South Gloucestershire
Locality Partnership

South Gloucestershire Priorities
2023-2028

Introduction

The South Gloucestershire Locality Partnership brings together GPs, community services, mental health, social care and the voluntary and community sector under a shared sense of purpose: Working together with our communities, using our resource and expertise to support local people to reach their full potential.

We recognise that we can best do this by greater integration – working towards shared priorities and developing trust and a shared culture. Key to delivery is an understanding of our communities and their needs and strengths, and a willingness to step outside of organisational boundaries to think collaboratively and creatively.

South Gloucestershire is the largest of the six Locality Partnerships in Bristol, North Somerset and South Gloucestershire. We serve a population of over 295,896 residents (ONS 2021) across a large geography of 537 sq km – nearly five times the size of neighbouring Bristol. Our six Primary Care Networks help us maintain close links with communities, working with a range of local groups and services.

The Locality Partnership is coterminous with the Local Authority, and we are committed to working closely in partnership to promote and protect health and wellbeing, delivery quality health and social care and reduce inequalities. This partnership provides a platform for us to develop more joined-up services, underpinned by the Joint Strategic Needs Assessment and tailored to local need. This partnership approach to 'Place' will increase impact and reduce duplication of effort across our work, helping ensure best use of our collective resources. Our ongoing Development Sessions have enabled us to develop clear joint priorities under our One South Gloucestershire Plan, and we are moving forward to explore closer governance and ways of working.

Our programmes of work fall under four joint priority areas (1) Start Well, focussing initially on CYP mental health (2) Live Well, focussing on mental health and wellbeing (3) Age Well, and underpinned by (4) a focus on Prevention and inequalities.

Our Communities

South Gloucestershire is comprised of a mix of communities, including rural hamlets, market towns and a growing ‘urban fringe’. Our communities’ resilience is being tested by the pandemic and the cost of living crisis, with more people coming forward to say they are struggling to manage.

There is ongoing community development work in our Priority Neighbourhoods and in some of our newer communities, and in tandem our Village Agents are people who have come forward from rural communities to help those who feel isolated. They support people gain access to high quality information and services that will enhance their wellbeing, safety or securing and enable them to live independently for longer. Village agents can help identify and support rural communities to tackle pockets of deprivation or unmet need, and as we expand the model, we are evolving it to include the development and delivery of informal networks and support mechanisms.

South Gloucestershire is one of the fastest growing areas in England with developments particularly around the northern fringe and the A38 corridor. People from newly arrived communities, from Afghanistan, Hong Kong, Ukraine are being supported as they settle here. There has been an increase of 21.8% in people aged 65 years and over, an increase of 8.4% in people aged 15 to 64 years, and an increase of 7.6% in children aged under 15 years.

The Locality Partnership has recruited to a post hosted within our VCSE Lead Locality Partner, Southern Brooks, working to engage smaller community groups borne from identified unmet need within communities and who often do not have the time or resource to engage in more formal structures. The post is proving really valuable in engaging and mapping existing activity, understanding strengths and challenges and supporting innovation and development, linking closely with the established Keep It Local (KiL) work in South Gloucestershire.

Initiatives such as these will be further underpinned by our Asset Based Community Development approach. This aims to provide a consistent and agreed framework to bring about transformational change to the way in which we work with communities, supporting them to identify, mobilise and strengthen their assets. This builds resilience so that communities have the capacity to help themselves and each other. New approaches will be developed to improve the health and wellbeing of residents, tackle the impact of inequalities and deprivation, and improve services by focussing on what matters to people. Led under the South Gloucestershire Prevention Fund, this will lay the groundwork for our Community in Action programme which will test the approach's practical implementation to strengthen communities.

Local case study – Partnership Manager

Yan Lau started in post as Partnerships Manager in October 2022 hosted by Southern Brooks with funding from the Locality Partnership to enable greater connection with the wider VCSE sector, supporting the People and Communities strand.

Yan started by contacting small organisations and community groups who received a small health inequalities grant (from the One You South Glos Wellbeing project/Locality Partnership) to build the relationship, understand each organisation's objectives, client target group, their strengths and challenges. The groups she visited offered a range of activities tailored to their particular beneficiary group from specially adapted cycling sessions for people with learning disabilities, to woodworking sessions for isolated men to pay-as-you can café and tea & coffee socials.

The greatest strength of each VCSE group is the passion and dedication of the lead employee or volunteer/s who are running the project/organisation. Driven by their strong belief that their activity or project is much needed, many leaders go over and above in terms of hours and effort to make sure that their activities happen for their beneficiaries. Their passion and conviction help them to overcome barriers in running their organisations/projects.

Common challenges emerged - lack of recurrent funding and not enough workers to carry out the work. No matter the size of the organisation a substantial part of each leader's time is spent chasing funding and putting together bid applications and then servicing monitoring and evaluation requirements. An oft complaint is that recurrent funding is not made available for core costs or salaries and that funding is often target at new or innovative work rather than for ongoing work that is established and successful. Lack of capacity comes from the instability and nature of funding. Having sufficient senior leadership time without adequate core funding remains challenging.

Yan Lau
Partnerships Manager

Inequalities

Inequalities are not always visible, and at the wider Locality Partnership level can be hidden through relative affluence. This masks significant areas of deprivation, and an understanding of community and population need is vital to addressing this. We also know that people experiencing multiple disadvantage including poor housing, social exclusion, poverty , debt and worklessness are at risk of poor mental and physical health outcomes often living with more than one health problem.

Public health in South Gloucestershire Council are key within our partnership, and the Joint Strategic Needs Assessment, and ‘deep dive’ Needs Assessments into priority cohorts inform our priorities and underpin our work.

South Gloucestershire Council

Delivering for you

Headline inequality statistics

South Gloucestershire

The life expectancy gap widens with deprivation

2018 - 20

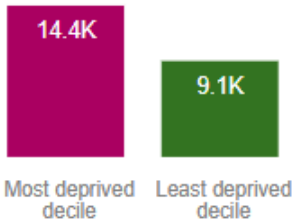
Life expectancy gap in years between the least and most deprived areas of South Gloucestershire (slope index of inequality)

Year 6: Prevalence of overweight (including obesity) (%)

2017/18 - 2018/19

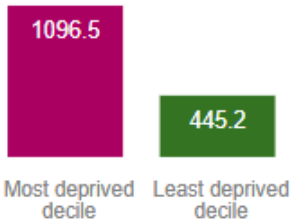
Emergency hospital admissions (per 100,000)

2018/19 - 2020/21



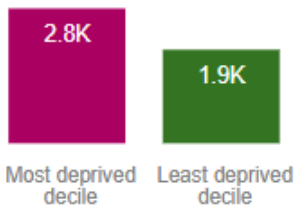
Admission episodes for alcohol-specific conditions (Persons) (per 100,000)

2018/19 - 2020/21



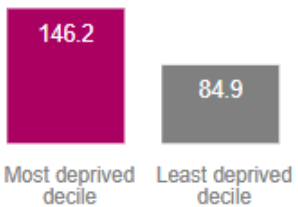
Emergency hospital admissions due to falls in people aged 60 and over (per 100,000)

2018/19 - 2020/21



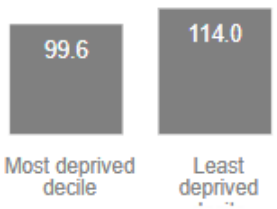
Hospital admissions as a result of self-harm (15-24 years) (per 10,000)

2018/19 - 2020/21



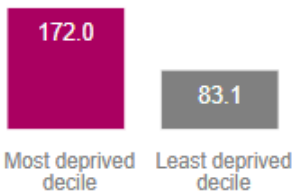
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years) (per 10,000)

2019/20 - 2020/21



Under 75 mortality rate from causes considered preventable (2019 definition) (Persons) (per 100,000)

2018 - 2020

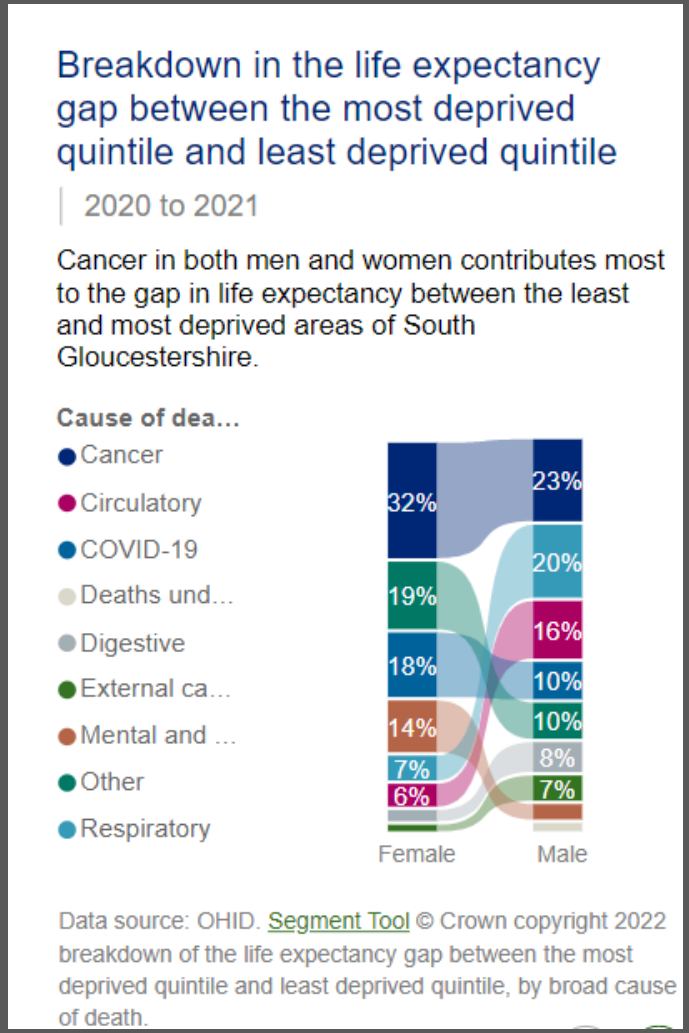


Data sources: Hospital Episode Statistics. National Child Measurement Programme (NCMP). Primary Care Mortality Database. OHID. Public Health Profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022.

Statistically higher than South Gloucestershire average

Statistically lower than South Gloucestershire average

There are large differences in life expectancy between different geographical areas with deprivation associated as a key factor (gap at birth of 4.3 years for males, 5.7 for females).



Local case study - 'Keep it Local'

There is a commitment by South Glos Council to further embed Keep it Local principles and practice.

Working with the locality partnership and VCSE leaders' board there is an emerging sector transformation plan including a distributed leadership model whereby sector leaders attend strategic meetings on behalf of one another in addition to attending for their own organisation, small grants to enable hyper local and small-scale groups to increase their delivery (eg supporting a breast-feeding group in Lyde Green, disability bike maintenance in Warmley, online choir for people with aphasia https://www.youtube.com/watch?v=ty93jpQ2UCo&t=2s).

Future plans for Keep it Local and VCSE sector transformation include strengthening collaboration in the VCSE sector so that innovative solutions to addressing agreed shared priorities can be found, cross-sector training to develop and foster the culture of partnership, and a leadership development programme for existing and aspiring sector leaders.

International Aphasia Choir: What A Wonderful World - YouTube

OUR STORY:In 2020, choirs from around the world were discouraged from meeting in person due to COVID-19. In light of this, a virtual choir was created, reach...

www.youtube.com

Starting well

Children & Young People's Mental Health

There is compelling evidence that a child's experiences have a major impact on their health and life chances both as children and adults, and early support and intervention is vital to reducing health inequalities and giving children the best start in life. Our work on Children and Young People's Mental Health focuses on an initial six priority areas, informed by the 2021 needs assessment and led through our multi-agency Whole Systems Group.

These are

- Perinatal mental health and early years – including family resilience and early years networks
- Promoting emotional health and wellbeing – including through mental health support in schools
- Transition to adulthood – with an initial focus on care leavers and young homeless people
- Understanding, preventing and responding to self-harm
- Special Educational Need and Disabilities (SEND) and Social, Emotional and Mental Health (SEMH)
- Eating Disorders and Eating Distress

Our **Children's Connected Clusters** project is exploring how we can better link up practitioners across health, social care, education and voluntary and community bodies in geographic clusters. Further integration of children's services and a real understanding of local assets and resource within these footprints will support improved outcomes for children and families. The work is led by South Gloucestershire Council and builds on very successful work as part of the SEND Strategy, where strong cluster relationships between schools and health, care, education and support services have been forged.

We are working to better identify family need and increase the provision of joined up early help and support around the whole family. A team of **Family Link Workers** will be rolled out across our clusters to support early intervention, prevent needs escalating and reduce referrals into social care services.

Living well

De-medicalising wellbeing

Mental health and physical health needs, such as **chronic pain** in South Gloucestershire, have a significant impact on the ability of our residents to live well. Our first phase of work has focussed on adult mental health and those with both mental and physical needs, transforming the way support is delivered to the individual with their needs at the heart of our approach.

We also want to ensure that people receive the right care, from the right service, when they need it, aiming to provide holistic and de-medicalised support to those that are struggling.

Integrated personalised care teams

Holding the person at the centre of the care we deliver, an approach we call **'My team around me'**, we come together, as integrated personalised care teams, to provide support rather than a person having to be referred to lots of different services. This approach also means that people only need to tell their story once.

These teams are a collaboration of clinical and practitioner networks working closely together and include voluntary sector organisations, psychological therapies, social services, community network teams, mental health services and general practitioners.

They are embedded in the local community and can offer continuity of care by being connected to Primary Care Networks (PCNs) .

We are mindful of the wider determinants of health in our approach and are supporting debt advisors in South Gloucestershire's Citizen's Advice Bureau to work directly with our PCNs and their patients.

Looking forward

Learning from the transformation and benefits people and practitioners are experiencing we hope to expand the approach to other areas of complex care.

Local case study – Mental Health Personalised Care Teams

Mental Health IPCTs are virtual teams of practitioners, supported by IPCT coordinators, that work around the needs of an individual. Their aim is to move towards a shared responsibility and a shared approach to risk, moving away from cold referrals into services and to more frequent and facilitated informal discussion with team members, in order to develop closer working relationships, better understand how we all work and gain a greater knowledge of the services available.

Mental Health IPCTs are being mobilised throughout the South Gloucestershire PCN footprints as part of a phased roll out plan, and there has been invaluable feedback and learning taken from the virtual meetings that have been taking place so far over the initial 3-6 months of the programme, attended by practitioners across General Practice, AWP Primary Care Liaison Service, AWP Psychological Therapies Service, Vita Minds, Adult Social Care and Social Prescribing.

Here are some of the insights gained, which have fed into our recent lessons learned report.

IPCT attendees have praised the space the IPCT meetings create to informally discuss pressures and challenges alongside cases. One practitioner described the meetings as 'therapeutic'. The meetings have been described as somewhere to have a more natural conversation around cases, compared to the formality of written notes. Further positive feedback includes that IPCT meetings are helpful in providing context about an individual before they are referred into another service's care.

Through regular meetings with one other, IPCT partners have learnt more about the services each other offer, and what 'level' of mental health support they offer. For example, the Recovery Team have noted discharge challenges when arranging 'step down' support and feel that knowing more about the Social Prescribing offer could help with this. Both the Recovery Team and the Psychological Therapies Service are now linking with Social Prescribing to discuss the potential for working together.

Ageing Well

Our over 75 population is projected to increase by over a third in the next 15-20 years. High levels of multimorbidity in combination with older age is the major driver of hospitals admissions and other health service use – we need to find ways to live in better health.

Our capacity to 'age well' is impacted by a broad range of social, economic and environmental factors. Our aim is to work together to understand how we holistically meet those needs 'at place' through developing and championing a proactive and preventive approach.

We are working across the Locality Partnership to develop our **approach to Anticipatory Care**. Working with our general practices and community and VCSE colleagues we will develop proactive models of care for those who are increasingly frail and complex, building on our existing frailty Multi-Disciplinary Teams and using a population health driven approach. We are exploring how **specialist community-based Complex Care GP and Advanced Nurse Practitioner (ANP) roles** could further support complex patients through holistic assessment and advanced care planning, preventing hospital admissions and supporting people to stay in their home.

In South Gloucestershire, the rate our residents fall is significantly higher than the Southwest average (2,132 per 100,000 compared to 1,947 per 100,000) *(OHID Public Health Profiles 2022)).* We have the goal of **reducing the number of falls requiring hospital admission by 10% over the next two years** and are developing an action plan to work to address this.

Our workforce underpins the care and support we can provide. Our **workforce development and training plan** will help ensure our clinical and non-clinical teams are supported to work at the 'top of their licence', including residential and nursing home staff, and that care provided is personalised and grounded in shared decision-making.

We are developing a model of **community clinics** which will offer early intervention or treatment for targeted conditions, geographies or groups delivered in hyperlocal, non-clinical community venues. There is an emphasis on social interaction, participation and peer support for positive impacts on mental health and loneliness as well as recovery rates.

We will ensure access to effective **advice, guidance and information** through our Community in Action programme, led by our Local Authority partners. The **Improving Homes and Wellbeing Service**, funded by our joint Prevention Fund, will support homeowners to access advice and practical assistance to improve their unkempt homes whilst also identifying and addressing root causes, barriers and broader support needs.