Barnet Borough Partnership

North Central London Integrated Care System

Barnet Neighbourhood health and care model plans

Health and care overview and scrutiny sub-committee

October 26th 2023

Barnet Borough Partnership

North Central London Integrated Care System

Background to Neighbourhood working in Barnet

- Neighbourhood programme agreed at Barnet Borough Partnership Executive Board in October 2022
- System buy-in to prioritise a neighbourhood approach, through funding neighbourhood, health inequalities and coproduction posts, as well as hosting of neighbourhood workshop in February 2023.
- Decision made to adopt pragmatic position of 'PCN = neighbourhood' as a starting point, and to focus on hyper-local place-based initiatives e.g. in Grahame Park
- Where progress has been made in other boroughs, agreeing a common language has helped move things forward (see 'key terms' below) and starting with small pilots or 'test and learn' sites. It has embraced an asset-led approach and actively ensured resident co-production.
- The February workshop looked at what further initiatives (either hyper-local or PCN MDT-based activity) could be developed at neighbourhood level, and looked to develop further engagement from key stakeholders including PCN leads.
- Agreement that Barnet neighbourhood programme should reflect previous insights and knowledge from local and wider resources.
- Building consensus that, using a shared terminology, we need to understand what PCN level neighbourhood progression is and take the early adopters to test and progress further, and build on work in one hyper-local area (for example, Grahame Park), before looking to other targeted initiatives.
- April 2023 – now: engagement with system partners including PCNs, sign-off of programme approach at BBP Board and Barnet HWBB, PCN event on 13th July, commencement of GPE hyper-local, navigation and CYP asthma workstreams, alignment with health inequalities agenda
- Engagement around CYP early-help/ child development centre, and enablement and community services workstreams
- Value of neighbourhood models first seen in examples such as Manchester and now promoted through work such as the Fuller Stocktake of Primary Care
- Barnet system workshop on 11th October had representation from across different settings and sectors in Barnet and focussed on developing local ideas for PCN-based neighbourhood pilots.

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What is our vision?

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- MORE SUPPORT FOR RESIDENTS through provision of integrated teams to help residents to get healthy, stay well, keep safe and be as independent as possible
- ACTIVELY SUPPORTED COMMUNITIES within neighbourhoods to help themselves and each other
- INVOLVING AND ENGAGING RESIDENTS to ensure their interests come first and resources are collectively focussed on improving their health outcomes
- FLEXIBLE APPROACH BASED ON NEEDS and complex issues at place, addressing health inequalities and co-morbidity, and focussing efforts in more deprived areas
- CARE THAT IS SEAMLESS at the point of delivery, joined up and personalised
- A CONNECTED WORKFORCE who feel socially and logistically connected to each other, and able to work flexibly, better able to meet people's needs
- REDUCED BOUNDARIES between organisations so that care meets physical, mental, social and related needs of residents and families

Updated from November 2022 slide

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Programme Overview – August 2023

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Barnet Borough Partnership Neighbourhood Model: 3-pronged approach:

Establishing Integrated Neighbourhoods at Primary Care Network level:

Developing framework (gold standard) for how integrated neighbourhood teams can work.

Recruit and fund Integrated Neighbourhood pilots (2-3) with Primary Care Networks (PCNs) as the integrated neighbourhood 'host' ('engine room') involving multi-disciplinary teams of professionals including statutory and voluntary services **wrapped around the needs of people**. To do so, developing data available to PCNs to help them make informed neighbourhoods and health inequalities decisions.

Working closely with VCS organisations to help identify gaps and need for capacity building.

Establishing and testing out a 'hyper-local' approach to neighbourhood health and care:

Grahame Park 'Adults, Health and Wellbeing' Group as the 'host'/ engine room for this work.

Group has met and agreed aims, including reviewing existing initiatives for their uptake and impact, in order to build on or adapt them, and identifying new areas of work to take forward together. Existing interventions already in place include substance misuse clinic, mental health wellbeing service, social and exercise opportunities such as walking groups, coffee mornings and an outdoors gym.

Group is now establishing workplan and achievables for the next year, with the principle of ensuring that interventions are multi-disciplinary, integrated and **wrapped around the needs of people.**

Once fully established, will explore other areas to further test the 'hyper-local' approach.

Projects that encapsulate the integrated nature of neighbourhood working and present opportunities to bring different system partners together:

Mapping navigation, prevention, signposting and wellbeing services across health, council and voluntary sector, in order to increase familiarity with services across staff groups and management, enable easier onward referral, encourage review of services and possible duplication, and make patient/ resident journey to the right services easier.

Developing community-based approach to preventing, managing and treating children's asthma.

Early stages of projects improving coordination of community health and enablement services; and coordination of health and early-help 0-19 services.

Opportunities to align projects to PCN and hyper-local approaches.

Engagement (system and peer), user involvement and coproduction underpinning all the work.

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Programme governance, resource and alignment

- **Accountable to:** Barnet Borough Partnership (BBP) Joint Programme Board; Barnet Neighbourhood Programme Delivery Board
- **Resource:** 1 Programme Lead (hosted by BBP/ ICS, funded by partner organisations), 1 Clinical Lead (GP in the borough), matrix working with BBP colleagues across organisations, including SRO from CLCH
- **Funding:** confirmed seed primary care funding for PCNs to pilot initiatives (max £90k available, non-recurrent), PCN commissioning funding, other funding needs to be identified and sought as appropriate
- **Alignment:** Health and Wellbeing Strategy, Our Plan for Barnet, Children and Young People's Plan, JSNA, Barnet Together Alliance

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What's in place already?

Current core PCN 'neighbourhood model ' services include:

- *Ageing Well Multi-disciplinary team (MDT/)pathway – all residents able to access this*
- *Integrated Paediatric clinic*
- *Social prescribing*
- *Prevention services such as Health Checks – in place*
- *PCN referral/access links to 0-19 hubs and Prevention and Wellbeing team*
- *Mental Health Practitioner based in each PCN*
- *First access physiotherapist*
- *Practice pharmacists and structured medication reviews*

Further building on existing work such as aligning wider prevention, signposting and wellbeing services with PCNs

Other areas: including building back-office functionality and data analysis

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What's in place already?

- Hyper local work creates the opportunity for microscopic view of issues and challenges, and an opportunity to target specific stakeholders on very specific issues.
- The Grahame Park Estate 'Adults, Health and Wellbeing' workstream of LBB programme is responding to the Health Needs Assessment and Community Research Project, and using the Colindale Integrated Hub development as an opportunity. Hyper-local mental health and substance misuse services are now in operation on Grahame Park.
- Peer support and education - Healthy Hearts project to support targeted (e.g. Somali and South Asian) communities with heart health, prevention and wellbeing challenges, and Art against Knives, who run local projects on young black men's mental health and young women in overcoming barriers to employment.
- Ensuring that primary care services are engaged with hyper-local approaches.

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Barnet Integrated Neighbourhood Framework

DRAFT – comments welcomed

- The definition of ‘neighbourhoods’ in a health and wellbeing context is not agreed upon nationally.
- **This framework is built from previous work in Barnet and a best practice review of neighbourhood working across the UK, to develop the ‘gold standard’ of neighbourhood working for system partners to work towards over time**
- **It should guide thinking, provide structure to the concept of developing integrated neighbourhoods, and enable evaluation**
- **The framework provides examples of options for integrated neighbourhood Hosts to direct Neighbourhood resource towards**
- This is an early draft developed with input from some system partners. Further input is welcomed to ensure that it represents the vision of all system partners in delivering neighbourhood services and interventions.

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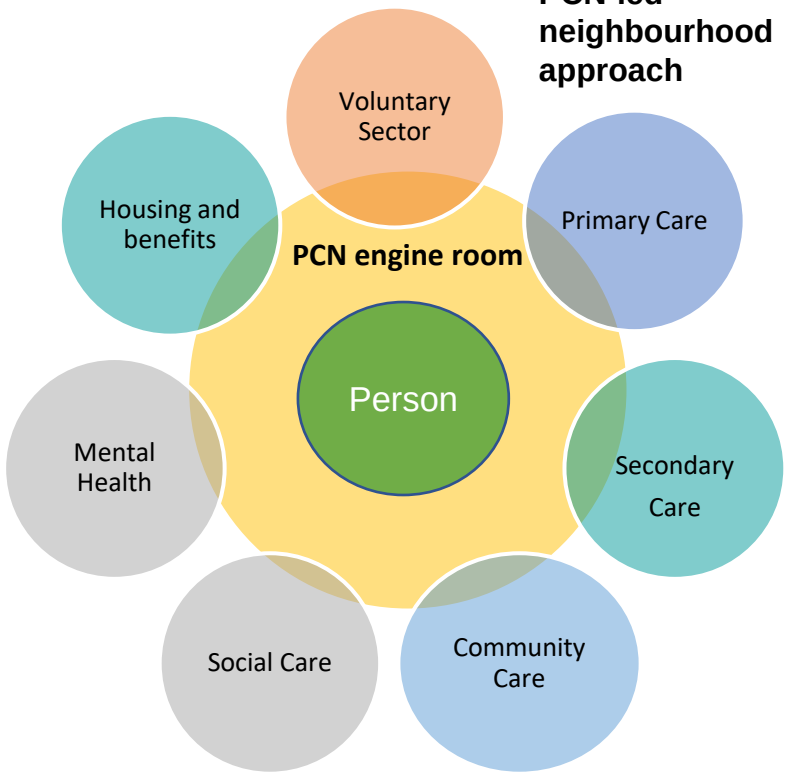
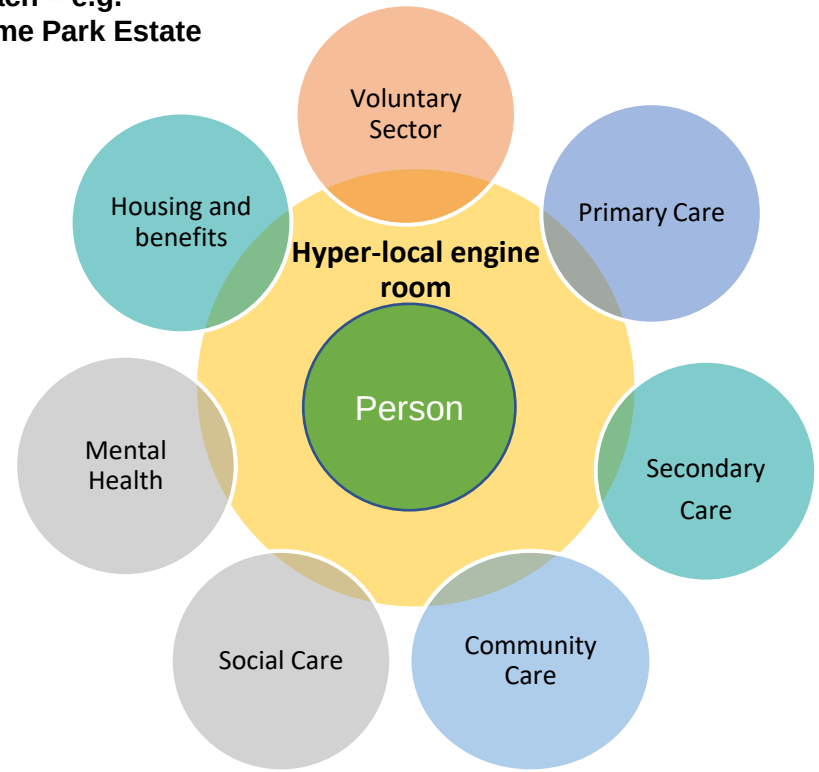
	INTEGRATED NEIGHBOURHOOD FRAMEWORK DOMAINS	What does this mean?	Constituents of domains
A	Integrator Host (engine room)	Which organisation is responsible for holding the Integrated Neighbourhood team/ initiatives together?	PCN, Community trust, Hospital trust, Local authority hub, community organisation etc
B	Integrator enablers	Factors that are likely to enable the host to be an effective host organisation, and for organisations to work effectively together.	Governance, Leadership, Strategic vision, ICR, Pooled budgets, Estates, communications, resident involvement
C	Integrated partnership	Principles to inform the approach to developing Integrated Neighbourhoods.	Systems focus, Individual role in system, Integrated care skill set, team work etc
D	Core integrator workforce team members	Should be based within the host organisation; key to enabling the partnership to work.	Examples: Clinical and non-clinical leads, project management et
F	Core areas of work	What, besides provision of healthcare at a provider level, does the integrated neighbourhood partnership do to improve the health and wellbeing of its residents and service users?	Access and demand/capacity management, Health promotion, Prevention, Care coordination, Personalised care
G	Services provided in an integrated manner	To fulfil the core areas of work, what services currently exist to improve the health and wellbeing of residents and service users? What is missing/ could be developed?	Examples: MDTs, social prescribing, mental health worker etc
E	*Workforce type in place at neighbourhood (PCN Additional roles - as part of PCN DES)*	*Existing roles across organisations and services to provide the neighbourhood services.*	*Examples: Pharmacist, physician associate, social prescriber etc*

Barnet Neighbourhood Programme

PCN-led neighbourhood approach



Hyper-local neighbourhood approach – e.g. Grahame Park Estate



CORE NEIGHBOURHOOD MODELS:

Different 'engine rooms' possible to convene system partners (including but not limited to those displayed) together to work in partnership, wrap around the needs of local people.

Opportunities to align projects/ workstreams with both PCN-led and hyper-local neighbourhood models.

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What's happening now…

Programme governance – first Neighbourhood Programme Delivery Board took place on Thursday 24th August.

PCN data and analysis – working with Primary Care Network (PCN) Digital & Transformation Leads, Integrated Care Board (ICB) data team and Public Health data leads to support PCNs to develop data packs to support them to meet primary care commissioning and contractual requirements to address neighbourhood and health inequalities priorities.

Sharing knowledge/networking - Next system workshop confirmed for October 11th to bring together health and care system partners and PCNs and encourage collaboration on addressing neighbourhood and health inequalities priorities.

Expanding existing neighbourhood provision including integrated paediatric multidisciplinary team (MDT) clinics and continuing to grow the Ageing Well MDTs.

Expressions of interest for programme funding – we are developing an expression of interest (EOI) process for PCN teams to apply for seed funding to support new or expanding Integrated Neighbourhood initiatives or evaluating existing initiatives.

Evaluation support – we are exploring options and developing a framework for evaluating neighbourhood initiatives funded through programme funding and/or health inequalities funding.

Collaboration and Partnership – we work in partnership with all stakeholders to ensure that our local residents receive the best, most personalised and localised care possible.

See slide 4 for more information on projects including Grahame Park, navigation project, and Children and Young People's Asthma.

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Provisional Timelines

September: #AskAboutAsthma campaign sharing messaging about impact of smoking, vaping, air pollution, access on green spaces, and much more, on children's asthma; shared across schools, youth settings, clinical settings. Children and young people's neighbourhood asthma stream launched

October: Barnet Neighbourhood System Workshop

October: Applications for PCN seed funding open

October: Grahame Park Estate: 'Adults, Health and Wellbeing' work-plan to be agreed and confirmed

November: Communications campaign promoting and clarifying access to borough-wide navigation, signposting, prevention and wellbeing services

December: 2 – 3 PCN joint pilots funded/ launched

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Neighbourhood workshop

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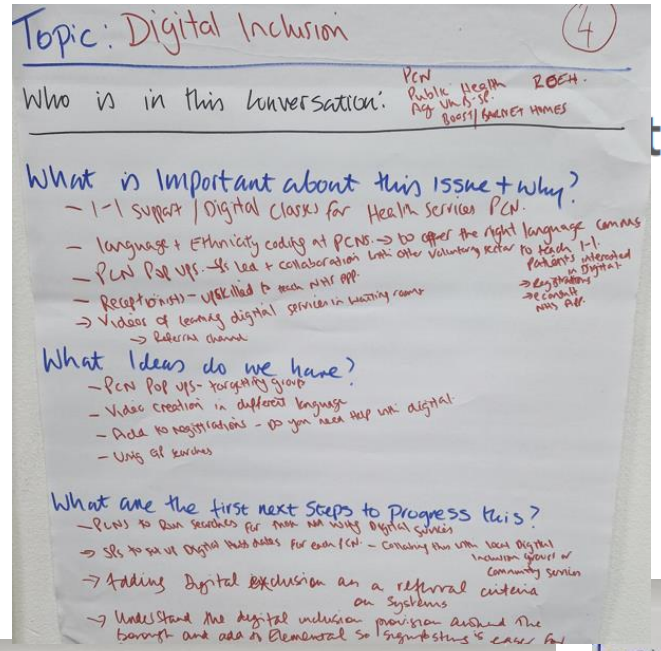
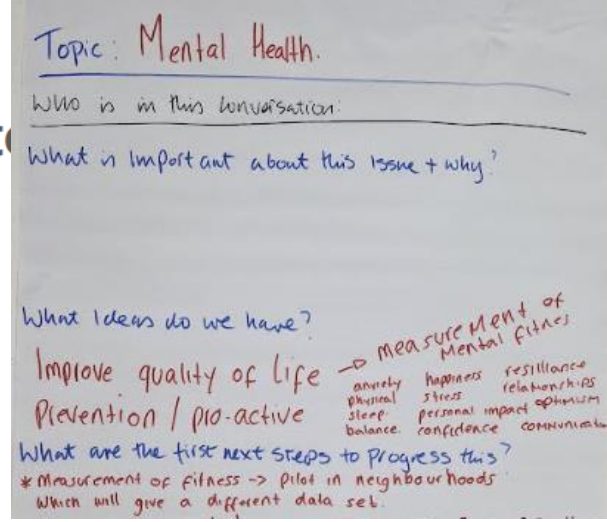
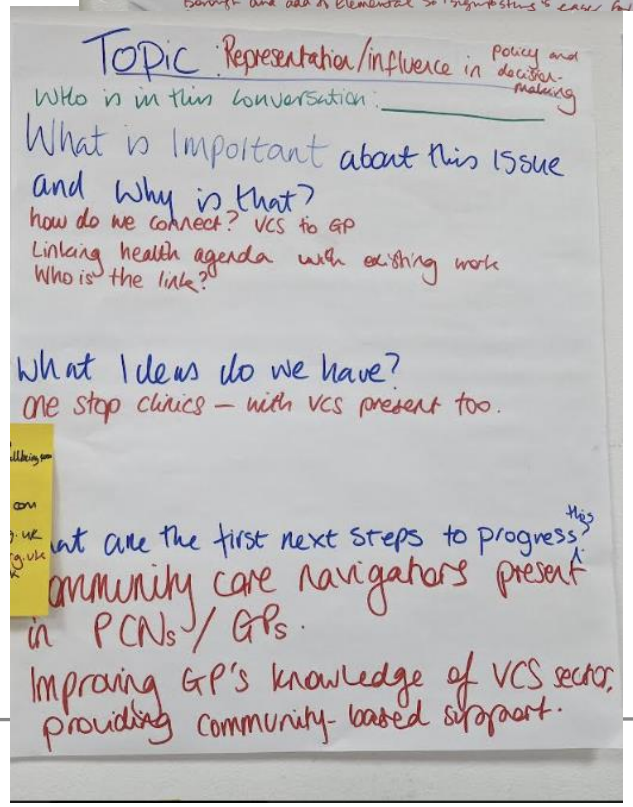
Neighbourhood workshop

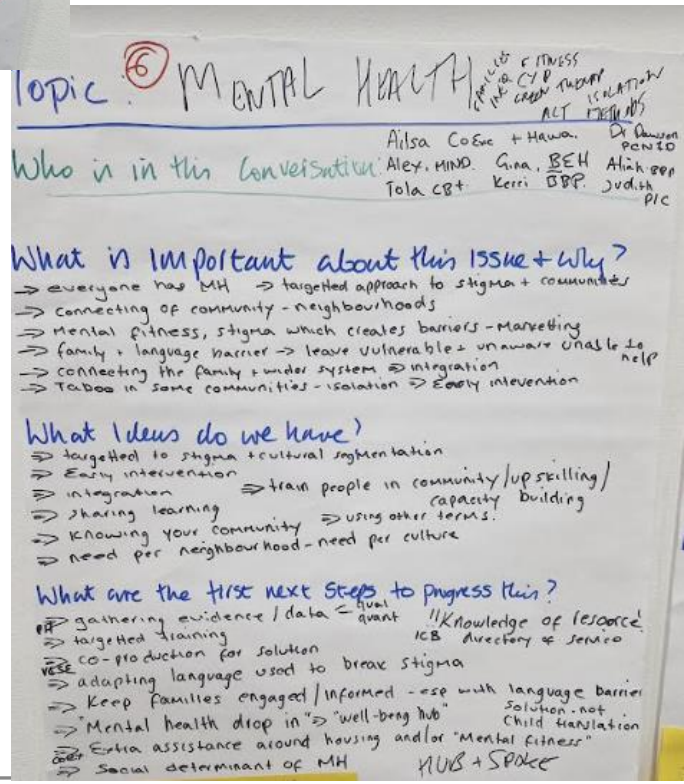
13 key ideas to take forward to potentially develop into pilot funding bids:

- Representation/influence in policy & decision-making
- Mental Health
- Housing & Health
- Inequalities
- Housebound & isolated people
- Interface between all providers
- Preparing for exponential growth of our ageing population
- Partnership working
- ‘Live’ neighbourhoods
- Expanding on Frailty MDTs
- Single point of access
- Cardiovascular disease & targeted communities
- Digital inclusion









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Integrated neighbourhood early adopter examples

What is being done across the UK to deliver Neighbourhood care?

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Examples: National and Local

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Greater Manchester: reframing relationship between services away from 'council + health services', towards 'public services'. Local Care Organisations built to connect organisations catering for 30k – 50k populations. Shared leadership, culture, governance and collocated, open-plan office space to enable true joint working. Huddles bringing people together 2 – 3 times a week.

Wigan New Deal: Footprints as common currency across system, colocation of services encouraged, weekly huddles with rotating leadership depending on priorities of patients, brought together by footprint manager. Improved health outcomes, life expectancy, staff satisfaction, system financial outcomes, school readiness etc.

Haringey & Islington: integrated care conferences – weekly face-to-face MDTs re 'complex patients' (similar Ageing Well MDT and borough-wide risk panel). Haringey Connected Communities drop-in sessions for residents, assisting re housing, benefits and health (similar to BOOST centres and Prevention and Wellbeing Team). This presents a simplified offer of navigation and signposting services in the communities that have no wrong front-doors. Underpinned by joined up services and enabled by a shift in culture.

Neighbourhood Integration Project: Leeds, Luton, Norfolk, with focus on overcoming barriers to integration: **shared** governance, **shared** practices and workforce

Well London: Partnership approach working from the ground up to understand local communities and work with their assets and strengths. Adds value to and informs development of services to better meet local needs.

Lancashire & South Cumbria: PCN and Neighbourhood Development Support Tool. Jointly developed checklist.

Gloucestershire: Integrated Locality Partnerships aligned to PCN footprints (aka Integrated Neighbourhood Teams) made up of local Government, NHS, Voluntary Community and Social Enterprise (VCSE) sector, housing and increasingly communities, people and wider partners such as police, education etc. They work with each other to bring services together and plan how they are delivered to their local populations.

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Keys to successful neighbourhood working

Such as:

- Embedding closer coordination and governance between different parts of a local system – resulting in better responsiveness to emerging/ changing needs
- Resource into organisational/ system development to lay the groundwork for cross-system working
- Asset/ strengths-based coordination and sharing resources
- Connecting health with services addressing ‘wider determinants of health’ e.g. police, housing, benefits, VCFS
- Navigation support for patients/ residents – underpinned by a care coordinator
- Weekly MDTs with widening coverage beyond frailty e.g. including people whose needs are complex, or where risk is increasing, and those most impacted by inequality
- Note that Barnet Ageing Well MDT, Borough wide risk panel, Prevention and Wellbeing Team, and BOOST service fulfil some of the key factors above.