Health and Wellbeing Board

Agenda

BRISTOL CITY COUNCIL

NHS
BRISTOL CCG

Date: Thursday, 18 March 2021

Time: 2.30 pm

Venue: Virtual Meeting - Zoom Committee Meeting with Public Access via YouTube

Issued by: Jeremy Livitt, Democratic Services
City Hall College Green Bristol BS1 5TR
Tel: 0117 9223758
E-mail: democratic.services@bristol.gov.uk
Date: Wednesday, 10 March 2021

Agenda

1. Welcome and Introductions

2. Apologies for Absence and Substitutions

3. Declarations of Interest

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

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

4. Minutes of previous meeting held at 2.30pm on Wednesday 27th January 2021

To agree the minutes of the previous meeting as a correct record. **(Pages 4 - 11)**

5. Public Forum

Up to 30 minutes is allowed for this item

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

Questions - Written questions must be received 3 clear working days prior to the meeting. For this meeting, this means that your question(s) must be received in this office at the latest by **4.30pm on Friday 12th March 2021.**

Petitions and Statements - Petitions and statements must be received on the working day prior to the meeting. For this meeting this means that your submission must be received in this office at the latest **by 12 Noon on Wednesday 17th March 2021.**

Anyone who wishes to present their public forum statement, question or petition at the zoom meeting must register their interest by giving at least two clear working days' notice prior to the meeting **by 2pm on Tuesday 16th March**

2021.

PLEASE NOTE THAT IN ACCORDANCE WITH THE NEW STANDING ORDERS AGREED BY BRISTOL CITY COUNCIL, YOU MUST SUBMIT EITHER A STATEMENT, PETITION OR QUESTION TO ACCOMPANY YOUR REGISTER TO SPEAK.

6. Forward Plan

To note the Forward Plan. **(Page 12)**

7. COVID-19 update - Christina Gray, Director of Public Health - Verbal Report **2.40 pm**

A verbal report will be given on the day to include up-to-date data

8. Building an Age-Friendly City - - Carly Urbanski, Head of Programme, Bristol Ageing Better, Age UK Bristol **2.55 pm**

(Pages 13 - 38)

9. Bristol Health Partners Academic Health Science Centre - Professor David Wynick (Director, Bristol Health Partners AHSC), Lisa King and Olly Watson (Joint Chief Operating Officers, Bristol Health Partners AHSC) **3.15 pm**

(Pages 39 - 41)

10. Fast-Track Cities Bristol (HIV) - Dr Joanna Copping, Consultant in Public Health, Bristol City Council **3.35 pm**

(Pages 42 - 43)

11. Date of Next Meeting

The next meeting is provisonally fixed for 2.30pm on Wednesday 26th May 2021.

Bristol City Council
Minutes of the Health and Wellbeing Board

27 January 2021 at 2.30 pm

Board Members Present: Alison Bolam (Co-Chair), Helen Holland (Co-Chair), Asher Craig (Vice Chair) Christina Gray, Tim Poole, Vicky Marriott, Jacqui Jensen, Cathy Caple (substitute for Robert Woolley), Tim keen (substitute for Evelyn Barker), Janet Rowse and Jean Smith

Apologies – Board Members: David Jarrett, Robert Woolley, Evelyn Barker and Hugh Evans

Officers in Attendance:- Sally Hogg, Raquel Aguirre and Jeremy Livitt

Apologies – Officers: Mark Allen

Other Attendees:
Agenda Item 8 - Anna Smith (CEO Pause Bristol One25), Ann James (Director – Children and Families, Bristol City Council)

Agenda Item 9 – Councillor Brenda Massey (Chair of the Health Scrutiny Commission) and Councillor Claire Hiscott (Chair of the People Scrutiny Commission)

1. Welcome, Introductions and Safety Information

The Chair for the meeting, Alison Bolam, welcomed all parties to the meeting and asked everyone to introduce themselves.

2. Apologies for Absence and Substitutions

The meeting noted the following apologies and substitutions:

Committee Members

Tim Keen attending for Evelyn Barker who sent her apologies
Cathy Caple attending for Robert Woolley who sent his apologies
David Jarrett sent his apologies
Hugh Evans sent his apologies

Officers
Mark Allen sent his apologies

3. Declarations of Interest

There were no Declarations of Interest.

4. Minutes of Previous Meeting held on Wednesday 28th October 2020

The minutes of the meeting held on Wednesday 28th October 2020 were agreed as a correct record subject to the following amendments:

Agenda Item 10 - Minutes of 281020 HWBB Meeting – Rewording First Part of Bullet Point (i) to More Accurately Reflect What Was Said by Tim Keen

Tim Keen advised said there were regulations on charging to be followed and acknowledged that presentation raised some areas where there could be improvements for identifying chargeable patients. In addition, he indicated that he could facilitate a conversation about whether more data sharing could help improve the system.

Also that the minute is amended to clarify that the second sentence referring to "The need to better identify the status of patients and distinguishing those who are travelling just for free health care" was made by Councillor Asher Craig.

Page 7 281020 Minutes – Paragraph (b)

The reference to University of Bristol Hospital to be amended to read University Hospitals of Bristol and Weston.

5. Public Forum

There were no Public Forum requests.

6. Draft Forward Plan

The meeting discussed the Forward Plan and noted the following:

- A Stakeholder event would be taking place at 10am to 12pm on Tuesday 2nd February 2021. 189 people would be attending. One of the issues to be discussed would be the importance of COVID vaccinations. In addition, there would be discussion of Health and Care Integration and Mental Health issues.

- At the webinar on Tuesday 26th January 2021, over 500 people had watched from 875 who had signed up to attend and over 400 questions had been asked. There had been a turnout of 47% amongst the BAME community from those who had signed up. A great deal of thanks had been passed on for this event which had helped dispel the most common myths about it. Everybody who signed up would receive a copy of the presentation. It was agreed that all stakeholders would be sent a link to the event.
- The next development session was scheduled for 2.30pm on Thursday 25th February 2021 and would discuss City Funds
- A City Gathering would take place at 10am to 1pm on Friday 12th March 2021
- The next full Board meeting was scheduled for Thursday 18th March 2021 and would include a closed session beforehand at 1.30pm on the Drug and Alcohol Strategy
- A HWBB Development Session was also scheduled for 22nd April 2021
- Christina Gray referred to the short JSNA which was available with framework intelligence. It would be helpful to update this and use it **ACTION: Mark Allen to add to Forward Plan**

7. COVID-19 Outbreak Management Update and Vaccines (Christina Gray, Director of Public Health - Verbal Report)

Christina Gray, Director for Communities and Public Health, gave a verbal report on this issue as follows:

- The number of cases are starting to level out from the third wave which had been the most difficult period so far. The rate of reduction in rates has been slower than during the second wave.
- The south west R Number is now moving below 1 but there is still a need to get this much lower.
- Rates remain high and the pressure on hospitals remains challenging
- 13,000 tests were being carried out a week (15,000 had been carried out at peak)
- The positivity rate is currently around 10%. In Summer 2020, it had been below 1%
- The high rates in south Bristol reflect the fact that many people have come forward to take a test even though it may be challenging for people financially.
- Christina emphasised the importance of people to come forward for testing as this is how we can see where the virus is and take steps to stop it spreading.
- The reduction in the infection rate indicates that the interventions of the lockdown are effective.
- However, there is still a need to keep driving down background rates of infection as these are still incredibly high. For contact tracing to be effective rates need to be much lower.
- The vaccine is being rolled out to cohorts 1 to 4. These first four groups account for the majority of severe illness and mortality

ACTION: that the priority list of the first four cohorts and analysis of clinical risk is circulated to HWBB Members

- Cohort 1 – Care Homes and Staff. Almost all of these had now received the vaccine – 100% of residents and all staff would shortly receive it

- Cohort 2 – Over 80's. Well above 80% had now received this vaccine via local hospitals and the mass vaccination centre. All Health and Social Care Staff would also receive it
- The next to receive it would be based on age and the clinically extremely vulnerable
- There was sufficient vaccine with a clear clinical plan to deliver it using the best health care system in the world. The local system was very good in delivering it
- All people needing the vaccine would be invited to attend for an appointment based on a clinical analysis of who is at risk
- A number of at risk groups, including people with learning difficulties and other extremely vulnerable groups, would be in the next cohort to be vaccinated. Equality and equity would be at the core of the process

It was also noted that GPs and Sirona were already delivering for over 80s patients who were housebound. The local system had already received a letter from Matt Hancock thanking them and congratulating them for having one of the highest vaccination rates in the country of over 80% of care homes.

The following comments were also made:

- The recent Government announcement concerning provision of extra funding to help challenge anti-vaccine myths was important.
- Work was also required in helping other groups obtain access to the vaccine, such as the homeless and those who misused drugs and alcohol. The homeless health service would be supporting work with this client group.
- A spectrum of people with learning difficulties would be invited as part of the next cohorts
- Alison Bolam advised that in her practice GPs were contacting all over 80s to invite them for n vaccination. Sirona were also working to ensure all individuals within this group were vaccinated
- Although previously only 57% of care workers had indicated they were prepared to receive the vaccines, these refusal levels had now much improved

8. Pause Bristol (Anna Smith, CEO of One25)

The Board received a presentation from Anna Smith, CEO of One 25 and Ann James, Director of Children and Families on the Pause Bristol programme.

Ann James explained that the programme formed part of Bristol City Council's One City Approach to work with women and help them with their recovery from bad childhood experiences and to help in reducing the need for demand in criminal health, justice and housing demand.

Anna Smith explained that Pause 25 helped women involved in street sex work.

The presentation made the following points:

- Women who had two or more children permanently taken into care were at the heart of the One25 service which had been operating since 2017. It had been established to address the problems caused by a repeated cycle of children being removed from parents
- 65,000 women were involved in care proceedings with 1 in 5 returning to family court order concerning the child. Many were out of care themselves and their babies were born into care. Many had also experienced neglect and physical and sexual abuse in their past
- The purpose of Pause was to identify those women who were frequently disengaged from all other services and to intervene to help provide them with goals and to break the cycle of birth and removal
- The team consisted of 5 people, including 3 practitioners with a caseload of 7 to 8 each that was kept deliberately low to ensure intensive work could be carried out. The other two members of staff consisted of a lead and co-ordinator
- The first cohort of women in Bristol being supported included 100% who had suffered domestic abuse, 91% with mental health problems and 65% with problems caused by alcohol and drugs addiction
- Details were provided of different elements of situations faced by women using this service. In Bristol there were particularly complex problems facing women of drugs and homelessness. Many did not realise they were supposed to stop their child support benefit and were getting into debt. They might have low self-esteem, not have a GP and lead very chaotic lives either on the streets or in inappropriate housing. They might also be in a controlling and abusive relationship
- Details were provided of women who had completed the programme and obtained more secure housing. Outcomes included an improvement in dealing with issues caused by past loss, trauma and self esteem
- There had been two cohorts of women completed. Details of the results of Cohort Number One were provided with Cohort Number Two currently being evaluated. A third cohort was about to start
- As part of the process, women agreed to accept long term contraception.
- An analysis of Cohort One showed that 91% of women had mental health diagnoses with just under half receiving a further assessment by the NHS, 30 had received statements given to the Police concerning violence or abuse, there was a 50 per cent reduction in A and E visits, 9 had face to face contact with children, 14 had been helped to leave abusive partners and 10 had been helped to secure a tenancy with 4 being street homeless
- An assessment had shown that in the first few months 40% of women would have liked support but it was not necessary and at the end 20% more felt this – also 17% felt they didn't need to use the service any further. A baseline of life satisfaction of 3.8 had increased to 6.5, whilst an assessment of worthiness had increased from 4.4 to 6.7 which was a huge success given that many of the women involved frequently expressed suicidal thoughts
- A slide showing a number of quotes from women were shown – one which was particularly notable was from a woman who said that now she felt confident about getting on a bus which was hugely difficult for her before
- The success of the service is if the women no longer require this service, don't become pregnant until they want to and deal with their problems of drug use

- The Board was then shown a video of a case study involving a woman being able to cope with looking after her children following intervention from Pause
- The most important part of the work of Pause was helping women take control of their lives
- The current cohort (Cohort 3) ends in November 2021. This was a rolling programme requiring three year corporate and Bristol City Council funding.

At the end of the presentation, Board Members made the following comments:

- It was hoped that the Health and Well Being Board could engage as required in the work of Pause
- Thanks to Ann James and Anna Smith for a very moving film and personal stories.
- The Health and Well Being Board does not hold a budget so is not in a position to discuss funding.
- However, one option might be to facilitate partners to examine possible options for funding. It was noted that there had been dialogues with a number of family law firms about this
- Some Local Authorities provided Pause programmes as a cost avoidance measure. A case could be made for change in each of the organising bodies involved
- A contribution of £100,000 had been provided by Public Health but a strategic approach is required to look at the wider picture.
- It was good to see local outcomes from the programme

- Janet Rowse indicated that discussions with Healthier Together and Children's Services could take place concerning possible options for funding for the One25 Programme.

ACTION: Janet Rowse (Sirona Care and Health) and Jacqui Jensen (Director of Children's services, Bristol City Council) to have discussions concerning this, together with Healthier Together.

9. Working Group Reports of the People and Health Scrutiny Committees - Councillors Claire Hiscott and Brenda Massey

The Board received reports from Councillor Brenda Massey (Chair of the Health Scrutiny Committee) and Councillor Claire Hiscott (Chair of the People Scrutiny |Committee).

Councillor Brenda Massey made the following points:

- There had been cross-party collaboration in this area which attempted to address concerns about the impact of the current pandemic on Planned Health Care
- The report provided a snapshot of the current situation with lots of different inputs concerning communication, impact on communities and changing ways of working
- The report had noted that there had been a fear amongst some communities of attending for planned health care in view of the risk of catching COVID-19 and who were therefore reluctant to attend
- Concerns raised included the gap between treatments, how people are contacted about changes and problems for people with a limited IT ability

- There were also language and culture difficulties for BAME communities and it was acknowledged that it was important for local communities to help out in this area
- There was an impact on mental health particularly for older people who were forced to stay at home
- The difficulties caused by school closures had made a particular impact on single parent families
- Changes to the way the NHS worked in the current situation resulted in people relying on the role of health providers even more
- Certain areas have been identified as being very good ie partnerships, social prescribing and advice by chemists
- Leaflets had been produced in a range of different languages to help provide information to all communities

Board Members made the following comments:

- It was important for the system to see the problems and be accountable for them and to be as well organised as possible
- It was also important for systems to be as well organised as possible
- One City had put together a Digital Exclusion Task Force to address the problems caused by Digital Exclusion. It was important that vulnerable people had access to machines
- This was a really good report. It could cross reference against work which was already happening in these areas

Councillor Claire Hiscott made the following points:

- The challenges of child protection in the first lockdown period were analysed in order to capture learning while it was still fresh in people's memories ie what did you do, what went well and what didn't go well
- She expressed her thanks to the wide range of participants who were all extremely helpful. Input was obtained from Avon and Somerset Police, Cirona, the Youth Service and Keeping People Safe. There were comments from experts and academics
- The Board's attention was drawn to a diagram on Page 42 of the agenda papers. This helped to understand the risks and harms concerned. It identified how partners identified children at risk including the effects on schooling and attendance for those children who were at risk to begin with as well as those children who were not at risk to begin with but became vulnerable
- Community support had been looked at including the effect on Children and Young People's Mental Health together with the harm from lockdown as children went back to school. An analysis had shown that the inequality was very obvious and that every contact with a Young Person or child was important
- The incredible stress on some families was noted and the need to help parents and carers to support young people
- Partnership work was vital during lockdown. It was important that these were strengthened and built on

- Some of the recommendations contained in the report had already been acted on
- The report had looked at children in foster care but did not look at young carers. This issues would be considered in future.

Board Members made the following comments:

- Councillor Hiscott and the Scrutiny Committee members were thanked for their work with many issues being pertinent. Both reports had captured the essence of very complex discussions
- The accountability of the Local Authority in CCG work was very important and helped as part of a policy development role
- The use of this report as a critical friend was very helpful. The formal response from Children's Services to the report would be submitted to Scrutiny as part of an assessment of how Children's Services can protect children
- This was a very good report in assessing feedback from young carers and helping find the right support

It was noted that any actions with clear organisational owners would be implemented as soon as possible. Those recommendations which required system changes would be submitted to the Healthier Together Executive Board for action and to Jacqui Jensen in her capacity as Chair of the Children and Young People's Maternity Board.

It was also noted that these recommendations would be considered by the next meeting of the Joint Scrutiny meeting of North Somerset and South Gloucestershire.

10 Any Other Business

It was noted that Board Members would shortly be receiving a request to complete an Equalities Questionnaire.

11 Date of Next Meeting

It was noted that the next Health and Well Being Board Meeting was scheduled for 2.30pm on Thursday 18th March 2021.

Meeting ended at 4.20pm

CHAIR _____

DRAFT Forward Plan 2021 as of March 2021

1st April 9-11 am - joint meeting of BNSSG Health and Wellbeing Boards

- Population Health, Prevention and Inequalities Group
- Action planning to reduce health inequalities
- Health and Social Care White Paper

Thursday 22nd April 2:30-4:30pm – development session

- Updating our Plan on a Page for 2021/22
- Community approaches to improving mental health and wellbeing

Wednesday 26th May 2:30-5pm – formal Board [PROVISIONAL]

- COVID-19 update
- BNSSG NHS Sustainability and Health network update
- Joint Strategic Needs Assessment (JSNA) summary
- Health and Wellbeing Board working group on participation

Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

Bristol Health and Wellbeing Board

Title of Report:	**Building an Age Friendly City**
Author (including organisation):	**Carly Urbanski, Head of Programme, Bristol Ageing Better, Age UK Bristol**
Date of Board meeting:	**March 18th**
Purpose:	Decision

1. Executive Summary

Loneliness and isolation is a substantial issue for older people in Bristol and is closely linked to pressures on health, social care and community services. The Bristol Ageing Better (BAB) programme adopted a whole-system, age friendly, test-and-learn approach to identify solutions. The UWE-led evaluation has identified statistically significant improvements for people across twelve health and psycho-social measures (*1*). BAB is now funded for a final year to embed the learning for local and national service development, as well as incorporating the best of the national Ageing Better learning back into Bristol. We want to ensure that Bristol benefits from our findings and applies the learning to help the city recover from the pandemic.

The Coronavirus has had an impact on older people that will last well beyond the pandemic. Learning from the BAB programme on how to tackle social isolation and the effects it has on older people can inform us in how to reduce these impacts and lessen health inequalities. The HWB is requested to:

- Oversee a programme of work to utilise the learning from the BAB programme, taking an age-friendly approach to improve the health and wellbeing of older people post Covid-19.
- Work with the City Office to champion learning from the BAB programme and urge each thematic board to incorporate age-friendly targets in the One City Plan. A whole-system approach is necessary to enable the change needed.
- Utilise the BAB team to support the work programme until March 2022.
- Consider how the work of the BAB programme could be enabled to continue after April 2022 as part of a whole city approach.

2. Purpose of the Paper

Investment in early intervention and prevention can have benefits for people's health and longevity and a corresponding reduction in the need for more expensive intervention by health and social care. To support preventative work, there is a need to invest in social infrastructure to change how people connect with each other and the spaces in which they live and work. The BAB programme has 6 years of learning to support the required changes in the city. A whole-system approach, embedding age-friendly practices into all aspects of an older person's life, requires us to focus on improvements in housing, connectivity, learning, environment, economy, culture and intergenerational relationships as well as health and wellbeing.

Age-friendly cities have been found to optimise opportunities for health, participation and security to enhance quality of life as we grow older. BAB has practical evidence of how to move forward post COVID-19, building back the city by creating connections and enabling people to stay active and engaged as they age.

1. Mat Jones et al. BAB Outcomes Report, UWE 2021.
2. Center for Ageing Better. 2020. https://www.ageing-better.org.uk/sites/default/files/2021-02/community-spirit-survey.pdf
3. The Kings Fund, Feb 2021. COVID-19 recovery and resilience: what can health and care learn from other disasters?

The BAB team have the capacity to take concerted action over the next year to embed learning in the most effective ways. We need the help of the Health & Wellbeing Board to make this happen.

3. Background and evidence base

In the past year, due to the pandemic, we have seen people more disconnected and isolated than ever before, with huge impacts on the older population and the largest effects on mental health still to be seen. Research from the Centre for Ageing Better demonstrates that there is a real difference in people aged 50-69 who are 'living comfortably' versus those who are 'struggling to get by' (*2*). The latter, have lower levels of contact with others, feel less of a sense of belonging in their neighbourhood, and are less likely to be aware of the local voluntary groups offering to help. While all of this might have been true before, it has been at an all-time high since the start of the pandemic.

Furthermore, a divide between the ages is at risk of growing as a result of the way that age has framed policy during the pandemic. There is a need to ensure intergenerational understanding given that younger people have also suffered as a result of the pandemic. Now more than ever, we can demonstrate how our BAB evidence and age-friendly agenda are vital for ensuring that post COVID-19 we are able to reconnect people to their surroundings.

The BAB programme has had statistically significant positive impacts on social and emotional wellbeing, and a very positive impact on the overall health of the participants (*1*). BAB's evidence can be used to ensure that older people are able to reconnect to their communities and that Bristol is able to build back stronger than before.

4. Community/stakeholder engagement

The BAB programme was co-produced with older people from original concepts through to delivery and evaluation. Local stakeholder engagement was also undertaken with:

- Focus groups of older people, consultation with older people, projects led by older people, older people as volunteers and researchers. Our Programme Board is chaired by Judith Brown, Ambassador for Bristol Older People's Forum
- The City Office, Clinical Commissioning Group, Public Health (Bristol City Council), Adult Social Care (Bristol City Council), wider city council and community health providers
- Key funders across the city including Bristol Older People's Funding Alliance
- The voluntary sector via the BAB Partnership that enabled networking and learning as well as via funded 'test and learn' projects
- The business sector.

5. Recommendations

With both the One City Plan and your Plan on a Page having included actions around this work previously, the foundation has been laid, however, now is the time to progress it further. The Health & Wellbeing Board is asked to now actively promote the use of BAB learning in improving older people's lives post COVID and in building resilience in communities by:

- Having oversight of a work programme to 'build back better' by working towards an age-friendly city. BAB would undertake the work for this programme, but we need the HWB to champion and host it to ensure whole-system impact.

1. Mat Jones et al. BAB Outcomes Report, UWE 2021.
2. Center for Ageing Better. 2020. https://www.ageing-better.org.uk/sites/default/files/2021-02/community-spirit-survey.pdf
3. The Kings Fund, Feb 2021. COVID-19 recovery and resilience: what can health and care learn from other disasters?

- Calling for cross-sector support from city leaders via the One City thematic boards, to build an age-friendly city, encouraging them to set appropriate targets in their section of the One City Plan.

6. City Benefits

The BAB programme took a **whole-system** approach to tackling social isolation, with a focus on the importance of 'creating the conditions' for change. Building an age-friendly city is a about ensuring longer term sustainability. Change that has cross-sector support is key. Bristol's One City Plan offers the potential to make systemic change over time.

We worked with a very **broad range of stakeholders**, with a view of enabling whole-system and cross-sector approaches. There is a need to ensure that responses to the pandemic do not fragment Bristol's approach. BAB's learning can unify efforts by different organisations and sectors.

BAB learning has been **co-produced with older people** and can inform a recovery from the pandemic that also empowers them and their communities. People's feelings of connectedness have been boosted by helping each other during the pandemic and can continue to play a part in recovery. Our learning shows the value of incorporating direct community empowerment in constructing effective short and long term responses to the pandemic.

Research by The Kings Fund shows that the path to recovery post COVID is not a linear one and people will need a **range of services** in the years to come, from support to access the community and activities focused on wellbeing through to the provision of mental health support (*3*). BAB has funded this type of support and has evaluation to inform a longer term plan for funding. The BAB programme reached a significant number of older people from low income and deprived communities and also engaged with older people from BAME communities and LGBTQ communities. Our learning is informed by co-production with a diverse range of older Bristolians.

7. Financial and Legal Implications

8. Appendices

BAB Outcomes Report

1. Mat Jones et al. BAB Outcomes Report, UWE 2021.
2. Center for Ageing Better. 2020. https://www.ageing-better.org.uk/sites/default/files/2021-02/community-spirit-survey.pdf
3. The Kings Fund, Feb 2021. COVID-19 recovery and resilience: what can health and care learn from other disasters?

Effects of Bristol Ageing Better Projects for Older People

Evaluation of the impacts of the programme on loneliness, isolation and a range of associated outcomes

Mat Jones, Amy Beardmore and Jo White

Acknowledgements, authorship and contacts
This report has been produced by researchers at UWE's Centre for Public Health and Wellbeing - Mat Jones, Amy Beardmore and Jo White. We would like to thank the BAB Community Researchers for their support in completing questionnaires and advice on the interpretation of the findings. We would also like to thank all BAB participants who agreed to complete the questionnaires, BAB programme staff, and BAB project delivery staff and volunteers.

Citation for this report
Jones, M., Beardmore, A., White J. (2020) *Effects of Bristol Ageing Better Projects for Older People. Evaluation of the impacts of the programme on loneliness, isolation and a range of associated outcomes.* UWE Bristol.

ISBN
9781860435898

Further information
Bristol Ageing Better: http://bristolageingbetter.org.uk/

UWE Centre for Public Health and Wellbeing:
https://www1.uwe.ac.uk/hls/research/publichealthandwellbeing.aspx

Abbreviations

BAB	Bristol Ageing Better
CMF	Common Measurement Framework
DjG	De Jong Gierveld: an instrument for measuring loneliness
EQ5D	EuroQol-5D: an instrument for measuring quality of life
EQVAS	EuroQol-visual analogue scale: an instrument for measuring general health
SWEMWBS	Short Warwick-Edinburgh Mental Wellbeing Scale

Executive Summary

Bristol Ageing Better is a city-wide programme running between 2015-2022 aimed at reducing social isolation and loneliness amongst older people. The programme has run a wide range of initiatives to promote community involvement, participation in social activities and local decision-making, and personal support.

Many participants in BAB projects agreed to provide questionnaire based information about their personal circumstances over the course of their involvement. This report brings together the findings from this questionnaire-based data, with a focus on the main outcomes concerned with isolation, loneliness, health, wellbeing and social engagement.

Between March 2016 and March 2020, the total number of people completing registration questionnaires for all BAB projects was 2,918.

Of the 2,918 completing a registration form, 1020 (35%) also completed both a baseline and follow-up questionnaire.

The mean age of participants was 71 years old, with an age range of 42 to 103 years. About 30% of participants were in the age groups of 65-69 and 70-74. Further demographics show:

- 69.2% of participants were female, 28.3% were male.
- 73% of participants identified as White, while 22.5% were from BAME (Black Asian and Minority Ethnicity) backgrounds.
- 53.4% of participants reported having a long-standing illness or disability.
- 21.9% of participants were carers.
- 45.4% of participants lived alone; 43.7% lived with a spouse, partner or family member; 3.1% lived in residential accommodation.
- 67% participants were living in areas of higher multiple deprivation.

At entry to projects, 39% of participants scored as ‘intensely lonely’, 23.9% ‘moderately lonely’ and 37.1% ‘not lonely’, according to the DjG scores.

Before and after measures show statistically significant positive impacts on BAB projects for social and emotional loneliness (DjG and UCLA); wellbeing (SWEMWBS), health (EQVAS) and health related quality of life (EQ5D).

In addition, there were statistically significant positive effects on social contact with family and non-family members; social participation in formal groups; participation in social activities; involvement in activities and ability to influence decisions.

These changes are in line or greater than the outcomes for the national Ageing Better programme, of which BAB is a part.

When we assessed projects separately, there were differences in outcomes. Structured and intensive 1-1 projects (such social prescribing and talking therapies) tended to have greater impacts on health and emotional isolation. Group-based projects such as community development and community-based activity projects showed greater effects on social participation, co-design and influences on local decision-making.

The effects of BAB projects were broadly consistent across age groups, although the effects on isolation and health were clearer for younger age groups. It is noteworthy that those 70 years and over report positive changes in their ability to influence local decisions.

There are some broad patterns in which the outcomes examined tended to be better for females than males, White ethnic groups than BAME groups, those resident in areas of lower multiple deprivation than higher deprivation.

For other social categories, there were similarities in outcomes for those with long-standing illness and disability, caring responsibilities, and those living alone compared to those not experiencing these circumstances.

A minority of participants provided a third set of questionnaire responses after a longer period of involvement in BAB projects. The findings showed continued statistically significant improvements for reduced social isolation and loneliness.

These findings are important because they provide evidence on the effects of community-based projects led by voluntary sector providers across a range of outcomes. The findings indicate that these initiatives can make a positive contribution towards key aspirations in the city to improve the lives of older people, and particularly those experiencing loneliness and isolation.

Introduction: overview of participants in BAB projects

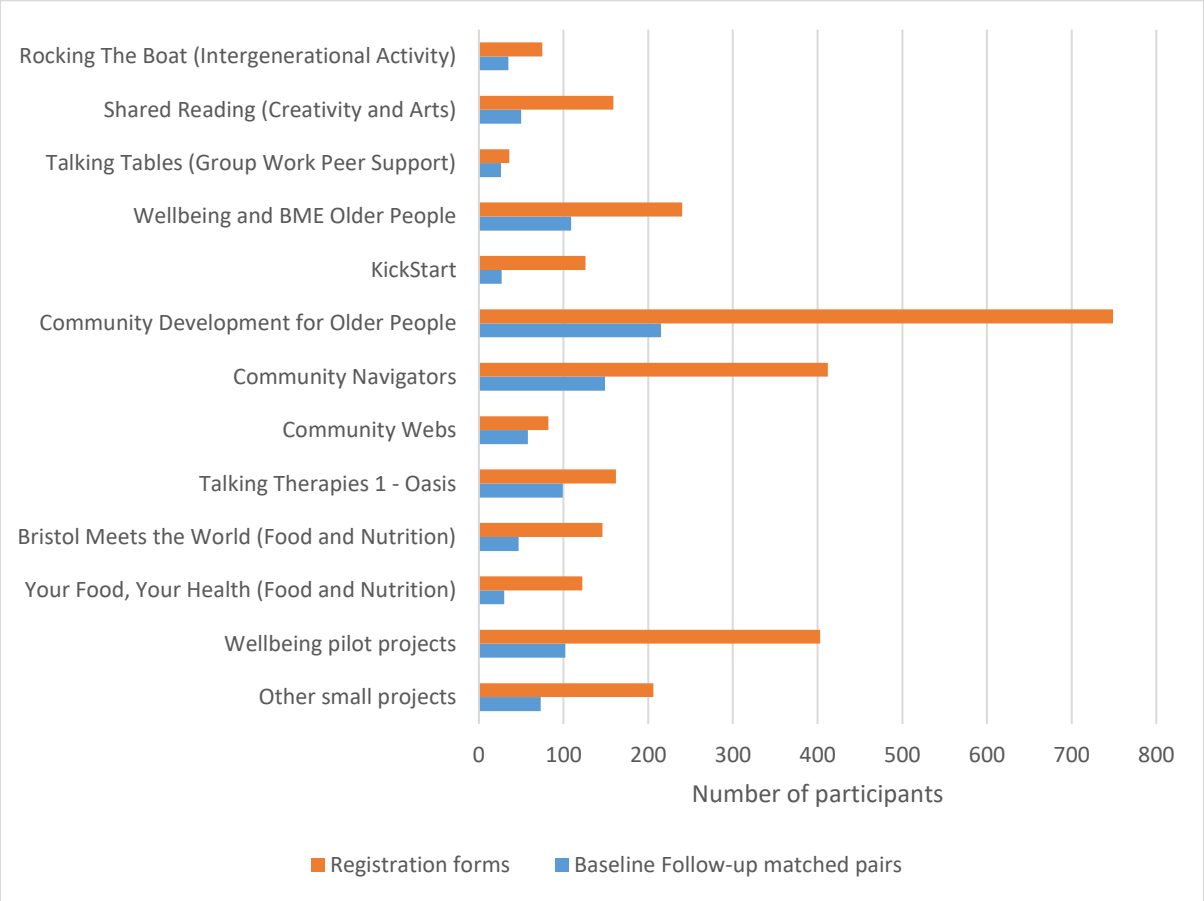
This report gives an overview of the characteristics of people taking part in the BAB projects. It presents evidence on whether the projects succeeded in reaching and engaging key groups. The report then analyses the role of the changes for participants in terms of social isolation and loneliness, health and wellbeing and social engagement.

Between March 2016 and March 2020, the total number of people completing registration questionnaires for all BAB projects was 2,918. Of those who responded, 27.8%% (n=811) had some form of assistance to complete the registration and baseline questionnaire.

Of the 2,918 completing a registration form, 1,020 (35%) completed both a baseline and follow-up questionnaire[1].

Participants first encountered BAB projects through a wide range of routes, with at least 20% coming through a health, social care or social housing referral route.

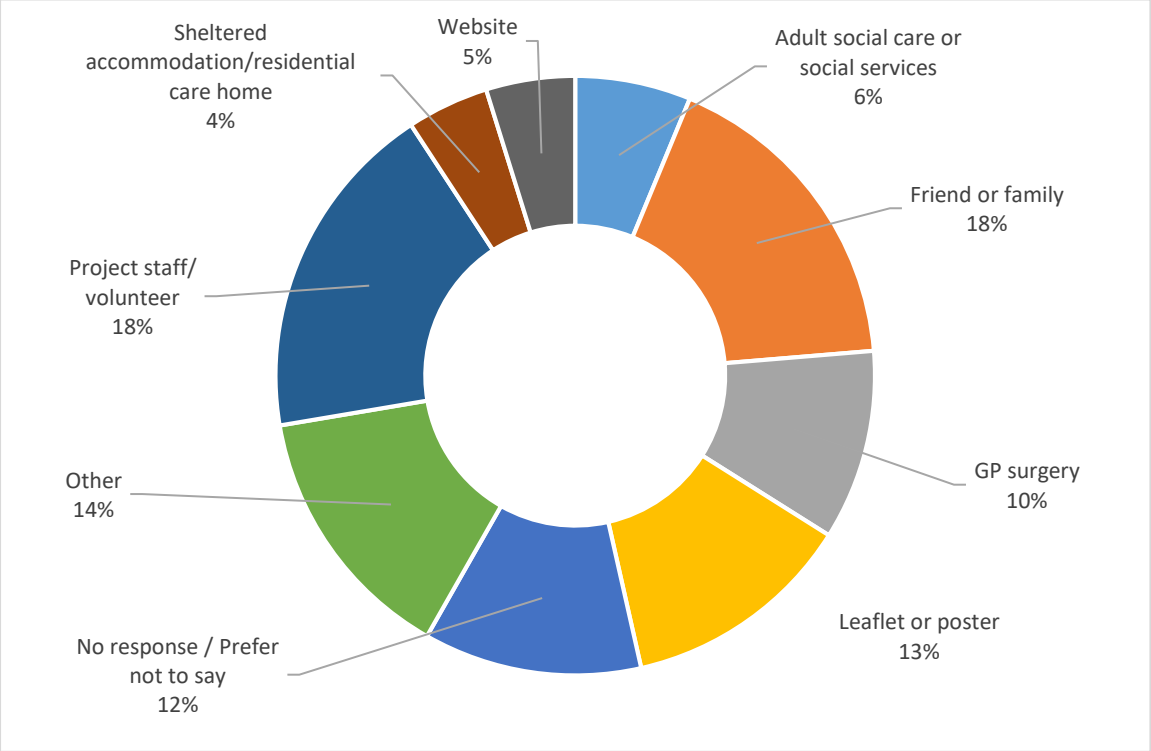
Chart 1: Registrations and matched follow-up questionnaire returns from BAB projects (n=2918)



[1] Not all questions were fully answered, which means that the number of responses for baseline-follow-up questions varies by measure.

Chart 2 shows that participants first encountered BAB projects through a range of routes, with at least 20% coming through a health, social care or social housing referral route.

Chart 2: Routes through which participants found BAB projects (n=2918)



Gender. 69.2% of participants identified as female, 28.3% identified as male. The percentage of females is higher than that of the national Ageing Better programme (61.9%).

Age. The mean age of participants was 71 years old, with an age range of 42 to 103 years. About 30% of participants were in the age groups of 65-69 and 70-74[2] (see Chart 3).

Ethnic group. 73% of participants were White, while 22.5% were from BAME (Black Asian and Minority Ethnicity) backgrounds. Discounting the BME Wellbeing project. This is higher than the general BME population in the UK (14%) and Bristol (16%).

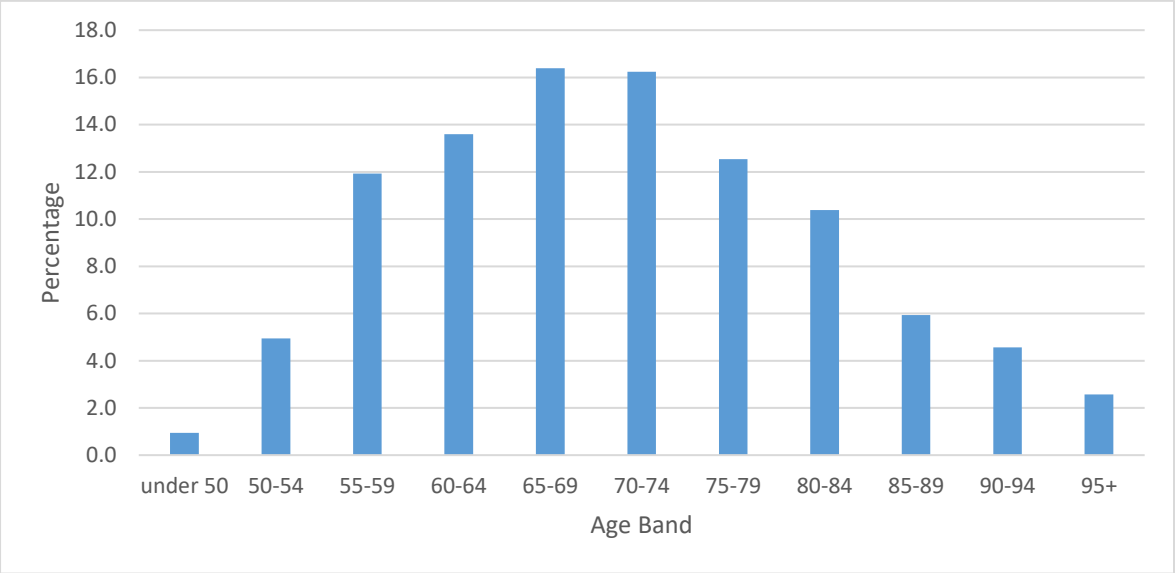
Sexual orientation. 83.3% of participants identified as heterosexual, while 1.9% identify as being lesbian, gay, bisexual or other sexual orientation.

Religion. Christianity was the most common religion among participants (48.8%). 24.3% have no religion while the second most common religion among participants was Islam (7.9%).

Disability. 53.4% of participants reported having a long-standing illness or disability[3].

[2] Missing data for 269 individuals
[3] Missing data for 46 individuals

Chart 3: Age of BAB project participants (n=2918)

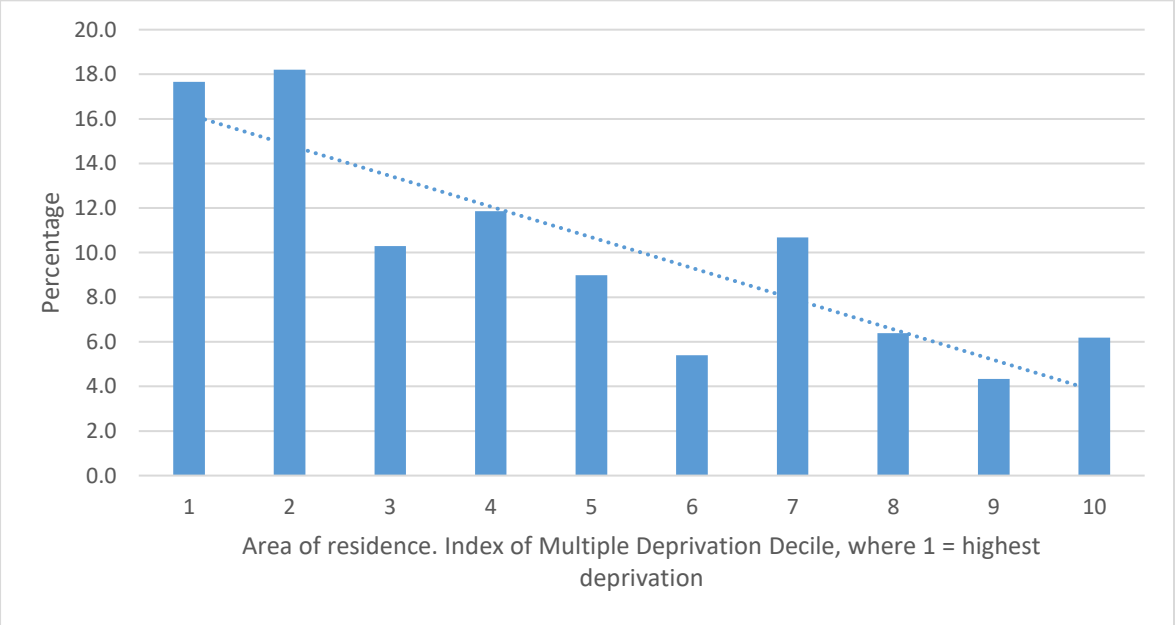


Caring responsibilities. 21.9% of participants were carers[4].

Living arrangements. 45.4% of participants lived alone; 43.7% lived with a spouse, partner or family member; 3.1% lived in residential accommodation[5].

Area of residence. Chart 4 shows that, based on postcode of residence, 67% participants were living in areas of higher multiple deprivation (67%, n=1700, living in top five deciles for the Index of Multiple Deprivation)[6].

Chart 4: Area of residence by multiple deprivation (n=2537)



[4] Missing data for 46 individuals
[5] Missing data for 46 individuals
[6] Missing data for 381 individuals

Methods for assessing outcomes

Measures

Outcome based questionnaires were developed as part of the national Ageing Better programme (the Common Measurement Framework), and termed “Wellbeing Questionnaires” in the BAB programme. Participants completing baseline and follow-up questionnaires responded to questions using twelve sets of validated measures. These are:

1. Loneliness: De Jong Gierveld (DjG) 6-item scale
2. Loneliness: UCLA 3-item scale
3. Social contact with children, family or friends
4. Social contact with anyone who is not a family member
5. Social participation: membership of clubs, organisations and societies
6. Social participation: comparison with others
7. Activities involved in (Co-design)
8. Volunteering and unpaid help
9. Ability to influence local decisions
10. Wellbeing: SWEMWBS
11. Quality of Life: EQ 5D 3L
12. Health score: EQ VAS

Administration and Responses

CDOP project staff, with the assistance of BAB staff and BAB Community Researchers were the main administrators of the baseline questionnaires. All administrators received training on how to complete the questionnaires. Participants were provided with an option to complete the questionnaires by post through direct contact with BAB staff.

Projects varied in the number of returned completed questionnaires, with the Greater Brislington CDOP project completing the largest number.

Analysis

Completed questionnaires were returned for data entry at the BAB office. BAB staff used the Ecorys Ageing Better online system to enter the data, with an SPSS software dataset then downloaded for analysis by the UWE team.

The primary outcomes of interest were loneliness and social isolation. However, given the focus of the CDOP projects, outcomes linked to social participation, involvement and influence were also important areas of focus.

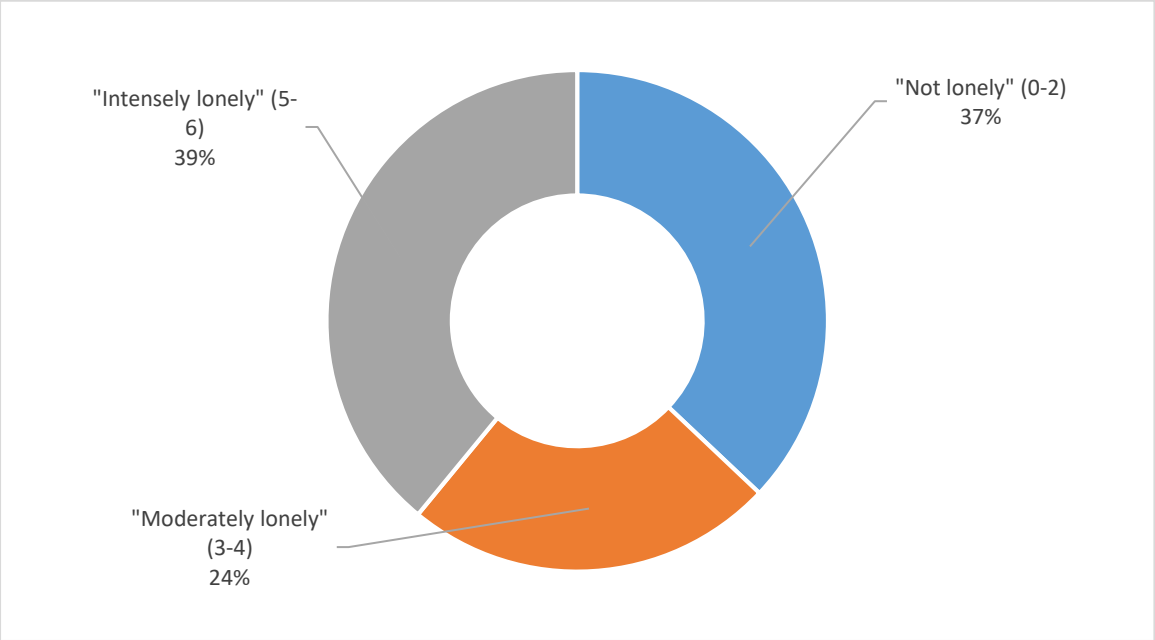
We used a number of statistical techniques to analyse the data dependent upon the type of measure and the distribution of the data. The main test was the paired sample t-test, although we also used other tests such as the Wilcoxon Signed-rank test for non-parametric data. Results were tested at the standard level of significance ($p<.05$), the higher level of significance ($p<0.001$) noted where appropriate. Where the result ‘p’ value is lower than .05 it is unlikely to have occurred by chance. However, it should be noted that a statistically significant difference does not necessarily show a difference that is meaningful from the perspective of participants, practitioners or decision makers.

Reach and engagement: addressing social isolation and loneliness

At baseline, the overall score for the 0-6 DjG scale was a mean of 3.37, which indicates that BAB participants were somewhat less lonely that participants for the national Ageing Better programme overall (3.2).

In total, 39% of participants scored as intensely lonely, 23.9% moderately lonely and 37.1% not lonely, according to the DjG scores (n=753).

Chart 5: Scores for the DjG loneliness scale at the beginning of taking part in BAB projects (n=753)



The UCLA 3-item loneliness scale gives a scale with a possible range of 3 to 9. For participants in all BAB projects 45.8% (n=486) scored between 3 and 5, which is classified as 'not lonely'; 54.2% (n=486) score between 6 and 9, which is classified as 'lonely'. While, the DjG and UCLA score classifications are somewhat different, they show a similar profile for the participants. The data provides evidence that the projects were reaching individuals that were the focus for the BAB programme, bearing in mind that most BAB projects were all designed to work with a range of older people rather than focus only on those experiencing loneliness.

Outcomes for participants

Table 1 presents a summary of the outcomes for BAB project participants alongside the outcomes for the national Ageing Better programme. At baseline, the overall pattern is that participants in BAB projects were - on average – somewhat more socially and emotionally isolated than the average for the national programme overall.

For the primary outcomes, the DjG and UCLA measures show that there was a statistically significant improvement in scores for social and emotional loneliness.

The other measures show statistically significant positive changes for wellbeing (SWEMWBS), health (EQVAS) and health related quality of life (EQ5D). There are also positive changes for social contact with family and non-family members; social participation in clubs etc; participation in social activities; involvement in activities and ability to influence decisions. It is notable that for social contact with children family and friends was one

outcome that did not show a significant change. This may be because the BAB projects were not directed at influencing these types of social contacts.

Table 1: Outcomes for participants in the BAB projects, alongside outcomes for the national Ageing Better programme. Statistically significant positive change highlighted in red

		BAB programme overall				National Ageing Better*		
Area of measurement	Measure	Number of matched pairs	Baseline mean	Follow up mean	Significance (p value)	Number of matched pairs	Baseline mean	Follow up mean
Social and emotional isolation	DEJONG	753	3.37	3.16	0.001	8290	3.2	2.9
Social and emotional isolation	UCLA	897	5.66	5.35	0.000	8277	5.5	5.1
Social contact with children, family and friends	CONTACT	808	3.27	3.30	0.442	8059	3.00	2.89
Social contact with non-family members	SPEAKLOCAL	1020	6.70	6.82	0.033	9576	6.68	6.89
Social participation in clubs etc	SOCIALSCORE	966	1.35	1.52	0.000	9477	1.1	1.3
Taking part in social activities	TAKEPART	1015	1.40	1.58	0.000	9456	1.49	1.73
Co-design. Activities involved in	INVOLVED	843	1.02	1.10	0.082	-	-	-
Ability to influence local decisions	INFLUENCE	915	2.85	3.00	0.004	-	-	-
Volunteering, unpaid help	HELP	981	1.26	1.41	0.002	-	-	-
Wellbeing	SWEMWBS	865	21.10	22.18	0.000	8493	21.5	22.9
Health/Quality of Life	EQ5DIndex	787	0.65	0.67	0.042	4485	0.61	0.63
Health	EQVAS	828	62.41	67.31	0.000	4477	63.05	67.00

* Ecorys Ageing Better national CMF dashboard, July 2021

Charts 6 and 7 present the same information in Table 1 to provide a clearer visual picture of these changes.

Chart 6. Positive changes for loneliness, wellbeing & health.

Notes. Matched pair range: 753-897. Statistically significant change for all measures (p<0.05). Data presented as percentage change. Not as values for each measure.

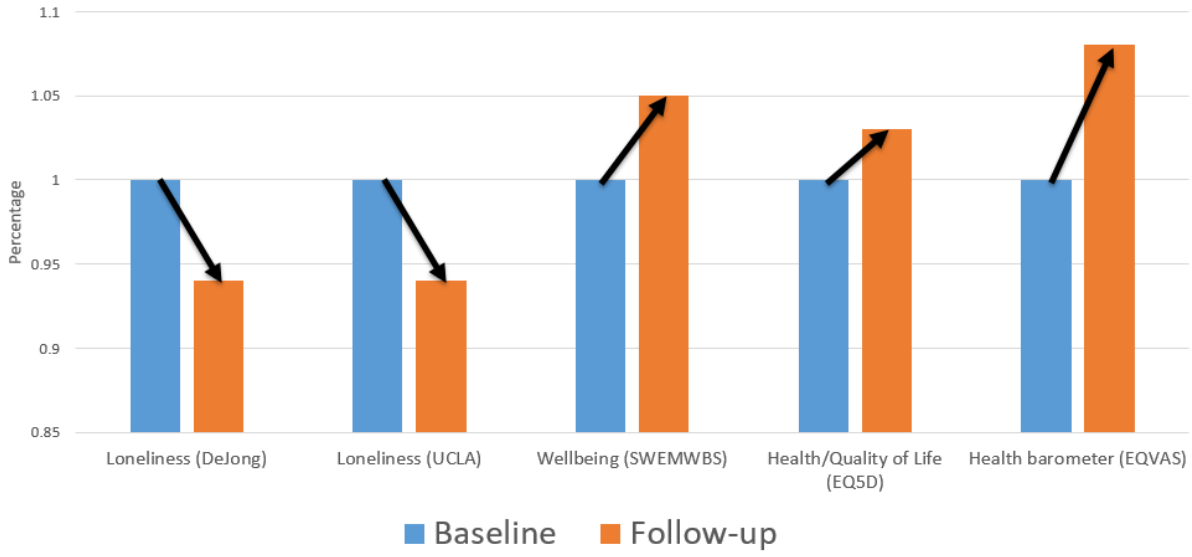
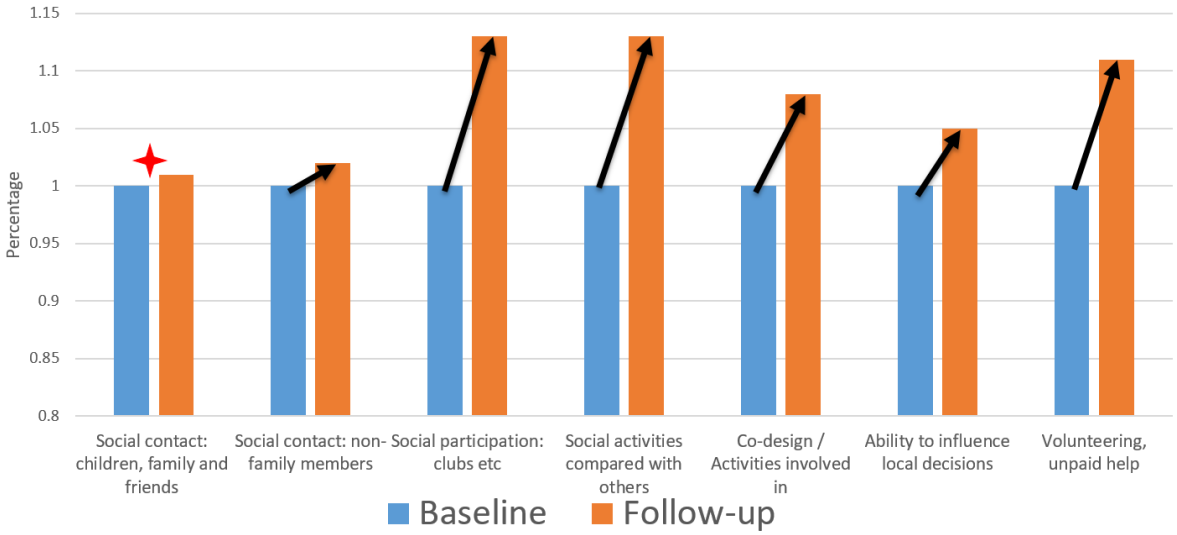


Chart 7. Positive changes for social engagement. Notes. Matched pair range: 808-1020. Statistically significant change (p<0.05) for all measures except "Social contact: children, family & friends". Data presented as percentage change. Not as values for each measure.



No significant change for this measure

Further analysis: projects and outcomes

Table 2 presents a summary of outcomes for the main BAB projects where there are sufficient matched pairs to test changes over time. The projects show a different pattern of evidence of change. Some key features are as follows:

- **Social and emotional isolation.** As well as the BAB programme overall, several of the projects show a positive impact on isolation and loneliness. The DjG and UCLA scales are largely consistent, but the differences are likely to be due to somewhat different measurement systems.
- **Health outcomes.** Community Navigators and Oasis Talking Therapies show positive effects on health related quality of life (EQ5D). This is a measure widely used in healthcare setting to determine the effectiveness of interventions. The positive outcomes for this measure may be due to the high health (mental and physical) needs of clients and the structured personal support delivered by the projects.
- **Health and wellbeing outcomes.** Most projects show positive outcomes for health (EQVAS) and wellbeing (SWEMWBS). Apart from indicating the benefits of these projects for a wide range of social groups, it should be noted that these measures are sensitive to, even small, changes.
- **Social contact with children, family and friends.** Only the Community Development projects show a positive impact using this measure. This is likely to be because most BAB projects were not designed to have an effect on these social groups: their focus has been on wider community social engagement. Positive changes in **Taking part in social activities** are widely demonstrated for the main BAB projects.
- **Influence on local decision-making** and **co-design in activities** are two areas of outcome that we can link to projects that have sought to empower older people as individuals and groups. Community development projects are a particularly good example.

Table 2: Outcomes compared for the main BAB projects. Key: Green = statistically significant positive change. Grey = no statistically significant change

Area of measurement	Measure	All projects	Community Webs	Community Navigators	Community Develop'nt	Oasis-Talking therapies	Shared reading	Bristol meets the world (food)	Come on board (physical activity)	Wellbeing & BAME Older People
	Minimum no. matched pairs	753	61	123	162	81	41	57	56	75
Social and emotional isolation	DEJONG						N/A			
Social and emotional isolation	UCLA									

Social contact with children, family and friends	CONTACT									
Social contact with non-family memb's	SPEAKLOCAL									
Social participation in clubs etc	SOCIALSCORE									
Taking part in social activities	TAKEPART									
Co-design. Activities involved in	INVOLVED		N/A							
Ability to influence local decisions	INFLUENCE		N/A							
Volunteering, unpaid help	HELP		N/A							
Wellbeing	SWEMWBS									
Health/Quality of Life	EQ5D Index		N/A							
Health	EQVAS		N/A							

We should note that there are a number of caveats involved in interpreting the outcomes. While the qualitative process evaluations and test and learn events provide evidence of how projects have created change, the baseline and follow-up design can only test associations and not determine whether projects cause change. There are also reason why there is no evidence of change for some projects. These include insufficient interval between questionnaires to detect change; the challenging nature of some changes measured; and the potential for some participant's health and wellbeing to decline over time due to factors outside the project, such as the ageing process. Therefore, absence of evidence of change does not necessarily mean that projects have not produced beneficial outcomes for participants.

Further analysis by demographic characteristics

The following sections examine the key outcomes in terms of the leading demographic variables of age, gender, living arrangement, area of residence, ethnicity, disability, and caring responsibilities. Due to low numbers of LGBT+ respondents we have not examined differences in terms of sexuality.

Age

We divided the respondents into two age groups: up to 69 years old, and 70 years and over. The following table shows that there is evidence of effects of the project for both younger and older respondent groups on social and emotional isolation, social participation, wellbeing and health (EQVAS). However, the effects health and isolation are clearer for those up to 69 years old. This group also show changes for volunteering. It is noteworthy that those 70 years and over report changes in their ability to influence local decisions.

Table 3. Outcomes assessed by age group

Area of measurement	Measure	Up to 69 yrs pairs	Baseline mean	Follow up mean	P value	70 plus yrs pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	372	3.61	3.32	.001	347	3.04	2.95	.324
Social and emotional isolation	UCLA	426	5.89	5.50	.000	425	5.46	5.21	.001
Social contact with children, family and friends	CONTACT	402	3.43	3.50	.145	366	3.11	3.08	.512
Social contact with non-family memb's	SPEAKLOCAL	463	6.64	6.47	.234	494	6.84	6.94	.181
Social participation in clubs etc	SOCIALSCORE	440	1.27	1.50	.000	469	1.44	1.55	.034
Taking part in social activities	TAKEPART	459	1.27	1.50	.000	492	1.51	1.66	.002
Co-design. Activities involved in	INVOLVED	370	1.11	1.20	.194	417	0.94	1.01	.300
Ability to influence local decisions	INFLUENCE	399	2.96	3.10	.064	450	2.76	2.92	.029
Volunteering, unpaid help	HELP	439	1.39	1.58	.002	480	1.17	1.25	.230
Wellbeing	SWEMWBS	410	20.46	21.62	.000	393	21.78	22.67	.000
Health/Quality of Life	EQ5D Index	336	0.65	0.69	.004	398	0.65	0.65	.999
Health	EQVAS	363	60.73	67.52	.000	412	64.21	67.46	.000

Gender

We explored differences in outcomes for females and males. The following table broadly shows that there were clearer positive effects of the programme for females than males – notably for social isolation and health. This may be due to the smaller sample sizes for males, although there are other potential explanations such as the gender relevance of projects or the higher levels of needs for males.

Table 4: Outcomes assessed by gender

Area of measurement	Project	Female pairs	Baseline mean	Follow up mean	P value	Male pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	532	3.27	3.04	.001	205	3.64	3.47	.188
Social and emotional isolation	UCLA	634	5.63	5.26	.000	240	5.78	5.62	.116
Social contact with children, family and friends	CONTACT	568	3.38	3.43	.167	216	2.98	2.93	.494
Social contact with non-family memb's	SPEAKLOCAL	721	6.78	6.96	.003	267	6.53	6.46	.594
Social participation in clubs etc	SOCIALSCORE	689	1.41	1.50	.029	249	1.19	1.53	.000
Taking part in social activities	TAKEPART	713	1.43	1.61	.000	273	1.32	1.53	.004
Co-design. Activities involved in	INVOLVED	579	1.08	1.12	.474	237	0.87	1.00	.082
Ability to influence local decisions	INFLUENCE	631	2.84	3.03	.003	252	2.88	2.96	.410
Volunteering, unpaid help	HELP	691	1.29	1.46	.002	262	1.20	1.30	.237
Wellbeing	SWEMWBS	618	21.26	22.46	.000	227	20.65	21.41	.006
Health/Quality of Life	EQ5D Index	544	0.65	0.67	.010	219	0.67	0.65	.365
Health	EQVAS	570	62.93	67.90	.000	230	60.73	65.93	.000

Living arrangement

We examined the differences between those participants who reported living alone and those living with others. The following table suggests a very similar pattern of outcomes for both groups. This is a positive finding for the programme overall, because it indicates that there are clear benefits for the main target beneficiary group.

Table 5: Outcomes assessed by living arrangement

Area of measurement	Project	Living alone pairs	Baseline mean	Follow up mean	P value	Living with spouse, family or other pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	351	3.64	3.43	.010	365	3.16	2.96	.027
Social and emotional isolation	UCLA	427	6.11	5.72	.000	423	5.29	5.05	.001
Social contact with children, family and friends	CONTACT	380	3.19	3.17	.795	384	3.42	3.45	.486
Social contact with non-family memb's	SPEAKLOCAL	484	6.72	6.79	.369	483	6.66	6.79	.102
Social participation in clubs etc	SOCIALSCORE	470	1.21	1.41	.005	452	1.40	1.60	.000
Taking part in social activities	TAKEPART	490	1.37	1.58	.000	473	1.40	1.57	.000
Co-design. Activities involved in	INVOLVED	410	0.86	0.90	.493	390	1.19	1.29	.107
Ability to influence local decisions	INFLUENCE	442	2.69	2.86	.023	427	3.05	3.14	.202
Volunteering, unpaid help	HELP	466	0.98	1.15	.005	464	1.54	1.68	.045
Wellbeing	SWEMWBS	407	20.65	21.82	.000	414	21.41	22.39	.000
Health/Quality of Life	EQ5D Index	374	0.61	0.64	.058	370	0.68	0.71	.054
Health	EQVAS	395	60.69	64.27	.000	391	64.14	70.77	.000

Area of residence

We divided participants into those living in areas of higher multiple deprivation (Index of Multiple Deprivation deciles 1-3) and those in areas of lower deprivation (Index of Multiple Deprivation deciles 4-10). The following table indicates that those living in less deprived areas showed a clearer pattern of positive changes according to the leading outcomes. This may reflect wider evidence of barriers towards reaching those experiencing higher levels of deprivation. Nevertheless, we note that those in areas of higher deprivation do show positive changes for isolation (UCLA), health (EQVAS), as well as social participation scores.

Table 6: Outcomes assessed by area of residence

Area of measurement	Project	IMD 1 to 3 pairs	Baseline mean	Follow up mean	P value	IMD 4-10 pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	332	3.50	3.42	.338	358	3.25	2.90	.000
Social and emotional isolation	UCLA	383	5.91	5.55	.000	441	5.52	5.22	.000
Social contact with children, family and friends	CONTACT	345	3.10	3.08	.726	404	3.46	3.51	.169
Social contact with non-family members	SPEAKLOCAL	450	6.73	6.72	.942	489	6.72	6.97	.000
Social participation in clubs etc	SOCIALSCORE	430	1.25	1.40	.005	460	1.52	1.66	.009
Taking part in social activities	TAKEPART	445	1.53	1.53	.001	488	1.47	1.66	.000
Co-design. Activities involved in	INVOLVED	368	1.05	1.03	.813	411	1.04	1.16	.038
Ability to influence local decisions	INFLUENCE	406	2.88	2.94	.446	441	2.86	3.04	.014
Volunteering, unpaid help	HELP	437	1.16	1.28	.082	466	1.43	1.57	.035
Wellbeing	SWEMWBS	370	21.06	21.91	.000	427	21.09	22.34	.000
Health/Quality of Life	EQ5D Index	333	0.59	0.62	.100	394	0.70	0.72	.056
Health	EQVAS	361	59.71	65.20	.000	405	64.74	69.28	.000

Ethnicity

To explore potential differences in outcomes in terms of ethnicity, we divided participants between those identifying themselves as any White group and those identifying themselves as any BAME group. The following table indicates that the pattern of outcomes are more positive for White groups. It is not clear why this might be the case, although it is worth noting that the sample sizes are smaller for the BAME group and it is possible that they are not large enough to detect a change. Alternatively the lack of evidence of outcomes for BAME groups may indicate the greater level of health and social disadvantages experienced by these groups.

Table 7: Outcomes assessed by ethnicity

Area of measurement	Project	White (All) pairs	Baseline mean	Follow up mean	P value	BAME pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	580	3.36	3.09	.000	152	3.34	3.36	.868
Social and emotional isolation	UCLA	680	5.73	5.38	.000	184	5.40	5.21	.124
Social contact with children, family and friends	CONTACT	630	3.28	3.32	.224	147	3.25	3.15	.226
Social contact with non-family memb's	SPEAKLOCAL	748	6.80	6.93	.019	227	6.46	6.41	.702
Social participation in clubs etc	SOCIALSCORE	707	1.30	1.51	.000	220	1.49	1.50	.854
Taking part in social activities	TAKEPART	740	1.33	1.56	.000	232	1.63	1.65	.740
Co-design. Activities involved in	INVOLVED	596	1.01	1.07	.238	209	1.04	1.17	.175
Ability to influence local decisions	INFLUENCE	637	2.75	2.92	.004	232	3.12	3.22	.379
Volunteering, unpaid help	HELP	711	1.23	1.32	.062	228	1.35	1.61	.027
Wellbeing	SWEMWBS	661	20.80	22.01	.000	173	22.31	22.57	.472
Health/Quality of Life	EQ5D Index	567	0.64	0.66	.127	183	0.67	0.69	.288
Health	EQVAS	583	62.04	66.60	.000	204	62.99	69.25	.000

Long standing illness and disability

Despite reporting less positive health and social circumstances at the start of their entry to projects, the following table shows that individuals reporting long standing illness and disability were clearly likely to report positive changes in terms of isolation, health and wellbeing as well as social engagement. Indeed the pattern of positive changes is stronger for this group than those without long standing illness or disability.

Table 8: Outcomes assessed by long standing illness and disability

Area of measurement	Project	Disability (Yes) pairs	Baseline mean	Follow up mean	P value	Disability (No) pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	437	3.93	3.64	.000	292	2.51	2.46	.609
Social and emotional isolation	UCLA	513	6.24	5.87	.000	358	4.85	4.64	.007
Social contact with children, family and friends	CONTACT	459	2.99	3.04	.251	322	3.66	3.64	.779
Social contact with non-family memb's	SPEAKLOCAL	581	6.54	6.64	.114	405	6.99	7.05	.329
Social participation in clubs etc	SOCIALSCORE	558	1.11	1.32	.000	382	1.69	1.78	.135
Taking part in social activities	TAKEPART	580	1.12	1.35	.000	402	1.80	1.91	.058
Co-design. Activities involved in	INVOLVED	457	0.84	0.91	.182	356	1.24	1.34	.188
Ability to influence local decisions	INFLUENCE	498	2.67	2.79	.077	385	3.12	3.29	.018
Volunteering, unpaid help	HELP	557	1.07	1.15	.145	392	1.52	1.73	.008
Wellbeing	SWEMWBS	497	19.87	21.19	.000	338	22.87	23.54	.005
Health/Quality of Life	EQ5D Index	414	0.49	0.53	.009	346	0.83	0.83	.460
Health	EQVAS	455	53.60	59.36	.000	345	73.94	77.71	.000

Caring

As with the analysis of outcomes for people with long standing illness and disability, those reporting carer responsibilities clearly showed a positive pattern of outcomes for isolation, health and wellbeing, along with other issues such as an ability to influence local decisions.

Table 9: Outcomes assessed by caring responsibility

Area of measurement	Project	Carer pairs	Baseline mean	Follow up mean	P value	Not a carer pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	194	3.86	3.51	.003	540	3.19	3.06	.065
Social and emotional isolation	UCLA	234	5.98	5.61	.000	638	5.57	5.29	.000
Social contact with children, family and friends	CONTACT	207	3.33	3.41	.179	575	3.25	3.25	.869
Social contact with non-family memb's	SPEAKLOCAL	260	6.71	6.78	.480	728	6.69	6.81	.065
Social participation in clubs etc	SOCIALSCORE	243	1.30	1.43	.050	695	1.36	1.53	.000
Taking part in social activities	TAKEPART	261	1.19	1.37	.005	723	1.47	1.65	.000
Co-design. Activities involved in	INVOLVED	182	1.04	1.16	.263	633	1.01	1.07	.193
Ability to influence local decisions	INFLUENCE	201	2.77	3.01	.037	683	2.90	3.01	.063
Volunteering, unpaid help	HELP	253	1.64	1.66	.848	698	1.12	1.30	.001
Wellbeing	SWEMWBS	226	20.48	21.66	.000	613	21.28	22.27	.000
Health/Quality of Life	EQ5D Index	169	0.63	0.67	.070	591	0.62	0.67	.144
Health	EQVAS	184	59.93	66.64	.000	617	63.11	67.47	.000

Longer term outcomes

A smaller number of individuals completed a third questionnaire at approximately 6 months after enrolling with a BAB project. With a focus on loneliness, Chart 8 shows a continued reduction in scores over time. Participant responses on the De Jong Gierveld Loneliness Scale found that the mean participant score at baseline was 3.37 (n=753). At the third questionnaire point the score was 3.10 (n=403). This difference was statistically significant (Z= -2.184; p=0.029).

Chart 8. Continued positive impacts on loneliness over time using the De Jong Gierveld Loneliness Scale. Note that chart presents as percentage change, not as values for the measure.

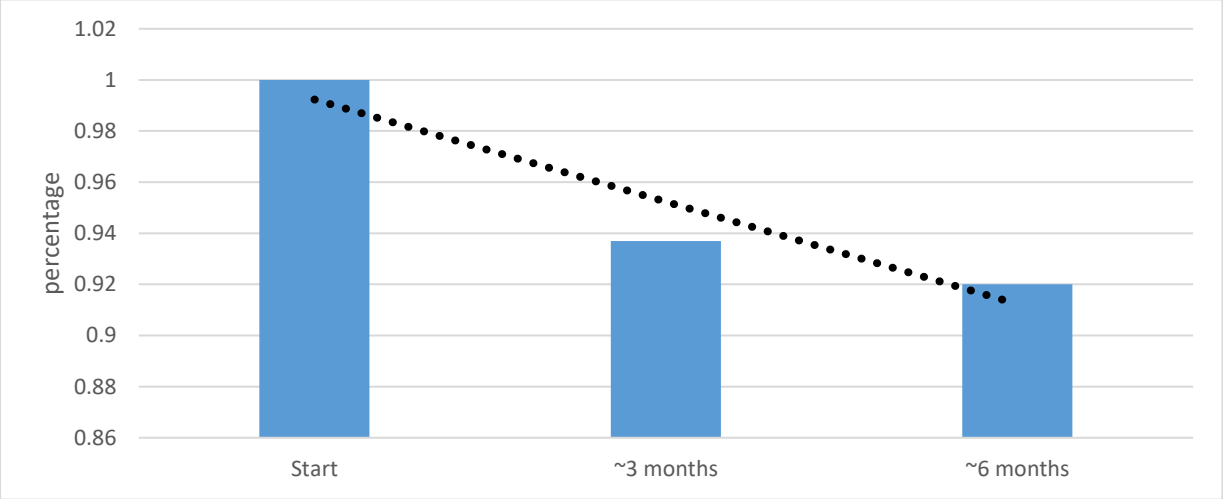
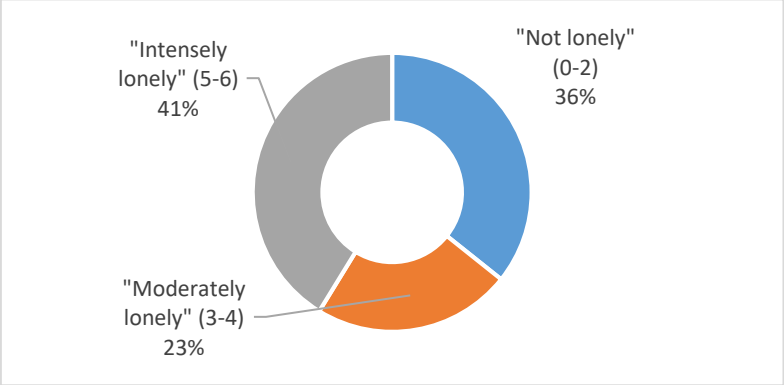


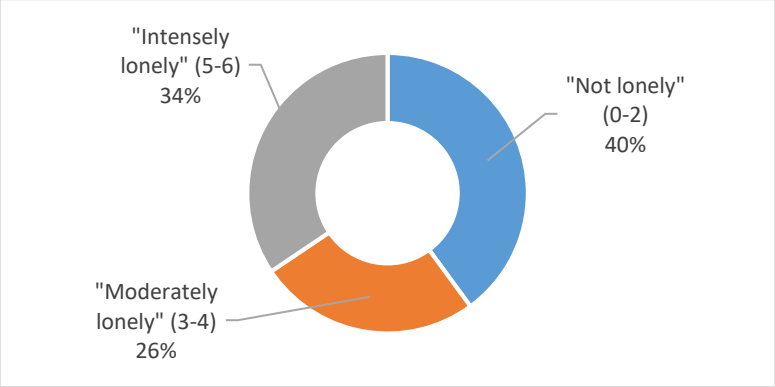
Chart 9 presents similar data to Chart 8, but focuses on the set of respondents that completed questionnaire at approximately 6 months. For this set, it shows a reduction in reported 'intense loneliness' from 41% at the start, to 34% after approximately 3 months, to 31% after approximately 6 months.

Chart 9. Continued positive impacts on loneliness over time using the De Jong Gierveld Loneliness Scale. Comparison of the same group of respondents at three time points (n=403)

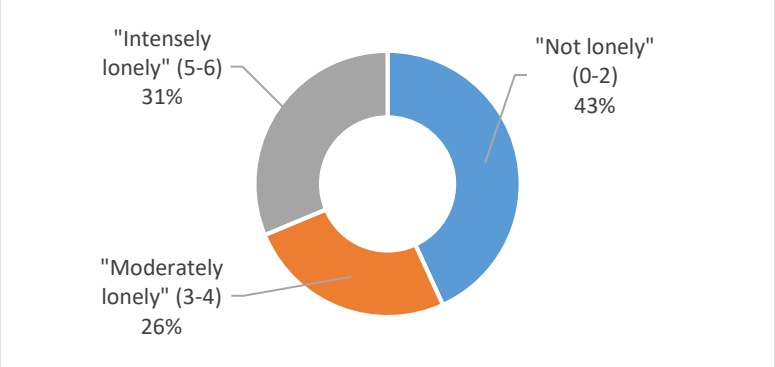
Start



~3 months



~6 months



Conclusions

The BAB projects were successful in engaging a large number of participants in their projects, although we do not have evidence of registration from the majority reported in monitoring returns to BAB.

There were variations between projects in the completion of registration forms and wellbeing questionnaires. Some variations are clearly a consequence of the project model. For example, the CDOP Strategic Coordination project was not primarily engaged in direct work with groups of community participants, whereas the CDOP Greater Brislington project was heavily activity focused. However, low data returns from some projects appear to be due to issues with project planning, delivery and skills, as well as value-based objections and ethical concerns with the use of questionnaires in community development practice.

BAB projects show success in reaching out and engaging older people who report high levels of social and emotional isolation, illness, disability and caring responsibilities. The overall patterns show that participants have a range of social needs and reflect some priority groups for the programme.

Analysis shows that there were statistically significant improvements for:

- loneliness,
- wellbeing,
- general health,
- social contact and participation,
- co-production and influence of decision–making.

This evidence indicates that the BAB projects were addressing the central goals of the programme overall. However, it should be noted that there are some limitations with the evidence in terms of uncertainty about how representative the questionnaire respondents were of all those taking part. Also, other limitations need to be recognised in terms of the duration of the changes over the longer term. Nevertheless, the outcomes findings in this evaluation show very encouraging evidence of the effectiveness of a range of initiatives on the wellbeing of older people in the city of Bristol.

These findings are important because they provide evidence on the effects of community-based projects led by voluntary sector providers across a range of outcomes. The findings indicate that these initiatives can make a positive contribution towards key aspirations in the city to improve the lives of older people, and particularly those experiencing loneliness and isolation.

Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

Bristol Health and Wellbeing Board

Title of Report:	**Bristol Health Partners Academic Health Science Centre – update**
Author (including organisation):	Professor David Wynick (Director, Bristol Health Partners AHSC), Lisa King and Olly Watson (Joint Chief Operating Officers, Bristol Health Partners AHSC)
Date of Board meeting:	**18 March 2021**
Purpose:	Information and discussion

1. Executive Summary

- Bristol Health Partners is a strategic collaboration between the city region's universities, major health and care providers and commissioners, covering the Bristol, North Somerset and South Gloucestershire area.
- On 1 April 2020, Bristol Health Partners was awarded the prestigious designation of Academic Health Science Centre by NHS England, NHS Improvement and the National Institute for Health Research.
- Through its Health Integration Teams and other initiatives, the partnership's mission is to use our combined strengths and expertise in population and applied health research to coproduce better, more equitable, appropriate and sustainable health and care.
- We seek support from the Bristol Health and Wellbeing Board in understanding how best to support local strategy.

2. Purpose of the Paper

This paper gives an update on Bristol Health Partners Academic Health Science Centre. The designation of the partnership as an Academic Health Science Centre provides a renewed opportunity to discuss our contribution the Health and Wellbeing Board, and Bristol's wider Health and Wellbeing Strategy.

Therefore, we invite the Board to consider:

- How can Bristol Health Partners and its Health Integration Teams best support Bristol's Health and Wellbeing Strategy 2020 – 2025?
- What challenge would you set for the partnership over the next five years?
- Whether/how the Board would like future updates on our work?

3. Background

On 1 April 2020, Bristol Health Partners was awarded the prestigious designation of Academic Health Science Centre by NHS England, NHS Improvement and the National Institute for Health Research. Academic Health Science Centres (AHSCs) are partnerships between top universities and NHS organisations that combine excellence in research, health education and patient care.

Our Board is chaired by Robert Woolley, Chief Executive of University Hospitals Bristol & Weston NHS Foundation Trust and co-lead Healthier Together Integrated Care System.

Our Executive Group is chaired by Professor David Wynick, AHSC Director and joint Research Director at North Bristol and University Hospitals Bristol & Weston NHS Trusts.

There are 11 partner organisations, including NHS trusts and the local clinical commissioning group, Bristol's universities, the adult community health services provider and the local authorities from Bristol, North Somerset and South Gloucestershire.

- Avon and Wiltshire Mental Health Partnership NHS Trust
- Bristol City Council
- Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
- NHS Blood and Transplant
- North Bristol NHS Trust
- North Somerset Council
- Sirona care & health
- South Gloucestershire Council
- University Hospitals Bristol and Weston NHS Foundation Trust
- University of Bristol
- University of the West of England (UWE Bristol)

4. Our Health Integration Teams

The main way by which Bristol Health Partners delivers system wide change for the benefits of the BNSSG population is through the work of the Health Integration Teams. These bring together the right people from across our partnership, networks and beyond to tackle health priorities by working in new ways, harnessing the best research, innovation, care and education. Our HITs must evaluate, involve patients and the public and have a whole system approach.

HITs develop health and care system relevant research programs and drive service developments and interventions that improve healthcare delivery, reduce health deprivation and inequalities, and increase population health and well-being.

Our 20+ Health Integration Teams comprise health professionals, public health staff, researchers, commissioners, voluntary sector organisations and service users. HIT aims include:

- Removing organisational barriers across the health and care system;
- Ensuring all implementation activities meaningfully involve patients and the public;
- Delivering and promoting evidence-informed care and interventions;
- Creating an integrated, equitable and whole-system approach to health and care.

Figure 1 below lists the HITs we support by theme:

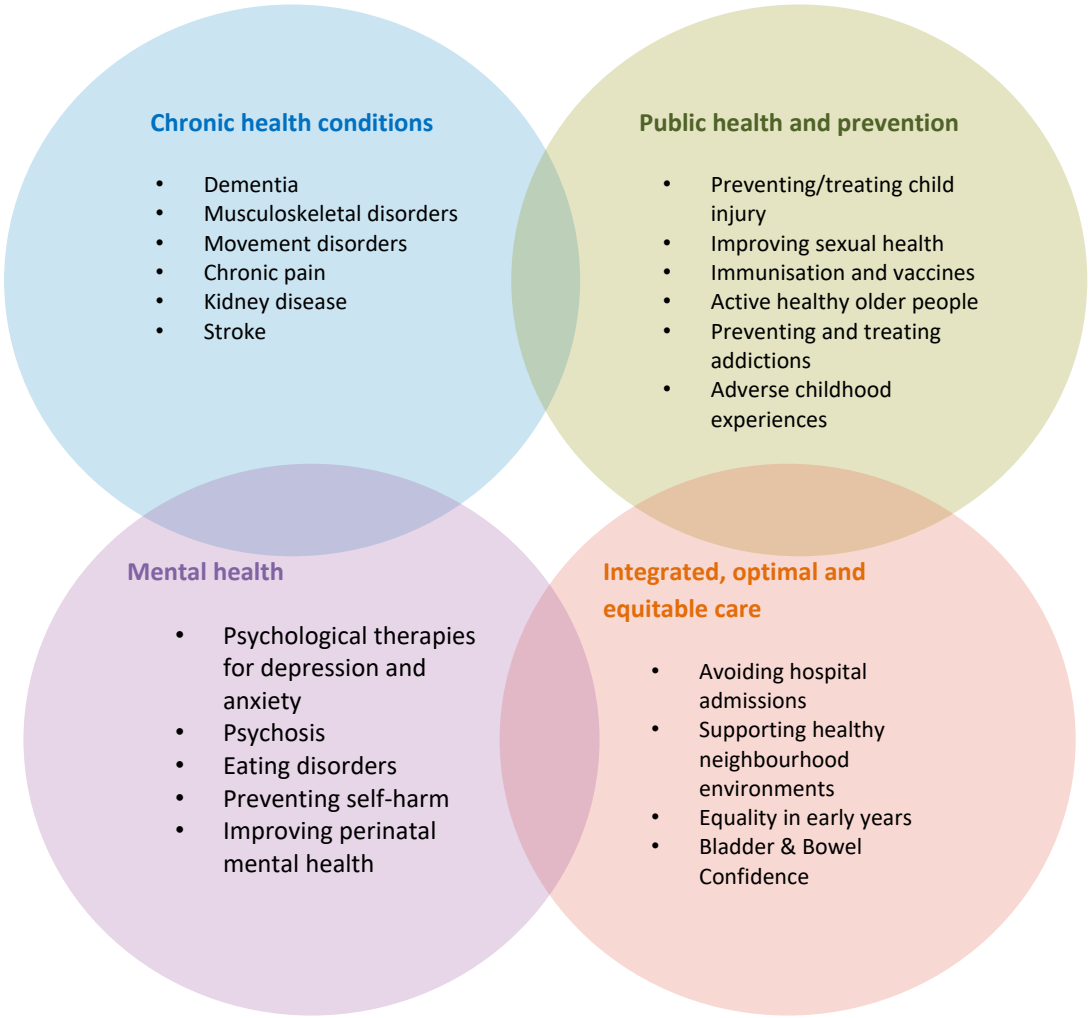


Figure 1: Bristol Health Partners Health Integration Teams

Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

Bristol Health and Wellbeing Board

Title of Report:	**Bristol Fast Track City Update**
Author (including organisation):	**Dr Joanna Copping**
Date of Board meeting:	**18/03/2021**
Purpose:	information and discussion

1. Executive Summary

Bristol signed up to become a Fast Track City (FTC) at the end of 2019 to accelerate work to end HIV. The FTC Steering Group has developed 3 workstreams to take forward actions identified through the HIV Needs Assessment. Significant challenges remain if we are to attain the goal of ending HIV and addressing inequalities.

2. Purpose of the Paper

To update the Health and Wellbeing Board on the recent and future work of the Bristol Fast Track City Initiative including progress towards the One City Plan goals, and to seek views and support on how to achieve the challenging FTC goals we have signed up to.

3. Background and evidence base

In September 2019 the Health & Wellbeing Board endorsed the decision for Bristol to sign up as a Fast Track City to accelerate work to address HIV. Members also agreed to promote FTC to their respective organisations throughout the life of the project. Subsequently, the Mayor signed the FTC Paris Declaration with a pledge to attain the following 2030 targets:

- 95% of people living with HIV know their HIV status
- 95% of people who know their HIV-positive status are on HIV treatment
- 95% of those on HIV treatment have suppressed viral loads
- To reduce stigma and discrimination for people living with HIV

These are reflected in the One City Plan and thus under ownership of this board. In addition, the UK government set the goal of eradicating HIV transmission in England by 2030.

Since signing the declaration, the Bristol FTC Steering Group has brought key partners across a wealth of organisations together to deliver a collaborative approach to tackling HIV. We published an extensive HIV Health Needs Assessment HIV Health Needs Assessment 2020 (bristol.gov.uk), developed and consulted on a Bristol FTC action plan for 20/21, and created 3 workstreams to take this work forward.

In March 2020 Bristol was visited by the national HIV Commission to inform their report to Government on what was needed to achieve zero new HIV transmissions by 2030. The recommendations were published in December 2020 with a strong focus on normalising HIV testing and reducing stigma. The Government will publish their national action plan this year.

Despite Covid, FTC workstreams have continued to meet and progress the action plan. For example, a successful Undetectable= Untransmittable campaign took place in the summer, we developed a FTC website, a new free PrEP (Pre Exposure Prophylaxis) service was set up, and we contributed to developing and delivering a 2 day national FTC conference. Notably, we were successful in a highly competitive bid in conjunction with African Voices

Forum to The Health Foundation for a new project. Common Ambition Bristol was launched in February and takes a co-production approach, working with people of African and Caribbean Heritage to address HIV inequalities.

Recently updated HIV data can be found in the JSNA JSNA 2020/21 - HIV (bristol.gov.uk). Whist we are performing reasonably well on the FTC 95/95/95 targets and late diagnosis of HIV appears to have reduced, it remains unacceptably high. We still have around 70 people unaware of their diagnosis and a number of people with HIV are not engaged in treatment. Bristol is considered a high prevalence city for HIV and in 2019, 47 Bristol residents were newly diagnosed. Inequalities within HIV remain, with men who have sex with men and Black African people disproportionately affected.

The FTC Steering Group have recently held a workshop to consider the year 2 action plan. Proposed actions include taking forward NICE recommendations for HIV testing in primary care and the Emergency Department, exploring vending machines for HIV tests, undertaking a stigma survey, developing training for GPs and workplaces, co-ordinating HIV research, continuing to engage with all partners and delivering Common Ambition Bristol. Commissioning of HIV is complex, and funding for these proposals is not established.

Although Bristol FTC has been commended for its strength of partnership work, tackling the significant inequalities and getting to zero new transmissions remains challenging. We already have the tools to end HIV, and the potential to be the first city to achieve this.

4. Community/stakeholder engagement

The voluntary sector, academia, the NHS, the council, Public Health England, and the public are represented on the FTC Steering Group and workstreams. Significant public engagement took place for the HIV Needs Assessment and action plan development and in the development of the Common Ambition Bristol bid and launch. The community will be at the centre of this new project.

5. Recommendations

That the Health and Wellbeing Board:

1) Note the progress made by Bristol Fast Track Cities and plans for future action including Common Ambition Bristol.
2) Consider how to support FTC in getting to zero new transmissions and stigma.

6. City Benefits

Fast Track City is bringing key partners together to deliver a collaborative approach to tackling HIV inequalities. This includes the reduction of stigma through education, and normalising testing, whilst targeting testing, care and support for specific groups.

7. Financial and Legal Implications

N/A

8. No Appendices