PROVIDER COLLABORATION

Welcome to today's event:

Learning from provider collaboratives for effective integration with Neighbourhood and Place

NHS Providers

Agenda

Welcome and introductions
Facilitated by chair, Jenny Reindorp – Director of Development and Engagement, NHS Providers

Case study 1: North Central London Health Alliance
Kate Petts, Managing Director, North Central London Health Alliance
Sally Lydamore, Head of Camden Integrated Community Health Services (CICH)

Case study 2: Our Dorset
Nick Johnson, Joint Chief Strategy, Transformation and Partnership Officer of Dorset Healthcare and Dorset County Hospital NHS Foundation Trust (DCH)

Interactive Q&A
Facilitated by the chair

Housekeeping

- Please note, this event is being recorded
- Please keep your camera on wherever possible
- If you lose connection, please re-join using the link in your joining instructions or email provider.collaboration@nhsproviders.org
- Please ensure your microphone is muted during presentations to minimise background noise
- We will come to questions after each speaker
- Please feel free to use the chat box for questions and sharing examples of what has delivered sustained progress in your organisation
- If you would like to ask a question audibly, please use the raise hand function during the Q&A section and we will bring you in
- Any unanswered questions will be taken away and answered after the event
- You will receive a link to an evaluation form after today's event. Please take the time to complete it, we really do appreciate your feedback.

North Central London Health Alliance Neighbourhoods

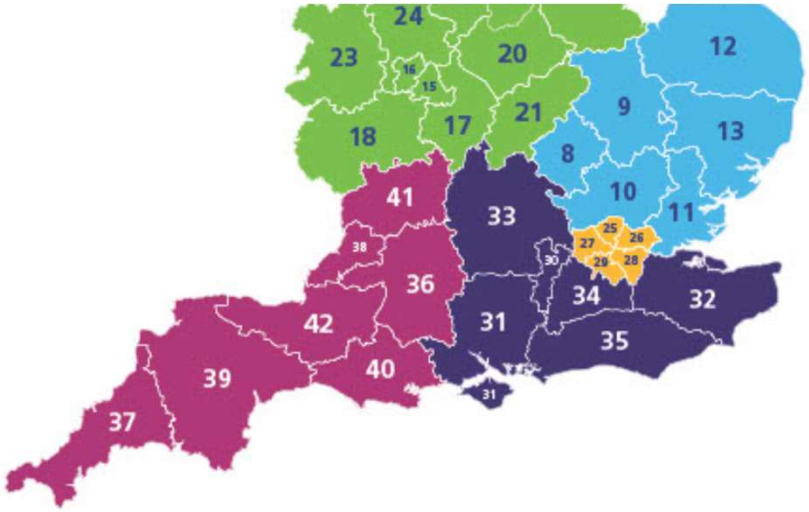
March 25

UCLPartners
Health Innovation

Who are our population?

- North Central London has

- 1.8m residents
- 5 boroughs (Places) stretching from Tottenham Court Road to M25.
- Second most deprived ICS in London
- Relatively young population
- More than 1 in 5 people in NCL live in the 20% most deprived areas nationally, while almost 1 in 3 live in the second most deprived areas
- High level of population health needs and inequalities
- Ethnically diverse - around 20% are of an Asian ethnicity and 20% a Black ethnicity
- There is nearly 20 years' difference in life expectancy between most and least affluent areas of NCL



UCLPartners
Health Innovation

NCL Health Alliance –provider collaborative
Our members and partners

3 Acute Trusts:

- Royal Free London NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- Whittington Health NHS Trust

3 Specialist Trusts:

- Great Ormond Street Hospital for Children NHS Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust

2 Mental Health Trusts:

- North London NHS Foundation Trust
- The Tavistock and Portman NHS Foundation Trust

2 Community Trusts:

- Central London Community Healthcare NHS Trust
- Central and North West London NHS Foundation Trust

1 Primary care member:

NCL GP Provider Alliance

Integrated care system

North Central London Integrated Care System

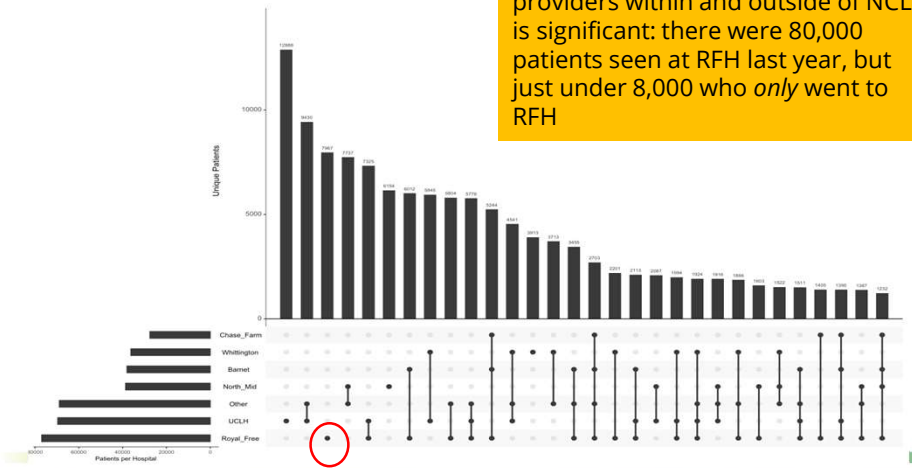
UCLPartners Health Innovation

Case for change

Life expectancy is **10-15 years** earlier for patients with LTC in a deprived community

"There are 52 weeks, and I had 68 appointments. It just got to the point where it was easier to give up work"

The overlap in patients with multiple appointments across different providers within and outside of NCL is significant: there were 80,000 patients seen at RFH last year, but just under 8,000 who *only* went to RFH



NCL data

- Since the start of the pandemic there has been a **21% increase** in people with 3 or more LTCs
- NCL Population is forecast to grow by **1% by 2030**
- The LTC cohort is forecast to increase by **8% (24,259 people)** in the same time period
- People with long term conditions (LTCs) account for around **half** of all GP appointments, **two-thirds** of outpatient appointments and **70%** of hospital bed days.

UCLPartners Health Innovation

Collaborative working

- We set out to develop a collaborative test and learn approach to improving the healthcare and healthcare utilisation of LTC patients
- Secured **executive sponsorship** – CEOs and ICB executives (including Exec Director for Place)
- Clinical leadership – integrated consultants, primary care leaders, mental health consultants
- **Data driven** approach – helping us to understand our population – including
  - Deep dive into population health data
  - Healthcare utilisation data
  - Service mapping
- **In person** workshops
  - Getting to know each other
  - Developing and refining the approach – clinical (primary, secondary, community, mental health), operational leads, ICB leads
  - Live experienced group
- **Steering group**
  - Executive and operational leadership from providers
  - **System clinical leadership**
  - ICB leadership

UCLPartners
Health Innovation

Building the teams

PCN GP and Royal Free (Barnet) Consultant

PCN GP and Royal Free (NMUH) Consultant

PCN GP and Whittington Health Consultant

PCN GP and Royal Free Consultant

PCN GP and UCLH Consultant

Admin Coordinator

Clinical & Admin roles

Clinical Coordinator

Acute specialist consultants

Mental Health and Community Teams

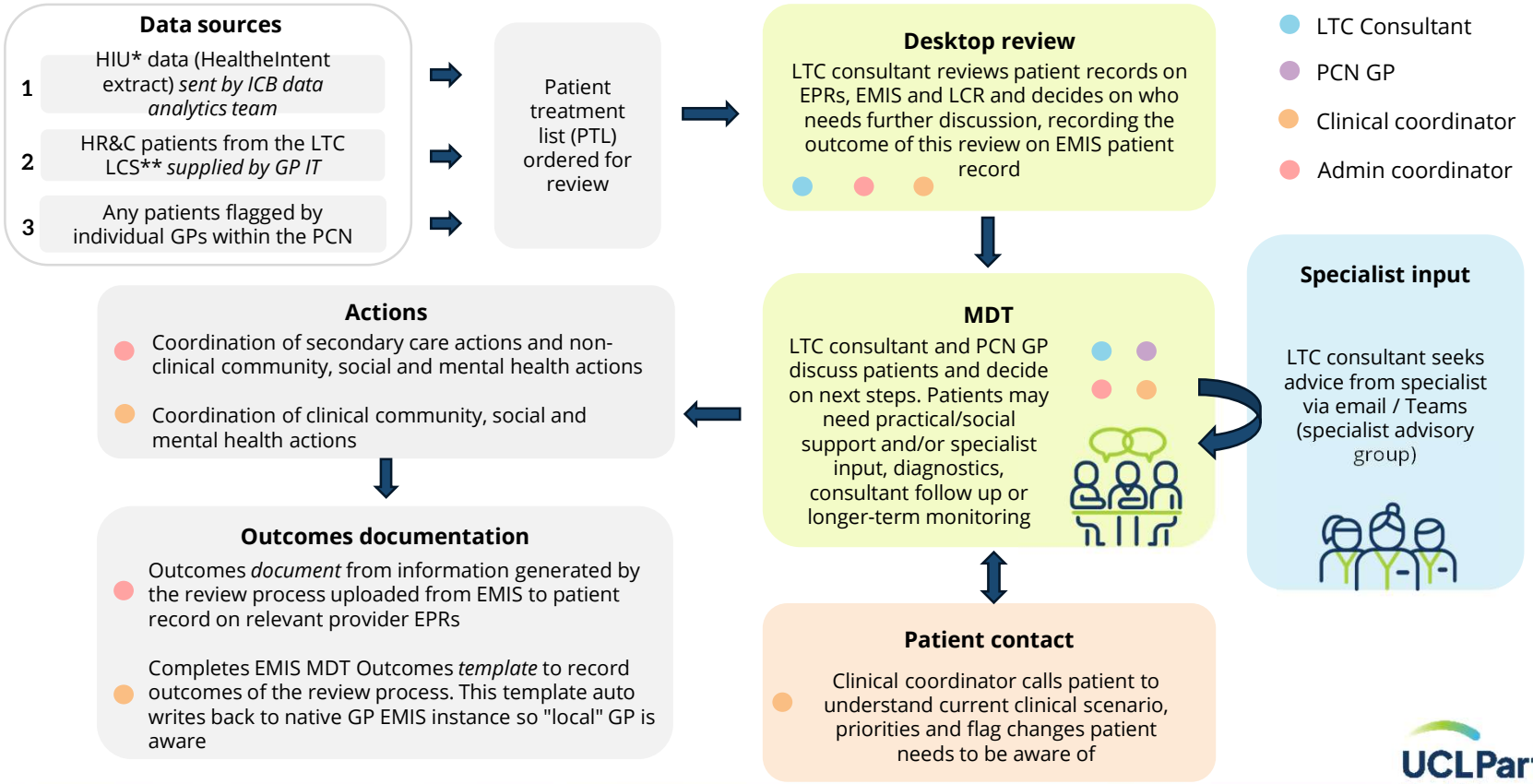
Borough based services
Wider PCN team, VCSE and social care,

Operational teams within Trusts

UCLPartners
Health Innovation

Clinical Model January 2025

*ICB-held data analysis of high utilisation of secondary care resources across NCL
** Long Term Conditions Locally Commissioned Service Risk Stratification



UCLPartners Health Innovation

The challenges

- ***Digital access***
  - Our clinical model relies on all clinicians being able to Iee the full details of all the patient records
  - London Care Record only shows summary care information from some providers
  - Each clinician and co-ordinator has access to every EPR **– 32 data sharing agreements**
- ***Data –*** Healtheintent vs LTC LCS data
- ***Developing new risk stratification***
  - Developing a robust case finding methodology linked to risk stratification – including opportunity to test an AI approach
- ***Workforce portability and capacity***
  - Each staff member needs several honorary contracts as existing portability agreements do not support this type of working
  - Releasing staff to work in a different way with continuing organisational pressures
- ***Variation in delivery model***
  - Each PCN has a different approach to delivery and leadership
- ***Variation in Place based services***
  - community diabetes services is a present in some boroughs but absent in others
  - availability of social prescribers, links to VCSE groups etc varies from neighbourhood to neighbouhood

Early insights

- The first 5 MDTs across 3 PCNs (mid December to end of January) – 86 patients were desk top reviewed and 65 discussed in detail at the MDTs. **Case finding hit rate = 75%**
- From the 65 patients at MDT review 28 secondary care appointments were cancelled, **a rate of 43%**
- The most common actions were specialist advice given (approx 1.5 specialists per pt), this resulted in preventative actions being identified for both GPs and the co-ordination teams
- 0 referrals to secondary care but several new referrals to social prescribing teams
- Links to social care, community service, mental health teams
- Patients being identified are the rising risk group often not well known to existing local services
- Lots of opportunites to bring the clinical model to other cohorts of patients and clinical services

Key messages

1. Use the data to know your population
2. Be tenacious in solving the system barriers
3. Be clear about your purpose to keep stakeholders engaged and on track

UCLPartners
Health Innovation

NHS
Central and
North West London
NHS Foundation Trust

Camden Integrated Neighbourhood Teams (INT)

Sally Lydamore
Head of Camden Integrated Community Healthcare (CICH)

Wellbeing for life

The Vision for Integrated Neighbourhood Teams (INT)

NHS
Central and
North West London
NHS Foundation Trust

What we wanted:

- To tackle the deep-rooted health inequalities in Camden
- To improve people's physical and mental health outcomes through more joined up, holistic support
- To improve the experience of care and support for local people
- To create a better working environment for our staff
- To develop local solutions for big health challenges
- Enhance productivity and impact through seamless, collaborative intervention
- Stop silo/parallel working and maximise prevention and innovations

How we would achieve it:

- A multiagency working model of practice
- By having sustainable, creative, integrated, responsive services rooted in long-term support.
- Building upwards from community ownership
- Providing an adaptable core offer to meet changing demands
- Have a primary focus on frailty and long-term conditions and hospital avoidance through proactive intervention

The Drivers for Change – the “ Why”?

NHS
Central and North West London
NHS Foundation Trust

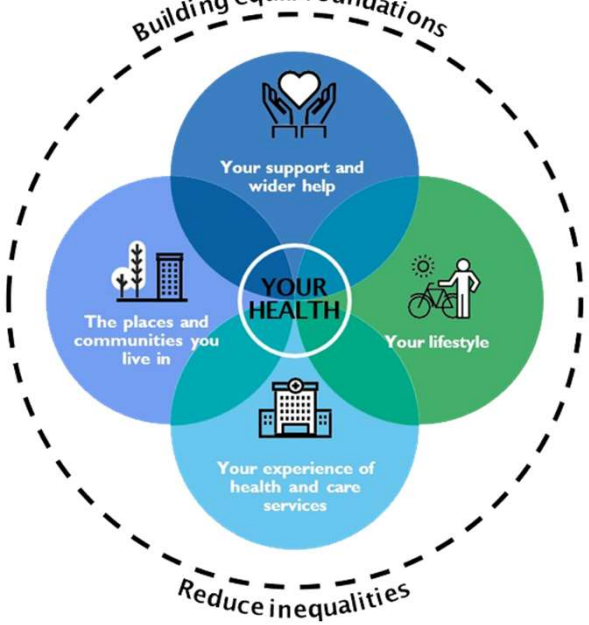
National and local policy directives highlighted the need for statutory and voluntary services to integrate and thereby enhance access and reduce health inequalities.

The Fuller Stocktake Report (NHS England 2022) highlights a vision for statutory and voluntary sectors to be integrated

Fuller and Darzi highlight a *‘neighbourhood health service’* to be the focus for community health service reform

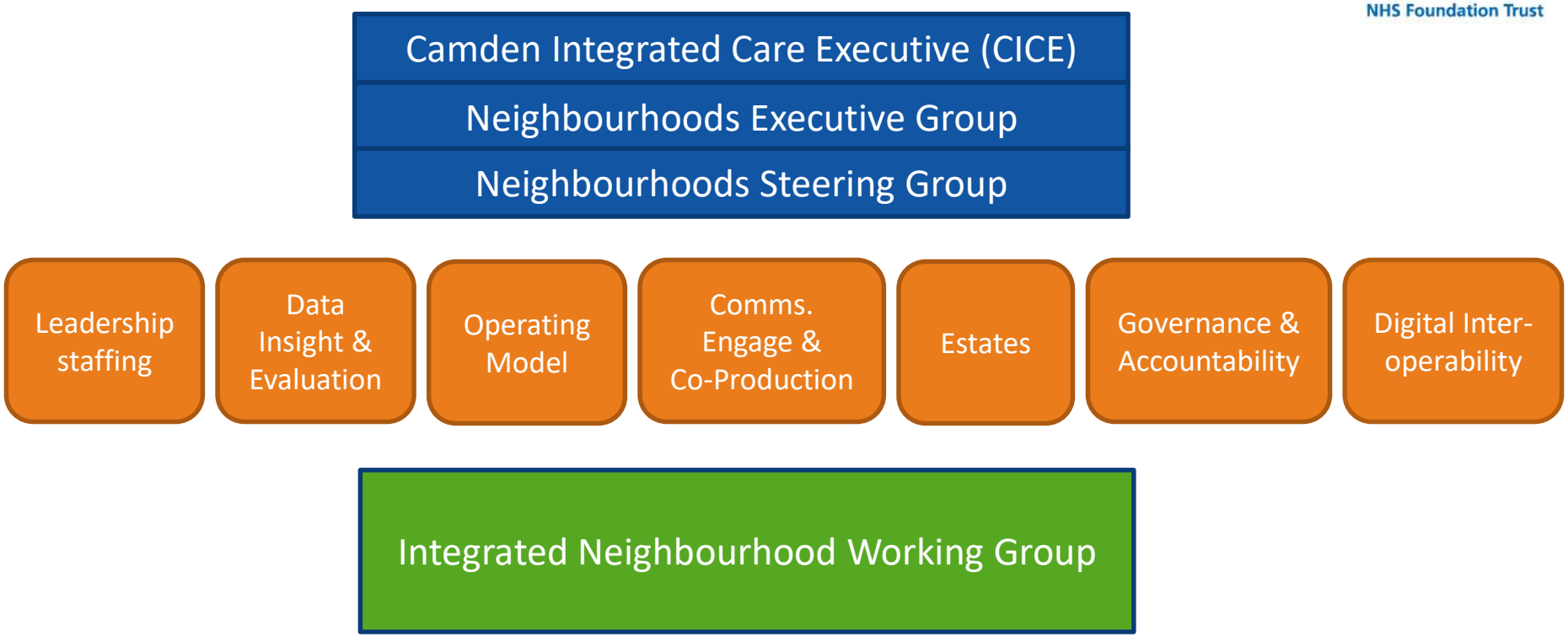
The London 10 Year Plan launched in January 2025 for all London community services to be working in neighbourhood models of practice

The Camden health and Well being Strategy 2022-2030 (Camden health and Wellbeing Board) “Stay well for longer” philosophy, sets out a populations approach towards improved health with a community call to action for all to make Camden the very best place to “start well, live well and age well”



The Management delivery structure

NHS
Central and
North West London
NHS Foundation Trust



The Project Proposal

NHS
Central and
North West London
NHS Foundation Trust

The Vision

To realign the CNWL Community Health Teams from three large integrated District Nursing and Therapy skill mixed teams made up of 143 staff, into five Neighbourhood Teams **co-located** with other public sector and community partner agencies. A consultation took place both to align staffing and create new workflows

The Ambition

- For the first INT to be set up in the East before the end of 2024 with our partners and communities in the Kentish Town area as the “test and learn” site and the other four teams to follow in 2025
- For the multi-agency resident focussed coordinated care to increase hospital avoidance

How

A partnership project across Camden Services, building relationships through collaborative change management and shared vision for integration between Health, Council and Community

The operational principles of the INT proposal

NHS
Central and
North West London
NHS Foundation Trust

Leadership and Management capacity

Develop the vision, support caseloads, develop systems and processes and training for integration

Shared Infrastructure

Co-location with a flexible space for networking models and shared ownership of team development

Wider delivery capacity

Avoiding overlap/ promoting self care/ finding safety netted capacity. Resident centred care

Strong relationships with local communities and the voluntary sector

Developing expertise in person-centred care and strengths-based approaches promoting professional curiosity and enhancing skills across agencies (NHS providers, Special Services and the voluntary sector)

Building Resilience: The Key elements of the INT

NHS
Central and
North West London
NHS Foundation Trust

- A purposeful and consistent connection between the context of people's lives and the support offered
- A bridged gap between voluntary and public sector
- A person-centred approach that focuses on resilience and safety netting
- Targeted interventions driven by population and heath needs analysis data
- Co-production
- Outreach and early identification
- Mitigation of risk and safety netting
- Optimising community assets, skills, communication and empowerment
- Coordinating dual diagnosis and hard to reach population
- Better staff capacity – working together with more focus, wider problem solving, professional curiosity and holistic intervention

Local community partners and networks

NHS
Central and
North West London
NHS Foundation Trust

A shared vision for neighbourhood working

- A ready-made foundation across the voluntary sector, health & social care with active neighbourhood hubs modelled by children's services
- Established Camden resident engagement with health and social care
- Camden resident feedback asking for streamlined co ordinated services reducing repetition and over assessment
- Proactive long-term conditions investment model with GP& PCN's

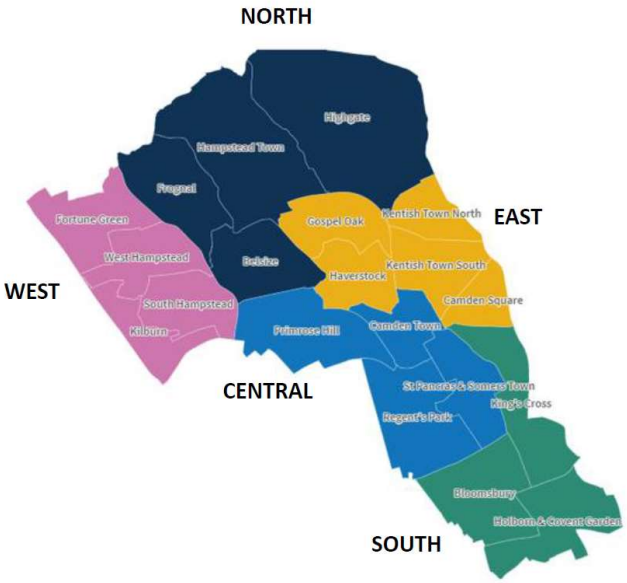
Collaborative Complex care model and multidisciplinary frailty teams

- Wide core offer of planned and unplanned services
- Collaborative partnerships with hospitals
- Professional development of pharmacy and allied health professionals
- Social Prescribing
- Population demographics & health inequalities data
- Active and innovative Primary care networks willing to work on a broader geographical footprint to support integration
- Very engaged voluntary sector

The Camden INT Footprint

- Neighbourhood electoral wards provide ready made caseload footprints for integration
- The local infrastructure and community assets are developed with an emphasis on prevention, proactivity and local care, data and insight, technology and workforce reform
- Integrated Neighbourhood Teams (INT) are building on the pre-existing Multidisciplinary Team Model (MDT) and the specialist Frailty Hubs

NHS
Central and North West London
NHS Foundation Trust



Neighbourhood	Electoral Ward
North	Highgate
North	Hampstead Town
North	Belsize
North	Frognal
West	Fortune Green
West	West Hampstead
West	Kilburn
West	South Hampstead
East	Gospel Oak
East	Haverstock
East	Kentish Town North
East	Kentish Town South
East	Camden Square
Central	Regent's Park
Central	St Pancras and Somers Town
Central	Camden Town
Central	Primrose Hill
South	King's Cross
South	Bloomsbury
South	Holborn and Covent Garden

Who is the Integrated Neighbourhood Teams?

NHS
Central and
North West London
NHS Foundation Trust

A multi-agency and multi-disciplinary group of staff working in flexible co located spaces, based in the heart of the community. The resident is at the centre of their care through information sharing and co ordinated care plans. Individual skills are enhanced through knowledge exchange and seamless wrap around of care

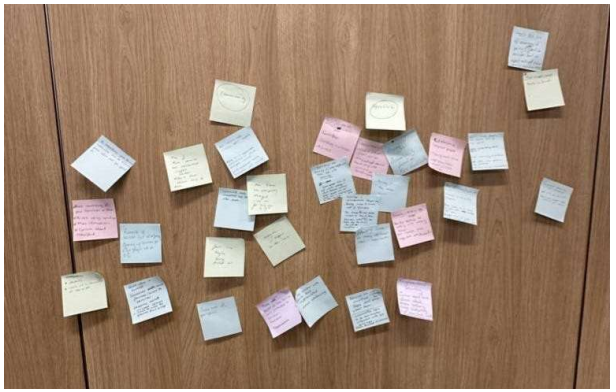
- Social Workers
- Community Mental Health Workers
- GP partners
- Home Care
- Social Prescribing
- CNWL District Nursing Staff
- CNWL Community Rehabilitation staff
- CNWL Community Administration staff

Managing the change

NHS
Central and
North West London
NHS Foundation Trust

Effective Change and Project Management and building trust:

- Extensive District Nursing and Community Rehabilitation Therapy consultation which reformed staffing configuration and clinical practice workflows
- Social Services and the Community Mental Health Trust managed their sperate consultations
- Each service was split into five teams ready to mobilise before the project went live
- Operational Manager worked closely with the Human Resources Team, Staff Side, the Transformation Team, Finance Team, Estates and the Data Analyst Team
- A series of drop-in meetings for CICH staff, 1:1s, and a live Q&A document. An outcome paper was published, followed by a staff allocation paper with weekly staff comms and a dedicated website that hosted live questions and answers
- Multi-agency steering group meetings took place to set the vision and build relationships
- Multiple away days, informal discussions post-it note and flip chart events to collate and hear ideas



Opening the East Neighbourhood

NHS
Central and
North West London
NHS Foundation Trust

- Stage 1: colocation ✓
  - Setting ground rules
  - Getting to know each other/tap on the shoulder days
  - Share and learn lunches
  - Hot desking only
- Stage2: Lunch and Learn ✓
- Stage 3: Working together/reflective practice ✓
- Stage 4: NW5 Frailty/complex MDT SOP- Current Stage
  - SOP for the MDT
- Stage 5: measurables/ outcomes

Additional considerations and challenges

NHS
Central and
North West London
NHS Foundation Trust

- Co-design work with estates (site risk assessment tool, insurance to change to 7 day opening times, key access, parking, clinical storage space)
- Management of Wi-Fi, shared spaces, hot desking and private meeting rooms
- Integrated Business Continuity Plan
- Changes to finances and governance systems
- Patient information
- Caseload realignment on Systmone
- Moving staff on ESR, rosters, budget lines, job titles.
- Leadership alignment, hub models, supervision matrix
- IProc, contact telephone numbers, patient information and clinic spaces
- Creating the Practice Development Nurse role to develop the Neighbourhood scope of District Nursing Practice
- Developing the crossover leadership skills of Therapists and Nurses to lead skill mixed teams
- Refining peripatetic roles across the borough
- Correct referral pathway and change management with the Transfer of care Hub and hospitals

Project Timeline

NHS
Central and North West London
NHS Foundation Trust

Nov 2023	Form the East INT Operational Leadership Group and develop theory of change
Dec 2023	Staff engagement and input. Identify who is best placed to form the initial INT and plan how it happens
Jan-Jun 2024	Formal staff consultation on realignment of teams. East INT begins to take shape, developing shared identity and principles. Cohort identified for MDT-type support
Jul 2024	Initial launch of caseload footprint of five team caseload management
Oct 2024	East Neighbourhood co-locates and goes live at Kentish Town health Centre
Oct 2024 to Present	• East INT Test & Learn commences, developing new ways of working together and with communities, services and stakeholders. • Evaluation of impact on residents, system & workforce • Co-location and relationship building • Test & Learn (models of care). A Public Health Consultant is supporting with measuring outcomes: looking at data/case studies/ staff views/ productivity/ length of stay • Shaping and driving the change continues via the INT Operational Group, the INT clinical staff, the East Neighbourhood network and residents and patients

The benefits already identified

NHS
Central and
North West London
NHS Foundation Trust

- Early recognition of the soft signs of clinical deterioration (designing a QI project that incorporates the Triangle Care Champions/ involving carers in recognition of the signs)
- Cross fertilization of skills and knowledge
- Joined up home visiting
- Improved standard of referrals between services
- The role of the Practice Development Nurse has been defined with a clear scope of practice work plan that centres around governance, safety competencies and enhancing excellent nursing practice
- Prompt support when patients are discharged from hospital
- Efficient escalation to unplanned care services
- More efficient joined up working with the Care Homes
- Marie Curie involvement has released District Nursing capacity
- Now that the service has been working in a neighbourhood format for 6 months and staffing has changed due to the recent financial controls, a review can take place to look at caseload numbers. Skill mix and travel around the neighbourhoods to keep the ratio of staffing to patient numbers safe in each neighbourhood. This will also be linked to pattern of Datix incidents

Learning and challenges

NHS
Central and
North West London
NHS Foundation Trust

- Using the East test and learn model to inform plans for the remaining 4 INT
- Designed and delivered changes with staff consultation and multiagency discussion
- A key theme has arisen around the role of Complex Care Nurses and measurable outcomes
- Further stages for location and line management change as each INT is formed dependant upon estates
- Many staff were affected but there were no redundancies or pay band changes as each job role was re-scoped around neighbourhood working
- The hub model was needed to manage specialist job roles and part time staffing hours
- Any equality needs were captured which enhanced staff engagement to embrace change
- Engagement from Staff-side colleagues
- We did notice an increase in sickness and attrition
- The change management regular comms and live questions and answers web page were essential
- The balance between HR matters and clinical patient need had to be maintained
- Upskilling Therapy and Nursing leadership cross over
- Ensuring a robust supervision matrix across the borough

One Key Message

NHS
Central and
North West London
NHS Foundation Trust

Do not under-estimate how big a commitment running a project like this will be…

- Have realistic timeframes for each stage of the process – work out how long you think each will take each and then add in a generous contingency
- Get a dedicated Project Manager to run the project
- Anticipate significant need for change management and staff support (at all levels) throughout **and** after the project
- Keep your eyes on the prize because the community health provision improvements are what makes the effort worthwhile

Any questions?

PROVIDER COLLABORATION

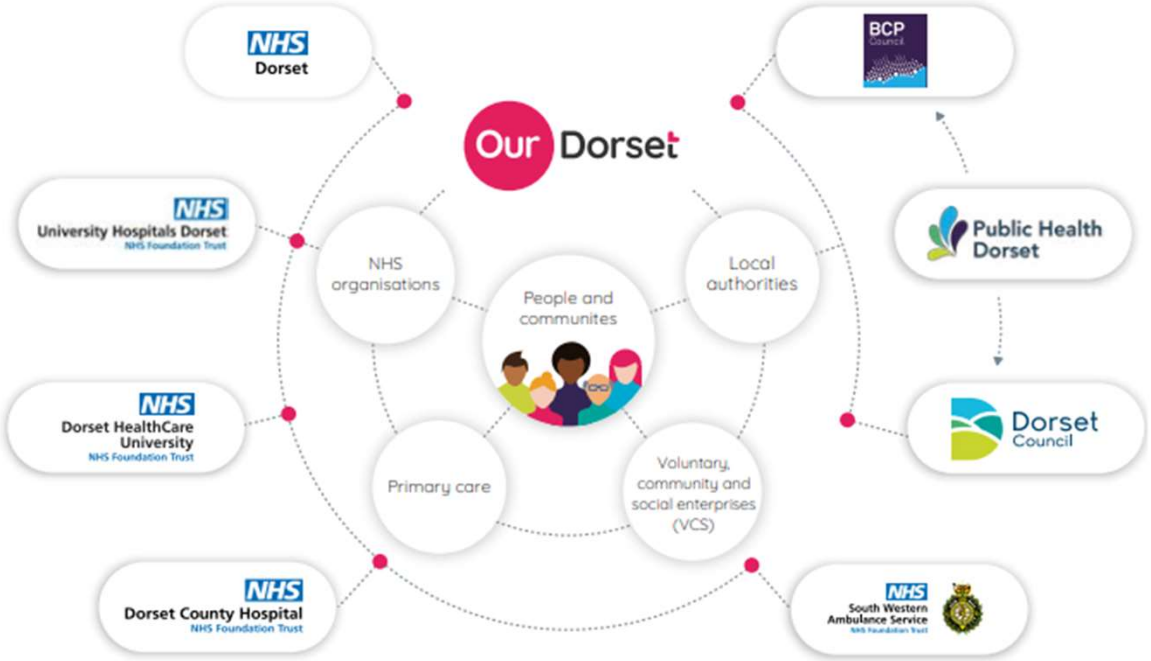
NHS Providers

Integrated Neighbourhoods

NHS Providers : Provider Collaboration
Effective integration with neighbourhood and place

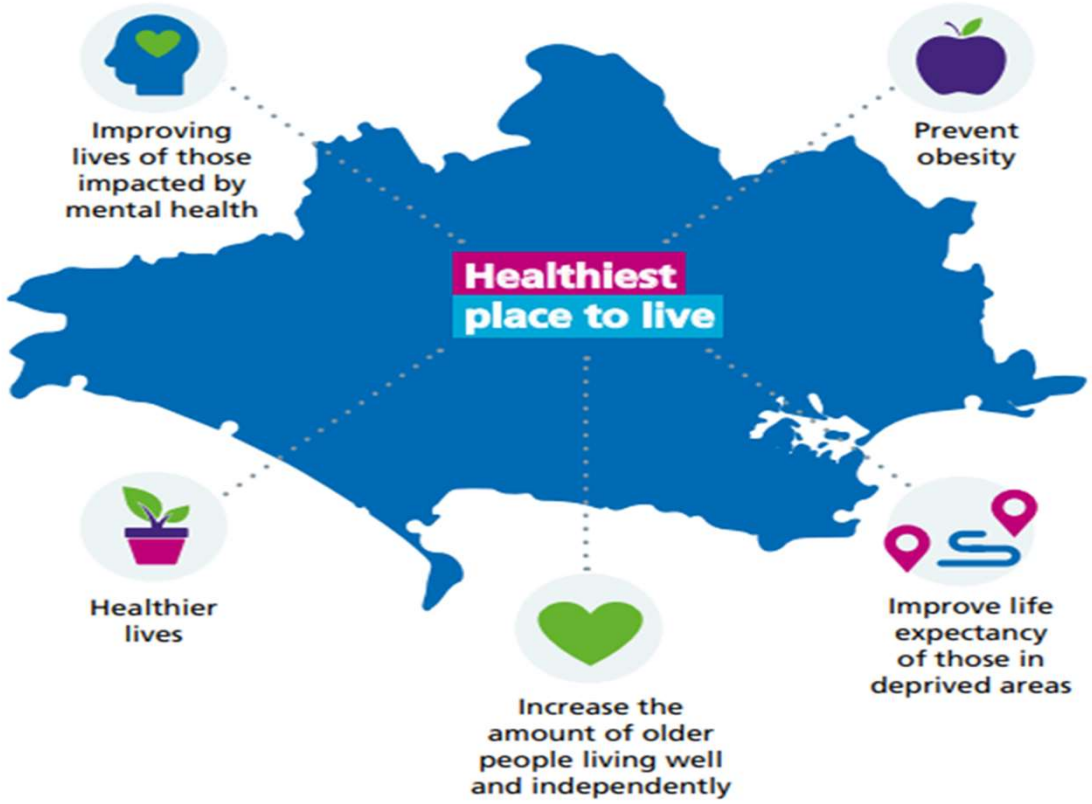
February 2025

The Dorset System



Our Dorset

Improving health and wellbeing in Dorset



Our Dorset vision is to work together to deliver the best possible improvement in health and wellbeing.

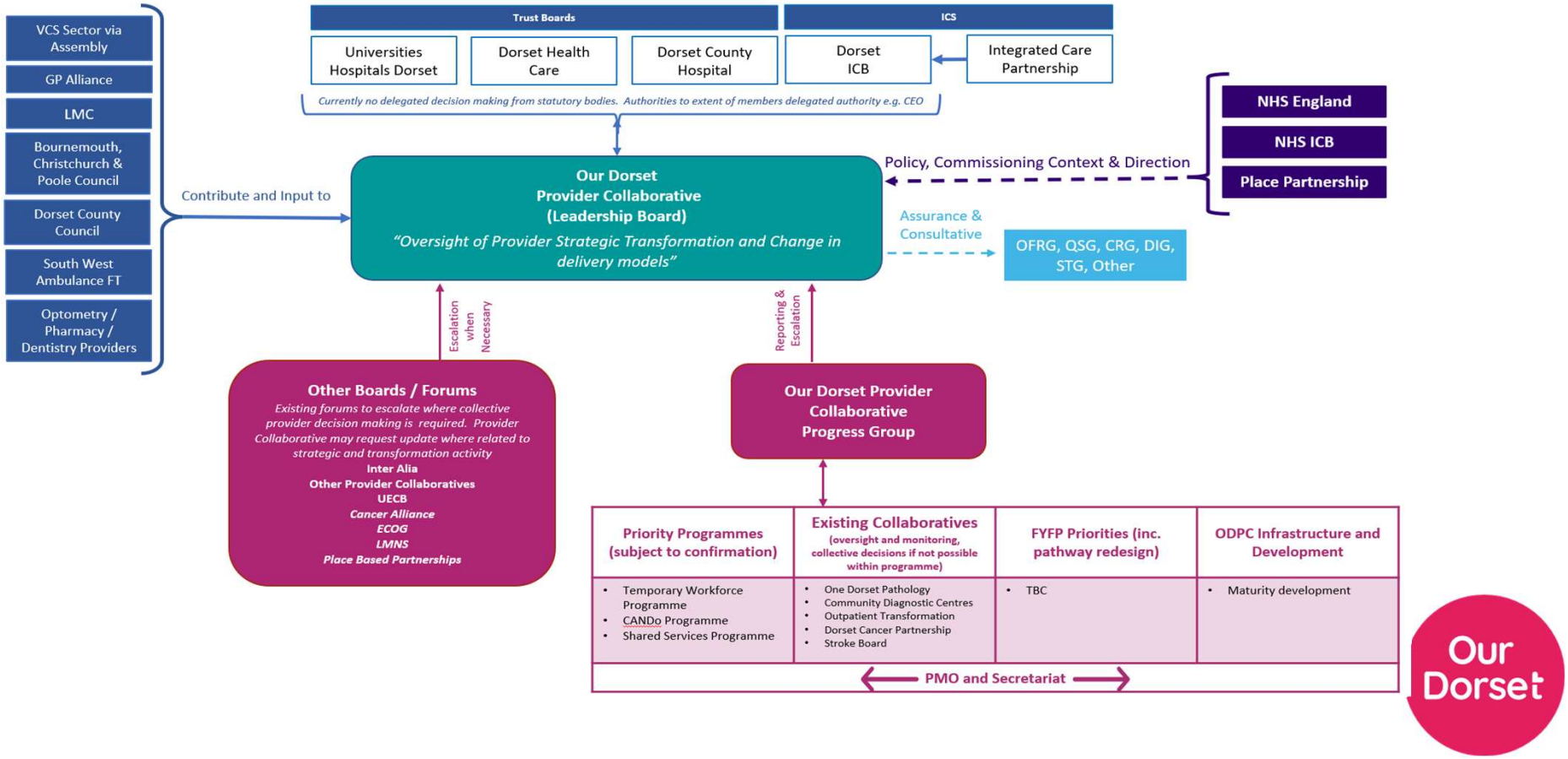
Our priorities are:

- Prevention and early help
- Thriving communities
- Working better together

Our Joint Forward Plan sets out priority outcomes.

Our Dorset

Our Dorset Provider Collaborative

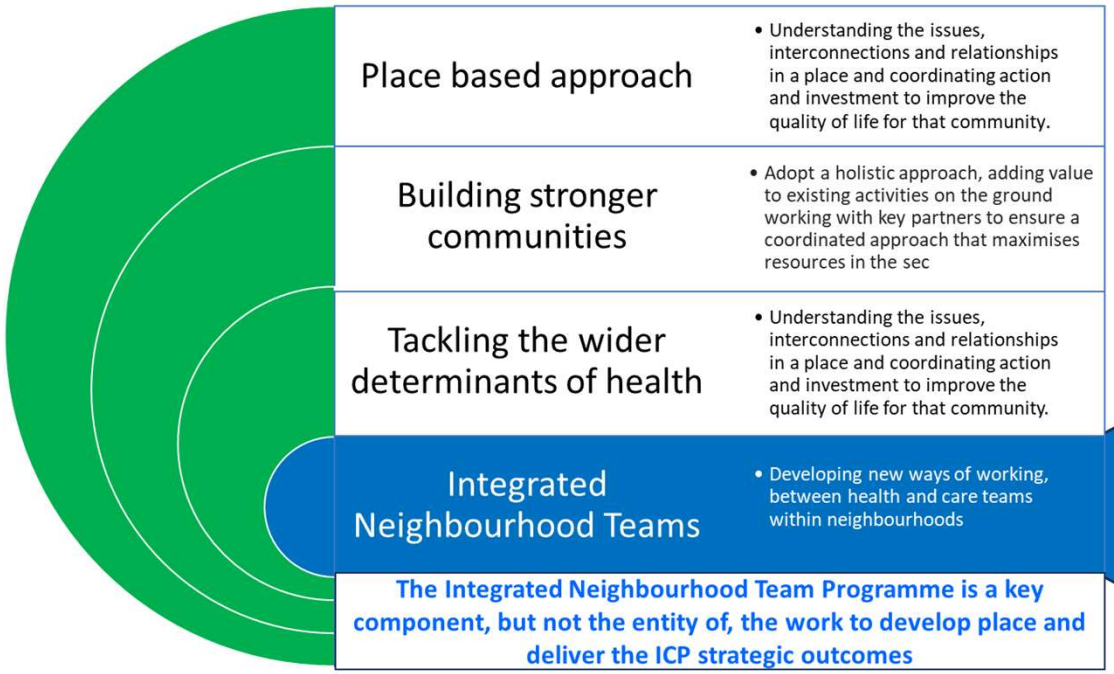


What is an Integrated Neighbourhood Team (INT)

- The INT will be made up of primary care, community health services such as district nursing and therapy services, adult social care, community mental health services, public health, voluntary and community services and services for children and young people
- The INT will serve natural communities and have a range of expertise within the team that means knowledge can be combined and shared to provide the best care for the diverse needs of individuals.
- The INT will support:
  - Tackling health inequalities
  - Co-ordinating teams
  - Build co-production skills and an understanding of local community needs,

Our Dorset

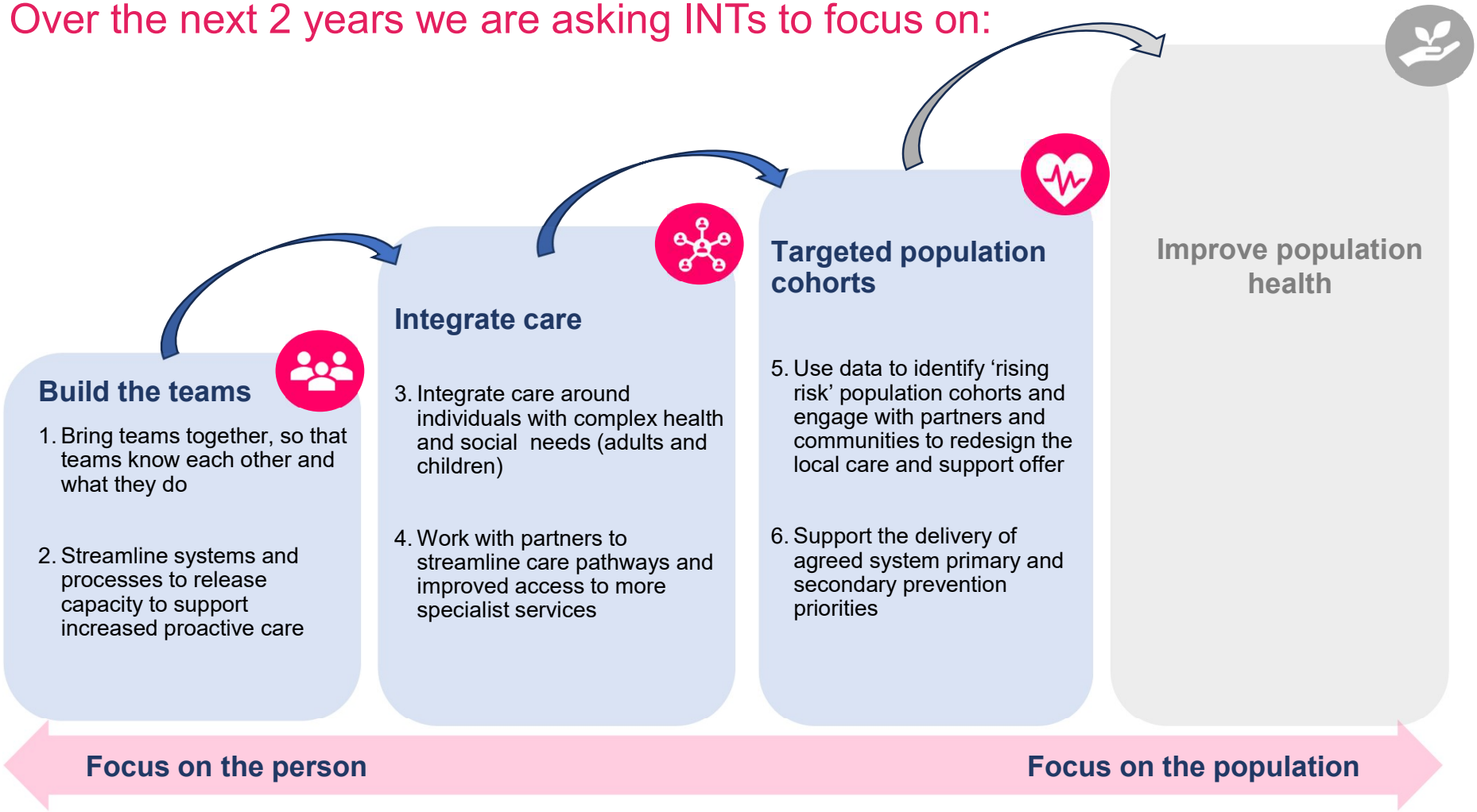
The Integrated Neighbourhood Team Programme fits within the wider Place agenda



The Integrated Neighbourhood Team Programme is focused on the development of Integrated Neighbourhood Teams that brings together multi-disciplinary practitioners from across health and care organisations to deliver services to meet the neds of their defined population by focusing on personalised care that is as far as possible anticipatory rather than reactive.

Our Dorset

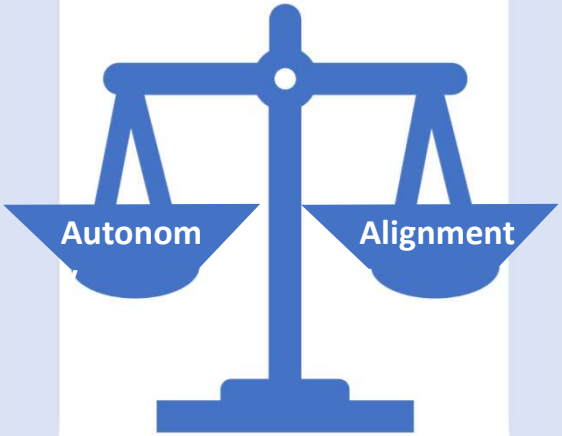
Over the next 2 years we are asking INTs to focus on:



Locally developed within a framework

Locally developed
(bottom-up approach)

- Local knowledge and buy-in
- Enhanced innovation
- Employee engagement and motivation
- Efficiency and adaptability
- Effective problem solving



In a framework
(programme approach)

- Aligned with strategic goals
- Widely sharing ideas and feedback
- Buy-in from senior management
- Prioritising and allocating resources
- Equity of outcomes

Principles for setting up INTs

Population focus

- Supporting natural communities that people of Dorset identify with
- Ensure that what matters to people/citizens is at the heart of what drives the team

Culture

- Collaborative and trusting
- Developing and learning together
- Bringing partners together including secondary care

Responsibilities

- Autonomy to make decisions
- Accountable for delivering objectives
- Break down barriers, build relationships
- Help people make better health and wellbeing choices
- Care for those who need support

Processes

- Holistic, co-designed care and support
- Supported by flexible information management and technology
- One public estate approach to maximise assets
- Investment based on need

Our Dorset

Connecting with places and communities

Integrated Neighbourhood Teams (INT)

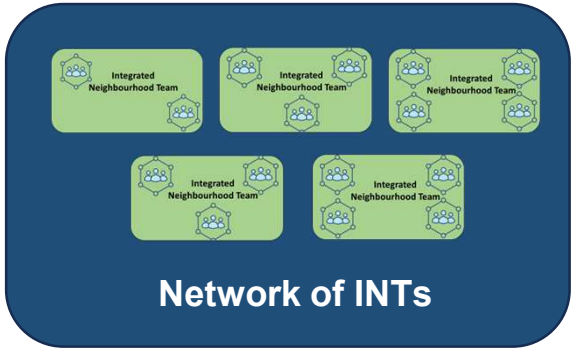
INTs bring together members of health and care staff who work closely together and have a shared responsibility for improving the health and wellbeing of the population.

We are starting with **18 INTs across Dorset**, using GP practices, within PCN footprints, as the building blocks for integration

Each Integrated Neighbourhood Team will support a number of natural communities, working with them to understand what is important to them and co-designing services that meet local needs, delivered in a way that works for the community. population.

Wider Community and Specialist Support

Where there are shared priorities or health and care pathway changes that involve wider community and specialist services who work across INT areas, groups of INTs may work on these together in a local network or at system or place level.

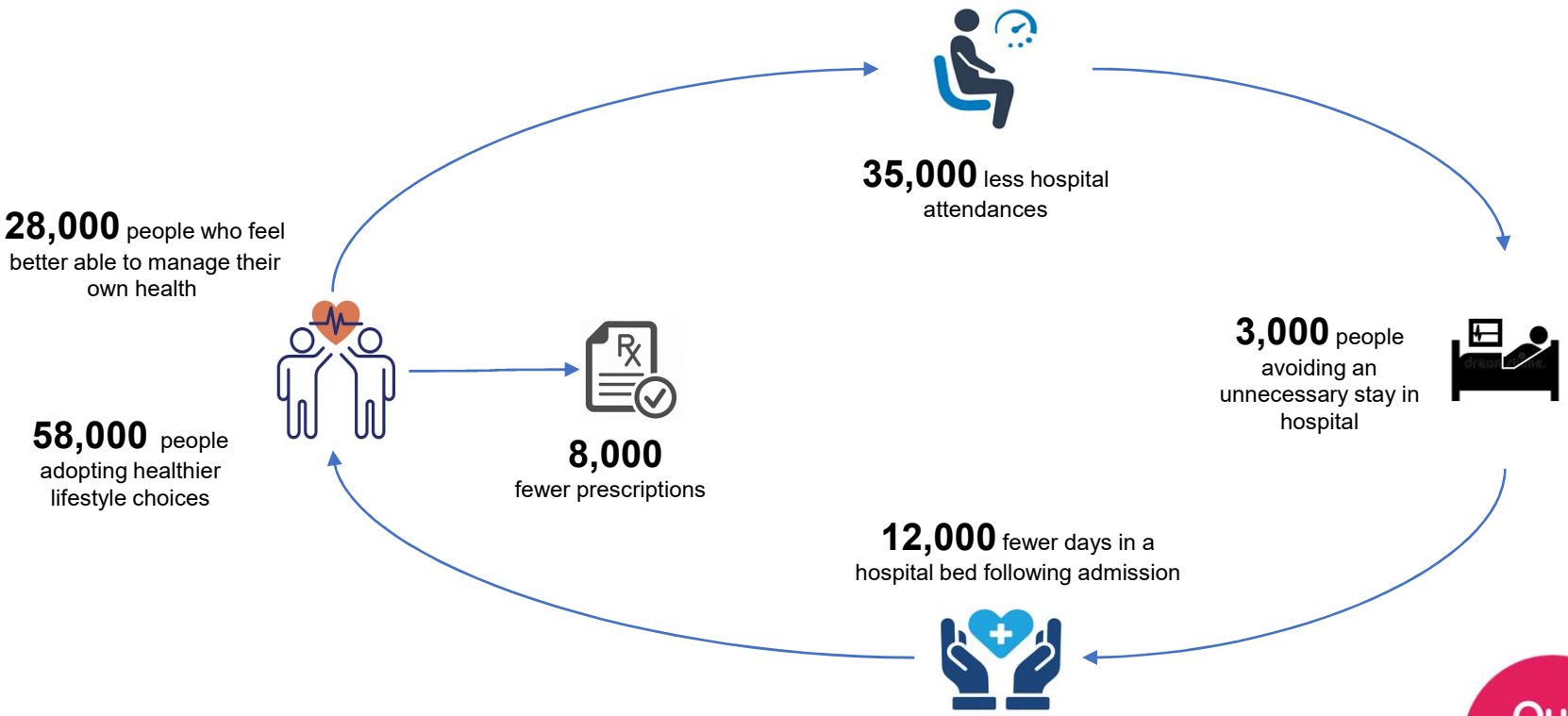


The logic model at the heart of successful INTs

National and international evidence suggests that **supporting teams to work together** and removing the barriers that get in the way, **can deliver significant outcome and system benefits.**

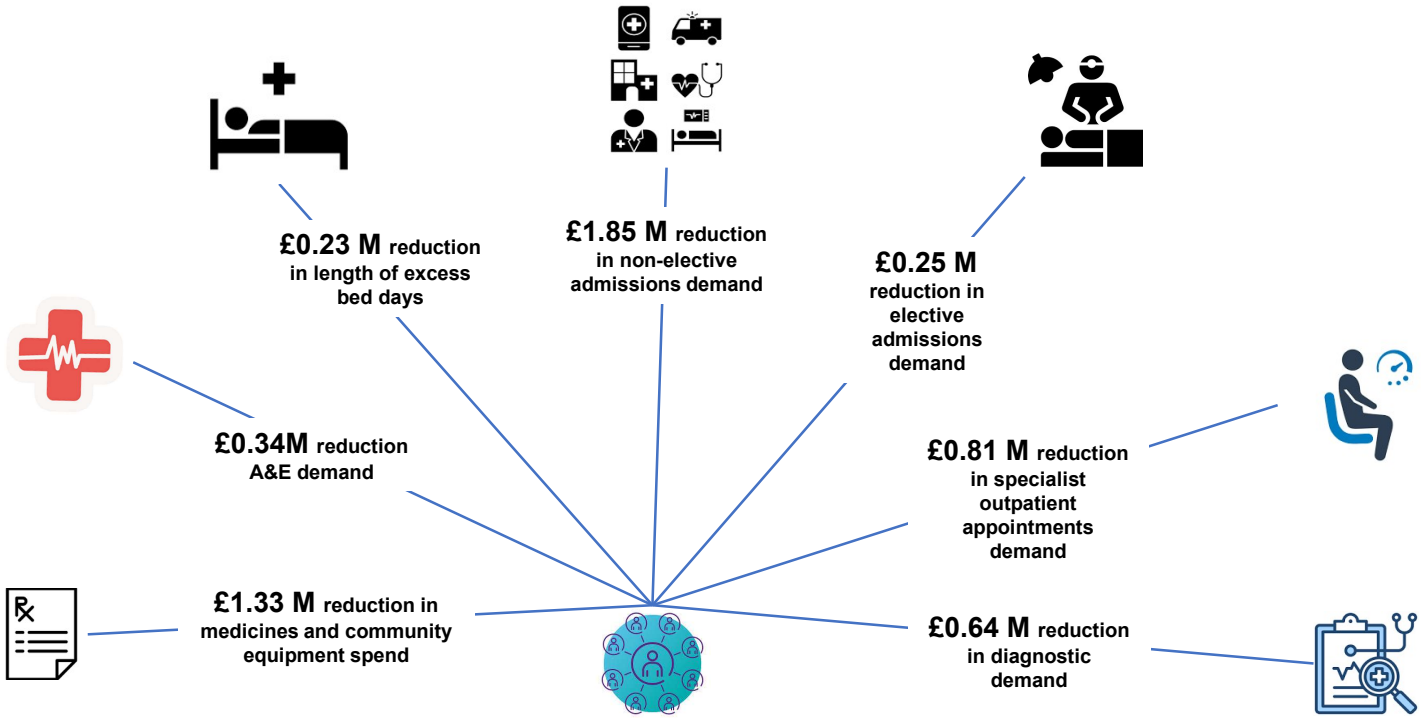
Our Dorset

Expected impact (2025/26 – 2026/27)



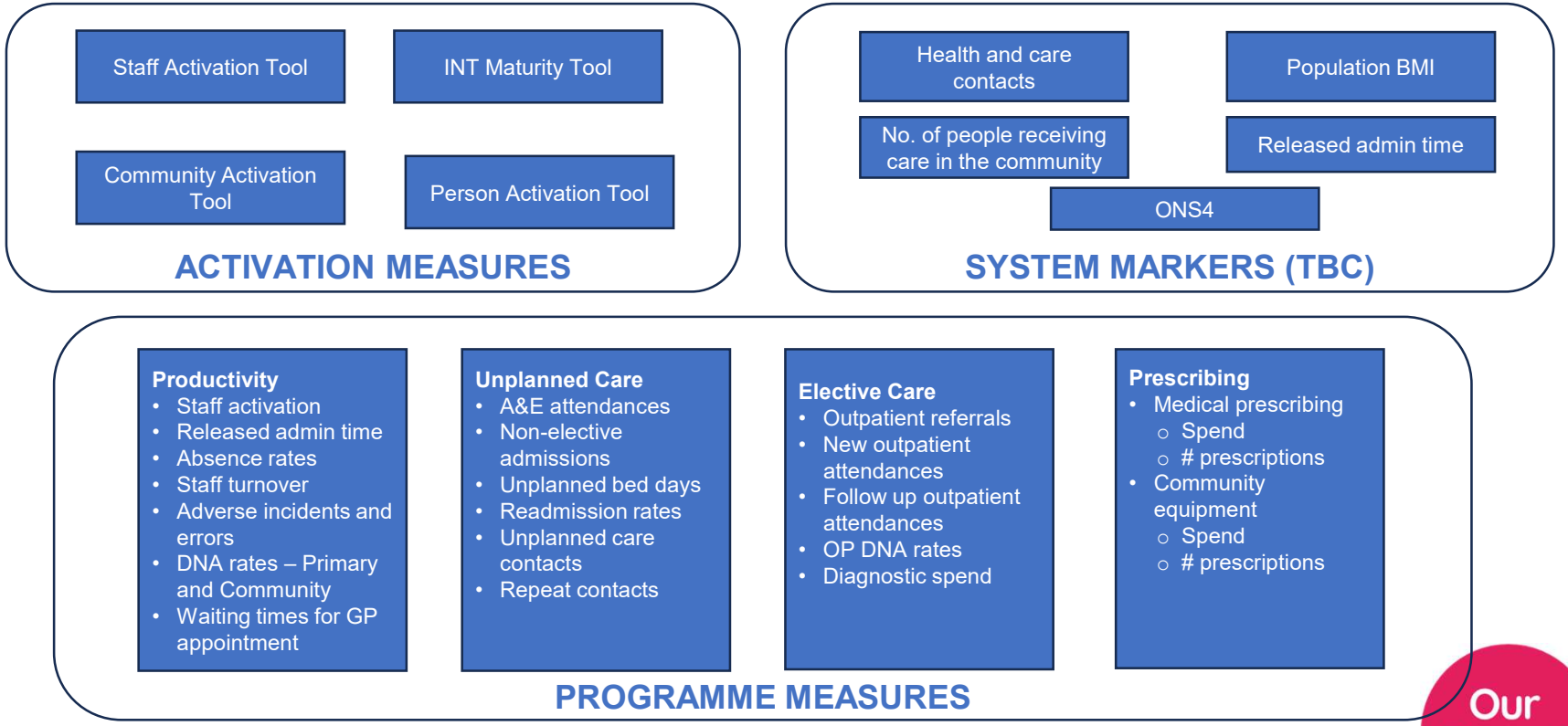
Our Dorset

Cash releasing savings over the 2 years - £5.45 M



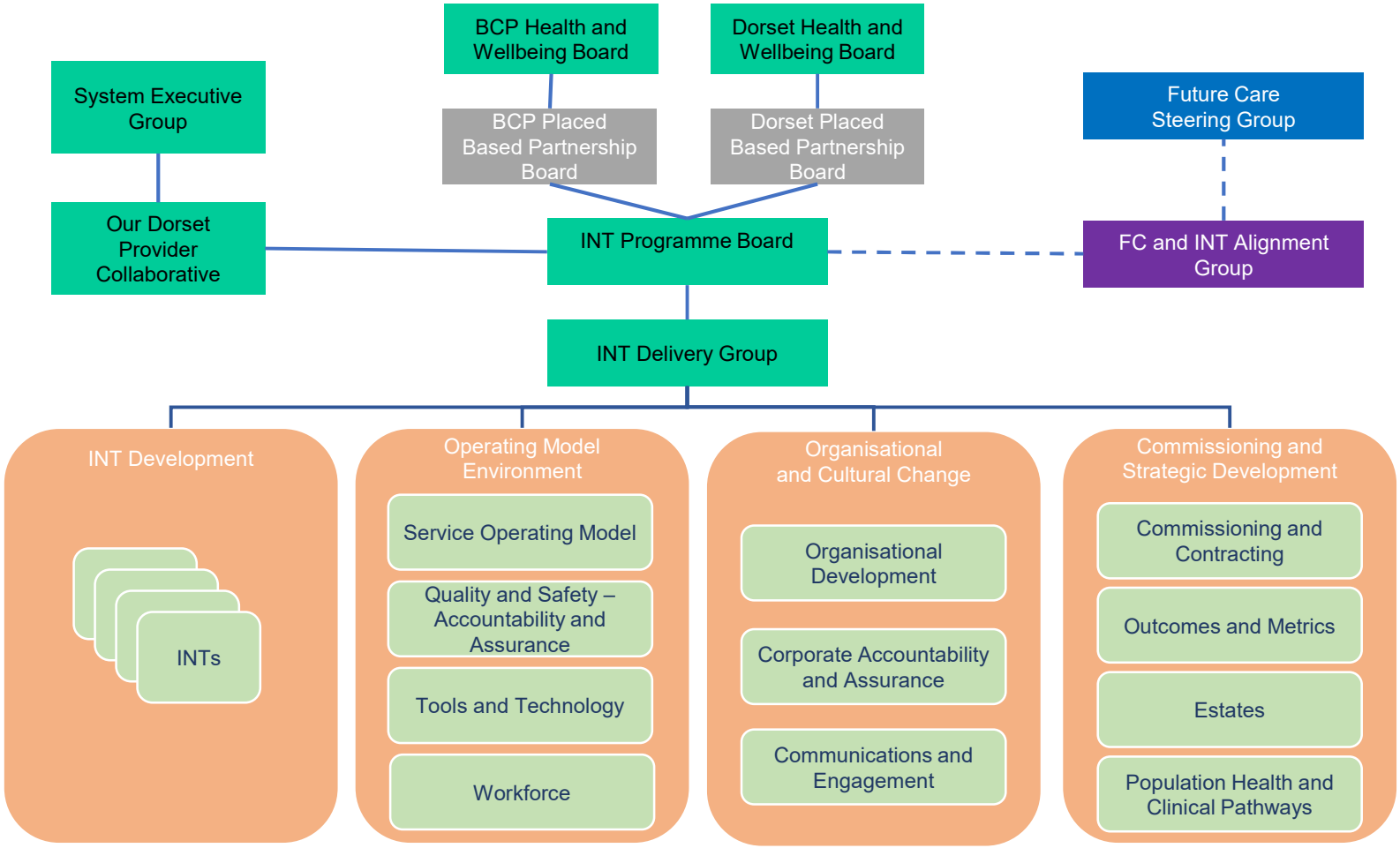
Our Dorset

Benefits tracking



Our Dorset

INT Programme Governance



Reflections & Questions

Any questions?

PROVIDER COLLABORATION

NHS Providers

PROVIDER COLLABORATION

Book now:

- **Peer learning forum | All sectors** | Wednesday 14 May 11.00am – 12.30pm

- **Improvement | Building improvement capacity and capability |** Monday 24 March 3.00pm -4.00pm

NHS Providers

PROVIDER COLLABORATION

Tell us what you think

Scan here to access our evaluation
or use the link in the chat

NHS Providers

PROVIDER COLLABORATION

Thank you for attending

NHS Providers