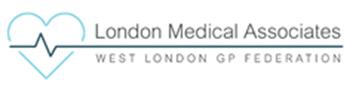
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**Expression of interest ‘Forever Care’**

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| --- | --- |
| **Organisation Name:** |  |
| **Name of authorised representative:** |  |
| **Contact email address:** |  |
| **Contact telephone contact:** |  |
| **Website address (if available):** |  |
| **Main business address:** |  |

**BACKGROUND INFORMATION**

Traditionally, organisations within the health and voluntary sector delivering social prescription have tended to work quite separately. **This can lead to duplication of service** by different agencies and people becoming involved in a **‘revolving door’** where they are in and out of services in a cycle without achieving long-term stability or improvement in their health and wellbeing outcomes.

As part of the development of the South Neighbourhood two workshops were held to look at how those involved in social prescribing in the south of the borough could work more closely together in an integrated way to address health inequalities more effectively and efficiently. A key theme arising from the workshop was the gap in local services to address the needs of people requiring ‘forever care’. These are people who, do not respond to short term interventions and as a result of unmet need become frequent users of community, primary care and voluntary sector services without ever getting the joined up support that might help them to feel better and have an improved quality of life.

This project seeks to develop an integrated local community of practice in the south of the borough bringing together key partners to address the needs of people who have lived experience of accessing community and voluntary sector services regularly without having their need for support met. Aligned with the local Health and Wellbeing plan this project is intended to test a community partnership approach to addressing the health and wellbeing needs of the most vulnerable in the local community. It supports delivery in core areas of the Health and Wellbeing strategy with a particular focus on:

**We support people to look after their mental health and wellbeing**

**We have access to the best services when needed**

**We are all treated with fairness and are able to shape decisions that affect us**

**We are supported and empowered to live as independently as possible**

These will be delivered by ensuring personalised health and wellbeing plans, ongoing support and care to address the complex needs of the most vulnerable local people. This will be achieved by pooling our local resources, knowledge and skills to ensure that people have the right care at the right time with a shared plan in place providing stability and tailored ongoing support.

We are looking for a local provider to co-ordinate the multi disciplinary team of professionals from the voluntary sector, health and social care who, with the consent of the person concerned, will come together to offer more joined up, longer term support to people who have needs that are not being met by current arrangements of services.

Over 18 months the project will support a minimum of 25 people

**Budget**

|  |  |  |  |
| --- | --- | --- | --- |
| Funding allocation | Year 1 | Year 2 | Total |
| MDT co-ordination | £22,600 | £11,300 | £34,200 |
| Voluntary sector interventions / participation | £7,00 | £3,500 | £8,500 |
| \*PCNs to fund MDT Primary Care Clinical Leadership | £0 | £0 | £0 |
| TOTAL |  |  | £42,700 |

**SCOPE**

We are looking for a local provider to co-ordinate the multi disciplinary team of professionals from across the voluntary sector, health and social care who, with the consent of the person concerned, will come together to offer more joined up, longer term support to people who have needs that are not being met by current arrangements of services. We anticipate that the individuals involved in the MDT will vary according to the needs and preferences of the person concerned

Over 18 months the project will support a minimum of 30 people. The project will focus on the south of the borough working closely with providers there and the two primary care networks (Brompton PCN and K&C South PCN) The provider will also manage a small budget to secure the input of the voluntary sector.

The provider will ensure that there are regular updates on progress to the West London INT Leadership Group

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| **1. Service model – evidence of experience. How would your organisation deliver this project. Please specify any previous you have of running similar initiatives? (maximum 250 words)** |
|  |
| **2. Service model – local challenges. What challenges do you anticipate in mobilising and running this model of working ? How would you manage and mitigate these? (max 250 words)** |
|  |
| **3. Service model – mobilisation . Please provide a timeline of key milestones in mobilising this project? (max 250 words)** |
|  |
| **4. Service model quality How would you monitor and report on the work providing assurance that it is addressing health inequalities, effective, provides good user experience and is safe? (Max 250 words)** |
|  |
| **5. Project impact – How will you ensure those who experience the greatest levels of deprivation are supported through this project.** |
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Expressions of interest should be returned to Mark.Day2@nhs.net by 12 noon July 14th 2025

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