Avon and Wiltshire Mental Health Partnership NHS Trust

Band 6 Mental Health Practitioner – Social Worker, OT or RMN Primary Care Network (PCN) ARRS (Additional Reimbursable Roles Scheme) for Bristol, North Somerset & South Gloucestershire

Bristol Locality

South Bristol

Name of Locality: South Bristol

Population Overview:

The South Bristol locality has a population of approximately 170,000 people with this expected to increase by 8% by 2025, the largest increase will be in the 75-84 population.

The population has diverse demographic mix with some more affluent areas and a lot of regeneration taking place, alongside less affluent areas. The locality contains some of the most deprived wards in Bristol and these socioeconomic determinants correlate with poorer health outcomes. Hartcliffe & Withywood is the most deprived ward in Bristol with Filwood also being the third most deprived ward in the city. Further to these areas, income deprivation affecting children and older people is also significant in other certain pockets of South Bristol. The average life expectancy at birth within the locality is lower than the averages for the South West with the main causes of this gap being attributed to: cancers, circulatory diseases and respiratory diseases.

A high proportion of adults in South Bristol are overweight or obese with Filwood and Hartliffe & Withywood having some of the highest proportions. Hartcliffe & Withywood also has some of the highest alcohol related admissions in Bristol. The South Bristol locality as a whole has been identified as having the highest rate of limiting long term illness in Bristol.

Around 19% of those living in South Bristol have poor mental health. Rates of depression and/or anxiety are high in South Bristol, with Bristol overall showing as higher than England average on all mental health and wellbeing prevalence indicators. All Bristol localities

experience a low conversion rate for mental health referrals and South Bristol has the highest rate of emergency admissions for self-harm in BNSSG, including for children and young people.

Geographically South Bristol is well placed to allow easy access to the city centre but benefits from having distinct, strong communities in its own right.

Primary Care Networks and Practices

South Bristol is made up of 14 GP practices grouped within three PCNs as follows:

Bridge View Medical PCN
Clinical Director – Dr Andrew Platt
Population – approximately 38,000

- A single practice/PCN model following the merger of a number of individual practices into Bridge View Medical. This practice operates across 5 sites.

Swift PCN
Clinical Directors – Dr Lesley Ward and Dr Kate Jones
Population – approximately 77,000

- Armada Family Practice
- Hillview Family Practice
- The Lennard Surgery
- Grange Road Surgery
- Bedminster Family Practice
- Hartwood Healthcare
- The Merrywood Practice
- Crest Family Practice

Connexus PCN
Clinical Directors – Dr Caroline Perkins and Dr Claire Rowell
Population – approximately 55,000

- Priory Surgery
- Birchwood Medical Practice
- Wells Road Surgery
- Stockwood Medical Centre
- Nightingale Valley Practice

ARRS Roles and the PCNs
South Bristol PCNs have recruited to and currently work with a number of roles employed via the ARRS route and are proud to offer strong support to staff working as part of friendly practice and PCN teams.

The PCNs have audited GP Mental Health presentations in South Bristol earlier in the year to help inform the MH practitioner role on offer, which the PCNs are very excited to be recruiting for.

Our South Bristol Vision and Shared Goals

Our vision (aspiration) as defined by our developing Integrated Care Partnership (ICP) is to deliver meaningful care and support that enables individuals and communities in South Bristol to optimise their own wellbeing.

Our Shared Goals

Starting with an individual and the community in which they live, we work together to:

- Understand the root causes of health inequalities and the wellbeing challenges that people of all ages, their families and communities face in South Bristol.
- Empower individuals, families and communities to identify and realise solutions to enhance their wellbeing.
- Enable individuals, families and communities to access information and help themselves via self-care or with simple, understandable and genuinely integrated community-based support where the person is at the centre of every decision
- 'Pull in' health, care and community expertise when it is needed.
- Ensure a powerful voice for the people of South Bristol in the wider BNSSG Integrated Care System.

In doing this, we seek to be OF the community, not just IN it.

Inner City & East Bristol

Name of Locality: Inner City and East Bristol

Population Overview:

The Inner City and East (ICE) Locality has a population of 167,181. The locality contains some of the most deprived areas in Bristol. 34% of Inner City and 11.7% East Bristol residents live in the 20% most deprived areas of Bristol with Lawrence Hill Ward is the 2nd most deprived ward in Bristol. In addition, 26% of children under 16 in Inner City and 15.7% in Bristol East live in low income families[2]. These socioeconomic determinants correlate with poorer health as expounded in the Marmot Review.

ICE has proportionately more young people and adults than Bristol overall. In contrast, the locality has the lowest BNSSG locality population of people aged 65+. The majority of new migrants to Bristol live in the Inner City areas of Bristol which are characterised by a high proportion of BME residents, a high proportion of rented accommodation, a high

proportion of non-family households and higher than average levels of unemployment. Evidence suggests that ethnicity is a key indicator of health inequalities[4].

Life expectancy for men in Bristol (78.8 years) is just below the England average of 79.5 years. For women life expectancy in Bristol (82.8 years) is broadly similar to the England average (83.1 years). Inner City Life expectancy is 77.7 years and 83.4 years for male and female respectively and in East Bristol is 78.8 and 82.2 for Male and Female respectively.

Inner City and East have the third highest rate of depression in Bristol in 2015-2016, with Bristol showing as higher than England average on all mental health and wellbeing prevalence indicators. All Bristol localities experience a low conversion rate for mental health referrals. East Bristol has a large student population. A 2017 survey by University of West England showed that over 60% of University West of England students reported having had lived experience of mental ill health and half of those respondents experienced problems whilst at University.

Within Inner City and East Bristol, alcohol attributable secondary care admissions are high. People who sleep rough tend to be located in central Bristol and will therefore more likely use service located in the centre. Bristol has an estimated 4943 heroin and/or crack cocaine users, which equates to approximately 16 in every thousand adults aged between 15 and 64. This rate per 1,000 is the highest of any England area. Whilst the proportion of Bristol residents using drugs is relatively small the impact can be extensive.

Primary Care Networks and Practices

FABB PCN Fishponds Family Practice, Air Balloon Surgery and Beechwood Medical Practice

FOSS PCN Fireclay Surgery and Old School Surgery

BIC, Bristol Inner City PCN, Wellspring Surgery, Charlotte Keel Medical Practice, Broadmead Medical Centre, East Trees Health Centre, Montpelier Health Centre, Lawrence Hill Health Centre, Homeless Health Service

Our Vision and Shared Goals

The vision for Primary Care in Inner City and East Bristol is to offer accessible, high quality, holistic, person centred care to all of its population.

North & West Bristol

Name of Locality: Affinity PCN- one of 4 PCNs in North & West Locality

Population Overview:

Affinity PCN has approx. 50,000 patients with a really interesting demographic. The PCN has some patients from the most deprived socioeconomic decile in the whole country, and others from the most affluent. We have the second highest population of elderly in Bristol. We also have a lot of young families.

It is a population with huge inequalities, so people living within one mile of each other can have a difference in life expectancy of approx. 10 years. Addressing inequalities in health is very important to our PCN.

Higher socioeconomic status is no guarantee good mental health though and there is a great need to improve the mental health offer to our local population across all practices.

Primary Care Networks and Practices

There are 4 PCNs in North &West Locality: Affinity, Northern Arc, Phoenix and Health West.

Affinity PCN
Clinical Director – Dr Jenny Eachus
Population – approximately 50,000
Currently 6 practices but the post holder would work across these 4 practices 38000 patients:

- Greenway Centre, Southmead
- Fallodon Way Medical Centre, Henleaze
- Westbury on Trym Surgery
- Sea Mills Surgery

Shared Vision for the PCN:

For our independent practices to work together and collaborate to provide a wider range of services for our population and to strengthen each other.

Our PCN core values:
To be **Honest and Trustworthy** (in our dealings between practices and outside our PCN)
To be **Collaborative**
To be **Supportive** (of one another)
To be **Creative and Innovative**
To be **Fair**

Name of Primary Care Network: Northern Arc- one of 4 PCNs in North & West Locality

Member Practices:

Pioneer Medical Group – practices in Brentry, Lawrence Weston and Avonmouth

Shirehampton Group Practice

Southmead and Henbury Family Practice - practices in Southmead and Henbury

Staffing:

Northern Arc PCN has full GP and nursing teams supported by PCN staff of 3.8 WTE social prescribers, a first contact physio, 1.2 WTE community pharmacists and a part time pharmacy technician.

Population overview:

Northern Arc PCN spans from Avonmouth up to Southmead. We have large pockets of deprivation with significant rates of mental illness.

We have 1% (approx. 420 patients) of our population with Significant Mental Illness, 0.5% of our population with a new diagnosis of depression in the last 12 months, 0.75% with a dementia diagnosis and 0.75% of patients on our learning disability registers

What you want to achieve with these new roles:

We have invested significant in our social prescribing team and the team is well established. It is currently supporting a large number of our patients with mental health conditions. The new ARRS role we hope to work closely with our GPs, Urgent Care Practitioners, Care Navigators and Social Prescribers to give additional help, support and appropriate input to our patients with unmet mental health needs in a timely fashion.

Name of Primary Care Network: Phoenix

Member Practices:

Horfield Health Centre
Gloucester Rd Medical Centre

Staffing:

We have a full complement of clinical and non- clinical staff. In addition to our directly employed clinical staff we also currently engage the following through the PCN:

- 3 FTE social prescribers including a services for children and young people, 2 care co–ordinators, 3 pharmacists, a pharmacy technician, a first contact physiotherapist and a nurse associate.
- We utilise extended roles within our core staff team for example with nurse prescribers and nurse specialists working alongside GPs
- We do not employ any mental health professionals currently

Population overview:

We have a very mixed population of almost 35,000 patients ranging across all ages and levels of deprivation. Gloucester Road's catchment includes an above average number of patients aged 18 – 50. Horfield's catchment includes deprived wards and has an above average prevalence of long term conditions. Patients do not necessarily have access to transport to travel freely across the PCN geography and may see services not being in walking distance as a barrier to engagement. Both practices have a significant number of students attending local universities registered with them. Both practices have a high number of mental health contacts.

PCN vision and priorities:

Our vision is to deliver excellent, coordinated and appropriate services to our patient population. We need the right people in our teams in order to provide this over the next 5 years we aim to recruit many ARRS staff (estates/space allowing) to help our patients' journeys.

Mental health defines a large proportion of our daily workload and we certainly feel that dedicated MH workers could alleviate some of these pressures and offer patients the service they need.

If this is successful we would hope to expand this in the future and also consider how holistically our social prescribers and care-co-ordinators support our overall approach to our patients mental health and well being

What you want to achieve with these new roles:

We have an increasing number of consultations regarding mental health, more so since the covid-19 pandemic. The referral times for Vitahealth and other counselling/CBT resources are currently too long. We are holding a lot of patients whilst they wait for ongoing support. We would like our MH workers to be able to signpost to appropriate services, pick up urgent/acute MH crises and refer on appropriately and to be able to offer low level CBT/counselling support whilst patients wait for other services

Any other relevant information:

We would like 2 MH workers across our PCN if/when that becomes possible. We are aware currently we are only allowed one per PCN < 10,000 patients

Name of PCN: Healthwest PCN- one of 4 PCNs in North & West Locality

healthwest
practices in partnership

Population Overview:

Healthwest PCN serves over 70,000 patients in the heart of Bristol.

We have a very varied patient population which includes the student body of the University of Bristol.

Primary Care Networks and Practices

There are 4 PCNs in North &West Locality: Affinity, Northern Arc, Phoenix and Health West.

Healthwest PCN
Clinical Director – Dr Lee Salkeld
Population – over 70,000
4 practices:

- The Students' Health Service
- Pembroke Road Surgery
- The Family Practice
- Whiteladies Health Centre

Shared Vision for the PCN:

Our 4 practices have fully embraced the PCN concept and have established teams of clinical pharmacists, first contact physios and social prescriber link workers. We have developed a prescribing centre and an IT hub. We are very enthusiastic to develop a similar team of mental health professionals to improve the care that we offer and reduce the barriers between different services and patients accessing care.

Our PCN has successfully administered nearly 40 000 Covid vaccinations.

We were the highest general practice recruiting research collaboration in the South West prior to Covid19.

We have learnt over the past 3 years that drawing on each other strengths and innovation can significantly improve the quality of care that we can offer to our patients and improve the sustainability of general practice.

North Somerset

Woodspring

Name of Locality: Woodspring

Population Overview:

Woodspring has a population of around 129, 223. Geographically, whilst 81.8% of residents live in urban towns and cities; 12.7% live in rural villages and dispersed, and 5.4% live in rural town and fringe. The demographic of the locality is older with fewer young children. 23% of the population is aged 65 and over, with a high proportion living with frailty in their own home. The health status of the population is generally better and many benefit from longer life expectancy. Even so about 17% report a long-term disability that limits day-to-day activities. Around 19% of the Woodspring population have a mental health code. 10% of the population have depression, whilst 1% have an eating disorder and 1% have dementia.

Woodspring has the low overall rates of ED, 111, IAPT and AWP adult outpatient activity within their Mental Health Cohort. Primary care activity, while typical for the whole population, is relatively high compared with the general low rates of activity for other points of delivery. This may be accounted for by relatively higher rates of anxiety, which typically results in presentation to primary care but with typically lesser need for secondary services. The proportion of ED attendances made up of high impact users is also the lowest of the ICPs (17.8%). Prevalence data shows Woodspring to have relatively low levels of typically 'complex' mental health cases.

Primary Care Networks and Practice:

Woodspring is covered by three Primary Care Networks (PCN), incorporating six main GP practices and six branch surgeries:

Tyntesfield PCN
Population – approx. 32,873
Clinical Director: Dr Sarah Pepper
Tyntesfield Medical Practice

Mendip Vale PCN
Population – approx. 45,295
Clinical Director: Dr Shruti Patel
Mendip Vale Practice

Gordano Valley PCN
Population – approx. 32,873
Clinical Director: Dr Karen Hathway (Dr Natasha Ward deputy)
Heywood Family Practice; Clevedon Medical Centre; Portishead Medical Group; Harbourside Family Practice

Our Vision and Shared Goals:

The Woodspring Integrated Group (WIG) are leading the development of an Integrated Care Partnership (ICP) Strategy for Woodspring.

The ambitions for a successful Integrated Care Partnership in Woodspring are to:

- Enable people to stay healthy, well and independent in the community
- Ensure equity of service across BNSSG, helping to address health inequalities. While there will be an overarching model of care, this will be flexed to adapt to locality communities, taking account of differences
- Work in an integrated way with partners across the system
- Develop resilience and sustainability in locality systems through a collaborative and comprehensive resilience programme working across system partners

Weston, Worle & Villages

Name of Locality: Weston, Worle & Villages

Population Overview:

The registered population is approximately 95,000 patients, 102,000 weighted.

All providers in the Locality, including third sector, are working together under the Healthy Weston Board and shadow Integrated Partnership Board ('*One Weston*') to transform health and social care services locally, to better service the needs of the population which includes areas of high deprivation and inequalities.

Primary Care Networks and Practice:

Pier Health Group is a Super Partnership and Primary Care Network of all 8 GP practices in Weston, Worle and Villages Locality.
Our organisation is a 'coalition of the willing' and we are here to make a difference alongside other providers by empowering our teams to work collaboratively together, designing new roles and encouraging new ways of working to join up and enhance service offerings to our patients.

- 168 Medical Group
- Tudor Lodge Surgery
- The Cedars Surgery
- The Milton Surgery
- Stafford Medical Group
- Winscombe & Banwell Family Practice
- Pier Health Group Limited
- *(includes Graham Road Surgery and Horizon Health Centre)*

The PCN collaborates with three other PCNs in North Somerset and a number of innovative new services have been developed in our Locality and expanded to the wider population of North Somerset. E.g. Acute Frailty Virtual Ward Rounds, High Impact Users service.

Our Vision and Shared Goals:

We have created our leadership and vision for the PCN and we seek to develop successful working partnerships with fellow providers to transform local services and care pathways for our patients using a holistic approach.

The Integrated Care Partnership Board of all local providers meets monthly and are focussed on understanding the needs of the population and requirements for future integrated care service provision. Together, they have agreed priorities to fast-track transformation in two key areas: community mental health support, and frailty, with service delivery planned from April 2022.

Co-design of services is in progress with contributions from our patients with lived experience and we are working to ensure community support services and social prescribing can be joined up to enhance the offering to patients.

The expectation is that from April 2022, 'One Weston' will be designated the ICP for this Locality, with delegated budgets as appropriate to care for the population.

South Gloucestershire

Name of Locality: South Gloucestershire

Population Overview:

South Gloucestershire is a large Locality of 282,644 residents served by 23 GP practices that operate as five PCNs, three of whom are looking to recruit a mental health practitioner role at this time.

Key challenges include higher than average rates of both alcohol-related and self-harm related hospital admissions, and higher numbers of over 65s emergency admissions due to falls, particularly for those age 80+.

Primary Care Networks and Practices:

4PCN

Working with Southern Brooks and Second Step to employ Mental health care navigators/social prescribers who will be a first contact point for patients with mental distress. The team will involve GPs, Physicians associates and Mental health navigators together with this role and patients will be identified at first contact and triaged to the right

person. This role would oversee this team across the four practices and carry a case load, seeing and care planning a number (to be agreed) of their own complex patients. We see them also as the access point to PCLS and Recovery team and the wider MH team in South Gloucestershire. An important role that finally may synchronise mental health care across our PCN and improve outcomes for the mentally ill and the mentally distressed

The Stokes PCN – *Clinical Director: Dr Peter Young*
The Stokes PCN Board comprises of a Practice Manager, a GP Partner plus the PCN Manager. Under the Additional Roles scheme we have employed four Clinical Pharmacists, four Pharmacy Technicians, Social prescribers, a Paramedic and are looking to recruit further roles over the next 12 month period. Through recruitment of this role we are looking to support our patients and their mental health, helping them to feel empowered and to make healthy choices with regard their wellbeing.

Severnvale PCN – *Clinical Director: Dr Greg Clarke*
Severnvale has a relatively old population, and we are keen to improve the mental health support available to them. We also wish to focus on patients experiencing Serious Mental Illness, and on high intensity users who are currently not having their care needs met. We are a small PCN with a friendly and welcoming team.

Yate & Frampton PCN – *Clinical Director: Dr Sam Davies* - *not participating in this round*

Network 4 PCN – *Clinical Director: Dr Richard Berkley*
Network 4 Primary Care Network is made up of 4 practices in South Gloucestershire; Downend Health Group, Green Valleys Health, The Orchard Medical Centre, and Three Shires Medical Practice and together serve a population of approximately 69,000 patients. We are committed to providing high-quality personalised care for our population and working collaboratively with partners across the Integrated Care System. We are invested in recruiting a team of Mental Health Practitioners to work across our network practices as we know that anxiety and depression is one of the most prevalent conditions in our PCN. We also want to be able to better support patients in General Practice who have severe mental illness and on high intensity patients who are currently not having their needs met.

Our Vision and Shared Goals:

Our vision is to l build a new approach to leadership: one that will be collaborative, effective, responsive, and safe, and that has ownership by our wider stakeholders, partners and local people. Through this we will work together to promote healthier living and to empower patients to make healthy choices.