Neighbourhood Working: People, Partnerships, Prevention

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

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How our system is changing

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

1. **Local Government Reorganisation:** Reorganising local government across England by replacing county and city/district councils, consolidating services they provide, with unitary authority. By May 2028.

2. **Devolution**: Transfer powers and funding from national to local government, helping to ensure more decisions are made locally and closer to communities and businesses. Devolution would see the creation of a new combined strategic authority which would be led by an elected mayor.

3. **Transforming Social Care**: Baroness Louise Casey to chair independent commissioning into adult social care aiming to address current and future care needs and fulfil Labour election manifesto commitment to a 'National Care Service'. Report due in 2028.

4. **Abolition of NHS England**: Reducing headcount across NHS England and Dept of Health and Social Care (DHSC) by 50% and taking back into direct government control. Process expected to take 2-years, to complete by April 2027.

5. **50% cut in ICB costs:** ICBs remain as 'strategic commissioners' (see slide 3) and the 'performance management' of trusts moves to DHSC. Running cost reduction by Q3 2025/26 (October).

6. **Reduction in provider corporate costs:** 50% reduction in corporate cost growth during Q3 2025/26, with savings reinvested locally to enhance services.

7. **10-year Plan:** The government has a mission to improve health and is working to produce a 10 Year Health Plan structured around 3 shifts – sickness to prevention, hospitals to homes/communities, analogue to digital.

Thames Valley ICB

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Thames Valley ICB Operating Context

- Serves a diverse urban and rural population of c. **2.5m** and has a commissioning budget of c. **£5.7Bn**.
- Good partnerships across NHS, local authorities, VCFSE and community organisations.
- Shared commitment to integration and preventative care.
- System priorities aligned with national and regional expectations.
- Rising demand and complexity in long-term conditions.
- Workforce pressures across primary, community and social care.
- Variation in access, outcomes and experiences.

Three Key Headlines:

1. Our population is generally less deprived compared to the rest of England is in mostly good health
2. We have areas of considerable deprivation e.g. Slough, Reading, Oxford, Banbury, High Wycombe, Aylesbury and some smaller areas which leads to inequalities.
3. People living in the most deprived parts of Thames Valley have lower life expectancy and health life expectancy than those living in the less deprived areas, this is also reflected in a higher prevalence of long-term conditions.

Introduction

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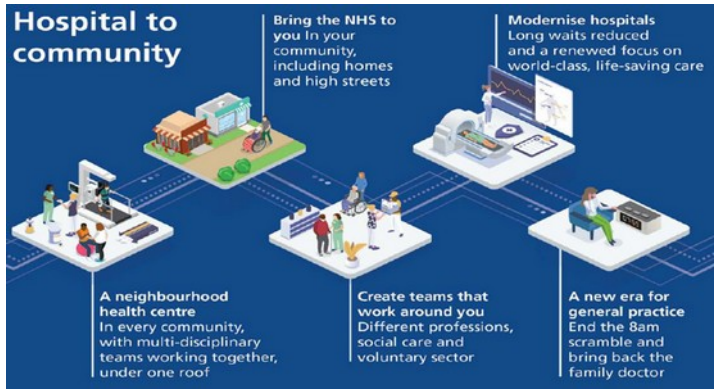
Integrated Care System

The 10-year plan aims to end hospital by default care by 2035.

Most health and care will be delivered locally, proactively and joined-up through revitalised neighbourhood service designed around people's needs with prevention and integration at its core.

Neighbourhoods are the primary delivery vehicle for the NHS's 3 strategic shifts:



At its core, the model is population-based and driven by Population Health Management (PHM), segmentation and stratification using the Johns Hopkins Adjusted Clinical Groups (ACG) system to provide a consistent way to understand need, prioritise resources, organise integrated and multidisciplinary teams and commission for value and equity.

The model recognises health and wellbeing are shaped as much by things like housing, employment, education and social connection as by clinical care, therefore explicitly integrates wider determinants into neighbourhood priorities and delivery.

Context and Rationale

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Neighbourhood health and care is the foundation of our integrated care system (ICS). It brings together primary care (general practice, pharmacy, optometry and dentistry), NHS acute, ambulance, community and mental health service providers, social care, VCFSE and local communities to support where people live. **Partnership is the intervention**.

Evidence shows:

- **Deprivation and disadvantage** remain the strongest predictors of poor health outcomes, lower healthy life years and lower life expectancy.
- **Minoritised communities** often face systemic barriers in access, cultural safety, and trust in health and care services.
- **Early years** development has the biggest impact on life-long health and wellbeing.
- **Long-term conditions** are the biggest driver of health service demand and inequalities.
- **Frailty and ageing** are increasing, placing pressure on health and care services whether provided by NHS, LA or VCFSE.

The Role of Partnerships

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Partnerships offer a unique opportunity for **leaders from health and care sector** to come together, accelerate integration and find new ways to use our collective resources and improve outcomes for the residents we serve and value for our system.

They act as a **bridge between system strategy and neighbourhood delivery**, making choices and prioritising actions to deliver the 3 shifts, develop neighbourhood working, reduce health inequalities and increase our investment in prevention. There are ample examples of success, not least in improving urgent and emergency care and working with priority communities to reduce inequalities and increase upstream prevention

Health and Care Partnerships are:

- Accountable boards for programmes and populations
- Building on existing joint working arrangements where they exist to increase delegation.
- Transfer, fund and host people in joint roles with skills essential for our success.

Place-based Partnerships

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Place-based Partnerships are critical enablers of neighbourhood success.

Core Responsibilities:

- Agree neighbourhood footprints and develop population health improvement plan with Health and Wellbeing Boards.
- Align commissioning, BCF, public health and transformation funding.
- Support workforce development, estates and digital enablement.
- Enable VCFSE and community involvement and co-production.
- Hold shared accountability for neighbourhood outcomes.

Place is where strategic intent is translated in local prioritisation and delivery support.

Berkshire West Place Governance

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West Berkshire H&WB Board
- Ownership of JSNA/JHWS and Neighbourhood Health Plan
- Holds UE to account for delivering on behalf of West Berks residents

Reading H&WB Board
- Ownership of JSNA/JHWS and Neighbourhood Health Plan
- Holds UE to account for delivering on behalf of Reading residents

Wokingham H&WB Board
- Ownership of JSNA/JHWS and Neighbourhood Health Plan
- Holds UE to account for delivering on behalf of Wokingham residents

Direction & Scrutiny

Accountability

Direction & Scrutiny

Accountability

Berkshire West Joint Governance Arrangements

Berkshire West Unified Executive

Berkshire West NHS Executive Group

BW Neighbourhood Working Steering Group

Other programme steering groups – currently Community Rehab

Community Wellness Outreach and Prevention Workstream Group

BW Urgent & Emergency Care Place Programme Board

MDT/INT workstream group

Data workstream group

Placeholder: CYP Workstream Group

West Berkshire Locality Integration Board

West Berkshire Children and Young People's Partnership

Reading Integration Board (RIB)

Reading Children and Young People's Partnership

Wokingham Integrated Partnership (WIP)

Wokingham Children and Young People's Partnership

Vision and Purpose

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Vision for Neighbourhood Working

Everyone in Thames Valley will experience neighbourhood health and care that is easy to navigate, accessible to all, rooted in prevention, and strengthened by integrated working and trusted partnerships with communities.

Strategic Outcomes

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Improved population health and wellbeing, particularly for Core20Plus5 and inclusion health groups

Reduced inequalities in access, experiences and outcomes.

Earlier intervention and prevention for people with long-term conditions, frailty and complex needs.

Improved coordination, continuity and experience of health and care.

Reduced avoidable demand on statutory services.

More sustainable, supported and productive integrated teams and workforce.

Core Neighbourhood Health and Care Offer

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Every Thames Valley neighbourhood will deliver a clear, consistent core offer of health and care, with additional services tailored to local needs and assets. The core offer describes what residents, carers and frontline staff can expect in every neighbourhood, regardless of geography. This is a long-term programme that requires change in

Access and Coordination

- A single neighbourhood '**front door**' including signposting between primary care, community services, local authority services and VCFSE.
- **Care coordination** for people with multiple illnesses, frailty or complex needs, with shared care plan across agencies.
- **Same-day access for clinically urgent needs**, with proactive follow-up for people at risk of deterioration.

Proactive, Preventative Support

- Routine use of **PHM** and Johns Hopkins segmentation to identify cohorts for proactive review.
- Routine multi-agency '**huddles**' focussed on PHM-defined cohorts, using shared care data and insight to agree interventions and responsibility.
- A standard **prevention offer**, including lifestyle support, smoking cessation, vaccination, screening uptake and evidence-based self-management.
- Routine identification of people whose health is most affected by **wider determinants** of health and targeted support through partnerships and community assets.

Community and VCFSE Involvement

- Access to **community connectors or link workers** who support navigation to local assets, peer support and wider determinants support.
- Formal **VCFSE participation** in planning, INT meetings and case-finding/prevention initiatives including organisations working on housing, money advice, employment support, physical activity, arts and culture.

Community Power and Co-production

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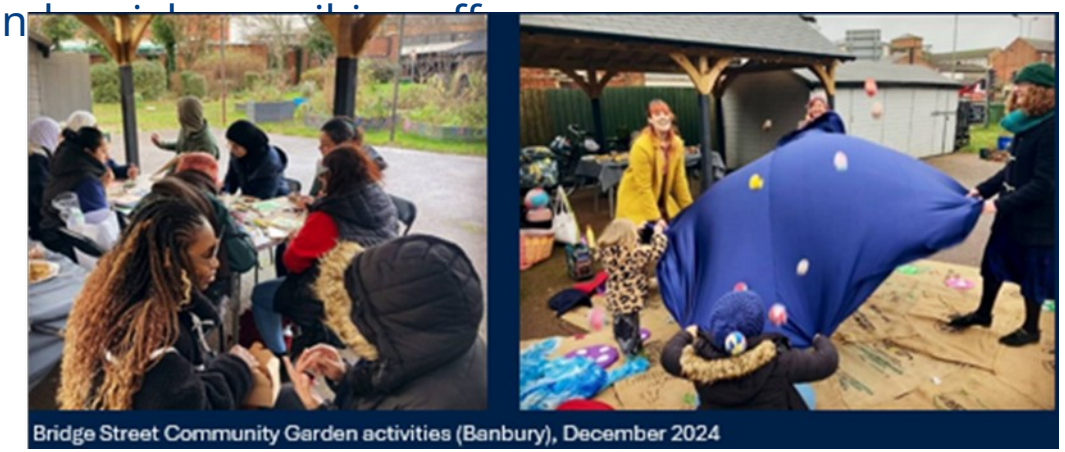
Real change requires **shifting power, not just shifting service delivery**. Neighbourhoods will be designed and delivered with communities, not just for them. This includes formal mechanisms for resident voice, co-design of priorities, and sustained involvement of VCFSE and community organisations, with particular focus on CORE20plus5 and inclusion groups.

Neighbourhoods will **map** local community assets, including faith groups, cultural organisations, mutual aid networks, peer support groups, housing associations, employers, leisure and sport facilities, parks and green spaces and

Barton Coffee Morning, November 2024



Bridge Street Community Garden activities (Banbury), December 2024

Community-led development is a core operating assumption of this model. Community-led programmes in Thames Valley have demonstrated that when local people shape priorities and solutions, they generate high levels of trust, improve access for underserved groups and deliver measurable improvements in mental health, physical activity and self-management.

Asset-based community development approaches emphasise that up to **80% of the determinants of wellbeing depend on community connections and mobilisation of local assets**, and that over-reliance on professional

Neighbourhood Delivery Model

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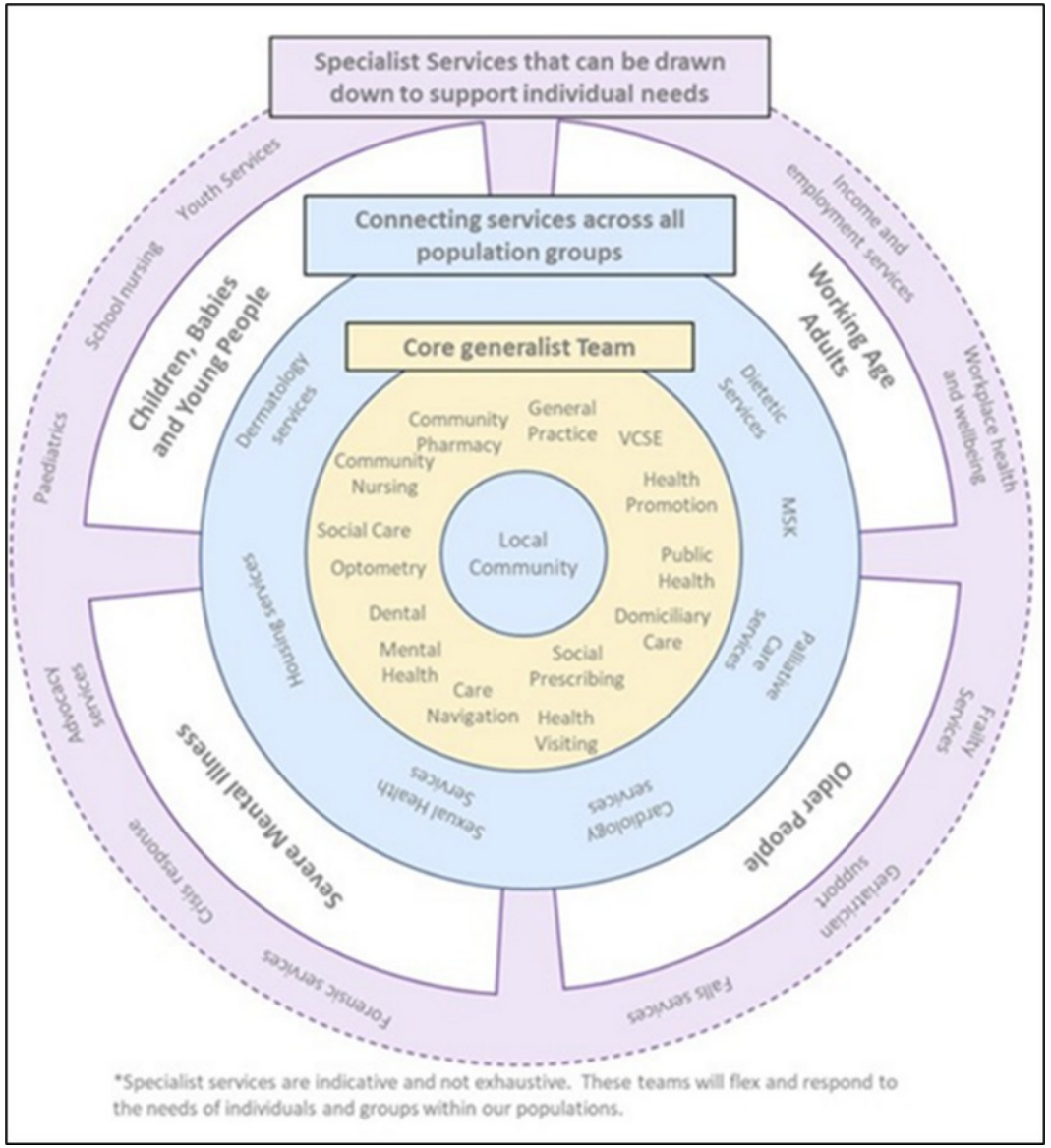

Integrated neighbourhood teams - NAPC

Integrated Neighbourhood Teams (INTs)

INTs are a partnership that provides the **operating framework** for delivery.

INTs are not single teams but a way of working that brings together primary care, community services, mental health, social care, VCFSE partners and community assets.

INTS focus on:

- Prevention and early intervention.
- Proactive support for PHM-defined cohorts.
- Coordination of care and support.
- Reducing fragmentation and duplication.

Neighbourhood Delivery Model

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Multidisciplinary Teams (MDTs)

MDTs operate within INTs for **defined cohorts of people** with specific needs or for complex cases.

Team membership is stable across cases, and they function via scheduled meetings e.g. case conferences, with a shared agenda and goals focussed on outcomes for the individuals or families.

They typically include:

- GP.
- Community nurse and therapist.
- Social workers.
- Pharmacists.
- Mental health or acute health specialists
- Voluntary sector staff.

The emphasis for MDTs is decision-making around individual patients or cohorts, with a one-case, one-team mindset. They are oriented toward immediate coordination of care, reducing fragmentation in episodic or acute settings.

Population Health Management as Core Engine

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BW Neighbourhood health priorities

Priority cohorts

1. Low/medium mental health
2. Cardiovascular disease
3. Frailty / Complex needs
4. Respiratory / COPD
5. Locally Determined Priorities

Live workstreams

- MDTs
- Prevention and inequalities
- Data and Population Health

Currently scoping Children and Young People and Engagement / Co-production workstreams

Outcomes we want to measure – in development

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Complex Patients

Reduce the % of avoidable admissions
Increase the no of people at end of life cared for in their '*preferred* place of care', and 'dying in their preferred place of death'
Reduce the no of bed days in hospital
Increase the number of patients with a proactive care plan
Improved experience for patients and their carers
Increase no of patients accessing advice and self management
Reduce the number of primary care contacts
Increase the number of patient contacts with VCSE services (note this would require appropriate investment & concern that reduction in health appointments

CVD

Reduce no of attendances/admissions for exacerbations of long-term conditions – HF/Diabetes
Increase the no of NHS Health Checks
Increase the no of early identification of people at risk of CVD
Increase the no of people living with CVD proactively managed as part of the neighbourhood team
Increase the no of people with CVD engaged in self management
Increase the no of people with CVD quitting smoking by an agreed date
Increase the no of patients engaging in physical activity
Improved experience for patients and their carers (patient reported outcomes)

Respiratory

Reduction in % of ED visits for respiratory conditions
Increase the no of people with a respiratory disorder quitting smoking by a set date
Increase the no of people with a respiratory disorder accessing pulmonary rehabilitation
Increase the no of people with a respiratory disorder engaged in self management
Increase the no of patients with a respiratory disorder engaging in physical activity:
Improved experience for patients and their carers
Increase in no of households with damp/mould/ventilation issues resolved through neighbourhood referrals
Increase in no of respiratory residents accessing warm hubs or winter-support schemes

Mental Health

Increase no of people living with depression engaged in self management
Increase the no of patients living with depression engaging in physical activity, arts, creative or social groups
Reduce the no of primary care contacts for people living with depression
Increased no of contacts with VCSE services of people living with depression
Increase the no of people living with depression accessing Talking Therapy services
Increase the no of people living with depression accessing IPS
Improved Patient and carer experience (patient reported outcomes)
Reduction in UCLA 3 item loneliness scale/isolation scores

Geographical Alignment

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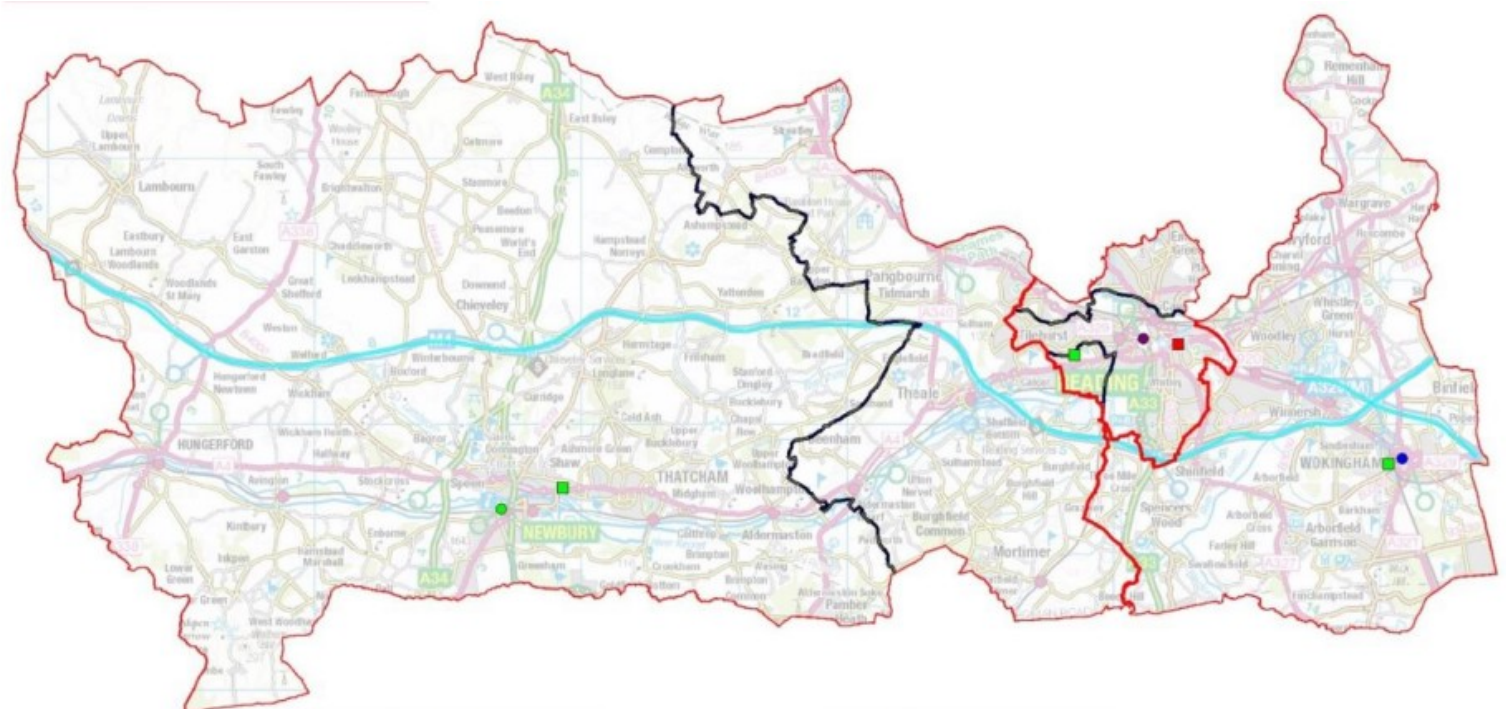
Most existing neighbourhood MDTs across Berkshire West are aligned with PCN boundaries, there are some areas where geographical boundaries are not as neat as others.



PCNs as of March 2025

West Berkshire
A34
Kennet
West Berkshire Rural
West Reading Villages

Wokingham
Wokingham North
Wokingham South
Woosehill & Crowthorne
Modality Wokingham
Earley +
Phoenix

Reading
Reading Central
University
Elm Park
New Reading
Reading Holybrook
The Triangle
Caversham