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

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 <u>with</u> people not <u>to</u> 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

GP Locality Leadership Role

Katrina Boutin
Co-Chair
PCN Director FOSS

Nikki Carr
Co-Chair
Associate Director of Locality, Sirona

BNSSG CCG	Healthwatch	Sirona	Bristol City Council	AWP	NBT	One Care	General Practice	Wellspring Settlement
Joe Poole ICP Delivery Director, ICE	Julie Bird Bristol Area Lead	Charlie Ewer-Smith Locality Hub Manager, ICE	Maria Hamood Deputy Director Operations, Adult Social Care	Jane Rowland Associate Director of Strategy	Carmen Arnaiz Head of Primary Care Liaison	Bex Tilling Senior Development Manager (ICE & South)	David Porteous PCN Director, FABB	Anya Mulcahy-Bowman Deputy CEO
Rhian Loughlin Head of Locality, ICE			Sally Hogg Consultant in Public Health	Jainie Patel Service Manager ICE Assessment & Recovery			Ewan Cameron Practice Manager, Lawrence Hill Health Centre	
Paige Ingram Locality Development Manager, ICE	Vitaminds Richard Cooper CEO		Stephen Beet		UHBW Evelyn Elliott Deputy Head of Commissioning and Planning		Julie Boardman Governing Body Rep & GP, Easttrees Health Centre	
			Mohammed Elsharif Community Development Manager		Julie Marshall Project Manager		Kate Frances Practice Manager, Air Balloon	
			Su Tucker Operational Manager, Care and Support-Adults				Wil Klinkenberg PCN Director, BIC	

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.

Transformational Coproduction

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

Practical steps:

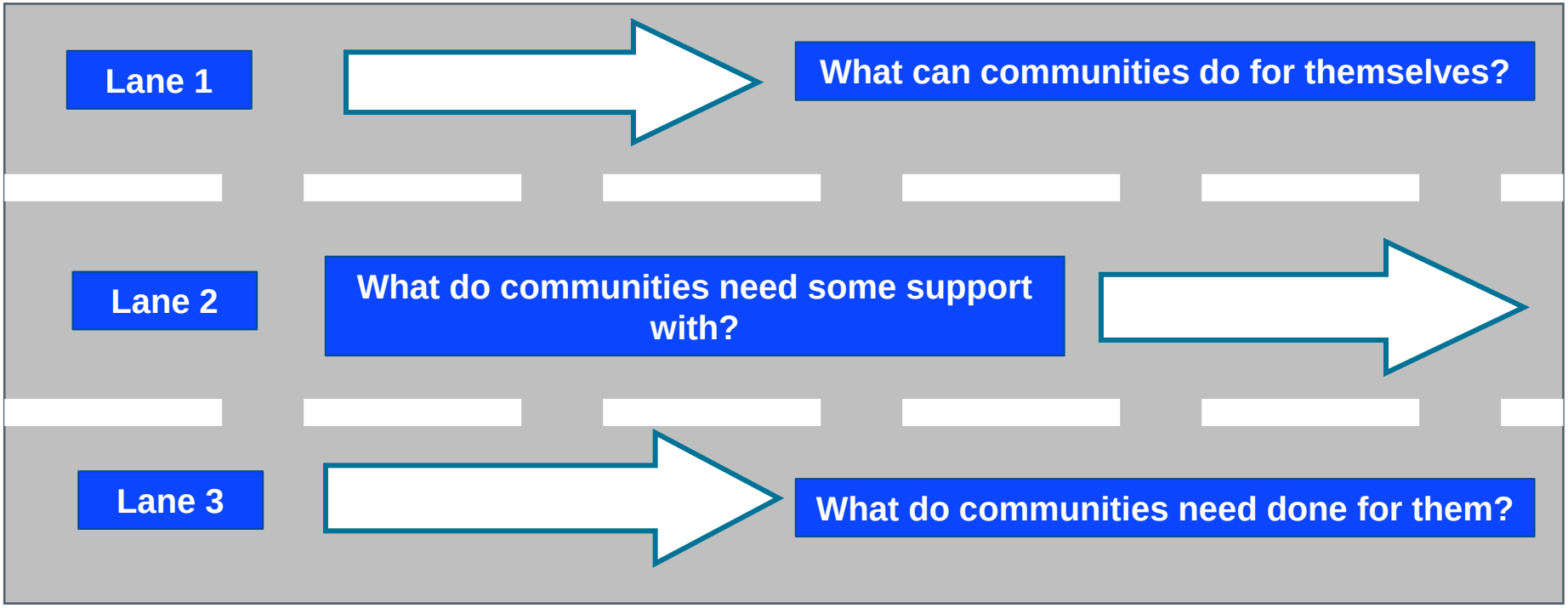
- Design at the margins – start with those individuals who are most marginalised from mainstream services, and then work in from there
- Design *with* and *not for* people
- Work to people's strengths and capabilities
- Ensure those closest to the problem are closest to decision making

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.

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

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