Our Dorset

Integrated Neighbourhood Teams Programme Summary

National Context

The NHS ambition is to enable people to live more years of healthy, active and independent life and improve their experience of health and care, whilst connecting and making optimal use of health and care resource by:

- Moving care from hospital to community, so that more people can be cared for at home, helping them to maintain their independence for as long as possible, only using hospitals when that is the best place for people to be.
- Making better use of technology to support people to take better care of themselves, to improve treatment and diagnostics, and to provide seamless care across organisations.
- Focussing on preventing illness with an increased focus on prevention and proactive care.

To realise this, we need to:

- Streamline access to care and advice for people who get ill, or become in need, but only use health and care services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it.
- Provide more proactive, personalised care with support from a multidisciplinary team, of professionals and practitioners, to people with more complex needs, including, but not limited to, those with multiple long-term conditions.
- Help people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

Our approach is to develop Integrated Neighbourhood Teams

- Integrated Neighbourhood Teams will be responsible for working with their local communities to improve health and wellbeing outcomes, co-design sustainable and high-quality health and care provision and improve the quality of life for individuals across the community by increasing accessibility to services.

- These teams will work together to provide joined-up services which work more efficiently and provide quicker access to the care and support that people need. Integrated Neighbourhood Teams will be the gel that keeps things together for people within our communities.

- We will need to work across partners, with citizens and communities, to co-design local solutions and also to improve systems and processes to reduce the burden of administration for our staff.

- This will not be simple; it will take time to deliver the full extent of the ambition and get everything in place. The first two years of the Integrated Neighbourhood Team programme is building the foundations for this way of working and supporting the development of Neighbourhood Health Services.

Why will INTs be better for local people?

MORE

- Joined-up focus on prevention to help you stay well for longer in your community.
- Information and support so that you can stay well, take better control of your own health to reduce the risk of developing ill health.
- Access to streamlined support so when you become ill or have an urgent need, you can see the right person the first-time round.
- Proactive, personalised support from a multidisciplinary team for your chronic or complex health and care needs.
- Services co-designed with local communities.

LESS

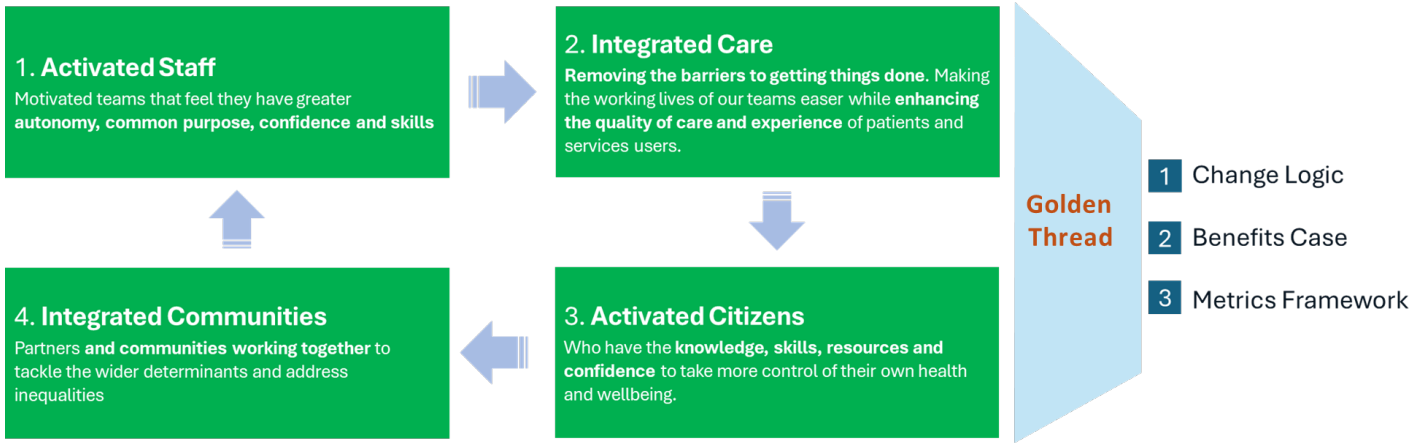
- Need to travel to a hospital for care, as more care and support will be provided in the community.
- Health complications and poor outcomes for adults and children with complex needs because of the support available locally from a mixed team of health and care professionals.
- Need for you to repeat your story to different staff because the team works closely together and have access to shared health and care information.

Why will INTs be better for staff?

- More efficient working and improved coordination help reduce frustrations and improve the experience of colleagues at work.
- Pooling resources, knowledge and expertise helps foster innovation, learning and improved problem-solving.
- Collaboration and clearer roles can lead to a more supportive and fulfilling working environment for frontline staff.
- Working in a team with clear communication and shared objectives helps reduce stress and enhances job satisfaction.
- The chance to create new and innovative roles offers career development opportunities for colleagues.
- For manager and leaders there are fewer issues to manage giving the opportunity to focus on continuous improvement and solution-finding – they can lead to success rather than manage failure demand.

The change logic at the heart of successful INTs

Increasing productivity, reducing demand and improving outcomes through activation and integration



What is activation?

- A positive change in activation for a person/patient can lead to positive changes in self-care behaviours which improves health and care outcomes and reduces demand on the healthcare system.
- Activated staff are more innovative in the workplace and attentive to their own health and wellbeing for the benefit of themselves, their patients and colleagues.

Why is activation important?

- The evidence from the National Association of Primary Care shows that as a persons' activation increases:
  - People experience improved health and wellbeing outcomes, as people engage in preventive behaviours (eat more healthily, move more within their capability, sleep better and make connections)
  - Staff experience greater satisfaction in their professional role, and are motivated and empowered to make changes that benefit both themselves and the population they serve
  - There is a reduced need for health and care services over time

Expected impact over the two years of the programme

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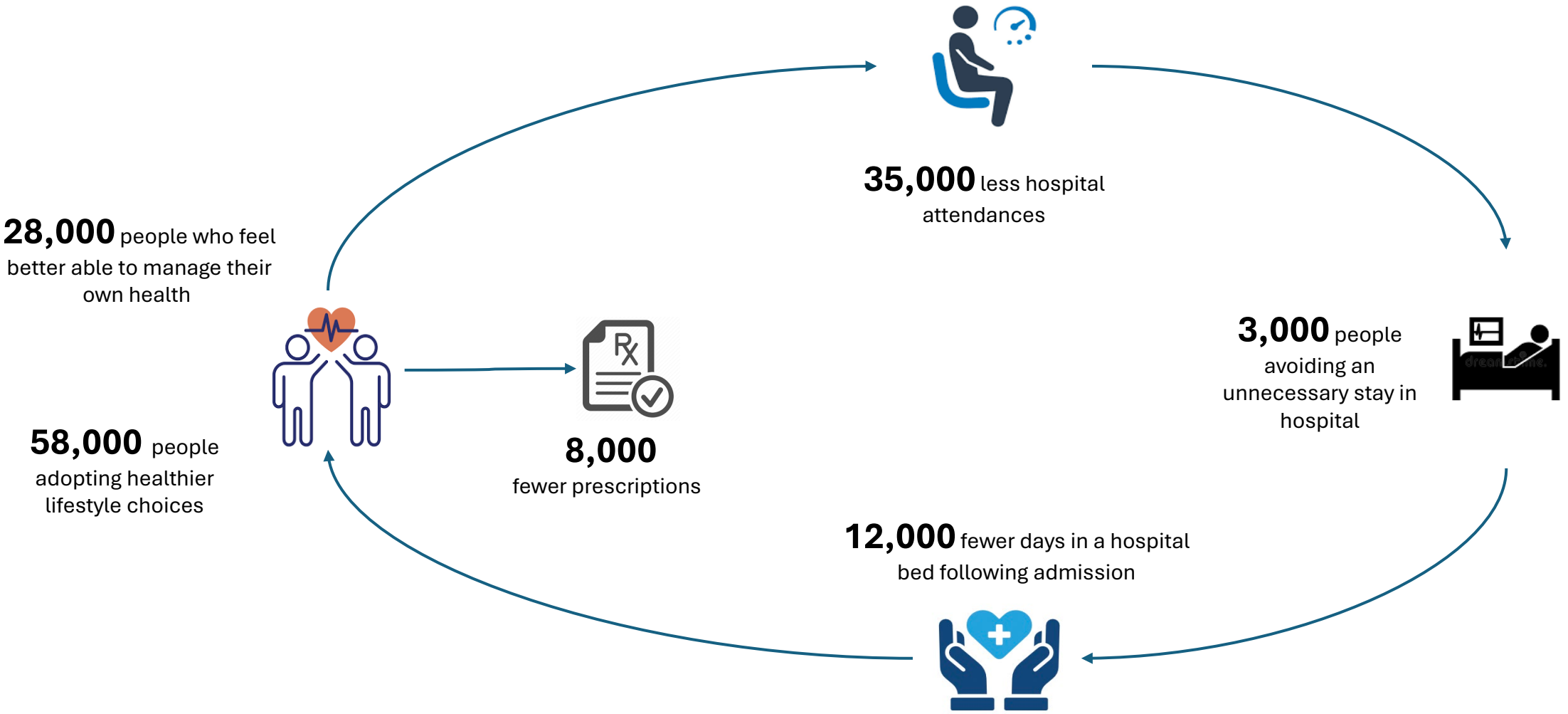
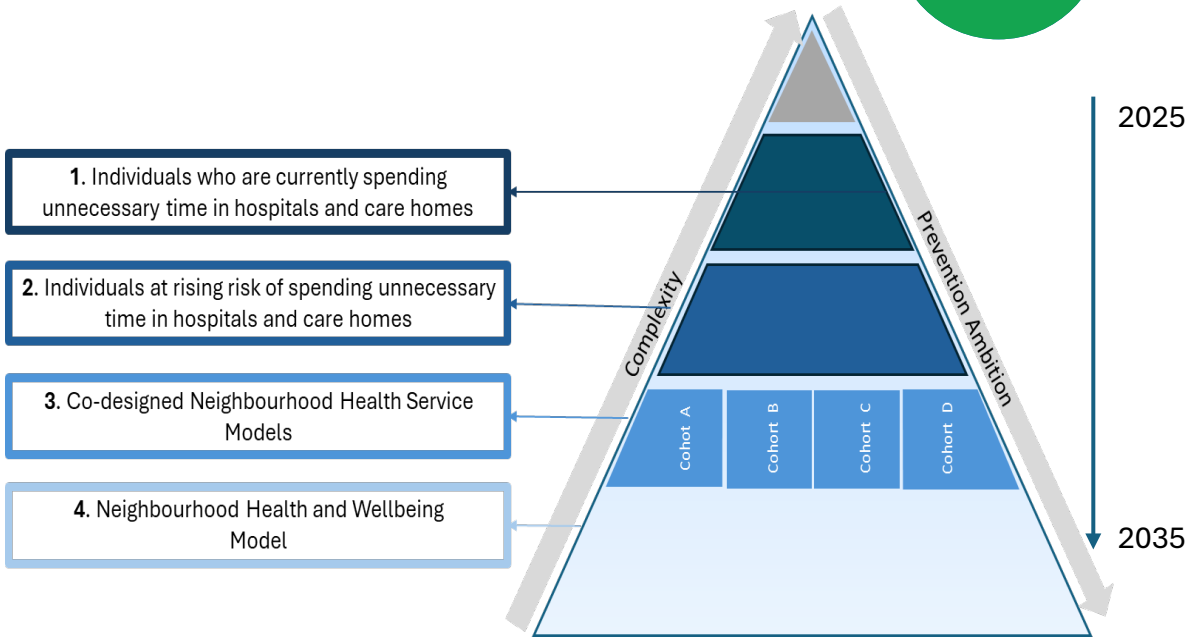


Neighbourhood Health Programme Development

- Recognising the immediate, and growing pressures, on services we started with a focus on those people who are already in our services to reduce their need to spend unnecessary time in hospitals and care homes.
- We are just starting to develop plans to identify and provide support for those individuals who have a rising risk of admissions
- As we progress through the programme, we will increasingly work with people and communities to co-design new service models and reimagine the future model for Neighbourhood Health and Wellbeing.
- Our emerging approach will be underpinned by strengths-based and relational practice at an individual and community level.

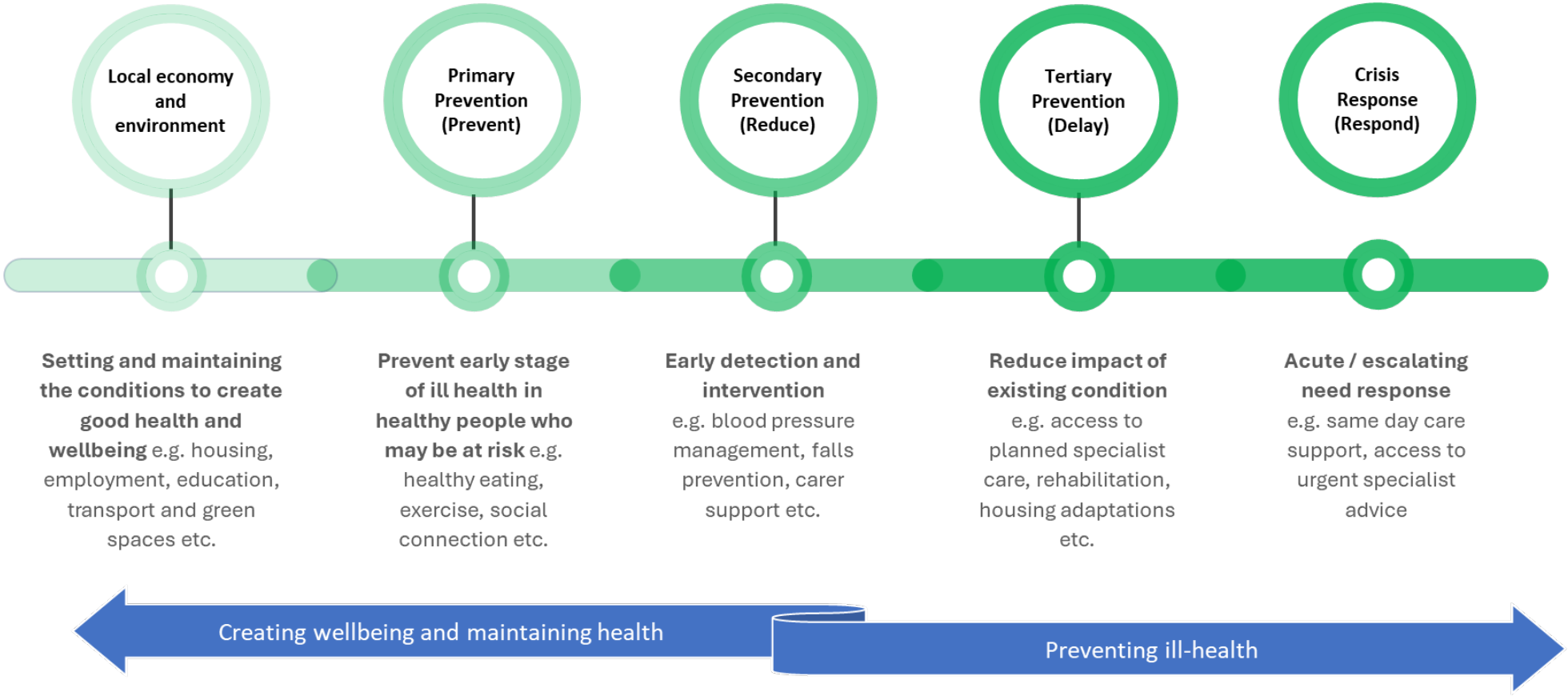


The Neighbourhood Health programme is a key component, but not the entirety, of the work to improve the Health and Wellbeing of the people of Dorset.

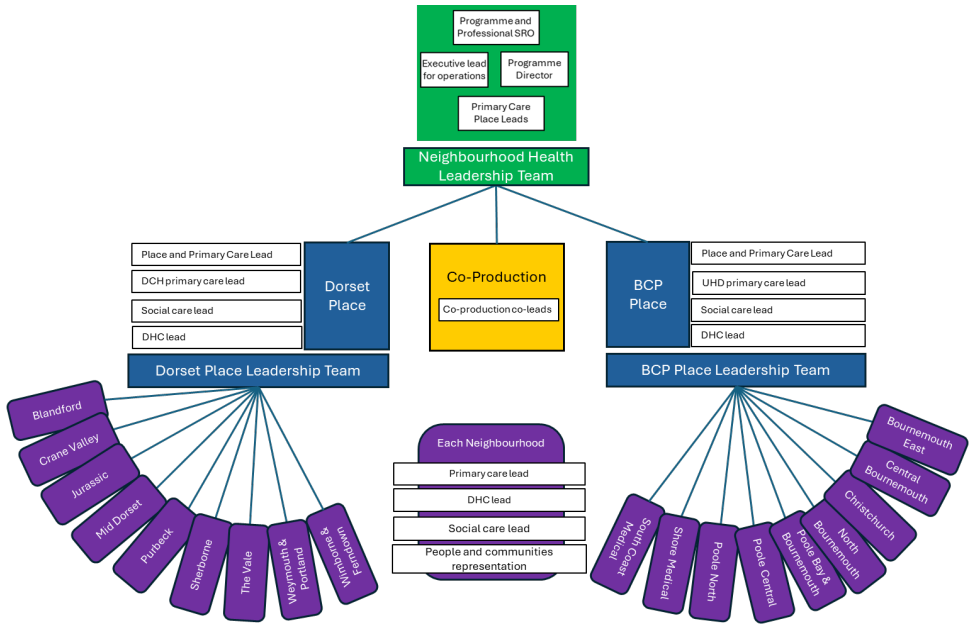
Local Authorities and Neighbourhood Health Services are partners in improving community well-being, with local authorities leading the work around social care, housing, public health and activities that support broader neighbourhood work, collectively addressing some of the wider determinants of health.

Changing the conversation from what is the matter with you, to what matters to you

At every stage of the programme, be it co-creating plans to support individuals who are currently spending unnecessary time in hospital or working with communities to co-design a new service models, we will adopt an approach that considers the whole person – not only their medical needs, but also the social and emotional factors that affect their health and wellbeing - doing with, not doing to and addressing the root causes of poor health, not just treating illness.



Programme Leadership



There are nine INTs within the BCP Place, and each is establishing a leadership team consisting leads from Primary Care, Community Health Services and Social Care, with People and Communities representation.

Neighbourhood Health Place leads from Primary Care, Community Health, Secondary Care and Adult Social Care will bring together the INTs leadership teams, VCSE, Public Health, communities and people with lived experience to create the conditions for Neighbourhood Health to flourish – rooted in relationships, shared purpose and collective action to:

- Deliver care differently for people with long-term conditions and those at rising risks of escalating need
- Generate the necessary changes in culture and integrated working across neighbourhoods and Place teams
- Create mechanisms to share learning and accelerate spread across neighbourhoods
- Listen to, and act on, feedback from the Neighbourhood Teams and develop plans that reflect their insights and experiences

Aligning INT Activity

Over the two years of the programme, we are asking Integrated Neighbourhood teams to:

- Build the team
    - Get to know each together and build the relationships, streamline internal processes and address the barriers to working together – the aim being to create the capacity to increase the focus on proactive care

- Integrate care around individuals and population cohorts:
    - Identify individuals with complex health and care needs who would benefit from joined up approach between teams and develop proactive care and support plans for them
    - Identify population cohorts with complex health and care need and redesign proactive care models with partners and local communities

Summary of Programme Progress

Building the Teams (well underway)

- ✓ INTs building relationships and streamlining systems and processes to create capacity
- ✓ Addressing escalated barriers to integration
- ✓ Integrated Nursing Team Blueprint
- ✓ Staff activation baselines
- ✓ INT maturity assessment baselines

Integrating care around individuals (making progress)

- ✓ Identify and support individuals experiencing high intensity use of multiple services
  - ❖ Care and support plan cconversations with individuals (asking what is happening for them and what would help)
  - ❖ Co-created plan that includes connection to VCSE offers and streamlined access to specialist services
  - ❖ Citizen activation measures
  - ❖ Tracking changes in unplanned care use
- ❑ Rising risk cohorts (tomorrow's users of multiple services)

Population cohort redesign (in development)

- ✓ Identify common themes from complex individuals work
- ❖ Data and insight informed priority cohort selection
- ❖ Targeted cohort focused community insights and co-production and co-design of 'left shift' care and support pathways
- ❑ Citizen and community activation measures
- ❑ System markers

INT Development progress - BCP

Our Dorset

Poole Central

Focus on shared understanding of "housebound" within Frailty context
Integrated Nursing development identified as a key objective.

Improvement focus:

- Frailty & Housebound
- CYP & Families
- Mental health Pathways

Castleman (3 PCN)s

Service mapping underway to support SPOA/INT referral pathway improvements
HIU lists: W&F – Frailty team/MH Team and Health and Wellbeing Coach contacting patients. Crane Valley has reviewed HIU list and are looking at non-clinical staff to care co-ordinate. Extra HIUs identified locally.
Requesting SystmOne coding/templates and SOP

Improvement Focus

- Frailty and Housebound
- Nursing Teams Communication and Integration
- CYP Mental Health

North Bournemouth

Developing understanding of UHD HIU offer to create a comprehensive approach.
Holistic Pre-Op Pathway group met, and mapping work planned to understand need and potential impact.
Regular events taking place with community groups to engage in social, physical and mental health.

Central Bournemouth

Reviewed high-intensity use, compiling lessons learned. Looking at ways to reduce duplication in visits. Work on understanding immigrants' access needs/ issues; meeting in Jan to review survey findings.

Improvement focus:

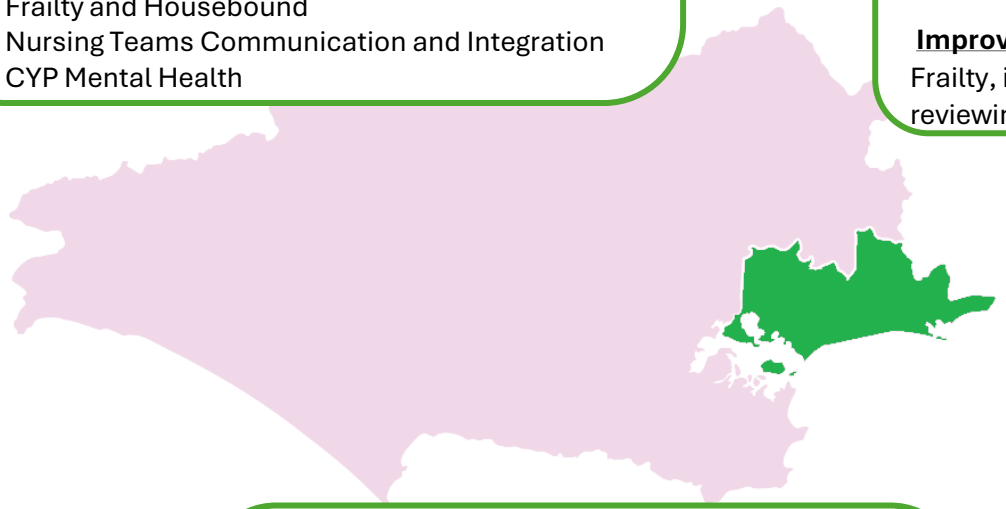
Frailty, inc. reducing care home duplication; mental health, reviewing pathways; pharmacy

Shore Medical (Poole)

Opportunities to adjust CMHT boundaries to support joined up working being explored.
Clinical review of HIU completed and key themes identified for individuals
Daily sharing of housebound patient caseload to avoid duplication of effort between District and Practice Nurses

Improvement Focus:

- All age Mental Health
- Housebound
- 'Who's in your neighbourhood' posters
- Referral pathways (via GP)
- Upskilling care navigators.



Christchurch

Core leadership group meeting scheduled for 17th December. HIU review has identified a few patients whose need is not being met clinically.

Improvement Focus:

Advantage project trialling outreach for people not in recent contact with healthcare. Success with >90 years; expanding to lower ages.

Poole Bay & Bournemouth

Initial core team meeting held and seeking to expand to include Local Authority and MH leads.
Work started to improve referral pathways between Primary Care and MH.

Improvement Focus:

Frailty, Mental Health - Both need further exploration

South Coast Medical

Reviewing high-intensity users. Reviewing MH pathways with neighbouring INTs. Pilots with primary care/ DHC to remove bureaucracy & duplication (podiatry, heart failure, ENT, audiology). Looking at roll-out of insulin mgmt. in community.

Improvement Focus:

Integrated nursing; mental health; medicines administration.

Bournemouth East

Reviewing high-intensity users. Progressing work with South Coast Medical around mental health. Consolidating patient information leaflets. Piloting review of suitability for patients on insulin.

Improvement Focus:

Housebound patients/ care at home; catheter clinics for mobile patients; trial w/o catheter (TWOC) service; frailty; mental health; support for ED discharges.

Integrating care around individuals

We are using data from the Dorset Intelligence and Insight Service (DiiS) to identify and support individuals to reduce their need to spend unnecessary time in hospitals. Through this we are able to see that a number of individuals across BCP are attending health services more frequently than might be expected i.e. attending Primary Care 20 or more times, Emergency Departments 5 or more times or having 3 or more emergency admissions.

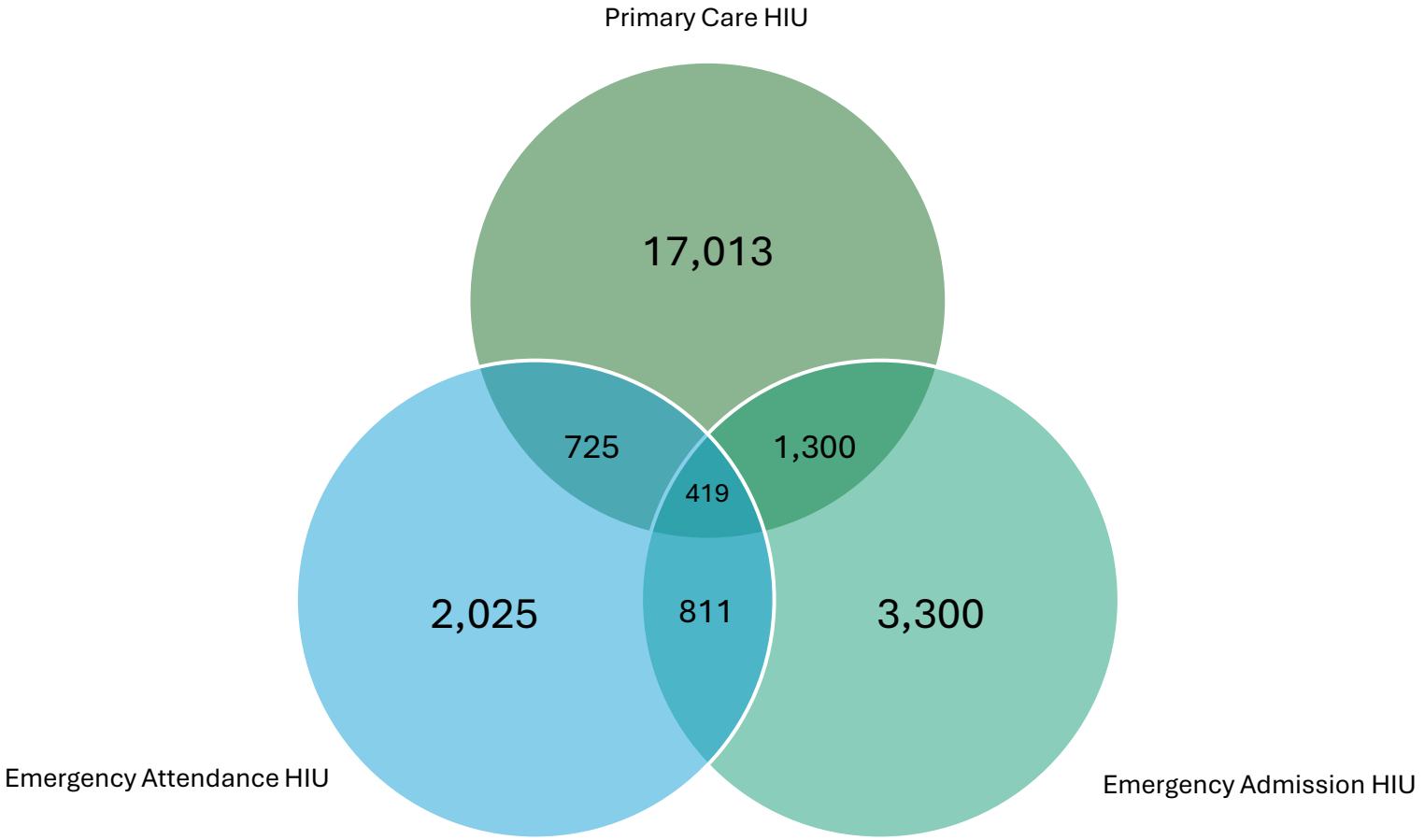
3.7% of the population account for 21% of Primary Care Appointments

0.4% of the population account for 11.7% of A&E Attendances

0.7% of the population account for 28% of Emergency Admissions

High Intensity Multiple Service Users (HIMSU)

There are approximately **22,338** people across BCP Local Authority who are experiencing High Intensity Use of health services, with **419** people who are experiencing High Intensity Use of multiple health services



These 419 individuals, 0.09% of the BCP population, account for:

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15,500
GP appointments

3,756
ED attendance

2,319
Emergency admissions

Average of 36 GP appointments (7 times Dorset average)

Average of 9 ED attendances (28 times Dorset average)

Average of 5 emergency admissions (53 times Dorset average)

Nearly half are also in the social care data as having requested support or receiving a service.

These individuals have a **higher rate of unplanned reviews and more repeat requests** compared with the rest of the social care population.

Shifting our approach to supporting

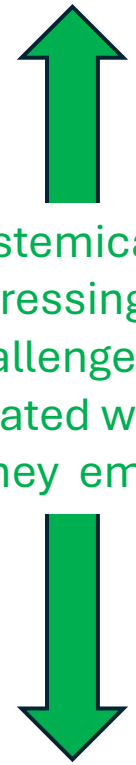
- As health care services only influence around 20% of a person's health and wellbeing, Dorset is seeking to understand what is important to these individuals, and their networks, and work with them to co-create holistic plans

- Shifting the conversation from 'what is the matter **with** you', to 'what matters **to** you'; by asking, listening and responding to what matters, we believe that by doing this we will be able to promote person-centred care and improve outcomes

- Identifying the individuals and supporting our multi-agency, multi -disciplinary teams (including VCSE)to be able to work together support these individuals are essential building blocks for this

Next steps

- ✓ All INTs have now had their data
- ✓ Co-produced framework agreed for testing
- ✓ Re.ID individuals
- ❖ MDT discussion to agree the best person to make contact
- ❖ Invite individuals to take part in a care and support conversation
- Co-create plans and put in place support offer – connections to other services et
- Review progress
- Share learning, identify common themes and test of change opportunities
- Review and refine approach and widen cohort to include rising risk



Systemically addressing the challenges to integrated working as they emerge