Hammersmith & Fulham
Health and Care Partnership
Better Together.

Neighbourhood Health – Linkworker Forum

Caroline Farrar – Managing Director, Hammersmith & Fulham Health and Care Partnership

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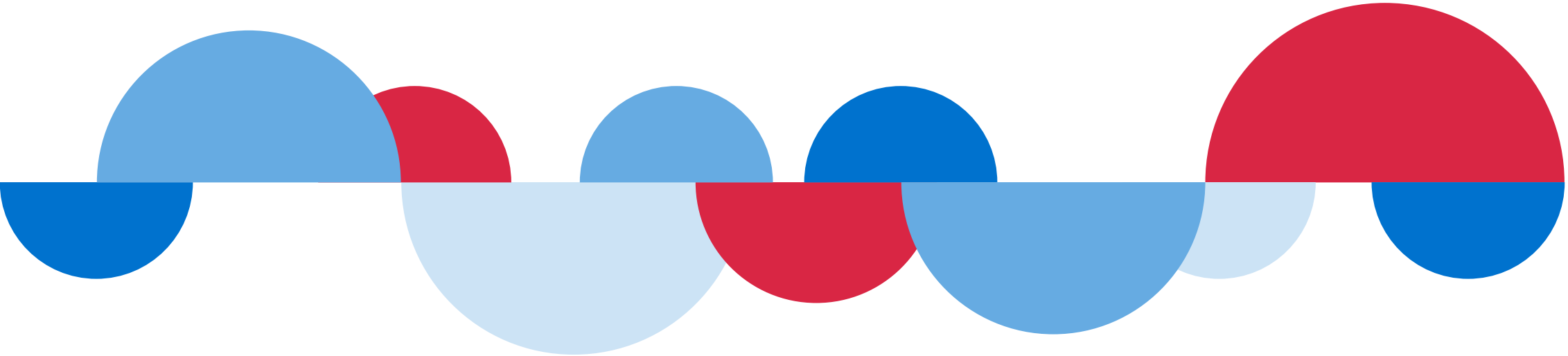


Our Partnership

Hammersmith & Fulham Health and Care Partnership
Better Together.

The Hammersmith & Fulham Health and Care Partnership, our borough-based partnership, was first established in 2016 to work with and for local residents to improve health, care and wellbeing outcomes.

The partnership includes health and care organisations working together with residents of Hammersmith & Fulham to improve health and care services for local people. It is a key part of the changes in the NHS which has seen commissioning responsibility move to North West London level, but with the borough-based partnerships responsible for planning and delivering care.

Purpose of the partnership

We will work together as partners in Hammersmith and Fulham to improve health and wellbeing and reduce inequalities.

We will develop more integrated, connected services that deliver tangible improvements that are better for our population and more sustainable for our organisations.

We will focus on tackling the wider factors that influence health and wellbeing.

We will work with local people to develop trusting relationships, empower communities and co-produce service changes.

Understanding “neighbourhood health”

- Many years ago, GP practices were surrounded by a wider primary care health offer for people with additional needs, with linked team members including professionals such as midwives, health visitors, district nurses, therapists and mental health practitioners
- Services were accessed through the surgery and associated clinics, and were trusted and understood in a very local neighbourhood context – with the family doctor at the heart of this
- GPs also had strong relationships with their local hospital colleagues – often they had trained at their local hospital, and people knew each other by name and had each other’s phone numbers
- Over time, as demands on the NHS grew and services were increasingly delivered by multiple different providers, professionals retreated from GP practices and into organisational teams. As the population has grown and aged, it is no longer possible for GPs to know most hospital doctors
- Over a long period, working practices have become more transactional (based on referral forms, criteria and operational protocols) than relationship-based, and some services have reduced in size relative to the size of the population

Why does this matter?

- As the population has aged and general health has declined, many more people have medium (more than one long term condition) or highly complex needs
- Our population continues to change, in particular our older population, which is small but growing. It has increased by 16% since 2011 and is predicted to further increase by 36% by 2033. Dementia prevalence is predicted to rise by 34% by 2030
- This will increase demand for health and social care services
- For people who have limited need for contact with the NHS, who are generally well and have no ongoing needs, the current way of working can work well – but the pressure services are under from people with greater needs affects them too, and general practice is a good example
- For people with more complex needs, the requirement for coordinated, joined up services has increased, but it has proved difficult to deliver this in practice

Why “neighbourhood health” could help

- Neighbourhood health involves reconnecting professionals from different organisations together, working around general practice, in a more relationship-based way
- It is important to be connected through general practice as the only truly local “neighbourhood” service that is continuously serving and in touch with our whole population
- However, it is no longer possible to align services around single practices, with very variable sizes (in H&F our smallest practice has about 2,300 patients and our largest has 19,000)
- Our health “neighbourhoods” will serve local populations of around 70,000 to 100,000 residents – this is a size that we believe means a greater range of services can be more connected
- Much of this work will be behind the scenes, in the day-to-day contact between professionals and the way they work – it will also involve working more closely in co-production with people, particularly those with additional needs
- Services will continue to be delivered more locally than at “neighbourhood” level – at GP surgeries, in people’s own homes, and at other locations in the borough – this is not about all services being delivered in one location, and most services are unlikely to move

What will be different?

- NHS organisations serving the Hammersmith and Fulham population are working together to develop what Neighbourhood Health means locally – this will take some time
- We are also working with council colleagues to work out how best to connect their services
- We believe we need three Integrated Neighbourhood Teams in Hammersmith and Fulham, formed around groups of GP practices who are already working together – North, Central, and South
- We hope this will mean that people experience:
  - Better access to services
  - More joined up services
  - More personalised care, meeting people's holistic needs
  - Better continuity of care
  - Better health outcomes

What do people say about our services?

People rate most individual services very highly, and we have high quality providers

There are significant inequalities in experience of accessing healthcare with a lack of trust in large organisations such as the NHS, particularly within some of our black communities

Care is often perceived as fragmented and disjointed between providers, including between health and social care

Specific areas of feedback include patient transport and disabled access

Experience of general practice is variable and this has been a recent focus locally

People experience a lack of continuity in some services, with multiple professionals involved in their care

These are issues being experienced in most areas across the country, and the partnership is focusing on working together where this will help us improve

The Case for Neighbourhood Health

The Fuller Stocktake Report proposed a new vision, focusing on improving access, providing proactive care, and enhancing prevention. **Integrated Neighbourhood Teams (INTs)** are the vehicles for implementing these changes, aligning with the goals of Integrated Care Systems (ICSs) and Borough Based Partnerships.

Even where performance across our system is high, **our current models of care are still leading to declining health outcomes for our population**. Moving towards integrated neighbourhood teams is being driven by both macro and micro factorrs

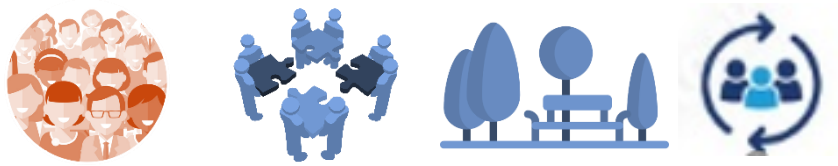
MACRO

- The healthcare system is often **fragmented**, with services operating in silos, leading to disjointed care and inefficiencies.
- Funding for healthcare and social services is often compartmentalised, making it **difficult to pool resources effectively**.
- An **increasing elderly population with multiple chronic conditions** places a significant strain on healthcare systems.
- There is a **shortage of healthcare professionals**, and existing staff are often overworked, stressed and burning out.
- **Disparities in health outcomes and access** to care persist across different populations.
- The current system is often **inefficient with high costs**, particularly due to hospital readmissions and unnecessary emergency department visits.

MICRO

- Different healthcare providers often **lack coordination**, leading to fragmented care and patient confusion.
- Traditional care models often **fail to consider the individual needs** and preferences of patients.
- **Difficulties in sharing patient information** across different systems and providers hinder coordinated care.
- **Building trust and engaging with the community** can be challenging, particularly in underserved areas, leading to inequitable access and poor outcomes.
- **Standardised care models** may not address the specific health needs of different local populations.

Key elements of Neighbourhood Health



Health creation and community empowerment – strengthening communities

Neighbourhood Working

Working more closely with local communities, providing a demonstrable improvement in experience for staff and residents and working to reduce health inequity.

This includes community outreach and building comprehensive networks in local areas, such as voluntary, community and faith sector organisations, as well as schools, leisure, libraries and parks, building on the existing assets within a community.

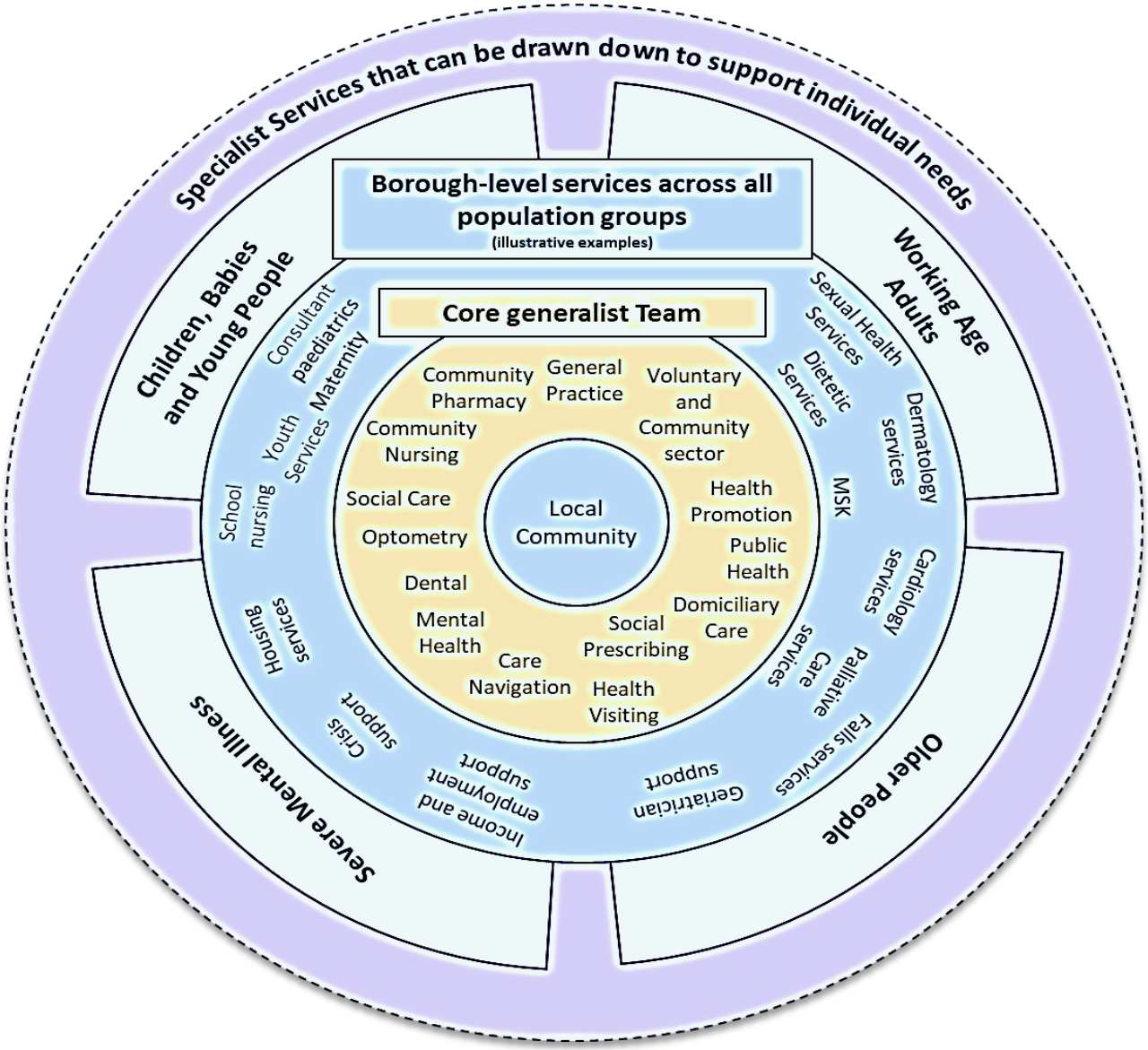
It also means supporting concepts such as health literacy and digital literacy, enabling people to better manage their own health and care needs where possible.

Integrated care – holistic, inclusive, high-quality

.

Prevent	Proactive	Reactive
Preventative Planned Care Improving uptake of key preventative interventions such as screening and immunisations. Improving overall population health to delay the onset of ill-health, long term conditions and/or frailty.	**Proactive Planned Care** Optimising treatment, and supporting self-management of long term conditions. Reducing exacerbations and escalation of people with more complex needs. Keep people with complex needs well via services that are personalised to their needs, provided through a multi-disciplinary approach with different professionals working together.	**Reactive Care** Enabling urgent needs to be better managed in the community, including same day care and admission avoidance. Expediting discharge following an inpatient admission.
Outcome: Increased uptake of preventative interventions reduces communicable diseases and the onset of conditions like cancer, heart disease and frailty.	**Outcome:** Improved management of existing long term conditions and complex needs through personalised care reduces hospital admissions and enhances patient quality of life.	**Outcome:** Faster access to urgent care prevents escalation of need and unnecessary admissions and supports timely discharge for better patient outcomes.

Integrated neighbourhood teams (INTs) include “team of teams” approach, with the core generalist team operating in the neighbourhood



Whilst many aspects of how an Integrated Neighbourhood Team functions will be defined in line with local population need, they will share some common qualities:

- They will all be **geographically aligned** to a population of c.50,000 - 100,000 residents.
- They will all **contain the core services** of General Practice, VCSE, Public Health intelligence, Adult Social Care, Domiciliary Care, Children’s Services (including antenatal and post-natal care), Health Visiting, Social Prescribing, Care Navigation, Community Mental Health, Community Nursing, Community Therapies, Community Pharmacy, Dentistry and Optometry.
- **Within our organisations**, staff will take a **“no wrong front door” approach** for all services, which can be access digitally, by telephony or in person. **We** will get people to the help and service they need.
- They will access connecting services for all population groups, which operate at Borough or wider footprint, in an **agile and responsive way**.
- The core teams will **pull down on more specialist, services at scale for specific population groups** through their acute trusts and other specialist service provision.

Key population groups and models of care for Neighbourhood Health

This diagram outlines some of the key care models and population segments, acknowledging overlaps and complexity. All models support population health management, personalised care, community strengths, and bringing services closer to people.

Each of these proposed models of care will be overseen by quartet leadership team: Clinical Lead, ICB Programme Lead, Provider collaborative lead, Place / LA Lead (slide 12)

System /Place	Age Cohort	Generally well (no long-term condition)	Long-term condition(s)	Complexity of conditions/needs
Children and young people	0-25	**Health creation and community empowerment**		
Working age adults	26-69			
Older people	>70			

Early years/Family Hubs

SEND and complex needs

Children and young people's mental health

Health creation and community empowerment

Secondary prevention (including common mental health conditions)

Adult mental health

Proactive care for adults and older people with complex needs

Health creation and community empowerment

Examples of current integrated models of care across NW London

The borough based partnerships are developing models of care that support a population health management approach across the whole population. This approach aims to bring services closer to local communities with examples of good practice highlighted below:

Harrow - Cardio renal metabolic model

Developed a personalised and proactive model of care with increased identification of people living with CRM conditions:

- developing a 'Harrow lifestyle prescription' including health check results, lifestyle prescription and personalised goal setting
- holistic support in terms of health coaching, social prescribing and peer support based on what matters to people.

Hammersmith and Fulham – Family Hubs

Family hubs in Hammersmith and Fulham centralise services like parenting support, health advice, and youth activities. They enhance accessibility and service coordination, improving family wellbeing, fostering community ties, and strengthening the integrated neighbourhood team's ability to deliver impactful support.

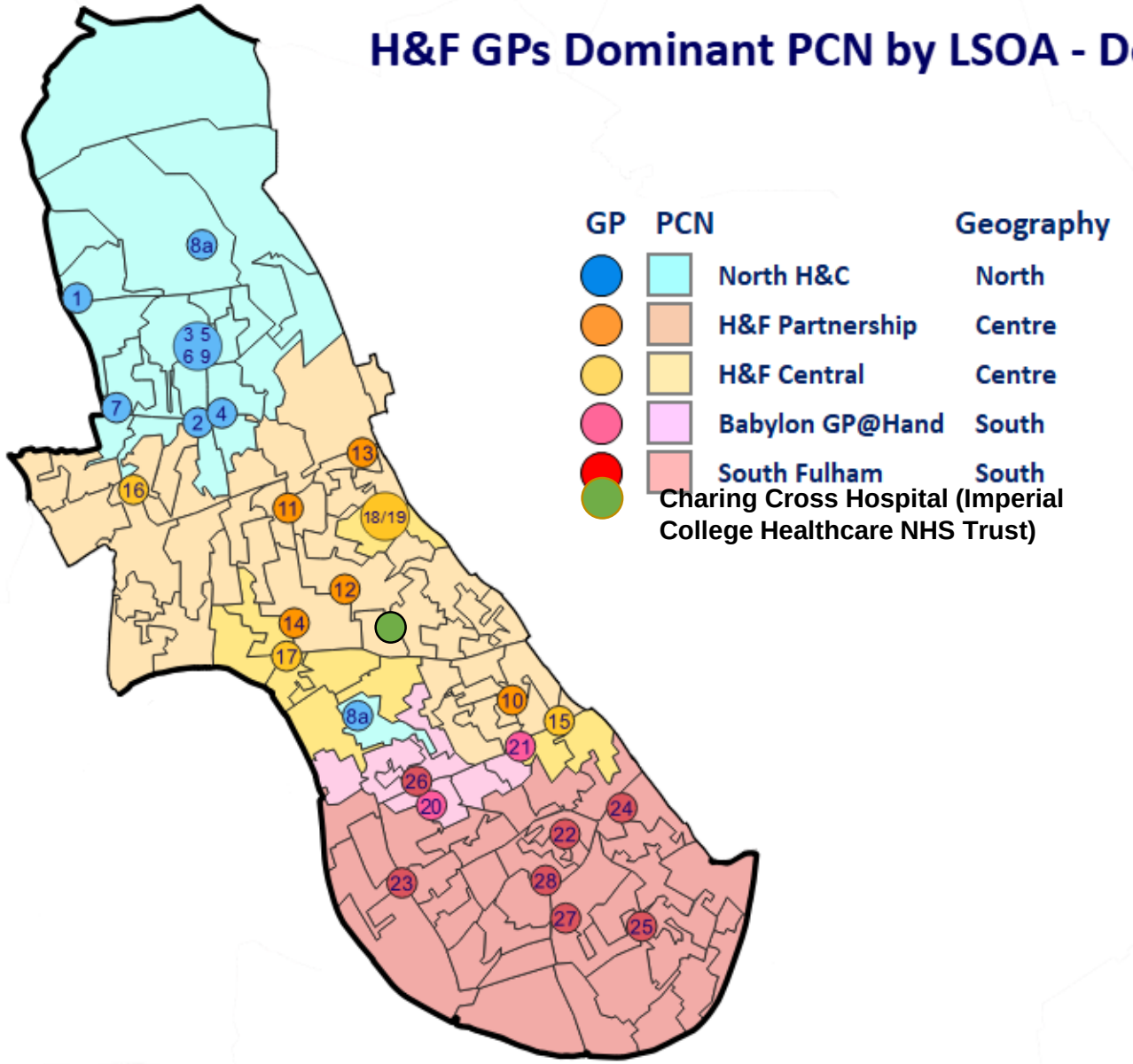
Hillingdon – Paediatrics integrated model

Neighbourhood working has been alive in Hillingdon since 2017. Since then they have established Integrated Paediatric Clinics which bring together Paediatric Consultants with GPs in neighbourhood settings. As well as providing a community setting for specialist care and reducing the outpatient waiting lists, the clinics support the development of relationships between primary care and consultants.

Ealing – High Intensity Users Services

Acute and Community HIU Coordinators are working with all partners in the hospital and community setting to join up care for residents and think holistically about how to support some of our most High Intensity Users of services.

Integrated Neighbourhood Teams



GP	Primary Care Networks	Geography	Number
Westway Surgery	North H&F PCN	North	1
The New Surgery	North H&F PCN	North	2
Parkview Practice	North H&F PCN	North	3
Shepherd's Bush Medical Centre	North H&F PCN	North	4
Dr Uppal & Partners, Parkview	North H&F PCN	North	5
Dr Kukar, Parkview	North H&F PCN	North	6
Dr Kukar, The Medical Centre	North H&F PCN	North	7
H&F Centres for Health (Hammersmith)	North H&F PCN	North	8a
H&F Centres for Health (Charing Cross)	North H&F PCN	North	8b
Canberra old oak Surgery	North H&F PCN	North	9
North End Medical Centre	H&F Partnership PCN	Centre	10
Richford Gate Medical Practice	H&F Partnership PCN	Centre	11
Brook Green Medical Centre	H&F Partnership PCN	Centre	12
The Bush Doctors	H&F Partnership PCN	Centre	13
Park Medical Centre	H&F Partnership PCN	Centre	14
North Fulham Surgery	H&F Central PCN	Centre	15
Ashchurch Surgery	H&F Central PCN	Centre	16
Hammersmith Bridge Surgery	H&F Central PCN	Centre	17
West Kensington GP Surgery	H&F Central PCN	Centre	18
Sterndale Surgery	H&F Central PCN	Centre	19
Dr Jefferies & Partners	Babylon GP at Hand PCN	South	20
Babylon GP at Hand	Babylon GP at Hand PCN	South	21
Cassidy Road Medical Centre	South Fulham PCN	South	22
Palace Surgery	South Fulham PCN	South	23
Fulham Medical Centre	South Fulham PCN	South	24
Sands End Health Clinic	South Fulham PCN	South	25
Fulham Cross Medical Centre	South Fulham PCN	South	26
Lillyville @ Parsons Green	South Fulham PCN	South	27
Ashville Surgery	South Fulham PCN	South	28

Our whole partnership programme and workstreams

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Priorities	Health Creation / Integrating Services
Workstreams – develop once, then organise at neighbourhood level	Health creation and community empowerment; Adult mental health; Older people and dementia
Develop each INT individually, focus on relationships and one or two workstreams	North H&F INT; Central H&F INT; South H&F INT
Develop and organise at place level, including the enabling workstreams	Children and young people crisis pathways; Workforce and OD; Estates; Data, Insights and Digital; Engagement and Co-production; Task and Finish Group on Contract Gaps and Overlaps