HEALTH & ADULT SOCIAL CARE

SCRUTINY PANEL

DATE	**31st January 2024**
REPORT OF	**Helen Kenyon/Katie Brown**
SUBJECT	**Integrated Neighbourhood Teams (INTs) Update**
STATUS	**Open**

CONTRIBUTION TO OUR AIMS

The Integrated Neighbourhood Team's programme contributes to the Council aim of 'Enjoy good health and wellbeing', it also contributes to the public health ambition of reducing health inequalities and improving health.

EXECUTIVE SUMMARY

This report gives an overview of the Integrated Neighbourhood Teams (INT) Programme which is one the five 'Key Impact Areas' for the Health and Care Partnership. It highlights the rational for the programme, what it is, the aims of the programme, work to date and how it will be delivered over the next two plus years.

MATTERS FOR CONSIDERATION

The purpose of this paper is to highlight the work to date and planned work for the Health and Care Partnership Integrated Neighbourhood Teams Programme.

1. BACKGROUND AND ISSUES

The NHS Long Term Plan, the White Paper: Integration and Innovation: Working Together to Improve Health and Social Care and more recently the Fuller report all recommend providers to collaborate to respond to the needs of their local population. To achieve this ambition, the Health and Care Partnership (HCP) is building on the work already done to date with Primary Care Networks (PCNs). The development of the Integrated Neighbourhood Teams is a phased programme of work, which will take two plus years to implement and will aim to include a range of services/professions to meet the needs of all ages in the local population.

The INT programme started in January 2023; this paper details the work to date and planned future work.

CURRENT SITUATION

Community/Primary Care services are provided by a range of local organisations. Whilst positive steps have been made to deliver integrated care, particularly within mental health teams, this work is not aligned across all providers / PCNs or across all ages. The development of Integrated Neighbourhood Teams is required to build on the work to-date to effectively use our total resource to respond to the needs of our local population, adopting an ethos of service user and system first, organisation second. Whilst also having a focus on more proactive care, strengths-based approach and population health management.

There is a WORSENING NATIONAL PICTURE and a range of local issues including:

- Workforce crisis (health and care)
- More GPs leaving then entering the profession.
- Pressures in general practice
- A&E, Elective care and Ambulance waits
- Patient Flow/discharge
- Increased usage of locums
- Increased funding pressures
- Rising demand
- Increased complexity & acuity
- Increased expectations
- Rapidly aging population

CURRENT ISSUES

- Un-coordinated and fragmented care (evidence from safeguarding briefings)
- IT interoperability challenges
- Challenges with access
- Reliance of GPs/default option
- Challenges with communication across teams
- Support and care that does not always focus on the whole person
- Shared care across organisations is patchy
- Ineffective use of NEL £
- Data and a PHM approach is limited
- A focus on reactive care and less on prevention and proactive care
- Poor management of the wider determinants of health – it is estimated that 25-30% of GP appointments are for non-medical reasons
- Too many hospital admissions and A&E attendances
- Too many assessments for each person
- Too many referrals/handoffs

INEGRATED NEIGHBOURHOOD TEAMS PROGRAMME

What is an Integrated Neighbourhood Team?

This is not a new concept and has been around for a number of years in different sectors and is fundamentally a way of working. It's based around a population that is small enough to have a tangible impact, in NEL this is the five PCN areas. Using the registered PCN population (detailed in appendix 1) enables the INT to have a targeted and proactive approach using Population Health Management data to develop a good understanding of their local population's health and wellbeing needs.

The Integrated Neighbourhood Team consists of people from a number of different teams, sectors or professions, this can be far ranging e.g. GP, nursing, therapy, social care, police, fire, secondary care, mental health, VCSE, public health and it can include joint roles across organisational boundaries.

People from these teams work together to reduce silo working, help people maintain independence, enable self-care and be at 'home'. The INT provide a more

proactive, person-centred approach through sharing caseloads, utilising wider community assets, ensuring the person is cared for and receive services from the most appropriate profession/services, reducing referrals or 'hand-offs'.
This can result in……

- Reductions in permanent admissions to residential/nursing care
- Increased effectiveness of reablement i.e. getting people moving again
- Reductions in non-elective emergency hospital admissions
- Better health and wellbeing outcomes
- Reduced rates of re-referral i.e. treating people multiple times
- Ensuring that the 'voice of the service user' is clearly heard.

It is not about….. All team members being employed by the same organisation

2023-2025 PROGRAMME
The Integrated Neighbourhood Teams Programme is a Key Impact Area of the Health and Care Partnership (see appendix two). Governance has been established, with a Steering Group in place reporting to the Health and Care Partnership Board; the membership of the steering group has good representation from the NHS, Focus & NELC, VCSE and community rep (governance diagram in appendix three).

The programme has been split into three phases and the timeline is detailed in appendix four. Phase one is developing INTs in Meridian and Panacea, Phase two is developing INTs in SLC, Apollo and Freshney Pelham and Phase three is looking at expanding all INTs.

INT Programme Vision: "Caring Together: Building Healthier Communities, One Person at a Time"

"Our vision is to develop Integrated Neighbourhood Teams that focus on the health of the whole community, works together with different organisations, and puts the service user at the centre of their care.

We want to improve health & social outcomes, reduce inequalities, make sure service users are satisfied, treat everyone fairly, and use resources effectively. We will do this by collaborating, implementing a population health and strengths-based approach, creating personalised care plans, and having shared goals."

Below gives a brief overview of the INT Programme:

Why are we doing this: We want to improve healthy life expectancy and outcomes for everyone in North East Lincolnshire

Who is involved: The programme includes multiple stakeholders: local people, NEL communities, PCNs, social care, VCSE, Integrated Care Board, Council, Public Health, the Wellbeing Service, Focus, FP Care Ltd, CPG, NAViGO & NLAG.

What are we doing: We are working with partners from across the HCP to bring different teams together from healthcare, social care and the voluntary sector, putting the person at the centre, to develop an integrated way of working across the

Primary Care Network (PCN) localities.

How are we doing this: by working with local people, PCNs, community nursing, social care, mental health, the wellbeing service and VCSE colleagues to come together in each locality as an Integrated Team, to build strong relationships and open communication, look at the data to develop joint priorities, develop shared ways of working, sharing knowledge and testing new approaches to delivering care and support.

When is this happening: The programme has commenced in January 2023 and is a 2+ year programme.

- Phase one - 2 localities
- Phase Two - 3 localities
- Phase 3 – Expansion

Where is this happening: This programme is based around the PCN localities in North East Lincolnshire (NEL):

- Meridian Health Group
- Panacea
- SLC Medical Group
- Apollo
- Freshney Pelham

From previous alignment of services work and feedback from key stakeholders, integrated working was quite variable across NEL. Different programmes of work have taken place over the years with varying levels of success; some areas have teams that have good working relationships, whilst with others, this was much more limited.

Due to the importance of relationships and culture we started the programme with each INT having dedicated time to come together to:

- Get to know each other and build relationships.
- Understand each other's 'worlds'.
- Asset mapping and understanding what is available to support service users and teams across NEL
- Develop and agree shared goals, ways of working, values and objectives.
- Understand common challenges and issues and develop solutions for these
- Review and analyse the PHM data to understand the local health needs and implement a dedicated PHM project.

There has been good engagement across phase one and two from a range of organisations including: Navigo, PCNs, CPG, Focus, Public Health – The Wellbeing Service, Thrive, Centre4.
These organisations are developing into being the core group, additional organisations are involved in the PHM projects, and particularly a range of VCSE organisations.

For phase one, priorities have been identified at both an INT level and a wider NEL level and are detailed below:

NEL wide priorities

Population Health & Inequalities

- Implement NEL's population health approach to reduce inequalities

Integrated Ways of Working

- Implement Multi-Disciplinary Team (MDTs) Meetings for different groups of patients based on data and local intelligence (including frailty and frequent service users)

Digital Workstream

- Develop Shared Care Records
- Develop Shared Care Plans
- Digital Directory of Services (Connect NEL/Simply Connect)

Meridian INT priorities

Population Health Management Project

- Improve co-ordination and outcomes for newly diagnosed people with cancer (we are working with MacMillan and potentially sourced some funding to support this project)

Integrated Ways of Working

- Build relationships between organisations, breaking down barriers, reducing complex referrals, trusting assessments and reducing the number of unnecessary patient/person contacts

Be Proactive Early Adopters

- Implement Shared Care Records
- Implement Shared Care Plans
- Use of SystmOne across organisations

Panacea INT Priorities

Population Health Management Project

- Improve co-ordination and outcomes for housebound people with dementia

Integrated Ways of Working

- Collaboration across organisations to reduce duplication of information, improve access to information and teams working from the same software

Digital Improvements

- Implement Shared Care Records
- Implement Shared Care Plans
- Use of SystmOne across organisations

We have recently started phase two and will be developing priorities for the other three INTs by March 2024.

A highlight report in appendix five shows the work to date and the PHM projects for Meridian and Panacea that are underway.

IMPACT

The focus in the development of INTs in phase one and two has been organisation development and relationships and understanding the local population through population health management data. It is essential we have a solid platform of strong relationships across organisations to then build upon in delivering care and support in a more integrated way and improve outcomes. Recent feedback from

organisations who are part of the INTs has been positive with the following themes being shared:

- Improved communication
- Knowing who to contact in other organisations
- A better understanding of what health/or social care can do
- Organisations now working more closely together
- Barriers removed between clinical and community care
- A greater understanding of what other support is available to people/patients in particular from the VCSE Sector

A number of outcome measures have been developed for the INT programme which are highlighted in appendix six.

We have captured baseline data from the workforce in an initial survey and will repeat this throughout the programme. We are also capturing patient experience and outcome data as part of the PHM projects.

Phase one and two overall are progressing well with core organisations and teams involved, predominantly focusing on adult and older people. Phase three will see the expansion of the teams involved including across services and programmes of work for children, young people and families.

2. RISKS AND OPPORTUNITIES

Key risks include: current system pressures resulting in reduced capacity of professionals across all INTs to be involved with the programme and on-going PHM projects, this is mitigated by additional support from the programme team and extending deadlines.

Limited community engagement across INTs is a risk with this is being improved by working with Experts by Experience for PHM projects and working with the INT Steering Group for wider engagement through existing groups/forums.

Opportunities for expansion at phase three is to be developed.

3. REPUTATION AND COMMUNICATIONS CONSIDERATIONS

Communication considerations are engaging with more people from across NEL both local communities and the wider workforce.

We have developed an INT ‘plan on a page’ as a communication tool (in appendix seven).

4. FINANCIAL CONSIDERATIONS

None for the Council at this stage.

5. CHILDREN AND YOUNG PEOPLE IMPLICATIONS

Phase three of the programme will expand to include services or programmes of work that relate to children, young people and families. We are connected in to the Start for Life Programme and developing these connections further as we scope phase three.

6. CLIMATE CHANGE AND ENVIRONMENTAL IMPLICATIONS

None identified at this stage.

7. FINANCIAL IMPLICATIONS

None identified at this stage.

8. LEGAL IMPLICATIONS

None identified at this stage.

9. HUMAN RESOURCES IMPLICATIONS

None identified at this stage.

MONITORING COMMENTS
As this is a key HCP strategic priority it is part of the integrated health and care governance at place which sits under the shadow Joint Committee.

10. WARD IMPLICATIONS

All Wards across NEL.

11. BACKGROUND PAPERS

None

12. CONTACT OFFICER(S)

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Helen Kenyon/Katie Brown
(LEADERSHIP TEAM SPONSOR)

APPENDIX ONE – Registered GP practice list size

PCN	GP Practice Name	GP Practice List Size As at Jan '24
Freshney Pelham	Woodfield Medical Group	21584
	Littlefield	5453
	Pelham Medical Group	10360
Meridian Health Group	The Roxton Practice	34862
	The Roxton Practice (Weelsby View site)	
	The Roxton Practice (Keelby, branch only)	
	Open Door Surgery	2396
	Quayside Practice	3802
Panacea	Dr A Kumar	3321
	Dr P Suresh Babu	2816
	Birkwood Medical Centre	8161
	Greenlands Surgery	3161
	Clee Medical Centre	16799
	Clee Medical - Stirling Street (Branch only)	
	Dr Sinha	4615
	Dr Mathews	4357
	Dr OZ Qureshi	4397
SLC Medical Group	Scartho Medical Practice	24490
	Chantry Health Group (Branch only)	
	The Lynton Practice (Branch only)	
Apollo	Beacon Medical Practice	12789
	Raj Medical Practice	6789
	Healing Surgery	2413
	Core Care Family Practice	2802
	Total Number of Registered NEL Patients	**175367**

APPENDIX TWO

North East Lincolnshire – Health and Care Partnership Priorities

Our ambition

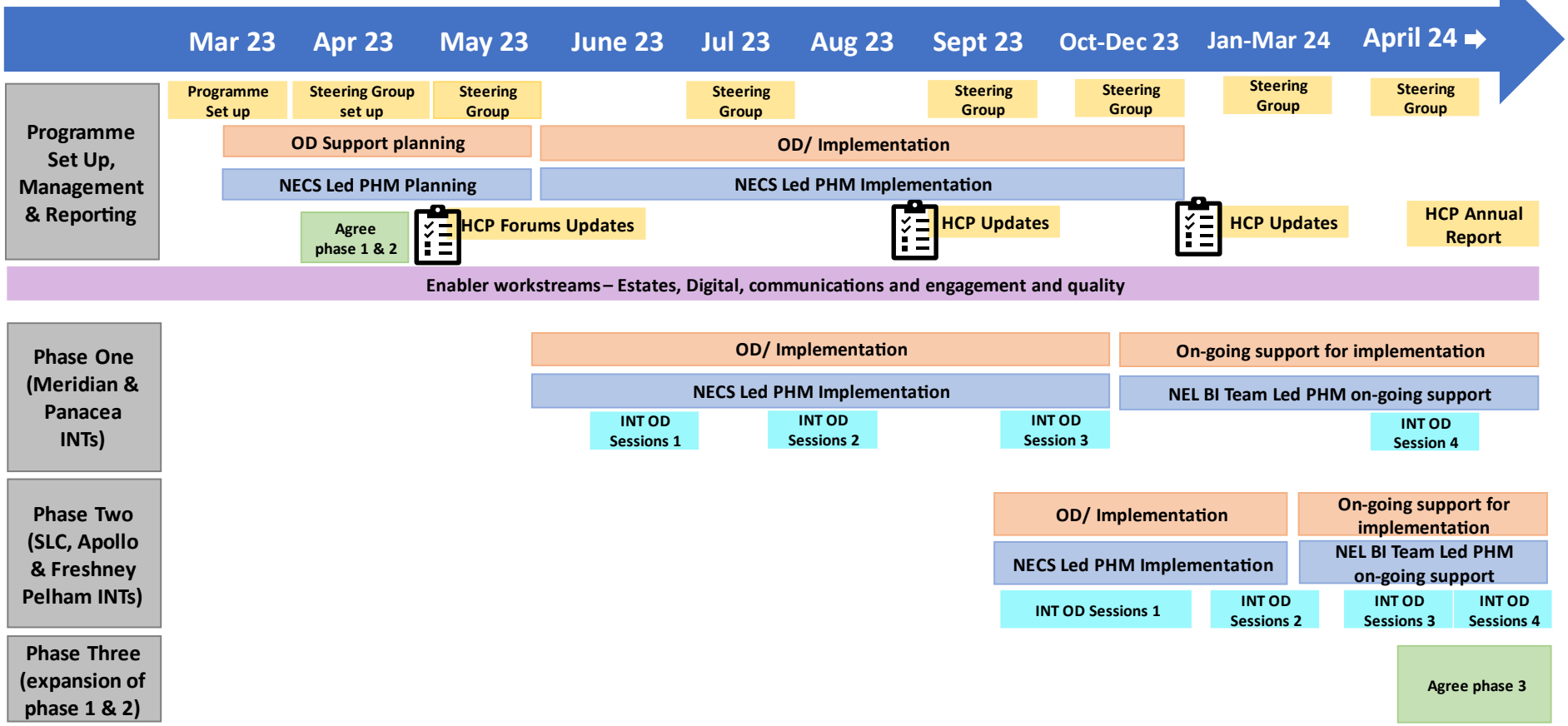
Our local community, health and care system is currently building on a lengthy, proud and powerful history of collaborative and integrated working ensuring our community, health and care organisations work hand in glove and this has benefitted local people for many years. Our Health and Care partnership enables partners to work together where a multi-agency approach is required to tackle and deliver local priorities whilst still undertaking their own functions and service delivery.
Our local community, health and care system is becoming more holistic – bringing together and delivering mental, physical and social care together for both children and adults. As a place we will continue to work in an integrated way to deliver better outcomes for our population, linking in on a system and collaborative level, where working together in this way supports better outcomes for our population. We will work together to reduce unfair and avoidable differences in health across the population, with a focus on reducing inequalities, and ensure that our residents are at the heart of all we do. We will come together across population groups in Accountable Care Teams using a population health approach to do this.

Where we are now:				
NEL has a 156,940 resident population of mostly coastal and urban communities. NEL has variation in inequalities and deprivation: 37.7% of population live in 20% most deprived areas.	In the 2021 census 43.1% of the population reported very good health compared to 48.5% nationally. 35% reported good health compared to 33.7% nationally	NEL is in the highest 10% nationally for fuel poverty at 21%. Across the area it ranges from 7.6% in the least deprived up to 26% in the most deprived areas.	NEL has the highest premature birth rate in England and 1 in 4 children live in poverty.	
Our Outcomes	Improve health outcomes and access to healthcare and reduce health inequalities	Improve outcomes for children, young people and families	Improve mental health outcomes	Strengthen our local health and care workforce	Reduce the number of people in hospital
Our Key Impact Areas	Primary & Community Care	Children, Young People & Families	Mental Health	Workforce	Frailty
What we will deliver in 2023/24	• Implement Integrated Neighbourhood Teams • Expand Connected Health Model • Develop and implement an NEL approach to population health management and reducing health inequalities	• Produce CYPF Strategy and implement • Deliver Best Start for Life Programme • Improve outcomes for Children Looked After	• Co-produce a Mental Health Strategy and implement • CYP MH Transformation (Eating Disorder, Neurodiversity, Children Looked After, Perinatal mental health and parent/infant relationships)	• Develop HCP People Plan • Continue International recruitment programme • Expand Grow Our Own programme • Develop Joint and flexible posts	• Establish End of Life Accountable Care Team, develop the clinical model and workforce. • Establish acute frailty team • Fully embed a consistent proactive care model • Develop consistent & accurate frailty performance measures

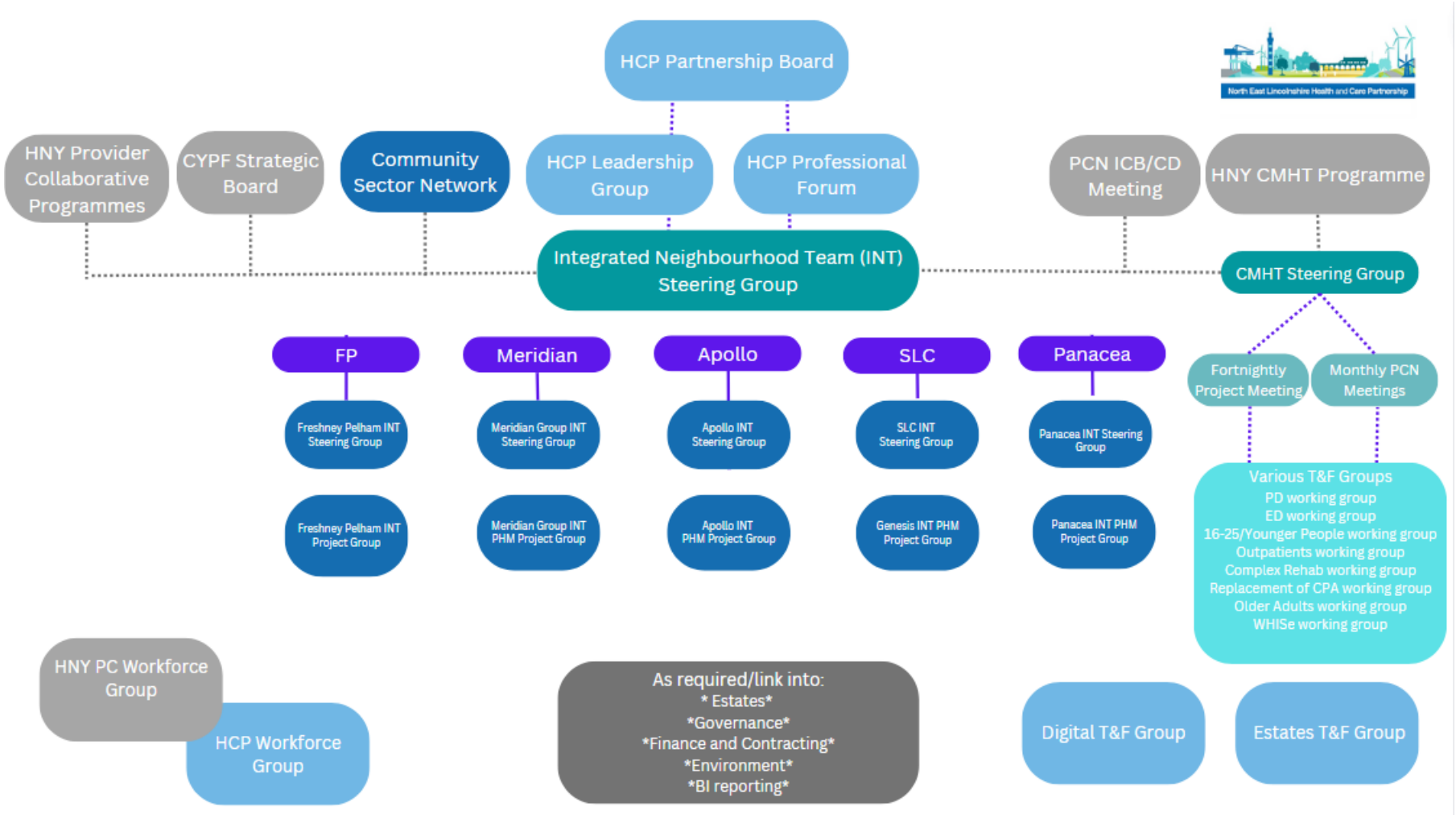
Enabler work programmes: Digital, estates, communications and engagement, quality, finance and environment

APPENDIX THREE

Integrated Neighbourhood Teams Outline Workplan and Timeline (March 2023-April 2024) – Refreshed Jan 2024



APPENDIX FOUR – Governance



APPENDIX FIVE

HCP HighlightReport

Programme Name: Integrated Neighbourhood Teams (INTs) Programme (Key Impact Area)

Period CoveredJune-Dec 2023

North East Lincolnshire Health and Care Partnership

Progress Against Plan	Phase One Completed	Phase Two Completed	Digital enablers
On Target	Slightly behind target – momentum with PHM projects	On Target	On Target

Key Risks (mitigation in brackets)

- Current system pressures reduced capacity of professionals across all INT to be involved with the programme and on-going PHM projects (additional support from programme team and extending deadlines)
- Limited community engagement across INTs (work with Experts by Experience for PHM projects and working with the INT Steering Group for wider engagement through existing groups/forums)

Escalation

- Acknowledgement of system pressures and impact it's having on the pace of INT development and PHM projects

What's been done?

- Programme set up (incl. governance, outcomes, resource, reporting)
- Phase one completed– 2 INTs – 3 facilitated sessions (Panacea & Meridian)
- Relationship building across Focus, CPG, The Wellbeing Service, Navigo, PCNs and VCSE
- 2 Population Health Management (PHM) data deep dives & 2 PHM projects scoped and agreed
- Support from enablers workstreams e.g. digital
- Phase 2 planned and commenced
- Data Sharing Agreement (DSA) developed
- Staff survey developed
- Learning from national and regional work
- Collated benchmarking data

What's in process?

- Phase two commenced:
  - 1 INT commenced (SLC)
  - 2 INTs planned for Nov-Feb (Apollo & Freshney Pelham)
- Digital workstream– scoping
- PHM project & steering group meetings for phase 1 INTs
- Comms – development of a plan on two pages
- Engagement with the wider workforce
- Signing of the DSA
- Engagement with HNYs INTleader's forum

Plan for two next month (Jan & Feb)

- Wider community engagement
- Phase 2 facilitated sessions for Apollo & SLC
- Implementation of PHM projects for Meridian and Panacea
- Interface with NEL population health management work
- Promoting INTs
- Staff survey dissemination
- Connecting INTs and out of hospital frailty work
- INT dashboard and outcome measures implementation
- Digital workstream focus – Systm1 consistent access and shared care plans

Impact

Quality, Efficiency & Productivity (QEP)

- Outcomes measures agreed including quality measures developed
- Benchmarking in progress
  - Staff survey
  - Patient survey
- Digital workstream
  - SystmOne access
  - Shared care plans
  - Digital directory of services

Engagement

- Varying levels of service user representation at phase one and two workshops
- Experts by experience involved in phase 1 PHM projects
- Expand wider community engagement
- Engagement with organisational teams e.g. CPG community nursing teams
- Development of INT on 2 pages for sharing across teams

Health Inequalities

- Population Health Management Projects scoped and agreed for 2 INTs
  - Panacea - improving care, outcomes and experience for people who are housebound with dementia
  - Meridian – improving co-ordination, outcomes and experience for people with a new cancer diagnosis
- Work underway on analysing the data for Apollo, SLC and Freshney Pelham
- Link into the wider NEL population health management programme – workshop Nov 23
  - Inclusion health groups
- Link into HNYs population health, prevention and inequalities work programme

APPENDIX SIX

Integrated Neighbourhood Team Programme Outcomes:

Integrated neighbourhood teams (INTs) are designed to provide a coordinated and integrated approach to health and social care for individuals and families within a local community. To measure the impact of these teams on population health, several measures can be considered, below are the draft programme outcomes that all INTs will work towards and then each INT will have agreed joint priorities that they will measure to determine impact.

1. **Set up and delivery of the Integrated Neighbourhood Team:** Process measure for establishing the programme.
    - Integrated neighbourhood teams will bring together a range of health and care professionals, including PCN teams, community nurses, social workers, the Wellbeing Team members and the VCSE, to work collaboratively to provide local populations with a comprehensive and integrated care experience.
    - All INTs to be set up by Jan 2024
    - All INTs to have agreed joint priorities by Jan 2024
    - All INTs to report quarterly to the Integrated Neighbourhood Team Steering Group.
2. **Community involvement:**
    - Integrated neighbourhood teams will work closely with local communities to understand their needs and provide care and/or advice that is responsive to local needs.
    - All INTs to have local people as part of the INT to co-design the development and delivery of joint priorities.
3. **Access to Care:** This measure involves tracking the availability and accessibility of health and care services provided by INTs. The number of individuals who have received care, the timeliness of service delivery, and the waiting time for appointments can be used to assess access to care.
    - Reduced need to access unplanned care.
    - Improved access to appointments
    - Improved access to information advice and guidance about local support.

4. **Service User Satisfaction**: Service user satisfaction is an important indicator of the quality of care provided by INTs. Service user surveys feedback mechanisms to identify issues and opportunities for improvement can be undertaken to measure the level of satisfaction with the care received, including the responsiveness and sensitivity of the INTs to service user needs.
    - Service users feel empowered and better able to manage their health and care needs.
    - Service users feel satisfied with the care and/or advice they receive.
5. **Staff satisfaction:** Staff satisfaction and engagement, measured by regular staff surveys and feedback mechanisms to identify issues and opportunities for improvement.
    - Staff feel empowered and better able to manage their workload.
    - Improved staff job satisfaction
    - Improved wellbeing of the workforce
6. **Health and Social Outcomes:** Health and social outcomes are a crucial measure of the effectiveness of healthcare interventions. Health and social outcomes such as reductions in morbidity and mortality rates, improved quality of life, and decreased healthcare utilisation can be used to assess the effectiveness of INTs (the detail will be developed by the INTs).
    - All INTs to use a population health approach for determining their joint priorities for improving their local population health and social outcomes and reducing inequalities.
    - All INTs to use population health management data to develop, implement and measure their local plans for improving integration of care for their population.
    - All INTs to consider the health inequalities of their population when developing their joint priorities.
7. **Care Coordination:** INTs are designed to provide integrated care across health and Care. Care coordination measures can be used to assess how well the INTs are functioning in terms of coordinating care across multiple providers and ensuring that service users receive appropriate care.
    - Streamlined and effective communication methods are in place.
    - Care is coordinated for all service users on a shared caseload.

- High functioning multi-agency working, and the use of a single care plan is standard practice.
- The service user's voice is clearly heard, and they tell their story once.
- INTs will take a proactive approach to care management, identifying and addressing health needs before they escalate and ensuring that service users receive the right care at the right time.
- Data and digital infrastructure in place to allow a level on interoperability.

8. **Cost-effectiveness:** Cost-effectiveness analysis can be used to evaluate the value of the services provided by INTs. This analysis involves assessing the costs of care delivery compared to the health and social outcomes achieved.
    - Using population health data (resource value) to inform pathway and care development to deliver care in a cost-effective way.
    - All INTs when developing joint priorities to consider QEP(HI) (Quality, Efficiency and Productivity and Health Inequalities)
    - Reduction in unwarranted health and care contacts by better coordinated care, which results in a reduced resource value.

APPENDIX SEVEN – INT 'on a page' communication tool – Meridian INT example

North East Lincolnshire wide priorities

Health and Care Partnership Outcomes:

1) Improve health outcomes and access to healthcare and reduce health inequalities
2) Improve outcomes for children, young people and families
3) Improve mental health outcomes
4) Strengthen our local health and care workforce
5) Reduce the number of people in hospital

Connected frameworks/strategies:

Children, Young People and Families Strategy
All-age Mental Health Strategy
Carers Strategy
Practice Framework in Adult Social Care
Primary Care Recovery Plan

Connected work programmes:

Frailty Programme
Estates review
Connected Health Network
NELC Family Hub Programme
Out of Hospital Care Programme
Community Mental Health Transformation Programme

Contact us or get involved

Programme team
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What is the North East Lincolnshire Health and Care Partnership?

The formal partnership of organisations who have committed to come together to plan and meet the health and care needs of the people of North East Lincolnshire, making it easier for people to access the care and support they need. This means that the different organisations will work even closer together in the background but, for the person, it will feel like a single and continuous care experience. The HCP has several priorities called Key Impact Areas of which Integrated Neighbourhood Teams are a Key Impact Area.
The partnership is not a merger of organisations. It is important that individual organisations continue to preserve the focus on the delivery of skills and capacity in areas of expertise necessary across the health and care system. What is important is that the different skills and capacity working alongside each other wrapped around the needs of the individual.

What your Integrated Neighbourhood Team does

The Integrated Neighbourhood team is a way of working, with different professionals coming together from different teams to plan, discuss and organise care and support around an individual, in a locality. The aim is to reduce handoffs between organisations, have a strengths based approach and ensure the person is at the centre. Local people, PCNs, community nursing, social care, mental health, the wellbeing service and voluntary sector colleagues come together in each locality as an Integrated Team, to look at the data to develop joint priorities, develop shared ways of working, sharing knowledge and testing new approaches to delivering care and support.

What we have done

We have been coming together over the last few months to build relationships, develop shared goals and strengthen how we work together. The INT has looked at the population health data and developed a project to improve population health around a specific cohort of the community. For Meridian INT it's focusing on newly diagnosed people with cancer. If you would like to be part of this project or hear more about it please get in touch with a member of the INT leadership team.

Local Leadership Team (TBC)

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