NHS England

Fit for the Future
Working together to keep people well

NHS Improvement

Cambridgeshire & Peterborough

Integrated Neighbourhoods
Framework for implementation

VERSION 14

November 2018

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

NHS Cambridgeshire and Peterborough NHS Foundation Trust

NHS Cambridgeshire Community Services NHS Trust

NHS Cambridge University Hospitals NHS Foundation Trust

NHS North West Anglia NHS Foundation Trust

NHS Royal Papworth Hospital NHS Foundation Trust

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

NHS East of England Ambulance Service NHS Trust

Confidential Draft: work in progress

Purpose

Objective

To define what the Integrated Neighbourhood model looks like for Cambridgeshire and Peterborough STP and the programmes of work to roll this out.

This framework sets out the following at STP level:

1. **Case for change.**
2. **Common characteristics for Integrated Neighbourhoods** and **how they will work**.
3. **Where we are now** and the key **next steps** for developing Integrated Neighbourhoods.
4. **Expected benefits** of Integrated Neighbourhoods, for people and the local healthcare system.
5. **Resource required** at both Alliance and Integrated Neighbourhood level to deliver.

Audiencee

The intended audience for this document is the Cambridgeshire and Peterborough Health and Care Executive.

Outwith this framework, each Alliance will:

1. Articulate what **needs to be done in 2018/19 and subsequent years** to accelerate Integrate Neighbourhood development.
2. Set out the **key milestones and timeline for delivery**, including immediate next steps for both North and South Alliances.

Principles

- This framework sets out the agreed key features that will be constant across the whole STP.
- Within the STP, the **North and South Alliances will have primacy for leading and developing the Integrated Neighbourhood approach** across their respective geographies.
- Within each Alliance, **Integrated Neighbourhoods** will develop local models of integrated care with primary care networks as their cornerstone, bringing together community, social, secondary care, mental health and voluntary services.
- **Within each Integrated Neighbourhood the iindependent contractor status of Primary Care will remain unaffected. The development of Integrated Neighbourhoods does not preclude or require changes to organisational form.** The model will focus on collaboration between primary care and other key partners.
- **Each Alliance will develop and tailor the approach to implementation**, reflecting their readiness and working across their geography and local challenges illuminated by detailed data analysis informing their understanding of their populations, deepening and iterating over time.
- The **Alliances will work very closely with emerging Primary Care Networks (PCNs) as the key leaders and drivers of change** across each Integrated Neighbourhood as PCNs adopt, adapt and scale the Integrated Neighbourhood approach in each unique geography of 30-50k.
- The developing Integrated Neighbourhood approach will **go beyond traditional Health and Social Care organisations**. For example:
  - we can use the same geographical definitions of neighbourhoods to enable the Local Authority to test the **Think Communities** approach to address a 'rising risk' cohort of people through community development and seeking individuals and families at risk to ensure early pre-emptive intervention, e.g. to avoid entry to criminal justice system or avoid homelessness.
  - Collaborations with third sector organisations will also be crucial, e.g. in testing **Integrated Prevention Hubs**, using a **social action research** approach within the South Alliance area.
- **Alliances will learn from national lessons** on the principles for implementing new care models, using learning from the Health Foundation Trust and The King's Fund .

Definitions

Primary care at scale

- GP practices working together to cover any population size or community.
- May include wider primary care services.
- Variety of underpinning contractual forms – does not require or preclude changes to organisational form.

Primary Care Networks

- GP practices working together to cover communities of 30-50k and providing wider primary care services.
- Variety of underpinning contractual forms – does not require or preclude changes to organisational form.
- Terminology used by NHS England.
- More information available here .

Primary Care Home

- A brand of Primary Care Network supported by the National Association of Primary Care (NAPC).
- More information available here .

SCOPE OF THIS FRAMEWORK

Integrated Neighbourhoods

- **With primary care networks as their cornerstone, bring together community, social, secondary care, mental health, voluntary and wider services (see diagram 2.1) to provide proactive and integrated care to local communities which keeps people well and out of hospital.**

1. Case for Change

The health needs of the population are changing, but the way services are structured has not kept up.

- In Cambridgeshire and Peterborough, the number of people over 75 could increase by up to 50% in the next ten years.
- Around 1 in 10 local people have more than one long-term condition
- A&E attendances and non-elective admissions are continuing to increase in Cambridgeshire & Peterborough at an even faster rate over the past 5 years than England as a whole
- There are major threats to stability nationally, particularly around workforce, including the numbers of GPs retiring in the next ten years leaving a gap that we can only partly fill

There is growing evidence that integrating health and care services and providing these closer to where people live will:

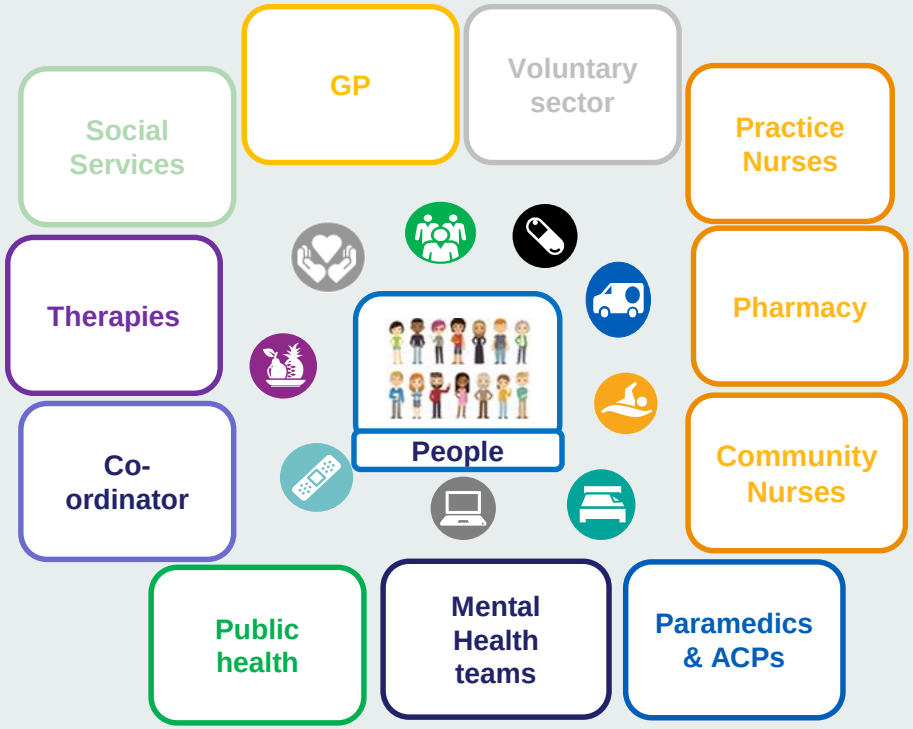
- Improve **health and care outcomes**, and reduce avoidable illness and inequalities.
- Improve **personal wellbeing and confidence** of people to manage their own health
- Offer more **joined-up, co-ordinated care**; better experience and quality of life for people
- **Increase capacity in primary and community care** to enable more care to be delivered at home and in the community
- **Slow growth in hospital utilisation** and **reduce permanent admissions to residential care**
- Improve **staff satisfaction**, staff confidence and morale
- Contribute to **closing the financial gap**

2.1 Characteristics of Integrated Neighbourhoods

Integrated Neighbourhoods provide proactive and integrated care to communities of 30,000-50,000. They aim to keep local people well and out of hospital. Integrated Neighbourhoods build on the base of primary care networks, bring all parts of the workforce together and put the people at the centre of the care they receive. The cornerstone of each Integrated Neighbourhood is a Primary Care Network.

Integrated Neighbourhood working in a specific community around primary care and their registered population

- Size and shape will vary, but share common characteristics.
- Delivery is multi-disciplinary, but there will be differences in how services and functions are organised at Integrated Neighbourhood level.



Additional Specialities at larger scale feeding in as needed, including:

- Specialist Nurses: Parkinson, Diabetes, Continence, Respiratory
- Dietetics
- Continuing Care
- Complex Pathways
- Wider public Services – Fire, Police, Housing
- Enhanced Recovery and Support at home
- Re-ablement at home Community Beds and Diagnostics
- Drug and alcohol services

The registered GP Surgery is the 'cradle to grave' care co-ordinator. All partners work as one team to provide wrap-around and specialist care with patients in the centre. Working in this way:

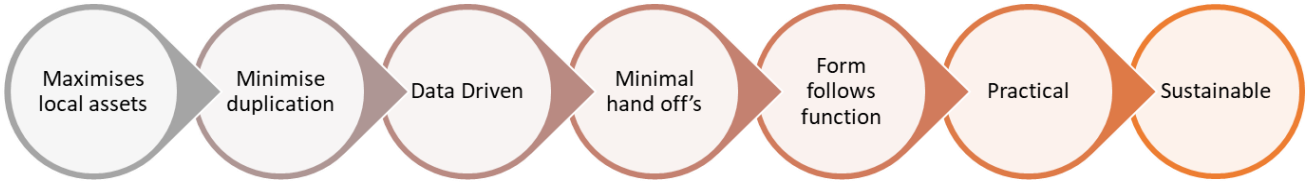
- Focuses on **what matters to the person.**
- Delivers **more care at home**, keeping people out of hospital.
- **Supports people to remain independent in their own homes** for as long as possible.
- Provides **consistent and quality healthcare** across the system.

2.2 How will Integrated Neighbourhoods work?

The aim of the integrated neighbourhood approach is to shift the pattern of care and services to be more preventative, proactive and local for people of all ages. Team members will work with people as active participants rather than passive recipients of care.

With **Primary Care Networks as the core building block**, Integrated Neighbourhoods:

- Focus is on population health management: **data is used to segment population,** identify 'at risk' groups. Services and interventions are stratified and designed accordingly.
- Are **GP-led but multi-professional:** aligning frontline health and social care teams such as community nursing, mental health professionals, community pharmacists, physiotherapists, community paramedics, social navigator, mental health, third sector around the needs of the population
- Recognise the independent contractor status of Primary Care i.e. core GMS services will remain with Primary Care.
- Support **team members to have a shared set of skills**, recognising the need to access more specialist knowledge from some members of the team
- Foster a culture of inter-professional working allowing members to spend their time where they add most value. Regular **community MDTs discuss and problem solve** - conversation not referral.
- Are much **more closely linked into secondary care** - Technology: Epic and Consultant Connect; Data: share records; in reach and outreach: community geriatricians and 'hospitalist' GPs



3.1 Steps to establish Integrated Neighbourhoods – model of change

2018/19

- Understand and identify the core components of the target model in each Integrated Neighbourhood, co-producing this with local teams and patients.
- Rigorously stress test against what is happening nationally Manchester, Dorset, Frimley - and internationally .
- Establish a clear logic model that maps interventions to outputs and outcomes over time.
- Establish a clear evaluation methodology to track progress, outputs and outcomes.
- At least one Integrated Neighbourhood identified in the South and three in the North.
- Lay the groundwork for developing further Integrated Neighbourhoods.

2019/20

- Establish primary care networks across the whole of the STP. Cluster practices into 30-60k. These will tessellate and cover the whole patch.
- Further Integrated Neighbourhoods identified.Aim for three in each alliance.
- Public engagement and co-design of models within each Integrated Neighbourhood.
- Iteration and spreading learning as care models begin to mature.

2020/21

- Subsequent Integrated Neighbourhoods identified.
- First Integrated Neighbourhoods deliver proactive, integrated care to identified groups of people, keeping them well and out of hospital.

Continuing system-wide engagement and collaboration to build momentum

3.2 Key next steps for the members of both Alliances

1. **Resourcing allocated** to support the Alliance to develop wave one Integrated Neighbourhoods at pace – Jan 2019
2. **Existing teams aggregated and moved into Integrated Neighbourhoods**, starting with wave one areas. To include community staff, mental health, social care – Jan 2018.
3. **Readiness tool used** to understand each Integrated Neighbourhood's development needs (see annex) - Jan 2019.
4. **Support package developed** and implemented for each Integrated Neighbourhood, enabled by Alliances and in line with development areas highlighted by readiness tool. – March 2019. To include:
    - Setting out inputs, outputs, outcomes and developing an evaluation method and facilitating sharing of best practice.
    - Data analysis to support segmentation for each primary care network.
    - Supporting citizen, patient and service user co-design and engagement.

4. Expected benefits

For people

- People are supported to stay well and take greater responsibility for their own health and wellbeing.
- People can easily access support and advice that is timely, delivered close to home and with the right professional to meet their needs.
- People with chronic or complex illness receive care that is consistent, joined-up and centred around their needs and wishes, with fewer hand-offs and reduced duplication.
- People are only in hospital for the acute phase of their illness and injury and are supported to regain/retain independence in their usual place of residence.
- People have greater choice and control over decisions that affect their own health and wellbeing.

For the health and care system

- Increased capacity in primary and community care to manage local health and care needs.
- Reduction in rate of acute non-elective activity growth and demand for urgent care services.
- Optimised resource utilisation as a result of better managed chronic conditions and reduction in preventable conditions.
- Reduction in variation in access and outcomes
- Fewer permanent admissions to residential and nursing care.
- Primary care is sustainable and supported leading to improving GP recruitment and retention rates.
- Attract and retain the right workforce in all sectors
- More efficient bed use and fewer delayed transfer of care.

Measuring impact

The Alliances will support each Integrated Neighbourhood to use a evaluation methodology to agree local outcomes. Alliances will work at a system level to ensure some consistency in reporting. Outcomes will be monitored by each Alliance. Learning from the first wave will inform later waves.

5. Resources required

Alliances will oversee and support Integrated Neighbourhoods as they develop across the STP. To deliver at pace, Alliances will require the below resource as an absolute minimum:

Alliance resource:

- GP lead backfilled for two days per week.
- Full time senior leadership team.
- Support from existing teams across the system with specialist skills, including but not limited to:
  - Population health
  - Finance
  - Communications and engagement

Integrated Neighbourhood resource:

- Dedicated project manager.
- Dedicated change agent/enabling resource.
- Clinical leadership (clinicians within IN).
- Able to draw on support from existing teams with specialist skills, including but not limited to:
  - Business intelligence
  - Analytical support

- Resources should be re-aligned from all partner organisations (including all teams already working on primary care development).
- Detailed resource requirements within each Alliance to support implementation will be set out within each Alliance's implementation plan.

Annex

Readiness tool

Readiness tool

- The readiness tool has been developed in line with national learning, learning other systems and with input from partners across the North and South Alliances.
- The purpose of tool is to:
  - Outline the functions of Integrated Neighbourhoods.
  - Help understand the readiness of local areas to develop Integrated Neighbourhoods. Level 0 is the required level to join the programme.
  - Identify the support needs of each Integrated Neighbourhood.
- It is recognised that Integrated Neighbourhoods will develop in different ways, in line with their local context. The tool aims to support development.
- The functions of an Integrated Neighbourhood in its most mature state are not yet known. The readiness tool gives an estimate of these functions and it is expected that the Alliances' understanding of a mature Integrated Neighbourhood will develop over time.

Fit for the Future
Working together to keep people well

Measuring progress: Readiness tool (1 of 2)

Between each level partners will made a decision on the progression of the Integrated Neighbourhood

Decision Decision Decision

	Level 0	Level 1	Level 2	Level 3
Leadership and Engagement	• Is there dedicated clinical & operational leadership, including a GP lead from PCN? • Have the IN partners been engaged in the co-design of an IN plan? • Is there management capacity within the IN to support its development?	• Is there a dedicated leadership team working effectively to lead IN?	• Is clinical and GP leadership embedded with defined responsibilities for co-ordination of IN services? • Is there a mechanism for co-production of plans and services with local people in place?	• Is there an established network with other IN leaders to share learning develop strategy and provide peer support?
Workforce and OD	• Do partners recognise they are part of the IN?	• Is a workforce plan defined with targeted action to support recruitment/retention of key roles? • Is an IN level OD/ team development plan in place? • Are staff working effectively as a multi-disciplinary team?	• Is there development of new/extended roles in IN to meet local need? • Have generic tasks been identified that can be undertaken by any care professional?	• Is there a highly functioning collaborative workforce?
Population Health Management	• Is there baseline population health data that describes the neighbourhood effectively?	• Is IN level population health data available to define patient needs in order to support priority setting and planning? • Are the priorities for the IN identified and a delivery plan produced with timescales?	• Is data used to drive improvement and reduction in variation within and across INs in place?	• Is data used to shape longer-term IN objectives to deliver improved population health?
Primary Care Network	• Are practices working together across the geography on areas to improve resilience/access?	• As part of this model are practices identifying functions to share, e.g. back office, estates or learning and development ? • Has community asset mapping and engagement been undertaken to inform the model?	• Have practices identified how they want to work together moving forward? • Have practices identified how they might share clinical resource and access specialist services in community?	• Is the PCN model fully operational?
Care model	• Have IN partners agreed a high-level care model which proactively identifies patients and keeps them well and out of hospital?	• Has an IN care model delivery plan been developed which aligns with logic model? • Is data being used to target high risk groups and provide evidence-based interventions?	• Do the components of delivery in model for each function (50+%)? • Is active signposting to community assets in place? • Is there a shift of specialist resource to support IN and improve access?	• Is the IN model fully operational across all planned functions? • Are there simplified/integrated points of access to IN services?

Collaboration continuum

Fit for the Future
Working together to keep people well

Measuring progress: Readiness tool (2 of 2)

Between each level partners will made a decision on the progression of the Integrated Neighbourhood

Decision | Decision | Decision

	Level 0	Level 1	Level 2	Level 3
Culture and behaviour	• Is IN team membership defined (core)? • Does membership include all sectors including primary care, community services, mental health, social services and voluntary sector?	• Do all members of the team understand the principles of collaborative team working? • Are integrated primary and community care teams in place (joint assessment and planning processes)?	• Is the infrastructure in place to enable effective team working?	• Are there fully functioning integrated teams in these areas? - internal referrals - Personalised care offer - Standardised protocols in use
Data sharing and inter-operability	• Are IN partners willing to share data to enable effective joint working?	• Are information sharing agreements in place between all partners? • Is the plan for shared care record confirmed? • Do referral pathways promote joined up working and are they streamlined?	• Has a shared care record been develop (health)?	• Has a shared care record been developed (health and social care)?
Accountability and governance	• Are IN partners collaboratively thinking about clinical risk differently? • Are IN partners willing to take some decisions jointly across the IN?	• Are IN responsibilities documented via an MOU/Alliance agreement? • Is IN engaged in the care system/partnership decision making processes?	• Do INs have sight of resource use to enable them to pilot new incentive schemes?	• Is there collective oversight of IN and decision making?
Metrics and Outcomes	• Have IN partners considered the high level outcomes they expect their care model to deliver?	• Have the IN collectively developed a logic model, which informs their evaluation strategy? • Are IN-level outcomes and dashboard in place to track progress and impact?	• Is there evidence of impact on key outcomes in line with logic model?	• Is impact against logic model outcomes demonstrated through reporting? • Has reporting been used to target and make improvements to outcomes?
Back office enablers		• Are IN assets mapped to inform future planning (estate, people, back office, funding)? • Are resources identified to enable/support IN plan delivery e.g. change management?	• Is there an IN-level plan to optimise use of assets and early components in place?	• Are partners collectively thinking about how best to use shared resources e.g. shared estate, back office or workforce?

Collaboration continuum