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Health and Wellbeing Board

Agenda

BRISTOL CCG

Date: Wednesday, 19 October 2016

Time: 2.30 pm

Venue: The Writing Room, City Hall, College Green, Bristol, BS1 5TR

Distribution:

Mayor Marvin Rees, Dr Martin Jones, Alison Comley, John Readman, Jill Shepherd, Linda Prosser, Becky Pollard, Cllr Lesley Alexander, Cllr Fi Hance, Cllr Clare Campion-Smith, Ellen Devine, Elaine Flint, Keith Sinclair, Steve Davies, Justine Mansfield and Pippa Stables

Issued by: Ian Hird, Democratic Services
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Date: Tuesday, 11 October 2016

www.bristol.gov.uk

Agenda

1. Welcome, apologies and introductions 2.30 pm

2. Public forum

Petitions and statements (must be about matters on the agenda):
Members of the public and members of the Council may present a petition or submit a statement to the Health and Wellbeing Board. One statement per member of the public and one statement per member of Council is permitted. A maximum of one minute shall be allowed to present each petition and statement. The deadline for receipt of petitions and statements for the 19 October Health and Wellbeing Board is **12.00 noon on Tuesday 18 October.** These should be e-mailed to democratic.services@bristol.gov.uk or sent to Democratic Services, City Hall, P.O. Box 3176, Bristol, BS3 9FS, to be received by the above deadline.

Questions (must be about matters on the agenda):
Questions may be asked by a member of the public or a member of Council. A maximum of 2 written questions per person can be asked. At the meeting, a maximum of 2 supplementary questions may be asked. A supplementary question must arise directly out of the original question or reply. Replies to questions will be given verbally at the meeting. If a reply cannot be given at the meeting (including due to lack of time) or if written confirmation of the verbal reply is requested by the questioner, a written reply will be provided within 10 working days of the meeting. The deadline for receipt of questions for the 19 October Health and Wellbeing Board is **5.00 pm on Thursday 13 October.** These should be emailed to democratic.services@bristol.gov.uk or sent to Democratic Services, City Hall, P.O. Box 3176, Bristol, BS3 9FS by the above deadline.

3. Declarations of interest

To note any declarations of interest from 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 declaration 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 5 - 12)**

5. Key decision - Re-commissioning of substance misuse services **2.40 pm**

Report to be presented by Pete Anderson, Safer Bristol Manager **(Pages 13 - 19)**

6. Sustainable Transformation Plan **3.00 pm**

Presentation from Robert Woolley, Chief Executive, UHBT

7. CCG commissioning intentions and 2 year operational plan **3.20 pm**

Presentation from Justine Rawlings, CCG

8. Bristol City Council draft Corporate Plan and budget consultation **3.35 pm**

Presentation – presenter to be confirmed

9. Joint Health and Wellbeing Strategy refresh 2016 **3.50 pm**

Report to be presented by Becky Pollard, Director of Public Health **(Pages 20 - 27)**

10. Bristol citywide alcohol strategy - update from working group **4.05 pm**

Report to be presented by Leonie Roberts, Consultant in Public Health **(Pages 28 - 98)**

11. Proposed procurement of a Behaviour Change for Healthier Lifestyles Service for Bristol **4.15 pm**

To be presented by Viv Harrison, Consultant in Public Health Medicine, and Sally Hogg, Consultant in Public Health **(Pages 99 - 104)**

12. Health Protection Annual Report **4.25 pm**

Report to be presented by Thara Raj, Consultant in Public Health **(Pages 105 - 150)**

13. Information item - Endorsement of Bristol's Strategy for Children, Young People and Families 2016-20

(Pages 151 - 160)

Bristol City Council
Minutes of the Health and Wellbeing Board

10 August 2016 at 2.30 pm

Members of the Board present:-
Dr Martin Jones, Alison Comley, John Readman, Jill Shepherd, Becky Pollard, Linda Prosser, Clare Campion-Smith, Lesley Alexander, Steve Davies, Justine Mansfield, Keith Sinclair and Pippa Stables

1. Welcome, safety information, introductions and apologies

Attendees were welcomed to the meeting, and introduced themselves.

Apologies were received from Mayor Marvin Rees and Elaine Flint.

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

With the agreement of the Chair, the Board received the following public forum items:
1. Mike Campbell – Statement on Sustainability & Transformation Plan.
2. Dr Charlotte Paterson – Health & Wellbeing strategic refresh work programme including sexual health services.
3. Andy Burkitt – question on relationship between Senior Officers, DPH & Mayor and on STP and health inequalities.

Officers responded as appropriate to the issues raised.

3. Declarations of interest

It was noted that no Board members had any declarations of interest with regard to the matters to be discussed at this meeting.

4. Minutes of previous meeting

RESOLVED –

That the minutes of the meeting of the Board held on 22 June 2016 be confirmed as a correct record and signed by the Chair.

5. Key decision - Adult social care community support services re-commissioning

The Board considered a report seeking approval of a key decision on the re-commissioning of adult social care community support services.

It was noted that the Mayor had given delegated authority to Councillor Clare Campion-Smith, Cabinet member for People, to take this decision.

Mike Hennessey, Service Director, presented the report with reference to an accompanying presentation.

Key points highlighted included:

a. The report and presentation provided context about the service that is provided to 1300-1400 service users within community settings or at home for adults (18 years+) with eligible social care needs.
b. The CSS budget is £14.4m with an annual spend of £19m. A targeted reduction from £19m down to £17m.
c. Service users have complex needs, but effort was made to engage them in consultation.
d. Acknowledged that there were concerns that the Council would use the lowest cost provider to meet service users need.
e. The 'Service User Choice' diagram was explained that demonstrated how the service user would be supported. Exceptions will apply and the Council will reserve the right to apply a tolerance in exceptional cases.
f. The new model allows for Bristol based providers to apply.

Main points raised/noted in discussion:

a. The service acknowledged the feedback on the terminology and wording used in the published report:
    - Section 1.5 reference to carers taking a break and allowing others to sit with their loved one.
    - It was suggested that the following wording would be more appropriate: "by providing appropriate alternative care for the cared for person for a short period of time".
b. Reference made to section 3.4.5 and the impact on service users during the change and it was felt that the paperwork failed to capture the genuine spirit of cooperation that arose during the consultation period.
c. Section 3.5 includes the Council's duty under the Care Act to support the needs of those caring, providing them with an assessment of their own needs.

Having noted the above, and the Board's general support for the proposals, Councillor Campion-Smith then took the following key decision:

That approval be given to:

1. To approve the Community Support Services Re-commissioning model as outlined in this report.

2. Delegate authority to the Strategic Director – People and the Service Directors – Strategic Commissioning and Care & Support (Adults) to implement the commissioning model set out in the report and approve all associated tender documents.

3. Delegate authority to the Strategic Director – People and Service Directors – Strategic Commissioning and Care & Support (Adults) to award contracts to providers of CSS that successfully meet tender requirements.

6. Key decision - Commissioning of out of hours home care services

The Board considered a report seeking approval of a key decision to change the way that out of hours home care services are commissioned.

Leon Goddard presented the report with reference to an accompanying presentation.

Key points highlighted included:

a. The service is concerned with the care given to service users in their home from 10pm to 7am.
b. Service is provided to service users recently discharged from hospital and those needing care during the final days of their life.
c. The quality of the service currently provided is good but the re-commissioning is concerned with providing stability of service to service providers; in turn, to provide assurance to staff and support provision.
d. The same service standard will be required from providers whether providing service in the south and/or the north of the city.
e. Care workers would be assured of fixed hours to allow the delivery of the service.

Main points raised/noted in discussion:

a. Emergency out of hours service did not form a part of the out of hours service and therefore was not a part of the re-commissioning.
b. It was suggested that the name 'out of hours' could be changed to something more reflective of the service such as 'planned night-time home care'.
c. Accepted that the consultation and community engaged had been good although there had been some difficult conversations. It was undertaken with the spirit of listening and developing.

Having noted the above, and the Board's general support for the proposals, Councillor Campion-Smith acknowledged all those involved, then took the following key decision:

That approval be given to:

1. **Approve the re-commissioning of out of hours home care provision, on the basis of the model and approach set out in this report.**
2. **Approve the inclusion of the planned long term out of hours care currently delivered by BCC staff, within the scope of the new contracts and commissioning model.**
3. **Delegate authority to the Strategic Director – People to agree the detailed commissioning model.**
4. **Delegate authority to the Strategic Director – People and Section 151 Officer to award contracts to the home care providers who are successful in this tender process.**

7. Director of Public Health annual report

The Board considered the annual report of the Director of Public Health.

Becky Pollard presented the report with reference to an accompanying presentation.

Key points highlighted included:

a. The report titled 'Living Well for Longer –The Case for Prevention' to focus effort and resources in this area, setting this out over four sections and providing 5 recommendations.

b. Explanation was provided on the 4:4:48 model that identified 4 non-healthy habits that contribute to 4 main diseases for 48% of the population.

c. Collaborative working supports the delivery of prevention.

d. The DPH requested the Board to note the 5 recommendations on the presentation that differ from the report.

Main points raised/noted in discussion:

a. The Board welcomed the report and the opportunity to work together. The inclusive of school age population was welcomed as they were seen as a captive audience.
b. Clarity was provided that the 4:4:48 model was devised in the United States but included international research material to form conclusions.

Having noted and taken account of the above, the Board

RESOLVED –

1. **The Director of Public Health should work through Bristol Health and Wellbeing Board and other stakeholders to implement the 4:4:48 prevention model to address modifiable unhealthy lifestyle behaviours (including smoking and tobacco, alcohol misuse, poor diet and lack of physical activity) and put 'Health in All Policies'.**
2. **The Health and Wellbeing Board should oversee an audit of the current prevention and early intervention programme against the evidence based interventions set out in this report and identify any gaps.**
3. **The Bristol Children and Families Partnership Board should seek to strengthen a cost effective public health programme aimed at children and their families to give them a better and healthier start in life (specifically targeting those who experience the greatest disadvantage).**
4. **The Bristol City Council Public Health Team should coordinate the roll out of a 'Making Every Contact Count' training programme for multidisciplinary front line staff to improve health and wellbeing.**
5. **The Director of Public Health will work with the emerging Mayor's City Office, other city partnerships, the Bristol, North Somerset and South Gloucestershire Sustainability Transformation Plan and the West of England devolution deal to find ways to strengthen and consolidate public health effort to reduce health inequalities, preventable death and disease.**

8. Oral Health Promotion Strategy

The Board considered a report on – An Oral Health Promotion Strategy for Bristol.

Kate Conlon, Registrar Public Health, presented the report with reference to an accompanying presentation.

Key points highlighted included:

a. Outlined the strategic priorities:
    - Promote oral health through healthier food and drink choices.
    - Promote oral health by improving levels of oral hygiene.
    - Improve population exposure to fluoride.
    - Improve early detection, and treatment, of oral diseases.
    - Reduce inequalities in oral health.
b. Success will depend on wide health and social care engagement by
    - Embedding of oral health promotion within health and social care.
    - Integrated lifestyle interventions.
    - Making every contact count.
    - Ownership of oral health promotion within work plans across public and voluntary sector organisations.

Main points raised/noted in discussion:

a. Discussion on lining up resources to support the drive to improve children's brushing technique.
b. Of the 47 interventions listed to be delivered, 30 have been included in the work programme. 10-15 of the interventions require extra effort with services moving to change service delivery. The remaining intervention would require the drawing up of business cases to ensure delivery.
c. The dental community including hygienists were supportive and would engage in promotion of oral hygiene.

Having noted and taken account of the above, the Board

RESOLVED –

To agree the overall approach of the oral health promotion strategy and the development of a Bristol specific delivery plan.

9. People scrutiny report on mental health

The Board considered a report setting out recommendations from the People Scrutiny working group on mental health.

Councillor Lesley Alexander presented the report.

Key points highlighted included:

a. The People Scrutiny Commission identified issues around mental health as a high priority and following a series of working groups produced a report that was agreed by the Mayor and Cabinet on the 4th July 2016.

b. The report supported the development of a Mental Health Strategy for the city.

Main points raised / noted in discussion:

a. The proposed Mental Health Summit would not now take place in October 2016 due to a clash of events. An alternative date is being sought.

b. A report 2 years ago devised its own mental health recommendation that partners included in work programmes. Consideration should be given to the outcome of that work and what the current report recommends.

c. On the 10th October 2016 a Youth Council led 'Freedom of mind' event is to take place.

Having noted and taken account of the above, the Board

RESOLVED –

To support the development of a Mental Health Strategy for the city, as one of the three top priorities for the Health and Wellbeing Board.

10. Developing the Joint Health and Wellbeing Strategy re-fresh

The Board considered an update report on the refresh of the Joint Health and Wellbeing Strategy.

Kathy Eastwood presented the report.

Key points highlighted included:

a. Three key priorities have been identified:
   - Mental wellbeing and social isolation.
   - Alcohol misuse.
   - Healthy weight.

Main points raised / noted in discussion:

a. The proposed Mental Health Summit intends to scope out how added value looks.

b. The actions identified must be assigned to appropriate partners.

c. There is a need to understand the connectivity between partners and what each partner brings to the strategy.

d. The Board asked partners to consider ways in which the decision making can be influence within budget restrictions.

Having noted and taken account of the above, the Board

RESOLVED –

To note the report and the agreed direction of travel.

11. Any other business

None

12. Draft Work programme 2016/17

Noted.

Meeting ended at 4.12 pm

CHAIR ___________________

Health & Wellbeing Board

19th October 2016

Report Title: Re-commissioning of Substance Misuse Treatment Services (ROADS)

Ward: City Wide

Strategic Director: Alison Comley

Report Author: Peter Anderson, Safer Bristol Manager

Contact telephone no. & email address 0117 9222309 peter.anderson@bristol.gov.uk

Purpose of the report:

Substance misuse services in Bristol provide a wide range of treatment and support for people who use drugs and alcohol. A commissioning and procurement process is required to replace the current contracts by October 2017 to continue to deliver this support.

This report will provide the Mayor with the relevant information to make a decision to commence planning the tender process.

Recommendation for the Mayor's approval:

1. To agree on behalf of Bristol City Council to the recommissioning of substance misuse services.

2. To agree on behalf of Bristol City Council to the multi-agency Substance Misuse Joint Commissioning Group managing the commissioning process and developing the Commissioning Plan, reporting back through the Health and Wellbeing Board and the Safer Bristol Partnership.

3. To note that a further report will be brought to the Board for the Mayor to consider recommendations with regard to funding and the tender process.

The proposal:

1. Substance misuse services in Bristol currently provide a wide range of treatment and support under the Recovery Orientated Alcohol and Drugs Service (ROADS) banner. This treatment system has been commissioned by the Substance Misuse Team (SMT) in line with the current National Drug Strategy (2010) and other key guidance from Public Health England (e.g. Medications In Recovery, NICE Guidelines etc.). These contracts were commissioned in November 2013 until March 2016 with the option of a further 2 years. An 18 month extension has been agreed with the current providers and these are now due to expire in September 2017.

2. Given the financial challenges (e.g. reducing national Public Health Grant) combined with shifting profiles (e.g. an increasing number of alcohol users accessing treatment, ageing drug users with complex physical health needs) a new commissioning strategy and contracts are required to future plan service delivery.

3. Key drivers for this project include the National Modern Crime Prevention Strategy 2016 which reflects the Government's focus on the role of treatment in reducing acquisitive crime. It has been indicated that a new National Drug Strategy is to be published over the coming months that will inform the development of the Commissioning Strategy for this project. At a local level, Bristol City Council is developing a new Alcohol Strategy which addresses the need to develop treatment services for those that are alcohol dependent.

4. The scope of this re-commissioning process will provide services to Bristol citizens aged 18 years plus (treatment services for under 18s are commissioned through Public Health & Safer Bristol). The contracts will be commissioned to work with drug and/or alcohol users. A range of delivery options including community, inpatient and residential settings will need to be considered to meet these needs in the Commissioning Strategy. This commissioning cycle will also include substance misuse related contracts that were previously commissioned by Public Health (e.g. Primary Care and Pharmacy services).

5. Given that substance misuse impacts on a number of different areas of an individual's life, it is recognised the need for joint working and co-commissioning of new contracts where possible to address multiple needs of clients with this project. These areas include, but are not limited to, mental health, criminal justice, preventing homelessness, safeguarding and employment, training & education.

6. The commissioning process will follow the agreed commissioning framework for Bristol City Council (Enabling Commissioning Framework) to commission and procure these new contracts and are now coming to the end of the 'Analyse' stage. During this stage a comprehensive Needs Assessment (**https://www.bristol.gov.uk/documents/20182/33003/Final+Report+Substance+Misuse+Needs+Assessment.pdf/59068c70-6504-4831-b8ab-68b6916c6dbd)** was completed to ascertain levels of need around substance misuse in Bristol. The information and recommendations from this document are being used to shape the Commissioning Strategy that is currently being developed.

7. Whilst there is a need to re-define primary care providers' involvement in meeting the needs of drug and alcohol users, the recommendation is that primary care providers are not part of the formal procurement process. Once the treatment system has been developed and there is a clear view of funding for primary care, primary care providers will be approached to define what exactly their role will be and will develop contracts accordingly. This is similar to the process that has taken place for the recent sexual health commissioning and has been approved by the Council's Procurement Team.

8. The Substance Misuse Joint Commissioning Group is currently working with VOSCUR and BCC Procurement to explore commissioning options relating to the use of competitive dialogue, grants and contracts. The length of agreements and contracts are being discussed also including a five year term including the appropriate break clauses.

9. If possible, the newly commissioned contracts will ensure that Social Value is considered. Providers bidding for these contracts will need to demonstrate how they have considered economic, social and environmental benefits in addition to the core outcomes of the contract.

10. These contracts will be funded through a pooled budget that consists of the Public Health England grant, Adult Health & Social Care funding and BCC revenue funding.

Consultation and scrutiny input:

a. Internal consultation:

The Substance Misuse Team has complied with the Bristol City Council decision making pathway process. The initial plans for the project have been presented to Bristol City Council's SLT, People and Neighbourhoods DLTs & Public Health's DMT. In addition, the Safer Bristol Executive has been provided with a commissioning update. Positive feedback has been received further to these sessions and is being inputted in to the Commissioning Strategy.

Overall these Boards supported the initials proposals and supported the need to strategically align with some of the wider agendas in Bristol City Council through joint working and co-commissioning.

Scrutiny input will be sought following this report to the Health & Wellbeing Board.

b. External consultation:

A series of stakeholder engagement events took place during September and October 2016 in the North, East and South Bristol. These events were designed to engage professionals (e.g. both current and potential providers/referrers), service users and members of the public on the recommendations from the Substance Misuse Needs Assessment and feed in to the development of the new treatment system model in the Commissioning Strategy.

Following the publication of the Commissioning Strategy in December, a formal 12-week consultation, required by commissioning and procurement regulations when tendering for services, will take place to further refine the contracts outlined in the Commissioning Strategy that will go out to tender in 2017.

Initial plans for the project have also been presented to the Clinical Commissioning Group whilst input has been sought from VOSCUR and relevant Unions to support the process.

Other options considered:

No alternative option

EU Procurement regulations stipulate that certain contracts are regularly put out to tender. Given that the current contracts will expire shortly there is now a need for these to be put out to the market again.

Furthermore uncertainties regarding current and future funding levels would have meant that we may have not be able to vary the current contracts due to this changes being potentially above the 10% threshold of the overall contract value. Again procurement regulations stipulate that any changes above this value need to be put out for tender.

Risk management / assessment:

FIGURE 1

The risks associated with the implementation of the *(subject) decision* :

No.	RISK Threat to achievement of the key objectives of the report	INHERENT RISK (Before controls)		RISK CONTROL MEASURES Mitigation (i.e. controls) and Evaluation (i.e. effectiveness of mitigation).	CURRENT RISK (After controls)		RISK OWNER
		Impact	Probability		Impact	Probability	
1	Overall funding envelope for the substance misuse contracts are currently still be confirmed due to reductions in PHE Grant and BCC funding. The level of overall funding will determine the range and capacity of services that can be commissioned	**High**	**High**	Confirmation of funding to be sought as soon as possible to allow model design work for the Commissioning Strategy.	**Medium**	**Medium**	Kath Williams
2	Risk of delays to the commissioning process when key decisions are required in relation to the overall governance of the project	**High**	**Low**	Will need to consider delaying contract start date if overall governance for the project does not sit with the Substance Misuse Joint Commissioning Group due to the less frequency nature of alternative boards.	**High**	**Low**	Pete Anderson
3	Success of the	**Medium**	**High**	Contact local	**Low**	**High**	Kath Williams

	recommissioning strategy will be linked to access to services for clients that are not within the commissioning remit of the Substance Misuse Team e.g. welfare reforms, jobs and training, mental health services. If service users are unable to have their needs met in these areas they may not access/benefit from substance misuse treatment			commissioners to explore co-commissioning opportunities to ensure that strategic objectives are aligned.			
4	Risk that local VCS providers will be excluded from the bidding process due to the financial implications imposed by BCC procurement. Particularly where the incumbent providers are concerned due to their funding streams being reliant on BCC already.	**High**	**Medium**	Ensure clarification from BCC Finance on the financial regulations and share with stakeholders. Consider these implications in the overall design of the treatment system model in the Commissioning Strategy to consult on. Engage with VOSCUR throughout the process.	**High**	**Medium**	Kath Williams

The risks associated with not implementing the *(subject) decision*:

A decision is required by the Health & Wellbeing Board to proceed with the re-commissioning due to procurement regulations. Please see "Other sections considered" on page 4 of this report.

Public sector equality duties:

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

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

ii) advance equality of opportunity between persons who share a relevant protected characteristic and those do not share it. This involves having due regard, in particular, to the need to:
- remove or minimise disadvantage suffered by persons who share a relevant protected characteristic.
- take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of people who do not share it (in relation to disabled people, this includes, in particular, steps to take account of disabled persons' disabilities);
- encourage persons who share a protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

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

Following an initial EqIA Screening Tool in the 'Analyse' phase of the commissioning cycle it was recognised that a full EqlA would be required to be completed as part of this project. This is currently being developed alongside the Substance Misuse Commissioning Strategy and will be published in December 2016 for consultation with stakeholders.

This EqIA will need to address how both equality of access and equality of outcomes will be considered for all protected characteristic groups in the Commissioning Strategy and delivered in the new contracts.

Eco impact assessment

Non applicable to this project.

Resource and legal implications:

Finance

The current services included in the scope cost £11,140,806 per annum. The Joint Commissioning Group is working closely with the relevant DLTs to understand and agree the funding level available for substance misuse treatment service.

a. Financial (revenue) implications:

See above

Advice given by	Pauline Batchelor Management Accountant, People Robin Poole, Finance Business Partner, Neighbourhoods
Date	05/10/16

b. Financial (capital) implications:

Non applicable to this project.

Comments from the Corporate Capital Programme Board:

Non applicable to this project.

c. Legal implications:

Whenever the Council procures services where the value is over certain thresholds, the services must be procured in compliance with the Public Contracts Regulations 2015. The value of these services will be over the threshold, so when the tender process for these services is carried out, it must comply with these regulations.

Advice given by	Sinead Willis, Contracts and Procurement Solicitor
Date	11/10/16

d. Land / property implications

Non applicable to this project.

e. Human resources implications:

Non applicable to this project. Services are delivered by third parties.

Appendices:

Appendix 1 – Abridged Commissioning Timeline:

This is the current commissioning provisional timeline:

- Publish draft needs assessment and opportunities for stakeholder engagement: July 2016 to September 2016
- Publish draft Commissioning Strategy: December 2016
- Formal consultation of Commissioning Strategy: December 2016 to February 2017
- Provider tender events: April 2017
- Invitation to tender: May 2017
- Award contract: August 2017
- Contract start date: October 2017

NHS
Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Joint Health and Wellbeing Strategy Re-fresh 2016	
Author, including organisation	Becky Pollard, Director of Public Health, Bristol City Council
Date of meeting	19th October 2016
Report for Discussion and Decision	

1. Purpose of this Paper

To formalise the endorsement of the re-freshed Health and Wellbeing Strategy priorities and agree methods for holding to account on their delivery.

2. Executive Summary

In re-freshing the Strategy, the Health and Wellbeing Board decided that it needed to focus its efforts on the issues that it had the most direct influence over. The HWB will work with other partnerships, such as the Children and Families Partnership Board and Safer Bristol Partnership and other organisations to deliver on the issues on which they have the greatest influence. Through this co-ordinated approach we believe that we will make progress, albeit in a challenging financial environment.

3. Delivering the strategy

3.1 **Alcohol Misuse**.

There is a well developed Action Plan in progress for the delivery of this priority. The working group is chaired by the Chair of the CCG.

3.2 **Mental Wellbeing and Social Isolation**

An “Open Space” Summit event is planned for Thursday 24th November, a.m. to scope the breadth of this priority.

3.3 **Healthy Weight**

It is proposed to hold an event in January 2017 to scope the work programme for this priority.

4.0 Holding to account

It is proposed that the lead for each priority co-ordinates a twice yearly performance report for the Health and Wellbeing Board. This will report against actions in the Action Plan. A few metrics will also need to be chosen for measuring success over the next 3 years.

5. Key risks and Opportunities

There is a risk that momentum for the delivery of these priorities will diminish over time. The Health and Wellbeing Board will need to “hold to account” to ensure that momentum is not lost. There is significant opportunities to add value, due to the inter-related nature of the priorities.

6. Implications (Financial and Legal if appropriate)

Not for the purposes of this report.

8. Recommendations

8.1 It is recommended that

- The priorities are endorsed.
- A lead organisation is identified to lead on the development of action plans to deliver against these priorities.
- Mechanisms for holding to account are agreed. (See paragraph 4 above).

9. Appendices

Appendix A: Refreshed Health and Wellbeing Strategy

Bristol Joint Health and Wellbeing Strategy – Re-fresh 2016

This paper was up-dated on 7th October 2016

This paper sets out the rationale, process and outcomes to date for the re-freshing of the Bristol Health and Wellbeing Strategy.

2016: Our Approach: What has changed?

Our strategy in 2013 was ambitious, and it should remain so. It recognised that our health and wellbeing is influenced much more by where we live, what we eat and drink and whether or not we have a job, than by the services we receive. The strategy can be found here:

https://www.bristol.gov.uk/documents/20182/34772/HW%20Strategy%20Document_2013_web.pdf/9dcfd365-4f01-46be-aaf3-0874d75c7c33

We took the approach that almost everything the partners on the Health and Wellbeing Board do, affects our health and wellbeing. This very much reflected a "Bristol" way of doing things. We have so much to be proud of – a cycling city, a Green Capital and so much more. We need to continue to reflect this. The priorities we agreed were:

Built Environment
Food
Tackling Domestic Violence
Smoking
Alcohol Misuse
Children – best start in life
Mental Wellbeing and Social Isolation
Dementia
Maternity Services
Integrated Care

But, this number of priorities has been hard to track and the health and care landscape has changed. The Health and Wellbeing Board is a

system leader for Health and Wellbeing in the city, but we cannot do it all and we do not need to do it all – there are other partnerships, with whom we need to work closely with, that may be better placed to deliver on some of the things that we would all like to achieve in the city.

There are also new national policy changes, for example the Sustainable Transformation Plans, the NHS 5 Year Forward View, the Better Care Programme. Plus, the public sector has been experiencing unprecedented reductions in resources. There has also been a new push on health and work, looking at the relationship between health, employment and unemployment. We are also working in the context of potential devolution of powers to the sub region.

Bristol also has a new directly elected Mayor.

What does the Joint Strategic Needs Assessment 2015 tell us?

The big intractable problems are however still the same. National challenges such as premature deaths from cancer, heart disease and stroke. Plus the challenge of Dementia and Long term conditions and the health impacts of smoking, alcohol, and unhealthy weight. Mental Health is also a national and local issue. Our 2013 Strategy did not reflect the obesity challenge within the city.

Specific issues for Bristol are a growing and changing population, both children and older people. Around 16% of the population are from BME backgrounds but amongst children it is 28%. The city is increasingly diverse, with significant differences in ethnicity between areas.

Stark health inequalities persist and do not appear to be improving. There remain large differences in life expectancy for both men and women. The number of years lived in poor health also varies hugely and in some areas people are living over 30 years of their lives in poor health; overall around 72,000 people report themselves as having a limiting long term illness or disability.

An increased focus on tackling health inequalities needs to be a key part of this strategy.

What now?

Prevention, Early Intervention and Self Care have got to become more than just slogans, if we are to meet the challenges of reducing public expenditure.

Hence, the Health and Wellbeing Board decided that it needed to focus its efforts on the issues that it had the most direct influence over. The HWB will work with other partnerships, such as the Children and Families Board and Safer Bristol Partnership and other organisations to deliver on the issues on which they have the greatest influence. Through this co-ordinated approach we believe that we will make progress, albeit in a challenging financial environment.

Key Themes

It is proposed that there are important themes that should be taken into account when delivering on all of the priorities. This means that demonstrable actions to address these need to be developed in delivering on the priorities.

These themes are:

Tackling health inequalities	Prevention and Early Intervention and self care	Tackling the wider Determinants of health	Promoting Integration	Innovation

For example, when tackling the issue such as "Healthy Weight" the Action Plan will consider what can be done to prevent problems of unhealthy weight developing. This could be through health visitor or Children's Centres. It will also consider how to better target communities and population groups that have the biggest challenges in order to reduce inequalities. It is acknowledged that the evidence base for effectively tackling childhood obesity is limited. Therefore, innovative approaches will need to be adopted. The wider determinants could be issues such as lack of access to fresh food or open spaces.

Better Care Bristol

The focus of this strategy is not just about the delivery of services, but these do play an important part.

In fulfilling the Health and Wellbeing Board's responsibility to promote integration, the HWB is the body responsible for oversight of the Better Care Bristol programme. This programme, based on a national programme, but further expanded in Bristol, is aimed at achieving a better integration of services between health and adult care. Whilst this work is about the improvement and transformation of services, it is also heavily focussed on prevention and early intervention.

The vision for Better Care can be summarised by three themes:

- Integrated Locality Based Services – developing a coherent, locality model that brings together local, integrated resources and services
- Public health and Self-Care – supporting a massive shift towards prevention and self-care, including how people see themselves in relation to their own health.
- Integrated Pathway re-design – developing pathways that support people in managing conditions from the earliest indications through to becoming severe and complex. To do this we need to deploy the right resources that can help across this journey, at whatever point they are most relevant.

A possible mechanism in supporting people to stay independent for longer is through the use of personal health budgets and integrated health and social care budgets. Bristol CCG is working alongside Bristol City Council and the local voluntary and community sector to introduce these for a small number of people. More information can be found on the CCG's personal health budgets webpage.

Refreshing the Strategy: How did we prioritise?

In developing the Health and Wellbeing Strategy in 2013 our goal was to name priorities based on strong evidence, stakeholder and public feedback, and identify specific areas where the Health and Wellbeing Board could have the biggest impact.
These are areas where we can make progress on addressing health inequalities in our city between local areas, communities and groups of our population.

This goal still stands, but the Health and Wellbeing Board has now agreed a set of criteria that aimed to really examine whether there are ***gains to be made across the whole system***. These criteria were applied to the existing priorities. The Health and Wellbeing Board also considered the up-dated Joint Strategic Needs Assessment from December 2015 and agreed that the issue of Healthy Weight was not adequately reflected in the current strategy, so this was also included.

We asked the following**:**

1. Is there a problem we are trying to solve? (Why are we doing this?)

2. Is there evidence of need and potential impact? (Burden on the health of the local population/health inequalities).

3. What can and will be done differently if this priority is in the Joint Health and Wellbeing Strategy?

4. Is this an issue that partnership working can impact upon?

5. Is the Health and Wellbeing Board the right body/partnership to lead on this? (or is another body already leading on this?)

6. Does this fit well with partners organisational must-do's (or HWB must-do's)?

7. Is it a priority for all partners on the Health and Wellbeing Board?

8. Is it feasible to make some demonstrable progress on this in a 2 – 3 year period?

The emerging priorities

Following this process, the priorities that emerged were:

- Tackling alcohol misuse
- Mental wellbeing and social isolation
- Healthy Weight

These priorities are often inter-related and always complex. For example, poor mental wellbeing can have a big influence on alcohol consumption and the other way round. While alcohol can have a very temporary positive impact on our mood, in the long term it can cause big problems for our mental health. It's linked to a range of issues from depression and memory loss to suicide

Likewise, there are bi-directional associations between mental health problems and obesity, with levels of obesity, gender, age and socioeconomic status being key risk factors. The mental health of women is more closely affected by overweight and obesity than that of men. (PH England 2011 Obesity and Mental Health).

By focussing on these three priorities and the links between them, there is the opportunity to add up to "more than the sum of the parts".

This is a strategy for all ages: a life-course approach will be developed to deliver outcomes on these priorities.

Next steps. The Health and Wellbeing Board is asked to

- endorse the three priorities
- discuss which organisations should lead on the development of action plans to deliver against these priorities
- consider what mechanisms for "holding to account" are required

Alcohol Misuse. There is a well-developed Action Plan in progress for delivering progress on this priority. This is the delivery mechanism for this priority.

Mental Wellbeing and Social Isolation. This is potentially a very broad issue to tackle. An "Open Space" Summit event is being arranged for Thursday 24th November a.m., in the Conference Hall, City Hall.

Healthy Weight. Again, this is a multi-faceted issue, which would benefit from a scoping event to define this work. It is proposed to hold an event in January 2017 to progress this.

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Bristol City-wide Alcohol Strategy – up-date from working group	
Author, including organisation	Leonie Roberts, Consultant in Public Health, Bristol City Council
Date of meeting	19th October 2016
Report for Information and assurance	

1. Purpose of this Paper

To update the Health and Wellbeing Board of the strategic planning and actions taken by the Bristol Alcohol Misuse Short-life Working Group to tackle the negative impact of alcohol misuse on individuals, families and communities in Bristol.

2. Context

2.1 Alcohol is a complex issue. In recent years the sale of alcohol has shifted from the on-trade to the off-trade, as supermarkets take over dominance of sales and more people choose to drink at home. Alcohol has become more affordable over time and the amount of alcohol being sold has been increasing.

2.2 Excessive intake of alcohol has clear effects on crime and health; on communities, children and young people. Levels of alcohol-related harm to the health and wellbeing of individuals, families and communities have risen, and health problems caused by heavy drinking are now being identified in young people.

2.3 About 84% of Bristol population aged 16 years and over engage in drinking. Of those, 20.3% drink at increasing levels that risk harm in the long term, and 7.5% drink at higher risk levels that harm themselves and others. Furthermore, 26.3% reported to binge drink, hence are vulnerable to the acute effects of intoxication such as assault, falls and poisoning. The percentage of binge drinkers in Bristol is higher than the regional and national average.

2.4 Excessive drinking is a major cause of wide range of diseases and injuries. Alcohol and drug use was identified to be the fifth

leading risk factor of the burden of disease in England. Alcohol consumption was the third leading behavioural risk factor overall, and the leading behavioural cause of injury. About a third of deaths from cirrhosis could categorically be assigned to alcohol as the underlying cause.

2.5 In Bristol there were 5,408 persons admitted to hospital due to alcohol-related conditions in 2013/14 where alcohol-related condition was the primary diagnosis or any of the secondary diagnoses with an alcohol-attributable code. Bristol alcohol-related admissions has been consistently higher than the England average, with 1,513 persons per 100,000 population admitted (broad measure) in 2013/14 compared to the England rate of 1,253 admissions per 100,000. The most common reasons for alcohol-related admission episodes in Bristol were cardiovascular disease and mental & behavioural disorders due to use of alcohol.

2.6 There were 187 alcohol-related deaths in Bristol in 2014, which corresponds with the rate of 53.2 per 100,000 population (significantly higher than the England rate of 45.5 per 100,000). It is a bigger problem in males where the rate of alcohol-specific mortality was 28.5 deaths per 100,000 men in 2012-14, compared to females with 7.9 deaths per 100,000 women.

2.7 Alcohol misuse also places a significant cost burden on society. The estimated cost of alcohol harm to society is £21 billion per year which takes into account the impact alcohol has on health and other public services, the cost of alcohol- related crime and disorder, the impact of alcohol misuse on worklessness and lost productivity, and the estimated social costs as a result of alcohol misuse. The cost of alcohol-related crime itself was estimated at £11billion.

2.8 On the one hand alcohol causes significant harm and contributes to health inequalities; on the other it brings benefits to the community and enhances the economy. Balancing the two facets of alcohol (use and misuse) requires us to work in partnership across the sectors to ensure that the benefits are felt and the harms are minimised.

2.9 The Bristol City-wide Alcohol Strategy and Action Plan attempts to address the key points by bringing all partners together and setting out a vision for Bristol. It aims to facilitate the establishment of a safe, sensible and harm-free drinking culture in Bristol, and set a direction of travel to achieve this.

3. Up-date from the Alcohol Misuse Short-life Working Group

3.1 The strategy has been developed and the focus is very much on practical actions that can be taken in partnership. The vision for Bristol is to create safe, sensible and harm-free drinking culture.

3.2 The overarching aim of the strategy is to prevent and reduce the harm caused by alcohol to individuals, families and communities in order to ensure Bristol is a healthy and safe to live work and visit. This can be achieved through partnership working and using the best available evidence of what works.

3.3 Three workstreams have been identified, with senior leads from the CCG, Public Health and Avon and Somerset Constabulary.

3.4 There are three broad aims of the Strategy:

1	**Increase individual and collective knowledge about alcohol, and change attitudes towards alcohol consumption.** (PREVENTION/CAMPAIGNS)	*Alcohol Prevention Workstream*
2	**Provide early help, interventions and support for people affected by harmful drinking.** (ACCESS TO SERVICES AND PATHWAY FOR LIVER DISEASE)	*Alcohol Intervention Workstream*
3	**Create and maintain a safe environment.** (REDUCTION OF AVAILABILITY AND ACCESSIBILITY, SAFE NIGHT TIME ECONOMY)	*Alcohol Environment Workstream*

3.5 Each workstream suggested desired outcomes and proposed an action plan to be pursued. Further detail of the workstreams, the deliverables and actions can be found in Appendix A.

3.6 The draft Strategy was presented and consulted at the Alcohol Misuse Strategy Workshop on July 21st 2016 and the consultation feedback included in the final report.

4. Key risks and Opportunities

There is significant opportunity to make progress on this issue through targeted partnership working. There is also a risk of losing momentum due to the scale of this national challenge. The Health and Wellbeing Board will want to be assured that activity and outcomes on this priority are delivered. The Health and Wellbeing Board will oversee further activities through the Alcohol Misuse Short-life Working Group and the three Strategy workstreams.

6. Implications (Financial and Legal if appropriate)

None arising directly from this report.

7. Recommendations

The Health and Wellbeing Board is asked to note the progress on this priority and seek further assurance at future meetings if required.

8. Appendices

Appendix A: Bristol City-wide Alcohol Strategy 2016-2020

APPENDIX A

Bristol Clinical Commissioning Group

BRISTOL

CITY-WIDE

ALCOHOL STRATEGY

2016 – 2020

October 2016

Draft v4.0 (final)

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FOREWORD

Becky Pollard, Director of Public Health, Bristol City Council

The consumption of alcohol is an established part of life in the UK. There are many people who choose not to drink but, for the majority of adults, alcohol is accepted in the routines of daily life.

Yet, alcohol can bring a whole world of harm. For the individual, regular drinking increases the risk of developing illnesses such as cancer, liver cirrhosis and heart disease, and excessive alcohol consumption can lead to dependence. For families, alcohol consumption can lead to relationship breakdown, domestic violence and become a significant factor in poor parenting. For communities alcohol can fuel crime and disorder and can transform parts of the City into no-go areas. For the society, the cost of alcohol consumption includes huge financial burden on public services as health, social care and criminal justice agencies all have to invest a significant amount of resources providing response to the effects of drinking. Alcohol-related work absence due to alcohol consumption and the loss of productivity impact on the local economy and can reduce the ability of our City to thrive and achieve its potential.

The Bristol Alcohol Strategy aims to make our City safer, healthier and happier place to live, to work, and to visit by working with individuals and communities to reduce alcohol consumption and alcohol-related harm. While we have already made a considerable progress in developing effective ways we deal with alcohol misuse in the City, we recognise the great potential for us to work with partner organisations to promote a positive behavioural change leading to improved health and wellbeing for everyone.

Dr Martin Jones, Chair Clinical Commissioning Group, NHS Bristol Clinical Commissioning Group

Alcohol misuse presents a major problem in Bristol that requires a system-wide response. Nationally liver disease is the only major cause of death still increasing year-on year and this statistic is also reflected in our local population with deaths caused by or associated with alcohol higher than the England average. This strategy has been the culmination of a wide range of stakeholders working collaboratively to identify key issues and proposed solutions to ensure that Bristol is a healthy and safe place to live work and visit.

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Rhys Hughes, Superintendent, Avon and Somerset Police

Bristol is a large, diverse and vibrant City with a thriving night time economy. It is also host to a number of large public events and sporting occasions throughout the year, where thousands of people come together to enjoy what Bristol has to offer.

Maintaining a safe environment, particularly when alcohol is involved, is essential for people to be safe and feel safe. To help achieve this, everyone has their part to play.

Unfortunately, alcohol can cause people to act in a negative way, leading to physical and verbal assaults and ultimately, arrest or serious injury. This can have a dramatic impact on those involved and they may live to regret an alcohol fuelled moment for the rest of their lives. It is also important to recognise the impact such behaviour has on society as a whole as it can be felt by the wider community in terms of experiencing anti-social behaviour, detrimental quality of life as well as the health and cost implications.

This workstream brings together a number of partner agencies to identify ways to protect vulnerable people, reduce demand on public services and work with events organisers to make sure their visitors can have an enjoyable and safe time. It has to be a team effort and some of our work has already had tangible success in reducing the number of alcohol related incidents at large events.

I am confident that working with the other leads, to deliver the Bristol Alcohol Strategy, will reduce the harm alcohol can cause and bring real benefits to the city.

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1 EXECUTIVE SUMMARY

1.1 Introduction: Alcohol, public health problem

Alcohol is a complex issue. In recent years the sale of alcohol has shifted from the on-trade to the off-trade, as supermarkets take over dominance of sales and more people choose to drink at home. Alcohol has become more affordable over time and the amount of alcohol being sold has been increasing.

Excessive intake of alcohol has clear effects on crime and health; on communities, children and young people. Levels of alcohol-related harm to the health and wellbeing of individuals, families and communities have risen, and health problems caused by heavy drinking are now being identified in young people.

Alcohol consumption in Bristol

About 84% of Bristol population aged 16 years and over engage in drinking. Of those, 20.3% drink at increasing levels that risk harm in the long term, and 7.5% drink at higher risk levels that harm themselves and others. Furthermore, 26.3% reported to binge drink, hence are vulnerable to the acute effects of intoxication such as assault, falls and poisoning. The percentage of binge drinkers in Bristol is higher than the regional and national average. It should be noted that people are likely to underestimate the amount they drink in self-reported surveys.

The pattern of alcohol misuse over Bristol is varied and complex, sensitive to cultural and socio-economic characteristics that greatly differ across the City. In deprived areas people who misuse alcohol are also more likely to also smoke tobacco, hence at increased risk of developing complicating medical condition such as cancer. This increased risk results in a higher burden of mortality caused by alcohol in deprived areas, despite less people in the areas misusing alcohol.

Health harms

Excessive drinking is a major cause of wide range of diseases and injuries. Alcohol and drug use was identified to be the fifth leading risk factor of the burden of disease in England. Alcohol consumption was the third leading behavioural risk factor overall, and the leading behavioural cause of injury. About a third of deaths from cirrhosis could categorically be assigned to alcohol as the underlying cause.

In Bristol there were 5,408 persons admitted to hospital due to alcohol-related conditions in 2013/14 where alcohol-related condition was the primary diagnosis or any of the secondary diagnoses with an alcohol-attributable code. Bristol alcohol-related admissions has been consistently higher than the England average, with 1,513 persons per 100,000 population admitted (broad measure) in 2013/14 compared to the England rate of 1,253 admissions per

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100,000. The most common reasons for alcohol-related admission episodes in Bristol were cardiovascular disease and mental & behavioural disorders due to use of alcohol.

Similarly the alcohol-specific hospital admissions where the primary diagnosis or any of the secondary diagnoses were an alcohol-specific code, have been consistently higher than the England average over the past few years (e.g. the rate of 555 per 100,000 locally versus 374 per 100,000 nationally in 2013/14). Furthermore the number of alcohol-specific admissions was more than double in men than women (1,505 versus 650 in 2013/14).

There were 187 alcohol-related deaths in Bristol in 2014, which corresponds with the rate of 53.2 per 100,000 population (significantly higher than the England rate of 45.5 per 100,000). It is a bigger problem in males where the rate of alcohol-specific mortality was 28.5 deaths per 100,000 men in 2012-14, compared to females with 7.9 deaths per 100,000 women.

Bristol has a problem with the hospital admissions for alcoholic liver disease among men; the Bristol rate of 96 admissions per 100,000 male population was significantly higher to the national rate of 44 for 2013/14. Similarly the deaths from alcoholic liver disease among men under 75 years dominated in Bristol in 2012-14, corresponding with mortality rate in males of 20.9 per 100,000 which was significantly higher the England rate of 11.5 per 100,000.

It is known that alcohol-related harm is placing increasing demands on the NHS and potentially avoidable strain on ambulance trusts, Accident and Emergency (A&E) departments and hospital services. In England, A&E attendance rates due to alcohol poisoning doubled from 2008/09 to 2013/14. Three in four people who attended A&E due to alcohol poisoning arrived by ambulance and one in three were subsequently admitted to hospital overnight. The cost of alcohol misuse to the NHS is estimated to be £3.5 billion every year.

In Bristol there is unprecedented demand for alcohol treatment services since the launch of Recovery Orientated Alcohol & Drugs Services (ROADS). Unfortunately there are also high attrition rates of alcohol clients from assessment to engagement. Bristol had a significantly lower proportion of individuals leaving alcohol treatment successfully as a proportion of all treatment exits compared to the national figure (44% versus 61%).

Social & economic harms, crime & disorder

Alcohol misuse also places a significant cost burden on society. The estimated cost of alcohol harm to society is £21 billion per year which takes into account the impact alcohol has on health and other public services, the cost of alcohol- related crime and disorder, the impact of alcohol misuse on worklessness and lost productivity, and the estimated social costs as a result of alcohol misuse. The cost of alcohol-related crime itself was estimated at £11billion.

In Bristol there were 3,461 alcohol-related offences recorded in 2012/13. The rate of recorded crime per 1,000 population attributable to alcohol has been consistently higher than the regional and national average (e.g. in 2012/13 the Bristol rate of 8.08 per 1,000 compared to the national rate of 5.74 and regional rate of 4.90). Comparing the core cities, Bristol had the third highest rate of alcohol-related recorded crime in 2012/13. There is a

strong correlation between alcohol-related crimes and the night-time economy that brings many Bristol residents and visitors into the city.

Alcohol is one of the leading factors contributing to accidents, from domestic to traffic related. There is also a well-known link between alcohol misuse and offending.

Harms to children and families

Alcohol misuse can affect families in a range of ways. Parental alcohol misuse can impact on relationships and family functioning, and can impact on a child's environment in many social, psychological and economic ways. It can also be linked to a variety of mental health problems for family members and domestic violence and abuse.

Around 30% of children under 16 years of age (3.3-3.5 million) in the UK are living with at least one binge drinking parent. In 2000 it was estimated that 22% lived with a hazardous drinker and 6% with a dependent drinker. Substance misuse, mental health problems and domestic abuse are key factors in many child protection and safeguarding cases.

Alcohol multi-faceted problem

On the one hand alcohol causes significant harm and contributes to health inequalities; on the other it brings benefits to the community and enhances the economy. Well-run community pubs and other businesses form a key part of the fabric of neighbourhoods, providing employment and social venues in local communities. Balancing the two facets of alcohol (use and misuse) requires us to work in partnership across the sectors to ensure that the benefits are felt and the harms are minimised.

This strategy attempts to address the key points by bringing all partners together and setting out a vision for Bristol. It aims to facilitate the establishment of a safe, sensible and harm-free drinking culture in Bristol, and set a direction of travel to achieve this.

1.2 Where are we now? Current responses to alcohol-related harm in Bristol

Bristol has higher than the national average alcohol related crime as well as higher alcohol related morbidity and mortality.

Current responses to alcohol-related harm in Bristol comprise prevention work, provision of specialist treatment and care, and response to alcohol-related crime and disorder.

Prevention work

The preventative approach to tackling alcohol misuse through education and campaigns is targeted at all children and young people in the city and is incorporated into other work focusing more widely on substance misuse, with an awareness that alcohol is by far the

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most likely substance that young people will use. The majority of alcohol prevention with young people in Bristol is delivered in schools. The influence of parents over young people's substance use is also taken into account and campaigns and information are incorporated into other public health work.

Identification and Brief Advice (IBA) is a cornerstone of adult prevention work. This means that people are screened using set questions to find out their level of alcohol use. If they are found to be drinking above guidelines, they are given information and signposted to appropriate services. Furthermore social marketing campaigns have been carried out to raise awareness about alcohol and its risks.

Treatment and care

Alcohol treatment and care for children and young people is delivered through early intervention work with young people as part of the Bristol Youth Links programme. Young people who misuse alcohol and have more complex needs are referred into the young people's substance misuse treatment services.

The Recovery Orientated Alcohol and Drug Service (ROADS) is an integrated adult substance misuse service available across Bristol for access to structured interventions aimed at overcoming physical and psychological dependence on alcohol and drugs as well as offering support around housing, education and employment. Support for families and carers who are affected by the alcohol use of others are provided as part of ROADS to reduce the wider impact alcohol has on communities.

In Bristol hospitals there are alcohol nurses who provide support and extended interventions for dependent drinkers and work with self-harmers whose harming is linked to alcohol. Furthermore alcohol-related problems are a big and increasing part of the primary care workload. Some Bristol GPs offer community detoxification in partnership with the treatment services.

Response to alcohol-related crime and disorder

The Police have developed their operational approach to policing the night-time economy, combining public order policing with uniformed officers entering specific licensed premises to identify drunkenness or underage drinkers. The police response to alcohol-related violent crime offences and incidents of anti-social behaviour involves the deployment of a significant number of additional officers on these nights.

The Police also work with licensed premises to seize and return identity documents used by underage people to gain entry to licensed premises. The Police Public Protection Unit delivers a specialist approach to incidences of domestic violence, and there is a defined referral process for children at risk within chaotic households.

As part of their work, Probation Services in Bristol assess the people they supervise to find out whether the misuse of alcohol contributes to their offending behaviour. People can be

referred to a range of interventions around problematic alcohol use. Other structured interventions are available as part of community orders or post-release Licences.

The Bristol City Council Licensing Service has two key areas of responsibility for alcohol: administration of the Licensing Act and enforcement work. They conduct proactive inspections at alcohol licensed premises to ensure legislation compliance. The Trading Standards Service enforces legislation regarding the sale, supply and use of illicit alcohol products and underage sales. The Crime Reduction and Substance Misuse Team works with retailers to improve the management of the night-time economy and operates the CCTV presence in the city centre.

1.3 Where do we want to be? Vision for Bristol and our strategy

Our vision for Bristol is to create safe, sensible and harm-free drinking culture, through partnership working and using the best available evidence in order to ensure the following:

- Bristol is a healthy and safe place to live, work and visit.
- People of Bristol are drinking within the nationally recognised guidelines.
- Individuals and families are able to access the right treatment and support at the right time.

The overarching aim of the strategy is to prevent and reduce the harm caused by alcohol to individuals, families and communities in order to ensure Bristol is a healthy and safe to live work and visit. This can be achieved through partnership working and using the best available evidence of what works.

There are three broader aims of the Strategy:

1. Increase individual and collective knowledge about alcohol, and change attitudes towards alcohol consumption.
2. Provide early help, interventions and support for people affected by harmful drinking.
3. Create and maintain a safe environment.

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1.4 How do we get there? Deliverables and action plan

The aims of the Strategy will be achieved through close collaboration of three Alcohol Workstreams:

1. Alcohol Prevention Workstream
2. Alcohol Intervention Workstream
3. Alcohol Environment Workstream

Each Workstream suggested the desired outcomes and proposed an action plan to be pursued.

Alcohol Prevention Workstream

Suggested Outcome(s):

- ➢ Reduce alcohol consumption causing harm to individuals, families and communities in Bristol.

Suggested Actions:

- Social marketing
    - Deliver a large-scale social marketing campaign across Bristol City
    - Deliver preventative campaigns using social marketing tools and methods
    - Use social marketing tools to gather intelligence about attitudes to alcohol use and drinking behaviour
- Education in schools
    - Implement alcohol education in schools
    - Develop work with schools about delivering training for parents
    - Work with young people and adults with caring responsibilities
- Workplaces
    - Work in partnership with businesses across the city to promote and support the development and implementation of workforce alcohol policies and interventions to reduce alcohol-related harm in the workplace
- Alcohol Workplace policies
    - Review Bristol City Council alcohol policy and support available for employees with alcohol problems.
- Workforce (Making every contact count)
    - Deliver Alcohol Identification and Brief Advice training (IBA) to groups including but not limited to pharmacists and tenancy support officers
    - Workforce development in alcohol IBA - (making every contact count
- Community
    - Encourage parents to have conversations with their children through a social marketing campaign
    - Develop training on supporting parents to talk to their children on the harms of alcohol.
    - Develop community engagement strategies.

Alcohol Intervention Workstream

Suggested Outcome(s):

- ➢ Reduce alcohol related harm to individuals.
- ➢ Earlier identification of health harm caused by alcohol.
- ➢ High quality evidence-based treatment to reduce alcohol related harm.
- ➢ Children and young people free from alcohol related harm.

Suggested Actions – Planning:

- Needs assessment
    - Provide an overview of current service provision of Bristol Recovery Orientated Alcohol & Drug Service (ROADS) against need and identify how services can meet the identified needs
- Mapping of existing services

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- Mapping of patient pathway – specialist services
- Evidence review and economic evaluation
- Primary care review
    - Review of screening and identification used within primary care to include alcohol and liver disease
- Activity data
    - Review of secondary care data (Commissioning for Value datasets) and explore opportunities

Suggested Actions – Delivery:
- System approach to alcohol and liver disease
    - Development of a system approach to alcohol treatment and liver disease (all causes)
- Harm minimisation for high risk groups
- Young People
    - Promoting the young people's substance misuse pathway across all agencies working with children and young people
- Training and education – Healthcare staff
    - GP training
    - Explore the opportunities for online training for ambulance staff and information sharing with primary care
    - Develop Paramedic training at UWE in IBA
    - Mutual aid training for practice based staff (PMs/Community resource co-ordinators)

Alcohol Environment Workstream

Suggested Outcome(s):
- ➢ Reduce individual and community impact from alcohol related crimes and anti-social behaviour.
- ➢ Protect vulnerable people from alcohol related harm.
- ➢ Reduce demand on public and emergency services.
- ➢ Safe events held within the City; reduce alcohol related incidents.

Suggested Actions:
- Wider use of technology
    - Increase the availability of technology to improve the quality of information and evidence
- Diversionary events/activities
    - Provide an alternative to traditional night time economy activities
- Brio night time economy operation
    - Continue to develop this operation into a multi-agency approach to Bristol night time economy
- Intelligence sharing between agencies
    - Enabling an intelligence led, effective and efficient multi-agency approach to dealing with alcohol related issues across the City
- Identification and management of problematic licensed premises

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    - Improving the safety of establishments
- Training and awareness for licensed trade staff
    - Raising awareness of CSE and other vulnerability issues. Early recognition by staff
- Alcohol Recovery Centre
    - Reducing demand for NHS and police. Improved early care for users.
    - Demographic data will assist other work streams
- Re-invigoration of the Pub-Watch Scheme
    - Improve the cooperation of licensed premises to ensure a safer environment
- Management of Cumulative Impact areas
    - To ensure areas are monitored to manage the number of licensed premises
- Structured approach to licensing implications for larger events
- Providing support for people using and working in the City Centre during the night time economy
    - Identification of vulnerable people due to alcohol consumption, providing a safe environment
- Providing support to vulnerable people within the street drinking community

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2 INTRODUCTION

Alcohol is a complex issue. In recent years the sale of alcohol has shifted from the on-trade to the off-trade, as supermarkets take over dominance of sales and more people choose to drink at home. The overall trend of alcohol affordability has been increasing over time. In 2014 alcohol was 53.8 per cent more affordable than it was in 1980[1].

Licensing laws have changed allowing the trade to operate late into the early hours. National HM Revenue & Customs data[2] shows that the amount of alcohol being sold is increasing, however this picture may be confounded by the amount of smuggled and counterfeit alcohol. In more recent years tax and duty receipts from alcohol have been noticeably higher due to sustained periods of good weather, or major outdoor/sporting events, which typically increase alcohol receipts.

Over the last decade there has been a culture grow where it has become acceptable to be excessively drunk in public and cause nuisance and harm to ourselves and others[3]. Excessive intake of alcohol has clear effects on crime and health; on communities, children and young people. Levels of alcohol-related harm to the health and wellbeing of individuals, families and communities have risen, and health problems caused by heavy drinking are now being identified in young people.

In England in 2013, 18% of men and 13% of women drank at an increased risk of harm, and 5% of men and 3% of women at higher risk levels. There were about 1,059,210 alcohol-related hospital admissions in England in 2013/14, where an alcohol-related disease, injury or condition was the primary reason for hospital admission. This was a 5% increase from 2012/13. There were 6,592 alcohol-related deaths in 2013, a 1% increase from 2012. About 194,706 items for the treatment of alcohol dependence were prescribed in 2014 (in a primary care setting or NHS hospital), at the Net Ingredient Cost of £3.43 million.

At the same time alcohol plays an important part in our social lives and in the local economy. Well-run community pubs and other businesses form a key part of the fabric of neighbourhoods, providing employment and social venues in local communities.

On the one hand alcohol causes significant harm and contributes to health inequalities; on the other it brings benefits to the community and enhances the UK economy. Balancing the two facets of alcohol (use and misuse) requires us to work in partnership across the sectors to ensure that the benefits are felt and the harms are minimised.

This strategy attempts to address the key points by bringing all partners together and setting out a vision for Bristol. It aims to facilitate the establishment of a safe, sensible and harm-free drinking culture in Bristol, and set a direction of travel to achieve this.

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[1] Statistics on Alcohol, England, 2015. Health and Social Care Information Centre. June 2015. Available from: http://www.hscic.gov.uk/catalogue/PUB17712/alc-eng-2015-rep.pdf. (Accessed 24/02/2016)
[2] Tax and Duty Bulletins. HM Revenue and Customs. Available from: https://www.uktradeinfo.com/Statistics/Pages/TaxAndDutyBulletins.aspx. (Accessed 24/02/2016)
[3] The Government's Alcohol Strategy. HM Government. March 2012. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf.

2.1 Safer levels of drinking

The UK Chief Medical Officers' (CMOs) proposed new guidelines to inform the public about the known health risks of different levels and patterns of drinking, and to limit the health risks associated with the consumption of alcohol. These guidelines should help people to make informed choices and judge the risks they are willing to accept from alcohol, whether to drink alcohol, and how much and how often to drink[4].

The guidelines include the following three main recommendations.

1/ A weekly guideline on regular drinking (for both men and women):

- You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level.
- If you do drink as much as 14 units per week, it is best to spread this evenly over 3 days or more. If you have one or two heavy drinking sessions, you increase your risks of death from long term illnesses and from accidents and injuries.
- The risk of developing a range of illnesses (including, for example, cancers of the mouth, throat and breast) increases with any amount you drink on a regular basis.
- If you wish to cut down the amount you're drinking, a good way to help achieve this is to have several drink-free days each week.

2/ Advice on single episodes of drinking, i.e. advice on short term effects of alcohol (for both men and women):

You can reduce the short term health risks from a single drinking occasion to a low level by:

- limiting the total amount of alcohol you drink on any occasion;
- drinking more slowly, drinking with food, and alternating with water;
- avoiding risky places and activities, making sure you have people you know around, and ensuring you can get home safely.

The sorts of things that are more likely to happen if you don't judge the risks from how you drink correctly can include: accidents resulting in injury (causing death in some cases), misjudging risky situations, and losing self-control.

These risks can arise for people drinking within the weekly guidelines for regular drinking, if they drink too much or too quickly on a single occasion; and for people who drink at higher levels, whether regularly or infrequently.

Some groups of people are likely to be affected more by alcohol and should be more careful of their level of drinking on any one occasion: young adults; older people; those with low body weight; those with other health problems; those on medicines or other drugs.

As well as the risk of accident and injury, drinking alcohol regularly is linked to long term risks such as heart disease, cancer, liver disease, and epilepsy.

3/ A guideline on pregnancy and drinking:

- If you are pregnant or planning a pregnancy, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.
- Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.

Most women either do not drink alcohol (19%) or stop drinking during pregnancy (40%).

The risk of harm to the baby is likely to be low if a woman has drunk only small amounts of alcohol before she knew she was pregnant or during pregnancy.

Women who find out they are pregnant after already having drunk during early pregnancy, should avoid further drinking, but should be aware that it is unlikely in most cases that their baby has been affected. If you are worried about how much you have been drinking when pregnant, talk to your doctor or midwife.

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[4] UK Chief Medical Officers' Alcohol Guidelines Review. Summary of the proposed new guidelines. January 2016. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/489795/summary.pdf.

In short, the guidelines change the safe alcohol units for men who should not drink more than 14 units of alcohol per week (compared to 21 units in the previous guidelines), the same level as for women. It recommends to spread the 14 units over 3 or more days as 1-2 heavy drinking sessions each week increase the risk of death from long term illnesses, accidents and injuries. It updates the guidelines for pregnant women, clarifying that no level of alcohol is safe to drink in pregnancy.

A unit of alcohol is roughly half a pint of normal strength lager (4.1% ABV). A unit is calculated by reference to the amount (or volume) of the drink and the alcoholic strength (Alcohol by Volume (ABV))[5].

$$\frac{\text{Volume (ml) x Strength (ABV \%)}}{1{,}000} = \text{Number of units}$$

A unit is 10ml of pure alcohol (i.e. the amount of alcohol that would be left if other substances were removed). For example 1 litre (i.e. 1000ml) bottle of whisky at 40% ABV has 400ml, or 40 units of alcohol.

The alcohol risk levels as described by Public Health England are defined in the table below. These definitions were amended in line with the new guidelines.

Drinker type	Men	Women
Lower risk drinkers	Men and women who regularly drink less than 15 units of alcohol per week	
Increasing risk drinkers	Men who regularly drink between 15 and 50 units per week	Women who regularly drink between 15 and 35 units per week
Higher risk drinkers	Men who regularly drink more 50 units per week	Women who regularly drink more than 35 units per week
Binge drinkers	Consumption of at least twice the daily recommended amount of alcohol in a single drinking session	

[5] How to keep health risks from drinking alcohol to a low level: public consultation on proposed new guidelines. January 2016. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/489796/CMO_alcohol_guidelines.pdf.

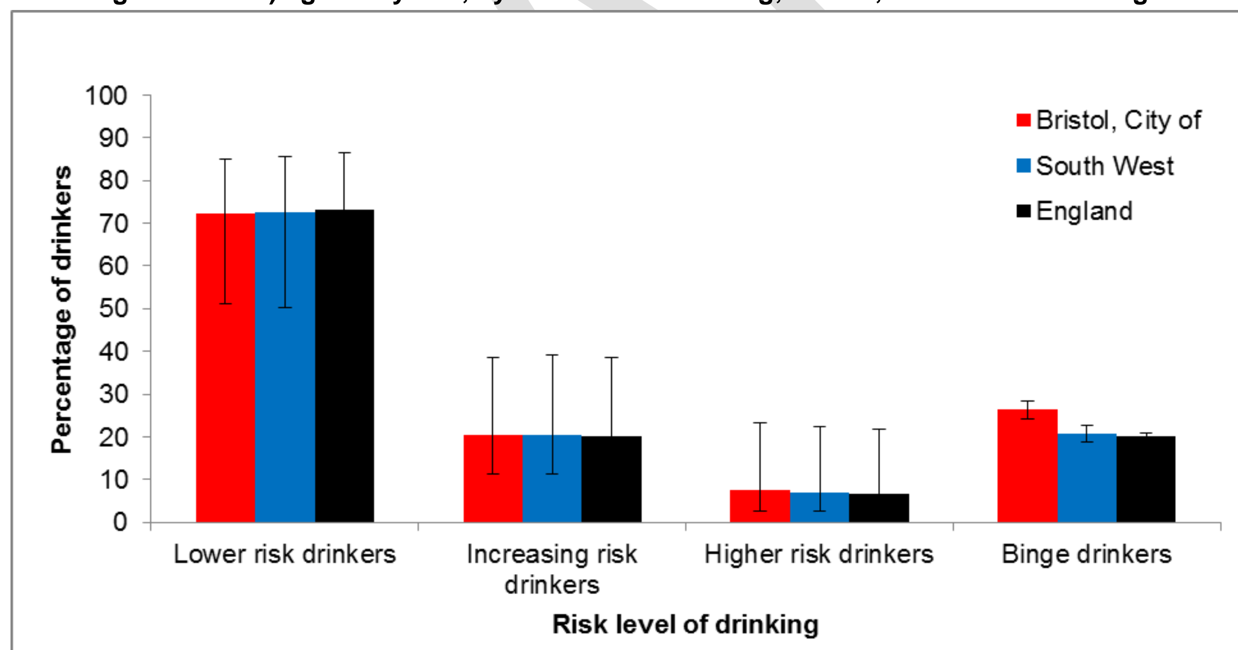
2.2 Alcohol consumption in Bristol

Estimates of local alcohol use are based on national self-reported surveys. The mid 2009 synthetic estimates produced by Public Health England, Local Alcohol Profiles for England (LAPE)[6], reported that;

- 16.0% of Bristol population aged 16 years and over abstain from drinking;
- The remaining 84.0% of Bristol population aged 16 years and over who drink reported to engage in drinking at different levels:
  - 72.2% stay within the national low risk limits;
  - 20.3% drink at increasing levels that risk harm in the long term;
  - 7.5% drink at higher risk levels that harm themselves and others (this includes dependent drinkers);
  - 26.3% binge drink and are vulnerable to the acute effects of intoxication such as assault, falls and poisoning.

Figure 2.2a compares the Bristol percentages of drinkers with the South West and England estimates. There is some evidence that the percentage of binge drinkers in Bristol is higher than the regional and national percentage. There are no significant differences between Bristol, the South West and England in the other percentages.

Figure 2.2a: Mid 2009 synthetic estimate of the percentage within the drinking population (not including abstainers) aged 16 years, by risk level of drinking; Bristol, South West and England



Some research evidence indicates that these estimates could be too low as they do not marry with the Revenue and Customs data that describes the amount sold or brought into Britain[7]. It is likely that people underestimate the amount they drink in self-reported surveys and the true amount may be as high as 60 % more than stated. Given this it is likely that

[6] LAPE (Local Alcohol Profiles for England). Public Health England. Available from: http://www.lape.org.uk/data.html. (Accessed 20/02/2016)
[7] Boniface S, Shelton N. How is alcohol consumption affected if we account for under-reporting? A hypothetical scenario. European Journal of Public Healh 2013. Feb 26 2013.10.1093.

many people who describe themselves as low risk drinkers may in fact be drinking at higher levels and misusing alcohol.

Alcohol use is sensitive to cultural and socio-economic characteristics that greatly differ across the City of Bristol. Some communities have traditions that dissuade alcohol misuse; these communities include some ethnic and religious groups. For instance many observant Muslims are abstinent. The socio-economic effect of alcohol use includes:

- People from lower socio-economic classes are less likely to misuse alcohol, however if they do drink to excess they tend to develop very severe drinking problems.
- More affluent people with higher income much more likely to drink alcohol daily[8].

Thus the pattern of alcohol misuse over Bristol is varied and complex. In deprived areas people who misuse alcohol are also more likely to also smoke tobacco. This combination of smoking and drinking results in a higher risk of getting cancer. Evidence suggests that non-smokers who drank alcohol were around a third more likely to develop mouth and upper throat cancer than those who didn't drink alcohol. But people who were (ex-) smokers and also drank alcohol, were around 3 times as likely to develop the disease. Furthermore the risk of liver cancer was found almost 10 times greater in people who smoked and drank heavily[9]. This increased risk results in a higher burden of mortality caused by alcohol in deprived areas, despite less people in the areas misusing alcohol.

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[8] Adult Drinking Habits in Great Britain, 2013. Office for National Statistics. Available from: http://www.ons.gov.uk/ons/dcp171778_395191.pdf.

[9] Alcohol facts and evidence. Cancer research UK. Available from: http://www.cancerresearchuk.org/about-cancer/causes-of-cancer/alcohol-and-cancer/alcohol-facts-and-evidence#alcohol_facts6. (Accessed 25/02/2016)

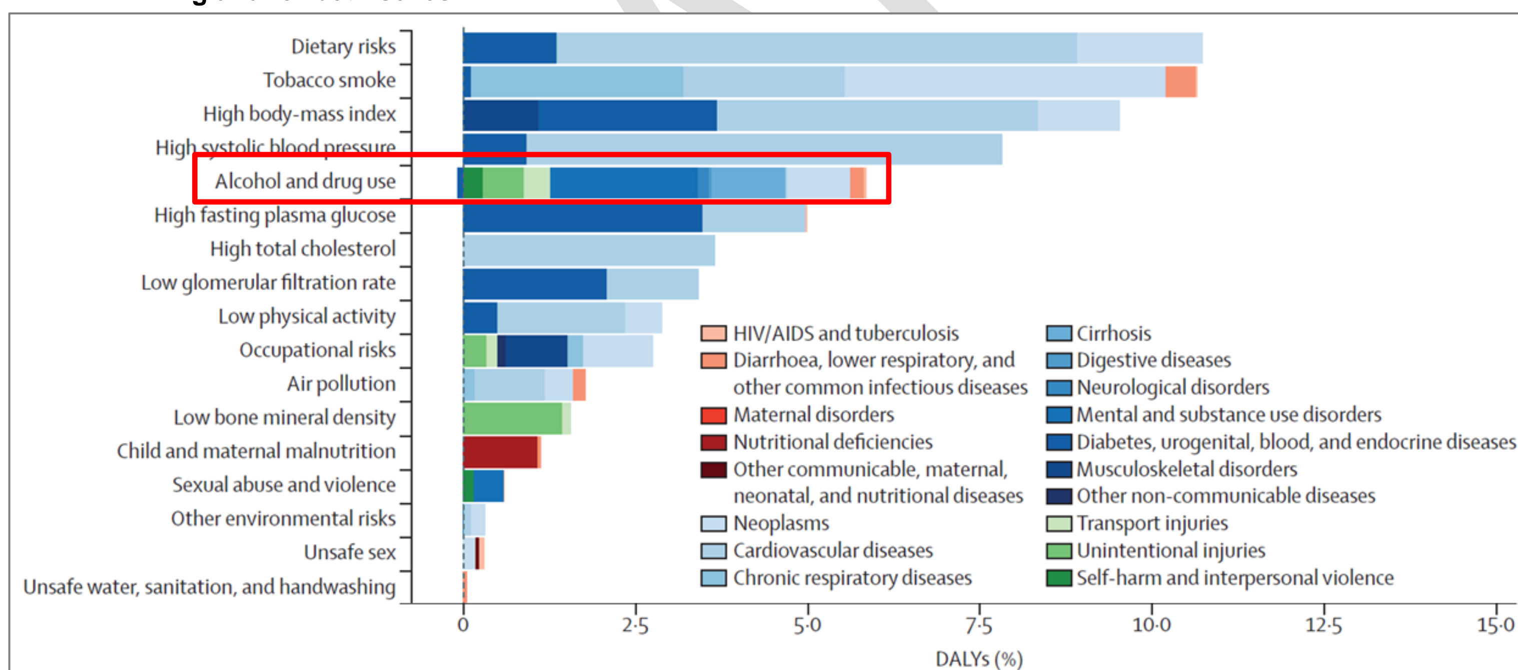
2.3 The impact of alcohol misuse

2.3.1 Health harms

Excessive drinking is a major cause of wide range of diseases and injuries in the UK. In the Global Burden of Disease Study 2013 (GBD 2013), alcohol and drug use was the fifth leading risk factor of the burden of disease in England, and accounted for approximately 6% of disability-adjusted life years (DALYs) (Figure 2.3.1a). Alcohol and drug use caused a greater proportion of total DALYs in men than in women (8% versus 4%). Alcohol, high body-mass index and high fasting plasma glucose were the only leading risks for which attributable burden did not fall between 1990 and 2013.

In GBD 2013, alcohol consumption was the third leading behavioural risk factor overall, but was the leading behavioural cause of injury. About a third of deaths from cirrhosis could categorically be assigned to alcohol as the underlying cause (cirrhosis due to alcohol accounted for 29% of DALYs due to cirrhosis). However, alcohol also contributed to cirrhosis where it was not the underlying cause. Therefore, the overall proportion of cirrhosis of the liver DALYs attributed to alcohol was 70% in England in 2013[10].

Figure 2.3.1a: Disability-adjusted life-years (DALYs) attributed to level 2 risk factors in 2013 in England for both sexes



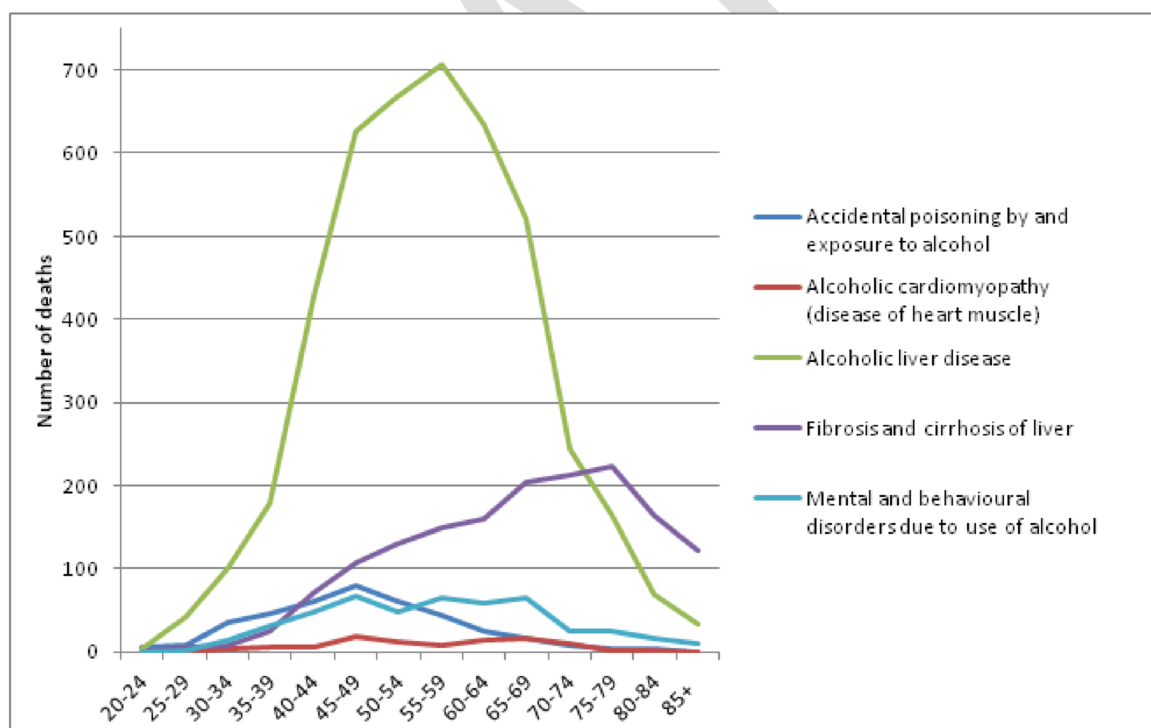
[10] Newton JN, Briggs ADM, Murray CJL, et al. Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet. 2015. Published Online September 15, 2015. http://dx.doi.org/10.1016/S0140-6736(15)00195-6.

Alcohol is linked to, or causes, a range of serious and preventable diseases[11], including the following:

- Causally related to a range of acute and chronic medical conditions, including cancers, cardiovascular disease, and obesity;
- A significant cause of morbidity and premature death;
- Associated (through heavy drinking by pregnant women) with a range of preventable mental and physical birth defects (collectively known as Foetal Alcohol Spectrum Disorders);
- Implicated in many areas of mental ill health, including depression, anxiety and suicide;
- Linked to unintentional injuries and trauma due to violence.

The age-standardised rate of alcohol-related deaths in the UK rose steeply from 1994 to 2008 when it peaked. It has reduced since then, but the 2014 rate of 14.3 deaths per 100,000 population (i.e. 8,697 alcohol-related deaths) was still higher than the rate in 1994 (9.1 deaths per 100,000 population). About 65% of alcohol-related deaths (65%) in the UK in 2014 were among males[12]. Figure 2.3.1b shows the top five alcohol related deaths by causes and age group in 2012[13].

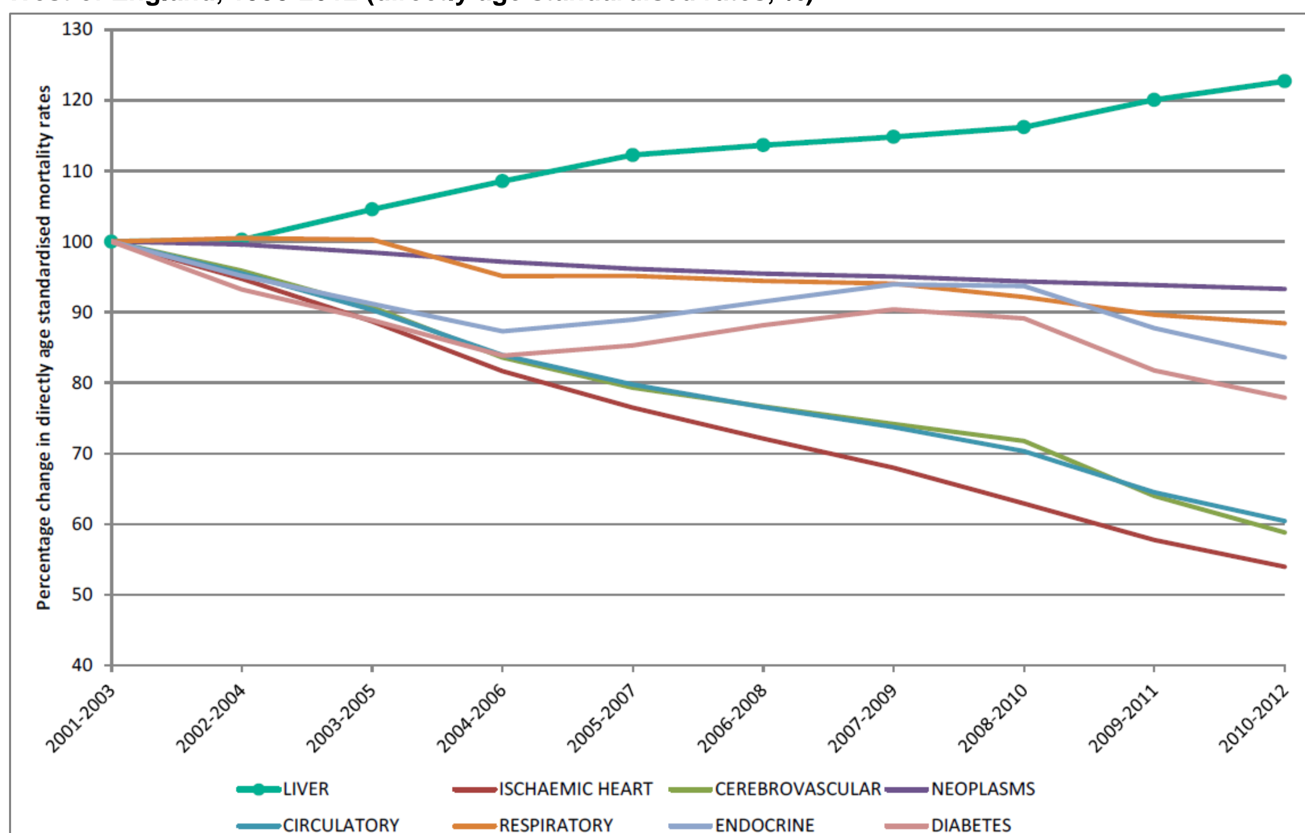
Figure 2.3.1b: The top 5 alcohol related deaths by causes and age group, England and Wales, 2012[13]



[11] Alcohol misuse: tackling the UK epidemic. BMA Board of Science. February 2008. Available from: http://www.dldocs.stir.ac.uk/documents/Alcoholmisuse.pdf.
[12] Alcohol-related deaths in the UK, registered in 2014. Office for National Statistics. Available from: http://www.ons.gov.uk/ons/dcp171778_431695.pdf.
[13] Liver disease biggest cause of alcohol-related deaths in England and Wales. February 2014. Available from: http://www.ons.gov.uk/ons/rel/subnational-health4/alcohol-related-deaths-in-the-united-kingdom/2012/sty-alcohol-releated-deaths.html. (Accessed 25/02/2016)

In 2014 the All-Party Parliamentary Hepatology Group report[14] stated that liver disease is rising at an alarming rate. Between 2001 and 2012, deaths with an underlying cause of liver disease have risen by 40% in the UK and by 23% in the South West[15]. Liver disease is the only major preventable killer disease where annual deaths are on the rise, both nationally and regionally (Figure 2.3.1c). Liver disease is mainly caused by alcohol misuse (but can be also caused by obesity and viral hepatitis).

Figure 2.3.1c: Trend percentage change for the main preventable causes of mortality in South West of England, 1995-2012 (directly age standardised rates, %)



2.3.1.1 Hospital admissions

Alcohol-related hospital admission episodes and admissions

The trend in hospital admission episodes for alcohol-related conditions (broad measure) in Bristol was rising from 2008, until it peaked in 2011/12. Since then it has reduced to 2,487 admission episodes per 100,000 population in 2013/14 (Figure 2.3.1.1a). This rate was significantly higher than the 2013/14 England average of 2,111 admission episodes per 100,000 and has been consistently higher than England since 2008/09.

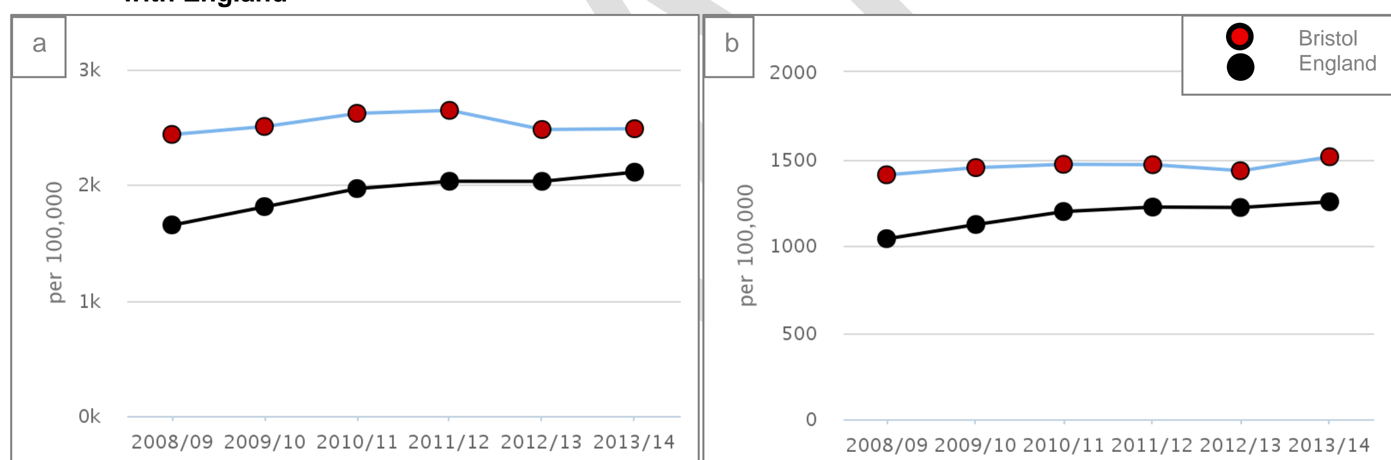
[14] Liver disease: today's complacency, tomorrow's catastrophe. The All-Party Parliamentary Hepatology Group (APPHG) Inquiry into Improving outcomes in Liver Disease. March 2014. Available from: http://www.appghep.org.uk/download/report/APPHG%20Inquiry%20into%20Outcomes%20in%20Liver%20Disease,%20March%202014.pdf.
[15] Public Health England. (2015) Liver Disease in the South West Centre: A health needs assessment. Public Health England: South West. July 2015.

Similarly a rising trend, though with a less significant recent decline, can be observed in alcohol-related admissions (broad measure), with 1,513 persons per 100,000 population admitted to hospital due to alcohol-related conditions in Bristol in 2013/14 (Figure 2.3.1.1b). Again the Bristol rate was significantly higher than the England rate (1,253 admissions per 100,000), as it has been in the past few years.

In crude numbers, there were 8,750 hospital admission episodes for alcohol-related conditions in Bristol in 2013/14. This corresponds to 5,408 persons admitted to hospital due to alcohol-related conditions in the same year.

Alcohol-related conditions comprise all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome[16]. These patients might have conditions linked to alcohol use, for example hypertensive diseases, various cancers and falls. Alcohol-related admission episodes and admissions include the primary diagnosis or any of the secondary diagnoses with an alcohol-attributable code. Attributable fraction values are the proportion of a health condition or external cause that is attributable to alcohol consumption. Therefore these indicators refer to alcohol misuse in the population rather than admissions caused directly/specifically by alcohol.

Figure 2.3.1.1: a/ Admission episodes for alcohol-related conditions (broad measure)[17], and b/ alcohol-related hospital admissions (broad measure)[18], Bristol, 2008/09-2013/14; compared with England



Alcohol-specific hospital admissions

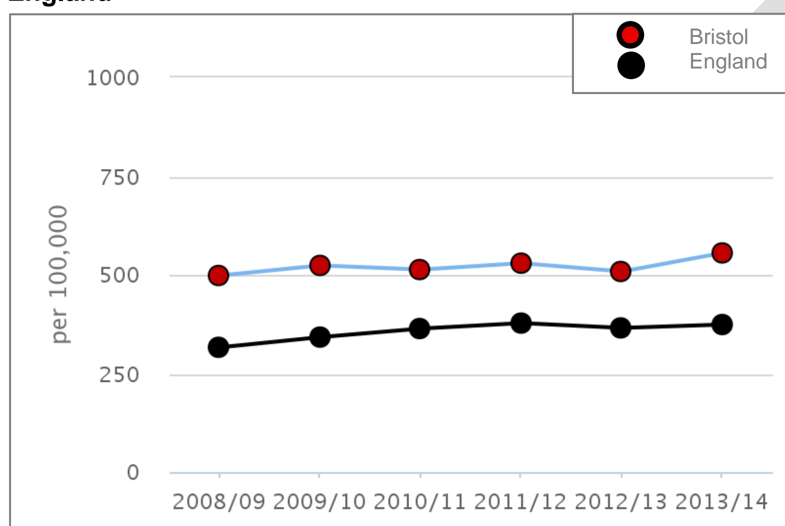
In Bristol the trend in alcohol-specific hospital admissions was fairly stable around 500 admissions per 100,000 population between 2008/09 and 2012/13, but increased to 555 admissions per 100,000 in 2013/14 (Figure 2.3.1.1c). The local rates have been significantly higher than the England rates during the same time period (for example the rate of 555 per 100,000 locally versus 374 per 100,000 nationally in 2013/14).

[16] Public Health England. (2015) Local Alcohol Profiles for England: 2015 user guide. Public Health England: knowledge and Intelligence Team (North West). Available from: http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf
[17] Public Health England (PHE), Local Alcohol Profiles for England (LAPE). Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000023/iid/91409/age/1/sex/4
[18] PHE. LAPE. Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000023/iid/91385/age/1/sex/4

In crude numbers, there were 2,160 persons admitted to hospital due to alcohol-specific conditions (where the primary diagnosis or any of the secondary diagnoses were an alcohol-specific code) in Bristol in 2013/14.

Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; e.g. alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because 100% of cases are caused by alcohol.

Figure 2.3.1.1c: Alcohol-specific hospital admissions, Bristol, 2008/09-2013/14; compared with England[19]

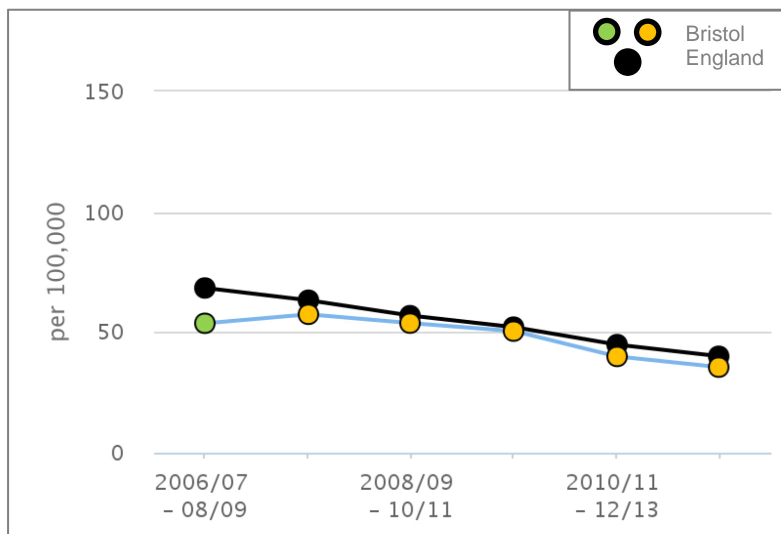


In 2013/14 in Bristol, the number of admissions due to alcohol-specific conditions was more than double in men than women (1,505 versus 650). The trend in alcohol-specific hospital admissions among men looked similar to the overall trend shown in Figure 2.3.1.1c. It was fluctuating around 750 admissions per 100,000 male population between 2008/09 and 2011/12, then slightly dropped to 712 per 100,000 in 2012/13, and increased to 798 admissions per 100,000 in 2013/14. The trend among women was steadily rising, from 261 admissions per 100,000 female population in 2008/09 to 321 admissions per 100,000 female population in 2013/14. The Bristol figures for both males and females were higher than the national average (for example the rate per 100,000 of 798 in males and 321 in females locally versus 515 in males and 241 in female nationally in 2013/14).

Figure 2.3.1.1d shows that in Bristol between 2006/07 and 2013/14, the (three-year average) rates of hospital admissions for alcohol-specific conditions among under 18's were lower than or similar to the national figures. The Bristol rate peaked at 57.5 per 100,000 under 18 population in 2007/08-09/10, and has declined since. In 2011/12-13/14 there were 95 persons aged less than 18 years admitted to hospital due to alcohol-specific conditions in Bristol, which corresponds to a rate of 35.5 admissions per 100,000 population under 18s.

[19] PHE. LAPE. Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000023/iid/91384/age/1/sex/4

Figure 2.3.1.1d: Alcohol-specific hospital admissions among under 18s (3-year averages), Bristol, 2006/07-2013/14; compared with England[20]



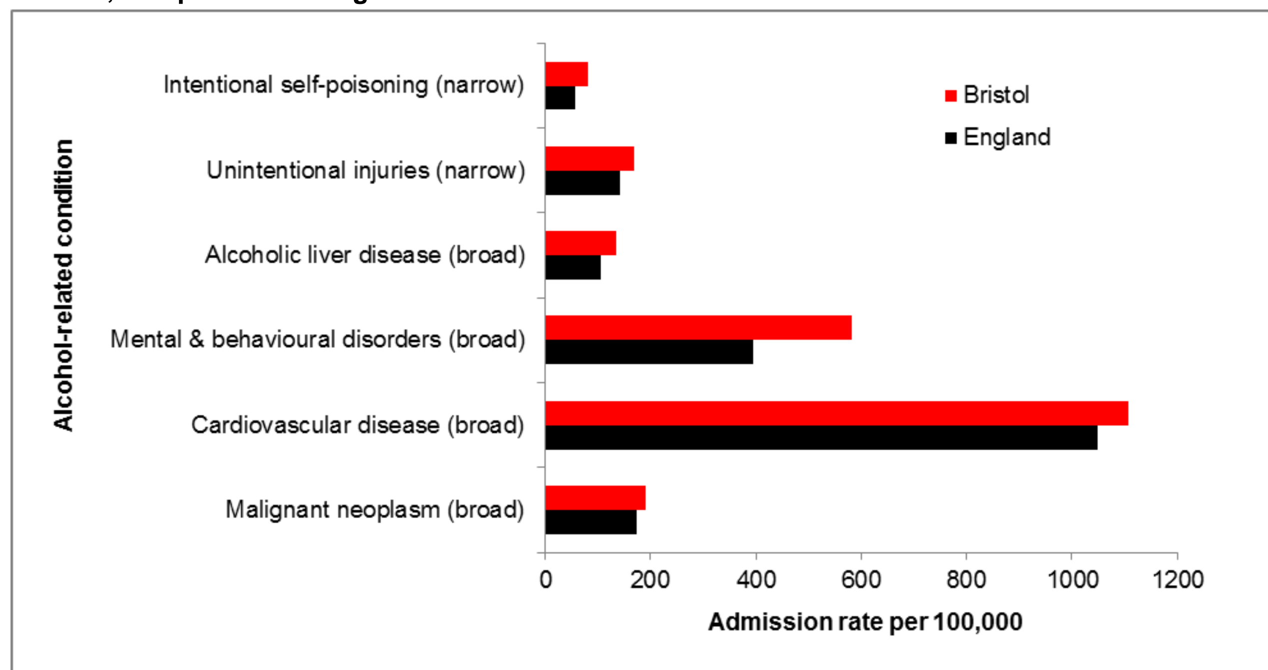
Admission episodes by alcohol-related condition

Figure 2.3.1.1e shows that in Bristol in 2013/14, the most common reasons for alcohol-related admission episodes, i.e. partially attributable to alcohol, were cardiovascular disease (1,108 admission episodes per 100,000 population) and mental & behavioural disorders due to use of alcohol (581 admission episodes per 100,000 population).

The rates of admission episodes for all alcohol-related conditions listed in Figure 2.3.1.1e were significantly higher than the England rates for the same conditions in the same year.

[20] PHE. LAPE. Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000023/iid/90856/age/173/sex/4

Figure2.3.1.1e: Admission episodes for alcohol-related conditions by condition group, Bristol, 2013/14; compared with England[21]



Broad measure refers to admissions to hospital where the primary diagnosis or any of the secondary diagnoses were an alcohol-attributable condition code (e.g. alcohol-attributable malignant neoplasm code);
Narrow measure refers to admissions to hospital where the secondary diagnosis was an alcohol-attributable external cause code (e.g. alcohol-attributable unintentional injuries code).

2.3.1.2 Mortality

In Bristol, the trend in the alcohol-related mortality (i.e. deaths from alcohol-related conditions) was fairly stable between 2008 and 2012, with a rate fluctuating between 52.5 per 100,000 in 2012 to 55.1 per 100,000 in 2008. During this time period the Bristol rates were similar to the national rates. In 2013, the rate of alcohol-related mortality rose to 56.0 per 100,000 (corresponding to 196 alcohol-related deaths) and then dropped again to 53.2 per 100,000 in 2014 (corresponding to 187 deaths). In these last two years the Bristol rates were higher than the rates in England (e.g. in 2014 a rate of 53.2 locally versus 45.5 per 100,000 nationally) (Figure 2.3.1.2a).

The alcohol-specific mortality refers to deaths from alcohol-specific conditions and due to low numbers is reported as three-year pooled estimates. The rate of alcohol-specific mortality has been slightly increasing since 2009-11, from 14.7 per 100,000 in 2009-11 (corresponding to 157 alcohol-specific deaths) to 18.3 per 100,000 in 2012-14 (corresponding to 200 deaths).

As shown in Figure 2.3.1.2b, the Bristol rates have been consistently higher than the England average since 2006-08 (e.g. in 2012-14 a rate 18.3 locally versus 11.6 per 100,000 nationally). This was mainly because of a problem with alcohol-specific mortality in males. In Bristol, the rates among men have been significantly higher than England since 2006-08. For

[21] PHE. LAPE. Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0/gid/1938132848/pat/6/par/E12000009/ati/102/are/E06000023/iid/91410/age/1/sex/4

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example there were 28.5 deaths per 100,000 men in 2012-14, compared to the national rate of 16.1 per 100,000. In females the rate of alcohol-specific mortality was 7.9 per 100,000 in the same period (similar to the national rate of 7.4). In crude numbers, there were 157 alcohol-specific deaths among Bristol men in 2012-14 compared to only 43 deaths among Bristol women.

Figure 2.3.1.2a: Alcohol-related mortality[22], Bristol, 2008-2014; compared with England

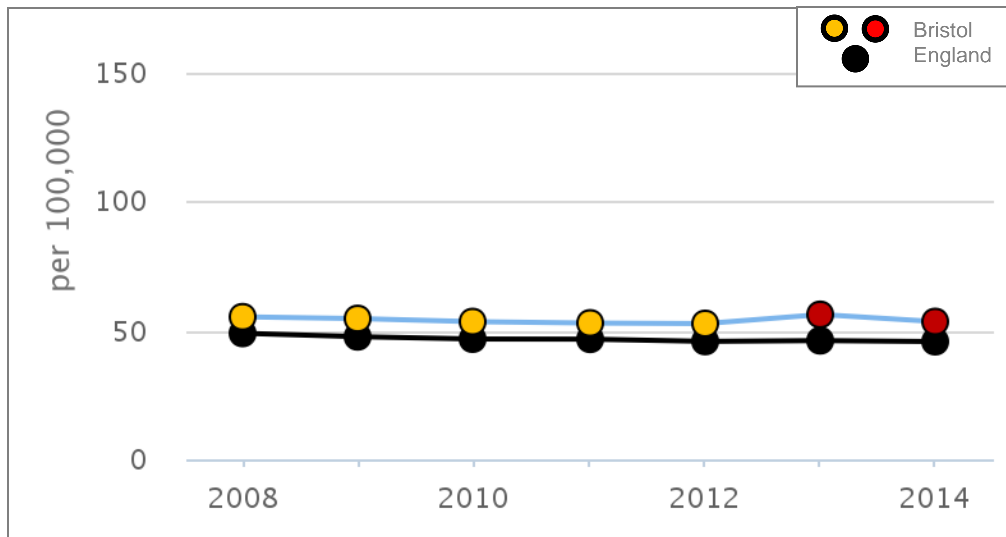
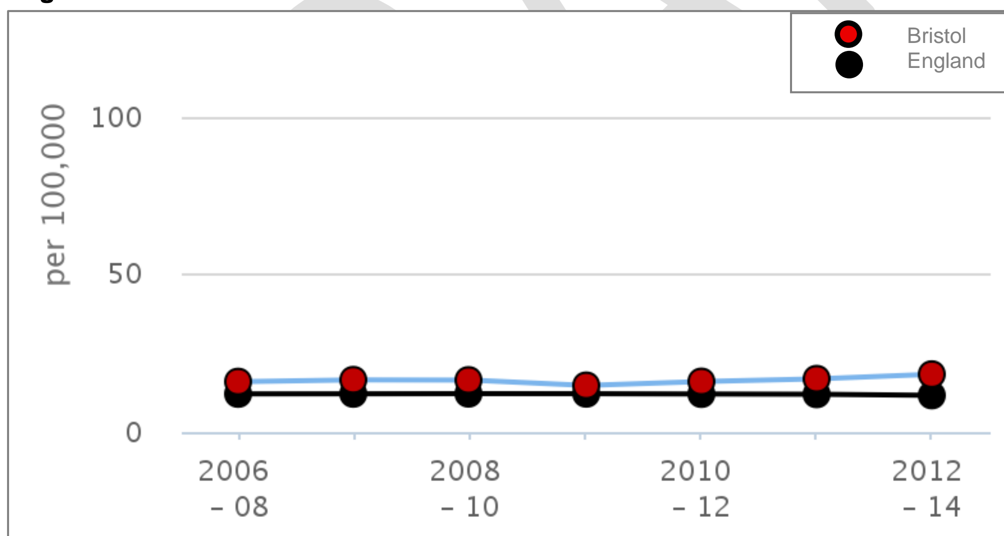


Figure 2.3.1.2b: Alcohol-specific mortality[23], Bristol, 2006-08 to 2012-14; compared with England

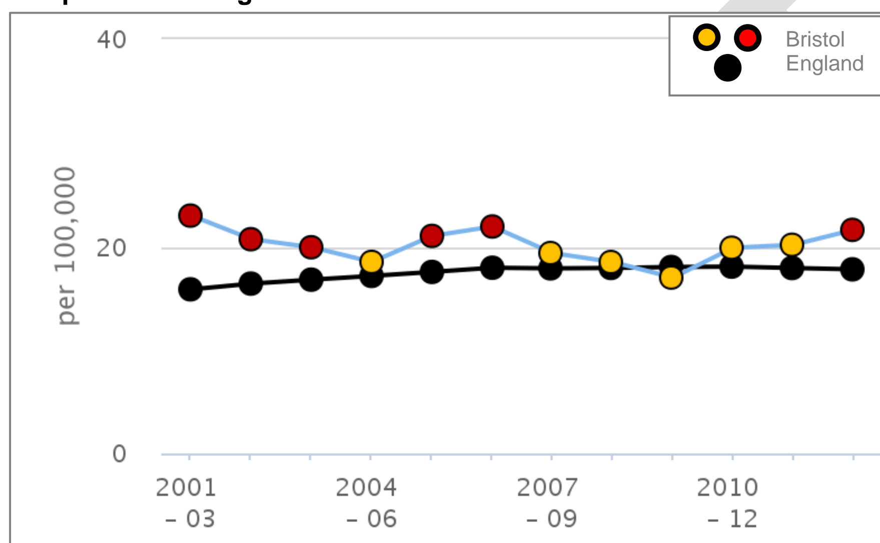


[22] PHE. LAPE. Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132832/pat/6/par/E12000009/ati/102/are/E06000023/iid/91382/age/1/sex/4
[23] PHE. LAPE. Available from: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132832/pat/6/par/E12000009/ati/102/are/E06000023/iid/91380/age/1/sex/4

2.3.1.3 Alcoholic liver disease

The increasing trend in mortality from preventable liver disease was shown earlier in Figure 2.3.1c. Figure 2.3.1.3a compares the trend in the under 75 mortality from liver disease in Bristol and England during 2001-03 and 2012-14. The red circles on the Bristol trend line indicate rates higher than the England average. To understand the impact of alcohol on the liver disease burden the hospital admission rates for alcoholic liver disease (i.e. number of admissions with a primary diagnosis of alcoholic liver disease) and the under 75 mortality rates from alcoholic liver disease (i.e. number of deaths from alcoholic liver disease in people aged under 75 years) are presented below.

Figure2.3.1.3a: Under 75 mortality rate from liver disease, Bristol, 2001-03 to 2012-14; compared with England[24]



The hospital admission rates for alcoholic liver disease were reported in 2012/13 and 2013/14 only, thus time trend comparisons cannot be made. In Bristol in 2013/14, the admission rates for alcoholic liver disease were 57.1 per 100,000 population which was much higher than the England rate of 31.9. Figure 2.3.1.3b shows that Bristol has a problem with the hospital admissions for alcoholic liver disease among men; the Bristol rate of 96 admissions per 100,000 male population was significantly higher to the national rate of 44 for 2013/14. In females the rate of admissions for alcoholic liver disease was 19.4 per 100,000 in the same period (similar to the national rate of 20.3).

The under 75 mortality rates from alcoholic liver disease are due to low numbers reported as three-year pooled estimates. In Bristol in 2012-14, the deaths from alcoholic liver disease among men under 75 dominated, a similar picture to that described above for the admission rates. The mortality rate in males was 20.9 per 100,000, which was significantly higher than England (11.5 per 100,000); whereas the mortality rate in females was only 5.4 per 100,000, similar to the national rate of 5.8 (Figure 2.3.1.3c).

[24] PHE. Liver Disease Profiles. Available from: http://fingertips.phe.org.uk/profile/liver-disease/data#page/4/gid/8000063/pat/6/par/E12000009/ati/102/are/E06000023/iid/90929/age/1/sex/4

Figure2.3.1.3b: Hospital admission rate for alcoholic liver disease by gender, Bristol, 2013/14; compared with England[25]

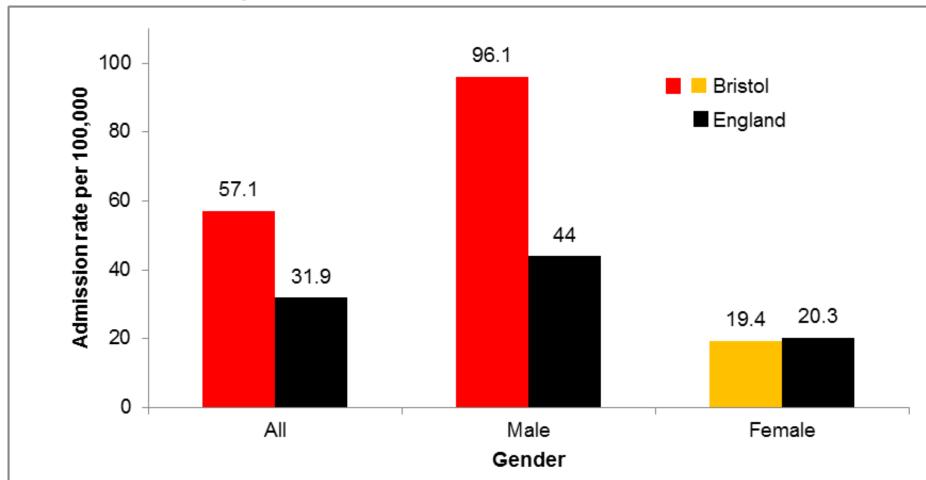
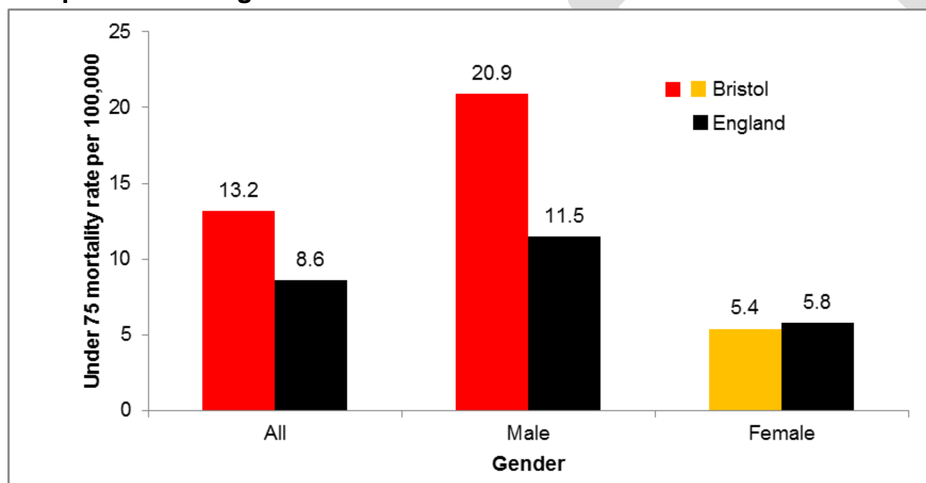


Figure2.3.1.3c: Under 75 mortality rate from alcoholic liver disease by gender, Bristol, 2012-14; compared with England[26]



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[25] PHE. Liver Disease Profiles. Available from: http://fingertips.phe.org.uk/profile/liver-disease/data#page/4/gid/8000063/pat/6/par/E12000009/ati/102/are/E06000023/iid/90929/age/1/sex/4
[26] PHE. Liver Disease Profiles. Available from: http://fingertips.phe.org.uk/profile/liver-disease/data#page/4/gid/8000063/pat/6/par/E12000009/ati/102/are/E06000023/iid/90861/age/163/sex/4

2.3.1.4 Accident and Emergency burden

It is known that alcohol-related harm is placing increasing demands on the NHS and potentially avoidable strain on ambulance trusts, Accident and Emergency (A&E) departments and hospital services[27].

In England, A&E attendance rates due to alcohol poisoning doubled from 2008/09 (rate of 72.7 per 100,000 population) to 2013/14 (rate of 148.8 per 100,000). Three in four people who attended A&E due to alcohol poisoning arrived by ambulance. One in three of those attendees were subsequently admitted to hospital overnight (compared to one in five admissions among people attending A&E for other reasons). In 2013/14, approximately 1 in 20 emergency admissions were for alcohol-specific conditions.

The highest rates of emergency admissions related to alcohol were seen in men in the older age groups (45–64 years of age) which may reflect the chronicity of alcohol-related problems. In 2013/14, 90% of people who attended A&E due to alcohol poisoning and 72% of those who had an alcohol-specific emergency admission, only attended hospital once in that year. This presents a 'teachable moment' and an opportunity to intervene, identify issues of alcohol dependency and provide a specialist advice to prevent progression into alcohol-related chronic disease.

A&E attendance rates due to alcohol poisoning and hospital emergency admissions specific to alcohol has been three to four times higher in the poorest fifth of the population over the past five years.

2.3.1.5 Alcohol treatment

There is unprecedented demand for alcohol treatment services in Bristol since the launch of Recovery Orientated Alcohol & Drugs Services (ROADS). Unfortunately there are also high attrition rates of alcohol clients from assessment to engagement[28].

Routes into treatment

Understanding the routes into alcohol treatment gives an indication of the levels of referrals from various settings into specialist treatment. In Bristol in 2014/15, 50% (308/614) of all referrals in alcohol treatment were made by GPs, followed by 22% (135/614) of self-referrals. Nationally these proportions were inverted, with 45% of self-referrals and 19% of GP referrals[29].

Demographic and social characteristics of individuals in treatment

[27] Currie C, Davies A, Blunt I, Ariti C, Bardsley M. Alcohol-specific activity in hospitals in England. Research report. Nuffield Trust. December 2015. Available from: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/alcohol-specific-activity_final-web.pdf.
[28] Bristol Substance Misuse Needs Assessment. Substance Misuse Team. September 2016.
[29] Alcohol data: JSNA support pack. Key data to support planning for effective alcohol harm prevention, treatment and recovery in 2016-17. Bristol. Public Health England.

Demographic characteristics of people in alcohol treatment in Bristol are similar to the national picture. In 2014/15, there were 716 adults in alcohol treatment in Bristol. Of those, 63% were male, similar to the national proportion of 62%. The proportion of adults starting the treatment in 2014/15 was 86% (614/716) which was higher than the national proportion of 69%.

Both locally and nationally, the 40 to 49 year age group is the most represented among adults in alcohol treatment (around 33%), followed by the 50-59 and 30-39 year age groups (around 24% and 23% respectively).

The employment status at the start of alcohol treatment differed locally compared to the national picture. In Bristol in 2014/15, 47% of adults starting treatment reported 'long term sickness or disability', 25% were in 'regular employment' and 24% were 'unemployed or economically inactive'. Nationally these proportions were distributed differently (22%, 27% and 37% respectively).

Length of time in treatment

NICE Clinical Guidance CG115 suggests that harmful drinkers and those with mild alcohol dependence might benefit from a package of care lasting three months while those with moderate dependence might need a six month package and those with severe dependence or those with complex needs may need a package of care lasting up to a year.

Nationally the length of a typical treatment period is around 6 months. However in Bristol the rates of early treatment drop out were high. In 2014/15, 24% of adults in treatment exited in less than a month and further 46% in less than 3 months (compared with much lower national proportions of 12% and 26% respectively).

Treatment outcomes

The data on successful completions of alcohol treatment provides an indication of the effectiveness of the treatment system. A high number of successful completions and a low number of re-presentations to treatment indicate that treatment services are responding well to the needs of those in treatment.

In Bristol, 35% (249/710) of all adults in alcohol treatment successfully completed the therapy in 2014/15[30]. In comparison, nationally the proportion of individuals leaving alcohol treatment successfully was 39%. However Bristol had lower proportion of individuals leaving alcohol treatment successfully as a proportion of all treatment exits compared to the national figure (44% versus 61%).

There is a wider issue in Bristol with high numbers of unplanned exits from alcohol treatment. The Bristol proportion of new treatment presentations that had an unplanned exit or transferred and not continuing a journey before being retained for 12 weeks was 38% between October 2014 and September 2015. This is much higher than the national average

[30] The Diagnostic and Outcome Monitoring Executive Summary (DOMES). Quarter 3 2015-2016. Bristol.

of 14% and an audit is underway locally to look into the circumstances for people leaving treatment early.

In terms of re-presentations to treatment, Bristol had 27% of individuals in alcohol treatment leaving the treatment successfully (between 1st Jan 2014 and 31st Dec 2014) and not returning within 6 months. This proportion was much lower than the national proportion of 38% during the same time period.

Waiting times for alcohol treatment are an issue in Bristol. The percentage of patients who waited over three weeks to start first intervention was 39% in quarter Oct-Dec 2015, compared to the national average of 4%. Recently some additional funding has been agreed to increase treatment group work capacity in Bristol.

2.3.1.6 Alcohol and mental health

There are close links between alcohol misuse and mental health problems. Some people with mental ill health drink alcohol to alleviate their difficult feelings or cope with their mental illness (called 'self-medication'[31]). Some people with alcohol problems may subsequently develop some mental health problems, such as anxiety and depression, as alcohol may exacerbate these conditions or caused for example alcohol induced dysphoria.

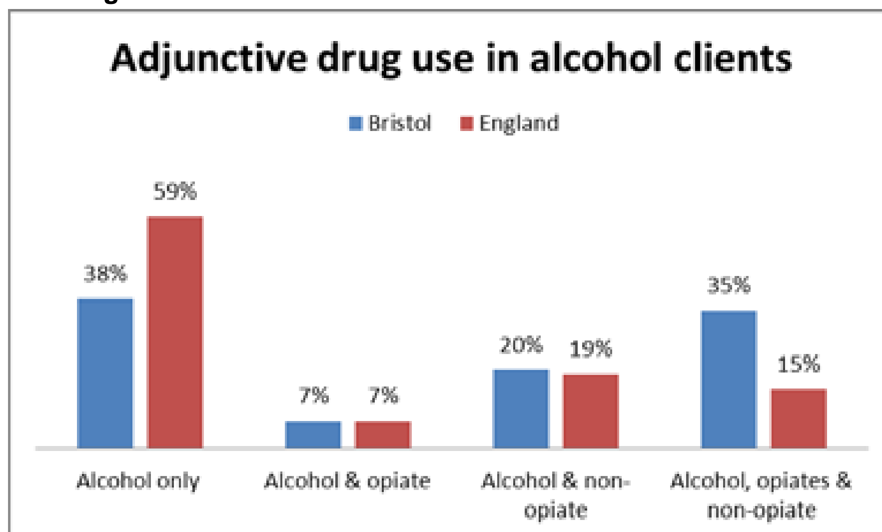
Earlier presented Figure 2.3.1.1e showed that in Bristol, 2013/14, the second highest rate of admission episodes for alcohol-related conditions were for mental and behavioural disorders due to use of alcohol (581 per 100,000 population). A similar picture can be seen nationally when in England in 2013/14, the second highest number of admissions (19%) was for mental and behavioural disorders due to alcohol[1]. Also between 2003 and 2013 about 45% of suicides occurred in patients with a history of alcohol misuse[32].

2.3.1.7 Combination of alcohol and other drugs

People in treatment for alcohol misuse in Bristol are more likely to use alcohol alongside other drugs, which can make treatment challenging. Figure 2.3.1.7a compares the English averages with Bristol for adjunctive drug use[33].

[31] Mental Health Foundation. Alcohol and mental Health. Available from: https://www.mentalhealth.org.uk/a-to-z/a/alcohol-and-mental-health. (Accessed 05/04/2016)
[32] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report – July 2015. Healthcare Quality Improvement Partnership. Available from: http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked2.pdf.
[33] Joint Strategic Needs Assessment (JSNA) report 2015. Data profile of Health and Wellbeing in Bristol. Available from: https://www.bristol.gov.uk/documents/20182/305531/JSNA+2015+v4/fc4df8f4-5c65-4b2e-8ee3-e6ad56f1004f.

Figure 2.3.1.7a: Additional drug use in alcohol clients of ROADS, Bristol, 2014/15; compared with England



Most young people up to age of 18 years, who attend young people's substance misuse services, report that they use a combination of substances, mainly alcohol and cannabis. Patterns of substance misuse in Bristol are also changing among adults. There is an aging population of opiate and crack users, and fewer young adults joining the cohort. It is thought to be due to an increasing use of a range of substances in combination, including alcohol and 'novel psycho-active substances'.

The population of Bristol is relatively young with a median (average) age of 33 years compared to 39 years for England and Wales[33]. It is therefore important for the drug and alcohol treatment system to ensure appropriate targeting of services towards the younger population.

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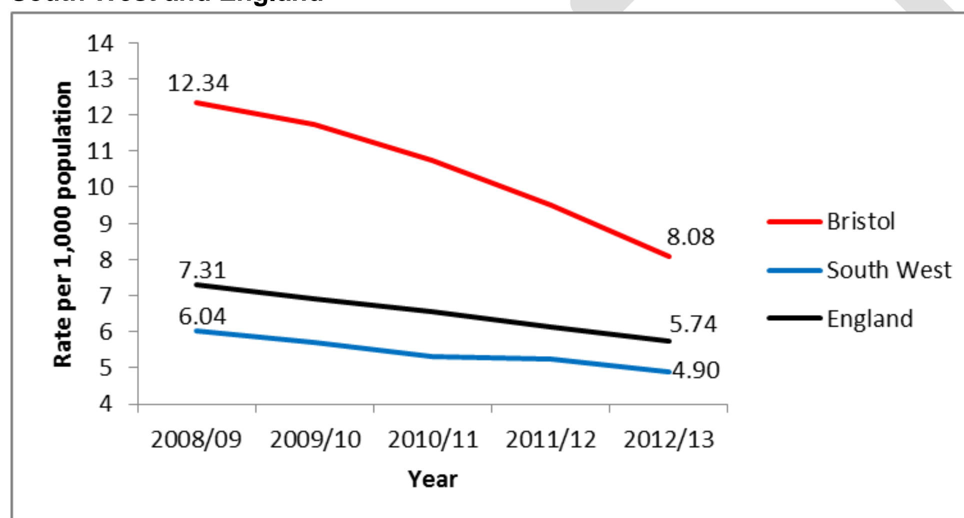
2.3.2 Crime and disorder

2.3.2.1 Alcohol-related crime

Figure 2.3.2.1a shows that alcohol-related recorded crimes (based on the Home Office's former 'key offence' categories) have decreased in Bristol in the recent years. The rate of recorded crime per 1,000 population attributable to alcohol dropped from 12.34 per 1,000 in 2008/09 to 8.08 per 1,000 in 2012/13. However the Bristol rate of 8.08 per 1,000 was still significantly higher than the regional and national average in the same year (4.90 and 5.74 per 1,000 respectively).

In crude numbers, there were 5,081 alcohol-related offences recorded in Bristol in 2008/09 and 3,461 offences in 2012/13. There is a strong correlation between alcohol-related crimes and the night-time economy that brings many Bristol residents and visitors into the city.

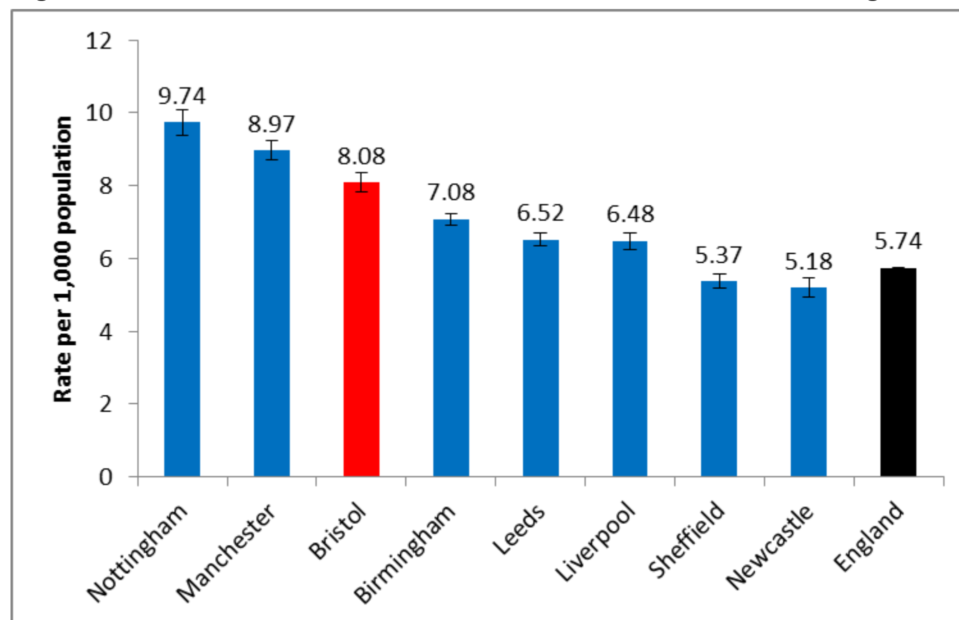
Figure 2.3.2.1a: Alcohol-related recorded crimes, Bristol, 2008/09-2012/13; compared with South West and England[34]



Comparing the core cities, Bristol had the third highest rate of alcohol-related recorded crime in 2012/13 (Figure 2.3.2.1b). To some extent, this could be due to different arrest policies in the different police forces which lead to different reporting outcomes, and to different recording practices by different forces. For example, reporting of domestic violence has increased in Bristol due to the excellent work by operation Bluestone, which has resulted in more victims feeling confident to come forward and report incidences to the police.

[34] PHE. LAPE. Available from: http://www.lape.org.uk/data.html

Figure 2.3.2.1b: Alcohol-related recorded crimes, core cities and England, 2012/13[34]



Also the Bristol rate of alcohol-related violent crime reduced from 7.39 per 1,000 in 2008/09 (corresponding to 3,043 offences) to 5.57 per 1,000 in 2012/13 (corresponding to 2,385 offences). Despite the decline, Bristol rates remained significantly higher than those of the South West (3.66 in 2012/13) and England (3.39 in 2012/13) (Figure 2.3.2.1c).

Furthermore, Bristol had one of the highest alcohol-related violent crime rates out of all the core cities in 2012/13 (Figure 2.3.2.1d).

Figure 2.3.2.1c: Alcohol-related violent crimes, Bristol, 2008/09-2012/13; compared with South West and England

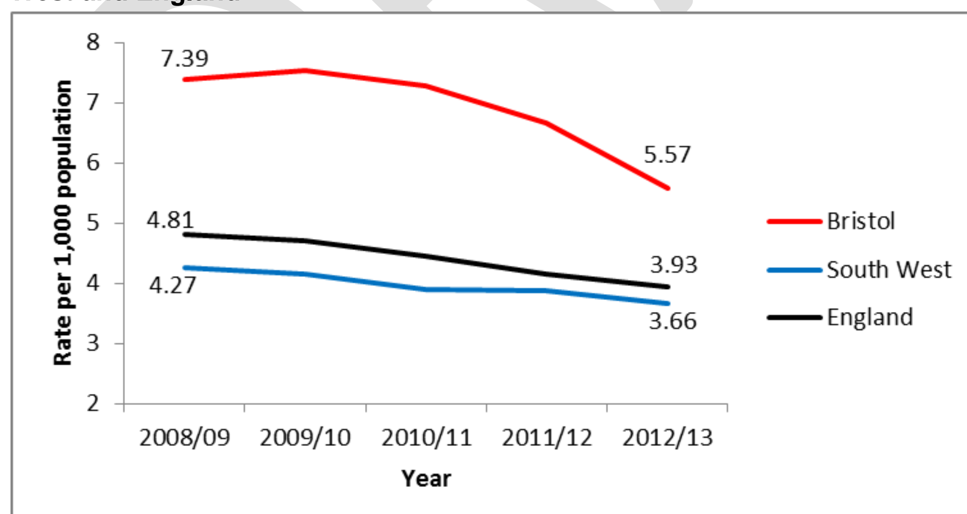
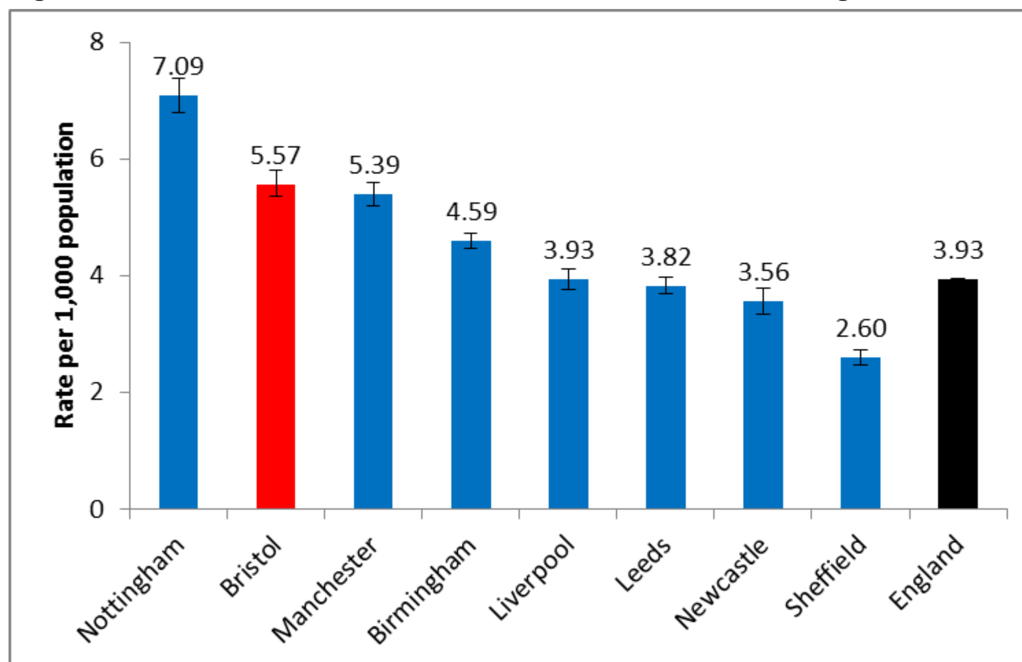
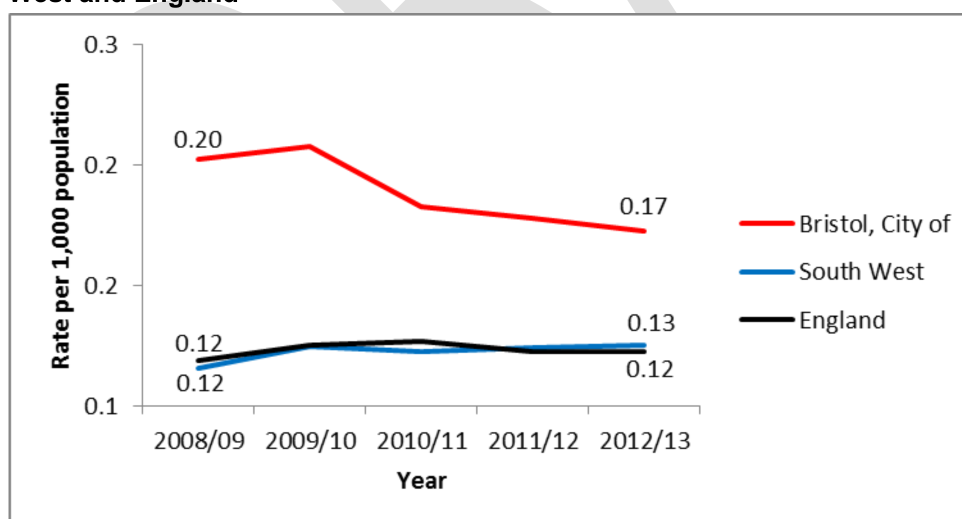


Figure 2.3.2.1b: Alcohol-related violent crimes, core cities and England, 2012/13[34]



In terms of alcohol-related sexual crimes, the number of offences and rates are much lower, locally and nationally. For example, in 2012/13 there were 74 sexual crimes related to alcohol reported in Bristol, corresponding to a rate of 0.17 per 1,000 population which was higher than the national and regional rate in the same year, but the difference was not statistically significant (Figure 2.3.2.1e).

Figure 2.3.2.1e: Alcohol-related sexual crimes, Bristol, 2008/09-2012/13; compared with South West and England



2.3.2.2 Anti-social behaviour

Data about community perceptions of anti-social behaviour is gathered in the annual Quality of Life in Bristol survey.

In 2013, 29% of Bristol residents perceived anti-social behaviour was a problem in their local neighbourhood. This indicator measures concern with anti-social behaviour in the neighbourhood that is likely to include vandalism, graffiti, rowdiness, drunkenness, harassment, drug dealing, prostitution etc. People with lower educational qualifications, Black and minority ethnic people and people living in social housing were more likely to report anti-social behaviour was a problem in the local area[35].

Survey respondents experienced a greater problem specifically from drunk and rowdy behaviour. 50% of residents felt drunk and rowdy behaviour in public places was a problem in the city. This indicator measured a perceived problem in the city rather than in the local neighbourhood. The 2013 percentage represented an improvement since 2009, when the indicator measured 54%, however it still indicated that in the perception of the community alcohol is considered to play a greater role than the data indicates. The highest proportion of concerned residents were from the inner city and deprived areas[35].

2.3.2.3 Alcohol misuse in offenders

A link between alcohol misuse and offending is well known. Overall, the rate of alcohol use among prisoners was slightly lower than that of general population, when comparing those who said they drank on at least one occasion in the previous 12 months (78% of prisoners versus 83% of the general population)[36]. However, amongst those prisoners who drank alcohol in the four weeks before custody, the amount of hazardous drinking was higher than in the general population. They drank alcohol on a median 12 days in the month before custody, and reported consuming similar amounts of alcohol on days on which they drank, a median of 12 units. 63% of prisoners who drank alcohol in the four weeks before custody would be classified as binge drinkers and a third of them said they drank on a daily basis[36].

19% of prisoners (who drank alcohol in the year before custody) reported needing help for an alcohol problem. Alcohol use among prisoners was also associated with reconviction on release (although to a lesser extent than drug use)[36].

In 2009/10, an analysis of 19,225 prison based Offender Assessment System assessments found that 19% of prisoners who received an assessment were reported to have needs in relation to alcohol misuse. Furthermore, 36% of prisoners who received an assessment were reported to have exhibited violent behaviour related to their alcohol use[36].

[35] Quality of Life in Bristol. Quality of Life in your neighbourhood survey results 2013. Bristol City Council. April 2014. Available from: https://www.bristol.gov.uk/documents/20182/33896/qol2014final.pdf/f9b9cb4a-7dc4-4f6c-9dca-5b11d893217d.
[36] Light M, Grant E, Hopkins K. Gender differences in substance misuse and mental health amongst prisoners. Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners. Ministry of Justice Analytical Series. 2013.Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf.

The Bristol Youth Offending Team carried out 1,350 assessments of young people in 2012/13. Of these, 199 (15%) assessments identified that alcohol use was a re-offending risk factor for 114 individuals (some were assessed more than once).

Between April 2012 and March 2013, Avon & Somerset Probation Trust assessed some of their clients to see if they have an alcohol need linked to their offending behaviour. They found that of the Bristol offenders who were supervised in the community and assessed, 54% had alcohol needs.

Prisoners are screened for substance misuse issues at the reception screen. In 2014/15 in HMP Bristol, 36% of new receptions began a drug treatment episode. Of those, 13% were alcohol only users and further 16% alcohol and non-opiate users. There are occasions where prisoners are not honest at reception about their alcohol use, and initially do not receive any intervention. They usually re-present a few days later when they start feeling unwell without any clinical support. In 2014/15, the outcome of the secondary screen showed that monthly additional 38% of prisoners were referred onto Integrated Drug Treatment Service. Of those referrals, 29% were alcohol only users and further 27% alcohol and drug users[37].

2.3.2.4 Alcohol and victims of crime

Evidence suggests that drinking may increase vulnerability to crime, especially among young adults. Over the last decade, in around half of all violent incidents the victim believed the offender(s) to be under the influence of alcohol at the time of the offence. This proportion increases in incidents that occurred in the evening and night, at weekends, and in public places[38].

Alcohol can increase the risk of being a victim of crime such as assault or mugging. Certain population groups are identified as being particularly at risk from these types of crimes, such as students. The Bristol Royal Infirmary A&E department produces monthly reports on the number of people attending A&E after an assault. This is shared with the council crime reduction team and the Police. The data contributes to the intelligence available for police to use to target poorly managed licensed premises.

Alcohol can also be used by victims of domestic abuse as a coping mechanism. In some cases, alcohol can be used by perpetrators to further control and stigmatise victims.

2.3.2.5 Alcohol and accidents

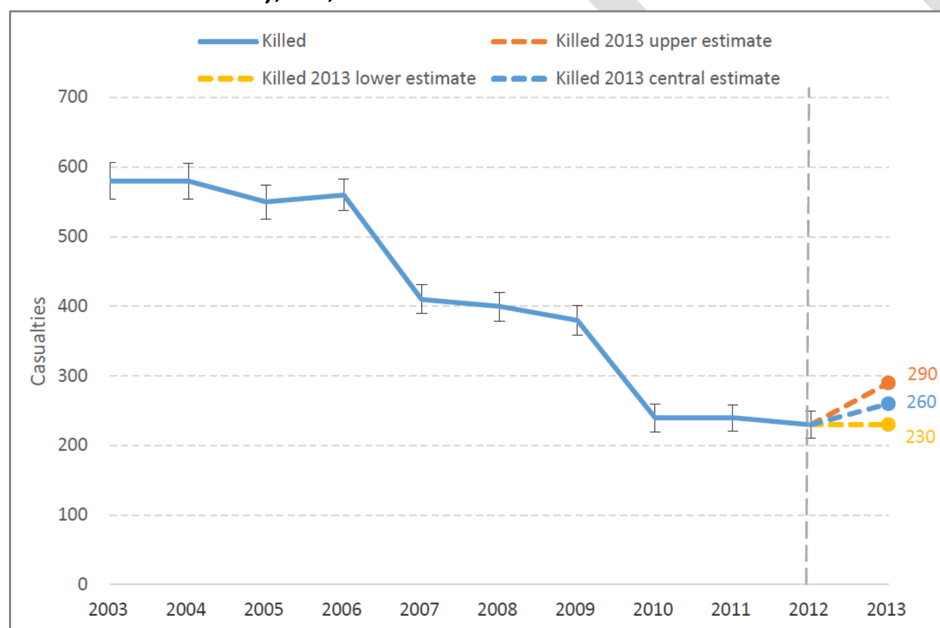
Alcohol is one of the leading factors contributing to accidents, from domestic to traffic related.

[37] Prison Health and Social Care Needs Assessment. HMP Bristol. S Squared Analytics. 2015.
[38] Modern Crime Prevention Strategy. Home Office. March 2016. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/509831/6.1770_Modern_Crime_Prevention_Strategy_final_WEB_version.pdf.

The effect of alcohol or drugs on casualty rates in accidental dwelling fires is well known. In England in 2011/12, there were 8% (2,483) of accidental dwelling fires where impairment due to suspected drug or alcohol use was recorded as a contributory factor. Impairment due to alcohol or drug use resulted in 41 deaths and 1,208 injuries from these fires. The fatality rate is three times higher and the rate of serious injuries is four times higher where drug or alcohol impairment was a contributory factor than where alcohol or drug impairment was not a factor[39].

Alcohol is a recognised contributory factor in road accidents. In the UK in 2013, about 15% of all deaths in reported road traffic accidents involved at least one driver over the drink drive limit. Over the last 10 years, the number of drink drive deaths has been decreasing (Figure 2.3.2.5a). However, there were still about 260 drink drive deaths reported in 2013 which might have been prevented if drivers did not consume alcohol. Furthermore, 8,290 casualties of all types in drink drive accidents were reported in the UK in 2013, of which 1,100 were seriously injured casualties[40].

Figure 2.3.2.5a: Killed casualties in reported drink drive accidents (error bars show 95% confidence intervals), UK, 2003-2013



[39] The effect of alcohol or drugs on casualty rates in accidental dwelling fires, England, 2011-12. Department for Communities and Local Government. December 2012. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/35829/effect_of_alcohol_on_casualty_rates_in_fires_in_the_home_FINAL__2_.pdf.

[40] Estimates for reported road traffic accidents involving illegal alcohol levels: 2013 (second provisional). Self-reported drink and drug driving for 2013/14. Statistical release. Department for Transport. February 2015. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402698/rrcgb-drink-drive-2013-prov.pdf

2.3.3 Harms to children and families

Alcohol misuse can affect families in a range of ways. Parental alcohol misuse can impact on relationships and family functioning, and can impact on a child's environment in many social, psychological and economic ways. It can also be linked to a variety of mental health problems for family members, such as anxiety, depression and social exclusion. Adults who are considered to be 'vulnerable' can be adversely affected either through their own alcohol misuse or because they are at increased risk of abuse and neglect from family members or carers who are misusing alcohol.

Around 30% of children under 16 years of age (3.3-3.5 million) in the UK are living with at least one binge drinking parent, 8% with at least two binge drinkers and 4% with a lone (binge drinking) parent. In 2000 it was estimated that 22% (2.6 million) lived with a hazardous drinker and 6% (705,000) with a dependent drinker[41]. Substance misuse, mental health problems and domestic abuse are key factors in many child protection and safeguarding cases.

In a serious case reviews done by the National Society for the Prevention of Cruelty to Children (NSPCC) it was found that babies are at risk of sudden infant death syndrome if their parents/carers co-slept with their child when under the influence of alcohol or drugs, this was due to overlaying. Children were also at higher risk of accidents (fire, drowning) due to a lack of adequate supervision from an intoxicated parent/carer[42].

The normalisation of alcohol misuse in some families means that children may be more likely to develop alcohol problems themselves in later life, thus continuing the cycle. Intervening can build greater family resilience, which in turn can lead to better outcomes for children.

2.3.3.1 Domestic violence and abuse

The relationship between alcohol and domestic abuse is complex. While it is not possible to state a direct causal relationship that alcohol misuse automatically results in domestic abuse, there is evidence that where domestic abuse exists, alcohol is often present, either for the perpetrator or the victim[43]. Alcohol misuse can increase the severity of violence[44] and is often used as an excuse for violence.

In Bristol in 2012/13, there were 595 Multi Agency Risk Assessment Conferences (MARAC) cases, of those 185 recorded perpetrator alcohol misuse (31%). MARACs are organised for the most serious and high risk cases of domestic violence and abuse.

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[41] Manning V, Best DW, Faulkner N, Titherington E. New estimates of the number of children living with substance misusing parents: results from UK national household surveys. BMC Public Health. 2009; 9(1):377-389.

[42] Learning from case reviews involving parental substance misuse. NSPCC Briefing. November 2013.Available from: https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/parents-misuse-substances.

[43] Galvani S. Grasping the nettle: alcohol and domestic violence. Alcohol Concern's information and statistical digest. June 2010. Available from: http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2014/12/Grasping-the-nettle-factsheet-revised-June-2010.pdf.

[44] Gilchrist E, Johnson R, Takriti R, Weston S, Beech A, Kebbell M. Domestic violence offenders: characteristics and offending related needs. Findings 217. Research, Development and Statistics Directorate. Home Office London. 2003. Available from: http://webarchive.nationalarchives.gov.uk/20110218135832/http:/rds.homeoffice.gov.uk/rds/pdfs2/r217.pdf.

2.3.3.2 Parental substance misuse

Children whose parents/carers misuse alcohol can suffer a range of poor outcomes, including behavioural and/or psychological problems, poor educational attainment, low self-esteem, offending behaviour, and risk of sexual exploitation.

Drug and alcohol misuse is a factor in a significant number of children in need and child protection cases. Evidence suggests that alcohol is a factor in at least 33% of child protection cases, and drug and alcohol misuse is a factor in up to 70% of care proceedings[45].

An analysis of serious case reviews of children found that parental substance misuse was featured in 25% (47/189) of cases reviewed[46]. This may be an underestimate as there is currently no routine screening by children and families services for parental alcohol misuse. Local experience is that parental mental health issues and domestic abuse also commonly featured in serious case reviews, in many cases concurrently with substance misuse.

Maternal alcohol misuse in pregnancy can also be linked to Foetal Alcohol Spectrum Disorders (FASD). These are a series of preventable mental and physical birth defects resulting from maternal alcohol consumption during pregnancy. FASD are lifelong conditions that can significantly impact on the life of the individual and those around them.

2.3.3.3 Young people's alcohol misuse

Young people's misuse of alcohol is addressed as part of a wider range of responses to substance misuse. Alcohol and cannabis are the substances most commonly used by young people. Alcohol use among children and young people can result in a range of adverse outcomes, including organ damage, increased risk of unsafe or regretted sex, teenage pregnancy, unintentional injuries, and being a victim or perpetrator of crime or antisocial behaviour. Early use of alcohol is also a predictive factor in problematic use of alcohol in adulthood.

As shown earlier in Figure 2.3.1.1d, there were 95 persons aged less than 18 years admitted to hospital due to alcohol-specific conditions in Bristol in 2011/12-13/14, which corresponds to a rate of 35.5 admissions per 100,000 population under 18s.This was similar to the national figure in the same time period.

There were 196 young people under the age of 18 years in treatment for substance misuse in Bristol in 2011/12. Of those, 101 used alcohol (16 used alcohol only, 85 used alcohol and cannabis).

[45] Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services. NHS National Treatment Agency for Substance Misuse. 2011. Available from: http://www.nta.nhs.uk/uploads/supportinginformation.pdf.

[46] Brandon M, Bailey S, Belderson P, et al. Understanding Serious Case Reviews and their Impact. A Biannual Analysis of Serious Case Reviews 2005-07. Department for children, school and families. June 2009. Available from: http://www.haringeylscb.org/sites/haringeylscb/files/biennial_review_scrs_200507_brandon-3.pdf.

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Bristol Drug Project provides the Bristol Youth Links Substance Misuse Service, which supports young people who have lower levels of need than those in the treatment services. The service aims to target young people in the earlier stages of substance use in order to prevent escalation into more problematic patterns. In the first three quarters of 2013/14, they saw 215 young people about substance misuse issues, of those 72 (33%) recorded alcohol as the substance that they use most frequently.

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2.3.4 Social and economic harms

2.3.4.1 Worklessness

While the alcohol industry brings benefits to Bristol, alcohol misuse also has a damaging effect on the performance and productivity of our local economy. It can be a barrier to rejoining the labour market for those out of work, and can impact on the workplace through absences and reduced productivity.

It is estimated nationally that up to 17 million working days are lost each year through sickness absence attributed to alcohol[32]. Alcohol misuse may also affect productivity of workers in their workplace and may result in shorter working lives and early retirement.

Alcohol can be responsible for inability to work and unemployment. The prevalence of dependent drinkers among benefit claimants is twice the prevalence in the general population[47]. Being out of work can put people at increased risk of ill health and premature mortality, and can be linked to increased substance misuse and mental ill health, as well as reduced psychological wellbeing.

In Bristol, 47% of patients who started alcohol treatment in 2014/15 self-reported long-term sickness or disability, and 24% of patients were unemployed or inactive. Improving job outcomes for this group is essential to sustaining recovery and requires improved multi-agency responses.

2.3.4.1 Homelessness

Links between alcohol misuse and homelessness are well established, both as a cause and a consequence. Alcohol misuse can impact on an individual's ability to maintain a tenancy; conversely, lack of stable accommodation is considered by many homeless alcohol misusers to be a significant barrier to their recovery.

Physical and mental health problems are prevalent among the homeless population, and evidence suggests that one third of all deaths among the homeless population are a result of drugs or alcohol[48]. In Bristol, housing problem was self-reported by 7% of adults who started alcohol treatment in 2014/15, and urgent housing problem by additional 3% of new treatment starters. Also the Bristol Compass Health, which provides the primary care for homeless people, estimates that 18% of their clients have problematic alcohol use or are dependent drinkers.

[47] Hay G, Bauld L. Population estimates of alcohol misusers who access DWP benefits. Department for Work and Pensions. 2010. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214391/WP94.pdf.
[48] Homelessness: a silent killer. A research briefing on mortality amongst homeless people. Crisis. December 2011. Available from: http://www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf.

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2.4 Cost of alcohol misuse

Alcohol misuse places a significant cost burden on society and a strain on our NHS services.

The estimated cost of alcohol harm to society is £21 billion per year’. This figure takes into account the impact alcohol has on health and other public services, the cost of alcohol-related crime and disorder, the impact of alcohol misuse on worklessness and lost productivity, and the estimated social costs as a result of alcohol misuse. The cost of alcohol-related crime itself was estimated at £11billion[38].

Information on estimated cost to the NHS of alcohol misuse shows that it costs £3.5 billion every year, which is equal to £120 for every taxpayer. This estimate of £3.5 billion is an updated figure to the one given in 2008 when it was estimated that the cost of alcohol harm to the NHS in England was £2.7 billion (in 2006/07 prices). This updated estimate takes into account increases in unit costs as well as more recent and accurate data on alcohol consumption and harm.

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3 CURRENT RESPONSES TO ALCOHOL-RELATED HARM IN BRISTOL

3.1 Education, prevention and campaigns

3.1.1 Prevention work for children and young people

Prevention

The main focus of the approach to tackling alcohol misuse in young people is prevention. This is targeted at all children and young people in the city and is incorporated into other work focusing more widely on substance misuse, with an awareness that alcohol is by far the most likely substance that young people will use. In England in 2013, 39% of young people aged 11-15 years said they had drunk alcohol at least once, compared to 16% who said they had ever taken drugs[49].

The majority of alcohol prevention with young people in Bristol is delivered in schools. Alcohol education is statutory within the school science curriculum, it is often taught within personal social and health education (PSHE), which is non-statutory. PSHE is part of a programme focusing on substance misuse more broadly, under the guidance of the Bristol City Council's Healthy Schools team manager. The guidance focuses on high quality, evidence based drug and alcohol education and knowledge of best practice. It is advised that alcohol education should be part of a whole school approach and should be delivered in both primary schools at Key stages 1 and 2 and secondary schools at Key stages 3 and 4.

Outside of schools, other colleagues within the wider children and young people's workforce are also encouraged to deliver good quality education focusing on the prevention of alcohol misuse among young people. Bristol City Council's Public Health team deliver training on basic drug and alcohol awareness (level 1) and delivering drug and alcohol education (level 2) as part of the 4YP programme and all workers are encouraged to attend these sessions.

Working with Parents

The influence of parents over young people's substance use is also taken into account and campaigns and information are incorporated into other public health work. Examples include advice to pregnant women about alcohol use, advice and information to parents of teenagers based on the guidance from the Chief Medical Officer[50]. Training is delivered through the 4YP training programme for those working with parents, carers and families on how to support their clients to talk to effectively to children and young people about alcohol and drugs.

[49] Fuller, E and Hawkins, V. Smoking, drinking and drug use among young people in England in 2013. Health and Social Care Information Centre. 2014. Available from: http://www.hscic.gov.uk/catalogue/PUB14579/smok-drin-drug-youn-peop-eng-2013-rep.pdf

[50] Donaldson, L. Guidance on the Consumption of Alcohol by Children and Young People. Department of Health. 2009. Available from: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110256.pdf

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The Safeguarding Children's Substance Misuse Group, which reports to Bristol Safeguarding Children's Board, has produced a protocol for agencies working with drug using parents to ensure that the safeguarding of children is prioritised and that recommendations from previous serious case reviews become part of service delivery. The council's Safer Bristol team commission Hidden Harm work from the Drugs and Young People Project to reduce risk and build resilience with young people who have child protection concerns. This work has recently been evaluated and there is significant evidence to show that it effective in reducing risk and building resilience among these young people, reducing the likelihood that these young people will grow up with substance misuse problems.

Hidden Harm work is also offered within Bristol Youth Links service for those aged 9-19 years who fall outside the threshold for social care involvement.

Training for the children and young people's workforce on working with children affected by Hidden Harm issues is available through the 4YP programme.

3.1.2 Adult prevention work

Identification and Brief Advice (IBA) is a cornerstone of adult prevention work. This means that people are screened using set questions to find out their level of alcohol use. If they are found to be drinking above guidelines, they are given information and signposted to appropriate services.

IBA services have been developed and are operational in:

- Bristol Royal Infirmary Accident and Emergency Department, the Medical Assessment Unit, and some wards;
- Some wards in North Bristol NHS Trust;
- GP practices who operate the National Direct Enhanced Service (for new registrations), or the Public Health Alcohol Service (for patients with hypertension, newly diagnosed depression, or who have been to hospital with an alcohol misuse related injury);
- Custody suites.

An IBA service is being developed for pharmacies, aimed at people who buy hangover cures for gastric problems.

In addition Public Health trains front-line workers to deliver IBAs. Workers already trained include: Support to Stop Smoking workers, sexual health services staff, health visitors, community workers for older people, and children's centre staff.

Social Marketing campaigns have been carried out to raise awareness about alcohol and its risks. The DrinkSmart campaign has been operational since 2010, and includes self-help materials for people who are concerned about their alcohol use and want to make changes. Targeted campaigns include: a series of campaign aimed at young people using the

council's Ministry of Cheer web site, a safeguarding vulnerable people campaign aimed at carers who drink, and pharmacy campaigns targeting people with high blood pressure.

Alcohol awareness sessions have been developed for front-line workers.

3.2 Treatment and care

3.2.1 Treatment and care for children and young people

Early Intervention

Funding is in place to deliver early intervention work with young people as part of the Bristol Youth Links programme. This is provided by Bristol Drug Project and is mainly delivered in secondary schools. The Youth Links Service is the first point of referral for young people aged 19 and under living in Bristol who need extra support because of their alcohol or drug use. They may be offered up to six 1:1 sessions or they may attend group work. The worker helps them to think about how they can make positive changes to their alcohol use, including cutting down and stopping, in order to reduce risks. Referral into this service can be made by anyone and the referral pathway is dealt with in detail in the 4YP level 1 training.

Treatment

Young people who misuse alcohol and have more complex needs are referred into the young people's substance misuse treatment services. Bristol City Council's Safer Bristol team commissions two treatment services, with funding from Bristol Public Health and the Police and Crime Commissioner.

The first is the Young People's Substance Misuse Treatment Service, which supports young people with mental health problems and other health needs and is based in Children and Adolescents Mental Health Service (CAMHS). The second is the Drugs and Young People's Project, which supports young people who have social work involvement and is based in the council's Children and Families Service. There is also a treatment worker in the council's Youth Offender Team (YOT). Current practice is for these agencies to work together as one treatment service. Treatment is care planned with the young person and may include psychosocial elements, harm reduction, prescribing and family support, depending on the young person's needs.

3.2.2 Treatment and care for adults

The "Recovery Orientated Alcohol and Drug Service" (ROADS) is an integrated adult substance misuse service available across Bristol for access to structured interventions aimed at overcoming physical and psychological dependence on alcohol and drugs as well as offering support around housing, education and employment. Support for families and carers who are affected by the alcohol use of others are provided as part of ROADS to reduce the wider impact alcohol has on communities.

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ROADS is comprised of 5 Clusters designed to operate as a single integrated treatment system (Appendix 1). The 3 treatment clusters (Engagement, Change and Completion) deliver appropriate interventions dependent on a client's stage of change. Engagement focuses on engaging individuals into treatment and delivers low threshold brief interventions. Change provides higher tier structured treatment interventions including specialist services for people with complex needs and inpatient detoxification & access to residential rehab. Completion offers post-treatment support around training, education, volunteering and employment to enable people to reintegrate with their community.

Advocacy and support for families and carers is delivered by the Support cluster whilst Housing Support provides accommodation and support for people to sustain their tenancies.

There are multiple referral routes into ROADS, including self-referral, GPs, hospital, Job Centre and the criminal justice system to ensure services are accessible for all the people in need of them. The services on offer respond to the varying needs of Bristol's problematic drinkers and work to motivate and support people to achieve sustained recovery from addiction. This reduces the negative impact alcohol has in Bristol.

In the hospitals there are alcohol nurses in the Bristol Royal Infirmary and at Southmead. These nurses provide support and extended interventions for dependent drinkers and work with self-harmers whose harming is linked to alcohol, some also provide symptom triggered prescribing for patients. There are sound safeguarding processes in place for children and vulnerable adults, and good working relations with the mental health team. The alcohol nurses cover A&E, the hepatology ward and the medical assessment unit.

Alcohol-related problems are a big and increasing part of the primary care workload. Most practices screen new registrations for alcohol misuse, and some operate a local alcohol service targeting people with specific ailments.

Some GPs offer community detoxification in partnership with the treatment services. ROADS Complex Shared Care nurses work in primary care in areas where there are high numbers of problem drinkers. They support GPs to work with clients with complex needs to enable their care to remain within their local practice and GPs have further support from the ROADS lead consultant to support the delivery of primary care based interventions.

The Clinical Commissioning Group commissions hospital services and there are a number of planned care pathways that relate to alcohol, for instance inpatient and outpatient hepatology services for cirrhosis of the liver.

3.3 Alcohol-related crime & disorder; night-time economy

3.3.1 Police

The Police have developed their operational approach to policing the night-time economy. Called 'Brio' this approach combines public order policing, which uses identification and

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targeting of problem areas, with uniformed officers entering specific licensed premises to identify drunkenness or underage drinkers.

On a typical Saturday or Sunday night (22.00-04.00), in the Bristol city-centre night-time economy area, the police deal with an average of six violent crime offences. Of these three are recorded as involving Actual Bodily Harm with the bulk of the remainder being for more minor violent crime or disorder offences. In addition to this there are usually more than ten reported incidents of Anti-Social Behaviour which the police respond to, they also deal with spontaneous demand from bad behaviour observed by patrolling officers. For the overwhelming majority of these crimes and incidents alcohol is deemed to be a significant factor. The police response to this demand involves the deployment of a significant number of additional officers on these nights.

The Police also work with licensed premises to seize and return identity documents used by underage people to gain entry to licensed premises.

The Police Public Protection Unit delivers a specialist approach to incidences of domestic violence, and there is a defined referral process for children at risk within chaotic households.

3.3.2 Probation

Since June 2014 Probation Services in Bristol have been delivered by two organisations – the National Probation Service (responsible for advice to the courts and the supervision of offenders assessed as high risk of harm) and a Community Rehabilitation Company (covering Bristol, Somerset, Bath, Gloucester and Wiltshire, and responsible for the supervision of offenders assessed as low and medium risk of harm). Their responsibility is to protect the public and reduce reoffending by delivering the punishment and orders of the courts and supporting rehabilitation by helping offenders to change their lives.

As part of this work they assess the people they supervise to find out whether the misuse of alcohol contributes to their offending behaviour. People can be referred to a range of interventions around problematic alcohol use, including the Drink Impaired Drivers Programme, the Low Intensity Alcohol Programme or the Building Skills for Recovery Programme.

Other structured interventions are available as part of community orders or post-release Licences and if the person is drinking at dependent levels they can be referred to specialist services sometimes by using the Alcohol Treatment Requirement associated with a community order.

The National Probation Service also supervises offenders included in the IMPACT (serious acquisitive offenders often with multiple substance misuse) and IRiS cohorts (dangerous offenders).

3.3.3 The Bristol Council's services

Licensing Service
This service has two key areas of responsibility for alcohol: administration of the Licensing Act and enforcement work. The Licensing Service conducts proactive inspections at alcohol licensed premises to ensure compliance with premises licence conditions and other related legislation. The Service undertakes to work with licence holders in effecting compliance, recommending and ensuring improvements where necessary, but takes punitive action where necessary.

Trading Standards Service
This service enforces legislation regarding the sale, supply and use of illicit alcohol products and underage sales. They use an intelligence led approach to achieve compliance and respond to complaints alleging the illegal sale of alcohol products. The Service can undertake checks for compliance for underage sales and works in partnership with other enforcement agencies to tackle the problem of underage sales, and of counterfeit and smuggled alcohol products.

Crime Reduction and Substance Misuse Team
This team works with retailers to improve the management of the night-time economy through initiatives like Pubwatch. They operate the CCTV presence in the city centre which contributes to reducing alcohol fuelled disorder.

3.3.4 Joint working

Partners in Bristol have a co-ordinated approach to dealing with licensed premises that sell alcohol illegally or irresponsibly. The regulatory authorities: council licensing, Police licensing, planning, pollution control, environmental health work together to identify problem premises and take action through a Joint Tasking process. Problem premises are 'Red' tagged and worked with to improve their performance against the National Licensing Objectives. There are joint enforcement visits involving the Police, council licensing and trading standards staff.

Bristol's management of its lively and attractive night-time economy has resulted in the award of Purple Flag Status for the last three years.

3.4 Targeting and protecting vulnerable groups

3.4.1 People with complex needs and chaotic lifestyles

Police and council workers address street drinking issues by supporting the work of the Streetwise Team (a joint police/council team) who use the integrated offender management method to assist street drinkers to change their offending behaviour and address their alcohol misuse.

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Bristol runs two 'wet sessions' a week where street drinkers can access, health services, housing advice and mental health workers. The Wet Clinic is the only GP lead health clinic for street drinkers in England.

The Big Lottery 'Fulfilling Lives – Multiple Needs' project started in 2014, it will enable people with chaotic lives and complex health and social issues to access help, and be case managed by specialist workers.

The re-commissioning of Bristol Mental Health services in 2014 will result in a new Assertive Engagement Service for people with chaotic lifestyles and complex needs, many of the most vulnerable dependent drinkers will be able to access this service. Formerly the mental health services were unable to assess or treat dependent drinkers.

3.4.2 Children, young people and families

Young people's treatment services are delivered by three agencies, forming an integrated treatment team. These are:

- The Young People's Substance Misuse Treatment Service (YPSMTS), which is part of Children and Adolescent Mental Health Service (CAMHS) and works with young people up to the age of 18 years with substance misuse problems and complex needs.

- The Drugs and Young People Project (DYPP), which is part of Children and Young People's Services (CYPS) and works with young people who misuse substances and have social workers.

- The Youth Offending Team which supports young offenders who also misuse drugs and alcohol.

DYPP also supports young people with social workers whose parents and carers misuse drugs and alcohol. The child protection concerns for most of these families are closely related to their parents' substance misuse.

Early intervention work is delivered by Bristol Drugs Project, as part of 'Bristol Youth Links' targeted work. They work with young people who are using drugs and alcohol and with those whose parents use drugs and alcohol where there is no social care involvement.

Support for families of alcohol misusers is provided by Developing Health and Independence (DHI) in the new ROADS service.

4 VISION FOR BRISTOL

Our vision for Bristol:

To create safe, sensible and harm-free drinking culture in Bristol,
through partnership working and using the best available evidence
in order to ensure the following:

- Bristol is a healthy and safe place to live, work and visit.
- People of Bristol are drinking within the nationally recognised guidelines.
- Individuals and families are able to access the right treatment and support at the right time.

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5 OUR STRATEGY

5.1 Aim of the strategy

The overarching aim of the strategy is to prevent and reduce the harm caused by alcohol to individuals, families and communities in order to ensure Bristol is a healthy and safe to live work and visit.

This can be achieved through partnership working and using the best available evidence of what works.

There are three broad aims:

1	**Increase individual and collective knowledge about alcohol, and change attitudes towards alcohol consumption.** (PREVENTION/CAMPAIGNS)	*Alcohol Prevention Workstream*
2	**Provide early help, interventions and support for people affected by harmful drinking.** (ACCESS TO SERVICES AND PATHWAY FOR LIVER DISEASE)	*Alcohol Intervention Workstream*
3	**Create and maintain a safe environment.** (REDUCTION OF AVAILABILITY AND ACCESSIBILITY, SAFE NIGHT TIME ECONOMY)	*Alcohol Environment Workstream*

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6 STRATEGY WORKSTREAMS

		ALCOHOL PREVENTION (Workstream 1)	ALCOHOL INTERVENTION (Workstream 2)	ALCOHOL ENVIRONMENT (Workstream 3)
Aim		**Increase knowledge and change attitudes towards alcohol**	**Provide early help, interventions and support for people affected by harmful drinking**	**Create and maintain a safe environment**
Team	**Lead**	Becky Pollard	Dr Martin Jones	Supt Rhys Hughes
	Coordinator	Leonie Roberts	Dr Kate Rush, Kath Williams	Insp Martin Rowland, Nick Carter
	Members	Sarah Westlake, Cllr Claire Hiscott, Petra Manley, Blanka Robertson, Jackie Beavington, Geraldine Smyth, Liz McDougall, Rob Bennington	Lynn Stanley, Dr Anne McCune, Dr Tim Williams, Sally Arnold-Jones, Jude Carey, Blanka Robertson	Michelle Phillips, Sally Arnold-Jones
Suggested outcomes		• **Reduce alcohol consumption causing harm to individuals, families and communities in Bristol**	• **Reduce alcohol related harm to individuals** • **Earlier identification of health harm caused by alcohol** • **High quality evidence-based treatment to reduce alcohol related harm** • **Children and young people free from alcohol related harm**	• **Reduce individual and community impact from alcohol related crimes and anti-social behaviour** • **Protect vulnerable people from alcohol related harm** • **Reduce demand on public and emergency services** • **Safe events held within the City; reduce alcohol related incidents**
Suggested outputs		• Improve community discussion about alcohol leading to change of attitude and behaviour to alcohol consumption • Increase knowledge about recommended limits and about the health risk of not drinking in moderation • Increase staff information and training on alcohol awareness and harm • Reduce stigma and shame associated with alcohol dependence • Increase skills of people to drink within the recommended guidelines • Advocacy role to reduce the availability of alcohol and increase the price	• Improve screening and detection of alcohol-related health harm in primary care • Reduce alcohol related hospital admissions • Improve individual and family access to treatment and support • Increase successful completion of treatment	• Develop multi-agency information sharing at tasking meetings • Enforcement of alcohol related violence • Increase knowledge of legal and social responsibilities within the licensed trade • Effective monitoring of cumulative impact areas • Reduce community impact of the street drinking community

7 DELIVERABLES AND ACTIONS

Alcohol Prevention (Workstream 1)					
Suggested Actions	**Evidence and/or Baseline**	**Activity/Targets**	**Timescale**	**Lead Agency**	**Contributing Agencies**
Social marketing Deliver a large-scale social marketing campaign across Bristol City	The Government's Alcohol Strategy, HMGovernment, 2012 UK Chief Medical Officers' Alcohol Guidelines Review, DoH, 2016 EU Social marketing guidance [Evidence\social-marketing-guide-public-health.pdf](Evidence\social-marketing-guide-public-health.pdf)	Scoping document produced– steering group formed. Target audience identified.	2016	Public Health and Addictions Health Integration Team	Public Health England
		Development of a social marketing plan.	Start 2017		
		Implementation e.g. social media, media stories.	2018		
		Evaluation report produced, e.g. number of campaigns, number of people reached, feedback from stakeholders.			
Social Marketing Deliver preventative campaigns using social marketing tools and methods Use social marketing tools to gather intelligence about attitudes to alcohol use and drinking behaviour		Implement Public Health England OneYou campaign across Bristol	2016/2017	Public Health delivery teams/Public Health England	Public Health England
		Dry January Campaign		Public Health Strategic and Delivery Teams	
		Promote use of Drinkaware Application			
		Introduce Alcohol Free Zones at public events		Bristol City Council Events Team	
		Host the Alcohol Big Debate		Public Health Strategic and Delivery Teams	

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Education in schools – Implement alcohol education in schools Develop work with schools about delivering training for parents Work with young people and adults with caring responsibilities		Increase the number of schools delivering alcohol education within PSHE, according to best practice recommendations.	2016/17	Public Health- Children and Young People's Strategic Team and Children and Young people's Delivery team	
Workplaces Work in partnership with businesses across the city to promote and support the development and implementation of workforce alcohol policies and interventions to reduce alcohol-related harm in the workplace	Health and Safety Executive https://www.bhf.org.uk/publications/health-at-work/health-at-work-guide-to-alcohol http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2015/03/Alcohol-and-the-Workplace.pdf http://www.cipd.co.uk/NR/rdonlyres/EFE87A7D-B088-43C0-A0B5-B6F71DA1E678/0/mandrgalcmisuseg.PDF	Provide alcohol awareness training for local employers (first priority – organisations signed up to the Workplace Wellbeing Charter. Currently 30 organisations who employ 30,000 staff). Support Charter organisations to achieve the Alcohol standard (this includes policy, practice and support to staff - target 20 organisations). Provide brief intervention training for Charter organisations. Provide materials and resources to assist organisations to promote awareness amongst their own staff (using One You materials). Include guidance and campaigns which promote alcohol awareness in monthly Health at Work Newsletter.	January 2017	Public Health	
Alcohol Workplace policies Review Bristol City Council alcohol policy and support available for employees with alcohol problems.	Alcohol and Substance Misuse Policy NICE Guidance PH24 https://www.nice.org.uk/guidance/ph24	Policy reviewed Brief intervention and e-learning module developed.	2016/17	Public Health	

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Workforce (Making every contact count) Deliver Alcohol Identification and Brief Advice training (IBA) to groups including but not limited to pharmacists and tenancy support officers Workforce development in alcohol IBA - (making every contact count	NICE Guidance PH24 https://www.nice.org.uk/guidance/ph24 http://www.alcohollearningcentre.org.uk/eLearning/IBA/	Commission Pilot Pharmacy Alcohol Identification and Brief Advice Service (IBA)	2016/17	Public Health	
		Plan the roll out of IBA to professionals in health care and non-health care settings.			
		Develop and implement mechanism for training follow-up			
Community Encourage parents to have conversations with their children through a social marketing campaign Develop training on supporting parents to talk to their children on the harms of alcohol.		4YP parents' campaign launched April 2016. Evaluate after 6 months. Re promote every six months through schools, GP surgeries, parent support groups, Think Family, Early Help etc.	Launch April 2016. Evaluate Oct 2016. Re-promote Nov 2016. Evaluate March 2017	Public Health-Children and Young People's Strategic Team and Children and Young people's Delivery team	
		Alcohol will be included in redesigned 4YP training programme, especially in the course focusing on supporting parents to talk to children and young people about difficult issues.	New courses launched 2017	Public Health-Children and Young People's Strategic Team and Children and Young people's Delivery team	
Community Develop community engagement strategies.		Enable Neighbourhood Partnerships to develop local action plans to address the harms related to alcohol.	2016/17	Public Health Strategic and Delivery Teams	Bristol City Council
		Promote community events that don't involve alcohol.			
		Encourage local licensed businesses to promote alcohol-free hours during opening times.			

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Alcohol Intervention (Workstream 2)

Planning

Suggested Actions	Evidence and/or Baseline	Activity/Targets	Timescale	Lead Agency	Contributing Agencies
Needs assessment Provide an overview of current service provision of Bristol Recovery Orientated Alcohol & Drug Service (ROADS) against need and identify how services can meet the identified needs	Needs assessment	Health needs assessment Review current service provision (multidisciplinary) Identify unmet needs Identify how services can address unmet needs	Complete 2016	Substance misuse team	Public Health
Mapping of existing services	None	A comprehensive mapping exercise to capture all existing services (primary care, secondary care, specialist)	End 2016/ 2017	Substance misuse team	CCG
Mapping of patient pathway – specialist services	None	Consider service provision from patient perspective Identify potential changes/improvements to inform re-commissioning process		Substance misuse team	Healthwatch
Evidence review and economic evaluation		Understand the current evidence base including cost effectiveness in relation to specific services/interventions (e.g. alcohol nurses) Collaborative working with South Gloucestershire. Short life working group to be established to define parameters of work	To commence Autumn 2016	Bristol CCG/Public Health	In conjunction with South Gloucestershire CCG
Primary care review Review of screening and identification used within primary care to include alcohol and liver disease	NICE CG115 Audit will provide baseline	Audit of current practice	Apr - Jul 2016	CCG	
		Repeat audit	Apr 2017		
Activity data Review of secondary care data (Commissioning for Value datasets) and explore opportunities	Right Care – Commissioning for value datasets	Initial review of opportunities and deep dive to test initial findings	End 2016	CCG	

Alcohol Intervention (Workstream 2)					
Delivery					
Suggested Actions	**Evidence and/or Baseline**	**Activity/Targets**	**Timescale**	**Lead Agency**	**Contributing Agencies**
System approach to alcohol and liver disease Development of a system approach to alcohol treatment and liver disease (all causes)	NICE CG115 Lancet 'Addressing Liver disease in the UK'	Develop a standardised approach for screening and identification within primary care using outcomes from audit	Jul - Oct 2016	CCG	Secondary Care (UHB and NBT)
		Develop clear pathways between primary care, community care and secondary care services	Jul 2016 – Jul 2017		
		Explore new models of working including non-invasive measurement of fibrosis and outreach management of cirrhosis complications e.g. elastography		Public Health – pilot, CCG – longer term	Secondary Care, Local Authority Commissioning, GP practices, Service providers
Harm minimisation for high risk groups	Needs assessment	Identify treatment resistant cohort Address through harm reduction strategies incorporated into re-commissioning process	Jul-Oct 2017	Substance misuse team	
Young People Promoting the young people's substance misuse pathway across all agencies working with children and young people	Baseline to be determined following review of training delivery	Training programme delivered by Public Health Number of people in the children and young people's workforce who are trained to screen young people, identify those who are using alcohol and refer them into the Bristol Youth Links early intervention service	Apr 2016 – Mar 2017	Public Health- Children and Young People's Strategic Team and Children and Young people's Delivery team	

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Training and education – Healthcare staff					
GP training	NICE CG115	Update for GPs on current pathways and best practice in relation to alcohol/liver disease incl. mutual aid	October 2016	CCG	Secondary care (UHB and NBT)
Explore the opportunities for online training for ambulance staff and information sharing with primary care	None	Review online Identification and Brief Advice (IBA) training		Public Health	
		Develop electronic information sharing with primary care		South West Ambulance Service	
Develop Paramedic training at UWE in IBA	None	Scoping		South West Ambulance Service	
Mutual aid training for practice based staff (PMs/Community resource co-ordinators)	Measure through representations – Proportion who successfully completed treatment in the first 6 months of the latest 12 month period and re-presented within 6 months	Run a specific Facilitated Access to Mutual Aid training session for all practice managers		Substance misuse team Bristol City Council	

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Alcohol Environment (Workstream 3)					
Suggested Actions	**Evidence and/or Baseline**	**Activity/Targets**	**Timescale**	**Lead Agency**	**Contributing Agencies**
Wider use of technology Increase the availability of technology to improve the quality of information and evidence		Real time Sec 35 dispersal information sharing with partners (app to circulate photos of those issued orders to increase likelihood they will actually disperse)	6-12 months	Police	Bristol City Council
	Number of incidents reported by taxi marshals 15/16	Issuing of body-worn cameras to taxi marshals		Bristol City Council	
Diversionary events/activities Provide an alternative to traditional night time economy activities		Diversionary events/activities in areas of high alcohol use and/or proliferation of licensed premises – use links to events managers	6-12 months	Bristol City Council	Police
Brio night time economy operation Continue to develop this operation into a multi-agency approach to Bristol night time economy		Enhancement to Police Night Time Economy Operation through implementation of mini multi-agency operations and thematic leads within police teams for issues such as taxis, drugs, underage sales etc.	6 months	Police	
Intelligence sharing between agencies Enabling an intelligence led, effective and efficient multi-agency approach to dealing with alcohol related issues across the City		Monthly review meetings Weekly Brio debrief/review meetings	Immediate	All agencies	All agencies
Identification and management of problematic licensed premises Improving the safety of establishments	Number of 'red' premises in 15/16 and average time at red	Police and Bristol City Council Joint Enforcement Team tasking group delivering targeted multi-agency work towards problem premises	Immediate	Bristol City Council	Police
		Monitor length of time premises stay as 'red or high risk'			
Training and awareness for licensed trade staff Raising awareness of CSE and other vulnerability issues. Early recognition by staff		Training for Licensing Sub-Committee members on aims of strategic plan Adoption of Child Sexual Exploitation awareness training by Security Industry Association	6-12 months	Bristol City Council	
Alcohol Recovery Centre Reducing demand for NHS and police. Improved early care for users. Demographic data will assist other work streams	Number of Alcohol Recovery Centre (ARC) users for 15/16	Monitor demographic data of users. Number of users Night Time Economy	3-6 months	South Western Ambulance Service NHS Foundation Trust	
	Number of days ARC deployed	Consider signposting to other care paths where appropriate			

Re-invigoration of the Pub-Watch Scheme Improve the cooperation of licensed premises to ensure a safer environment		Review of current process involving all stakeholders to suggest new approach	6-12 months	All agencies	All agencies plus Trade
Management of Cumulative Impact areas To ensure areas are monitored to manage the number of licensed premises		Review of current zones for effectiveness and scoping for potential new areas (Stapleton Road/Church Rd/Arena)	6 months	Bristol City Council	Police
Structured approach to licensing implications for larger events		Joint Enforcement Team to review events calendar and suggest suitable events for approach and protocol for managing licensing applications	6-12 months	Bristol City Council	Police
Providing support for people using and working in the City Centre during the night time economy Identification of vulnerable people due to alcohol consumption, providing a safe environment	Number of incidents reported to Bristol Stand against Racism and Inequality (SARI) by staff working in the Night Time Economy Number of hate crimes reported	Develop strategies and interventions to help people working in the Night Time Economy e.g. taxi/bus drivers Education re CSE and vulnerability	12 months	Bristol City Council	Police, Bristol Stand against Racism and Inequality, Transport providers
Providing support to vulnerable people within the street drinking community	Number of homeless people recorded (Charity and BCC data)	Deliver on the joint strategy for the homelessness situation	12 months	Bristol City Council	
		Provide interventions and support for street drinkers			
	ASB and other crime related calls	Enforcement activity to reduce ASB/criminality			

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APPENDICES

Appendix I

Bristol Recovery Orientated Alcohol & Drugs Service (ROADS)

The new Bristol ROADS was launched in November 2013 following a competitive tendering process. It is a single service consisting of 5 clusters delivered by different providers working together to deliver the Public Health Outcome 2.15: Increase the number of problematic substance misusers who successfully complete drug treatment, and Public Health Outcome 2.18: Decrease the numbers of alcohol related admissions to hospital.

All providers are supported by SARI & The Diversity Trust to ensure delivery of culturally competent services responsive to the needs of Bristol's population.

ROADS links with different forms of Mutual Aid including SMART, AA, NA, CA and FA in order to support clients' recovery journey.

Breaking Free Online an on-line treatment and recovery programme offers support and tools to sustain individual treatment benefits is also offered to all clients.

Engage Cluster

Delivered by St Mungo's subcontracting with Bristol Drugs Project (BDP) and AWPT Bristol Specialist Drug & Alcohol Services (BSDAS).

Engagement offers people their route into ROADS treatment and support services and is designed to work with people experiencing problems with a broad range of substances:

- primary alcohol users
- opiate users (OUs)
- non -opiate users (NOUs) including users of New Psychoactive Substances (NPS)
- prescribed and over the counter medicines.

A key role for Engagement is to 'set the tone' for an individual's treatment and recovery journey, whether this is their first contact or the most recent over, perhaps, a long period. Service users will be encouraged to 'try change' through asset-based assessment and high visibility of recovery – through images, conversations, Peers involvement in service delivery and through 2 Trainee posts which will offer progression into work opportunities for Peers and other volunteers who have a history of problematic drug or alcohol use.

The key elements of Engagement are:

1. Triage, comprehensive assessment and Recovery planning

Service users are assessed using an asset-based assessment system – which assesses individual need at the point of initial referral and then refers to appropriate ROADS interventions.

It’s important to stress that this single system isn’t a single physical point of contact – which would make it more difficult for people across Bristol to access – but a service delivered at multiple locations including over 50 GP Surgeries. BDP’s main premises at 11 Brunswick Square, BS2 8PE will offer direct access for self-referrals Monday –Friday 9am – 8pm and Saturday 10am – 5pm.

Referrals from other agencies will be made using a simple faxed referral form and many will continue to be self-referrals.

2. Assertive Outreach
Targeting individuals and groups who aren’t in treatment but who can benefit from advice and information to reduce risk - and, where appropriate, can be supported into treatment.

Reaching out to particularly vulnerable or under-represented populations’ e.g. street homeless, female sex workers as well as early adopters of ‘new’ substances e.g. LGBT community and student population through regular involvement in night time economy events.

3. Low threshold and brief interventions
There are separate routes for primary alcohol and primary drug users – to offer maximum choice for people.

Primary alcohol pathway:
AUDIT will be used to identify severity of alcohol use and the most appropriate interventions:

- AUDIT score 8-15 Alcohol Brief Intervention (ABI) at assessment or single 30 min session if needed;
- AUDIT score 16-19 ABI at assessment plus onward referral to Controlled Drinking Group or up to 3 x 1-1 sessions;
- AUDIT score 20+ ABI at assessment then onward referral to CHANGE.

Group work for Controlled Drinking, Preparation for Alcohol Detox and Alcohol Detox Support groups are held weekly at venues in North (Gloucester House, Southmead Hospital); Central (Colston Fort) and South Bristol (Knowle West Media Centre).

Primary drug pathway offers:

- Brief interventions for users of non-opiates or new psychoactive substances– with integrated ITEP mapping.
- And Preparation for Recovery groups (2 groups a week). These build motivation for change and offer a clear pathway for criminal justice referrals.

4. Needle and Syringe Programme

5. Harm reduction and healthcare interventions
Interventions designed to reduce harm and death including:

- Dry Blood Spot Testing for HBV/HCV testing will be offered ‘there and then’ to people who express interest in having a test;

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- ‘Super Accelerated’ HBV vaccination (course complete in 21 days), targeting at-risk populations;
- Safer Injecting, Overdose Prevention and Naloxone training and supply: Naloxone reverses the effect of opiates/opioids and can save lives if rapidly administrated.

Other groups for targeted harm reduction work are people using controlled substances like Ketamine – which can causes significant urinary tract damage and those using New Psychoactive Substances – where little may be known about their chemistry or effects.

6. Transitions from Young People’s Drug Treatment Services

BSDAS will have a dedicated role to ensure the safe transition of young substance users from Bristol’s Young People’s Drug Treatment Service to adult services – where appropriate. This will involve joint working during a 4-6 month period before a young person needs to move into ROADS but the main aim of this work will be to secure a successful exit from treatment wherever possible.

Change Cluster

Delivered by BSDAS with sub-contractor BDP.

The Change Cluster provides the core treatment elements of ROADS working with both drugs and alcohol and focus on detoxification and abstinence. It will be client-focused and offer a range of psychosocial group work and individual care packages to support the effectiveness of the clinical interventions offered.

Services will be delivered from Colston Fort (which will retain an alcohol and abstinence focus), Stokes Croft (which will take on a ‘Complex’ focus and continue the dispensing function), and a number of BDP sites. There will also be satellite group work provision in the North, South and Centre of the city to increase access.

Following assessment in the Engagement Cluster, service users will have an individual care plan which will contain a number of the following treatment options. Care will be co-ordinated and reviewed throughout the Change Cluster and on exit.

1. Shared Care:

The Change Cluster will increase support for primary care, enabling people to be cared for by their GP, rather than needing referrals to specialist provision.

This service offers a layered approach including an Enhanced Shared Care service for people pursuing abstinence. There will also be a Complex Shared Care element which will provide nurses with six surgeries to work with clients with alcohol and dual diagnosis issues.

2. Specialist Prescribing:

This includes detoxification, substitute prescribing and prescribing to prevent relapse. Daily dispensing will run every weekday morning from Stokes Croft. Pharmacy links will be further developed to strengthen delivery and practice.

3. Group work:

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Group work will contain a number of options within the Change Cluster (in addition to those offered within Engagement and Completion Clusters):

- 12-step programme – Three times a week co-facilitated by group workers and peers;
- Structured Recovery Programme – This operates daily and contains both topic-based and psychosocial interventions;
- Alcohol Detox Support Group - Run from satellite sites and open to people pursuing alcohol detox through specialist services and shared care.

4. Psychosocial Interventions:
This follows a mind-mapping format Motivational interviewing techniques will be used alongside ITEP/BTEI approaches.

5. Specialist Psychological Interventions:
A limited number of intensive, specialist interventions such as DBT will be available for those service users who would most benefit from this approach.

6. Maternity and Family Support Services:
This covers both drug and alcohol problems and is delivered by a multi-disciplinary team, comprising of Midwives, Social Workers, Family Liaison workers and Specialist Drugs workers with named leads for professional liaison and client work. The focus of this service is to minimise the harm to mother and baby from problematic misuse, focusing on any Safeguarding concerns.

7. Inpatient Services:
There are seven beds on Acer Unit, Blackberry Hill Hospital, for stabilisation and detoxification. Whilst the majority of detoxification will happen in community settings, ROADS aspires to increase demand for detox and with this will come a proportion of complex cases, requiring inpatient treatment.

<u>Completion Cluster</u>

Delivered by BDP subcontracting with Business in the Community, VOSCUR & Volunteer Bristol, Windmill Hill City Farm, Demand Energy Equality, The Community Farm.

There are three key elements in Completion:

1. Recovery Sustainment Programmes
These offer real choice for individuals – with separate programmes for primary alcohol and primary drug users as well as one combining drug and alcohol users.

1.1. Combined Drug & Alcohol pathway
Individuals can access:

- 12-Step aftercare programme
  With two groups a week delivered at Colston Fort, supporting 12 Step Fellowship meetings;
- Community Reinforcement Approach (CRA) programme

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An individual programme for 8 weeks running alongside a weekly group which promotes individual engagement with their family and community. This builds on BDP's successful Boost CRA programme.

1.2. Primary Drug Pathway

- A Relapse Prevention group programme – running each week in North, Central and South Bristol - including evening and Saturday sessions.

1.3. Primary Alcohol Pathway

- A Relapse Prevention group programme – running each week in North, Central and South Bristol – including evening and Saturday sessions.

2. Targeted programmes to support individuals

2.1. Parenting Workshops

These offer support for people with a drug or alcohol problem who are also a parent. Their primary aim will be to help individuals identify with their role as a parent more strongly than with their role as a user of drugs or alcohol. These will be available across ROADS and with partners external to ROADS e.g. Children's Centres.

2.2. Peer Recovery check-ups

These are structured follow-ups of individuals who have successfully completed treatment in the Change cluster. Undertaken by Peers this involves a proactive structured intervention by telephone, using ITEP guided maps to support service users successfully exiting ROADS by reinforcing success and offering opportunities to re-engage early if needed.

2.3. Peer HCV support

Peers will offer individual support to service users who are starting HCV treatment – walking alongside them to maximise the opportunity for individuals to stay engaged with treatment through 'rough patches' and to successfully complete HCV treatment. Increasing the number of people completing HCV treatment is the only effective way of reducing HCV prevalence (number of people who have Hepatitis C) and the consequent future health care costs – so has important Public Health impact as well as improving individuals' quality of life.

2.4. Naltrexone Prescribing

Bristol City Council Substance Misuse commissioning team will be working with the Change Cluster to initiate and expand prescribing of Naltrexone (opiate-blocking drug) as part of an individual's recovery support plan. This is currently under-used in Bristol – but can offer tangible support to individuals during the early months of their recovery to reduce the risk of relapse.

3. Training Education Volunteering & Employment (TEVE) Opportunities

These offer meaningful occupation at a time of great vulnerability for individuals who approaching the end of their treatment, or who have just successfully left it.

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3.1. TEVE-Lite: short-term focused sessions (1-3) to explore options, sign-posting and referrals e.g. completing TPR3's to engage JCPlus in conversation about an individual's recovery plan and opportunities to increase their readiness for work.

3.2. TEVE–Contingency Management (CM) – "rewards for recovery"
This service will in reach into Change to establish TEVE CM prior to successful exit from treatment. This will be targeted at individuals in the Enhanced Shared Care stream who are completing their detox over a 6 month period as well as those completing alcohol detox.

A TEVE CM contract will be developed over 3-5 sessions which identifies behaviours and activities which are meaningful to an individual and can earn them 'rewards for recovery' e.g. successful completion of programmes in Completion, completing a volunteering placements, negative drug screens.

Individuals can accumulate 'rewards for recovery' as credits on a 'Capital Card' for which can be used against a range of training programmes run by City of Bristol college or other relevant source.

Support Cluster

Developing Health and Independence (DHI) will be delivering a new and innovative service in Bristol, called the 'Support Service', which will work closely with the other Recovery Orientated Integrated Substance Misuse Treatment (ROIS) providers.

The Support Service will have four main elements:

1. **Tackling discrimination and Stigma**
   During the journey of recovery and social reintegration, service users may face discrimination and stigma. DHI will be engaging with local communities to dispel misunderstandings around drugs and alcohol. This will include promoting closer working with the treatment service, those being supported in recovery and the communities in which they live.

2. **Carer Support**
   Holistic recovery means supporting the families and carers of those with drug and alcohol issues. DHI will be providing advice, information, one to one and group support for families in need, and will also be providing training for family members to become 'family champions' who can help run peer led family groups to support one another.

3. **Peer Support**
   Recovering service users can often be the best support for those a little further behind in their own recovery. DHI will be providing a comprehensive recruitment, training, and support package to those in recovery so that they can provide the best encouragement to others in their recovery and develop skills for their own future.

4. **Advocacy**

Service Users can sometimes lack confidence to raise their own voice when things go wrong or services do not meet their expectations. DHI has teamed up with The Care Forum who will provide advocacy support for individuals to resolve issues in relation to their treatment and thereby maximise their chances for a prolonged successful recovery.

Housing Support Cluster

Delivered by Addiction Recovery Agency (ARA) with sub-contractors, The Junction Project and the Salvation Army, the housing support cluster provides accommodation based and floating support.

Appropriate and safe housing is an integral part of a person's recovery and the Housing Support Cluster provides:

- Preparation Accommodation
  For those people where the treatment provider has a clear pathway for recovery in place but advocates that the service user is unable to maintain non problematic substance misuse use without stable housing.

- In Treatment accommodation
  For those people stabilised and engaged and working on their recovery plan with the Change provider, on stable medications and working towards non problematic use

- Abstinent Accommodation
  For those people who are totally abstinent after detox programme and needing an abstinent environment supporting their abstinent programme.

Floating support work with service users at all stages of engagement with ROADS where there person is a risk of homelessness or treatment breakdown which would jeopardise the tenancy.

- This service will be cross tenure and include owner occupiers, licensees and tenants. Floating support services will work with a range of private and social landlords including registered social landlords and Bristol City Council.

For further information, please go to: http://www.bristol.gov.uk/page/community-and-safety/drug-and-alcohol-misuse-treatment

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Bristol Health & Wellbeing Board

Proposed procurement of a Behaviour Change for Healthier Lifestyles Service for Bristol	
Author, including organisation	Viv Harrison and Sally Hogg Bristol City Council
Date of meeting	October 2016
Report for discussion and agreement	

1. Purpose of this Paper

This paper sets out proposals for the procurement of a Behaviour Change for Healthier Lifestyles Service for Bristol. It aims to highlight the proposed scope and emerging potential models for such a service, and links with the wider council and local health and care services.
The work is at an early stage and this paper aims to inform regarding the current position and proposals, prior to more detailed work to define options for a service model. This will be brought back to the Health and Wellbeing Board at a later date for decision to go out for formal consultation.

2. Healthy lifestyles

In Bristol every year approximately 819 people die prematurely through preventable disease such as heart disease, diabetes, certain cancers and respiratory conditions.
Bristol City Council, like many other councils throughout the country, faces a big challenge to meet the rising costs of health and social care. There is robust evidence recognising the importance of good health and wellbeing in reducing levels of chronic disease and premature death and placing a priority on investing in prevention.

In addition, the burden of ill-health is not distributed equally, with people from more disadvantaged backgrounds developing long term conditions about ten years earlier than those from more affluent backgrounds. Tackling inequalities through targeted prevention, intervening early when risks are identified and taking action when long term conditions are identified is critical.

2.1 Lifestyle risks to health

Lifestyle behaviours such as smoking, physical activity levels and diet are a major influence on health, wellbeing and life expectancy. There is overwhelming evidence that changing health-related behaviours can have a major impact on the largest causes of early death and disability.

There are 4 key modifiable lifestyle behaviours which contribute to the 4 preventable diseases that lead to 48% of the early deaths in Bristol (early death is death before the age of 75 years).
These are:

- Unhealthy diet
- smoking
- physical inactivity
- excess alcohol consumption.

These behaviours lead to:

- cardiovascular diseases
- cancers
- respiratory diseases
- liver disease

These contribute to almost half of the early deaths in the city. Modifying these lifestyle risk factors is likely to significantly reduce the harm and early deaths associated with these conditions, and reduce the inequality in health outcomes across the city.

The greater the number of unhealthy lifestyle behaviours the greater the risk of ill health and early death. Evidence suggests that the most vulnerable and disadvantaged are more likely to have higher risk lifestyles across several behaviours, resulting in higher risks for ill health. The strong and persistent link between deprivation and ill health underlines the importance of tackling the underlying determinants of unhealthy behaviours as well as the behaviours themselves.

Many individuals who want to make changes to their lifestyle to improve their health are able to do so without support. However, the evidence is clear that people who are motivated to make changes and who receive the right level of support significantly increase their chances of achieving and sustaining behaviour change.
Although support can come from family and friends it is often professional support that is sought and trusted. Support may be required over a period of time to embed long term behavioural change such as stopping smoking or changing eating habits.

2.2 Public health work to support prevention through healthier lifestyles

Local authorities have a responsibility for public health as leaders of the public health system, enabling the broader determinants of health that impact on people's health and wellbeing to be addressed, such as people's local environment, transport, housing and employment. These wider environmental factors are estimated to influence between 15% and 43% of our health. Approaches to prevention need to address and take account of these wider determinants and to focus in areas and communities where need is highest.

Approaches to prevention with individuals include a wide range of activities or interventions aimed at reducing risks to health and wellbeing, and the impacts of disease.
Primary prevention aims to prevent a condition or disease developing e.g. through promoting healthier behaviours;
Secondary prevention aims to reduce the impact of a condition that has already occurred – this can include early detection and management, and lifestyle programmes to improve healthier behaviours and slow progression of the condition;
Tertiary prevention aims to reduce the impact of long term illness e.g. through rehabilitation programmes and long term condition management programmes, to maximise capacity for living well.

Individual-level interventions aimed at changing health-damaging behaviours are complemented by interventions at a **population, community and organisational** level, such as campaigns for raising awareness and prompting behaviour change.

The proposed integrated healthy lifestyle service will work with and support individuals, for primary and secondary prevention of preventable ill health through behaviour change.

3. Commissioning healthy lifestyles support services

The contracts for a number of current public health services that support individual behaviour change for healthier lifestyles come to an end in 2017. This provides an opportunity to review the future delivery of healthy lifestyle services in Bristol.

There are currently different contracts for each of the commissioned lifestyle services. This means that there has been no holistic approach to behaviour change, taking account of the wider determinants (where people live, work).

A behaviour change for healthier lifestyles service will need to provide the right people with the right information, advice and support, in an accessible and engaging format and style for them. It will need to be flexible and dynamic to respond to differing needs and emerging technology, and provide support at various levels including potentially a more targeted, intensive offer to those in greatest need.

Potential strategic objectives are:

- To empower, enable and motivate people who want to be able to take control of their own health and wellbeing and change their behaviour
- To deliver an integrated holistic approach to healthy lifestyles services
- To make more effective use of the available assets across this system, including the capacity of existing services and communities to support healthy lifestyles
- To deliver behaviour change support appropriate to the needs of our diverse population

The lifestyle services commissioned by the Council constitute only a part of the total investment in promoting healthier lifestyle in Bristol. In addition, many people make positive lifestyle choices and changes without any external support at all.

4. Services considered in scope

Services considered to be potentially in scope for a Behaviour Change for Healthier Lifestyles Service are:

- NHS Health Check programme - to enable the population to stay healthier for longer by identifying and reducing the risk of developing preventable conditions, particularly cardiovascular and related conditions. Contracts held with Primary Care and Social Enterprises

- Stop Smoking Service – to reduce the prevalence of smoking among young people, adults and pregnant women. Contracts held with Primary Care, Pharmacies, Children's Centres, and a variety of Community Interest companies and Social Enterprises.

- Adult Weight Management on Referral – to reduce the rates of overweight and obesity among adults. Contracts currently held with Slimming World and Weight Watchers, United Hospitals Bristol (community dietetic led service to support more complex weight management cases) and a variety of targeted small projects, including Fit Club and Fans4Life.

- Alcohol Brief Interventions – to reduce harm from alcohol. Contract currently held with Primary Care. Expected to include some of the work on harmful drinkers currently provided by ROADS

- Children and family Weight Management programme – to reduce the rates of childhood obesity. Contract currently held with Alive N Kicking

- LiveWell Hub – digitalised information, signposting and referral point. Currently being developed and provided by public health

- Specific initiatives/campaigns related to the healthy lifestyles within scope including support for Food for Life in schools.

- Public health delivery of training for healthy lifestyle provider staff e.g. stop smoking services

There will be a continuous iterative review process during the next few months to ensure that each of the individual elements is suitable for inclusion in the scope of the Integrated Lifestyle Service.

5. Developing an Integrated Lifestyle model

Potential models for the proposed behaviour change for healthier lifestyles service are currently being explored. The innovative, dynamic and flexible service will offer levels of support appropriate to need, with a strong focus on enabling self-care, and will include informing and signposting, and single interventions through to higher intensity programmes over a number of sessions.

The service will primarily focus on initiating and sustaining behaviour change that will impact on future ill-health and premature mortality, and will take account emotional health and wellbeing when delivering change interventions.

It is likely that the service will be divided into three personas:

- Inform me – high use of digital technology for self-motivated individuals
- Enable me- requiring additional support
- Support me –support by phone or face to face contact

It will be consistent with evidence based guidance on behaviour change (NICE Guideline PH 49, Behaviour Change : Individual approaches. Jan 2014).

The provider / providers will be expected to focus their efforts in the most deprived areas of Bristol, whilst having access to a universal offer. The service specification will be outcome focused with trajectories for on-going improvement, enabling the provider(s) to be innovative and creative in their approach.

In considering our role in supporting healthy lifestyles, and how we commission this support, we must consider the 'fit' of our offers within the wider health and wellbeing system.
The proposed service will need to link effectively with services such as BCC Information, Advice and Guidance, Care Direct and Well Aware.

A stakeholder event was held in September as a discovery and market warming event to explore options and issues in developing an integrated healthy lifestyle service for Bristol. It provided opportunity to listen to the experience of setting up integrated lifestyle services in other areas, and will directly inform the new service.

6. Procurement process

6.1 Timescale

- Integrated Healthy Lifestyle Service stakeholder event - September 2016
- Development of potential models and commissioning plan
- Health & Wellbeing Board for approval prior to formal consultation.
- Services specification will be drawn up and approval will be sought to proceed with the procurement.
- The aim is to be in a position to go out to tender by October 2017
- Procurement process complete by April 2018
- The proposed duration of this contract is 3 years plus 2 years plus 2 years.

6.2 Current Contracts and Expenditure

Current yearly expenditure for services that are considered in scope for the proposed Behaviour Change for Healthier Lifestyles Service for Bristol are shown in table 1 below:

Table 1: Yearly cost envelope for the Integrated Healthy Lifestyle Service

Service	**Bristol**
	£
NHS Health Checks (incl non-pay)	400,000
Weight Management on Referral	100,000
Adult Specialist Weight Management Service	205,772
Stop Smoking Delivery - primary care (incl non-pay)	294,500
Stop Smoking Delivery - community grants	45,000
Alcohol Brief Interventions	5,000
Child weight management services	220,000
Delivery of Livewell Bristol Hub and Community Health Improvement Support	319.247
Current Total	**£1,589,519**

It is inherent that there will be a 10% saving delivered by the new service.

6.3 Governance Arrangements

A Project Steering Group with agreed Terms of Reference has been established.

Options for procurement on a wider footprint have been explored with neighbouring authorities, however neither wished to be part of this commissioning process.

7. Recommendations

The Health and Wellbeing Board is asked to agree to the proposed development of a Behaviour Change for Healthier Lifestyle Service, including services currently considered in scope.

The Health and Wellbeing Board is asked to consider the following questions:

1) What else could be included in this service?

2) How would the CCG and other organisations wish to contribute to the Behaviour Change for Healthier Lifestyles Service?

Dr Viv Harrison and Sally Hogg
Consultants in public health

10/10/16

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Health Protection Committee Annual Report 2015-2016	
Author, including organisation	Sophie Prosser, Public Health Principal (Health Protection) Bristol City Council Thara Raj, Consultant in Public Health, Bristol City Council. Becky Pollard, Director of Public Health, Bristol City Council **This report contains contributions from the Health Protection Committee members**
Date of meeting	19th October 2016
Report for Information	

1. Purpose of this paper

To provide assurance on behalf of the population of Bristol about whether there are safe, effective and well-tested plans in place to protect the health of the population and planned actions to strengthen these.

2. Executive summary

The Director of Public Health (DPH) has examined arrangements for health protection in Bristol in line with her statutory responsibility. These include checking the quality of the systems in place for surveillance, prevention, planning and response required to protect the public's health.

This Bristol Health Protection Report 2015/16 has been kept deliberately short so that the information can be digested easily. We have included appendices that outline achievements to date and what more is being done to strengthen arrangements and improve outcomes in the following areas:

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

Bristol sees more than its share of outbreaks and health protection events compared to neighbouring local authority areas. It is a vibrant and culturally diverse city where people choose to live, learn, work and socialise. Many of its health protection issues reflect this vibrancy and diversity. Bristolians are resilient but need to remain vigilant if we are to avoid damaging that resilience.

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 and screening rates and tackling inequalities are also pressing issues in Bristol that are systematically being addressed.

3 Context

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

The health protection duty for local authorities came into force on the 1st April 2013 as part of the Health and Social Care Act 2012 (section 6C Regulations).

One of the mechanisms for fulfilling this duty is through the local Health Protection Committee (HPC), chaired by Bristol City Council's (BCC's) DPH, under the governance of the Health and Wellbeing Board (HWBB). The HPC brings together key partners from within BCC and external agencies who have a responsibility for parts of the health protection system.

Achieving success in health protection relies on strong working relationships at a local level. The DPH helps facilitate this relationships ensuring that clearly defined roles and responsibilities are in place that underpins the local public health response to threats, outbreaks and major incidents.

4. Main body of the report

Please see Bristol Health Protection Report 2015/16 attached.

5. Key risks and opportunities

Every day Bristol's cleaners, refuse collectors, Environmental Health Officers, health protection specialists, police, fire, ambulance, GPs, nurses, pharmacists, allied healthcare professionals, planners, councillors, carers, volunteers and communities work hard together to keep Bristol resilient and safe from harm and protected. This is becoming increasingly difficult when resources are limited. Investing in effective and cost effective interventions and solutions that protect health and tackle inequalities is one of the main ways to mitigate against this.

Specific health protection risks and opportunities are outlined in the main body of the Bristol Health Protection Report 2015/16.

6. Implications (financial and legal if appropriate)

The Health and Wellbeing Board plays a critical role in holding its partners to account if local health protection arrangements are not adequate and for freeing up resources and helping to overcome barriers. The body of the Bristol Health Protection Report 2015/16 includes several effective and cost effective interventions and solutions and we ask the HWBB to continue to support these.

7. Conclusions

There are still major challenges, particularly in reducing influenza like illnesses, tackling TB, increasing immunisation and screening rates. The majority of the health protection burden is experienced by the most vulnerable of our communities. Tackling inequalities in the economy, in health, education, housing and employment in a sustainable and fair way remain critical.

8. Recommendations

- To note the major issues highlighted in the report.
- To identify any additional concerns or contributions the HWBB can make.
- To note the considerable progress that has been made in Bristol in tackling some of the key health protection challenges the city faces and some of the major challenges that remain.

BRISTOL HEALTH PROTECTION ANNUAL REPORT 2015/16

NHS
Bristol Clinical Commissioning Group

BRISTOL CITY COUNCIL

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EXECUTIVE SUMMARY

This report summarises the significant progress that has been made in securing effective partnerships that have strengthened health protection arrangements in Bristol.

Bristol sees more than its share of outbreaks and health protection events compared to neighbouring local authority areas. Bristol is a vibrant and culturally diverse city where people choose to live, learn, work and socialise. Many of its health protection issues reflect this vibrancy and diversity. Bristolians are resilient but we need to remain vigilant if we are to avoid damaging that resilience. Every day people in Bristol work hard together to keep the city resilient and safe from harm. These include Bristol's cleaners, refuse collectors, environmental health officers, health protection specialists, police, fire, ambulance, GPs, nurses, pharmacists, allied healthcare professionals, planners, councillors, carers, volunteers and communities. This is becoming increasingly difficult when resources are limited.

Through a series of appendices the report outlines how specific health protection issues are being addressed in Bristol.

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
IPC	Infection, Prevention and Control
IPV	Inactivated Polio Vaccine
LHRP	Local Health Resilience Partnership
LTBI	Latent Tuberculosis Infection
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
STI	Sexually Transmitted Infections
TB	Tuberculosis
Td	Tetanus and diphtheria
WHO	World Health Organisation

INTRODUCTION

This is the second annual report to be presented to the Health and Wellbeing Board (H&WB). A summary of the recommendations made in the first annual report are listed in appendix 1. It 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). Appendix 2 outlines the different responsibilities for partner organisations.

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 H&WB, 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 place 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 3 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 pollution control

ASSURANCE STATEMENT

The Director of Public Health 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.

In the inaugural Health Protection Annual Report for 2014-15, the Director of Public Health provided an overview of the Health Protection arrangements within Bristol, primarily focusing on the set-up of the Health Protection Committee (HPC).This annual report provides updates on progress made and identifies areas to focus on for 2016/17.

RECOMMENDATIONS

To note the significant progress that has been made in 2015/16 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 2014/15 Bristol (First) Health Protection Annual Report

Tuberculosis (TB)

- Establishment of a TB Control Board (building on the BNSSG Prevention and Control Strategy Group) with agreed Terms of Reference and membership to oversee the local implementation of priorities outlined in the National Collaborative Strategy for England. This will be led by Public Health England and the Health Protection Committee will oversee and support its development through existing assurance arrangements.
- Led by Public Health England in collaboration with Bristol City Council, a Comprehensive Tuberculosis Health Needs Assessment will be undertaken that will further inform local priorities for action to reduce TB incidence and identify opportunities to further improve local TB services.

  The production of a local Collaborative TB Strategy to ensure delivery of both national objectives and local priorities as outlined by the Health Needs Assessment.

Healthcare associated infections

- Investigate the reasons behind the high levels of MRSA (Methicillin Resistant Staphylococcus Aureus) within the intravenous drug user population.
- Reduce the number of pre-48 hour MRSA (MRSA developed within 48 hours of admission).

Sexual health

- Improving sexual health information systems.
- Chlamydia partner notification pilot in primary care.
- HIV Screening and reducing late diagnosis; introducing appropriate screening in primary care.
- Consideration of re-commissioning all sexual health services across Bristol and surrounding areas.
- Carrying out a sexual health needs assessment and developing a new strategy for Bristol.

Foodborne disease

- Inspection of highest risk rated premises and new businesses.
- Review of foodborne disease in Bristol: undertake a service review to identify optimum structure.

Immunisations

- 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 primary school aged children (Years 1 & 2).
- Implement the Meningitis B programme for children (this will be dependent on successful national negotiations on vaccine costs).

Screening

- 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 programmes.
- Develop effective pathways for Hep B diagnosis, treatment and follow up of babies born to Hep B mothers.
- Improve the performance of the UHB neonatal hearing screening programme.

Emergency Preparedness, Resilience and Response (EPPR)

- Through the Health Protection Committee, the Director of Public Health for Bristol City Council will ensure that plans are in place and tested with regards to the management of a suspected case/cases of Ebola Virus Disease (EVD) identified in Bristol.
- The Director of Public Health for Bristol City Council will continue to work alongside Public Health England to oversee the management of EVD related incidents and to engage with Local Resilience Forum members as required in response to the management of a suspected case / cases in the area served by the Local Authority.

Environmental hazards to health, safety and pollution control

- Bristol City Council to extend the period of monitoring air quality to ensure that at least 12 months data can be analysed.
- Bristol City Council to further investigate further potential exposure of the local community to nuisance dust.
- Public Health England to work collaboratively with Bristol City Council and community members to produce a localised report on the health outcomes of residents in closest proximity to the industries operating at the docks. This report will be used to inform any additional action required to reduce identified inequalities in health outcomes compared to Bristol as a whole.

Appendix 2: Primary organisational roles and responsibilities in the prevention and control of infectious disease outbreaks or health protection incidents in Bristol

<table>
<tr>
<td>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.</td>
<td>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
</td>
</tr>
</table>

	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	**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

Local authorities have defined health protection functions and statutory powers in respect of environmental health and health and safety.	that threatens the public's health; • exercising powers under the health protection regulations to prevent or limit the spread of an infectious disease; • 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	**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.

services).	**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.

Appendix 3: 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.

UK TB incidence is higher than most other Western European countries and the US[1] (14.0 per 100,000 population UK, 8.8 per 100,000 France, 5.8 per 100,000 Germany and 3.0 per 100,000 US). England has not seen the consistent reductions that have been achieved in some comparable countries and if current trends are not reversed then within two years England could expect to have more TB cases than the whole of the US. In England TB has now been identified as a public health priority due to current trends and the health, social and economic burden of the disease. The rates of TB and the risks of delayed diagnosis, drug resistance, onward transmission and poor treatment outcomes are greatest among socially marginalised, under-served populations such as illicit drug users and the homeless.

Globally, the Millennium Development Goal of halting and reversing the TB epidemic by 2015 has been met[2] (WHO 2016).

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 in response to concerns that overall rates of the disease have not shown a sustained reduction in recent years with an aim to achieve a year-on-year decrease in incidence, a reduction in health inequalities and ultimately the elimination of TB as a public health problem in England.

Figure 1 shows how the rate of TB in Bristol during 2014 was 22.4/100,000. This is the highest value in 13 years and is part of an increasing trend. In contrast the national rate has seen a year on year decrease since 2011. The rate in Bristol is considerably higher than for the rest of the South West (4.5/100,000). In 2014 from culture confirmed pulmonary cases that underwent antibiotic sensitivity testing a higher proportion of Bristol's notifications (18.2%) were found to have infections with resistance to at least one first line drug compared to the rest of the South West (3.0%). Furthermore 2.3% of 2014 infections were multidrug resistant compared to 0.8% for the rest of the South West.

[1] PHE (2013). Tuberculosis rates by country in 2014 (worldwide table). Last updated 2016. London: Public Health England.

[2] WHO (2016). *Tuberculosis. Factsheet N 104.* http://www.who.int/mediacentre/factsheets/fs104/en/ [accessed 24/05/2016]

Figure 1. Annual TB incidence rates, 2002-2014

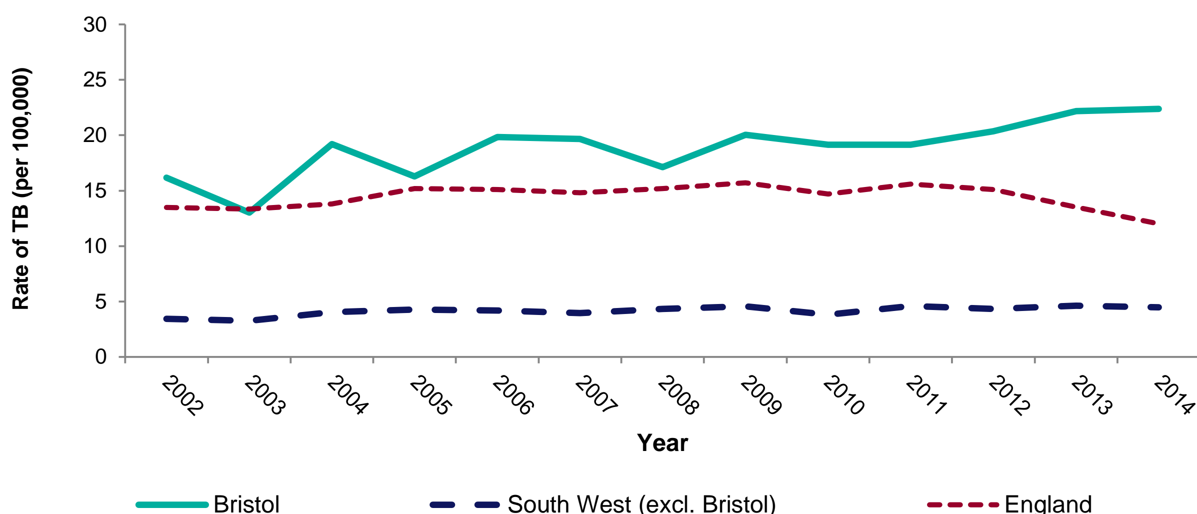

Table 1 shows that a lower proportion of Bristol's notifications, 5.8% (95% CI: 2.4% to 13.3%), reported at least one social risk factor compared to 10.9% (95% CI: 7.1% to 16.4%) in the rest of the South West. However overlapping 95% confidence intervals suggest that the difference is not statistically significant. A higher treatment completion rate in cases with drug sensitive and non-Central Nervous System, spinal, miliary or cryptic disseminated disease was found for Bristol (74.7%, 95% CI: 63.2% to 83.5%) compared to the rest of the South West (70.2%, 95% CI: 63.6% to 76.1%). However overlapping 95% confidence intervals suggest that the difference is not statistically significant.

Table 1. TB epidemiology: Bristol and South West (excl. Bristol) residents, 2014

TB INCIDENCE	**Bristol**	**South West***
Number of TB notifications (proportion pulmonary TB)	99 (62.6%)	222 (60.8%)
Rate per 100,000 population	22.4	4.5
DRUG RESISTANCE		
Proportion of culture confirmed notifications with any first line resistance	18.2%	3.0%
Proportion of culture confirmed notifications with multi-drug resistance**	2.3%	0.8%
SOCIAL RISK FACTORS (history of past or current homelessness, imprisonment, drug and/or alcohol misuse)		
Proportion of notifications with any social risk factor	5.8%	10.9%
TREATMENT COMPLETED within 12 months ***		
Number completing treatment in 2013 (Proportion completing)	53 (74.7%)	146 (70.2%)

Successes/Progress

TB Control Board

As outlined in the Collaborative TB Strategy, a significant step towards achieving the reverse of TB incidence is the establishment of TB control boards. The TB Control Board for the South of England covers Bristol and has been operational since September 2015. The Board's intent is to focus on high incidence areas (>20 per 100,000 population) whilst also liaising, guiding, sharing work and expertise with low incidence areas. Bristol is the only high incidence area in the South West of England.

Health Needs Assessment (HNA) for Tuberculosis in Bristol, North Somerset, Somerset and South Gloucestershire (BNSSG)[3]

A comprehensive TB health needs assessment (HNA) has been completed for BNSSG. The aim was to help understand the epidemiology of TB for the area, identify any unmet health needs of the affected population, including barriers to accessing community services. The report will inform and support the development of a local TB strategy and action plan in line with the 'Collaborative TB Strategy for England 2015 – 2020'.

Key initial findings from the local TB health needs assessment report identified a gap in service provision for active case finding and TB screening amongst under-served populations (i.e. migrants, homeless, substance misusers etc.), a lack of funded paediatric services and barriers to BCG access.

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 2015/16 Bristol has had several cohort review meetings and these have used enhanced local data collection to identify local issues for action.

Pathway to accommodate TB patients with no recourse to public funds

Bristol CCG, Local Authority Public Health and PHE Health Protection Unit have drafted a patient pathway for those exceptional circumstances where homeless TB patients have no permanent secure accommodation and no recourse to public funds. Individuals with TB who are homeless in Bristol undergo housing, social care and asylum assessments as necessary and if it is deemed that they are not eligible for support from these streams then a case conference is held to discuss the patient pathway and public health implications of their

[3] Tuberculosis (TB) Health Needs Assessment. Bristol, North Somerset and South Gloucestershire working draft. March 2016.

situation. This patient pathway includes a tripartite agreement between the CCG, Local Authority Public Health and PHE Health Protection team to fund prompt housing for the individual in question for the duration of their TB treatment. While housed and on treatment, the City Council Tenant Support Services and Asylum services (if appropriate) will work with the individual to facilitate longer term support. The pathway went live on 1st April 2016 following consultation from the TB Strategy Group.

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 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 are offering IGRA blood tests to migrants who have moved to the UK in the previous 5 years.

Key current risks

- TB prevalence rates in Bristol are not reducing as they are in other parts of England.
- **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 recorded, 20.0% were unemployed.

  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.

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[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).

A working group (with membership involving Local Authority Public Health (Health Protection), PHE, CCG and Bristol TB Nursing Service) has been established to look at various options for active case finding in under-served populations. An options paper has been written and the group are currently exploring funding for hire of a mobile chest x ray service.

- **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.
- **BCG immunisation:** There is a global, national and local shortage of BCG vaccination supply which has resulted in interruptions to targeted immunisation programmes in high risk groups.

Areas for focus in 2016-17

- 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.

1.2 Infection Prevention and Control (IPC)

Preventing healthcare associated infections (HCAI) is an important component of infection prevention and control and patient safety. NICE (National Institute for Health and Care Excellence)[6] 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 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.

Succeses/progress

Healthcare associated infections

A healthcare associated infection (HCAI) Group meeting is held each month hosted by Bristol Clinical Commissioning Group (CCG). Membership is drawn from commissioners (CCG and NHS England) hospital and community providers, local authority and public health across Bristol and South Gloucestershire. 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.

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

During 2015-16, Bristol CCG led a review of processes to manage MRSA and supported the implementation of a robust action plan with providers that focused on targeted interventions and education for intravenous drug users (IVDU). These interventions included alternatives to injecting, safer injecting, skin and injecting site care, skin preparation prior to injecting, signs and symptoms of infection and signposting for prompt clinical intervention. These interventions are being taken forward by the Bristol Drugs Project.

[6] 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.

Although the national zero tolerance target for MRSA was not achieved in 2015/16, Bristol CCG had established a local ambition to only have 3.70 cases per 100,000. Through the concerted work of the Healthcare associated infection group in partnership with communities in Bristol, the number of CCG assigned pre 48 hour MRSA cases was reduced significantly to three cases. The national average in England is 0.70 per 100,000 population. Tackling such preventable healthcare associated infections will continue to be a key priority for the health community in 2016-17 to meet the zero tolerance target.

Clostridium difficile (C. diff) review meetings

A monthly post infection review (PIR) meeting that includes public health infection control specialists and Bristol CCG 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 48 hour Clostridium difficile and identify any learning that can be addressed and shared to improve practice. In 2015/16 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 2015/16 was 134 which meant the local ambition was not achieved.

During 2015-16 Bristol CCG through the efforts of its Infection Prevention and Control Nurse and a Medicines Management team, developed a root cause analysis (RCA) tool for primary care (GP practices and community pharmacies) to support the review of pre 48 hour C.diff cases. This has been well received. All the pre-48 hour C.diff community cases were reviewed during the year.

In January 2016 the CCG developed and implemented an action plan that focuses on interventions to ensure that C.diff infections are maintained within the annual threshold set by NHS England. The plan includes objectives to share best practice across providers, reduce broad spectrum antibiotic prescribing in primary care, develop key messages for patients, GPs and staff and develop an electronic survey tool to gather and analyse data for community C.diff infection cases.

Antimicrobial Resistance (AMR)

The Medicines Management team at Bristol CCG 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 February 2015, a national framework was introduced to the NHS to benchmark performance and to be able to compare primary care prescribing rates. Data is now systematically collected on prescribing rates of three classes of broad spectrum antibiotic use (co-amoxiclav, cephalosporins, and quinolones), as a proportion of overall antibiotic use. Public Health England published the English surveillance programme for antimicrobial

utilisation and resistance (ESPAUR) 2010 to 2014: report 2015 which shows national and local performance.

In 2015-16, a new national quality premium (QP) target was introduced for primary care to reduce the overall prescribing of antibiotics by 1% and to reduce the prescribing of cephalosporin, quinolone and co-amoxiclav by 10% (due to broad spectrum antibiotics being associated with an increased risk of Clostridium difficile infection and antimicrobial resistance). The quality premium target for 2016/17 is to reduce overall prescribing of antibiotics by 4% and reduce the prescribing of cephalosporin, quinolone and co-amoxiclav by 20%.

In addition to this clinicians across Bristol have access to locally endorsed evidence based guidance on the use of antibiotics in primary care settings[7]. Such 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. In 2015/16 a smartphone app was introduced for healthcare professionals to improve access to best practice guidelines.

A project was undertaken by the Medicines Optimisation pharmacists to retrospectively review broad spectrum antibiotic prescribing over a one week period at each of the Bristol GP practices in Quarter 1 2015/16. Results of this project were fed back to individual clinicians in Quarter 2 with the aim of improving prescribing practice of antibiotics and facilitating compliance with the BNSSG antimicrobial resistance guidelines. This project has significantly contributed to Bristol GP Practices achieving a 27% reduction in broad-spectrum antibiotic prescribing (compared to the same period in 2014/15) and ensuring both QPs were achieved in 2015/16. The AMR QPs remain for 2016/17 although targets are more stringent. The project is to be repeated in Quarter 1 2016/17 to further improve practice.

A South West Antimicrobial Pharmacist network continues to meet biannually 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.

Key current risks

- Infection prevention and control is fundamental to stop the spread of infectious and communicable disease. Performance in Bristol has not been optimal in reducing the number of healthcare associated infections.
- Arrangements for oversight of infection prevention and control outside hospital settings. Primary care trusts used to have this oversight but since the change in commissioning arrangements in April 2013 this oversight role has been split between

[7] NHS Bristol, North Somerset and Gloucestershire (BNSSG) (2015) Antimicrobial Prescribing Guidelines for BNSSG Health Community 2015.

different commissioning bodies including the local authority, CCD, NHS England and Public Health England.

- We need to avoid situations where Bristol residents continue to demand antibiotics when they do not need them and prescribers continue to prescribe when there are alternative courses of action. 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 2016-17

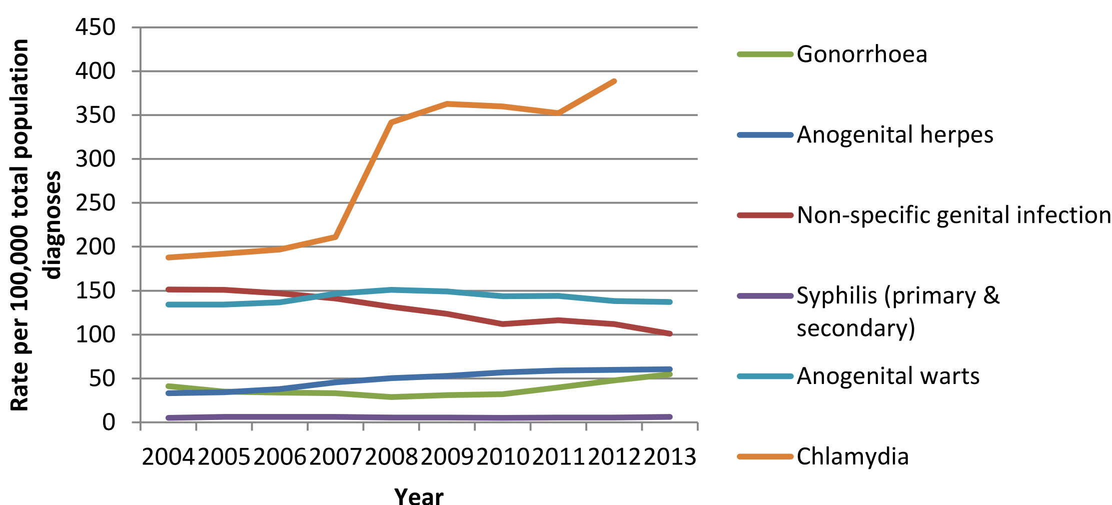
- Achieve the zero target for pre 48 hour MRSA blood stream infections
- Reduce the number of Clostridium Difficile pre 48 hour community cases
- Reduce overall prescribing of antibiotics in primary care by 1%
- Reduce prescribing of cephalosporin, quinolone and co-amoxiclav by 20%.
- Review arrangements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

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 sharp rises have been observed for syphilis and gonorrhoea in particular. **Figure 2** shows the trends in STI diagnoses between 2004 and 2013. Bristol's rate of new STI diagnoses in 2014 was 989 per 100,000 (excluding chlamydia in the under 25s). The Bristol rate was higher than the national average of 829 per 100,000.

Figure 2. Rate per 100,000 population of STI diagnoses in England (2004 to 2013) (PHE, 2014[8])



There is variation in the distribution of the most commonly diagnosed STIs by age, gender, sexual orientation and ethnicity as outlined below.

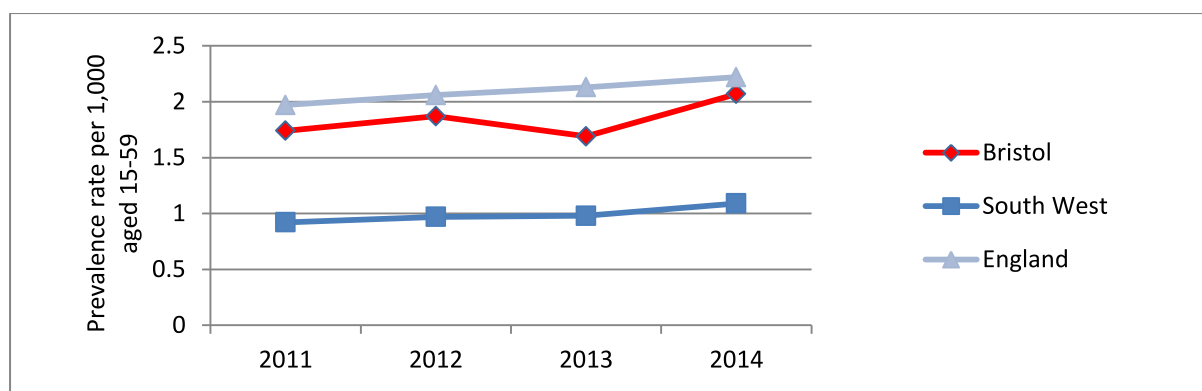
- Young people (15-24 year olds) continue to experience the greatest burden of STI diagnoses.
- There has been a rise in STI diagnoses amongst the population of men who have sex with men (MSM). High levels of condomless sex probably account for most of this rise, although better detection of STIs may have contributed.
- Diagnoses of syphilis and gonorrhoea are more likely to be reported in men who have sex with men than other groups.

[8] Public Health England (2014c) Table1: STI diagnoses & rates in England by Gender, 2004-2013, London, https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables (accessed 19.2.15)

- 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 2014 to 2.07 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 44.7% of people in Bristol presenting at a late stage of infection, which is slightly higher than the national rate of 42.2%.

Figure 3. HIV prevalence rate per 1,000 population (2011-2014)



Successes/Progress

Sexual health needs assessment

A comprehensive sexual health needs assessment for Bristol has been conducted in order to inform the recommissioning of sexual health services. The needs assessment provides a detailed overview of sexual health need and current service provision. It identifies key sub-groups of the population at greater risk of poor sexual health and draws out potential areas of unmet need and recommendations for commissioners. The summary is available at www.sexualhealthconsultation.co.uk.

Recommissioning sexual health services

A procurement of sexual health services across Bristol, North Somerset and South Gloucestershire is currently underway in order to comply with EU procurement law. This has provided an opportunity to address some of the gaps in the current sexual health system. The aim of this exercise is to achieve better outcomes for Bristol residents and those who use the sexual health services in Bristol by commissioning more joined up services to

achieve more equitable outcomes, and with an improved focus on the needs of vulnerable and high risk groups. Additionally, it is an opportunity to increase the focus on prevention and address the wider determinants that impact on people's sexual health in Bristol. It is anticipated that the new contract will be awarded in 2016/17 and the new service will be in place from April 2017. Services delivered through primary care were out of scope for this procurement.

Strengthening HIV testing

An audit of cases of very late HIV diagnosis found evidence that there were missed opportunities to test for HIV in Bristol's general practices. As a result 20 high prevalence practices have received free training in order to strengthen their approach to HIV testing. The training takes the form of a one hour interactive workshop delivered at each practice, based on the MEDFASH HIV TIPs (Testing in Practice) online educational tool. The effectiveness of the training is currently being evaluated by the University of Bristol. The next phase of the intervention will be a pilot to offer HIV screening in the six highest prevalence practices. This will include offering tests to newly registering patients or opportunistically offering tests to patients from high risk groups.

Chlamydia partner notification pilot in primary care

A new approach to the management of cases of chlamydia and gonorrhoea diagnosed in the community was piloted in 11 south Bristol practices. During the evaluation both practice staff and patients reported positively on the alternative care pathway which provided the option for telephone-based management by a centralised team of specialist nurses for any test taken in the practice. An application for a larger, definitive cost-effectiveness evaluation was submitted to the NIHR (National Institute for Health Research) in April 2016.

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.

Key current risks

- There has been a reduction in the government grants to local authorities including an in year reduction in the ring-fenced public health grant. This has meant that funding available for services such as sexual health services is reduced. This is of concern given that there is increasing demand for the service and an increasing population in Bristol. The ability to procure a service that can meet this rising demand within the financial envelop available is a challenge.
- There has been a large increase in STI diagnoses amongst the MSM (men who have sex with men) population.

Areas for focus in 2016-17

- 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.

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 1260 cases of gastrointestinal infection reported between April 2015 and March 2016 (see **Table 1**).

Table 1. Cases living in Bristol Local Authority April 2015 to March 2016

Infection	Total Cases on HPZone living in City of Bristol Local Authority April 2015 to March 2016
Campylobacter	500
Cryptosporidium	83
E coli VTEC	<5
Giardia	151
Shigella	27
Salmonella	63
Parathyphoid Fever	<5
Typhoid Fever	<5
Norovirus	343 (SGSS lab imports rather than HPZone records))
Rotavirus	83 (SGSS lab imports rather than HPZone records)

Source: Public Health England HPZone record system or SGSS electronic lab reports (where indicated)

Bristol City Council is required to register or approve food businesses by inspecting them within 28 days of the commencement of food operations to give them a rating. This rating then informs a rolling programme of inspection.

Bristol City Council currently has around 4800 premises on the food premises register. These give rise to an inspection programme of approximately 4000 for the year 2016-17.

Limited resources are targeted to the highest risk and non-compliant food businesses. These are carried out by environmental health officers who are authorised to exercise appropriate enforcement powers, such as issue of legal notices requiring improvements and in the most serious cases prosecution. Due to the large number of food businesses in Bristol, many of those in the medium risk category are out-sourced to a specialised Environmental Health contractor.

A Food Standards Agency Audit of the Food Service flagged the low numbers of Authorised Officers and the need to adequately resource the service to address this and clear the backlog of over 2500 inspections. The service is only able to complete 39% of the required interventions.

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.

Key current risks

The key risks relate to the ability to clear the backlogs, 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. Now funding has been secured Environmental Health will look at all options to try and reduce the risk.

Areas for focus in 2016-17

- 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.

1.5 Communicable Disease Management

Through close partnership working, Public Health England South West (North) Health Protection Team (PHE) aims to provide 'assurance that infection prevention and control measures are in place to ensure the protection of those members of the Bristol Community that may be vulnerable to acquiring an infection both in the general population and whilst in a Health or Social care setting'.

The PHE Health Protection Team responds to any Notifiable Infectious Diseases (NOIDs) in Bristol as well as the rest of England. In 2015/16 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 Cryptosporidium

An increase in Cryptosporidium was seen in all regions of England, Wales and Scotland in Quarter 4 2015/16. The increase was seen from November 2015 onwards and confirmed by the reference laboratory to be Cryptosporidium Parvum. In the South West, cases were higher in the reported quarter than for the equivalent quarter the previous year. However it must be noted that increases may not be directly attributable to the national increase.

Increase in Influenza-like illness (ILI)

The 2015/16 Flu season was later than usual with the circulation of Influenza A and Influenza B viruses continuing to be high in March 2016 within Bristol and nationally. Laboratory reports of Influenza A and Influenza B were higher during the 2015/16 season than in the previous winter season 2014/15.

The peak in reports of laboratory confirmed influenza coincided with a peak in GP consultation rates locally and at a national level. In the South West, seven out of ten local authority areas, including Bristol, saw their consultation rates amongst the highest in England.

During the peak of ILI activity, the vast majority of outbreaks were in nursery and school settings.

National outbreak of Salmonella Braenderup

A national outbreak of Salmonella Braenderup was identified, with cases occurring from March 2016. Whole genome sequencing showed the cases were genetically matched and in total there were 8 cases across the PHE South West centre. The outbreak is still being investigated at a national level but information regarding the potential cause of this outbreak is not yet available.

Increase in Scarlet Fever

The Health Protection Teams in the PHE South West Centre observed increased notifications of scarlet fever (primarily school-aged children) during March 2016. Reported

cases were higher than the comparable period in the previous year and above seasonal expected levels in Bristol.

PHE and Bristol City Council Public Health took the opportunity to write to all head teachers to raise the awareness of the signs, symptoms and the actions to be taken should they become aware of an outbreak in their school.

Notifications of TB

See also section 1.1 in this report. Cases of TB continue to be managed in Bristol. Outbreak control teams have been convened, where needed. For example to manage contact tracing and screening within the local prison. Of the contacts screened to date, there has been no evidence of transmission from index cases to other prisoners or to staff who work in prisons.

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

An exercise was conducted in the first quarter of 2016 to run through potential outbreak scenarios and to discuss the role and responsibilities of local health partners, and to determine how resources can be accessed for possible outbreak responses in Bristol. This identified the need for a localised mass response framework to sit underneath the Avon, Wiltshire and Gloucestershire (AGW) Communicable Disease Framework. Bristol City Council Public Health and PHE are currently working to draft this guidance. The plan will include guidance on how to coordinate mass incidents requiring prophylaxis, vaccination, screening and phlebotomy, as well as linking into existing guidance and plans such as the Health Protection Part 2A orders.

Strengthened partnership Working

A Consultant in Public Health post was created and joint funding for this post was agreed between Bristol City Council and PHE.

Communicable Disease Port Health Arrangements

As a Port Health Authority (PHA), Bristol City Council enforces a range of international, European and domestic legislation at Royal Portbury Dock and Avonmouth Dock and aboard vessels carrying passengers and freight to protect the public, animal and environmental health of the UK and Europe.

The Port Health Authority is responsible for preventing the spread of infectious disease from seafarers and passengers into Britain. One of the ways they achieve this is to monitor ships that have visited "high risk" ports over a three week period prior to arrival into Bristol.

The procedures for handling infectious diseases at Bristol seaports has been extensively reviewed in 2015, and several training exercises have been undertaken to validate the plan.

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.
- **Infection Prevention and Control:** See section 1.2.

Areas for focus in 2016-17

- **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 (same area has been identified in section 1.2 of this report).

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2. Immunisations and Screening

2.1 Immunisations

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 2. Total cases of vaccine preventable infections in Bristol local authority area between April 2015 to March 2016

Infection	Total Cases on HPZone living in City of Bristol Local Authority April 2015 to March 2016
Measles	15 (1 confirmed)
Mumps	75 (3 confirmed)
Rubella	<5 (not laboratory confirmed)
Diphtheria	<5 (confirmed)
Tetanus	0
Pertussis	157 (125 confirmed)
Polio	0
Meningococcal	12 (8 confirmed cases of which 4 were Group B)
HiB	0

Source: Public Health England HPZone record system

Successes/Progress

Influenza Vaccine Uptake 2015/16

Bristol achieves uptakes in line with the national average for seasonal flu, with the exception of those with existing medical conditions. Improving uptake in the under 65 at risk group, amongst pregnant women, Health Care Workers and amongst children were identified as key priorities for the 2014/15 Seasonal Flu Plan. During 2015/16 Bristol saw a small

increase in flu uptake for pregnant women, which was higher than the national picture, which saw a small decrease.

Childhood flu immunisations for Years 1 and 2 were implemented in Bristol in 2015/16. Following a national procurement a pharmacy model was commissioned late in Bristol through Boots and offered to all eligible children. Uptake was lower than in school based programmes, but mirrored uptake levels achieved in the national pharmacy pilots. For 2016/17 it is hoped to commission a school based model much earlier in the year. The delivery model should see much higher levels of uptake because plans will be in place to achieve a national and locally agreed threshold for Years 1, 2 and 3 across every school in Bristol.

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).

During 2014/15, uptake for the DTaP/IPV booster at 5 years appeared to be lower than expected. An investigation of this data found that coverage for this immunisation was higher than reported and this was due to an error in the call/recall from the Child Health Information Service. This resulted in children being invited and receiving immunisation before 3 years 4 months, which would not have been included in the COVER data reporting specifications. By taking this into account and including children vaccinated earlier than 3 years 4 months showed that there was an uptake increase to over 90%. The Child Health Information Service team have corrected the call/recall so that children are being vaccinated at the correct time and national and local discussions are underway to discuss data reporting for this immunisation.

School age immunisations

HPV and MenC uptake for 2014/15 (academic year) was recognised as being poor and immediate action was undertaken to review the service during 2015/16 (academic year). This has resulted in the implementation of monthly meetings with the provider and more frequent data reporting. 2015 saw the implementation of MenACWY (meningitis strains A, C, W and Y) immunisation programme in response to the national MenW outbreak. In Bristol MenC vaccine was replaced with MenACWY vaccine for year 9 students, with an additional mop up for year 11 students. Available data at the time of writing this report suggested there was a positive improvement in uptake during 2015/16 and the providers have worked hard to deliver additional catch-up clinics through the summer holidays. Td/IPV booster vaccinations continue to be delivered through primary care (GP practices).

Adult immunisations

The uptake of pertussis vaccine in pregnancy during 2014/15 has remained similar to 2013/14 uptake at ~60%. Estimates[9] for 2015/16 show monthly uptake in the Bristol, North Somerset and Gloucestershire NHS England Area team ranged between 53.9 and 67.8% over the year.

Uptake of pneumococcal vaccine was 71.4% in 2014/15 and is 71.3% in 2015/16. The shingles (varicella zoster) vaccine has an annual cohort and for the last cohort (vaccinated between 01.09.2014 – 01.09.2015) uptake was 53.8% for 70 year olds, and 56.3% for 78 year olds (catch up cohort).

Reducing health inequalities

During 2015/16 the screening and immunisations team have been focusing on improving uptake for school aged children in Bristol, with a focus on improving uptake at schools with low uptake last year. A needs assessment of 0-5 immunisations is underway which will also inform future work streams to target reducing inequalities in uptake.

Implementation of MenB and MenACWY programmes

See also school age immunisation section. MenB and MenACWY have now been successfully implemented within Bristol according to the national immunisation schedule. This implementation was supported by the provision of training sessions, held via Webex across the South West. This has continued to be supported following feedback from practice nurses in Bristol particularly in relation to implementing the MenB booster at 12 months, which sees 12 month olds receiving four immunisations in one session.

Development of targeted neonatal hepatitis B immunisation pathways

Neonatal HepB immunisation pathways have been developed and successfully implemented. This means that babies born to mothers who are hepatitis B positive are offered a course of immunisation and their immunity is tested through a serology test at 12 months of age. This is an important intervention in protecting those babies from contracting hepatitis B.

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:

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[9] PHE (2016). Prenatal pertussis coverage estimates by area team and clinical commissioning group: England, April 2015 to March 2016. London: PHE

- **Bristol Immunisations Group**

  2015/16 saw the implementation of the Bristol Immunisations Group (May 2015). 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. The group has a work plan and has prioritised support to improve the accuracy of data held by the Bristol CHIS, particularly in relation to data for school age children; improvement of uptake for HPV and Men ACWY.

- **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 2016-17

- 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.

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.

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.

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 2016-17

- 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.

Successes/Progress

LHRP Assurance Process Outcomes

The LHRP Annual EPRR assurance review in October 2015 highlighted high levels of preparedness for Bristol Community Health and Avon and Wiltshire Mental Health Partnership NHS Trust with both being assessed as substantially compliant against the emergency preparedness, resilience and response core standards set out by NHS England.

Bristol CCG had shown progress from 2014 and was considered partially compliant, however areas of concern were identified with regards to levels of preparedness being achieved and maintained by the University Hospital Bristol NHS Foundation Trust (UHB) whose status at the end of the review was considered to be non – compliant.
Since October 2015 UHB has worked hard to improve and in May 2016 at their quarterly review meeting with Bristol CCG demonstrated that they had made positive progress in addressing a number of areas. Progress continues to be closely monitored by the CCG with Accountable Emergency Officer (AEO) quarterly review meetings continuing to take place.

LHRP Pandemic Flu Framework

A framework has been produced on behalf of Avon and Somerset Local Health Resilience Partnership (LHRP) to support the delivery of an effective response in the event of an Influenza Pandemic. It is not intended to fully replicate national strategy and guidance; however it does include some key information for ease of reference.
The aim of this framework is to enable Avon and Somerset LHRP to develop and deliver a co-ordinated and joint response to influenza pandemic that threatens the health of, or the delivery of health services to, the population of Avon and Somerset.
The framework builds upon existing arrangements for escalation and winter planning, and is intended to be proportionate, flexible and able to manage a range of scenarios that may present different attack rates and patterns of disease spread across Avon and Somerset and which may impact on the health of the population or carry severe adverse effects for health service provision.

Response to Ebola Virus Disease (EVD)

The outbreak of the Ebola virus in 2014 primarily affected 3 countries in West Africa: Guinea, Liberia and Sierra Leone. In total, more than 28,600 cases and 11,300 deaths have been reported by the World Health Organization

In response to this threat, an Avon and Somerset LRF (ASLRF) and Local Health Resilience Partnership (LHRP) exercise was held to review local preparedness and response arrangements to an importation of a suspected Ebola case at a UK port of entry.

Following a request by the Director of Public Health, a further local level exercise was developed to test the preparedness of Bristol City council if an outbreak of Ebola Virus Disease occurred in the city. The aim of the exercise was to consider both the role Bristol City Council will play should a case of Ebola be identified in Bristol and the wider impact on Bristol and its communities.
In addition, Bristol City Council Public Protection Team and Public Health England worked together to develop an exercise for the seaport. This was the first one of its kind in the UK. The aim of the exercise was to review local preparedness and response arrangements to an importation of a suspected Ebola case at Bristol Seaport. Acting on recommendations from this exercise, the port arrangements policy for dealing with infectious diseases was reviewed and Port Health staff are now on-call and provide cover at the port 24 hours a day, 365 days a year.

The Ebola pandemic in West Africa has now been declared over. Should a similar threat occur in the future, it is extremely unlikely to result in a sizeable outbreak in the UK, or Bristol specifically, given the robust plans that have been put into place.

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. The Ebola pandemic in West Africa is now over, and the risk to the population of the UK was low.

  There is an ongoing outbreak of Zika virus infection, mostly focussed in South and Central America and the Caribbean. Based on a growing body of research, there is scientific consensus that Zika virus is a cause of microcephaly and other congenital anomalies. Symptomatic Zika virus infection is typically mild and short-lived in most individuals, but particular attention is required for women who are pregnant or who are planning a pregnancy due to the risks of Zika virus to the developing foetus. A very rapid spread of a pandemic due to an emerging infectious disease could have a considerable impact on the health economy in Bristol.

- **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.

  A short but severe pandemic may place a greater strain on health and social care services than the same number of people becoming ill over a more prolonged period. Critical care services may be at risk of being overwhelmed in a short severe pandemic, whereas primary care may shoulder the greater part of the burden during a mild, extended pandemic wave.

- **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).

  An estimated 43,900 excess winter deaths occurred in England and Wales in 2014/15; the highest number since 1999/00, with 27% more people dying in the winter months compared with the non-winter months. Excess deaths due to premature winter mortality in Bristol are lower than the UK average (7.2% of deaths compared to 11.1% nationally), but a catastrophic event such as an Influenza Pandemic could put added pressure on the local health system.

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.

Areas for focus in 2016-17

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

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[10] calculated that 188 deaths of Bristol residents can be attributed to air pollution in 2010, with a proportion (24 deaths) attributed to pollution from local road transport emissions in Bristol. These deaths attributed to air pollution compare, on average, to 9 people killed in road traffic collisions in Bristol each year. In addition to deaths, 52 additional hospital admissions for breathing difficulties and 42 for heart problems can be attributed to air pollution in 2010.

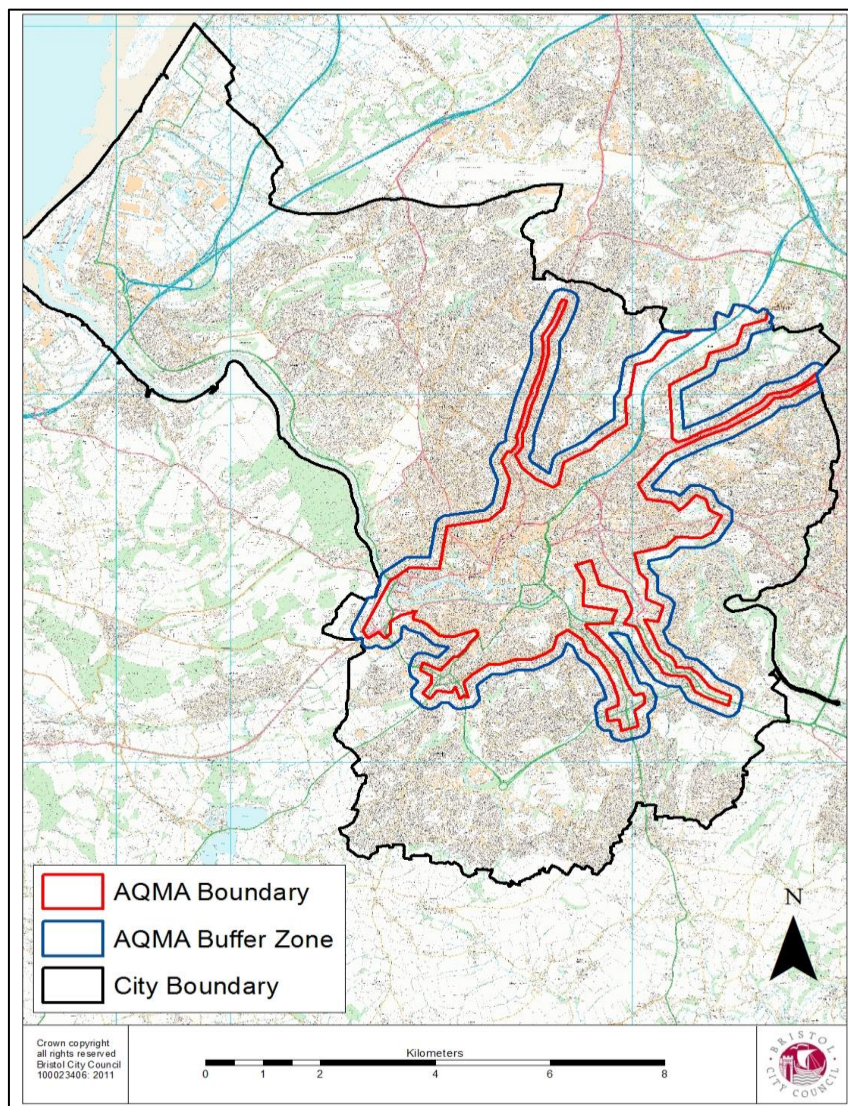
Since this report was published, the weight of evidence of health impacts associated with nitrogen dioxide (NO_2) has grown. This evidence puts the health impacts of this pollutant on a par with those associated with particulate matter. The figures quoted in the Bristol health report are likely to significantly underestimate the health impacts of air pollution as they do not take into account the latest evidence on the impacts of NO_2.

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.

[10] Air Quality Consultants (2014). Health Impacts of Air Pollution in Bristol. London: Air Quality Consultants

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 ('PM10') and 2.5 microns ('PM2.5').

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 will focus on larger particles; this is dust which can be seen, typically appearing on cars windscreens and other locations. This nuisance dust has also been of concern to the community. Monitoring measures have been proposed including having a number of dust deposition monitors located around Avonmouth with one control site. The public have been asked to help identify locations, (officers have already suggested several sites) and to report issues when problems arise. The dust deposition monitoring is planned to run for 6 months and results reported back to the community. A private contractor has been procured to undertake the monitoring and they will use accredited laboratories to analyse any samples as necessary. Environmental Health Officers from the Pollution Control Team will then review the findings to establish if a statutory nuisance exists and if so where the potential sources of any dust are located.

Key current risks

- Maintaining an effective dialogue with Bristol residents about environmental hazards to health.

Areas for focus in 2016-17

- 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.

- Implement phase 2 of the Nuisance dust monitoring and report back analysis and results to the community after the six months of monitoring.

- 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. Aim to implement measures to achieve compliance with air quality objectives in shortest time possible.

NHS
Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Bristol's Strategy for Children, Young People and Families 2016 - 2020	
Author, including organisation	Michele Farmer Service Director, Early Intervention and Targeted Support, Bristol City Council
Date of meeting	19th October 2016
Report for Information	

1. Purpose of this Paper

The Children and Families Partnership Board endorsed Bristol's Strategy for Children Young People and Families (Appendix 1) at their September meeting. The Board agreed to take the strategy to their networks and Governing Bodies to seek their commitment to the strategy, and their agreement to participate in more detailed action planning. The Health and Wellbeing Board are being asked to endorse the strategy in this context.

The Children and Families Partnership Board will then be asked at their meeting on November 3rd to agree the strategy having gained the support of partners.

2. Key background / detail:

2.1 There is no longer a statutory requirement to produce a children and young people's plan. However, the duty to cooperate to improve children's wellbeing, as set out in section 10 of the Children Act 2004, remains in force, with guidance that local areas should continue to produce a plan where it makes sense locally. This is observed in inspection.

2.2 The Children and Families Partnership Board instigated the development of this strategy in March 2016 and established a cross sector reference group to lead the process.

2.3 This has not been a refresh of an existing strategy or plan, but builds on, pulls together and signposts to a number of existing strategic documents from across the partnership.

2.4 The development of this strategy has run in parallel with other strategic planning, such as the refresh of the Health and Wellbeing Strategy, and the development of the Children's Services Improvement Plan and the Adult Social Care Plan, and links have been made as appropriate.

2.5 Bristol's Strategy for Children, Young People and Families aims to:

- Establish a shared focus for the Children and Families Partnership
- Set out the focus of our shared work for the next four years
- Promote prevention and early intervention
- Provide the strategic context to drive future commissioning
- Support the implementation of the Mayoral City Vision and other city planning
- Demonstrate how partners fulfil the duty to cooperate to improve children's wellbeing

2.6 This is the overarching strategy for the Children and Families Partnership. It focusses on shared priorities and does not detail all of the work of the partnership. It signposts to other strategies that the partnership have agreed, and includes a new city-wide outcome framework that will be used to improve the alignment of our future work.

2.7 The development of this strategy has run in parallel with other strategic planning such as the refresh of the Health and Wellbeing Strategy, the Children's Services Improvement Plan and the development of the Adult Social Care Strategic Plan, and links have been made where appropriate, for example:

- The same prioritisation criteria were used for the Health and Wellbeing strategy refresh and Bristol's Strategy for Children, Young People and Families
- Bristol's Strategy for Children, Young People and Families and the draft Health and Wellbeing Strategy both propose the prioritisation of emotional health and wellbeing in the city.

2.8 The reference group jointly agreed the draft vision statement and the draft outcomes and priorities that were consulted on from June to August.

2.9 During the consultation period, we attended several events to promote the consultation and talk about the proposals. We also spent some time with community groups finding out what they felt was important. We also made use of existing consultation data from children, young people, parents and carers, and engaged the Youth Council and Young Health Watch in the process.

2.10 The strategy includes high level priorities that will remain relevant throughout the course of 2016 – 2020. The Children and Families Partnership Board will agree annual action plans for each of the priorities, and the board will oversee and report on these. This work programme will be within the context of increasing demands and diminishing resources across the partnership.

2.11 We will be working closely with other City Partnerships and the Bristol Safeguarding Children Board to address the priorities in the strategy and to support priorities that they have identified, for example will envisage working closely with the Health and Wellbeing Board on Healthy Weight.

APPENDIX 1

Children & Families
PARTNERSHIP

Bristol’s Strategy for Children, Young People & Families 2016 – 2020

INTRODUCTION

Bristol is one of the most vibrant, wealthy, well-educated and creative cities in the UK. There are 97,900 children and young people aged 0-18 (including 18 year olds) living in the city and we want to ensure that they are all able to take advantage of the benefits of living here. Most do, but there are some children and young people who cannot, or who need help to do so. Bristol is a city of geographical inequality and poverty. The place we are born, or the place we live, is likely to dictate our life chances, unless actions are taken to change this.

This is a shared responsibility and requires a whole city response. Strong partnership working between organisations, businesses, and communities will help target effort and limited resources. By working together and sharing expertise, experience and commitment we can ensure the best outcomes at all stages of childhood, and support the most vulnerable.

The Children and Families Partnership work with children, young people and families, across sectors. We focus on the life chances and outcomes of children from conception to 19, and in some cases up to 25. We exist to promote their health and wellbeing and to safeguard vulnerable children, young people and families.

This strategy sets out the priorities that the Children and Families Partnership have agreed as the focus of our joint work for the next four years.

VISION

Bristol has bold ambitions for its children and young people. All children get a good start in life, whatever their background and wherever they live. Together, the Partnership, is listening to their needs and aspirations.

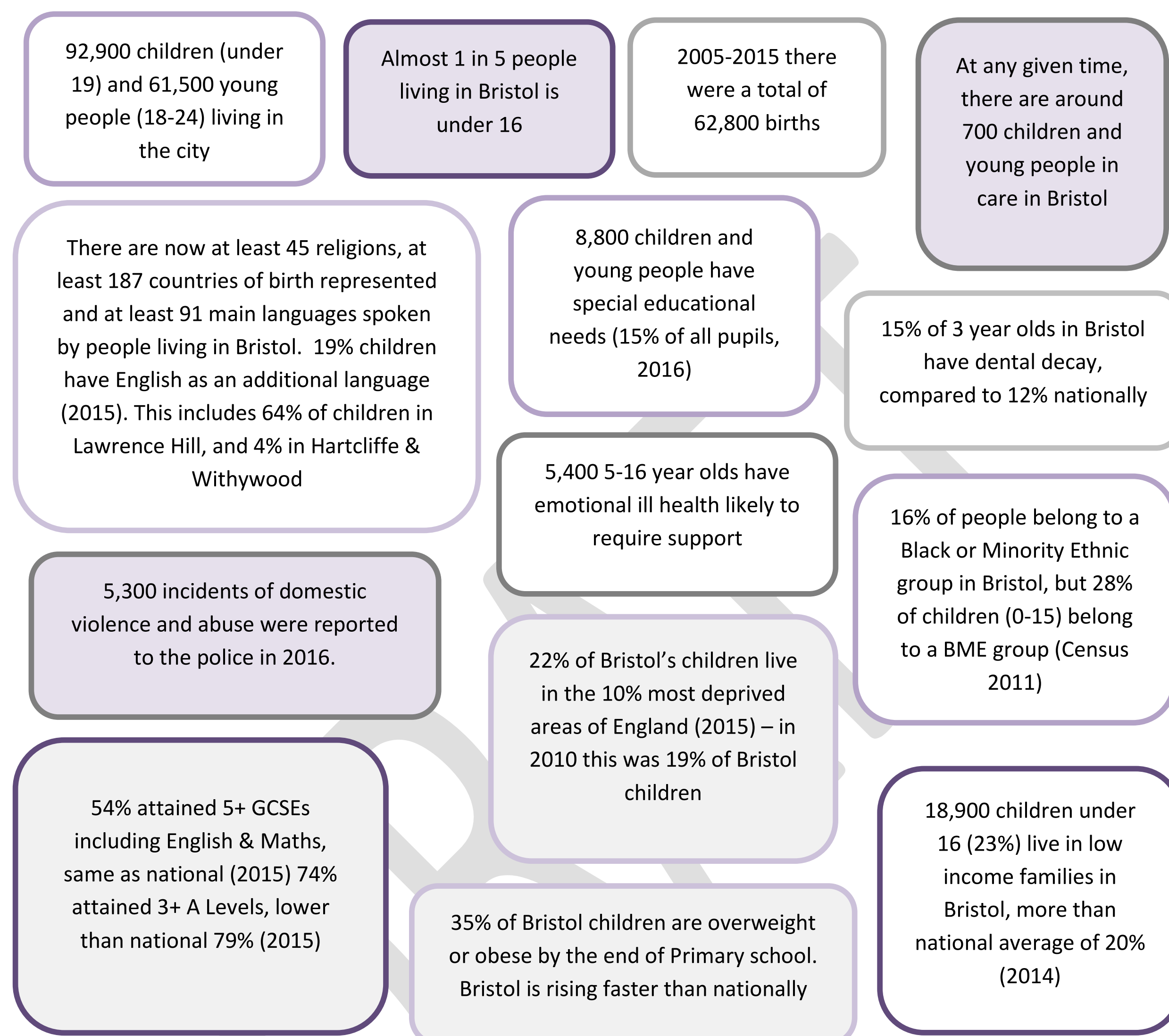
We are investing early to prevent harm, helping families build lifelong resilience and self-reliance. All of us together, working beyond boundaries, across neighbourhoods - families, friends, communities and professionals.

When children and young people are at risk of harm, we act swiftly. We protect them, by listening to them and acting on their behalf to restore their rights – stability, permanence, security, education, health and wellbeing.

Bristol is an inclusive city that respects difference. Even the most vulnerable children and young people are participating, shaping and enriching the life of the City.

Whether at the start of life, or on the way through, no-one gets left behind

CHALLENGES AND OPPORTUNITIES



Poverty – financial, social and health deprivation – remains the leading predictor of poor life outcomes. In Bristol, ***one in every four children***, live in poverty. These are the children whose life chances start or fall significantly behind that of their peers. In reality, if you walk through some of our neighbourhoods, almost ***every other child*** you pass is living with the effects of poverty. Elsewhere in the city, only ***one in every fifty*** children you see is living in poverty.

There is strong evidence that poor health is linked to social and economic disadvantage and deprivation which starts before birth and accumulates throughout life. If we are to effectively promote health and wellbeing and reduce cycles of health inequalities we need to take action before birth and across the life course.

Enabling ***everyone*** to have fair access to the opportunities Bristol offers, means addressing the root causes of poverty in the places where we know people are struggling, and addressing

inequality in access to the city's opportunities. We need to work in partnership with communities to change this.

Our evidence base for this strategy is the Joint Strategic Needs Assessment along with evidence from recent work and feedback from consultation.

OUTCOMES

The Partnership is committed to working across all sectors and with local communities to find solutions that improve the life chances of children, young people and families.

The Partnership's work aims to achieve these outcomes for all children and young people:

Safe & Nurtured	• Have the best possible start in life; protected from abuse, neglect or harm, at home, at school and in the community, with a secure and supportive network of family or carers and friends • Live in a nurturing home, in a family setting, with additional help or adaptations if needed, or, where necessary in a suitable care setting • Live in safe and stable accommodation, free from financial exclusion, and from fear indoors and out; giving the permanence and security upon which they can build
Healthy & Active	• Have the best physical and mental health possible, access to suitable health care and support in learning to make healthy, safe choices from the outset • Engage in opportunities to have fun and take part in activities, such as play, recreation and sport, which build independence and contribute to healthy growth and development at home, in education and in the community
Respected & Involved	• Are heard and have control in decisions that affect them and the communities in which they live and learn • Aware of how their views, opinions and experiences have helped shape Bristol; the opportunities and services available to them, and the physical environment • Show respect, care and pride for other faiths communities, cultures, identities, abilities, backgrounds and experiences, and feel that their own identity, is valued by other people
Responsible & Achieving	• Supported and inspired in lifelong learning, and in the development of skills, confidence, individuality and aspirations at home, in education, in work, in the community and beyond • Engage in positive opportunities and are encouraged to play active and responsible roles at home, in education and in the community • Benefit from fair access in education, in the community to experience of work, to employment and independence or supported living

DRAFT

PRIORITIES
The strategies in place across the Children and Families Partnership all play a role in ensuring that children and young people will achieve the outcomes, with the support of their families, friends and communities. However, we recognise that we need to come together to focus on the following priorities to ensure the most vulnerable children and young people are able to achieve these outcomes.

This Strategy places poverty and inequality as a key theme throughout all of the following priorities. We know where in the city children and young people are living in poverty, and with the effects of this, and we will use this data in our targeting of resources.

1. **Emotional Health and Wellbeing** (design – link to the Health and Wellbeing Board)
Data Link: Emotional Health and Wellbeing in Bristol Needs Assessment 2015 (Children and Young People)

- We will promote and create positive, fun and challenging opportunities to help children and young people develop their confidence, creativity and resilience through investment in youth services and early years provision, and by promoting their engagement in physical activity and the cultural life of the city
- We will pursue the local transformation of emotional health & wellbeing services for children and young people and invest together with schools in the things we know work to ensure that every child and young person, everywhere, receives the right support, as early as possible
- We will work with the Health and Wellbeing Board to improve health and wellbeing across the city, for parental emotional health and wellbeing in particular

2. **Safe and Inclusive Communities** (design – link to the Safer Bristol Partnership)

Data Link to embed:

Safer Bristol Crime and Disorder Strategic Assessment, January 2015
Bristol Domestic & Sexual Abuse Needs Assessment 2013

- We will work closely with partners including the Safer Bristol Partnership to reduce the number of young people entering the criminal justice system by focussing on intergenerational offending and preventing involvement in street conflict and anti social behaviour
- Through joint safeguarding practices, procedures and protocols we will protect children and young people from coercion and exploitation and work to prevent bullying, harassment and discrimination
- We will work with families where there are multiple, complex needs, particularly where children and young people have special educational needs or disabilities, are living with the effects of drug and alcohol misuse or domestic violence and abuse, or where young people have been identified as carers
- We will continue to support the use of restorative approaches in the city and champion inclusion and diversity

Children & Families PARTNERSHIP

3. **Education, Employment & Skills** (design – link to Learning City)
Awaiting link to new attainment figures

- From the earliest years we will encourage children and young people to be aspirational and to develop positive attitudes to learning
- We will work with Bristol Learning City Partnership to provide clear skills development and employment pathways to provide experience of work, mentoring and in work training opportunities to help all young people make positive, informed choices that lead to interesting and inspiring careers
- We will improve learning outcomes for vulnerable groups, and provide targeted support for those most at risk of underachieving or being excluded from learning, including children with Special Educational Needs and disabilities, Children in Care, Care Leavers, young carers, BME children and young people and those at risk of becoming involved in street violence

4. **Housing** (design – link to Bristol Homes Board)

Link to the strategy / needs assessment: https://www.bristol.gov.uk/housing/housing-strategy-and-supporting-strategies

- We will work with the Bristol Homes Board and support the Preventing Homeless Strategy to ensure access to safe, stable, suitable or adapted and affordable housing for vulnerable families and young people including children in care and care leavers

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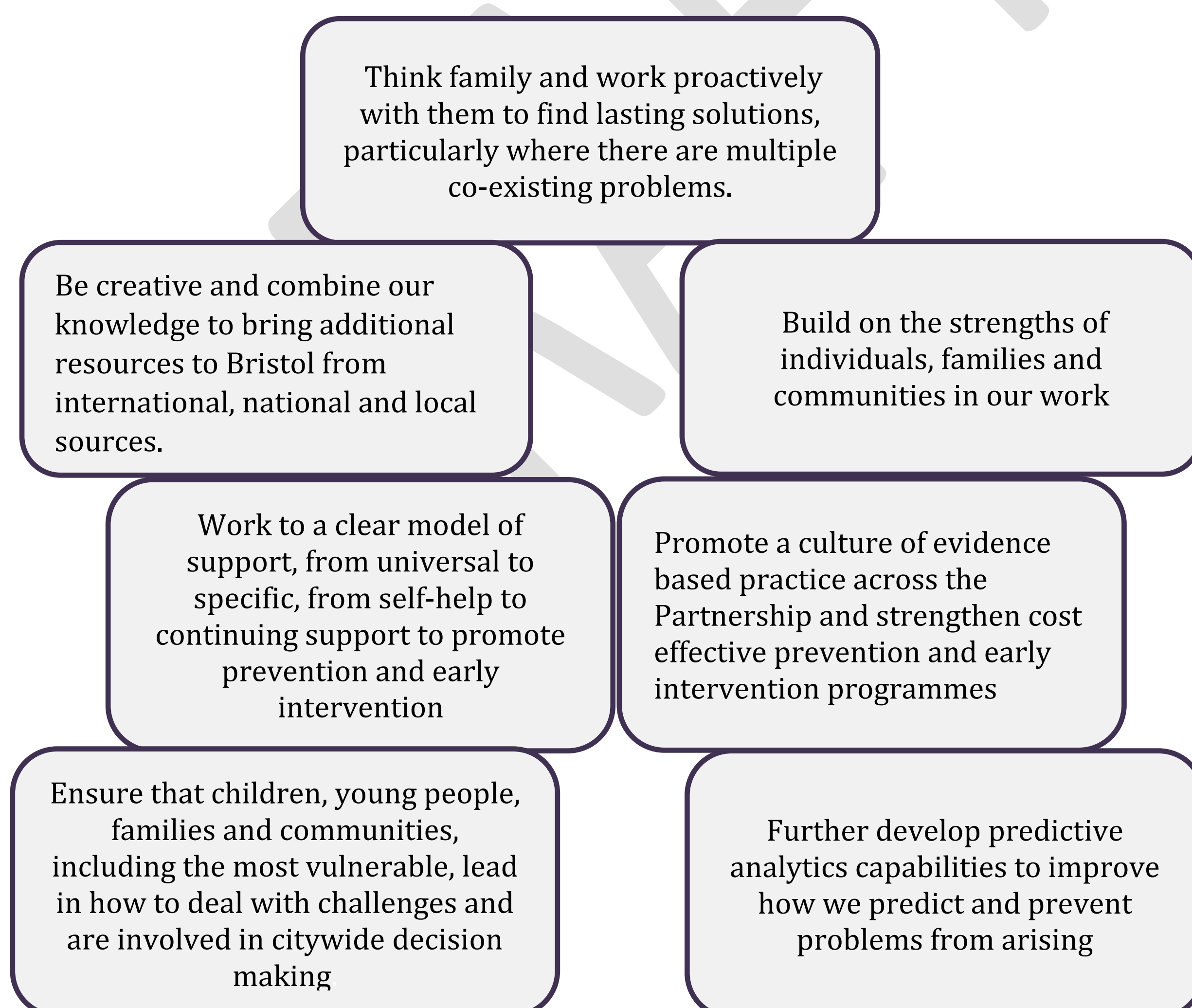
THE PARTNERSHIP AND GOVERNANCE ARRANGEMENTS

The Children and Families Partnership is one of Bristol's City Partnerships. We work in partnership because addressing these issues is the responsibility of everyone who works and cares about children and young people.

The role of the Children and Families Partnership is to identify the needs of children, young people and families, and work with them to steer the whole city's response in order to give them the best possible start in life, reducing inequalities that are due to economics, education, health and disability. We join together and pool resources, targeting the right help, at the right time, to the right people to improve their life chances. It is about identifying people early, protecting them when needed, building their resilience and helping them to participate fully and independently in Bristol's economic, social and cultural life.

We are developing the following approaches that require agencies and organisations to work together effectively to support families, with a shared purpose to achieve joint outcomes. We will:

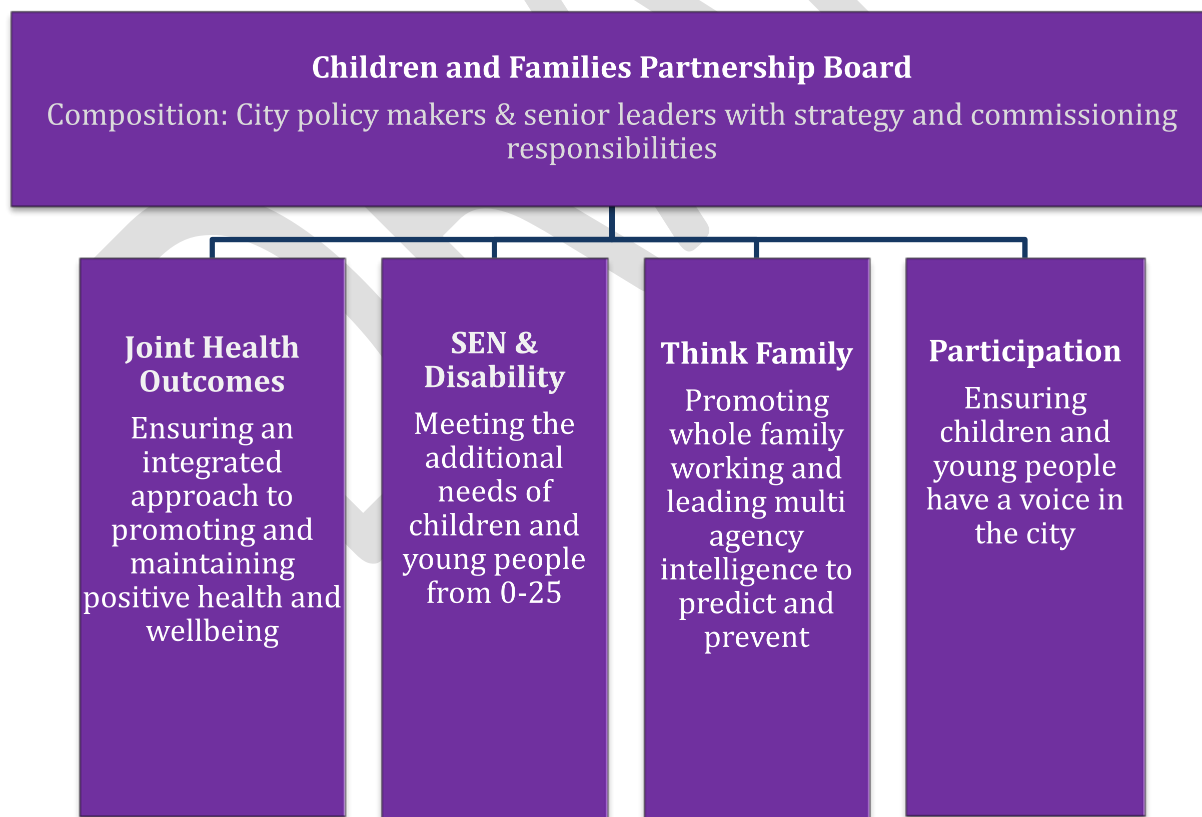


We work closely with other city Partnerships, so that we can be sure the needs of children, young people and families are at the forefront of decisions about housing, health, community safety and other important decisions across our city. You can find more about these here:

- Health and Wellbeing Board
- Safer Bristol Partnership
- Bristol Learning City Partnership
- Bristol Safeguarding Children Board
    - The Children and Families Partnership Board has a crucial relationship with the **Bristol Safeguarding Children Board** who ensures that there are robust arrangements in place across agencies to protect children and young people from harm and to promote their welfare. This includes effective information sharing. Everyone within the partnership follows agreed policies and procedures.

The Children and Families Partnership Board are responsible for the delivery of this Strategy. The Board will develop annual Action Plans to deliver these priorities through the Partnership's subgroups and with other partners. These Action Plans will have clear measures so that we can check that the Strategy is making a difference.

The Action Plans, measures and relevant data are available here.



Children & Families PARTNERSHIP