Healthier Together

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

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:

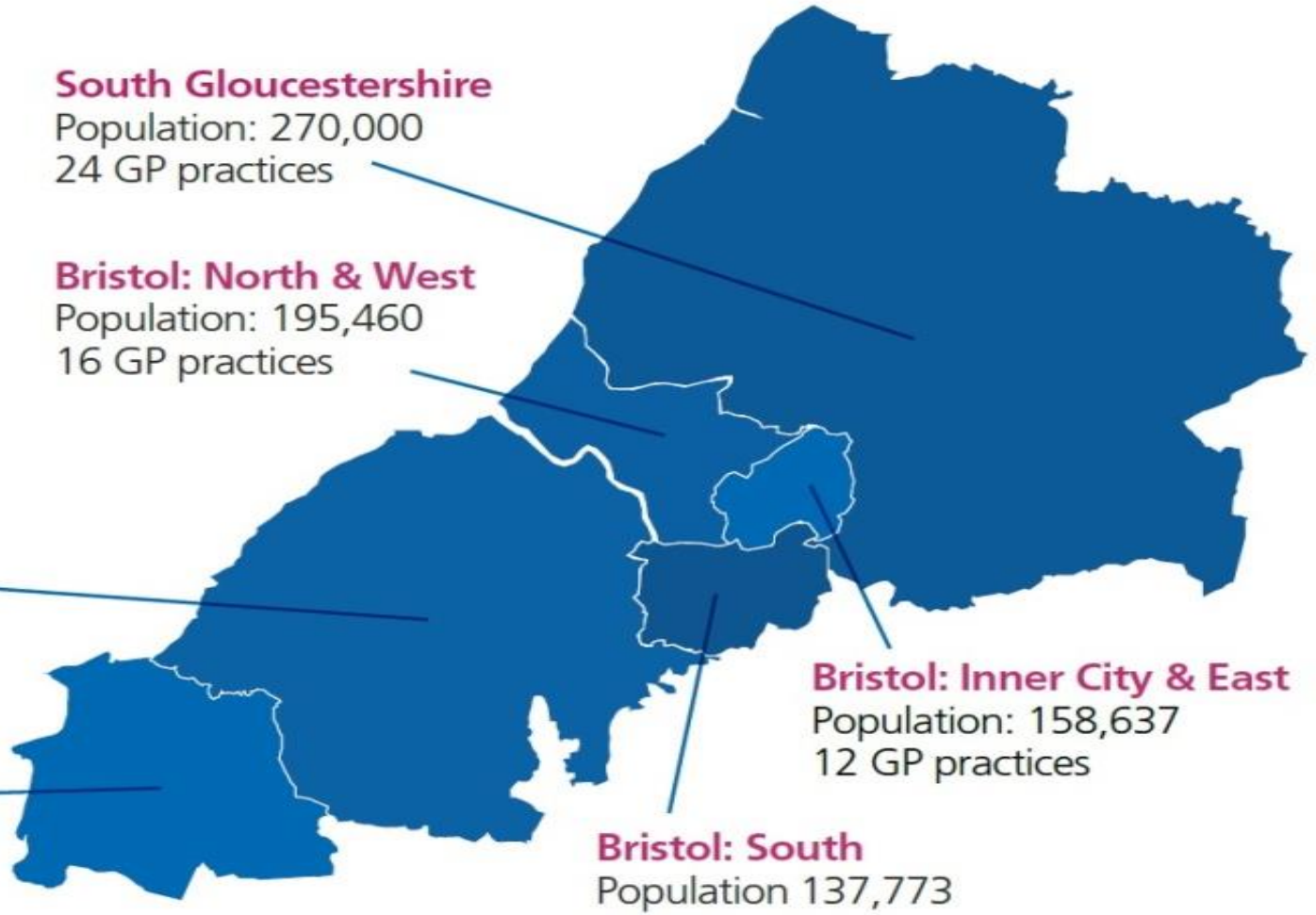
- There is no single approach to defining how, and at what scale, partners should come together to work in an ICS. Place-based partnerships should start from understanding people and communities and **agreeing shared purpose before defining structures**.
- Effective partnerships are often **built 'by 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.



South Gloucestershire
Population: 270,000
24 GP practices

Bristol: North & West
Population: 195,460
16 GP practices

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

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

Bristol: Inner City & East
Population: 158,637
12 GP practices

Bristol: South
Population 137,773
14 GP practices

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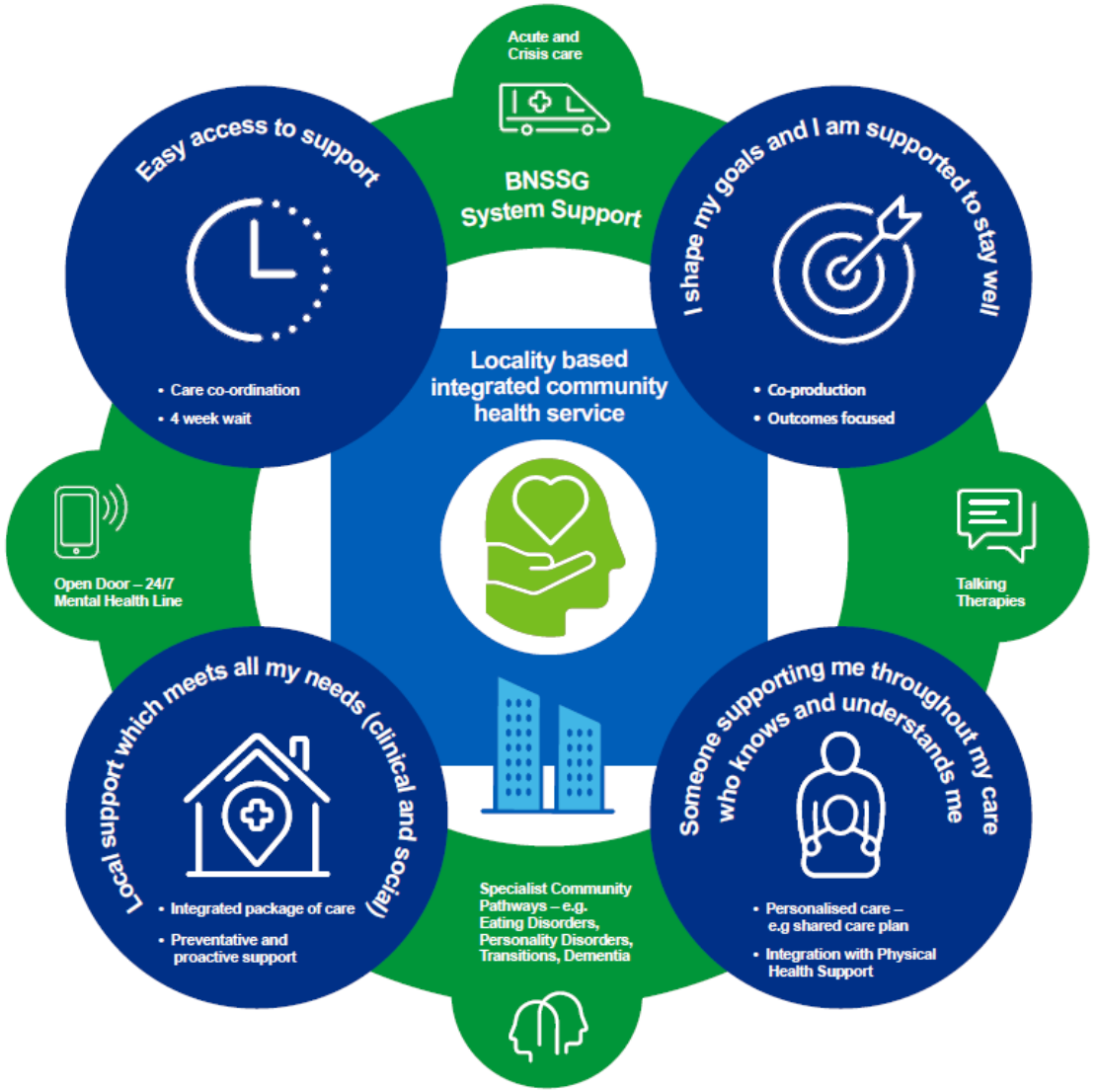
BNSSG Community Mental Health Programme

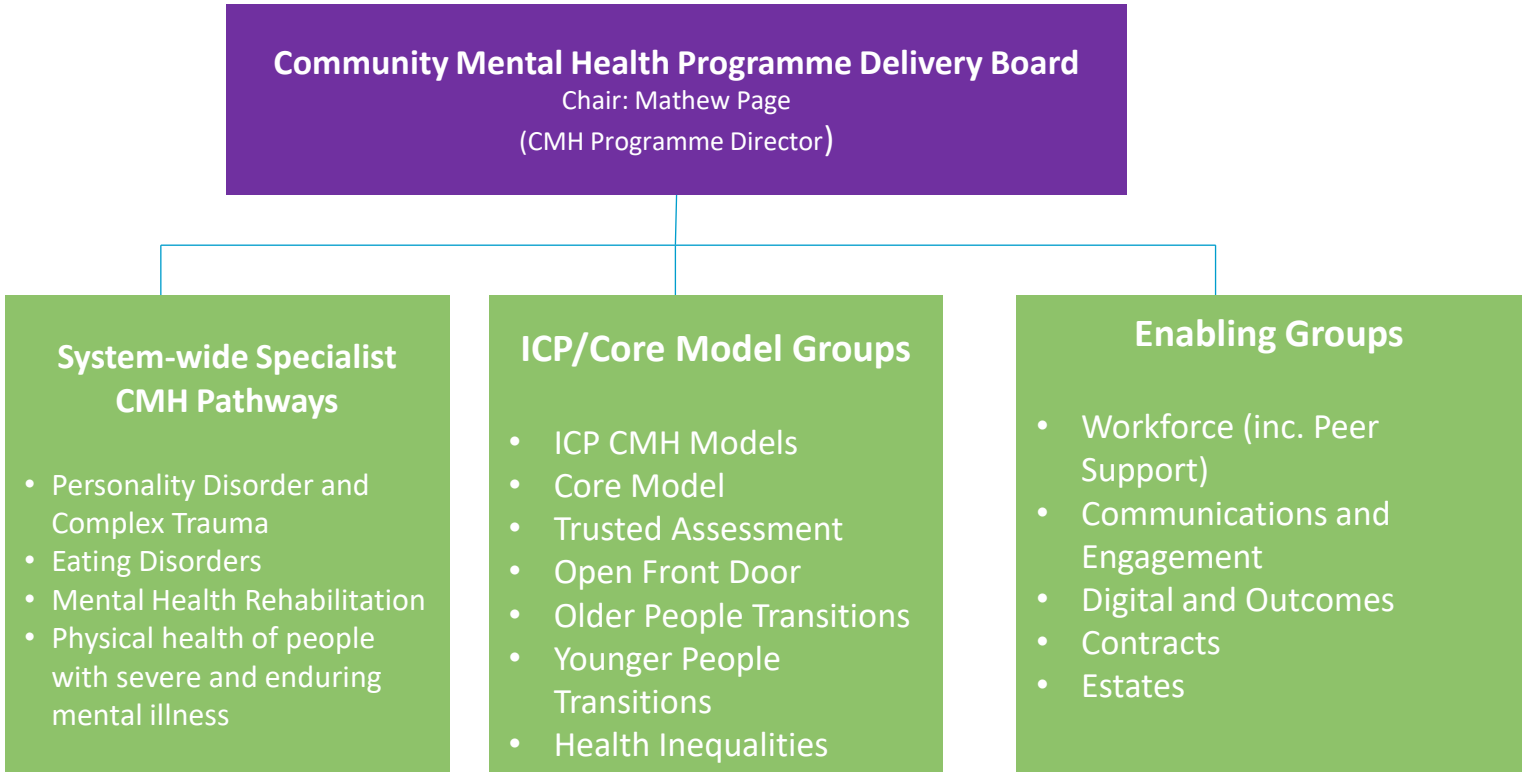
Community Mental Health Programme: Aims

- 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



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.

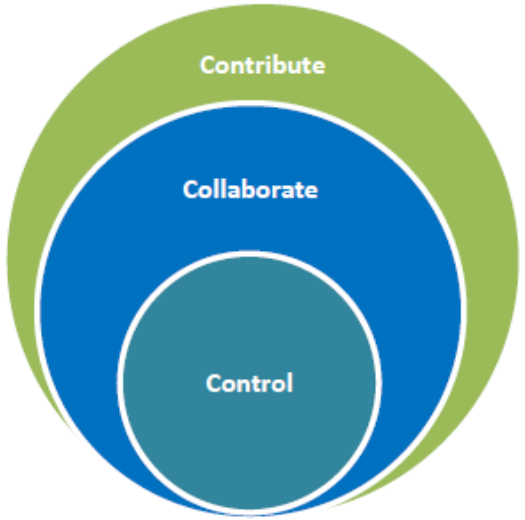
Aligned working is essential to ensure a certain level of consistency in offering for our whole population to prevent confusion or a 'post code lottery' – whilst not detracting from local service offerings based on need.

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



APPENDIX

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

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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.

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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

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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

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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

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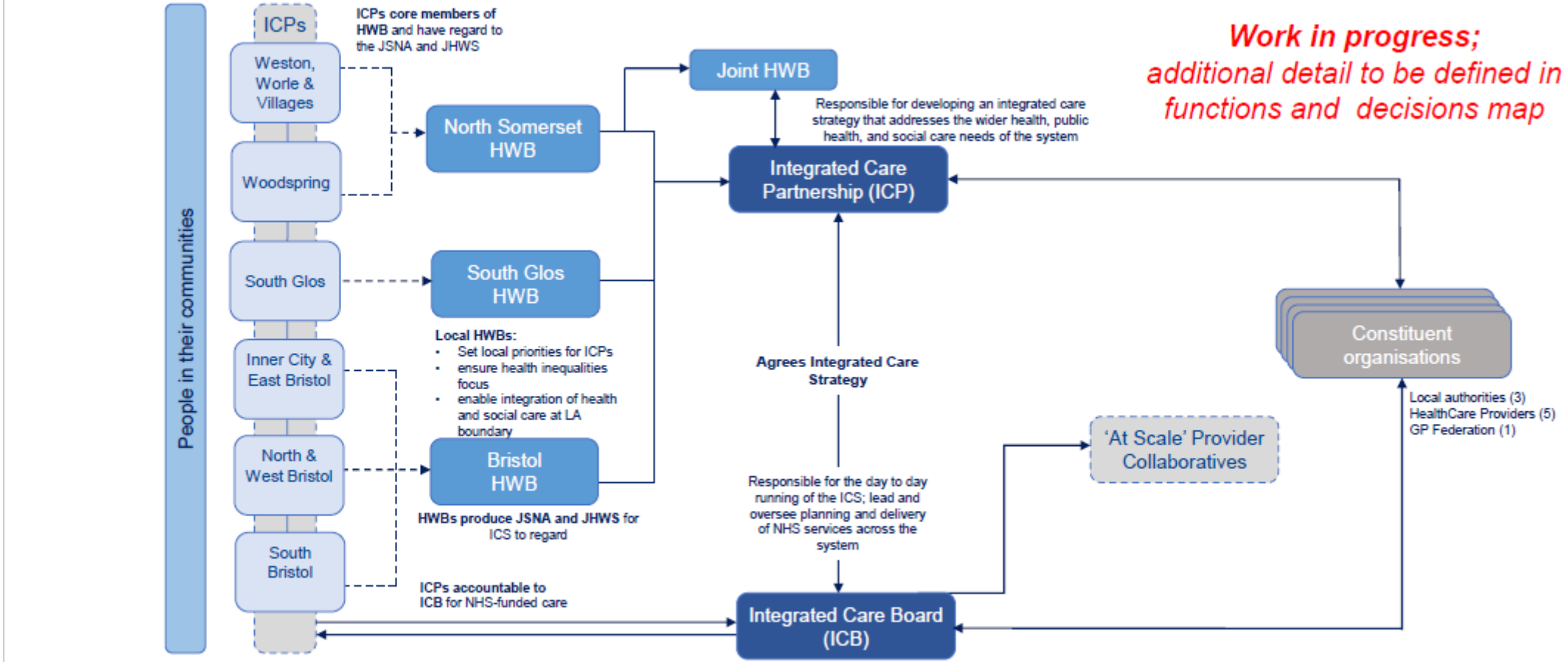
11	**Digital**	**Shared Data** Our connecting care system is now pervasive in its use and clinical teams have identified it is now an integral part of their practice. This service will continue to grow to reflect the needs of our integrated care approaches. This will include the person having access 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



Healthier Together

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