# REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

## Integrated Neighbourhood Teams in Oxfordshire:

**REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY COUNCIL, DR OMID NOURI**

## INTRODUCTION AND OVERVIEW

1. At its meeting on 06 June 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on Integrated Neighbourhood Teams in Oxfordshire.

2. The Committee felt it crucial to receive an update on the development as well as the activities of Integrated Neighbourhood Teams, particularly in light of the increased demand for health services throughout the county, including at the local level. The Committee also sought to assess the degree to which the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (ICB) was taking adequate steps to ensure sufficient resourcing for these teams and for their geographical spread to be in line with patterns of demand throughout the county.

3. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects of health as a whole; and this includes the nature of healthcare services being provided at the local neighbourhood level. When commissioning this report on Integrated Neighbourhood Teams, some of the insights that the Committee sought to receive were as follows:

   - The geographical spread of Integrated Neighbourhood Teams and how they operate throughout the county.
   - The levels of staffing currently dedicated to these teams, and whether there is an adequacy of staffing levels.
   - The extent to which there is good partnership working within the Oxfordshire system around the design and the delivery of this service.
   - How extensive/important the role of Primary Care Networks and Individual GP practices are in the context of Integrated Neighbourhood Teams.
   - How Oxfordshire compares to other areas in the effectiveness and the resourcing for Integrated Neighbourhood Teams (including relative to the other areas under the BOB footprint).

- The competencies around the staff involved in such teams, and whether such competencies are standardised/measured?

- How effectively Integrated Neighbourhood Teams are operating in Oxfordshire, and whether there is room for improvement.

## SUMMARY

4. The Committee would like to express thanks to Lily O' Connor (Programme Director Urgent and Emergency Care for Oxfordshire, BOB ICB); Dan Leveson (BOB ICB Director of Place for Oxfordshire); Karen Fuller (Director for Adult Social Care, Oxfordshire County Council); Victoria McDermott (Proactive Care Manager at The Manor Surgery); Dr Bethan Willis (GP lead for inequalities, Banbury Cross Health centre and Frailty GP); Dr Sarah Lourenco (Clinical Director of Banbury Alliance PCN); Deborah White (Team Manager West Adult Social Care Team); Dr Suzanne Summers (Bicester Health Centre, Integrated Neighbourhood Team Bicester GP); for attending this meeting item on 06 June 2024 and for answering questions from the Committee.

5. The Programme Director provided a comprehensive overview of the Integrated Neighbourhood Teams (INTs) initiative in Oxfordshire, which included GPs, social workers, community therapists, district nurses, and other healthcare professionals. These teams worked collaboratively to address unmet health needs, in areas of deprivation such as Banbury, Bicester, and the OX3 area.

6. The Programme Director explained that while many aspects of the initiative might seem like they should already have been happening, the challenge in implementing them lay in the lack of additional workforce and funding necessary for providing the level of care required in these areas. The INTs aimed to provide that additional funding and staffing, particularly in areas of unmet health needs.

7. The Committee asked for elaboration on how the existence and functions of INTs would help to tackle and reduce inequalities in Oxfordshire and deliver continuity of care, and whether this would be delivered in rural areas. The Programme Director responded that continuity of care was a fundamental component of INTs. The initiative ensured oversight and coordination across multiple healthcare professionals, which was crucial for patients who preferred to interact with a single trusted individual. This approach not only benefited patients but also enhanced job satisfaction among healthcare professionals due to the continuous relationship with the same patient group.

8. Regarding rural areas, the Programme Director acknowledged the challenges and explained the phased approach to expanding INTs. Currently, the focus was on areas with the highest unmet health needs owing to limited funding, but there were plans to extend the initiative to other areas, including rural areas, if more resources became available. The Oxfordshire Place Director emphasised that in Oxfordshire they had chosen to prioritise supporting the development of integrated neighbourhoods through the Better Care Fund and it was a central part of their primary care strategy.

9. The Committee enquired about the focus on different conditions in different localities. The Programme Director clarified that the INTs were designed to address the specific health needs of each local population, which was why the focus areas differed. The initiative was not limited to single conditions but took a holistic approach to managing the overall health of the population. The emphasis on different conditions in various areas was based on thorough background work and population-health data, ensuring that the INTs addressed the most pressing health issues in each community. A GP from an OX3 INT provided a practical example to illustrate the concept of integrated care. He described a case involving a terminally ill patient with advanced cancer who preferred to stay at home. The coordinated effort between the hospital teams, care teams, and district nurses ensured the patient received comprehensive care at home. Dr McManners emphasised that this level of integration was essential for managing complex cases effectively and providing patients with the best possible care.

10. The Committee enquired about the extent of Oxfordshire County Council's involvement in both the development as well as the services provided by INTs. A GP from a Bicester INT reported that they participated in pilot sites and collaborated closely with Oxfordshire County Council. Their work primarily focused on weekly multidisciplinary team meetings. These sessions involved the hospital's care team, responsible for discharge planning, and the County Council's social work team. The goal was to track patients' status and care needs, ensuring timely support. The OCC Director for Public Health added that Public Health had developed ten community profiles in Oxfordshire's most deprived areas, which highlighted some of the tailored needs in those communities and linked directly with the work done by INTs.

11. The Committee asked whether coproduction was at the heart of the design and the development of INTs, and what definition of coproduction they were using. The Programme Director acknowledged that while there had been efforts to engage with public groups, the level of coproduction needed more depth. Going directly to the communities and understanding their specific needs was crucial as a granular level of detail was necessary for making impactful changes.

12. Regarding the management of these teams, the Programme Director explained that the integrated team setup required more than just additional sessions by GPs. It also required the involvement of care coordinators, voluntary sector social prescribers, and non-clinicians who focused on the person rather than the condition. This bottom-up approach ensured that the design of each INT was based on the experiences and needs of the local community.

13. The Programme Director detailed the complexities of information sharing and highlighted the need for agreements within GP surgeries and Primary Care Networks to ensure safe and effective data sharing. The challenges posed by different healthcare systems used by primary care, community services, and secondary care were noted. Efforts were ongoing to integrate these systems, though significant risks remained.

14. Regarding funding, the Programme Director explained that the true cost of INTs was still being assessed with the help of health economists from Oxford University. They were measuring the impact of INTs by comparing data from INT patients with control groups to determine the cost-effectiveness and benefits of the initiative.

15. The Committee enquired as to the extent to which the public were aware of and understood what INTs were and how they operated. The Programme Director recognised the complexity of the initiative and the need for public education. Plans were in place to engage with local community groups and educate the public about the benefits and operations of INTs. This ongoing engagement would help ensure that residents understand the new approach to coordinating health needs.

## KEY POINTS OF OBSERVATION & RECOMMENDATIONS

16. Below are three key points/themes of observation that the Committee has in relation to Integrated Neighbourhood Teams (INTs) in Oxfordshire. These three key points of observation relate to some of the themes of discussion during the meeting on 06 June, and have also been used to shape the recommendations made by the Committee. Beneath each observation point is a specific recommendation being made by the Committee.

***Governance and Management of INTs:*** The Committee is pleased to see that the system's commitment to INTs would involve more than just the provision of additional sessions by GPs. The focus should therefore be on individuals as opposed to the medical condition(s) that they are presenting with. The Committee understands that the operations of these teams would have to involve care coordinators, voluntary sector social prescribers, and non-clinicians. This should, in effect, help focus on the unique needs of each individual patient as opposed to relying on a generalisable model of care that would be based on the presumed patterns of specific medical conditions.

It is therefore crucial that a bottom-up approach is explicitly adopted. Each INT should continue to be developed and shaped in accordance to the health patterns, needs, and experiences of each local community.

Related to the above, the complexity of INTs would mean that clear processes are required to effectively manage the operations of these teams and the services they provide at the local level. Part of this involves an imperative for good partnership working and collaborative efforts amongst the various teams and system partners who are contributing to the activities of these teams. Nonetheless, it is crucial that the governance and management of these teams goes a step further in having coherent and somewhat centralised structures in place for the purposes of managing and governing the setup and activities of INTs. This is vital for two reasons:

1. Having a clear structure of governance would allow for clear guidance and management of the overall coordination, collaboration, and activities of INTs.

2. The existence of such structures can contribute to the development of performance indicators to help determine the degree to which INTs are performing effectively. There may also be a case for developing performance indicators that are unique to each INTs based on local population health trends.

Furthermore, it is also paramount that there is clear transparency around the process of both the creation as well as the governance/management of INTs. Given the increased strains and demand faced by the healthcare system, the public need to be in a position to understand how the system is operating to reassuringly provide services to residents in their localities as and when they need it. If locals are to be reassured with the introduction of coordinated teams at the local level, then they should ideally be in a position to understand how their local INT is structured and how it will operate.

**Recommendation 1:** *That there are clear governance and management processes around both the development and ongoing activity of Integrated Neighbourhood Teams. It is recommended that there is clear transparency around this.*

***Importance of coproduction:*** The Committee is pleased to see that Integrated Neighbourhood Teams are in the process of being rolled out, and again perceives this to be a key development that should mean better health outcomes for local neighbourhoods. Nonetheless, it is also crucial that coproduction remains at the heart of how these teams are designed as well as how they go about undertaking their activities. The Committee is pleased to hear that the ICB acknowledges that a more in-depth level of coproduction was required, and the JHOSC would not only strongly recommend that more extensive coproduction is pursued around INTs but would also be willing to support this. It is vital for system partners to directly approach communities and neighbourhoods in Oxfordshire. This would help INTs to understand the specific needs of each community and to shape the nature of these teams and their activities accordingly.

Related to this is how coproduction is defined. Coproduction, as a term and principle, has been conceptualised in a plethora of ways and can often be interpreted differently. The Committee would like to emphasise that coproduction should not be conflated with codelivery. Coproduction should revolve around working with the local communities and patients who would be on the receiving end of services. The Committee therefore is strongly recommending that there is an agreed definition of coproduction, as this would help to support the ever-crucial endeavour to work with local communities around the development of INTs. Coproduction is important here in two respects:

1. It can help improve the communication with communities to help them to understand what INTs are and how they may help to improve health outcomes at the local level.

2. It can provide opportunities for local communities and stakeholders to have a say in how their local INTs should be designed and operated. In this regard, the system can be better placed to understand any concerns local residents may have, and to either reassure these residents or shape services accordingly.

**Recommendation 2:** *To ensure ongoing coproduction with neighbourhoods and key stakeholders around the formation as well as the activities of Integrated Neighbourhood Teams. It is also recommended that an agreed definition of coproduction is outlined by system partners in this regard.*

***Determining local health needs and resources for INTs:*** The Committee is pleased to see that efforts have been made to shape INTs in accordance to the health patterns of their localities. This is a positive development; there is a point about having a stronger understanding of the health needs of each locality. This will be conducive toward effectively determining which areas would require more resourcing. The type and level of resourcing that each INT/locality would require could vary, and this should be taken into account when determining which resources/personnel to allocate where. In line with what has previously been emphasised in the context of other items of its scrutiny, the Committee recommends that every effort is made by system partners to secure adequate levels of funding for the purposes of supporting the development and operations of INTs.

Indeed, the importance of determining local health needs and resourcing accordingly would contribute to tackling and reducing health inequalities in Oxfordshire. If the system is able to identify where health and broader socioeconomic vulnerabilities lie, then it is able to take concrete action in designing and coordinating neighbourhood teams in a manner that targets the most vulnerable sections of the County's population and geographies. Additionally, this could help to ensure the delivery of continuity of care for patients with long-term conditions who would require further and consistent support at home in their communities upon leaving hospital. The Committee understands and appreciates the need to prioritise care in people's homes when it is appropriate to do so. However, INTs should be at the forefront of helping to support the system's ability to discharge patients safely and to ensure that they continue to receive the care and support that they need. Again, there is also a point about having clear communication with patients regarding the type of support and care they could expect to receive, particularly if they're suffering from a long-term condition.

**Recommendation 3:** *To develop a clear understanding of the health needs and population patterns for each locality, and to allocate resources for Integrated Neighbourhood Teams accordingly.*

## Legal Implications

17. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
    - Power to scrutinise health bodies and authorities in the local area
    - Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
    - Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

18. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

19. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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