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

BRISTOL, NORTH SOMERSET & SOUTH GLOUCESTERSHIRE (BNSSG) INTEGRATED CARE PARTNERSHIP BOARD (ICPB) MEETING

2.00 – 3.40 pm, Thursday 28 September 2023

Venue: Bordeaux Room, Bristol City Hall, College Green, Bristol BS1 5TR

AGENDA

STANDING ITEMS (2.00 – 2.30 pm)

1. Welcome from the Chair (and to note any apologies)

2. To note the emergency evacuation procedure

3. Minutes of previous meeting held on 16 June 2023 (enclosed)
To approve the minutes of the previous meeting.

4. Public forum items
Note: details of public forum items received will be circulated in advance of the meeting (the deadline for receipt of items is 5pm Wed 20 Sept, i.e. 5 clear working days ahead of the meeting).

5. Health and Wellbeing Board updates
Updates from the respective Chairs on the work of the BNSSG Health and Wellbeing Boards.

6. ICB update
Update from Jeff Farrar, Chair, Integrated Care System for BNSSG.

REPORTS/ITEMS FOR DISCUSSION (total time: 2.30 – 3.40 pm)

7. Integrated Care System All Age Mental Health Strategy (2.30 – 2.50 pm)

- The enclosed All Age Integrated Care System (ICS) Mental Health Strategy and plan on a page is being presented to the Integrated Care Partnership Board for endorsement prior to a draft being published on the ICB website for an 8 week engagement period.
- Item to be presented by Christina Gray, Director: Communities & Public Health, Bristol City Council.

8. Voluntary, Community and Social Enterprise (VCSE) Alliance update (2.50 – 3.10 pm)

- Item for information/discussion.
- To receive an update/presentation from Mark Hubbard on the VCSE Alliance.

9. Black South West Network (BSWN) presentation on the findings of the BSWN 'Make it Work' programme's learning and evaluation report (3.10 – 3.40 pm)

- Item for information/discussion.
- To receive a presentation from Sado Jirde, BSWN Director and colleagues Chiara Lodi and Tutu Adebiyi on the findings of the BSWN 'Make it Work' programme's ***Learning & Evaluation Report***

10. Date of next meeting

- 2.00 pm, Wednesday 29 November 2023 (Venue: North Somerset, community venue - TBC)

Meeting close: 3.40 pm

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Meeting of the BNSSG Integrated Care Partnership – 2pm on Friday 16th June **ITEM 3**

Attendance List:

Partnership Board Leadership Group: Councillor Mike Bell (Chair) – North Somerset Council; Councillor Jenna Ho Marris -North Somerset Council; Councillor John O'Neill – South Gloucestershire Council; Councillor Helen Holland – Bristol City Council; Jeff Farrar – BNSSG ICB Chair

Community And VCS Voices: Aileen Edwards (Second Step), Bureau), Mark Hubbard (VOSCUR), Kay Libby (Age UK Bristol), Kirstie Corns on behalf of Fiona Cope (Head of Woodspring Locality); Clare Mclnerney (NECS Consultancy)

Voices in the Community: Alun Davies & Laura Welti

Constituent Health and Care Organisations: Hugh Evans (Executive Director Adults and Communities, Adult Social Care), Chris Sivers (Director of Children's Services, South Gloucestershire), Matt Lenny (Director of Public Health, North Somerset), Charlotte Hitchings (AWP), Jonathan Hayes (Primary Care Services), Ruth Taylor (Primary Care Services), Michelle Romaine (NBT), Jayne Mee (UHBW), Amanda Cheesley (Sirona Care & Health), Jonathan Hayes (Primary Care Services),

Locality Partnerships: Steve Rea (South Bristol Locality Partnership), Ruth Thomas (South Glos)

Other Attendees: Ellie Wetz (ICS Development Programme Manager), Shane Devlin (BNSSG ICP), Nicola Knowles (Policy and Public Affairs Manager), Colin Bradbury (Director of Strategy, Partnership and Population – Bristol City Council) Rosi Shepherd (Chief Nursing Officer) Claudette Campbell (Democratic Services Officer, Bristol City Council), Becky Balloch (ICB), Ros Cox (ICB), David Smallacombe (Care and Support West), Katherine Tanko (North Bristol Advice Centre), Joe Poole (ICB),

Apologies for Absence: Alison Findlay (Southern Brookes), Mandy Gardner (VANs), Dominic Ellison (WECIL), Fiona Cope (North Bristol Citizens Advice), Chris Head (WERN), Dr Joanne Medhurst (Chief Medical Officer), Georgie Bigg (Healthwatch), Mark Coates (Creative Youth Network), Matthew Jordan (ICS Development Programme Manager), Sado Jirde (Black South West Network, Bristol), Steve Curry (CVS), Gail Bragg (SWASFT), Ben Stevens (ICS Strategy Programme Manager),

1. **Welcome, introductions and Member Updates**

Councillor Mike Bell (Chair of the BNSSG ICP Board) welcomed all parties to the meeting and asked everyone to introduce themselves.

The Chair gave the following notices:

i. Welcome to the Board Councillor John O'Neill from South Gloucestershire and Cllr Jenna Ho Morris from North Somerset; both will be joining the Leadership Group

2. **Bristol Music Trust's work with people with Dementia**
    a. Apologies were referred with the ask that this item to be deferred to another meeting

3. **Apologies, minutes and actions from previous meeting**
    a. That a correction was required at 5e to properly reflect the situation and that Jeff Farrar will provide the correct wording
    b. Subject to the above change the minutes of the 21st April was agreed

4. **Public Statement and Questions**
    a. None were received

5. **Health and Wellbeing Board Updates**

Councillor Helen Holland – Bristol City Council

a. The HWB received reports on the issues of Discharge and Better Care Fund updates
b. Noted that it was a challenging time for spend and resources
c. Reference the work being done by SPARKS from the former M&S building in Broadmead

Councillor John O'Neill – South Gloucestershire

d. New to his role and looked forward to working with the Board and had been aware that the ICP Strategy framework was to be presented to the HWB

Councillor Jenna Ho Marris – North Somerset

e. New to her role and look forward to working with the Board and would provide future updates following attendance at the HWB

6. **Integrated Care Board Update**

Jeff Farrer, Chair of the ICB, provided the following update with Shane Devlin:

a. Shared that the structure of the Board was well embedded with good attendance; that the forthcoming financial challenges will have an impact
b. That they have advertised for a Chair to lead on Race & Health
c. An independent advisor group was in placed to review and report back
d. The operation plan had been signed off and NHS targets are progressing well
e. Running cost continues to be a challenge; 30% reduction in budget; work continues on the remodelling to be in place by September/October to enable savings for 2024/25
f. The aim is to maintain the core role of adding value to the Integrated Care Plan
g. JF confirmed when asked that he reported back to the ICB on outcomes from the ICP Board

7. Break – due to the hot weather conditions the meeting ran through to the next item

8. Integrated Care Strategy

Matt Lenny, Director of Public Health and Regulatory Services for North Somerset Council, introduced the report, explained the work of the editorial group and the proposed next steps.

a. The Editorial group primarily used as a collective wisdom to develop the strategy document
b. The document incorporated the five opportunities from the strategic needs assessment
c. The introduction section outlines how the strategy was developed and the scope for change and development based on the voices in our communities and the requirement to adapt to meet changing needs
d. The next step is to work through how we progress from a strategy document into action for the wider partners and agencies to implement
e. The board is asked to;
    I. Comment on the draft strategy guided with references to the identified issues set out in the 'discussion section' of the report
    II. Agree that the final version can be signed off on the 30th June
    III. Agree the delegation of sign-off to the ICP Board Chair, vice-chair and the chairs of the two HWBS to sign off the document on completion of final amendments

The following is a summary of the discussion points that arose:

f. The voices in the community representative where valued contributors to finalising the strategy document; were in support of the document presented; acknowledging that the balance struck in the final outturn was about right; noted that some work was still required on accessibility with regards the language used; although not perfect in all aspects and could expand to include such areas as; community & organisation based prevention champions; the issue of digital exclusion; ethics of genomics.
g. The VSCE representative shared concerns that the voice of this sector was missing and the comments arising from the review undertaken by the alliance steering group should be worked through before final sign off; that the strategy needed to be more diverse; highlighted the issues preventing that sector's participation; naming one preventer as the lack of funding to enable

smaller voluntary organisation participating and supporting any outturn; that without appropriate remuneration the voice of the sector would be missed.

h. The representative of the Care and Support West Board shared that the providers would welcome the opportunity to comment on the strategy document.
i. The document reference 'we' but it was unclear who the 'we' represented; is this the health professionals or wider community? It was suggested that this was clarified.
j. The version shared failed to mention the wider determinants of health; not clear how this is incorporated into the strategy.
k. The strategy document overall was seen as good and agreed it was appropriate to align it with the five opportunities; that the older population was reference as well as the first 1000 days; ageing can be seen as an inequality; deprivations is not the only driver of inequality; local partnerships will have varied needs depending on the age of the population that they mostly serve; looked for a stronger emphasis on prevention and the needs of those aged 25-35 years and the healthier for longer benefits.
l. The issues arising from poor housing and lack of housing is one that forms a thread that connects to wider issues.
m. Editorial board representative shared the good progress that had been made on the final iteration; reminded the board that the development work had been condensed into one ten-page document; that it was a framework strategy document to be interpreted and delivered by all partners.
n. There was a call to support the strategy framework document; that there had been many opportunities for board members organisations to input during the 12 months strategy development stage.
o. The Chair asked that all comments from partners to be noted and addressed directly with them.
p. ML thanked all board members for their comments; confirmed that all comments would be noted, and a response provided; that the reasonings on the decisions made will be shown on a document with the appropriate cross references.
q. The ICB is tasked with delivering the ICP strategy and in order to do so, it requires the signed & agreed Integrated Care Plan framework.
r. Next Steps
s. It is for the Board to consider what follows the strategy document and address the question of 'so what' and 'how'; for example, how to provide clarity and direction of travel for partner organisations; how resources are aligned to support the strategy; how do we ensure the participation of the voluntary sector; one of many questions that must be addressed by the partner organisations to ensure that the strategy is indeed 'integrated'.
t. It was suggested that the Foreword in the document included, direction on how the strategy is to be applied; that it included wording to explain that it is a live document to be updated and revised on a regular basis.
u. The Chair made the following comments and gave the following direction:
    a. The Board must consider how to make the strategy document 'a living document'.
    b. The Strategy document will be published on the agreed date.
    c. That a critical area of work is to formulate away to enable the feedback from VCSE to be reflected in the document
    d. That the Boards future discussions should include, financial spend/funding.

e. That Board members are to endorse the version draft shared, that ML will formulate a response to the issues raised that will be considered by the Editorial Group and
f. That the final version to be signed by the leadership group
g. Noted that:
h. The discussion had combined the issues of the strategy versus business and spending plans.
i. The issue of funding applies not only to VCSE but a number of partners involved in the process.
j. Concluded that:
k. Progress had been made. That the strategy was not the answer to everything but it had facilitated many conversation and would continue to do so
l. Confirmed that the next step was to put the strategy into operation; encouraging all partner organisations to discuss the strategy and report back with implementation plans together with arising constraints.
m. That VCSE representatives to be invited to the appropriate meetings to enable input into the ongoing conversations

v. ML concluded that;
n. The final version is to be shared with the Chairs of the 3 HWB
o. Nothing would be lost as it will be noted in a working document to be viewed alongside the strategy
p. The development day would enable a discussion on practical steps to make the strategy real

9. <u>The CQC integrated care assessment</u>

Shane Devlin referenced the invitation letter attached at p116 in the agenda report pack. The Board were asked to consider the invitation and whether it was appropriate at this stage to be a part of the pilot.

The following comments were noted from the discussion that arose.

a. Concerns were raised about the risk as well as of the benefits of being a part of the pilot
b. Noted that several areas were currently being assessed across the partnership and the same teams may be asked to divert resources to facilitate a further assessment and this would bring additional strained on people resource
c. Although it could be viewed as providing some benefit in focusing attention what to do to be successful it had to be balance with a possible outcome rating that maybe below what is expected
d. The question was asked as to whether the pilot assessment would support moving the strategy forward
e. The LGA Peer review was schedule to take place shortly and would the one feed into the other
f. Action: CB to liaise with the CGQ on the areas of concerns and come back with answers to the Chief Executives
a.

10. <u>AOB</u>

The Chair Mike Bell formerly handed the chairing of the Board to Councillor Helen Holland. Advising that he would no longer be chairing the HWB for North Somerset that now fell to Councillor Jenna Ho Marris. He confirmed his continued interest in the work of the ICP Board. Thanking Officers, Colin Bradbury and Ellie Wetz together with the team in Bristol for their continued support and hard-work to enable the work undertaken to date by the Board.

Councillor Helen Holland thanked the outgoing Chair for his good work in setting the tone for each meeting and for ensuring the direction of travel.

The meeting closed at 15.17hrs.

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Integrated Care Partnership Board

Agenda Item 7		**Meeting Date**	28th September 2023

Title	**Integrated Care System All Age Mental Health Strategy**			
Scope: System-wide or Programme?	Whole system	X	Programme area (Please specify)	
Author & role	Julia Chappell, Senior Business Development & Planning Manager, AWP			
Sponsor / Director	Dominic Hardisty, Chief Executive of AWP NHS Trust Jo Walker Chief Executive of North Somerset Council As Co-chairs of the MH LD & A HCIG			
Presenter	Christina Gray, Director of Public Health, Bristol City Council Julia Chappell, Senior Business Development & Planning Manager, AWP			
Action required:	Decision			
Discussion/ decisions at previous committees	*Please list below all relevant Steering Groups/Boards, along with dates and what decisions/endorsements were made)*			
	Key system governance meetings have been highlighted below. A full engagement log is available upon request; • MH, LD & A HCIG – 15th May & 11th September • Community Mental Health Delivery Board – 17th May – comments provided & draft endorsed • VCSE MH alliance – 7th June – comments provided & draft endorsed • Children's Operational Delivery Group – 27th June - comments provided & draft endorsed • Children's HCIG – 4th July - comments provided & draft endorsed			

***Please delete this sentence and all wording in italics below.*

Purpose:
Please provide a brief and concise summary of what you are seeking approval from Cabinet for in no more than 100 words - report for information, to approve, to implement, to delegate, to adopt, to accept, etc. The all age Integrated Care System (ICS) Mental Health Strategy and plan on a page is being presented to the Integrated Care Partnership Board for endorsement prior to a draft being published on the ICB website for an 8 week engagement period. ICB engagement leads have indicated there is no statutory consultation period required for the work.

Following the engagement period the document will be revised to accommodate feedback and then presented to the three Health & Wellbeing Boards and the Integrated Care Partnership Board for final sign off in early 2024.

Summary of relevant background:

Please provide any background and papers that have been used in the development of these recommendations and report here. What is the problem or issue we are trying to solve? Briefly justify your recommendations with appropriate factual evidence. How are they going to solve the problem and improve outcomes? Please refer to the appendices below for any supporting evidence.

This cover paper accompanies the full strategy document and the plan on a page which will be published for engagement.

All systems are required by NHS England to have a mental health strategy describing their vision and ambitions for mental health within their system. A system wide mental health strategy brings all partners together to work towards a set of collective priorities.

This draft strategy has been developed building on the co-production which took place to form the draft 2018/19 MH strategy (which was not finalised) as well as the co-production to design and deliver Community Mental Health Programme. In addition to this, specific co-production workshops are continuing to take place with professionals from across the system and people with lived experience including young people, to inform this version of the strategy.

The strategy aligns to the overarching Integrated Care System strategy which identifies mental health as a key priority area. The mental health strategy provides the next level of detail on specific areas of work within the mental health system.

The strategy development has been overseen by a task and finish group comprising representatives from AWP, the ICB, 3 Local Authority Public Health Departments, acute providers and the VCSE mental health alliance.

The strategy;

- Provides a high level overview of the policy context and needs within BNSSG
- Sets out our system vision as 'People having the best mental health and wellbeing in supportive, inclusive, thriving communities'
- Identifies 6 ambitions to help deliver the vision;
    - **Holistic care:** People of all ages will experience support and care which considers everything that might help them stay well
    - **Prevention and early help:** People of all ages, their families and carers will get the support they need in the right place and in a timely way, as early as possible.
    - **Quality treatment:** High quality treatment is available to people of all ages as needed closer to home, so they can stay well in their local communities.
    - **Sustainable services:** We will have an economically and environmentally sustainable mental health system where maximum benefit is delivered to the Community.
    - **Health Inequalities:** We will reduce health inequalities by improving equity of access, experience and outcomes throughout people's lives.

- **Great place to work:** We will have a happy, diverse, inclusive, trauma-informed and stable workforce across our system.

- Sets out key areas of work required to deliver each of the ambitions above and identifies which metrics will help us know if we have been successful
- Notes that Joint Forward Plans for mental health will be developed annually to progress the priorities identified within the strategy
- Concludes by explaining our system governance and noting that "When all organisations in our system work together to deliver change, the impact can be transformational"

Following approval by the Integrated Care Partnership Board, the strategy and plan on a page will be published on the ICB website for an 8 week engagement period. ICB engagement leads have indicated there is no statutory consultation period required for the work.

Following the engagement period the document will be revised to accommodate feedback and then presented to the three Health & Wellbeing Boards and the Integrated Care Partnership Board for final approval early in the new year and subsequent sign off by individual organisations.

Discussion / decisions required and recommendations:

The Integrated Care Partnership Board is requested to;

- Endorse the draft strategy and plan on a page for the next stage of public and partner engagement including publication to the ICB website
- Support active engagement in the next phase of the strategy development. A survey monkey will accompany the document when published and specific feedback can be emailed to awp.businessdevelopment@nhs.net
- To approve the final version of the strategy following the engagement along with Health & Wellbeing Boards

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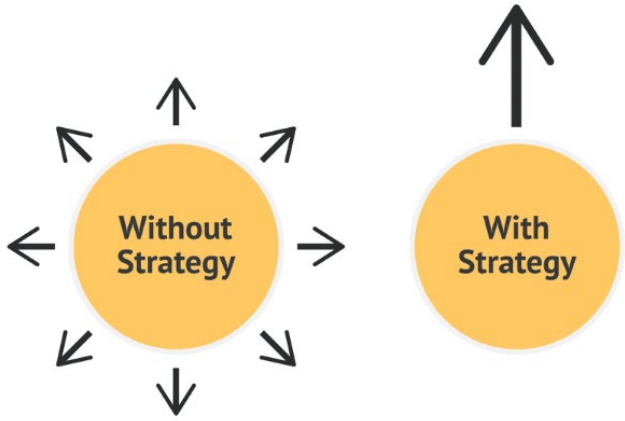
BNSSG System Wide MH Strategy

Integrated Care Partnership Board

28th September 2023

Why are we having a strategy?

- All systems are required by NHS England to have a mental health strategy describing their vision and ambitions for mental health within their system.



- A system wide mental health strategy brings all partners together to work towards a set of collective priorities.
- Our all age strategy is based on the co-production to develop the 2018/19 draft MH Strategy as well as the CMH programme co-production & specific co-production on this draft
- Work has been led by a system wide task and finish group

ICS Strategy, MH Strategy & JFP

ICS Strategy

- Identifies mental health as a key priority area for our system

All Age Mental Health Strategy

- States the specific priorities and ambitions within the mental health system over the next 5 years

Joint Forward Plan

- Set's out detailed deliverables for programmes and projects annually

Our Integrated Care System vision is:

“Healthier together by working together”

People enjoying healthy and productive lives, supported by a fully integrated health and care system – providing personalised support close to home for everyone who needs it.

Out Integrated Care System vision for Mental Health is:

“Better Mental Health for All”

People having the best mental health and wellbeing in supportive, inclusive, thriving communities

Six Ambitions:

1 Holistic care

People of all ages will experience support and care which considers everything that might help them stay well.

2 Prevention and early help

People of all ages, their families and carers will get the support they need in the right place and in a timely way, as early as possible.

3 Quality treatment

High quality treatment is available to people of all ages as needed closer to home, so they can stay well in their local communities.

4 Sustainable system

We will have an economically and environmentally sustainable mental health system where maximum benefit is delivered to the Community.

5 Advancing equalities

We will reduce health inequalities by improving equity of access, experience and outcomes throughout people's lives.

6 Great place to work

We will have a happy, diverse, inclusive, trauma-informed and stable workforce across our system.

Underpinned by:

Working together to create the wider social and economic conditions to support positive mental health and wellbeing, including investing in a healthy start in life.

Next steps

Spring & Summer 23	• Co-production and engagement on first ‘engagement’ draft across the system
September	• Engagement draft approved for publication by the ICP Board
Oct - Nov	• Engagement draft published on ICB website and accompanying survey monkey shared with all partners
Dec	• Final draft compiled using feedback from engagement
Jan & Feb 24	• Final version endorsed by 3 x HWBB & ICP Board • Individual organisations seek sign off as required

Ask of Integrated Care Partnership Board

The ICP Board are asked to:

- Endorse the draft strategy and plan on a page for the next stage of public and partner engagement including publication to the ICB website
- Support active engagement in the next phase of the strategy development. A survey monkey will accompany the document when published and specific feedback can be emailed awp.businessdevelopment@nhs.net
- To approve the final version of the strategy following the engagement along with Health & Wellbeing Boards

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Thank you

Bristol, North Somerset & South Gloucestershire Integrated Care System Mental Health Strategy

Plan on a page

This strategy is for anyone who wants to understand the vision and ambitions for the future mental health system in BNSSG as well as the work which will deliver this.

It is 'all age' meaning it covers mental health for our whole population from pre-conception to end of life.

It covers all mental health conditions, including people who may or may not have a formal mental health diagnosis. It also considers everyone from those who have good mental wellbeing through to people who might need high levels of support.

It considers where people may have mental ill health alongside other needs such as learning disabilities, autism or ADHD.

It has been co-produced in collaboration with people who have mental ill-heath, as well as staff in organisations who provide support and treatment, incorporating their valuable insight and experiences.

Where are we now?

As a system, we have made real progress in improving mental health support and care over recent years.

However, we know that there is still much more to do and that many people do not get the support they need when they need it. Becoming an Integrated Care System gives us the opportunity to work creatively and collaboratively to deliver transformation.

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How will we get there?

We have chosen six priority areas to help us achieve our vision of 'Better mental health for all'. In our full strategy document each of these areas has a set of actions that will be taken to support the improvement of our mental health system.

Six Ambitions:

1 Holistic care

People of all ages will experience support and care which considers everything that might help them stay well.

2 Prevention and early help

People of all ages, their families and carers will get the support they need in the right place and in a timely way, as early as possible.

4 Sustainable system

We will have an economically and environmentally sustainable mental health system that delivers maximum benefit to the community.

3 Quality treatment

The treatment provided to people of all ages is of a high quality and supports them to stay well in their local communities or closer to home.

5 Advancing equalities

We will reduce health inequalities by improving equity of access, experience and outcomes throughout people's lives.

6 Great place to work

We will have a happy, diverse, inclusive, trauma-informed and stable workforce within our system.

Underpinned by: Working together to create the wider social and economic conditions to support positive mental health and wellbeing, including investing in a healthy start in life.

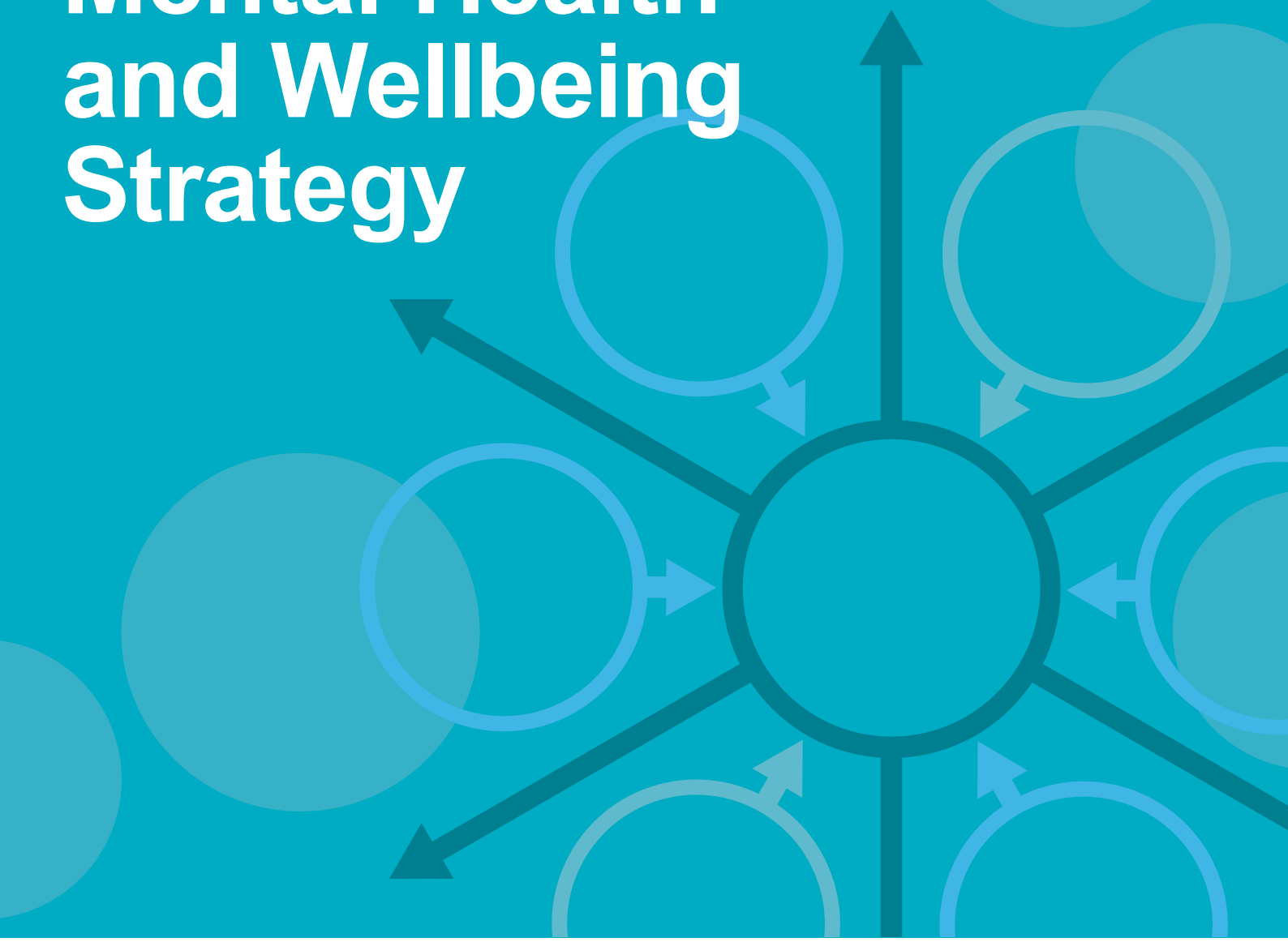
How will we know we have been successful?

We have identified ways to measure the impact of the work under each action so that we can know if we are making the difference we want. As a system, we will develop annual 'Joint Forward Plans' which will be aligned to the priority areas within our strategy and will include more detail on how we will deliver change.

When all organisations in our system work together to deliver change, the impact can be transformational.

NHS
Bristol, North Somerset
and South Gloucestershire
Integrated Care Board

Integrated Care System All Age Mental Health and Wellbeing Strategy



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Introduction

We are delighted to present our all age, Integrated Care System Mental Health Strategy, setting out our partnership approach to transforming mental health and wellbeing in Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System. This strategy is provided for anyone who wants to understand the vision and ambitions for the future mental health system in BNSSG as well as the work which will deliver this.

This vision and strategy has been co-produced and is co-owned by people with lived experience and their families, Community and equality representatives, Voluntary sector organisations, statutory health and social care providers, wider mental health stakeholders, providers and local commissioners.

The strategy is also informed by engagement and co-production and takes account of engagement and co-production undertaken as part of the BNSSG Integrated Care Partnership Framework and the Avon & Wiltshire Mental Health Partnership NHS Trust Strategy.

The Strategy takes an **all age** life course approach recognising that good mental health is an underpinning principle of wellbeing which is embedded in family and Community life. Adult Mental Health impacts on children and children become adults.

The strategy sets out **six key** ambitions for more effective joint working through which it will deliver a five year vision for our mental health system, driving improvements against key outcomes supported by detailed delivery plans.

The strategy takes a **thrive approach** embracing the spectrum of mental health from thriving through to those who need higher levels of support.

Recognising that Mental Health is everyone's business we are committed to becoming a Community that **works together** and delivers the best mental health outcomes for people of all ages, is person centred, trauma informed, recovery focussed and is a place where people want to live and work.

We recognise that whilst mental health and wellbeing is our focus, we will strive to deliver wider social, economic and environmental benefits as part of this work.

A separate strategy is being developed with and for people with learning disabilities and neuro diversity, although interdependencies and the need for personalised support have been recognised in this strategy.

AWP

VCSE Alliance

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

The wider context

The Strategic Needs Assessment for our system – Our Future Health – has identified that mental health conditions are among the biggest drivers of population health and care need. This Mental Health Strategy supports the overarching Integrated Care Partnership Strategic Framework and emerging strategy. Part of the ICS strategy will be to prioritise specific projects to deliver transformation in health outcomes. We will ensure this work aligns with the ambitions within the strategy and includes priority projects for mental health.

Mental health and age

Children and young people (CYP): 75% of children and young people who experience mental health problems aren't getting the help they need.

Students: This is a time of major life transition with social and academic pressures during a developmental transition to adulthood. Adding in financial stresses and potentially negative consequences of the use of digital technologies and social media means this it is a high risk group for developing wellbeing and mental health problems.

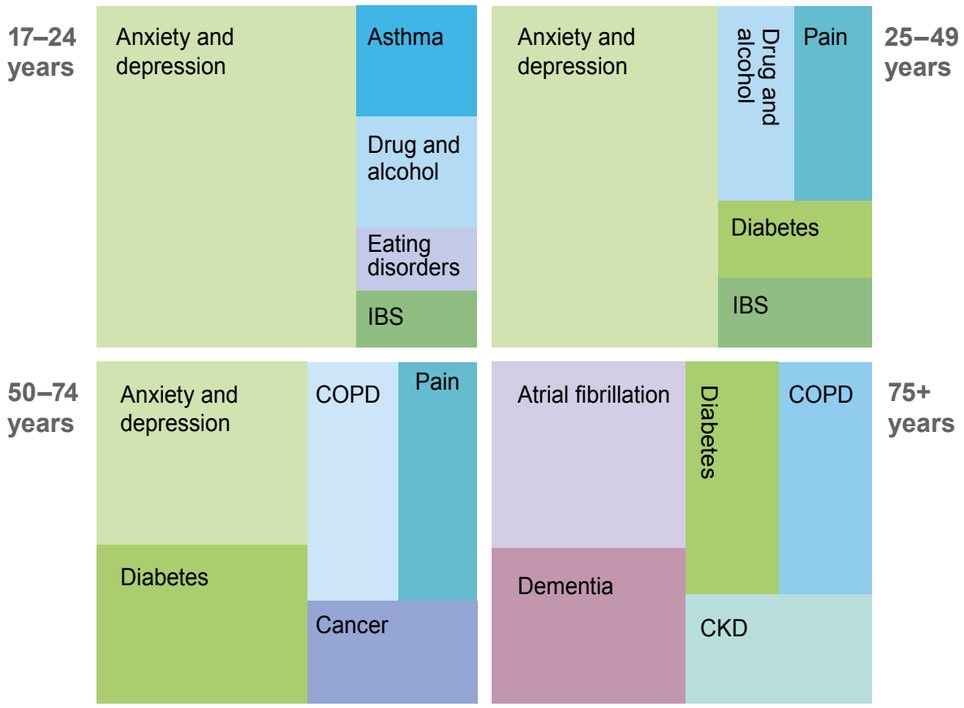
Parenting and mental Health: All parents face challenges; there may be additional difficulties if you have a mental health problem. Other stressful life experiences such as money problems or a relationship breakdown can negatively affect mental health.

Later in life: Changes in our lives as we get older such as retirement, bereavement, loneliness, becoming a carer and physical illness can affect mental health and wellbeing.

Source: Mental Health Foundation 2021.

Our Population

The impacts on health through the life-course in BNSSG



This graph above shows the conditions that have the greatest impact on the population, in four different age groups. The bigger box within each of the four squares, the bigger the impact of that condition. This only includes people over 16 years old as the tool that has been used to create this graph has only been validated in adults.

Painful conditions are in the top five most impactful conditions in BNSSG across the life course but particularly among the older, over 50s population. There is significant overlap with mental health issues especially anxiety and depression, and this is unlikely to be resolved through more prescribing or faster access to procedures.

Eating disorders rank in the top five most impactful conditions among 17-25 year olds in BNSSG

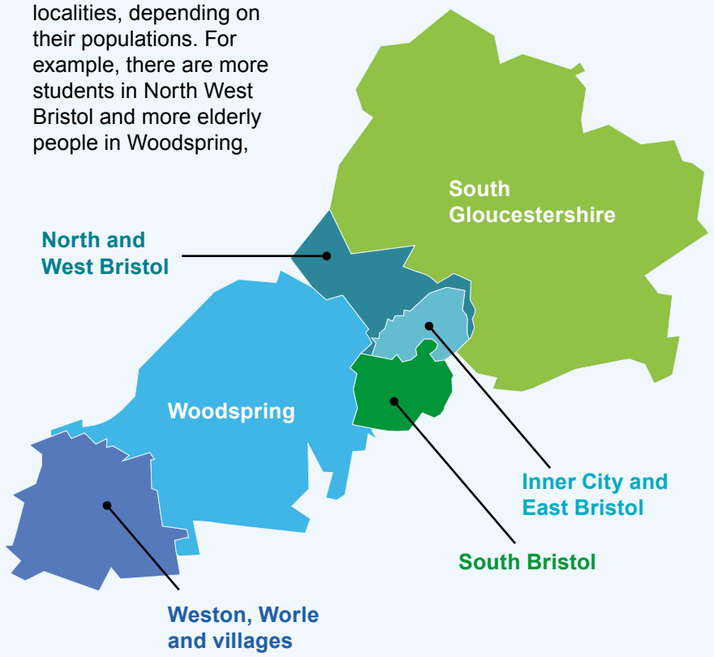
The numbers of children and young people in treatment for eating disorders in BNSSG has increased from 107 in 2017-18 to 367 in 2021-22

Suicide is uncommon but a leading cause of years of life lost as it is more common in young people with more years ahead of them.

Suicide is our second biggest cause of years of life lost, after heart disease.

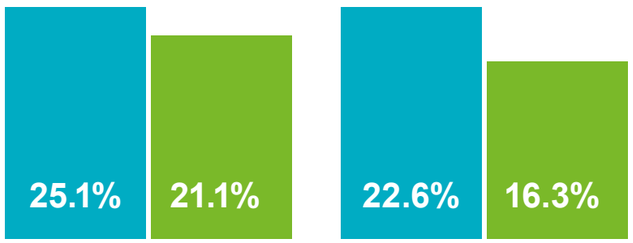
Our Mental Health Population

There are differences in mental health needs across localities, depending on their populations. For example, there are more students in North West Bristol and more elderly people in Woodspring,



Mental health in areas of deprivation

People with a mental health need are more likely to be living in the most deprived areas compared to those without.



Source: BNSSG System Wide Dataset Analysis.

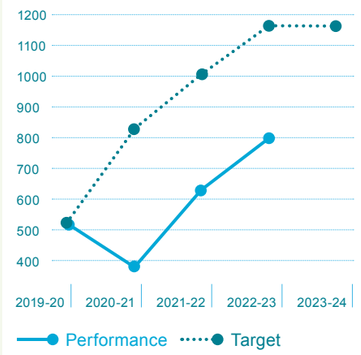
Where are we now?

Long Term Plan for mental health

In 2019 the NHS Long term Plan (LTP) for mental health was published setting out ambitious expectations for health systems across the country to deliver significant improvements in all age mental health and wellbeing through to 2023/24.

In line with the NHS Long term Plan, through concentrated work with key partners and increased investment, significant progress has been made in improving our mental health offer over the past few years. This progress is demonstrated through our systems improved performance against some of the core national measures highlighted here.

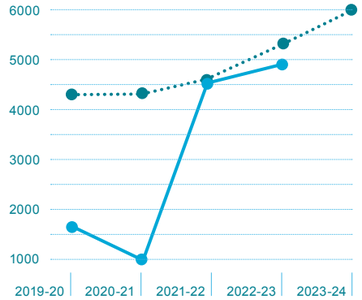
Perinatal Access



Data Source: MHSDS Digital Publication (Indicator MHS91). 2020/21 Performance impacted by Coronovirus Pandemic.

More than £2.7 million has been invested into improving perinatal mental health since 2019 and a brand new Maternal Loss and Trauma service was established in 2023.

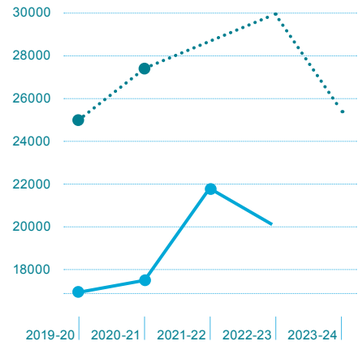
Physical Health Checks for people with Serious Mental Illness



Data Source: NHS Stats Physical Health Checks SMI Publication. 2020/21 Performance impacted by Coronovirus Pandemic.

There has been collaborative work across primary and secondary care to help people with SMI access an annual physical health check. We have more work to do to make sure this happens every year.

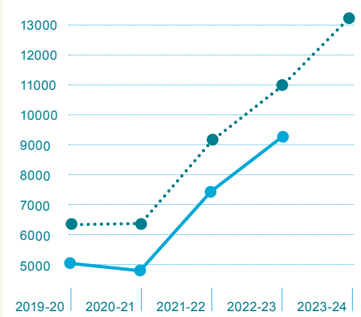
NHS Talking Therapies



Data Source: Psychologoical Therapies, Reports on the use of IAPT services – NHS Digital (Indicatore MO31). 2020/21 Performance impacted by Coronovirus Pandemic.

As a system we are meeting multiple national NHS Talking Therapies targets such as those which measure recovery from illness. However the increasing access to NHS Talking Therapies target, which measures the number of people able to get help from NHS Talking Therapies, has been significantly challenged as a result of a lack of workforce and the pandemic. This is a national challenge and the target for 2023/24 was reduced to reflect this. Due to a combination of investment and transformation we are planning to meet the target in 2023/24.

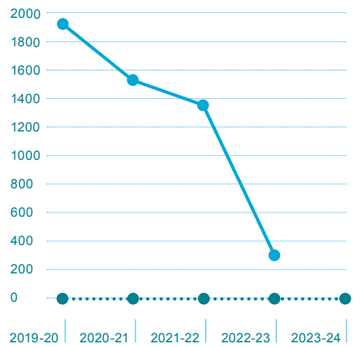
Children and Young People Access



Data Source: MHSDS Digital Publication (Indicator MHS95). 2020/21 Performance impacted by Coronovirus Pandemic.

By 2025, 50% of schools and colleges in BNSSG will have a team who provide early help, information, advice and guidance to children and young people, parents, teachers and guardians.

Out of Area Placements

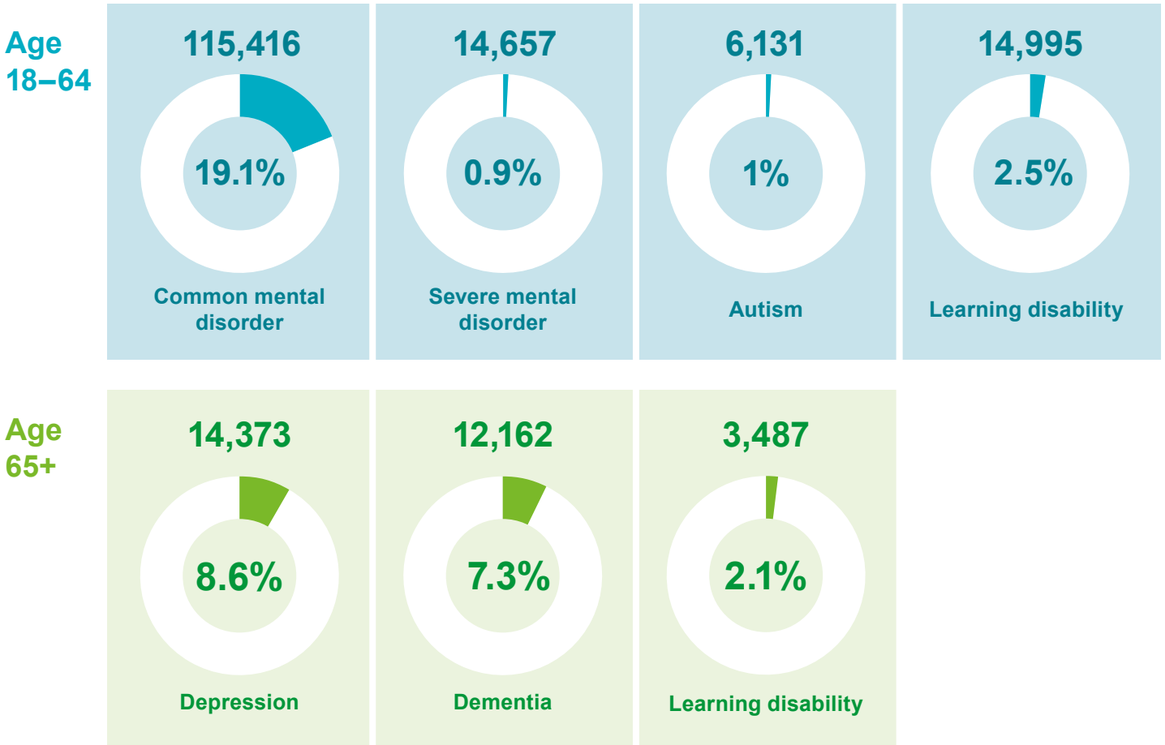


Data Source: Out of Area Placements in Mental Health Services NHS Digital. 2020/21 Performance impacted by Coronovirus Pandemic.

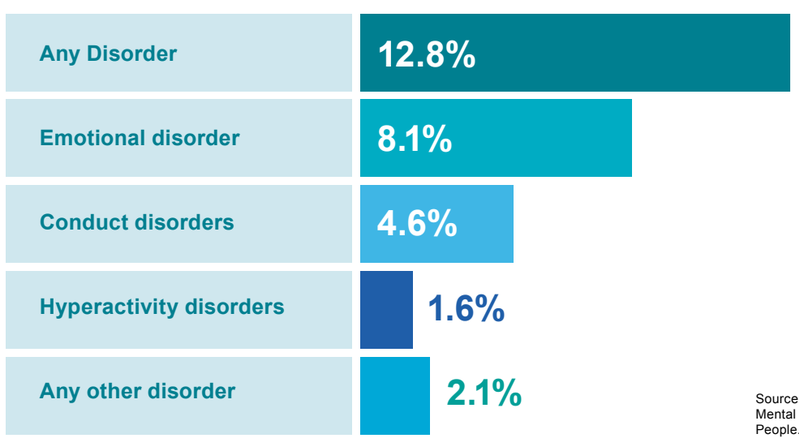
Many staff across organisations in our system have worked intensively to bring people placed in out of area hospitals back to BNSSG to be near their families and communities. Our efforts mean that nearly no one is now placed out of area unless they have highly specialist needs that cannot be met by local services.

Whilst our system has made significant progress, the performance above also demonstrates that there is much further to go to meet our ambitions and improve care for our population. It is also significant that current national metrics have focused on measuring access to services. A vital part of our next steps as a mental health system will be to embed the measuring of meaningful outcome and experience measures so that we know what is helping people of all ages the most in their recovery.

Mental health, learning disability and autism in adults across BNSSG



Estimated levels of metal health need among 5-19 year olds across BNSGG



Source:
Mental Health of Children and Young People. NHS Digital (2017, 2020)

Costs for Adults (18+) with a mental health condition in BNSSG

1% of the BNSSG population with a mental health condition flagged in Primary Care or contact with Mental Health Services account for 20% of the total costs across the whole system.

For BNSSG this is 1609 people

Cost: £52.5m

Average cost per person of £32,648

People (% of total)	Total cost (%)	Total cost (£)
1%	20%	£52,530,436
1-5%	25%	£66,065,629
5-10%	16%	£40,433,118
10-20%	16%	£41,601,705
20-30%	9%	£22,395,331
30-50%	9%	£23,276,330
50-100%	5%	£13,239,970

Cost include admissions and attendances across primary, secondary and Community care as well as prescribing (1 year, 2021/22). Some costs are PBR, some are indicative. Maternity inpatient activity is included because it cannot be separated from outpatients using the system wide dataset

Costs for children and young people aged 0–17 with a mental health condition in BNSSG

1% of the BNSSG population aged between 0 and 17 with a mental health condition flagged in Primary Care or contact with Mental Health Services account for 19% of the total costs across the whole system.

For BNSSG this is 116 people

Cost: £3m

Average cost per person of £26,442

People (% of total)	Total cost (%)	Total cost (£)
1%	19%	£3,067,289
1-5%	22%	£3,536,470
5-10%	15%	£2,334,801
10-20%	17%	£2,733,376
20-30%	10%	£1,597,053
30-50%	11%	£1,683,247
50-100%	6%	£1,026,234

Costs include admissions and attendances across primary, secondary and community care as well as prescribing (1 year, 2021/22). Some costs are Payment By Results (PBR), some are indicative. Maternity inpatient activity is included because it cannot be separated from outpatients using the system wide dataset. Kooth data is not included as no patient details available and OTR (Off The Record) data is limited as not all records have NHS numbers or costs, so some patients are not included.

Mental health cohort derived from primary care mental health flags, secondary care mental health inpatient stays or any referral or outpatient activity in MHSDS – all reasons, all services, including OTR where NHS number is available. learning disability and autism included.

Community Mental Health Framework

Following the Long Term Plan, The national Community Mental Health Framework for adults and older adults was published in 2019. It set out a fundamental change to the delivery of Community mental health services for adults and young people moving into adult services with a vision for mental health services which are integrated, personalised and delivered close to home. In line with this vision, the framework also removes the requirement for the Care Programme Approach in favour of much more individual and goal focussed care planning for everyone.

Locally, significant work has commenced to implement the Community Mental Health framework.

As an Integrated Care System we have:

Co-produced and implemented a First Episode and rapid early intervention for Eating Disorder (FREED) service and introduced a new Voluntary, Community and Social Enterprise partner delivering holistic support closer to home.

Co-designed an integrated model of care for people with difficulties associated with Personality Disorders, inclusive of Complex Emotional Needs, to address the current gap in provision of specialist interventions at primary care level.

Started implementing integrated personalised care teams for adults across the BNSSG foot print focussed on ensuring everyone has access to the right mental health support at the right time.

Strengthened our community mental health rehabilitation team and introduced a flexible grants scheme to support individuals' returning home.

Commenced work to understand and target support to key groups who have historically experienced poorer access to, experience of and outcomes from mental health support and care to tackle inequalities in mental health and related outcomes.

Increased capacity in Primary Care, AWP's Physical Health Teams and peer support roles to enable more people on GP Severe Mental Illness registers receive an annual physical health check and have their physical health needs met.

Introduced a range of mental health support accessible to people calling 999 or 111 to make it easier for people to get the right support when they may be becoming more unwell.

We still have more to do with our Community Mental Health model, such as implementing the new Community waiting time of four weeks from assessment to intervention.

Prevention concordat

The Prevention Concordat for Better Mental Health was published in 2017 and provides resources for local areas to take an evidenced based approach to public mental health and prevention. The Concordat was updated in 2022 to reflect the impact of the COVID 19 pandemic on mental wellbeing. BNSSG Integrated Care System is committed to implementing evidence based prevention at every level of need.

Trauma Informed System Approach

In January 2023, the Integrated Care Board employed a Trauma Informed Systems Manager to lead on a programme of work looking to promote and embed trauma informed practice across Bristol, North Somerset and South Gloucestershire. This programme has provided dedicated resource to further develop a shared language and approach to trauma informed practice and to support organisations and different parts of the system to consider how to recognise and effectively respond to trauma and adversity experienced by individuals, families, communities and staff.

Children and Young People's policy context

Transforming Children and Young People's Mental Health Provision – a Green Paper outlined the Department of Health and Department of Education's commitment to improving and embedding new ways of working across our children's mental health services and education settings. The ambition with the Green Paper was to put schools at the heart of efforts to intervene early and placed significant emphasis on the role education could play in early identification and support.

There are synergies between the Green Paper and Public Health England's Best Start in Life and Beyond which outlines the role that School Nurses and Health Visitors have in supporting children, young people and their families with a particular emphasis on the high impact areas, one of which is supporting maternal and family mental health and early identification.

The Long Term Plan builds on the commitments within the Green Paper and additional funding and support has been utilised to develop mental health support in schools and colleges across BNSSG. Furthermore, the Long Term Plan has, and will continue to, drive to expand and transform.

There has been and will continue to be a drive to expand and transform:

Eating disorder services

Crisis services

Support for transition from child to adult services

Mental health support in schools and colleges

Locally, significant work has already begun to achieve the aims of the Long Term Plan. This includes:

Mental Health Support Teams in Schools: BNSSG has completed three waves of MHSTs, with 10 teams now available across the geography, which have been chosen on a needs-led based approach. At the end of 2022/23, MHSTs had delivered both individual interactions and wider engagement of the whole school approach in 115 schools.

Crisis: Our local Crisis Outreach and Intervention Teams have been expanded to provide additional support to children and young people presenting in crisis to our local hospital. There is a 24/7 response line in place and young people requiring a mental health assessment will receive one sooner, to ensure that appropriate care is received. Further, the Crisis Team provide additional support in the Community to help prevent hospital admission and keep young people safe and well at home.

Eating Disorders: The capacity of our Specialist CAMHS and Acute Emergency Department eating disorder teams have been increased alongside the recruitment of a CAMHS Home Treatment Team to provide intensive support to Children and Young People in the Community, helping keep them safe and well at home. There have been improvements in joint working across Bristol Royal Children's Hospital and CAMHS teams to ensure that young people are well supported regardless of the setting. This has been further developed through a pilot across the two organisations that helps to support young people in the Community, who may otherwise require a specialist eating disorder bed.

Transition: Scoping on the current pathways for young people aged 16-25 is taking place with discussions being held with key organisations across the system. This work is in its infancy but there is dedicated project management in place looking at options to improve the current pathway for children and young people, ensuring that their transitions are planned for and support is available when needed.

A lot of work has already taken place across BNSSG, with plans to expand and build on this work to ensure that we are meeting the aims of the Long Term Plan and improve access and provision of services to our CYP population.

Changes to the Mental Health Act

The Mental Health Act 1983 is currently being updated to reflect a shift to less restrictive and more personalised care.

The key changes are expected to be:

People of all ages are detained for shorter periods of time, and only detained when absolutely necessary.

When someone is detained the care and treatment they get is focused on making them well.

People of all ages have more choice and autonomy about their treatment.

Everyone is treated equally, fairly and disparities experienced by people from black and minority ethnic backgrounds are tackled.

People with a learning disability and autistic people are treated better in law, and reliance on specialist inpatient services for this group of people is reduced.

Whilst the legislation is still progressing through parliament, it is clear there will be important implications for our system to consider, such as fully understanding the demographics of our inpatient population so we can target preventative approaches accordingly, as well as ensuring we have the best quality inpatient care and treatment.

Advancing Equalities

In September 2020 the national Advancing Mental Health Equalities Strategy was published. It sets out the need for local systems to use a population health management approach to co-produce local solutions to health inequalities within mental health. As part of the strategy, a Patient Carer Race Equality Framework has been tested in pilot sites and will be rolled out nationally during 2023/24. The Framework is a practical tool to help mental health trusts work with ethnic minority communities and understand what steps the trusts can take to achieve practical improvements. An Equality and Diversity Workforce Improvement Plan covering all NHS services has also been published, setting the ambition of having a diverse and inclusive workforce at all levels.

Locally, we know we must ensure services are accessible to and inclusive of specific communities experiencing inequality of access, experience and outcomes. To do this we must improve data capture and embed training and culture change to ensure everyone in our system understands the drivers of and impact of health inequalities and the compounding effects of intersection of different needs or characteristics.

> **“I feel like I am not taken seriously by doctors because I am black. I have to exaggerate for them to take what I am saying seriously and for them not to think it’s just because I am black”.**
>
> Young person, BNSSG young people’s Black and Brown Minds Matter group

> **“ethnic inequalities in access to, experiences of, and outcomes of healthcare are longstanding problems in the NHS and are rooted in experiences of structural, institutional and interpersonal racism”**
>
> NHS Race and Health Observatory (2020)

Understanding local need

We have provided a snapshot of information about our local population. Further information can be found through our Local Authority Joint Strategic Needs Assessments for Bristol, South Gloucestershire and North Somerset as well as through ‘Our Future Health’ – the needs assessment supporting our Integrated Care System whole population strategy.

Our whole Population

Around **one million** people live across BNSSG

Youngest population is in Bristol with an average age of

30 compared to age **46** in North Somerset and age **40** in South Gloucestershire

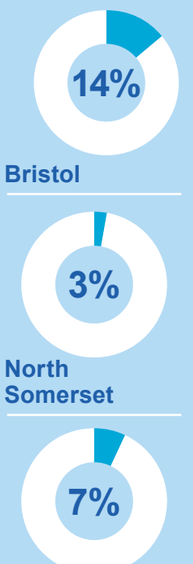
74.6 years – **83.2 years**

A man living in the most deprived area of Bristol lives 9.9 years less than a man living in the least deprived area.

80.3 years – **87.8 years**

A woman living in the most deprived area of North Somerset lives 7.9 years less than a woman living in the least deprived area.

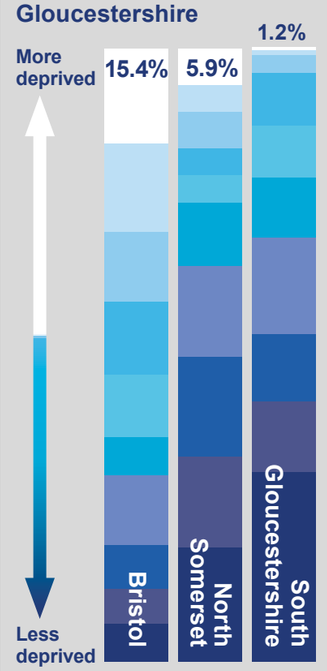
Black and Ethnic minority groups:



1 ICS | **3 Local Authorities** | **6 Localities**

Index of multiple deprivation:

15.4% of people living in Bristol are in areas of high deprivation compared to 5.9% in North Somerset and 1.2% in South Gloucestershire



What do we want to achieve?

Our Integrated Care System vision is:

“Healthier together by working together”

People enjoying healthy and productive lives, supported by a fully integrated health and care system – providing personalised support close to home for everyone who needs it.

Out Integrated Care System vision for Mental Health is:

“Better Mental Health for All”

People having the best mental health and wellbeing in supportive, inclusive, thriving communities

Our Mental Health Ambitions

As a mental health system we are committed to the following priorities, based on the significant co-production to date.

Six Ambitions:

1 Holistic care

People of all ages will experience support and care which considers everything that might help them stay well.

2 Prevention and early help

People of all ages, their families and carers will get the support they need in the right place and in a timely way, as early as possible.

3 Quality treatment

High quality treatment is available to people of all ages as needed closer to home, so they can stay well in their local communities.

4 Sustainable system

We will have an economically and environmentally sustainable mental health system where maximum benefit is delivered to the Community.

5 Advancing equalities

We will reduce health inequalities by improving equity of access, experience and outcomes throughout people’s lives.

6 Great place to work

We will have a happy, diverse, inclusive, trauma-informed and stable workforce across our system.

Underpinned by:
Working together to create the wider social and economic conditions to support positive mental health and wellbeing, including investing in a healthy start in life.

For each ambition we have started to develop plans to address them which are described on the following pages. These plans will be developed with further projects and detail added over the lifetime of the strategy. We expect new information to be added to our Joint Forward Plan as it is refreshed annually. We have also described how we will know we have achieved each ambition; these descriptions all link to a metric that is being measured in the system either through the Long Term Plan, BNSSG ICS population outcomes framework or through something we can qualitatively track.

Our holistic care ambition

People of all ages will experience support and care which considers everything that might help them stay well.

What will we do to achieve this:

We will have integrated personalised care teams based around Primary Care level. These teams will include a wide range of NHS, Local Authority, private therapies and Voluntary Sector partners to deliver a new Community-based offer including access to psychological therapies, improved physical health care, employment support, peer support, green social prescribing, personalised and trauma informed care, medicines management and support for self-harm and co-existing substance use.

Our integrated teams will use shared personal wellbeing plans that capture peoples' strengths and assets alongside their mental health needs.

We will aim to integrate our Voluntary Sector within all our models of care to make sure people of all ages get holistic support that is offered at an early point and which considers the social determinants of health as well as mental health needs.

We will invest in targeted initiatives for groups of the population who are less likely to access physical healthcare, including a specific focus on addressing the mortality gap for people with serious mental illness.

We will ensure our models of care consider the needs of carers. For children and young people, services will consider the whole family and the role of education. .

We will ensure holistic care is delivered where people may be in an acute physical health hospital and require mental health support.

We will know we are making a difference when:

We have integrated personalised care teams fully established in every locality within BNSSG.

Everyone with a serious mental illness has access to an annual health check.

The gap in premature mortality between people with serious mental illness and the general population starts to close.

People of all ages will report experiencing integrated care.

> **"Early autism diagnosis is needed to help people understand themselves and mitigate a crisis caused by masking."**
>
> Young person, BNSSG Neuro diverse subgroup

70%

of rough sleepers had a mental health need

45%

of respondents to the latest health needs audits for homelessness nationally reported using drugs or alcohol to help them cope

Our prevention and early help ambition

People of all ages, their families and carers will get the support they need in the right place and in a timely way, as early as possible.

What will we do to achieve this:

There will be clear, publicly accessible information available describing what is available for people of all ages, families and carers close to where they live, work or study and effective signposting to sources of support across the system.

We will ensure we systematically monitor all waiting lists and wait times within the mental health system, including the wider impact of delayed care. We will consider both service re-design and investment to address long waits for support.

Our key NHS early intervention and early life services such as Child and Adolescent Mental Health Services (CAMHS), infant mental health services, specialist perinatal services and Early Intervention in Psychosis (EIP) will meet national performance expectations and will receive particular focus on embedding best practice models of care.

We commit to working together to create the wider conditions for good mental health, including early years work, mental health in schools, thrive approaches, social prescribing, access to employment, debt, housing advice etc.

We will ensure we work as a trauma informed system, adapting services to reduce potential unintended negative effects on those who have experienced trauma.

We will know we are making a difference when:

Our NHS services which provide early intervention such as EIP, perinatal mental health (evidenced to improve babies outcomes) and CAMHS will meet or exceed all national NHS performance measures.

People of all ages using early intervention or early help will report it is high quality and easy to access.

People of all ages experience service support as being timely.

All service waiting times are in line with national guidance.

> **"At the moment it feels like you have to get iller to get help so you almost want to get worse to get help. This also creates a fear of getting better because you want to get better but you are scared of losing the support which is helping you if you do"**
>
> Young person BNSSG Helping Young People Engage (HYPE) group

During the pandemic

1 in 3

children lived with at least one parent reporting emotional distress

Our high quality treatment ambition

High quality treatment is available to people of all ages as needed closer to home, so they can stay well in their local communities.

What will we do to achieve this:

As a system we will take a Quality Improvement approach to all services and projects. This means all projects and programmes will be required to state the evidence base they are using or in the case of innovation, expecting to build on and have clear agreed evaluation points. Where there is no evidence base for a service or initiative the system will refocus resource.

We will proactively work closely with housing providers and employers to support people to live as independently as possible, to improve overall mental health and improve outcomes in treatment and recovery.

We will continue to invest in crisis alternatives such as crisis houses and ensure these are integrated with our clinical support, as well as developing new initiatives such as our Integrated Access Hub (mental health phone support available through calling 111 or 999).

The ICB, Local Authorities and other relevant organisations in BNSSG will work with the South West Provider Collaborative (who manage Child and Adolescent Mental Health inpatient beds) to minimise the number of children admitted to inpatient settings and ensure that where children and young people need a stay away from home, this is as close to where they live as possible and in as homely an environment as possible.

We will use the opportunity of changes to the Mental Health Act alongside embedding the learning from our Rightcare programme to ensure people who require inpatient care have high quality treatment and as short a stay as possible and are discharged as soon as they are well enough.

As a system we commit to implementing new approaches to working with people who have mental ill health as part of wider multiple disadvantage.

We will know we are making a difference when:

We have embedded the use of 'paired outcome measures' across our system which allow people of all ages using services, clinicians and the wider system to understand which support has helped someone with their recovery.

Fewer people of all ages are placed in an acute bed outside of our local area.

Fewer people of all ages require an admission to an acute ward.

Fewer people of all ages experience a delayed discharge from an inpatient bed.

Fewer children and young people rely on Emergency Department support when in crisis.

> **"My mum can't speak English and when I go to health appointments with her, they don't take her seriously".**
>
> Young person, BNSSG young people's Black and Brown Minds Matter group

10%

of children and Young People in BNSSG who have regularly attended Accident and Emergency have done so because of a mental health need

Our advancing equalities ambition

We will reduce health inequalities by improving equity of access, experience and outcomes throughout people's lives.

What will we do to achieve this:

We will invest in our local community groups and grass roots organisations and work in partnership with them to deliver services and support.

We will create opportunities for community led groups to become involved in designing, delivering and evaluating services and grow their organisations.

All work undertaken within the BNSSG mental health system will clearly address health inequalities and improve equity of access and outcomes.

Our NHS Talking Therapies service will deliver specific activities to outreach to people they currently do not reach enabling everyone in our population to access help early.

We will improve data capture across the system so that we fully understand where gaps in equity exist. This will include supporting our workforce to understand why capturing demographic information is so important. We will then use this data to set out targeted improvement plans.

Co-production will be a feature of all projects encompassing both a range of partner organisations as well people of all ages, families and carers with lived experience. We will specifically seek to understand from people of all ages with lived experience what does or could have helped them stay well. This will also include paid progression opportunities and lived experience leadership roles.

We will have a diverse and inclusive workforce, representative of our population, and equipped with the skills and knowledge needed to address inequalities.

We will know we are making a difference when:

We can demonstrate impactful investment in our local communities.

We have good quality data flowing which lets us know if people of all ages with protected characteristics, or other measure of health inequalities such a socio-economic status, are achieving outcomes at the same level as the rest of the population.

Where inequity of access, experience or outcomes have been identified, there are targeted and time bound improvement plans which are scrutinised by the ICB's Health and Care Improvement Group.

For every project in the system there is strong evidence of co-production and measurable action to address health inequalities.

1 in 7

LGBTQ+ people have avoided health treatment for fear of discrimination

52%

of LGBTQ+ people have experienced depression in the last 12 months

Around

1 in 5

women have a mental health problem

3x

as many men as women die by suicide

Black people are

3x

more likely than white people to be sectioned under the mental health act

Our great place to work ambition

We will have a happy, diverse, inclusive, trauma-informed and stable workforce within our system.

What will we do to achieve this:

Alongside and learning from the South West Workforce Forum, We will pilot new approaches to staff skill mix ensuring people are able to use and develop their skills appropriately.

We will seek out proposals from staff about how their work could be done differently.

We will have a focus on staff wellbeing, such as providing staff with access to regular reflective practice and ensuring staff can be supported through experiences of trauma.

We will establish new development opportunities for staff at all levels, including the chance to access career development opportunities across healthcare organisations within BNSSG.

We will establish pathways for young people and adults with lived experience to progress into peer support roles and onwards.

We will actively work with regional and national workforce teams to understand what more we can do as a system to contribute towards addressing national workforce shortages.

We will know we are making a difference when:

An increased % of mental health staff say they are satisfied with the quality of care they provide.

An increased % of mental health staff would recommend their organisation as a place to work.

An increased % of mental health staff say they feel their role makes a difference to the people they support / care for.

We can see more staff from under-represented groups are progressing to senior roles.

There is an increase in Lived Experience recruitment and progression, to ensure we are making the most of the significant contribution people with lived experience can bring to the workforce.

Spend on agency across the system reduces and is in line with national benchmarks.

Recruitment and retention rates improve and are above national benchmarks.

“You need to create more conversation around these jobs – what makes them good and what impact do they have? Then more people would want to go into these roles and you might get a more diverse workforce”

Young person BNSSG Helping Young People Engage (HYPE) group

78%

is the gap between the employment rate for people incontact with secondary mental health services and the overall employment rate in the South West.

PHE 2021

Our sustainable services ambition

We will have an economically and environmentally sustainable mental health system, where maximum benefit from our actions and services is delivered to the community.

What will we do to achieve this:

We will consider the short and long term social, economic and environmental impact of all investment decisions within our system and act proportionately to address any negative impacts identified.

We will ensure mental health is fully considered in our ICS digital strategy, maximising opportunities for digital innovation to improve the efficiency of integrated working for our partners, and reduce the need for people of all ages to repeat their stories.

We will ensure people of all ages have a range of options for accessing services both virtually and in person based on individual needs. For many people a virtual offer can be more convenient and better for the environment as well as helping us retain staff who want to work flexibly. Other people may experience digital poverty or may prefer a face to face option and so this will also need to be available as close to public transport routes as possible.

We will have sustainable contracting approaches that offer longer term funding, to allow partner organisations to be committed to transformation and support their staff retention. Any procurement exercise will fully consider environmental and social impact as key elements.

We will require new contracts to include commitments to address the climate emergency.

We will know we are making a difference when:

As a system, we can demonstrate the wider social and environmental impact of our services.

We have a clear commissioning and contracting plan supporting the sustainability of our whole system.

We have digital solutions which allow rapid information sharing across partners.

Providers can evidence that they have reduced their carbon footprint.

Providers can evidence local recruitment.

Providers can evidence use of local supply chains.

£105 billion per year

is the estimated economic and social cost of poor mental health

Next steps

Integrated Care Systems (ICSs) represent the best opportunity in a generation for that urgently needed transformation of our health and social care system. They provide the opportunity to break out of organisational siloes, enabling all partners to work together to tackle deeply rooted challenges, drawing together their collective skills, resources and capabilities.

5 key principles which would allow Integrated Care Systems to thrive:

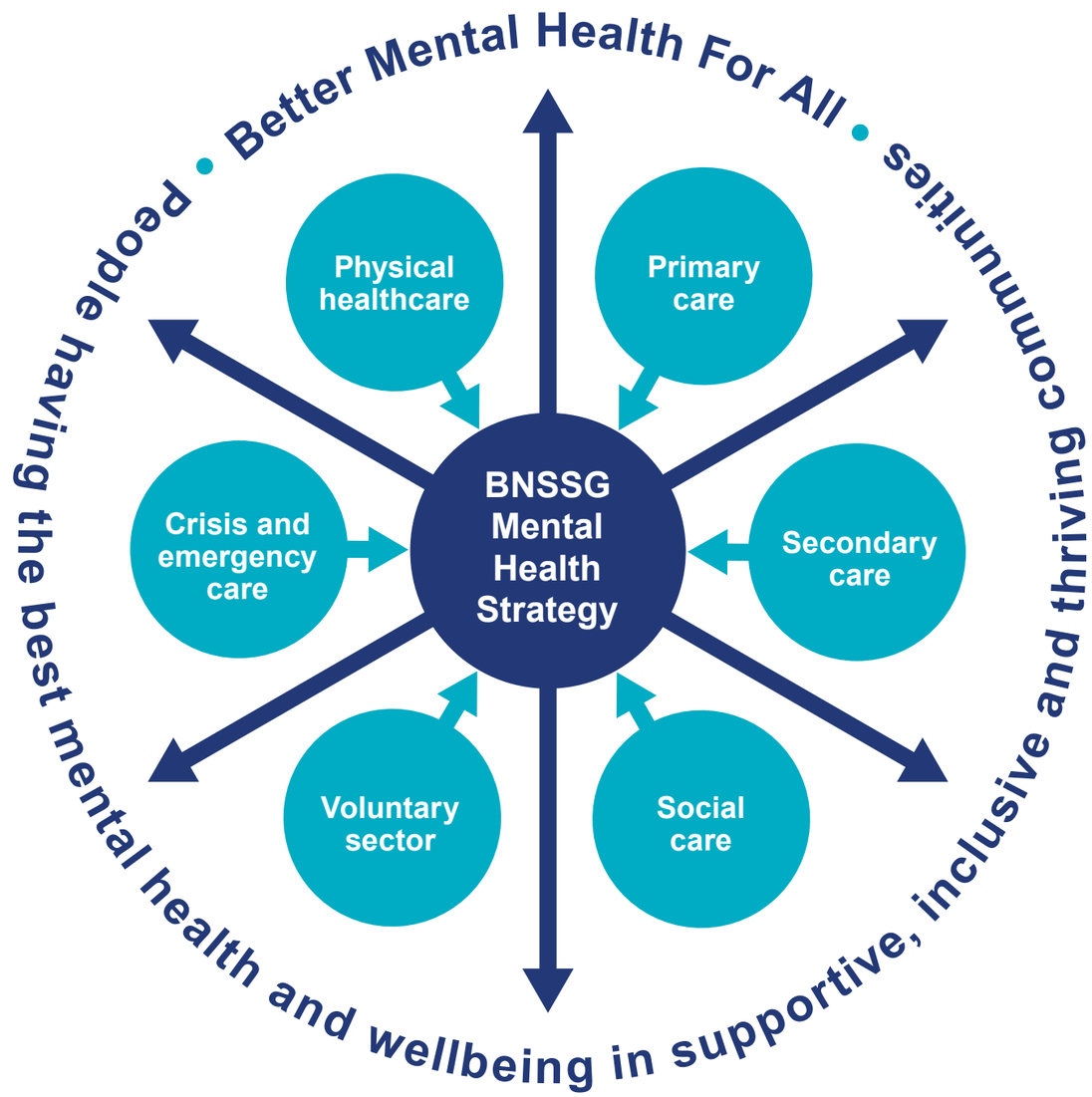
1	2	3	4	5
Collaboration within and between systems and national bodies	A limited number of shared priorities	Allowing local leaders the space and time to lead	The right support, balancing freedom with accountability	Enabling access to timely, transparent and high-quality data

Locally we are absolutely committed to the transformative power of working together to deliver change. There will be a Mental Health, Learning Disabilities and Autism Health and Care Improvement Group which will oversee the delivery of the vision, ambitions and priorities set out within this strategy. The Health and Care Improvement Group will include representatives from partners across our system. There will also be a Children's Health and Care Improvement Group which will provide additional scrutiny on the delivery of work to improve mental health access and outcomes for Children and Young People.

During 2023-24, the Mental Health, Learning Disabilities and Autism Health and Care Improvement Group will oversee the production of plans to deliver our ambitions. These will form our five year Joint Forward Plan. Each year, our Joint Forward Plan will be updated to demonstrate the progress we have made and include further detail on the projects which will be delivered in that year to meet our aims.

Delivering this strategy will also require all partners to commit enabling resources for key projects, so that we can take a system approach to workforce planning, digital, estates and quality improvement, to make the best use of all our resources.

When all organisations in our system work together to deliver change, the impact can be transformational.



Appendix one: Glossary

TERM	DEFINITION
Acute care	Acute care is where a patient receives active, short-term treatment for a condition.
Assets	This describes things which can support good mental health and wellbeing, such as family, community relationships, social networks, community and neighbourhood services, activities and facilities.
Autonomy	Autonomy is about a persons ability to act on their own values.
BNSSG	Bristol, North Somerset and South Gloucestershire.
Care Programme Approach	A way to create a plan for someone's care and support in secondary mental health services, usually using a standard set of documents. This approach is due to be replaced by new care planning approaches being developed by the Community Mental Health Framework Programme.
Context	When we talk about understanding our wider context (page 4), we mean we need to understand the local needs of people in the areas we cover (see BSW and BNSSG). We also need to understand our financial position, any areas of our services which need to be improved and so on.
Co-produced/Co-owned	This describes how we work with people who use our services to make sure care and the way it is delivered meets their needs, rather than providers deciding this on our own.
Digital innovation	This is about new technologies such as software programmes, apps or use of mobile phones, tablets or computers.
Equalities	Ensuring people have equal rights and opportunities.
Green Social Prescribing	A national programme offering people the opportunity to access wellbeing activities outside and in nature in order to support their mental health and meet other people.
Health and Care Improvement Group	The name of a meeting of different organisations from across BNSSG who come together to make decisions about health and care services in the area. The two Health and Care Improvement Groups most relevant to this document are the Mental Health, Learning Disability and Autsim Health and Care Improvement Group.
Holistic care	A holistic approach means to provide support that looks at the whole person, not just their mental health needs. The support should also consider their physical, emotional, social and spiritual wellbeing.
ICS	Stands for Integrated Care Systems. From 1 July 2022, 42 of these were set up across the country. They are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. AWP works in two of these systems: BSW (Bath & North-east Somerset, Swindon and Wiltshire) and BNSSG (Bristol, North Somerset and South Gloucestershire). Since 1 July, we work with the other providers in each system – these include Voluntary sector organisations (such as Mind, Second Step, and Nilaari), GP's (doctors) and acute hospitals (such as Royal United Hospital in Bath and Southmead Hospital in South Gloucestershire).
Inequalities	The state of not being equal, especially in status, rights, and opportunities. We know that some groups of our population currently find it harder to access mental health services than others.
Inpatient care	When a patient is being cared for in hospital rather than at home.
Integrated	Where people work together to deliver something.
Joint Forward Plan	A five year document that every healthcare system is required to produce to describe how they will deliver improvements in local services. It is refreshed annually.
Joint Strategic Needs Assessment	Joint Strategic Needs Assessments are documents held by local public health departments within Local Authorities which set out what the health and social care needs of a local area are.
Legislation	The process of making or enacting laws.
Lived Experience	The knowledge people gain from treatment or going through services. This provides invaluable insight to what services are like for the patient.
Local Authority	A Local Authority, commonly referred to as a Council, in the government body responsible for delivering local services in an area.
Long Term Plan (LTP)	The NHS Long Term Plan 2019-2024 was a policy document published to provide guidance to local areas about the improvements expected in mental health services during this time.
Paired Outcome Measures	Tools which are used to understand changes in mental health and wellbeing. Often a set of questions completed at the start and end of a period of support or treatment to understand how much it has helped.
Peer Support	People who have experienced services are uniquely placed to support others who follow in their footsteps, they can explain what to expect and how they felt whilst under the care of a service.
Personalised care	This means service users have choice and control over the way their care is planned and delivered.
Mental Health Act	The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.
Primary care	Healthcare provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment.
Recovery focussed	This means working with people to target ways to help their mental ill health get better and achieve the things they want to do as they improve.
Secondary care	This refers to services being provided by health professionals who generally do not have first contact with a service user for example, a hospital rather than a GP surgery.
Severe mental illness (SMI)	Historically Severe Mental Illness was a term used to refer to people who experienced psychotic illnesses, where people may see or hear things which are not real, and/or struggle to think or act clearly. Often, when this term is used for national targets or in data this is the group being referred to. GP 'SMI' registers also only record people who have a psychotic illness. However, the Community Mental Health Framework, introduced in 2019, has widened the scope of the term and has used it to mean a much wider group of conditions and needs using the following definition: "SMI covers a range of needs and diagnoses, including but not limited to; psychosis, bipolar disorder, 'personality disorder' diagnosis, eating disorders, severe depression and mental health rehabilitation needs – some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use".
Social determinants of health	The things outside of our biology which can affect our physical and mental health such as housing, debt, social isolation.
Sustainable	Something that is able to be maintained at a certain level.
Trauma informed	A trauma informed approach to care acknowledges that health professionals recognise the impact of trauma and understand the correct processes for recovery. This includes recognising the symptoms of trauma in patients and their family.
Voluntary Community and Social Enterprise (VCSE) sector	Organisations which deliver services but do not seek to make a profit from these services. Often services will be free to access but where there is a charge this money will be reinvested into delivering the organisations social or charitable aims.

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

Design: marlesandbarclay.co.uk

ITEM 9

Black South West Network

Make it Work

Learning and Evaluation Report

Building Equity within the Adult Social Care Market in Bristol

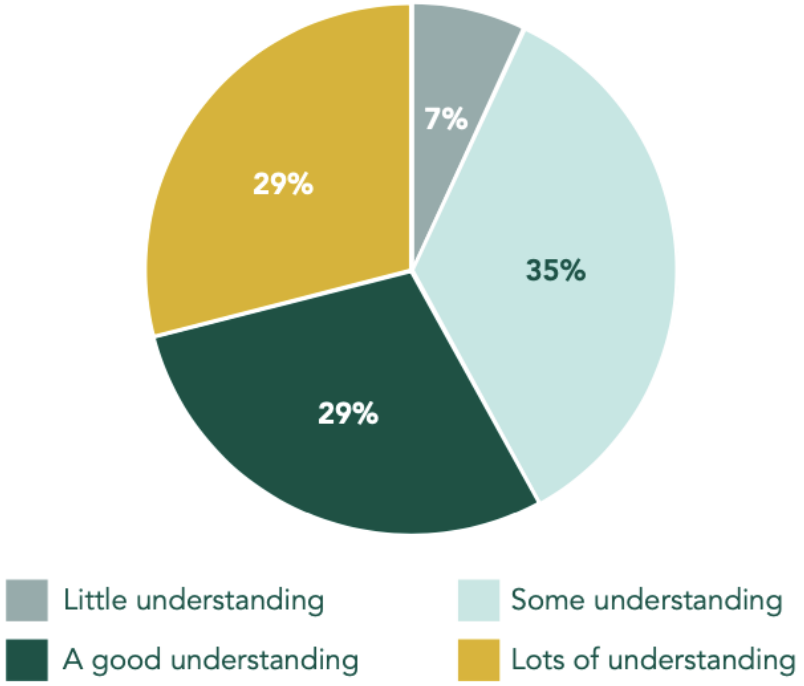
Research undertaken by
Black South West Network (BSWN).
Funded by the Bristol City Council.

1. Improving the quality of services for Black and Minoritised communities

Smaller local Black and Minoritised organisations by nature are **closer to their communities** than larger organisations or institutions can be and possess **culturally diverse skillsets** that are better placed to respond to the personalised care that Black and Minoritised individuals tend to require.

Figure 1 - Related to Objective 1

Do you know your users and the needs of your community?



*"I've spoken a lot about the skillset, the diversity, the local knowledge and **local intelligence** of those community organisations, the richness of the combined skills across the various organisations.*

*Without a shadow of doubt, coming from the space of **knowing the actual citizens** that the commissioners want to support, they all had that."*

Interview 1 – Programme Consultant 1

2. Increasing diversity and economic opportunities in the ASC market

The second programme objective was to enable the diversification of the ASC market by addressing inequity within the traditional implementation of the tendering and contract framework. That is;

- to increase **equitable access** to opportunities for Black and Minoritised smaller organisations and have them join the supply chain as competitive providers.
- to provide opportunities for Black and Minoritised workers with **underutilised caring skillsets** to formally enter the ASC labour market.

> *"It's having that **diverse workforce** and upskilling providers. So, it's been a good opportunity for us to be able to do that, because we want more providers, we want **more competition**."* - Interview 2 – Local Authority Representative 1
>
> *"I was inspired by the [organisation name] people because some of the people that work for them, they didn't think that they could work [...] and then all of a sudden, **they're in established roles**. They're doing work, earning money."* - Interview 4 – Local Authority Representative 2

3. Enhancing overall access to care via alternative financial models

Individual Service Funds

*"In order to help **increase access**, this is part of the ambition of what this project is doing... It can be done in many diverse ways, whether it's through the channel of the framework or whether through other avenues. So, **exploring what other avenues** besides the traditional commissioning process... Could it be through **Individual Service Funds**?"*

Interview 1 – Programme Consultant

Direct Payments

*"Generally speaking, in areas where there are large numbers of people from BME communities, there tend to be large numbers of what we call **Direct Payments**. That means that someone who needs a service gets the money themselves and chooses how to spend that money and what they quite often do is find a [non immediate] family member to deliver that service."*

Interview 8 - Local Authority Representative 3

Care Introductory Agencies

*"We had [participating in the programme delivery] some of the voluntary community organisations within Bristol who are leading on **Care Introductory Agencies** so that they would then be the lead as the mechanism to enable smaller organisations to advertise their services."*

Interview 1 – Programme Consultant 1


Learning

Barriers to Contracting: The Framework

1)	**The framework is perceived as bureaucratic and time-consuming.**	"It is difficult to know which framework to apply to…" "Bureaucratic and long tedious forms to complete."
2)	**The process is inequitable for smaller and/or newer organisations.**	"Bigger organisations are likely to receive contracts because they are known and have experience." "Smaller/new organisations are not offered opportunities to prove themselves."
3)	**Expectations/questions are unclear, resulting in communication failures.**	"The framework application questions are misleading especially where there is an indication that the question is optional but it's not really optional."

Barriers to Contracting: Rigidity Hindering Innovation

- The experience of being constrained by **rigid and bureaucratic systems and processes** was one of the most frequently mentioned barriers cited by all parties in the interviews (by participants to the programme, expert consultants, BCC officers).
- More specifically, the rigidity of systems was a direct barrier to **innovation**.
- This hurdle was not perceived as originating from the lack of willingness of individuals involved, but it was rather stemming from the very nature of the local authority being a big institution that – like all big structures – **functions at a slower pace and following a strict set of already-tested common practices.**

> *"I think the commissioners in middle management and the directors, I think they are really keen on this stuff, and I think they get it – **translating** is the problem. You get a lot of people who want to do it but the systems and the structures, they just act as **barriers to innovation**."*
>
> Interview 9 – Programme Consultant 2

Barriers to Contracting: Fear of “unfair advantage”

- Black and Minoritised led organisations are more likely to be **smaller organisations**, with a core team of two or three people, or often even a one-man business. This means less capacity for writing tendering and proposals as all the staff’s time is spent on delivery.
- Whilst they tend to have extremely specialised and high-quality skillsets and personal experience in caring, Black and Minoritised nurses and carers are often **not trained in business and financial fields**. This – in addition to the general lower access to contracts and investment opportunities – equals a lower probability to develop a financially sustainable model for their businesses.
- As a consequence, the lifespan of a Black and Minoritised business is generally shorter. However, due to being rooted in communities, new ASC businesses are **born out of necessity** to respond to community needs. That means, a number of new Black and Minoritised ASC organisations is routinely created across the landscape and simply needs to be enabled to grow.
- Whilst the ASC technical language and ‘jargon’ is often named as a barrier across the board, it becomes even more relevant for recent migrant communities who are non-native English speakers and might be **less familiar with UK ASC systems** in general as these differ from their home countries’.
- Lastly, due to all the barriers described above, Black and Minoritised providers are overall **less likely to enter the formal ASC market** and be recognised for their potential and value, as they are simply less likely to be known and seen.

Due to all described and more, Black and Minoritised ASC providers' access to contracts is disproportionately lower than other ethnic groups. Therefore, positive action and equitable responses are needed to repristinate an equal ground for all providers to be enabled to enter the competition.

"It is equity, isn't it? It is about how do you step up.

Yes, equality is fantastic, but it is the ***equity that this project provided*** *which* ***made a difference*** *that made it achieve tangible goals more than any other project.*

They haven't given us anything different, they have just given us ***the same information in a more suitable way*** *instead of putting it on their website or on Pro-Contract or on their market service workshops.*

The platforms where the information was available, I wouldn't have had access to these platforms.

But you know, if it is a group of ***people I can relate to****, an organisation I can relate to.*

The people from the council who I was not able to reach came to ***my safe space****, and that enabled me with information that I needed, in a different platform that I can understand."*

Barriers to Contracting: Systemic Disadvantage

Lack of Capacity

- A **vicious cycle**, where lack of capacity hinders their ability to hire personnel to increase – in turn - capacity, even when they already have the contacts for **qualified workforce.**
- If they access a contract, they are still less likely to receive a follow-up contract due to their reduced capacity to collect and provide **impact evidence** compared to bigger organisations.

Lack of Information

- Systemically lowered levels of access to the **information and data** required to successfully win a contract, in some cases simply due to being new to the system.
- By far, the most common type of information mentioned in this instance was **pricing and costing** market information.

Lack of Visibility/Poor Comm

- The poor communication and disconnection caused Black and Minoritised providers to **feel under-valued** by the formal ASC market.
- In this sense, the programme had the greatest impact, by truly connecting Black providers to commissioners and allowing for the creation of **space for mutual learning.**

Impact of Make it Work

*"I think definitely the programme has **opened up the lines of communication** a lot better and not only the communication but the opportunities because speaking to commissioners, we are able to identify […] that there are **more opportunities** I didn't even pick up on Pro- Contract before."*

"I would have given up without your support."

*"There was such a high level of **data intelligence** that I felt through this project. I was able to use it in order to devise or put together my bid that is in line with the standards or the costing for the tenders I was looking into. It has just really helped me so much."*

The State of the Sector

In conclusion, what type of support was needed?

1) Technical support for increasing **contract-readiness** within organisations, which often included support with registering on the Pro-Contract Council's Tendering and Contracts System and with becoming CQC registered.

2) Financial guidance to **increase sustainability** via alternative routes, e.g., through enhancing understanding of ISFs, DPs and CIAs.

3) Business **development support**, which as previously mentioned included impact tracking, data capturing and reporting, but also risk assessment and risk management, budgeting and governance and accountability.

4) Building a **relational approach** to allow for better communication and understanding between the Bristol Black and Minoritised ASC providers and the commissioners and procurement officers at Bristol City Council.

5) Creating spaces and opportunities **for peer learning and networking** between the Black and Minoritised ASC providers sector to build on each other's knowledge and skillsets, as much as on each other's resilience and strengths.

Evaluation

Overview of Phase One & Two

One-to-one capacity building & mentoring, peer-to-peer learning/small group support workshops, monthly whole-group workshops delivered by the council and other external organisations.

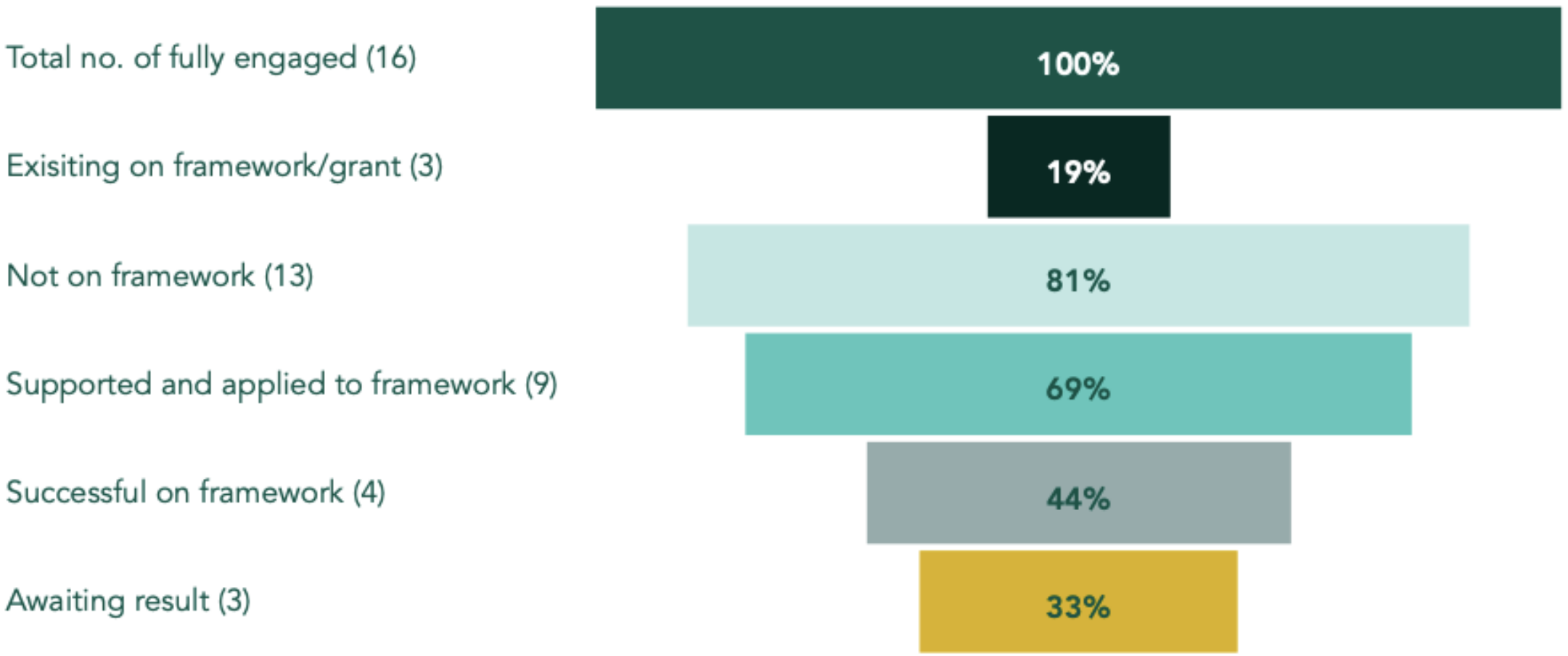
Submission and/or resubmission of applications, organisational strengths, leadership skills, policy improvements, project scoping etc.

What did participants find most useful about the programme?

Frameworks Application Analysis & Outcomes

Figure 14

Framework application analysis and outcomes



Economic Benefits of Providing Homecare & Community Support Services

Total combined turnover of 4 successful framework applicants	
Pre-MIW programme	£0
On-MIW programme	£377k

Total combined staff level of 4 successful framework applicants		
	Full-time	Part-time
Pre-MIW programme staff level	0	4
On-MIW programme staff level	10	46*

*PT hours from 5hrs to 20hrs per week

Service Users Supported across Homecare & Community Support Services

Total combined number of service users supported	
Homecare	29
Suppported living	12
Supported accommodation	1
Support to access the commnity	7
Carer support	1

Impact Highlights

Participants' average satisafction rate

4.3

out of 5 stars

98%

of participants would strongly recommend the MIW programme to their colleagues

75%

of the actively engaged cohort is currently active on the framework, spanning across 7 different services

Over

268

hours of support delivered

Spanning from 1-1, peer learning and specialised workshops

Impact Highlights

The average level of knowledge and understanding of ASC systems reached 4 stars out of 5 by the end of the programme

89%

successful outcome in increasing contract-readiness

(with 8 organisations out of 9 successfully newly registered on Pro-Contract)

Original engagement target was doubled

The total combined turnover of the 4 newly successful framework applicants amounts to £377k

Strategic Impact

1) Inclusion of Black and Minoritised organisations' views in BCC senior managers' decision-making of future commissioning framework.

2) Active involvement and contribution of Black and Minoritised organisations into the BCC procurement strategy review via the diverse supplier forum.

3) Representation and contribution of a Black and Minoritised communities' member at the BCC procurement and contract management scrutiny panel.

Lastly, the MIW programme has created a general open learning environment that allows mutual sharing with ongoing participation of Black and Minoritised organisations into pilot programmes e.g., care provision/carer services; system testing, introductory agency platform testing and more.


Where are we and what is next?
Investing in building effective relationships
Community anchor
Capacity building, market access, on-going support
Co-design long term strategy for sutainability
Service users
Care providers
Choices, cultural appropriateness, better outcomes
The council
Investing in sustaining long term relationships

Recommendations

1) Investing into capacity-build under-developed organisations to increase their access to the market and build their track-record.

2) Moving towards the co-production of type- based processes, e.g., there is opportunity for social capital organisations to act as Introductory Agencies and deliver services through micro-org and self-employed.

3) Moving away from transactional and traditional commissioning to a range of relational commissioning processes.

4) Setting up projects with clear lines into key/ future opportunities e.g., ICSs to ensure equity and sustainability.

5) Post contracting (on-going and long- term) relationship and support to ensure service performance, greater outcomes, and sustainability.

Thank You