

BOARD MEETING

Title	Buckinghamshire Place-based Partnership Update		
Paper Date:	30 June 2025	Board Meeting Date:	8 July 2025
Purpose:	Information	Agenda Item:	12
Author:	<i>Daniel Leveson, Director for Places and Communities</i>	Exec Lead/ Senior Responsible Officer:	<i>Matthew Tait, Chief Delivery Officer</i>

Executive Summary

The presentation provides a brief overview of:

- The purpose of Buckinghamshire Place-based Partnership and opportunities it offers for the system's future operating model.
- The approach to developing neighbourhood health and care, including integrated neighbourhood teams.
- The role of communities and voluntary community sector partners delivering community development and support foundational for neighbourhood health and care.

The development of neighbourhood health and care is a system priority that is likely to be a central feature of the NHS 10-year plan. Places, described as the engine room for integration and delivery for neighbourhood health and care, are working closely with ICB to ensure our approach is consistent and aligned.

Success requires close collaboration and integration with colleagues across NHS, local authorities and voluntary and community sectors. It will be built on a foundation of community development to coordinate existing assets that contribute to shifting from treatment to prevention and acute to community.

Action Required

The Board is asked to:

- Note and discuss the update, considering the context of the NHS 10-year plan and future operating model.

Conflicts of Interest:	No conflict identified
-------------------------------	------------------------

Date/Name of Committee/ Meeting, Where Last Reviewed:	N/A
------------------------------------------------------------------	-----

Buckinghamshire Place-based Partnership: Integrated Neighbourhood Teams and working with communities



Executive Summary

In Buckinghamshire we have made significant progress in developing and implementing a whole place approach to neighbourhood health. Working in partnership with the ICB at place and across primary care, the council, acute and community trust, mental health trust and voluntary and community sector we have:

- Agreed the six neighbourhood teams and their geographies.
- Leveraged place-based budgets to agree funding for integrator roles in each team, joint director of integrated care role and development monies for each team.
- Aligned our Health Inequalities funding to our neighbourhood health approach to best support our areas of greatest deprivation – Aylesbury and Wycombe. This includes agreeing funding for a community health and well-being model.
- Agreed an overarching strategy of priorities that will be the new 10-year Health and Wellbeing Strategy for Buckinghamshire. Integrated neighbourhood teams are a key element of achieving the agreed outcomes of the strategy, supported by annual action plans.
- Held the first meetings of the Integrated Neighbourhood Teams, using population health data and insights to develop initial priorities for action.

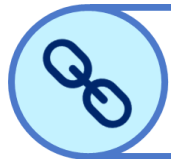
As a Place-based Partnership we are ambitious to further develop our progress to date, working in collaboration with the ICB as to how we do this in alignment with the proposed ICB blueprint, recognising the opportunity for delegation of funding, accountability and delivery.

The Purpose of Place-based Partnerships (PBP)

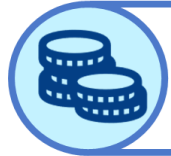
PBPs offer a unique opportunity for leaders from health and care sector to come together, accelerate integration, find new ways to use our collective resources and improve outcomes for the residents we serve.

We make choices about how to leverage our collective resources and prioritise actions and interventions to develop neighbourhood health and care, reduce health inequalities and increase our investment in prevention.

We work in a complex system with a great deal of change and uncertainty. PBPs can help meet some of our future challenges, especially as the ICB reduces its capacity and re-focusses covering a larger geography.



Join-up services for priority people/populations



Deliver new models of better value care



Increase prevention and reduce inequalities

PBPs can:

- Become accountable boards for programmes and populations including SEND, UEC, Neighbourhoods.
- Build on existing s75 agreements, pooled budgets and joint commissioning to increase delegation.
- Transfer and host people with skills essential for our success.

Integrated Neighbourhood Teams

Integrated Neighbourhood Teams (INT) are professionals from health, the council, the voluntary and community sector that work within a specific geographic area to provide coordinated and preventative care, to address the needs of the population and improve health and wellbeing.

They are not a new team, but existing teams working better, together that:

- Focus on preventative care and early intervention.
- Improve coordination and communication between different services to provide holistic and seamless service.
- Further develop partnership working including working with communities.

The people of Buckinghamshire have told us:

- They want more co-ordinated and joined up care
- They want more focus on early prevention and personalised support
- They want a more holistic approach to support provided

The data tells us:

- Our Buckinghamshire population is ageing, people spend more years in ill health and live with more long-term conditions
- Some communities face health inequalities which are unfair and cause avoidable differences in health.

Our current model of care is unsustainable:

- We are seeing increasing demand and for a finite resource
- Our current workforce model is not resilient and is unsustainable with current demand increases
- We know we need to transform services to be more efficient, reduce duplication and deliver what the people of Buckinghamshire have told us we want

Better co-ordinated care, closer to home, is a key principle of the Health and Wellbeing Strategy. Integrated Neighbourhood Teams (INTs) will be the key delivery vehicle for the Health and Wellbeing Strategy.



INT Geographies

In Buckinghamshire we are proposing to align our INTs to Primary Care Network Boundaries. Each proposed INT includes between 1 and 3 PCNs.

This requires the reorganisation of teams and services across partners.

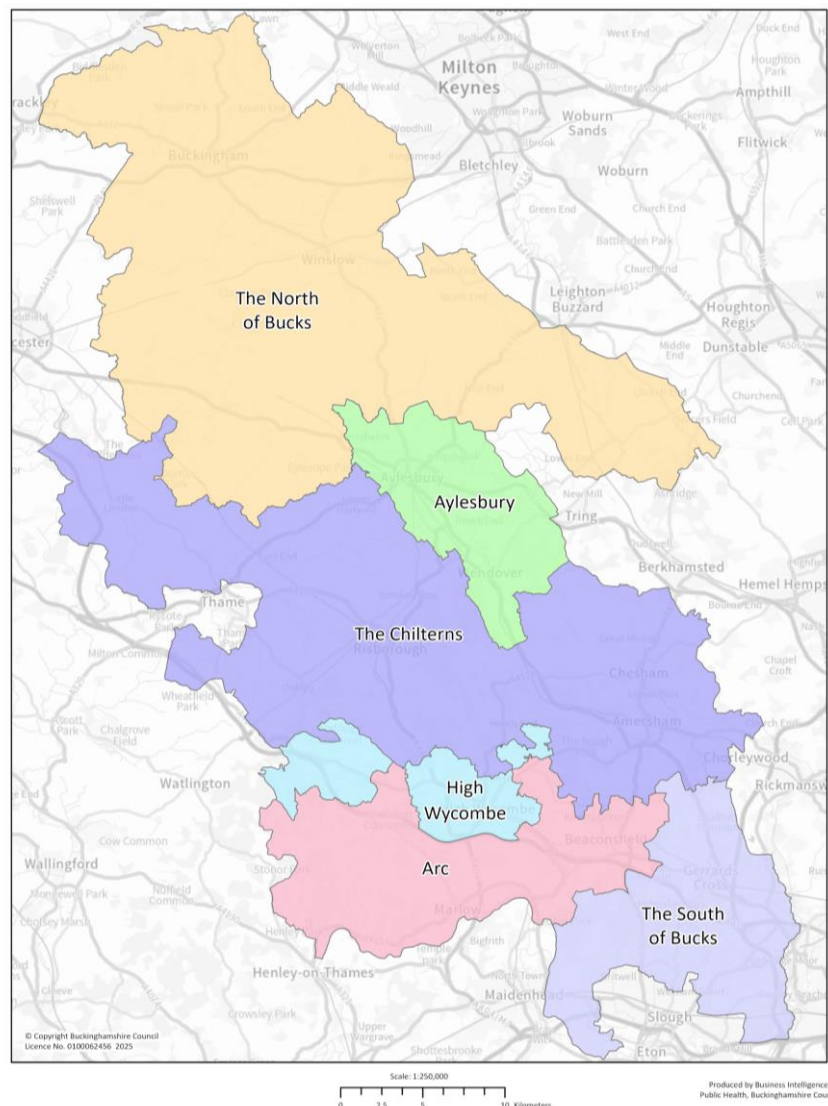
The rationale for using PCN boundaries:

Population focus:

- A person makes a choice in the GP surgery they register to and practices are a part of that person's community / neighbourhood.
- A person's first point of contact is often with their GP practice and the wider primary care team.

General Practice Ambition

- General Practice has been a driver for developing our proposed approach to INTs, coming together to work in a transformed way for the first time. The potential of this cannot be underestimated.
- INTs provide an opportunity to address the long standing capacity and capability issues in our Opportunity Bucks areas of Aylesbury and Wycombe.



Map of proposed 6 INTs.

Outcomes

As a key enabler of the draft Health and Wellbeing Strategy INTs will be implemented over a five-year time frame, aligning to the annual delivery plans of the draft Health and Wellbeing Strategy.

The outcomes for INTs will align to those of the draft Health and Wellbeing Strategy, recognising that there will be localised prioritisation based on population health analysis.

Endorsed Health and Wellbeing Strategy Outcomes

Priority	Start Well		Live Well		Age Well	
	Primary Outcome	Inequalities Outcome	Primary Outcome	Inequalities Outcome	Primary Outcome	Inequalities Outcome
Prevention	Reduce percentage of children who are overweight or obese in reception and year 6	Reduce the percentage children who are overweight or obese in reception and year 6 in DQ5 vs DQ1	Reduce premature mortality and increase healthy life expectancy Reduce smoking prevalence	Reduce smoking prevalence manual workers	Reduce hospital admissions due to falls age 65 and over	Hospital admissions due to falls age 65 and over DQ5 vs DQ1
Empowering Communities	Increase the percentage of parents accessing parenting support programmes	Increase the percentage of parents accessing parenting support programmes in Opportunity Bucks wards	Increase percentage of people in employment	Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	Increase percentage of adult social care users who have as much social contact as they would like	% of people aged 65 and over who are economically active
Proactive Care	Building blocks for health: Increase the percentage of children that achieve a good level of development at the end of reception	Increase percentage of children in receipt of Free School Meals that achieve a good level of development at the end of reception	Increase levels of wellbeing through ONS self reported wellbeing: high anxiety score	Access to NHS talking therapies DQ5 vs DQ1	Increase percentage of people aged 65 and over who enter talking therapies treatment	Percentage of people aged 65 and over who enter talking therapies treatment DQ5 vs DQ 1

Working with VCS and Communities

Aligning with two of our Opportunity Bucks areas, Aylesbury and Wycombe, the health Inequalities funding is enabling integrated neighbourhood working for our communities experiencing the greatest health inequalities. Involving these communities and the VCS we are laying foundations for sustainable, culturally competent neighbourhood working that will reduce inequalities and prevent avoidable illnesses.

Each INT will have 4 Community Health and Wellbeing Workers to focus on proactive population health management, which is developed by Public Health to increase access, and improve experience and outcomes for those experiencing worse health inequalities. Increasing referrals into preventive services and targets set out as part of the 5 clinical areas (5) in the Core20Plus5. Based on proven evidence from other areas, for example see Westminster pilot below: <https://youtu.be/MPtE4vwZvDI>

The proposal is underpinned by an integration and community workforce development programme which is coordinated to develop and connect those working and volunteering in/with these communities.

By establishing an integrated neighborhood (INT) structure that facilitates community and workforce engagement, we'll deliver more joined services to populations who will benefit the most.

Buckinghamshire approach includes:

Integrated Community & Workforce Development

The introduction of 9 Community Health and Wellbeing Workers as part of the Integrated Neighbourhood Teams in Aylesbury and Wycombe

Integration and Community Engagement Support, with a particularly focus through our VCSE partners.

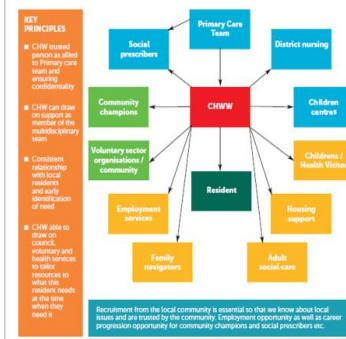
- Communities Of Practice for front line workers focussed on Health Inequalities
- Health Coaching
- Deep End Network for GPs
- Community Researchers providing community insights
- JOY (continued funding from partners)

Community Health and Wellbeing Workers pilot in Westminster

How the pilot began in Westminster

The CHWW role was aligned to the local 'City for All' vision to create vibrant communities, where residents are able to 'make the most of the incredible opportunities in our city' with emphasis that the CHWW model would also deliver a comprehensive map of unmet need for Churchill Gardens, in Westminster, that will inform future service provision. Health inequalities, social isolation and higher childhood obesity rates were identified as priority areas that the CHWWs would address, including raising immunisation and screening uptake. Providing local employment and upskilling residents was an important factor.

The relational model below allowed stakeholders to understand how the model would work within the local ecosystem. Appreciating the CHWW could act as a single point of access without a referral was a turning point in getting the model of the ground.



Leveraging close collaboration with Imperial College London, two Masters students projects demonstrated that the role would be largely beneficial and appreciated by local community health professionals with a notable return on investment. One-year pilot was funded through the Local Authority and Public Health.

In Westminster where the model was first implemented it has shown:

- The households were **47%** more likely to have immunisations that they were eligible for and **82%** more likely to have cancer screenings and NHS health checks.
- These households saw a **7.3%** drop in unscheduled GP consultations.
- Residents were appreciative of the ease of access, support and comprehensive approach provided
- Engagement had been maintained with **60%** of residents and increasing. Residents who engaged with CHWWs did not disengage.
- Multiple instances of issues being unearthed around suicidal ideation, child carers, domestic violence and intractable housing.

Watch a 6 min clip 'Community Health Workers in Churchill Gardens – Learning from the Brazilian Model': <https://youtu.be/MPtE4vwZvDI>

This model has already been rolled out across 25 other sites following the success of the early pilots, with more in the pipeline. There is an established network and Communities of Practice for pilots of CHWWs across England supported by The National Association of Primary Care.

Progress to date

- Proposal approved through Buckinghamshire Executive Partnership (BEP) with Neighbourhood Health being one of the key priorities of the place-based partnership.
- INT Programme Group established, aligned with BOB programme and representation from all partners including VCSE and Healthwatch.
- Aligned our Health Inequalities Funding to Integrated Neighbourhood Team Delivery
- We have leveraged resources across budgets available to Place to enable the progress of this core priority.
- Communication pack developed for partners to use and engage front line staff

Formal Launch of Integrated Neighbourhood Teams

- INT launch events took place on 11th June with up to 50 attendees at each neighbourhood event, making connections, sharing ideas and opportunities for better joined up working and using Population Health Management (PHM) data and insights to shape priorities.
- Population Health Management (PHM) Packs were developed by Public Health for each INT to ensure priorities are evidence led and a PHM approach will be developed and integral to neighbourhood health delivery.
- Integration Lead roles for each INT are due to be appointed in July

Key Next Steps

- Develop priority areas within each neighbourhood
- Develop and implement communication and engagement plan, including engagement with people and communities of each INT
- Recruit community health and wellbeing workers in Aylesbury and High Wycombe

Appendices

Buckinghamshire context – What people want

As part of the development of the Health and Wellbeing Strategy we have collated the public feedback and engagement from a wide variety of sources including Healthwatch reports, BOB primary care strategy consultation and specific feedback exercises from the other organisations, we have also engaged with the Public and Patient Group Steering Group and multiple partners including a wider variety of voluntary and community organisations. Key themes identified from our analysis of the feedback and engagement are people want:

- Joined up, person centred care
- To tell their story less frequently
- Easier to navigate services
- More holistic care – supporting people as an individual not a condition or a need
- A greater focus on prevention and supporting people proactively
- More integration of services at a local level

Integrated neighbourhood teams will aim to deliver these for people through working in a joined-up way and with our communities.

Integrated Neighbourhood working in Buckinghamshire



Tony's Story

- Tony is 25 and has a long history of rough sleeping, substance misuse, learning difficulties and self-neglect. As a child, he was under Children's Social Services, he had Leukaemia and a stroke. During his adult life, he has been in and out of temporary accommodation, hospital and custody.
- Tony was often found unconscious, walking into traffic, reported as missing, had multiple safeguarding concerns raised and emergency calls were frequent. When offered accommodation, Tony would return to rough sleeping.
- The Making Every Adult Matter (MEAM) team started working with Tony in 2023. They worked collaboratively with Adult Social Care, One Recovery Bucks, GP and Thames Valley Police to support Tony's needs and were able to do things such as GP going out to assess Tony where he was rough sleeping as he would not visit a GP.
- Tony's health has significantly improved. He has maintained stable supported accommodation for two months, and he has slept in his room for four consecutive weeks. There has been a notable decrease in emergency service call-outs and he has not been admitted to hospital for seven months, and safeguarding concerns have lessened.
- Tony's story highlights the need to work in a collaborative way personalised around an individual. By doing this the team were able to improve outcomes for Tony and reduce demand on services. INTs will help to identify people who require this support earlier and ensure there is local knowledge about the services and key people who can work together.



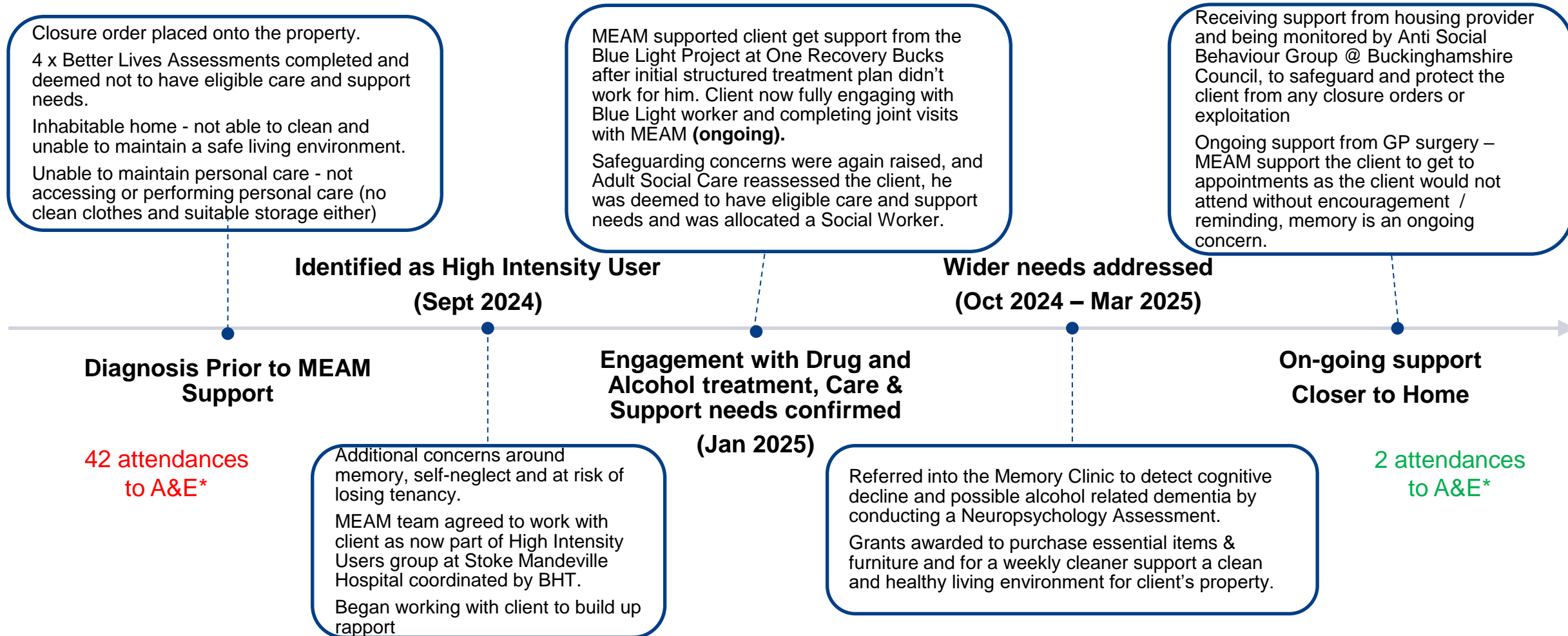
Increasing Vaccination Rates

- The Buckinghamshire School Aged Immunisation team identified a school that had a poor uptake of immunisations. The school was very diverse and has a history of low parental engagement.
- The immunisation team worked with the school to increase uptake of immunisations. Two assemblies were held to highlight the importance of immunisations and allow time for questions, which were run collaboratively with the deputy head teacher and immunisation team.
- Resources were given students in different languages to take home. Telephone conversations were made to parents prior to the day of vaccination and then again on the day with the student present.
- This led to a compliance of 98.7% compared to 72% the year before. It also helped to increase awareness of vaccinations to the students and their families and increased the positive relationship between the immunisation team and the school.
- Working as an INT would support this way of working through having population health data readily available and key relationships already in place, meaning this could be developed more quickly and replicated more easily.



Sophie's Story

- Sophie was being discharged following a short admission to hospital. She felt she wasn't ready to go home as she had mobility issues and mild concussion. Once home, she struggled to get out of bed, cook or dress herself, this caused her to become very distressed.
- After getting support from Age UK they were able to contact social services who were able to refer her to the Rapid Response and Intermediate Care Service (RRIC). Following this referral Sophie's immediate concerns were addressed quickly, "Within two hours it was all sorted."
- Sophie now has the equipment she required to help with her mobility, such as a raised toilet seat and shower chair at home. The team also sent in carers twice a day. She is now looking forward to regaining her independence.
- Age UK also continued to support Sophie, and a volunteer visited once the carers left. She has also been put on the waiting list for a befriender.
- Working in an INT would ensure that the right support is available (across all providers) for individuals, improving outcomes, preventing re-admissions and unnecessary primary care appointments.



Before the intervention, the person was going to the hospital around once every 3 weeks. After the intervention, that dropped dramatically to just 2 visits in 7 months equating to a 95.2% decrease — a huge improvement and a sign that the support put in place is working.

Principles for Integrated Neighbourhood Working in Buckinghamshire

As part of the delivery of the Draft Health and Wellbeing Strategy we have agreed we all need to work by the following principles to deliver our principles and aims. These will also be the core principles for integrated neighbourhood working:

Working with our communities

We are committed to working in and with our communities to understand their needs and wants. This will mean people are more closely involved in developing services to ensure we make the best use of all our local assets and resources.

Joining up care

We will work together to plan and coordinate care that has the person at the centre. This will mean people will experience more seamless care that is personalised to them and will be able to more easily navigate the services they require.

Evidence Led

We will use data and community insights to support care and service improvements, ensuring we are able to target improvements where we will get the biggest benefit for the population

Equity focused

We will aim to tackle health inequalities and the wider determinants of health in everything we do.