# Health and Wellbeing Board
## (Extraordinary meeting)
## Agenda

**Date:** Thursday, 14 September 2017

**Time:** 2.00 pm

**Venue:** Meeting room, floor 1, City Hall, College Green, Bristol, BS1 5TR

**Distribution:**

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

**Issued by:** Claudette Campbell, Democratic Services
Tel: 0117 92 22342
E-mail: democratic.services@bristol.gov.uk
**Date:** Wednesday, 6 September 2017

# Agenda

**1. Welcome, apologies and introductions** **2.00 pm**

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

**Written questions (must be about items on the agenda):**
Written questions may be submitted in advance of the meeting by a member of the public or a member of Council. These must be about items on the agenda for this meeting. A maximum of 2 written questions per individual can be submitted. The deadline for receipt of questions for the 14 September Health and Wellbeing Board is **5.00 pm on Friday 8 September.** These should be emailed to democratic.services@bristol.gov.uk
Please note: wherever possible (bearing in mind the limited time available in advance of the meeting for the preparation of replies), a written reply will be provided to a question at the meeting, and the questioner will then receive an opportunity to ask one supplementary oral question per question submitted.

**Petitions and written statements (must be about items on the agenda):**
Members of the public and members of the Council may submit a petition or submit a written statement to the Health and Wellbeing Board. These must be about items on the agenda for this meeting.
The deadline for receipt of petitions and statements for the 14 September Health and Wellbeing Board is **12.00 noon on Wednesday 13 September.**
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.

**3. Declarations of interest**

**4. Key decision - Bristol Behaviour Change for Healthier Lifestyles Programme** **2.05 pm**

**(Pages 4 - 119)**

**5. Information item - Pharmaceutical Needs Assessment update** **2.25 pm**

**(Pages 120 - 121)**

## Key Decision – Health & Wellbeing Board – 14 September 2017

| | |
|---|---|
| **Title: Bristol Behaviour Change for Healthier Lifestyles Programme** | |
| **Ward: All** | **Cabinet lead: Cllr Asher Craig** |
| **Author: Sally Hogg / Viv Harrison** | **Job title: Consultants in Public Health** |

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| **Revenue Cost:** £4,755,518 (over 3 years) | **Source of Revenue Funding:** Public Health Ring-fence grant |
| **Capital Cost:** N/A | **Source of Capital Funding:** N/A |
| **One off** ☒ | **Saving** ☒ |
| **Ongoing** ☐ | **Income generation** ☐ |

**Finance narrative:** This report sets out Public Health's strategy to commission and procure a new contract to deliver changes to the lifestyle behaviours of Bristol residents.

This is intended to be a 3 year contract effective from 1/4/18-31/3/21. Procurement of the current relevant services represents an annual expenditure budget (17/18) of £1,864,909 (composition as detailed in section 4.1). This is paid for from the ring-fenced Public Health grant. The total annual cost of the proposed contract is planned to be £1,585,173 which will represent a 15%/£0.279m saving per annum. This £0.279m saving will contribute to the anticipated ongoing annual reductions to Public Health's grant funded budget envelope.

Bidding providers will be required to consider the TUPE implications when developing their proposals and budgets in response to BCC's invitation to tender.

**Finance Officer:** Jemma Prince; 14th August 2017

**Summary of issue / proposal:**
The purpose of this paper is to update on progress with the planned procurement of the Behaviour Change for Healthier Lifestyles Programme.

**Summary of proposal & options appraisal:**
See commissioning strategy and lotting options appraisal (appended)

**Recommendation(s) / steer sought:**

- Seek permission to issue an invitation to tender in September 2017.

**City Outcome:**
To improve the health and wellbeing of Bristol residents and reduce health inequalities through prevention and early intervention.

**Health Outcome summary:**
To reduce the prevalence of unhealthy lifestyle behaviours specifically smoking; poor diet; alcohol; physical inactivity, that contribute to ill-health and premature death through cancers, cardiovascular disease, respiratory disease and liver disease.

**Sustainability Outcome summary:**
To deliver a whole systems approach that improves lifestyle behaviour through building on community assets which focusses on families and local communities.

**Equalities Outcome summary:**
To deliver an approach that uses the principle of proportionate universalism and targets resources to where health outcomes are poorest.

**Impact / Involvement of partners:**
A series of consultation events have been held including a range of key stakeholders, alongside focus groups targeting population groups who are less likely to engage.
A representative from Voscur has been a member of the Steering Group.

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| Voscur and The Care Forum/Health Watch will be represented on the evaluation panel subject to them not tendering for the programme. |
| **Consultation carried out:**<br>Full consultation held from 9th May to 1st August 2017.<br>NLT: 29th March 2017; 9th August 2017<br>SLT: 4th April 2017; 29th August 2017<br>Cabinet Member briefing: 23rd March 2017; 10th August 2017; Cabinet Member is also a representative on the Steering Group<br>Mayor's briefing: Monday 14th August 2017 |

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| **Legal Issues:**<br>A simple one stage tender process shall be used for this light touch procurement exercise. Provided the Council procures the Service in accordance with Regulation 18 of the Public Contract Regulations 2015 (i.e. the Council treats all potential bidders equally, does not discriminate against any potential bidders, acts transparently and proportionately, and does not unduly favour or disfavour any potential bidder) the risk of a challenge should be low. The Specification will need to be drafted to ensure that the staff providing services that shall be TUPE transferred to the new Service provider, are clearly identified. |
| **Legal Officer:** Eileen Walters |

| **DLT sign-off** | **SLT sign-off** | **Cabinet Member sign-off** |
|---|---|---|
| Alison Comley 09/08/2017 | 29th August 2017 | Cllr Asher Craig 22/08/2017 |

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| Appendix A – Further essential background / detail on the proposal | **YES**<br>**Commissioning Strategy**<br>**Lotting Options Appraisal**<br>**Service Specification** |
| Appendix B – Details of consultation carried out - internal and external | **YES**<br>**Consultation results** |
| Appendix C – Summary of any engagement with scrutiny | **NO** |
| Appendix D – Risk assessment | **NO** |
| Appendix E – Equalities screening / impact assessment of proposal | **YES**<br>**Included in Commissioning Strategy** |
| Appendix F – Eco-impact screening/ impact assessment of proposal | **NO** |
| Appendix G – Exempt Information | **NO** |

# Bristol Behaviour Change for Healthier Lifestyles Programme

# Final Commissioning Strategy 2017

# Contents

# 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.

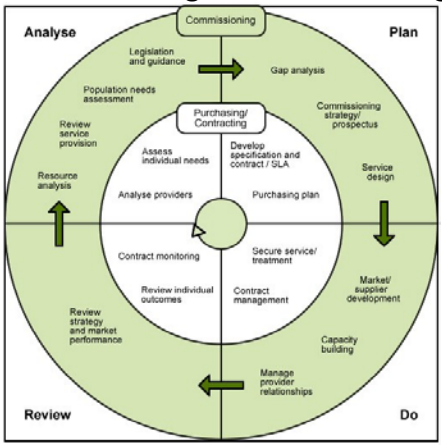
It outlines the development of a new behaviour change model for healthier lifestyles, to meet the needs of people in the city who wish to change their lifestyle behaviour, acknowledging that people live within communities and as part of their family. It will address the key lifestyle factors of smoking, 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 financial 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 Bristol City Council's Enabling Commissioning Framework (Fig.1). This is the agreed four stage commissioning cycle that has been adapted from the Institute for Public Care Joint Commissioning Model for public care. The 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 provides additional information in relation to the specific commissioning activity of a Behaviour Change for Healthier Lifestyles Programme and is intended for use by a range of stakeholders in order to develop a collaborative 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 lifestyles.

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.

Other additional factors were considered during the discussion period including:

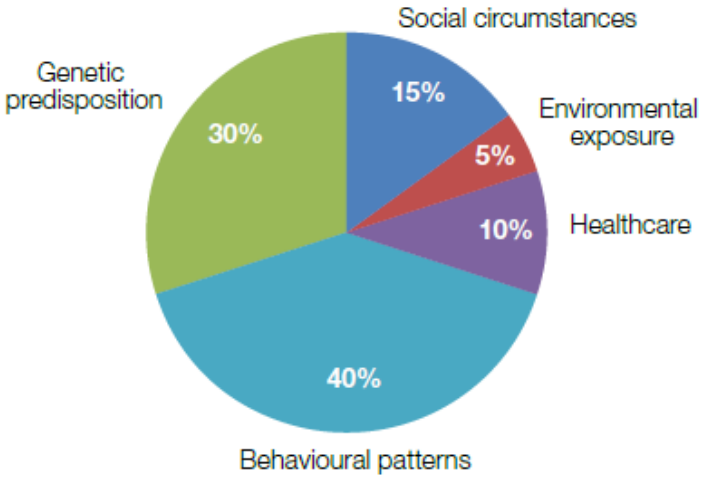
- Expected reductions in levels of funding. The Council has consulted on a proposed Corporate Strategy for 2017-2025 which aims to make £92m savings. This is required due to changes in Government funding and increasing demands for services. The Council will have to look at all areas of spend, including 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 View (2014).
- The robust international, national and local evidence about supporting people to make lifestyle changes (NICE, 2014).
- 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 (Public Health England, 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 wider /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 (2014) 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 the corporate plan outlines the way Bristol City Council will conduct its business in the future, including:

- 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 need 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 the following three areas, which 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 will focus 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 Programme 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**

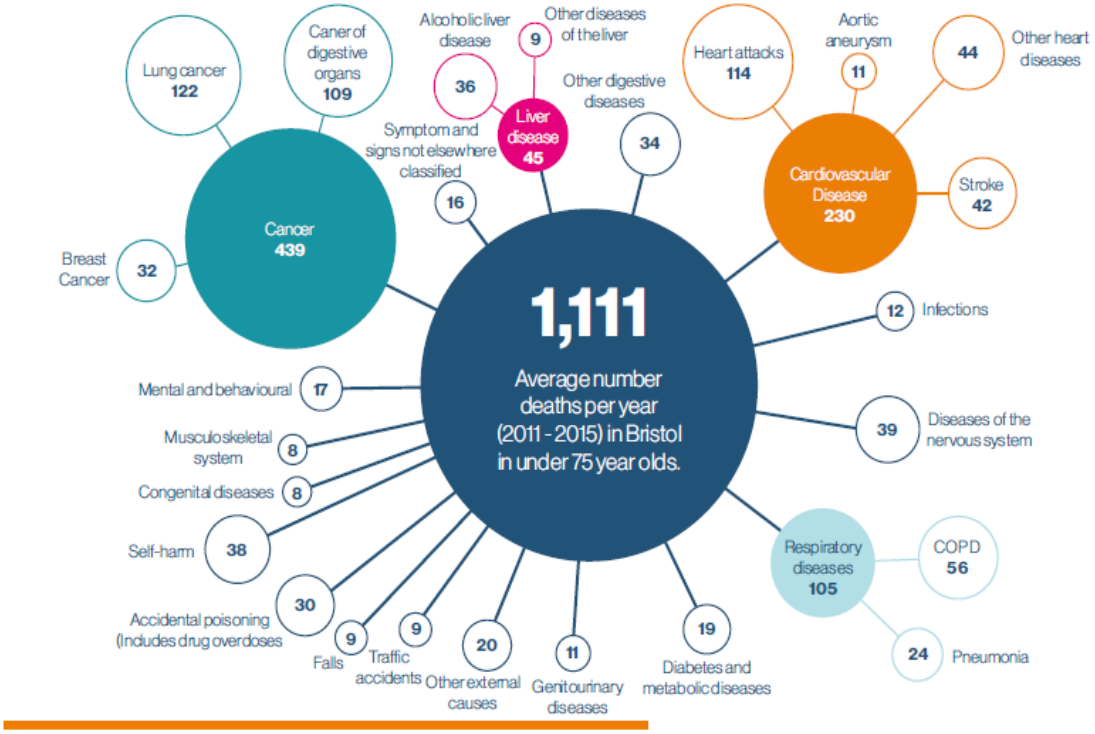



Figure 6: Main causes of premature death in Bristol (average per year 2011 - 15). *Source: calculated by Bristol Public Health Knowledge Service using ONS mortality data.*

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 (APHR, 2016).

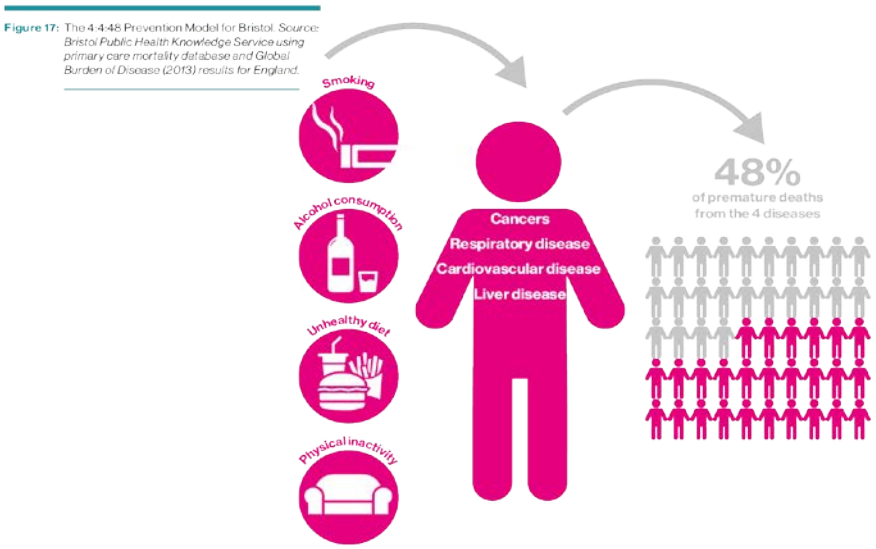
In addition, the burden of ill-health is not distributed equally, with people from more disadvantaged backgrounds developing long term conditions about ten years earlier than those from more affluent backgrounds. Tackling inequalities through targeted prevention, intervening early when risks are identified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

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.

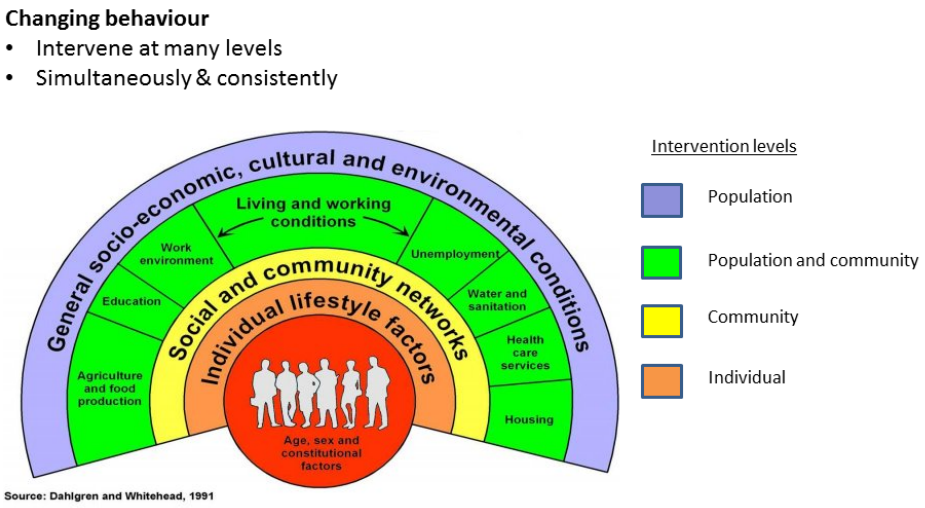
**Individual-level** interventions aimed at changing health-damaging behaviours are complemented by interventions at a **population, community and organisational** level, such as campaigns for raising awareness and prompting behaviour change.

Making Every Contact Count (HEE, 2016) is an approach to behaviour change that utilises the many day to day interactions that organisations and individuals have with other people in order to support them to make positive changes to their physical and mental health and wellbeing. It encourages opportunistic concise healthy lifestyle information which enables people 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)

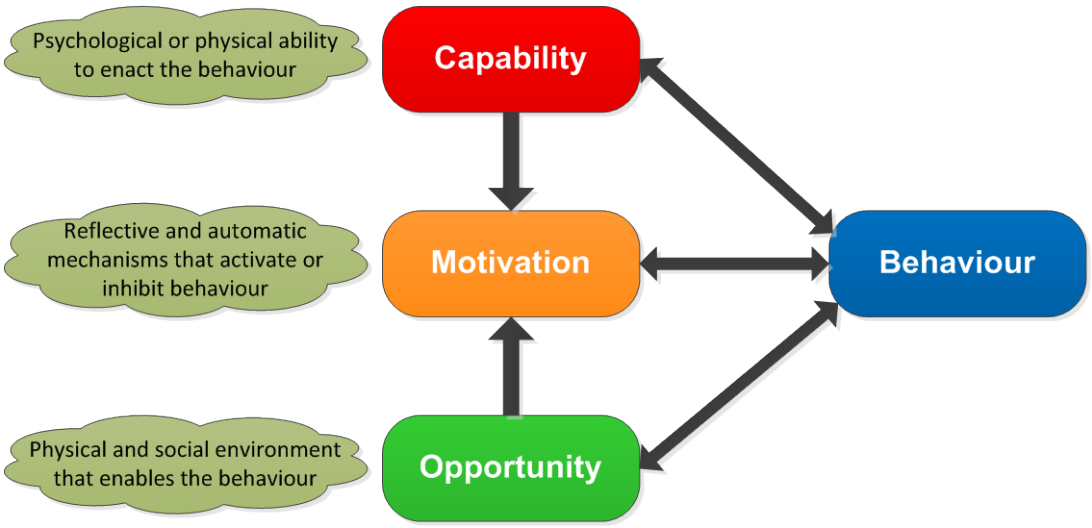
Changing behaviour requires intervening at many levels. It takes into account the determinants of health – where people live, work and play.

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 Lifestyles 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 (2 to 18 years), taking a family approach where appropriate and linking with the National Childhood Measurement Programme (NCMP) 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 that is appropriate for them, 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 individual 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 (see Appendix A), 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.

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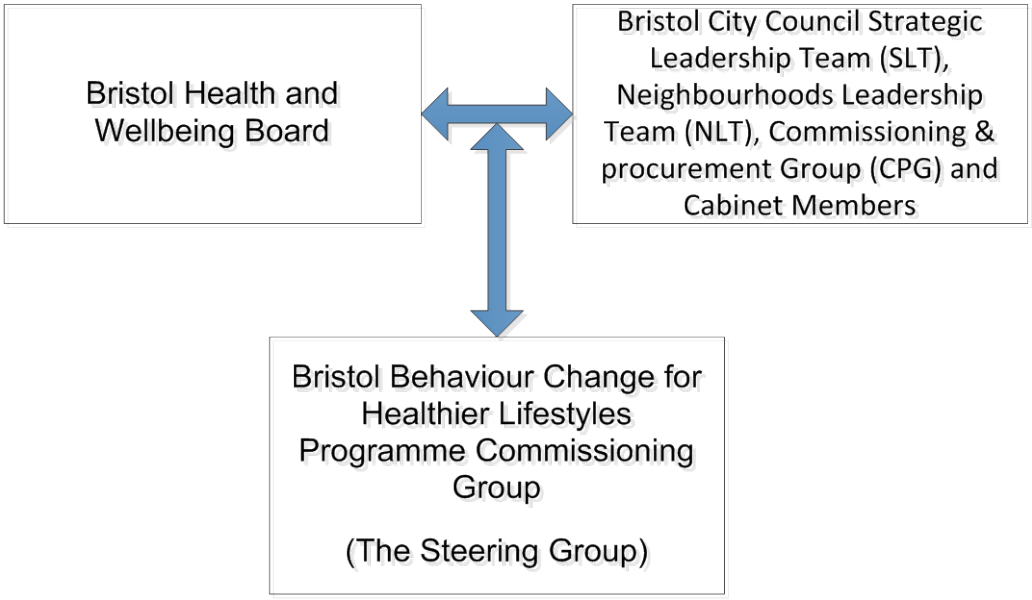
|---|---|
| 211,259 (57.8%) | Overweight adults |
| 85,367 (19%) | Adults who smoke |
| 142,545 (39%) | Physically inactive adults |
| 69,445 (28%) | Adults drinking at harmful levels |
| 29,665 (35.4%) | Children and young people who are overweight |

## 1.3 Governance and Decision Making

The Bristol Behaviour Change for Healthier Lifestyles 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 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 includes members from Bristol City Council public health team, equality and cohesion officer, commissioning and procurement Officer, substance misuse commissioner, the Head of Collaboration and Commissioning from VOSCUR 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 Deputy Mayor 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 Lifestyles Programme for Bristol is outlined below. We have:

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| **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?<br>• 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 early years/children versus an integrated approach.<br>• Considered what people need to support them change their lifestyle related behaviours.<br>• Considered the implications for a wider geographical footprint, including the Sustainability Transformation Plan (STP).<br>• Considered the financial implications and context.<br>• Considered BCC Corporate Strategy. |
| **Applying the evidence** | • Reviewed the international, national and local evidence for lifestyle services and behaviour change approaches.<br>• Reviewed the implications of findings in the Gap Analyses/Health Needs Assessments.<br>• Considered the best commissioning and procurement approaches that are suitable for this innovative approach.<br>• Reviewed how other local authorities and organisations are providing lifestyle services to their population, and lessons learnt. |

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| **Consultation** | We have shared our high level intentions with<br>• Cabinet Member for Health and Wellbeing<br>• Bristol City Council Neighbourhoods Cabinet Briefing<br>• Bristol City Council Commissioning and Procurement Group<br>• Bristol Health and Wellbeing Board<br>• Bristol Clinical Commissioning Group (CCG) Leadership Group<br>• CCG locality Clinical Fora<br>• Bristol City Council Directorates<br>• Current service users<br>• The wider Bristol Communities<br>• Compact (Voscur)<br>• 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:

- 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 B 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; 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 and 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 C).

**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 were tested at the market warming event in March 2017 to ensure that they provided appropriate groupings, on which to base the behaviour change for healthier lifestyles programme.

The event also enabled us to encourage collaboration between organisations through a speed networking event and sharing of information about those organisations in attendance.

A second stakeholder day was held in May 2017, to give potential providers further opportunity to network, innovate and collaborate; and to start the consultation process for this commissioning strategy.

## 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.

## 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.

A questionnaire was carried out at our last stakeholder event to find out more about the organisations who are interested in this programme. The responses showed that there are a range of large and small organisations who are interested in potentially bidding to deliver this programme; and that there is an appetite for collaboration between these organisations. More detailed information on our market analysis can be found at Appendix D.

# 4. Current Contracts and Financial Envelope

## 4.1 Current Contracts and Expenditure

2016/17 financial year 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 team, Learning Difficulties Healthy Living team and Resource and Information Team | 327,909 |
| **Current Total** | **£1,864,909** |

## 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 | 1,585,173 | 279,736 |
| 2019/20 | 1,585,173 | |
| 2020/21 | 1,585,173 | |
| **Totals** | **4,755,518** | **279,736** |

Financial penalties will be incurred if key targets are not met, this will be discussed and agreed with provider during contract negotiations.

# 5. Commissioning Model

## 5.1 Our Ambition

Our ambition is to create and procure an innovative Behaviour Change for Healthier Lifestyles 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 support 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 of all ages (children, young people and adults) 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, with a focus on those whose health outcomes are poorest.
- 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 provide supporting information and resources to the wider public health work force to support behaviour change.
- 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, ensuring emotional and mental wellbeing is embedded.

## 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
- 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.
- **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 among people accessing the programme and wishing to reduce their alcohol intake

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 age15
- 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 are 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)<br>Healthy Living Centres<br>Community based services |
| Adult Weight management on Referral | To reduce the rates of overweight and obesity among adults | Slimming World and Weight Watchers<br>Targeted small projects, including Fit Club and Fans4Life |
| Alcohol Brief Interventions | To reduce harm from alcohol | Primary Care; Healthy Living Pharmacies; Healthy Living Centres |
| Children and family Weight Management | To reduce the rates of childhood obesity | Alive ‘N’ Kicking |

| | | |
|---|---|---|
| programme | | |
| LiveWell Bristol | Digitalised information, signposting and referral point | Bristol City Council, Public Health |
| Resource and Information Service | Provision and distribution of quality assured information and resources to support behaviour change interventions to wider public health workforce | 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 | Alive 'N' Kicking, Bristol City Council, Public Health |
| Learning Difficulties Healthy Living Advisors Team | Providing 1:1 support for people with learning difficulties. | Bristol City Council, Public 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.
- Enable, empower and motivate people using a coaching approach.
- Connect 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 three personas:

- Inform me
- Enable me
- 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.

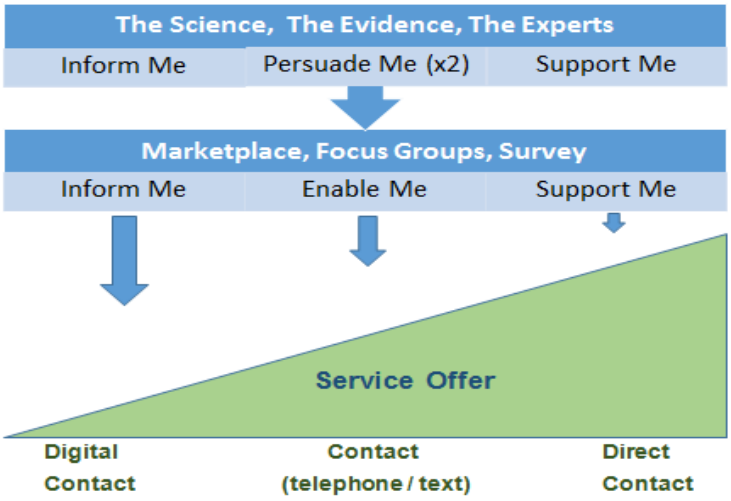
### Support me

- 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).

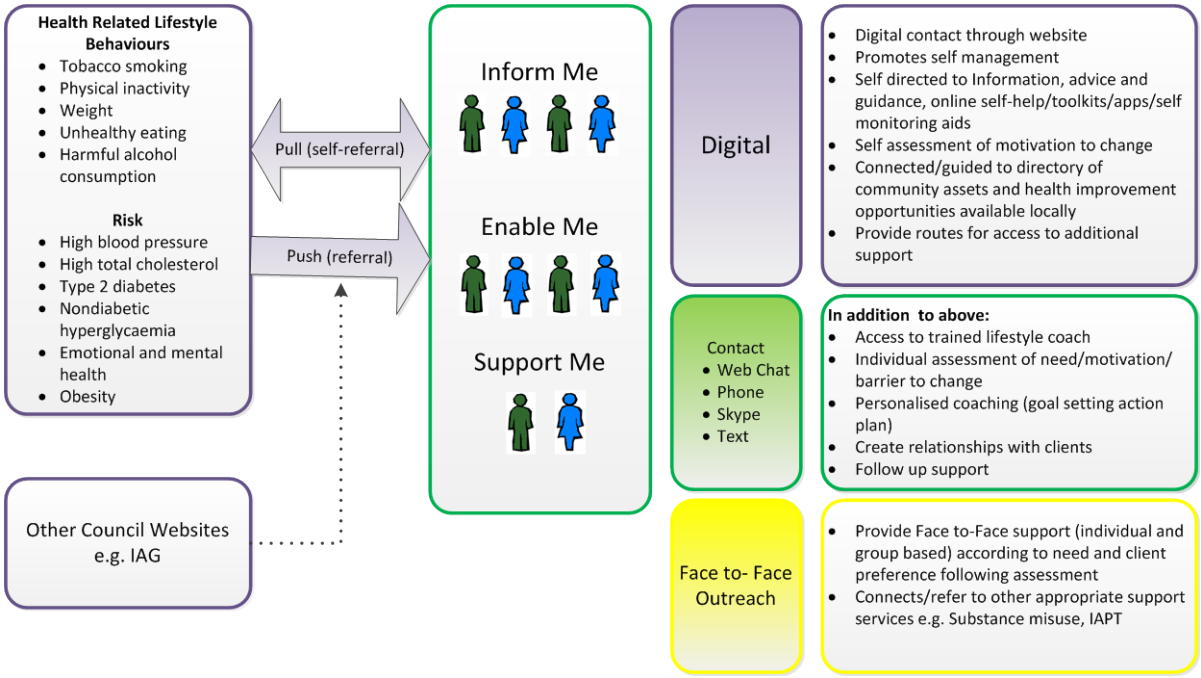
**Figure 10: Developing the principle of Proportionate Universalism into our Behaviour Change Lifestyles Programme**




Devon Public Health, 2016

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

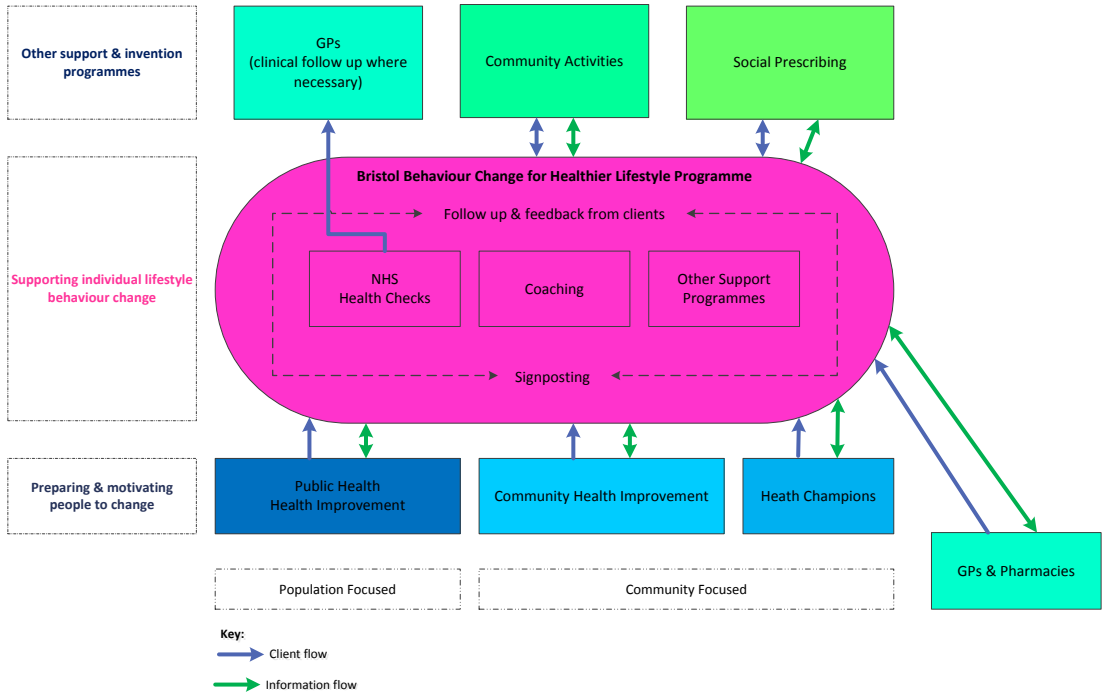
**Figure 11: Bristol Behaviour Change Support for Healthier Lifestyles**




The NHS health check 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 identified with lifestyle risks would be referred to the appropriate service or offered support to change their behaviour.

The Bristol Behaviour Change for Healthier Lifestyles Programme will link with other relevant activity within the city, ensuring that people, who require it, are supported to be ready to change their lifestyle behaviour and supported to sustain their new lifestyle behaviour following engagement with the programme.

**Figure 12: Bristol Behaviour Change Programme Links with Other Relevant Activities within the City**




Need to add in data from NHS Digital for Health Check (eligible lists); Information Advice and Guidance link for signposting; IAPT

## 5.6 Lotting

Following the consultation it has been agreed that there will be a single lot for whole programme including all services in scope (1 service provider).

The advantages of this will be:

- Simplifies commissioner/provider relationship.
- Joined up services.
- Cost efficient.
- Still allows for localisation and more intensive support in high need areas.

We will require the provider to ensure that there will be a presence/visibility in locality areas and to target a more intensive 'support me' offer where appropriate.

We will use an Open Procedure to procure this programme.

We encourage organisations to submit collaborative bids following the Bristol City Council's 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).

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.

Bristol City Council 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 involvement of micro, small and medium size businesses, social enterprises and voluntary / community organisations to bid. This could be achieved through collaborative bids from providers working together in, for example, lead partner collaborations or sub-contracting arrangements.

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. Bidders will need to provide written evidence (for example, a Memorandum of Understanding) that describes sub-contracting and collaborative arrangements.

Part of Bristol City Council's procurement process is an assessment of the financial risk of individual providers. This involves looking at a range of measures including, for example, the bidders most recent financial statements (along with those of any ultimate parent company if appropriate), the general liquidity and assets held. The assessment will be on combined contract values where the organisation applies for several contracts at the same time. Further detail will be provided in the tender documentation

## 5.7 Social Value

The Public Services (Social Value) Act 2012 requires public bodies to consider how the services they commission and procure might improve the economic, social and environmental well-being of the area.

In line with BCC's Social Value policy the provider should deliver benefits and outcomes (social value) which go beyond the explicit requirements (including service objectives and outputs) of this tender and contribute to building the capacity, capability, skills, assets and resources of Bristol's communities.

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.

## 5.8 Evaluation Approach

The evaluation criteria are 80% quality and 20% 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.

## 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.

## 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 invitation to tender to enable provider to 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 held a stakeholder consultation from 9th May to 1st August 2017; this included an online consultation questionnaire; focus groups and visits to key stakeholder groups and meetings.

The findings of the consultation can be found in Appendix G.

## 6.2 Procurement Timetable

Please note that dates may change through the course of the process.

| | |
|---|---|
| Bidders Day | 18th September 2017 |
| Invitation to tender (open process) | 21st September 2017 |
| Deadline for tender submissions | 3rd November 2017 |
| Contract Award | Week commencing 19th December 2017 |
| Decommissioning period of current services | Week commencing 19th December 2017 |
| Service planning and implementation of new service | 1st April 2018 |
| Current contract extensions expire | 31st March 2018 |

# Appendix A: 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; Carers 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)
- Specific BAME groups eg South Asian men; African-Caribbean/Black British men and women; Polish; Romanian
- Ethnicity Dual heritage populations have the highest prevalence rate of 22.4% (PHOF)
- Lone parenthood (national data); pregnant women; young people
- Mental health problems- Over 60% of those experiencing poor mental health smoke (national data)
- Youth offenders, ex-offenders: 80% (national data)
- Sexual orientation - lesbian, gay, bisexual (national data)
- Other excluded groups e.g. travellers, homeless (national data), ex-substance misusers.

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 African-Caribbean/Black British 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 African-Caribbean/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 , African-Caribbean/Black British 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
- South Asian and African-Caribbean/Black British 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 British, 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 BAME Groups have higher rates of CHD (South 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 BAME groups for certain cancer types
- Screening uptake is lower amongst BAME and disabled groups
- Prostate cancer is higher amongst African-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.

# Appendix B: 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 where preventable CVD premature mortality is highest
- Activity (invitations for a Health Check and uptake of Health Check) is variable across providers
- Eligibility is currently determined from Practice population lists, future arrangements will need to consider alternative methods for obtaining this data, eg NHS Digital.
- The focus is on risk assessment (physiological and behavioural risks), rather than behaviour change to reduce identified risks
- Follow up after the health check appointment, for both clinical and lifestyle risks is 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 deprived 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 deprivation 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 acute secondary and mental health services to implement relevant NICE guidance on smoking cessation and support the CQUIN, ensuring 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 of 21,000 more referrals per year to weight management services in Bristol to achieve 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.
- The proportion of children with excess weight in England has been largely constant, around 22- 23%, since the National Childhood Measurement Programme began in 2006/07. The Bristol rate had been around 25%, higher than England, for 2007 to 2010, but since 2010/11 has been broadly similar to average Bristol is 22.9% in 2015/16, similar to England, at 22.1%.
- The 2014/15 data showed more boys (23.5%) had excess weight than girls at 21.9%
- Within Bristol, the proportion of 4-5 year olds who are overweight or obese is much lower in North & West (inner) (17%) and highest in North & West (outer) (26%).
- The proportion of 10-11year old children overweight or obese in England has been largely constant, around 32-33% since the National Childhood Measurement Programme began in 2006/07. However, in Bristol the rate has been rising in recent years and in 2015/16 the proportion of 10-11year olds

who were obese or overweight was 35.4%. This is broadly similar to the national average of 34.2%

- The data to 2015 showed more 10-11 year old boys (35.7%) have excess weight than girls (33.6%).
- Within Bristol, the proportion of 10-11yr olds overweight or obese has risen sharply in Bristol East in recent years. It is significantly lower in North & West (inner), whilst all other areas have more than 1 in 3 children overweight or obese by the time they leave primary school.
- The World Health Organisation regards childhood obesity as one of the most serious global public health challenges for the 21st century stating obesity in childhood is associated with a wide range of serious health complications and an increased risk of premature onset of illnesses, including diabetes and heart disease.
- The proportion of Bristol children who are obese or overweight is similar to the national average; at school entry 22.9% have excess weight, but this has now reached 35.4% for those leaving primary school.
- The What About YOUth (WAY) survey 2014-15, estimates that every day 17% of Bristol's 15 year olds take part in at least an hour of physical activity. This is significantly higher than the national average of 13.9%.
- The Pupil Voice survey estimates that around 90% take part in exercise / physical activity or sport at least once a week. In all year groups, boys took part more often than girls.

## 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.
- Weight management support should be targeted to areas and population groups where overweight/obesity rates are highest

# Appendix C: 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?**

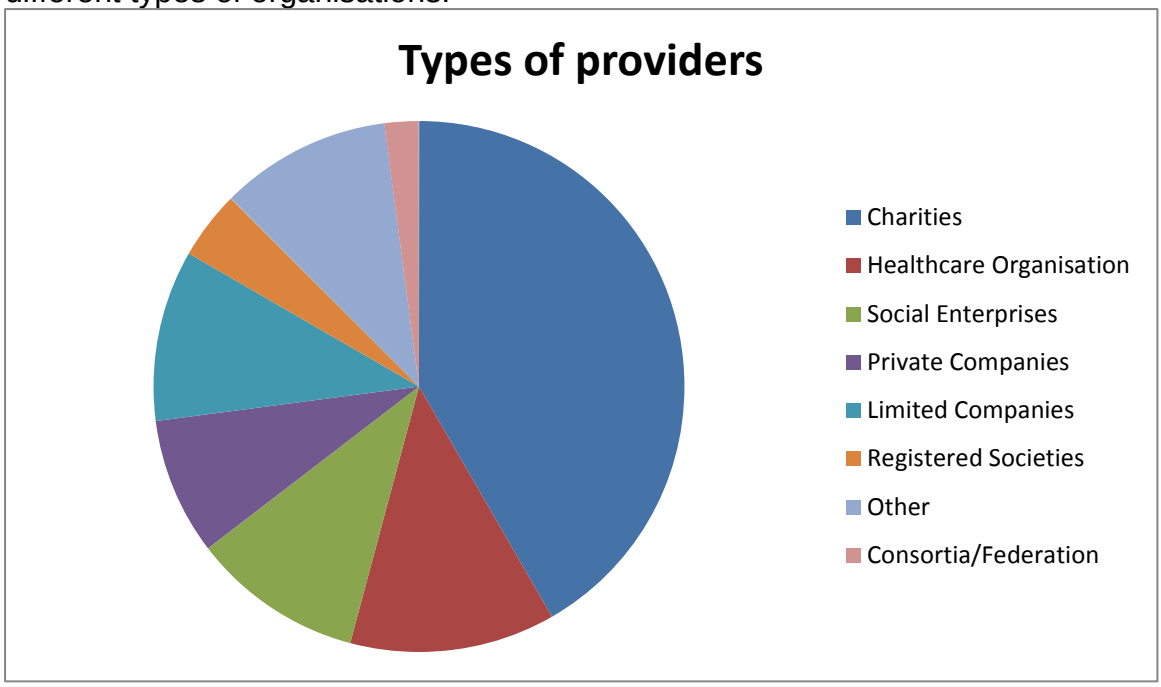
**Please give us your postcode** (it helps us to know which area you live in)

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 D: Market Analysis

A questionnaire was used to assess the types of organisations interested in our new Bristol Behaviour Change for Healthier Lifestyles Programme. The respondents were organisations that signed up to attend our 'Market Warming' event in March 2017. Invitations were sent out from a list put together from existing contractual providers; internal knowledge; information received from external organisations offering similar contracts, through Voscur and through our internal procurement notification.

A total of 53 providers completed the questionnaire, showing a wide range of different types of organisations.




The providers ranged in size by number of employees, there responses grouped below (taken from National Office of Statistics) were:

| Band | No. |
|---|---|
| 0-4 | 5 |
| 5-9 | 1 |
| 10-49 | 15 |
| 50-249 | 8 |
| 250+ | 22 |

These figures do not include the use of volunteers.

Of these providers 7 are currently not providing any health & wellbeing programmes, but the remaining 46 have declared that they do currently provide some health & wellbeing programmes.

The 46 providers identified a range of programmes, learning and development skills that they provide, which included:

| Support programmes | Lifestyle programmes | Skills programmes | Other programmes |
|---|---|---|---|
| Community Empowerment | Healthy Eating | Gardening – allotments; growing food | Workplace Health |
| Motivational Interviewing | Weight Management – adults and children | Arts based activities | Mental Health outreach |
| Digital Tools | Smoking Cessation | Singing for wellbeing | Youth work, CASS |
| Service Directories | Physical Activity programmes | Healthy cookery | Volunteer befriending |
| Information, Advice and guidance | Events | Job clubs | Supporting people into volunteering or employment |
| IT for silver surfers | 1:1/Group Coaching | Eat well for less | Engagement with community groups |
| ESOL and other languages | Counselling | Let's get Active | Social prescribing |
| Life coaching | NHS Health Checks | Improving good food culture | ITEP Outcome Advanced Skills Training programme |
| Solutions Focussed Therapy | Footcare | Acupuncture | Employability Work programme |
| Helpline | Oral Health | | Justice Prison Education |
| Information systems | Sexual Health | | Adult Further Education |
| Technology Enabled Care Services | Falls prevention | | Independent Living Service/Carers Support |
| Behaviour Change | Chronic disease self-management | | CPD Training |
| Advocacy | Diabetes Management | | Social inclusion |
| Psychotherapy | Horticultural therapy | | Supporting people with mental health and learning disabilities |

Many providers also provide comprehensive learning and development programmes for their employees.

**What factors would encourage you to bid for a contract to deliver these services?**
There was a range of suggestions providers identified that would encourage them to bid for the behaviour change contract, including:

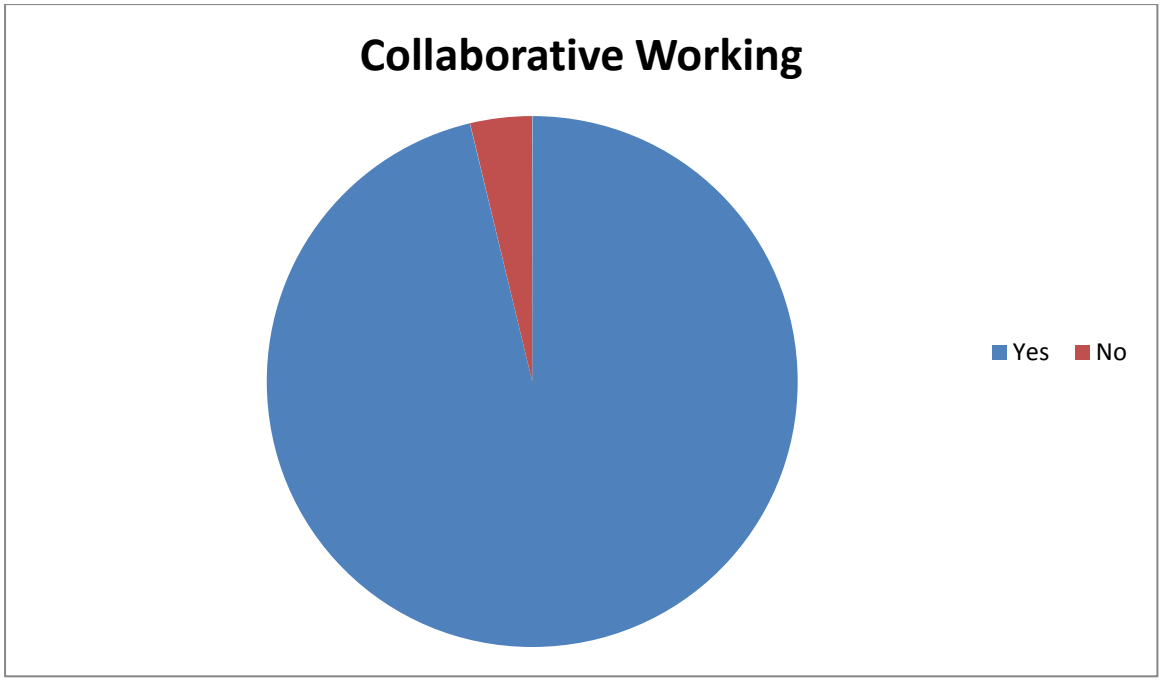
- Models that look at local population health; that reflect the interrelationship between healthy behaviours and the wider determinants of health, that build on the current assets in the community to maximise opportunities and delivery.
- Recognition of the need to address inequalities in health by modifying delivery models to target those who experience the greatest inequality in life expectancy and life lived in good health.
- A model that promotes social inclusion, and social change.
- Adequate funding - the financial envelope is sufficient to deliver the services, and appropriate pathways
- Delivers social value
- Opportunities to form partnerships and strengthen our bond with communities.
- Recognised targeted interventions to address health inequalities in the groups we work with, i.e. homeless and drug and alcohol users.
- Consistent monitoring requirements
- The details of the contract, a full-cost recovery model, how the service ties into our other services, clear evaluation methods
- A sense of real integration or the possibility of it - with other relevant services within the area i.e. a buy-in from all. That makes for a really exciting prospect.
- Funding or support in kind to deliver activities.
- A programme developed in line with NICE guidance which supports the role of commercial weight loss organisations.
- Holistic approach to service delivery, avoiding a silo'd approach. Asset based approach utilising the wealth of community assets across Bristol
- Length of contract.
- Flexibility in Commissioner relationship to respond to the needs of citizens and legislation
- Shared risk; practical and pragmatic approach to TUPE
- At least 5 years contract
- Open to innovation and co-creation
- Capacity funding
- A collaborative approach to the development of clear cross theme outcomes and to the delivery framework.
- Clear delivery expectations.
- Fairness; clear and transparent process.  Fits with our core strategy
- Equal platform for all FCR
- Good lead in time
- Support, where needed, for VCS Impact on our community of interest
- Clear achievable outcomes and plenty of time to build relationships with other delivery organisations to develop service delivery partnerships.
- Better communication across the Council to break down the service delivery barriers between departments, particularly those delivering physical activity outcomes such as public health, sport and transport teams.
- Contract length, size, full support of commissioners
- Sufficient lead in time to plan developing an application in partnership with similar service providers in and adjacent to our area of benefit.

A few of the smaller providers identified the difficulties of bidding for a contract of this size, but were keen on the possibilities of sub-contracting or joint bidding with others. An understanding of the process and information required for bidding was also recognised as an important component to enable successful bids.

**What factors would discourage you from bidding for a contract to deliver these services?** Responses are listed below:

- Unviable contracts – too short, not person centred, not flexible
- Unmanageable TUPE levels
- Short term contracts
- A service specification that considered healthy lifestyles as independent of other factors.
- Achievable Key Performance Indicator's.
- The inability to partner when the contract has not been split into lots.
- Lack of coordination across the programme if the contract is split in to lots
- Financially unviable
- Support from trusted sources
- If the project was ill conceived or unrealistic in its expected outcomes given the budgetary and time constraints.
- No opportunity to use our relevant skills and experience of the existing workforce
- If bid did not take into account psychosocial and community factors.
- A lack of clarity of the service
- A lack of full cost recovery model
- We do all work but no credit.
- Disproportionate bidding process.
- Unrealistic expectations on outcomes compared to value of contract.
- An over complex integrated health and wellbeing program.
- Pre prescribed content and delivery.
- Specification not based around best practice and the wealth of evidence available
- No accurate data or effective performance measures which are outcome not output orientated
- No ability to work collaboratively across sectors including health (in particular mental and social wellbeing), education, employment and the third sector – without these factors in place or development it would prove difficult to engage in the bidding.
- A lack of clear outcomes and an over emphasis on sport.
- Short timescales for tendering with short delivery periods.

**Is your organisation open to collaborative working with other organisations?** The majority of providers completing the questionnaire were open to collaborative working.

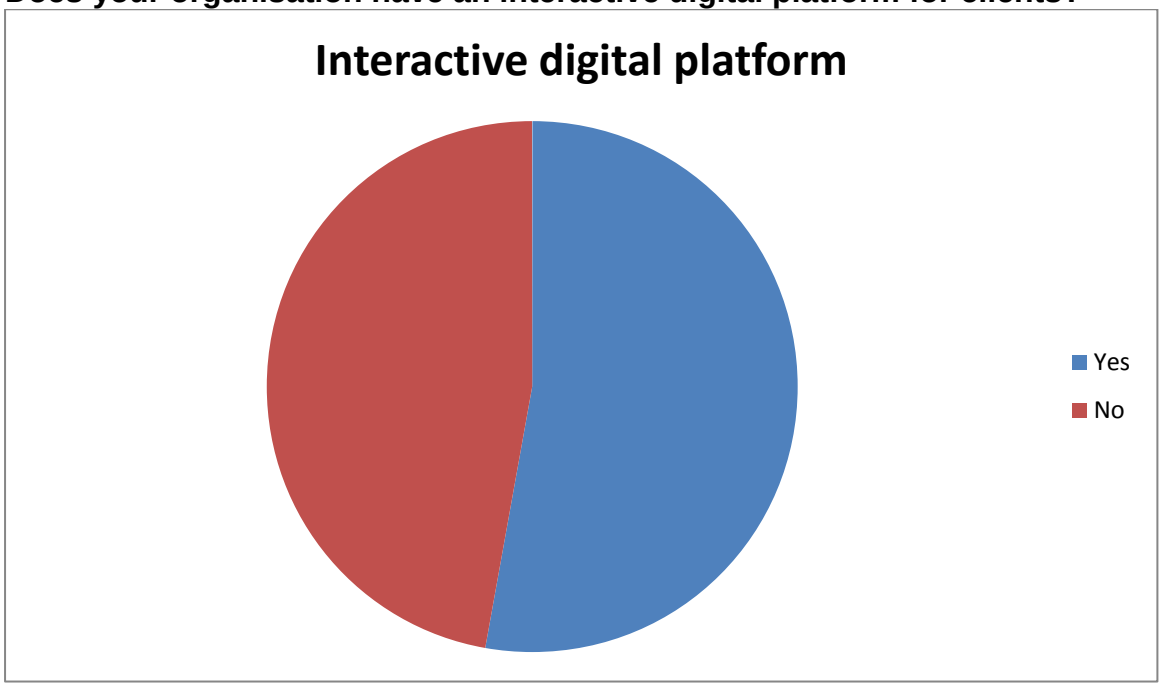



The information days for stakeholders have ensured time is included for networking and opportunities to enable collaboration between organisations.

**Do you currently collect health data and is there a process by which this can be shared? Please explain briefly**

There was a mixed response to this question with approximately 1/3 of providers responding with just a yes or N/A (not applicable). Most of the providers who responded do collect health data, but not all feel they are able to share this data. Some have systems whereby data can be stored and shared through a portal.

**Does your organisation have an interactive digital platform for clients?**




Slightly more providers responded positively to having an interactive digital platform, however, there were different interpretations as to what this meant:

- Website/ Interactive website
- Facebook
- Twitter
- Social media
- All or a couple of the above

**What experience have you had of working with local communities?**
Not all providers answered this question and many did not give a clear picture of how they work with local communities. However, these are some of the more detailed responses which give a varied picture:

- All our provision is well embedded in local communities, for example our smoking cessation programme operates from 108 GPs, 123 community pharmacies 4 hospitals, a prison and other community locations. We have a referral and partnership building team that's responsible for generating effective partnerships
- We have over 10 years of experience working with children and young people with SEND, parent carers, young people in care and care leavers to coproduce our solutions.
- Bristol work zones, Funded projects, Contracted work in the community, Partnerships
- Worked with a broad range of local communities, including BME, women, asylum seekers, the homeless, mental health, ex-offenders, LGBT, young and older people
- Extensive experience of working with local communities, all of our clinicians are based in community settings across all Bristol areas, and are often liaising with voluntary and community services in these areas to support the local people. We are often key in reaching isolated and lonely people in communities who would otherwise not have contact with anyone.
- We are a 30 year old community organisation
- As an organisation, we have worked in Southmead for over 30 years. As an individual I have worked in community settings for the last 20 years, abroad and across the UK
- All our integrated services are based within the community and access and engagement is key to getting people into the service or indeed delivering health promotion and prevention services to the wider community. We have over 40 years' experience.
- Communities are the biggest assets - all services take a community based approach actively encouraging volunteering and integration of the wider determinants of health throughout.
- We have experience of delivering outreach lifestyle services in a wide variety of community locations, specifically targeting hard to reach groups such as BAME, young adults, individuals with multiple health needs and those that have mental health problems. We deliver services in clinics embedded in convenient community locations such as educations setting, religious/worship venues, supermarkets, libraries, leisure centres, voluntary organisations and workplaces.
- We have a wide range of experience of working with local communities. Out of our yearly 100,000 client engagements, 70% are from priority groups.

- We have worked with schools and local communities for over a decade, often in deprived neighbourhoods where addressing health inequalities is the key outcome of the programme.
- We have operated in some of the most deprived and multicultural settings including Hull, Hounslow and Luton. The diversity within our groups is extremely mixed and our data clearly shows that we are successful in attracting a client base that is reflective of the commissioning locality and what is more, the efficacy of the programme is equally high across all demographic user groups. Not only are our programmes successful in spanning cultural and social groups, but it is also equally efficacious for children across the spectrum of overweight classifications. For instance in Hounslow and Luton it was shown that the numbers engaged on the programmes were proportional to those living in the Boroughs for all of the main ethnic groups. Weight loss and adherence to the programme was no different for minority groups than for the general population.
- We have extensive experience of working with local communities through our services, 50+ retail shops and eight Social enterprises which are fully integrated into the community to ensure maximum social impact. Our aim is to create brighter futures for the people and communities we serve and the best way to do this is to ensure we understand the needs of local communities and work with them as well as empower them to meet these needs. Local stakeholders engage with us because they share the charity's mission to improve lives and trust us to put the needs of their community first. This is the core of our business. We work to serve the local community to encourage them to improve their lifestyle.
- Over 30 years' experience of delivering projects at the heart of communities. We are experts in community engagement and co-design of projects. We have 4.500 volunteers across the UK.
- We have had over 4 years' experience on a number of projects working with local communities, and our team members and associates have between 8-20 years of experience.
- 27 years of a community development approach to improving health and wellbeing. Social prescribing

### Summary

There is a wide range of providers who are interested in our Behaviour Change for Healthier Lifestyle Programme, from larger corporate providers to smaller charities and volunteer groups. The larger providers are capable of putting in an independent bid, where the smaller providers s are reliant on a collaborative approach or being sub-contracted.

These providers have shown an appetite for collaboration, but require clarity of process, time and an appropriate financial envelope in order to do so.

Data collection and sharing is an area which will need to be made clear as part of the commissioning process.

## Annex 1: Organisations responding to the market analysis questionnaire

- All About Food
- Bristol City Council
- Bristol Community Health
- Cranstoun
- Dhek Bhal
- Everyone Health
- Guide dogs
- Hartcliffe Health and Environment Action Group
- HENRY
- ICE Creates Limited
- Knowle West Health Association
- Knowle West Health Park
- Miles Bramwell Executive Services Ltd t/a Slimming World
- MJ Williams Pharmacy/ Local Pharmaceutical Committee
- North Bristol Community Project Ltd
- One Care
- PeoplePlus
- Public Health Action
- Safe Sociable London Partnership
- Second Step
- Shaw Trust
- Soil Association
- Solutions 4 Health
- Southmead Development Trust
- Sustrans Ltd
- This is Focus Ltd (focusgov)
- Thrive Tribe
- ToHealth
- TSCG
- University Hospitals Bristol NHS Trust
- Weight Management Centre
- Weight Watchers
- Wellspring Healthy Living Centre
- Wesport
- Windmill Hill City Farm
- Women's Independent Alcohol Support

# Appendix E: Equality Impact Assessment

| | |
|---|---|
| Name of proposal | Bristol Behaviour Change for Healthier Lifestyles Commissioning Strategy |
| Directorate and Service Area | Public health |
| Name of Lead Officer | Amanda Chappell and 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?**

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 healthy lifestyle contracts, which include weight management and the stop smoking service, and the NHS Health Checks programme.

<u>Preventing premature death</u>
We know that four key behaviours are the biggest preventable risk factors for preventing premature death:

- 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.

<u>The support needed</u>
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.

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. It 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 reduce health inequalities.

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

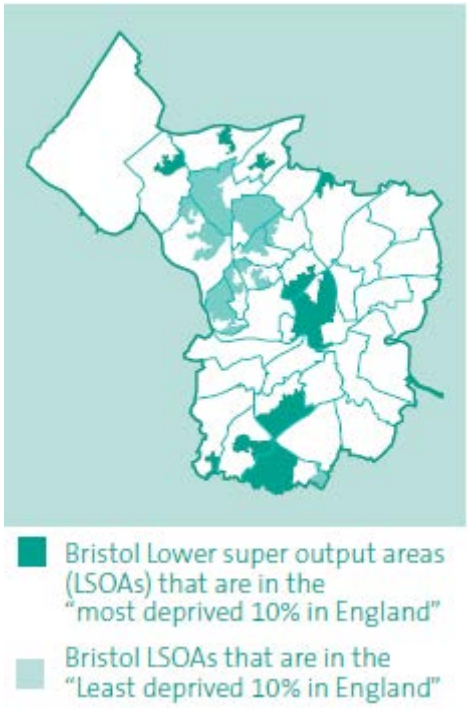
**2.1 What data or evidence is there which tells us who is, or could be affected?**

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.

There is a persistent inequality in life expectancy , and average life expectancy in Bristol is 8.2 years lower for men and 6.1 years lower for women in the most deprived 10% areas of Bristol than in the least deprived 10% (almost all of which are in North & West (inner)[1].

Life expectancy in Bristol




[1] Slope Index of Inequality; 2010-12; released Public Health England 2014

**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)
- Overall the local data highlights that people with Learning Disabilities in Bristol are more likely to have a range of (often multiple) health conditions and poorer health outcomes, linked to difficulties in their access to health care.(JSNA2014)

**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
- We need to include those with learning difficulties

**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 team have used Acorn data, JSNA, Census and Other data to accurately map the needs of residents of Bristol in relation to the inform, enable and support me model.

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

- Large gaps in information for BME groups locally.
- The census and JSNA are weak on ethnicity data.
- In general data on LGBT is poor due to issues around disclosure and discrimination.
- The current services have not monitored equalities data and there is little evidence available on the success of current services.

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

The consultation process will include:

- A survey by survey monkey and paper copies on request
- A consultation event held at City Hall
- An offer to visit equality voice and influence groups funded by the council to explain the project and gain feedback.

**Step 3: Who might the proposal impact?**

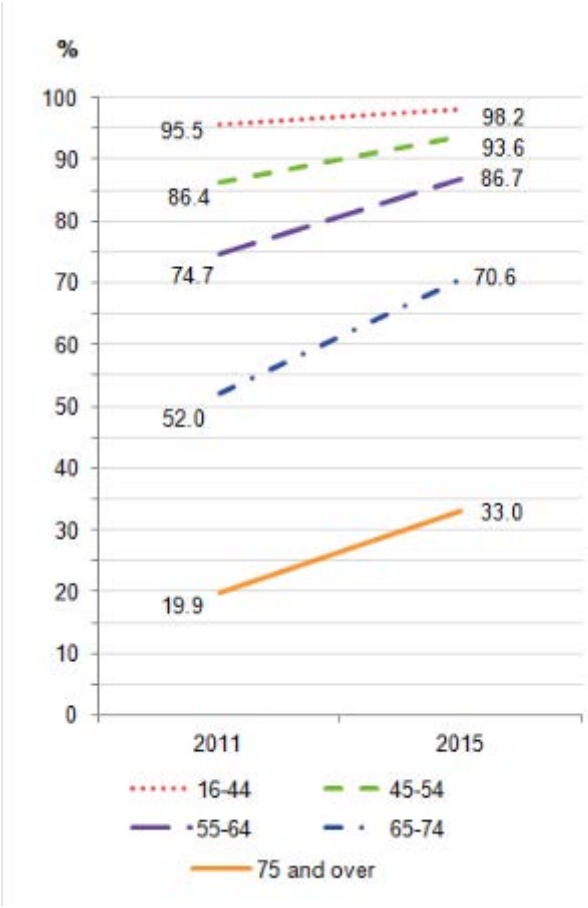
Analysis of impacts on people with protected characteristics must be rigorous. Please demonstrate your analysis of any impacts in this section, referring to all of the equalities groups as defined in the Equality Act 2010.

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

People with protected characteristics have different health problems and different ways of seeking help. The commissioning plan therefore needs to take these differences into account when planning services and drawing up contract specifications.

There is a shift to a digital offer that could affect a number of equality groups.

Internet use by age in the UK.




General national issues in internet use.

- 87.9% of adults in the UK (45.9 million) had recently (in the last 3 months) used the internet, compared with 86.2% in 2015.
- 10.2% (5.3 million) had never used the internet compared with 11.4% in 2015.
- Almost all adults aged 16 to 24 years were recent internet users (99.2%), in contrast with 38.7% of adults aged 75 years and over.
- 89.4% of men (22.8 million) and 86.4% of women (23.1 million) were recent internet users, up from 87.9% and 84.6% in 2015.
- Women aged 75 and over, had seen the largest rise in recent internet use, up 169.0% from 2011; however, still less than a third (32.6%) were recent users in 2016.
- 25.0% of disabled adults had never used the internet in 2016, down from 27.4% in 2015.
- Of the NUTS 1 regions, Northern Ireland had seen the largest increase (13.2 percentage points) in recent internet use since 2011; however, in 2016 it was still the

region with the lowest recent usage (82.0%).
- Inactive adults who had never used the internet or who used the internet more than 3 months ago, has decreased by 13.3 percentage points since 2011.

The help to help yourself offer may work best with wealthier people living in strong/resilient community settings and worst with poorer people living in weak/non resilient community settings.

A reduction in face to face services in a time where there are many other services closing or being reduced will impact on people with protected characteristics.

- Gender
- Lone parents struggle with poverty in the support me geographical areas and this group is predominately women
- Age – Older people are in general less digitally included. Research suggests that this is diminishing as a factor but advocacy groups for older people still report that digital inclusion is a reality for a proportion.
- Sexual orientation – Research suggests that digital platforms work well for the LGBT community.
- Ethnicity – Communication issues arise about publicity and about how the digital offer is made to be user friendly to those whose first language is not English.
- Gender reassignment – see LGBT
- Religion – N/A
- Pregnancy and maternity – see gender
- Disability – Visual impairment and other disabilities could affect how or if some disabled people can access services.

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

The aim of the commissioning is that the provider or providers will address the need identified in the research. The research has highlighted the areas where each of the inform me, support me, enable me methods will best suit the needs of the population. The service specification will ask how the potential provider will meet the needs of all the community including those with protected characteristics. This will mean the provider/s will need to address local issues and have a presence in local communities.

The cohorts identified as needing the support me method of delivery largely correlate with other data sets in Bristol on poverty, education, lone parents, disability and life expectancy. Services will need to be based in and focussed on these areas of deprivation. The provider/s will need to explain how they will promote behaviour change in these environments.

The service specification for the digital platform will require that it is made as accessible as possible for those with disabilities, those without access to a computer and those whose first language is not English.

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

If the new service(s) deliver the vision of the commissioning plan the needs of the whole community should be met including those with protected characteristics.

| **3.4 Can they be maximised? If so, how?** |
|---|
| |

**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?** |
|---|
| Commissioners have answered questions of the equalities team in order that this EqIA be completed fully. |
| **4.2 What actions have been identified going forward?** |
| |
| **4.3 How will the impact of your proposal and actions be measured moving forward?** |
| The service specification must include an outcome that the three methods of delivery, inform me, enable me and support me meet the needs of equalities communities in terms of accessibility. It should also require that they demonstrate that they understand the level of need for each method and have a plan to deliver behaviour change initiatives to meet the need. |

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

# Appendix F: 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:**

| | |
|---|---|
| Bidders Day | 18th September 2017 |
| Invitation to tender (open process) | 21st September 2017 |
| Deadline for tender submissions | 3rd November 2017 |
| Contract Award | Week commencing 19th December 2017 |
| Decommissioning period of current services | Week commencing 19th December 2017 |
| Service planning and implementation of new service | 1st April 2018 |
| Current contract extensions expire | 31st March 2018 |

# Appendix G: Findings from the Consultation

## Report on Consultation Engagement

A comprehensive plan for engagement and consultation has been undertaken. This includes the following events and meetings as well as an on-line survey on the key aspects of the Commissioning Strategy:

- Launch event (See attendee in appendix A)
- Consultation Meetings with:
    - BDP users
    - Practice Managers – (ICE and South Done, North on 18th July 2017)
    - BCC People Directorate (19th July 2017)
    - Youth Mayors
    - Tenants Housing Scrutiny
    - Public Health staff briefing
    - Youth Event - Takeover
    - Youth Network
    - Inner City and East Community Groups
    - Learning Difficulties Team
    - One Care

At these events the commissioning strategy was outlined and attendees were encouraged to complete either on–line or paper copies of the consultation survey.

A summary of comments from BDP and three practice managers meetings are at the end of this report.

- Emails sent to raise awareness to:
    - GP Clinical Forums
    - Practice Nurse Forums
    - Pharmacists
    - Voluntary Organisations (Via Voscur)
    - Neighbourhood Forums
    - Patient Groups (Via Healthwatch)
    - GP Practices
    - Children Centres
    - Schools (they have included a link from their websites)
    - Tenants Forum
    - Social Landlords
    - Current providers
    - All other BCC DLTs
    - Health and Wellbeing Board
    - Mental Health groups
    - Healthy Living Centres
    - Other BME Groups
- On the LiveWell Bristol website

Requests sent, not being taken up:

- Youth Moves Consultation meeting

- South Asian Women Consultation meeting
- South Asian Men Consultation meeting
- Healthy Living Centres
- Other BME Groups

The survey questions with the key findings are summarised below.

| | | |
|---|---|---|
| **Individuals** | **88** | **77.19%** |
| **Organisations** | **26** | **22.81%** |

A total of 112 responses have been received to date. Of these, 73 (82.95%) are individuals, 15 from organisations (17.05%), 24 unknown.

**Question 2: Model**
*At the moment we have separate services to help people to stop smoking, have a healthier diet, take up exercise etc. We plan to commission a new programme that will offer support to people to help them change behaviours for example on smoking, healthier eating, being more active, healthier body weight. The lifestyles programme will include all of these, so people do not have to access different services for different lifestyle behaviours (page 23, section 5.5).*

*Do you agree with this proposal?*

| | | |
|---|---|---|
| **Yes** | **90** | **81.82%** |
| **No** | **20** | **18.18%** |

A total of 57 comments were left, including many that were favourable although a large number of these (21) were only partly in favour of the model with provisos about specific groups or provisions that would be required so that everyone can access the service. Suggestions were made about marketing and ensuring that there are sufficient staff directed at supporting people who need it. Ten respondents expressed the view that there was too much emphasis on digital provision and that we are in danger of increasing health inequalities.

The needs of specific groups were also highlighted by three respondents, one of whom wanted Women only service and two disease specific (COPD (2) and diabetes), specific services for Learning Disabilities (2) and for people with mental ill-health (2.)

Eleven respondents left a variety of critical comments relating to the model, for example ‘If I want say a healthier body weight my smoking habits are irrelevant.’ Others expressed concern that this was a cost saving exercise and that it would exclude small local providers.

Other comments included suggestions for including other services, e.g. drug and alcohol, and for the services to continue to be provided by the NHS.

**Question 3: Personas**
*We have considered how different people of all ages across the city might wish to access and engage with this lifestyle programme, and have identified 3 broad categories: 'Inform me', 'Enable me' and 'Support me'.*

*Do you agree with this approach?*

| | | |
|---|---|---|
| **Yes** | **89** | **82.41%** |
| **No** | **19** | **17.59%** |

A total of 48 comments were received. Fourteen respondents were in favour of the personas with some qualifications. Four really liked it, 14 did not think it would help the people who needed it and a further four did not like it and thought it simplistic and patronising. Other comments were about categorisation, stereotyping, people not knowing what support they need and the importance of face to face.

**Question 4: Digital Offer**
The proposed model for the new programme is shown in figure 11 (page 25) in the *commissioning strategy. It includes a strong focus on helping people to help themselves, making the most of digital technologies. Enhanced support which may include face to face support will be available for those who need it.*

*Do you agree with the focus on the digital technologies to support people to help themselves?*

| | | |
|---|---|---|
| **Yes** | **73** | **65.77%** |
| **No** | **38** | **34.23%** |

A total of 73 comments were left. Twenty-two respondents did not like the proposal for a digital offer. A further 38 had concerns about groups of people who are not able to access the internet and digital information. A typical quote is:
"One of the focuses not THE focus - many vulnerable people will find using technologies a barrier to starting the process of behaviour change."

Eight responses were very positive. Other comments asked about the quality of data and how the programme would be evaluated.

**Question 5: Levels of Support:**
*Do you agree with the model to provide different levels of support according to needs of individuals?*

| | | |
|---|---|---|
| **Yes** | **104** | **92.86%** |
| **No** | **8** | **7.14%** |

Thirty-six comments were left. Sixteen respondents expressed the need for local services, face to face and person centred support. A further six responses were partly in favour but expressed concerns about the ability of the provider to assess or afford the higher levels of support. Eight responses were not in favour of the support levels suggesting it was too universal or not appropriate for a variety of reasons.

Other support suggested included swimming and specialist services for disabled people.

**Question 6:**
*Have you any further comments or ideas on the proposed model for the programme...*

These comments have been amalgamated into the main question about the model.

**Question 7 Outcomes:**
*We have set out a range of outcomes we want this programme to achieve, over short, medium and longer term (page 21, section 5.3).*

*Do you agree with these outcomes?*

*i. Short*
*ii. Medium*
*iii. Longer term*

| | | |
|---|---|---|
| **Yes** | **97** | **88.99%** |
| **No** | **12** | **11.01%** |

A total of forty-two comments with very mixed responses were left. People raised questions about whether there was sufficient money available to achieve the outcomes and whether they were the right outcomes. There were 15 suggestions for additional outcomes including healthy eating, eating less sugar, less fruit, less meat and fish. Other suggestions included social engagement, community groups and weight loss. There were also many comments about how the outcomes would be measured.

**Question 8 Social Value:**
*What social value do you think could be offered around these outcomes (page 28, section 5.7)?*

A total of 77 comments were left.

Of these, 20 were about volunteering, training, including apprentice scheme and one about local employment. Eleven related to mental wellbeing, happiness or social isolation. Six comments suggested various group activities including gardening and

cookery. Eighteen were about supporting the local community, including strengthening local activities and opportunities to bring people together. Some people didn't understand the question and a couple thought that the programme was social value enough. Other suggestions included an alcohol worker and working in schools.

**Questions 9 Scope:**
*The plan sets out the range of existing healthy lifestyles support services that are in scope for this new programme, and those that are out of scope (page 22, section 5.4).*

*Do you agree with this scope?*

| | | |
|---|---|---|
| **Yes** | **75** | **74.26%** |
| **No** | **26** | **25.74%** |

*If no, please add your comments and suggestions below, and tell us any other support services that you feel should be included in the scope of this service, or out of scope, and give your reasons…*

A total of 51 comments were left, including from respondents who agreed with the scope but wanted to suggest the inclusion of other services or raise concerns. Two of these wanted assurance that services would meet the needs of BAME and Disabled people and those who have a Learning Disability.

Thirty respondents (including some who agreed with the scope) wanted it to be wider. Thirteen of these suggested the addition of healthy schools (4), healthy schools and leisure centres (4), leisure centres (2) and some form of physical activity. There was one suggestion for Therapy services, libraries and Children's Centres to be in scope.

Four respondents wanted the inclusion of mental wellbeing/stress management services. Other suggestions included falls (2), Sexual health and specialist drug and alcohol services. Three respondents wanted more of a focus on children and families.

A variety of other comments were received including about TUPE, Healthy Living Centres and linking to other out-of-scope services. Four respondents did not understand the question and one wanted it to be scrapped. Concerns were also expressed about the current service providers, the effect on primary care and GP services, and stating that the focus should be primary prevention. One respondent wanted BCC transport department to be in scope to promote physical activity and another wanted pavements to be repaired to prevent falls.

**Question 10 Lots:**
*Our plan sets out some options for how we might commission different aspects of the programme as separate contracts (lots), to provide an integrated programme of support that meets the principles, desired outcomes and the model described in the commissioning plan (page 28, section 5.6).*

*Which option do you feel would be the best way to deliver this programme to meet the outcomes?*

| | | |
|---|---|---|
| **A** | **24** | **23.76%** |
| **B** | **27** | **26.73%** |
| **C** | **34** | **33.66%** |
| **None** | **16** | **15.84%** |

*If no please explain why and give any suggestions…*

A total of 28 comments were left. Four respondents wanted one lot but with suggestions about lead provider and contracting with a wide range of specialisms. A combination of lots was proposed by four respondents suggesting one or two lots with a geographical focus. A further four stated that it had to be local 'on people's doorsteps' to gain access to the people who needed it.

Four found it difficult to choose and a further three wanted to keep the services the same as they are now. One wanted public health to provide it themselves.

A further eight comments were received on a variety of topics including expressing concern about the model suggesting it was too universal, ready for 'Virgin to hoover up' and that there was no way for smaller organisations to participate.

**Question 11 Price/Quality:**
*In our plan, our proposed evaluation criteria will be 80% quality and 20% price (page 28, section 5.8).*

*Do you feel this ratio is correct?*

| | | |
|---|---|---|
| **Yes** | **89** | **86.41%** |
| **No** | **14** | **13.59%** |

*If not, please state what you feel it should be and the reasons why?*

Twenty –two comments were left of which four thought that quality should have a greater weight and four thought that price should be a bigger percentage than proposed with one suggesting a 50:50 split.

Seven respondents did not understand the question or didn't have the knowledge to comment. A further two were unsure.

Other comments received were about how quality would be measured, the living wage, subcontracting and a suggestion that a criteria should be added about knowledge of Bristol communities and the ability to work with disabled people. One respondent felt it would be difficult to decide between the bids with the proposed ratio.

**Question 12 Equalities:**
*The following characteristics are protected characteristics: Age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation (page 31, Appendix A).*

*Do you think that there is anything in the proposals set out in the draft strategy that may adversely impact on people with protected characteristics, and is there anything we can do to prevent this?*

A total of 56 comments were left. Ten expressed a need for services for particular groups including single sex (2), age appropriate, including one who wanted us to remember young people, LGBT and people with Learning Disabilities (4). There was one suggestion that the age for health checks (40 -75) should be the age range that the programme catered for.

Three respondents wanted a balance between digital and specialist services and issues with the digital offer were highlighted by a further nine respondents for disabled people (3) and older people (6).

Seventeen people did not think that anything further was required.

Nine comments on a range of issues were left including about the difficulties of reaching people with protected characteristics who may need the services the most. One respondent wanted translation services whilst another wanted all services to be provided in English to save on translation costs. It was noted that Park Runs may discriminate against disabled people and finally we were reminded that people on low income and in poverty may not be covered by the Equality Act.

**Question 13:**
*Please add below any other comments you would like to make about our plans for commissioning a behaviour change for healthy lifestyles programme…*

Thirty-four comments were received covering a variety of topics.

Eight of these re-stated the need for services to be local and/or use small specialist and individual services working though grass roots organisations. One related to the opening hours, one wanted a bigger (STP) footprint. Five comments were in support of the programme, one of whom thought it visionary. Four respondents wanted to remind us about the vulnerable in society and those who would have difficulty

accessing it, including those with protected characteristics or mental health problems.

Other comments included health conditions, infant feeding, the need to work with local communities, and taking a holistic approach. Reference was made to data collection, behaviour change, links to children's services, corrections required in the survey question. There were two comments about the need for new weight loss guidance and one suggestion that we already had a service lined up. Finally, there was one criticism for the lack of opportunity to meet and another with thanks for the opportunity to comment.

**Summary of Group Meeting responses**

| **Group** | Date | Numbers attended |
|---|---|---|
| BDP | 14th July 2017 | 10 |
| North Practice Mangers | 18th July 2017 | |
| South Practice Managers | 22nd June 2017 | |
| ICE Practice Mangers | 14th June 2017 | |

Cuts/could fund other things e.g. parks

- In the Fishponds Voice is it saying that BCC are cutting things, like parks and public toilets which are public health issues so why are we funding this? Shouldn't we use the £1.5M to fund these instead?
- If there are no parks how can people take exercise?
- A lot of community centres provide this now, but now there is nobody to support and eve thing is cutting resources.
- Concept is good; the issue is the cost to the public.
- What happens when you run out of money?

Process

- Do you have a service user at the group? Should have a service user as part of the service planning group.
- Should you have views from other groups?
- We would like a voice is setting up the programme.
- How can you measure outcome?

Service question

- Is this just Bristol only?
- How do people move on from the service?
- What agencies may want to do this and how long will they have, what happens in the service and can we choose who shares our information.
- Need to good access to where we live.
- How will it be implemented? What's the liability of the service user?
- Could connect with other services e.g. Bristol Fish Project (growing things), Arnos Vale Cemetery, Free Dog, First Bus – discounted travel or people being part of the service
- BDP helps us change our behaviour!
- TEAVE helps with social isolation, it bring people together e.g. working on allotments together, why don't we utilise them?
- How will we know this is working?
- Health Champions and other navigation services in the community – how will this programme link up with this programme?
- How long the contract?
- Will there be break clauses?
- Did we expect a larger organisation to take on this contract?
- Need to have face to face support for those who need it, have we factored in less face to face?
- Is this BNSSG wide?
- Digital offer can be a problem around language, accessibility and literature?

- Is intention to invite Health Checks centrally?

Digital

- Digital –not everyone will use it.
- How do you intent to encourage people to access the service?
- Do we have evidence and digital works?

NHS Specific

- GPs and health centres already support us– need consistency.
- GPs treat holistically and wouldn't like to be seen by someone else – would like to see more money to GPs.
- People trust the NHS – wouldn't want private companies have access to our records.
- What do GPs think of it?
- Would the prescribing come back to GPs or will the new provider prescribe?
- How do we update medical records? Will we expect GPs to update?
- Wanted to know if GPs were part of this?
- I will lose stop smoking, and then have to refer to the service?
- We need to take on board the learning points identified from the recent Sexual Health procurement. We cannot make assumptions around engaging with primary care and to ensure they make referrals to the new service.
- Are they examples of other areas: are GPs offering these services?

What about Mental Health?

- There is no mention of mental health and it should be the golden thread.
- The current mental health services are crap!

Other comments

- What happens if I say no!
- What is the feedback from the other areas?
- Quality of life is effected by the weight of the wallet – how ae we going to change this?
- Is this about chance? To be healthy or not?
- Change concerns me, very suspicious.
- Isn't there a similar programme being ran in Bristol? The Advocacy service ran by BCC?
- Are we clear on what we are achieving from the current
- Any uplifts?
- Funding envelope?

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**Bristol Behaviour Change for Healthier Lifestyles Programme**

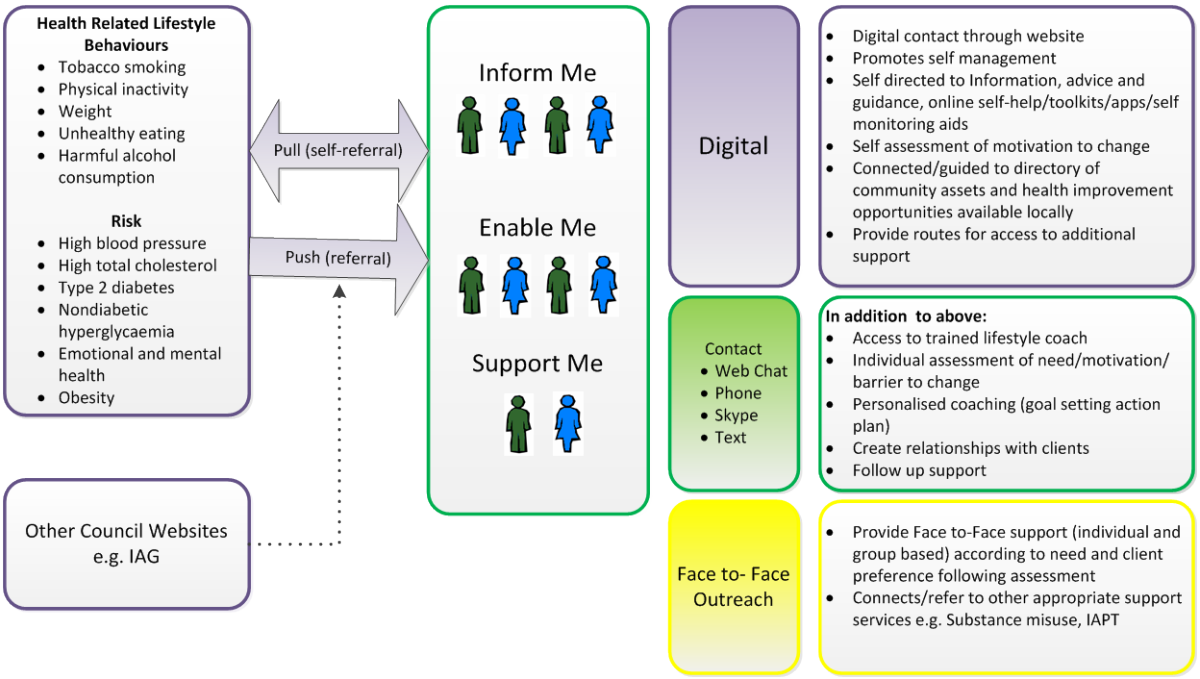
**Options for procurement lotting arrangements**

## 1. What are the key aims of the programme?

- Integrated support for individual / family behaviour change (including children and young people) rather than focussed on a single lifestyle issue.
- Provide a service for all, with a level of support proportionate to individual need:
  - Help to help yourself – maximising use of digital technology
  - Telephone support
  - More intensive face to face support through local groups/individual support for those with highest needs wishing to change their health related behaviours
- To have a presence in local communities and connect effectively with local community assets.

## 2. What was the agreed service model for the new programme?

The following service model was agreed and put out for consultation:



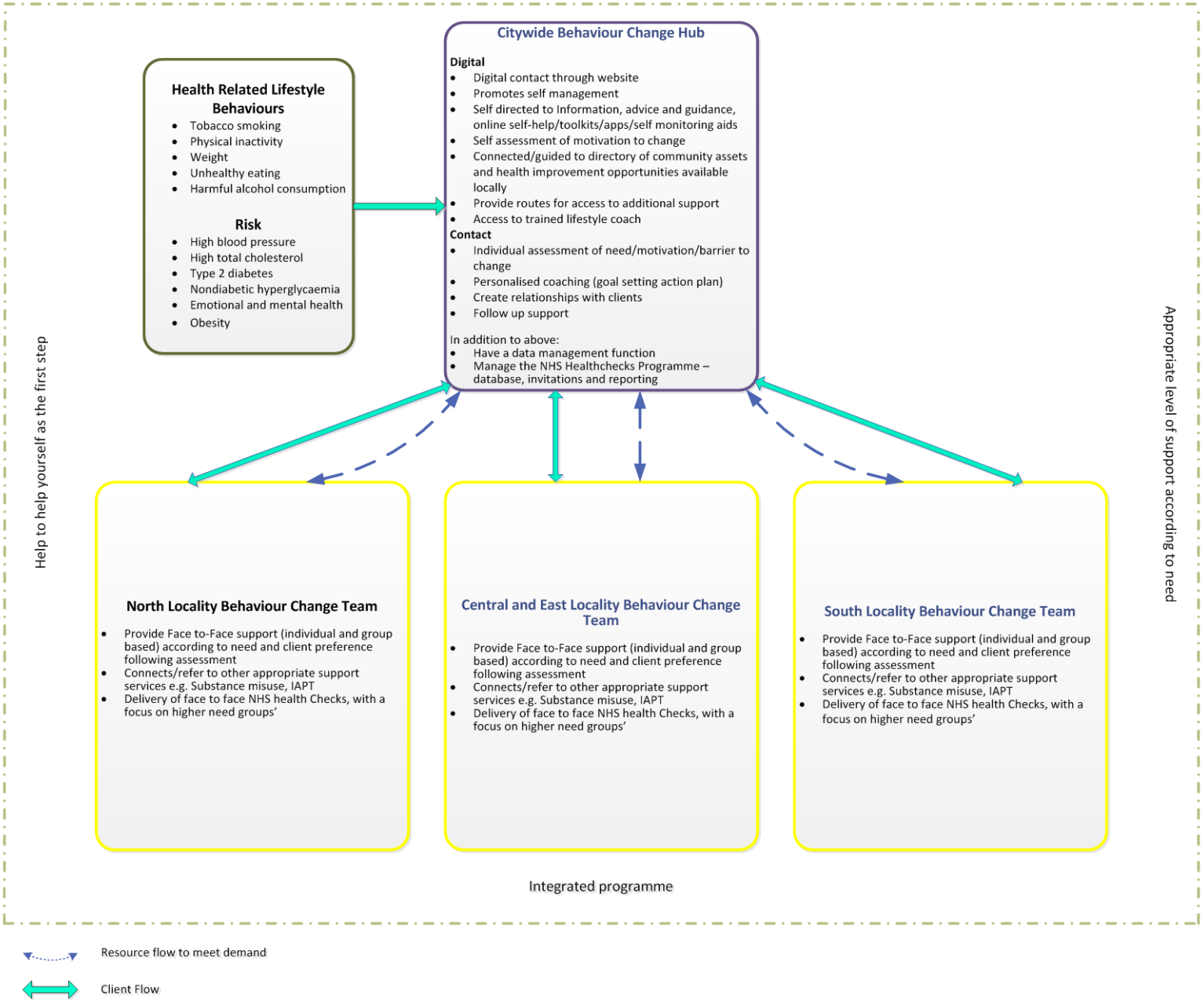

The behaviour change programme also includes inviting adults in Bristol aged 40-74 for a face to face **NHS Health Check**, delivery of these health checks, and reporting activity to PHE (Health checks are a mandated LA responsibility).

## 3. What has the consultation told us?

- The vast majority of consultees supported the above programme model, with support proportionate to need.
- In terms of lotting arrangements, responses were split across the three options –
    - a single lot for the whole programme,
    - one lot for behaviour change programme with a separate lot for the NHS health Checks element,
    - geographically based lots
- The Care Forum, Southmead Development Trust, Wellspring and Knowle West Healthy Living Centre and Wellspring supported the second option rather than a geographically based model
- There was a strong focus throughout in support of a programme that included a locality focus, with 93% of respondents supporting a model which provides different levels of support according to needs
- The majority – 86% felt the ratio of 80% quality and 20% price in the evaluation was correct, and there was a range of comments regarding equalities, including the balance between digital and face to face service provision.

## 4. How might the service model work, taking account of consultation findings?

The consultation found strong support for the service model proposed above, and for maximising the use of digital technologies. It also highlighted the need for strong face to face support in local communities.
A proposed model for the programme, building on the original service model, is found below, assuming an integrated programme coordinated by the city wide hub.


Citywide Behaviour Change Hub
Digital
Digital contact through website
Promotes self management
Self directed to Information, advice and guidance, online self-help/toolkits/apps/self monitoring aids
Self assessment of motivation to change
Connected/guided to directory of community assets and health improvement opportunities available locally
Provide routes for access to additional support
Access to trained lifestyle coach
Contact
Individual assessment of need/motivation/barrier to change
Personalised coaching (goal setting action plan)
Create relationships with clients
Follow up support
In addition to above:
Have a data management function
Manage the NHS Healthchecks Programme – database, invitations and reporting
Health Related Lifestyle Behaviours
Tobacco smoking
Physical inactivity
Weight
Unhealthy eating
Harmful alcohol consumption
Risk
High blood pressure
High total cholesterol
Type 2 diabetes
Nondiabetic hyperglycaemia
Emotional and mental health
Obesity
Help to help yourself as the first step
Appropriate level of support according to need
North Locality Behaviour Change Team
Provide Face to-Face support (individual and group based) according to need and client preference following assessment
Connects/refer to other appropriate support services e.g. Substance misuse, IAPT
Delivery of face to face NHS health Checks, with a focus on higher need groups'
Central and East Locality Behaviour Change Team
Provide Face to-Face support (individual and group based) according to need and client preference following assessment
Connects/refer to other appropriate support services e.g. Substance misuse, IAPT
Delivery of face to face NHS health Checks, with a focus on higher need groups'
South Locality Behaviour Change Team
Provide Face to-Face support (individual and group based) according to need and client preference following assessment
Connects/refer to other appropriate support services e.g. Substance misuse, IAPT
Delivery of face to face NHS health Checks, with a focus on higher need groups'
Integrated programme
Resource flow to meet demand
Client Flow

## 5. Appraisal of lotting options

- A single lot approach was proposed by the project group, and taken to the wider steering group. A 4 lot approach was proposed by the wider steering group, as a means to ensure smaller community sector organisations had the opportunity to bid and the needs of the most deprived communites were met.
- Further advice was taken on this with legal and procurement colleagues, and legal advice was strongly against separating in to 4 lots.

Appraisal of these 2 options against both aims of the programme and wider council aims are set out below:

| **Programme/wider council aim** | **Single lot - with collaboration** | **4 separate lots: digital hub, plus 3 x locality services** |
|---|---|---|
| An integrated behaviour change programme | Facilitates a joined up service through a single contract for whole behaviour change programme which meets the needs of communities. | Fragmentation and loss of ability to move seamlessly with the behaviour change programme to different level /locality for support. |
| Flexible and responsive to need | Single contract allows flexing of resources and staff between the hub and localities, and between localities, to meet needs and demand | Individual contracts and resources for each of the 4 lots limits opportunity to flex resources to meet people's needs. Variation in programme quality within each of the 3 localities. Diverse provision in line with range of local population needs still required within localities. |
| Support proportionate to individual need | Allows for a mainstream approach to individual /family behaviour change with localisation and more intensive support in high need areas. | Ensures localisation at 3 locality level. |
| Presence in local communities, linking to community assets | Collaborative commissioning under lead provider arrangement with clear locality | Ensures presence in local communities across 3 localities |

| | | |
|---|---|---|
| and meeting community needs | specifications to ensure prescence, visibility in local communities and expertise | |
| Take account of market potential | Open to wide range of bidders through collaborative arrangements | Open to wide range of bidders |
| Efficient use of council resources | Cost efficient.<br>Simplifies commissioner/provider relationship - Single procurement, single contract | Higher cost for same level of service delivery<br>4 procurements, 4 contracts to manage, 4 sets of liabilities and potential disputes. Requires additional council resource for contract management, reducing resource available for face to face service delivery |
| Delivery of the council responsibility for the NHS health checks programme, including inviting people, delivering checks, increasing uptake, reporting to PHE. | Clear responsibility for NHS health checks programme across the city with lead provider. Single data management system for invitations, activity monitoring and reporting. Allows for flexing resource across localities to increase uptake | Fragmented responsibility, duplicate data management, administration and risks. No single system for sending invitations. |
| Encouraging involvement of SMEs and community organisations | Specification for locality teams to be set out in overall spec for a single lot, including requirement for local knowledge and expertise in working with diverse local communities (Lead contractor arrangement doesn't exclude smaller organisations) | Specification for a hub with 3 locality teams will encourage involvement of SMEs and community organisations. Risk working in isolation within their own area to their individual contract. |
| Ability to TUPE existing Public Health staff | 11 public health employees have been identified for possible TUPE, including The Learning disabilities team, the Resource and information Team and the existing Hub staff. A single provider will enable staff to resource areas of the model, appropriate to skills, knowledge and needs of the system. | Employees will be identified for a specific lot (contractor), which does not offer flexibility according to need of the employee or community. |

## 6. Suggested way forward and proposed risk mitigation

1 lot, with collaboration, and actions as below to ensure participation of smaller community organisations.

To date we have encouraged our voluntary and community groups to collaborate with each other and other organisations at a Market Development Day, which included a ‘speed dating’ element, and a request that interested parties work together in advance of the formal procurement process beginning.

- The service specification will be structured to protect the locality element and encourage smaller community sector organisation to bid in a collaborative way. We will draft a locality team specification within the overall specification, that clearly sets out our expectations and requirements for locality teams. It will state clearly that the provider/lead provider must have appropriate knowledge and expertise for delivering this contract to Bristol City Council (either through themselves or a collaborative arrangement, or both).

- These requirements will be strongly weighted in the tender evaluation process.

- We have extended the period for preparation of bids, to support development of collaborative bids.

- The procurement process is based on an open procedure, which means we will provide the equivalent of a shopping list, and the supplier will provide a pricing for the list. We will require a project plan, a structure, and pricing.

- We will expect a presentation/interview as part of the tender evaluation process, which will enable us to discuss with the provider how they will meet the needs of local populations, particularly where needs are highest.

- Our Bidder Day in September will make these intentions very clear.

  We are aware of several local community organisations that are having collaborative conversations.

Sally Hogg, Viv Harrison
18/8/17
*Amended 5/9/17 after review by BCC procurement officer*

# Bristol Behaviour Change for a Healthier Lifestyle Programme Service Specification

***DRAFT – in progress***

## 1. Purpose

This document sets out the requirements for a city wide Behaviour Change for Healthier Lifestyles Programme, which is accessible to all, whilst having a strong locality focus. It will offer support to people in Bristol to encourage them to make changes to their lifestyle behaviours to improve their health outcomes, and reduce their risk of developing conditions such as cancer, diabetes and heart disease.

The document should be considered in conjunction with the Bristol Behaviour Change for Healthier Lifestyles Commissioning Strategy which provides the background and evidence to this service specification.

In providing the services under this Programme, all providers must consider and comply with their obligations under the Law, including the Equality Act 2010.

## 2. Introduction

2.1 Changing health related behaviour requires a range of strategic approaches combining individual (all ages), community and population level interventions, and takes into account other determinants of health such as people's personal circumstances, neighbourhood, and work opportunities. The Bristol Behaviour Change for Healthier Lifestyles Programme will be focused on support for individual behaviour change as one part of this bigger picture.

2.2 The Bristol Behaviour Change for Healthier Lifestyles Programme moves away from the traditional approach of lifestyle services being commissioned separately and focused on a single issue, to an integrated holistic approach that informs, guides and supports people to change their lifestyle behaviour.

2.3 The programme will seek to connect, motivate, empower, enable and support people, to help and encourage them to change the four key lifestyle behaviours that lead to preventable ill-health, specifically tobacco smoking, healthy eating, physical activity and excessive alcohol consumption.

2.4 Evidence suggests that lifestyle risk factors can cluster and in England, more than 25% of adults have three or more risk factors. People with multiple risk factors tend to come from more deprived backgrounds[1].

2.6 Models of support provided by traditional lifestyle services have largely focused on face-to-face interventions. Advances in digital technology and use of the internet and social media mean that many individuals may benefit from, and /or prefer to use

[1] The Kings Fund. *Clustering of unhealthy behaviours over time. Implications for policy and practice.*2012

remote and self-management support to change their behaviour. Incorporating self-management options within the programme, where appropriate, means face-to-face resource can focus on those with higher or more complex needs. This is in keeping with the Marmot principle of proportionate universalism[2].

## 3. Aims and Objectives

### 3.1 Aim

To design and deliver an integrated Behaviour Change for Healthier Lifestyles Programme which will:

- Contribute to actively reducing early ill-health (from childhood and throughout life), health inequalities and early deaths in Bristol from conditions that are largely preventable through healthier lifestyles.
- Provide behaviour change information, guidance and support for reducing harm from smoking, unhealthy diet, physical inactivity and excess alcohol.
- To increase the numbers of people who are changing their lifestyle behaviours, and in particular are physically active, eat a healthy diet, do not smoke, drink sensibly and have a healthy weight.
- Deliver the NHS Health Checks programme for Bristol.

### 3.2 Objectives of the Programme

- To provide a high quality, evidence based Behaviour Change for Healthier Lifestyles Programme to support individuals and families to change health related behaviours and choices.
- To provide a locality focus that is visible, and works collaboratively with local communities in the North, Central and South of Bristol through Locality Teams.
- To enable easy and equitable access to appropriate, high quality information, guidance and support for healthier lifestyles for all ages and cultures, taking account of lay and local wisdom about barriers and change where possible[3].
- To offer and provide a range of information, guidance and support options, with support that is proportionate to individual needs and circumstance. Programme options available to individuals and families will include support for self-management through digital media, telephone contact, web-chat, email, texting and instant messaging and video capability (eg using Skype, hangouts etc) and face to face support in community settings through Locality Teams.
- To facilitate, support and encourage self-help and self-management, maximising use of digital technology via use of the Hub.
- To develop and maintain a central digital media website and App (the 'Hub') which shall act as a central accessible point of entry for the programme, and a source of information, advice, support and signposting to local services and sources of lifestyle change support.
- To meet the behaviour change needs of population groups and individuals with multiple lifestyle risks and those likely to have poorer health outcomes.

[2] Marmot, M. *Fair Society, healthy lives: The Marmot Review.* 2010

[3] NICE Public Health (6) Guidance; Behaviour Change: General Approaches, 2007

- To consider the impact of wider determinants of health and where appropriate to connect people with other services that address these wider determinants.
- To deliver the NHS Health Checks programme for Bristol, including inviting eligible people, delivery of Health Checks, and support to address health related lifestyle behaviours
- To ensure that staff delivering behaviour change support are appropriately trained, skilled, and competent.
- To develop, implement, manage and review a programme-wide customer data management system for the effective and accurate recording of the delivery of all services, data capture, analysis and performance reporting, review and changes.
- To ensure that people with multiple lifestyle risk factors, who wish to change their lifestyle behaviour are supported to do so, in the most appropriate and effective way for them.
- Works with families, and in partnership with, amongst others, the Public Health Community Health Improvement teams, Schools/Colleges, Early Years settings and others who work with individuals and families to motivate them and get them ready to change their lifestyle behaviour, and build local and community resilience, and legacies from this involvement.
- Uses a 'strengths based' and interests based approach that looks at the person not the condition, acknowledges and builds upon the strengths, skills, interests, capacities and support networks of local people.
- Encourages social interaction and a reduction in social isolation, supporting people to build self-esteem and confidence.
- Connects to effective evidence based programmes to improve people's emotional and mental wellbeing including the 'Thrive Bristol' programme.
- Ensures that all aspects of the service it provides to members of the public is fully accessible to all protected equalities communities and that people with a learning difficulty are supported to change their behaviour.

## 4. Programme Requirements

4.1 The programme will provide high quality and accessible information and support, available to all residents of Bristol to help them adopt and maintain healthier lifestyles focusing on the four lifestyle behaviours that have the greatest impact on health and wellbeing:

- Smoking
- Physical inactivity
- Excess alcohol consumption
- Poor diet (linked, along with inactive lifestyles to overweight and obesity).

4.2 The programme will maximise the use of digital technologies and support and facilitate self-help.

4.3 The programme will be suitable for all ages, and encourage a whole family approach to behaviour change.

4.4 The programme will assess people's (individual and families) level of need and motivation to change their behaviour using an evidence-based approach, such as the Com-B Behaviour Change Model.

It will deliver a range of evidence based behavioural change interventions, for example, brief interventions, motivational interviewing, coaching, goal setting, monitoring and feedback with the individual for smoking, alcohol, physical activity and healthy weight.

It will provide high quality support, working with the individual to best meet their needs and if appropriate maintain contact over an extended period.

The programme will connect people and families to local community assets and services, such as local voluntary programmes, groups and commercial services to support healthier lifestyles, and will provide up to date local information on current activities and events available, to which people can be signposted to support their behaviour change.

The programme should be supported by a clear behaviour change strategy and targets, and manual of intervention approaches, including innovative approaches which recognise individual and families with different needs, aspirations and motivation.

4.5 The Programme will promote and deliver the NHS Health Checks programme for eligible residents of Bristol (age 40-74 or from age 30 for specific targeted groups).

4.6 The programme will include a behaviour change for healthier lifestyles digital/telephone 'hub', as a usual first point of contact with the programme, and locality behaviour change teams.
The hub will offer information, guidance, support, self-help options, and signposting through both digital and telephone media.
Locality behaviour change teams will provide all face to face support, including group support for specific lifestyle behaviours and individual support where needed.
The programme shall provide a city wide programme, that shall maximise the use of digital technologies, and which is enhanced with robust face to face support within local communities, tailored to meet the needs of people in Bristol.

**4.7 City wide Behaviour Change Hub description**
The city wide behaviour change Hub will act as a first point of contact for the Behaviour Change for Healthier Lifestyles Programme, through digital and telephone contact routes. It will be accessible to any Bristol resident, of all ages, including families, who are seeking advice, information and /or support to achieve healthier lifestyles, in a way that they wish to receive it. The Hub service is likely to be predominately web-based and must be age appropriate (particularly for children and young people), and also encompass the needs of our equalities communities.

The provider will:

- Develop an innovative, interactive digital website platform and App which shall encompass the use of the newest software and technology throughout the Contract Term to promote and support self-management.

- Create a bespoke website platform for children and young people, which is age appropriate and interactive. The website should be capable of providing on-line coaching and support for children, young people and their families to address lifestyle choices and issues, particularly focusing on healthy weight.
- Ensure it is user –friendly, easily accessible, easy to navigate and have the right look and feel/brand to attract and engage people to encourage them to make use of the programme.
- Ensure the content has a local focus.
- Provide a single point of access for information and resources, including:
  - Pregnant women
  - Breastfeeding and breastfeeding support
  - Healthy Start – including weaning
  - Emotional health and wellbeing including stress management
  - Information for parents and children about the National Child Measurement Programme
  - Information about the NHS Health Checks programme
  - Food and nutrition (including maintaining a healthy weight)
  - Physical activity
  - Reducing harm from smoking.
- Deliver self-assessment of motivation to change and direct people to relevant and appropriate on-line behaviour change programmes / toolkits / apps / self-monitoring aids.
- Provide a section for Health Professionals – detailing current guidance and information on lifestyle factors/signposting into the Programme /training etc.
- Provide links to other current and updated sites and particular pages within those sites e.g. NHS Choices, Change4Life, skills development, adult learning, Bristol Information, Advice & Guidance (IAG) (welfare and debt); adult education and skills; volunteering opportunities; housing and employment support; Improving Access to Psychological Therapies (IAPT); Leisure Services; Bristol Youth Links, community services, Bristol Social Prescribing.
- Provide an option for individuals / families to contact the programme for additional support. This must include a telephone contact but also provide the option for assisted support to enable digital access and use of; web-chat, email, texting, instant messaging and video capability e.g. skype, hangouts, etc. ie. ‘digital support’.
- Identifies those who wish to make changes to their lifestyle but need more intensive support than that offered through the digital support services and telephone services, and connects people with one of the three locality teams.
- Provide access to trained lifestyle coaches
- The programme shall provide 24 hour, seven day a week access through the website and extended office hours (8am-8pm / Monday-Friday), and a minimum of one weekend a month, telephone access in which residents must be able to contact a trained health coach if they wish.
- Connect people to local activities through for example, providing the location, times, information, etc. on community activities, including private, public and voluntary services within their local community.

- Manage and deliver the NHS Health Check programme for Bristol, including maintaining and updating a database of eligible individuals, inviting people to a Health Check and reporting on activity and outcomes from this activity.
- Actively target and support people with the highest health needs to access and use the programme (for example, Black, Asian & Minority Ethnic groups (BAME), and areas of deprivation in quintiles 3, 4, & 5), people with mental ill-health and people with Learning Difficulties.
- Provide a data base function.
- Follow people up on a regular basis in order to track, record and review outcomes.
- Ensure that there is a digital Hub gateway incorporated to ensure that those referred through the Hub to locality teams are residents of Bristol.

**4.9 Locality Behaviour Change Teams (Locality teams)**

Locality Teams will:

- Provide a local presence for the Bristol Behaviour Change for Healthier Lifestyles Programme and provide face-to-face support for those who need it. They will work collaboratively with local communities, particularly in deprived areas of the city, helping identify their own health needs and aspirations, and linking to local assets and services. Providers will develop an offer that is appropriate to diverse needs across localities with a presence in each of:
  - Central and East
  - North,
  - South

Locality behaviour change team providers will demonstrate local knowledge and expertise of working with diverse local communities and community leaders at a very local level in Bristol (or equivalent), particularly among communities with high health needs. They will demonstrate understanding of the differences between the localities and the population groups within the different geographical areas and knowledge applicable to working with people in Bristol who have multiple lifestyle risk factors and those likely to have poorer health outcomes to support them in achieving healthier lifestyles.

The Locality Teams will work closely with the Public Health Community Health Improvement Teams and others who work with individuals and families to get them ready to change their behaviour, and support them in overcoming the barriers to changing their Health –related lifestyle behaviour.

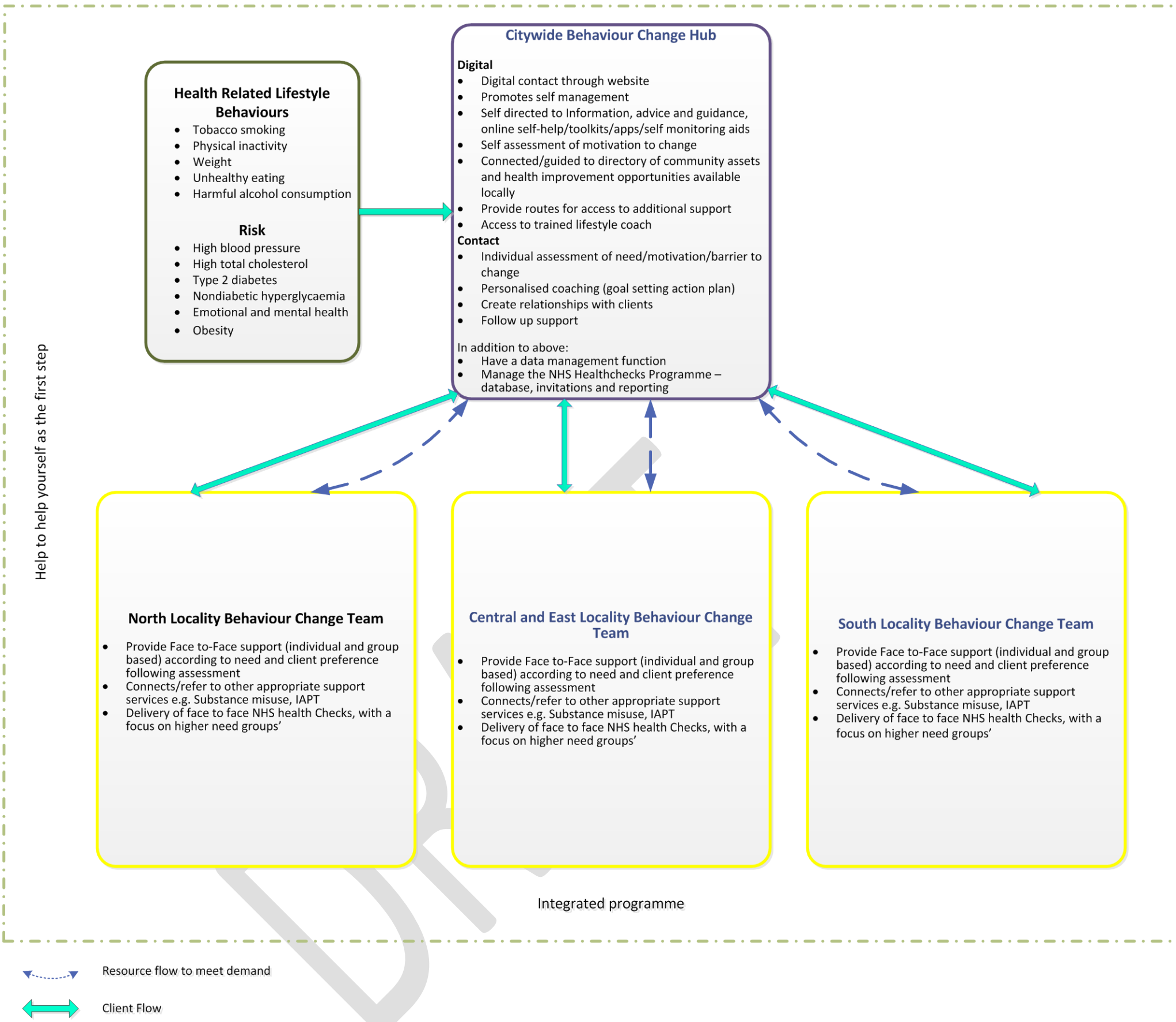
Locality Teams shall:

- Provide face to face support to individuals and groups according to need and preference following an initial assessment through the Hub.
- Provide personalised support / coaching to enable people to access the digital support offered through theHub if appropriate.
- Provide access to group support for stop smoking/smoking harm reduction, weight management, healthier eating, physical activity, and individual support as appropriate for those with greatest needs.

- Connect / signpost people to appropriate sources of support in their community.
- Provide support that is age appropriate for children and young people, particularly for weight management, healthy eating and increasing physical activity. This may be as a result of letters to parents following the National Child Measurement Programme.
- Deliver face to face NHS Health Checks, with a focus on higher need groups and populations.
- Support the hub to maintain an up-to-date 'directory' of local opportunities to support behaviour change.

**4.8 Sustainable Community Assets**

The Behaviour Change for Healthier Lifestyles Programme will have a role in contributing to and creating sustainable, healthy, thriving communities in Bristol. The programme will have the flexibility to identify funding from within its overall budget to support and enable local community groups to receive relevant lifestyle support. This may be used to lever in additional funding or used as a grant to sustain valuable local programmes. The utilisation of any budget for this purpose must be reported to the Commissioner. The programme will have a role in contributing to community capacity building and creating sustainable, thriving communities in Bristol, through working with the Public Health Community Development and Health Improvement teams.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Connects/refer to other appropriate support services e.g. Substance misuse, IAPT
Delivery of face to face NHS health Checks, with a focus on higher need groups'
Integrated programme
Resource flow to meet demand
Client Flow

## 5. Lifestyle Specific Support Requirements

### 5.1 Alcohol

The provider will focus on the adult population who are 'increasing risk' or 'higher risk' drinkers –individuals who are likely to develop alcohol-related health problems by drinking above the recommended limits for a number of years. Screening, brief advice and brief interventions, motivational support are the most effective method of preventing and reducing harmful drinking for this cohort[4].

The Provider will:

- Offer a brief intervention consisting of assessing an individual's current alcohol consumption using the Audit-C (Alcohol Use Disorders Identification Test Consumption) screening tool.
- Develop innovative mechanisms to reach, motivate and support people (including young people) to reduce their drinking to be within safe recommended levels in line with Bristol Alcohol Strategy, 2016.
- Ensure individuals who have previously been referred to ROADS (Recovery Orientated Alcohol & Drugs Service) specialist alcohol support, but do not reach their eligibility criteria are encouraged to access the Bristol Behaviour Change for Healthier Lifestyles Programme.
- Refer individuals identified as requiring specialist support (alcohol-dependent or 'chaotic' drinkers) following assessment of eligibility to ROADS for alcohol treatment.
- Provide opportunistic screening for alcohol use among people accessing the programme through the various gateway routes e.g. via website, telephone or face-to-face.

### 5.2 Healthy Weight

Bristol has a city wide approach to Healthy Weight, with an aim to halt the year on year rise in obesity by 2022. Healthy Weight is one of the three priorities of the Health and Wellbeing Board, and Sugar Smart Bristol has been launched as part of this. The Bristol Behaviour Change for Healthier Lifestyles Programme will be linked directly to this approach and the provider will be invited to sit on the Steering Group for Healthy Weight. Healthy weight in this context includes food and nutrition (including growing and cooking from scratch), physical activity and participating in activity within communities.

The Provider will:

- Provide a range of support options for adults, children and young people, including families to achieve and maintain a healthy weight, and to include options appropriate to priority groups such as early years, BAME and pregnant women, and also shall take into account cultural needs. Where appropriate, this will include a focus on specific weight management activities. Maintaining a healthy weight is likely to include:
    - On-line coaching, personal / family based goal setting and monitoring.
    - A focus on Healthy Eating – Eatwell Guide; physical activity; growing and cooking food, adapted for specific groups of people, e.g.

[4] NICE, PH24. Alcohol-use disorders: Prevention, guidance and guidelines. 2010

pregnancy and a range of different cultures and religions. https://www.gov.uk/government/publications/the-eatwell-guide

- A rolling programme which includes opportunities for increased movement through sport, activity, games; understanding food and nutrition, including providing opportunity for e.g. growing, cooking from scratch, budgeting, weaning advice.
- Emotional health and wellbeing, Sugar Smart, oral health and stress management should be an integral part of the programme.
- Provision of appropriate tools to support any weight loss programmes.

- Offer weight management interventions using the recommended evidence-based behaviour change techniques for inclusion in effective weight management interventions. This should include: [5]
  - Self-monitoring, promoting independence and self-management
  - Setting a target weight that is sustainable in the long term
  - Identify sources of ongoing social/community support once the programme has ended
  - Set goals to maintain new dietary behaviours and increased physical activity levels
  - Discuss and develop strategies to overcome any difficulties encountered such as barriers, relapse, weight regain
  - Identify dietary behaviours that will support weight maintenance and are sustainable in the long term
  - Promote ways of being more physically active and less sedentary which are sustainable in the long term
  - Encourage peer led groups for longer term support
- Maintain links and provide support to the National Child Measurement Programme (NCMP), Healthy Weight Nurses and Children's Community Health Partnership (CCHP).
- Ensure that children and young people who access the Programme as a result of the NCMP are offered an evidence based intervention[6] to help them and their families (if appropriate) achieve and maintain a healthy weight see the Bristol Pathway http://cchp.nhs.uk/sites/default/files/attachments/Bristol%20Care%20Pathway%20For%20Child%20Weight%20Management.pdf
- Be aware of, and link with, local provision for weight management and physical activity support offered by specialised child and adult services.
- Make links with providers of physical activity provision e.g. Bristol City Council Leisure facilities, local walking groups.
- Encourage individuals and families who are assessed as eligible for specialist weight management support using an agreed obesity care pathway criteria to go to their GP for referral to specialist support.

### 5.3 Tobacco Harm Reduction/Stop Smoking

The programme will provide information and support for all Bristol residents wishing to make a quit attempt or cut down to quit, and will target priority populations who are

[5] Public Health England Changing Behaviour: Techniques for Tier 2 Adult Weight management Services
[6] Weight management: Lifestyle services for overweight or obese children and young people. NICE, 2013

known to have high smoking prevalence. The provider will be invited to be a member of the Tobacco Alliance Steering Group.

The provider will:

- Be responsible for delivering a comprehensive support programme for all smokers who wish to quit or reduce their harm from smoking, linking with other service providers as appropriate.
- Offer and provide a range of treatment aids including Nicotine Replacement Therapy (NRT), free electronic cigarette vouchers (Electronic Cigarettes[7]): and Champix (according to prescribing regulations).
- Adopt evidence based behaviour change techniques[8], to support individuals who wish to stop smoking, and develop innovative mechanisms to help people to reduce their harm from tobacco.
- Ensure that children and young people who access the Programme are offered an evidence based intervention to help them and their families (if appropriate) be Smokefree. A particular focus will be on engaging vulnerable young people who smoke, or are more likely to take up smoking.
- Ensure the programme addresses health inequalities through proactive targeting and prioritisation of specific groups, working in collaboration with other service providers who treat groups where smoking prevalence is high, for example Black, Asian & Minority Ethnic groups (BAME) groups, those from lower socio-economic groups, pregnant women, people with mental health conditions in the community, ex-offenders, looked after children and care leavers, youth offenders, young people attending pupil referral units, those who are not in education training or employment (NEET) .
- Offer digital, telephone, face to face contact or group support as appropriate, and ensure accessibility of face to face support across a range of settings.
- Assess appropriate therapy, in conjunction with the individual, taking into account:
  - contra-indications and the potential for adverse effects
  - individuals personal preferences
  - availability of appropriate advice or support
  - likelihood that the individuals will follow the course of treatment
  - individuals previous experience of smoking cessation aids and support
- Provide motivational interviewing and harm reduction support for people not ready to quit, for example people using e-cigarettes.
- Provide appropriate advice and support for young people to quit smoking.
- Support people with relapse prevention to maintain a sustained quit attempt.
- Use carbon monoxide testing as a tool to support quitting or reducing tobacco and to confirm a client has stopped smoking (this could include a complete switch to e-cigarettes, with no tobacco smoking).
- Provide information to partners and families on creating and maintaining a smoke free home (linking to the training module available via Https://www.ncsct.co.uk/publication secondhand-smoke-training-

[7] A briefing for Stop Smoking Services (2016)
[8] NICE (2006) PH 1, Smoking: Brief Interventions and Referrals.
NICE (2013) PH10 Stop Smoking Services. Guidance and guidelines.

module.php and relevant updates and upgrades) to support a quit attempt, acknowledging the role of interpersonal relationships and situational issues that are connected to cigarette use.

- Actively promote tobacco control campaigns

## 6. NHS Health Checks Programme Requirements

The NHS Health Check programme aims to prevent heart disease, stroke, type 2 diabetes and kidney disease, and raise awareness of dementia, both across the population and within high risk and vulnerable groups.

It includes 3 components: (1) risk assessment, (2) risk awareness and (3) risk management.

The NHS Health Check programme is a statutory public health service in England. Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74, once every 5 years.
The provider will be responsible for offering NHS Health Checks to eligible individuals and delivery of a programme of Health Checks for the eligible population in Bristol, and reporting activity and outcomes to the commissioner.

The provider will:

- Offer a face to face NHS Health Check to all eligible Bristol residents over a 5 year period (approximately 25,000 people will be offered a check annually).
- Prioritise and target offers to population groups where the burden of ill health related to cardiovascular diseases is highest.
- Deliver NHS Health Checks to eligible people through a face to face consultation with a competent person, including the 3 components of cardiovascular risk assessment, risk awareness and risk management. Health Checks delivered will be consistent with current NHS Health Check Best Practice Guidance[9], and include and record all the specific assessments, measurements, and risk calculations as set out in the guidance.
- Offer health checks in a range of settings, including in workplaces, (in agreement with the commissioner) and in line with the Equality Act 2010, to ensure accessibility for a wide range of people and maximise take up among groups with the greatest need.
- Ensure specific information and data is recorded on NHS Health Checks, as set out in the national guidance.
- Ensure robust and timely arrangements for data from NHS Health Checks to be forwarded to the individual's General Practitioner.
  Ensure staff carrying out NHS Health Checks are appropriately trained and qualified, in line with the NHS Health Check competence framework. http://www.healthcheck.nhs.uk/document.php?o=664

- Implement and report on a quality assurance programme to ensure a high quality and safe service is provided, in line with national NHS Health Checks programme standards. http://www.healthcheck.nhs.uk/document.php?o=547

[9] NHS Health Check Best Practice Guidance, Public Health England

- Secure continuous improvement in the numbers of people having an NHS Health Check.
- Submit information to the commissioner on the number of health checks offered and the number of Health Checks completed each quarter.
- Develop and maintain relationships with local General Practices.
- Ensure data flows between various parties, including the provider and General Practices adhere to the Data protection Act, The Law and information governance, as set out in the Best Practice Guidance.
- Work with the commissioner to access NHS Digital eligibility data if this cannot be made available through General Practices. The provider will be responsible for costs incurred for initial data transfer and updating.

## 7. Programme Wide Requirements

### 7.1 Information Governance

- Provide a robust information governance system, which has the capability to collect accurate, standardised and comparable routine data to measure outcomes and impact in accordance with the Data Protection Act (1998), and the requirements for the new General Data Protection Regulation (GDPR) May 2018.
- The information governance system must be capable of obtaining clear documented consent for personal data to be used for Hub and service purposes, and shared appropriately.
- Work with the Commissioner to develop a reporting dashboard capable of presenting accurate, complete and timely activity and outcome data which can be used to inform and review programme development.
- The Provider will secure clearly documented consent for all information use to and information to be shared with the Council and the individuals General Practitioner (GP) where appropriate.
- Equalities monitoring should be in place across the whole programme.
- Take into account the new Accessible Information Standard to ensure people have information they can understand.

### 7.2 Clinical Governance

- Ensure all staff are trained and competent for their roles in line with national guidance where appropriate. Key personnel must be identified and curriculum vitaes supplied setting out the services they shall be required to supply under the contract.
- Ensure a policy is in place to cover supervision, training and management of staff; incident reporting; updating resources in keeping with national recommendations.
- Link with the Bristol City Council Clinical Governance Group to update and ensure best practice.
- Ensure that appropriate structures are in place with which to ensure that the obligations required to be met by the Provider in providing the services and the quality of the Programme supplied are met, maintaining high standards of care within a culture of continuous learning and improvement.
- Provide clarity on any exclusion criteria in consultation with commissioners.

- The provider will be required to have an up to date Safeguarding Policy for adults and children. It will comply with the Safeguarding Vulnerable Groups Act 2006 and the Police Act 1997, and will include checks of staff or individuals who are employed by the Provider. Compliance with safeguarding standards should be reviewed with the Commissioner at regular intervals and any issues of non-compliance must be addressed at the earliest opportunity.
- Use of term clinical governance does not imply that all staff delivering the services under the programme have to be health professionals.

**7.3 Performance Monitoring and Evaluation**

Performance management of the Programme will be based on the Public Health Outcomes Framework and behaviour change outcomes relating to the four key lifestyle behaviours, smoking, healthy eating, physical activity, alcohol consumption and the delivery of NHS Health Checks to the eligible population.

The provider will be expected to demonstrate that the Bristol Behaviour Change for Healthier Lifestyles programme is reaching population groups where need is the greatest.

Equalities monitoring will be required to evidence the accessibility of the service and the outcomes achieved.

On-going evaluation of the programme will be required, with the ability to provide evidence to assure commissioners of the performance, standard and quality of the programme including evidence of the individual/family:

- Goal setting by the individual/family.
- Monitoring the individual/family behaviour.
- Receiving feedback from the individual/family, including satisfaction reviews at 12 weeks, 26 weeks and 52 weeks after the date of the behaviour change intervention or NHS Health Check.

The Commissioner and Provider will be expected to develop a working relationship to ensure continued learning and development as the programme model evolves through a co-design and co-production approach during the contract period.

The Provider will explore external research grant opportunities and upon receipt of prior written agreement by the Commissioner, submit appropriate grant /research applications which will help support external evaluation of the programme.

**7.4 Equipment**

The Provider must provide and maintain at its own cost, all equipment necessary for the delivery of the Programme and must ensure that all equipment is fit for purpose. All equipment used must be standardised, calibrated and tested on a regular basis in accordance with manufacturer's recommendations e.g. weighing scales, carbon monoxide monitors.

Where appropriate the provider must participate in regular quality assurance of testing equipment.

**7.5 Technology Requirements**

It is recognised that the delivery of innovative services as required for the success of this Programme, promoting self-care, shall have at its core a specialist IT system, which shall be accessible to the public via Apps and websites, and which the council shall require Administrative Access rights to the data captured within the Hub and the ability to produce reports on various elements of the programme.
A central element of the Hub shall be an overarching Data Management System that shall record all requisite data and provide requested reports of all individual / family journeys that have been taken as part of this Programme. The Hub services shall be subject to a Service Level Agreement, with Key Performance Indicators required to be met.
Where specialist systems are used to deliver Behaviour Change or Self-care support, sufficient relevant and current information in those systems must be captured and transferred into the overarching CRM element of the system so that a total view of the Programme delivery, or particular aspects of it, at individual level is available to the Council.

Throughout the Contract Period the provider shall ensure that all Hub hardware and software used in the provision of the Programme is up- to-date, updated, upgraded and patched (as appropriate) at no additional cost to the council, and that regular maintenance of the hardware and software, as well as emergency maintenance protocols, are in place and complied with.

Data that is published on the Hub should be regularly reviewed and updated, at least once a week.

All the software and hardware used in the provision of the Hub and used to provide and support the Programme must ensure:

- It is compliant with the new General Data Protection Regulation (GDPR), May 2018.
- Comprehensive data capture, storage and retrieval is managed in an effective and efficient manner.
- Information and data provided during individual / family assessments and reviews shall be recorded within the Hub and securely stored, including consents.
- Engagement with individuals / families is effective e.g. individuals are well informed; asking the same question more than once is to be avoided.
- Information recorded on one aspect of the Hub can be combined with the data available on activities and pathways to support decisions made by Behaviour Change for Healthier Lifestyles staff, to ensure that the provider delivers evidence based behavioural support.
- Prompts are forwarded to relevant staff to ensure that they undertake an agreed activity in a timely way e.g. review appointments; individual follow up.
- Individual / family facing sections of the Hub are engaging, secure and easy to use for people of all abilities including children and young people, those with visual impairments, those with learning difficulties.
- Ensure the platform meets the needs of our equalities communities and young people.
- Pathways for each element of the Programme are relevant, accessible and up to date.

- Referrals and messages sent and received can be passed securely between all parties involved in requesting, delivering and receiving the service.
- Information analysis and reporting of data is done in an intelligent and useful way.
- Availability of timely information to inform any need to change approaches at individual and strategic level.
- Utilise an online ordering facility for leaflets and other resources.
- Flexibility and ability to adapt to changes in needs, based on, amongst others, Customer insight.
- Maximise appropriate use of social media.
- Provide an online lifestyle risk assessment/stratification website/app capturing baseline data.
- Ensure that the Hub services can be accessed and available on all commonly used forms of hardware and software, including PC, laptop, mobile phones, tablets etc.
- Software licensing costs will be covered by the provider.

A fuller specification can be found in Appendix 2

**7.6 Staff Development and Training**

The programme provider will be responsible for the recruitment, training and clinical governance of all staff supplying the services under the Bristol Behaviour Change for Healthier Lifestyles Programme. All staff and contractors providing, for example, training, individual/family assessments and interventions must have an appropriate level of competence to deliver the relevant parts of the programme, and must adhere to professional guidelines if they are registered with a governing body. Competencies will be agreed with the commissioner.

The Provider will:

- Ensure staff are trained, competent and experienced to engage with individuals and families of varying needs to assess their motivation for change and deliver brief interventions to enable them to stop smoking, increase physical activity levels, reduce alcohol consumption, or improve their diet.
- All staff should be skilled in the engagement and retention and in delivering face to face and group interventions tailored to the needs of individual. They will be trained and competent in behaviour change theory, motivational strategies, and communication techniques in order to encourage sustainable health behaviour change.
- Ensure staff are competent to work with people of all ages and cultures who live in areas of greatest need, including those with physical and learning disabilities and mental health problems.
- Ensure staff are able to communicate in an appropriate manner with children and young people of all ages and their families.
- Provide training for staff in weight management (children and adults) including the National Child Measurement Programme and follow up.
- Provide Level 2 stop smoking training for staff in accordance with guidance (NICE, PH10, National Centre for Smoking Cessation and Training (NCSCT)).

- Ensure appropriate staff are trained, competent and supervised in the delivery of NHS Health Checks, in line with the NHS Health Checks competency framework.*(insert link).* To include:
    - Use of the Global Physical Activity Questionnaire (GPAQ)
    - QRISK tool and communicating results of cardiovascular risk estimation
    - Ensure staff are competent in the dementia assessment part of the health check
    - Ensure staff are trained in the use of the Audit C Alcohol tool and in brief interventions to support people to reduce their alcohol intake.
- Ensure staff are trained in Equalities, Adult Safeguarding, Children Safeguarding as mandatory.
- Ensure staff are adequately supervised and receive an annual appraisal. Any development need identified during the appraisal should be documented in a personal development plan and reviewed on a regular basis.
- Any qualified health professionals working within the Service will have training, professional qualifications and Continual Professional Development (CPD) in line with the national professional body relevant to the profession.
- Ensure that all training provided is regularly updated. Records of all training provided by provider staff under this Programme shall be retained within the Hub.
- There shall be a Complaints procedure set out to deal with any dispute or complaint regarding the Programme Services. Where a complaint has been received a regarding a member of the provider's staff, the Council may at its absolute discretion ask that the staff member involved is removed from providing the Programme services and replaced with a similarly trained, experienced and competent staff member.

**7.7 Communications and Marketing**

7.7.1 The Provider shall develop a Marketing Strategy encompassing the latest digital technologies that builds on the data collection outlined above.

The provider shall develop a brand that is marketed across the city.
IPR for the Bristol Behaviour Change for Healthier Lifestyles programme brand will be assigned to the council.

The Provider will be required to collect individual's information, analyse and segment the data and have ongoing models to continually assess individual's experiences, views and needs. Ensuring mechanisms are in place to continually gather intelligence and insight from individuals will be critical.

The Marketing Strategy will build on the objectives outlined in the programme design to drive individual and stakeholder engagement in the programme, to develop the brand and digital technologies including the use of multiple platforms and use of different marketing tactics as appropriate.

Effectively targeted marketing has the ability to reach people at their trigger points when they are most likely to consider making a change. The Provider will be required to continually market the programme through effective channels and tactics to ensure the public can access the Programme at their convenience and that

appropriate stakeholders e.g. midwives, schools are encouraged to signpost to the Programme.

Marketing approaches will be both universal – the population of Bristol, and in addition, tailored to those in greatest need. Children and young people will require an approach that is appropriate to culture, age and ability.

Good relationships across community, voluntary, NHS and Local Authority providers will be essential to the individuals/families experience and achieving the behavioural outcomes. The Provider will be expected to market The Bristol Behaviour Change for Healthier Lifestyles Programme in a range of ways, and develop a brand that becomes easily identified and trusted in all areas of the city.

7.7.2 The Provider will utilise and locally deliver national campaigns that address the 4 key lifestyles (smoking, diet, inactivity and excess alcohol) run by for example, Public Health England e.g. *Start4life, Change4life, One You, Know your Numbers.* The provider will also support and engage in local campaigns led by Public Health Bristol e.g. *This Bristol Girl Can, Sugar Smart Bristol*. The provider will particularly focus on local delivery of campaign messages in a way that is appropriate across the diverse communities in Bristol.

The provider will provide and distribute resources and information to ensure a variety of agencies including Bristol City Council, the NHS and other voluntary and statutory agencies receive up-to-date relevant information and resources to support behaviour change campaigns. This will include downloadable leaflets and hard copies where appropriate and necessary, as well as items such as models and kits for use in face to face behaviour change support in group settings.

The provider will ensure all material is compliant with the Law, is of high standard, quality assured and accessible e.g. where first language is not English, those with learning difficulties, visual impairments.

**7.8 Social Value**

Social value is about ensuring that the commissioner achieves value for money and maximises the benefits to, and positive impact on society, the economy and the environment from the way this Programme is provided. Bristol City Council, like other public bodies, is required by Law (Public Services (Social Value) Act 2012) to consider how the services they commission and procure might additionally improve the economic, social and environmental well-being of the area.

The provider should deliver benefits and outcomes (social value) which go beyond the explicit specification requirements (including service objectives and outputs) of this tender and contribute to building the capacity, capability, skills, assets and resources of Bristol's communities.

This might include volunteering, training, work experience and apprenticeships.

**7.9 Implementation**

The Provider will attend a monthly Implementation Steering Group meeting and provide updates on progress against key milestones and any risks or issues relating to implementation. This group will act in an advisory capacity and will not be a decision making body.

### 7.10 Contract monitoring

The contact will be monitored and the Provider's Hub shall be required to provide the Council with monthly reports, and reviewed quarterly and annually by the Council's commissioning lead.

The provider will be required to obtain the following monitoring information (*to be developed)* and be able to report it to the commissioner as and when required.

### 7.11 On-going Programme Development

It is acknowledged that the programme will need to develop and evolve during the life of the contract. Critical to the long-term success of the programme is a real commitment from the Provider to work collaboratively with the Commissioner and other key partners as part of an ongoing co-design and co-production of the Programme. The provider must show that the services being provided are flexibly being tailored to meet the needs of communities in Bristol. The Provider must build on the current insight and commit to a continued programme of evolution which includes capturing insight and clients' views.

The programme will continue to increase its relationship with the community and test and evaluate new innovative approaches to contribute to ensuring and enabling a strong and thriving community base so the Programme is able to connect people to local health and wellbeing opportunities. The programme will test different approaches to ensure they have a presence within communities as part of this process, particularly in the most deprived parts of the city.

It is expected that the programme will develop in its capability to respond to increased demand, as a result of stakeholder engagement, marketing of the Programme, and the Programme brand becoming recognised by Bristol residents and professionals.

A Review of the Bristol Behaviour Change for Healthier Lifestylesprogramme will be conducted annually, with the opportunity for amendment of the specification / contract by mutual agreement.

The Provider will be encouraged to make active links with the academic establishments in Bristol (University of Bristol, University of the West of England (UWE)), to maximise the potential of participating in relevant research proposals and outcomes from research projects.

## 8. Financial information

The total maximum budget available for the delivery of the programme is £1,585,173 per annum, (through an agreed schedule of payments across the year). *(payment plan to be developed)*

## Appendix 1: Outcomes

### Outcomes Measures

The Provider will be expected to demonstrate how they will contribute to the relevant Public Health Outcomes. They will work collaboratively with the Commissioner to agree SMART key performance indicators, and performance thresholds following award of the contract. Once agreed, the contract will reflect the agreed key performance indicators.

### Relevant 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 age15
- 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
- Admission episodes for alcohol-related conditions – male/female/persons
- Cumulative percentage of the eligible population aged 40-74 offered an NHS
- 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.

### Programme Outcomes (to be agreed with the provider)

### Alcohol

- A reduction in reported alcohol use among people accessing the programme, and wishing to reduce their alcohol intake.
- A reduction in adults drinking above safe recommended limits.

### Emotional and Mental Wellbeing

- Improved mental/emotional wellbeing (using an evidence based self-reported measurement of wellbeing tool), linking to Thrive.

### Healthy Weight

- Reverse the trend in proportion of children classified as overweight or obese
- Reverse the trend in proportion of adults classified as overweight or obese
- Reverse the trend in proportion of adults and children in BAME groups and those living in quintiles 3,4 and 5 classified as overweight or obese
- Increase in the number of adults and children eating 5 portions of fruit a day
- Increase in the number of adults and children eating 5 portions of vegetables a day

Increase in the number of children and young people reported to eat breakfast
- Decrease the percentage of adults and children who are physically inactive
- Increase the numbers of children and adults meeting the recommended physical activity levels
- Reduction in the proportion of children identified as overweight or obese through the National Child Measurement Programme
- Increase the number of adults in a healthy weight range
- Increase in the percentage of people using outdoor space for exercise or health and wellbeing

### Smoking

- Reverse the trend in smoking prevalence among current smokers
- Reverse the trend in smoking prevalence among routine and manual workers
- Reverse the trend in smoking prevalence among young people
- Reverse the trend in smoking prevalence among pregnant women (smoking at the time of delivery)
- Proportion of people in locally agreed priority groups who are smokefree or reduce the harm from tobacco
- Reduce the % of people with mental ill-health who are smokefree

### NHS Health Checks

- Increase of the uptake particular in areas of high preventable cardio-vascular disease mortality.
- Increase the number of adults in priority groups being supported to change lifestyle behaviours through NHS Health Checks

### Potential Programme Key Performance Indicators (to be co-designed with the Commissioner and Provider)

### Digital Offer

- Number and % of people all ages accessing the digital hub
- Number and % of children and young people accessing the digital hub
- Number and % of families accessing the digital hub
- Number and % of individuals setting a behaviour change goal in relation to:
  - Smoking
  - Healthy weight
  - Alcohol use
  - Physical activity
- Number and % of families setting a behaviour change goal in relation to:
  - Healthy weight
  - Physical activity
- Number and % of people accessing an intervention on the digital hub
- Number and % of people being offered a NHS Health check via the digital hub

### Contact

- Number and % of people all ages receiving telephone contact
- Number and % of people of all ages utilising the digital support services
- Number and % of children and young people receiving support following telephone contact

- Number and %  of individuals setting a behaviour change goal in relation to:
    - Smoking
    - Healthy weight
    - Alcohol use
    - Physical activity
- Number of individuals / families accessing the digital hub following telephone contact
- Number and % of people being offered a NHS Health check

### Face to face

- Number and % of people all ages receiving face to face support
- Number and % of children and young people receiving face to face support
- Number and %  of individuals setting a behaviour change goal in relation to:
    - Smoking
    - Healthy weight
    - Alcohol use
    - Physical activity
- Number and %  of families receiving face to face support setting a behaviour change goal in relation to:
    - Healthy weight
    - Physical activity
    - Support to stop smoking
- Number and % of people receiving a face to face intervention
- Number and % of people being offered a NHS Health check
- Number and % of people taking up the  offer of an NHS Health check

### Alcohol

- Number and %  of people who completed audit tool
- Number and % of people who screened positive (5 plus)
- Number and % of people give a brief intervention (those scoring 8-19)
- Number and % of people signposted to general practice (those scoring 20 plus)

### Healthy Weight

Reported by age and demographic.
Children:

- Increase in children and young people reporting eating 5 A DAY
- Increase in physical activity (use a validated tool)
- Increase in  self-esteem (validated tool such as Edinburgh and Warwick)
- Increase in children and young people reporting eating breakfast
- Reduce children and young people who report eating no portions of fruit and veg

Adults

- Number of people accessing weight management support
- Number of people setting a weight management goal
- Number of people increasing their physical activity as part of their weight management  goals
- Number of people achieving a % weight loss from initial weight in following groups:

    - 0.5 – 3%
    - 3.1 – 5%
    - >5%
- Number of people attending a range of community activities supporting weight loss by individual activity
- Follow up at 12, 26 and 52 weeks to review % weight loss (within agreed ranges) and/or weight maintenance
- Number of people accessing support to maintain weight
- Number of people who have successfully lost weight with a plan for weight maintenance
- Proportion of people eating 5 portions of fruit or vegetables per day

### Increased Physical Activity

- Number and % of people by age and demographic accessing the Behaviour Change for Healthier Lifestyles programme
- Number and % of people by age and demographic who scored active, moderately active or inactive
- Number and % of people by age and demographic who are moderately active or inactive who were supported to increase their physical activity
- Number and % of people taking up new opportunities to be physically active
- Number and % of people participating in utilising outdoor leisure facilities as a result of the Behaviour Change for Healthier Lifestyles programme
- Number and % of people participating in utilising indoor leisure facilities as a result of the Behaviour Change for Healthier Lifestyles programme
- Number and % of people who have started or increased walking as a result of the Behaviour Change for Healthier Lifestyles programme
- Number and % of people who have started or increased cycling as a result of the Behaviour Change for Healthier Lifestyles programme
  Number of people who have a recorded outcome of follow up at 12, 26 and 52 weeks related to physical activity

### Smoking and Harm Reduction

- Proportion of people setting a quit date by demographic area
- Number of pregnant women setting a quit date
- Number of people setting a quit date by deprivation quintile and priority group
- Number of people setting and achieving harm reduction goals
- Number of people achieving their goal as specified
- Proportion of people who are Smokefree at 12, 26 and 52 weeks
- Number of children and young people ( 12 years +) who are identified as vulnerable e.g. NEET's, PRU, Children in Care and care leavers, Youth Offenders etc
- Number of parents accessing stop smoking support

### NHS Health Checks

- Number, % and demographic of NHS Health Checks offered in total
- Number % and demographic of NHS Health Checks offered to priority populations
- Number of opportunistic NHS Health Checks

- Number and  % of health checks converted to actual check by demographic and population group
- Number and % of  people who did not attend their health check following invitation by demographic area
- Number and % of  people who have had a previous health check ( 5 years prior)
- Number and % of people setting a goal as a result of an NHS Health Check
- Number and % of people who have made lifestyle changes as a result of their previous health check ( 5 years prior)
- Number and % of those offered a NHS Health checks receiving a NHS Health Check
- Number and % offered in a workplace setting
- Number and % of above converted to an actual check
- Number of people signposted to clinical follow-up as a result of an NHS Health Check
- Number of people followed up to check they have received clinical input following signposting from an NHS Health Check.

## Community Engagement

- Number of people reporting increased motivation to participate in and engage with community opportunities for healthier lifestyles
- Number of people who feel they are better informed and equipped to manage their own health and wellbeing
- Number of people reporting that they have better access to, and are more engaged with, community activities which meet their needs
- Number of families reporting they are more engaged with community activities for healthier lifestyles
- Number and % of people who felt enabled, through support available to take up opportunities that are available
- Number and % of those setting an action plan achieved their behaviour change goals

## Data Collection

Data required to monitor the KPIs will be broken down into at least (but not limited by) the following:

- Gender
- Ethnicity
- Age group
- Postcode
- Setting (school, library etc)
- Protected characteristics
- Priority population group

## Appendix 2: Draft Data Management System and Website Functionality (to be reviewed by IT)

# 1. Introduction

### 1.1. Document Purpose

This specification provides a functional description of the Data Management System required to record and support client data throughout the Bristol Behaviour Change for a Healthier Lifestyle programme and Website Functionality so that the intended audience has a clear understanding of the high level requirements.

### 1.2. Audience

The primary audience for this document is the service provider.

### 1.3. Overview of Requirement

We require the service provider of the City Wide Hub to have a data management system with a proven track record of working effectively across a number of organisations.

# 2. Functionality

### 2.1. Basic Functionality

2.1.1. The system must be able to record and store standard client details as described in Appendix II and II.

2.1.2. The application must display current client name, Date of Birth and reference number whenever the personal data is shown.

2.1.3. The system must create a unique reference number for each client that is entered on to the system.

2.1.4. The system must be able to record the client's journey from referral, showing all the contact and outcomes of each one.

2.1.5. The system must be adaptable with the ability to be responsive in accommodating required changes within the agreed timeframe and all testing completed and signed off.

2.1.6. The system must include an integrated function allowing internal and external providers to receive and send referrals, including functionality for external agencies and individuals to make referrals into the system using a secure web-form.

### 2.2. General Usability

2.2.1. The system should be easy to use, menu driven with shortcut keys and familiar technology.

2.2.2. Through consistency in screen layout there must be a 'common look and feel' for the application generally. The use of standard function keys must be consistent at all levels.

2.2.3. The system must provide the ability to print screen dumps, reports and client notes.

2.2.4. The system must support full and flexible diary management, appointment scheduling and attendance outcomes.

2.2.5. The system must support triggered alerts for required follow ups.

2.2.6. The system must support SMS options and offer email.
2.2.7. The system should have the facility to attach documents, emails and other relevant info to the client record.
2.2.8. The system should have the ability to create and store templates for repeated use, for example common letters.
2.2.9. The application must be anglicised for data items, reference number, post code, date and time formats.
2.2.10. The system must be designed so that one piece of information is only entered once.
2.2.11. The system has to comply with the Equality Act 2010 and the s.149 public sector equality duty.
2.2.12. The system must be able to have customisable data views so as to support individual groups and ways of working e.g. individual caseload, team views etc.
2.3.13 The system must support an online shop and ordering service with shopping basket facility for provision of leaflets and resources.

### 2.3. Technical Functionality

2.3.1. The system must be web based.
2.3.2. The database should comply with Open Database Connectivity standards.
2.3.3. The service provider must provide details of the server structure and the system architecture provided to run the system with resilience.
2.3.4. The service provider must demonstrate successful transfer over N3 security network[10].
2.3.5. The system must provide archive and back up facilities.
2.3.6. The system must provide the ability to add fields locally within an agreed process and link to reporting.
2.3.7. The system must respond with clear and consistent error messages when an error is encountered, suggesting corrective action and informing the user how to leave the system or how to continue in addition to logging an error. The system must provide alerts for major system events.
2.3.8. The system must have an inbuilt function for handling and merging duplicate clients.
2.3.9. A quick entry screen for adding multiple client data at one location is preferable (i.e. at an outreach event with the local community).
2.3.10. On screen data labels must be agreed at the system start up and any future alterations need to be possible via a controlled process.

## 3. Data Protection and Security

3.1.1. The provider must adhere to current European data legislation, and must be hosted within the EEA, a list of these countries can be found using the link https://www.gov.uk/eu-eea

3.1.2. It is compliant with the new General Data Protection Regulation (GDPR), May 2018.

[10] http://n3.nhs.uk/TechnicalInformation/N3NetworkSecurity.cfm

3.1.3. The system must be resilient to hacking and responsive to emerging security risks.
3.1.4. Remote access to the system must be via the secure network and the host site firewall with appropriate authorisation.
3.1.5. The system software must allow for different levels of user privilege, differentiating between various applications users and system management roles including the option for accessing the system on a read only basis. Individual users will then be assigned to this user type.
3.1.6. The system must ensure that any identifiable client information is encrypted during transmission over insecure networks.
3.1.7. The system must allow local configuration and management of password functions e.g. reset and expiry setting at system administrator level.
3.1.8. A thorough audit log must be accessible for all changes made to client records held on the system. The system must provide a comprehensive audit trail. Every transaction must be date, time and user-id stamped.
3.1.9. Letters and documents that are created on or stored on the system must be held within a secure application database. The provider must supply details of their system.
3.1.10. Use of the system must comply with the Bristol Data Sharing Protocol and client consent process see Appendix I.

## 4. Performance and System

4.1.1. The system must provide restore capability with a maximum outage of half a day.
4.1.2. The system must adhere to the following bug fixing downtimes: if the whole system is down (100%) it should be treated as a top priority and fully restored within a maximum of 0.5 of a working day from notification, if the majority of the system is down (75%) it should be fully restored within a maximum of 1 working day, if half system down (50%) or less than half of the system is down it should be fully restored within a maximum of max 2 working days. During any system downtimes it is the system provider's responsibility to ensure the Commissioner and system users are fully up to date and informed of actions being taken to address any issues.
4.1.3. The system must have comprehensive backup facilities.
4.1.4. It is not expected that the number of concurrent users making enquiries or updating client records will exceed 50. However, the system should be capable of accommodating more users at no additional cost to the council.

## 5. Hardware Interface Requirements

5.1.1. The System must be compatible with current, and commit to future, leading industry standard products and operating systems for the life of the contract.
5.1.2. The System must have a Web Browser user interface and meet with the national e-GIF standards, ensuring efficient use of WAN links and bandwidth.
5.1.3. The system provider is required to provide full details of the physical and logical environment required for the proposed hardware installations.

5.1.4. The system must be capable of being used on remote entry devices (for example Laptop, Tablet or other devices as they come onto the market), and must enable robust record locking to maintain data security and integrity, and appropriate security measures.
5.1.5. The System must ensure that in the event of a connection or hardware failure the user is informed of which data items have been lost.
5.1.6. Performance of the system must not be negatively affected by the use of any data services.
5.1.7. Data services must be available independently to any direct user access.

## 6. Reporting

6.1.1. The system must support export to third party systems for more complex analysis of data for example Excel, CSV or Crystal Reports. Appropriate views/data extract will be required for more complex analysis.

### 6.2. Reporting and Printing

6.2.1. The system must provide an integrated report generator that can be used by staff without specialist IT skills and be supported and maintained at no additional cost to the Council. The report generator must have the capabilities to enable publishing of approved reports to users. The report generator must enable an unlimited number of reports on all data fields on the system in line with security profiles and have the ability to export to other data formats including Excel.
6.2.2. The system must produce text, tabular and graphical reports.
6.2.3. Reporting must encompass all provision of summary data capture from activity and where appropriate include the ability to “drill down” into data.
6.2.4. The system must support service level performance reports and be adaptable to encompassing any future additions to these and local service targets.
6.2.5. The system must allow for the creation of new reports and modifications to existing reports to support new fields.

### 6.3. Data

6.3.1. The system provider must deliver a system and application program that is fully date compliant. British Summer Time changes must be achieved without extra system downtime.
6.3.2. Where appropriate the system must incorporate validation rules/plausibility checks at data entry to ensure high levels of data quality.
6.3.3. The system must use automatic data formatting on all data input screens, where required.
6.3.4. Where a coded entry is made, the system must always display the decoded equivalent
6.3.5. The system should allow user-defined defaults for all appropriate data entry fields, e.g. current date, yes, no, don’t know, blank etc.
It must be possible to print a complete listing of all data held on file for any identified client in a single function and report.

## 7. Training

7.1.1. The system must have a training environment that mirrors the local live environment in configuration and functionality throughout the life of the system.
7.1.2. The training system must be locally configurable.
7.1.3. Any software upgrades and/or releases must be accompanied by detailed release notes prior to implementation. If appropriate, training must be provided and the training system must be updated in a reasonable time frame.
7.1.4. The system must have all relevant implementation documentation including a comprehensive User Manual (in plain English) in an electronic format. The service provider must include a full list of all documentation that they will provide with the complete solution.
7.1.5. The system provider must supply training for system users. On selection a detailed plan will be developed by the system provider to describe the specific training details. A 'Train the Trainer' approach is required.

## 8. Support

8.1.1. When changes to the system are made there must be a clear sign-off process in place for any changes.
8.1.2. The system provider must offer a staffed Helpdesk/Helpline to respond to queries and error reporting from Monday – Friday 9am – 5pm. All calls must be logged and an overview of the issues and outcomes should be provided at regular intervals, as agreed. The system must have a tracking function for issues raised with the helpdesk and an 'out of hours' fault reporting mechanism (e.g. email, voice recording).
8.1.3. The system must have an online help function.
8.1.4. There must be an account manager provided throughout the length of contract at no additional daily charge.

## 9. Service Levels

### 9.1. System Hours

9.1.1. The system should be routinely available 24 hours a day, 7 days per week. The majority of the system users will access the system between 8am – 7pm and it is expected that any major upgrades where possible will take place outside of these times.

## 10. Website Functionality

### 10.1. Integrated System

10.1.1. All of the functionality is fully integrated, which means that you only have to learn one system and it is designed specifically to work as an "integrated system" should – reliably.

### 10.2. Easy to use content management system

10.2.1. The website should be designed specifically so that non-technical people can create and edit all of the content on the website. It should be possible to create web pages, image galleries, forms, interactive programmes and any other content that is appropriate to the specification

### 10.3. Mobile Responsive website

10.3.1. The service provider must develop a “responsive” website which allows the webpage to change shape based on the size of the device that is viewing it, so that it may be viewed on other devices such as mobile phones.

### 10.4 E-Marketing system

10.4.1 The e-marketing function should allow an unlimited number of marketing initiatives to be sent to specific segments of your database of clients. There must be no limit to the number of e-newsletters, promotions, shopping cart (for resources/leaflets) or other marketing initiatives and no additional costs for using this function. The system must allow the provider to create automated e-marketing campaigns that support the online engagement objectives.

### 10.5 Search Engine Optimisation

10.5.1 The website system must allow easy optimisation of specific pages on your website and to ensure that the entire site is optimised for search engine visibility.

### 10.6 Forms/Surveys

10.6.1 The website should enable the service provider to create an unlimited number of online forms or surveys by using a Content Management System. These may be enquiry forms, customer feedback forms, or competitions so the functionality will enable the provider to capture information and use that information to create reports or analyse performance at a number of levels. Form responses can be sent to anyone that needs to see them and information submitted via forms must be captured in the data management system.

### 10.7 Social Media Integration

10.7.1 Social Media will be an important aspect of the online profile for the provider. The website system must cater for the seamless integration of social media platforms to the website, such as, Facebook, Instagram or Twitter. If the website is used to constantly interact with service users using Facebook, Twitter, LinkedIn and other social networks you should show those conversations to be carried over to your website. There should be ‘hang-outs’

and chat rooms available to encourage peer support and self-help for the different activities.

### 10.8 Photo Galleries

10.8.1 The website should have the facility to host a photo gallery which must be accessible to iPhone and iPad viewers, for example using an HTLM5 based option. This should contain high quality photos that are regularly reviewed and appropriate to the viewer.

### 10.9 Interactive Commenting System

10.9.1 The system must allow for more interaction than simple commenting. It should invoke a sense of camaraderie among site visitors while providing as much interaction as possible.

### 11.1 Usability

11.1.1 The website is designed to be easily accessed and easy to use by a wide range of Bristol residents but essentially those that are identified as 'Inform me' or 'Enable me' personas. It needs to take into account the range of different cultures and abilities of those accessing the website, including people using screen readers.

11.1.2 The information available on the website must have credibility and be quality assured as are any additional links taking people to external websites. It must include evidence based information and be updated regularly.

11.1.3 The website must consider that people do not read detail but tend to scan information expecting instant gratification when they find what they are looking for. Young people in particular will expect interactive elements to the website.

11.1.4 The website will have a recognised brand and look which will draw residents in to look for help with lifestyle issues. It should provide sufficient information for people to know how to deal with the specific lifestyle issue they are interested in, directing them to local support groups where appropriate, and providing an opportunity to identify and record their own goals.

11.1.5 The website should offer an opportunity to ask questions by the user through 'live chat' with times specified when this is available.

## Appendix A - Bristol Data Sharing Protocol

### Information Sharing Protocol

### Introduction

For the purposes of clarity, 'Bristol Behaviour Change for a Healthier Lifestyle' refers to all services commissioned by Bristol City Council Public Health Team within this contract. This protocol sets out reasons and standards for information sharing between workers.

### Rationale

The success of integrated service provision relies on the ability to share information in order to provide clients with the best possible support and services; and to enable service changes for clients, in response to shared information.
It can be extremely beneficial to clients if workers from different agencies are able to communicate with one another about the client's journey.

### Procedures

Where a client has consented - workers should communicate about them, provided that information is provided or sought on a 'need to know' basis, guided by the following. Information sharing should take place when:

- It is in the best interests of the client
- It includes changes made and can include
    - a client not attending appointments
    - a client's behaviour having changed;
- It helps to provide or improve a service e.g. communicating information about changes
- NB It is strongly recommended that personally identifiable information is not sent via email because this is not a secure medium.

Clients in Bristol Behaviour Change for a Healthier Lifestyle' programme will have signed, giving their informed consent to allow information about them to be shared with others involved in their journey. This is **not limited** to sharing information with Bristol Behaviour Change for a Healthier Lifestyle' providers - clients can also give informed consent to their information being shared with other relevant providers.

### Sharing Information

Where clients have given their informed consent, workers may share information. This information should be within the guideline bullet points above and usually should not include irrelevant or sensitive detail.

The informed consent of the client should always be sought if they have not previously agreed to the sharing of their information with the requesting organisation.

- A secure fax machine is one where only authorised people will have access to it i.e. it is not an open plan office.
- Personal information should not be transmitted over email/internet unless it is known to be securing (i.e. at least password protected). The "By Fax" diagram should be followed for secure email/internet information sharing. If email is used then it should only include a client's initials.

## APPENDIX B – Data Sharing and Security Requirements

### Introduction

This document describes the user access security requirements that the new case management system must provide.

The high level over-arching requirement is two-fold:-

- That the new system will operate within a multi-agency environment where, with appropriate client consent, data will be shared across agencies.
- That the new system will provide varying user profiles/access rights allowing different sets or layers of an individual client's data to be accessed.

In this way the system should be capable of providing a wide range of access rights, from basic client data look up/read only, through limited change/update for a specific services, e.g. needle exchange, to full and total access, across the whole of the Bristol Behaviour Change for a Healthier Lifestyle' programme.

Bristol Clinical Commissioning Group

# Bristol Health & Wellbeing Board

| Pharmaceutical Needs Assessment Update | |
|---|---|
| Author, including organisation | Barbara Coleman<br>Service Manager – Public Health, BCC |
| Date of meeting | 14 September 2017 |
| Report for Information | |

## 1. Purpose of this Paper

The purpose of this briefing is to update the Health & Wellbeing Board on the progress in producing the revised PNA.

## 2. Executive Summary

The HWB is required to produce a Pharmaceutical Needs Assessment every three years. The purpose of the PNA is to inform commissioners and NHS England of the health needs of the local population and whether there are any gaps or access issues in respect of community pharmacies.

The document is now out to consultation until 27th November 2017.

## 3. Key risks and Opportunities

Key issues arising from the health needs assessment include:-

- Planned and recent increases in dwellings across Bristol (6,737) and the peripheral area (South Gloucester) – 7,715
- Decrease in numbers of pharmacies since last PNA (1 less in Bristol North and West Locality)
- Increased population levels 437,500 in 2013 to 454,900 in 2017 ( increase of 4,000 persons per annum

## 6. Implications (Financial and Legal if appropriate)

There are no financial or legal implications arising from this report.

## 7. Evidence informing this report

**What evidence have you used to inform:**

- Population demography and health needs were derived from the Bristol JSNA (updated 2017)
- Data on opening hours and numbers of pharmacies were provided by NHS England (June 2017)
- Current service provision was provided from NHS England, Bristol CCG and the public health team in Bristol City Council
- Housing developments data were provided from Strategic Planning BCC and South Gloucestershire
- Bristol Citizen's Panel survey
- Young People's Mystery Shopping
- Data on complaints / incidents from Healthwatch and BCC teams

## 8. Conclusions

Two small areas of Bristol (Charlton Mead 400n population and Broomhill Road 1,500n population) fall outside of 1.6m walking distance by 0.4 km and 0.9km respectively. Bristol has 93 pharmacies, 31 in each locality area. There were no gaps identified currently in provision of pharmacies across Bristol and in terms of opening hours.

## 9. Recommendations

That Health & Wellbeing Board receive the PNA and note the contents. The final report will come to the Board for agreement in February 2018, following the consultation.

## 10. Appendices

Draft Pharmaceutical Needs Assessment 2018 – viewable at this link:

https://bristol.citizenspace.com/public-health/bristol-pharmaceutical-needs-assessment-2017/