NHS
Berkshire Healthcare
NHS Foundation Trust

Neighbourhood Health Services

Reading Patient Voice Group

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CareQuality Commission Inspected and rated Outstanding

#NoExcuseForAbuse

disability confident LEADER

VETERAN AWARE

Stonewall LGBTQ+ INCLUSIVE EMPLOYER TOP 100 2023

RACE EQUALITY MATTERS SILVER TRAILBLAZER

Neighbourhood Health Services

Berkshire Healthcare NHS Foundation Trust

Neighbourhood Health Services are a key component of the 10 Year Health Plan.

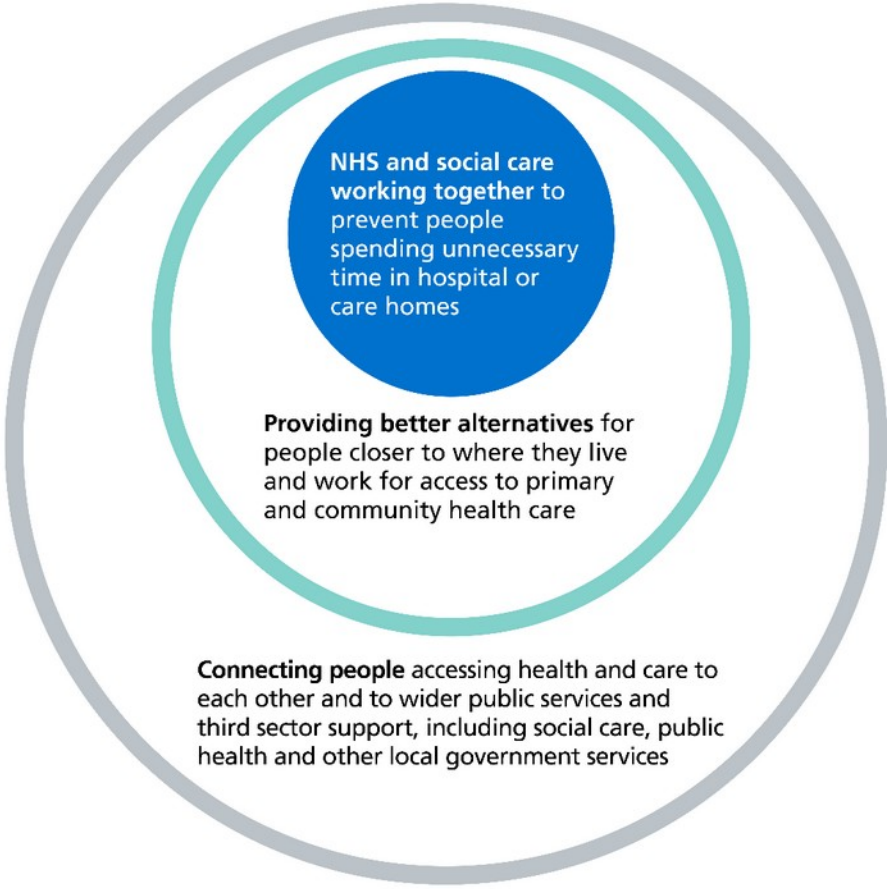
The aim is to “create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care” through better connecting health services and health and social care services and optimising health and care resource.

It is a key element of the ‘three left shifts”:

- **from hospital to community** – providing better care close to or in people’s own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care
- **from treatment to prevention** – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health
- **from analogue to digital** – greater use of digital infrastructure and solutions to improve care

The 10 Year Health plan can be found here: [10 Year Health Plan]

Visual of the aims 5 to 10 years



Neighbourhood health services include:

Population health management

Modern general practice

Standardising community health services

Neighbourhood multidisciplinary teams (MDTs)

Integrated intermediate care with a 'Home First' approach

Urgent neighbourhood services

We are adding **community engagement, data, finance, and leadership development** to the nationally required components

Neighbourhood Health Vision (draft)

- Residents in Berks West, will be enabled to improve their health and wellbeing holistically via world class neighbourhood based care. Focused on the whole person, a prevention-centred approach supporting seamless access to care, rooted in communities.

- Holistic health & wellbeing for residents
- World-class neighbourhood care
- Prevention-centred, de-medicalised approach
- Seamless, community-rooted services

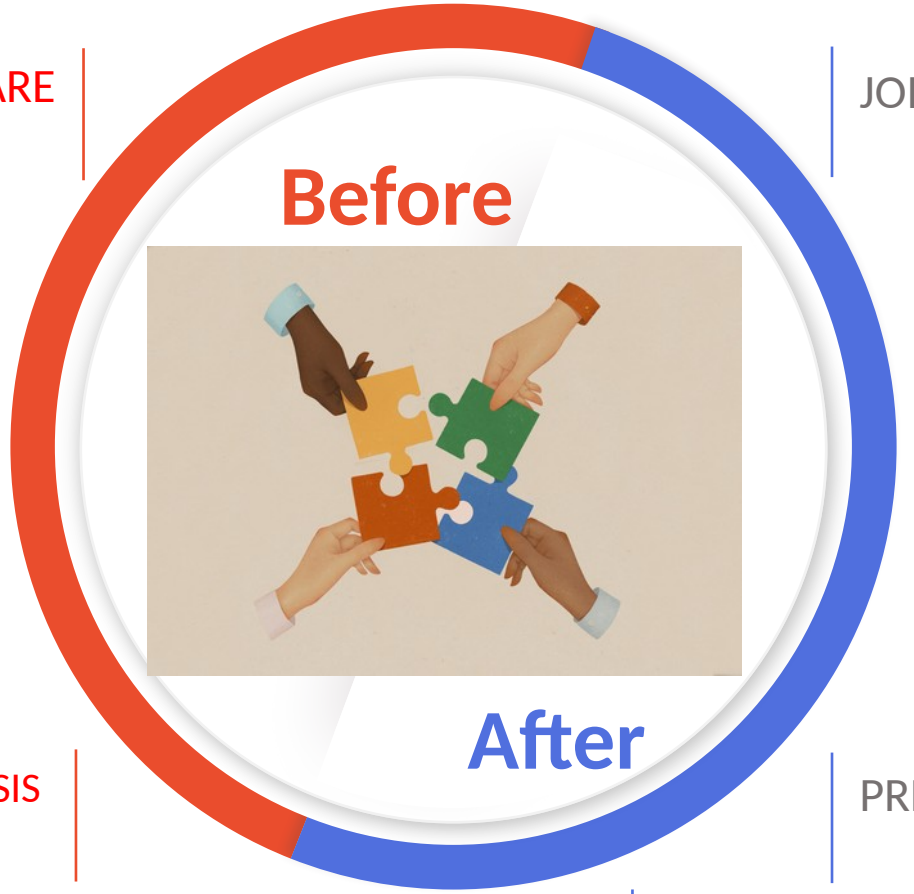
How neighbourhood working benefits people

FRAGMENTED CARE

LONGER WAITS

GENERIC TREATMENT

CRISIS



JOINED UP CARE

FASTER, EASIER ACCESS

PERSONALISED COMMUNITY ROOTED SUPPORT

PREVENTION & INDEPENDENCE

BETTER OUTCOMES, BETTER EXPERIENCE

Residents and VCFS voices

What would you like to see neighbourhood health working achieve?

The clinical priorities

1. Low/medium mental health across the board but significantly higher in bottom deprivation quintile = focused intervention in deprived areas (IMD 1-4)

2. Cardio-vascular disease in higher need Population Need Group (PNG) across all localities: end to end pathway, from primary prevention (e.g. community wellness) to secondary prevention (hypertension, cholesterol, heart failure). To start in Whitley, evaluate, learn and roll out across all areas

3. Respiratory Asthma and COPD focused within deprived areas (smoking is a key factor)

4. Frailty interventions for all high-risk red patients and in targeted interventions for moderate (amber patients) in deprived Reading wards

Low/medium mental health: focused intervention in deprived areas (IMD 1-4)

Why this priority has been picked: Depression is more prevalent in the most deprived areas, particularly amongst people with multiple long-term conditions.

What's the problem to be solved?

- Impact of depression on people's daily life, including cognitive, physical and social impacts.
- Depressed people who may be undiagnosed and therefore untreated.
- Cultural issues, including perceptions about mental health and the presentation of symptoms.

What are the interventions that will make the difference?

- Community outreach for mental health awareness.
- Optimal use of existing therapies, including non-pharmacological methods
- Preventative measures, such as life skills for positive mental health.

What will 'good' look like in 2 years time from the perspective of people?

- Reduced depressive symptoms, new coping skills to prevent future depressive episodes, and improved overall well-being.

Cardiovascular disease: across all localities

Why this priority has been picked: CVD is the leading cause of death and disability.

What's problem to be solved?

- Unhealthy diet, lack of physical activity, smoking, and excessive alcohol consumption are significant contributors to CVD.
- Unmanaged medical conditions such as hypertension and blood cholesterol.

What are the interventions that will make the difference?

- Community support and engagement
- Lifestyle changes.
- Better identification those at high risk of CVD.
- Optimum management of conditions.
- MDT working.
- Early diagnosis.

What will 'good' look like in 2 years time from the perspective of people?

- Greater patient self management with knowledge and confidence to manage their own health.
- Reduce the number of people developing CVD and prevent people from having CVD events.
- Reduce ED attendances and emergency admissions for heart attacks and strokes

Respiratory conditions – Asthma and COPD focused within deprived areas (IMD 1-4)

Why this priority has been picked: Taken together, *COPD and Asthma are more prevalent in the most deprived areas.*

What's the problem to be solved?

- Impact on people's daily lives including breathlessness, fatigue, muscle deconditioning, and mental health.
- Particularly high prevalence of COPD in deprived areas.
- Higher levels of smoking amongst people with COPD in deprived areas (43%).
- Higher levels of obesity amongst people with Asthma in deprived areas (20%).

What are the interventions that will make the difference?

- Smoking cessation (taking account of high level of digital inaccessibility amongst people with COPD).
- Administration of the flu vaccine (baseline 68%).
- Reduce variation in QOF compliance.
- Improved integration of respiratory and obesity pathways.
- Improvements in air quality and decent housing.

What will 'good' look like in 2 years time from the perspective of people?

- Better management of respiratory conditions.
- Reduction in ED visits for respiratory conditions.

Frailty interventions for high-risk red patients and proactive for Amber patients across all localities

Why this priority has been picked: Frailty makes older people extremely vulnerable to health crises, leading to an increased risk of falls, disability, hospital admissions, and dependence on others for care.

What's problem to be solved?

Frailty problems including weight loss, weakness, exhaustion, slow walking speed, and low activity levels, leading to an increased risk of falls, immobility, hospital admissions, and a greater vulnerability to health changes from common events like infections.

What are the interventions that will make the difference?

- Frailty MDT working involving a holistic person-centred approach.

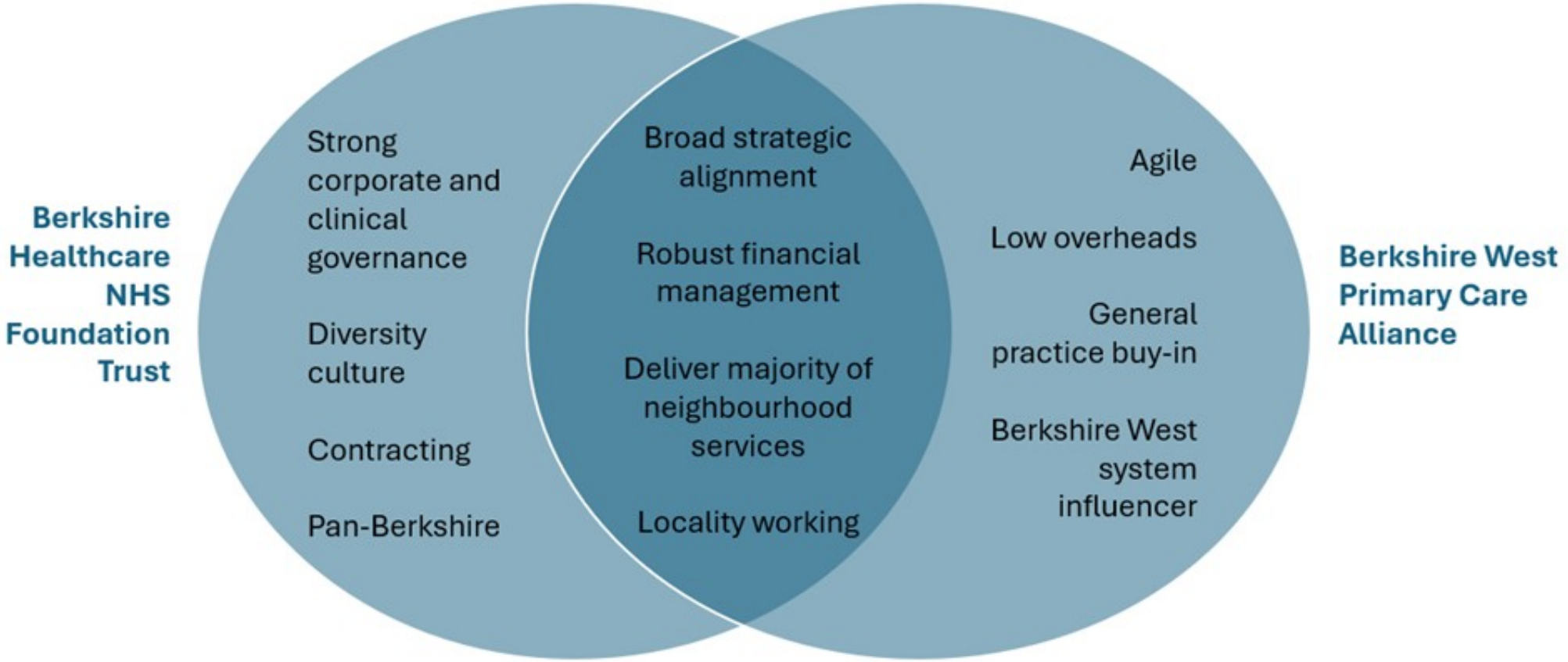
What will 'good' look like in 2 years time from the patient perspective?

- Reduced hospitalisation.
- Better control over own health.
- Living in own homes for longer.

BHFT/BW Primary Care Alliance working together

- Previous work on IPASS (Pain and Spinal Clinical Assessment Service), Multi disciplinary teams (MDTs), Mental Health practitioners etc.
- Jointly led two applications:
  - National Neighbourhood Health Implementation Programme (Berks West)
  - South-East Neighbourhood Health Accelerator Programme (Reading)
- Shared leadership and chairing of the Berkshire West Neighbourhood programme.
- Positive working relationships established.

Benefits of working together



Delivering Neighbourhood Health Services

- Partnership working
- Clear governance & reporting
- PHM
- MDT working
- Community engagement
- Simplify care pathways
- Co-production with people and communities
- Neighbourhood working as BAU
- Efficient use of resources
- Build upon existing workstreams and good practice
- Equal partners participating in the programme and direction of travel

The workstreams

Workstream	Lead	Expected outcomes	Work required	Impacts
Population health management	BWPCA/BHFT joint lead (Mark Davidson)	Standardised, system wide approach to PHM. Proactive segmentation and management of patient cohorts.	Establish a standard approach to PHM and segmentation across BHFT. Embed PHM in MDT working.	BHFT, Frimley Connected Care Team, RBFT, LAs, GPs, ICBs
Modern general practice	BWPCA lead	Deliver the Modern General Practice model.	https://www.england.nhs.uk/gp/national-general-practice-improvement-progra	GPs
Standardising community health services	BHFT lead (Helen Williamson)	Standard community service offer as part of the neighbourhood health service model.	Likely to be commissioner led. BHFT will want to be part of the review team.	BHFT, ICBs
Neighbourhood multidisciplinary teams (MDTs)	BWPCA/BHFT joint lead (Sri supported by Natasha)	Neighbourhood based MDT supporting complex patients and agreed cohorts.	BHFT internal MDT review. Partner in the West and East reviews. Implementation of any relevant recommendations.	BHFT, BWPCA, GP, LAs, RBFT, VCFS
Integrated intermediate care with a 'Home First' approach	BHFT lead (Sue White interim)	Short-term rehabilitation, reablement and recovery services (integrated intermediate care) taking a therapy-led approach (rehab or reablement care overseen by a registered therapist) working in integrated ways across health and social care and other sectors.	Review/evaluation of current BHFT Int Care offer. Partner in the review/evaluation of integrated (with partners) Int Care offer.	BHFT, GPs, RBFT, LAs, BWPCA, VCFS VCFSE
Urgent neighbourhood services	BWPCA lead	Includes alignment of UCR & VWs with a SPA. Aligned to the front door of ED - UTC & SDEC.	Alignment of UCR & VW covered in the CHS transformation programme. Alignment with UTC & SDEC here or CHS?	BHFT, BWPCA, EBPC (out of hours), RBFT, LAs VCFSE

BHFT services

- Community nursing (all age)
- Mental health community services, and crisis (all age)
- Community paediatrician
- Musculoskeletal (MSK) services and Community physiotherapy
- Children and Young People's Speech and Language Therapy (SaLT)
- Audiology (adult and Children and Young Peoples's)
- Specialist Tissue viability or Wound care
- Palliative Care and End of Life Care
- Intermediate care (rehabilitation, reablement and recovery) services
- Discharge to assess and home-first approaches
- Urgent community response and virtual wards
- Mental health care coordinators and dedicated mental health support in schools

Neighbourhood services

- At system
- At borough
  - Reading
  - Wokingham
  - West Berks
- Sub-borough interventions as required with some services aligned to this (in likelihood PCNs)

Example

System level services
System level acute care services, e.g. major trauma, orthopaedic elective, vascular, cancer, etc.
Cross-borough services
Community inpatient beds
Urgent community response
Virtual wards
Hospital discharge
In reach team
Physiotherapy (MSK outpatients)
Sexual health services (RBH)
Children's integrated therapies
Mental health inpatient beds
Minor injuries unit
Hearing & balance (RBH)
EOL and palliative care
Hospice care (Sue Ryder)
Borough level services
Discharge pathways (LAs)
Intermediate care
Community nursing
Looked after children's assessments
Same day urgent care services (depending on model)
Social care services (depending on model)
MSK AQPs
Sub-borough services
Community rehab
Social care services (depending on model)
Community mental health services
Primary care - GP, dentistry, pharmacy, optometry
Same day urgent care services (depending on model)
Social prescribing
Care navigation
Health promtion

Reading: part of the regional neighbourhood health accelerator programme

Southeast Regional Programme that aims to support neighbourhood team development and understanding:

The Reading Neighbourhood team:

- Nadeem Ahmed (clinical director)
- Dan Haines (digital)
- Rachel Spencer (VCFSE)
- Paul Trinder (Public health analyst)
- Bev Nicholson (Reading LA integration manager)
- Helen Daw Team Lead (BHFT CVD nurse)

Final thoughts

1. Not just community based physical health services
2. Neighbourhood health services include physical health for adults and children and young people, and community based mental health services
3. Commitment to coproducing Neighbourhood Health Services
4. Teams could be working very differently
5. Neighbourhood health should not just be about joining up different bits of the NHS and local authority services
6. This presents an opportunity to think about how we design neighbourhoods to support ‘health’