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

Date: Monday, 6 December 2021

Time: 10.00 am

Venue: The Council Chamber - City Hall, College Green, Bristol, BS1 5TR

Distribution:

Councillors: Graham Morris (Chair), Jos Clark (Vice-Chair), Brenda Massey, Paul Goggin, Lorraine Francis, Chris Windows, Mohamed Makawi, Tom Hathway and Amal Ali

Issued by: Dan Berlin, Scrutiny Advisor
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Tel: 0117 3525232
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Date: Friday 26 November 2021

www.bristol.gov.uk

Agenda

1. Welcome, Introductions, and Safety Information

(Pages 4 - 6)

2. Apologies for Absence and Substitutions

3. Declarations of Interest

4. Annual Business Report

(Pages 7 - 10)

5. Chair's Business

6. Minutes of Previous Meeting

(Pages 11 - 18)

7. Public Forum

Up to 30 minutes is allowed for this item.

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

Questions - Written questions must be received 3 clear working days prior to the meeting. For this meeting, this means that your question(s) must be received in this office at the latest by **5pm on Tuesday 30 November.**

Petitions and Statements - Petitions and statements must be received on the working day prior to the meeting. For this meeting this means that your submission must be received in this office at the latest by **12 noon on Friday 3 December.**

8. Child and Adolescent Mental Health Services

Report to follow

9. Community Mental Health Framework and Integrated Care Partnerships in Bristol

(Pages 19 - 87)

10. Work Programme

(Page 88)

Public Information Sheet

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

You can find papers for all our meetings on our website at www.bristol.gov.uk.

Changes to how we hold public meetings

Following changes to government rules, public meetings including Cabinet, Full Council, regulatory meetings (where planning and licensing decisions are made) and scrutiny will now be held at City Hall.

COVID-19 Precautions at City Hall (from July 2021)

When attending a meeting at City Hall, COVID-19 precautions will be taken, and where possible we will:

- Have clear signage inviting you to check in to the venue using the NHS COVID-19 app or record your contact details for track and trace purposes.
- Provide public access that enables social distancing of one metre to be maintained
- Promote and encourage wearing of face coverings when walking to and from the meeting
- Promote good hand hygiene: washing and disinfecting hands frequently
- Maintain an enhanced cleaning regime and continue with good ventilation

COVID-19 Safety Measures for Attendance at Council Meetings (from July 2021)

To manage the risk of catching or passing on COVID-19, it is strongly recommended that any person age 16 or over attending a council meeting should follow the above guidance but also include the following:

- Show certification of a negative NHS COVID-19 lateral flow (rapid) test result: taken in the 48 hours prior to attending. This can be demonstrated via a text message or email from NHS Test and Trace.
- An NHS COVID-19 Pass which confirms double COVID-19 vaccination received at least 2 weeks prior to attending the event via the NHS App. A vaccination card is not sufficient.
- Proof of COVID-19 status through demonstrating natural immunity (a positive NHS PCR test in the last 180 days) via their NHS COVID-19 pass on the NHS App.
- Visitors from outside the UK will need to provide proof of a negative lateral flow (rapid) test taken 48 hours prior to attendance, demonstrated via a text message or email.

Reception staff may ask to see this on the day of the meeting.

No one should attend a Bristol City Council event or venue if they:

- are required to self-isolate from another country
- are suffering from symptoms of COVID-19
- have tested positive for COVID-19 and are requested to self–isolate

Members of the press and public who wish to attend City Hall are advised that you may be asked to watch the meeting on a screen in another room due to the maximum occupancy of the venue.

Other formats and languages and assistance for those with hearing impairment

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

Committee rooms are fitted with induction loops to assist people with hearing impairment. If you require any assistance with this please speak to the Democratic Services Officer.

Public Forum

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

The following requirements apply:

- The statement is received no later than **12.00 noon on the working day before the meeting** and is about a matter which is the responsibility of the committee concerned.
- The question is received no later than **5pm three clear working days before the meeting**.

Any statement submitted should be no longer than one side of A4 paper. If the statement is longer than this, then for reasons of cost, it may be that only the first sheet will be copied and made available at the meeting. For copyright reasons, we are unable to reproduce or publish newspaper or magazine articles that may be attached to statements.

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

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

During the meeting:

- Public Forum is normally one of the first items on the agenda, although statements and petitions that relate to specific items on the agenda may be taken just before the item concerned.
- There will be no debate on statements or petitions.
- The Chair will call each submission in turn. When you are invited to speak, please make sure that your presentation focuses on the key issues that you would like Members to consider. This will have the greatest impact.
- Your time allocation may have to be strictly limited if there are a lot of submissions. **This may be as short as one minute.**
- If there are a large number of submissions on one matter a representative may be requested to speak on the groups behalf.
- If you do not attend or speak at the meeting at which your public forum submission is being taken your statement will be noted by Members.
- Under our security arrangements, please note that members of the public (and bags) may be searched. This may apply in the interests of helping to ensure a safe meeting environment for all attending.
- As part of the drive to reduce single-use plastics in council-owned buildings, please bring your own water bottle in order to fill up from the water dispenser.

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

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Members of the public attending meetings or taking part in Public forum are advised that all Full Council and Cabinet meetings and some other committee meetings are now filmed for live or subsequent broadcast via the council's webcasting pages. The whole of the meeting is filmed (except where there are confidential or exempt items). If you ask a question or make a representation, then you are likely to be filmed and will be deemed to have given your consent to this. If you do not wish to be filmed you need to make yourself known to the webcasting staff. However, the Openness of Local Government Bodies Regulations 2014 now means that persons attending meetings may take photographs, film and audio record the proceedings and report on the meeting (Oral commentary is not permitted during the meeting as it would be disruptive). Members of the public should therefore be aware that they may be filmed by others attending and that is not within the council’s control.

The privacy notice for Democratic Services can be viewed at www.bristol.gov.uk/about-our-website/privacy-and-processing-notices-for-resource-services

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

Report of: Director, Legal & Democratic Services

Title: Health Scrutiny Committee Annual Business Report 2021/2022.

Ward: N/A

Officer Presenting Report: Dan Berlin, Scrutiny Advisor

Contact: dan.berlin@bristol.gov.uk

Recommendations:

1. To note the Scrutiny Committee's Terms of Reference.
2. To note the membership of the Committee for the 2021-22 municipal year.
3. To note the Chair and Vice-Chair for the 2021-22 municipal year.
4. To note that the dates and times for meetings for the 2021-22 municipal year.

1. Context

1.1 Terms of Reference of the Committee

At the annual meeting on 25 May 2021 Full Council established this committee (as a sub-committee of the People Scrutiny Commission) with the following terms of reference:

Terms of Reference – Overview

To undertake the scrutiny of local Health Service provision in accordance with Section 7 of the Health and Social Care Act 2001, the Health and Social Care Act 2012 and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Functions

i) To review and scrutinise any matter relating to the planning, provision and operation of the health service in its area.

ii) To review and scrutinise any proposal for the substantial development or substantial variation of the Health Service as referred by a local NHS commissioner or provider under its statutory obligation to consult with the Council. To consider and assess impact assessments from such bodies and decide whether proposals are substantial variations or developments.

iii) To require the local NHS body to provide information about the proposal under consideration and where appropriate to require the attendance of a representative of the NHS body to answer such questions as appear to it to be necessary for the discharge of its function in connection with the consultation.

iv) To report to the Secretary of State in writing where it is not satisfied that consultation on any proposal referred to in paragraph 2 above has been adequate in relation to the content or time allowed.

v) To report to the Secretary of State in writing in any case where it considers that the proposal referred to in paragraph 2 above would not be in the interests of the health service in the area

vi) Where a matter is referred to it by Healthwatch to consider whether to exercise any powers in relation to the matter, taking into account information supplied by Healthwatch.

vii) To scrutinise matters relating to the health of the authority's population and contribute to the development of policy to improve health and reduce health inequalities.

viii) To review and scrutinise the impact of the authority's own services and key partnerships on the health of its population.

ix) Review and scrutinise decisions made, or other action taken in connection with the discharge of any functions which are the responsibility of the Mayor/Executive, functions which are not the responsibility of the Executive, and functions which are the responsibility of any other bodies the Council is authorised to scrutinise.

x) In relation to the above functions:
    a) To make reports and/or recommendations to the full Council, Executive of the Council, any joint committee, NHS bodies or any relevant partner authority as appropriate;
    b) To consider any matter affecting the area or its inhabitants

xi) To report on an annual basis to the People Scrutiny Commission on progress against the work programme and any recommendations it makes.

1.2 Membership of the Committee

The Committee contains 9 Members (Labour 3; Green 3; Conservative 2; Liberal Democrat 1); details as follows;

- Cllr Graham Morris – Chair
- Cllr Jos Clark – Vice Chair
- Cllr Amal Ali
- Cllr Lorraine Francis
- Cllr Paul Goggin
- Cllr Tom Hathway
- Cllr Mohamed Makawi
- Cllr Brenda Massey
- Cllr Chris Windows

1.3 2021-22 Meeting Dates

- There will be two meetings of the Committee during 21/22.
- The first meeting will be held on Monday 6 December, 10am.
- The second meeting will be held on Monday 14 March 2022, 10am.

Please Note: the Health Scrutiny Work Programme can be located at Agenda Item 10.

2. Public Sector Equality Duties

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

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

    ii) Advance equality of opportunity between persons who share a relevant protected

characteristic and those who do not share it. This involves having due regard, in particular, to the need to --

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

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

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

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

4. Legal and Resource Implications

N/A

Appendices:
None

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

- Full Council, 25 May 2021

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

25 February 2021 at 1.30 pm

Members Present:-
Councillors: Brenda Massey (Chair), Eleanor Combley, Paul Goggin and Gill Kirk

Also in Attendance:-
Councillor Asher Craig, Deputy Mayor (Communities, Equalities & Public Health)

Christina Gray, Director for Communities and Public Health, Bristol City Council (BCC); Carol Slater, Health Equity Lead, BCC; Lewis Peake, Public Health Registar; Leonie Roberts, Consultant in Public Health; Victoria Bleazard, Head of Mental Health Services, BNSSG CCG; Michelle Smith, Associate Director for Communications & Engagement, Bristol North Somerset South Gloucestershire Clinical Commissioning group (BNSSG CCG); Lisa Manson, Director of Commissioning, BNSSG CCG; Emma Moody, Head of Mental Health Commissioning, BNSSG CCG; Anna Norris, Senior Contract Manager – Non-Acute, BNSSG CCG; Andy Newton, Head of Planned Care, BNSSG CCG; Tim Whittlestone, Clinical Lead for Vaccination Programme, BNSSG CCG; Claire Thompson, Chief Operating Officer, Nightingale Hospital Bristol

1. **Welcome, Introductions, and Safety Information**

The Chair welcomed all attendees to the meeting.

2. **Apologies for Absence and Substitutions**

Councillor Clough sent apologies.

3. **Declarations of Interest**

There were no declarations of interest.

4. Minutes of Previous Meeting

The minutes of the meeting held on 11th March 2020 were agreed as a true record.

5. Chair's Business

The Chair noted that the written response to the Health Scrutiny Working Group report by the CCG Governing Body would follow, and that there would be a verbal update at this meeting.

6. Public Forum

There were no public forum submissions.

7. COVID-19 Update (For Information)

The Director for Communities and Public Health introduced the report.

- The Committee was advised that the 'collect and drop' test kits were successful and more people had used this facility and dropped their kit back than attended the mobile testing units.

- The Director for Communities and Public Health was thanked, and the Public Health team commended for the clarity and timeliness of the information brought to the Committee and the public.

- There was a discussion about the use of libraries, that they had provided a central role in communities. It was agreed that this should be learnt from.

- The Deputy Mayor (Communities, Equalities & Public Health) commended the Communities & Public Health team for the work accomplished over the last year and stated that libraries were community hubs and had a role to play to support public health.

- The Committee was advise that Government funding had been secured to support the Library strategy, and there would be investment in a group of libraries to extend entrepreneurship.

8. Health Scrutiny Working Group Report

The Associate Director of Communications & Engagement from the Clinical Commissioning Group provided a verbal update for the Committee.

- The Committee was advised that there had been a meeting of the Clinical Commissioning Group (CCG) Governing Body in February, at which the Scrutiny Working Group report was well received and appreciated.

- The Governing Body thanked the Working Group for the report and a formal written response would follow.

- Members heard that the Governing Body had commented that the range of partners brought together in the evidence sessions had been a useful way to inform the report.

- The Governing Body welcomed the joint working, and provided three core themes of reflection: (i) digital exclusion and digital literacy (informed recovery planning), (ii) screening services (the importance of the establishment of clear messaging of the safety of screening as well as elective care), and (iii) the importance of effective communication with patients on waiting lists - these would be expanded upon in the formal written response.

- The Director for Commissioning thanked the Committee for the report.

- It was noted that the Committee, during the evidence sessions, also received views from the NHS Trusts which was helpful and constructive; and the important thing was to pick up the learning and ensure it was included in the recovery planning.

- The Committee heard that the CCG had noted the importance of digital literacy, and this would be one of the key points included in recovery planning.

- The Deputy Mayor (Communities, Equalities & Public Health) advised the Committee that a One City Digital Inclusion Group had been convened, instigated by the feedback of the Working Group, feedback from the business community, and the recognised needs of young people to access the internet and devices. The scope had been broadened to include different cohorts and communities which included older people and refugee communities. There were over 4000 laptops that would be distributed; and training had been made available for older people to learn how to use the devices; this would help tie together the need for and access to health apps.

- The Committee was advised the CCG was aware that many people had no access to the internet. It was agreed that the digital inclusion strategy that the CCG and Trusts were working on should therefore be joined up with the work the Council had been doing in this area.

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

The Clinical Commissioning Group (CCG) Senior Contracts Manager introduced the report. The Associate Director, Operations for Specialised Services, Avon & Wiltshire Mental Health Partnership (AWP), also spoke to the report.

- The Committee was advised that the bed process was overseen by NHS England and Improvement; AWP had a key role in the delivery of that service.

- Members heard that the inpatient bed capacity was closed in March 2020, and the figures until the end of January 2021 were as follows: Of all referrals for Tier 4 beds
    - 37 have been supported by the Riverside enhanced service
    - 35 have been admitted to Tier 4 beds within SW region – 6 of these were to Bristol Priory before it closed
    - 7 were admitted out of region
    - 34 supported by Tier 3

- The Committee was advised that young people with eating disorders were not included in those figures as there were no specialist eating disorder Child and Adolescent Mental Health Services **(**CAMHS) beds within region; all would have gone out of region, managed by NHS England & Improvement.

- Members were advised the closest specialist eating disorder provision was Coventry; AWP had been working with commissioners to plan how that service provision could be delivered closer to home.

- Members heard that there had been plans for service user evaluation and this would be reported upon; that AWP had a service agreement with Barnardo's to assist with the young person and child engagement.

- The Chair raised concern about out of region placements and recommended that this item be monitored, and the Committee updated.

RESOLVED;

That changes in specialist bed provision be considered when Members plan the 2021-22 work programme.

10. Carers accompanying patients for outpatients appointments

The Head of Planned Care, Bristol North Somerset South Gloucestershire Clinical Commissioning Group (BNSSG CCG) introduced the report.

- It was confirmed that carers could attend face to face appointments along-side patients; and that guidance provided to the patient stated that patients should attend alone unless a carer was required.
- The Committee heard that there was not a policy on differentiation of types of carer, which included voluntary or paid.

11. Delivery of the BNSSG Mass Vaccination Programme - Update

The Clinical Lead for Mass Vaccinations for Bristol North Somerset South Gloucestershire Clinical Commissioning Group (BNSSG CCG) introduced the report. The Operations Lead for Mass Vaccination, Director of Commissioning, Associate Director of Communications and Director of Commissioning, BNSSG CCG, also spoke to the report.

- The Chair stated that Councillors had a role to ensure information reached communities; and invited the CCG to send updates which would be passed on to known networks and via social media.
- The Committee heard that the Clinical Governance Group had recorded all known side effects; local reporting for moderate to severe side effects had shown low rates and no difference between the vaccinations. The most common side effect was a local one (painful arm).
- The report was commended, and Members commented that it was good to see data used in a smart way, with a geographical focus and used to identify at-risk groups.
- There was a discussion about how prioritisation of cohorts had worked in practice, and the Committee heard that all GP practices were grouped in Primary Care Networks (PCN) and cohort populations were identified within them, the vaccine supply was matched to that, and it was ensured that all PCNS were in line and had not fallen behind others so no area of the population would be disadvantaged.

- Members heard that in practice, due to the way the vaccine had arrived and that it had to be used within a week, there might not have been a completely even roll out across the PCNs, but it had been kept as even as possible.

- The Committee heard that GP records were used to identify those who had underlying health risks, and so assessed at a higher risk for COVID-19, and would be prioritised.

- The team were commended for the way the vaccination roll out had been coordinated and delivered so far.

- Cllr Goggin shared with the Committee that he had received the AstraZeneca vaccine and had posted a photo on social media which provided positive messaging about the vaccine. Mohamed Abdi and Mohammed ElSharif at Muslims for Bristol were commended for their work to provide information and dispel myths about the vaccine.

- The Committee was advised that there was a national observatory system which monitored every vaccination, provided information and ensured 2nd doses were appropriately provided.

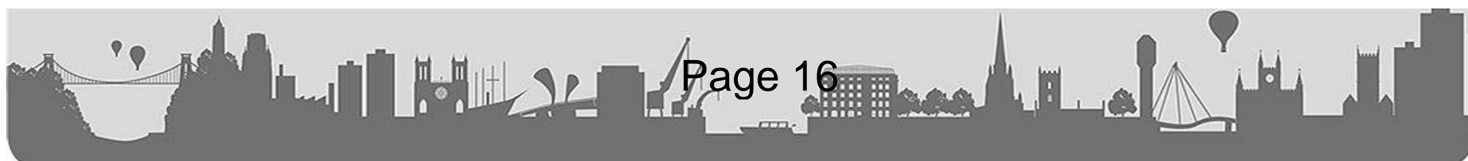
- There was a discussion about how not being registered with a GP affected access to vaccinations, and the Committee was advised that there had been work to encourage people to register, with assurances that information would be only used for health purposes.

- Members heard that, as a fail-safe, there was the ability to vaccinate those people who were unregistered; this ensured there were no barriers to receiving the vaccine. This was particularly important for people who were homeless and asylum seekers.

- Also, it was recognised that some people had not registered with a GP or would not share all health issues with their GP, and so if they had a risk factor and had not been registered, they could still receive a vaccination.

- The Committee heard from Vicky Marriott, Healthwatch Bristol, who explained that there had been enquiries from people how considered themselves carers and tried to register with a GP but had been unable to do so; and there was a discussion about whether there was a criteria for how GPs would recognise carers.

- Healthwatch and Members were advised that there was a definition for unpaid carers; the issue was a number of people who identified as carers did not fit into those categories; but this would be mitigated by the ability for people to self-declare which would be available soon.



12. Drug and Alcohol Strategy

The Registrar in Public Health introduced the report. The Consultant in Public Health and the Bristol North Somerset South Gloucestershire Clinical Commissioning Group's Head of Mental Health and Learning Disabilities also spoke to the report.

- The report was commended; it was described as being comprehensive and data-rich.
- The Chair recommended that a note should be sent to the Licencing Committee to highlight the importance of the availability of alcohol-free drinks on licensed premises.
- There was a discussion about the clarity of the strategy and whether it was accessible to the public and service users, and Members were advised that it was tailored to providers and commissioners, and being accessible was important so communities could engage.
- Members heard that there was a question In the consultation document which asked people if they found the strategy clear, legible and readable; broadly speaking most people agreed that it was clear and legible, although too much jargon was referenced, and this would be considered.
- There was a discussion about how mental health could be more embedded within the strategy across the key points and members were advised that references to the importance to mental health throughout had been increased; further reference to mental health within the vision would be considered.
- Members recommended that the strategy would have benefited from a greater focus on the lived experience of service users and marginalised groups. It was acknowledged that consultation and engagement with groups was difficult during the pandemic.
- There had been engagement with individual service users directly, although due to the current circumstances there had been a lot of engagement with organisations that worked closely with service users and people with lived experiences.
- Members were advised that this was a high level strategy which set out the vision, and the next steps would require more specific pieces of work where people with lived experiences and from marginalised communities would be engaged and inform the its development.
- The Committee was advised that it was important that the trauma informed work in the city was aligned with the drug and alcohol strategy, and there would be consideration about how to make those links more explicit; and that the CCG could offer support to link in the information from its engagement with marginalised groups which referred to experience with alcohol and drugs.

- The Committee heard that the CCG, as part of the whole systems approach to mental health, had developed a mental health and wellbeing outcomes framework and there was an opportunity to link up with the alcohol and drugs strategy and the outcomes framework could be aligned.

- The whole systems approach where organisations would be working together was commended.

- Members stated that there should be, over and above a focus on individual behaviour change, more emphasis on structural inequalities and underlying issues which could be more strongly reflected within the strategy.

- There was a discussion about safe consumption rooms and the Committee heard that the law had not changed and so they were still illegal and there was not a commitment to produce one.

- Members heard that the strategy highlighted the Council's intent to be on the forefront of conversations to be had about legislative and policy change on safe consumption room; and that the Council would take the strategic view that this was something there was growing evidence for and Bristol would want to be part of the conversation.

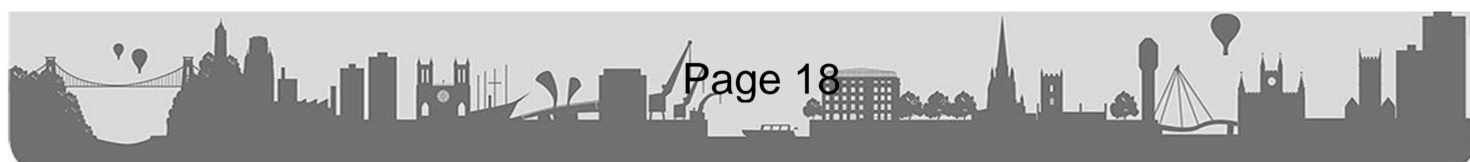
- The Deputy Mayor (Communities Equalities and Public Health) noted the Committee's comments that more clarity was needed, and this would be considered, together with how to build on the existing positive joint work with the CCG.

- Vicky Marriott, Healthwatch, informed Members of the coproduction project Healthwatch had completed with service users of alcohol and drug services in North Somerset, which had a recommendation that there should be stronger availability of community mental health support at the same time as recovery.

- The Chair invited Vicky Marriott to send a list of Healthwatch priorities which could be considered by the Committee.

Meeting ended at 3.35 pm

CHAIR ____________________



Health Scrutiny Committee
(Sub-Committee of the People Scrutiny Commission)
6 December 2021

Report of: Bristol, North Somerset and South Gloucestershire CCG

Title: Integrated Care Partnership Update including new Community Mental Health Framework and three ICPs in Bristol

Ward: **All**

Officer Presenting Report: David Jarrett, Area Director
Contact Telephone Number: Kate Groves, Snr External Relations Manager, 07765 656170 (m)

Summary

Please find attached:
PowerPoint presentation on Integrated Care Partnerships, outlining:
- principles of how we work
- an overview of the Community Mental Health Programme, the first programme to go live under the new ICS and a supporting Overview of BNSSGs CMH Target Operating Model paper.

In addition, also attached are presentations from the three Bristol-based ICPs:
- North & West Bristol Shadow ICP
- Inner City and East Bristol Shadow ICP
- South Bristol Shadow ICP

Points to note:
The Overview of the Target Operating Model (TOM) paper was developed and shared in June 2021. Since June ICPs have been working to develop proposals to align with the TOM. The latest developments on this work are covered in the first ICP presentation and are being shared with HOSC to provide an overview of the aims of the Community Mental Health programme and what is envisaged to change for the Bristol population as a result of this programme.

1. Context

NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) is part of the Healthier Together Integrated Care System (ICS), a partnership of local health and care organisations working together to improve the health and wellbeing of the 1.1 million residents of the BNSSG area.

In BNSSG we have developed a shared vision between our partners to transform the experience of health and care to one of personalised, preventative and proactive care.

This is particularly important for people with complex needs, who often have the poorest experience. Local people have told us about the difficulties they face when services are not connected or joined up making it hard and frustrating to navigate. We want to make sure we deliver the right care and support for the person as early as possible, as close to home as possible, with the lowest level of acuity as possible and empowering the person as much as possible. By doing this we not only improve experience but we protect the capacity in our acute and emergency services so they are able to respond quickly when people really need them.

Key to achieving this vision is the development of integrated place-based partnerships of health and care organisations working together locally to design and deliver person-centred services.

In BNSSG these Integrated Care Partnerships (ICPs) are formal partnerships of provider organisations working together to deliver care by collaborating rather than competing. They include hospitals, community services, councils, mental health services General Practice, Social Care and voluntary/ community sector providers

ICPs will focus on delivering integrated services at 'place' level and develop as accountable care systems evolving the services that their population need and want. While ICPs will be determined by their population, they will still be required to meet the same quality standards both nationally and locally defined; to improve the health and care of the people they serve, integrate services for the benefit of the local population and to reduce health inequalities.

Our draft ICP model of care is one of fundamental integration, partnership and place-based working. The key attributes of our draft model of care are as follows:

- Leaves no-one behind and promotes wellbeing and prevents ill health for everyone in the community throughout their lives
- Directly and urgently addresses the inequalities in health outcomes meeting needs earlier to mitigate against disadvantage and the health impacts of disadvantage
- Really works with and mobilises communities to co create health and wellbeing
- Works with people to promote healthy, fun, safe and caring places where everyone feels that they belong
- Listens to people to understand what matters to them, their family, carers and their community.
- Is seamless and coordinated around the individual using a single assessment of their needs and a coordinated care plan.

- Identifies who needs care and support and offers them help early on, restoring them to best possible health.
- Is available 24/7 to people when they have a crisis or need support urgently.
- Works alongside people when their needs become more complex or urgent so they can easily get the care and support that works for them.
- Ensures that as far as possible people receive the care they need close to their home
- Is based on good quality relationships and networks that enable a thriving ecosystem of provision to support people with their health and wellbeing.

Our ICPs are currently responding to requirements to deliver new community mental health services starting from April 2022.

Members may want to consider how ICPs might collaborate more closely with elected representatives?

Currently collaborating with: Adult Social Care, Public Health, Neighbourhood and Communities. Emerging ideas for other areas of collaboration include Community Safety Partnerships, Education (primary, secondary and tertiary), Care Leavers. Additional suggestions welcome.

3. Policy – not applicable

4. Consultation – not applicable

a) Internal

b) External

5. Public Sector Equality Duties

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

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

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

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

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

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

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

Appendices:

- Powerpoint ICP and Community Mental Health Presentation
- Overview of BNSSGs CMH Target Operating Model paper
- X3 Bristol ICP presentations

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Improving health and care in Bristol, North Somerset and South Gloucestershire

Integrated Care Partnerships (ICPs) & Community Mental Health (CMH)

Bristol Health Overview & Scrutiny Committee

December 2021

What are ICPs?

- **Integrated care partnerships (ICPs) are an exciting opportunity for health and care organisations to come together and re-think the way services are delivered for the benefit of local communities, by collaborating instead of competing.**
- ICPs will share a common purpose to improve the health of the people they serve and reduce health inequalities
- ‘Integration’ means coordinating services around people’s needs, and making it easy for them to access support.
- The community will become the default setting of care, sometimes also referred to as ‘place-based care’. Hospitals will only be used for highly specialist or emergency support.
- GP services, community services, councils, mental health services, social care and voluntary sector providers are all involved.
- Each ICP will have to meet the same quality standards, but will have flexibility to operate based on their local population and geography.

ICPs will be the key delivery vehicles for achieving our BNSSG system goals

Reduce the inequality in how many years people in BNSSG live in good health, particularly improving healthy life expectancy for those with the poorest outcomes

Make it easy for people working in health and care to work with each other

Reduce our adverse environmental impact in energy, travel, waste, water, food, biodiversity and land use

Increase the number of years people in BNSSG live in good health

Become a place where health and care services fit with people's lives and makes sense to the people engaging with them

Our workforce is healthy and fulfilled

Our communities are healthy, safe and positive places to live

They will be embed the principles of how we work together as an ICS at place

People @ the Centre	1. We work to achieve **our vision** to meet our citizens' needs by working together within our joint resources, as one health and care system. We will develop a model of care and wellbeing that **places the individual at its heart**, using the combined strengths of health and social care. **2. Citizens** are integral to the design, co-production and delivery of services 3. We involve people, communities, clinicians and professionals in all decision-making processes. 4. We will take collective, considered risks to cease specific activity to release funds for **prevention, earlier intervention and for the reduction of health inequalities.** 5. We will focus on the causes of inequality and not just the symptoms, ensuring **equalities is embedded** in all that we do.
Subsidiarity	**6. Decisions taken closer to the communities** they affect are likely to lead to better outcomes. The default expectation should be for decisions to be taken as close to communities as possible, except where there are clear and agreed benefits to working at greater scale**.**
Collaboration	**7. Collaboration between partners in a place** across health, care services, public health, and the voluntary sector can overcome competing objectives and separate funding flows to help address health and social inequalities, improve outcomes, transform people's experience, and improve value for the tax payer. **8. Collaboration between providers** across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity. 9. Through **collaboration as a system** we will be better placed to ensure the system, places, and individual organisations are able to make best use of resources 10. We **prioritise investments based on value**, ensuring equitable and efficient resource allocation, and we take shared ownership in achieving this.
Mutual Accountability & Equality	11. We are coming together under a distributed leadership model and we are committed to working together as an **equal partnership.** 12. We have a **common understanding** of the challenges to be addressed collectively and the impact organisations can have across other parts of the system. We engage in honest, respectful, and open dialogue, seeking to understand all perspectives and recognising individual organisations agendas and priorities. We accept that diverse perspectives may create dissonance, and we seek to understand and work through any disharmony, and move to conclusions and action in service of our citizens. We strive to **bring the best of each organisation** to the partnership. 13. We adhere to a **collective model of accountability**, where we hold each other mutually accountable for our respective contributions to shared objectives. 14. We develop a **shared approach to risk management taking collective responsibility** for driving necessary change while mitigating the risks of that change for individual organisations.
Transparency	15. We **pool information** openly, transparently, early, and as accurately and completely as practical to ensure one version of the truth 16. We work in an open way and establish **clear and transparent accountability for decisions.**

National Guidance – Thriving Places (1/2)

Since we began our journey national legislation and guidance has begun to include reference to developing place based partnerships. Particularly the NHS England and Local Government Association's Thriving Places report which includes the following guiding principles:

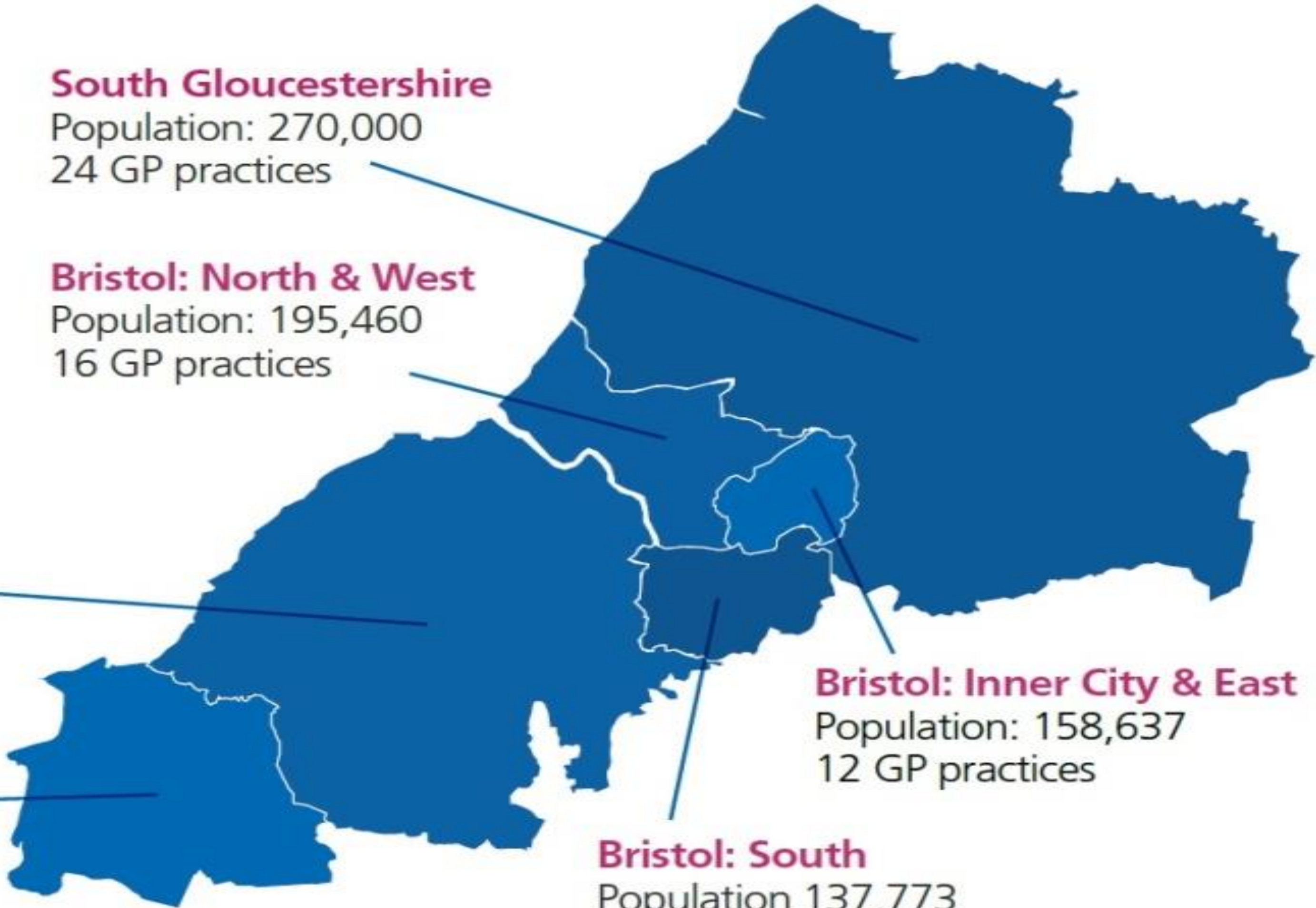
- There is no single approach to defining how, and at what scale, partners should come together to work in an ICS. Place-based partnerships should start from understanding people and communities and **agreeing shared purpose before defining structures**.
- Effective partnerships are often **built 'by doing'** – acting together and building collaborative arrangements to support this action as it evolves.
- Governance arrangements must **develop over time**, with the potential to develop into more formal arrangements as working relationships and trust increase.
- Partnerships should be built on an ethos of **equal partnership** across sectors, organisations, professionals and communities.
- Partners should consider how they develop the **culture and behaviours** that reflect their shared values and sustain open, respectful and trusting working relationships supported by clearly defined mechanisms to support public accountability and transparency.

National Guidance – Thriving Places (2/2)

The guidance also sets out potential place based activities and approaches for consideration by partnerships:

- **Health and care strategy and planning at place:** a common understanding of its population, and has agreed a shared vision, including local priorities for the delivery of health, social care and public health services in the place
- **Service planning:** agreed approaches to align the commissioning of NHS and local government services around shared objectives and outcomes, involving relevant partners, people and communities
- **Service delivery and transformation:** continued integration and co-ordination of the delivery of health, social care and public health services around the needs of the population, and to empower people who use services
- **Population health management:** intelligence and analytical capabilities at-scale, as well as approaches to draw on this insight to support care redesign locally, building on existing expertise across the place and system
- **Connect support in the community** working with a wide range of community partners to leverage and invest in community assets and support for improved wellbeing
- **Promote health and wellbeing** working with local agencies and community partners to influence the wider determinants of health and wellbeing, and to support other local objectives such as economic development and environmental sustainability
- **Align management support** agree options to align and share resources

The six ICPs in BNSSG have been formed, based on the current locality areas.



North Somerset: (Woodspring)
Population: 102,000
7 GP practices

North Somerset: (Weston & Worle)
Population: 81,200
10 GP practices

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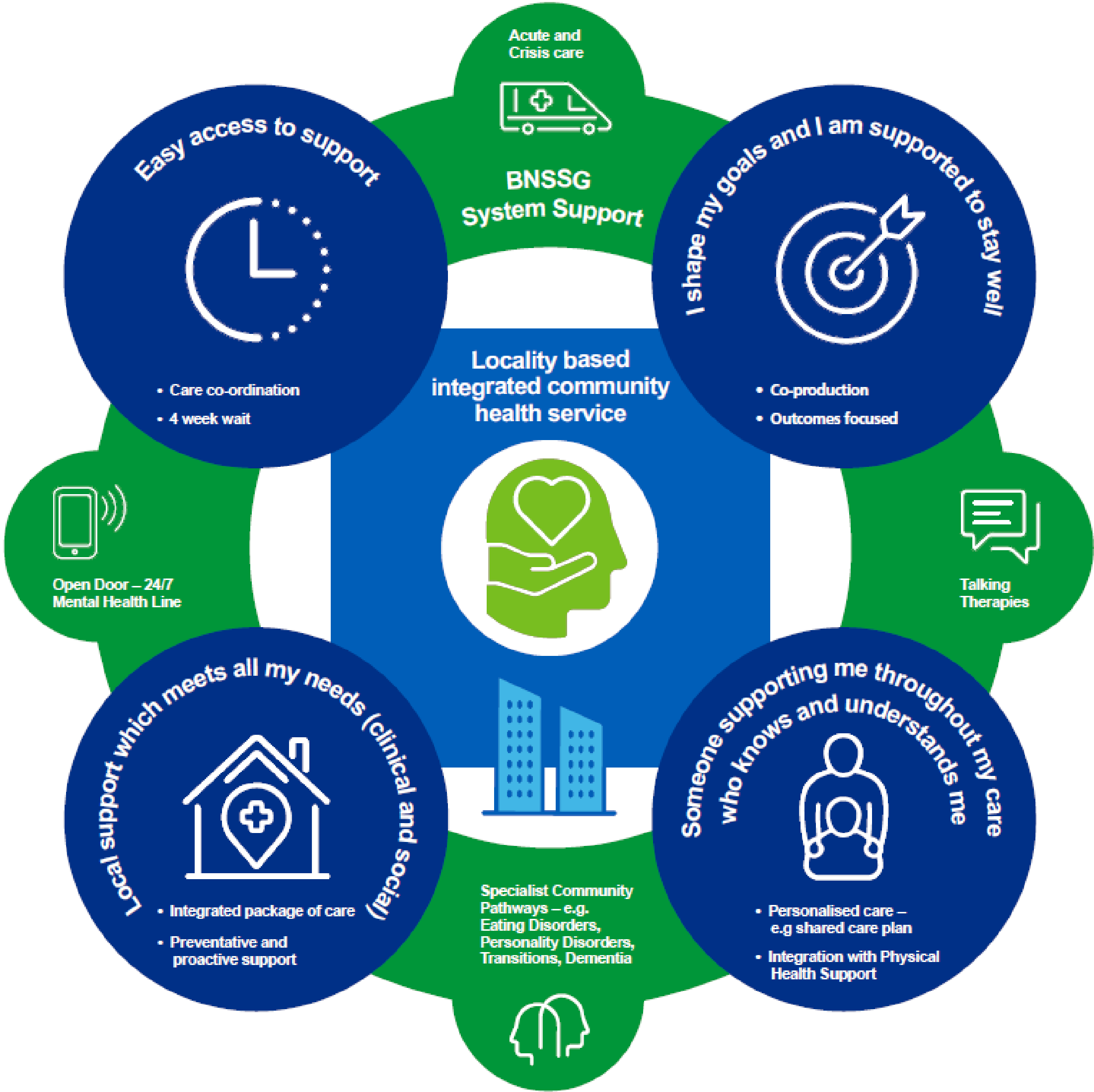
BNSSG Community Mental Health Programme

Community Mental Health Programme: Aims

- Support people to access integrated, holistic and preventive mental health care – the right support, at the right time, in the right place.
- Bring staff together as 'one team' – eradicating barriers between primary, secondary, voluntary and community sector partners.
- Develop a new workforce of people with lived experience of mental ill health.
- Provide accessible, trauma-informed and culturally inclusive care.
- Seek the fastest improvements in those with the poorest outcomes, helping to tackle the entrenched mental health inequalities people experience.
- Programme encompasses:
  - NHSE Community Mental Health Framework (£12m+).
  - BNSSG's current adult community mental health services.

Locality example:



CMH Programme Structure

Community Mental Health Programme Delivery Board
Chair: Mathew Page
(CMH Programme Director)

System-wide Specialist CMH Pathways

- Personality Disorder and Complex Trauma
- Eating Disorders
- Mental Health Rehabilitation
- Physical health of people with severe and enduring mental illness

ICP/Core Model Groups

- ICP CMH Models
- Core Model
- Trusted Assessment
- Open Front Door
- Older People Transitions
- Younger People Transitions
- Health Inequalities

Enabling Groups

- Workforce (inc. Peer Support)
- Communications and Engagement
- Digital and Outcomes
- Contracts
- Estates

Progress Timeline

- Early 2021, Discovery phase to capture learnings before the Community Mental Health Target Operating Model was shared with Integrated Care Partnerships (ICPs) in June

- From June, the ICPs and Specialist Pathways (including Eating Disorders, Community Rehab and Personality Disorders and Complex Trauma) have been developing transformation plans

- In November, all groups are sharing an update on progress and next steps, which will be reviewed by the Community Mental Health Programme Delivery Board panel, the aim of these is to have supportive conversations to ensure the programme is on track

- April 2022 – Commencing phased approach of ICP plans to offer an integrated community mental health service that is personalised, proactive and preventative to support individuals to get the right service, at the right time in the right place

Collaborative leadership and delivery across ICPs

We recognise the benefits of working at the level of 'place' within our 6 ICPs, however understand that sometimes our work will need to align with local authority boundaries, and sometimes it will need to be system-wide.

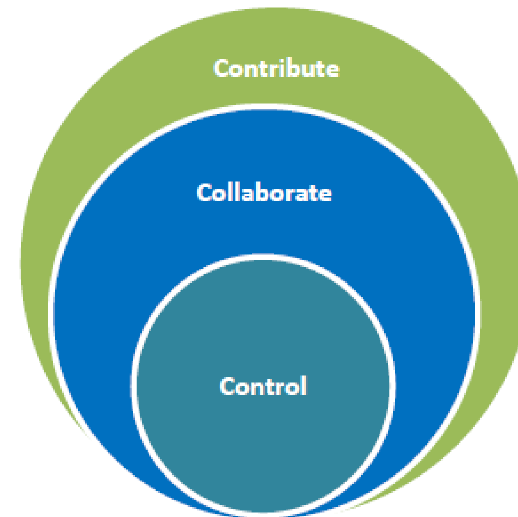
Aligned working is essential to ensure a certain level of consistency in offering for our whole population to prevent confusion or a 'post code lottery' – whilst not detracting from local service offerings based on need.

For community mental health we have established a **Pan-ICP model development work stream** with all ICPs represented to cover the elements of the CMH model that need to be coherent across the ICPs, this includes the important aspects of clinical governance and risk management around the model of care.

Contribute – e.g. Eating Disorder and Personality Disorder pathways, Crisis response & suicide prevention, availability of specialist psychological therapies, legal & statutory compliance, contractual framework

Collaborate – e.g. ICPT outline model development Workstream , how specialist services plug in, Digital Infrastructure, Open Door, trusted assessment * , specialist VCSE, contractual arrangements

Control – IPCT 'one team' arrangements, Local access arrangements, local VCSE involvement, ownership and accountability, local partnership approach, co-production



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APPENDIX

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Appendix – ICP Model of Care

	Our Care Model	Approaches to implementation and practical considerations
1	**We see the person** - People are not defined by the conditions or symptoms they have	**Our culture considers the *person first* in all interactions across the BNSSG health and care system** This will start by recruiting our staff for values as well as competence and expertise. We will embed *person first* training and development staff as a core shared component across BNSSG. We consider the person as the key shareholder / stakeholder of the service, their experience of care and their outcomes are how we measure our success. **Continuity of Carer** We will work to give each person a dedicated co-ordinator who will be able to get to know them to better understand their needs in context of their lives, personal aspirations and goals. This will be particularly focused on people who have multiple/ complex conditions and/ or support needs **Best Practice and existing models to be adopted into our Model of Care** NHS E/I model of Personalised Care : This includes Shared Decision making, Personalised Health Budgets these will be standard approaches Sirona Integrated Care Approach Asset based / Three Conversations model of social care
2	**We focus on individual needs** Supporting physical health, mental health and social needs must be integrated around the person We create a balance of services and supporting the person, this depends upon what the person needs and wants	**Person First** Our person first approach means we start with the whole person, our ICP teams work as a collective jointly creating the care plan across professions and with the person. This may include running appointments as a team rather than a series of referrals , multiple waiting list and fragmented steps for the person. We measure our success based on shared outcomes and achievements with the person and for the community and population. We have a powerful and well designed shared care record that enables the team and the person to become and stay connected. **Responsive to individual and population needs** We will continuously monitor where we have needs that we are not able to meet and consider how personalised packages can be constructed or how this will shape future commissioning decisions. We have a single point of access for information and connection to services by dialling 111 people will be able to be connected to the information and connected to the service they need (Open Door) **Empowering and activating the person** We adopt approaches support the person as an expert in their own health and well -being. We use peer support, social prescribing, health and well being co-ordinators and our personalised information prescriptions' to ensure that people have as much help and literacy about their condition as they can. We make as many services as possible direct access e.g. first contact physios / pharmacy reviews.so that people don't need a GP appointment to be able to access services. **Best Practice and existing models to be adopted into our Model of Care** iThrive model (CAMHS): Health Literacy; Social Care Asset Based Model of Care Social PX movement Care and Support Planning : House of Care model

Appendix – ICP Model of Care

	Our Care Model	Approaches to implementation and practical considerations
3	**We make accessing the right service/ support easy** The journey of getting to care is an important component of our model we consider the experience of the person as central to our designs and pathways	**Direct Access and BNSSG Open Door** There are many services that can be accessed directly without a GP appointment or a referral. personalised information prescriptions can be created by the person or supported by a co-ordinator so that people know the services that are available to them, what to expect and how to decide which to use. **Designing for ease of access** Our services have been actively designed to consider inequalities age, disability, language, having a learning disability or autism. We design for experience and constantly seek to understand the needs of differently groups and communities to ensure we are maintaining and improving on our 'ease of access' commitment. **Best Practice and existing models to be adopted into our Model of Care** Co-production principles Design council double diamond design methodology Human Centred Design / Desire Code Value stream mapping
4	**We are integrated** We are moving away from referrals to different services as the mechanism that people are transitioned along a pathway. We have shared teams in each ICP. These include health, mental health, social care and the VCSE and with high levels of trust and partnership we make better use of the resources we have to improve outcomes for people	**From collaboration to integration and shared case loads** Our teams create a single team around the person. This means that all the collective expertise and knowledge from across disciplines and professional groups is valued and can contribute to the care, support and recovery of the person. We don't use our scarce resources making and receiving referrals we have repurposed this time to working on shared caseloads and delivering care. Up to 20% of time in the working week of a professional can be spent making responding to or chasing up referrals. By being integrated we are able to do more in the community preserving our acute hospital based services for the most acute cases. **Active waiting** Whilst our ambition is to remove waiting where it adds no value to the care - this will take time and there are currently unavoidable waits for some services. Our model of care considers that people need support whilst they are waiting. We have adopted a model of active waiting that means depending upon need there are a series of support offers that can be made available – this may include remote monitoring, prompting use of social prescribing or recommendation of a peer support service. As an example people waiting for complex surgery and living with pain may benefit from well being support to address the likely impact upon their mental health. **Digital support systems** We are working to ensure that integrated care is underpinned and enabled by digital systems: we are currently working with EMIS to become a strategic partner with roadmap of Digital systems that will address the connection between community / primary / social care and VCSE services. We have already implemented Elemental social prescribing system and are testing a range of products to help support shared caseloads.

Appendix – ICP Model of Care

	Our Care Model	Approaches to implementation and practical considerations
5	**We value the role of Carers and Families** We recognise the critical role played by carers and families. They are integral to the care co-ordination for the person	**Caring for our carers / families** We are committed to supporting carers and families and ensuring they are valued as part of the resources and assets around the person. We have designed the Open Door service to be able to support carers and has been explicitly designed with input from carers and families. **Support to cope** For many carer advanced care planning is a critical component of the care planning process Helping carers to know 'what to do if' is an important part of the process. We have dedicated support and social prescribing offers for carers across health and care and alongside the local community development in this area **Best Practice and existing models to be adopted into our Model of Care** integrated approach for identifying and assessing carers' and wellbeing needs: NHSE/I Working for carers
6	**We manage risk together** so we can help people get the care they need as close to home as possible	**Building trust to co-ordinate care** Each of our ICPs has a programme of development in place to bring health, social care, care home and VCSE partners together. It is critical that each professional group has an understanding of the potential, skills, capability and opportunities that each staff group can contribute. This is a foundation step for our SOP for Integrated risk management. **Approach to Integrated Risk Management** We will develop a system wide SOP for Integrated Risk Management building on the work we have done in urgent care and the 111 first programme. This will cover - How to consider risk management as a team in the community rather than risk transfer to acute settings How to build a trusted assessment process that is recognised by all agencies and aviod the person having multiple assessments done each time they encounter a new organisation How we move beyond guideline/criteria driven approaches and consider how all agencies can contribute **Best Practice and existing models to be adopted into our Model of Care** Global accountable care systems such particularly SDF Alaska and Christchurch New Zealand Sirona Integrated Care Approach

Appendix – ICP Model of Care

	Our Care Model	Approaches to implementation and practical considerations
7	**We use our shared financial resources** A shared approach means we can focus on removing duplication and gain the most impact for he person and population Our ICPs have a collective view on the available budget and are able to consider how to prioritise the needs of the population rather than the individual organisations	**Moving to Shared budgets** We believe that the more we are able to work across organisations to consider how we make the best use of the available funding and resources the greater opportunity we have of delivering sustainable value. The ICP funding allocation model is based on population and adjusted for deprivation and deviation from target. This model is being tested and iterated through the CMH delivery programme **Shared KPI and outcomes** The collective focus on specific outcomes for the individual, the population and the system means we remove wasted effort. For example the time spent on referrals/ assessment and managing the thresholds we have created between services and groups of staff. Many of our system goals can only be achieved by services working as a collective with a shared goal. Being given a level of delegated decision making about how to make best use of available resource **Best Practice and existing models to be adopted into our Model of Care** Global accountable care systems such as • Chen Med US • SDF Alaska • Christchurch New Zealand These system amongst many others have been to demonstrate improved impact with no net increased in resource / funding. COVID Pandemic has demonstrated the delivery potential when funding shift to a shared rather than a competitive resource focus
8	**We have clear partnership agreements in place**	**ICP Partnership Agreements** Our ICPs have developed their own partnership agreements that enable them to work together to deliver services, optimise the impact of all staff and professional groups for their local population. Manage risk ,in line with the system integrated Risk Management SOP. This agreement also sets out the governance and financial arrangements in each partnership. MoUs between ICPs and ICS are in development and will form part of this approach. **Commissioning within the ICP** Each ICP has a VCSE lead partner these organisations will connect the VCSE into the partnership. The VCSE is an equal partner in our ICPs helping to connect and strengthen the ICP into the communities of each geography. The ICP will consider the needs of the population and has the agency within budgets allocated to commission additional services and support for the population **Aligned and Joint Commissioning between Health and Local Authorities** We are aligning elements around MH for example S117, Drug and Alcohol services with the ICP approach. Each ICP has strong connections to the health and well being strategies that are overseen by HWBBs in each LA area. **Other Links** Links with Pharmacy, Optometrists and Dental services locally are important to ensure alignment with ICP - Dental remains nationally commissioned

Appendix – ICP Model of Care

	Our Care Model	Approaches to implementation and practical considerations
9	**We co- create services where people feel they belong and have a sense of shared ownership**	**Understanding our population** We have invested in gaining greater insights into the needs of our population. We want to create services where people feel they belong, services that reflect and respect the cultural, ethnic, religious beliefs of our communities. Where people feel welcome and able to access the services and understand and trust these services. Connecting and developing trust and understanding between our services and the population is an on – going development objective as part of our model care. Making efforts to ensure our staffing reflects the diversity of the population is a foundation step to demonstrating and gaining trust **Working with our population** 'People own what they help to create' We have a clear and on going commitment to developing co-production with our communities and [particularly to address health and other inequalities. Asking people what matters to them is an embedded part of our care model.
10	**We measure our success through the Value we deliver** We consider value as the combined effect of the Experience of the person, the outcome for the person and the wider population and the allocative resoiurce element value	**Population Health Management** PHM is an embedded component of ICPs. We use data across our system to understand and discern patterns and or trends. As providers of direct care the ICP is able to use aggregated data to identify groups of people who would benefit from specific support and treatment. This enables our ICPs to consider proactive approaches and interventions alongside Public Health partners. **Understanding and measuring Experience** We are developing experience based KPIs that will help ICPs to understand the impact they are having for the people they serve. We advocate a range of services to collect this data such as Care Opinion. **Understanding and measuring Outcomes** We need to be able to collect the right data as a by product of delivering care that connects to outcomes. We are currently defining a system wide Integrated Care Data Standard to support ICPs to gain insight into outcomes **Population Health Academy** We are investing in a learning and development resource that will skill up staff to be able to embed PHM into their practice as part of day to day working **Best Practice and existing models to be adopted into our Model of Care** Global care systems such as • Israel • Manchester • Frimley These system amongst many others have embedded PHM into standard operating models

Appendix – ICP Model of Care

	Our Care Model	Approaches to implementation and practical considerations
11	**Digital**	**Shared Data** Our connecting care system is now pervasive in its use and clinical teams have identified it is now an integral part of their practice. This service will continue to grow to reflect the needs of our integrated care approaches. This will include the person having access to records and being able to contribute data. Read write capability is an important development this is currently being tested in EoL care **Shared care planning and case management** We are exploring roadmaps and strategic partnering with system providers such as EMIS and system C **Remote monitoring and Virtual Wards** Building on the success of the Covid virtual Wards our approach will expand the use of virtual wards for other conditions and as part of management of risk. We are working in conjunction with our universities to explore the deployment of new technologies. Advice and guidance systems are helpful to connect up acute specialists and ICP teams **Digital Inclusion** We recognise that digital first access is not possible for everyone - we respect choice and work to ensure that we do not exclude anyone.
12	**Estates**	**Shared Estates** Our buildings and environments are a significant resource across our ICPs staff teams need shared space to be able to work together, run clinics see people, undertake treatment. The places that people come to need to be accessible, welcoming and designed to meet peoples needs. Eg considering autism friendly spaces requires througt rather than complex investment. Mapping our estate to create a baseline is underway and will evolve into and estates plan for each ICP.
13	**Workforce**	**Shared Approaches to Workforce** Our workforce is our greatest resource, we are facing shortages in clinical and social work professional roles and therefore the need to optimise and think creatively about workforce has never been more pressing. Through the ICPs and integrated teams we will accelerate the shared approach to staff, training and skills. Each ICP will be able to consider the pipeline of staff recruitment to direct resource to where they are needed most. **Developing New Roles and development opportunities** ICPs have started to consider how to use staff and professional groups more effectively eg use of Trainee Psychologists in MH, the adoption of apprenticeship and clinical fellow schemes and making best use of the BNSSG training hub

Emerging concept of what our ICS will look like from April 2022

Work in progress; additional detail to be defined in functions and decisions map

People in their communities

ICPs

- Weston, Worle & Villages
- Woodspring
- South Glos
- Inner City & East Bristol
- North & West Bristol
- South Bristol

ICPs core members of HWB and have regard to the JSNA and JHWS

North Somerset HWB

South Glos HWB

Bristol HWB

Local HWBs:

- Set local priorities for ICPs
- ensure health inequalities focus
- enable integration of health and social care at LA boundary

HWBs produce JSNA and JHWS for ICS to regard

ICPs accountable to ICB for NHS-funded care

Joint HWB

Responsible for developing an integrated care strategy that addresses the wider health, public health, and social care needs of the system

Integrated Care Partnership (ICP)

Agrees Integrated Care Strategy

Responsible for the day to day running of the ICS; lead and oversee planning and delivery of NHS services across the system

Integrated Care Board (ICB)

'At Scale' Provider Collaboratives

Constituent organisations

Local authorities (3)
HealthCare Providers (5)
GP Federation (1)

Acronyms:

- HWB: Health and Wellbeing Board
- JSNA: Joint Strategic Needs Assessments
- JHWS: Joint Health and Wellbeing Strategies

Work in progress – does not currently include key functions, such as:

- Clinical and professional leadership
- System planning and performance oversight
- Quality improvement and oversight
- Health and wellbeing transformation and enabling programmes
- Statutory functions for all sovereign bodies

Overview of BNSSG's Community Mental Health Target Operating Model and Implementation Process

1. Overview and Principles

We want everyone across Bristol, North Somerset and South Gloucestershire to have happier, healthier and more fulfilled lives. In developing BNSSG's Integrated Community Mental Health Service we are sparking the beginning of a radically different approach to drive better outcomes. It is a new model of proactive, personalised and preventive mental health care that brings people, communities and organisations together to offer the right support, at the right time, in the right place.

This approach aligns with the Government's White Paper 'Integration and innovation: working together to improve health and social care for all' (published in February 2021) which seeks to:

- Establish Integrated Care Systems (ICSs) across England to develop greater integration between the NHS and social care.
- Reduce the requirement for competitive procurements within the health system.
- Increase the focus on commissioning at a smaller population level (than CCGs have traditionally served) and give partners within those populations greater agency to decide what services are needed for their populations. The organisations who will deliver care at a local level will be called Integrated Care Partnerships (ICPs). These organisations are currently in shadow form in BNSSG.

This paper provides an overview of:

- BNSSG's Community Mental Health Target Operating Model.
- The process for implementation and delivery of the Service from 1st April 2022.
- Existing contracts associated with the Target Operating Model.

1.1 Principles underpinning the model

The Service will:

- Have a whole system, 'one team' approach with a collaborative culture: it will break the traditional divide between primary care, community services, social care, mental health services, hospitals and VCSE provision with partners responsible for all outcomes 24/7, with extensive co-production throughout.

- Deliver value for individuals: it will be driven by outcomes that matter to the people we serve, as defined by people with lived experience and our communities, with high levels of transparency around performance and improvement.

- Be personalised, preventative, proactive and trauma-informed in delivering support: it will be tailored to someone's individual needs, responsive to them and co-designed with them, ensuring their carer or support network is actively supported and engaged.

- Provide a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation. The Advancing Mental Health Equalities Strategy will be delivered in full to tackle inequalities in access, experience and outcomes.

- Create a system and culture which enables professionals to collect and report outcome measures routinely, and a system-wide Mental Health and Wellbeing Outcomes Framework and dashboard. The service will embed quality improvement to sustain and build upon effective approaches.

- Be supported by a system leadership and cultural change programme to enable collaborative and effective working across BNSSG.

2. A Population Health Management approach

The Service will take a Population Health Management Approach. This means:

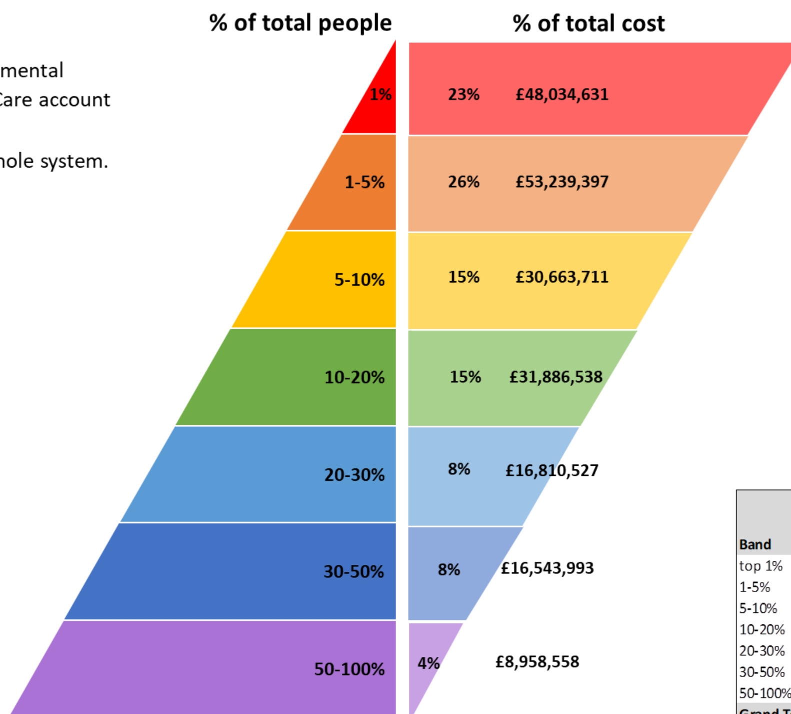
- Meeting the goals of Population Health: improving physical and mental health outcomes, promoting wellbeing and reducing health inequalities, for a whole population and not just those who present to services.
- Focusing on achieving the experiences and outcomes that matter to people and making the best use of resources (value).

This will involve using robust data to understand the needs of our local population. For example, Figure 1 below illustrates that 1% of the population (1,342 people) with a mental health condition accounts for 23% (£348 million per annum) of the cost across the health system. Using a Population Health Management approach will strengthen our understanding of the characteristics and needs of different individuals and groups. This will help us to design services that will more effectively meet needs and offer opportunities to prevent illness in the future.

Figure 1: Costs for people with a mental health condition in BNSSG

Costs for people with a mental health condition in BNSSG

- **1%** of the BNSSG population with a mental health condition flagged in Primary Care account for
- **23%** of the total costs across the whole system.
- For BNSSG this is **1342** people
- Costing **£48m**
- An average of **£35,793** per person



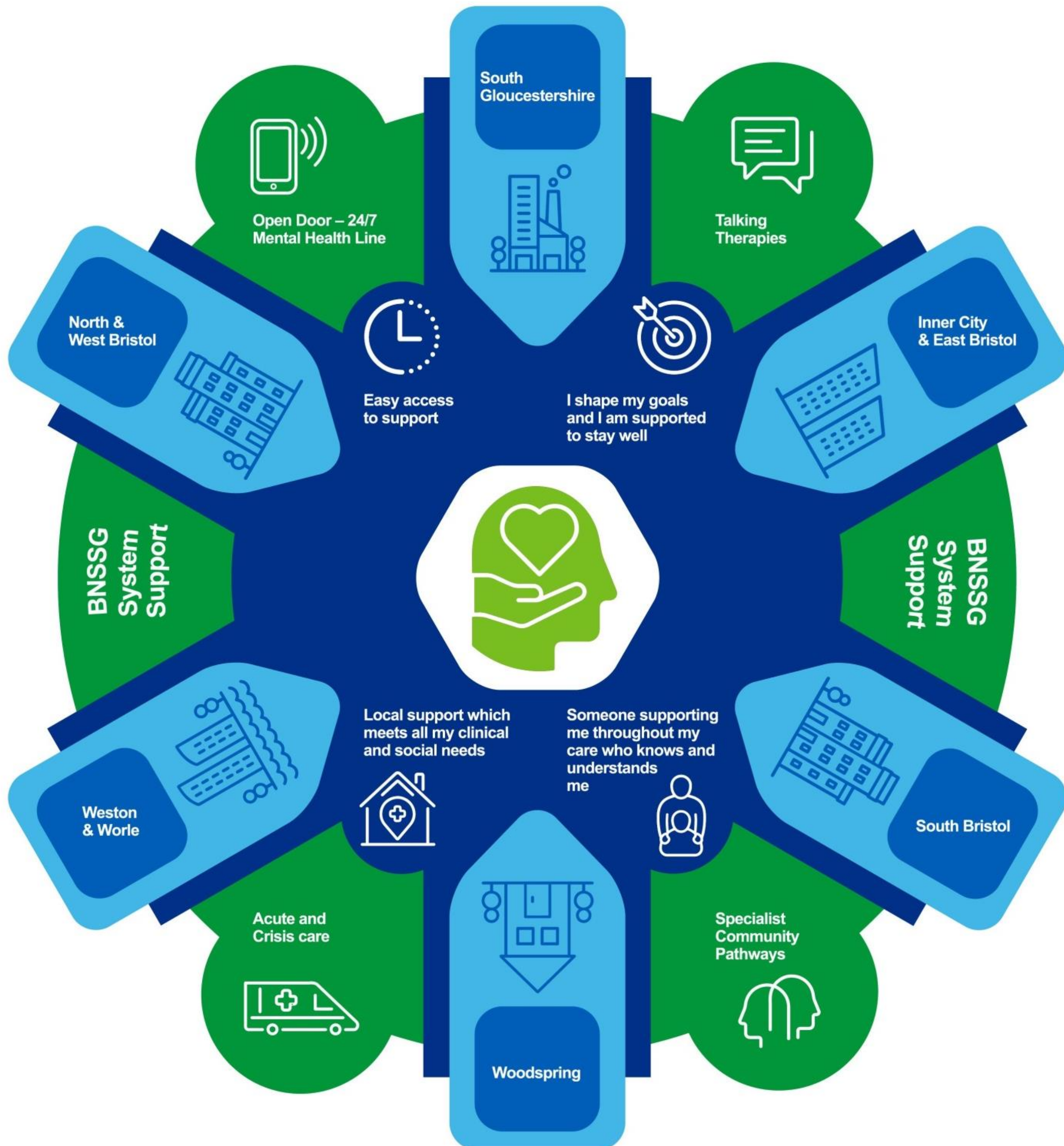
Band	Number of people	Average cost per person
top 1%	1342	£35,793
1-5%	5372	£9,911
5-10%	6715	£4,566
10-20%	13430	£2,374
20-30%	13430	£1,252
30-50%	26860	£616
50-100%	67151	£133
Grand Total	**134300**	**£1,535**

Cost include admissions and attendances across primary, secondary and community care as well as prescribing - (1 year average). Some costs are PBR, some are indicative. Maternity inpatient activity is included because it cannot be separated from outpatients using the system wide dataset

3. Summary of the model

BNSSG's Integrated Community Mental Health Service's Target Operating Model has been co-designed with a wide range of partners. It focuses on what matters most to people, their carers' and our staff. The following diagram summarises the Integrated Community Mental Health Service's approach:

- **Figure 2: Whole BNSSG System**



- **Figure 3: Example of the model at a locality or ICP level**

Further details on the core aspects of the model of care are outlined below:

3.1 Access

- Easy access to support is a core part of the model. The model suggests that people can access help either directly through their locality OR via the 'Open Door' 24/7 mental health line if they are unsure of what support they need. Locality health partners will develop a response that ensures accessible care for all (e.g. considering the needs of people who find it hard to access support via telephone) that will effectively meet local needs and demand.
- In line with this there will be ambitious accessibility targets:
  - A 24 hour response period from initial point of contact with the Mental Health System (either via locality or the 'Open Door'). The level of response will relate to presenting need.
  - A '4 week wait' from initial point of contact to the commencement of treatment, in line with national ambition.

3.2 Locality level:

- Each locality (blue within diagrams) will have an offer that is tailored to the needs of their local population, in line with a Population Health Management Approach.
- Integrated and Personalised Care Teams (IPCTs) will deliver support at a locality level considering someone's mental and physical health and social care needs. A number of partners within localities will work as 'one team' to provide support.
- Support will be delivered by a wider range of roles. For example, there will be a growth in peer support workers and the non-clinical workforce, in line with national expectations. Exact workforce arrangements will be designed by localities to meet their population's needs.
- People will receive a trusted core assessment. This means that, with their consent, relevant information will be shared across partners so that they do not have to tell their story multiple times. Partners can then build on the initial assessment so that there is a holistic and shared understanding of an individual's needs.
- Within localities people will have a 'link worker' (name TBC) who will be responsible for their care and will support someone through their journey. Dependent on someone's needs the link worker could be a primary care worker, mental health specialist, peer supporter or VCSE worker.
- Carers will be treated as equal partners with access to carers' assessments to understand and meet their support needs.
- Localities will be supported by Population Health analytics, enabling them to provide tailored approaches to care for different groups within their population. There will be specific focus on those at risk of poorer outcomes, whether due to an additional need (e.g. substance misuse), or because they are at greater likelihood of experiencing stigma and discrimination (e.g. due to their ethnicity or sexuality).
- Talking Therapies would be delivered by a system wide provider (Vita Health Group contracted until 2029). However, this would be experienced as part of someone's local care package with additional support to meet other needs being drawn in from the locality. For example, if someone was experiencing depression due to loneliness and problems with debt, they may be offered a course of talking therapies and support to access local community assets to address their isolation and debt. This holistic and integrated approach would help sustain any improvement in wellbeing delivered through talking therapies.

3.3 System level:

- Some care may need to be delivered at a system level (green within the diagrams), but only if this is the best way to improve patient outcomes. For example, NHS England has mandated that specialised pathways for eating disorders, personality disorders and rehabilitation are developed during 2021/22 using an evidence-based model across BNSSG. However, from a patient perspective, most care would still be experienced locally. For example, their locality team might be supported through clinical supervision or training to deliver early intervention support in these areas, or specialist therapy might be delivered from a base within their local area.
- Crisis care may be delivered at system level to ensure that out of hours support is rapidly available to those who need it. Patients will experience this as part of their local support offer.
- The 'Open Door' 24/7 mental health line may be provided at system level, although locality partners may propose alternative approaches.
- The Target Operating Model sets out the expectation that Integrated Care Partnerships will need to proactively develop a system-wide digital approach to delivering the Service.

4. Target Operating Model: Process for Design and Development Phase into Implementation and Delivery Phase

There are six shadow Integrated Care Partnerships in BNSSG. These are listed below:

- South Gloucestershire
- North and West Bristol
- Inner City and East Bristol
- South Bristol
- Woodspring
- Weston, Worle and Villages

These Shadow Integrated Care Partnerships will be invited to respond to the Target Operating Model with Integrated Delivery Plans. These plans will set out how the Target Operating Model's vision will be delivered in practice, to meet the needs of their communities. The plans will be developed through a supportive review and development based assurance process during the summer and early autumn of 2021.

4.1. Community Mental Health Steering Groups

System Steering Groups have been established to lead the development of specific areas of work. These focus on the areas specified by NHS England in the Community Mental Health Framework. The groups are as follows;

4.1.2. Infrastructure Steering Group Support

- **Outcomes and Digital** - An Outcomes and Digital Infrastructure Steering Group has been established to help deliver a system level response to these elements of the TOM. Emerging work packages include: Outcomes, Analytics (which will include Population Health Management, see below), Technical Infrastructure and Information Governance.

  As part of, and overseen by, this Steering Group, there will be a series of Population Health Management (PHM) workshops to support Shadow ICPs and improve understanding of the population characters and needs for each locality. The aim of these workshops will be to co-design PHM data packs with members of the Shadow ICP Boards and support teams to utilise this in their Community Mental Health Framework response.

- **Peer Support Workforce Steering Group** – This group is developing a Peer Support Framework to help localities understand and embed best practice. It is planned for a draft to be circulated with localities over July and early August for their input.

4.1.3. Models of Community Mental Health Care Steering Groups

- **Eating Disorders**, **Mental Health Rehabilitation**, **Personality Disorder and Complex Trauma** – These groups are developing whole-system pathways. They will seek support from Shadow ICP partners to develop and deliver these pathways, draft models to be agreed by September/ October.

- **Transitions (Young People and Older Adults)** (in development) - partners looking to agree scope and map existing support to help inform future best practice.
- **Improving the Physical Health of People with Severe and Enduring Mental Illness** – Focusing on addressing physical health needs of people with severe and enduring mental illness (including through health checks).

4.2. Resources and support for design and development phase

To support each Shadow ICP, a range of opportunities have been developed to help understand and connect key elements into the design process for Shadow ICPs:

- **Population Health Management workshops:** (See section 4.1 for further detail).
- **Understanding the estates profile across the Shadow ICP**
- **Learning Partnerships**: We have established links with a number of accountable care systems with international reputations for being at the forefront of integrated design delivery and development, to offer support and guidance.
- **Leadership and Organisational Development**: Some funding has been made available for Shadow ICPs to develop and progress their own choice of ICP OD priorities.
- **Supporting the ICP Model of Care design process:** Shadow ICPs have already embarked on the design of future integrated services and have in all six areas established community mental health sub groups. To support and enable the design process, each Shadow ICP will have access to an 18 week programme of learning and development with the Design Council.
- **Support from Mental Health Groups**, including Clinical Reference Group.
- **Digital and Data expertise**: System wide digital group of technical experts who will be able to advise Shadow ICPs on what existing digital infrastructure is available and its functionality.

Healthier Together and Locality Partnerships will jointly agree plans to deliver the Target Operating Model and assure that each Shadow ICP has a robust and credible plan for delivery of services from April 2022, including any phased delivery and development.

From autumn 2021 to the end of March 2022, the Service will begin to be implemented before it commences on the 1st April 2022.

5. Contracting Approach for Existing Contracts

As part of the delivery of the Target Operating Model, a decision is required on existing mental health contracts. These mental health contracts currently expire in March 2022, having been granted up to 1 year extensions by BNSSG in January 2021. The contracts vary in footprint with some matching local authority boundaries and some commissioned to a BNSSG footprint. The contracts include contracts from historic grant arrangements, as well as commissioned contracts, such as those resulting from the Bristol Mental Health procurement.

As part of the development and mobilisation of the Target Operating Model, the CCG will work in co-production with Shadow ICPs between June and August 2021 to develop a set of recommendations on the contracts due to expire in March 2022. In autumn 2021, the

CCG will seek to inform the existing providers of these contracts of the next steps in compliance with the 6 month notice period in contracts.

6. Contact Details

For queries relating to individual Shadow ICPs' development, please contact the following:

- Bristol Shadow ICPs (Inner City and East, North West and South Bristol) - bnssg.bristolareateam@nhs.net
- North Somerset Shadow ICPs (Weston and Woodspring) - bnssg.ns-area-team@nhs.net
- South Gloucestershire Shadow ICP - bnssg.sgloslocalitycalendar@nhs.net

For overarching Community Mental Health Programme queries – bnssg.mh.community@nhs.net

7. Timeline of activity

Month	activities
June 2021	• Community mental health working groups continue to provide expertise • Target Operating Model shared with Shadow ICPs and wider system • Support sessions for Shadow ICPs to begin developing response to Target Operating Model • Population Health Management workshops for Shadow ICPs begins • Work to consider existing mental health contracts begins
July 2021	• Population Health Management workshops conclude • Design Council programme to support Shadow ICP service design and innovation begins
August 2021	• Conclusion of work to consider existing mental health contracts
September 2021	• Draft delivery plans from Shadow ICPs due
October 2021	• Further work by Shadow ICPs to iterate draft delivery plans
November 2021	• Final delivery plans from shadow ICPs due • Mobilisation commences
December 2021 – March 2022	• Mobilisation ongoing
April 2022	• Services commence

* Please note some Shadow ICPs may wish to take early adoption approach and therefore work to accelerated timeframe

Healthier **Together**

Improving health and care in Bristol, North Somerset and South Gloucestershire

North & West Bristol Shadow ICP

An update for HOSC – 6th December 2021

North & West Locality

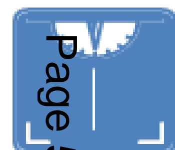
North & West Bristol population: 200,981

A Locality of extremes

- **Significant health problems in the outer wards,**
- **Relative good health of people living in the more affluent inner wards, and**
- **Significant number of students.**

Wellbeing and Prevention

19.4% with either a QOF SMI or depression flag also have a BMI of 30+



41.7% of those in the MH cohort also have a lifestyle marker where early intervention could improve MH outcomes

Life Expectancy

North & West has the greatest gap in life expectancy between inner and outer:
7.5 years for males and **7.9 years for females**

Dual Diagnosis

11.4% of those in the MH cohort have >2 mental health diagnoses

31% of those in the MH cohort also have a long term physical health condition (QOF)

5% with a depression marker and/or SMI code have a dual diagnosis with drug/alcohol dependence

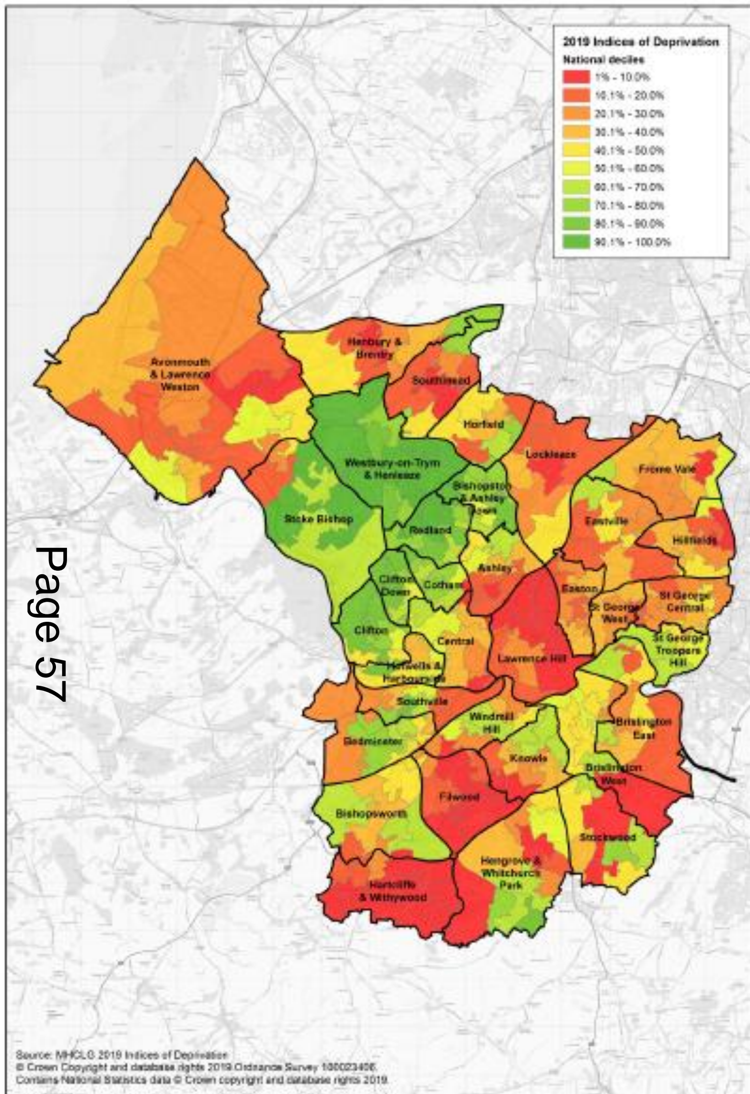
3.4% of those in the MH cohort have additional frailty complexity.

Respiratory disease

North & West outer has the **highest prevalence** of asthma in Bristol and the **highest crude rate** of emergency hospital admissions due to asthma.

4 wards in outer North & West are amongst the highest contributors to premature mortality due to respiratory disease deaths

Figure 1. 2019 National Deprivation Deciles by Lower Layer Super Output Area (LSOA)
Source: Strategic Intelligence and Performance using MHCLG 2015 and 2019 Indices of Deprivation



This locality covers some of the most affluent parts of Bristol where many benefit from longer life expectancy and better health.

However, there is **significant deprivation** in some communities where people are more likely to die younger from cancer, heart disease and stroke.

There is a **significant difference in life expectancy** between the most deprived and the most affluent areas of this locality.

Tackling this health inequality is one of our major challenges and we're committed to working with our citizens to support them to make healthy choices.

Healthier Together

Shadow ICP Board Representation

Our Shared Vision is….

To develop models of community based integrated service delivery, that will:

- **Help to keep more people healthy, well and independent in their homes and communities**
- **Developing holistic, multi-disciplinary and multi-agency teams that can meet a much wider range of needs**
- **Increase care coordination between services**
- **Integrates peer support, social prescribing and voluntary sector experts within existing pathways ensuring we always hold the person at the centre of what we do**
- **Recognise the wider determinants of mental health and wellbeing and works towards providing equality of access**
- **Celebrates the diverse population of North and West Bristol**

Our Shared Priorities are….

- To design a Community Mental Health model of care that is owned by all and has the person at the centre of what we do
- To build on shared assets creating more capacity through integrated approaches
- To develop the VCSE workforce expanding and further integrating in all programme workstreams
- To learn and build on the work already completed under the frailty programme
- To continue to work as a Locality to deliver the respiratory pathway
- To explore what benefit a Locality Hub could bring to our population and staff.

Where we are now…

- Our Collaborative Agreement defines our vision, goals, values and priorities for:
  - The health, care and wellbeing of our community
  - The way that we work together
- Organisational Development programme has helped us:
  - strengthen collaboration
  - improve understanding of each other's roles/organisations
- We are ready to embrace the next stage of our development focusing on:
  - Bringing our wider teams with us and making N&W Locality a good place to work
  - Embedding best practice across all organisations
  - Developing an infrastructure and capability which will enable N&W ICP to deliver services to our population in a collaborative person centred way

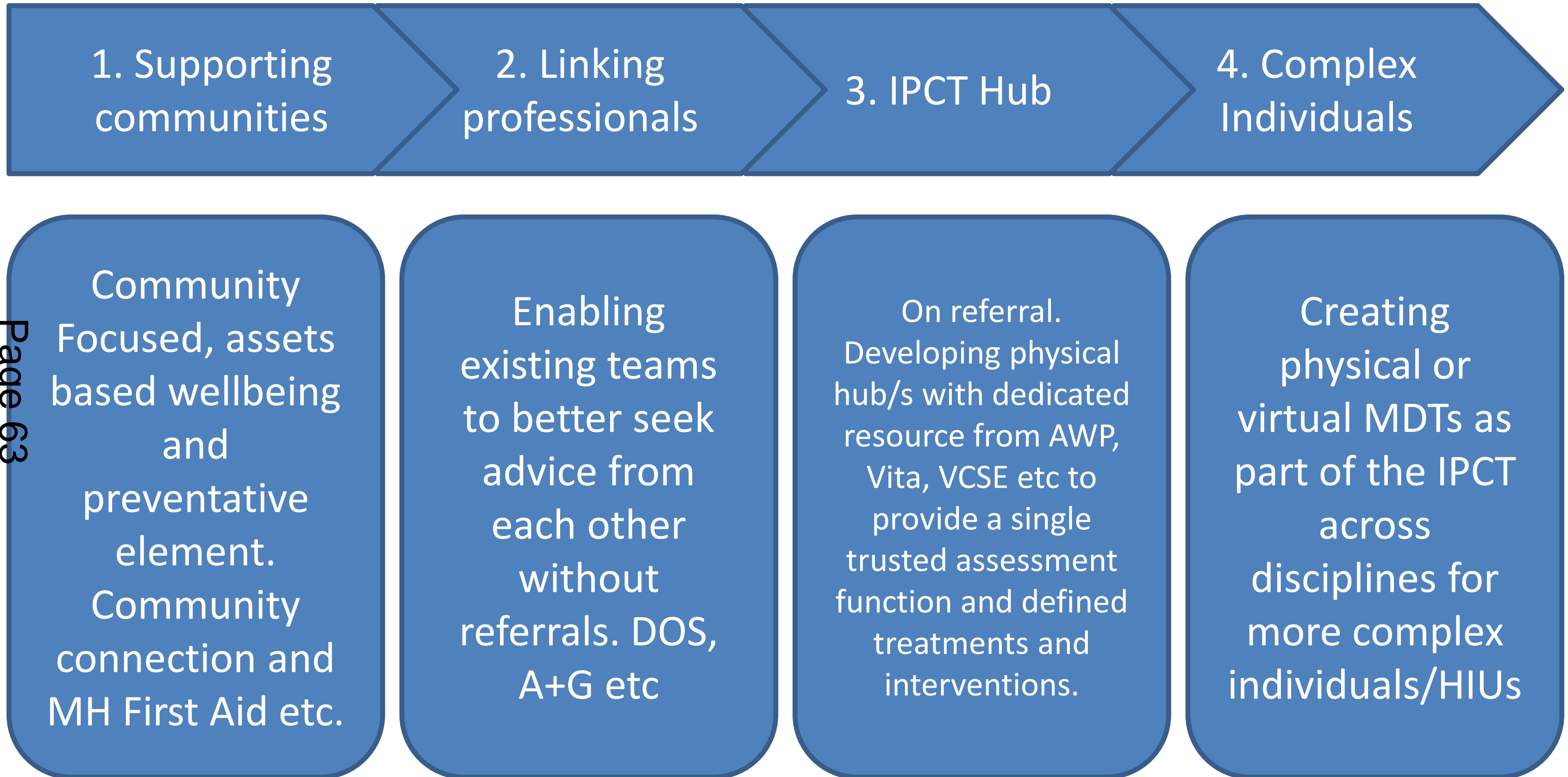
Healthier Together

•Community Mental Health (CMH)

- Our aim is to deliver a community mental health service that is **responsive, timely, integrated, individualised and holistic**.
- We aim to offer timely **early intervention** to support people in need, where possible preventing escalation requiring specialist/intensive intervention. We will deliver this through personalised approaches, centred around the individual, tailored to their specific goals, and focused on what matters to them.
- We plan for **early contact** (telephone/IT enabled or F2F as required). We recognise that people may enter the system in a variety of ways including via existing routes, e.g. primary care, social care, SWAST, Emergency Departments, VCSE organisations etc., and new integrated routes, i.e. BNSSG Integrated Access Hub.
- We will support System work to ensure that there is co-ordinated approach between these entry parts of the system.
- Once an individual has made contact with the system we plan to flex our approach by involvement of **wraparound team** bespoke to that person's needs as they change (step up and step down) in active response
- We will invest in our VCSE workforce to enhance navigation and peer support, whilst supporting local communities and non-profit sector

Healthier Together

Key Elements of our CMH Response



Learning / What is working well…

- We have seen the value of working together and now need to develop our ICP Board membership
- We have used workstream groups to broaden participation in our planning
- We have worked with IMHN to establish a Lived Experience Reference Group
- We need to listen to all our communities and staff and ensure there is an effective feedback loop
- We need to take the learning from the Design Council and create a toolbox to help us think through problems and solutions

Healthier Together

Thank you

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www.bnssghealthiertogether.org.uk

Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

Inner City & East (ICE) Bristol Shadow ICP

Progress – 6th December 2021

HOSC – 6th December 2021

Where we are now

- **Strong multi-agency partnership** formed with shared values and aspirations and building a culture of working well together and real integration
- Identified **set of priorities** that target inequalities based on talking to people in our communities and Population Health Management Data
- Commitment to a **transformational co-production** approach in all our work
- **Work streams** progressing around identified priorities:
  - Mobilising Community Mental Health Services for people in ICE
  - Tackling inequalities in ICE, initially through C19 vaccination and now focusing on children's mental health and healthy weight
  - Designing a health and wellbeing network to deliver what people need within their communities
  - Ageing well agenda underway - practice-based frailty MDTs set-up

Healthier Together

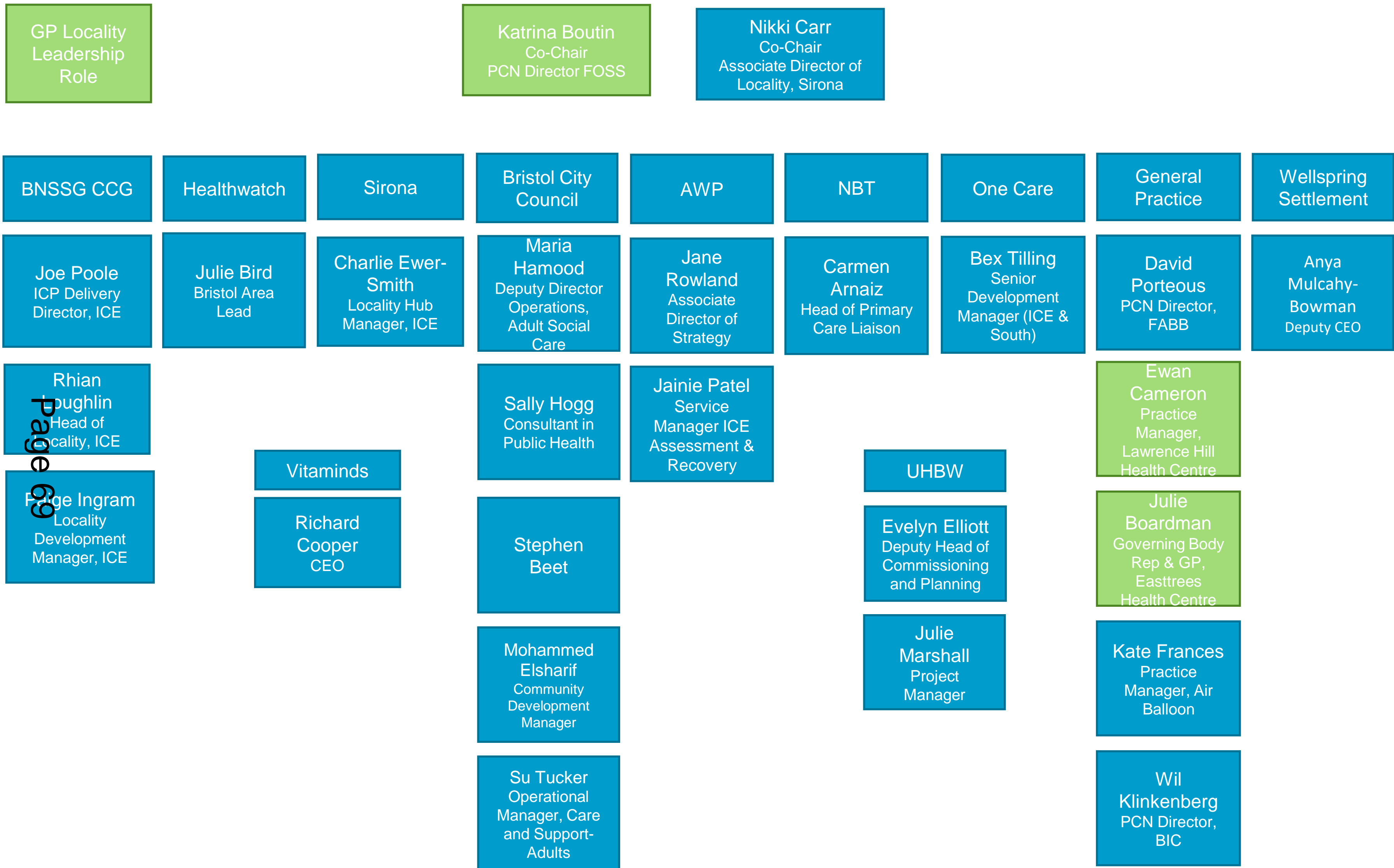
Our Shared Values

Based around the Shared Vision of:

"Reducing health inequalities in Inner City and East Bristol"

- We are **community focused**
- We are **person-centred** and understand the needs of our population, shifting our focus from a reactive to proactive using population health data
- We will have an offer to respond to those needs – **we say "Yes"** ("no "wrong door"), eliminating repeat assessments and thresholds
- We **deliver seamless care together** at the right time/place, creating invisible links between organisations
- We care for more people through **non-medicalised support** – we take a whole person, holistic, person-centred approach to our population (no mind/body split)
- We address **the wider or core determinants of health** as well as health and social care.
- We actively engage with our communities - **we do things with people not to people**.
- We focus on a multidisciplinary approach to **reducing inequalities** and involves whichever services are necessary.
- We provide more care outside of hospital, **supporting people in their own homes**

Inner City and East Bristol Shadow Integrated Care Partnership Board



ICP Development

- Organisational development work is taking place to bring to life our shared vision, our values, our behaviours and ways of working - all to be captured in a collaborative agreement
- Working with Brown Jacobson – law firm to support around legalities of becoming an ICP – risk management
- Working with Archus to develop an estates strategy
- We recognise the ICP as an anchor organisation and we are looking at the Greater Manchester Good Employment Charter
- Commitment to using Transformational Coproduction and ways to 'unleash' the community – building on the learning from Community Mental Health development.

Healthier Together

Transformational Coproduction

You won't find the solution in the place that made the problem…

Practical steps:

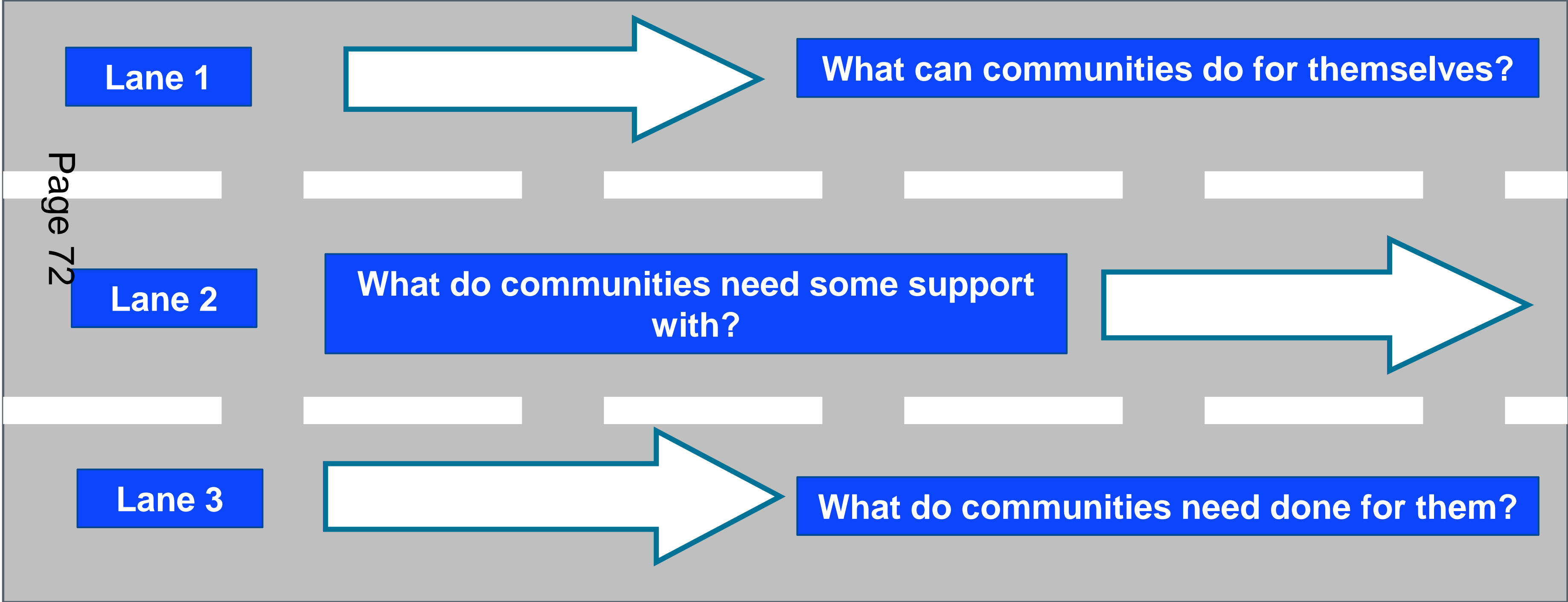
- Design at the margins – start with those individuals who are most marginalised from mainstream services, and then work in from there
- Design *with* and *not for* people
- Work to people's strengths and capabilities
- Ensure those closest to the problem are closest to decision making

Personal steps:

- Unearth the mental models that are so often invisible, our unconscious bias and norms
- Understand how mental models shape our relationships with individuals and communities, pay attention to the power dynamics
- Be curious and open to feedback about how these power dynamics and relationships shape resource flow, practices and policies

Ways to Unleash the Community

Asset-Based Community Development: The Three Lanes (Cormac Russell)



Community Mental Health Service

The Integrated and Personalised Care Team: Roles

Core IPC Team (one team with alignment around their aim & values)

- Link Worker – the main worker for the person, ensuring the person is at the centre, acts as an advocate, ensures care is personalised & integrated
- Peer-Support Worker – to share experiences; provide emotional support; discuss coping strategies; be a listening ear
- Carers Support Worker – understands the needs of carers, offer support for carers, advocate for the carer, support carers to access finance and advocacy. **Carers will be able to access the service even if their loved one does not engage**
- Mental Health Worker– clinical expertise, understanding of the specialist pathways, waiting lists, and will hold a caseload
- GP/Nurse – link to primary care, including physical health conditions
- Admin support

Plus (these roles will spread across several Core IPC Teams)

- Psychologist; Psychiatrist; Social worker; Occupational therapist

The Integrated and Personalised Care Team (IPCT): Ways of Working

- They will work as a Multi-Disciplinary Team
- They will have protected time to form and develop as a team with shared values and behaviours, reflective practice and clinical supervision
- Workers will be from communities under-served by mainstream services
- Workers will be visible in the community so they are known by local people
- Success will be framed by the difference made to people, not just by KPIs

The Integrated and Personalised Care Team: Recruitment and retention

- Looking at innovative and new models of recruitment, with an emphasis on values and core behaviours rather than qualifications and paid experience e.g., Helen Sanderson and Associates Wellbeing Teams
- Value the workforce – salary, flexible working, health and wellbeing support, training, mentoring and coaching towards meeting career development goals of the worker
- Recognise good employment is a key factor in addressing inequalities

The Integrated and Personalised Care Team: Delivery

- They will start with a *What Matters To You* conversation and any assessment will seek to understand the needs of the person rather than suitability for the service
- They will talk about recovery early on and have an understanding of what recovery means to the person, not the service
- They will deliver personalised care: shared-decision making, personalised care and support plans, connections to local activities in the community and use personal health budgets
- The PCSP will be owned by the person, it will be 'live' and people can ask for changes if it does not accurately reflect the person
- They will use a relational not a transactional approach
- Use of non-clinical settings – go to places that work for people
- Think accessibility – what works for people
- The person will only need to tell their story once
- The person will only be discharged once this is agreed with them, not when they are considered 'safe' by the service
- The person can come back into the service without need for a referral – contact the link worker directly

Other Priorities:

Improving uptake of C19 vaccinations

- Continue to design interventions tailored to different communities where uptake is lower than average.
- Focus currently on under 40s, in communities where there is still low uptake.
- Work ongoing to establish root cause for not getting vaccinated.
- Pilot family clinics in community and faith venues

Children's mental health and healthy weight - Link into Public Health using a test and learn approach for potential future interventions, continuing to explore options for funding; adopting transformational coproduction approaches and involving the wider community

Wellbeing Network - Sirona moving out of early listening phase and beginning to clarify principles and foundations for co-creation work. Strengthened collaboration with community partners as a result of listening.

Ageing Well - frailty MDTs are running at all GP practices. Next steps to link with the wider BNSSG system.

Healthier Together

If you want link in with ICE on any of this, please drop Rhian Loughlin an email at

rhian.loughlin@nhs.net

@htbnssg

www.bnssghealthiertogether.org.uk

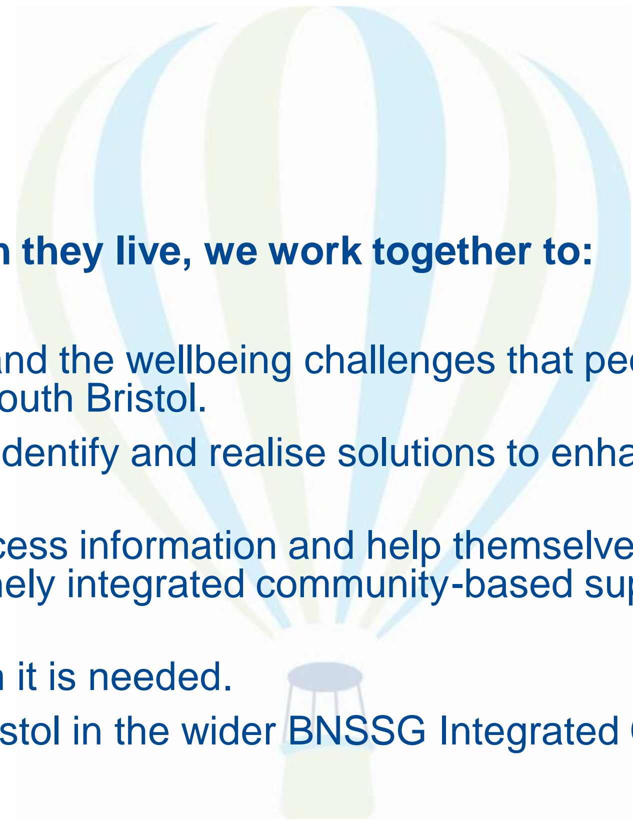
South Bristol ICP

An update for the Bristol HOSC – 06 December 2021

Our Vision

Our vision is to deliver meaningful care and support that enables individuals and communities in South Bristol to optimise their own wellbeing.

Our Shared Goals



Starting with an individual and the community in which they live, we work together to:

- **Understand** the root causes of health inequalities and the wellbeing challenges that people of all ages, their families and communities face in South Bristol.
- **Empower** individuals, families and communities to identify and realise solutions to enhance their wellbeing.
- **Enable** individuals, families and communities to access information and help themselves via self-care or with simple, understandable and genuinely integrated community-based support where the person is at the centre of every decision
- '**Pull in**' health, care and community expertise when it is needed.
- **Ensure** a powerful voice for the people of South Bristol in the wider BNSSG Integrated Care System.

In doing this, we seek to be OF the community, not just IN it.

Healthier **Together**

Our Initial 3 Priorities

- Develop a new whole life model of **integrated community mental health support** with a wellbeing and prevention focus, using the Community Mental Health Framework to help us deliver it.

- **Work with residents of South Bristol** to identify what matters to them, focusing initially on Covid-19 then young people and families.

- Ensure that we provide **meaningful information** to communities and staff to help them manage their wellbeing.

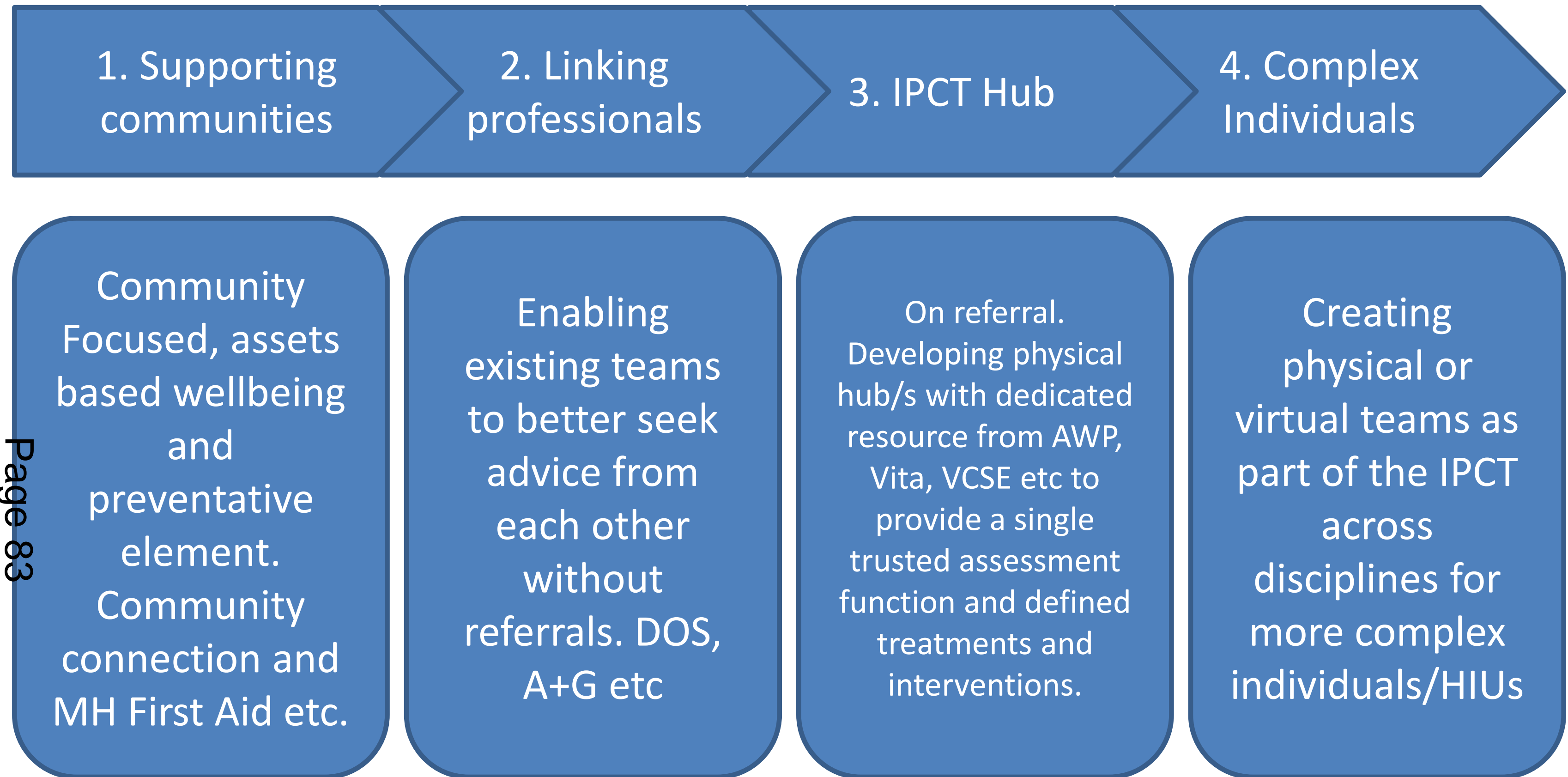
- **Broaden multi-disciplinary team (MDT) ways of working** to enable proactive support for vulnerable people of all ages, achieved through different ways of working together.

Where we are now

- Our **Collaborative Agreement** defines our vision, goals, values and priorities
- **Organisational Development** programme underway to:
  - strengthen collaboration
  - improve understanding of each other's roles/organisations
  - build a partnership culture
  - understand our relationship with the Integrated Care System and Primary Care Networks
  - help develop our governance and ways of working
- Agreed commitment to a **person-led and asset-based** community development approach
- Developing our local, tailored response to the **CMH** Operating Model
- Outputs of initial **JSSA** work to be shared shortly
- **Design Council** programme supporting our approach to improving wellbeing with a focus on mental health needs.
- South Bristol **ICP Newsletter** shares key info and messages

Healthier Together

Key Elements of our CMH Response



A focus on wellbeing and prevention as well as dedicated teams supporting those in need.
A phased approach for the IPCT starting with high intensity users who fall between services.
A holistic client centred approach, supporting trust building, engagement & stabilisation.

IPCTs – more than a standard MDT

MDT

- Team members hold the work
- Fixed membership
- SOPs, edges, boundaries between agencies
- Refers client for onward support
- Eligibility thresholds may conflict
- Protocol of support offers
- Limited time offer/sessions
- ‘Pathways’ create sequential interventions
- Team is ‘person-centred’

IPCT

- Core team manages work
- Virtual, extended team holds the work
- Flex membership to meet client need
- Employed by multiple agencies
- Draws support, as needed, from virtual members
- Lead worker has authority to act
- Client prioritizes interventions
- Unconditional & enduring – agencies do not withdraw
- Matches client experience of complexity
- Agencies are ‘*collectively* person-centred’

Developed, with thanks, from the My Team Around Me approach in Changes Bristol.

Learning / What is working well

- Partners agreed to provide **consistent representation** on the Board which has helped build stronger relationships, trust and commitment
- Process of writing our Collaborative Agreement helped articulate our vision and values and ensure we are all **working together towards the same goals**
- Importance of investing time in **partnership development** to enable us to become an effective ICP
- Need to **involve local people and communities** more to understand what matters to them
- Need to work with our other ICPs and the wider system to develop co-working and essential governance aspects.

Healthier Together

Next Steps for Bristol ICPs

- ICPs continue working on Target Operating Model for CMH and wider model of care with support to enable them to deliver by April 2022 including continued expert support via Design Council, Expert Delivery Partner and National Support Consortia
- Ageing Well programme is adopting the model of care and approach to co-production and design
- Partner organisations and provider collaboratives are considering how they align with ICPs and give good support into partnerships at place level
- Strengthening links and activity across VCSE to ensure greatest possible connection with communities
- Delegation from ICB to ICPs and how we move from contractual arrangements to the delegation of budgets and accountability
- Core focus on developing ICP Alliance Agreements that will enable them to become load bearing, have robust and clear internal governance and financial arrangements to underpin the delivery and continued evolution of the model of care.

Thank you

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Health Scrutiny work programme 2021-22

Joint Health Overview & Scrutiny Committee

Monday 15 November, 10.30am; Joint Health Overview & Scrutiny Committee (S Glos)
Stroke Programme – substantial variation
Integrated Care System

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

Monday 6 December, 10am; BCC Health Scrutiny Committee
Annual Business Report
Children's Mental Health and Child and Adolescent Mental Health Services
Community Mental Health Framework

Monday 14 March, 10am; BCC Health Scrutiny Committee
Healthy Eating
NHS waiting lists; access to planned health care (including a review of findings and recommendations of the 2020 Working Group Report) and availability of services, support and messaging
CCG Strategic Estates Plans

Items to be scheduled / Scrutiny Working Group (to be confirmed)
NHS Dentists
Health Inequalities
Suicide Prevention