

# **Bristol Behaviour Change for Healthier Lifestyles Programme**

## **Final Commissioning Strategy 2017**

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# 1. Introduction

## 1.1 Background and Purpose

### Purpose

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

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

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

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

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

**Figure 1: Bristol City Council Enabling Commissioning Framework**



This document provides additional information in relation to the specific commissioning activity of a Behaviour Change for Healthier Lifestyles Programme and is intended for use by a range of stakeholders in order to develop a collaborative approach to the commissioning model that will go out to tender in 2017. In particular, this document is intended for:

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

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

Other additional factors were considered during the discussion period including:

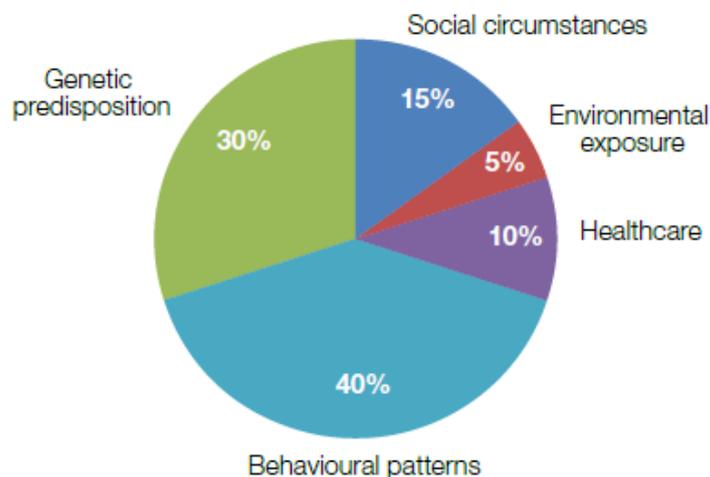
- Expected reductions in levels of funding. The Council has consulted on a proposed Corporate Strategy for 2017-2025 which aims to make £92m savings. This is required due to changes in Government funding and increasing demands for services. The Council will have to look at all areas of spend, including commissioned services, to determine what areas have priority and where to make savings. At present the Public Health grant is ring fenced for 2017/18 and 2018/19 but there is uncertainty regarding the future of this, which has been a component part of the planning process.
- The current and future demands on health and social care – including an ageing population, inequalities in health, complex healthcare and pressures on social care outlined in national documents, particularly the NHS Five Year Forward View (2014).
- The robust international, national and local evidence about supporting people to make lifestyle changes (NICE, 2014).
- The changes in the way people lead their lives with increased digitalisation and use of technology and an expectation that information and support is readily available (PHE, 2017).

## **Context**

In 2013 Bristol City Council (as for all councils across the country) became responsible for the public health and wellbeing of its residents. Local authorities are seen as leaders of the public health system, with the Director of Public Health creating the influence and leverage that enables the broader determinants of health to be addressed, such as local environment, transport, housing and employment.

These wider factors are estimated to influence between 15% and 43% of our health. All approaches to prevention need to address and take account of these wider determinants, with a focus in areas and communities where need is highest.

**Figure 2: Opportunities to Improve Health**



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

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

Bristol City Council, like many others around the country, is facing a major challenge to meet the rising demand and cost of health and social care. National reports and policies including the NHS Five Year Forward View (2014) recognise the importance of good health and wellbeing in reducing levels of long term disease and premature death and placing a priority on investing in prevention.

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

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

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

Bristol Health and Wellbeing Board brings together a range of partners with an interest in, or responsibility for improving health in Bristol. The Board has a duty to 'encourage integrated working' and is responsible for producing the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. It is jointly chaired by the Mayor of Bristol and the Chair of Bristol Clinical Commissioning Group (CCG).

The Board have recently refreshed their Joint Health and Wellbeing Strategy and have committed to focus on the following three areas, which have potential to reduce health inequalities and improve the long term health of Bristol residents:

- Mental health
- Alcohol
- Healthy Weight

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

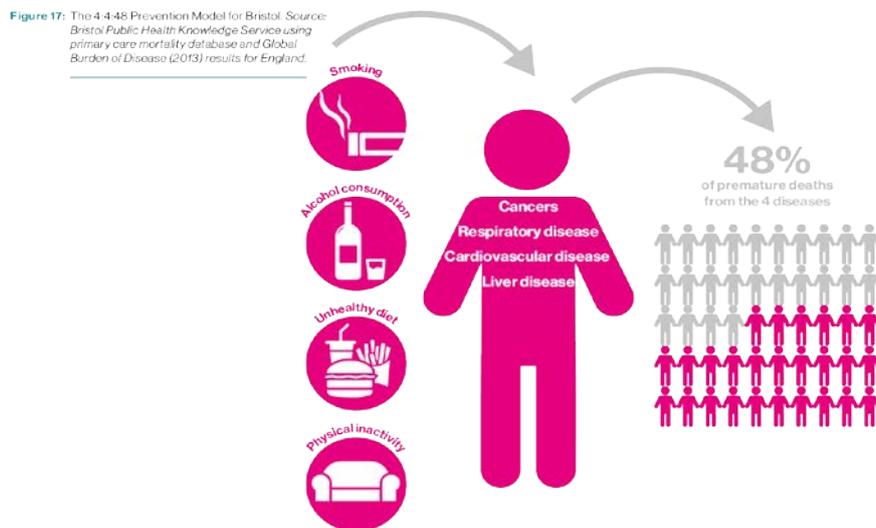
Following discussion with neighbouring authority colleagues at the beginning of this commissioning process, Bristol has proceeded with the development and commissioning of a Behaviour Change for Healthier Lifestyles Programme for the Bristol population. We are working to share principles and experience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

### **Preventable Disease**

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



## Figure 4: The 4:4:48 Prevention Model



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

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

### Approaches to Prevention

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

- **Primary prevention** aims to prevent a condition or disease developing e.g. through promoting healthier behaviours;
- **Secondary prevention** aims to reduce the impact of a condition that has already occurred – this can include early detection and management, and lifestyle programmes to improve healthier behaviours and slow progression of the condition;
- **Tertiary prevention** aims to reduce the impact of long term illness e.g. through rehabilitation programmes and long term condition management programmes, to maximise capacity for living well.

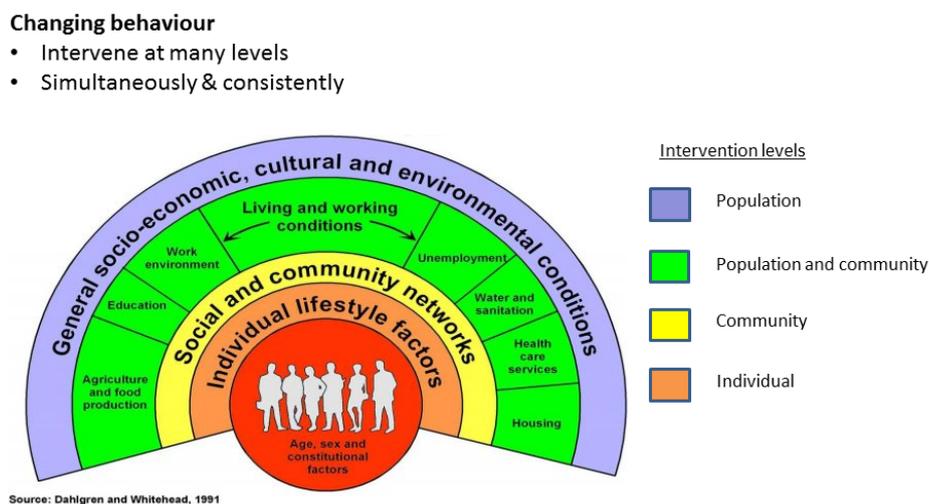
**Individual-level** interventions aimed at changing health-damaging behaviours are complemented by interventions at a **population, community and organisational** level, such as campaigns for raising awareness and prompting behaviour change.

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

## Behaviour Change

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

**Figure 5: Behaviour Change Model**



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

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

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

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

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

**Figure 6: COM-B Behaviour Change Model**



*Michie et al, 2011. Implementation Science*

The COM-B Behaviour Change Model focuses on:

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

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

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

## **1.2 The Bristol Behaviour Change for Healthier Lifestyles Programme**

The Bristol Behaviour Change for Healthier Lifestyle Programme will be expected to work with and support families and individuals, including children and young people (2 to 18 years), taking a family approach where appropriate and linking with the National Childhood Measurement Programme (NCMP) in the primary and secondary prevention of preventable ill health through behaviour change.

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

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

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

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

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

### **Our Challenge**

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

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

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

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

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

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

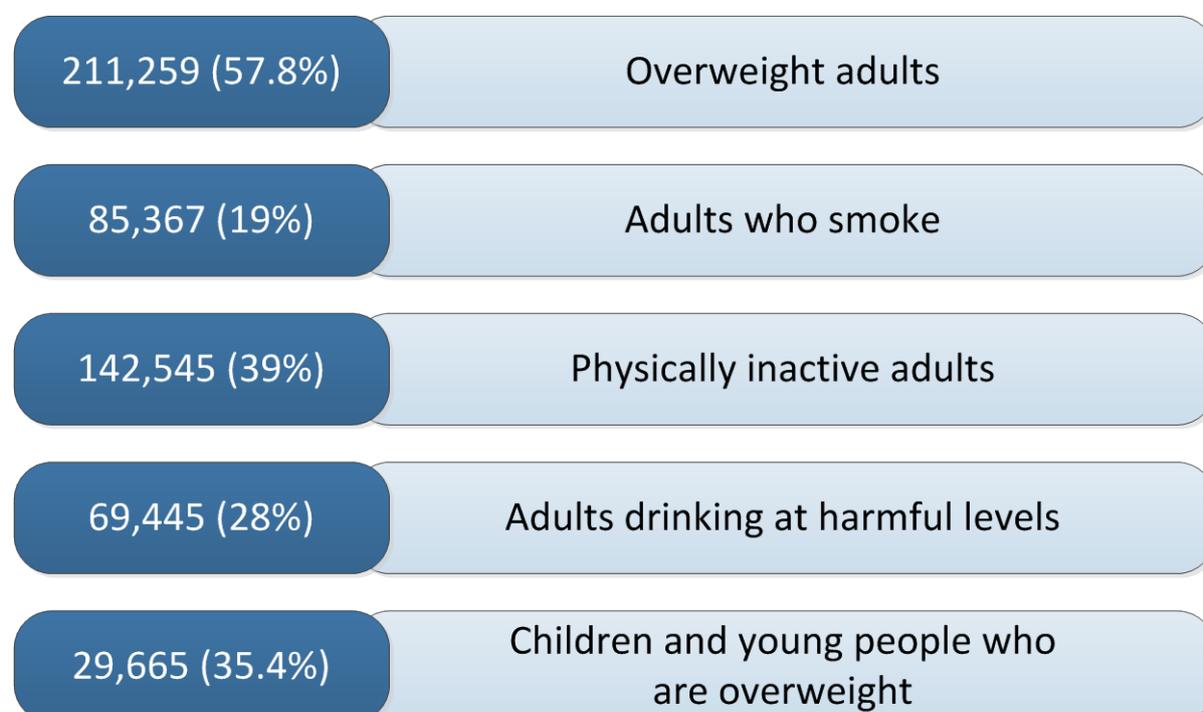
Because people are characterised by a range of circumstances, challenges and behaviours, it is important that a solution is based around the individual rather than access to separate services for a range of needs, and takes account of the root causes of the behaviours.

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

### **Health-related behaviours in the Bristol population**

Bristol has a population of around 449,300 individuals; 365,500 adults and 83,800 children (ONS mid 2015 resident population estimate).

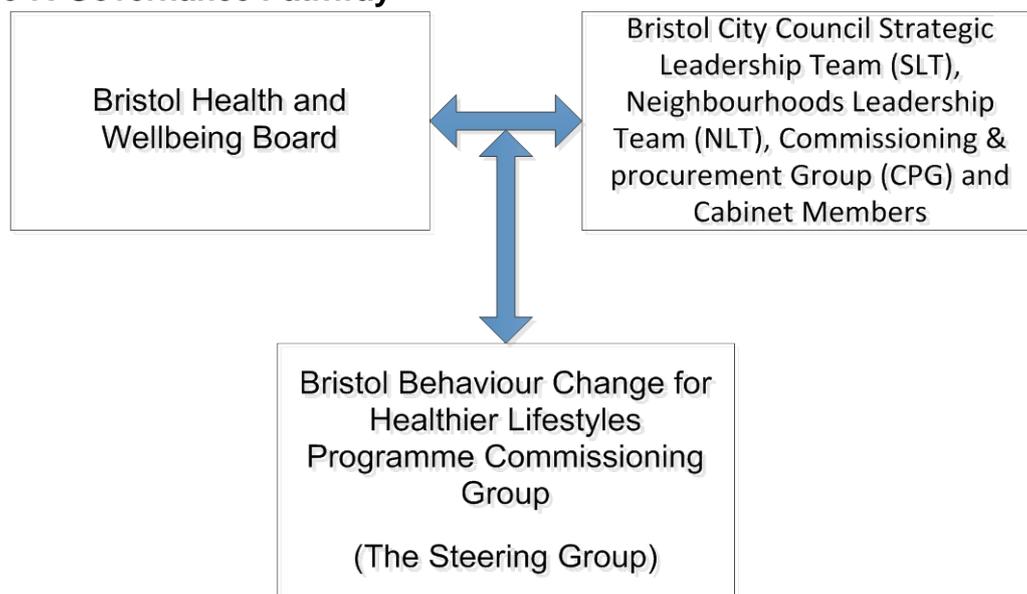
The table below shows the number (and percentage) of people in the Bristol population at risk from specific health-related lifestyles. More detail can be found in the JSNA Data Profile 2016.



### 1.3 Governance and Decision Making

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

**Figure 7: Governance Pathway**



The steering group includes members from Bristol City Council public health team, equality and cohesion officer, commissioning and procurement Officer, substance misuse commissioner, the Head of Collaboration and Commissioning from VOSCUR representing the voluntary and community sector, and a GP representative for the Bristol Clinical Commissioning Group.

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

## 2. Methodology and principles

### 2.1 Method

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

<p><b>Current issues and context</b></p>	<ul style="list-style-type: none"><li>• 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?</li><li>• Obtained the views of service users and others in communities across Bristol.</li></ul>
<p><b>Understanding the drivers</b></p>	<ul style="list-style-type: none"><li>• Considered the implications of providing separate services to adults and early years/children versus an integrated approach.</li><li>• Considered what people need to support them change their lifestyle related behaviours.</li><li>• Considered the implications for a wider geographical footprint, including the Sustainability Transformation Plan (STP).</li><li>• Considered the financial implications and context.</li><li>• Considered BCC Corporate Strategy.</li></ul>
<p><b>Applying the evidence</b></p>	<ul style="list-style-type: none"><li>• Reviewed the international, national and local evidence for lifestyle services and behaviour change approaches.</li><li>• Reviewed the implications of findings in the Gap Analyses/Health Needs Assessments.</li><li>• Considered the best commissioning and procurement approaches that are suitable for this innovative approach.</li><li>• Reviewed how other local authorities and organisations are providing lifestyle services to their population, and lessons learnt.</li></ul>

## 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:

- Weight management
- Support to stop smoking
- NHS health checks

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

Key recommendations are:

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

### 3.2 Stakeholder Day – September 2016

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

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

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

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

### 3.3 Survey and Focus Groups

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

Figure 8: Key themes from the survey:





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

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

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

### **3.5 Benchmarking**

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

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

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

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

### **3.6 Market Analysis**

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

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

## 4. Current Contracts and Financial Envelope

### 4.1 Current Contracts and Expenditure

2016/17 financial year expenditure for services that are considered in scope for the proposed Behaviour Change for Healthier Lifestyle Programme for Bristol is shown in the table below:

<b>Contracts and Service Providers</b>	<b>Bristol</b>
	<b>£</b>
NHS Health Checks	350,000
Adult Weight Management Services	305,000
Stop Smoking Delivery - primary care	620,000
Stop Smoking Delivery - community grants	60,000
Alcohol Brief Interventions	17,000
Children and young people's weight management services	185,000
Delivery of Livewell Bristol team, Learning Difficulties Healthy Living team and Resource and Information Team	327,909
<b>Current Total</b>	<b>£1,864,909</b>

### 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:

<b>Year</b>	<b>Contract Value</b>	<b>Saving</b>
2018/19	1,585,173	279,736
2019/20	1,585,173	
2020/21	1,585,173	
<b>Totals</b>	<b>4,755,518</b>	<b>279,736</b>

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

## 5. Commissioning Model

### 5.1 Our Ambition

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

### 5.2 Objectives

- To empower, motivate and enable Bristol residents of all ages (children, young people and adults) to take control of their own health and wellbeing and change their health-related behaviour.
- To provide a universal programme that is proportionate to need, with a focus on those whose health outcomes are poorest.
- To provide the right level of advice, information and support for people who are motivated to change.
- To find solutions that are based around the needs of the individual and which understand the root causes of their behaviour.
- To make more effective links with available assets, including the capacity of existing services and communities to support healthy lifestyles.
- To provide supporting information and resources to the wider public health work force to support behaviour change.
- To deliver an innovative cost- effective behaviour change programme, maximising the use of digital technologies.
- To enable long term behaviour change without continuous face to face support.
- To ensure there is a family approach where appropriate.
- To provide a person-centred holistic approach, ensuring emotional and mental wellbeing is embedded.

### 5.3 Programme Outcomes

#### Programme Outcomes

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

- Reduced alcohol intake by people in priority groups.

The high level outcomes this programme will contribute to:

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

### Intermediate Outcomes

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

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

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

### Public Health Outcomes Framework (PHOF)

- Average number of portions of fruit consumed daily at age 15
- Average number of portions of vegetables consumed daily at age15
- Mortality rate from causes considered preventable
- Under 75 mortality rate from cardiovascular diseases considered preventable
- Under 75 mortality rate from cancer considered preventable
- Under 75 mortality rate from liver disease considered preventable
- Under 75 mortality rate from respiratory disease considered preventable
- Smoking prevalence in adults- current smokers
- Smoking prevalence in routine & manual occupations
- Smoking prevalence at aged 15 years – current smokers, occasional smokers, regular smokers
- Excess weight in adults

- Percentage of physically active and inactive adults – active adults
- Percentage of physically active and inactive adults – inactive adults
- Child excess weight in 4-5 and 10-11 year olds – 4-5 year olds
- Admission episodes for alcohol-related conditions – male/female/persons
- Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check
- Estimated diagnosis rate for people with dementia
- Self-reported wellbeing, people with a low satisfaction score
- Self-reported wellbeing, people with a low wellbeing score
- Self-reported wellbeing, people with a low happiness score
- Self-reported wellbeing, people with a high anxiety score.

## 5.4 Scope

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

### In Scope

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

Service	Purpose	Current providers
NHS Health Check programme	This is a mandated Local Authority Public Health service. It provides a risk assessment, risk awareness and risk management programme, addressing the major risk factors (both behavioural and physiological) for cardiovascular and related diseases. 40-75 year olds are eligible for a face to face NHS Health Check every 5 years	Primary Care (GP practices); Healthy Living Centres
Stop Smoking Service	To reduce the prevalence of smoking among young people, adults and pregnant women	Primary Care (GP practices and Pharmacies) 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 Pharmacies; Healthy Living Centres
Children and family Weight Management	To reduce the rates of childhood obesity	Alive 'N' Kicking

programme		
LiveWell Bristol	Digitalised information, signposting and referral point	Bristol City Council, Public Health
Resource and Information Service	Provision and distribution of quality assured information and resources to support behaviour change interventions to wider public health workforce	Bristol City Council, Public Health
Initiatives / campaigns	Specific initiatives/campaigns related to the healthy lifestyles within scope	
Training	Training for healthy lifestyle provider staff; referrers and community based groups or other agencies	Alive 'N' Kicking, Bristol City Council, Public Health
Learning Difficulties Healthy Living Advisors Team	Providing 1:1 support for people with learning difficulties.	Bristol City Council, Public Health

## 5.5 Service Model for Bristol Behaviour Change for Healthier Lifestyles Programme

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

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

The Behaviour Change for Healthier Lifestyles Service for Bristol will use digital technology based on three personas:

- Inform me
- Enable me
- Support me

It will focus on prevention and early intervention, based on who the customer is, their needs, the offer they find acceptable and the way they wish to access it.

The model is being developed with these three personas in mind. These have been described to try and better understand the characteristics, behavioural patterns, health risk factors, motivators and barriers of people living in Bristol. We have used the information gained from focus groups and the survey, in addition to ACORN data and other demographic data.

Please note this approach is for illustrative and planning purposes only. It is not intended to categorise or over simplify people and their behaviours. By using this approach, it is our intention that the programme will be accessible to people based on their lives, communication preferences and readiness to participate in change.

### Three Personas

#### Inform me

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

#### Enable me

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

#### Support me

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

### Universal Offer Proportionate to Need

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

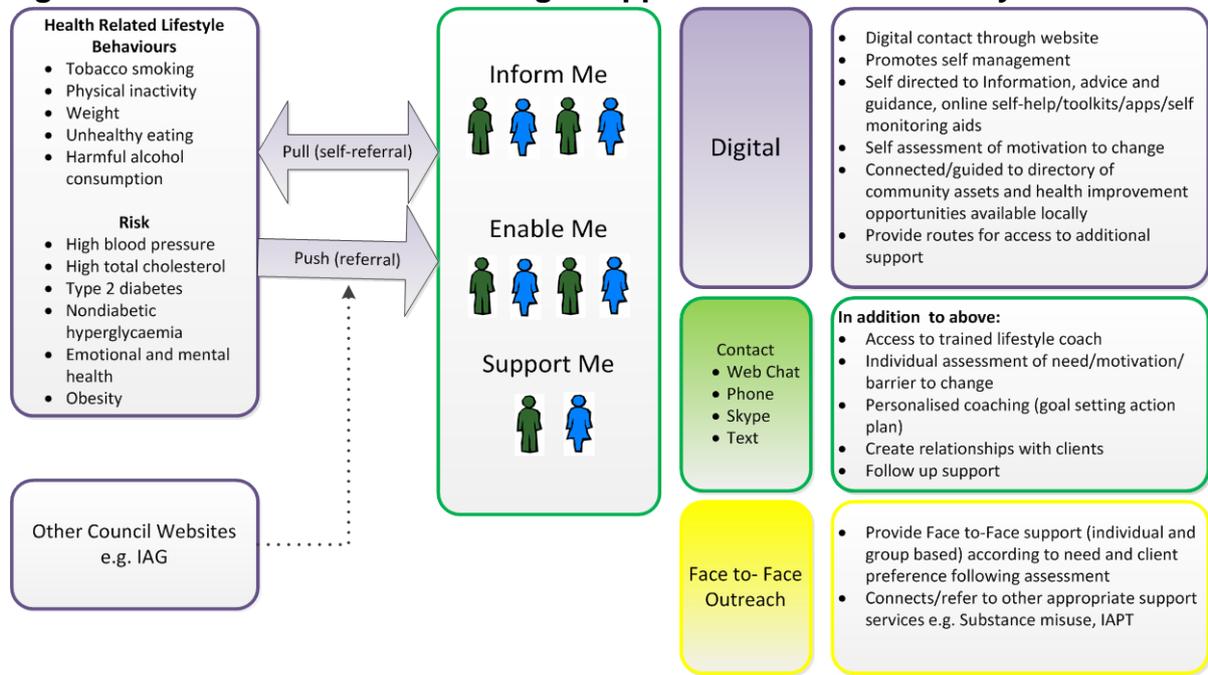
**Figure 10: Developing the principle of Proportionate Universalism into our Behaviour Change Lifestyles Programme**



Devon Public Health, 2016

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

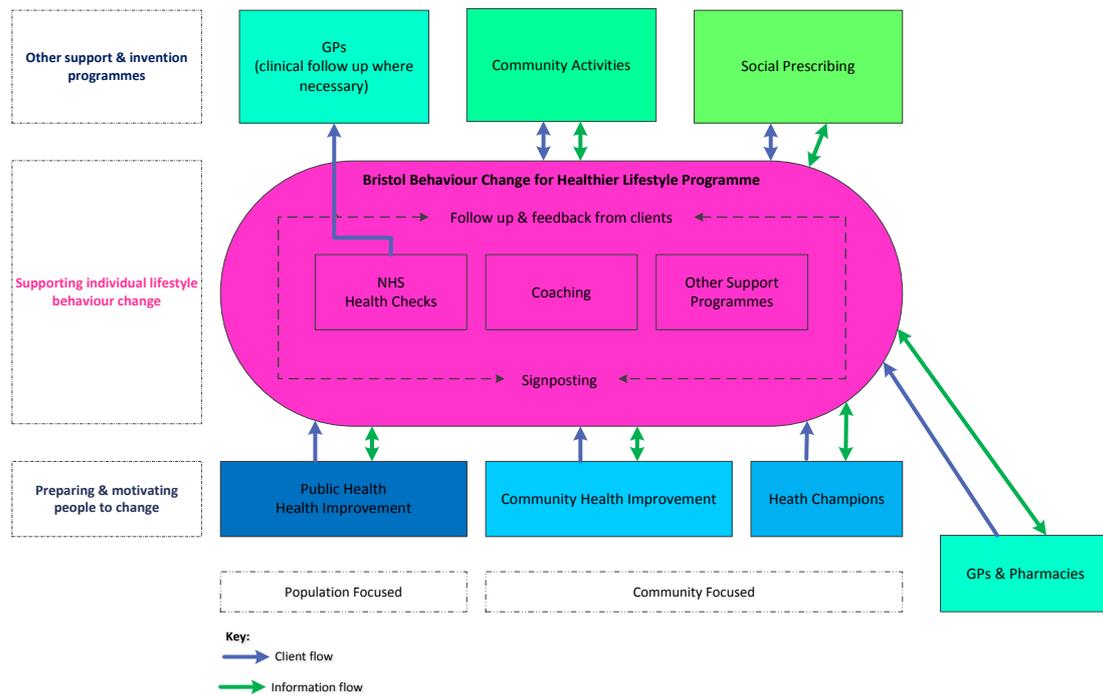
**Figure 11: Bristol Behaviour Change Support for Healthier Lifestyles**



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

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

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



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

## 5.6 Lotting

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

The advantages of this will be:

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

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

We will use an Open Procedure to procure this programme.

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

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

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

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

Bristol City Council aims to spend at least 25% of the Council's total procurement budget with micro, small and medium size businesses, social enterprises and voluntary / community organisations (less than 250 employees), as per the Social Value Policy. Within this commissioning process we intend to encourage involvement of micro, small and medium size businesses, social enterprises and voluntary / community organisations to bid. This could be achieved through collaborative bids from providers working together in, for example, lead partner collaborations or sub-contracting arrangements.

Sub-contracting arrangements are welcomed with the expectation that the majority of the activity will be carried out by the main provider as opposed to being sub-contracted out, which makes the contract management convoluted. Where collaborative bids or sub-contracting arrangements are proposed details will need to be provided at the Invitation to Tender stage where the role(s) of the sub-contractors/collaborators will need to be provided with the approximate percentage of contractual obligations assigned to the sub-contractor/collaborators. Bidders will need to provide written evidence (for example, a Memorandum of Understanding) that describes sub-contracting and collaborative arrangements.

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

## **5.7 Social Value**

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

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

This could include, for example, improving local employment opportunities, offering work placements or apprenticeships, or using local contractors including those with social objectives. 10% of the quality score will be related to adding social value. Bidders may wish to refer to the social value toolkit to consider how they may incorporate social value into their proposals.

## **5.8 Evaluation Approach**

The evaluation criteria are 80% quality and 20% price. A panel will be formed to include a range of stakeholders and perspectives and the views of service users will form part of the evaluation.

## **5.9 Contract Duration**

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

The contracts will include the need for providers and commissioners to work together to review and adapt according to population / community and individual needs of the residents of Bristol.

## **5.10 Performance Monitoring**

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

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

## **5.11 TUPE**

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

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

Bidding providers will need to consider the implications of TUPE. The council will obtain from current providers basic information about the employees who will

potentially be affected by this commissioning process. It is our intention to provide such information in advance of the invitation to tender to enable provider to develop accurate proposals and budgets.

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

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

## 6. Consultation

### 6.1 Stakeholder Consultation

We held a stakeholder consultation from 9<sup>th</sup> May to 1<sup>st</sup> August 2017; this included an online consultation questionnaire; focus groups and visits to key stakeholder groups and meetings.

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

### 6.2 Procurement Timetable

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

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

## Appendix A: Priority Population Groups

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

### Smoking

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

- Socio-economic status-education, income, employment: 31.1% in manual and routine workers
- Gender- Higher rates in men although rates for women have increased over the past 20 years (PHOF)
- Specific BAME groups eg South Asian men; African-Caribbean/Black British men and women; Polish; Romanian
- Ethnicity Dual heritage populations have the highest prevalence rate of 22.4% (PHOF)
- Lone parenthood (national data); pregnant women; young people
- Mental health problems- Over 60% of those experiencing poor mental health smoke (national data)
- Youth offenders, ex-offenders: 80% (national data)
- Sexual orientation - lesbian, gay, bisexual (national data)
- Other excluded groups e.g. travellers, homeless (national data), ex-substance misusers.

Most national and local surveys only focus on SES.

### Diet and Nutrition

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

- Men are less likely than women to eat 5 portions of fresh fruit and veg a day (PHOF)
- LGBT communities (aged 15 years) are less likely to eat 5 portions of fresh fruit and veg a day (PHOF).

### **Physical Activity**

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

### **Excessive Alcohol Intake**

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

### **Self-reported Wellbeing: Worthwhile Score**

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

## **Cardiovascular Disease**

Under 75 mortality rate - considered preventable

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

## **Cancer**

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

## **Respiratory Disease**

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

## **Liver Disease**

- Closely linked to deprivation
- Higher mortality rates for men.

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

### NHS Health Checks

#### Key issues

- Current patterns of local provision do not always align well with patterns of need across the population
- There are gaps in current service provision, some of these in areas of higher deprivation and where preventable CVD premature mortality is highest
- Activity (invitations for a Health Check and uptake of Health Check) is variable across providers
- Eligibility is currently determined from Practice population lists, future arrangements will need to consider alternative methods for obtaining this data, eg NHS Digital.
- The focus is on risk assessment (physiological and behavioural risks), rather than behaviour change to reduce identified risks
- Follow up after the health check appointment, for both clinical and lifestyle risks is low.

#### Recommendations

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

### Support to Stop Smoking

#### Key issues

- Smoking prevalence, and smoking in pregnancy varies widely across wards. Higher rates are seen in some population groups eg. those in routine and manual occupations, unemployed, those with mental health problems.
- Smoking is increasingly concentrated among people living in more deprived areas and among certain population groups
- Numbers accessing support to stop and setting a quit date have declined locally, in line with the national trend
- Support to stop smoking activity amongst current providers is low, and activity does not align with areas of higher deprivation where smoking prevalence is highest

- Referrals from health services including secondary care acute and mental health and health visiting services are low.

### Recommendations

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

## Healthy Weight

### Key issues

- Estimated modelling based on the Quality of Life data for adult overweight and obesity suggests a need of 21,000 more referrals per year to weight management services in Bristol to achieve 1000 people successfully losing and maintaining weight loss and reducing the prevalence of overweight and obesity
- Current patterns of local provision do not always align well with patterns of need across the population
- Evaluation of current services showed that less than one third of people referred to weight management services have successfully lost weight. Sustained weight loss is not currently known
- Uptake rates into the Weight Management schemes currently available are low compared to population need. Although they do appear to target the most appropriate population (quintiles 3, 4 & 5) there are still significant numbers accessing these services that could with the appropriate information access other self-help services with the same success rate.
- The proportion of children with excess weight in England has been largely constant, around 22- 23%, since the National Childhood Measurement Programme began in 2006/07. The Bristol rate had been around 25%, higher than England, for 2007 to 2010, but since 2010/11 has been broadly similar to average Bristol is 22.9% in 2015/16, similar to England, at 22.1%.
- The 2014/15 data showed more boys (23.5%) had excess weight than girls at 21.9%
- Within Bristol, the proportion of 4-5 year olds who are overweight or obese is much lower in North & West (inner) (17%) and highest in North & West (outer) (26%).
- The proportion of 10-11year old children overweight or obese in England has been largely constant, around 32-33% since the National Childhood Measurement Programme began in 2006/07. However, in Bristol the rate has been rising in recent years and in 2015/16 the proportion of 10-11year olds

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

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

## Recommendations

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

# Appendix C: Survey Questionnaire

## Introduction:

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

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

1. **What does being healthy mean to you?** (please tick all that apply)

- Physically active
- Emotional wellbeing
- No diagnosed health condition
- Socially active
- Other, please state.....
- Eating a healthy diet
- Mentally fit
- Smokefree
- Controlling my alcohol intake
- Spiritual wellbeing
- Healthy weight

2. **Are there any areas of your own health that you need (or would like) to improve?** (please tick all that apply)

- Stop smoking
- Lose weight
- Be more active generally
- Get out more
- Feel better mentally
- Cycle more
- Be happier
- Sleep better
- Other, please state.....
- Feel less stressed
- Be less socially isolated
- Be able to take more care of myself
- Walk more
- Eat healthier
- Nothing I need to improve
- Have more confidence
- Drink less alcohol

3. **Which of our current healthy lifestyle services have you tried?** (please tick all that apply)

- Slimming World
- Adult Specialist Weight Management Service
- NHS health check
- Exercise on prescription
- Cooking on prescription
- Not tried any
- Other, please state.....
- Weight Watchers
- Waist Watchers
- Support to stop smoking
- Walking for health
- Community growing clubs
- Recovery Orientated Drug & Alcohol Services

**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



- 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
- No time for myself
- Don't feel motivated
- Additional responsibilities eg carer
- Not a priority for me
- Difficult to access activities
- Don't know what to do
- Not enough money
- I feel I am healthy enough
- 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
- Safer parks/pavements
- Well women events
- Fewer cheap alcohol outlets
- More green space to grow own food
- More services available for me and my children/family
- More growing & cooking skills
- Easier access to Leisure Centres
- Well men events
- Stop sale of illegal tobacco
- Easier access to fresh foods

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

| \_\_\_\_\_ |  
1 not important at all 10 very important

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

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

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

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

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

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

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

18. Are you disabled?

- Yes
- No
- Prefer not to say

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

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

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

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

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

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

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

**Name:**

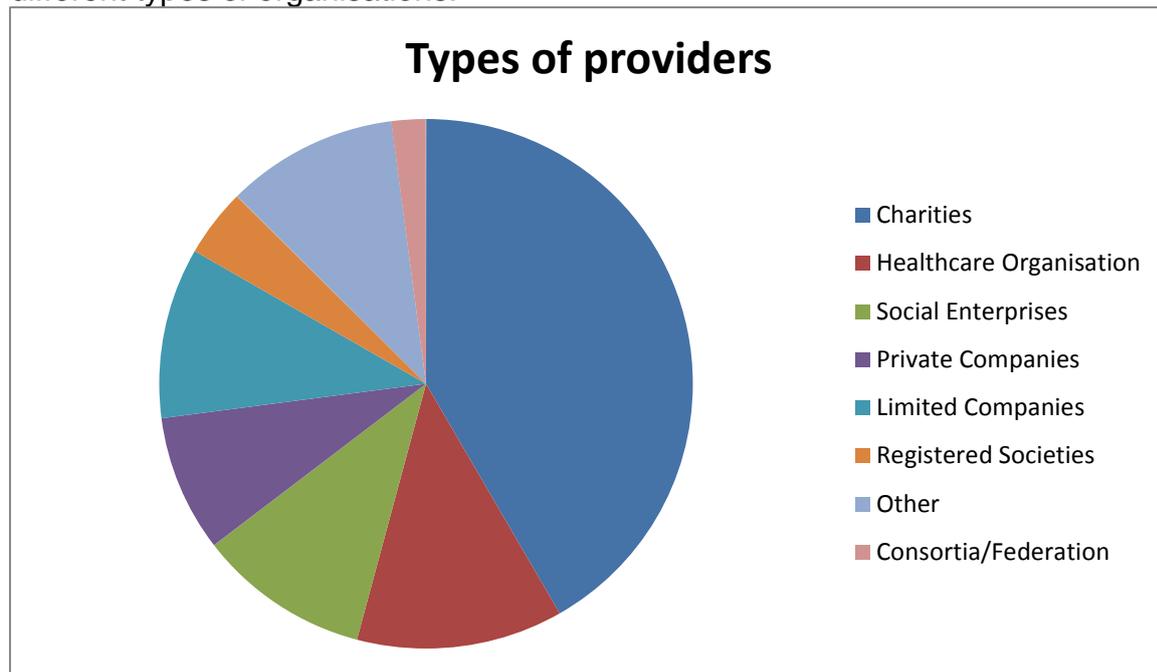
**Address:**

**Contact tel.no.**

## Appendix D: Market Analysis

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

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



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

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

These figures do not include the use of volunteers.

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

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

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

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

**What factors would encourage you to bid for a contract to deliver these services?**

There was a range of suggestions providers identified that would encourage them to bid for the behaviour change contract, including:

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

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

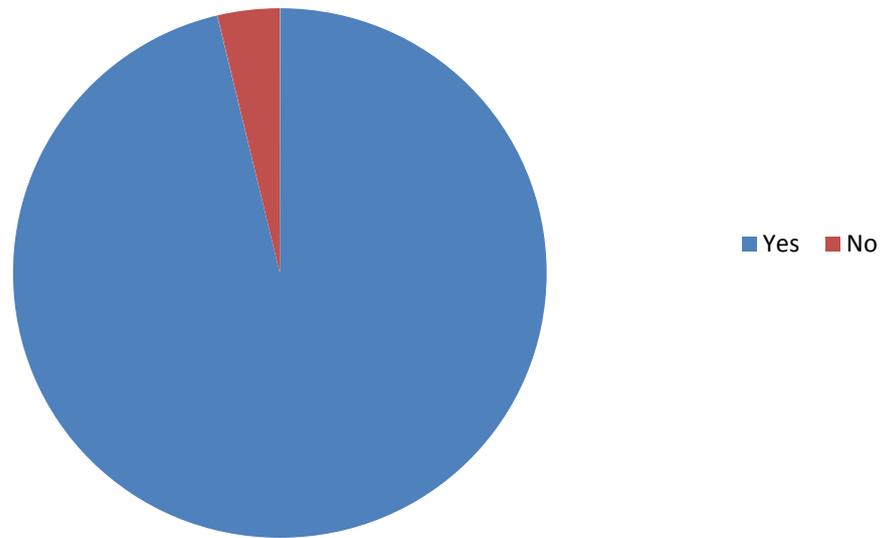
**What factors would discourage you from bidding for a contract to deliver these services?** Responses are listed below:

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

**Is your organisation open to collaborative working with other organisations?**

The majority of providers completing the questionnaire were open to collaborative working.

## Collaborative Working



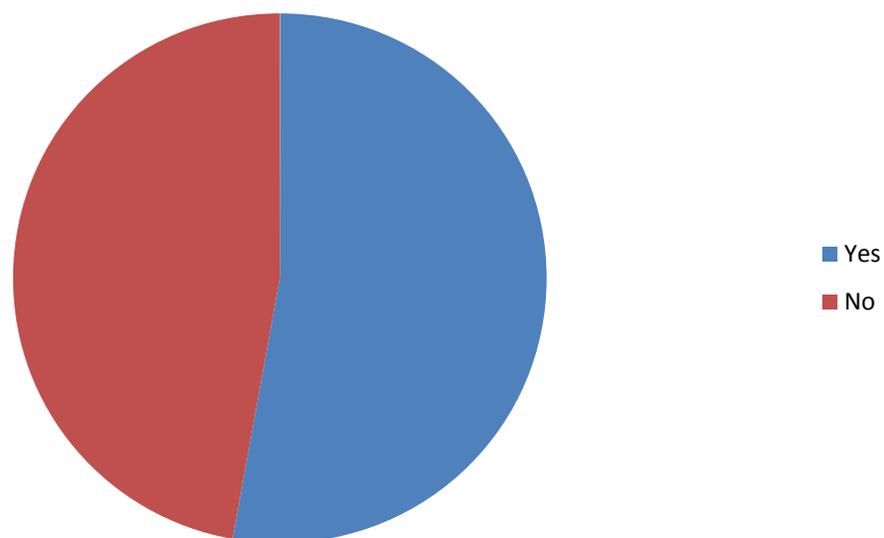
The information days for stakeholders have ensured time is included for networking and opportunities to enable collaboration between organisations.

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

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

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

## Interactive digital platform



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

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

### **What experience have you had of working with local communities?**

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

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

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

## Summary

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

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

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

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

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

## Appendix E: Equality Impact Assessment

Name of proposal	Bristol Behaviour Change for Healthier Lifestyles Commissioning Strategy
Directorate and Service Area	Public health
Name of Lead Officer	Amanda Chappell and Wendy Parker

### Step 1: What is the proposal?

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

#### 1.1 What is the proposal?

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

##### Preventing premature death

We know that four key behaviours are the biggest preventable risk factors for preventing premature death:

- Smoking
- Excess alcohol
- Physical activity
- Poor diet

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

##### The support needed

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

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

We want to be able to provide the right people with the right information, advice and support, in the right format and style for them, which is flexible and dynamic to respond to people's different needs and to emerging technology. It also needs to have the ability to deliver a targeted, potentially more intensive offer to those in greatest need, applying the

principal of Proportionate Universalism (Marmot, 2011) in order to reduce health inequalities.

## Step 2: What information do we have?

Decisions must be evidence-based, and involve people with protected characteristics that could be affected. Please use this section to demonstrate understanding of who could be affected by the proposal.

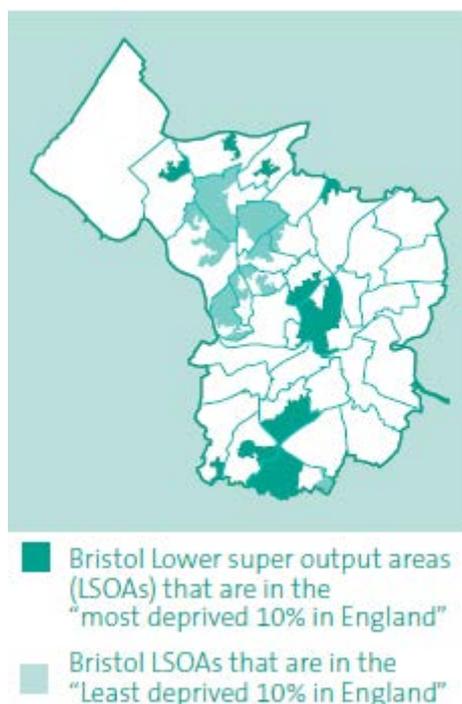
### 2.1 What data or evidence is there which tells us who is, or could be affected?

Research on health inequalities indicates the importance of improving access to public health services. The Five Year Forward View and Public Health Outcome Framework identify the need to reduce premature mortality and improve quality of life for those with poorest health. Marmot review also recommends using a proportionate universalism approach to delivery of these services.

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

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

Life expectancy in Bristol



<sup>1</sup> Slope Index of Inequality; 2010-12; released Public Health England 2014

## **Smoking**

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

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

Most national and local surveys only focus on SES

## **Diet and Nutrition**

- 59% of the Bristol population is overweight and obese ( PHOF)
- S. Asian and Afro Caribbean populations are at higher risk of diabetes ( type 2)
- Obesity is closely linked to Type 2 Diabetes
- Rates of diabetes are high amongst those with serious mental health issues
- Deprivation is closely linked to less consumption of fruit and veg ( PHOF)
- Men are more likely to be overweight than women ( PHOF)
- There are more obese women than men ( PHOF)
- Over 70% of those over the age of 35 are overweight or obese (PHOF)
- Both White and Black British groups have the highest prevalence for being overweight and obese (PHOF)
- Deprivation and obesity are closely linked (PHOF)
- Disabled populations are more likely to be overweight (PHOF)
- Obesity is closely linked to poor mental health (PHOF)
- South Asian , Black and other ethnicities are less likely to achieve 5 portions of fresh fruit and veg a day (PHOF)
- Black British , African-Caribbean and White young people ( aged 15) are less likely to consume 5 a day (PHOF)
- Men are less likely than women to eat 5 portions of fresh fruit and veg a day (PHOF)
- LGBT communities ( aged 15years) are less likely to eat 5 portions of fresh fruit and veg a day (PHOF)
- Overall the local data highlights that people with Learning Disabilities in Bristol are more likely to have a range of (often multiple) health conditions and poorer health outcomes, linked to difficulties in their access to health care.(JSNA2014)

## **Physical activity**

- 62% of adults are physically active in Bristol
- 25% of adults are inactive
- Asian and Black have the highest prevalence of inactive adults
- Women are much more likely to be inactive than men

- Older adults are more likely to be inactive
- There is a big disparity between disabled and non-disabled
- Deprivation is closely linked with inactivity
- We need to include those with learning difficulties

### **Excessive alcohol intake**

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

### **Self-reported wellbeing**

#### **Worthwhile Score**

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

### **Cardiovascular Disease**

#### **Under 75 mortality rate - considered preventable**

- Closely linked with deprivation
- Men are 3 times more likely to have heart disease
- Some BME Groups have higher rates of CHD ( S.Asian) and Hypertension ( Stroke) African Caribbean
- People with a diagnosis of Serious Mental Illness (SMI) are twice as likely to die from coronary heart disease
- Rates of hypertension are also high amongst those with SMI

- People with learning disabilities have a higher risk of ischemic heart disease than the general population and this is the
- second most common cause of death in people with learning disabilities
- People with learning disabilities are 58 times more likely to die before the age of 50 than the general population.
- Ex-offenders are more likely to have high rates of CVD

#### **Cancer**

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

#### **Respiratory Disease**

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

#### **Liver Disease**

- Closely linked to deprivation
- Higher mortality rates for men

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

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

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

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

The consultation process will include:

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

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

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

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

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

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

Internet use by age in the UK.



General national issues in internet use.

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

region with the lowest recent usage (82.0%).

- Inactive adults who had never used the internet or who used the internet more than 3 months ago, has decreased by 13.3 percentage points since 2011.

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

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

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

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

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

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

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

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

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

<b>3.4 Can they be maximised? If so, how?</b>

**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.

<b>4.1 How has the equality impact assessment informed or changed the proposal?</b>
---

Commissioners have answered questions of the equalities team in order that this EqIA be completed fully.
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<b>4.2 What actions have been identified going forward?</b>
---

<b>4.3 How will the impact of your proposal and actions be measured moving forward?</b>
---

The service specification must include an outcome that the three methods of delivery, inform me, enable me and support me meet the needs of equalities communities in terms of accessibility. It should also require that they demonstrate that they understand the level of need for each method and have a plan to deliver behaviour change initiatives to meet the need.
---

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

## Appendix F: Communications Strategy

### Aim

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

### Objectives

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

### Current Services

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

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

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

### Commissioning Documents

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

- Market Position Statement
- Equality Impact Assessment
- Commissioning Strategy

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

### Consultation

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

- Tuesday 28<sup>th</sup> March – workshops in morning and afternoon
- Community based workshops – mid February to end March

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

**Timeline:**

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

## Appendix G: Findings from the Consultation

### Report on Consultation Engagement

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

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

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

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

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

Requests sent, not being taken up:

- Youth Moves Consultation meeting

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

The survey questions with the key findings are summarised below.

<b>Individuals</b>	<b>88</b>	<b>77.19%</b>
<b>Organisations</b>	<b>26</b>	<b>22.81%</b>

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

### **Question 2: Model**

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

*Do you agree with this proposal?*

<b>Yes</b>	<b>90</b>	<b>81.82%</b>
<b>No</b>	<b>20</b>	<b>18.18%</b>

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

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

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

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

### Question 3: Personas

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

*Do you agree with this approach?*

<b>Yes</b>	<b>89</b>	<b>82.41%</b>
<b>No</b>	<b>19</b>	<b>17.59%</b>

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

### Question 4: Digital Offer

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

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

<b>Yes</b>	<b>73</b>	<b>65.77%</b>
<b>No</b>	<b>38</b>	<b>34.23%</b>

A total of 73 comments were left. Twenty-two respondents did not like the proposal for a digital offer. A further 38 had concerns about groups of people who are not able to access the internet and digital information. A typical quote is:

*"One of the focuses not THE focus - many vulnerable people will find using technologies a barrier to starting the process of behaviour change."*

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

### Question 5: Levels of Support:

*Do you agree with the model to provide different levels of support according to needs of individuals?*

<b>Yes</b>	<b>104</b>	<b>92.86%</b>
<b>No</b>	<b>8</b>	<b>7.14%</b>

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

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

**Question 6:**

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

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

**Question 7 Outcomes:**

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

*Do you agree with these outcomes?*

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

<b>Yes</b>	<b>97</b>	<b>88.99%</b>
<b>No</b>	<b>12</b>	<b>11.01%</b>

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

**Question 8 Social Value:**

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

A total of 77 comments were left.

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

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

**Questions 9 Scope:**

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

*Do you agree with this scope?*

<b>Yes</b>	<b>75</b>	<b>74.26%</b>
<b>No</b>	<b>26</b>	<b>25.74%</b>

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

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

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

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

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

**Question 10 Lots:**

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

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

<b>A</b>	<b>24</b>	<b>23.76%</b>
<b>B</b>	<b>27</b>	<b>26.73%</b>
<b>C</b>	<b>34</b>	<b>33.66%</b>
<b>None</b>	<b>16</b>	<b>15.84%</b>

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

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

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

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

**Question 11 Price/Quality:**

*In our plan, our proposed evaluation criteria will be 80% quality and 20% price (page 28, section 5.8).*

*Do you feel this ratio is correct?*

<b>Yes</b>	<b>89</b>	<b>86.41%</b>
<b>No</b>	<b>14</b>	<b>13.59%</b>

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

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

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

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

**Question 12 Equalities:**

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

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

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

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

Seventeen people did not think that anything further was required.

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

**Question 13:**

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

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

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

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

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

## Summary of Group Meeting responses

Group	Date	Numbers attended
BDP	14 <sup>th</sup> July 2017	10
North Practice Mangers	18 <sup>th</sup> July 2017	
South Practice Managers	22 <sup>nd</sup> June 2017	
ICE Practice Mangers	14 <sup>th</sup> June 2017	

### Cuts/could fund other things e.g. parks

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

### Process

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

### Service question

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

- Is intention to invite Health Checks centrally?

#### Digital

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

#### NHS Specific

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

#### What about Mental Health?

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

#### Other comments

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

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