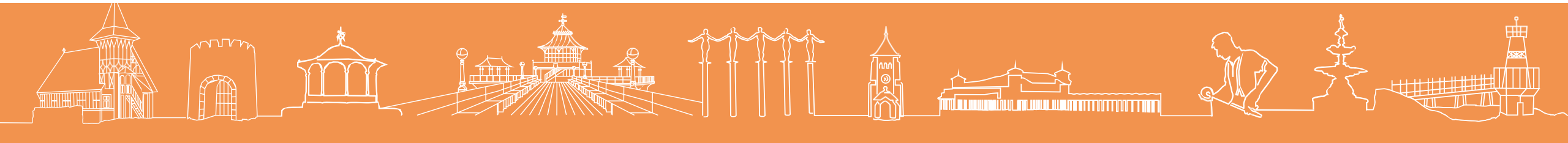
North Somerset Council

Open, Fairer, Greener

Improving health and care collaboration in North Somerset – developing a new Operations Group

1 November 2023



North Somerset Council

(1) The challenge
(2) Our local picture
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(1) The challenge

Working with complexity

- There are several tiers of strategy and policy from the National and Regional, Health System, Local Authority and Localities that are related to improving the health and wellbeing of, and reducing inequalities, in the North Somerset population.
- Strategies include the BNSSG ICS strategy, the North Somerset Health and Wellbeing strategy, Better Care Fund Plan, and the Locality Partnership workplans.
- Complexity around different drivers for strategic direction, and related prioritisation, partnership working and commissioning activity complicates integrated working at Local Authority and Locality levels.

Align with a direction of travel

DHSC want greater alignment of Locality Partnerships to Health and Wellbeing Boards, and for them to utilise existing governance.

In preparation for this, BNSSG Locality Partnerships have started to explore:

- Formal governance and strengthened alignment with H&WB's.
- Roadmap for closer integration with H&WB's.
- Role of Locality Partnerships and H&WB in the planning, allocation and delivery of the Better Care Fund (BCF) – *plus in NS considering other areas of development*

(2) Our local picture

North Somerset Health and Wellbeing Board

Terms of reference

- The Health & Wellbeing Board is a statutory board that provides senior strategic oversight of health and wellbeing matters across North Somerset.
- The Board meets as a full committee of NSC at least three times each Municipal year.
- The Board undertakes the statutory duties proscribed in the Health and Social Care Act 2012.

Board responsibilities

- Development, sign-off and monitoring the implementation of the Health & Wellbeing Strategy.
- Overseeing and advising on the development of the Joint Strategic Needs Assessment (JSNA).
- Co-production and public involvement and engagement across the board's activity.
- Supporting the development of local joint commissioning arrangements.
- Strategic coordination of health and wellbeing matters with safeguarding functions.
- Monitoring and responding to the performance of local health and wellbeing services in the statutory, voluntary and commissioned sectors, and services that impact on the wider determinants of health.
- Liaison with other Health & Wellbeing Boards across the region to share learning, coordinate activity and identify joint commissioning opportunities.

North Somerset Health and Wellbeing Board

- The Board is looking to develop its approach to leadership, implementing the learning from a LGA review undertaken in 2022.

- Reflection in that process identified that more engagement from departments/agencies is required to create a true partnership and some focus on key areas of activity is needed rather than passive receipt of updates.

- The aim is to use appreciative inquiry to understand key challenges in more detail, including the strengths that exist in North Somerset, and work as a partnership to improve outcomes in those priority areas.

ICS at Place

ICS Aim 1: Improve outcomes in population health and healthcare

- Primary delivery mechanism for the prevention agenda set by the Integrated Care System
- Support the HWB Board membership to develop the Health and Wellbeing Strategy (for each HWB Board area)
- Key design and delivery partner for enaction of the Health & Wellbeing Plans
- Identify needs based on population engagement and local data analysis
- Draw insights / define care priorities based on local needs
- Public Health teams support Localities by providing data and analysis

ICS Aim 3: Enhance productivity and value for money

- Maximise benefits of PCNs, local networks / community connections and local assets
- Supporting System Lead to co-design a sustainable VCSFE offer for each HWB Board area
- Work with ICB to maximise use of local Estate through Locality Estates strategies and plans
- Organisational Development / collaborative working between providers and teams in the Locality
- Localities are the place to innovate, test, fail fast, learn lessons and grow what works across the System

ICS Aim 2: Tackle inequalities in outcomes, experience and access

- Focus on reducing inequalities and delivery of CORE20PLUS5
- VCSFE Partners support Localities by providing 'hyper-local' information on needs and potential response
- Define a clear 'citizen involvement' approach
- Lead genuine coproduction with service users, communities and providers
- Model of Care: Embed System wide change. Define, design, implement and deliver interventions tailored to population need and reduction of inequalities

ICS Aim 4: Support broader social and economic development

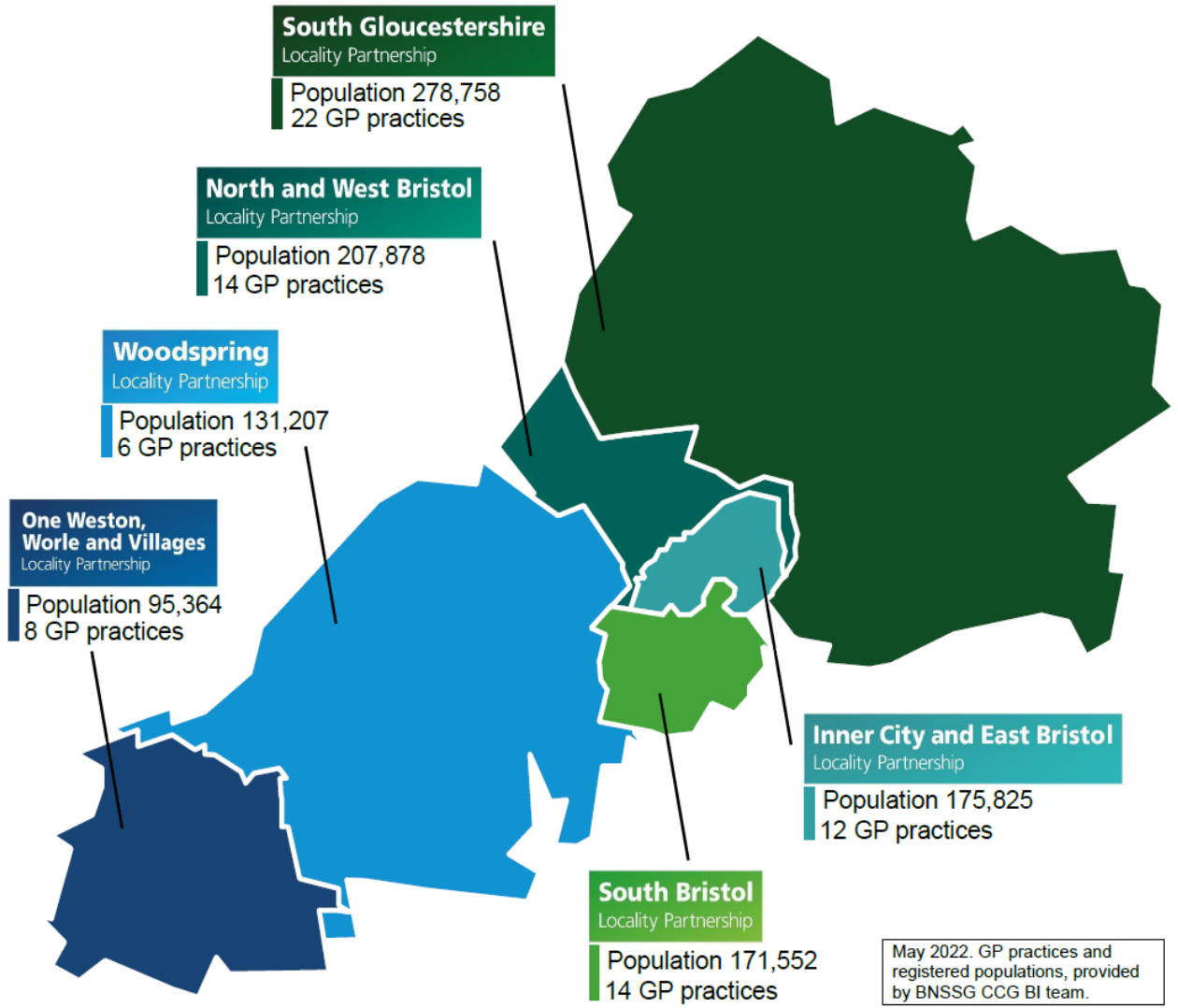
- Work Programmes structured to address the wider determinants of health across life stages
- Engage Community Anchor Organisations
- Cultivate relationship with VCSFE and community groups
- Understand the existing and future workforce available at Place and play to its strength to deliver outcomes

Our Locality Partnerships

Our Locality Partnerships are referred to in the Health and Care Act as 'place-based partnerships'.

The six Locality Partnerships in BNSSG are made up of local health, social care, and voluntary sector partners. They recognise citizens as equal partners, and work as one team to understand what matters most to their local community.

In time, the majority of people's care will be designed and delivered at this level. Locality Partnerships will ensure that care is tailored to people's individual needs and considers the wider determinants of health and wellbeing.



Woodspring

A population of around **131,140**.

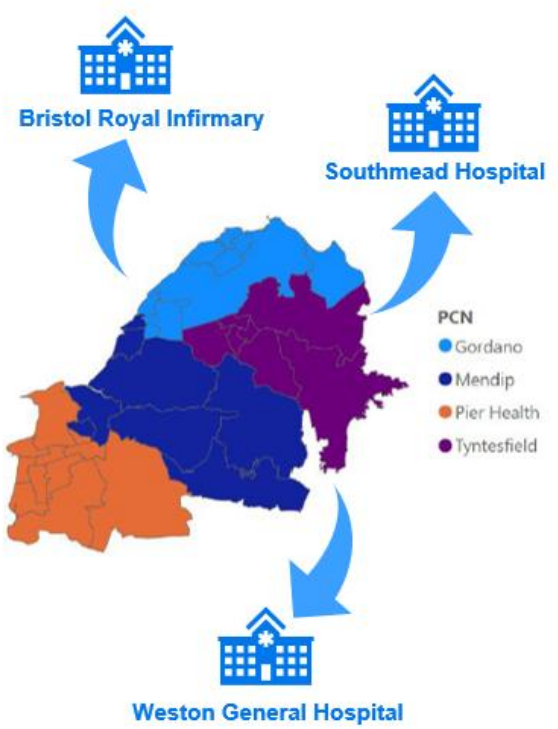
Woodspring has the **highest rate of frailty** across all BNSSG localities, with an older population; **over 20% are aged over 65**, that is double the percentage of the Bristol localities. The majority of over 65's **live at home**.

There is a high prevalence of **Dementia** in our population and a scarcity of services available, compared with other parts of BNSSG.

Anxiety and depression are a concern across all age groups. For our older population this is compounded by **social isolation** and **loneliness**. For our **children and young people**, poor mental health manifests in a high prevalence of **eating disorders** and **self-harm**.

Whilst there are no Indices of Multiple Deprivation (IMD) LSOAs scoring less than 4, there are **pockets of high deprivation which are hidden** by surrounding areas that are less deprived. This is true in wards within Portishead, Clevedon and Pill.

Context and complexity



Woodspring is served by **3 Primary Care Networks** (PCNs) consisting of **6 GP Practices** across **12 sites**.

2 of our PCNs are **single practice PCNs** (Tyntesfield PCN and Mendip Vale PCN); Gordano Valley PCN is a **collaboration** of the remaining 4 individual practices.

Residents flow to all 3 Acute Hospital sites.

For Woodspring, integrated service improvement across primary, community and secondary care pathways, is undertaken across 6 General Practice providers and 3 Acute Hospital sites.

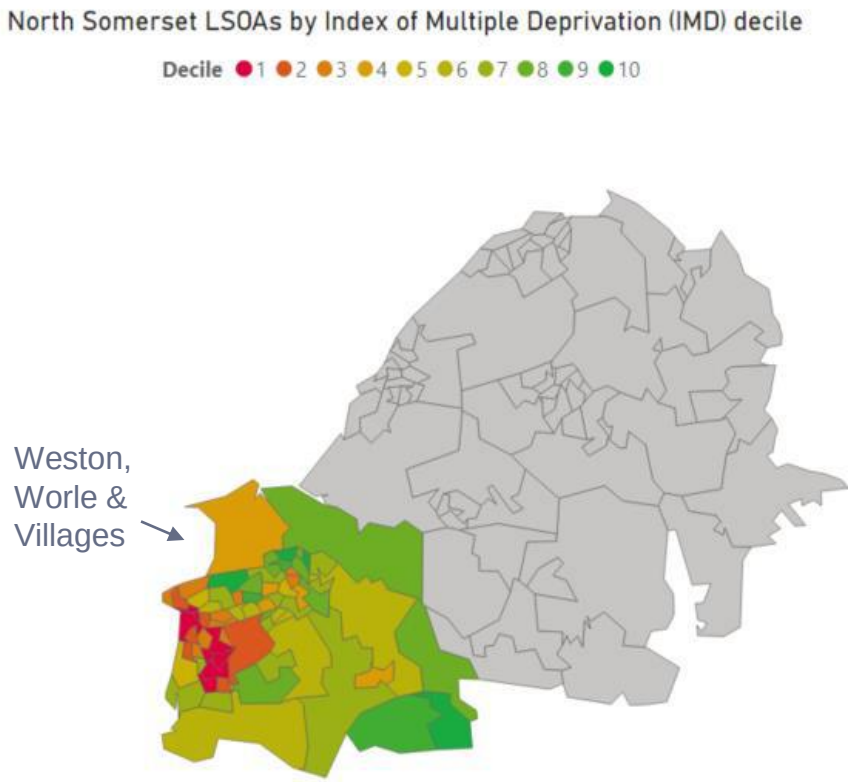
Residents **struggle to access services and opportunities** across, and from, this **rural locality** with poor public transport links. Access shows a marked disparity between more densely populated towns like Clevedon, Nailsea and Portishead and smaller, more rural areas such as Pill and Langford.

In the last decade, **migration** has been a **key driver of population growth** for our Locality. At the top end of the spectrum, one of our PCNs has experienced relative population increases of 467% in Children & Young People and 399% in the over 65s.

Woodspring Priorities

- Addressing **inequity of opportunities and outcomes** derived from our rurality and large, older population
- Supporting families, schools and services to manage the **increased anxiety in Children and Young people** in our communities
- Launch the Woodspring **Mental Health & Wellbeing Integrated Team** (MINT) and mobilise other specialist pathways within our Locality
- Phased roll out of the **North Somerset Together Virtual Hub**, community asset
- Further explore and scope how we can support the 3,000 people in Woodspring aged between 50-74 who suffer from **painful conditions**
- Mobilisation of the **Woodspring Ageing Well** model focussed on prevention, pro-active care and complex care (including dementia)
- Increase the number of people discussing their **end of life** wishes and dying in their place of choice

One Weston



A population of around **96,376**. Served by one Primary Care Network (Pier Health Group) consisting of 8 practices.

Weston has 5 LSOAs within the most deprived 5% in England by Index of Multiple Deprivation (all within the Central or South wards) and 24% of the population live in the 20% most deprived LSOAs in England.

There is a higher prevalence of children and young people who are an unhealthy weight, with 25.2% of Reception aged children being overweight or obese compared to the South West average of 22.7%.

Weston has the highest concentration of care homes in the South West, and people over 65 years are more likely to be admitted to a Nursing or care home (594.5 per 100,000 population compared to South West average: 518.9).

The most deprived neighbourhoods have a lower life expectancy compared to other areas, and this is also reflected in higher levels of mental health issues, unhealthy weight and lower physical activity. There are high levels of hypertension and cholesterol in the population.

One Weston Priorities

- Creation of a One Weston Community Frailty Hub to deliver out of hospital care and reduce demand for acute and social care services; addressing health inequalities, strengthening collaborative partnerships, and sharing skilled multi-disciplinary workforce.
- Further development of the One Weston Mental Health & Wellbeing Integrated Team (MINT) and mobilisation of other specialist pathways.
- Reduction in children at Reception and Year 6 being an unhealthy weight, creating a longer term platform of healthy eating.
- Reduction in hypertension/high cholesterol results that contribute to shorter life expectancy and additional health problems.
- Increase the number of people discussing their end of life wishes and dying in their place of choice.
- Across the programme, focussing on reducing health inequalities created by higher levels of deprivation in the Locality.

(3) Our response

Aim

- Develop a cohesive approach to improving health and wellbeing outcomes and tackling health inequalities through the collaborative efforts of the H&WB and the Locality Partnerships.

- This will happen through a new Health and Wellbeing Operations Group which will support the Health and Wellbeing Board and Locality Partnerships in their roles around agreeing priorities, identifying resources and ways to secure good partnership working to deliver improved outcomes.

- A shared planning space will ensure we make clear and coordinated decisions to help deliver the 4 ICS aims, the Council's Corporate Plan and the Health and Wellbeing Strategy.

Building on success: Better Care Fund (BCF)

- Via the BCF the H&WB are setting a joined-up approach to integrated person-centred services between Health, Social Care, Public Health and Housing.
- The BCF will enable us to deliver joint commissioning at both system and place level.
- The latter demonstrated by the recent establishment of a Joint Service Development post across the Locality Partnerships and NSC.

Enabling VCFSE partnerships

- We need to ensure clarity in scope, specifications, and commissioning against outcomes for VCFSE.
- Availability of longer term, sustainable, funding for VCFSE delivered initiatives is a perennial issue.
- Opportunity to channel resources (particularly around inequalities and prevention) through Locality Partnerships to VCFSE without reliance on short-term contracts.
- Maximise the potential of external and competitive funding opportunities to improve place-based outcomes e.g. national research or other grants.

Functions of H&WB Operations Group

- Strategy and workplans.
- Funding and budgets.
- Joint commissioning.
- Community engagement, data and insights including KPI tracking.
- Best use of Appreciative Inquiry.
- Communications and tools to keep people informed and engaged in support of improved outcomes.

(DRAFT) Membership

- North Somerset Council (NSC)
  - Adult Social Care
  - Children's
  - Public Health
  - Housing
- One Weston, Worle and Villages Locality Partnership
- Woodspring Locality Partnership
- VCSFE (through existing LP leads)
- UBHW
- Sirona
- AWP
- PCN’s

Format and tools

The Operational Group will:

- Convene every two months
- Be sequenced within the meeting flow of H&WB and LP's
- Have dedicated administrative support
- Maintain workstreams/task and finish groups to deliver activity outside of meetings
- Use a dedicated space to share resources and update e.g. shared Teams channel or NHS Futures site.
- Be chaired by: Agree at first meeting (offer of DPH will be made)

(4) The benefits

Potential benefits for North Somerset population

- Streamline BNSSG complexities by localising service design and enhancing alignment and integration.
- Connect the group into existing robust governance and joint ownership of budgets, teams and resources, and joint commissioning activity.
- Enable improved alignment of strategic objectives through System, Local Authority and Locality levels.
- Place based focus will strengthen our joint action plans.
- Address long term equality and health inequalities issues.
- Ensure regular touchpoints and opportunities for engagement between H&WB and Locality Partnerships to build trust and understanding.
- Give North Somerset a stronger voice within our Integrated Care System.