Public Document Pack

Health Scrutiny Committee (sub-committee of the People Scrutiny Commission) Agenda

Date: Thursday, 25 February 2021

Time: 1.30 pm

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

Distribution:

Councillors: Brenda Massey (Chair), Harriet Clough, Eleanor Combley, Paul Goggin, Gill Kirk and Chris Windows

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Date: Wednesday 17th February 2021

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Agenda

1. Welcome, Introductions, and Safety Information

(Pages 4 - 5)

2. Apologies for Absence and Substitutions

3. Declarations of Interest

4. Minutes of Previous Meeting

(Pages 6 - 15)

5. Chair's Business

6. 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 **5 pm on Friday 19th February.**

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 **12.00 noon on Wednesday 24th February.**

Register to Attend - Your intention to attend and speak to your Public Forum submission must be received 2 clear working days prior to the meeting. For this meeting, this means that your registration to attend must be received in this office at the latest by **5pm on Monday 22nd February.**

7. COVID-19 Update (For Information)

The Council aims to publish a COVID-19 bi-weekly Bristol statistics update twice a week, on Mondays and Thursdays. This may be delayed until the following day,

depending on when data is made available. The up-to-date report will follow.
Previous reports can be found at the link below;

COVID-19 data: including cases in Bristol and R number for the South West - bristol.gov.uk

8. Health Scrutiny Working Group Report

The report was brought to the Bristol, North Somerset, South Gloucestershire Clinical Commissioning Group (BNSSG CCG) Governing Body. The BNSSG CCG to provide verbal feedback to the Committee on the 25th February.

(Pages 16 - 31)

9. Specialist Children's Mental Health Inpatient Beds in Bristol - Update

(Pages 32 - 35)

10. Carers accompanying patients for outpatients appointments

(Pages 36 - 37)

11. Delivery of the BNSSG Mass Vaccination Programme - Update

(Pages 38 - 59)

12. Drug and Alcohol Strategy

(Pages 60 - 164)

Public Information Sheet

Inspection of Papers - Local Government (Access to Information) Act 1985

You can find papers for all our meetings on our website at https://www.bristol.gov.uk/council-meetings

Covid-19: changes to how we hold public meetings

Following changes to government rules, we will use video conferencing to hold all public meetings, including Cabinet, Full Council, regulatory meetings (where planning and licensing decisions are made) and scrutiny.

Councillors will take decisions remotely and the meetings will be broadcast live on YouTube.

Members of the public who wish to present their public forum in person during the video conference must register their interest by giving at least two clear working days' notice to Democratic Services of the request. To take part in the meeting, you will be required to register for a Zoom account, so that Democratic Services is able to match your named Zoom account to your public forum submission, and send you the password protected link and the instructions required to join the Zoom meeting to make your statement or ask your supplementary question(s).

As part of our security arrangements, please note that we will not permit access to the meeting if your Zoom credentials do not match your public forum submission credentials. This is in the interests of helping to ensure a safe meeting environment for all attending or observing proceedings via a live broadcast.

Please note: Members of the public will only be invited into the meeting for the duration of their submission and then be removed to permit the next public forum participant to speak.

Changes to Public Forum

Members of the public may make a written statement, ask a question or present a petition to most meetings. Your statement or question will be sent to the Committee Members and will be published on the Council's website before the meeting. Please send it to democratic.services@bristol.gov.uk. The following requirements apply:

- The statement is received no later than **12.00 noon on the working day before the meeting** and is about a matter which is the responsibility of the committee concerned.
- The question is received no later than **5pm three clear working days before the meeting**.
- Any statement submitted should be no longer than one side of A4 paper. For copyright reasons, we are unable to reproduce or publish newspaper or magazine articles that may be attached to statements.
- **Your intention to attend the meeting must be received no later than two clear working days in advance. The meeting agenda will clearly state the relevant public forum deadlines.**

By participating in public forum business, we will assume that you have consented to your name and the details of your submission being recorded and circulated to the Committee, published on the website and within the minutes. Your statement or question will also be made available to the public via publication on the Council's website and may be provided upon request in response to Freedom of Information Act requests in the future.

We will try to remove personal and identifiable information. However, because of time constraints we cannot guarantee this, and you may therefore wish to consider if your statement contains information that you would prefer not to be in the public domain. Other committee papers may be placed on the council's website and information within them may be searchable on the internet.

During the meeting:

- Public Forum is normally one of the first items on the agenda, although statements and petitions that relate to specific items on the agenda may be taken just before the item concerned.
- There will be no debate on statements or petitions.
- Public Forum will be circulated to the Committee members prior to the meeting and published on the website.
- If you have arranged with Democratic Services to attend the meeting to present your statement or ask a question(s), you should log into Zoom and use the meeting link provided which will admit you to the waiting room.
- The Chair will call each submission in turn and you will be invited into the meeting. When you are invited to speak, please make sure that your presentation focuses on the key issues that you would like Members to consider. This will have the greatest impact.
- Your time allocation may have to be strictly limited if there are a lot of submissions. **This may be as short as one minute, and you may need to be muted if you exceed your allotted time.**
- If there are a large number of submissions on one matter, a representative may be requested to speak on the group's behalf.
- If you do not attend the meeting at which your public forum submission is being taken your statement will be noted by Members.

For further information about procedure rules please refer to our Constitution https://www.bristol.gov.uk/how-council-decisions-are-made/constitution

Webcasting/ Recording of meetings

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Other formats and languages and assistance for those with hearing impairment

You can get committee papers in other formats (e.g. large print, audio tape, braille etc) or in community languages by contacting the Democratic Services Officer. Please give as much notice as possible. We cannot guarantee re-formatting or translation of papers before the date of a particular meeting.

Bristol City Council
Minutes of the Health Scrutiny Committee (sub-committee of the People Scrutiny Commission)

11 March 2020 at 2.00 pm

Members of the Committee Present:-
Councillors: Brenda Massey (Chair), Harriet Clough, Eleanor Combley, Gill Kirk, and Celia Phipps

Also Present:-
Councillors: Asher Craig, Deputy Mayor, Communities, Public Health, Public Transport, Libraries, Parks, Events and Equalities; Helen Holland, Cabinet Member, Adult Social Care

1. Welcome, Introductions, and Safety Information

Scrutiny Advisor welcomed all those present.

2. Elections of the Chair and Vice-Chair

Members of the Committee elected the Chair and Vice-Chair.

Councillor Brenda Massey was elected Chair; nominated by Councillor Celia Phipps, seconded by Councillor Gill Kirk.

Councillor Celia Phipps was elected Vice-Chair; nominated by Councillor Brenda Massey, seconded by Councillor Gill Kirk.

RESOLVED;

That;

- **Councillor Brenda Massey be elected as Chair**
- **Councillor Celia Phipps be elected as Vice-Chair**

3. Annual Business Report

The content of the Annual Business Report was noted.

RESOLVED;

That;

- **The Sub-Committee note and agree the Terms of Reference;**
- **The Sub-Committee note and agree the Membership;**
- **The meeting on the 11 March 2020 be the only meeting of the 2019/20 municipal year.**

4. Apologies for Absence and Substitutions

There were no apologies for absence.

5. Declarations of Interest

The following non pecuniary interests were declared;

Councillor Celia Phipps declared she was a Social Prescriber, working with Bridgeview Medical Primary care Network; employed in the Voluntary sector in partnership with Knowle West Healthy Living Centre and BS3 Community.

6. Chair's Business

The Chair explained that this was the first meeting of Health Scrutiny Sub-Committee of the People Scrutiny Commission; and this provided an opportunity to have more focus on topics for health scrutiny which was not previously able to fit on the People Scrutiny Commission work programme.

The Chair asked the Director of Public Health to provide an update on Covid-19. An update was given to the Sub-Committee.

7. Public Forum

The following public forum was received and a copy placed in the minute book;

Questions
Q1 -11: Questions from Councillor Massey.

Q12-13: Questions from Councillor Kirk.

RESOLVED;
That the Public Forum be noted.

8. Bristol mental health services update and performance report

The Director of Strategy, AWP, spoke to the report (in the published pack).
The following points were made during the ensuing discussion:

- Area placements were a significant focus; there were a number of work programmes with the aim of provision of a more sustainable service.

- Deputy Mayor (Communities, Public Health, Public Transport, Libraries, Park, Events and Equalities) raised concern about issues with communication; that people were not able to navigate the system due to lack of communication.

- The Committee was advised that the issues surrounding communication were taken on board; it was acknowledged that more needed to be done to find a way to deal with this. It was agreed that a coherent pathway that showed people what services were available, what they looked like, and what to expect, was needed.

- Whilst performance had been good there were situations where people were unable to access services due to communication problems.

- Members stated that the performance in the report did not reflect some constituents' experiences. Members were advised that whilst the Key Performance Indicators were good and showed some improvement it was acknowledged that there were experiences of waiting times which needed addressing; some could be addressed with existing resources, but this was limited.

- The Committee was advised that due to system pressures there was not the capacity to deal with those that did not engage or had disengaged – this was an indicator of pressure on the system.

- The issues were not due to workforce churn, but due to capacity - more referrals than workforce.

- There was a very low bed base compared to the rest of the UK; there was a need to improve recovery capacity. Rising caseloads had impacted the Intervention and Recovery teams. It had been identified that not all referrals had needed to be made.

- It was very important to work in partnership to utilise other sector preventative work which would free up capacity for people in need of care. Working in Multi-disciplinary teams was a positive way of providing people with more opportunities; a way of working that has not been implemented thus far.

- Delayed Transfer of Care was an issue for people with acute mental health conditions. Reasons for DToC included waiting for housing, including supported and specialist housing; key groups being stepped up into secure pathway – there was need nationally for those placements (MoJ involvement).

- If someone had a specific need the supported housing staff may require specialist training and so this would take more time. There was little provision outside acute mental health.

- The Committee was advised that there were good close relationships and links to social care; housing was coming on board with a better relationship with AWP now.

- It was very positive that the staff retention rate had improved.

- There had been workshops with GPs to instil confidence regarding prescribing; GPs were under pressure and so there was a need to ensure they were aware that specialist support was available if needed and that it was accessible. Relationships with GPs had improved. There had been plans for future programmes for newly qualified GPs to acquire mental health specialisms.

- Shared care protocol had been important to enable people to live independently in their communities.

- Out of area placements was a national issue. There had been a struggle to get beds in the country.

- People have needed to be placed a distance away from their homes which was not good for their treatment pathways, and so the strategy had been to get them back as soon as possible. This was not just about beds, but the whole system, including what happened in the lead up to needing a bed in the first place.

- Beds were not the whole story – early interventions and care could prevent a need for beds. There was a need for community solutions so as to lower the need for hospital stays. Resource pressures meant there was a need to come up with creative and flexible solutions.

- There was evidence to show that when a Trust concentrated on community mental health, need for bed numbers went down.

- The Committee was advised that a completed single mental health strategy was due in June 2020. There was a need to ensure it represented views of communities and other stakeholders. There was a need for a joint vision – THRIVE was part of that.

- The production of the strategy required a robust evidence based to inform it, which included an understanding of need in different parts of the city. There would be a focus on well-being to crisis.

- The Director of Public Health told the Committee that the Council was part of an editorial team commenting on the strategy; and that it had been to the Health & Wellbeing Board for comment. The next version would go to the Health & Wellbeing Board again before Cabinet and partner organisations decision making bodies.

- There was a lot of ownership of the strategy; with all partners invested in it.

- The Cabinet Member for Adult Social Care raised an issue of how jobs could be more joined up – voluntary community work and formal mental health employment; which would increase pathways into mental health work more generally.

- The Committee was advised that despite increase in retention there was still an issue of workforce shortages including psychiatrists. There were plans to increase pathways to enter mental health work, which included apprenticeships.

- Director of Public Health stated that this issue links with BAME mental health groups; there was a need to reach communities which would help to build workforce. There were good links which could be built on.

- AWP have had 2 people on the Stepping Up programme.

- There was a discussion about the gap between primary and secondary care. The Committee was advised that there was a group in the middle where there was a gap of service provision. AWP was commissioned to provide high need service provision; there was work starting to bridge the gap.

- There was ongoing work with partners to implement a system that worked with Sirona as they embedded community models – which was a system response.

9. Hospital pressures

Head of Service Hospitals and Front Door spoke to the report (in the published pack).
During the ensuing discussion the following points were made:

- Community services were being developed; an in-house trading company was being investigated for homecare provision. There was a review on current in-house services – how they were used and how they could be improved.

- The Committee was advised that in-house homecare company could provide greater value for money and this in principle was a sustainable proposition.

- It was damaging to older people's health to remain in hospital longer than required; there was concern about step down not being back to home. The Committee was advised that a mixed model approach was important, that the aspiration was to have as many people at home as soon as possible, but appropriate pathways were required for those who presented with complex needs.

- There was value in keeping people well at home; there was a need to utilise the voluntary and charity sector to improve the offer and achieve this; the way the voluntary sector was enabling services now was not sustainable.

- 3% of annual income related to the Community Care contract must be spent on the voluntary sector. £3M /year would now go into the voluntary sector. There was ongoing work to ensure value would be added within the sector, which included how and where money should be spent; there had been innovative projects come forward. The voluntary sector would now help to design the system.

- The challenges have included the move to what the goals were for individuals rather than what prescribed goals should be; which referred to the Wigan model, which would achieve buy-in via co-production of services.

- The Cabinet Member for Adult Social Care said there had been workshops with national and local providers which highlighted that organisations were more engaged with this approach than originally thought, which was positive. This provided a positive opportunity to use direct payments in a way that people would like, which took note of their own goals, what the individual would like.

- The Chair stated that it was important to ensure the home was ready for people to return to, which included appropriate adaptations. Some of that meant working with housing providers as well. All services need to work together. This needed to be considered if home care was to be taken in-house.

RESOLVED;

That the viability of using an in-house trading company for homecare provision should continue to be investigated and findings reported to the Committee.

There was a 10 minute break at 3:20.

10 Bristol GP closures and new arrangements

The Director of Commissioning, BNSSG CCG, spoke to the report (in the published pack). The Area Director (Bristol) and the Director of Business Development, Sirona, was also present.

During the subsequent discussion the following points were made;

- The Committee noted that GPs were independent but integral to NHS.

- There was a resilience dashboard to understand what were the key indicators to show any issues with practices.

- There had been a Primary Care strategy developed. It was agreed that this should be brought to the Committee at a later date.

- Members raised residents' concern that the temporary arrangements including portacabins would last more than 1 year.

- The Committee noted that due to a low amount of residents that had asked for information and/or support with moving practices as part of the dispersals it suggested a well-managed process.

- The Committee was advised that, regarding Bishopston, planning permission process had taken longer than envisaged, and so would be longer than 10 months; it was the intention to maintain Bishopston.

- Increased lists as a result of housing delivery activity were discussed, and Members were advised that there were assessments for the capacity of each practice and how this related to how they operate and utilise space. For example, Horfield was identified as needing more space to meet need, although after further analysis better use of space was identified as a solution.

- There were ongoing meetings and partnership working with Council planning, public health and housing teams to work in an integrated way. There was a need to gain a better understanding of how planning for new housing related to and impacted upon need and capacity.

- Members were advised that some practices worked with a reduced number of Partners as opposed to GPs; that some new GPs did not necessarily want to be Partners; and that different practices worked on differing ratios of GPs/Partners.

- To ensure appropriate capacity there was a need for practices to work together.

- There was a challenge around appropriate bus routes between practices. The Committee was advised that transport was an important consideration when assessing dispersal arrangements and decisions.

- Part of the new community health contract involved ensuring community services could work more closely with GP practices; workforces were already working closer together. The Committee was advised that the aim was to take as much pressure/load as possible from GP practices, and there was a strong willingness for improved partnership working.

- Members were advised that the participation patient groups (PPG) would exist within surgeries; it was also important for full consultation and so feedback from many patients as possible was key. There was work to improve PPG engagement; this had not happened in some parts of Bristol.

- The Chair stated that there was a strong group at Greenway Community Practice.

- The Chair raised concern that some patients had issues seeing the same GP on occasions.

- There was a discussion about 'did not attend' rates and the related costs to practices.

- The Committee was advised that there was not local routine monitoring of missed appointment rates. This was monitored nationally; not for smaller localities.

- There had been communication about costs to pratices due to missed appointments. Previous publication of these figures did not work.

ACTION:
The Sub-Committee to receive clarification as to whether personal list systems were in operation in GP practices.

RESOLVED;
That the Primary Care strategy be on the Health Scrutiny Sub-Committee work programme 2020-21.

11 Service transfer of the Adult Community Contract

The Director of Commissioning, BNSSG CCG, spoke to the report updating the Sub-Committee on the mobilisation and service transfer of the adult community contract. The Director of Business Development, Sirona, was also present.

During the ensuing discussion the following points were made;

- The Committee was advised that, from 1 April 2020, there would be a single adult community services provider and single children's service provider over the Bristol, North Somerset, and South Gloucestershire area.

- Appropriate TUPE arrangements for all staff (3000 approx.) would be in place by the 1 April 2020.

- Part of the contract specification was a requirement to level up services, which would result in a consistent offer based on need.

- The integrated care approach had a focus on prevention and early intervention.

- Members of the Committee agreed that there should be a focus on consistency of approach across the area, and it was positive that Continuing Healthcare (CHC) teams were brought in-house, which could provide more consistency and higher standards.

12 Work programme

The work programme was noted.

RESOLVED;

That the mental health strategy would be brought to the Health Scrutiny Sub-Committee on the 2020-21 work programme.

Meeting ended at 4.45 pm

CHAIR ___________________

Access to planned health care within the context of Covid-19 response and recovery planning

Report of the Health Scrutiny Committee (Sub-Committee of the People Scrutiny Commission)

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Executive Summary

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The Health Scrutiny Working Group, a cross-party group of elected Members, Chaired by Councillor Brenda Massey, was convened in July 2020 to focus on the effect Covid-19 has had on equitable and timely access to planned health care in Bristol, what the city-wide response has been, and what learning there is to help inform and build resilience for the ongoing challenges and for risks of future pandemics. In August 2020 evidence was heard from 10 participants and the Working Group also considered 9 further submissions. The issues, reflections and responses that came out of the two evidence sessions have been organised across 3 key areas: (i) Communication and messaging; (ii) Communities and support; (iii) Capacity and ways of working.

Significant findings were;

- Despite complex changes being implemented extremely quickly and efficiently to ensure NHS settings were made as safe as possible for patients, many still stayed away due to, for some, not fully understanding information, and fear of catching Covid-19. Members thought that better, more accessible and culturally competent communication was required to support people to attend their elective care appointments and help manage the huge increase of patients on waiting lists.

- Limitations with digital communications were flagged as an issue. This included vulnerable and older people finding it difficult to access services on digital platforms; and some households having limited access to online resources due to a lack of devices and/or broadband. There had been distribution of devices with connectivity to economically deprived households, although this was limited. There was a need, therefore, to tackle digital poverty; and for additional coaching and training to use digital technology.

- Capacity across the health system had been severely reduced with the need to implement infection control measures, impacting the time taken for care, and adding to the numbers of people waiting longer. This demanded a greater focus on community support and resilience.

- The role of Social Prescriber Link Worker was noted as vital to help people navigate the health and social care system, and to free up capacity for health professionals. Members agreed that there should be a greater focus on this role within the context of community-led provision. An approach to welfare and service provision which involved building relationships and enabling capabilities was identified as essential.[1] The positive development of locality-based community health, care and wellbeing services during this period was welcomed and Members thought this should be developed further.

- An awareness of a 'second pandemic' of mental health was raised as a concern; and the Members heard about the Healthier Together joint systems approach as a response to this. Members thought this example of positive collaboration should be encouraged.

[1] Members were recommended Hilary Cottam's 'Radical Help' which includes principles and ideas grounded in on Cottam's relational welfare approach, including the importance of relationships and capabilities.

- There had been an increased and deepened partnership working across the system and with the voluntary sector. This had provided for innovative and quick change, and those working arrangements should remain and develop.
- The social status and importance of health and social care workers increased during this period. Members thought this should be built upon to make the recruitment more attractive, helping to build more capacity. The expertise, dedication and flexibility of the workforce across social care and NHS settings was highlighted and commended.

Introduction

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Cllr Brenda Massey, Chair of the Health Scrutiny Committee, convened the Health Scrutiny Working Group, a cross-party group of elected Councillors (also known as Members) in July 2020. The Working Group's focus was the effect Covid-19 has had on equitable and timely access to planned health care in Bristol, what the city-wide response has been, and what learning there is to help inform and build resilience for the ongoing challenges and for risks of future pandemics.

A starting point for Working Group was that a health system working well requires equitable and timely access to effective health care. Covid-19 has shone a light on inequalities, delays and concerns across the health system. The pandemic has also highlighted the positive work already underway across health providers; and it has illustrated the 'art of the possible', how people and partnerships have pulled together and risen to the immense challenge.

In August 2020 evidence was heard from 10 participants and the Working Group also considered 9 further submissions. The findings and recommendations are made in the knowledge this is a fast moving landscape with many changes and challenges to come, and so elected Members, following Centre for Public Scrutiny guidance, have concentrated on consideration of how well partners work together across the system to address people's concerns, and aims for its findings to contribute to smooth, effective decision-making to address blockages, barriers and inequalities.

The Health Scrutiny Committee's priority is to ensure local communities and individuals' needs and experiences inform Bristol's health services; and that those services are effective and safe.[2] Therefore, within the context of how Covid-19 has affected, and continues to affect, Bristol's health and wellbeing, the role of health scrutiny is now more important than ever.

[2] Department of Health (2014), 'Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny'

The purpose of the Working Group

Reflection and Learning

The Working Group would like these findings and recommendations to support the Bristol, North Somerset & South Gloucestershire Clinical Commissioning Group (BNSSG CCG), local health providers, the Council and city partners to reflect and learn from the experience of lockdown so as to:

1. Increase resilience and improve accessibility should Covid-19 remain for the foreseeable future or escalate again, and also for the risk of future pandemics;

2. Help improve timely access to planned health care whilst keeping people safe during the recovery period; and to support people where there are delays.

3. Aim for equitable access to planned health care and support for people from different backgrounds, with all protected characteristics, and for those with economic disadvantages.

How the Working Group investigated and collected evidence for this report

The 3 aims above were framed around the following key questions which were referred to when collecting and reviewing evidence;

1. In your view, observations and experiences, how is the waiting list for planned health care being managed and what are the most successful methods of supporting people in need of, but have not had timely access to, required health care?

2. What can be learnt from the response to Covid-19 in terms of ensuring timely access to planned health care; that people are properly supported if delays occur; and that timely access is equitable for all people with different protected characteristics and socio-economic backgrounds across the city?

Participants and submissions

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Members of the Health Scrutiny Working Group heard from 10 participants in person, and received a further 9 written submissions.

Session 1

Christina Gray Director, Public Health, Bristol City Council

Hugh Evans Director, Adult Social Care, Bristol City Council

Lisa Manson, Director of Commissioning, Bristol, North Somerset & South Gloucestershire Clinical Commissioning Group

Mark Smith Chief Operating Officer, University Hospitals Bristol and Weston NHS Foundation Trust

Evelyn Barker, Chief Operating Officer, North Bristol NHS Trust

Session 2

Vicky Marriott Area Manager, Healthwatch Bristol, North Somerset & South Gloucestershire

Rhian Loughlin Regional Learning Coordinator for Social Prescribing (South West)

Ruth Thorlby Assistant Director (Policy), The Health Foundation

Evidence not in person

Ade Williams, Community Pharmacist, Bedminster Pharmacy

Healthier Together Citizens Panel (x8)

Cllr Asher Craig Deputy Mayor, Communities, Equalities & Public Health

Cllr Helen Holland Cabinet Member, Adult Social Care; Co-Chair of the Health & Wellbeing Board

Findings

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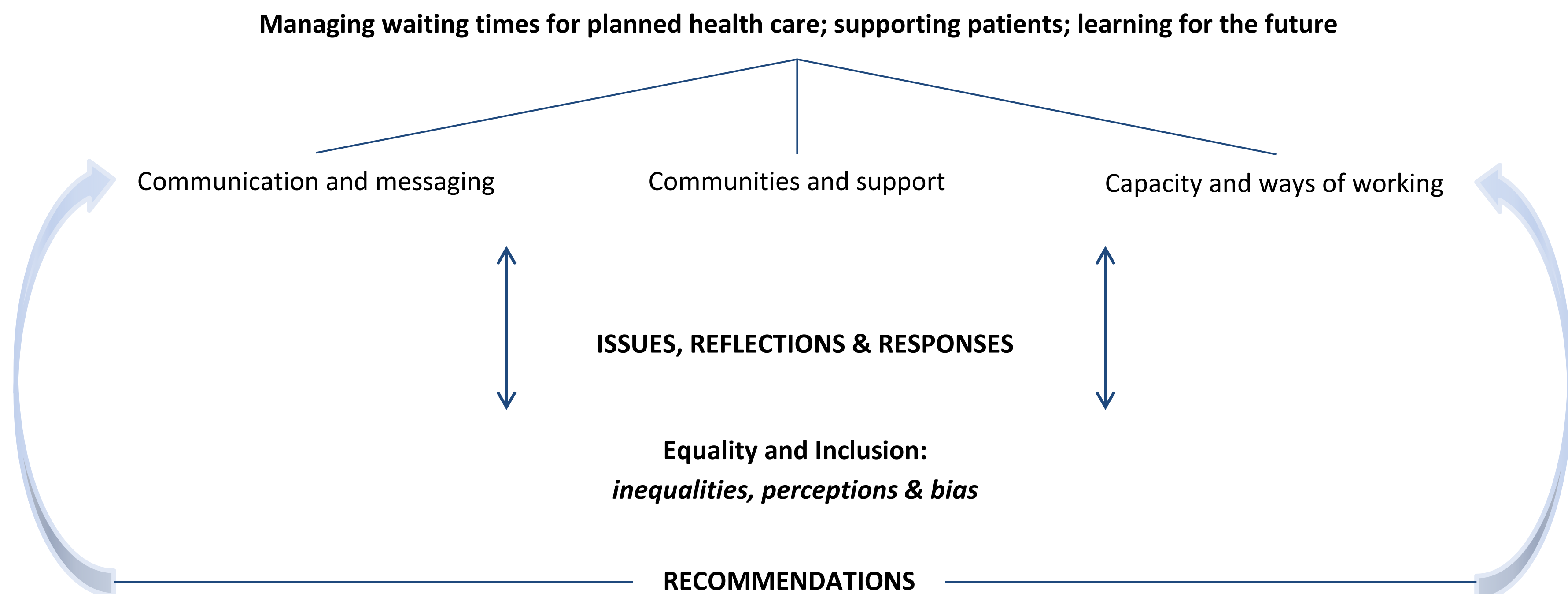
The diagram below is a visual representation of what the Working Group has found. Members organised the issues, reflections and responses that arose from the two evidence sessions into 3 key areas: (i) Communication and messaging, (ii) Communities and support, and (iii) Capacity and ways of working.

Members asked questions about patients' support and managing waiting times for planned heath care during the period of lockdown; and, as lockdown restrictions have been relaxed (although with a clear understanding guidance and rules may change quickly), there were reflections on what has worked well and what has been learnt to help increase resilience and generally improve patients' experiences. Members appreciated the relationships and interconnectivity between the 3 key areas, demanding a holistic approach to analysis. Their recommendations are all framed and informed by issues of equality and inclusion.



Communication and messaging

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ISSUES	RESPONSES & REFLECTIONS
• Fear of catching Covid-19 in hospital has deterred some people from attending appointments. • Some information needs more clarity, and some should be more culturally or linguistically appropriate for minority groups. • There were reports of people having difficulties navigating the health system. • People still required support whilst face to face contact was reduced. • Limitations with digital communications, including vulnerable and older people had difficulty accessing digital platforms; and some households had limited access to resources due to lack of devices or broadband.	• There is national guidance , public information and local public information about new safety measures, which included separate zones for patients with confirmed negative tests for accessing health care. • Face to face contact had been maintained where necessary (based on risk assessments); and for shielding patients there had been a special pathway, including clearer waiting areas for social distancing. • It was noted that clear, accessible, and more culturally competent communication was required. • Safety measures could prevent family members and carers attending consultations; Members heard that there could be more clarity around how this has been applied. • Patients' feedback and stories were raised as an important source of learning; patients could utilise the Healthwatch share your views page. • Healthwatch document '*North Somerset: stories of shielding or self-isolating, June 2020'* was identified as providing relevant recommendations for clear, age appropriate communication and guidance. • Members heard the Joint School App had supported patients waiting for orthopaedic surgery, replacing services otherwise disrupted by Covid-19. Specialist nurses had kept in contact with patients; and physio-therapy teams contacted patients to take them through the exercises to support them. • Members heard that devices with connectivity had been distributed to economically deprived households, although this was limited and further work was required to address digital poverty; and a need for coaching and training opportunities to use digital technology was recognised.

"One of the important things to us is reassuring patients that they are safe coming into any of the NHS facilities, and how we are putting in place changes to make sure we can create as Covid secure environment for patients as possible".

Lisa Manson, Director of Commissioning, BNSSG CCG

Communities and support

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ISSUES	RESPONSES & REFLECTIONS
• There were reports of increased isolation and anxiety during this period. • An awareness of a 'second pandemic' of mental health. • Black, Asian, Minority Ethnic (BAME) communities were more likely to fear hospitals and preferred community-based services. • There was an identified risk of losing local accountability with the evolution to 'Integrated care systems' • Economic disadvantage had come more into focus during this period, with the risk of it becoming worse within the context of an expected economic downturn.	• Public Health and BNSSG CCG co-chaired the mental health and well-being response cell, which took a systems approach (involving clinicians, front-line workers and people with lived experience) to respond to increased demand, including focus on intervention, prevention, and protecting capacity. This work was described as a 'collaborative bid to address the second pandemic in mental health'. • It was noted that Social Prescriber Link Workers have played a vital role to help people navigate the health and social care system; and could free up capacity, including for GPs to focus on medical issues. • There had been a positive recognition that 'health is made in communities'; and that personalised care had become 'business critical' for the NHS. • An approach to welfare and service provision which involved building relationships and enabling capabilities was identified as essential, which would avoid communities being 'managed' by way of top down transactional arrangements.[3] *"It's all about relationships; you can badge it as social prescribing link work, and you can badge it as humans talking to other humans; It's about normalising that in a way that that makes it really straight forward and reduces barriers."* Rhian Loughlin, Regional Learning Coordinator for Social Prescribing (South West) • It was noted that the development of Integrated Care Systems demand a focus on local needs and democratic accountability. • Members were advised that there should be higher investment in community based resources; allocations should be more flexible to target areas of need; and that Covid financial support received by Public Health had been allocated to community development and health champions to reach those most in need.

[3] Members were recommended Hilary Cottam's 'Radical Help' which includes principles and ideas grounded in on Cottam's relational welfare approach, including the importance of relationships and capabilities.

Capacity and ways of working

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ISSUES	RESPONSES & REFLECTIONS
• Existing NHS problems exacerbated by Covid-19, including staff shortages. • Covid-19 caused a dramatic fall in planned care to save beds and ICU capacity. • Promoting Covid safety has placed huge restrictions on the NHS and created a lack of capacity. • A greater demand on primary care and adult mental health services within the recovery phase is expected. • Upcoming winter pressures, including flu demands, require strong planning taking into account the extra impact Covid-19 would create.	• Waiting lists were intensified due to fear associated with Covid-19 and a requirement to shield for 2 weeks either side of an operation impacting child care and employment, leading to some n attending. • It was noted that patients who had not engaged in elective treatment weren't referred back to their GPs and so remained on the waiting list. • Whilst routine surgery was stood down, medical staff were trained to work differently; many anaesthetists and surgeons were trained to support medically ill patients. • The mobilisation of 'whole system' 'out of hospital' service approaches ('Home-First') during this period was positive, and could address a discharge system that has had challenges. • There had been a positive development of locality-based community health, care and wellbeing services. • An increase and deepening of partnership working across the system and with the voluntary sector was noted. • The contribution of private hospitals was limited, as they relied on surgeons and anaesthetists from NHS, not adding to workforce capacity. • The status of health and social care workers increased; this should be built on to make the recruitment more attractive, helping to build capacity.

"Infection control measures have meant reduced capacity within the acute sector, and it is likely the much attention will still need to be paid to the challenges of upcoming Covid-19 waves"

Hugh Evans, Director, Adult Social Care, Bristol City Council

"Although Covid has been very stressful for everybody, there has been a tremendous amount of transformation that has occurred in a matter of weeks; the deepening relationships and the working arrangements we have got in place will now stand us in good stead".

Mark Smith, Chief Operating Officer, University Hospitals Bristol and Weston NHS Foundation Trust

Equality and inclusion

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ISSUES	RESPONSES & REFLECTIONS
• Communication and guidance was difficult to understand for some people. • Not all households have access to the internet. • Older people have found it difficult to access digital platforms. • Health inequalities persist in the city. • Gaps in data, including ethnicity and mental health.	• It was noted that clear, accessible, and culturally competent communication of information was required. • Members' heard about the national information standard where every hospital records how a patient prefers to receive information, recognising not everyone has access to the internet or is able to use it. • It was noted that devices with connectivity have been distributed to economically deprived households, although this was limited and required further work to address digital poverty. • Coaching and training opportunities to use digital technology were needed to enable access. • Members were advised that community organisations need to be supported during this period to help bring about culturally competent responses and services; and be adequately resourced.

"We know that the contribution of unhealthy weight, smoking, and underlying health conditions have created much higher risk factors in some groups; and whether its Covid or not, if we can address those risk factors in our population, which we all know are associated with inequality, then we will improve health outcomes across the piece"

Christina Gray, Director, Public Health, Bristol City Council

Summing up

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Despite an array of national and local guidance and information about Covid-19, the Working Group heard that some people have either been unable to access it or it has lacked clarity. Members found that health providers have clearly worked hard to reassure patients, and they have implemented complex changes, including special pathways for vulnerable patients, in a quick and efficient manner. Regardless, and although there have been recent improvements, a great deal of people stayed away due to fear and anxiety of catching Covid-19 in hospital, and decided to not attend their elective care appointment. The huge increase in numbers on the waiting list is partly a result of this with hospitals preferring, for better outcomes for patients, to keep them on the list rather than referring back to GPs due to missed appointments.

It was noted that people from Black, Asian, Minority Ethnic (BAME) communities, and especially Black people, felt inclined to avoid hospital visits due to fear of catching Covid-19, within the context of the knowledge Covid-19 has disproportionately affected BAME communities, with people from Black ethnic groups most likely to be diagnosed, and that death rates from Covid-19 had been highest among people of Black and Asian ethnic groups.[4] Members heard that there was a clear need for a more culturally competent approach to communications and information. Although Covid-19 has shone a light on the need for more cultural competency (as it has also highlighted all structural inequalities), it is relevant and important not just for communications, but for all future policy and service development to ensure health care is available and responds to the needs of the diverse communities across the city.

The Working Group also heard that people with disabilities were also likely to be more fearful of hospitals and preferred community based services. This may be tied to a greater risk in contracting Covid-19 due to extra barriers to social distancing and implementing hygiene measures, including access to regular hand-washing.[5] Due to the fact the largest disparity in how the national population has been affected by Covid-19 was by age[6], it was noted clear and accessible information for older people was vital, as well as ensuring hospital and community services were accessible.

> *"People will be worried and frightened; good care at the moment means someone being in touch with that person to make sure that they are ok, they know what's happening and there is care put in place; it's a worrying and, for some a very painful time, while they wait."*
>
> Ruth Thorlby, Assistant Director (Policy), The Health Foundation

As face-to-face contact needed to be reduced, online communications and service provision was introduced, which although broadly successful, Members were advised about limitations with digital communications including that vulnerable and older people found it difficult to access services on digital platforms; and some households had limited access to online resources due to lack of devices and/or broadband. Face-to-face contact, as well as other methods of communication, was therefore flagged as important for people. Members

[4] Public Health England (2020), 'Disparities in the risk and outcomes of COVID-19'
[5] World Health Organization (2020) 'Disability considerations during the Covid-19 outbreak'
[6] Public Health England (2020), 'Disparities in the risk and outcomes of COVID-19'

heard about the national information standard where every hospital records how a patient prefers to receive information, recognising not everyone has access to the internet or is able to use it.

Members were advised, therefore, that digital solutions to mitigate disrupted services due to Covid-19, including the 'Joint School App' which supported patients waiting for orthopaedic surgery, were just one element of supporting patients needing to wait longer who may be concerned and in pain. Specialist nurses had kept in contact with patients and physio-therapy teams had contacted patients to remotely take them through exercises to support them.

> *"There has been very good close contact with our specialist nurses; a lot of our physio-therapy teams have been contacting patients and taking them through the exercises as well. So, although there are lots of people using it, it's not just all about the app".*
>
> Evelyn Barker, Chief Operating Officer, North Bristol NHS Trust

Elected Members acknowledged the work of Healthwatch, which helped inform the Working Group about the needs, experience and concerns of patients across the area. Recommendations from recent research based on peoples experiences of shielding and self-isolating were reflected upon and it was noted that learning could be applied to Bristol, and Members supported Healthwatch recommendations, including that communication and guidance should be clear and age appropriate.[7]

The Working Group heard that there is an awareness of a 'second pandemic' – that of mental health; that is, people have presented with increasingly poor mental health, anxiety and trauma, and Members were advised a rise in demand of mental health services was expected. Health providers' and the Council's response involving clinicians, front-line workers and people with lived experience, with focus on intervention, prevention, and protecting capacity, was flagged as an example of what could be achieved in collaboration with shared purpose.

> *"We need to prepare for the scenario that those communities who have been hardest hit by Covid will be hardest hit by second pandemic of mental health."*
>
> Rhian Loughlin, Regional Learning Coordinator for Social Prescribing (South West)

Concern was raised about the risk of losing local accountability within the context of the evolution of Integrated care systems, although Members heard that if utilised correctly a more collaborative approach was possible with community care organisations. Members were advised that there has been a positive recognition within the NHS that 'health is made in communities'; with a strong focus on personalised care and agency of individuals and communities. Members thought that there should be higher and targeted investment in

> *"We felt that involving community organisations and local groups was a really key part of helping to ensure those people who are isolated and those without internet access could be reached; and Volunteer NHS Responders who didn't play a huge part in the initial community involvement could be utilised more in the future".*
>
> Vicky Marriott, Area Manager, Healthwatch Bristol, North Somerset & South Gloucestershire

[7] Healthwatch (2020), 'Shielding stories – an insight into how vulnerable people coped in North Somerset'

community based resources; and they were advised that this was happening in Bristol with Covid financial assistance allocated to community development and health champions to reach those most in need.

The role of Social Prescriber Link Workers was highlighted as vital to help people navigate the health and social care system; they could not only free up capacity and remove barriers (such as arranging transport for ill and vulnerable people), but also help enable a relational approach[8] to services and welfare, avoiding communities being 'managed' by way of top down transactional arrangements. Members were advised that there had been a positive development of locality-based community health, care and wellbeing services.

Maintaining some capacity within the context of responding to Covid-19 was a huge challenge. The Working Group heard that promoting Covid safety placed wide-ranging restrictions on health providers and created a lack of capacity. Members heard that with challenges came opportunities, and acceleration and strengthening of partnership working across the system and with the voluntary sector was noted. Examples of how deepened partnership working created efficiency included, during this period, the mobilisation of 'whole system' 'out of hospital' service approaches ('Home-First'), which, Members were advised, could address a discharge system that has had profound challenges.

> *"One of the highlights is how quickly we have been able to adapt, pivot and work differently."*
>
> Cllr Asher Craig, Deputy Mayor, Communities, Equalities and Public Health

Members were advised that the Nightingale Hospital, converted from the Exhibition and Conference Centre at the University of the West of England to address the risk of lack of capacity for intensive care beds, would be re-purposed unless a second wave demanded use. Re-purposing options had yet to be agreed, but included use for diagnostics, 'step-down', and/or training facilities – all assisting with building capacity.

The expertise, dedication and flexibility of the workforce across social care and NHS settings was highlighted and commended. Members heard that whilst routine surgery was stood down, medical staff were trained to work differently, including anaesthetists being trained to support medically ill patients and trained to work in intensive care. Members were told that the contribution of private hospitals was limited due to the reliance on NHS surgeons and anaesthetists not adding any workforce capacity.

The workforce had received a positive profile during this period, and it was noted that the status of health and social care workers increased. Members agreed that this should be built upon to make recruitment more attractive, helping to build more capacity.

> *"There's a really important piece about making sure those health and care jobs look attractive to young people and to returners"*
>
> Cllr Helen Holland, Cabinet Member Adult Social Care; Co-Chair of Health & Wellbeing Board

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[8] An approach to welfare and service provision which involves building relationships and enabling capabilities. Members were referred to Hilary Cottam's 'Radical Help'; see also Cottam's relational welfare approach.

The Working Group heard how the pandemic had shone a light on structural inequalities across society, which makes the task of enabling equitable and timely access to appropriate care, whilst ensuring people are supported, more difficult, and so a focus on community-led provision according the needs of local communities, cultural competency, economic disadvantage and health inequalities were called for.

Recommendations

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The Health Scrutiny Working Group recommends that;

1. Health partners should work with the Council to consider how guidance about keeping safe and well and information about elective care appointments could be more easily understood, and more accessible to everyone. This should involve consulting with the Race Equality Covid-19 Steering Group, community groups, Healthwatch and social prescribers to better understand the needs of Bristol's diverse communities and increase the cultural competency of information provision.

2. The Council should work with city partners to place a greater focus on tackling the digital divide, and explore options that would enable every household to have equitable access to the internet.

3. BNSSG CCG and the Council should build on the recognition that 'health is made in communities', and so should further invest in community-led provision, including supporting local assets and expertise such as social prescribers and community pharmacies.

4. Preparations for the 'second pandemic' of mental health should be prioritised by health partners and the Council in terms of building capacity to meet increased demand as well as a focus on prevention. The systems approach being developed was commended as a good example of collaborative work between the Council and health partners and this should be built upon, taken forward, and an update of progress brought to by the Health Scrutiny Committee in 2021.

5. Healthier Together and its constituent parts should explore ways to make recruitment to health and care roles more attractive, helping to build more capacity. The expertise, dedication and flexibility of the workforce across social care and NHS settings was highlighted and commended, and arrangements should be made to ensure the work force is supported and able to manage increased demand in the future.

6. The feedback from patients was extremely useful, although better value could be gleaned by enabling more responses and a wider and more representative range of views across Bristol's diverse communities. Healthier Together should, therefore, explore ways to extend the patients' voice in future service developments of health care; and Healthwatch should be supported to build better representation of Bristol's communities within its valuable insights.

7. The positive role of volunteers and mutual aid groups during this period should be learnt from and the Council ought to explore further ways of supporting them.

8. Covid-19 has shone a light on structural inequalities, and so the Council's and health partners' response and recovery planning should build on the current focus on tackling underlying causes of health inequalities and ways to better enable equitable access to health care, no matter people's economic or ethnic backgrounds. This requires utilising the insight and expertise of the Health & Wellbeing Board, as well as local community groups, Healthwatch and national organisations including the Health Foundation. Also, this requires Healthier Together partners to investigate and agree a strategy to increase cultural competency across health care provision, and should ask the Race Equality Covid-19 Steering Group for advice.

9. Through robust data collection, Healthier Together should continue to reflect on known disparities in the risks and outcomes of COVID-19[9] to help gain an understanding of the disproportionate effects on BAME communities. The BNSSSG CCG report 'Impact of COVID-19 and lockdown on health inequalities and steps that need to be taken to address this in BNSSG'[10] should also be referred to and built on, and the Health and Wellbeing Board ought to be supported to identify how health inequalities effect Bristol's diverse communities, building knowledge, preventative strategies, and resilience for the future.

10a. This report should be considered at the Health & Wellbeing Board and be brought to the Healthier Together Executive and the Bristol, North Somerset & South Gloucestershire Clinical Commissioning Group Governing Body for response.

10b. The development of plans to manage waiting lists and support patients within the context of the impact of Covid-19 and to build resilience for the future should be considered by the Health Scrutiny Committee at the next meeting of the Health Scrutiny Committee in 2021, and there should be a review on the 2021-22 work programme.

10c. The scope of the Working Group did not allow time to explore the developments of testing and a Test and Trace system. Due to the importance of a robust Test and Trace system, and that there have been developments which may provide more local control (although this is not certain at the time of publication), an update should be brought to the Health Scrutiny Committee in 2021.

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[9] Public Health England (2020), 'Disparities in the risk and outcomes of COVID-19'

[10] BNSSG CCG (2020) 'Impact of COVID-19 and lockdown on health inequalities and steps that need to be taken to address this in BNSSG'

Cllr Massey and all the Members of the Health Scrutiny Working Group (listed below) would like to thank all those who submitted evidence and participated in the Evidence Sessions, sharing their knowledge and experience, which has helped provide valuable scrutiny.

Health Scrutiny Working Group

Cllr Brenda Massey (Chair)

Cllr Celia Phipps

Cllr Eleanor Combley

Cllr Gill Kirk

Cllr Harriet Clough

Cllr Paul Goggin

Cllr Chris Windows

Health Scrutiny Working Group Report

Access to planned health care within the context of Covid-19 response ad recovery planning - Report of the Health Scrutiny Committee (Sub-Committee of the People Scrutiny Commission), Bristol City Council

28th October 2020

Contact: scrutiny@bristol.gov.uk

Health Scrutiny Committee

25th February 2021

Report of: Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG)

Title: Update on Specialist Children's Mental Health inpatient beds in Bristol

Ward: N/A

Officer Presenting Report: Anna Norris, Senior Contract Manager – Non-acute, BNSSG CCG

Contact Telephone Number: 0117 984 1639

Recommendation;

For the Committee to note the report.

The significant issues in the report are:

- An update on the provision of Specialist Children's Mental Health inpatient beds in Bristol
- Additional services in place to support young people

1. Summary

The Health Scrutiny Committee have requested an update on the provision of Specialist Children's Mental Health inpatient beds for Bristol patients.

The update below seeks to outline the developments in relation to Riverside Unit and the impact on placements for children and young people during this time.

2. Context

The Specialist Children's Mental Health inpatient beds are commissioned as specialised services by NHS England in the South West.

In November 2020, BNSSG CCG provided a detailed update on these services, commissioned by NHS England, highlighting that the Banksy Ward, provided by the Priory Group, remains closed due to serious safeguarding concerns. There is no further update since this was provided.

The other Specialist Children's Mental Health inpatient beds (Riverside Unit), provided by AWP, are currently undergoing refurbishments and these are expected to conclude at the end of March 2021. The Provider has confirmed that this remains on plan to complete by this date. The refurbishment will mean beds will increase from 10 to 12 at this unit.

As a result of the temporary closure of the Riverside Unit, AWP have been providing additional services which includes:

- An extended crisis intervention, outreach and day programme.
- The enhanced day programme provides wraparound care tailored to each individual, operating from 7.30am to 10pm, seven days a week.

  All young people will attend the Enhanced Day Service which follows a structured treatment programme, providing wraparound care. This is personalised to each individual by developing a specific treatment plan in line with appropriate NICE guidelines. The programme has many strands which can include Individual Therapy, Group Work, Family Therapy, Parents Group, Education and Medication.
- Telephone support and advice 24 hours a day, seven days a week, with home visits if required.

All referrals for young people across the South West that may require an inpatient admission are considered according to clinical priority. NHS England is committed to do everything it can to minimise travel during this difficult period, and wherever possible children and young people will be accommodated in their nearest adolescent inpatient unit; for young people in Bristol, this would be Bridgwater.

From August 2020, when the Priory confirmed it would be closing the Banksy Ward, there have been 31 admissions of BNSSG patients to General Adolescent Unit beds, 26 of which have been to beds in region.

There are less than 10 young people in the day care programme and there are currently no Bristol patients in General Adolescent Units out of area.

3. Policy

Not applicable

4. Consultation

a) Internal

Not applicable

b) External

Consultation with NHS England and Improvement and Avon and Wiltshire Mental Health Partnership (AWP)

5. Public Sector Equality Duties

5a) Before making a decision, section 149 Equality Act 2010 requires that each decision-maker considers the need to promote equality for persons with the following "protected characteristics": age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Each decision-maker must, therefore, have due regard to the need to:

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

ii) Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it. This involves having due regard, in particular, to the need to --

- remove or minimise disadvantage suffered by persons who share a relevant protected characteristic;

- take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of people who do not share it (in relation to disabled people, this includes, in particular, steps to take account of disabled persons' disabilities);

- encourage persons who share a protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

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

5b) This report is an update on commissioned services and is not a proposal for new services. The provision of Specialist Mental Health services has a positive impact as it ensures access to

appropriate services for those children and young people with a mental health need.

When commissioning and developing new services, equality duties are taken into account by the CCG and an equality impact assessment will be undertaken.

Appendices:
None

LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985
Background Papers:

None

Health Scrutiny Committee

25th February 2021

Report of: Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG)

Title: Carers accompanying patients for outpatients appointments

Ward: N/a

Officer Presenting Report: Andy Newton, Head of Planned Care, BNSSG CCG

Contact Telephone Number: 0300 123 4476

Recommendation;
Members are to note that there are no restrictions in place regarding carers accompanying people to outpatient appointments.

The significant issues in the report are:

Healthcare providers in BNSSG have confirmed that carers are able to attend outpatient appointments with people, taking account of current Covid-19 policies.

If members are aware of any recent incidents where this has not been the case, we would welcome further information so we can investigate further.

1. Summary

Following a previous discussion focused on maternity services, members requested clarification regarding the policy on carers accompanying patients for all outpatients services.

The CCG has spoken with our healthcare providers and is able to confirm that carers are able to attend appointments alongside patients where a face-to-face appointment is required.

Like patients, carers are required to go through standard Covid-19 screening checks on arrival in accordance with an organisation's standard operating procedure. For example, a temperature check and questionnaire.

Where an appointment is conducted via phone or video, carers can be sent an additional invite so they can join the call without needing to be physically present with the patient.

In response to some specific questions that have been posed by members, we can confirm:

There are no policies on carers accompanying patients for all outpatients appointments. Further to this, therefore there are no differences between paid or voluntary carers and no conditions or eligibility criteria is applied to determine whether people are allowed a carer to accompany them.

Members are asked to note the above findings. However, if members have been made aware of any specific examples where problems have arisen recently we would welcome further information so it can be discussed further with our providers.

LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985
Background Papers:

None

Health Scrutiny Committee

25th February 2021

Report of: Bristol, North Somerset, South Gloucestershire (BNSSG) mass vaccination programme board

Title: Update on delivery of the BNSSG mass vaccination programme

Presenter: Dr Tim Whittlestone, clinical lead for the vaccination programme and Deputy Medical Director at North Bristol NHS Trust (NBT) and Claire Thompson, Chief Operating Officer - Nightingale Hospital Bristol

Recommendation: That the Health Scrutiny Committee note the report.

The key points are:

- Overview of vaccination model
- Priority cohorts
- Ashton Gate Stadium Mass Vaccination Centre / Pharmacy sites
- Primary Care Network sites
- Vaccinating all frontline health and care staff
- Reaching all communities
- How are we doing?

Please refer to Appendix 1

Summary

This update is an overview of the Bristol, North Somerset and South Gloucestershire Covid-19 vaccination programme. It provides a comprehensive update on the model being used locally to deliver the vaccinations at scale, the priority cohorts and the progress we are making locally in vaccinating against the Joint Committee on Vaccination and Immunisation (JCVI) guidance. The update includes an overview of our progress against key Government milestones and our work in reaching underserved communities and vaccinating all our health and care staff across the local area.

Bristol Health Overview & Scrutiny Panel

BNSSG Covid-19 Vaccination Programme Update

25 February 2021

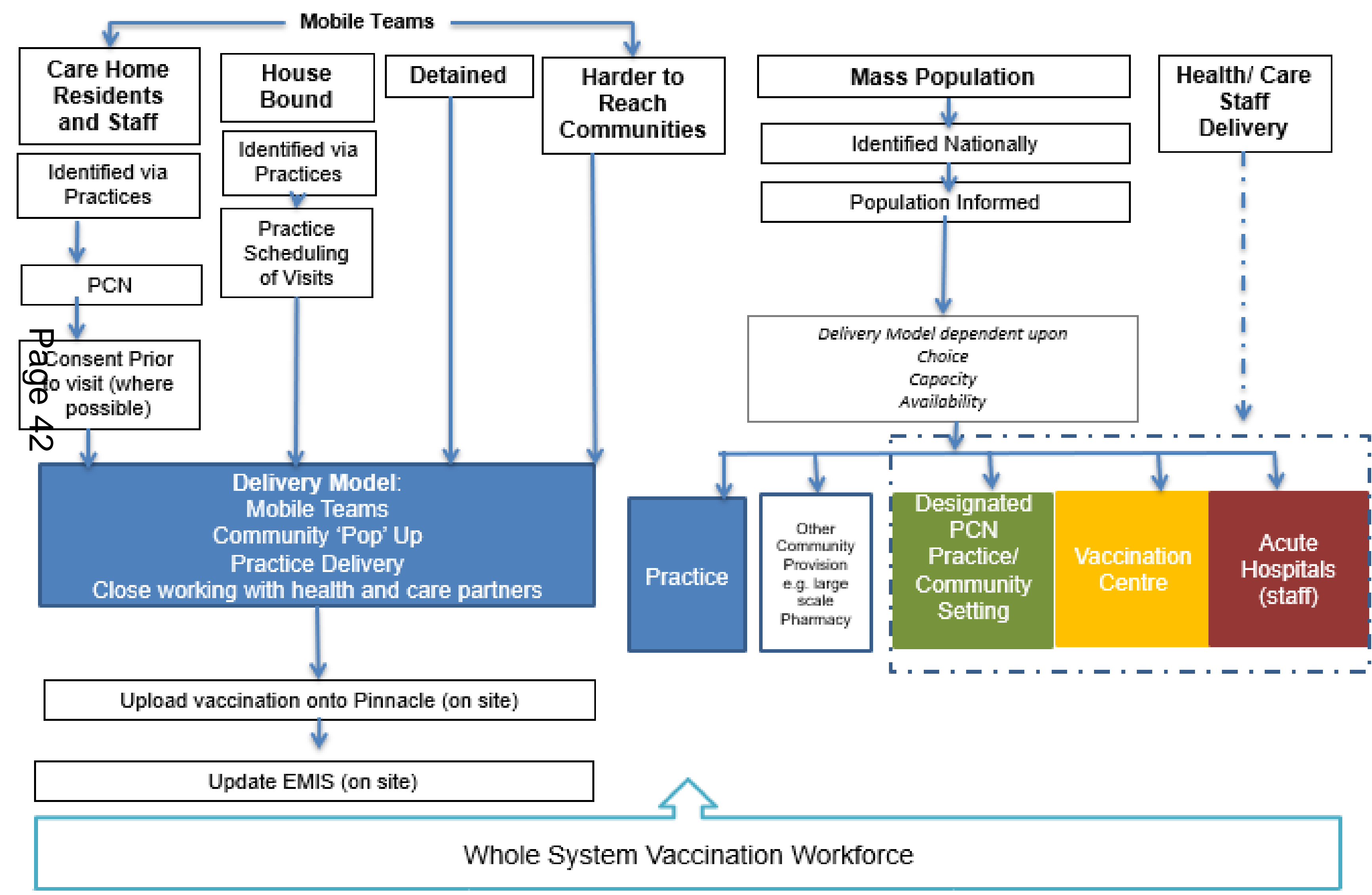
Overview

1. Overview of vaccination model
2. Priority cohorts
3. Ashton Gate Stadium Mass Vaccination Centre and Pharmacies
4. Primary Care Network sites
5. Reaching all communities
6. How are we doing?
7. Next steps

Overview of vaccination model

- **Ashton Gate stadium** – one of the first seven nationally designated mass vaccination sites accessible to population via national booking service (NBS)
- **Primary Care Network** (PCN) sites –19 sites in BNSSG, majority practice sites
- **Care home vaccinations** – delivered by general practice and national leader in terms of coverage
- **Roving model** (finalising details) to vaccinate housebound and vulnerable groups
  - delivered by general practice/Sirona, and community outreach by pool of staff
  - AWP also vaccinating mental health patients on long stay units
  - Hyper localised outreach pop up clinics in areas of low uptake
  - Grassroot initiatives – using trusted voices to share messages to increase confidence and reduce hesitancy
- **Hospital Hubs** – located at North Bristol NHS Trust and University Hospitals Bristol & Weston Foundation NHS Trust vaccinating health and social care staff
- **Pharmacy-delivered model** – Nine sites live in BNSSG, delivering vaccine via National Booking System

BNSSG Mass Vaccination Delivery Model



Prioritisation Criteria

All sites operating to the JCVI (Joint Committee on Vaccination and Immunisation) prioritisation criteria:

- residents in a care home for older adults and their carers
- all those 80 years of age and over and frontline health and social care workers
- all those 75 years of age and over
- all those 70 years of age and over and clinically extremely vulnerable individuals
- all those 65 years of age and over
- all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality
- all those 60 years of age and over
- all those 55 years of age and over
- all those 50 years of age and over

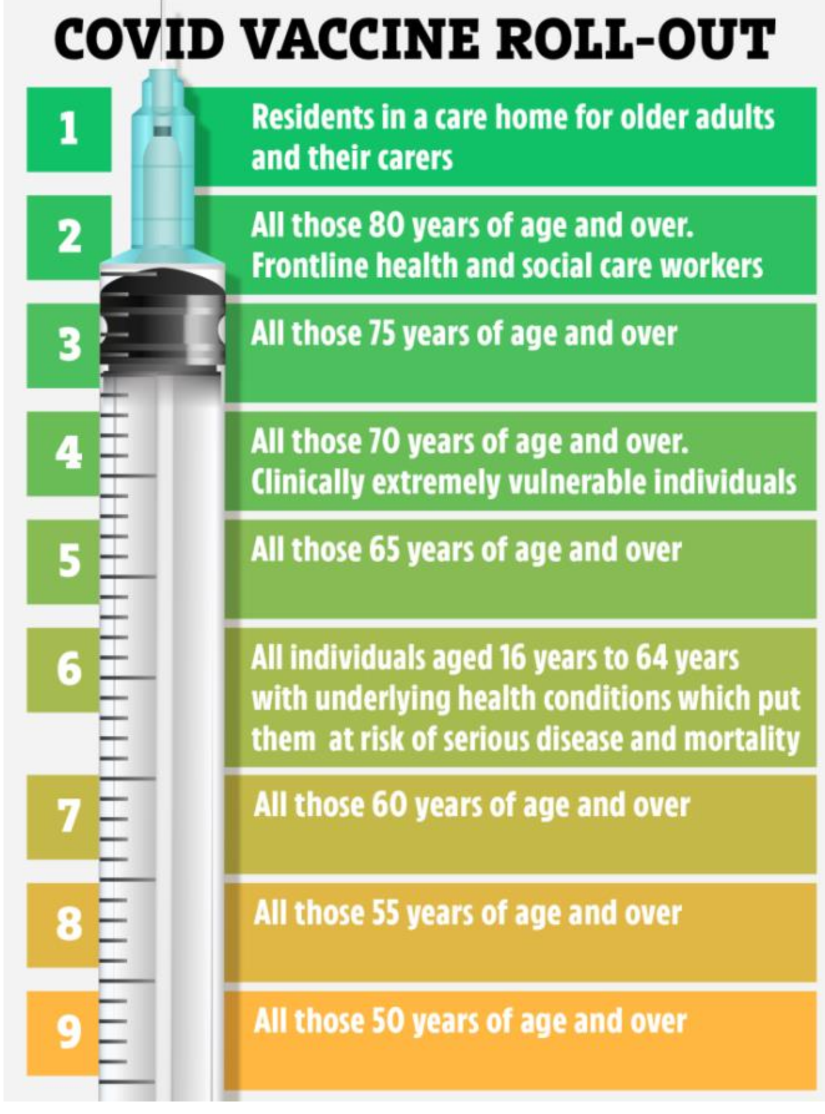
- It is estimated that taken together, these groups represent around 99% of preventable mortality from COVID-19
- National ambition is to vaccinate first four priority groups by mid February, we are on target to achieve this
- JCVI reissued guidance to recommend move to first dose prioritisation with second dose moved to 12 week interval

Roll out plan

Completed by mid-February

Target completion by March

Target completion by end of April



Large scale vaccination centre

- Site opened on 11 January, PM visit and activity ramp up that day
- National Booking System (NBS) end to end testing as used on day one
- Booking over 1,000 vaccinations a day
- Excellent feedback from those working and treated there

Primary Care Network sites

- 19 Primary Care Network sites

- 9 are operational in Bristol

  - The Greenway, Greenway Community Centre
  - Healthwest, Clifton College Preparatory School Hall
  - Bridge View Medical Marksbury Road Branch, Bedminster
  - Horfield Health Centre
  - East Trees Health Centre, Fishponds
  - Shirehampton Group Practice
  - Stockwood Medical Centre
  - Fishponds Family Practice, Fishponds
  - Lodgeside Surgery, Kingswood

- National vaccine supply is phased nationally, so sites were brought on line in waves. All sites are now well established and have vaccinated everyone in cohorts 1-4.

- Practices have also supported staff vaccinations where needed

Primary Care Network sites

- In tandem, practices vaccinated care homes that were under their care, and those registered as housebound with support from Sirona
- Initially PCNs vaccinated using the Pfizer-BioNTech vaccine, they are now vaccinating using both Pfizer-BioNTech and Astra Zeneca depending on what is 'pushed' out nationally
- A national SOP supporting the movement of Astra Zeneca has been published. The medicines optimisation team have developed a local site assurance process to support the CCG to sign off alternative PCN vaccination sites which support improved access for the population.
- Significant PCN support to vaccinate health and care frontline staff and to provide mutual aid to each other to fast track population coverage across waves
- PCNs will play a vital role in vaccinating those in cohort 6

Vaccination of front line health and care staff

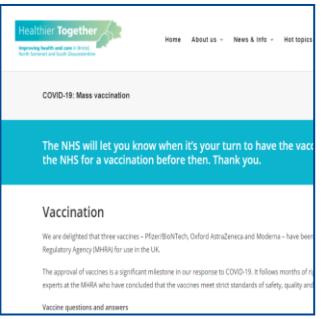
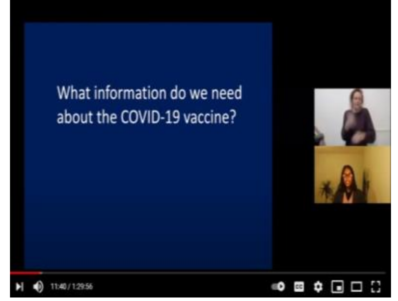
- Staff were invited to be vaccinated in waves starting with those most at risk
- Over 1,300 employers contacted
- Self employed front line health and care staff also vaccinated
- Outreach to employers of front line health and care staff, working closely with the council and local employers
- Staff invited to book at Ashton Gate or the hospital hubs

I just wanted to pass on a huge thanks to you and to all of the vaccination sites that we have experienced as a service; East Trees Medical Centre, Bridge View Medical Practice, Ashton Gate, BRI and Southmead Hospital. The feedback has been overwhelmingly positive for all aspects of the experience from the organisation to the professionalism and approach.

Dementia Wellbeing Service

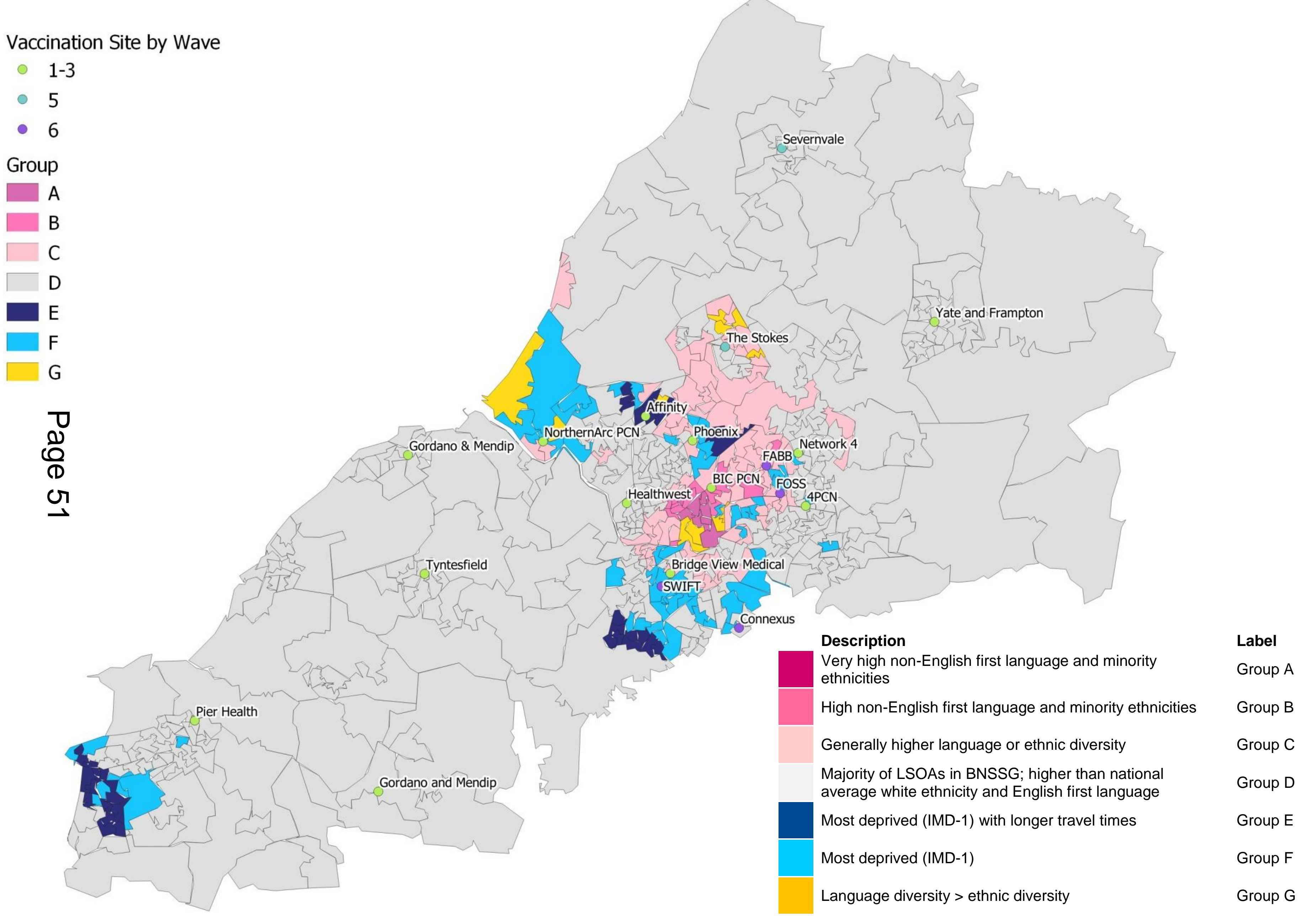
Reaching all our communities

Communications and Engagement activity: Overview

Gathering data and insights	Define Critical areas of focus	Activate across channels
• Bring together system-wide data (flu vaccines, public health datasets) • System-wide engagement (existing data) to understand attitudes issues and concerns • Insights from community partners	• Identify communities of concern • Review and refine as new data and insights become available • Continuously informed by community conversations	 

Vulnerable Groups - Key

Description	Label
Very high non-English first language and minority ethnicities	Group A
High non-English first language and minority ethnicities	Group B
Generally higher language or ethnic diversity	Group C
Majority of LSOAs in BNSSG; higher than national average white ethnicity and English first language	Group D
Most deprived (IMD-1) with longer travel times	Group E
Most deprived (IMD-1)	Group F
Language diversity > ethnic diversity	Group G



Vaccination Site by Wave
1-3
5
6
Group
A
B
C
D
E
F
G
Severnvale
Yate and Frampton
The Stokes
Affinity
NorthernArc PCN
Phoenix
Network 4
FABB
Gordano & Mendip
BIC PCN
FOSS
4PCN
Healthwest
Tyntesfield
Bridge View Medical
SWIFT
Connexus
Pier Health
Gordano and Mendip
Description
Label
Very high non-English first language and minority ethnicities
Group A
High non-English first language and minority ethnicities
Group B
Generally higher language or ethnic diversity
Group C
Majority of LSOAs in BNSSG; higher than national average white ethnicity and English first language
Group D
Most deprived (IMD-1) with longer travel times
Group E
Most deprived (IMD-1)
Group F
Language diversity > ethnic diversity
Group G

Mitigating inequalities - vaccine access

- Risk of lower uptake - groups known to be disproportionately less likely to take up the vaccine, and to be most vulnerable to the virus – planning based on robust modelling
- Work underway to ensuring vulnerable people will have access maximised, both in terms of health inequalities and physical access (eg transport)
- Community leaders as part of the outreach vaccination team
- New community based sites based on pop up roving model
- Comms & engagement strategy & practicalities; languages, tackling misinformation, staff concerns
- So much to do – we we need your help, thoughts and advice…

Governance of mobile delivery group

Clinical Delivery Group

Mobile delivery group

Task and finish group

Group 1	Group 2	Group 3	Group 4	**Group 5**
Homeless	Non English Speaking, BAME, Refugees, Asylum Seekers	Those living a distance from the vaccine centre / in areas of high deprivation / rural communities / Gypsey Roma traveller population	Identified hospital patients, P3 Beds	Those who may struggle to access via a vaccination centre; learning disabilities, severe mental illness, physical disabilities, Drug and Alcohol Addition, people with physical and sensory impairment

Mobile delivery model

- Every eligible person to have parity in access and benefit from the vaccine, no one left behind

Purpose

- Increase awareness and uptake across BNSSG in those groups that have been significantly disproportionally effected by the Covid-19 pandemic.
- JCVI priority groups means unequal access and thus has implications for health inequalities, which presents both opportunities and risks

Approach: Do better…raise the bar

- What is the data surveillance and insight telling us?
- Establish task and finish groups - multi disciplinary stakeholder engagement, key to have representation from those who are embedded within the target communities
- Build on good work already going on/share best practice from other initiatives- good practice in pop up flu clinics

How

- Roll out - accelerated pace
- Quick wins/ short & medium term plans
- Technical support sub group
- Target EMIS searches
- Utilise community strengths and assets
- Offer flexible delivery models utilise localise resources to most in need-more convenient access in a wide variety of settings

Test and learn pilot

- Working with T&F Group 2 (embedded in ICE) mobilising an action plan to set up first pop up site

Challenges

- Managing risks
- Hidden inequalities
- Lack of trust, poor engagement with NHS historically - rebuilding trust through key advocates, religious leaders
- Misinformation-fake news/ counteract myths – understanding peoples concerns, one place for trusted messages?
- Digital and literacy barriers-getting the comms and engagement right
- Role models who look like me - BAME vaccinators/Doctors - male and female support staff
- Logistics of delivery-protocol for delivery in a Mosque? (housebound protocol)
- Viability of sites - safe set up, electricity, fridge's with thermometer, Wi-Fi etc….
- Resources-workforce/ vaccine supply

How are we doing?

Vaccinations Given

110,000
First dose vaccinations to over 70s as of 7 February

90%
of over 70s vaccinated

181,000
First dose vaccinations given

23%
of eligible people in our area received first dose

Care Homes

100%
Offered the vaccination

Covid-19 Vaccination Programme

For More Information

Visit the BNSSG Healthier Together website

Vaccination Sites

- 3 Hospital hubs
- 1 Super vaccination hub
- 19 GP led sites
- 7 Pharmacy teams

Social Media

@HTBNSSG
@BNSSGCCG
@BNSSG_CCG

Next steps

- Vaccinate all those in cohorts 5-6
  - all those 65 years of age and over
  - all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality

- Finalise and operationalise roving model

- Complete a 'lessons learned' exercise capturing feedback and learning from the sites including staff and patient feedback

- Constant review of vaccine uptake data (both population and staff) to refine and adapt our approach

- Engagement ongoing with seldom heard groups and community leaders to ensure equity of access/ take up (e.g. webinars so people can access an expert panel)

Thank you

@htbnssg

www.bnssghealthiertogether.org.uk

Health Scrutiny Committee

25 February 2021

Report of: Director of Public Health

Title: Drug and Alcohol Strategy for Bristol, 2020-24

Ward: All

Officer Presenting Report: Dr Lewis Peake, Public Health Registrar

Recommendation;

For Health Scrutiny to note and provide feedback on the proposed final draft of a new city-wide Drug and Alcohol strategy, which has benefited from an open consultation.

The significant issues in the report are:

Issues relating to drug and alcohol misuse, including drug-related deaths and alcohol-related hospital admissions, continue to be a problem in Bristol.

Bristol City Council is a leading partner in the development of a new city-wide drug and alcohol strategy.

The purpose of the strategy is to align city stakeholders in a common approach to tackling substance misuse issues, through one shared vision, six priority areas, and 20 commitments to inform future action planning.

A draft strategy was made available for public consultation; a final strategy is now presented which reflects the feedback received.

1. Summary

A new, multi-agency drug and alcohol strategy for Bristol started being developed last year, under the auspices of the Keeping Communities Safe Group (of the Keeping Bristol Safe Partnership). The strategy aims to provide an overarching framework for the production of regular action plans. The BCC Public Health team have led on the drafting of the strategy; Avon and Somerset Police, the Office of the Police and Crime Commissioner, and BNSSG CCG are other key partners.

A draft version of the strategy was approved for open consultation, which was held in Dec 20/Jan 21. Precisely 150 complete responses were received, as well as additional feedback from attendees at stakeholder group meetings. Appropriate edits to the strategy have been made, and a final copy is now ready for consideration. The supporting equalities impact assessment has also been updated.

The Keeping Communities Safe Group are to consider this final version at a joint meeting with the Bristol Health and Wellbeing Board in March.

2. Context

2.1 Issues relating to drug and alcohol misuse, including drug-related deaths and alcohol-related hospital admissions, continue to be a problem in Bristol.

- There are an estimated 6,500 alcohol-dependent adults in the city, as well as an estimated 5,000 users of opiates and/or crack cocaine
- Nearly 200 people die a year in Bristol from alcohol related conditions, in addition to an average of over 30 drug-related deaths per year
- There were over 10,500 admissions to hospital in 2018/19 from alcohol-related conditions, and this number is growing

2.2 With the above in mind, Bristol City Council is a leading partner in the development of a new city-wide drug and alcohol strategy. Governance of the strategy falls to the Keeping Bristol Safe Partnership, which delegates this authority to its Keeping Communities Safe group. Avon and Somerset Police, the Office of the Police and Crime Commissioner, and BNSSG CCG join Bristol City Council as co-badges of this strategy.

2.3 The purpose of the strategy is to align city stakeholders in a common approach to tackling substance misuse issues, and seeks to highlight the entire range of impacts that the use of alcohol and other drugs has in Bristol (including with respect to health, the night-time economy, policing, community engagement, culture and stigma).

2.4 Development of the strategy began in late 2019 / early 2020, informed by a substance misuse needs assessment and engagement work with 25 stakeholder organisations across Bristol. The drafting process was affected by the Covid-19 pandemic, but ad-hoc meetings with further stakeholders continued, and a first complete draft was produced in the Autumn of 2020. After input from Scrutiny, and agreement from a joint meeting of the Keeping Communities Safe Group and Bristol's Health and Wellbeing Board, this first draft was made available for public consultation on December 2020 for a period of 6 weeks. This report presents the proposed final draft, shaped by comments received through the public consultation.

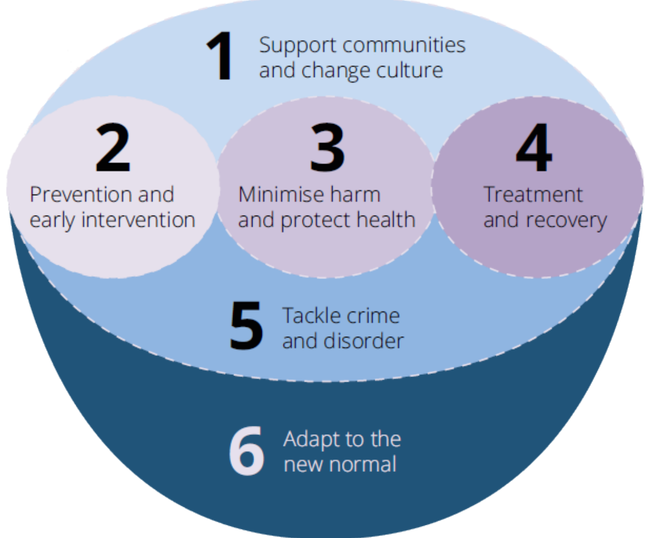
2.5 The strategy presents one agreed vision, six priority areas, and 20 'commitments'. This format will act as a high-level strategic framework for the production of regular action plans, to be generated and

owned by stakeholders across the system (including service users). The practicalities of how this will be achieved, for example through the formation of a new city-wide drug and alcohol board, are yet to be decided.

2.6 The vision of the strategy states that:

> *"Bristol aspires to be a vibrant, inclusive and compassionate city, where prevention is prioritised, and everyone has the right to a healthy life safe from the harms of alcohol and other drugs.*
>
> *Individuals and their families - regardless of starting points - are well-informed and empowered to reach their full potential, access treatment if needed, and reduce harm within their community."*

2.7 The resulting six priorities are outlined below:



2.8 Each priority area describes 3 or 4 broad commitments which will acts as focus points and agenda setting for future action planning. For example, commitment 1.1: *Use planning and design to create public places and spaces which support healthy behaviours and reduce harms*, which points to actions on healthy environments and choice architecture (such as piloting an intervention that licensed venues have at least one alcohol-free beverage on draught). The full list of commitments can be found within the strategy (Appendix 1).

2.9 The importance of tackling health inequalities through the accessibility and cultural competence of services, and removal of stigma, is a recurring theme throughout the strategy.

2.10 The relationship between poor mental health and alcohol and other drug use is another theme that runs throughout this strategy. Mental health conditions can both lead to, and result from, excess consumption of substances. The so called 'dual-diagnosis' of mental health and substance misuse issues can require more complex interventions and specialist support. With that in mind, the strategic commitments include reference to:

- the importance of prevention and early intervention of poor mental health, especially relevant in light of impacts from the Covid-19 pandemic
- the provision of mental health support for people within drug and alcohol treatment services
- the continuity in access to mental health support during the 'recovery' period

3. Policy

This new Drug and Alcohol strategy aligns with commitments made within the Wellbeing section of the corporate strategy (specifically, commitment 1).

The new Drug and Alcohol strategy sets out objectives which seek to address health inequalities relating to substance misuse.

4. Consultation

a) Internal

a.1. BCC People DMT, EDM and CMB
a.2. BCC Finance, Legal, HR, IT and PR have been asked to review, as per decision making pathway
a.3. Closed joint meeting of Health and People Scrutiny in Sept 2020

b) External

b.1. Avon and Somerset Police, the Office of the Police and Crime Commissioner and BNSSG CCG (all of the supporting co-badges of the strategy)
b.2. Engagement events / workshops with representatives from 25 local stakeholders
b.3. 150 responses received through an online public consultation
b.4. Attendance at meeting of various groups and boards, including Bristol@Night, Bristol City Youth Council, Keeping Children Safe Group, etc.

5. Public Sector Equality Duties

5a) Before making a decision, section 149 Equality Act 2010 requires that each decision-maker considers the need to promote equality for persons with the following “protected characteristics”: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Each decision-maker must, therefore, have due regard to the need to:

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

ii) Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it. This involves having due regard, in particular, to the need to --

- remove or minimise disadvantage suffered by persons who share a relevant protected characteristic;

- take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of people who do not share it (in relation to disabled people, this includes, in particular, steps to take account of disabled persons' disabilities);

- encourage persons who share a protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

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

5b)

An equalities impact assessment has been produced, with support from the BCC equalities team. This has been informed by data summarised within the Bristol Substance Misuse Needs Assessment 2019, comments received as part of the open consultation process, and an 'equalities workshop' held with equalities representatives from some stakeholder organisations.

The full equalities impact assessment is included as an appendix to this report. This assessment outlines where changes to the strategy have been made as a result of the findings.

However, it is important to note that the strategy is a high-level framework for the purposes of supporting action planning. An attempt has not been made to consider the precise equalities impacts of individual actions and interventions that may result from this strategy over the next 5 years.

Appendices:

A. Drug and Alcohol Strategy 2020-24 v2.0 (post-consultation)
B. Drug and Alcohol Strategy – EqIA (post-consultation)
C. Drug and Alcohol Strategy – Open consultation report
D. Drug and Alcohol Strategy – Response to the consultation report and changes made

LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985
Background Papers:

Please note - this is a pre-design version of this document

Drug and Alcohol Strategy for Bristol

2020-2024

Everyone has the right to a healthy life, safe from the harms of alcohol and other drugs

[KBSP Logo]

[A+SP Logo] [OPCC Logo] [BNSSG CCG Logo] [BCC Logo]

Acknowledgements

This is a strategy for the city of Bristol. It has been developed and will be delivered in partnership, with oversight from members of the Keeping Communities Safe group (a delivery group of the Keeping Bristol Safe Partnership) and Bristol's Health and Wellbeing Board.

Representatives from organisations across the city came together to oversee the development of this strategy:

Avon and Somerset Police
AWP Mental Health Partnership
BDP
BNSSG CCG
Brisdoc
Bristol City Council (Community Safety)
Bristol City Council (Public Health)
Bristol ROADS Peers
DHI
Goldenkey
Office of the Police and Crime Commissioner
University Hospitals Bristol
UoB/UWE Multiagency drugs group

In addition to the above, we are grateful to the following stakeholders who helped to shape this strategy, through attendance at engagement events, workshops, and meetings:

Addiction Recovery Agency
Bristol City Centre BID
Bristol City Council (Communities)
Bristol City Council (Housing)
Bristol City Council (Licensing)
Bristol City Council (Targeted Youth Services)
Bristol City Council (Youth Offending Team)
Bristol City Youth Council
Bristol Students Union
Bristol@Night
Hawkspring
Bristol's Keeping Children Safe Board
Key 2 Futures
Live West
Missing Link
One 25
Public Health England South West
Salvation Army
South Gloucestershire Council (Public Health)
St Mungo's
Street Space
The Junction
Transform
University of Bristol
University of the West of England
Youth Moves

Finally, thank you to everyone in Bristol who provided input into the final version of this strategy by responding to the open consultation.

DRAFT

Foreword

The impact of drug and alcohol use is felt by all of us in this city, whether directly or indirectly.

Close to 200 people died in Bristol in 2018 from a condition related to alcohol, and between 2016 and 2018 there were 95 deaths in the city from the use of drugs. This is, of course, just the tip of the iceberg. Drug and alcohol use has an impact on families and communities, as well as being a key contributor to both crime and long-term illness.

These are not straightforward issues. There is mounting evidence pointing to the harm caused by alcohol, and yet consumption of alcohol is legal and plays an important part in our city's economy, as well as in the social lives of many.

The Covid-19 pandemic has increased the stressors that can lead to increased drinking and drug taking for some, whilst also putting pressure on the night time economy, as our bars, pubs and clubs struggle to survive. We will endeavour to work with the sector, not against it, to build in better practices as our city's venues re-open.

We will also seek to support those we've been able to engage with through the homelessness accommodation scheme, representing some of the most vulnerable people in our city, to use substances more safely or to stop using altogether.

And so, recognising how 2020 has altered the context in which we find ourselves, this strategy lays out how we will achieve our vision of a vibrant, inclusive and compassionate city, where prevention is prioritised, and everyone has the right to a healthy life safe from the harms of alcohol and other drugs.

We remain committed to the principles of prevention and early intervention, and to focusing on hope and recovery.

We will seek to create healthy places, for example through exploring alcohol free zones, and consider whether they have the potential to help redefine the relationship the city has with alcohol.

Where people do continue to use drugs or alcohol, we will use the best available evidence to reduce harm and provide appropriate support, recognising the importance of working with families and wider communities to ensure the services we provide are more than just a sticking plaster.

When events and festivals return to our city, we intend to continue the work we pioneered in 2018, as the first UK city to facilitate on-site drug testing services.

We will strengthen connections with the full diversity of our city as we seek to reduce health inequalities and improve access to services.

Finally, and perhaps most importantly, we will continue to work with partners in health, the criminal justice system, the voluntary sector and business to improve the health of our city for everyone, recognising that these are not problems we can solve in isolation.

Cllr Asher Craig, Deputy Mayor for Bristol
(Communities, Equalities & Public Health)

DRAFT

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DRAFT

Our vision

This strategy's vision was developed through engagement events with a number of stakeholders and interested parties across the city. It is deliberately aspirational, and aligns with visions set out within the city's other key strategies, such as in the *One City Plan*.

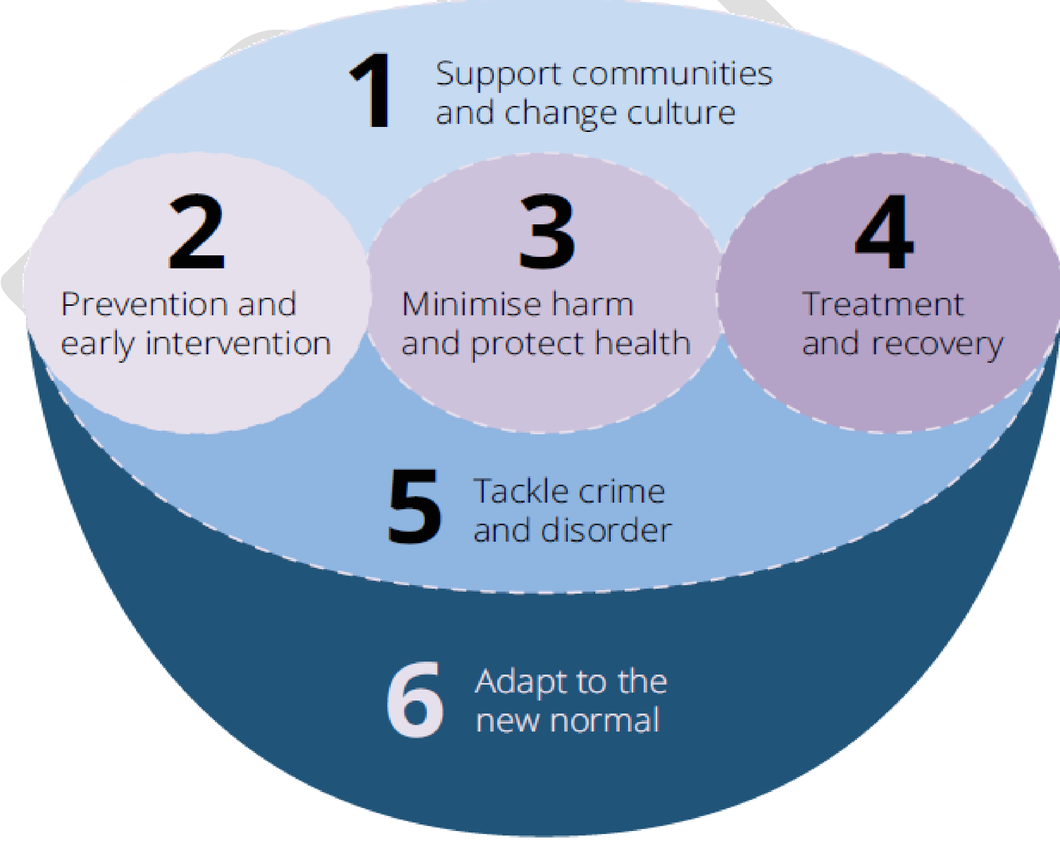
We have also set out six priority areas to deliver on this vision. These are based on local need and align with the strategic priorities of the national *UK Drug Strategy 2017*. Priority 1 reflects the ambitions of the *One City Plan* and *Healthier Together* to strengthen communities and advocate partnership working at a locality level, and priority 6 seeks to address challenges highlighted by the Covid-19 pandemic.

Vision

Bristol aspires to be a vibrant, inclusive and compassionate city, where prevention is prioritised, and everyone has the right to a healthy life safe from the harms of alcohol and other drugs.

Individuals and their families - regardless of starting points - are well-informed and empowered to reach their full potential, access treatment if needed, and reduce harm within their community.

Priorities



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The impacts of alcohol and other drugs

Bristol is a welcoming, multi-cultural, and lively place to work and live. Our city's communities are active, supportive, and tolerant, but the use of alcohol and other drugs remains a significant problem. This strategy outlines our approach to tackling this issue, and our commitment to creating the conditions which promote health and reduce stigmatisation around the use of alcohol and other drugs, so that people are aware of the potential harms and feel able to seek help.

We know that many individuals in Bristol routinely consume alcohol and other drugs in quantities they enjoy, and may perceive to be harmless. However, the potential health impacts from these choices are an issue of public health concern which disproportionally affect the most vulnerable people in our city.

Alcohol is known to cause liver disease, a range of cancers, a variety of cardiovascular diseases, and is damaging to reproductive health. Any amount of alcohol has the potential to cause harm [1]; there is no safe level. Other drugs - including cannabis, cocaine and heroin - are also known to cause significant diseases of the liver, lung and cardiovascular system, as well as mental health issues and outbreaks of blood-borne viruses.

Harms are not just limited to personal health; the impact on families, communities, the economy, and public services is vast. However, alcohol consumption is also a part of the city economy. Pubs and other licensed premises act as employers and community hubs for many of our residents. Partnership working across the city is vital if we are to balance these benefits against increasing evidence of harm.

Lifelong harms

> "*…highly stressful, and potentially traumatic, events or situations that occur during pregnancy, childhood and/or adolescence and can have an impact on physical and mental health throughout life*"
> - A definition of Adverse Childhood Experiences [2].

A child exposed to harmful behaviours, such as violence, abuse or neglect caused by adult drug use, may experience lifelong personal impacts, including through development of their own substance misuse issues. Many adults in substance misuse treatment services report a history of being exposed to these adverse childhood experiences.

Protecting children from harm by working with parents and families, and adopting a trauma-informed approach when working with adults, will help to break this inter-generational cycle and deliver improved support to individuals, families and communities

DRAFT

The use of alcohol and other drugs in Bristol

The below data summarises the scale of drug and alcohol issues in Bristol. These challenges are not unique to us; many other UK cities are seeing similar trends, at a time when Local Authority public health funding has fallen. We must work collaboratively in Bristol, and across the Bristol, North Somerset and South Gloucestershire geography where appropriate, to address this difficult and complex issue.

There are an estimated 6,500 alcohol-dependant adult drinkers in Bristol [3].

During the year 2018/19, Bristol had 10,773 admissions to hospital for alcohol related conditions, equivalent to a rate of nearly 3,000 admissions per 100,000 people [4]. This was the highest rate in the South West, and higher than the England average of 2,367 admissions per 100,000 people.

There are an estimated 5000 users of opiates and crack cocaine in our city [5]. This is equal to a rate almost double the national average.

Deaths from alcohol and other drugs in Bristol are increasing. Nearly 200 people in Bristol die each year from an alcohol related condition [6]; over the three-year period covering 2017 and 2019, there were 99 drug related deaths [7].

A quarter of Bristol's 14-15 year old's consumed alcohol, when asked, over the previous month [8]. The rate of under-18's being admitted to hospital because of alcohol in Bristol has been above the national average since 2017 [9].

29% of year 10 pupils say they have been offered cannabis, and 15% report trying cannabis at least once [8].

DRAFT

Treatment and support services in Bristol

More than 3000 adults received treatment for substance misuse issues in 2018/19 through our commissioned drug and alcohol services [10]. Bristol ROADS (recovery orientated alcohol and drug service) is commissioned by Bristol City Council, and offers a single point of contact for a range of medical and psychological treatment and support options, delivered through a consortium of specialist organisations. There is also a targeted provision for individuals from underserved populations with complex needs.

Over 40 GP practices from across the city work in collaboration with ROADS to provide local access to opiate substitution therapy, and support for alcohol dependent patients. Registered Bristol pharmacies dispense these substitution therapies, and provide supervision of administration where required.

For young people in Bristol, information and support on the use of alcohol and other drugs is provided by one of the ROADS' specialist providers, delivered jointly with Bristol's Creative Youth Network (which is part of the Council's Targeted Youth Support).

In addition to the commissioned services, a range of voluntary and community sector organisations provide additional physical, emotional or social support to individuals affected by alcohol and other drugs. Examples of these organisations include Addiction Recovery Agency, Hawkspring, Key 2 Futures, Live West, One 25, Salvation Army, St Mungo's Homeless Charity, The Junction Project, and Youth Moves; as well as a range of organisations supporting 12-step recovery approaches.

Health inequalities and cultural competence

A running theme throughout this strategy is to consider actions which will reduce inequalities in health outcomes that result from the use of alcohol and other drugs.

To do this, our approach to prevention, treatment and wider support will need to be culturally competent. This is where organisations and professionals have awareness of different faiths and cultures, are free from stereotyping and stigma, and deliver services which are adaptable to meet cultural needs.

This awareness, understanding and adaptability should be as applicable to people with different cultures and faiths as it is to people with different ethnicities, sexuality, gender, disabilities, and all protected characteristics (such as pregnancy). Overlap, or 'intersectionality', of these characteristics can compound inequalities.

The visibility and accessibility of services within communities is vital to this ambition. The services we commission should be funded with these ambitions in mind, and monitored to ensure equality of access.

Substance misuse, mental health, and physical health

The relationship between poor mental health and alcohol and other drug use is another theme that runs throughout this strategy. Mental health conditions can both lead to, and result from, excess consumption of substances. This requires better understanding at all levels of interventions and including specialist support.

The use of alcohol and other drugs has important implications for physical health services also, including in relation to A+E attendances.

The local clinical commissioning group is responsible for mental and physical health services in Bristol. Crucially, improvements in outcomes from alcohol and other drugs require culturally competent services that: prevent mental health conditions within communities; provide for individuals in drug and alcohol treatment; and offer ongoing support for the health needs of people in 'recovery'.

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Priority 1: Support communities and change culture

The first priority of this strategy is to create the conditions which will support healthy behaviours and reduce harms, through a focus on the planning and design of public spaces; the fostering of cohesive, inclusive and resilient communities; and on the provision of services locally available to all.

Place-based

To see true improvement in the health of our population, we must address at a city-level the societal drivers behind the use of alcohol and other drugs. Interventions targeting places rather than individuals, for example a requirement that all licensed premises offer at least one alcohol-free drink on draught, could alter or 'nudge' individuals towards healthier behaviours [11] [12]. Alcohol-free spaces - streets, or parks where alcohol is prohibited - is a further intervention which should form the basis of a city-wide conversation on drinking that would help to redefine the city's relationship to alcohol, and instead promote a culture of safety and family-focused entertainment.

Communities

Through this strategy's life cycle, we will work to understand and be responsive to the self-identified needs, concerns and aspirations of our diverse communities with respect to alcohol and other drugs. These 'communities' could be defined by geography, protected characteristic, or even workplace.

Stigma, which can prevent individuals from seeking the help they need, or impact on how much someone in treatment engages with the support offered, is a vital issue to understand and tackle through this future work. The Communities team within Bristol City Council, and our networks of community and voluntary organisations, will be key partners in exploring, and responding to these needs through co-design methods.

Locally available services

Local healthcare is increasingly being designed, commissioned and delivered through three localities in Bristol (Inner City and East; North and West; and South). At this geographical level, services are more accessible, and can better reflect the needs of the local population. Proposals from Healthier Together are looking to strengthen this approach, through consideration of 'locality hubs'.

Our existing drugs and alcohol services benefit from 3 referral units for engagement and assessment, which map to the above locality areas. ROADS works in collaboration with 42 GP practices and multiple pharmacies across Bristol, to provide treatment access in the heart of our communities. We intend to increase the range of support and treatment options delivered locally, and develop pathways that integrate with the proposed Healthier Together locality hubs.

We will…

1.1 Use planning and design to create public places and spaces which support healthy behaviours and reduce harms.

1.2 Tackle inequalities and stigma by anchoring support within our communities which is responsive to the local population need, and prioritising prevention interventions which utilise place-based approaches.

1.3 Streamline our services and ensure collaboration across ROADS, the voluntary sector, specialist care providers, and the NHS, to make support more accessible, efficient, joined-up, and localized.

DRAFT

Priority 2: Prevention and early intervention

Behaviours with the potential to cause harm, such as the use of alcohol and other drugs, are easier to address where those behaviours haven't become routine for an individual, or 'normal' within a community. Preventing those choices in the first place, by working with teenagers, schools, and at-risk communities must be a key priority, alongside education and health messaging throughout the life course.

What's more, early engagement with individuals exhibiting such behaviours is vital to halt a potential lifetime of alcohol and other drug use that will impact on health. For young people in Bristol, we must provide the right supportive and educational environment which limits the harmful use of substances. Local research suggests a focus on alcohol, cannabis, amphetamines and cocaine would be of greatest benefit as these have the highest lifetime prevalence [13].

This means universal access to educational interventions that inform and empower young people to make healthy life choices, as well as additional, accessible support and life skill development for those who may be at increased risk of alcohol and other drug use (such as those who have been exposed to Adverse Childhood Experiences, or had involvement with youth offending) which is delivered in a non-stigmatising way.

New national guidance on health education in schools came into effect in 2020 [13]. This new curriculum reinforces the importance of drug and alcohol education, including the relevance to mental health and criminal exploitation. The recently revised Bristol Healthy Schools Award Scheme will be promoted amongst schools as a way to demonstrate their achievements in supporting substance misuse awareness and prevention.

Colleges and Universities remain a key stakeholder in spreading awareness of drug and alcohol issues. University campuses are just one place in our city where prevention interventions must be targeted. The Bristol Universities already host a multi-agency drugs group, and the University of Bristol recently established a drug safety-testing programme for students. Opportunities for wider population access to such facilities will be considered, alongside education that informs of the dangers of 'party drugs' and 'chemsex'.

The early identification of individuals engaging in the misuse of alcohol and other drugs, and the provision of brief advice, is known to be important to the improvement of health outcomes. We will do more to reinforce these skills in our healthcare workforce, and build capacity in our communities and voluntary organisations to identify those at risk and ensure appropriate signposting to support.

Finally, the earlier diagnosis of physical manifestations of alcohol misuse, in the community, is vital to reduce the burden of hospital admissions secondary to drinking.

We will…

2.1 Reduce the appeal, affordability and availability of alcohol and other drugs within communities in Bristol, and detect health impacts from these behaviours earlier.

2.2 Educate children, their parents, and young adults on the risks from the use of alcohol and other drugs, such as cannabis; support them to make healthy choices, including through changes to the environment, such as parks, where alcohol and other drugs are used; and increase awareness that any level of alcohol consumption is potentially harmful.

2.3 Strengthen skills and understanding amongst health workers on the concepts of

‘adverse childhood experiences’, ‘trauma informed practice’ and ‘identification & brief advice’, increasing support to families	affected by substance misuse and breaking inter-generational cycles.

Priority 3: Minimise harm and protect health

Identifying people with established use of alcohol and other drugs, and providing them with support to change their behaviours and mitigate against the known health risks, is crucial to lower the burden of ill health and reduce inequalities in Bristol.

For alcohol, optimising heart health, mental health, and diet, can all reduce the consequences of drinking. For other drugs, such as opiates taken intravenously, there are multiple measures that should be taken to lower the chance of associated harms; rates of blood-borne viruses can be reduced by needle exchange programmes and opioid agonist treatment, and the potentially fatal effects of accidental overdose can be targeted through widespread use of Naloxone.

Bristol has committed to giving due consideration to additional harm reduction measures, such as safe injecting rooms (drug consumption rooms). These installations, not currently legal in the UK, are used in a number of countries with the aim of limiting risky injecting practices and deaths from overdose. As a system, we will be led by the best available evidence on issues such as these, and within the current legal framework will take assertive action to advocate for measures that will protect our population. We will collaborate with other cities nationally and internationally, to build mutual understanding.

Everyone engaged in the harmful use of alcohol or other drugs has their own story; each person is in a different place in their journey, and desired outcomes are individual and unique. A harm reduction approach must accommodate this diversity of experience, and protect not only the person themselves, but their families and communities.

We have an opportunity to better utilise data from across the system - consumption, licensing, police, community safety and healthcare services - to better understand where resources should be focused to best minimise harm and protect health.

Alcohol and drug related deaths have been increasing year-on-year in Bristol [6] [7]. This strategy sets out our commitment to reverse this trend. We will consider our current local mechanisms of learning from individual drug-related deaths, and look to re-commission new expertise to identify what lessons can be taken from any death in an individual with complex needs. As highlighted throughout this strategy, the joint management of both substance misuse issues, and mental health conditions, has a key part to play in protecting health.

We will…

3.1 Reduce the number of deaths in Bristol which are associated with the use of alcohol or other drugs.

3.2 Improve the use and availability of data and public health intelligence in a number of areas, including ROADS performance, and to inform alcohol licensing decisions.

3.3 Strengthen existing initiatives that mitigate against the risk from injecting drug use, and consider the evidence base behind new harm reduction measures such as drug consumption rooms.

3.4 Address the wider health implications that arise from the use of alcohol and other drugs - such as chronic liver disease, bacterial infections, and impacts on cardiovascular and respiratory health - so as to reduce hospital admissions.

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Priority 4: Treatment and recovery

The use of alcohol and other drugs has been a prevailing challenge for large cities throughout the UK for many years. During this time, local systems have considered whether the priority of services should be on minimising harm and retaining individuals in treatment, or on successful treatment 'completion' and 'recovery'.

This strategy reaffirms Bristol's commitment to hope, aspiration and recovery for all. We will support service users in treatment for the period required, without arbitrary limits, recognising that true 'recovery' relies on holistic support in areas such as housing, employment, mental health, and adult education.

The existing national performance metrics for drug and alcohol services often do not demonstrate the full positive impact of a service, and do not capture the perception of stigma through a treatment journey; we will consider how this important information can be better gathered.

We will ensure that those new to treatment can aspire to health, and that they (and their families) can meet and be supported by people with lived experience. For people that do 'complete' treatment, opportunities for ongoing support to maintain their recovery (for example through skill development in the peer mentor scheme, and provision of mental health and parental/family support) will be strengthened during this strategy's life cycle.

The concept of 'relapse' will not be stigmatising within our system, and planned for. Relapse will be seen as part of the cycle of personal recovery.

The existing treatment and support options for individuals who use alcohol and other drugs in Bristol are broad, ranging from less formal peer-led group support, to intensive rehabilitation within a residential facility. All of these interventions must be provided in a way that is sensitive to issues of culture, accessibility, and wider (often complex) needs. Services offered in Bristol will continue to be shaped by those with lived experience, and reflect the needs of both those new to the service, and those within the ageing cohort of opiate users. Referral pathways will be flexible and culturally appropriate to meet those traditionally underserved (for example those with protected characteristics, such as a learning disability or autism) or at-risk (for example victims of domestic abuse).

Consideration will continue to be paid to interventions where evidence is developing, such as Heroin Assisted Treatment rooms.

The aspiration for the next 5 years is to see an increase in the number of people being identified and engaging with treatment, which is provided in the communities where it is needed most. Greater visibility of support options, and the positive experiences of service users, will help to de-stigmatise services and promote engagement.

We will…

4.1 Increase the proportion of service users who remain in 'recovery' by providing opportunities for ongoing personal development, and support around mental health issues.

4.2 Increase the number of people in Bristol engaging with support for their drug and alcohol behaviours, who are retained in treatment, and who leave the ROADS service with a successful treatment outcome.

4.3 Provide holistic, person-centred treatment and support that addresses any needs in relation to housing, unemployment, child safeguarding, mental health etc.

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Priority 5: Tackle crime and disorder

This strategy emphasizes Bristol's commitment to view the low-level personal use of illicit substances as a social - rather than criminal justice - issue, while at the same time taking a relentless and systematic approach to the reduction of alcohol and drug related criminal activity, including driving offences. This includes multi-agency working to restrict the supply of drugs within our city.

The use of alcohol and other drugs is a significant factor in violence, sexual violence, intimidation, and anti-social behaviour. It is estimated that 45% of all acquisitive crime in England is related to heroine and crack cocaine use [14]. The tackling of drug related serious organised crime, including the exploitation of minors in the distribution of drugs, is a local and national priority.

Through Bristol's Safer Options Team, young people identified as being at risk of substance-related crime are provided with support that diverts them away from criminal activity. Additionally, our city's Youth Offending Team engages with individuals after their first arrest for crimes such as drug possession. The future of these vital services must be secured, and specialist drug and alcohol support to this service will be strengthened.

Similarly, for adults a number of schemes currently exist aimed at first time offenders for drug possession (drug education programme) and drug dealing (the Call-in programme, delivered by Goldenkey), as well as for repeat offenders of drug-related crimes (Integrated Offender Management). The future of all of these schemes will depend on their ongoing evaluation, and identification of funding throughout the years covered by this strategy.

Currently in Bristol, any individual found to be in possession of a drug for personal use is offered attendance on a drug education programme as an alternative to conviction, provided they have not attended it before. This is a non-sanction disposal option that avoids criminalising a person found in possession of drugs for personal use. This reinforces our consideration of low-level personal drug use as a health issue, and ensures individuals receive professional support for substance misuse.

The use of alcohol and drug community treatment orders as part of sentencing, and closer integration between the ROADS treatment service and Integrated Offender Management, are both areas with the potential to deliver an enhanced offer of specialist substance misuse support.

We will…

5.1 Reduce the negative consequences to local communities that result from the use of alcohol and other drugs, such as anti-social behaviour and sexual violence, and build confidence within communities to report concerns.

5.2 Strengthen initiatives that underline the criminal justice system response to substance misuse as a health issue, ensuring that all perpetrators of crime secondary to drug or alcohol use are referred to treatment services, and that there is a seamless transition of support between prisons and the community.

5.3 Adopt a multi-agency, partnership approach towards intelligence sharing and development of interventions which: disrupts the supply of drugs in Bristol through place management approaches; targets the cohort of repeat offenders of less serious drug and alcohol related crimes; and eliminates the exploitation of children and vulnerable people in serious organised crime.

Priority 6: Adapt to the new normal

The Covid-19 pandemic has highlighted the importance of drug and alcohol services which are resilient and reactive to emerging needs. Intermittent lockdown precautions will challenge the workforce and volunteers; the mental health impacts of the pandemic may manifest as increasing use of alcohol and other drugs; and the night-time economy, looking to bounce back from months of lost earnings, may increasingly depend on alcohol sales.

National data suggests that 1 in 5 people consumed alcohol during lockdown as a way to manage stress or anxiety, and more than 1 in 4 people increased their alcohol intake since the start of the pandemic [15]. Local research [17] highlighted issues including access to needle and syringe programmes during lockdown, and an exacerbation of mental health issues which affected drug use. This priority area demonstrates our commitment to learn lessons from the Covid-19 pandemic, and ensure responsiveness for future times of challenge.

Importantly, the pandemic has reinforced a need to strengthen engagement with, and support for, individuals with complex needs. As the likely exacerbation of health inequalities resulting from this pandemic emerge, this strategy's action plans will outline how our underserved and at-risk populations will be prioritised and inequalities addressed.

The housing of all of Bristol's street homeless during the Covid-19 pandemic, enabled us to better address the health needs of this vulnerable group of people. The city's newly re-established Homeless Health Forum will contribute to ongoing work to support this population.

At a time when the night-time economy - impacted greatly by lockdown precautions - looks to adapt and reinvigorate, we must think about how public health considerations can be given a focus; for example, the promotion of low-alcohol and alcohol-free drink options, especially relevant in this time of social distancing. Support can be made available to businesses in this sector, including education for staff on the misuse of alcohol and other drugs (including emerging substances such as 'party drugs'), as well as its relationship to sexual violence. The regulatory responsibilities of licensed premises and delivery services, including local shops and kiosks, should be closely monitored.

In numerous ways, Covid-19 will have ongoing impacts on drug and alcohol use, and therefore on services. The drive towards digital services risks widening inequalities, for example amongst the ageing cohort who use substances. Although not written to address these issues, this strategy will need to adapt to this 'new normal'.

We will…

6.1 Support the re-invigoration and re-design of the night-time economy, and other social events such as festivals, through consideration of alcohol-free spaces and other public health principles

6.2 Re-define, and strengthen resilience in, the multi-agency city-wide approach to addressing harmful use of alcohol and other drugs amongst at-risk groups and those with complex needs, such as the homeless.

6.3 Consider new approaches to commissioning of services to mitigate against the impact of funding challenges.

6.4 Strengthen support for emotional and mental health conditions in Bristol, reflecting

the impacts of the Covid-19 pandemic on unemployment, social isolation etc., and the	effects on drug and alcohol behaviours.

Delivering this strategy and monitoring the impact

As Bristol's *One City Plan* makes clear, public, private and third sector organisations all have a role to play in improving the health and wellbeing of Bristol residents. This strategy sets out our city-wide vision for drug and alcohol services, and the priorities we will be focusing on.

The strategy will be supported by action plans that will underpin the delivery of the priority areas and associated commitments (Appendix A).

Oversight of the strategy will be provided jointly by the multiagency *Keeping Communities Safe Delivery Group* (of the *Keeping Bristol Safe Partnership*), and by the Bristol Health and Wellbeing Board. Bristol City Council, Bristol North Somerset and South Gloucestershire Clinical Commissioning Group, and Avon and Somerset Police are all statutory members of these partnerships.

A new city-wide drug and alcohol board, reporting to the *Keeping Communities Safe Delivery Group*, will be responsible for ensuring the delivery of the strategy action plan. Key stakeholders involved in housing, children and young person health, road safety, police and probation services, and substance misuse service users will be represented in this process.

A local outcomes framework, based on the priorities and commitments outlined in this strategy, will be developed to monitor its impact. This will draw on the range of existing national and local outcomes measures and service-level metrics. In addition, the experience of people in treatment, their families, and the public will be essential to understand the effectiveness of the strategy and ensure the continuous improvement of services.

National and local outcome measures and service metrics which will be considered for the monitoring of this strategy:

Public Health Outcomes Framework (PHOF**)**

A nationally defined set of metrics for the monitoring of public health. The following have relevance to drug and alcohol services:

C19a - Successful completion of drug treatment (opiate users)
C19b - Successful completion of drug treatment (non-opiate users)
C19c - Successful completion of alcohol treatment
C19d - Deaths from drug misuse
C20 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison
C21 - Admission episodes for alcohol-related conditions (Narrow)

Bristol's Health and Wellbeing Board Strategy

The H+WB board strategy highlights the following metrics:

Number of dependent drinkers
Number of opiate/crack users
Number of drug related deaths per year
Number of alcohol related hospital admissions

National Drug Treatment Monitoring System

Drug and alcohol services report data on all individuals they are providing treatment to. This data produces numerous metrics to allow for local comparisons and trend monitoring.

ROADS Key Performance Indicators

The three main commissioned providers of ROADS services have agreed a core list of key performance indicators which reflect the service area they deliver on.

Targeted Youth Support Performance Indicators

As for ROADS, the Early Years Intervention Service has performance metrics for services delivered to under-18's through its targeted youth support.

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Research and evaluation to inform evidence and best practice

The development of this strategy has identified the need for new areas of research into substance misuse prevention and treatment. Fortunately, Bristol benefits from excellent opportunities for collaborative academic work; partners from the city's academic institutions are already working on projects that will build understanding across this strategy's life cycle.

Further work is needed to build this agenda, and research priorities must be informed by service users and people affected by drugs and alcohol. Examples of potential projects include:

- Strengthening public health audit of drug related deaths, through local intelligence and data sharing processes, to identify missed opportunities for prevention
- Developing and testing initiatives to manage physical complications of drug use, such as skin and soft tissue infections
- Evaluating impacts of interventions which aim to increase the safety of drug-users and non-users in night-time venues
- Piloting of choice architecture interventions, such as alcohol-free options on draught in licensed venues
- Improving monitoring and understanding of substance use amongst young people
- The design of information packs to support education in primary care settings on alcohol harms amongst regular drinkers who are not dependent

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How this strategy fits with other policies

National policies and strategies

HM Government's recent *UK Drug Strategy (2017)* has the **overall aim to reduce illicit and other harmful drug use, and increase the rate of individuals recovering from their dependence**. This aim is delivered through measures focused on the priorities of: Reducing Demand, Restricting Supply, Building Recovery, and Global Action. There is considerable scope to act locally on these priorities, and this ambition is reflected in this strategy.

HM Government's latest *UK Alcohol Strategy (2012)* is less up to date, but has a number of objectives which are important at a local level, such as a reduction in alcohol-related deaths, and a reduction in the numbers of 11-15 year olds drinking alcohol. It also calls for a change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others. This Bristol strategy pushes this ambition for people to be aware of the risk from harm from any level of alcohol use.

Bristol's policies and strategies

Bristol's ***Health and Wellbeing Strategy 2020-2025*** identifies substance use as a priority area; this drug and alcohol strategy is included in its forward plan. Partnership working, both through the *One City approach* and *Healthier Together*, is highlighted as a vital means to 'grow positive health', 'prevent disease occurring', 'protect from harms to health', and 'reduce inequalities in health'. Key indicators that the Health and Wellbeing Board are prioritising for the city include, amongst others, the number of dependent drinkers, and the number of drug related deaths; all of these indicators are reflected within this strategy.

Healthier Together is the local health and care system partnership, which includes Bristol City Council. Key partners in *Healthier Together*, such as our local Clinical Commissioning Group, and our acute hospitals, have been involved in the development of this strategy. The Strategy contributes to *Healthier Together's* ambitions to provide more care within communities, in a joined-up way.

Bristol's ***One City*** approach is an ambitious, long term vision to align the work of public, private, and third sector partners in Bristol towards improvements in six priority themes; of which health and wellbeing is one. The *One City Plan* sets out three decades of milestones which build towards the objective that, by 2050, everyone in Bristol will have the opportunity to live a life in which they are mentally and physically healthy. Many of these milestones and targets rely on addressing harms from alcohol and other drugs, such as those focusing on adverse childhood experiences, reducing crime, anti-social behaviour, and creating safe communities.

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Appendix A: Priorities and commitments

This drug and alcohol strategy will act as a framework for the development of annual action plans which address the priority areas identified. Three key actions will be targeted for each priority area, per year.

Support communities and change culture
1.1 Use planning and design to create public places and spaces which support healthy behaviours and reduce harms. 1.2 Tackle inequalities and stigma by anchoring support within our communities which is responsive to the local population need, and prioritising prevention interventions which utilise place-based approaches. 1.3 Streamline our services and ensure collaboration across ROADS, the voluntary sector, specialist care providers, and the NHS, to make support more accessible, efficient, joined-up, and localized.

Prevention and early intervention
2.1 Reduce the appeal, affordability and availability of alcohol and other drugs within communities in Bristol, and detect health impacts from these behaviours earlier. 2.2 Educate children, their parents, and young adults on the risks from the use of alcohol and other drugs, such as cannabis; support them to make healthy choices, including through changes to the environment and contexts where alcohol and other drugs are used; and increase awareness that any level of alcohol consumption is potentially harmful. 2.3 Strengthen skills and understanding amongst health workers on the concepts of 'adverse childhood experiences', 'trauma informed practice' and 'identification & brief advice', increasing support to families affected by substance misuse and breaking inter-generational cycles.

Minimise harm and protect health
3.1 Reduce the number of deaths in Bristol which are associated with the use of alcohol or other drugs. 3.2 Improve the use and availability of data and public health intelligence in a number of areas, including ROADS performance, and to inform alcohol licensing decisions. 3.3 Strengthen existing initiatives that mitigate against the risk from injecting drug use, and consider the evidence base behind new harm reduction measures such as drug consumption rooms. 3.4 Address the wider health implications that arise from the use of alcohol and other drugs - such as chronic liver disease, bacterial infections, and impacts on cardiovascular and respiratory health - so as to reduce hospital admissions.

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Treatment and recovery
4.1 Increase the proportion of service users who remain in 'recovery' by providing opportunities for ongoing personal development, such as through strengthening of the peer-mentor scheme, and support around mental health issues. 4.2 Increase the number of people in Bristol engaging with support for their drug and alcohol behaviours, who are retained in treatment, and who leave the ROADS service with a successful treatment outcome. 4.3 Provide holistic, person-centred treatment and support that addresses any needs in relation to housing, unemployment, child safeguarding, mental health etc.

Tackle crime and disorder
5.1 Reduce the negative consequences to local communities that result from the use of alcohol and other drugs, such as anti-social behaviour and sexual violence, and build confidence within communities to report concerns. 5.2 Strengthen initiatives that underline the criminal justice system response to substance misuse as a health issue, ensuring that all perpetrators of crime secondary to drug or alcohol use are referred to treatment services, and that there is a seamless transition of support between prisons and the community. 5.3 Adopt a multi-agency, partnership approach towards intelligence sharing and development of interventions which: disrupts the supply of drugs in Bristol through place management approaches; targets the cohort of repeat offenders of less serious drug and alcohol related crimes; and eliminates the exploitation of children and vulnerable people in serious organised crime.

Adapt to the new normal
6.1 Support the re-invigoration and re-design of the night-time economy, and other social events such as festivals, through consideration of alcohol-free spaces and other public health principles 6.2 Re-define, and strengthen resilience in, the multi-agency city-wide approach to addressing harmful use of alcohol and other drugs amongst at-risk groups and those with complex needs, such as the homeless. 6.3 Consider new approaches to commissioning of services to mitigate against the impact of funding challenges. 6.4 Strengthen support for emotional and mental health conditions in Bristol, reflecting the impacts of the Covid-19 pandemic on unemployment, social isolation etc., and the effects on drug and alcohol behaviours.

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Bristol City Council Equality Impact Assessment Form

Name of proposal	Bristol's Drug and Alcohol Strategy, 2020-2024 (city-wide)
Directorate and Service Area	Public Health, People
Name of Lead Officer	Lewis Peake (Public Health Registrar) Leonie Roberts (Public Health Consultant)

Step 1: What is the proposal?

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

1.1 What is the proposal?

The use of alcohol and other drugs is an important issue, both in Bristol and nationally. A new, multi-organisation strategy has been drafted; this draft sets out:
 	
- **A vision**, to describe the city's future relationship to drugs and alcohol:
    o *Bristol aspires to be a vibrant, inclusive and compassionate city, where prevention is prioritised, and everyone has the right to a healthy life safe from the harms of alcohol and other drugs.*
 	
    Individuals and their families - regardless of starting points - are well-informed and empowered to reach their full potential, access treatment if needed, and reduce harm within their community.
 	
- **6 priority areas**, with associated 'commitments', for where multi-agency partners will focus their efforts in coming years:
    o Support communities and change culture
    o Prevention and early intervention
    o Minimise harm and protect health
    o Treatment and recovery
    o Tackle crime and disorder
    o Adapt to the new normal
 	
The specific purpose of the new city-wide strategy will be to co-ordinate efforts across Bristol to improve drug and alcohol outcomes for our population. The strategy vision, priority areas and commitments, will act as a strategic framework for the development of action plans.
 	
The draft strategy considers broader issues than just commissioned treatment services; there is consideration of healthcare provision, prevention initiatives, the criminal justice implications of drug and alcohol use, community safety, the night-time economy, and a

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range of inter-dependencies (homelessness, mental health, etc.). The draft strategy (and this draft equalities impact assessment) has been informed by a Substance Misuse Needs Assessment which was completed in late 2019, and has considered academic evidence where it has been available.

This new draft strategy has been developed under the auspices of the Keeping Communities Safe Group (of the Keeping Bristol Safe Partnership). Multiple agencies have already fed into the development of the draft strategy, including: BCC Public Health, BNSSG CCG, Avon and Somerset Police, the Office of the Police and Crime Commissioner, drug and alcohol service providers, academics and University representatives, clinicians, and previous service users.

The draft strategy was made available for public consultation, alongside a draft version of the equality impact assessment. A consultation report has been produced, and feedback to both documents has been considered in the production of the final drafts.

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?

A recently produced Substance Misuse Needs Assessment for Bristol has given us a good understanding on who is most impacted by issues related to substance misuse. This assessment summarised data on drug and alcohol health needs in Bristol, and how these vary by protected characteristic (where data was available). The full needs assessment has not been published, due to its inclusion of some data not yet in the public domain. Relevant data is highlighted below, where available, broken down by protected characteristic. Data presented includes:

- Published data (with references provided)
- Data held by Bristol City Council on the characteristics of individuals who have received treatment through our commissioned drug and alcohol services

In addition to the above, through the open consultation process for this strategy qualitative data has been gathered from service users, the professionals that work with them, and representatives of equalities groups. Examples of this feedback is provided below, and outlined in full within the consultation report which will be published alongside the final strategy.

Age

Alcohol

- As declared in the 2019/20 quality of life survey for Bristol, there were no significant differences by age in the risk of reporting alcohol use at a high-risk level [1].

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- Rates of hospital admissions for alcohol related conditions (‘narrow’ definition) in people aged 65+ in 2018-19 was higher in Bristol (1,209 per 100,000 people) than for South West Region (997) and England (1,049) [2].

Other drugs

- Nationally produced data estimates in 2016-17 suggest that 367 15-24 year old, 1236 25-35 year olds, and 3340 35-64 year olds in Bristol were using opiates or crack cocaine [3]. This reflects an aging cohort of opiate users.

In treatment services

- Of those adults in Bristol ROADS treatment service within the year 2019/20, just under 80% were between the ages of 30 and 55.

Feedback during the open consultation process

- The move towards digital services, in light of Covid-19, has the potential to be a barrier to treatment for the older generation.
- A focus on prevention within the strategy has the potential to stigmatise or shift focus away from older people in need of treatment.
- The housing of young people with no permanent residence, for example within hostels, has the potential to further expose them to substance misuse.
- The city’s safeguarding work needs to be more linked up across disciplines and organisations, and ensure that substance misuse issues are assessed whenever a young person is flagged for safeguarding concerns.

Disability

Alcohol

- Of those children who responded to the Bristol Pupil Voice survey 2019, 26% of those who identify as having a ‘disability or long-term illness’ consumed alcohol in the last month (compared to a 19% average) [4].
- As declared in the 2019/20 quality of life survey for Bristol, 7.4% of disable people reported alcohol use which would put them at a high risk of health problems (compared to the Bristol average of 16.1%) [1].

Other drugs

- Of those secondary school children who responded to the Bristol Pupil Voice survey 2019, 19% of those with a disability or long-term illness reported ever taking illegal drugs (compared to a 12% average for all pupils) [4].

In treatment services

- Of those adults in Bristol ROADS treatment service within the year 2019/20, 11% were recorded as having a disability (17.5% if excluding service users were disability status was ‘not stated’ or ‘blank’).

Feedback during the open consultation process

- Individuals with learning disabilities benefit more from one to one work, tailored to their disability, than from mixed group support sessions. Currently there is not a lot of sessions like this available within the community recovery service offer.

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- However, in contrast to the above, group sessions do allow people to expand their recovery capital and build networks.
- Accessible information and services are needed; the costs of accommodating people with physical and learning disability is rarely factored into funding.
- Intersectionality of multi-disability (i.e. physical and mental disability) increases risk of substance misuse and adds complexity levels to treatment.
- There is a need to raise awareness of interactions between prescription medication and alcohol/drug use.

Marriage or civil partnership status

- No specific data identified or feedback received

Pregnancy and maternity

- No data identified on local needs. However, it is important to note that the evidence is clear on the harmful effects of substance use in pregnancy and early years, either directly or by association.

Feedback during the open consultation process

- Women who use drugs are more likely to attend antenatal care late and/or conceal their drug issue due to fear or professionals' reactions, or fear of the child being taken away.
- On the flipside, pregnancy may be an important opportunity for change, when a woman may be highly motivated to come off drugs.
- Lack of childcare is a significant barrier for women to attend support group and treatment appointments.
- If Covid-19 has led to barriers in antenatal care and health visitor appointments, there is a risk of missing opportunities for interventions and spotting substance use concerns.

Race

Alcohol

- As declared in the 2019/20 quality of life survey for Bristol, 8% of Black, Asian and minority ethnic respondents and 9.3% of White minority ethnic groups respondents reported alcohol intake which would put them at a high risk of health problems (compared to the Bristol average of 16.1%) [1].
- Of those children who responded to the Bristol Pupil Voice survey 2019, 13% of those from a minority ethnic background consumed alcohol in the last month (compared to a 19% average) [4].

Other drugs

- Of those secondary school children who responded to the Bristol Pupil Voice survey 2019, 11% from a minority ethnic group reported ever taking illegal drugs (compared to a 12% average for all pupils) [4].

In treatment services

- Of those adults in Bristol ROADS treatment service within the year 2019/20, for whom ethnicity was recorded, 85% were White British (% for Bristol population

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overall and 9.5% were from Black, Asian and minority ethnic groups (16% for Bristol population overall).

Feedback during the open consultation process

- Language barriers are important; certain communities in Bristol are not currently served by a named service worker with language skills, or through sessions which are culturally sensitive. Given the sensitivity of issues, use of community translators is often not appropriate.
- Some fear that disclosing drug use may negatively affect immigration status.

Religion or belief

Alcohol

- As declared in the 2019/20 quality of life survey for Bristol, individuals with 'no religion or faith' were more likely to report alcohol use which would put them at a higher risk of alcohol related health problems than those with a stated religion or faith (18.9% compared to 10.5%) [1].

Other drugs

- No data identified

In treatment services

- No data identified

Feedback during the open consultation process

- The time, and day, or support session will be important to different communities.
- The acknowledgement of an individual's substance misuse needs can be a significant barrier if their faith forbids use of alcohol and other drugs. To that end, although faith leaders are important in accessing communities, they may not appreciate the scale of issues in their community.
- There is greater value from support services when they are designed from the bottom up.

Sex (gender)

Alcohol

- According to results from Bristol's most recent quality of life survey, Males are more than twice as likely as Females to report alcohol use which would put them at a higher risk of alcohol related health problems (21.6% compared to 10.7%) [1].
- The rate of hospital admissions in under 18's for alcohol-specific conditions was higher in Bristol between 2016/17 and 18/19 for Females than Males (50.7 per 100,000 compared to 34.8 per 100,000) [2]. By contrast, adult Males in Bristol are twice as likely as Females to be admitted to hospital for an alcohol-related condition (3985 per 100,000 compared to 2137 per 100,000) [2].
- Alcohol-related mortality amongst Males in Bristol in 2018 was double that seen in Females (82.6 per 100,000 compared to 34.3 per 100,000) [2].

Other drugs

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- Males were more likely to die from drug misuse than females (11.7 per 100,000 compared to 3 per 100,000) in Bristol between 2016 and 2018 [5].
- Of those children who responded to the Bristol Pupil Voice survey 2019, 30% of Year 10 Males and 32% of Year 10 Females had ever been offered drugs (17% and 21% respectively had ever used drugs) [4].

In treatment services

- Of those adults in Bristol ROADS treatment service within the year 2019/20, 69.2% were Male.

Feedback during the open consultation process

- Women can experience greater stigma when accessing services, strengthened by the risk of referral to social services etc.
- There is a need for women-only and men-only services and groups
- Women's groups have previously identified a lack of aftercare support from current services, especially in relation to mental health and family support.
- There is a recognised link between substance misuse and sexual violence; more data on this is needed, and prevention should also include prevention of violence.

Gender reassignment

- Stonewall research indicates that Trans people face widespread discrimination in healthcare settings; may avoid seeking healthcare for fear of discrimination from staff; and are likely to have a higher prevalence of drug and alcohol use [6].

Sexual orientation

Alcohol

- As declared in the 2019/20 quality of life survey for Bristol, individuals identifying as LBGT+ were slightly more likely to report alcohol use which would put them at a higher risk of alcohol related health problems than the general population (18.4% compared to 16.1%) [1].
- Of those children who responded to the Bristol Pupil Voice survey 2019, 49% of Year 10's identifying as LGBT+ consumed alcohol in the last month (compared to a 19% average) [4].

Other drugs

- Of those secondary school children who responded to the Bristol Pupil Voice survey 2019, 25% from a LGBT+ group reported ever taking illegal drugs (compared to a 12% average for all pupils) [4].

In treatment services

- Of those adults in Bristol ROADS treatment service within the year 2019/20, for whom sexual orientation was recorded, 94% were 'Heterosexual or Straight'; 2.8% were recorded as 'Bisexual' and 1.8% as 'Gay or Lesbian'

Feedback during the open consultation process

- The LGBTQ cohort is diverse; the varying needs of individuals cannot be catered for within one LGBTQ support group.

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- There are few LGBTQ venues and socialisation opportunities which are not focused around alcohol. This is an important issue if wanting to focus on prevention.
- Chemsex is a particular issue for this population, especially gay men.

This strategy's purpose is to improve on these health outcomes, with explicit reference within the strategy objectives to reducing inequalities and serving Bristol's varied communities; as such, the strategy (and any future action plans) will seek to positively impact on a number of these recognised inequalities by protected characteristics.

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

The open consultation process has enabled some gaps to be filled, as had been identified in the draft version of this equalities impact assessment. However, there remains some uncertainty about areas of interest:

- Data on health needs related to drug and alcohol use for a number of protected characteristics is not routinely available. No data was identified based on marital status, pregnancy, religion, or gender reassignment. Where data is available, e.g. for Sex and Race, this often reflects those individuals in treatment services and may not fully capture the amount of unmet need.
- This strategy concerns more than just health needs, and one priority area focuses exclusively on criminal justice. However, data on arrests and criminal convictions secondary to, or associated with, use of alcohol and other drugs has not been available for consideration in the development of this strategy. As such, data was also not available on how such crime figures vary by protected characteristics. Any variation (or not) in how individuals with protected characteristics are involved in crimes attributed to drug or alcohol use (either as perpetrators or victims) remains an important gap.

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

The early stages of the strategy development benefited from 5 engagement events / workshops, attended by 68 individuals from across 25 organisations and key stakeholders in Bristol. Further engagement events were subsequently planned, specifically aimed at drug and alcohol service users, but had to be cancelled as a result of the Covid-19 pandemic.

Efforts were therefore made to meet virtually with voluntary care sector organisations, including groups based within at-risk communities. ROADS Peers (previous service users who now act as peer mentors for individuals currently in drug and alcohol treatment services) also attended our strategy oversight group meetings.

A first draft of the strategy, and this equalities impact assessment, were made available to the public through an open consultation. This has allowed for further consideration to be given to the views of the general public, as well as key stakeholders, in the final shaping of this strategy. The open consultation received 150 individual responses as well as further engagement from a number of stakeholders, including a focused meeting of professionals

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and representatives from certain key stakeholders with an interest in protected characteristics and inequalities.

Importantly, the production and publication of this strategy is not the end-point. Annual action plans that will result from this strategy will bring further opportunities for community engagement.

Step 3: Who might the proposal impact?

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

3.1 Does the proposal have any potentially adverse impacts on people with protected characteristics?
This proposal relates specifically to Bristol's new Drug and Alcohol Strategy. This strategy document is high-level and broad; outlining a vision for the city, 6 priority areas, and a number of 'commitments'. Because of its high-level nature, the specific impact for people on the basis of their protected characteristics is difficult to evaluate. Importantly however, the strategy's purpose is to have a positive impact on the health outcomes of our population, with explicit reference to reducing inequalities and serving Bristol's varied communities; as such, the strategy (and any future action plans) will seek to reverse any recognised inequalities by protected characteristics. The open consultation process presented an opportunity for members of the public to highlight ways in which they felt the strategy's vision, priority areas, and commitments may adversely impact on people with protected characteristics. It also allowed for general comments and reflections on how drug and alcohol issues may disproportionately impact on certain members of our society. These views have been collated within section 2.1 above, with the impact of these comments outlined in section 4 below.
3.2 Can these impacts be mitigated or justified? If so, how?
As part of the consultation process, we have further engaged with members of the public and with equalities groups; comments have been considered on how services can be made more accessible and inclusive, and changes made to the strategy to reflect these (see section 4 below).
3.3 Does the proposal create any benefits for people with protected characteristics?
As outlined above, there was awareness at the start of this strategy's development process that drug and alcohol issues were leading to a number of inequalities across the city. The strategy has therefore sought to set a framework for the production of future annual action plans that will actively address these inequalities and benefit those with protected characteristics. The open consultation process provided an opportunity for members of the public to highlight ways in which they felt the draft strategy's vision, priority areas, and

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commitments would positively impact on people with protected characteristics. Comments have been collated in section 2.1, and reflected on in section 4 below.
3.4 Can they be maximised? If so, how?
The views of equalities stakeholders, and members of the public, were gathered as part of the consultation process, with a view to better understand how the strategy can maximise benefits for people on the basis of their protected characteristics. Comments have been collated in section 2.1, and reflected on in section 4 below.

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?
This equalities impact assessment has provided some evidence on which groups may be experiencing inequality with respect to drug and alcohol misuse in Bristol, including those groups where we may be seeing an unmet need. This evidence has been strengthened by feedback received as part of an open consultation process. The strategy vision makes clear that all individuals - regardless of starting point - should be able to access appropriate drug and alcohol support. Commitments made within the strategy reflect the need to reduce inequalities (from both protected characteristics and other factors, such as household income). Additions/alterations have been made to the original draft strategy following the open consultation. Those changes with relevance to the equalities' agenda include: - Stronger reference to cultural competence as a running theme throughout the strategy, and the expectation of services and professionals to be adaptable to the needs of different communities and populations (including different ethnicities, sexualities, genders, disabilities etc). - The expectation that future commissioning contracts and budgets for Bristol's drug and alcohol services should reflect the funding needed to ensure accessibility. - The goal for referral pathways into services to be flexible to meet the needs of those traditionally underserved, or who experience barriers (such as those with a physical or learning disability) - Reference to the need for greater support after 'completion' of treatment, including for mental health conditions and parental/family support - Highlighting the risk of digitalisation of services, as a result of the Covid-19 pandemic, widening inequalities between age groups and deprived communities. - Reference throughout the strategy of the need to de-stigmatise seeking support; this includes with respect to stigmatisation of older people in treatment, mothers and pregnant women seeking support etc.

- Explicit reference to education programmes, and testing schemes, which inform of the dangers of 'party drugs' and 'chemsex'.	
4.2 What actions have been identified going forward?	
This draft strategy presents a framework for future action planning. The impact of drug and alcohol issues on individuals with protected characteristics has been considered within this draft strategy; the vision, priorities and commitments have been written to ensure that future actions reflect the need to provide culturally-aware services, which are accessible to all. Specific actions on how this will be achieved will be decided in the next phase, after the strategy has been published. As a result of feedback received through the open consultation process, these actions should now better reflect the issues highlighted in this equalities impact assessment.	
4.3 How will the impact of your proposal and actions be measured moving forward?	
The impact of substance misuse on Bristol's population - including outcomes from its drug and alcohol services - is routinely monitored in a number of ways (within national frameworks and local performance monitoring approaches). These metrics will therefore detect the impact of the strategy over the coming years. The Keeping Communities Safe Group (of the Keeping Bristol Safe Partnership) holds governance for drug and alcohol issues across the city. Suggestions raised during the open consultation process, for example that equality, diversity and inclusion be built into future commissioning contracts, and that regular health equity audits of the drug and alcohol services should be performed, will both need to be considered as part of the action setting and process.	
Service Director Sign-Off: CAGray *Christina Gray Director of Public Health, Bristol*	Equalities Officer Sign Off: *Reviewed by Equality and Inclusion Team*
Date: 15/2/2021	Date: 29/1/2021

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Consultation and Engagement

Drug and Alcohol Strategy 2020-2024

Consultation Report

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Executive Summary

ES1 Bristol City Council Drug and Alcohol Strategy 2020-2024

Bristol's existing alcohol strategy expires in 2020. This presents an opportunity to develop a new, city-wide strategy which looks to address issues relating to all substances (not just alcohol, but all drugs) within one document.

Bristol City Council has worked with partners across the city to draft a proposed new Drug and Alcohol Strategy, on behalf of the Keeping Communities Safe Group (of the Keeping Bristol Safe Partnership). This draft strategy was subject to public consultation.

ES2 The Drug and Alcohol Strategy 2020-2024 consultation

The Drug and Alcohol Strategy 2020-2024 consultation took place between 27 November 2020 and 8 January 2021 and sought views from the public (including service users and stakeholders) on the strategy's vision and six priority areas.

The Drug and Alcohol Strategy 2020-2024 consultation sought citizens' views on the strategy's vision and six priority areas. Respondents were asked to rate their level of agreement or disagreement with the vision and each priority area on a scale from "strongly agree" to "strongly disagree".

Respondents were then asked to provide their comments on the strategy using a free text box. Respondents were provided with a second free text box to provide their comments on the draft Equalities Impact Assessment and to suggest any ways to make the Drug and Alcohol Strategy more inclusive and accessible.

Finally, respondents were asked for their postcode and equalities information was collected.

ES3 Scope and use of this report

This report describes the methodology and presents the outcome of the Drug and Alcohol Strategy 2020-2024 consultation. It includes quantitative data and analysis of free text comments from the consultation survey responses.

This consultation report does not contain the council's recommendations for the Drug and Alcohol Strategy 2020-2024, nor an assessment of the feasibility of any of the suggestions received. The consultation feedback in this report is taken into consideration by officers in developing final proposals for the Drug and Alcohol Strategy 2020-2024. The final proposals are included in a separate document.

ES4 Drug and Alcohol Strategy 2020-2024 consultation - Key findings

ES4.1 Response rate

The Drug and Alcohol Strategy 2020-2024 consultation survey received 150 responses, all of which were completed online.

107 responses (71%) were received from postcodes within the Bristol City Council area, 6 (4%) responses were from South Gloucestershire, North Somerset, and Bath & North East Somerset (B&NES). A further one (0.7%) response was from an unspecified location within the four West of England authorities and one response was from further afield.

33 (22%) did not provide a postcode.

Analysis of respondents' postcodes shows that there was an under-representation of responses from the most deprived 20% of the city, and response rates from the least deprived 30% of the city were over-represented.

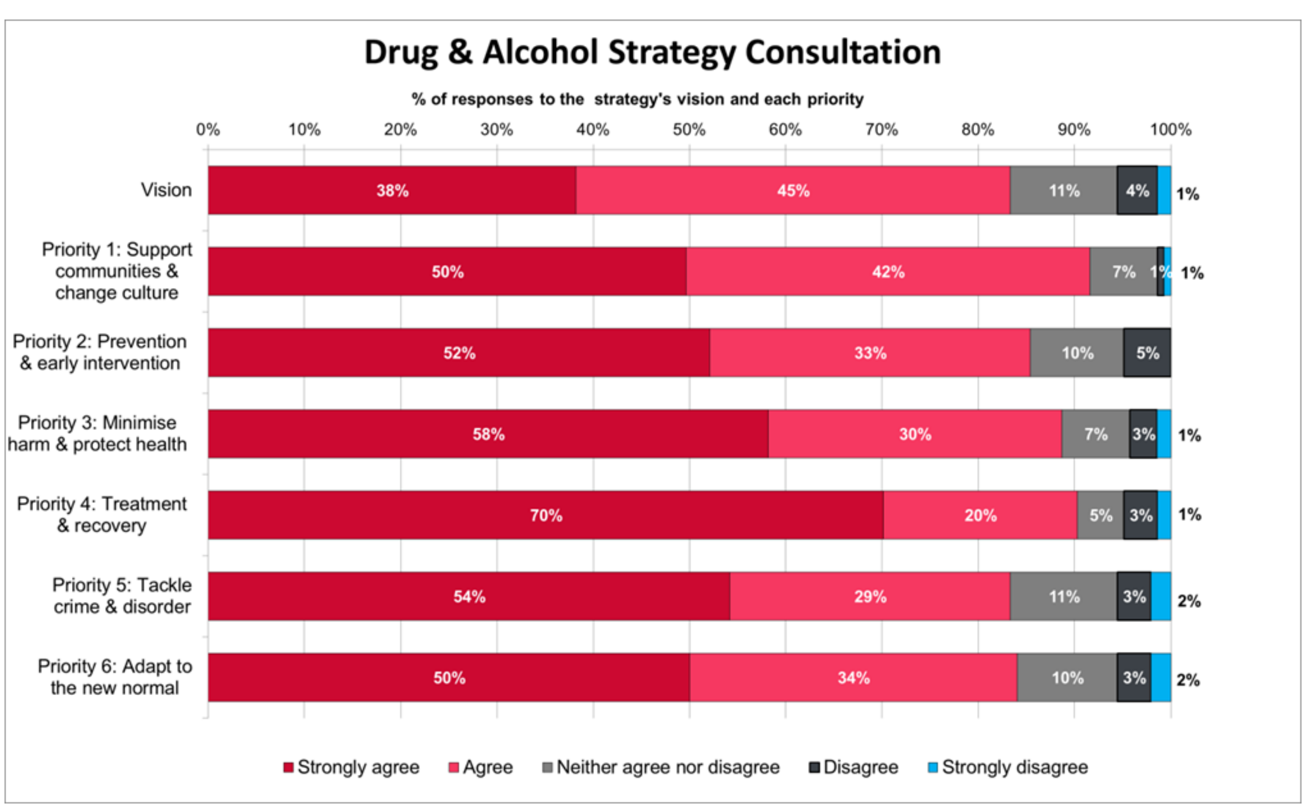
Response rates from young people (aged 24 and younger), black, Asian & minority ethnic (BAME) citizens, and people of faith were under-represented compared to these groups' proportions of Bristol's population. A map of response rate by ward for the Bristol respondents is presented in Chapter 3 along with the details of age profile, sex and other respondent characteristics.

ES4.2 Drug and Alcohol Strategy 2020-2024

Respondents were asked to rate their level of agreement or disagreement with the Drug and Alcohol Strategy's vision and six priority areas (Figure ES1).

- 144 (96%) respondents expressed a view on the strategy's vision
- 143 (95%) respondents expressed a view on Priority 1: Support communities and change culture
- 144 (96%) respondents expressed a view on Priority 2: Prevention and early intervention
- 141 (94%) respondents expressed a view on Priority 3: Minimise harm and protect health
- 144 (96%) respondents expressed a view on Priority 4: Treatment and recovery
- 144 (96%) respondents expressed a view on Priority 5: Tackle crime and disorder
- 144 (96%) respondents expressed a view on Priority 6: Adapt to the new normal

Figure ES1: Agreement or disagreement with the Drug and Alcohol Strategy Vision and Priorities



A majority of respondents agree or strongly agree with the strategy's vision and each of the six priority areas.

ES4.4 Differences in views on the Drug and Alcohol Strategy Vision and Priority Areas in areas of high and low deprivation

Views on the Drug and Alcohol Strategy vision and six priority areas were compared for respondents from the 20% most deprived areas of Bristol (deciles 1 and 2) and the 20% least deprived areas of Bristol (deciles 9 and 10) as well as all Bristol respondents (Figures ES3 to ES9).

Figure ES3: Vision

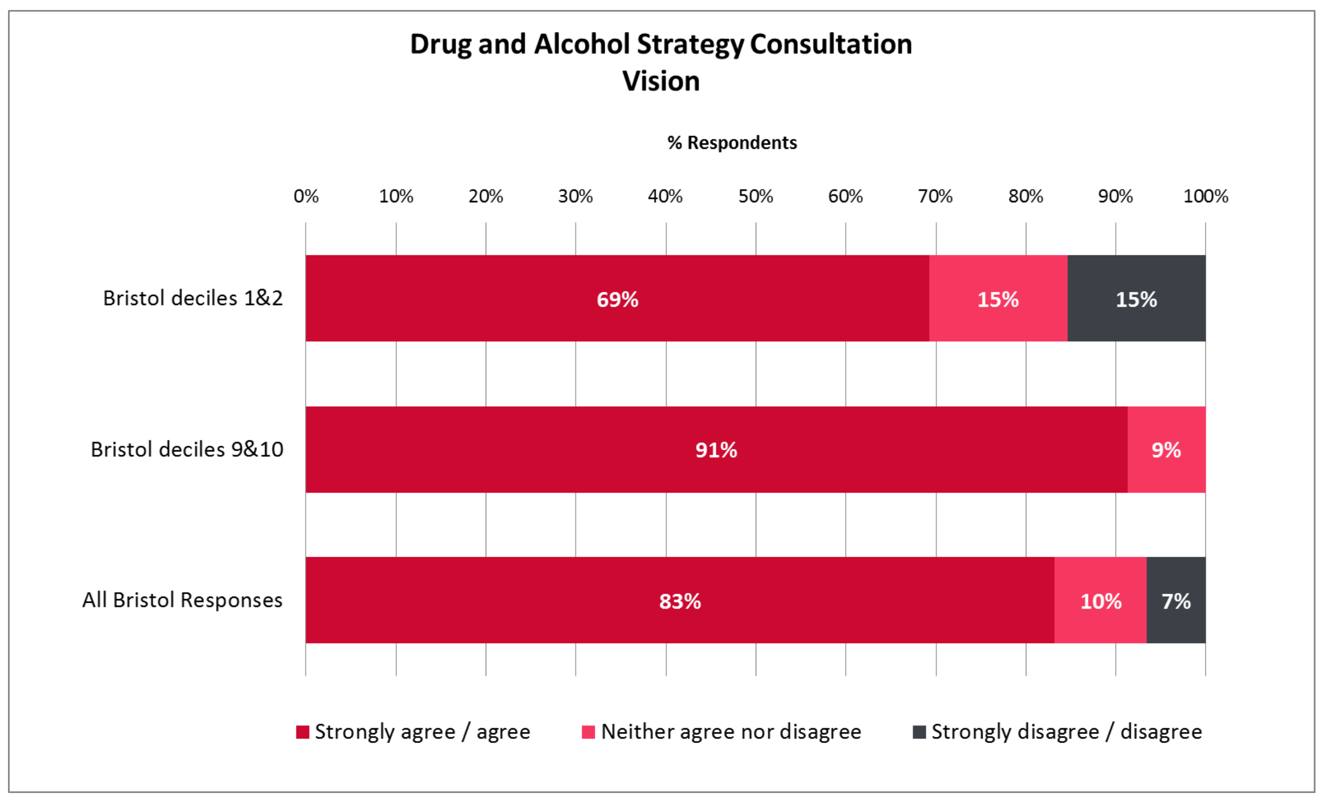


Figure ES4: Priority 1

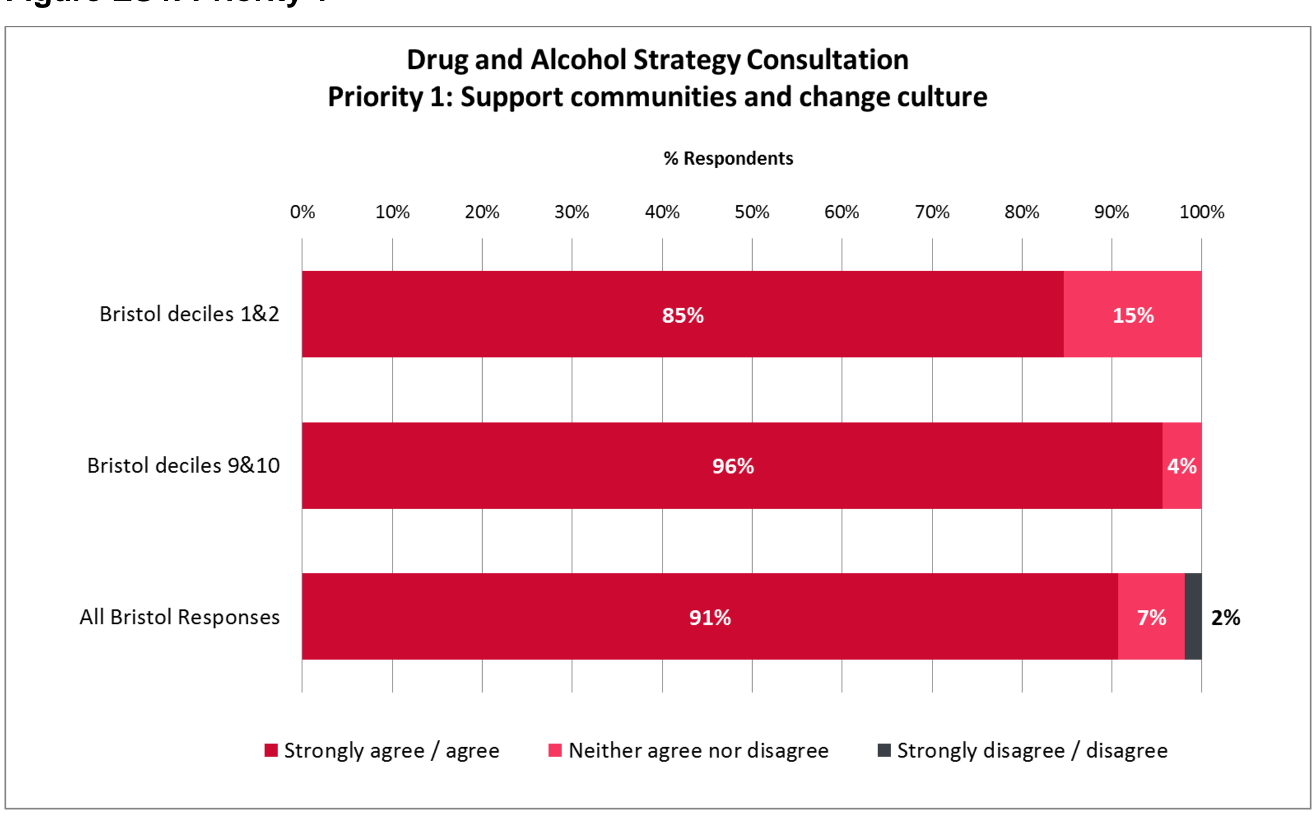


Figure ES5: Priority 2

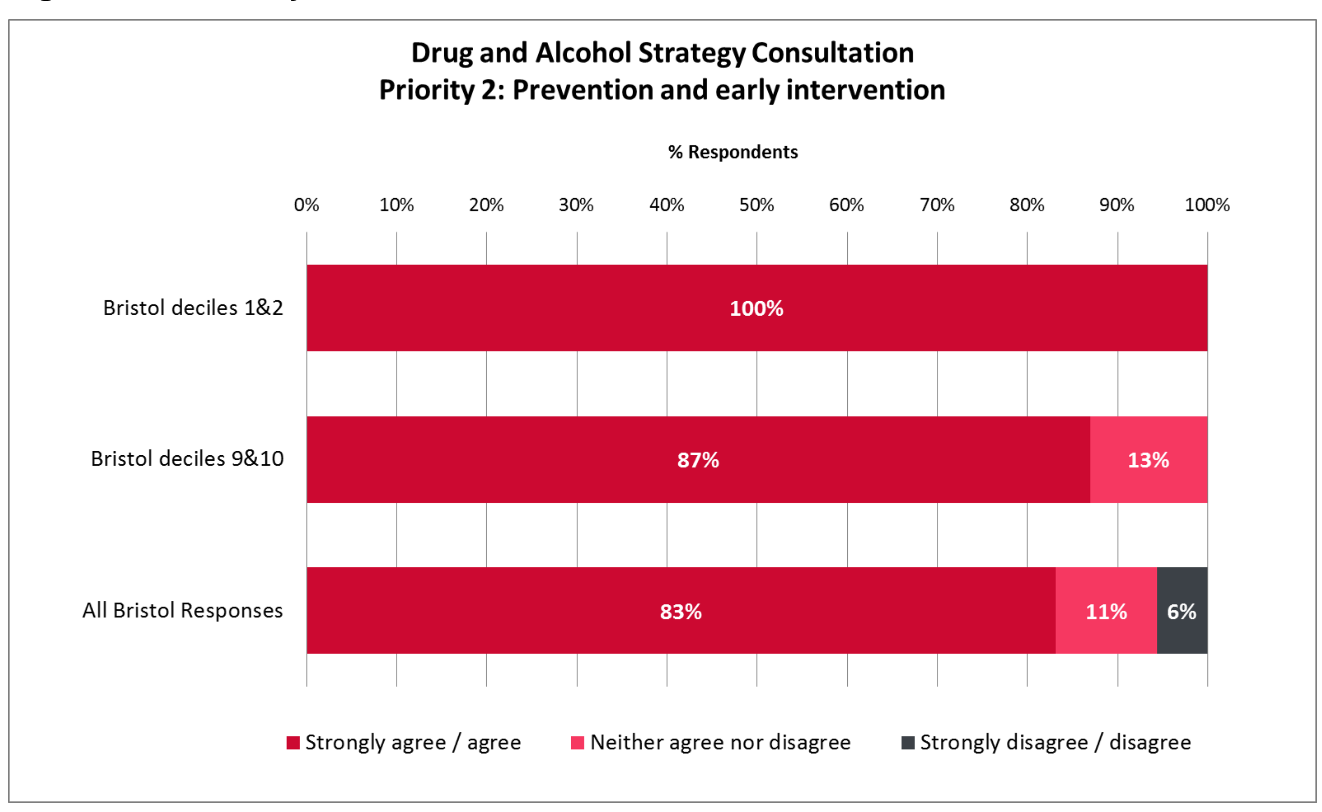


Figure ES6: Priority 3

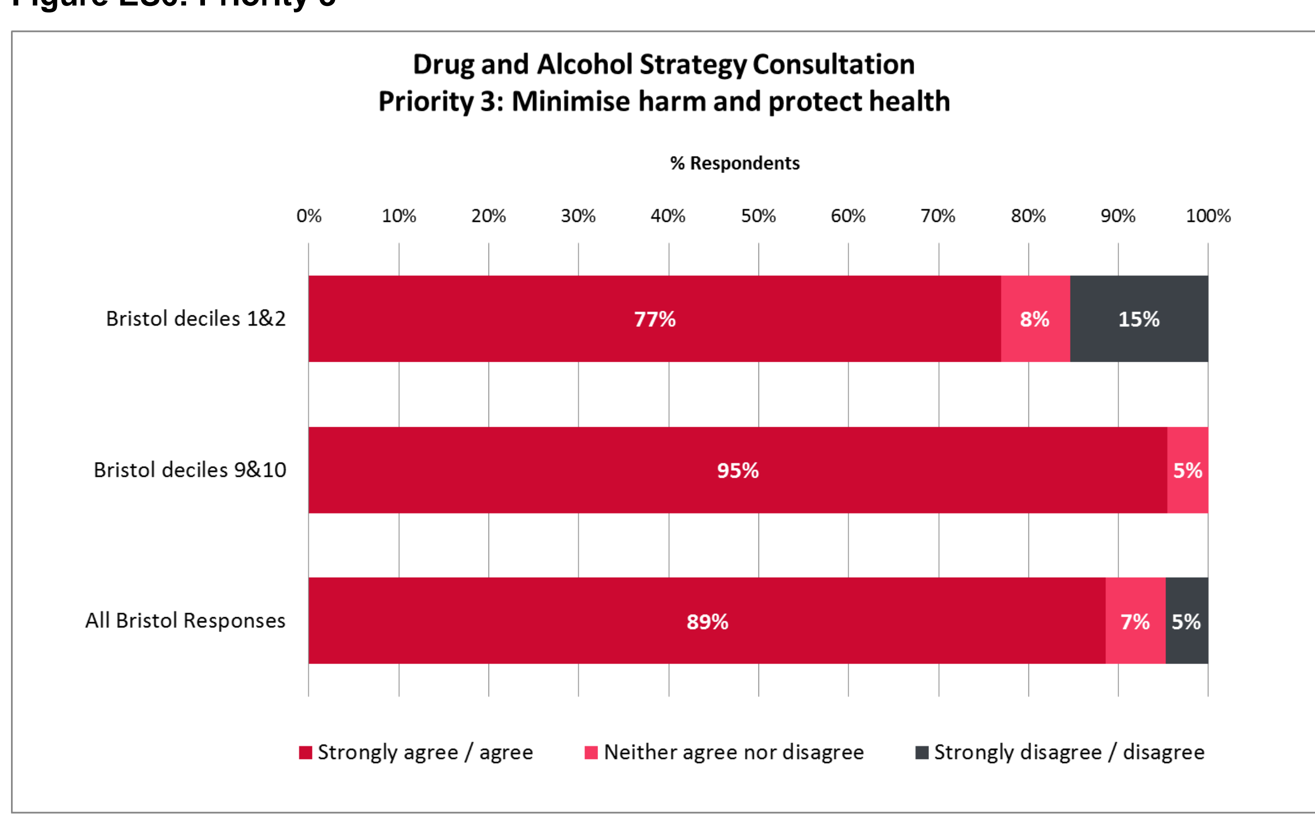


Figure ES7: Priority 4

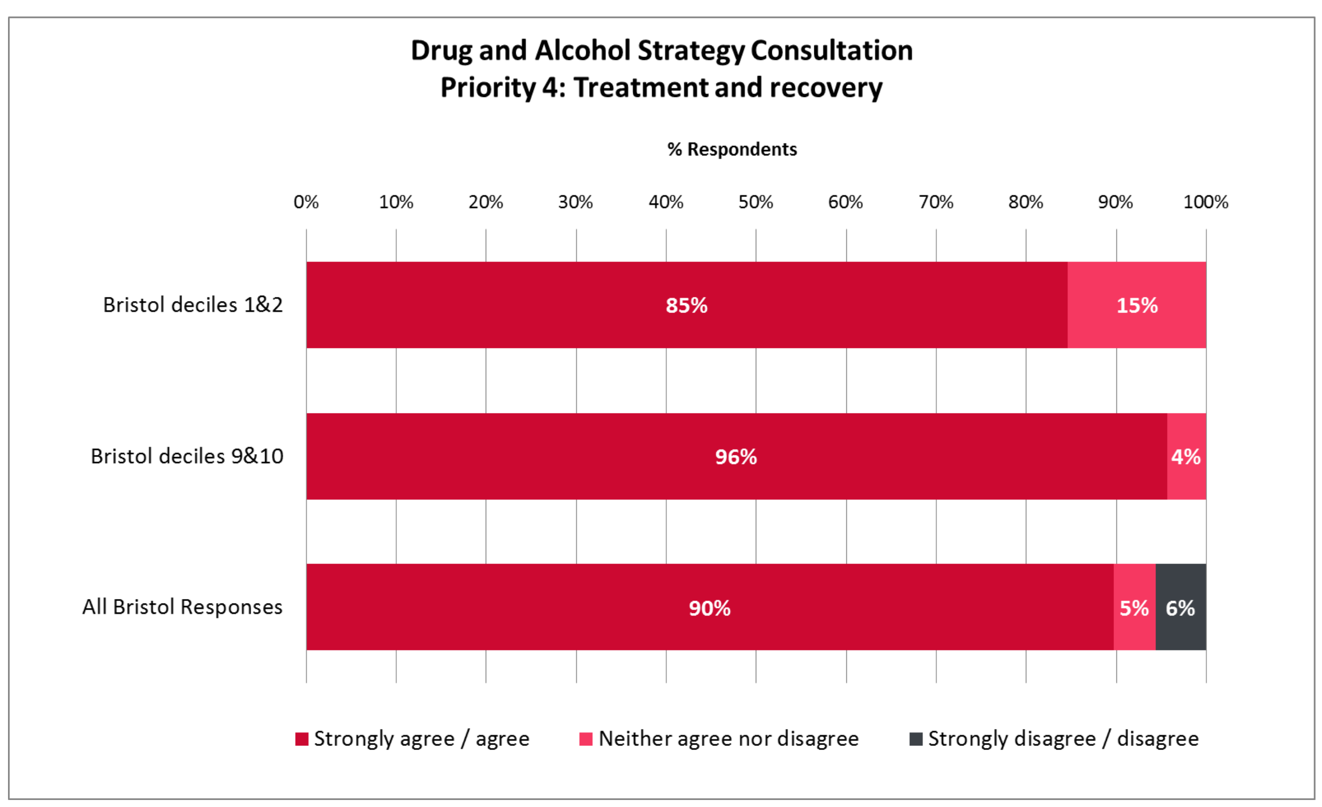


Figure ES8: Priority 5

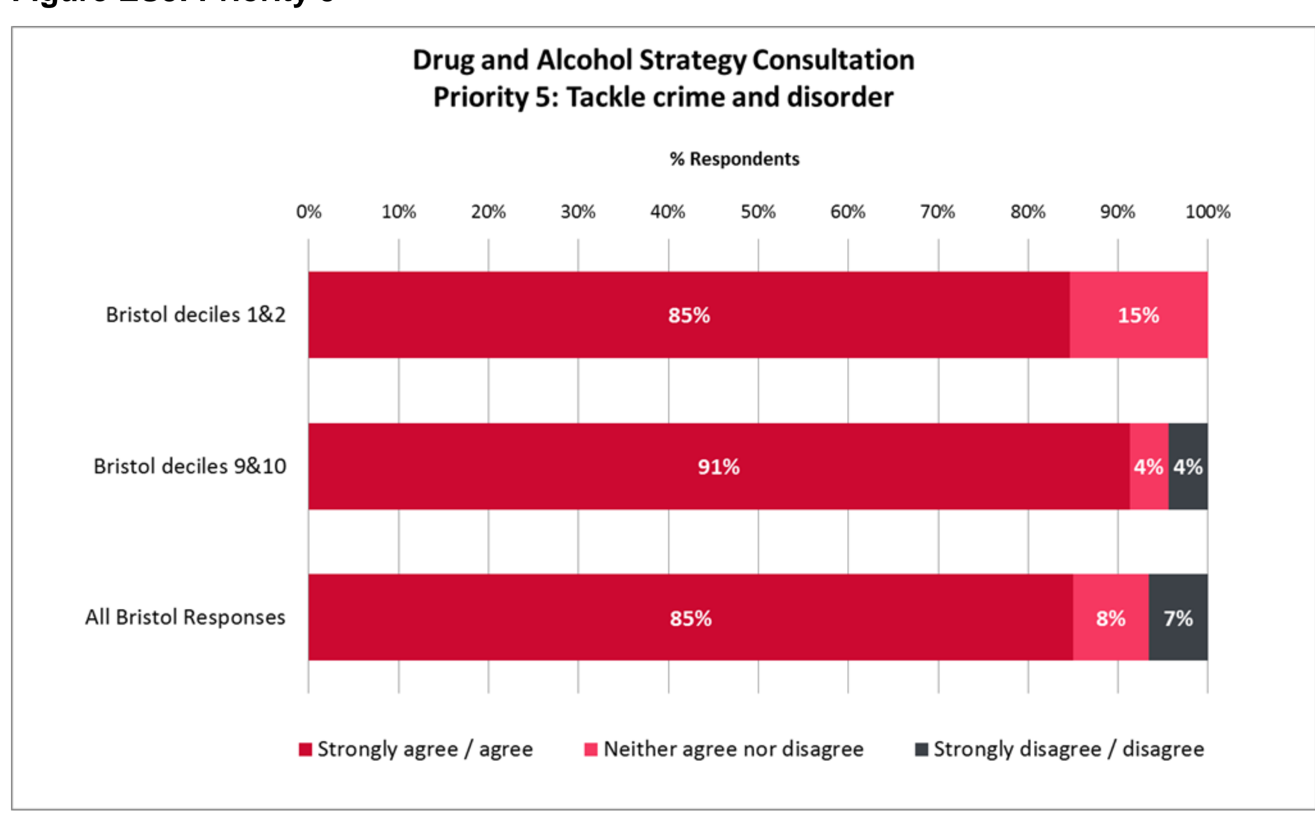
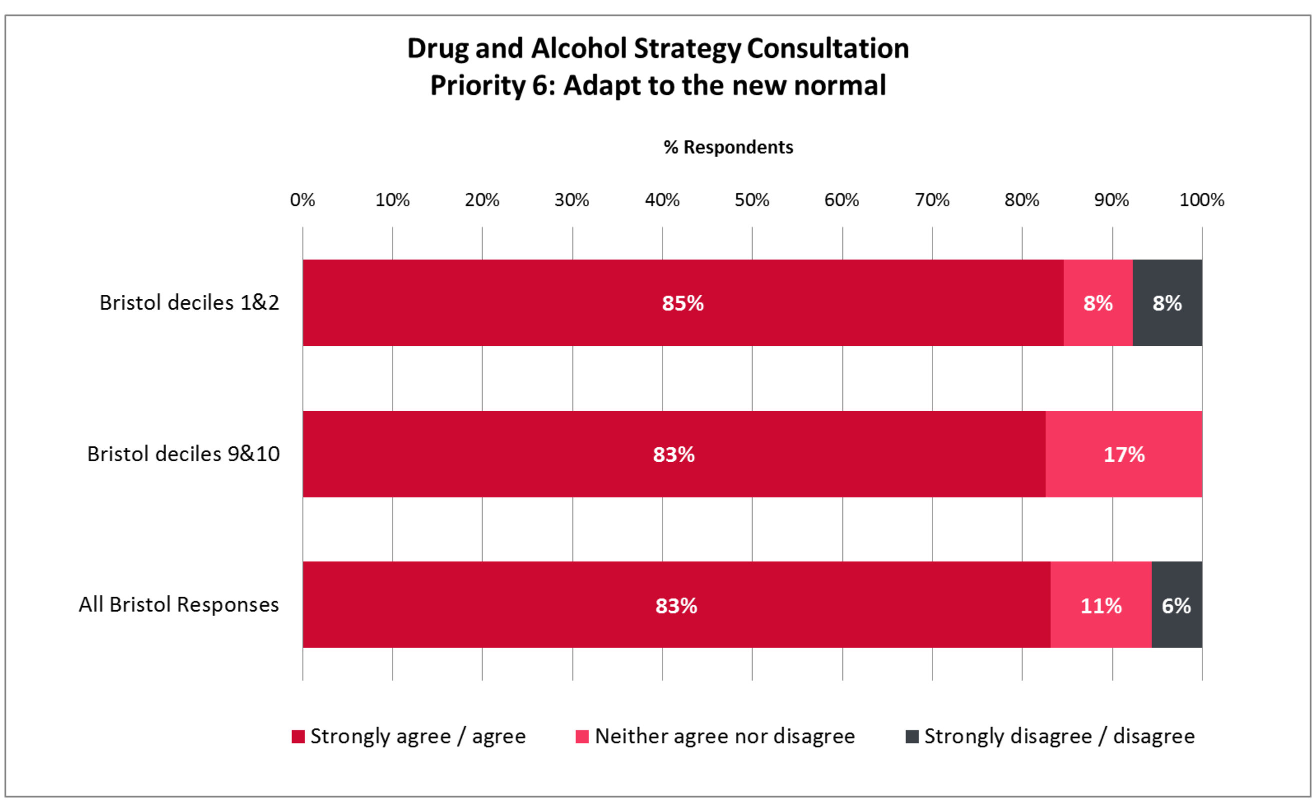


Figure ES9: Priority 6



Agreement with the strategy's vision and six priority areas is similar in the most deprived 20% areas of Bristol compared with the least deprived 20% areas of Bristol.

However support for the strategy's vision and Priority 1, Priority 3, Priority 4 and Priority 5 is higher in Bristol deciles 9 and 10 than it is in Bristol deciles 1 and 2. Support for Priority 2 is higher in Bristol decile 1 and 2 than it is in Bristol deciled 9 and 10.

1 Introduction

1.1 Context

Bristol's existing alcohol strategy expires in 2020. This presents an opportunity to develop a new, city-wide strategy which looks to address issues relating to all substances (not just alcohol, but all drugs) within one document.

Bristol City Council has worked with partners across the city to draft a proposed new Drug and Alcohol Strategy 2020-2024, on behalf of the Keeping Communities Safe Group (of the Keeping Bristol Safe Partnership). This draft strategy was subject to public consultation.

The Drug and Alcohol Strategy 2020-2024 consultation took place between 27 November 2020 and 8 January 2021 and sought views from the public (including service users and stakeholders) on the strategy's vision and six priority areas.

This consultation report describes the consultation methodology and the feedback received.

1.2 Drug and Alcohol Strategy Vision and Priorities

The consultation sought views from the public on the Drug and Alcohol Strategy's proposed vision and six priority areas. The proposed vision for the strategy stated:

"Bristol aspires to be a vibrant, inclusive and compassionate city, where prevention is prioritised, and everyone has the right to a healthy life safe from the harms of alcohol and other drugs.

Individuals and their families - regardless of starting points - are well-informed and empowered to reach their full potential, access treatment if needed, and reduce harm within their community."

The six priority areas that consultation respondents were asked to provide feedback on were:

- Priority 1: Support communities and change culture
- Priority 2: Prevention and early intervention
- Priority 3: Minimise harm and protect health
- Priority 4: Treatment and recovery
- Priority 5: Tackle crime and disorder
- Priority 6: Adapt to the new normal

1.3 Drug and Alcohol Strategy 2020-2024 consultation

The Drug and Alcohol Strategy 2020-2024 consultation sought citizens' views on the strategy's vision and six priority areas. Respondents were asked to rate their level of agreement or disagreement with the vision and each priority area on a scale from "strongly agree" to "strongly disagree".

Respondents were then asked to provide their comments on the strategy using a free text box. Respondents were provided with a second free text box to provide their comments on the draft Equalities Impact Assessment and to suggest any ways to make the Drug and Alcohol Strategy more inclusive and accessible.

Finally, respondents were asked for their postcode and equalities information was collected.

The consultation information and questions are summarised in section 2.1.1 and the full consultation survey can be viewed online.

1.4 Structure of this report

Chapter 2 of this report describes the Drug and Alcohol Strategy 2020-2024 consultation methodology.

Chapters 3 to 6 present the Drug and Alcohol Strategy 2020-2024 consultation survey results:

- Chapter 3 presents the survey response rate and respondent characteristics;
- Chapter 4 describes the survey feedback on the level of agreement or disagreement with the strategy's vision and six priority areas;
- Chapter 5 summarises respondents' reasons for their preferences and other comments provided as free text.

Chapter 6 describes feedback received in other correspondence (emails and letters).

Chapter 7 describes how this report will be used and how to keep updated on the decision-making process.

2 Methodology

2.1 Survey

2.1.1 Online survey

The Drug and Alcohol Strategy 2020-2024 consultation survey was available on the council's Consultation and Engagement Hub (bristol.gov.uk/consultationhub) between 27 November 2020 and 8 January 2021.

Survey information

The survey contained the following information as context for the survey questions:

- Information on the need for a Drug and Alcohol Strategy, including that the existing Alcohol Strategy for Bristol had expired and the importance of addressing drug and alcohol issues in the city
- Information on the work which had been carried out with city partners and stakeholders to draft the proposed Drug and Alcohol Strategy
- Information on the purpose and scope of the Drug and Alcohol strategy
- An outline of the Drug and Alcohol Strategy's proposed vision and six priority areas
- A link to the proposed Drug and Alcohol Strategy
- Information on the purpose of a public consultation and how respondents' views would be taken into account

Survey questions

The survey questions sought respondents' views on the following:

- Level of agreement or disagreement with the strategy's proposed vision
- Level of agreement or disagreement with the strategy's Priority 1: Support communities and change culture
- Level of agreement or disagreement with the strategy's Priority 2: Prevention and early intervention
- Level of agreement or disagreement with the strategy's Priority 3: Minimise harm and protect health
- Level of agreement or disagreement with the strategy's Priority 4: Treatment and recovery
- Level of agreement or disagreement with the strategy's Priority 5: Tackle crime and disorder

- Level of agreement or disagreement with the strategy's Priority 6: Adapt to the new normal
- Respondents' comments on the proposed Drug and Alcohol Strategy
- Respondents' comments on the Equalities Impact Assessment and on the accessibility and inclusivity of the strategy

The 'About you' section requested information which helps the council to check if the responses are representative of people across the city who may have different needs.

- Respondents' postcode – this identifies if any parts of the city are under-represented in responding to the consultation and it can show if people from more deprived areas of the city have different views compared to people living in less deprived areas;
- Equalities monitoring information – this enables the council to check if we receive responses from people with protected characteristics under the Equality Act 2010;
- Other information about respondents; for example whether they are a Bristol resident, a councillor or MP, or a professional working in Bristol;
- How respondents found out about the consultation – to help the council publicise future consultations effectively.

Respondents could choose to answer some or all of the questions in any order and save and return to the survey later.

2.1.2 **Alternative formats**

The consultation was available in paper copies and alternative formats (Easy Read, braille, large print, audio, British Sign Language (BSL) and translation to other languages) on request.

2.1.3 **Other correspondence**

Six emails were received in response to the consultation. These are reported separately to the survey responses in Chapter 6.

2.2 Publicity and briefings

2.2.1 **Objective**

The following programme of activity was carried out to publicise and explain the Drug and Alcohol Strategy 2020-2024 consultation. The primary objective was to involve residents and stakeholders across the city in the Drug and Alcohol Strategy by ensuring that

information was shared across a wide range of channels, reaching as broad a range of audiences as possible in order to maximise response rates.

2.2.2 Bristol City Council channels

Copy and electronic materials were shared via the following council and partner channels and networks:

- Ask Bristol e-bulletin – 4,923 recipients;
- Bristol City Council website
- Emails to over 100 stakeholders in the city

2.2.3 Members

An email containing information about the consultation was sent directly to members.

2.2.4 Bristol City Council Partners and Voluntary Sector Organisations

Council officers attended several meetings with Bristol City Council partners and voluntary sector organisations in the city to promote the consultation, including Bristol@Night, Youth Council and meetings with equalities representatives. The consultation was also advertised on partner websites, including Bristol Health Partners and the Carers Support Centre.

2.2.5 Media engagement

Press releases were distributed to media contacts and local community newsletters on detailing how to take part in and promote the consultation.

2.2.6 Social Media

Regular posts on Bristol City Council's social media channels (Twitter, Facebook, Next Door and Instagram) were made for the duration of the consultation, with increased posts at launch, 'two weeks left' and in the final days.

3 Survey response rate and respondent characteristics

3.1 Response rate to the survey

The Drug and Alcohol Strategy 2020-2024 consultation survey received 150 responses, all of which were completed online.

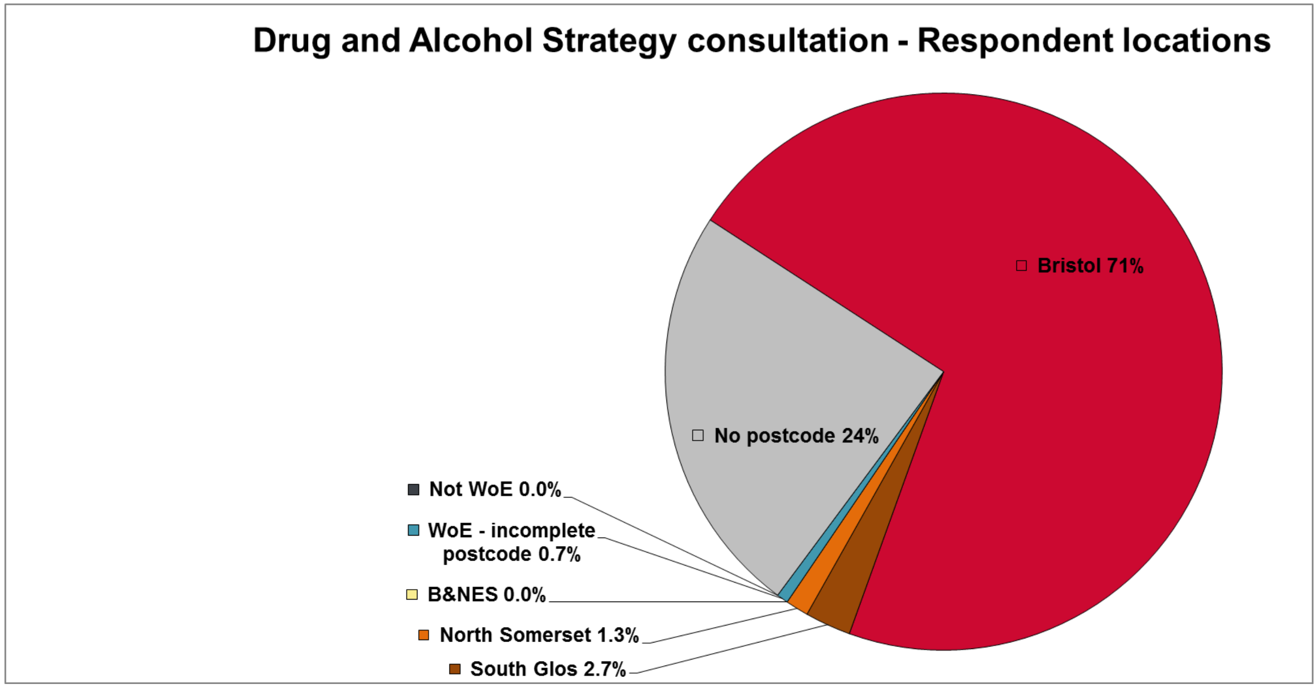
3.2 Geographic distribution of responses

107 responses (71%) were received from postcodes within the Bristol City Council area, 4 (2.7%) responses were from South Gloucestershire, two (1.3%) were from North Somerset, and none (0.0%) were from Bath & North East Somerset (B&NES). A further one (0.7%) response was from an unspecified location within the four West of England authorities[1] and no responses were received from further afield (Figure 1).

33 (22%) did not provide a postcode.

Of the 107 responses from within the Bristol City Council area, 104 provided full or partial postcodes from which the ward of origin could be identified[2] (Figure 2).

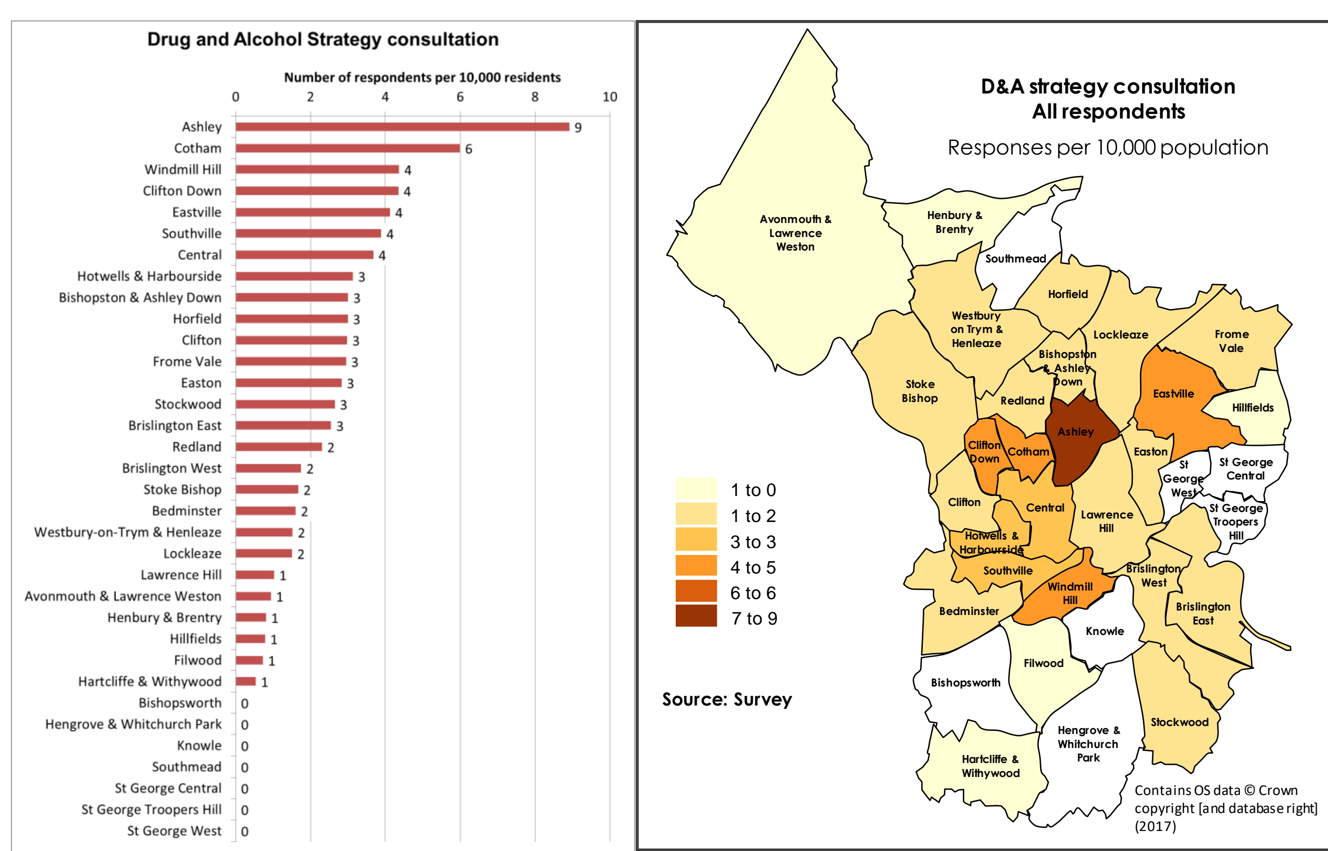
Figure 1: geographic distribution of responses



[1] Incomplete postcodes identified the home location as within the WOE authorities area (Bristol, B&NES, North Somerset and South Gloucestershire), but not which authority.

[2] The other 3 responses included incomplete postcodes which are within Bristol but do not include enough information to identify a specific ward.

Figure 2: geographic distribution of responses in Bristol



3.3 Response rate from areas of high and low deprivation

The home location of respondents in Bristol was compared with nationally published information on levels of deprivation across the city[3] to review if the responses received include a cross-section of people living in more deprived and less deprived areas. This helps the council to know if the views of citizens in more deprived areas differ from people living in less deprived areas.

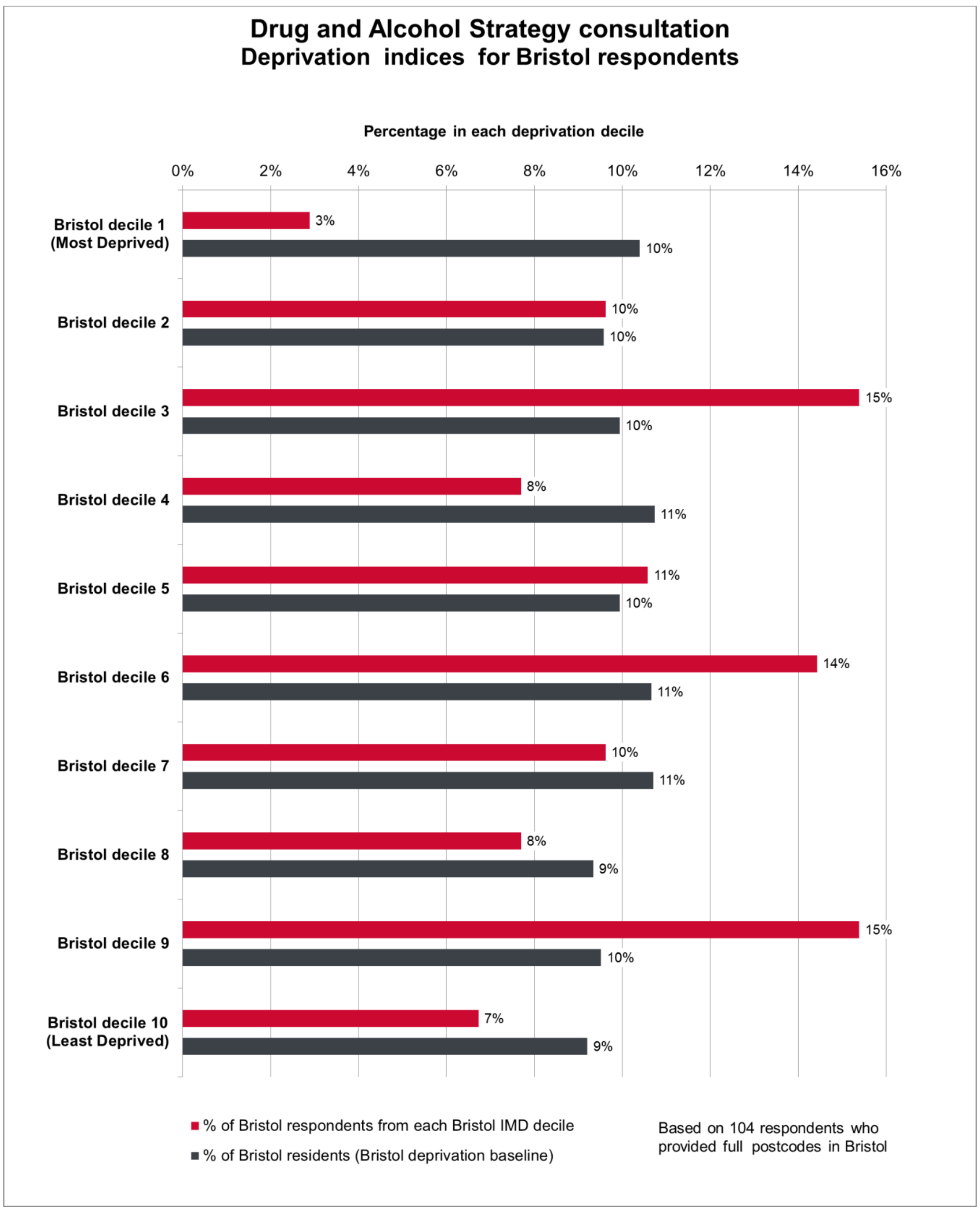
The comparison looked at levels of deprivation in 10 bands (known as 'deciles') from decile 1 (most deprived) to decile 10 (least deprived). Figure 3 compares the percentage of Bristol respondents[4] living in each of the deprivation deciles (red bars) to the percentage of all Bristol citizens who live in each decile (grey bars).

[3] The Office for National Statistics (ONS) publishes information about deprivation for 32,844 small areas - known as 'Lower Super Output Areas' (LSOAs) - throughout England. For each of these areas, a measure of deprivation is published called 'Indices of Multiple Deprivation' (IMD), which takes into account 37 aspects of each area that cover income, employment, education, health, crime, barriers to housing and services, and living environment. The postcodes provided by respondents to the consultation enabled each respondent to be matched to one of the 263 Lower Super Output Areas that cover the Bristol City Council area and thus to one of the deprivation deciles. Note that postcodes provide approximate locations; they are not used to identify individuals or specific addresses.

[4] Based on 104 respondents who provided full postcodes in the Bristol administrative area from which deprivation decile can be identified.

Figure 3 shows that there was under-representation of responses from the most deprived 10% of the city (decile 1) and in the least deprived 10% of the city (decile 10). Response rates from deciles 3, 4, 6 and 9 were over represented. Response rates from deciles 2, 5, 7 and 8 closely match the proportion of Bristol citizens living in these deciles.

Figure 3: Comparison of response rate from areas of high and low deprivation



(Percentages in Figure 3 are given to the nearest integer. The length of bars in the chart reflects the unrounded percentage; hence bars shown as 10% may be slightly different in length.)

3.4 Characteristics of respondents

144 (96%) people answered one or more of the equalities monitoring questions.

Respondent characteristics are summarised below. The charts compare:

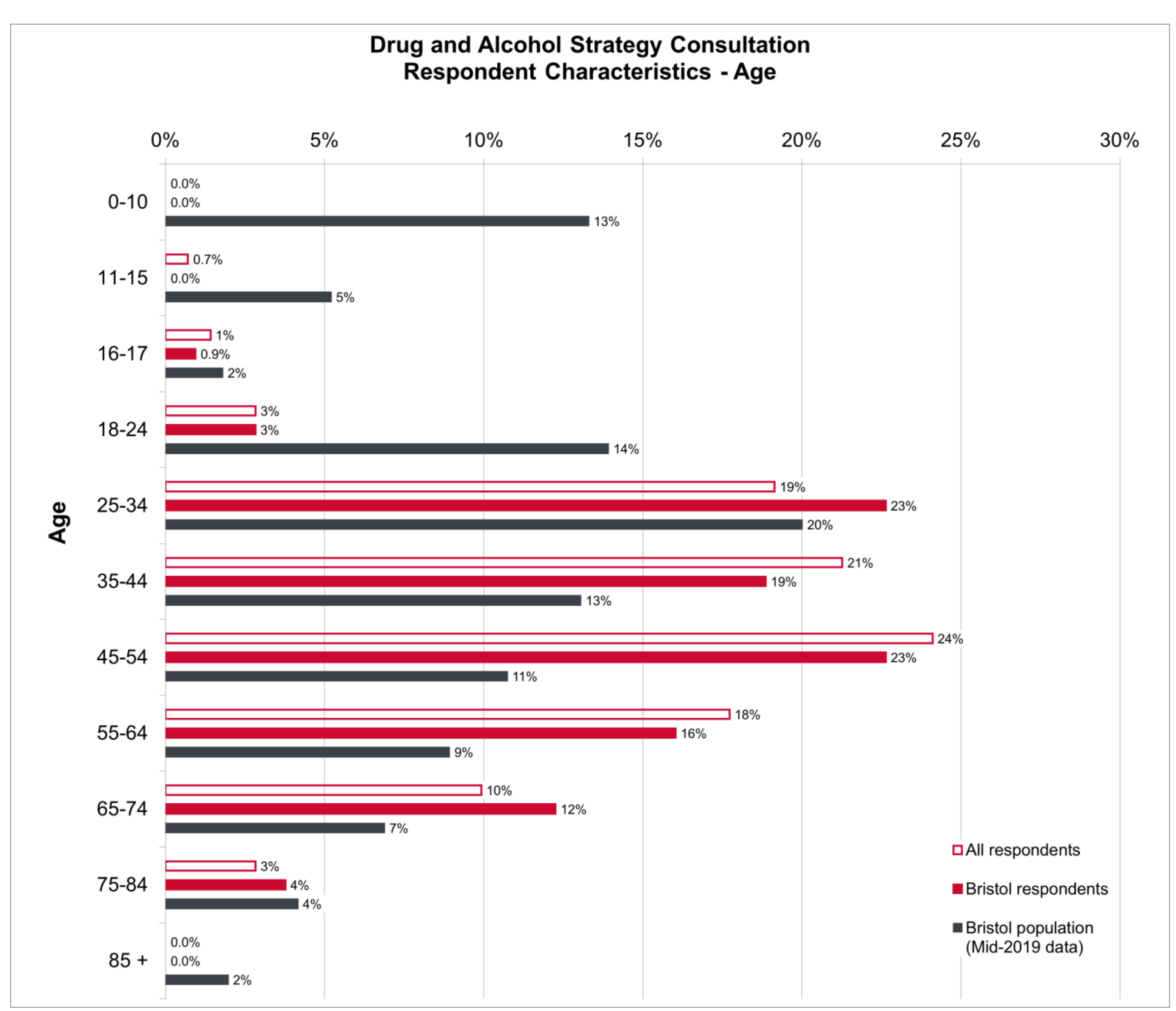
- Characteristics for all respondents who answered the equalities questions;
- Characteristics of respondents who provided a Bristol postcode;
- Characteristics of all Bristol citizens. This is available for five protected characteristics (age, sex, disability, ethnicity and religion/faith) for which population data are available from the 2011 Census and subsequent updates.

Note that many of the respondents who did not provide postcodes may also live in the Bristol administrative area, but are not included in figures for 'Bristol respondents'

Age

The highest number of responses were from respondents aged 45-54 years (24%), followed by 35-44 (21%).

Figure 4: Age of respondents



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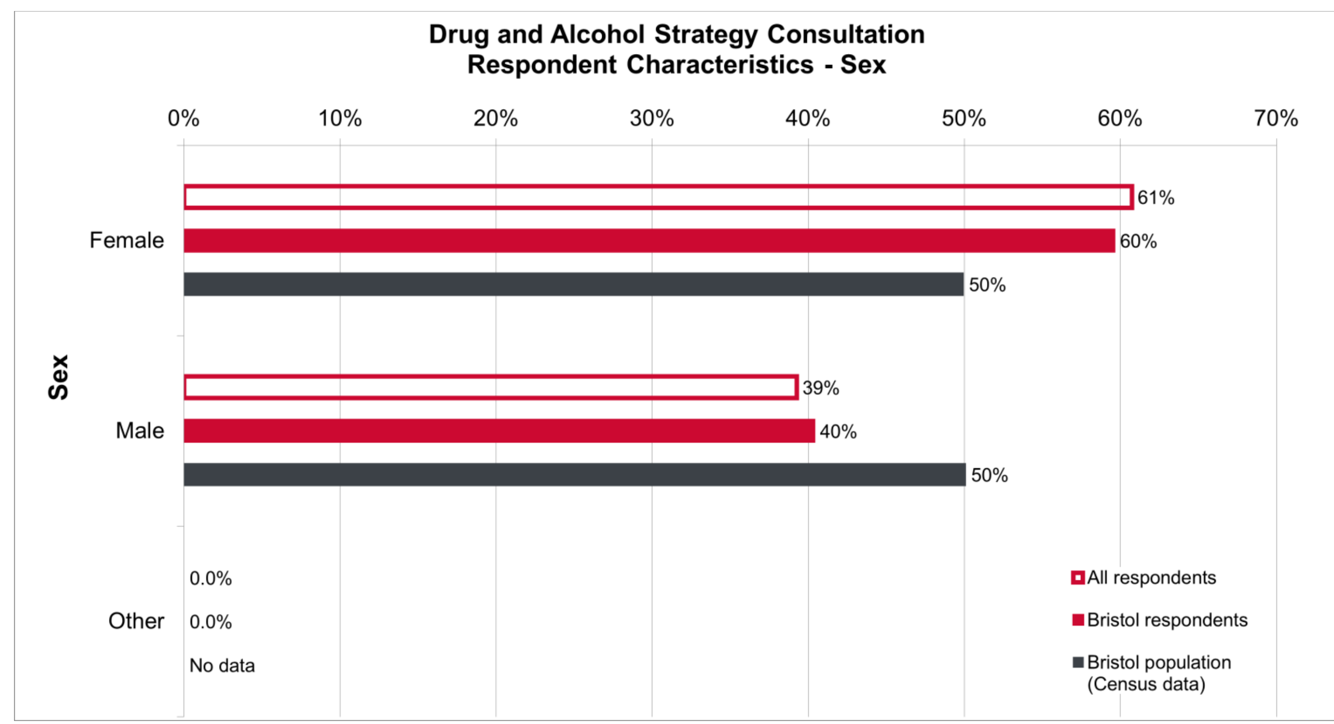
The proportion of responses in the age categories 25-34 years, 35-44, 45-54, 55-64 and 65-74 was higher than these age groups' proportion of the population in Bristol. Survey responses from children (under 18), young people aged 18-24 and people aged 75-84 and 85 and older were under-represented. In each age category, the proportions of 'all respondents' and 'Bristol respondents' were similar.

Sex

61% of all responses were from women and 39% were from men. 0.0% were from people who identified as 'other'. These percentages exclude the 6% of respondents (2.8% of Bristol respondents) who answered 'prefer not to say')

Figure 5: Sex of respondents



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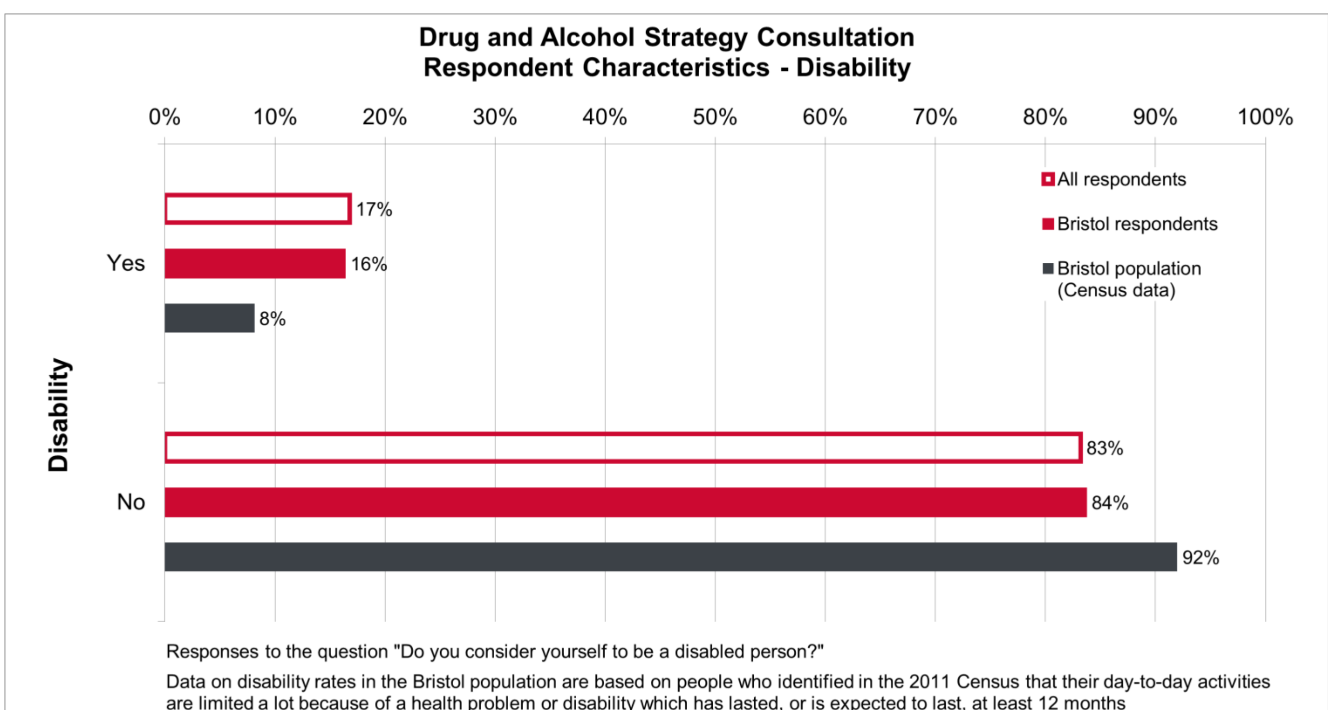
Disability

The proportion of disabled respondents (17%) is higher than the proportion of disabled people living in Bristol.These percentages exclude the 8.4% of respondents (7.5% of Bristol respondents) who answered 'prefer not to say')

Figure 6: Disability



Ethnicity

The response rate from White British respondents (82%), Other White respondents (9%) and Other Ethnic Backround respondents (1%) is higher than the proportion of these citizens in the Bristol population.

The proportion of White Irish people (0.7%) is just under the proportion of these citizens in the Bristol population.

All black, Asian and minority ethnic (BAME), mixed/multi-ethnic respondents and Gypsy, Roma and Traveller respondents were under-represented in the response rates compared to the proportion of BAME citizens and mixed/multi-ethnic citizens living in Bristol.

These percentages exclude the 4.9% of respondents (2.8% of Bristol respondents) who answered 'prefer not to say')

The proportion of each ethnicity for all respondents closely matches Bristol respondents.

Figure 7: Ethnicity of respondents

Drug and Alcohol Strategy Consultation Respondent Characteristics - Ethnicity

Ethnicity	All respondents	Bristol respondents	Bristol population (Census data)
White British	82%	87%	78%
White Irish	0.7%	0.0%	0.9%
White other	9%	7%	5%
Black /African / Caribbean / Black British	1%	1.0%	6%
Asian / Asian British	2%	3%	6%
Mixed / Multi ethnic group	3%	2%	4%
Gypsy / Roma / Irish Traveller	0.0%	0.0%	0.1%
Other ethnic background	1%	1.0%	0.9%

Religion/Faith

People with no religion (70% of respondents) responded in higher proportions than people of no religion in Bristol's population (41%). Buddhists (3%), and people of Other religions respondents (2%) also responded in greater numbers than the proportions of these faiths in Bristol.

Christians (23%), Muslims (0.8%), Hindus (0.0%), Jewish people (0.0%) and Sikhs (0.0%) were under-represented compared to the proportions of these faiths living in Bristol.

These percentages exclude the 9.1% of respondents (7.5% of Bristol respondents) who answered 'prefer not to say').

The proportion of each religion/faith for all respondents closely matches Bristol respondents.

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Figure 8: Religion/faith of respondents

Drug and Alcohol Strategy Consultation
Respondent Characteristics - Religion/faith

Religion/Faith	All respondents	Bristol respondents	Bristol population (Census data)
No Religion	70%	72%	41%
Christian	23%	21%	51%
Buddhist	3%	2%	0.6%
Hindu	0.0%	0.0%	0.7%
Jewish	0.0%	0.0%	0.2%
Muslim	0.8%	1%	6%
Sikh	0.0%	0.0%	0.5%
Pagan	0.8%	0.0%	No data
Other	2%	3%	0.7%

Other protected characteristics and refugee/asylum status

The survey also asked respondents about three other protected characteristics (sexual orientation, gender reassignment, pregnancy and recent maternity) and if they are a refugee or asylum seeker.

Census data are not available for the proportion of people with these characteristics living in Bristol. Figures 9, 10, 11 and 12 show the proportions of all respondents and Bristol respondents for each of these characteristics. The proportion of each characteristic for all respondents closely matches the proportion for Bristol respondents.

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Figure 9: Sexual orientation

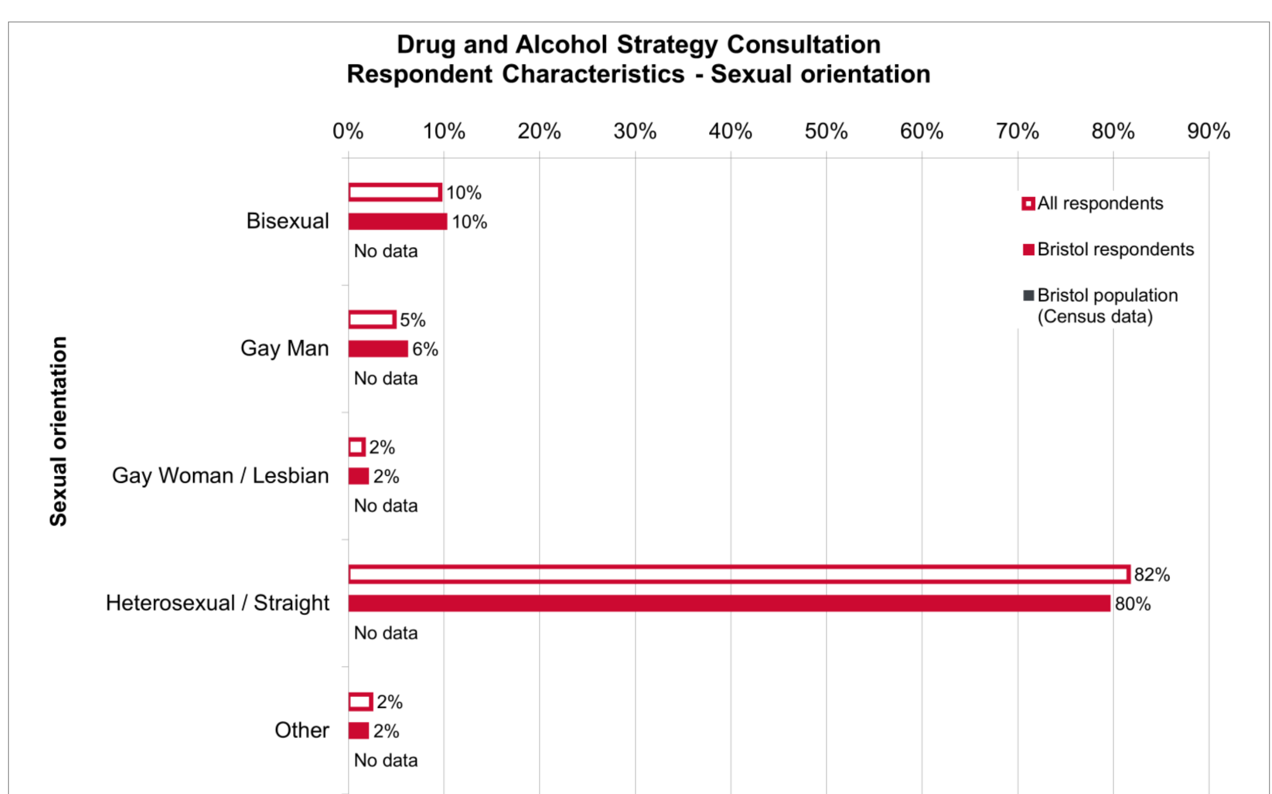


Figure 10: Gender reassignment

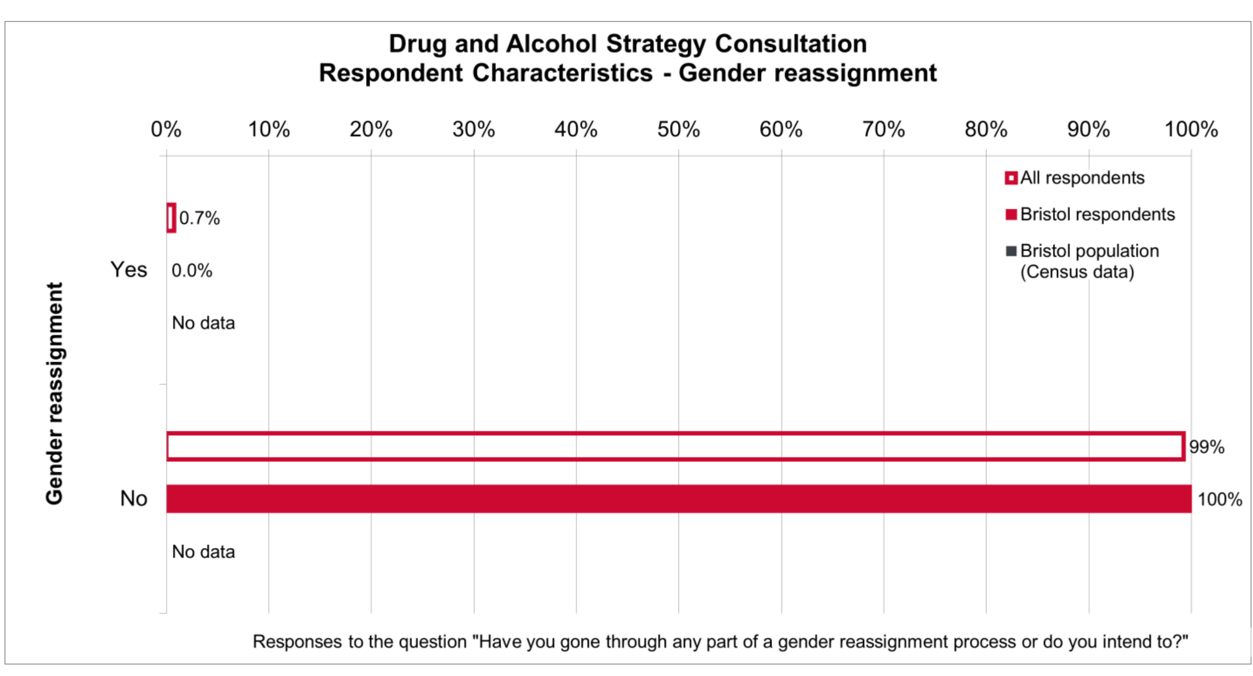


Figure 11: Pregnancy/Maternity

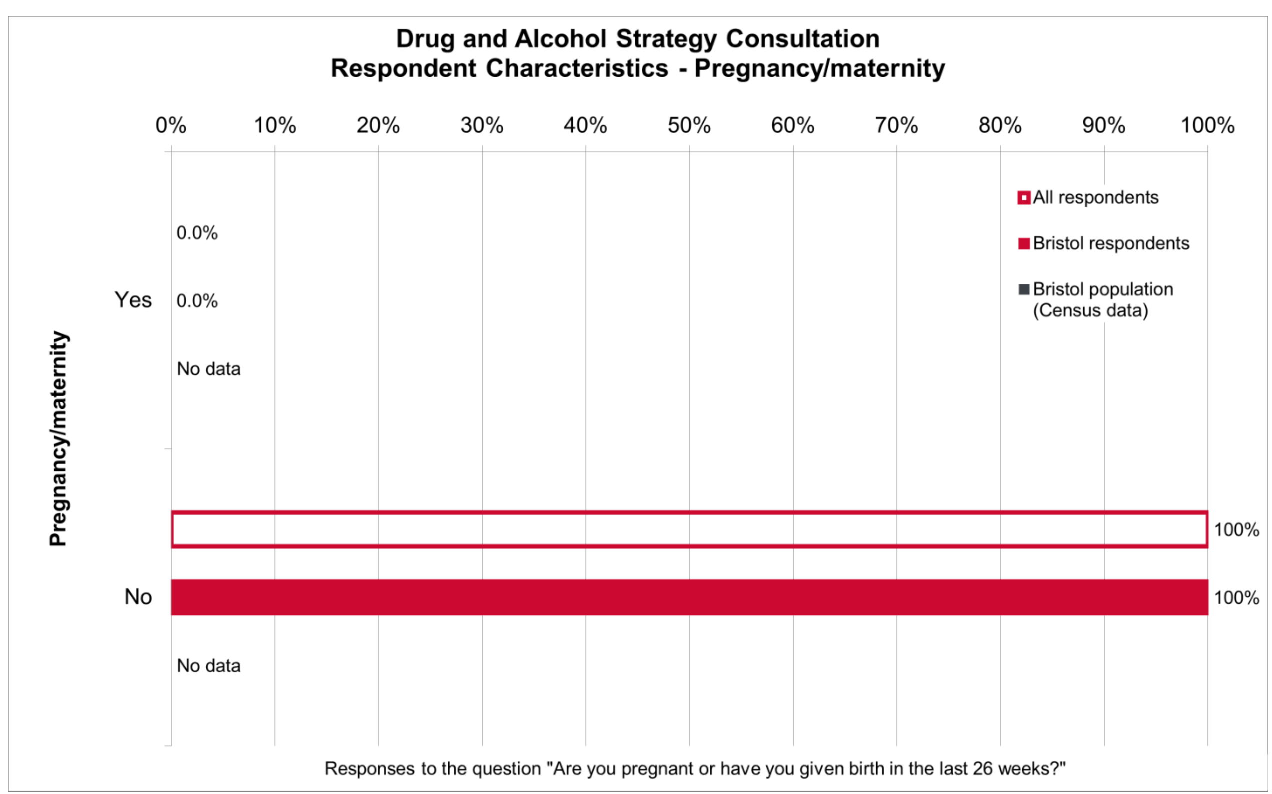
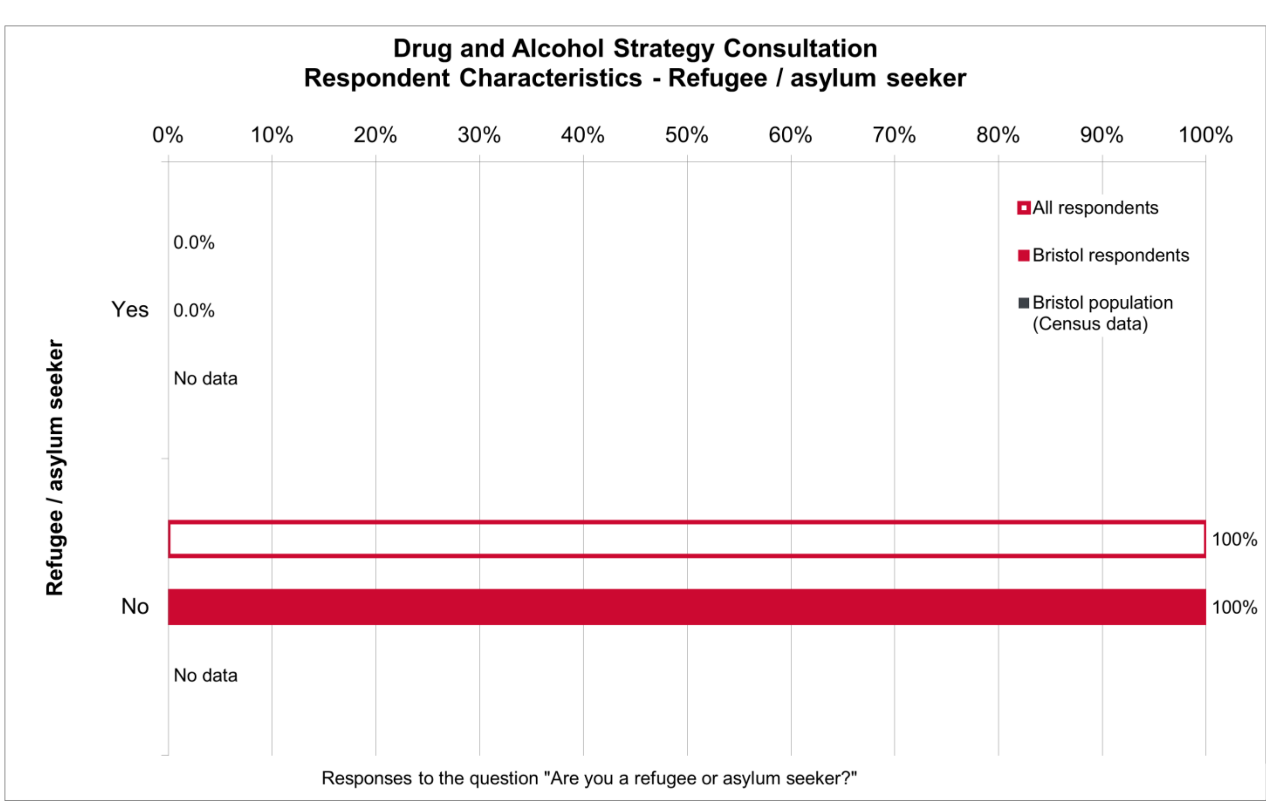
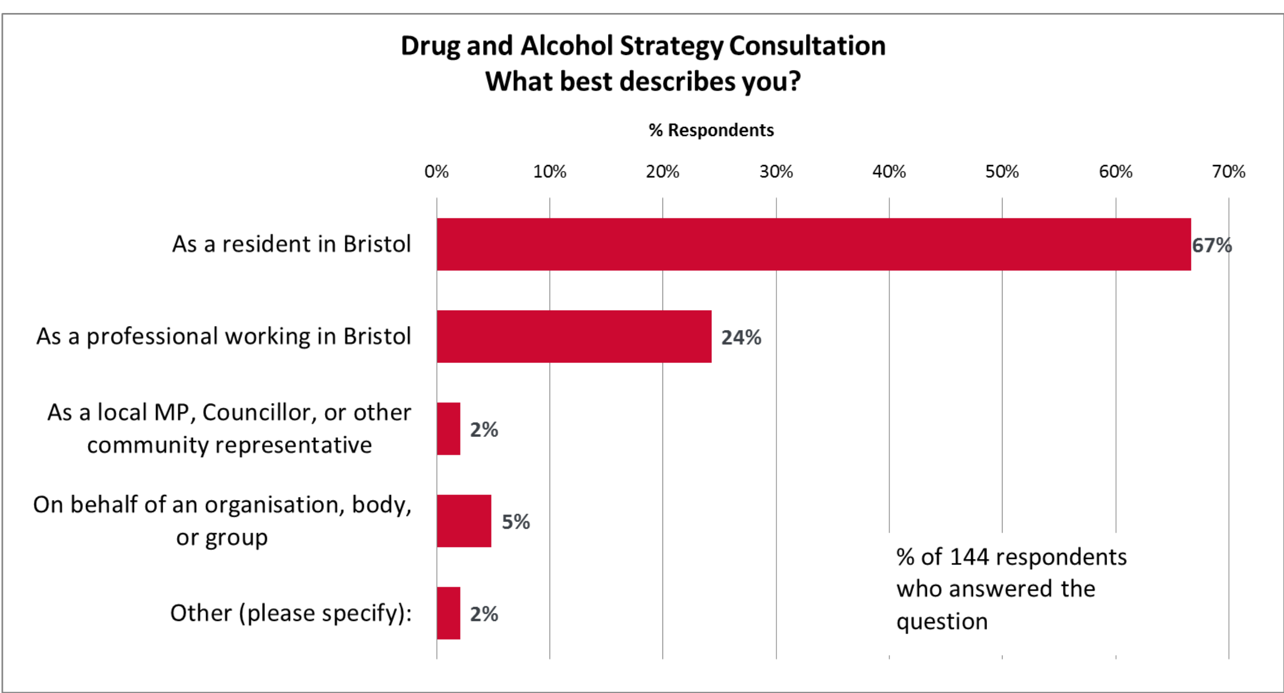


Figure 12: Refugee or asylum seeker



Other respondent characteristics

Figure 13



144 (96%) respondents provided other details of their personal situation, selecting from the following list of 11 options:

- 96 (67% of the 144 respondents who answered the question) are Bristol residents;
- 35 (24%) are professionals working in Bristol;
- 3 (2%) responded as a local MP, Councillor or other community representative
- 7 (5%) responded on behalf of an organisation, body or group
- 3 (2%) responded in another capacity

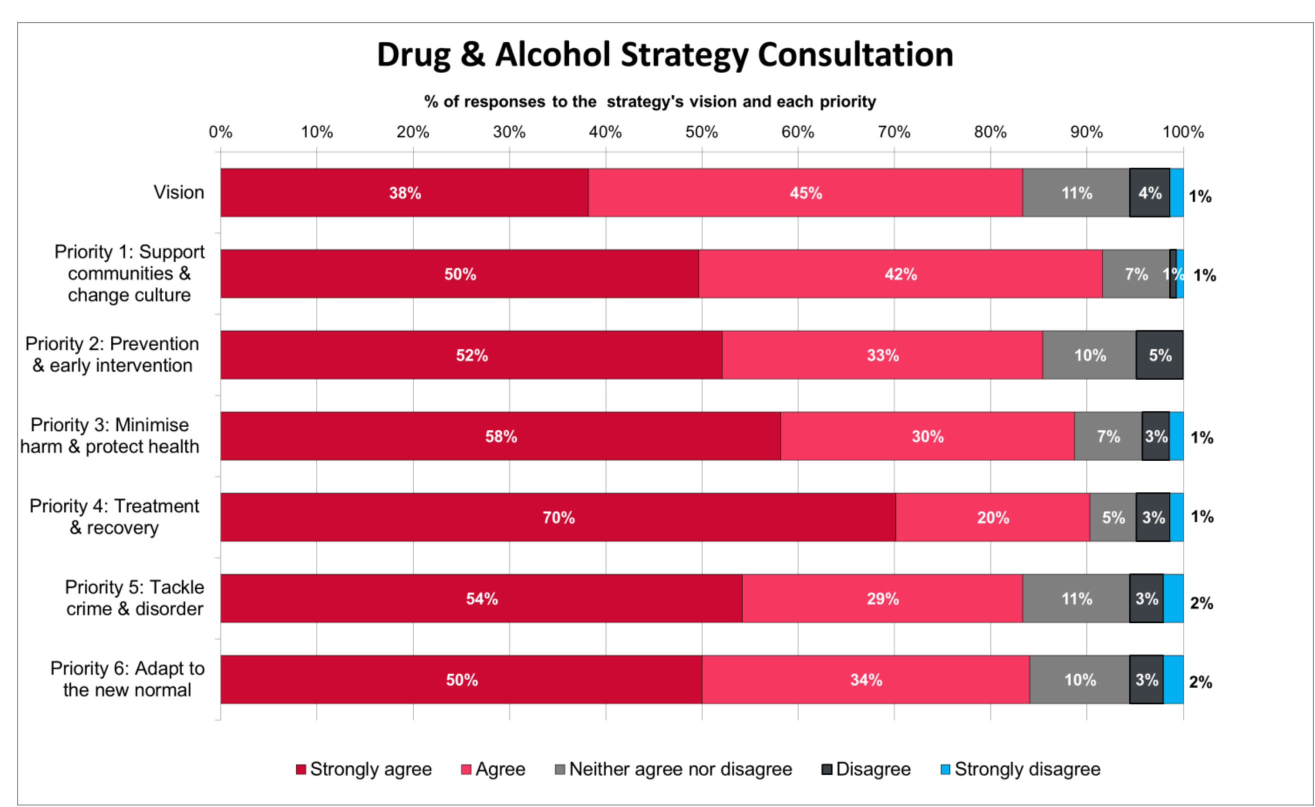
4 Survey results: Drug and Alcohol Strategy Vision and Priorities

4.1 Drug and Alcohol Strategy Vision and Priorities – all respondents

Respondents were asked to state the extent to which they agree or disagree with the Drug and Alcohol Strategy's vision and the following six priorities (Figure 14):

- Priority 1: Support communities and change culture
- Priority 2: Prevention and early intervention
- Priority 3: Minimise harm and protect health
- Priority 4: Treatment and recovery
- Priority 5: Tackle crime and disorder
- Priority 6: Adapt to the new normal

Figure 14: Agreement or disagreement with the Drug and Alcohol Strategy Vision and Priorities



144 (96%) respondents expressed a view on the Drug and Alcohol Strategy's vision, of these:

- 55 (38%) of respondents strongly agree with the vision
- 65 (45%) of respondents agree with the vision
- 16 (11%) of respondents neither agree nor disagree with the vision
- (4%) of respondents disagree with the vision

- 2 (1%) of respondents strongly disagree with the vision

143 (95%) respondents expressed a view on the Drug and Alcohol Strategy's Priority 1: Support communities and change culture. Of these:

- 71 (50%) of respondents strongly agree with this priority
- 60 (42%) of respondents agree with this priority
- 10 (7%) of respondents neither agree nor disagree with this priority
- 1 (1%) of respondents disagree with this priority
- 1 (1%) of respondents strongly disagree with this priority

144 (96%) respondents expressed a view on the Drug and Alcohol Strategy's Priority 2: Prevention and early intervention. Of these:

- 75 (52%) of respondents strongly agree with this priority
- 48 (33%) of respondents agree with this priority
- 14 (10%) of respondents neither agree nor disagree with this priority
- 7 (5%) of respondents disagree with this priority
- 0 (0%) of respondents strongly disagree with this priority

141 (94%) respondents expressed a view on the Drug and Alcohol Strategy's Priority 3: Minimise harm and protect health. Of these:

- 82 (58%) of respondents strongly agree with this priority
- 43 (30%) of respondents agree with this priority
- 10 (7%) of respondents neither agree nor disagree with this priority
- (3%) of respondents disagree with this priority
- 2 (1%) of respondents strongly disagree with this priority

144 (96%) respondents expressed a view on the Drug and Alcohol Strategy's Priority 4: Treatment and recovery. Of these:

- 101 (70%) of respondents strongly agree with this priority
- 29 (20%) of respondents agree with this priority

- 7 (5%) of respondents neither agree nor disagree with this priority
- (3%) of respondents disagree with this priority
- 2 (1%) of respondents strongly disagree with this priority

144 (96%) respondents expressed a view on the Drug and Alcohol Strategy's Priority 5: Tackle crime and disorder. Of these:

- 78 (54%) of respondents strongly agree with this priority
- 42 (29%) of respondents agree with this priority
- 16 (11%) of respondents neither agree nor disagree with this priority
- (3%) of respondents disagree with this priority
- 3 (2%) of respondents strongly disagree with this priority

144 (96%) respondents expressed a view on the Drug and Alcohol Strategy's Priority 6: Adapt to the new normal. Of these:

- 72 (50%) of respondents strongly agree with this priority
- 49 (34%) of respondents agree with this priority
- 15 (10%) of respondents neither agree nor disagree with this priority
- (3%) of respondents disagree with this priority
- (2%) of respondents strongly disagree with this priority

4.2 Views on The Drug and Alcohol Strategy Vision and Values with different levels of deprivation

Respondents' agreement or disagreement on the Drug and Alcohol Strategy's vision and values were compared for respondents from areas with different levels of deprivation (figures 14 to 20). The comparison used the postcodes provided by respondents in Bristol to match each response to one of 10 deprivation bands (deciles) as described in section 3.3.

Each chart shows the percentage of respondents who either agree / strongly agree, neither agree nor disagree or disagree / strongly disagree with either the strategy's vision or its priorities. The charts compare respondents' views in the most deprived 20% areas of Bristol (deciles 1 & 2), respondents' views in the least deprived 20% areas of Bristol (deciles 9 & 10) and all Bristol respondents' views.

Figure 14

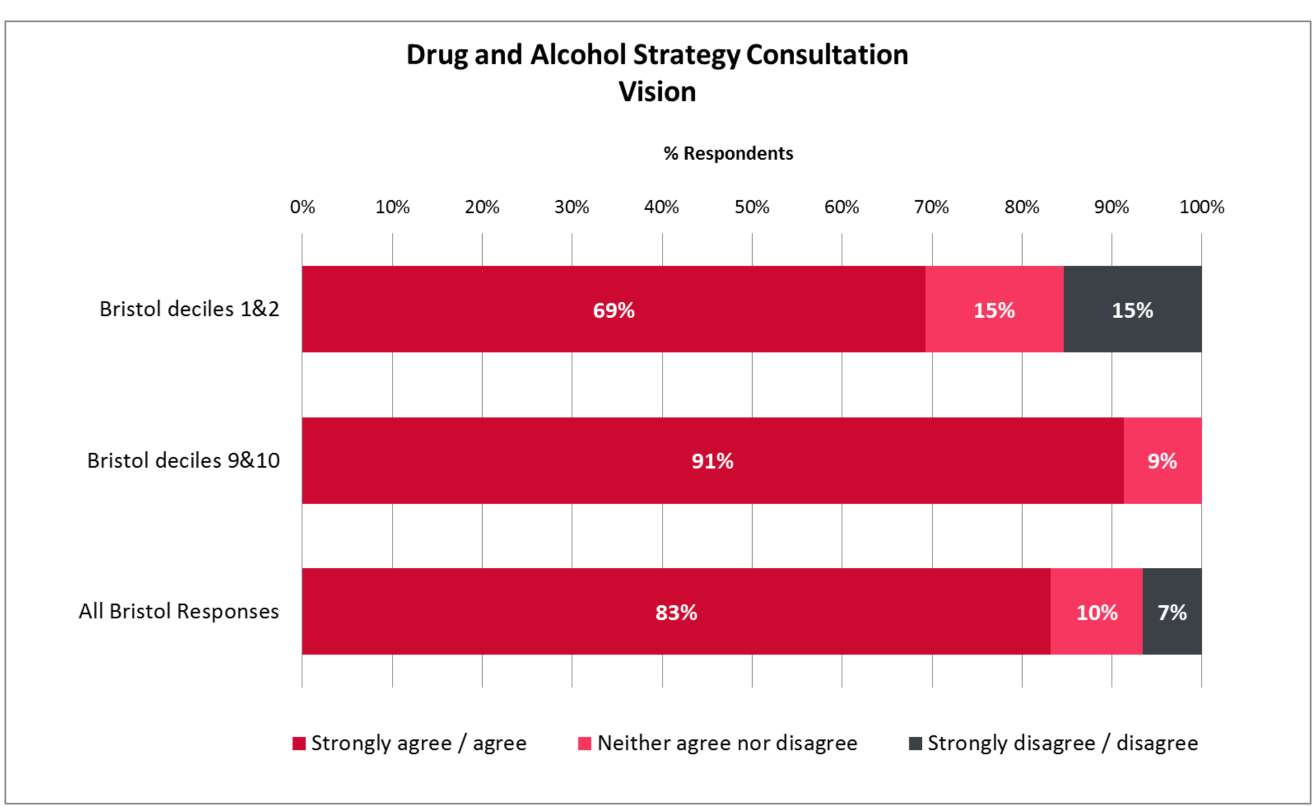


Figure 14 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's vision. This is based on 13 respondents from deciles 1 and 2, 23 respondents from deciles 9 and 10 and 107 Bristol respondents. Figure 14 shows that there is much higher support for the strategy's vision in the 20% least deprived areas of Bristol (91%) than in the 20% most deprived areas of Bristol (69%).

Figure 15

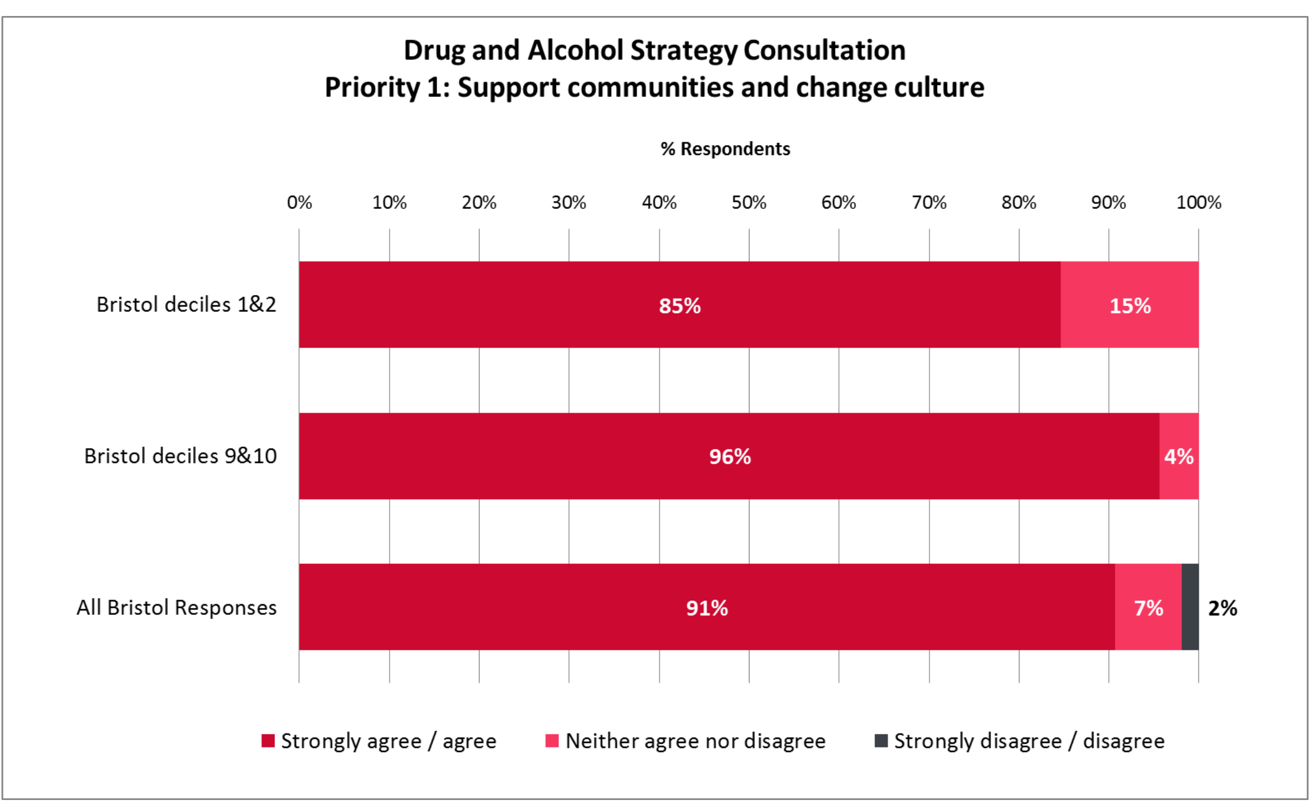


Figure 15 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's Priority 1. This is based on 13 respondents from deciles 1 and 2, 23 respondents from deciles 9 and 10 and 107 Bristol respondents. Figure 15 shows that there is higher support for Priority 1 in the 20% least deprived areas of Bristol (96%) than in the 20% most deprived areas of Bristol (85%).

Figure 16

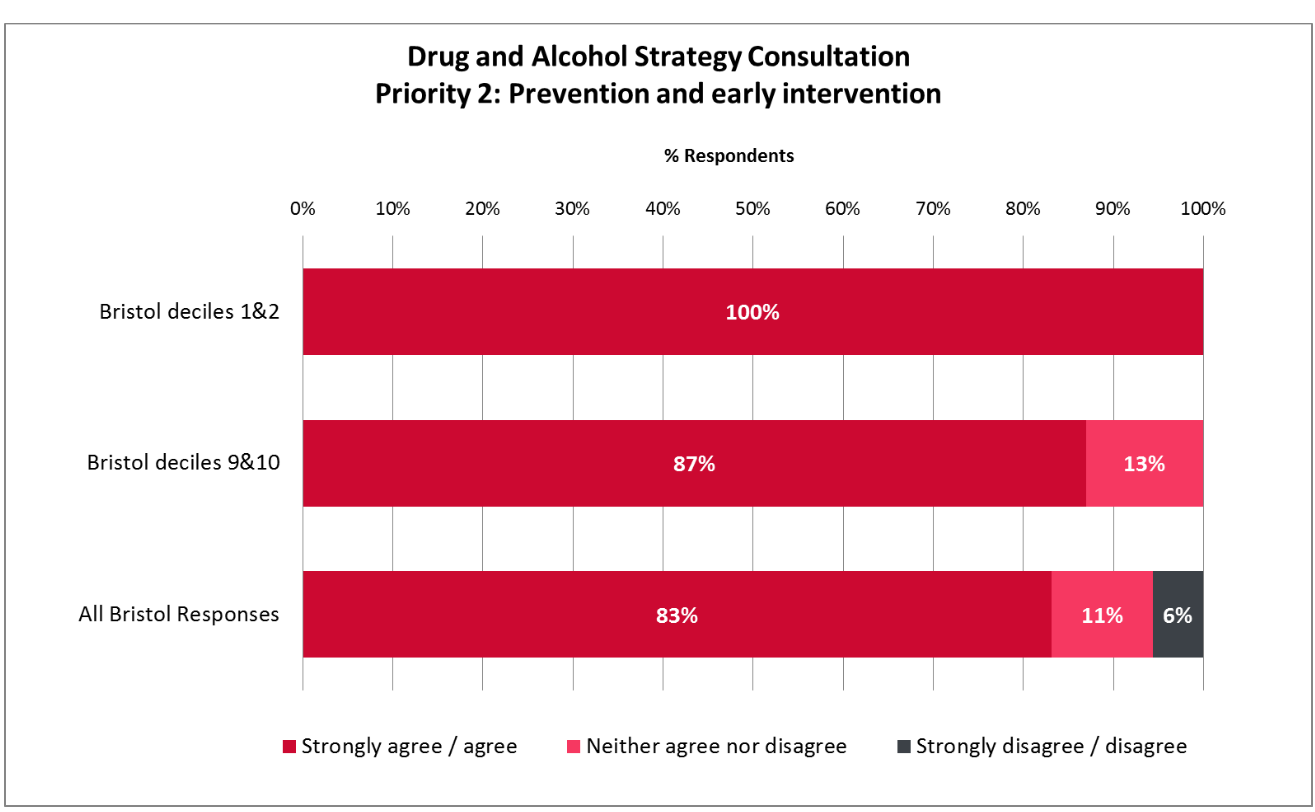


Figure 16 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's Priority 2. This is based on 13 respondents from deciles 1 and 2, 23 respondents from deciles 9 and 10 and 107 Bristol respondents. Figure 16 shows that there is much higher support for Priority 2 in the 20% most deprived areas of Bristol (100%) than in the 20% least deprived areas of Bristol (87%).

Figure 17

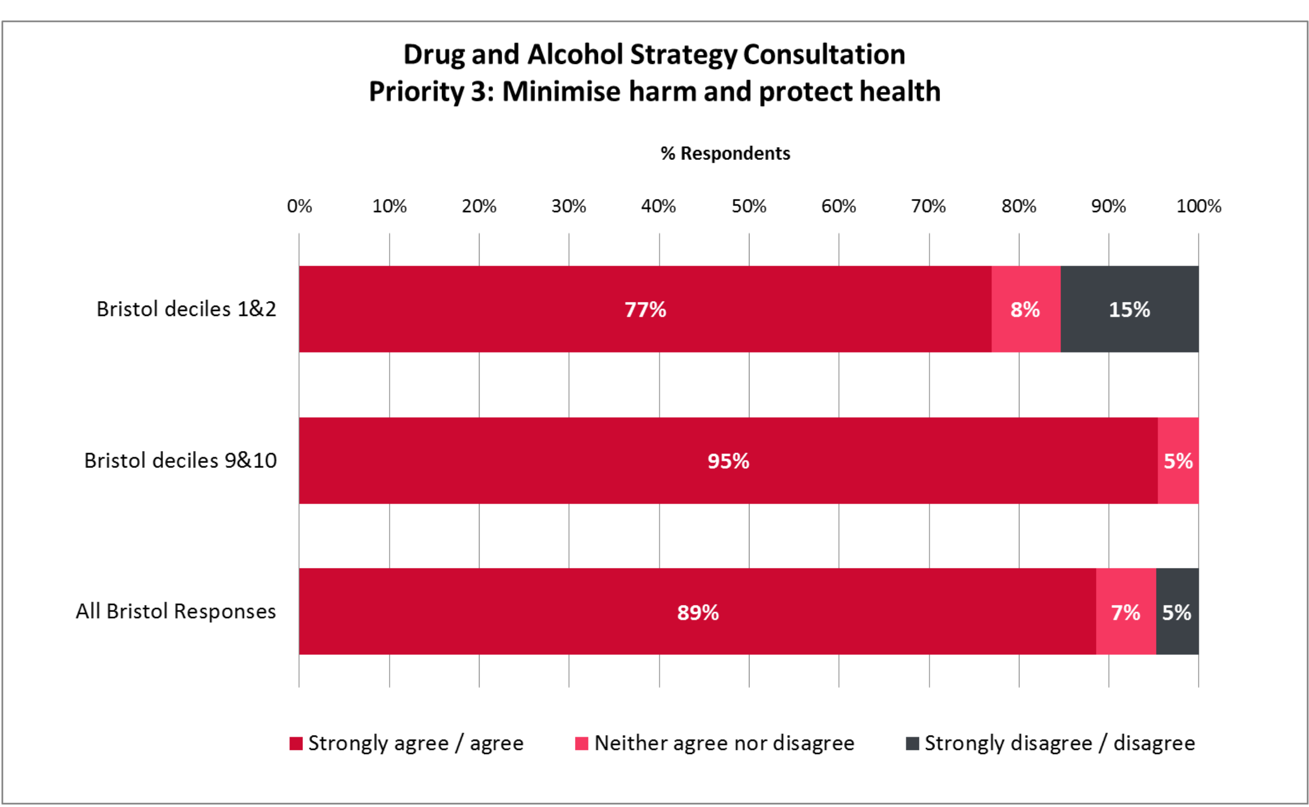


Figure 17 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's Priority 3. This is based on 13 respondents from deciles 1 and 2, 22 respondents from deciles 9 and 10 and 105 Bristol respondents. Figure 17 shows that there is higher support for Priority 3 in the 20% least deprived areas of Bristol (95%) than in the 20% most deprived areas of Bristol (77%).

Figure 18

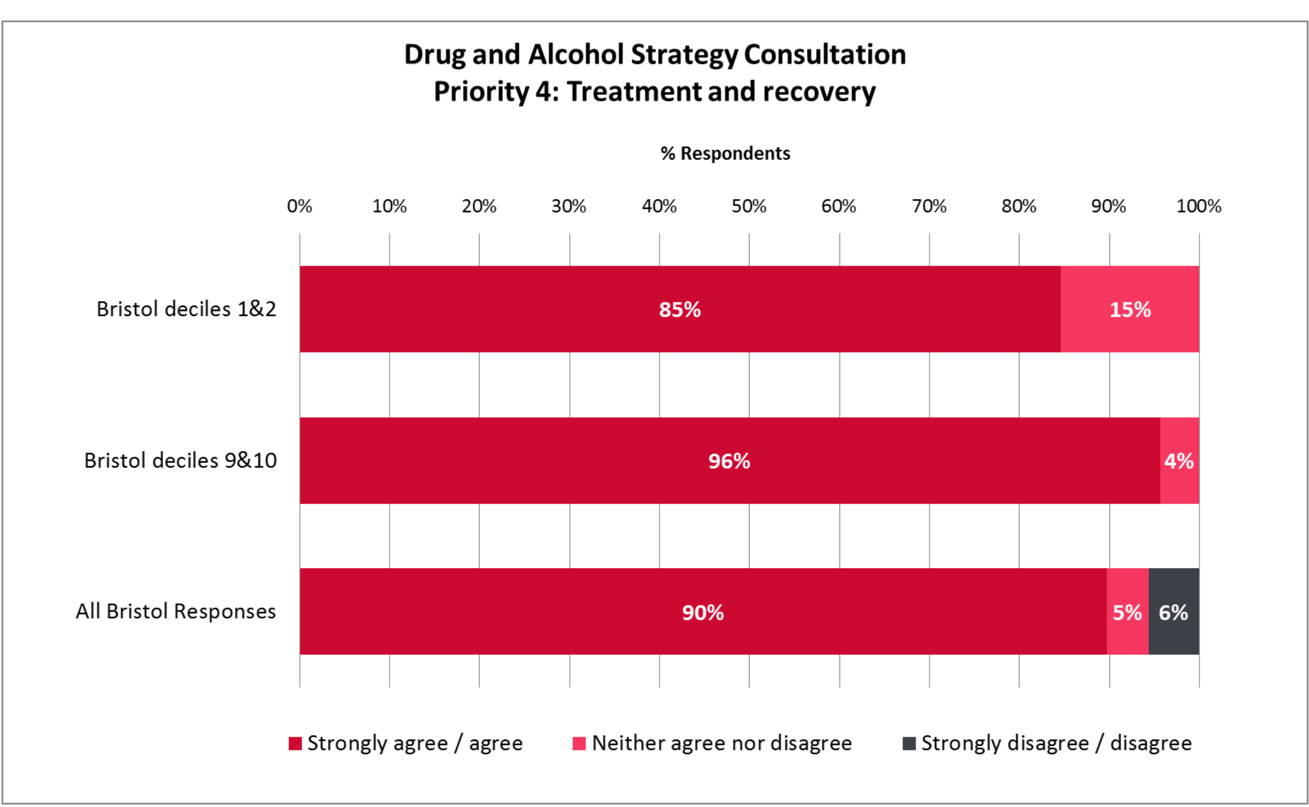


Figure 18 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's Priority 4. This is based on 13 respondents from deciles 1 and 2, 23 respondents from deciles 9 and 10 and 107 Bristol respondents. Figure 18 shows that there is higher support for Priority 4 in the 20% least deprived areas of Bristol (96%) than in the 20% most deprived areas of Bristol (85%).

Figure 19

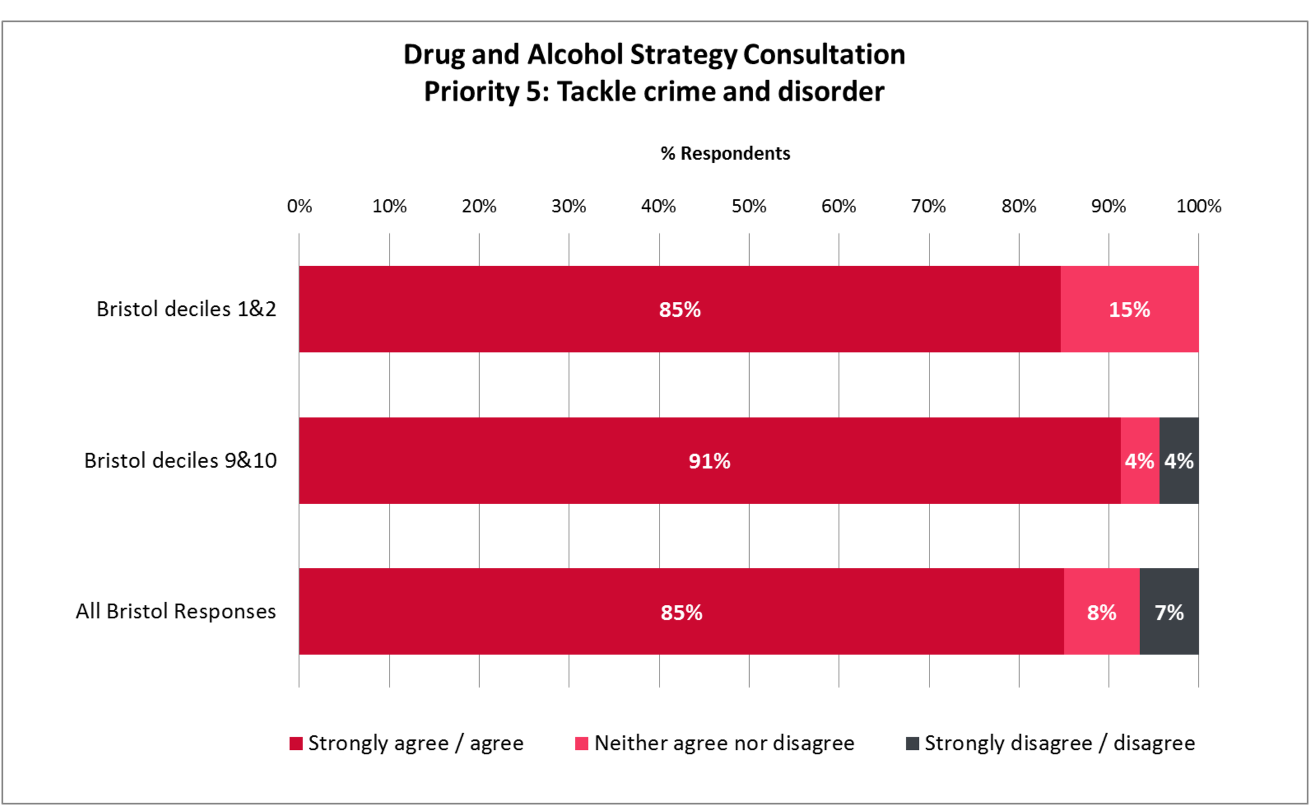


Figure 19 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's Priority 5. This is based on 13 respondents from deciles 1 and 2, 23 respondents from deciles 9 and 10 and 107 Bristol respondents. Figure 19 shows that there is higher support for Priority 5 in the 20% least deprived areas of Bristol (91%) than in the 20% most deprived areas of Bristol (85%).

Figure 20

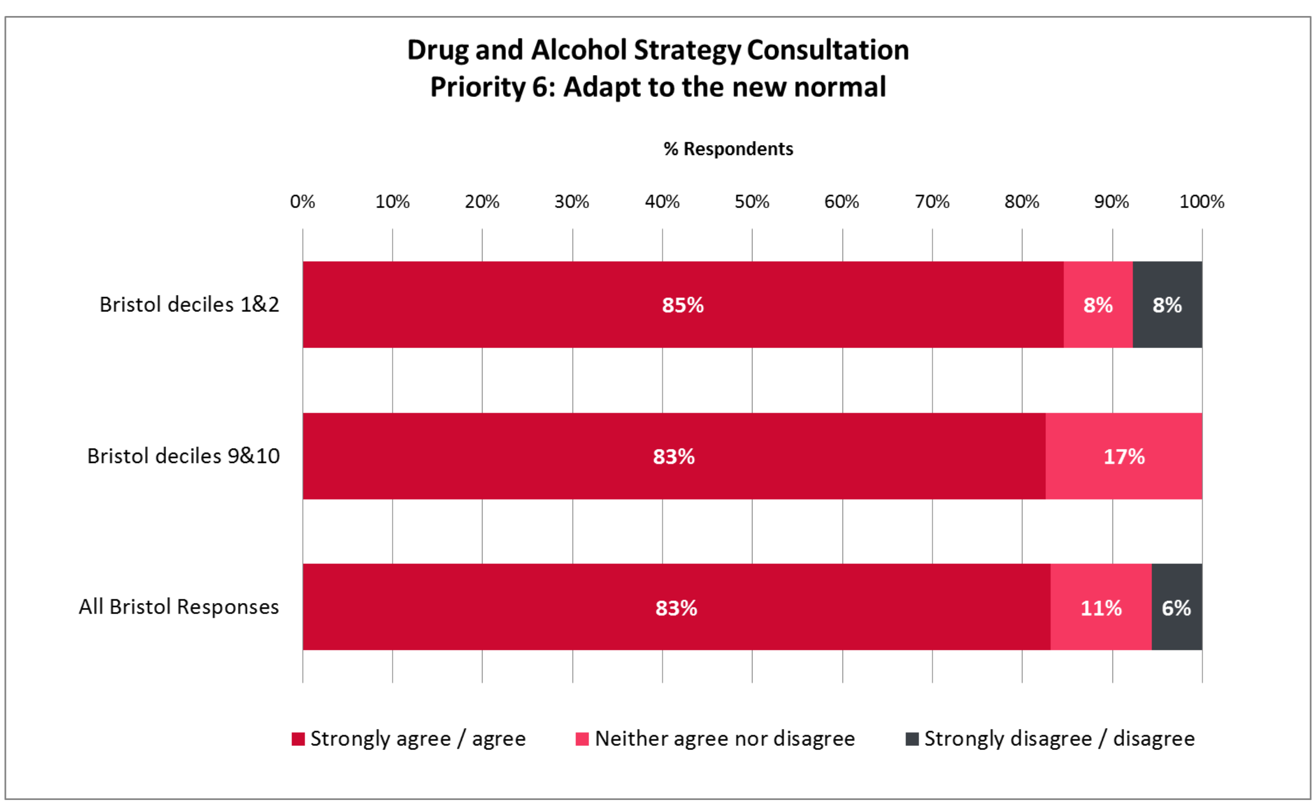


Figure 20 shows the percentage of respondents from deciles 1 and 2, deciles 9 and 10 and all Bristol respondents who stated their views on the Drug and Alcohol Strategy's Priority 6. This is based on 13 respondents from deciles 1 and 2, 23 respondents from deciles 9 and 10 and 107 Bristol respondents. Figure 20 shows that there is a slightly lower level of support for Priority 6 in the 20% least deprived areas of Bristol (83%) compared with the 20% most deprived areas of Bristol (85%).

4.3 Views on The Drug and Alcohol Strategy Vision and Values – other characteristics

Respondents' level of agreement or disagreement with the Drug and Alcohol Strategy's vision and values was also compared for respondents from BME and non BME background, respondents who described themselves as disabled compared with those who did not and respondents who identified as LGBT compared with respondents who identified as heterosexual / straight.

Figures 21 to 41 show the proportion of respondents who either agree / strongly agree, neither agree nor disagree or disagree / strongly disagree with the vision or values from each characteristic.

Figure 21 Ethnicity - Vision

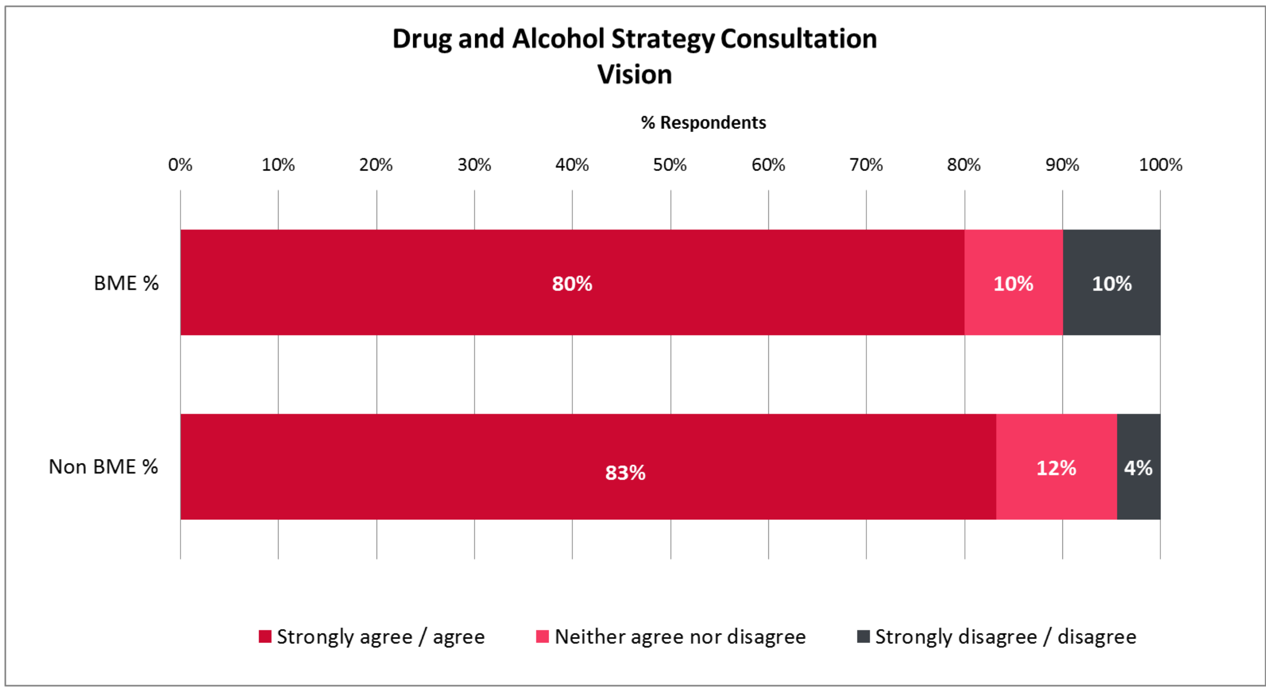


Figure 22 Ethnicity - Priority 1

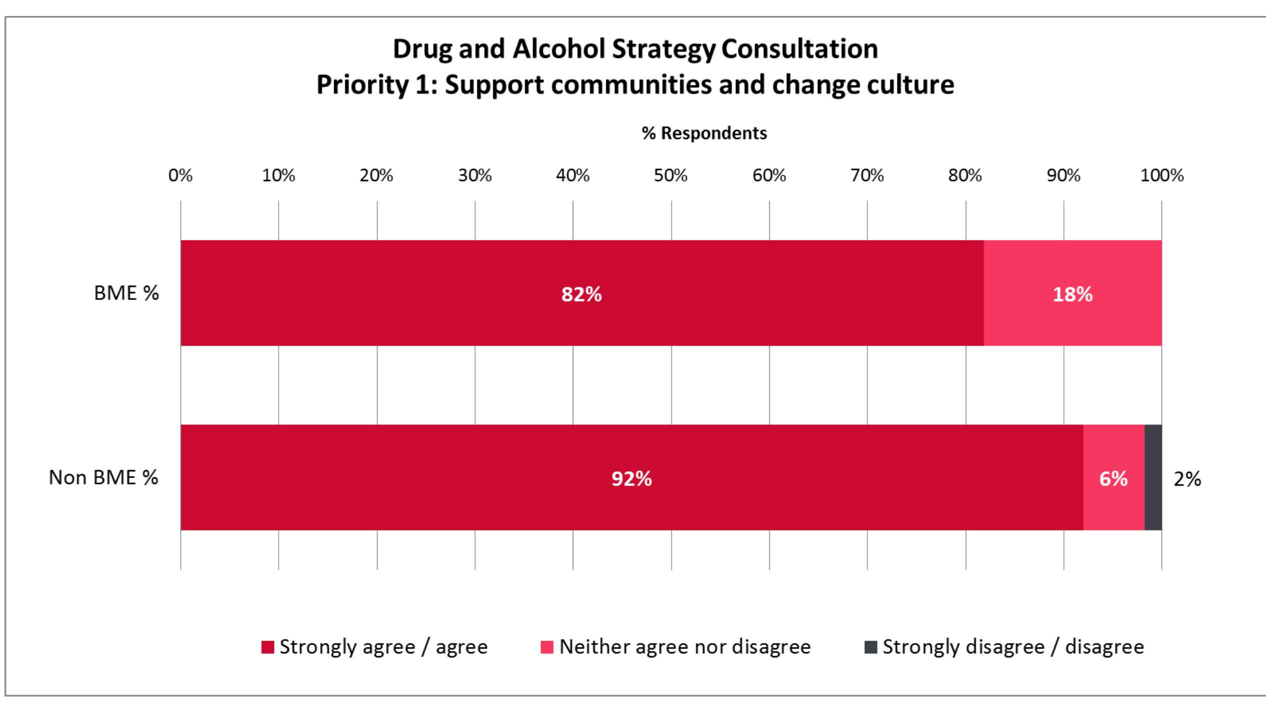


Figure 23 Ethnicity - Priority 2

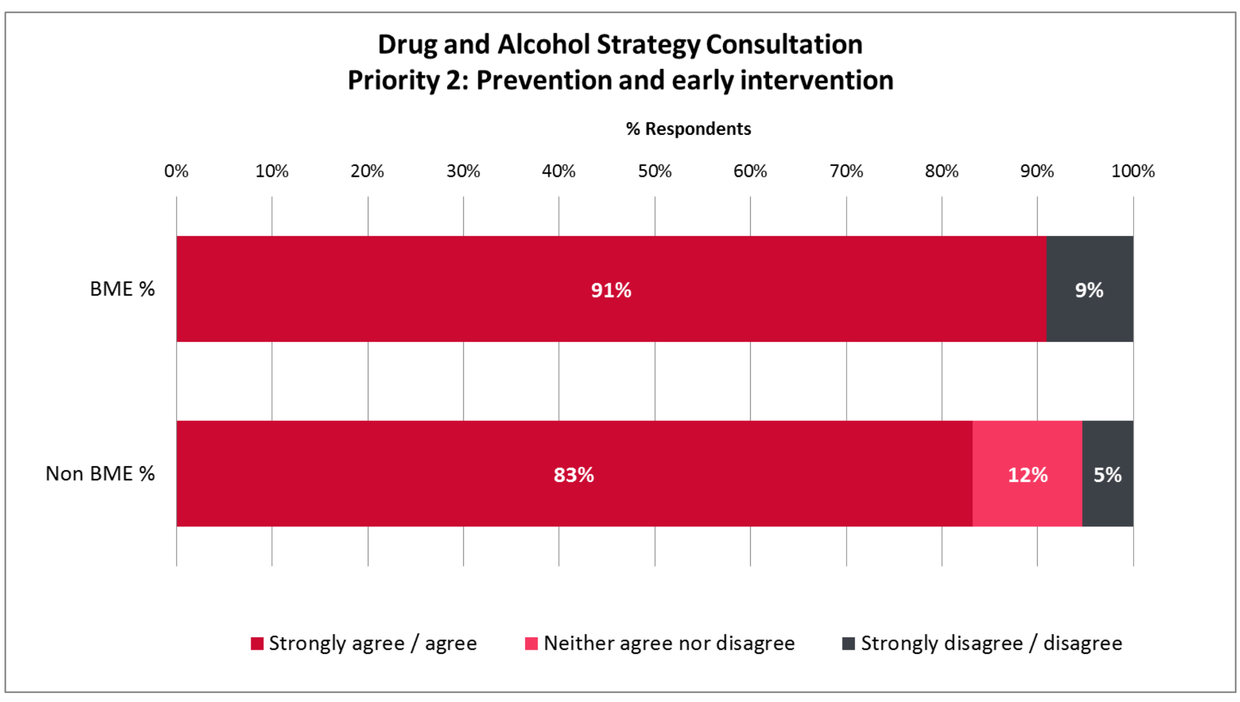


Figure 24 Ethnicity - Priority 3

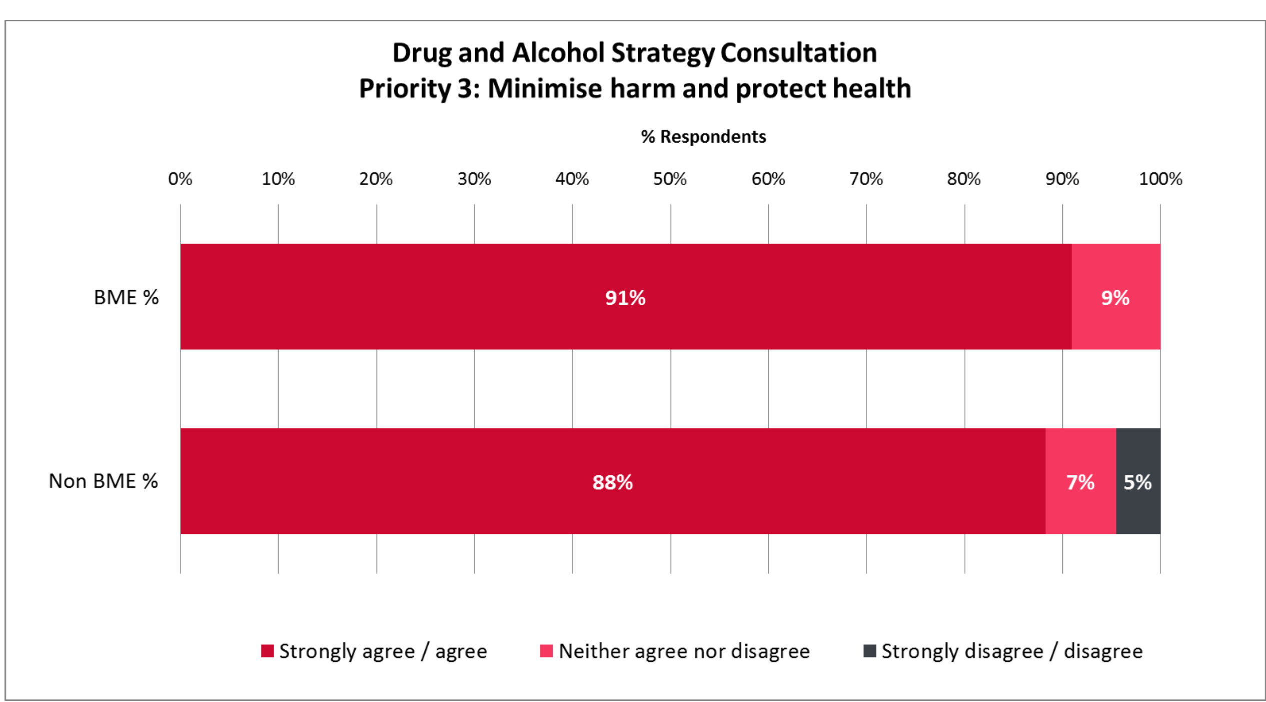


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Figure 25 Ethnicity - Priority 4

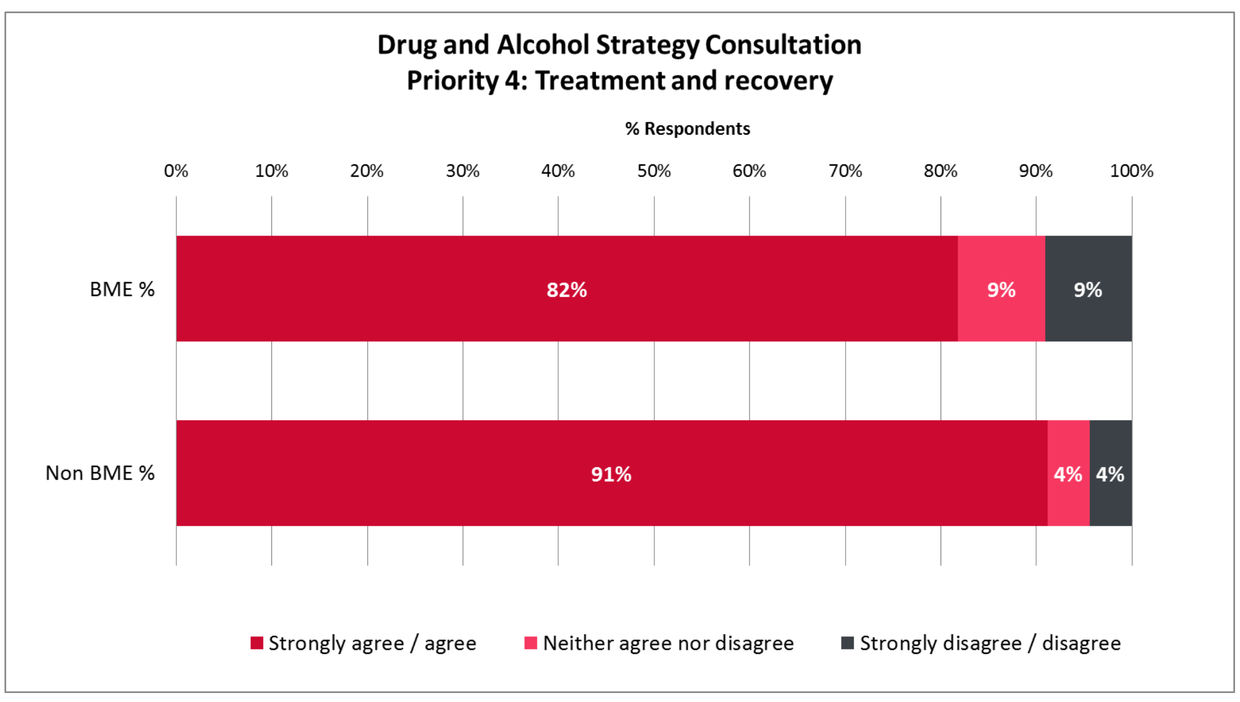

Figure 26 Ethnicity - Priority 5

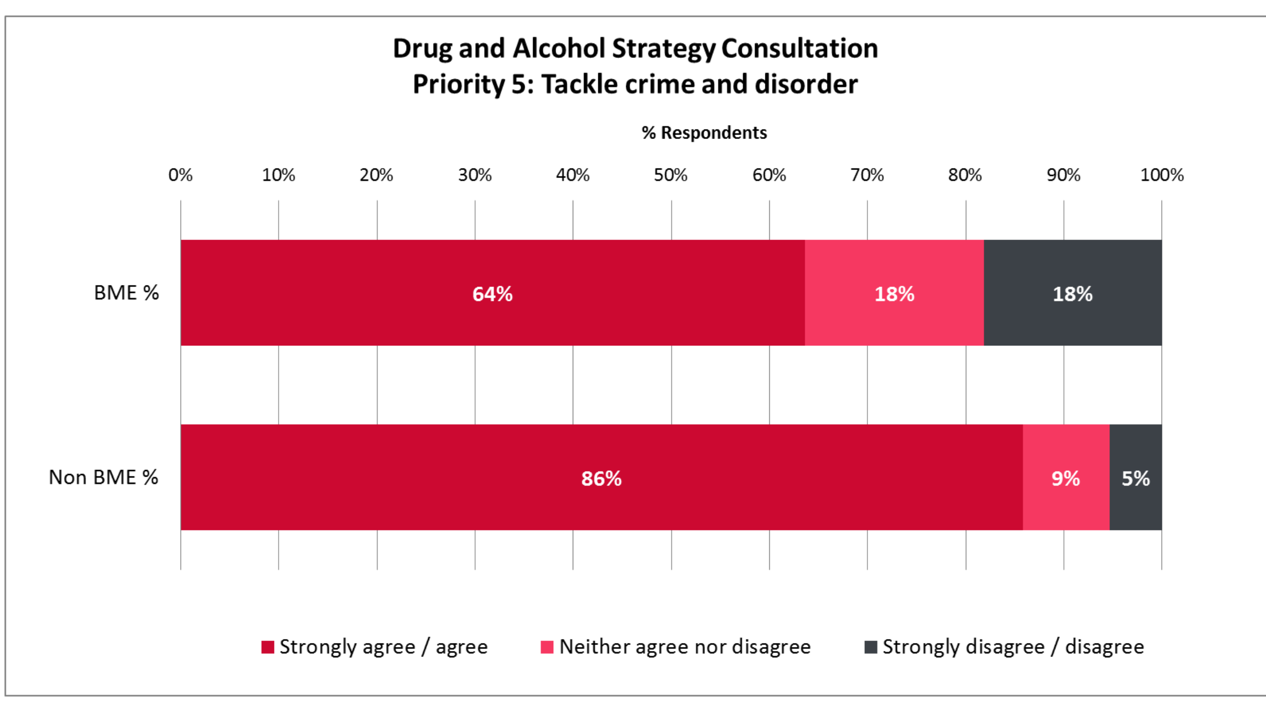

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Figure 27 Ethnicity - Priority 6

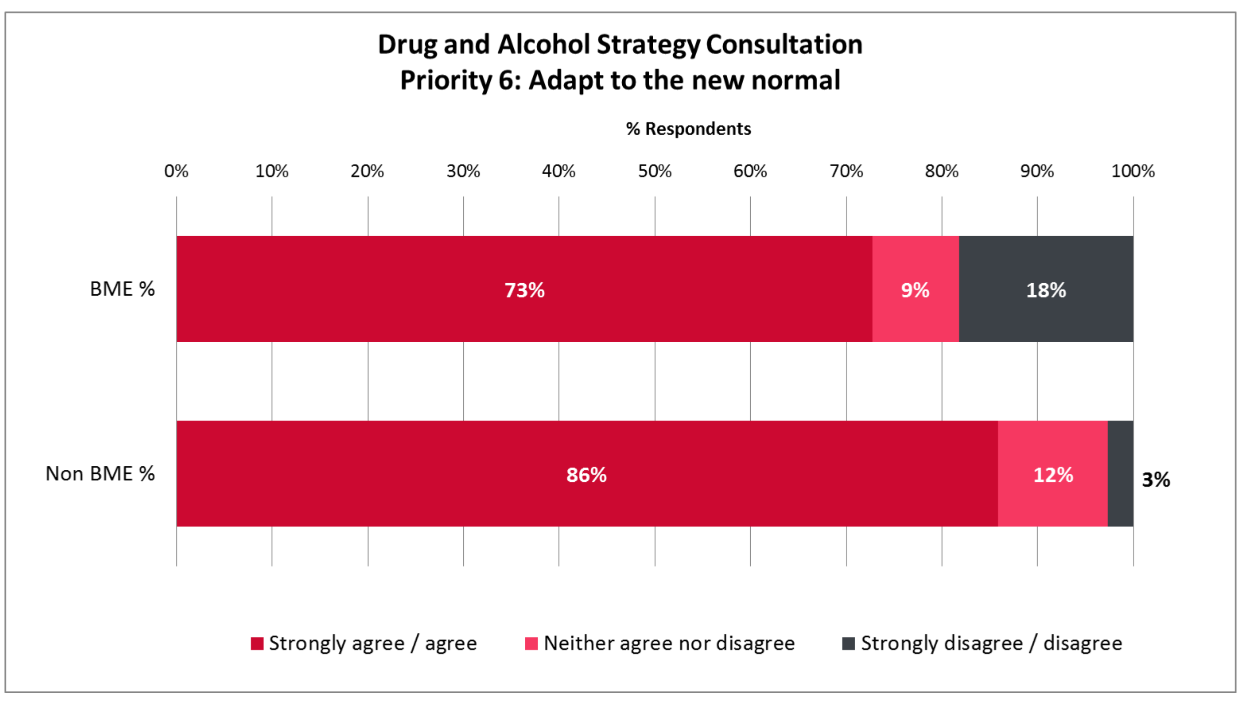

Figure 28 Disability - Vision

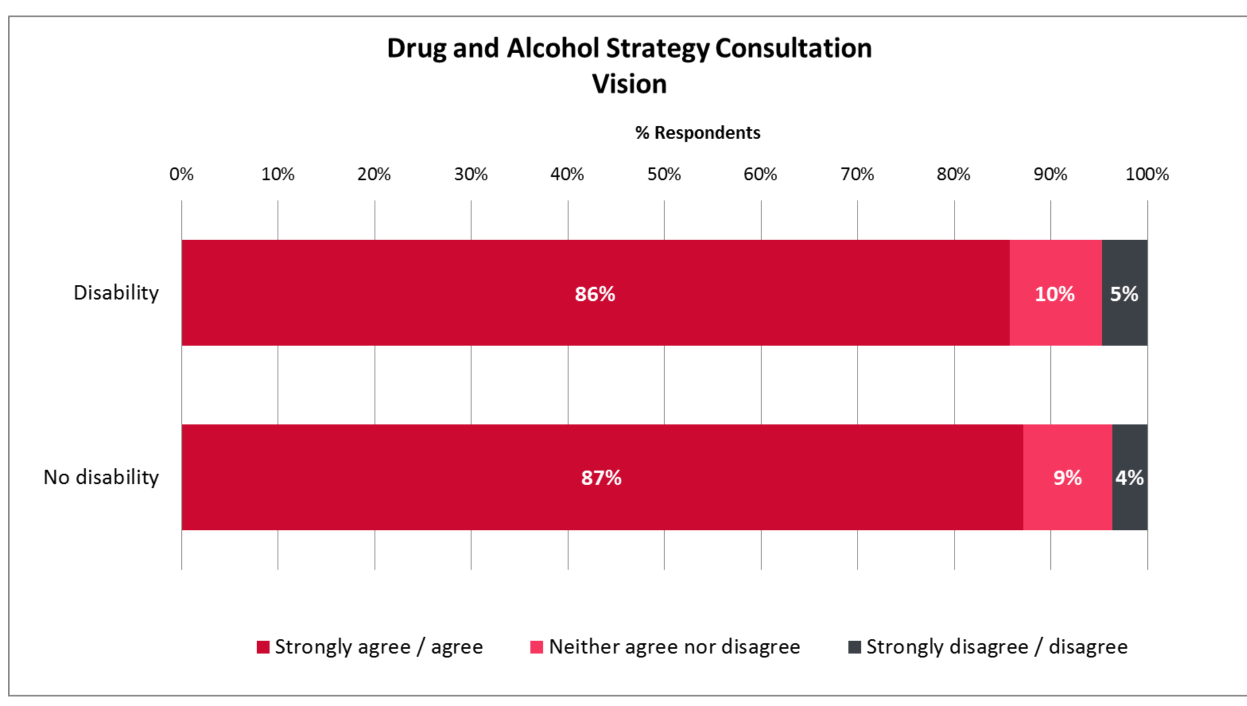

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Figure 29 Disability - Priority 1

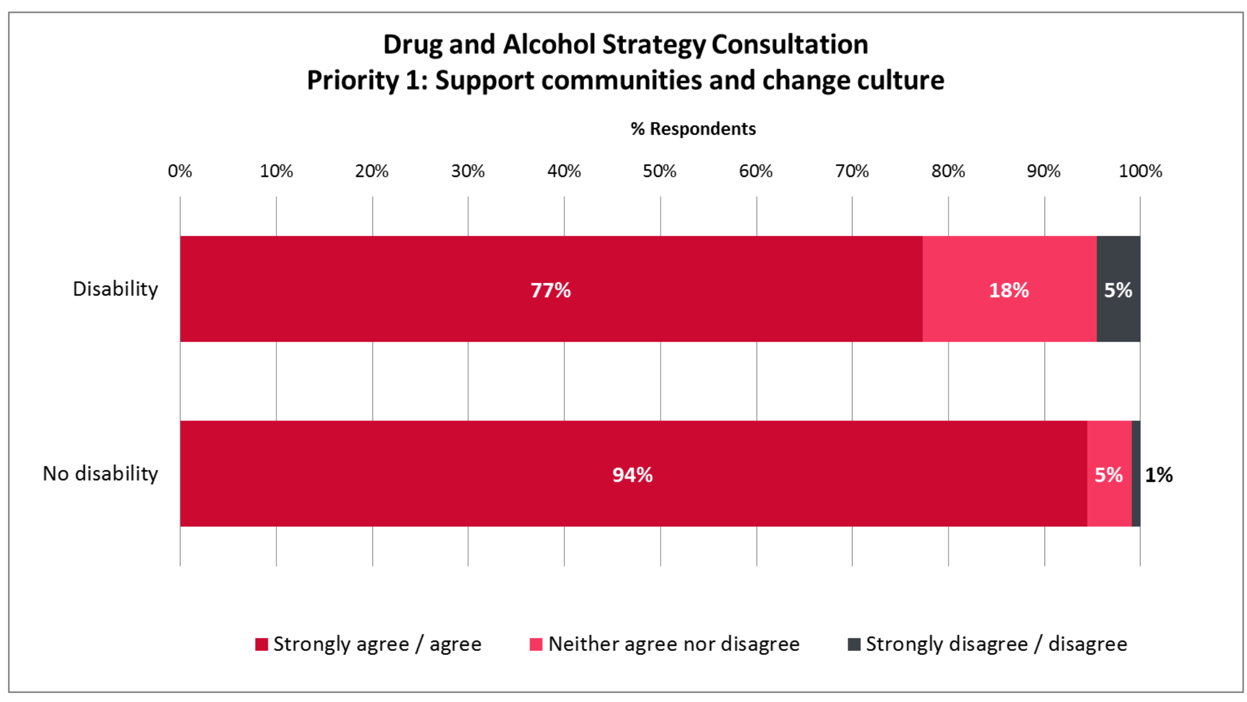

Figure 30 Disability - Priority 2

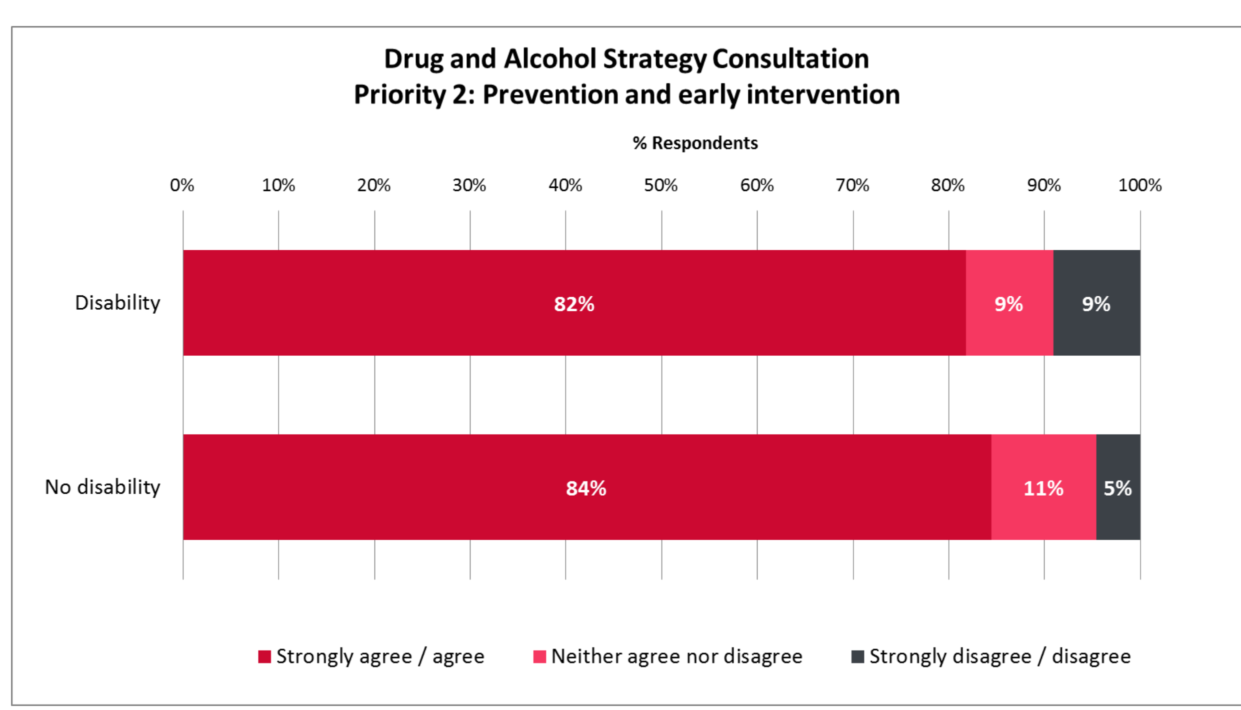

Figure 31 Disability - Priority 3

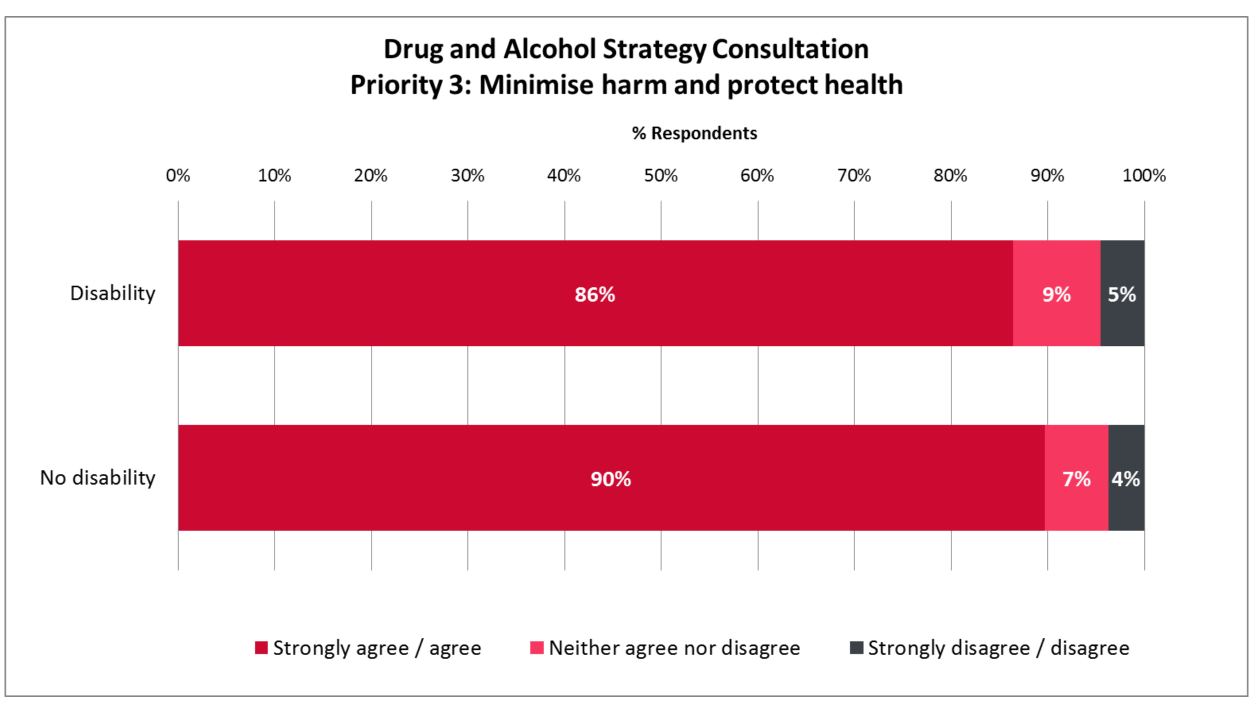

Figure 32 Disability - Priority 4

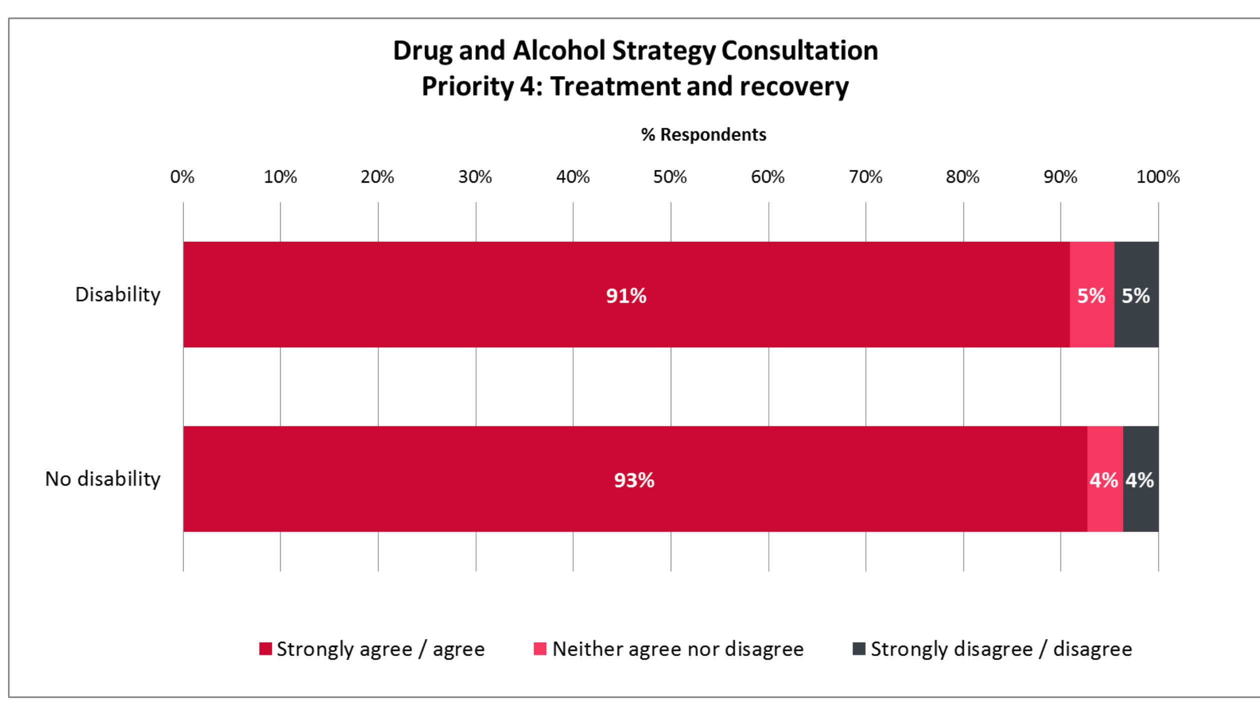

Figure 33 Disability - Priority 5

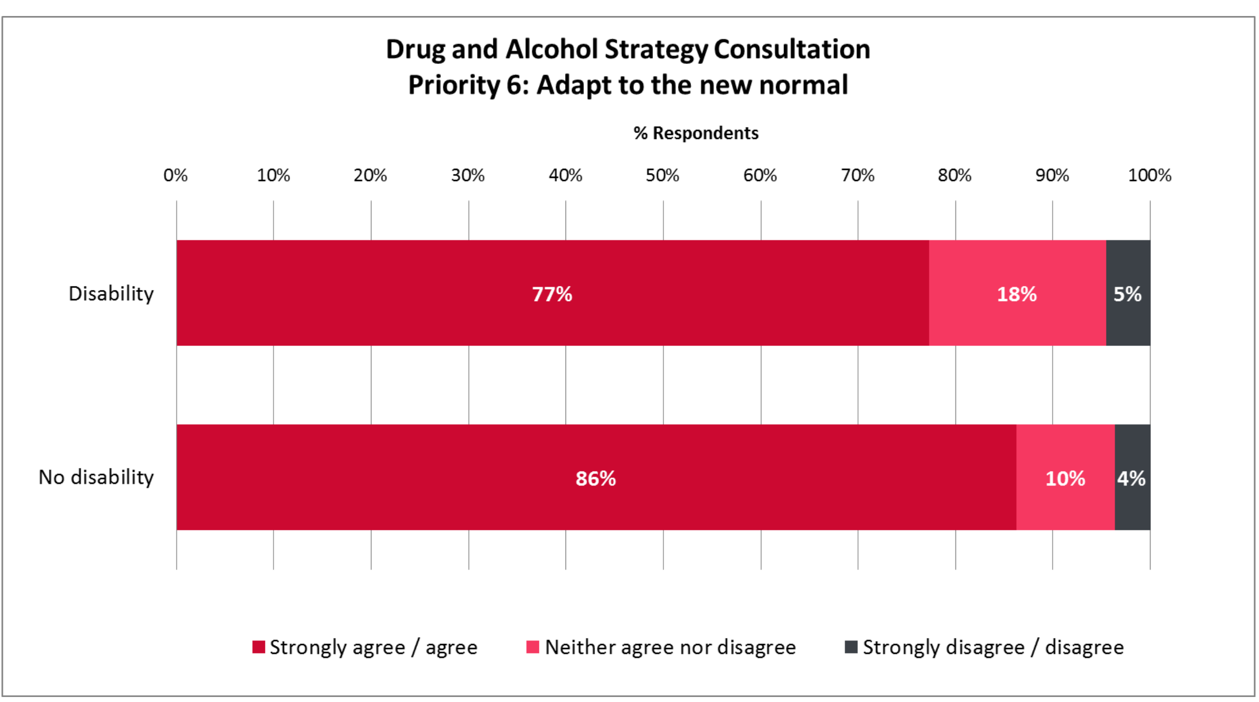

Figure 34 Disability - Priority 6

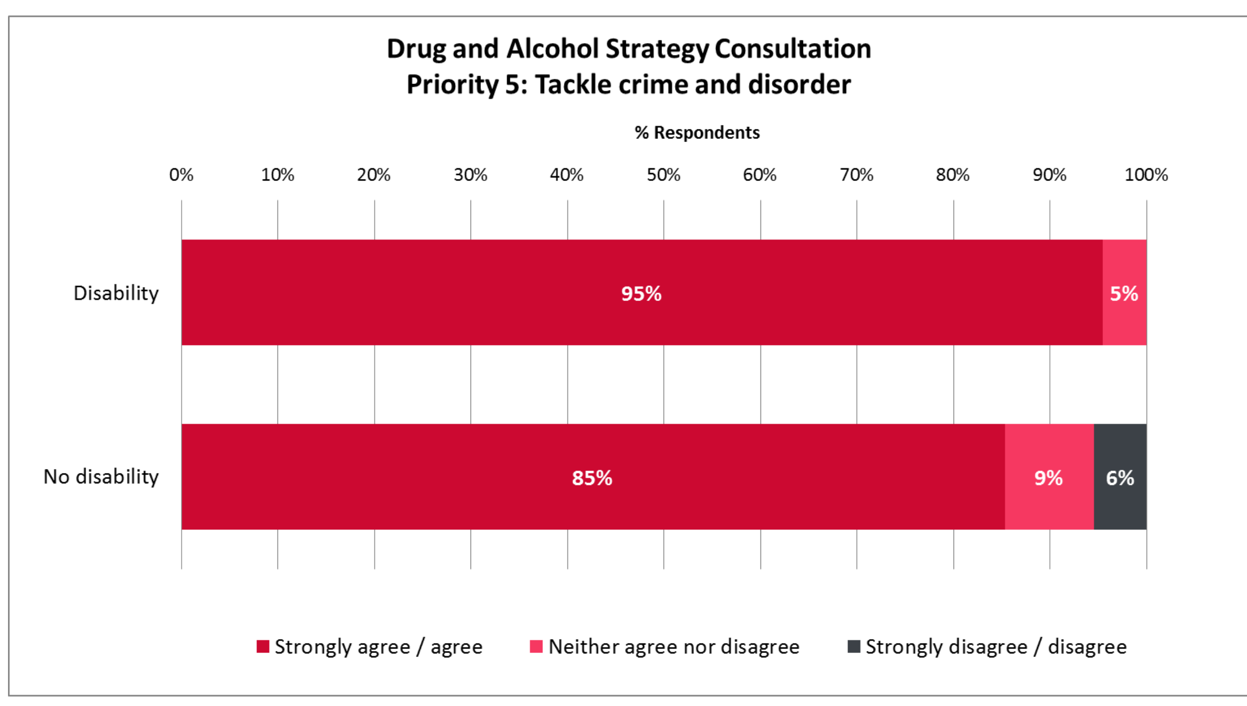

Figure 35 LGBT - Vision

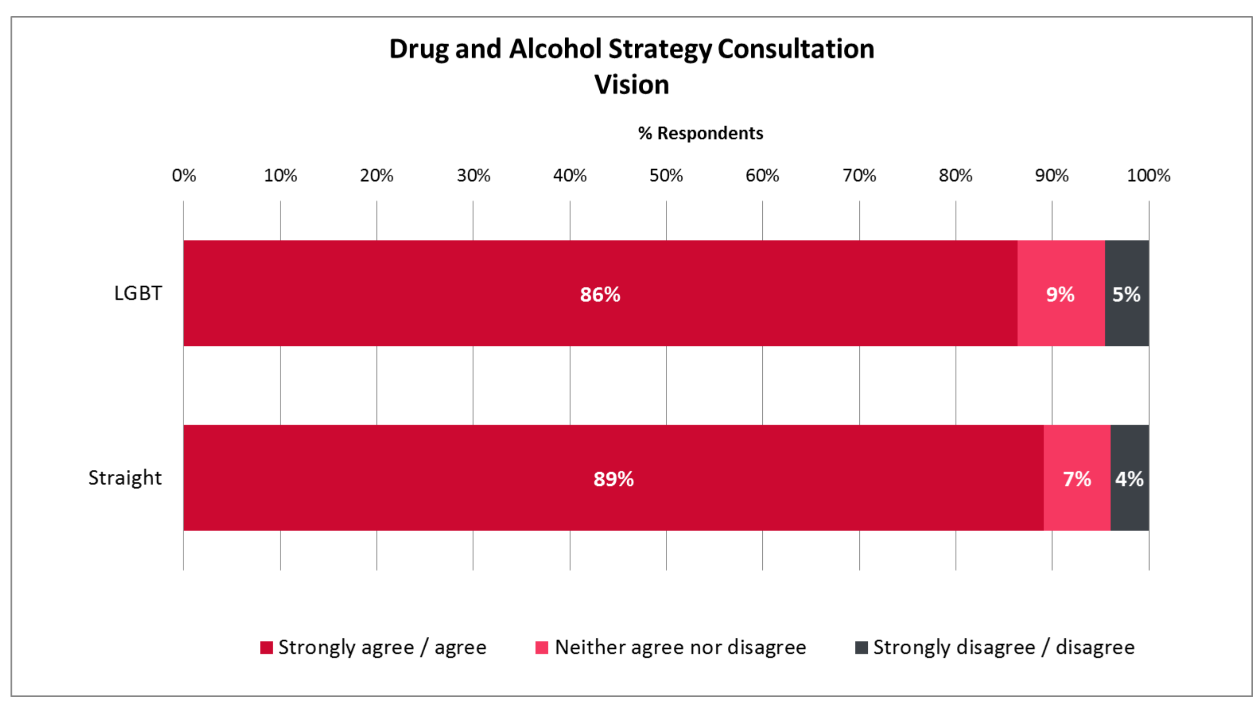

Figure 36 LGBT - Priority 1

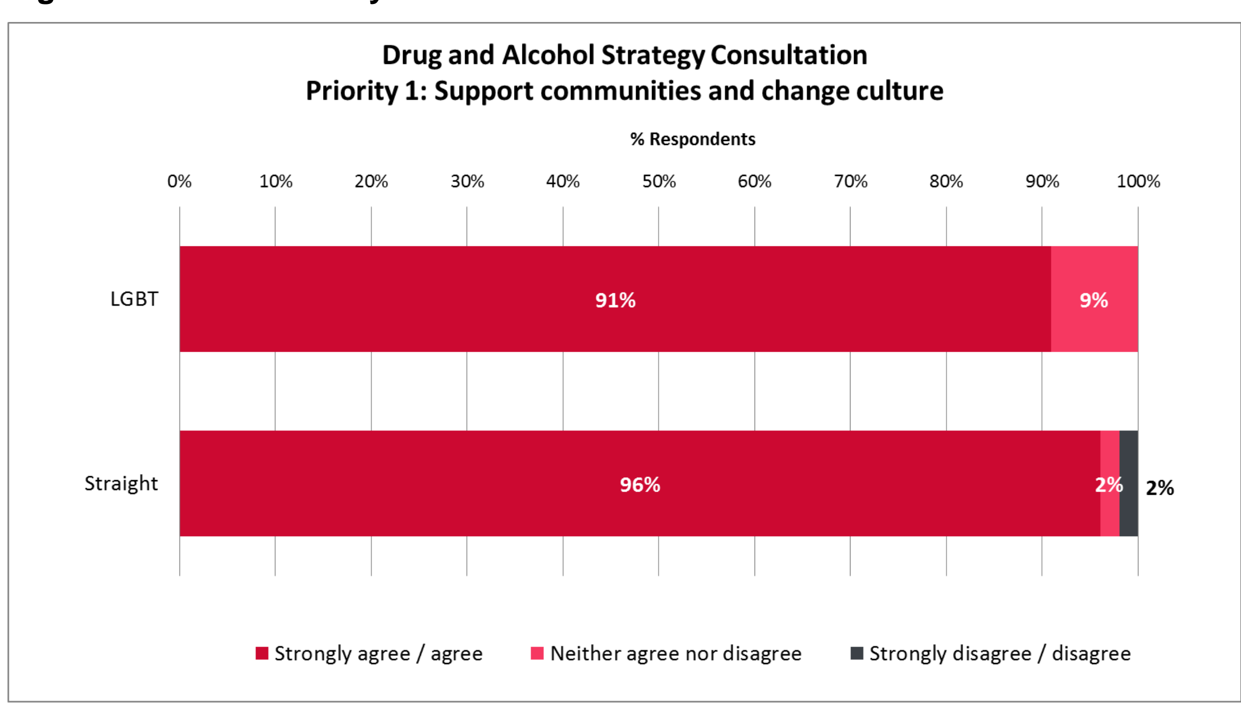

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Figure 37 LGBT - Priority 2

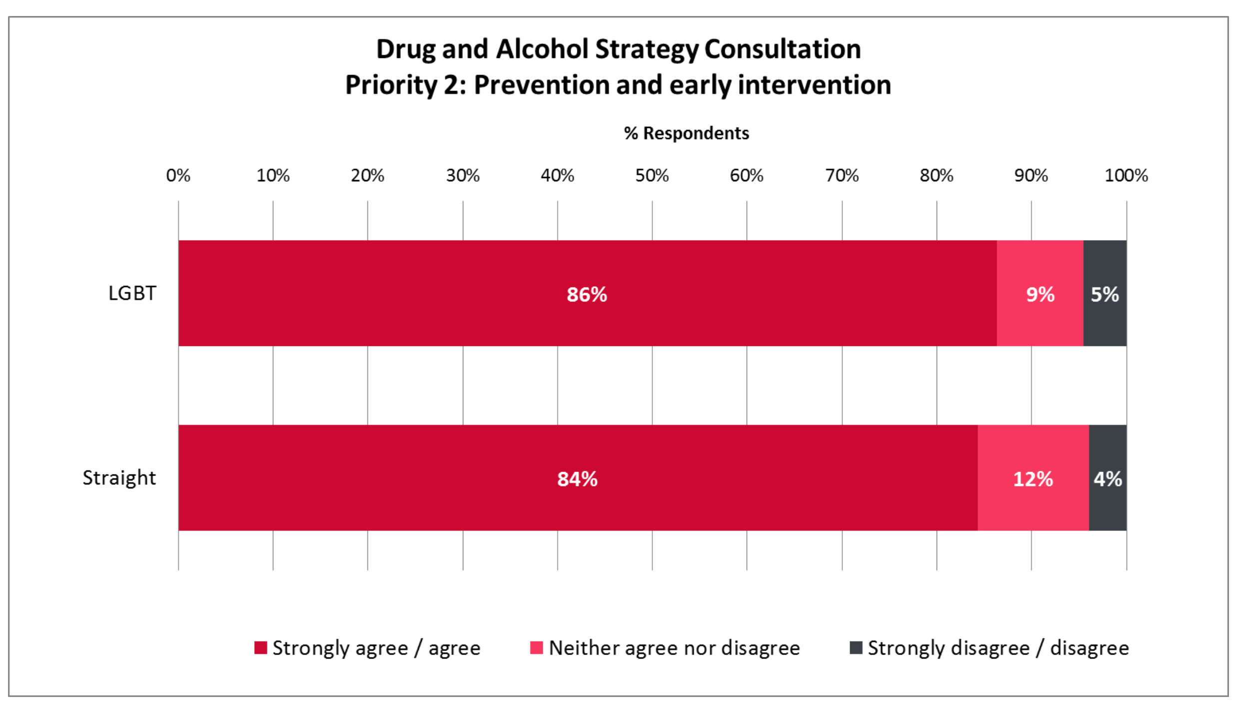


Figure 38 LGBT - Priority 3

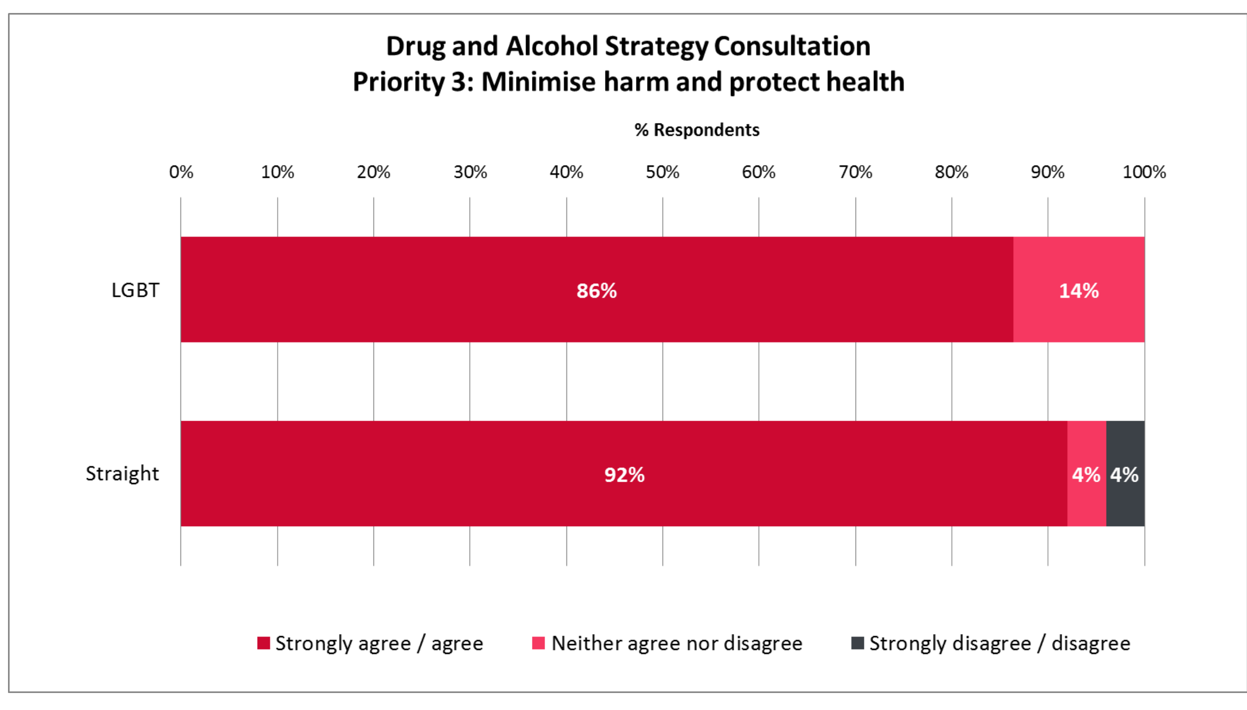


Figure 39 LGBT - Priority 4

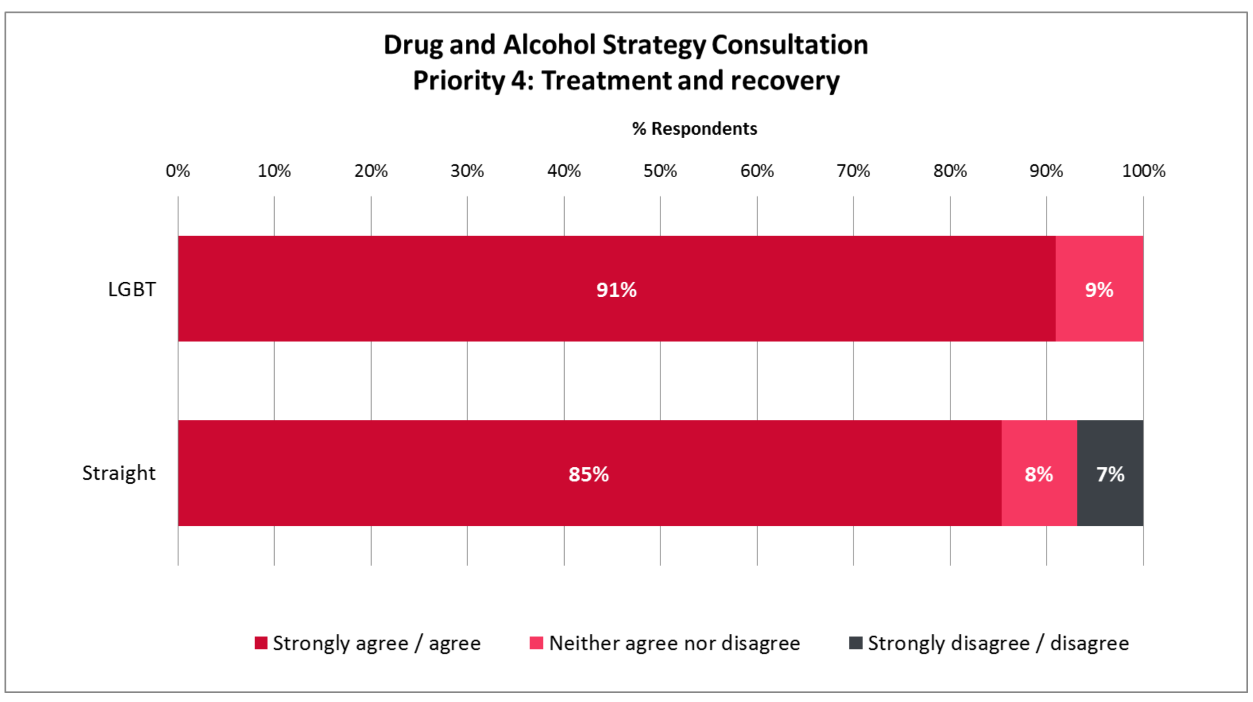


Figure 40 LGBT - Priority 5

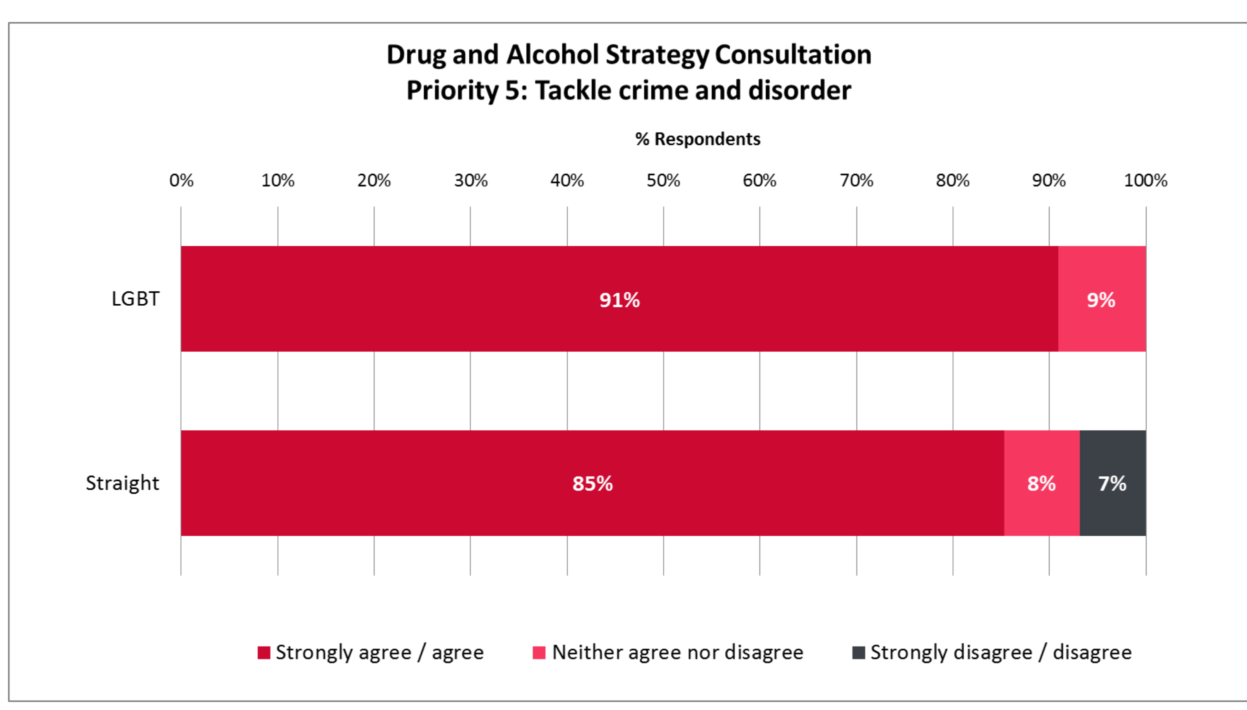
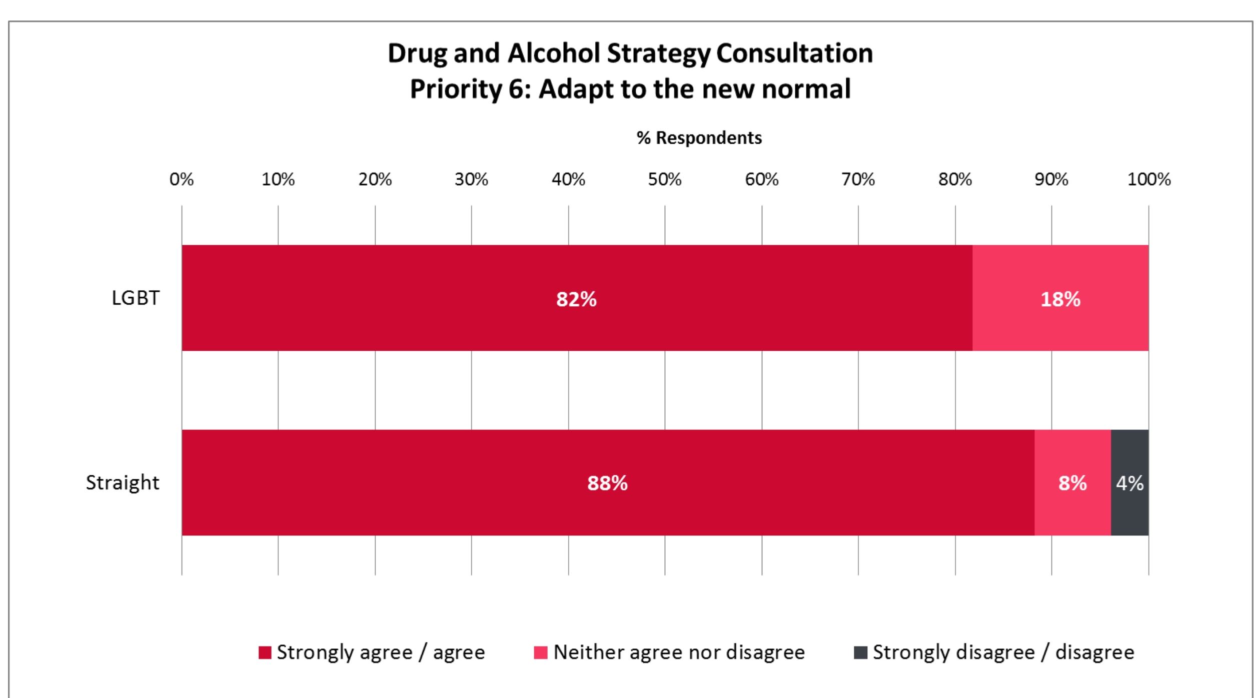


Figure 41 LGBT - Priority 6



5 Survey results: Comments on the Drug and Alcohol Strategy

5.1 Overview

In question 10, respondents were invited to provide their comments on the draft drug and alcohol strategy.

In question 11, respondents were invited to provide their comments on the draft equalities impact assessment and to provide suggestions on how to make drug and alcohol support more accessible and inclusive.

Respondents provided a view on both the drug and alcohol strategy and the equalities impact assessment in question 11, therefore responses to questions 10 and 11 have been analysed and summarised together.

137 (91%) of the respondents provided free text feedback to these questions. All comments were categorised into themes which are summarised below[5].

- 51 comments were categorised under the theme Priority 1: Support communities and change culture
- 87 comments were categorised under the theme Priority 2: Prevention and early intervention
- 25 comments were categorised under the theme Priority 3: Minimise harm and protect health
- 173 comments were categorised under the theme Priority 4: Treatment and recovery
- 47 comments were categorised under the theme Priority 5: Tackle crime and disorder
- 4 comments were categorised under the theme Priority 6: Adapt to the new normal
- 29 comments were categorised under the theme Equality, Diversity and Inclusion
- 49 comments were categorised under the theme Other

5.2 Priority 1: Support communities and change culture

- 10 comments said the strategy should recognise differences between communities and cultures and offer tailored or culturally appropriate support
- 9 comments said the strategy should focus on reducing the stigma of D&A use and/or increasing compassion towards D&A users

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[5] Because respondents commented on multiple issues, the total number of comments is greater than the 137 respondents

- 8 comments said communities need to be strengthened/ invested in / better resourced to increase resilience against effects of D&A use and /or reduce community-based causes of D&A use (e.g. poor community resources)
- 8 comments said the strategy should commit to working with night time economy businesses to reduce D&A consumption, change binge drinking culture and reduce harms
- 5 comments said the strategy should focus on reducing D&A consumption by promoting or rewarding alternative behaviours
- 3 comments said alcohol and drug use are a problem in the UK
- 3 comments said place-based approaches (e.g. alcohol-free spaces) won't have an impact on city-wide consumption and/or are difficult to enforce
- 3 comments said the strategy too accepting of D&A use and/or should focus on reducing the acceptability of D&A use
- 1 comment said to reduce the number of sex establishments in Bristol to reduce D&A consumption
- 1 comment said the strategy's focus on changing culture is patronising / nanny state

5.3 Priority 2: Prevention and early intervention

- 26 comments said the strategy should take (more of) a trauma / Adverse Childhood Experiences / mental health informed approach to D&A prevention and early intervention
- 12 comments said the strategy should acknowledge the role of mental health support for CYP in reducing D&A use later in life
- 11 comments said early intervention is important and/or effective in reducing D&A use
- 8 comments said educating (young) people on safe / less harmful D&A use is more effective than education that focuses on abstinence
- 8 comments said the strategy should include a commitment to provide support for families and children of D&A users (preventing later in life D&A use among children of users)
- 7 comments said the strategy should acknowledge the role of holistic support for CYP / families in reducing D&A use later in life / reducing impacts of ACE
- 4 comments said D&A education should be delivered to adults as well as CYP
- 4 comments said D&A education should be delivered to younger (primary-aged) CYP
- 4 comments said prevention and/or early intervention does not work or does not reduce D&A consumption
- 2 comments said the strategy needs to reference the prevention of violence against women (D&A are used to facilitate VAW)
- 1 said drug education should be more honest about the harms of alcohol

5.4 Priority 3: Minimise harm and protect health

- 8 comments said drug testing should be (more widely) available
- 6 comments said safe drug consumption rooms should be offered
- 4 comments said the strategy should focus more on reducing harm and less on promoting abstinence
- 2 comments said offer women-only consumption rooms should be offered
- 2 comments provided ideas for reducing harms associated with alcohol
- 2 comments said the strategy needs to be clearer on what drugs are the priority or what drugs cause the most harm
- 1 respondent said the strategy should include a focus on reducing suicide among (young) D&A users

5.5 Priority 4: Treatment and recovery

- 25 comments said the council should increase the quantity / quality of D&A support available, or increase funding for D&A services, or said there is poor service provision currently
- 21 comments said D&A services must be made more accessible
- 13 comments said D&A service users need more holistic support or that D&A services need to provide more holistic support (e.g. housing, employment)
- 13 comments said to provide D&A users with mental health support in addition to D&A support (dual support) as part of their treatment
- 11 comments said D&A services need to work in a more mental health-informed way and / or that mental health services need to work in a more D&A informed way
- 8 comments said better after-care is needed for those in recovery
- 8 comments said D&A services need to be more targeted at people with additional needs or those who experience more barriers to support
- 7 comments said community services need to be more joined up, talk to each other more, train each other and / or work more closely with the council
- 7 comments said community services need to be more localised or said to increase availability of local community services
- 7 comments said D&A services need to be more patient-centred or patient-led and / or need to empower service users
- 7 comments said D&A support needs to be more bespoke and / or responsive to individual needs
- 7 comments said more 1:1 or link-worker model support is needed

- 7 comments said the strategy needs to focus on plugging gaps in provision to stop patients "falling through" gaps
- 6 comments said the strategy should commit to providing more or better quality treatment services for CYP (separately from adult services)
- 5 comments provided ideas for D&A treatment
- 3 comments said D&A services need to be better regulated and / or more transparent
- 3 comments said GPs need more training as gatekeepers of support
- 3 comments said more focus is needed on recreational drug use (as opposed to long-term addiction) in the strategy
- 3 comments said to provide more support for cannabis users or users of less harmful drugs
- 2 comments said more information is needed on how the D&A strategy will approach people who do not want help or provided suggestions for enforced treatment
- 2 comments said multiple D&A services creates barriers (being passed back and forth), or said support should be streamlined with fewer service providers
- 2 comments said the strategy should focus on increasing support for those who want help (rather than "nudging" people who haven't sought help)
- 2 comments said the strategy should focus more on treatment than on prevention
- 1 comment said support for drugs and support for alcohol should be separate services

5.6 Priority 5: Tackle crime and disorder

- 17 comments requested improvements to the safety of or police presence in neighbourhoods or the centre
- 13 comments said to approach drug use as a health and / or social issue, not a criminal one, or said drugs should be decriminalised
- 6 comments said the strategy should focus on reducing crime and disorder associated with D&A use (ASB, street drinking, graffiti)
- 4 comments said to approach drug use as a criminal issue (not health/social) or asked for a crackdown on drug use
- 4 comments asked for a crackdown on drug dealing
- 1 comment said to allow communities to report drug dealing anonymously
- 1 comment said to approach drug misuse as both health and criminal issue; that balance is needed between the two
- 1 comment said the strategy should commit to providing support for victims of D&A-associated crime

5.7 Priority 6: Adapt to the new normal

- 1 comment said national government campaigns to support the night time economy post-COVID would be counterproductive to the aims of the D&A strategy
- 1 comment said drinking in public places (e.g. parks) has increased due to COVID
- 1 comment said funding cuts (to staffing/provision) post-COVID should be avoided (priority 6.3)

5.8 Equality, Diversity and Inclusion

29 people provided feedback on the equalities impact assessment, or made recommendations to make drug and alcohol support more accessible and inclusive.

The comments are summarised in table 1.

Table 1

Characteristic	Number of comments	Summary of comments
LGBT	9	• LGBT-specific support/prevention is needed (high D&A use among group) • Use of party drugs in LGBT community not referenced in strategy • Use of party drugs in LGBT community not referenced in strategy - needs targeted approach • More trans/gender-identity specific support need to be provided
Disability	4	• Hidden disabilities (LD, autism) needs to be a focus/ more tailored support required • Support venues need to be more accessible for physical disabilities
Gender	4	• Need to recognise that women are less likely to seek help (more stigma, risk of children being removed) – need tailored services and prevalence data is unrepresentative • Need more services tailored to women • Strategy needs to focus more on D&A use

		among pregnant women (addressing FAS)
Ethnicity	2	• Alcohol use in BME communities should be an area of focus • D&A use among GRT not mentioned
Age	1	• Older people need tailored support
Equality / diversity of D&A services	3	• D&A service providers need to be more diverse/ less discriminatory/ more reflective of the communities they serve • ED&I should be built into contracts/KPIs • Need an independent review of inequality in D&A service provision
Feedback on the Strategy / EqIA	3	• EqIA not reflective of the D&A problem in Bristol • Strategy needs to be informed by views of a diverse range of D&A users • Use of date rape drugs not mentioned in strategy
Other	3	• Sex workers need tailored support • More support needed for asylum seekers/refugees (including MH/trauma support) • Prisoners/ex-prisoners need tailored support

5.9 Other comments

- 14 comments said the strategy lacks detail, or data or is not specific enough
- 10 respondents provided positive feedback on strategy
- 9 comments said the strategy is too long, has inaccessible language and/or uses too much jargon
- 7 comments said the strategy should focus on ways to incorporate service users into decision-making
- 4 comments said the strategy should commit to learning from approaches / interventions in other countries
- 2 comments said the strategy is not deliverable at local level (needs changes at national level)
- 2 comments said the strategy should commit to leading on or advocating for new approaches / interventions

- 1 comment said method in which the success of the strategy will be measured is not mentioned in the strategy

6 Other correspondence on the Drug and Alcohol Strategy

6.1 Meetings

6.1.1 Overview

Council officers held meetings with six partner organisations across the city to review the draft Drug and Alcohol Strategy and invite comments. The organisations who took part in these meetings is summarised in table 2.

The meetings held during the consultation period were in addition to engagement workshops and development meetings attended by numerous stakeholders throughout 2020, which helped to inform the consultation draft strategy. A full list of these stakeholders is provided within the strategy acknowledgements.

Table 2

Type of organisation	Name of organisation
Interest groups / boards	Keeping Children Safe Group (of the KBSP) Bristol City Youth Council Bristol at night board
Clinical Commissioning Group Partnership Board	South Bristol BNSSG Partnership Board
Universities	UoB/UWE Multi-agency drugs group

Analysis followed a similar approach to analysis of the feedback in open text questions of the questionnaire. Respondents' comments were grouped and categorised.

Comments are categorised into the following four main themes[6]:

- Priority 1: Support communities and change culture
- Priority 2: Prevention and early intervention

[6] Because attendees commented on multiple issues, the total number of comments is greater than the six meeting attendees

- Priority 3: Minimise harm and protect health
- Other

Each of these is summarised in the following sections 6.1.2 – 6.1.5.

6.1.2 **Priority 1: Support communities and change culture**

The comments and suggestions made by attendees on supporting communities and change culture are summarised below:

- One attendee suggested that the strategy should consider contextual and place-based safeguarding approaches for children and young people (e.g. police presence in parks)
- One attendee said the council should involve wider communities (not just drug and alcohol users and services) in developing and implementing the Drug and Alcohol Strategy
- One attendee said the council should work closely with voluntary and community sector in developing and implementing strategy

6.1.3 **Priority 2: Prevention and early intervention**

- One attendee said children and young people need to be represented and involved in the strategy moving forward
- One attendee said the council should focus on reducing the accessibility of drugs and alcohol for children and young people
- One attendee said the strategy should focus on reducing the number of children and young people who drink in parks
- One attendee said the strategy should focus on providing children and young people with alternative, healthy activities
- One attendee called for better drug and alcohol education for children and young people
- One attendee said the strategy should focus on drug and alcohol use among all young people, not just university students

6.1.4 **Priority 3: Minimise harm and protect health**

- Drug testing should be provided in universities
- The strategy should focus on the excess amount people drink before and / or after going to an event
- The strategy should consider alcohol delivery companies
- Venues and establishments need support (from the council) to provide drug testing
- Intelligence on the amount, content and / or safety of seized drugs need to be shared with the public

- Venues would like a more coordinated approach to drug possession that moves away from zero tolerance
- Drug consumption near to venues should not be included in data on consumption within venues
- Road safety teams need more involvement in preventing drink driving

6.1.5 Other

One meeting attendee queried whether the "prevention" focus in the vision includes prevention of harm.

6.2 Email responses

6.2.1 Overview

The consultation received six email responses from partner organisations in the city and one survey response from University of Bristol which has been analysed with the email responses. The organisations that provided email responses summarised in table 3.

Table 3

Type of organisation	Name of organisation
Police and crime	Avon and Somerset Police Bristol Probation Service
Universities	University of Bristol
Local Authority	Bristol Public Health

Analysis followed a similar approach to analysis of the feedback in open text questions of the questionnaire. Respondents' comments were grouped and categorised.

Comments are categorised into the following four main themes[7]:

- Priority 1: Support communities and change culture
- Priority 2: Prevention and early intervention

[7] Because attendees commented on multiple issues, the total number of comments is greater than the six meeting attendees

- Priority 3: Minimise harm and protect health
- Priority 4: Treatment and recovery
- Priority 5: Tackle crime and disorder
- Priority 6: Adapt to the new normal
- Other

Each of these is summarised in the following sections 6.2.2 – 6.2.9

6.2.2 **Priority 1: Support communities and change culture**

- The council should work with other city councils on reversing drug-related trends
- The strategy should make a stronger reference to promoting low-alcohol alternatives

6.2.3 **Priority 2: Prevention and early intervention**

- Youth drug use is underestimated in population data
- Cannabis, amphetamine (including MDMA) and cocaine have the highest prevalence among children born in the 90s, therefore these drugs should be a focus in drug education
- Public health messaging and education around cannabis should focus on potency of cannabis (e.g. skunk) as well as frequency of use

6.2.4 **Priority 3: Minimise harm and protect health**

- Opioid agonist treatment (OAT) should be included in the harm reduction priority of the strategy
- Retention in Opioid agonist treatment (OAT) and managing “complex needs” / comorbidity is important to reducing overdose deaths, therefore should be emphasised in the strategy
- The strategy should commit to outreach provision of physical healthcare services targeted to people who inject drugs
- The strategy should commit to creating opportunities for supporting sterile injection and expand reach of effective harm reduction
- Strategy should focus on cost-effective tools to reduce the spread of the Hepatitis C Virus in people who inject drugs (e.g. needle programmes, offer both fixed and detachable low dead space syringes, providing training to pharmacy staff)
- The strategy should include the priority area of preventing invasive bacterial infections among people who inject drugs in and around Bristol

6.2.5 Priority 4: Treatment and recovery

- Evidence-based services need to be developed for managing alcohol use disorders in primary care
- The strategy should commit to providing support to people who use party drugs less harmfully (e.g. education, drug testing, safer places)
- Commissioners of drug and alcohol treatment services should consider how to communicate alternative routes to treatment, particularly in instances of domestic abuse.
- Bristol City Council should ensure the ROADS substance misuse treatment services are promoted through the city's business and commercial sector through Public Health's annual targeted health promotion campaigns.
- The strategy should include a commitment to provide separate treatment and support for patients dependent on prescribed drugs and to improve GP prescribing practices.
- The strategy should highlight the importance of trauma-informed drug treatment services for street sex workers

6.2.6 Priority 5: Tackle crime and disorder

- The strategy should include providing or enforcing drug and alcohol support for ex-offenders in the community or when leaving prison
- More information is needed in the strategy on the impact of reduced drug and alcohol use on offending / reoffending
- Policing of cannabis should focus on the highest potency cannabis (e.g. skunk)
- The strategy's intention to work more closely with Integrated Offender Management and join up services is welcome

6.2.7 Priority 6: Adapt to the new normal

- Needle and syringe street outreach programmes should be increased during COVID and pharmacy services should be maintained
- Overdose prevention efforts including Naloxone should be scaled up during COVID
- Changes to Opioid Substitution Treatment (OST) during the first lockdown (including less frequent collection, removal of supervised consumption and, rapid prescribing) should be maintained
- A mobile phone scheme should be provided to drug and alcohol users who lack phone/internet access in order to stay in touch with services during COVID
- The council should ensure outreach of mental health care during this time

6.2.8 **Other**

- The infographic in the strategy that provides data on drug and alcohol use (page 7) should focus on hazardous consumption, early exposure and public health harm
- Tobacco use should be included in strategy (harm reduction through vaping, preventing a gateway to substance use)
- The strategy should commit to improving the evidence base and supporting policy relevant research
- The strategy should refer to "drugs including alcohol" not “drugs and alcohol”

6.2.9 **Equalities workshop**

On 16 December 2020 an equalities workshop was held between council officers and professionals working in Drug and Alcohol, equalities and other organisations in Bristol. The meeting was held to collect feedback on the draft Drug and Alcohol strategy in relation to characteristics protected by the Equality Act 2010. Meeting attendees included:

- Public Health, Bristol City Council
- Equalities and Inclusion, Bristol City Council
- The Care Forum
- Bristol Drugs Project
- Bristol Women’s Voice

The points raised in the equalities workshop are summarised in table 4.

Table 4

Please find below a bullet point summary of discussions and points raised in relation to each equality group (as defined in the equalities act).

Age
- Impact of digital services, especially in a Covid-19 climate, has the potential to impact on access for older people and those who can’t afford it
- Greater focus towards prevention risks further stigmatising older people accessing services. Need services to be visible, e.g. with GP practices
- Young people often exploited as part of serious organised drug crime
- Need to link up with city-wide safeguarding work - if a young person is flagged for safeguarding issues, need to consider exposure to substances
- Housing of young people with unsecure housing (e.g. within hostels) could further expose them to alcohol and drug misuse

Gender
- Stigma experienced by women accessing treatment services, including risk of association with social services etc. if self-identifying issues
- Need for women-only and men-only services/groups

- Previously suggested that women highlighted lack of aftercare when completing treatment; women often have additional support needs related to the family unit
- Prevention activities also need to focus on violence against women and girls secondary to alcohol use. Need more data on this
- Using shared-cared approach for alcohol means that services can be localised, but also results in greater risk of being associated/seen with drug users
- Need to highlight the link between alcohol and sexual violence and exploitation towards women

Pregnancy and maternity
- Women less likely to attend treatment/services unless childcare is available
- Risk of missing opportunities for intervention and spotting concerns if Covid-19 has led to barriers to antenatal care/ health visitor visits etc.
- Link in with the Pause project from One25

Disability
- Individuals with learning disabilities and mental health needs benefit more from one to one work, which is flexible, for longer durations (not a lot of one to one available within the Community Recovery Service)
- However, group work does allow possibility for increasing tools for recovery and building networks
- Overall, flexibility is needed within the general support offer, as well as targeted treatments
- Accessible information is needed. Costs of accessibility rarely factored into funding; could be based on previous reasonable adjustment requests
- Mental health support needs to continue after drug and alcohol treatment; suggestion that the thresholds are currently too high for this, and therefore likely missing opportunities to prevent relapse
- Intersection of multi-disability (physical and mental) and therefore increased risk of substance issue and additional levels of complexity. Individuals with multi-morbidity continue to have to see multiple specialists/support services for their varying needs.
- There is a need to raise awareness of interactions of alcohol/drug use with prescription medication

Race
- The time, and day, of support sessions will be important to different communities
- Importance of language barriers - certain communities not served by named ROADS worker with language skills, or through sessions that are culturally sensitive.
- Given the sensitivity of issues, use of community translators often not appropriate
- The costs of interpreters etc. needs to be factored into funding; there is a potential for technology to address this gap
- Feasibility and balance between offering multiple bespoke services that are targeted to specific communities vs general services that are “accessible to all”

Faiths / religions
- There is a significant barrier to the acknowledgement of an individuals’ substance misuse if their faith forbids use of drug and alcohol; often requires a discussion around spirituality
- Faith leaders are important in accessing communities, but should be the sole representation as may not reflect reality. Can be denial from faith leaders of issues in their community.

- There is greater value from support services when designed from the bottom up

Sexual orientation
- The LGBTQ cohort is diverse; people cannot be catered for in one contingent. Gay males tends to dominate LGBTQ groups in terms of numbers
- There are few LGBTQ venues / socialisation opportunities not focused around alcohol
- Chemsex is a particular issue for this population; especially gay men
- PRISM and Freedom Youth are useful groups to link with

General discussion on other topics
- Accessibility of technology (especially important in a Covid-19 climate)
- Need flexibility of services - not everyone has internet / phone
- Mental health difficulties, such as anxiety, can be further barrier to technology use
- Older people - may not have access / feel comfortable using it
- Joined up data/technology between sectors
- Big barrier to treatment is people having to repeat their story multiple times; need one system (Theseus, RIO, EMIS)
- Intersectionality of equalities considerations, and the compounding effect of them on marginalisation
- There was not time to explore the role of the criminal justice system

7 How will this report be used?

The consultation feedback in this report is taken into account by officers in developing the final Drug and Alcohol Strategy 2020-2024.The final proposals are included in a separate report which, together with this consultation report, will be considered by the Keeping Bristol Safe Partnership, Keeping Communities Safe Group, the Health and Wellbeing Board, the Bristol Clinical Commissioning Group and the Bristol City Council Cabinet.

How can I keep track?

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Email consultation@bristol.gov.uk

Bristol's Drug and Alcohol Strategy 2020-24

Response to the open consultation report

February 2021

The Public Health team at Bristol City Council, and its partners, are grateful to everyone who took the time to respond to the open consultation on Bristol's new drug and alcohol strategy.

The results, which are described in a separate report produced by the Council's Consultation and Engagement team, have helped to shape the final version of this strategy. This short document outlines some of the changes that have been made, in light of the feedback received.

The vision and priority areas

We were pleased to see that the overwhelming majority of responders were in favour of the vision and six priority areas. These therefore remain unchanged. Results also suggested that the strategy document was clear, readable, and largely reflected the key issues for Bristol in relation to the use of alcohol and other drugs.

The commitments and supporting chapter text

Free text responses have helped to further refine the strategy text as outlined below. It should be noted however that a number of these free text responses highlighted the importance of issues which were either felt to already be appropriately addressed within the first draft, or which suggested specific actions which were out of the scope of this high-level, focussed and succinct strategy document. All comments received will be further considered as part of future detailed action planning.

Small changes have been made to the 20 'commitments' within the strategy, including:

- The addition of the importance of services responsive to the local population need (1.2)
- A focus on environmental interventions (for example, lighting within parks) as a way to reduce alcohol and other drug use amongst young people (2.2)
- The need for mental health support as part of the recovery process (4.1)
- Reference to a seamless transition of support between prisons and community services (5.2)

More widely, numerous changes have been made to the strategy text to support the understanding and meaning of these 20 'commitments' and to help guide future action planning. Examples include:

- Reinforcement, and greater highlighting, of the relationship between substance misuse and mental or physical health needs. The importance of mental health services as a way of preventing, treating, and supporting recovery from substance misuse issues is made clear.
- Stronger reference to cultural competence as a running theme throughout the strategy, and the expectation of services and professionals to be adaptable to the needs of different communities and populations (including different ethnicities, sexualities, genders, disabilities etc).
- Reference throughout the strategy of the need to de-stigmatise seeking support; this includes with respect to stigmatisation of older people in treatment, mothers and pregnant women seeking support etc.
- The expectation that future commissioning contracts and budgets for Bristol's drug and alcohol services should reflect the funding needed to ensure accessibility.

- The goal for referral pathways into services to be flexible to meet the needs of those traditionally underserved, or who experience barriers (such as those with a physical or learning disability).
- Reference to the need for greater support after 'completion' of treatment, including mental health and parental/family support
- Highlighting the risk of digitalisation of services, as a result of the Covid-19 pandemic, widening inequalities between age groups and deprived communities.
- Explicit reference to education programmes, and drug safety testing schemes, which inform of the dangers of 'party drugs' and 'chemsex'.
- The commitment to work with, and learn from, experiences in other cities national and internationally on this agenda.
- Clarity on the regulatory responsibilities of all premises permitted to sell alcohol, such as corner shops and kiosks (i.e. not just night-time economy venues).
- The input of service users and those with lived experience into the action planning stage, and ongoing development of services.
- Setting of a research agenda with academic colleagues, to promote understanding of these important issues.

The equalities impact assessment

An equalities impact assessment was also included for comment as part of the open consultation. Comments on this, and issues relevant to people with protected characteristics, were received from 29 consultation responders. Further comments were also gathered during a workshop held with equalities representatives.

Additions have been made to the equalities impact assessment (as well as to the strategy) which reflect these comments, and will provide further support in ensuring the needs of people with protected characteristics are addressed as part of next stage of action planning.