Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

Bristol Health and Wellbeing Board

Title of Report:	**Integrated localities**
Author (including organisation):	**Justine Rawlings**
Date of Board meeting:	**27th November 2019**
Purpose:	Information and discussion

1. Executive Summary

This paper provides an update on the shared aim for developing integrated working across the three Bristol localities. This element of the plan was previously described as follows:

"We aim to develop health and care integration across all 3 Bristol localities so that the community is the preferred setting of care, supporting people to stay independent and active in their own homes and promoting their wellbeing. By focusing on the population health needs of local communities and creating joined up services across key agencies we will build resilience and support people in the places where they live rather than institutional settings. Our key priority groups include

- older people who are frail or at risk of becoming frail
- people with mental health needs
- people when they need more urgent care
- children and families

It is a high priority for us to work together to develop a joint approach that recognises the important contribution the VCSE makes to our communities. We want to work in genuine partnership to empower the sector and encourage new models of care through supporting small to medium enterprises and user led organisations. Such a partnership approach to micro-commissioning in collaboration with local anchor organisations will build healthier communities and develop resilience."

2. Purpose of the Paper

The purpose of this paper is to provide an update on Bristol localities which are a key shared objective within the Bristol Health and Wellbeing Board plan on a page as well as the Bristol, North Somerset and South Gloucestershire Healthier Together Partnership.

3. Evidence Base

We know from work with the Healthier Together Citizen's panel, specific deliberative research and our outcomes data that too many people are living with preventable and poorly managed health conditions, particularly in our more deprived areas, and that some people, as they live longer lives, can struggle as their health and social care needs become more complex. This results in significant differences in healthy life expectancy.

We also know that in some areas people receive excellent care and are either able to look after themselves or are supported, to lead healthy lives, others with long term conditions are amongst the least likely to feel happy and healthy and feel less informed about what they could do to keep themselves well. We have been told that most people with long term conditions would prefer to receive more of their care closer to where they live, for that care to be seamless including ensuring there is effective communication, sharing of information, and consistent care.

The picture across our localities is outline din the paper.

4. Recommendations

The Health and Wellbeing board is asked:

- To note the contents of this update and the proposal to share regularly further detail and progress with the specific Bristol locality plans at future meetings
- To note the progress made to date in Bristol to develop integrated partnerships to deliver locality plans including the role of VCSE in those partnerships

5. City Benefits

This place based approach allows agencies within Bristol to join together and align their work in order to deliver the goals of increasing healthy life expectancy and reduced inequalities in healthy life expectancy.

6. Financial and Legal Implications

None applicable for this report.

7. Appendices

Update report Developing Integrated Care in Localities and Building Healthier Communities

Developing Integrated Care in Localities and Building Healthier Communities

The Healthier Together vision for integrated care in localities is that

“Everyone in Bristol North Somerset and South Gloucestershire is able to lead a healthy and fulfilled life”

Our ambition is to deliver this joined up care for people in their communities. We want to:

“Build one single health and care system, so that the community becomes the preferred place for care and so that people can maximise their health and independence and be active in their own wellbeing”.

At present, we have a range of disparate primary care practices, community health services, social services and voluntary sector services. Despite the best efforts of staff, it is extremely difficult to provide joined-up care in this system. People sometimes receive care from too many separate services, which may duplicate activities while struggling to coordinate. Without the right type of community-based services, we end up sending people to hospital or residential care when they could have been better supported in their own homes.

Our shared goals are:

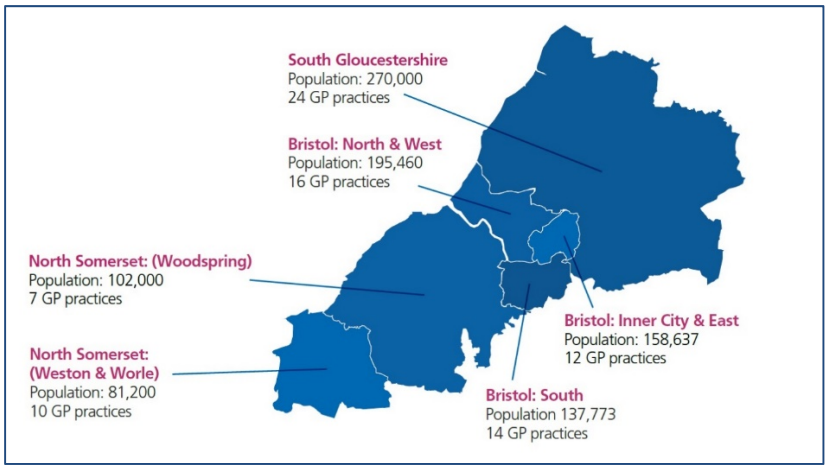
1. Local People are healthier and the gap in healthy life expectancy is reduced
2. Communities are healthy, safe and positive
3. People are able to make decisions about what matters to them
4. People’s lives are less affected by dealing with ill health
5. Our teams are supported to be at their best for people
6. Local People receive more care at home or in the community

This work is led by the Healthier Together Integrated Care Steering Group which reports to the Healthier Together Partnership Board.

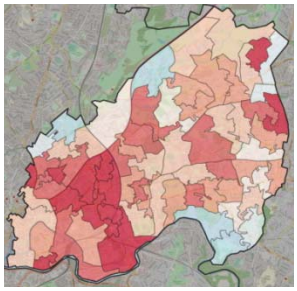
The strategy is for developing integrated community services, capable of delivering proactive, holistic and joined up care to people at home or close to their homes. We want to support everybody to maintain their own health and wellbeing. We want to ensure that our older residents remain fit and healthy for as long as possible. And we want to ensure that nobody attends hospital or is admitted to a hospital ward or to long term residential care who could be better treated in the community or could be supported to stay in their own home. Our strategy for achieving this includes establishing new locality hubs and joined-up community health and care teams capable of providing flexible support to people with a wide range of health and social challenges and stronger support to communities.

The overall strategy will be outlined in the Healthier Together Long Term Plan.

Our localities

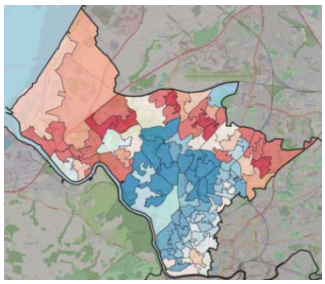


The Bristol localities are Inner City and East, North and West and South Bristol.



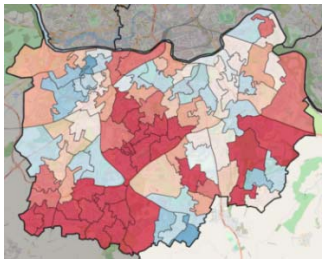
Inner City and East Bristol

Population: 158k, Median age: 29
Control: **5.5***, health: **7.3***, happiness: 7.1
Smoking: **30%***
T1ED SAR: **111**, ambulance covey. rate: **140**
NEL admissions: **109**
1st OPA: 92

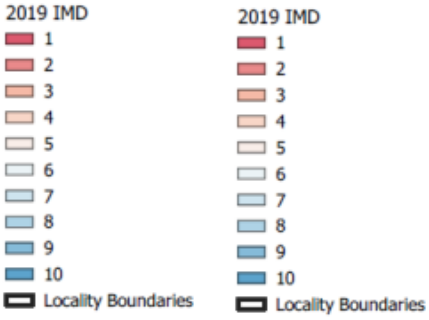


North and West Bristol

Population: 195k, Median age: 31
Control: 7.7, health: 8.2, happiness: 7.4
Smoking: 5%
T1ED SAR: 103, ambulance covey. rate: 102
NEL admissions: 96
1st OPA: 93



South Bristol
Population: 137k, Median age: 34
Control: 7.0, health: **7.0***, happiness: **6.4***
Smoking: **29%***
T1ED SAR: 93, ambulance covey. rate: **137**
NEL admissions: **107**
1st OPA: 100



*indicates statistically different from highest score
LSOA: lower-layer super output area
IMD: index of multiple deprivation (IMD1, red is most deprived)
Control, health and happiness self-reported on 10-point scale [citizens' panel]
T1ED: Type 1 emergency departments
NEL: non-elective admissions
SAR: standardised admission rate per 1,000 population
OPA: outpatient appointment

We know that:

- Inner City and East (ICE)
    - Youngest age profile in BNSSG
    - Self-reported health is statistically lower than the 'healthiest' localities, associated with lowest levels of 'feeling in control of life', though levels of happiness on par with 'happiest' localities
    - Highest rate of smoking.
    - Just over 30% from a BME background.
    - Ranks high for all key markers of unplanned care use, with highest ambulance conveyance rates
    - Ranks lowest for key marker of mean unplanned care use; 1st outpatient appointment (OPA)
- South Bristol
    - Seemingly similar profile to ICE with marked difference in ethnic diversity with just 8% from a BME background.
    - Characterised by low happiness self-rating, but statistically similar feeling of control.

    - Similar pattern of high unplanned care use
- Weston, Worle and Villages (WWV)
    - Lowest overall self-rating for control, health and happiness.
    - Much older population than ICE and South Bristol.
    - Highest rate of ED attendances and strikingly low ambulance conveyance rate, though also has highest rate of 1st OPA.
- North and West Bristol, South Gloucestershire and Woodspring
    - Similar self-reported health, control and happiness.
    - Similar activity rates, with lowest unplanned care rates and relatively high planned care rate in least deprived Woodspring locality
    - North and West historically viewed at 'inner' and 'outer', with the latter being significantly more deprived. All-cause age-standardised premature mortality for males and females in outer North and West were 545 and 377 per 100,000 population respectively, compared with 297 and 180 for inner North and West (2012-2014).

Overall high markers of unplanned care use associated with deprivation, high smoking rates, feeling either not in control of life or lower levels of happiness or both.

ICE, North and West and Weston, Worle and Villages have the highest rates of attendance at type 1 emergency departments and each contain an acute hospital within their boundaries.

Despite varying deprivation, associated factors and known correlations with disease burden, planned acute care rates (adjusted for age) are similar across localities, indicating potential underuse in deprived areas relative to need.

Our ambition is to use this understanding of the variation and specific needs to enhance the way we design interventions with our communities.

Integrated Partnerships in localities

Over the last two years, we have established partnerships in each locality to oversee the development of integrated local services. These include:

- GPs
- Community services
- Local Authority public health and social care colleagues (children and adults)
- VCSE organisations
- AWP

In Bristol, the partnerships have been meeting informally for some time and have, on the whole, had strong representation from each of these providers. There have been small "test and learns" conducted to try out new ways of working, for example multi-

disciplinary/multi-agency team meetings which have addressed long standing high use of services by people or individuals whose complex needs had previously not been amenable to being resolved, provision of drug and alcohol services at GP surgeries to serve a whole new cohort who would not attend other clinics.

The next phase is to design and implement integrated community services in localities, beginning with frailty. The procurement of a new community provider with means that from April 2020 we can start to develop the new community model of care, a significant element of which will be the new frailty model. However, there is already work going on in Bristol with the existing provider and Bristol City Council adult social care to roll out multi-disciplinary working to support our most frail older people through this winter. There are already successful Multi-disciplinary team pilots in South Bristol and plans to start further pilots in North Bristol this year. The aim of these is to reduce risk of hospital admission as well as improve joint working relationships and reduce unnecessary referrals between partners. Our 6 localities are planning how they will further join up services in the community into a system of care at every level. Integrated Locality Partnerships (ICPs) will bring together our primary care networks, community services, local authority services, mental health and the voluntary sector in communities jointly to coordinate services for their populations. They will use population health management data to focus on the specific needs of the people in their communities, taking into account the very different outcomes, circumstances and challenges that are experienced by people across BNSSG. Taking a strengths based approach, agencies will work together to ensure that people can stay independent and in control of their lives and remain living at home for as long as possible.

We will also be looking at the opportunities to use digital technology and equipment to help people manage their own health conditions,live independently and access their communities.

Building Healthier Communities together

We know that alongside developing services, we also need to find a very different way of working with people and their families. There are large numbers of community led, faith and voluntary and social enterprise organisations who already do a considerable amount to keep people healthy well and independent. In many cases these organisations are supported by our Local Authorities. In Bristol, there has been significant support over time and there are already well-established VCSE organisations working closely with health and care providers. This has meant, for instance, that most primary care networks in Bristol have chosen to employ their social prescribing link workers through these VCSE rather than directly into the practice and we have had.

However, we also know that there is considerable challenge for us as a health and care system to make better use and value more the contribution of the VCSE and to

understand communities own assets and strengths. Communities and the VCSE, in turn, share our challenge of increasing demand and unsustainable funding. We know that VCSE, community and faith groups have a reach into the heart of communities and we also know strong communities are good for health

Health, VCSE and local authority colleagues and potential funding organisations are working to develop an entirely new way of working with communities in our localities that is more ambitious, radical and sustainable. There has been a collective failure to reallocate resources to "upstream" preventative support and care – and we want to think more broadly about the resources we collectively have to achieve our common aims to help people lead healthy and fulfilling lives.

Our plan is to establish community based VCSE organisations as equal partners in each of our integrated locality partnerships to support thriving communities where people are able to have healthy and fulfilled lives. Their role will be to extend the reach into communities, supporting them to make the most of what they have, making available health and care resources to be used differently but also to draw in new resources so that communities themselves can determine what is needed and develop services and social support alongside the services provided by the NHS and local authorities. These partnerships will be established in each locality by April 2020.

Working in and with community organisations in this way will facilitate taking a more asset-based approach, supporting and stimulating those communities to create healthier environments, making use of people's strengths. As well as the VSC this will involve working with other services and buildings, (e.g. shops, libraries, private companies) within communities to be accessible and support the needs of their population. We are working with Local Authority colleagues to align with other discussions relating to community organisations in both adult care and community development.

Summary

The steps we have taken to date and have in train have begun to establish our localities as follows:

- Establishing localities, through the locality transformation scheme beginning in August 2017 with a strategic business case for our integrated model of care for frailty having been signed off in September 2019.
- Procuring one provider of community services for the Healthier Together footprint, beginning to deliver care from April 2020
- Setting up 18 primary care networks (PCNs) in July 2019.

- Building Healthier Communities through integrated locality partnerships, including the community, and from April 2020, integrating with VCSEs.
- Integrated network teams working within PCNs.
- Extended our integrated multi-disciplinary team working to cover the whole population is in progress.
- Integrating system data through our population health management (PHM) programme.

Our integrated localities and PCNs will provide an enhanced level of capability including new locality services, above that of any single current primary care or community provider and these will become the new default setting of care.