Appendix 2

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Developing Integrated Neighbourhood Teams across Kent and Medway

Development Framework

29th July 2024

Introduction, purpose and contents

Introduction and purpose

This document sets out the framework for the development of Integrated Neighbourhood Teams in Kent and Medway. It has been developed by the National Association of Primary Care, working with partners in the Kent & Medway Integrated Care System, and follows a broad engagement exercise with more than 200 stakeholders undertaken during March-June 2024.

The concept of integrated team working has been the focus of NHS & Local Authority transformation drives for decades. Whilst these initiatives have delivered benefits for patients, residents and staff, rarely have they resulted in the transformational changes in the way we work that are needed to turn the dial across the whole system in patient outcomes, experience, performance or cost effectiveness.

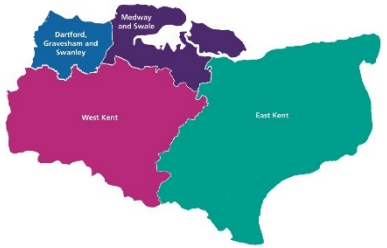
In Kent and Medway there is now a shared strategic priority and a collective ambition to make a fundamental shift in the model of care across primary and community services in each of the four HCPs. There is a groundswell of support in the NHS to make a fundamental shift in the model of care across primary and community based physical and mental health services in each of the four HCPs. Social care colleagues are very positive about working in new ways with the NHS and are keen to work through how this can work in detail. There is interest in building stronger links with other parts of local authority services such as housing. The VSCE are keen to play a greater part and have unique access to engage people in neighbourhoods in different ways.

The shared aim is to build effective teams with the necessary skills and capabilities to meet the needs of local populations. Building on the work already underway in the system, this is seen as key to overcoming the current fragmentation of care and to improve population health and wellbeing outcomes, improve experience of care and mitigate health inequalities. There is also the opportunity to make tangible improvements in the performance and productivity of the Kent and Medway health and care system, with earlier intervention and improved transitions within the health and care system leading to lower utilisation of high-cost health care interventions.

Contents of this document

The purpose of this framework is to build consensus across the system on what the future model might look like, and on the initial steps that are needed for implementation. The Framework has the following sections:

Executive Summary	Provides a summary of why change is needed, what the future model of integrated care looks like and the key steps on how move forward with implementation. This section also sets out a summary of the recommendations made in this report.
Section 1	Describes the context within which this framework has been developed including the key messages from the engagement.
Section 2	Sets out the emerging consensus about what the future integrated model should look like. This includes what we mean by Integrated Neighbourhood Teams and the benefits sought.
Section 3	Describes the key initial steps and actions – how to go about introducing the model in each of the four Health & Care Partnership areas in Kent & Medway.
Appendix	The appendix sets out more details on Integrated Care research and case studies, and a How-To Guide for developing measures of integration.



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Developing Integrated Neighbourhood Teams across Kent and Medway

Executive Summary

July 2024

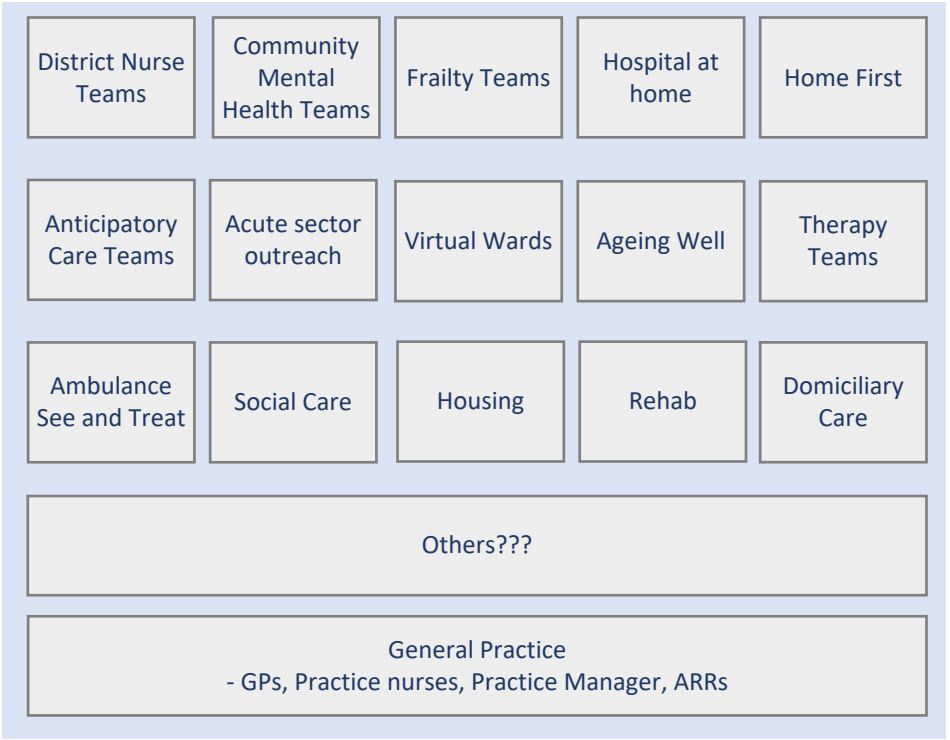
There is consensus that the current model in Kent & Medway is broken

Through the engagement exercise we heard the overwhelming consensus that the current siloed approach to primary, community and mental health care delivery is broken.

- Fragmented with multiple layers, plethora of teams, too many hand-offs.
- Confusing and complex for patients, and not meeting their needs.
- Frequently misses the opportunity to keep people well and at home, failing to deliver the system ambitions/objectives.
- Frustrating for staff.

Current state is not fit for purpose

It is fragmented, does not meet the needs of patients, and misses the opportunity keep people well which in the long term would reduce demand on acute services.



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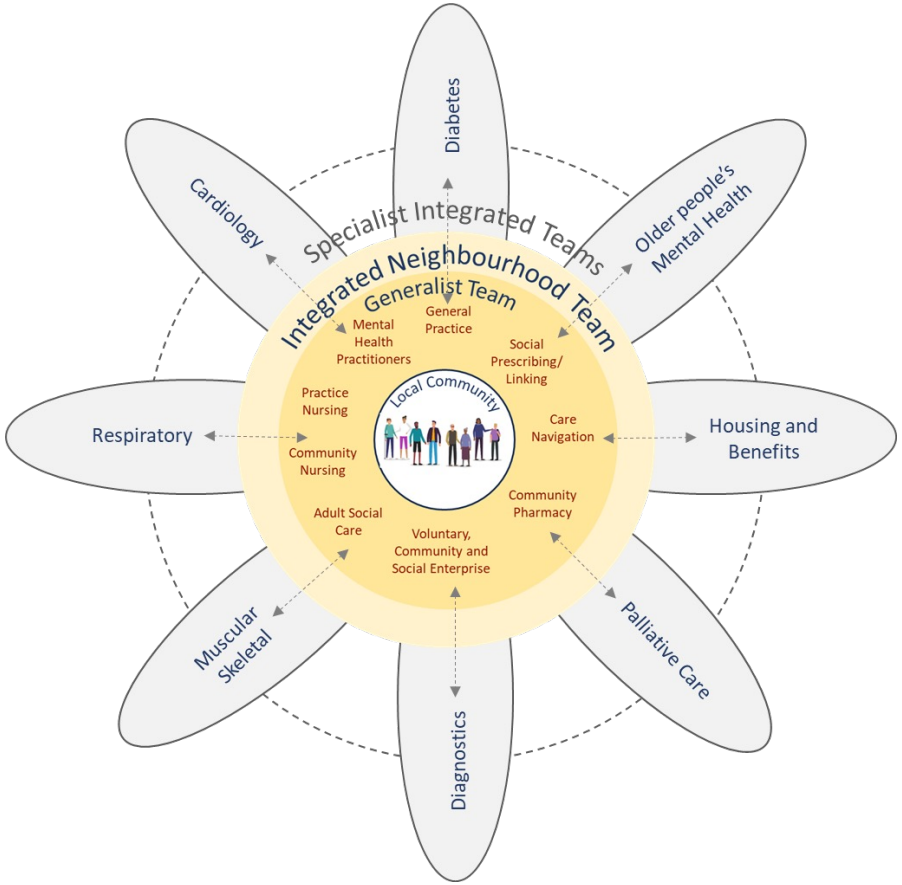
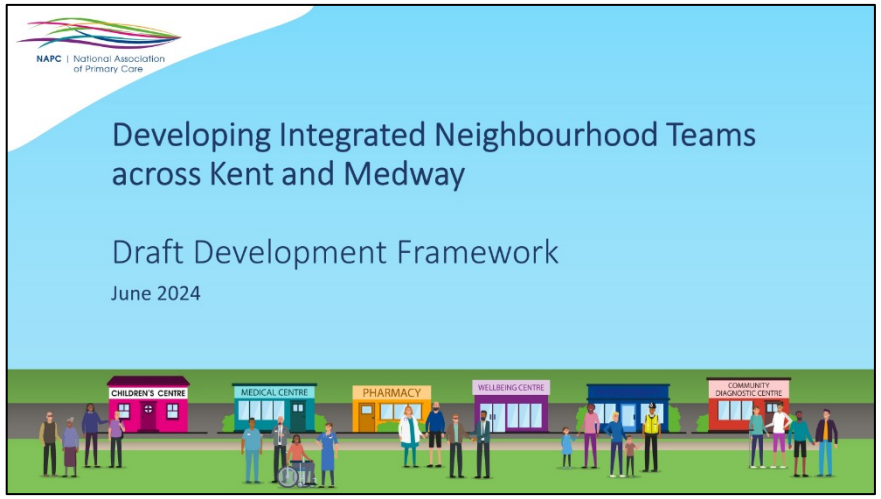
There is a shared desire to implement a much more integrated model

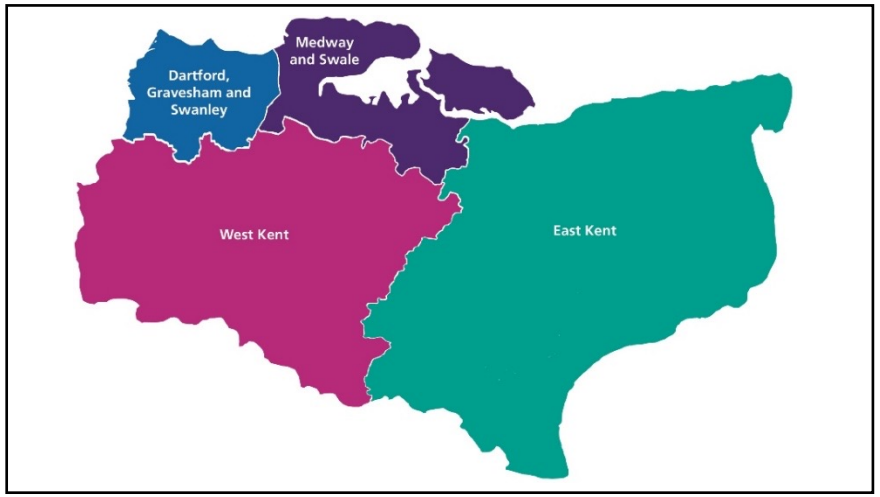
Possible Future State
Confident and autonomous integrated team of teams built around local neighbourhoods



- A model that moves beyond traditional organisational and cultural boundaries.
- General practice, community services, mental health services, voluntary sector and social care working together as one autonomous, flourishing team at neighbourhood level.
- This team taking responsibility for meeting the neighbourhood population needs – whether the patients are at home, in hospital or in a care home.
- Early interventions to prevent escalation.
- Turning the dial on outcomes, experience and system performance.

A Development Framework has been prepared, building on the Engagement Exercise, to set out the way forward





The Development Framework for Kent & Medway Integrated Neighbourhood Teams seeks to address two key questions:

1. **What does the future integrated model look like?**
   We agree we need change, but what are we changing to?

2. **How do we introduce the new model in each of our four HCPs?**
   What are the steps, where do we start?
   What will make the biggest impact?
   Roles, responsibilities, governance & risks.

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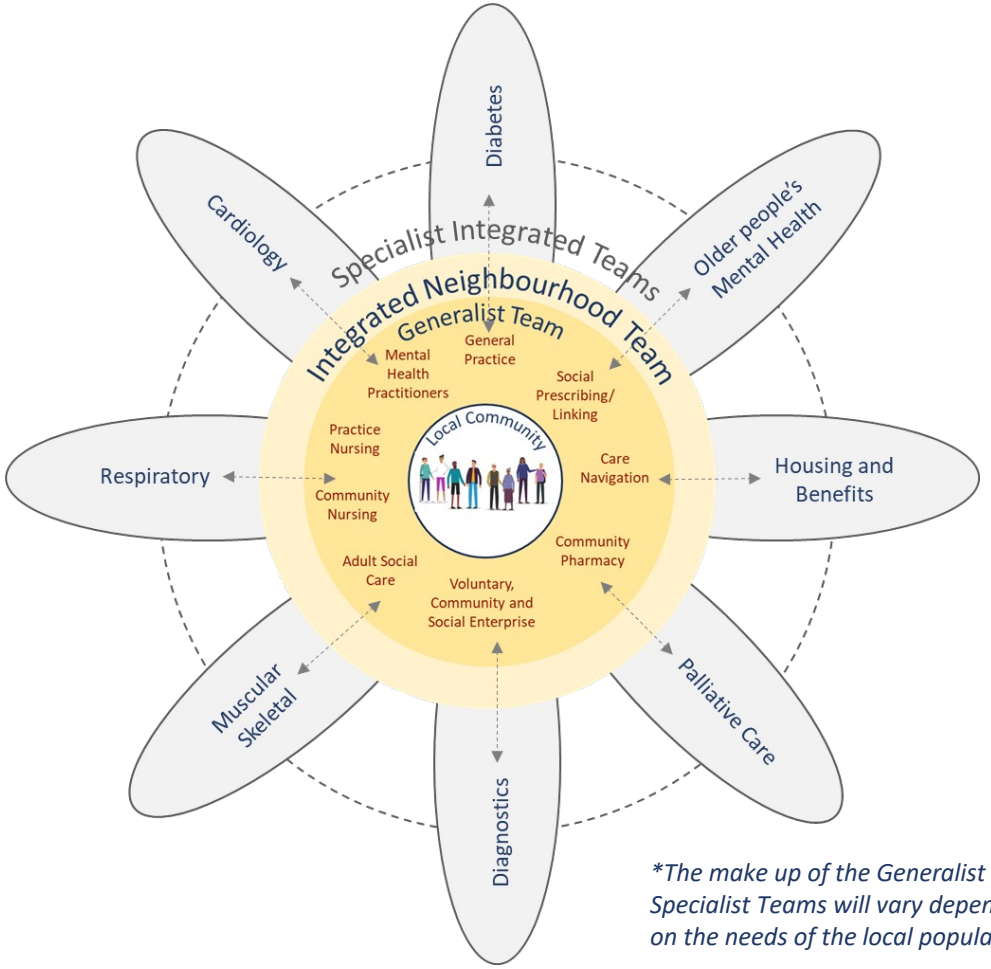
Question 1:
What does the future integrated model look like?

A single Integrated Neighbourhood Team for each natural community

Possible Future State
Confident and autonomous integrated team of teams built around local neighbourhoods



**The make up of the Generalist and Specialist Teams will vary depending on the needs of the local population*

- Each INT brings together the current siloed professional teams into one team.
- Includes primary care, community and mental health services, voluntary sector and social care.
- The team knows the population it serves and has freedom to act to meet the needs of that population.
- The team has shared objectives – quality, outcomes, access, performance.
- The team has leaders who are responsible for building the culture and trust that enables delivery.
- Access specialist support as needed.

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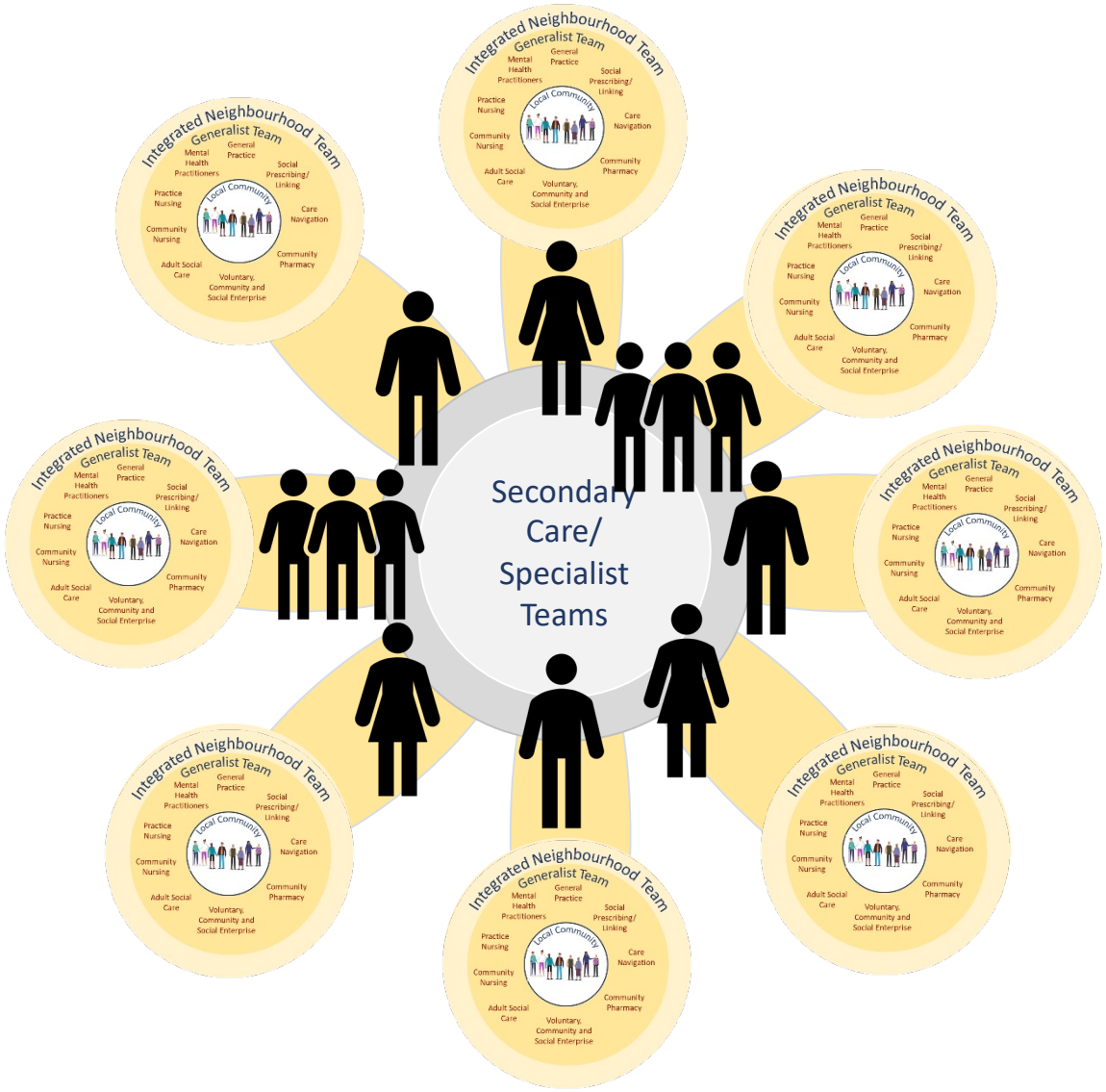
Secondary care specialists are integral to the new model



- Secondary Care is as much part of the community as those working in primary and community care.
- That means taking more responsibility for the whole population - not just those who end up in crisis or end up on an elective waiting list.
- We heard a strong desire from secondary care leaders and some clinicians to work more closely with primary and community care services.
- Creating time for specialists to work with INTs is essential to help to reduce demand. The framework describes what this could mean in practice.

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Integrated Neighbourhood Teams – design principles

Building on the Engagement Exercise, the following design principles are proposed, which serve to support the ambition and aims. These will need to be developed and refined in the next stages, however they ought to form the guide for the development of the early Integrated Neighbourhood Teams.

Population focus	1. INTs are based around **the natural communities that people of Kent and Medway identify with** 2. At the heart of what drives each team is **what matters to people/citizens** - they find ways of seeking out and hearing the voice of local people 3. The Teams **know each other and the populations they serve,** they are proudly focused on getting to know smaller numbers of people well
Responsibilities	4. They are **accountable for the delivery of the ICS objectives** for the populations they serve including addressing inequalities 5. They have the **autonomy to make decisions** and flexibility over how skills and capabilities are deployed. 6. They focus on **helping populations make better choices for their own health and wellbeing (prevention)** as well as caring for and supporting those with episodic and complex needs
Culture	7. They have a **collaborative, trusting and "can do"** culture that is developed, supported and measured 8. They have access to a **support network and professional supervision 7 days a week** 9. They have in place a **culture and processes for developing together, learning together and for sharing lessons** across all INTs
Leadership	10. They are **led by a single, multidisciplinary, leadership team** that is invested in to develop and grow. 11. They are **agnostic of employment model and employer** and non-hierarchical (team lanyard not organization) 12. Investment in the Neighbourhoods is based on **need rather than by per head of population.**
Processes	13. They provide **holistic rather than task/case-oriented care and support** that is co-designed with the local population, and are able to provide **continuity of care where and when it matters** **14. Hand-offs and referrals between teams are removed wherever possible** and replaced by clear lines of communication and trusting, collaborative relationships including effective messaging in real-time 15. They have **Information Management & Technology infrastructure that supports them flexibly** across the system. They have access to systems that have a unified user experience that have been designed once with citizens and users at the heart. 16. They have **quality and safety governance processes and culture, aligned to HCPs,** keeping patients, users and professionals safe

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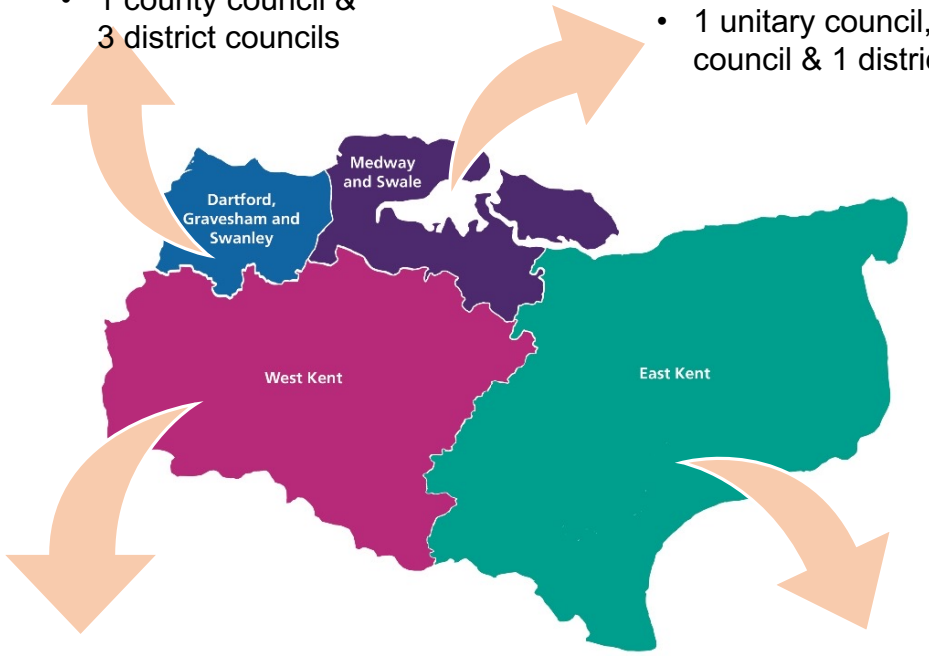
How many INTs will we need across Kent and Medway?

- INTs must be small enough for team members to know each other and the population, and to build trust.
- Think about scale from the perspective of the whole team from multiple organisations.
- Our advice: **no larger than current PCN geographies** – this could be a good place to start, with 42 INTs.
- Resist any urge to go larger than this.
- Some PCNs may need further sub-division into 2-3 INTs. Be open to this evolving over time.

DGS HCP
- Population 260,000
- 7 PCNs
- 23 General Practices
- 1 county council & 3 district councils

Medway & Swale HCP
- Population 427,000
- 10 PCNs
- 47 General Practices
- 1 unitary council, 1 county council & 1 district council



West Kent HCP
- Population 504,000
- 9 PCNs
- 51 General Practices
- 1 county council & 4 district councils

East Kent HCP
- Population 720,000
- 16 PCNs
- 63 General Practices
- 1 county council & 6 district councils

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Question 2:
How do we introduce the new model?

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The immediate next steps to build on the momentum and energy across K&M are:

1. Confirm the **workforce for each INT** – NHS family partners and wider LA services / VSCE - who is in which team.
2. **Invest in team development and OD:** Bring together the people from primary, community, mental health, social care and VSCE who work in each PCN/Practice area and begin the work to develop them as a team. This takes place alongside Organisational Development within organisations providing community services, led by Provider Collaborative.
3. Work on the HCP approach to **leadership for each INT and implement it**
4. Agree the **objectives and success measures** with each INT
5. Address the **digital and estate infrastructure needs** of INTs
6. Confirm system **roles and responsibilities and governance**

We recommend combining targeted local and HCP/ICS level action in each of these six areas to make progress over the next 6 months

Neighbourhood level action in 4 selected INTs

Accelerated development of 4 Integrated Neighbourhood Teams, one in each HCP area, bringing the model to life at a practical level using the principles set out in this framework.

- Fully implementing the new one-team delivery model with a small number of thriving 'first mover' sites, selected by HCPs.
- Learning from this implementation to enable successful roll out to other areas.*
- Meeting the needs of patients with Complex Care needs is likely to be one of the first priority areas in each HCP

Alongside collective, at-scale action in each HCP

Implementing the next phase of the strategic programme for INT development in each HCP and across the ICS.

- Actions to align each partner's workforce to INTs, creating the leadership approach and roles, establishing the team development programme, addressing digital and governance issues.

We recommend combining targeted local and HCP/ICS level action to make progress over the next 6 months.

These are described in more depth on the next slide.

* DGS HCP are implementing INTs across their whole area

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Summary of recommended implementation actions for the next 6 months

	In 4 'first mover' INTs, at least one in each HCP Supporting accelerated full implementation in 4 INTs	Across Kent and Medway HCPs Enabling at-scale implementation of new model of care
1 **Confirm INT workforce - who is in which team**	• Establish the four selected INTs by identifying the named individuals that comprise each INT.	• Agree the alignment of the NHS workforce to INTs and local government and VCSE where possible. • Continue roll out of complex care INTs
2 **Invest in team development and OD**	• Deliver a series of action-oriented workshops for each INT with the named team to build trust and relationships and co-produce new working practices.	• Scope and establish the ongoing programme of team development for INTs to enable them to thrive. • Deliver community service providers OD programme.
3 **Select and appoint INT leadership**	• Select the leadership team for each of the four INTs, who take responsibility for nurturing the required culture and leading the team to deliver objectives.	• Create the role profiles, person specs, process to fill appointments and process to identify leadership development needs, followed by implementation.
4 **Agree INT objectives and success measures**	• Agree the immediate objectives for each of the four INTs based on system priorities and local needs. Agree 30, 60 and 90-day action plans.	• Agree at HCP and ICS level the key priorities and metrics that INTs are best placed to deliver, to enable clear focus at neighbourhood level.
5 **Address digital and estate needs of INTs**	• Through the accelerated implementation of these four INTs, identify and seek to meet digital and estate infrastructure requirements.	• Progress agreed actions of existing digital and estate infrastructure workstreams, adding learning from four 'first-mover' INT teams.
6 **Confirm governance, roles and responsibilities for INT programme**	• Identify local champions who can support the 'train-the-trainer' programme to cascade learning across subsequent waves of INTs.	• Agree transitional governance, roles and responsibilities to manage this programme.

1 Identify the workforce that will form each INT

ICB

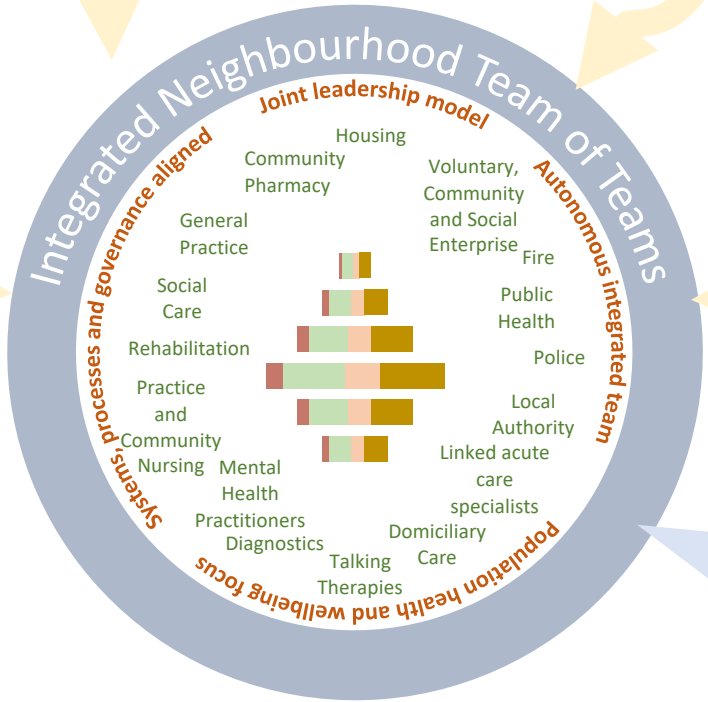
Community and Mental Health

Primary Care

Acute Providers

Taking current skills and experience….

…and deploying in Integrated Neighbourhood Teams



INTs will bring together the currently siloed professional teams. The starting point is GPs, nursing, allied health professionals, mental health practitioners, social care, social prescribers, domiciliary care.

Review the existing layers of fragmented teams and absorb them into INTs – otherwise INTs become another layer. The opportunity is to deploy the skills that currently exist in different parts of the system in a potentially more effective way.

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2 Invest in an INT level OD programme that brings INT members together to develop as a flourishing, autonomous, motivated team.

The 3 things that motivate us as individuals and teams (and its not 'carrot and stick')

Dan Pink 2009: Drive - The Surprising Truth about what motivates us

Autonomy – our desire to be self directed

Mastery – our urge to get better at things and be challenged

Common Purpose – we care and want to make things better

"Real Teams" are more effective at delivering safer and higher quality care than "Pseudo Teams"

Prof Michael West: Professor of Work and Organisational Psychology at Lancaster University

Clear shared objectives – do we understand what it is we are trying to achieve together

Working interdependently – working closely together, communicating and coordinating effectively together

Meeting regularly – to review performance, improve quality and close gaps in efficiency

Leaders that create a climate of Psychological Safety where it is ok to speak up with ideas, questions or concerns

Amy C Edmondson, Harvard Business School

Frame the work or challenge as a **learning problem**

Acknowledge own vulnerabilities

Model curiosity

- This is the single biggest action to make progress.
- Facilitated programme
- Teams get to know each other and increase trust.
- Build common purpose and shared objectives.
- Begin to create the culture needed

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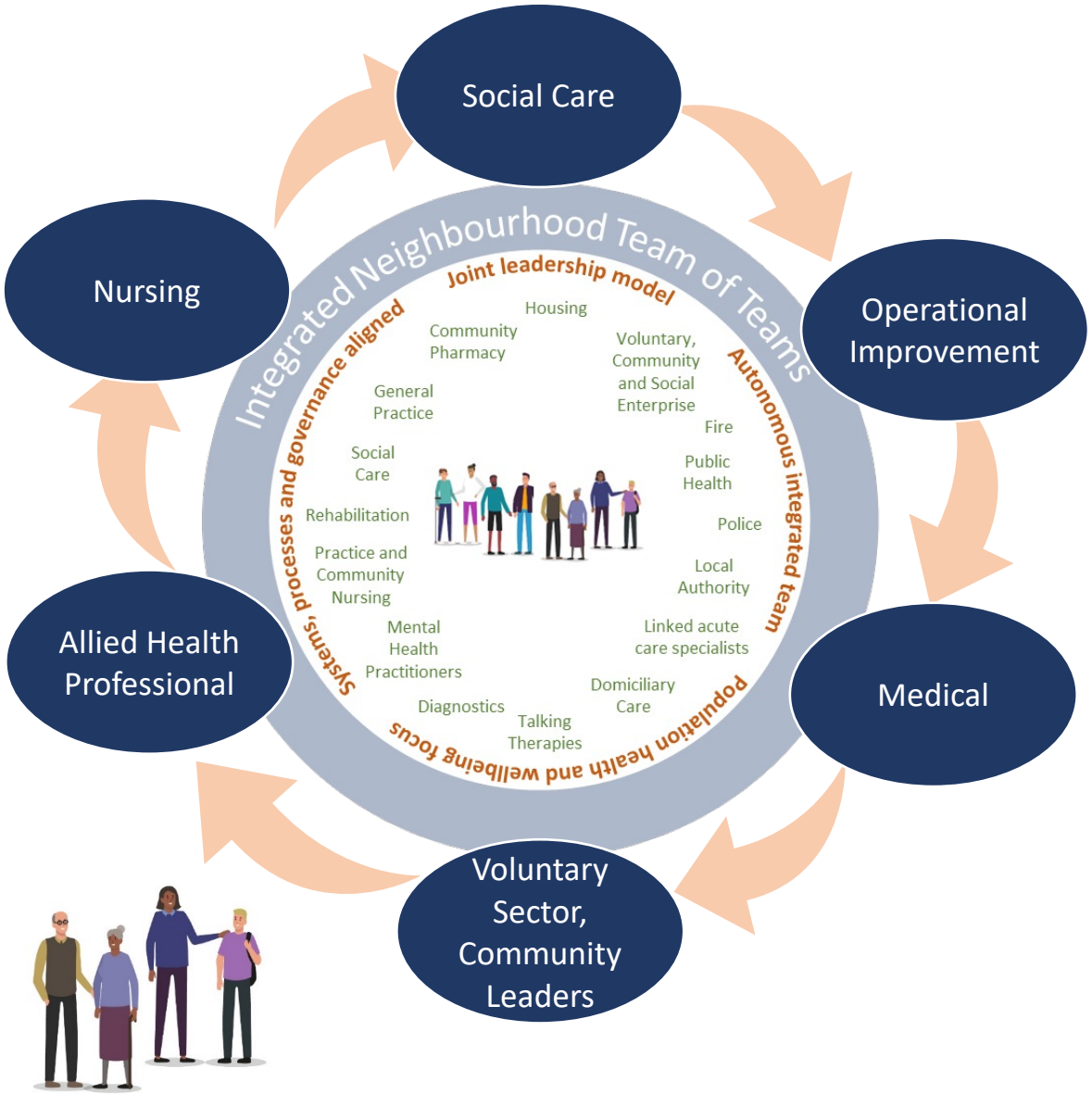
3 Select the capable unified leadership team to support each INT



- Leadership Team drawn from Social Care, Nursing, Medical, Allied Health Professionals & Operational management.
- Accountable for organising the team to deliver the agreed objectives for the local population.
- Leadership teams capable of nurturing the culture required for flourishing, high performing, motivated teams are not formed by chance – they are selected, developed, supported, coached.
- Develop the role profile & competency framework. Identify the leaders from across the system and appoint into INT leadership roles.

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4 Develop and agree outcome and success measures with each INT

- It is essential that we agree the measures of success for INTs and can track progress.
- However, stakeholders can have competing priorities and pressures which means there is a risk of disagreement about what to measure and the value of these measurements.

Our recommendation is to agree a core measures linked to overarching strategic outcomes, with local teams and people able to also establish measures that are locally-relevant to their services and the people they provide for.

Core set + Locally agreed

- A toolkit has been developed to support the development and agreement of outcome measures in Kent and Medway.

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4

Activating Staff & Patients to Reduce Healthcare Utilisation

A Simple Set of Metrics to Support Innovation

	Staff Activation 1+ Month	**Patient** Activation 3+ Months	**Health** Improvement 6+ Months	**Demand** Reduction 12+ Months
Metrics	• **#1 Staff Activation:** Employee Net Promoter Score (eNPS) 'I would recommend my organisation as a place to work' • **#2 Team Effectiveness:** 1 Belonging, 2 Competence, 3 Autonomy and 4 Innovation • **Proxies:** Survey response rates, % participation in training and development, % turnover, % sickness levels	• **#1 Patient Activation:** 'How good are you at taking care of your health?' • **#2 Pillars of Health:** 1 Diet, 2 Activity, 3 Sleep and 4 Social Connection • **Alcohol Units** per capita • **Smoking** prevalence • **Social Barriers to Activation:** Social need codes per capita (e.g. housing, deprivation, substance misuse) can proxy for level of social need	• **#1 Physical Health:** BMI • **#2 Mental Health:** PHQ2/GAD2 or anxiety/depression codes per capita • **#3 Aging:** Rockwood or eFI • **#4 Multimorbidity:** Repeat medications per capita can proxy for clinical need • **Chronic Disease** prevalence and average HbA1c (diabetes) and BP (hypertension) • **Chronic Pain** prevalence or pain codes per capita	• **#1 Contacts:** Visits per capita • **#2 Connections:** Referrals per capita • **#3 Cost:** Spend per capita
Why	**40%** of hospital performance is explained by staff engagement but only **20%** by staffing levels and **0%** by staff pay.	Analysis shows individuals who effectively take care of their health cost the NHS **£981** less per year.	Up to **50%** of an ICB's population can have preventable health risks, leading to nearly **double** the number of GP contacts per year.	Tracking changes in resource use per capita paints a picture of **population demand**, guiding prevention and resource allocation.
How	ICB teams can improve performance through quicker, team-level eNPS data alongside shorter Team Climate checks for action. Engaging tools and displaying key metrics in physical spaces (noticeboards) can keep everyone involved.	Shorter surveys with single-item questions will boost response rates and provide better insights into individual social barriers affecting health activation. The simple act of asking can nudge positive behaviour changes (like 1kg weight loss) and transform routine healthcare interactions into preventive care opportunities.	Metrics should pinpoint root causes and work at patient, team, and regional level. Simply tracking and reporting them (not rewarding) can nudge organisational change. Focus on improvement, not comparison. Celebrate regions with the biggest BMI reductions to identify the very best practices for national improvement.	Analyse resource use (admissions, A&E, etc.) across departments for internal improvement, not competition. Connect this data to staff/patient actions and health outcomes to predict demand reduction and accelerate improvement. Start small with high-ROI interventions, building evidence for larger-scale transformation.

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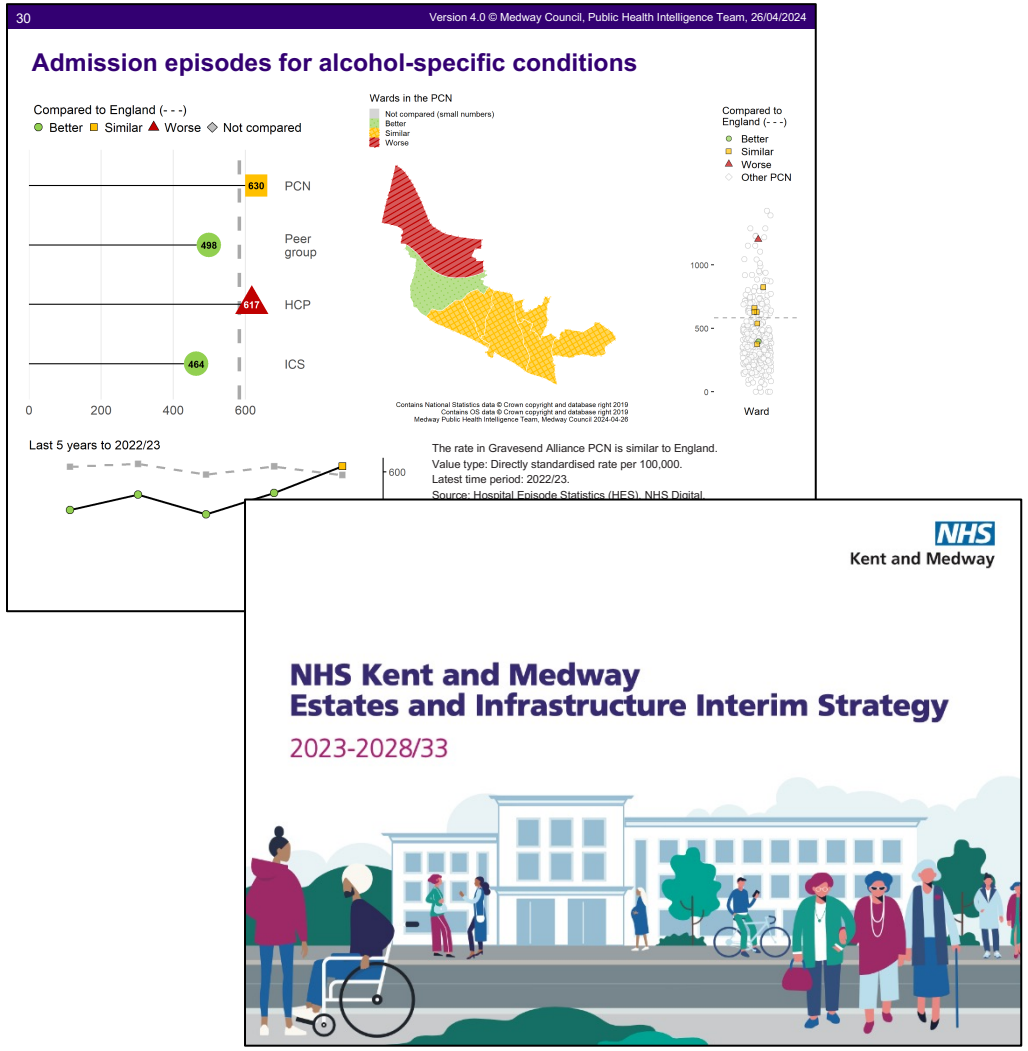
5 Accelerate the work to address digital and estate infrastructure needs



- Throughout the engagement exercise the constraints of multiple digital systems (which exacerbate fragmentation) and estate capacity for integrated team working were highlighted.
- The K&M ICS Digital strategy is being developed and there are powerful HCP and PCN level population profiles which enable teams to drill down to understand the issues for their population.
- The Interim Estates strategy recognises the importance of INTs in the future.
- The work needs to be accelerated to meet the needs of INTs in each HCP.

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6 Roles and Responsibilities – our recommendations

Provider Collaborative	• Given the mandate and responsibility to implement the new model of integrated care. • Provide the leadership and constancy of purpose required to deliver this bold ambition. • Be commissioned by the ICB to work with the 4 HCPs to prepare their local delivery plans, which they then compile and review before seeking agreement at the whole system level.
Health and Care Partnerships	• Responsible for nurturing, developing and supporting INTs in their area to flourish and grow. • Less about command and control and more about setting the tone, the culture and the broad context for their autonomy and local accountability. • Continue to build the local partnerships needed and to remove barriers to progress. • Senior leaders in HCPs should take an active mentoring and coaching role for INTs: in touch with their progress & successes, curious about their failures, helping them to learn.
NHS Trusts and Councils	• Assign workforce to INTs and support the establishment of INT leadership teams. • Delegate authority to INTs to act – developing shared governance arrangements.
ICB	• Set the system ambition and strategy to develop Integrated Neighbourhood Teams across Kent and Medway • Align system resources and commissioning plans behind the strategy. • Support short-term transformation funding to enable INTs to develop and change. • Provide the mandate to the provider collaborative and to HCPs to lead.
PCNs	• Enable and support INT development for their population • Review whether there is 1 or more than 1 INT for their area

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The actions for the next 6 months are part of a multi-year programme

ILLUSTRATIVE

	2024-25	2025-26	2026-27
Neighbourhood level action, supported by HCPs	-Identify first 4 INTs to work with; mobilise -Confirm the named individuals in each INT	-Identify next (say) 25 INTs to work with -Confirm the named individuals in each INT	-Identify next (say) 25 INTs to work with -Confirm the named individuals in each INT
	1 2 3 Action-oriented workshops for each INT to build trust and co-produce new working practices.	1 2 3 Action-oriented workshops for each INT to build trust and co-produce new working practices.	1 2 3 Action-oriented workshops for each INT to build trust and co-produce new working practices.
	-Confirm INT leadership -Agree immediate actions	-Confirm INT leadership -Agree immediate actions	-Confirm INT leadership -Agree immediate actions
	-Review -Support	-Review -Support	-Review -Support
	Expand to next cohort of INTs	Expand to final cohort of INTs	
Action at scale, across Kent & Medway	Agree transitional governance, roles and responsibilities to manage this programme. Agree at HCP and ICS level the key priorities and metrics that INTs are best placed to deliver		
	Agree the alignment of the workforce to INTs for all elements of the NHS family, and from local government and VCSE where possible.		
	Scope, source and establish the ongoing programme of INT team development	Ongoing team development and system OD programme delivery	
	Create the role profiles, person specs, process to fill appointments and process to identify leadership development needs	Progress agreed actions of existing digital and estate infrastructure workstreams, adding learning from four ‘first-mover’ INT teams.	

INT operating model prepared March 2025 based on learning from first movers

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Development Framework for Integrated Neighbourhood Teams across Kent and Medway

Summary of recommendations

Recommended Next Steps (1)

In this section we have pulled all the recommended next steps that have been made throughout the report. The very first step after establishing the Transition Governance, will be to agree the sequencing for actioning these recommendations.

1. **Communicate the shared ambition to build Integrated Teams around the natural communities in each of the four Health and Care Partnership areas.**
   - Declare the shared ambition and intent to introduce the new model of Integrated Neighbourhood Teams – explicitly supported by all partners. Work with Social Care colleagues to enhance the citizen centred approach
   - Agree the timeline to be pursued for the implementation of Integrated Neighbourhood Teams at pace across Kent and Medway over the next 24m.
   - Align this development framework to the Community Services Procurement timeline – influencing the model, target outcomes and procurement strategy.
   - Develop options for the organisational and governance models that will enable the vision and ambition to come to fruition.
   - Identify the best way to address the needs of patients with Complex Care needs as an early priority for INTs in each of the four HCPs
2. **Determine the number and geographies of the Integrated Neighbourhood Teams in each Health and Care Partnership, starting with PCN geographies**
   - Systematically work through each natural community across Kent and Medway, using General Practice as the building block, and agree sensible geographies around which to build the Integrated Neighbourhood Teams.
3. **Identify the workforce for each Integrated Neighbourhood Team**
   - Review the existing layers of fragmented teams and absorb them into INTs, otherwise the new INTs simply become another layer.
   - Develop and create the workforce model aligned to each practice and emerging Neighbourhood, using actual numbers, current skill-mix and understood needs. Initially this should focus on the NHS workforce, including: General Practice; Primary Care Networks; Community Services; Talking Therapies, Mental Health Integrated Community Care Transformation; Community Mental Health Teams; Admin and Management; Corporate services where appropriate. Over time the shape and skills mix of the workforce will evolve as understanding of the local needs of the population are better understood. This work will also need to include children and young people's services considering the best fit around their lives.
   - Work with education providers to ensure that the curriculum is influenced by the future model of Integrated Neighbourhood Teams and that placement opportunities are explored and exploited.
4. **Build a capable unified leadership team for each INT**
   - Develop the role profiles for the leadership positions for each Integrated Neighbourhood Team and for the intermediate tier between them and each of the 4 place-based geographies across Kent and Medway. This will need to cover all parts of the new care model, be agnostic to organisation but clear on autonomies, accountabilities and reporting lines.
   - Develop the competence framework that articulates the qualities and skills required in the leadership team and design a selection and development centre programme that supports leadership teams to develop self-insight, understand collective strengths and weaknesses and agree a programme of ongoing development.
   - Look across the current system partners and ICB to identify where the future leadership talent and capacity will come from.
   - Develop a mentoring programme for the leaders of Integrated Neighbourhood Teams that connects them to the wider system.

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Recommended Next Steps (2)

5. **Support the development of the Integrated Neighbourhood Teams, with the objective of enabling them to be flourishing, autonomous and highly motivated**
   - Design and develop a programme of 'Real Team' development and support, building on the emerging Design Principles, that is practical and leads to high performing flourishing teams. This programme should focus on sustained cultural change (building trust and collaboration) as well as practical team processes and skills e.g. population health improvement, information sharing, problem solving, and process improvement
   - Make the investment in teams to create the head space to allow them to develop together and problem solve together.
   - Create a development framework (matrix) to guide and support Integrated Neighbourhood Teams as they form and mature.
   - Develop a survey instrument to measure team effectiveness in each Integrated Neighbourhood Team. Use this data to support INT leaders to share best practice and in continuing to develop their team culture.

6. **Agree objectives and success measures with each INT, aligned to local and system priorities**
   - Agree objectives and success measures with each Integrated Neighbourhood Team (balanced scorecard), using the Outcome Measures approach described in the INT framework. The outcome measures should be informed by a combination of local need and system priorities.
   - Equip Integrated Neighbourhood Teams in the 4 place-based geographies with the data, skills, and processes to enable them to focus their efforts on tackling inequalities and improving population health effectively.
   - Use the success measures to track progress in each INT and across the system.

7. **Agree the action needed to ensure the digital and estate infrastructure is in place to support Integrated Neighbourhood Teams to thrive**
   - Address the digital architecture to make it better suited to the INTs enabling a more flexible workforce. Ensure a set of minimum requirements while longer term solutions are explored.
   - Engage with the HCP plans for estates to ensure that these support the development of INTs.

8. **Put in place the leadership and governance needed to succeed**
   - Bring system partners together to work through how a new approach to governance and accountability that will work at the level of Integrated Neighbourhood Team and up through the mid tiers to the Kent and Medway System as a whole. This should support a culture of "Doing the right thing". Engage with NHSE and CQC in this effort to seek alignment and influence.
   - Agree the sequencing and responsibilities for actioning these recommendations. Encourage the use of proven change management approaches in particular the NHS Change Model.
   - Identify the risks in the transition to new ways of working and develop the mitigating actions required. Create a robust risk management process to provide assurance that as new teams are formed, they are maintaining at least current levels of quality and safety for patients.
   - Hold the Provider Collaborative accountable for the implementation and delivery of the new model of integrated care. It must provide the leadership and constancy of purpose required to deliver on this bold ambition. The Provider Collaborative should commission each of the 4 geographical areas of Kent and Medway to prepare their local delivery plans, which they then compile and review before seeking agreement at the whole system level.

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Development Framework for Integrated Neighbourhood Teams across Kent and Medway

Section 1
Introduction and Context

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Introduction

An engagement exercise in Spring 2024 confirmed that health and care partners across Kent and Medway share a desire and commitment to implement a much more integrated model of care which moves beyond traditional organisational and contractual boundaries and delivers a step change in patient and population outcomes, service performance and efficiency.

This integrated model involves general practice, community services, mental health services and social care working together in a different way - with each other and with acute hospital partners. It sees these partners coming together at a local level into autonomous, flourishing, high performing Integrated Neighbourhood Teams, in which team members are able to deploy their combined skills, expertise, energy and resources to deliver more effective and more efficient prevention, early intervention and proactive community-based care, focussed on meeting the needs of the community and improving health and wellbeing outcomes.

There is a high degree of alignment in each of the four Health and Care Partnerships about the need to introduce the new model of care, and a shared view that this model will be better for patients and for staff, result in improved outcomes and performance, and support partners to reduce increasing costs.

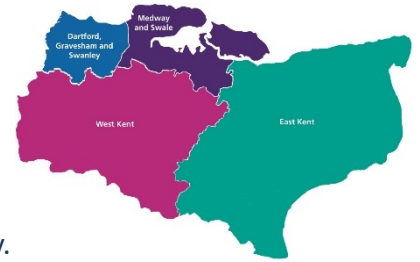
- **Better for patients,** providing the joined up, holistic care that is needed to support people to stay well, manage their ongoing health and care needs, and to co-ordinate their care in times of crisis and/or when hospital treatment is needed.
- **Lead to improved overall population outcomes**, with resources aligned with need and tackling inequalities
- **Better for staff**, with higher levels of morale and satisfaction through working as part of a high performing team with freedom to act to meet the needs of patients and communities.
- **Result in improved performance** across Kent and Medway, and more appropriate use of health and care resources, with fewer hand-offs between teams and patients receiving the right care in the right setting, at the right time.

However: statements like this have been written many times before in Kent and Medway, and in other health and care systems. At a national level, the introduction of integrated care has been a mainstay of NHS policy for decades, and the establishment of 'Integrated Care Systems' was the core purpose of the most recent reform of the NHS commissioning system.

At a local level there are already a plethora of programmes, projects and initiatives on this topic, across the ICS and in each local system. Whilst the national and local initiatives have undoubtably delivered some benefits for patients, residents and staff, they haven't yet translated into the sustainable, transformative changes in the way we work that are needed to turn the dial across the whole system in patient outcomes, experience, performance or cost effectiveness.

What is different this time? In 2024, set against a backdrop of increasing demand and a very challenging financial context, leaders set out their strategy to improve and integrate care in Kent and Medway. There is now a groundswell of support for action in the NHS to make a fundamental shift in the model of care across primary and community-based services (physical and mental health) in each of the four HCPs, to deliver the agreed ICS strategy, delivering improvements in outcomes, performance and financial sustainability. Social care colleagues also are very positive about working in new ways with the NHS and keen to work through "how" this can work in detail.

The shared ambition is for bottom-up change, to build effective teams – Integrated Neighbourhood Teams – in each of the four HCPs, with the necessary skills and capabilities to meet the needs of the local community they serve. Integrated Neighbourhood Teams bring together currently siloed professional teams, with clear accountabilities for the population they serve.



This document describes what the future model looks like, and make recommendations about how to go about implementing it in the 4 HCPs in Kent & Medway.

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Key message from the Engagement Exercise – the case for change

The overwhelming consensus from the Engagement Exercise is that **the current siloed approach to primary, community and mental health care delivery is broken** – it was described to us as fragmented, with multiple handoffs between teams and providers, inefficient, it doesn't meet the needs of patients and is frustrating for the workforce. In order to meet the needs of our population, we need to change the way we organise and deliver care.

Over time multiple teams have been created, working alongside each other for the same people in the same communities. Driven by well-intentioned commissioning behaviours; historical custom and practice; contracts; regulator behaviours; and small pots of money being allocated nationally to discrete schemes have resulted in:

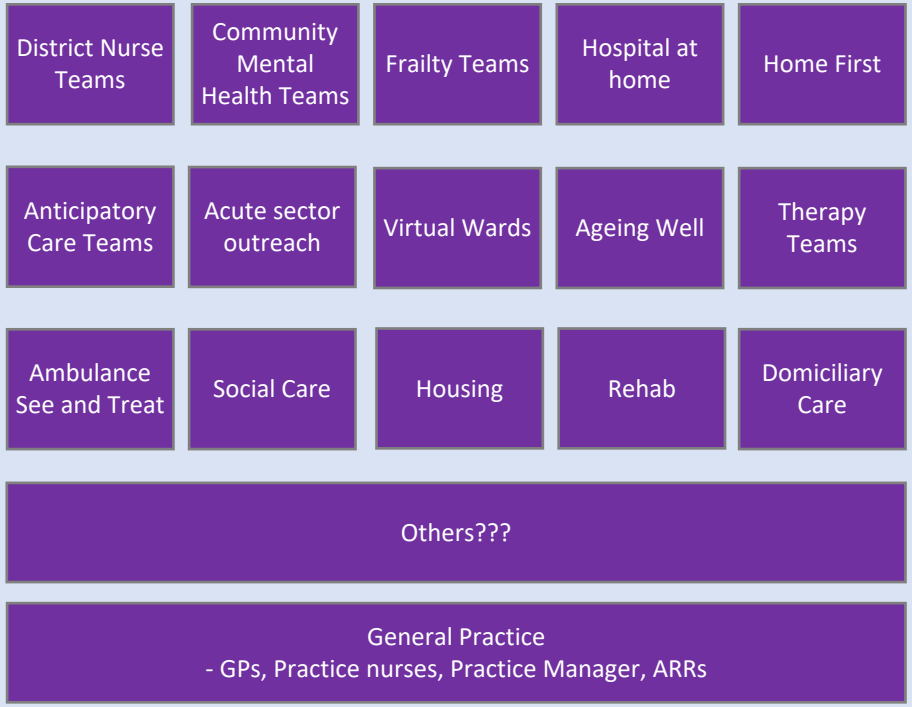
- Confusion for patients, service users and our workforce
- Lack of continuity, knowledge of and connection to local populations
- Multiple layers, referrals and handoffs that suck up the time and capacity of already overstretched teams through wasteful bureaucracy
- A lack of trusting relationships and collaboration between teams

The combined impact is that we are not meeting the health and care needs of the population at the right time or in the right setting. Whilst the shared aspiration is for prevention, early intervention and co-ordinated community-based care, the on-the-ground reality is of services that respond to demand as it arises and where many hundreds of patients are in hospital beds who could have been better served with an alternative, effective primary and community care model. These operational challenges fuel the extra-ordinary financial challenges facing the NHS and Local Authorities in Kent and Medway.

However, and notwithstanding the challenges, we also heard that health and care partners across Kent and Medway share a desire and commitment to implement a much more integrated model of care which moves beyond traditional organisational and contractual boundaries and delivers a step change in patient and population outcomes, service performance and efficiency.

Current State is not fit for purpose

It is fragmented, does not meet the needs of patients, and misses the opportunity keep people well, which in the long term would reduce demand on acute services.



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National and Local Strategic Context

National and local strategic context

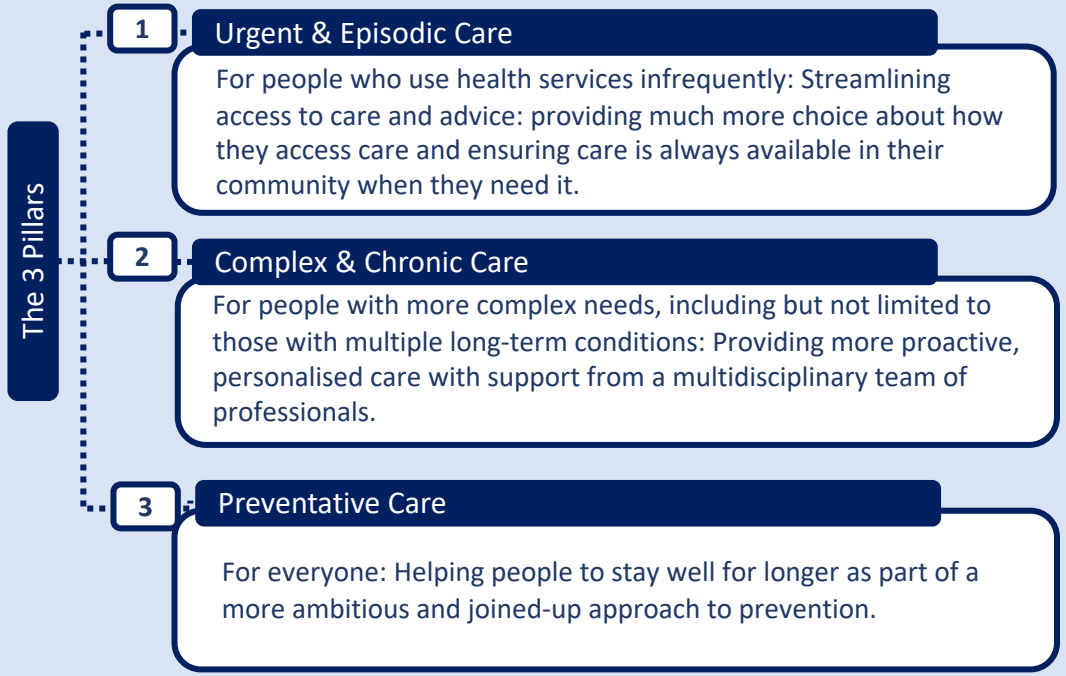
The national policy context underlines the importance of this work. Integrated Care Systems were placed on a statutory footing in July 2022, formalising the partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

The Fuller Stocktake, "Next Steps for integrating Primary Care", published in May 2023, set out a vision of an integrated support offer for our populations, pledging improved access, experience and outcomes. The heart of Fuller's vision is to bring together previously siloed teams and professionals to do things differently, to manage their whole population and create united shared capacity.

Central to the vision is the formation of what the report calls **Integrated Neighbourhood Teams (INTs),** that should build a single approach through one team made up of multiple teams across all primary care providers, secondary care teams, social care teams, domiciliary and care staff. These are teams that can work together to share resources and information dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

Whilst being rooted in Primary Care (first point of contact), the Fuller Stocktake suggests that this requires a much wider reaching transformation and the development of relationships to inspire a cultural shift to meet the needs of our populations. That means working closely together with Local Authority partners, the Voluntary Sector and community champions: This is not just about the NHS.

Three pillars of Integrated Neighbourhood Teams *(As defined in the Fuller Review)*



Kent and Medway Integrated Care Strategy

In 2024, set against a backdrop of increasing demand and very challenging financial context, leaders set out their strategy for the Kent and Medway ICS (see next slide). The strategy describes the vision for vision for Kent and Medway which brings together system partners to make a significant difference, improving local services and supporting healthier living. Establishing high performing INTs is central to the realisation of the vision set out in the ICS strategy.

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INTs are central to the delivery of the Kent and Medway Integrated Care Strategy

Through the Integrated Care Strategy, system leaders have pledged to bring the full weight of their organisational and individual efforts to collaborate to enable the people of Kent and Medway to lead the most prosperous, healthy, independent and contented lives they can.

Establishing high performing INTs is central to the Joint Forward Plan, the NHS delivery plan for the ICS strategy.

Our vision
We will work together to make health and wellbeing better than any partner can do alone.

Together, we will...

Give children and young people the best start in life	Tackle the wider determinants to prevent ill health	Support happy and healthy living for all	Empower patients and carers	Improve health and care services	Support and grow our workforce
• Support families and communities so children thrive. • Strive for children and young people to be physically and emotionally healthy. • Help pre-school and school-age children and young people achieve their potential.	• Address the social, economic and environmental determinants that enable people to choose to live mentally and physically healthy lives. • Address inequalities.	• Support people to adopt positive mental and physical health. • Deliver personalised care and support centred on individuals providing them with choice and control. • Support people to live and age well, be resilient and independent.	• Empower those with multiple or long-term conditions through multi-disciplinary teams. • Provide high quality primary care. • Support carers.	• Improve equity of access to services. • Communicate better between our partners when changing care settings. • Tackle mental health issues with the same priority as physical illness. • Provide high-quality care to all.	• Grow our skills and workforce. • Build 'one' workforce. • Look after our people. • Champion inclusive teams.

What we need to achieve

Enablers
We will drive research, innovation and improvement across the system.
We will provide system leadership and make the most of our collective resources, including our estate.
We will engage our communities on our strategy and in co-designing services.

Kent and Medway Integrated Care Strategy (published 2024): Summary

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Connections and interdependencies with existing system programmes to support the development of INTs

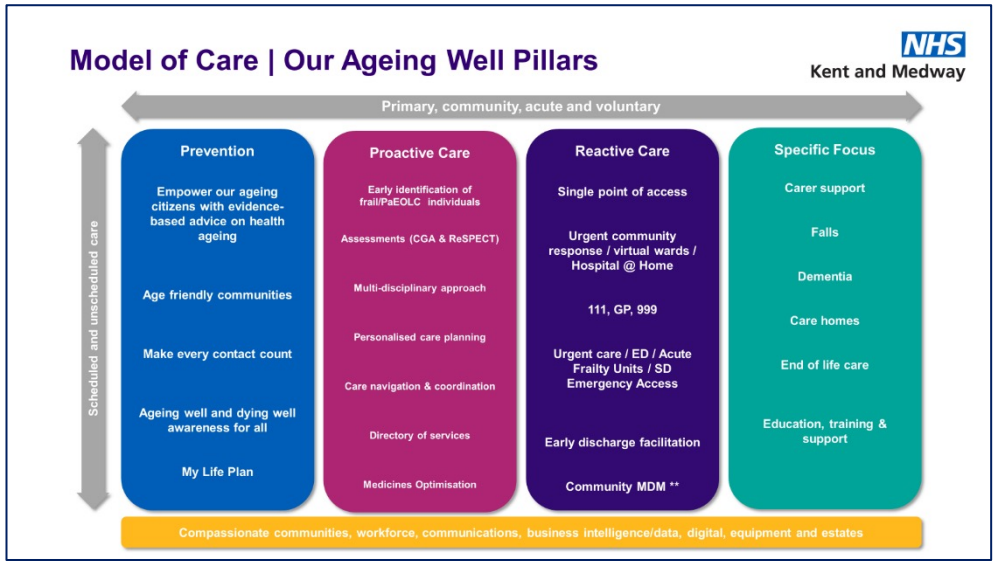
New Ageing well model of care

The engagement exercise highlighted success stories where barriers have been broken down and teams are working in a more integrated way. Examples exist in each HCP, but these tend to be small pockets that struggle to scale and flourish.

Over the last year work has been underway to develop new 'ageing well' and 'dying well' models of care which are now being brought into the main community and primary care model of care work supported by Kent and Medway community provider collaborative.

This work provides a further strong foundation for the establishment of fully integrated neighbourhood teams and sets a helpful frame for how generalist INTs can focus on particular cohorts of patients.

This positive work has all led to the ICB wanting to see an initial focus on seeing how INTs can best meet the needs of Complex Care patients.

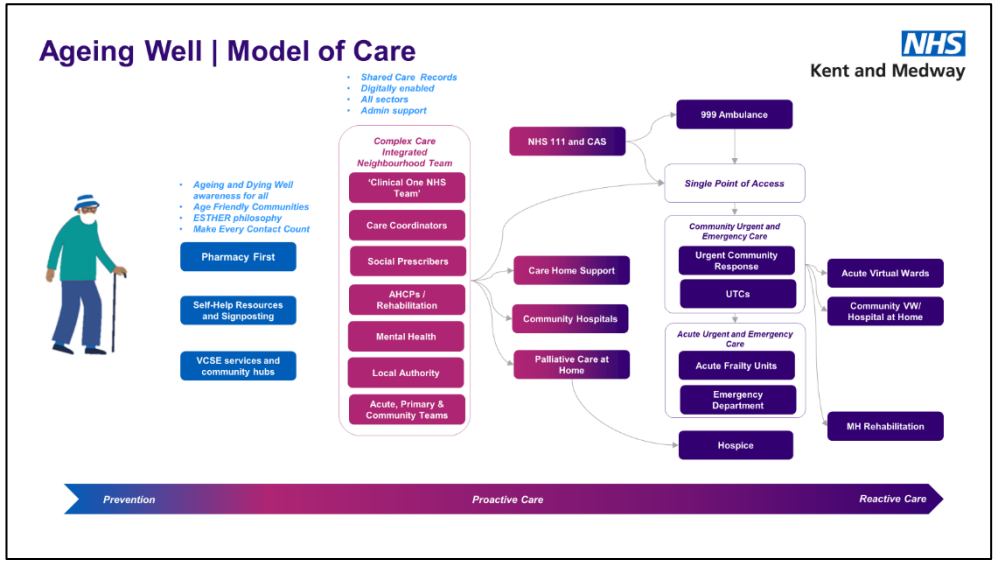


Re-procurement of community services

NHS community out of hospital services in Kent and Medway are delivered (predominantly) through three main providers: HCRG Group, Kent Community Health NHS Foundation Trust and Medway Community Healthcare. A programme is underway to re-procure community services.

We heard through the Engagement Exercise that the community re-procurement is welcomed as a vehicle to define a new model of care that supports the transformation of services.

However, a recurring theme was the risk that the procurement may distract delivery teams and system partners from starting to implement the Integrated Neighbourhood Teams until the contract process concludes. There is a risk that partners may feel constrained to be able to form the partnerships and 'team of teams' ways of working that are needed, whilst competing as part of the procurement process.



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Development Framework for Integrated Neighbourhood Teams across Kent and Medway

Section 2:
The future model for Integrated Neighbourhood Teams

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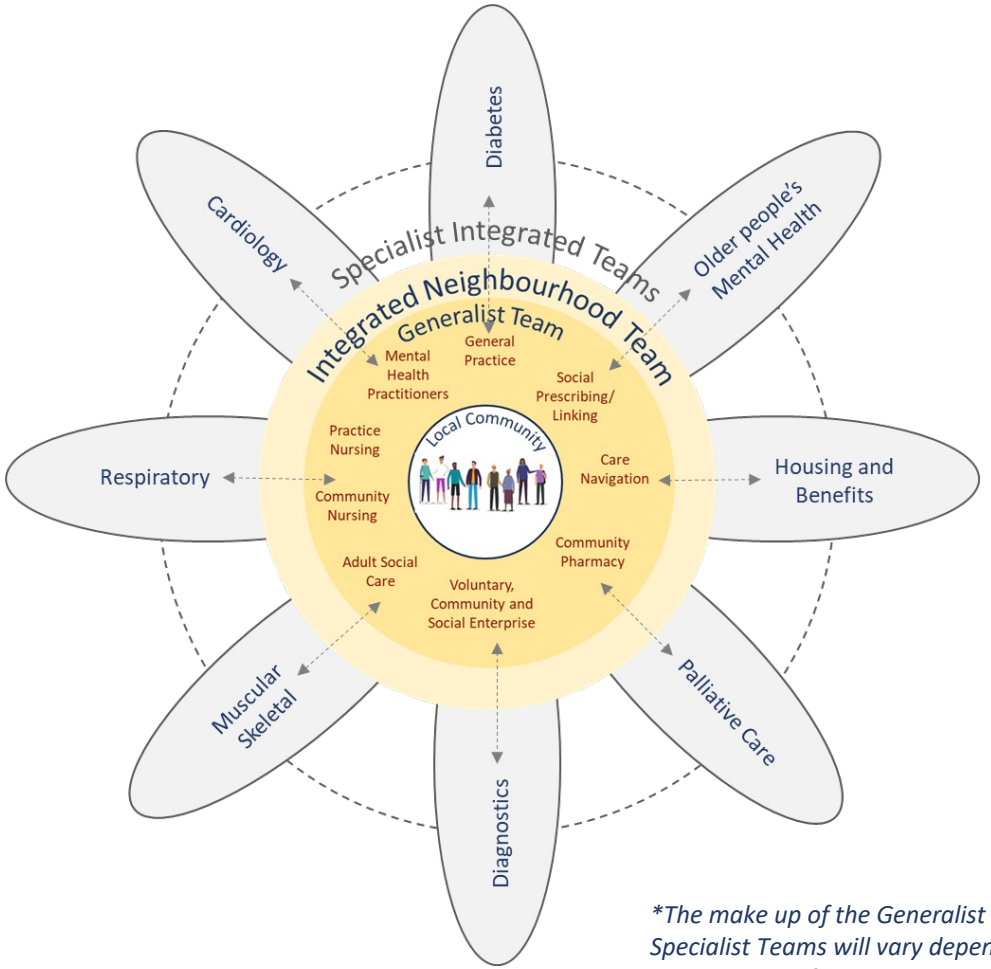
Integrated Neighbourhood Teams – future model

Possible Future State

Confident and autonomous integrated team of teams built around local neighbourhoods



**The make up of the Generalist and Specialist Teams will vary depending on the needs of the local population*

A single Integrated Neighbourhood Team for each natural community

The sustainable solution to the challenges we face is to create confident and autonomous **Integrated Neighbourhood Teams across primary and community care** that are accountable for their local defined population and the individual needs within it.

These 'Integrated Neighbourhood Teams' will bring together the currently siloed professional teams. Rooted in a sense of shared ownership for improving the health and wellbeing of the population, they will know the populations they serve.

The INT will take responsibility for their population wherever they may be – in their own home, acute inpatient setting or care home. That means building strong connections with specialist services and neighbourhoods - advice, guidance, clinics. In case of admission, the Neighbourhood takes accountability for receiving the person back into the community as soon as possible and supporting them as they get well again. This requires acute providers to develop their own Neighbourhood response to link closely with the emerging Neighbourhood Teams (see next page).

Integrated Neighbourhood Teams will need a balanced set of both freedoms and accountabilities. They should have the autonomy to work with local communities to determine what matters to them to design interventions that will make a difference, including a renewed focus on prevention, and determine how to spend or allocate resources. The focus will be on delivering more holistic, person-centred care.

In having an overview of the whole population, they will focus on the most pressing issues that those local people face and will establish ways of working to better meet those needs in a more integrated way. This generalist team will at times provide specialist care and connect with specialist teams to ensure patients receive the best care - but always maintaining a holistic, whole patient, whole population perspective.

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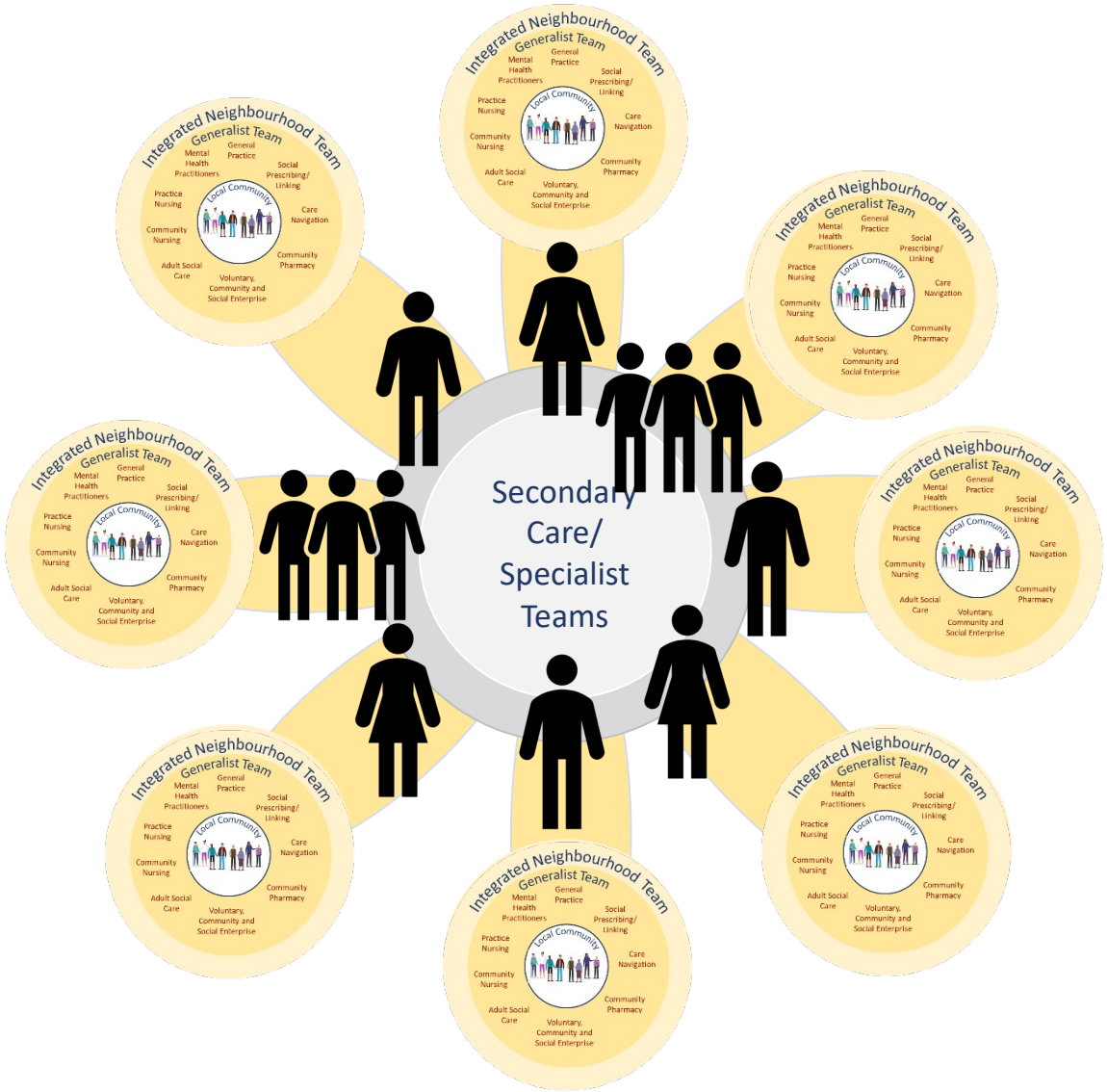
Integrated Neighbourhood Teams – connection with secondary care



Secondary care specialists are integral to the new model

The introduction of Integrated Neighbourhood teams is not just about those teams outside of hospitals. It requires a shift in mindset from those who work inside secondary care and other specialist teams; secondary Care is as much part of the community as all their colleagues working across primary and community care.

That means taking more responsibility for the whole population and not just those who end up in crisis and flow through the emergency department or end up on an elective waiting list.

Through the listening exercise we heard of great examples of more joined up working and a strong desire from secondary care leaders and some clinicians to work more closely with primary and community care services.

Creating time for specialists to support and work with the INTs will be essential to support their success and help to reduce demand. That could mean any number of approaches, eg: joining Multidisciplinary Team Meetings in Neighbourhood Teams, reviewing what the Population Health data is telling us about inequalities and working with local teams to develop effective prevention and treatment interventions that reduce the numbers ending up in crisis; supporting the upskilling of Neighbourhood Teams to give them confidence and experience to keep patients and service users where they prefer to be – at home and in their communities.

Areas of initial high impact through greater integration include better supporting patients with long term conditions, multi-morbidity as well as frail patients. Specifically Respiratory, Diabetes, Cardiology and both older people and children.

Integrated Neighbourhood Teams – benefits for patients, staff and the health & care system

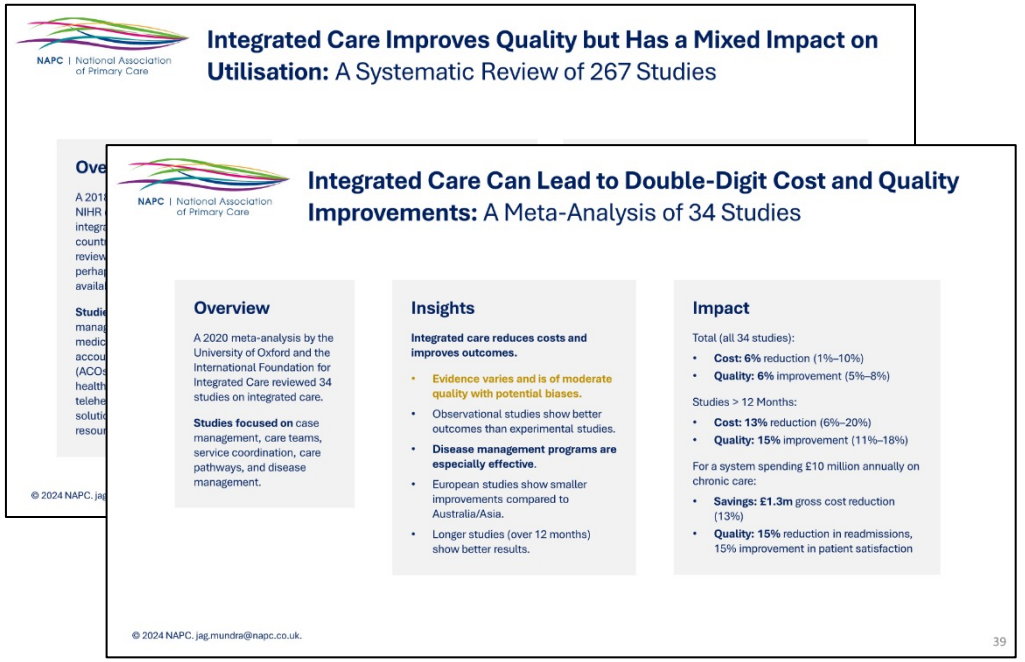
We heard a shared confidence that this model will be better for patients and for staff, result in improved outcomes and performance, and support partners to reduce increasing costs.

Summary of expected benefits:

Better for patients	Better for patients, providing the joined up, holistic care that is needed to support people to stay well, manage their ongoing health and care needs, and to co-ordinate their care in times of crisis and/or when hospital treatment is needed.
Better population outcomes	Lead to improved overall population outcomes, with resources aligned with need and tackling inequalities
Better for staff	Better for staff, with higher levels of morale and satisfaction through working as part of a high performing team with freedom to act to meet the needs of patients and communities.
Better for the health and care system	Result in improved performance across Kent and Medway, and a better use of the Kent & Medway £ (Pound) over time, through more appropriate use of health and care resources, with fewer hand-offs between teams and patients receiving the right care in the right setting, at the right time, reducing waste and rework; more focus on prevention to reduce demand; and streamlining working practices and admin.

Research and Case Studies

Appendix 2 of this report synthesizes the significant volumes of research into Integrated Care, including a systematic review by the NIHR that includes 267 studies and a meta-analysis undertaken by the University of Oxford and the International Foundation for Integrated Care. Appendix 2 also includes a series of relevant case studies.



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Integrated Neighbourhood Teams – design principles

Building on the Engagement Exercise, the following design principles are proposed, which serve to support the ambition and aims. These will need to be developed and refined in the next stages, however they ought to form the guide for the development of the early Integrated Neighbourhood Teams.

Population focus	1. INTs are based around **the natural communities that people of Kent and Medway identify with** 2. At the heart of what drives each team is **what matters to people/citizens** - they find ways of seeking out and hearing the voice of local people 3. The Teams **know each other and the populations they serve,** they are proudly focused on getting to know smaller numbers of people well
Responsibilities	4. They are **accountable for the delivery of the ICS objectives** for the populations they serve including addressing inequalities 5. They have the **autonomy to make decisions** and flexibility over how skills and capabilities are deployed. 6. They focus on **helping populations make better choices for their own health and wellbeing (prevention)** as well as caring for and supporting those with episodic and complex needs
Culture	7. They have a **collaborative, trusting and "can do"** culture that is developed, supported and measured 8. They have access to a **support network and professional supervision 7 days a week** 9. They have in place a **culture and processes for developing together, learning together and for sharing lessons** across all INTs
Leadership	10. They are **led by a single, multidisciplinary, leadership team** that is invested in to develop and grow. 11. They are **agnostic of employment model and employer** and non-hierarchical (team lanyard not organization) 12. Investment in the Neighbourhoods is based on **need rather than by per head of population.**
Processes	13. They provide **holistic rather than task/case-oriented care and support** that is co-designed with the local population, and are able to provide **continuity of care where and when it matters** **14. Hand-offs and referrals between teams are removed wherever possible** and replaced by clear lines of communication and trusting, collaborative relationships including effective messaging in real-time 15. They have **Information Management & Technology infrastructure that supports them flexibly** across the system. They have access to systems that have a unified user experience that have been designed once with citizens and users at the heart. 16. They have **quality and safety governance processes and culture, aligned to HCPs,** keeping patients, users and professionals safe

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How many Integrated Neighbourhood Teams will we need in each HCP area?

There is a consensus of view that Integrated Neighbourhood Teams should be built around the natural communities of Kent & Medway. That is, those communities that people recognise themselves as belonging too. The important principles to hold on to are that we should be building INTs that are small enough for team members to know each other and the populations they serve, and that they are the right size to provide continuity of care too.

There are, naturally, differences of view about what size populations or communities around which to wrap Integrated Neighbourhood Teams and where to start: GP Practice; Primary Care Network; Local Authority Ward; Public Health Localities or another typology.

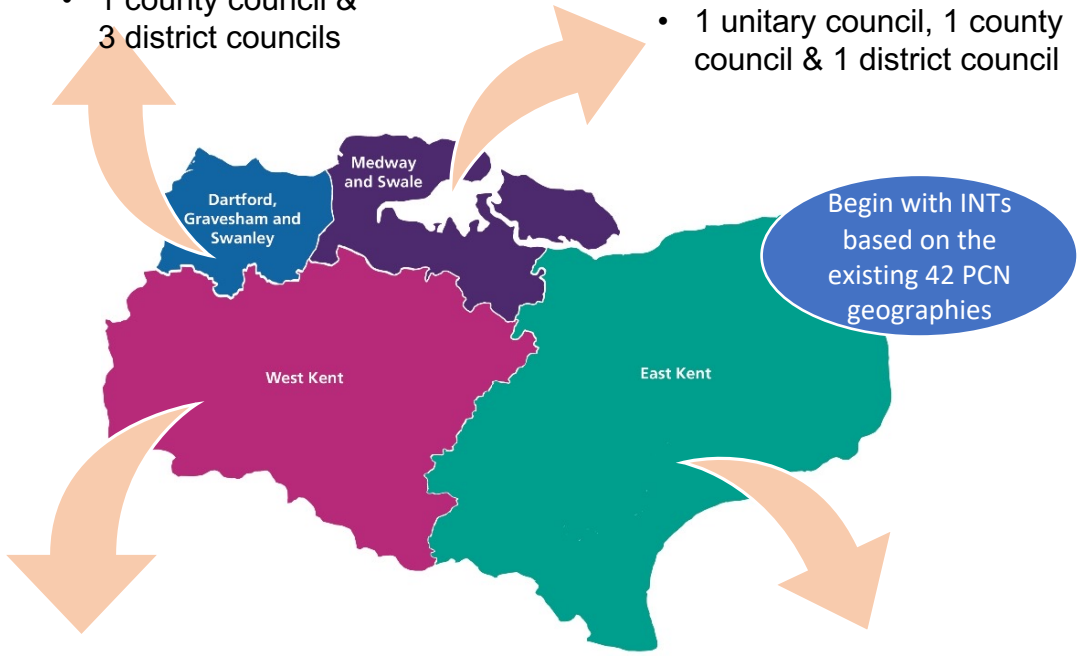
There is, understandably, concern from some organisations about the ability to deliver sustainably at smaller population levels than they are currently organised. The counter to that we heard from the Engagement Exercise is that it is important to be thinking about scale from perspective of whole team, and not just individual organisations. For instance, when we think about an integrated nursing team, that means General Practice nurses being in the mix as well as District Nursing, Frailty Nurses, Virtual Ward Nurses and so on. We have also heard that it is important that Integrated Neighbourhood Teams take accountability for covering absence and vacancies by co-operating with their adjacent Neighbourhood Teams.

There are 42 PCNs and 184 General Practices across Kent & Medway. Our sense is that there are unlikely to be as many as 184 Integrated Neighbourhood Teams, but that, in the end, some PCNs will contain more than 1 INT.

Our advice is to ensure that INTs are no larger than current PCNs, and that current PCN geographies are a good place to start - this would provide 42 INTs across K&M. Over time, each PCN will need to supported by the relevant HCP to think through whether it contains one, or more than one natural community, and whether it therefore makes sense to develop more than one INT within the PCN area.

DGS HCP
- Population 260,000
- 7 PCNs
- 23 General Practices
- 1 county council & 3 district councils

Medway & Swale HCP
- Population 427,000
- 10 PCNs
- 47 General Practices
- 1 unitary council, 1 county council & 1 district council



West Kent HCP
- Population 504,000
- 9 PCNs
- 51 General Practices
- 1 county council & 4 district councils

East Kent HCP
- Population 720,000
- 16 PCNs
- 63 General Practices
- 1 county council & 6 district councils

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Summary of recommendations to communicate the shared ambition and timeline to build Integrated Teams around the natural communities in each of the four HCP areas in Kent and Medway.

Summary of recommendations to communicate the shared ambition and timeline to build Integrated Teams around the natural communities in each of the four HCP areas in Kent and Medway.

- ☞ *Declare the shared ambition and intent to introduce the new model of Integrated Neighbourhood Teams – explicitly supported by all partners.*
- ☞ *Agree the timeline for how you pursue the implementation of Integrated Neighbourhood Teams at pace across Kent and Medway over the next 24 months.*
- ☞ *Align this development framework to the Community Services Procurement timeline – influencing the model, target outcomes and procurement strategy.*
- ☞ *Support HCPs to develop an initial focus for INT development on how best to meet the needs of patients with Complex Care to use this as an opportunity to explore and learn in readiness to meet other population needs*
- ☞ *Develop the options for organisational and governance models that will enable the vision and ambition described in this Framework to come to fruition.*

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Development Framework for Integrated Neighbourhood Teams across Kent and Medway

Section 3:
Recommendations about how to implement Integrated Neighbourhood Teams in HCPs in Kent and Medway

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The immediate next steps to build on the momentum and energy across K&M are:

1. Confirm the **workforce for each INT** – NHS family partners and wider LA services / VSCE - who is in which team?

2. **Invest in team development:** Bring together the people from primary, community, mental health, social care and VSCE who work in each PCN/Practice area and begin the work to develop them as a team. This takes place alongside Organisational development within Community Providers led by Provider Collaborative

3. Work on the HCP approach to **leadership team for each INT and implement it**

4. Agree the **objectives and success measures** with each INT

5. Address the **digital and estate infrastructure needs** of INTs

6. Confirm system **roles and responsibilities and governance**

We recommend combining targeted local and HCP/ICS level action in each of these six areas to make progress over the next 6 months

Neighbourhood level action in 4 selected INTs

Accelerated development of 4 Integrated Neighbourhood Teams, one in each HCP area, bringing the model to life at a practical level using the principles set out in this framework.

- Fully implementing the new one-team delivery model with a small number of thriving 'first mover' sites, selected by HCPs.
- Learning from this implementation to enable successful roll out to other areas. *
- Meeting the needs of patients with Complex Care needs is likely to be one of the first priority areas in each HCP

Alongside collective, at-scale action in each HCP

Implementing the next phase of the strategic programme for INT development in each HCP and across the ICS.

- Actions to align each partner's workforce to INTs, creating the leadership approach and roles, establishing the team development programme, addressing digital and governance issues.

We recommend combining targeted local and HCP/ICS level action to make progress over the next 6 months.

These are described in more depth on the next slide.

* DGS HCP are implementing INTs across their whole area

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Summary of recommended implementation actions for the next 6 months

	In 4 'first mover' INTs, at least one in each HCP Supporting accelerated full implementation in 4 INTs	Across Kent and Medway HCPs Enabling at-scale implementation of new model of care
1 **Confirm INT workforce - who is in which team**	• Establish the four selected INTs by identifying the named individuals that comprise each INT.	• Agree the alignment of the NHS workforce to INTs and local government and VCSE where possible. • Continue roll out of complex care INTs
2 **Invest in team development and OD**	• Deliver a series of action-oriented workshops for each INT with the named team to build trust and relationships and co-produce new working practices.	• Scope, source and establish the ongoing programme of team development for INTs to enable them to thrive. Includes 'train the trainers' programme.
3 **Select and appoint INT leadership**	• Select the leadership team for each of the four INTs, who take responsibility for nurturing the required culture and leading the team to deliver objectives.	• Create the role profiles, person specs, process to fill appointments and process to identify leadership development needs, followed by implementation.
4 **Agree INT objectives and success measures**	• Agree the immediate objectives for each of the four INTs based on system priorities and local needs. Agree 30, 60 and 90-day action plans.	• Agree at HCP and ICS level the key priorities and metrics that INTs are best placed to deliver, to enable clear focus at neighbourhood level.
5 **Address digital and estate needs of INTs**	• Though the accelerated implementation of these four INTs, identify and seek to meet digital and estate infrastructure requirements.	• Progress agreed actions of existing digital and estate infrastructure workstreams, adding learning from four 'first-mover' INT teams.
6 **Confirm governance, roles and responsibilities for INT programme**	• Identify local champions who can support the 'train-the-trainer' programme to cascade learning across subsequent waves of INTs.	• Agree transitional governance, roles and responsibilities to manage this programme.

Each is described in more detail on the following pages

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1 Identify the workforce for each Integrated Neighbourhood Team

Integrated Neighbourhood Teams will bring together the currently siloed professional teams. They will be rooted in a sense of shared ownership for improving the health and wellbeing of the population. Integrated Neighbourhood Teams will need to lose the constraints of siloed commissioning specifications; the requirement to make referrals to each other; separate case-loads across organisations.

The skills mix required will vary but will be drawn from all statutory bodies within each HCP and work closely with the voluntary sector and community champions. The focus will be on delivering more holistic, person-centred care.

Agreement is needed about what the core team skills look like and how the multi-disciplinary teams will access specialist advice, professional support and supervision. This should be consistent across Kent and Medway. Teams should be given the clarity and freedom to act at the 'top of their licence' and to use common sense.

The skills mix required in each team will ultimately depend on need. However, through the Engagement Exercise we have heard that the starting point should be General Practitioners, Nursing, Allied Health Professionals, Mental Health Practitioners, Social Care, Social Prescribers, Domiciliary Care. There will need to be a strong skill mix of leadership, clinical, operational, admin, business analyst, data and digital and technology skills. Over time, wider skills could be rolled into the team. It is unlikely that all of these skills exist in one organisation, and so Kent & Medway will want to explore the capacity and skills that is available from across all organisations, with a view to deploying them a in potentially more effective way. The starting point for the emerging Neighbourhoods in all of this must be to explore what matters to their local populations.

There is major opportunity, and necessity, here to align the student workforce with the future of how Kent & Medway will deliver health and care. INTs will provide an important learning environment for students regardless of profession. The opportunity is to expose students to an exciting, dynamic workplace environment that encourages them to want to develop their careers in the area.

Summary of recommendations to identify the workforce for Integrated Neighbourhood Teams

- ☞ *Review the existing layers of fragmented teams and absorb them into INTs, otherwise the new INTs simply become another layer.*
- ☞ *Work with Social Care colleagues to explore a more citizen centred approach to INTs and integrated working*
- ☞ *Develop and create the workforce model aligned to each practice and emerging Neighbourhood, using actual numbers, current skill mix and understood needs. Initially this should focus on the NHS workforce, including: General Practice; Primary Care Networks; Community Services; Talking Therapies Mental Health Integrated Community Care Transformation; Older People Mental Health (not specialist or beds); Community Mental Health Teams; Admin and Management; Corporate services where appropriate. Over time the shape and skills mix of the workforce will evolve as understanding of the local needs of the population are better understood. This work will also need to include children and young people's services considering the best fit around their lives.*
- ☞ *Work with education providers to ensure that the curriculum is influenced by the future model of Integrated Neighbourhood Teams and that placement opportunities are explored and exploited.*

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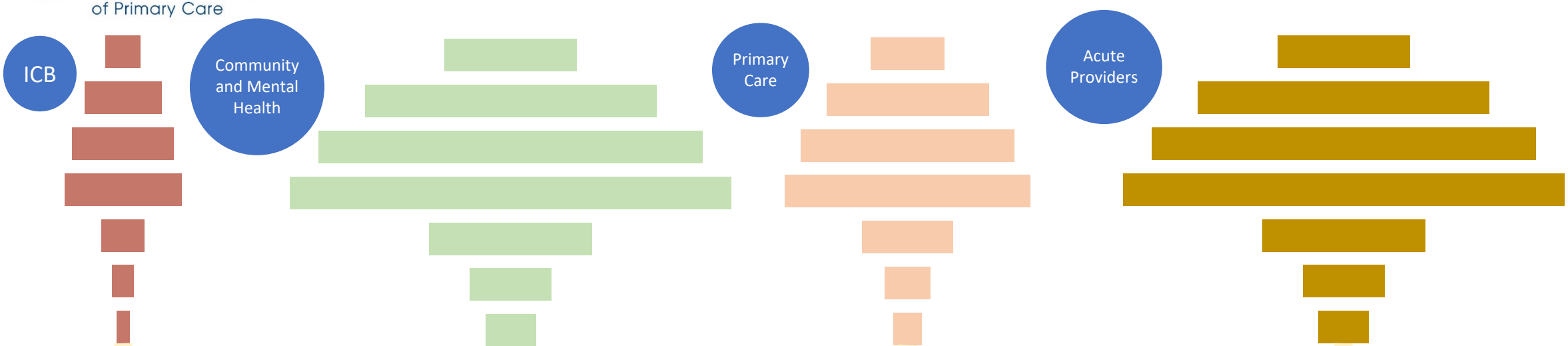
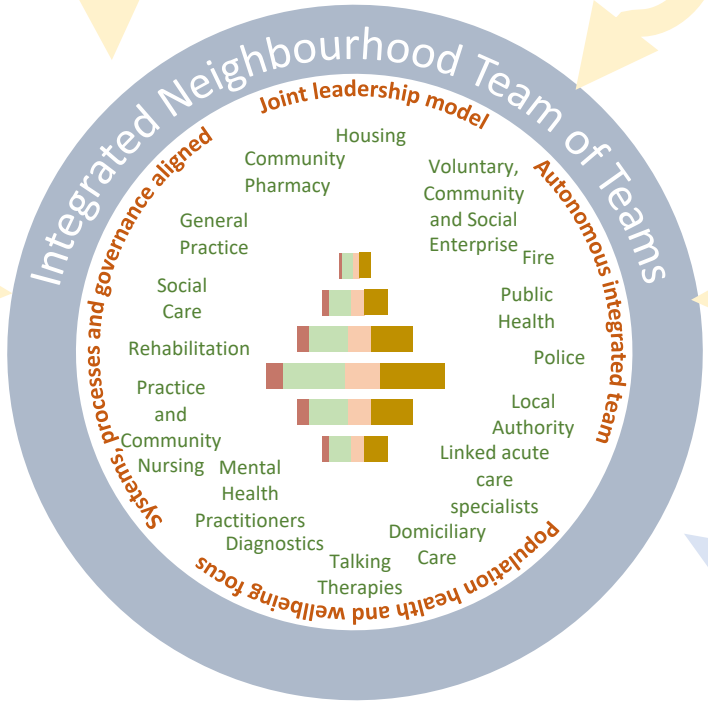
Developing the model for workforce, skills and roles

- Deploying Kent & Medway's skills and capacity in a potentially more effective way



Taking current skills and experience….

…and deploying in Integrated Neighbourhood Teams



'Integrated Neighbourhood Teams' will need the operational, improvement, data, digital, administrative skills as well as clinical skills. The opportunity is to deploy the skills that currently exist in different parts of the system in a potentially more effective way.

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1 Developing the model for workforce, skills and roles - Possible Core Skills and Roles

Illustrative only

Acute Services

The skills mix and roles for each Integrated Neighbourhood Team will need to be defined and developed based upon need. However, a pragmatic starting point is to build a picture of what currently exists and move on from there.

Psychosocial Health and Wellbeing Domains

- Prevention
- Urgent and Episodic
- Complex and Chronic

Core skills?

General Practice	Social Work	Therapies & Allied Health Professionals	Autism and disabilities
Community Support	Nursing	Domiciliary Care	Pharmacy
Healthcare Assistants	VCSE	Public Health	Rehab
Mental Health Nursing	Talking Therapies	Housing	End of Life Care

Leadership | Analyst | Digital Competences | Operational | Financial | Community Engagement | Admin

Emergency/Acute

Specialist Elective

Out/In Reach to Specialist Services

Dementia	Mental Health	Disabilities	Discharge Management
Palliative	Cardiology		
Respiratory	Diabetic	Autism	Admission Avoidance
Renal	Disabilities/ Autism		

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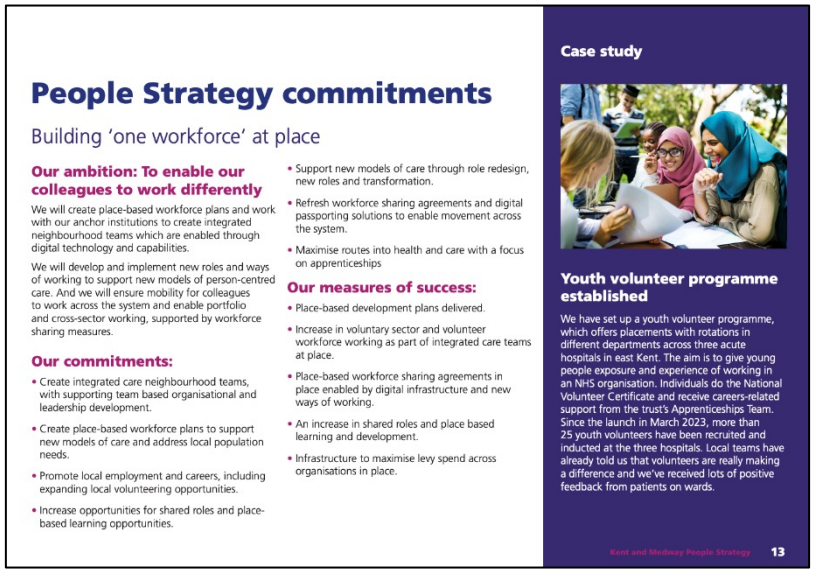
1

Organisational development aligned to the K&M People Strategy

The K&M People Strategy describes the challenges the ICS faces with its workforce and people working in it. It lays out the commitment to *"Building 'one workforce' at place"*.

The work we describe in "**Investing in flourishing, autonomous and motivated Integrated Neighbourhood Teams"** will contribute to the approach to fulfilling this commitment.

This will include the investment needed in team based organisational and leadership development in line with the enablers described in the strategy including workforce planning and intelligence and cross organisational working.



People Strategy commitments

Building 'one workforce' at place

Our ambition: To enable our colleagues to work differently

We will create place-based workforce plans and work with our anchor institutions to create integrated neighbourhood teams which are enabled through digital technology and capabilities.

We will develop and implement new roles and ways of working to support new models of person-centred care. And we will ensure mobility for colleagues to work across the system and enable portfolio and cross-sector working, supported by workforce sharing measures.

Our commitments:

- Create integrated care neighbourhood teams, with supporting team based organisational and leadership development.
- Create place-based workforce plans to support new models of care and address local population needs.
- Promote local employment and careers, including expanding local volunteering opportunities.
- Increase opportunities for shared roles and place-based learning opportunities.
- Support new models of care through role redesign, new roles and transformation.
- Refresh workforce sharing agreements and digital passporting solutions to enable movement across the system.
- Maximise routes into health and care with a focus on apprenticeships

Our measures of success:

- Place-based development plans delivered.
- Increase in voluntary sector and volunteer workforce working as part of integrated care teams at place.
- Place-based workforce sharing agreements in place enabled by digital infrastructure and new ways of working.
- An increase in shared roles and place based learning and development.
- Infrastructure to maximise levy spend across organisations in place.

Case study

Youth volunteer programme established

We have set up a youth volunteer programme, which offers placements with rotations in different departments across three acute hospitals in east Kent. The aim is to give young people exposure and experience of working in an NHS organisation. Individuals do the National Volunteer Certificate and receive careers-related support from the trust's Apprenticeships Team. Since the launch in March 2023, more than 25 youth volunteers have been recruited and inducted at the three hospitals. Local teams have already told us that volunteers are really making a difference and we've received lots of positive feedback from patients on wards.

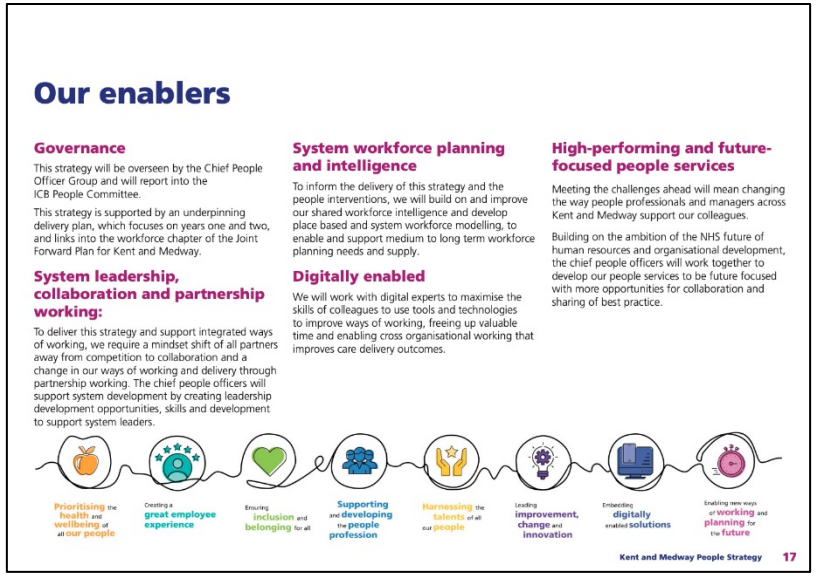
Kent and Medway People Strategy 13

Kent and Medway Integrated Care System

Together, we can

A great place to live, work and learn

Kent and Medway People Strategy 2023 to 2028



Our enablers

Governance

This strategy will be overseen by the Chief People Officer Group and will report into the ICB People Committee.

This strategy is supported by an underpinning delivery plan, which focuses on years one and two, and links into the workforce chapter of the Joint Forward Plan for Kent and Medway.

System leadership, collaboration and partnership working:

To deliver this strategy and support integrated ways of working, we require a mindset shift of all partners away from competition to collaboration and a change in our ways of working and delivery through partnership working. The chief people officers will support system development by creating leadership development opportunities, skills and development to support system leaders.

System workforce planning and intelligence

To inform the delivery of this strategy and the people interventions, we will build on and improve our shared workforce intelligence and develop place based and system workforce modelling, to enable and support medium to long term workforce planning needs and supply.

Digitally enabled

We will work with digital experts to maximise the skills of colleagues to use tools and technologies to improve ways of working, freeing up valuable time and enabling cross organisational working that improves care delivery outcomes.

High-performing and future-focused people services

Meeting the challenges ahead will mean changing the way people professionals and managers across Kent and Medway support our colleagues.

Building on the ambition of the NHS future of human resources and organisational development, the chief people officers will work together to develop our people services to be future focused with more opportunities for collaboration and sharing of best practice.

Prioritising the health and wellbeing of all our people

Creating a great employee experience

Ensuring inclusion and belonging for all

Supporting and developing the people profession

Harnessing the talents of all our people

Leading improvement, change and innovation

Embedding digitally enabled solutions

Enabling new ways of working and planning for the future

Kent and Medway People Strategy 17

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2 Invest in an INT level OD programme that brings INT members together to develop as a flourishing, autonomous, motivated team.

NOTE: This is the single biggest action to make progress.

The 3 things that motivate us as individuals and teams (and its not 'carrot and stick')

Dan Pink 2009: Drive - The Surprising Truth about what motivates us

Autonomy – our desire to be self directed

Mastery – our urge to get better at things and be challenged

Common Purpose – we care and want to make things better

"Real Teams" are more effective at delivering safer and higher quality care than "Pseudo Teams"

Prof Michael West: Professor of Work and Organisational Psychology at Lancaster University

Clear shared objectives – do we understand what it is we are trying to achieve together

Working interdependently – working closely together, communicating and coordinating effectively together

Meeting regularly – to review performance, improve quality and close gaps in efficiency

Leaders that create a climate of Psychological Safety where it is ok to speak up with ideas, questions or concerns

Amy C Edmondson, Harvard Business School

Frame the work or challenge as a **learning problem**

Acknowledge own vulnerabilities

Model curiosity

The need is for a facilitated programme through which members of each INT are supported to get to know each other and increase trust, build common purpose and shared objectives, begin to create the culture needed and start to take action together. This is described in more detail in the following pages.

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2 Investing in flourishing, autonomous and motivated Integrated Neighbourhood Teams

Few industries match the scale and complexity of health and care. If we just look at the NHS in England, each year: General Practice provides over 300 million patient consultations; there are around 23 million visits to ED; over 120 million outpatient appointments; and 2.3 million elective procedures.

Each and every one of those interactions requires collaboration among a multidisciplinary group of clinicians, administrative staff, patients themselves, and their loved ones. Multiple visits often occur across different professionals working in different organisations. Ineffective care coordination and the underlying suboptimal teamwork processes are a public health issue (Rosen M et al, 2018).

By any definition, the NHS (and Local Authorities) exemplifies a complex and unpredictable system - not just complicated and predictable. It operates in an increasingly high stakes environment – with extreme financial, workforce, regulatory pressures. The system response to this environment is, understandably, often hierarchical and concerned with control and keeping a grip. Individual organisations can demonstrate to commissioners, regulators and to their own boards, that they are providing quality and safe services and are well led on the one hand, and still fail the population it serves. Individuals, and whole communities can fall between the gaps created by silos, fragmented teams and the hand-offs between them and triage criteria. This leads to further inequalities and poorer health and wellbeing outcomes. This isn't a criticism of any one organisation, it is the result of the way in which we have collectively designed and led the system – although always from a place of good intent.

The alternative approach, is to put people and communities back at the heart of what we do.

It involves creating integrated teams close to the communities they serve, with the freedoms to make decisions and adapt to the need as it presents itself, rather than having to defer to middle or senior managers, a predetermined case list, a commissioned contract, a service level agreement or referral criteria.

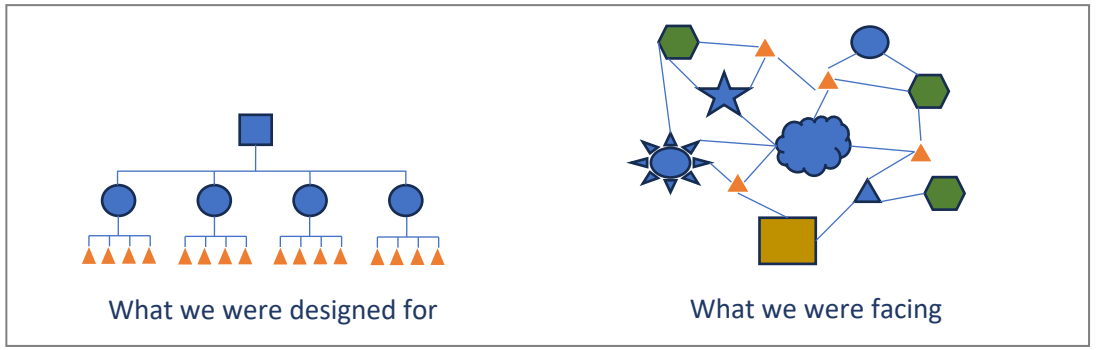
Teams released to '***do the right thing***' for the person and their loved ones, rather than feel they must do '***the right things by the system***'.

Doing the right thing, demands reliable teamwork, collaboration within, as well as across, organisational, disciplinary, technical, and cultural boundaries.

The foundation stones for this way of working, as well as bringing the workforce with the right skills together, is through cultural change, building trusting and collaborative relationships and effective team working disciplines. The good news is, with investment, building these foundations is very doable.

The importance of team working in health care has been emphasised in numerous NHS reports and policy documents, particularly over the last 20 years. Wider than health, an increasing body of research over the last half century has shown links between effective team-based working and organisational effectiveness. Teams are now the unit of performance in most organisations (Lawler, Mohrman & Ledford, 1992).

Perhaps one of the most talked about recent examples in the the literature of teams operating in a complex environment, comes from outside of healthcare. US Army General Stanley McChrystal who led Joint Special Operations Command against Al-Qaeda between 2003-08, describes in his book "Team of Teams", how his vastly superior and incredibly disciplined forces were losing to an enemy of no uniform, no fixed location, shifting identities and cyberspace channels to recruit and deploy propaganda.



Team of Teams. Source: Gen Stanley McChrystal et al, *Team of Teams*

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2 Developing flourishing, autonomous and motivated Integrated Neighbourhood Teams

McChrystal's answer was to create autonomous teams, built around principles of extremely transparent information sharing ("shared consciousness") and decentralised decision-making authority. Interconnectedness and the ability to transmit information instantly, he explains, endowed small teams with unprecedented influence.

Realising that the old-school, hierarchical command system based on rank was no longer working, McChrystal pushed a new way of organising , one he calls "team of teams". Team of teams is about working together to find solutions. They draw on the intuition and knowledge of everyone in the organisation. They rely on familiarity, building trust, and empowerment. They have a common purpose that everyone can align to. The structure of the team *is* the strategy.

It is worth also reminding ourselves of the work that Professor Michael West has done on work on effective team working in the NHS. He notes that in team-based organisations the emphasis is not on vertical power relationships, but on achieving a shared purpose and understanding, and the integration across teams.

West's research demonstrates the clear link between effective team working and innovation, staff wellbeing, reduced errors and incidents, and higher quality of care and improved outcomes.

West draws the distinction between **'Pseudo Teams'**, in effect a team by name only, and **'Real Teams**'. Real Teams are distinct because they:

1. **Have clear shared objectives:** they understand what they are trying to achieve together.
2. **Work interdependently:** working closely together, communicating and co-ordinating effectively together
3. **Meet regularly:** to review performance, improve quality and close gaps in efficiency

Another, complementary, study to throw in the mix here is the fascinating work of Daniel Pink set out in his book 'Drive' which explores the academic research evidence base on what really motivates people and teams towards higher performance. It turns out that the three things that motivate us as individuals and teams are:

1. **Autonomy** – our desire to be self directed
2. **Mastery** – our urge to get better at things and be challenged
3. **Common Purpose** – we care and want to make things better

This flies in the face of the remuneration policies and performance management systems that exist in most business enterprises. Once the issue of money is off the table, the traditional 'carrot and stick' approach manifestly does not work.

Finally, the work of Amy Edmondson is important too. She argues that if you change the nature and quality of the conversations in teams, the outcomes will improve exponentially. Psychological safety is the core component to unlock this - a belief that 'one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes, and that the team is safe for interpersonal risk-taking'.

There is an overwhelming academic evidence case for building teams along the lines of some, or all, of these principles. If Kent & Medway is serious about creating Integrated Neighbourhood Teams, it will need to invest in the developing the right culture and team processes that will make them 'Real Teams', not just 'Pseudo Teams'.

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2 Organisational development within Provider Collaborative, HCPs and NHS providers to support the new model of care implementation

A programme of Organisational Development will be needed to support each part of the system to adapt to implement the new models of care.

Location	Focus
Provider Collaborative	• Partnership working models
Health and Care Partnerships	• Developing approaches to support and lead INT development together across the HCP area
Community Providers	• Work through revised model of delivery in line with new INT model of care. • Identify INT related roles • Identify HCP wide services/ roles
MH Provider	• Work through revised model of delivery in line with new INT model of care. • Identify INT related roles • Identify HCP wide services/ roles

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2

Recommendations to support the development of the Integrated Neighbourhood Teams, with the objective of enabling them to be flourishing, autonomous and highly motivated

Summary of recommendations to support the development of the Integrated Neighbourhood Teams, with the objective of enabling them to be flourishing, autonomous and highly motivated

- ☞ *Design and develop a programme of 'Real Team' development and support, building on the emerging Design Principles, that is practical and leads to high performing flourishing teams. This programme should focus on sustained cultural change (building trust and collaboration) as well as practical team processes and skills e.g. population health improvement, information sharing, problem solving, and process improvement*
- ☞ *Make the investment in teams to create the head space to allow them to develop together and problem solve together.*
- ☞ *Create a development framework (matrix) to guide and support Integrated Neighbourhood Teams as they form and mature.*
- ☞ *Develop a survey instrument to measure team effectiveness in each Integrated Neighbourhood Team. Use this data to support INT leaders to share best practice and in continuing to develop their team culture.*

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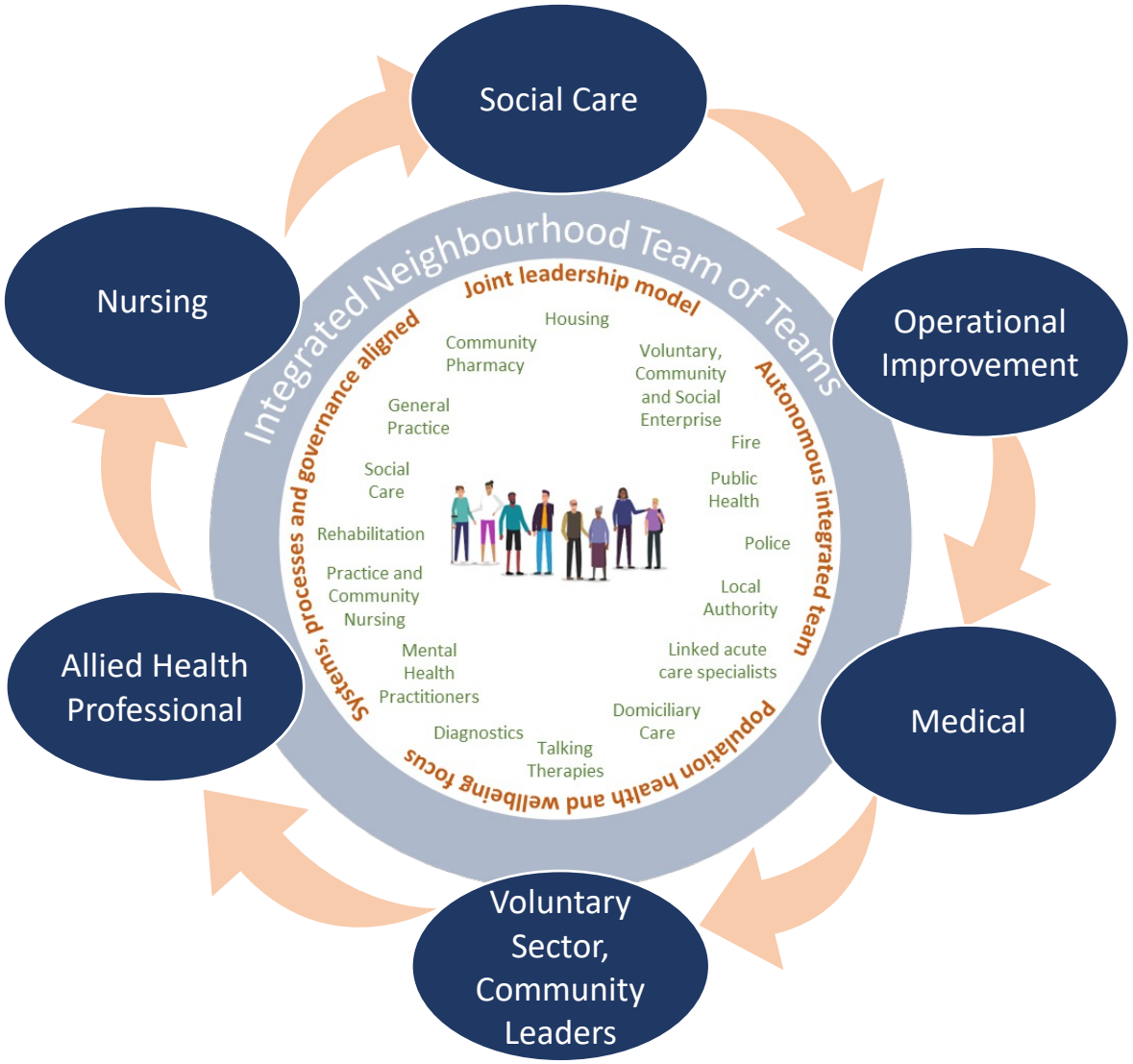
3

The next key step is to build a capable unified leadership team supporting each Integrated Neighbourhood Team



It will be important to build a single unified leadership team around each Integrated Neighbourhood Team.

This should be drawn from Social Care, Nursing, Medical, Allied Health Professionals and Operational Improvement backgrounds, and where possible the Voluntary and Community Sector. They will be accountable for organising their workforce to deliver the 6 Kent & Medway strategic priorities for their local population.

In order to select the leadership team for each INT it will be important to:

- Develop role profiles for the leadership positions for an INT and for the intermediate tier that may be needed between INTs and each HCP
- Develop the competency framework that articulates the qualities and skills needed and design a selection and development centre programme.
- Identify where the future leadership talent and capacity will come from, looking across the whole system.
- Develop a mentoring programme.

The INT leadership team will take accountability for their population wherever they may be – in their own home, acute inpatient setting or care home. That means building stronger connections between Specialist Services and Neighbourhoods - advice, guidance, clinics. In case of admission, the Neighbourhood takes accountability for receiving the person back into the community as soon as possible and supporting them getting well again. This requires acute providers to develop their own Neighbourhood response to link closely with the emerging Neighbourhood Teams.

They will be accountable for safety and quality governance in a new system wide approach aligned to the HCPs.

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3

Building a capable unified leadership team supporting each Integrated Neighbourhood Team

The key ingredient to delivering this way of working is leadership fostering an improvement culture and a safe environment for people to learn and experiment. Without this the risk rises of not realising the benefits of integration. The leaders of Neighbourhood Teams will need:

- To model new behaviours, build relationships and trust
- Autonomy for decision making
- Control or influence over resources and budget
- Accountability for promoting a culture of collaboration and pride
- To not be afraid of conflict but rather lean into it and resolve issues
- Headspace to create the time and space within teams to problem solve together
- To be enabled to move the culture away from command and control towards shared consciousness and responsibility
- To empower and expect decision making by whomever is closest to the work/content
- Be willing to learn and fail
- Be capable of calling out poor behaviour and constructively challenge
- Be accountable for governance - ensuring safety for the communities they serve and for the professionals in the team

Leadership teams capable of nurturing this kind of culture are not formed by chance. They are selected, developed, supported, coached and mentored. It will be important to define the expected skills and competences of these teams, support them through development processes.

The wider system leadership will need to play a visible and active role in nurturing these leadership teams. One way to consider achieving this is to have senior leaders from each HCP adopt one or two Neighbourhoods, with the aim of supporting them in difficult periods, listening to them, and guiding them in unblocking barriers.

Kent & Medway will need to shape its own philosophy when selecting and developing these critically important Leaders. Our NAPC Faculty's experience from developing Boards and senior system leadership teams is built on a handful of principles, honed over the years. These may provide a starting point:

1. The first step is to **build a foundation of trust based on vulnerability**. Only by doing this first, can leadership teams move on to have healthy dialogue about the issues that really matter.

2. Leadership teams need to **understand themselves and each other** – self-knowledge is key to developing emotional intelligence and leading themselves, their teams and the Integrated Neighbourhood teams effectively.

3. Leaders need to learn to **assume that all behaviours have their roots in good intentions** – and develop the habit of being curious about those good intentions in each other, and in those outside the Team.

4. The **systems (teams, organisations, communities, institutions) are an unconscious and powerful driver of all our behaviours** – it is important to help leadership teams notice the impact that the system has on them, and those around them. This helps to develop empathy and depersonalise issues so that they can find common ground on which to move forward.

5. **An appreciative approach.** More progress is made by building on the existing strengths, capabilities and potential in teams. This generates energy and spins the flywheel of momentum. A focus on weaknesses often leads to teams getting stuck.

This compassionate approach helps build confidence and honesty in Leadership Teams that: see the lessons in failure rather than blame; listen to staff; get curious about issues, and mine them until resolved; aren't afraid to have difficult conversations; that hold each other to account (without taking it personally) in the interests of the collective purpose of the Team.

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3

Building a capable unified leadership team supporting each Integrated Neighbourhood Team

Summary of recommendations to build a capable unified leadership team supporting each Integrated Neighbourhood Team

- ☞ *Develop the role profiles for the leadership positions for each Integrated Neighbourhood Team, the intermediate tier above them and for each of the 4 place-based geographies across Kent and Medway. This will need to cover all parts of the new care model, be agnostic to organisation but clear on autonomies, accountabilities and reporting lines.*
- ☞ *Develop the competence framework that articulates the qualities and skills required in the leadership team and design a selection and development centre programme that supports leadership teams to develop self insight, understand collective strengths and weaknesses and agree a programme of ongoing development.*
- ☞ *Look across the current system partners and ICB to identify where the future leadership talent and capacity will come from.*
- ☞ *Develop a mentoring programme for Integrated Neighbourhood Leadership Teams that connects them to the wider system*

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4 Developing and Agreeing outcome and success measures for INTs

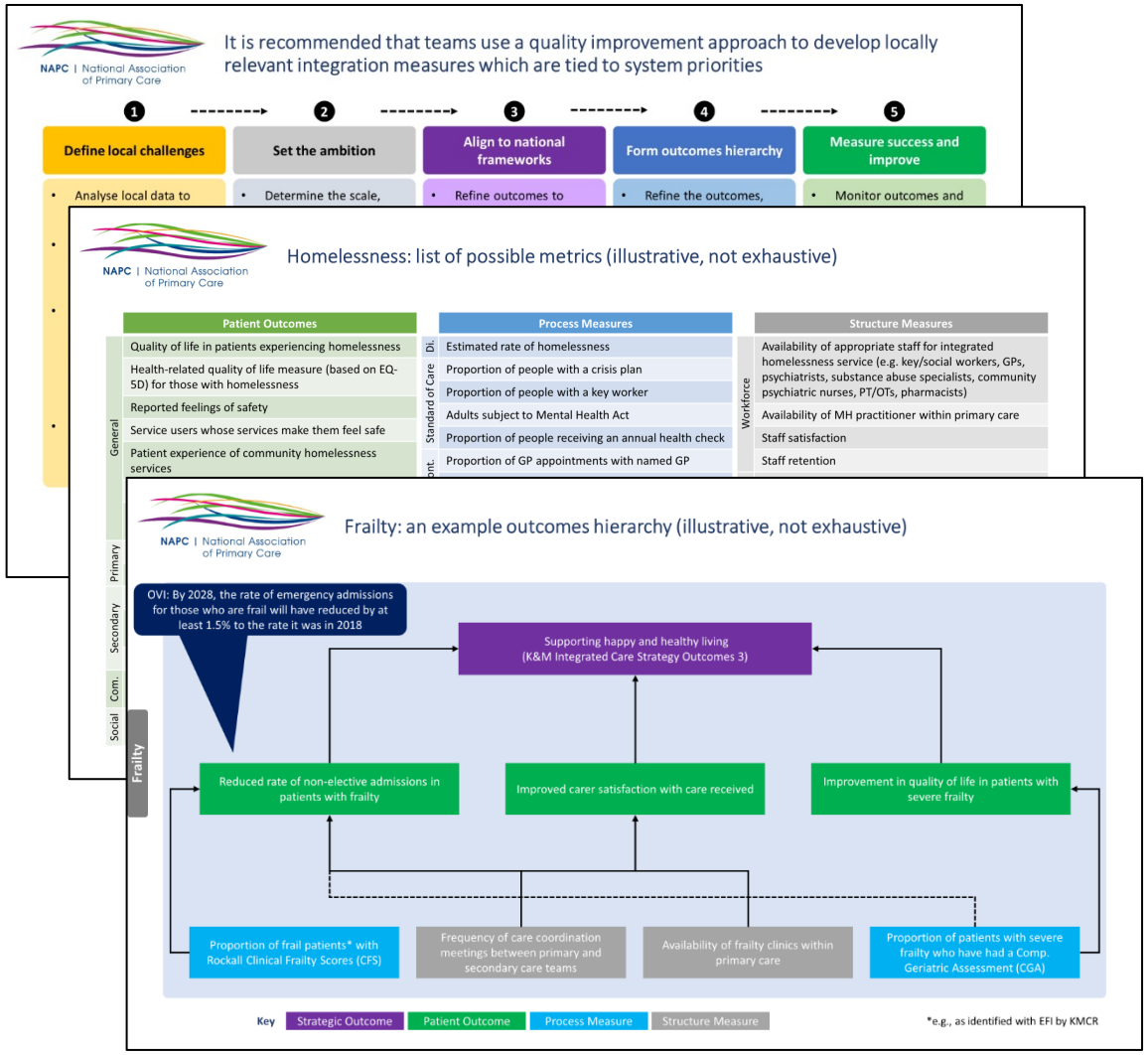
An Integrated Neighbourhood Team comprises a group of professionals from NHS, local authority, charitable and other sectors who come together to share joint responsibility for a cohort of people in their locality. These cohorts might be identified through population health management tools or through local expertise/knowledge. The expectation is that working in this holistic and more proactive way eases the burden on the neighbourhood/ system as a whole and reduces the risk of escalation to hospital-based care.

It is essential that we agree the measures of success for INTs and are able to track progress against these measures. However, stakeholders can have competing priorities and pressures which means there is a risk of disagreement about what to measure and the value of these measurements.

A compromise is to agree a small set of core measures linked to overarching strategic outcomes, with local teams and people able to establish measures that are locally-relevant to their services and the people they provide for.

Core set + Locally agreed

A toolkit has been developed to support the development and agreement of outcome measures in Kent and Medway. This can be found in Appendix 3. The toolkit includes a detailed process for measure development and example measures which could be utilised across the system.



Extracts from toolkit, attached in Appendix 3

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4 Activating Staff & Patients to Reduce Healthcare Utilisation

A Simple Set of Metrics to Support Innovation

	Staff Activation 1+ Month	**Patient** Activation 3+ Months	**Health** Improvement 6+ Months	**Demand** Reduction 12+ Months
Metrics	• **#1 Staff Activation:** Employee Net Promoter Score (eNPS) 'I would recommend my organisation as a place to work' • **#2 Team Effectiveness:** 1 Belonging, 2 Competence, 3 Autonomy and 4 Innovation • **Proxies:** Survey response rates, % participation in training and development, % turnover, % sickness levels	• **#1 Patient Activation:** 'How good are you at taking care of your health?' • **#2 Pillars of Health:** 1 Diet, 2 Activity, 3 Sleep and 4 Social Connection • **Alcohol Units** per capita • **Smoking** prevalence • **Social Barriers to Activation:** Social need codes per capita (e.g. housing, deprivation, substance misuse) can proxy for level of social need	• **#1 Physical Health:** BMI • **#2 Mental Health:** PHQ2/GAD2 or anxiety/depression codes per capita • **#3 Aging:** Rockwood or eFI • **#4 Multimorbidity:** Repeat medications per capita can proxy for clinical need • **Chronic Disease** prevalence and average HbA1c (diabetes) and BP (hypertension) • **Chronic Pain** prevalence or pain codes per capita	• **#1 Contacts:** Visits per capita • **#2 Connections:** Referrals per capita • **#3 Cost:** Spend per capita
Why	**40%** of hospital performance is explained by staff engagement but only **20%** by staffing levels and **0%** by staff pay.	Analysis shows individuals who effectively take care of their health cost the NHS **£981** less per year.	Up to **50%** of an ICB's population can have preventable health risks, leading to nearly **double** the number of GP contacts per year.	Tracking changes in resource use per capita paints a picture of **population demand**, guiding prevention and resource allocation.
How	ICB teams can improve performance through quicker, team-level eNPS data alongside shorter Team Climate checks for action. Engaging tools and displaying key metrics in physical spaces (noticeboards) can keep everyone involved.	Shorter surveys with single-item questions will boost response rates and provide better insights into individual social barriers affecting health activation. The simple act of asking can nudge positive behaviour changes (like 1kg weight loss) and transform routine healthcare interactions into preventive care opportunities.	Metrics should pinpoint root causes and work at patient, team, and regional level. Simply tracking and reporting them (not rewarding) can nudge organisational change. Focus on improvement, not comparison. Celebrate regions with the biggest BMI reductions to identify the very best practices for national improvement.	Analyse resource use (admissions, A&E, etc.) across departments for internal improvement, not competition. Connect this data to staff/patient actions and health outcomes to predict demand reduction and accelerate improvement. Start small with high-ROI interventions, building evidence for larger-scale transformation.

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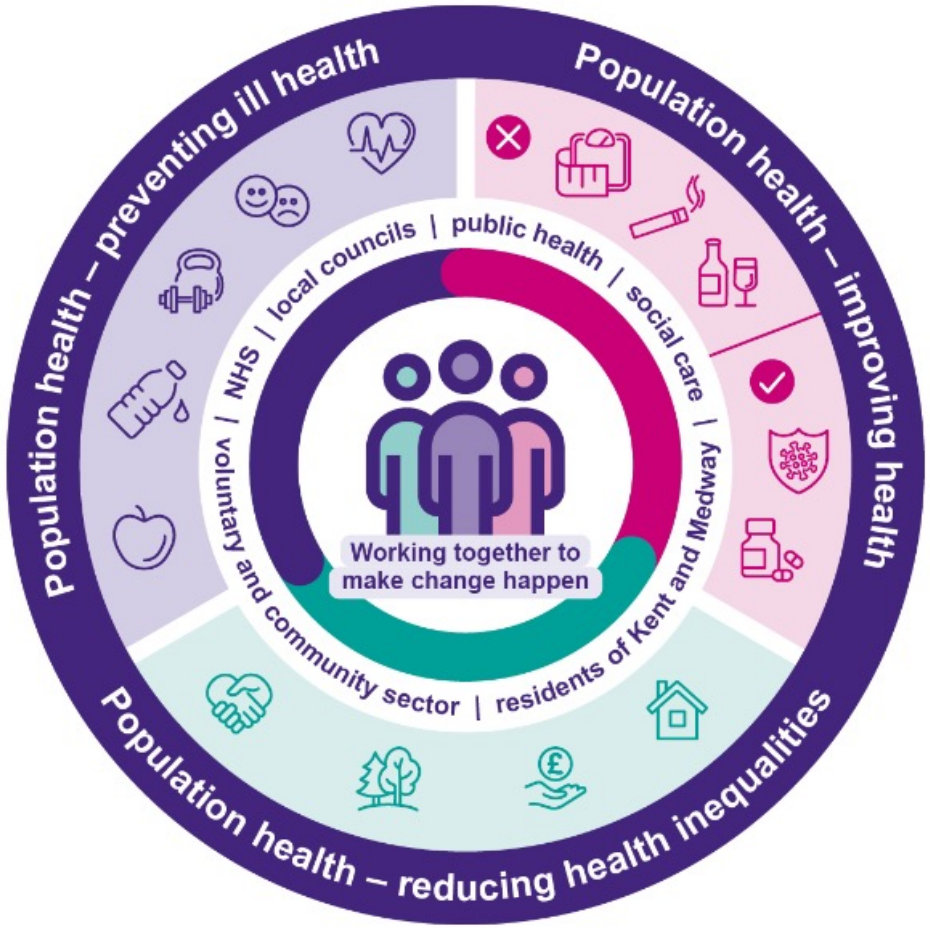
4

Improving Population Health and Wellbeing and Tackling Inequalities

Kent and Medway is an attractive place for so many who choose to make their lives here. With close proximity to London and mainland Europe, and a plethora of green spaces, known as the garden of England, it is home to some of the most affluent areas of England. Nevertheless, it is also home to some of the most (bottom 10 per cent) socially deprived areas in England. This correlates with the health outcomes achieved. With the current cost of living crisis, these disparities will persist or worsen without our concerted, collective effort.

We all want people in Kent & Medway to live healthy, independent, happy lives for as long as possible. But we know that there are huge differences in the age at which people die, develop health and care needs and/or live well with long term conditions. England's Chief Medical Officer's annual report 2021 highlighted that coastal communities have some of the worst health outcomes in England, with low life expectancy and high rates of many major diseases. Coastal communities – of which there are many in Kent and Medway – often have multiple overlapping, but addressable, health problems. Some of the specific challenges we face are:

- The number of people living in Kent and Medway is predicted to rise by almost a quarter by 2031.
- Life expectancy is no longer increasing. In Medway, Swale and Thanet, it is below the average for England.
- More than two thirds of adults are overweight or obese. Physical activity levels for children and young people are not increasing.
- More people are experiencing depression or severe mental illness. People with a serious mental illness die on average 15-20 years earlier than the general population.
- Over 528,000 people – that's almost one in three – live with one or more significant long-term health conditions, including around 12,000 with dementia.



For Kent & Medway, the population health programme is about improving the physical and mental health and wellbeing of everyone in Kent and Medway. It also looks at why some people's health is better than others, understand the causes and help close the gaps.

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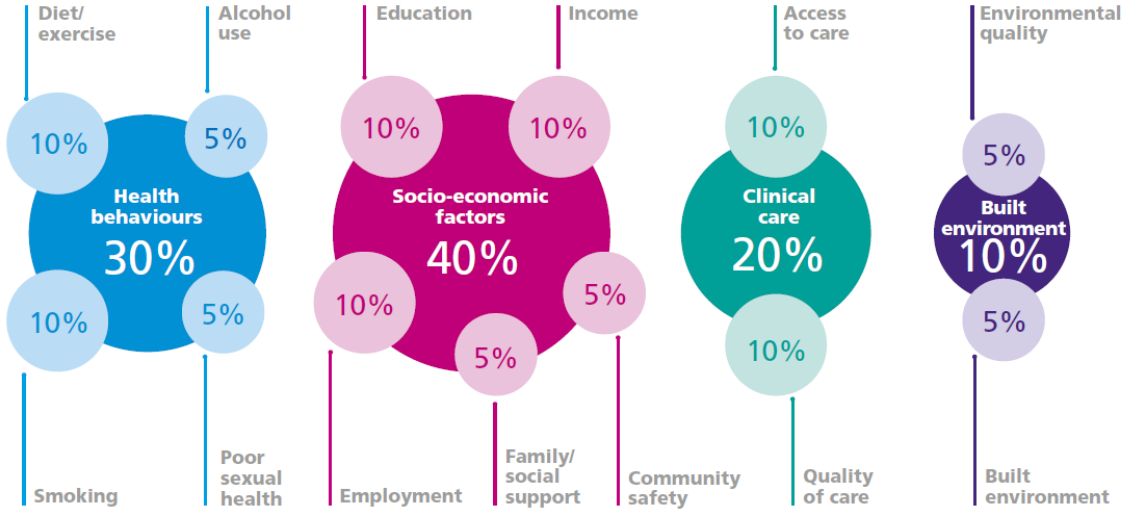
4

Improving Population Health and Wellbeing and Tackling Inequalities

The causes of health inequalities are complex. Different risk factors such as health related behaviour; risk conditions such income, education levels, discrimination; and protective psychosocial factors such as social support, interact contributing to risk conditions such as high blood pressure or depression.

The variation in distribution of risk factors influences the likelihood that some groups of people will experience poorer health than others. This helps to explain why health services alone have only a small impact on health outcomes (see figure below).



Based on: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, US County health rankings model 2014
www.countyhealthrankings.org/sites/default/files/media/document/CHRR_2014_Key_Findings.paf

Integrated Neighbourhood Team action an essential component of tacking health inequalities. To put this into practice they will require bespoke data, skills and processes to embed action on health inequalities in their everyday work.

- **Data:** Population health management (PHM) data insights will help INTs identify groups of people who are not benefitting equally from services and support. We can find people at risk of a poor outcome, such as a fall, or emergency admission or attendance, enabling us to take pre-emptive action to improve outcomes.
- **Skills:** Data insights are an essential tool. However, practical action on health inequalities requires teams to have the skills, knowledge and confidence to change practice and embed new ways of working into business as usual, across the whole system. Design of interventions to generate measurable change at population level will require a range of service level, community level and civic level approaches that are delivered and integrated through health and care services, the community and around the wider determinants of health.
- **Process:** The Kent & Medway Population Health Management (PHM) approach provides guidance, tools, resources and training that will be available to support local action to tackle health inequalities.

The key next step is to equip Integrated Neighbourhood Teams the 4 place-based geographies with the data, skills, and processes to enable them to focus their efforts on tackling inequalities and improving population health effectively.

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4 Success measures and population health: Recommendations

Summary of recommendations to agree objectives and success measures with each INT, aligned to local and system priorities

☞*Agree objectives and success measures with each Integrated Neighbourhood Team (balanced scorecard), using the Outcome Measures approach described in the INT framework. The outcome measures should be informed by a combination of local need and system priorities.*

☞*Use the success measures to track progress in each INT and across the system.*

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5

Digital, Technology and Intelligence

The overwhelming consensus from the Listening Exercise is that the current digital enterprise architecture is suited to organisational fit but not to Integrated Neighbourhood Teams enabling a flexible workforce. The enterprise architecture individual design is not the root cause but as you see in some of the scenarios is a symptom of organisational boundaries and bureaucracy and prevents integrated team working for a flexible workforce. The current online experience is fragmented with varying software experiences and sign in's that are bound by organisational barriers. This often leads to duplication in teams capturing data in electronic patient records. Such fragmentation is increasing patient risk with examples given in contraindicated prescriptions and missed test results.

The ambition of 'Integrated Neighbourhood Teams' and breaking down siloed professional and clinical teams is ultimately dependent on having Smart Foundations as set out in What Good Looks Like for an ICS digital enablement. These listening and engagement events greatly influence the requirements for:

- having a system-wide strategy for building multidisciplinary teams with clinical and non-clinical, operational, informatics, design and technical expertise to deliver the ICS digital and data ambitions.
- driving organisations towards 'simplification of the infrastructure' by sharing and considering consolidation of spending, strategies and contracts
- ensuring levelling up of electronic care record systems, including using greater clinical functionality and links to diagnostic systems and Electronic Prescribing and Medicines Administration and to also explore their use in Social care settings.

Health 'What Good Looks Like'

Social care What Good Looks Like

K&M ICS has been developing a digital strategy which puts data analytics at the heart of driving change for patients. The three initiatives will support this:

1. #democratisedata - Through greater use of self-service it will make data simple to access, trusted and embedded within operational and strategic decision-making.
2. #fastdata - By establishing trust and transparency and high levels of data quality across the system we will make available in near real-time data across organisational boundaries to encourage greater collaboration.
3. #dataforpatients - By encouraging patients to engage in understanding data about themselves and their peers we hope to 'nudge' patients into healthier choices and to reduce inequalities between different cohorts of the population.

The Kent & Medway Shared Record (KMCR) also offers the opportunity for sharing information about patients amongst team members drawn from different organisations.
"The Kent and Medway Care Record (KMCR) provides healthcare professionals with a joined-up view of an individual's care and treatment from multiple health providers.
It contains automated, regular data feeds from acute hospital trusts, community services providers, mental health providers, GP practices and social care teams based in local authorities."

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5

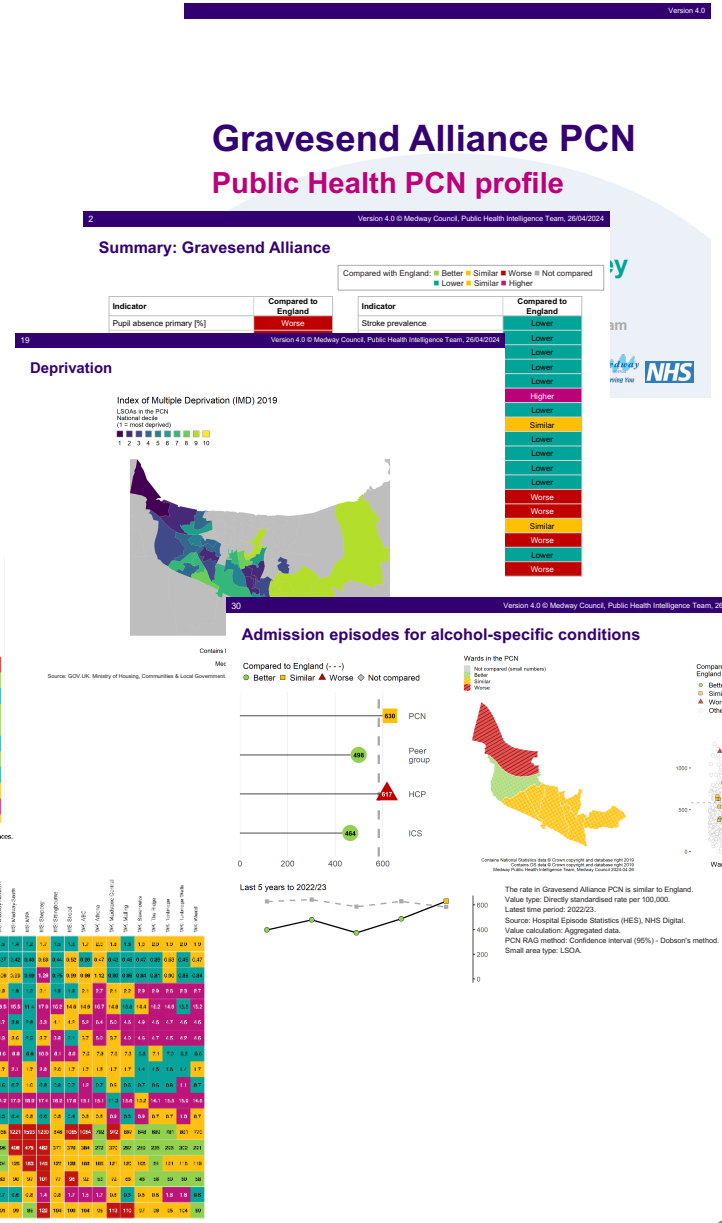
Digital, Technology and Intelligence

Making the most of the existing information and profiles

The K&M HCP and PCN Profiles developed by Medway Council offer the opportunity for HCPs and PCNs to drill down into the detail health needs of their populations.

These powerful profiles will be key in helping to define the natural communities for each INT as well as indicate the areas where local teams can start to focus their integration priorities based on need.

This targeted approach when aligned to the **Developing and Agreeing outcome and success measures for INTs** will allow the INTs to track their impact on shifting improvements in population health.



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5

Estates and Infrastructure Interim Strategy

NHS Kent and Medway

Throughout the listening and engagement exercise the restraint that Estates made to more integrated working was highlighted to us. There is an appetite for creating greater space that can be used by all parts of the INT. A number of people indicated that work could not continue on INTs without addressing the lack of estates capacity.

The K&M interim Estates and Infrastructure Strategy lays out the national and local context building integrated care teams at neighbourhood level. It outlines "*Over recent years we have shifted our focus towards a shared, co-located estate, which can be used by all organisations within the ICS. This will lead to improved utilisation and general estates efficiencies*."

It describes the importance of linking estates investment in addressing inequalities - "*Work has also been undertaken to address health inequalities through our Core20PLUS5 programme. This has helped to identify how estates can support improved models of care and access.*"

It describes "*Our vision is to provide efficient, adaptable and sustainable premises in the right location and condition. This will enable delivery of excellent, integrated health and social care to the communities of Kent and Medway, now and in the future.*"

We are aware of the importance of estates as a key enabler in the development of INTs and each HCP is working on their local Estates Strategies.

National and local context

Our approach is founded on the NHS Long Term Plan, and key national goals for infrastructure...

- **Consolidating non-clinical estate** (as set out in the 2015 Carter Report)
- **Raising funds for investment through disposing of surplus estate** (recommended in the 2017 Naylor Report) and
- **Building integrated care teams at neighbourhood level** (as set out in the 2022 Fuller Stocktake Report)
- **Driving sustainability and delivering a Net Zero NHS** (reflected in our own Green Plan)

...as well as our specific local context in Kent and Medway:

- **Inequality:** Kent and Medway is home to some of the most affluent areas of England, but we also have some of the most (bottom 10%) socially deprived areas in England.
- **Geography:** Kent and Medway has over 350 miles of coastline and a mix of rural and urban areas. Road and rail infrastructure and travelling times for patients, staff and visitors all have an impact on how we plan our estate and the services we provide from it.
- **Population growth:** Our population of 1.9m is expected to grow by 5.4% within the next ten years. Some localities will see much higher growth linked to large scale housing developments. This has implications for how we plan and where we locate our services.
- **Care Strategy:** Our interim Integrated Care Strategy, published in December 2022, sets out our strategy for delivering six shared outcomes. Our estate and infrastructure plays a key role in supporting delivery of these outcomes. For example, a system-led network solution for community diagnostic centres aims to reduce time to diagnosis through improved patient flow. Urgent Treatment Centres and facilities that can provide Same Day Emergency Care are also able to redirect people who would otherwise have visited an emergency department.

The following partners have contributed to development of this strategy:

- Community Health Partnerships (CHP)
- Dartford and Gravesham NHS Trust (DGT)
- East Kent Hospitals University NHS Foundation Trust (EKHUFT)
- HCRG Care Group
- Kent Community Health NHS Foundation Trust (KCHFT)
- Kent and Medway NHS and Social Care Partnership Trust (KMPT)
- Kent County Council (KCC)
- Maidstone & Tunbridge Wells NHS Trust (MTW)
- Medway Community Healthcare (MCH)
- Medway Council (MC)
- Medway NHS Foundation Trust (MFT)
- NHS Property Services (NHSPS)
- NHS South East Coast Ambulance Service NHS Foundation Trust (SECAmb)
- North East London NHS Foundation Trust (NELFT)
- Kent and Medway Primary Care

Our Vision

Our vision is to provide efficient, adaptable and sustainable premises in the right location and condition. This will enable delivery of excellent, integrated health and social care to the communities of Kent and Medway, now and in the future.

To achieve our vision, we will make sure that all estate and infrastructure initiatives, investments and frameworks align with our **8 principles:**

Development must meet identified need of local communities, and be driven by the clinical, health and well-being priorities.	Estate must enable provision of high quality, fit-for-purpose environments which aid patient and staff experience and outcomes. Equality, diversity and inclusion needs will be at the heart of designs.	We will invest in good estate and take every opportunity to dispose of surplus / poor estate that is not economically viable or does not meet our need.	We will optimise the use of all our estate, including partner estate, recognising the drive for greater integration and co-location of services.
Working with partners we will identify greater opportunities to ensure our buildings are used flexibly and as much as possible, recognising changes in societal behaviours and expectations.	There must be a clear commitment to driving forward the sustainability and environmental requirements in everything we plan and do, to meet our climate change commitments.	We will appropriately target our limited investment opportunities, focused on areas of greatest need, that minimises risk and delivers greatest value for money.	We will embrace and future proof our estate with regards to new and emerging digital, clinical and environmental technologies. Our estate will enable safe, high quality, agile clinical and professional working practices that can adapt over the medium and long term.

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5

Addressing the digital and estate infrastructure requirements of INTs: Recommendations

Summary of recommendations to address the digital and infrastructure requirements of INTs

☞*Address the digital architecture to make it better suited to the INTs enabling a more flexible workforce. Ensure a set of minimum requirements while longer term solutions are explored.*

☞ *Engage with the HCP plans for estates to ensure that these support the development of INTs.*

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6 Roles and Responsibilities – our recommendations

Provider Collaborative	• Given the mandate and responsibility to implement the new model of integrated care. • Provide the leadership and constancy of purpose required to deliver this bold ambition. • Be commissioned by the ICB to work with the 4 HCPs to prepare their local delivery plans, which they then compile and review before seeking agreement at the whole system level.
Health and Care Partnerships	• Responsible for nurturing, developing and supporting INTs in their area to flourish and grow. • Less about command and control and more about setting the tone, the culture and the broad context for their autonomy and local accountability. • Continue to build the local partnerships needed and to remove barriers to progress. • Senior leaders in HCPs should take an active mentoring and coaching role for INTs: in touch with their progress & successes, curious about their failures, helping them to learn.
NHS Trusts and Councils	• Assign workforce to INTs and support the establishment of INT leadership teams. • Delegate authority to INTs to act – developing shared governance arrangements.
ICB	• Set the system ambition and strategy to develop Integrated Neighbourhood Teams across Kent and Medway • Align system resources and commissioning plans behind the strategy. • Support short-term transformation funding to enable INTs to develop and change. • Provide the mandate to the provider collaborative and to HCPs to lead.
PCNs	• Enable and support INT development for their population • Review whether there is 1 or more than 1 INT for their area

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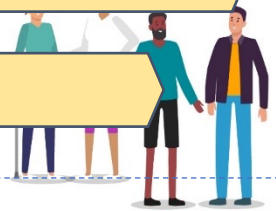
The actions for the next 6 months are part of a multi-year programme

ILLUSTRATIVE

	2024-25	2025-26	2026-27
Neighbourhood level action, supported by HCPs	-Identify first 4 INTs to work with; mobilise -Confirm the named individuals in each INT Action-oriented workshops for each INT to build trust and co-produce new working practices. -Confirm INT leadership -Agree immediate actions -Review -Support	**Expand to next cohort of INTs** -Identify next (say) 25 INTs to work with -Confirm the named individuals in each INT Action-oriented workshops for each INT to build trust and co-produce new working practices. -Confirm INT leadership -Agree immediate actions -Review -Support	**Expand to final cohort of INTs** -Identify next (say) 25 INTs to work with -Confirm the named individuals in each INT Action-oriented workshops for each INT to build trust and co-produce new working practices. -Confirm INT leadership -Agree immediate actions -Review -Support
Action at scale, across Kent & Medway	Agree transitional governance, roles and responsibilities to manage this programme. Agree at HCP and ICS level the key priorities and metrics that INTs are best placed to deliver Agree the alignment of the workforce to INTs for all elements of the NHS family, and from local government and VCSE where possible. Scope, source and establish the ongoing programme of INT team development Create the role profiles, person specs, process to fill appointments and process to identify leadership development needs	**INT operating model prepared March 2025 based on learning from first movers** Ongoing team development and system OD programme delivery Progress agreed actions of existing digital and estate infrastructure workstreams, adding learning from four ‘first-mover’ INT teams.	



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6

Integrated Neighbourhood Teams in the context of our Health & Care Partnerships

The wider system will need to help create the conditions that support the Integrated Neighbourhood Teams to flourish and grow, and ruthlessly focus on removing the barriers that prevent flexibility and adaptation to meet need.

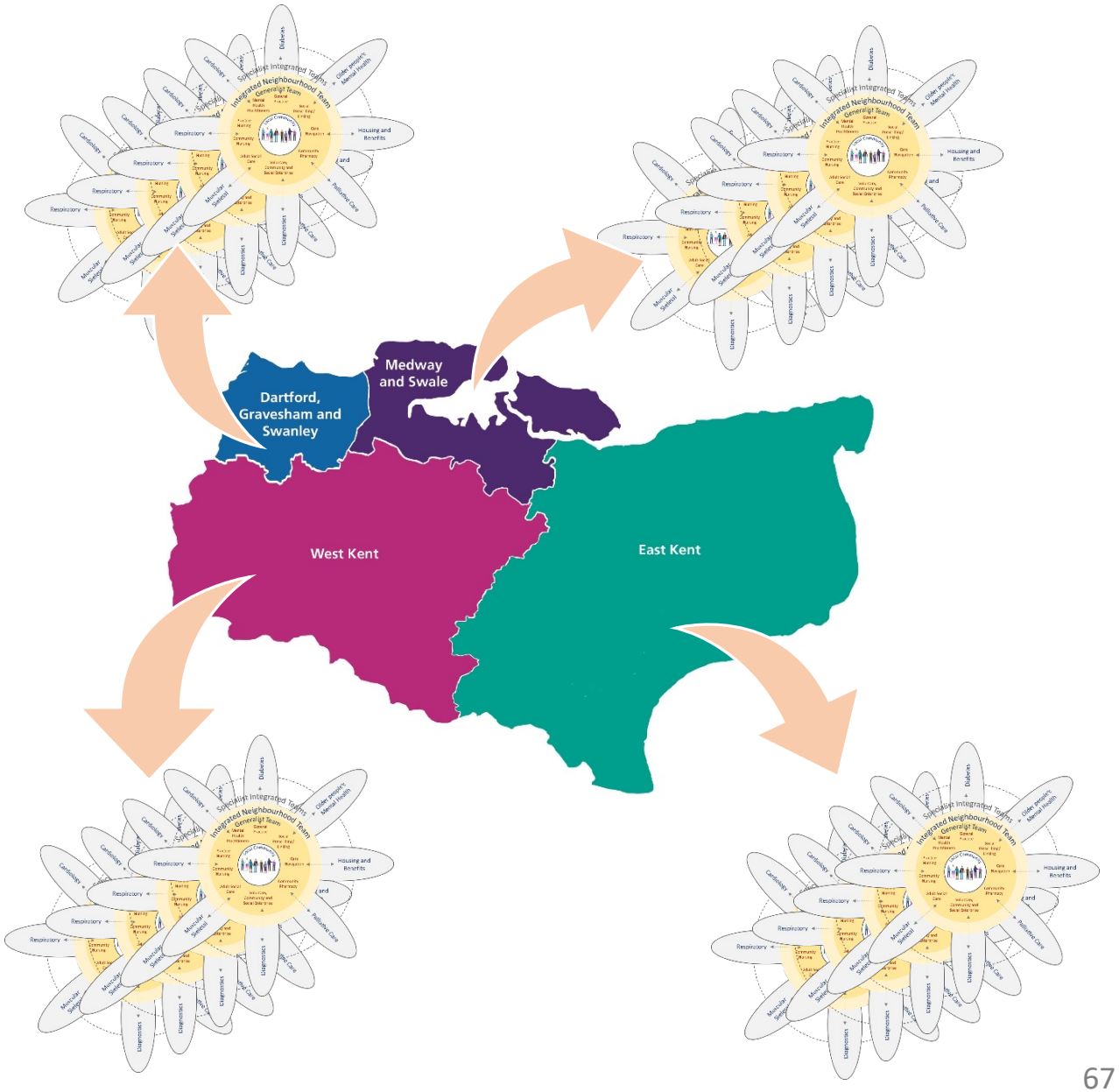
The four Health and Care Partnerships bring together those Partners accountable for delivering the shared Kent and Medway strategy in each area. Partners have balanced and equal voices around the table.

In the context of implementing this plan, their purpose will be to to support and enable the Integrated Neighbourhood Teams to flourish and grow, using this framework as a guide. This is less about command and control and more about setting the tone, the culture and the broad context for their autonomy and local accountability.

They are also accountable for ensuring that the Specialist Services: Acute Planned, Emergency, Physical and Mental Health Services, are connected into the Neighbourhoods and the Neighbourhoods connected into them.

Senior leaders from across the HCPs should take an active mentoring and coaching role for the Integrated Neighbourhood Teams: being in touch with their progress, successes, being curious about their failures and helping them to learn the lessons and promote the sharing and learning across Kent and Medway.

HCPs have a crucial role, taking responsibility for nurturing, supporting and developing the INTs in their area



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6

Learning and improving together – Governance in Integrated Neighbourhood Teams

Through the Engagement Exercise, we heard that some attempts at greater integration in community settings have failed in the past because of governance policies and processes. We also heard a strong view that perhaps things get overcomplicated sometimes in the desire to make things safe for patients, users and our teams.

If Integrated Neighbourhood Teams are to be effective, Kent & Medway will need to develop a new approach to governance. One that supports Teams ***"Doing the right thing"***, not doing ***"things right"*** by their own organisations. It will be a core building block for the culture that underpins effective Team working in a Neighbourhood

Any new approach to Governance in Integrated Neighbourhood Teams will need to be aligned with the Health and Care Partnerships and the accountabilities across/ between Neighbourhood Teams and individual organisations worked through.

We recognise this is a complicated topic and the implications will need to be thought through carefully. As Kent & Medway pushes ahead with this integration journey ahead of other systems around England, there is an opportunity to engage nationally with NHSE and the Care Quality Commission and influence the future direction.

Through the conversations so far, the following principles for a new Governance approach emerged:

1. Our approach to Governance needs to have some simple agreed principles, a shared vision, and defined values and behaviours.
2. We should build our approach to governance around the people the Integrated Neighbourhood Team serves. We should require just one patient or service user story, not require it multiple times.
3. We need to share, and own communication together with patients and service users – same messages, not contradicting.
4. We should be much more trusting of the professional judgement of colleagues when it comes to assessment and triage.
5. Our approach needs to embed shared learning and risk sharing – across organisations within a Neighbourhood
6. It should encourage greater empowerment of people – shared decision making
7. We need to learn from other areas where integration is (if it is) more advanced
8. We need to challenge assumptions we all make about what we can and can't do.
9. The approach needs to reflect our new focus on prevention and a shift towards commissioning for outcomes

Recommendations for roles, responsibilities and system governance

☞ *Bring system partners together to work through how a new approach to governance and accountability that will work at the level of Integrated Neighbourhood Team and up through the mid tiers to the Kent and Medway System as a whole. This should support a culture of "Doing the right thing". Engage with NHSE and CQC in this effort to seek alignment and influence.*

☞ *Agree the sequencing and responsibilities for actioning these recommendations. Encourage the use of proven change management approaches.*

☞ *Identify the risks in the transition to new ways of working and develop the mitigating actions required. Create a robust risk management process to provide assurance that as new teams are formed, they are maintaining at least current levels of quality and safety for patients.*

☞ *Hold the Provider Collaborative accountable for the implementation and delivery of the new model of integrated care. It must provide the leadership and constancy of purpose required to deliver on this bold ambition. The Provider Collaborative should commission each of the 4 geographical areas of Kent and Medway to prepare their local delivery plans, which they then compile and review before seeking agreement at the whole system level.*

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6

Financial, operational and people risks to delivery of this programme

Financial Risks	• System financial constraints limit the investment available to support INT development • Significant financial pressures felt by ASC impact on their ability to form INTs • VSCE reduced funding limits their input
Operational risks	• Impact on providers of community services re-procurement • GP morale and national contract discussions impact on GP and PCN engagement and opportunity for transformation of primary care. • Risk that growing operational pressures in the system take leadership focus and effort away from delivering the development of INTs
People risks	• Risk of insufficient buy-in and support at intermediate management tiers in the system which hinders progress and limits workforce commitment to change

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Appendix

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References

Reed S, Oung C, Davies J, Dayan M and Scobie S (2021) *Integrating health and social care: A comparison of policy and progress across the four countries of the UK* Research report, Nuffield Trust

Thorstensen-Woll, Wellings D, Crump C, Graham C (2021) *Understanding integration - How to listen to and learn from people and communities*, The King's Fund

Bartholomew T, Beresford M, Carlow R, Francis M, Howell J, Prangnell M, Weaver R, Weaver O, (2023) *General practice and secondary care – Working better together*, Academy of Medical Royal Colleges

Creating Sustainable General Practice in Dorset (2023) , Dorset General Practice Alliance

Ham C (2010). *'The ten characteristics of the high-performing chronic care system*'. Health Economics, Policy and Law, vol 5, pp 71–90.

Curry N, Ham C (2010) *Clinical and service integration, The route to improved outcomes*, The King's Fund

Lewis RQ, Rosen R, Goodwin N, Dixon J (2010). *Where Next for Integrated Care Organisations in the English NHS*? London: The Nuffield Trust.

Pink D H, (2009) *Drive, The Surprising Truth About What Motivates Us*, Riverhead Books

McChrystal S, Collins T, Silverman S (2015) *Team of Teams, New Rules of Engagement for a Complex World,* Penguin

Fuller C, (May 2022), *Next steps for integrating primary care: Fuller Stocktake report,* Commissioned by NHS England.

Carter M, West M, Dawson J, Richardson J, Dunckley M (2008) *Developing Team-Based Working in NHS Trusts*, Aston University

Edmondson A C (2018) *The Fearless Organisation, Creating Psychological Safety in the Workplace for Learning, Innovation and Growth*, Wiley

Rosen M, DiazGranados D, Dietz, A, Benishek L, Thomson D, Pronovost P, Weaver S, (2018) *Teamwork in Healthcare: Key discoveries enabling safer, higher-quality care,* American Psychologist

Labonte R. Heart health inequalities in Canada: Modules, theory and planning1992.

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Integrated Neighbourhood Teams Research and Case Studies

June 2024

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Integrated Care Can Lead to Double-Digit Cost and Quality Improvements: A Meta-Analysis of 34 Studies

Overview

A 2020 meta-analysis by the University of Oxford and the International Foundation for Integrated Care reviewed 34 studies on integrated care.

Studies focused on case management, care teams, service coordination, care pathways, and disease management.

Insights

Integrated care reduces costs and improves outcomes.

- **Evidence varies and is of moderate quality with potential biases.**
- Observational studies show better outcomes than experimental studies.
- **Disease management programs are especially effective**.
- European studies show smaller improvements compared to Australia/Asia.
- Longer studies (over 12 months) show better results.

Impact

Total (all 34 studies):

- **Cost: 6%** reduction (1%–10%)
- **Quality: 6%** improvement (5%–8%)

Studies > 12 Months:

- **Cost: 13%** reduction (6%–20%)
- **Quality: 15%** improvement (11%–18%)

For a system spending £10 million annually on chronic care:

- **Savings: £1.3m** gross cost reduction (13%)
- **Quality: 15%** reduction in readmissions, 15% improvement in patient satisfaction

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Integrated Care Improves Quality but Has an Impact on Utilisation: A Systematic Review of 267 Studies

Overview

A 2018 systematic review by the NIHR examined new models of integrated care in developed countries, including the UK. The review included 267 studies and is perhaps the most comprehensive available.

Studies focused on MDTs, case management, patient-centred medical homes (PCMHs), accountable care organisations (ACOs), integrated care pathways, health and social care integration, telehealth and digital health solutions, and shared budgets and resource allocation.

Insights

Workforce Engagement: Effective staff engagement, including training and role clarity, is crucial. High GP involvement and strong leadership significantly influence positive outcomes.

Shared Goals: Developing common values, beliefs, and priorities among staff and organisations is vital for creating a unified identity and achieving alignment in integrated care initiatives.

Multicomponent Initiatives: Single-element interventions, like case management or MDTs, should be part of broader multicomponent strategies to improve outcomes.

Impacts

- Integrated care models generally **improve patient satisfaction and quality** of care.
- 15 out of 21 UK studies reported **reductions in hospital stay lengths** and Six studies noted **fewer outpatient appointments**.
- **The impact on healthcare utilisation is inconsistent** e.g. scheduled and unscheduled admissions, readmissions, and emergency department.
- **The impact on healthcare costs is unclear,** with some studies noting cost reductions and others finding no significant change.
- Integrated care models **may reduce patient waiting times** and outpatient appointments, particularly in end-of-life care scenarios.

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Chronic Disease - Integrated Care Can Yield Reductions in Utilisation: A Review of 50 Systematic Reviews

Overview

A 'first of its kind' 2016 study by Birmingham University, published in the BMJ, reviewed 50 systematic reviews and meta-analyses on the impact of integrated care on hospital activity for patients with one or more chronic diseases.

Studies focused on case management, chronic care model, discharge management, complex interventions, MDTs and self-management.

Insights

Interventions were most effective when targeting **single chronic conditions** and providing care in patients' homes.

Patients with **diabetes** show the greatest utilisation reduction compared to vascular disease and respiratory illness[1].

Interventions with **multiple components**, such as those of the Chronic Care Model (CCM), were more effective than single-component ones.

MDT care with teams including **condition-specific expertise**, specialist nurses, and/or pharmacists, and **self-management** adjuncts, was effective.

Discharge management with post-discharge support was also effective.

Impact

- **58%** (29/50) of reviews reported improvements in **at least one utilisation outcome**
- **44%** (4/9) showed significantly lower **A&E attendance** (30–40%)
- **52%** (11/21) reviews reported significantly reduced **emergency admissions** (15–50%)
- **46%** (11/24) showed significant reductions in all-cause (10–30%) or condition-specific (15–50%) **readmissions**
- **56%** (9/16) reported **LoS** reductions of 1–7 days
- **40%** (10/25) reviews reported significant **cost reductions** but provided **little robust evidence**
- The greatest cost reduction was for diabetics, with a saving of **£668** per patient per year[1]

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Older People - Integrated Care can Reduce Healthcare Utilisation: A Review of 46 Studies

Overview

The 2019 systematic review examined 46 studies on the cost-effectiveness of interventions aimed at preventing frailty and managing complex health issues in older adults.

Interventions included
Comprehensive Geriatric Assessment (CGA) and care planning, case management programs, multidisciplinary teams, home visits, health education, frailty screening, and coordination of health and social services.

Insights

Most studies do not show overall utilisation and cost savings, but when they do they: -

1. Use primary care **screening tools** to identify high-risk individuals and focus resource on **community** and home-based care.
2. Emphasise **prevention education** and support **self-management** through home-based interventions to foster independence.
3. Implement single-entry service points, utilise **remote monitoring**, and manage chronic conditions proactively with **coordinated case management**.
4. Tailor interventions to address individuals' **biopsychosocial** needs.
5. Train **staff** in frailty management and involve and support **caregivers** in care planning and education.

Impact

- **Economic Impact:** Evidence is mixed; some studies show cost savings while others show high costs per quality-adjusted life year.
- **Admissions and Length of Stay:** Integrated care models may reduce hospitalisation rates and duration of hospital stays.
- **Patient Satisfaction and Readmission:** Results vary, with some studies showing improvements and others not, depending on the specific model.
- **Mortality:** Integrated care models generally do not impact mortality rates.

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Community Health and Wellbeing Workers Improve Service Uptake and Reduce GP demand

Overview

The Community Health and Wellbeing (CHWWs) initiative aims to reduce health inequalities in deprived communities by providing personalised, proactive health and social care.

Inspired by Brazil's Family Health Strategy, CHWWs are embedded within communities, visiting residents monthly to identify and address health issues early.

Insights

Initial integration into general practice was slow due to staff shortages and turnover, but positive trends are now emerging.

CHWWs successfully **built trust and relationships**, with less than **17%** of households refusing the service.

Unmet medical needs were effectively addressed, including **A&E avoidance and suicide prevention**, with fewer non-medical consultations.

Regular community activities, like coffee mornings, **enhanced social connections** and trust within the community.

Impact

- CHWWs **increased overall service** uptake by 40%, immunisation by 47%, and cancer screening and NHS Health Checks by 82%.
- **GP consultations decreased** by **7.4%** in the intervention group, compared to 0.6% in the control group.
- CHWWs **provided holistic support** with housing, employment, and social prescribing, enhancing overall wellbeing.
- One resident described her community health and wellbeing worker as her "**saviour**".

Case Studies: NAPC

Integrated Nursing in Mid Dorset Locality

Since 1998, several practices in Mid Dorset have implemented an integrated district and practice nursing model (INT). This includes Cerne Abbas, Milton Abbas, and Puddletown practices, covering 27% of the locality population.

A&E Admissions: National A&E admissions increased by 13%. Mid Dorset practices without Integrated Nursing Teams (INT) saw a 40% increase, while those with INT experienced a 22% increase. This results in potential annual savings of £320k, discounted to £96k, due to reduced growth in admissions.

Bed Days: National bed days increased by 0.5%. Mid Dorset practices without Integrated Nursing Teams (INT) saw a 7.6% increase, while those with INT experienced an 11.6% decrease. This results in potential annual savings of £500k, discounted to £150k.

Patient Experience: 80% of patients in INT practices rated their experience as very good (vs. 60% in non-INT practices and 43% nationally). 84% would recommend their GP (vs. 63% in non-INT practices and 47% nationally)

Return on Investment: The estimated additional cost for operating the INT model is £69k annually. With a combined potential saving of £171k from reduced A&E admissions and bed days, the return on investment is approximately 2.5, alongside significant improvements in patient satisfaction.

Staff Feedback: The INT model enhances patient-focused care, continuity, and resilience among healthcare teams, improving overall patient and staff satisfaction.

This case study illustrates the positive impact of integrated nursing models in reducing healthcare utilisation and costs while improving patient experience in Mid Dorset.

Case Studies: NAPC

Aging Well Programme in Calderdale

Implementation and Approach: Started in Upper Calder Valley PCN, expanding with funding for Ageing Well Practitioners. Integrated teams of health, social care staff, and voluntary sector roles including social prescribers. Utilised anticipatory care, personalised care plans, and regular multidisciplinary meetings.

Patient Outcomes: Increased ability to manage health, Improvements in BMI and blood pressure; average BMI decreased by 1.2 points, systolic blood pressure dropped by 2 points.

Healthcare Utilisation: Reduction in GP contacts and hospital costs; GP appointments dropped from 6.1 to 5.5 annually, average hospital costs reduced by £155 per patient, and hospital visits decreased by 0.25 annually per patient.

Challenges and Opportunities: Building integrated teams and ensuring broad team understanding. Expanding the team, upskilling, incorporating independent prescribers, and enhancing medication reviews.

The programme showcases the effectiveness of integrated care in improving health outcomes and reducing healthcare utilisation and costs among older adults.

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Case Studies: Kings Fund

Care for Older People in Torbay

- **Integrated Teams:** Care is provided by integrated teams of health and social care staff, initially piloted in 2004 and expanded throughout the area.
- **Locality-Based:** Each team serves 25,000 to 40,000 people and is aligned with local general practices.
- **Flexible Budgets:** Teams use pooled budgets flexibly to meet older people's specific needs.
- **Intermediate Care:** Focus on spending to support older people at home, reducing hospital admissions.
- **Positive Outcomes:** Reduction in occupied beds from 750 (1998/99) to 502 (2009/10), lowest emergency bed day use in the region for 65+, negligible delayed care transfers.
- **Residential Care Reduction:** Since 2007/8, responsibility for 144 fewer people in residential care, with increased home care services for prevention and low-level support.

Diabetes Care in Bolton

- **Establishment:** The Bolton Diabetes Centre, established in 1995, comprises a team of community-based specialists.
- **Collaborative Care:** The team collaborates with the local hospital for inpatient care and with general practices for shared consultations.
- **Right Place Right Time:** Aim to deliver care at the appropriate place and time by the right professional, striving for a fully integrated diabetes service without gaps or duplication, ensuring quick referrals from primary to specialist care.
- **Satisfaction and Outcomes:** Patients and staff report high satisfaction levels, with Bolton having the lowest number of hospital bed days per person with diabetes in Greater Manchester in 2005/6.

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Case Studies: Kings Fund

Stroke Care in London

- **Implementation:** London introduced a pan-London stroke care pathway and developed eight hyper-acute stroke units.
- **Access and Efficiency:** 85% of high-risk stroke patients are treated within 24 hours, compared to the national average of 56%.
- **Dedicated Stroke Units:** 84% of patients spend at least 90% of their time in a dedicated stroke unit, compared to the national average of 68%.
- **Performance:** Five of the top six performing hospitals in the National Sentinel Audit for Stroke are London-based hyper-acute stroke units.

Chronic Care Management in Wales

Demonstrators: Three Chronic Care Management Demonstrators in Carmarthenshire, Cardiff, and Gwynedd Local Health Boards pioneered coordinated care strategies.

Shared Care Model: Employed a ‘shared care’ model involving primary, secondary, and social care, with investments in multidisciplinary teams.

Results: Reported reductions in emergency bed days for chronic illness by 27%, 26%, and 16.5% respectively from 2007 to 2009.

Cost Savings: Achieved an overall cost reduction of £2,224,201 (NHS Wales 2010).

Case Studies: NHSE

Integrated Care in Birmingham

Aim and Approach: To prevent unnecessary hospital admissions, reduce delays in discharge, and support independent living.

Solution: A partnership of over 1000 staff from six organisations delivered Early Intervention (EI) services. The approach was tested over four months, focusing on rapid, appropriate care coordination involving health, social care, and voluntary sector resources.

Results: Prevented over 10,000 hospital admissions, saved 90,000 bed days annually, and reduced care home admissions, with a financial benefit of £26.7 million.

Challenges: The previous system was fragmented, with inefficiencies in elderly care and discharge processes.

Learning Points: Integrated multi-professional teams streamlined care, ensuring effective navigation and reduced patient care needs post-discharge.

Mental Health Crisis Response in London

Aim and Approach: The scheme aims to reduce mental health hospital admissions by dispatching a specialist nurse and paramedic team to respond to mental health crises.

Solution: When an emergency call is received, call handlers and mental health nurses in the control room decide whether to dispatch the mental health car. At the scene, the team assesses both mental and physical needs, providing immediate care and directing patients to appropriate services.

Results: Expected to reduce hospital admissions from 58,000 to 30,000 per year, improve patient care, and prevent unnecessary hospital trips.

Challenges: Previous systems often directed patients to emergency departments, which are not always suitable for mental health crises.

Learning Points: The integrated approach ensures patients receive appropriate care closer to home, highlighting the importance of collaboration between health and social care professionals.

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Measuring the Success of Integrated Neighbourhood Teams (INTs)

Kent & Medway ICB

A How-To Guide for Developing Locally-Important Measures of Integration

WORKING DRAFT

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This document is to aid clinical leaders in developing metrics that will help build the evidence base for integrated neighbourhood teams

What and who is this document for?

This document has been produced to aid **clinical leaders** in **developing metrics that will help measure within their own teams:**

1. Whether or not 'integration' is taking place, and
2. The effectiveness of integrated neighbourhood teams (INTs)

The aim is that this will help teams **build the evidence base for INTs** and provide leaders with the evidence they need **to continue building successful integrated teams**.

Note: you may wish to use this in conjunction with other toolkits that have been developed by quality improvement teams in Kent & Medway – there is not a singular approach to outcomes development.

What's inside?

The document is split into four main sections:

1. **Introduction** – provides the context to integrated neighbourhood teams (INTs) in Kent & Medway and the outcomes measurement challenge
2. **The Outcomes Development Process** – takes individuals through the methodology and rationale of outcomes development
3. **Examples of Outcome Measures for INT** – this comprises specific examples of metrics for three 'typical' INTs focusing on frailty, mental health and homelessness
4. **Generic Measures** – a list of other generic measures that individuals may wish to consider when developing their own outcome framework

The appendix contains some information on tools that may be useful to measure employee satisfaction, team effectiveness and team climate.

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The measurement challenge: there is no fixed definition of an ‘INT’ and there are many different types and levels of integration

What are ‘integrated neighbourhood teams’ (INTs) / What is ‘integrated neighbourhood working’?

An ‘INT’ comprises a group of professionals from across primary/ secondary/ community/ local authority/ charitable sectors who come together to share joint responsibility for a cohort of people in their locality.

These cohorts might be identified through population health management tools or through local expertise/knowledge. The expectation is that working in this holistic and more proactive way eases the burden on the neighbourhood/ system as a whole and reduces the risk of escalation to hospital-based care.

‘INT’ or ‘integrated neighbourhood working’ is not a formal one-size-fits-all organisational entity, and many already working in this way may not necessarily use this terminology.

The different types and levels of integration*

- **Organisational integration** focuses on coordinating structures and governance systems across organisations, such as organisational mergers, or developing contractual or cooperative arrangements.
- **Administrative or functional integration** involves joining up non-clinical support and back-office functions, for example, accounting mechanisms or sharing data and information systems across organisations.
- **Service integration** involves the coordination of different services, such as through multidisciplinary teams, single referral structures, or single clinical assessment processes.
- **Clinical integration** involves the coordination of care into a single or coherent process, either within or across professions. This could involve developing shared guidelines or protocols across boundaries of care.

* Nuffield Trust: Integrated Care Explained

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Stakeholders have competing priorities and pressures which means there is often disagreement about what to measure and the value of these measurements

We need accountability and evidence to justify spending decisions

We want the freedom to measure what we think is important to provide the best service we can

We want to live well and have a voice in how local services are designed

ICB

Integrated Neighbourhood Team

People

A compromise is to agree a small set of core measures linked to overarching strategic outcomes, with local teams and people able to establish measures that are locally-relevant to their services and the people they provide for.

Core set

Metrics to satisfy the centre

+

Locally agreed

Metrics to motivate teams

Metrics that matter to people

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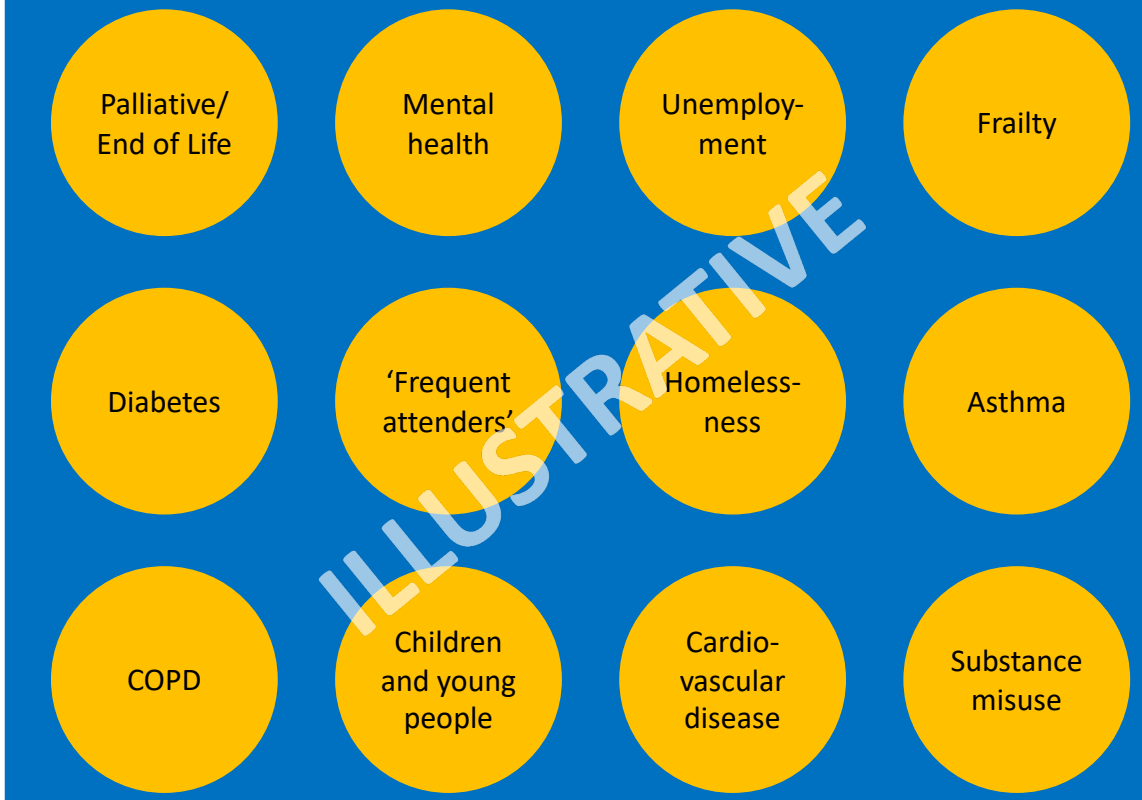
There is a whole range of areas that local teams may wish to focus on; Kent & Medway's strategy outcomes have a wider relevance to these

Examples of INT cohorts/clinical areas that may be local priorities



Kent & Medway Integrated Care Strategy Outcomes

1. Give children and young people the best start in life
2. Tackle the wider determinants to prevent ill health
3. Supporting happy and healthy living
4. Empower people to best manage their health conditions
5. Improve health and care services
6. Support and grow our workforce

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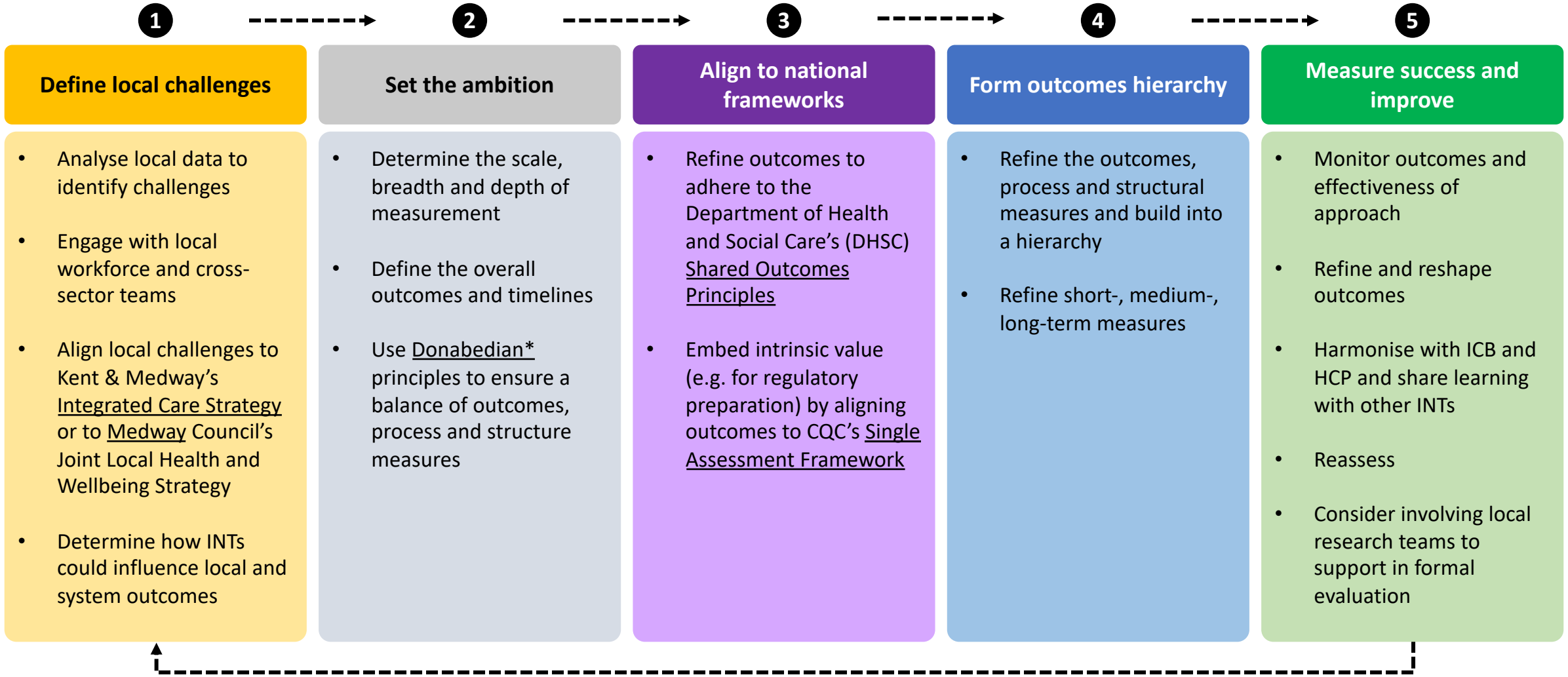
Teams should use a quality improvement approach and Donabedian principles to develop locally relevant integration measures which are tied to system priorities



* NHS Improvement: A model for measuring quality care

1

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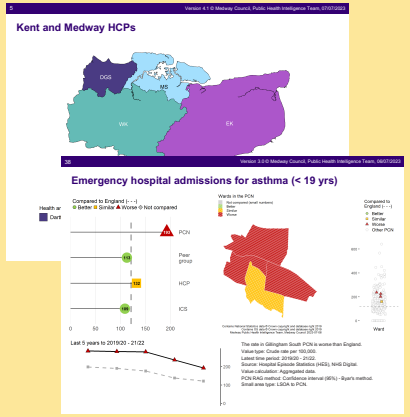
Local challenges should be identified by speaking to staff and using available data platforms; communities and cross-sector teams must also be involved

Define local challenges

i ⟶ ii ⟶ iii ⟶ iv ⟶ v

Contextualise

While local leaders will be acutely aware of the challenges their neighbourhoods face, they may find it useful to contextualise their local knowledge using Medway Council's Healthcare Partnership (HCP) and Primary Care Network (PCN) profiles.



Corroborate

Frontline staff should be given the opportunity to provide feedback on how the service can be improved.

Platforms such as GraphNet, sidm health, and APEX (by Edenbridge) should be used to further corroborate local expert knowledge:

Graphnet Transforming Care

sidm systems

edenbridge

Co-Produce

Communities should be given the opportunity to communicate their local priorities and influence outcomes, e.g. via patient participation groups (PPGs).

Healthcare priorities should not be decided in isolation and instead informed through engagement with primary, secondary and community care.

Wider sectors partners (e.g. from social care, VCSE) must also be involved in outcomes development.

Circumstance

Determine which priorities/ population(s) most likely to benefit from a multi-modal cross-sector approach.

This may include cohorts of patients whose care is often affected by interface issues within healthcare and with other services.

Most likely to include cohorts of patients whose quality of care is interdependent on other services.

Co-ordinate

Identify aspects of the service that are important and translate these into indicators that can be used to assess change over time.

Priorities should align to:

- Kent & Medway Integrated Care Strategy Outcomes, or
- Medway Council's Joint Local Health and Wellbeing Strategy

The Kent & Medway Logical Framework (Logframe) **objectively verifiable indicators (OVIs)** (if relevant) could be used as the basis for agreeing the 'core set' of outcomes that the INT aims to affect.

1

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Teams may find it helpful to use a logical framework ('logframe') approach to define their local challenges and how to address them

Define local challenges

Step 1: Define the challenge you are facing

Children and young people have high rates of emergency attendances and admissions for asthma

Why? Why?

Step 2: Ascertain why it is occurring

Poor knowledge of asthma triggers, poor ability to recognise symptoms, poor asthma technique

High exposure to environmental triggers at home

Why? Why?

Poor education of children, parents and carers

Lack of interventions to reduce home environmental triggers

Step 3: Translate into solutions/future statements of ambition

Goal

Children and young people will have lower rates of emergency attendances and admissions for asthma

Purpose

Better knowledge of asthma triggers, poor ability to recognise symptoms, poor asthma technique

Lower exposure to environmental triggers at home

Outputs

Better education of children, parents and carers

More interventions to reduce home triggers

Current Challenge → **Future Aspiration**

2

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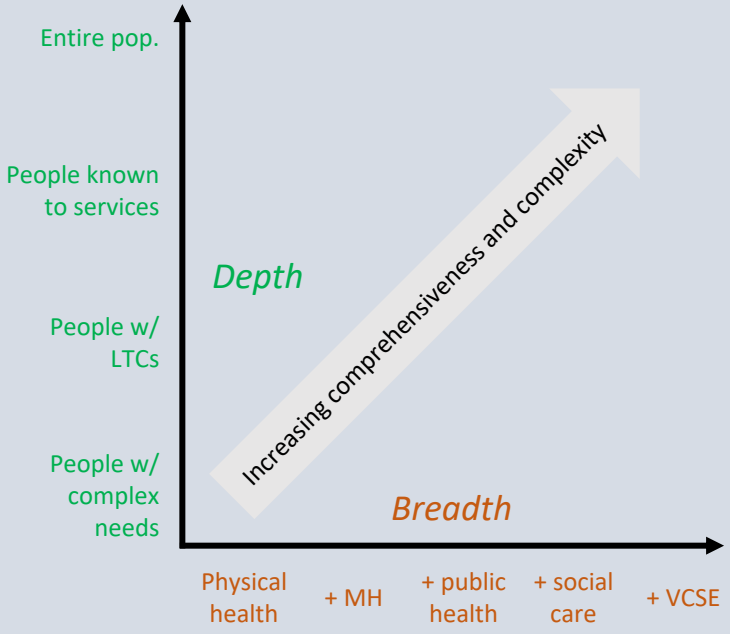
Measurement ambitions should be set by the service function and data constraints, and developed according to Donabedian principles

Set the ambition

i → ii → iii

Determine the breadth and depth

Breadth of measurement (i.e. the range of sectors involved in measurement) and depth (i.e. the measured population) should be determined based on how the local INT is expected to influence outcomes and data considerations (e.g. whether there is an **established reporting process**, **timely meaningful comparators**, **availability** at ward/LSoA/PCN level).



Donabedian principles

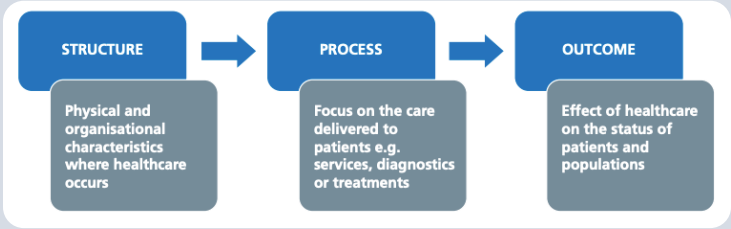
All evaluation approaches should have three components - **structure, process and outcomes** – alongside balancing measures.

Outcome measures reflect the impact on the patient (e.g. mortality, length of stay, emergency admissions).

Process measures reflect the way systems and processes work to deliver the desired outcome (e.g. if a patient receives certain standards of care or not, recording of incidents and acting on the findings).

Structure measures reflect the attributes of the service (e.g. staff:patient ratios and operating times of the service.

Balancing measures reflect unintended and/or wider consequences of the change (e.g. monitoring emergency re-admission rates following initiatives to reduce length of stay).



Define overall outcomes

Outcomes should be SMART* with a range of short-, medium, and long-term measures that address **access**, **continuity** and **health inequalities** (e.g. CORE20PLUS5)**.**

'Core set' and 'Locally agreed' outcomes must be negotiated between the ICB, HCP and neighbourhood teams.

Those involved may wish to choose their own measures, or may wish to select measures from various useful lists:

- **Policy Innovation Research Unit (PIRU):** Indicators for measuring the quality of integrated care - Appendix A
- **Nuffield Trust:** Integrating health and social care - Page 75/76
- **Institute for Public Policy Research (IPPR):** Delivering on the promise of integration in health and care - Page 23
- See Appendix in this document for further examples

Consider available data sources for selected measures, e.g.

- NHS Outcomes Framework
- Adult Social Care Outcomes Framework
- Emergency Care Data Set (ECDS)
- GP Data (Appointments, QOF, Workforce, GPPS)
- Hospital Episode Statistics (HES)
- Secondary Uses Service (SUS)
- Fingertips

*Specific, Measurable, Attainable, Relevant, and Time-Bound

3

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Outcomes selected should align to DHSC shared outcomes framework principles and it may be useful to consider how they would help with CQC assessment

Align to national frameworks

i → ii

Department of Health & Social Care

Shared Outcomes Framework Principles[1]

Check that your chosen outcomes align to the principles below and adapt if not:

1. Focused on the population at place level (**or other system levels where appropriate**)
2. Creates a **shared vision and brings organisations together**
3. **Supports relationships and cultural change**
4. **Minimises burden** to organisations within the place
5. Focused on **local outcomes**, not organisational processes or outputs
6. **Complements existing responsibilities and regulatory frameworks**
7. **Embeds organisational mutual accountability** for delivery and progress

CareQuality Commission

Single Assessment Framework[2]

The CQC assessment framework is made up of 5 key questions and, under each key question, a set of quality statements.

The 5 key questions are the things CQC asks of all health and social care services. CQC asks if they are:

- **Safe**
- **Effective**
- **Caring**
- **Responsive to people's needs**
- **Well-led**

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care.

It may be helpful to consider how your chosen metrics could be used as evidence for CQC.

1 DHSC – Shared outcomes toolkit for integrated care systems

2 CQC – Single Assessment Framework

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Before developing an outcomes hierarchy, it may be helpful to think about what structures need to be in place to achieve change and the holistic patient journey

Form outcomes hierarchy

Structure Measures

Workforce
- What cross-sector relationships currently exist and how can we build on them? Who has accountability?
- What staff and other resources are required to deliver this service?
- Which sectors should be involved in delivery?

Education
- Do we have processes in place to adequately train staff for the service?
- Do we have a quality improvement lead for the service?

Infrastructure
- What digital/data infrastructure is required to deliver the service?
- What physical infrastructure (e.g. estates, equipment) will be required for the service?

Holistic Patient Journey

Proactive

- Identification of those at risk and prevention
- Identification, segmentation and management of those with the condition and risk reduction
- Ongoing management of high-intensity users including effective transfer of care

Reactive

Achieving Change

Starting position ---------- **End goal**

Workforce activation → *Workforce behaviour change* → *Patient activation* → *Patient behaviour change* → *Patient health improvement* → *Demand reduction*

4

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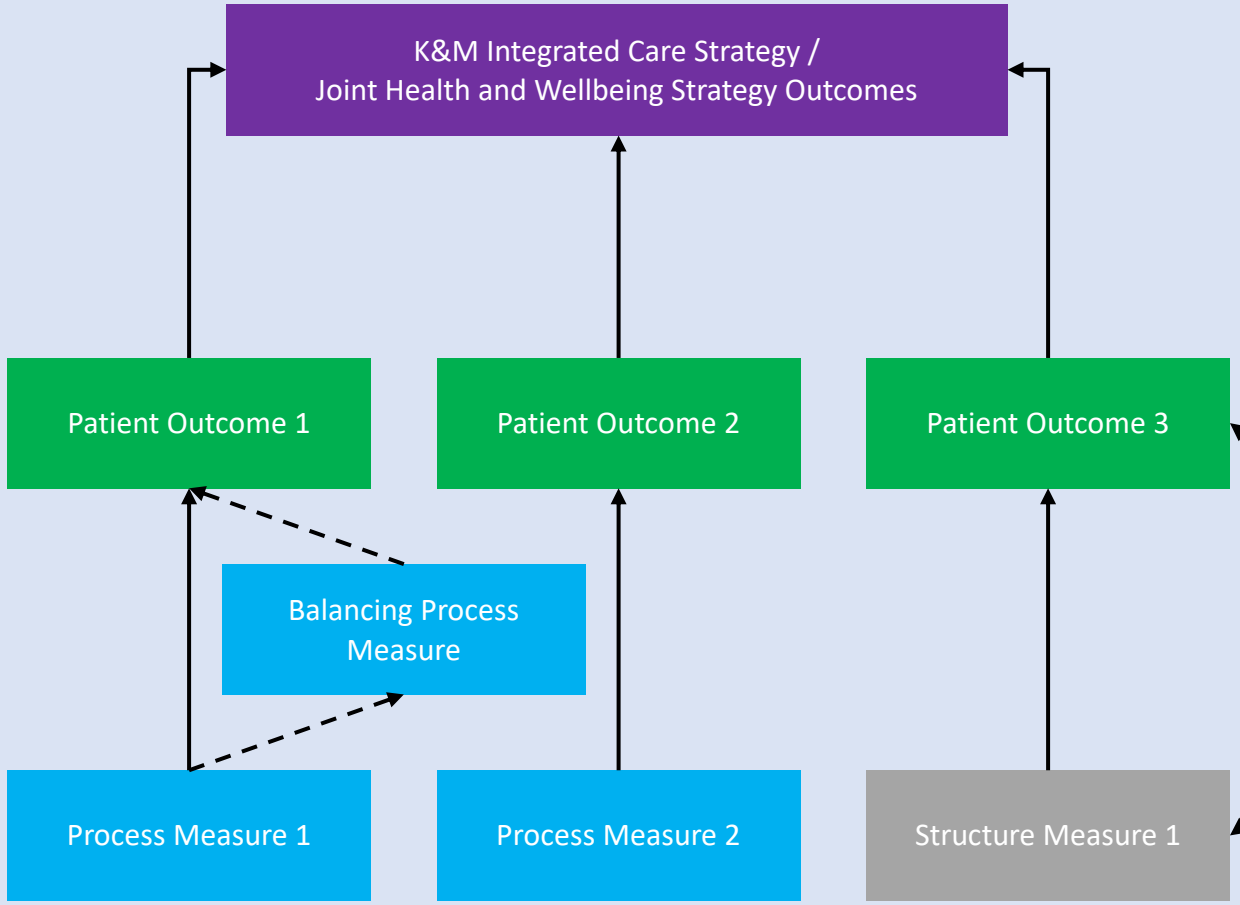
Measures should be built into a hierarchy so that the relationship between structure/process measures and patient outcomes can be determined

Form outcomes hierarchy



Sense Check for Metrics

1. Is it **SMART**?
2. Is there a **timely/easy process for obtaining the metric**?
3. Is it available at GP/PCN/HCP/ICB level?
4. Will the metric help **bring about change**?
5. Is it necessary to have a balancing measures (e.g. length of stay impact on readmission rates)
6. Does the metric help **build a collective lens** for bringing organisations together?
7. Is it **minimally burdensome** to measure?
8. Might it complement / be useful for CQC?
9. Is there a balance of **process, structure and patient outcome** measures?
10. Do I have metrics for **access, continuity and health inequalities**?

Core Set

Objectively Verifiable Indicator (OVI)*

**Where relevant, OVIs from the Kent & Medway Integrated Care Strategy Outcomes Logical Framework may be inserted into the outcomes hierarchy to form part of the 'core set' of metrics that the ICB/HCP may wish to monitor.*

Key Strategic Outcome | Patient Outcome | Process Measure | Structure Measure

5

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Over time, outcomes should be monitored and refined, with efforts to eventually harmonise outputs at Place/ICB level if appropriate

Measure success and improve

i → ii → iii

Monitor outcomes and effectiveness of approach

Engage with ICB and HCP integrated data teams to agree best approach for capturing information and demonstrating success.

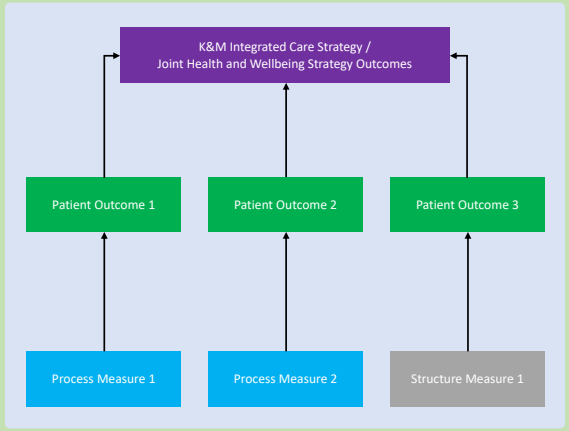
Ideally short-, medium-, and long-term measures should be monitored.

Consider whether balancing measures are needed to be accommodated into your outcomes measures (e.g. how readmission rates might be impacted by initiatives that aim to reduce length of inpatient stay)

Effectiveness of approach should be reviewed according to ease of data collection, data quality, ability to process and ability evaluate data.

Refine and reshape

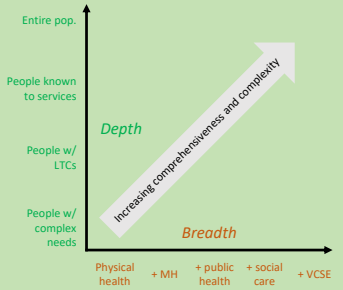
Outputs, processes and inputs should be refined according to how the service evolves.



Harmonise with Place and ICB

Efforts should be made to share outcomes measurement learning with Place and ICB in a view to harmonising outcomes wherever possible.

Reassess the ambition of measurement, including scale, breadth and depth of measurement.



Tip: when first evaluating your outcomes, it might be initially better to use a 'fail quickly' approach whereby you focus on short-term measures. An example of this might be assessing your interventions and outcomes every month over six months, rather than once over six months. While each cycle is shorter, you are likely to gain valuable insights on how to improve your service more quickly from shorter cycles in the short-term before moving to medium- and long-term measures to build a better evidence base.

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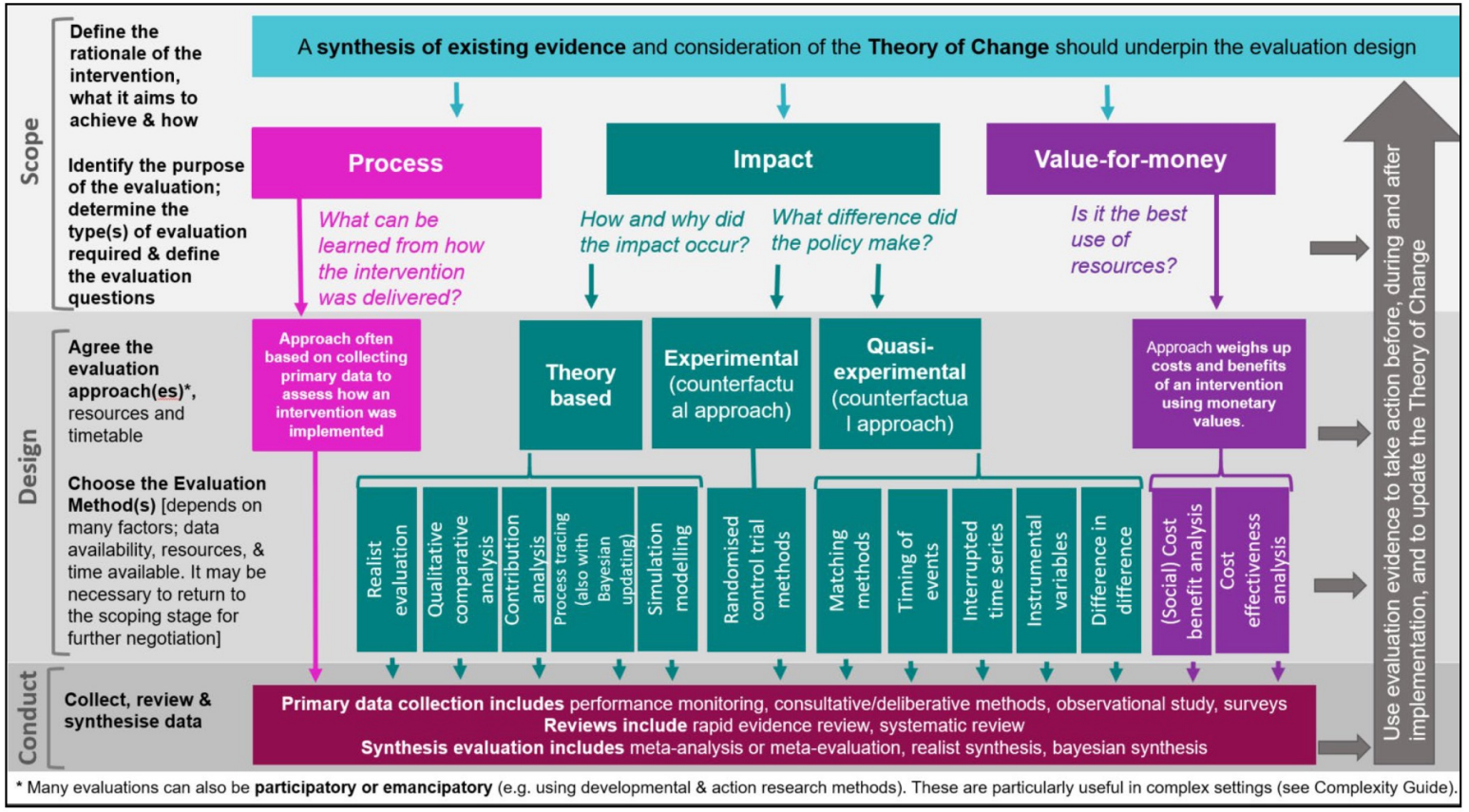
Teams should also consider involving their local research teams from Kent or Medway County Council who can assist in formal scoping, design and evaluation

Formal Research and Evaluation

- Local research teams can assist with formal evaluation, including support for generating insights around financial sustainability and workforce planning.
- The use of, for example, counterfactual/natural experiment/matched controls (as demonstrated in the adjacent figure from HM Treasury Magenta Book) can help teams build a stronger evidence base for research purposes.
- Teams are encouraged to seek support from local research teams to aid in evaluation – in particular they can help in measuring system impact and what other opportunities may be available for improvement

Figure 2.1: Scoping, designing and conducting an evaluation



HM Treasury - The Magenta Book - Guidance on what to consider when designing an evaluation

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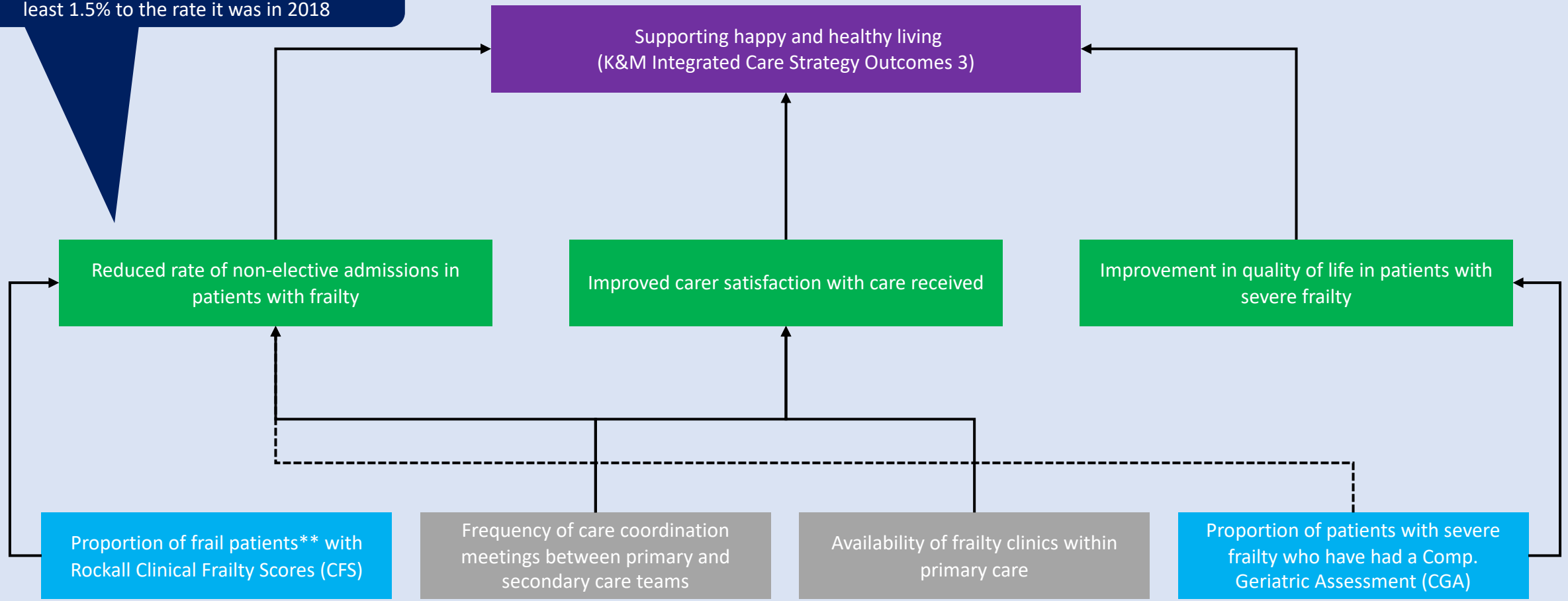
Frailty: an example outcomes hierarchy (illustrative, not exhaustive)

Frailty

OVI*: By 2028, the rate of emergency admissions for those who are frail will have reduced by at least 1.5% to the rate it was in 2018



Key: Strategic Outcome | Patient Outcome | Process Measure | Structure Measure

*Objectively Verifiable Indicators are from Kent & Medway's Logical Framework (see Slide 9)

**e.g., as identified with EFI by KMCR

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Frailty: list of example patient outcomes, process measures and structure measures

Frailty

	Patient Outcomes
General	Quality of life in patients with severe frailty
	Health-related quality of life for people with long-term conditions
	Carer satisfaction with care received
	Injuries due to falls in people aged 65 and over
	Proportion of people dying at place of their choosing
Primary	GP Patient Survey questions (relevant to service)
	Rate of urgent GP appointments for patients with frailty
Secondary	Rate of A&E attendances in patients with frailty
	Rate of non-elective admissions in patients with frailty
	Rate of unplanned readmissions within 30/60/90 dates of discharge from hospital
Community	Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement/rehabilitation services
	Proportion of patient with severe frailty maintaining independence
	Proportion of patients with fractures recovering to their previous levels of mobility at 30 days

	Process Measures
Diagnosis	Proportion of frail patients (e.g. EFI as identified by KMCR) with Rockall Clinical Frailty Scores (CFS)
	Estimated diagnosis rate for people with dementia
Standard of Care	Proportion of patients with (severe) frailty who have had a Comprehensive Geriatric Assessment (CGA)
	Time from identification of frailty to CGA
	Proportion of patients with (severe) frailty who have been assessed by a frailty MDT within the last year
	Proportion of patients with (severe) frailty who have a ReSPECT form / Advanced Care Plan
	No. of structured medication reviews
	Proportion of patients with severe frailty on palliative care register
Cont.	Proportion of GP appointments with named GP
	Proportion of nurse appointments with same nurse
Resource Use	Admissions to residential and nursing care homes
	Ambulance calls/conveyances from nursing homes
	Number of GP home visits for frail patients
	Hospital use in last 100 days of life
Staff	Frequency of work duplication reported by staff
	Proportion of time spent on high/low value processes

	Structure Measures
Workforce	Availability of appropriate staff for integrated frailty service (e.g. GPs, geriatricians, frailty nurses, PT/OTs, social workers, pharmacists)
	Availability of social prescriber
	Staff satisfaction
	Staff retention
Infrastructure	Availability of frailty clinics (e.g. within the community or in primary care)
	Availability of shared care record for all members involved in the MDT
	Availability of virtual wards
	Frequency of care coordination meetings between primary and secondary care teams
	Frequency of care coordination meetings between health and social care teams
	Frequency of care coordination meetings between health, social and VCSE teams
Education	QI training availability
	Digital transformation training availability
	Cross-sector training opportunities

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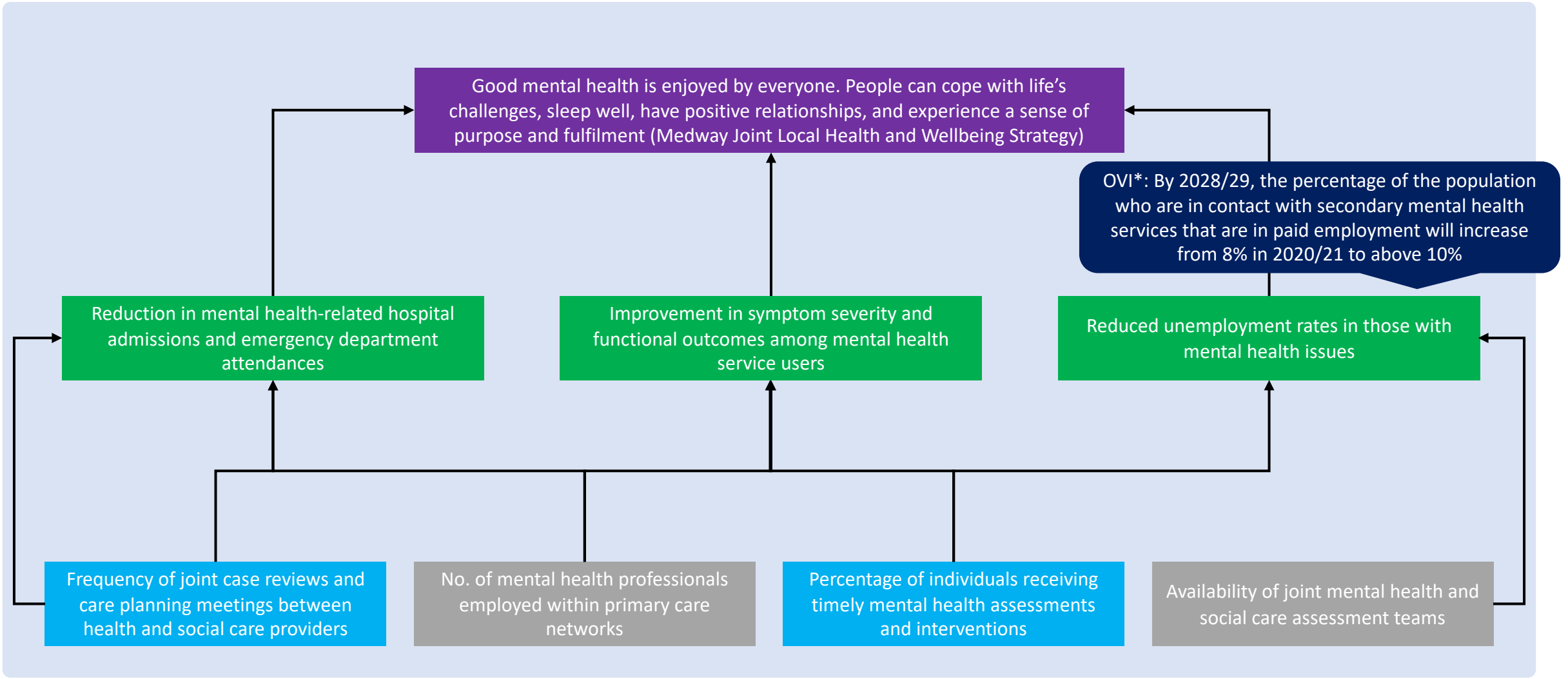
Mental Health: an example outcomes hierarchy (illustrative, not exhaustive)

Mental Health



Key Strategic Outcome | Patient Outcome | Process Measure | Structure Measure

*Objectively Verifiable Indicators are from Kent & Medway's Logical Framework (see Slide 9)

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Mental Health: list of example patient outcomes, process measures and structure measures

Mental Health

	Patient Outcomes
General	Quality of life in patients with severe mental illness
	Health-related quality of life measure (based on EQ-5D) for those with self-reported mental health problems
	Carer satisfaction with care received
	Years of life lost due to suicide
	Excess under 75 mortality rate in adults with serious mental illness
Primary	GP Patient Survey questions (relevant to service)
	Rate of urgent GP appointments for patients with severe mental illness
2°	Rate of A&E attendances in patients with MH issues
	Rate of non-elective admissions in patients due to self-harm or substance misuse
Com.	Patient experience of community mental health services
Social	Proportion of adults with anxiety/depression in paid employment
	Proportion of adults in contact with secondary mental health services in paid employment
	Proportion of adults in contact with secondary mental health services who live independently

	Process Measures
Diag.	Proportion of admissions to acute wards gate kept by Crisis Resolution Home Treatment teams
Standard of Care	Proportion of people under adult mental illness specialties on Core Programme Approach who were followed up within 7 days of discharge from psychiatric in-patient care
	Adults subject to Mental Health Act
	Proportion of people with severe or complicated mental health problems with a crisis plan
	Proportion of people with severe or complicated mental health receiving an annual health check
	Proportion of children and young people presenting to emergency services for mental health reasons and seen by specialist mental health services within four weeks
Cont.	Proportion of GP appointments with named GP
	Proportion of nurse appointments with same nurse
Resource Use	Readmission rates <30 days for those with long-term mental health conditions for mental health diagnosis or for both mental and physical health conditions
	Ambulance calls from people in crisis
Staff	Frequency of work duplication reported by staff
	Proportion of time spent on high/low value processes

	Structure Measures
Workforce	Availability of appropriate staff for integrated mental health service (e.g. GPs, psychiatrists, community psychiatric nurses, PT/OTs, social workers, pharmacists)
	Availability of MH practitioner within primary care
	Staff satisfaction
	Staff retention
Infrastructure	Availability of integrated mental health clinics (e.g. within the community or in primary care)
	Availability of shared care record for all members involved in the MDT
	Frequency of care coordination meetings between primary and secondary care teams
	Frequency of care coordination meetings between health and social care teams
	Frequency of care coordination meetings between health, social and VCSE teams
Education	QI training availability
	Digital transformation training availability
	Cross-sector training opportunities
	Dedicated MH training for all staff

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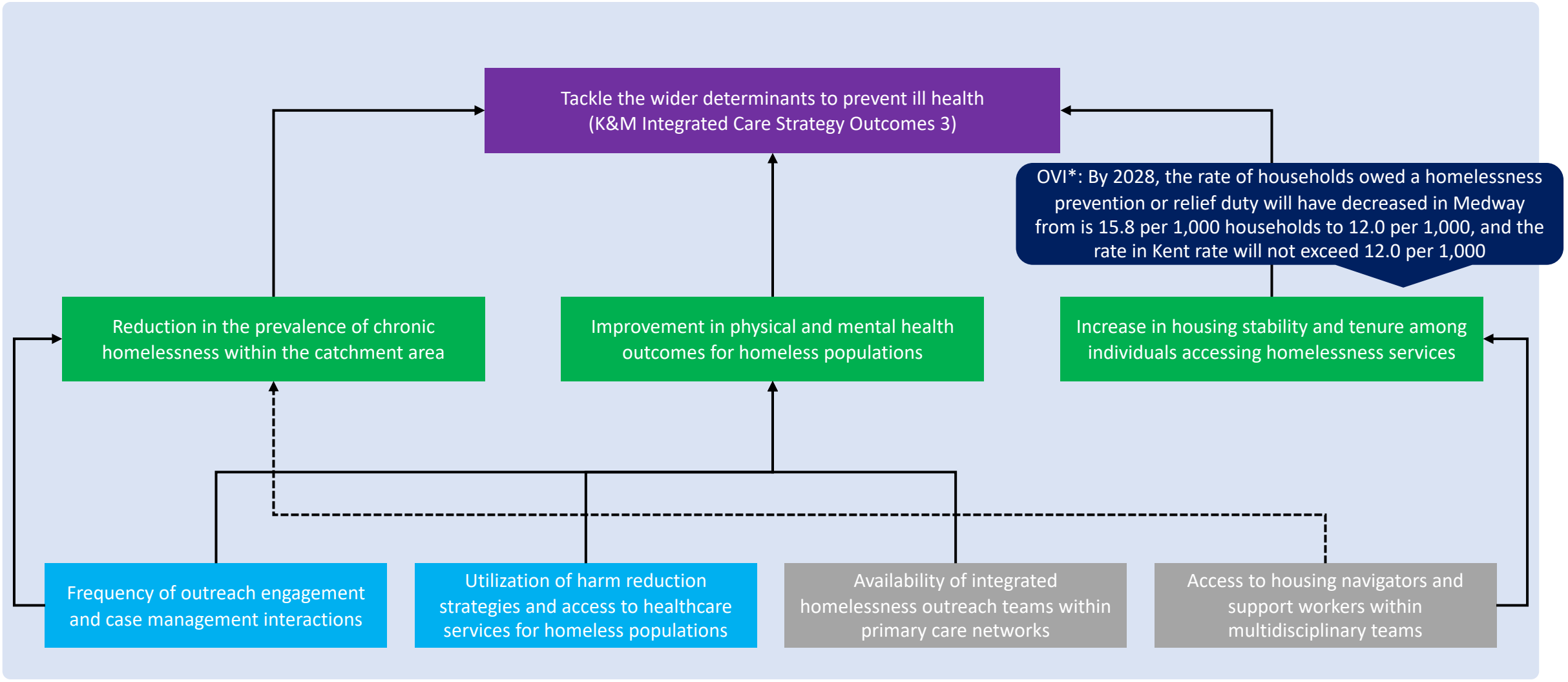
Homelessness: an example outcomes hierarchy (illustrative, not exhaustive)

Homelessness



Key Strategic Outcome | Patient Outcome | Process Measure | Structure Measure

*Objectively Verifiable Indicators are from Kent & Medway's Logical Framework (see Slide 9)

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Homelessness: list of example patient outcomes, process measures and structure measures

	Patient Outcomes
General	Quality of life in patients experiencing homelessness
	Health-related quality of life measure (based on EQ-5D) for those with homelessness
	Reported feelings of safety
	Service users whose services make them feel safe
	Patient experience of community homelessness services
	Years of life lost due to suicide
	Excess under 75 mortality rate in adults with homelessness
Primary	GP Patient Survey questions (relevant to service)
	Reported ease of accessing services
Secondary	Reported ease of accessing services
	Rate of A&E attendances (e.g. due to substance misuse or MH crisis)
	Rate of non-elective admissions
Com.	Patient experience of community homelessness services
Social	Proportion of adults experiencing homelessness in paid employment

	Process Measures
Di.	Estimated rate of homelessness
Standard of Care	Proportion of people with a crisis plan
	Proportion of people with a key worker
	Adults subject to Mental Health Act
	Proportion of people receiving an annual health check
Cont.	Proportion of GP appointments with named GP
	Proportion of nurse appointments with same nurse
Res. Use	Readmission rates <30 days for those with homelessness
	Ambulance calls from people in crisis
Staff	Frequency of work duplication reported by staff
	Proportion of time spent on high/low value processes

	Structure Measures
Workforce	Availability of appropriate staff for integrated homelessness service (e.g. key/social workers, GPs, psychiatrists, substance abuse specialists, community psychiatric nurses, PT/OTs, pharmacists)
	Availability of MH practitioner within primary care
	Staff satisfaction
	Staff retention
Infrastructure	Availability of dedicated homelessness clinics (e.g. within the community or in primary care)
	Availability of shared care record for all members involved in the MDT
	Frequency of care coordination meetings between primary and secondary care teams
	Frequency of care coordination meetings between health and social care teams
	Frequency of care coordination meetings between health, social and VCSE teams
Education	QI training availability
	Digital transformation training availability
	Cross-sector training opportunities
	Dedicated homelessness/inclusion training for all staff

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Additional example list of generic patient outcomes (illustrative, not exhaustive)

Patient Outcomes	Source
Excess winter deaths	ONS
Health-related quality of life for people with long-term conditions	NHS Outcomes Framework
Health-related quality of life for carers	NHS Outcomes Framework
Proportion of people feeling supported to manage their condition	NHS Outcomes Framework
Employment of people with long-term conditions	NHS Outcomes Framework
Employment of people with mental illness	NHS Outcomes Framework
Patient experience of hospital care	NHS Outcomes Framework
Social care-related quality of life score	Adult Social Care Outcomes Framework
Satisfaction with care and support	Adult Social Care Outcomes Framework
Levels of control over daily life	Adult Social Care Outcomes Framework
Levels of social contact	Adult Social Care Outcomes Framework
Service users whose services make them feel safe	Adult Social Care Outcomes Framework
Proportion of people who use services who reported that they had as much social contact as they would like	Adult Social Care Outcomes Framework
Long-term support needs met by admission to residential and nursing care homes	Adult Social Care Outcomes Framework
Healthy life expectancy at 65	Public Health Outcomes Framework
Disability-free life expectancy at 65	Public Health Outcomes Framework
Inequality in life expectancy at 65	Public Health Outcomes Framework
Level of involvement in decisions of care	GPPS

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Additional example list of generic process measures (illustrative, not exhaustive)

Process Measures	Source
Delayed transfers of care from hospital, and those which are attributable to adult social care	Adult Social Care Outcomes Framework
Proportion of people using social care who receive self-directed support, and those receiving direct payments	Adult Social Care Outcomes Framework
Proportion of older people (65 and over) who were offered rehabilitation following discharge from acute or community hospital	NHS Outcomes Framework
Rate of unplanned readmissions within 30/60/90 dates of discharge from hospital	NHS Outcomes Framework
Emergency admissions for acute conditions that should not usually require hospital admission	NHS Outcomes Framework
Bed days for selected patient types	Hospital Episode Statistics
Numbers receiving long-term community-based care as a proportion of total numbers receiving long-term care services	Social Care Collection Materials
Numbers receiving long-term social care as a proportion of the sum of numbers receiving emergency hospital care and numbers receiving long-term social care	Social Care Collection Materials
Numbers of people receiving long-term community-based social care relative to population	Social Care Collection Materials
Patients with multiple admissions per year for specific age groups/prior conditions	Hospital Episode Statistics
Hospital use in last 100 days of life	Hospital Episode Statistics
Readmissions for selected patient groups	Hospital Episode Statistics

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Additional example list of generic structure measures (illustrative, not exhaustive)

Structure Measures	Source
Existence of multidisciplinary teams comprising relevant healthcare professionals (e.g., doctors, nurses), social workers, and representatives from voluntary organisations	-
Co-location of health, social, and voluntary care services, such as primary care clinics within community centres or joint health and social care hubs	-
Frequency of care coordination meetings between relevant teams	-
Availability of virtual wards	-
Integration of electronic health records (EHRs) with social care and voluntary care systems	-
Existence of joint governance structures or committees involving representatives from health, social care, and voluntary sectors to oversee integrated neighbourhood teams	-
Existence of pooled budgets or joint funding mechanisms across health, social care, and voluntary sectors to support integrated neighbourhood teams	-
Availability of cross-sector training and education programs aimed at enhancing the skills and knowledge of staff working across health, social care, and voluntary sectors.	-
Implementation of referral systems enabling seamless communication and coordination of care between health, social care, and voluntary organisations	-
Engagement of local communities and service users in the planning, delivery, and evaluation of integrated health and social care services	-
Consistency and alignment of policies, procedures, and performance standards across health, social care, and voluntary sectors to support integrated care delivery	-
Implementation of joint quality improvement initiatives aimed at enhancing the effectiveness, efficiency, and safety of integrated health and social care services	-

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Team Effectiveness Measure (1): the eNPS may be a simple yet effectiveness way of measuring staff satisfaction and team effectiveness

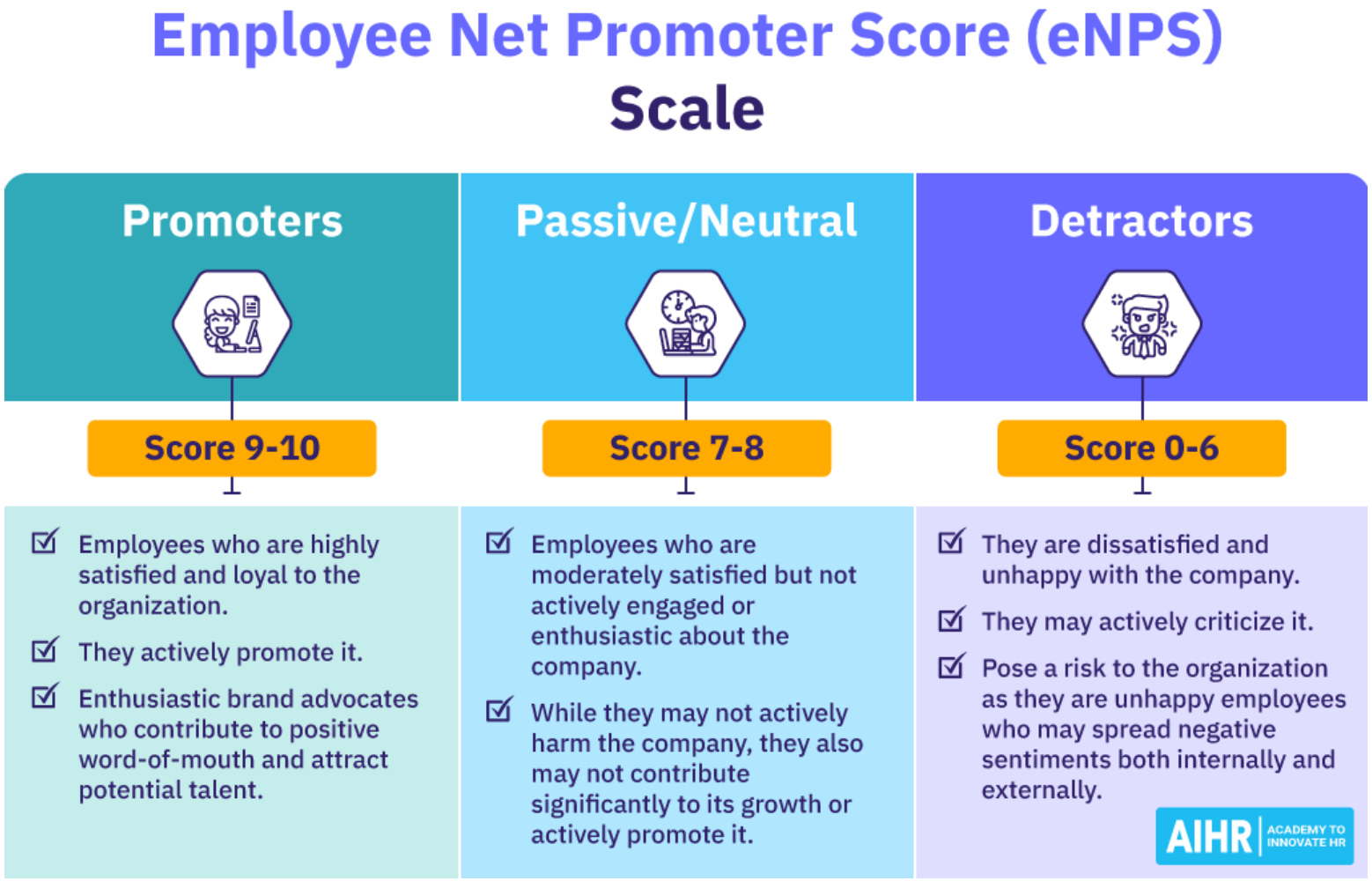
What is the Employee Net Promoter Score (eNPS)?

The eNPS is a tool that helps companies measure and improve employee satisfaction/engagement. It is a simple metric that allows companies to assess how likely their employees are to recommend their organisation as a place to work.

The eNPS borrows its logic from a concept called the *service profit chain,* a well-known measure in business that ties employee satisfaction to profitability.

What is the rating system for eNPS?

A standardised eNPS questionnaire that asks employees to rate the likelihood of recommending their company on a scale of 0 to 10, with 0 being "not at all likely" and 10 being "very likely."



AIHR - Employee Net Promoter Score (eNPS): The Ultimate 2024 Guide

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Team Effectiveness Measure (2): The Team Climate Inventory (TCI-14) may be a useful tool to assess to measure how team climate affects outcomes

What is the Team Climate Inventory (TCI-14)?

The TCI is a self-report measure designed to assess the climate for innovation within teams based on 4 dimensions: vision, participant safety, task orientation, and support for innovation.

The rationale is that a team's performance may be facilitated (or hindered) by the climate in the team. Teams whose members agree upon realistic objectives, participate in decision making, are committed to high standards of care, and receive support for innovation, are more likely to develop new ideas and working methods.

The TCI has a 5-point response scale from 'strongly disagree' to 'strongly agree', in which higher scores indicate a better or more desirable team climate. Scores for each item in a scale are summed to determine the scale score.

TCI-14 Questions

Vision

1. How far are you in agreement with these objectives?
2. To what extent do you think your team's objectives are clearly understood by other members of the team?
3. To what extent do you think your team's objectives can actually be achieved?
4. How worthwhile do you think these objectives are to the organisation?

Participative safety

5. We have a "we are in it together" attitude.
6. People keep each other informed about work-related issues in the team.
7. People feel understood and accepted by each other.
8. There are real attempts to share information throughout the team.

Task orientation

9. Are team members prepared to question the basis of what the team is doing?
10. Does the team critically appraise potential weaknesses in what it is doing in order to achieve the best possible outcome?
11. Do members of the team build on each other's ideas in order to achieve the best possible outcome?

Support for innovation

12. People in this team are always searching for fresh, new ways of looking at problems.
13. In this team we take the time needed to develop new ideas.
14. People in the team cooperate in order to help develop and apply new ideas.

BMC Health Services Research - Psychometric test of the Team Climate Inventory-short version investigated in Dutch quality improvement teams

BMJ Quality & Safety - The Team Climate Inventory: application in hospital teams and methodological considerations