Wiltshire Council

Health and Wellbeing Board

May 2024

Subject: Neighbourhood Collaboratives - update

Executive Summary

This report offers a summary of the background on Neighbourhood Collaboratives and then explains progress against the aims for 2023/24. These have been met, with clear plans moving ahead into 2024/25. There is only one PCN area without any ongoing conversation or plan to establish a Collaborative; this will be an area for development.

The learning and challenges for the developing Collaboratives are articulated, as well as opportunities arising from other regions to share insights from the work so far – which includes the importance of partnership; Collaboratives are an example of this in action.

The Collaboratives will continue to share learning and offer insight as the changes and transformation aims in the BSW ICS system continue to take shape.

Purpose of Report

1. To share progress against the objectives for the Neighbourhood Collaboratives as set out in the Joint Local Health and Wellbeing Strategy, which states “Every area (13) will have a mature and well-functioning neighbourhood collaborative”.

The ICS Implementation Plan

Relevance to the Health and Wellbeing Strategy

2. The Neighbourhood Collaboratives support the progression towards the objectives of the Health and Wellbeing Strategy and are specifically referenced in both the JLHW and Integrated Care System Strategies. The specific objectives for 2023/24 were:-

1	**Launch Neighbourhood collaboratives across Wiltshire**
2	April 2023 – Pathfinder site launched.
3	May 2023 – Onboarding Launch programme agreed and online portal established

4	June 2023 – Devizes and Chippenham, Corsham, Box areas commence launch, first pathfinder report.
5	July 2023 – First Wiltshire Collaborative event; share learning; and Pathfinder report.
6	By April 2024 5 neighbourhood areas will be on their collaborative journey and will have completed or commenced the Launch programme.

Figure 1- Summary of 2023/4 objectives in JLHW strategy.

3. The ICS Strategy Implementation Plan states in 5 years time through this work:-

1	**Local population health and wellbeing outcomes will be improved from today's position, as people are empowered and equipped to design and deliver care and solutions with a preventative and early intervention approach.**
2	Care will feel individualised as teams and services operating an Integrated Neighbourhood Team (INT) approach will drive clinical practice and interventions based on population health need
3	People will experience more coordinated support, delivered in partnership and including VCSE local services and assets in their community to meet their health, wellbeing and care needs.
4	People will be proactively offered interventions to reduce their risk of Long Terms Conditions (LTCs) as teams and services start to utilise data predictively.

Figure 2- 5-year aims of the Collaboratives; ICS Implementation Plan

Background

4. In early 2022, Wiltshire ICA Partners recognised the right approach to improving health outcomes in our communities, is to work directly with them to do so – bringing together partner colleagues, organisations, partners and residents in a new way. The Alliance developed the Neighbourhood Collaboratives approach to achieve this.

5. Integrated and explicit in the Joint Local Health and Wellbeing Strategy (2023) for Wiltshire, The Neighbourhood Collaborative programme has been co-designed by Integrated Care Alliance members to enable partnership working to flourish across services, organisations and community groups within areas loosely defined by each of the Primary Care Network footprints. The Collaboratives also align with the Primary and Community Delivery Plan. Once fully established, every area will be 'covered; by a Collaborative group.

6. Once at fully maturity, each Collaborative will connect partners from health and Social Care, Voluntary Community Social Enterprise, Local Authority partners, (including Area Boards, Education and Housing), Police, Fire and many Community Groups who will offer their resources and share their expertise and assets to enable solutions to be developed that can tackle health inequalities and promote health and wellbeing within their local community. Community views and engagement will be the key to success.

7. The Wiltshire Collaborative group provides a forum for Collaboratives to share their learning, celebrate success, and in times of need, seek support. It also offers a place to learn from best practice elsewhere and to collaborate on improvements Wiltshire-wide.

8. Each Neighbourhood Collaborative is grown from the ground up, which means they may be structured differently to each other, and partner staffing models may look different depending on what works for each area. With support, they will establish their own aims and priorities.

9. The pre-launch evolutionary work designed a structure to support Collaborative development consisting of:

- A Readiness Review that provides a series of insights and questions to identify the strengths and growth areas across a Neighbourhood, informing the Collaborative plan
- A Launch Programme, tailored to the individual Neighbourhood area based on the outcomes of the Readiness Review, bringing neighbourhood partners together to design and agree their work across six principle areas which underpin the model.
- A Toolkit which is a comprehensive set of resources linked to each principle area, that Collaboratives can use to support their work and embed the model.
- The ICA Partnership provides support, facilitation and system convening to the Collaboratives.
- In addition, each Collaborative is supported by a named lead who offers support and connection across the system.

10. The six Principle Areas are:-

- Partnership working
- Community Participation and Engagement
- Community-led approach for health & wellbeing (population health and prevention approach)
- Working as one using data analysis
- Enabling volunteers and staff to thrive
- Creating a movement for change

11. The Collaborative approach aligns with guidelines set out in the Fuller Primary Care Stocktake report (2022) and has been integrated into the Joint Local Health and Wellbeing and ICS strategies.

12. The work takes a strengths-based approach and supports other key areas of focus within Area Boards, Families and Childrens Transformation, Community Conversations and Mental Health, LD and Autism.

13. A Steering Group was established in December 2022 to provide a means of driving the programme forward. The Group has brought colleagues together who have formed new relationships and links and will continue to develop, providing direction and support to the work as it progresses.

14. Now including more than twenty partners from across the county, it is demonstrating a shared enthusiasm for delivering new ways of working within local communities as it grows.

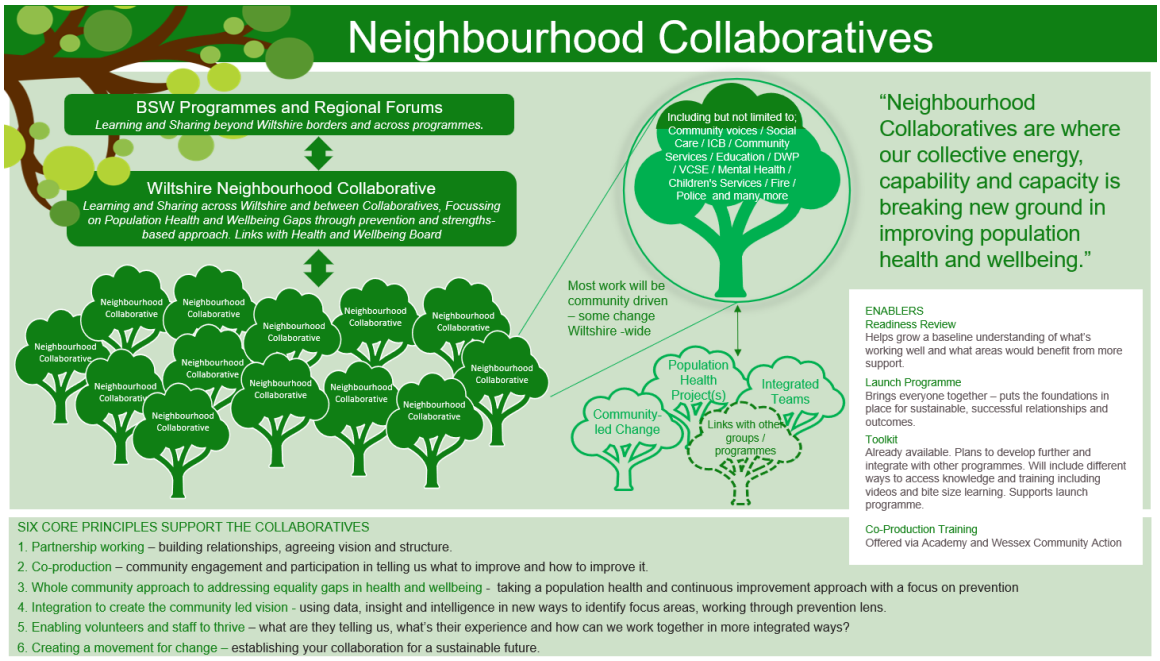

Figure 3 'At a glance' view of the Collaborative model

Progress

15. The first-year objectives have been achieved. The following section sets out current progress within the Collaboratives.

16. **Wiltshire Collaboratives Steering Group** – this group now meets quarterly in a Conference style setting. It is building strength in the relationships between partners, facilitating collaboration outside of the Neighbourhood Collaboratives programme as well as within. In 2023 / 24 the group has hosted 10 speakers and facilitated development work arising from each of those sessions. The main focus of the group recently has been on communication and engagement with communities, particularly those in inequality groups. It has also provided the outline framework for the Health Inequalities Sub Group to focus on.

17. **Health Inequalities Sub Group –** This group was established to deliver against the £100,000 award from the Health Inequalities funding. The money will support

- Engagement and co-design/co-production with population groups aligned to the CORE20Plus5 cohorts within the Wiltshire area and development of the model.
- Actions to address the needs arising from the engagement process will reduce/ improve an identified gap or inequality.
- Learning from the process to transfer across Collaboratives
- Dedicated resource to progress the spread of the collaborative movement.

18. The funding is divided into three key areas:-

- 30K = Project Co-ordinator for engagement model (20-25 hrs/wk).
- 30K = Delivery of an engagement model (60 days direct engagement and training at £500/day).
- 40K = Delivering interventions based on the Core20plus5 following the engagement work.

19. In line with the principles of the Collaboratives, community partners (VCSE) will be supported by the funding to deliver the work which will connect with other services and programmes (Voice It Hear It, Community Conversations and others). A Host Organisation has been selected, criteria for the Engagement Lead and a milestone plan have been agreed.

20. **Neighbourhood Collaborative Groups**

- **Melksham and Bradford on Avon** – this group is the Pathfinder and initially agreed the focus of the first project is to reduce the risk of falls for those who have not reported a fall, but are identified as being at significant risk (following pattern and cohort analysis and population health methodologies to identify risk factors associated with people who have experienced a fall).

  Engagement work took place with the cohort of people identified which has identified key points of learning. There were challenges in this exercise however which will feed into the Health Inequalities work to develop appropriate engagement approaches.

  As a result, the following improvements have been made:-

  - Separate organisations supporting the same cohort group now know about each other and can refer into each other's service offers.
  - A shared set of resources is now available across the partner organisations
  - Patients are now known to be 'at risk' and monitoring / support plans are in place – people will be monitored to understand if falls prevention is a success.

    An extended cohort has been identified who will be included into this work. Learning will be shared at the Steering Group.

- **Chippenham, Corsham and Box** – this group are just completing their launch programme. They have identified *'Non-hypertensive CCB residents who are not diabetic but are on the obesity register, aged 30-49 and recorded as current smokers'* as their first group to work with (they may add 'pre-diabetic' as a sub-cohort)

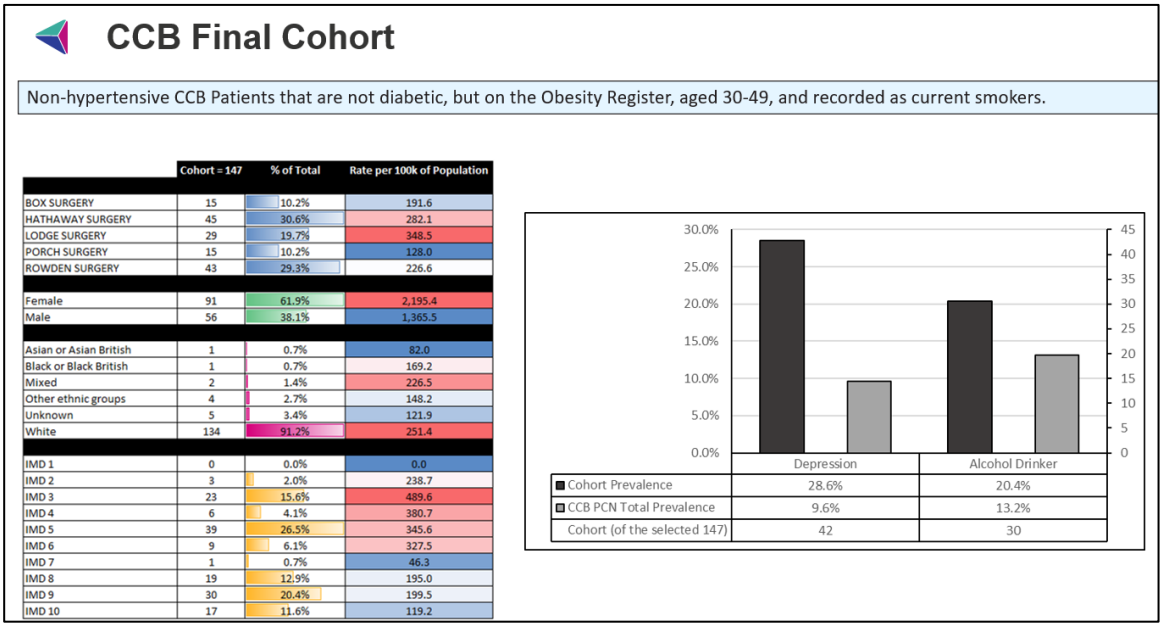

Figure 4 - example data analysis information for the CCB cohort

At the end of the last session, the group co-developed their 'purpose statement' which summarises the work they want to do together.

Figure 5 - The Chippenham, Corsham and Box Collaborative Purpose

The next step for CCB is to finalise their project plan and engagement work.

- **Salisbury Area** – This area is covered by a number of PCNs, who have expressed an interest in working together and exploring a 'super collaborative' model. This Collaborative is taking a different route to development – by working together on a project prior to undertaking the launch programme which will follow on.

This Collaborative group has started to develop a plan to pilot delivering health and wellbeing support within Salisbury Livestock market to farmers and the wider rural community. There is involvement from the Public Health team, Salisbury Foundation Trust, Primary Care, the ICB and the VCSE sector – with specific mention to the Rural Chaplaincy team who are a driving force and essential partner in this work, having built strong relationships with the community.

A visit to the market identified:-

- Farming community unable / unwilling to access traditional services and when they do it's often with advanced disease / symptom progression.
- They are very unlikely to take up opportunities for screening and vaccination.
- Anecdotally there are significant number of undiagnosed hypertension, diabetes, podiatry, dental, respiratory, orthopaedic and other types of illness / injury
- Farmers are routine / manual workers and experience impacts on their bodies as a result of prolonged work in often difficult conditions.
- Farmers and their families often 'leave it too late' before seeking advice / assessment around health or other issues / risks, which impacts outcomes and demand on services.
- We observed children of all ages – including school age who were brought along to the market by their parents.
- The community are struggling with isolation and additional cost pressures and other factors which are leading to increased mental health concerns and a higher rate of more serious issues such as suicidal thinking.
- People are struggling as informal carers without realising they are in fact taking on a caring role and are entitled to additional support.
- This community are often 'missed' as our own data and insights don't allow us to identify people and understand their needs etc..

Using a small amount of funding from the Vaccine Accelerator programme, the group will offer vaccines, health checks, mental health support and financial advice during June and July, alongside undertaking some engagement work. An evaluation will inform development of a future offering.

The Readiness Review and Launch Programme is currently scheduled for September.

- **Trowbridge** – this was the initial test site, which developed much of the approach embedded in this way of working. Their initial cohort was the prevention of people becoming housebound having identified people who were at risk, using population health methodologies. This group has paused because of capacity challenges however with renewed enthusiasm this group is aiming to start meeting again and complete the Readiness Review by August.

- **Devizes** – This group will go ahead without PCN participation at the current time. The VCSE and other community groups have identified children and families as an area they wish to progress with. Their launch programme will be scheduled over the summer, pending confirmation of attendance over the holiday period.
- **Warminster / Westbury –** the Warminster Area Health and Wellbeing Forum are taking the lead in bringing partners together to undertake the Readiness Review and launch programme. This is another exciting way to explore how Collaboratives can be established through a different pathway, taking a strengths based approach where there is already an active community organisation with ambitions to work in this way.
- **North Wiltshire –** The PCN in this area has approach the Collaboratives Team to explore how a Collaborative can be established in that area. Further updates will be provided as these discussions progress.
- **Kennet –** Remains the only PCN area yet to commence discussion on the development of a Collaborative. The Collaborative team aim to approach this area in the autumn.

21. **Reflections and Learning**

22. The work has entered its second year since the Pathfinder Collaborative was launched. Taking a learning approach is core to the way in which Collaboratives work. The following are a some key highlight points gathered through reflection and feedback from the participants in the work.

- This is breaking new ground; it's sometimes hard and frustrating but important.
- Making time to build relationships is essential to success – and is also delivering other benefits outside of the Collaboratives themselves and having wider impact.
- Leadership does not need to be heavily involved, but does need to 'give permission'.
- It's powerful to have shared understanding across organisations of the needs of our population and aligning together to work on priorities.
- It's the only available route for many to learning and develop skills in population health, good engagement, improvement methodology and other skills.
- As an 'organising group' partnership working is essential – and can avoid duplication / support others. For example, the Health Inequalities Team (HIT) have been key partners.
- Communities often have better answers to the challenges, 'services' don't need to solve everything, but they do need to share and engage.
- Impact may be both immediate but also longer term – may not see results for years in some ways and we need to be OK with that.

- This work continuously yields sight on other people and organisations working on similar things that [I] never knew were out there and we can have more impact together.
- Doing all of this without funding is making things more challenging but will also lead to built-in sustainability.
- Energising and positive – participants feel connected, supported and thankful to be working in a future, prevention focussed and 'holistic' way but…
- …it's hard to spend time in this space during exceptional demand pressures (though this way of working will be part of the future solution).
- Hopeful that this way of working will be sustained – it needs to not be a 'short term top down quick flash and move on project'.
- Takes effort to keep convening people and bringing us together.
- Opens thinking to different approaches, often stimulated by VCSE expertise and experience.

Next Steps and Priorities for 2024/25

23. The following sets out at high level the priority developments within the Collaboratives and how they relate to other areas of work.

24. **Wiltshire Collaborative Steering Group** – will continue to meet and learn from best practice both within Wiltshire and nationally. Relationships will be a key priority as well as providing guidance to the developing collaboratives and undertaking a potential project across Wiltshire.

25. **Continued Neighbourhood Collaborative development** – the team are committed to making progress within each collaborative area; capacity is challenged in being able to keep pace with each area therefore a priority will be to expand the project team across partner organisations to support. The aim is for each PCN area to have completed the launch phase by the end of 2024/5 and to have commenced or completed at least one cohort project.

26. **Delivery of the Health Inequalities Project** – the Sub group will ensure continued progress and achievement against the objectives of this work which will inform the way in which engagement works in the Collaborative model, as well as sharing learning with the Community Conversations team and across all Collaborative partners.

27. **Integrated Neighbourhood Teams Blueprint –** BSW ICS is aiming to establish a 'Blueprint' for Integrated Neighbourhood Teams across B&NES, Swindon and Wiltshire as part of the ICS Primary and Community Care Delivery Programme. This also links to the Intermediate Community Based Care programme. The Neighbourhood Collaborative group will support the development work and share learning.

28. **Regional and National Sharing of Good Practice**– the Collaboratives work has drawn attention from a number of other areas and partners will support sharing the learning beyond Wiltshire borders. Including:-

- The Collaboratives were featured as part of a recent PCN sustainability learning conference.
- The Gloucestershire PCN network have invited the Collaboratives to share the work and progress in their system so they can learn and establish their own version.
- The regional NHS England team have asked the Collaboratives team to lead a regional learning session on progress of Integrated Neighbourhood Teams and population health management.
- The national NHS England Inequalities team have asked for the Collaborative teams' view on the resources, advice and support offer being prepared for national launch.

29. **Assurance**

30. Neighbourhood Collaboratives have met the ambitions set out in the Joint Local Health and Wellbeing Strategy and the Integrated Care System Strategy Implementation Plan and continue to make progress into 2024/25.

Report Author:-

Emma Higgins
Associate Director – Wiltshire ICA Programme & Delivery Lead
BSWICB