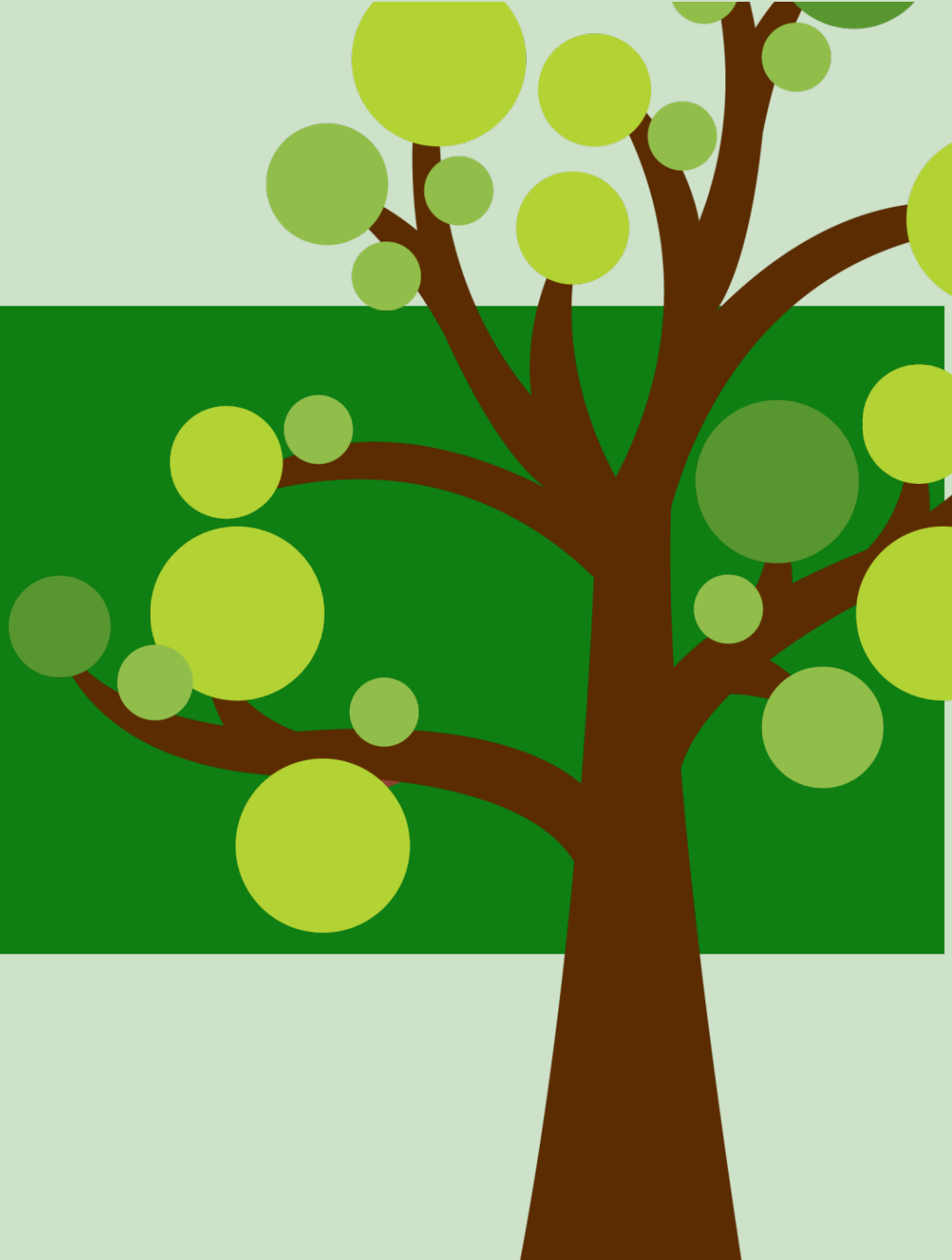
Neighbourhood Collaboratives

Health Select Committee Update

January 2024



Neighbourhood Collaborative Model

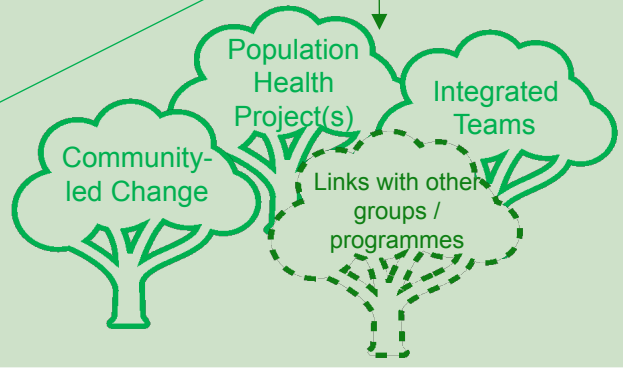
Vision and Purpose	To reduce health and wellbeing inequality gaps within neighbourhoods across Wiltshire by working together on the priorities and improvements that are important to local people. Collaboratives align with our Joint Local Health and Wellbeing Strategy.
The Model	Establish a Collaborative group in each 'neighbourhood' to develop areas of work, addressing local health and wellbeing challenges together – with support from a Wiltshire-wide group of professionals and each other. Underpinned by data (new tools and methodologies), community and staff feedback, views and engagement. share data, knowledge, resources, and experience to co-produce and design solutions to local community challenges Will develop integrated working (Fuller Stocktake) Roughly on PCN footprints, without prescribed structures Sustainable and long term vision – no new funding Supports integrated working and enhances other programmes. Prioritises prevention, relationships, mutual aid, test and learn culture
Membership	Collaboratives will include partners across Health and Social Care, Voluntary Community Social Enterprise, Local Authority partners, (such as Area Boards, Education, Housing), Police, Fire and many Community Groups
Wiltshire Collaborative Network	A forum to connect, learn and share across all the Neighbourhood Collaboratives – celebrating success, seeking and receiving support, and connecting into networks of professionals

Neighbourhood Collaboratives

BSW Programmes and Regional Forums
Learning and Sharing beyond Wiltshire borders and across programmes

Wiltshire Neighbourhood Collaborative
Learning and Sharing across Wiltshire and between Collaboratives, Focussing on Population Health and Wellbeing Gaps through prevention and strengths-based approach. Links with Health and Wellbeing Board

Most work will be community driven – some change Wiltshire -wide



"Neighbourhood Collaboratives are where our collective energy, capability and capacity is breaking new ground in improving population health and wellbeing."

ENABLERS

Readiness Review
Helps grow a baseline understanding of what's working well and what areas would benefit from more support.

Launch Programme
Brings everyone together – puts the foundations in place for sustainable, successful relationships and outcomes.

Toolkit
Already available. Plans to develop further and integrate with other programmes. Will include different ways to access knowledge and training including videos and bite size learning. Supports launch programme.

Co-Production Training
Offered via Academy and Wessex Community Action

SIX CORE PRINCIPLES SUPPORT THE COLLABORATIVES

1. Partnership working – building relationships, agreeing vision and structure.
2. Co-production – community engagement and participation in telling us what to improve and how to improve it.
3. Whole community approach to addressing equality gaps in health and wellbeing - taking a population health and continuous improvement approach with a focus on prevention
4. Integration to create the community led vision - using data, insight and intelligence in new ways to identify focus areas, working through prevention lens.
5. Enabling volunteers and staff to thrive – what are they telling us, what's their experience and how can we work together in more integrated ways?
6. Creating a movement for change – establishing your collaboration for a sustainable future.

Fuller & Integrated Neighbourhood Teams

The stocktake includes a compelling new vision for integration that centres on three essential offers:

- Streamlining access to care and advice for people who get ill but only use health services infrequently, providing them with much more choice about how they access care and ensuring care is always available in their community when they need it.
- Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs.
- Helping people to stay well for longer as part of a more ambitious and joined up approach to prevention.

Building fully integrated teams in each neighbourhood is critical to making these essential offers a reality. No single organisation or ICB can make this happen without radical cultural change in working arrangements in neighbourhoods.

The ‘team of teams’ approach, evolving from primary care networks, needs to be rooted in a shared ownership of local wellbeing across all local public servants, including primary care in its widest sense, community care, adult and children’s social care, mental health, acute, housing, the police, public and environmental health and, importantly, local grassroots community and voluntary organisations.

A different kind of leadership that provides an environment of psychological safety where it is ok to try new things and for teams to innovate to find new ways to support individuals, their families and communities. Top-down hierarchical leadership of neighbourhood co-ordination risks alienating the frontline workforce.
A shift to a preventative wellbeing model with a clear focus on sharing data, having a joined-up action plan and focusing on inequalities.

https://www.nhsconfed.org/articles/making-fuller-stocktake-real-communities

STEERING GROUP becoming the WILTSHIRE COLLABORATIVE

WILTSHIRE COLLABORATIVE

- Well established – cycle of quarterly in person meetings
- Conference of learning and external speakers
    - Invited speakers offer insight from other systems
- Driving change and progress
- Sub-group system established
- Collective bid for Health Inequalities Funding - successful
- Exploring other funding opportunities using partnership expertise
- Identified opportunities across Wiltshire to develop into Collaborative catalysts
- Commissioned the pathfinder
- Driver models in place for each steering group objective

STRUCTURAL ENABLERS

Communications

Glasscubes established and developing. Good signup and hosts all available information. Elevator pitch, Newsletters, recorded ‘pod casts’ and GP Team Net in place. ‘Branding’ away from corporate style.

Strong Links with work programmes

NCs work with the HIT Team, Community Conversations, FACT, Fuller and more to be mapped – single navigation graphic to be produced.

Governance Structure

Established via Steering Group, WHIG, Population Health Board, ADG and ICA Committee.

Strategy Inclusion

Included in JLHW and ICS Strategies – sustainable integration in future models.

Representative organisation/service	
ICB Wiltshire Locality Team	AWP
RUH	SFT
ICB – Population Health	Safeguarding
Area Boards – Wiltshire Council	WHC
Wiltshire Council Social Care	Children & Young People
Public Health	Police
GWH	System data leads
Wiltshire Council – Library Services	Fire & Rescue
Healthwatch	Education (awaiting rep)
Primary Care	Housing
VCSE – Alliance and many other partners	Environment (awaiting rep)
Acute Trust - Strategy Teams	Community Groups
Wiltshire Council – Systems Thinking	ICB – Estates
HCRG	Council Leisure Service

Collaboratives in 2023

Neighbourhood	Highlights
Trowbridge	(initial pilot area) continues with its work in preventing increases in the housebound population. Health Inequalities and Neighbourhood Collaboratives project teams met with Trowbridge and agreed a plan to establish a broader collaborative group and commence launch programme in early 2024.
Melksham and Bradford on Avon	Pathfinder site – quick testing and learning from the model and will be able to share the learning to inform the tools and the approach that will be used by other sites. Coproduction training has taken across partners in this area. Feedback from the training will be used to help identify our baseline awareness of Co-production within the locality which should help to identify areas of future need. Cohort identified: Previously unidentified people as first of a first serious fall – aiming to reduce prevalence of serious first falls and subsequent ambulance attendances / hospital admissions. • Mapped and collected existing falls prevention resources across MBoA – will share example • Engagement with the identified group of patients is competed– utilising co-production; learning identified (to be repeated via PDSA) • Delivery of the Development programme, (an adaptation of the Launch Programme), happened 27/11/23
Devizes	After a period of engagement with partners in this neighbourhood and plans to focus on children and young people, the support team stepped back whilst this area discussed and agreed it's way forward. This area will progress in early 2024 with the Readiness Review and launch programme.
Chippenham, Corsham & Box (CCB)	Areas of interest reviewed and undertaken data analysis with the Health Inequalities team. The early stages of this collaborative are progressing well and there is a structure of meetings in place. The Readiness Review has been completed – launch programme due early 2024. Reducing Hypertension is initial area of focus.
Salisbury – area wide	Three of the four Salisbury PCNs (offer to join will be extended to the 4th PCN area) have proposed a Salisbury-wide approach to developing a Collaborative. This will be taken forward – next step is to undertake the Readiness Review. Plans also in place to work with farmers and support a dementia network approach.

Pathfinder – Melksham and Bradford on Avon

Pathfinder Rationale

Rapid test and learn site to inform the development of collaboratives across Wiltshire.

Collaborative Aim

To reduce health and wellbeing inequality gaps within BOA & Melksham neighbourhood by working together on the priorities and improvements that are important to local people.

Initial Project

Following extensive relationship building and collaborative data analysis using new tools, it was agreed the focus of the work for the initial 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).

Initial Cohort

The initial cohort is intentionally small as we test and develop new ways of working - Determinants included hypertension, being housebound, are taking 10 or more medications (polypharmacy), are over 65 and have a carer.

Methodology

- Data Analysis
- Deep engagement with identified cohort; visiting them at home.
- Identify individual and cohort insights which the collaborative can collectively work to resolve and apply across a wider group.

Progress / Outputs

- Identified partners involved in MBoA in supporting people in this cohort
- Shared understanding of the challenges and issues
- Network of people and organisations able to support each other and personalise care
- Coproduction training through Wessex Community Action – shared sessions
- Developed shared collated tool of all resources already available to offer people, which can be rolled out now, and used as part of the engagement process.
- Initial engagement undertaken; insights gained however *did not go according to plan and there is significant learning that has arisen as a result. This is being fed into the next steps and the engagement process undertaken again with an expanded cohort.*

Project Learning

- Shared understanding of the data and what it means is essential
- Services supporting the same cohorts are not connected and don't share information (we're resolving that!)
- Engagement model was not entirely appropriate for this exercise (explaining risk v inquiry approach)
- Utilise competency of expert partners
- Patients are unused to a personalised approach and are sceptical of why it's being offered.

Project planning is essential – but bringing everyone to the same page is key in doing this. SMART objectives now in place.

Pathfinder Learning

- New and different – takes time to build relationships
- Launch programme is essential to develop shared purpose and capability
- Funding – some non-statutory organisations are challenged in being able to spend time in the development spaces
- How do we create space for everyone?; learning when partners need to participate more or remain informed.
- Many different perspectives and areas of expertise.
- Sometimes co-design is just a useful as coproduction
- Joining things together in a way we haven't before!
- New relationships already having an impact – opportunities are endless
- Joining together resources in new ways which will benefit our population
- What can be done to change the culture to create the behaviours and values that are needed to sustain the model
- There is an opportunity to take risks – trust is required to explore these risks
- Challenges in managing operational demand v long term improvement and transformation like this

Development Day

Overwhelmingly positive. Established role, responsibilities, and vision

The Health Inequalities Funding

Our Aim

To provide seeding for increased pace & scale of the Neighbourhood Collaboratives movement and
to be able to develop and test an innovative model of community engagement and co-production principles.

Sub Group to meet from January 2024 to ensure delivery

The 'Knowns'

The funding will support:-

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

Funding 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.

- Timescales – window for delivering on these objectives April 2024 to April 2025

Actions and Next Steps

RISKS

- New way of working – challenges accepted norms and requires commitment to continue progress.
- Extraordinary operational demands divert operational capacity away from NC development.
- Long term development and vision – requires belief and support for longer term benefits. Risks losing engagement.
- Perception that funding is required to move to this way of working – seen as ‘additional’. This is not the case; it’s about how we make use of expertise and resources together.
- Consistent messaging from leadership to reinforce change in cultural and behavioural values and enable Neighbourhood Collaborative to thrive.

NEXT STEPS / CURRENT ACTIONS

- Continue to develop and support Collaboratives to establish across the Wiltshire area as per plan.
- Establish the HIF Sub Group. Develop and share plans for the £100k Health Inequalities funding that the programme has been awarded to develop engagement best practice collaborative model and support interventions around Core20Plus5 cohorts.
- Demonstrate connection to other work steams – all interconnected
- Continue to share insights and learning from Pathfinder (repeat initial co-production cycle following learning from round 1 and expand the cohort).
- Develop plan for future Wiltshire meetings – including schedule of national speakers.
- Explore opportunities for learning and support with B&NES and Swindon – joining up our work where alignment is identified
- Continue to develop and refine comms and engagement plans – continuous engagement is one of the biggest challenges as partners change and join.

Thank You – you are invited to join the Newsletter Circulation and to attend the Steering Group Conferences.

Questions?

Propose to update again in 8 months.