and celebrate the contribution to the life of the city made by people who come here as asylum seekers and refugees."

'City of Sanctuary' status was awarded to Bristol by the national City of Sanctuary Network in 2011, in recognition of both the Council's commitment, and the depth and breadth of support for the movement locally.

In 2012, four Bristol schools and colleges were awarded status as a School or College of Sanctuary, recognising their commitment to education about and inclusion of refugee and asylum seeking children.

In 2013, Bristol Council, as a City of Sanctuary, passed a further motion aiming to end the destitution of asylum seekers in our city, through understanding the causes of asylum destitution, by joining the anti-destitution coalition 'Still Human, Still Here', and by lobbying for a more co-ordinated, humanitarian and just approach.

In 2015, Bristol hosted the UK's largest conference on asylum destitution, resulting in the passing of a 'Joint Commitment to Action on Destitution' supported and signed by the elected Mayor at the time. This resolution deplored the enforced destitution of people seeking sanctuary, recognising the impact on individuals and communities, and was later adopted by other City Councils across the UK.

3 Principles

Our aims and priorities are underpinned by a *Human Rights* approach with an emphasis on self- help. Bristol City Council will seek to act in accordance with City of Sanctuary principles to demonstrate good practice in working with asylum seekers and refugees to encourage others within the city to offer the same good practice.

In Bristol there is a firm commitment to creating a *Co-ordinated Community Response* to providing support for refugees and asylum seekers. We will work in partnership with the voluntary sector and with asylum seeking and refugee communities, and with all organisations who support City of Sanctuary principles and who are committed to welcome, inclusion and equality.

We recognise the *influence* which the Council can have on public perceptions and understanding of asylum seekers and refugees, and their reasons for seeking sanctuary in Bristol, if we use positive and accurate language about asylum seekers and refugees in all media, policy statements and publicity materials.

4 Aims & Priorities

Priorities

- Making Bristol a safe place for people seeking sanctuary, and to create an environment in which they can feel welcomed and are able to integrate
- Ensure a wide range of city partners (businesses, voluntary sector groups, universities, health and other agencies) work together to make Bristol a City of Sanctuary.
- Promote mutual understanding between Bristolians and a support an inclusive culture in which longer-standing communities feel able to understand and welcome refugees
- Strengthen the capacity of refugees and asylum seekers to develop the skills and access opportunities to support themselves and their families to lead fulfilling lives which contribute to the social and economic wealth of the city.

Aims

- Deliver culturally sensitive statutory and non-statutory provision
- Ensure co-ordinated provision of English Speakers of Other Languages
- Reduce unemployment and under employment of refugees
- Promote safety and integration through appropriate welcoming support
- Decrease destitution and homelessness amongst asylum seekers and refugees
- Increase affordable housing options
- Improve data and linkages with the Joint Strategic Needs Assessment and Department of Work and Pensions
- Monitor outcomes for refugees and asylum seekers
- Improve understanding and skills for staff through workforce development and training
- Improve specific support for families and young people, including for unaccompanied minors

Cross cutting aims

- Uphold human rights
- Empower women and children
- Challenge harmful stereotypes
- Involve service users and co-produce services

5 Consultation

Refugee and asylum seeker support organisations (as listed in Appendix 1) have been consulted as part of the development of the Bristol Refugee and Asylum Seeker Needs Assessment (2017) and the Welcoming Asylum Seekers and Refugees Strategy 2017-20.

Consultation has been undertaken with organisations, asylum seekers and unaccompanied asylum seeking young people to identify what should be the priorities for action in Bristol. To date service users identified the following as priorities for the action plan:

Priority order	Priorities as identified by organisations	Priorities as identified by asylum seeking young people	Priorities as identified by adult asylum seekers
1	Local structure where issues are discussed	Specialist help with immigration status	Joint first priority - Housing and Specialist help with immigration status
2	Integration support & Employment	Health	
3	More provision for children and young people	Housing	Joint third priority - Health and well being
4	Housing	Wellbeing	
5	English for Speakers of Other Languages	School/college place	Money

Priority order	Priorities as identified by organisations	Priorities as identified by asylum seeking young people	Priorities as identified by adult asylum seekers
6	Health	Money	Advice
7	Support Welcome Centre Hub – 5 days a week	Advice	School/College/Employment
8	Support for families		

The strategy aims to improve consultation with refugees and asylum seekers on city issues. In the design of services or policies specifically relating to asylum seekers or refugees, the council will ensure consultation with asylum seekers and refugees, via refugee community groups and/or the organisations who support and work with them. Specific use will be made of the consultation 'member forums' which currently exist at Bristol Refugee Rights, Refugee Women of Bristol, Borderlands and Bristol Hospitality Network.

Both the Action Plan and Needs Assessment will be reviewed annually through the Governance Framework.

6 A Co-ordinated Community Response

The Welcoming Asylum Seekers and Refugees Strategy sets the city's priorities and will focus energy and resources to achieve the aims and priorities. Work to develop the strategy will strengthen operations and ensure partners work towards a common goal.

The added value of a co-ordinated community response is to bring people together to identify who does what and when to know when to pass a service user or issue onto someone else. Some refugee sand asylum seekers need generic services to help them to rebuild their lives and flourish and others have specialist care or health needs and need to use specialist services. Generic services need to be supported to ensure they have sufficient understanding to include refugees and asylum seekers in everything they do, but also understand when to refer to specialist support services. It is noted that some specialised knowledge is needed to work with asylum seekers and refugees, especially when offering advice, legal advice and advocacy.

As the strategy and action plan are implemented, a co-ordinated Community Response will develop to ensure better outcomes for the refugee or asylum seeker. Outcomes of a co-ordinated community response will be:

- Generic services and the universal offer in Bristol will be more accessible and responsive to the needs of refugees and asylum seekers and enable people to get help to help themselves.
- Asylum seeker and Refugee support services have specialist knowledge to help people when they need help
- Better pathways will assist support organisations to know when to make referrals to specialist services, such as acute mental health services, specialist assessments and

therapeutic treatments when people need longer term or specialist services to help them to lead their life.

The strategy has a common aim to make Bristol a place of sanctuary and the strategic aims and priorities are wide ranging to ensure that everyone, who wants to do more to support refugees and asylum seekers, is able to contribute. Resettlement programmes in particular, where refugee families are brought to the UK and are given full citizenship rights from arrival, provide opportunities for active citizens and volunteers to volunteer and contribute to improving the lives of resettled families. Any volunteering must comply with safeguarding best practice and there should be supervision of volunteers working with resettled families.

The governance framework will ensure the strategy and action plan help to co-ordinate, shape and share resources more effectively, to create improved pathways and outcomes by building on the strengths of the sector. Progress will be measured against agreed outcomes and regular reviews will assess and adjust the direction of the strategy and action plan in response to the changing environment.

Refugees and asylum seekers from outside Bristol may come into Bristol to use support services or specialist therapeutic interventions. The strategy will work with regional partners to ensure fair funding for local services.

7 Asylum Seeker and Refugee Welcome Action Plan 2017-20

This action plan details how the council seeks to deliver on the priorities identified by organisations and refugees and asylum seekers (Section 5). Following publication of this draft strategy, the city council would like to invite other organisations to tell us about their activities and plans related to these priorities so we can publish a comprehensive plan to make a step change in Bristol to create a welcoming city for asylum seekers and refugees

7.1 Housing

7.1.1 To incorporate the needs of refugees and asylum seekers into the Local Housing Strategy Implementation Plans and into the Homelessness Prevention Strategy.

7.1.2 To research innovative models of housing provision for refugees and asylum seekers including supporting social enterprises, maximising private rented shared accommodation for under 35 year olds on benefits, better pathways from NASS accommodation for families, Real Lettings (joint investment in new private rented short term let properties), making best use of empty residential and other properties, use of permitted development to convert disused properties into residential accommodation and active engagement with local people who want to buy properties to accommodate refugees and/or asylum seekers.

7.1.3 To share and promote translated information on housing rights and maintaining tenancies information.

7.1.4 To use all of our powers to monitor the quality of private rented and NASS accommodation and take action against Rogue Landlords

7.1.5 To work with providers of night shelter accommodation in the City too monitor numbers of refugee individuals and families in emergency and homelessness provision and work to provide additional spaces, especially in the winter.

7.1.6 To develop a Communications Strategy to create greater awareness for landlords on refugee and asylum seeker issues, what documentation is needed under Right to Rent and promoting more lettings for refugees.

7.1.7 To improve information to those seeking social housing in the city to understand the application and allocations process.

7.2 Economic Integration

7.2.1 Work Zone Migrant Project will employ a navigator with experience of overcoming the barriers to employment faced by migrants within the community. The Navigator will coordinate a multi-agency approach through the established Work Zone programme and facilitate the engagement of 70 migrants onto the programme through developing community based peer support networks and groups.

7.2.2 Workforce development for the employment and skills sector will be offered to improve understanding of the specific barriers experienced by refugees and to support employment agencies in recognizing skills of refugees.

7.2.3 To work with employers to develop volunteering and work experience opportunities for refugees.

7.2.4 To develop better information in the refugee sector about what are the labour market needs and gaps.

7.2.5 To improve signposting to NARIC guidance (specialist advice on transferable qualifications), advice on loans, grants and scholarships and access to specialist funded schemes

7.2.6 To work closely with employers who are recruiting in significant numbers, to develop positive action to upskill refugees to compete successfully for vacancies.

7.2.7 To work with employers to develop more in-work ESOL provision and in-work ESOL mentors to support people who want accelerated English learning, Developing an in-work mentoring package to assist with retention and workplace training to prepare the employer for diversifying its workforce and reviewing its fair recruitment and selection processes.

7.2.8 For Bristol City Council to model good practice in the employment, development and retention of refugees in its workforce and to influence its contractors and to monitor progress.

7.2.9 To review Apprenticeship Provision (SFA) which is currently planned and delivered through a local partnership to ensure it is accessible to refugees.

7.2.10 To research national or industry specific models for on-the-job accreditation of existing skills and practical tests for refugees whose qualifications aren't recognised, who do not have evidence of qualifications and those without references.

7.2.11 To review support for entrepreneurs and small business development to ensure it is accessible for refugees

7.2.12 To develop better case management and quality assurance to monitor employment outcomes for refugees using local employment support services.

7.3 English for Speakers of Other Languages (ESOL)

7.3.1 To develop a local ESOL Strategy covering both Bristol and the West of England area to inform adult education resource allocations to provide sufficient ESOL in both college and community sectors with effective progression pathways

7.3.2 To deliver ESOL Training the Trainers to support the training of volunteer ESOL trainers and facilitators that work across a range of partner organisations, ensuring that all volunteer trainers can deliver quality ESOL that embeds employability; digital/ financial skills; intercultural issues/British values. This would include promoting opportunities to become ESOL teachers and access to shared resources.

7.3.3 To set up an ESOL Development Fund to procure high quality ESOL schemes of work, and resources for community based courses

7.3.4 To share and disseminate the ESOL materials and best practice and support the local ESOL Providers network

7.3.5 To strengthen and maintain 15 local conversation clubs that are run by trained volunteers from established communities and hosted by partner agencies (children's centres; health centres; housing agencies; community organisations.

7.3.6 To develop the Learning English in Bristol website where information on ESOL across the city will be in one place, updated by the ESOL Providers Network. This will enable people who support asylum seekers and refugees to be able to sign post people to their nearest classes, advice on how to get to classes and where are the classes with crèche.

7.3.7 To work with partners to increase capacity in the city for accredited ESOL at all levels and to maximise ESOL funding from Government.

7.3.8 To develop courses which integrate ESOL with improving understanding of how services and systems work in the UK for example ESOL for Health, ESOL for Parenting, ESOL for Employment.

7.3.9 To develop linkages with supplementary schools and ensure supplementary schools can be promoted to unaccompanied Asylum seeking young people.

7.4 Young People

7.4.1 To ensure culturally sensitive service provision and health provision through workforce development for our staff, foster carers and the wider workforce: Training programme for newly approved foster carers and more complex modular offer for staff, partners and more experienced foster carers and supported lodgings providers to include cultural competence,

handling disclosure, legal framework, age assessments, wider political and economic reasons for migration and information on trauma and the culture shock cycle

7.4.2 To improve provision for young people awaiting college placements and set up a task and finish group to develop an action plan for newly arrived children and young people without English who arrive mid year in years 6,11, 12 and 13.

7.4.3 To support unaccompanied asylum seeking young people (UASC) to integrate in Bristol, within their own ethnic and language groups and the wider community.

7.4.4 To develop a resource pack on social inclusion activities which may be of interest to UASC and at the first LAC review agree a social inclusion plan.

7.4.5 To co-produce a young people's PHSE curriculum in collaboration with young people to encourage cross cultural understanding including gender roles, healthy relationships, tackling discrimination, staying safe.

7.4.6 To map out current processes and work with advice and legal provider to clarify and improve the legal pathway for unaccompanied asylum seeking children and to prepare young people for what will happen in terms of rights and entitlements after they turn 18..

7.4.7 To develop a multi- agency model to support young people's mental and emotional distress, including access to primary and secondary health care as appropriate.

7.4.8 To support Dublin III children and their relations, to provide sustainable homes and prevent family breakdown where possible.

7.5 Family Support

7.5.1 To improve understanding of local generic services for refugee families who don't meet the threshold for early intervention.

7.5.2 To use additional Specialist Leader in Education time to ensure best practice is adopted in different Early years settings in terms of induction, language acquisition, integration and inclusion of refugee families.

7.5.3 To deploy Early Years staff to support the Bristol Refugee Rights specialist induction and support centre for up to 150 newly arrived pre-school children each year.

7.5.4 To devise and deliver a package of specialist training on the needs of refugee and asylum seeker parents to mainstream Early Years settings receiving children.

7.6 Workforce development

7.6.1 To ensure that Council staff have opportunities for increasing their understanding of asylum and refugee issues, by engaging with the voluntary sector to provide training through one-off, service specific and core training programmes.

7.6.2 We will be open to suggestions from the voluntary sector about where key services are not inclusive or informed, and to taking up offers of free training.

7.6.3 To ensure that equalities impact assessments take into account the impact on asylum seekers and refugees in the design or change of services or policies.

7.6.4 To collaborate and bring together training materials on refugee and asylum seeker issues, and skill building for working in the sector including Looking After Yourself support for volunteers working in the field

7.7 Information, Advice and Guidance

7.7.1 To develop a better understanding of the volume and levels of immigration advice needed in the city. This will anticipate the impact of Brexit and the additional workload from migrants (which could adversely impact on the refugee and asylum sector) and also recognise the debt advice needs for debts accumulated by people purchasing immigration advice.

7.7.2 The council to assist with attracting external funding for immigration advice to communities; to ensure accredited OISC advisors at level 1, 2 and 3 (Office of the Immigration Services Commissioner) and to ensure support for the ongoing need to regularise status and travel documents. There is a particular need for OISC level 2 advisors in Bristol.

7.7.3 Create a transparent landscape of services to mitigate against the damaging impact of unregulated or poor advice.

7.7.3 To work with the advice sector and recommissioning of advice services to find a sustainable model to offer legal advice for asylum seekers and refugees

7.7.4 The Advice Services Needs Assessment highlights the need to further refine services to ensure that the most vulnerable in Bristol are able to access high quality legal advice in social welfare law and to meet the advice needs of refugees and asylum seekers

7.8 Health, social isolation and mental health provision

7.8.1 To consolidate the learning, pathways, good practice and expertise which has been developed in thirteen years of running the Haven service to ensure everyone working in the field understands the role of the Haven and consults with the Haven for referrals for refugees to specialist Health provision.

7.8.2 To work with refugees and asylum seekers to promote knowledge of health systems in the UK to manage expectations and improve access to appropriate provision, for example promoting ESOL for Health

7.8.3 To work with refugees to develop preventative health messages for example diet, smoking.

7.8.4 Create and promote opportunities for settled citizens from similar refugee backgrounds to have a more active role in supporting new arrivals.

7.8.5 To support refugee welcome centres through the Bristol Impact Fund, to reduce social isolation

7.8.6 To work Bristol Hate Crime Services to ensure refugees and asylum seekers know what is a hate crime and how to report

7.8.7 To support the initiative where First Bus subsidise bus fares for vulnerable asylum seekers by 50%.

8 The Governance Framework

The Refugee and Asylum Seeker Partnership Board (RASP) will oversee the implementation of the strategy. Membership will consist of champions for key refugee and asylum seekers needs: Housing, Information, Advice and Guidance, Health, Employment, Young People, Destitution. There will also be a representative from the ESOL Network, two representatives from the Bristol Refugee Forum, a representative from City of Sanctuary (the organisation), the Syrian and MENA Projects Partnership Board and two representatives from refugee

backgrounds. The VCS have requested this be chaired by Bristol City Council who is happy to chair and support the success of the partnership.

Bristol City Council has senior leadership and operational points of lead contacts on refugee and asylum seeker issues; the Service Director – Children and the Commissioning Manager-Refugees respectively. Their roles will be to oversee the welfare, inclusion and integration of asylum seekers and refugees, and lead on asylum seeker and refugee strategy and action plan for the Council.

In addition, the Commissioning Manager role will oversee effective delivery of the council's resettlement schemes and provide support to the RASP governance structures. The Commissioning Manager will enable and support strategic partnerships including the South West Regional Strategic Migration Partnership (quarterly) and the Bristol Refugee Forum (bi-monthly) and lead on collaboration with the voluntary and private sectors on initiatives which include asylum seekers and refugees, increase opportunity, or which bring asylum seekers, refugees and other Bristolians together as equals

9 Performance Management Outcomes

The council is committed to including refugee and asylum seeker status on equalities monitoring forms to assist with identifying outcomes for refugees and asylum seekers using generic services.

There are examples of confidential case management systems used by the council and the voluntary sector to case manage service users who use more than one service, for example substance misuse, domestic abuse and homeless accommodation. More work will be done to identify what current recording systems are used and the viability of introducing a cross sector case management system to measure progress through pathways.

In the meantime we will work with partners to monitor the following outputs:

- Numbers of refugees into work experience
- Numbers of refugees into apprenticeships
- Numbers of refugees who are supported by refugee agencies to find employment
- Number of asylum seekers in meaningful occupation*
- % refugees enrolled in ESOL
- % asylum seekers enrolled in ESOL, community and college, under/over 18 years old, within 1 month, 3 months, 6 months
- Monitor progression through ESOL stages

*Asylum seekers are not allowed to work so 'meaningful occupatio'n covers the need for asylum seeker to find something meaningful to occupy some of their time which will benefit their wellbeing and contribute to the city.

To work with the Home Office to identify the

- Number asylum seekers refused asylum within 40 days, under/over 18 years old
- Number asylum seekers appealing refusal under/over 18 years old
- Number of destitute asylum seekers and length of destitution for asylum under/over 18 years old

- Number of homeless refugees by age and family status

10 Conclusion

Bristol is an international city that looks towards people and cultures beyond its boundaries. It is a diverse, creative, innovative and open city, made up of communities from around 120 countries around the world who speak over 90 languages and practice at least 45 religions.

The Welcoming Asylum Seekers and Refugees strategy and action plan will make a step-change in the co-ordination and development of the city's approach towards refugees and asylum seekers living in Bristol: in the inclusive practices of the council itself, across departments, and in the language and narrative used. The changes will be sufficient for Bristol to be seen as in the vanguard of good practice, motivating other authorities to embark on the same path; and, across the city, for refugees and asylum seekers to experience a greater sense of inclusion and belonging.

Appendix 1 – Bristol Refugee and Asylum Service providers

1625 Independent People house homeless young people aged 16 to 25 offering safety and support and enabling young people to achieve their aspirations. 1625 currently support nine UASC offering 7.5 hours support a week per child. All young people are 16 and over. The young people need an initial health assessment with the Haven health centre for refugees and asylum seekers for vaccinations and registering with GP, and also a Looked After Children health assessment. Out of Hours support is provided through 1625ip other homeless projects, which is important as trauma symptoms may manifest in the quiet hours of the night rather than during the day when there are more distractions.

AidBoxCommunity – have set up a free shop in Bristol for refugees and asylum seekers which is also a community hub for refugees and asylum seekers in the city

Ashley Community Housing is a registered housing association offering a holistic wrap around service for people who have recently received status including housing, training, budgeting, advice guidance and employment support. ACH is the Careers National Service for employment for BME people in the city.

Barnardo's – Barnardo's provide a Friday evening Youth Provision focussing on participation, voice and influence for children in care which is attended by unaccompanied asylum seeking young people.

Borderlands Bristol offer a drop in for two days a week offering a safe space with a focus on welfare and listening. Borderlands work with people seeking asylum in the UK and people who have recently become a refugee, including people who have been trafficked. Borderlands offer hot food, English lessons, advice, access to mentors and courses to assist people to manage their money.

Bridges for Communities and B.Friend – Offer a befriending service to provide social support and meet individual needs for vulnerable refugee and asylum seeking adults who can't access the drop ins. Bridges also provide cross cultural understanding courses, trips and multi cultural meals.

BCC Asylum Team are a casework team. Main duties are statutory assessments and payments. The key works well with the UK Border Agency. The Asylum Team are a specialised team and can offer training on legislation and issues for UASC, and vulnerable asylm seekers and their families.

BCC Community Learning Team: Provide conversation clubs & introduction to ESOL, Read Easy scheme, Adult basic skills English classes, intensive tenancy courses to sustain tenancy, introduction into world of work. Provide ESOL:

- Pre entry (for people with additional needs or a learning difficulty)
- Entry 1
- Entry 2 (functional English to make self-understood)
- Entry 3 (ability to form structural sentences)
- Level 1 (language of persuasion and opinion) and
- Level 2(reading, writing, speaking, listening)

Brigstowe Project support many refugees and asylum seekers as part of its work which aims to improve the quality of life for people living with HIV to ensure people living with HIV live long, healthy lives; building resilience and reducing their inequalities and disadvantages in poverty, stigma, prejudice and discrimination.

Bristol Hospitality Network predominantly support people who are refused asylum. BHN co-ordinates a hosting network to offer accommodation for free on a full board basis and a Solidarity Fund of £10 a week for the most vulnerable members. They also offer volunteering opportunities and involvement in a catering business and run a drop in centre on a Monday at Easton Christian Family Centre and which is open to all, offering a hot lunch and support from an advocacy team for destitute asylum seekers, they offer English classes at 3 levels, games, art therapy, barbers shop, and choir. Advocacy is most the important service because destitution is a temporary state between claims. BHN can't support families as infrastructure does not allow supported lodgings to host children.

Bristol Refugee Rights – Provides a welcome hub for three days a week, offering a safe supportive place where refugees and asylum seekers can receive hot food, ESOL with a creche, advice, advocacy, clothing. The Asylum Support Project provides advocacy and advice on asylum support applications and appeals, finding long term solutions to homelessness and destitution. BRR is registered with OISC at level 1 to provide immigration advice. The Early Years Project supports young children and their families and works closely in partnership with St Pauls Children's Centre. Their VOICE project trains interpreters and encourages members to speak out about their experiences. Peer support enables dignity and solidarity and mobilising around Action for Change. Other agencies also support the Welcome Centre e.g. education, welfare, MIND, the Haven, SARI. The Asylum Support Service is now based at the centre

Calais Refugee Solidarity Bristol is a grassroots organisation which provided humanitarian assistance to the Calais camp known as the Jungle. The organisation aims to raise funds for medicine and to meet essential needs for shelter and safety for children. The project also campaigns for the rights of refugees and their safe passage through Europe.

Citizens UK – Co-ordinates the will, skills and experience of Bristol Citizens to benefit refugees in the city and to lobby local and national Government to improve provision for resettlement.

City of Bristol College ESOL - 932 places are available on part-time ESOL courses for adult learners at the College. Classes are held in the mornings, afternoons and evenings enabling learners to fit their courses around their work and family commitments. Courses are divided into two 18 week semesters, Sept to Feb and Feb to July. Extra Skills classes are also available in addition to the part-time courses to support development of specific skills (i.e. Maths, Writing and Speaking & Listening)

170 places are available on full-time courses for students aged 16-18, ranging from Entry 1 to GCSE. The GCSE/ESOL course is run over 2 years. Year 1 includes functional skills English, maths GCSE and core science GCSE. Year 2 includes GCSEs in English, sociology and additional science.

City of Sanctuary focuses on supporting asylum seekers and refugees who have been recently awarded status to create a welcoming environment for asylum seekers in the city. City of Sanctuary launched with full council support in 2011, activity was co-ordinated

through the council's Community Cohesion Strategy 2010. Most recently, Full Council council agreed a Destitution motion in January 2014 (to work to relive destitution in the city for refused asylum seekers) and, at a national City of Sanctuary conference held in Bristol in March 2015, re-pledged to relive destitution.

Home for Good is a charity which aims to make adoption and fostering a significant part of the life and ministry of the Church in the UK and promote fostering and adoption in places of worship, referring interested carers to register with the local authority.

Knightstone Housing are providing support for the Syrian VPR scheme in South Glos.

Migrant Help – Asylum Help, part of the Migrant Help organisation, provides free independent advice and guidance to asylum seekers across the UK. Migrant Help is a UK charity that has been delivering support services ro migrants in the UK since 1963. Asylum Help operates across the UK and is dedicated to providing confidential and impartial advice funded by UKVI (UK Visas and Immigration). The Asylum Advice (UK) Teams can provide advice and support on; How to claim asylum, The Asylum Process, Accomodation Support, Financial Support; finding legal representation, accessing health care amonst other asylum issues. Services are provided face to face in initial accommodation on arrival (this is based in Cardiff). Once allocated accommodation in Bristol, services can be accessed via a freephone helpline with language support. Monthly outreach sessions are available with partner agencies' venues including a reactive outreach service available on request to assist very vulnerable people. They provide people with information and resources specific to the client's circumstances to help them to understand their situation and make informed decisions. They do not provide any advocacy, but can refert o local support organisations if appropriate. Throughout the UK Migrant Help offer additional services for EU nationals. Foreign national prisoners and victims of modern day slavery (human trafficking). Freephone advice 0808 8000630 (Monday – Friday) 8.30-17.30

Nightstop is funded by the Big Lottery Fund from 1 January 2016 for three years, to provide supported lodgings for young people aged 18-25. 15% of people using Night Step are asylum seekers, refugees or refused asylum seekers. In 1st 8 months provided 408 bed nights. 30 families offer their spare rooms for one or two nights or longer.

Pride Without Borders – a new service supporting LGBTI refugees and asylum seekers with practical and emotional support aswell as representation and advocacy

RedCross offer 'Move On' advice and advocacy for people newly granted Leave to Remain. Destitution support to destitute asylum seekers and new refugees: £10 per week per person in family, for up to 8 weeks, + 4 weeks in exceptional circumstances, sleeping bags for street homeless clients, food vouchers for food banks, toiletries, and clothes vouchers to be used in Red Cross charity shops. International Family Tracing for people to try and re-establish contact with family after separation due to war, conflict, disaster or migration. Training and talks for other organisations on refugees' experiences and needs

Refugee Women of Bristol is a safe space for women to share their experiences. RWOB help women to learn English, communicate with people around them, to begin a new life and learn how systems work in the UK. They also support more settled communities who have less immediate needs and can focus on preventative awareness such as health and safeguarding issues. They provide a drop in with ESOL with crèche and computer club, which works for women whose busy lives make it hard to get ongoing commitment to ESOL.

Refugee Welcome Homes provide accommodation for single male refugees who are under 35 who are applicable for HB but not for home choice. Currently have 8 bedspaces. The organisation is run by volunteers. RWH is in discussion with JRF to persuade JRF to invest in Bristol to try to attract social entrepreneur funding to buy 50 houses for RWH.

SARI – Provide support for refugees who are victims of racist and religious hate crimes, and can act as a referrer into specialist support for victims of disablist, homophobic and transphobic hate crime.

The Haven – a special clinic run by GPs and nurses who offer a service adjusted to better meet the needs of asylum seekers and refugees, joining families and unaccompanied asylum seeking children and victims of human trafficking. They operate in a holistic way dealing with all health needs – physical, psychological and social. The Haven facilitate registration with local GPs and offer a comprehensive health assessment including appropriate public health screenings and updating immunisations. The lead nurse liaises on people's behalf with relevant services, developing pathways and systems for improved provision. There is close liaison with other people working in the sector and GP practices. The Haven manages people within their service for as long as the refugee or asylum seeker needs to be supported within a specialist service.

The HOPE is the name of Bristol's virtual school for children in care and is a structure to improve the education of Children in Care. Unaccompanied Asylum Seeking Children aged 16 and under are registered with the Hope.

University of Bristol – Providing 5 scholarship places for refugee students

University of the West of England – Providing in depth advice on transferable qualifications

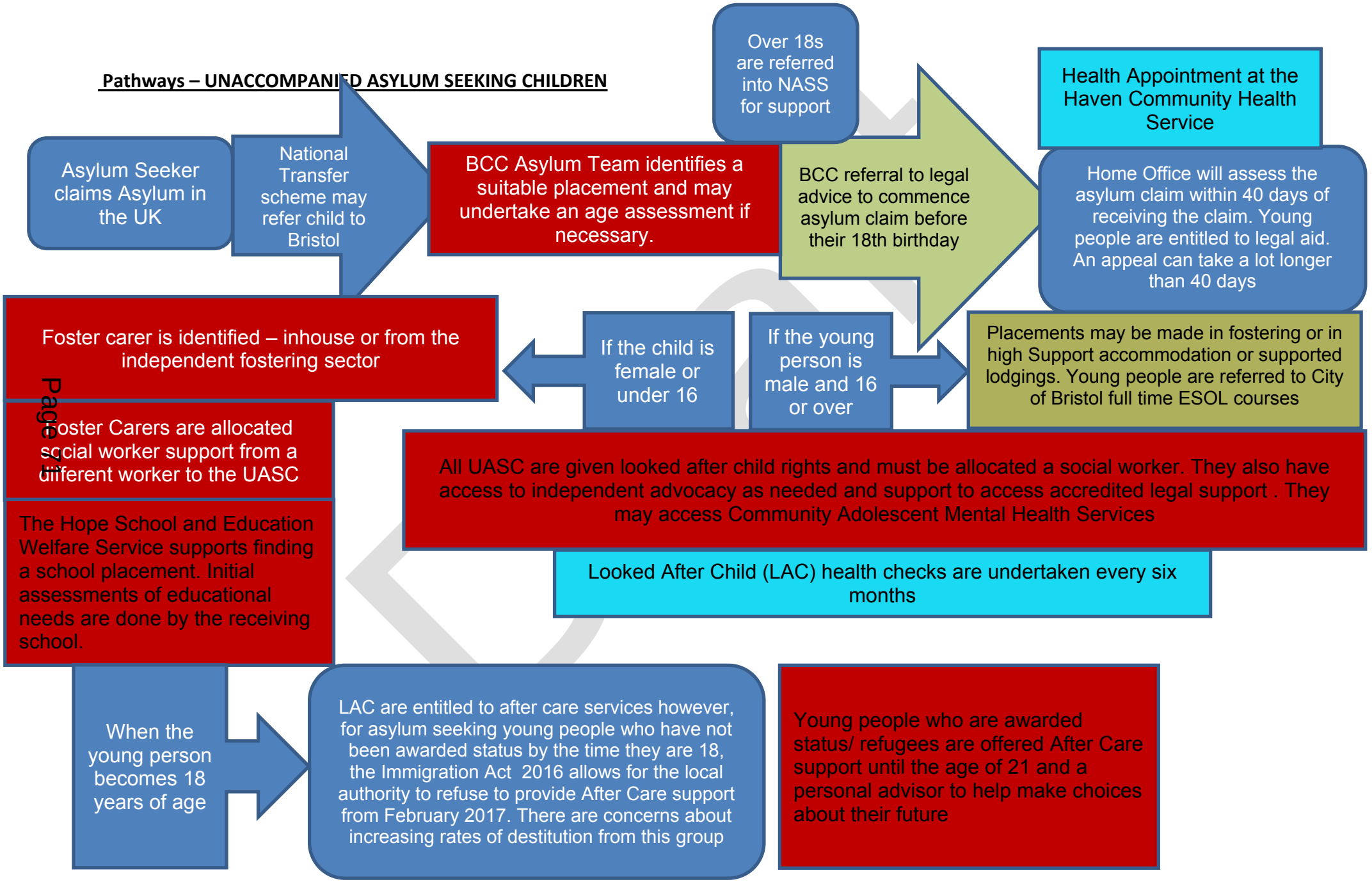
Unseen provide specialist accommodation and outreach support for victims of human trafficking and modern slavery across the South West of England, many of whom are asylum seekers, refugees or have been refused asylum.

We Care Too – Fund raising charity with strong links into Muslim community, providing aid abroad and household goods and practical support locally

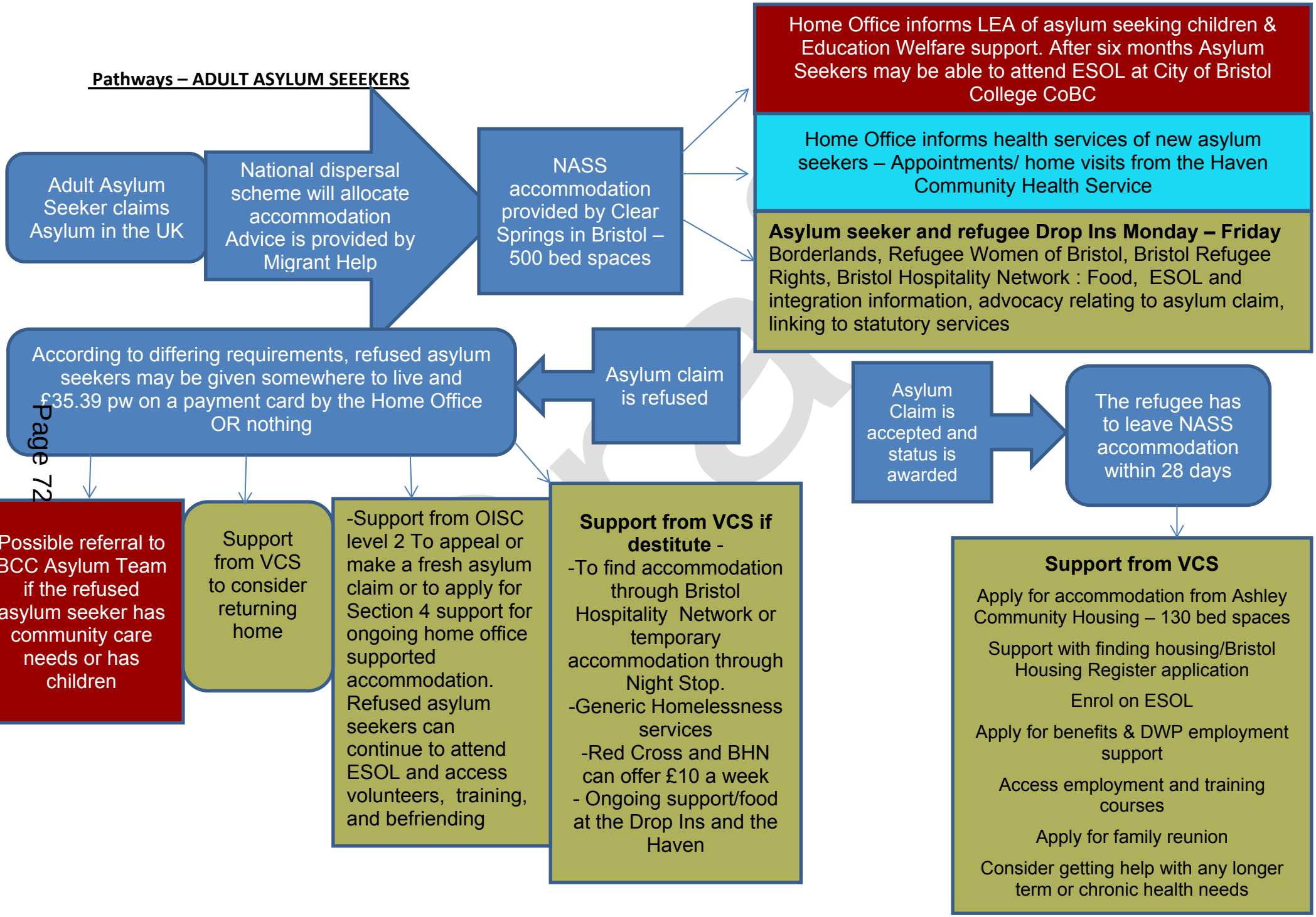
Welcome Committee – Membership includes the Red Cross, B-Friend and Bridges for Communities, local Syrian activists, We Care Too, Severn Vineyard and Brighter Bristol Storehouse, and Westbury On Trym Baptist Church, but has a much wider e-membership who can be called upon for donations. Established to provide wrap around support for Syrian Refugees with strong links into Christian and Muslim communities providing household goods and practical support locally. An additional group has formed to provide wrap around support for UASC

Welcome Wednesdays – Creative Youth Network provide a youth club for unaccompanied asylum seeking children who meet at the Station on Wednesdays at 6pm

Pathways – UNACCOMPANIED ASYLUM SEEKING CHILDREN



Pathways – ADULT ASYLUM SEEEKERS



Bristol Asylum Seekers and Refugees Needs Assessment and Current Activities 2017

Contents

1 Numbers of refugees and asylum seekers in Bristol

Asylum seekers

The UK is a signatory to the 1951 Geneva Convention relating to the Status of Refugees, which defines a refugee, and guarantees fair treatment.

The world has seen unprecedented numbers of people forced into refugee situations in the past few years. The United Nations High Commission on Refugees has counted over 60 million people forced out of their homes for the first time. Over half of these are children. All 145 signatory countries have been asked to ensure that people in need can reach sanctuary, either by making asylum claims ('spontaneous arrivals') or via 'resettlement schemes'.

'Spontaneous arrivals'

People in need of sanctuary have the right to apply for asylum in the UK. In 2016, 38,517 people applied, including dependents – a fall on 2015 figures. In terms of the number of asylum seekers per 1000 population, the Europe average in 20016 was about 2.4. The corresponding figure for the UK was 0.6. Nationally, 90% of asylum seekers came from Asian or African countries in 2016. The top five nationalities for UK asylum applications were Iranian, Pakistani, Iraqi, Afghan and Bangladeshi. The highest number of asylum grants (before any appeal) were awarded to Syrians, followed by Iranians, Eritreans, Sudanese and Afghans.

Those who do claim asylum in the UK are barred from claiming any welfare benefits, from applying for or receiving Social Housing or Housing Benefit, from working, or renting privately. The only legal form of income is a Home Office allowance of £35 pw pp. Accommodation is a room in shared housing, allocated on a 'no choice' basis by the Home Office. The private contract for provision of accommodation to asylum seekers in Bristol (and the rest of the South West) is with Ready Homes. Therefore the Home Office have responsibility for asylum seekers not the local authority (* except for a minority of asylum seekers who have additional needs see page 2)

Ready Homes can provide up to 500 bed spaces in Bristol, although at May 2017 the number was 340.

This exclusion from mainstream services and from working lasts until a positive decision is made on the asylum claim, which can take anything from a few months to many years.

For further information on Asylum seeker data see here

In addition to the asylum seeker families housed through Ready Homes,:

- Approximately 80 individuals and families receive support from the local authority. This includes people who are destitute failed asylum seekers and also those who have No Recourse to Public Funds who are fleeing safe countries but who have humanitarian needs (e.g. fleeing FGM) and who are making an application to the Home Office on Human Rights grounds. Support from the local authority is given only to those who have needs under the relevant sections of the Children Act 1989 and/or Children Act 1989. Support is co-ordinated from Bristol City Council's Asylum Team *

What percentage of asylum seekers are awarded status?

In 2016, there were around 39,000 applications for asylum in the UK, this number includes dependent family members of the main applicant and 21,000 people were turned down by the Home Office at the initial stage of the asylum process.

What is refugee status?

Refugee status is awarded to someone the Home Office recognises as a refugee as described in the Refugee Convention. A person given refugee status is normally granted leave to remain in the UK for 5 years, and at the end of that period can apply for Indefinite Leave to Remain. Other status include Humanitarian Protection, Discretionary Leave

What changes when a person is awarded status?

If a person has claimed asylum and been given refugee status, Asylum Support stops 28 days after the decision. This means the refugee stops getting their cash allowance and has to move house(if they have been given asylum seeker accommodation). Once a person has refugee status, he or she has permission to work in the UK - in any profession and at any skill level. The person has to open a bank account and get a National Insurance number.

This is a vulnerable time for refugees as there most do not have savings to be able to wait for a new welfare benefit claim and most do not have savings to fund a deposit for new accommodation.

How many people are 'new' refugees in Bristol?

The Bristol Red Cross move-on service works with refugees for one year after they receive status. In any one year, there are at least 259 people eligible for a 'within one year of status' service. In the calendar year 2016 the Bristol Red Cross worked with 113 'new' refugees and an additional 146 refugees who had started with the move on service in the previous calendar year but were still within their one year of receiving status.

Refused Asylum Seekers without Support

Bristol Hospitality Network support 30 destitute failed asylum seekers by providing supported lodgings in homes throughout Bristol. BHN estimate a further 100 refused asylum seekers without support are in Bristol. Many may be destitute, homeless or vulnerably

housed for many months or years whilst waiting for their claim to be reconsidered so they are a significant but often hidden part of the asylum seeker population in Bristol.

Refugees and Asylum seekers receiving support in Bristol

Refugees may of course have additional support needs for longer than 12 months after receiving their status, so the number of 'refugees' in Bristol is higher than just 'new' refugees. The different welcome centres record the number of refugees and asylum seekers who access their services but people may attend more than one welcome centre so the numbers quoted below are not all different people.

- October2015 to September 2016, Bristol Refugee Rights welcomed at least 850 different members. From March 2016-March 2017 BRR welcome 391 new members. BRR March 2016 Asylum Status Review: 27% of members were asylum seekers without financial support.
- October2015 to September 2016, Borderlands welcomed at least 469 different people from over 48 countries; 255 of these for the first time. Borderlands estimate that about 40% of its members are asylum seekers.
- Refugee Women of Bristol support around 300 women who are asylum seekers, trafficked women, refugees, spouses of refugees and women granted refugee status in EU countries. 22% of Refugee Women of Bristol's members are asylum seekers and it continues to increase

Resettlement schemes

Resettlement schemes are partnerships between UNHCR and national governments, whereby nations welcome fixed numbers of people already designated as Refugees by UNHCR, usually from refugee camps where living conditions place their lives at risk. Bristol has acted strongly to participate in schemes designed to provide safety to those refugees deemed most at risk in the current crisis.

The Syrian Vulnerable Person's Resettlement Scheme (VPR scheme)

The SVPRS is central government funded, with funding including provision for housing, English for Speakers of Other Languages (ESOL), education and integration support. Families on the VPR scheme have Humanitarian Leave to stay in Britain for five years and from July 2017, families on the scheme have refugee status.

The MENA Vulnerable Children's Scheme (RVC)

The Resettlement of Vulnerable Children scheme is central Government funded with the United Nations High Commissioner for Refugees (UNHCR) to resettle children and adults from the Middle East and North Africa (MENA) region. The scheme supports vulnerable and refugee children at risk and their families. Similarly families have 5 years leave to stay in the UK

Bristol City Council has an ambitious target to resettle 25 families or 100 people each year for the duration of the programme (until 2020), but the target is dependent on identifying appropriate and affordable accommodation. Support is managed in-house by the Equality and Community Cohesion Team but from 2018 the service will be commissioned externally.

By the end of August 2017, 101 people have been resettled which includes two RVC families and 18 VPR families. The scheme offers private landlords a housing management service at no cost for the landlord in return for a property with an affordable rent. Every suitable property offered to the scheme results in a new family being invited to Bristol under either scheme. The growth of the scheme has been limited by lack of supply of affordable properties.

What is the difference between resettlement schemes and 'spontaneous arrivals'?

Unlike spontaneous arrivals, people arriving under the schemes immediately have the right to claim welfare benefits, to freedom of movement and to work.

Therefore people from comparable situations receive different rights and support, for example two families from Syria may have fled at the same time. One found their way to a refugee camp, and from there, via the SVPRS, to Bristol, where they are recognised as refugees and can work, study and receive funded integration support.

The other family found their way to the UK themselves, claimed asylum and were dispersed to Bristol. They are prohibited from working, have no integration funding attached, and need to wait for a decision on their asylum claim. If they have children not yet in the UK, they will have to wait until a decision is made on their claim before they can be reunited.

Unaccompanied Asylum Seeking Children and Young People

This describes asylum seekers below the age of 18, who arrive in the EU / UK unaccompanied by a responsible adult, or who are left unaccompanied after their arrival. Legally, UASC are treated in the same way as UK born looked after children.

'Dubs' Children

The Government has made a commitment to accommodate unaccompanied asylum seeking children who sought sanctuary in Europe or who are in northern European camps trying to reach the UK before March 2016, known as 'Dubs' children. BCC has accommodated children under this scheme and intends to continue doing so if national numbers require.

'Dublin III' children

Some UASC in Europe have family resident in the UK, and so have a right to have their asylum claims considered in the UK, under the Dublin III Convention. They are treated as children who have a family in the Uk and therefore do not have looked after status and the same rights as UASC children.

Spontaneous arrivals

There are also children who arrive spontaneously and claim asylum alone. Many may not know that the a particular age significantly changes their rights and responsibilities. BCC Social Services have a duty to make age assessments for young people referred to them whose age is unknown or disputed, and to provide care and ensure legal advice if they are found to be children. Children arriving via Dover and claiming asylum in Kent or London may be moved to other areas of the UK under the Government's Transfer Scheme

Bristol City Council is currently supporting 65 unaccompanied asylum seeking children and young people, 45 of whom are under 18 and 20 are care leavers. Within these, two have come to Bristol via the Transfer Scheme and three under the Dubs agreement. Seven asylum seeking young people have come to Bristol to join family under the Dublin agreement and have been supported by children's services.

Key Issues for Refugees and Asylum Seekers in Bristol

2 Housing

Housing is a key issue for refugees and asylum seekers, and when consulting with asylum seekers housing was joint top priority alongside legal support, for unaccompanied asylum seeking young people it is the third most important priority and for support organisations is was fourth most important priority.

The main issue was lack of accommodation and homelessness, but concerns also included poor quality accommodation, overcrowding, lack of affordability and transport/proximity to local services. Asylum seekers highlight that safe housing is a priority with many feeling unsafe in their accommodation and they feel little seems to be done by authorities to protect them. Refugees highlighted they would like more support to understand how to apply for social housing and what are the processes used to apply and be assessed for social housing with either the council or registered social landlords in Bristol.

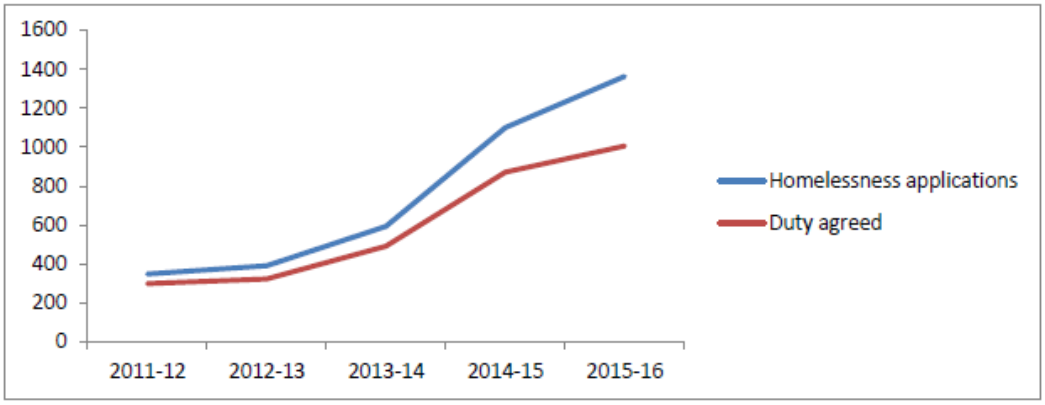
When an asylum seeker is granted refugee status, those who are receiving accommodation and subsistence payments from the Home Office are informed that it will cease in 28 days. This is central Government policy. This is known as the 'grace' or 'move on' period and it is expected that the newly recognised refugee will be able to secure housing and income in this timeframe. As described above, approximately 120 people in a 12 month period will need to find accommodation within this 28 day timeframe In Bristol. In reality the 28 days may indeed be less as refugees need to wait until they have a letter to notify them of status before they can begin to apply for benefits and new housing.

There are considerable housing pressures on Bristol with a significant number of people at any one time presenting as homeless and a limited supply of affordable accommodation. The high levels of rent in Bristol mean it is much harder for people on low incomes to access the private rental market.

Newly recognised refugees are just one of many groups at risk of homelessness and thresholds for services are high. When compared with other groups who are vulnerable to homelessness who have high and complex needs such as significant and enduring mental health conditions, substance misuse issues, rough sleeping and those at risk of domestic abuse, sexual exploitation and sexual violence; newly recognised refugees on the whole have lower needs when compared with the types of complex needs experienced by other homeless people. New refugees do indeed have needs relating to trauma, poverty, isolation and other needs specific to refugees which are not experienced by the settled population.

As competition for accommodation increases and demand outstrips supply, the degree of prioritisation for different needs is important. Below is a table from the Needs Assessment for single homeless adults 2016 showing increasing pressures on homelessness services. The changes to asylum support in the Immigration Act 2016 could increase the number of homeless asylum seekers in Bristol.

The amount of homelessness applications received by the council has increased significantly over the past three years, the majority of which the council has a duty to provide for.



There were 8849 households on the Home Choice Bristol waiting list on 22-06-2016.

What is being done to address Housing Needs?

Ashley Community Housing provide 130 rooms for newly recognised refugees in Bristol, there are 100 people on the waiting list. ACH is a registered housing association which identify properties, apply for exempt status, purchase the properties and then let them to refugees. They provide wrap around support, training, employment pathways and ESOL and aim to move on tenants within 12 months due to the need to free up accommodation for newly recognised refugees. Provision is mainly for single refugees rather than families due to nature of the current housing stock. They have a significant waiting list.

Bristol City Council has agreed to lease three properties to ACH so that they can be used for move on accommodation as part of their refugee resettlement programme. All three properties required extensive repair and refurbishment and the cost of this was funded by ACH. In return, the Council agreed to grant leases for 10 years at peppercorn rents in order that ACH could fund the repair work. These three properties are part of an ongoing

programme where the council has been looking at various options to bring empty flats and houses back into use. The three properties are now fully renovated and will be used to house 5 tenants and enable the resettlement of 40 refugees over the next ten years. ACH are keen to work with other partners in the same way, to minimise empty houses in the City and help house the refugees on their waiting list.

Refugee Welcome Homes provide accommodation for single male refugees who are under 35 who are applicable for Housing Benefit, there are currently have 8 bedspaces. The organisation is run by volunteers. Refugee Welcome Homes are working to attract social entrepreneur funding to buy houses to be offered to at affordable rent levels for working refugees (not exempt rents).

Green Pastures is a social investment company working with 50 partners nationally to provide accommodation and support for over 780 people. Green Pastures is approaching local authorities in the South West to provide accommodation for refugees but there are no specific plans for Bristol at present. Other local social entrepreneurs and community interest companies are considering purchasing accommodation to let to refugees.

Community and Faith organisations which own properties could be persuaded to let accommodation to refugees , most are charities and have to earn a 'market rent' from any property in line with charity regulations therefore accommodation for asylum seekers with no recourse to public funds is limited.

The Syrian Refugee Resettlement Programme supports refugees and approaches private landlords offering a housing management service to encourage landlords to offer quality housing at Local Housing Allowance rates

Bristol Hospitality Network support predominantly refused asylum seekers. They offer accommodation for free on a full board basis and a Solidarity Fund of £10 a week for most vulnerable members. This is offered by volunteers who donate a room from their home. They also offer volunteering opportunities and involvement in a catering business and run a drop in centre on a Monday at Easton Christian Family Centre and which is open to all, offering a hot lunch and support from an advocacy team for destitute asylum seekers. BHN can't support families as infrastructure does not allow supported lodgings to host children.

Bristol City Council has obtained funding from the Controlling Migration Fund for two years to identify and target rogue landlords in the city who exploit migrants, and to take legal enforcement action. To undertake this work the council is recruiting 1.5FTE additional officers to provide support and prevent unlawful eviction and to take a range of legal action and an Environmental Health caseworker to undertake targeted inspections of known rogue landlords' properties.

Unaccompanied asylum seeking children are entitled to accommodation up to the age of 18 (and thereafter if status is granted). Some young people will need a foster placement and

some young people aged 16 and over will use supported lodgings (co-ordinated by Reconstruct) or supported accommodation provided by a number of youth-specific contractors. Supported accommodation placements are baed on the need of the child and not their status so these bedspaces can be used by UASC and care leavers with status. Young people are particularly challenged by the high costs of rents because age affects wage levels for example the National Living Wage affects people aged 25 and over and the National Minimum Wage is affected by age, see below.

Year	25 and over	21 to 24	18 to 20	Under 18	Apprentice
April 2017	£7.50	£7.05	£5.60	£4.05	£3.50

3 Employment

Social Integration

Finding employment is key to the social integration of refugees and is identified by support organisations as the second most important issue for refugees. Consultation with asylum seekers highlighted how the legal restrictions which prevent them from working and from some volunteering, is harmful to their health because they are unable to have a meaningful activity to structure the day/week to give them purpose or enable them to provide for themselves. They also feel de-skilled through under usage of their occupational skills.

The UK has a high productivity, highly accredited workforce. Many jobs require a minimum of GCSE English or Maths or require evidence of technical qualifications. Refugees may have qualifications but these may not be recognised in the UK or they do not have paperwork to evidence their qualifications, or they do not have the technical English to pass health and safety tests, or the Driving Theory test.

> Age, education and skills as well as motivation and work ethics are key to the labour market integration of all migrant groups, including refugees….A lack of (English) language skills, a low educational background or a lack of transferable job qualifications are barriers explaining a slow labour market integration of all categories of migrants. Refugee-specific obstacles are legal restrictions to access the labour market, a long duration of the asylum procedure and a temporary, insecure residence status. These barriers prevent refugees from quickly and fully participating in the labour market. Beyond these barriers, factors like less developed social networks, housing regulations, health conditions like trauma and violence during flight have strong links with the labour market outcomes of refugees. Additionally, cultural barriers are aggravating factors, and are likely to be greater for the recent refugees than earlier migration groups
>
> **Labour Market Integration of Refugees: Strategies and good practices**
> **IP/A/EMPL/2016-08 PE 578.956 March 2016 EN**

Child poverty

Employment is a key factor in alleviating child poverty. Migrant and refugee children are overrepresented among children living in poverty in the UK.

> The causes of child poverty in poor migrant families are often the same as in the larger population, as are the solutions. These include enabling parents to move into and stay in work, affordable childcare, ensuring that benefit levels do not punish children and supporting low-income families in work. But migrant families also face some specific issues. Many are starting again, without the accumulated possessions of others. Support networks that enable other low-income families to cope can be severed by migration. Language barriers can impact on migrants' employment prospects and lead to a lower uptake of benefits. Remittance payments and support for destitute irregular migrants also impact on family welfare.
>
> IPPR – Shared Ground 2014

Commonalities between refugees and migrants

There are strong correlations between support the refugees need to enter the labour market and the support economic migrants need to enter the labour market. The Census 2011 highlighted that people not born in the UK are 16% of the population in Bristol and 9% of Bristolians not born in the UK are relatively new arrivals, so devising a policy response which meets the needs of economic migrants and refugees could have a positive impact on a significant proportion of the local population.

Figure 14: Length of residence in the UK

Source: ONS © Crown Copyright 2013.ONS Crown Copyright Reserved [from Nomis]

	Bristol	%	E&W%
Born in the UK	365,108	85.3	86.6
Resident in UK: Less than 2 years	9,610	2.2	1.7
Resident in UK: 2 years or more but less than 5 years	12,256	2.9	2.1
Resident in UK: 5 years or more but less than 10 years	16,262	3.8	2.8
Resident in UK: 10 years or more	24,998	5.8	6.8
Total population	**428,234**	**100.0**	**100.0**

Both groups need an early offer of language tuition and skills assessment. Both groups need quality careers counselling to develop an individualised integration plan. Both groups struggle with a lack of recognition of foreign credentials and a lack of alternative methods of assessing informal learning and work experiences. Both would benefit from job search assistance and quality mentoring.

However there are also important differences.

- Economic migrants have chosen to come to the UK, but refugees have enforced migration.
- Both groups may have acquired employment experience and skills in a labour market at home which is very different from that in the UK but economic migrants are more likely to choose to relocate to an area which has a similar job market or where they have a local connection from home who can assist them to find work.
- Economic migrants can apply for work and have their qualifications validated, sometimes before arrival in the UK. Refugees generally arrive with weak, if any attachment or link to the host country and have gained qualifications and work experience in very different labour market conditions. Many refugees are not able to provide proper documentation that would clarify their level of education or skills.
- Refugees will establish long-term residence in their destination countries, whereas economic migrants can travel between countries for seasonal work or family needs.

Job Seekers need specialist ESOL Support

The Community Learning Team estimate generic ESOL courses can take up to three years (1000 teaching hours) to move from pre-entry level to Level 2 (reading, writing, speaking, listening). Ashley Community Housing report that refugees need Level 2 English skills to be able to move from minimum wage level work into work earning £10 an hour or more.

Refugees in work have less access to ESOL and can stagnate in entry level jobs, because they cannot progress their English skills to obtain higher level jobs which may be more commensurate with the kinds of work they were doing in their home country. There needs to be an Increased availability of on-the-job training for high-skilled refugees to improve content and delivery of skills-based language learning

People with previous experience of education find it easier to learn English so language courses should differentiate in length and level of offered language courses to take into account refugees' varying educational levels

> While each individual arrives with a unique set of human capital endowments and abilities, receiving country labor market structures and economic conditions influence how readily this human capital can be put to use. Human capital that can be easily transferred to the host country labor market allows for the fastest integration. But immigrants with (1) low levels of education, (2) human capital that is not in demand in host country labor market, or (3) human capital that is not transferable (because of language, credentials, or other barriers) are more likely to work in unskilled positions—or to have difficulty entering employment all together.
>
> MOVING UP OR STANDING STILL? -Access to Middle-Skilled Work for Newly Arrived Migrants in the European Union -Meghan Benton, Susan Fratzke, and Madeleine Sumption July 2014

Specific barriers for Refugee Women seeking employment

Research published in 2015 by IPPR 'Migrant employment outcomes in European labour markets' identified the low employment rates of non-EU migrants in Germany and the UK (relative to those of non-migrants) can be almost entirely accounted for by lower employment rates among women in the migrant population compared with women in the non-migrant population. In the main, dual income households live above poverty levels, but single income households with entry level jobs are more likely to need tax credits to lift their above poverty levels. Therefore supporting employment for women migrants is important is enabling families to support themselves and to achieve better outcomes for children.

Many refugee women are actively looking for employment but have experienced barriers that are a consequence of being a refugee, such as trauma and stress and health problems and need more support in terms of language and access to specific skills. Refugee Women of Bristol (RWOB) report that in the cultures and the norms that many refugee women grow up in, it is uncommon to be in the labour market, therefore it takes a long time for them to gain the confidence, skills and language they need to secure employment. Furthermore, most of the RWOB members are single parents and find it difficult to access affordable childcare.

The importance of Accessible Generic Provision

In Bristol employment and skills providers are developing generic pathways to meet the needs of diverse citizens who experience additional barriers to the labour market. It is important that generic provision is accessible and relevant for refugees. Initial assessment's follow an ABCD model and employment navigators work with individuals to produce a personal pathway plan

- **Assets** – What I'm good at
- **Barriers** – What's stopping me
- **Commitment** – What's needed to get and keep a job
- **Development** – What more I need to get and keep a job

It is important that the generic provision recognises the main barriers to employment for refugees:

- Lack of English which causes an immediate barrier to finding work, a barrier to finding work in a specific field due to lack of technical English and longer term causes a barrier to progression.
- Lack of tailored English language support provided by competency level or available to people who already in work and who want to progress their English
- Imperfect information about and access to a range of services, entitlements, and support, for example access to housing when given status and needing to move

from NASS (asylum seeker) accommodation, family reunion, transferability of qualifications, access to higher education funding, employment rights.

- There can be lack of self-belief and/or motivation to take action and invest in skills development which would increase their employability and which could then lead to higher earnings
- The higher incidence of barriers which can diminish employability , such as: lack of adequate housing supply; health inequalities, including higher levels of long term illness and disability; lower educational attainment and qualifications, including lower levels of literacy, numeracy and IT skills.
- Employer practices and behaviour which do not sufficiently encourage staff training and development and/or where individuals are in employment which is less likely to benefit from progression support, such as zero hours contracts, temporary contracts, and self-employment.
- Employer lack of confidence to 'take a risk' on an employee who has no previous employment history in the UK, may require a longer induction than other employees

The impact of the Flexible Job Market

In 2015, as part of a research project conducted with Bristol Refugee Rights and the University of Bristol, a group of members were interviewed. They had been granted leave to remain for varying lengths of time within the previous 7 years:

- Only about 50% had ever had any employment.
- Only 12% currently had regular (part time) hours.
- 30% had zero hour contracts.
- 60% had experienced homelessness in the UK
- 11% were homeless when interviewed.

The changing nature of the UK labour market has led to increased insecure employment and self-employment.

Work with employers

Initiatives to improve employment for refugees needs to include work with employers to increase security of employment and working hours, improve access to on the job training including language provision, encourage staff progression, understanding specific issues such as cultural issues and difficulties in getting a reference from an overseas employer and provide more flexible working for parents and those with caring responsibilities.

What is being done to address Employment Needs?

The council has successfully obtained Controlling Migration Funding from the DCLG to progress a Work Zone Migrant Project which will provide a dedicated fund to support at least 70 migrants to obtain the personalised support they need into employment. This service will be targeted at people with ESOL language development needs, including both

established community members who have experienced long term unemployment (for example people from local Pakistani and Bangladeshi communities) and also more recent migrants and refugees who are either unemployed or under-employed (i.e. not utilising their full qualifications and professional work experience).

All potential service users will undergo an in-depth diagnostic assessment from a local 'Navigator' resulting in a detailed action plan and individualised support package, resourced through a personalised budget allocation to help overcome specific barriers e.g. lack of qualification evidence; lack of UK work experience to develop work related English language skills at an appropriate level; specific language 1-2-1 coaching in a specific technical area etc.

Ashley Community Housing is funded by the national Careers Service to provide employment support for refugees (in addition to other target groups). Ashley Community Housing worked with DWP to support 40 very disadvantaged people and 50% were in work within 6 months. ACH Guard to Earn course includes a work placement, Security Industry Authority door supervision training, employability skills and for successful learners, a fully funded SIA badge. For people with Entry Level 3 English skills, volunteer work placements with local organisations provide a progression route for those tenants completing employability courses and an opportunity to showcase their skills and complete key employability units such as 'Working in a Team'.

The Society is a small social enterprise offering help to refugees with finding employment, writing a CV and an application form and preparing for job interviews.

Borderlands deliver the My Futures Project aimed at refugees, especially people who have recently received 'status' in the UK and who often have very limited understanding of UK systems in which they must now participate. The programme is delivered by local expert charities, Pennywise, The Society and Ashley Community Housing to advise on Housing, Benefits & Grants for people on low incomes, Managing money and a household budget on a low income; reducing utilities costs; and avoiding debt, Opening a bank account, Employment and Supported volunteering to prepare for work

Bristol City Council has published a Welcome to Bristol pack to support refugees and migrants into work, which is published on the Ways2Work website in ten languages.

Public Health have experience of providing health improvement training and support working through social networks, for example by working with community activists to spread the no smoking message and to provide one to one support for people wanting to give up smoking. These same community dynamics could be used for employment champions and these organisations could be upskilled to support people into work. As a first step, the Welcome to Bristol translations are being promoted using posters in community languages which will be displayed in cafes and through community networks which have credibility amongst refugee and migrant communities.

The Refugee Welcome Centre Network is used by people in work and those who are out of work. Once people get their status there is a sudden need for English skills to be of a level where they can access employment, for example refugees are expected, in order to qualify for Job Seekers Allowance, to be able to work and actively looking for work. A key theme that came out of the Bristol Refugee Rights research in 2015 was the lack of knowledge refugees have of services and support available to them once they have leave to remain and so they keep returning to the Welcome Centres as an organisation they know and trust, for support and information.

3 English for Speakers of Other Languages (ESOL)

To accelerate community integration, the Casey Review has recently reinforced the strong case for ESOL and support for economic inclusion, including:

- Building on classes to tackle English language deficiencies with the development of classes to tackle cultural barriers born out of segregation
- Supporting further targeted English language provision by making funding available for community based English language classes
- Reviewing whether community based and skills funded programmes are consistently reaching those who need them most, and whether they are sufficiently co-ordinated.

Key ESOL issues in Bristol

Provision for 19+ ESOL has developed in an ad hoc way across the City as a response to increasing demand and decreasing funding. Many of the providers are meeting on a regular basis as a network to share information and discuss referral routes, but there is no mechanism to review provision or to plan strategically for the needs of the City and City Region;

There is anecdotal evidence that demand for formal Skills Funding Agency ESOL delivered primarily through the City of Bristol College is higher than can be met; there are often waiting lists for the next enrolment round and they take about 20 enquiries a day.

The City Council and local VCS organisations are responding to the excessive unmet need for community based provision by providing flexible classes run by volunteers. There is a need for more customised volunteer training and resource development to improve the quality and outcomes from this provision.

There is a lack of strong progression pathways and support through ESOL levels and into work. Much of the provision is unaccredited, and so the curriculum is not prescribed and is left to individual tutors to develop. As learners move from one setting to another they are often repeating work or have skills gaps that are not addressed and they are not progressing quickly. This also means that learners may not be getting the technical language they need for particular career pathways or the skills they need to enter the local job market.

ESOL learner destinations are not systematically collected, so the longer term impact on much of the provision is hard to measure and there are still limited opportunities to study ESOL alongside vocational qualifications.

There is also a shortage of IELTs courses and these have to be paid for privately – this is the International English Language Test System qualification required to prove English competence for students entering university or overseas professionals transferring to the UK.

There is also a growing demand for ESOL for social and community purposes, e.g. older people who have not acquired English skills, or parents supporting their children – whereas current funding is directly linked to getting people into employment.

There is a lack of crèche places supporting ESOL classes. Refugee Women of Bristol (RWOB), Borderlands and Bristol Refugee Rights (BRR) provide ESOL classes with crèche support. The Workers Education Association has 11 creche places and a waiting list of 25. The College and Beacon Centre have no crèche facilities, and the College has no on- site nursery provision, but can fund some childcare through the Learner Support Fund. It is also important for many learners to match class times with their children's nursery sessions.

What is being done to address ESOL Needs?

The Bristol ESOL Network brings together ESOL providers to update information on what is being provided in which locality to which level to enable people needing ESOL to be signposted to the provision which best meet their needs in terms of locality, or child care or English levels.

Pre-16 Provision

Provision for learners under 16 years is mainly delivered through schools, nurseries and Children's Centres, which receive an element of EAL funding in their general funding formula Children now tend to be 'immersed' in mainstream classes with limited small group EAL backup. There are limited numbers of multi-lingual support staff and associated in-class support is not always available. The challenge now is to ensure all teachers and support staff really understand the needs of EAL learners, and incorporate effective strategies into their planning, but teachers report that they do not feel that this area is adequately covered in generic initial teacher training programmes.

Some schools and colleges support students to take Level 1 or 2 ESOL qualifications as a stepping stone to GCSE and to help them access post-16 provision. Others put a significant emphasis on supporting them to gain qualifications in their home language.

The admissions process has led to higher numbers of EAL learners being concentrated in particular schools (in Central and East) which places pressure on them to deliver EAL as part of an inflexible Key Stage 3/ 4 , and has led to the appointment of a specialist support

worker by the Cabot Learning Federation. Unaccompanied asylum young people are on the school roll but also are entitled to additional support from the HOPE Virtual School as children in care, and to financial support through Pupil Premium.

There is particular expertise in certain inner city Early Years settings, in some of which the majority of learners have EAL, and where the curriculum is designed to assist their English language acquisition as well as supporting the ESOL needs of their parents. Children's Centres often supplement their provision with ESOL as part of family learning programmes. An increasing number of multi-lingual staff are being employed in these settings as teaching assistants, family support workers etc. Bristol Refugee Rights and Refugee Women Bristol also have a joint early years project supporting the children of newly arrived refugees and asylum seekers in their English acquisition, and preparing them for transition into school or nursery.

16-18 year old provision

The City of Bristol College is the largest provider for 16-18 year old ESOL learners (and has 170 students, plus two under 16). This is full time provision funded by the Education Funding Agency, consisting of a two year programme with Reading, Writing, Speaking and Listening, Functional Skills Maths, ICT and Sport the first year, with an opportunity to add in GCSEs in the second year. They have a 95% retention rate and 40% move on to take Level 1 qualifications. There has been a recent increase in the numbers of unaccompanied asylum seekers, and they now have 24. In other sixth form provision, it is sometimes possible to take ESOL Level 2 qualifications alongside A Levels or BTECs, but little specialist support is available.

Post-19 (adult) provision

City of Bristol College has the most extensive adult provision, and caters for 930 students at three centres (College Green, Ashley Down and Kingswood). Demand is higher than can be met, and there are often waiting lists for the next enrolment round and they take about 20 enquiries a day.

The College also contracts with community organisations to deliver Skills Funding Agency (SFA) accredited courses (59 places with Ashley Community Housing for Entry level only classes, and 277 places with the Beacon Centre (part of City Academy) for Entry 1 to Level 1 provision plus Literacy and ICT).Recently, a contract with SPAN to deliver classes to 100 people with crèche support ceased, which has caused particular issues in the Easton and Lawrence Hill area of the City .

The Workers Education Association provide SFA funded Pre-Entry to Entry 3 classes at Barton Hill Settlement and Pre- entry to Level 2 classes at St Paul's Family Learning Centre .

The City Council's Learning Communities Team currently facilitates 28 courses in community venues and schools which include 314 learners (with 158 creche places). Information,

Advice and Guidance is built into their courses and 42% progress to further learning with second step providers and 10% progress internally to employability through functional skills etc. They also commission partners to deliver where they identify gaps e.g. St Mungos at their Recovery College, New St Centre. They have conversation clubs with crèche provision in 15 venues run by volunteers as a sustainable model of provision in times of limited funding, and have ESOL work with parents embedded in some Children's Centres (like Bannerman Rd) with crèche provision.

The Refugee Welcome Centre Network have responded to the unmet need for flexible ESOL provision with childcare, or for classes fitting into school times and not requiring a regular commitment for those who have unstable housing, and have developed unaccredited classes run by volunteers, funded by trusts or donations. There is no standardised curriculum or quality assurance, but local people are increasingly relying on this provision. BRR (Bristol Refugee Rights) is the largest, catering for over 200 students last year, with classes at seven levels from Entry Level to IELTs preparation, funded by a national trust. It also fundraises to provide a creche to support the parents while in class. Bristol Hospitality Network, Refugee Women of Bristol and Borderlands also provide small non-accredited ESOL classes. RWOB has with crèche support.

Refugee and Asylum seeking Young People

There are five main groups of refugee and asylum seeking children and young people who may have additional needs

- Unaccompanied asylum seeking children and young people
- Refugee children
- Children of parents who don't have refugee status
- Early years provision
- Dublin III children and their host families

4 Unaccompanied asylum seeking young people

In the year ending March 2016, 22 UASC children started to be looked after, a rise of 32%on the previous year's total of 15. The 2016 figure is in line with this year's referrals with 25children becoming looked after up to 5th July 2017. As of July 5, 2017 Bristol had 50 unaccompanied asylum seeking children in our care and 21 care leavers.

Currently all young people who are the responsibility of Bristol are cared for either within the Bristol area or placed as closely to Bristol as possible but remain the responsibility of Bristol under Looked After Children's requirements. The majority of all unaccompanied children and young people live in foster care: 37 (75%),;11 (21%) live in supported independent accommodation; and 2 (4 %) are living in a children's home.

Bristol has 21 care leavers aged 18-21 who were unaccompanied asylum seeking children when they came into care. The majority live in supported accommodation, however 7

(33%), continue to live with their former foster carer and (4=19%) live in supported independence and2 (10%) in a children's home.

The largest group are children from Afghanistan (28= 60%), with smaller numbers from Eritrea, Albania, Egypt, Iran, Iraq, Nigeria and Somalia. Similar to the national picture, the majority are male (40 = 93%) and aged 16 or 17 (24 = 56%).

Bristol has cared for and supported unaccompanied children arriving in the city and seeking asylum since the early 1990s when children and young people travelled to the UK escaping conflict in Bosnia, Serbia and Croatia. Since that time, children and young people have presented in the city with increasing frequency and from a variety of countries of origin escaping conflicts in Afghanistan, the Middle East and Africa.

There are three groups of unaccompanied children who arrive in the city:

- Spontaneous arrivals are those who first present once they have arrived in Bristol
- Those accepted through the National Transfer Scheme which is administered by South West Councils coordinate the Regional Strategic Migration Partnership of Local Authorities in the region. This is the mechanism by which children and young people, who have arrived in Kent or other areas where there is a higher than average ratio[1] of unaccompanied children to total child population, are relocated across councils in England. Local Authorities work on a voluntary and in this region, rota'd, basis to accept children through the national scheme.
- Those accepted from Europe and the camps in Northern France or elsewhere (often referred to as 'Dubs' children).

Upon arrival in Bristol or the UK, for those coming from European Camps or through the National Dispersal Scheme, an initial interview and age assessment is undertaken to determine the child or young person's age. Those reporting and initially assessed as under 18 become looked after children under Section 20 of Children Act 1989 and a placement found that is best able to meet their needs. The child or young person will then receive all the support and services provided to children in our care whilst the full age assessment is completed. This is generally a time of uncertainty for young people as most are aged 15-17, have poor English and little understanding of the looked after children's system in the UK. Use is made of translation services to help us, the young person and carers or others understand what's happening and what's needed.

In addition to the looked after children system, unaccompanied young people are required to negotiate the Immigration system. If they are under 17.5 years, they will be given

[1] No region is expected to have in excess of 0.07% in relation to their current total child population with each region expected to increase their numbers to this threshold where appropriate. The ratio does not include children leaving care or out of area placements, with the plan that the transfer scheme will be used to enable out of area placements to be transferred to the host authorities where this is mutually agreed.

discretionary leave to remain if their asylum case is unsuccessful and the Home Office accept there are insufficient reception arrangements in their home country for them to be returned. Alternatively if their asylum claim is successful, they will be granted 5 years refugee status. If they are granted leave to remain until they are 17.5, they will then need to make a further application to remain in the UK before their 18th birthday.

At age 18, unaccompanied children who have leave to remain or who are appealing against the end of their leave to remain will become Former Relevant Care Leavers provided with the full range of support and services available to all care leavers. Pathway Planning with such young people is complex as it must incorporate plans to stay in the UK alongside the possibility of departure from the UK and must include support for legal and Home Office requirements alongside the support required for the young person to develop the skills for a successful adulthood.

For those whose appeal rights have ended however, the Immigration Act 2016 removed all rights under the Children Act. The expectation is that these young people will be returned to their country of origin and that support and services revert to the Home Office support that would be available to any other adult asylum seeker. There is a risk that as a refused asylum seeker, they won't get any support from the Home Office unless they agree to making a voluntary departure which means they could find themselves homeless at age 18.age assessment

Health

Children and young people often require additional health care with young people having both physical and mental health needs relating to their experiences and journey to the UK.

Their experience suggests that for the first few weeks after arrival young people appear to cope well, sometimes showing signs of relief that their journey is over. However, leaving family, friends and country and travelling to the UK is often traumatic and on arrival the immigration process is complex, challenging and anti-therapeutic. After a number of months they often hear that some of these young men are having trouble sleeping, are irritable and short tempered, with formal assessment finding that they are showing signs of Post-Traumatic Stress Disorder.

Whilst there is no dedicated health service for unaccompanied children and young people in Bristol and the treatments offered are not always adapted or appropriate to their specific requirements, when a child or young person presents at the Children Looked After Nurses (CLAN) and Thinking Allowed (a service for foster carers) are notified. The child's social workers and foster carer will then be invited to an appointment soon after the young person's arrival to begin to think about their emotional well-being and mental health and to identify things to look out for.

Additionally, the locality CAMHS' teams have developed considerable expertise, with the East Central Team in particular providing therapy to unaccompanied children and young people, support to foster carers and consultation to schools and other CAMHS teams. Their time is limited, and the absence of a dedicated health service means that some young people have to access adult specialist reception services or rely on school and foster carers.

A recent survey undertaken by Barnardo's in Bristol identified that staff and carers feel they lack the knowledge, experience or skills to feel confident in working with asylum seeking children and young people.

Education

The education of unaccompanied children and young people (UASC) who are in care is overseen by The HOPE; Bristol's Virtual School for Children in Care.

The HOPE supports Social Workers to apply for appropriate educational provision for all UASC.

- For UASC presenting with a date of birth which makes them of statutory school age (school years 7 to 11), this is an application to the closest school to the home address with a good or outstanding Ofsted judgement. The HOPE aims for all statutory school age UASC to be admitted within 20 school days of coming into care as per the Admissions Code. Bristol currently has 24 UASC of school age; of whom 23 are in school and 1 is newly arrived and awaiting a place.
- For older young people this is usually an application to the closest college offering a suitable ESOL course (English for Speakers of Other Languages). Bristol currently has 24 UASC in Years 12-14; of whom 22 are in college and 2 are newly arrived and awaiting a place.

Where The HOPE is made aware by the child's social worker or Asylum Team worker that it is thought the child may be older than the age they have given or may even be an adult, the HOPE work with social care colleagues and the education setting to ensure an appropriate course of action to safeguard all involved.

Asylum team

Children's social workers work in close liaison with the asylum team to jointly undertake age assessments with the child's social worker and advise on immigration application and appeals process. Case law requires all age assessments to be completed by two qualified social workers[2] and for an appropriate adult to be present. Bristol's asylum team have developed considerable expertise in undertaking age assessments and are sometimes commissioned by other local authorities. The process must be evidence based and can require an extended period particularly when the assessment finds the young person to be older than their given age are often subject to legal challenge.

[2] Referred to as 'Merton compliant'

Legal Support

Specialist help with immigration status was the most important issue for the unaccompanied asylum seeking young people. At present young people use legal support from local solicitors but a more rigorous pathway is needed. The University of Bristol Law Society is scoping a piece of work to develop concrete principles to

- Align the best interests of the child as defined in the United Nations Convention on the Rights of the Child within the legal pathway
- Research and define and improved legal pathway
- Produce guidance and training for professional Guardians
- To highlight the effects that lack of full legal status has on children

Safeguarding

In relation to age assessments, due regard must be given to safeguarding both unaccompanied and other children in foster care and at schoolensuring that young adults or those who declared age may not reflect their true age are not placement and, as noted above, in school.

In 2014 the Government issued statutory guidance on unaccompanied and trafficked children outlining and enhancing local authority and other agencies' responsibilities under the Children Act to unaccompanied and trafficked children. It required local authorities to clearly record and plan measures that will safeguard and support children where trafficking is a concern.

Bristol's Community support for asylum seeking children – the offer

The media coverage of the refugee camp in Calais captured the interest of many people in Bristol who then pledged their support for children and young people coming to live in the city. The Mayor too has been explicit in his commitment to Bristol as a City Of Sanctuary, offering an initial 10 placements to unaccompanied children.

As a result of this groundswell of support from various sections of the community, including refugee and faith communities, a project group chaired by the Placement Services Manager was formed to coordinate the offer to newly arrived children and young people. The offer includes practical help such as training to staff and carers as well as gifts such as 'start up home packs' for older young people, copies of the Quran, and donations of money. At Christmas, friends of the Bristol Calais Refugee Solidarity group in Bristol and the USA raised over £1000 for the young people who had recently arrived from Calais that was gifted to young people and used in the January sales!

Increasing Placements for UASC

Bristol has developed its carer and supported accommodation provision to be better able to meet the needs of unaccompanied children and young people. Ensuring there is sufficient provision across a range of placement types remains a challenge.

The recent campaign to recruit foster carers for asylum seeking children and young people indicated that there is willingness in Bristol to care for this vulnerable group. Following a recruitment event, which was well attended, 8 potential carers are progressing with fostering or specialist lodgings assessments, and 10 are wishing to be trained as mentors. However, further care placements are needed to meet demand.

In terms of supported accommodation, whilst all supported accommodation options are available to unaccompanied young people, Bristol has recently worked with 16-25 Independent People to secure two specific houses and additional support for two friendship groups of unaccompanied young people.

Bristol's Independent Reviewing Service

All children in care are allocated an Independent Reviewing Officer. The Reviewing Service has provided the following comment for Corporate Parenting Panel:

"There is often delay at the beginning of the child's journey in care as age assessments can take a long time. This has varying consequences for the council. Some UASC in semi-independent living are at a disadvantage as support workers do not leave the accommodation, which in turn places a lot of pressure on the Social Worker to provide everything from a trip to the GP, to medicals, purchasing clothes, bedding and general company, whereas carers can meet a number of these needs in other placement types.

There has been huge improvement in progressing applications and working with the Home Office as it is now better understood by more workers. Bristol is so lucky to have the Asylum Team and Angela Evans whose knowledge is amazing. The team is now larger which we hope will speed up the completion of age assessments."

Unaccompanied Asylum Seeking Young People's experiences of Social Inclusion

As part of the consultation for this strategy, eleven UASC were consulted at City of Bristol College and three young people at Welcome Wednesdays youth provision. As part of the discussion at City of Bristol college we focussed on young people's views of social inclusion and the young people highlighted high levels of social isolation.

'When I'm in college I'm free but when I'm outside I am alone."

One young person highlighted that he made a great effort to approach people to make friends, but others recalled being quiet because they were scared they would get things wrong and were worried about upsetting people. One person highlighted how initially he was the only Black and minority ethnic person on a national citizenship residential course

and he felt unconfident, but because the young people persisted in their efforts to communicate, at the end of the two weeks he felt genuine friendships were built. On a more personal level, some of the young people said 'some people just give you the money and food and they don't ask you about yourself'. The conclusion of this discussion was the young people felt 'more should be done' by both new arrivals and settled communities so they can "meet in the middle". This would dispel stereotypes, "people think you are bad because they don't understand until they know you."

For the boys, sport was a gateway to making new friends, but none of the girls had been invited to be involved in sport. Some young people used the adult services at Bristol Refugee Rights and Red Cross highlighting the helpful people at the centre, that they 'push you to do something' and one young person highlighted he enjoyed the support to write poetry. All young people highlighted shopping as a place to go, wanting the shops to be open more hours as it was a place to feel part of the community.

In terms of issues, the young people highlighted similar issues to other people in Bristol – to improve the frequency, reliability and customer service on public transport, to reduce the amount of street rubbish, to improve provision for rough sleepers and highlighted that not receiving any response to an employment application was demoralising.

In terms of suggestions for improvements the young people said

"people need to know we are here… we are different but we know we are part of the community."

The young people would like support to bring together ESOL and other students at the college. Also they suggested that there a day in Bristol to celebrate people from around the world and celebrate 'what we bring', to bring food from different countries or to have a concert to showcase talent from around the world. The young people would like to be supported to have more day trips to get to know the city and surrounding areas and to mix with different people.

The refugee sector does organise the annual Bristol Refugee Festival where many of these ideas are taken on board.

Monitoring progress

UASC have specific needs which are different from the settled population and foster carers need additional training to understand how best to support the young people living with them; living with a young person who doesn't speak English, how to work with your young person to develop cross cultural understanding, understanding UK laws and values. Foster carers are familiar with understanding trauma caused by broken family attachments, but may be less familiar with the symptoms of post-traumatic stress. Training for foster carers, and social workers to support their development in working with this group by having a clearer understanding of the legislation, cultural issues and potential trauma that young

people have experienced has been developed. Training for social workers has been arranged during 2017 and 80 social workers will have received training by the end of 2017.

There is a need for the differentiation of outcomes for UASC from other children in care and for reporting on the numbers getting status and the numbers entitled to the after-care support that other children in care get. Monitoring progress should include numbers of successful asylum claims which have resulted in status before 18 and number of asylum seekers refused status who are removed when they become 18 years old. Some UASC disappear from the system at 18 as they fear being sent home or just get recorded as 'missing'. It is important to note that the council has little influence over status outcomes so the council will be accountable but not responsible these figures and this should be reiterated in reporting processes, but it is important to monitor these outcomes in order to lobby Government or to better understand if local legal support is as effectives as possible.

Again, the numbers of UASC getting into employment and training and continuing in education, qualifications gained, and progress made should be differentiated from other children in care as their barriers in education are different and their added value scores will be different. It is also important to monitor pathways into emotional support (Thinking Allowed and CAMHS) in terms of wellbeing and mental health support.

5 Refugee children

Children of refugees have the same legal entitlements as other children and aren't distinguished as 'refugees' in equalities monitoring or school census forms. This should be changed because it is purposeful to be able to differentiate outcomes for the different groups of children.

There are social, economic and cultural factors which create specific needs for refugee communities, but these are often not sufficient to meet thresholds for specific support services, for example:

- refugee and asylum seeker communities have specific information and advice needs and language needs which are not experienced by more settled communities.
- Families and individuals may have specific cultural and religious needs, issues around inclusion and integration, and inter-generational issues which could create additional stressors and these needs may not be met by schools or other generic provision.
- Refugee communities may experience discrimination, exclusion and historical disadvantage and are more likely to live in poverty and experience long term unemployment than White British people.
- Most refugee communities are younger than the Bristol average and are proportionately more reliant on children and families' services

The recommissioning of youth services is committed youth work provision with a high level understanding of the diversity of young people's challenges across the city and how best to meet these challenges.

6 Children of parents who don't have refugee status

Some families who have been refused status are supported by the local authority under the Children Act 1989, but these children do experience significant hardship in comparison to other children.

Some children have parents who are asylum seekers or who have humanitarian status and this is not an issue when they are at school for the school, parents or children. However when the children are 18 the children become aware of their status for the first time because they are not entitled to tuition fees and cannot pursue higher education goals. There are additional risk when they reach 18 without being awarded because the 'children' can be removed. At aged 18, the 'child' within the family needs to make their own application for status which costs £900 and is often unaffordable.

Access to Education

Newly arriving children and young people who don't speak English have the same rights as any other under 18 year old in Bristol. However there are age groups where schools find it hard to accommodate the children and meet their English language needs whilst also giving specific attention to the rest of the year group. There a problem with provision for new year arrivals mid year 11, as other pupils are on a GCSE cycle and to a lesser extent arrivals in mid year 6 may receive less attention due to the importance of SATs. There are difficulties for over 16s arriving in between bi-annual intakes for ESOL at City of Bristol College as there are safeguarding risks to mix under 18s with adults in community ESOL classes. New arrivals need some form of sex and relationship education (PSHE).

7 Early Years Provision

Access to information, services and opportunities is particularly difficult for parents whose first language is not English. Specifically newly arrived parents do not understand the education system and the importance of parents playing an active role by participating in children's education, talking to teachers and forging social ties with other parents and neighbours in the local community. Newly arrived refugee and asylum seeking mothers struggle to understand how mainstream British services work, how to navigate health and social care nor how to access the support available with their parenting. This is needed at a time when their lives are often still not stable (in terms of housing, work etc.) and they are often still dealing with stress and trauma. There is also a need to provides specialist high quality support to their pre-school children, to enable them to feel safe, establish a routine, and to acquire the basic language and cultural skills to enable them to move successfully into mainstream early years settings.

Parents of early years children often need more support to feel safe to leave their children; they are often less likely to access the support of Children's Centres and Health Visitors despite being in high need of their services. Parents need flexible options for early years care which can fit in with the many other appointments and requirements involved with being an asylum seeker or refugee. Many early years children have access to little or no

toys at home, and have limited access to outside space. If English is not spoken at home (which it often is not), children are at high risk of starting school far behind their peers in terms of communication. Many asylum seeking/refugee children live or have lived chaotic lives, perhaps moving around a lot, and need support to understand and settle into routines.

8 Financial and food poverty:

Asylum support consists of basic accommodation and £36.95 per week for an individual (£5.28 per day) to meet all other needs (food, toiletries, communication, travel etc.), families would receive more. Requirements of the asylum process involve attending distant Home Office appointments, meeting with solicitors and reporting regularly (in Bristol this involves a 14 mile round trip to Patchway Police Station). Bus fares quickly use the daily £5.28 for example a First Day Rider @£4 a day, and thus attending appointments around the city involves walking long distances. If people are in receipt of Home Office support some travel to required appointments may be refundable from the Home Office.

In Bristol a collaboration between First travel company and the City of Sanctuary has resulted in a travel scheme where bus tickets can be given to vulnerable asylum seekers. City of Sanctuary raise funds each month and purchase tickets at half price from First and distribute the tickets to those most in need.

Those in local authority care have more support and are given bus passes and support with the cost of their utilities. Payments can be made to assist with school uniforms and winter clothing for children, with extra allowances for people with dietary needs

New status refugees have to leave their asylum seeker accommodation and because there is a gap between getting status and them being able to obtain a National Insurance number to access housing, benefits or employment many are made destitute and live on the streets.

> *Asylum seekers are not entitled to local authority housing, state benefits, or allowed to work. They have a legal right to Home Office accommodation and financial support but it is difficult to access. Our members are people under huge stress, are vulnerable, have mental and physical health problems. Some have been trafficked. All struggle with complex bureaucracy. (Bristol Refugee Rights)*

Bristol Refugee Rights' Welcome Centre Asylum Status Review showed that

- 15% of members are are asylum seekers *without* support
- A further 28% are asylum seekers with support.
- 16% of members stated that the hot meal provided once a week is the only hot meal they eat.
- Many members live in survival mode with an increasing number of people being supported by our Destitution Support team for food and toiletries (a rise from 14 referrals in 2015 to 25 in 2016).

Asylum seekers who have had their claims refused often end up destitute with no support except from charities. Around 25% of Borderlands members are in this position and approximately 15% the members manage to have a hot meal only at Drop-in centres (based on Borderlands in house research data). Many members live daily in 'survival mode'.

Women asylum-Seekers have an uncertain future and will be continually aware of the fragile place in the local community. Women refugee and asylum seekers are often lone parents and struggle to feed their families. Not having enough income coupled with many children in the family means shortage of nutritious food for the family. In addition, many of them report to us that they are not able to heat their houses in the winter mornings and sometimes don't cook a hot meal for the family.

Bristol is part of a feeding Britain pilot. In terms of meeting short term needs, There is relatively good coverage of emergency food aid providers across the city (including foodbanks (or similar), and also places where the homeless can get a hot meal), so that there is almost always this option for those in need. A reliable, and sustainable, source of food donations needs to be in place for these operations. A more strategic approach to providing a reliable and sustainable source of food is required for support specifically targeted at children – this includes holiday lunch clubs and breakfast clubs. Feeding Bristol will develop projects to target particularly vulnerable groups, to reduce social exclusion as a key contributor to food poverty. For example: Initiatives to increase the inclusion of asylum seekers into our food supply system; and food provision to include minority ethnic groups (taking account of dietary needs).

Longer term action planned to support a move towards eradicating food poverty including improving education in the area of cooking healthily on a low budget; Improving accessibility to good quality food at affordable prices across all communities: and encouraging policy change to reduce poverty.

There are specific barrier to finance systems for asylum seekers

- It is difficult to open a bank account without having a financial history in the UK, without references and without evidence (a council tax bill) which proves your address
- Benefit payments require a bank account
- Any hold ups in benefit payments result in destitution and applications for the Local Crisis and Prevention Fund and ongoing dependency on the local authority
- If the Local authority funds a deposit for accommodation, this can no longer be reclaimed.
- As a positive, the Credit Union and Post office can provide accounts for benefit payments

Some asylum seekers are sent bills for their health care which can cause tremendous stress and unpaid health care bills can negatively affect an asylum claim. Most asylum seekers are entitled to emergency health care and with help from local voluntary agencies, can successfully appeal to have the bills removed. However for asylum seekers who have been refused status, then costs can be incurred for emergency treatments and for maternity care. Families can be sent bills between £3-£5,000 and are unable to pay for these costs.

9 Information, access to services and opportunities:

The Office of the Immigration Services commissioner regulates immigration advice. Advisors need to be accredited by OISC. There are three levels of accreditation

A level 1 adviser can give you advice on simple cases, for example getting a business visa extension when you have no problems with work and all necessary documents, entry clearance, leave to enter, leave to remain, nationality and citizenship and EU and EEA law.

In Bristol, the Red Cross has one Level 1 advisors and 3 trainee advisors, St Pauls Advice centre has a 0.8 FTE level 1 advisors and Bristol refugee Rights has a 0.5 FTE level 1 advisor.

Level 2 advisers can do everything that Level 1 advisers can do, but can also accept more complicated cases. You may want to use a level 2 adviser if you've had problems in the past with immigration and want permission to remain in the UK. Advisers in this category can also help:with claims for asylum and human rights applications, get your visa application decision reviewed (an 'administrative review'), if you entered the UK illegally or stayed after your visa expired and if you're being removed or deported.

There are no level 2 advisors working in the voluntary sector in Bristol

Level 3 advisers can do everything that Level 1 and 2 advisers can. They can also appear on your behalf at an immigration tribunal. In certain situations they can help you if you go to court. Avon and Bristol Law Centre have a 0.6 paralegal and an immigration solicitor and one vacancy. ABLC have a Children in Need worker to support under 18s applications but they can't support people in adulthood.

Immigration advice is becoming increasingly complex. Brexit is creating concerns there will be additional work for EEA citizens which will have an impact on what is already small amounts of service. There would be benefits in being more proactive to ensure people regularise their status to get and keep in employment, private landlords need to make checks and children of refugees should regularise their status when they are approaching 18 years old

The voluntary sector cannot meet the demand for immigration advice. People need immigration advise when newly arrived butt here is an ongoing need for immigration advice to regularise status. In Bristol there are no level 2 advisors so there isn't a layer of advice which the level 1 advisors can refer into. This means the level 3 advisors are not used

effecgtively. Level 2 advisors need ongoing supervision, so there is an ongoing resource which is needed to sustain the accreditation of level 2 advisors.

People therefore have to pay for immigration advice and there can be a problem when people use unregulated solicitors. If they receive poor advice then they revert back to using VCS services to help them to solve their problems, but the problems have often escalated due to debts accumulated by paying for advice and possibly new problems with housing and employment which weren't present before.

Access to information, services and opportunities is particularly difficult for people whose first language is not English. Bristol Refugee Rights recorded people who speak 18 different languages attending the Welcome Centre, the vast majority also use a different script from Roman/English. Asylum seekers dispersed to Bristol and new refugees coming to the city lack geographical knowledge and cultural awareness of services they are entitled to.

> *Asylum seekers are among the equalities groups who are known to be disadvantaged because of their difficulty in accessing services and because of the experiences they have had prior to entering the UK*
>
> *(Migrant Health Needs Assessment 2012).*

Asylum seekers and new refugees need to be able to access support in their own language or through an interpreter. They need a place to go where they can make friends, build a support network that can help them to navigate the city. Advice is given at the Welcome Centres on a wide range of issues but formal immigration advice can only be given by the 0.5 FTE worker at Bristol refugee Rights. This position is not currently funded from the Bristol Impact Fund and the Welcome centres are keen for immigration advice to be included within the new Advice Services commissioning process.

Limited English language skills, poverty, discrimination, feeling unwelcome, lack of local knowledge, living in areas of deprivation and poor mental or physical health problems will all combine to prevent asylum seekers and refugees from participating in the community. Without a voice the needs and contribution of asylum seekers and refugees is easily overlooked. They feel alienated in society as they have little opportunity and support to participate in decisions that impact their lives or shape local outcomes which causes exclusion in communities.

Women refugees and asylum seekers are unfamiliar with what resources are available in the community and lack confidence to assert their rights. Not having English as a first language can make navigating health and social care difficult and participating in their children's education, talking to teachers and befriending other parents is a huge obstacle. Inability in the English language can seriously inhibit the forging of social ties to other people in the local community. In a survey conducted of RWOB members last year, 68% were unable to read maps and 46% could not locate local amenities without assistance. An inability to

follow signs, locate amenities, read maps or ask for directions can seriously inhibit life in a UK city such as Bristol.

Refugee Women of Bristol members come from 48 different countries and many different languages. Most of them can't read or write their own languages, after translating some of the languages they still rely on interpreters and a word of mouth. 25% of women attending the refugee women provided ESOL classes are aged between 45-70 who have never been in education. This group of women found it extremely difficult to even understand the process they need to go through to access help and support in Bristol. They consistently report to their teachers a lack of confidence to try and communicate to the service providers, shop keepers and neighbours and therefore wait for their family and friends to assist them. Many of our members would like to access ESOL classes and colleges but can't find accessible childcare facilities and that creates a huge obstacle to access important opportunities.

10 Health

The Haven

Since 2004, Bristol has had a special NHS Asylum and Refugee Health service known as The Haven. It was initially setup as a pilot project by the then Bristol North PCT to provide a dedicated service to meet the needs of people seeking asylum in Bristol, and is now a mainstream service, commissioned by Avon CCG and provided by Bristol Community Health. The service aims to promote access to healthcare and provide a service adjusted to better meet the needs of this vulnerable group of patients, thus reducing inequalities.

The Haven works with those claiming asylum, those refused asylum, trafficked persons, unaccompanied asylum seeking children and those who join a refugee family member. We work with all ages and with physical, mental and social problems. We are a small team of nurses, GPs and admin staff based in a community health care setting offering our patients nurse and GP clinic appointments as well as nurse contacts in community settings.

Most of the Haven's referrals come from asylum housing providers, but the service also accepts referrals from any agency. Appointments can be offered for a nurse led comprehensive health assessment to include a health screening, health promotion, update of immunisations and facilitate registration with a local GP practice. The nurse can pass any patients who need medical attention onto the Haven GPs, who have longer appointments and expertise in this field, and can refer on to specialist if needed. The Haven sends our medical records to the GP at each contact and discharge to standard GP care when appropriate to their needs.

Over the years, the Haven has developed networks and pathways with other many agencies in health and the asylum field to develop services, improve patient care, co-ordinate

patient care, and act as a hub for all health related issues with all other organisations including GP practices .

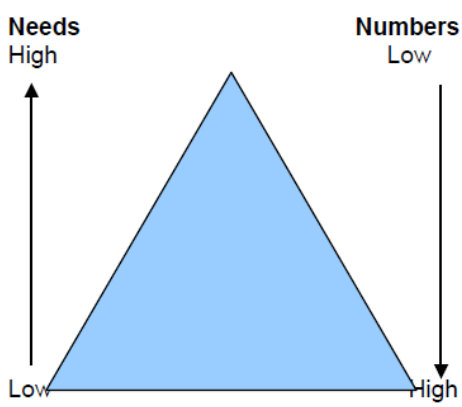
There is much confusion about entitlement to health care within health and other sectors, due to complexities in how health care is organised and complicated rules set by government. In brief, all those the Haven work with are entitled to register with a GP practice (primary care) and receive free community based NHS services. All except refused asylum seekers are entitled to free secondary (hospital) NHS services. Those who are refused can complete a course of hospital treatment started before refusal, and some hospital services are free e.g. TB services. Each hospital trust has an overseas department to check entitlement and those not entitled to free secondary NHS care are charged, a rule set by central government.

The Migrant Needs Health Assessment 2012 highlights there are general health needs experienced by all migrants:

- All migrants need to know how the NHS work
- All migrants need to be registered with a GP
- GPs need to access to appropriate information, resources and support
- Language and communication is a central issue in the provision of health care for migrants
- All migrants need to be up-to-date with the UK immunisation schedule
- Infectious disease and injury are more likely to be issues for migrants.
- Key local issues have been established as registration, language, and expectations

It is useful to conceive of the health needs of migrants as a “pyramid of need” with

vulnerable migrants at the apex (few in number, but with large health needs) spreading to those higher in number, but with fewer needs, i.e. families and working migrants, students, and visitors.



What we know
Vulnerable Migrants, ~200, High needs, Kurds, Sudanese, Arabic speakers, Somalis
Family and Workers, 20,000, Medium needs, Somalis, Indians, Polish
Other, ~1,000, Medium needs, Returning British residents
Students, 6,000, Medium needs, Chinese, Asians
Visitors, upto 200K individual, low in duration of stay, Low needs, Americans, Australians, Asians. Temporary stay (<= 6 months).

In the Bristol Community Health Assessment 2008 “Asylum seekers are among the equalities groups who are known to be disadvantaged because of their difficulty in accessing

services and because of the experiences they have had prior to entering the UK". The same comment could be made for all vulnerable migrants, which includes asylum seekers, those who have been refused asylum (failed and destitute asylum seekers), those who have been granted asylum (or other similar statuses – new refugees), and people who have been trafficked. The latter group can cross over with other categories above, but by definition includes those who have been exploited by others.

Many health issues relate to all of the conditions of migration including country of origin and circumstances there, route of transport, and subsequent marginalisation and exclusion in the UK, including exclusion from the health system on the basis of lack of knowledge, changing laws, or other institutional barriers. Health circumstances can include both physical trauma and psychological trauma as well as an array of infectious diseases.

The International Organisation for Migration published a book to assist medical staff in the treatment of trafficked persons, much of it is useful to other vulnerable migrants. They summarise health risks in a table which is reproduced here (IOM 2009):

HEALTH RISKS	**POTENTIAL CONSEQUENCES**
Physical abuse, deprivation	Physical health problems, including death, contusions, cuts, burns, broken bones
Threats, intimidation, abuse	Mental health problems including suicidal ideation and attempts, depression, anxiety, hostility, flashbacks and re-experiencing symptoms
Sexual abuse	Sexually transmitted infections (including HIV), pelvic inflammatory disease, infertility, vaginal fistula, unwanted pregnancy, unsafe abortion, poor reproductive health
Substance misuse Drugs (legal & illegal), alcohol	Overdose, drug or alcohol addiction
Social restrictions & manipulation & emotional abuse	Psychological distress, inability to access care
Economic exploitation Debt bondage, deceptive accounting	Insufficient food or liquid, climate control, poor hygiene, risk-taking to repay debts, insufficient funds to pay for care
Legal insecurity Forced illegal activities, confiscation of documents	Restriction from or hesitancy to access services resulting in deterioration of health and exacerbation of conditions
Occupational hazards Dangerous working conditions, poor training or equipment, exposure to chemical, bacterial or physical danger	Dehydration, physical injury, bacterial infections, heat or cold overexposure, cut or amputated limbs
Marginalization Structural and social barriers, including isolation, discrimination, linguistic and cultural barriers, difficult logistics, e.g.,	Unattended injuries or infections, debilitating conditions, psycho-social health problems

HEALTH RISKS	POTENTIAL CONSEQUENCES
transport systems, administrative procedures	

11 Social isolation and poor mental health:

Social isolation can have physically and emotionally damaging effects resulting in: depression, poor nutrition, decreased immunity, anxiety, fatigue (&) social stigma". Anxiety, poor mental health and poor wellbeing are common for asylum seekers and refugees. Migrant Health Needs Assessment 2012 stated "…this group is likely to have the highest health needs of all migrant groups. Much of this will relate to all of the conditions of migration …. Health circumstances can include both physical trauma and psychological trauma..."

JSNA 2015 states (pg 62)

The Refugee Council state that "Around half of all asylum seekers find themselves detained during the asylum process." It is very difficult to get refugee status recognition and can involve numerous applications. In 2015, the courts overturned Home Office decisions in 38% of asylum appeals (Home Office asylum statistics - November 2015). Hopelessness and depression can result from exposure to a complex asylum process with no discernible timeframe. I

n addition the series of events that have led to a person fleeing their country often leads to post flight trauma. Loss of family and friends and a social network in a home country can increase feelings of isolation. The loss of employment and regular and meaningful activities, policies of deterrence and restrictive measures lead to poor mental health. An academic study on mental health consequences of immigration policies of deterrence found that:

> *"There is growing evidence that salient post-migration stress facing asylum seekers adds to the effect of previous trauma in creating risk of ongoing post-traumatic stress disorder and other psychiatric symptoms."*
>
> (D. Silove, Z. Steel, C. Watters - JAMA 2000 – europepmc.org).

Asylum seekers and new refugees need somewhere to go that they can make friends, where they can relax, get support and learn about appropriate health and support services they can access. This is the very real value of the Welcome Centre Network in Bristol

Refugee Women of Bristol report many women have witnessed the killings of their husbands, sons, brothers, fathers and rest of their families. In addition to recovering from this trauma they are trying to stay strong for their children and don't always seek emotional support. Many elder members have long term health problems and disability which hinders their regular attendance to the centre; in addition, where they are from, counselling services are unknown and often relate to the stigma of mental illness, therefore they distance themselves.

The Haven service is keen to stress that primary services, meeting the physical and mental health issues for patients can provide holistic mental health services for asylum seekers and refugees if provided in a culturally appropriate manner. The Haven can advise on when secondary services referrals are appropriate for refugees and asylum seekers.

People from a refugee background do report that accessing counselling/therapy can be an extremely difficult process with a number of hurdles to overcome; at times asylum seekers and refugees are required to undergo an assessment involving completing a questionnaire which they find difficult. Or they may be required to undergo a course before they can access treatment and this can be difficult for someone with trauma issues. They also complain they may then be placed with a therapist with little or no experience of working with people from a refugee background suffering from Post-Traumatic Stress Disorder. There are also cultural barriers to receiving support. For most refugees, counselling services are unknown and may be stigmatised as a sign of 'mental illness', therefore they distance themselves.

10 LGBT issues

At BRR, about 2% of members have identified themselves as being LGBT. Most of these have left their own country due to persecution over their sexual orientation. There are over 70 countries in the world where same sex relationships are illegal. In 13 countries being gay or bisexual is punishable by death. BRR also have members who, as a result of having lived in such hostile environments, do not identify as LGBT but who are seeking support to understand their gender identity. Although being LGBT is considered a protected status through British law many members continue to feel isolated and judged.

LGBT asylum seekers and refugees would prioritise safety and feeling safe as being a very high priority for them

LGBT asylum seekers and refugees are mostly either destitute or in receipt of Home Office support, and have no disposable income to spend on activities. Cultural barriers and limited language skills are another obstacle to participation in mainstream LGBT groups. Refugee and asylum seeker community groups and faith groups are generally not places where people feel safe to be open about being LGBT. The effects on people include severe social isolation. A gay member of BRR said that he knew nobody in Bristol for months and was spending most of his time in his bedroom. He was severely depressed and anxious, was taking medication and had become very ill. People do not access the support available. They are often unaware of their legal rights in the UK and the protections from discrimination.

Asylum seekers and new refugees need somewhere to go that they can make friends, where they can relax, get support and learn about appropriate health and support services they can access. Pride without Borders is a fortnightly support group for Lesbian, gay, bisexual and transgender refugees and asylum seekers in Bristol.

12 Older People

A proportion of refugees and asylum seekers are older people. Older refugees make up some 8.5 per cent of the overall population of concern to UNHCR which reports that older people are sometimes reluctant to leave their homes and the last to flee from danger and in exile, they can become socially isolated and physically separated from their families, compounding their vulnerability.

Most older refugees in Bristol have strong local family connections or have lived in the UK for a number of years. Older refugees and asylum seekers are entitled to health and social care services. Older asylum seekers who have been refused status may have entitlements to services if they have community care needs.

13 Safety and discrimination

The asylum seeker community is aware of issues of discrimination experienced personally or by others and this adds to a fear of crime. In a consultation at Bristol Refugee Rights, asylum seekers referred to three deaths of people who used the welcome centres and were known to the asylum seeking community: Bijan Ebrahimi, Kamil Ahmad living in supported accommodation on the Wells Road and the death of Mohammed Abdurezek on Christmas Eve. The community would like the council to give more assurances that they are welcome and safe in Bristol as the murders have passed without the police or the council coming to the welcome centres to reassure the community as to their safety.

Almost all will face the extra dimension of discrimination and isolation. Refugee Women of Bristol report that women particularly, are faced with daily harassment, racism and social isolation in our city. Muslim women are particularly vulnerable in the current political climate as they can be easily identified. Many of them report fear, anxiety and daily racial harassment in the streets of Bristol. Recovering from trauma of war coupled with racial harassment can cause poor health and social isolation.

Glossary

A refugee is a person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country…' (Definition quoted from the 1951 Refugee Convention)

An asylum seeker is a person who has sought protection as a refugee, but whose claim for refugee status has not yet been assessed. An asylum seeker is someone who has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the European Convention on Human Rights. Many refugees have at some point been asylum seekers, that is, they have lodged an individual claim for protection and have had that claim assessed by a government or UNHCR (United Nations High Commissioner for Refugees).

A 'refused' or 'failed' asylum seeker is someone whose claim for asylum has been refused and any subsequent appeals have been unsuccessful. Unsuccessful asylum seekers are often referred to as 'appeals rights exhausted (ARE)'. The UK Government expects refused asylum seekers to leave the country. The Immigration Act 2016 is reducing support to refused asylum seekers but at present some refused asylum seekers are entitled to Section 4 support from the Home Office if there are specific reasons as to why they can't leave the country.

Local authorities may have responsibilities under the Children Act 1989 in order to safeguard and promote the welfare of the child or children asylum seekers who have been refused status. The local authority is responsible for providing accommodation and/or subsistence for asylum seekers who have been refused status but who have additional community care needs as defined in Section 47 of the Community Care Act 1990.

Unaccompanied children seeking asylum are children who have applied for asylum in their own right, who are outside their country of origin and separated from both parents, or previous/legal customary primary care giver. These children and young people have the same rights as looked after young people and are entitled to support from the local authority, under section 17 of the Children Act 1989, and accommodation under section 20.

Unaccompanied asylum seeking children (UASC) may arrive in Bristol through being trafficked or making their own way to Bristol, or by a government agreement to support UASC who travelled to Europe before March 2016 (the Dubs agreement), to join family members (Dublin III Agreement) or through being transferred from areas with high numbers of new arrivals such as Kent or Surrey (under the Transfer Scheme).

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Thrive Bristol	
Author, including organisation	Victoria Bleazard
Date of meeting	25th October 2017

1. Purpose of this Paper

This paper provides an update on 'Thrive Bristol', the new ten year programme to improve the mental health and wellbeing of everyone in Bristol, with a focus on those with the greatest needs (to launch in early 2018). The programme's detail will be developed by the Thrive Bristol Steering Board, but the enclosed paper outlines proposed activities for Year One (2018) and the mechanism for developing the longer term programme plan.

2. Executive Summary

In June, the Health and Wellbeing Board agreed to explore how the international 'Thrive' model might be applied in Bristol.

To recap, Thrive' is a model that began in New York, led by Mayor Blasio. It has more recently been brought to the West Midlands and London through the Thrive Cities network – which Bristol has now joined. It takes a city-wide population health approach to improve mental health and wellbeing. At its core is a recognition that as little as 10% of the population's health and wellbeing is linked to access to healthcare. As such, rather than beginning with treatment, its focus is on the role schools and universities, employers, housing organisations, businesses and the police can play, and on the importance of our relationships, our surroundings and our access to good food, money and wider resources in achieving good mental health.

'Thrive' works by mobilising public, private and third sector collaboration and leadership (and resources) across a city. It also aims to simplify and strengthen leadership and accountability across the whole system.

3. Context

Bristol has significant mental health need, including:

- Higher prevalence of poor mental health than the national average both for children and young people and for adults (Avon Longitudinal Study of Parents and Children research reveals that almost 1/5 of Bristol's young people are self-harming).
- High numbers of individuals who are at greater risk of mental ill health, such as looked after children; unaccompanied asylum seekers; and first time entrants to the criminal justice system (Bristol has the highest rate in England). In addition, those from BAME or LGBTQ+ communities have higher risk of poor mental health.
- The 6th highest rate of Employment and Support Allowance (ESA) claimants for mental health reasons in England.
- High suicide rates compared to the rest of England (12.8 per 100k compared to national average of 10.1 per 100k). The city also recently experienced a 'suicide cluster' within its student population.
- Huge disparities in need with our most deprived communities having far higher rates of mental ill health. For example, Lawrence Hill has more than twice the number of people claiming ESA because of mental health problems than any other ward.
- People with a severe and enduring mental illness being at high risk of dying prematurely from physical illnesses. For example, whilst smoking rates in Bristol for the wider population have fallen, smoking prevalence in adults with serious mental illness in Bristol is high: 47.3% compared to England average of 40.5% (smoking is the key factor behind people with mental illness being at risk of dying up to 20 years prematurely).
- In BNSSG, mental health service users attend A&E 3x as often as the wider population, and approximately 15 % of all A&E attendances and emergency admissions can be attributed to mental health service users (who make up 5% of the population). BNSSG could potentially save up to £886k in A&E attendances and up to £19.7m in inpatient care by reducing MH service user acute hospital activity to levels of the rest of the population, in subgroups that may be amenable to change

The cost of this to individuals, families and communities is incalculable. However, we have begun to calculate what mental ill health costs Bristol financially. Through working with the Centre for Mental Health we can estimate that mental ill health costs Bristol at least £1.38 billion a year.

4. Main body of the report

The enclosed programme overview paper outlines:

- The 'Thrive model.
- Local need for this programme (including a new analysis of the financial cost of poor mental health for Bristol).
- The programme's proposed focus and approach, including components for success.
- An overview of the first year's work, as well as the approach to develop a longer term approach (considering what makes a mentally healthy Bristol in 2050 and working back).
- Measures of success.
- Funding models.
- Governance model.
- Equality and diversity information.
- Summary of evidence to inform the paper.

5. Key risks and Opportunities

Opportunity:

- To create a single vision for improving mental health and wellbeing across the city to align our resource and identify duplication.
- To create a coordinated approach to improving mental health – for those currently experiencing it, as well as preventing future ill health.
- To galvanise support from different parts of the city who have a great deal to contribute to improving mental health and wellbeing, e.g. business, education and arts sectors.
- To focus on the wider determinants of mental wellbeing and positive mental health, rather than mental health services alone.
- To be supported by the 'Thrives Cities' global network, to enable Bristol to take an informed and ambitious approach to improve mental health and wellbeing.

Risks:

- We do not have any initial investment to support this programme.
- This is being developed in a context of reduced budgets.
- Organisations involved need to ensure that they are doing all they can to improve the mental wellbeing within their own organisations.
- Mental health stigma does still exist and we may struggle to gain the support from different agencies that is needed. Senior level championing from the Health and Wellbeing Board will help to mitigate this.

6. Implications (Financial and Legal if appropriate)

As the enclosed paper notes, there are no financial or legal implications at this stage.

7. Evidence informing this report.

The paper identifies local need, and draws upon wider Thrive models and national guidance, including:

- Overview of 'Thrive NYC':
https://thrivenyc.cityofnewyork.us/

- West Midlands' Thrive Action Plan:
https://www.wmca.org.uk/media/1723/wmca-thrive-full-report.pdf

- London 'Thrive'
www.london.gov.uk/what-we-do/health/london-health-board/thrive-london-improving-londoners-mental-health-and-wellbeing

- Public Health England's Prevention Concordat
www.gov.uk/government/collections/prevention-concordat-for-better-mental-health

- NHS England's Five Year Forward View for Mental Health
www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

8. Conclusions

Feedback is being sought around the following questions:

- Is this the right approach to help address the city's significant mental health needs?
- If Thrive Bristol is the right approach, what does it need to do to try and ensure it is successful? I.e. key programmes to align with; individuals and organisations to engage?
- Who should be part of the senior Thrive Bristol Steering Board?
- What would you consider to be the key metrics of success?
- What wider role might the Health and Wellbeing Board play in ensuring this whole-city approach is effective?

9. Appendix 1

Thrive Bristol: City wide programme to improve mental health and wellbeing in Bristol - Programme overview.

Thrive Bristol
City wide programme to improve mental health and wellbeing in Bristol
Programme overview

1. What is Thrive Bristol?

'Thrive Bristol' is a new ten year programme (launching in early 2018) to improve the mental health and wellbeing of everyone in Bristol, with a focus on those with the greatest needs. It covers all ages and considers mental health in its broadest sense, with initiatives to improve the whole population's wellbeing to interventions for people experiencing mental illness.

'Thrive' is a model that began in New York, led by Mayor Blasio. It has more recently been brought to the West Midlands and London through the Thrive Cities network – which Bristol has now joined. It takes a city-wide population health approach to improve mental health and wellbeing. At its core is a recognition that as little as 10% of the population's health and wellbeing is linked to access to healthcare. As such, rather than beginning with treatment, its focus is on the role schools and universities, employers, housing organisations, businesses and the police can play, and on the importance of our relationships, our surroundings and our access to good food, money and wider resources in achieving good mental health.

'Thrive' focuses on prevention and early intervention and works by mobilising public, private and third sector collaboration and leadership (and resources) across a city. It also aims to simplify and strengthen leadership and accountability across the whole system.

This approach aligns closely with the findings of the Marmot Review (2010) on health inequalities which called on us to address the social determinants of health and the 'causes of the causes'. Drawing on this and existing Thrive models, Thrive Bristol is a programme which aims to bring the city together to*[1]:

- Enable individuals and communities to take the lead
- Create a city free from mental health stigma and discrimination
- Maximises the potential of children and young people
- Create a happy, healthy and productive workforce
- Become a city with services that are there when, and where, needed
- Enable people to have enough money to lead a healthy life, and safe and stable places to live
- Become a zero suicide city.

2. Why do we need Thrive Bristol?

Despite often being cited as a great place to live, Bristol has:

- Higher prevalence of poor mental health than the national average – both for children and young people and for adults (Avon Longitudinal Study of Parents and Children research reveals that almost 1/5 of Bristol's young people are self-harming).
- High numbers of individuals who are at greater risk of mental ill health, such as looked after children; unaccompanied asylum seekers; and first time entrants to the criminal justice system (Bristol has the highest rate in England). In addition, those from BAME or LGBTQ+ communities have higher risk of poor mental health.

[1] *TBC – these aims are provisional and will be decided by the Thrive Steering Board.

- The 6th highest rate of Employment and Support Allowance (ESA) claimants for mental health reasons in England.
- High suicide rates compared to the rest of England (12.8 per 100k compared to national average of 10.1 per 100k). The city also recently experienced a 'suicide cluster' within its student population.
- Huge disparities in need with our most deprived communities having far higher rates of mental ill health. For example, Lawrence Hill has more than twice the number of people claiming ESA because of mental health problems than any other ward.
- People with a severe and enduring mental illness being at high risk of dying prematurely from physical illnesses. For example, whilst smoking rates in Bristol for the wider population have fallen, smoking prevalence in adults with serious mental illness in Bristol is high: 47.3% compared to England average of 40.5% (smoking is the key factor behind people with mental illness being at risk of dying up to 20 years prematurely).
- In BNSSG, mental health service users attend A&E 3x as often as the wider population, and approximately 15 % of all A&E attendances and emergency admissions can be attributed to mental health service users (who make up 5% of the population). BNSSG could potentially save up to £886k in A&E attendances and up to £19.7m in inpatient care by reducing MH service user acute hospital activity to levels of the rest of the population, in subgroups that may be amenable to change

3. Financial cost for Bristol

The cost of this to individuals, families and communities is incalculable. However, we have begun to calculate what mental ill health costs Bristol financially. Through working with the Centre for Mental Health we can estimate that mental ill health costs Bristol at least £1.38 billion a year.

4. Thrive Bristol's focus

The programme will focus on improving the mental health and wellbeing of everyone in Bristol, with a focus on those with the greatest needs. Work will be split into three components:

a.) Whole population approach
b.) Life course approach
c.) Targeted prevention approach

The programme will be run by a high profile Thrive Bristol Steering Board which will bring key organisations and individuals together to oversee the programme's development. It will be responsible for creating a programme of work and maximising any available resources. Bristol does not have a city-wide mental health Board so this will bring senior leadership, focus and accountability to mental health and wellbeing in the city. Within this, specific attention will be given around to how to share the costs and benefits of 'upstream' mental health interventions, which might accrue to 'downstream' organisations.

The Steering Board will agree an approach for developing a strategy / action plan to cover the breadth of mental health and wellbeing, which may include, for example: support from birth and early years; children and young people; further education; employment and skills; housing; criminal justice; public mental health (including the physical health of people with mental illness / suicide prevention) and art, sport and nature.

Worksteams will be initiated where needed, for example in Year One on children and young people's mental health, and employment and mental health, but the Board will also draw upon and support the large number of related programmes and projects in place within the city (for example, the Children and Young People's Transformation Plan, Bristol Ageing Better, Golden Key, Bristol's Crisis Concordat and the city's social prescribing programme).

The programme builds upon the work of existing Thrive models, and maintains strong links with these partners to share learning through membership of the Thrive Cities network. This is being led by the International Initiative for Mental Health Leadership (IIMHL) and is bringing cities and urban regions from eight countries together to solve problems and share innovations, enabling Bristol to learn from best practice globally and share our learning / ask for support as our plans develop.

5. Components for success

Learning from other Thrive models reveals that key components are needed for a successful city-wide programme, as outlined below:

Needs and assets assessment
A thorough understanding is needed of the local context, including both needs and assets (drawing on JSNAs, with data broken down by different equality characteristics). In addition, citizens, third sector organisations, young people and adults with lived experience, and a wide range of others, need to be involved throughout this work, with a focus on engaging with voluntary groups (including community, equality and faith groups) and directly with children, young people, adults and parent carers who are at risk of mental health problems.

Partnership and alignment
We wish to work collaboratively across organisational and sectoral boundaries and disciplines to secure place-based improvements that are tailored to Bristol's needs and assets, in turn increasing sustainability and the effective use of limited resources (i.e. pooling resources together to share benefits whenever possible).

Translate need into deliverable commitments
This programme needs to ensure that high-level strategic aims to promote better mental health are translated into an action plan, as well as integrated into wider operational plans across a range of organisations. It needs to build upon the latest evidence around effective interventions, with the exception of where we undertake innovative work to test new approaches.

Define success outcomes
The programme needs to clearly define the mental health improvement we want to see; the role of different projects in making progress; and must specify how improvement will be measured. Further below, examples are suggested around what this might look like.

Leadership and accountability
Bristol's Health and Wellbeing Board and Mayor are leading – and accountable for - 'Thrive Bristol', and a wide range of organisations will be involved in developing and implementing this work. It needs to be embedded within Bristol's One City Plan and the Bristol, North Somerset and South Gloucestershire Sustainability Transformation Programme.

Coordination of Thrive Bristol is led by Bristol City Council's Public Health Team.

6. What might Year One of Thrive Bristol achieve?

Thrive Bristol needs to be developed with partners across the city. However, in covering such a broad range of topics it may appear nebulous as to what 'Thrive Bristol' will achieve, particularly at the outset. The summary below aims to outline what might be achieved in the first year of the programme (January – December 2018) of Thrive Bristol, breaking the programme into its three component parts: whole population; life course and targeted prevention. This is based on discussions with partners across Bristol and nationally.

a.) Whole population approach

Theme	Activity	When?
Launch Thrive Bristol	City and community leaders together share their vision for Bristol becoming a mentally healthy and thriving city. Within this, new data is shared, i.e. mental health costs Bristol £1.3 billion a year , as well as initial commitments, such as1 in 5 Bristolians to have access to Mental Health First Aid over the next decade (tbc). It invites everyone in Bristol to get involved in the programme with a clear menu of ways to do so.	Early 2018
Run city-wide mental health social marketing programme (with Time to Change and Bristol Anti Stigma Alliance)	Begin social marketing campaigns to support people to open up to mental health problems, to talk and to listen. Part of this will be city-wide, but much of it will be targeted to priority populations, such as children and young people, BAME groups and men. City partners will be encouraged to support this, from buses providing in-kind media space, to employers and schools signing the Time to Change Employer Pledge. Through ongoing evaluation, we can modify our approach. National campaigns such as 'Time to Talk' day; Mental Health Awareness Week; World Mental Health Day will be prominent, as well as non-mental health campaigns such as Stoptober. We will link in with related initiatives such as Mind's Blue Light programme, which provides mental health support for emergency services staff, and mobilise support for key city partners (e.g. work around male suicide in partnership with sporting clubs, pubs, barber shops etc). These will bring Bristol together to get talking and break the silence around mental health problems.	From launch onwards with campaign bursts throughout the year
Roll out Mental Health First Aid training at scale	In partnership with Mental Health First Aid England, we will begin a ten year programme to roll out Mental Health First Aid (Adult and Youth) across the city so that 1 in every 5 (tbc) Bristolians will have access to this. We will explore public and private partnerships to fund such a programme.	Ongoing

Embed mental health leadership across the city	Bristol City Council will sign up to national Local Authority Mental Health Challenge and host an event for mental health champions from across the South West region to share best practice and provide mutual support. Following recommendations from the Academy of Medical Sciences (and in line with CQC-approach), we will seek for key NHS bodies to have a mental health / champion at Board level (such as our acute and community trusts). The new Bristol Leadership Challenge programme will initially focus on the mental health needs of people in the city. This programme brings together leaders from across public, private and voluntary sectors in Bristol to strengthen collaboration and civic leadership. More broadly, the Steering Board will seize opportunities to embed mental health and wellbeing within wider strategies and policies, including current spatial planning / housing work.	Ongoing
Longer-term planning and analysis	With partners, develop a vision for what a mentally healthy Bristol would look like in 2050, and work backwards to identify what needs to be done to achieve this (using 'theory of change' model).	March 2018 onwards
Publish key data and strategies	Publish Bristol's Mental Health and Wellbeing JSNA and launch Bristol's new Suicide and Self Harm Prevention Strategy.	January / February 2018
Media engagement	Proactive work with media, including through local media leads being Thrive Bristol partners, to raise awareness and understanding around mental health, especially their role in supporting suicide prevention work. This will be in partnership with the Samaritans and local academic leads (Professor Gunnell).	Ongoing

b.) Life course approach

Based on local need and interest, we propose prioritising children and young people's mental health and employment and mental health in the first year of the programme, with each having a workstream that are led by partners from across the city to identify and act upon key needs. Whilst these are the priority workstreams that Thrive develops, wider life course programmes – such as Bristol Ageing Better – will feed into Bristol Thrive's Steering Board and action plan.

Theme	Activity	When?
Children and Young People's Mental Health Workstream	As noted above, high numbers of children and young people in Bristol are experiencing mental health problems, and we have higher numbers of children at risk of developing mental health problems. This need has recently been captured by the Children and Young People's Mental Health JSNA. A great deal of activities are taking place in across Bristol to support children and young people's mental health. However, we do not have an overarching strategy which joins this work together and ensures that those with the greatest needs are having these met. This workstream will be led by key organisations from across the city who support children and young people affected by poor mental health (linking with existing groups such as the Youth Council and Schools' Mental Health Network).This group will both develop this overarching strategy, and use its expertise and resource to address key gaps. This will aligns with CYP iThrive model, led by Bristol's Community Children's Health Partnership (CCHP), and wider activities. e.g. Time to Change's secondary school programme and its Young Regional Coordinators and Young Champions. It will proactively seeks to work in partnership with organisations across the city, including those working with young people from diverse backgrounds (such as BAME). As part of this, bring local universities and higher education bodies together to share learning around suicide prevention, and state what extra support might be needed from the city.	Late 2017 onwards
Employment and Mental Health Workstream	Mental health conditions have a greater impact on people's ability to work than any other health issue. This workstream needs to develop a city and WECA-wide approach to supporting people in employment to be well and access help if they need it for mental health problems, but also consider how people with mental health problems out of work can be supported into the workplace.	Autumn 2017 onwards

	It will support Bristol to proactively respond to national policy changes, specific: - National review into mental health in the workplace to be published in late 2017 (led by Paul Farmer, CEO of Mind). We are hoping that Paul might join us for a roundtable with employee / business leaders to discuss how we might act upon his recommendations (aligning with WECA). - The DWP's Work and Health Green Paper is due to be published in early 2018 which takes a broader look at how people who are disabled / have long term conditions can access work. This workstream will be undertaken with West of England public health leads with the aim of WECA committing to creating mentally healthy and thriving workforces. It will be led by and involve city partners, ideally Business West, Chamber of Commerce, unions, and bodies with expertise, such as Mind. We plan to create a city-wide mental health and employment strategy. We understand that no city as yet has one, so this could be a first in the UK.	

To note, on both of these priority workstreams we are seeking to work with national experts (such as the Centre for Mental Health) to ensure that Bristol applies the latest, and most robust evidence around what works, learning from the experience of other areas (including around meaningful data collection and metric development).

c.) Targeted prevention approach

Thrive Bristol explicitly wishes to focus on those with the greatest needs, which is why a targeted approach for key groups and communities is required.

Fortunately Bristol has programmes in place which do focus on areas like this, such as Golden Key which is a citywide partnership of people with experience of prison, homelessness, long-term mental health problems and drug and alcohol dependency, service providers, commissioners and city leaders, and programmes such as Pause, a programme that works with women who have experienced repeat removals of children from their care.

However, we have identified groups with significant needs whereby we don't have a city-wide approach to supporting them. Within these, we propose prioritising the following groups in year one.

Theme	Activity	When?
Debt and mental health (ahead of introduction of Universal Credit)	Half of adults in problem debt also have a mental health problem, and one in four British adults with a mental health problem has problem debt – it also has a strong relationship with suicide.	ASAP

	There is concern that welfare reforms may exacerbate this, and that people who need debt support are not accessing it. We propose setting up a working group of Bristol's advice services, relevant voluntary and statutory agencies and local academics to quickly consider what can be done to mitigate the impact of welfare reforms and the issue of debt more broadly. Within this, assessment will be made around whether a recent pilot of debt support in mental health services might be rolled our across healthcare settings (in light of debt concerns leading to greater use of NHS services).	
Community models of Thrive	Frequently our maps of poor mental health outcomes in Bristol match identically with the areas of greatest deprivation in the city. Poverty and mental health are inextricably linked, and we want to Thrive Bristol to work to address this, specifically exploring how resilience can be strengthened in a time of increased austerity. For example, community leaders from Hartcliffe are developing #ThriveHartcliffe and are hosting events in Autumn 2017 to determine what this looks like. Other areas of the city are being encouraged to consider this approach, including areas with BAME communities (acknowledging that BAME people live across the city and that those living in predominantly non-BAME areas may experience isolation and other challenges). We are scoping whether we might localise the city's public mental health awareness campaigns within local settings of high need and evaluate the impact. Over 2018 we seek to host a roundtable or workshop event(s) within communities with national agencies such as the Joseph Rowntree Foundation, BLF, and Comic Relief, as well as academics and local partners to begin to look at the evidence and information on what works in terms of strengthening wellbeing and resilience in challenging financial times, with discussion to focus on what might make a difference. We're keen for these funders to be involved in shaping this with us at the outset, to try and co-develop grant / investment opportunities.	Ongoing
Equally Well: integrating mental and physical healthcare	People's mental health and physical health should be considered and treated wherever people present in the health and social care system. For example health issues within mental health settings, and also mental health issues wherever people present for physical health issues. This would be true whether in community settings or within hospital settings. This work will be undertaken with partners across the STP, with key changes required in how Bristol works. A specific example of what this will involve is below: People affected by severe mental illnesses, such as schizophrenia, are at risk of dying 20 years prematurely due to	Ongoing

	their physical health. A key factor is smoking. People with serious mental illness in Bristol have much higher smoking rates (47.3% compared to England average of 40.5%). In Bristol we do not have a city-wide pathway of smoking cessation support for people with mental illness. As such, the NHS' current efforts (via their CQUIN) to reduce smoking rates for those using secondary mental health services may be limited if people cease to have this when they return to their community. We propose creating a city-wide smoking cessation pathway for people with serious mental illness, over 2018. Within this, a target will be set to reduce smoking rates (e.g. to reduce the smoking rate of people with mental illness in Bristol to the national average by 2022).	
Mental health and domestic abuse	Domestic violence and mental ill health are intrinsically linked. Between 50 - 60% of women mental health service users have experienced domestic violence and in certain mental health settings prevalence is particularly high, with 70% of women psychiatric inpatients and 80% of those in secure settings having histories of physical or sexual abuse. As these figures illustrate, domestic abuse has devastating and often long-term consequences for survivors. However reporting on domestic abuse has traditionally given priority to physical injuries to the detriment of highlighting the significant mental, financial and social impact on survivors and their children. Such abuse is a more common experience for people with mental health problems than without, and individuals who use mental health services may be more vulnerable to being targeted by perpetrators of domestic abuse. This workstream, co-chaired by a large domestic abuse provider (Missing and Next Link) and a leading professor in domestic abuse and health, will explore how Bristol can ensure best practice (from NICE and other guidance) is acted upon in Bristol. For example, through mental health professionals being aware of the link between domestic violence and mental health problems to ensure that service users are safe from violence and are treated for the mental health impact of such abuse, and for professionals to respond effectively and safely after disclosure. This group will also consider how mental health and domestic violence services can be better integrated.	

The above are suggestions for Year One, and each project will take an improvement approach of testing and learning. In parallel long-term strategy and development work will be undertaken via the Steering Board. We are deliberately not beginning with a strategy, but enabling Thrive Bristol to be an approach that builds up and develops, as opposed to a 'big bang' launch that may be unsustainable – especially in uncertain financial times.

Finally, this work needs to closely align with the One City Plan and its indicators. The programme is particularly conscious of the poorer mental health outcomes of people from BAME communities, and is discussing with the new Bristol Race Equality Commission how the two programmes can join efforts to address these inequalities.

7. How will we know if Thrive Bristol has been successful?

The programme needs to clearly define the mental health improvement needed; the role of different projects in making progress; and must specify how improvement will be measured. To support this, a full 'theory of change' process will be undertaken over the first year. This will define long-term goals around what a mentally healthy Bristol will look like in 2050, and then map backward to identify necessary preconditions and actions to achieve these.

As Thrive Bristol is a long-term programme, its dashboard of measurement indicators can include areas which may take some time to change, such as some of the below which draw upon the national Public Health Outcomes Framework and recent research (to note: Bristol currently fares poorly on many of these):

Mental health-focused indicators:
- Self-reported wellbeing scores
- Smoking prevalence in adults with mental illness
- Excess under 75 mortality rate in adults with serious mental illness
- Employment rate for people in contact with secondary mental health services
- Suicide rate
- Adults using secondary mental health services living in stable accommodation.
- People in prison who have a mental illness or a significant mental illness
- Proportion of adults in the population in contact with secondary mental health services
- Rate of people claiming Employment Support Allowance for mental health reasons.

Purely for illustrative purposes, short/medium term targets relating to these may include:
- Reduce Bristol's suicide rate by 10% by 2020
- Reduce smoking rates in people with severe mental illness to 40% (England average) from Bristol's current rate of 47.3%.

Indicators which may predict poor mental health in later life:
- Children in low income families
- School readiness (& of children with free school meal status achieving a good level of development at the end of reception)
- First time entrants to the youth justice system
- Children excluded from school (children with psychological distress and mental health problems are more likely to be excluded, but their exclusion acted as a predictor of increased psychological distress in later years).

Within the above, we would seek to break data down by equality characteristics and to prioritise key aspects of this. One example might be for the programme to closely monitor the number of Afro-Caribbean boys being excluded from school and ensure they receive effective support (as well as ensuring work is being down to understand this issue and prevent it). This is because Afro-Caribbean boys nationally (we need to verify Bristol data) are more likely to be excluded from school, to end up in care and to become involved in the criminal justice system, yet they are less likely to be offered help for their mental health. We are unlikely to reduce the over representation of Afro-Caribbean men in the psychiatric system without intervening in schools settings or earlier.

Coupled with these indicators and targets, the programme will have delivery outcomes relating to its activity, which may include some of the following:

- Improve mental health awareness through training 1 in 5 Bristolians in Mental Health First Aid.
- Ensure 100% of pregnant women / new mothers receive preventative mental health support.
- For the programme's public awareness campaign to reach X% of Bristol residents, and for levels of stigma and discrimination to reduce by x% (Time to Change to support with baseline data).
- For all key NHS bodies in Bristol (and possibly wider public sector bodies) to have a Board-level mental health champion.

8. How will Thrive Bristol be funded?

The 'Thrive' model focuses heavily on the programme being co-developed with a broad range of local partners – including community, education, employment, housing, economic development, culture and health sectors. Within this, it seeks to mobilise wider resources.

Rather than focusing on large investment from statutory bodies, other UK examples of 'Thrive' have included innovative approaches to incentivise improvements:

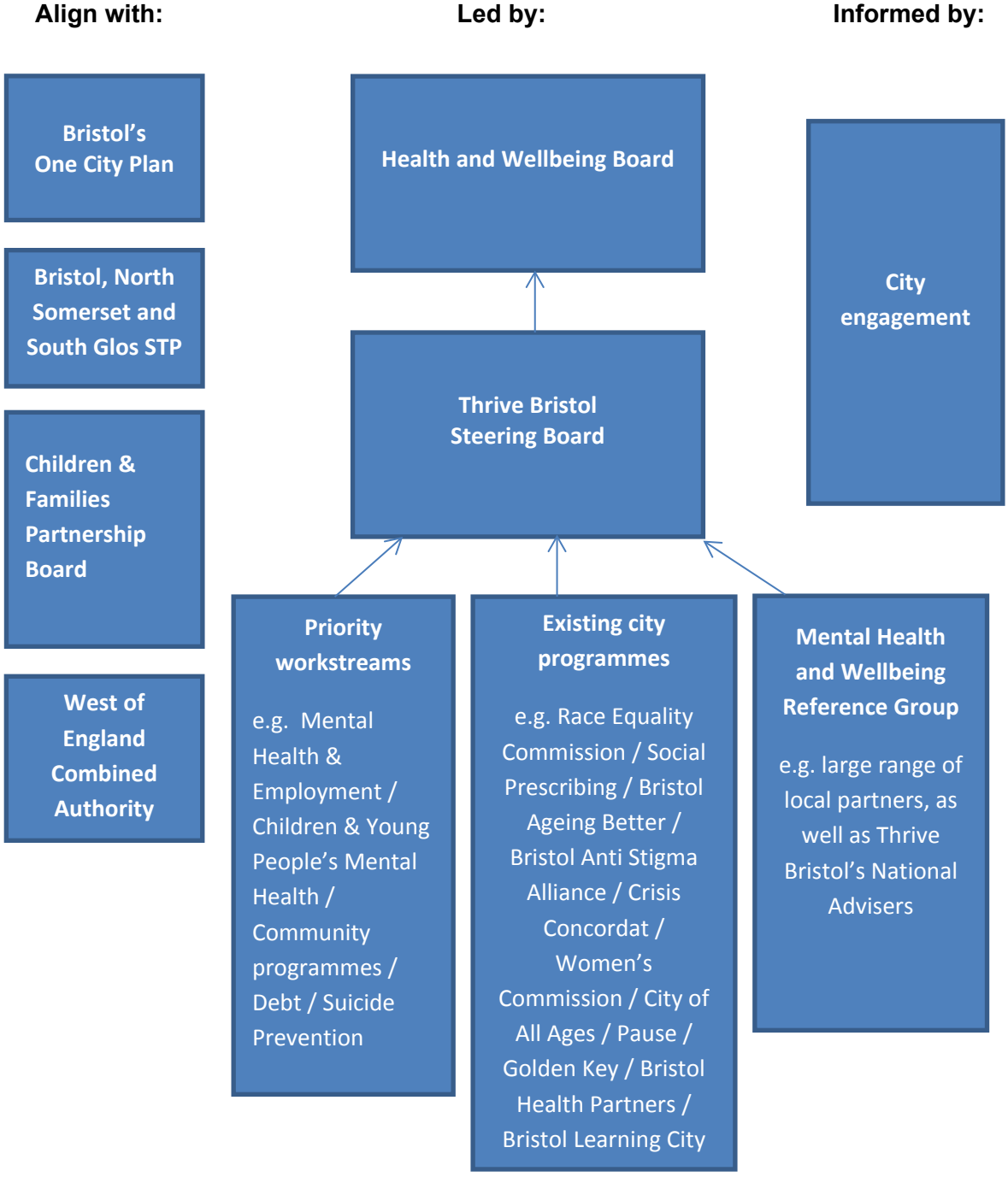
- 'Thrive West Midlands' is undertaking a two year pilot of a 'Wellbeing Premium'. This will reward employers that introduce measures to support the mental and physical wellbeing of their workforce, such as through reduced business rates (an approach advocated by NHS England's CEO).
- 'Thrive London' is working to align philanthropic funds and social investment with their programme.

As such, we are hopeful that the implementation phase of this programme will be financed through a mixture of investment through:

- City partners agreeing to play an enhanced role in improving mental health and wellbeing (e.g. employers funding greater mental health support for employees; acute providers prioritising mental health).
- From external sources (e.g. philanthropy / grants / social investment – the Quartet Community Foundation and Big Society Capital are supporting this approach)
- Existing budgets / projects being aligned with 'Thrive'.
- Exploring income generation opportunities (e.g. providing Mental Health First Aid to businesses).

Through the development of this programme we may identify additional resource needs. However, the programme is being created within a context of reduced budgets, so its success should not be dependent upon significant council funding. The programme is open and transparent around the limited budget attached to it at the outset, but is ambitious in seeking resource from a range of sources in the city and beyond.

9. How will Thrive Bristol governed?



Advised by national partners

Centre for Mental Health · mind for better mental health · Mental Health Network NHS CONFEDERATION · Thrive NYC · International Initiative for Mental Health Leadership

10. How is Thrive Bristol considering equality and diversity?

Mental ill health is currently influenced by factors such as race, disability and sexual orientation, and men and women have different risks of mental ill health. We propose undertaking work which focuses on those with the worst health outcomes and as part of this. Improvements may take time, but are needed in areas such as:

- Reducing the significant over-representation of black people in the acute end of services.
- Improving levels of trust that black communities have in services.
- Improving levels of early support received by people from LGBT backgrounds.
- Reducing suicide levels in men / self-harm in women.

Within this we may need to ensure we have tailored indicators to gather and monitor data (e.g. LGBT-specific indicators, or numbers of BAME boys excluded from school). We plan to align aspects of this with work with the new Bristol Race Equality Commission and the Bristol Women's Commission.

11. What has informed this paper?

This paper has been developed following discussions with a large number of partners from public, voluntary and private sector organisations across Bristol (including an event of 120+ community leads, organised by CASS); and national mental health leads (including those involved in with other Thrive initiatives). It draws heavily on Public Health England's Prevention Concordat guidance, as well as wider Thrive models.

- Overview of 'Thrive NYC':
https://thrivenyc.cityofnewyork.us/

- West Midlands' Thrive Action Plan:
https://www.wmca.org.uk/media/1723/wmca-thrive-full-report.pdf

- London 'Thrive'
www.london.gov.uk/what-we-do/health/london-health-board/thrive-london-improving-londoners-mental-health-and-wellbeing

- Public Health England's Prevention Concordat
www.gov.uk/government/collections/prevention-concordat-for-better-mental-health

- NHS England's Five Year Forward View for Mental Health
www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

12. Further information

For further information on this paper, please contact:
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Appendix 1. Overview of mental ill health in Bristol

Prevalence of mental ill health nationally:
- 1in 4 adults will experience a mental health problem each year.
- 1 in 6 workers will experience depression, anxiety or unmanageable stress.
- 1 in 10 children will experience a mental health problem. Approximately half of all lifetime mental illness starts by mid-teens.
- WHO (2017) noted that depression is now the leading cause of ill health and disability.
- Having a severe mental illness can lead to you dying up to 20 years early due to preventable physical health conditions.

More broadly, mental ill health:
- Is a significant driver of demand for public services
- It has a negative impact on productivity.
- Is a whole system problem: schools, employment, housing, communities.
- Has an increasing evidence base around what works – we are not always acting on it.
- Public opinion is changing: greater openness and increased expectation for support.

Bristol: prevalence of mental ill health:
Bristol has a higher prevalence of mental ill health than the national average – both for children and young people and for adults.
- 8.8% of Bristol patient population has depression diagnosis (8.3% nationally)
- 1 in 10 children will experience a mental health problem (9,000 children in Bristol). Figures are unlikely to fully reflect need.

Mental health is the largest cause of Employment & Support Allowance claims in Bristol (54%). This is the 6th highest rate in England. Lawrence Hill has more than twice the number of mental health claimants than any other ward.

Bristol has high numbers of individuals who are at greater risk of mental ill health, such as:
- Looked after children
- Unaccompanied asylum seekers
- Highest rate in England of first time entrants to the criminal justice system
- Higher rates of young people Not in Education, Employment or Training.

Suicide in Bristol:
- Bristol has a much higher suicide rate than the national average: 12.8 per 100k compared to average 10.1 per 100k. It has 2nd highest female suicide rate in England.
- In the UK, 3 x higher suicide rate for men, middle aged men represent highest suicides in UK, especially in Bristol (28.2 per 100k, compared to UK 20.2).
- There is a strong link between deprivation, poverty and suicide.
- Particular needs in Bristol's student community (7 student in Bristol: 'suicide cluster')

Self-harm in Bristol:
- Self-harm admission to hospital in Bristol is higher than the national average.
- Almost twice as many females as males self-harm (1:9).
- 5 young people per week attend Bristol Children's hospital following self-harm.
- Approximately 1/5th of young people in Bristol self-harm (ALSPAC).

Smoking and Mental Health:
Smoking rates in Bristol have fallen. However, smoking prevalence in adults with serious mental illness in Bristol is high: 47.3% compared to England average of 40.5%.

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Health Protection Committee Annual Report 2016/17	
Author, including organisation	Thara Raj (Consultant in Public Health, Sophie Prosser (Public Health Principal) and members of the Health Protection Committee
Date of meeting	25th October 2017
Report for Information	

1. Purpose of this Paper

The Chair of the Health Protection Committee has examined arrangements for health protection in Bristol and has provided this report to the Health and Wellbeing Board in line with their statutory responsibility to ensure that adequate arrangements are in place for the surveillance, prevention, planning and response required to protect the public's health.

2. Executive Summary

This is the third annual report of the Bristol Health Protection Committee. Whilst significant progress has been made in Health Protection in Bristol, there is still more needed to address what needs to be done.

The main burden of disease is in our most vulnerable communities within Bristol. For example between April 2016 and March 2017 we have seen a rise in em66 Invasive Group A streptococcal infections (IGAS) in intravenous drug users within the homeless community in the city.

We have seen and managed multi drug resistant tuberculosis (MDR TB), in vulnerable patients such as those with no home, or coinfection with HIV, patients with alcohol and drug dependency and who need extra help from the local health economy. In 2016/17 we have taken an active case finding approach with Bristol's homeless communities focusing on TB, hepatitis and drug and alcohol use.

Influenza and antimicrobial resistance (resistance to antibiotics) remain urgent health protection risks for Bristol residents and these also appear on the national risk register of civil emergencies. Tackling tuberculosis (TB), increasing immunisation rates and reducing variation in health outcomes are also pressing issues in Bristol that are being systematically addressed.

3. Context

In the Annual Report for 2015-16, the Director of Public Health outlined progress in Health Protection arrangements within Bristol, and provided a set of recommendations. This annual report provides updates on progress made against those recommendations and identifies areas to focus on for 2017/18.

4. Main body of the report

Please see accompanying Health Protection Committee Annual Report 2017/17.

5. Key risks and Opportunities

Please see accompanying Health Protection Committee Annual Report 2017/17.

6. Implications (Financial and Legal if appropriate)

Please see accompanying Health Protection Committee Annual Report 2017/17.

7. Evidence informing this report.

Please see accompanying Health Protection Committee Annual Report 2017/17.

8. Conclusions

Please see accompanying Health Protection Committee Annual Report 2017/17.

9. Recommendations

Please see accompanying Health Protection Committee Annual Report 2017/17.

10. Appendices

Health Protection Committee Annual Report 2016/17.

BRISTOL HEALTH PROTECTION ANNUAL REPORT 2016/17

Contents

ACKNOWLEDGEMENTS

Thank you to members of the Health Protection Committee in particular the following individuals for their significant contributions to the authorship of this report. Becky Pollard (Bristol City Council Public Health); Sophie Prosser (Bristol City Council Public Health), Thara Raj (Bristol City Council Public Health), Annette Billing (Bristol City Council Public Health), Mike Wade (Public Health England), Helen Trudgeon (Public Health England), Julie Mann (Public Health England), Madeleine McMahon (Public Health England), Julie Yates (Public Health England Screening and Immunisations), Jo Ferrie (Public Health England Screening and Immunisations), Bridget James (Bristol Clinical Commissioning Group), Cecily Cook (Bristol Clinical Commissioning Group), Michelle Jones (Bristol Clinical Commissioning Group),James Gillman (Bristol City Council Civil Protection, Adrian Jenkins (Bristol City Council Environmental Health), Indira Barker (Bristol City Council Environmental Health), Emma Tournier (Bristol City Council Environmental Health) and Andrew Edwards (Bristol City Council City Innovation and Sustainability).

EXECUTIVE SUMMARY

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We have seen and managed multi drug resistant tuberculosis (MDR TB), in vulnerable patients such as those with no home, or coinfection with HIV, patients with alcohol and drug dependency and who need extra help from the local health economy. In 2016/17 we have taken an active case finding approach with Bristol's homeless communities focusing on TB, hepatitis and drug and alcohol use.

Influenza and antimicrobial resistance (resistance to antibiotics) remain urgent health protection risks for Bristol residents and these also appear on the national risk register of civil emergencies. Tackling tuberculosis (TB), increasing immunisation rates and reducing variation in health outcomes are also pressing issues in Bristol that are being systematically addressed.

GLOSSARY

AGW	Avon, Gloucestershire, and Wiltshire
AMR	Antimicrobial Resistance
AQMA	Air Quality Management Area
ASLRF	Avon and Somerset Local Resilience Forum
BCG	Bacillus Calmette-Guerin
BNSSG	Bristol, North Somerset and Gloucestershire
BSI	Bloodstream infections
CBRN	Chemical Biological Radiological Nuclear
CCG	Clinical Commissioning Group
CDI	Clostridium difficile (C.diff) infection
COMAH	Control of Major Accident Hazards
CPE	Carbapenemase-producing Enterobacteriaceae
DTaP	Diphtheria, Tetanus and Polio
EPPR	Emergency preparedness, resilience and response
EVD	Ebola Virus Disease
GI	Gastro Intestinal
H&WB	Health and Wellbeing Board
HCAI	Healthcare associated infections
HIB	Haemophilus influenzae type b
HIV	Human Immunodeficiency Virus
HNA	Health Needs Assessment
HPC	Health Protection Committee
HPV	Human Papilloma Virus
IGAS	Invasive Group A Streptococcal
IPC	Infection, Prevention and Control
IPV	Inactivated Polio Vaccine
LHRP	Local Health Resilience Partnership
LTBI	Latent Tuberculosis Infection
MDR TB	Multi drug resistant tuberculosis
MMR	Measles Mumps and Rubella
MRSA	Methicillin Resistant Staphylococcus Aureus
NHS E	NHS England
NICE	National Institute for Health and Care Excellence
NOIDs	Notifiable Infectious Diseases
PCV	Pneumococcal conjugate vaccine
PHE	Public Health England
PIR	Post-infection review
QP	Quality premium
RCA	Root cause analysis
STAR-PU	Specific Therapeutic group Age-sex Related Prescribing Unit
STI	Sexually Transmitted Infections
TB	Tuberculosis
Td	Tetanus and diphtheria
WHO	World Health Organisation

INTRODUCTION

This is the third annual report to be presented to the Bristol Health and Wellbeing Board (HWBB). A summary of the recommendations made in the second annual report are listed in appendix 1. This report is part of a locally agreed assurance process that was put in place following the 2012 Health and Social Care Act (section 6C regulations). Health protection arrangements are governed by a range of statutory regulation which applies to a number of organisations, including Bristol City Council (BCC).

Bristol City Council (BCC) has a critical role in protecting the health of its population. BCC's Director of Public Health has set up a local Health Protection Committee (HPC) whose role is to ensure, on behalf of the HWBB, that adequate arrangements are in place for the surveillance, prevention, planning and response required to protect the public's health.

Health protection seeks to prevent or reduce the harm caused by communicable and non-communicable diseases, and minimise the health impact from environmental hazards.

Achieving success in health protection relies on strong working relationships at a local level. The Health Protection Committee (HPC) helps facilitate this relationship, ensuring that clearly defined roles and responsibilities are in places that underpin the local response to public health threats, outbreaks and major incidents. This report has been written to a framework that was agreed by the HPC and appendix 2 outlines progress to date against the following health protection areas:

- Infectious and communicable diseases
- Screening and immunisation
- Emergency preparedness, resilience and response (EPPR)
- Environmental hazards to health, safety and air quality

Appendix 3 outlines the different responsibilities for partner organisations.

ASSURANCE STATEMENT

The Chair of the Health Protection Committee has examined arrangements for health protection in Bristol and has provided this report to the Health and Wellbeing Board in line with their statutory responsibility to ensure that adequate arrangements are in place for the surveillance, prevention, planning and response required to protect the public's health.

The Annual Report for 2015-16 outlined current progress in Health Protection arrangements within Bristol, and provided a set of recommendations. This annual report provides updates on progress made against those recommendations and identifies areas to focus on for 2017/18.

RECOMMENDATIONS

To note the significant progress that has been made in 2016/17 to ensure that sustainable and effective local systems are in place for protecting the health of Bristol residents and their neighbours.

Appendix 1: Recommended actions in the 2015/16 Bristol Health Protection Annual Report

Tuberculosis (TB)

- Continue to explore options and opportunities to provide TB screening and active case finding among migrants and other under-served populations.
- Review commissioning arrangements for paediatric TB patients.
- Explore the potential for use of mobile x-ray units (MXUs) for use in prison.
- Clearly agree and outline local sustainable funding arrangements for TB incidents and outbreaks.

Healthcare Associated Infections

- Achieve the zero target for pre 48 hour MRSA blood stream infections
- Reduce the number of Clostridium Difficile pre 72hour community cases
- Reduce overall prescribing of antibiotics in primary care by 1%
- Reduce prescribing of cephalosporin, quinolone and co-amoxiclav by 20%.
- Review arrangements for oversight of infection prevention and control outside hospital settings.

Sexual Health

- Ensure a successful mobilisation of the new sexual health service
- Develop a new sexual health strategy for Bristol, to include a strategic action plan on HIV prevention and testing
- Review the work programme of the sexual health HIT (SHIPP) to ensure it aligns with the delivery of the new sexual health service and the priorities identified in the needs assessment
- Evaluate the interventions to strengthen HIV testing in primary care
- Explore the opportunities to utilise new technologies to offer increased access to STI testing.

Foodborne Illness

- To develop a healthy eating award for the city.
- To clear the backlog of Food Safety Inspections prioritising the highest risk rated premises and new businesses.

Communicable disease management

- Funding: Clearly agree and outline funding arrangements for incidents and outbreaks.
- Infection Prevention and Control: Review arrangements for oversight of infection prevention and control outside hospital settings

Immunisations and screening

- Maintain and improve current performance across all programmes.
- Reduce variability in coverage within and between programmes, with a focus on the Inner City Bristol locality.
- Implement the extension of the Childhood Flu programme to Year 3 primary school aged children and improve uptake for all eligible children.
- Improve uptake of seasonal flu vaccines by clinical ‘at risk’ groups.
- Improve uptake of flu and pertussis vaccines by pregnant women.
- The Screening and Immunisation Team, Bristol City Council Public Health Team and CCG locality chairs to work together to review uptake data by practice and by provider and develop action plans to target areas of poor uptake and coverage for each of the screening and immunisation programmes.
- Continue to strengthen collaborative multi-agency action plans to target areas of poor uptake and coverage for each of the screening programmes.
- Implement the actions arising from each of the Quality Assurance visits to programmes to ensure compliance with national standards and continuous service improvement.
- Closely monitor demand and capacity, and care pathways within the cancer screening programmes, escalating concerns promptly and reviewing pathways of care, as required, to maintain service effectiveness, to ensure waiting times remain within acceptable standards, and to meet any increase in demand.

Emergency Planning, Resilience and Response

- To validate existing plans and procedures, ensuring plans are effective and well-practised.
- To review local level arrangements for mass fatalities and excess deaths

Appendix 2: Progress made on areas of health protection

1. Infectious and communicable disease

1.1 Tuberculosis (TB)

TB is a priority issue for Bristol as identified by the Health Protection Committee. TB is caused by the bacterium *Mycobacterium tuberculosis.* It is a notifiable disease in the UK.

The Collaborative Tuberculosis Strategy for England 2015 – 2020 was published in January 2015 following extensive consultation. The strategy was jointly launched by PHE and NHS England, aiming to achieve a year-on-year decrease in TB incidence, a reduction in health inequalities, and ultimately the elimination of TB as a public health problem in England.

There has been a year-on-year decline in the incidence of TB in England over the past four years, down to 10.5 per 100,000 (5,758 cases) in 2015, a reduction of one-third since the peak of 15.6 per 100,000 (8,280 cases) in 2011 but UK TB incidence is higher than most other Western European countries and the US[1] (8 per 100,000 France, 8 per 100,000 Germany and 3 per 100,000 US). The recent decline in the incidence of TB in England is likely to reflect a combination of different initiatives, including the impact of the UK TB pre-entry screening programme, a reduction in the number of new migrants from high TB burden countries and the early impact of testing and treating patients with latent TB infection (LTBI)[2].

Despite the reduction in overall TB cases, the number of cases with social risk factors (homelessness, drug or alcohol misuse or imprisonment) has not declined. The proportion of cases with at least one of these risk factors increased from 9.8% in 2014 to 11.8% in 2015. The rates of TB and the risks of delayed diagnosis, drug resistance, onward transmission and poor treatment outcomes are greatest among these individuals. TB cases with social risk factors are more likely to have pulmonary disease and drug resistance, and have worse TB outcomes. TB in England remains a public health priority due to current rates and the health, social and economic burden of the disease.

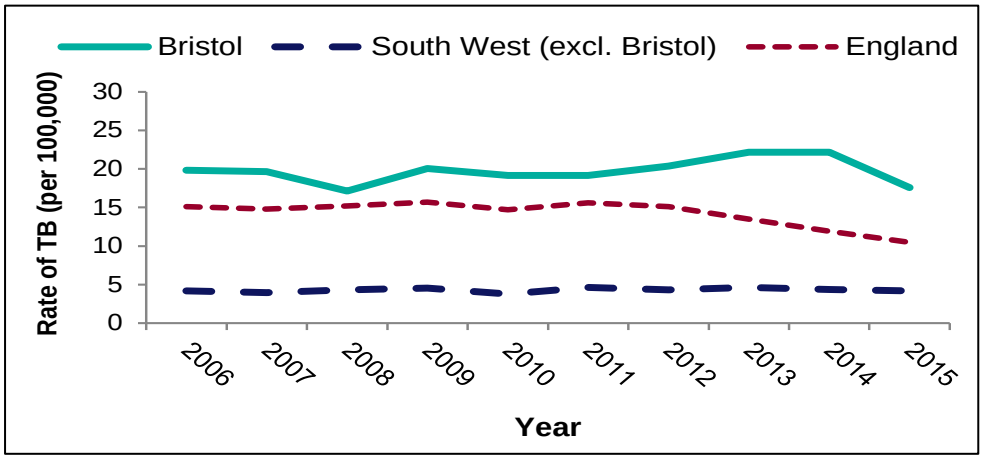
Annual TB incidence rates in Bristol remain considerably higher than in the rest of the South West and England (figure 1). At its peak in 2014, the rate of TB in Bristol was 22.4/100,000 although this has decreased in 2015 to 17.6/100,000. In 2015 from culture confirmed pulmonary cases that underwent antibiotic sensitivity testing a higher proportion of Bristol's notifications (12.2%) were found to have infections with resistance to at least one first line drug compared to the rest of the South West (3.1%). Furthermore 2.4% of 2015 infections in Bristol were multidrug resistant whereas there were none in the rest of the South West.The national picture for TB is not indicative of what is represented within the Bristol Population. Data from the BNSSG Field Epidemiology Service (South West) suggests that we are seeing

[1] World Health Organization (WHO) estimates of tuberculosis incidence by country, 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/581013/WHO_estimates_of_tuberculosis_incidence_by_country__2015.pdf Last updated January 2017. London: Public Health England

[2] Tuberculosis in England: 2016 report (presenting data to end of 2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/581238/TB_Annual_Report_2016_GTW2309_errata_v1.2.pdf London: Public Health England.

more cases of TB in Bristol Residents who are UK Born. We have also seen complicated cases of drug resistant TB in patients who are homeless, and who have no recourse to public funding.

Figure 1. Annual TB incidence rates per 100,000 resident population, 2006-2015



Data source: Enhanced Tuberculosis Surveillance (ETS). Data extracted: September 2016.

Table 1. TB epidemiology: Bristol and South West (excl. Bristol) residents, 2016-17

TB INCIDENCE	**Bristol**	**South West***
Number of TB cases notified (proportion pulmonary TB)	79 (62.0%)	211 (67.8 %)
Rate per 100,000 population	17.6	5.0
DRUG RESISTANCE		
Proportion of culture confirmed cases with any first line resistance	12.2%	3.1%
Proportion of culture confirmed cases with multi-drug resistance**	2.4%	0.0%
SOCIAL RISK FACTORS (history of past or current homelessness, imprisonment, drug and/or alcohol misuse)		
Proportion of cases with any social risk factor	19.4%	11.0%
TREATMENT COMPLETED within 12 months ***		
Number completing treatment in 2014 (Proportion completing)	66 (81.5%)	150 (73.5 %)

* South West excluding Bristol upper tier local authority

**Resistant to at least isoniazid and rifampicin

***Excluding those with rifampicin resistance, CNS, spinal, miliary or cryptic disseminated TB, patients with these forms of disease may have planned treatment for 12 months or longer

Data source: Enhanced Tuberculosis Surveillance (ETS). Data extracted: September 2016.

Successes/Progress

TB Control Board

The TB Control Board for the South of England covers Bristol and has been operational since September 2015. This has resulted in coordinated leadership across Bristol, North Somerset & South Gloucestershire at a time when we are seeing more and more complex TB cases.

Bristol, North Somerset, Somerset and South Gloucestershire (BNSSG) TB Network/Strategy Group

A strategy for reducing TB incidence in the area has been created by the network/strategy group[3]. Recommendations from a 2016 TB Health Needs Assessment informed six priority areas for action which are identification and removal of barriers of access to TB treatment services, reduction in the time from symptom onset to treatment commencement, expansion of Latent TB Infection Screening and roll-out of retrospective screening, develop outreach services and active case finding in at risk groups, maximising BCG uptake in eligible new-borns and provision of comprehensive TB services to support paediatrics. Named leads have been identified from the network group for each area.

Tuberculosis Cohort Review

Much of the work by the TB Control Board is informed by a quarterly TB Cohort Review meeting of patients being treated within their geographical boundaries. Cohort reviews aim to strengthen the prevention and control of TB through a review of case management and assessment of outcomes compared to local and national TB targets, also providing an opportunity to identify unmet health and social care needs of cases and highlight system-issues in the TB control pathway at case-level. Cohort review meetings are multidisciplinary and multi-agency with representation from nurses, doctors, and public health practitioners from the NHS, local councils, and Public Health England. This ensures that TB control is joined up at all levels. In 2016/17 Bristol has had several cohort review meetings and these have used enhanced local data collection to identify local issues for action.

Latent TB screening programme for migrants

The majority of active TB cases diagnosed in England are a result of reactivation of Latent TB infection (LTBI). Systematic screening and treatment of LTBI in new entrants should significantly reduce the incidence of TB. This is one of the key interventions supported in the 'Collaborative Tuberculosis Strategy for England[4]' and is supported by NICE[5] as being a cost-effective intervention. In January 2015, as a high incidence area in the South West, Bristol received funding from the TB Control Board to establish new migrant LTBI testing and treatment services in areas with high incidence (>20 per 100,000 population). Phase one of

[3] PHE. (2017) DRAFT *Reducing TB Incidence in the South West . A TB Strategy for Bristol, North Somerset & South Gloucestershire.* April 2017.

[4] PHE & NHS England (2015) *Collaborative Tuberculosis Strategy for England 2015 to 2020.* (Jan 2015).

[5] NICE (2015). NG33: Tuberculosis. Jan 2015. https://www.nice.org.uk/guidance/ng33/chapter/Recommendations [accessed 24/05/2016] PHE (2016).

the Bristol LTBI testing and treatment service was launched in January 2016. As a result a majority of GP surgeries (including the Haven) with the highest incidence of active TB in Bristol started offering IGRA blood tests to migrants who have moved to the UK in the previous 5 years. Currently phase two is underway targeting medium incidence practices.

Active TB case finding event for individuals who were homeless/used drugs

In early 2016 a cluster of TB cases was identified among individuals who were associated through recreational drug use and homelessness in central Bristol. Traditional contact tracing is challenging in these situations and a local working group had already been exploring various options for active case finding in under-served populations such as those who are homeless or use drugs. Active case-finding with mobile Chest X-Ray units has been shown to be effective in homeless and/ or drug misuse populations in London.(Jit, Stagg, Aldridge, White, & Abubakar, 2011[6]) Whilst population rates of TB are lower in Bristol, the working group identified that that a programme of active case-finding in these groups was still likely to meet the threshold for cost-effectiveness according to the NICE guidelines. (NICE (NG33), 2016)

In February 2017, the London 'Find and Treat' service was commissioned to bring a mobile chest x-ray unit to Bristol to screen homeless and/or substance-misusing individuals for TB. The event facilitated several interventions including symptom questionnaires and digital chest x-rays to identify active pulmonary TB, vaccination for Hepatitis B and Influenza, testing for blood-borne viruses (point-of-care saliva test for hepatitis C and dry bloodspot for hepatitis B, C and HIV), and a fibroscan to test for hepatitis C – associated liver disease. A rapid enrolment service was also established enabling currently un-registered individuals to register on site with homeless heath primary care services and local drug outreach services were also available to link individuals into their service if required. Local TB nurses and Hepatology staff were also on site to ensure swift follow up where necessary. Over 215 individuals were screened over the two day event and nine were referred to the Avon TB Clinic following abnormal chest x rays.

The event involved staff from over 20 different organisations including the NHS and numerous third sector agencies. Front line staff training prior to the event highlighted a lack of TB awareness and referral processes which is subsequently being reviewed by a subgroup from the BNSSG TB Network/Strategy Group.

Key current risks

- **Under-served populations:** TB is not only a serious infectious disease but it also has major social impacts for those affected. TB is associated with marked inequalities in health; with deprived populations more likely to get TB and suffer worst outcomes. The local health needs assessment (HNA) indicated that TB incidence in Bristol is related to deprivation, with the highest incidence rates observed in the most deprived groups. Sixty six percent of TB cases notified were among individuals who live in the two most deprived quintiles. Of TB cases where occupation status is

[6] Jit, Stagg, Aldridge, White, & Abubakar. Dedicated outreach service for hard to reach patients with tuberculosis in London: observational study and economic evaluation. British Medical Journal. https://www.ncbi.nlm.nih.gov/pubmed/22067473 2011 Sep 14;343:d5376. doi: 10.1136/bmj.d5376

recorded, 20.0% were unemployed. Some areas where we have seen high prevalence, have been in areas with a high population of white, UK born residents.

In addition, a substantial proportion of notified TB cases possess at least one social risk factor. Under-served and vulnerable populations are continuously highlighted in the qualitative findings of the HNA as well as in literature as groups requiring more support to engage with health services and complete treatment.

- **Paediatrics:** There is no dedicated paediatric TB nurse to undertake outreach work with children who have TB. This is done by the paediatric immunology nurses alongside their other work, but they have limited capacity to meet the needs of children with TB and their families.

- **Prison TB healthcare**: A lack of X-ray machines (and trained technicians) on site at HMP Horfield prison can prove a challenge for clinicians in the diagnosis of TB. This means that if a prisoner requires a chest x-ray staff need to be available to escort them to and from a hospital. In the event of a large screening exercise or an outbreak, this would be difficult.

- **Outbreak management**: The funding arrangements for TB incidents and outbreaks need further local clarity. This has been added onto both Bristol City Council Public Health and PHE SW Risk Registers. A financial plan to underpin the communicable disease framework is needed.

Areas for focus in 2017-18

- Continue to explore options and opportunities to provide active TB screening within the city, targeting underserved populations

- Review commissioning arrangements across the BNSSG area for paediatric TB patients.

- Escalate the need for national clarification for sustainable funding arrangements for TB Incidents and outbreaks.

1.2 Infection Prevention and Control (IPC)

Preventing healthcare associated infections (HCAI) is an important component of infection prevention and control and patient safety. National Institute for Health and Care Excellence (NICE)[7] estimated that 300,000 patients a year in England acquire a healthcare associated infection as a result of care in the NHS. In 2007, methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections (BSI) and *Clostridium difficile* infections were recorded as the underlying cause of or a contributory factor in, approximately 9000 deaths in hospital and primary care in England. Healthcare associated infections are estimated to cost the NHS approximately £1 billion a year and £56 million of this is estimated to be incurred after patients are discharged from hospital.

All patients identified with MRSA BSI are subject to a comprehensive post-infection review (PIR), which upon completion, is submitted to Public Health England. The purpose of the PIR is to identify how each case occurred and to agree actions to prevent the same circumstances recurring.

Similarly all cases of Clostridium difficile are subject to a root cause analysis (RCA) investigation to identify learning and share best practice to reduce the incidence of infections.

Successes/progress

Healthcare associated infections

A healthcare associated infection (HCAI) Group meeting is held bi-monthly chaired by Bristol Clinical Commissioning Group (CCG). Membership is drawn from commissioners (CCG and NHS England) hospital and community providers, local authority and public health England across Bristol, South Gloucestershire and North Somerset (BNSSG). The aim of the group is to ensure that the appropriate governance systems and processes are in place to prevent avoidable healthcare associated infections. The group provides regular updates and assurances on performance, antimicrobial stewardship, identified trends and associated work for improvement including sharing best practice and lessons learned from post infection reviews. In bringing together all commissioning bodies the group also supports improved oversight of infection prevention and control outside hospital settings.

During 2016/17 North Somerset CCG commissioners and providers joined the HCAI group. The terms of reference were updated to reflect the purpose of the group across a wider geographical area.

MRSA Steering Group/ Report into MRSA in people who inject drugs

During 2016/17, Bristol CCG continued the work, commenced in 2015, to reduce the incidence of MRSA amongst intravenous drug users (IVDU). This work included educating individuals on alternatives to injecting, safer injecting, skin and injecting site care, skin preparation prior to injecting, signs and symptoms of infection and signposting for prompt

[7] NICE (2012) Healthcare-associated infections: prevention and control in primary and community care Healthcare-associated infections: prevention and control in primary and community care. CG139.

clinical intervention. These interventions have been taken forward by the Bristol Drugs Project.

In addition during 2016, funding was obtained to undertake a joint research project by University of Bristol and Public Health England, to look at intravenous drug users and transmission networks to identify interventions to reduce MRSA BSI and onward transmission, including a baseline assessment for evaluating impact of targeting and distributing chlorhexidine wipes allied to suppression strategies. The recommendations of this research are due to be published in July 2017.

The national zero tolerance target for MRSA was not achieved in 2016/17. Through the concerted work of the healthcare associated infection group in partnership with communities in Bristol, the number of CCG assigned healthcare associated pre 48 hour MRSA cases remained the same as the previous year at three cases. However the overall number of cases rose with a notable increase amongst the homeless drug injecting population. These cases were not associated with healthcare interventions, but tackling such infections will continue to be a key priority for the health community in 2017/18 to meet the zero tolerance target.

Clostridium difficile (C.diff) review meetings

A Clostridium difficile post infection review meeting, including public health infection control specialists and Bristol CCG quality and medicines management representation is held each month with acute trust providers. The purpose of the post infection review meeting is to review every case of post 72 hour Clostridium difficile and identify any learning that can be addressed and shared to improve practice. In 2016/17 NHS England assigned a local ambition for Bristol CCG to have no more than 131 cases of C.diff. This figure takes into account Bristol acute hospital trust apportioned cases and community apportioned cases. The total number of C.diff cases in 2016/17 was 122 which meant the local ambition was successfully achieved and was a reduction of 12 cases from the previous year.

During 2016/17 an electronic version of the root cause analysis (RCA) tool for primary care (GP practices and community pharmacies) was developed to support the review of pre 72 hour C.diff cases. The aim of the electronic tool was to aid the completion of root cause analysis by GP practices and support the further analysis of the information collated. Unfortunately the compliance for completing the electronic tool dropped during 2016/17 to 59% from 73% the previous year when the tool was paper based. As a result of this a reminder process has been established, which includes notifying the practice pharmacist, plus improved feedback to practices to support learning.

All the pre-72 hour C.diff community cases were reviewed by quality and medicines management colleagues. All learning identified was fed into an action plan to aid the reduction in incidence of C.diff infections in the community.

Antimicrobial Resistance (AMR)

The Medicines Management team at Bristol CCG continue to work with colleagues and partners across Bristol to address antimicrobial resistance. AMR is of global, national and local concern. The World Health Organisation (WHO) cites the issue as a great threat to human health. The government published a UK 5 Year Antimicrobial Resistance Strategy 2013 to 2018 (DH, 2013) which sets out actions to slow the development and spread of antimicrobial resistance.

In 2016/17, a national quality premium (QP) target was introduced for primary care to reduce the overall prescribing of antibiotics by 4% or equal to (or below) the England 2013/14 mean performance of 1.161 items per STAR-PU (Specific Therapeutic group Age-sex Related Prescribing Unit) and to reduce the prescribing of cephalosporin, quinolone and co-amoxiclav by 20% (due to broad spectrum antibiotics being associated with an increased risk of Clostridium difficile infection and antimicrobial resistance). Work was undertaken by local GPs and Medicines Optimisation Pharmacists to support this quality premium across Bristol. This involved a re-audit of broad spectrum antibiotic prescribing. The results positively demonstrated that there has been a reduction in the number of patients prescribed any antibiotic, a reduction in broad-spectrum antibiotic prescribing and increased compliance with BNSSG antimicrobial guidelines over the previous year. The quality premium targets were met for 2016/17.

A new quality premium has been introduced for 2017/18 which aims at reducing gram negative blood stream infections (BSI) across the whole health economy, part of this quality premium involves a reduction of inappropriate antibiotic prescribing for urinary tract infections in primary care as well as reducing inappropriate prescribing of all antibiotics in primary care. Supportive projects involve a review of prophylactic antibiotic prescribing for urinary tract infections as well as an educational project aimed at improving urinary tract infection diagnosis in a Care Home with Nursing setting.

In addition to this, clinicians across Bristol have access to locally endorsed evidence based guidance on the use of antibiotics in primary care settings[8]. This guidance helps prescribers to choose the most appropriate antibiotic for the infection they are treating, and to prescribe it for the most appropriate duration. These guidelines encourage the use of narrow-spectrum antibiotics rather than broad-spectrum antibiotics where appropriate and are updated every two years or more frequently if there are significant changes to recommendations. Further to these guidelines, extra guidance on recurrent urinary tract infections, lower urinary tract infections and supportive guidance for nursing homes have been developed.

A local BNSSG Antimicrobial Pharmacist network continues to meet three times a year to share clinical audit, best practice and to provide support to healthcare professionals. It offers a reliable communication cascade system and an opportunity to collaborate on the delivery of the AMR QPs and CQUINs as well as local best practice guidance.

[8] NHS Bristol, North Somerset and Gloucestershire (BNSSG) Antimicrobial Prescribing Guidelines for BNSSG Health Community v4.1, May 2017

Key current risks

- Infection prevention and control is fundamental to stop the spread of infectious and communicable disease. Performance in Bristol has improved in terms of reducing the number of C.diff infections, but the MRSA zero target was not met for 2016/17 and an increase was noted in cases amongst homeless individuals who inject drugs.
- Maintaining an oversight of infection prevention and control outside hospital settings, to ensure all different commissioning bodies including the local authority, CCG, NHS England and Public Health England are sighted and aligned on infection prevention and control risks.
- Improved prescribing practice of antibiotics including broad spectrum antibiotics needs to be maintained so that the right people receive the right antibiotics at the right time.

Areas for focus in 2017/18

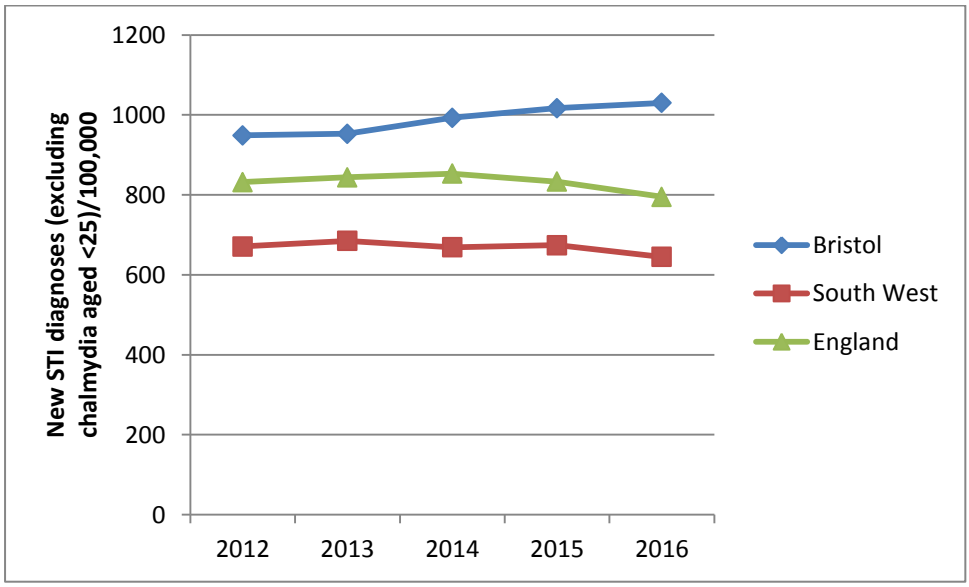
- Increased focus on the number of MRSA blood stream infection amongst the intravenous drug user population. Relaunching the MRSA IVDU task and finish group with input from all agencies. Achieve the zero target for pre 48 hour MRSA blood stream infections
- Maintain a reduction in the number of Clostridium Difficile pre 72 hour community cases
- Maintain a reduction in overall prescribing of antibiotics in primary care, with antibiotic items/STAR-PU being equal to or below England 2013/14 mean performance value of 1.161 items per STAR-PU.
- Reduce the number of trimethoprim items prescribed to patients aged 70 years or greater by 10% on baseline data (June15-May16)
- Reduce the Trimethoprim: Nitrofurantoin prescribing ratio by 10% based on CCG baseline data (June15-May16)
- Focus on reduction of E.coli bacteraemias through establishing a task and finish group and developing a PIR process for investigating and analysing all cases.

1.3 Sexually Transmitted Infections

Sexually Transmitted Infections (STIs) is a term used to describe a variety of infections passed from person to person through unprotected sexual contact. STIs can have lasting long term and costly complications if not treated and are entirely preventable.

Over the last decade the rates of all STIs diagnosed in genitourinary medicine (GUM) clinics have risen across England as a whole, and these increases have been reflected in Bristol. This is partly explained by increased testing through the National Chlamydia Screening Programme (NCSP) and improvements in diagnostic tests, however also reflects ongoing unsafe sexual behaviours. In Bristol syphilis rates are now better than the national average, and gonorrhoea rates are similar to the national average. **Figure 2** shows the trends in new STI diagnoses between 2012 and 2016. Bristol's rate of new STI diagnoses in 2016 was 1,030 per 100,000 (excluding chlamydia in the under 25s). The Bristol rate was higher than the national average of 795 per 100,000 and has continued to increase since 2014, when nationally the rate is declining.

Figure 2. Rate per 100,000 population of STI diagnoses in England (2012 to 2016) (Data from PHE Fingertips)

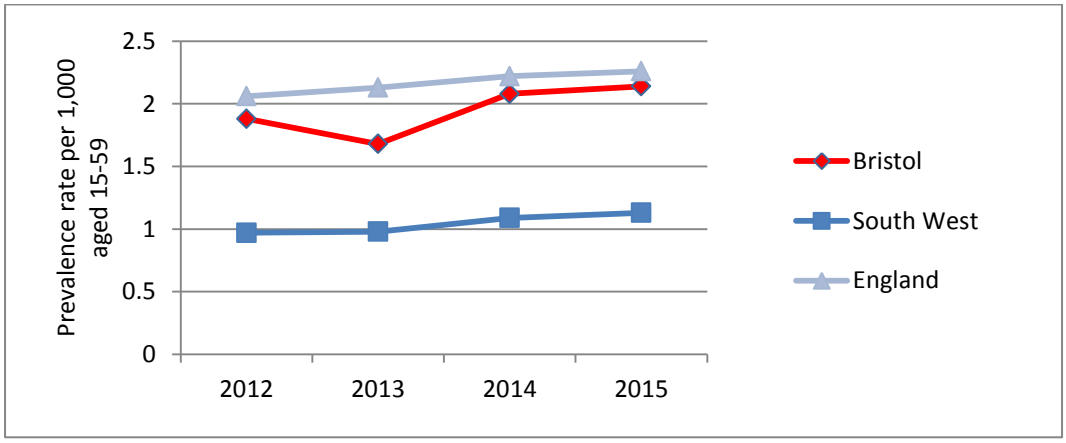


There is variation in the distribution of the most commonly diagnosed STIs by age, gender, sexual orientation and ethnicity as outlined below.

- Young people (15-24 year olds) continue to experience the greatest burden of STI diagnoses.
- Diagnoses of chlamydia, syphilis and gonorrhoea are more likely to be reported in men who have sex with men than other groups.
- There is wide variation in the rates of STIs diagnosed within different ethnic groups. The highest rates of STI diagnoses are found among persons of black ethnicity, and the majority of these cases were among persons living in areas of high deprivation, especially in urban areas.

HIV is associated with considerable morbidity and mortality and requires significant long-term care and treatment. Drug therapies have reduced the incidence of HIV-related deaths but it remains a life-threatening infection. The overall prevalence of HIV for Bristol increased in 2015 to 2.14 per 1,000 residents aged 15-59 year which means Bristol is now considered to be over the threshold for expanded HIV testing (see **figure 3**). The prevalence rate is slightly below the national average. Some groups in society are affected disproportionately by HIV, including MSM and black African communities. Late diagnosis of HIV remains a concern, with 43.2% of people in Bristol presenting at a late stage of infection between 2013 and 2015, which is slightly higher than the national rate of 40.1%.

Figure 3. HIV prevalence rate per 1,000 population (2012-2015) (Data from PHE Fingertips)



Successes/Progress

Procurement of new integrated sexual health services

During 2016/17 a new integrated sexual health service was successfully procured as a collaboration between Bristol, North Somerset and South Gloucestershire local authorities and the accompanying Clinical Commissioning Groups. Bath and North East Somerset Council joined the collaboration for the chlamydia screening programme only. A competitive tender was advertised in 2016, following an extensive consultation exercise. The contract was awarded to University Hospitals Bristol (UHB) NHS Foundation Trust 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 contract started on 1 April 2017 and the service now operates under the brand name 'Unity'. Commissioning the new service has provided an opportunity to address some of the gaps in the previous current sexual health system in order to achieve better outcomes for Bristol residents.

Introducing online STI testing

Unity has launched a new website which gives Bristol residents the option to order STI self-test kits online. The test kits available include a female, male and MSM kit. The service is being promoted through social media channels that target high risk groups.

Relationships and Sex Education

Bristol Public Health have continued to support Bristol schools to deliver high quality PSHE, including relationships and sex education (RSE). A notable success this year has been the investment in a comprehensive primary PSHE education curriculum, which has allowed Bristol schools to purchase the resource at a reduced price. A full training programme was delivered to support schools to introduce the scheme. This curriculum includes age appropriate progressive lessons for the teaching of Relationship and Sex Education, which means that Bristol schools using the resource are fully prepared in advance of the new statutory status for primary schools. PSHE is an integral part of the Heathy Schools programme and from September 2017 schools will be able to gain recognition in good and outstanding delivery of RSE through a 'Bristol Ideal' badge.

Sexual Health Population and Patients Health Integration Team (SHIPP HIT)

The mission of the Sexual Health Improvement HIT is to transform services to improve sexual health for the people of Bristol, North Somerset and South Gloucestershire. The team tackles a range of local sexual health challenges, including increasing rates of HIV infection, higher than national average rates of chlamydia, high teenage pregnancy rates in some disadvantaged communities and a rise in abortions amongst women over 25. During 2016/17 the work programme of the sexual health HIT (SHIPP) to ensure it aligns with the delivery of the new sexual health service and the priorities identified in the needs assessment.

Key current risks

- The local authority continues to need to achieve financial efficiencies in spend on sexual health services whilst managing an increasing demand for the services.
- Cost pressures on local authority sexual health budget arising from the introduction of HPV vaccine, Hepatitis A vaccine and the national Pre Exposure Prophylaxis trial in GUM services
- Concerns of emerging gonorrhoeal antibiotic resistance
  Increasing number of national STI outbreaks, such as hepatitis A and hepatitis B

Areas for focus in 2017-18

- Ensure schools continue to be supported to teach high quality relationship and sex education in order to equip young people with the skills to improve their sexual health and overall wellbeing, in light of the recent decision to make RSE statutory in all secondary and primary schools
- Develop a strategy to improve chlamydia diagnosis rate in 15 -24 year olds through opportunistic screening, which has been in constant decline from 2012 to 2015.
- Involvement in the national trial of HIV PrEP (Pre-Exposure Prophylaxis). The trial should begin towards the end of 2017.
- Strengthen local prevention efforts focused on groups at highest risk, including young adults, black ethnic minorities and MSM.
- Strengthen partner notification work across sexual health services and primary care
- Further explore the opportunities to utilise new technologies to offer increased access to STI testing.

1.4 Foodborne illness

Foodborne illness (more commonly referred to as food poisoning) is any illness that results from eating contaminated food. Foodborne illness can originate from a variety of different foods and be caused by many different pathogenic organisms at some point in the food chain, between farm and fork. Although the majority of cases in the UK are mild they are unpleasant, result in absences from education or the workplace and place a significant demand on healthcare services. Occasionally foodborne illness can lead to complications or even death.

Access to safe food and water is one of the most fundamental human needs. Latest figures from the Food Standards Agency state that there are over 500,000 cases of food poisoning per year across the UK from identified causes and if the unidentified causes were to be included this figure would more than double. In Bristol, there were 842 cases of gastrointestinal infection reported between April 2016 and March 2017 (see **Table 1**).

Table 1: Confirmed cases of gastrointestinal infection reported to HPZone in residents of Bristol local authority, April 2016 to March 2017*
Source: PHE HPZone

Infection	**Total cases reported to HPZone**
Campylobacter	506
Cryptosporidium	76
E. coli VTEC	13
Giardia	147
Shigella	17
Salmonella	78
Paratyphoid Fever	5
Typhoid Fever	0

* Cases were extracted and analysed based on date entered onto HPZone.

Table 2: Cases of norovirus and rotavirus in residents of Bristol local authority, April 2016 to March 2017^
Source: PHE Second Generation Surveillance System (SGSS)

Infection	**Total cases reported to SGSS**
Norovirus	235
Rotavirus	26

^ Cases were extracted and analysed based on specimen date.

Please note that under-reporting to SGSS from Severn Pathology is known to have occurred in October 2016 – December 2016. This is in the process of being rectified .

Successes/Progress

Food Standards Agency Audit Report

The food service was recently audited by the Food Standards Agency, and as a result an action plan has been agreed with the agency. A key action included identifying additional funding from the public health ring fenced budget in order to act as a catalyst to address barriers to the food businesses inspection programme and to develop a new Healthy Eating Award for the city with public health. Additonal budget was secured for 2016-18 and a number of Fixed term EHOs have been recruited. This has led to an increase in the percentage of inspection's undertaken from 38% to 46% for the 2016-17 year. Although there has been an increase the FSA require the backlog is reduced at a faster pace.

Key current risks

The key risks relate to the ability to clear the backlogs and sustain the service on a long term basis, this will be affected if Environmental Health are unable to recruit suitably qualified Authorised Officers to undertake this work and the availability of Environmental Health Contractors. Although funding has been secured on a temporary basis longer term funding is required, and a report will be presented to Senior Management to try and secure this.

Some cases of Shigella may be associated with sexual health practices. EHOs are aware of this and can refer these cases to the Health Protection Team at PHE if further investigation is needed.

Areas for focus in 2017-18

- To continue to develop a healthy eating award for the city.
- To continue clear the backlog of Food Safety Inspections prioritising the highest risk rated premises and new businesses. Secure funding past March 2018 and put a more sustainable plan to reduce the backlog and prevent it building up in future/continue to build up.
- Sexual Health history taking training is needed for EHOs

1.5 Communicable Disease Management

The PHE Health Protection Team responds to any Notifiable Infectious Diseases (NOIDs) in Bristol as well as the rest of England. In 2016/17 the team managed a range of enquiries, cases and outbreaks in Bristol. The majority of outbreaks the team managed in Bristol were Norovirus and Gastroenteritis in care homes and school settings.

Health Protection Team incidents of note

National increase in Vero cytotoxin-producing Escherichia coli O157 Phage Type 34

At the end of June 2016 there was a national increase in Vero cytotoxin-producing E. coli O157 phage type 34. The South West was the most affected region in the country, with a total of 56 cases associated with the outbreak. The majority of cases in the South West were in residents of South Gloucestershire and Gloucestershire local authorities although some affected individuals were residents from Bristol. A case control study found a significant association with the consumption of mixed salad leaves, bagged salad and consumption of salads purchased in restaurants. The outbreak was pronounced over in August 2016.

UK-wide Norovirus Outbreak

In October 2016 there was a UK-wide norovirus outbreak associated with a chain of restaurants. The outbreak included the Bristol branch, with norovirus reports amongst staff and patrons of the restaurant. Investigations indicate there to be an association between illness and a nationally distributed ingredient used at the time of the outbreak.

Influenza in Care Home Residents

There was substantial influenza activity among cases resident in care and residential homes across PHE South West during the 2016/17 winter season. This was associated with significantly higher reports of outbreaks of influenza-like illness in care homes compared to the previous winter season.

Invasive Group A Streptococcal infection (iGAS) emm66 in homeless individuals/people who inject drugs (PWID)

An increase in iGAS infections in homeless people and PWID was identified nationally in January 2016. Clusters were noted in several parts of the country including Bristol (10 cases identified between January 2016 and March 2017), all with strain type emm66 (a sequence type infrequently seen in the UK prior to 2016). An enhanced questionnaire was completed with every case where possible to investigate potential links or common exposures between cases. Work was undertaken with local hostels and drug services to raise awareness of the infection amongst service users and staff. Enhanced surveillance was ceased in June 2017 and the final outbreak report is still pending.

Notifications of TB

(See also TB section in this report.) Cases of TB continue to be managed in Bristol. Outbreak control teams have been convened where needed

Any failure to comply with TB treatment is followed up and where there have been concerns teleconferences with appropriate parties have been convened to improve compliance.

Any cases in healthcare professionals have been followed up promptly and multiagency teleconferences convened as appropriate and follow up of workplace contacts was conducted to identify those who needed screening at the Bristol Royal Infirmary.

Successes/Progress

Scenario Testing and Development of an operational Communicable Disease plan for Bristol

Building upon the work conducted in 2016 surrounding potential outbreak scenarios, clarification of the role and responsibilities of local health partners and identification of resource access as part of possible outbreak responses in Bristol, a localised mass response framework to sit underneath the Avon, Wiltshire and Gloucestershire (AGW) Communicable Disease Framework. Bristol City Council Public Health and PHE was drafted. The plan includes guidance on how to coordinate mass incidents requiring prophylaxis, vaccination, screening and a meeting was held in the first quarter of 2017 with key stakeholders from Bristol City Council Public Health, PHE, the CCG and various other organisations to review the document and agree to the contents. This response framework is held by Bristol City Council Public Health team. This plan was then adopted by the LHRP, amended to suit all localities involved leading to a more consistent approach across the area.

Integration of Local Authority Public Health and PHE Health Protection

A year in post, the integration of a Public Health Consultant split between the local authority and PHE Health Protection team has brought a more coordinated approach to health protection in the locality. This cross-organisational working has facilitated the PHE screening and immunisation team and health protection team to contribute to the Bristol local authority work plan and vice versa, also enabling a more focussed approach to various aspects of health protection during the year, including reviewing TB in the homeless community and rates of invasive Group A Streptococcal infection (iGAS) in people who inject drugs (PWID).

Key current risks

- **Funding Arrangements for Health Protection Incidents**: There is a lack of clarity from stakeholders that confounds the management of communicable disease regarding which organisation is responsible for funding which part of the incident response.

Areas for focus in 2017/18

- **Infection Prevention and Control**: Review arrangements for oversight of infection prevention and control outside hospital settings.

2. Immunisations and Screening

Immunisation is one of the most effective ways of protecting against serious infectious diseases. Immunisations are given at various points across a person's lifetime, at times when they are vulnerable to disease. Performance across the range of immunisation programmes is improving, however, coverage is variable and this requires attention to ensure that the local population is protected and does not become susceptible to outbreaks of these diseases.

In Bristol, there were 261 cases of vaccine preventable diseases notified between April 2015 and March 2016 (See Table 2).

Table 1. Total cases of vaccine preventable infections in Bristol local authority area between April 2016 to March 2017

Infection	**Confirmed Cases on HPZone residents of City of Bristol Local Authority April 2016 to March 2017**
Measles	7
Mumps	19
Rubella	0
Diphtheria	<5
Tetanus	0
Pertussis	107
Polio	0
Meningococcal*	14
HiB	0

*includes all cases (possible, probable and confirmed) Source: Public Health England HPZone record system

Successes/Progress

Influenza Vaccine Uptake 2016/17

Bristol achieves uptake above the national average for seasonal flu vaccination rates for over 65 year olds, at risk groups and pregnant women. Vaccination of 2, 3 and 4 year olds follows the national trend with uptake being highest in 3 year olds, and uptake in Bristol is higher than the national average.

During 2016/17 there was a significant change to the childhood flu programme for school aged children where the model moved from pharmacy based to school based delivery. This saw uptake improve significantly from 2015/16. Despite this improvement Bristol's uptake

for school aged children remains lower than the national average, however, it is anticipated that 2017/18 will see further improvements as the delivery model builds on school relationships established this year. 2017/18 will see the extension of the school based programme to include Reception and Year 4. Local commissioning arrangements will also see all children at special schools being offered vaccinations by the school based team in order to address health inequalities by improving access to vaccinations for vulnerable young people.

Maintaining uptake for routine immunisations

Childhood immunisations

For uptake of Hib/MenC (meningitis strain C) at 2 and 5 years, PCV booster at 2 years, MMR at 2 (one dose) and 5 years (two doses) coverage remains similar to 2014/15 levels and Bristol is now consistently meeting the 95% target for MMR at 5 years (one dose).

In April 2016 a South West Needs Assessment for 0-5 year old vaccinations was published, which included a Bristol chapter. The Needs Assessment's recommendations for Bristol included: improving data flows between Child Health and GP surgeries; supporting practices with low uptake; and improving awareness of immunisations training. Other local work to address improving childhood immunisation uptake includes: immunisations becoming part of the 'Bristol Standards' for children's centres and piloting easy read information to support MMR uptake. Priorities for 2017/18 include: delivering immunisation training to all Health Visitors in Bristol; including immunisations as part of core children's centre training; continuing to address and improve uptake of MMR vaccination; supporting the introduction of the hexavalent vaccine. All these work streams are supported through the Bristol Immunisations Group which is chaired by the Screening and Immunisations Team.

School age immunisations

Uptake for HPV and MenACWY for 2015/16 (academic year) remained lower than national and South West figures, however, during 2016/17 there have been significant changes to provider engagement. This has resulted in changes to staffing structures and the team now have staff exclusively targeting immunisation uptake. 2016/17 is the last academic year of the MenACWY catch-up for Year 11 (school based) and Year 13 (GP based) vaccinations. From September 2017 Td/IPV (teenage booster) will move to Year 9 school based vaccination and will be delivered alongside the routine MenACWY cohort. Td/IPV uptake in Bristol has been historically very low uptake and moving to school based delivery will ensure 100% offer of vaccination to young people and see a marked improvement in uptake.

Adult immunisations

The uptake of pertussis vaccination in pregnancy during 2016/17 has seen significant and sustained improvement in comparison to 2015/16, ranging from 69.6 to 78.7%. This is higher than the England average. During 2017/18 the Screening and Immunisations Team will be working with providers to move towards midwifery led vaccinations to further support improving immunisation uptake.

Uptake of pneumococcal vaccine was 71.3% in 2015/16 and is 71.2% in 2016/17. The shingles (varicella zoster) vaccine has an annual cohort and for the last cohort (vaccinated

between 01.09.2015 – 01.09.2016) uptake was 52.9% for 70 year olds, and 55.3% for 78 year olds (catch up cohort): this is a small decline from the previous year, but in line with a national decrease in uptake.

Targeted immunisations

In January 2017 dry blood spot serology testing was introduced for Hepatitis B at 12 months of age. This is a change from a blood test and is an improvement in patient care.

Key immunisation groups

The organisation and governance of processes to ensure the effectiveness of local immunisation programmes is now well-established. This governance process reports to the Health Protection Committee and comprises of:

- **Bristol Immunisations Group**

  The group provides an operational forum for key stakeholders involved in the delivery of immunisations in Bristol. It is well attended and has clear action plans in place to improve immunisation uptake and reduce inequalities.

- **Bristol Immunisation Group Health partners Integration Team (BIG HIT)**

  The BIG HIT is a collaboration of key senior stakeholders formed as part of the CLARHC and allows key stakeholders from clinical practice and academia to work together to steer clinical and research development priorities for immunisation in Bristol.

- **Vaccine Preventable Diseases Group**

  The Vaccine Preventable Diseases Group is the high level strategic oversight and governance group for immunisations. It sets the strategic direction for the overarching work plan for programme delivery and provides strategic response to issues raised by the previous two groups.

Key current risks

- **Meningococcal disease:** Incidence of meningococcal disease (W) continues to increase nationally and atypical presentations of both strain B and strain W have occurred, particularly in teenagers. GPs and hospital clinicians have been alerted to this via Bulletins and national Briefing Notes. It is important that uptakes of ACWY vaccine for school leavers and university students ‘Freshers’ aged under 25 are improved to minimise the potential for cases and outbreaks.
- **Pertussis:** Incidence continues to increase nationally with cases across all ages, but with higher incidence in younger children resulting in neonatal deaths. New public health guidelines for the management of pertussis are being developed nationally and the priority remains the promotion of the maternal immunisation programme.
- **Measles and MMR:** Cases of measles continue to arise and a large outbreak has recently occurred in London with transmission to local areas. There remain pockets of under-immunised populations within the Bristol locality who remain susceptible to

measles. Targeted immunisation plans for specific groups need to be developed to provide an effective response

- **BCG supply:** See section 1.2 of this report. An international shortage has occurred following problems associated with the manufacturing of BCG vaccine. This situation is being managed by the national immunisation team and alternative supplies are being sourced but in the interim supply is restricted, with priority being given to the neonatal programme for infants of high risk mothers. Records are being kept of those who would normally be eligible but not able to be prioritised and these individuals will be recalled when further vaccine supplies become available.

Areas for focus in 17/18

- Maintain and improve current performance across all programmes.
- Reduce variability in coverage within and between programmes, with a focus on the Inner City Bristol locality.
- Implement the extension of the Childhood Flu programme to Reception and Year 4 primary school aged children and improve uptake for all eligible children.
- Improve uptake of flu and pertussis vaccines by pregnant women.
- The Screening and Immunisation Team, Bristol City Council Public Health Team and CCG locality chairs to work together to review uptake data by practice and by provider and develop action plans to target areas of poor uptake and coverage for each of the screening and immunisation programmes.
- Implementation of the hexavalent vaccine
- Movement to school based vaccination for Td/IPV
- Continuing to support improvement of the school based programmes

2.2 Screening

The UK National Screening Committee defines screening as “The process of identifying apparently healthy people who may be at increased risk of a disease or a condition so that they can be offered information, further tests and appropriate treatment to reduce their risk and/or complications arising from the disease or condition.”

There are currently three national cancer screening programmes: breast, bowel and cervical; and eight non-cancer screening programmes: six antenatal and new-born (Fetal Anomaly, Infectious Diseases in Pregnancy, Sickle Cell and Thalassaemia, New-born and Infant Physical Examination, New-born Blood Spot and New-born Hearing) and two young person and adult (Abdominal Aortic Aneurysm and Diabetic Eye).

Successes/Progress

Cancer screening

The Screening and Immunisation Team have worked with colleagues in the local authority and the CCG to collaboratively address health inequalities in relation to these programmes. Service reviews and equity audits have been completed for each of the three cancer screening programmes and actions identified to improve uptake and coverage. Specific activity has included the production of a DVD for women with learning difficulties to provide accessible information for them on what to expect when attending for a cervical screening test (‘smear test’). This resource received a national award and can now be accessed via The Jo’s Trust and NHS Choices national websites.

Focus groups were also convened in collaboration with community groups and leaders in inner city Bristol to look at potential barriers to accessing bowel cancer screening amongst minority ethnic and other under-represented groups. A work plan has been developed to implement the actions arising from this piece of work which continues to be led by the provider (UHB) and informed by local community representatives. The Bristol and Weston Bowel Cancer Screening Programme had a very successful Quality Assurance visit in 2015/16 and has continued to improve.

Antenatal Screening

University Hospitals Bristol performs at the higher achievable level for all indicators within the Antenatal screening programmes, with the exception of timely referral of hepatitis B positive women for specialist assessment, which is not achieved within acceptable timescales, and timeliness of the Antenatal sickle cell and thalassaemia test which is achieved but at the lower acceptable level. Hepatitis B pathways have been reviewed and these standards continue to be closely monitored. The Antenatal and Newborn Screening Service (including the Newborn Hearing Screening Service) had a PHE Quality Assurance visit during 2015/16 and a comprehensive action plan has been developed to ensure continuous service improvement going forward.

Antenatal screening for rubella ceased on 1st April 2016. Instead there is renewed focus on improving MMR uptake across the whole population as a more effective way of preventing congenital rubella infection

In the Fetal Anomaly Screening Programme, screening for Trisomy13 and Trisomy18 was introduced to the combined first trimester screening test, and the 3-vessel/trachea (3VT) screening was introduced in to the mid-trimester fetal anomaly scan.

Newborn Bloodspot Screening

Screening tests for four additional inherited metabolic disorders were added to the newborn bloodspot screening programme in 2015 / 16. The six disorders now screened for include:

- phenylketonuria (PKU)
- medium-chain acyl-CoA dehydrogenase deficiency (MCADD)
- maple syrup urine disease (MSUD)
- isovaleric acidaemia (IVA)
- glutaric aciduria type 1 (GA1)
- homocystinuria (pyridoxine unresponsive) (HCU)

About 1 in 10,000 babies born in the UK has PKU or MCADD. The other conditions are rarer, occurring in 1 in 100,000 to 150,000 babies. Without treatment, babies with inherited metabolic diseases can become suddenly and seriously ill. The diseases all have different symptoms. Depending on which one affects their baby, the condition may be life threatening or cause severe developmental problems. They can all be treated with a carefully managed diet and, in some cases, medicines as well. The Newborn and Infant Physical Examination (NIPE) screening programme saw the roll-out of the new IT system, NIPE SMaRT. This, for the first time, has provided a systematic and robust way of identifying the eligible cohort for the NIPE examination, for recording screening results, referral in to diagnostic services and outcomes, and for failsafe.

The move from HV registered to resident populations required the NHSP teams to work together to address boundary changes and ensure all babies were offered screening. In addition, the new national IT screening system, Smart4Hearing (S4H) went live in December 2016. Both these transitions were achieved without disruption to patients and screening services.

Adult screening programmes

Non Cancer Screening

In relation to the adult screening programmes, the Bristol Diabetic Eye Screening and the Abdominal Aortic Aneurysm Screening programme continue to perform well.

Cancer Screening

The cervical screening programmes in the South West have continued to perform well with no significant issues or incidents. Reducing coverage has been the main issue over several years with local rates mirroring the slow but consistent reduction in national rates. The Screening and Immunisation Team has identified cervical screening coverage as a priority and has targeted work to groups here uptake is lowest. Sample-taker training and its effective oversight is a critical factor in the quality and safety of the screening programme. The Screening and Immunisation Team has reviewed and updated the training policy including escalation procedures, and created a single South West sample-taker data base to

ensure that all sample-takers are registered, have a unique ID code to track samples, and are alerted to when they need to update.

Breast screening services have seen significant and continued pressure on the programme due to a combination of demand from the symptomatic service and capacity pressures within screening teams due to shortages of key staff (radiographers, radiologists, and specialist breast care nurses). This is a national problem that is starting to affect many programmes across the country. The workforce issue has been escalated nationally and a working group is developing options to address the issue. In some areas, the increasing number of GP practice mergers and closures is having a negative impact on round length. As breast screening is a three yearly cycle, women who have to re-register, or move into a new practice due to a merger, may have their screening invitation date delayed depending on where the practice is the three year cycle. These women have to be slotted in to already busy routine lists across the area creating pressure on the service and impacting temporarily on KPIs. This issue is affecting all areas of the country and has been escalated nationally. Potential solutions are being investigated for the service and also to track affected women to ensure screening is offered within the appropriate timescales, as far as possible.

There continues to be a lot of activity in the bowel screening programme. This is primarily due to the continued roll-out of Bowel Scope screening and ongoing work to maintain delivery to national standards in the face of a national shortage of endoscopists and radiographers that have created significant pressures within colonoscopy services. Providers have so far maintained KPI performance despite these challenges.

Key current risks

There has been an increase in demand on the symptomatic / treatment end of the service. This is having an impact on the screening services, resulting in increased waiting times for patients at points during 2015/16. There are a number of reasons for the increase in demand, including demographic change resulting in more eligible people within the population, a greater focus on prevention and early diagnosis, and a number of successful, high profile awareness raising ‘Be clear on Cancer’ campaigns, and other activities to improve uptake of these services. The increase in demand has occurred at a time of reduced staffing capacity which has compounded the problem. There is a national shortage of specialist staff, especially specialist clinical staff, radiographers, radiologists and pathologists and recruitment to vacancies within the programme teams has proved challenging. This issue has been escalated nationally.

Areas for focus in 17/18

- Continue to strengthen collaborative multi-agency action plans to target areas of poor uptake and coverage for each of the screening programmes.
- Implement the actions arising from each of the Quality Assurance visits to programmes to ensure compliance with national standards and continuous service improvement.
- Closely monitor demand and capacity, and care pathways within the cancer screening programmes, escalating concerns promptly and reviewing pathways of care, as required, to maintain service effectiveness, to ensure waiting times remain within acceptable standards, and to meet any increase in demand.

Successes/Progress

Cancer screening

The Screening and Immunisation Team have worked with colleagues in the local authority and the CCG to collaboratively address health inequalities in relation to these programmes. Service reviews and equity audits have been completed for each of the three cancer screening programmes and actions identified to improve uptake and coverage. Specific activity has included the production of a DVD for women with learning difficulties to provide accessible information for them on what to expect when attending for a cervical screening test ('smear test'). This resource received a national award and can now be accessed via The Jo's Trust and NHS Choices national websites.

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or cause severe developmental problems. They can all be treated with a carefully managed diet and, in some cases, medicines as well.

Adult screening programmes

In relation to the adult screening programmes, the Bristol Diabetic Eye Screening programme has had a successful Quality Assurance visit and has achieved all three key performance targets and the Abdominal Aortic Aneurysm Screening programme also continues to perform well.

Key current risks

There has been an increase in demand on the symptomatic / treatment end of the service. This is having an impact on the screening services, resulting in increased waiting times for patients at points during 2015/16. There are a number of reasons for the increase in demand, including demographic change resulting in more eligible people within the population, a greater focus on prevention and early diagnosis, and a number of successful, high profile awareness raising 'Be clear on Cancer' campaigns, and other activities to improve uptake of these services. The increase in demand has occurred at a time of reduced staffing capacity which has compounded the problem. There is a national shortage of specialist staff, especially specialist clinical staff, radiographers, radiologists and pathologists and recruitment to vacancies within the programme teams has proved challenging. This issue has been escalated nationally.

Areas for focus in 17/18

- Continue to strengthen collaborative multi-agency action plans to target areas of poor uptake and coverage for each of the screening programmes.
- Implement the actions arising from each of the Quality Assurance visits to programmes to ensure compliance with national standards and continuous service improvement.
- Closely monitor demand and capacity, and care pathways within the cancer screening programmes, escalating concerns promptly and reviewing pathways of care, as required, to maintain service effectiveness, to ensure waiting times remain within acceptable standards, and to meet any increase in demand.

3. Emergency Preparedness, Resilience and Response (EPRR)

The local health economy needs to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident.

The Civil Contingencies Act 2004 (CCA2004) requires health organisations to show that they can deal with such incidents while maintaining services. Organisations must have effective, well-practiced emergency plans in place in order to protect the population of Bristol.

In Bristol, EPRR is facilitated by two fora; The Local Health Resilience Partnership and the Local Resilience Forum.

3.1 The Local Health Resilience Partnership

The Local Health Resilience Partnership (LHRP) is a strategic forum for organisations in the local health sector. The LHRP facilitates the production of local sector-wide health plans to respond to emergencies and contribute to multi-agency emergency planning.

Each constituent organisation remains responsible and accountable for their effective response to emergencies in line with their statutory duties and obligations. This includes maintaining plans detailing organisational capability to support the response to a major incident, including pandemic flu, mass casualty and chemical, biological, radiological and nuclear (CBRN) incidents.

3.2 The Avon and Somerset Local Resilience Forum

The Avon and Somerset Local Resilience Forum (ASLRF) is one of a number of Local Resilience Forums (LRFs) across England set up to align with the local police area. The LRF is not a legal organisation in itself, but a partnership made up of a number of organisations and agencies.

The overall aim of the Avon and Somerset Local Resilience Forum is to ensure that agencies and organisations plan and work together, to ensure a co-ordinated response to emergencies that could have a significant impact on communities in Avon and Somerset.

Key current risks

- **Emerging infectious diseases:** An emerging disease is one that has appeared in a population for the first time, or that may have existed previously but is rapidly increasing in incidence or geographic range. Many of these emergent diseases are zoonotic, meaning there can be transmission between animals and humans, such as Ebola Virus Disease (EVD) or Zika Virus.

- **Pandemic Influenza:** The impact of a new pandemic on health and social care services will vary according to the nature of the virus and its effects, as well as the underlying status of the health economy and the context such as severe weather.

Excess Deaths: Significant events can occur that are detrimental to the health of the population and can result in an excess of deaths locally. These events challenge the delivery of the routine death management process, and can be health-related (e.g. due to a communicable disease outbreak) or environmentally related (e.g. heatwave or cold weather).

- Excess winter mortality in England and Wales was back in line with average trends in 2015/16. There were an estimated 24,300 excess winter deaths where 15% more deaths occurred in winter months than non-winter months. In 2015/16 excess winter mortality significantly decreased from 2014/15 when the number of excess winter deaths was uncommonly high. The demand on local body holding capacity has been highlighted as a risk at both the LHRP and the LRF since the loss of Frenchay hospital and its mortuary in 2014.
- Recent high-profile incidents in London and Manchester have highlighted the need to expand and strengthen emergency and continuity planning arrangements in the city.

Areas for focus in 17/18

- To validate existing plans and procedures, ensuring plans are effective and well-practised.
- To review local level arrangements for mass fatalities and excess deaths.
- To review emergency and continuity planning arrangements in the city.

4. Environmental hazards to health, safety and pollution control

Poor air quality can have an impact on health at all stages of life, from being associated with low birth weight, impacts on lung function development in children, an increased risk of chronic disease and acute respiratory exacerbations, to acute and chronic premature death. Latest evidence is linking air pollution with impacts on cognitive function. All these health impacts can impact upon a person's quality of life. The most vulnerable are the young and old.

Air quality in Bristol is sufficiently poor in many locations for the health impacts described in the previous paragraph to be experienced by citizens in Bristol. Monitoring data shows continued exceedances of the annual and hourly nitrogen dioxide (NO_2) air quality objective close to roadside locations in the city centre and along the main arterial routes.

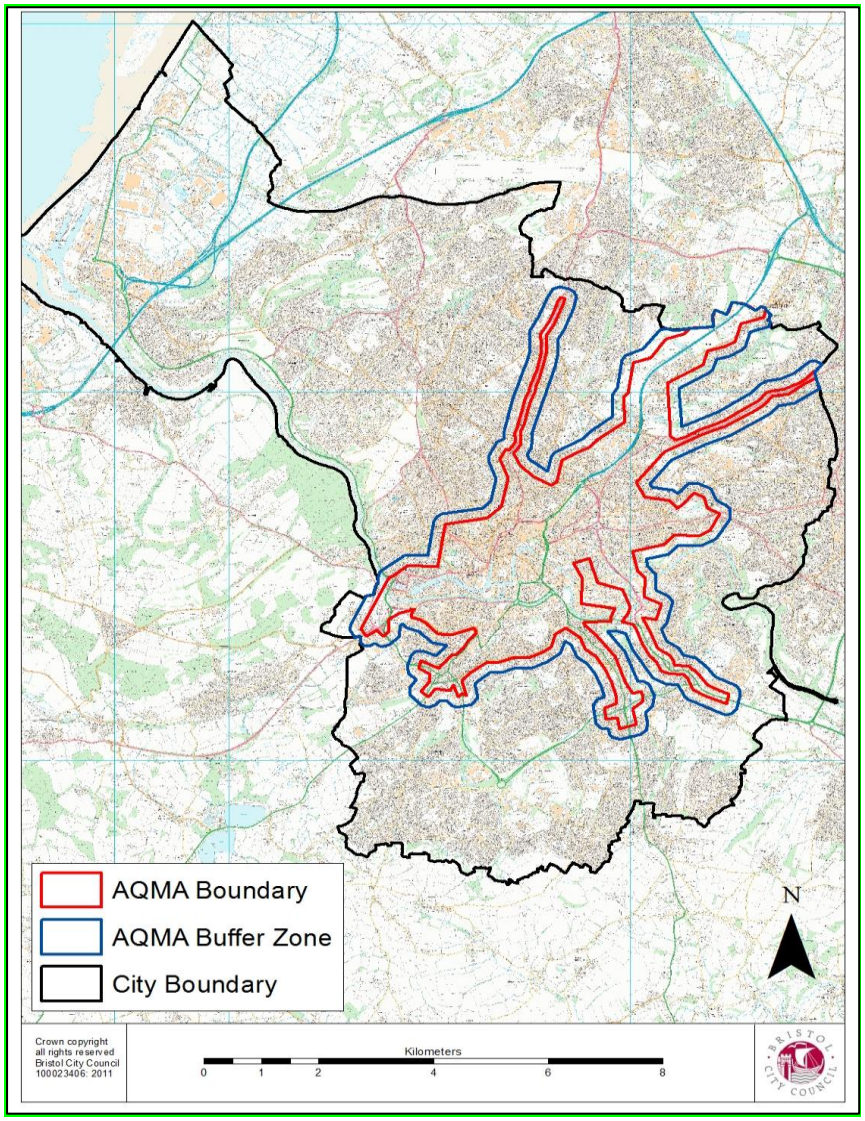
A report commissioned by BCC[9] calculated that approximately 300 deaths of Bristol residents can be attributed to air pollution (particulate matter - $PM_{2.5}$ and nitrogen dioxide – NO_2) in 2013,. This equates to 8.5% of all deaths in Bristol annually. These deaths attributed to air pollution compare, on average, to 9 people killed in road traffic collisions in Bristol each year.

Local authorities are required to declare an Air Quality Management Area (AQMA) (**see figure 5**) where exceedances of air quality objectives occur and people are present for the relevant averaging period. The current air quality management area for Bristol is shown in Figure 3 and covers those locations where exceedance of objectives for NO_2 has been measured and relevant exposure to this pollution occurs. Once an air quality management are has been declared, an air quality action plan is required in order to identify measures aimed at achieving compliance with the air quality objectives.

Monitoring of NO_2 concentrations in the Avonmouth and Lawrence Weston areas showed one location exceeding the annual objective for this pollutant. This is a location close to the M5 where no relevant exposure occurs. Monitoring at 12 other locations showed compliance with the objective and no requirement for an AQMA to be declared. The situation will continue to be monitored closely.

[9] Air Quality Consultants (2017. Health Impacts of Air Pollution in Bristol.: Air Quality Consultants Ltd

Figure 5. Bristol Air Quality Management Area



Successes/Progress

Avonmouth Air Quality and Dust Nuisance

The Environment Agency and Bristol City Council carried out monitoring of Air Quality in Avonmouth from August 2014 until September 2015 in response to resident concerns about air quality. The Bristol City Council monitoring station measured the very small particles in the air which can't be seen, finer than the kind of dust which people see on car window screens or window sills. These small particles can get past the body's natural filters and into people's lungs. They are measured at 10 microns ('PM_{10}') and 2.5 microns ('$PM_{2.5}$').
The results after 12 months of monitoring showed that all the measurements were well under the European Union Air Quality limits. The dust monitoring also analysed the heavy metal content in the Avonmouth samples. Four key metals in terms of their impact on human health have been measured: lead; arsenic; cadmium and nickel all were within European Air Quality standards.

Avonmouth 2nd Phase Nuisance Dust Monitoring

A second phase of monitoring has taken place focusing on larger depositional dust for six months between July 2016 to January 2017. As this type of dust can be seen, typically appearing on cars windscreens and other locations, it has been a concern to the community. However as this type of dust cannot be inhaled it is not considered a human health risk such as PM10. Monitoring consisted of six omnidirectional deposition monitors with directional monitors located throughout Avonmouth with one control site taking fortnightly samples. The public helped identify locations for the monitors and also asked to report issues if any dust problems if they arose during the study. A private contractor, SLR Consulting, were procured to undertake the monitoring and they used accredited laboratories to analyse samples.

A report was produced at the end of the monitoring period and Environmental Health Officers from the Pollution Control Team will further review the findings against custom and practice values and also procure further detailed analysis of samples if likely to be helpful in establishing whether there is any likelihood of a statutory nuisance and if so where the potential sources of such dust arise and if any regulatory effort can help resolve.

For the duration of the monitoring two dust events were reported, investigated by officers and reflected in the deposition results:

- July 2016 - Complaints alleging dust from Avonmouth Dock area (the part of the docks running parallel to Portview road) and this was reflected in a higher than average reading from one monitor although it should be noted this was still only 64% of the Custom and Practice limit value of 200mg/m2/day
- August 2016 – Complaints regarding dust from road resurfacing works, this reflected a higher than average reading at the childcare centre site but was only 51% of the Custom and Practice limit value of 200mg/m2/day

Other reports made to us were not reflected in the monitoring results. Due to a lengthy procurement process for a new scientific services provider for the Council and financial restrictions during the latter part of the 2016/2017 financial year we have only recently been able to submit additional samples to the new provider and are currently awaiting these results. Once received a final report will be prepared and provided to the public.

The first round of samples were analysed for heavy metals but were found to be “all significantly below the relevant EA criteria” and not attributable to any particular source. We have submitted further analysis of later samples to compare with the original results.

The SLR report comes to the following conclusions “the results of the dust deposition monitoring using omni-directional Frisbee Gauges have recorded rates consistently below the custom and practice criteria of 200mg/m_2/day.” None of the monitors recorded dust at a level above the criteria throughout the duration of the monitoring period”. This was also reflected in the low number of complaints made directly to ourselves during this period.

At this time results are indicating that there is no underlying depositional dust issue for residents from industrial activities in and around Avonmouth. However with all industrial areas should there be an acute dust episode residents are advised to

continue to report concerns to the Pollution Control Team by calling the Customer Service Centre on 01179 222500 Option 3.

Mayoral Air Quality Working Group

A Mayoral Air Quality Working Group (MAQWG) has been established tasked with improving air quality in the city. The key focus of the group is to provide a positive impact on health and wellbeing for all communities including the most vulnerable, support a flourishing local economy and accelerate the transition to a zero emission city. The group is co-chaired by the cabinet member for transport and cabinet member for health and wellbeing.

Key objectives of the MAQWG are;

- To advise on the implementation of the Administration's Air Quality Commitments.
- To guide the development of a new Air Quality Action Plan that improves health and addresses compliance with the exceedances of air quality objectives and fulfils the council's statutory duty.
- To develop plans for the implementation of a Clean Air Zone as part of the Air Quality Action Plan.
- To contribute to national policy and guidance such as from DEFRA and NICE.
- To monitor the impact of interventions on air quality and public health in Bristol.

The Group is attended by Bristol City Council officers from across the authority, including Public Health, who seek to engage with all stakeholders on the impact of poor air quality on public health and wellbeing, communities, economics and the need for city wide air quality improvement measures in order to promote less polluting lifestyle and business choices.

Key current risks

- Maintaining an effective dialogue with Bristol residents about environmental hazards to health.

Areas for focus in 2017-18

- Initiate a Liaison Group to bring together Community members and representatives from the Avonmouth Industrial companies to discuss improvements in community impacts and improve the working relationship/good neighbours culture. Work to create this Liaison group has been started by the Neighbourhood Partnership with local residents and will be put in place in 2016/17. With the changes to the NP system this Liaison group needs to be reviewed moving forward.

- Issue the final nuisance dust deposition report to the community

- Work with the BCC Sustainable City and Climate Change Service and Strategic Transport to develop a new air quality action plan for the Bristol AQMA. This will include supporting the development of a CAZ Feasibility Study as part a wider air quality action plan. An important part of this will be to ensure the right messages are

communicated to citizens and stakeholders with regards to the health impacts associated with current levels of pollution in Bristol. The aim is to implement measures to achieve compliance with air quality objectives in shortest time possible. Promoting a wider understanding of the health issue associated with air pollution is considered to be a vital part of the consultation process for air quality action plan measures.

- Support BCC Sustainable City and Climate Change Service with the development of an awareness raising and communications campaign with the aim of engaging the citizens and wider stakeholders in the city and surrounding areas on the causes, and impacts of air pollution.

Appendix 3 : Primary organisational roles and responsibilities in the prevention and control of infectious disease outbreaks or health protection incidents in Bristol

PHE Centre (AGW) The Centre Director will ensure that PHE, through the health protection team will lead the epidemiological investigation and provide the specialist health protection response to public health outbreaks / incidents. They or their designate (Deputy Director of Health Protection / Consultant in Communicable Disease Control / Health Protection Consultant) have the responsibility to declare a health protection incident, major or otherwise.	**Preparation** • Providing advice (through the Local Health Resilience Partnership) to local NHS providers and commissioners regarding any preparation that they might need to undertake to ensure an effective and timely response when a public health outbreak / incident occurs; • supporting local authorities to understand and respond to potential threats; • collection, analysis, interpretation of surveillance data; • providing expert advice on hazards that pose a risk to the public's health and effective interventions to prevent and respond accordingly; • coordinating an out of hours rota for the delivery of specialist health protection advice by qualified personnel; • participating in arrangements for exercising and testing plans to respond to outbreaks / incidents; • providing access to regional and national PHE expertise as required; • advising on the requirement for prophylactic treatment and immunisation for all health protection incidents; • keeping the DPH informed about significant health protection issues and actions being taken to overcome them; • providing the local authority with information to support the Joint Strategic Needs Assessment and Joint Health and Wellbeing Board strategies as required; • supporting local authorities to develop a trained and knowledgeable workforce in the area of health protection. **Response** • Leading the Public Health response to declared Major Incidents; receiving and investigating notifications (with partners); • initiating immediate control measures when required; providing expert epidemiological advice through field epidemiology teams to support incident / outbreak investigation (both in the response and recovery phases); • sharing information concerning incidents / outbreaks with the local authority through the Director of Public Health; • chairing the 'Outbreak/Incident Management Team' and keeping health protection risks under review throughout the incident; communicating to partners when an Outbreak/Incident Management Team is established; • providing updates until the outbreak/incident is declared

	over; • coordinating public communications / media response in collaboration with the local authority, CCG and NHS England.
BCC Public Health Through the Director of Public Health, the Local Authority has overall responsibility for the strategic oversight of an incident / outbreak impacting on their population's health. They should ensure that an appropriate response is put in place by NHS England South West and PHE supported by the CCG. In addition, they must be assured that the local health protection system is robust enough to respond appropriately in order to protect the local population's health and that risks have been identified, are mitigated against and adequately controlled.	**Preparation** • Preparing for and leading the local authority's response to incidents that present a threat to the public's health; providing information, advice, challenge and advocacy; • chairing the Bristol Health Protection Committee to ensure that the health protection system is meeting the needs of its local authority population and that risks identified are adequately mitigated against and control arrangements are in place; • coordinating the Joint Strategic Needs Assessment to support the understanding of local health protection risks; • reporting local health protection arrangements and escalating health protection risks to the Health and Wellbeing Board; • ensuring that relevant commissioned services (including providers of sexual health services, drug and alcohol services and school health services) can provide an appropriate response to any incident that threatens the public's health and that business continuity plans are in place; • participating in arrangements for exercising and testing plans to respond to outbreaks / incidents. **Response** • Collaborating with PHE to lead the PH response to a major incident; • participating (as required) in Outbreak/Incident Management Teams, to help inform decision about the appropriate level of NHS response from providers AND working alongside PHE and the CCG to agree and source through agreed plans the resources needed to be released; • briefing Local Authority colleagues and elected members regarding health protection incidents/outbreaks; • mobilising local authority resources required to support an incident (e.g. Scientific Services and Animal Health and Welfare & Trading Standards).
BCC Environmental Health Local authorities have defined health protection functions	**Preparation** • Ensure that relevant services and providers have effective health protection and business continuity arrangements in place to guarantee an appropriate response to any incident that threatens the public's health; • exercising powers under the health protection regulations to prevent or limit the spread of an infectious disease;

and statutory powers in respect of environmental health and health and safety.	• prosecuting environmental and public health offenders; • informing the Drinking Water Inspectorate of an outbreak of illness associated with, or suspected to be associated with, a private water supply; • participating in arrangements for exercising and testing plans to respond to outbreaks / incidents. **Response** • With the Public Health England Centre, supporting local leadership in responding to communicable disease incidents and outbreaks; • inform Director of Public Health / Public Health England Centre of any emerging outbreaks/incidents; • with the Public Health England Centre, investigating clusters and outbreaks of foodborne infectious diseases; • participating (as required) in Outbreak/Incident Management Teams to help inform decisions about the appropriate level of Environmental Health (specialist and administrative) resources required to support the incident response; • provide specialist help and advice on the environmental aspects of the outbreak; • when required, undertake inspections, collection of specimens and investigations of implicated premises; • as an Health and Safety enforcement authority, execute the statutory duty to investigate infectious disease linked to workplace settings, undertake inspections, regulate; • as a Port Authority, responding to any outbreak of infectious or gastrointestinal disease at Bristol Seaports (Avonmouth and Royal Portbury Dock).
Bristol CCG The primary role of the CCG is to ensure through contractual arrangements with provider organisations that healthcare resources are made available to respond to health protection incidents or outbreaks (including screening/diagnostic and treatment services).	**Preparation** • Ensuring provider organisations commissioned by the CCG are able to respond adequately to health protection incidents / outbreaks where screening, diagnosis, treatment or vaccination might be required; • disseminating information as required by PHE or the local authority regarding the prevention of / response to, health protection incidents/ outbreaks across the local system of health care; • with regards to planning and preparedness, obtain appropriate advice from persons with the professional expertise in the protection or improvement of public health; • participating in arrangements for exercising and testing plans to respond to outbreaks / incidents. **Response** • Participating (as required) in Outbreak/Incident Management Teams to help inform decisions about the appropriate level of NHS response from providers and any

	CCG resources needed to be released; • Providing (if requested by NHS England South West), clinical support for the prescribing and administration of medication.
NHS England Has responsibility for managing/overseeing the NHS response to the incident, ensuring that relevant NHS resources are mobilised and commanding / directing NHS resources as necessary. Additionally NHS England South West is responsible for ensuring that their contracted providers will deliver an appropriate clinical response to any incident that threatens the public's health.	**Preparation** • Planning and securing the health services needed to protect the public's health; • with regards to planning and preparedness, obtaining appropriate advice including from persons with a broad range of professional expertise in the protection or improvement of public health. • participating in arrangements for exercising and testing plans to respond to outbreaks / incidents. **Response** • Mobilising NHS resources in response to incidents and outbreaks; • participating (as required) in Outbreak/Incident Management Teams to help inform decisions about the appropriate level of NHS response from providers and working alongside the CCG to agree the resources needed to be released; • co-ordinating the primary care response to the incident with the Area Team Pharmacy Advisor (as required); • Supporting CCGs to coordinate any response required by Community Trusts and/or Acute Trusts.

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Better Lives: Improving outcomes for adults in Bristol	
Author, including organisation	Stephen Beet, Care & Support Adults, Bristol City Council
Date of meeting	25th October 2017
Report for information and discussion	

Purpose of this Paper

1. The purpose of this item is to provide an introduction to the Better Lives programme and to engage Health and Wellbeing Board members in a discussion about the programme.

2. This paper provides a very brief introduction to the programme and there will be a detailed presentation at the meeting.

Better Lives: Improving outcomes for adults in Bristol

3. This programme has been developed to bring together the work in adult social care and with partners across the wider health and social care system to achieve the following vision:
   - People can get the right level and type of support, at the right time to help prevent, reduce or delay the need for ongoing support, and to maximise people's independence.

4. The overall purpose for the programme (the "Statement of Intent") is to make cost savings whilst holding our ambition to improving outcomes, commissioning and delivering quality services and keeping "people" at the heart of what we do.

5. To deliver the vision and the statement of intent, the programme will focus on our four key delivery priorities which are:
   - Deliver a balanced budget
   - Support the workforce to be fit for the future
   - Maximise the provider market
   - Strengthen partnership working

Key risks and opportunities

6. The Better Lives programme is taking place at a time of significant change and pressures in the health and social care system nationally and locally, and is designed to meet these challenges and to deliver the outcomes in the context of:
   - demographic growth;
   - reduction in funding;
   - changes in the health and social care system including the collaboration on the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan.

Implications (Financial and Legal if appropriate)

7. There is a savings target attached to the programme..

Evidence informing this report.

8. The programme has been developed taking into account:
   - Bristol City Council Corporate Strategy 2017-2022
   - Adult Social Care Strategic Plan 2016-2020
   - Workshop to develop longer term vision for service
   - Development and implementation of the Three Tier Model

Recommendations

9. The Health and Wellbeing Board is asked to:
   - note the details of the Better Lives programme;
   - discuss how it can make links with, and contribute to, the programme.