Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

An Implementation Guide for Proactive Care for people with complex needs in Neighbourhood Teams

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for a healthier future

Using This Toolkit

This toolkit provides Neighbourhood Teams and HCPs with guidance on the operational, clinical and Population Health Management resources that will support the development, implementation and delivery of proactive care through neighbourhood teams.

Neighbourhood Teams present a new way of delivering joined up, person centred care, embedding population health management and integrated care delivery. The priority is to establish Neighbourhood Teams (INTs) over 2026/27 that are focused on people with complex needs at higher risk of hospital admissions (people living with frailty, care home residents, housebound and people at end of life)

Practical support, for example specific SNOMED codes, templates, searches, training and development are incorporated throughout to provide INTs with the tools that will enable effective delivery.

INT Infrastructure

- Outline of Neighbourhood Health
- Roles and responsibilities in an INT
- Maturity Matrix
- Administration and coordination

Delivering care in INTs

- Identifying people for INT management
- Consenting and adding to the caseload
- Assessing needs and developing a care plan
- Supporting people with complex needs

Tools & resources

- PHM case finding resource
- Clinical templates
- Remote monitoring
- Tracking delivery and outcomes
- Shared Care Record

About Neighbourhood Health

What is Neighbourhood Health?

- Neighbourhood health is a locally integrated, multi-agency model of care, bringing together health and care providers with voluntary and charitable partners and not statutory organisations. Neighbourhood Health focusses on personalised, accessible and community-based care.

- One way Neighbourhood Teams can support people locally is through delivering coordinated and proactive care for complex patients who are at highest risk of poor outcomes. This is achieved through patient-centric care that is coordinated, making best use of local assets and services to meet the needs of an individual. This approach helps improve experience, outcomes and reduce the risk of escalation of need.

Alignment to national and local strategy and policy

- Neighbourhood Health is a core component of the NHS 10 Year Health Plan (10YHP). This supports the Government's ambitions to shift care from hospitals into community, analogue to digital and sickness to prevention. Neighbourhood Health also forms a core part of local strategies, with HWE Primary Care Strategic Delivery Plan and The Care Closer to Home Strategy outlining the core role of the INTs locally.

- The National Neighbourhood Health Implementation Programme (NNIHP) is an initiative to test and develop Neighbourhood Health working. Exemplar sites are testing new ways of working, allowing for scale and spread of best practice. Local sites selected for the programme include South West Hertfordshire and West Essex. Learning from these sites will be scaled across other areas.

Proactive care in INTs – Roles			Responsibilities
Administrative support			Running GP IT searches, supporting leadership team & MDT meetings, support to care coordinator
Care coordinator			Consents patient for inclusion in case management. Collates information for MDT discussion. Acts as a point of contact for patient and their carers as well as the INT. Escalates to named lead professional/case manager.
Case manager / named lead professional			Reviews notes and undertakes initial assessments. Holds the caseload. Acts as a point of contact for patient and their carers as well as the INT. Responds to alerts from remote monitoring/care technology and escalates to relevant specialist professionals.
ICB			Acts as the system convenor and provides framework for Neighbourhood working
Clinical/ care professional involvement	General practice	**General practitioner**	Generalist clinical input (including for assessments) and provision of continuity of care for patient and carer. Default “Named lead professional”
		Social prescriber/care navigator	Knowledge of, and signposting to, local assets / services
		Practice pharmacist/ARRS pharmacist	Prescribing specialist. Complete structured medication reviews, anticholinergic burden scores and support deprescribing
	Community provider	**Locality/Integrated Community Team**	Delivery of specialist community care and support in the patient’s home. Liaison with wider community services.
	Integrated specialist team E.g. Community frailty service, Integrated respiratory service, palliative care teams		Accept referrals from INT and provides specialty specific support and care on an as needed basis Support with remote monitoring and agreeing disease specific management plans Input into care priorities and symptom management and advance care planning
	Acute provider	Dedicated consultant out-reach (e.g. Frailty service, Geriatrician)	Specialist acute general medical input, including advice on tests and monitoring required Liaison with wider secondary care specialty teams. Coordinates specialist medical advice and rationalises care.
	Mental health provider	E.g. older age MH physician	Provide mental health specialty specific clinical advice to MDT, and mental health care in line with identified needs.
	Hospices		Rehabilitation and reablement support, advance care planning and palliative care support.
	Adult Social Care workers		Provide expertise and input into the MDT from perspective of Adult Social Care
	Home care and care home providers		Invited in on an as needed basis to inform care plan
	Voluntary sector (e.g. local VCFSE lead)		Invited on an as needed basis to provide knowledge of community assets and signpost/refer to local community services that can compliment statutory organisational interventions

Suggested core INT members are shown in bold. Each INTs to consider additional membership according to maturity and need

INT Infrastructure

Neighbourhood team working provides a range of different opportunities to support the health of their local population. A key function is the proactive management of complex cases. This function will support the local ambition to improve outcomes and experience for people with complex needs at higher risk of hospital admissions through coordinated care and case management

For INTs to effectively deliver this care the following key infrastructure need to be in place:

- A clearly defined purpose and function for proactive management of complex cases through INT (and all members of the team) is working towards
- Dedicated resource from core partners is identified (funding or staffing resource) and aligned to INT delivery
- A core INT delivery team is in place
- INT leadership team is in place
- Roles & responsibilities of staff and organisations is defined, with work planning dedicated to INT delivery
- Data sharing agreements are in place to support INT staff to gather and share information with INT partners
- Tools and resources (e.g. EPR, clinical templates, clinical codes etc) are in place to capture and record clinical information and agreed Plans. See Support tools
- Remote monitoring, if relevant, is available for patients who will benefit

Mature and independent INTs adopt an active, enquiring approach to development, learning from cases and multi-disciplinary discussions to adapt and improve the quality of proactive care offered and the maturity of the INT.

- Use of Frailty dashboard on DELPPHI
- Use of Theographs to review the delivery of care and ensure that individuals' care is coordinated and gaps in care are closed.
- Use of (and updating) the maturity matrix to understand progress towards 'mature' neighbourhood working.

Neighbourhood Maturity Matrix

Each INT will be starting from a different point, depending on the maturity of relationships and established integrated working. The aim is for INTs to deliver proactive care for complex cases at the scale that meets current capacity and adopt a culture of improvement that supports a move towards increasing maturity and independence.

For INTs to effectively deliver care the right combination of infrastructure need to be in place. The Neighbourhood Maturity Matrix provides a framework for Neighbourhood Teams to assess current infrastructure across the range of capabilities required to effectively deliver Neighbourhood Health.

The domains covered by the Maturity Matrix are:

1. Understanding our neighbourhood
    a) Defined population
    b) Team composition
    c) Estates and facilities
    d) Services and community
    e) Activity and expenditure
2. Operating model
    a) Governance
    b) Data infrastructure
    c) Population Health insights
    d) Shared priorities
3. People and behaviours
    a) Leadership
    b) Culture and behaviour
    c) Relationships

Adoption of processes, tools and resources in this toolkit support Neighbourhood Teams to deliver at ‘Mature’ or ‘Optimising’ level across a range of domains in the matrix.

Neighbourhood teams should baseline current maturity and develop a plan, in collaboration with local health and care partnerships to develop maturity, focused on key actions that will improve capabilities. This should be regularly reviewed, with reassessment against using the Maturity Matrix. Comparison with previous assessments will demonstrate progress and provide evidence for system partners.

Administration and Coordination

Delivery of Proactive care through INTs requires administrative resource to arrange and convene case reviews as part of multi-disciplinary working. Not all partners are required in case review meetings but should have the opportunity to contribute to the development of plans. Wherever possible, the case review and development of the plan should be done with the patient, alongside their carer or family member if appropriate.

The INT should consider:

- Defining membership (core + extended), roles and responsibilities and who is chairing and managing the meeting
- Having an identified core membership (see previous slide) within the neighbourhood team
- Ensuring there is a named person recording information, decisions and actions with good quality, coded data.
- The amount of time that needs to be allocated to each case discussion
- How many new cases and reviews should be discussed in a session
- Sharing documentation prior and accurately documenting and sharing notes from the case review/MDT.
- Whether all partner members need to attend in person, or if hybrid/remote sessions are suitable and increase involvement
- How each partner in the Neighbourhood team can contribute with information on the patient's and carer's needs and developing the Plan.

For all partners to engage in MDT working, teams will need to work flexibly. Not all meetings need to be multi-disciplinary, and the focus is on integrated, multi-disciplinary care. Some follow up and review may be completed by a sub-group of the core team and care can be coordinated asynchronously, through information sharing, a shared care plan and action plan, enabled by technology solutions.

INTs will need to develop and improve their processes, learning from what works within their local area, adopting a learning culture.

Hertfordshire and West Essex Integrated Care System

Integrated Neighbourhood Teams - Proactive Care Blueprint

Identify the Cohort

Use **INT Service Report** in DELPPHI to identify individuals.

Use individual Theographs to identify people suitable for INT proactive care.

Review needs of prioritised cohort, clinical validation to check will benefit from proactive care in INT.

Add to the Caseload

Contact people considered suitable for INT caseload, explain the service and gain consent.

INT Care Coordinator adds adult to the Caseload – SNOMED Code “On Integrated Care Pathway” 818241000000105, or records as declined service.

Deliver Proactive Care

Named Lead Professional

INT MDT

Care Coordinator

Shared Care Record

Continuous improvement cycle

- Iterative development of cohort and intervention
- Evaluating impact and outcomes

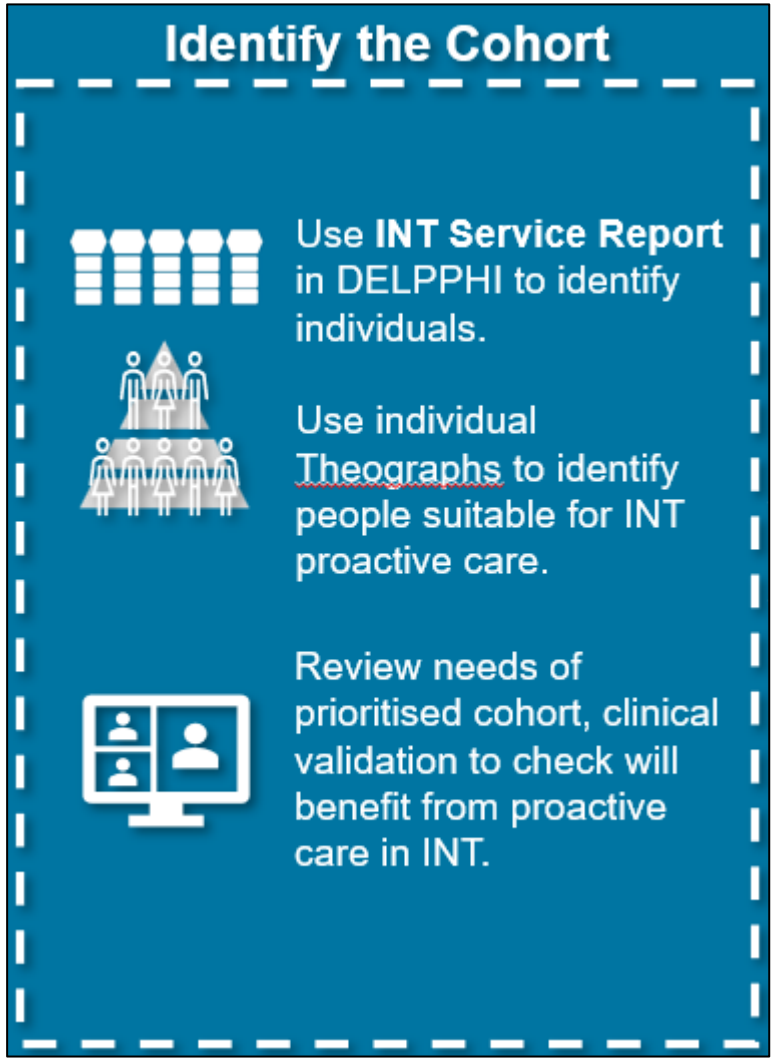
Identifying Patients

Practices should use the DELPPHI case finding tool: Health Analytics - INT Service Report to identify individuals suitable for proactive care through:

- Practice staff selecting relevant patients for inclusion should consider all information in the INT Service report, including demographic characteristics, conditions the person suffers from, use of services over the last 1-2 years, predicted risk of emergency admission and information on gaps in care. This should be used in combination with knowledge of the individual to determine suitability.

- Detailed guidance on the processes for accessing the reporting, applying filters in line with agreed Neighbourhood priorities, reviewing Theographs for potential cases, and selecting patients for proactively including on the Neighbourhood Team case load

This tool builds on previous searches used for identification to increase accuracy of identification.



Gaining Consent & Adding People to the Caseload

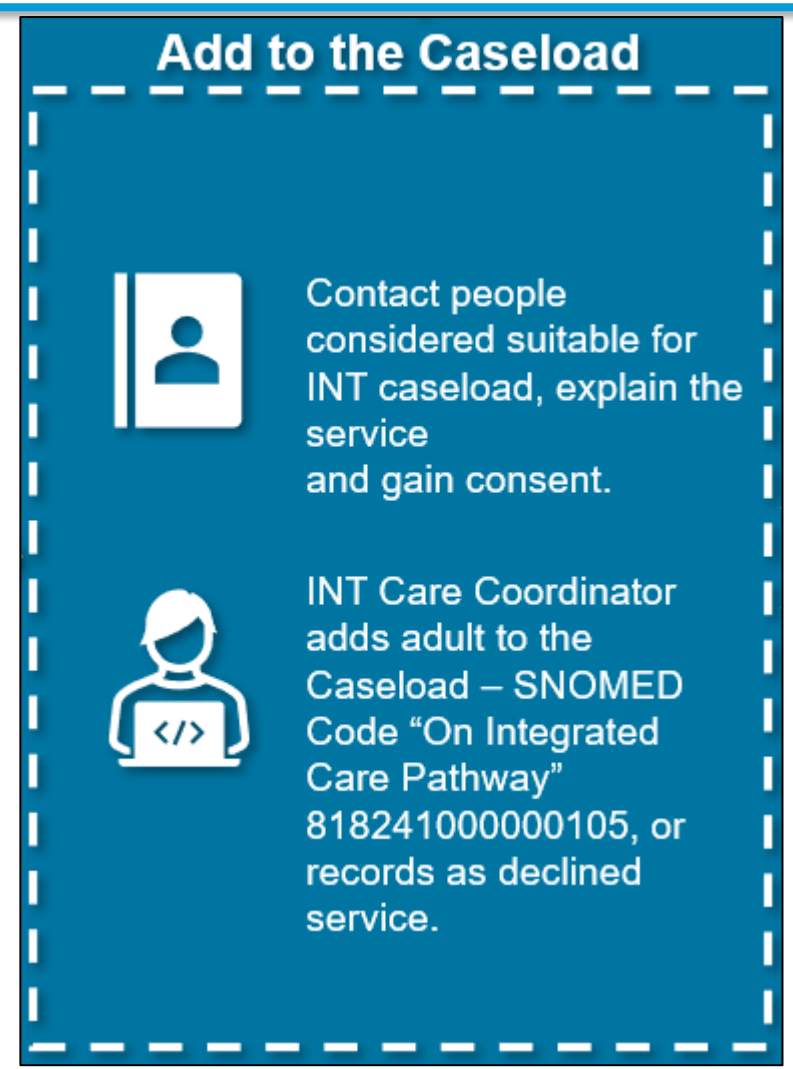
For people identified as suitable for inclusion in the Neighbourhood Team case load:

1. Proactively contact the person or their next of kin/carer

2. Explain the service and why it is being offered. Provide the patient information leaflet

3. Gain consent for inclusion in the service

4. Record the decision using the relevant SNOMED code.
   - If the patient consents, add the SNOMED code ‘On Integrated Care Pathway’ **818241000000105**
   - If the patient declines, add SNOMED code ‘Integrated care pathway declined’ **877011000000107**



Ageing well and frailty communications toolkit is actively used to inform conversations with patients.

Case Management and Care Coordination

1. Assessing and monitoring needs

Understand the individual's needs

Assess the patient's holistic (physical, mental, social and functional) needs through information gathering and conversations with the patient, their carers and others. Confirm Next of Kin (NoK).

Review current Medication and Anticholinergic burden and any Advanced Care Plan with patient.

Agree patient goals and priorities.

Summarise information for MDT discussion.

2. Multidisciplinary care and Planning

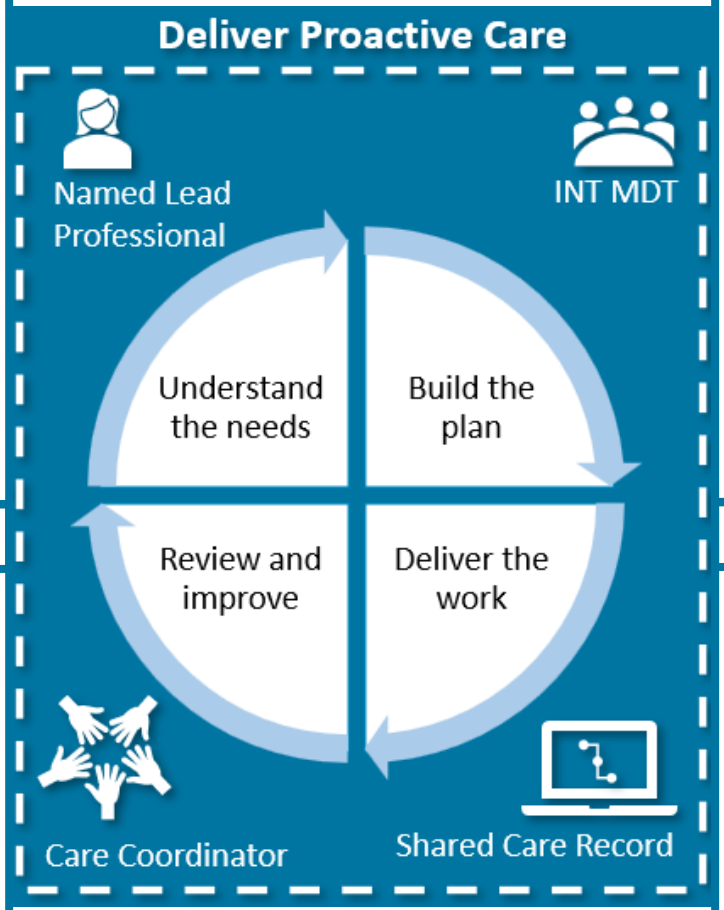
Build the plan

MDT review needs and goals and identify problem list and priorities for action.

Consolidate and rationalise care aligned to patient priorities.

Agree the most appropriate named lead professional.

Develop a joint plan with the patient, including escalation plans and actions in the event of a crisis.



3. Implement changes and coordinate care

Coordinate and streamline care, including input from specialist teams as required. Take actions to achieve goals and reduce risks.

Communicate and share the plan with relevant teams. Ensure upload to Shared Care Record (in particular ACP) with Named Lead Professional, Care Coordinator & NoK.

Respond to urgent issues as needed. Use remote monitoring where appropriate.

4. Review to improve

Continue to involve and engage the patient in the ongoing monitoring and assessment of needs.

Set a review date according to complexity alongside dynamic review as needs change.

Update individual holistic assessments and plans as they develop, particularly if urgent issues arise.

Understand Needs – Initial Assessments and Information Gathering

Assessment 'bundle' for frail and end of life cohort

Consider the following as part of the holistic assessment and review of the patient's needs. This is based on the BGS Comprehensive Geriatric Assessment toolkit. Use the SNOMED code **"Subject of Comprehensive Geriatric Assessment" 836131000000104**

- Physical health – disease specific assessment and review (e.g. heart failure, COPD, diabetes review) as part of a holistic physical assessment, vaccination status, osteoporosis/FRAX
- Mental health – mood/depression (PHQ2 or PHQ9), anxiety (GAD-2 or GAD-7), loneliness (UCLA 3-item scale), dementia/memory (6-CIT)
- Social – carer status, safeguarding, housing and home safety, smoking status and behaviour risks
- Functional – frailty status (Rockwood), falls risk assessment (FRAT), hearing, vision, nutrition and dental, gait and balance, activity of daily living
- Medication – structured review of current repeat medications and anticholinergic burden score, including indications and feedback from patient

All assessments should be recorded using relevance SNOMED codes.

Identify recent assessments completed across care settings and record results

Meet with the patient (and any relevant carers and family members) to discuss and complete holistic assessments

Collate assessments on health, social and wider needs (including carers) using clinical templates

Record information into the electronic patient record using appropriate clinical templates or codes.

Create a summary of the patient's needs and wishes for discussion at MDT. Include a problem list that has been agreed with the patient
Add the patient to an upcoming review meeting

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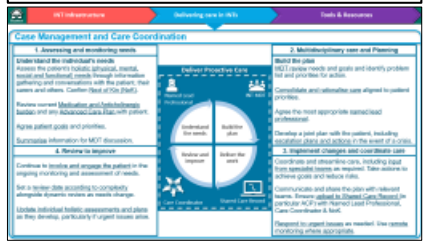

Patient defined goals

As part of the initial and ongoing support, the individual's personal goals should be identified and documented and considered at all stages of decision making, involving carers and relatives.

MDT Review and Building Agreed Plans

Multi-disciplinary review

- Complete a multi-disciplinary review of information on patient needs and medication/treatment regimen, involving the patient (and their carer or family if appropriate).
- Develop a prioritised problem list and management plan, including key risks.
- Agree the most appropriate named professional lead for the individual, based on the needs and problems.
- Complete a structured medication review, consolidating medicines and deprescribing where appropriate.
- Agree a plan for coordinating and consolidating care around the needs and wishes of the individual. Consider avoiding multiple specialist appointment.
- Consider the role of technology to support remote monitoring.
- Identify additional care, services and support the individual requires.
- Agree a plan for responding in a crisis with the individual (and their carer or family if appropriate).

Information sharing

Consent to share the agreed Plan with system partners and services directly involved in care and support.
Ensure the patient and services are aware of key contacts to communicate with, both proactive and in a crisis.

Recording MDT completion

Once the case review and action plan is completed, record using SNOMED code **"Multi-agency case management review" 1026051000000106**

Outputs

1. An agreed Care and Support Plan that includes ReSPECT or PEACE advance care plan documentation, treatment escalation plan and management plan for conditions. The Plan should include a medication regimen, care coordination plan and **sharing** of the plan with services/specialties supporting the individual's care.
2. An agreed set of actions for managing care, linked to Plan, with named leads and timelines for implementation.
3. Agreed timeline for routine reassessments and follow up review by Named lead professional +/- multi-disciplinary team.

Principles

- Patient centred care that considers the individual's holistic goals, wishes and circumstances.
- Managing multiple care touch points and coordinating care and delivering joined up care and support close to home.
- Multidisciplinary care, not always multi-disciplinary meetings.

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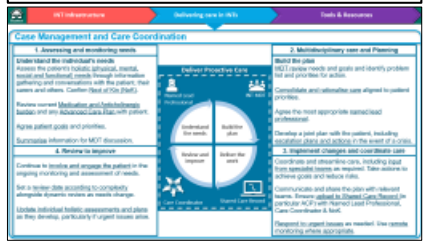

Deliver the Work - Proactively Manage Care

Ongoing case management and care coordination

Following case review, the care coordinator collates the action plan and coordinates care.

- Complete assigned actions
- Arrange any additional tests or investigations (e.g. blood tests)
- Liaise with specialists and named action owners to complete tasks, e.g. structured medication review and changes to medication regimen
- Sign post and refer to services that will support the needs and issues identified in the Plan.

Specialty and provider leads complete assigned actions as per the Plan.
Care is consolidated and rationalised, creating coordinated support around the patient. The patient avoids contacts with services that are unnecessary, duplicate care or are low value.
Medications are aligned to the Plan, avoiding overprescribing and medication related harm.

Proactive monitoring and response to crisis

Care coordinator or Care Coordination Centre

- Acts as the single point of contact for the patient or as per local arrangements (including out of hours).
- Gathers information from the patient, carers and additional information (e.g. remote monitoring) to identify signs of deterioration.
- Reviews the care plan and escalation plan.
- Where there is evidence of acute illness or deterioration, links with named lead professional to agree an action plan.
- Responds to urgent needs and care wishes, using escalation options in the community (e.g. Hospital@Home/Virtual Hospital).

INT leads from partner organisations

- Provide on the day advice on managing urgent issues, including liaising with Hospital @ Home and Virtual Hospital.
- All providers to prioritise face to face response and consideration of community response to urgent needs in line with the individual's Plan.

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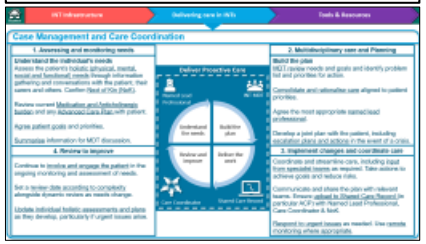

Directory of Service

Review local Directory of service to identify relevant services.

Patient education and advice on self-management

Escalation plans support patient decision making.
Patient provided information on when and how to contact the care coordinator.
Share relevant patient leaflets, information and advice.

Review and Improve the Plan

Reason for review by INT

Agreed date for review
The review date should consider the complexity of need and clinical benefit of reviewing and updating the agreed plan

Identified change in status or need, e.g. following an acute illness or urgent episode of care (e.g. a hospital admissions) or evidence of disease progression.

Reassess needs

Update relevant assessments and record patients wishes and goals
Review escalation plan and Advance decisions
Assess what is working well for the patient and what can be improved
Update the Plan and ensure sharing across partners.

Schedule for MDT discussion / case review
Arrange follow up for completion of reassessments, review in INT case discussion with updated Plan and actions (see MDT Review slide)

Consider step-down from the service/MDT
If discharged from case load record using SNOMED code **"No longer on integrated care pathway" 894581000000106**
Consider options for step down, including remote monitoring and patient initiated review, or transfer to alternative service (e.g. palliative care teams)

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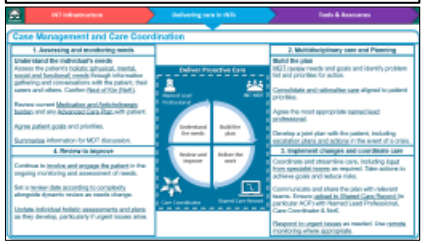

Measuring impact and outcomes

Indicator	Desired change
Increase in patient-reported outcomes (PROMs) and patient-reported measures (PREMs)	↑
Increase in people's activation (confidence, skills, knowledge) to manage their long-term conditions	↑
Improvement in staff experience	↑
Reduction in outpatient activity	↓
Reduction in unplanned hospital admissions	↓
Rate of Admission for Chronic Ambulatory Care Sensitive Conditions	↓
Total cost of emergency care	↓
Emergency admissions for LoS >0 (not frailty specific)	↓
Delay progression to frailty and EoL cohort	↑

Neighbourhood teams can use DELPPHI to track and monitor the delivery of care and outcomes for people who are managed by INTs.

Key Contacts and Resources

Place/Team	Details
Directory of Services	https://digital.nhs.uk/services/directory-of-services-dos
East and North Hertfordshire	ICB primary care support managers - hweicbenh.localities1@nhs.net HCP leads - Sabina Tai and Cathy Galione
West Essex	Sara Choudhry - sara.chaudhry2@nhs.net
South West Hertfordshire	ICB primary care locality support managers - hweicbhv.localities@nhs.net Central London Community Healthcare NHS Trust (CLCH) leads - Leanne Fishwick, Louise Ayers, Kevin Barrett - clcht.herts@nhs.net
HWE ICB PHM Team	Team Email - hweicbhv.phm@nhs.net Team website - HWE ICB PHM website

Key documents:

- Maturity Matrix (available on the ICB PHM website)
- How to guides will be available on PHM website
- 10 Year Health Plan (10YHP)
- Neighbourhood Health Guidelines 2025/26
- National Neighbourhood Health Implementation Programme (NNIHP)
- Hertfordshire and West Essex ICB Strategy
- Implementation Guide for Proactive Complex Case Management in INTs – Version 1 (2024)
- Care Closer to Home Strategy:

Clinical Templates

Clinical templates support the systematic, standardised recording of clinical information in the patient record and enable sharing of coded information between providers. It is recommended that all clinical information is recorded using templates to ensure appropriate codes are used. This ensures information is visible to general practice IT systems as well as through shared care records.

Templates below include the relevant SNOMED codes for reporting and payment through local and national contracts. It is recommended that the templates below are used for recording assessment, care delivery and management of individuals on Neighbourhood teams:

- SystmOne Ardens templates
  - **Comprehensive Geriatric Assessment**. A general template that captures information across all areas of the CGA (physical, mental, functional and social domains). Good template for recording onward referrals and signposting to services.
  - **Frailty template**. A general template specific to frailty but has good links to other templates for undertaking specific assessments and recording scores.
  - **MDT Care Coordination template**.
  - **Care team relationships**. A template for recording carer status and named leads involved in the individual's care

- EMIS Ardens template
  - **Frailty and over 75s Review template**. A general template specific to frailty but has good links to other templates for undertaking specific assessments and recording scores.

- Ardens Support website has a range of useful tools, articles and information to support general practice team with practical tips on what templates are available, how these can be accessed and used.

Role of Self-reported Measures, Remote Monitoring and Care Technology

Remote monitoring cane be used by neighbourhood teams to actively monitor individuals on caseloads. Details of providers who can support with remote monitoring can be found in Directory of Services.

Remote monitoring and self-reported measures have a role in care coordination to reduce number of face to face visits, improve productivity and identify urgent and emergency issues early. INTs should consider which measurements will support monitoring and care (e.g. clinical observations, in home readings etc), the frequency of taking readings and the level of involvement of the INT. The use of self-reported measures and remote monitoring should consider the complexity of need and potential to benefit, consider the patient's and carers wishes as well as practical considerations.

Monitoring can be patient reported, using existing systems for completing questionnaires and submitting readings. Data is incorporated directly into the patient's electronic record and readings can be reviewed by members of the INT. Patients can be proactively contacted by members of the INT. Patients should be given information and advice on when and how to contact the INT or out of hours service if readings are abnormal, supporting early identification of deterioration.

Monitoring options, depending on local availability. Note that technology is rapidly evolving and new solutions may become available.

- Clinical observations – BP, temperature, pulse, daily weights etc
- Assistive technology in someone's house looking at how often patients mobilise, turn on taps, flush the toilet etc, this can be helpful to reduce needs for a social care package and or reduce the number of calls per day. INTs can establish if these tools are available through discussion with Adult Social Care leads.
- Use of complex monitoring should involve the local specialist teams.

Data Sharing

Data sharing agreements support partners from different organisations to collaborate and work from a single set of information.

The ICS My Care Record has a range of tools to support INTs and can be used for Proactive Care MDT discussions. An example 'Information Sharing Agreement is available on the My Care Record website in the For Professionals section.

Data sharing to DELPPHI enables INTs to

- Take an insights driven approach to planning and prioritising INT activities through understand the health needs of the local population
- Identify individuals most likely to benefit from care through INTs
- Track the delivery of care and impact on patient outcomes.