Humber and North Yorkshire
Health and Care Partnership

Agenda Item No:	

Report to:	East Riding Health and Care Committee
Date of Meeting:	26.07.24
Subject:	**Vibrant and Healthy Communities Programme Spotlight on Integrated Neighbourhood Teams – Journey, Impact and Learning to Date**
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STATUS OF THE REPORT: *(Please click on the appropriate box)*

Approve ☐ Discuss ☒ Assurance ☒ Information ☐ A Regulatory Requirement ☐

SUMMARY OF REPORT:

This paper provides an in-depth update to the Committee on the impact to date of the Integrated Neighbourhood Teams (INT) project across the three focus areas of the newly adopted evaluation framework: the population, individuals, and integration. Benefits are aligned to the five focus areas of INTs in the East Riding, providing clear cohesion between agreed ambitions and the work programme. These are amplified through examples and quotes from those involved, in line with the Committee's agreed evaluation framework that brings greater emphasis on qualitative measures. Challenges in the development of INTs and key learning points are also highlighted which will be of relevance to new and existing INTs within the East Riding and more broadly across the Humber and North Yorkshire Integrated Care System (HNY ICS) footprint.

RECOMMENDATIONS:

The Committee is recommended to:

1. Note the contents of this report
2. Share the report with system partners to highlight the progress made by INTs and the ongoing challenges faced to raise the profile of the work and gain wider system engagement.
3. Act on the opportunities identified to allow for further growth and development. Insight gained should also be shared with newly formed INTs to support them to develop.
4. Support continued evaluation work to understand the progress being made across all INTs and to enable key learning to be shared across the wider system.

ICB STRATEGIC OBJECTIVE (*please click on the boxes of the relevant strategic objective(s)*

Managing Today	☒
Managing Tomorrow	☒
Enabling the Effective Operation of the Organisation	☐

IMPLICATIONS (*Please state N/A against any domain where none are identified)*

Finance	Minimal and significantly lower than presented in the report to the Health and Care Committee in November 2023
Quality	Quality representatives are involved in the INT project.
HR	N/A
Legal / Regulatory	N/A
Data Protection / IG	Process established as part of the INT development; now managed as a routine process. All data is anonymised.
Health inequality / equality	All INT work is informed by population health intelligence.
Conflict of Interest Aspects	Conflict of Interest Register in place for the INT Steering Group
Sustainability	Limited investment required to continue to develop INTs. Some INTs have identified initial 'pump-priming' as an enabler for development.

ASSESSED RISK: N/A

MONITORING AND ASSURANCE:
Outcomes are being monitored and will provide periodic assurance to the Health and Care Committee as required by the Committee.

ENGAGEMENT:
Partners from across the system and people being supported by the project have input into the spotlight on Integrated Neighbourhood Teams.

REPORT EXEMPT FROM PUBLIC DISCLOSURE No ☒ Yes ☐

If yes, please detail the specific grounds for exemption.

Spotlight on Integrated Neighbourhood Teams

Journey, impact and learning to date

JULY 2024

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1. Executive summary

1.1 The purpose of the paper is to provide an in-depth update to the Committee on the impact to date of the Integrated Neighbourhood Teams (INT) project across the three focus areas of the newly adopted evaluation framework: the population, individuals, and integration. Benefits are aligned to the East Riding five focus areas of INTs (section 1.3), providing clear cohesion between agreed ambitions and the work programme.

1.2 Background

In May 2022, the Fuller stocktake report1 highlighted opportunities to transform primary care, encouraging local systems to drive change in their neighbourhoods and communities. INTs were at the heart of the new vision, bringing together previously siloed teams and professionals to do things differently to improve care for whole populations.

In November 2022 INTs were mandated as part of the Health and Care Committee (HCC) Vibrant and Healthy Communities Programme. Since May 2023, INTs have been systematically establishing across the East Riding.

1.3 Outcomes

Utilising learning from established INTs, the initial outcomes have been refined as INTs have progressed to the following five focus areas:

1. To create the conditions for operational practitioners to come together and work seamlessly, sharing information, providing advice and support, etc. Empowering people, building relationships, providing nurturing environments.
2. To create a team / function that can support any individual, cohort, or community that our teams/intelligence think or demonstrate are causing concern. To avoid INTs that are focused on specific individuals and/or conditions; that have the fluidity and flexibility to move between different needs.
3. To utilise a population health approach to identify need for the INT to respond to. Primarily to focus on the 'middle 40%' (see Appendix A) through an early intervention and proactive care approach, utilising a 'conditions of living' approach.
4. To support individuals and their immediate family / community whilst simultaneously providing peer support to our practitioners.
5. To raise ourselves back to a population health approach by identifying key themes that the system needs to address.

1.4 Method

The first step in mobilising the East Riding project was to gather learning from previous models of integration at a neighbourhood level, which pointed a series of themes including, but not limited to:

- Governance
- Leadership
- System maturity
- Data sharing
- Creating the conditions for collaboration
- Developing a strategic vision

[1] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

Senior system partners were invited to participate in the development of INTs through a series of scoping meetings, which led to four 'Test and Learn' neighbourhoods being established. Each of these neighbourhoods were given the initial set up support required to create the conditions for collaboration and had the freedom to address local need, based on intelligence and local knowledge. All established INTs started in the same way and diverged at the point of understanding the local need within their neighbourhood. Each INT has then followed their own path, experiencing their own successes and challenges, which are detailed in this report.

Once local need had been established, most INTs identified an initial cohort of people to work with and utilised an MDT approach to identify individual cases where working in collaboration could support those individuals. The purpose of the MDTs being two-fold, to support cohorts of people, and to identify themes to act on, which can be scaled up across the system.

This report details the cohorts of people supported through the MDTs and explores the different approaches that have since been taken by each INT, such as the localised model of Brazilian Community Health Workers.

1.5 Impact

The evaluation framework for the Vibrant and Healthy Communities Programme has been used to produce an overview of progress to date for the INT project. This report explores in detail the insight gathered from the evaluation methods including case studies, semi-structured interviews, and quantitative data to show the results that are emerging from the INTs. This insight is intended to be utilised by the Steering Group and wider system partners to inform the future direction of INTs and enable key learning to be acted upon to create a cycle of change.

The key findings have been themed into the three areas outlined in the evaluation framework, showing how changes have impacted the population, individuals, and integration.

Population benefits:

- Service transformation, such as embedding adult social care workers within general practice, where access has been improved through colocation.
- There is increased understanding of communities through joint intelligence and work with Voluntary, Community and Social Enterprise (VCSE) partners.

Individual benefits:

- System partners taking a holistic view through the design and implementation of INT Multi-disciplinary Team (MDT) meetings has enabled professionals' perspectives to change due to being more informed about the individual. Hearing different insights has led to changes in how individuals are supported and cared for. For example, a patient who was presenting to the GP as obstructive was highlight by another organisation as being frightened and vulnerable, which led to the GP taking a different approach.
- Data Sharing Agreements (DSA) have enabled exchange of individual level data, enabling those individuals to co-produce their desired outcomes, allowing for more personalised care. A consequence of this has been the ability to gain direct access to a range of appropriate support services, such as the PCN pharmacist who wasn't previously involved.
- Relationships that professionals have developed have led to direct referrals into services. Consequently, these services are better connected, people have improved access and a shorter referral/consent process.

Integration benefits:

- Integration has been reported as having the greatest impact for professionals to date, highlighting the siloes that currently exist within the health and care system and the lack of knowledge and awareness of what support system partners are able to offer.
- INTs have created a space for professionals to come together and gain a better understanding of each other and their services, developing direct relationships which have enabled them to overcome connectivity barriers.
- Services which have previously worked in a reactive way are being given the opportunity to take a proactive and preventative approach.
- Broad governance and, more specifically, information governance issues have been addressed resulting in the exchange of person level information and confidence in the process. Addressing these issues has had a subsequent impact, broader understanding and support to address the challenges and solutions that are needed by the VCSE to work collaboratively in this way.

1.6 Challenges

Whilst there have been tangible successes, INTs have also faced several challenges. Professionals have been honest and open about their experiences, which has allowed for barriers to be identified and discussions around potential solutions to take place. Allowing professionals to continue to raise concerns in a constructive way and act upon them is a real opportunity not only to improve the outcomes of the INTs, but also to empower professionals to recognise that their voice can influence and shape the system.

Some of the challenges identified have been:

- Ensuring that all professionals involved fully understand the concept of INTs as business as usual, rather than an additional task
- Gaps in representation from some parts of the system, resulting in work not being able to progress
- Maintaining engagement with professionals when a focus does not align with their services
- Communication has been highlighted as inconsistent in some places, and presents a potential opportunity to better engage with services with little or no representation
- Data sharing has been highlighted as a particular barrier to working in an integrated way, and having a centralised data sharing agreement with a consistent process for gaining consent has been helpful to overcome some of the limitations INTs have faced. Whilst the flexibility for each INT to take their own localised approach has been key to success, there are some areas in which a consistent approach across all INTs is necessary.

Broader system issues include:

- Several colleagues from partners across the system have supported, advocated and led the development of INTs. These individuals are stepping into system roles for the first time – this should be encouraged and nurtured proactively through various means, not least of which would be some formal leadership development.
- A single, readable care record across partners remains in development and is likely still to be over a year away. This enabler would create a significant step change in integrated working.
- INTs represent a place in the system currently where two significant, cross-cutting ambitions are coming together – integration of teams / sectors and the ongoing development of a Population Health approach. The proposed development of the East Riding Population Health Steering Group would support delivery of the Population Health approach, specifically knowledge acquisition and understanding of the concepts and the transition to practical delivery. A ‘toolkit’ of different approaches and techniques will need to be developed / synthesised to enable INTs to have several tools at their disposal, particularly when trying to address issues relating to deprivation.

- Systemic processes still hinder integration and remain outside of the control of individual INTs. For example, if an individual is recognised through an INT MDT that they would benefit from support from another agency (and this agency accepts this during the MDT), the organisation that brought the individual to the MDT would still need to return to work and generate a referral.
- There has been a maturing of some system partners and relationships throughout the process however there remain many occasions where partners are passive in discussion and/or will take actions readily for their own organisation but are reluctant to step into a system leadership role.
- Lack of additional funding has been raised by several INTs as a barrier to progressing projects.

1.7 Future scope

Partners have expressed their motivation and commitment to collaborative working and shared their perspective on what could be achieved in the future and how. As INTs are becoming more established, local partners are now starting to take ownership and lead for the future. As more partners step into system leadership roles, there may be a requirement for workforce development and leadership support.

1.8 Recommendations

The Committee is recommended to:

1. Note the contents of this report
2. Share the report with system partners to highlight the progress made by INTs and the ongoing challenges faced to raise the profile of the work and gain wider system engagement.
3. Act on the opportunities identified to allow for further growth and development. Insight gained should also be shared with newly formed INTs to support them to develop.
4. Support continued evaluation work to understand the progress being made across all INTs and to enable key learning to be shared across the wider system.

2. Purpose of the paper

2.1 The purpose of the paper is to provide an in-depth update to the Committee on the impact to date of the INT project across the three focus areas of the newly adopted evaluation framework: the population, individuals, and integration. Benefits are aligned to the East Riding five focus areas of INTs, providing clear cohesion between agreed ambitions and the work programme. Examples and quotes in coloured boxes throughout this report highlight the experiences and perceptions of the professionals interviewed as part of the evaluation process. Challenges when working in this way and key learning are also highlighted which will be crucial in supporting the expansion of INTs across the East Riding.

3. Introduction

3.1 In November 2022 INTs were mandated as part of the HCC Vibrant and Healthy Communities Programme. Over the last 18 months, INTs have been systematically establishing across the East Riding. In May 2024, the HCC supported the adoption of an evaluation and outcomes approach for the Healthy and Vibrant Communities programme. It was agreed that the approach would be trialled with the INT project during May and June and reported back to the HCC in July. The approach will then be implemented across the whole HCC programme and INTs will be revisited for follow-up evaluation in six monthly intervals.

4. East Riding INT context

4.1 In May 2022, the Fuller stocktake report highlighted opportunities to transform primary care, encouraging local systems to drive change in their neighbourhoods and communities. INTs were at the heart of the new vision, bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations.

The primary aims of INTs as defined by the Fuller Report are:

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

Although the Fuller Report proposed “INTs as an evolution of PCNs,” a conscious decision was made to organise around flexible neighbourhoods rather than PCN footprints. This means that some INTs are a sub-PCN geography, and others span more than one PCN. A partner’s perspective on neighbourhoods:

> It’s what people identify as a community. [For example] Driffield makes sense to the people who are working there and the people that are living there.

4.2 Ambitions for the East Riding

Integrated Neighbourhood Teams is a project that sits within the East Riding Health and Care Committee Vibrant and Healthy Communities portfolio, introduced in November 2022. The ERY Integrated Care Board (ICB) Place Director is the Executive Lead with the SRO for the project also from the (ICB). The following comment was observed.

It felt like there was a natural synergy with what we were trying to do, strategically taking the population health approach, listening to the voice of local communities, wrapping care and support around people.

4.3 Outcomes

Each neighbourhood was given the freedom to address local need and/or barriers to integration and therefore set its own outcomes as long as supported by independent intelligence sources. However, in addition to any local agreements, the Committee agreed to overarching outcomes relating to the following:

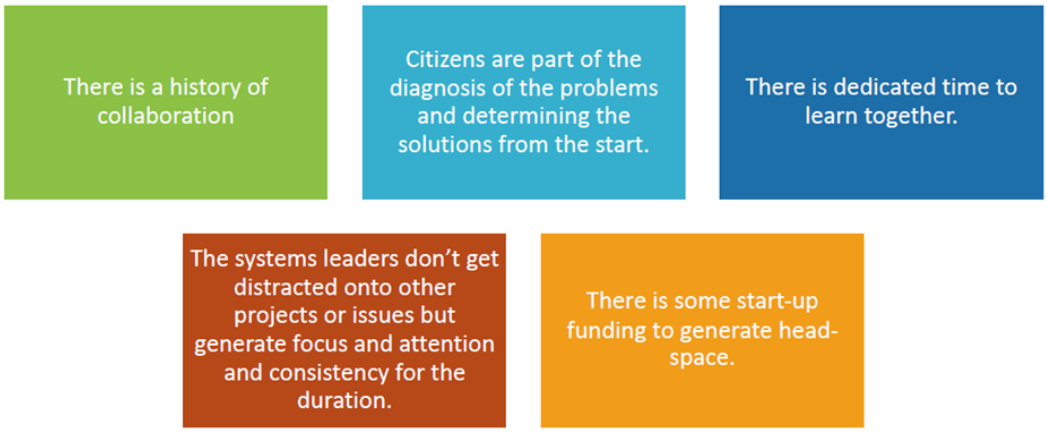
- Support individuals to tell their story only once
- Create the conditions for operational practitioners to work together seamlessly
- Support scalability of any model
- Explore opportunities to reduce unplanned/chaotic demand
- Adopt a system integration approach – not just health outcomes

4.4 Utilising learning

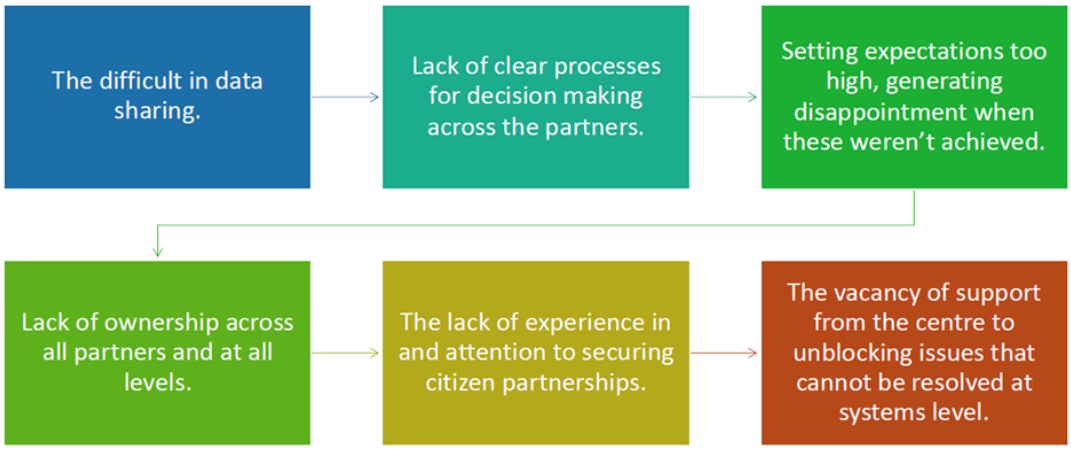
Attending an INT learning day in York reconfirmed the East Riding's approach and provided reassurance that the challenges that were being experienced, were not dissimilar to those of other partners across the country.

The following two diagrams were shared at the event, synthesising learning from partners across the country that were all trying to establish INTs.

Evidence shows integrated care works where:



Evidence shows what gets in the way of integrated care:



The first step in mobilising the East Riding project was to gather learning from previous models of integration at a neighbourhood level, which pointed to developing a strategic vision, creating the conditions for collaboration, involving operational teams for buy in and understanding and testing in real world situations.

4.5 Taking the learning forwards, four Test and Learn communities in the East Riding were identified: Holderness, Driffield (Yorkshire Coast and Wolds Primary Care Network (PCN)), Goole (Cygnet PCN), and Bridlington, with the aim of having full coverage by March 2025.

4.6 Change in Focus

As the INT project has evolved, it has become apparent that some initial outcomes were too ambitious for the maturity of the system and level of integration. A local ambition was to develop an early identification and support process by utilising MDTs as a way of understanding what the intervention points are and then to have a system which flags individuals when these are triggered. This was to avoid the wait for meetings and reliance on people to identify individuals who could be supported. A mechanical algorithm process would trigger when an agreed criteria was reached and then the whole neighbourhood team would support, with the person being fed into an MDT. A partner shares their refection:

> It's a fabulous ambition, we're just nowhere near it. We are so far away of anything of that kind of scale and complexity.

Also, as INTs have developed, early intervention and prevention has become the focus, requiring the initial high-level outcomes to be refined. Many partners cite that they believe that the INTs should be, and are, supporting communities and individuals by focusing on the wider determinants of health rather than using a medicalised approach to treating health issues. This is a new way of thinking and working for some. Partners spoke about the focus:

> The focus was subtly shifting to early intervention and prevention. I became really aware of that as a tangible. I'd never said that was the purpose of the neighbourhood team. Some of that had been triggered by frequent attendance, the solution was early intervention. I started to talk about the teams being more focused on early intervention and prevention. I was making a conscious narrative shift.

> Trying to prevent them needing to go into practice in the future, being proactive and so they know we are listening, putting things in place and getting a better understanding.

4.7 The **outcomes** were refined to the following **five focus areas**:

1. To create the conditions for operational practitioners to come together and work seamlessly, sharing information, providing advice and support, etc. Empowering people, building relationships, providing nurturing environments
2. To create a team / function that can support any individual, cohort, or community that our teams / intelligence thinks or demonstrate are causing concern. To avoid INTs that are focused on specific individuals and/or conditions; that have the fluidity and flexibility to move between different needs.
3. To utilise a population health approach to identify need for the INT to respond to. Primarily to focus on the 'middle 40%' (see Appendix A) through an early intervention and proactive care approach, utilising a 'conditions of living' approach.
4. To support individuals and their immediate family / community whilst simultaneously providing peer support to our practitioners.
5. To raise ourselves back to a population health approach by identifying key themes that the system needs to address.

The impact of the INT project to date will be presented in detail in the following sections in line with the Healthy and Vibrant Communities evaluation approach under the two headings of 'What has changed' and 'How is change happening.' The key findings have been themed into the three areas outlined in the evaluation framework, showing how changes have impacted the population, individuals, and integration. An overview of the benefits and their alignment to the five focus areas are displayed in Appendix B. Evidencing the linkages in more depth, Appendix C highlights the following examples of change, utilising an explanatory account approach to provide a plausible explanation as to how the benefits contribute to the overarching HCC Strategic Ambitions:

- The capacity and resource of the VCSE is now recognised
- Connections have been made with the Goole migrant community
- Partners have a better understanding of each other and their services

5. Implementing the evaluation approach

5.1 Throughout May and June 2024, several data collection tools were trialled:

- All INTs were provided with 'individual journey logs' to gather the micro-changes that individuals being discussed at MDTs were experiencing from the perspectives of the individual and the services involved.
- 19 partners undertook a semi-structured interview to gather their individual perspectives having been involved in the work. The semi-structured interviews were purposefully flexible in structure to enable understanding of what were the most important to those interviewed, and covered areas such as milestones, significant changes, challenges, learning and future direction. Anonymised quotes from these interviews have been included in coloured text boxes throughout this report.
- Ad-hoc evaluation materials held by partners were collated.
- All data was synthesised and subjected to thematic analysis. The findings are presented in this paper.

5.2 Outcome measures for the INT programme have been co-produced with the Steering Group and agreed by the Senior Responsible Owner (SRO). A range of qualitative and quantitative measures have been chosen to provide a holistic view of the outcomes of the programme. Each measure aligns to one of the three strategic ambitions of the Vibrant and Healthy Communities Programme, as shown in Figure 1, enabling us to report the impact the programme is having on these strategic ambitions.

Data for each measure will be collated and analysed at regular intervals throughout the year as outlined in the framework in Figure 1. Several measures have a baseline and current position and will be shared when the framework is fully complete.

Figure 1 Outcomes Framework

Integrated Neighbourhood Teams (INT)				
Strategic Ambition	**Outcome**	**Measure**	**Data Source**	**Reporting Frequency**
Improving outcomes for everyone - social value - maximising independence	INT's add social value	Social value attached to work of INTs	Social Value Engine	Annual
	People are supported to maximise their independence	Targeted interventions for people at risk of poor health or wellbeing	Case studies / journey logs	6 monthly
		Goals are coproduced and agreed with each individual	Consent / referral forms	6 monthly
	Professionals feel empowered to make a difference	Professionals find it easier to navigate the system	Changes to referral pathways	6 monthly
		Professionals report feeling empowered to make a difference	Surveys / interviews	6 monthly
Removing barriers to access - Access to services	Organisations across different sectors are actively participating in INT's	More organisations are part of the INT network	Count of attendees	Quarterly
		Number of organisations actively participating in INTs	Meeting minutes/actions	Quarterly
		Under represented services have become part of INTs	Delegate list	Quarterly
		Level of engagement in INT from different sectors has increased	Meeting minutes / action tracker	Quarterly
		Professionals reporting increased awareness and knowledge of other organisations	Interviews / case studies	6 monthly
	Improved relationships, trust, and peer support	Frequency of contact between professionals outside of INT meetings	Interviews / surveys	6 monthly
		Professionals reporting improved access to information/data from system partners	Interviews / surveys	6 monthly
		Professionals reporting improved relationships between different organisations	Interviews / surveys	6 monthly
		Attendees value having time to meet with system partners	Interviews / surveys	6 monthly
	INT's enable greater access to holistic support	People are able to access support from INT partners	Referrals	Quarterly
		Increase in referrals between organisations	Referrals	Quarterly
		Direct action taken as a result of INT	Interviews / case studies	6 monthly
Focussing on experience of care and support - co-production - The voice of those seldom heard	MDT's support people to achieve their goals	Outcomes for individuals	Case studies	6 monthly
		Compliments and complaints	Praise / complaints / social media	6 monthly
		Shared language and use of common terminology	Interviews / observations	6 monthly
	INT's have created opportunities for co-production	Evidence of including communities / seldom heard groups in decision making	Interviews / case studies	6 monthly
		Improved engagement and participation with inclusion groups	Case studies	6 monthly

Progress against the outcome measures will be reported back into the Steering Group at regular intervals to enable them to take an agile approach, whereby the group can act on findings and adapt ways of working based on examples of best practice and lessons learned. Enabling this agile approach will be key to future success as it will enable each INT to evolve and adapt. As each INT is at a different stage in development, the newly established INTs will benefit from the intelligence and feedback generated by the evaluation cycle of existing INTs.

Outcome measures will be reported back into the HCC every six months, or where there is significant progress to report.

6. What is changing?

6.1 What East Riding INTs have achieved to date

- A compelling strategic vision and call to action
- Created safe conditions for partners to engage, build trust and relationships; to get things wrong without criticism and learn from success and failure
- Clear governance into the Health and Care Committee. Oversight from the established INT Steering Group
- A Population Health focus to individuals and communities
- Clear Information Governance and person level data shared
- Bringing to the surface a range of issues from support to the ethnic community in Goole to the information governance infrastructure of VCSE partners
- Improvement to system maturity and emerging leaders
- A highlight of known commissioning gaps. For example, neurodiversity assessment.
- East Riding configuration for full coverage is confirmed and a rollout plan agreed - five INTs have been established to date and another three are in development.
- 18 partner organisations engaged initially and as INTs have become further established, there are now over 50 professionals that have attended from strategic and operational roles, wider geographical and service areas.
- 43 cases have been reviewed by MDTs.
- INT-wide processes have been developed and adopted, for example data sharing agreements and MDT terms of reference. In some circumstances this sharing has been across the whole ICB footprint.
- There have been numerous benefits for individuals such as system partners taking a holistic view, leading to a better understanding of them as a person – see section 6.3
- Several scalable projects have been identified such as increasing our understanding of our communities through working with VCSE partners – see section 6.2
- There has been increased integration between system partners allowing them to overcome connectivity barriers by developing direct relationships – see section 7.1

6.2 Population benefits

One of the main focuses of the INTs is to better understand the population and their experiences, enabling scalable approaches for more integrated health and care to be developed. Several scalable population approaches have been identified and developed, as shown below.

Adult social work and general practice partnership

Social workers are now based in several GP surgeries across the East Riding, demonstrating a ‘business as usual’ approach to integration. An INT meeting provided the opportunity for an informal conversation between partners, to discuss bringing to life an Adult Social Care

ambition. A trial in Goole to co-locate social workers in GP practice has led to the joint approach now being embedded in Goole, Holderness and Driffield.

The pilot has enabled practitioners to work in an integrated way, allowing patients access to a social worker without having to navigate through existing referral routes which are often lengthy and complex for the individual. Social Workers can act in a preventative way, by reaching people sooner and supporting them to maximise their independence before they reach crisis and require a more in-depth intervention. Joint home visits between Social Workers and Nurse Practitioners have enabled better access to services and joined up care for individuals. Several partners perspectives are shared below.

> We've never been joined up with the council before, other pieces of work have naturally come about from INTs. A social worker is assigned to the surgery, they come in every Monday and have an MDT. We are about to be able to refer into them for appointments and they will see their own patients.

> The joint visits are working well. The social worker has bookable sessions in the morning, and will attend the practices MDT. In the afternoon they will do joint visits with the nurse practitioner, it might not even be our case but it is someone who concerns them, so it's a common sense approach.

> Piloting a project with a social worker in practice one day per week, they are seeing patients closer to home. GP can refer directly into that clinic, trying to get that cohort before they get to crisis, and they are also supporting at the frailty clinic now to prevent too-ing and froing between services, we can raise queries and concerns there and then.

> Social Workers into GPs thing was a 'corridor conversation', something I had wanted to do for some time and while we were standing in a queue to get a free sausage roll, the conversation just evolved that way, at which point I realised I could replicate that at other sessions. The conversations are often better than the planned agenda.

Feedback from professionals and patients involved in the pilot has been positive. GPs feel that they can now access better guidance and support from social workers, whilst also delivering more holistic support together. Social Workers feel able to work in a proactive and strengths-based way, offering holistic support tailored to the individual. Example of feedback received:

Patient feedback: A kind and helpful lady had visited her. As a result of this conversation, she had spoken with her family and everything is getting sorted, so she can remain independent and "in charge of her own remote control". This is of huge importance to her and she can now occupy her time with new things, such as the arrival of a new great grandchild, her third in total.

Service lead quote: *"I love how we have empowered her by giving her time and space to tell us what's important to her and love the bit about staying in charge of her remote control"*

Understanding our communities – The Goole migrant community

When partners from Goole came together as an INT to review local intelligence and demographic data in relation to childhood immunisations, people from the migrant community were identified as the target population. As this was explored further, it became clear that the population were not well enough understood amongst partners for the system to be able to support them. Partners shared their perspectives:

Despite it being a community that we all knew about and have been trying to help for over a decade, we've never come together to do. I'm astonished by that. The Goole INT shone a light on the gap. It links to behaviour insights and hearing the voice of those seldom heard. It's pointless sending out reminders that are going to be ignored. We're clearly not engaging with this community at the right level to understand what it is they need. There's an element here of co-production which we could do.

The migrant population and people who didn't start their life in the town were identified. It became clear early on that the community were not represented, and we didn't actually know the breakdown of that population. We didn't know what language skills they had or anything.

There's not a lot of knowledge around that community, 400 Portuguese speakers were flagged up by the census, none of us necessarily expected that. We know little about them. We have to build it up from nothing, it might be just they all go to the same supermarket or that there is something we don't know that we have yet to find.

Goole Community Conversations: Bridging Gaps and Building Trust project

It was assumed that the Voluntary Sector are connected to the migrant community, yet there is not always a direct connection unless there is a specifically funded service. Research found that there were no VCSE organisations supporting this population, local leaders were unknown and, as all data was leading back to the same community, this work was essential.

A VCSE-led engagement process was mobilised with the aim to foster trust, provide culturally relevant information, and improve health outcomes for the town's migrant (refugee and asylum seekers) population. A partnership approach between HEY Smile Foundation, East Riding of Yorkshire Council Adult Learning, Opportunity Goole, and Welcome House led the Community Conversations project. This enabled the most appropriate organisation to instigate conversations with different parts of the community whilst bringing the insight together collectively. The approach listened to people's experiences with the aim of understanding them rather than immediately looking for solutions.

The project has identified both the positive aspects and significant challenges faced by the migrant (refugee and asylum seekers) community. Key themes identified are:

- Community spirit and challenges
- Cultural appreciation and adjustments
- Stress management and healthcare barriers
- Volunteering and job opportunities

Next steps:

- Four additional conversation sessions, focusing on living, learning, and working.
- Progress partnership opportunities
- Continue to support individuals – two local people have accessed training and are volunteering at Home-Start Goole & District.
- Secure grant support to enhance activities for the group.

'When to worry' parent education campaign

In Driffield, demographic data, attendances at surgeries, out of hours and A&E attendances, and local insight defined a cohort of children under 5 years of age. INT partners agreed that it was a cohort that many partners could get involved with. Several MDTs were held, and the main learning point was that 'it's not just about the children, it's about the parents too.'

An information sharing project has since developed which aims to support parents to be better informed about how to practice self-care within their family and access localised community support. Attendance data from October 2023 will be used as a benchmark to assess the impact of the campaign against autumn 2024. Bridlington INT also identified children as a cohort and linked with Driffield to share the campaign across both geographical areas. The ambition evolved to become an East Riding-wide campaign for Autumn 2024.

> Driffield had already done a few MDTs and come up with an action to send out some details to parents, so when Bridlington set up and wanted to look at children they could learn from Driffield's approach.

> That was brilliant because it was the first example of taking the learning and scaling it back up. That's a good example of initially getting neighbourhood teams to work together across boundaries and then scale it across the full ER.

New services in neighbourhoods

Developing relationships with new partners has enabled new local opportunities outside of the INT that were not otherwise available:

- Another GP practice is starting NHS Health Checks from their locality that are not currently available to residents.

- The Tuberculosis service has been reconnected to a GP practice which had previously lost the direct connection.
- Bridlington PCN is working together with The Hinge (a local VCS organisation) 'Warm Welcome' sessions to support local people with the NHS App.
- One GP practice has linked with a drama organisation to enable local people to tell their stories.

Partners spoke about the benefits:

> We're working with people that we wouldn't usually speak to. Our practice is going to start doing the health checks, not something we would previously have been involved in.

> At one of the collaborative meetings at the library, there was a lady to do with CVD, so I've linked in with her and started another piece of work separately, there might be resources she can bring to table. There have been a few others that we have linked in with since. There's a shared culture of working together in partnership, we are all linked, not necessarily direct links, but trying to pull it all together and make those connections. Before this work was done, I couldn't believe how many organisations were doing the same thing, so much duplication, all separate meetings, we are working smarter and working together.

Residents accessing services in one place - co-location of partners

The development of the Bridlington Health Campus is a priority of the Estates and Infrastructure workstream, that sits within the Bridlington Place-Based programme of work. The co-location of partners in the Crown Buildings, Bridlington, has enabled partners to work together in a more integrated way. The synergies between the Estates and Infrastructure workstream and the Bridlington INT has helped to accelerate relationships and integration between partners involved in the Bridlington INT which has had a positive impact on the support that individuals and staff are receiving as shown in the comments below. The VCSE-led facility hosts partners such as the GP practices, The Hinge, Carers Plus and community health support groups for conditions such as dementia and cancer. The aim of the single estate is to be a 'one stop shop' in the community. Monthly meetings with all partners based in the building enable them to connect with what is happening.

Partner perspectives on the approach:

> More organisations are moving in and we are trying to link up with them. We're trying to bring people into the building as a central hub. The plan is to develop building into a place where you can come in here before you go to the doctor. If someone has money or debt worry, or suddenly their relationship has broken down, unsure where are they going to live, they can come and have those conversations and get guidance instead of approaching the GP, but then if they do need to see a doctor, they can make that appointment. It's looking at them more holistically and able to access everything in one place.

> The PCN is literally next door. We can just walk in and talk to them. There's easier access for our service users and staff as we can have a conversation.

> The building itself has its challenges as it is old and some parts have been disconnected.

Further updates on the Bridlington Health Campus will be available in due course as part of the Bridlington programme reporting and evaluation.

Service Transformation – Driffield Chronic Pain Hub in development

At the Driffield INT, gathering data and listening to people and colleagues across the system led to a chronic pain focus. Chronic pain MDTs enabled several individuals to receive multiple-partner support, as well as informing several themes, which provided insight into how the population living with chronic pain could better receive care and support.

Working relationships between professionals, such as the GPs and pharmacists, have been developed, enabling those with a special interest area in pain prescribing to become more involved with supporting chronic pain patients.

Low referral numbers into pain services had been interpreted as there being little demand for support, but the MDT highlighted issues with access to services resulting in them not being utilised, leading to a better understanding of the actual need for change.

As a result of this focus there is an ambition to develop a chronic pain hub. The vision is that the hub would bring different agencies together such as the PCN, social prescribers, City Health Care Partnership (CHCP), pharmacy and a peer support drop in café. Initial scoping work has commenced.

Partners reflected on insight gained:

> What people thought was working well because people aren't being referred into a service, is actually not working well because people are avoiding referring in because the service isn't working well.

> The Alfred Bean work has had positive reviews on Facebook, which is really unusual.

> I didn't know her that well before and think there is things that we could take forward.

6.3 Individual benefits

Individuals supported by an MDT are asked at the point of consent what they would like to gain from the process and supported to co-produce their desired outcomes.

Some of the benefits that individuals have expressed they would like to achieve are:

- A better quality of life after pain medication is reduced as they were not managing well
- Local services helping to sort the problem
- Advice and support to live a full and active life
- Reasons for experiencing falls

Several themes were identified from supporting the individuals, including:

- The stigma around mental health support that stops people from engaging with help
- Most chronic pain patients needed pharmacy input
- A lack of knowledge about services
- Support approaches not being joined up, for example pain clinics and locums
- A lack of health literacy

Individuals have benefitted from accessing support through an INT in the following ways:

- Referrals to wider support services such as:
  - British Red Cross
  - Family Links
  - Stop Smoking Service
  - Matthews Hub
  - Social Prescribing
  - Humberside Fire and Rescue
  - 0-19 Service
  - Emotional Wellbeing Service
  - Exercise Referral
  - GP appointments.

- A holistic view of individuals has led to a better understanding of them as a person and enabled more personalised care. This benefit was highlighted most often by the partners interviewed. Listening to other partners enabled professionals' perspectives to change due to being more informed about the individual. Hearing different insights has led to changes in how individuals are supported and cared for. Utilising the different relationships that professionals have with individuals has enabled more personalised and timely care.

  Partners shared how and why the felt this was a benefit:

> There were a couple of service users we took to MDT at Driffield, the surgery saw a real benefit to the insight around one gentleman and his past, trust issues and issues around managing his symptoms. He had not really engaged and now he is. Another one was discussed at MDT and what we said about her raised flags for the GP who said we need to see this woman and identify health needs. If we'd not taken her to MDT, I don't think things would have changed for her.

> It's allowed us to revisit what has worked in the past for that patient and what might work going forward. Spotted that one person does better with one male GP who sees them on a regular basis, this has helped stop him being so erratic in his behaviour.

> The MDT highlighted that people were accessing every partner but weren't telling each partner they were being supported by other organisations. This insight gave the group a more holistic view of each person.

> It's really helpful for us when we have service users with those conditions, we know what their GPs will be telling them when we're not there.

> What other partners could bring was an eye opener in some cases.

- Direct access to the right services - Many individuals were offered additional support from numerous services, some of whom took up the support offered, for example, medication reviews with the PCN pharmacist have taken place, where required. Others were more aware of the support that they could access but turned down the support for reasons such as 'feeling it's not the right time for them.'

A direct relationship between the British Red Cross and Community Mental Health teams has developed, enabling direct referrals rather than through the Adult Social Care Independence and Advice Hub. Consequently, these services are better connected, people have improved access and a shorter referral/consent process. A partner spoke about the change:

> Especially with Community Mental Health teams, we've supported lots of people who have mental health issues and we've needed to contact them, but we've always found them hard to get hold of because they're really busy. Now we are getting more direct referrals form Community Mental Health teams, we've been to their team's meetings, met the Clinical Leads, and we're getting direct referrals from them, cutting out the Independence and Advice Hub.

- MDTs have enabled capacity in the system for individuals to be supported earlier and in some cases, avoid an urgent care attendance. Partners spoke about the impact on individuals:

> It has given us extra capacity; these people would otherwise have ended up in an urgent care centre.

> Often service users are open to a lot of services at the same time without us knowing what each other are doing, it can be confusing for the service user and also delay treatment. By each having an action plan and a consistent response to our service users, it makes a difference. Especially the more challenging service users, or sometimes people who don't understand a lot that's going on, because of their condition they don't know that their social worker is a different person to their mental health nurse.

- Engagement with individuals not often seen - Outreach work at Driffield Rugby Club has enabled several services to have direct conversations with those that do not often present at GP practice, enabling conversations about health and wellbeing. This has led to several people accessing the GP practice for follow-up support.

- Confirmation that individuals are receiving the right holistic care - Partners coming together has enabled a holistic view of support, of which for some individuals, it has confirmed that they are receiving the right support available to them from across the system. This is reassuring for the individual and partners involved, enabling greater peer support in and across teams. A partner reflects on what this means for individuals and staff:

> The service could go back to each person and say 'actually you have all of this support'. Maybe not the perspective they were being given, so it was quite eye opening for them, and they were better informed when working with people. It was more a lack of understanding that they had exhausted all the support available.

Alongside individual benefits, the scalable population benefits described in section 6.2 are being shaped by the insight and feedback from individuals involved in MDTs. Their voices are being heard and action is being taken.

6.4 Individual case study examples

Example one - An individual supported through the MDT process

Background

The Individual has been supported by a local VCSE organisation for the last couple of years and was identified for an MDT due to their multiple, long term health conditions, including PTSD, anxiety and depression, IBS and diverticulitis, GERD, hiatus hernia, chronic tooth ache and sleeping difficulties

What's changed?

- Sleeping better
- Individual feels that they have built a good relationship with their councillor and now has a space for emotional support. Their mental health has been positively impacted
- Oral health improved – pain free
- Reduced health anxiety

Support received in a one-month period

- GP appointment to adjust sleep medication
- Mental health support review leading to weekly counselling through VCSE organisation.
- Tooth extraction due to major discomfort. Oral health was impacting on mental health. Relationship between VCSE and dental practice enabled timely action.
- Face to face appointment with hospital consultant to review colitis. Transport and access barriers were minimised by the VCSE organisation by supporting with access to transport and attending the appointment

Who was involved?

Individual
Local VCSE organisation
GP
Primary Care Mental Health
Dentist
Hospital consultant

Example two – Individual accessed specialist support through the MDT process

Background

The individual was identified as part of the chronic pain MDT.

Insight from the GP and Red Cross helped partners to understand how they could better build a trusting relationship with the individual. The need for specialist support from the PCN Pharmacist was identified. The PCN pharmacist has built a relationship and understanding with the individual so that they can work together to improve the individuals pain management. Focused support has been provided- they have met five times over an 11-week period.

Process

- Initial structured medication review – Discussed and reviewed appropriateness of current medicine. Individual was able to query the medication and better understand.
- PCN Pharmacist and individual discussed alternative options for managing chronic pain better. A cross-titration process was started.
- Regular bi-weekly follow up monitoring to ensure safe doses and better management of pain.
- Further monitoring and urgent same day GP assessment due to identification of high blood pressure.
- Individual continues to be supported and progress continues to be made. New drug has been introduced to manage pain better with the planned reduction for opiate exposure. Blood pressure is being managed better.

7. How is change happening?

7.1 Integration benefits

The progress made on system integration was highlighted by those interviewed as the biggest impact in the journey of INTs to date. All partners interviewed felt that changes had occurred which meant that system partners are now better integrated for the benefit of the health of our residents.

The following three integration benefits were identified by most partners:

- Partners have a better understanding of each other and their services. This means that they are better informed and can offer more joined up care to individuals. Multiple partners spoke about what this means to them:

A patient's health was being managed, but the patient's home environment and lifestyle issues needed addressing. The patient wasn't housebound but there were times when they could have done with providing home care. The patient was the only one they couldn't transfer to Goole clinics due to issues of transport refusing to take the patient who was particularly unkempt. By building relationships in the INT, they were able to find a solution with the Red Cross advising that they can support patients such as this and transfer them to appointments. Through building these relationships they were able to gain an awareness of what help might be available in other areas. They suggested that another colleague speak to the Red Cross due to issues patients were having attending a leg ulcers clinic in Hull due to taxi costs and taxi companies refusing patients due to non-payment.

It has been really useful having dialogue with GPs and getting to understand the type of advice they give to patients on managing certain health conditions.

They have been attending the INT meetings to understand the variety of other services and support that there is, and they have been able to share that with the frontline staff.

It also gave partners insight into health care and support that they didn't understand or have knowledge of.

CHCP recognised the benefit of what we deliver. They approached us as they wanted to know more. We've learnt more about each other and built a relationship outside of the INT. They're linking us to their other contacts too.

- Partners are developing direct relationships, enabling them to overcome connectivity barriers. The breadth of partners engaged from across the system is enabling new connections to develop. Building a network between partners is the foundation for INTs to work together in an integrated way. Many partners share their perspectives on developing relationships:

From my service's perspective it gave the opportunity to make links with services that are quite hard to reach. It is really difficult to talk to a GP and we've been able to have those links.

The relationship we've built through the INT means we know they're there if we need them.

It has been helpful to build relationships between providers, that's probably biggest success, health visitors, GPs, social workers are all talking to each other now about people.

It was challenging on my time, I can't deny that, but I felt it was important for our service to have that representation there. It was beneficial for our service, sometimes trying to access these professionals is really, really difficult but you need to have those conversations for the people you're supporting.

Integration, being on first name terms with people involved, agricultural charities, local pharmacies who do blood pressure screening, there has been a lot of good conversations and getting involved and meeting those people.

It definitely is the case that teams can work in silos of each other, which obviously is not in the best interests of our service users. I think although it can feel like this process is quite resource heavy, everybody is probably doing more work to less quality and to less good outcomes by not having those connections.

When you go to these you are meeting other organisations and services that you wouldn't normally have met. We are making relationships with other people that can be used in other areas.

My last year has been spent networking, collaborating and trying to build relationships. I know I can now ring Smile or the Red Cross and say I need some help. I would never of had them connections before.

People are more likely to come directly to you now. I wouldn't be afraid of picking up the phone and trying to get in touch with anyone at the local authority.

Service users in Goole have needed that MDT approach, and because we've had names and email addresses, we've been able to fix that up more quickly.

By having a better understanding of each other and building relationships, it has enabled partners to be able to think differently and learn from each other. The growth of a network enables everyone to have a voice:

Everyone who attends has a voice and comes to give an input.

It's a really good discussion. Everyone feels they're able to take part. Everybody's able to contribute, even if they don't bring somebody.

The voluntary services who have attended have encouraged thinking in a different way, and back and forth, they kind of understand our statutory needs a bit better too. I have really benefitted from the opportunity to expand that thinking about how we might do things in way that is not so rigid.

Developing relationships between partners has also enabled a greater sense of peer support contributing to the personal resilience of staff:

It's not just about an end product in terms of population health, the focus is about supporting each other. You're not alone with the patients and people you're supporting.

- Partner boundaries are changing - There has been a shift in thinking from treatment to prevention. INTs are trialling approaches that address the wider determinants that are impact on people's lives, rather than putting healthcare at the front and centre. Partners shared examples of how this is changing:

Picking cohorts where there was only so much the GPs could do and picking up the social needs around that.

We've not done anything like this before, people think you go to the doctor when you are ill. This has made us realise that actually there's a lot wider social problems going on that have an impact on health. It's a different approach for us, being more proactive.

I feel like the surgery is now more open to collaboration with others. The pharmacist has a better relationship with the surgery because she's involved in the MDT. The surgery is very open to trialling different things to see if it works.

Some of the most gratifying things are the people who's outlook has shifted. He's now in a population health approach mindset. You can see that with others too. It's given some people a vehicle for their thinking but others have shifted. They now speak about it being all about people and relationships, not medical and disease. The best of this work is when the VCSE are in the room. They say it every time.

It took a few sessions to realise that the purpose of the INT wasn't solely about health issues and related to the wider determinants of health. Coming from a health background and within health services it was hard to discuss patients needs from anything other than a health perspective. What they found though was that voluntary services were able to support with patients' complex needs.

Several practical opportunities for better integration have also been addressed, such as:

- Aligning patient lists enables partners to ensure that information across the system is consistent. A partner shared their experience:

> They said that they were able to improve pathways as, when attending the INT steering group meeting, the goal a practice mentioned around wanting to focus on care leavers but the practice weren't sure if their list was correct, so as one of their services is looked after children they would have this information and they could make sure that the right services were attending the INT.

- Partners are taking a lead on aspects of the project, not relying on one partner for everything. For example, partners have spoken about how Yorkshire Health Partners (YHP) stepped forward and volunteered to coordinate and chair the MDTs, ensuring that the MDT terms of reference were followed, that the right partners attended and that the MDTs adhered to statutory requirements. They wanted to have a steady representation and input at all INTs. This is an example of system development and maturity. INTs being system-led is part of the development and sustainability, which is ongoing.

> There needs to be somebody at scale that is living and breathing this that can support teams going through it.

> YHP got involved. Nobody else would stand forward for it. Nobody understood what was going to happen or the level or responsibility that the chair was going to have.

> YHP have a rhythm now, in terms of designing templates, when things need to be defined and sent out by.

- Capacity within the VCSE sector is better recognised - Perspectives of system and partners have changed, and action has been taken on the back of that. Although not a direct result of INTs, the learning from INTs has provided evidence to progress a new approach with increased ongoing resource, funded through the Improved Better Care Fund (iBCF). This example is described by a partner below and explored in more detail in Appendix C.

> We have recognised that there is not sufficient capacity or resource to effectively involve the VCSE in pieces of work like this. This has been built into a bid and a project that is really going to bring resource and capacity to support projects like this.

- Sharing training opportunities - NHS staff have accessed East Riding Council's (ERYC) Dementia Friendly Communities and Domestic Abuse training, and vice-versa NHS training is offered to ERYC staff. Learning from the East Riding has already been shared across the ICB and continues to be.

- Attitudes of system partners towards the INT approach is changing. Commitment to the INT approach is growing and partners are becoming advocates for INTs, encouraging others to get involved. Partners spoke passionately about their role in the INTs:

what I have heard is that as it's gone on I've heard greater enthusiasm. People are starting to see the benefit and realise it themselves and see the collaborative way of working. Feedback that I've received. The representatives that are there, I've sensed a change in their attitude towards INTs. In terms of staff commitment, I've sensed a difference. In the beginning I was always spending time chasing representatives to be there but after chasing some around, certainly from a mental health point of view, I saw more commitment.

[Talking about the most recent INT meeting] More people than I've seen at any INT meeting ever, lots of really good conversation, place for people to share work and a clear idea of where they want to go moving forward.

One of the most rewarding things I've done in my career, I've really enjoyed the opportunity to do this.

There has been a drive to be part of the conversation. There's a place for INTs.

As a PCN we are not going to own it, but need to drive it to make sure it carries on and lead it. We're the trusted guardians trying to keep everything together.

8. Method – From inception to system ownership

8.1 When establishing INTs a participatory development approach was taken, starting with senior level system partners. Several, well attended, scoping meetings were held with the intention of gaining buy in, translating the vision, and eventually transitioning to operational teams. Senior partners shared their insight into this approach, as shown in the comments below.

It's always about the people and this more than anything else. Synthesising the learning showed a number of things but there was something very clear about a strategic vision, and articulating that, particularly to our operational teams. And then working with those operational teams to build trust, relationships, and recognising that that's ok to do in theory but you need to at some point pick a piece of work and test that through. Test and learn gives permission for people to try something and not be successful.

There was a series of meetings with all partners, mental health, social services, children's, voluntary sector, etc. Initial meetings were relatively high-level directors, it needed to be of that level to get that initial buy in.

It created a common identity and feeling, by having people in the room, it created space for ideas and conversation.

Many organisations from across the system were encouraged to participate in the initial scoping meetings, and beyond, to the roll out of INTs, including:

- ICB Strategy and Population Health – consistent SRO of the project
- Primary Care representatives, including PCN managers, Practice Managers and GPs – collective regular attendance
- CHCP Chief Operating Officer initially, which transitioned to local leads and specialist representation

- Adult Social Care Team Lead – routine attendance initially and then when relevant
- Public Health Intelligence and Health Improvement – consistent intelligence input with health improvement input based on subject
- Children's services – issues with consistent representation
- Humber Teaching Foundation Trust Operational and Strategy Lead initially, which transitioned to local leads and specialist representation
- The Smile Foundation Community Development – consistent attendance
- NHS Business Intelligence - routine attendance initially and then when relevant
- ICB Communications – occasional attendance, as required
- ICB Primary Care – transitioned from strategic to managerial representation
- NECS Accelerator Programme – has not attended
- ICB Digital Team – occasional attendance, as required
- ICB Community Services – transitioned from strategic to managerial representation, as required
- Humber Teaching Foundation Trust Health Visiting – frequency dependant on locality and need
- ICB Clinical Place Director – initial attendance and then when relevant
- Humber Teaching Foundation Trust Mental Health – consistent attendance
- Yorkshire Health Partners – consistent attendance, transitioned from CEO to locality leads

As the INTs have developed, an increasing number of organisations and services have become involved, such as practice managers, VCSE organisations (e.g. the Hinge), Humberside Police, Humberside Fire and Rescue, Healthwatch and Yorkshire Ambulance Service.

A VCSE partner reflected on their role in their INT

> Local voluntary organisations have felt overlooked in the past by statutory organisations. It's still a battle as some don't see us as equal partners. INTs was a new concept to us and it's great that we were a player round the table. The first one felt really exciting, what it would look like and what it could be as a collaborative.

Creating the conditions for people to engage was a key element of this approach. Meetings were held in person and in community venues, with food and drink provided and an informal structure. Recognising the barriers for GPs to be released from practice, the ICB provided assurance regarding backfill payments, however only two claims have been made to date. A small amount of pump-prime funding was required to help create these conditions and make it easy and enjoyable for people to attend.

> It's about people and relationships. I wanted people who were driving to those meetings, who didn't know that area or perhaps only visited it infrequently, to drive through some of the neighbourhoods and experience for themselves what some of the issues were. I wanted them to recognise that it's a difficult journey to get to some of the places.

> I didn't want to build what could be seen as a traditional way of managing stuff. I didn't want it to feel bureaucratic. I wanted those teams to shape it and let it flow within the construct of the cycle.

> Some of the best conversations happened over the sandwiches.

8.2 The Quality Improvement Cycle was proposed as a cyclical process for measurement and evaluation.

Applying this model led to an important learning point about following the process:

> Hadn't appreciated at all that you can quite quickly get through the first 3 stages but point 3 takes so much time to try things. One year down the line, we're nowhere near doing the evaluation [stage]. Recognising now that some of the stages take a lot longer than you think and on a number of teams, we've gone back to stage one and started a new process before we've started to evaluate the ones currently up and running. It starts to snowball. That's brilliant for building momentum and keeping people engaged, bringing in different ideas and people but you increasingly feel like you're holding more and more balls.

Once strategic consensus was gained, the first steps of the cycle were 'being intelligence led' to identify cohorts. This was embraced quickly by all INTs, combining data with local experience. Joint Strategic Needs Assessment (JSNA) data, locality and PCN profiles were presented, for partners to add their local knowledge to. Data on specific cohorts was then sought to help inform next steps as described below.

> The intelligence is a combination of hard metrics that we capture, the voice of local people and the voice of local practitioners.

> We looked at the initial broad data in the beginning, and that matched up with the experience of working in Driffield. Gathering data and listening to other people and colleagues across the system led to our chronic pain focus.

> [How did you identify your focuses?] Local knowledge mainly, along with data received from public health intelligence. We know we can pinpoint exactly where that is through local knowledge. We don't want to look at health data, we want to see the social side which isn't coming through on clinical system data. The BI teams, they can get more specific data to areas which would be more beneficial.

8.3 Most INTs chose to utilise the MDT approach with system partners, identifying cases from the focus cohort. The individual benefits from those supported through an MDT are explained in section 6.3 and the benefits for partners are explained in section 7.1.

The purpose of an MDT is twofold; to better support the individuals identified and to understand the experience of individuals to identify themes and take action to scale up and change the system. Examples of scalable projects are explained in section 6.2. Co-production is a key element of MDTs providing an opportunity for individuals to shape what they would like to get out of being part of an MDT.

> The initial results from all of the MDTs was teething problems, but the benefit was almost universally consistent which was just having the people in a room, talking about the individual they all knew about, even if they couldn't change anything, there was just something about peer support that allowed you to think, someone else knows this person, I'm not carrying the can.

> Driffield MDT was really successful, even though there were only a few of us, and we only discussed a small number of cases, we were really able to pick out some themes and extrapolate that back to a population health level.

> I want our INT to be about how we can improve the whole system and how we can improve the system for the whole town.

Some INTs have found MDTs to be particularly useful in terms of improving care for individuals and identifying key themes that can be scaled up for action, whilst others have faced challenges including defining cohorts and identifying cases. Section 7.3 highlights the experiences of MDTs for each of the INTs.

Alongside MDTs, other approaches are being trialled such as the Brazilian Community Model[2], VCSE insight development, virtual teams, and project groups etc. These models are explained in more detail throughout Section 7.3. INTs are also connecting with wider systemic work such as the Health and Wellbeing Board deep dive insight and Healthwatch through presentations and discussions at meetings. Each INT has the flexibility to choose their own approach as shown below.

> There are different ways of integrating. They have permission to do something different.

8.4 A process was undertaken to set up INTs and MDTs in a consistent way with robust governance. The ICB Information Governance (IG) Lead committed their time to develop a data sharing approach and utilised their relationship with IG leads from partner organisations to gain system-wide consensus. A known and problematic barrier to integration was therefore largely resolved within three months. Tools include a data sharing agreement, Data Protection Impact Assessment (DPIA), adoption of the NHS data toolkit and an MDT term of reference, which are all being utilised across the East Riding.

8.5 As INTs started to meet regularly and develop cycles of MDTs, the need for administrative support was identified. Yorkshire Health Partners (YHP) offered to fulfil this role, but as resource requirement increased, it became apparent that they could not continue to deliver this within current capacity. Once rolled out across the East Riding, with an MDT meeting taking place in each INT each month, extrapolated cost implications totalled circa £75k per annum. This need was escalated to the HCC who gave assurance to the INTs, YHP and partners to continue to progress through to the end of March 2024 but to work through mitigation to this risk. A partner reflects on this milestone:

> We either carry on and keep racking this up or we say we don't support this. They all said that they support this. The committee reconfirmed it's commitment to neighbourhood teams. That was massive.

As INTs matured across quarter 4 of 2023/24, they did not rely as heavily on MDTs, therefore the requirement was significantly smaller than anticipated. YHP have since offered this service to all current and future INTs at no cost as part of a commitment to the joint strategic vision of the Health and Care Partnership.

8.6 As INTs grew organically, the SRO was increasingly responsible for sharing cross-cutting issues such as data sharing, outcomes, lessons learned and the rollout plan in each INT

[2] Community Health and Wellbeing Workers (CHWW) - National Association of Primary Care (napc.co.uk)

meeting. This was inefficient and missed opportunity for broader strategic discussion. As such, in March 2024, an East Riding INT Steering Group was established to enable system partners to have more involvement and greater strategic leadership in the overall direction, configuration and responsibilities of INTs.

An ongoing issue is the calendar commitments for those who need to be there, such as clinicians, which can make it challenging to attend.

8.7 As INTs are becoming more established, and local partners are passionate about championing the approach, they are now starting to take ownership and lead for the future. The next step is to gain further organisation and system-wide support and nurture our future leaders. As more partners step into system leadership roles, there may be a requirement for workforce development and leadership support as we continue to develop our future leaders.

Although the passion and commitment from key partners is a driving force of the INTs, partners also reflected on the need to ensure that this does not rely too heavily on one or two individuals to make them sustainable.

> We've got to get this so everybody in the practice understands. There's one or two individuals with will or passion at the moment. It needs to be integrated into just what we do. It needs to be part of what we do naturally. It's not there yet.

> I think we have had good buy in across the networks, some of the teams are a bit fragile, I don't know how much longevity they might have once ICB steps out.

> I don't know if this is an example of my own rigidity from my background, but It isn't a requirement from anybody, so therefore I'm worried people won't want to do it.

> I don't think it would work without me, I am driving it. No one else has investment in the local area in quite the same way. It needs someone to drive it and take leadership of it otherwise they won't work and if someone is really committed to it then it is sustainable.

9. INT overviews

9.1 The final East Riding configuration for INTs has been confirmed, and all INTs are now established or in development. The configuration is as follows:

Established:	In development:
Bridlington (PCN footprint)	Harthill
Cygnet (PCN footprint)	West Wolds (River and Wolds PCN plus Market Weighton from Harthill))
Driffield Hornsea, Leven and Beeford (2 x INTs aligning to the Yorkshire Coast and Wolds PCN footprint)	Beverley and Cottingham
Holderness (PCN footprint)	

All established INTs began in the same way and diverged at the point of understanding the local need. Conversations were had about how partners would work together, as described below.

> It was all conceptual and we'd start talking almost academically about how we'd improve relationships and work better together. People get defensive about sharing their contact details. There is fear about giving away access and becoming inundated and being able to deal with it. The fear holds it back and then you don't get the integration. You've got to try it.

The established INTs have trialled a variety of approaches in terms of what cohorts they have supported and how:

9.2 Driffield

Partners were brought together in May 2023 and looked at the broad data for the town, which matched the insight from those working in Driffield. When identifying what to work on, the INT focused on things that were causing concerns, with a local GP being instrumental in driving forward discussion.

MDTs have taken place with fourteen cases presented.

Cohorts that have been supported are:

- Children and young people - frequent attendance in under 11s
- Chronic Pain
- Childhood vaccinations and respiratory illnesses

Utilising the insight and learning from the MDTs, scalable parent education and pain clinic projects are being scoped for development. See section 6.2 for more details and the below comments on how these projects came about.

> We ran some MDTs from the list of frequent attenders, ran through cases and kept everyone focused on pulling out themes. I want our INT to be about how we can improve the whole system and how we can improve the system for the whole town. We can look at the bigger themes and take action.

> Gathering data and listening to other people and colleagues across the system led to chronic pain focus. Same approach, look at themes and what we could develop in larger way. In discussions with ICB about setting up chronic pain hub in Alfred Bean.

The consensus from those involved in the INT is that they have developed a successful process which now has a rhythm – partner discussion, data gathering, focus agreed (see comment below), MDT (individual support, learning and insight) to action to scale up. Partners feel that the INT has clear direction and strong leadership.

> Even though it did come from a health perspective, there was actually social needs that were impacting on their health presentation. Looking at that space where health and unmet social needs are coming together and exacerbating that individual, that might be a really good way for the INTs to work.

Next steps include progressing the care homes and house bound people focus, of which one workshop has already taken place, and linking with wider partners such as the Love Driffield Food Bank to utilise the established MDT process to support the most vulnerable.

9.3 Holderness

Holderness is a single practice PCN with strong foundations such as its Proactive Care Team and community assets. Initial meetings were well attended with senior level representatives from services, such as mental health, adult social care, children's services, and the voluntary sector.

Holderness INT is motivated to work differently, focusing on integration:

> We came at it a bit differently, as we didn't want it to become just another pathway, which is really resource intensive for a few people. Wanted to focus on the reality of how we work together in an integrated way, what does that look like? What does that mean?

> If we could capture 5-10% of the population who are going to go on to develop a condition, that would make a difference. It's a bit of a holy grail, but we've reached the point where we want to try and do something different.

> We are really good at saying let's find a condition and do things to or for this person and actually just going through the loop we've always done.

An ambitious approach was explored which involved all partners identifying 200 individuals who would be cross referenced to identify those who were known to everyone. Once discussed, it was ultimately felt that there was not enough capacity within the system to develop something of this scale at this time.

As a result, a survey was developed to gain insight from practitioners – focusing on those individuals who were 'worrying them.' Circa 75 people were identified, and four MDTs have taken place to date (with sixteen cases presented). Issues identified included social isolation and poor mental health. A focus has also been given to children and young people.

The INT has been faced with several challenges:

- Variable attendance with some partners not being clear what they were going to. Although attendance was good at the beginning from senior representatives, there has been a high turnover of staff and inconsistent representation. To increase attendance, the INT has evolved to a hybrid model with a mixture of face to face and online meetings. Varying attendance remains a challenge.
- Partners not putting cases forward, which may be due to a lack of understanding.
- The 'who is worrying you' MDT cohort was too broad.

- Solidifying the direction for the INT:

> The difficulty is what we target, didn't want it to be health focussed. We wanted it to be about the way we work together. The risk is that we keep doing what we've done before.

Benefits to date have been highlighted:

- Staff support – a strong sense of peer support, relief, and personal resilience of staff.
- The INT has taken a collaborative approach to projects, such as lung health checks:

> We've piloted lung health checks in our locality which has gone really well, the proactive care team have worked with ERYC to capture people at the time they are starting to think about their lung health to do a proactive and preventative project.

- A greater knowledge of local services:

> Some of the cases we had were offered a referral, but the individuals declined it in the end, but even though they didn't come to us, the GP was able to go away with some other service they could suggest to the patients

Most recently, other organisational priorities, such as the migration of IT systems, have taken priority. Moving forwards, the INT is planning to pilot a more specific project with a preventative focus.

9.4 Hornsea, Leven and Beeford

As with Holderness, Hornsea, Leven and Beeford already had a history of partnership working and strong foundations when forming their INT. They had an established Inequalities Team and were undertaking integrated project work; therefore, it made sense to develop into an INT rather than start something new.

The INT initially sought to understand local data and identified that the group with the greatest health challenges is working-class men aged 45-65 with cardiovascular health risk. The INT has taken a proactive approach to engaging with their target cohorts, going out to them in the community, for example to builder's merchants, rugby clubs, grain suppliers and local events. The following comment provides insight into the approach:

> We then started thinking about where and who are those people. Not the people in the surgery or going to the pharmacy, working class labourer was the mental image of who we want... where is that person going to be?

Projects are now running simultaneously with specific focuses which are led by frontline staff who are working directly with individuals and who can seek more senior support as and when required. This approach is described in the below comment. They have clarity of vision within a more limited scope. This approach, whilst different to some other INTs, potentially gives an increased probability of moving integration into a 'business as usual' model.

> I can do that and physically see that patient. It feels like we get more done on the project side, less needing meetings and more 'I'll just do that' and not got somebody there who isn't really involved.

Project focuses:

- Agricultural Workers/Farmers – cardiovascular disease (CVD), mental health (specifically suicide prevention) and access to services.
- Care Home Patients - stop/start review of medications, links with care home MDTs. Mental health care homes – Cancer Champion training, increasing screening uptake, and sex education for residents.
- Cancer Screening - general review and looking at low uptake groups - specific work has been done around learning disability groups.
- Working class men aged 45-65 years - outreach sessions targeting cardiovascular screening in the community, and access to services.
- Patients who have been lost to follow-up and/or have polypharmacy - crossover with working age groups, mental health, working class and agriculture. Proactive approach to contacting and enabling access to healthcare.

The make-up of the PCN has also influenced the INT approach in Hornsea, Leven and Beeford:

> Other PCNs have got a much bigger team within the PCN, whereas we've put the resource into the practice. Hence why we're having to do things a little bit differently to other areas. Both practices are GP heavy and there is a low use of non GP doctors, we've stayed pretty traditional because we have been able to, we can still recruit. here we have nine partners, so we've been able to go out and we're quite happy to do that and feel it's good for our patients.

Engagement with local people and integration between surgeries and partners has been highlighted as a benefit of the INT, which is described in the following quotes:

> Integration, being on first name terms with people involved, agricultural charities, local pharmacies, there has been a lot of good conversations and getting involved and meeting those people. We are getting people talking more about things, the biggest thing we got the most from was the rugby club, and we did see people coming in for follow up from that, probably the biggest success we've had.

> How we're working together to do those things and just like I say almost being less formal with the meetings seems to have worked better, 'oh right can we just do this' and have a chat

The INT will continue the project work that it is doing and expand where required. People with mild to moderate dementia, living in their own homes, who are just about managing is going to be a proactive future focus.

9.5 Cygnet

The PCN demographic is a diverse mix of rural and urban, with the highest deprivation being in Goole. Initially, it was agreed that the INT geography would cover the Goole area specifically with a focus on childhood immunisations (understanding why and targeting those who do not come forward for them) as the first cohort.

Intelligence and demographic data highlighted that people from the migrant community were the cohort missing routine childhood and vaccinations and immunisations and therefore would be the target population. As this was explored further, it became clear that the population were not well enough understood amongst partners for the system to be able to

support them. A VCSE-led piece of work is being undertaken to better understand this population and to establish a local community collaborative (see section 6.2 for more details).

All the data was leading to this community, therefore, whilst the insight work was being undertaken, an MDT approach was trialled. Two MDTs have taken place to date supporting eight cases. Colleagues who had attended the Holderness INT suggested adopting the 'who is worrying you' survey. Unfortunately, similar challenges were experienced in Goole to those in Holderness with this cohort, such as partners not knowing why they were there or what cases they should have brought.

Partners felt that there were benefits in utilising the MDT approach:

> We worked with a smaller cohort and talked about individuals that were covered in every service. They may present at the practice on a regular basis and they may present with the police or social services or district nurses.

The INT is committed to getting out into the local community through the engagement work to better understand the migrant community. The Brazilian Model of Community Health and Wellbeing Workers has been explored as a potential approach to progress community engagement and support, however it was decided that it will not be pursued now.

Next steps:

A review of the INT geographical areas has led to an increase in coverage that will encompass the whole Cygnet PCN geography going forwards.

A PCN lead connected with the ERYC Care Leavers Team at the recent East Riding Population Health event. They fed back to all practices within the PCN and have since completed an audit which highlighted that anxiety/mental health support and substance use were common concerns amongst their registered care leavers. This has enabled them to gain buy-in from partners that everyone has a role to support. As such, Care Leavers will be an area of future focus. The comment below describes this in more detail. As with Driffield and Bridlington, the INT will also consider the Care Home and foodbank user populations.

> Although it's not a large number, the benefit to those would be great. Initially we're trying to code correctly and then working with practices on what they're entitled to (like veterans) to take away the barriers.

9.6 Bridlington

Bridlington as a place has been described as integrated, passionate, and closely connected with system partners having a history of working together:

> There's a sense of a team and across teams.

Bridlington was the fourth INT established and benefitted from processes that have been developed through other INTs, such as data sharing, and from the experience (and advocacy) of partners who have an East Riding wide remit and have taken part in other INTs.

Initial exploratory scoping meetings identified rough sleepers / people on the verge of homelessness, children, and young people, and those with multimorbidity as potential cohorts. Work in Driffield focusing on children and young people meant that Bridlington could collaborate on a scalable parent education campaign.

An MDT was held for five individuals supported in the community by The Hinge. This was recognised as a positive experience by multiple partners which may have scope to be repeated in the future:

> The Hinge provided patients from their perspective and did an MDT which worked really well.

> A Small group of partners came together that didn't talk over each other and were focused on the vision and creating action. Systems were accessed there and then, appointments were made, action was taken instantly where possible. Individuals were looked at holistically.

As momentum built, multimorbidity was agreed as the second MDT cohort, however, challenges were identified which meant that the MDT was postponed. Partners perspectives on data sharing was raised as a challenge, although this had been addressed at other INTs. Perceptions and risk levels of different organisations and individuals still need to be individually addressed. A lack of partners bringing cases for the MDT led to the postponement. A partner shared their experience:

> The vision was focused but it wasn't happening. There needs to be understanding and commitment from partners for the approach to be successful. I was empowered, they helped me and I wanted to help them. Everyone has a part to play.

The INT decided to have a 'mini reset', and, in May 2024, they agreed to progress the 'Bridlington Model', a localised version of the 'Brazilian Model of Community Health and Wellbeing Workers' which will focus on the residents and families living in specific streets/neighbourhoods by building relationships, developing a deeper understanding and supporting households in a holistic way. Data and local insight will steer which streets are supported first. A partner has shared what the approach means to them:

> Our clear purpose is getting those people that we don't see at practice that have hidden issues. There will be families down there that are not very vocal but do have issues, perhaps domestic violence, finances issues, that maybe then has that knock on effect, the impact of that deprivation on kids. I understand we can't fix all the problems, but if we can do something down there to raise their standard of living. Maybe people are not aware of what services are there, or where to go for support, and probably not going to come into practice and ask. Trying to prevent them needing to go into practice in the future, being proactive and so they know we are listening, putting things in place and getting better understanding.

Attendance is high at all meetings with a number of partners wishing to be involved, which creates lots of opportunities but can also be a challenge to ensure that everyone attending gets value out of the meeting. Building relationships remains a priority for the INT. The comments below reflect the opportunities and challenge:

> To me it is all about networking and links.

> More people than I've seen at any INT meeting ever, lots of really good conversation, place for people to share work and a clear idea of where they want to go moving forward.

> You can't have as much detailed conversation with a big group. If it's too big, you don't know anyone. The network needs to group and build relationships.

10. Challenges and opportunities

10.1 Whilst there has been tangible success, INTs have also faced several challenges. Professionals have been honest and open about their experiences, which has allowed for barriers to be identified and discussions around potential solutions to take place. Allowing professionals to continue to raise concerns in a constructive way and act upon them is a real opportunity not only to improve the outcomes of the INTs, but also to empower professionals to recognise that their voice can influence and shape the system.

Quotes and comments for this section from system partners interviewed can be found in Appendix D due to the volume of relevant perspectives.

10.2 The most talked about challenge in establishing the INTs was ensuring that the right people are involved at the right time, as gaps in service representation can limit the scope of the partnership work. Wide-ranging involvement is essential for effective collaboration for the benefit of the population.

There are some services who consistently do not attend any of the INTs. Possible reasons for this lack of engagement could include staff turnover, insufficient capacity, or that INTs are seen as an additional task rather than a step towards more integrated ways of working. This may result from a failure to convey the strategic and operational vision, benefits, and objectives to those on the front line.

Education and schools have been identified as a key partner whose attendance would be beneficial in terms of prevention to build resilience in young people. Other service areas that it would be beneficial to have more input from include wider Children's Services, more services of providers such as CHCP and Humber FT, emergency services such as Police and Fire services, Housing, wider VCSE representation from smaller local organisations and partnerships.

It can however be challenging to get the balance right with the number of partners involved. Several partners interviewed reflected on how it can be difficult to develop relationships in a large network, and the conversations are often not as detailed, yet having a limited number of partners can also limit the breadth of perspectives involved.

10.3 When services are represented, they need to establish who is the most appropriate person within their service to attend and ensure they understand their involvement. Half of the partners interviewed mentioned 'limited knowledge of what INTs are' as a barrier, with several partners sharing experiences of front-line staff attending MDTs but not really understanding what the purpose of the meeting was or why they were there. This had a knock-on effect on cases being brought to MDTs, with several being postponed due to partners not submitting cases.

10.4 Whilst the INTs are testing and learning there is a risk that partners will disengage if they are unable to see value to their service early in the process, as they are investing their time and resource. There have been examples of partners attending initial meetings and then withdrawing when the chosen focus did not fit with their service.

There are also several scenarios where a service has not been involved in the initial development of an INT and have been brought in to discuss a particular cohort, which has

led to challenges with understanding the work, being able to contribute, and developing relationships.

10.5 Communication has been highlighted as inconsistent in some places and presents a potential opportunity to better engage with services with little or no representation. Some partners interviewed said they struggled to stay informed with what was happening due to actions from meetings not being circulated, particularly if they had been unable to attend. Others involved in multiple INTs highlighted receiving communication from different sources for each INT rather than one central point causing confusion, and struggling to keep up to date with what was happening in each when receiving eight different sets of minutes.

10.6 Data sharing had been highlighted as a challenge in previous learning, it was recognised as a 'bear trap' as it was still an unavoidable barrier. When initially establishing the first INTs, data sharing was raised by partners as a requirement for a single care record. Representatives from the ICB Digital Team were in attendance and able to provide an update on progress of the single care record work. The Information Governance Lead at the ICB led a piece for work to develop a DSA and, as a result, East Riding INTs are now utilising a DSA.

Having a centralised DSA with a consistent process for gaining consent has been helpful to overcome some of the limitations INTs have faced. Whilst the flexibility for each INT to take their own localised approach has been key to success, there are areas such as data sharing in which a consistent approach across all INTs is necessary.

However, some partners are not involved in MDTs due to data sharing, which has been described as a challenge to maintaining input and staying up to date. Our VCSE, particularly the smaller organisations, do not have the suitable secure infrastructure in place to be able to manage data at the required level. Secure email is used to share data, but some VCSE organisations are still unable to access this approach. More recently, it has been agreed that the NHS Data Toolkit will be used as the minimum standards for data sharing, which currently excludes many VCSE organisations and is being escalated to the national NHS Digital Team.

Another data sharing challenge is around buy-in, risk aversion and confidence of some partners in utilising the arrangements. Some services are more protective about the data, and front-line practitioners are nervous about sharing personal information between system partners.

From a population health management perspective, the use of data to understand the population need is a challenge when the right people do not have access to systems that would generate insight. Some practices within the same PCN use different systems, making analysing data for a particular area more challenging.

Looking at overlapping neighbourhoods or PCN boundaries has been challenging for colleagues involved in providing data insight and intelligence, due to Ward boundaries not aligning to INT footprints.

10.7 In practical terms, what is meant by 'neighbourhood' was also identified as one of the most common challenges when trying to establish INTs. Many PCN footprints have a varying demographic within them. INTs bring an opportunity to work across PCN boundaries. It can break down barriers, enabling partners to work with others that are geographically closer.

It can be a challenge for professionals working across the East Riding to know which practice an individual is registered at, and therefore which MDT is appropriate to bring their case to. There have been examples of cases being brought to MDT where the individual is registered at a practice outside the INT boundary.

On the other hand, there are others who believe that INTs should align with PCN boundaries and that there are challenges with bringing multiple PCNs together to work across a footprint that does not align to them. The development of working within PCNs and overlapping geographies can create more complexity.

10.8 Further challenges that have been identified when attempting to develop and maintain a complex system-wide team include:

- Breaks in momentum due to immediate high-level priorities, some INTs have experienced gaps between meetings
- Partner's perceptions and understanding of each other – Many of the partners involved in INTs have not worked together before so, understanding each other is the first step in being able to soften their positions to work together
- Hierarchy has been a challenge with a couple of partners sharing that they felt their ideas were not being heard or that operational staff had been turned away at a meeting by clinical staff
- For partners who have an East Riding-wide remit, it can be challenging to remain updated and attend all meetings with numerous INTs now established
- The differing geographical set up of services can be a challenge due to partners not knowing who to approach
- Rigid referral processes
- Lack of feedback to partners on outcomes of interventions from MDTs
- Cases being brought to MDTs were already receiving all the support available
- Understanding and engaging with our communities - there are parts of our communities that the system does not understand well, and expectations have had to be managed in terms of the amount of time required to undertake community engagement and gather insight
- Limited resources in terms of time and capacity of those involved to take on all the opportunities presented
- Lack of capacity for evaluation - Utilising an evaluation approach from the beginning would have enabled a better understanding of what has worked and what has not worked. A lack of capacity has meant that evaluation has been small scale to date. Pre-existing evaluation tools were researched and trialled such as the Recovering Quality of Life Questionnaire (ReQol) but there were concerns about duplication, capacity, and not seeing the full picture. Increased capacity within the ICB and Public Health, funded by the iBCF has enabled the new bespoke evaluation framework to be developed and implemented

10.9 Broader system issues that are impacting on INTs are:

- Several colleagues from partners across the system have supported, advocated and led the development of INTs. These individuals are stepping into system roles for the first time – this should be encouraged and nurtured proactively through various means, not least of which would be some formal leadership development.
- A single, readable care record across partners remains in development and is likely still to be over a year away. This enabler would create a significant step change in integrated working.
- INTs represent a place in the system currently where two significant, cross-cutting ambitions are coming together – integration of teams / sectors and the ongoing development of a Population Health approach. The proposed development of the East Riding Population Health Steering Group would support delivery of the Population Health approach, specifically knowledge acquisition and understanding of the concepts and the transition to practical delivery. A 'toolkit' of different approaches and techniques will need to be developed / synthesised to enable INTs to have several tools at their disposal, particularly when trying to address issues relating to deprivation.
- Systemic processes still hinder integration and remain outside of the control of individual INTs. For example, if an individual is recognised through an INT MDT that they would

benefit from support from another agency (and this agency accepts this during the MDT), the organisation that brought the individual to the MDT would still need to return to work and generate a referral.

- There has been a maturing of some system partners and relationships throughout the process however there remain many occasions where partners are passive in discussion and/or will take actions readily for their own organisation but are reluctant to step into a system leadership role.
- Lack of additional funding has been raised by several INTs as a barrier to progressing projects.

11. What does the future look like?

11.1 When asked about their vision for the future of INTs, partners expressed the following concerns and opportunities:

Future Concerns

A small number of concerns were raised in the comments below:

> A fear that someone somewhere will try and tell us what to focus on. That's not where some of these teams are. They want to do what they understand that local need is. There's a fear around being given time to do it. I've lived this.

> I'm at the point where I feel this kind of anxiety, and sadness, and worry that it might not continue, and I don't know how much that is reflective in the other services. Are they fully bought in? It would fill us with deep sadness if this did not proceed. It is so important and I hope everybody feels the same I guess.

> Our current political stance before the election was called, we were on a path of austerity for public service which has an impact to sustain stuff like this.

> I have the drive and the passion to make it work. I don't want to be the one driving it if no one else is interested.

11.2 **Future Opportunities**

Partners identified several opportunities for the future, some of which were building on what the INTs have already achieved and others were further system integration ambitions:

- Continuing to link strategy to tangible action:

> I find it really hard to think about stepping away because on the one hand, I appreciate that my time here is limited. I can't manage personally eight INTs. I always had that realism in my head, however being involved in those and understanding how they work and the dynamics of them is fantastic in terms of being able to funnel and challenge things that are happening at a strategic level into some tangible action on the ground. For example, linking the cost of living work from Health and Wellbeing board to INTs. There's a route to connect it.

I'm massively encouraged by all of the connections people have made, the positive feedback, the sense of peer support, the sense of not feeling alone and shouldering responsibility, the release of a burden. I'm really encouraged by, you know, the conversations around individuals to MDTs that feels like there's some notable change for those people. And there is some demonstrable examples of us being able to take some learning and scale it up. On the other hadn't, I still feel like they're very fragile and I fear outside influence.

- More capacity within the VCSE - Embedded within the East Riding communities, a Connecting Communities Team is being established, consisting of a manager and three coordinators covering the North, West and East of the county. The VCSE face barriers of time, number of volunteers and skills. INTs create an opportunity to develop volunteer recruitment, record impact, and use robust measurement tools. By linking voluntary groups together to signpost to each other, individuals have multiple support options rather than just that one or groups duplicating services. Funding can then go further, and they can access more opportunities. A partner shared a key need:

We need to work to make some of the smaller organisations commission ready to make it more equitable to allow for micro commissioning.

- Further growing our work as an integrated system:
  - How: Continuing to work in a flexible way based on the needs of our communities:

We have to get away from labelling things. People section and segment it. It's making sure that we don't silo things that all need to ebb and flow together. You label it an INT so people become very fixed about what it is. It should be looking at what are the needs to the community and what are all the tools that we can use to make an impact and get them the right outcomes so that they live well for longer. How do we get that proper helicopter oversight and make sure that the dots are joined in the right ways to get the outcomes. You're then not getting duplication.

  - How: A holistic view of care can be achieved through relevant information being shared with partners with individuals only having to tell their story and give their consent once. Beyond, having processes in place such as integrated care records, a system-wide change in culture for data sharing. Partners share their perspectives on what this means and how it could be achieved:

We need to create a platform where talking to anyone in healthcare is like talking to your GP. It's about messaging. To get holistic and seamless care, you need seamless communication and this comes with data sharing but it's sharing only to appropriate professionals and not beyond that. Consent that it's dealt with in confidence and that means it could be shared with other that are working for the benefit of your care.

More of the same, however I think we need some better data. We need an integrated care record that will give us the tools to evaluate stuff better.

For us as a team it's helping them find cohorts they can do something with more, then feeding back the finding and feeding it back, locally, nationally, etc.

> Give the community the way that they think we work already – we all speak to each other, collaborate and pick up the phone and talk.

- How: There is a national directive about INTs in the PCN Direct Enhanced Services Contract. If Clinical Directors commit and lead, there is support within the system from other partners:

> INT needs to be a standard agenda on the PCN board meetings. Will start to invite others to the meetings when they become more mature and it will become a more integrated board.

- How: There have been notable successes from social workers being based on GP practices, as described in section 6.2 Working together in shared spaces has been identified as an approach that could be expanded across other service areas:

> I think what we need to be doing more of is working in shared spaces just to try it and see what happens. Put a couple of operational people in a room as a pilot, a trial, to see what happens. Relationships and building that within networks in communities so they can speak about how are we going to manage this person, take a more holistic approach. In the time that has been spent on the governance we could have just tried it.

- Shared resources and budgets being used differently for a collective outcome, so that all partners can see the benefits of investing their resources and working together:

> In hindsight, when we introduced additional ARRS roles, it could have been an opportunity to meet with the local authority and different groups and say look, we've got this pot of money, you've got this pot of money and we could have done it together.

- Greater collective influencing power:

> I'm really hopeful that it's going to bring us more working collectively as a partnership. It will be good to raise things together. It does just come with more weight, doesn't it? When it comes from a group of more partners saying this is what the issue is.

- KEEP GOING: Due to the nature of this work, it will take time for some of the benefits to be realised:

> Even with the work we've done with CVD the job is still certainly not done, stats will probably show this is still the biggest thing in 3-5 year's time, so carry on and keep refining these things and keeping an eye out for anything else.

12. Conclusion

12.1 Following the reference to INTs in the Fuller report in 2022, full East Riding configuration coverage has been confirmed and several test and learn neighbourhoods have been mobilised.

This paper has provided an in-depth update on the impact to date of the INT project across the three focus areas of the newly adopted evaluation framework: the population, individuals, and integration. Benefits are aligned to the five focus areas of INTs.

Population benefits have included service transformation, such as collaborations between adult social care and general practice. New services have been introduced to neighbourhoods, and access has been improved in some areas through colocation. The system has a greater understanding of communities through joint intelligence and work with VCSE partners.

Individuals have seen benefits from system partners taking a holistic view, leading to a better understanding of them as a person. Individuals have been able to co-produce their desired outcomes, allowing for more personalised care, and have been able to gain direct access to the right range of support services. As relationships between professionals have developed, individuals have benefitted from more streamlined support between services.

Integration has been reported as having the biggest impact for professionals to date. INTs have created a space for professionals to come together and gain a better understanding of each other and their services, developing direct relationships which have enabled them to overcome connectivity barriers. Services which have previously worked in a reactive way are being given the opportunity to take a proactive and preventative approach.

Whilst there has been tangible success, INTs have also faced several challenges. Professionals have been honest and open about their experiences, which has allowed for barriers to be identified and discussions around potential solutions to take place.

Some of the challenges identified have been ensuring that all professionals involved fully understand the concept of INTs and maintaining engagement with professionals when a focus does not align with their services, so that everyone sees value in participating. There are still gaps in representation from some parts of the system. Communication has been highlighted as inconsistent in some places, leading to confusion about what INTs are and who should be attending, and presents a potential opportunity to better engage with services with little or no representation.

Partners have expressed their motivation and commitment to collaborative working and shared their perspective on what could be achieved in the future and how. As INTs are becoming more established, local partners are now starting to take ownership and lead for the future. As more partners step into system leadership roles, there may be a requirement for workforce development and leadership support as we continue to develop our future leaders.

It is recommended that the contents of this report are shared with system partners to highlight the progress made by INTs and the ongoing challenges faced, to raise the profile of the work and gain wider system engagement.

13. Next steps

13.1 Sharing and Learning

- Share the evaluation findings with all established INTs for them to utilise and to add any further input.
- Share the evaluation findings with INT partners identified as part of the East Riding roll out for them to utilise as they mobilise their new INTs.
- Share the evaluation findings with all relevant partners, for example, INTs in other Places of the ICB such as Hull and NEL who have already connected to request learning and insight, other HCC programmes and projects, East Riding Population Health Community of Practice.
- Input findings into the JSNA through the Behavioural Insights Pro forma.

13.2 Evaluation Continuation

- Work with the other programmes and projects that are part of the Healthy and Vibrant Communities Programme to gather evaluation data.
- Measurement and reporting of outcomes in the Outcome Frameworks
- Revisit INT project in 6 months to gather further evaluation data

14. Recommendations

14.1 The Committee is recommended to:

1. Note the contents of this report

2. Share the report with system partners to highlight the progress made by INTs and the ongoing challenges faced to raise the profile of the work and gain wider system engagement.

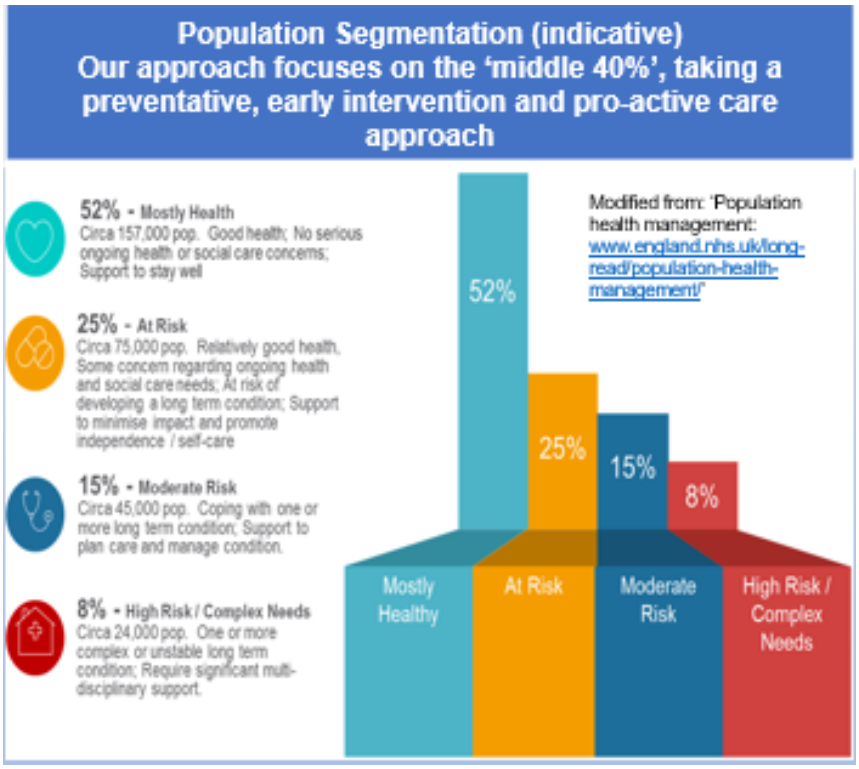
3. Act on the opportunities identified to allow for further growth and development. Insight gained should also be shared with newly formed INTs to support them to develop.

4. Support continued evaluation work to understand the progress being made across all INTs and to enable key learning to be shared across the wider system.

July 2024.

15. Appendices

Appendix A – East Riding population segmentation. The graphic below highlights the 'middle 40%' of the population of which the population health early intervention and proactive care approach focuses on.



Appendix B – Alignment of benefits to the five focus areas of the INT outcomes

The five outcome focus areas:

1. To create the conditions for operational practitioners to come together and work seamlessly, sharing information, providing advice and support, etc. Empowering people, building relationships, providing nurturing environments.
2. To create a team / function that can support any individual, cohort, or community that our teams/intelligence think or demonstrate are causing concern. To avoid INTs that are focused on specific individuals and/or conditions; that have the fluidity and flexibility to move between different needs.
3. To utilise a population health approach to identify need for the INT to respond to. Primarily to focus on the 'middle 40%' (see Appendix A) through an early intervention and proactive care approach, utilising a 'conditions of living' approach.
4. To support individuals and their immediate family / community whilst simultaneously providing peer support to our practitioners.
5. To raise ourselves back to a population health approach by identifying key themes that the system needs to address.

	Focus				
	1	2	3	4	5
Population benefit					
Service transformation	●		●	●	●
Understanding our communities better			●	●	●
Parent education campaign			●		●
Adult social work and GP partnership	●			●	
New services in neighbourhoods				●	
Residents accessing services in one place	●	●		●	
Individual benefit					
Referrals to wider support services	●			●	
A holistic view has led to better understanding and personalised care		●		●	●
Direct access to the right service				●	
Supported sooner				●	
More streamlined support		●		●	
Engagement with those not often seen			●	●	●
Confirmation that individuals are receiving the right holistic care		●		●	

Integration					
Partners have a better understanding of each other	●	●		●	
Direct relationships developing	●	●		●	
Boundaries are changing	●	●	●		
Practical changes - Data sharing, aligned patient lists, partners leading, reduced duplication, VCSE capacity recognised, shared training, change in attitude	●	●		●	

Appendix C – Three examples of change, utilising an explanatory account approach to provide a plausible explanation as to how the benefits contribute to the overarching HCC Strategic Ambitions.

Example of a most significant change

The capacity and resource of the VCSE is now recognised
Perspectives of system and partners have changed and action has been taken

HCC Strategic Ambition Focusing on experience of care and excellence (**Outcome theme** System Integration)

Where is the impact? How (integration)

Barrier to integration - VCSE organisations don't have the capacity, knowledge of healthcare system, or data standards, to be able to participate in INTs effectively. They are invited to be involved in INTs but don't have the infrastructure to participate meaningfully. *"The voluntary groups are ones doing the grassroots activity, they know things about the service users but don't specifically record that information. Groups don't know how to collaborate with each other, or don't have the skills to, it is quite easy to only focus on their one activity without appreciating the wider value that has."*

Different levels of infrastructure means some organisations can participate and others can't. *"The Hinge are directly involved in Bridlington because of the infrastructure they have in place, but Bridlington Street Angels are a three person show who don't have any of that. It is a case of working with what you've got and trying to get everyone to the same level."*

The Change - Smile bridges the gap and builds capacity in the grassroots but there is a lack of capacity. The work with INTs has highlighted the need and provided evidence to progress the development of a funded Community Team resource to increase the capacity to develop the VCSE.

"[The new resource will focus on] Highlighting the importance of working together, so we have a joined up approach of groups working together rather than two separate groups duplicating services, so that the funding can go further."

Explanatory account - If capacity is added to the VCSE development team with a focus on infrastructure and partnership development **then** East Riding residents will have a better experience of care **because** more VCSE organisations in the East Riding will collaborate with the health system, providing more joined up care and less duplication.

Example of a most significant change

Connections have been made with the Goole migrant community

Their needs are better understood

HCC Strategic Ambition Focusing on experience of care and excellence (**Outcome theme** The voice of those seldom heard)

Where is the impact? What is changing (population)

Barrier -People from the migrant community were identified as the target population for childhood immunisations. As this was explored further, it became clear that the population were not well enough understood amongst partners for the system to be able to support them. "*It became clear early on that the community were not represented, and we didn't actually know the breakdown of that population. We didn't know what language skills they had or anything."*

The Change - A VCSE-led engagement process was mobilised with the aim to foster trust, provide culturally relevant information, and improve health outcomes for the town's migrant (refugee and asylum seekers) population. A partnership approach between HEY Smile Foundation, East Riding of Yorkshire Council Adult Learning, Opportunity Goole, and Welcome House led the Community Conversations project. The project has identified both the positive aspects and significant challenges faced by the migrant (refugee and asylum seekers) community.

Explanatory account - If system partners engage with the migrant community by listening to their experiences **then** partners can make changes so that the Goole migrant community will have a better experience of care **because** system partners have a better understanding of the strengths and challenges faced by the migrant community, can make less assumptions and can co-produce opportunities through the new connections and enhanced trust.

Example of a most significant change

Partners have a better understanding of each other and their services

The are developing relationships, enabling them to overcome connectivity barriers

HCC Strategic Ambition Removing barriers to access (**Outcome theme** Access to Services)

Where is the impact? How (integration)

Barrier to integration - Partners often work in silo. They may have awareness of each other but don't understand what each other does or how they can work together to offer more joined up and accessible care.

"It definitely is the case that teams can work in silos of each other, which obviously is not in the best interests of our service users."

The Change - INTs have provided a space for partners to connect, get to know each other, build relationships and support individuals from a more holistic viewpoint.

"A patient's health was being managed, but the patient's home environment and lifestyle issues needed addressing. By building relationships in the INT, they were able to find a solution with the Red Cross advising that they can support patients such as this and transfer them to appointments. Through building these relationships they were able to gain an awareness of what help might be available in other areas."

"It has been helpful to build relationship between providers, that's probably biggest success, health visitors, GPs, social workers are all talking to each other now about people."

Explanatory account - If partners have direct relationships and understand each other **then** some barriers to access for East Riding residents will be removed **because** care is more joined up and signposts/ referrals can be made with a better understanding.

Appendix D – comments and quotes from Section 10. Challenges and Opportunities

10.2 Service representation

The first cohort of children was really restricted by lack of children's services, health visitors, etc. There was a whole section that we didn't understand, but they were just too busy and couldn't come.

There is another person who keeps getting back on pain meds because they are contacting out of hours, but we can't understand how we can improve that as the service provider haven't been involved.

Is it that people aren't there because messaging isn't right, it's not a priority, or they don't understand it?

I think they probably don't know the importance. The manager thinks it's not in their contract so they don't need to do it instead of seeing it not as a commissioned thing but the bigger picture.

Capacity within the VCSE sector is still a challenge. The VCSE don't get paid to sit around the table. We're bought in but need to see the benefit.

If we talk about wider primary care, what about dental, optometry and community pharmacy. They might be the trusted person that somebody comes to.

Time is huge barrier for them, but education and targeting children has slipped into each INT.

When there are more people, it gets lost. You can't have as much detailed conversations in a big group.

How do we involve everybody? We've got the big players there but we've just got the tip of the iceberg.

Weakness of not having a big meeting is that we don't have that prompting.

It's still a bit stifled as we're not sure who we need from the organisations. As the system matures, that will support.

Mental health services have been attending to make sure that the service is represented but they noticed that they may have needed more operational people to attend to have the discussions.

It was quite challenging to get the right people in the room because people have got a day job and actually this is something that is sort of over and above. It was a pilot. Trying to get the operational people that could make things happen in the room so that they could realise that the pilot was a worthwhile thing to do and to keep the momentum. Maybe what it needed was their interjection at an earlier point in time so that the issues are their issues.

The other big factor is capacity. I simply think it's because of capacity of the team to engage. You're choosing between that nebulous thing that I don't really understand or giving up seeing 20 patients this afternoon. People are working really hard to keep seeing the people they're seeing, I get it. I can really understand that it's a challenge.

They're busy with visits and couldn't see the benefit of dealing with this small cohort of patients and to get them more engaged maybe what we or I should have done is to get their ideas to the table in the first instance so that they feel as if they are resolving their problems rather than someone else's.

It depends on who is in charge of the locality teams. Comes back to, has the strategic vision been sold to the strategic leaders and have they in turn sold it to their teams. There's potentially a flaw in both of those steps.

Not always able to agree to things in a timely manner as might it not be right person at the meeting. They might need to relay to a manager so there's still bureaucracy. We need to get beyond it to flow better.

10.3 Understanding what INTs are

People are very unsure about the INTs because you're trying to make it turn out what it needs to be but it means lack of engagement from others because they need it to be 'this is what it is and this is what we're getting out of it' which is where we may get to but at the minute, it's test and learn.

Fundamentally I wouldn't be able to summarise what the outcomes were meant to be collectively. I know what we're trying to focus on for each area. I could say what we're looking at for each area.

Being clear about what was trying to be achieved from INT as initially the perception was that it was a duplication of the MDT. They felt that initially health was leading it, especially with GPs picking the type of issues to discuss which led to a very health focused model that felt like a duplication of the MDT. More voluntary services attending, and even leading could move the focus away from health.

Are partners talking to people in their organisations about what we're doing? We've not got the news out there to the other providers. They might've heard of INTs but they won't know the specifics. Who's role is this?

Strategy could have been too nebulous, let it flow too much and find it's own way. What we're asking for is partnership working. Maybe it was too intangible for people to grasp. Or they could have got it but not translated well to teams.

Mixed bag as to [knowing] what an INT is. We don't have a cohesive or single voice of what an INT is. Not one size fits all, concept the same but all INTs will operate differently depending on the population need.

I think it's a really difficult concept for services and staff. So did initial data gathering, and most services didn't bring anything. We are really good at saying let's find a condition and do things to or for this person and actually just going through the loop we've always done.

10.4 Maintaining engagement

I wasn't there from the very beginning. I've been brought in at different stages where people said oh, this is children and young people, you should be involved in it. Then you can feel like you're halfway. I sometimes feel a bit like I'm a bit naïve in some of the conversations.

We had very variable attendance, and even within teams it varied from time to time and quite often people didn't really know what they were coming to or why, they had just been told to come to a meeting.

Not really been heavily involved in all of them but have sort of dipped in and out. Initial conversation about worried well families and then into an MTD. I'm not sure how we got there. Probably because I hadn't attended so I didn't know.

I get a little bit lost because I wasn't really heavily involved in that point, I thought I could step away. So I had stepped away and then maybe I shouldn't have done. So now I'm back at the table.

Every time that consistency falls down or you don't have the buy in, the group reduces in confidence in the process. Every time we get it wrong we're increasing the risk.

My concern is how do others perceive it in the system and how do you get people back when you've had a break.

I thought, naively maybe, that the strategic people would transition to the operational people but all partners would be represented all the way through all the time. The whole point is it's an integrated team and if you come back to population health it's recognising the conditions of living and wider determinants of health so everyone has a part they could potentially play. By picking kids, they effectively disengaged a lot of people who are adult focused. Teams struggled to see what they would bring. The kids have parents so if the children are having issues then the parents might be too. There's still a need for a holistic team.

10.5 Communication

Action logs, something practical to take away and discuss, enabling people to work better together before and after meetings.

Sometimes when we'd be in a meeting or MDT and the outcome might have been ok we will take a referral, I never found out what went on after that unless I did a bit of digging and asked.

Level of comms is very difficult as it is not coming from a central point, getting emails from different places and comms for each INT. It is all coming to me so it's very difficult being able to keep on top of that.

Not possible to get to them all. Idea is great in terms of trying to drive it forwards but not possible in terms of calendars. How you maintain a network that doesn't need the level on connectivity, particularly for those that work across the full ER.

I do believe that when you're trying to build networks, being able to have the open and honest conversations in person. Maybe every other one on teams or they happen every 6 weeks. Some sort of conversation group that you can have on Teams in-between.

One situation report instead of eight different sets of minutes, or a newsletter so there is only one email to read, saying this is the focus, this is what we've done, and these are the outcomes, at the moment. It is just very difficult to keep on top of.

It's not quite business as usual yet, it needs admin oversight.

10.6 Data sharing

Some elements of INTs need a consistent process, for example data sharing. Good to have flexibility within each area to take their own approach, but some things need to be standardised across the INT network.

Hard to keep track of information, updates, and focuses that change at MDT level across 4 INTs let alone 10. Need one person or one place to coordinate / see all of that information, however the VCSE still can't access this due to data sharing.

We have been able to gather consent and we have a Data Sharing Agreement, so I feel comfortable.

It enabled us in the other two INTs, to say we've picked this up so you're already short circuiting some of the conversations you have.

They need the skills, understanding and processes in place. If they can't receive NHS data then they can't be involved. It's easier for bigger VCSE organisations to get involved because they may already be working with system partners to deliver commissioned services and have the infrastructure in place.

Learning from this is around reputational damage from doing what has been asked without knowing the full process. Also need to consider the reputation of voluntary groups who could end up in trouble for doing something we've asked them to deliver.

Data sharing is a key barrier to overcome to accelerate the involvement of VCSE organisations. Understanding that different groups will have different levels of understanding and require different levels of support to get to the required standard.

Ward level data is not reflective of the area, needs local knowledge to understand the issues with the intelligence.

Improved access to systems would help. Being able to aggregate conditions that people have by administrative geography or practice they are registered at. It's the individual practices within the PCNs that hold the data. Some practices use one system and some use another.

Public health can't attend MDTs. It's difficult to engage [when you can't attend the MDTs] from a team or individual point of view. Conversations evolve in MDTs. It then makes if difficult for us to try and pick it back up.

Strangely, we quickly followed a governance line of separating ourselves out from MDTs, it's pretty hard to evaluate something if you're not in the room, not my experience in other places. It introduced a blind spot in our knowledge by segregating ourselves out from those conversations.

Without creating the absolute total confident for our children's nurses etc then their instinct is just that I'm going to steer clear of this because if I stay clear I don't have to get put in the hot seat.

From a children's point of view, sharing information, they are a bit more protective about the data. Although there is a data sharing agreement in place and it's sorted, from their point of view they're still very nervous. They might have been told that I can share your data but if I sit at your house tomorrow and you say what have you done sharing my information, I've told you that in confidence. There was nervousness there in terms of that fact that while we say we've got the data sharing agreement sorted, have we communicated that across our communities to say that actually when you tell a health professional something, it might be in their best interest to share that with another party. The ones sat with the patient are the ones that get the brunt end of it.

10.7 Geography

It's important that we understand that the PCN is not growing into an INT. INT is for a community area or a particular group of inequalities but there's a wider team around that.

They are currently working geographically based on where the patient is based or where the treatment will be administered, but when working with INTs based around PCNs it brings in multiple teams from multiple geographic areas due to not being set up in the same geographical way of PCN. If INTs were to be broken down by PCNs it doesn't fit with their geographical focus which is essential for effective care delivery, regardless of GP registration.

Where services overlap footprints, they never know which team or who to call.

10.8 Further challenges

What I hope would be avoided if these are expanded was the trap we fell into, where they got too far discussing people who had been through every single service already. There was nothing anybody had missed, but there was nothing more anyone could do. We need to be discussing people a bit earlier to try and have a positive outcome for them.

If we'd done this evaluation stuff 2 years ago we would have been further on and done some different things.

Sometimes the services aren't there for them, there is a gap. Adult ADHD and autism services kept popping up as a gap.

Some partners don't recognise how much it takes to get a GP in the room and keep them in the room, let alone leading it. The NHS has shifted it's position over the last 5 years and is moving much more into population health and leaning into the council and VCSE facing space. We've done 80 years of diagnose and treat and were now in this space talking to you about this stuff.

We had the freedom to deliver and plan it, but it wasn't a structured ask, so it took some time to figure out what was actually needed and how we were going to do it. The people around the room needed to recognise that it is data gathering and speaking to people, and won't necessarily be a data change overnight, it is about hearing the story behind the data.

It is a balancing act, there is a lot going on. People are quite eager for PCNs to take charge and run things, but we can only do so much. Really lucky that we have a good, flexible team, including social prescribers and care coordinators. I don't know how other areas are made up but we don't have a lot of admin support. We're working with partners to be able to delegate things out and have boundaries so we don't end up with everything.

It was challenging on my time, I can't deny that but I felt it was important for our service to have that representation there. I have attended all strategy meetings and MDTs, another staff member went to one in Goole and another to one if Driffield, but actually their time is better spent delivering service, so I chose to go to all of them to represent us.

We can be very rigid about referral processes, trying to get people to understand that it's probably not a problem to pick up a small number of referrals without directing them through a different process or pathway.

Sharing what has worked at other INTs would help get people engaged with it.

We've been trying to get the maturity of PCNs, so they're working as a more cohesive unit, making decisions democratically, utilising their ARRS funding, sharing role so they're seeing the benefit of working in a larger system.

We have PCN mental health teams now and the idea is that they would be able to do those things.

Something we learned a lot in the pandemic was when approaching different groups use different methods. You can't just write a letter. Talk to them in different ways and find where they are in the communities.

ICB has no money so can't create funded roles to allow you to step out of your own job. The funding for this is coming out of the PCN pot, so all partners have to be happy with it. I am doing double the amount of work I'm getting paid for, there is a limit to how much I can do.

The contract and all the pressure is about access, all about appointments, so every time I take a GP out to do an MDT I lose 15 appointments, so there needs to be a return on that investment.