Bi-Borough Integrated Neighbourhood Team Development Overview

Westminster & Royal Borough of Kensington and Chelsea Health & Wellbeing Board

23rd November 2023

City of Westminster

Chelsea and Westminster Hospital NHS Foundation Trust

London Medical Associates WEST LONDON GP FEDERATION

volunteer centre kensington & chelsea

HCL Healthcare Central London

healthwatch Central West London

ONE WESTMINSTER

North West London Integrated Care System

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

NHS Central and North West London NHS Foundation Trust

NHS North West London

NHS Imperial College Healthcare NHS Trust

NHS 75 Central London Community Healthcare NHS Trust

Kensington & Chelsea Social Council

volunteer centre kensington & chelsea

INTs are the deliverable vehicle for …

What's the purpose, ambition & scope?

DRAFT

Why Integrated Neighbourhood Teams?

- Multi-sector professionals of local providers working with community
- Integrated service teams working on priority groups / cases / issues; sharing care plans, approaches and processes
- Reducing health inequalities - achieving improvement in population health outcomes and deliver a more holistic support system that addresses wider social determinants
- Reducing health inequalities
- Improving collaboration, reducing barriers, silos and handoffs
- Defining population health strategy and priorities in given neighbourhood

Why is this important?

- Opportunity to **work with residents and partners differently** - tailoring to our communities - addressing equity (e.g. rough sleeper, lonely resident, patient with complex needs, etc.)
- Direction of **policy travel**, regulators are asking provider partners to work in an integrated way
- Bringing together **what we already have** and making it '**business as usual**'
- Creating **economies of scale** (e.g. CYP, Specialist Support, etc.)
- This is not new, it's about ***building on existing integrated delivery models*** and programmes of work:

The Change We Want to See

Stories we want to create with our residents

DRAFT

Joy and her family are supported to keep her healthy at home and out of hospital.

The Past

"Without my children I don't know what I'd do. They used to spend so much time repeating information and trying to book appointments, and helping to make sense of the system. I was stuck in hospital for two extra weeks because I needed a special bed and alarm fitting in my home to be discharged. When I returned home, I felt I was keeping up with the system rather than focusing on getting better."

The Future

"Now we have health visitors who sorted out my flat and check in on me to make sure I'm doing my exercises and managing my medication. They set up my phone and showed me how to make appointments with my GP. They even found a local church that does day trips and picks me up every week. My children have more of their lives back and don't worry so much."

Alina, Krish and their children are supported in more suitable housing, and managing their youngest child's health conditions.

The Past

"Where we used to live and our whole family's health were intertwined. The flat had damp and mould, and the kids would get chest infections in winter. We couldn't afford to open the windows each day and heat the house again. The school used to call to ask why they had been absent so much. We tried everything to get better housing, but were on waiting lists for waiting lists."

The Future

"When our youngest who has epilepsy and autism started to deteriorate, we were brought into conversations between a nurse, housing support and a social worker. By joining the dots together, we could create a plan to make sure where we live now is going to a place where we see them all thrive."

Graham is supported in managing his mental health and training to get back into work.

The Past

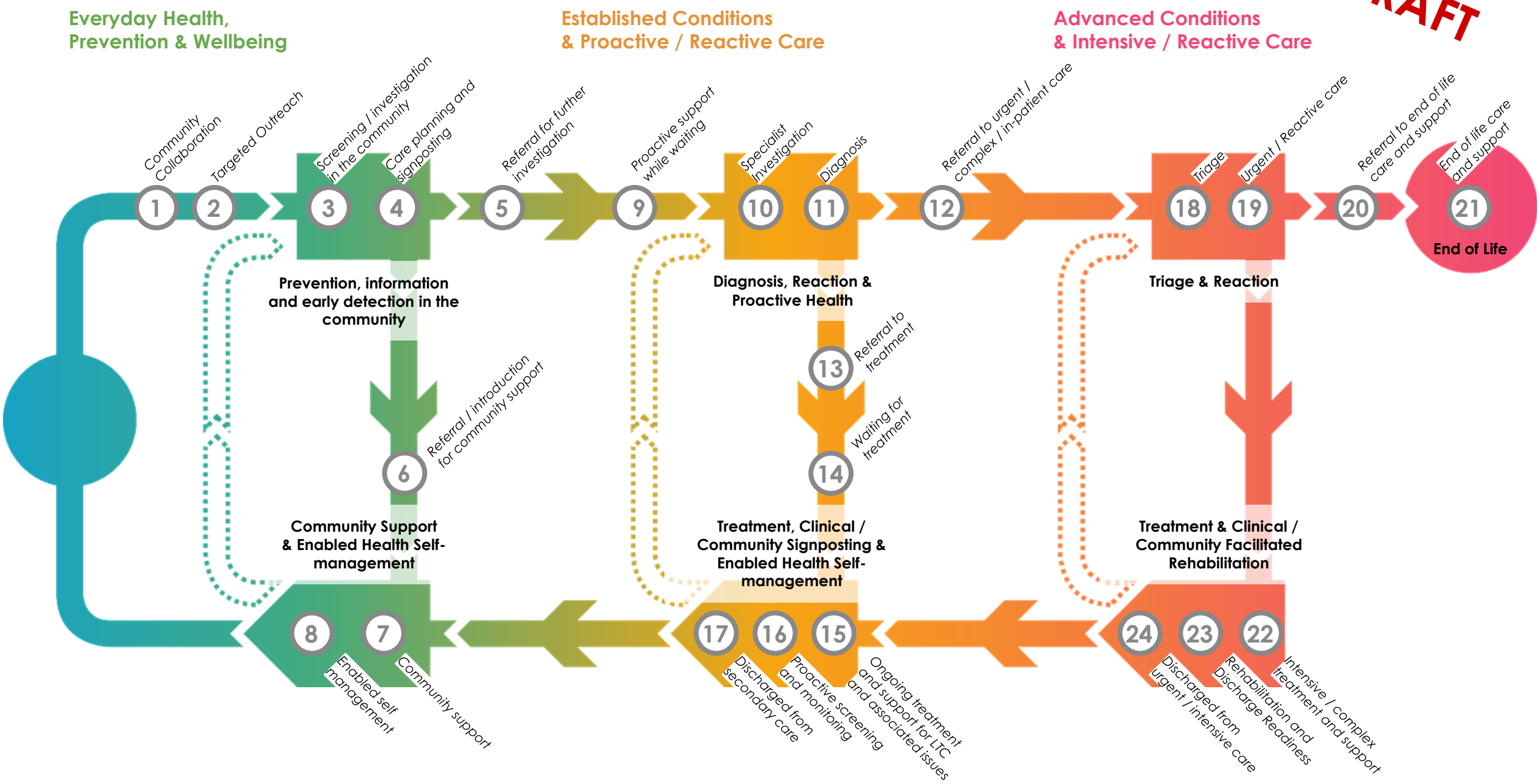
"After losing my job, I felt isolated. My confidence and mental health were really low. Medicine and treatments are one side of things. The other is being connected to other people going through similar situations, and doing things that make me feel independent. I missed that so much when I lost my job, and couldn't bounce back financially or mentally."

The Future

"My GP introduced me to a Social Prescriber. They sat down with me and listened to what I thought might help. Now I'm a regular at a mindfulness class in the local library, get exercise and volunteer at my local parkrun and am on a training course to ease me back into work. If you try to live positively, and get support to help you stay at work it has a great impact on all parts of your health."

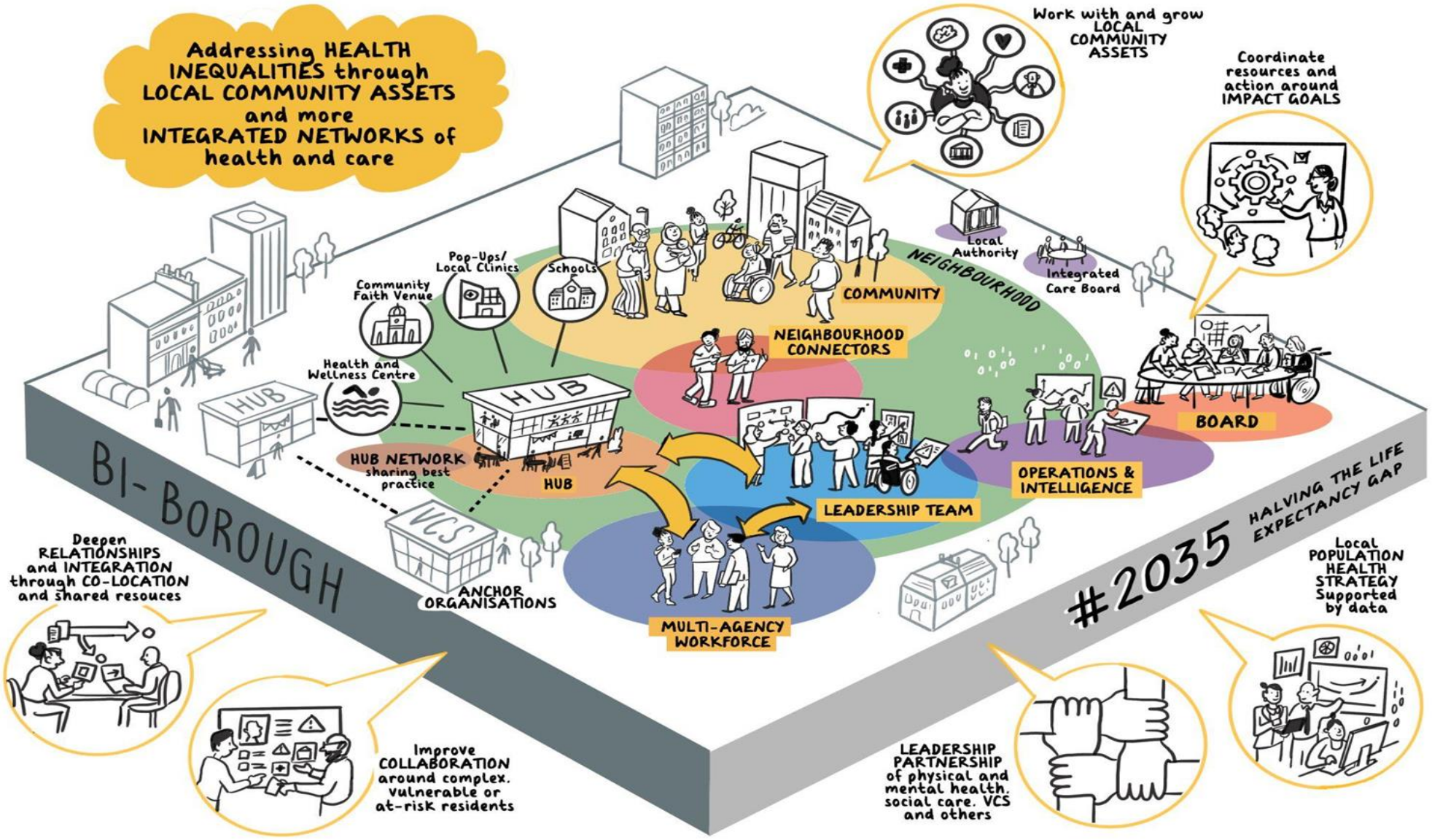
Our over-arching operating model

DRAFT



Our co-designed operating model

DRAFT



Our Fundamentals

DRAFT

For residents and communities

Growing and Connecting Local Community Assets

Residents are connected to, and supported by rich and thriving local health and wellbeing offers. Residents and community groups are involved in co-delivering support.

Smart Collaboration Around At-Risk Residents

Residents in complex or deprived circumstances experience joined-up care from a broad range of professionals. Care plans are personalised; tasks and data are shared where appropriate

Co-Location and Collaboration

We foster closer relationships between professionals, agencies and community organisations. This includes multi-agency working at local hubs, as well as simplifying ways to collaborate virtually.

For staff

Informing and Adapting Services to Local Needs, Evidence and Data

We are data-led and gather research with community members to influence how services are delivered to meet local needs and reduce health inequalities.

Multi-agency Partnership Leadership

A core group leaders work together to set the course of action and monitor its collective impact on local residents. These include physical and mental health, social and community services.

Coordinating Action Towards Shared Goals

We galvanise action around shared missions with agreed priorities and measurable targets. These are acted upon by a local network of staff and community, including connector roles, Hubs, PCNs and other partners.

We're already doing it

INTs are not new: It's about ***building on existing integrated programmes of work:***

Vibrant & Healthy Communities
Our delivery vehicle to address health equity across Bi-Borough
including vax/imms/screening, Connector Roles, Core 20+5 (pathways), #2035, Homelessness / Changing Futures

My Care My Way:
An integrated health and social care system for older adults

North Kensington Grenfell Recovery
A wide range of community-based support to bereaved and survivors

Violet Melchett
Wide-Ranging health & care for our residents

Connector (Octopus) Network
Connecting the ecosystem of health and care in our communities

Access
Primary Care & PCN

0-5 Early Start - Family Hubs

People with Long Term Conditions