Health and Wellbeing Board

Agenda

BRISTOL CITY COUNCIL

NHS
BRISTOL CCG

Date: Wednesday, 15 February 2017

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 Fi Hance, Cllr Claire Hiscott, 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, 7 February 2017

Agenda

1. Welcome, apologies and introductions — 2.30 pm

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

Petitions and statements (must be about reports 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.
The deadline for receipt of petitions and statements for the 15 February Health and Wellbeing Board is **12.00 noon on Tuesday 14 February.**
These should be e-mailed to democratic.services@bristol.gov.uk

Questions (must be about reports 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 individual can be submitted. The deadline for receipt of questions for the 14 February Health and Wellbeing Board is **5.00 pm on Thursday 9 February.**
These should be emailed to democratic.services@bristol.gov.uk

3. Declarations of interest

4. Minutes of previous meeting

To agree the minutes of the previous meeting as a correct record. — **(Pages 4 - 8)**

5. Key decision - Children's community health services contract duration — 2.40 pm

(Pages 9 - 16)

Report authors:
Anne Colquhoun, Programme Manager - Children and Young People's Public Health
Fiona Butter, Programme Director - CCHS Recommissioning, Bristol CCG
Mike Pingstone, Associate Director of Procurement - NHS South, Central and West Commissioning Support Unit

6. Mental health and wellbeing in Bristol — 3.00 pm

(Pages 17 - 22)

Report authors:
Leonie Roberts, Consultant - Mental Health and Social Inclusion
Dr Joanna Copping, Consultant - Young People's mental health

Victoria Bleazard, Programme Manager - Mental Health and Social Inclusion

Note: as part of this item, verbal feedback will also be received from one of Bristol's Youth Mayors relating to the 'Freedom of Mind' conference for young people held in October 2016.

7. Making every contact count — 3.30 pm

Report author:
Katie Porter, Senior Public Health Principal

(Pages 23 - 28)

8. Work, health and disability green paper — 3.50 pm

Report author:
Becky Pollard, Director of Public Health

(Pages 29 - 33)

9. Sugar Smart City update — 4.10 pm

Verbal update, for information, from Sally Hogg, Public Health Consultant.

10. Any other business — 4.25 pm

Bristol City Council
Minutes of the Health and Wellbeing Board

14 December 2016 at 2.30 pm

Board members present:-
Mayor Marvin Rees, Dr Martin Jones, Alison Comley, John Readman, Jill Shepherd, Cllr Lesley Alexander, Cllr Fi Hance, Cllr Clare Campion-Smith, Ellen Devine, Elaine Flint, Steve Davies, Justine Mansfield and Pippa Stables

Officers in attendance:-
Kathy Eastwood, Service Manager – Health Strategy, BCC (supporting the Board)
Ian Hird, Democratic Services, BCC
Mike Hennessey, Service Director – Care, Support & Provision – Adults, BCC
Simon Dicker, Commissioning Manager, BCC
Nick Smith, Strategic Intelligence & JSNA Manager, BCC
Dr Jo Copping, Consultant in Public Health Medicine, BCC
Sally Hogg, Public Health Consultant, BCC
Beth Bennett-Britton, Speciality Registrar – Public Health, BCC
Rebecca Cross, Strategic Commissioning Manager, BCC

1. Welcome, apologies and introductions

Attendees were welcomed to the meeting.

Apologies were received from Keith Sinclair, Linda Prosser and Becky Pollard.

2. Public forum

The following public forum item was received and noted:

Public forum statement from Cllr Clare Campion-Smith

The Board received a statement from Cllr Clare Campion-Smith about the subject of workforce training and the need to ensure joint training as part of continuing to build understanding between the Council and the NHS, particularly in relation to the integration of health and social care.

It was noted that one of the aims of the Board continued to be to encourage joint work, integration and synergies between the two organisations. Whilst recognising there was more to do in this area, there had been good examples of this approach, e.g. through the commissioning of children's community health services.

3. Declarations of interest

Ellen Devine declared an interest in agenda item no. 5 – Key decision: Local HealthWatch and Independent Complaints Advocacy Service arrangements for 2017-18 in light of her employment by HealthWatch. It was noted that she would not participate in the discussion of this item, other than to respond as necessary to any specific questions that might be asked in connection with the item.

4. Minutes of previous meeting

RESOLVED:
That the minutes of the meeting of the Board held on 19 October 2016 be confirmed as a correct record and signed by the Chair.

5. Key decision: Local HealthWatch and Independent Complaints Advocacy Service arrangements for 2018-19

The Board considered a report seeking approval of a key decision on arrangements for local HealthWatch and Independent Complaints Advocacy Services arrangements for 2017-18.

Simon Dicker, Commissioning Manager presented the report.

The following issues were noted:

a. There was general acknowledgement from the Board about the reasons why this proposal had come forward for decision, recognising the financial position and challenges faced by the Council.

b. It was noted that the taking of this decision would inevitably result in a reduction of resource for HealthWatch, and that future expectations of the service would need to be viewed in the light of this reduction.

c. In response to a question from the Mayor, Ellen Devine commented that a main impact from the budget reduction would be a consequent reduction in the level of engagement and consultation work carried out by HealthWatch. The Mayor advised that it would be important to log and be fully aware of the consequences of this difficult decision.

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

1. **That approval be given to the option of a final years extension to this contract.**

2. **That approval be given to this being at a reduced rate of £320,000 creating a total saving of 20% whilst maintaining the service capacity of ICAS.**

3. **That approval be given to sending notification to the provider during December 2016, to ensure that savings of £80,000 are achieved in 2017-18.**

6. Bristol Joint Strategic Needs Assessment 2016-17

The Board considered a report setting out the final draft of the Bristol JSNA data profile 2016-17 and an update on the progress of priority JSNA chapters.

Nick Smith, Strategic Intelligence and JSNA Manager and Dr Jo Copping, Consultant in Public Health Medicine presented the report.

Main points raised/noted in discussion:

a. The JSNA data profile would be launched and made available on-line at the end of December.

b. The Mayor drew attention to the importance of ensuring robust systems were in place to collect data so that race inequalities in health could be tracked reliably. Following discussion, it was agreed that action on this must be taken forward to enable all providers (e.g. GP practices) to collect ethnicity data in a consistent way.

c. The 2016-17 data continued to identify the 3 priority areas as per the refreshed Health and Wellbeing Strategy (mental health and wellbeing, alcohol misuse and healthy weight) as key issues. Whilst noting that JSNA priority chapters were being developed, it would be important for the Board to retain a focus on the 3 priority areas, holding partners to account for delivering key outcomes.

d. In developing the priority chapters, consideration should be given to challenging key partners to make “leap of faith” changes to achieve greater impacts, e.g. by using resources in different ways if this would achieve improved outcomes. The priority chapters should also look to provide assurance to the Board about action that is being taken in respect of the key areas of health data.

e. The Mayor suggested that links should be made between the JSNA and the recently published city resilience strategy.

At the conclusion of the discussion, the Board

RESOLVED:

- **That the report/presentation and the above information/comments be noted.**

7. Developing the Healthy Weight Strategy and Sugar Smart city

The Board considered reports setting out information on the development of the Healthy Weight Strategy and Sugar Smart City initiative.

Sally Hogg, Public Health Consultant and Beth Bennett-Britton, Speciality Registrar presented the reports.

The Board generally welcomed the progress of these initiatives. However, whilst recognising the need for accountability, given the resource constraints faced by the Council and partners, governance should be through existing structures rather than creating a new / additional governance structure. For example, the Joint Health Outcomes sub-group might be an appropriate governance vehicle for monitoring progress on the Healthy Weight strategy and action plan, once these were approved by this Board.

RESOLVED:

- **That the reports and the above information/comments be noted.**

8. Children and Young People's Emotional Health Transformation Plan 2016-17

The Board considered a report setting out details of the refreshed Children and Young People's Emotional Health Transformation Plan for 2016-17

Rebecca Cross, Strategic Commissioning Manager presented the report.

Main points raised / noted included:

a. This transformation programme was being led by a joint NHS and City Council team, working with providers, the voluntary sector, children, families and young people including the Youth Council and the Freedom of Mind team. This integrated partnership approach would continue to shape and deliver the plan.

b. It was noted that emotional health and wellbeing was an important factor for all children. It was also important to identify risk factors for children of primary school age.

c. It was suggested that it would be useful to produce an "easy to read" digest of the plan that could be shared with children and young people.

RESOLVED –

- **That the report and the above information/comments be noted.**

9. Any other business

Update from the Mayor:
The Mayor updated the Board on the development of the new City Office, the key aim of which was to play a crucial role in both getting things done and uniting Bristol's key institutions around shared goals.

Two projects were already underway:

a. A project to tackle street homelessness and rough sleepers through the current winter months.

b. A project to ensure that all young people in Bristol schools gain a meaningful work experience opportunity.

In addition, building on the recently published city resilience strategy, work was to begin on developing a single city plan for the next 50 years.

All partners were asked to be appropriately involved / represented in these initiatives.

Sexual health services contract award:
It was noted that University Hospitals Bristol NHS Foundation Trust had been appointed to manage sexual health services across Bristol and the surrounding region. The new service, commissioned by Bristol City, South Gloucestershire and North Somerset councils, and the accompanying CCGs would begin on 1 April 2017.

Kathy Eastwood, BCC Service Manager - Health Strategy:
The Board noted that Kathy Eastwood would shortly be leaving her role with BCC. On behalf of the Board, the Chair thanked Kathy for her work, contribution and highly professional support over many years and extended very best wishes for the future.

Meeting ended at 4.35 pm

CHAIR _____

Health & Wellbeing Board

Date of Meeting 15th February 2017

Report Title: Children's Community Health Services Contract Duration

Ward: City Wide

Strategic Director: Alison Comley

Report Author:
Anne Colquhoun Programme Manager Children and Young People's Public Health
Fiona Butter, Programme Director CCHS Recommissioning, Bristol CCG
Mike Pingstone, Associate Director of Procurement, NHS South, Central and West Commissioning Support Unit

Contact telephone no. 0117 9223696
& email address anne.colquhoun@bristol.gov.uk

Purpose of the report:

To request that the Health and Wellbeing Board agree to increase the potential period of extension within the contract for the provision of Children's Community Health Services (CCHS) from 2 years to 5 years. The initial term of the contract is 5 years to commence 1 April 2017. The contract duration was initially advertised as 5 year contract with an option to extend up to 2 years (a 5+2 contract). The contract was won by Sirona care and health as Prime Provider working in partnership with Bristol Community Health (BCH) Community Interest Company (CIC), Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and University Hospital Bristol NHS Foundation Trust (UHBristol). The agreement to extend the contract after the initial 5 year period will be sought from all commissioners and could be in increments of 1 year or variations of up to a total of 5 years based on this recommendation. The 4 other commissioning organisations have agreed to the extended contract period and are awaiting a decision from Bristol City Council.

Recommendation for the Mayor's approval:

1. To approve the increase of the potential period of extension of the CCHS contract from 2 years to 5 years.

The proposal:

1. Bristol Clinical Commissioning Group (CCG) is the lead Commissioner for the CCHS contracts on behalf of itself, Bristol City Council, South Gloucestershire CCG, South Gloucestershire Council and NHS England. In order to source a substantive provider, the Commissioners undertook a robust competitive procurement process as required by procurement guidelines. In November 2016 we awarded the contract and have since been working to finalise contract details.
2. The contract for Bristol & South Gloucestershire's Children's Community Health Services (CCHS) was awarded to Sirona care and health CIC as the Prime Provider of the partnership consisting of;
    - Sirona care and health CIC
    - Bristol Community Health CIC (BCH)
    - Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
    - University Hospital Bristol NHS Foundation Trust (UHBristol)
3. At this point all commissioners of CCHS are in agreement to award a 5+5 year contract though we await a decision from Bristol City Council. Seeking this future option at this stage, rather than later into the contract term, reduces the risk of challenge related to the procurement process.
4. In summary the reasons for proposing a longer extendable period are that it would enable:
    - A greater ability on the part of Sirona to enter into a risk share agreement with commissioners over the term of the contract and to commit to:
        - Staff
        - Premises
        - IT
        - Peripherals (photocopiers; communications; mobile phone contracts; outsourcing)
    - a clear statement of intent, support and partnership between all parties
    - a greater focus and energy in bringing about change thereby creating more chance of successful transformation
    - an ability to seek investment partners, especially in the field of technology, who are often looking for longer term relationships
    - a reduction in costs at both commissioner and provider level associated with procurement processes. This will also negate the service development void experienced during procurement as both provider and commissioner attention is focussed on procurement not development.
    - stability both for service users and for staff thereby enabling the delivery of a high quality solution for a longer period
    - the offset of set up costs over a longer period and negate the need to hold back funding for re-tendering within a relatively short period of time
    - commissioners to build longer and more lasting relationships with providers thereby increasing our chances of on-going high performance; better relationships often lead to fewer incidents and or issues of poor performance. In addition, a greater shared understanding of our service models and requirements will enable us to both look for areas of consolidation across existing services as well as the potential addition of new service offerings
    - to deal with fluctuating demand and costs more flexibly knowing we have a longer period over which to absorb the variances

- greater opportunity for efficiencies in non-critical/non pay activities where this is more efficient as suppliers are more likely to want to do business with a stable, long term partner
- the joint development of meaningful KPIs and outcome measures which might not materialise for a number of years but which could demonstrate the real added value that the services give to children, young people and families in our communities.

5. Key risks and opportunities based on the above and the likely consequences of not extending the contract will be:

- The CCHS contracts are jointly commissioned by 5 commissioning organisations and there are in excess of 15 different service specifications. The recommissioning process is therefore complex and has taken 3 years from commencement to contract start. The process, led by Bristol Clinical Commissioning Group, has required a dedicated team of project managers, procurement specialists with financial support and it has consumed considerable time of all service managers/ commissioners. The cost of the dedicated recommissioning team and the project has been £650,000 over 3 years which, if spread across the contract term of 7 years is £93k per annum, the cost of which was split pro rata across all commissioning organisations. If the contract duration is longer then there will not be a need to repeat the process for possibly 10 years and the equivalent annual cost is £65k per annum thereby creating a saving of £28k per annum so over 3 years saving of £84K.

- There are significant financial challenges that come with this contract and our provider is committed to working with commissioners to do everything possible to meet these and deliver a high quality service for all children, young people and their families. Knowing that there is a potential for a longer term partnership would enable Sirona to manage risk and enable us to deal with fluctuating demand and costs more flexibly. We are unable to place a financial value on this at this stage although we already know that there are year on year pressures on the contract of circa 7% (£2.4m). We are currently in negotiation with Sirona about how these pressures will be met including proposals for reductions in service provision.

- Sirona is also keen to look at the potential for greater efficiencies in non-critical/non-pay activities; the potential for a longer term will allow better procurement of non-pay elements of the service. Early indications are that suppliers are more likely to want to do business with a stable, long term partner and an extension to the contract will strengthen their ability to negotiate better terms. A 5% saving on the 10% non-pay element of the contract value would lead to an annual saving of £173k per annum.

- The Commissioners are confident that a robust, auditable procurement has been undertaken, however there is risk of challenge in any process. It was recognised at the start of the process that the services were highly cost-pressured, but also that the ability to modernise the service – both in terms of service delivery and IM&T/Estates infrastructure – was key to the successful delivery of the service. Given the nature of the procurement it is believed that the award of contracts on the basis of 5+5 is both proportionate and necessary. In terms of transparency (as a form of risk mitigation), it will be necessary to make clear within the formal EU award notice that the contracts have been let for a period of 5+5, however there is no need to send out any additional contract notices through the OJEU (the formal EU public procurement portal). Rules governing the ability of a contracting authority to vary a contract (PCR2015 regulation 72) are not relevant to this case

because the contract has not yet been let, and that regulation only applies to in-contract variations.(see legal comment below)

- There are risks associated with awarding the contracts on the basis of 5+5 rather than 5+2. The key risk is that an aggrieved party (likely a potential bidder), comes forward to challenge the Commissioners' decision, stating that they would have expressed interest in the procurement had it originally been advertised on the basis of 5+5. There was limited interest in the formal advert for the service, and only one bidder was taken past the initial pre-qualification questionnaire stage of the procurement. Given the limited initial interest, and the significant cost and other pressures associated with the services, it is unlikely that any organisations would formally challenge a modification to the contract term.

- In terms of challenge, it should also be noted that costs do not immediately or significantly accrue upon receiving threat of a legal challenge - costs accrue through the defence of a legal challenge. . any challenge would be received by the lead commissioner – Bristol CCG. It is therefore Bristol CCG on which any initial internal resource and expenditure would fall. Serious consideration would be given by the commissioning partners as to whether to defend any challenge

Consultation and scrutiny input:

a. Internal consultation:

The proposal has been discussed at People Leadership Team, Neighbourhoods Leadership Team, and CPG, Senior Leadership Team, Cabinet members for People and Neighbourhoods and The Mayor. The recommendation was to proceed to health and Well Being board for a decision. Discussions at these meetings have raised the question of the likelihood of challenge and the opportunities for agreed cost savings from the provider if the contract period is extended. The CCG who are leading the procurement process believe the risk of challenge is low (see above point 5). In terms of savings the provider is already facing significant financial challenges, but there will be opportunities for year on year financial savings to be made with 6 months' notice.

b. External consultation:

Bristol CCG, the lead Commissioner for the CCHS contracts in addition to all other commissioners of CCHS; South Gloucestershire CCG, South Gloucestershire Council and NHS England have been consulted and agree to this proposed extension option.

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) Impact	 Probability	RISK CONTROL MEASURES Mitigation (i.e. controls) and Evaluation (i.e. effectiveness of mitigation)	CURRENT RISK (After controls) Impact	 Probability	RISK OWNER
1	Risk of any challenge being received regarding the contract length	**Medium**	**Low**	Explicitly note the extended term at the appropriate committee of each Commissioner whilst formally awarding the contract – This puts the 5+5 amendment in to the public domain through multiple channels, and starts the standard 30 day timescales for a procurement law challenge. Send associated Contract Award notices to the OJEU on the basis of a 5+5 contract term – Similarly to above, this ensures that the market knows about the length of the awarded contract. Ensure that the contract with Sirona would not be signed within 30 days of the formal award – This limits the potential cost of any challenge received, as the Commissioners would not have entered in to any binding relationship with Sirona during the 30 day period referenced above. Within the signed contract with Sirona, the extension options would clearly state that the offering of the 5+5 would be at the gift of the Commissioners, and that the Commissioners would be able to exercise any extension or extensions up to a maximum of 5 years, thereby allowing the Commissioners to only take up a 2 year extension if necessary. Although the standard timescale for a procurement challenge is 30 days, making clear the Commissioners right to revert to 5+2 within the contract would limit the risk of challenge throughout the entire life of the contract, not just prior to contract signature.	**Low**	**Low**	SW CSU (Bristol CCG)

FIGURE 2

The risks associated with <u>not</u> implementing the *(subject) decision*:

No.	RISK Threat to achievement of the key objectives of the report	INHERENT RISK (Before controls) Impact	 Probability	RISK CONTROL MEASURES Mitigation (i.e. controls) and Evaluation (i.e. effectiveness of mitigation).	CURRENT RISK (After controls) Impact	 Probability	RISK OWNER
1	Loss of financial benefits and service developments; • Slower transformation and therefore longer to deliver outcomes • Higher cost • Inability to attract external investment to support transformation moving forward • Higher procurement costs over the period • Earlier procurement will distract from service delivery during a period of significant transformation. • Reduces the "window of opportunity" to make far reaching changes to services	**Medium**	**Medium**		**Medium**	**Medium**	Public Health Bristol City Council
2							

Public sector equality duties:

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.

During the reprocurement there has been extensive consultation including an equalities impact assessment. This proposal to extend the contract period does not change the service delivery model that

has been designed as a result of the consultation. Public sector equalities duties will be maintained and monitored throughout the life of the contract.
No extra advice sought.

Eco impact assessment
This has been considered at the awarding of contract stage. The contract extension will be likely to have a positive eco impact as it will delay the need for a new tender process and the associated costs that are required when a new provider is awarded a contract. For example, a change in IT systems, paperwork etc.

I agree that there are no significant impacts arising, and a small benefit in terms of reduced paperwork etc.
Steve Ransom, Environmental Programme Manager

Resource and legal implications:
The total annual contract value is £34.6m a year commencing in April 2017. The contract value for a 5 year period is therefore £173.m. Extending for 5 years would be an additional £173.m

The BCC contribution to this is
Public Health Grant £8.65m
People - General Fund £1.27m
DSG £0.54m.
Total £10.46m

Based on the current annual contract value, the BCC contribution is 10.46M. The contract allows for BCC to propose reductions to the annual contract value and service levels.at 6 months notice, however there may be mitigating costs associated with this, e.g. cost of redundancies.

Based on the current BCC funding, a contract extension of 5 years will cost £10.46m each year, a total of £52.3m for 5 year

There are additional savings through delaying the recommissioning process because the cost of the dedicated recommissioning team has been £650,000 over 3 years which, if spread across the contract term of 7 years is £93k per annum, the cost of which was split pro rata across all commissioning organisations. If the contract duration is longer then there will not be a need to repeat the process for possibly 10 years and the equivalent annual cost is £65k per annum thereby creating a saving of £28k per annum so over 3 years saving of £84K

a. Financial (revenue) implications:

The financial (revenue) implications of this are in practice subject to future decisions about whether BCC's exercises its option to extend the contract and if so by how long. Based on the current annual contract value the cost per annum to BCC would be £10.46m, split between funding sources as set out in the report. The report outlines that the contract allows for BCC to propose reductions to the annual contract value, allowing some flexibility for BCC to manage any changes in funding available both during the initial term and for any period of extension. There may be mitigating costs associated with this, e.g. the cost of redundancies and these would need to be taken into account in any assessment of changes to the annual contract value proposed.

Advice given by **Robin Poole Finance Business Partner**

Date **02/02/17**

b. Financial (capital) implications:

Comments from the Corporate Capital Programme Board:
No advice sought

c. Legal implications:
Although the contract has not been let, the principles set out in Regulation 72 (variations) would still be relevant in assessing the materiality of the proposed changes. So if the change would breach the Regulation if implemented after award, then making the change prior to award is likely to be viewed as a significant change in the contract terms requiring a new tender. However it is noted that the change is being promoted by the Council/CCG etc. and not to suit a particular bidder i.e. it is primarily a change in the interests of the commissioners. Also the contract term was not raised as an issue by any bidder, or any non-bidder as an issue. The issue will be whether any unsuccessful bidder (or indeed anyone who did not bid) could legitimately argue that the additional 3 years would have been significant, and impacted on their bid, or any decision not to bid. The Commissioners' view is that, in context, the change is not so significant that it would have had a material impact on those who might have been interested in providing the service either bidding or not. The intention not to give a once only 5 year extension, but extend by increments of one year helps mitigate any risk of challenge. Given that the additional 5 years is entirely at the discretion of the Commissioners, and there is therefore no guarantee of even one year extra, all potential bidders would have to assume they were bidding for a 5 year contract. Accordingly the change from a possible extension of up to 2 years, to a possible extension of up to 5 years, is unlikely to be viewed as material.

Advice given by **Eric Andrews**
Date 01/02/2017 **Senior Solicitor, Legal and Democratic Services**

d. Land / property implications:
No advice sought

e. Human resources implications:
There are no specific HR issues to consider as part of this request
Advice given by Alex Holly HR Business Partner
Neighbourhoods, Talent and Resourcing
Date 26th January 2017

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Mental Health and Wellbeing in Bristol	
Author, including organisation	Leonie Roberts: Consultant, Mental Health and Social Inclusion Dr Joanna Copping: Consultant, Young People's Mental Health Victoria Bleazard: Programme Manager, Mental Health and Social Inclusion
Date of meeting	15th February 2017
Report for Decision	

1. Purpose of this Paper

This paper provides an update on the Mental Health and Wellbeing Summit that was held in November. It also proposes an approach to developing a city-wide strategy for Mental Health and Wellbeing.

2. Executive Summary

In October 2016 the Health and Wellbeing Board (HWB) agreed that mental health and wellbeing is one of its three top priorities. This paper outlines the national and local context for this work; highlights some of the key themes that arose from the Health and Wellbeing Board's Mental Health Summit (held in November); and proposes a way forward for developing a city wide approach to improving mental health and wellbeing in Bristol.

To support this approach, we recommend that the HWB:

- Endorse the approach to developing a Mental Health and Wellbeing Strategy and action plan for Bristol
- Establish a working group to develop the draft strategy. This will require representation from across Bristol City Council, Bristol CCG, patient/user, voluntary and community groups.
- Secure champions from the HWB to inform and promote this work.

3. Context

It is widely reported that one in four people will develop a mental health problem at some point in their lives, and that mental illnesses account for the largest burden of ill health in England. The growing costs to individuals, families and society are not sustainable. The solution lies in promoting mental wellbeing and preventing mental illness, both of which are shaped by the social, economic, physical and cultural environments in which people live.

National drivers:

No Health without Mental Health strategy (2011). This strategy takes a life-course approach to improving mental health outcomes for people of all ages with a strong focus on early and effective intervention.

Preventing suicide in England: A cross government outcomes strategy to save lives (2012)

Five Year Forward View for Mental Health (2016). This is a strategic approach to improving mental health outcomes across the health and social care system. This has 3 key aspects, a

1. High quality 7 day crisis service,
2. Integration of physical and mental health
3. Promoting good mental health and preventing poor mental health.

One of the key recommendations is the establishment of a prevention concordat. Public Health England is expected to produce guidance in April.

Future in Mind (2015) focuses on promoting, protecting and improving our children and young people's mental health and wellbeing. In October 2015 CCGs in England were required to submit a **Transformation Plan** detailing how they would work with partners to support increased capacity/capability across whole system as a result of Future in Mind.

Local context:

Mental health is a priority for Bristol HWB. A mental health summit was held in November 2016. Over 70 people attended the event from wide ranges organisations across the City. It demonstrated that mental health and wellbeing is complex and it needs a system approach.

The public health team is currently developing Joint Strategic Needs assessment chapters on mental health and wellbeing for children and for adults in conjunction with key partners. These JSNA chapters will bring together quantitative data around mental health and wellbeing in Bristol, the evidence of effectiveness of interventions, current services within Bristol and local stakeholder views. This will include feedback from the Mental Health Summit as well as the 'Freedom of Mind' conference for young people held in October 2016. The JSNA chapters will identify key issues for mental health and wellbeing and will be used to inform the development of the strategy

4. Key themes from mental health summit

The mental health summit was held as an open space session. 43 conversations took place on subjects varying from nature to self-harm, social isolation to physical activity. The subjects have been broadly grouped into themes. The themes provide a framework for better mental health for all.

a) Creating mentally healthy people: children and adults

The life course approach provides a framework for understanding the development of mental health across the population, both in terms of mental wellbeing and mental health problems.

Some of the issues and population groups mentioned included

- Vulnerable and looked after children
- Unemployment
- Isolated older people
- BME communities
- Alcohol and substance misuse
- Homeless
- Physical activity and mental health

- Self-harm
- Suicide

b) Creating mentally healthy places

The built environment, local economy and the wider social cultural environment can have an effect on individuals and communities mental health. Living in an area with significant access or exposure to green spaces can have a lasting positive effect on mental wellbeing.

- Healthy workplaces
- Employment
- Environment and nature
- Money
- Emotional health and wellbeing in schools
- Arts and culture
- Children's centres

c) Creating mentally healthy neighbourhoods

Communities have many assets that can support mental wellbeing. The issues raised under this theme included:

- Social prescribing
- Community and social networks
- Access to services
- Challenging stigma
- Community led approaches
- Housing
- Parks
- Sports and physical activity

There were also some cross cutting themes which could be classed as:

d) Better data and information about mental health

- Clear definition of mental health and wellbeing
- Need data on employment and mental health
- Lack of information on mental health and wellbeing services
- Good practice guidance?
- Measurement tools

e) System wide issues

- Joint commissioning needed
- Multi-disciplinary teams essential
- Joined up approach between voluntary sector and statutory sector
- Explore impact of austerity and budget cuts

5. Indicative timeframe

The proposed working group will agree the approach for developing the Mental Health and Wellbeing Strategy. We currently anticipate launching the strategy in October to coincide with World Mental Health Day (10th October).

To note, this programme will incorporate our responsibility to develop a 'Prevention Concordat' (Five Year Forward View for Mental Health commitment), and will embed our suicide prevention activities.

6. Key risks and Opportunities

Opportunity:

- Far greater evidence now exists on the impact and cost effectiveness of interventions in mental health and wellbeing. Other parts of England have developed different approaches and have invited us to learn from these. Public Health England is also offering guidance and support.
- There is far greater recognition of mental health and wellbeing and a wider movement of activity to encourage people to speak out and seek help, which will support our efforts locally.

Risks:

- We may lack investment to develop new approaches to improving mental health and wellbeing.
- Mental health stigma does still exist and we may struggle to gain the support from different agencies that is needed. Senior level championing from the Health and Wellbeing Board will help to mitigate this.

7. Implications (Financial and Legal if appropriate)

To be considered within the working group.

8. Conclusions

Mental health is not just the absence of illness, but is a state of well-being in which the individual realises his/her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his/her community.

Mental health is more crucial today than it has ever been.

9. Recommendations

1) HWB to endorse the approach to developing a Mental Health and Wellbeing Strategy and action plan for Bristol.
2) HWB to establish a working group to develop the draft strategy. This will require representation from across Bristol City Council, Bristol CCG, patient/user, voluntary and community groups.
3) Champions to be secured from the HWB to inform and promote this work.

9. Appendices - None.

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Making Every Contact Count	
Author, including organisation	Katie Porter, Bristol City Council
Date of meeting	15th February 2017
Report for Information/Discussion	

1. Purpose of this Paper

This paper is to update the HWB on the Making Every Contact Count Programme.

2. Executive Summary

Making Every Contact Count (MECC) is about training workers to use simple coaching conversations with people to help them decide how they are going to change their health behaviour. By using 'open discovery questions', which are questions starting with 'how…' or 'what…' workers help people think through what they want to change and how they will do it. For instance, if a person mentions that they want to give up smoking; the worker might ask *how* much they smoke, and *how* much they want to cut down to, and *what* they need to do or have in place to achieve that goal. The worker does not give advice, or take a judgemental position. It is a useful and simple way to for the workforce to facilitate 'Helping people to help themselves'.

3. Context

MECC is a nationally lead initiative. The NHS Standard Contract now requires NHS providers to produce a Making Every Contact Count plan, see Appendix 1.

In November 2016 Public Health England published 'Local Health and Care Planning: menu of preventative interventions', which describes evidence-based approaches to improving the health of the population through prevention interventions. MECC is recommended.

Public Health England and the Local Government Association have produced guidance on implementing MECC. The advice is to:

- Establish organisational readiness
- Establish staff readiness

- Roll out training.

They describe various levels of MECC rising in complexity from simple health chats to longer interventions based on motivational interviewing. In the south west region the South West MECC steering group has decided to roll out the basic healthy chats level at scale, and leave longer, more intensive interventions to local discretion as they can be resource heavy and need to be targeted at specific workforces.

The South West MECC steering group has enabled 3 cohorts of workers to be trained as trainers and is currently developing a strategy for the region.

The Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan (STP) has adopted MECC as one of its priority work streams; the Workforce Development Programme Group of the STP has agreed that MECC training should be rolled out to all workers in health and social care.

4. MECC in Bristol

Rolling out a MECC programme is a recommendation of the Director of Public Health's annual report 2016.

- 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.

By delivering MECC the council and partners should be able to improve the health of the adult population and reduce future demand for care and the associated costs. MECC fits into the work on Early Intervention and Public Health prevention in Bristol.

What MECC deals with: There are 4 main diseases that cause early death before the age of 75 years. These diseases are: cancer, cardiovascular disease, respiratory disease and liver disease. The percentages of these early deaths that are preventable are: cancer (60%), cardiovascular disease (61%), respiratory disease (49%) and liver disease (94%). Unhealthy lifestyles contribute to the development of these diseases.

In Bristol, of adults:

- 19% are smokers
- 57% are overweight or obese
- 28% drink at risky levels
- 39% do not get enough physical activity each week
- 47% do not eat 5 or more fruit and vegetables a day.

The MECC programme addresses the core lifestyle choices of alcohol

misuse, smoking, physical inactivity and unhealthy diet as well as mental health. It is estimated that of the early deaths from the 4 main diseases: smoking contributed to 22.1%, unhealthy diet contributes to 16.8%, alcohol misuse causes 5.5% and physical inactivity causes 4%. In total, 48% of the early deaths from the four main diseases are linked to lifestyle risk factors.

MECC training enables workers to have effective coaching conversations about lifestyle behaviours with their clients and their own families. The workers do not become health experts but do become better able to help people identify how they can change their health behaviour for the better and signpost them to help.

The face to face training is augmented by elearning which provides basic information about the main lifestyle behaviours (smoking, alcohol misuse, unhealthy diet and physical inactivity) and workers also receive basic information about mental health. One of the benefits of MECC is that it has been evidenced to improve the health of the people in receipt of MECC training and their families, as they make their own lifestyle changes.

In addition each workforce manager is asked to identify whether their workers face particular lifestyle issues in their client base, for instance in older age groups this could include falls, keeping warm in winter and cool in summer. The MECC training can then incorporate basic information on these topics.

Organisational readiness in the STP. The STP Workforce Group has made available a one-off grant of £55,000 available to roll out MECC across Bristol, South Gloucestershire, and North Somerset health and social care staff, of which there are estimated to be over 46,000 people. The South West Workforce Development Group (health) has just made an additional grant of £62,500 to roll MECC out across the STP footprint to the wider workforce. Resulting in total grants of £117,500 for BNSSG.

The three authorities' MECC leads plan to use the STP Workforce Group grant to commission a project coordinator for a year to roll out MECC in the health and social care workforce. The use of the additional grant of £62,500 has to be agreed, but it is intended that it strengthen the approach.

Organisational readiness in Bristol.
In June 2016 Bristol City Council's Directorate Leadership Teams (DLTs) were asked to recommend priority groups to target for MECC training in the council and commissioned services.

Three Bristol council Public Health workers took part in the regional MECC, they can deliver train-the-trainer and front line training.

The council's Health Improvement Team have been working with the identified priority group managers to design training specific to their workforce needs, some already have high level skills in coaching in areas other than health and need less intensive training, other are new to coaching and need a different approach. The roll out of the training has been slowed due to the

existing programme of professional training that some workforces were in the middle of, and by the amount of restructuring going on across the council.

To take the programme beyond targeting priority groups to making MECC 'business as usual' across the council the programme needs the strategic direction reinforced by the Strategic Leadership Team and the HWB to ensure that departments understand the importance to the organisation of this approach. This will help them to appreciate how MECC is integral to helping people to help themselves.

Council providers have not been approached yet apart from Care & Repair who are keen to be trained in MECC in March 2017.

Bristol Community Health (BCH) workforce development team now has an accredited MECC trainer who will be able to roll out training in BCH.

North Bristol Trust organisational development team has been developing health coaching and is keen to take part in rolling out MECC to primary and secondary care and social care in the STP area.

AWP, UHB, Primary Care and the voluntary and community sector have not developed MECC plans and it is anticipated that the STP grants will enable this work to happen.

Staff readiness:

In Bristol City Council the priority workforces' service managers were contacted, a timetable for implementation was mapped out which took into account the current training programmes for the teams and council restructuring.

Each workforce manager was sent a questionnaire to identify if there were particular issues that needed covering apart from alcohol, smoking, physical activity, healthy diet and mental health. Additional topics identified included keeping warm in winter, keeping cool in summer and falls prevention.

To ready the workers the council MECC trainer lead is also attending team meetings when requested to explain the style and purpose of the MECC training. Upcoming meetings include community development, and Family Support workers

A Bristol city council web page for staff (the Source) will be developed to assist the workers.

Training:

The MECC training has been piloted and the Health and Social Care Apprentices have been trained. Workforces that are now ready to set a date for training include; Reablement, Museums and culture, Care & Repair and Citizens Service Point Staff. A bespoke training approach for Social workers has been agreed and will be piloted in the spring.

Evaluation
The regional MECC Steering Group is developing a region wide evaluation.

Next Steps
The next stage of implementation is to:

- Work with council DLTs to roll out MECC train the trainer training to other front line workforces in the council.
- Produce a Source web page to provide a simple guide to MECC – to enable staff to be ready to implement MECC
- Work with partners to roll MECC out across the STP footprint.

It is recommended that the next wave of workforces targeted to receive MECC training includes:

- Housing officers
- Trading standards officers
- Avon Fire & Rescue Service
- NHS workers

5. Key risks and Opportunities
There are three main Key risks. Firstly, several of the key organisations are in special measures due to their financial situation and therefore may find it difficult to release workers for MECC training as they are short staffed. Secondly, the restructuring of the council will continue to slow the delivery of the training in the council. Thirdly, the Live Well hub is expected to be the place where people are signposted for help, however the development of this has been delayed.

Opportunities are: using MECC healthy chats to coach people who want to change their health habits and to find ways to do this that suit them is a powerful change in the relationship between providers and the public. It changes the conversation from providing top-down advice, which is not suited to the individual's wants and needs, to enabling the person to help themselves in a manner best suited to their own circumstances.

6. Implications (Financial and Legal if appropriate).
The grants of £117,500 that cover the STP area will greatly assist the roll out of MECC. Bristol City Council will manage the grants for the STP area.

7. Conclusions
Rolling out MECC will enable workers in the public, voluntary and community sector to assist people to make decisions and act for themselves. It will contribute to the cultural change needed as people move away from depending on solutions provided by others (the dependency culture) to one of more self- determination and self- help.

It is anticipated that the grants for the STP area will greatly strengthen the work in Bristol and the rest of the STP, as they can be used for dedicated resources to roll out and embed MECC systematically across the health and social care workforce and the wider workforce.

8. Recommendations

The board is asked to

- Support and endorse the MECC approach both at board level and at organisational level.
- Consider how to roll out the programme most effectively across all partners.
- Appoint a MECC champion on the HWB.
- Review the progress in 6 months' time.

9. Appendices

Appendix 1

NHS England has included MECC in its 2016/17 NHS Standard Contract Service Conditions in section SC8 on page 11:

The Provider must develop and maintain an organisational plan to ensure that Staff use every contact that they have with Service Users and the public as an opportunity to maintain or improve health and wellbeing, in accordance with the principles and using the tools comprised in Making Every Contact Count Guidance.

Bristol Clinical Commissioning Group

Bristol Health and Wellbeing Board

WORK, HEALTH AND DISABILITY GREEN PAPER	
Author, including organisation	Becky Pollard, Director of Public Health
Date of meeting	15 February 2017
Report for Discussion	

Purpose of this Paper

1. The Work, Health and Disability Green Paper was published on 31 October 2017. The Green Paper is out to consultation until 17 February 2017. The Green Paper can be found here: https://www.gov.uk/government/consultations/work-health-and-disability-improving-lives).

2. It contains a series of proposals covering reform of the welfare system, the role of work coaches and service provision available at Jobcentres, the contributions of employers in providing work opportunities and supporting staff once in work, a review of fit notes, occupational health support and the necessity for commissioners to recognise the importance of work as a health outcome.

3. This report provides a briefing on the issues contained in the Green Paper, their relevance for Bristol and proposes some comments for inclusion in a response to government from the Health and Wellbeing Board.

Executive Summary

4. Bristol Health and Wellbeing Board welcomes the principles contained in the Green Paper but would like a number of considerations to be taken into account.

Context

5. Evidence shows that work and income are major determinants of health, wellbeing, quality of life and life expectancy:

- Musculoskeletal and mental health conditions are major causes of unemployment and sickness absence.

- ‘Good’ work which allows people to learn, develop and achieve, has a positive effect on physical and mental wellbeing. Insecure, low paid and unsafe work has the opposite effect.

- There is a significant and unacceptable gap in employment rates between disabled people and non-disabled people.

- One in three of the working age population has a long term health condition. Many people with long term health conditions are in work but many are not, even though they could be.

- The percentage of the population living with long term health conditions will rise as the population ages. This means that managing health conditions in the workplace is going to be essential.

- Being out of work and not being able to find a suitable job can have a profoundly negative impact on health and wellbeing.

- Sickness absence and unemployment have economic costs as well as personal costs for individuals and communities. In 2012, sickness absence was estimated to be costing the Bristol economy more than £240 million a year.

- Although the West of England has been successful in attracting inward investment and creating jobs, there are people living and working in our city who have not benefitted from this success.

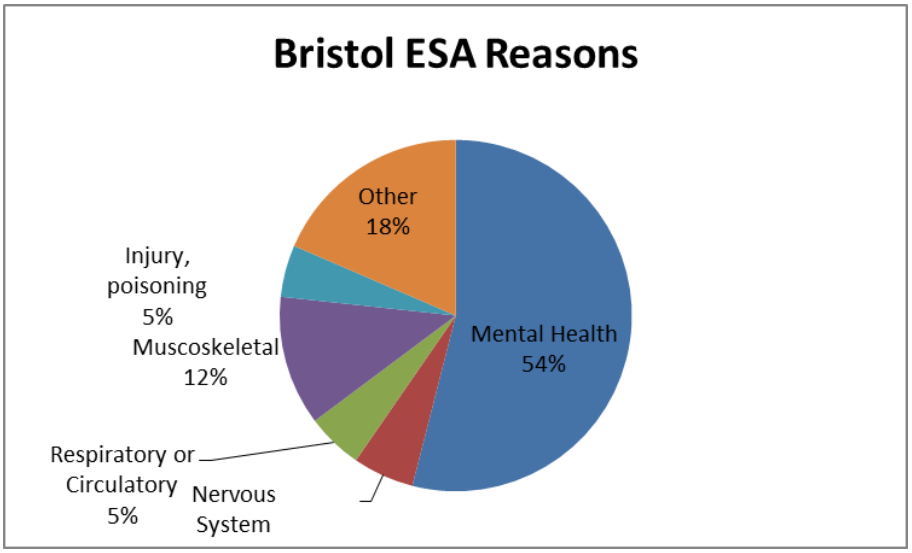
- Some of our economic and health inequalities are persistent and have shown little change.

- No single organisation can resolve these issues alone so a collective and collaborative approach is essential.

Local background

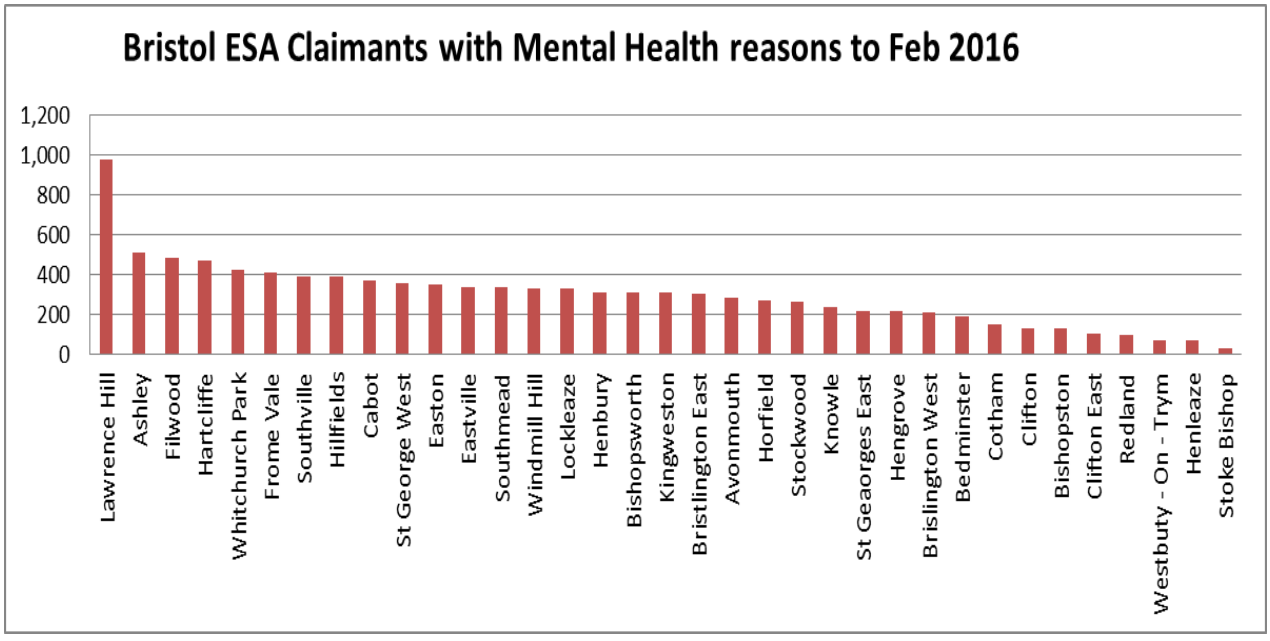
6. One of the main ambitions of the Green Paper is to narrow the gap in employment rates between disabled and non-disabled people. In Bristol, the employment rate for non-disabled people is 80.8% compared to 54% for disabled people.

7. In Bristol, poor mental health is the single largest cause of Employment and Support Allowance claims (54%), followed by musculoskeletal conditions (12%) (see diagram below).



ONS statistics, NOMIS, October 2016

8. The diagram below shows the distribution of mental health claimants across Bristol by ward. Lawrence Hill has more than double the number of any other ward.



ONS statistics, NOMIS, October 2016

Proposed issues for inclusion in consultation response

9. Below are some of the issues raised during local consultation on the Green Paper for inclusion in the Board's response:

10. The principles contained in the Green Paper and the ambition to narrow the employment gap between disabled and non-disabled people are welcome.

11. Additional resource nationally is welcomed but integration with existing health provision and employment support landscape will be the key to success. There is danger that national initiatives are not fully integrated with existing successful local schemes.

12. Local agencies should be proactively encouraged to influence and support the development and implementation of new employment initiatives. Engagement will need to include a variety of partners who may not have typically been involved. For example, the health community has not traditionally been included in discussions about employment and employment support, despite the potential for work programmes to improve or impair health outcomes.

13. Jobcentres often are not the right route for support for people with health conditions and disabilities. A wider range of alternative service providers needs to be considered, including the expertise and knowledge of professionals and practitioners living and working with health conditions and disability, in order that appropriate support can be identified and provided. Experience shows that one route does not fit all.

14. Benefit claimants who find their benefits stopped as a result of being found fit for work are mainly those with mental health and musculoskeletal conditions and disabilities.The high rate of successful tribunal appeals for those wrongly declared fit for work shows that mandation and sanction are inappropriate for this group of claimants.

15. We welcome the review of fit notes. Fit notes are required to serve a number of purposes and GPs face significant challenges in making assessments that can fulfil all of these. It would be helpful if a wider range of professionals could be involved in making recommendations. This should include those with wider experience of what's required for different job roles and those with an understanding of the characteristics of long term health conditions, particularly for conditions where symptoms fluctuate.

16. The voice of service users needs to be included in the development of new initiatives and programmes, both locally and nationally. Services and programmes which focus on the individual are more likely to provide sustainable employment outcomes.

17. Clarity of what is required from employers will be important. This needs to be ambitious but realistic.

18. Most employers in Bristol are small and medium sized enterprises who will struggle with additional responsibilities for health-related recruitment and retention unless external support is free and readily available.

19. Local awareness of the Fit for Work service is very low. Many employers and GPs are unaware of the Service and have not used it (http://fitforwork.org/).

20. Linking employment support and welfare benefit support to social prescribing frameworks has the potential to provide opportunities for local integration.

21. The prevalence of long term health conditions will rise as the working population ages. As a result, proposals need to be future proofed in order to ensure they meet emerging, as well as current, needs.

22. The evidence base for what works must be taken into account in the design of reforms, services and commissioning, for example, building on the success of Individual Placement and Support programmes (https://www.centreformentalhealth.org.uk/individual-placement-and-support).

23. The role and suitability of volunteering as a pathway to employment requires clarification in order to ensure it is offered appropriately and does not become an end in itself.

Consultation

24. The Green Paper was discussed at a Work and Health Think Tank on 30 January 2017, hosted by Bristol Health Partners and Bristol City Council, and attended by a wide range of public, private, voluntary and community sector partners. Participants included Shelley Fuller, a speaker from the Joint Work and Health Strategy Unit, which is responsible for the Green Paper and the consultation process, and members of this Board.

25. Evidence from Bristol's Joint Strategic Needs Assessment demonstrates that high rates of unemployment, disadvantage and mental health conditions coincide in Bristol. Representation from equalities groups and people with lived experience were included in the consultation. Employment rates are significantly lower for disabled people and those living with long term conditions. Improving access to work and supporting people with health conditions in the workplace will help to address health inequalities.

Implications (Financial and Legal if appropriate)

None

Recommendations

That the Health and Wellbeing Board comment on the issues raised in this briefing and agree for final submission to be delegated to the Board's Joint Chairs in order to comply with the deadline of 17 February.

Appendices

None