Friends of Chalfonts and GX Hospital

The NHS Vision of Neighbourhood Health and Care

Applied to South Buckinghamshire

Neighbourhood Health Policy

The Labour Party Manifesto and NHS 10 Year Plan include Neighbourhood Health as a key objective, 250 Neighbourhood Health Centres are currently planned.

This reflects long term aims to empower people to manage their own health to achieve sustainable health and care

The Buckinghamshire Oxfordshire and Berkshire West Integrated Care Strategy calls for Integrated Neighbourhood Teams working with Community Support Groups

The Friends have been suggesting steps towards this approach for 10 years

Wanless review 2002 noted the NHS would only be sustainable with full community engagement

Darzi review 2024 notes that 7% of patients with complex needs account for 46% of hospital costs

Objectives

A place based approach to service delivery and leadership closer to people's homes

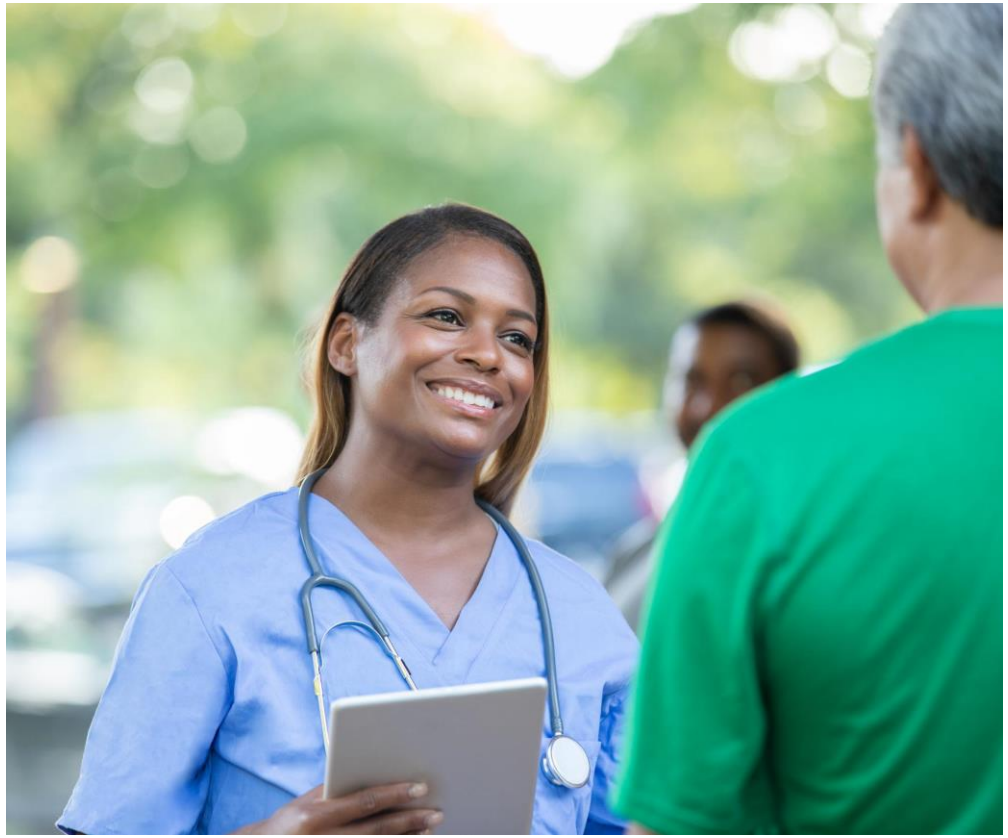
Integrated Primary Care with Physical/ Mental Health and Social Care and Local Community Support

Greater focus on Prevention and Support for Wellbeing for those with complex needs

Personalised Coordinated Care that tailors support to individual needs and preferences

Providing equitable services and community support for those in greatest need

Better communications using eHealth so that neighbourhoods know their care services



Outcomes

Improved health and wellbeing

Better experience for patients & staff

Less hospital/care home stay needed

Less cost for NHS and LAs

Neighbourhood Health and Care Services at the Hospital

Current and planned services include:

- Rapid Response and Intermediate Care Team
  - Providing urgent care for patients in crisis, allowing them to remain safely in their own homes and empowering their recovery.
- Health Visitor and School Nursing Services
  - Providing guidance and support for families with young children and school children to empower tham to achieve better physical and mental health
- Clinics and services for patients:
  - Including earwax removal, physiotherapy, ultrasound scans, warfarin management, audiology, diabetes control,.,
- Current plans include support for patients with a range of needs
  - Colorectal surgery, ENT (Ear Nose and Throat), Vascular surgery, Ophthalmology (enhanced Services), Paediatrics, Haematology, Warfarin, Diabetes care, Tissue Viability, Abdominal Aortic Aneurysm (AAA), Cardiology, Podiatry, Continence, Community Neuro Rehabilitation, Pulmonary Rehabilitation, MSK Therapy and Physio service

New services at the hospital will soon include:

- Community Wellbeing Hub
- Integrated Neighbourhood Team for Fragile people
- Social Prescribing service

All Primary Care and Community Service need to work together with local community groups as a partnership to create an Integrated Neighbourhood Health and Wellbeing Centre.

The South Buckinghamshire Neighbourhood

A small Town and Villages in Buckinghamshire County Council (BCC) with commuting to London

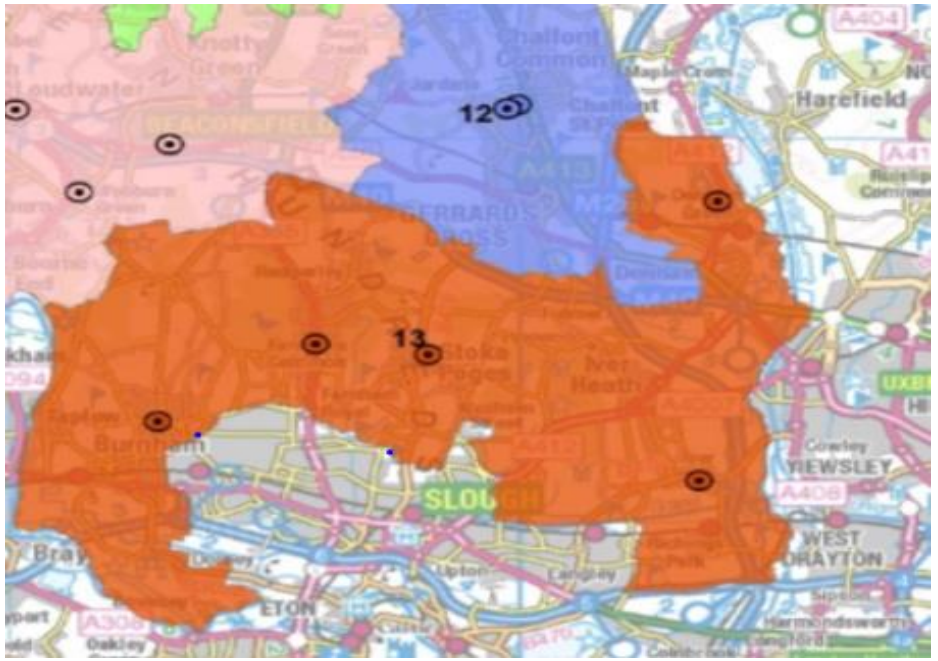
80,00 people served by 2 Primary Care Networks (PCNs) and Chalfonts and GX Community Hospital

Chalfonts PCN serves: Gerrards Cross Town (8,500), Chalfont St Peter(13,600), Chalfont St Giles (8,000), and Hedgerley (900) villages.

South Bucks PCN serves: Denham, (8,000), Iver (7,500), Fulmer (500). Jordans and Seer Green (3,000), Richings Park (6,000) Wexham (4,000), Farnham (7,000) and Stoke Poges (4,000)

Patient use BHT services at High Wycombe and Amersham Community Diagnostic Centre as well as the nearby Frimley Health Wexham Park Hospital

Mental health services are provided by a team from Oxford Health NHS Trust (OHT), High Wycombe



Characteristics include:

A somewhat older age profile .

High incomes low relative deprivation

About 400 community support groups

Good access to green spaces

Friends Suggestions

For 10 years we have sought Partnership with Community Groups

Suggestions and offers of support here have included:

- **A Community Wellbeing Hub and Drop in Café**
- **Frailty Support**
- **Social Prescribing**
- **Local Provision of Health checks**
- **Community support for mental health wellbeing**
- **A Start Well Hub**
- **Support for disability access to arts, sports etc Breathe Easy Support Group**
- **A Joint Pain self-help support group**
- **Support for those with post-natal depression.**
- **Self-care support for people with diabetes.**
- **Integrated care for carers network**
- **Support for hospice at home services**
- **An eHealth and Wellbeing Centre.**
- **Support for people discharged from hospital .**
- **Facilities for staff such as a common room**
- **Support to improve access to Amersham CDC**

We are delighted to work in partnership

With BHT, BCC, PCNs & Community orgs for:

A Community Wellbeing Hub led by the Bucks Health & Social Care Academy

Integrated Neighbourhood Team for people with Frailty Led by our PCNs

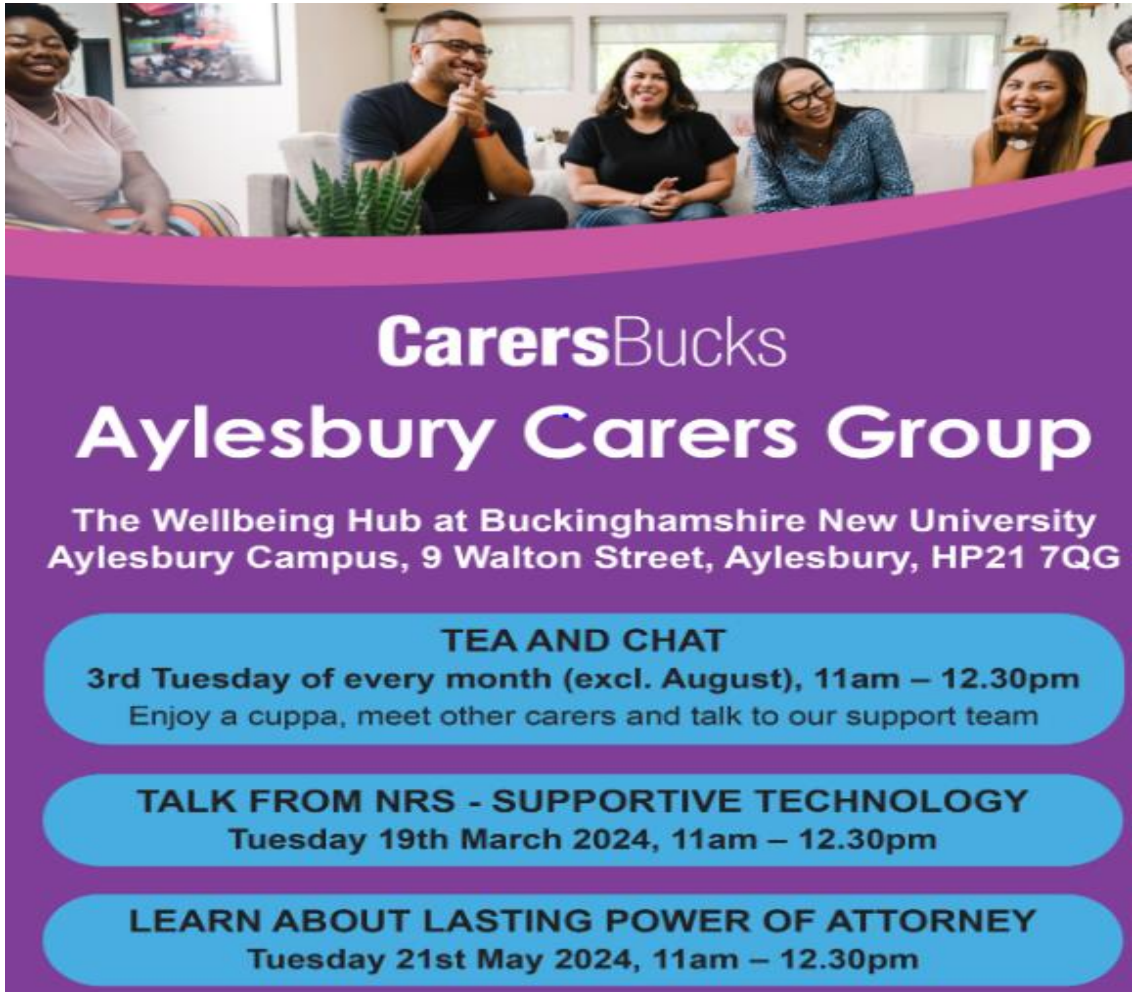
Social Prescribers and support groups

The Community Wellbeing Hub could provide space for:

Multi agency early intervention, prevention and support from co located health, social care and VCSE partners

Possible partners identified by Claire Tilson at the Friends AGM

- Carers Bucks
- Alzheimer's Society
- Adult Social Care
- Integrated Neighbourhood Teams
- Community Dieticians
- Oxford Health Mental Health Services
- Social Prescribed Activity Groups
- BHT Health Coaching Team
- Age Concern GX Plus
- Free Blood Pressure Checks
- Health & Wellbeing Events
- Signposting & Support
- Training & Education for students



The Community Hub works with health and social care providers and community support groups for wellbeing and health of all

Integrated Neighbourhood Teams deliver integrated personal care closer to home for Fragile people (usually 85+ with complex needs)

Multi agency early intervention, prevention and support from health, social care and VCSE

Possible partners identified by Natalie Judson at the Friends AGM

- Voluntary, Community and Social Enterprises
- Local Authority Service
  - Adult Social Care
  - Housing
  - Education
  - Public Health
  - Transport
  - Welfare
- NHS
  - Primary Care
  - Hospital Care
  - Community Services
  - Mental Health
  - Urgent Care
  - Emergency Care

Integrated Neighbourhood Team works in partnership with health and social care providers and community support groups for the wellbeing and health of frail patients

Social Prescribing guides people to community support groups to help them manage their mental physical and social wellbeing

This may include:

- Voluntary, Community & Social Enterprises offering:
  - Befriending and understanding
  - Activity like walking football or bowls
  - Shared experience perhaps of illness
  - Memory Cafe
  - Support for shopping or transport
  - Sometimes financial help
- Access to health and Social Care Services

joy is a computer system/ app that helps health and social prescribers to link patients to local community groups and services.

Social prescribing is a partnership between the primary care team community support groups and other care providers

Community Wellbeing Hub Integrated Neighbourhood Teams and Social Prescribing all require a partnership culture

They all engage with:

- Voluntary, Community & Social Enterprises (VSCE) and groups
- Physical & Mental Health Services
- Social Care Services
- And others

joy could be useful to all three

This needs Teamwork and:

- Empathy and listening skills
- A shared understanding of patient/ client needs
- Knowledge of available resources
- Trust in one another
- Clarity as to client facing roles and team leadership

Neighbourhood Partnership must include all those working for the health and wellbeing of the local community

This will include:

- Nurses ANPs and other health and care services at the Chalfont & GX Hospital
- Local Town and Parish Councils
- Community and patient support groups
- Pharmacy and dental professionals
- Police and Education staff
- Informal and other Carers
- And many others
- We all need to work together

This may be difficult because:

- Organisational boundaries between BHT/BCC/OHT/FHT/PCNs/Community
- Professional Team leadership from HQs
- Lack of clear local leadership
- Patient confidentiality and info sharing
- The changing nature of Patient Care Plans
- Staffing and resource constraints
- Require wider commitment to change

Neighbourhood health: the idea isn't radical but implementing it would be:

As the King's Fund point out here:

- Community Health, Social Care and Mental health teams are directed by heads of profession from headquarters
- Can these teams also contribute as partners in supporting local health and wellbeing?
- While values of integrated patient centred care are shared, the local teams must decide how this should affect their behaviour in practice.
- Personalised care plans, supporting patient choice and healthy behaviour can improve health and patient experience, while reducing costs, but this will depend on how it is delivered.
- Community support groups are seen as important partners for health and wellbeing but do they have the resources, will and skills this will require?

We need to rethink our partnership issues together, as examples:

- How and when should community information or personalised care plans be passed for one team e.g. RRIC to another e.g. INT for Frailty
- Who will decide priorities for use of resources
- How can partnership issues be resolved locally
- How will community organisations be engaged
- How will the idea of a Neighbourhood Centre for Health and Wellbeing be communicated to the public

Next Steps toward Neighbourhood Health and Care by the South Bucks Partnership for Health & Wellbeing

We need to think through together

- **What works and what doesn't?**
- **What are the barriers & obstacles?**
- **What should we try?**
- **How will we know if it works?**

We suggest thinking about:

- **How all local Health & Care staff are recognised as neighbourhood partners**
- **How all local services work together as partners and how the partnership is led**
- **How teamwork and knowledge of roles of staff and community groups is shared**
- **How community groups and the public are informed, engaged and supported**
- **How Joy will be developed and used to include all our neighbourhood resources**
- **How listening skills and empathy are developed and shared**
- **Priorities and costs/benefits of next steps**

References

Labour Party Manifesto 2024: Our Plan to Change Britain Change – The Labour Party

"we will trial Neighbourhood Health Centres, by bringing together existing services such as family doctors, district nurses, care workers, physiotherapists, palliative care, and mental health specialists under one roof"

NHS Neighbourhood health guidelines

Neighbourhood health guidelines 2025/26

calls for "visible clinical and professional leadership and management, at both system and place level, supported through the effective clinical and care professional leadership framework. This includes working in partnership with communities"

Chancellor of the Exchequer

Budget Statement November 2025

Included the announcement of plans to provide 250 Neighbourhood Health Centres

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Partnership: Integrated Care Strategy

integrated-care-strategy.pdf

"Develop strong integrated neighbourhood teams so that people's needs can be met in local communities." "These include local councils, social care support, hospitals, emergency services, GP practices, dentists, mental health providers, care homes, and many voluntary, community and social enterprise organisations."

Friends of the Chalfonts and GX Hospital

https://www.friendscandgxhosp.online/

have suggested steps to support community engagement and improve health and wellbeing