The Neighbourhood model in North Central London

System management board

January 2025

Context

North Central London
Health and Care
Integrated Care System

Neighbourhoods are the third pillar of our ICS. Reinforced by Fuller, Darzi & the 3 shifts and Govt 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 supporting 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'; outcomes are a struggle & inequalities persist.

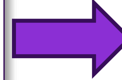
Major reform delivered largely via existing resources needs shared focus, appetite and widespread sponsorship.

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.

The change sought

System

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

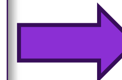


System

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

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
- Can lack of trust and confidence in offers made.

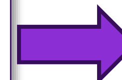


Patients and residents

- ✓ Recognise that services talk to each other. Problems get solved
- ✓ Are equipped to stay well for longer & have more control
- ✓ Offers from professionals are more relevant and effective
- ✓ Are clear about steps to avoid illness & where to access help

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



Staff

- ✓ Work together to avoid handoffs and unnecessary red-tape.
- ✓ More focus on multimorbidity, 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

NCL has strong foundations

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There is growing consensus around **3 key focus areas for Neighbourhoods**: **targeted prevention, proactive care for chronic and complex needs, fostering strength and resilience in individuals & communities.** In NCL:

- The Population Health Strategy & Outcomes provide 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 (PCNs) 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 govt.

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 Team (INT) build on 'MDTs' and include NHS providers, Council teams and the VCSE. Specialists support. Patients and residents are a key partner.
- Borough Partnership work to date suggests at least **18 Neighbourhoods in NCL** with populations of 60,000 – 130,000.
- We would expect each to have:
  - ✓ **Leadership and management capacity** to support caseloads, systems and processes, training & development (an '*integrator function* as per recent London work), accountability
  - ✓ **Shared infrastructure** (IT, co-location where possible but flexi space & networked models where necessary, population health data)
  - ✓ **Wider delivery capacity** (including high street services)
  - ✓ **Strong relationships with local communities and the VSCE –** stability for VCSE partners, expertise in person-centred care and strengths based approaches

18 NCL Neighbourhoods identified by Borough Partnerships

Examples of work to date

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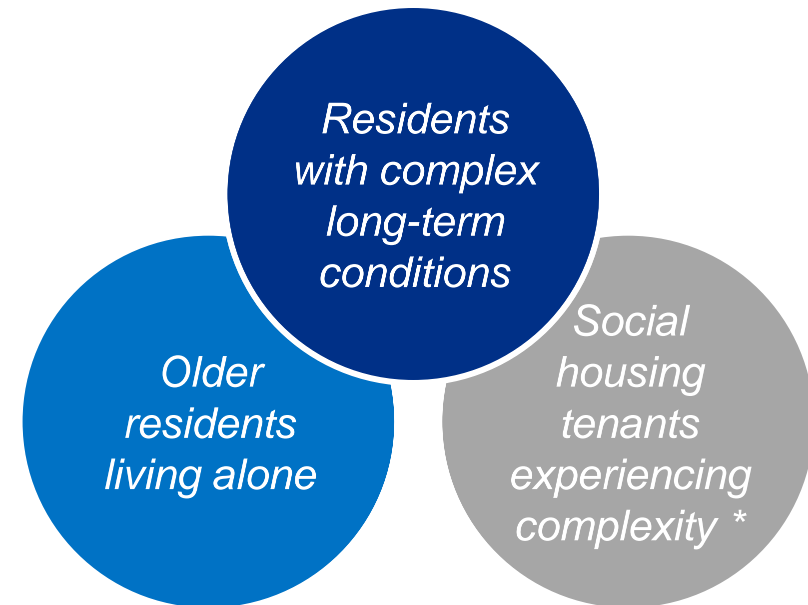
Camden: 5 established localities/neighbourhoods. East INT team fully established in dedicated space at Kentish Town Health Centre supported by ICB. Learning from Mchst. 2 years to land - Council & CNWL formally consulted staff and moved into Neighbourhood teams. GP leadership & engagement. Brings together 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.

Haringey: 3 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 eg *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 lost. Looking at how services can operate fully on neighbourhood footprint.

Islington: 3 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

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 Govt 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 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.



Note: ** Encompassing the intersection of mental health issues, drug use, domestic abuse)*

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 **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 + coproduction.
- **Can be applied to a range of population groups and priority cohorts** and works meaningfully across the life course (Start, Live, Age Well)

Creating community assets for health and well-being
Acting across the population to maximise well-being and keep people well

Outreach & early identification
Case-finding to identify conditions early and make impact quicker and easier

Targeted Interventions and Secondary Prevention
'Treat to Target' 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

Across risk levels and communities

Building strength and resilience in individuals and communities
activation, mental well-being, healthy lifestyles, healthy spaces and healthy communities

Understanding the population and local assets
Demography, geography, risk levels
voluntary services/capabilities, as well as statutory services

Working to address wider determinants of health

A day in the life…

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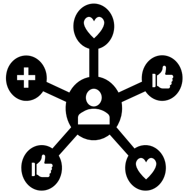
Scoping the difference – how integrated neighbourhood teams are going to look and feel

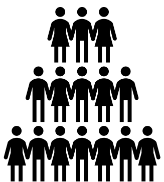
- ✓ **Ring-fenced time** to focus on prevention, early intervention and proactive care – weekly at minimum – to focus on the four pillars
- ✓ **Coordinated acute input** to reduce duplication and provide specialist input (eg geriatrician, LTC consultant)
- ✓ A **leadership team** made up of statutory services across housing, employment, public health, community care, primary care, and nominated VCSE
- ✓ **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-focussed neighbourhood hubs focussed 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 govt 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 Govt (e.g. economic development, early help, childrens and families). Works with more complex caseload and supports proactive outreach, prevention and earlier intervention. Patient / resident is a partner in their care.

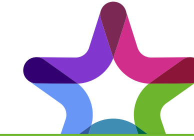


Neighbourhood network of services & support: local care capacity & capability strengthened and aligned to the neighbourhood model as part of the 'left shift'. Includes teams from core services above. At least in short term will still deliver a large % of care episodes. Will interface with INT and be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

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 VCSE 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), VCSE, 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

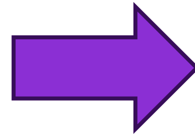
Connects processes, tools and models of practice

- 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

NCL opportunities to scale: Proactive care for Complex + LTC population

A neighbourhood approach will help because…

- **Population:** 20% of people have at least 1 LTC. 2/3rds have more than 1. Cost of care is significant. Numbers are rising rapidly – up 20% since the pandemic.
- **Cost:** 70% of NHS activity and spend is linked to long-term conditions
- **Relevant to all** – LTCs drive cost and frailty, they can be managed, they require individual action and personalised care, interdependency with mental health is significant, as is relationship with wider determinants of health (incl employment).
- **VCS & community groups are vital** to build trust, reach and engage key groups, narrow inequalities, support people to take control & stay well
- **Addressing variation** using population health data and working hyper-locally is effective
- **Rising risk needs local coordination and a multi-agency approach** to prevent admission
- **Coordinated proactive care** can improve outcomes and reduce hospitalisations



We already have or are building these fundamentals:

- ✓ Proactive LTC model being embedded in general practice via LTC LCS
- ✓ Provider Collaborative Complex Long Term Health Service and hyper-local Spirometry model
- ✓ Longer Lives - focus on the physical health of people with serious mental illness
- ✓ Community core offers – standards and investment
- ✓ Developing diagnostic infrastructure in the community
- ✓ Multiple examples in each borough of MDT, multi-agency models for LTCs (eg MACCs in Haringey)
- ✓ Growing role for Pharmacy and AHPs
- ✓ Social prescribing delivered with the voluntary sector
- ✓ Population health intelligence - risk stratification & tools to identify rising risk
- ✓ Outcomes data to highlight variation and inequalities
- ✓ Differential investment models at Practice / PCN weighting for inequalities providing resources to address variation in LTC outcomes

NCL opportunities to scale: Insights and tools to build on

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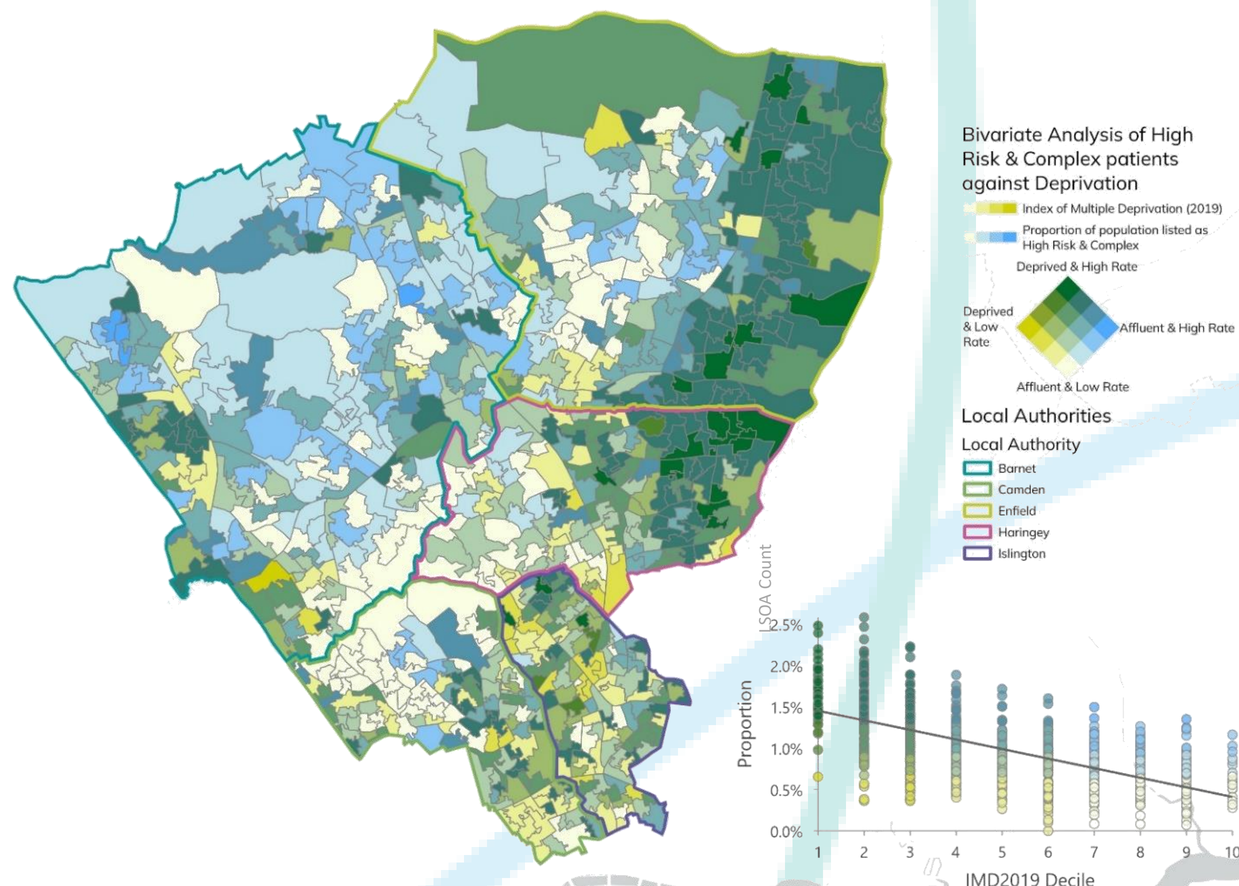
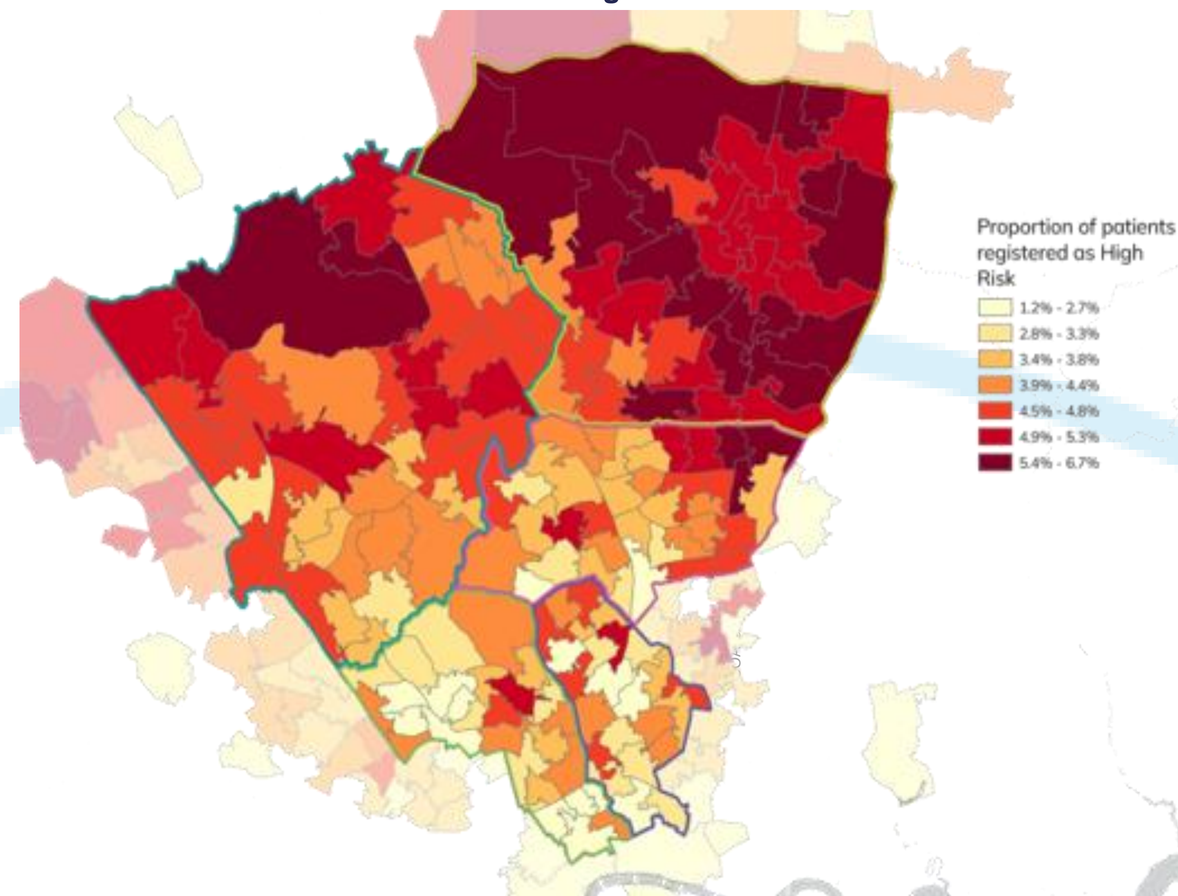
Our single data infrastructure lends itself to consistency of data definition, segmentation and shared clinical and planning tools. We can generate insight into the relationship between health and wider determinants, inform our understanding of risk and interventions that can positively impact outcomes. Neighbourhood data will be key. Work by partners to date means there is a particular opportunity to address people who are complex with multiple LTCs bouncing between multiple providers and specialties.

High Risk & Complex vs Deprivation



Rising Risk



NCL opportunities to scale: Insights and tools to build on

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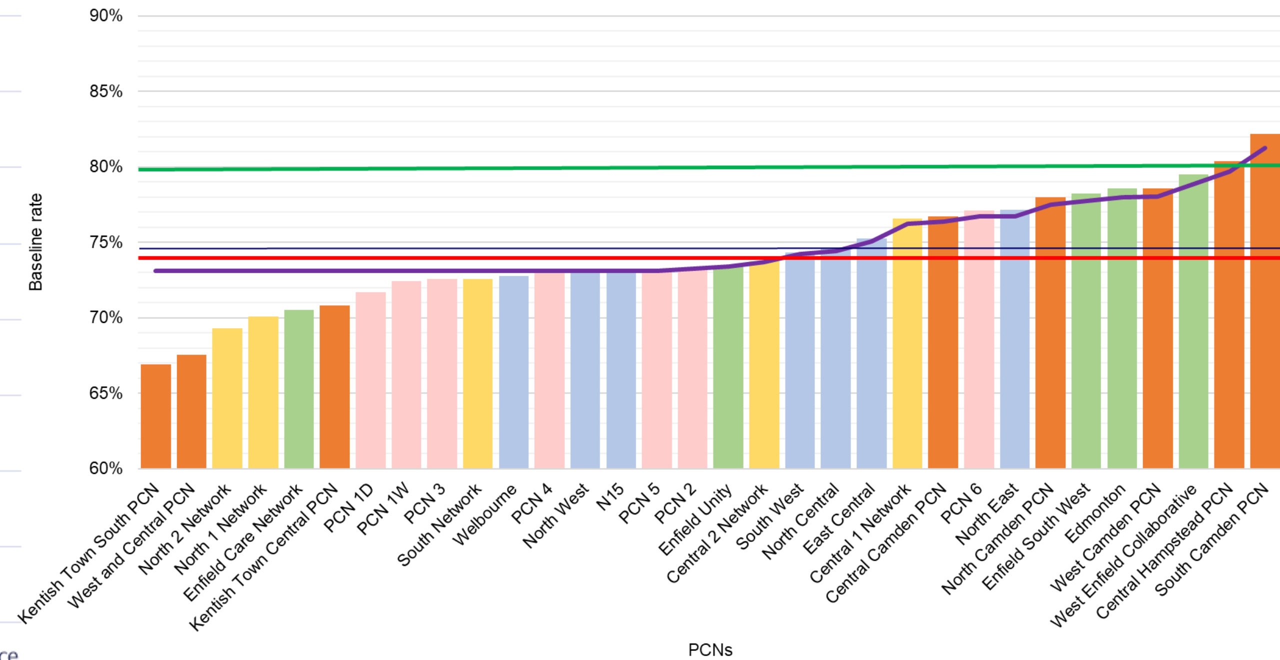
Early Diagnosis

Identify health conditions early and make treatment quicker and easier

Public Health spearheading work on detection

Secondary Prevention



'Treat to Target' - halting progression of conditions or individual risk factors

General Practice focus on proactive, personalised care and reducing variation in outcomes

Impact

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

- Pop 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

Pop Health Outcomes: e.g. core measures, prevalence gaps, outcomes relevant to wider determinants

Neighbourhood delivery

Patient / Resident and Staff expectations: e.g. experience, outcomes confidence, control, autonomy

Standards & KPIs: e.g. constitutional standards (RTT, diagnostic steps), regulator expectations & contract KPIs

Pillars of a plan for Neighbourhoods

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1. **Outcomes & metrics:** outcomes drawn from pop health outcomes fmwk, key standards & metrics and experiential measures and a way to track
2. **Care model:** what our ICS looks like at the Neighbourhood level, care model & offer (NHS, Local Govt, VCS and others), staffing and resourcing, ways of working, scope for tailoring (assuming 80/20 rule applies), relationship to London & National priorities
3. **'Business Case':** the overall 'case' for this, modelled in the NCL context & linked to the Medium Term Financial Strategy (e.g. potential benefits, resource alignment, financial model, risks, phasing and key choices)
4. **Infrastructure solutions:** system-wide approaches population segmentation, risk stratification, data for neighbourhood working (e.g. dashboards), digital delivery, IG, IT, estates solutions and 'masterplans', workforce flexibilities & development, flexible budgets
5. **System Operating model:** relationship to Provider Alliance, implications for Borough Partnerships, implications for role of Place, strategic commissioning role

Phases of delivery (draft)

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Current focus

1. Scoping the change

- Describing vision, purpose & tangible outcomes
- Info requirement- the 'case' needed to move forward
- System-level (re)commitment
- Consensus building (system and local) clinical, professional, executive
- Aligning system and partner plans ('masterplanning')
- Mobilising for change

Note: to influence & take account of National & Regional plans for Neighbourhood development *e.g.* 10-year plan, National policy on Neighbourhoods & Place, Planning Guidance, London case for change and target operating model

2. Refining and agreeing our plan

- Detailed work up of outputs under each pillars
- Borough 'gap analysis' to inform resourcing and delivery plans
- Detailed case & testing viability
- Directing capacity at key enablers
- Workforce – planning, offer, engagement

3. Leading the change

- Formal commitment to model (system & organisation)
- Aligning resources and incentives
- Overseeing and proactively supporting delivery
- Unblocking operations
- Enabling and rewarding success

4. Building continuous improvement

- Evaluating and learning from operating neighbourhoods
- Reviewing progress against outcomes

Next steps

1. Continue to influence national policy ahead of the 10-year plan and inform the London 'case for change' and 'operating model'.
2. Refine the vision and plan for NCL through engagement across the ICS and within each Borough, working closely with Local Govt partners.
3. How - working up '*how*' this works in practice, plans for each key pillar of the programme and the transition plan (in Borough and overall)
4. Strengthen approach to benefits and flesh out the business case – value, feasibility, resource implications and opportunity to align existing assets - to support more formal sign up
5. Identify where system sponsorship could help us accelerate and succeed and key implications for each sector to inform decision making
6. Operating model and governance - clarify the role of Place/Borough Partnerships and of the Provider Alliance, shape the governance approach needed to deliver this scale and type of system transformation

Discussion

1. Does this help us form a shared view of what we mean by a ‘Neighbourhood’ in NCL? What is missing?
2. How might Neighbourhood development impact existing priorities and plans in NCL? What are the key interdependencies?
3. What questions need to be answered as a priority to push this plan to the next level?
4. What role do different forums (borough partnerships, ICP etc.) play in supporting the development and implementation of neighbourhood model? What role should they play?