DRAFT

Bristol Behaviour Change for Healthier Lifestyles Programme Commissioning Strategy 2017

1. Introduction

1.1 Background and Purpose

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

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

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

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

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

Figure 1: Bristol City Council Enabling Commissioning Framework

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

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

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

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

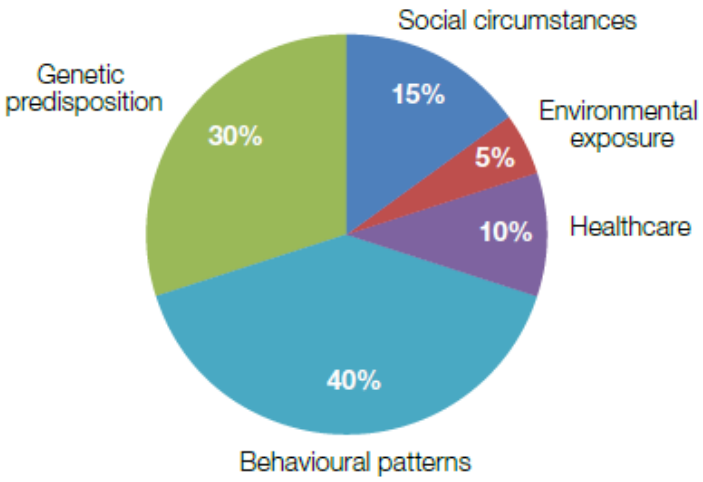
Other additional factors were considered during the discussion period including:

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

Context

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

Figure 2: Opportunities to Improve Health



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

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

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

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

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

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

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

- Mental health
- Alcohol
- Healthy Weight

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

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

Preventable disease

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

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

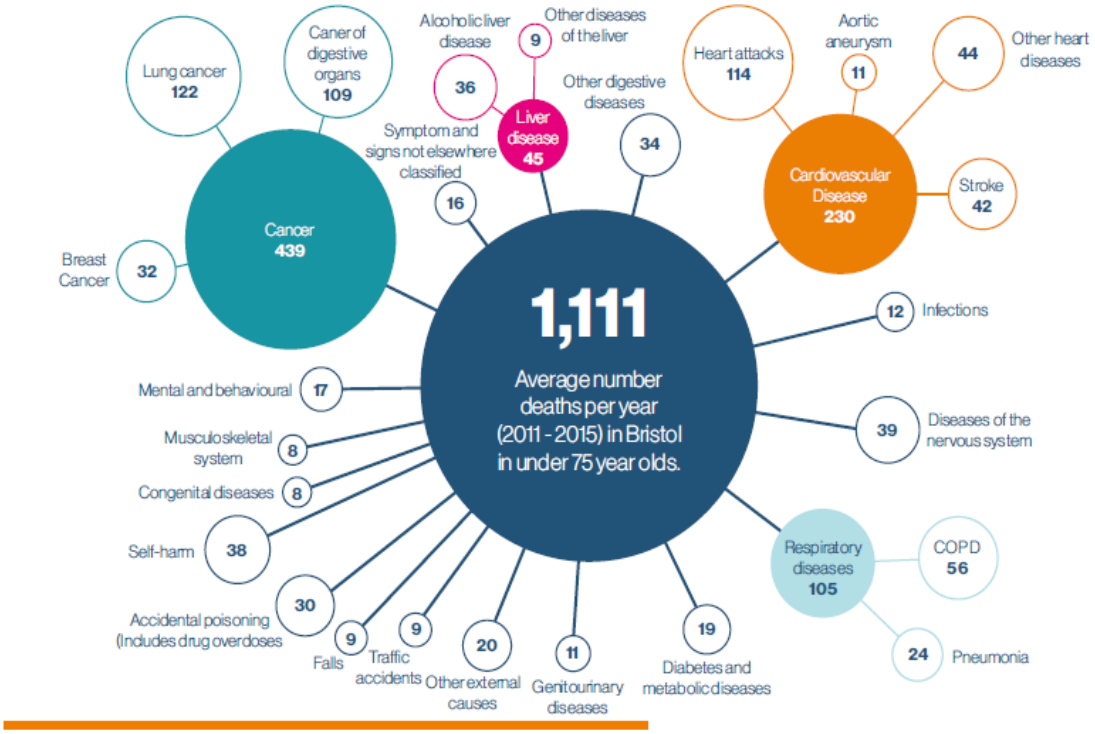


Figure 6: Main causes of premature death in Bristol (average per year 2011 - 15). *Source: calculated by Bristol Public Health Knowledge Service using ONS mortality data.*

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

In addition, the burden of ill-health is not distributed equally, with people from more disadvantaged backgrounds developing long term conditions about ten years earlier than those from more affluent backgrounds. Tackling inequalities through targeted

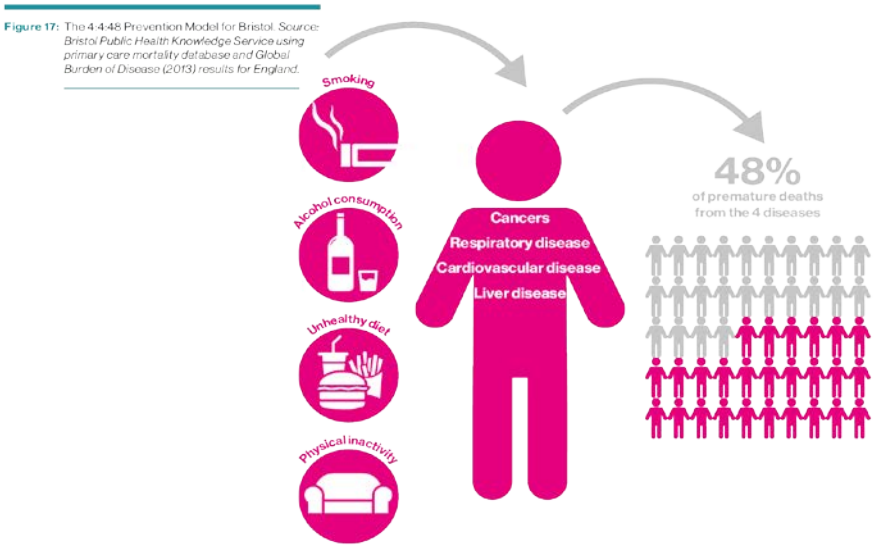
prevention, intervening early when risks are identified and taking action when long term conditions are identified is critical.

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

- Smoking
- Excess alcohol
- Physical activity
- Poor diet

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

Figure 4: The 4:4:48 Prevention Model



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

The greater the number of unhealthy lifestyle behaviours the greater the risk of ill health and early death. Evidence suggests that the most vulnerable and disadvantaged are more likely to have higher risk lifestyles across several behaviours, resulting in higher risks for ill health. The strong and persistent link between deprivation and ill health underlines the importance of tackling the underlying determinants of unhealthy behaviours as well as the behaviours themselves.

Approaches to prevention

Approaches to prevention with individuals include a wide range of activities or interventions aimed at reducing risks to health and wellbeing, and the impacts of disease.

- **Primary prevention** aims to prevent a condition or disease developing e.g. through promoting healthier behaviours;

- **Secondary prevention** aims to reduce the impact of a condition that has already occurred – this can include early detection and management, and lifestyle programmes to improve healthier behaviours and slow progression of the condition;

- **Tertiary prevention** aims to reduce the impact of long term illness e.g. through rehabilitation programmes and long term condition management programmes, to maximise capacity for living well.

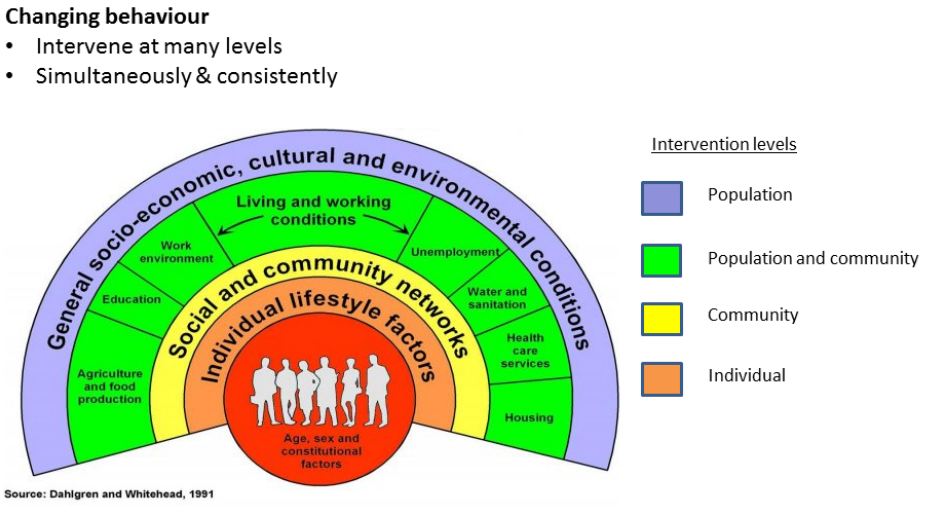
Individual-level interventions aimed at changing health-damaging behaviours are complemented by interventions at a **population, community and organisational** level, such as campaigns for raising awareness and prompting behaviour change.

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

Behaviour change

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

Figure 5: Behaviour Change Model



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

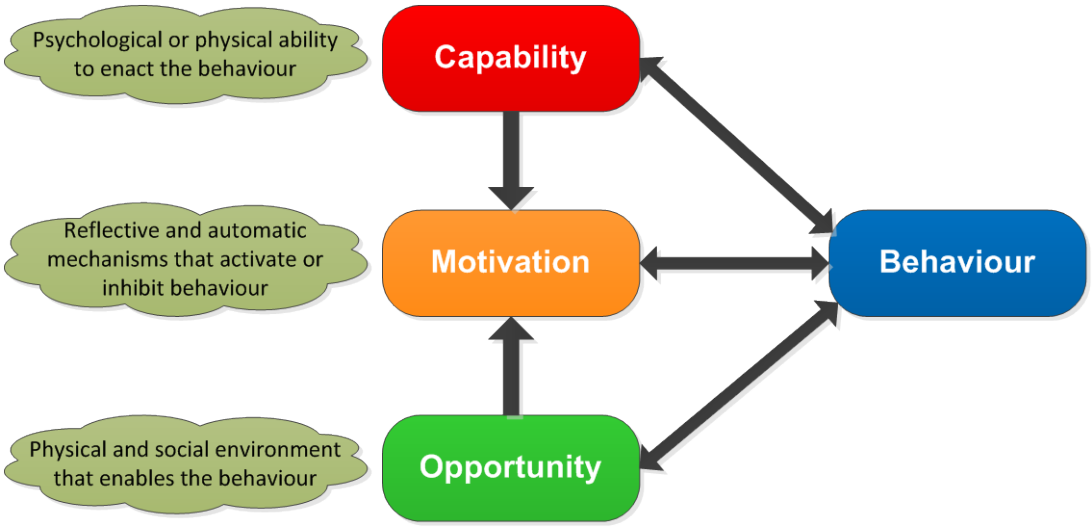
Changing behaviour requires intervening at many levels. It takes into account the determinants of health – where people live, work and play.

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

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

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

Figure 6: COM-B Behaviour Change Model



Michie et al, 2011. Implementation Science

The COM-B Behaviour Change Model focuses on:

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

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

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

1.2 The Bristol Behaviour Change for Healthier Lifestyle Programme

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

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

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

Many individuals who want to make changes to their lifestyle to improve their health are able to do so without support. However, the evidence is clear that people who are motivated to make changes and who receive the right level of support significantly increase their chances of achieving and sustaining behaviour change.

Although support can come from family and friends it is often professional support that is sought and trusted. Support may be required over a period of time to embed long term behavioural change such as stopping smoking, changing eating habits and increasing the amount of physical activity taken.

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

Our Challenge

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

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

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

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

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

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

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

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

Health-related behaviours in the Bristol population

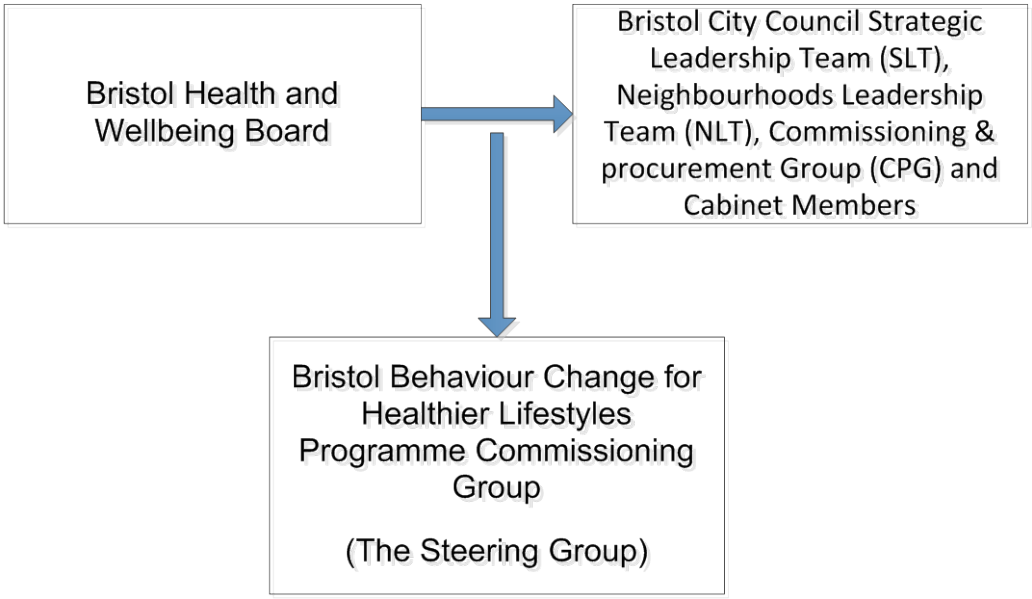
Bristol has a population of around 449,300 individuals; 365,500 adults and 83,800 children (ONS mid 2015 resident population estimate).
The table below shows the number (and percentage) of people in the Bristol population at risk from specific health-related lifestyles. More detail can be found in the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

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

1.3 Governance and Decision Making

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

Figure 7: Governance Pathway



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

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

2. Methodology and principles

2.1 Method

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

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

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

2.2 Principles underpinning this commissioning process

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

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

3. Needs Assessment and Stakeholder Engagement

3.1 Health Needs Assessments

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

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

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

Key recommendations are:

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

3.2 Stakeholder Day – September 2016

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

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

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

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

3.3 Survey & Focus groups

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

Figure 8: Key themes from the survey:

Figure 9: Key themes from the focus groups:

3.4 Customer Insight

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

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

- Effectively reduce health inequalities

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

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

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

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

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

3.5 Benchmarking

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

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

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

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

Social Value:

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

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

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

3.6 Market analysis

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

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

4. Current contracts and financial envelope

4.1 Current Contracts and Expenditure

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

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

4.2 Financial envelope

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

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

5. Commissioning model

5.1 Our ambition

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

5.2 Objectives

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

5.3 Programme Outcomes

Programme Outcomes

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

The high level outcomes this programme will contribute to:

- **Smoking** – reduction in smoking prevalence

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

Intermediate outcomes:

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

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

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

Public Health Outcomes Framework (PHOF)

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

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

5.4 Scope

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

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

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

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

Out of Scope

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

5.5 Service model for Bristol Behaviour Change for Healthier Lifestyles Programme

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

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

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

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

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

Three personas:

Inform me

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

Enable me

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

Support me

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

Universal offer proportionate to need

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

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

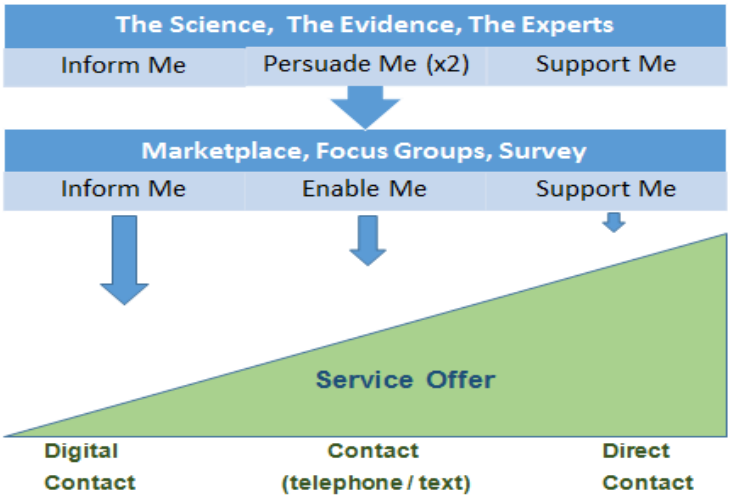
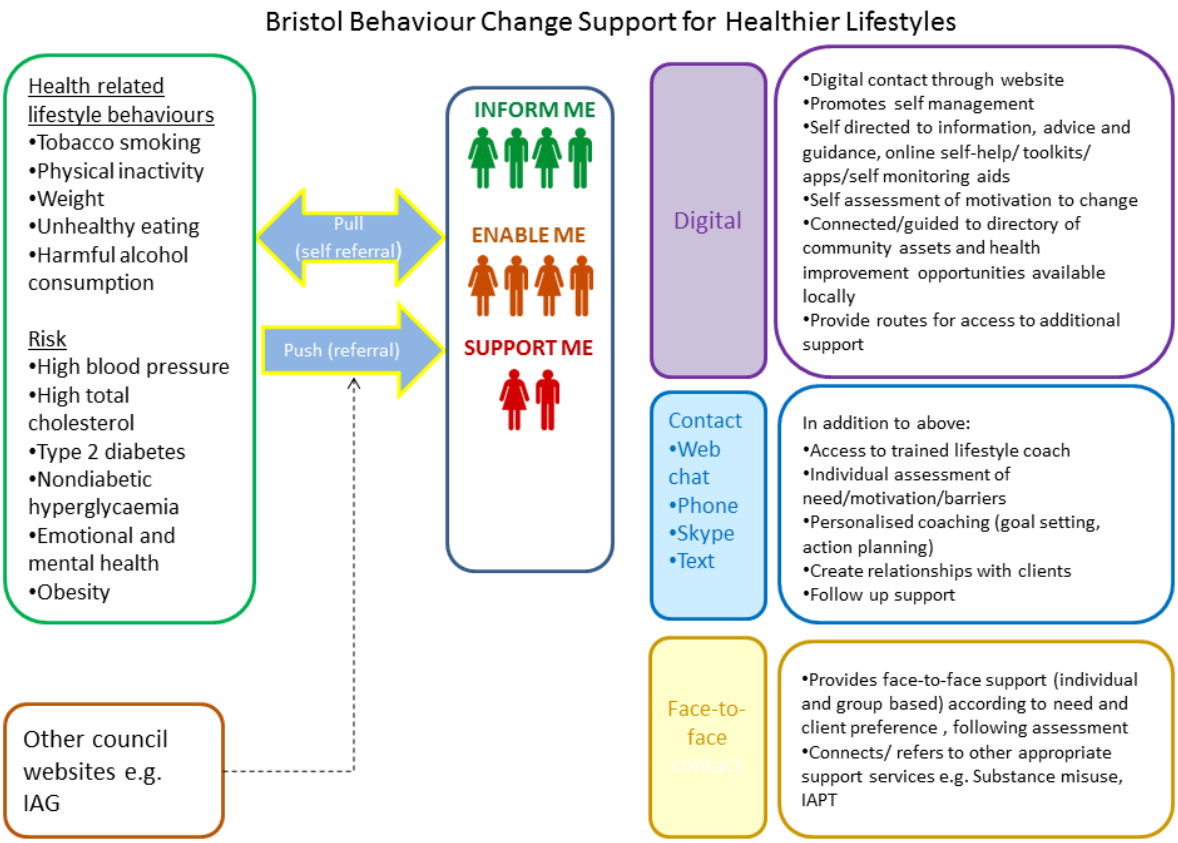


Figure 11 below sets out the model for the Bristol Behaviour Change for Healthier Lifestyles Programme.

Figure 11: Bristol Behaviour Change Support for Healthier Lifestyles



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

5.7 Proposed tendering approach and allocation of resources

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

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

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

We will use an Open Procedure to procure this programme.

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

5.8 Evaluation approach

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

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

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

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

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

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

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

5.9 Contract duration

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

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

5.10 Performance monitoring

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

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

5.11 TUPE

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

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

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

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

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

6. Consultation

6.1 Stakeholder consultation

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

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

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

6.2 Procurement timetable

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

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

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

NHS Health checks

Key issues:

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

Recommendations:

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

Support to Stop Smoking

Key issues:

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

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

Recommendations:

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

Healthy Weight

Key issues:

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

Recommendations:

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

Appendix B: Survey Questionnaire

Introduction:

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

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

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

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

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

   Please list the services you had most success with:

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

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

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

I_____I____I_____I

1very easy 5 OK 6 10 very hard

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

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

_____
☐Workplace ☐Faith groups
☐Other, please state……

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

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

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

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

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

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

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

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

☐ More services available for me and my children/family

Options for other weight management support, please state:

Options for other physical activity support, please state:

Options for other support to stop smoking, please state:

Options for healthier diet support, please state:

Events to be offered at different times, please state:

Other, please state:

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

I_____I

1 not important at all 10 very important

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

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

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

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

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

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

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

18. **Are you disabled?**

☐ Yes
☐ No
☐Prefer not to say

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

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

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

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

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

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

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

Name:

Address:

Contact tel.no.:

Appendix C: Market Analysis

To be inserted after stakeholder day on 28th March 2017

Appendix D: Equality Impact Assessment

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

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

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

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

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

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

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

Most national and local surveys only focus on SES

Diet and Nutrition

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

Physical activity

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

Excessive alcohol intake

- About 84% of Bristol population aged 16 years and over engage in drinking.
- Of those, 20.3% drink at increasing levels that risk harm in the long term, and 7.5% drink at higher risk levels that harm themselves and others.
- Furthermore, 26.3% reported to binge drink, hence are vulnerable to the acute effects of intoxication such as assault, falls and poisoning. The percentage of binge drinkers in Bristol is higher than the regional and national average.
- Alcohol use is sensitive to cultural and socio-economic characteristics that greatly differ across Bristol. Some communities have traditions that dissuade alcohol

misuse; these communities include some ethnic and religious groups. For instance many observant Muslims are abstinent. The socio-economic effect of alcohol use includes:

• People from lower socio-economic classes are less likely to misuse alcohol, however if they do drink to excess they tend to develop very severe drinking problems.

• More affluent people with higher income much more likely to drink alcohol daily.

- In deprived areas people who misuse alcohol are also more likely to also smoke tobacco, hence at increased risk of developing complicating medical condition such as cancer. This increased risk results in a higher burden of mortality caused by alcohol in deprived areas, despite less people in the areas misusing alcohol.

Self-reported wellbeing
Worthwhile Score

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

Cardiovascular Disease
Under 75 mortality rate - considered preventable

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

Cancer

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

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

Respiratory Disease

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

Liver Disease

- Closely linked to deprivation
- Higher mortality rates for men

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

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

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

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

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

Step 3: Who might the proposal impact?

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

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

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

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

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

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

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

3.4 Can they be maximised? If so, how?

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

Step 4: So what?

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

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

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

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

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

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

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

Appendix E: Communications Strategy

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

Objectives:

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

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

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

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

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

- Market Position Statement
- Equality Impact Assessment
- Commissioning Strategy

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

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

- Tuesday 28th March – workshops in morning and afternoon

- Community based workshops – mid February to end March

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

Timeline:

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

Appendix F: Priority Population Groups

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

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

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

Most national and local surveys only focus on SES

Diet and Nutrition

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

Physical activity

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

Excessive alcohol intake

- About 84% of Bristol population aged 16 years and over engage in drinking.
- Of those, 20.3% drink at increasing levels that risk harm in the long term, and 7.5% drink at higher risk levels that harm themselves and others.
- Furthermore, 26.3% reported to binge drink, hence are vulnerable to the acute effects of intoxication such as assault, falls and poisoning. The percentage of binge drinkers in Bristol is higher than the regional and national average.
- Alcohol use is sensitive to cultural and socio-economic characteristics that greatly differ across Bristol. Some communities have traditions that dissuade alcohol misuse; these communities include some ethnic and religious groups. For instance many observant Muslims are abstinent. The socio-economic effect of alcohol use includes:
    - People from lower socio-economic classes are less likely to misuse alcohol, however if they do drink to excess they tend to develop very severe drinking problems.
    - More affluent people with higher income much more likely to drink alcohol daily.
    - In deprived areas people who misuse alcohol are also more likely to also smoke tobacco, hence at increased risk of developing complicating medical condition such as cancer. This increased risk results in a higher burden of mortality caused by alcohol in deprived areas, despite less people in the areas misusing alcohol.

Self-reported wellbeing: Worthwhile Score

- People with fair to poor health status are more likely to have a low worthwhile score
- Unemployed and inactive work groups are more likely to have a low worthwhile score
- Groups between the ages of 45 -59 and 80+have the lowest worthwhile scores
- Men have lower scores than women
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- Men are 3 times more likely to have heart disease
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- People with learning disabilities have a higher risk of ischemic heart disease than the general population and this is the second most common cause of death in people with learning disabilities
- People with learning disabilities are 58 times more likely to die before the age of 50 than the general population.
- Ex-offenders are more likely to have high rates of CVD

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- Mortality is higher in more deprived areas
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- Screening uptake is lower amongst BME AND disabled groups
- Prostate cancer is higher amongst afro Caribbean men
- Cancers linked to the gastro-intestinal system are closely linked to deprivation

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- Respiratory disease and COPD are closely linked to smoking prevalence
- People with learning disabilities are three times more likely to die from respiratory disease

Liver Disease

- Closely linked to deprivation
- Higher mortality rates for men