NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Buckinghamshire, Oxfordshire and Berkshire West Joint Overview and Scrutiny Committee

Integrated Neighbourhood Teams, Oxfordshire

Introduction

1. This paper outlines the programme of work in Oxfordshire for the implementation of Integrated Neighbourhood Teams (INT's).

2. The papers cover:

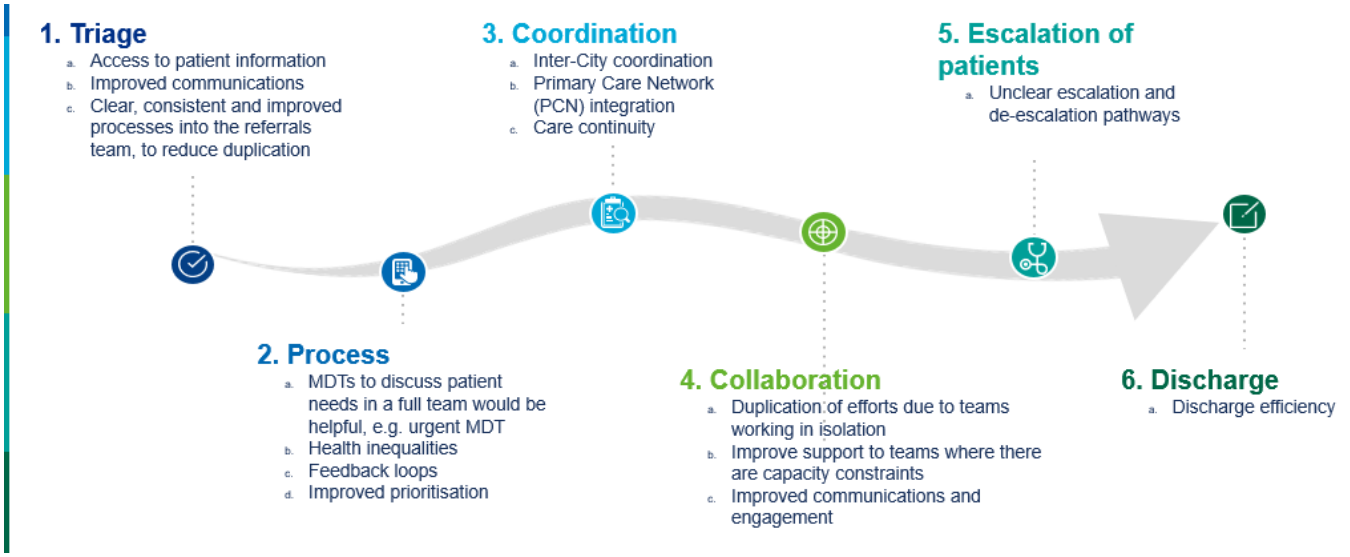
   - What are Integrated Neighbourhood Teams (INT's)
   - Areas where they have been implemented.
   - Co-production with the local population

Integrated Neighbourhood Teams

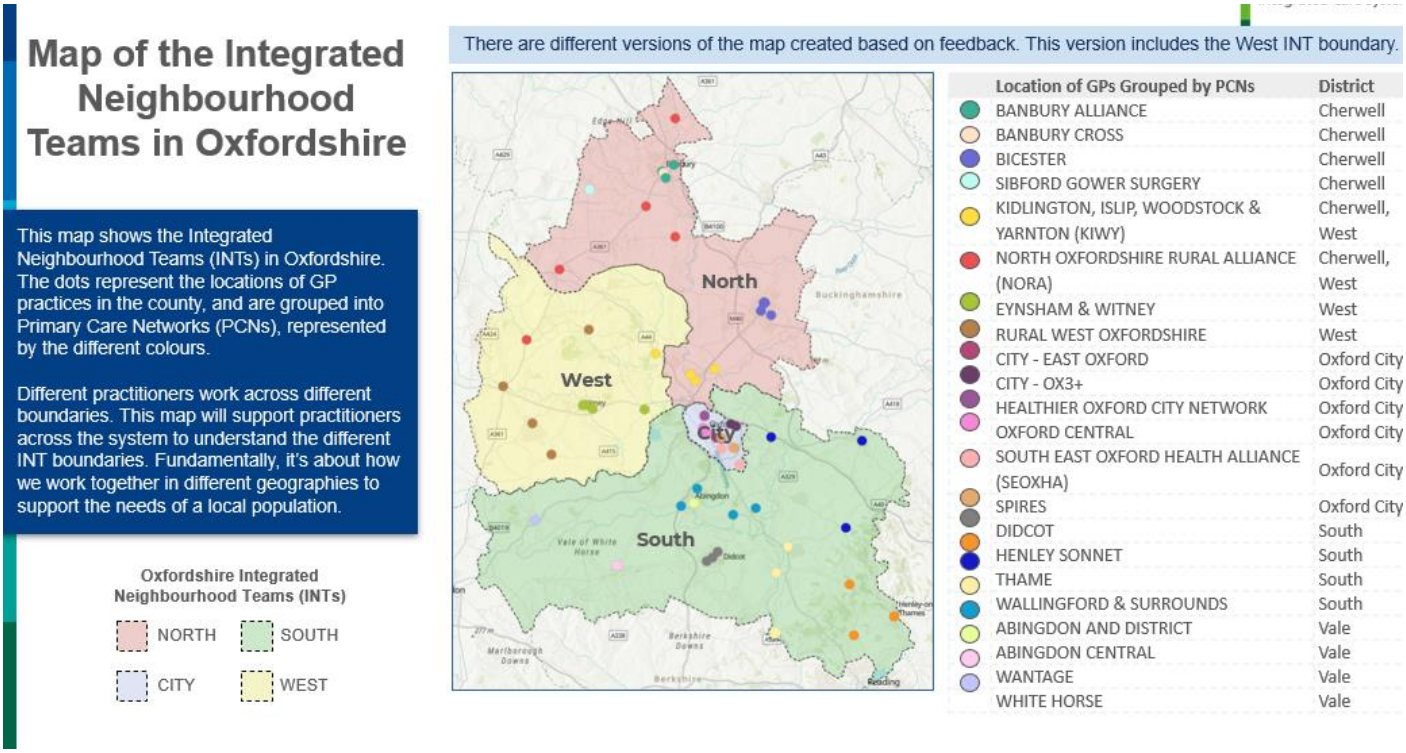
3. Integrated Neighbourhood Teams are an NHS England collaborative approach that brings together healthcare providers, social care services, and community resources within a geographic area (https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf).
4. The development of Integrated Neighbourhood Team's is a key component of the BOB ICB Primary Care strategy.
5. Its goal is to provide coordinated, person-centered care that meets the immediate needs of a patient, and prevention of further healthcare needs.
6. INTs bring together health care professionals from different organisations across health and care services with the aim of delivering a coordinated approach for the local population whose health and social care need cuts across multiple teams.
7. INTs aim to develop the community integration close to the person who requires the intervention e.g., at GP practice or Primary Care Network (PCN) level.
8. INTs will join-up services by simplifying pathways and coordinating care for people with complex needs.
9. INTs aim to reduce inequalities (deprived areas & minority groups) by providing a consistency of service across an area.
10. INTs streamline the access to care and advice for people when they need it. This will provide patients with much more choice about how they access care and ensure care is always available to patients in their communities when they need it.
11. INTs provide more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions; as well as patients that use services less frequently.
12. For more information, please read the Fuller Stocktake Report.

Integrated Neighbourhood Teams Process

13. This process has been piloted across the City of Oxford and Bicester INT's. The process works through the current challenges and identify areas for further development which are worked through during the regular meetings.



Map of Oxfordshire, split into North, City, West and South areas.



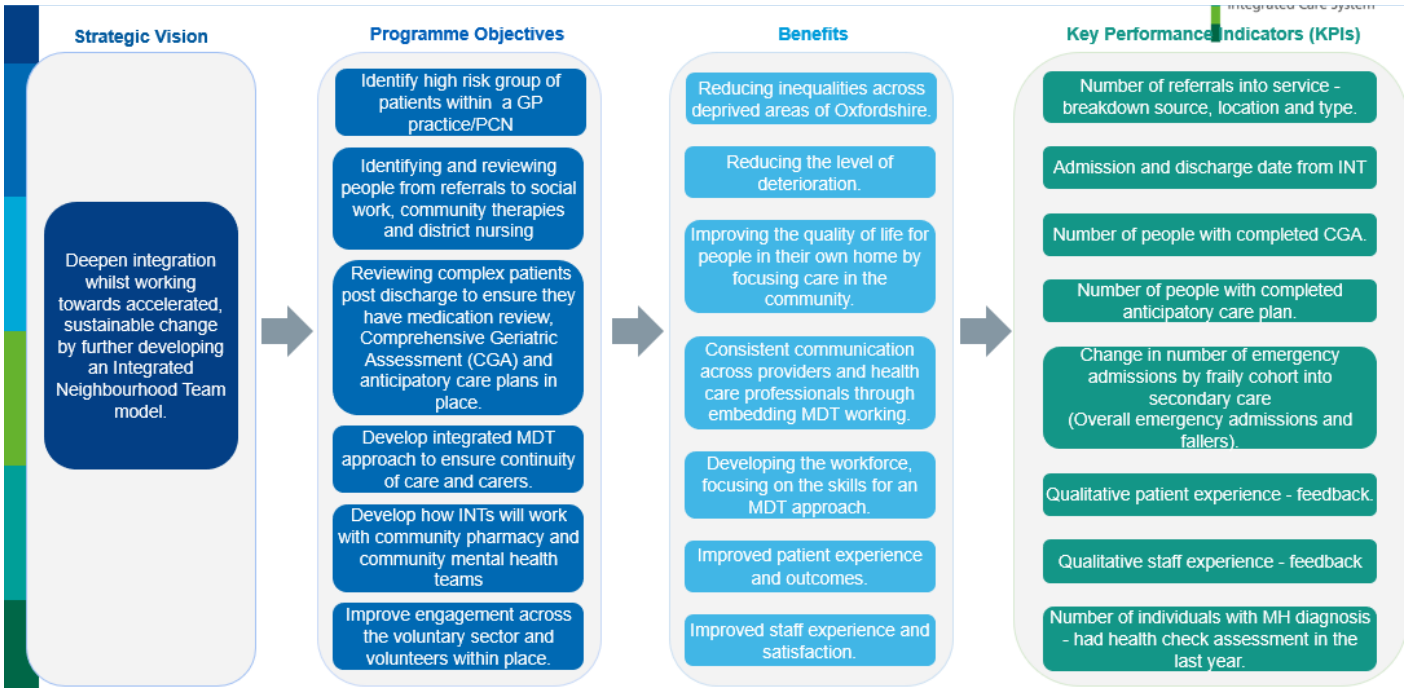
Vision of INTs for Oxfordshire

14. INTs cover 30,000-50,000 population and once established cost approximately £400,000 per INT.

15. The cost effectiveness is based on bed days saved e.g., a monthly run rate of £30,000 and savings of £180,000 following bed days saved.

16. The outcomes for INTs focus on the following.

    a. Increased proactive prevention services and care to keep people well for longer, rather than waiting for illness to set in.
    b. Levelling up of outcomes e.g., people in deprived areas to experience better outcomes, equivalent to those in other areas.
    c. Reducing the need to access emergency or other unplanned health services because patients are provided integrated personalised care in the community.



Areas with Integrated Neighbourhood teams

17. INTs are being developed across North, City, West and South Oxfordshire. The first INT was developed within Bicester Primary Care Network. This was closely followed by the development of an INT within the OX3 area, The Manor surgery, and Hedena Practice. We have started an INT with the two PCN's in Banbury and are at the early stage in Witney and Eynsham PCN and are due to start one in south Oxfordshire.

Operational model

Oxford City

18. The operating model is based on the needs of the local population. In Oxford OX3 area, the focus is on frailty and those with social and mental health needs. This covers areas such as Barton, Wood farm and Headington. The INT in this area, covers two GP practices and areas of deprivation. Referrals come into the INT from on the day triage calls, post home visits or from any health care professional working within OX3 and registered with one of the two GP surgeries. The INT care coordinators also screen a daily email from the OUH discharge team to identify high risk discharges.
19. They hold a daily meeting with key health care professionals to triage new referrals, to review the caseload and agree any urgent actions, and to plan the visits for the day. In addition, they

run a weekly meeting with the wider group such as Gerontology consultants, social care, district nursing, and any health care professionals who they need an opinion from for the list of patients they are discussing.

20. The focus is working with people and what is important to them and maintaining them safely within their own home if that is what the person wants.
21. The INT within this area has funding for additional GP time, care coordinator, Gerontology consultants and the voluntary sector. This has created the capacity required to provide assessment interventions, treatments, and the overall coordination of those who have the highest care needs.
22. Over the forthcoming 12 months, INTs will be rolled out in different PCN's across the city of Oxford.

Banbury

23. In Banbury the focus is on the population, all ages within the deprived areas. This involves integrated working with Cherwell District Council, local volunteer groups, community services, social care, and Primary Care. The operating model varies from council colleagues delivering webinars for all healthcare staff who visit people in their own homes, to ensure they know what to look out for and refer housing or other issues to the relevant service. The areas of focus in the deprived areas of Banbury are as follows.
    a. Respiratory disease and investigating why the admissions are increased for this area all ages.
    b. Childhood obesity- mainly primary school ages
    c. Heart failure
    d. Frailty population living in the deprived areas.
    e. Reducing the risk of stroke by early diagnosing high blood pressure and irregular heart rates (atrial fibrillation).

Bicester

24. The INT within Bicester PCN covers three GP practices. It was the first on and started in 2022. It focuses mainly of those who are the highest risk in the local population, mainly frailty. The team consists of GP sessions covering Monday to Friday, care co-ordinators, AGE UK, additional district nurse and community therapy. They have integrated working across all the visiting services and social care.

25. They run daily and weekly meetings to discuss new referrals and those on the INT caseload. GPs across the three surgeries refer people to them in addition to referrals from any healthcare professional within that area. Staff from the OUHFT refer any complex discharges to them for discussion prior to discharge and planning what support may be required after the person has returned to their own home.

26. The work in Bicester INT has shown that the intervention, discussion, and care plans developed have maintained people in their own home and reduce the need to return to hospital. The integrated working with the Rowan Day unit on the Horton has supported people being assessed in that unit and then followed up by the INT when they return home.

Witney

27. The development of an INT within the Witney and Eynsham PCN is at an early stage. The Primary care within his are keen to maintain continuity of care and are not at this stage looking for additional GP time dedicated to those with the highest needs. The focus in this area is developing what is already there, developing the joint working with the local Witney frailty unit know as Witney EMU and developing the capacity and skill set of the local primary care visiting service.
28. They run a weekly meeting with community services and social care where those that there is a concern about are discussed. This is supported by Gerontology input from the OUHFT.

Workforce and funding

29. The initial funding came from a successful bid from the national team and the continuation and further development funding will come from the Better Care Fund until a more permanent recurrent funding stream is organised.

Challenges, one size does not fit all.

30. The approach is based on the local population health and the gap in unmet health care needs. To understand this for each area, the following needs to be carried out.
    a. Scoping exercise of what services are already established within the area.
    b. Regular reviews of referrals into social care, community therapy and community services to help identify unmet health care needs.
    c. Identifying high risk people registered at the GP practice and those housebound.
    d. Rate of emergency admissions and reasons for admission
    e. Identifying what would make a difference to improve health outcomes.
    f. Establishing what is required in workforce and skill set.

31. There are challenges understanding the unmet health needs in each area. It requires the local populations views, analysis data from different sources and a project group to assess and agree what is required.

Co-production with the local areas

32. There has been significant assessment of view from the people living within the deprived areas of Banbury. However, this will continue as the INTs within Banbury are developed.
33. Within OX3, we have met with the Barton Health and Wellbeing Partnership group and are in the process of meeting Wood Farm Health and Wellbeing Partnership and Headington groups.
34. In Witney we have asked to meet with the public partnership group.

Future work and next steps

35. We are working with colleagues from the various information teams across OUHFT, County Council, OHFT and we are in the process of working with a health economist to establish how we can develop the data set to illustrate the benefits across the various pathways.
36. Each INT has developed using a bottom-up approach based on the local population health needs. When we have established the metrics that provide an accurate overview of an INT we can review and see how INTs can be implemented across the county of Oxfordshire.