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Date: 6 February 2024

Dear Sir or Madam

The Health and Wellbeing Board – Wednesday, 14 February 2024, 2.00 pm – The Campus, Highlands Lane, BS24 7DX

A meeting of the Health and Wellbeing Board will take place as indicated above.

The agenda is set out overleaf.

Yours faithfully

Assistant Director Legal & Governance and Monitoring Officer

To: Members of the Health and Wellbeing Board

Georgie Bigg, Jeremy Blatchford, Paula Clarke, Kirstie Corns, Ros Cox, Emma Diakou, Mandy Gardner, Catherine Gibbons, Mark Graham, John Heather, Jenna Ho Marris (Chair), David Jarrett, Matt Lenny, David Moss, Sarah Pepper, Stephen Quinton, Julie Sharma, Dan Thomas, Helen Thornton, Joe Tristram, Sarah Truelove (Vice-Chairperson), Hayley Verrico and Roger Whitfield.

This document and associated papers can be made available in a different format on request.

Agenda

1. Public participation (Standing Order 17)

To receive and hear any person who wishes to address the Committee. The Chairperson will select the order of the matters to be heard. Each person will be limited to a period of five minutes. Public participation time must not exceed thirty minutes.
Requests to speak must be submitted in writing to the Assistant Director Legal & Governance or the officer mentioned at the top of this agenda letter, by noon on the working day before the meeting and the request must detail the subject matter of the address.

2. Apologies for absence and notification of substitutes

3. Declaration of disclosable pecuniary interest (Standing Order 37)

A Member must declare any disclosable pecuniary interest where it relates to any matter being considered at the meeting. A declaration of a disclosable pecuniary interest should indicate the interest and the agenda item to which it relates. A Member is not permitted to participate in this agenda item by law and should immediately leave the meeting before the start of any debate.
If the Member leaves the meeting in respect of a declaration, they should ensure that the Chairperson is aware of this before they leave to enable their exit from the meeting to be recorded in the minutes in accordance with Standing Order 37.

4. Minutes 011123 (Pages 5 - 8)

Minutes of the Health and Wellbeing Board Meeting on 1 November 2023, to approve as a correct record.

5. Matters referred by Council, the Executive, other Committees and Panels (if any)

None.

6. Joint Health and Wellbeing Strategy (Pages 9 - 34)

7. Healthwatch Report- Time to think differently about Adult Social Care (Pages 35 - 74)

8. Weston Worle and Villages and Woodspring Localities updates (Pages 75 - 80)

9. BNSSG Integrated Care System All Age Mental Health and Wellbeing Strategy (Pages 81 - 120)

10. Pharmaceutical Needs Assessment and Consultation Response (Pages 121 - 136)

11. Work Plan - Draft forward plan for HOSP and HWBB engagement (Pages 137 - 138)

Exempt Items

Should the Health and Wellbeing Board wish to consider a matter as an Exempt Item, the following resolution should be passed -

"(1) That the press, public, and officers not required by the Members, the Chief Executive or the Director, to remain during the exempt session, be excluded from the meeting during consideration of the following item of business on the ground that its consideration will involve the disclosure of exempt information as defined in Section 100I of the Local Government Act 1972."

Also, if appropriate, the following resolution should be passed –

"(2) That members of the Council who are not members of the Health and Wellbeing Board be invited to remain."

Mobile phones and other mobile devices

All persons attending the meeting are requested to ensure that these devices are switched to silent mode. The chairman may approve an exception to this request in special circumstances.

Filming and recording of meetings

The proceedings of this meeting may be recorded for broadcasting purposes.

Anyone wishing to film part or all of the proceedings may do so unless the press and public are excluded for that part of the meeting or there is good reason not to do so, as directed by the Chairman. Any filming must be done as unobtrusively as possible from a single fixed position without the use of any additional lighting, focusing only on those actively participating in the meeting and having regard to the wishes of any members of the public present who may not wish to be filmed. As a matter of courtesy, anyone wishing to film proceedings is asked to advise the Chairman or the Assistant Director Legal & Governance and Monitoring Officer's representative before the start of the meeting so that all those present may be made aware that it is happening.

Members of the public may also use Facebook and Twitter or other forms of social media to report on proceedings at this meeting.

Emergency Evacuation Procedure

On hearing the alarm – (a continuous two tone siren)

Leave the room by the nearest exit door. Ensure that windows are closed.

Last person out to close the door.

Do not stop to collect personal belongings.

Do not use the lifts.

Follow the green and white exit signs and make your way to the assembly point.

Do not re-enter the building until authorised to do so by the Fire Authority.

Go to Assembly Point C – Outside the offices formerly occupied by Stephen & Co

Agenda Item 4

North Somerset COUNCIL

Minutes

of the Meeting of

The Health and Wellbeing Board
Wednesday, 1 November 2023

For All Healthy Living Centre, Weston-super-Mare

Meeting Commenced: 2.00 pm Meeting Concluded: 3.03 pm

Board Members:

Cllr Jenna Ho Marris (Chair)
Georgie Bigg
Jeremy Blatchford
Paula Clarke
Kirstie Corns
Emma Diakou
Mandy Gardner
Catherine Gibbons
Mark Graham
Matt Lenny
Joe Tristram
Hayley Verrico
Roger Whitfield

Apologies: Colin Bradbury (Vice-Chairperson) Carolyn Fair, John Heather, David Moss, Stephen Quinton, Julie Sharma, Dan Thomas and Helen Thornton.

Officers in attendance: Gerald Hunt, Georgie MacArthur (North Somerset Council); Anna Freyer? .

16 Declaration of disclosable pecuniary interest (Standing Order 37)

None.

17 Minutes

Resolved: that the Minutes of the last Board meeting held on 24 August 2023 be approved as a correct record.

18 Health and Wellbeing Board Terms of Reference and Membership update

Members received the report proposing an amendment to the Health and Wellbeing Board Terms of Reference (ToR).

Resolved: that the ToR be amended such that the Executive Member for Adult Services and Stronger Communities be added list of designated Members of the

Board.

19 Proposal for new Operations Group

The Director of Public Health presented the report proposing the establishment of a new Operations Group to better coordinate collaboration between the Health and Wellbeing Board and the Locality Partnerships.

Resolved: that the proposal to establish an Operations Group be adopted and the Board's ToR be revised accordingly.

20 Joint Health and Wellbeing Strategy Update and Draft North Somerset Mental Health Strategy

The Consultant in Public Health presented the report which included: proposals for review by the Board regarding allocation of funding aimed at improving Mental health and oral health and an overview of the updated draft North Somerset Mental Health Strategy, for review and feedback.

Members commented or sought assurance on the following issues:

- Challenges around access to children's dental services - The Director of Public Health confirmed the Integrated Care Board (ICB) were working in partnership with providers to put together an improvement plan. He referred to a recent detailed report to the Health Overview and Scrutiny Panel setting out further details and agreed to circulate a copy for information.
- Services for refugees/asylum seekers – The Director of Public Health acknowledged the challenges giving assurance that work was underway with the ICB towards establishing a common approach across BNSSG.
- Anecdotal link between child obesity and poor dental hygiene – officers confirmed that parent support was available via schools but that this was targeted at areas of greatest need.
- Link between housing needs and mental health – Members' comments included: concern that the £40k allocated for support was limited and more work was needed around prevention; and concern that focus should not be limited to mental health (physical health as well).
- Need for specific reference in the proposals to mental health support targeted at older people.
- Better utilising communities to support early intervention.
- The need to include hearing loss as a significant factor contributing to social isolation and challenges around dementia.

Resolved:

(1) that progress in implementing the joint Health and Wellbeing Strategy be noted;

(2) that Members' feedback be provided to officers in the form of the minutes;

(3) that the proposal for extended capacity to implement oral health programmes for children and young people to complete strategy actions be

approved;

(4) that the allocation of funding for Phase 2 workstreams (adult mental health and children and young people's mental health) be approved; and

(5) that suggestions for the foundation structure of the next Joint Local Health and Wellbeing Strategy 2024-2028 be noted.

21 Development of the Joint Forward Plan

The ICB Programme Delivery Manager presented the report outlining the background to, and process for, the development of the Joint Forward Plan (JFP).

It was noted that this iteration of the JFP needed to be published on 28th March 2024 and feedback was invited by Members, particularly in respect of better integrating existing local strategies and plans whilst also addressing wider system ambitions and universal NHS commitments.

In discussion, feedback included:

- The potential for the Board's Operations Group to coordinate planning.
- Emphasis on the strengths of Health and Wellbeing Strategy's place-based approach to locality planning and opportunities for the Operations Group to reinforce and integrate this approach within the JFP.
- The need to ensure the JFP was accessible and understandable for the general public.

In concluding discussion, the ICB Programme Delivery Manager confirmed that following feedback, an updated version of the detailed Plan would be circulated in January and, noting comments about the need to make this more accessible, a "visual format" of the plan would also be produced.

Resolved: that the report be noted.

22 Better Care Fund

The Assistant Director of Commissioning, Partnerships and Housing presented the report proposing delegated arrangements for the approval of the Better Care fund Quarter 2 performance report.

Resolved: that approval of the Quarter 2 Better Care Fund performance report be delegated to the Chair of the Health and Wellbeing Board.

23 Weston Worle and villages, Woodspring localities updates

The Head of Locality, Woodspring, presented the report outlining the headline plans and the work that the ICB localities in Weston Worle and Villages and Woodspring participated in and how this work was being conducted with partners

to ensure alignment across North Somerset whilst also identifying the needs of the population within each locality, working closely with lived experience representatives.

Resolved: that the report be noted.

24 HWB Work Plan

In updating Members, the Director of Public Health reported that the Board's work plan was still in development, noting the need to align it with the Council's 2024-2028 Corporate Plan which was due to be published in the new year. He said the Board's work plan would be presented to the next meeting of the Board in February 2024, possibly as an appendix to the Board's Terms of Reference.

He also encouraged Members to consider appreciative inquiry topics for future Board meetings and submit suggestions at the appreciative inquiry following this meeting - or submit them by email.

Resolved: that the update be received.

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Chairman

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North Somerset Council

REPORT TO THE HEALTH AND WELLBEING BOARD

DATE OF MEETING: 14 February 2024

SUBJECT OF REPORT: Joint Health and Wellbeing Strategy

TOWN OR PARISH: All

OFFICER PRESENTING: Dr Georgie MacArthur, Consultant in Public Health

KEY DECISION: No

REASON: Paper for information and discussion.

RECOMMENDATIONS:

The Health and Wellbeing Board are invited to:

- Consider and endorse proposals for the overarching structure in development for the next Joint Local Health and Wellbeing Strategy 2024-2028.
- Consider and approve minor changes to delivery of actions in the current Joint Health and Wellbeing Strategy and a proposal for funding of additional capacity to support development of the next strategy.
- Note the progress report.

1. SUMMARY OF REPORT

This report aims to summarise status regarding development of the next Joint Local Health and Wellbeing Strategy 2024-2028 and to provide an opportunity for the Health and Wellbeing Board to input into, and shape, its development. The Health and Wellbeing Board are also invited to approve funding for additional capacity to support development of the next strategy.

2. DETAILS

2.1. Development of the next Joint Local Health and Wellbeing Strategy 2024-2028

As previously described, it is intended the structure of the next Health and Wellbeing Strategy be similar to that of the current version, but updated to ensure a strong focus on reducing health inequalities and addressing all determinants of health. The structure is outlined further below.

Proposed vision:

Working together to ensure equality of opportunity for everyone in North Somerset to start, grow up, live, work, age and die well and to enjoy good wellbeing and health.

Approaches:

(i) **Prevention**: We will ensure children have the best start in life and focus on preventing health and wellbeing problems throughout the lifecourse.

(ii) **Early intervention**: We will improve outcomes by intervening as early as possible to address any health and wellbeing-related needs experienced during people's lives.

(iii) **Holistic action and support**: We will implement person-centred action on the social, economic and environmental determinants of health.

(iv) **Healthy and caring communities**: We will empower people and communities to be connected, healthy and resilient through strengths-based approaches, engagement and involvement.

(v) **Tackling inequalities:** We will prioritise action to ensure equality of opportunity in access to services, experience and outcomes to reduce inequalities between groups.

Priority topics will include, as previously:

- Mental health (including mental health and wellbeing, suicide prevention, self-harm, social isolation and loneliness, and trauma-informed practice)
- Food, nutrition and oral health (to address the spectrum of food and diet-related ill-health, including eating disorders)
- Tobacco dependence
- Drug and alcohol use
- Being active
- Healthy places and communities (wider determinants of health e.g. employment and skills, education, housing quality, climate change, discrimination, violence, community safety etc).

The guiding principles will be as previously, with one addition proposed, further to feedback obtained, around using trauma-informed and compassionate approaches to wellbeing and health.

1. Partnerships and collaboration
2. A focus on inequalities
3. Taking a place-based approach
4. Using data, intelligence and insight to drive decision-making
5. Taking action across the lifecourse
6. Empowering people and communities and building on local strengths
7. Using trauma-informed practice and compassionate approaches to improving wellbeing and health.

The action plan will be structured by priority topic, ensuring that actions address each of the five approaches. Where appropriate, actions will directly mirror those in the North Somerset Council Corporate Plan 2024-2028 (to be published later in 2024) to ensure synergy.

Priority topics are also consistent with commitments in the BNSSG Integrated Care System Strategy and actions will reflect system-wide workstreams e.g. regarding tobacco dependence and healthy weight. The latter, for instance, includes a more compassionate approach to considering health benefits from eating well and we aim to implement such an approach in North Somerset through the next strategy.

2.2. Consultation and Engagement

In agreement with the Health and Wellbeing Strategy Oversight Group, it is proposed that findings of recent consultation programmes should be used as much as possible, to avoid duplication with recent consultation and engagement. As such, recent contributions from members of the public and stakeholders have been collated and synthesised to identify key themes. In addition, a programme of consultation is being developed and implemented, which will include consultation with: North Somerset Council Members, Leadership Teams, and Officers; equalities groups, primary care practice groups, Locality Partnerships, Town and Parish Councils, and representatives of the VCFSE sector including the VANS Leaders Forum, Wellbeing Collective, and North Somerset Together. Consultation will take place between February and April. We will also seek public consultation on the draft strategy in the summer.

2.3. Monitoring, Evaluation and Reporting

Looking ahead, a slight alteration to the monitoring and reporting approach is proposed. First, the dashboard is being updated so that it is consistent with other North Somerset Council reporting dashboards. It will now feature outcome data and the RAG rating around progress, with commentaries being reviewed and synthesised internally for reporting to the Health and Wellbeing Board. It is also intended that reporting be fully outcome-focused based on data available via the Public Health Outcomes Framework, local surveys and/or reporting of data from service providers or project leads themselves. Reporting to the Board may therefore be quarterly, six-monthly or annual, depending on the measure and availability of data in question. The evaluation framework will be set during development of the strategy in 2024.

2.4. Support for strategy development

Since development of the strategy requires dedicated capacity, it is proposed that underspend in the Health and Wellbeing Strategy budget be used to fund a secondment (North Somerset Council, level 7) for 0.4WTE for 6 months at an indicative cost of £10K. The postholder would also support with organisation of a dedicated workshop to celebrate the achievements of the current Health and Wellbeing Strategy.

- The Health and Wellbeing Board are invited to state whether they approve of this proposal.

2.5. Delivery of the Joint Health and Wellbeing Strategy action plan.

The latest update of strategy implementation for 2023-24 Q2, is outlined below.

Table 1. Summary of progress in implementing Health and Wellbeing Strategy actions in 2023-24 Q1.

	Q1	
Status	**Actions (n)**	**Actions (%)**
Completed	5	7
In-Progress	24	33
In-progress	35	49
In-progress (but delayed) or Not Started	9	13
Total	73	100

A snapshot of feedback and impact-related data from selected projects is outlined in Appendix 1. Mitigation or changes in place regarding the minority of actions where challenges have been met are summarised in Appendix 2. For one action which is not able to progress ('We will reduce short term harms relating to alcohol misuse by working more effectively with licensed premises to reduce risk for: hospital admission, impact on young people and feeling of safety in the town centre'), it is proposed that £5K of the funding is repurposed and committed to the Knife Angel project, which aims to address knife crime and improve community safety; retaining a further £8K for alcohol-related work. Funding would contribute to supporting the overall project, which will include a range of projects and events, such as sessions with young people, first aid skills development, and medical training for night-time economy venues.

In relation to phase 2 workstreams:

(i) Mental health and wellbeing among children and young people

Off the Record have recruited a Wellbeing Practitioner to deliver the two groups: MindAid, which aims to tackle anxiety and low mood; and Shameless, which focuses on body image. Forty young people have engaged with these groups and half reported positive outcomes. Feedback obtained demonstrated '*my mood improved, I have some ideas how to feel better when I feel low*'.

Funding for the projects approved regarding mental health among adults will be mobilised during 2024.

(ii) Physical activity

The launch event for ‘Get Active – a Physical Activity Strategy for North Somerset’ was held on 29th January 2024. Further feedback on the action plan was gathered at the event and the first physical activity strategy steering group meeting will take place in early March 2024.

The steering group will have responsibility for delivery of the action plan and in April 2024, the group plans to submit proposals to the Health and Wellbeing Strategy Oversight Group highlighting planned use of the phase 2 funding of £80,000, to support delivery of key actions included within the action plan. Approval for projects from the Health and Wellbeing Board will be sought in the next meeting.

(iii) Children and young people and risk

As previously approved by the Health and Wellbeing Board, this work will focus on children and young people who are vulnerable to harm from outside of their home, such as exploitation and gangs, which will be led by the Multi-Agency Safeguarding Partnership sub-group. The aim of the work is to ensure all children and young people who are known to, or coming into contact with, multiple professionals get a consistent approach and that no information about their lives is overlooked. This will enable multi-agency planning to be co-ordinated to ensure the most appropriate support is offered. The Adolescent Safeguarding Framework is a holistic approach that ensures consistent pathways to assessment, support and safety for individual children as well as a clear multi-agency response to contexts of harm including their school, peers and their communities. This workstream will involve training to support practitioners with this new framework and approach, thus equipping them with knowledge, skills and confidence to offer high quality intervention. Details and costs are being finalised and the work will be taken forward through 2024.

1. FINANCIAL IMPLICATIONS

Funding of certain phase 2 workstreams has been delayed due to limited capacity, however, projects can continue through implementation of the next strategy. Any funding for implementing the next strategy, from underspends to date or any other sources, will be subject to a funding process to be implemented once the action plan has been developed. This will be presented to the Health and Wellbeing Board for approval.

The cost of a short-term post to support development of the Health and Wellbeing Strategy, proposed in this paper, is approximately £10K.

2. CLIMATE CHANGE AND ENVIRONMENTAL IMPLICATIONS

The next joint local Health and Wellbeing Strategy will include actions regarding climate change. We will work with providers of services to ensure that impacts on the climate are considered and are limited as far as possible.

3. RISK MANAGEMENT

Delivery and implementation of the strategy and action plan is overseen by the Health and Wellbeing Board, and risks to delivery of this work will be identified to the Board for discussion and resolution.

4. EQUALITY IMPLICATIONS

All projects and proposed workstreams aim to tackle inequalities in health.

5. CORPORATE IMPLICATIONS

The next Health and Wellbeing Strategy will represent actions in the forthcoming Corporate Plan and the overarching vision of being Open, Fair and Green.

AUTHOR

Dr Georgie MacArthur, Consultant in Public Health

REFERENCES

N/A

APPENDICES

Appendix 1: Recent examples of reach, outcomes and/or feedback from ongoing Health and Wellbeing Strategy projects.

Theme	Organisation and project	Feedback
Food and nutrition	North Somerset Council, Weight Management Services	Six 12-week groups have been delivered in local community venues – uptake has been very good and positive feedback received. 196 clients are currently engaged with the Healthy Lifestyles Advisors Service. The Lose Weight tier 1 and 2 information and offers of support have been promoted via betterhealthns.co.uk and the website had over 52,000 views in Jan to Dec 2023.
Oral health	North Somerset Council, oral health promotion	Toothbrush Pack distribution project – over 1,000 children have received packs and 150 reception children have received oral health education. The regional supervised toothbrushing scheme for early years settings has been mobilised and 41 settings have been identified as eligible. Eight training sessions have been delivered to 57 professionals, and approximately 130 professionals have been trained through organisation team meetings/training days. The team have spoken to over 2,000 children and approximately 100 parents/carers about oral health.
Physical activity	North Somerset Council, Health Walks and Parkplay	Parkplay, health walks and new programmes for people with long-term conditions are being delivered. A total of 2,028 individuals attended Health Walks in 2023/24 Q2 alone. For ParkPlay, in total, 537 individuals have registered with 92 attending at least one ParkPlay session.
	Age UK, Physical activity classes for older adults.	A total of 2,864 visits were recorded in Q2, with throughput in Q1&2 combined being 5,101. There are a total of 24 ageing well exercise classes available across North Somerset. *“The lady who does it is very friendly and I leave the class feeling somewhat lighter.* *I am pleased i could do it at my age*

		I think it is actually helping my knee, and my balance is getting better too"
Mental health	Training and community grants	162 people have received mental health training. 35 community grants were funded in 2023/24 (£88K of funding) and the evaluation reports an improvement in outcomes. In 23/24 Q2, 82 people engaged with these projects.
	Holiday playschemes for children (aged up to 5 years) with additional needs	The Summer Play Scheme for young children with Special Educational Needs and/or Disabilities (SEND), led by Springboard Opportunity Group, was delivered successfully across Springboard bases for the first two weeks of the school summer holiday. Data collected and feedback from parents shows that parents' anxieties about the long summer break were reduced as a result of their children having the opportunity to attend. Parents also reported that their happiness increased as a result of seeing their children thrive in Springboard's specialist SEND play scheme. From multiple case studies, parents generally feel their children have become more interactive with other children, and that their confidence and communication skills have increased.
	Reclaim counselling	Reclaim offers free counselling and therapeutic support for people who have been affected by domestic abuse. Adults receive ten sessions, while children and young people receive 15 sessions. In the last quarter, 77 individuals were seen by the service. Over the year, 147 people have received and are currently receiving counselling. Feedback from one client highlighted that the impact was '*extremely beneficial'*.
Drug and alcohol use		Focus on specific areas of activity to increase engagement and improve treatment and care, led by the North Somerset Drug and Alcohol Partnership, has improved outcomes, as outlined below.

Outcome measure	Year	Trend
Percentage of people in treatment who complete successfully & do not have acute housing problems	2022/23	↓
Continuity of care for prison leavers (percentage)	2022/23	↓

		Increased engagement of non-opiate prison leavers with identified treatment need (percentage) 2022/23 ↑ Numbers in treatment (adults) 2022/23 ↑ Numbers in treatment (YP) 2022/23 ↑ *"I'm able to have a relationship with family now."* *"[Treatment] changed my life."* *"it has built [my] confidence and self-esteem"*
Wider determinants of health	Workplace health	Eight workplaces are enrolled in the Healthy Workplaces scheme, meaning a reach of 10,360 employees. Two workplaces have reached the Bronze Award. The network is growing with 115 on mailing list and engaged with 98 different businesses.
	Warm homes (WHAM: warmer homes, advice and money)	In total during 2022-23, 295 households were provided with in-depth advice with £155,192 household savings evident in the quarter and £526 average financial impact per household. Overall, 66% percent of clients were aged over 50 years old and 32% of clients were living with a physical disability; 10% reported a mental health condition. 34.5% of clients were in receipt of work-related or disability-related benefits.

Table A1. Actions where progress has been delayed and next steps to progress implementation.

Action	Detail and mitigation
We will develop a food award programme for food businesses to improve the quality and sustainability of food offered to local residents.	The capacity required for this action has not been available to date, as originally anticipated. However, an options appraisal is underway focused on where we can best invest capacity and resource to bring about the best outcomes for our population to enable a healthy diet. This options appraisal includes how we can work with partners across the ICS to enable healthy eating.

We will review all policies in light of health and wellbeing among partners of the Health and Wellbeing Board, sign up to the Local Authority Declaration on Healthy Weight, Sugar Smart and review advertising and planning policies.	There is now scope and capacity in the public health team for 2023-24 to consider opportunities to take this action forward working as a system. Progress is therefore anticipated in 2023-24 and 2024-25, for instance relating to the Declaration on Healthy Weight.
We will undertake a review of 'Health in All Policies' across Health and Wellbeing Board partners.	Capacity has not been available to deliver this action. The action is likely to be included in the next strategy.
We will refresh our tobacco control plan.	The tobacco control plan will be refreshed following partnership working with BNSSG ICS to ensure it fits with system priorities and action.
We will reduce short term harms relating to alcohol misuse by working more effectively with licensed premises to reduce risk for: hospital admission, impact on young people and feeling of safety in the town centre. (Phase 1)	Service pressures have meant that the project has not commenced. It is proposed that part of the funding be re-purposed to support the Knife Angel project, which would support related community safety outcomes.
We will improve understanding of the health and wellbeing of taxi drivers to identify interventions needed to help promote and improve their health and wellbeing. (Phase 1)	Training for taxi drivers has been implemented. Staff changes meant that leadership for this project is not available. As such funding has been returned for re-purposing in the next strategy.
We will evaluate the impact of inclusion of social value-related health and wellbeing measures in new contracts.	Staff changes mean that this full evaluation has not been completed. However, social value health and wellbeing measures are included as standard.

Joint Health & Wellbeing Strategy 2021-2024

Health and Wellbeing Board
February 2024

Summary

The Health and Wellbeing Board are invited to:

- Consider, discuss and endorse proposals for the overarching structure of the next Joint Local Health and Wellbeing Strategy 2024-2028

- Consider and approve proposals for funding

- Note the quarterly progress report

1. Joint Local Health and Wellbeing Strategy 2024-28

Developing the next strategy

- Aim to build on existing structure, style, approaches and priorities

Gantt Chart (overview)

	2023-24						2024-25							
ACTION	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**
1. SCOPING														
Planning design, scope, output	■	■												
Strategic links	■	■												
Exemplar strategies	■	■	■											
2. ASSESSMENT OF NEED														
Our Future Health	■	■												
NS JSNA and HNAs	■	■	■	■	■									
NS survey data				■	■	■	■							
3. SUMMARY OF ENGAGEMENT														
Existing community engagement	■	■	■	■										
Targeted engagement			■	■	■	■	■							
Stakeholder engagement			■	■	■	■	■							
4. DRAFTING AND ACTION PLANNING														
Principles, ambitions, objectives		■	■	■	■	■	■							
Action planning					■	■	■	■	■	■				
Monitoring and evaluation plan					■	■	■	■	■	■				
Draft strategy						■	■	■	■	■	■			
Design and typesetting										■	■			
5. CONSULTATION														
Pre-consultation approval										■	■			
Public consultation											■	■		
Post-consultation update													■	
Approval by HWB Board													■	■

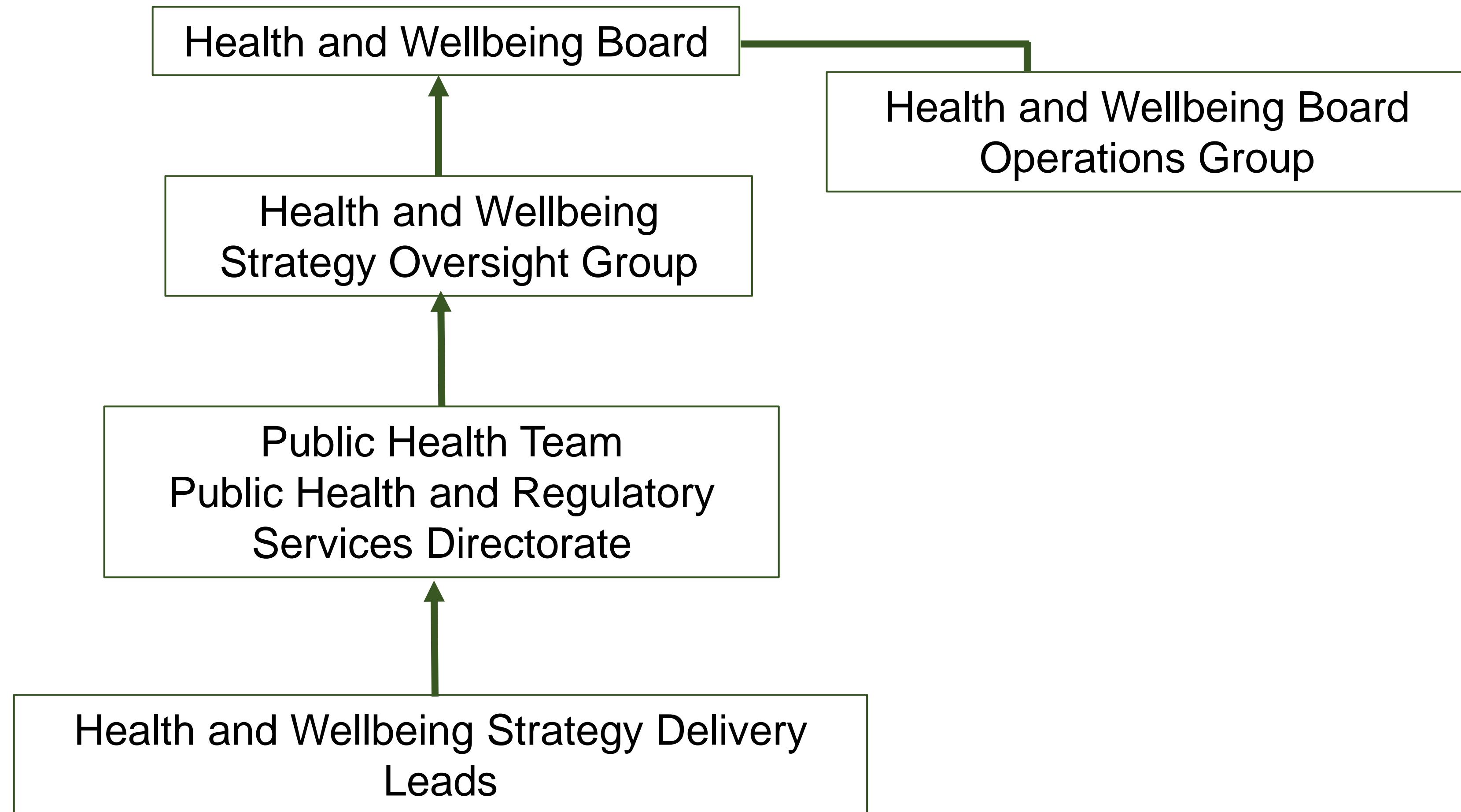
Approaches:

Approach	Description
Prevention	We will ensure children have the best start in life and focus on preventing health and wellbeing problems throughout the lifecourse
Early intervention	We will improve outcomes by intervening as early as possible to address any health and wellbeing-related needs experienced during people's lives
Holistic action and support	We will implement person-centred action on the social, economic and environmental determinants of health
Healthy and caring communities	We will empower people and communities to be connected, healthy and resilient through strengths-based approaches, engagement and involvement
Tackling inequalities	We will prioritise action to ensure equality of opportunity in access to services, experience and outcomes to reduce inequalities between groups

Vision e.g.: *Working together to ensure equality of opportunity for everyone in North Somerset to start, grow up, live, work, age and die well and to enjoy good wellbeing and health*

Starting and growing up well, Living well, Ageing well, Dying well

Governance Structure



Next steps

- Consultation with a range of groups and forums
  - Reporting and feedback of what we have heard and how this has impacted on strategy development

- Pooling and synthesis of data, intelligence and insight from existing sources

- Development of underlying structure and drafting of strategy and action plan

- Development of monitoring and evaluation plan
  - Propose quarterly, 6-monthly or annual outcome reporting, depending on the measure in question and data source
  - Quarterly reporting RAG rating only with commentary for internal review and use in deep-dive/ topic-specific reports to the Health and Wellbeing Board
  - Reports to the Health and Wellbeing Board for the next strategy to be topic focused and in-depth, including qualitative feedback

2. Progress Report 2023-24 Q2

Progress update 2023-24 Q2 (phase 0 and 1)

Status	2023/24 Q2	
	Number	Percentage (%)
Completed	5	7
In-Progress (Green/Green-Amber)	24	33
In-progress (Amber)	32	44
In-progress (Amber Red) or Not Started (Red)	11	15
No update	1	1

N.B. Previously completed actions not counted in this quarter as completed actions are closed.

Actions delayed/ not started

Action	Challenge & solution
Develop food award programme for food businesses	Capacity required has not been available, as anticipated. Options appraisal underway regarding healthy weight interventions and ICS programme being initiated
Review policies in light of health and wellbeing among members of the HWB board, sign up to LA declaration on healthy weight and review advertising and planning policies. We will undertake a review of 'Health in all Policies' across Health and Wellbeing Board partners	Significant delay but new capacity in place; plans to take forward Healthy Weight Declaration in 2024 alongside ICS workstream. To be included in next strategy.

Actions delayed/ not started

Action	Detail
We will refresh our tobacco control plan	To be actioned in line with partnership working with BNSSG ICS
We will reduce short term harms relating to alcohol misuse by working more effectively with licensed premises to reduce risk for: hospital admission, impact on young people and feeling of safety in the town centre. (Phase 1)	Service pressures have meant that the project has not commenced. Suggestion to re-purpose funding to Knife Angel project which has outcomes relating to community safety.
We will improve understanding of the health and wellbeing of taxi drivers to identify interventions needed to help promote and improve their health and wellbeing. (Phase 1)	Staff changes meant that leadership for this project was not available. £5K budget to be used in next strategy
We will evaluate the impact of inclusion of social value-related health and wellbeing measures in new contracts	Staff changes mean that this full evaluation has not been completed. However, social value health and wellbeing measures are included as standard.

Capacity – proposal for funding

Proposal for enhanced capacity to support development of the Health and Wellbeing Strategy 2024-2028

- Fixed-term support for development of the next strategy
- 0.4 WTE, level 7
- Indicative cost £10K

Proposal to re-purpose funding from action '*We will reduce short term harms relating to alcohol misuse by working more effectively with licensed premises to reduce risk for: hospital admission, impact on young people and feeling of safety in the town centre'*

- Fund Knife Angel project which aims to address knife crime and community safety
- A range of projects and events planned, sessions with young people, first aid skills development, medical training for night-time economy venues.

The Health and Wellbeing Board are invited to:

- Consider, discuss and endorse proposals for the overarching structure of the next Joint Local Health and Wellbeing Strategy 2024-2028

- Consider and approve proposals for funding

- Note the quarterly progress report

Thank you

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With thanks to:
Health and Wellbeing Strategy Action Plan Delivery Leads
Health and Wellbeing Strategy Oversight Group

North Somerset Council

Report to the Health and Wellbeing Board

Date of Meeting: 14 February 2024

Subject of Report: Healthwatch Report: Time to think differently about Social Care

Town or Parish: All

Officer/Member Presenting: Georgie Bigg, Chair, Healthwatch Bristol, North Somerset and South Gloucestershire

Key Decision: No

Reason: It does not meet the criteria for a key decision.

Recommendations
That the Board review and feedback on the Healthwatch Report "Time to Think Differently about adult social care".

1. Summary of Report

The report is attached at Appendix 1 and sets out feedback received from people not currently using social care services about what is important to them in seeking social care now, and in the future and draws a number of considerations to take forward. Feedback was collected via two focus groups and written feedback from participants living in the Weston, Worle & Villages, and Woodspring Locality partnership areas.

2. Policy

Healthwatch is the independent national champion for people who use health and social care services. There is a local Healthwatch in each area of England looking to find out what people like about services and what could be improved. Nationally and locally, Healthwatch has the power to ensure that those in charge of health and social care "hear people's voices" as well as seeking the public's views and encouraging health and social care services to involve people in decisions that affect them.

3. Details

Healthwatch North Somerset was commissioned by North Somerset Adult Social Care to collect qualitative feedback to help inform and design the commissioning of services by hearing from local residents. The aim was to:

- Connect with non-users of social care and those who are carers or potential service users of North Somerset Adult Social Care services.
- Identify participants in both the Woodspring, and Weston, Worle & Villages Locality Partnerships in North Somerset, and gather feedback from local communities.
- Agree group representation and size for each location and contact participants to manage their expectations, needs and ability to participate.

- Conduct focus groups and facilitate open conversations.
- Gauge interest in ongoing involvement and manage consent to be contacted by North Somerset Council in future.

4. Consultation
N/A

5. Financial Implications
N/A

6. Legal Powers and Implications
N/A

7. Climate Change and Environmental Implications
N/A

8. Risk Management
N/A

9. Equality Implications
N/A

10. Corporate Implications
N/A

11. Options Considered
N/A

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Appendices:
Appendix 1 Time to think differently about adult social services

healthwatch North Somerset

Time to think differently about adult social care

December 2023

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Executive summary

Healthwatch North Somerset received feedback from people not currently using social care services about what is important to them in seeking social care now, and in the future. Feedback was collected via two focus groups and written feedback from 24 participants living in the Weston, Worle & Villages, and Woodspring Locality partnership areas. For the most part, feedback revealed that participants knew little about North Somerset Council social care provision. The few that did know about provision, this was because they cared for family members or had made enquiries about what care is available or volunteered with local support organisations and had signposted people to care.

Informal care support was primarily provided by family and friends.

What participants emphasised in stating what a good service looks like was the following:

- Being listened to
- Good communication between staff and service users
- A timely and responsive service
- A flexible service tailored for individual needs
- A service that promotes independent living
- A compassionate service
- An accessible service

Participants felt that the most important starting point when deciding what care and support they may need in the future would be:

- for people to be able to access information on care and support independently
- clearly accessible information on North Somerset Council's online directory of services, including the social care webpages
- the availability of social care
- accessing a care assessment
- accessing peer support

Many of the projects' participants found themselves thinking for the first time about their future care needs. For those more familiar with social care, they cared for family members, or volunteered with local support organisations, or lived with a long-term condition or disability. These participants stated that they

would access support in the future via 'Care Connect' (North Somerset Council Social Services).

In relation to accessing information on social care, participants emphasised the need for information that was accessible through a single point of access, that they could find independently.

Considerations to take forward

Participant feedback evidences a need for:

- a single point of access for the information on social care
- clearer signposting about access points for information on social care
- explicit information on care processes, how people are assessed and the potential outcomes of care assessments for example, in the form of a flow chart – using 'social care journey maps' was suggested
- easily accessible information available
- information people can access independently
- guidance and opportunities for people to consider social care planning to address their potential future needs
- information on social prescribing and eligibility for referral
- information on advocacy services and eligibility for these
- accessible information on financial planning in relation to social care
- accessible language in all social care documents and on the North Somerset Council social care online site (https://n-somerset.gov.uk/my-services/adult-social-care-health)

Equalities Statement

Healthwatch North Somerset is committed to promoting equality and diversity and tackling social exclusion in all our activities. We aim to ensure equitable access to our initiatives and projects.

We include people's lived experiences in our work and identify and mitigate against barriers to enable people to become involved in our research. We address the participation needs of those who share one or more protected characteristic, or those that experience hidden discrimination, or are part of an 'invisible minority'. We provide access to communication support to adjust for people's needs and proactively assist people in attending events and meetings we hold and renumerate for people's time.

Healthwatch North Somerset connects with existing patient, service user and voluntary sector organisations to reach into, and develop relationships with diverse communities and inclusion groups.

Background

North Somerset Adult Social Care provides support for people with a range of needs. This includes older adults, people with mental health needs, people with disabilities, people with Learning Disabilities, people with physical and sensory impairment, and carers.

As of 2020 the current age profile in North Somerset is inverted. There are more residents aged over 65 years than aged under 19 years. Sub-national population projections suggest this inversion will continue to increase with fewer young people and more older people year on year. Considering the split by age bands within the over 65s population, North Somerset has a higher percentage of over 65s, over 75s, over 85s and over 90s compared to regional and national averages[1]. Ageing and multiple health conditions are one of the key public health issues North Somerset faces.

North Somerset has a less diverse population in terms of ethnicity than regional or national averages. Over 97% of people gave their ethnicity as 'white' in the Census compared to 95% in the southwest and 86% nationally. Around 19% of North Somerset residents said their day-to-day activities were limited a lot or a

[1] JNSA Report, North Somerset Council, 2023

little compared to 17.9% nationally (due to disability and life-limiting long-term conditions). (2011 census [2])

The Woodspring Locality has the highest rate of ill health (for older people) across all BNSSG localities and residents in this rural locality face poor public transport links.[3] 11% of North Somerset residents provided unpaid care of some kind (carers) similar to the national percentage[4].

Carer reported quality of life has fallen in recent years as has the amount of social contact they would like. Overall satisfaction with social services from carers has fallen in recent years. The proportion of carers who reported that they find it easy to find information about services has decreased over the years in North Somerset [5].

North Somerset's Health and Wellbeing Strategy (2021-24)[6] states an action plan centred around the following:

- prevention - prevent people from becoming unwell or experiencing poor health and wellbeing.
- early intervention - support people to identify and manage health and wellbeing problems as early as possible. Ensure support is in the right place geographically and the interventions tailored to address the problems.

Purpose

Healthwatch North Somerset was commissioned by North Somerset Adult Social Care to collect qualitative feedback to help inform and design the commissioning of services by hearing from local residents. The aim was to:

- Connect with non-users of social care and those who are carers or potential service users of North Somerset Adult Social Care services.
- Identify participants in both the Woodspring, and Weston, Worle & Villages Locality Partnerships in North Somerset, and gather feedback from local communities.
- Agree group representation and size for each location and contact participants to manage their expectations, needs and ability to participate.
- Conduct focus groups and facilitate open conversations.

[2]JNSA Report, North Somerset Council, 2023
[3] JNSA Report, North Somerset Council, 2023
[4] JNSA Spotlight report: North Somerset Population Demographics, 2023
[5] Spotlight report: Carers for adults, JNSA, 2023
[6] North Somerset's Health and Wellbeing Strategy (2021-24)

- Gauge interest in ongoing involvement and manage consent to be contacted by North Somerset Council in future.

Engagement methodology

This project ran from October – December 2023. Focus groups were held online via Zoom, and written feedback was collected verbally and by email. The Project Officer contacted 20 care, support and advocacy organisations, and Patient Participation Group Chairs of GP surgeries across North Somerset to inform them of the project and to recruit participants. Healthwatch North Somerset contacted organisations in their networks and via their social media to recruit participants to the project (see Appendix). This was followed up by telephone calls and meetings with staff in voluntary and community sector organisations. North Somerset Council Adult Social Care distributed information through their carers and disability support networks via their Engagement Officer, and Inclusion Officer.

Involvement

All participants were sent the participant information sheet and completed a consent form and provided demographic details. Each participant was renumerated with a high street shopping voucher once their feedback had been received. The online focus groups were recorded on Zoom for purposes of professional transcription. Recruitment coincided with another local survey, and this impacted on recruitment to the focus group numbers initially – 5 people were involved in focus groups. These included people aged over 65 years and adults with long-term conditions from the Woodspring, and Weston, Worle & Villages Locality areas. Participants were offered the opportunity to give written feedback by email or post, 19 participants provided written feedback, and this proved to be a successful method particularly for those with access issues.

Participants' ages ranged from 34 – 84 years, 23 were White British, 18 were female and 6 were male. 11 had long-term conditions or lived with a disability. 15 lived in the Weston, Worle & Villages locality, and 9 lived in the Woodspring

locality. Long-term conditions included diabetes, heart disease, fibromyalgia, rheumatoid arthritis, mental health conditions, axial spondylarthritis, and autism.

Four participants stated that they were long-term unemployed, one stated that they were living in poverty, one had, had contact with alcohol or drug services and one had limited social networks. Table 1. gives the demographic details of participants.

Table 1. Demographic table of participants

Disabled person or having a long-term condition	Number of participants
Yes	11
No	12
Information not provided	1
Postcode locality area	Weston, Worle & Villages 15 Woodspring 9
Age	25 - 49 years 11 50 - 64 years 4 65 - 79 years 7 80+ years 1
Information not provided	1
Gender	Female 18 Male 6
Ethnicity	White: British 23 White: Irish 1
Sexual orientation	Heterosexual 10 Not stated 14
Is your gender the same as the sex you were assigned at birth?	YES 23 NO 1
Carer	YES 5 NO 19
Total participants	**24**

Table 2. Inclusion groups represented

	Number of participants
Homeless	0
Limited family/social networks	1
Long-term unemployed	4
Living in poverty	1
Refugee	0
Contacted alcohol/drug services	1
Geographically isolated	0

Themes of feedback

Focus group questions to elicit feedback were developed in collaboration with North Somerset Council Adult Social Care staff. Topics that were discussed at these groups and in individual conversations were: (See the Appendix for focus group questions)

- Knowledge of adult social care
- Knowledge of eligibility for adult social care
- Who currently provides people with care and support in the community?
- Most important things for people in accessing social care services
- Accessing information and what are the gaps in information provided?
- Most important aspects for people when deciding about care and support for the future
- What makes a good service?
- What independence means to people in relation to social care?
- Prevention of poor health
- Knowledge of advocacy services

Findings

What do people know about Adult Social Care in North Somerset?

Most participants had little knowledge of adult social care services provided by North Somerset Council. Those that did know of services this was because they were caring for their family members or because family and friends had accessed services or tried to find out if they were eligible for services. Participants who volunteered or worked for support organisations locally knew of services because of working with vulnerable people or those who had social care needs. Those that did know about services did so because they had accessed information from the council's online directory and the pages about adult social care.

One participant commented:

"I am aware and yes, I do know how to find out whether I am or the individuals I am caring for are eligible for services. This is due to the fact we have leaflets within our office. If I did not work in health care, I do not feel I would be aware of this service unless I spoke to my GP practice". (Woman, 31)

Those who knew about how to find out about eligibility for adult social care support, knew about this via the council social care website or knew they would need to contact Care Connect.

Who provides people with their current care and support?

Current informal care and support was mainly provided by family and friends, voluntary sector organisations, and private counselling, which enabled people to maintain their independence at home. This included help with transport and personal care. A few participants knew of Care Connect and 'We Care and Repair' as a first port of call to access care services. The following quotes illustrate this.

"If I need help, I have good friends, many from my church, who will take me to things beyond the reach of my pavement mobility scooter, or shop if I cannot go out". (Woman, 84)

"I'm fortunate that I have family and friends around definitely…I'm aware of a number of voluntary organisations who can signpost and support in various ways, so 'We Care and Repair' and the like are very good for signposting". (Woman, 55).

Participants were not necessarily aware of the eligibility criteria for adult social care services in North Somerset and felt that they were not necessarily of high need enough to be eligible. Some stated that their first port of call when they may need to access social care services would be their GP or possibly a social prescribing service if that was provided by their GP surgery.

"I manage alone using online deliveries and services, prioritising basic care for myself over socialising. When desperate a friend might help, or I just go without or have a shower another day when my friend is there"

(Woman, 27, living with a long-term condition)

Most important things about care and support?

We asked participants what the three most important things for them were when seeking care and support provision. Overall, these were:

- Being in control/independence
- Care that promotes independence
- Quality (of service)
- Cost – the financial implications of social care
- Being listened to
- Flexibility of service provision
- Involving family in care decisions for the future

This is illustrated by the following comments:

"Being treated like the person with a disability and actually listening to your needs and what your disability is about, rather than suggesting things that people are asking you, if that makes sense". (Man, 50, living with a long-term condition).

"I'll say quality – the quality of the helper. You need somebody that you can actually engage with". (Woman, 69, living with a long-term condition)

"Affordability, regularity and familiarity in professionals. Consistency with professionals which then builds trust. Receiving care seems like such a daunting thought, particularly for someone who hasn't received that sort of help before. For this reason, building trust I feel is key in providing a good service". (Woman, 32)

"Help to support me in the things I like doing; help me make decisions on my own; hep me give feedback in surveys like this". (Autistic man, 31)

"To understand the bigger picture and financial implications to use the resource available wisely (over the) long term....To invest more resources in prevention". (Woman, 44, Carer)

Flexibility of services

The importance of having flexible care support available was highlighted by several focus group participants that lived with long-term conditions which meant that the level of care they needed varied from day to day.

One participant commented on this:

"...you should be able to say, 'Right, I need the carer today or next week or something like that and somebody should be there and saying `Right, I will put this in place for you". (Woman, 69, with a long-term condition)

Phrases and words that revealed what was most important to participants when seeking social care are illustrated below.

"Trustworthy, competent and available at the point of need". (Man, 61, with a long-term condition)

"Being in control, independence, quality". (Woman, 75)

"Control, independence, pride". (Man, 70, with a long-term condition)

"Reliable, empowering, individualized". (Woman, 27, with long-term condition)

"Needing help with managing money; help with mental health; help with anxiety". (Disabled woman, 27)

"Fast accessibility to information; understanding what my options would be; involving my family and friends in decisions for the future". (Woman, 52, with a long-term condition)

"Accessibility to all, quality of care, and affordability". (Woman, 57)

"Maintaining some form of self-respect and being with my wife.

"Not being kept alive beyond the point where the discomfort of living exceeds the pleasure of living". (Male, 61, with a long-term condition)

"Personal care; meal provision/shopping; mobility aids and advice". (Woman, 68)

Where do you access information?

We asked participants where they access information about their current care and support and was there anything missing in the information. Participants who were living with a long-term condition mainly sought information from national charities representing their condition, and from medical specialists at

Southmead Hospital or the Bristol Royal Infirmary; others used the NHS app. Participants also emphasised the ongoing importance of their family in providing care and support. The following comments reveal this.

"I think the Rheumatology Department at the hospital, which is where I go, they're really good at suggesting things. They say 'Have you thought about going to see occupational health, that sort of thing, which tends to be more of the driver for that as opposed to me going through my local GP or through more options in North Somerset Council. I would say, the hospital's a pretty big driver for that". (Woman, 34 living with a long-term condition)

"I would say Muscular Dystrophy UK because it's a charity that knows my condition or my team at Southmead because they know my condition. Using the person that knows my condition I think having them there is important and it does scare me in ten years' time as our Mum – what happens when she's no longer here? Who'll I fall back on, and you need to have that safety net". (Disabled man, 50).

"I get information from the North Somerset LGBT+ forum". (Disabled woman, 27).

"...because I've got so many complex conditions I'm struggling regarding getting healthcare...I'm just not confident in knowing what I'm doing because I'm autistic perhaps it also complicates things, so it's not clear to me the route, therefore I would tend not to even ask about it until it gets to a crisis situation...didn't know who to ask or what words to mention".

(Man, 70, living with multiple long-term conditions)

What information is missing?

In terms of what is missing from the information available the main comments were the need for a single point of access to receive information on social care support, one participant suggested that this could be through for example, the NHS App.

Participants commented on the need for information on adult social care available through the Council website could be easier to access, an example given was the need for some kind of flow chart of social care.

“I feel that there are two areas of improvement: All signposting to be centralised and heavily promoted. (Clearer) visibility over next steps in any process so a carer & those cared for can assess the amount of time, resources and financial planning”. (Woman, 41, Carer)

Others described not knowing where to go to find information on social care for a family member:

“I had real difficulty last year trying to source care for my 94-year-old grandmother who was unable to safely carry out daily tasks. I looked online but it wasn’t clear on what my options were and whether they were suitable for what we needed at the time. This was all private care; I wouldn’t know where to start with anything provided by the NHS. It’s something I expected the district nurses to be able to sign post me to, but they didn’t seem to be able to do so”.

(Woman, 32)

What participants emphasised was the need for information to be accessible for them to be able to access it independently.

“I personally rely on the NHS app for a lot of my stuff, knowing that that’s medical….I can see that people are going to look at the NHS app and want to find things there and at the moment it’s lacking from a social care viewpoint. To me, the NHS app is the single point of contact but more needs to be added to it that isn’t there at the moment. I’d like to see that expanded so that it can offer a single point of contact (and could signpost to social care services). (Man, 70 living with long-term conditions)

“I think a nice clearly set out website where you can look things up when you’ve got a free five minutes and then just see what could be available an then the option to maybe book a further appointment because I would very much struggle to have the time to do it….need to provide information on what you could be entitled to – maybe even like a flowchart explaining things and these are the potential next steps. The starting point would be information you can look at without someone else”. (Woman, 34, living with a long-term condition)

"If I was thinking about what's the most important starting point, then to me it would be having a single point (of access for information) that I can go to that I would hopefully understand, (it's about) being set off in the right direction". (Woman, 51)

Use of professional language

An important factor when participants talked about accessing information was the language used in social care and it being difficult to understand. A couple of participants, despite having complex care needs in relation to their long-term conditions did not fully understand terms such as 'signposting', 'care assessment' or 'capacity assessment' for example. This is revealed by the following comment:

"Care assessment, I've never known the term care assessment. Can you see that I'm coming from a completely different viewpoint. These terms don't mean much to me at all". (Man, 70, living with multiple long-term conditions).

What is the most important starting point when you think about deciding what care and support you need in the future?

Focus group participants felt that they may need these things to help them navigate care in the future:

- clearly accessible information on the North Somerset Council social care website
- for people to be able to help themselves, finding information on care and support independently
- the availability of a range of social care services
- being able to get a care assessment
- having some peer support
- finding services that help maintain their independence

These priorities expressed by participants are s by the following quotes:

"When I'm unable to care for myself, I would contact social services via Care Connect". (Woman, 68)

"Thinking about what care needs are required and whether care is the correct route to go down". (Woman, 31)

"The most important starting point is to have a clear understanding and visibility over what options are available and the processes needed in order to plan resources". (Woman, 44, Carer)

"It would be good if the foster system would keep the support up to the age of 30 instead of the age of 25". (Disabled woman, 27)

"I'm not sure what you mean, I would start looking on the internet/contact Care Connect for an assessment when I do need it. In the meantime, I just adapt to what I still can do so I don't need it, as I'm aware that there is not enough support available unless you are completely desperate". (Woman, 27, with a long-term condition)

What does a good service look like?

What participants articulated in relation to a good service was the following:

- Being listened to
- Good communication between staff and service user
- A timely and responsive service
- A flexible service addressing individual needs and changing needs
- A consistent service with professionals that people can trust
- A compassionate service
- An accessible service

This is revealed by the following participant comments:

"Friendly, efficient and delivered on time". (Woman, 63)

"Compassionate, flexible and adaptable service to each individual". (Man, 61)

"Being able to look after myself for as long as possible". (Woman, 67)

"Consistency with professionals which then builds trust. Receiving care seems like such a daunting thought, particularly for someone who hasn't received that sort of help before. For this reason, building trust I feel is key in providing a good service". (Woman, 32)

"A service that listens and is honest. Care and compassionate and looking at an individual as a whole and not being task orientated. The frustration occurs when an individual feels their expectations are different than what Is being provided. Communication is also the key, accepting when things go wrong and keeping individuals in the loop about important information/ changes". (Woman, 31)

"Good access to pain relief and medication, identifying the best way of empowering the "patient/user" to retain as much independence as possible". (Woman, 75)

"Continuous investment in interventions that promote independent living, consistency & continuity, a holistic approach and a joint approach from supporting organisations". (Woman, 41, Carer)

"Reliable, empowering, individualised, good communication – listening to my needs and informing me of how this can be best met with the restricted budget and lack of staff". (Woman, 51, with a long-term condition)

"A good service – the right time, right place, right service, working with patients in decision making, just to put it in a nutshell". (Woman, 55, living with a long-term condition)

Looking at future needs

Those participants that had thought about their future care needs tended to be people with long-term conditions or those living with a disability, and people who cared for or had sought care for family members. This is illustrated by the following comments.

"I have (thought about future care needs), since my mother needed support from 2002 to today and particularly when I first started struggling in 2015 to present day as my own abilities to care for myself have changed". (Woman, 27, with a long-term condition)

"I would like to start before the needs arise, perhaps informative regular workshops & surgeries would work for the general public". (Woman, 41, carer)

"I'm 31 and I am already in the process of arranging Lasting Power of Attorney for health and finances for myself and my mum who is 68. The earlier we talk about care provision and individual wishes the easier the topic is when the time comes. Care is sometimes stigmatised to the older age range, whereas it should be a subject that all ages think about". (Woman, 31)

"No, I have not been thinking about the future. If I was to get support, it should start as soon as possible". (Woman, 27, with a disability)

What does 'Independence' mean in relation to social care?

Participants felt that independence in relation to social care meant:

- Shared decision-making about care
- Being given the right support to maintain individual independence
- Having and maintaining physical mobility

- Independence with personal care capabilities
- Autonomy over people's decisions (people who receive care)
- Good levels of support
- Choice of care

This is revealed by the following comments.

"Being able to do the things, my day-to-day things in my life with the tools to be able to deliver it properly, like having a neat and tidy garden that's like I would want a tidy house as opposed to not being able to do it because I can't do the cleaning, so it's about having the tools to be able to do things properly". (Woman, 34, with a long-term condition)

"(It's about) not having your life change, you know, you have a carer come in and then they suddenly change everything, being able to fit in with your life, which is important and not having things forced on you (by care support)". (Man, 50, living with a long-term condition)

"Being able to live your life fully". (Woman, 67)

"Being able to safely undergo day to day tasks without needing the help of anyone else". (Woman, 32)

"Independence is a word which I believe has a purpose. I do however feel this word is thrown around a little too often. We as humans are dependent on family / friends / support services at times to provide support and prevent social isolation. I do feel it's a term recognised by individuals though, so it is important to consider what this means to the individual first. Independence to me means I can do a task myself such as eating / drinking / washing / getting out of bed. It does not mean I want to live an independent life". (Woman, 31)

"Making your own decisions; choice in care; good levels of support". (Woman, 48, with a long-term condition)

"Individualised care, choice, choice of accommodation and social life". (Woman, 47, carer)

"Helping people to live as independently as possible". (Woman, 34).

"Enabling the service user to maintain as much control of their lives as possible". (Woman, 55) "having control over my own life and time."

"Living in my own home, having means of transport". (Woman, 41, Carer)

"Allowing people to do as much as they can for themselves with support, allowing people to choose their lifestyle for example, staying in their own home, deciding when and what they eat, how their personal care is carried out". (Woman, 27, with a long-term condition)

"Independence - it means we do things by ourselves and if we need help, we could talk to someone". (Woman, 27, with a disability)

“This seems to be mostly about the retention of self-respect – providing enough but not more support than is needed”.

“The ability to make decisions for myself obviously within the physical and medical constraints that I may be dealing with. It’s about retaining as much control over one’s life as possible”. (Man, 70)

What aspects of their independence is the most important to them?

These were mainly retaining decision making, physical mobility and the ability to go out, revealed by the following comments.

“Decision making; physical mobility”. (Woman, 34, with a long-term condition)

“…being able to still do things for yourself rather than, you know, just having somebody to help you more than doing everything for you….” (Woman, 69, living with a long-term condition)

Awareness of the importance of preventing poor health

Participants were aware it was very important to prevent the development of poorer health. This was helped significantly by the availability of ‘good medical care’, accessible transport, physiotherapy and opportunities to exercise locally. People felt that this was their responsibility and highlighted the need for support with this for example, being provided with accessible transport, or having access to a physiotherapist or an exercise class. People emphasised the importance of prevention of poor health in terms of both physical and mental health. People also felt that prevention of poor health had a significant role in saving the cost of care later in people’s lives. This is illustrated by the following comments:

“You keep healthier and it helps keep health problems at bay by, you know, seeing physios…helping to stay stronger because…it’s all connected with your joints and things and help stop the problems in the first place as much as possible…I think very much a top thing (prevention)…so especially with lots of other health conditions…and how if you don’t look after yourself, it can deteriorate sort of thing…” (Woman, 34, living with a long-term condition).

“So having exercise, gaining access to exercise and sport. I do wheelchair yoga, I do hydrotherapy and I played football so having those options…I know North Somerset Council’s doing a project on that at the moment…improving sport in our area which is lacking…But I think without my hydrotherapy which I go to every week with my Mum and my brother, I wouldn’t be as I am now. I mean I drive a van and couldn’t get there without my van – that’s (hydrotherapy) probably stopped me having deteriorated so quick. I’m stable now, so quite lucky”. (Disabled man, 50)

"Prevention in medical terms to me is very important and mental health and wellbeing comes into this. Having someone there to talk to, to keep your mental health from declining." (Woman, 27, with a disability)

"I think taking responsibility to stay as fit and as active as possible is very important". (Male, 55)

"Incredibly important but an area that is not high priority – at least until more recently. There is much more information about falls prevention, personal wellbeing and good mental health than there used to be and that's a good thing. I hope that continues to develop and that middle-aged people might start to plan and be more aware of how they can maintain their independence rather than waiting until a crisis happens". (Woman, 52, with a long-term condition)

The importance of prevention of poor health in relation to self-management and how social care services can support this was highlighted by one participant:

"Self – management of long-term conditions is vital. With the right support services in place this can be achieved. Prevention of poorer health (to delay) long-term care is very important, given the lack of care support that is available. I believe that previously healthcare professions were given the time to support individuals to manage their long-term conditions. However, as the health system changes, there is now not enough time to do this. I know linking closely with the social prescribing team to find support services available that can prevent the need for care". (Woman, 31)

Awareness of advocacy

Most people giving feedback were not generally aware of what advocacy services provide or of the advocacy services provided by North Somerset Council. Those that did know of advocacy services this was because they had accessed them for a member of their family or had acted as an advocate on their behalf or had volunteered as an advocate. Others thought that they may be able to access advocacy services through their GP or a social prescriber. One participant found out about an advocacy service via their district nurse. What was emphasised was the need to receive advocacy at the right time before people got to a crisis point in their care. This is revealed by the following comments:

"I have been an advocate for my mother when I was well enough but not now. Someone at her care agency advocated for her when social services tried to cut her care package. If the time comes when I need advocacy I would look online – North Somerset Council or (the) Citizens Advice Bureau websites to see what is available". (Woman, 27, living with a long-term condition)

"I've got no experience of it (advocacy), I've been crying out for a long time to have someone to help me with this because I'm literally on my own. I just wish I could have this when I was at my worst rather than a little bit late now. I wouldn't

know where to start. I was told that my GP could refer me to an advocacy service, they can't, they don't know anything about that, so that's what I want and hopefully I'm on the first step to get there. I don't know where I'll be signposted. I hope someone will know that I do need some advocacy from somewhere. I feel much happier knowing that hopefully something can be arranged for me. A district nurse, she came round for me yesterday, and she said about advocacy and that's what I want, that's what I've been asking for, for so long but I wouldn't have known it was there until yesterday". (Man, 70 living with long-term conditions).

"I've actually done advocacy work because I've done training in advocacy as well for my (condition)…I've used that knowledge with the (support group the participant facilitates)". (Disabled man, 50)

Other participant comments suggest the need for advocacy to access care support. What was also emphasised was the need to receive advocacy at the right time before people got to a crisis point in their care.

Participants with learning disabilities stated that they would like access to advocacy services. One commented on this:

"I would need someone to help me understand everything; I would need this service". (Man, 28, with learning disabilities)

Considerations for Adult Social Care

Participant evidence suggests the need for:

- a single point of access for information on social care
- clearer signposting where to find information on social care
- explicit information on the care process, how people are assessed and potential outcomes of care assessments
- easily accessible information available
- information people can access independently
- guidance and opportunities in order that people can consider care planning for their future
- Information on social prescribing and eligibility for referral
- information on advocacy services and eligibility for these
- accessible information on the financial planning of social care
- accessible language in all social care documents and on the North Somerset Council social care website.

Future engagement

One of the aims of this project was to gauge participant interest in engagement work for North Somerset Council Adult Social Care in the future. Eight participants agreed. These participants will be invited to be involved in further work, to codesign of Adult Social Care services.

Acknowledgements

We would like to acknowledge all the support and advocacy organisations involved in this project and all the people with lived experience who gave us their valuable feedback, and North Somerset Council Adult Social Care.

Quality assurance

This project was designed using Healthwatch BNSSG methods and templates for research and engagement. Graphics and pictures: Healthwatch England, The Centre for Ageing Better.

References

JNSA report North Somerset Council https://n-somerset.gov.uk/council-democracy/north-somerset-insight-data-statistics/joint-strategic-needs-assessment-jsna-health-social-care (accessed December 2023)

JNSA Spotlight report: North Somerset Population Demographics https://n-somerset.gov.uk/sites/default/files/2022-04/JSNA%20population%20demographics%20spotlight%20report.pdf

(accessed December 2023)

Spotlight report: Carers for adults, JNSA, 2023 https://www.n-somerset.gov.uk/sites/default/files/2022-04/JSNA%20carers%20spotlight%20report.pdf (accessed December 2023)

North Somerset's Health and Wellbeing Strategy (2021-24) https://n-somerset.gov.uk/sites/default/files/2023-01/HWBS%20action%20plan%20-%20acc.pdf (accessed December 2023)

APPENDIX 1.

Organisations contacted to engage and recruit participants:

Age UK North Somerset

Alcoholics Anonymous group, Weston-super-Mare

Big Worle

Bournville Healthy Living Centre, Weston-super-Mare

Bridging the Gap Together, North Somerset

Community Centres

Community Connect

Multicultural Friendship Association, North Somerset

Nailsea Leg Club

North Somerset BME Network

North Somerset Council Disabled Access Group

North Somerset Together

Patient Participation Group Chairs of GP surgeries across North Somerset

Sirona Wellbeing Lead, North Somerset

Somewhere to Go – community centre

Voluntary Action NS

West of England Rural Network (Curo Group)

Weston College

Weston-super-Mare Citizens Advice (NS)

Weston-super-Mare Library

APPENDIX 2. FOCUS GROUP AND WRITTEN FEEDBACK QUESTIONS

North Somerset Adult Social Care project

Written feedback questions for Weston-super-Mare & Worle, and Woodspring residents who have not used North Somerset Social Care services. Please complete these questions and email them back to us by the 11th of December 2023.

1. Are you aware of what Adult Social Care Services North Somerset Council currently provide?
    a. Do you know how to find out if you're eligible for services?
    b. Would you know how to access these services?
2. If you need care and support currently, where do you access it? Who do you rely on for support? (practical, and care support) (e.g. Informal care/support, family, friends, neighbours, VCSE organisations, health services)
3. What would be the most important starting point when you think about deciding what care and support you may need in the future?
4. What are the 3 most important things for you in terms of care and support provision?
5. What does a good service look like in terms of care and support?
6. Have you thought about your future needs in relation to care and support in the future? Have you/When do you think you should/ started thinking about your future care needs?
7. a. What do you think 'independence' means in relation to social care?

    b. What aspects of your independence are most important to you?
8. How important is prevention when talking about adult social care? (Prevention of poor health)
9. Where do you access information about your current care and support? Is there anything missing in the information available?
10. Advocacy services – do you have experience of this, know what it involves and what's available?
11. Would you be interested in any ongoing engagement group/activity in the future for North Somerset Council? Please confirm this in an email to Anna King, Healthwatch BNSSG.

Thanks very much for your participation today. You will be sent an E-voucher after today to acknowledge your contribution to the focus group.

APPENDIX 3. DEMOGRAPHIC FORM

North Somerset Adult Social Care Project

Sharing this information helps social care providers understand how people's experiences may differ depending on individual characteristics. Your personal details will not be passed on. All of this information will be kept confidential and will be anonymised.

Please tell us the **first part of your postcode and the number in the second part of your postcode** (e.g. **BS14 3**) ……………..
Please tell us your **age**: ……………...
Please tell us your **gender**: ……………………………...
Is your **gender the same as the sex you were assigned at birth**?
………………..
Please tell us which **sexual orientation** you identify with:
………………………………………...
Please tell us your **ethnicity (your background)**:
……………………………………………………...
Do you consider yourself to be **disabled, to have a disability, or to have a long-term health condition?** YES ……..NO...
If you answered 'Yes' to the last question, please tell us more about what these are:……………………………………………………………………………………

Do you consider yourself to be a **carer**? YES…………NO……..

Do any of the below apply to you? (Please tick any that apply)

Homeless	Refugee or asylum seeker
Live in poverty	I've come into contact with drug or alcohol services
Limited family or social networks	I am geographically isolated
Long-term unemployed	I am in a stigmatised occupation

Thank you for completing this form.

Healthwatch North Somerset
Unit 21, Union Gallery, The Galleries
Broadmead
Bristol
BS1 3XD

www.healthwatchnorthsomerset.co.uk
t: 03300 553251
e: contact@healthwatchnorthsomerset.co.uk
@HealthwatchNS
Facebook.com/HealthwatchNorthSomerset

Time to think differently about Adult Social Care

Commissioned research for NSC

Received feedback from people not currently using social care services

Analysed what is important to them in seeking social care now, and in the future.

Collated rich insights from focus groups and written feedback from 24 participants

Involved residents from the Weston, Worle & Villages, and Woodspring Locality partnership areas

Insights from 'Time to think Differently' are informing the following changes;

Updating the information on NSC website

Making sure the information is available in various formats (like Easy Read versions) explaining what Adult social care is about and how NSC are addressing people's needs.

Working on an online financial calculator so people can check on the potential financial implications for them before requesting services.

Information about how to access advocates.

Information and reassurance about how people receive person-centred services.

Reviewing how current arrangements work at NSCs 'front door' /looking at making it more accessible and simplified.

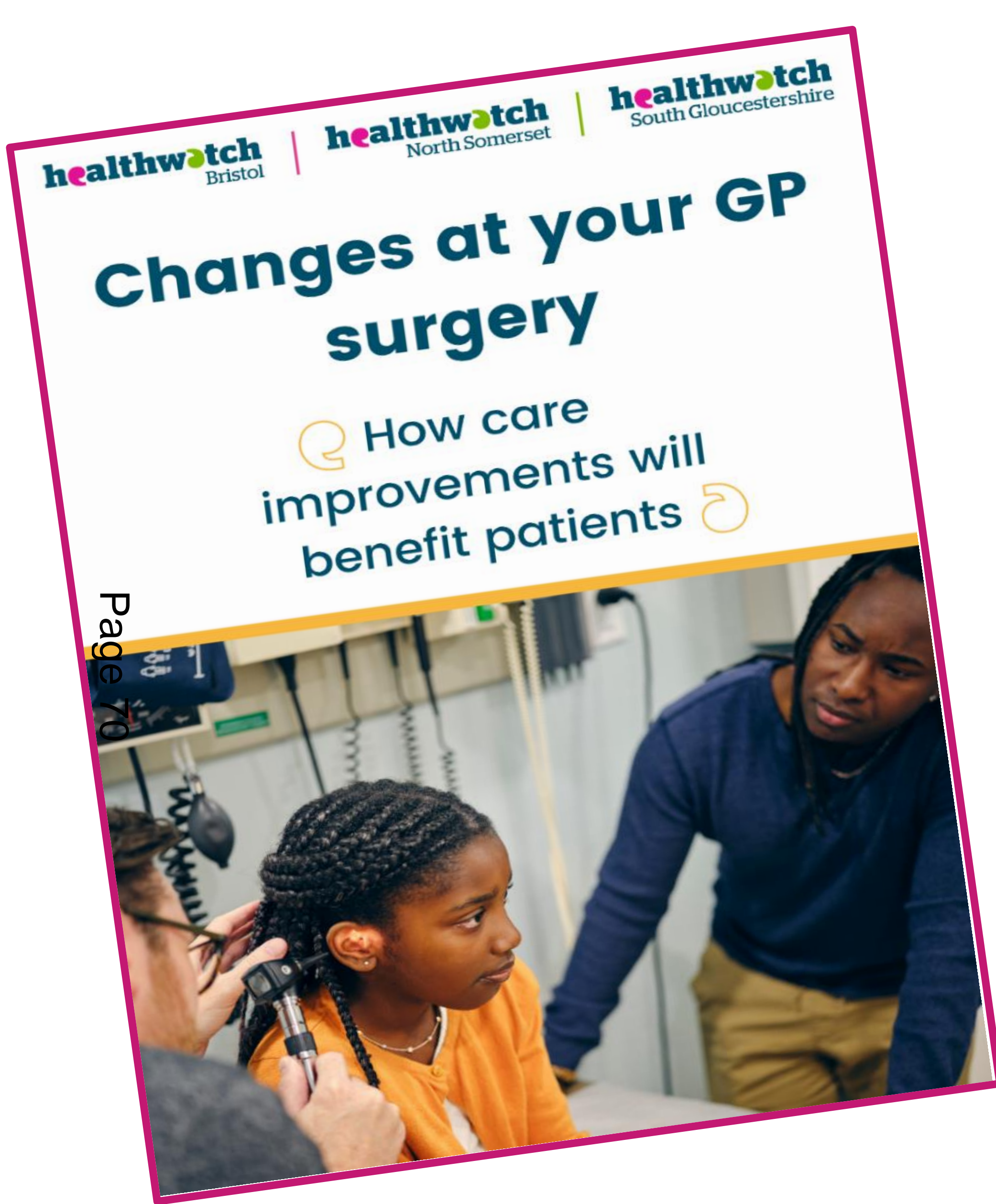
healthwatch Bristol | healthwatch North Somerset | healthwatch South Gloucestershire

'Changes at your surgery' our workplan project about access to GPs

- **Explains what changes patients may see**
- **Explains the GP Access Recovery programme by NHS England**

Contains 28 pages:

- Listing changes which the public & Healthwatch can monitor and scrutinise.
- Staff roles in GP practices; new additional roles and what they do.
- Information about Pharmacy's new services ~ the Pharmacy First Programme.
- Healthwatch BNSSG public survey Autumn 2023 – 325 responses; what was good about their GP surgery and what could be improved. Baseline for comparison in a year or so?
- Positive initiatives already happening in the local area using real life case studies.
- Digital promises explained ~ March edition 2024 once telephony changes are rolled out.



Sharing the booklet

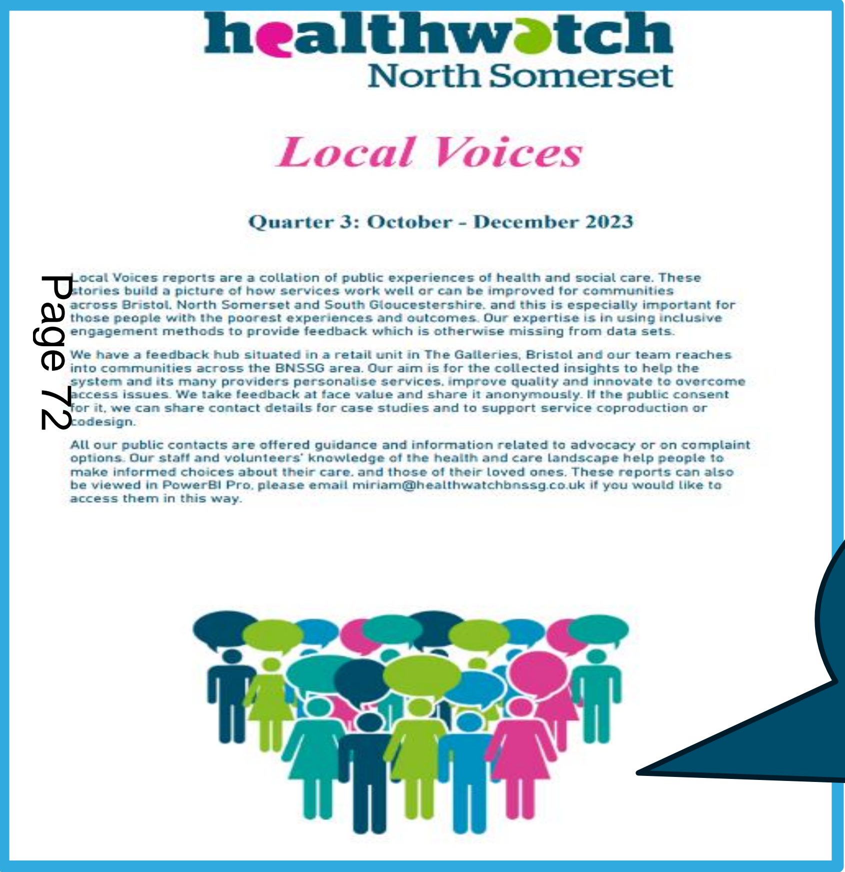
- BNSSG-wide newsletters (ICBs)
- Local newsletters
- On North Somerset website for downloading
- Healthwatch BNSSG newsletters
- Social media and tagging participants
- Print version in high quality A5 booklets
- Healthwatch BNSSG staff to share digital copies, physical copies, and links to websites
- Mailout to all GP practices and other services e.g. pharmacies
- Presenting at meetings (staff/Board) with messages
- Engagement Hub window display to encourage people to pick up a printed copy in Bristol office base
- Email to contact lists in Feb including city and local councillors

Healthwatch Engagement Strategy 2024~2028

Main changes to our outreach in communities (the kind that forms basis of Local Voices)

1. Equalities engagement (hard to reach or inclusion groups) will be measured in new ways and given allocated time each week
2. Robust stakeholder mapping, establish stakeholder forums for effective engagement work in those communities
3. Targeted communications to reach out into communities
4. Real time data sharing via our PowerBI dashboard.Expansion of feedback categories/themes to capture wider determinants of health

Quarter 3 Oct-Dec 2023 public feedback & insights snapshot



healthwatch
North Somerset

Local Voices

Quarter 3: October - December 2023

Local Voices reports are a collation of public experiences of health and social care. These stories build a picture of how services work well or can be improved for communities across Bristol, North Somerset and South Gloucestershire, and this is especially important for those people with the poorest experiences and outcomes. Our expertise is in using inclusive engagement methods to provide feedback which is otherwise missing from data sets.

We have a feedback hub situated in a retail unit in The Galleries, Bristol and our team reaches into communities across the BNSSG area. Our aim is for the collected insights to help the system and its many providers personalise services, improve quality and innovate to overcome access issues. We take feedback at face value and share it anonymously. If the public consent for it, we can share contact details for case studies and to support service coproduction or codesign.

All our public contacts are offered guidance and information related to advocacy or on complaint options. Our staff and volunteers' knowledge of the health and care landscape help people to make informed choices about their care, and those of their loved ones. These reports can also be viewed in PowerBI Pro, please email miriam@healthwatchbnssg.co.uk if you would like to access them in this way.

77 contacts provided feedback in Q3
36.5 % of the pieces of feedback are positive about services
2.6% identify as a carer
27 have a long-term condition
9 live in poverty
4 are homeless
2 have limited social networks/ family

Primary Care negative comments:

24 said they had limited/ no access to NHS dentist or GP
6 had a poor care experience from a service
4 said interface between services was bad
4 were concerned about quality, diagnosis or their treatments management
1 had problems with medication at discharge

For access to Healthwatch BNSSGs PowerBI App for monthly live data from your Local Authority area?

For Local Voices PDFs each quarter; public feedback narratives sorted by service, theme, sub-theme, service-user demographics etc?

Contact:
Data and Insights Officer, Healthwatch BNSSG, Miriam Booth

Miriam@healthwatchbnssg.co.uk

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One Weston, Worle and Villages Locality Partnership

Woodspring Locality Partnership

REPORT TO THE HEALTH & WELLBEING BOARD

DATE OF MEETING: 14TH FEBRUARY 2024

SUBJECT OF REPORT: Weston Worle and Villages and Woodspring Localities updates

TOWN OR PARISH: N/A

PRESENTING:
MATT LENNY, DIRECTOR OR PUBLIC HEALTH (ON BEHALF OF NS HEADS OF LOCALITY PARTNERSHIPS).

KEY DECISION: NONE

RECOMMENDATION

MEMBERS OF THE PANEL ARE ASKED TO:
a) Consider and comment
b) Give suggestions and observations about any areas not covered within the report

1. SUMMARY OF REPORT

This report outlines the headline plans and the work that the ICB localities in Weston Worle and Villages and Woodspring participate in and how this work is being conducted with our partners to ensure alignment across North Somerset whilst also identifying the needs of the population within each locality working closely with lived experience representatives.

2. POLICY

The key purpose of ICSs is to bring partner organisations together to:

- improve outcomes in population health and healthcare.
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money.
- help the NHS support broader social and economic development.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent.
- acting sooner to help those with preventable conditions.
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

All activities and plans developed will both fit into the above objectives but also will align with the HAWB strategy along with conversations that are being undertaken with the physical health strategy.

This is entwined in the frameworks that we jointly have started to work on, across Ageing Well and Community Mental Health.

3. DETAILS

Both Locality Partnerships continue to deliver their respective work plans, based on agreed priorities included in the July report.

Highlights from the last 3 months include:

North Somerset

Both Locality Partnerships continue to work closely with North Somerset Council colleagues to establish a structured approach for collaboration between North Somerset's **Health & Wellbeing Board (H&WB)** and Locality Partnerships. Following approval of this approach at the November H&WB Board, work is underway to establish the HWB Operational Group, with the inaugural meeting expected to take place before April this year.

Work to develop an **evaluation framework** to enhance the role of evidence in informing partnership decision-making has convened partners and enabled us to agree and prioritise the inputs, activities, outputs, mechanisms of change and outcomes. The logic models which represent the **theory of change** are supporting the production of an evaluation framework. This work will allow the Local Partnerships and system to evaluate and mutually recognise the impact of their integrated work and is already being used in the design and development of new projects - ensuring that initiatives such as Power2Pill and proposed Complex Care Teams reflect the partnership's case for change and strategic objectives.

See [Co-developing a theory of change to evaluate integrated working in two Locality Partnerships – Primary Care Research & Teaching Blog (bristol.ac.uk)](https://capcbristol.blogs.bristol.ac.uk/2023/12/05/co-developing-a-theory-of-change-to-evaluate-integrated-working-in-two-locality-partnerships/).

Both Locality Partnerships are taking part in a **Cardiovascular Disease prevention project**, which will have a focus on reducing the disparity and inequality in blood pressure screening uptake and hypertension case finding and management. The project is funded by NHS England following a successful Expression of Interest submitted by the Inner City & East Locality Partnership on behalf of all BNSSG Localities, with Accure Health Consultancy Ltd the contracted provider. Project objectives are to introduce blood pressure screening points closer to where people live, work, shop and visit regularly; empower community health champions from trusted groups to promote blood pressure screening,

hypertension case finding, appropriate referral and self-management; and make blood pressure and hypertension related information available and more accessible to populations and in residential areas where there are health inequalities. Rollout will be phased across the six BNSSG Localities, with Weston, Worle & Villages likely to be in February/March, and Woodspring following a little later in the Spring.

A North Somerset Community of Practice for **End of Life** pathway improvement and advance care planning has been convened. The aim of this group is to share information and learning, provide peer support, build shared understandings and ways of working, and problem solve on shared issues.

Woodspring

Soft launch and roll out of the **Woodspring Mental Health & Wellbeing Integrated Team (MINT)** continues. Two stakeholder welcome days were held in December and January, and a 'culture change' workshop is scheduled in February. The team started taking a small number of referrals from the AWP Primary Care Liaison Service (PCLS) late January and will continue to ramp up as staff come on board.

Work has progressed well on development of a **business case for a community based Complex Care Team** to provide focussed support for a cohort of circa 400k older residents living with complex, long-term conditions. The business case will be submitted to Woodspring Locality Partnership Board in March for approval, whilst clarity on the System decision making process continues to be sought.

Work progresses to articulate and address the **health inequalities** within Woodspring, with a priority focus on Pill (where one of its three LSOAs falls in the 20% most deprived areas of NS). In November, Locality Partnerships secured in-year health inequalities funding which Woodspring Locality Partnership Board elected to invest in the existing Power to Pill infrastructure. £19k was allocated for part-time Pill based Community Development Worker at three days a week for nine months, with an additional £2k allocated for costs that provide or enable interventions (e.g. dehumidifiers for damp housing). The insights from this role will help the Board understand the needs of the community better and will inform future service provision.

Three years recurrent Health Inequalities funding is expected to be devolved to Localities from 2024/25. Over the next couple of months, Woodspring Locality Partnership will agree how to invest year one allocation (c.£83k), informed by concurrent data and insights work.

Portishead Wellbeing Partnership continue to deliver **free wellbeing workshops** for residents of Portishead. Since November, workshops on the topics of developing a health relationship with food; living with chronic pain and diabetes management have taken place. As part of the NS Mental Health Strategy, funding has been allocated to each Locality to deliver parent / carer workshops to help manage anxiety in children and young people. The planning for these workshops will take place over the next couple of months.

More detailed scoping of the Woodspring **Starting Well** Programme is underway, with Dr Tanya Beer appointed as Clinical Lead. Priorities include anxiety in children and young people; self-harm; Adverse Childhood Experiences (ACEs) and asthma.

Weston, Worle & Villages
In line with Starting Well priorities, the One Weston Locality Partnership Board have agreed a focus on early years for its allocation of **health inequalities** funding for Q4 23/24. Following an initial scoping exercise, engagement opportunities with local families will be identified and consideration given to the range of current interventions offered in the early years, and how this offer could be scaled up in key areas that matter to these families. The funding will then be used to provide additional dedicated time and resources as part of these interventions to reduce barriers to accessing support, or in consideration of this cohort's preferences for when and how support is provided. Evidence and insight from the initial scoping exercise will then be used during Q4 to help inform investment of the 24/25 allocation.

Pier Health Group are one of six Primary Care Networks in the South-West to host a **Digital Neighbourhood Vanguard**. This is a multi-year NHS England programme which will bring new digital tools to use in primary care, with a mission statement to 'transform the experience of the citizens we serve and the workforce we support by empowering integrated neighbourhood teams with the digital technology and data capabilities required to enable proactive care and unplanned healthcare events. The programme is currently in the discovery phase, exploring what working across team and organisational boundaries is like now, what digital tools and data are already used, and how useful these are.

The draft Outline Business Case for an **Integrated Community Frailty Hub** was agreed by the One Weston Locality Partnership Board in December. Work continues to develop the Case, pending confirmation of System decision making processes.

4. PAN-LOCALITY PARTNERSHIP WORKING

The 6 BNSSG Locality Partnership Chairs and Heads of Locality have formally established the Locality Partnership Collaborative. The group meets monthly to discuss collaboration in areas of commonality and consider how we make it easier for the ICS and System partners to interact with us as a collective.

A Terms of Reference has been agreed and shared with the Communities Health & Care Improvement Group (HCIG).

5. BNSSG ICB CONSULTATION

The ICB continues its organisational change process driven by the NHS England mandate that all ICBs need to deliver a further 30% saving on running costs. All ICB staff, including Locality Partnership staff employed by the ICB, are included within this consultation.

Around 30 voluntary redundancy applications were approved by the ICB and await final NHSE sign off. The consultation came to an end 24th January 2024 and the outcome will be communicated to staff at the end February 2024. Mobilisation of the new structures will take place between March and May 2024. Costs (ideally) need to be removed from the ICB running costs by 1st April 2024.

In terms of ICB employed Locality Partnership staff, the structure included within the consultation proposed the following changes (noting that this is subject to change, post-consultation):

- Senior Manager role at Local Authority level
  - 6 x B8c Heads of Localities to be replaced by 3 x B8d Locality Directors
- B7 Locality Development Managers to remain at Locality level (x 6)
- B6 Senior Programme Officer role to reduce from Locality (x6) to Local Authority level (x3)
- B4 Locality Administrator role to reduce from Locality (x6) to Local Authority level (x3)

There is an expectation that scoping a new model for the management of localities will take place with System partners during the coming months and that any changes to delivery models will happen during 2024/25. There are no firm plans at present (but recurrent funding has been confirmed for Locality Partnership Chairs). The teams that deliver these activities will remain as part of the ICB at this stage and are aware that future changes may include further service and system consultation in the next financial year.

6. EQUALITY IMPLICATIONS

The ICB collaborating with its partners will ensure that all approaches are fair and equitable to the population of North Somerset.

A clear framework will be established to ensure we can evaluate both our successes and learnings from activities that are being undertaken.

AUTHOR

Kirstie Corns – Head of Woodspring Locality
Kate Debley – Locality Development Manager for One Weston, Worle and Villages Locality

BACKGROUND PAPERS

N/A

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North Somerset Council

REPORT TO THE HEALTH AND WELLBEING BOARD

DATE OF MEETING: 14th february 2024

SUBJECT OF REPORT: Bristol North Somerset & South Gloucestershire (BNSSG) Integrated Care System All Age Mental Health and Wellbeing Strategy

TOWN OR PARISH: All of North Somerset

OFFICER/MEMBER PRESENTING: Georgie MacArthur, Consultant in Public Health. Report prepared by Julia Chappell, Senior Business Development and Planning Manager, AWP NHS Trust

KEY DECISION: The North Somerset Health and Wellbeing Board are asked to make a decision to endorse the Integrated Care System (ICS) All Age Mental Health and Wellbeing Strategy. The strategy is also being submitted for endorsement to the Integrated Care Partnership Board and the Bristol & South Gloucestershire Health and Wellbeing Boards.

REASON: To enable the strategy to be implemented across BNSSG

RECOMMENDATIONS

It is recommended that the North Somerset Health and Wellbeing Board;

- Endorse the final version of the strategy following the engagement
- Note that the strategy is also being submitted to the Bristol & South Gloucestershire Health & Wellbeing Boards and the Integrated Care Partnership Board for endorsement.
- Note that the Mental Health Learning Disability and Autism Health and Care Improvement Group (MH LD & A HCIG) will implement and monitor the strategy through a combination of an action plan and the annual refreshes of the NHS Joint Forward Plan. The HCIG consists of mental health leaders from across the health and care system in BNSSG with North Somerset Council represented by the Chief Executive of the Council who co-chairs the meeting.

1. SUMMARY OF REPORT

1.1. The North Somerset Wellbeing Board are asked to endorse the final draft of the Bristol North Somerset & South Gloucestershire (BNSSG) All Age Mental Health and Wellbeing Strategy and plan on a page which are appendixes 1a and 1b to this cover paper. This cover paper summarises the process of, and feedback from, engagement between the first and final draft as well as the edits which have been made as a result.

2. BACKGROUND

2.1. All Integrated Care 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. 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.

2.2. In late 2022, AWP were asked to lead on the development of a new All Age Mental Health & Wellbeing Strategy on behalf of the system. This would be based on previous co-production completed for a draft strategy developed, but not finalised, between 2018-20.

2.3. A steering group was established to guide the development of the draft. The group included representatives from across the three Local Authorities, the mental health Voluntary and Community Sector alliance, AWP and acute trusts.

2.4. As the draft document was developed, it was shared widely in partnership meetings across the system. A full engagement log detailing the meetings attended and feedback received was kept and reviewed by the steering group.

2.5. In addition to formal partnership meetings, some of which also included people with lived experience, specific meetings were held to share the draft strategy with people with lived experience. These included the Barnardo's Helping Young People Engage (HYPE) Group which has representatives from a number of young people's sub groups, the Independent Futures (IF) group representing people who have experience of multiple disadvantage and the Independent Mental Health Network (IMHN).

2.6. Through this initial engagement process over 300 people had the opportunity to input into the draft.

2.7. This process led to a strategy which;

- 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"

2.8. The draft strategy was endorsed by the Integrated Care Partnership Board on the 28th September and published for an 8 week engagement period on World Mental Health Day, the 10th October.

3. COMMUNITY AND STAKEHOLDER ENGAGEMENT

3.1. Alongside the draft strategy being published on the ICB website, a survey monkey was published to give people in BNSSG a chance to further shape the strategy. The survey

asked if the strategy was clear and accessible, what was missing from the strategy and what was the key thing people would like to change within the mental health system.

3.2. There were 53 responses were received to the survey monkey. 20 of these were from groups/Organisations (reflecting at least 124 individuals with 7 group responses not confirming how many people took part) and 33 from individuals.

3.3. People who answered as individuals were asked to share their demographic information. An analysis of demographics indicated those who took part were broadly reflective of the BNSSG population in terms of age, ethnicity, sexuality and religion. However, in terms of gender 23 responses were female and only 8 were male. This may reflect the higher number of female staff within the health and social care workforce.

3.4. The themes and changes which have been made as a result are summarised below;

Theme	Edits as a result
The strategy reflects the correct aspirations, but how will it be delivered?	Including graphic on the final page explaining JFP will have detail on projects to deliver the strategy. As described below there will also be a strategy action plan led by the ICB.
Are there enough resources to deliver the strategy and how will this be managed?	An opportunity costs graphic was developed to demonstrate the benefits of investing in prevention. However, it is recognised resources will continue to be a challenge requiring HCIG to prioritise and phase investments over the lifetime of the strategy.
How will you measure impact?	A table with all the detailed metrics we will use has been added as appendix 2 of the strategy.
You need to emphasise social support more	Case studies have been added to show impact of social support and text added to strengthen to highlight the impact of social support.
You need to emphasise multiple disadvantage/dual diagnosis more.	A paragraph to be added to specifically address this and it has been addressed through case studies.
The strategy should recognise the change from the Care Programme Approach to Support Conversations.	Text has been added to explain the move to Support Conversations under our holistic care ambition.
The Strategy talks a lot about children, young people and adults but not enough about older people.	We have added text under holistic care to describe the programme of work being led by our older people's mental health clinical lead across both functional mental ill health and dementia.

4. NEXT STEPS

4.1. A strategy action plan is being developed to pick up on the specific, immediate term, commitments within the strategy and ensure that these are being delivered. Once populated, this plan will be shared with the Mental Health Learning Disability and Autism Health and Care Improvement Group (MH LD & A HCIG) for approval and onward monitoring.

4.2. In the medium to long term, the strategy will be implemented through the NHS Joint Forward Plan (JFP) and its annual refreshes. The 2024/25 JFP has therefore been structured so that all projects are aligned against the six strategy ambitions.

4.3. Finally, a brief cover sheet will be developed for MH LD&A HCIG so that every paper coming for discussion or decision is aligned to the ambitions within the strategy. This will allow the MH LD&A HCIG all work against the ambitions and consider where there may be gaps.

5. FINANCIAL IMPLICATIONS

5.1. Implementing the strategy will have financial implications as it will be the guide through which both new NHS investments and proposals for transformation are viewed. This will be governed by the Mental Health, Learning Disability and Autism Health and Care Improvement Group where the Council are represented by the Chief Executive who Co-Chairs.

6. LEGAL POWERS AND IMPLICATIONS

6.1. There are no legal implications from endorsing the strategy

7. CLIMATE CHANGE AND ENVIRONMENTAL IMPLICATIONS

7.1. The strategy includes a specific priority on ensuring services are financially and environmentally sustainable. This will includes ensuring all providers in the system have sustainable and ethical supply chains and plans to work towards net zero.

8. RISK MANAGEMENT

8.1. Risk management will sit with the Health and Care Improvement Group. Key risks associated with the strategy are;

- There is a risk that system resource will be insufficient to allow all the ambitions of the strategy to be delivered of the next 5 years. This will be mitigated by the system carefully scrutinising the use of new and existing resource to ensure value is being delivered
- There is a risk that new policy developments such as a new 'Long Term Plan' for mental health make the strategy out dated. This is mitigated by the fact that the Joint Forward Plan will be refreshed annually and can account for any changes in national focus

9. EQUALITY IMPLICATIONS

9.1. The strategy contains a specific priority and initial plan to address health inequalities in mental health. This will support groups in the North Somerset community who do not currently have equity of access, experience or outcomes from mental health support.

10. CORPORATE IMPLICATIONS

10.1. Having an Integrated Care System wide strategy will improved partnership working and a focus on prevention which is expected to improve mental health outcomes in North Somerset and the wider BNSSG area.

AUTHOR

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APPENDICES

1. A. BNSSG All Age Mental Health and Wellbeing Strategy – final version
   B. BNSSG All Age Mental Health and Wellbeing Strategy Plan on a Page – final version

2. Communications plan for the final strategy

BACKGROUND PAPERS

None

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Healthier **Together**

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

Bristol, North Somerset and South Gloucestershire Integrated Care System All Age Mental Health and Wellbeing Strategy 2024-2029

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Introduction

We are delighted to present our All Age Mental Health and Wellbeing Strategy, setting out our partnership approach to improving mental health and wellbeing in the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System. This Strategy is for anyone who wants to understand the vision and ambitions for the future mental health services and support in BNSSG, including the work which will deliver this.

This vision and Strategy has been co-produced and are co-owned by people with lived experience and their families, community representatives, voluntary sector organisations, statutory health and social care providers, wider mental health stakeholders and commissioners.

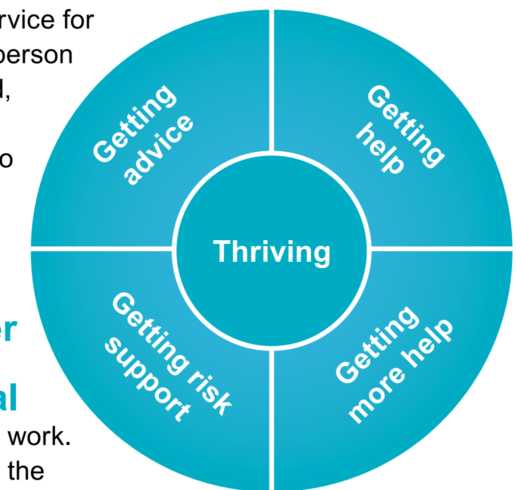
The Strategy takes an **all age** life course approach, recognising that good mental health is a key principle underpinning wellbeing, and is embedded in family and community life.

This Strategy sets out six key ambitions for more effective **joint-working**. In doing so, 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,** delivering the best mental health outcomes.

Whilst also delivering a service for people of all ages, that is person centered, trauma-informed, recovery focused and is a place where people want to live and work.



Whilst mental health and wellbeing is our focus, we will strive to deliver **wider social, economic and environmental benefits** as part of this work. In particular, we recognise the absolutely vital role of stable housing in supporting good mental health.

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

Healthier Together

The wider context

Our system has developed a document which assesses the health needs of the people who live here; Our Future Health This has identified that mental health conditions are among the biggest drivers of population health and care needs. This Mental Health and Wellbeing Strategy supports the overarching BNSSG Integrated Care Partnership Strategy. The ICS Strategy prioritises specific projects to support delivering transformation in health outcomes. We will ensure this work aligns with the ambitions within the Strategy and includes priority projects for mental health.

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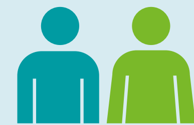
Mental health and age

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

Students: With social and academic pressures, this is a time of major life transition during the developmental transition to adulthood. Adding in financial stresses and potential negative consequences of digital technology and social media, students are a high risk group for developing mental health and wellbeing problems.

Parenting and mental health: All parents face challenges and 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.

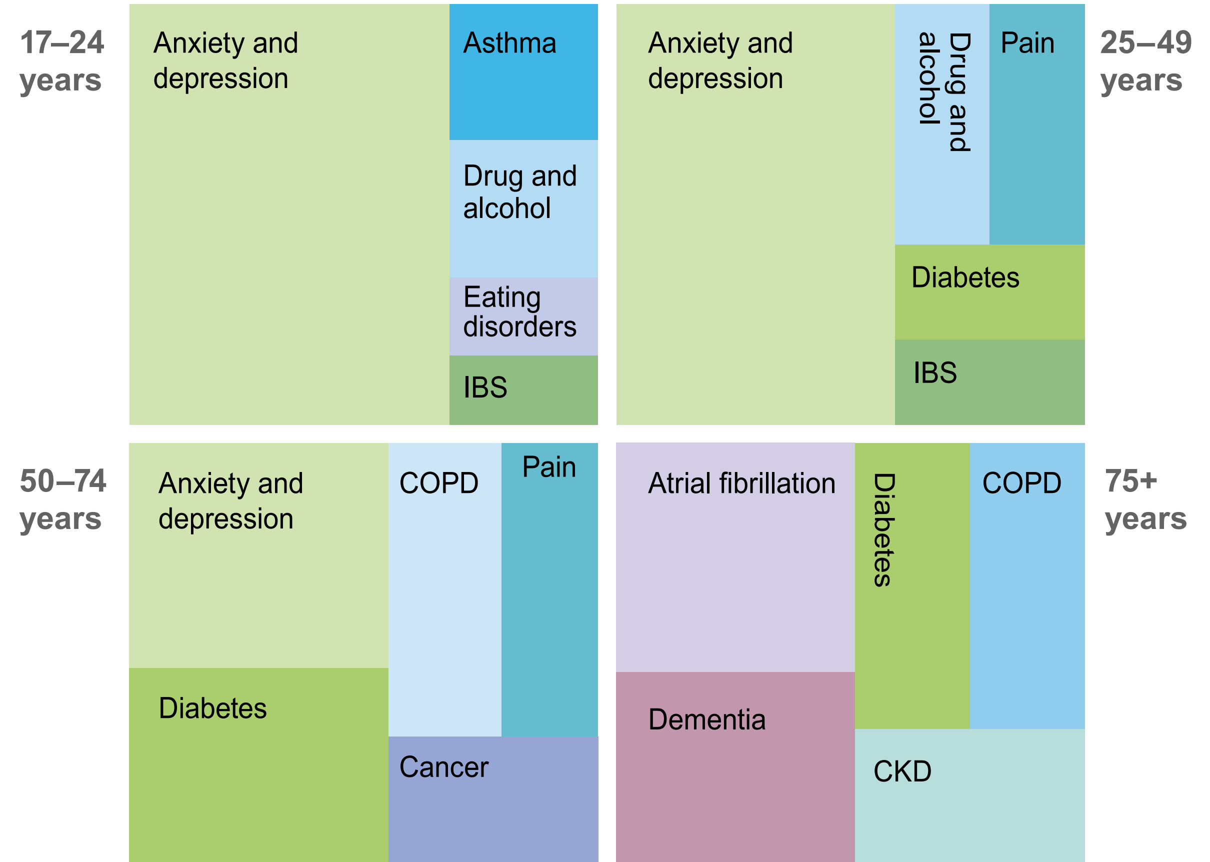


Later in life: Changes in life as we get older such as retirement, bereavement, loneliness, becoming a carer and physical illness can affect mental health and wellbeing.

Source: Mental Health Foundation 2021.

Our population

The impacts on health through the life course in BNSSG



Source: Our Future Health 2022

The graph above shows conditions that have the greatest impact on the population, shown in four different age groups. The bigger the 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 within the top 5 most impactful conditions across the life course (particularly among the over 50s population) within BNSSG. 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.

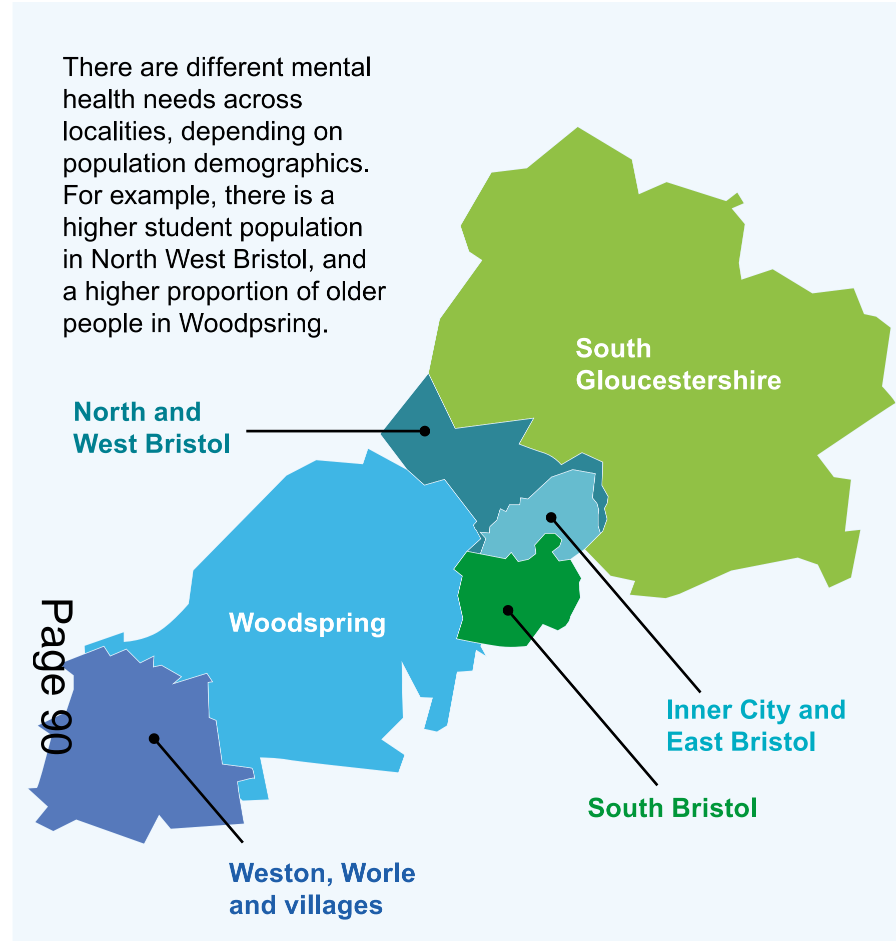
Eating disorders rank in the top five most impactful conditions among 17-25 year olds in BNSSG.

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 population



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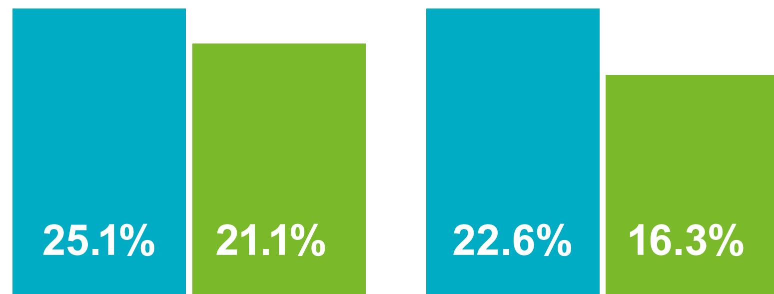
Mental health in areas of deprivation

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



Children and Young People

Adults

Most deprived areas

Least deprived areas

Source: BNSSG System Wide Dataset Analysis.

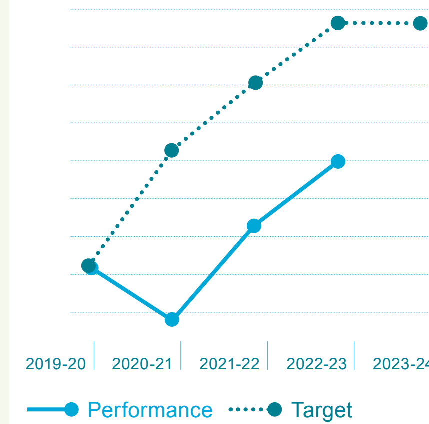
Where are we now?

Long Term Plan for mental health

In 2019, the NHS Long Term Plan (LTP) for mental health was published. This set out ambitious expectations for health systems across the country to deliver significant improvements in all age mental health and wellbeing over the next four to five years.

Significant progress has been made in improving our mental health offer over the past few years. Concentrated work has been completed in line with the NHS LTP, through working with key partners and with increased investment. This progress is demonstrated through our system's improved performance against some of the core national measures highlighted here.

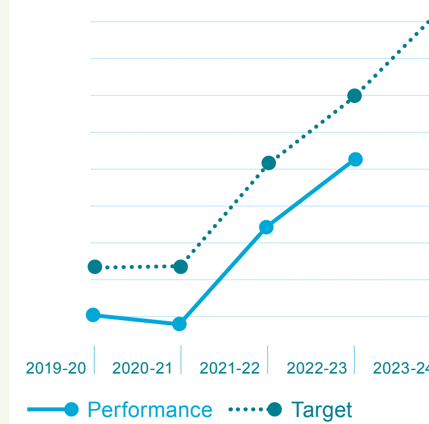
Perinatal Access



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.

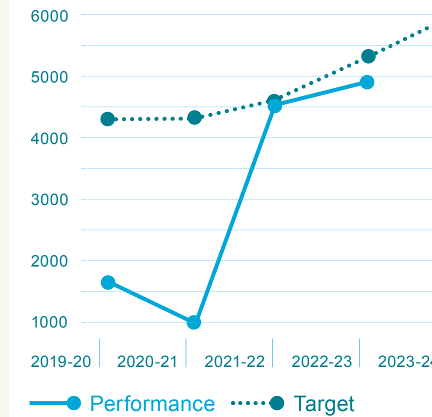
Children and Young People Access



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

By 2025 over 50% of school aged pupils in BNSSG will have access to early help delivered by a mental health support team in their school.

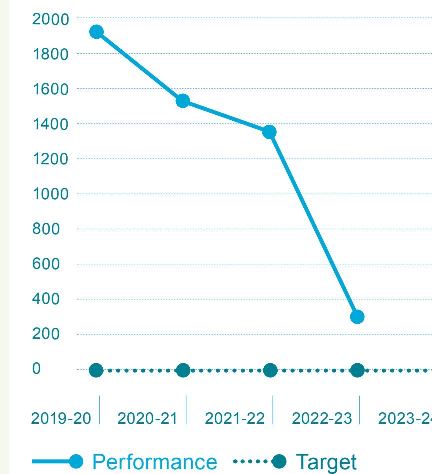
Physical Health Checks for people with Severe Mental Illness (SMI)



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.

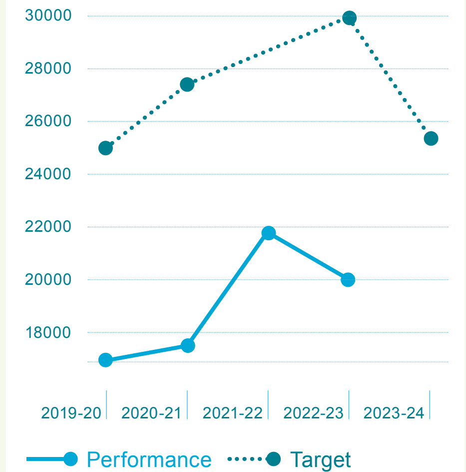
Out of Area Placements



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 very few people are now placed out of area unless they have highly specialist needs that cannot be met by local services.

NHS Talking Therapies

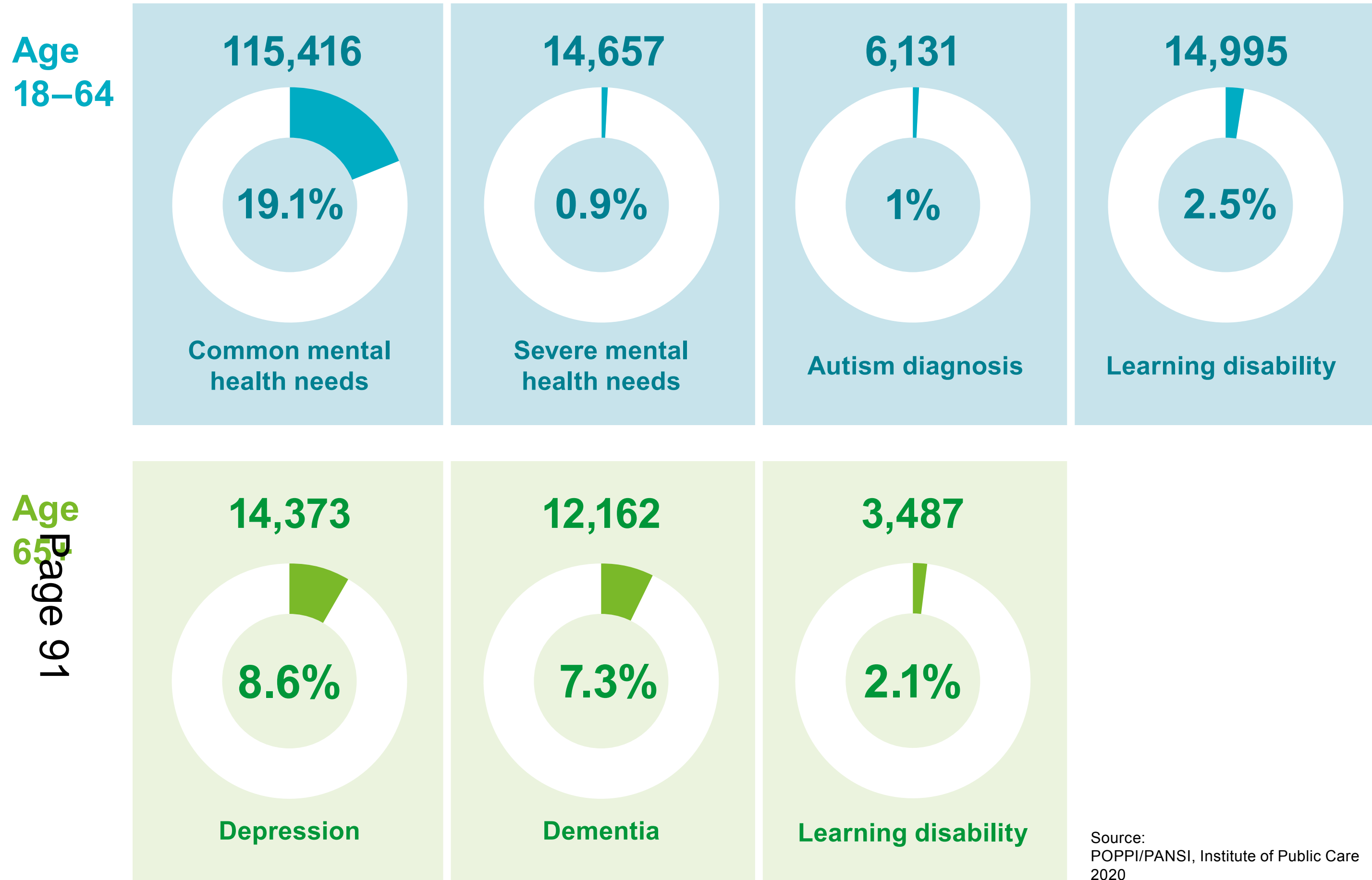


Data Source: Psychologoical Therapies, Reports on the use of IAPT services – NHS Digital (Indicatore MO31).
2020/21 Performance impacted by Coronovirus Pandemic.

As a system we are meeting multiple national NHS Talking Therapies targets, such as those which measure recovery from illness. The NHS Talking Therapies target measures the number of people able to get help from NHS Talking Therapies. Increasing the access to Talking Therapies has been difficult due to a combination of investment and transformation however we are planning to meet the target in 2023/24.

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 outcomes and experience measures so that we know what is helping people of all ages the most in their recovery.

Estimated levels of mental health needs, learning disability and autism in adults across BNSSG



Source: POPPI/PANSI, Institute of Public Care 2020

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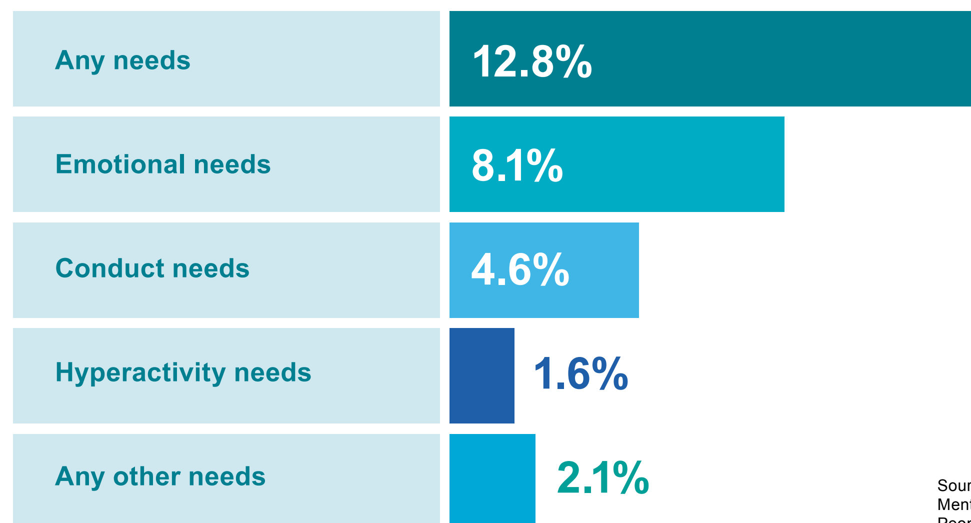
Estimated levels of metal health need among 5-19 year olds across BNSGG



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

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

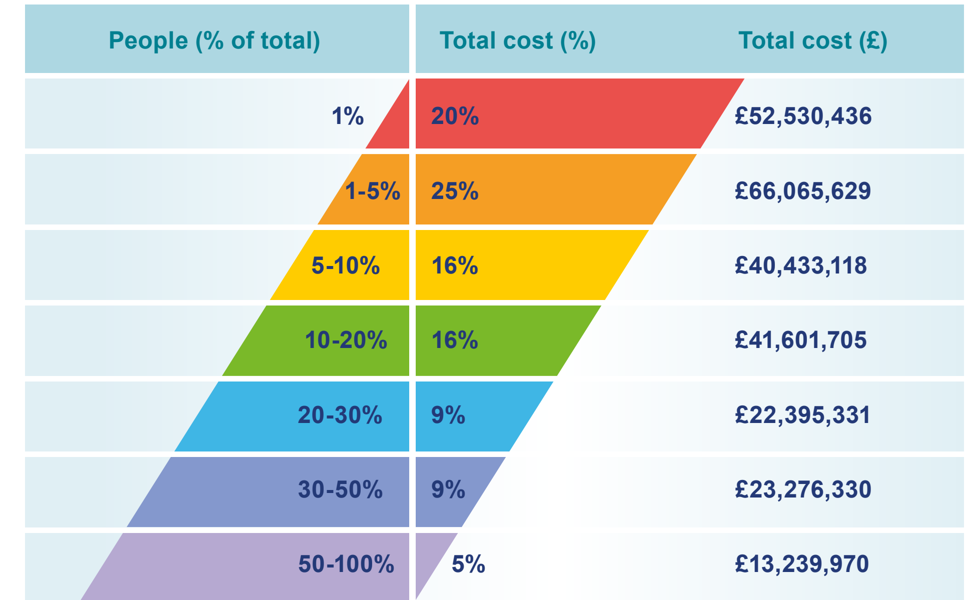
The pyramid diagrams below are designed to show how, currently, very large amounts of funding are spent on a small group of the most unwell people. Our ambition is to create a shift so that more money is invested in prevention to keep people well.

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

For BNSSG this is 1609 people

Annual 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

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

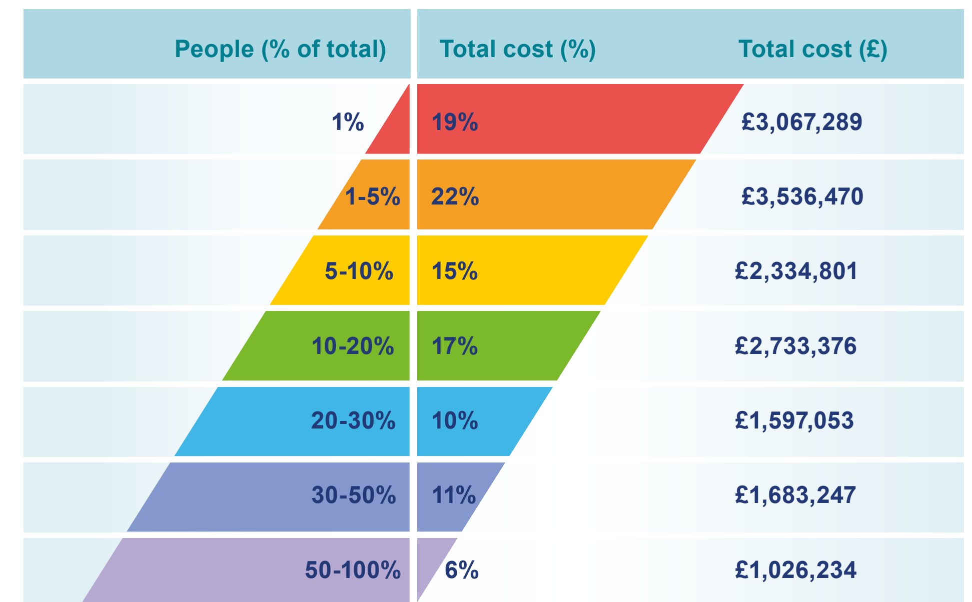
Costs for children and young people aged 0–17 with a mental health condition in BNSSG

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

For BNSSG this is 116 people

Annual 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

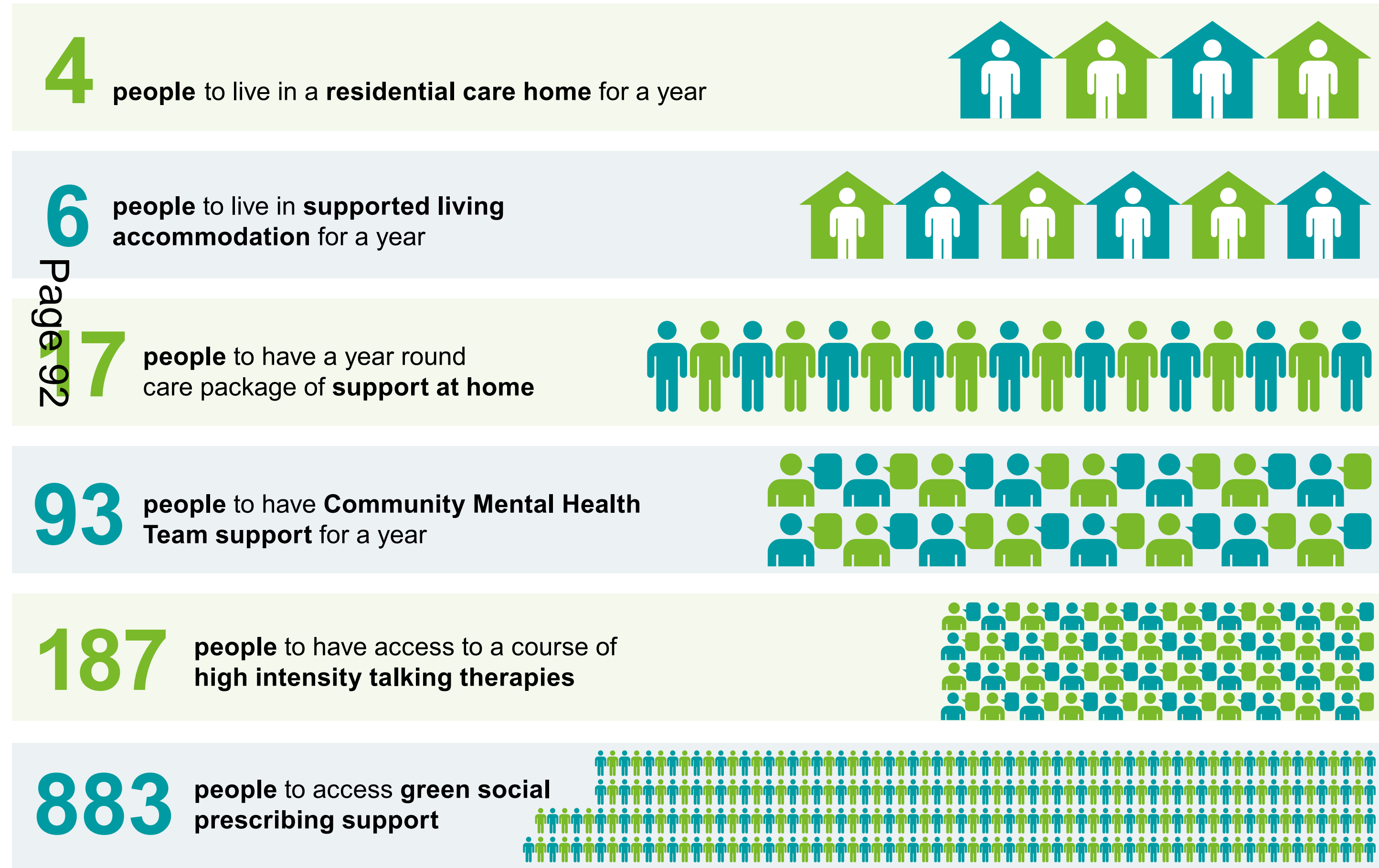
Costs include admissions and attendances across primary, secondary and community care as well as prescribing (1 year, 2021/22). Some costs are Payment By Results (PBR), some are indicative. Maternity inpatient activity is included because it cannot be separated from outpatients using the system wide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

Opportunity costs for our system

We have analysed examples of average costs within our system to understand what we could buy if we were able to stop using one mental health inpatient bed a year. The diagram below demonstrates that we must focus on prevention because we can help far more people with our resources through this approach.

For the cost for **1 mental health inpatient bed** each year we could pay for:



Sources: AWP RiO, Bristol City Council Social Care purchasing system, BNSSG Green Social Prescribing Programme, VITA Health Talking Therapies Service. N.B. talking therapies is based on an average length of 9 sessions not including assessment.

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 focused care planning for everyone.

As an Integrated Care System we have:

Co-produced and implemented a First Episode Rapid Early Intervention for Eating Disorder (FREED) service and introduced a new Voluntary, Community and Social Enterprise (VCSE) partner, called Sweda, who deliver holistic support closer to home. This quickly offers people more holistic support and has reduced waiting lists by over 50%.

Co-designed, and started to deliver, 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 providing Mental health and wellbeing Integrated Network Teams (MINTs) for adults across BNSSG. These bring health, social care and VCSE partners together to meet people's diverse needs, offering access to the right mental health support at the right time.

Strengthened our community mental health rehabilitation team and introduced a flexible grants scheme, which has reduced the number of people requiring care outside our local area by 45%.

We have co-designed a new personalised, system based, care planning approach that focuses on creating a team around each person, with enhanced involvement of family and carers. We will use co-produced 'Support Conversations' to ensure that all agencies are working together to support people achieve the outcomes that are important to them.

Increased capacity in primary care, Avon and Wiltshire Partnership's Physical Health Teams and peer support roles to enable more people on GP Severe Mental Illness registers to receive an annual physical health check and have their physical health needs met. This increased provision from 12% (2021) to 62% (2023).

Introduced a range of mental health support accessible to people calling 999 or NHS 111 to make it easier for people to get the support they need 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. This will build on the positive progress we have already made.

Prevention concordat

The Prevention Concordat for Better Mental Health was published in 2017 and provides resources for local areas to take an evidence 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.

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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 trauma-informed approach to practice. This helps 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 within 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 health 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. As a result of this, additional funding and support has been utilised to develop mental health support in schools and colleges across BNSSG. Furthermore, the Long Term Plan has driven, and will continue to drive expansion and transformation.

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

Mental Health Support Teams in Schools (MHSTs): BNSSG has completed three waves of MHSTs, with 10 teams now available across the geography, in locations 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 hospitals. There is a 24/7 response line in place, enabling young people requiring a mental health assessment to receive one sooner, and ensuring that appropriate care is received. Furthermore the Crisis Teams 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 Child and Adolescent Mental Health Services (CAMHS) and Acute Emergency Department eating disorder teams have been increased. Alongside this, 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 Hospital for Children 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: Discussions are being held with key organisations across the system to scope transitions pathways for young people aged 16-25. 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.

Significant transformation 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 children and young people.

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 and fairly, and disparities experienced by people from 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 and Carer Race Equality Framework is now being rolled out nationally. 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.

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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, embed training and establish culture changes. This will ensure everyone in our system understands the drivers and the impact of health inequalities. Furthermore, 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 Minds Matter group

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.

Complex Multiple Disadvantage

We recognise that data and statistics cannot tell the full story. People who need mental health support will have a wealth of life experiences that impact their mental health. Some of these will be positive and support their mental wellbeing and some will result in trauma that can have a negative impact on mental health. For example, someone may have experienced trauma or domestic abuse which has caused them to be homeless and the impact of that trauma and homelessness may lead people to misuse drugs or alcohol to self-medicate. In addition, people from minority ethnic groups, people who are LGBTQIA+, people with learning or physical disabilities and neuro-divergent people are more likely to experience barriers in accessing mental health support. When they do access mental health support they tend to have a poorer experience and worse outcomes.

The data and needs analysis that we have done does not tell us about peoples real life stories and the complex difficulties that they experience. These experiences are not always well documented and different data sets look only at one kind of need or experience. Different aspects of people's lives can intersect and compound their trauma and inequality; we want partners in the mental health support system to recognise and understand the complexities of the lives of people and, in so doing, better enable their recovery.

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 typically 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 typically lives 7.9 years less than a woman living in the least deprived area.

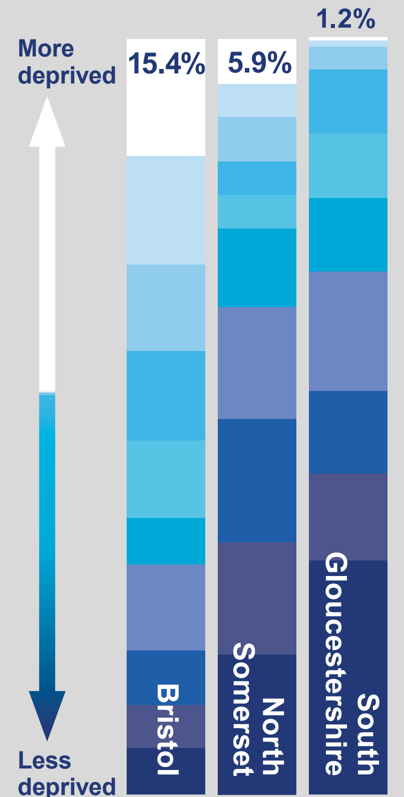
Minority ethnic groups:

- **19%** Bristol
- **4.3%** North Somerset
- **9%** South Gloucestershire

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



BNSSG Our Future health (ethnicity statistics updated from 2021 Census)

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.

Our 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

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.

We are proud of what we have achieved so far

Link Team
(Holistic care)

The Link Team supports people in Bristol who are street homeless and experiencing other challenges like addiction, domestic violence, learning disabilities or neurodiversity. The team bridges the gap ensuring mental health support gets to people, often for the first time in years.

They are a skilled multi-disciplinary team from organisations across Bristol. Support is person-centred and trauma-informed, meaning the team take time to understand a person's past, the social context of their experiences (such as racism), and how this affects their life now.

“He completely took the lead, made a workout plan, and directed the session. It was a great bonding opportunity that strengthened the relationship and also created some equalising of power through role reversal: I was asking questions, he had the answers.”

Link team worker

Mental Health in Schools
(Prevention and early help)

AWP has worked with local charity, Off The Record, to provide Mental Health Support Teams in schools in Bristol, North Somerset and South Gloucestershire.

They provide interventions for young people with mild to moderate mental health needs, and help develop a whole school approach to mental wellbeing. This type of support is non-stigmatising for young people and less disruptive to education. Families are included as a key part of the support team and there is access to further services if needed. The service covers approximately half of our schools and colleges, based on need.

“OTR's intervention has had a huge impact – the students have been supported quickly and proactively, and at an early stage.”

BNSSG teacher

Integrated Access Partnership
(High quality treatment)

The Urgent Assessment Centre is a pilot crisis service operating 7 days a week between 5pm - midnight. It provides a safe space for people in mental health crisis who are referred from 999, NHS 111 or emergency departments.

Offering holistic mental health assessments to understand needs during a crisis, it provides mental health coping skills, emergency support with housing and finance, and ongoing help. The service provides clear and planned recovery next steps, preventing people feeling alone in a period of crisis. This has meant reductions in police use, ambulance time and those waiting in an emergency department for mental health support.

“I think that it was just the fact that I didn't have to go into hospital. I felt like I could come here and it was a way of calming down without having to spend hours at the hospital for them not to do much. I feel a lot safer going home now.”

UAC service user

Green Social Prescribing (GSP)
(Sustainable services)

The BNSSG ICS Green Social Prescribing partnership is one of seven pilot sites helping people access nature to improve health outcomes. Since 2021, more than 3,000 people have been supported to access the natural environment; ranging from mothers experiencing post-natal depression, school age children experiencing anxiety, working adults with low mood and older adults with dementia.

Whether it is care farming, woodland conservation, nature photography, horticulture therapy or open water swimming, there are a range of high-quality interventions available to support our community, which also make a positive contribution to biodiversity. We are also working to offer alternatives to prescribing anti-depressants.

“Wild swimming has helped significantly reduce the quantity and intensity of suicidal thoughts I was having.”

Open water swimmer referred via primary care

Women's Health Training
(Advancing equalities)

Womankind and Missing Link, two local charities, were funded by the ICB to deliver women's health training.

The training supported mental health practitioners, staff and volunteers in the NHS and VCSE to better understand the barriers women face in accessing mental health support and the factors affecting their mental health throughout their life.

“Early autism diagnosis is needed to help people understand themselves and mitigate a crisis caused by masking.”

Training participant

Staff Support Debriefs
(Great place to work)

Working in mental health services, staff can be exposed to events that can be very distressing and potentially traumatic for them. AWP has implemented Staff Support Debriefs to help staff affected by such situations.

The process involves AWP trained facilitators providing a voluntary session to any staff member affected by a traumatic event. During the session the staff can speak about the event, discuss the impact on them, receive information about trauma responses, and identify further sources of support that may be of benefit.

“It has felt very supportive and I am hopeful it will allow me to move forward without feeling so bad…”

AWP Staff Member

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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 Mental health and wellbeing Integrated Network Teams (MINTs) established across BNSSG. These teams include a wide range of NHS, local authority, talking therapies and voluntary sector providers. This will 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.

These teams will use shared personal wellbeing plans called a 'Support Conversation'. These plans will replace the Care Programme Approach and will capture people's strengths and assets alongside their mental health needs.

We will aim to have the voluntary sector as an equal partner within all our models of care. This ensures that people of all ages get holistic support that is offered at an early point. It also ensures consideration of the social determinants of health such as housing, debt or social isolation.

We will continue to 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 severe 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.

Where people are in an acute physical health hospital and require mental health support, we will ensure holistic care is delivered.

We will know we are making a difference when:

We have Mental health and wellbeing Integrated Network Teams (MINTs) fully established in every locality within BNSSG

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

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

People of all ages will report experiencing integrated care. We see indicators for crisis presentations reducing.

We will have a dedicated clinical lead for older adults, who is reviewing care pathways to ensure they are accessible to older adults with functional illness, who currently do not always get the support they need.

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 people who sleep rough have a mental health need

Source: Bristol City Council

45%

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

Source: Homeless Link 2022

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 and housing advice.

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 develop a dementia Strategy which delivers equity of offer across BNSSG, and seeks to support early diagnosis.

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.

We see improvements in everyone's wellbeing.

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.

We see self harm rates in young people reducing.

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

Source: Statistical commentary on UK Household Longitudinal Study wave 11

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.

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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 Partnership (mental health phone support available through calling NHS 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. We will ensure that where children and young people need to 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 local work, to ensure people who require inpatient care have high quality treatment and as short a stay as possible and are supported to be 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 disadvantages.

We will know we are making a difference when:

We have embedded the use and monitoring 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 most 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 inpatient 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. Our service models meet national best practice requirements. Our service models meet national best practice requirements.

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

Source: BNSSG System Wide Dataset Analysis 2023

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, working 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 offer specific activities to those previously not reached, 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 including Healthwatch as well as people of all ages and backgrounds, families and carers with lived experience. We will specifically seek to understand from people of all ages and backgrounds 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 Mental Health, Learning Disability and Autism 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

LGBTQIA+ people have avoided health treatment for fear of discrimination

Source: Stonewall 2017

52%

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

Source: Stonewall 2017

Around 1 in 5

women have a mental health problem

Source: Mental Health Foundation, 2021

3x

as many men as women die by suicide

Source: Mental Health Foundation, 2021

Black people are 3x

more likely than white people to be sectioned under the Mental Health Act

Commission for Equality in Mental Health, 2020

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 learning from the South West Workforce Forum, we will pilot new approaches to staff skill mixes 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.

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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 percentage of mental health staff say they are satisfied with the quality of care they provide.

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

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

The health and wellbeing of our staff improves.

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 experience of mental health services 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 in contact 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. It also is 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 ensure our new co-created support plans will be shared with people directly via Digital Patient.

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.

Accessing mental health support should be easy – where to start, who to contact. It should be as simple as calling 999 is when there's an emergency"

Independent Futures (lived experience) group member

£105 billion per year

is the estimated economic and social cost of poor mental health

PHE 2018

Next steps

Forming an Integrated Care System (ICS) represents the best opportunity to deliver urgently needed transformation of our health and social care system. The ICS provides the opportunity to break out of organisational silos, enabling all partners to work together to tackle deeply rooted challenges, drawing together their collective skills, resources and capabilities.

Five key principles which will allow our ICS 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

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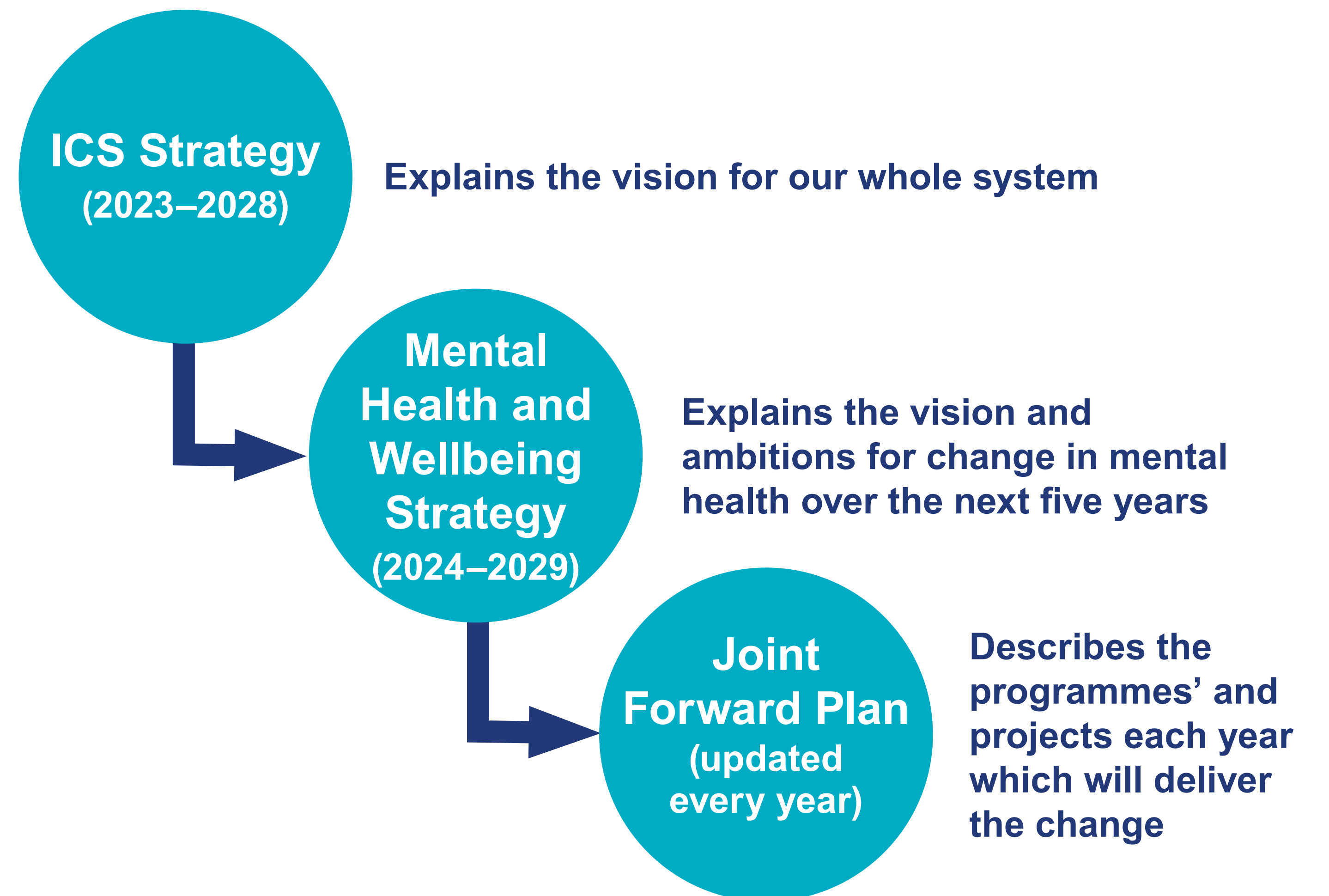
Locally we are absolutely committed to the transformative power of working together to deliver change. There is a Mental Health, Learning Disabilities and Autism Health and Care Improvement Group which oversees the delivery of the vision, ambitions and priorities set out within this Strategy. The Health and Care Improvement Group includes representatives from partners across our system. There is also a Children's Health and Care Improvement Group which provides additional scrutiny on the delivery of work to improve mental health access and outcomes for children and young people.

During 2024–25, 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 support 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.

How will the Strategy be delivered?



Glossary

TERM	DEFINITION
Acute care	Acute care is where a patient receives active, short-term treatment for a condition, often staying in hospital.
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 person's 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.
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, and the Children and Young People's 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. 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. Our local ICS is BNSSG.
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, is the government body responsible for delivering local services in an area.
Locality Partnership	These are groups of providers and wider partners working together at a local level to delivery care specific to the needs of local populations. In BNSSG there are 6 Locality Partnerships; North & West Bristol, South Bristol, Inner City & East Bristol, South Gloucestershire, Woodspring, Worle & Villages and Weston (both of which are in North Somerset).
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.
Mental health Integrated Network Team (MINT)	A new type of team around primary care bringing together NHS, social care and voluntary sector organisations (VCSE) to offer quick access to a broad range of support.
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 focused	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.
Safeguarding	protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility.
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 program, organisation, or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in individuals, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist retraumatisation. In BNSSG we have adopted 6 trauma-informed principles that underpin our approach: Safety, Trustworthiness & Transparency, Choice & Clarity, Collaboration, Empowerment and Inclusivity.
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.

Metrics to be used to measure impact against priorities

DOMAIN	WE WILL KNOW WE ARE MAKING A DIFFERENCE WHEN	CODE	INDICATOR
Holistic Care	Integrated personalised care teams are established in every locality within BNSSG.	HOL1 HOL2	Number of Primary Care Networks in your system meeting the data flow criteria for transformation. Activity within community mental health services for adults and older adults with severe mental illnesses.
	Everyone with a serious mental illness has access to an annual health check.	HOL3	People with severe mental illness receiving a full annual physical health check and follow up interventions (rolling 12 months).
	We see indicatiors for crisis presentations reducing.	HOL4 HOL5	Rates of total Mental Health Act detentions Rates of restrictive interventions.
	We see the gap in premature mortality between people with serious mental illness and the general population close.	HOL6 HOL7	Severe mental illness mortality gap close. Rate of suicide deaths (persons rate/100K).
	People using services report satisfaction with the practical help they receive.	HOL8	Proportion of DIALOG question 10 responses from 5-7 (fairly, very or totally satisfied).
	People using services report satisfaction with their meetings with mental health professionals.	HOL9	Proportion of DIALOG question 11 responses from 5-7 (fairly, very or totally satisfied).
	People of all ages will report experiencing integrated care.	HOL10	To be developed.
Prevention & Early intervenion	All our NHS mental health services will meet or exceed all national access and wait time standards.	PRE1	A new national approach to monitoring community mental health service waiting times has been released and provisional reporting in place. No wait time expectations have yet been set. We are working on reporting these locally.
	We see improvements in everyone's mental wellbeing.	PRE2 PRE3	ONS wellbeing 4 domains (% low happiness score). CYP Warwick-Edinburgh Wellbeing Score (proportion scoring very low/low.
	People of all ages using early intervention or early help will report it is high quality and easy to access.	PRE4	Adult mental health services use a Patient Reported Experience Measure to check peoples views of services.
	We see self harm rates in young people reducing.	PRE5 PRE6	Self-reported harm in young people . Hospital admissions as a result of self-harm (10-24years).
High Quality Treatment	We have embedded the use of 'paired outcomes measures' across our system which allow people of all ages using services, clinicians and the wider system to understand what support has helped someone with their recovery.	QUA1	Positive change in DIALOG between paired scores for questions 1-8.
	Services demonstrate helping people feel better.	QUA2	Talking Therapies recovery rate.
	Our service models meet national best practice standards.	QUA3 QUA4 QUA5 QUA6 QUA7	EIP services achieving Level 3 NICE concordance. Mental Health Liaison services within general hospitals meeting the "core 24" service standard. Coverage of 24/7 adult and older adult Crisis Resolution and Home Treatment Teams operating in line with best practice. Proportion of discharges from adult acute beds eligible for 72 hour follow up – followed up in the reporting period. Coverage of 24/7 crisis provision for children and young people (CYP) that combine crisis assessment, brief response and intensive home treatment functions.
	Fewer people of all ages are placed in an acute bed outside of our local area.	QUA8	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days for adults requiring non-specialist acute mental health inpatient care.
	Fewer people of all ages require an admission to an acute ward.	QUA9	Mental Health Acute admissions - adult and children.
	Fewer people of all ages experience a delayed discharge from an inpatient bed.	QUA10	Mental Health Trust Reporting.
	Fewer children and young people rely on Emergency Department support when in crisis.	QUA11	Mental Health A&E attendance for children and young people.
Advancing Equalities	We can demonstrate impactful investment in our local communities.	EQU1	We will analyse data from indicator QUA1 by locality and provider.
	We have good quality data flowing which indicates 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.	EQU2	Mental Health Services Dataset - Data Quality Maturity Index Score.
	Where inequity of access, experience or outcomes have been identified there are targeted and time bound improvement lans which are scrutinised by the Healthcare Improvement Group.	EQU3	Project documentation.
	For every project in the system there is strong evidence of co-production and measurable action to address health inequalities.	EQU4	We will monitor the following five indicators by age, sex, deprivation and ethnicity as a minimum: HOL3 HOL4 HOL5 PRE1 QUA2
Great place to work	An increased % of staff say they are satisfied with the quality of care they provide.	STA1 STA2 STA3	% of NHS staff who say they are satisfied with the quality of care they give to patients/service users. % of NHS staff who say their role makes a difference to patients/service users. Proportion of staff recommending their organisation as a place to be treated or cared for.
	We will improve the health and wellbeing of our staff.	STA4 STA5 STA6 STA7 STA8	Sickness absence rates - working days lost to sickness. Sickness absence rates - annual average. Vacancies. % of NHS staff who say their organisation takes positive action on health and wellbeing. Average reported health and wellbeing (emotionally exhausting, burn out, frustration, exhaustion, tired, time for friends and family).
	Increase in staff who are from underrepresented groups progressing to senior roles.	STA9	There are four data sources we can use to monitor different staffing groups.
	Increase in Lived Experience recruitment and progression to ensure we are making the most of the significant assets people with lived experience can bring to the workforce.	STA10	In development.
	Spend on agency across the system reduces and is in line with national benchmarks.	ST11	In development.
	Recruitment and retention rates improve and are above national benchmarks	STA12	In development.
Sustainable System	As a system we can demonstrate the wider social and environmental impact of our services.	SUS1	In development.
	We have a clear commissioning and contracting plan. supporting the sustainability of our whole system.	SUS2	In development.
	Providers can evidence use of local supply chains.	SUS3	In development.
	Providers can evidence that they have reduced their carbon footprint.	SUS4 SUS5	Measure annual carbon emissions across all scopes. Total financial cost to the system if we were to off-set our carbon emissions at £75 per tonne (all scopes).
	We have a digital solution/s which allow rapid information sharing across partners .	SUS6	Number of staff across different providers using the single mental health patient administration system In development.
	Providers can evidence local recruitment.	SUS7	In development.

Healthier **Together**

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

360 Bristol – Three Six Zero
Marlborough Street
Bristol
BS1 3NX
Tel: 0117 900 2655 or 0800 073 0907 (freephone)

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Bristol, North Somerset and South Gloucestershire Integrated Care System All Age Mental Health and Wellbeing Strategy 2024-2029

Our vision

Our vision is better mental health for all. People having the best mental health and wellbeing in supportive, inclusive, thriving communities. Our Strategy describes what we will do to achieve this.

The strategy is 'all age' meaning it covers mental health and wellbeing for our whole population from conception to end of life.

It covers the whole mental health spectrum regardless of whether people have had a formal mental health diagnosis. From people who have good wellbeing, to those who might need more intensive support.

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

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

Where are we now?

Good progress has been made in improving mental health support and care in recent years.

However, we know that there is still much more to do to make sure that everyone gets the support they need, when they need it. Our Integrated Care System gives us the opportunity to work even more closely to help make improvements for people.

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 six ambitions has a set of actions that will be taken to support the improvement of our systems' mental health services.

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 early 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 that delivers maximum benefit to the community.

5 Advancing equalities

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

6 Great place to work

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

Underpinning principle: 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 impact for each action so we can know whether we are driving positive changes. As a system, we will develop an annual 'Joint Forward Plan' which will be aligned to the ambitions 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.

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Communications Plan – The Bristol, North Somerset and South Gloucestershire All Age Mental Health and Wellbeing Strategy

1. Background

The BNSSG All Age Mental Health and Wellbeing Strategy outlines our ambitions and vision for mental health services across our area. All Integrated Care Systems (ICSs) are required by NHS England to have a strategy in place that provides in-depth detail on specific areas of mental health services.

The Strategy has been created, with organisations and people with lived experience, to build on the overarching ICS Strategy providing an overview of the policy context and the health needs of the BNSSG population. It identifies six ambitions for mental health services: holistic care, prevention and early help, quality treatment, sustainable services, health inequalities, great place to work.

Engagement was undertaken throughout development, including a final survey, to collect feedback from organisations and stakeholders to shape the final draft of the Strategy. The draft will now go through Health & Care Improvement Group (mental health and children's), Integrated Care Board and Integrated Care Partnership Board for final sign off. Once this has been completed, system partners should take responsibility to promote the strategy to their staff and local communities to help them understand and support our vision of 'better mental health for all'.

2. Governance

Governance arrangements

- The communications plan will initially be signed off by ICB Head of Communications and Engagement, Becky Balloch and AWP Senior Business Development and Planning Manager, Julia Chappell.
- Further sign-off will be required from the HCIG, ICB Board and ICP Board in February 2024 where the communications plan will be shared as part of the pack to accompany sign off the final strategy.

3. Objectives

The aim of this communications plan is to ensure staff, stakeholders and the local community are aware of the BNSSG Mental Health and Wellbeing Strategy.

- Make the Strategy readily available on our Healthier Together website and promote this widely to staff, stakeholders, and local communities, outlining why we have created it, and its long-term purpose.
- Support the promotion of addressing health inequalities in mental health services.
- Further develop effective relationships between partners delivering mental health and wellbeing services.
- Inform the local community of the mental health services available in BNSSG.

4. Audience/insight

The table below shows the stakeholders and community organisations we can communicate with to encourage promotion of the BNSSG Mental Health and Wellbeing Strategy:

- Integrated Care Board
- Integrated Care System / Integrated Care Partnership Board
- Local authority safeguarding teams
- Health and Wellbeing Boards
- Directors of Public Health
- Directors of children and adult social care
- Locality Partnerships
- GPs/Primary Care
- System staff
- VCSEs and equalities groups including the mental health VCSE alliance
- Mental health stakeholders, particularly anyone that has contributed to the development of the strategy
- Media

5. Key messages

Below are the key messages for promotion:

- We want people across Bristol, North Somerset and South Gloucestershire to have the best mental health and wellbeing in supportive, inclusive and thriving communities.
- Our Integrated Care System Mental Health Strategy provides key priorities for people of all ages, encompassing the whole mental health spectrum, from those have good mental health and wellbeing to those who may require more support.
- The ICS Mental Health Strategy highlights six ambitions and their actions to support the improvement of mental health services in (BNSSG) – holistic care,

prevention and early help, quality treatment, sustainable system, advancing equalities and ensuring our services are a great place to work for staff. When we collaborate, we can support, improve, and transform our mental health services for our local communities with greater impact.

6. Implementation and channels

Video
A video highlighting the value of the strategy and some of the key points it contains. This provides improved accessibility as well as sharable content that can be disseminated across ICS partner websites. Interviewees should include someone with lived experience of using mental health services and ICS partners who have led on developing the strategy.

Social media
Coincide with mental health awareness days such as Mental Health Awareness Week in May and National Suicide Prevention Month (September), Mental Health and Suicide Prevention Month (NHS South West led in February 2024) and Children's Mental Health Week (5-11 February 2024).

The long version of the video can be edited to share information about the Strategy on social media channels.

Webpage
Creating a webpage on the Healthier Together website to house the Mental Health and Wellbeing Strategy which will include the strategy on a page, the full strategy, easy read and video. We are also looking into the possibility of a British Sign Language (BSL) interpreted video.

Other channels and activities that will be utilised include:

- Signposting from partner websites
- ICS newsletter
- ICS intranets
- Stakeholder update and email cascades, such as via the VCSE Alliance
- Internal all-staff briefings (e.g. ICB Have We Got News For You)
- Press release

7. Evaluation

- All ICS partners engaging with the social media content through Healthier Together's X channel.
- ICS partners embedding the video into their websites where appropriate.
- Impressions on social media content totalling to 5,000 (5% of the average impressions achieved in 6 months on this channel).

- ICS partners actively endorsing the strategy.
- Local pick-up from local media regarding the strategy.

8. Timeline and activity plan

Below is a table outlining the communications activities we are looking to undertake during the first quarter of 2024.

Timing	Activity
December	Final draft of the Mental Health & Wellbeing Strategy to be created following engagement period - Julia
January	Virtual circulation to MH LD&A HCIG - Julia Meeting with Children & Young People's HCIG - Julia Work commences to build a webpage on the Healthier Together website – Naomi Commission agency to create an easy read of the strategy – Astra Explore options for creation of a BSL video Sense checking and storyboarding video – Becky/Naomi Scoping PR potential - Naomi
February	ICB Board meeting for sign-off ICP Board meeting for sign-off Drafted content for internal communications to be signed off - Naomi Stakeholder update to be drafted and released – Julia (Becky/Naomi to support) Shooting/creating video – Naomi News item on Healthier Together website – Naomi
March	Dissemination of social media promotion and encouraging partners to engage. Using relevant awareness days to highlight this work – Naomi Work with ICS partners to embed the video on their websites for further promotion – Becky ICS newsletter inclusion – Naomi ICB internal briefing Have We Got News For You – Naomi (to co-ordinate) MP/councillor update – Becky

April	
May	

Healthier Together

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

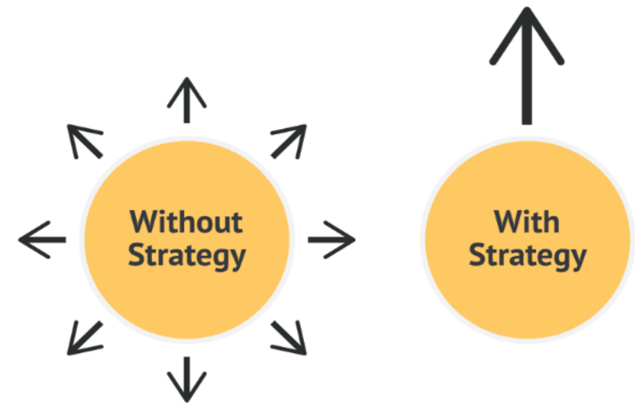
BNSSG Integrated Care System
All Age Mental Health & Wellbeing Strategy

North Somerset Health & Wellbeing Board

14th February 2024

Why are we having a system wide Mental Health Strategy?

- All ICS systems are required by NHS England to have a mental health strategy for population mental health



- The system mental health strategy brings all partners together to work towards a set of collective priorities and ambitions.

The Mental Health Strategy

- is an all age, **population** mental strategy
- **complements** and does not replace individual organisation Mental Health strategies
- **builds** on the work undertaken to develop the 2018/19 draft MH Strategy and the development of Community Mental Health programme
- has been **co-produced** by system partners, with strong input from the mental health alliance and lived expertise
- has been developed and is owned on behalf of the system by the **Mental Health, Learning Disability and Autism Health and Care Improvement Group (HCIG)**

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.

Engagement

- Draft document had input from over 300 people working in the mental health system and people with lived experience through formal meetings, 121s and focus groups

- Document was then published for an 8 week engagement period with over 160 people feeding back as groups or individuals via survey monkey

- Final document has been endorsed by the ICB Board and will be going to Bristol & South Glos HWBs as well as the ICP Board for sign off

- There will be signed and easy read copies available

Ask of North Somerset Health and Wellbeing Board

It is recommended that the North Somerset Health and Wellbeing Board;

- Endorse the final version of the strategy following the engagement
- Note that the strategy is also being submitted to the Bristol & South Gloucestershire Health & Wellbeing Boards and the Integrated Care Partnership Board for endorsement.
- Note that the Mental Health Learning Disability and Autism Health and Care Improvement Group (MH LD & A HCIG) will implement and monitor the strategy through a combination of an action plan and the annual refreshes of the NHS Joint Forward Plan.

Thank you

@htbnssg

www.bnssghealthiertogether.org.uk

North Somerset Council

REPORT TO THE HEALTH AND WELLBEING BOARD

DATE OF MEETING: 14 FEBRUARY 2024

SUBJECT OF REPORT: PHARMACEUTICAL NEEDS ASSESSMENT AND CONSULTATION RESPONSE

TOWN OR PARISH: ALL

OFFICER/MEMBER PRESENTING: MATT LENNY, DIRECTOR OF PUBLIC HEALTH AND REGULATORY SERVICES

KEY DECISION: YES

REASON: APPROVAL OF REVISED TERMS OF REFERENCE

RECOMMENDATIONS

1. The Health and Wellbeing Board, support the decision to issue a supplementary statement to the pharmaceutical needs assessment (PNA) following the closure of Boots Pharmacy on St. Andrews Parade, Weston-super-Mare.
2. The Health and Wellbeing Board issue a supportive response to the application to open a new pharmacy on St. Andrews Parade and delegates the final draft of a letter to the Health and Wellbeing Board Chair with support from the Director of Public Health and Regulatory Services.

1. SUMMARY OF REPORT

The report provides details of the pharmacy closure, a brief overview of pharmaceutical needs assessment and regulation of pharmacy services, including the role of the Health and Wellbeing Board in this process and informing their decision to issue a PNA supplementary statement, and response to the current application for a new pharmacy on the same site.

2. DETAILS

Boots Pharmacy, 16 St Andrews Parade, Weston-super-Mare, BS23 3SS has given notice to NHS England that it intends to close on 24th February 2024. In response to the notification this briefing report is to inform members of the Health and Wellbeing Board (H&WB) on:

1. A decision to issue a supplementary statement to the pharmaceutical needs assessment following the closure of Boots Pharmacy on St. Andrews Parade, Weston-super-Mare to assist decision making on a new pharmacy application.
2. A decision to issue a H&WB response to the application to open a new pharmacy on St. Andrews Parade. 1.

The report provides a summary of the current North Somerset PNA, data and information on population health and wellbeing needs, access to pharmacy provision and pharmacy use on Bournville Estate, and details of alternative pharmacy provision.

3. FINANCIAL IMPLICATIONS

There are no direct financial implications of this PNA update or a response the consultation on a new pharmacy application.

4. CLIMATE CHANGE AND ENVIRONMENTAL IMPLICATIONS

Close access to a pharmacy service may reduce the need to drive to alternative locations. The area and population impacted by the proposed closure may be more vulnerable to the affects of climate change due to heat and cold vulnerability from underlying burden of deprivation and related morbidity (NSC, Draft Climate Change Adaptation Strategy, 2024).

5. RISK MANAGEMENT

Pharmacies play a key role in improving the health of our local population and provide vital access to professional support and services. Maintaining good coverage for our local communities, particularly in areas with great challenges, is an important aim.

In accordance with North Somerset Council's Risk Management Strategy a risk assessment has been undertaken by Public Health and Regulatory Services Directorate Leadership Team. The unmitigated inherent risk is assessed as High (Likelihood 4, Impact 4). Based on the risk assessment the following outline mitigation measures have been implemented:

1. Support residents to access alternative provision.
2. Communicate with local partners
3. Adjust Public Health commissioned services temporarily
4. Engage with consultation process led by NHS England
5. Monitor mitigating actions by partner organisations
6. Progress updates to PNA
7. Liaison with landlord of existing premises
8. Shared learning with Association of Directors of Public Health regional group
9. Explore ways of identifying at risk individuals affected by reduced access
10. Support pharmacy applications in areas where gaps identified in line with the PNA and supplementary statements.

Decisions within this report align to delivery of planned mitigation measures. With mitigation measures in place, the adjusted risk assessment score is medium/high (Likelihood:3 Impact:4). Meaning there will still likely be significant impact to some individuals affected by the pharmacy closure.

6. EQUALITY IMPLICATIONS

The Health and Wellbeing Strategy (HWBS) includes actions targeted to areas of greatest deprivation or health need or prioritise activities that address needs in particular population groups with higher need to address health inequalities. The report provides detailed information on local population health, including vulnerable groups, in relation to the proposed pharmacy closure, with recommendations within the report taking these into account.

7. CORPORATE IMPLICATIONS

The HWBS reflects North Somerset Council's vision of being open, fair and green through the focus on consultation, engagement, community-focused action, and ongoing review of impact; and a central aim of reducing inequalities. The strategy also aims to support a range of strategies and programmes already in place, such as the Economic Plan, Green Infrastructure Strategy, Active Travel Strategy, Volunteering Strategy, Carers Strategy, and

Libraries Strategy among others, as well as being linked to strategic developments across the ICB.

The strategy has direct links and consistency with the emerging Locality Partnerships and Integrated Care Strategy to ensure consistency with health and social care priorities.

AUTHOR

Matt Lenny, Director of Public Health and Regulatory Services

APPENDICES

1) St. Andrew's Parade Pharmacy Briefing Paper
2) Public information leaflet on pharmacy closure

BACKGROUND PAPERS

None

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North Somerset Council

Open, Fairer, Greener

Health and Wellbeing Board Briefing: St. Andrews Parade Pharmacy Closure and response to new pharmacy application

February 14th, 2024

Executive summary

Boots Pharmacy, 16 St Andrews Parade, Weston-super-Mare, BS23 3SS has given notice to NHS England that it intends to close on 24th February 2024. In response to the notification this briefing report is to inform members of the Health and Wellbeing Board (H&WB) on:

1. A decision to issue a supplementary statement to the pharmaceutical needs assessment following the closure of Boots Pharmacy on St. Andrews Parade, Weston-super-Mare to assist decision making on a new pharmacy application.
2. A decision to issue a H&WB response to the application to open a new pharmacy on St. Andrews Parade.

The report provides details of the pharmacy closure, a brief overview of pharmaceutical needs assessment and regulation of pharmacy services, including the role of the Health and Wellbeing Board in this process and informing their decision to issue a PNA supplementary statement, and response to the current application for a new pharmacy on the same site.

The report provides a summary of the current North Somerset PNA, data and information on population health and wellbeing needs, access to pharmacy provision and pharmacy use on Bournville Estate, and details of alternative pharmacy provision.

Based on the summary of relevant information it is recommended that:

1. The Health and Wellbeing Board, support the decision to issue a supplementary statement to the pharmaceutical needs assessment following the closure of Boots Pharmacy on St. Andrews Parade, Weston-super-Mare.
2. The Health and Wellbeing Board issue a supportive response to the application to open a new pharmacy on St. Andrews Parade and delegates the final draft of a letter to the Health and Wellbeing Board Chair with support from the Director of Public Health and Regulatory Services.

North Somerset Council

Purpose

This briefing report is to inform members of the Health and Wellbeing Board (H&WB) on:

1. Decision to issue a supplementary statement to the pharmaceutical needs assessment following the closure of Boots Pharmacy on St. Andrews Parade, Weston-super-Mare.
2. Decision to issue a H&WB response to the application to open a new pharmacy on St. Andrews Parade.

About the closure of Boots Pharmacy, St. Andrews Parade

Notice of pharmacy closure and Pharmacy services

Boots Pharmacy, 16 St Andrews Parade, Weston-super-Mare, BS23 3SS has given notice to NHS England that it intends to close on 24th February 2024.

The pharmacy provides the following pharmaceutical services:

- Essential services including dispensing prescriptions.
- Community Pharmacy Consultation Service (CPCS).
- New Medicines Service.
- Seasonal influenza vaccination.
- Hypertension case-finding.
- Primary Care Public health services.
- Other locally commissioned services.

These services were provided at the following times:

Day	Monday to Friday	Saturday	Sunday
Time	09:00-18:00	09:00-13:00	Closed

Pharmaceutical Needs Assessment (PNA) and regulation of pharmacy provision

North Somerset's PNA

The PNA is a statutory duty of the H&WB[1]. The H&WB is required to assess the need for pharmaceutical services in its area and to publish a statement of its assessment every three years, this is termed a 'pharmaceutical needs assessment'. Regulations[2] set out the minimum information that must be contained within a PNA and outlines the process that must be followed in its development. Guidance is available to support this process[3]. The current PNA for North Somerset is available

[1] Section 128A of the National Health Service Act 2006 (NHS Act 2006)
[2] NHS (2013) NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013, as amended (the 2013 regulations). Online: https://www.legislation.gov.uk/uksi/2013/349/contents/made
[3] DHSC (2023 and 2021) Pharmaceutical needs assessments: information pack. Online: https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

on the North Somerset Council Website[4]. The drafting of the PNA is delegated from the H&WB to the PNA Steering group that includes representation across the board membership[5].

Regulation of pharmacy applications and H&WB's

The 2013 regulations set out the arrangements for pharmaceutical applications[2]. NHS England are responsible for decisions on the opening of new pharmacies. Applications for new, additional or relocated premises are made by the local NHS England Area Team. Most routine applications for a new pharmacy will be assessed against the PNA for the area.

North Somerset's H&WB / PNA steering group can issue a PNA supplementary statement in accordance with regulatory requirements[1,2,3]. A supplementary statement can be published to explain changes to the availability of pharmaceutical services where:

> *(a) the changes are relevant to the granting of an application or applications for inclusion in the pharmaceutical list for the area of North Somerset's health and wellbeing board's area; and*
>
> *(b) North Somerset's health and wellbeing board is satisfied that producing a new pharmaceutical needs assessment would be a disproportionate response to those changes or it is already producing its next pharmaceutical needs assessment but is satisfied that it needs to immediately modify the existing document in order to prevent significant detriment to the provision of pharmaceutical services.*

Decision to issue a PNA supplementary statement and gap identification

In accordance with the guidance relating to the closure of a Pharmacy within an area of deprivation North Somerset's H&WB / PNA Steering group should consider that, if when the PNA was written, the St. Andrews Parade pharmacy had not been there would it have been identified as a gap in the provision of pharmaceutical services. There are a number of considerations that the H&WB may take into account when making a decision if there would have been a gap in pharmaceutical service provision on the Bournville estate, had St. Andrews parade not been open at the time of the PNA publication. This includes, population health and wellbeing, demographic, economic, and geographic factors, and access to alternative pharmacy provision.

PNA, Population health and access to pharmacy provision

North Somerset PNA (2022-2025)

At the time of publication analysis for the whole of North Somerset showed that 84.4% of the population were within 1.6km (1 mile) or 20-minute walk of a community pharmacy. Almost the entire population (99.2%) was within a 10 minute average peak drive time of a pharmacy. 90.3% percent of the population were within a 5

[4] North Somerset Council (2021) North Somerset Pharmaceutical Needs Assessment 2022-25. Online: https://n-somerset.gov.uk/sites/default/files/2022-09/pharmaceutical%20needs%20assessment%202022-25.pdf
[5] North Somerset Council (2020) PNA Steering Group Terms of reference. Unpublished.

minute average peak drive time to a pharmacy. More than three quarters of the population were within a ten minute journey by public transport of a pharmacy, with 98.5% of the population within a 30 minute public transport journey time.

Access was similar when analysed by localities, with all having good drive time and public transport access times. There was generally good pharmacy coverage after 5pm and at weekends, but with some scope for improvements, particularly in rural areas.

At the time of writing there was generally good pharmacy provision in North Somerset. Weston and Worle PNA locality had a higher level of pharmacies per 100,000 population than the North Somerset and South West averages, but a level similar to the England average.

Population health on Bournville Estate and South Ward

The health and wellbeing of the local population is likely to impact on the need for above average access for pharmaceutical and other health services, and at the same time limit accessibility to such services within a wider geographic area. The Bournville Estate (where St. Andrews pharmacy is located) is in IMD decile 1, meaning it is in the 10% most deprived areas in England[6] (see
).

Life expectancy in South Ward is below the North Somerset average and the second worst in the Authority area (76.7 years, NS 80.3 years), with healthy life expectancy and years lived in poor health, well bellow the North Somerset average. The standard mortality ratio (SMR) is significantly higher than the North Somerset average (148.8, NS 94.7). With deaths from all causes, for all ages significantly higher than the North Somerset average (SMR 166.5, NS 93.8), this same pattern is repeated for cancer deaths, preventable deaths, deaths from circulatory disease, coronary heart disease, respiratory diseases, and stroke[7].

The population of the Bournville Estate is mainly served by the Horizon Healthcare Centre, which is located opposite the Boots pharmacy on St. Andrew's Parade. The practice has the highest deprivation score in North Somerset[8].The registered population has high rates of diabetes, smoking, obesity, and mental health conditions (other than dementia) and respiratory conditions such as COPD and asthma.

As defined in the Equalities Act, the area has a population with the second highest level of disability, that limit day-to-day activities a lot, in North Somerset (11.6%; compared to 7.6% across North Somerset). The proportion of South Ward residents reported as living with a limiting long-term illness or disability is 24.3% (NS 19.1%).

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[6] ONS (2019) English indices of deprivation 2019. Online: www.gov.uk/government/statistics/english-indices-of-deprivation-2019
[7] North Somerset Council JSNA () Ward Profiles. Weston-super-Mare South Ward. Online: https://n-somerset.gov.uk/council-democracy/north-somerset-insight-data-statistics/joint-strategic-needs-assessment-jsna-health-social-care
[8] OHID (2019) National General Practice Profiles, IMD 2019.

The area has a significant population of very vulnerable groups that have very limited means of accessing other pharmacies nearby.

Demographic, economic, and geographic factors are likely to impact on individuals need for, and ability to access pharmacy services. There are higher levels of household overcrowding in the area (7.5%, NS 4.6%), and households experiencing fuel poverty (17.4% NS 9.3%). The number of families affected by absolute (23.1%, NS 10.4%) and relative (33.2%, NS 13.8%) poverty are significantly higher than the North Somerset averages. There are higher proportions of unemployed people (6.4%, NS 2.4%) and people with no qualifications (24.3%, NS 14.9%) living in the area.

A third of households in this ward do not have access to a car or van (Weston-super-Mare South 34%, North Somerset average 15%[9]). The X1 bus services is the primary Bus route that travels through the estate[10]. The route of this service takes it past one pharmacy within 1 mile (Jhoots 37 Whitecross Rd, Weston-super-Mare BS23 1EN). There are other bus routes that travel around the fringes of South Ward, including the 7, 62 and 125. However, each would require walking a distance similar to those described for the next nearest pharmacies (see Figure 2). The Bournville estate is also bisected by 2 main railway lines, meaning there are a limited number of road and footway access points to and from the estate, resulting in increased travel times and limited route options for people with limiting conditions.

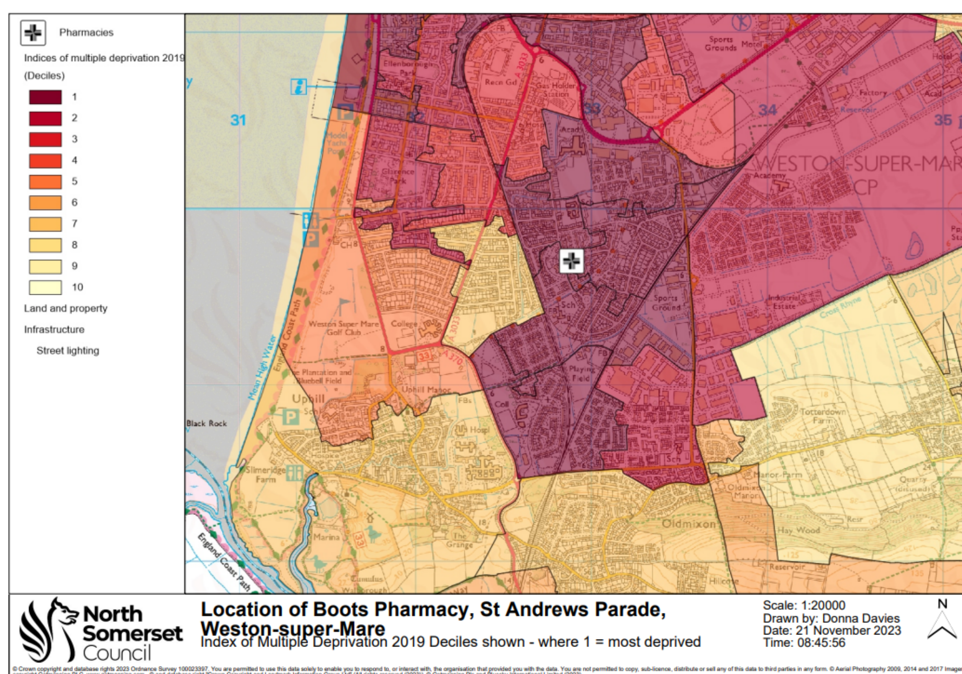

Figure 1: Location of Boots, St Andrew's Parade and social deprivation (IMD2019)

[9] ONS (2023) Car or van availability. Census 2021. Online: https://www.ons.gov.uk/datasets/TS045/editions/2021/versions/1
[10] Travel West (2024) Service X1. Operated by First in Bristol Bath & the West. Online: https://journeyplanner.travelwest.info/routes/service/X1/39-X1-%25-y10-2/3

Population pharmacy use on Bournville Estate

The relative majority (44%) of the patients registered at Horizon Healthcare use the Boots pharmacy on St Andrew's Parade to get their prescribed medication. Fourteen percent use Boots on Monkton Avenue on the Oldmixon Estate, and a further 9% use Milton Pharmacy. The rest of the patients use a variety of local, online and distance-selling pharmacies[11]. The majority (75%) of prescriptions that Boots on St. Andrew's Parade dispense, originate from Horizon Health Centre, with 7% from Graham Road Surgery (has its own pharmacy), and 6 % from 168 Medical (also has pharmacy).

Data and information in relation to the use of public health services delivered in Boots St. Andrews pharmacy is summarised here:

Substance misuse services	There are currently 17 clients accessing opiate substitution therapy, often daily; usually 4 of these clients which require additional supervised consumption 5-7 times a week; in the past three years, around 300 packs of needles per year were provided for injecting drug users, indicating a significant need. This vulnerable population is unlikely to travel to other pharmacies daily and there is a risk that they will stop engaging with treatment and safer injection practices
Smoking cessation services	Most affected is the handling of Community NRT vouchers provided by the specialist smoking cessation service. This area has a particularly high rate of high-risk smokers, experiencing significant health inequalities and higher premature mortality rates. Smoking remains the single biggest preventable cause of premature mortality and reducing smoking has been set as a key target of the BNSSG ICS.
Emergency hormonal contraception (EHC)	This pharmacy provides a proportionately high level of EHC, around 50% more than the large Tudor Lodge pharmacy and a third more than Boots at Oldmixon. A third of consultations are for girls under the age of 18 with three times as many teenagers seen as in the other two pharmacies. Restricted access to emergency contraception is likely to lead to more unwanted pregnancies and/or terminations.

[11] NHSBA (Sept 2023) Dispensing data. Unpublished data.

Mitigations to ensure continued access to Public Health services delivered through pharmacies for the Bournville population have been put in place. Commissioners are working with other pharmacies and service providers to support clients to access medication. Although it is recognised that these mitigation changes may be disruptive and could impact on individual outcomes. We will keep mitigation measures under review for potential impacts.

Alternative pharmacy provision

The nearest, most accessible pharmacy to St. Andrews Parade, is on the Oldmixon Estate (Boots Monkton Avenue). This location is a 23 minute walk away. This pharmacy has already indicated capacity issues that would limit its ability to take on more clients.

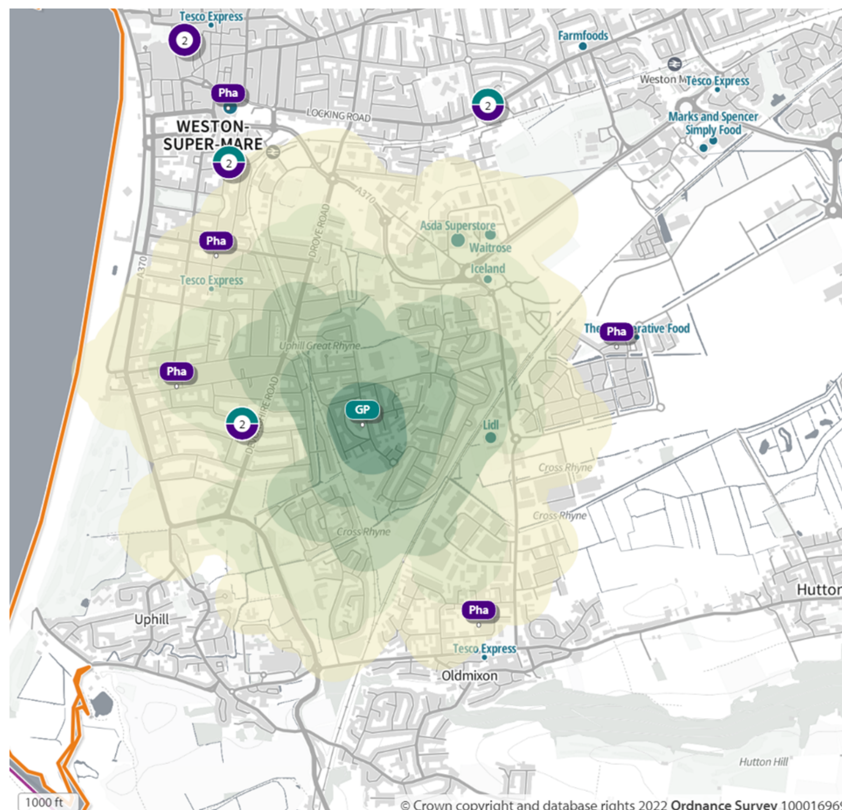

Figure 2: Pharmacies within 1 mile (1.6km) walking distance of the Horizon Healthcare Centre after closure of Boots, St Andrew's Parade

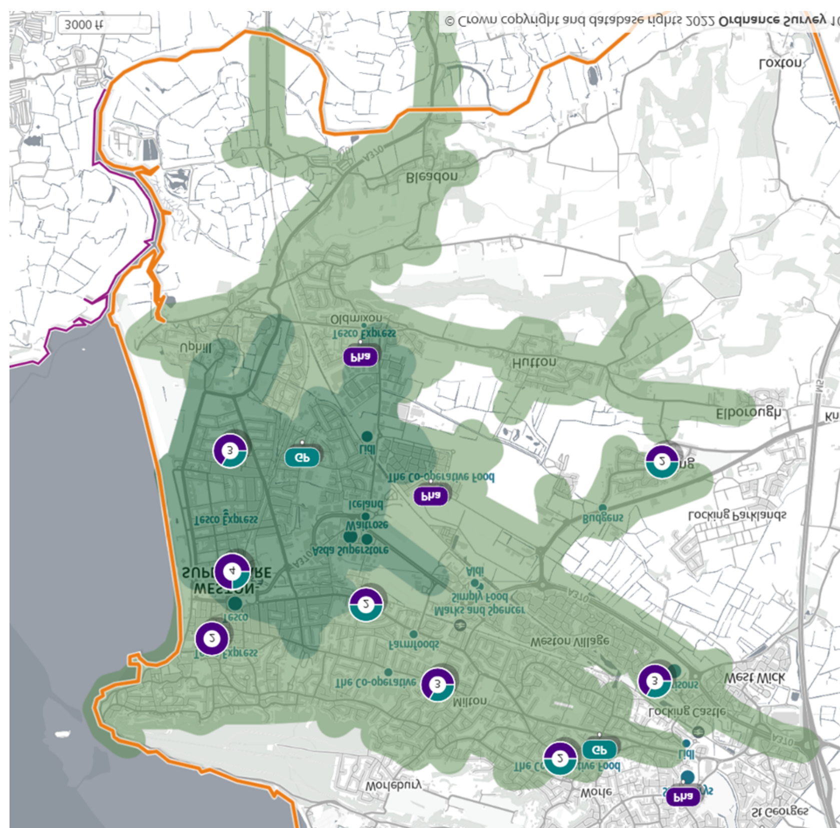

Figure 3: Pharmacies within 10 minute driving of the Horizon Healthcare Centre after closure of Boots, St Andrew's Parade.

Summary and gap identification

Data and information in relation to local pharmacy provision, population health and wellbeing needs, demographic, economic and geographic factors, indicates that the H&WB could consider that there would have been a gap in pharmaceutical service provision on the Bournville estate, had St. Andrews parade not been open at the time of the PNA publication. The H&WB should consider:

- The local population has significant underlying health and wellbeing needs that will increase need for pharmacy services.
- The same health and wellbeing needs will impact on the population's ability to access pharmacy services in a wider area (mobility, ability, and capacity).
- Health literacy of local population may impact ability that individuals have to access, understand, process, and use information in relation to pharmacy services needed to make decisions about their health and wellbeing.
- Economic factors may restrict travel choice for individuals.
- Transport and travel options are limited for those without access to a car, or can't afford to use the bus. Public transport options are also limited in this area.
- Economic factors may restrict time availability for additional travel.
- Capacity issues in neighbouring pharmacies that could limit taking on more clients.

- Vulnerable groups living on the estate that have very limited means of accessing other pharmacies nearby.

Recommendations

Based on the summary of relevant information and gap identification it is recommended that:

1. The Health and Wellbeing Board, support the decision to issue a supplementary statement to the pharmaceutical needs assessment following the closure of Boots Pharmacy on St. Andrews Parade, Weston-super-Mare.
2. The Health and Wellbeing Board issue a supportive response to the application to open a new pharmacy on St. Andrews Parade and delegates the final draft of a letter to the Health and Wellbeing Board Chair with support from the Director of Public Health and Regulatory Services.

Authors

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North Somerset Council

Information on pharmacy closure:

Boots St. Andrew's Parade

16 St. Andrew's Parade, Weston-super-Mare BS23 3SS

Where and when is this pharmacy closing?

Boots pharmacy on St. Andrews Parade, Weston-super-Mare, will cease trading at close of business on Saturday 24 February 2024.

Where is your next nearest pharmacy?

Pharmacy	Address	Distance from St Andrew's Parade	Opening hours	Tel
Tudor Lodge Pharmacy	3 Nithsdale Road BS23 4JP	0.7 mi (foot) 1.1 mi (car)	Mon-Fri 7am-9pm Sat 8am-9pm Sun closed	01934 615111
Moorland Road Pharmacy	53 Moorland Road BS23 4HP	0.8 mi (foot) 1.2 mi (car)	Mon-Fri 9am-5.30pm Sat-Sun closed	01934 629669
Pharmacy* (formerly Lloyds)	37 Whitecross Road BS23 1EN	1.1 mi	Mon-Fri 9am-5.30pm* Sat 9am-5.30* Sun closed	01934 620740
Boots Pharmacy	Monkton Avenue, Oldmixon BS24 9DA	1.5 mi	Mon-Fri 9am-5.30pm Sat 9am-1pm Sun closed	01934 813720
Magna Pharmacy	Whitney Crescent, Haywood Village BS24 8ES	1.3 mi	Mon-Fri 9am-6.30pm Sat 9am-1pm Sun closed	01934 708 050 (free home delivery)

*Pharmacy and opening hour details subject to change.

Nominations to other pharmacies

You can change which pharmacy you get your medicine from. This is called your pharmacy 'nomination'. You can do this is you are moving, or if your local pharmacy closes. If Boots, St. Andrews Parade is your regular pharmacy you can 'nominate' a new pharmacy.

You'll need your NHS number.

You can choose one of the following options:

- Speak to your new pharmacy
- Via the NHS App
- Ask your GP Practice

For more information please visit: **https://[illegible]qr.link/9prnk**

Where to go for minor ailments and injuries, and other health services

For full details of health services in Weston-super-Mare and North Somerset that you can use, please visit: **www.bnssg.icb.nhs.uk**

NHS111

If you need medical help urgently, but it's not life-threatening, contact NHS 111. NHS 111 will help you right away and direct you to the best service for your needs. If needed, a healthcare professional will call you.

They are available 24 hours a day. You can access it online at **111.nhs.uk**, on the NHS App or by calling 111, free of charge, from a landline or mobile phone.

If you or a loved one have a life-threatening illness or injury, you should call **999** straight away.

Where to access

Emergency Hormonal Contraceptives (EHC)

To prevent unplanned pregnancy following unprotected sex, you can use EHC. Your next nearest pharmacies for EHC are:

- **Boots UK**, Oldmixon, Monkton Avenue, BS24 9DA. Tel: **01934 813720**
- **Tudor Lodge Pharmacy**, 2-4 Nithsdale Road, BS23 4JP. Tel: **01934 615111**

Confidential EHC text service

You can find out your nearest pharmacies that provide emergency contraception by: **Texting 'Pharmacy emergency contraception [and your post code]' to 80011**

You will get a text response with the three nearest pharmacies with their names, addresses, telephone numbers and distance from the post code you've entered. (It may take a couple of minutes). Standard text message rates from your provider may apply when using this service.

Access Emergency Contraceptive at UNITY

If more than five days have passed since unprotected sex, you should still seek advice by visiting a Unity sexual health clinic or calling Tel: **0117 342 6900**

Unity @ WISH - 1 mile away

Weston General Hospital, Grange Road, Uphill, Weston-super-Mare, BS23 4TQ.

WISH Booking line, Tel: **01934 881 234**

For more information please visit **www.unitysexualhealth.co.uk**

Opiate substitution treatment and syringe exchange

For syringe exchange or opiate substitute treatment enquiries, please call With You on **01934 427940**.

For more information please visit: **www.wearewithyou.org.uk/services/north-somerset/**

Nicotine Replacement Therapy (NRT) for Stopping Smoking

You can access NRT from Tudor Lodge Pharmacy.

Please contact Smokefree North Somerset on **01275 546 744**

Smokefree North Somerset can issue you with free NRT via voucher when you sign up for free support.

For more information please visit: **www.betterhealthns.co.uk/stop-smoking**

Better Health North Somerset

For information on health and wellbeing support services please visit:

www.betterhealthns.co.uk

Draft forward plan for HOSP and HAWB engagement

FORUM/ METHOD DATE	HOSP *Note: dates for 24/25 tbc, likely to be July, Nov and March.*	HAWB *Note: dates for 24/25 tbc, likely to be June, Oct and Feb.* Standing items: • Health and Wellbeing Strategy • Healthwatch reports • Locality Partnership Updates • Better Care Fund • Forward Plan	Combined HOSP/HAWB webinar	Appreciative Inquiry Topics
Jan				
Feb		14.02.24 • Health and Wellbeing Strategy • Healthwatch reports • Locality Partnerships update • Forward Plan • Better Care Fund • BNSSG Mental Health Strategy		14.02.24 • Tackling health inequalities through the new NSC Corporate Plan
March	14.03.24 TBC. Likely to include: • NHS Dentistry/Oral health • Pharmacy provision • Follow up on GP CQC reports			
April				
May				
June				
July				
August				
September				

October				
November				
December				

Long list of ideas of items –

1. Development of Health and Wellbeing Strategy
2. Health inequalities action plan (within NSC Corporate Plan and wider links)
3. Evaluation of winter plan delivery
4. CQC Adult Social Care inspection/action plan
5. Health Protection Annual Report
6. Update on Sexual Health Procurement
7. Food strategy
8. Mental health strategy
9. Update on delivery of physical activity strategy
10. Self-harm review
11. Healthy settings – early years, schools, and workplaces. Impact of those programmes.
12. Substance use and alcohol – needs assessment, delivery through partnerships etc.
13. Smokefree North Somerset and leadership from North Somerset for BNSSG work
14. Oral health/dentistry
15. Primary care