

Healthier **Together**



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

# Health and Wellbeing Board Locality Partnership Delivery Plan 22/23 and beyond

**One Weston,  
Worle and Villages**  
Locality Partnership

**Woodspring**  
Locality Partnership



# Overview for 22/23

**Locality Partnerships are developing an overarching plan for 22/23 . Our Key areas are:**

- Start Well
- Live Well
- Age Well
- Dying Well

**Each of these workstreams will have top priorities which are currently being defined within the partnership to include :**

- Key priority areas of the JSNA for North Somerset
- Actions arising from the North Somerset Council Health and Wellbeing Board.

**Key priorities agreed so far:**

- Our Integrated Mental Health Team is our top priority and will be in place by September 22
- Increased number of Care Homes supported by the Care Home Team (WWV)
- Increased support to the VCFSE sector including commissioning services for CMH and Ageing Well
- Joint investment into the Virtual Hub to link VCFSE across North Somerset to support the CMH Team
- Locality partnership board members will take lead roles (SROs) in specific workstreams, responsible for overseeing delivery, outcomes and outputs

## ***Model of Care Design & Delivery***

Area	Objective(s) for 2022/23
<b>Start Well</b>	<ul style="list-style-type: none"> <li>• Top 5 priorities developed for 22/23</li> <li>• Clinical lead in place to support the programme</li> </ul>
<b>Live Well</b>	<ul style="list-style-type: none"> <li>• Enhanced support to people with mental health needs with the Integrated Mental Health Team, mobilised by Sep 22</li> <li>• Befriending service(s) commissioned to support people typically feeling isolated, lonely: a CHM ‘gap’ in provision</li> <li>• Personalised care OD work to support teams on the ground</li> <li>• CMH Small Grant Schemes 22/23 complete with reported outcomes, supporting grassroots VCFSE organisations to offer more support to local people</li> <li>• Development and implementation of the community light houses across North Somerset</li> <li>• British Red Cross HIU pilot complete with clear evidence of improved outcomes for local people</li> <li>• Develop live well top 5 priorities for 22/23 in addition to CMH</li> <li>• Community Virtual VCFSE Hub supporting the social prescribing offer to local people</li> </ul>
<b>Age Well</b>	<ul style="list-style-type: none"> <li>• Increased number of local care home residents and staff supported by the Care Home Team</li> <li>• Reduced number of NELs from Care Homes</li> <li>• Enhanced integrated ageing well end-end pathway for adults living with frailty and older adults</li> <li>• Top 5 priorities developed for 22/23 by end of June</li> <li>• Ageing Well Pilot Schemes 22/23 (£4.4m) complete with reported outcomes with opportunity for Locality Partnerships to assess</li> <li>• Ageing well VCFSE development lead in post from VANS – scoping and mapping exercise to understand existing provision and gaps</li> </ul>
<b>Dying Well</b>	<ul style="list-style-type: none"> <li>• Top priorities developed for 22/23 – Programme and name TBC</li> <li>• Clinical lead in place to support the programme</li> </ul>

# Model of Care Design & Delivery

Area	Objective(s) for 2022/23
<b>Communication &amp; Engagement</b>	<ul style="list-style-type: none"> <li>• Website content management to inform our staff and population</li> <li>• Engagement with local groups and forums as part of a 'Big Conversation' July – Sept 22</li> <li>• Communication with partner organisations</li> <li>• Co-design with lived experience representatives</li> </ul>
<b>Co-production</b>	<ul style="list-style-type: none"> <li>• Co-design and co-production with lived experience reps in planning and implementation</li> <li>• Involvement with people with Lived experience in 'starting well, living well, ageing well and dying well ' workstreams</li> </ul>
<b>Workforce</b>	<ul style="list-style-type: none"> <li>• Develop a locality Workforce strategy</li> </ul>
<b>OD</b>	<ul style="list-style-type: none"> <li>• Support organisations to have a place to obtain insight into each other's roles, people, and organisations</li> <li>• Create a culture that supports staffs to embrace, show appreciative enquiry and supports staffs to work across boundaries</li> <li>• CMH Team development</li> </ul>
<b>Financial Management</b>	<ul style="list-style-type: none"> <li>• Balance budget</li> <li>• Monthly forecasting</li> <li>• Oversight form CCG Finance team</li> <li>• Financial reporting</li> </ul>
<b>Governance</b>	<ul style="list-style-type: none"> <li>• Scrutiny and oversight of decision making, risk and finance</li> </ul>
<b>Estates</b>	<ul style="list-style-type: none"> <li>• Locking parklands development TBC October '22</li> <li>• Central Weston development, timeframe TBC</li> <li>• Move Locality Partnership Strategies into delivery</li> </ul>

# Principals for designing the medium term plan (2-5 yrs)

- Continuation of the **Start Well, Live Well, Age Well and Dying Well** program as an Anchor for our joint priorities
- Consultancy support from North of England Commissioning Support Unit (NECS) to support each locality Partnership with:
  - ❖ Joint Locality Partnership planning
  - ❖ NHS Long Term plan refresh and Locality Partnerships input to this
  - ❖ Draw together key priorities such as North Somersets directorate plans , the Health and Wellbeing strategy, H&WBB priorities
- JSNA and Population Health driven
- Governance and progress monitored via the Locality Partnership Board , HWBB, ICB/ICP
- Development of a 2-5 year plan that Locality Partnerships can sign up to

# Healthier Together



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## Thank you

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# ***We are aligning our priorities to the Health and Wellbeing Strategy Outcomes developed by NS Council***

## **Health & Wellbeing Strategy Outcomes**

The outcomes from the strategy will underpin our Locality Partnership plan, either directly or as enablers, notably:

- Reduction in the prevalence of self-reported poor mental health in the NS population
- Improvement in access to timely mental health support
- Prevention of adversity and trauma during childhood
- Improvement in access to, and early provision of, perinatal support
- Prevention of suicide
- Reduction in social isolation
- Increase in the prevalence of good mental health and emotional wellbeing
- Reduction in inequality in prevalence of unhealthy weight at ward-level (all ages)
- Reduction in inequality in inactivity by increasing engagement in physical activity in the most deprived areas in North Somerset
- Reduction in the prevalence of falls (as measured by hospital admissions for falls)
- Reduction in the rate of alcohol-related admissions among those aged
- Reduction in exposure of [young] non-smokers to cigarette smoke and role modelling of smoking
- Improved treatment outcomes for people with substance-use dependence
- Introduction of strengths-based approaches to improving health and wellbeing
- Enhanced capacity to implement community-based approaches to improving health and wellbeing

# In addition to the NS HWBS outcomes, we will also be aligning our workplan to meet system outcomes.

Domain	System Outcome	
The health and wellbeing of our POPULATION	POP1	We will increase population healthy life expectancy across BNSSG and narrow the gap between different population groups
The health and wellbeing of our RESIDENTS	RES2	We will reduce early deaths from preventable causes in the communities which currently have the poorest outcomes
	RES3	We will lower the burden of infectious disease in all population groups
	RES4	We will reduce the proportion of people in BNSSG who smoke
	RES5	We will improve everyone's mental wellbeing
	RES6	We will give the next generation the best opportunity to be healthy and well
The health of our SERVICES	SER7	We will increase the proportion of our residents who report that they are able to find information about health and care services easily
	SER8	We will increase the proportion of our residents who report that they are able to access the services they need, when they need them
	SER9	We will increase the proportion of our residents who report that their health and care is delivered through joined up services
The health and wellbeing of our STAFF	STA10	We will increase the proportion of our health and care staff who report being able to deliver high value care
	STA11	We will reduce sickness absence rates across all our Healthier Together partner organisations
	STA12	We will improve self-reported health and wellbeing amongst our staff
	STA13	We will improve Equality and Diversity workforce measures in all Healthier Together Partner organisations
The health and wellbeing of our COMMUNITIES	COM14	We will reduce the number and proportion of people living in fuel poverty
	COM15	We will reduce the number of people living in poor housing conditions
	COM16	We will increase the number of people in homes and communities where they are safe from harm
	COM17	We will reduce levels and impact of child poverty
	COM18	We will increase the number of our residents describing their community as a healthy and positive place to live
The health and wellbeing of our ENVIRONMENT	ENV19	We will improve the overall environmental impact and sustainability of our services
	ENV20	We will reduce the impact of our services on the environment by achieving net zero carbon across all emissions scopes by 2030
	ENV21	As anchor institutions, we will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity and the quality of the natural environment