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)

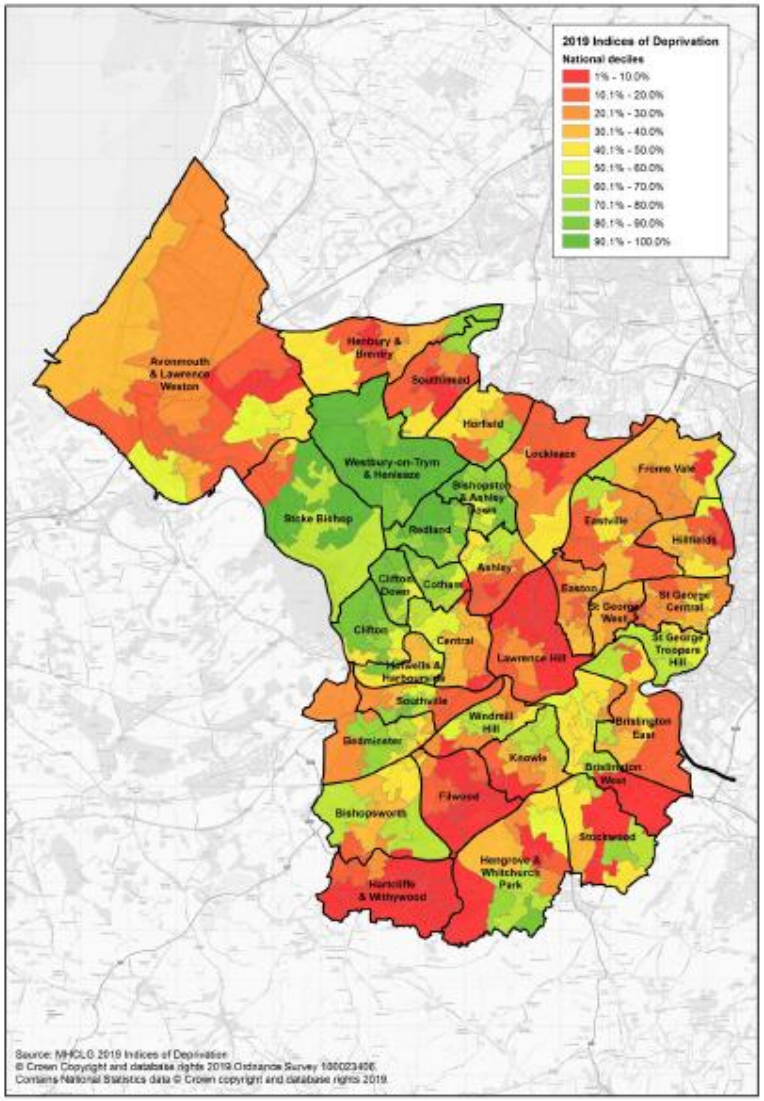
5% with a depression marker and/or SMI code have a dual diagnosis with drug/alcohol dependence

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



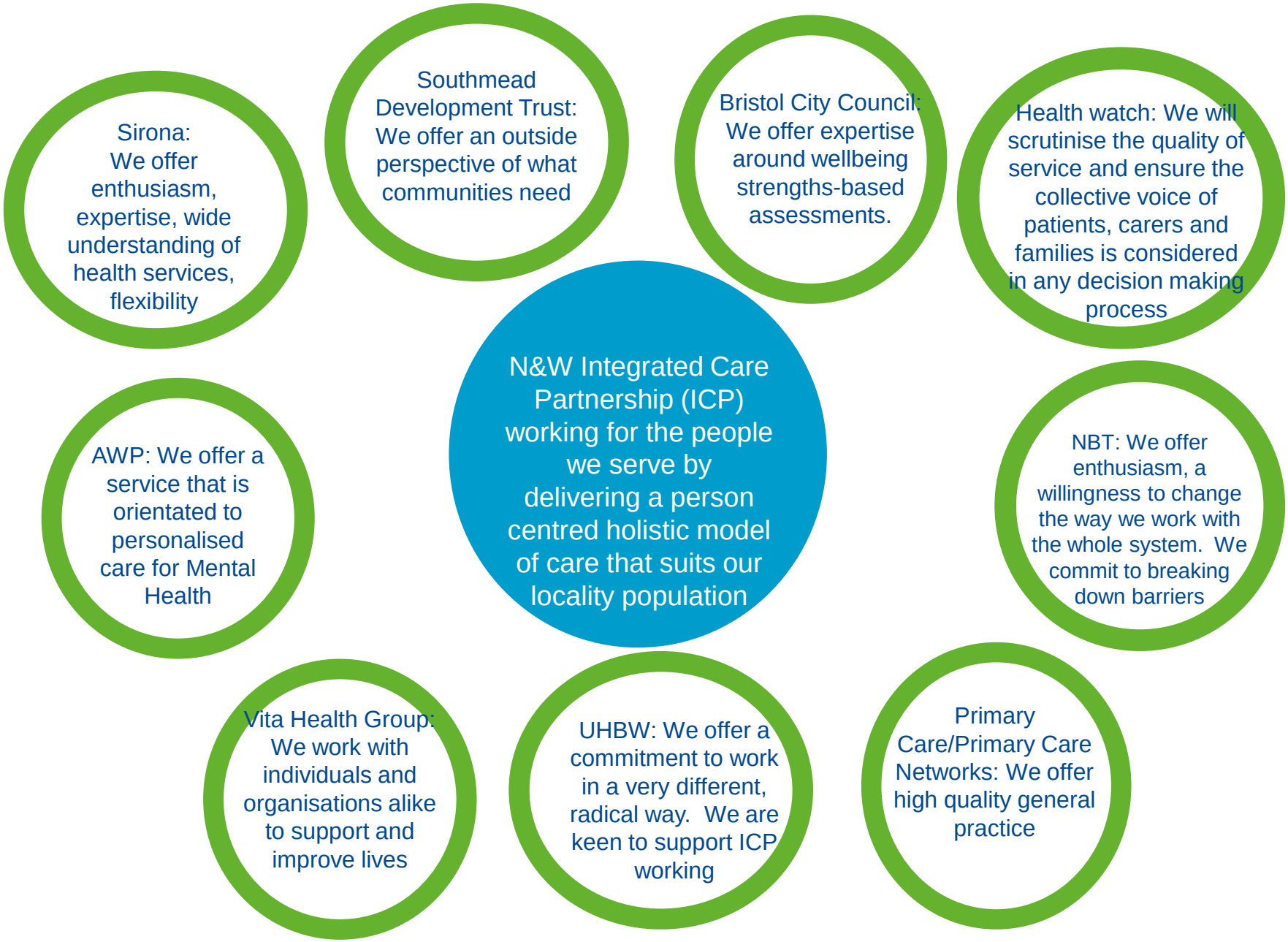
This locality covers some of the most affluent parts of Bristol where many benefit from longer life expectancy and better health.

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.

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.

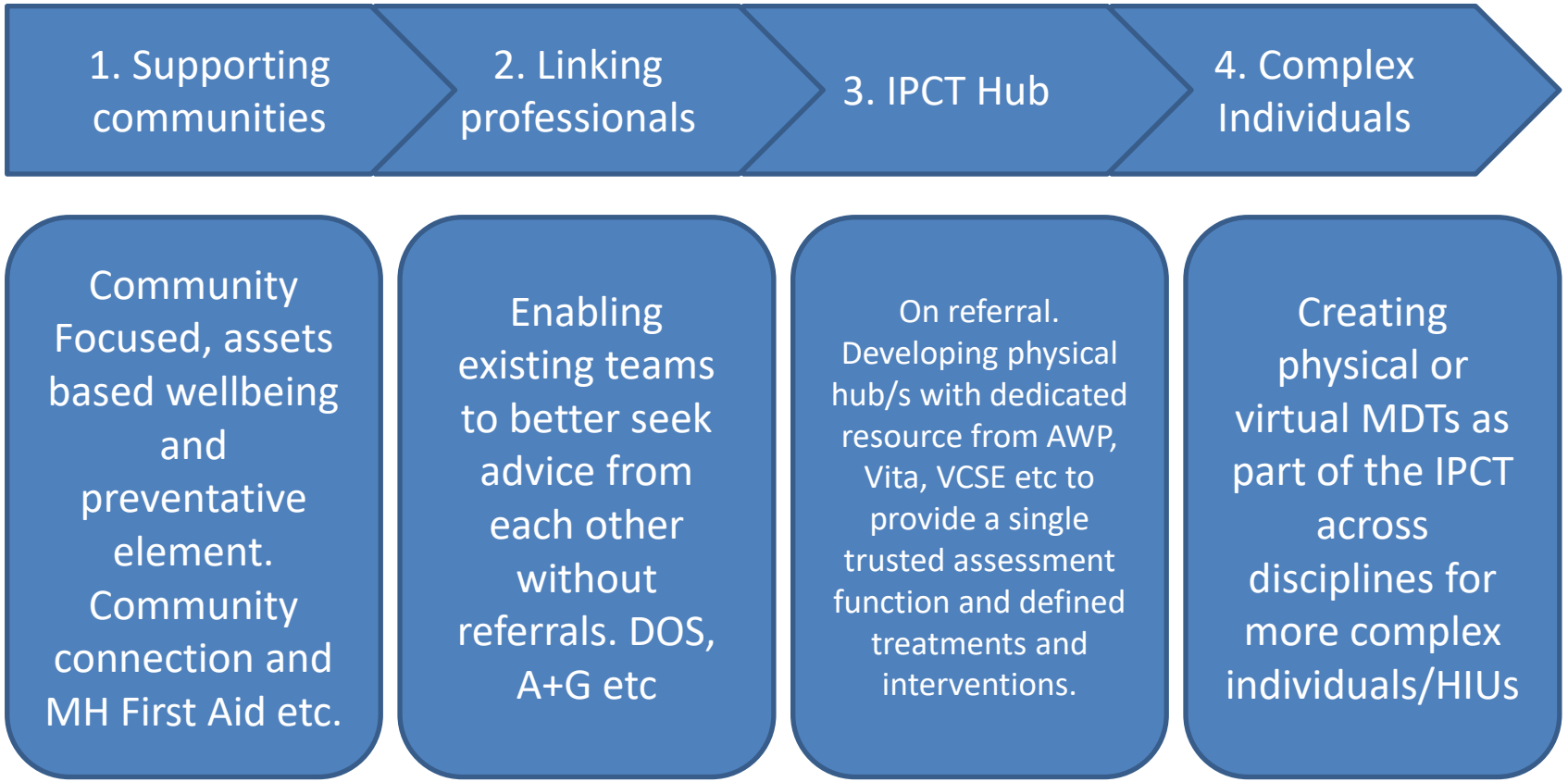
Where we are now…

- 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

•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

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

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Thank you