Health and Wellbeing Board

Agenda

BRISTOL CITY COUNCIL

NHS
BRISTOL CCG

Date: Wednesday, 12 April 2017

Time: 2.30 pm

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

Issued by: Ian Hird, Democratic Services
Tel: 0117 92 22384
E-mail: democratic.services@bristol.gov.uk
Date: Tuesday, 4 April 2017

Agenda

1. Welcome, apologies and introductions

In terms of membership, the Board is asked to note that since its last meeting, Ellen Devine has left her position as the HealthWatch representative on this board (her replacement is Vicki Morris, CEO of the Care Forum).

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

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

Members of the public and members of the Council may submit a petition or submit a written statement to the Health and Wellbeing Board. These must be about items on the agenda for this meeting.
The deadline for receipt of petitions and statements for the 12 April Health and Wellbeing Board is **12.00 noon on Tuesday 11 April.**
These should be e-mailed to democratic.services@bristol.gov.uk

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

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

Written questions may be submitted in advance of the meeting by a member of the public or a member of Council. These must be about items on the agenda for this meeting. A maximum of 2 written questions per individual can be submitted. The deadline for receipt of questions for the 12 April Health and Wellbeing Board is **5.00 pm on Thursday 6 April.** These should be emailed to democratic.services@bristol.gov.uk

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

Maximum time allocation for public forum – 30 minutes

3. Declarations of interest

4. Minutes of previous meeting

To agree the minutes of the 15 February 2017 meeting as a correct record. **(Pages 5 - 10)**

5. Bristol Safeguarding Adults Board - Annual Report 2015-16 **2.40 pm**

To be presented by Richard Kelvey (Avon and Somerset Police), Vice-Chair of the Board and Becky Lewis, Bristol Safeguarding Boards Joint Unit Business Manager. **(Pages 11 - 77)**

6. CCG / Sustainability and Transformation Plan (STP) - update for information **3.10 pm**

To be presented by Martin Jones, CCG Chair.

7. Integrated healthy lifestyles service procurement: Bristol Behaviour Change for Healthier Lifestyles Programme **3.30 pm**

To be presented by Becky Pollard, Director of Public Health. **(Pages 78 - 132)**

8. Health in all policies **3.40 pm**

To be presented by Katie Porter, Senior Public Health Principal. **(Pages 133 - 141)**

9. Healthy weight strategic plan - progress report **3.50 pm**

To be presented by Beth Bennett-Britton, Public Health Registrar and Sally Hogg – Consultant in Public Health. **(Pages 142 - 148)**

10. Pharmaceutical needs assessment **4.00 pm**

To be presented by Becky Pollard, Director of Public Health. **(Pages 149 - 151)**

11. Information item - SEND reforms **4.10 pm**

Author: Michele Farmer – Service Director – Early Intervention & Targeted Services **(Pages 152 - 154)**

12. Information item - European City of Sport **4.20 pm**

Author: Guy Fishbourne, Sport & Physical Activity Development Manager. **(Pages 155 - 161)**

13. Dates of meetings 2017-18

As follows (all at 2.30 – 4.30 p.m.):
* 28 June 2017
* 16 August 2017
* 25 October 2017
* 13 December 2017
* 21 Feb 2018
* 11 April 2018

Bristol City Council
Minutes of the Health and Wellbeing Board

15 February 2017 at 2.30 pm

Members Present:-
Councillors: Dr Martin Jones (Chair), Jill Shepherd, Becky Pollard, Fi Hance, Claire Hiscott, Clare Campion-Smith, Ellen Devine, Elaine Flint, Keith Sinclair, Justine Mansfield and Pippa Stables

Officers in Attendance:-
Alison Comley (Strategic Director - Neighbourhoods), Mike Hennessey (Service Director, Care and Support (Adults), Statutory Director of Adult Social Services), Claudette Campbell (Democratic Services Officer), Sarah Sharland (Legal Officer), Sally Hogg, Liz McDougall, Wendy Parker and Katie Porter

1. Welcome, apologies and introductions

The Chair, Dr Martin Jones, led introductions.

Apologies were received from Mayor Marvin Rees, Linda Prosser, Steve Davies

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

The following public forum items were received and noted:

- Public Forum Question from Mr Viran Patel regarding agenda item 5 – a written reply was supplied
- Public Forum Question from Mr Viran Patel regarding agenda item 6 - a written reply was supplied
- Public Forum Statement from Mr Viran Patel regarding agenda item 6
- Public Forum Statement from Sam Downie regarding agenda item 8

3. Declarations of interest

None

4. Minutes of previous meeting

RESOLVED:

That the minutes of the 14th December 2016 be confirmed as a correct record and signed by the Chair.

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

The Board considered a report seeking approval of a key decision on arrangements for the provision of Children's Community Health Services (CCHS) from 2 years to 5 years (contract extension).

Becky Pollard, Director of Public Health, presented the report and Fiona Butter, Programme Director CCHS Recommission, Bristol CCG was present to take any questions.

a. The Board were asked 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.
b. The initial term of the contract is 5 years to commence 1st 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).
c. 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).
d. The agreement to extend the contract after the initial 5 year period has been sought from all commissioners and could be in increments of 1 year or variations of up to total of 5 years based on this recommendation.
e. The 4 other commissioning organisations have agreed to the extended contract period and are awaiting a decision from Bristol City Council.

The following Comment was noted:

f. The Cabinet Member for People, endorsed the recommendation commenting that cabinet was fully supportive of the move as it would allow for long term planning and cost benefit for the delivery of the service.

Having noted and taken account of the above, Cllr Fi Hance Cabinet Member for Health & Wellbeing, with delegated authority for the Mayor, then took the following key decision:

i. To approve the increase of the potential period of extension of the Children's Community Health Services contract from 2 years to 5 years.

6. Mental health and wellbeing in Bristol

The Board considered a report that provided an update on the city wide strategy developed from the outcomes of the Mental Health and Wellbeing summit held in November 2016.

Ella Marshall was invited to give an overview of the outcomes from the Freedom of Mind Festival.

- She thanked the Board for the opportunity to attend last year to outline the vision for the festival. She acknowledged the support received from Martin James and guidance from Board members.

- The result was the establishment of the Freedom of Mind Festival that took place between 30th September to 10th October 2016. The aim was to stimulate conversation around mental health; educate people on how to look after their emotional wellbeing; to create lasting change throughout the city.

- The event was well received. Feedback had been positive with attendees reporting that the informal setting encouraged open conversations around supporting healthy mental wellbeing benefiting the whole family.

- Going forward the Board of Directors of the Festival would be looking at ways to engage the wider community and would be appointing a Diversity Officer to support this work.

- As a member of the Youth Council she shared that because she had a vision to pursue she was able to obtain the support required but that had not been the experience of other members of the Youth Council.

Questions/comments

a. Members of the Board applauded Ella Marshall for translating her vision into a success and ultimately an event that would feed into the overall mental health strategy.

b. The presentation would be circulated to the Board Members.

c. Members acknowledged the innovative way that art therapy was used at the event to support conversations for young people and the wider family.

d. The brand was seen as strong and continued promotion would result in an alternative source of information for the community. It would link strongly with the practice of social prescribing.

e. The Director of Public Health, shared that work on a strategy on suicide affecting young people at University and in society would commence as a direct result of the recent 4 suicides of university students. The team would look at lesson learnt from the incidents and produce a suicide prevention strategy.

The Board having taken into account the report and presentation;

RESOLVED

i. **To endorse the approach to developing a Mental Health and Wellbeing Strategy and action plan for Bristol.**

ii. **To establish a working group to develop the draft strategy. With representation from across BCC, the CCG, patient/user, voluntary and community groups.**

iii. **The following Board Members would be Champions; Dr P Stables; Cllr Hance; Cllr Campion-smith.**

7. Making every contact count

The Board considered the report of Katie Porter, Public Health that outlined how the concept and application of the principles of MECC would be rolled out.

a. The Service Director for Care and Support (Adults), Statutory Director of Adult Social Services commented that the principles of MECC aligned with Tier One of the 3-Tier Model. The principles should be promoted as a positive for the organisation. 'Helping People to help themselves'

b. Concern was expressed on whether colleagues who are currently juggling multiple priorities and time pressure would have the opportunity to engage people in a way that would have the appropriate impact.

c. MECC was concerned with developing in colleagues the skill to have the right conversations that plants a seed in the mind of the recipient that nudges them towards positive healthy decisions.

d. The Healthwatch Board member shared that the organisation were currently working with community barbers to share information and the principles of MECC could be incorporated in that work.

e. It was also acknowledged that MECC aligned with the principle of social prescribing.

At the conclusion of the discussion the Board;

RESOLVED

i. **To support and endorse the MECC approach at Board and organisational level**

ii. **Support the roll out of the programme to partners**

iii. **Propose the appointment of Steve Davies as Champion**

iv. **To review progress after 6 months**

8. Work, health and disability green paper

The Board received a report on the Work, Health and Disability Green paper published on the 31st October 2016. The consultation period ran to the end of February and the Director of Public Health sought support from the Board to submit the response detailed in the report from points 9 to 23.

Liz McDougall, Public Health Principal was present to take any questions. The Board were asked to note that the response was qualitative, based on local priorities in order to bring them to the attention of government.

a. The public forum statement submitted by Sam Downie was noted at this time.

b. The Board noted that the Green Paper was silent on the issue of funding.

c. There was general consensus for the need to support people into work in place of forcing them into work and possibly work that was inappropriate.

Resolved:

That the Chair sign-off the consultation response on behalf of the Board.

9. Sugar Smart City update

The Board received an audio presentation on the launch of the Sugar Smart campaign.

Sally Hogg, Public Health Consultant was joined by Fi Argent the Jamie Oliver Food Foundation Ambassador; Wendy Parker, Public Health Principal.

- Sugar Smart was launched to an audience of 40,000 people over the first weekend at Bristol/Bath Rugby, Bristol/Cardiff football. There was the opportunity to share information on Type 2 diabetes, obesity and making alternative food choices.
- Contact made with 12,000 staff members at the two hospital Trusts.
- Contact with 30,000 students at UWE via messaging and engaging in activities on campus around sugar.
- Information sharing with GPs, dentists, nurseries and schools.
- Working with Bristol Water to share information to half a million homes. The company has agreed to provide water fountains in schools that do not currently have them.

The Board viewed the video introduced by Jamie Oliver.

The following comments were noted from the discussion that followed the presentation:

a. The question was asked about how success would be measured. The team would be looking to note the reduction in pre-diabetes, childhood obesity and reduction of sales of sugary drinks in public sector buildings. Work is underway to determine the mechanism to measure these outcomes.

b. The government proposed tax on sugar was progressing slowly with no information on implementation.

c. A sugar smart survey would be included in the Quality of Life survey that is sent to all households. This would help establish a baseline for future measurement.

d. Further initiatives will continue, for example, with Bristol Sport and retail stores to encourage them to put water options in a prominent place ahead of sugary drinks.

The Chair thanked the team for updating the Board and for the work undertaken during to launch the brand.

10 Any other business

None

Meeting ended at 4.14 pm

CHAIR _____

Annual Report 2015-2016

Adam Bond

BSAB Annual Report 2015/2016

Report suspected abuse: safeguarding adults at risk

How to report suspected adult abuse

If you're being abused or think someone else is being abused, you must tell someone.

Report suspected adult abuse

- If you're a professional use the online **safeguarding adults referral form for professionals** or download a Word version of the form here: **Report suspected abuse: safeguarding adults at risk**

Call Care Direct

Telephone 0117 922 2700
8.30am to 5pm Monday to Friday (answerphone outside office hours).

Call the Police

Telephone 101
In an emergency telephone 999
Textphone 18001 followed by 101
Textphone in an emergency 18000

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Foreword

As Independent Chair of Bristol Safeguarding Adults Board I am pleased to introduce the first Bristol Safeguarding Adults Board Annual Report since the introduction of the Care Act. The Care Act came into force in April 2015. This legislation puts Safeguarding Adults Boards on a statutory footing better equipped to prevent abuse and respond effectively when it occurs.

Over the last 12 months Bristol Safeguarding Adults Board has undertaken a huge amount of work to ensure that the Board has a firm foundation on which we can build and develop our business further. This has involved reviewing membership, establishing stronger governance systems and developing our Strategic Plan. The Board has begun to look at how we can ensure that the views and experiences of service users are captured in all our work.

Significant progress has been made in strengthening our partnership working. The Board is committed to ensuring that we create a challenging and supportive partnership.

The Board now has a number of subgroups that are taking forward the priorities identified within our Strategic Plan. I am very grateful to the partners who chair and sit on these groups as their commitment and expertise is critical to the success of our work.

This year the Board published its first Serious Case Review in recent years. The Board is determined to ensure we learn from this review and that all recommendations are implemented and their effectiveness monitored.

The continued contraction of public finances remains a challenge alongside continued organisational change in many agencies. The Board will continue to work closely with Bristol Safeguarding Children's Board and other Boards regionally to identify efficiencies wherever possible.

There remains a lot to do but given the strength and commitment of our partnership I am confident we will continue to make progress in all areas of our work. I hope you find the report informative and helpful. We welcome feedback on the report and what more we can do to ensure that we help and protect vulnerable people in Bristol.

Louise Lawton
Independent Chair
Bristol Safeguarding Adults Board

Executive Summary

2015-2016 has been an eventful year for Bristol Safeguarding Adults Board, having been established as a 'statutory' body under the Care Act on 1 April 2015. Bristol is a large, vibrant city; it is the 10th largest in the UK and has a growing population which is increasingly diverse with 91 languages spoken, 45 religions and 50 countries of birth reported.

Achievements - activity and impact.

The primary focus of the year for the Board has been establishing and developing an effective structure in order for the Board to meet its strategic priorities. The predecessor to the Board, the Safeguarding Adult Partnership, started this process during the preceding year and this activity has continued throughout the year. The Board has restructured its sub-groups creating a new Safeguarding Adults Review group and developing an Executive board to oversee the operation of the 4 sub-groups as they implement the strategic priorities of the Board.

The change from operating as a local partnership to being a statutory board with specific responsibilities has been a challenge and the Board has worked hard to develop a greater understanding of how members can work in partnership as a Board more effectively. The Partner Development survey is a key element of this activity and will be repeated in 2016-2017.

BSAB published its first Serious Case Review for some years in January 2016, regarding the death of RC. Actions from this review have been implemented and progress will be reported to the Board to ensure the issues raised in the review are addressed effectively. There are a number of Serious Case Reviews that are still in process that are expected to be published in 2016-2017. The process for undertaking these reviews has been challenging for the board and many lessons have been learned that the Board will seek to implement in the future should there be a need to undertake a Safeguarding Adults Review[1]. In partnership with the Safeguarding Children's Board training in a systems methodology will be commissioned in order for Board members to improve capacity and knowledge with respect to Safeguarding Adults Reviews.

The Board has successfully held 3 conferences during 2015-2016 and 3 conferences will be held during 2016-2017.

Statutory Intervention to protect Adults at Risk

The implementation of the Care Act in April 2015 has significantly changed how activity to safeguard adults at risk of abuse is managed and recorded. The Performance and Information Sub group have developed a performance framework which will be implemented during 2016-2017 and will enable the Board to better understand what needs to be done to improve safeguarding practice across the partnership. The local authority has

[1] Serious Case Reviews are now referred to under the Care Act 2014 as 'Safeguarding Adult Reviews'

implemented a new case recording system during this year which it is expected will provide data to enable the Board to better understand how the requirements of the Care Act are being implemented.

Quality assurance and learning and improvement framework

During 2015-2016 the board has developed a **Learning and Improvement Framework** which will be implemented moving into 2016-2017. Activity in relation to Safeguarding Adults is expected to be audited and reported to the board to enable lessons to be learned and issues where practice needs to improve to be addressed.

Policies, Procedures and Guidance

During 2015-2016 procedures and guidance in relation to safeguarding adults have been developed and a **Safeguarding Adults Multi-Agency Policy**[2] has been developed alongside neighbouring LSAB's in South Gloucestershire, North Somerset and Bath & North East Somerset agreed by the board and published.

In addition guidance regarding **Information Sharing** and **Resolution of Professional Disagreements in Work Relating to the Safeguarding of Adults at Risk** is in development and is expected to be published during 2016-2017.

Partners

As can be seen in the report our statutory and other partners have responded effectively to the implementation of the Care Act 2014 during 2015-2016. They have addressed the challenges and demands of the legislation and committed time, energy and resources to ensuring that their services are effectively equipped to meet the needs of adults at risk. Key areas for further improvement and focus include adults with mental health needs, adults who 'self-neglect' and those who are hoarding. Further work is also need to improve the understanding of the Mental Capacity Act 2005.

Ongoing Challenges

The primary focus of the Board in its first year has been establishing its governance and structure. This has identified a clear need for the Board to be supported effectively by its partners in achieving its priorities. To this end, alongside the Safeguarding Children Board a joint business unit will be established in 2016-2017 in order to support the work of both Boards. This has required a clear commitment from statutory partners towards the funding of the joint business unit over the next 3 years.

Improving the provision of effective training is a key element that the Board will be addressing during 2016-2017 with the development of a training strategy.

[2] https://www.bristol.gov.uk/documents/20182/33728/Bristol+Safeguarding+Adults+Policy2015.pdf

It is planned that work to highlight issues around abuse of adults will be continued with the Stop Adult Abuse week in July 2016. This will be promoted alongside neighbouring LSABs and partner agencies.

BSAB and its partners have achieved much during its first year as a statutory board. Though there remains much to be done moving into 2016-2017.

Adam Bond,

Joint Business Unit Manager

Bristol[3]

Bristol is the 8th largest city in England and the 10th largest local authority in England. Bristol Local Authority accounts for around 70% of the total population of the built-up area of the city, which is often referred to as 'Greater Bristol', or the 'Bristol Urban Area'. The population of the Bristol Urban Area is estimated to be 639,400 (mid-2014).

Population by age

Bristol has a relatively young age profile with more children aged 0-15 than people aged 65 and over. The median age of people living in Bristol in 2015 was 33.1 years old, this compares to the England and Wales median of 39.9 years. The profile of Bristol's population by five year age band and sex is illustrated in Figure 1 and estimates for broad age bands and sex are shown in Table 1.

Table 1. 2015 Population estimates by age and sex

Source: ONS 2015 Mid-Year Population Estimates. Crown Copyright.

Age Band	Males		Females		Persons	
	number	%	number	%	number	%
0-15	42,600	19.0	41,200	18.3	83,800	18.6
16-24	35,000	15.6	35,500	15.8	70,500	15.7
25-49	88,200	39.2	82,400	36.7	170,500	38.0
50-64	32,400	14.4	32,900	14.7	65,300	14.5
65 and over	26,600	11.8	32,700	14.6	59,300	13.2
All ages	**224,800**	**100.0**	**224,600**	**100.0**	**449,300**	**100.0**

Children

Overall, there are more children living in Bristol than people aged 65 and over. Bristol's 83,800 children make up almost 19% of the total population, i.e. 1 in every five people living in Bristol is aged under 16.

Working age

Bristol has a much higher proportion of working age (16-64 year old) people than nationally - 68% of the total population in Bristol is of working age compared to 63% in England and Wales. The highest proportions are amongst the 20-39 year olds which make up more than a third (37%) of Bristol's total population compared to just over a quarter (26%) nationally.

Older people

Bristol's 59,300 older people make up 13% of the total population, i.e. 1 in every seven people living in Bristol is aged 65 or over. The proportion of older people is lower than in England and Wales as a whole where 18% of the population are aged 65 and over. There are 9,100 people living in Bristol aged 85 and over.

[3] Population information taken from 'The Population of Bristol: July 2016. https://www.bristol.gov.uk/documents/20182/33904/Population+of+Bristol+July+2016/858ff3e1-a9ca-4632-9f53-c49b8c697c8c

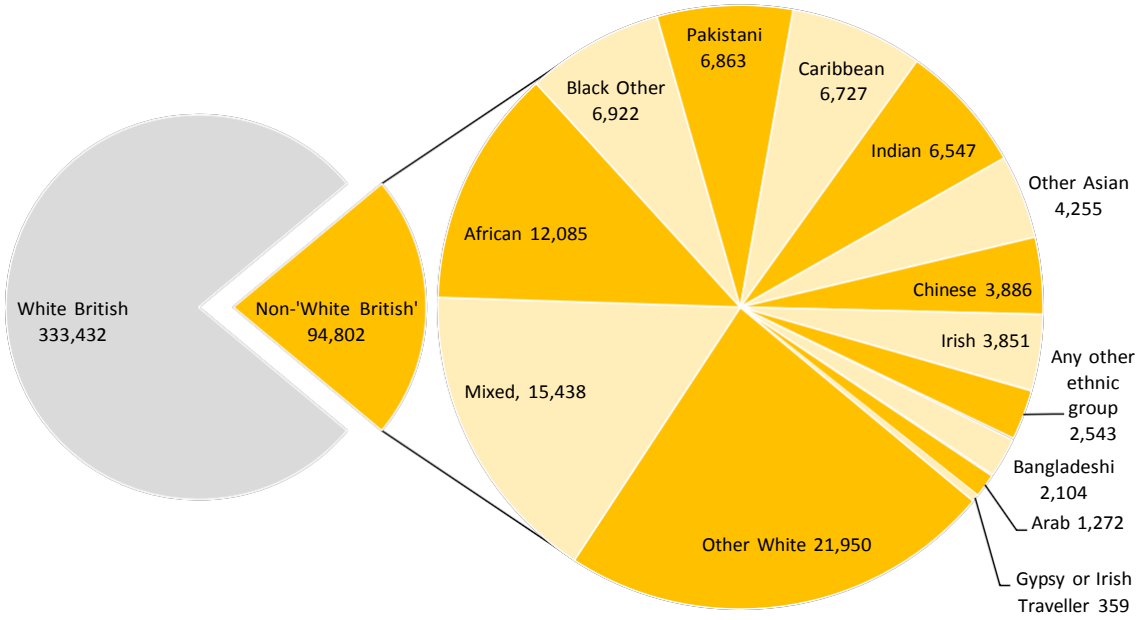
Ethnic group

The Black or Minority Ethnic group (BME) population (all groups with the exception of all the White groups) make up 16% of the total population in Bristol. This is an increase from 8.2% of all people in 2001.

An alternative definition of the population that can be used is the non-'White British' population (all groups with the exception of White British) which includes the Eastern European population. The non-'White British' population make up 22% of the total population in Bristol - this is an increase from 12% of all people in 2001.

Figure 15. Population by ethnic group

Source: 2011 Census Office for National Statistics © Crown Copyright 2013 [from Nomis]



Bristol Safeguarding Adults Board Statement of Principles

Safeguarding is a responsibility for everyone. The following 6 key safeguarding principles must be followed and underpin the ways in which professionals and other staff work with adults:

- **Empowerment** – Presumption of person led decisions and informed consent. People feeling safe and in control, being more able to share concerns and manage risk of harm either to themselves or others.
- **Prevention** – It is better to take action before harm occurs. Working on the basis that it is better to take action before harm happens.
- **Protection** – Support and representation for those in greatest need. Support and help for those adults who are vulnerable and most at risk of harm.
- **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented. Responding in line with the risks and the minimum necessary to protect from harm or manage risks.
- **Partnership** – Local solutions through services working with their communities. Working together in response to local needs and expectations.
- **Accountability** – Accountability and transparency in delivering safeguarding. Focusing on outcomes for people and communities and being open about their delivery.

What is Safeguarding Adults?

Safeguarding adults is about protecting those at risk of harm from suffering abuse or neglect. Abuse can happen anywhere. It can happen at home, in a residential or nursing home, in a hospital, at work or in the street.

Safeguarding adults is about working with adults with care and support needs to keep themselves safe from abuse or neglect. It is about people and organisations working together to prevent abuse.

Section 42 (1) of the Care Act 2014 states: Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.
- These duties also apply to organisations other than the Local Authority, for example the NHS and Police.

Who we are and what do we do?

The Care Act 2014 brings a statutory requirement for each local authority to establish a Local Safeguarding Adults Board (SAB).

The Local Safeguarding Adults Board for Bristol is established by Bristol City Council in accordance with the provisions of The Care Act 2014 sections 42 – 46 and is known as the Bristol Safeguarding Adult Board (BSAB).

BSAB is accountable to its member agencies, which in turn are jointly responsible for the BSAB's policies, procedures and actions.

Membership

The following organisations are the core statutory members of the Board and operate as an Executive Group with responsibility for overseeing the governance of the BSAB:

- Bristol City Council
- Bristol Clinical Commissioning Group (NHS)
- Avon and Somerset Constabulary

Alongside the above the following partners are also members of the Board.

- NHS England
- University Hospitals Bristol NHS Foundation Trust
- North Bristol NHS Trust
- South West Ambulance Service NHS Trust
- Avon and Wiltshire Partnership Mental Health NHS Trust
- Bristol Mental Health providers
- Police – Avon and Somerset Constabulary
- Safer Bristol/ Youth Offending Team
- National Probation Service
- Bristol Community Health
- Avon Fire and Rescue
- Named Service Provider Representatives
- Named Voluntary Sector Representatives
- BCC Councillor (Assistant Mayor/Lead Member) for People Directorate

Associate partners are comprised of the following organisations:

- The Prison Service
- The Crown Prosecution Service
- Care Quality Commission (CQC)
- Faith groups
- Bodies providing specialist care to adults with severe disabilities and complex needs
- The wider City Council

- Representatives of service users and carers
- Voluntary and Community Sector organisations providing services to adults and families.

Independent Chair

BSAB is led by an independent chair appointed for a term of no more than 3 years. Appointment is made by the Chief Executive of the Local Authority (City Director of Bristol City Council). The Current independent Chair of BSAB is Louise Lawton who commenced in this role in October 2014.

The Independent Chair role is to hold all agencies to account and they are themselves accountable to the Chief Executive (City Director of Bristol City Council) and should be held to account for the effective working of the BSAB.

The Independent Chair will work closely with all partner agencies and particularly the Director of Peoples Services to ensure that there are effective arrangements for safeguarding and promoting the welfare of all adults in Bristol. The Independent Chair of the BSAB will provide twice yearly reports on the BSAB activity to the Bristol City Council People Scrutiny Committee.

The Board and Independent Chair will publish an annual report on the Annual Strategic Plan, covering the previous financial year and be submitted to:

- The Chief Executive (City Director of Bristol City Council)
- The Police and Crime Commissioner for Avon & Somerset
- Bristol Clinical Commissioning Group
- Bristol Health and Wellbeing Board
- Healthwatch Bristol
- Bristol City Council People Scrutiny Committee

Strategic Links for the BSAB

The BSAB reports to the Health and Wellbeing board, which was created by The Health and Social Care Act, 2012. The core purpose of the Health and Wellbeing Board is to join-up commissioning across the NHS social care, public health and other services that the board agrees are related to health and wellbeing. The Independent Chair of BSAB attends the Health and Wellbeing board annually to share this annual report and will where necessary raise issues regarding safeguarding adults at risk with the Health and Wellbeing board.

The BSAB also work alongside the Bristol Safeguarding Children Board with which they will share a Joint Business unit to be established in 2016-2017. In addition the work of Safer Bristol (Bristol's Community Safety Partnership) sits alongside the work of BSAB and Safer Bristol staff sits on the SAR sub group.

The work of the Safeguarding Adults Board during 2015/2016

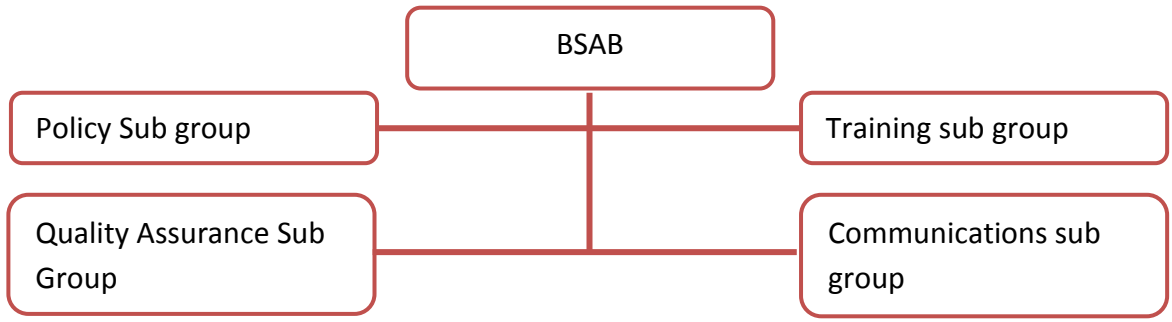
The work of the BSAB contributes to the wider goals of improving the wellbeing of all adults. Its role is to ensure the effectiveness of the arrangements made by individual agencies and the wider partnership to safeguard and promote the welfare of adults.

Bristol SAB Subgroups

During 2015-2016 the Board revised its structure as it established itself as a statutory body. In undertaking this work the Board have worked closely with the Safeguarding Children Board and appointed an interim Board Manager to assist the board in developing its governance and reporting structure. The number of sub groups has remained the same but the Policy and Quality Assurance have merged and a Safeguarding Adults review Sub group has been established to oversee this aspect of the boards work.

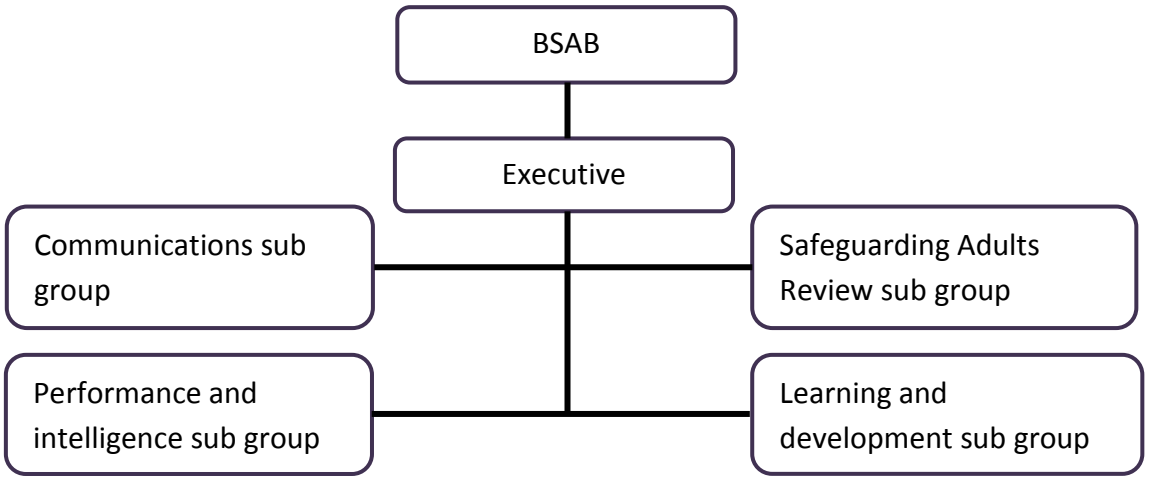
A further addition has been the creation of an Executive Sub group. The role of this sub group is to oversee and co-ordinate the work of the sub groups, develop and implement the BSAB Strategic plan and ensure that the work of the BSAB is effectively resourced, co-ordinated and meaningful in relation to ensuring that adults in Bristol are effectively safeguarded.

Previous structure



Subgroups meet at least quarterly and will be scheduled to allow reporting to the Executive and Board.

Revised structure



Financial

Expenditure			Income		
	1516 Budget	1516 Outturn		1516 Budget	1516 Outturn
Employment Costs			Partner contributions		
Agency Staff [1)]	0	14,464	Better Together Fund	-65,000	-65,000
			BCC : People	-21,000	-21,000
Safeguarding Adults Review			BGSW CRC		-1,500
Fees 2015/16	65,000	80,231	CCG		-3,000
Fees 2015/16	21,000	0	UHB		-3,000
			BCH		-3,000
			AWP		-3,000
			NBT		-3,000
			NPS		-1,500
Training & Conference			Police		-5,000
BSAB Conference Expenses	0	2,646	Total partner contributions	-86,000	-109,000
BSAB Presentation	0	460	Other Income		
Contributions to other projects			CCG – SAR		-2,250
			CCG – SAR		-2,250
			CCG – SAR		-3,000
			CCG – BSAB Efficiency		-3,000
			Police –SAR		-2,250
Other Expenditure			Police – SAR		-2,250
Catering	0	115	Police – SAR		-3,000
ICT Expenses	0	1,250	Total other income	0	-18,000
Total Expenditure	86,000	99,166	Total available (Contrib + other income)	-65,000	-127,000
			Shortfall/ Surplus*	-21,000	-27,384

Surplus is due to unpaid costs relating to the SAR's that remain in progress into the next financial year.

Development activity

In establishing a new Statutory Safeguarding Adults Board several activities have been undertaken in order to identify where it is that partners who are members of the board and its various sub groups consider that the board needs to improve and develop in order to be more effective as a board.

Partner development survey

Principles of Partnerships

A survey was developed and circulated amongst the membership of the Board in order to better understand where it is that the board need to improve. Five questions were asked of the board members allowing for a range of answers from strongly agree to strongly disagree.

To what extent do you agree with each of the following statements in respect of the BSAB Partnership?

	Strongly	Agree	Disagree	Strongly Disagree	Rating Average	Response Count
1. There have been substantial past achievements within the partnership	1	17	0	0	1.94	18
2. The factors associated with successful working are known and understood	1	14	3	0	2.11	18
3. The principal barriers to successful partnership working are known and understood	0	12	6	0	2.33	18
4. Working in partnership is the main way in which we must conduct our business (re BSAB)	12	5	1	0	1.39	18
5. There is clear understanding of partners' interdependence in achieving some of their goals	1	13	3	1	2.22	18
6. The need for partnership working has been successfully communicated at all levels of the member organisations	0	12	6	0	2.33	18

Question 2:	Strongly	Agree	Disagree	Strongly Disagree	Rating Average	Response Count
1. Our partnership has a clear vision, shared values and agreed service principles	1	13	3	1	2.22	18
2. We have clearly defined joint aims and objectives	2	11	5	0	2.17	18
3. These joint aims and objectives are realistic	2	9	6	0	2.24	17
4. The partnership has defined clear service outcomes	0	12	6	0	2.33	18
5. The reasons why each partner is engaged in the partnership are understood and accepted	0	9	9	0	2.50	18
6. The areas where early partnership success is most likely have been identified and	0	6	12	0	2.67	18

Question 3:	Strongly	Agree	Disagree	Strongly Disagree	Rating Average	Response Count
1. There is widespread ownership of the partnership within and across all partners	0	10	8	0	2.44	18
2. There is a clear commitment to partnership working from the most senior levels of each of the partners	2	10	6	0	2.22	18
3. The way the partnership is conducted recognizes and values each partner's contribution	1	12	5	0	2.22	18
4. Benefits from the partnership are fairly distributed across the BSAB member organisations	0	4	13	1	2.83	18
5. Levels of trust within the partnership are high enough to encourage significant risk-taking	1	7	9	1	2.56	18

6. There is zero tolerance of individuals and organisations who fail to work constructively within the partnerships	0	6	12	0	2.67	18

Question 4:	Strongly	Agree	Disagree	Strongly Disagree	Rating Average	Response Count
1. All significant and relevant stakeholders are represented in the partnership governance arrangements	1	10	5	2	2.44	18
2. Each partner's areas of responsibility are clear and understood	0	9	9	0	2.50	18
3. The way in which partnership business is conducted is open and fair	2	11	3	2	2.28	18
4. It is clear what resources (both financial and non-financial) each partner brings to the partnership	0	2	15	1	2.94	18
5. The partnership has dedicated staffing to support its working arrangements	1	7	10	0	2.50	18
6. There are clear lines of accountability for the performance of the partnership as a whole	0	8	9	1	2.61	18

Question 5:	Strongly Agree	Agree	Disagree	Strongly Disagree	Rating Average	Response Count
1. The partnership has robust procedures for monitoring its progress	0	8	8	2	2.67	18
2. Clear criteria exist to judge the extent to which partnership goals are achieved	0	7	10	1	2.67	18
3. Clear criteria are in place to judge the way in which the	0	5	12	1	2.78	18

partnership itself is working						
4. Partnership achievements are well communicated amongst the partner agencies and beyond	1	3	13	1	2.78	18
5. The key measure of success is the effect the partnership has on holding each other to account, working together to solve issues that might arise, and by listening to and learning from the experiences of people involved in safeguarding processes	3	8	5	1	2.24	17
6. The partnership shows evidence of learning and changing in light of experience	3	9	6	0	2.17	18

The survey will be repeated in 2016 to establish whether the board has made progress against these criteria in establishing principles for board members to work towards. The board will consider how the result have developed over the year and

Conferences

'Stop Adult Abuse' event for Older people - June 2015

In June 2015, the BSAB communication and engagement sub group ran a conference for older people within @Bristol. The aim of the event was to increase their knowledge and skills to stay safe both within their home and in the community. There were two key note speakers: the Mayor, George Ferguson and the Police and Crime Commissioner for Avon and Somerset, Sue Mountstevens who both talked about personal experiences and their vision for a safe city.

There were a number of workshops and stands where people could gain further information including trading standards, financial information, Care Quality Commission, care and repair, and Bristol Community Health. Although the attendance was not as high as we would have liked, those that attended found it really useful.

BSAB Annual Staff Conference - November 2015

In November 2015, the BSAB communication and engagement sub group ran a conference in the new conference centre in Keynsham. Over 140 individuals attended from statutory, voluntary and private sectors within health and social care attended.

The opening speaker was Louise Lawton who gave an overview of the changes to safeguarding in light of the Care Act (2014) and the impact on the residents of Bristol and the staff and others within the sector. Louise was followed by Graham Enderby, the carer for 'H', the subject in the in the Bournewood case[4] which brought about the implementation of Deprivation of Liberty Safeguards (DoLS). Graham gave his account of the events that led to the decision by the European Court of Human Rights (ECtHR). The

[4] The European Court of Human Rights ('ECtHR') - HL v United Kingdom – the "Bournewood" case (2005).

third speaker was Sanchita Hosali from the British Institute of Human Rights who spoke about the relationship between Human Rights and Safeguarding. Sanchita was followed by Professor Michael Preston-Shoot; he gave an account of the work he has undertaken regarding self-neglect and the lessons learnt.

The last two speakers were from local organisations, the first, Freeways[5], is a charity which supports mainly adults with a learning disability and their focus on increasing feedback including complaints from this client group in order to improve empowerment. The last were two service users, with their support, from 'Yoursay'[6] regarding their views on the safeguarding process.

'Ensuring Good, Achieving Excellence' Joint Conference March 2016

In March 2016, a joint conference was run by Bristol Safeguarding Adults Board and South Gloucestershire Safeguarding Adults Board. The keynote speakers were the strategic Director of the People Directorate within Bristol, John Readman and his counterpart in South Gloucestershire, Peter Murphy. This conference was workshop based and people chose from areas as diverse as:

- 'thresholds for safeguarding'
- 'service user perspective'
- to CQC to
- Commissioning safe neglect services.

Although the plan was to hold a conference for 150 attendees we over-subscribed and 162 people attended on the day. 100 people completed feedback forms with over 95% positive responses on all questions.

[5] http://www.freeways.org.uk/
[6] http://www.yoursay-advocacy.co.uk/

Safeguarding adult reviews

Published in 2015 – 2016

RC - This Serious Case Review was commissioned by Bristol Safeguarding Adults Board (BSAB) following the death of RC on the 9th August 2013. The review was completed in 2015 and an executive summary published in January 2016[7]. The Board accepted the findings and recommendations of the Serious Case Review into the death of RC at an extraordinary Board meeting held on the 30 November 2015.

Recommendation 1

Improve information sharing across all agencies working with people who are on the Housing Support Register (HSR).
Outcome: Timely, detailed and accurate information is available for users of HSR to make decisions.
Actions proposed: An information sharing agreement will be in place between agencies who inform referrals, or who refer into, the HSR. There will be improved partnership working, information sharing and a greater level of co-creation from all HSR stakeholders.
Progress: expected completion date December 2016

Recommendation 2

Housing Support Register referrers and providers to use an agreed risk assessment and risk management protocol and process across Bristol
Outcome: Providers are able to risk assess and manage reliably and consistently against an agreed model.
Actions proposed: An improved risk assessment process will include amended risk assessment forms on the HSR with questions which are relevant and useful in assessing all known risks. This will ensure that risk assessments contain all the information needed for services to make an informed decision about accepting a high risk individual into their service. It will also ensure services are able to prepare an appropriate plan for risk management, support and move on through the pathway. This will form the basis for future assessments and moves.
If risk assessments, client background and support needs are entered correctly and in enough detail on the first referral onto the HSR, clients will not need to give a full history to each new service they access. Services will be able to review and build on previously recorded information using it as a basis for a support and risk management plan.
Progress: expected completion date December 2016

[7] https://www.bristol.gov.uk/documents/20182/354651/Serious+Case+Review+-+RC+Executive+Summary.pdf/e11c9e04-93f4-4760-b0fa-4b7e8e0a03ca

Recommendation 3

Housing support providers must ensure their staff are competent to use the agreed risk assessment. Management protocol and processes must be available and mandatory, and staff must be able to identify and access support, advice and mentoring.

Outcome: Information about potential risk is defined and shared appropriately at referral stage. Training will ensure that Staff in provider services are able to use the agreed models confidently, consistently and reliably.

Actions proposed: All HSR users to have access to training so that they are competent in using the agreed protocols to gather detailed and appropriate risk information from a wide range of sources and have a clear understanding of what is expected from them when they create a referral on the HSR.

Progress: expected completion date December 2016

Recommendation 4

Housing support providers must have ready access to consultation, advice and support on mental health issues, including autism and Asperger's. There must be an escalation route should grave concerns or a crisis develop. Providers must know when and how to access multi agency forums.

Bristol Mental Health and Bristol City Council are engaged in taking recommendation 4 forward via a multiagency working group.

Outcome: HSR providers are able to access timely information, consultation advice and support and can escalate appropriately in crisis or to prevent crisis situations.

Actions proposed: Access points are created for advice and consultation and these are known and used by HSR providers. An escalation pathway is in place and escalations are responded to and managed consistently.

Progress: This recommendation has yet to be progressed.

Recommendation 5

The range of available accommodation for people with mental health issues needing housing related support must be urgently reviewed. Commissioners must review accommodation options for people with severe and enduring mental health issues. This will link to accommodation as well as mental health strategies. The nature of provision needs to be captured and analysed, the gaps and changes needed analysed and a mental health accommodation strategy confirmed.

Outcome: There is a range of accommodation available for people who are both at risk of losing tenancy and have mental health issues/autism which will support them to regain and retain independence and wellbeing.

Actions proposed: Accommodation offered via the HSR will be reviewed by commissioners in the light of recommendation 5 and a further strategy confirmed.

Progress: This recommendation has yet to be progressed.

The Board is determined to ensure we learn from this review and that agencies continue to work together to minimise the risk of events such as these happening again. It remains a matter of concern that as of March 2016 progress had not commenced in addressing recommendations 4 and 5.

Currently in process

Simon Reynolds - Died in November 2014. His death occurred at a mental health 'place of safety' following an attempt to take his own life when Mr Reynolds was experiencing an acute psychotic episode. A coroner's inquest has concluded in July 2015 and the Serious Case Review is expected to be published in 2016.

MM – Died following an assault in October 2014. MM, aged 18, was living in supporting accommodation and was murdered by another resident in the home. The perpetrator was convicted of MM's murder in October 2015. A Serious Case Review is currently being undertaken and will be published in 2016.

Mr C - In September 2014, Mr C, aged 61, died in a fire at his flat in Bristol. There were no other casualties. A serious case review has been commissioned following concerns raised by Avon Fire and Rescue Service regarding the circumstances of Mr C's death. The Review will be published during 2016.

Strategic Plan 2015 – 2018

The safeguarding adult board has amongst its core duties the requirement to publish a strategic plan for each financial year. The plan sets out how the board will meet the main objectives and what the members will do to achieve this. The plan will be developed with local community involvement, and the Board must also consult Healthwatch: Bristol. The plan should be evidence based and make use of all available evidence and intelligence from partners to form and develop its plan.

During 2015-2016 the strategic plan and an accompanying business plan have been developed. It is available as a separate document to this annual report.

The main objective of the board is to improve local safeguarding arrangements and ensure partners act to help adults at risk experiencing, or at risk of neglect and/or abuse.

Strategic Priorities

The strategic priorities are aligned with the six principles of safeguarding:

Priority One: Empowerment

Presumption of person led decisions and informed consent.

People feeling safe and in control, being more able to share concerns and manage risk of harm either to themselves or others

'I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

"I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able"

Outcomes	Progress at March 2016
Adults at risk are involved and empowered to control the Safeguarding Adults process for themselves	This will require analysis of service user feedback. A mechanism to develop this will be developed by the proposed Data Analyst once this position has been recruited. This is expected for 2016/17.
Advocacy support services are provided to all adults at risk and / or their appointed person (as appropriate)	This will require analysis of service user feedback. A mechanism to develop this will be developed by the proposed Data Analyst once this position has been recruited. This is expected for 2016/17.
People feel safe and in control as a result of the use of safeguarding adults procedures	This will require analysis of service user feedback. A mechanism to develop this will be developed by the proposed Data Analyst

	once this position has been recruited. This is expected for 2016/17.

Priority Two: Prevention

It is better to take action before harm occurs.

"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

Outcomes	Progress at March 2016
The Board has a clear communications & engagement strategy to raise awareness of abuse with service users, professionals, public and professionals	A communications strategy has been drafted and is expected to be signed off in 2016/17.
The roles of the Board are known and understood in the community	This should be achieved with the production of an independent Safeguarding website. A proposal to develop this in conjunction with the BSCB has been agreed, and will be progressed by the Business Unit once in place.
PREVENT is integrated into the Board's Prevention and Early Intervention Strategy and is implemented and understood by all Partners	A Task group has been convened to progress the Prevention and Early Intervention Strategy.
People are aware of how to safeguard themselves and those they are supporting.	A mechanism to receive service user feedback will be developed by the proposed Data Analyst once this position has been recruited. This is expected for 2016/17.
Partners commissioning processes have safeguarding embedded throughout	There is an expectation that this will be reported through the Core Partners and Executive sub group
Partners contract monitoring has safeguarding central to its process	There is an expectation that this will be reported through the Core Partners and Executive sub group

Priority Three: Proportionality

The least intrusive response appropriate to the risk presented.

"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

Outcomes	Progress at March 2016
Service users are satisfied with their experience of the safeguarding process	A mechanism to receive service user feedback will be developed by the proposed Data Analyst once this position has been recruited. This is expected for 2016/17.
Safeguarding practices are professional, appropriate, proportional and focussed on individual need	Multi-agency policy improvements and developments will be progressed by the Policy and Projects Officer once this position has been recruited. An overarching Safeguarding Adults policy and Escalation policy has been agreed.

Priority Four: Protection

Support, representation and help for those in greatest need and who are vulnerable and at risk of harm.

"I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able"

Outcomes	Progress at March 2016
Bristol's Safeguarding practices are professional, appropriate and focussed on individual need and adults at risk are supported to be involved at the earliest possible point in the safeguarding process	Multi-agency policy improvements and developments will be progressed by the Policy and Projects Officer once this position has been recruited. An overarching Safeguarding Adults policy and Escalation policy has been agreed.
Professionals involved in the safeguarding process are trained and supported	The Learning and Development Sub Group have taken ownership of assessing the provision of training across Bristol, with the expectation of producing a multi-agency training options paper in 2016/17

Priority Five: Partnership and Engagement

Local solutions through services working with their communities.

Communities have a part to play in preventing, detecting and reporting neglect and abuse.

"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me."

Outcomes	Progress at March 2016
Local safeguarding arrangements are effective and partners act to help and protect vulnerable adults in Bristol.	Analysis of local safeguarding trends will be conducted by the Data Analyst once recruited in 2016/17.
Service user involvement is evident in the work of the Board and wider communication with the community	The CESG is developing a database of service user forums to use for consultation on BSAB policies and procedures, and will scope the potential for creating a service user reference group.
Adults at risk are involved with and informed of the work of the Safeguarding Adults Board	The CESG is developing a database of service user forums to use for consultation on BSAB policies and procedures, and will scope the potential for creating a service user reference group.
The Board policies and procedures are influenced and informed by service users their families, and advocates,	The CESG is developing a database of service user forums to use for consultation on BSAB policies and procedures, and will scope the potential for creating a service user reference group.
The roles of the BSAB are widely known and understood in the community	This should be achieved with the production of an independent Safeguarding website. A proposal to develop this in conjunction with the BSCB has been agreed, and will be progressed by the Business Unit once in place.
Data and information sharing protocols are agreed	An information sharing protocol has been drafted and is expected to be signed off in 2016/17
Effective partnership and quality services in all safeguarding activities	Board and Executive group to consider how to evidence this has been achieved with the Joint Safeguarding Business Unit once recruitment is complete.

Priority Six: ACCOUNTABILITY.

Accountability and transparency in delivering services. Bristol Safeguarding Adults Board is collaborative, accountable and learning.

"I understand the role of everyone involved in my life, and so do they."

Outcomes	Progress at March 2016

Outcomes	Progress at March 2016
Local safeguarding arrangements and partners act to help and protect adults in Bristol	Partner Development days are held annually, and recruitment to the Joint Safeguarding Business Unit should achieve this.
Local safeguarding arrangements are effective and deliver what people want	Annual partner agency audits are conducted, and challenge and escalation through the BSAB is encouraged.
The Strategic Plan is agreed and widely consulted on	The development of a service user database to be used for consultation will help to achieve this in future years.
Stakeholders are satisfied with safeguarding arrangements	Stakeholders are requested to submit information for the production of the annual report.
The Board is responsive, learning and promotes examples of good practice	An annual peer review process is in place. A mechanism to disseminate learning from SCRs and SARs will be developed across sub groups.
BSAB develops a SAR protocol to ensure there is a clear and transparent process.	A Learning and Development framework is in place, and this will be reviewed and updated in 2016/17 as a response to learning from processes already undertaken.
BSAB undertakes SARs as required and learns lessons in accordance with the Care Act 2014	A SAR sub group has been convened to ensure that this practice is embedded.

BSAB Sub Groups

Communication and engagement Sub Group

Chair: Claire Hayward

Overview

In the last 12 months the Communication and Engagement sub group have worked significantly to review their membership, and complete a business plan in line with the BSAB's strategic plan in order to create and meet the majority of the targets set within their business plan with targeted communication.

Achievements/improved outcomes

A database of community groups was created to ensure information was sent directly to voluntary and others groups that support adults at risk within our community as well as commissioned services.

The Easy read guide was updated in line with the Care Act 2014 to include the additional areas of concerns.

Three conferences were run by the group, one of which was in conjunction with a neighbouring authority. Two were aimed at professionals and one was targeted at adults at risk with the Elected Mayor and PCC as keynote speakers highlighting the level of importance to local residents.

The conference which was for older people was run during Stop Adult Abuse Week, which is a local initiative that started in 2014 when the Local Safeguarding Adult Board Communications Groups in the four unitary authorities decided to join together to run a week to focus attention on Safeguarding. This week meant we focussed our communications and events to promote safeguarding increasing the impact that one authority could have.

Challenges

The greatest challenge for the Communication and Engagement Sub Group has been recognising the boundaries of our work and the interaction with the other sub groups of the board to ensure joined up thinking to maximise the limited resources. This has now been recognised and the chairs are meeting up regularly to ensure we are all clear as to the work plans and responsibilities and to identify specific barriers.

All members of the sub group have responsibilities outside of the group and therefore the constant drive to move forward when there are a number of priorities outside is a challenge and it is a testament to the group that so many outputs and outcomes have been achieved.

There is an inherent challenge when trying to support providers and practitioners to ensure their knowledge is as good as it can be with the knock on effect of improve the quality within provided services whilst there are economic pressures. The group aims to continue to put on free conferences for as long as possible but recognises this may not always be the case.

Plan for the year ahead

The plan for the year ahead is to work closely with the communication sub group of the children's safeguarding board to merge the work to make better use of resource.

The local communications groups have also worked together to agree using core templates for campaigns and a shared photo bank to allow for improved dissemination and greater impact with restricted funds. The communication sub group for the children's and adult's

boards are still separate and we are working to join these two groups through the merging of business plans so that neither group getting an overriding focus and strategic plans for both boards are equally prioritised.

A new leaflet and poster campaign to be launched during Stop Adult Abuse Week which incorporates many of the changes brought about by the Care Act 2014 and aimed at the public to increase their awareness.

A press and social media campaign linking with other authorities to maximise the impact; although this has run for a number of years we aim to increase the number of local authorities which are part of the campaign and use the twitterhashtag #stopadultabuseweek[8]

The largest part of our plans for the next year is the creation of the website ensuring the branding is evident throughout but the differences are also visible which will allow all residents and those supporting people, whatever age, in Bristol to be able to access all the information they want about the board or need in order to keep people safe, or report concerns, from one site.

Once the website is created the next part is to ensure that as many other organisations link to this one website for all safeguarding issues and ensure the information remains current and valuable through the use of analytical tools.

Whilst the website is important, we are still aware that a number of adults at risk will not currently have the skills or resources to access the internet and therefore ensure we continue to use alternative engagement methods to directly reach certain sectors according to the information we receive from the Performance and Intelligence Sub Group.

To understand the best way to engage with adults at risk and their families to ensure the work of the board remains valid and valued by the people of Bristol. It is imperative that we ensure the people we aim to protect are at the heart of everything we do and their voice is the loudest and clearest.

Performance and Intelligence Sub group

Chair: Tracey Judge

Overview

The remit of the PISG is to fulfil the BSAB's responsibility to undertake themed audits and evaluation of multi-agency safeguarding activity and provide analysed data reports on this activity to the Board. In the last 12 months the sub-group have worked to increase their

[8] https://twitter.com/hashtag/stopadultabuseweek

membership, and meet the targets set within their business plan to meet the BSAB's strategic plan.

Achievements/improved outcomes

The sub group has completed a performance framework document and is now working on specific elements to deliver the outcomes.

The members of the sub–group have worked hard to ensure that with the forming of the Statutory Board that systems are in place to collate, analyse and report qualitative and quantitative intelligence from all Partners to the Board in order to inform policy, practice and service delivery. This work is not complete but good progress has been made against the targets set.

The PISG have established a set of quarterly data reports to be able to report to the Board and these data sets and reporting mechanisms have been improved. This will enable better analysis and information gathering on safeguarding activity and will lead to greater understanding of the activity that lies behind local data returns. We will be able to use the information to inform and improve the strategic plan and operational arrangements.

With the data set in place one of our aims in 2016-2017 will be to be able to evidence to what extent the adults who have experience the safeguarding process have had the outcomes they wanted realised.

The PISG has also established how it will hold partners to account and gain assurance of the effectiveness of its arrangements through its publication of the Escalation Policy. In 2016-2017 we will be in a position to audit how it has been working and its effectiveness.

Challenges

The biggest challenge has been being able to progress and deliver our allocated actions in the BSAB strategic plan without the resources in the Joint Business Unit being available to us. This should be rectified in 2016-2017 as a Policy and Projects Officer, a Policy and Projects Support Officer and a Data Analyst post will be recruited to. This will enable the PISG to deliver more of its business plan.

The members of the sub group have important responsibilities and roles in other agencies and provider organisations so have competing demands on their time. However despite these they have been committed and it is important to recognise their achievements, the outcomes they have delivered under these difficult circumstances.

Plan for the year ahead

The plan for the 2016-17 is to get the Joint Business Unit posts filled to enable policies, tools and analysis of data sets to be progressed. Allied with this will be the development of a scorecard that will enable us to collect and collate information from the BSAB's Statutory Partners, agencies and providers.

The sub-group will develop a process and tools to gather and understand feedback from adults at risk who have experienced the Safeguarding process

The sub-group will identify and carry out thematic review and audits following the learning from Serious Case Reviews to understand the impact of training and analyse future need.

Learning and Development Sub Group

Chair: Paulette Nuttall

Overview

The Learning and Development Sub Group (LDSG) was established to support the Bristol Safeguarding Adults Board (BSAB) to fulfil its responsibility in relation to the learning, training and development aspects of the Board's strategic plan.

The purpose of the LDSG is to enable the BSAB to fulfil its statutory duties by developing and implementing a 3 year learning and development strategy and supporting business plan.

Achievements/improved outcomes

In the last year, the membership of this group has taken some time to become established and we canvassed through colleagues to encourage expression of interests. We expect to have achieved full membership representation from a wide range of agencies early in the 2016-2017.The terms of reference for the group have been agreed.

LDSG Business Plan

The LDSG are currently working on the development of the business plan and have aligned work streams with the chairs from Communication and Engagement, Performance and Intelligence and the Safeguarding Adults Review sub groups.

Plan for the year ahead

Our immediate priorities as a group include identifying training and development needs and delivering and evaluating learning events for the BSAB.

The development of Self-Assessment Questionnaire by the group will be circulated to the BSAB partner agencies. The outcome of the information received will form the development of an option paper regarding multi-agency training provision.

Another priority for the group is the learning from the Safeguarding Adult Reviews and ensuring that the learning identified in these and previously commissioned serious case reviews are effectively disseminated.

Safeguarding Adult Review Sub Group

Chair: Victoria Caple

Overview:

During 2015-2016, the Safeguarding Adult Review Sub-Group was formed, as part of the Bristol Safeguarding Adults Board, and has devised and implemented the Terms of Reference and Business Plan. The Sub-Group meets quarterly to discuss key themes and progression against action plans.

Within this time, the Sub-Group has taken responsibility for four Serious Case Reviews and has provided quality assurance and oversight for each of these.

Achievements/Improved Outcomes:

During 2015-2016, one SCR was published – RC. The key themes from this review are improved information sharing and the need for adequate risk assessments being completed between housing providers and support agencies. This is being monitored via the Sub-Group Action Plans.

Challenges:

It has been identified, how imperative it is to ensure that reports are commissioned and produced in such a way to carefully capture the learning required. When the previous SCR were commissioned, the IMR methodology was used, but by the time it was presented by the author to the Sub-Group, the preference of forthcoming reviews had changed to a systems methodology. This has meant that evaluation and quality assurance of SCR's has become challenging, requiring complex legal advice and support in order to ensure that once published, the learning and recommendations are effectively identified.

As a consequence of the above, but not wholly limited to, all members of the Sub-Group have had to invest a considerable amount of time and resource in order to ensure that the finished Review is fit for purpose. There is a risk, for all agencies, that sufficient availability is not given to this critical work. This can be evidenced by the challenge in commissioning, writing, auditing and publishing a report within six months – this is the accepted time limit within BSAB guidance, although there is an option to increase this - due to complexities or ongoing Court procedures for example.

Another challenge has been ensuring the right partners are attending the Sub-Group meetings. Previous reviews have highlighted how important it is to get the necessary expertise being involved in the process at an early stage. This has been difficult for some partners given the level of commitment required.

As we move towards commissioning review authors using the systems methodology, I envisage we will face a challenge in ensuring that the skills and competencies of review authors are appropriate, as there is a relatively small pool from which to choose from. As a result of this, the timeliness of reviews may diminish as we struggle to appoint suitable authors.

Plan for the Year Ahead:

The Safeguarding Adults Review Sub-Group expects to commission future SARs, using the systems methodology. This is a relatively new review methodology, in use for SARs and training will be arranged for the Sub-Group in December 2016. The expectation is that all forthcoming SARs use this methodology.

Safeguarding in Practice:

Who did we help in 2015/2016?

For the year 2015/2016 Bristol City Council received 4019 alerts (4 of the alerts involve children under 18). 3540 of these alerts were made subject of a s.42 enquiry in the safeguarding process. The remaining alerts were either resolved quickly within triage or via a community care process.

Of the 3540 cases, 200 ceased at the individuals request, 335 were deemed ineligible for a s.42 enquiry, 535 had an outcome that was inconclusive, 333 had an outcome that was 'partially substantiated', 855 had an outcome fully substantiated; and 848 had an outcome that was 'unsubstantiated'. At present 913 do not have an outcome recorded.

Inconclusive outcomes often occur where there are mental capacity issues and the adult at risk is unable to give their own account and there are no witnesses. In these cases a protection plan is still put into place as the person may still be at risk of further harm or neglect.

Comparing the dataset with that of 2014/2015 is problematic as different criteria are now used since the Care Act came into force in April 2015. Also The Local authority implemented a new case recording system within the year and this has affected the dataset.

How were people being harmed?

Where did the alleged abuse happen?

Abuse type	Total	%	Care Home	Community	Community Service	Hospital	Location not recorded	Other	Own Home
Abuse type missing	165	6.5	37	0	1	12	34	32	49
Discriminatory	42	1	8	0	2	5	0	10	17
Domestic	1	-	0	0	0	0	0	1	0
Financial	716	18	44	1	28	31	4	129	479

Neglect	1489	37	444	1	29	196	4	147	668
Organisational	98	2.4	59	0	1	12	1	7	18
Physical	1072	26.7	495	6	33	137	7	168	226
Psychological	271	6.7	35	1	11	27	2	58	137
Sexual	165	4.1	30	0	8	23	1	56	47

Who reported alleged abuse?

26% of cases were reported by Health partners compared to 24% in 2014/2015

29% of cases were reported by providers compared to 24% in 2014/2015

5% of cases were reported by the Police compared to 24% in 2014/2015

Self, Family or friends reported 5% of cases.

There were 55 self-referrals – 1% of cases reported. Frequently people report to another professional who will then alert Bristol City Council. These are not counted as "self-referrals" at present.

Who is abusing?

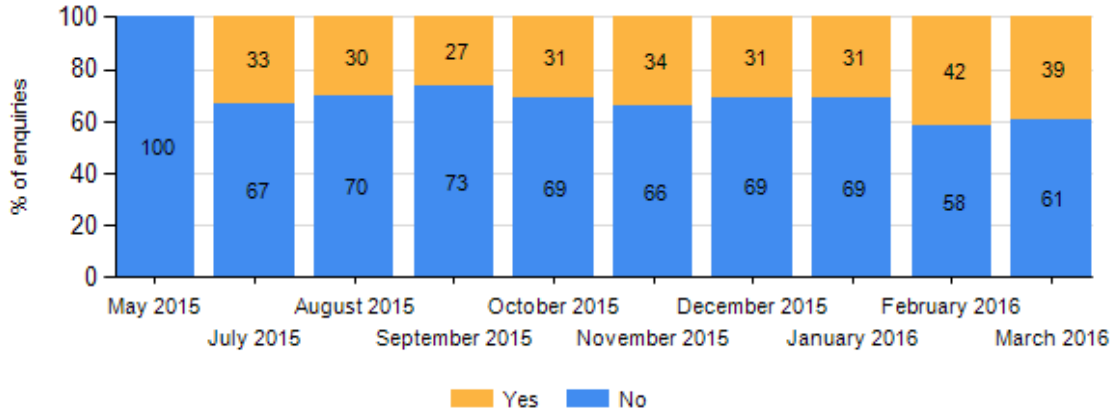
Abuse type by perpetrator type

Abuse Type	Friend/ neighbour	Health Worker	Not known	Not recorded	Other	Other family member	Other Professional	Other Vulnerable adult	Partner	Social Care Staff	Stranger	Volunteer/ Befriender
Abuse type missing	3	13	35	38	17	22	4	10	6	15	1	1
Discriminatory	6	6	4	0	5	3	1	6	4	3	4	0
Domestic	0	0	0	0	0	0	0	0	1	0	0	0
Financial	103	20	108	14	52	235	11	21	42	43	44	23
Neglect	22	304	243	68	240	139	33	17	41	376	5	1

Organisational	1	28	6	2	6	2	5	2	0	45	1	0
Physical	35	60	100	12	58	136	12	502	78	60	17	2
Psychological	21	16	23	6	24	77	3	41	31	19	7	3
Sexual	18	15	35	4	16	16	0	37	7	7	9	1

Consent

A priority of BSAB is that those who are victims of abuse are empowered to either report the abuse themselves or alternative provide informed consent. There has been a gradual and small increase over the year regarding the victim of abuse providing consent to a referral being made.

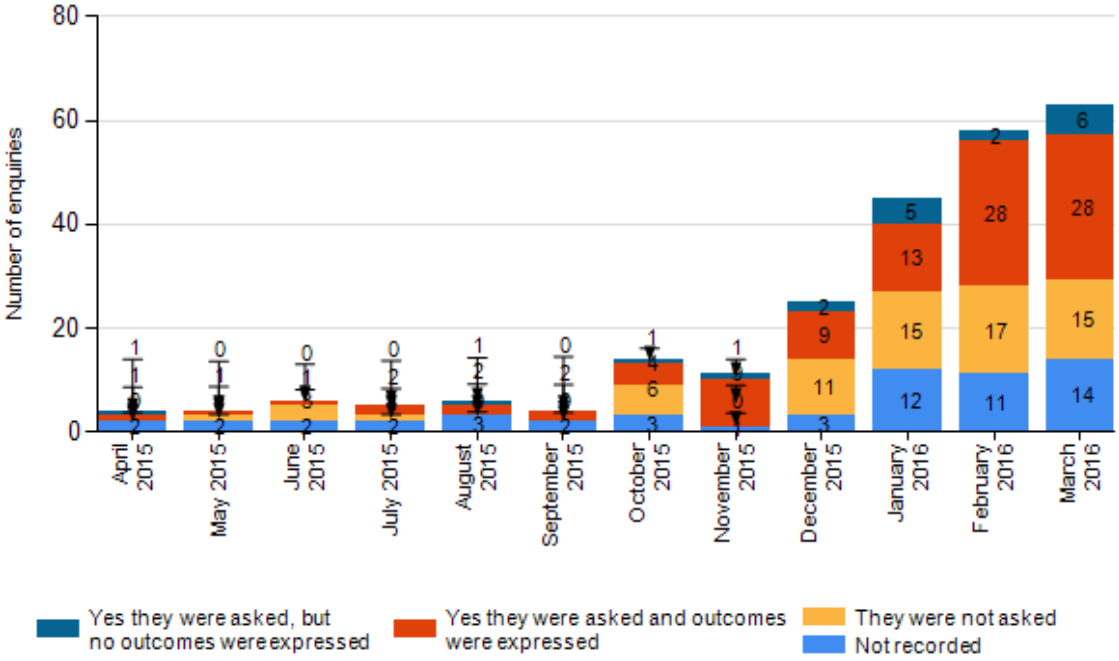


Further understanding of why the number of referrals being made without consent remains the majority of referrals.

Outcomes

Prior to December 2015 the action of informing the referrer of the outcome of a referral was not recorded.

It is now expected practice that the desired outcome of the referral is recorded and it is also expected that this is checked with the referrer at the conclusion of the enquiry.

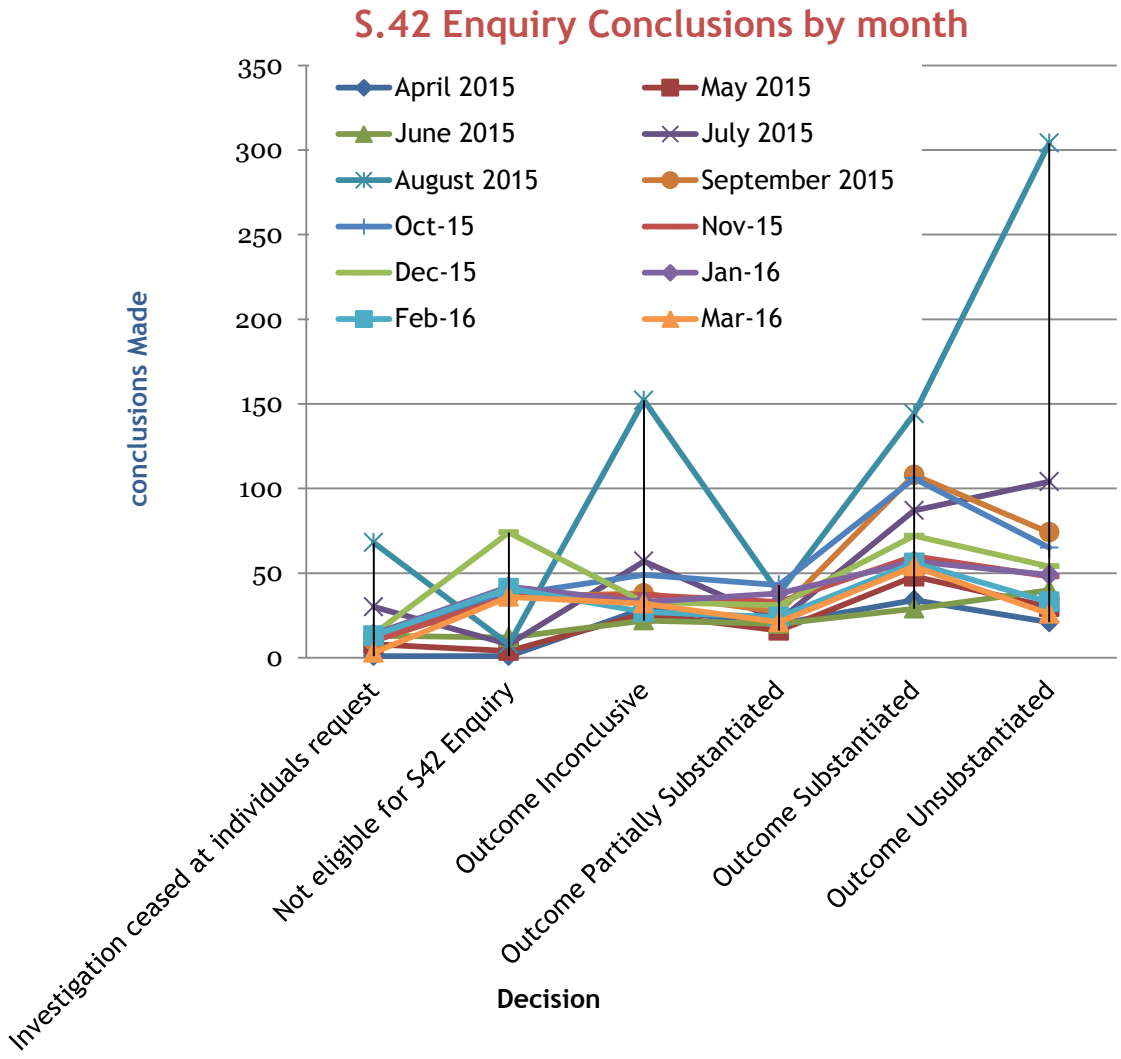


It is also expected practice that the referrer is informed of the outcome. Detailed recording is only available since December 2015.

Month	Informed	Not informed	total
December 2015	111	69	180
January 2016	95	73	168
February 2016	93	64	157
March 2016	73	83	156

Of those referrers that were informed the great majority expressed satisfaction with the outcome of the enquiry.

Enquiry Conclusions



Healthwatch Bristol

Brief outline of agency function:

The Care Forum is an independent voluntary and community sector infrastructure organisation working across Bristol, North Somerset, South Gloucestershire, Bath and North East Somerset. We work to promote health and wellbeing, challenge inequalities and enable organisations and individuals to have choice, influence and engagement around health and social care.

Healthwatch Bristol is an independent watchdog for health and social care services. We engage with Bristol residents to understand their experiences of using local the health and social care system, with a particular focus on identifying and sharing best practice in order to make improvements to services based on public need. Healthwatch has a particular focus on engaging with seldom heard groups and communities in order to help tackle health inequalities and ensure equity of access.

Achievements during 2015/16: (bullet points)

- Revised Safeguarding Adults policy and procedure and ran briefings for staff to ensure they were up to date
- Ran safeguarding training for staff and volunteers (new and existing)
- Carried out a training review across The Care Forum, which identified the need for enhanced training for safeguarding leads
- Set up a working group to develop a safeguarding policy and procedure for children and young people to complement the adult work
- Revised the administrative process in place to make The Care Forum's safeguarding log easier to use

Describe how you raise awareness of safeguarding in your agency:

- Staff and volunteer induction
- Policies and procedures
- Annual training programme
- Sharing literature from the BSAB, including key messages, details of local/national campaigns and events.
- Regular discussion and learning between staff and managers

Describe how you supported service users and carers through the safeguarding adults' procedure:

- Helping service users to understand the safeguarding process, including confidentiality, what happens if a disclosure is reported and keeping them informed
- Supporting service users to make complaints about the safeguarding process if they wish to do so via The Care Forum's complaints procedure advocacy service
- Sharing information with partner organisations and stakeholders via key messages, e-bulletins, social media and website

- Ensured that staff are up to date with the safeguarding adults policy and procedure through lunchtime briefings

Objectives for 2016/17:

- Bringing policies and procedures 'to life' by engaging with staff during supervisions. This will include talking through scenarios and drawing on the relevant policies and procedures to ensure that staff are aware, confident and understand what to do in various circumstances, including if a safeguarding concern is raised.
- Safeguarding training will continue to be provided to all new and existing staff and volunteers.
- Enhanced safeguarding training to be provided to safeguarding leads.
- Bringing together The Care Forum's BSAB representatives for Bristol, B&NES, South Gloucestershire, Somerset and Swindon to share information, guidance and best practice across the organisation and staff group.

Performance Indicators:

Indicator 5: Training	Target%	Outcome %	Comment
5.1 Relevant staff will have completed SA level 2 training within 6 months of taking up post and/ or completed refresher training every 3 years thereafter (the term 'relevant' is defined by CQC)	90%	100%	
5.2 Relevant staff to have undertaken Mental Capacity Act training within 6 months of taking up post (relevant staff includes people that directly provide health and social care or are in a position to make decisions about the service users care - training to include DOLS awareness)	80%	100%	
5.3 Relevant staff to have undertaken DOLS training within 6 months of taking up post (the term relevant here includes those staff responsible in law for making a DOLS application)	95%	100%	
5.4 New staff to undertake safeguarding learning as part of Induction within 3	95%	100%	Safeguarding policy and procedure included in staff induction (first two

months of starting employment			weeks in post). Safeguarding training is compulsory for all new staff and volunteers.
Indicator 6: Safer Recruitment			
6.1 Relevant staff to have an up to date DBS check	100%	100%	

Partner Statements - Achievements in 2015/16

Bristol City Council, Avon and Somerset Constabulary and Bristol Clinical Commissioning Group are the three core statutory partners which support and fund the board. In addition there are statutory and other members who provide services to support and identify adults at risk of abuse. Those partners have provided a brief summary of their activity as regards safeguarding adults at risk during the first 12 months following the establishment of Bristol Safeguarding Adults Board in April 2015.

Bristol City Council, People Directorate, Care and Support Adults

Brief Outline of agency function and safeguarding arrangements:

This year we have implemented the new statutory safeguarding duties in partnership with statutory and non-statutory partners. The Local Authority (LA) must lead a multiagency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens. It must make enquiries, or request others to make them, when it is thought an adult with care and support needs may be at risk of abuse or neglect.

An important part of our safeguarding effort is to help prevent abuse occurring. We aim to ensure that we raise awareness of abuse in all its forms. We ran a successful media campaign to raise awareness about abuse. We aim to make information about reducing the risk of abuse easily available, so people are supported to protect themselves from risk and abuse. We want to support older and disabled people and carers who may be at risk of abuse to help themselves to minimise the risk and harm that abuse causes.

Where abuse may have occurred, the Council safeguarding adults team triages all safeguarding adults concerns that come into Care Direct and are responsible for making the decision whether a section 42 enquiry is needed or not and whether this is a single agency or a multiagency enquiry. The team undertakes many of the proportionate single agency enquiries.

Within these new duties we particularly want to ensure that people who are adults at risk and using the safeguarding adults process are as involved as possible in their own safeguarding. At the beginning of every safeguarding enquiry the adult at risk is asked what they wish to happen as an outcome and they are kept informed of progress. A proportion of adults at risk, lack the capacity to make their own decisions and so any decision regarding their protection must therefore be made in their best interests and their family and friends are consulted about these matters.

Safeguarding Activity / Achievements 2015/16

In 2015-16 we received just over 3000 concerns, all of which were carefully screened to see if matters could be resolved easily and if any harm was likely to have occurred. To put this into context the total safeguarding episodes raised in 2014-15 was 943. A high proportion of

these safeguarding cases the allegations made needed further enquiry and were co-ordinated by adult social care. Approximately 1200 of these were enquiries into the alleged neglect of an adult at risk. Around 1300 people allegedly experienced harm in their own home by a family member, friend or neighbour. Just over 950 people were allegedly harmed whilst living in a care home. After enquiries were made, 152 cases were found to have involved no harm to the adult at risk. In around 1000 cases the risk of harm was reduced and in 311 cases the risk removed completely. It is not always possible to completely remove risk, for example, some people will decide that they want to live with some element of risk in order to preserve a family relationship.

When people need to access to care and support, it is essential that their experience of this is positive and that they view it as something that supports them to live the life they choose and remain as independent as possible. We are working with local people, and the providers we commission, to make sure that people receive good quality, safe services, that they can control. We have monitored the quality and safety of all the services we buy, and we work hard to ensure only those agencies with robust safeguarding policies and procedures are considered for contracts to provide services within our procurement activities during 2015-16.

We have established Bristol's Safeguarding Adults board with its independent chair and set up the joint business unit to support it in its functions.

Bristol City Council responded well as a Supervisory Body in its efforts to protect Bristol's most vulnerable adults following the Supreme Court ruling of March 2014 which clarified the definition of a Deprivation of Liberty (P v Cheshire West and Chester Council and P and Q v Surrey County Council) and lowered the threshold, bringing thousands more people within the scope of the Deprivation of Liberty Safeguards (DoLS) process. The ruling triggered an unprecedented level of activity for the DoLS Service. To put this context, the total number of applications received in 2013-2014 was 151 and it went up to over 1300 for each year in 2014 -2016. In response to this demand a new team has been created and 40 Best Interest Assessors were trained.

Objectives for 2016/17

We aim to ensure that recruitment continues to fill all the vacant newly created posts within the joint business unit.

To increase the consistency and depth of risk assessment and joint decision making a pilot of the Multi agency Safeguarding Hub with statutory partners in Bristol will be undertaken.

Working with adults at risk who self-neglect and/or hoard is an area of work that challenges all agencies. Bristol Multi Agency Hoarding and Self Neglect Steering Group will be set up to develop protocols, best practice guidance and services to support staff working with these complex people.

The Social Workers will be able to choose safeguarding adults as a career progression pathway and a level 3 module to support this is being developed with the University of the West of England.

Avon and Somerset Constabulary

Brief outline of agency function and safeguarding arrangements

Avon and Somerset Constabulary provides professional policing services, working with partner agencies, including services to and for Adults at Risk, in order to keep them safe from harm. This includes working to prevent Adults at Risk from becoming victims of crime, investigating crimes against them, bringing perpetrators to justice and managing offenders.

During 2015/16 Avon and Somerset Constabulary built upon previous significant improvements to the strategic and operational response to identifying and dealing with incidents involving Adults at Risk, putting into practice the One Team approach introduced in October 2014.

Data Snapshot

The Constabulary identified in Bristol during 2015/16:

- 1498 “Safeguarding Adult flagged Crimes” and
- 698 “Safeguarding Adult flagged Incidents”,

increases of 66% and -0.6% respectively on the previous 12 months.

Achievements during 2015/16:

- refreshed our training for first responders and specialist interviewers around responses to sexual assault - both of these courses relate directly to Adults at Risk themes - and also delivered this to new police recruits and PCSOs, all of whom have safeguarding (for adults and children) woven into their initial training
- implemented a Mental Health Street Triage team, providing teams of two mental health nurses to deploy to police incidents in Bristol where officers were considering detention under the Mental Health Act. In the last six months of the year the team attended 185 incidents and in 146 cases where detention was being considered they were able to divert patients to more appropriate treatment pathways without the need for detention
- secured funding to introduce a two year pilot Control Room Mental Health Triage Scheme. Mental Health nurses are based in the Police Control Room in Portishead, enabling the Constabulary to meet mental health needs at the first point of contact, ensuring that intervention takes place at the earliest possible moment. Access to

both Police and Health information databases ensures that decisions made from that point onwards are fully informed and best placed to manage risk. The mental health professionals can advise officers on the appropriate course of action and importantly, provide timely access into services for people who need them

- appointed a Multi-Agency Safeguarding Hub (MASH) Development Manager, enabling the Constabulary to work with partners to embed MASH structures and/or processes within each local authority area - enabling us together to provide the best safeguarding response
- broadened the membership and scope of the Avon and Somerset Local Safeguarding Children Board Consortium to become a Safeguarding Consortium, comprised of all the chairs of both children's and adults safeguarding boards, providing a mechanism for improving the efficiency and effectiveness of partnership working to best meet the needs of children and Adults at Risk
- continued to work in partnership to implement the action plan to improve mental health care pathways which was created from the Local Government Association's peer review of mental health services in Bristol in February 2015
- conducted a Crime Data Integrity Audit which highlighted an issue in relation to our recording of some safeguarding crimes - this was purely an administration issue and, once rectified, the numbers of recorded crimes relating to safeguarding will increase
- made effective use of our Continuous Improvement Boards to carry out assurance work in relation to our policing priorities - themes included Domestic Abuse, Mental Health and Adults at Risk
- made effective use of our daily review meetings, which have a strong focus on vulnerability and managing risk - ensuring we direct our resources in the most appropriate way

Describe how you raise awareness of safeguarding in your agency:

- D/Chief Supt Geoff Wessell, Head of Prevention & Protection, chairs the Force Safeguarding Theme Leads Group which coordinates activity across the various safeguarding themes, identifying common issues for consideration by the Force Vulnerability Coordinating Group, which is chaired by the Deputy Chief Constable
- Chief Inspector Kevan Rowlands is the Thematic Lead for Adults at Risk and is responsible for driving improvement in the protection and safeguarding of Adults at Risk, and the improvement of associated investigations, across the whole organisation
- the vulnerability thematic leads are subject matter experts and keep their knowledge up to date, for example through attendance at national conferences. They bring their expertise to bear in a variety of ways, including the commissioning of awareness campaigns and training, advising upon course content and delivering inputs to courses. The leads also participate in regional and/or national networks, both contributing to and learning from best practice

- an induction process is in place within the Force for all staff who have contact with Adults at Risk, and training is provided for all new officers as part of their initial police training, including familiarisation with safeguarding policy and procedures. Training provision regarding the initial response to rape and sexual assault, and the inclusion of a first response element through the Initial Police Learning and Development Programme (IPLDP), means that all new recruits arrive at their first operational posting with an appropriate awareness of safeguarding adults issues in relation to sexual assault
- basic training is covered in College of Policing e-learning modules, including Mental Health, Diversity, Domestic Abuse Awareness, Domestic Violence Protection Order, Stalking and Harassment, Honour Based Violence, Hate Crime, Missing Persons and Modern Slavery
- the Corporate Communications Department maintains and delivers the vulnerability communications strategy, using appropriate opportunities to promote awareness of Adults at Risk issues and the appropriate safeguarding responses
- resources are available through the Safeguarding Adults intranet page, making clear the Force's safeguarding duties, detailing the common types of abuse and neglect, the principles that underpin adult safeguarding, briefing materials and statutory and other guidance
- the Force Individual Performance Review (IDR) process provides a formal supervision mechanism for every employee. This includes objectives setting and recording of evidence and is supported by regular one-to-ones with supervisors and progress checks, providing a mechanism for ensuring that staff are familiar with their responsibilities. The Safeguarding Coordination Unit Managers each have a specific IDR objective relating to the supervision of their staff working in the safeguarding arena. Individual's training and development needs are identified through this process
- the supervision of individual investigations is carried out in line with the Force Management of Investigations Framework. This supervision ensures that staff are able to discuss concerns regarding specific cases and Adults at Risk. The Management of Investigations Framework places a responsibility for reviews and assurance work on every supervisory rank up to Superintendent. A Team Management pack is created each week which shows if reviews have been conducted on every live investigation and this can be refined to individual team and officer level if required. In addition, Sergeants are required to completed monthly workload reports on their teams to provide overarching supervision and management. These are then communicated through the chain of command

Describe how you supported service users and carers through the safeguarding adults' procedure:

- the Constabulary identified 1498 "Safeguarding Adult flagged Crimes" and 698 "Safeguarding Adult flagged Incidents" in Bristol during 2015/16, increases of 66% and - -0.6% respectively on the previous 12 months
- safeguarding concerns are reported to the Safeguarding Coordination Unit (SCU). The Crime & Intelligence Recording and Management System, Niche, provides the means for recording safeguarding concerns and a task sent to the SCU. The Police and Crime Commissioner's and Chief Constable's internal auditors, RSM Tenon, earlier this year audited the Northern and Southern safeguarding units and "…found the Constabulary to have improved its processes around safeguarding… The role of the SCU is now more of coordination unit, taking referrals, undertaking the required research, multi-agency sharing and strategy discussions, and passing cases to the relevant teams in a timely manner, either internally or externally. We found consistent, well recorded notes and evidence of all actions taken"
- through our Lighthouse Victim and Witness Care Service, the Force provides enhanced support and guidance to our most the vulnerability victims and, on average, deals with some 200 referrals a day. All cases are allocated a Victim and Witness Care Officer (VWCO) and where possible repeat victims are allocated the same officer each time. Background checks are compiled to ensure safeguarding needs are met and to inform the support of the victim and appropriate means of contact. Contact is made with the victim via the phone to complete a needs assessment to establish any vulnerability they may have, and any support networks already in place. With their permission, referrals are coordinated to support services that may be of benefit to these vulnerable victims. Lighthouse acts as a single point of contact for any questions or queries victims may have. Follow up calls are scheduled to ensure support requested is being received. Victims are given the direct number of their allocated VWCO so they contact them directly. If the victim's case proceeds into the court process the VWCO remains with them throughout the Criminal Justice Process
- the Investigations Protect Team manages incidents involving vulnerable victims and/or high-risk offenders, and investigates offences requiring a public protection specialism, such as Adults at Risk. Significantly, the Force prioritises by victim vulnerability and the characteristics of the perpetrator, meaning that crimes involving Adults at Risk are invariably prioritised over those involving less vulnerable victims

Objectives for 2016/17:

In partnership with other agencies, Avon & Somerset Constabulary's objectives for the protection of Adults at Risk are:

- prevent Adults at Risk from becoming victims of abuse and crime

- where Adults at Risk do become victims, ensure they are recognised as such, are protected from further harm, and are given the support they need to help them remain safe and to deal with the physical, emotional and psychological consequences of the abuse
- bring perpetrators of abuse to justice and prevent them reoffending through robust offender management

Bristol CCG - Safeguarding Adults

NHS Bristol Clinical Commissioning Group

Responsibilities for safeguarding in the CCG

Bristol CCGs are statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. Bristol CCG are required to provide assurance that activity within all commissioned safeguarding services meets national safeguarding standards and demonstrates a model of continuous improvement. This is reflected in local policy and procedure in the CCG governance framework and the safeguarding adults work programmes.

As an organisation, Bristol CCG will also ensure that there is effective safeguarding arrangement in place. This is delivered through the Safeguarding Adults leads who work with commissioners, quality and contract monitoring teams. This also includes the provision of leadership, training supervision, specialist clinical advice on safeguarding to the CCG and the provider organisations.

Bristol CCG have a robust set of safeguarding adults standard which are based on statutory legislation, guidance, current good practice and evidence research. The standards are in line with the 6 key principles that underpin safeguarding adults work and include sections on Mental Capacity Act (2015) and Prevent.

Since the implementation of the Care Act (2014) in April 2015 safeguarding adults work within the CCG continues develop in discharging it statutory duties. Bristol CCG has worked effectively through strategic and multiagency arrangements, with partner agencies working with the remit of the Safeguarding Vulnerable People in the NHS[9] .

Key Achievements

- The Professional Adult Safeguarding Group has met three times this year and is chaired by the CCGs Transformation and Quality Director. Our purpose is to promote

[9] https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf

good working relationships between NHS providers working within the parameters statutory requirements and Legislation for adult safeguarding.

- The CCGs role as a statutory core member of the Bristol Safeguarding Adults Board (BSAB) is now established. the Safeguarding Adults Lead is the Chair of the Learning and Development Subgroup

In April 2016, an annual Internal Audit was undertaken to review the CCGs processes for monitoring and managing safeguarding events for adults and children's. The review was to provide assurance that the CCG has a robust and effective process in place to ensure that commissioned services are compliant with safeguarding duties. The internal auditors overall assurance opinion rating is green.

- The local Transforming Care Partnership (TCP) plan has been approved by NHSE validation process and RAG rated green in all areas of the planning framework.
- To support the increasing work capacity of safeguarding adults within the CCG, funding for a band 7 Safeguarding Adults Deputy has been secured

We have a lead GP for Safeguarding Adults providing a session a week

- All practices have nominated a practice lead in Adult Safeguarding and every lead has attended level 3 training which has included Self Neglect, Domestic Violence, Human Trafficking, Prevent, and Safeguarding in Learning Difficulties. supported by The CCG Safeguarding GP and the Safeguarding Adults Lead
- The Designated Safeguarding Adults and MCA Lead provide safeguarding level 2 (including MCA) training for the LMC/ GP Education when requested. Training has also been delivered to GP and Practice staff across the city. The development of a Safeguarding Adults workbook has proved successful and is being used to support ongoing practice in the work place
- We have secured funding through Better Care 206/17 to continue the work of the Care Home Support Team. The teams primary objective will be to improve quality of care provided in care home with nursing
- WRAP training for CCG is at 66%
- The Development of the Care Home Directory for Care home staff. The purpose of the directory is to inform Care Home Staff of all the specialist and community services they can access for residents. The directory provides a list of services available and with contact details about each of the services and criteria for referral.
- Stop Adult Abuse week 13th to the 17th of June if in Doubt Speak Out campaign. Bristol CCG actively took in the designing of the BSAB Safe City Leaflet.

Challenges

- There has been within the last year an increase in the number of requests for Safeguarding Adults and Domestic Homicide Reviews and the ongoing work activities this brings.

- As a result of the statutory requirements related to the BSAB and sub groups, this has increased the CCG multiagency working both internally and externally time and capacity is an issue
- Raising a section 42 enquiry about individuals who are failing to care for they i.e. self-neglect; is deemed not appropriate. The amendment of the Act states that Section 42 is primarily aimed at those suffering abuse or neglect from a third party. This amendment has caused concerns amongst professionals who are working with complex individuals within the community.
- Facilitating WRAP training for GPs and practice staff all agencies are to be WRAP trained and 85% compliant over a period of 3 years.
- Prevent Returns are now being requested for information to seek assurance that NHS partner agencies are undertaking WRAP training in line with the NHSE Prevent Competency Framework. Due to conflicting priorities for providers there is a risk of not receiving prevent returns in a timely manner.

Future work

- Embedding Prevent in safeguarding activities
- Linking children and adults safeguarding work this includes transitions and the work of the MASH, work already in progress
- Joint Children and Adult Safeguarding Standards. Work already in progress
- The development of level 3 safeguarding adults training working in partnership with health providers
- The future work with the *Safeguarding Adults: Roles and Competencies for health care staff –Intercollegiate Document*[10]
- Development of the CCG's Domestic abuse policy

University Hospitals Bristol NHS Foundation Trust

Brief Outline of agency function and safeguarding arrangements

University Hospitals Bristol NHS Foundation Trust consists of eight hospitals in the centre and south of Bristol, and is one of the largest NHS Trusts in the country and the major teaching and research centre for the South West of England. The Trust provides general medical and emergency services to the local population of Central and South Bristol, and a broad range of specialist services across a region that extends from Cornwall to Gloucestershire, into South Wales and beyond.

UHBristol Trust Board hold's ultimate accountability for ensuring that safeguarding responsibilities for both children and adults are met, led by the Chief Nurse as Executive

[10] https://www2.rcn.org.uk/support/consultations/responses/safeguarding-adults-roles-and-competences-for-health-care-staff-intercollegiate-document

Lead for Safeguarding. Day to day safeguarding activities are supported by well-established and experienced safeguarding professionals, who provide expert advice, support and supervision to practitioners across the Trust.

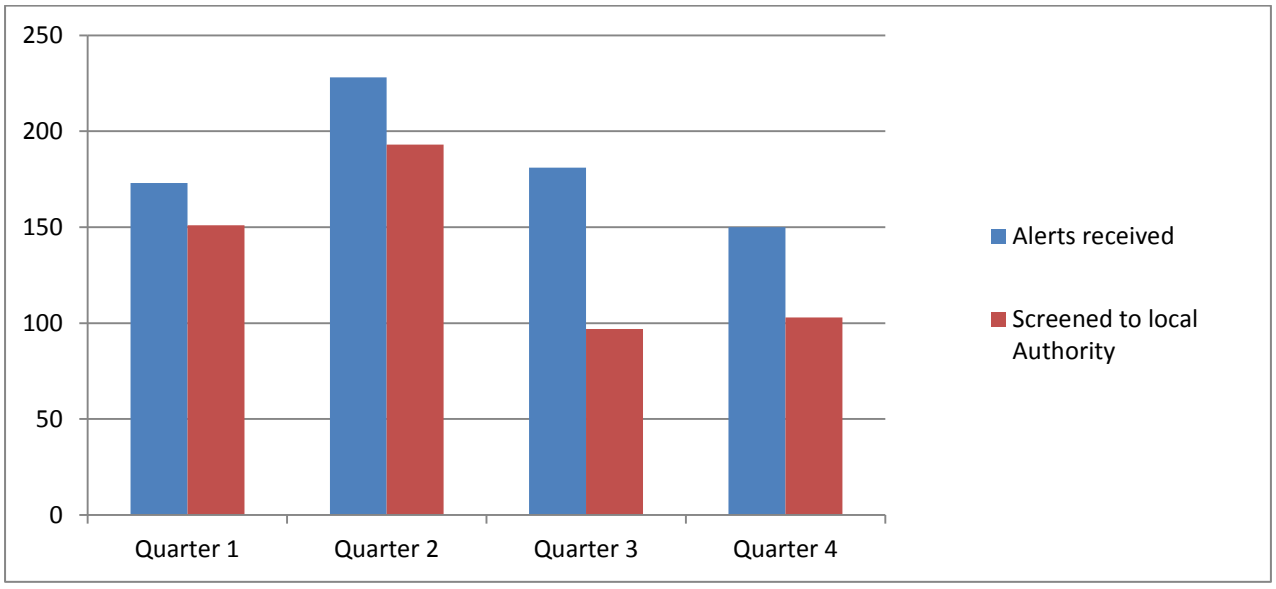
Safeguarding Activity / Achievements 2015/16

During this reporting period the number of concerns raised for safeguarding adults (alerts) has seen a slight increase in the total number, with 732 alerts received in 2015/16 in comparison to 670 in 2014/15.

The Safeguarding Nursing Team have been working closely with the Local Authority in this reporting period to ensure that the appropriate threshold has been reached before the referral is submitted.

This has involved a far greater degree of oversight and scrutiny of referrals supported by the guidance of the Bristol Safeguarding Adults Board Threshold document. A number of referrals have also been appropriately signposted to other services, such as Domestic Abuses support services rather than the Local Authority

Table 12: Number of Referrals screened prior to sending to Local Authority

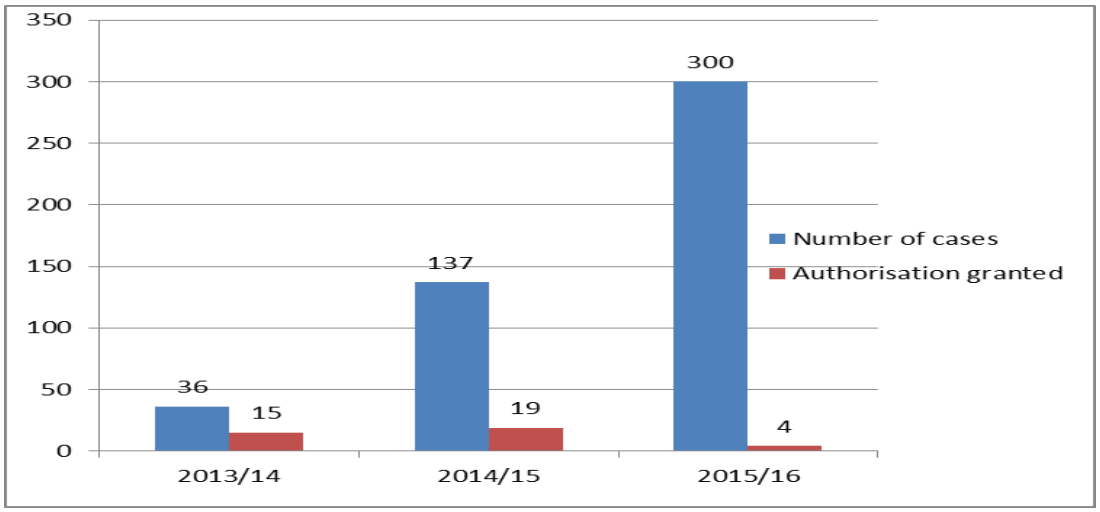


Deprivation of Liberty Safeguards (DoLS)

The Supreme Court judgment in March 2014, in relation to Deprivation of Liberty Safeguards, widened and clarified the definition of deprivation of liberty thereby reducing the threshold for the need to make an application for DOLS. The judgement continues to have a significant impact resulting in an increase in the number of DOLS applications being made by the Trust.

The impact of the change to the threshold for DoLS and the implications for frontline practice has been recognised as a potential risk within the Trust and is recorded on the Trust

Risk Register. The situation is closely monitored by both the Safeguarding Steering Group and the Operational Group.



Modern Slavery:

The Trust has made two referrals to the Local Authority during this reporting period under the category of Modern Slavery. Neither case was deemed by the Local Authority to meet the criteria of the Care Act, in that the patients did not have care and support needs. Both cases were subsequently reported to the Police.

Self - Neglect:

Self-neglect is a potential safeguarding responsibility and defines self-neglect as covering a wide range of behaviours such as neglecting to care for one's personal hygiene, health or surroundings and include behaviour such as hoarding. Self-neglect is a category which prompts a significant number of safeguarding referrals (65 in this reporting period) but will only be considered under the safeguarding legislation if the adult has needs for care and support. In practice the majority of the referrals do not meet the Local Authority criteria and are re directed to other services such as housing and discharge planning

Objectives for 2016/17

The safeguarding agenda for both children and adults is constantly changing and it is essential that the Trust continues to develop a proactive approach to ensure that safeguarding practice remains up to date and in line with new guidance and best practice. It has also been essential to maintain the quality of safeguarding practice across the Trust during a challenging period of local change. Safeguarding remains a key priority for the Trust. An annual report presented to the Trust Board summarises key safeguarding activities, developments and achievements. Its aim is to provide a level of assurance that the Trust is fulfilling its statutory safeguarding duties and responsibilities and is thereby fulfilling its contractual duty to safeguard children and adults.

Whilst there have been many achievements over the last twelve months, there are also areas in which further work is required. Key objectives for the next twelve months include:

- Raising awareness and understanding of the Mental Capacity Act for all Trust staff
- Ensuring front line practice is in line with key legislative changes for adult safeguarding practice.
- Working toward implementing the Intercollegiate Document for Adult Safeguarding Training.

North Bristol NHS Trust

Brief outline of agency function and safeguarding arrangements

North Bristol NHS Trust is an acute hospital provider with its main hospital based at Southmead in Bristol. We provide general and emergency acute care to the residents of north Bristol and surrounding areas. We also provide a range of specialist services on a regional basis including Neuro and Burns.

The Trust Board holds corporate responsibility for the delivery of adult safeguarding within NBT. The Director of Nursing is the Executive Lead for all safeguarding. The adult safeguarding service including Mental Capacity Act/Deprivation of Liberty, Domestic Abuse and Violence, Human trafficking is managed by the Adult Safeguarding Team, including a lead practitioner, specialist practitioners and the team administrators.

Safeguarding Activity

April 2015 saw the introduction of the Care Act 2014 which moved adult safeguarding on to a statutory footing. The Care Act has lowered the threshold for safeguarding intervention and also increased the number of adults who could fall under the adult safeguarding umbrella. This has seen a sharp rise in referrals from the clinical teams, who are the providers of care supporting the patient, families and carers.

Table 1: Alerts received by Adult Safeguarding Team

Year/Quarter	1	2	3	4
2014/5	54	67	107	119
2015/6	212	241	163	245

The above data shows the large increase in alerts received by the team. These numbers do not equate to safeguarding referrals sent to the Local Authority (LA). The adult safeguarding team will view each alert to insure that the statutory grounds for safeguarding have been met and then forward onto the relevant LA.

Harm can be caused to adults in any location, hence the team separates alerts into "community acquired harm" and "hospital acquired harm".

Table 2: Community Acquired Harm Alerts

Community Acquired Harm	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	73	86	63	58

For community NBT acts as referring agency and does not investigate the harm. Hospital acquired harm is managed differently. Whilst NBT alerts it also conducts the safeguarding inquiry under the management of the LA.

Table 3: Hospital Acquired Harm Alerts

Hospital Acquired Harm	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	45	37	27	31

Key Achievements/Impacts/Challenges

- Care Act 2014 implementation has proved a challenge for all agencies due to large increases in referrals.
- Staffing has been increased within the Safeguarding Adults team to meet the increased need.
- Training has been made Care Act 2014 compliant and the Trust is working toward implementing the Intercollegiate Document for Adult Safeguarding Training.
- The Trust has seen large increases in referrals in the newer areas of Adult Safeguarding Team i.e. Domestic Abuse, Human Trafficking and FGM.
- A new Trust policy framework for adult safeguarding is a key goal for the upcoming year.
- The Adult Safeguarding Lead is completing a project to incorporate all polices that relate to Adult Safeguarding.
- New reporting streams for Adult Safeguarding Activity are being developed to collect all the teams' activity, such as MCA/DoLS advice, DASH assessments and complex case management.

Avon and Wiltshire Partnership NHS Mental Health Trust

Brief outline of agency function:

Avon and Wiltshire Mental Health Partnership NHS Trust provides mental health services as leader of the Bristol Mental Health system, including talking therapies, to adults of all ages, as well as providing Drug and Alcohol Services as part of the ROADS system, and a number of specialist and secure mental health services in the Bristol area. These include inpatient services, community services, and a range of services working with primary care and acute hospitals to assess and support the care of people with mental health problems there.

Achievements during 2015-2016:

2015/2016 has seen a significant amount of activity to improve adult safeguarding practice in the Trust. This has included:

- Introducing modular guidance on adult safeguarding, incorporating the impact of the Care Act 2014 and Think Family principles.
- Delivering and recording regular supervision to all staff, including safeguarding supervision
- Developing and extending access to Health Places of Safety
- Deliver of a Trust wide action plan delivering the Lampard Report recommendations
- Improving adult safeguarding training rates, and delivering extended safeguarding training on domestic abuse and Prevent to practitioners
- Reviewing the Trust policies to reflect DBS and Care Act 2014 changes in relation to allegations management
- Actively supporting the support development of a MASH in Bristol
- Undertaking a staff survey of adult safeguarding and MCA/DoLS
- Launching of the Trust wide Safeguarding Supervision Tool.
- Changes in the process to make adult safeguarding referrals improve management oversight of referrals, quality assurance and recording
- Increased access to the Trust safeguarding team for specialist case advice on adult safeguarding issues

Challenges:

There were quality concerns identified by CQC inspections of crisis and recovery adult community mental health teams in Bristol in relation to identification, recording and management oversight of adult safeguarding cases, which required a dedicated action plan to improve and assure practice in these teams. These actions have been completed and the learning and systems changes disseminated across other clinical teams and services.

There have been considerable challenges in building and maintaining appropriate staffing levels to ensure effective safeguarding practice at all levels, as the number of people referred to services has significantly increased in 2015/2016, alongside a significant corresponding rise in the level and complexity of safeguarding activity and requirements (including participation in a number of local Safeguarding Adult Reviews.

Objectives for 2016-17:

- To further amend the RiO electronic record to support and assure effective safeguarding recording and reporting, and management oversight of cases
- To develop a strategy for personalisation of adult safeguarding
- To develop guidance and support on sexual exploitation and modern day slavery

- To introduce an extended adult safeguarding and MCA service in the Trust, with locally focussed Named Professionals, to support practitioners and practice development
- To embed improved identification, recording and management oversight of adult safeguarding cases in practice in all AWP adult mental health crisis and recovery teams
- Improving AWP participation in LSAB activities, including safeguarding adult and case reviews

National Probation Service – Bristol and South Gloucestershire

The role of the National Probation Service (NPS) is to protect the public, support victims and reduce re-offending. It does this by:

- assessing risk and advising the courts to enable the effective sentencing and rehabilitation of all offenders;
- working in partnership with Community Rehabilitation Companies (CRCs) and other service providers; and
- directly managing those offenders in the community, and before their release from custody, who pose the highest risk of harm and who have committed the most serious crimes.

In Bristol and South Gloucestershire the NPS hold around 1300 cases who are high risk of harm or sex offenders.

In carrying out its functions, we committed to protecting an adult's right to live in safety, free from abuse and neglect.

There are six key principles that underpin all adult safeguarding work and which should, therefore, be reflected in work with offenders:

- Empowerment - people being supported and encouraged to make their own decisions, and informed consent.
- Prevention - it is better to take action before harm occurs.
- Proportionality - the least intrusive response appropriate to the risk presented.
- Protection - support and representation for those in greatest need.
- Partnership - local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability - accountability and transparency in delivering safeguarding.

Over 2015-16 Bristol and South Gloucestershire NPS has endeavoured to improve practice in relation to safeguarding. We have welcomed the issue of three relevant safeguarding documents in relation to Adults;

- NPS policy on Safeguarding Adults at Risk
- NPS Safeguarding Adults Practice guidelines and
- NPS National Partnership Framework for Safeguarding Adults Boards.

These documents gave us a greater focus on safeguarding for our practice and lead to us implementing a safeguarding training plan.

We have made it our concern that all staff carry out the safeguarding training supplied by the NPS as a re-fresh to our current thinking and priorities. We have seen evidence of good safeguarding practice and for offenders and potential victims where concerns are noted. We continue to chair MAPPA meetings as required and fully participate in MARAC processes in compliance with practice guidance. We have taken a very comprehensive risk management system for adults at risk and are particularly vigilant in the management of Domestic Abuse cases. Our partnership work is good with good relationships awarded for support agencies.

Our work continues to strive for greater excellence and we are aware of the areas we need to focus for the oncoming year which we have identified as the areas of recording and data collation.

Bristol Dementia Partnership

Brief outline of agency function:

The Bristol Dementia Partnership provides a Dementia Wellbeing Service to people who are registered with a Bristol GP. It is a partnership between Alzheimer's Society and Devon Partnership NHS Trust. Since 1 April 2015, we have been responsible for delivering dementia services in the city. The service is commissioned by Bristol Clinical Commissioning Group as part of Bristol Mental Health services.

The service brings together a whole range of professionals who work with GPs, other health professionals and other partners across Bristol to support people with dementia and their carers. We create personalised wellbeing plans with the person with dementia at its heart, providing support, guidance and help when, and where people want it, and in a way that suits them.

Achievements during 2015-2016:

- We have secured membership on the BSAB
- One of our KPIs focuses on Safeguarding: "People using mental health services and their families and their friends or carers are safe and protected" and ensures that staff/volunteers have up to date training in safeguarding for adults and children to the appropriate level
- Related to the above, we have ensured that all Dementia Practitioners are trained to Safeguarding Adults Level 2 *[evidence of community awareness of adult abuse and neglect and how to respond]*
- All safeguarding that we raise within the service is reported via Devon Partnership Trust's Incident Reporting System (RMS). This is then discussed at Management Team Meetings and learning cascaded in our weekly Team Meetings (one per locality) *[better reporting of abuse and neglect]*
- We successfully bid to receive dedicated staff training from the British Institute of Human Rights, raising awareness about Human Rights legislation and applying this in practice. We now have Human Rights champions across the service [*evidence of success of strategies to prevent abuse or neglect]*

Challenges:

- Lack of robust communication systems to follow-up safeguarding reports/outcomes. There is a lack of process for BCC to communicate the outcome of safeguarding that we raise [how well agencies are co-operating and collaborating / how successful adult safeguarding is at linking with other parts of the system, for example children's safeguarding, domestic violence, community safety].
- Additionally there has been concern raised over the security of the BCC Safeguarding referral routes. We are now assured that this route is secure.

What difference has your organisations achievements made to children, young people, parents / carers?

- We do not routinely work with children although all staff have a basic awareness of Safeguarding children via mandatory e-Learning (Safeguarding Adults and Children Level 1)
- The staff training on Human Rights has helped our staff understand the legal framework which can support decision-making when addressing safeguarding concerns

  Reporting Incidents through RMS, we ensure we are a learning service and can have greater confidence to identify risks, both individually and collectively and put plans in place to minimise repetition of safeguarding/risk themes *[analysis of safeguarding data to better understand the reasons that lie behind local data returns and use the information to improve the strategic plan and operational arrangements]*
- Part of our Wellbeing Plans look at risk management, and we have received positive feedback via PALS and Friends & Family Test, including mitigating concerns over a

person with dementia's alcohol consumption by substituting for non-alcoholic fizzy drink which the carer reported made a big difference. *[feedback from local Healthwatch, adults who use care and support services and carers, community groups, advocates, service providers and other partners].*

Objectives for 2016/17:

- Developing pathway/ process for effective communication between our service and BCC Safeguarding.
- Maintaining the level of staff training.
- Continuing to support Human Rights through champions (as part of our 16/17 CQUIN target to develop specialism champions across the service).

Attendance

P	Present	NA	No attendance or apologies
D	Deputy attended	0	Not Board member at the time
A	Apologies sent		

Name	Role	Agency	Apr-15	Jul-15	Oct-15	Feb-16
Carolyn Belafonte	Detective Superintendent	Avon & Somerset Police	D	P	P	0
Rich Kelvey	D/Supt. – Head of Manage and Intelligence	Avon & Somerset Police	0	0	0	P
Victoria Caple	Head of SCU / SAR Chair	Avon & Somerset Police	0	0	A	P
Mark Bunker	Head of Professions & Practice	AWP	P	A	0	0
Mark Dean	Associate Director of Statutory Delivery, AHP and Social Care Leadership	AWP	0	0	P	A
Mike Hennessey	Service Director	BCC, Adult Social Care	D	D	P	P
Kate Spreadbury	Service Manager, Strategic Safeguarding Adults & DoLS	BCC, Safeguarding and DOLS	P	P	P	P
Tracey Judge	Strategic Safeguarding Adults / MCA & DoLS Co-ordinator	BCC, Safeguarding and DOLS	P	P	A	P
Ethera Morgan	Senior Practitioner, Safeguarding	BCC, Safeguarding and DOLS	A	P	0	0
Johnson Koikkara	DoLS Team Manager	BCC, Safeguarding and DOLS	P	P	P	P
Brenda Massey	Councillor for People Directorate	BCC, Cllr	P	P	P	P
Carmel Brogan	Housing Policy & Contracts	BCC, Housing Services	A	P	P	P
Mary Ryan	Service Director	BCC, Housing Delivery	A	A	P	P
Melanie Rogers	Strategic Commissioning Manager	BCC, Strategic Commissioning	0	0	A	P
Nancy Rollason	Service Manager	BCC, Legal Services	P	P	P	A
Gayna Mullan	Safeguarding Analyst	BCC, Performance and Information	P	A	A	0

Fiona Tudge	Service Manager - Safeguarding, C&FS	BCC, Children's Safeguarding	0	0	A	P
Alison Moon	Transformation and Quality Director	BCCG	A	P	A	A
Paulette Nuttall	Safeguarding Adult Lead	BCCG	P	P	P	P
Aileen Fraser	Clinical Director	BCH	P	P	P	D
Jessica Beach	Safeguarding and Dementia Lead	BCH	P	P	A	P
Will Hall	System Clinical Leader, Bristol Mental Health	BMH	0	P	A	P
David Elson	Service member	Bristol Older People's Forum	0	0	A	A
Jan Little	Care Homes Director	Brunelcare	P	P	A	P
Claire Hayward	Strategic Director	Freeways	P	P	P	P
Pat Foster	Health Watch Bristol	Health Watch Bristol	0	0	A	P
Steve Cross	Governor	HMP Bristol	0	0	A	A
Louise Lawton	Independent Chair	BSAB	P	P	P	P
Bronwen Falconer	Administrator	BSAB	P	P	P	P
Gill Brook	Head of Patient Experience	NBT	0	0	D	P
Sue Jones	Director of Nursing and Quality	NBT	P	D	0	0
Sean Collins	Adult Safeguarding Lead	NBT	P	P	P	0
Allason Hunt	Senior Probation Officer	NPS - Probation	A	P	D	P
Charlie Baker	Head of Bristol & South Glos LDU	NPS - Probation	0	0	P	A
Mike Hook	Team Leader	CRC - Probation	P	P	P	0
Gill Nowland	CEO	One25	0	0	0	P
Helen Morgan	Deputy Chief Nurse	UHB	P	A	P	P
Linda Davies	Adult Safeguarding Lead	UHB	P	P	0	0
Associate Members	**Please note: Associate members of the Board are not required to attend.**					
Ali Mann	Named Professional, Safeguarding	SWAST	A	0	0	0
Simon Hester	Named Professional Safeguarding	SWAST	A	A	P	A
Carol De Halle	Assistant Director	NHS England	A	A	0	0

Sue Burn	Head of Inspection	Bristol CQC	A	A	D	A
Malcom Kippax	Acting Inspection Manager	Bristol CQC	0	0	P	P
Mick Dixon		Avon Fire & Rescue Service	A	A	0	0
Rob Davis	Assistant Chief Fire Officer	Avon Fire & Rescue Service	0	0	A	A
John Readman	Strategic Director for People	BCC , Strategic Director	D	D	D	D

Bristol Safeguarding Adults Board

Annual Report 2015—2016

Who are we and what do we do?

Safeguarding adults is about working with adults with care and support needs to keep them safe from abuse or neglect. It is about people and organisations working together to prevent abuse.

Bristol Safeguarding Adults Board (BSAB) is a group of professionals which the Government says must meet to ensure that safeguarding adults at risk is managed well within the city.

The BSAB is led by an independent chair, Louise Lawton, whose role it is to oversee the BSAB and ensure the plans, made by each agency and the wider partnership, to safeguard and promote the health and welfare of adults within Bristol are met.

What has happened in the last year that has shaped what we do?

The Care Act 2014 is the law which stated what we must do in relation to the board. Some organisations such as the Police, Council and NHS must be on the Board. Other organisations for example providers of health, housing, social care services and people who use services or their representatives could also be on the board.

The BSAB must complete Safeguarding Adult Reviews (SAR). This is a process where agencies identify lessons that can be learned from cases where an adult with care and support needs has died or been seriously injured and abuse or neglect is suspected. The board published a Serious Case Review (SCR) this year which had five recommendations to improve practice in Bristol. There will be more published next year.

What are our priorities?

Our Priorities are aligned to the six principles of safeguarding as set out by the Care Act 2014:

Empowerment	Prevention
Proportionality	Protection
Partnership and Engagement	Accountability

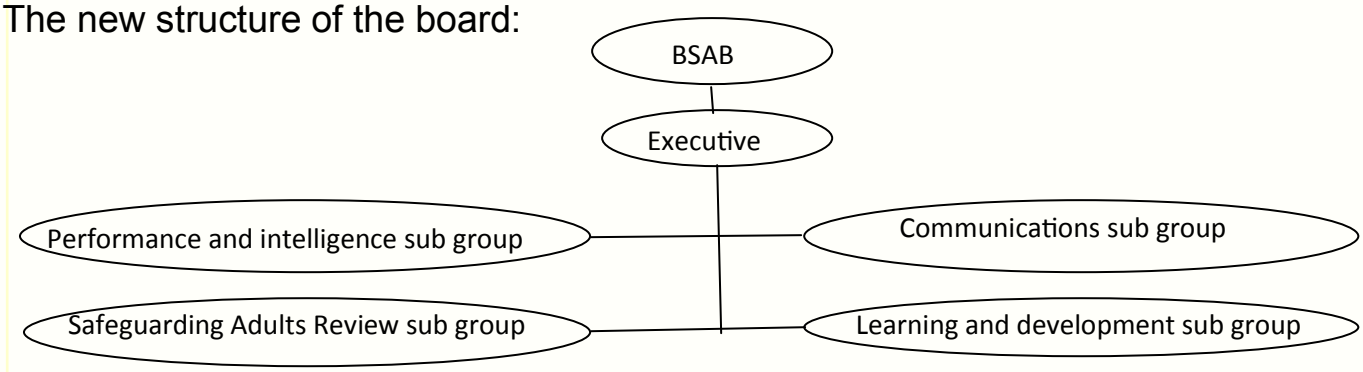
Bristol Safeguarding Adults Board

Annual Report 2015—2016

What were our plans for the year?

To review the structure of BSAB due to the Care Act to ensure it is effective and able to deliver the best outcomes.

The new structure of the board:

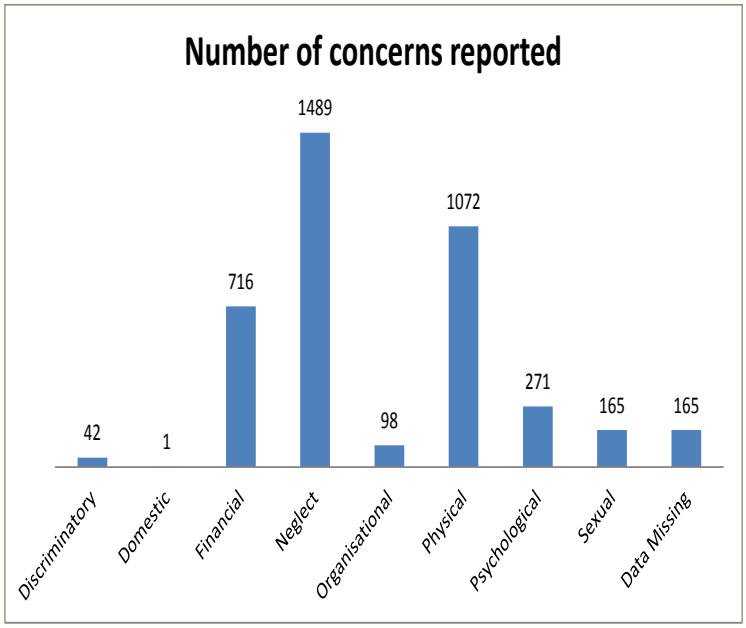


To publish a strategic plan (2015 – 2018) which states our strategic priorities.

These are contained within our Annual Report 2015/2016 where you will be able to see evidence of the progress that has been made.

Who did we help in 2015 / 2016

In this year the number of concerns that were reported to the local authority as safeguarding were 4019.



This table shows the largest number of concerns were about neglect and financial abuse. This is not surprising as self neglect is a new category and it is hard to determine where self neglect becomes harmful.

The majority of these concerns occurred in the person's own home and approximately the same number of concerns occurred either in a care home or hospital.

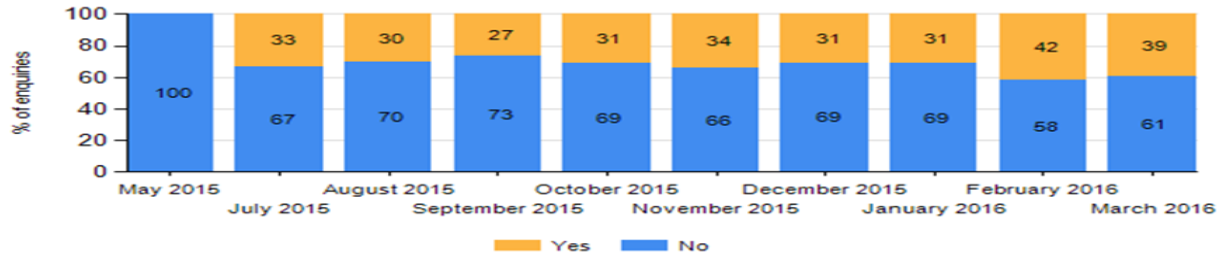
Bristol Safeguarding Adults Board

Annual Report 2015—2016

What were our plans for the year?

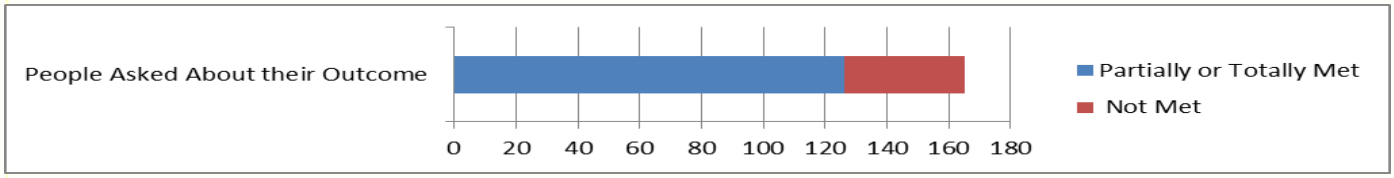
To increase the number of people who self refer to safeguarding or give consent for the referral.

The graph below shows some improvement but we will continue to work on this.



To ask the person what they wanted to happen at the end of the process and find out if we were successful.

We asked 165 people what they wanted to happen and 126 of them said, at the end, that we had fully or partially met their outcome; this is 76%.



To produce a quality assurance and learning and improvement framework.

During 2015-2016 the board has developed tools called a **Quality Assurance Framework** and a **Learning and Improvement Framework** . When this is used by everyone the work in relation to Safeguarding Adults can be measured and reported to the board so that we can learn where we can improve and work to make things better.

To improve our policies, procedures and guidance.

During 2015-2016 procedures and guidance in relation to safeguarding adults have been developed and a **Safeguarding Adults Multi-Agency Policy** has been developed with our neighbouring boards in South Gloucestershire, North Somerset and Bath & North East Somerset agreed by the board and published. This means that people who work in more than one place will be following the same policy and know what to do. People who live in one area but do activities somewhere else will have the same level of support.

Bristol Safeguarding Adults Board

Annual Report 2015—2016

What were our plans for the year?

To tell people at risk and professionals about safeguarding.

We held three events in the year:

June 2015

'Stop Adult Abuse' event for Older people: An event increasing the knowledge and skills of older people within Bristol to stay safe within their home and community.

November 2015

Staff Conference: This conference focused on the changes to safeguarding due to the Care Act 2014; Deprivation of Liberty Safeguards (DoLS); The Relationship between Human Rights and Safeguarding; Self-Neglect and Hoarding.

March 2016

'Ensuring Good, Achieving Excellence' Joint Staff Conference: A joint conference was run by BSAB and the board in South Gloucestershire. This conference covered lots of areas such as: Thresholds, CQC, Self neglect services and the adult at risk's perspective.

What are our plans for next year?

1. The development of a list of groups to help us get local people more involved in our work;
2. To increase the number of people asked about their preferred outcomes
3. To hold a conference with South Gloucestershire SAB for staff;
4. To produce a new leaflet and poster telling people in Bristol about safeguarding and how to report concerns;
5. To have guidelines in place to ensure we learn lessons from Safeguarding Adult Reviews;
6. Continue to monitor and hold to account the work of organisations in the city with the aim of making Bristol a "Safer City".

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Integrated Healthy Lifestyles Service Procurement; "Bristol Behaviour Change for Healthier Lifestyles Programme"	
Author, including organisation	Viv Harrison, Consultant in Public Health Sally Hogg, Consultant in Public Health
Date of meeting	12th April 2017
Report for Discussion and authorisation	

1. Purpose of this Paper

This paper seeks authorisation from the Health and Wellbeing Board to a twelve week formal consultation with Bristol population, stakeholders and potential providers on a draft Commissioning Strategy for a new Behaviour Change for Healthier Lifestyles Programme.

2. Context

Currently we commission services focused on single lifestyle issues e.g. stop smoking, weight management. The aim of the new programme is to move beyond single lifestyle issues to focus on individual behaviour change.

The draft commissioning strategy sets out proposals for the procurement of a Behaviour Change for Healthier Lifestyles Programme for Bristol.

It outlines the development of a new behaviour change model for healthier lifestyles, to meet the needs of people in the city who wish to change their lifestyle behaviour. It will address the key lifestyle factors of smoking, overweight, diet, physical activity and alcohol.

The new behaviour change programme will replace the current separate healthy lifestyle contracts, including weight management; the stop smoking service, and the NHS Health Checks programme.
Of the existing contracts, one weight management contract has been terminated and a contract extension has subsequently been agreed for the remaining contracts, which will now expire at the end of March 2018.

We wish to commission a Behaviour change for Healthier Lifestyles Programme which will:

- Provide behaviour change support focused on physical activity, smoking, alcohol and healthy weight.
- Enables, empowers and motivates people and uses a coaching approach.
- Connects people to support in a format appropriate to their needs and wider support in the community.
- Has a presence in the community and connects to community assets.
- Captures insight for monitoring, evaluation and customer feedback

We intend to run a 12 week formal consultation period from 2nd May to 25th July 2017 so that all stakeholders can consider the proposals in our draft commissioning strategy and provide feedback.

After the consultation we will consider all the feedback and use this to inform our final commissioning strategy and service specification. We will publish a summary of feedback and our response alongside the final commissioning strategy.

A paper was presented in November 2016 outlining the high level proposals for commissioning a new programme for healthy lifestyle support.

The next stage of the procurement process is consultation on the draft commissioning strategy (Appendix 1).

3. Timescale

Tasks	Date
Formal consultation of Commissioning Strategy commences (12 weeks)	5th May 2017
Formal consultation of Commissioning Strategy ends	28th July 2017
Market engagement day	9th May 2017
Publication of final Commissioning Strategy	31st July 2017
Invitation to tender (open process)	4th September 2017
Contract Award	4th December 2017
Current contract extensions expire	31st March 2018
New contract(s) start date	1st April 2018

4. TUPE

TUPE may apply to some Bristol City Council staff members working in the public health team, particularly staff working in the Livewell hub.

5. Implications (Financial and Legal if appropriate)

Current yearly expenditure for services that are considered in scope for the proposed Behaviour Change for Healthier Lifestyle Programme for Bristol is shown in the table below:

Contracts and Service Providers	**Bristol**
	£
NHS Health Checks	350,000
Adult Weight Management Services	305,000
Stop Smoking Delivery - primary care	620,000
Stop Smoking Delivery - community grants	60,000
Alcohol Brief Interventions	17,000
Children and young people's weight management services	185,000
Delivery of Livewell Bristol Hub and Community Health Improvement Support	156,791
Current Total	**£1,693,791**

We intend to make a 15% saving on the overall cost of the new programme. The cost envelope for the first three years of the new service is shown in the table below:

Year	**Contract Value**	**Saving**
2018/19	1,439,722	254,069
2019/20	1,439,722	254,069
2020/21	1,439,722	254,069
Totals	**4,319,166**	**762,207**

6. Evidence informing this report.

This is set out in the Draft Commissioning Strategy document.

7. Recommendations

The Health and Wellbeing Board are asked to agree to the 12 week formal consultation on the draft commissioning strategy for a Behaviour Change for Healthier Lifestyles Programme for Bristol.

8. Appendices

Appendix 1 – Commissioning Strategy

DRAFT

Bristol Behaviour Change for Healthier Lifestyles Programme Commissioning Strategy 2017

1. Introduction

1.1 Background and Purpose

Purpose
This commissioning strategy sets out proposals for the procurement of a Behaviour Change for Healthier Lifestyles programme for Bristol.

It outlines the development of a new behaviour change model for healthier lifestyles, to meet the needs of people in the city who wish to change their lifestyle behaviour, acknowledging that people live within communities and as part of their family. It will address the key lifestyle factors of smoking, overweight, diet, physical activity and alcohol. The new behaviour change programme will replace the current separate healthy lifestyle contracts, which include weight management; the stop smoking service, and the NHS Health Checks programme.

Public health services in Bristol that address health related lifestyles are currently provided as individual services, which are disjointed and based on historic commissioning pre-dating the public health move from the NHS to local authority in 2013. All the existing contracts come to an end during the current year, presenting an opportunity to review all the services and develop an integrated, innovative evidence-based approach which supports people living in Bristol to change their health–related lifestyle behaviours.

Of the existing contracts, one weight management contract has been terminated and a contract extension has subsequently been agreed for the remaining contracts, which will now expire at the end of March 2018.

The Behaviour Change for Healthier Lifestyles Programme will be commissioned and procured by the public health team, following BCC's Enabling Commissioning Framework (Fig.1). This is the agreed four stage commissioning cycle that has been adopted from the Institute for Public Care joint commissioning model for public care. This approach will enable Bristol City Council to comply with European Union (EU) procurement law and UK Public Contract Regulations 2015, and provide assurance that it is commissioning services in line with best practice.

Figure 1: Bristol City Council Enabling Commissioning Framework

This document seeks to provide additional information in relation to this specific commissioning activity and is intended for use by a range of stakeholders in order to develop a cooperative approach to the commissioning model that will go out to tender in 2017. In particular, this document is intended for:

- Existing and potential providers who will be able to use the information presented to identify the role they can play. We hope this document will enable providers to respond to the identified service model, identify potential opportunities for collaborative working, as well as bring forward new and innovative ways of working in the future.
- Voluntary and community sector (VCS) organisations who make a key contribution to building resilience in communities which enables support and behaviour change. We hope these stakeholders, who may or may not deliver currently commissioned services, will be able to use this document to understand the proposed changes to the commissioned service provision and to develop links between commissioned and non-commissioned support.
- Members of the public, who wish to contribute to the development of a new model for supporting behaviour change for healthier lifestyle.

The decision to consider innovative models for providing a behaviour change programme that meets the needs across the diverse Bristol population has been the subject of wide discussion, understanding of needs including the evidence and data relating to current provision of lifestyle services, options appraisal and citizen participation.

Initially, it was considered appropriate only to consider the contracts that were due to expire during 2017 for the adult population, whilst re-commissioning the children and young people's weight management service as a separate entity. There had been limited consideration regarding the way in which people live their lives as part of a community within a family, and the short, medium and long term outcomes that traditional lifestyle services were able to deliver.

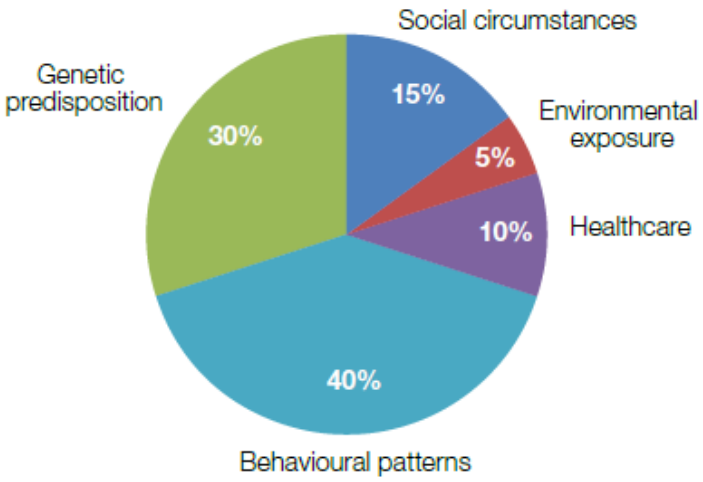
Other additional factors were considered during the discussion period including:

- Expected reductions in levels of funding. The Council has consulted on a proposed Corporate Strategy for 2017-2025 which aims to make £92m savings. This is required due to changes in Government funding and increasing demands for services. The Council will have to look at all areas of spend, including commissioned services, to determine what areas have priority and where to make savings. At present the Public Health grant is ring fenced for 2017/18 and 2018/19 but there is uncertainty regarding the future of this, which has been a component part of the planning process.
- The current and future demands on health and social care – including an ageing population, inequalities in health, complex healthcare and pressures on social care outlined in national documents, particularly the NHS Five Year Forward Plan (2015).
- The robust international, national and local evidence about supporting people to make lifestyle changes (NICE, 2015).
- The changes in the way people lead their lives with increased digitalisation and use of technology and an expectation that information and support is readily available (PHE, 2017).

Context

In 2013 Bristol City Council (as for all councils across the country) became responsible for the public health and wellbeing of its residents. Local authorities are seen as leaders of the public health system, with the Director of Public Health creating the influence and leverage that enables the broader determinants of health to be addressed, such as local environment, transport, housing and employment. These wider factors are estimated to influence between 15% and 43% of our health. All approaches to prevention need to address and take account of these wider determinants, with a focus in areas and communities where need is highest.

Figure 2: Opportunities to Improve Health



Source: From evidence to action: Opportunities to protect and improve the nation's health. Public Health England. October 2014

Health in all policies (2016) recommends a systematic approach to ensuring that all policies with the council and other major partnerships maximise the collective beneficial impact on health and the social determinants of health, with the overarching aim of improving the health of the population and reducing inequity.

Bristol City Council, like many others around the country, is facing a major challenge to meet the rising demand and cost of health and social care. National reports and policies including the NHS Five Year Forward View (2015) recognise the importance of good health and wellbeing in reducing levels of long term disease and premature death and placing a priority on investing in prevention.

Bristol City Council's Corporate Plan (2017-2022) sets out a direction of travel, with a vision for the city in which all services and opportunities are accessible and where life chances are not determined by wealth and background. To achieve this it outlines the way it will conduct its business in the future, including:

- The council reshaping services – looking at ways of delivering services more efficiently.
- Working closely and collaboratively with partners and communities, joining up services where it is possible.
- Seeing people living and working in Bristol as part of the solution. This will involve communities taking control of their own change, by reducing demand on services where they can, and by taking control of their own issues or changing behaviour.

We ned to acknowledge the changes in the way people lead their lives with increased digitalisation and use of technology, and an expectation that information and support is readily available (PHE, 2017).

Bristol Health and Wellbeing Board brings together a range of partners with an interest in, or responsibility for improving health in Bristol. The Board has a duty to 'encourage integrated working' and is responsible for producing the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. It is jointly chaired by the Mayor of Bristol and the Chair of Bristol Clinical Commissioning Group (CCG). The Board have recently refreshed their Joint Health and Wellbeing Strategy and have committed to focus on three areas that have potential to reduce health inequalities and improve the long term health of Bristol residents:

- Mental health
- Alcohol
- Healthy Weight

The Bristol Behaviour Change for Healthier lifestyles Programme focuses on the population of Bristol. There is a national drive for the NHS to join up prevention and early intervention initiatives as part of Sustainability and Transformation Plans (STP) with neighbouring authorities, CCGs and NHS Trusts. Bristol, North Somerset and South Gloucestershire STP has a Prevention, Early Intervention and Self-care work stream, through which local authority public health teams are collaborating on prevention initiatives.

Following discussion with neighbouring authority colleagues at the beginning of this commissioning process, Bristol has proceeded with the development and commissioning of a Behaviour Change for Healthier Lifestyles Service for the Bristol population. We are working to share principles and experience with STP partners through the prevention work stream, and there may be opportunities for other authorities to engage at a later date.

Preventable disease

On average 1,111 people die prematurely in Bristol (before the age of 75); this is approximately one third of the total deaths in Bristol each year. Some early deaths are not preventable, such as some accidents, cancers, and long term conditions, and congenital diseases.

Figure 3: The main causes of death in people under the age of 75 in Bristol

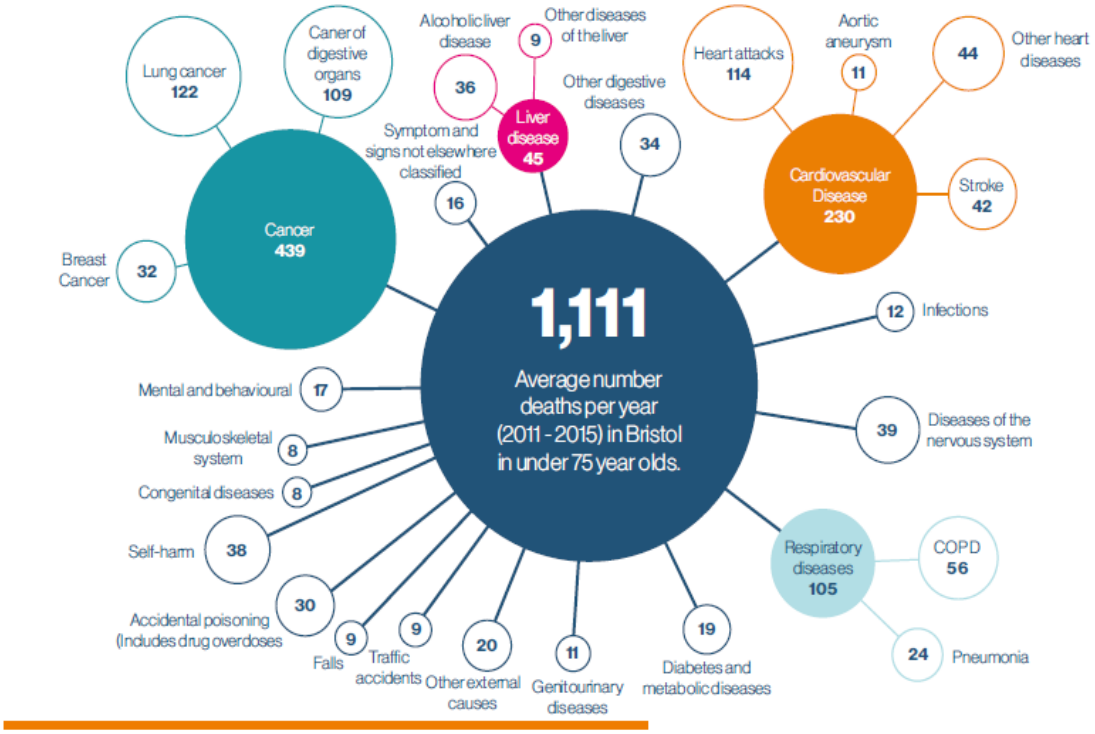


Figure 6: Main causes of premature death in Bristol (average per year 2011 - 15). *Source: calculated by Bristol Public Health Knowledge Service using ONS mortality data.*

However, approximately 819 of the 1,111 people that die prematurely in Bristol each year are dying early through preventable diseases. The four main disease groups that cause early death in Bristol are cancers, cardiovascular diseases (heart disease and stroke), respiratory diseases and liver disease. These four diseases contribute 70% (819 people) of premature mortality. Many of these deaths are considered preventable through known public health interventions such as supporting people to follow healthy lifestyles.

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

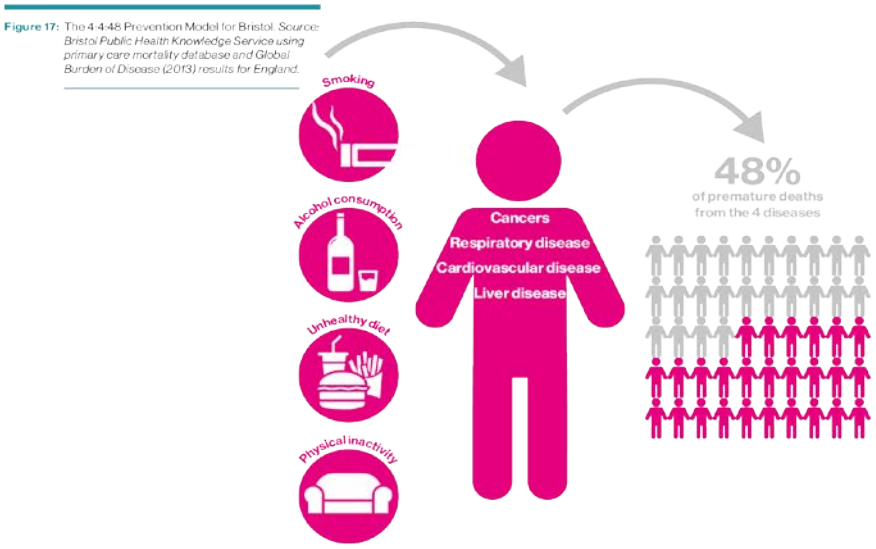
prevention, intervening early when risks are identified and taking action when long term conditions are identified is critical.

We know that four key behaviours are the biggest preventable risk factors:

- Smoking
- Excess alcohol
- Physical activity
- Poor diet

These together contribute to 48% of the premature deaths from cancers, cardiovascular disease, respiratory disease and liver disease – the 4:4:48 model.

Figure 4: The 4:4:48 Prevention Model



The evidence is clear that positive changes to behavioural risk factors during adult life will reduce an individual's risk of early death, ill-health, including dementia, disability and frailty in later life. Emotional and mental health is also an important contributing factor to people's overall health and wellbeing.

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.

Approaches to prevention

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.

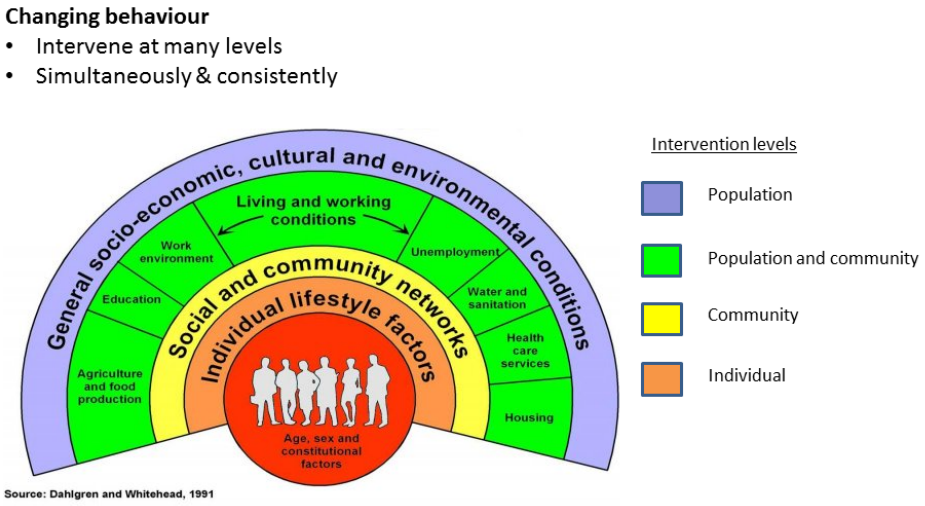
Individual-level interventions aimed at changing health-damaging behaviours are complemented by interventions at a **population, community and organisational** level, such as campaigns for raising awareness and prompting behaviour change.

Making Every Contact Count (MECC) is an approach to behaviour change that utilises the many day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.

Behaviour change

The Government Cabinet Office, Behavioural Insights Team, The Department of Health and Public Health England have undertaken a significant amount of work on behavioural insights and behaviour change. Sustained behaviour change is most likely to occur when a combination of individual, community and population-level interventions are used. There is a robust evidence base relating to motivation to change (Lai et al. 2010; Ruger et al. 2008), and changing the context in which someone makes a decision – nudge interventions (Thaler and Sunstein, 2008).

Figure 5: Behaviour Change Model



Nice Guidance for Behaviour change at population, community and individual levels (2007)
Obesity and the Economics of Prevention, OECD (2010)

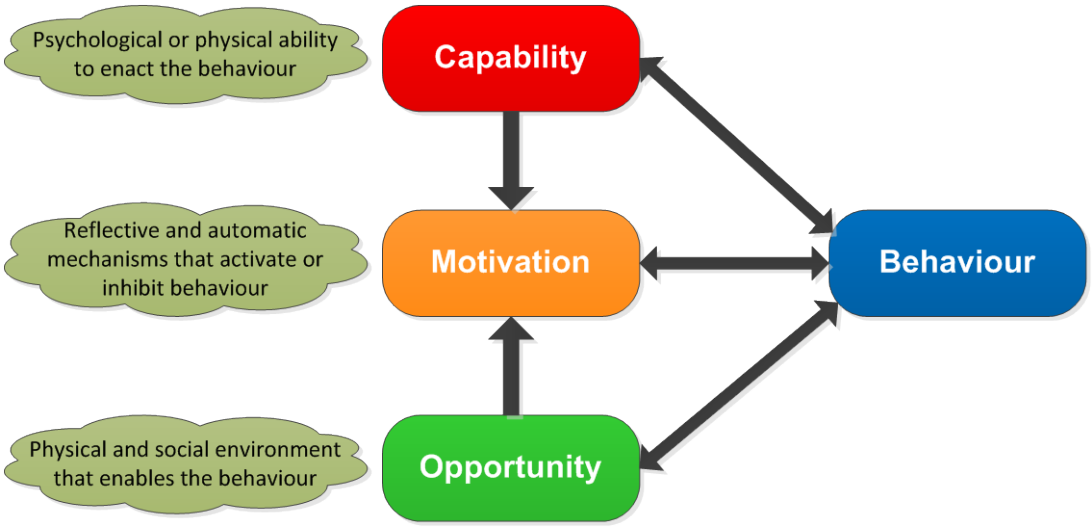
Changing behaviour requires intervening at many levels. It takes into account the determinants of health – where people live, work and play.

For any change in behaviour to occur, a person must:

- be physically and psychologically capable of performing the necessary actions;
- have the physical and social opportunity. People may face barriers to change because of their income, ethnicity, social position or other factors. For example, it is more difficult to have a healthy diet in an area with many fast food outlets, no shops selling fresh food and with poor public transport links if you do not have a car;
- be more motivated to adopt the new, rather than the old behaviour, whenever necessary.

This has been described in the COM-B Behaviour Change Model, recommended by NICE (2014).

Figure 6: COM-B Behaviour Change Model



Michie et al, 2011. Implementation Science

The COM-B Behaviour Change Model focuses on:

- Goals and planning
- Work with the client to agree goals for behaviour and the resulting outcomes
- Develop action plans and prioritise actions
- Develop coping plans to prevent and manage relapses
- Consider achievement of outcomes and further goals and plans
- Designed to work in conjunction with Cognitive Behaviour Therapy (CBT) where necessary

The King's Fund report (2013) *'Transforming our health care systems'* lists ten priorities for commissioners: the first of these is 'Active support for self-management'. The Richmond Group of Charities and the King's Fund (2012) called for people with long-term conditions to be offered the opportunity to co-create a personalised self-management plan which should include at least the following:

- Education programmes
- Advice and support about diet and exercise
- Use of digitalisation to aid self-monitoring
- Psychological interventions (coaching)
- Telephone based coaching

1.2 The Bristol Behaviour Change for Healthier Lifestyle Programme

The Bristol Behaviour Change for Healthier Lifestyle Programme will be expected to work with and support families and individuals, including children and young people, taking a family approach where appropriate, in the primary and secondary prevention of preventable ill health through behaviour change.

This approach is being taken acknowledging that children and young people who are overweight or obese, specifically, live in a family as part of a community. It therefore seems appropriate to provide family approaches for this cohort.

The Behaviour Change Programme will focus on improving lifestyles by a coaching approach to behaviour change.

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, changing eating habits and increasing the amount of physical activity taken.

All support to change behaviour should encourage use of support available in local communities.

Our Challenge

Health improvement services have traditionally been set up to address a single lifestyle issue, such as supporting a person to reduce their weight or to stop smoking, and the person is usually referred into the service by a health professional.

For some people, health professional referral is an important route into health improvement services, but there are many who do not visit health professionals but want professional support and guidance to help them change their health-related behaviour.

By focusing on behaviour change rather than the traditional approach of addressing a specific health-related lifestyle e.g. weight management or stop smoking services provides the opportunity for innovation, but also a challenge about how we reach or connect to the population across Bristol, and find out what sort of approach different citizens would feel able to respond to.

We have spoken to communities in a variety of different settings and found that stress is often quoted as a barrier to being able to change lifestyle behaviours.

'Being healthy means: Socialising; Stress free emotionally fit; Exercise; General activities, could include gardening, jogging etc' (Quote: Focus group with South Asian Women)

We intend to commission a holistic behaviour change approach to encourage people to adopt healthier lifestyles which will engage and support people in a way taking into account the pressures of everyday living.

Because people are characterised by a range of circumstances, challenges and behaviours, it is important that a solution is based around the individuals rather than access to separate services for a range of needs, and takes account of the root causes of the behaviours.

We want to be able to provide the right people with the right information, advice and support, in the right format and style for them, which is flexible and dynamic to respond to people's different needs and to emerging technology. The programme also needs to have the ability to deliver a targeted, potentially more intensive offer to those in greatest need, applying the principal of Proportionate Universalism (Marmot, 2011) in order to address health inequalities.

Health-related behaviours in the Bristol population

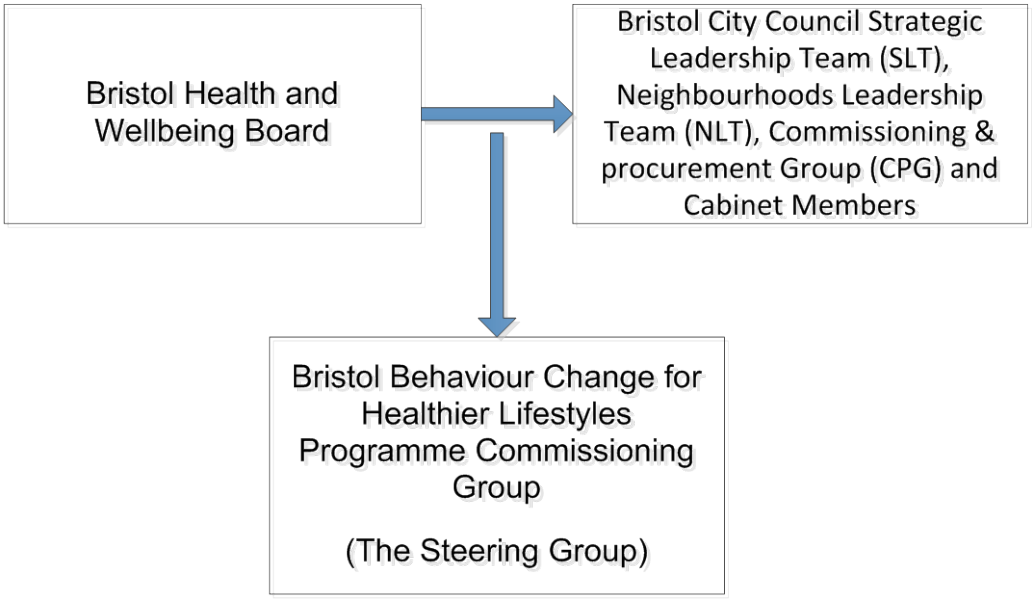
Bristol has a population of around 449,300 individuals; 365,500 adults and 83,800 children (ONS mid 2015 resident population estimate).
The table below shows the number (and percentage) of people in the Bristol population at risk from specific health-related lifestyles. More detail can be found in the JSNA Data Profile 2016.

211,259 (57.8%)	Overweight adults
85,367 (19%)	Adults who smoke
142,545 (39%)	Physically inactive adults
69,445 (28%)	Adults drinking at harmful levels
29,665 (35.4%)	Children and young people who are overweight

1.3 Governance and Decision Making

The Bristol Behaviour Change for Healthier Lifestyle Programme commissioning group is a multi-agency governance group (The Steering Group), led by two Consultants in Public Health with responsibility for designing and commissioning a new healthy lifestyle programme. This group will oversee the delivery of the commissioning process, reporting to the Bristol City Council internal commissioning processes including the Commissioning and Procurement Group at each stage of the process, and the Health and Wellbeing Board for agreement and sign off at key milestones.

Figure 7: Governance Pathway



The steering group (the commissioning group in the figure above) includes members from BCC public health, Equality and Cohesion Officer, Commissioning and Procurement Officer, Substance Misuse Commissioner and Voscur's Head of Collaboration and Commissioning representing the voluntary and community sector, and a GP representative for the Bristol Clinical Commissioning Group.

The Behaviour Change for Healthier Lifestyles Programme has been presented to Cabinet Briefings at various stages of its development, and the cabinet Member for Health and Wellbeing has accepted an invitation to be a member of the Steering Group.

2. Methodology and principles

2.1 Method

Our methodology for commissioning a Behaviour Change for Healthier Lifestyle Programme for Bristol is outlined below. We have:

Current issues and context	• Conducted Health Needs Assessments / Gap analyses for the current lifestyle contracts (Stop Smoking services, weight management, children's weight management and NHS Health Checks). We considered key questions such as: what are the services delivering; how easy is it to access them; do they reach our deprived communities; what is the cost and quality of the provision; what are the short and longer (if known) outcomes for the service user? • Obtained the views of service users and others in communities across Bristol.
Understanding the drivers	• Considered the implications of providing separate services to adults and children versus an integrated approach. • Considered the implications for a wider geographical footprint, including the Sustainability Transformation Plan (STP). • Considered the financial implications and context. • Considered BCC Corporate Strategy.
Applying the evidence	• Reviewed the international, national and local evidence for lifestyle services and behaviour change approaches. • Reviewed the implications of findings in the Gap Analyses/Health Needs Assessments. • Considered the best commissioning and procurement approaches that are suitable for this innovative approach. • Reviewed how other local authorities and organisations are providing lifestyle services to their population, and lessons learnt.
Consultation	We have shared our high level intentions with • Cabinet Member for Health and Wellbeing • Bristol City Council Neighbourhoods Cabinet Briefing • Bristol City Council Commissioning and

	Procurement Group • Bristol Health and Wellbeing Board • Bristol Clinical Commissioning Group (CCG) Leadership Group • CCG locality Clinical Fora • Bristol City Council Directorates • Current service users • The wider Bristol Communities • Compact (Voscur) • Healthwatch

2.2 Principles underpinning this commissioning process

We have developed some key principles to underpin this commissioning process:

1. Focus on prevention and early intervention
2. Focus on an individual behaviour change approach
3. A life course approach, acknowledging that families live in communities
4. Focus on citizens being able to help themselves
5. Using a digital hub as the key to the service
6. An expectation that other services and activities within communities will be signposted
7. Value for money services (economic, efficient and effective)
8. We will meet the needs of the diverse communities within Bristol
9. An adaptable, flexible and inclusive service
10. Quality service that citizens who use the service are satisfied with
11. A high profile service that is accessible to all

3. Needs Assessment and Stakeholder Engagement

3.1 Health Needs Assessments

Needs assessments or gap analyses have been completed for the currently contracted services including:

- Weight management
- Support to stop smoking
- NHS Health Checks

JSNA work on physical activity, food etc is underway and emerging needs are being identified. See Appendix A for further details.

Key recommendations are:

- The pattern of provision of current services does not always align with population need. The new programme will require a proportionate focus in areas and population groups where unhealthy lifestyle behaviours are most prevalent.
- The future programme needs to take a wellness approach, moving beyond looking at single lifestyle issues to focus on behaviour change.
- Consideration should be given to ensuring lifestyle support is accessible through a range of methods, particularly maximising use of technology.
- Face to face NHS health checks need to be accessible in a range of settings to maximise uptake among higher risk groups.
- Opportunities for follow-up will need to include individual coping plans to prevent and manage relapses.
- Use smart technologies to improve our ability to understand programme uptake, impact and future need.
- Future behaviour change approaches should be appropriate for all ages of the population.

3.2 Stakeholder Day – September 2016

A stakeholder day was held in September 2016, attended by current and potential healthy lifestyle providers including voluntary and community sector providers, commercial providers, primary care including GP and pharmacy and BCC cross-directorate colleagues. The purpose of the day was to:

- Hear about our commissioning intentions
- To explore integrated healthy lifestyles services including examples from elsewhere
- Share ideas for the development of a Bristol service
- Engage with national and local stakeholders

Information and insights from the day have been used in the development of the Bristol behaviour change service model. Key themes emerging included:

- **Organisational culture** – customer centred service; diversity of workforce; client led services; partnership working; better use of digital technology; greater flexibility and accessibility of workforce; locally based; reduce inequalities
- **Service development** – flexibility and accessibility of services for service user; variety of pathways of access eg use of social media; cater for diversity; single/mix gender services; intergenerational training; community hub
- **Behaviour change** – incentivising through loyalty cards, food vouchers; identify root causes of unhealthy lifestyles; apps, fitbits; less emphasis on medical conditions
- **Communication** – use of all forms of communication including social media, digital, word of mouth; integrate health messages with other messages; peer review; consistency of messaging; promote talking about issues; marketing/branding
- **Holistic approach** – emotional health and wellbeing through all services; family dynamics; population groups; use of environments; link to wider determinants; intergenerational; arts and cultural involvement; use of mindfulness, self-esteem and self-worth approaches; more focus on talking therapies and less focus on medical issues.

3.3 Survey & Focus groups

A series of focus groups were conducted with Bristol Drugs Project, South Asian women, Bengali men; learning disabilities, young people and carers, various other groups and a car boot sale in Whitchurch. In addition, we have provided an on-line survey via BCC consultation hub, which sought to understand how people respond to current lifestyle services and what they would like to see as part of the new Bristol offer. There were over 150 responses to survey from across Bristol (Appendix B).

Figure 8: Key themes from the survey:

Figure 9: Key themes from the focus groups:

3.4 Customer Insight

ACORN is a consumer classification that segments the UK population by demographics, social factors, population and consumer behaviours and gives an understanding of different types of people and population groups. The benefits of this are to:

- Identify differences in population groups at ward level
- Inform commissioning and resource allocation
- Shape and develop services
- Build up assets in appropriate areas
- Improve efficiency and effectiveness of services

- Effectively reduce health inequalities

This has been used to illustrate population groups or personas across Bristol, taking account of personal characteristics, behavioural patterns, health risk factors, motivators and barriers.

From these characteristics we have been able to broadly identify three groups or personas:

- ‘Inform Me’ – Professional; good income; higher education. Expect instant high quality support and self-sufficient.
- ‘Enable me’ –Family; time and disposable income, Friday night drinks/takeaway.
- ‘Support me’ – low qualifications; high unemployment; multiple negative lifestyle behaviours. Reluctant to engage with authority; living for today.

These personas will be tested at the next stakeholder day in March 2017 to further inform the commissioning model.

A market engagement day will be held in May 2017, to give potential providers an opportunity to network, innovate and collaborate. This is intended to encourage a collaborative approach to the tender process.

3.5 Benchmarking

We have explored integrated healthy lifestyle services elsewhere in the country, including examples from Knowsley, Devon, Suffolk, Luton and Gloucestershire.

A number of the models aim to link healthy lifestyle topic-based services more closely together, with easy access to information. There are fewer examples of services more focused on behaviour change, with access through digital formats, telephone and face to face support where needed.

Some of the models have more limited scope than the model we are proposing, particularly with NHS Health Checks being out of scope.

Devon and Suffolk presented their lifestyle models at the September 2016 stakeholder event.

Social Value:

The Public Services (Social Value) Act 2012 puts a requirement on contracting authorities to consider how procurement can be used to improve the social, economic and environmental wellbeing of the relevant area.

In line with BCC’s Social Value policy providers must also consider how they can provide additional social value to Bristol. This could include, for example, improving local employment opportunities, offering work placements or apprenticeships, or using local contractors including those with social objectives. 10% of the quality

score will be related to adding social value. Bidders may wish to refer to the social value toolkit to consider how they may incorporate social value into their proposals.

3.6 Market analysis

This is a new approach to improving healthy lifestyle behaviour; and the market is relatively underdeveloped. We are aware there are providers in the market who currently offer an integrated healthy lifestyle approach. There are examples of providers in the market with both digital and behavioural change expertise, and others with digital expertise or behaviour change approach.

More detailed information on organisations showing an interest in providing this programme will be collated at our next stakeholder event on 28th March.

4. Current contracts and financial envelope

4.1 Current Contracts and Expenditure

Current yearly expenditure for services that are considered in scope for the proposed Behaviour Change for Healthier Lifestyle Programme for Bristol is shown in the table below:

Contracts and Service Providers	**Bristol**
	£
NHS Health Checks	350,000
Adult Weight Management Services	305,000
Stop Smoking Delivery - primary care	620,000
Stop Smoking Delivery - community grants	60,000
Alcohol Brief Interventions	17,000
Children and young people's weight management services	185,000
Delivery of Livewell Bristol Hub and Community Health Improvement Support	156,791
Current Total	**£1,693,791**

4.2 Financial envelope

We intend to make a 15% saving on the overall cost of the new programme. The cost envelope for the new service is shown in the table below:

Year	**Contract Value**	**Saving**
2018/19	1,439,722	254,069
2019/20	1,439,722	254,069
2020/21	1,439,722	254,069
Totals	**4,319,166**	**762,207**

5. Commissioning model

5.1 Our ambition

Our ambition is to create and procure an innovative Behaviour Change for Healthier Lifestyle Programme for the residents of Bristol who want to take control of their own health and wellbeing and change their health-related behaviour. It will be a model that is empowering, enabling and motivating and centred around behaviour change to change modifiable lifestyle behaviours, specifically smoking, physical inactivity, healthy eating, alcohol use and overweight / obesity.

5.2 Objectives

- To empower, motivate and enable Bristol residents to take control of their own health and wellbeing and change their health-related behaviour.
- To provide a universal programme that is proportionate to need.
- To provide the right level of advice, information and support for people who are motivated to change.
- To find solutions that are based around the needs of the individual and which understand the root causes of their behaviour.
- To make more effective links with available assets, including the capacity of existing services and communities to support healthy lifestyles.
- To deliver an innovative cost- effective behaviour change programme, maximising the use of digital technologies.
- To enable long term behaviour change without continuous face to face support.
- To ensure there is a family approach where appropriate.
- To provide a person-centred holistic approach.

5.3 Programme Outcomes

Programme Outcomes

- Proportion of people in priority groups who are smokefree or reduce the harm from tobacco
- Increase the numbers of children and adults undertake physical activity
- Increase the numbers of children and adults in the healthy weight range (see Health Needs Assessment)
- Improved mental/emotional wellbeing
- Adults and children in the healthy weight range
- More adults and children eating 5 portions of fruit and vegetables a day
- Increasing the number of adults in priority groups being supported to change lifestyle behaviours through NHS Health Checks
- Reduced alcohol intake by people in priority groups.

The high level outcomes this programme will contribute to:

- **Smoking** – reduction in smoking prevalence

- **Overweight and obesity** – reduction in the proportion of adults classified as overweight or obese, - reduction in the proportion of children identified as overweight or obese through the National Child Measurement Programme
- **Physical Inactivity** – Increased percentage of adults meeting recommended physical activity levels
- **Alcohol** – Reduction in adults drinking above safe recommended limits

Intermediate outcomes:

- **Smoking** – Reduction in smoking prevalence in routine and manual workers, reduction in smoking in pregnancy (smoking at the time of delivery), increase in the number of smokers accessing support services.
- **Overweight and obesity** – increase in the numbers of people consuming five portions of fruit and vegetables a day, reduction in the proportion of adults classified as overweight or obese, - reduction in the proportion of children identified as overweight or obese through the National Child Measurement Programme.
- **Physical Inactivity** - Increased percentage of adults meeting recommended physical activity levels, reduction in the percentage of adults classified as inactive, a reduction in the percentage of children in Reception and Year 6 who are overweight or obese, increase in the percentage of people using outdoor space for exercise / health reasons
- **Alcohol** – Reduction in reported alcohol use

Programme outputs to achieve these outcomes will be monitored through the provider(s). Indicators are likely to include contacts with the programme (digital, telephone, text etc, face to face, coaching / brief interventions /motivational interviewing delivered, lifestyle interventions accessed, lifestyle changes achieved. This will include follow up to one year.

The proposed programme outcomes contribute to the Public health Outcomes Framework (PHOF) as listed below.

Public Health Outcomes Framework (PHOF)

- Average number of portions of fruit consumed daily at age 15
- Average number of portions of vegetables consumed daily at age
- Mortality rate from causes considered preventable
- Under 75 mortality rate from cardiovascular diseases considered preventable
- Under 75 mortality rate from cancer considered preventable
- Under 75 mortality rate from liver disease considered preventable
- Under 75 mortality rate from respiratory disease considered preventable
- Smoking prevalence in adults- current smokers
- Smoking prevalence in routine & manual occupations
- Smoking prevalence at aged 15 years – current smokers, occasional smokers, regular smokers
- Excess weight in adults
- Percentage of physically active and inactive adults – active adults
- Percentage of physically active and inactive adults – inactive adults
- Child excess weight in 4-5 and 10-11 year olds – 4-5 year olds
- Admission episodes for alcohol-related conditions – male/female/persons

- Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check
- Estimated diagnosis rate for people with dementia
- Self-reported wellbeing, people with a low satisfaction score
- Self-reported wellbeing, people with a low wellbeing score
- Self-reported wellbeing, people with a low happiness score
- Self-reported wellbeing, people with a high anxiety score

5.4 Scope

The steering group have sought opinion on the commissioning process and agreed that this innovative approach to behaviour change for Bristol residents should be procured. We have concluded that a competitive tender process is the most appropriate method to procure the programme.

In Scope
The following services are all considered to be in scope for the Behaviour Change for Healthier Lifestyles Programme:

Service	Purpose	Current providers
NHS Health Check programme	This is a mandated Local Authority Public Health service. It provides a risk assessment, risk awareness and risk management programme, addressing the major risk factors (both behavioural and physiological) for cardiovascular and related diseases. 40-75 year olds eligible for a face to face NHS Health Check every 5 years	Primary Care (GP practices); Healthy Living Centres
Stop Smoking Service	To reduce the prevalence of smoking among young people, adults and pregnant women	Primary Care (GP practices and Pharmacies) Children's Centres Healthy Living Centres Community based services
Adult Weight management on Referral	To reduce the rates of overweight and obesity among adults	Slimming World and Weight Watchers Targeted small projects, including Fit Club and Fans4Life
Alcohol Brief Interventions	To reduce harm from alcohol	Primary Care. Healthy Living Centres; Pharmacies
Children and family Weight Management programme	To reduce the rates of childhood obesity	Alive N Kicking
LiveWell Bristol	Digitalised information, signposting and referral point	Bristol City Council, Public Health

Initiatives / campaigns	Specific initiatives/campaigns related to the healthy lifestyles within scope	
Training	Training for healthy lifestyle provider staff; referrers and community based groups or other agencies	Bristol City Council, Public Health

Out of Scope

- Healthy Living Centres core funding – voluntary and community organisations (included in Bristol Impact fund).
- National Childhood Measure Programme (NCMP) delivery (provided via the community child health partnership contract).
- Healthy Schools
- Leisure Centres
- Specialist interventions for falls prevention, alcohol detox, substance misuse
- Specialist weight management (tier 3 and 4, including malnutrition, eating disorders, pregnancy).
- Sexual health

5.5 Service model for Bristol Behaviour Change for Healthier Lifestyles Programme

We wish to commission a Behaviour change for Healthier Lifestyles Programme which will:

- Provide behaviour change support focused on physical activity, smoking, alcohol and healthy weight.
- Enables, empowers and motivates people and uses a coaching approach.
- Connects people to support in a format appropriate to their needs and wider support in the community.
- Has a presence in the community and connects to community assets.
- Captures insight for monitoring, evaluation and customer feedback

The Behaviour Change for Healthier Lifestyles Service for Bristol will use digital technology based on the three personas of ‘inform me’, ‘enable me’ and ‘support me’. It will focus on prevention and early intervention, based on who the customer is, their needs, the offer they find acceptable and the way they wish to access it.
The model is being developed with these three personas in mind. These have been described to try and better understand the characteristics, behavioural patterns, health risk factors, motivators and barriers of people living in Bristol. We have used the information gained from focus groups and the survey, in addition to ACORN data and other demographic data.

Please note this approach is for illustrative and planning purposes only. It is not intended to categorise or over simplify people and their behaviours. By using this

approach, it is our intention that the programme will be accessible to people based on their lives, communication preferences and readiness to participate in change.

Three personas:

Inform me

- Regular users of digital technology (use Apps, web based tools to support them).
- Self-motivated, happy to set own goals.
- Take the initiative to find advice and guidance to manage own life.

Enable me

- Some are self-motivated.
- Require additional support to help them navigate where to find information, advice and support.
- Family and friends help them keep motivational goals.

Support me

- Prefer to seek support over the phone or face to face.
- Unless they perceive their health is an immediate problem they are not too worried.
- Funding and ability can be a barrier to access.

Universal offer proportionate to need

To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism (Marmot Review, 2011), (Fig 10).

Figure 10: Developing the principle of Proportionate Universalism into our Behaviour Change Lifestyles Programme (Devon Public Health, 2016)

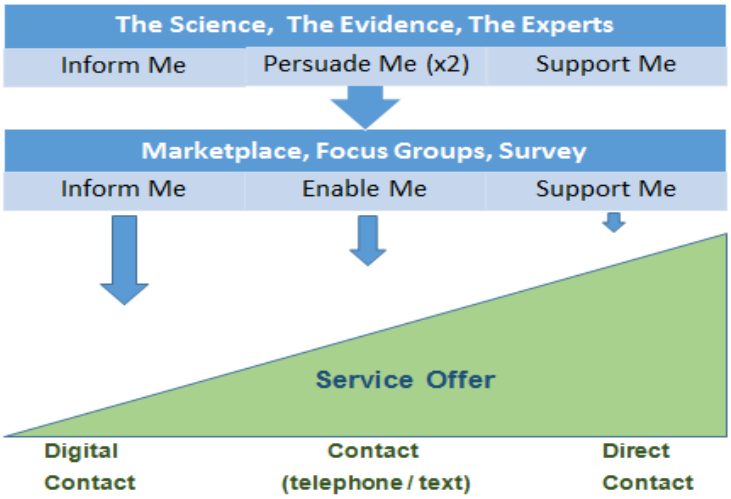
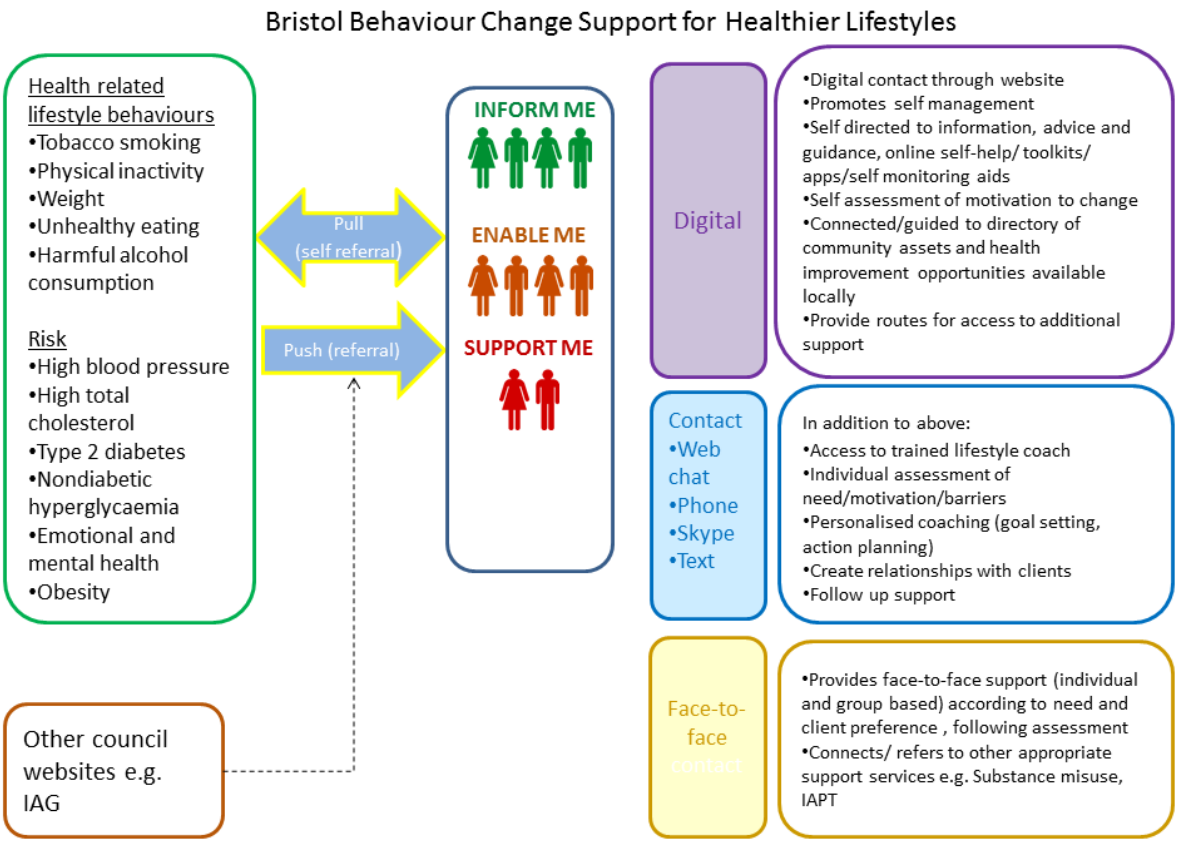


Figure 11 below sets out the model for the Bristol Behaviour Change for Healthier Lifestyles Programme.

Figure 11: Bristol Behaviour Change Support for Healthier Lifestyles



The NHS Health Checks programme is within the scope for this procurement (section 5.4) and provides an opportunity for a face to face Health Check for 40-74 year olds every 5 years. Risks for cardiovascular and related conditions are assessed – both lifestyle risks and physiological risks. Those with lifestyle risks would be referred or signposted on to the behaviour change support.

5.7 Proposed tendering approach and allocation of resources

We have considered a range of options for tendering through Lots, these options are set out in the table below.

Option	Lots	Potential advantages	Potential risks
A.	Single lot for whole programme including all services in scope – 1 service provider	• Simplifies commissioner/provider relationship • Joined up services • Cost efficient • Still allows for localisation and more intensive support in high need areas	• Lack of localisation • Increased risk of performance failure (all eggs in one basket) • Less flexibility in changing programme emphasis
B.	2 lots: i) NHS Health Checks programme ii) Support for behaviour change (all elements including digital and face to face)	• Encourages bids from providers with skills/capabilities around risk assessment and risk communication • More flexibility in programme • Mitigates risk of legislative change	• Weaker interface between Health Checks providers and ongoing support for behaviour change
C.	3 lots: based on geographical localities i) South ii) North iii) central	• increased presence/visibility in locality areas	• Likely to be more costly than single universal offer based on digital

		• potential to target a more intensive 'support me' offer where appropriate • diverse provision in line with local population needs • risks spread across providers	access • variation in programme quality • fragmentation and loss of ability to move seamlessly with behaviour change programme eg. to support in another locality • weaker links with community assets and support in other localities

We will use an Open Procedure to procure this programme.

We are collating further information on the provider market at our stakeholder day on March 28th, which will further inform the commissioning strategy. At this stage we are exploring and seeking feedback on all the above options.

5.8 Evaluation approach

We encourage organisations to submit collaborative bids following the Councils guidance on Collaborative Arrangements/Commissioning Procurement in relation to formation and risks. The four models of collaborative working arrangements that are acceptable include:

- Lead partner consortium
- Joint and several liability consortium
- Sub-contracting
- SPV – special purchase vehicle (formation of a new organisation/new company for the purposes of tendering)

The proposed evaluation criteria are 60% quality and 40% price. A panel will be formed to include a range of stakeholders and perspectives and the views of service users will form part of the evaluation. Details of the panel will be released in the tender documents.

To encourage collaborative bids, we have allowed more time in the process and have taken an approach to be flexible with our assessment approaches. For example, Bristol City Council is committed to full-cost recovery (a principle of the Bristol Compact) and as such recognises that, in some cases, overhead costs may be different in collaborations. As we are keen to encourage collaboration between providers, we will take into account different costs of effective collaborative and managing multiple relationships and will ask bidders to provide details.

Bidders are expected to factor in any increased costs into their proposals. Annual contract reviews will take place throughout the life of the contract and the financial position will be considered as part of this.

Furthermore, BCC aims to spend at least 25% of the Council's total procurement budget with micro, small and medium size businesses, social enterprises and voluntary / community organisations (less than 250 employees), as per the Social Value Policy. Within this commissioning process we intend to encourage that at least 25% of the funding available in the competitively tendered contracts goes to micro, small and medium size businesses, social enterprises and voluntary / community organisations. This could be achieved through collaborative bids from providers working together in, for example, lead partner collaborations or sub-contracting arrangements. We are open to hearing ideas and suggestions about this from providers in this consultation.
Sub-contracting arrangements are welcomed with the expectation that the majority of the activity will be carried out by the main provider as opposed to being sub-contracted out, which makes the contract management convoluted. Where collaborative bids or sub-contracting arrangements are proposed details will need to be provided at the Invitation to Tender stage where the role(s) of the sub-contractors/collaborators will need to be provided with the approximate percentage of contractual obligations assigned to the sub-contractor/collaborators.
Part of BCC's procurement process requires an assessment of the financial risk of individual providers. To be designated low risk, a provider's annual turnover would normally need to be twice the contract value. It is also recommended that this financial assessment is based on the total of all the contracts the provider is bidding

for i.e. if an organisation applies for several contracts their risk should be assessed on the combined contract values.
We are keen to ensure that the provider market is fully included in this process and based on the feedback received throughout our consultation the Joint Commissioning Group may wish to be more flexible about the financial risks if appropriate. Further detail will be provided in the tender documentation.

5.9 Contract duration

It is our intention that the contract/s are awarded for a three year period with the opportunity to extend for two years and a further two years i.e. potentially seven years in total.

The contracts will include the need for providers and commissioners to work together to review and adapt according to population / community and individual needs of the residents of Bristol. It is also essential for providers and commissioners to work together to react to any funding fluctuations.

5.10 Performance monitoring

The local authority is responsible for ensuring that appropriate quality governance is in place for commissioned services. Public Health England will monitor achievement against the national Public Health Outcomes Framework (PHOF) indicators – those indicators relevant to this behaviour change programme are listed in section 5.3.

Medium and short term performance measures will be developed to reflect the performance outcomes.

5.11 TUPE

Current and potential providers will need to be aware of the implications of both the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) as well as updated “Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014.

When service provision changes the relevant employees delivering that service may transfer from the old to the new provider on the same contractual terms and conditions of employment. In these cases, the new provider/employer takes on all liabilities arising from the original employment contracts.

Bidding providers will need to consider the implications of TUPE. The council will obtain from current providers basic information about the employees who will potentially be affected by this commissioning process. It is our intention to provide such information in advance of the 28 days (prior to contract start) required by current regulations so that bidders can develop accurate proposals and budgets.

Providers must seek their own legal and employment advice on TUPE. It is the responsibility of the bidders/providers to satisfy themselves regarding TUPE arrangements.

In future contract, we intend to include requirements of the contract holder to provide workforce information at earlier stages.

6. Consultation

6.1 Stakeholder consultation

We will be holding a 12 week formal consultation period from 2nd May to 25th July 2017 so that all stakeholders, including service users can consider the proposals in our draft commissioning strategy and provide feedback.

After the consultation we will consider all the feedback and use this to inform our final commissioning strategy and service specification. We will publish a summary of feedback and our response alongside the final commissioning strategy.

To make the consultation on this commissioning strategy as accessible as possible we will: (Details to be added).

6.2 Procurement timetable

Please note that dates are likely to change through the course of the process.

Tasks	Date
Key meetings: • Public Health Department Management Team • Cabinet Briefing – agreement to consult on the Commissioning Strategy • Neighbourhoods Leadership Team • Strategic Leadership Team • Health and Wellbeing Board – permission to go to consultation and to go to market after consultation	 20th March 2017 23rd March 2017 29th March 2017 4th April 2017 12th April 2017
2nd Stakeholder event to test the model, personas, market ability to respond	28th March 2017
Formal consultation of Commissioning Strategy commences (12 weeks)	5th May 2017
Formal consultation of Commissioning Strategy ends	28th July 2017
Market engagement day	9th May 2017
Publication of final Commissioning Strategy	31st July 2017
Invitation to tender (open process)	4th September 2017
Contract Award	4th December 2017
Current contract extensions expire	31st March 2018
New contract(s) start date	1st April 2018

Appendix A: Key Issues and Recommendations from Needs Assessment / Gap Analyses

NHS Health checks

Key issues:

- Current patterns of local provision do not always align well with patterns of need across the population
- There are gaps in current service provision, some of these in areas of higher deprivation and health need
- Activity (invitations for a Health Check and uptake of Health Checks) is variable across providers
- Eligible is determined from Practice population lists, which may not be accessible to other non –primary care providers
- Limited time is available in the health check for brief interventions and behaviour change , with the focus being on risk assessment (physiological and behavioural risks)
- Follow up after the health check appointment, for both clinical and lifestyle risks follow up, appears low

Recommendations:

- Explore opportunities for using wider data sources to identify and invite those eligible for a health check, including for targeting higher risk groups
- Offer heath checks through a range of methods and settings, to maximise engagement in areas and population groups likely to be at higher risk.
- Target deprived areas and population groups who have the highest prevalence of vascular diseases, and use risk stratification approaches to identify higher risk individuals to prioritise
- Ensure effective onward referral and follow up from a health check, including easy connection to behaviour change support
- Develop systems to monitor follow up as part of a wider framework of quality assurance

Support to Stop Smoking

Key issues:

- Smoking prevalence, and smoking in pregnancy varies widely across wards. Higher rates are seen in some population groups eg. those in routine and manual occupations, unemployed, those with mental health problems. Smoking is increasingly concentrated among people living in more derived areas and among certain population groups.
- Numbers accessing support to stop and setting a quit date have declined locally, in line with the national trend

- Support to stop smoking activity amongst current providers is low, and activity does not align with areas of higher derivation where smoking prevalence is highest
- Referrals from health services including secondary care acute and mental health and health visiting services are low

Recommendations:

- Support to stop services to be targeted to areas and population groups where smoking rates are highest
- Explore alternative delivery models to improve uptake and outcomes, adapting to needs of those groups where smoking is most prevalent
- Work with secondary services to implement relevant NICE guidance on smoking cessation, ensure a clear pathway for connecting to support to stop
- Ensure availability of equality data for monitoring equity of access to support services

Healthy Weight

Key issues:

- Estimated modelling based on the Quality of Life data for adult overweight and obesity suggests a need 21,000 more referrals per year to weight management services in Bristol to successfully achieve a 1000 people successfully losing and maintaining weight loss and reducing the prevalence of overweight and obesity.
- Current patterns of local provision do not always align well with patterns of need across the population
- Evaluation of current services showed that less than one third of people referred to weight management services have successfully lost weight. Sustained weight loss is not currently known.
- Uptake rates into the Weight Management schemes currently available are low compared to population need. Although they do appear to target the most appropriate population (quintiles 3, 4 & 5) there are still significant numbers accessing these services that could with the appropriate information access other self-help services with the same success rate.

Recommendations:

- Better use should be made of digital information including apps and online services.
- There is a need for some follow up support to help ensure behaviour change is sustained.
- There is very little or no linkage made to other lifestyle services by our current providers to ensure a more holistic approach to leading a healthy lifestyle. More opportunity needs to be made to integrate the current lifestyle services, particularly for those that have more than one negative lifestyle directly affecting their health.

Appendix B: Survey Questionnaire

Introduction:

Public Health in Bristol City Council would like to hear your opinion about some of the services we currently offer that support you to make healthy lifestyle choices. These services include weight management; smoking cessation; physical activity, diet and alcohol advice and NHS Health checks. We are in the process of re-designing our services and we want to be sure that we will be offering you a service that fits with your needs and which you will be able to access easily.

This survey will ask you a few questions about current services which you may have accessed and will invite you to tell us about healthy lifestyle services you would like to access.

1. **What does being healthy mean to you?** (please tick all that apply)
   ☐Physically active ☐Eating a healthy diet
   ☐Emotional wellbeing ☐Mentally fit ☐Spiritual wellbeing
   ☐No diagnosed health condition ☐Smokefree ☐Healthy weight
   ☐Socially active ☐Controlling my alcohol intake
   ☐Other, please state…….

2. **Are there any areas of your own health that you need (or would like) to improve?** (please tick all that apply)
   ☐Stop smoking ☐Feel less stressed
   ☐Lose weight ☐Be less socially isolated
   ☐Be more active generally ☐Be able to take more care of myself
   ☐Get out more ☐Walk more
   ☐Feel better mentally ☐Eat healthier
   ☐Cycle more ☐Nothing I need to improve
   ☐Be happier ☐Have more confidence
   ☐Sleep better ☐Drink less alcohol
   ☐Other, please state……..

3. **Which of our current healthy lifestyle services have you tried?** (please tick all that apply)
   ☐Slimming World ☐Weight Watchers
   ☐Adult Specialist Weight Management Service ☐Waist Watchers
   ☐NHS health check ☐Support to stop smoking
   ☐Exercise on prescription ☐Walking for health
   ☐Cooking on prescription ☐Community growing clubs
   ☐Not tried any ☐Recovery Orientated Drug & Alcohol Services
   ☐Other, please state……

   Please list the services you had most success with:

4. **How did you access our current healthy lifestyle services?** (please tick all that apply)
   ☐GP referral ☐Pharmacy referral

☐Self-referral ☐Heard about it in the community
☐Through a friend/relative ☐ Healthy Living Centre
☐ Not tried accessing these services ☐Other, please state……

5. **If you have used any of our services, on a scale of 1-10 please say how easy it was for you to access them?**

I_____I____I_____I

1very easy 5 OK 6 10 very hard

If your score is 6 or more please tell us why, eg, no interpreter available, lack of suitability for disabilities etc.

6. **Where do you get information or advice about your own health problems?** (please tick all that apply)
☐GP ☐Pharmacy ☐Family/Friends
☐Website (list below) ☐TV or Radio ☐Magazines
_____
_____
☐Workplace ☐Faith groups
☐Other, please state……

7. **Who are your social networks?** Who do you talk to about health issues? (please tick all that apply)
☐Family ☐Friends ☐Neighbours
☐Local pub group ☐Local sports group ☐social club
☐Church or other place of worship ☐Work colleagues
☐I don't have any networks ☐Online chat
☐Other, please state……..

8. **How can we best enable you to help yourself in becoming healthier?** (please tick all that apply)
☐Provide information on websites/apps ☐Signpost you to services
☐Provide written information ☐Telephone contact
☐Web chat/online support ☐One to one contact
☐Make information culturally specific
☐Groups for weight management, stop smoking, cooking skills etc
☐Other, please state……

9. **How can we better support you to make healthier choices** (please tick all that apply)
☐ tell me about my risks
☐ explore possible choices with me
☐ listen to me whilst I explore options to change my behaviour
☐ help me to set short term goals
☐ help me to set medium term goals
☐ help me to set long term goals
☐ guide me to services that will support me

☐ I can make those choices on my own
☐ I don't want help
☐ other, please state……..

10. **What prevents you from being healthier?** (please tick all that apply)

☐Don't feel safe	☐Difficult to access activities
☐No time for myself	☐Don't know what to do
☐Don't feel motivated	☐Not enough money
☐Additional responsibilities eg carer	☐I feel I am healthy enough
☐Not a priority for me	☐Other, please state……..

11. **What would you like to see happen in your community to help you to be healthier?** (please tick all that apply)

☐ More local services	☐ More growing & cooking skills
☐ Safer parks/pavements	☐ Easier access to Leisure Centres
☐ Well women events	☐ Well men events
☐ Fewer cheap alcohol outlets	☐ Stop sale of illegal tobacco
☐More green space to grow own food	☐Easier access to fresh foods

☐ More services available for me and my children/family

Options for other weight management support, please state:

Options for other physical activity support, please state:

Options for other support to stop smoking, please state:

Options for healthier diet support, please state:

Events to be offered at different times, please state:

Other, please state:

12. **On a scale of 1-10 please say how important it is for you to be able to look after your own health**

I_____I

1 not important at all 10 very important

Equality measures: In order to make sure we reach a wide range of people from the Bristol population, we need to ask you some general information questions about yourself. It would help us greatly if you could answer the following 7 questions, all answers will be kept confidential.

13. **What is your gender?**
- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Prefer not to say

14. **What is your age group?**
- ☐ Under 18 years
- ☐ 19yrs – 39 yrs
- ☐ 40 yrs – 59 yrs
- ☐ 60 years and over

15. **What is your sexual orientation?**
- ☐ Bisexual
- ☐Gay
- ☐Heterosexual
- ☐Lesbian
- ☐Prefer not to say

16. **What is your ethnicity?**
- ☐ White British
- ☐ White Irish
- ☐ White Other
- ☐ Mixed white & black Caribbean
- ☐ Mixed white & black African
- ☐ Mixed white & black Asian
- ☐ Mixed white & black other background
- ☐ Asian/Asian British Indian
- ☐ Asian/Asian British Pakistani
- ☐ Asian/Asian British Bangladeshi
- ☐ Asian/Asian British other background
- ☐ Black/Black British Caribbean
- ☐ Black/Black British African
- ☐ Black/Black British Other background
- ☐ Chinese/Chinese British
- ☐ Any other ethnic group
- ☐ Prefer not to say

17. **Do you have a religion or belief?**
- ☐ Atheist/Agnostic/No Religion

☐ Christian
☐ Hindu
☐ Jewish
☐ Muslim
☐ Sikh
☐ Spiritual belief
☐ Other (please state)
☐ Prefer not to say

18. **Are you disabled?**

☐ Yes
☐ No
☐Prefer not to say

19. **If yes, what is your disability**?
(please tick all that apply)

☐ Physical Impairment
☐ Visual Impairment
☐ Hearing Impairment
☐ Learning Disabilities
☐ Mental & Emotional Impairment
☐ Health related Impairment
☐ Other, please state
_____

20. **Any other points/comments you would like to make about what you think should be included in a new integrated healthy lifestyle service?**

Please give us your postcode (it helps us to know which area you live in)

Thank you for taking part. We are inviting all participants to add their names to a draw for a £30 voucher. If you would like to join this draw please fill in your contact details below.

If you would like to check on how your responses have shaped our decisions for the new integrated healthy lifestyle services please go to: https://bristol.citizenspace.com/ where there will be information on 'We asked, you said, we did'. This information may not be available for a few months after the survey is completed.

Contact details, if you wish to take part in the prize draw:

Name:

Address:

Contact tel.no.:

Appendix C: Market Analysis

To be inserted after stakeholder day on 28th March 2017

Appendix D: Equality Impact Assessment

Bristol City Council Equality Impact Assessment Form
(Please refer to the Equality Impact Assessment guidance when completing this form)

Name of proposal	Integrated Healthy Lifestyle Service
Directorate and Service Area	Neighbourhoods and Public Health
Name of Lead Officer	Amanda Chappell, Wendy Parker

Step 1: What is the proposal?
Please explain your proposal in Plain English, avoiding acronyms and jargon. This section should explain how the proposal will impact service users, staff and/or the wider community.

1.1 What is the proposal?
The proposal to deliver a behaviour change for healthy lifestyles service which will support local populations with high health and social care needs to better health. This will enable a proportionate universalism approach where groups with poorest health outcomes based on deprivation and protected characteristics. The service will follow the 4:4:48 prevention model which identifies the 4 main negative lifestyle behaviours that lead to 4 main preventable diseases that are the main causes of mortality and morbidity leading to health inequalities in Bristol.

Step 2: What information do we have?
Decisions must be evidence-based, and involve people with protected characteristics that could be affected. Please use this section to demonstrate understanding of who could be affected by the proposal.

2.1 What data or evidence is there which tells us who is, or could be affected?
Research on health inequalities indicates the importance of improving access to public health services. The Five Year Forward View and Public Health Outcome Framework identify the need to reduce premature mortality and improve quality of life for those with poorest health. Marmot review also recommends using a proportionate universalism approach to delivery of these services. Main population groups that require this level of support include: Socio-economic groups from quintiles 3,4 & 5 (highest deprivation areas); LGBT; Lone parents; Mental Health; Learning Disabilities; specific BAME groups; ex-offenders and other groups with protected characteristics. **Smoking** Smoking prevalence is currently 18.1% of the population as a whole and. Prevalence is highest amongst populations with the following characteristics: ➢ Socio-economic status-education, income, employment-31.1% in manual and routine workers ➢ Gender- Higher rates in men although rates for women have increased over the past 20 years (PHOF) ➢ Ethnicity Dual heritage populations have the highest prevalence rate of 22.4% (PHOF) ➢ Lone parenthood (national data)

- Mental health problems- Over 60% of those experiencing poor mental health smoke (national data)
- Youth offenders, prisoners -80% -(national data)
- Sexual orientation-lesbian, gay, bisexual- (national data)
- Other excluded groups e.g. travellers, homeless (national data)

Most national and local surveys only focus on SES

Diet and Nutrition

- 59% of the Bristol population is overweight and obese (PHOF)
- S. Asian and Afro Caribbean populations are at higher risk of diabetes (type 2)
- Obesity is closely linked to Type 2 Diabetes
- Rates of diabetes are high amongst those with serious mental health issues
- Deprivation is closely linked to less consumption of fruit and veg (PHOF)
- Men are more likely to be overweight than women (PHOF)
- There are more obese women than men (PHOF)
- Over 70% of those over the age of 35 are overweight or obese (PHOF)
- Both White and Black British groups have the highest prevalence for being overweight and obese (PHOF)
- Deprivation and obesity are closely linked (PHOF)
- Disabled populations are more likely to be overweight (PHOF)
- Obesity is closely linked to poor mental health (PHOF)
- South Asian , Black and other ethnicities are less likely to achieve 5 portions of fresh fruit and veg a day (PHOF)
- Black British , African-Caribbean and White young people (aged 15) are less likely to consume 5 a day (PHOF)
- Men are less likely than women to eat 5 portions of fresh fruit and veg a day (PHOF)
- LGBT communities (aged 15years) are less likely to eat 5 portions of fresh fruit and veg a day (PHOF)

Physical activity

- 62% of adults are physically active in Bristol
- 25% of adults are inactive
- Asian and Black have the highest prevalence of inactive adults
- Women are much more likely to be inactive than men
- Older adults are more likely to be inactive
- There is a big disparity between disabled and non-disabled
- Deprivation is closely linked with inactivity

Excessive alcohol intake

- 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.
- Alcohol use is sensitive to cultural and socio-economic characteristics that greatly differ across 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.

• 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.

Self-reported wellbeing
Worthwhile Score

- People with fair to poor health status are more likely to have a low worthwhile score
- Unemployed and inactive work groups are more likely to have a low worthwhile score
- Groups between the ages of 45 -59 and 80+have the lowest worthwhile scores
- Men have lower scores than women
- Black , African Caribbean , followed closely by dual heritage and other have the lowest worthwhile scores

Cardiovascular Disease
Under 75 mortality rate - considered preventable

- Closely linked with deprivation
- Men are 3 times more likely to have heart disease
- Some BME Groups have higher rates of CHD (S.Asian) and Hypertension (Stroke) African Caribbean
- People with a diagnosis of Serious Mental Illness (SMI) are twice as likely to die from coronary heart disease
- Rates of hypertension are also high amongst those with SMI
- People with learning disabilities have a higher risk of ischemic heart disease than the general population and this is the
- second most common cause of death in people with learning disabilities
- People with learning disabilities are 58 times more likely to die before the age of 50 than the general population.
- Ex-offenders are more likely to have high rates of CVD

Cancer

- Mortality from lung cancer is higher in women
- Mortality is higher in more deprived areas
- Mortality is high amongst some BME groups for certain cancer types
- Screening uptake is lower amongst BME AND disabled groups
- Prostate cancer is higher amongst afro Caribbean men

- Cancers linked to the gastro-intestinal system are closely linked to deprivation

Respiratory Disease

- People with a diagnosis of Serious Mental Illness (SMI) are four times as likely to die from respiratory disease as the general population
- Respiratory disease and COPD are closely linked to smoking prevalence
- People with learning disabilities are three times more likely to die from respiratory disease
-

Liver Disease

- Closely linked to deprivation
- Higher mortality rates for men

The commissioning strategy for behaviour change should link in with the commissioning arrangements for mental health and substance misuse .

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

Evidence suggests although some population groups with protected characteristics experience the poorest health outcomes, many of these groups are not accessing existing services. Most of the data extracted around these population groups is national as local; data is limited in identifying BAME and many other groups with protected characteristics. Despite equality monitoring being included in existing contracts this data is poorly recorded (or often not recorded at all) which makes it difficult to identify if we are reaching the populations with the poorest health outcomes. Qualitative data is limited and often excludes those communities who do not currently use our services.

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

A Stakeholder event was held on 15th September and a series of focus groups targeting groups with the poorest health outcomes taken to local areas to complement this. The aim is to target specific population groups as described above, to understand their needs and lifestyle behaviours. In addition, a survey was carried out to identify people's perceptions of current services and the opportunities for change.
In addition, behavioural insights work is being undertaken to better understand population clusters.

Step 3: Who might the proposal impact?

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

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

No – this service will be redesigned to specifically support these communities and those with protected characteristics with their health needs in relation to the 44 48 model.
The service is currently delivered through GP and Pharmacies and for some people this is convenient and local. The new service will be embedded in to local communities and work alongside local residents to make sustainable changes which will impact on positive lifestyles and associated health outcomes.

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

The new service will be co-designed and delivered to ensure those population groups with the highest need are the main focus for our services. Resource allocation will need to be weighted towards the population groups with the poorest health outcomes, whilst continuing to offer a modest universal service.
The purpose of the new service is to offer a more holistic approach looking at health and emotional wellbeing that are influenced by the wider determinants of health and wellbeing. We are most likely to achieve this by shifting from a medical model to adopting a community asset based approach.

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

The population groups and areas of deprivation are the main focus on the new service. The intention is to provide services at different levels appropriate to the targeted groups, for example; Help to help yourself (Inform me); Help when you need it (Enable me); Help to live your life (Support me) tiered levels of intervention. This will need to be co- developed alongside local communities and the new service provider (s).

3.4 Can they be maximised? If so, how?

The new service will focus on those with protected characteristics where this is a group for whom these 4 health issues are highest, socio economic factors, BME factors, age factors so the benefits will be maximised.
We are looking to include additional social value to the contract.

Step 4: So what?

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

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

We currently know that there are low levels of access to our services and poorer health outcomes for groups with deprivation and protected characteristics. To date, the focus groups and the survey have shown us that the vast amount of our targeted groups are not aware of existing services and have identified a preference for a less medical approach and a need to have locally based access. It has also been highlighted that people do want to help themselves, but do not always receive the information that they need in an appropriate way. Services need to work for people's lifestyles and be available at times and venues that

suit the needs of local communities and not the service providers. Active involvement by local's communities will develop and maintain trust in areas where this has been lacking in the past. Previous approaches have not had the same focus on protected characteristics (being mostly focused on deprivation), and as a result current services are not appropriate to need. This equality impact assessment has made us more aware of how important it is to scope and understand what community based assets are available, as there will be challenges to people helping themselves if this is absent within their community e.g. availability of fresh fruit and veg, good clear information and signposting to local services has been identified as being a key aspect for people making healthy choices, safer parks and pavements etc

4.2 What actions have been identified going forward?
To ensure that budget allocation is appropriate to level of need and the return on investment. Working in partnership (with existing and new organisations) to develop a commissioning model that will reflect the needs of the targeted audience. To link changes with the wider determinants of health through association with social care, housing, employment and welfare benefits. The importance of emotional health and wellbeing will be a strand running throughout all services. To enable sustainable change and opportunity to access peer support, mutual aid and community based assets to reduce likelihood of relapse.

4.3 How will the impact of your proposal and actions be measured moving forward?
Equality monitoring will be a key specification for all services provided and data used to inform future service improvements. Person reported outcome measures will be a significant measure of wellbeing alongside a tool to measure emotional health and wellbeing pre and post intervention. Ensuring pathways interlink with services addressing health and the wider determinants.

Service Director Sign-Off:	Equalities Officer Sign Off:
Date:	Date:

Appendix E: Communications Strategy

Aim:
Communication relating to the Behaviour Change for Healthy Lifestyle programme is available in straightforward language, and clearly explains the purpose of the new programme.

Objectives:

- Written communication is available in a range of formats for accessibility by service users and employees
- Communication around the programme is effectively managed with the media using the communications team within the City Council
- Opportunities to publicise the programme are maximised
- Corporate standards are observed
- People understand the commissioning intentions and purpose of the programme and have an opportunity to respond

Current Services:
Information relating to current healthy lifestyles services can be found in the following documents:

- Health Needs Assessments on Obesity, Smoking and Health Checks
- JSNA - https://www.bristol.gov.uk/statistics-census-information/new-wards-data-profiles
- Public Health Outcomes Framework - http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000042/pat/6/par/E12000009/ati/102/are/E06000023

A public consultation was carried out through a survey, focus groups and a stakeholder event to identify the wishes of service users in accessing support to change lifestyle behaviours. Outcomes from this public consultation are available in the Market Position Statement.

Commissioning Documents
The following documents will be available to go out to procurement for the Behaviour Change for Healthy Lifestyles programme:

- Market Position Statement
- Equality Impact Assessment
- Commissioning Strategy

These will be available to the public once the commissioning strategy is approved and publicised.

Consultation:
A further consultation period of 12 weeks will commence on publication of the Commissioning Strategy, which will include an opportunity to respond via a website link or attend a stakeholder event. Proposed dates for stakeholder events are:

- Tuesday 28th March – workshops in morning and afternoon

- Community based workshops – mid February to end March

Organisations interested in submitting a tender to provide the service will find documents available on our procurement site – Due North procurement system.

Timeline:

2nd Stakeholder event to test the model, personas, market ability to respond	28th March 2017
Formal consultation of Commissioning Strategy commences (12 weeks)	2nd May 2017
Formal consultation of Commissioning Strategy ends	25th July 2017
Market engagement day	9th May 2017
Publication of final Commissioning Strategy	31st July 2017
Invitation to tender (open process)	4th September 2017
Contract Award	4th December 2017
Current contract extensions expire	31st March 2018
New contract(s) start date	1st April 2018

Appendix F: Priority Population Groups

Main population groups that require this level of support include: Socio-economic groups from quintiles 3,4 & 5 (highest deprivation areas); LGBT; Lone parents; Mental Health; Learning Disabilities; specific BAME groups; ex-offenders and other groups with protected characteristics.

Smoking
Smoking prevalence is currently 18.1% of the population as a whole and. Prevalence is highest amongst populations with the following characteristics:

- Socio-economic status-education, income, employment-31.1% in manual and routine workers
- Gender- Higher rates in men although rates for women have increased over the past 20 years (PHOF)
- Ethnicity Dual heritage populations have the highest prevalence rate of 22.4% (PHOF)
- Lone parenthood (national data)
- Mental health problems- Over 60% of those experiencing poor mental health smoke (national data)
- Youth offenders, prisoners -80% (national data)
- Sexual orientation-lesbian, gay, bisexual (national data)
- Other excluded groups e.g. travellers, homeless (national data)

Most national and local surveys only focus on SES

Diet and Nutrition

- 59% of the Bristol population is overweight and obese (PHOF)
- S. Asian and Afro Caribbean populations are at higher risk of diabetes (type 2)
- Obesity is closely linked to Type 2 Diabetes
- Rates of diabetes are high amongst those with serious mental health issues
- Deprivation is closely linked to less consumption of fruit and veg (PHOF)
- Men are more likely to be overweight than women (PHOF)
- There are more obese women than men (PHOF)
- Over 70% of those over the age of 35 are overweight or obese (PHOF)
- Both White and Black British groups have the highest prevalence for being overweight and obese (PHOF)
- Deprivation and obesity are closely linked (PHOF)
- Disabled populations are more likely to be overweight (PHOF)
- Obesity is closely linked to poor mental health (PHOF)
- South Asian , Black and other ethnicities are less likely to achieve 5 portions of fresh fruit and veg a day (PHOF)
- Black British , African-Caribbean and White young people (aged 15) are less likely to consume 5 a day (PHOF)
- Men are less likely than women to eat 5 portions of fresh fruit and veg a day (PHOF)
- LGBT communities (aged 15years) are less likely to eat 5 portions of fresh fruit and veg a day (PHOF)

Physical activity

- 62% of adults are physically active in Bristol
- 25% of adults are inactive
- Asian and Black have the highest prevalence of inactive adults
- Women are much more likely to be inactive than men
- Older adults are more likely to be inactive
- There is a big disparity between disabled and non-disabled
- Deprivation is closely linked with inactivity

Excessive alcohol intake

- 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.
- Alcohol use is sensitive to cultural and socio-economic characteristics that greatly differ across 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.
    - 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.

Self-reported wellbeing: Worthwhile Score

- People with fair to poor health status are more likely to have a low worthwhile score
- Unemployed and inactive work groups are more likely to have a low worthwhile score
- Groups between the ages of 45 -59 and 80+have the lowest worthwhile scores
- Men have lower scores than women
- Black , African Caribbean , followed closely by dual heritage and other have the lowest worthwhile scores

Cardiovascular Disease

Under 75 mortality rate - considered preventable

- Closely linked with deprivation
- Men are 3 times more likely to have heart disease
- Some BME Groups have higher rates of CHD (S.Asian) and Hypertension (Stroke) African Caribbean

- People with a diagnosis of Serious Mental Illness (SMI) are twice as likely to die from coronary heart disease
- Rates of hypertension are also high amongst those with SMI
- People with learning disabilities have a higher risk of ischemic heart disease than the general population and this is the second most common cause of death in people with learning disabilities
- People with learning disabilities are 58 times more likely to die before the age of 50 than the general population.
- Ex-offenders are more likely to have high rates of CVD

Cancer

- Mortality from lung cancer is higher in women
- Mortality is higher in more deprived areas
- Mortality is high amongst some BME groups for certain cancer types
- Screening uptake is lower amongst BME AND disabled groups
- Prostate cancer is higher amongst afro Caribbean men
- Cancers linked to the gastro-intestinal system are closely linked to deprivation

Respiratory Disease

- People with a diagnosis of Serious Mental Illness (SMI) are four times as likely to die from respiratory disease as the general population
- Respiratory disease and COPD are closely linked to smoking prevalence
- People with learning disabilities are three times more likely to die from respiratory disease

Liver Disease

- Closely linked to deprivation
- Higher mortality rates for men

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Health in All Policies	
Author, including organisation	Katie Porter, Bristol City Council
Date of meeting	12th April 2017
Report for Information/Discussion	

1. Purpose of this Paper

The purpose of this report is to brief the Health and Wellbeing Board about the work Bristol City Council's Public Health Team is engaged with to ensure that the impact of polices and strategies on health is taken into account when they are developed across the city.

2. Executive Summary

Health in All Policies (HiAP) is a systematic approach to embed considerations about health and wellbeing in all relevant strategies and policies by targeting the factors that affect health (the wider determinants of health).

Many council policies impact on health, for instance the provision of green spaces impacts on residents' mental health. The outcome of a HiAP approach will be better health and wellbeing; this will help contribute to local priorities, such as economic growth and community cohesion, and reduce the burden on health and social care in the longer term.

HiAP is built on the engagement of key-players, decision makers and stakeholders. HiAP simultaneously and positively impacts on other important priorities, such as promoting the creation of good-quality jobs, local economic stability, educational attainment and many others priorities. Using a HiAP approach reduces uncoordinated effort and increases effectiveness.

3. Context

Nationally, Public Health England and the Local Government Association have both issued guidance on how to implement HiAP in 2016 (Ref 1, 2).

There are three recommended broad approaches to HiAP, these are:

- focus on specific public health issues (e.g. obesity) and identify policies with major impact
- focus on a key policy area with significant health impacts (e.g.

transport, housing) and work with relevant department/sector
- focus on windows of opportunity that can potentially provide success for all partners.

There are about 60 strategies and policies across Bristol that affect people's health including:

- Mayor's manifesto 'The Bristol Plan'
- Bristol City Council's corporate plan and budget proposals
- Bristol, North Somerset and South Gloucestershire's Sustainability and Transformation Plan
- West of England devolution deal
- Bristol Development Framework Local Plan
- Joint local Transport Plan 3.

By applying the first of the three approaches we can see that there are opportunities for the council and partners to work together on specific public health issues such as reducing obesity. Given that 83% of 15 year olds in Bristol are physically inactive, and 47% do not eat 5 fruit or veg a day there is clearly a need for cross-departmental working to improve the future health prospects of this group (Ref 3).

The second approach could include a review of the Bristol Development Framework Local Plan, to check if a health lens has been applied in Planning.

The third approach, taking windows of opportunities, is being applied to the current budget cuts. The Public Health Team is looking at the proposals and assessing the health impact of relevant cuts to identify mitigating actions that could be taken to reduce any identified health issues.

Examples of the application of HiAP by other councils can be found in appendix 1.

4. Health in All Policies in Bristol

The Director of Public Health Annual Report, 2016, recommends that:

> 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'. (Ref 3)

The report, points out that if the effect of genetics is taken away, a person's health is affected by four main factors:

- Social and economic factors: **40%**
- Health behaviours: **30%**
- Clinical care: **20%**
- The physical environment: **10%**

See appendix 2 for a breakdown on the factors that influence health outcomes.

These determinants drive differences between individuals in the length of life, the length of life lived in good health and the quality of life. The accumulation of detriments to health, such as poor housing, can be seen in areas of deprivation.

Adopting a HiAP approach in Bristol would help us tackle the 10 year life expectancy gap between wards in Bristol, and the 16 year healthy life expectancy gap between the least and most deprived areas of Bristol. People in these deprived areas, not only die early, but before their death live with poor health for longer than people in the least deprived areas.

There are a variety of methods to ensure that health outcomes are considered when developing policies and strategies.

Firstly, to ensure that health impact assessments are carried out on draft policies and strategies. Public Health Team can carry out these assessments and can train others to carry them out. If the health impact assessments are embedded in the processes of the council, for instance having a section on council report templates which relate to these assessments, then the work would become business as usual.

Secondly, to ensure that all upcoming policies and strategies, produced by the council and wider partners, are made known to Public Health. Public Health could then review the drafts and ensure that any resulting health impacts have been taken into account.

Thirdly, to ensure that health equity assessments are carried out if services are commissioned or decommissioned. This would include service redesigns. This method would highlight unequal provision of services which could have specific health impacts in specific areas of the city or groups. Public Health could also encourage commissioners to include terms in the service specifications to promote health, for instance Making Every Contact Count, to ensure service providers do take responsibility for health promotion and early intervention.

There is much good work already existing in Bristol that fits with HiAP. This solid foundation includes for instance; the SHINE (Supporting Healthy Inclusive Neighbourhood Environments) health integration team which is active in policy and advising on the direction of investment in walking provision, transport and producing neighbourhood place-based checklists for healthy urban development, and formerly, the Healthy Urban Team that used a health ‘lens’ and health impact appraisals, and provided the health evidence for 20 miles per hour areas.

The Council Public Health resource supports the Health and Wellbeing Board and other city partnerships to develop strategies and action plans to improve health and reduce inequalities. They also produce evidence of local health needs and ‘what works’ for effective interventions. The team have skills in carrying out health impact assessments and in training others to use health impact assessments. They also support, train and encourage others to make health everybody’s business.

In October 2016, as part of the Healthy Cities Week, the Public Health Team ran a HiAP event where the national Public Health England team launched their new HiAP resources. The event was well attended, amongst others by seven councillors and about 15 BCC service managers. The learning from that event is being used to inform our Bristol approach to HiAP. See appendix 3 for the workshop outcomes.

The council's Public Health Department has looked at a number of council proposals to implement budget cuts through a health lens, has identified the health impact to identified mitigating actions that can be taken to reduce the impact on health.

5. Key risks and Opportunities

Health in all Policies presents an opportunity to make better use of shrinking resources.

6. Implications (Financial and Legal if appropriate).

None.

7. Evidence informing this report.

The Local Government Association and Public Health England have both issued guidance on implementing Health in All Policies in councils (Ref 1, 2).

The World Health Organisation's Helsinki statement calls on all governments, at all levels, to implement health in all polices. They cite many examples of successful policy initiatives to improve health (Ref 4).

8. Conclusions

Many factors have an impact on people's health and wellbeing; these factors include social and economic factors, lifestyles and the physical environment. Policies that are designed to address these factors can be crafted so that they optimise the impact of these policies on health. Ensuring that health outcomes are considered when policies are developed will lead to better health in the population and a resulting reduction in the use of public services.

9. Recommendations

The board is asked to support the implementation of the HiAP approach in Bristol.

9. Appendices

Appendix 1: Examples from other council (Ref 5)

1. **Kirklees:** Economic, health & wellbeing strategy working as one in local government: Healthy people, healthy economy.

Aim
To address health inequalities and support the local economy through transformational system change at a time of decreasing budgets.

Summary
A Health in All Policies approach has enabled a discussion of the role of public health with councillors and of how it could support their portfolio of work. The Kirklees Joint Health & Wellbeing Strategy (JHWS) and Kirklees Economic Strategy (KES) were aligned to take advantage of joint opportunities. The two groups also identified links and areas of congruency – with the principles of health and economy being mutually supportive. Councillors have signed up to the joint vision and outcomes.

This collaborative working ensures that relevant health and economic issues are considered and the joint goals of both strategies are embedded across policy and delivery. It also enables early identification of interdependencies, reduces duplication and provides a focus on identified priorities. Areas of duplication and work that can be linked have been identified through the Q1/Q2 reports for each directorate.

Through joint governance arrangements, input from key leaders and influencers is guaranteed and both organisations are accountable.

The council is being redesigned and restructured to put delivery of economic prosperity and better wellbeing and health at its core. This refocus includes organisational and performance structures, from service delivery plans through to individual appraisals.

Early signs of success
• the Kirklees Local Plan vision and objectives have been jointly developed to reflect how ambitions for personal prosperity and health, together with ambitions for jobs and business growth effect planning for new development
• CCGs are now routinely consulted regarding significant planning applications and how this may impact on health services
• in areas being considered for land development, a methodology has been developed to prioritise for health impact assessment review according to greatest health need.
• guidance for procuring for social value has been produced
• The Health and Wellbeing Board and the Economy & Skills Board are meeting every six months

2. **Wakefield Council**: Developing wellbeing: creating health action plans for services responsible for the wider determinants

Aim
To create a health-promoting council by maximising the health improvement and protecting potential of non-health based council services. To develop public health skills in the wider public health workforce.

Summary
Council services, such as Transport, Housing, Environmental Health, Culture and Economic Development, have an influence on the wider determinants of health. Wakefield's Health Improvement team has a dedicated small team based in the Regeneration Directorate who support these council services in order to protect and promote health and wellbeing.
The team has held workshops with their colleagues in the respective services to develop a shared understanding of how the services impact on health and wellbeing – and identify areas of good practice and opportunities for future development. They have worked together to produce Health Improvement Action Plans for each service detailing current activity and future priorities. These have been signed off by the management teams.
Common features of the plans include using evidence to inform the development of policies/projects, partnerships and information sharing, evaluating impacts of an intervention and training and development. Progress on the plans is monitored and reported back to management teams on a regular basis.

Early outcomes
• Public Health approaches are being used to inform the planning and delivery of policies and plans
• plans developed by the staff have clear lines of accountability – with health and wellbeing at their core

3. **Derbyshire County Council:** Embedding health impact assessment in an equality impact assessment process**.**

Aim
To advance equality of opportunity, eradicate unlawful discrimination and harassment, and promote good community by embedding the systematic consideration of health into Council decision-making.

Summary
As part of its equality impact assessment (EqIA) process, Derbyshire County Council has worked to advance equality of opportunity, eradicate unlawful discrimination and harassment, and promote good community. The transfer of Public Health to local authorities presented an opportunity to extend the process to include the systematic consideration of health. The proposal was led by the Director in Public Health and supported by senior officers and members. The Council has developed and piloted a health impact assessment (HIA) screening tool, which included a consideration of mitigations.

During the pilot (March-June 2015), six Cabinet reports requiring an EIA were submitted. Of these, four had the HIA screening tool completed, including potential reductions to children's centres and the revised specification of the Council's domestic abuse services contract. One further checklist will be completed for the residential provision for older people. A further rapid, prospective, participatory health impact assessment of a major infrastructure development in Chesterfield (value: £21m) has begun. The Council intends to embed HIA screening into all Council EIAs and evaluate the impact of HIA screening.

Early learnings

• embedding HIA screening into Council EqIAs has been welcomed by members and officers and it has been a low-cost process (public health staff time + minimal officer time)

• it has led to full HIAs, which have resulted in recommendations likely to improve health and to mitigate harms to health and increased engagement of affected communities and partner agencies into the decision-making process.

Appendix 2: % contribution of the modifiable determinants of health. *Source: Robert Wood Foundation (2012).* (Ref 6)

Determinant	**%**	**Consisting of**	**%**
Social and economic factors	40	Education	10
		Employment	10
		Income	10
		Family and social support	5
		Community safety	5
Health behaviours	30	Tobacco use	10
		Diet and exercise	10
		Drug & Alcohol use	5
		Sexual health	5
Clinical Care	20	Access to care	10
		Quality of care	10
Physical built environment	10	Environmental quality	5
		Housing & travel	5

Appendix 3: Findings of the Table discussions at the HiAP event

Q1: What opportunities does HiAP offer the city over and above what we are already doing?

- 15 : it offers a better strategic approach to achieve common goals
- 7: it is a better use of public finances
- 3: health is everyone's business
- 3: it leads to better use of the evidence base to inform decisions
- 2: it will help us to evaluate the effect of policies
- 2: it is a way to approach the wider determinants of health
- 1: it is a way to tackle inequalities
- 1: it will help communications between different interest groups.

Q2: How do we take forward Health in All Policies?

Within our own organisations and within the wider partnership?

- 4: provide leadership
- 4: think strategically
- 9: use partnership working
- 12: better communications
- 11: identify shared priorities or themed topics
- 7: make the case for savings
- 5: research your evidence arguments so they are ready to use
- 4: develop communities
- 4: provide training
- 1: use health impact assessments
- 1: Audit of current policies and then prioritise which ones to work on.
- 1: take a whole person approach
- 1: work with commissioners
- 1: top-slice the PH ring-fenced budget to help wider determinants work
- 1: Created a badge award for policies that are health impact checked

Q3: What needs to be in place to do this, for instance structures, resources, information?

- 2: Strategic leadership and buy in
- 1: cross-department outcome measures (these are difficult to write)
- 2: take a HiAP strategic approach to transport and housing
- 1: an evidence base for HiAP
- 2: evidence of cost savings
- 3: audit BCC policies to see where you could make a difference
- 2: a shared digital platform
- 4: communication
- 3: more resources and finance
- 1: Integrate HiAP into Equality impact assessments
- 3: use work placements /secondments/buddying
- 1: put health into job descriptions

- 1: work with commissioning teams
- 2: use front-line workers to influence health

References

1. Public Health England. Local wellbeing, local growth. Adopting Health in All Policies (2016). Available at: https://www.gov.uk/government/publications/local-wellbeing-local-growth-adopting-health-in-all-policies [accessed 16/11/2016]
2. Health in All Policies: a manual for local government (2016). Available at: http://www.local.gov.uk/documents/10180/7632544/1.4+Health+in+ALL+policies_WEB.PDF/b21cf56f-403e-45c4-8a29-2c96df48acdb [accessed on 16/11/2016]
3. Director of Public Health Annual Report 2016. Available at: https://www.bristol.gov.uk/policies-plans-strategies/director-of-public-health-annual-report [accessed 7/11/2016]
4. World Health Organisation. Health in All Policies: Helsinki Statement: Framework for country action (2014). Available at: http://apps.who.int/iris/bitstream/10665/112636/1/9789241506908_eng.pdf?ua=1 [accessed 29/3/2017]
5. Public Health England. Local wellbeing, local growth. Adopting Health in All Policies at a local level: practical examples (2016). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/560593/Health_in_All_Policies_implementation_examples.pdf [accessed 16/11/2016]
6. Robert Wood Foundation and the University of Wisconsin Population Health Institute (2014). County Health Rankings and Roadmaps.

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Healthy Weight Strategic Plan Progress Report	
Author, including organisation	Beth Bennett- Britton –Pubic Health Registrar Sally Hogg – Consultant in Public Health Bristol City Council
Date of meeting	12th April 2017
Report for Information/Discussion	

1. Purpose of this Paper

This paper provides an update for members of the Health and Wellbeing Board on progress in developing a Healthy Weight Strategic Plan for Bristol. It is intended that a draft version of the Strategic Plan will be circulated to the HWB in June and the final version will be approved in October 2017.

2. Context

Healthy Weight is one of the Health and Wellbeing Boards three key priorities that have the potential to reduce health inequalities and improve the long term health of Bristol residents.

Unhealthy diet, and lack of physical activity are contributors to early death (75 or under) through the four main disease groups that cause early death in Bristol are cancers, cardiovascular diseases (heart disease and stroke), respiratory diseases and liver disease. Many of these deaths are considered preventable through known public health interventions such as supporting people to follow healthy lifestyles.

- 57.8% adults are overweight
- 35.4% children are overweight
- 47% adults not eating five portions of fruit or vegetable a day
- 39% physical inactive adults

There is great deal of work already underway in Bristol which contributes to the Healthy Weight agenda. We were awarded Silver Sustainable Food City in 2016 and are the European City of Sport 2017.

Despite this there has, to date been no strategy to ensure activity is joined up and cohesive; driving forwards to improve health and reduce inequalities.

The Public Health team are leading on the development of a Healthy Weight Strategic Plan for Bristol. The initial plan for this work was brought to the Health and Wellbeing Board in December 2016. This report provides an update on progress to date.

3. Main body of the report

Our vision

Our vision for Bristol is for every citizen to have information available to them to make an informed choice and have access to the necessary facilities to enable them to live a healthier lifestyle. By 2022 we want to see the trend in the number of people recorded as being overweight and obese stop rising and start declining.

To achieve this we have done the following:

a) Use of the London branding – The Great Weight Debate

We have collaborated with the Greater London Authority who coordinated the London Great Weight Debate. We are using the same branding for our Great Weight Debate reflecting a consistent message across the country where possible, although our scope is slightly different in that it focuses on the whole population, rather than childhood obesity.

The new branding is:

The Great Weight Debate

a Bristol conversation and action plan towards healthier lifestyles

b) The establishment of The Great Weight Group.

This steering group is responsible for leading the strategic direction of creating a city which promotes and enables healthy weight. It has a remit to lead the development and implementation of the Strategic Plan and will steer the work-programmes of new and existing sub-groups to deliver the Strategic Plan.

The Group is formed of senior leaders bringing relevant expertise and representing organisations across the City. The membership may be expanded as the work programme develops to include broader representation, in particular from sport and physical activity and businesses.

The membership is as follows:

Organisation/department	**Name**
Public Health, BCC	Becky Pollard (chair), Sally Hogg, Jo Williams, Beth Bennett-Britton, Wendy Parker
Health and Wellbeing Board / Cabinet Member	Councillor Asher Craig
Children and Families Board / Bristol CCG	Dr Kirsty Alexander
Planning, BCC	TBC
Regulation (EHOs/TSs), BCC	Nick Carter
Environment (parks, allotments etc.), BCC	Gemma Dando
Education	Head of Schools Partnerships (role starting in May 2017)
NBT, Facilities and Catering	Simon Wood
Chamber of Commerce/WoE LEP	James Durie (associate member) // Steve Ashworth
Academic representative, UWE	Judy Orme
Voluntary sector, VOSCAR	Mark Hubbard
Early Years, BCC	Sally Jaeckle
Sport and Physical Activity, BCC	Guy Fishbourne
Food agenda	Joy Carey
Transport, BCC	Peter Mann
National Diabetes Prevention Programme	John Moore, Practice Nurse and Clinical Lead for NDPP

The establishment of a working group

A working group has been established from members of the Public Health team to provide operational delivery of the Strategic Plan.

c) A first draft of the Strategic Plan

A first draft of the Strategic Plan is currently being considered by the Great Weight Group. A summary of the key aspects of the draft Strategic Plan is provided below for comment by the Health and Wellbeing Board.

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

Therefore, the aim is for this strategic plan to be developed in collaboration with multiple partners, across health, local authority, business, education and child care, sport and recreation, community groups, charities and government agencies. We want these partners to commit to achieving the proposed 18 objectives identified by this strategic plan.

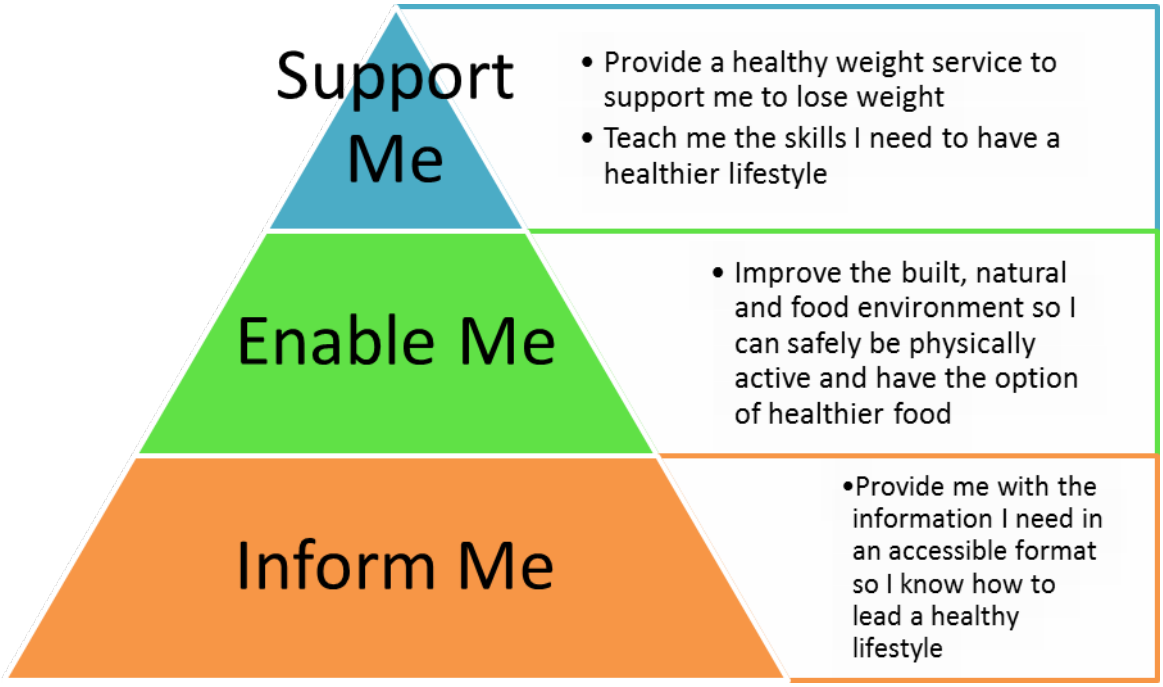
Strategic Objectives
The proposed 17 strategic objectives address the breadth of modifiable factors that contribute to overweight and obesity, from individual behaviour to the built, natural and food environment and social and cultural influences. They have been formed from a review of national guidance published by the Department of Health, Local Government Association, Public Health England, Sport England and the National Institute for Health and Clinical Excellence and in consultation with our partners.

What we aim to do		**How we will do it**
Create an environment which promotes healthy weight	1	Improve the built and natural environment to encourage physical activity.
	2	Improve the food environment to enable people to make informed, healthier choices.
	3	Ensure spatial planning processes support promoting a healthy weight.
	4	Enable and empower workplaces to be competent, confident and effective in promoting healthy weight.
Offer effective support for children and adults who want to lose weight.	5	Provide an evidence based, family focussed service to support children who are overweight.
	6	Provide the tools and support through a behaviour change programme to enable adults who are overweigh / obese to make adjustments to their lifestyles to address their weight..
Give all children the best start in life and address the generational cycle of lifestyle factors in families.	7	Engender healthy lifestyles throughout life with evidence based early intervention during the critical 1001 days of a child's life, from conception to age 2.
	8	Ensure early years, schools and other education settings promote the skills for life required to lead healthy lifestyles.
Address causes that put particular groups at greater risk of obesity.	9	Enable and empower communities to improve individuals and families' relationship with food.
	10	Enable and empower communities to improve individuals and families' physical activity levels.

	11	Make sport and recreational clubs and groups are inclusive and accessible to all.
	12	Ensure interventions are targeted towards and accessible to vulnerable groups at highest risk of overweight.
Build local knowledge and partnerships to effectively implement changes	13	Develop a comprehensive healthy weight strategic plan which is led by the Health and Wellbeing Board and owned by a partnership of stakeholders across the City.
	14	Establish a network of stakeholders to deliver the healthy weight strategic plan for Bristol.
	15	Develop training programmes to ensure professionals are aware of the causes and support available to people to maintain a healthy weight, linking with the Making Every Contact Count programme.
Influence the regional and national agenda to promote healthy weight	16	Work with Public Health England, the West of England Partnership and across our STP footprint to develop consistent messages and approaches to promote healthy weight.
	17	Influence the national agenda to implement evidence based policy to promote healthy weight.

Approach to achieving the Strategic Objectives

Different people will require different approaches to achieving or maintaining a healthy weight. The majority of people will only require the information on what constitutes a healthy lifestyle to achieve this goal. Others will require enablers such as changes to their environment. A smaller group will require more face to face support to get them into a position where they are able to take action and make healthier lifestyle choices. This model, described in Figure 2, will be used to design the approach we take to achieving our strategic objectives.



d) Webpage

We have a new webpage on the Bristol City Council site which will host up to date information about the progress of our Strategic Plan and how people can get involved - https://www.bristol.gov.uk/social-care-health/get-involved-in-the-great-weight-debate.

e) Event

We are hosting our Great Weight Debate, a partnership event on 23rd May, 9.30-2pm, the Conference Hall, City Hall. This will be an opportunity to consult on our Strategic Plan and start to develop our Action Plan.

We will also be launching the Bristol Eating Better Award and be promoting the Sugar Smart campaign and European City of Sport amongst other initiatives.

4. Next Steps

A draft Strategic Plan will be presented to the HWB for comment in June.

A three month public consultation will commence from July to September 2017 and the intention will be bring the final version of the Strategic Plan to the Health and Wellbeing Board in October 2017.

5. Evidence informing this report.

The Strategic Plan has been informed by Bristol's Joint Strategic Needs Assessment.

6. Recommendations

The Board is asked to comment on the progress to date and next steps in the development of the Strategic Plan.

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Pharmaceutical Needs Assessment	
Author, including organisation	Barbara Coleman, Bristol City Council
Date of meeting	12th April 2017
Report for Information	

1. Purpose of this Paper

The purpose of this paper is to advise the Health and Wellbeing Board of the need to update the Pharmaceutical Needs Assessment (last produced Feb 2015), and update on progress so far.

2. Context

Production of a Pharmaceutical Needs Assessment (PNA) is a statutory duty that transferred to the local authority under the Health and Social Care Act 2012. The current PNA was published in February 2015 and can be accessed through the link below.

https://www.bristol.gov.uk/documents/20182/35028/Bristol%20PNA%20February%202015.pdf/13b04b16-5b3b-4cb9-be83-01c149a183bf

The statutory requirement is to update every three years which means we need to refresh by March 2018. Production of the PNA necessitates some significant steps, including a minimum 60 day consultation period, so it is prudent that early planning takes place.

3. Purpose and content of the PNA

The PNA is primarily to inform the process of market entry for pharmaceutical providers (which NHS England must approve) although it is not bound by any content. The NHS Litigation Authority's Family Health Services Appeal Unit will refer to the PNA when hearing appeals of NHS England's decisions. The

courts may refer to the PNA as part of a judicial review. The content sets out the location of, and services provided by, Bristol's community pharmacies. It assesses whether these services match the patterns of need based on the JSNA. It also assesses likely future trends in population, and whether additional services may be required to meet needs within the three year period of the PNA.

4. Progress so far

A PNA Stakeholder Group has been set up to include appropriate membership from across Bristol, North Somerset, South Gloucestershire and Somerset to oversee the process, agree a common approach to the layout and content of the PNA and to share resources where appropriate. This group mirrors the footprint of NHSE, who will be the primary user of the PNA as described above. The group includes membership from all four local authorities, NHSE, the Local Pharmaceutical Committee (LPC), The Clinical Commissioning Group (CCG) and Public Health England (PHE). A working group has also been set up to take the work forward.

The latest data available in the Joint Strategic Needs Assessment will be used to inform the production of the PNA and Avon Local Pharmaceutical Committee have agreed to provide data on all of the services provided by local pharmacies across BNSSG and details of opening days / times. Our local intelligence teams will provide mapping to demonstrate the accessibility of current pharmacy locations.

5. Key risks and Opportunities

A number of issues will have arisen in the last three years which need to be taken into account in the revision of the PNA as follows:-

- The NHS 5 Year Forward View, and the BNSSG Sustainable Transformation Plan, proposes increasing the importance of prevention and self-management of conditions, which is likely to give pharmacies a larger role in the 'health economy'
- The Department of Health has introduced a new contract for community pharmacies which will reduce the funding available for pharmacies and may result in reduced numbers of pharmacies in the future. This needs to be acknowledged in the PNA where issues are likely to arise. The new contractual arrangements can be viewed here:-

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf

- New and future housing developments in the area where significant increases in populations will have an effect on the access requirements for primary care services, of which, pharmacies is one.

6. Implications (Financial and Legal if appropriate)

A small budget has been identified to take the work forward. This will be funded from the Public Health Ring-fenced Grant. The production of a PNA is a statutory duty for the Health and Wellbeing Board and will require full consultation with the public.

7. Recommendations

The Health & Wellbeing Board is asked to note that the production of the updated PNA is underway and to participate in the consultation.

9. Appendices

None

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

SEND reforms	
Author, including organisation	Michele Farmer
Date of meeting	12th April 2017
Report for Information	

1. Purpose of this Paper

To provide an overview of the

- statutory duties for the Local Area with regard children, young people with Special Educational Needs and Disability (SEND) and their families as required through the Children and Families Act 2014,known as the **SEND reforms**
- update on self- evaluation and progress of SEND reforms
- raise awareness of the Local area inspection framework

2. Executive Summary

In 2014 a key piece of legislation was implemented which had fundamental impact on the way that services are provided for children and young people with SEND and their families.

These reforms sought a ***Cultural Change*** with emphasis on improved lifetime outcomes for SEND children, young adults and their families through integrated, personalised ,early support approaches focussing on preparing for adulthood. The expectation is that the services provided will be jointly developed and commissioned with young people and their families.

In order to achieve this every area must publish a local offer in each area setting out the education, health and care provision the local authority expects to be available for local children and young people who are disabled or have special educational needs. This includes support in preparing for adult life.

The “Local Area” includes all education settings, health, social care and wider partners including parent carer and young people.

3. Context

Local Area agencies and partners all have a **duty to co-operate** with SEND reforms introduced through the Children and Families Act 2014 and through the Code of Practice 2015 and this includes preparations for inspection.

The Local Area has been restructuring and reviewing governance, systems and provisions since 2014 through the SEND Improvement and development plan 2015-2017, the development of the SEND partnership Board which reports to the Childrens and Families Board .Self- evaluation is ongoing and progress and identified strengths are the development of a Birth to 25 Collaboration across education, health and social care, co-production with parents has improved, timeliness and quality of education, health and care plans is improving, the Local Offer site *Findability* www.findabilitybristol.org.uk is available and up to date and joint commissioning continues to develop.

Logistical preparation for inspection is progressing with monthly briefings being sent across the partners and Findability. Attached Appendix i.

4. Main body of the report

The Children and Families partnership have outlined their SEND vision as part of their wider Children, young people and Families strategy. The SEND vision is;

Children and young people with special educational needs and disabilities in Bristol are given the best possible help towards a healthy, independent and fulfilling life. Working in partnership across organisational boundaries and with families we identify, support and empower those who need it most

There are 4 overarching strategic priorities, they are improving outcomes for children and young people with SEND, preparing for Adulthood, person centred planning and a seamless Multi-Agency Offer

The Local Area has recently undertaken a deep dive self- evaluation using Council Disabled children's tool with the Clinical commissioning group, local authority and wider partners including parent forums and support services, evidence from the first parental and young people survey and a review of the 2015-2017 SEND improvement and development plan. This will form the new SEND improvement and development plan 2017-2019.

Broad areas for developments and included within the 2017-2019 SEND improvement and development

- Improving collection and use of joint data to inform strategic co-production and supporting alignment of different processes and measuring outcomes collectively
- Further developing links between governance boards and groups
- Pathway development to ensure children and young people will have same strategic reach as Parent Carer Forum's
- Continued focus to improve consistency across EHCPs and partners providing advice
- Further aligning SEN Support and early intervention through a graduated approach

5. Key risks and Opportunities

Ofsted and CQC are now inspecting progress against the implementation of the SEND Reforms and are inspecting Local Areas in a 5 day inspection. Inspection considers the Local areas' ***effectiveness*** in ***identifying***, ***meeting the needs*** and ***improving the outcomes*** of children and young people who have special educational needs and/or disabilities against new duties under Children and Families Act 2014.

6. Evidence informing this report.

The Local Area has recently undertaken a deep dive self- evalution using Council Disabled children's tool with the Clinical commissioning group, local authority and wider partners including parent forums and support services, evidence from the first parental and young people survey and a review of the 2015-2017 SEND improvement and development plan. This will form the new SEND improvement and development plan 2017-2019.

7. Recommendations

HWB take note of the progress by the Local Area on the implementation of the SEND reforms and note the development of a new improvement and development plan 2017-2019.

8. Appendices

None

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

European City of Sport	
Author, including organisation	Guy Fishbourne / Bristol City Council
Date of meeting	12th April 2017
Report for Information	

1. Purpose of this Paper

1. To provide information on European City of Sport 2017.

2. Executive Summary

1. The European City of Sport title is awarded by ACES Europe, a not-for-profit group based in Brussels who promote sport across Europe. Cities are judged on their sporting facilities, residents' level of participation, the success of local teams and sporting events. Bristol is one of fifteen European cities to be awarded the title, which is announced annually.There is no funding attached to this award, but we will be working with existing partners to maximise any available resources.
2. Cities in receipt of the award were judged on their sporting facilities, residents' level of participation, the success of local teams and sporting events.
3. The year will mark a celebration of the part sport and physical activity plays in every aspect of life across Bristol's many and diverse communities.
4. The year is officially sponsored by Bristol Sport, The Gloucestershire Cricket Club, Everyone Active and Parkwood Community Leisure.
5. Our overall participation rates in sport and physical activity are amongst the highest of all major cities in England. However, participation levels vary widely across our communities. Some groups are much less active than others and a large proportion of our population remains inactive.
6. During the year we will illustrate the programme of events happening across Bristol which will include, the ICC Women's Cricket World Cup, with the Bristol County Ground, home to Gloucestershire County Cricket Club, one of five venues to host the global competition.

7. European City of Sport will bring together the best of what the city is already doing to support and celebrate sport and physical activity. Subject to resource being available, additional events will be planned along with the 'Are You Game' campaign being planned for the summer.
8. Across Bristol there are already a wide array of groups and organisations involved in delivering sports to local people and communities, and the aim is for everyone to work together throughout the year to highlight opportunities for everyone to get involved.
9. We want to build on the passion and enthusiasm of individuals and local sporting organisations to help raise the profile of sport and physical activity across the city - from the grass roots community clubs right through to our elite sportsmen and women.

10. We want to celebrate the role that sport places in our city, to promote healthy lifestyles and encourage people to be more active."

11. 39% of adults do not do enough physical activity, taking less than 150 minutes moderate or 75 minutes vigorous exercise each week. 83% of 15 years olds do not do enough physical activity each day, taking less than 60 minutes exercise a day and less than 3 days a week muscle and bone strength-building exercise like running, jumping and push-ups. 57% of adults are obese or overweight.

12. We hope that being a City of Sport will help begin to address this and inspire people to try something new.

3. Context

1. The European City of Sport is a title which is awarded by ACES Europe, a not-for-profit organisation based in Brussels who promote sport across Europe, acknowledging that sport has the power to unite communities and contribute towards many outcomes. Outcomes such as those highlighted in the new Sport England strategy, which include physical well being, mental well being, individual development, social & community development and economic development.

2. Bristol takes over from Stoke-on-Trent which held the UK title last year. Bristol is one of 15 cities to be awarded the title for 2017.

3. The accolade is awarded without any funding.

4. The title was bid for by the former independent sports partnership which had been set up by the former Mayor George Ferguson. It was the Independent Sports Partnership who was going to lead Bristol's European City of Sport year but after it was disbanded in late October 2016 this responsibility became that of the Council's in November 2016. A small steering group has been set up to help deliver the year.

5. The year is officially sponsored by Bristol Sport, The Gloucestershire Cricket Club, Everyone Active and Parkwood Community Leisure.

Why did Bristol win the title?

1. Cities are judged on their sporting facilities, residents' level of participation, the success of local teams and sporting events.

2. Bristol has a good stock of sports facilities. At the elite level we have the fantastically redeveloped Ashton Gate Stadium. The Gloucestershire Cricket ground which will be hosting the Women's Cricket World Cup this year and the Memorial Ground home to Bristol Rovers.

3. We have the new 50 meter Olympic size swimming pool, 150 station gym, sports hall, climbing wall and healthy living zone at the new Hengrove Leisure Centre. A facility which was built to spearhead the regeneration of South Bristol, and address some of the health inequalities which exist between different parts of the City.

4. We have a fantastic floodlit 6 lane athletics track at Whitehall in Central Bristol and the floodlit eight lane AAA accredited competitions athletics facility at the WISE campus in Filton.

5. The City of Bristol Gymnastics Centre located in Hartcliffe, the indoor tennis centre at Coombe Dingle, numerous climbing centres, an indoor bowls centre and half a dozen water sport facilities.

6. In addition, our schools have seen considerable investment over the past 15 years and now have some great dual use sports facilities which are used by their pupils and the community alike.

7. In total there are 222 individual indoor and outdoor sports facilities in the Bristol urban area:

    - 3 stadia, with total capacity of approximately 50,000 spectators
    - 10 cycle and wheel parks
    - 2 athletics tracks and arenas
    - 4 golf courses
    - 3 gymnastics centres
    - 40 health & fitness centres
    - 1 indoor bowls club
    - 3 indoor tennis centres
    - 19 multi-use games areas (MUGAs)
    - 25 outdoor bowls greens
    - 42 outdoor tennis facilities
    - 37 sports halls
    - 10 squash centres
    - 21 swimming pools
    - 6 watersports facilities

8. Despite all of this, we know there are still some gaps in provision and during this year of sport we are updating our needs assessment to inform the development of a new built sports facility strategy where we will evidence the strategic need for new facility provision and work hard with partners to secure funding in order to address these needs as best we can.

9. Bristol is amongst the highest of all major cities in England for overall participation rates in sport and physical activity; however this varies widely across our communities. Some groups are much less active than others and a large part of our population stays inactive, most of us could and should do more. In some areas of Bristol 4 out of 5 adults are physically inactive.

10. In addition to these facilities we have over 500 outdoor sports pitches, where over 1100 affiliated teams play their football week in week out, not to mention all of the cricket clubs, rugby clubs and Hockey Clubs playing across the city's pitches:

    - 173 adult football pitches
    - 22 artificial rubber-based pitches
    - 27 artificial sand-based pitches
    - 2 artificial water-based pitches
    - 15 artificial cricket wickets
    - 48 cricket pitches
    - 70 junior football pitches (mini)
    - 55 junior football pitches (youth)
    - 4 junior rugby pitches
    - 82 adult rugby pitches

11. Alongside this we have a great events calendar which includes such events as the Great Bristol 10k the Great Bristol Half, mass participation bike rides, triathlon events, last year the Tour of Britain, this year a European Urban Orienteering Championships, the cycling Grand Prix and this year host to the Women's Cricket World Cup to name but a few.

12. These are all great foundations for Bristol to be a successful city of sport and physical activity where people are healthy and motivated to participate for life but we do need to make sure that sport & physical activity is inclusive and accessible to all.

13. People are proud to live in Bristol and passionate about its potential to become one of the very best cities in Europe. Partners are working together to make Bristol a better city for all and partners must work together to make sport & physical activity inclusive and accessible for all.

What is the significance of this award?

1. Bristol is amongst the highest of all major cities in England for overall participation rates in sport and physical activity; however this varies widely across our communities. Some groups are much less active than others and a large part of our population stays inactive, most of us could and should do more. In some areas of Bristol 4 out of 5 adults are physically inactive.

2. As an example:

    a) The government recommendation for children from birth to five years is to aim for three hours every day of physical activity.

3. Only around one in ten children aged two to four years meets this government recommendation.

    b) The government recommendation for children aged five to eighteen is for 60 minutes of physical activity everyday including muscle and bone strengthening activities three times a week.

4. Only 1 in 5 boys and 1 in 6 girls aged 5 to 15 achieve these guidelines.

5. 83% of 15 years olds do not do enough physical activity each day.

6. Lord Sebastian Coe, Chairman of the London Olympic Games Commission stated in 2012 that today's children are the "least active generation in history" and could be the first generation in existence to have a shorter life expectancy than that of their parents.

    c) The government recommendation for adults is to do 75 minutes of vigorous physical activity or 150 minutes of moderate physical activity each week or a combination of both and muscle and bone strengthening activities two days a week.

7. In accordance with these guidelines, 39% of adults do not do enough physical activity.

8. Although people in Bristol are living longer, life expectancy varies considerably across Bristol with over 10 year's difference between the wealthiest and most deprived wards. Being active contributes hugely to our health and well-being and our life expectancy. We must encourage more people to be physically active.

What does European City of Sport mean for Bristol?

9. We hope this title will help harness the enthusiasm of individuals, partners and local sporting organisations and help raise the profile of

sport and physical activity in order to contribute towards increasing participation.

10. Being a European City of Sport is an exciting opportunity for Bristol. We want to use this status to help celebrate the role that sport plays in our city, to promote healthy lifestyles and encourage people to be more active.

11. We hope that being a European City of Sport will help begin to address some of the issues highlighted above, and inspire people to try something new.

12. Regardless of whom you are your age, shape or ability or where you live, there is and must be something for everyone and we need to ensure that everyone is able to take part and knows how to get involved. If they can't we need to understand why and help people change this.

13. There is no funding attached to the European City of Sport award, however, across Bristol there are lots of groups and organisations involved in delivering sports to local people and communities – from the grassroots to the elite clubs - so we will be working with and encouraging as many different partners throughout the year to highlight opportunities for people to get involved.

5. Key risks and Opportunities

Opportunities

1. The opportunity to engage and harness the enthusiasm of key partners involved in the delivery of sport and physical activity ie Mayoral Sports Gatherings.

2. The opportunity to bring together the best of what the city is already doing to support and celebrate sport with additional events and campaign during 2017.

3. Opportunities to engage and focus on underrepresented groups by promoting available opportunities and using sports ambassadors to inspire behaviour change.

4. The opportunity to create a new social media platform and website for European City of Sport 2017 in order to illustrate and highlight opportunities for people to get involved.

5. The year provides a platform to engage and work with Sport England and National Governing Bodies for Sport (NGBs) with a view to securing support for inward investment.

Risks

1. Not enough time to organise year.

2. Messages and communications related to sport and physical activity must be carefully managed during 2017.

3. Stakeholder / partner and public expectations must be carefully managed.

4. Stakeholders/partners do not engage

5. Risk that European City of Sport 2017 is not understood to include all physical activity opportunities beyond that of traditional sport.

6. Risk that opportunities either do not exist or are not identified in key geographic areas.