BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Priority 2

Integrated Neighbourhood Teams

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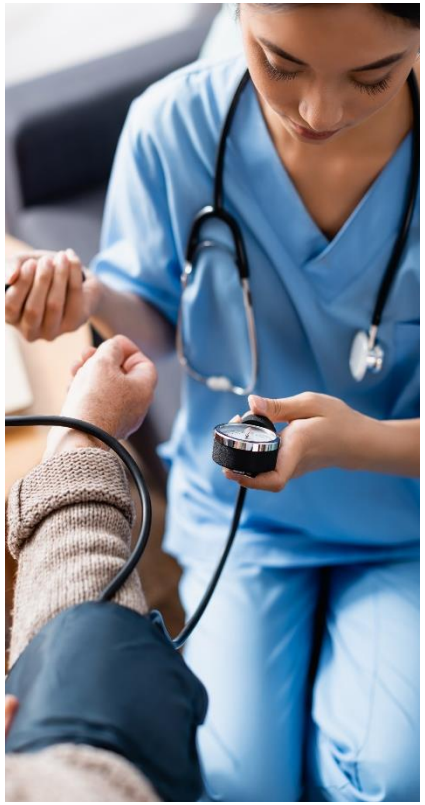
Our second priority is to create Integrated Neighbourhood Teams to coordinate care and support for at least one population cohort

As a system, we're committed to making a reality of integrated neighbourhood working, and this priority means we will begin that work by establishing Integrated Neighbourhood Teams in all areas beginning with a focus on one defined population cohort.



An integrated community-based model can make the biggest difference for those who have (or are at risk of having) complex medical or social issues. Often this is associated with multiple long term conditions, and inequalities in access, experience and outcomes.

We want to put primary care at the core of this model, with Integrated Neighbourhood Teams as the delivery mechanism to implement this way of working. All neighbourhoods will work to design and develop an INT to bring professionals from across the system to work together in the community (virtually and physically) to provide holistic support to **at least one population cohort** e.g. frail older people, children with health conditions.

There are already some Integrated Neighborhood Teams operating in BOB and lots of plans underway. Developing relationships and building trust amongst system partners will be key to the success of this approach.

What impact will this way of working have?

- Improve **patient experience** by providing continuity of care from a named professional, who can coordinate a holistic approach to meeting needs, combining expertise from different teams.
- Improve **outcomes** especially in the management of long-term conditions and reduce inequalities in outcomes.
- Reduce **demand for GP appointments** as continuity is provided by a multi-skilled team working together to manage needs, releasing capacity for GPs to focus on the most complex needs and prevention.
- Reduce **Emergency Department attendance and emergency admissions** as issues (medical and social) are addressed before they escalate.
- Improve **staff wellbeing** through development of a collaborative culture that puts patients needs first and supports flexible working in different teams.

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Defining an Integrated Neighbourhood Team for BOB

We recognise that INTs are not a new concept, but rather an evolution and extension of Multi-disciplinary Teams that have already been operating. Each INT will look different, based on the population it is focused on and the partners involved. As a system, we have developed core principles to guide how we build INTs that will make it easier for us to explain INTs to our population and staff, and learn from each other as we develop new ways of working.

Who

INTs are the delivery vehicle for a community based model. They will:

- Be a multidisciplinary team of generalist and specialist skilled health and social care professionals.
- Work with other partners in the neighbourhood – e.g. police, mental health services and local housing associations.
- Actively involve and engage the local community in planning and decision-making to ensure services align with actual population needs.
- Have a designated GP clinical lead with protected time.
- Have secondary care consultants aligned to support and deliver services to the population cohort.
- Be established from existing resources and infrastructure.
- Integrate into service and community development in neighbourhoods, with all pillars of Primary Care part of the offer.

What

Teams will develop their own standard working practices that may include:

- A daily call 'huddle' - where patient notes are reviewed, next steps for priority patients discussed and plans for home-visits agreed.
- A weekly INT meeting is scheduled to discuss high risk patients in more detail and create personalised care plans
- Any community-based care that is required for patients should be allocated to the most appropriate team e.g. district nursing.
- The secondary care consultant will provide specialist advice to the team and help resolve complex cases.
- Community teams will have regular contact with the clinical lead/ GP in the INT to ensure any complex issues are resolved.
- Across some teams, senior GPs may serve as the 'consultant in General Practice', providing holistic expert care to a population cohort.

Where

- Determine a local footprint for the INTs in each Place, which may be based on PCN or multiple PCNs.
- Teams do not have to be co-located in the same premises to work successfully but opportunities to engage in person, alongside virtual meetings are preferable

Supported by:

PHM tools to identify, understand and define a cohort to focus on

High degree of trust and a culture of collaboration between health and care teams and professionals

Virtual and physical space to come together

Ability to share patient records among system partners

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Action Plan for Integrated Neighbourhood Teams

Primary care is at different stages of adopting this approach to delivering care, and the detailed design of INTs must build from the Local Action Teams that are developing this team, alongside their system partners. Place Teams will support a Quality Improvement approach to delivery.

The **ICB and Place Teams will**:

- ✓ Support the determination of a **local footprint** for INTs, based on PCN or neighbourhood.
- ✓ Identify the **Local Action Teams** to take part in each cohort of the Delivery Programme, ensuring an early focus on deprived areas.
- ✓ Bring teams together for focused sessions – enabling them to **share learning**, do things once where **consistency** makes sense, and support each other to **overcome blockers**
- ✓ Make available ICB teams responsible for **key enabling areas** like workforce, digital, data and estates to provide updates, help unblock issues, escalate where needed
- ✓ Support the setting of **clear outcome metrics** and the tracking and collation of these to demonstrate impact
- ✓ Ensure **involvement of system partners** in the Integrated Neighbourhood Team approach e.g. ensuring specialist secondary care consultants job plans are aligned with this way of working, and promoting visibility of new ways of working across their Place.
- ✓ Roll out **Population Health Management tools** and support use of these to identify initial population cohort that each INT decides to focus on
- ✓ Continue to **expand shared care record** to enable patient records to be shared across all of Primary Care and broader system

Local Action Teams will be supported to:

- ✓ Review population health data to **agree a population cohort to focus on** based on the principles of tackling inequalities and reducing system pressure.
- ✓ Lead conversations with system partners (including primary, secondary care, community services, VCSE, social care and others) to **agree roles in the INT**, securing the required capacity and commitment.
- ✓ Work with providers to ensure Pharmacy, Optometry, Dentistry and others are appropriately involved and aligned to the team, **maximising the capacity of the whole system** to meet the needs of the population cohort.
- ✓ Define the **core capabilities of the INT and interactions** between all providers.
- ✓ Agree **ways of working** with INT core members e.g. daily huddles, weekly MDT meetings to review patients and care plans.
- ✓ Identify appropriate **virtual and physical space**
- ✓ Establish **Standard Operating Procedures** for referrals into and out of INT, clinical governance etc.
- ✓ **Test new way of working** with small segment of the population cohort - conduct daily and weekly calls, review patients and actions required.
- ✓ **Track and evaluate benefits**, share learnings and tweak processes (where required).
- ✓ **Scale** approach to whole population cohort once improvements are demonstrated.