ICP Integrated Neighbourhood Teams: Achievements

A summary of the programme's activities and achievements over 2024/25;

Brent ICP
Integrated Care Partnership

Integrated Neighbourhood Teams

The development of Integrated Neighbourhood Teams (INTs) continues to take place, priority areas for work have been agreed within these neighbourhoods. Shared learning sessions have commenced, with one happening every quarter. Willesden has presented the pilot project on Early Years and Asthma management. Harlesden will be presenting in the next quarter on the Diabetes MDTs they have been working on. Further detail can be seen below:

Diabetes Virtual Multi-Disciplinary Team (MDT)

Neighbourhood	Harlesden
Progress	The Diabetes virtual MDT has expanded significantly since its launch in November 2024, growing from 5 to 20 multidisciplinary members.
Intervention	A total of 9 complex diabetes cases were discussed and addressed through the MDT.
Impact	By preventing non-elective hospital admissions, the Diabetes virtual MDT has saved approximately £252,000 in potential hospital bed days. This demonstrates the effectiveness of integrated care in reducing unnecessary hospitalisations.

Early Years Asthma Clinic (Pilot) in Willesden

Objective	To improve asthma management among children by implementing Personalised Asthma Action Plans.
Achievement	Over the past 4-6 months, the clinic has successfully increased the percentage of children with Personalised Asthma Action Plans from 23% to 100%.
Impact	This initiative has the potential to reduce frequent A&E visits and hospital admissions for asthma symptoms that can be managed within the community. Specifically, 13 children who might have otherwise required repeated hospital visits are now receiving appropriate care locally.

Wembley, Kilburn and Kenton & Kingsbury

2025 focus – co-production sessions in planning phase.

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Integrated Neighbourhood Teams

Programme / workstream	Key deliverables	KPI / Metric	Achievements	Challenges to address in 2025/26
Programme Management	• Improve the outcomes of the residents in the neighbourhood including improved health and wellbeing, supporting people to live healthier, independent lives, and reduced inequalities in accessing services closer to home. • Champion co-production and inclusiveness throughout the neighbourhood as evidenced by better experience of staff and residents • Support the delivery of the quadruple aims, cooperate with statutory bodies and actively contribute to the wider place-based decision-making • Draw on the experience and expertise of professional, clinical, political and community leaders and promote strong system leadership amongst partners • Foster continued improvement & learning system, sharing evidence and insight across and beyond the neighbourhood, crossing organisational and professional boundaries	• Robust programme management template in place for the overarching transformational work • Programme and project plans in place for enabler workstreams with key deliverables and critical paths in place • Programme/ project plans in place for each neighbourhood with key deliverables and critical paths in place	• Successful recruitment into the Band 7- Senior Programme Officer (Enabler Workstreams) • Additional capacity to the team by way of a delivery officer • Establishment of the INT Executive (Senior Steering) Group • Programme plans in place for implementation of INTs • Programme plans in place for each neighbourhood • Programme plans in place for each enabler workstream • Set up of regular INT programme team meetings with other colleagues joining where there are interdependencies of work, starting with the primary care team. • First edition of the INT newsletter for professionals has been developed.	• Recruitment of two Band 8a INT Integrators Development of INT local explainer for residents and what it means for them • Sustainability of capacity and resource from programme team into the 5 neighbourhoods.

Neighbourhood Developments	• To roll out local model/s care through integrated health and care campus hub, embedding integrated MDT in a chosen priority cohort / area of need. This will involve population health data analytics, segmentation and stratification of the neighbourhood population; prioritising areas for improvement and tailoring the intervention/s provided.	• Local Integrated Health and Care Campus Hub Operational
		• Integrated MDT Embedded in Priority Cohort with Measurable Outcomes
			• Harlesden:
			  • Diabetes MDTs have been operational and have been growing to include a wide range of professionals. Deep dive into Diabetes prevention has led to relationships being formed with Thrive Tribe to deliver sessions in languages prevalent in the neighbourhood.
			  • 6-month stock take of neighbourhood development has been completed and is being written up with further priorities being set.
				• Undertake co-production sessions in the other 3 neighbourhoods, using the outcomes from this along with data to set priority areas of work
				• Continue to strengthen services for our CYP and their families upon the reopening of Granville FWBC.
				• Development of leadership structures for all 5 neighbourhoods

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Integrated Neighbourhood Teams (cont.)

Programme / workstream	Key deliverables	KPI / Metric	Achievements	Challenges to address in 2025/26

Neighbourhood Developments (cont.)			• Willesden:
			  • Priorities to take forward within the neighbourhood have been set.
			  • Early Years pilot has been taking place within the neighbourhood. MDT model includes child health hub and primary care colleagues. Increase in personalised care plans for Asthma from 23% to 100%
			  • Neighbourhood health and care fete organised in June 2024 with over 400 community members and residents in attendance.
			  • Stock take of neighbourhood development has been completed and is being presented as part of the Early Years Pilot: Learning Session last Dec. 2024.
			• Kilburn (South):
			  • South Kilburn initiative via Brent Council's Regeneration Team.
			  • There is a Community Working Party headed by South Kilburn Trust with 4-5 action groups underneath. One of the action group is dedicated to health and well-being.
			  • Meanwhile, integration work is continuing as demonstrated by delivery of core statutory services through Primary Care, Social Care, Public Health programmes and a number of VCSE-commissioned support services.
			• Wembley, Kenton & Kingsbury:
			  • Neighbourhood forums have been conducted with over 70 residents in attendance. They were consulted on their lived experience of health and care services they or their loved ones have experienced.
			  • Wembley neighbourhood leads started re-engaging in Autumn of 2024. Conducted further analysis on the number of residents living as well as those registered with their GPs in the neighbourhood.
			  • Further meeting with 2 x GP Federations covering Wembley to explore best ways of working moving forwards.
			  • A joint meeting was done on the 26th of Feb. to further prioritise opportunities for improvement and agree on where to commence its delivery
				• Continue to strengthen services for our CYP and their families upon the reopening of Granville FWBC.

Integrated Neighbourhood Teams (cont.)

Programme / workstream	Key deliverables	KPI / Metric	Achievements	Challenges to address in 2025/26
Workforce and Organisational Development (inc. Leadership)	Team of experts working together: • List of training offers available across the partnership and agreement of how partners can access training without the use of money as a currency. • Embed resilient MDTs, made up of colleagues supporting with the wider determinants of health.	• Staff survey results on confidence in MDT working and support. • Reduction in unplanned hospital admissions for patients with complex care needs.	Following a workshop that took place in May 2024, a thematic analysis was undertaken. This has then allowed 3 task and finish groups to form to take forward the work; Accessibility and Engagement (which will cover community and peer support), Education and Preventative Measures and Integrated Care Co-ordination.	• Align the steering group priorities with the new guidance (NHSE Neighbourhood Health 2025/26) released. • Complete the MDT workforce training mapping. • Align and connect with developmental needs of ARRs staff in Primary Care as well as the wider partnership
ICT, Data and Digitalisation	To tailor services to population needs: • Development and sign off on neighbourhood health dashboard, making it available for residents and staff. • Access to UCP for social care colleagues to allow for seamless care planning • Collaborate with IT and Information Governance (IG) colleagues to integrate social care records from MOSAIC into the Local Care Record (LCR).	• PHM dashboards (local Neighbourhood Dashboard) tracking preventative service uptake. • Population health reports measuring improvements in key health outcomes.	• Neighbourhood population health and care dashboard has now been completed and has received IG clearance to be published. • Governance for social worker's access to UCP has been worked through and has been signed off with BETTER and NWL. On-going Share Records working group to connect data from MOSAIC to LCR.	• Obtain sign-off on the neighbourhood dashboard. • Roll out the dashboard to frontline staff and also make available to residents. • Roll out access of UCP to social care • Continue to work on social care access to LCR so that the data feeds can occur when the technical solution is resolved
Estates	To establish health and care campus closer to where residents live: • Scope the potential campus hub options in each neighbourhood and sign off local estates strategy • Submit business cases and launch implementation of local estates strategy	• Patient service utilisation data for local health and care campus / hubs. • Emergency department attendance rates for preventable conditions.	• 5 neighbourhood workshops completed and overall options appraisal and risk scoring workshops completed for the refresh of our local estates strategy. • A draft local Brent Estates Strategy is being refreshed and will be shared around March 2025. Work at South Kilburn regeneration sites continues to progress. Whilst there is a delay at the Alperton site, conversations are happening with St Georges (site developer) for the GP Practice moving into the new site.	• Review and sign-off the refreshed local estates strategy. • Create a programme plan from this and begin to move to implementation based on short-term, medium- term and long-term actions.

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Radical Place Leadership in Brent

1. Working more closely together with partners in new and more innovative ways.
2. Working with communities rather than delivering services to communities.
3. Designing services that reflect the multiple, and often interconnected needs of our residents, rather than forcing residents to navigate rigid systems.

Our vision and principles

Start with the person

Genuinely shared vision and priorities

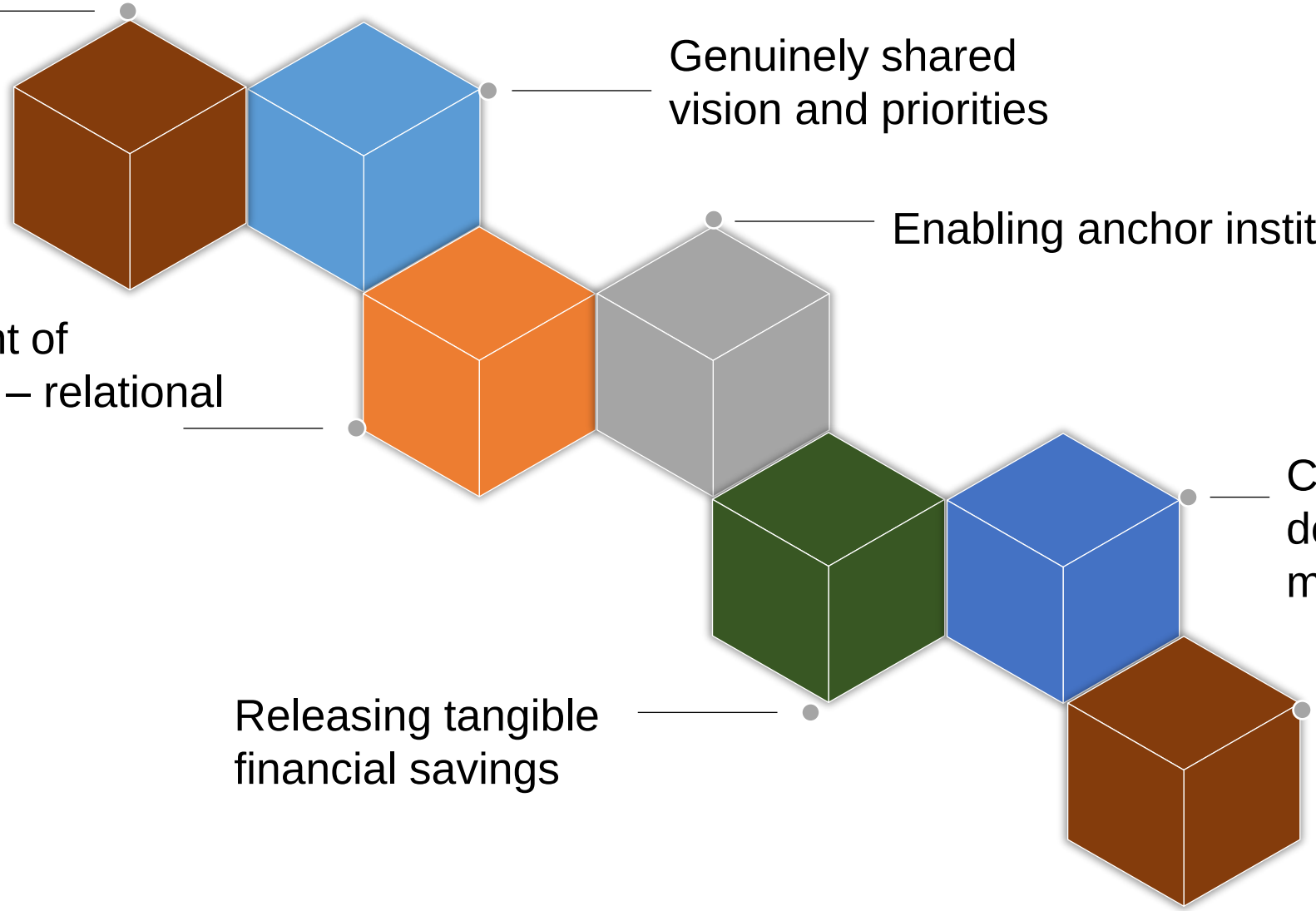
Enabling anchor institutions

Empowerment of professionals – relational practice

Community co-design, decision making and action

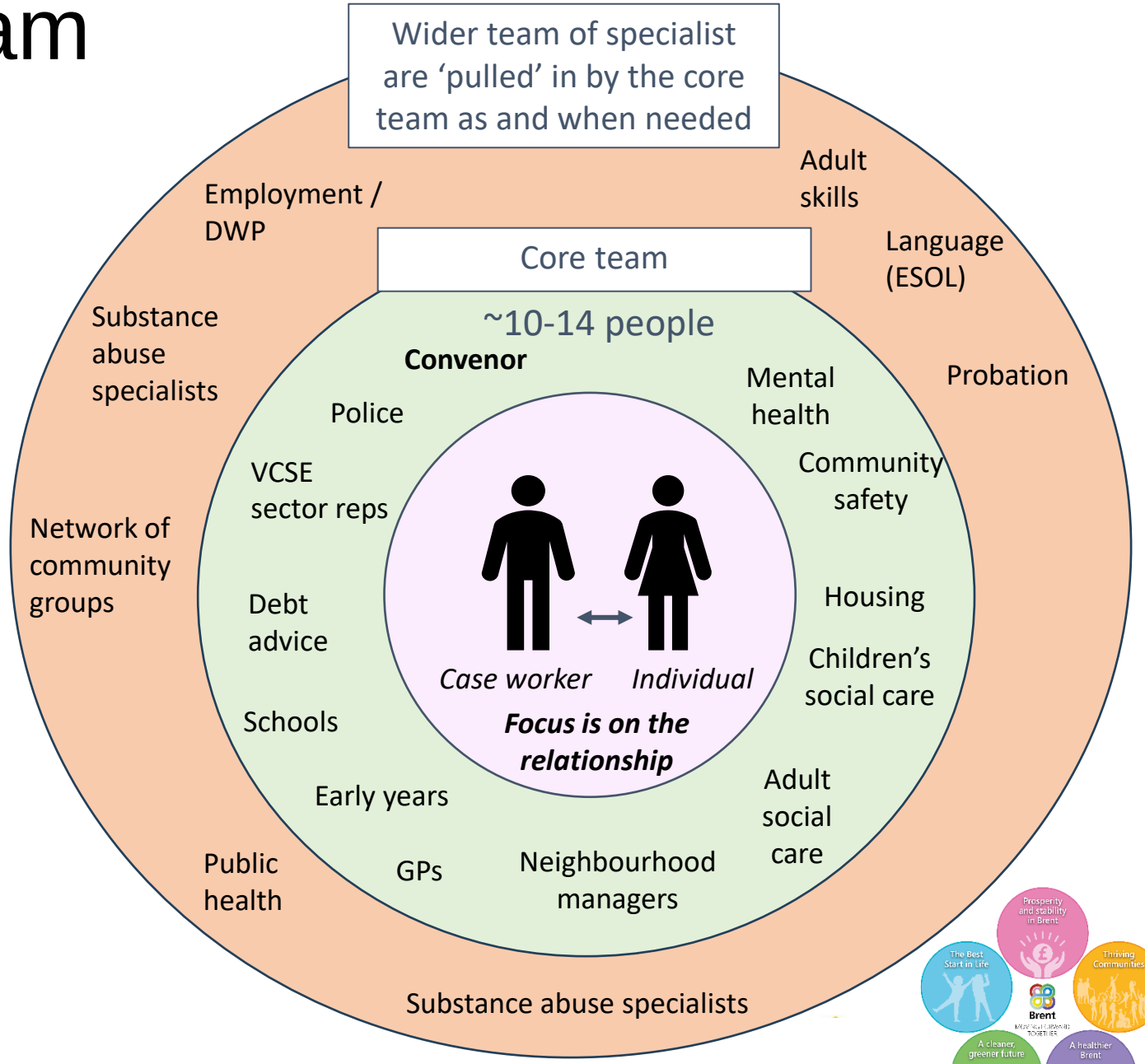
Releasing tangible financial savings

End with the person



Key features of the team

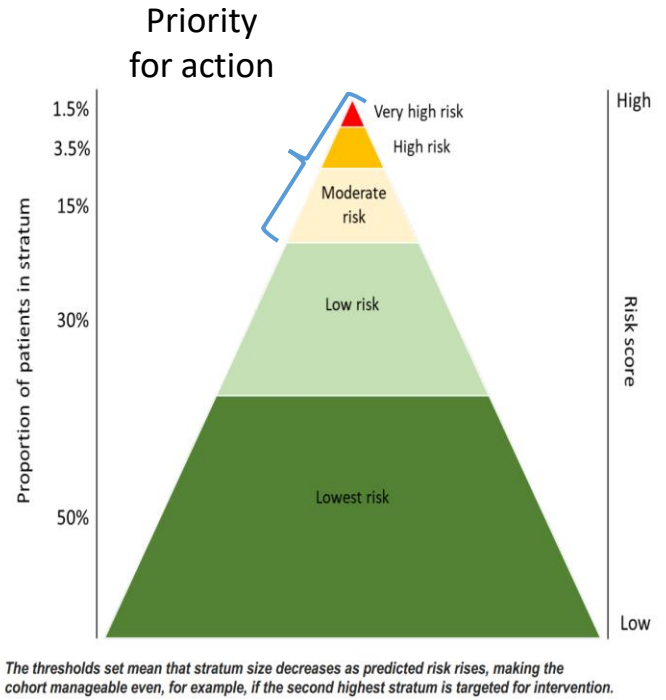
- Physically co-located
- Time for reflection
- Flexible budget
- Maintaining professional lines of accountability
- Focus on well-being
- Role of leadership to remove barriers.



Priorities

Strategic priorities emerging from the data and workshops

These centre on prevention and early help, though not to the exclusion of people in crisis.



The thresholds set mean that stratum size decreases as predicted risk rises, making the cohort manageable even, for example, if the second highest stratum is targeted for intervention.

Initial Priority 1. People at risk of homelessness - not living in a safe and secure place that's called home

Initial Priority 2. People living with debt - experiencing financial challenges and the risk of financial exclusion

Initial Priority 3. Children not being ready for school - unable to learn well and fulfil a child's potential

North West London Integrated Care System
Working together for better health and care

Community Power in Brent

1. Developing our own definition and shared understanding of what we mean by community power in Brent
2. Ensuring Brent residents have much greater say about the services and places they use.
3. What might this look like and how do we get there.

Rethinking how we work with communities

What is Community Power?

According to **New Local**, community power refers to the idea that local communities should be given **much greater say** and control over the **decisions**, **services**, **amenities**, and **places** that shape and affect their lives.

New Local's definition will serve as a foundation for co-developing Brent's own definition in collaboration with partners.

Individual health & wellbeing

Community wellbeing & resilience

Democratic participation & trust

Community cohesion

Preventative public services

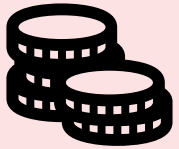
Financial savings

Brent

What the principles of community power may look like

Place-based approaches mean that engagement can be tailored to meet the specific needs of different communities.

People should **have a say** over the **places** in which they live and the **services** they use.



Communities should be **properly resourced** to make or influence decisions that will affect them.

Engagement approaches should take account of the needs of **diverse communities**.

Decisions should be made or **influenced** by the people that will be affected by them.

Often the best outcomes are achieved when communities and community organisations **collaborate** with one another.

Collaboration with community organisations presents an opportunity to **reduce engagement duplication** and/or **fatigue**.

Engagement with communities should always **adapt and evolve** based on feedback, and in response to community needs.