START • LIVE • AGE
WELL
HARINGEY BOROUGH PARTNERSHIP

North Central London Health and Care
Integrated Care System

Haringey Health and Wellbeing Board

Neighbourhoods & Integrated Neighbourhood Teams

March 2025

North Central London Health and Care
Integrated Care System

Context

Neighbourhoods are the third pillar of our ICS. Reinforced by Fuller, Darzi & the three shifts and government focus on a *'neighbourhood health service'* expected in the10 Year Plan. London is collaborating on a case and outline model.

Neighbourhoods pivot to integrated, proactive & community-oriented models. Multidisciplinary input, population health management techniques and innovation are essential. Individuals & VCSE are critical partners.

They are a key vehicle for integration and for public sector sustainability plans, which consistently focus on community-based support, mitigating complexity and building individual & community assets.

There has been a lot of work locally and progress. However, a significant gap still exists between vision and delivery. Despite efforts we have struggled for the step change our patients/residents want to see and we want to achieve. Services are struggling to support more complex needs; interdependent teams work in parallel for the same people & communities; staff do not have time for prevention and continuity; beyond the individual very few see the 'whole picture'; and outcomes are a struggle & inequalities persist.

Major reform delivered largely via existing resources needs shared focus, appetite and widespread sponsorship.

We need to set priorities, agree '*what needs to be true*', point assets at this approach (workforce models, infrastructure, data, financial flows), and mobilise at scale. We need system support for enduring change.

North Central London Health and Care
Integrated Care System

NCL has strong foundations

There is growing consensus around **three key focus areas for neighbourhoods: targeted prevention, proactive care for chronic and complex needs, and fostering strength and resilience in individuals & communities.** In NCL:

- The Population Health Strategy & Outcomes capture agreed priorities to anchor the neighbourhoods.
- Borough Partnerships are bought into neighbourhood working as a model for population health improvement.
- Major programmes and service developments in NCL give us key building blocks:
  - Long Term Conditions – core offer, vertical integration with secondary care, innovation
  - Core offers for community & mental health and strong relationships with council teams
  - CYP integration and Family Hubs
  - Hyper-local prevention offers (vax, screening, pharmacy) with outreach and health on the high street, partnering the VCS
  - Work Well – providing a vehicle through which employment outcomes for those managing complexity and LTCs can be improved
- We have a highly engaged VCS providing services, voluntary capacity and routes to partners with our diverse communities and community leaders.
- We have active and innovative Primary Care Networks willing to work on broader geographical footprints to enable integration with other services.
- We have a mature and innovative approach to infrastructure and estate across health and local government.

North Central London Health and Care
Integrated Care System

Neighbourhoods in NCL

- Neighbourhoods are footprints on which teams integrate, services work together, and local infrastructure and community assets are developed. There is emphasis on prevention, proactivity and local care, underpinned by shared infrastructure, data and insight, technology and workforce reform.
- Integrated Neighbourhood Teams (INT) build on MDTs and include NHS providers, council teams and the VCS. Specialists support. Patients an residents are key partners.
- Borough Partnership work to date suggests at least **18 neighbourhoo in NCL** with populations of 60,000–130,000.
- We would expect each to have:
  - ✓ **Leadership and management capacity** to support caseloads, systems, processes, training & development, and accountability – including an '*integrator function*' as per recent London work
  - ✓ **Shared infrastructure** (IT, co-location where possible but flexi spa & networked models where necessary, population health data)
  - ✓ **Wider delivery capacity** (including high street services)
  - ✓ **Strong relationships with local communities and the VSC –** stability for VCS partners, expertise in person-centred care and strengths-based approaches

18 NCL Neighbourhoods identified by Borough Partnerships

North Central London Health and Care
Integrated Care System

The change sought

System

- Health & local government challenged by complex & episodic need
- *'Failure demand'* – silos, disjointed provision, inefficiencies
- Unwarranted variation and inequity in outcomes
- Resources reducing with inflation

Patients & residents

- Complex bio-psycho-social needs; wider determinants impact motivation, engagement & outcomes
- Services seen as unresponsive and disjointed
- Confusion around access (statutory & wider support)
- Social isolation - sense of community challenged
- Lack of trust and confidence in offers made

Staff

- Struggling to provide the care they want to/may not see a future
- Thresholds for support increasing, gaps in pathways emerging
- Capacity for proactivity and continuity is squeezed out
- Struggling to arrange support for the most complex people

System

- ✓ Finding and supporting target populations – risk stratify, engage & learn, close prevalence gaps, reduce disparities
- ✓ Dedicate capacity to proactivity, continuity, and prevention
- ✓ Integrate provision– efficacy and efficiency in patient journey and outcomes
- ✓ Optimise statutory *and* individual & community assets

Patients & residents

- ✓ Recognition that services talk to each other and problems get solved
- ✓ Equipped to stay well for longer & have more control
- ✓ Relevant and effective offers from professionals
- ✓ Clarity about steps to avoid illness & where to access help

Staff

- ✓ Work together to avoid handoffs and unnecessary red-tape
- ✓ More focus on multi-morbidity, complexity & wider determinants
- ✓ Can leverage a diverse range of assets to help address drivers of poor health outcomes – which may not be about medical care at all

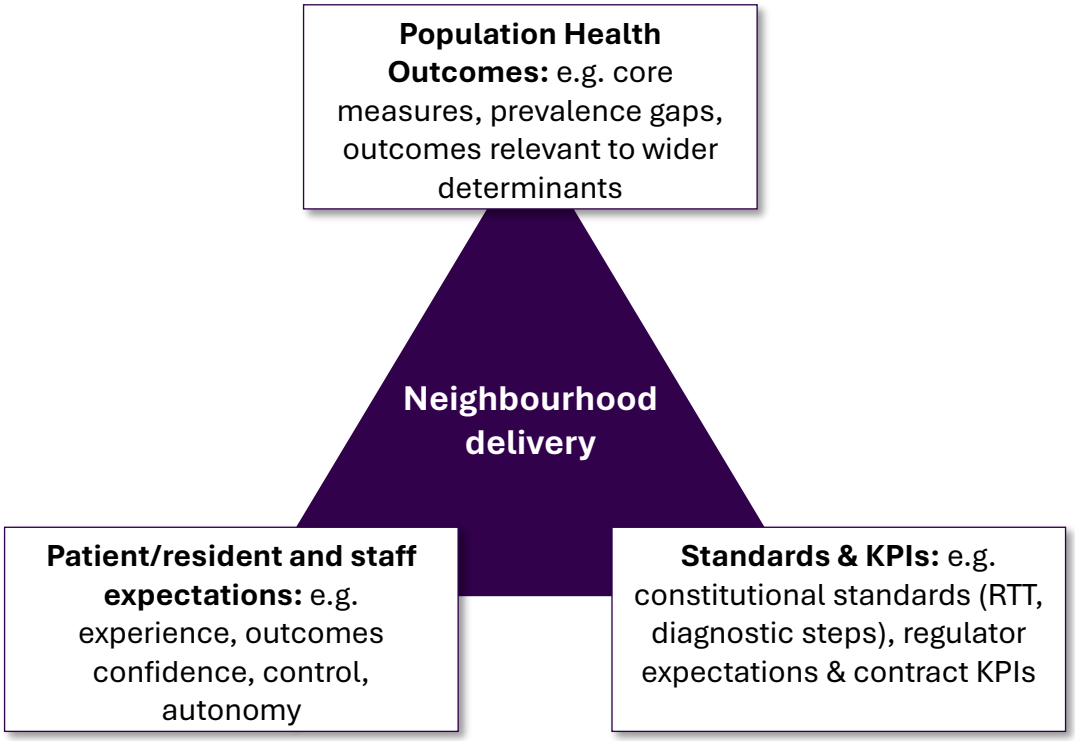
North Central London Health and Care
Integrated Care System

Impact

We believe neighbourhoods can help tackle three core sets of measures:

- Popultion health outcomes – the opportunity to deliver health & care differently and purposefully improve population health
- Standards – addressing core and statutory requirements to support operational needs and wider credibility
- Patient/resident and staff expectations – neighbourhoods will be rooted in communities, understanding or responding to their needs

Significant work is needed around benefits realisation including defining the range of potential benefits and impacts, monitoring and attribution.



North Central London Health and Care
Integrated Care System

Examples of work to date

Camden:
- Five established localities/neighbourhoods
- East INT team fully established in dedicated space at Kentish Town Health Centre supported by ICB
- Two years to land - council & CNWL formally consulted staff and moved into neighbourhood teams
- GP leadership & engagement
- Brings together housing and safety as well as health and social care
- Civic and community powered work a key feature
- Initial focus is alignment of existing caseloads but LTCs, older adults and tenants experiencing complexity are a priority
- Opportunities in the West and North being developed

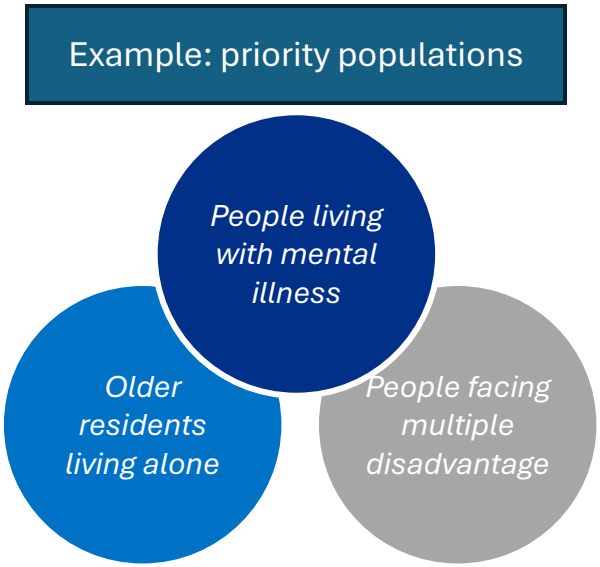
Islington:
-Three established localities/neighbourhoods
Whittington community staff aligned to locality
MDTs fortnightly on smaller footprints - general practice, social care, community matron, mental health, VCS navigator
Paediatric MDTs now set up
Council access hubs in each locality for early help and support
Nascent leadership teams keen to build clear roles and responsibilities

Haringey:
- Three established localities/neighbourhoods
- Social care, community mental health and community services (therapies and DNs) aligned to neighbourhood footprint
- GP leadership & engagement
- Online MDTs
- Council community hubs (e.g. *Northumberland Park Resource Centre)* for early help and support & NHS on drop-in basis
- Council Community Coordinators and GP Fed sponsored clinical leads but funding reducing
- Looking at how services can operate fully on neighbourhood footprint
- MACC team an exemplar early-stage INT – good practice being shared with London region drawing on evaluation of impact, and cited in Chris Witty's report on Cities and Health

North Central London Health and Care
Integrated Care System

Population cohorts

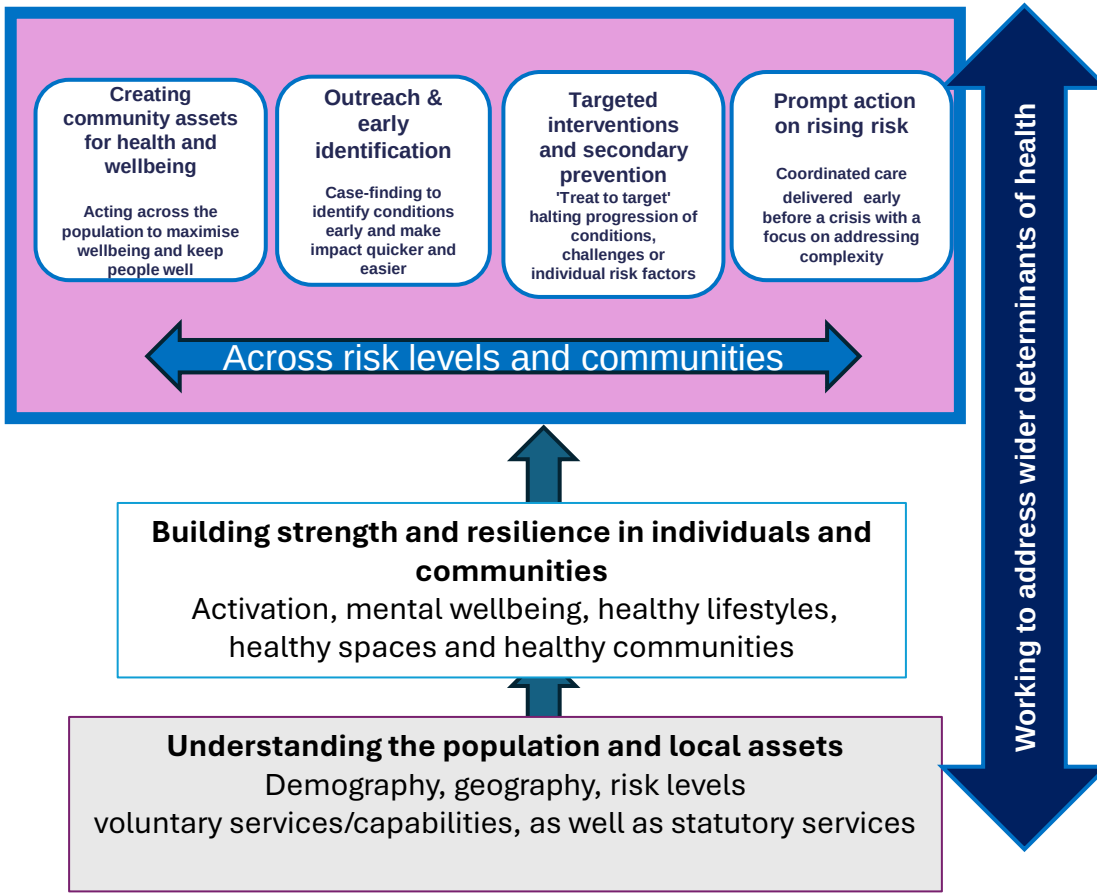
- The model should be **relevant to multiple population cohorts** and there is a clear link to the population segmentation work being discussed.
- **Each Borough Partnership has a view on its priorities**, informed by their understanding of the local population, gaps in outcomes and service pressures.
- We expect government to seek a **neighbourhood health offer 'for all'** – accelerating our integrated and proactive approach to **prevention** through each neighbourhood could provide such an offer. The impetus and levers for this will deepen again with future delegation to ICBs of specialised commissioning and Section 7a immunisation services.
- However, transformation at scale and pace benefits from some focus and consensus. We expect policy may point to those living with **multiple and complex long-term conditions** and have a very strong platform on which to build in NCL.



North Central London Health and Care
Integrated Care System

Key features

- The distinctive feature is the **purposeful and consistent connection between the context of people's lives and the support offered** to increase efficacy and achieve improved outcomes.
- The **link between statutory and voluntary services** is also fundamental. Voluntary services are the bridge to communities and offer hyper-local, trusted support for those most in need.
- This is a **person-centred and asset-based** approach to generate individual and community strength and resilience.
- Action is rooted in a more **sophisticated understanding of the population and drivers of variation in outcomes**. Population health data + qualitative insight + co-production.
- **Can be applied to a range of population groups and priority cohorts** and works meaningfully across the life course (Start, Live, Age Well).



North Central London Health and Care
Integrated Care System

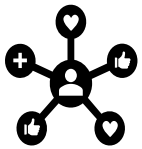
A day in the life...

Scoping the difference – how integrated neighbourhood teams are going to look and feel

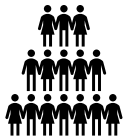
- ✓ **Ring-fenced time** to focus on prevention, early intervention and proactive care – weekly at minimum – to focus on the four pillars
- ✓ **Coordinated acute input** to reduce duplication and provide specialist input (e.g. geriatrician, LTC consultant)
- ✓ A **leadership team** made up of statutory services across housing, employment, public health, community care, primary care, and nominated VCS
- ✓ **Act as a place to problem solve**, unblock or take additional action
- ✓ **Able to connect with the Borough Partnership** to discuss gaps or strategic need
- ✓ **Links to local services** to coordinate action
- ✓ **Teams that know each other and know local resources**
- ✓ **Insightful integrated data** linked to each of the pillars which can be seen in aggregate to understand trends and at individual level to build targeted lists; risk stratified and segmented
- ✓ **Neighbourhood Manager** to facilitate and coordinate
- ✓ A growing **network of traditional sites moving toward becoming holistic, MECC-focused neighbourhood hubs focused on proactive care and early intervention**

Team features (*draft*)

Borough Partnership: owns the local implementation plan, priorities and outcomes. Oversees efficacy. Hosts the **'integrator function'** – accountable for development of the model, senior managerial/operational, technical support, analytics, estates planning, training, reporting. Shares learning and understands variation. Supports the community development effort. Key role in assessing VfM. Connections to innovate and optimise local assets



Integrated Neighbourhood Team (INT): core team of health, local government and VCS. Expect 80/20 rule to apply on offer and roles, e.g. expected membership from General Practice, Community Pharmacy, Adult Community, Mental Health, Social Care, Housing & Repairs, Public Health, VCS. Will link to wider NHS services (e.g. Specialist) and Local Government (e.g. economic development, early help, children and families). Works with more complex caseload and supports proactive outreach, prevention and earlier intervention. Patient/resident is a partner in their care.



Neighbourhood network of services & support: local care capacity & capability strengthened and aligned to the neighbourhood model as part of the 'left shift'. Includes teams from core services above. At least in short term will still deliver a large % of care episodes. Will interface with INT and be mobilised to support outreach, prevention, and earlier intervention via a population health approach.

System support (including role for provider alliances):

- Connects to policy
- Strategic commissioning for the neighbourhood model – aligning principles, pathways, incentives
- Learning from borough-level implementation
- Tackling key enablers once where possible (data sharing, data products, workforce planning, estates principles and plans, HR framework)
- Streamlining route into specialist support.
- Helps unblock key issues that can't be resolved by teams
- Coordinates formal decision making where system-wide
- Seeks income, assets & innovation to support the effort

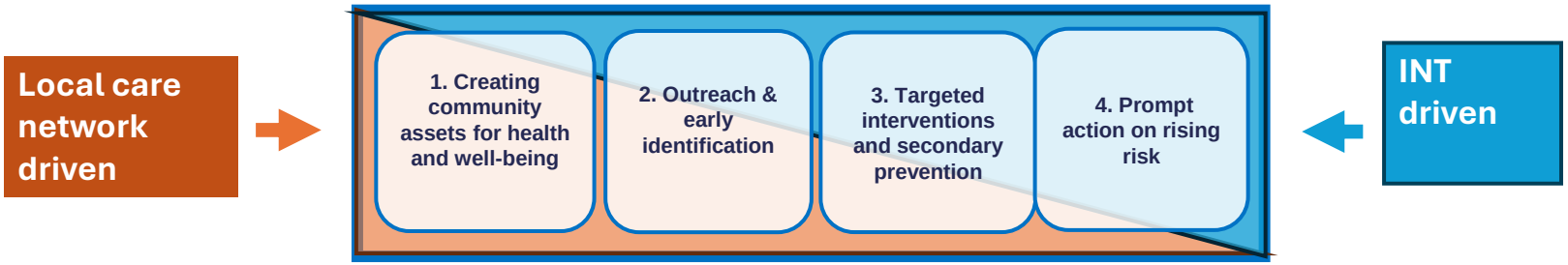
North Central London Health and Care
Integrated Care System

Neighbourhoods and INTs

Across the four pillars of proactive care, the INT will play a specific role within the wider neighbourhood's local care network (i.e. the statutory and voluntary services and partners that make up the neighbourhood), with greater input and leadership in pillars three and four.

At every point, person-centred and strengths-based approaches, patient activation, personalisation and holistic support are at the heart.

In **pillar one: creating community assets for health and well-being**, local government, VCS and Public Health leadership is strongest, creating the context for **thriving communities** and an improving context for health and wellbeing.
In **pillar two: outreach & early identification,** primary care drives case-finding, the local care network plays an increased role in closing prevalence gaps, underpinned by common data insight and coordinated by the INT leadership. Work with communities, supported by trusted VCS and others, to tailor the offer and outreach, reaching individuals and communities not engaged by existing offers.
In **pillar three: targeted Interventions,** the focus is on close working to ensure that all local resources are mobilised to support targeted work to close treatment gaps and provide early help. MECC strategies and coordination across the local care network is key.
In **pillar four: rising Risk,** INT leadership is most comprehensive, where the need for individual care coordination or case management is greatest. This could be to manage bio-psycho-social complexity, where multi-agency input is most needed to address rising risk or as part of the step-down from acute care where ongoing support for risk is needed. Coordinated primary, community and secondary care input is streamlined. There is a case-load and accountability needs to be clear and unambiguous.



North Central London Health and Care
Integrated Care System

Neighbourhood teams

Proactive and preventative care and support

- Building a picture of our existing caseloads and increasing the efficacy of our support
- Finding people before their needs deepen or intensify and/or those who are at rising risk
- Provide early support to get ahead of future needs
- Person-centred planning and support

Supports innovation in local care

- Creating space for teams to identify, plan for and respond to hyper-local needs
- Innovation in workforce and delivery models
- Person-centred, asset based & inclusive of VCS groups and patients/residents
- Shaping and adopting innovation (technology, new roles, alternate methods & modes of delivery)

Integrated delivery teams

- Comprising **primary care, community, mental health, local authority (social care and wider services), VCS, pharmacy**
- Majority of their time working together
- More integrated leadership and management capacity
- Support from Place and System to overcome the barriers to proactive and integrated working

Connects processes, tools and models of practice

- Brings caseloads together, reorganises the working week
- Risk stratification & care planning - optimising intervention and support offers
- Aligning around outcomes & standards
- Adopting a new approach to risk
- Sharing data and intelligence. Culture of continuous improvement and willingness to learn by doing

North Central London Health and Care
Integrated Care System

Workforce implications of neighbourhood working

Mobilising neighbourhoods across NCL implies profound change in the way that staff are employed, deployed, developed, and supported:

Supply

- Scoping/deploying new roles (e.g. Neighbourhood Manager, Health Coach, vaccinators, health and wellbeing workers)
- Supporting patients and residents to overcome health-related barriers to employment
- Integrated workforce planning between INT partners (coordinated at 'place')
- Promoting opportunities to work across statutory, non-clinical and voluntary roles

Development

- Supporting new roles
- New learning & development packages – embedding skills to lead/work in partnership
- Joint development pathways within INTs (including rotations)
- Testing whether INTs foster joy at work by providing a collaborative and creative environment - tracking staff experience on this

Transformation

- Joint workforce planning and oversight across partners – data, modelling
- Creating 'team of teams' culture through new INT 'rhythms & rituals'
- Developing new models of practice through population health data and tools
- Fostering innovation in ways of working/models of care through dedicating staff time

North Central London Health and Care
Integrated Care System

Where are we now in Haringey?

Some activity mapped against the four pillars

Creating community assets for health and well-being Acting across the population to maximise wellbeing and keep people well	Outreach & early identification Case-finding to identify conditions early and make impact quicker and easier	Targeted interventions and secondary prevention Halting progression of conditions, challenges or individual risk factors	Prompt action on rising risk Coordinated care delivered early before a crisis with a focus on addressing complexity
• VCS grassroots projects • Parks and leisure • Culture and arts • Public health programmes • Anchor institutes • Public realm and regeneration • Community centres (NRC) • Welfare and related advice	• GP's LTC model with case-finding • Health-checks • Community outreach from NHS/VCS partnerships • Schools in-reach and health visiting • Haringey Health Champions • 4 x Family Hubs • Data-led identification of financial strain • Responding to rent arrears	• GP's LTC model with care plans • Community NHS team delivery • Social care services to sustain independence • Housing related support and advice sector	• MACC team – INT exemplar • GP teleconference • Multi-agency solutions forum (LBH) • Rapid Response team • Roger Sylvester Centre • MASH hub and adult safeguarding • Incident response arrangements

North Central London Health and Care
Integrated Care System

Question for HWBB

How can we utilise the neighbourhoods' agenda to impact positively on health and wellbeing in Haringey?