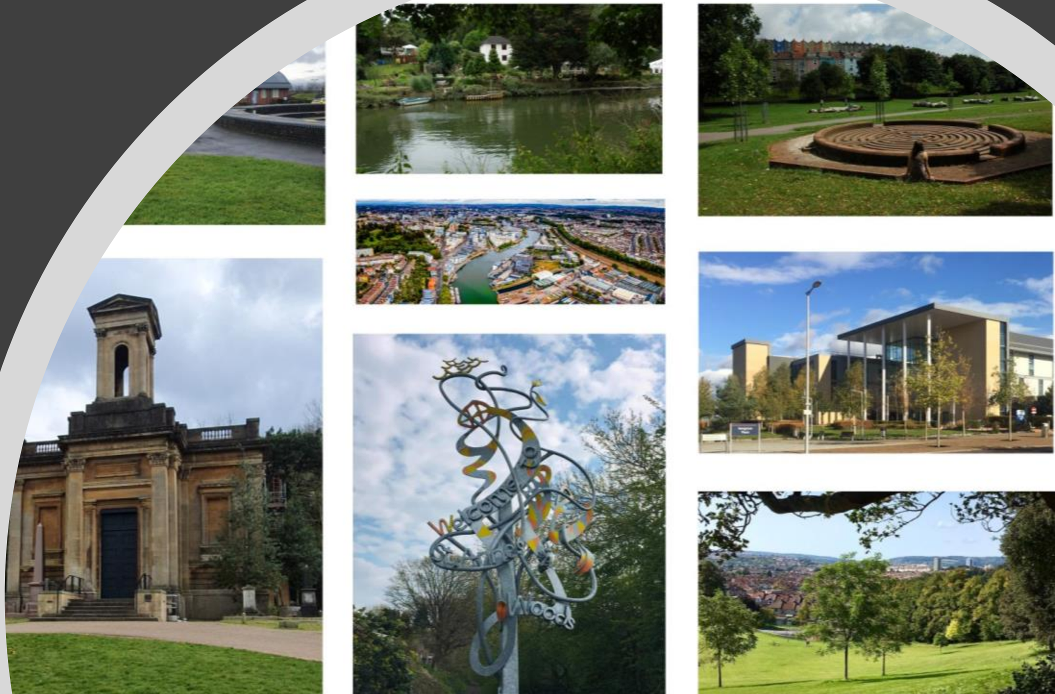
South Bristol
Locality Partnership

South Bristol Priorities
2023-2028

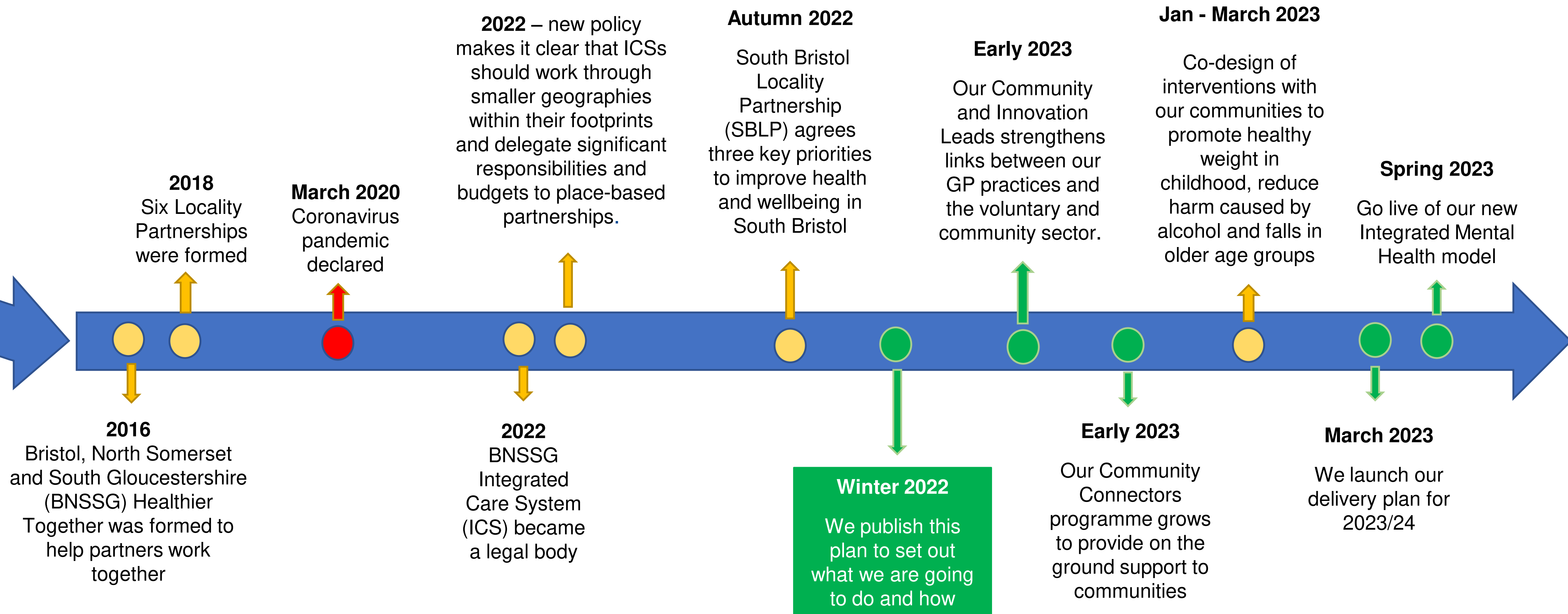
What we can achieve together



What we can achieve together

If we are serious about promoting better health and wellbeing and addressing health inequalities, we must take collective decisions based on a shared understanding of the local population and how people live their lives. We must look beyond health and care services to the wider determinants that influence the health of our populations – early years support, housing, leisure, transport, skills and education, employment support and the environment

Thriving Places, September 2021



Leanne began work in South Bristol in August as a community connector. Leanne is a member of a team we are building to help people to access the support available in their community. The team will be there, in person, to provide help and advice.

On Marksbury Road where she started her work Leanne went door to door to get to know people who knew the area and to find out what was most impacting on them. The night before Leanne's first day there had been a stabbing in the area. There was a sense of fear that left people hesitant about talking to her.

Since then Leanne has been able to speak to more people. She has found that people are sometimes sceptical about offers of support. There are concerns about accepting help but also about admitting you need help and there is a lack of trust in provision and about lasting change.

Leanne's work is starting to open doors. Local cafés and shops have been keen to provide time and space for Leanne to run drop-in sessions and to talk about her work. She has set up a knitting group at St Catherine's Court, a supported housing location, which is bringing people together and providing a space in which people feel happier to be engaged and talk about what matters to them.

Leanne has also found people that want to see change and many want to support it. That change just needs to respond to local needs. As a locality partnership our role is to understand those needs, to earn trust and channel community energy into keeping people well.

There are concerns about accepting help but also about admitting you need help

Introduction

South Bristol's Locality Partnership brings together GPs, hospitals, mental health, social care, voluntary organisations and charities to deliver meaningful care and support that enables individuals and communities in South Bristol to optimise their own wellbeing.

In the past services have tried to deliver change at regional or national level. Our partnership has the advantage of working across a smaller area where local community organisations and people can help us to deliver change in the place they live and work.

This plan outlines our priorities for 2023-2028. It has been developed by members of local health and social care workforce and local voluntary organisations. It is informed by their understanding of how we can change the way we work to meet local needs and of the people they work with.

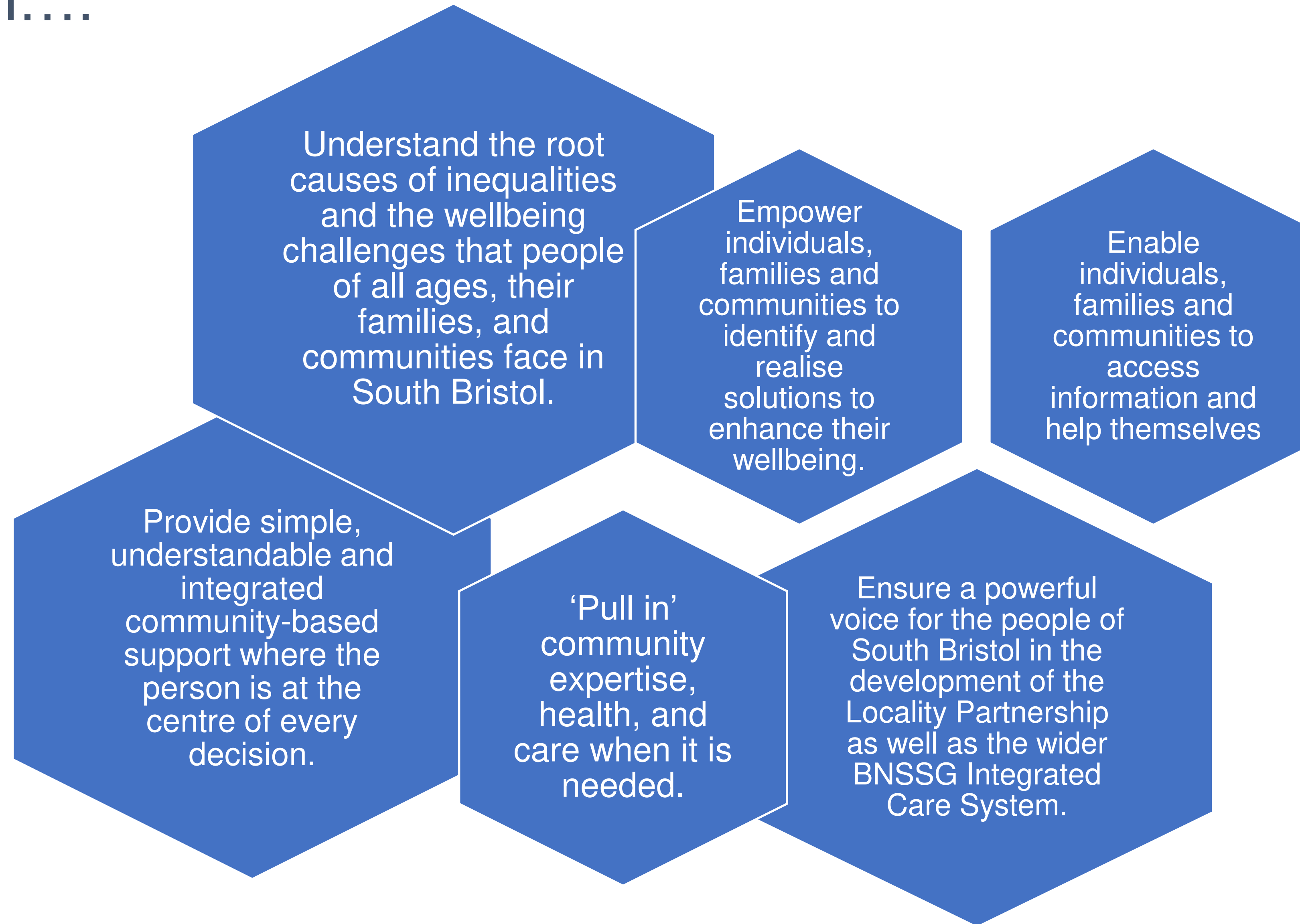
We have started with the basic premise that if we try to do everything, we won't deliver effective change. Instead, together we have reviewed the evidence we have and agreed five areas of focus for the coming five years – community mental health transformation, healthy weight in childhood, harmful use of alcohol, falls in older age and ageing well.

We will build on what we have already achieved and focus on achieving the goals we set out in this plan in the next five years.

Delivery of those goals will help people in South Bristol to live well and it will ensure our services are better able to support people when they are not well. We have developed our priorities collaboratively and we are collectively responsible for working together to achieve our goals and vision and to solve the problems we face.

Signed by both Co-Chairs

We will….



Asset-based – using the resources we have

We are committed to working with our community and to do that we need to be talking to our community and supporting them to help each other – not just when they have problems, but before that.

The development of **Community Connectors** builds on the need for support for growing numbers of individuals who have become increasingly visible because of the pandemic. The reliance and expectation that everyone can access everything they need online, or via an app, is unrealistic, and particularly affects older, less able and financially vulnerable people of South Bristol.

Community Connectors provide an actual person for individuals to talk to in their community to help them access local resources to improve wellbeing and to prevent their health deteriorating to the point of needing the support of health and social care agencies. We are also recruiting to a **Community Development and Innovation** post as part of our local response to the Fuller report. The post will support an ambitious and joined-up approach to prevention.

Training has also been provided by Changes Bristol to volunteers in the community to facilitate mental health peer-to-peer support groups provided to people in South Bristol. 23 volunteers have been trained to be **Peer Support Programme** facilitators in South Bristol so far.

There are seven peer support groups currently running in South Bristol - five that are in person and open to anyone experiencing low-level mental health, worries or concerns about their mental health, and two online groups that are specifically for LGBTQ+ community and Women of Colour. 2965 people attended between December 2020 – September 2022.

Peer support provides an opportunity for people to share their experience with people who have had similar experiences in their community. Research shows that peer-support can improve wellbeing, increase self-esteem and reduce isolation.

Reducing inequalities

In September 2022 there were over 15,000 people over 60 years old in South Bristol who were living with multiple long term conditions.

More than one in three of those people were experiencing health inequality.

Over 400 of that group were admitted to hospital in an emergency twice in just 12 months.

We are developing an Anticipatory Care model to help people to live well and independently for longer through proactive care for those at high risk of unwarranted health outcomes. That will involve structured proactive care and support from a multidisciplinary team (MDT). We determined to work with patients differently and to offer proactive care interventions to improve or sustain their health, and to avoid reliance on unplanned care and the distress caused by emergency admissions to hospital.

My Team Around Me

Whilst we work to prevent ill health there are many for whom a health condition, or disease or multiple health problems are already causing difficulty. Many of those people are well known to services. Our approach to providing support needs to be better at understanding what is happening in their lives and more responsive to their needs.

We recognise that people's lives are complex and we need to respond by addressing the issues which matter to them.

For those individuals with multiple long-term conditions or serious mental illness or both our response will be to develop a 'My Team Around Me' approach to Multi-Disciplinary (MDT) team working. This approach recognises that every individual is different and that we need to remove the organisational boundaries and artificial barriers between different health conditions and physical/mental health and truly put the person in the middle, understand their needs and what matters to them, and bring in support from different organisation and agencies as and when needed.

Evidence base

We have used the Joint Strategic Needs Assessment, produced by Bristol City Council's public health team, to inform our priorities for 2023-28. That assessment and the work of the Population Health Management team at the Integrated Care Board ensures our work is responsive to the needs of our population. We have also worked with organisations across South Bristol to ensure that the data reflects the reality of what they experience every day working in the area.

The problems we will focus on tackling

Area of focus	Local problem
Healthy weight in childhood	Excess weight in childhood at 4/5 years of age varies across South Bristol from 32.4% in Hartcliffe & Withywood to 13.7% in Southville
Harmful use of alcohol	The rate of admissions for alcohol-specific conditions in South Bristol (1,064) was significantly higher than England (587) in 2020/21
Falls in older age	One in four emergency department attendances for falls across BNSSG is a South Bristol resident

Starting well

Childhood healthy weight

Evidence

The National Child Measurement Programme is a mandated annual programme delivered by local authorities. It measures the height and weight of all children in schools in reception and year six. NCMP date in South Bristol reflects a national upwards trend in weight in both age groups. The specific problem in South Bristol is the significant variation in rates across the area. In areas of greatest deprivation there are also high levels of childhood excess weight which leads to poorer long-term health.

Obesity in children increases the risk of the onset of long-term conditions including Type 2 diabetes and asthma. It is also associated with anxiety and depression.

Goal

To reduce the rates of children who have excess weight at ages 4 to 5 in Hartcliffe, Withywood and Filwood relative to other areas of South Bristol.

Approach

- We will take an asset-based approach identifying resources which already exist in our communities to enable active lifestyles and healthy eating and identify where there are gaps in provision.
- We will work with schools, children's centres and families specifically in Hartcliffe and Withywood and Filwood to improve access to interventions which support healthy weight in childhood.
- With partners we will assess how we are working with families antenatally to provide support.
- We will work with public health to promote those resources and increase up take.
- We will ensure that if and when a family receives feedback after being measured at school that support is in place to help the family.
- We will ensure professionals who work with children and families are confident they can help people who are concerned about their diet to access support.

Sara is the Health and Social Care manager at Windmill Hill City Farm. The Farm provide courses, workshops and voluntary roles for over 100 people a week who are receiving support from secondary or primary care.

From 2023 the farm will offer mental health groups in animal care, gardening and woodwork. They already offer supported and paid farm placements as well as voluntary opportunities in the café, on the farm and in the garden. In March 2022 a new lease was signed in Hartcliffe for a second City Farm.

When we met Sara had just received a referral from the nursery for a parent who is known to social care. She was optimistic the City Farm could offer help.

However Sara also needs help. Much of her time is spent reporting to ensure continued access to a small but vital amount of funding from grants and donations to ensure public sector funders meet their different requirements for information. Sara wants to use her time as effectively as possible and to set up new referral pathways and increase the number of regular volunteers with health and social care needs. That is where the Partnership has a role to play.

The Farm provide courses, workshops and voluntary roles for over 100 people a week who are receiving support from secondary or primary care.

Living well

Harmful use of alcohol

Evidence

The rate of admissions for alcohol-specific conditions in South Bristol (1,064) was significantly higher than England (587) in 2020/21.

Across South Bristol the proportion of admissions increased significantly between 2017/18 and 2020/21 in Brislington East. In 2020/21 the rate was also above the Bristol average in Southville, Filwood and Hartcliffe & Withywood. In 2020/21 18% of admissions from South Bristol were from Harcliffe and Withwood compared to 5% from Bishopsworth.

We are concerned with the rate of admissions and about the clear link between alcohol misuse and poor mental health.

Goal

To reduce the number of admissions for alcohol-specific conditions across all areas of South Bristol to below the Bristol average rate.

Approach

- We will map admissions for alcohol specific conditions against deprivation, housing and type to examine connections and the geographical availability of support services to inform commissioning.
- We will work with service providers and their client base to engage with those who have recovered from addiction to share their experience and learn from it
- We will assess the pathway for treating alcohol use disorders and use our My Team Around Me Approach and help people to address the wider issues in their lives to support recovery
- Fundamentally we will focus on prevention by supporting people who are worried about their alcohol intake before they become dependent to reduce the number of people whose lives are harmed by addiction

Ageing Well

Falls

Evidence
South Bristol accounts for a quarter of all Emergency Department (ED) attendances for falls.
As a crude rate, South Bristol also has the highest number and proportion of admissions, based on its age 65+ population (1993 admissions or 8% of the over 65+ population).

The whole of the Bristol area has around 200 admissions more than would be expected based on the age, sex and deprivation distribution. Those admissions are largely from South Bristol.

When not accounting for deprivation, there are just over 100 more admissions that would be expected from those areas in South Bristol in the 20% most deprived in the country (IMD quintile 1) and 78 from the next 20% most deprived. The number of admissions from South Bristol is higher in all IMD quintiles however it is highest in quintiles 1 and 2.

Goal

Reduction in falls attending ED in the over 65s by 770 - 50% over five years

Approach

- Our broader Ageing Well programme encompasses work to reduce COPD and to halt the increase in the number of people with diabetes type 2. Our strategic priority is to reduce falls in older age groups – an issue which is causing preventable harm to people's physical and mental health and putting huge strain on our health system. To tackle the number of falls we will:
- Build the existing range of interventions to better meet the needs of those at risk by working with VCSE partners and drawing on expertise in frailty and the causes of falls
- Assess more specific hospital data showing primary diagnosis and HRG codes. That data will provide us with insight on the causes of falls and location of falls. That will in turn inform decision making on implantation of evidence-based interventions to target the most common causes of falls.
- Launch a campaign to promote practical measures which can reduce the chances of a fall and focus on a Making Every Contact Count approach
- Undertake multi-agency risk assessment of care settings and increase access to maintenance services to ensure care settings are appropriate (both homes and supported living) and to offer practical support to residents to reduce falls
- Provide VCS support people on discharge to reduce readmissions

Delivery and implementation

Our delivery plans will respond to the feedback we have received from professionals and from people in our community – **support provided needs to be sustainable.**

Our plan will also need to be realistic. The impact of Covid-19 on health and wellbeing and more recent impact of the rising cost of living has been devastating for communities. It has also left capacity across our organisations strained. We must work to reduce those impacts on our community and on the people who live in and work in South Bristol.

We will strive to innovate, to increase capacity and to deliver sustainable solutions which are co-designed with communities. We will take a phased approach to give us time to deliver intelligent and joined up care to people who need it and to utilise the capacity that change generates to focus on prevention.