Doing things differently

A strategy for embedding voluntary and community action in the health and care system to address health inequalities

January 2023

Kensington & Chelsea Social Council
Working to strengthen local voluntary and community organisations

ONE WESTMINSTER
where volunteering and community action transform lives

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Foreword

The voluntary and community sector in Kensington & Chelsea and Westminster is as diverse as the people and communities it serves. This is its strength. Every day, hundreds of voluntary and community organisations and groups work closely with, and within, our local communities.

Through our work, we see the daily challenges our residents and communities face. We understand the stark reality of what health inequalities really mean. Ours is one of most unequal areas in the country. This has to change. We want fewer people in Kensington & Chelsea and Westminster to live in unfair and unavoidable ill health, or have their lives cut short, because of the conditions in which they are born, grow, live, work and age.

However, tackling these health inequalities is not something that we can do alone. The building blocks of good health and wellbeing – like stable jobs, safe and secure housing, and social connections, alongside high quality health and care services – can only be put in place and improved if we work together. We must be ambitious and bring about this needed change.

Our vision is of a genuinely equal partnership, between the voluntary and community sector, NHS and local councils, working together in one system to tackle the health inequalities our residents and communities face.

This strategy aims to make this vision a reality.

It sets out how the voluntary and community sector, NHS and local councils in Kensington & Chelsea and Westminster can work together, within our new bi-borough place-based partnership for health and care.

Whole system thinking and working is a big change for us all. It requires a shift in the way we work together within and across sectors. To support this change, we worked collaboratively with our colleagues across the sector, over a six month period, to identify the four goals of this strategy.

Within this strategy we have set out practical steps to take to help us move towards achieving our goals.

We are now looking forward to working with the NHS and local councils to achieve these goals and become embedded as equal partners with the place-based partnership. Our immediate next steps are to engage colleagues through the 'Vibrant and Healthy Communities' programme, the health and wellbeing boards, in public health and adult social care, local organisations and other stakeholder groups to create a mutually agreed and realistic plan to operationalise our ambitions and progress the recommended actions. We are looking forward to doing things differently.

Angela Spence and Jackie Rosenberg
Kensington & Chelsea Social Council and
One Westminster
January 2023

Foreword

We are extremely fortunate to have such a diverse and vibrant voluntary and community sector in Kensington & Chelsea and Westminster. NHS North West London recognises the incredible work carried out every day by community organisations to support local people to improve their wellbeing. We consider the VCS as an essential partner in our integrated care system's future plans to deliver better health outcomes for all.

As an integrated care system we are striving to be community led in everything we do, and welcome the development and publication of this strategy by VCS organisations. Our involvement in this strategy commits us to working with the voluntary sector and to publishing and acting on the insights we will hear from local residents and communities. We look forward to working collaboratively in our local partnerships to make further progress with its ambitions and recommendations in the coming years.

Dr Jan Maniera and Dr Andrew Steeden, Borough Medical Directors for Kensington & Chelsea and Westminster

Introduction

Right now, in the least well-off neighbourhoods of Kensington & Chelsea and Westminster, people are dying nearly two decades earlier than people living in the wealthiest areas. Things like poor quality housing, social and economic exclusion, language barriers and low or insecure incomes can mean that people do not get the things they need to stay well – like a warm home, social connections and healthy food. This, and constant worry about making ends meet, results in increased stress, high blood pressure and a weakened immune system. It causes lives to be cut short.

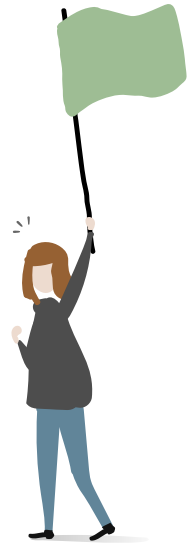
This is nothing new, but it has become apparent that the current health and care system has not delivered the change we need. As it stands it cannot tackle the stark and increasing inequalities and meet the demands on public services that result from it. Tweaking the existing system will not be enough. Ambitious new ways of working must be adopted if these challenges are to be overcome.

Business as usual is not an option

Nationally, the NHS has been working to revolutionise the way health and care is planned and delivered for some years. This resulted in the creation of 42 integrated care systems (ICSs) covering England in July 2022. Kensington & Chelsea and Westminster sits within the North West London ICS, and within that is the Kensington & Chelsea and Westminster Place-Based Partnership.

NHS, council and voluntary and community sector (VCS) colleagues in Kensington & Chelsea and Westminster have bold and ambitious plans to do things differently, drawing on our experience of what works and what doesn't. To enable this change, VCS organisations have come together to create this strategy.

About this strategy



This strategy was co-designed over a six-month period from August 2022 to January 2023. It involved over 45 organisations from across the voluntary, community and public sectors through a mix of workshops, engagement events and interviews (see Appendix 1 for further details).

The Kensington & Chelsea and Westminster VCS owns the strategy, as represented by the Bi-Borough VCS Strategic Group. Our local councils for voluntary service - Kensington & Chelsea Social Council and One Westminster - took the lead in the development of the strategy, supported by the external consultants Lev Pedro & Associates.

The strategy provides:

- A practical plan for harnessing and embedding the work of charities and community groups within the local bi-borough health and care system through partnership
- Recommendations for how the NHS, councils and VCS can work together in new ways, with the aim of reducing inequality and improving health and wellbeing outcomes for local people
- Proposals for specific actions and projects that will deliver improvements in health and wellbeing
- Case studies that highlight excellent existing practice that can be built upon as practical methodologies for collaborative working in the design and delivery of services.

We anticipate that this strategy will guide the place-based partnership's approach to working in partnership, through the 'Vibrant and Healthy Communities' programme. We look forward to working closely with our NHS and local government colleagues to develop and deliver these plans.

Why we need this strategy

Collaboration achieves better results

We know from experience that joined-up working achieves better results. We saw in the aftermath of the Grenfell disaster and during the Covid pandemic, that a lot can be achieved when we work together to do things differently. We must not put that down to 'extreme times requiring extreme measures'. Agile working methods, and the removal of inter-organisational barriers, must become the new normal.

New structures and systems are in development

The NHS has changed:

- **Integrated care systems** now bring together NHS bodies, local councils and the voluntary and community sector (VCS) to design and deliver health and care services in a more collaborative way. They were created with the purpose of devolving control and facilitating collaboration in order to make health and care services more efficient, effective and appropriate for patients
- **Place-based partnerships** have delegated authority to execute ICS business, such as commissioning. The place-based partnership for Kensington & Chelsea and Westminster sits within the **North West London ICS**
- **NHS guidance** requires the embedding of the VCS into the planning and delivery of healthcare at all levels, through **VCSE alliances**
- **Population health management** and **reduction of health inequalities** have become **core priorities** for health and care systems, and there should be **proactive intervention** delivered by **integrated neighbourhood teams.**

Community and voluntary assets must be mainstreamed

VCS organisations have always supported people and communities, and mobilised community action. No community is hard to reach. Yet for too long, VCS organisations have found themselves picking up the pieces from failures in statutory sector provision or referred to when the public system cannot cope. VCS organisations also tend to be far more agile and responsive than statutory services, because decision making and adapting services can be done far more quickly due to less bureaucratic processes to work through.

The VCS sector plays a vital role in health and care through:

- Health creation, prevention and early intervention, focusing on the wider determinants of health
- Facilitating access and trusted relationships within seldom heard groups and communities of interest and identity
- Service planning – amplifying voice, gathering insight, bringing intelligence and information forward, using co-production approaches
- Provision of health and care services
- Delivery of specialised support for people facing specific health conditions or from specific demographic groups
- Physical assets, such as buildings, open spaces, equipment and vehicles.

We now have an unprecedented opportunity to hardwire this asset into the health and social care system. By embedding the wide-ranging work of the sector as an equal partner in health and care:

- Duplication will be reduced
- Residents will experience more appropriate, efficient and seamless care
- Services will be designed from a social as well as a medical perspective
- Services can be delivered from more trusted community settings
- Money will be saved
- We will start to crack some of the most entrenched challenges that the system faces, including health inequalities and the improvement of health outcomes for all demographic groups.

Change will not happen on its own

People across the system acknowledge that fundamental changes are needed in what we do, and how we do it, if we are to see significant improvement in outcomes. Moving towards a common shared culture will require all of us to change how we do things, and it will require hard work. The breadth and depth of the transformation needed requires thought, planning and capacity, and there are many structural, practical, and capacity challenges to overcome.

What we want to do

Our mission is to reduce health inequalities by improving the health and wellbeing of residents, particularly the poorest.

Progress on health inequalities means that:

- **Fewer people live in unfair and avoidable ill-health because of the conditions in which they are born, grow, live, work and age**
- **Fewer people are avoidably excluded from the services they need to live well.**

Stable jobs, good pay, healthy food, clean air, quality housing, access to education, and opportunities to connect with others affect our health and wellbeing. Therefore, to reduce health inequalities, the building blocks for health and wellbeing need to be accessible by all our residents.

But putting the building blocks in place is not something that can be done by a single organisation, or one sector working alone. This can only be done by working together, collaboratively, as partners within one system, sharing resources, expertise and insight to contribute to the achievement of a shared mission. A genuinely equal partnership between ourselves, the NHS and local councils, all working together as one system, is therefore our vision.

How we will do it

Our bold vision requires a shift to whole-system thinking and working.

This involves:

- **Building strong relationships and shared culture**
- **Maximising the assets that already exist within the VCS** – including data, insight and expertise
- **Working collaboratively with the VCS as an equal partner from the outset** to ensure a holistic approach with a focus on people, early intervention and prevention, which will tackle the wider social determinants of health and address the needs and views of those sometimes overlooked in service design
- **Allocating appropriate resources** (with other system partners) to develop the capacity of VCS organisations, infrastructure and people.

Good collaborative working will involve:

- **Committing ourselves** to working within the sector and with our partners to overcome the challenges outlined above
- **Testing ideas**
- **Learning** from failure in a constructive way
- **Allowing time** for new ways of working to embed, and longer timeframes for systems to show positive outcomes.

Achievement of this will lead to:

- The VCS playing its part as an equal system partner within the place-based partnership and the integrated care system
- The VCS thriving and becoming more resilient, thereby being more effective in identifying and addressing health and wellbeing needs in the community and reducing health inequalities.

Where we are now

Kensington & Chelsea and Westminster

400,000 people

150 languages spoken

30% of population belongs to minority ethnic groups

18 year gap in life expectancy for men in the richest and poorest wards

76 GP surgeries grouped into 9 primary care networks

2 hospitals

620 charities registered with our local councils of voluntary service

Local area and population

Kensington & Chelsea and Westminster are two boroughs within northwest London with a resident population of approximately 400,000 people. It is one of the most ethnically and culturally diverse and densely populated areas of the UK. In Westminster over 150 languages are spoken and around 30% of the population belongs to a minority ethnic group. Inner city streets nestle among over 100 parks and green spaces. As the centre of the nation's capital, the population grows to over 1.5 million during the day. Air quality is an issue of particular concern.

Our area has neighbourhoods with some of the highest life expectancy in the country, but this good news masks stark disparity in outcomes depending on where people live. Health inequalities are among the highest in the UK, with a life expectancy gap of 18 years (for men) between our richest and poorest wards.

Local health and care services

Across Kensington & Chelsea and Westminster there are 76 GP surgeries (grouped into nine primary care networks), two hospitals (the Chelsea & Westminster and St. Mary's) and numerous minor injuries units, urgent treatment centres and private-sector facilities. Residents may also receive care from hospitals in neighbouring boroughs. The country's leading cancer centre, the Royal Marsden, is based in Chelsea, and world-leading HIV treatment facilities are delivered by the Chelsea & Westminster trust.

Local VCS assets

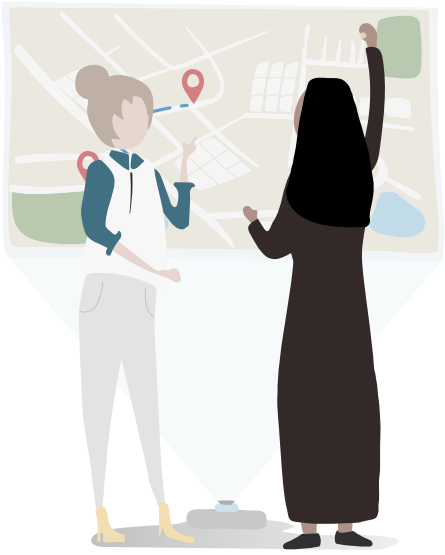
There are 620 charities registered with our local councils of voluntary service, Kensington & Chelsea Social Council and One Westminster. There are also hundreds of smaller unconstituted organisations and groups.

Our local VCS assets include:

- Service provider charities
- Grassroots community groups
- Informal resident action groups
- Religious institutions
- Two local councils for voluntary service, two volunteer centres, two youth foundations and a giving foundation
- Active citizens, including experts by experience and thousands of volunteers. The VCS provides a conduit for these voices to be heard.

Several national charities also have projects or activities in the area, for example:

- British Red Cross runs a **discharge from hospital scheme**, that supports elderly and vulnerable patients to stay at home, which is better for the patient and frees up NHS bed capacity
- Macmillan provides support to people with cancer and their families from a **dedicated centre at the Chelsea and Westminster Hospital**
- Turning Point runs the **Drug & Alcohol Wellbeing Service** that provides services ranging from one-to-one support, group work, prescribing and in-patient options.



Various programmes or projects that involve collaborative approaches have proven themselves to be effective and should be learnt from, sustained and replicated. Some are commissioned or grant-funded, others are not. These include:

- **Health Partners** in North Kensington, sponsored by the local NHS, and works though locally based community groups to build community resilience
- **Community Living Well** in Kensington & Chelsea, Queen's Park and Paddington
- The **BME Health Forum** (see case study)
- **My Care My Way**, an integrated care service that puts older people in the driving seat of their care and support (see case study)
- **Westminster Home-Start**, which offers a multi-disciplinary approach to assessing and supporting new mothers (see case study)
- **Westminster social prescribing**, which provides link workers, working collaboratively with primary care, to direct patients to social activities in addition to, or as an alternative to, medical treatment (see case study)
- **North Kensington community champions** and **Westminster community champions**, recruiting and training local residents to work on housing estates to promote health and wellbeing through neighbourhood activities and campaigns
- **For Women CIC**, which offers community-based mental health support, working collaboratively with mainstream IAPT services
- Cross-sector working groups that were set up to find agile and effective solutions that cut through bureaucratic processes to tackle the Covid pandemic and the cost-of-living crisis
- Volunteering programmes in the local NHS hospitals
- Volunteering programmes run by the two local volunteer centres that collaborate with wider statutory partners to support people into employment and reduce social factors affecting health, such as isolation.

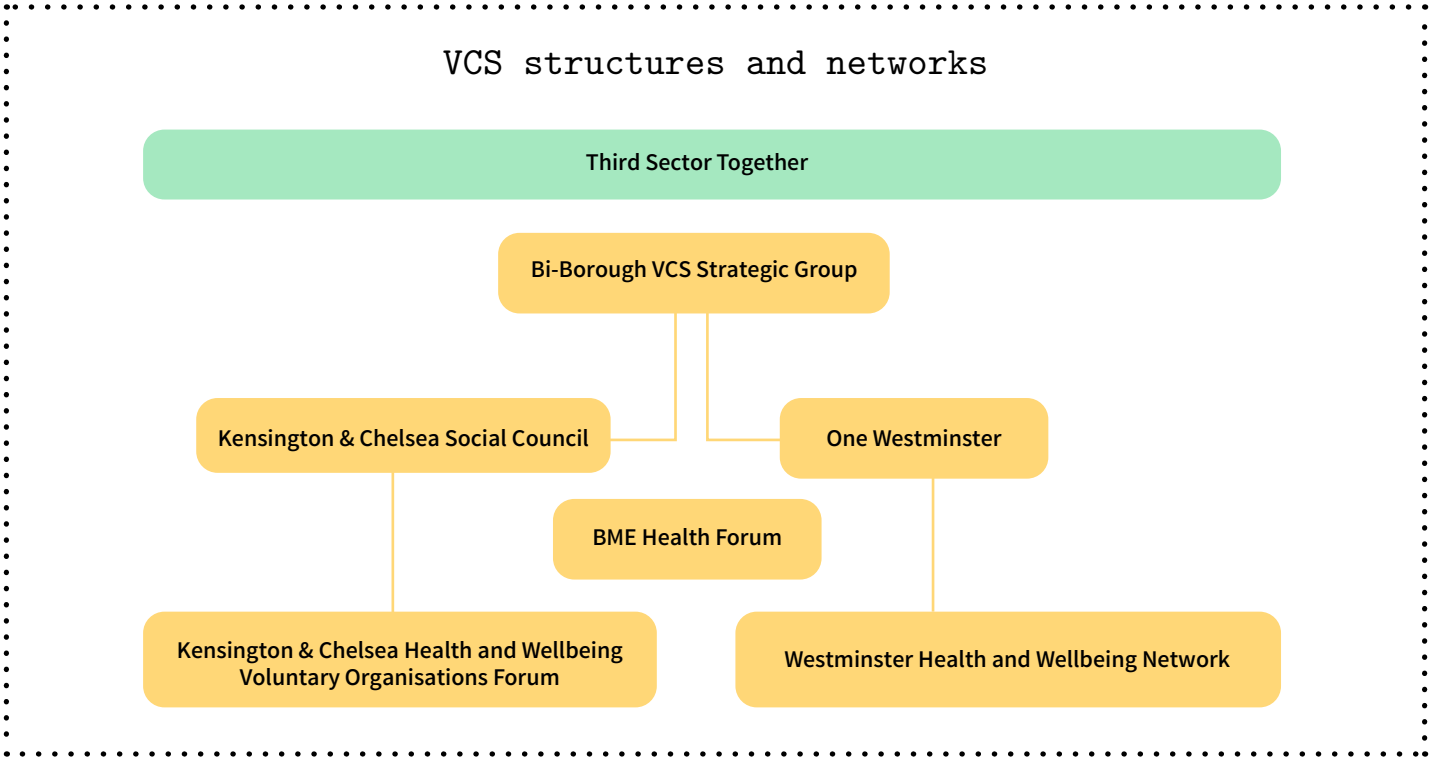
Local VCS structures and networks

The VCS in Kensington & Chelsea and Westminster has a long and deep history of working in partnership, since the merging of council back-office functions in 2011 and as part of the Kensington & Chelsea and Westminster health authority prior to primary care trusts being created in 2013.

Coming together to share insight and intelligence, connecting individuals into each other's support and services, and seeking opportunities to improve the lives of the residents with the poorest outcomes is what we do.

We have a model for partnership and representation within the VCS that is ready to be embedded within the place-based partnership. This is built on existing infrastructure, structures, networks, and forums mechanisms.

- Third Sector Together (3ST) provides a framework for networking, collaborative working and contracting across the eight boroughs of northwest London. This is our 'VCSE alliance' according to national policy
- A community interest company that could be developed to act as a contracting vehicle locally
- Kensington & Chelsea Social Council and One Westminster, contracted to deliver networking and representation in each borough, including:
- The Bi-Borough VCS Strategic Group (the new place-level structure for the VCS, as part of the 3ST North West London VCS structure)
- Kensington & Chelsea Health and Wellbeing Voluntary Organisations Forum and Westminster Health and Wellbeing Network, providing networking for local organisations as well as an access route to the sector for public sector colleagues
- A bi-borough health and wellbeing board, which is part of local government with VCS involvement
- Kensington & Chelsea Compact (operating since 2001)
- Various forums on issues such as children and young people's services, older people's services and advice agencies
- BME Health Forum – an independent charity providing voice, networking and a contracting vehicle for minority ethnic-led organisations (see case study).



Our bi-borough partnership

We are represented at 'system' level by **3ST**, which is embedded in the North West London ICS through a formal partnership agreement and governance, which includes VCS representatives from the two boroughs.

The local place-based vision for health and wellbeing (to be delivered through the Place-Based Partnership) has collaboration at its heart. The core aim is to tackle inequalities, through partnerships and community participation. Whilst longer term strategies are being developed, short term priorities for action have been set around children and young people, mental health, hospital discharge and care homes, and healthy weight.

Currently, representatives from the VCS sit at the table of most of the Place-Based Partnership boards, meetings and working groups. This includes the Organisational Development Group, working groups for each of the short-term priorities, and as part of the Vibrant and Healthy Communities programme. Our ambition is to build on these structures and go further, as a route to tackling health inequalities.

At the time of writing, other relevant and related pieces of work underway across the two boroughs include:

- The development of a 10-year health and wellbeing strategy for Kensington & Chelsea and Westminster
- The development of a North West London Inequalities Framework
- A bi-borough council review of VCS commissioning
- **Changing futures in Westminster** - a Department of Levelling Up, Housing and Communities funded programme
- The #2035 collaborative initiative - a local partnership between Imperial College Healthcare, Westminster City Council and community partners that aims to improve health and halve the 14-year gap in life expectancy between those with the highest and lowest life expectancies in Westminster by 2035
- Core20+5 project.

This VCS strategy seeks to complement this work by bringing all the assets of all the VCS into our ambitions to tackle health inequalities.

Our mission is to reduce health inequalities by improving the health and wellbeing of residents in Kensington & Chelsea and Westminster, particularly the poorest.

To achieve this, our vision is of a genuinely equal partnership between ourselves, the NHS and local councils, all working together as one system.

To turn our vision into reality, our goals are:

- **Build strong relationships and shared culture**
- **Enable an holistic approach with focus on people, early intervention and prevention**
- **Maximise the use of VCS assets, like data, insight and expertise**
- **Develop capacity and infrastructure for partnership**

Our goals

1 Build strong relationships and shared collaborative culture

Why?

- Experience shows us that the basis of good partnerships is relationships, and this is even more the case when moving to a system-based and less transactional way of working
- Good relationships build shared understanding of each sector's cultures, ways of working, challenges and opportunities
- This in turn helps to forge an inclusive culture, based on trust and respect, that appreciates diversity
- Once strong relationships and a shared culture exist, technical and governance challenges can be more easily overcome
- When people feel like they are part of a team with shared values, mission and goals, they are more able to draw on that teamwork and create impactful work
- Poor relationships and differences of approach lead to duplication of effort, worse outcomes for people and wasted resources.

What this means for how we work

- VCS organisations are part of a system that has a genuine shared culture, not (as in the past) the sector being asked to rearrange itself to fit in with an NHS restructure and way of working
- Space and time are created to develop systems and practical processes that will build relationships
- Health and care staff have a better understanding of how wider determinants affect health, and the role of VCS services in addressing health and wellbeing.

Examples of good practice to build on

- Thinking Differently Together (Suffolk & North East Essex)
- Home-Start
- Cost of Living Group.

Case study: Devon buddying scheme

Devon has a buddying scheme where 16 leaders from the voluntary and community sector link with 16 leaders from the wider system including the CCG, local authorities and NHS Trusts. They spend 12 months getting to know each other through phone calls or cups of tea every six weeks and learn how their role fits into the overall care picture for Devon. It has facilitated vital connections that help to reduce the invisible barrier that sometimes occurs between sectors.

Case Study: Collaboration and building a shared culture (Home-Start)

This case study demonstrates how developing a collaborative culture between organisations, as well as a co-design approach with clients, leads to better outcomes for new parents and their children and reduces inefficient use of resources.

Background

Kensington & Chelsea and Westminster based Home-Start offers social, practical and emotional support to new parents and those with children under five years old, through a team of professionals and volunteers. Working in close partnership with children's centres, healthcare professionals and VCS partners, they support people with a range of complex social and health needs.

How it works

1. Upon receiving a referral, the Home-Start coordinator aims to visit within two weeks. The family and coordinator **co-create** a plan of support (which can include befriending, counselling, onward referrals, access to a local baby/food bank for essential items, housing and welfare support, and introductions to parent networks and other social support)

2. Home-Start co-ordinators make **joint visits** with healthcare providers (health visitor, psychiatric teams, GPs, etc.) to ensure seamless support

3. Decisions about ongoing support are discussed at **multi-agency meetings**. It is agreed who is going to do what to provide ongoing support

4. Home-Start coordinators **monitor** their caseload to ensure that no-one falls through the gaps

What is different about this approach?

This way of working:

- Is based on building strong relationships between volunteers, professionals and agencies
- Promotes self-sufficiency by building families' confidence and strengthening their relationships
- Promotes a culture of collaboration and partnership between all those that need to be involved
- Helps service providers understand each other's roles, skills and expertise.

What is achieved?

- The service creates positive outcomes: **In 2021-22, 88% of clients reported feeling less isolated and 80% reported improvements in their mental health**

> "Home-Start has definitely [brought] a change to my life and what I am today I will not be without you."
>
> *Sarah, client*

Case Study: Collaboration and building a shared culture (Home-Start)

- Duplication is reduced: Multi-agency meetings ensure that those working with the family are aware of what is being offered by partner agencies, reducing the time spent on a particular issue. This also ensures that families are receiving the best support from the right person. By building a shared understanding across multiple agencies of the families in difficulty, it is easier to find the right solutions
- Resources are maximised by professionals coming together as one workforce around a family. Coordinators and volunteers can support and encourage the family to implement health strategies that have been identified by healthcare providers.

Key learning

1. The approach delivers more holistic and rounded care to families, with better outcomes and reduced duplication, and facilitates self-sufficiency
2. This approach allows for each agency to play to its strengths
3. The strong relationships that are built with client families enable staff and volunteers to 'build bridges' with other services that the families might otherwise be resistant to using

"I was thinking about the stress points in the system. … The one thing that stands out by working well together is flexibility. Most of the time when pressures mount, things can be missed, which is normal, but when all agencies show flexibility in their work and approach, it allows for much better outcomes. … The usual response to pressures in agencies and teams is to pull back and hunker down and protect oneself. And that's what families do when they're stressed and feel threatened. Services do the exact same thing."

Thien Huong Nguyen,
Scheme Manager

Case Study: Cost of Living Working Group

This case study demonstrates a shared culture and ways of working across organisations and sectors, focused on overcoming bureaucratic barriers to get things done in an agile and joined up way.

Background

The Cost of Living Working Group aims to find solutions for the residents most negatively impacted by the growing gap between basic costs and household incomes, which is leading to increasing levels of poverty and inequality.

The group emerged out of the Community Resilience Group, a multi-sector group in Kensington & Chelsea, which was formed in 2020 in response to Covid. It provided a useful local decision-making function during the pandemic and the Afghan refugee arrivals. It included local voluntary and community sector organisations, residents, local councillors and council and NHS colleagues, at different times.

How it works

The Cost of Living Working Group aims to be a partnership of equals, creating a space where there is constructive challenge and focus on solutions.

The group:

- Takes responsibility for co-ordinating the work of the participating agencies on reducing factors that cause poverty
- Acknowledges that power structures, behaviours, resource distributions and priorities have not improved outcomes for residents in greatest need
- Seeks to identify and address the causes as well as the symptoms of residents' problems, and challenge 'business as usual'
- Makes decisions by acting in the best interests of residents.

What is different about this approach?

Through joint work, the Cost of Living Working Group seeks to develop a culture of trust, challenge and rapid service adaptation that enables a far more effective response than would normally be the case. Voluntary and community sector partners make use of the project management support from statutory sector colleagues, and this increases the ability of voluntary sector colleagues to play a full part.

> "We try to bridge the divides between, and within, organisations, and be honest about the way economic and social inequality in the borough creates risk and vulnerability for residents and leads to poor outcomes."
>
> *Michae Ashe, Chair, K&C Cost of Living Working Group*

What is achieved?

- A "mobile one-stop-shop" model, taking a targeted approach to reach residents most in need where they are
- A data sharing protocol which aims to keep residents in need stay on our collective radar until we have delivered for them, placing the onus on the system, not the resident, to find solutions
- A systemic approach to understanding and tackling chronic problems, rather than a short term 'sticking plaster'.

Recommended actions

Embed relationship building and shared culture through ways of working

Short term (by Dec 2023)

- Full-time senior post within the place-based partnership with responsibility for oversight of VCS partnership, relationship building and culture change
- Directories of key contacts across all sectors that are kept up-to-date and shared with people open to being contacted
- Relationship building with the VCS as part of all place-based partnership job descriptions and the appraisal process
- Consistent approach to sending out meeting requests, setting agendas and circulating papers, avoiding short term requests unless critical, takes into account different working patterns, lines of accountability and external pressures within the VCS

Medium term (by Dec 2024)

- Funded posts with responsibility for VCS partnership / relationship building / culture change at all levels of the place-based partnership
- One consistent set of principles of good partnership working with the VCS for all place-based partnership boards / committees / working groups / steering groups / task and finish groups to adopt
- Place-based partnership programme development checklist ensures VCS involvement is written into the process and Chairs refer to it in every meeting
- VCS within induction processes and career development of place-based partnership personnel, e.g. attending VCS forums, walking tours, shadowing etc.
- 'Pick up the phone' culture, where 'name tags are left at the door' so people across sectors can contact each other outside of formal meetings, without judgement, for advice and guidance

Recommended actions

Build cross-sector understanding of different cultures and ways of working

Short term (by Dec 2023)

- Staff at all levels in VCS, NHS and councils come together (e.g. through leadership buddying or 'A Day in the Life' approach) to build understanding about different ways of working, culture and day-to-day challenges
- Monthly senior leaders 'social event with no agenda' programme
- Building on the work of the placed based partnership organisational development workstream, an online space enables cross-sector leaders to meet regularly to discuss, develop and learn about common interests and priorities in health and care, to develop shared understanding of the challenges, build awareness about what is already available within Kensington & Chelsea and Westminster and explore potential solutions

Medium term (by Dec 2024)

- Cross-sector 'joint action' matrix-working teams tackle priorities as they arise, building on the learning from heightened collaboration to tackle the Covid and cost of living crises

Share training, systems and assets

Short term (by Dec 2023)

- Relevant VCS and public sector training is available to cross-sector partners (where it can be provided at no additional unit cost or if costs are covered) and is accessible to all by funds available for VCS time if needed
- Analyse and assess opportunities to open up sharing of back-office functions, tech platforms, estates and other assets held by the VCS and public sector across Kensington & Chelsea and Westminster

Medium term (by Dec 2024)

- Open up system assets – like estates - to be shared by all system partners as much as practically possible
- Areas of delivery where VCS and public sector can improve outcomes by bringing together personnel and assets are identified
- VCS are consistently involved as partners within multi-disciplinary teams

Our goals

2 Enable an holistic approach with a focus on people, early intervention and prevention to reduce health inequalities

Why?

- Acting early prevents unnecessary suffering for patients and saves the system money in the future
- Studies show 80% of our health and wellbeing is driven by social, economic and environmental factors – only 20% by clinical services
- Offering people practical ways to deal with social, practical and emotional issues affecting their health and wellbeing, and intervening early, is a key route to tackling health inequalities.

What this means for how we work

- Prevention is an agreed system priority, long-term funding is found to invest in what we know works, and the VCS has increased responsibility for leading on funding decisions and allocations for self-care and prevention activities
- We adopt a whole-system approach that addresses both clinical and social causes of ill-health
- Our approach incorporates primary, secondary and tertiary prevention. We understand that this is not just about preventing people becoming ill in the first place, it is also about preventing deterioration of health and ensuring people can stay as well as they can at all stages, including those with multiple or complex health needs
- Resources are shifted 'up-stream' from acute and primary care to prevention
- We agree as a system where there is already evidence that something works and do not require new projects, that are known to work elsewhere, to prove themselves before being considered
- The VCS is resourced to measure and demonstrate impact of early intervention.

Examples of good practice to build on

- Westminster social prescribing
- My Care My Way
- Community Living Well
- Healthier Futures North Kensington
- Place-based approaches to tackle health inequalities in the Southwest.

Case Study: Integrated self-directed service for over 65s (My Care My Way)

This case study demonstrates how agencies working together across organisational and sector boundaries – focusing on self-care and wellbeing – can produce better experiences and outcomes for patients and provide a positive return on investment.

Background

My Care My Way is an integrated approach to promoting the health and wellbeing of people aged 65 and over. It includes the GP, NHS organisations, social services, voluntary organisations and patients themselves. As well as providing a more appropriate self-directed service to patients, evaluation has shown a significant positive social return on investment (SROI).

How it works

Once referred into the service, the patient is supported by an integrated care team, which includes the GP and a case manager. Together with the patient a care plan is drawn up, and this ensures that the patient receives appropriate support from a range of service providers working harmoniously together.

What is different about this approach?

From the outset the service was co-designed with local residents, and there is a high degree of focus on patient self-management, as well as a genuine multidisciplinary approach.

The financial model provides funding for the services that the patient receives support from, not just for the assessment and referring on process (as is the case mostly with social prescribing schemes).

Regular assessments and monitoring provides data to the supporting agencies collectively, and enables the integrated care team to coordinate their responses and anticipate changes in the patient's health.

What is achieved?

A social return on investment' (SROI) evaluation was carried out in 2018 and updated in 2019. This showed an SROI of £3.20 per £1 invested (at 2017-unit cost prices). This includes the value of subjective health and wellbeing improvement, and around £1.65-£1.80 resource savings to GPs, hospitals, and social care.

Key learning

Agencies working together across sector and organisational boundaries, with a focus on patient self-care, can:

- Deliver a more effective service that is better for the patient
- Take pressure off frontline GP services and secondary care services
- Create significant savings to public funds.

Case study: Westminster social prescribing

This case study demonstrates how outsourcing a service to the voluntary and community sector, whist maintaining strong working links with primary care, can improve the experiences of patients.

Background

Social prescribing is a way for GPs and other professionals to support patients to receive social, rather than, or in addition to, medical care. NHS England has funded social prescribing 'link workers' across England through the Additional Roles Reimbursement Scheme (ARRS), with a view to this approach being mainstreamed into primary care eventually. One Westminster manages the services through an NHS-commissioned contract.

How it works

- A social prescriber assesses the patient's needs and supports them to access services in the community
- The client develops a professional relationship with the social prescriber, who works alongside them to improve their wellbeing and to prevent further difficulties occurring in their lives. This relationship includes 'handholding' the person into the services and activities they are referred to
- The social prescriber continues to monitor the participation of the person in the recommended activities and services to ensure the person is supported with the needs that have been identified.

What is different about this approach?

- This is a systematic way to unlock the potential benefit to patients of a wide range of services that already exist in the community, that they might not know about
- It directs patients away from GPs and NHS services, where a community-based service is better for the patient
- In common with many areas around England, the management provider is the local infrastructure organisation, which enables seamless access to a network of service provider organisations through an existing local 'trusted' organisation.

What is achieved?

Evidence from around England shows that outsourcing the management of social prescribing (as opposed to the primary care network running it in-house) delivers a more holistic approach.

This **case study** shows why embedding link workers in the sector leads to better results.

Key learning

- Social prescribing is an effective model for providing more appropriate support to people with certain conditions, which also provides savings to public funds
- Outsourcing the management of such a service, whilst ensuring that it works closely with primary care, has benefits
- There is a gap in that social prescription can add pressure to services that are already under-funded, so a more strategic view needs to be taken across the bi-borough area, or even across the northwest London system, which also builds on approaches such as My Care My Way.

Recommended actions

Shift to early intervention and prevention

		Long Term (3 - 5 years)
Short term (by Dec 2023)	Shared understanding of evidence, from elsewhere if necessary, of prevention interventions that are known to work	A shared funding programme for prevention / early intervention
Medium term (by Dec 2024)	Mechanisms for collaborative working on prevention, with the VCS included all clinical pathways	

Target health inequalities

		Long Term (3 - 5 years)
Short term (by Dec 2023)	System agrees that 80% of health and wellbeing is generated outside of the health service	Budgets (across NHS and council departments) aligned to tackle wider determinants
	Good practice in the Kensington & Chelsea and Westminster VCS that tackles the social determinants of health and reduces exclusion is identified	Cross-sector secondments and joint staff posts
Medium term (by Dec 2024)	Partnership reflects impact of 80% and includes all those that can address wider determinants of health – housing, money, work, relationships, etc.	Funding to catalyse practical community projects that tackle health inequalities

Recommended actions

Strategically develop person-centred care

		Long Term (3 - 5 years)
Short term (by Dec 2023)	Cross-sector group steers strategy and implementation of social prescribing and other community-based approaches (e.g. out-of-hospital, high-intensity user programmes, support for adults with additional needs) on a wider scale, building on good practice in Kensington & Chelsea and Westminster and identifying barriers and challenges	Consistent bi-borough approach to social prescribing Adopt community-based approaches more widely
Medium term (by Dec 2024)	Gaps in community provision, identified through social prescribing and other community-based approaches, are explored and filled so that this approach grows and flourishes as an example of whole system working in practice	

Our goals

Maximise the use of VCS assets, like data, insight and expertise

Why?

- Historically, data and intelligence have not been collected and shared between organisations and sectors widely and systematically
- Research shows the barriers to data sharing include technical barriers (such as different data collection systems and access restrictions), cultural barriers (such as lack of recognition of different forms of data), financial barriers (for example organisations not being able to meet the cost of legally compliant data collection) and legal and regulatory barriers (such as GDPR compliance)
- Good sharing of data across organisations and systems provides insight and intelligence that can inform service planning and design; data that are held in the VCS pertain specifically to communities facing disadvantage and/or poorer health outcomes, ensuring that the full impact of services is reflected in decision making
- Harnessing insight from 'experts by experience' is invaluable in shaping services.

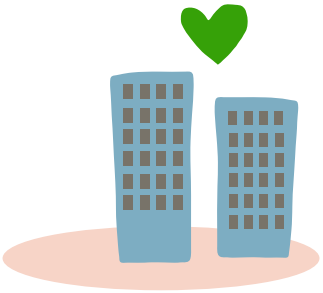
What this means for how we work

- We have a shared understanding of need across our population, and shared evidence about our impact
- A 'data and intelligence strategy' is co-designed, involving cross-sector partners at bi-borough and northwest London system levels
- Multiple sources of data, including lived experience, are valued
- There are simple, legally compliant and cheap online systems for capturing and reporting data and intelligence
- The VCS is supported and resourced to capture and report data and intelligence
- Data and insight are used systematically to inform service design in the bi-borough area, as well as across the North West London system
- The default method of service design is co-production
- Experts by experience are trained and remunerated for their contribution
- Residents and patients receive the most appropriate support.

Examples of good practice to build on

- Grenfell community-led response
- Milton Keynes Community Data Tool
- Working with Everyone mechanism for public authorities to engage experts by experience.

Community-led response to the Grenfell disaster



This case study demonstrates how, with the right conditions, people with direct lived experience of an issue can mobilise and create an effective community-led response.

Background

Latimer Community Art Therapy CIC (LCAT) is a grassroots community organisation offering professional mental health support through art psychotherapy, as well as creative, educational and sports activities, to support physical, social and emotional development - always with the aim to provide an inclusive, safe and inspirational space for the community.

How it works

LCAT provides a specialist community-led art psychotherapy service in 15 schools in Kensington & Chelsea with outreach to a further four for individual referrals. Alongside the school service is the 'Connected Community' art psychotherapy service in three local community centres. Art psychotherapy aims to help the individual make better use of future opportunities and relationships and assist children onto a healthy developmental path.

Support is needs-based and child-centred - LCAT psychotherapists work from the needs presented by the child, the parents, and the school, over a period that meets the child's individual need to ensure longer lasting, meaningful change. The duration of the intervention depends on the needs and progress of the individual. Interventions are between three months and two years, with a range of personalised individual and group offers.

What is different about this approach?

LCAT was formed as a response to the Grenfell disaster by Susan Rudnik, an art psychotherapist and resident of the Henry Dickens estate. It grew organically from the Henry Dickens Community Centre to meet the emotional and therapeutic needs of the community resulting from the trauma of the fire.

What is achieved?

The programme provides much needed therapeutic support to children, young people and adults that were traumatised by the fire and the immediate response to it.

In the 2021/22 academic year alone, LCAT:

- Worked with 1,074 individuals (501 children and young people accessing the Henry Dickens Centre and 573 individuals accessing art therapy)
- Received 178 new referrals to art psychotherapy and 6,512 accesses to therapy throughout the year.

Key learning

Given the right conditions, a community will identify its own needs, develop an effective response to those needs, and review and refine the response until it is as or more effective than established provision. This creates tensions between community-led development and business-as-usual, but if we focus on what is effective, especially what is effective as reported by the target population, and we empower local people within our decision-making systems, we will, sooner or later, move our limited resources to the places where they can make the most difference, improve outcomes, and reduce inequalities.

Recommended actions

Collect data and evidence

Long Term
(3 - 5 years)

Short term (by Dec 2023)

- Collective understanding of the data partners collect, what we need and what is missing with priorities for further action identified
- System invests in supporting VCS to collect and collate evidence through shared collection and reporting systems

Medium term (by Dec 2024)

- Common yet proportional approach to data and evidence collection, based on place-specific objectives
- Routes for feeding this data and evidence into service design and improvement are identified

Share data and information

Long Term
(3 - 5 years)

Short term (by Dec 2023)

- All partners understand the merits and relevance of different sources of the evidence and data collected (e.g. community insight, trends emerging from helplines, surveys, volunteer interaction, support groups etc.) alongside conventional clinical data
- Shared digital patient record, with different levels of access agreed, so relevant partners can review and update. Shared open area to update on social care and wellbeing interventions
- Existing cross-sector data approaches reviewed, interoperability of IT systems / data platforms assessed
- Guidance on data sharing, for strategic development purposes, outside of specific contracts. This is made as easy as possible for the VCS and is two-way (VCS to statutory and vice versa)

Medium term (by Dec 2024)

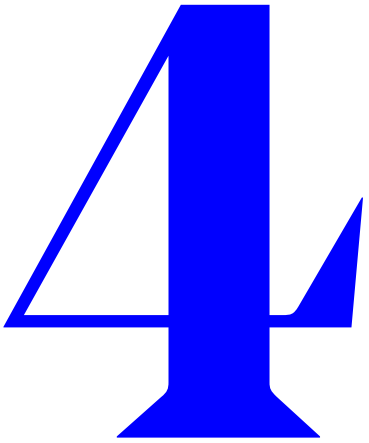
- External funding for working together as a system to overcome technical data sharing
- Systems to track people moving within and between statutory and VCS provision

Recommended actions

Shared outcomes

		Long Term (3 - 5 years)
Short term (by Dec 2023)	Assessment and analysis of existing outcome measures (for things like wellbeing) collected across Kensington & Chelsea and Westminster contracts	Agreed system outcome measures (for things like wellbeing)
Medium term (by Dec 2024)	Assessment of pros and cons of different outcome measures – related to accessibility, ease, cost etc – from the perspective of all partners and different communities of interest and identity	

Our goals



Develop VCS capacity and infrastructure for partnership

Why?

Increased capacity is needed to enable the VCS to:

- Thrive and play an increasing part in improving health and care outcomes
- Grow and sustain representation (building on existing networks)
- Develop robust communication networks among the sector and between statutory-sector partners and the sector
- Involve organisations that address health inequalities (e.g. faith and minority-led groups) in representation and decision-making
- Build contracting solutions for partnership delivery within the sector
- Integrate new data and evidence capture systems (as discussed above)

What this means for how we work

- Leadership and representation structures are resourced
- Longer-term grants and contracts are issued
- Grants to the VCS allow for core operational costs
- Emphasis is placed on inclusion of minority-led groups and people with lived experience at all stages of health service strategy, planning and design
- Local infrastructure organisations receive longer-term investment, to enable them to support the sector to achieve all the above goals.

Examples of good practice

Enabling diversity of involvement

- **Mosaic co-production**
- **BME Health Forum**

Putting VCS partnership model in place

- **West Yorkshire 'Harnessing the Power of Communities' programme**
- **Lincolnshire Voluntary Engagement Team CIC**

Investment in resilience and delivery

- **Manchester Alternative Provider Federation**
- **Community chests** for community provision, identified through social prescribing.

Case study: Co-production (Mosaic)

This case study demonstrates how a co-production approach with marginalised communities built community capacity, led to better strategic understanding of an issue and established a sustainable cross-sector business relationship.

Background

Mosaic Community Trust aims to empower diverse, socially and economically marginalised and disadvantaged communities, thereby enabling them to participate actively in strategic decision making at the community level and to access mainstream services and economic opportunities. They achieve this through the promotion of health and economic wellbeing, community leadership and a rights-based approach to community support.

In partnership with Imperial College London, they took a 'co-production' approach to a research project that investigated reasons for low vaccination rates among certain demographic groups.

How it works

The National Institute of Health Research sets out the five key principles of co-production:

1. Sharing of power – research is jointly owned, and people work together to achieve a joint understanding

2. Including all perspectives and skills – the research team includes all those who can contribute

3. Respecting and valuing the knowledge of all those working together – everyone is of equal importance

4. Reciprocity – everybody benefits from working together

5. Building and maintaining relationships – an emphasis on relationships is key to sharing power. There needs to be joint understanding and clarity over roles and responsibilities. It is also important to value people and unlock their potential

What is achieved?

The project:

- Captured the real experiences of members of the community that are seldom heard

- Supported Mosaic's stated aim to influence research programmes and health outcomes through collaboration

- Demonstrates how a co-production approach to research led to improved understanding of the reasons for low uptake of vaccinations among certain demographic groups

- Established a sustainable working relationship between a community-based organisation and a research institution.

> "Together with the Mosaic Community Trust, we are passionate about moving beyond tokenism in public involvement in research and meaningfully involving members of the public whose voices are underrepresented in research."
>
> Dr Helen Skirrow, Clinical Research Fellow, Imperial College London

Case study: Co-production (Mosaic)

Key learning

The research project highlighted lessons for those wishing to undertake a co-production approach:

1. Invest early in community relationships – it takes time but reaps rewards. For example, attending community meetings and just listening to people's views and ideas has informed research

2. Respect that community members have busy schedules and demands, like everyone. Plan sessions to coincide with a community group's regular meetings

3. Consider whether the research idea is a priority for those you wish to engage – if not, asking them for their time may not be in their best interests

Case study: BME Health Forum

This case study demonstrates how, through an intermediary organisation, a mutually beneficial relationship can be created that both improves experiences of diverse communities as well as provides a valuable mechanism for statutory bodies to engage with and those communities and work collaboratively to reduce health inequalities.

Background

It is widely known that people from some minority groups, particularly those for whom English is a second language, experience barriers and poorer access to health and care services, and public services more widely. The BME Health Forum was established in 2002 within Westminster NHS Primary Care Trust and later constituted as an independent charitable organisation, to address this.

The Forum:

- Is a unique and well-established partnership between voluntary and community organisations, healthcare providers, commissioners, and local authorities
- Improves the quality of health and social care services for patients from deprived backgrounds
- Empowers marginalised patients and communities to engage and influence local health and care provision
- Provides a way for health professionals and commissioners to listen to the health needs of marginalised patients and make improvements to health services.

How it works

The Forum operates through a small executive team, which, mainly through local statutory-sector funding, develops projects that support its mission. Recent examples are:

- Intermediary partner for Comic Relief, in partnership with the National Emergencies Trust, Barclays and The Clothworkers' Foundation, to distribute funds from the Global Majority Fund
- Awarding grants of between £4,000 and £20,000 to 21 organisations helping communities in London experiencing racial inequality meet their immediate needs related to Covid-19
- A Multilingual Emotional Wellbeing Support (MEWS) service supports ethnic minority residents who are experiencing emotional and mental wellbeing difficulties, but are not mental health service users.

What is different about this approach?

The Forum:

- Has a governance structure that enables it to be led by the local community: the majority of trustees are leaders of locally-based BAME-led charities which represent a diverse range of local communities, currently Chinese, Somali, Iranian, Middle Eastern, Francophone African and BAME youth
- Disseminates information about services, events, consultations, jobs, funding, and changes in policy or legislation through its website and news bulletins

Case study: BME Health Forum

- Holds quarterly engagement meetings that promote two-way communication between the NHS and the local ethnic minority community sector
- Facilitates and takes part in formal and informal consultations and focus groups that contribute to improved understanding of statutory providers and commissioners of the needs of the local population
- Provides advice and support to community organisations and individuals about how to engage with the NHS, and supports NHS commissioners and providers to successfully communicate and engage with local providers, users and patients
- Assembles partnerships of organisations to access funding and deliver health and wellbeing projects that improve the health and wellbeing of minoritised communities.

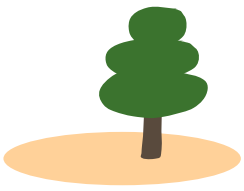
What is achieved?

Through its role as voluntary sector infrastructure organisation, the Forum provides a mechanism for statutory bodies to reach and engage with diverse communities and gives those communities voice and influence.

Evaluations have shown success. For example, an independent social return on investment (SROI) evaluation was carried out on the Multilingual Emotional Wellbeing Support service. The service generated c.£175,000 attributable social value in 2018, approximately £3.20 of attributable social value for every £1 spent. 100% of service users reported an improvement in health status. There was also some reduction in use of secondary care, GPs, and reduced risk of service user homelessness or eviction, and clients improved in a range of mental and emotional health indicators.

Key learning

A model that brings the voices of diverse communities together through an intermediary body is effective at tackling health inequalities.



Recommended actions

Enable diversity of people, communities and voluntary sector involvement

Short term (by Dec 2023)

- Gaps in existing networks and communications to/from minority ethnic communities, smaller VCS organisations, and different communities of interest identified
- Working with the VCS, language and communication is as accessible as possible, using plain English, avoiding jargon and acronyms, including for people with autism and learning disabilities, English as a Second Language, and visual or hearing impairments. Different routes and formats are used
- Place-Based Partnership agrees what good co-production looks like, and partners to commit to an agreed consistent approach to co-production
- Review of impact of communications, in partnership with diverse groups in VCS, identifies areas for further development. VCS plays a role in translation

Medium term (by Dec 2024)

- VCS commissioned to facilitate engagement and provide routes to access residents and communities that should be involved in designing services, particularly those from minority ethnic communities, other seldom-heard groups or groups with poorer health outcomes
- Co-production approach mainstreamed throughout the place-based partnership
- Budget available to do co-production properly and agree that no proposals will be considered by the PBP unless they demonstrate co-production in design

Recommended actions

Embed the VCS partnership model within the PBP

Short term (by Dec 2023)

- Short term funding for Westminster to enable the building of consistent and equal infrastructure for partnership working within the VCS across Kensington & Chelsea and Westminster
- Test feasibility of different models for VCS bi-borough partnership and representation models – including dynamic network, separate VCS partnership board, special purpose vehicle, and others

Medium term (by Dec 2024)

- VCS partnership model fully embedded within place-based partnership
- VCS further develops bi-borough partnership model and mechanisms for fully engaging with PBP
- Investment for mentoring, training and capacity building within VCS to ensure that reps have the skills, confidence and respect to participate fully and play their role as reps
- Place-based partnership schedule of fees for VCS leadership, representation and participation that covers time and other expenses of participation

Invest in resilience for delivery

Long Term (3 - 5 years)

Short term (by Dec 2023)

- Shared understanding by all partners of what is being funded in the VCS (by NHS and councils) on infrastructure and delivery, and whether it meets current needs and priorities
- Develop business models to showcase the system impact of VCS involvement in delivery – on workforce, costs, system outcomes
- Longer term Investment into a VCS contracting/delivery vehicle
- Commissioning and procurement reform to reflect co-productive and collaborative models

Medium term (by Dec 2024)

- Co-produced funding framework around grants and contracts related to size and complexity of activity
- Equalities impact assessments on major council and NHS decisions

Appendix 1: How the strategy was developed

This strategy was developed over a six-month period from August 2022 to January 2023.

The Bi-Borough VCS Strategic Group (BBSG) agreed in 2022 that a strategy should be developed and Kensington & Chelsea Social Council and One Westminster took ownership of the development process.

Kensington & Chelsea Social Council and One Westminster recruited consultant partners Aimie Cole and Lev Pedro of Raisin Consulting and Lev Pedro & Associates to facilitate the strategy development.

The consultants drew up a project plan which was agreed by the BBSG, and the BBSG became the co-design group for the project.

The consultants planned and delivered a programme of co-design activities to involve colleagues from both the VCS and local statutory sector stakeholders. This included:

- Background research
- Identification of key stakeholders, planning the engagement process and agreeing the approach with the BBSG
- Interviews with statutory sector stakeholders representing the NHS, the two local authorities and the place-based partnership
- Engagement sessions with the wider VCS through existing forums to gather insight
- A period of reflection, analysis and structuring the strategy
- Gathering and writing up of case studies that emerged from the engagement
- Presentation of key themes and outline structure of the strategy to the BBSG and a meeting of statutory sector stakeholders
- Refinement of the key themes
- Workshopping the practical actions that relate to each of the four goals
- Detailed writing of the strategy
- Circulation of the draft to the BBSG and some statutory-sector colleagues for final sense-checking and fact-checking
- Production of final version and design by Crackle & Pop
- Regular feedback and project review sessions with Kensington & Chelsea Social Council and One Westminster throughout.

Appendix 2: Who took part in the strategy design?

Bi-Borough VCS Strategic Group

Angela Spence, Kensington and Chelsea Social Council

Esma Dukali, Dalgarno Trust

Heidi Riedel, Woman's Trust

Helen Mann, Young Westminster Foundation

Iain Cassidy, Open Age

Ian Maxey, The Advocacy Project

Jackie Rosenberg, One Westminster

Jess Millwood, Age UK Kensington and Chelsea

Kathleen Lyons, Westway Community Transport

Lena Choudary-Salter, Mosaic Community Trust

Mary Fotheringham, Kensington and Chelsea Mind

Mehfuz Ahmed, Age UK Westminster

Mel Christodoulou, Family Friends

Michael Ashe, Volunteer Centre Kensington and Chelsea

Nada Calovska, MIND in Brent, Wandsworth and Westminster

Sarah Wilson, SMART

Thien Huong Nguyen, Home-Start Westminster, Kensington & Chelsea and Hammersmith & Fulham

Voluntary organisations

The Advocacy Project
Age UK Westminster
BME Health Forum
Breathe Easy Westminster
Carers Network
Caxton Youth Organisation
Church Army - Marylebone Project
Citizens Advice Westminster
Central and NW London NHS Foundation Trust
The Clement James Centre
Community Massage London
Dalgarno Trust
Egyptian Lotus Association
English National Opera
Equal People Mencap
Eritrean Lowlanders League
Family Friends
For Women
Healthwatch Central West London
Home-Start Westminster, Kensington & Chelsea and Hammersmith & Fulham
Imperial Health Charity
Kensington & Chelsea Social Council
Kensington & Chelsea Over 50s Forum
Latimer Community Art Therapy
Middle Eastern Women and Society Organisation
MIND in Brent, Wandsworth and Westminster
One Westminster
Open Age
Paddington Arts
PohWer
Pursuing Independent Paths
Resonate Arts
SMART
Sudanese Youth Club
TKG Partnership Ltd.
Turning Point
The Venture Centre
West London Zone
Westminster Befriend a Family
Westway Community Transport
Wigmore Hall
Woman's Trust
The Young Gamers and Gamblers Education Trust

Wider stakeholders

Andrew McCall, Vibrant and Healthy Communities Lead, Kensington & Chelsea and Westminster Place-Based Partnership

Christine Mead, Community Partnerships Lead, Westminster City Council

David Segal, PPL , Associate Director (independent consultants)

Dr. Jan Maniera, Westminster Borough Medical Officer

Joe Nguyen, Borough Director Westminster (Central London) NHS North West London

Keir Mann, Head of North Kensington Recovery and Partnerships, NHS North West London

Muskaan Khurana, Senior Public Health Strategist (Kensington & Chelsea and Westminster), Westminster City Council

Rachel Soni, Director of Health Partnerships, Westminster City Council and Royal Borough of Kensington & Chelsea

Saul Kaufman, St Johns Wood & Maida Vale Primary Care Network Clinical Director, Central London Healthcare CIC

Simon Hope, Borough Director (West London) NHS North West London

Thank you

to everyone involved