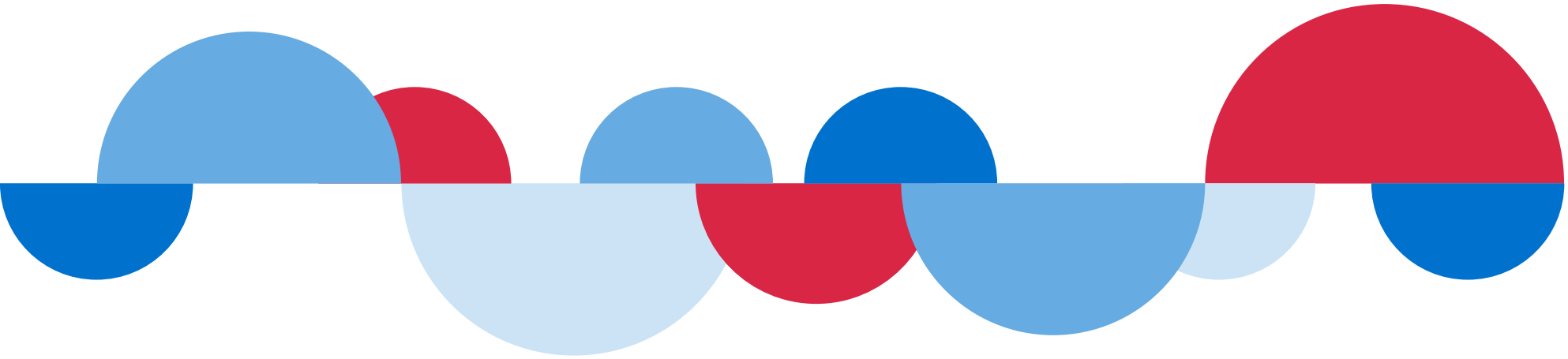
Hammersmith & Fulham
Health and Care Partnership
Better Together.

Progress on the work of the Hammersmith and Fulham Health and Care Partnership

Health and Adult Social Care Policy and Accountability Committee

17 November 2025



Overview

As a partnership we have very strong foundations locally, including high quality, resilient organisations and great people. In September 2024, partners met to refresh our approach and we reaffirmed our collective commitment to working collaboratively to improve the health and wellbeing of the population of Hammersmith and Fulham. We know that we will make the biggest impact if we do this together, and we agreed a small number of high impact areas to work on initially.

A year ago, we reflected on the challenges facing organisations following many years of austerity followed by the pandemic. All organisations are challenged financially and we have inherited an NHS provider landscape that is highly fragmented following years of commissioner focus on competition rather than collaboration. The external environment has continued to be difficult with uncertainty precipitated by the restructure and realignment of responsibilities within NHS ICB, regional and national teams.

Locally we are determined to overcome these challenges together and have huge ambition for the future. The 10 Year Health Plan has brought renewed clarity of purpose that confirms our direction of travel towards integration and collaboration. One year on from our partnership refresh we want to share some of our progress, which has built stronger foundations for us to make the biggest difference with and for our communities in Hammersmith and Fulham.

Our partnership purpose and priorities

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.

Integrating Services

Getting the right care to the right people, at the right time will improve quality and outcomes and reduce costs across the system.

We will:

- Join up our services for people with more complex needs
- Share care and risk collectively, rather than perpetuating a referral culture
- Develop more accessible services and support
- Improve quality of care
- Reduce repetition and duplication and address gaps

Creating health

Supporting communities to be more resilient with improved health and wellbeing will improve outcomes and reduce costs across the system.

We will:

- Focus on the wider determinants of health and wellbeing and work on reducing health inequity
- Empower communities to create health
- Leverage our social capital
- Support self-care and independence
- Ensure a focus on children

We will be guided by the more detailed priorities listed in the Hammersmith & Fulham Health and Wellbeing Strategy

Focus on integrated care

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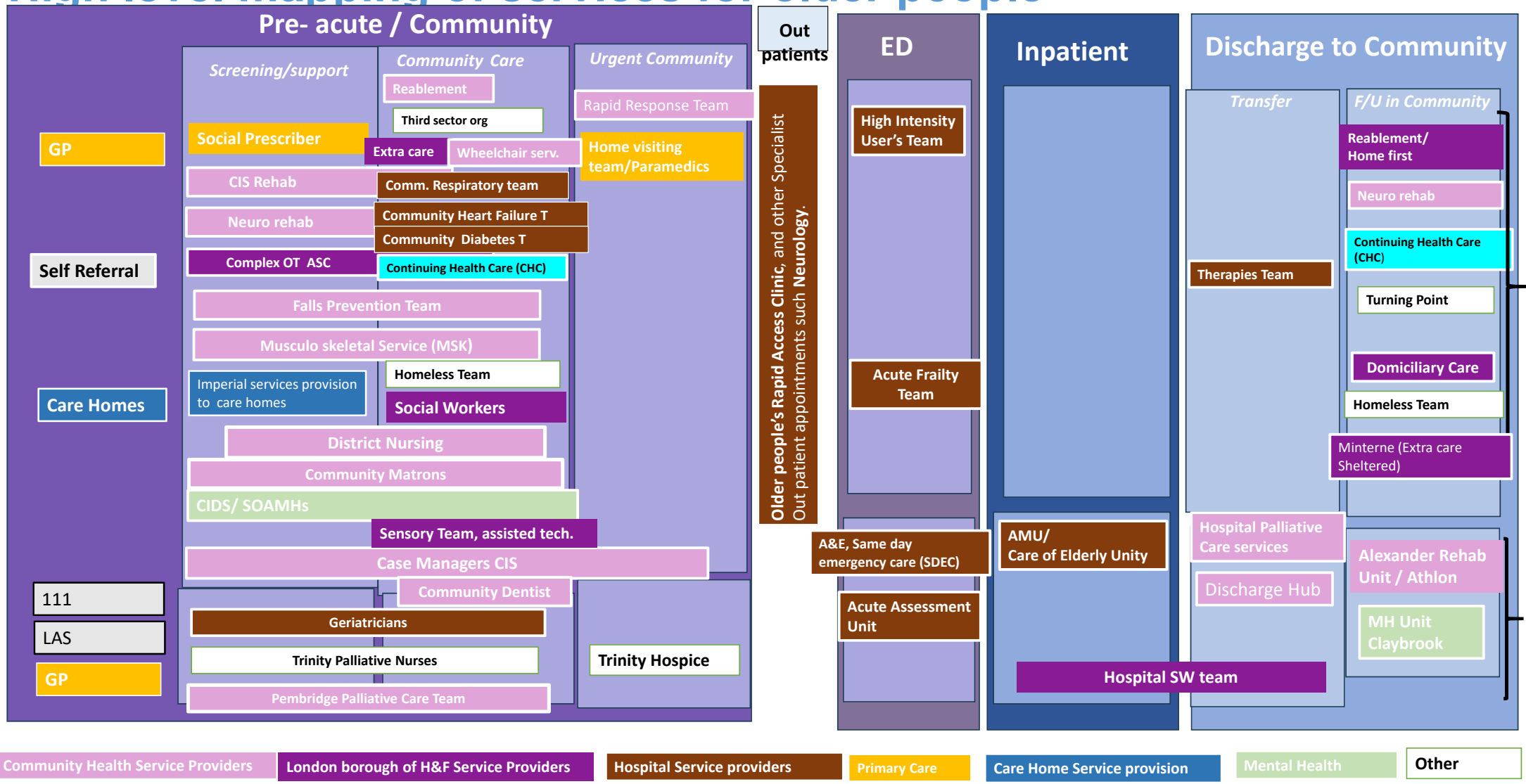
Over the last year we have focused on how we work together to make a difference for some of the people in our borough with the most complex needs – through working differently on transforming care and outcomes together. We have some amazing teams in the borough who are deeply committed to working differently and making the most of our joint investment. Our frontline professionals are eager to work in a more collaborative way but have been unclear about where to start, and what permission they have and tools they can use to help.

Our development of the Integrated Community Access Point (ICAP) has given our teams a real focus for their energy. The following slides set out the work we have been doing and the progress we have made, as well as the further work needed to extend and embed our approach.

Our starting point is one of multiple services and teams within six main statutory organisations and multiple private and voluntary sector services, created over many years as new services have been developed and layered over existing services – our high-level service map is shown on the next slide.

High level mapping of services for older people



Integrated Community Access Point (ICAP)

ICAP is an alliance of clinicians and professionals across organisations working with people with the most complex needs, which has been developed in response to the fragmentation of services across multiple providers.

Our aim is for providers and clinicians to work in an integrated way and break down organisational boundaries. Developing a proactive model that keeps people living as independently as possible for longer, and out of hospital where possible, is at the heart of our approach.

We started with a test and learn approach, developing an ICAP “prototype” in the South Neighbourhood area initially, as older people are a priority in this area. The prototype began in May, bringing together professionals from existing teams – this is about building new ways of working using existing resources.

We acknowledge that we are not starting from scratch and want to build on existing work, learning from good practice both in the borough and more widely across North West London and beyond.

Principles of our approach

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The Integrated Community Access Point is a core team of professionals working together across organisations and disciplines, to support people with complex needs. The team includes physical health, mental health and social care professionals, and links to a wider set of teams and resources through multidisciplinary (MDT) team meetings at PCN or INT level. Any adult with a combination of physical health, mental health and social needs can be referred.

Integrated Community Access Point

- ✓ We will make sure that right from the start of your journey, individual needs are assessed jointly by an integrated team
- ✓ We will make services easier to access - 'No door is the wrong door'
- ✓ We will provide personalised care that meets your needs and that is well coordinated with all our community services
- ✓ We will avoid you having to tell your story more than once

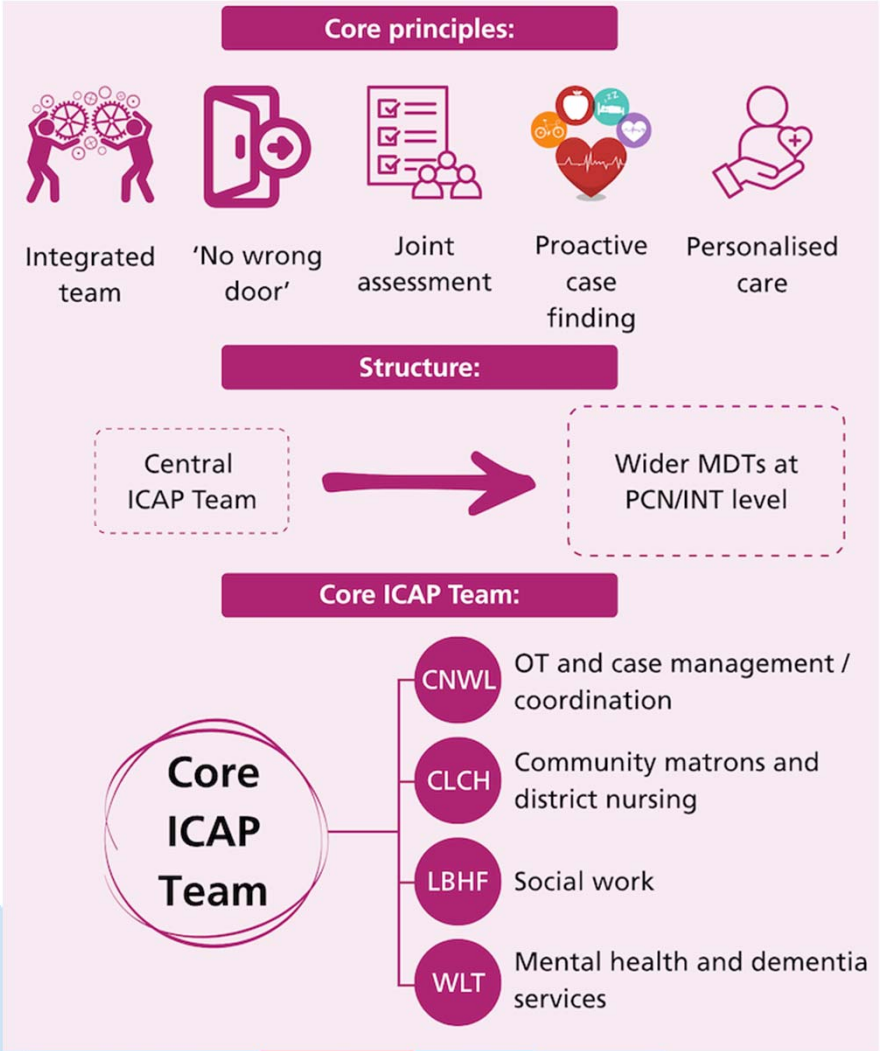
Wider MDT meetings – at PCN or INT level

- ✓ We will ensure that people with more complex needs are directed to the MDTs
- ✓ We will agree integrated action plans that are shared with people who are important to you
- ✓ We will ensure you know who to contact about your care as the need arises

Proactive care

- ✓ We will work with other local services to identify people before their needs reach a crisis

Our model



The core ICAP team meets daily to allocate referrals and arrange joint visits so that there is one coordinated response.

The team interfaces with GPs, geriatricians, other community teams and voluntary and community sector services, including through weekly multidisciplinary team meetings at neighbourhood level.

Once the relevant assessments have been completed, a person-centred plan is developed with the person and their carer, using the Universal Care Plan where possible so the person's needs and wishes are available if they need urgent care.

Benefits we have seen so far through this approach have included:

- ✓Faster responses
- ✓Streamlined pathways
- ✓Better communication
- ✓More personalised support

Case study

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Background

Mr. X, an elderly gentleman with advanced Alzheimer's dementia, severe frailty, and complex physical health needs, was referred to the Integrated Community Access Point (ICAP) to facilitate multidisciplinary input into his deteriorating condition and high-risk home situation. He lacked the capacity for decisions regarding his health and place of care. His wife, also living with severe dementia, was unable to provide effective support, and their son was the primary informal carer.

Medical and Social Context

- Diagnosis: Alzheimer's Dementia (no capacity), Chronic Kidney Disease (CKD), recurrent pneumonia (linked to suspected aspiration), and unintentional weight loss (47kg when last weighed)
- Medications: Donepezil discontinued under the Community Integrated Dementia Service (CIDS), with the expectation of reducing episodes of fainting
- Skin Integrity: Sacral pressure sore (category 2), managed by District Nurses
- Advance Care Planning: Not for further medical investigations or hospital admissions unless necessitated by traumatic injury

Referral to ICAP

Mr. X was referred to ICAP for:

- Specialist Occupational Therapy (OT) assessment
- Joint working with District Nurses (DNs) and Adult Social Care (ASC)
- Provision of essential equipment (e.g., hoist, riser recliner)
- Assessment to prevent further decline or falls
- Coordinated planning to ensure comprehensive care at home

Case study

Seamless Interdisciplinary Response

1 Triage and Allocation

- ICAP triage promptly identified the case as complex and allocated it for joint assessment by a Community Matron and Social Worker
- The patient was already referred by his GP to Neurorehabilitation Speech and Language Therapy due to aspiration risk

2 Community Matron's Leadership

- Led a holistic palliative needs assessment, identifying end-of-life care priorities
- Initiated and coordinated joint home visits with:
  - Neurorehabilitation SLT
  - Dementia services
  - Complex OT from ASC
- Conducted a Comprehensive Geriatric Assessment and completed a Universal Care Plan to ensure shared understanding across services

3 Occupational Therapy Intervention

- Complex OT provided crucial equipment (e.g., hoist, riser recliner) to support safe mobility and reduce carer strain
- OT Case Manager worked in close alignment with the Matron and Social Worker to review ongoing risks and functional needs

4 District Nurses

- Managed the sacral pressure sore with regular home visits
- Provided day-to-day palliative support under the Community Matron's guidance

5 Adult Social Care (ASC)

- The Social Worker ensured that all required care packages and home support systems were in place
- Recognised that standard homecare support was insufficient given the palliative trajectory

6 Key Outcome: Fast Track CHC

- Based on joint assessments and the patient's palliative condition, the Community Matron initiated a Continuing Health Care (CHC) Fast Track application, ensuring rapid access to end-of-life care funding and services
- Daily ICAP triage meetings facilitated ongoing updates and joint planning with input from OT Case Managers and ASC

7 Long-Term Management

Following six weeks of intensive multidisciplinary support, the case remained on the Community Matron's caseload for long-term case management, ensuring continuity and ongoing monitoring in the community

Case study

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Conclusion

This case illustrates exemplary interdisciplinary collaboration, with seamless working between:

- Community Matron (clinical lead and care coordinator)
- District Nurses (daily clinical support)
- Complex OT and OT Case Manager (functional safety and equipment provision)
- Adult Social Care (holistic support and care package oversight)
- Through integrated assessment, coordinated home visits, shared documentation, and daily team communication, the team delivered a safe, dignified, and person-centred palliative care pathway that enabled Mr. X to remain at home in accordance with his care plan and best interests

Patient and staff feedback

So far, 41 care plans have been completed by the ICAP core team. Patient feedback forms are issued prior to discharge from ICAP. Feedback received so far has shown that:

- ✓ People feel listened to and that the goals of the care or treatment plan are agreed jointly
- ✓ People feel that they are supported to regain some independence as a result of ICAP
- ✓ People feel that they are treated with dignity and respect

The ICAP core team came together in October to review their progress and develop plans for the future:

- ✓ The team are overwhelmingly positive about the new ways of working and benefits for patients, highlighting improved communication and supportive relationships between professionals and across organisations.
- ✓ Lots of opportunities for joint training have been identified, to build understanding and team cohesion.
- ✓ The team are working together to plan for rollout across the whole borough.

Impact and next steps

While it's still early days and there's more to do to evaluate the benefits and impact of our new approach, we can clearly identify the following so far:

- ✓ All people accepted onto the ICAP caseload were contacted within 24 hours of their case being discussed at the daily team meeting.
- ✓ All people seen by ICAP to date have had a comprehensive assessment of their needs, and goals jointly agreed with them.
- ✓ Improved communication between professionals and organisations.
- ✓ Reduced duplication amongst professionals – assessments are shared and not duplicated.
- ✓ Reduction in time taken to engage teams outside of ICAP.

Next steps include:

- ❑ Preparing for rollout across the borough – resource is secured from within existing teams, but we will monitor demand and capacity closely.
- ❑ Further development of evaluation and outcome measures to see impact, for example on hospital admissions.
- ❑ Planning further ICAP team workshops and joint training.