DRAFT

North East London Health & Care Partnership

NHS
North East London

# A NEL model for integrated neighbourhood working

# NEL Vision for integrated neighbourhood working

## Everyone in north east London lives in a neighbourhood which supports and actively contributes to their physical and mental health and wellbeing

As partners across the system we will work closely together in local neighbourhoods. This means **creating an environment in which a range of assets, facilities and services are available to enable local people to start, live and age well and healthily.**

### Our Vision

**Based in and for local geographic communities**

**Coordinated and joined up**

**Strengths based – building on the assets of the individual, family and the local community**

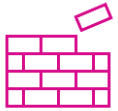
**A culture of prevention in all interactions**

**Use the hyper local footprint to address local need**

**Targeting and seeking to reduce health inequalities**

### Our Approach

**Use data to target our resources on those in most need**



**Build on existing integration work**

**Co-produce with communities**

**Recognise that this is a cultural change that will require new ways of working**

# This vision can be summarised into four strategic goals and desired outputs

| Goal | Desired outputs |
| --- | --- |
| Work with and for local communities | 1. Care delivery in a community settings wherever possible<br>2. Enable individuals and families to take greater agency over their health and wellbeing<br>3. Work effectively with local communities to co-produce solutions to the health and wellbeing issues which matter to them<br>4. Work in a strengths-based approach to build capacity in individuals, families and communities, enabling resilience<br>5. Leverage local assets, including community networks and partners, to support holistic wellbeing |
| Work in a proactive, preventative way to address rising need | 1. Use data to identify and target resources for individuals and groups at the highest risk of health decline / deterioration<br>2. Prioritise early intervention, preventative and proactive care to address health needs before they escalate |
| Deliver integrated, accessible care | 1. Neighbourhood to provide timely and coordinated interventions<br>2. Promote continuity of care for individuals with long term or complex needs<br>3. More targeted support for families and the highest users of services<br>4. Deliver care aligned with the Good Care Framework, ensuring services are trustworthy, accessible, competent and person centred |
| Support service sustainability | 1. Consider aligned financial incentives to support the quality and financial sustainability of core services ensuring the most effective role for general practice at the heart of neighbourhood services<br>2. Address current and future workforce pressures through workforce and care pathway transformation |

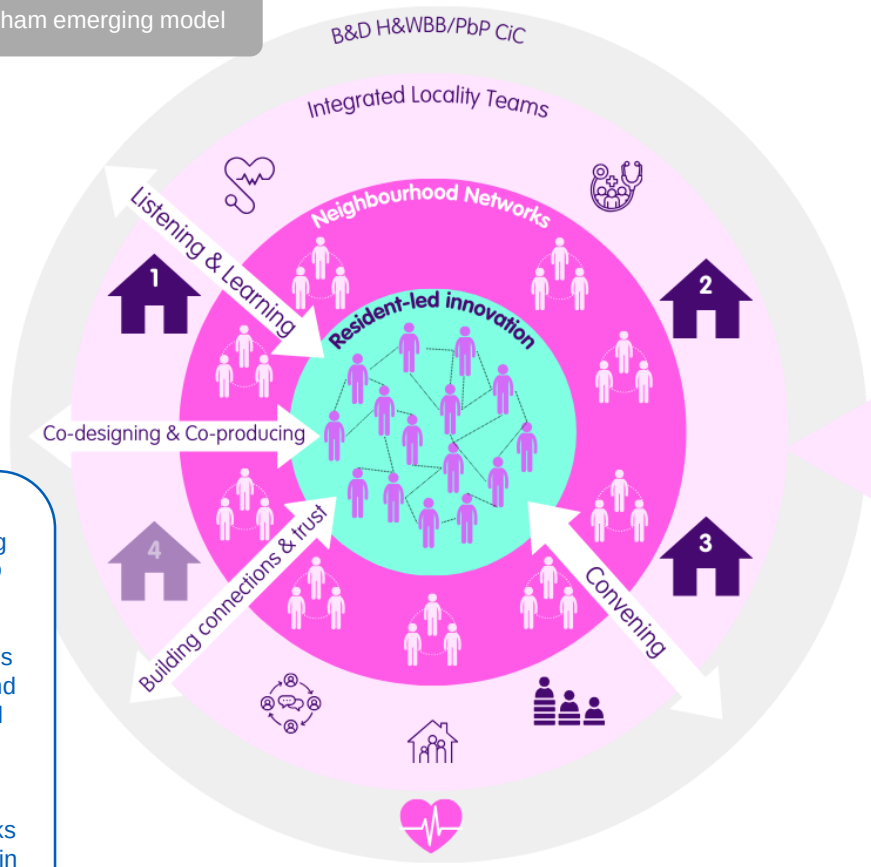
Developing teams

# This is a whole population model, with residents and communities at its heart.

We will use the neighbourhood footprint to bring together existing staff into integrated teams that support different population cohorts and draw on different local resources and assets.  These teams will be co-produced with and connected to their communities and take a population health approach

The following slides show how this is developing in two of our places:

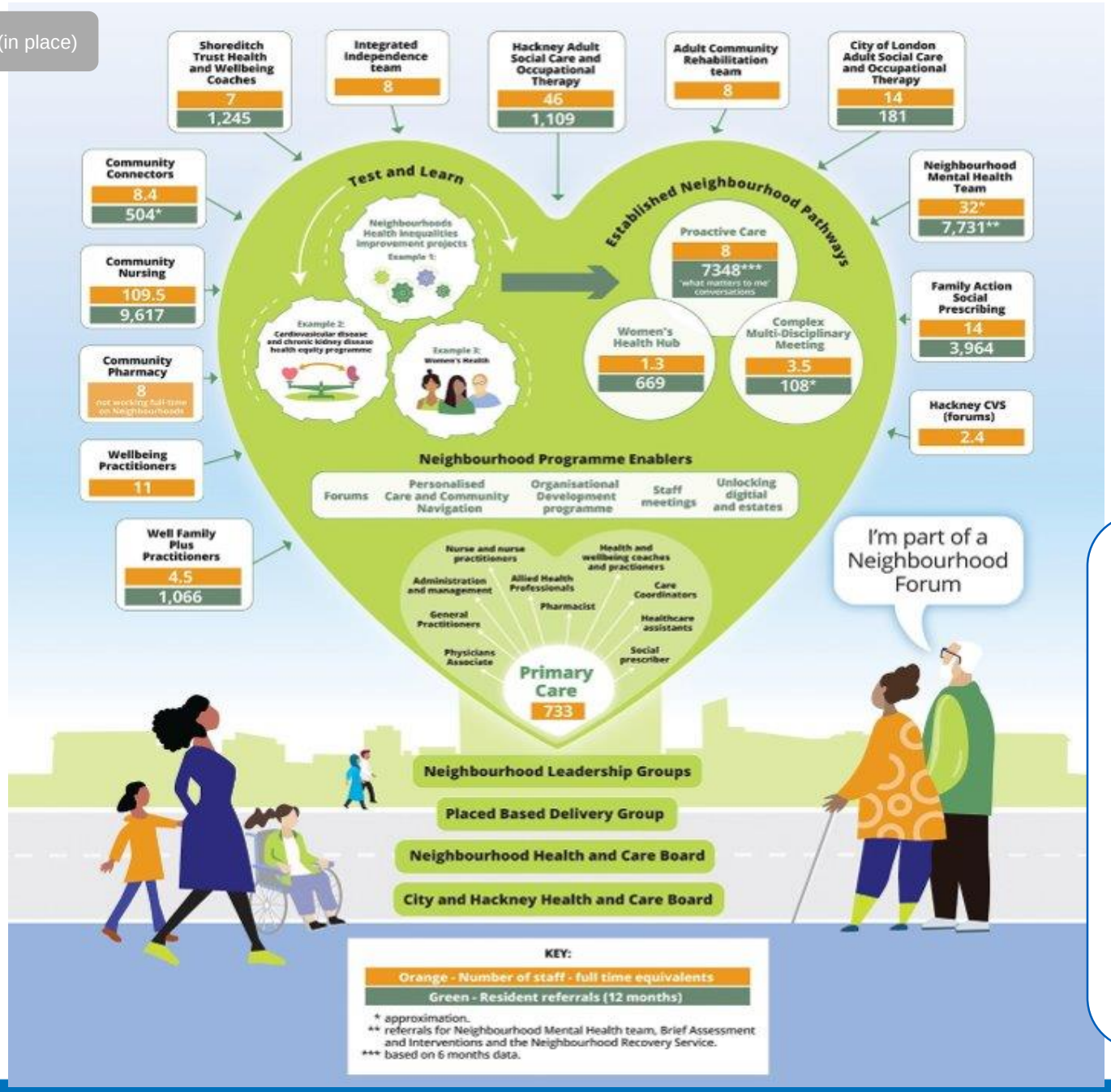
The Barking and Dagenham emerging model





This model is still being developed by the B&D team.
The proposal is that Integrated locality teams bring together health and care professionals and community groups to support specific populations
Neighbourhood networks bring together the VCS in each neighbourhood.

Neighbourhoods in City and Hackney (in place)




Many community and primary care services in City and Hackney are organised around the eight neighbourhoods across the place. The info-graphic shows the number of staff currently working in neighbourhoods and the existing neighbourhood pathways (or teams) that have been developed.

The neighbourhood forums bring together residents, VCS and staff to identify priorities and address local health inequalities

Developing a core team

# Each neighbourhood will implement a core team coordinating care for high intensity users with rising needs – the team will be strongly rooted in its neighbourhood, will be well connected to local communities and community assets and will take a population health approach.

## A core team coming together in each neighbourhood

They include:

- Primary care
- Community nursing
- Community therapies
- Community mental health
- Social care
- Community navigators
- Wider partners defined by each neighbourhood to meet local needs
- Encompass or may work closely with teams delivering proactive care

Deliver more joined up care for the most complex people*

*this is an ask of the operating plan

Take a preventative, holistic approach, connecting people to community assets

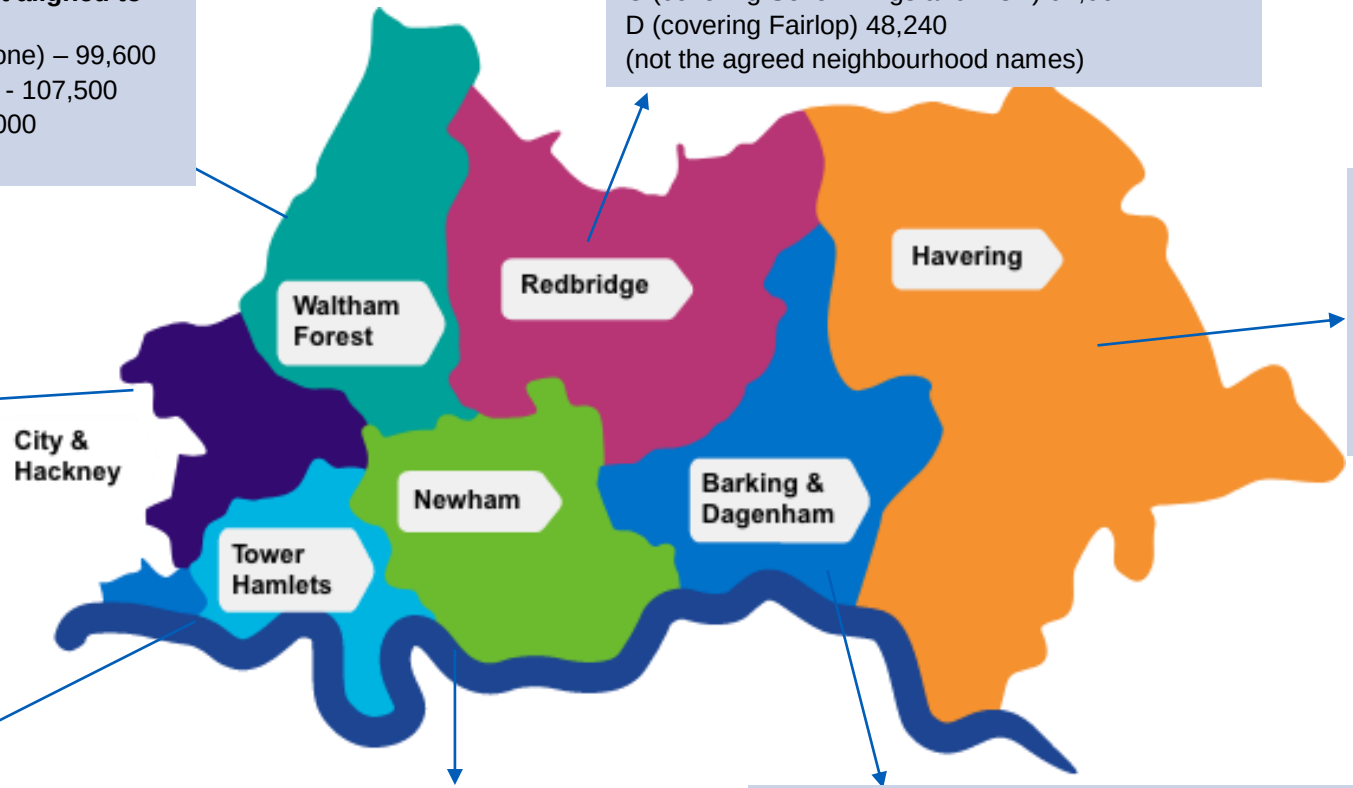
Support High Intensity Users*

Reduce pressure on other (e.g. urgent, acute, primary, social care) services*

# Most places have now agreed their neighbourhood boundaries

**4 neighbourhoods, each covers 2 PCNs**
A (covering Woodford and Wanstead) – 85,142
B (covering Cranbrook and Loxford) – 140,192
C (covering Seven Kings and NCA) 92,067
D (covering Fairlop) 48,240
(not the agreed neighbourhood names)

**3 neighbourhoods, not aligned to PCNs**
South (Leyton/Leytonstone) – 99,600
Central (Walthamstow) - 107,500
North (Chingford) – 72,000




***Still to be agreed***
**5 neighbourhoods, co-terminus with PCNs**
Liberty – 50,592
North – 91,435
Marshalls – 47,638
Crest -40,082
South – 64,627

**8 neighbourhoods, co-terminus with PCNs**
Springfield Park – 31,923
Woodberry Wetlands – 25,821
Shoreditch Park and City – 55,904
Hackney Marshes – 40,745
Clissold Park – 35,922
Well St Common- 33,245
London Fields - 38,835
Hackney Downs - 36,217

**4 neighbourhoods, each covers 2 PCNs**
- North East – 83,420
- North West – 70,261
- South East – 97,202
- South west - 74,906

**4 neighbourhoods, not aligned to PCNs**
- Plaistow – 42,472
- Forest Gate – 44,069
- Beckton and Royal Docks – 45,860
- East Ham – 62,262
- Manor Park – 62,576
- Stratford and West Ham – 64,593
- Custom House and Canning Town – 65,791
- Green Street – 68,942

**4 neighbourhoods, not aligned to PCNs**
North – 58,900
South – 54,200
East – 68,800
West 84,00
These each support and work with 10 VCS led Community Networks

# NEL Roadmap for 2025/26 delivery of neighbourhoods

**Q1**

- System and places to commit to the neighbourhood vision, strategy and goals
- Each place-based partnership to convene a neighbourhood delivery programme
- System-wide enabling structures mobilised, with strong links to pan-London enablers
- Neighbourhood boundaries defined by all places and agreed at system level

**Q2**

- Population health management platform (Optum) providing neighbourhood data
- Key make-up and functions of the integrated neighbourhood teams for adults and BCYP agreed by each place. To include: population cohort it will serve initially; membership of the team; model of care

**Q3**

- OD initiatives start– initially focusing on building relationships across the neighbourhood
- Early testing of the neighbourhood team model – taking a co-production approach
- Evaluation methodology and expected impact from the team agreed

**Q4**

- Implementation of integrated neighbourhood team– using a test and learn approach, so they will adapt over time
- Plans for Y2 developed, to focus on community connections, prevention and health inequalities

In year one we will focus on implementing the core integrated neighbourhood team for both adults and children, enabled by a PHM approach

In line with the approach across London, we will also work with partners in each Place to agree the optimal model for delivery of the Integrator functions, see following slide, which the ICB will commission

# Integrator role – requirements and next steps

**The role will be vital to the delivery of neighbourhood working, it will:**

- Host and facilitate the design and implementation of the team
- Bridge the fragmentation across existing teams
- Deliver key enabling infrastructure
- Support and enable a population health management approach
- Over time, the role may take on the place partnership functions as set out in the model ICB blueprint

**In order to fulfil this role the integrator must:**

- Have well established relationships across the partnership, and be represented within the place based partnership governance and geography
- Deliver services that will become part of the neighbourhood team or have a strong interaction with the neighbourhood team
- Have sufficient scale to deliver the enabling functions, including significant corporate infrastructure
- Have credibility and maturity as a service provider in the place
- Be present in and able to work across the geographical footprints of the neighbourhood teams across the place
- Have visible commitment to the neighbourhoods vision and ways of working

**How we will agree the integrator:**

- ICB will work with partners in each Place to understand local capability and identify which models work best
- The ICB will commission one integrator in each place, though the model may require work with other partners in delivering the role, either through formal or informal arrangements.
- Not setting a deadline for how this will be agreed at this point; Places need time to work through different models.
- Working with Places to enable the discussions to start before the summer break