The League of Friends of Chalfonts and Gerrards Cross Hospital: Thoughts on Our Development as a Community Hub

We are delighted to hear that Chalfont and Gerrard's Cross Community hospital is to develop as a community hub in line with the NHS Long Term Plan as part of an Integrated Care System focused on population physical and mental health and wellbeing, while providing personalised care. We hope these ideas will contribute to these plans. Our hospital works with primary and secondary providers to deliver services in our hospital, in people's homes and in schools. The Marlow and Thame Hubs show how services could be delivered closer to our homes. We support these ideas for "hospital at home" and "day hospital" provision and hope to go further. Working with Buckinghamshire Healthcare NHS Trust (BHT), Buckinghamshire CCG, Buckinghamshire County Council (BCC) and local GPs, we could engage health and social care professionals, community-based groups and local businesses to enhance community health and wellbeing as a step toward accountable care.

We look forward to the extension of diagnostic and treatment facilities and clinics at our hospital to meet local demand including: Community Assessment and Treatment Services, Rapid Response Intermediate Care and Community and Social Care Coordination. In this note we have focussed on how the voluntary sector, community action and social prescribing could be developed to support health and wellbeing for the community served by our local Primary Care Network and a wider area:

- Community support for people with early signs of potential mental health problems.
- A Dementia Friends initiative to provide community support for people with Alzheimer's.
- Integrated support for parents of children with special educational needs and disabilities.
- Action to improve access to arts, sports and other activities for people with disabilities.
- Re-establish Breathe Easy Support Group for those with Chronic Obstructive Pulmonary Disease.
- A self-help support group and improved services for people with joint pain.
- Integrated support for new mothers, including those at risk of post-natal depression.
- Extension of services and self-care support for people with diabetes.
- Development of an integrated care for carers network and respite services.
- Further support for hospice at home services to give people greater choice of end of life care.
- Social prescribing and other aspects of digitally enabled care to reduce A&E pressures.

Following recent consultations and national announcements we suggest the Community Hub could help address loneliness by providing facilities for Age Concern and could support use of IT in primary care, providing monitoring and training facilities to help patients use new technologies. Local Enhanced Services and NHS Health Checks could also be provided to reduce GP workload pressure.

We look forward to working with BHT and partner organisations in a local engagement group, to make contact with community organisations, GPs and LAs to help develop local services and initiatives such as those described here. Initiatives should be cost effective, safe and compassionate, reducing demand for overstretched services (in particular GP and A&E services) and building community engagement and self-care as a contribution to BCCG's Integrated Care Strategy.

We welcome BHT support for ongoing projects to develop audiology and podiatry facilities. In consultation with BHT we would ask relevant community providers to identify further resources and support that would help them develop appropriate local initiatives. Our hospital has rooms that are currently used to store records and other materials, they will require refurbishment, we also have a garden area and parking, which are important for some services. We can provide facilitation and limited funding for refurbishment and transport, as we have in the past.

We are encouraged by consultations with BHT and steps to remove and digitise records. We support the complex efforts to plan the use of these rooms for clinical services and suggest that at the same time we should consult potential community health and wellbeing groups concerning other uses.

Our Community Health and Wellbeing

The Chalfonts and Gerrards Cross includes communities of 36,000 people (12,900 in Chalfont St Peter, 5,900 in Chalfont St Giles, 6,700 in Little Chalfont, 2,300 in Seer Green and 8,200 in Gerrards Cross). The population has grown steadily and is expected to accelerate over the next 5 years with at least 500 homes under construction. There are small and medium sized employers locally and many people commute to work in London. Our population has a somewhat older age profile than other areas of Buckinghamshire, Indicators of health are relatively good and indicators of poverty and unemployment relatively low. The Joint Strategic Needs Assessment (JSNA) by BCC and CCCG includes Denham (which traditionally looks to Uxbridge) and Fulmer but not Little Chalfont, covering a population of 39,000. The needs of a wider area of South Bucks and Chilterns are discussed in Annex A. Two thirds of early deaths are preventable by addressing four risk factors: overweight, smoking, excess alcohol consumption and high blood pressure. Key objectives are therefore to improve physical activity, diet, drinking, smoking and other lifestyle self-care behaviour and attendance at NHS health checks.

Health care services are commissioned by the Buckinghamshire Clinical Commissioning Group. Four primary care practices will work together in our local Primary Care Network to coordinate health and wellbeing services: the Hall Practice serves 9,600 patients, Allen Practice 8,900, Misbourne practice 12,000 patients (including its surgery in Chalfont St Giles) and Brodie David and Partners also in CSG 12,000. BHT provides services from our hospital which houses some 30 Consultant, Nurse and Allied Health Professional led clinics and a base for School Nurses, Health Visitors and an integrated team providing Adult Community Healthcare for people in their own homes. BHT also provides hospital care and Oxford NHS Trust provides mental health services. Wexham Park hospital and private healthcare providers are also used. There are 8 dental practices and 6 pharmacies, which with GP practices could also be hub partners, as Healthy Living Pharmacies and Healthy Living Dentistry, providing health and wellbeing advice and signposting to relevant services. There is also a nearby ambulance station, which works with Community First Responders.

Public Health and Wellbeing and Social Care services are managed by BCC. Social care professionals are based in Amersham and High Wycombe. South Bucks District Council has launched a Prevention Matters initiative to help people maintain health and wellbeing and map local support groups. SBDC and CDC currently provide some environmental health services, to be unified at County level. Health and Social Care are coordinated by the Buckinghamshire Health and Wellbeing Board. There are 24 residential and care homes ranging from nursing homes to sheltered housing, and 4 homecare services, at least 7 offer support for people with Dementia. Specialist homes, including those operated by the Epilepsy Society, and Leonard Cheshire Disability, cater for people with disabilities.

Our communities have a great many community meeting rooms and halls available, including: sports halls, libraries (supported by community volunteers), GX Community Centre, Chalfont St Peter Community Centre, Little Chalfont Village Hall, Jordans Village Hall and Seer Green Jubilee Hall and some 15 church halls. There are proposals to renew both Chalfont St Peter and Little Chalfont halls, a new Church hall is opening close to our hospital. Chalfont St Peter Leisure Centre, which is also nearby, is run by a social enterprise called Better, which offers a range of paid and concessionary health regimes including: Physical Activity Referral Schemes, Balance and Falls Prevention, Cardiac, Cancer and Pulmonary Rehabilitation, Diabetes, Weight Management and Mental Health Classes.

The Town Council of Gerrards Cross and the Parish Councils of Chalfont St Peter, Chalfont St Giles and Jordans, Seer Green and Little Chalfont play active roles in stimulating and supporting community action and events. These include fun runs, walking events and dances that stimulate physical activity in many parks, open spaces and halls. Over 120 clubs, sports, social and volunteer groups are active in our area.

The Chalfonts and Gerrards Cross Hospital

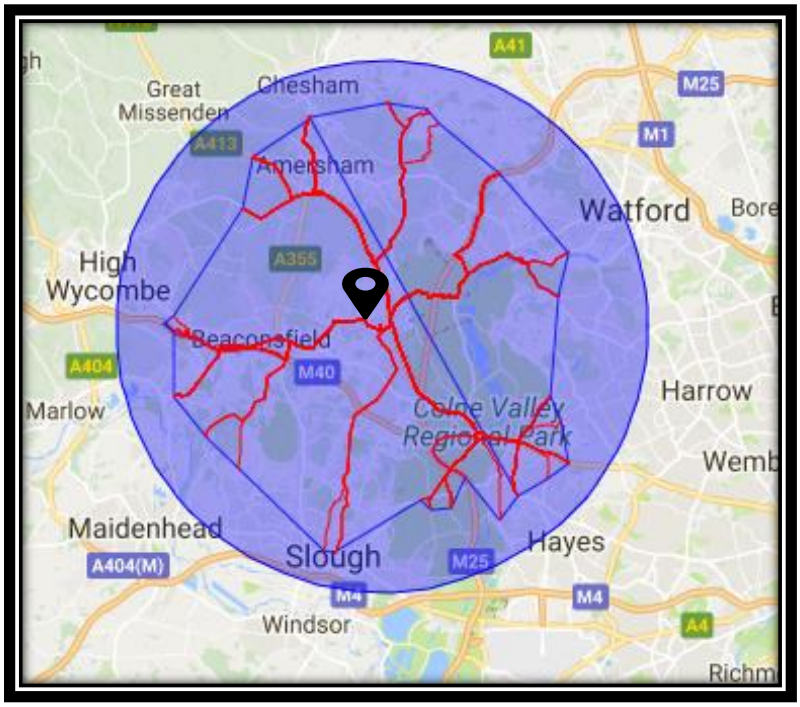
Our hospital currently provides a range of clinics and services, including:

- Aortic Abdominal Aneurisms screening for males over 65.
- Diabetic education -6 weekly sessions.
- Continence advice, No Smoking Clinic, Dietician advice.
- Consultant led clinics: Chest, ENT, General Surgery, Gynaecology, Neurology, Haematology, Ophthalmology, Orthopaedics, Paediatrics, Pain Control, Plastic Surgery, Rheumatology, Urology, Vascular Surgery, Colo-rectal
- Other Clinics include: Sexual Health, Heart Failure Clinic, Enuresis and Audiology
- Physiotherapy: Neuro Rehabilitation, Musculoskeletal and other conditions
- Podiatry (Chiropody), Warfarin (INR), Tissue Wound Care
- X-Ray and Phlebotomy
- Adult Community Healthcare Team providing home visits and care
- Health Visitor and School Health Nurses

The League of Friends has provided revenue funding to support the extension of clinics and services and is offering capital funding for facilities for an audiology clinic and extended podiatry services.

Our hospital could serve the area of South Buckinghamshire and Chilterns (see Annex A) and provide a base for a local integrated team covering the Chalfonts and Gerrards Cross within which it is centrally located. It has scope to provide additional rooms and facilities, as there are many rooms available, which are currently used only for storage, we have parking a garden area kitchens and disability accessible toilets. For many activities the ability for service users to access free parking for say one hour is important. It should be noted that adjacent to our site is a Community Health Centre owned by NHS Property Services but unoccupied for the past three years

Accessibility within 15 minutes driving at 30 miles per hour (or 30 minutes at 15mph)

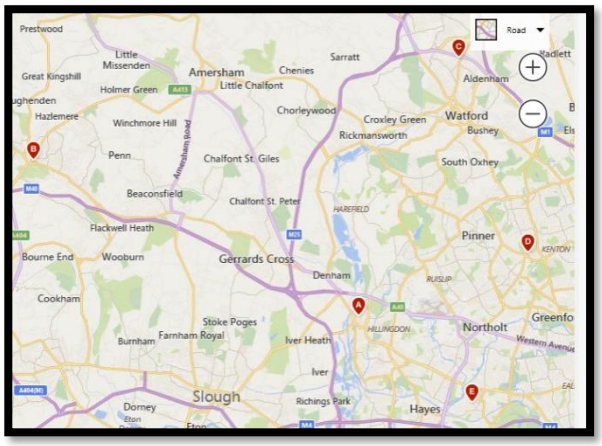


Integrated Action From Our Community Hub

Our communities have many resources, including Age Concern clubs, GP exercise referral schemes, Simply Walk groups and Dial a Ride services. But such services seem difficult to find and in some key fields community organisations, which support health action in neighbouring towns such as: Amersham, Beaconsfield, High Wycombe, Slough and Uxbridge, seem less active in our area. Though its powers and funding will be unchanged the transition of Gerrards Cross to Town status may improve this, as the Council has set a goal of establishing a health facility in the town. Our Community Hub will promote social prescribing to help people find services and community groups supporting integrated self-care and wellbeing. We identified 11 possible action areas:

1 People with Mental Health Problems

Mental Health Support Services



It is estimated that 1 in 4 people will experience some form of mental health problem each year, ranging from generalised anxiety to depression or some form of psychotic, bipolar or personality disorder, this equates to some 8,500 people in our community. Most do not progress to a severe mental illness, but in our area 7.8% of GP registered patients are identified as living with depression, some 2,500 people. If needs are recognised and integrated support is provided at an early stage progression to mental illness can be significantly reduced, lowering the burden of disease and demand on emergency services. Following principles shown by Vanguard Projects, such as CAMHS Community Team West: Frimley, we suggest a project might be developed to bring together health and social care professionals to provide early support for children and adults, incorporate opportunities for those experiencing mental health issues and their carers to share problems and gain community support. Buckinghamshire MIND might be able to assist in developing this approach. This could also meet the need for accessible mental health, a map of support services shows the gap in our locality.

2 People with Dementia

Support Services for People with Alzheimer's Disease

Dementia includes a range of diseases leading to impairment of mental functioning, the most common being Alzheimer's. This is distressing for the person with the condition and their carers it is estimated that over 300 people in our area are diagnosed with dementia, however, studies suggest that only 67% of cases are diagnosed, so the true total is likely to be at least 400 people. Recent pilots have shown that music, art and other activities such as gardening can be very beneficial for both those living with the condition and their carers. People with dementia tend to avoid confusing large spaces. They want to socialise

but need purpose and guidance and an inviting homely place to meet. For example, a local care home, Woodland Manor, provides such a meeting place for people with dementia and their carers. The Chalfonts and Gerrards Cross communities have choirs, art and gardening clubs that could assist in such programmes, perhaps with guidance from the Alzheimer's Society Dementia Friends and Memory Advisors. A wider community initiative might also engage local retailers and businesses (some of which have already shown willingness) in creating a Dementia Friendly Community. A map of support services shows the gap in our locality.

3 Parents of Children with Special Educational Needs and Disabilities

Parents of children with special educational needs and disabilities have long faced years of struggle to get their children's needs acknowledged in a Statement of Special Needs. This system has now been replaced by the requirement for each child to have a Personal Education, Health and Care Plan. However, for many parents this is still a challenge and the change to the system at a time of local authority cuts has led to further delays. In our area pupils with Special Educational Needs and Disabilities may be estimated at some 14% of children, that is some 830 children, some 2.5% of children may have Statements or EHC Plans, that is 150. This service is managed by BCC through its SEN team, drawing on education, health and social care resources. BCC also offers an Impartial Information and Advice Service (SEND IAS). However, in other areas parents have got together to offer mutual support. This is not a replacement for professional advice but a support group to help parents and children come to terms with the issues and options they face. Community organisations such as the Council for Disabled Children and I CAN might assist such an initiative.

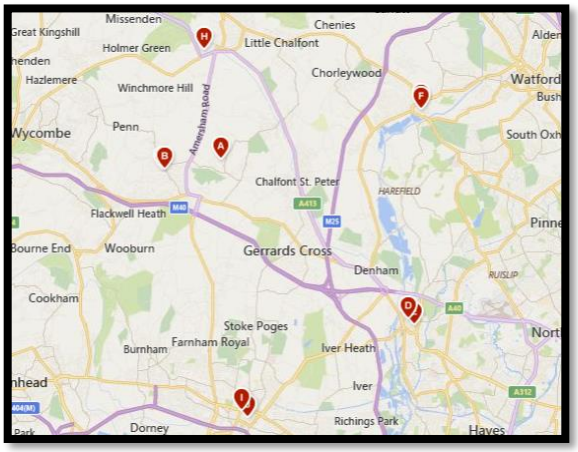
4 People with Disabilities

Children and adults with disabilities are less likely to have the opportunity to participate in the arts, sport, community organisations and events. And yet access to such activities is not only a right but has special significance and value for many of those with disabilities. Community support can enable better access while improving health and wellbeing and reducing demands on health and care services. Some 6% of children, 16% of working age adults and 45% of those over retirement age have one or more disabilities. In our community this equates to some 450 children, 3,000 working age adults and 3,200 people over 65 (these are broad estimates based on national statistics). We suggest local sports and leisure service providers and local clubs should be mobilised to support an initiative to meet this need, perhaps with the assistance of a community organisation such as the Befriending Networks based in Aylesbury and Slough, Active Bucks and national organisations such as Phab and Scope UK.

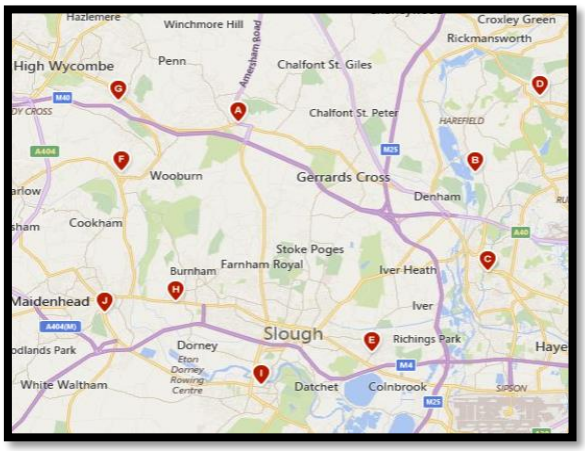
People with disabilities often require home adaptations and aides. The timely coordination of health and social care services for all those in need should be a focus for integrated action from the Community Hub. Other fields in which health and social care integration could be supported from our community hub include assessment of needs for people who need residential and nursing support.

The number of people with disabilities increases with age, but this is not an inevitable process. Timely support and exercise for people with balance and other movement issues can greatly improve wellbeing. Simple balance exercises, such as those available at the Chalfont St Peter Leisure Centre, can greatly lessen the risk of falls and injury and we suggest that, as in other countries, local rehabilitation services might include exercises that help in everyday life, such as boarding a bus, train or car and doing some simple gardening. A Falls Assessment and Clinical Care service for elderly patients could also encompass such prevention and rehabilitation measures. Such services have been shown to significantly reduce A&E attendances.

A Disability Information and Support Services

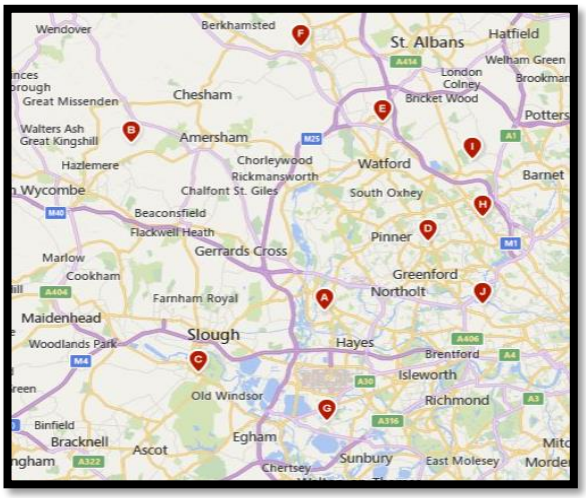


B Disability Sports and Classes



5 People with Breathing Difficulties

Breathe Easy Support Groups



Chronic Obstructive Pulmonary Disease (COPD) is a common cause of breathing difficulties, it is limiting for those living with the disease and causes multiple health emergencies. This range of conditions is diagnosed in about 4.5% of people over 45 for the UK as a whole, with rather less in South East England. For our community this suggest an estimate of some 300 - 500 people with COPD. It is a progressive disease that can be managed and aided by exercises such as singing and Pilates as well as psychological therapies as offered by Bucks Live Well.

Asthma is another condition that causes breathing problems affecting almost 3,000 people of all ages in our area. Asthma is a manageable condition that also gives rise to many emergency admissions. Breathe Easy groups for both COPD and Asthma are supported by the British Lung Foundation. Evaluation has shown that such support groups are very beneficial for those attending on a regular basis, particularly when the group can also access medical advice at the meetings. This reduces long term health and care costs by improving health outcomes and reducing the demand for emergency services. In the past a COPD support group met in our hospital but now, as the map shows, there is a gap in our area.

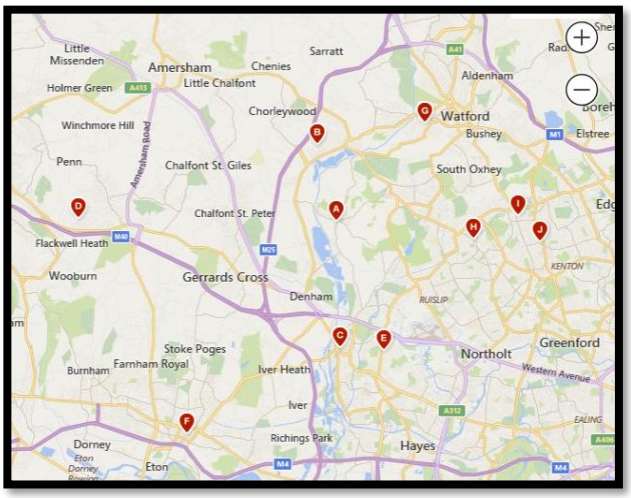
6 People with Joint Pain

Arthritis is one of the most common causes of pain in the back, hips, knees or other joints. It affects about 1% of women and 0.4% of men, this suggests a total of over 200 people in our community. It is most prevalent in women of 45 or older but forms of arthritis can also affect younger adults and children. Action to avert arthritis can be effective for health and, as arthritis leads to high costs of joint replacement, it can also be cost effective for the NHS. Measures to reduce the risk of arthritis progression include diet and exercise, as obesity is a major cause and complication for arthritis of knee and hip joints. The REAL Support Group in Harrow assisted by Arthritis Care, offering wellbeing

and Yoga sessions for people with arthritis, provides an example of a patient-led support group working with a clinical team, in this case, the Rheumatology Department of Northwick Park Hospital. The nearest similar group is in Watford.

7 New Mothers

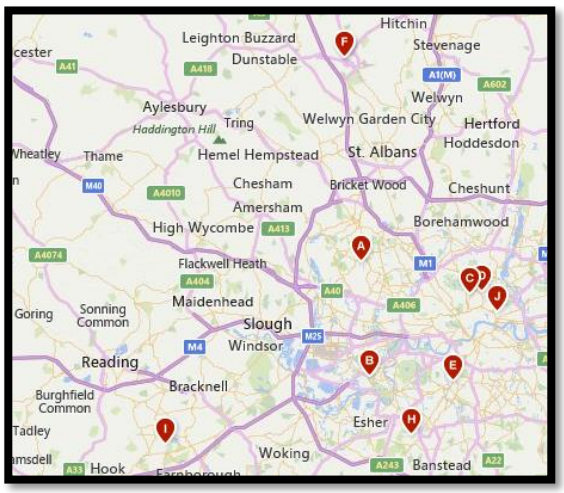
Breastfeeding Support Groups



Breast feeding initiation and continuation is a focus of support for maternal and infant health, while breast feeding initiation rates are relatively high, by UK standards, rates after 6 weeks are low compared to European Countries and there are many other challenges for new mothers. They face the pressure of forming new relationships from home, particularly if they had previously commuted to work. Social contacts can help mothers learn to manage their new babies' health and care, overcome breast feeding problems, develop a social support network and may help some deal with post-natal depression. In our community we estimate that there are some 350 births a year, of these at least 150 are likely to be first children. Mothers experiencing post-natal depression, whether new mothers or not, are likely to include some 50 local mothers per year. While there are parent and toddler and parenting groups supported by local churches, we know of no local breastfeeding or other support groups for young, first time mothers. Support for young mothers starts with Midwives, who often spot the first signs of problems, Health Visitors and other nurse specialists as well as GPs, but crucially community self-help groups can play a vital role. Support must be sensitive to the needs and preferences of the mothers but also well informed. Mothers for Mothers provides an example of a self-help group for those with post -natal depression. A more general range of support is offered by the National Childbirth Trust (NCT). The map shows the nearest breastfeeding support groups, showing the gap in our locality.

8 People with Diabetes

Diabetes Information and Support Groups



Diabetes, mostly type 2 Diabetes, is diagnosed in some 5.4% of patients at our local GP practices, that is over 1,750 people, as this condition is difficult to detect at an early stage, it is likely that the number of local people with this condition is over 2,500 people. Diabetes is a progressive disease that can lead to potentially life-threatening complications, such as heart disease, blindness and nerve damage. Self-care management of diet and exercise, alongside clinical monitoring, can greatly reduce the progression of the disease and consequently costs to the NHS, can be greatly reduced. All three local primary care practices focus on this as a major health issue for our

community and our hospital provides Diabetic Education in 6 weekly sessions. Building on this we suggest that consideration should be given to self-help and action groups such as those sponsored by Diabetes UK, and available in other areas but not locally, see map. The engagement of supermarkets and other food shops and restaurants in providing a “Healthy Eating Aisles” or menus with diabetic friendly food is a cost-effective approach that can also be popular with food retailers.

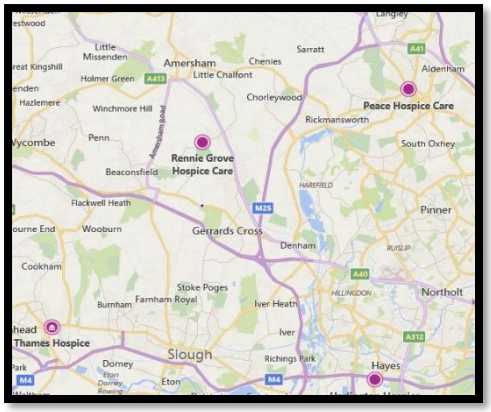
9 Carers

Carer Support Groups

Most care in our community (about 70%) is provided by relatives and partners– so called “informal carers”. They provide support, encouragement and guidance for their loved ones. This becomes more difficult as people with conditions like dementia progress and as carers get older; carers reaching 75-80 and/or when the person they care for dies, often face their own health and social isolation issues (more than 25% of local people over 65 live alone). There are probably over 3,000 people providing care for friends or family members in our community. Their support is not only invaluable to those with long term health problems, it also greatly reduces the cost to the NHS and LA Adult Social Care Services. Support for carers, including respite care, the provision of information and advice and social support can be very helpful in extending their ability to care. Care for Carers based in East Sussex provides an example of the sort of self help and support that could be provided to our informal carers. As our map shows there are some carer support groups in neighbouring towns but none, as yet, in our immediate locality. Surveys suggests 72% of carers face mental health and 60% other health issues.

10 End of Life Care

End of Life Care Services



Most people would prefer to die in their own home (56%), a hospice or care home would be their second choice (24%) but in practice 66% of people die in NHS or private hospitals, 15% die in hospices or care homes and only 19% die in their own homes. In our area, Rennie Grove and Thames Hospice provide care at home for some of the 350 people who die each year, but cannot meet all demands. This is not only distressing for those concerned and their families, it is also a major cost and cause of bed blocking for the NHS. We suggest that an augmented hospice at home scheme would be an important contribution that our community hub could provide, building on the skills and experience of our Adult Community Healthcare Team, which already provides a service which can include end of life care. This requires integrated care from GPs and nurses, to help people live as well as possible until death, and die with dignity. We suggest that collaboration with local religious and humanist organisations and volunteers would be welcomed, with support from Rennie Grove, Thames Hospice, the National Association of Hospice at Home and Marie Curie charities. We hope community action in all these areas will expand opportunities for Health Professionals to offer social prescribing and to provide support and advice to patient groups in a cost-effective way.

11 Social Prescribing for Health and Wellbeing

Our Hub should also work with a network of local GPs to provide social prescribing providing contact with local health, social, private and community organisations and promote healthy lifestyles and wellbeing. Social prescribing is now a national and local policy and funding priority; putting people in contact with the health, care and wellbeing support they need from mental and physical health and social services and community groups (see annex B). Pharmacy support and Local Enhanced Services (such as ear-syringing and monitoring) might also be provided more cost effectively from the Hub.

NHS Health checks, provided by GPs and at South Bucks Libraries and in other settings, should be expanded to consider social and self-care needs, encouraging search for support and lifestyle options, including joining groups such as those noted here. Nursing and therapy sessions also provide opportunities to guide people towards options to improve long term health and wellbeing. After hospital stays people could be given the opportunity to access a record of their discharge information, plus guidance on relevant options for lifestyle change, local support groups and their medication needs. This would help coordinate health, social care and community support around the needs of patients at home and could save costs due to delays and readmissions.

Social prescribing and pharmacy support can be of particular value to people with special needs, e.g.: women experiencing difficult menopause symptoms or endometriosis, people with hearing loss or sight loss problems, those who struggle to manage their prescribed medicines or face other drug, alcohol or tobacco addiction problems. In our community there may be some 1,000 women experiencing menopause symptoms and 800 with endometriosis, 5,000 people with some degree of hearing loss, 250 people with some degree of macular degeneration, up to 400 people with drug related issues and more than 2,500 people who drink alcohol very frequently and more than 2,500 who smoke. Our hub could help people contact local services and support groups and those based in nearby towns. It could also support screening programmes, such as those for breast cancer, affecting over 1,500 women and prostate cancer, affecting over 1,000 men in our area. Contact and referral to support groups in other areas would be an important first step in the formation of local groups.

Communication skills are needed to raise awareness of the Hub and its role, through newspapers, local directories (there are 5 in our area), Parish and Town Councils and Voluntary organisations, Libraries, GPs, pharmacies and dentists. The Hub should maintain an online presence, providing information on local health and wellbeing resources, advice on health and lifestyle choices and where necessary the ability to communicate with health and social care professionals and/or raise comments and concerns about their treatment. The Community Hub should develop an online integrated advice and information resource, with links to all local services and groups. This might be supported by the provision of terminals at our hospital and libraries where volunteers could help those less IT savvy find information they need. This online component might be supported by the local Computer Club and schools and libraries. This could be an effective way of engaging children in community health and wellbeing, as part of our local and national Healthy Schools programme which is supported by BCC and BHT School Nurses.

The Hub should support the provision of general health and wellbeing advice. NHS, LA staff and community volunteers could be encouraged to pass on health and wellbeing messages through a version of the NHS England - Making Every Contact Count initiative. With support of the Bucks Health Trainer Service we might develop local Health Champions. This could enable volunteers such as shop assistants, GP receptionists, hairdressers and community librarians as well as health and care professionals to pass on simple advice and information, raising awareness of health and wellbeing issues as well as the role of the Community Hub. This might be facilitated by simple training sessions to give people confidence to ask open ended questions that start a conversation about health and wellbeing. This approach could also further enhance local engagement with the BCC “Be a good neighbour scheme”, encouraging neighbours to offer support such as getting to health facilities, fetching medicines and on discharge from hospital.

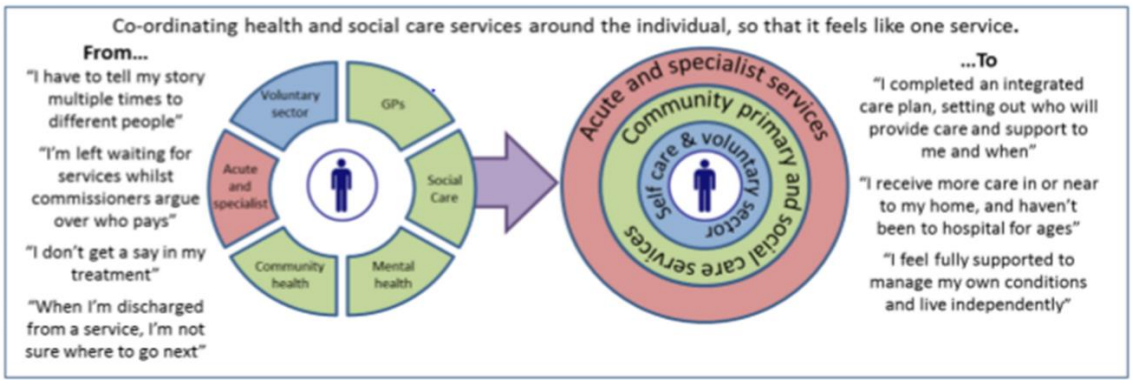
Into Action

We hope that the suggestions put forward here will help in the process of developing our hospital as a Community Hub for integrated action for health and wellbeing. This includes coordinating with other providers, such as GP practices, pharmacies, fitness centres, libraries, residential homes and community groups, as well as building on the resources and skills of the Nursing and Allied Health Professionals at our hospital in personal and community engagement for health and wellbeing.

We recognise that there is a lot of work to be done to translate ideas, such as these, into action and that this will require long term persistence, as shown by the Thame and Marlow hubs. For our part we stand ready to assist in facilitating these developments, by bringing together local and national community organisations to meet with health and social care professionals to find a way forward. We look forward to working with a stakeholder engagement group for our community hub. We also welcome discussion on future leadership, staffing, and coordination required for the creation of our Community Hub as well as practical issues such as parking, catering and refurbishment.

We offer to host (or co-host) discussions with GPs and other bodies identified in this note and in further consultations, to plan the steps required for the creation of the Community Hub and development of specific component elements, as agreed following this consultation. We could also offer limited funding to support appropriate facilities. These might include, transport to enable patients with limited resources or disability issues to access services, in the past support has been provided by volunteer drivers but needs are now more complex and this may no longer be appropriate. Another possibility would be the refurbishment of rooms to provide appropriate venues, as examples: for people living with dementia or new mothers. However, we also note that voluntary sector partners may require further funding beyond our resources, thus it will be important to consider any potential public investment in terms of the health and wellbeing values it provides and the future savings to health and care services.

Our hope in developing as a community hub for integrated health and social care, bringing NHS, LA and community support together, to provide a single point of contact and coordination, is to achieve the aims set out in the Integration and Better Care Fund Policy Framework 2017-19:



This note draws on the knowledge of the League of Friends of the social geography of our community, evidence taken from the JSNA, the NHS Choices and CQC web sites and the Buckinghamshire NHS Trust Consultation on bringing services closer to home. We have attempted to take a life course approach, estimating the extent of local needs at each stage, focussing on community resources that could improve health and wellbeing and reduce cost and demand pressures on health and social care services. Looking to the future we recognise that there are a lot more lessons to be shared from our local health and social care team, NHS Vanguard projects, including Marlow and Thame Community Hubs (who have been most helpful), the Chalfont St Giles and Jordans Steering Group, Neighbourhood Development Plan, the initiatives and groups coordinated by BCC and the Social Prescribing network.

Annex A

Serving a Larger Population

These notes were originally developed based on our understanding of the area that might be served by an Integrated Team based at our Hub, using local population statistics, but Parish or County boundaries do not define catchments. As BHT and BCC envision 5 Community Hubs serving the county population of some 550,000 people plus resident of Berkshire and Oxfordshire served by the Marlow and Thame hubs, this implies each would serve some 100,000-150,000 people. Within these areas 3 or 4 integrated teams might provide services to communities of some 30-50,000 people. This is the size of communities to be served by social prescribing services linked to networks of local GPs. Primary Care Networks have reduced GP workloads in fields such as Paramedic urgent care services, pharmacy advice to patients, staffing pools, out of hours services and IT support.

Using what BCC describes as "Local Community Areas Linked to Local Area Forums" our larger catchment area might include: Chalfonts (Chalfont St Peters, Chalfont Common, Chalfont St Giles, Seer Green, part of Little Chalfont – 22,500), Gerrards Cross (GX, Denham, Fulmer and Denham Green – 17,000), Wexham and Iver (Iver Heath, parts of Richings Park, part of Wexham, part of Stoke Poges-14,500), Beeches (Taplow Burnham, Farnham Common and Royal, part of Stoke Poges, part of Wexham- 25,000), Beaconsfield -13,000 (all figures approximate, total 92,000). Parts of the Chepping Wye Valley and Amersham local areas and the village of Harefield in Hillingdon might also be served. These would be within 30 minutes drive-time at 15 mph of our hospital see page 3.

This wider area is served by many different Primary Care Networks, dentists, pharmacists and other services including: Amersham, Wycombe, Stoke Mandeville, Hillingdon, Harefield and Wexham Park hospitals. Primary care services include some 20 different practises serving patients in the wider area, though many will also have links to services in neighbouring towns and may be included in the catchments areas of other prospective Community Hubs.

The health needs of these communities differ in some detailed respects, for example some of the wider areas show an increased risk of social isolation, but are broadly similar, thus the estimates provided in these notes can be multiplied by 3, to provide a broad indication of likely levels of need.

In order to provide integrated support closer to home, a Community Hub at Chalfont St Peter could combine the provision of services and support from its own site with support for the provision of integrated local service teams providing health and social services, social prescribing and support from access points in community facilities throughout the area. A large catchment would reinforce the case for co-locating health and social care professionals in the community hub. Integrated health and social care could provide improved support for some of the most vulnerable of the 14,000 people over 65 discharged from hospital to home care in this area. This point has recently been underlined by the Health Secretary Matt Hancock, who called for greater use of small hospitals in providing day services. He has also announced a £240 m fund to support health and social care for vulnerable patients discharged from acute hospitals and £4.5 m for Social Prescribing and pharmacy.

Other services could include mobile units providing services such as breast screening and audiology and visiting teams providing clinics and advisory services. An enhanced role for School Nursing Services as set out in the 2012 Development Plan could also facilitate greater coordination of health, education and social care in each community school area. Where necessary it might be appropriate to arrange local transport to bring patients to the hospital. Dedicated social prescribing support staff could provide advice from our hospital and from local access points, by phone and online.

Management of such community hub services would need to engage stakeholders from the primary and secondary physical and mental health care service, social care services and from the different communities served. An engagement strategy for all these stakeholders would be a first step towards our development as an integrated community hub for health and wellbeing.

Annex B

Social Prescribing

Social prescribing means offering patients options for improving their health and wellbeing by contact with appropriate health and social care services and engagement with community groups and activities. This approach has been trialed and promoted in the NHS for many years, The Royal College of General Practitioners, physiotherapists and nurses support this. Studies have shown that it offers an important way of reducing workload pressures as well as improving health and wellbeing. Early in 2019 the Health Minister, Matt Hancock agreed with the GPC (the BMA Committee that agrees GP contracts) that 22,000 posts would be created to support Social Prescribing and provide pharmacy support for local primary care networks covering populations of 30-50,000 people.

In Buckinghamshire health and wellbeing is supported by a range of services including: “Live Well Stay Well” which provides online, phone and face to face assistance in 8 fields, “Prevention Matters” who accompany people to community groups and services, “Health Trainers” who help people target their health and wellbeing issues, “Carers Bucks” who provide support for family carers, “Healthy Minds Bucks” who talk to and support people who are anxious, depressed or stressed, BCC provides “Telecare” services including monitoring equipment for elderly or confused. In other cases a Care Package (funded programme of social care support) may need to be identified with Adult Community Care services. Wider services might include: housing, employment, education advice and debt managements, which might be supported by referral to “Citizens Advice Services”.

The process of guiding people to find appropriate local support might start at a GP consultation, Health Check, nursing or therapy session, school nurse visit, hospital discharge or adult social care consultation. It could also be initiated by the person or their carer making direct or online contact. The initial point at which needs are recognised could be followed by referral to a dedicated care navigator who could hold a constructive conversation to explore the person’s needs and preferences and introduce them to the services and support that would be most helpful to them. Services offered might include the above teams plus care services, physical and mental health support, community groups and activities, gyms and weight loss services as well as activities for children.

Social prescribing could also engage local volunteers as “befrienders” (including the League of Friends) and as members of local community support groups, helping to introduce potential new members and helping care navigators to make contact with the groups who could help. This will ensure social prescribers develop an understanding of support services and groups as an up to date network of personal contacts to assist in meeting health, care and wider social needs.

Our hospital could provide a dedicated social prescribing and pharmacy support services to work with our local GP practices, as well as the therapeutic and nursing services provided from our premises. Dedicated support workers could provide personal assistance alongside the County-wide programmes and engage people with local services and support groups in the Chalfonts and Gerrards Cross community. This will require knowledge of health and care services and community development, with skills in communication, leadership and IT literacy. The social prescribing team would need to work closely with health and care professionals as well as community groups and the stakeholder engagement group for our community hub.

A social prescribing service based at our Hub could bring all these elements together providing a contact point for patients, volunteer befrienders and care teams. Space could be provided for NHS Health Checks and care navigation consultations. A larger room where the support groups noted above could be hosted and the team could work together to develop patient-based care and wellbeing plans (BITS Meetings, replacing former MAGS). Social prescribing may also provide a link to Enhanced Services, such as ear syringing, and Telecare digital support services which might also be provided from the Hub.