Healthier **Together**

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

Locality Partnerships and a focus on the Community Mental Health Transformation Programme

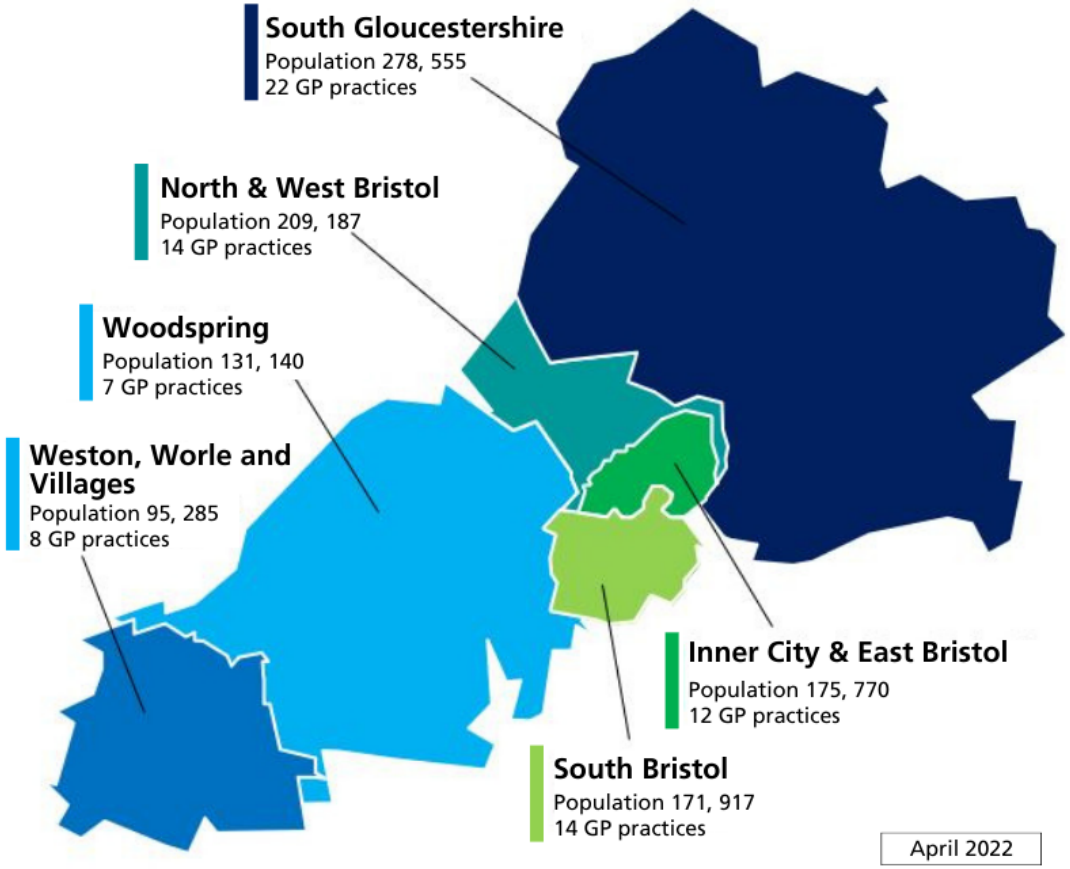
October 2022

Locality Partnerships in BNSSG

Our ability to stay healthy and well depends on a range of things, including social connections, employment, housing, and education. To make a real difference in people's lives, health and care services need to reflect the importance of these wider factors and the role they play in our health and wellbeing.

To help do this, six Locality Partnerships have been established in our area.

Locality Partnerships work at a local level with their communities, to improve health and wellbeing. Each partnership focuses on a given area and population, and designs services that fit in with people's lives.



Who is involved?

Locality Partnerships are made up of local health, social care, and the voluntary sector – with citizens and community as equal partners.

This can include GPs, councils, social care, community services, mental health support and local activity clubs. People with lived experience, their support networks and carers are also partners in each Locality Partnership.

Together they work as one team to understand what matters most to their local community. They then share their expertise, experiences, and knowledge to improve services for their population and ensure people are at the heart of every decision.

South Bristol Locality Partnership

Co-Chairs – Stephen Beet, Bristol City Council, Simon Hankins, BS3 Community

Delivery Director – Steve Rea

- **Our vision** is to deliver meaningful care and support that enables individuals and communities in South Bristol to optimise their own wellbeing.
- We have agreed commitment from partners to a person-led and asset-based community development approach
- As part of our Community Mental Health response we have developed the following key elements:
  1. Supporting communities: community focused, asset based wellbeing and prevention.
  2. Linking professionals: enabling existing teams to better seek advice and support without referrals.
  3. IPCT: where dedicated resources provide a single trusted assessment and defined interventions.
  4. Complex Individuals: physical or virtual teams working across disciplines to support the whole person.

North & West Bristol Locality Partnership

North and West Bristol
Locality Partnership

Chair – Dr Kirsty Alexander

Delivery Director – Sharron Norman

Our vision is to empower people and their communities, and their voices, to improve their health and wellbeing.

We have agreed a foundations approach to building collaboration:

- Working with trust and openness between partners
- Our understanding of gaps are based on both population health data and people's experiences
- Shared identification and ownership of these gaps

Using co-production (with service users and frontline staff) we have identified the outcomes we expect from our Community Mental Health model:

- Person centred, holistic model of care that suits our locality population
- Improved parity of awareness/wider knowledge of how to access mental health services.
- Planning progresses with an understanding of the needs of whole population community health in our minds (eg children and young people)
- Working together across localities/ICPs for equity of service

Bristol Inner City and East Locality Partnership

Co-Chairs – Katrina Boutin, GP & Nicki Carr, Sirona
Delivery Director – Joe Poole

Inner city and East Bristol
Locality Partnership

- Our vision is for transformational coproduction to change power and control, so that people who use services are actively involved in all aspects of designing, commissioning and delivering services.
- We have established reference groups to drive our design processes including people with lived experience, frontline workers and community and faith groups.
- We have established commitment to asset based community development (ABCD) approaches which builds on the resources in our communities.
- As part of our Community Mental Health response this means:
  - Placing our communities at the heart of our design processes e.g. through our reference groups
  - Utilising our network of community representatives (Nilaari, Bristol Black Carers, Somali Resource Centre etc.) to identify and maximise community assets
  - Proactively seeking to build our community workforce
  - Implementing the three lanes approach to ABCD

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Community MH - Why do we need to change?

- **Lack of early support to prevent crisis**
- **Fragmentation between services** – transitions (young people moving into adult mental health services / moving from adult services to those for older people); poor integration between physical and mental health care
- **Thresholds and other barriers to access –** multiple assessments increase the chance of drop out, delay treatment and is a poor use of resources; people with mental health needs not fitting rigid specifications and being left without support (primary / secondary care gap)
- **Difficulties in getting appropriate high quality care** – multiple assessments; long waiting times; inconsistent access to evidence-based care mean people's health can deteriorate and they are likely to go on to require more intensive or acute support.
- **Distance from community -** care needs to take place in the context of people's lives, and supports them to live better within and as part of their communities.
- **Inequity of access, experience and outcomes**
- **This approach is not sustainable:** Increased demand (e.g. eating disorders); recruitment challenges; financial challenges (e.g. AWP: £34m deficit).

What do we want to offer?

We will promote mental wellbeing and prevent mental ill health, supporting people wherever they live in Bristol, North Somerset and South Gloucestershire, and whatever their background, to stay well, play an active part in their communities, and have greater choice and control of their care, through:

- Evidence-based, integrated and holistic care, provided when and where it's needed: combining the best from the NHS, social care and voluntary sector
- Services shaped around the different needs of our local communities – trauma informed and culturally inclusive
- Staff working as 'one team' – eradicating barriers between primary, secondary, voluntary and community sector partners
- Support that is co-designed and provided by those with lived experience
- A system and culture that enables outcomes to be easily gathered to constantly learn and improve
- The fastest improvements in those with the poorest outcomes, proactively tackling entrenched mental health inequalities in access, experience and outcomes

What people have told us: ‘I Statements’

Experts by Experience

- I want to feel better
- I want to be listened to, be seen and respected, and have choice.
- I want to know who to call when I need support and be helped to quickly access care
- I want to share my story, knowing it will be properly listened to and valued; safely recorded; and help offered
- I want care that is tailored to my needs and sensitive to my experiences and trauma, from people who understand.
- I want care to be joined up and accessible (including across different stages of my life).

Carers

- I want to know that help is available if and when I need it
- I want to be heard, respected and valued as an equal partner in supporting the person.

Workforce

- I want to be effective and kind
- I want people to be supported to be as well as possible
- I want to feel part of “one team” providing care that wraps around people when they need it
- I want us to move from talking about health inequalities to addressing them
- I want trusted relationships to proactively manage risk across organisations
- I want IT systems that allow me to do my job.

BNSSG Community Health Model - Blueprint

Whole Population
Public-health led programmes (LA level)

Levels 1/2
Primary Care

Levels 2/3/4
Bridging the gap between Primary/Secondary Care

Levels 3/4
Secondary Care/Community Mental Health Service

Getting Help

Getting More Help

Getting Advice

Getting Specialist Support

BNSSG-wide advice and guidance offer

Carers, friends and neighbours

Primary Care Offer
- VCSFE
- Social Prescribers
- IAPT
- GPs
- Pharmacists
- Mental Health Practitioners

ARRS

Integrated Mental Health Service Offer x 6

AWP, VCSE, Sirona, Vita, Local Authorities
- Recovery Navigators
- Social Care / Housing / Employment / Welfare
- Counselling & therapy via VCSE
- Wellbeing College
- Peer Suport
- Specialised Secondary Care
- Drug and Alcohol
- IAPT
- Personalised Care Planning
- Physical Health (SMI)

Secondary Care Offer
- Recovery Navigators
- Intensive Suppport
- Evidence-based psycho-social interventions
- VCSE
- Psychological Therapies
- Peer Support
- Specialist Pathways
- Assertive Outreach
- Psycho-educational offer
- Care Planning
- Pharmacy

MH assessment (as appropriate)
a. Supportive conversation, b. Clinical assessment, c. IMHT assessment (LPs x 6) - information shard and built upon through the process

Inner City and East Bristol
Wellspring Settlement

South Bristol
BS3 and Knowle West Healthy Living Centre

North & West Bristol
Southmead Development Trust

South Glos
Southern Brooks Community Partnership

Woodspring
Citizen's Advice

Weston, Worle and Villages
VANS

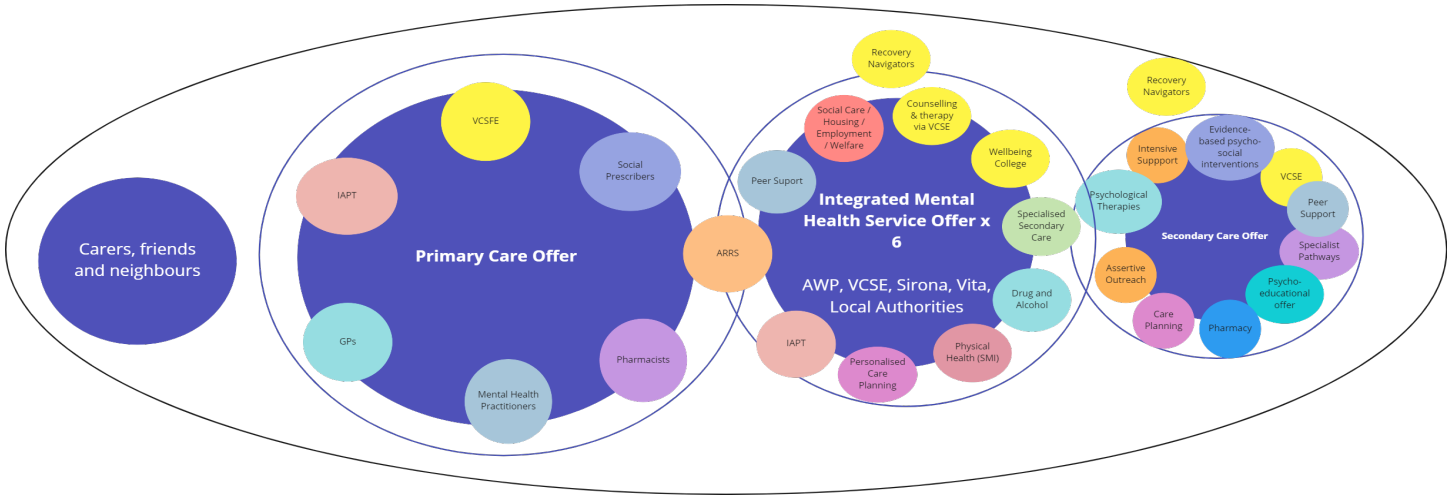
Mental Health VCSE Alliance

Voluntary, Community, Faith and Social Enterprise Support

Example Integrated Mental Health Team (IPCT) Pathway – Patient 1

New Integrated Mental Health Team (IPCT)

Presentation	Known to	Risk Factors	IMHT Intervention	Outcome of IMHT Intervention	Onward pathway
• Psychosocial need (financial & relationship issues) • Depression & anxiety • Physical health issues • Excess alcohol intake • Few coping strategies • Isolated	• GP surgery • PCLS • EDs • 999 Services • Local Authority • Local VCSE services • Vita	• Suicidal • Reduced daily living skills • Escalation by increasing use of emergency services	• Comprehensive assessment of needs • MDT meeting • Navigator • Stabilisation • Motivational interview	• Stabilisation and engagement • Reduced use of unplanned care • Holistic patient centred care plan • Increased motivation to engage in treatment offer	• Attends Drug and Alcohol services • Engagement with GP and ongoing support re: physical health • Meaningful social activities re: social prescribing • IAPT



Key objectives for Bristol Locality Partnerships' Developments

Through piloting place-based and person-centred care through new Integrated Mental Health Teams, each Locality Partnership will be able to evaluate how this approach:

- Increases people's access to high quality and personalised care, close to home.
- Affects people's mental health outcomes.

Test and Learn Approach

A key principle of this programme is ensuring equity of care and outcomes across BNSSG. As such, Locality Partnerships are piloting different approaches to help us to collectively develop a consistent model of community mental health care across BNSSG, which will be tailored to each area.

For this to be successful, we will collectively agree the approaches we are taking; how they will be evaluated; and work and learn together to support the development of the new model of mental health care. In parallel, key statutory and VCSE partners with be transforming key aspects of their care – working closely with Locality Partnerships.

Key Elements of the New Model

Inner City and East Bristol

ICE's IPCT will be accessed from a wide variety of sources. People will be screened and allocated a link worker or recovery navigator, with consideration given to their cultural context – with agreement sought from the individual. An MDT will be called if needed, but otherwise the link worker will have responsibility for advocating for the person, supporting them to access wrap around support and helping relevant professionals to understand cultural requirements. They will also work with those who aren't engaging with services.

North and West Bristol

To create a VCSE-led Integrated and Personalised Care Team which will assess need and sign post/support people to access other VCSE services including recovery navigators, peer support and the wellbeing college. It seeks to better meet people's needs and prevent escalation (reducing demand on primary and secondary care). In future, this model may be able to support people's step down. It is initially focusing on people who have been declined support from secondary care (as not eligible) and those with SMI cared for in primary care, which is currently 170 people per month. The team is assessing whether they further define the 170 people so that it fits with the available capacity e.g. initially begin in 1 PCN. A small MDT could be stood up if needed.

Key Elements of the New Model

South Bristol

To support the development of an IMHT, South Bristol Locality Partnership has developed a small but intensive MDT for people who have been declined support by multiple services. The MDT is drawing out learning for the wider system and is trying to use these examples to improve culture and integrated care. South Bristol are seeking to expand this model of working and implement a ‘IPCT2’ My Team Around Me approach.

Benefits of the new model

- **Integrated 'One Team'** working leading to seamless local support "no gaps" – receiving the best from the NHS, social care and voluntary sector (available across levels of need)
- Our **communities** always offer the foundation of our care
- **Timely access** (including re-access)
- Holistic, patient centred and **cumulative assessment** (tailored to need)
- **Focusing on treatment** and therapeutic intervention, with clear and aligned clinical pathways
- Rapid clinical advice and support for professionals (for both VCSE/Statutory): **dynamic Advice and Guidance Offer**
- Support that is co-designed and provided by those with **lived experience** (Lived Experience Leadership and Peer Support)
- Focus on achieving **equity of care and outcomes**
- New approach to gathering **outcomes** in real-time to constantly learn and improve

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